AN INVESTIGATION OF THE COMMUNICATION STRATEGIES USED IN PROMOTING MATERNAL HEALTH AMONG WOMEN IN KAWANGWARE, NAIROBI COUNTY

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DECLARA TION

This research is my original work and has not been presented for a degree or any other award in any other university.

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SUPERVISOR

I confirm that this research project has been written under my guidance and supervision.

……. Date: ……

Dr. Ndeti Ndati

DEDICATION

This research is dedicated to my Parents, Prof Kodero and Mrs Kodero. To all my siblings; Dan, Ben, Emma, and Beatrice Kodero for the support and care that you have given me words cannot describe. Through patience and love they provided has seen me go through it. I appreciate and love you all.

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ABSTRACT

The purpose of this research was to investigate the communication strategies used in promoting maternal health among women in Kawangware, Nairobi County. The specific objectives of the study were; to identify the communication channels being used in providing awareness on maternal healthcare in Kawangware slum, to examine the impacts of communication strategies on maternal health care in Kawangware and to identify ways of enhancing communication among women of reproductive age on maternal health. The study anchored on the Health Belief Theory and Theory of Reasoned Action. The study used mixed methods research approach. Questionnaires and interviews were used to collect data. Simple random sampling was used to pick the sample for quantitative data. Quantitative data was analyzed using descriptive statistics. Qualitative data was analysed thematically and presented thematically in narrative. Findings indicate that communication strategists have the ability to influence the public health institution to train the community health workers how well to communicate since it's the best mode of communication across all age groups, followed by television. Findings also revealed that there are various tools of communication used. The effectiveness of such tools depends on how the recipients of the information comprehend and responds to it, whether positively or negatively. The research recommends that healthcare workers ought to have regular training and capacity building in order to equip them with relevant up to date information that they would relay to the women during clinic visits and other forums of interaction. It also recommends that healthcare workers ought to do more preemptive programmes on health communication and education, not just when there is need like during disease outbreaks. The study therefore recommends that more emphasis should be laid on strengthening the healthcare workers' communication skills and on updating their knowledge on maternal and child healthcare since this was identified as the most effective mode of communication on maternal and child healthcare.

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LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
HBM	Health Belief Model
KDHS	Kenya Demographic health survey
TBA	Traditional birth attendant
WHO	World health organization

CHAPTER ONE

INTRODUCTION

Overview

This chapter looks into the background of the study, statement of the problem, study objectives, research questions, scope and limitation of the study and operational definition of terms.

1.1Background of the study

One of the most vital elements for improved customer satisfaction, compliance and health outcome in the provision of health care is effective communication between providers and clients. When patients understand the nature of their sickness and its diagnosis, and they have the perception that their wellbeing is a great concern to the health provider, express a lot of satisfaction with the treatment and care they receive and there is a great likelihood they will comply with the prescriptions. The subject of effective communication has not been always emphasized in medical training despite the widespread acknowledge of its importance (Negri *et al*, 2016).

The past 30 years have seen quite a substantial investment being made towards improving access to basic health care services in the third world. There is however quite few studies investigating on the quality of services offered, and even few that look into the quality of communication. According the quality of care research that has been carried out, health counseling and provider-client communication are consistently poor across countries, regions and health services. Provider fails to communicate effectively even when they know the messages to communicate due to lack of good communication skills. Health workers most of the time don't know how to communicate with their patients. Communication plays a major role in achievement

of health objectives. Scholars offer suggestion that there happens a relationship between communication and the success of health center or an organization (Elizabeth, 2016).

Maternal health is critical to human existence therefore it needs a lot of support and care. According to the world health organization (WHO), maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. The lifetime risk of a woman dying during pregnancy and childbirth is 1 to 3,300 in Europe, compared to 1 to 40 in Africa. The World Health Organization further states that the most dangerous place to give birth is Africa. Quality care before and after childbirth is identified as one of the five essential things needed to save women‘s lives (WHO, 2015).

In recent years, global leaders have made significant international commitments to strategies on women’s health. The Millennium Development Goal number 5 aims to reduce maternal mortality and improve maternal health. Though the communication strategies plans are to generate knowledge and commitment in place to save the lives of mothers and children, but targets have failed to be met. Long-term conditions disable women who survive delivery-related complications. These include fistula, chronic pelvic pain, depression, and exhaustion. Fistula is especially common in Kenya, primarily due to the frequency of adolescent pregnancy combined with neglected prolonged labor (Edward, 2005).

In Africa, one woman loses her life during childbirth. About half of these deaths happen in Sub-Saharan Africa. Regardless of the progress made in creating awareness in most countries in making maternal healthcare more available, the majority of women across Sub-Sahara Africa remain without full access to this care. A variety of

obstacle exists in these countries. These obstacles include; upgraded maternal health and insufficient data that hinder ministries from effectively implementing the communication strategies (APPP, 2010).

Death of women during childbirth remains an unresolved challenge in Kenya despite global and national efforts and initiatives to enhance and promote women's health. According to United Nations report, Kenya is rated the 10th most dangerous state for expectant women. This report highlights the trends and patterns of maternal deaths from year 1990 to the year 2013. A total of 32,021 women of reproductive age were reported to have died out of which 6,632 died of pregnancy-related causes in Kenya. Out of the 47 counties 15 counties were responsible for 98.7% of the total national maternal deaths provoking the need for public sensitization. However, the number of deaths masks various considerations such as the size of women population in the region as well as the frequency of pregnancies and other important consideration.

The proportion of births in the slums such as Kawangware that are conducted in a health facility is higher than those done in rural areas or Kenya as a whole but considerably lower the proportion in Nairobi or other urban areas in the country (KDHS, 2008/9). Although half of the deliveries in the slum are done in the health center, three-quarters of those done in Nairobi as whole take place in a health facility. Births at health center have a higher likelihood of being conducted by a medical practitioner while those that are done at home are likely to be conducted by traditional birth attendant, a family member or any other unskilled person. Overall, 54% of births are delivered by a medical personnel (doctor, nurse or midwife), 25% by a traditional birth attendant (TBA), 15% by a relative or other unskilled persons, while 5% were delivered without any assistance (KDHS, 2008/2009).

There is higher medical delivery assistance in the slums as compared to the rural areas or even Kenya as a whole but relatively lower compared to Nairobi or other urban centers. TBA delivery assistance is specifically high in the slums in comparison to other urban settlements. TBA only assists only 6% of the births in Nairobi, yet one in every four deliveries in the slum is delivered by TBA (KDHS, 2008).

In order to promote the adoption of health communication strategies and practices, the Ministry of Health designed the Reproductive Health Communication Strategy Implementation Guide that is used by all 47 counties in Kenya (RHCS, 2010). Reproductive health strategy analysis aims to promote the quantities of knowledge of national policy makers on the social-economic importance of reproductive health and allocating enough resources to cater for needs of maternal health of Kenyans. The Strategy on reproductive health communication also purposes to promote awareness and knowledge levels on reproductive issues affecting them and available services with the agenda to increase the percentage of persons within the productive age bracket exploiting existing modes of communication (RHCS, 2010).

This increased insight and awareness is important in ending delays while seeking health care services and in getting to the health facility. It is mandatory to empower communities and individuals so that they can not only recognize pregnancy related risks, but also to have the ability to respond and effectively once such challenge come up (SOCHARA, 2015).

1.2 Statement of the problem

Communication results to extended dialogue which gives patients the gut to disclose critical information on their health issues and providers to come up with more accurate diagnoses. Health care education and counseling are enhanced by good

communication leading to more appropriate treatment regimens and better compliance. When a health center has effective communication it benefits the dispensary or health center as a whole by making it known to the community of their great services (Negri *et al*,. 2016). An effective health communication strategy is essential, because it equips the public with the tools and knowledge to respond appropriately to health crises that may occur from time to time leading to maternal and child morbidity and mortality. For the benefit of people with marginal literacy skills, applicable health information should be provided at their level of understanding.

In spite of the past efforts and gains registered in maternal and child mortality programs, essential health services have not reached the grass-roots, as can be observed in Kawangware. Maternal and child mortality indicators show a slight decrease countrywide but in Kawangware, maternal and child morbidity and mortality are still high. This is probably made worse by the prevalence of violence against women, harmful traditional practices like early marriage and community attitudes towards such serious problems (Hassan et al, 2014).

There is strong evidence of positive health outcome in developing countries as a result of effective communication. Provider-caretaker communication is to be thanked for the patient satisfaction, compliance with therapeutics and appointment keeping, recall of information, as well as improvement in physiological markers such as blood pressure levels and blood glucose levels and functional status measures. Therefore, experience in the first world has shown evidently that providers can enhance communication skills, resulting to better outcomes. However, effective

communication does not always naturally occur, but it is easily and gradually acquired (WHO, 2015).

Communication strategies are used in promoting maternal health in Kawangware slums even though the Ministry of Health has established sufficient infrastructure like health posts. Gilroy and Winch (2006) observed that most health workers seem to lack skills to effectively communicate with the target community.

This study sought to investigate communication strategies used by health care providers in Kawangware in order to establish an effective way to create awareness about maternal health.

1.3 Study Objectives

1.3.1 General Objective

The main objective of this study was to investigate the various communication strategies being used in creating awareness among women and reducing maternal morbidity and mortality in Kawangware.

1.3.2. Specific Objectives

The specific objectives of the study included;

a) To identify the communication channels being used in promoting awareness about maternal healthcare in Kawangware, Nairobi.
b) To examine the impacts of communication strategies on maternal health care in Kawangware, Nairobi.
c) To identify ways of enhancing communication among women of reproductive age on maternal health.

1.4. Research Questions

The study was informed by the following research questions;

a) What are the communication strategies being used in promoting awareness on maternal healthcare in Kawangware slum?
b) What are the effects of communication strategies on maternal health care in Kawangware?
c) What ways can you identify to be put in place to enhance a communication among women of reproductive age on maternal health?

1.5 Rationale of the study

Maternal health information is one of the most important messages that need to be accessed to all women of reproductive age. The health of the mother and the child is very critical to the society since it creates another generation. Maternal death is not only a problem in Kenya but it's a global problem. International organizations such as World health organization (WHO), Planned Parenthood, intra health, care, Mama among others are working to foresee that there is better care on maternal and reproductive care.

In general, women need to be reminded and told the importance of seeking medical attention while they are pregnant or planning to be pregnant. New information is being released every day about maternal health and how to take care of signs and symptoms of any upcoming diseases. They can know the information when they go to healthcare providers.

1.6 Significance of the study

The findings of the study are worth to the health care providers to understand the importance of communicating effectively to women of reproductive age. It will also facilitate an increase in knowledge to women on the best mode of communication and how it can affect their health.

The study will also assist policy makers and other stakeholders on finding better ways of raising awareness on maternal health care.

1.7 Scope and limitation of the study

The study sample population was derived from women of reproductive age that attended Riruta dispensary and Nyina wa Mumbi dispensary in Kawangware slums. The study focused on women attending maternal health matters.

The study was limited to investigate the communication strategies used in two healthcare providers considering a large number of healthcare providers.

1.8 Operational definition of terms

ANC Clinics: Antenatal Care Clinics are specialized clinics that run specifically for expectant women during their pregnancy and puerperium, which is the six-week period after delivery.

Health communication: In this study, this refers to the use of different modes of communication and communication strategies to inform and influence individual and community decisions that enhance maternal and child healthcare.

Maternal health: This will refer to the health of women during pregnancy, childbirth and puerperium (the postpartum period).

Health awareness: This refers to the process of enabling people, including healthcare providers and consumers, to increase control over, and to improve, their health beyond a focus on individual behavior and towards a wide range of social and environmental interventions.

Infant mortality rate: In this study, this denoted a measure of the yearly rate of deaths in children less than one year old.

Maternal mortality rate: In this study it refers to the number of deaths of women arising during pregnancy, due to pregnancy-related complication or from puerperal causes during one year per number of live births during the same period of time.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

The chapter discusses literature review which has helped in achieving equality and participation in the society today. Communication Strategies used the different modes of communication and the people who need to be trained to use it on the ground.

2.1 Introduction

Development communication can be categorized into different fields of study such as health, education and agricultural. The topic under study falls under health communication. This section reviewed different studies in the development communication. Waisbord (2001) discusses that the aim of development communication is to achieve equality and participation in societies. With a lot of theories and concepts that have emerged during the past fifty years, many studies have offered different solutions to the problem of underdevelopment which are lack of information and power inequality.

As a result of the gap in the status of mother's wellbeing between developed and developing countries, maternal health has prevailed as one global priority. UN (2008) describes maternal health as the health of women during pregnancy, childbirth and the postpartum period. Giving birth is positive and fulfilling experience in first countries where women have better access to basic health provision. Women in third world countries on the other hand associate it with suffering, ill health and even death.

On a global outlook, the rising attention for maternal health has been majorly focused on reducing maternal mortality. The danger of not preventing these avoidable or treatable deaths is to blame for 536,000 maternal deaths globally in 2005 (WHO,

2006). 99% (533,000) of these deaths were in developing countries with 89 percent of them being in Sub-Saharan and Southern Asia (UN, 2008). This in other term is to say that in every minute of each year a woman dies from complications of pregnancy, abortion attempts and childbirth (UNFPA, 2004). The millions of women who survive later suffer from illness and disability related to pregnancy and childbirths. Estimates by the Safe Motherhood Initiative (SMI) indicate that 30 to 50 morbidities occur for each maternal death (Shiffman, 2003).

Several international health summit and conferences have adopted maternal health improvement and maternal mortality reduction as their major agenda. The international conference on safe motherhood held in 1987 and continued through International Conference on Population Development (ICPD) 1994 and again through ICPD+5 (five-year review of the 1994 ICPD) and the Millennium Development Goals have been the genesis of these global discussions. A declaration calling for a reduction in maternal mortality at least by half by the year 2000 was resolved at the end of the first conference. Goals for reducing maternal mortality to one half of the 1990 levels by 2000 and a further one-half reduction by 2015 were set by the ICPD (UNFPA, 2004). A call for a 75 percent reduction by 2015 in the mortality ratio from 1990 levels was made by the Millennium Summit in 2000 (UN, 2008).

However, with the approaching deadline, these ambitions had not been achieved yet, the world is not even close to achieving this objective, and it's not even sure that global maternal mortality levels had declined in the past decade to any significant degree (Shiffman, 2003). Three crucial factors underlying maternal deaths have been summarized by World health organization. Lack of access and utilization of essential obstetric services has been the first factor. Mortality rates and maternal health care

have a negative association. According to WHO, if all women would have access to effective reproductive health care services then 88 to 98 percent of all pregnancy related deaths are avoidable (Shiffman, 2003).The low social status of women in developing countries is the second factor. It can limit their access to economic resources and basic education, the end impact is that they have limited ability to make decisions, including a decision related to their health and nutrition. Thirdly, too much physical work together with poor diet also contributes to poor maternal health outcomes.

One of the most vital factors towards reducing the incidence of maternal mortality is utilization of maternal care. The following are United Nations report on maternal health care from developing countries: Approximately 74 percent of women in 2005 received at least one antenatal care (UN, 2008); 40 percent of deliveries take place in health facilities (UNFPA, 2004); nearly 61 percent of births in 2006 received assistance from skilled health personnel (UN, 2008). According to data, government commitment to maternal health care has not reached the levels required to make strong impact on mortality rates. Most of the current interventions have been realized to be ineffective in preventing maternal deaths. There have been legal and structural impediments on health care policies in many countries (mostly in specific areas such as sexuality education and access of adolescents to reproductive health information and services).

The quality of care that a mother receives during pregnancy, at the time of delivery and soon after delivery is important for the survival and wellbeing of both the mother and her child (KHDS 2008-09). Although KDHS reports shows a continuing increase in the proportion of women who make four or more antenatal visits from 52 percent in

2003 to 58 % in 2014, only 43% of women were informed of signs of pregnancy complications during an ANC visit (KHDS 2014) .

On average, 488 women in every 100,000 die each year due to complications related to childbirth according to the same 2008-09 KDHS report. One of the key reasons for this is that about half of pregnant women deliver without the help of trained health personnel and as highlighted earlier few attend antenatal clinics where pregnancy complications could be identified. Government and private sector efforts to reduce MMR have borne little success. During the last general election campaigns, Jubilee Coalition promised to give free maternal health care if they assumed power and true to their words they introduced policy on free maternity services in all public health facilities .All this towards achieving millennium development goals on reduction of child mortality and improving maternal health.

2.2 Communication Strategies Used

Communication is basically the process of transferring of information from one part to the other, or the impartial or interchange of thoughts, opinions, or information by writing, speech, or signs. It can also be said to be the process where information is encoded in a package and channeled and imparted by sender to a receiver via a medium of communication (Joseph, 2010).

Health communication as defined by Parvanta (2011) is the use of communication strategies to inform and influence individual and community decisions that enhance health, and it plays an integral part in maternal and child health practice and promotion (Parvanta, 2011). According to Muhiuddin Haider (2005) effective communication is essential for every health promotion and disease prevention project. The promotion of good health often requires changes in perceptions, attitudes,

behaviours and practices among target population (Haider 2005). Choice of health communication tools is key in effective message delivery. As discussed by Parker (2009) there is an ecological model of social determinants of health, and hence the various factors under each level determine the different choices of health communication tools. Such tools include websites and music videos at the social (macro) level, billboards at the community (meso) level, text messaging, brochures and pamphlets at interpersonal (micro) level, lastly medical records at an individual and population levels. The different levels interact with each other and the net result is a health outcome, whether desired or not (Parker, 2009).

According to Schiavo (2007), health communication as further quoted by Clancy in Krisberg, (2004) is the main currency of healthcare in the 21st century. When information is readily available, relevant, reliable and is culturally appropriate it makes it possible for the general public, patients, public health professionals, health care providers, and others in effectively addressing personal and public health concerns that it used to be in the past (U.S. Department of Health and Human Services, 2001). According to Centre for Disease Control and Prevention (CDC), health communication is the study and application of communication strategies to enlighten and inspire individual and community resolves that promote health‖ (2001; U.S. Department of Health and Human Services, 2005). Public health communicators mostly embark on attempting to persuade their audience to take up a specific belief or pursue a particular course of action (Yudell, 2012). The ethical defensibility of persuasion appears to be assumed to a larger extent by public health practitioners; a handful of academic treatments have however called into question the defensibility of persuasive risk and health communication (Yudell, 2012).

There has been a many record of successful use of health communication by non-profits organisations, the commercial sector, and others to further grow public, corporate, or product-related goals in relation to health. As evident to many authors, numerous disciplines contribute in one way or the other to health communication, marketing, anthropology, psychology and sociology (Bernhardt, 2004; Institute of Medicine, 2003; World Health Organization, 2003). It counts on various communication activities or action areas, which include interpersonal communication, public advocacy, professional communication, public relations and community mobilization. However, communication provides a long-term solution through creating understanding between players in the health sector and the public. Communication therefore is integrated into maternal and child health to provide a multifaceted and multidisciplinary approach to reach different audience and share maternal and child health related information, with the goal of influencing community health professionals and policy makers to achieve the desired child health care outcome, through encouraging behavior modification and social change (Schiavo, 2007; Parker 2009).

Strategy involves agreeing to the activities of community or organization to the environment in which it operates, so that there is a 'strategic fit' in where there is an attempt to identify the chances in the environment in which the community works (Osama, 2006)

Communication strategy is defined as the selection of appropriate communication objectives and the identification of the specific brand awareness and brand attitude strategy (Bronn, 2001). According to Fraser Seitel (1987) communication strategies are tools used to disseminate information. In health communication they include;

newsletters, television, meetings, letters, flyers and posters. Devising the right communication strategy is about choices of message, content and the media channel. Engaging the pregnant women and families as the center of communication has become crucial as it holds the key to the success of the community. Hence, communication strategy provides a link between women of reproductive age and communications planning and delivery of the health care provider.

When communication strategies are working well all information received from healthcare providers is relevant to the whole community. That means reputation of the health facility remains strong. The goals and the outcomes of communication should be well defined, measurable and help guide a defined plan of action. Audiences and key decision makers or individuals with influence on the issue should be identified. The messages that are to be developed should be specific, persuasive, reflect audience values and include a solution or course of action. Message carriers should be trained in key messages to ensure consistency in delivery (Coffman, 2004).

In Malawi, research indicates that mass media exposure to family planning messages and exposure to advertising that promotes the use of condoms have significant positive effect on the use of modern contraceptives (Cohen, 2000). Women who learn about family planning from the Radio Doctor program have a higher likelihood of using modern contraceptives than others (Lawrence, 2000).

Studies carried out in Nepal on exposure to messages in mass media showed an indirect effect on contraceptives use by increasing interpersonal communication and advocating positive attitudes change on social norms regarding family planning (Storey, 1999). On a similar note, in Tanzania women exposure to a mass media campaign were found to resulted to more positive attitudes towards family planning

and more likely to discuss such issues with their partners than those who were not exposed (Jato, 1999). In Mali, exposure to a campaign was linked to an increase in favorable attitudes toward contraception and a decline in the proportion of men and women who believed that Islam opposes family planning (Kane, 1998).

2.3.1 Interpersonal Communication

A research by Cameron and McCollum (1993) found that pregnant women preferred direct interpersonal communication over mediated communication when obtaining information. Pregnant women prefer to receive information from healthcare providers on one to one basis. These meetings also bring experts to immediately answer questions. Two way communications is also recommended because it allows feedback as soon as the question is asked making the expectant mother to be or not fulfilled with the answers given (Gruning, 1984).

One characteristic of Interpersonal mode is active negotiation of meaning among individuals. There is active monitoring and observation among participants to see how their meaning and intentions being communicated. Clarification and adjustment can be done accordingly. There is thus a higher chance of ultimately achieving the objective of successful communication in this manner than in the other two ways. Reading and writing can help in realizing both the interpersonal dimensions and dimensions. For example, exchange of personal letters or electronic mail messages (National Standards in Foreign Language Education Project, 2006).

2.3.2 Interpretive Mode

The cultural interpretation of meaning that is appropriate and taking place in the written and spoken form when there is no alternative to the active negotiation of meaning with the source of the communication is the focus of this interpretive mode.

An example of “one way” reading or listening is the cultural interpretation of text message.

In this case, the interpretive mode does not leave room for active discussion between the reader and the writer or the listener and the speaker, a much more profound knowledge of culture is required from the beginning. One’s chance of creating the appropriate interpretation of a written or spoken text is determined by ones knowledge and exposure of the other language and culture. It is important to note that cultural literacy and capacity to read or listen for the hidden meaning are developed and gained over time and through massive exposure to the language and the people’s culture.

2.3.3 Presentational Mode

This is the designing of a message in manner which facilitates interpretation by members of a different culture where no room for active negotiation of meaning between members of the other culture and no opportunity for active negotiation of meaning.

A guide for choosing the channels team will utilize to pass the message to the intended recipient will be guided by channels and tools. Focus being on identifying and assessing potential resources that could be vital in assisting you conduct a communication program. According to health communicators, communication channel id broadly a delivery system for messages. Piotrow & Kincaid (2001) categorizes health communication channels as follows:

Interpersonal channels: has a focus on either one-to-one or one-to-group communication. Interpersonal channels use verbal and nonverbal communication.

Community-oriented channels focus on spreading information through existing social networks, such as a family or a community group. This channel is effective when dealing with community norms and offers the opportunity for audience members to reinforce one another's behavior.

Mass-media channels reach large audiences. They are particularly effective at agenda setting and contributing to the establishment of new social norms. Formats range from educational to entertainment and advertising, and include television, radio, and print media, such as magazines, newspapers, outdoor and transit boards, the Internet, and direct mail (p. 26). However, selecting the appropriate channels and integrating them might be essential, but designing effective message is the underscoring issue.

2.4 Healthcare service provider

Communication between patients and service provider is said to have an impact on future application of maternal services (Lawson et al, 2003). Patient satisfaction on quality of the services is changed by issues like privacy, confidentiality as well as sensitivity of the staff. It is said to be reflected on the willingness to return for the same services in the forthcoming pregnancy. In Tanzania, a study associated poor communication by the health providers during antenatal attendance to prevailing low hospital delivery (Magoma et al, 2010). Similarly, others associated maternal delays in using maternal services with previous negative experiences with the health staff interaction (Sarker at el, 2010, Lawson et al, 2003). Likewise, discourtesy by health workers and disrespect for local cultural values causes resentment among clients.

2.4.1 Health Facility Factors

Unavailability of maternal services especially in rural communities are said to adversely contribute to delay in accessing emergency services. Lack of proper

transport system, poor road infrastructure and lack of communication network in most of developing countries negatively impact on maternal health (Lawson et al, 2003). Distance to reach a static health facility in Kawangware is estimated to be over 10 km though most of the rural population travels longer distances to access health facility (Bousery et al, 2009). These coupled with poor road infrastructure; poor communication network, lack of referral system and inadequate community mobilization, worsen the situation.

2.4.2 Quality of the services

Quality of care can be perceived from different stand point– provider, clients or even administrators perspective. In the client point of view, quality of service can be seen in respect to time taken to offer the services, privacy, cleanliness as well as availability of medical supplies and equipment's (Sheikh, 2010, Sarker et al, 2010). Patients will not use services unless they see their own needs are catered for and convinced that an effective remedy is available within the health facility (Witter et al, 2003). Quality service in relation to the client perception is to make services cost-effective by meeting women health needs in appropriate ways and this reflects in the future use of the services (Lawson et al, 2003).

Quality of the service provided is also said to improve staff ethics as properly trained staff with the right resources needed is more likely to facilitate positive attitude towards the clients (Lawson et al, 2003). Similarly, good quality of the service is associated with timely use of the maternal services by the community (Sarker et al, 2010). Quality of the service provided will have a profound effect on acceptability and uptake of the service. Dissatisfaction of the health services offered in northeastern

are stated in some studies as contributory factor in low service utilization (Boursery et al, 2009 and Ganga-Limando et al 2006).

2.4.3 Gender based factors

Globally, women are disadvantaged compared to men in not only health issues but many other developmental aspects. Cultural practices are as varied as there are ethnic groups in Africa. Though some cultural practices promote both prenatal and maternal health, many of the practices are exceedingly damaging and intolerant against the health of the women (Lawson et al, 2003). Formal education which is one of the proven interventions that contributes to better outcome of maternal health is very low for many African women. Related to this is economic empowerment and ownership of properties which marginalize many women that is also linked with cultural practices (Lawson et al, 2003).

Women in North Eastern Province equally encounter considerable problems that stem from cultural practices which make them more vulnerable than men (Sheikh, 2010). They have less access to general health care including reproductive health, education - both formal and informal as well proper health information (Ganga-Limando et al 2006).

2.4.4 Influence of Traditional birth attendants

Many African countries previously encouraged the Traditional Birth Attendant (TBA) to conduct deliveries after undergoing training (WHO, 2005). In Nairobi Slums, most mothers trust the traditional birth attendant over health facilities during deliveries, with more than 24.7% of women giving birth with the help of traditional birth attendants as opposed to 5.9% for the rest of Nairobi County (Magadi, 2008). However, there are strong indications that most mothers understand and embrace the

importance of antenatal and immunization services (Sheikh, 2010). Some argue that the design of existing lower facilities were not catering for the need of the mothers as maternal services were unavailable because of many factors including the basic in design of health facilities and lack of the necessary equipment (Ganga-Limando et al 2006). Presently, this seems changing as the ministry of health encourages all government health facilities to provide free maternity services to all pregnant women.

2.5 Effects of Communication Strategies

The most commonly used mode of communication in spreading health information in developing world is mass media (Kistiana, 2009). The electronic and media take lead. Access to mass media communication platforms greatly impact health care uptake. Women that have exposure to information on health services are in a better position to benefit from these health services hence mass media has promoted exposure leading to utilization of health related behaviors such as maternal health services (Kistiana, 2009). These informed women most likely will tend to initiate early maternal services, regularize schedule of visits and search prompt suitable medication like interconnection care, birth control and together with proper feeding(Walford et al,. 2011).

According to SIAGA Campaign on Maternal and Neonatal Communication Knowledge of Danger signs and birth preparedness in West Java, Indonesia, better informed decision concerning bleeding as a sign of danger as well as increased birth preparedness as a sign of anger as well as increased birth preparedness and antenatal behaviors is achieved through the channels of mass communication (Sood *et al.*, 2009).Valante and Saba (1998) on a study of interpersonal and mass media influence in a reproductive health communication campaign illustrates that mass media has a

huge impact of accelerating social change. While in Indonesia, Kistiana (2009) found that there was a strong connection between women's exposure to media and maternal uptake and other maternal services.

Knowledge of resource availability is identified as the cause being nonattendance ofmaternal health clinics while studying by Mugweni (2009) while studying prenatal health promotional needs of immigrant women in Winnipeg. Women who were studied expressed the urge to increase their awareness of maternal health services.This awareness can be met through the media hence the need for a comprehensive health public awareness campaign using the mass media which in turn would helpincrease the uptake of maternal services (Simkhada *et al.,* 2006). It is an important responsibility for the media to provide information that gives energy to action and are an alternative source people rely on for health information about new health risks, disease outbreak and healthy living. The media both print and electronic is also recognized in the WHO (2005) as to play a vital role in shaping public opinion and driving actions to raise their awareness about promotion of maternal and child health care. The media has also been endowed as powerful mechanism to promote the awareness and education of public issues and can probably influence decisions of government and policy makers on health policies and medical care (Evans & Ulasevich, 2005). Therefore, mass media plays a pivotal role in informing the public on health and medical issues (Thorson, 2006).

The media therefore has the power to create an information environment where development is stimulated (WHO, 2005). As Agudosi (2007) upholds, engaging in a mass media campaign which is believed, will reach the target audience and change behavior is one major way of promoting health care. Explaining the above one can

state that the mass media a element of the global strategy for sustainable health development through sharing of adequate information and education of topics of great concerns to the human. Therefore, the mass media can continue to play a pivotal role of change agent in promoting awareness about the significance of making use of maternal health services like antenatal care therefore decrease maternal mortality.

There has been other documentation of communication campaigns promoting family planning in other countries in the region (Rogers, 1999). Since behavior change theories show discussions offer come before bahaviour change, assessing the effects of mass media programs on discussion of family planning between two people in a relationship as a step towards embracing contraceptive method is important.

Various studies have shown it evident that individuals' exposure to mass media messages promoting family planning may affect behavior towards contraceptives (Kincaid, 2000).In Nigeria for example, the use of modern contraceptives, the intention to use them and the desire for a small family were established to be associated with exposure to mass media messages about family planning (Bankole, 1996).In Malawi, research show that mass media exposure to family planning messages and advertising that promote condom use can have a great positive effect on use of modern contraceptives (Cohen, 2000). Research has further indicted that women who get informed about family planning from Radio Doctor Program are more prone to using modern contraceptives (Lawrence, 2000).

According to Rogers (1999), there has been documentation of the significant effects of communication campaigns promoting family planning. This is because behavior change theories indicate that discussion often precedes behavioral change, in assessing the influence of mass media programs on discussion of family planning

between partners as a move toward accepting and embracing of contraceptive method is vital. In Nepal, it is evident from various studies that female contraceptive users are more prone than nonusers to either perceive or actually know that their husband approves of family planning, showing the significant impact of spousal communications and approval on contraceptives behavoiurs (Stash, 1996), yet 55 percent of married women in 1999 reported that they had never had a discussion on family planning with their husband (Pradhan, 1997).

Mass media campaigns have been confirmed to be effective at different stages in the process of altering reproductive behaviours, this is according to several empirical studies. A research study carried out in Nepal indicate that exposure to messages in mass media had an indirect impact of contraceptive use by increasing interpersonal communication and encouraging positive change in attitudes and perceived social norms regarding family planning (Storey, 1999). On a similar note, women who are exposed to a mass media campaign in Tanzania were found to have developed more positive attitudes toward family planning and were more open to discussions around family planning issues with their partners than those who were not exposed (Jato, 1999).

Exposure to a campaign in Mali was linked to a growing positive attitude towards contraception and a reducing in the number of people who believed that Islam is against family planning (Kane, 1998).

Key results of grandmother-involvement by The Grandmother Project (an American non-profit NGO) revealed that all over Asia and Africa, grandmothers have has significant influence on all matters pertaining women and children's well-being and other household members' perception and practice on this. Despite some of their

practices being harmful, on the overall, they have very positive experience, motivation and commitment to caring for women and children. Most of the grandmothers inclusive of the illiterate ones have the capacity to learn new things when pedagogical approach used is based on respect and dialogue. They have an open mind towards combining "new" practices with "old" ones, even when it entails abandoning certain traditions..

The Stanford project consequently expanded to a 5-year intervention. Similar demonstration projects in the United States were implemented in Minnesota (Loken et al,. 1990), and Pawtucket, New England (Flora et al,. 1989), both supported by the National Institutes of Health. Parallel projects in other countries have been hailed for holding significant promise for the development of models for community-level interventions (Bracht, 1990) and social marketing-style health promotion campaigns (Andreasen, 1995), the most noted being in North Karelia, Finland (Puskaet al,. 1985). One of the main components of these interventions has been the emphasis on the development of networks and social-support systems in the community. This approach expanded the social-marketing perspective (e.g., Solomon, 1989), which traditionally did not include such a component (Rogers &Storey, 1987).

2.6 Barriers of Effectiveness of Communication Strategies

A Country might have the best communication strategies but if they ignore the barriers to effective communication their efforts might be unsuccessful. According to Kumar (1993), communication barriers interrupt communication reducing the potentialities of messages which influences the audience reaction to communication. Barriers to effective communication can be physical, cultural and psychological. These barriers cloud the perceptions of the supposed receivers of any communication.

Physical barriers –Physical barrier is the environmental and natural condition that acts as a barrier in communication in sending message from sender to receiver. Organizational environment or interior workspace design problems, technological problems and noise are the parts of physical barriers

Cultural and psychological barriers – are within the receiver of the message. This is related to a person's ego, beliefs and values. People form their frame of reference from the part of the receiver beliefs and values of the group they belong to, if its family, job and society. A new experience is referred to the stored experience for interpretation. A message that challenges these beliefs and values may be rejected, distorted or misinterpreted.

Psychological barriers – can also be presented through empathy or a common area of experience. Schramm puts it as the ability of an individual to project them in the role of another. It is deep understanding of other people, identifying with their thought, feeling their pain, sharing their joy. Empathy is directly proportional to extend of communication effectiveness. To increase the effectiveness of communication the source must try to encode the message in a way that the receiver understands so that the receiver can properly decode the message.

2.7 Theoretical Framework

The study used two theories to explain the behavioral patterns of slum dwellers and how they use different communication tools to get information on maternal healthcare.

2.7.1 Health Belief Theory

The Health Belief Model (HBM) by Hochbaum (1958) is one of the most commonly used theories in health education and promotion, particularly preventive healthcare

behaviors. The Health Belief Model (Strecher and Rosenstock, 1997) was first aimed at explaining why people failed to take part in programs that could not help in diagnosing a disease they have (National Cancer Institute and National Institutes of Health, 2002).

A researcher stated the major assumption of this model is that so as to harmful procedures, intended audiences need to be fully informed of their risks for severe diseases and perceive that the benefit of behavior change is far more than the potential hindrances or other negative elements of recommended actions. This is one of the most ancient theories designed to provide explanation of the process of change in relation to health behavior. It has also been the inspiration for many other influences and models in the area of health education (Mercy, 2015)

Changing the perception of susceptibility in order so as to move toward behavior change has been one of the goals of the HBM (Burke, 2010). A person's perception directly speaks directly to the knowledge and beliefs that a person has about his behaviors and the results they could have. The context of the HBM is about perceived susceptibility looks into the individual's perception on how likely the behaviors they partake in are going to result to a negative health outcome (Burke, 2010). For instance, a mother who does not go to the antenatal clinic to get immunization which can prevent diseases is known to prevent children from developing illnesses.

In the HBM, perceived severity addresses how serious the diseases that a person is susceptible to can be (Burke, 2010). In the case of a mother not taking her children for immunization, some of these illnesses like Polio can cause serious disability in children for life. A mother may not understand how difficult it can be to bring up a child with disability and who is recurrently. The HBM seeks to increase awareness of

how serious the outcomes of behaviors can be in order increase the quality of one‘s life.

While Individual Perceptions were internalized, in the Health Belief Model, modifying factors step outside the body to examine and use outside influences to affect the how threatened a person feels by the outcomes of continuing the same behaviors that put him at risk (Burke, 2010). Susceptibility as stated before displayed how someone acknowledged that their behavior could lead to a specific disease. Threat takes the idea one step further by examining just how likely it is that the disease could be developed (Burke, 2010).

To use Polio again, a mother who did not take her children for immunization may feel threatened by potential disease because they have not been doing it and if they start; their children may be spared of disease. On the other hand, a mother whose child was not immunized and consequently developed Polio may feel very threatened by Polio and will have all her subsequent children immunized. Environmental factors can add to the threat of disease. Demographic background can cause one to be more at risk such as race, ethnicity, and socioeconomic status. Someone living in poverty would be more threatened by a disease if they could not afford health care. Also peers and other influential people can have an influence. If an entire community does not immunize their children, then it may be difficult for one mother or family to start. Lastly cues to action are reasons why an individual realizes he could be threatened by serious disease or complications. These could be media, healthcare practitioners or concerned loved ones. Cues to action are anything that triggers a decision to change behavior (Mercy, 2015)

With full awareness of the likelihood of developing illness for failing to change behavior, it is vital to evaluate the benefits and the hindrances to taking initiative and determining if it is worth it. The goal in HBM is greater quality for an individual both mentally and physically. Health would be increased clearly by the benefit to change but there still could exist other factors at an individual level (Burke, 2010).

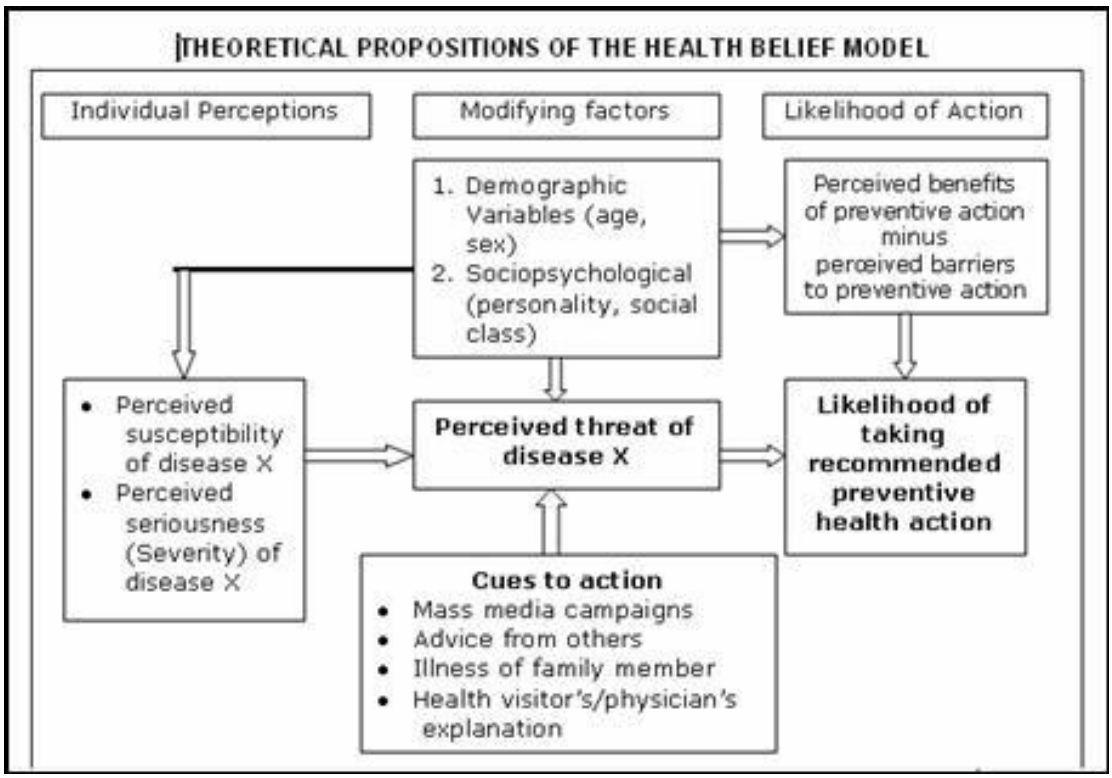
In maternal and child healthcare, benefits would be increased demand of family planning methods and better child spacing, hospital deliveries under skilled personnel, early management of pregnancy related diseases and complications, exclusive breastfeeding for the first six months of life, increased immunization rates of children etc. What are the reasons that one cannot change their behavior? Barriers could be anything from losing friends to not having enough money or even self-efficacy problems such as not believing in one self. For change to take place the benefits must be stronger than the barriers (Burke, 2010).

Burke (2010) concludes the HBM by stating that it is a simultaneous process used to encourage healthy behavior among individuals who put themselves at risk of developing negative health outcomes. "A person must evaluate their perceptions of susceptibility and severity of developing a disease. Then it is necessary to feel threatened by these perceptions. Environmental factors can contribute as well as cues to action such as television ads or caring relatives. Lastly the benefits to change must be weighed against the barriers to change behavior in order to determine that taking action will be worthwhile."

The theory will help the women who have negative attitude towards health facilities concerning antenatal care, giving birth and postnatal care to go to hospitals. This behavior will help them avoid individuals who put them at risk of developing negative

health outcomes. The women will be encouraged to evaluate their perceptions of susceptibility and severity of developing a disease. Then will be advised on the necessity of not to put their life in danger by having perceptions instead of reality. Environmental factors, that contributes to cues of action such as television, radio advertisement or caring relatives would be explained and clarified to them with a health care provider as to why not to follow the advises. Lastly the study will show the benefits to as to why they need to change behavior in order to give birth to healthy babies without complication

Figure 2.1 Health belief model



2.7.2 Theory of reasoned action

According to the theory of reasoned action, one's behavior is guided by their intention to be involved in the behavior (Ajzen, 1980). A person's behavior is predetermined by its behavioral aim to achieve it. This is by itself determined by the attitude of the

person and his/her subjective norms towards that behavior. Fishbein and Ajzen (1975, p. 302) define the subjective norms as "the person's perception that most people who are important to him think he should or should not perform the behavior in question" (Fishbein and Ajzen 1975, p.302).

TRA through focusing on attitudes and norms provides a framework for identifying and measuring the underlying cause for an individual's intention to behave a certain manner. The term the Theory of Reasoned Action is because of its emphasis on comprehending these reasons and it is not because of beliefs and attitude themselves are necessarily reasonable or correct (Nicole, 2007).

The components which construct theory of reasoned action are Behavioral Intentions (BI), Attitudes (A), and Subjective Norms (SN). The theory suggests that a person's behavioural intentions will be depending on his attitudes and Subjective norms. That is BI = A+SN.

The founders of this theory invented a simple formula, that is

BI = (AB) W1 + (SN) W2

In which

BI = behavioral intention

(AB) = One's attitude toward performing the behaviour

W = empirically derived weights

SN = one's subjective norm related to performing the behavior

The theory of planned action was used to help explain why information given by the health provider is going to change the behavior of the women visiting maternal clinics. Information that aim at attitudes, perceived norms and control in making change have a better result at changing the women action. The theory of planned

action seeks to explain rational behavior over which people have complete control. Furthermore, pursues to explain the choice behaviors, goals and outcomes, which are not entirely under the control of the person.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Overview

This chapter discusses the study site, study design, the sampling procedures, study population, sampling procedure, sampling size, data collection method, data analysis and ethical considerations that were observed.

3.1 The Study Site

The study was carried out in Kawangware slums of Nairobi County. Kawangware is a slum in Kenya located about 15 kilometers west of the city Centre of Nairobi. It is between Lavington Estate and Dagoretti. It is Kenya's second largest slum after Kibera, and the fourth largest in Africa with a population of over 350,102 people (Kenya 2009 census data) located in an area of 16sq.km. It is one of the fastest growing and poorest slums in the city (Eunice, 2013). Kawangware sub-location was purposively selected due to convenience.

According to Bonface (2011) there is constant growth in population in Kawangware making it appropriate place as a study site since the population. The women, who are in need of maternal health, are 54.3% of the population. The area is well covered with health facilities, 16 City Council, numerous private clinics, Community Based Organizations (CBO) and Faith Based clinics (Gichana, 2013).

3.2 Research Design

Research design is the plan, blueprint for the collection, measurement and analysis of data in research (Labaree, 2009). The importance of this study was to understand the effectiveness of communication between health care providers and clients.

3.3 Research Approach

This study used mixed-methods approach. This approach focuses on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies (Creswell, 2009). Its central premise is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone. The mixed methods approach complements each methodology so as to ensure validity and reliability of data collected (Campbell et al; 1999). The design also allowed for collection of data through guided questionnaires and interviews with key informants.

3.4 Study Population

This study targeted all women of reproductive age who are between 15-49years visiting Riruta dispensary and Nyina wa Mumbi dispensary in Kawangware slums. The two dispensaries were picked since they are the two largest and busiest in Kawangware slum and they have service providers such as doctors, nurses and clinical officers. Policy makers and officials in the ministry of health were also targeted (Gichana, 2013)

The study population was of 12,720 women of reproductive age found in Kawangware slum (KNBS, 2013).

3.5 Sample Size and Sampling Procedures

3.5.1 Sample Size

The sample that is chosen for a particular study is a subset of the entire population and it should be representative of the targeted population. It was calculated using Fischer et al (1991) formula as follows:

$N=z^2pq/d^2$

Where N= the desired sample size

z= the standard normal deviation which is 1.96 at 95% confidence interval

p= proportion of, women of reproductive age in Kawangware slums who prefer to go to health center is 54 % (Magadi, 2008)

q=1-p the proportion of women that have knowledge on maternal health.

d= the degree of accuracy desired set at 5%

Therefore;

$N= (1.96)^2(0.54\times0.25)/0.05^2 =210$

3.5.2 Sampling Procedures

According to Chakraborty (2009), sampling is the process of selecting units from a population of interest so that by studying the sample we may fairly generalize our results back to the population from which they were chosen.

Using the fishers formula 210 women were randomly picked to be a sample size of women who attended the maternal health matters such as like immunization, ANC Antenatal, PNC (Postnatal care) and FP (family planning) opposed to other sickness not related to maternal and child health.

Simple random sampling was used based on the large numbers of women coming in at the same time and depending on workers who were on shift. The researcher had to use the hospital list to randomly pick women who she gave to fill the questionnaire.

The researcher grouped the population into four strata based on maternal health matters immunization, ANC (Antenatal care), PNC (Postnatal care) and FP (family planning). From each of the strata, 50 women were selected to participate in the study. The remaining 10 were selected the same way to get the opinion of policy makers and officials. Stratified random sampling procedure was used because the technique

produces estimates of overall population parameters with great accuracy (Shuttleworth, 2009).

3.6 Data collection methods

3.6.1 Qualitative Data

Qualitative data was collected through Key Informant Interviews. Interviews were conducted with all the key informants to document their views on communication strategy that they use in creating awareness on maternal health in there county. Interview guides (attached as appendix II) were used to collect qualitative data from the key respondents comprising of the healthcare providers and the county health ministry official to document their opinions on adoption.

3.6.2 Quantitative Data

The survey method was used collect quantitative data using a structured questionnaire. The questionnaires had both close and open-ended questions targeting women on maternal and child health clinic visits. The research instrument of the study was to guide the question being asked during interview. The questionnaire (attached as appendix 1) contained linker scale, closed-ended question and also a few open ended questions. These types of questions were accompanied by a list of possible alternatives from which respondents are required to select the answer that best describes their situation. According to Sproul (2008), a self-administered questionnaire is the only way to elicit self-report on people's opinion, attitudes, beliefs and values.

3.7 Data analysis and presentation

Data analysis is the whole process after data collection and ends at the point of interpretation and processing data (Kothari, 2004). In analysing quantitative data from

all questionnaires were coded and analyzed using basic descriptive and inferential statistical methods and techniques (Frankfort-Nachmias & Nachmias, 2000). The researcher assigned numerical values to the questionnaire item responses which were done by developing a codebook for questionnaires. Data entry involved the process of keying the data into the Statistical Package for the Social Sciences (SPSS) software which was used to transform data into graphs, figures, bars and pie charts which represented respondent age brackets, educational level and gender.

Qualitative data was analyzed using content analysis and presented in narrative form. Both quantitative and qualitative data were compiled to generate the final finding of the research. The data was organized according to the key subjects emerging from the literature and the findings of the analysis were based on the objectives of the study.

3.8 Ethical Considerations

The research was conducted in accordance with ethical guidelines of research. Study objectives were explained to the participants by the researcher who also provided them with a written consent form that was translated into both English and Swahili. The women of reproductive age were informed that the information they gave would be confidential and they were allowed to withdraw at any stage in case they felt so. Results obtained from the study were treated with utmost confidentiality.

The researcher got a Certificate of Fieldwork that gave her the right to go and collect data attached as (Appendix 3), the University did a plagiarism test to approve that the work done is original attached as (Appendix 4) and after the correcting of the document the researcher got the Certificate of correction to show she had finished to do all correction that were there attached as (Appendix 5)

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Overview

This section presents the findings of this research, based on the data collected. It was guided by the four objectives that the researcher was seeking to study. Presentation of this research was done based on the key findings from the in-depth interviews, and the key informant's interviews.

4.1 Response Rate

The research was conducted on sample size of 210 respondents out of which 200 respondents completed and returned the questionnaires duly filled making a response rate of 95%.

Table 4.1 Response Rate

	Frequency	**Percentage distribution**
Returned	200	95
Not returned	10	5
Total	**210**	**100**

Source: Researcher, 2017

This response rate was considered representative enough to give results at the set confidence level as according to Nachmias and Nachmias (2005) a response return rate of more than 75% is enough for the study to continue. Table 4.1 shows the response rates.

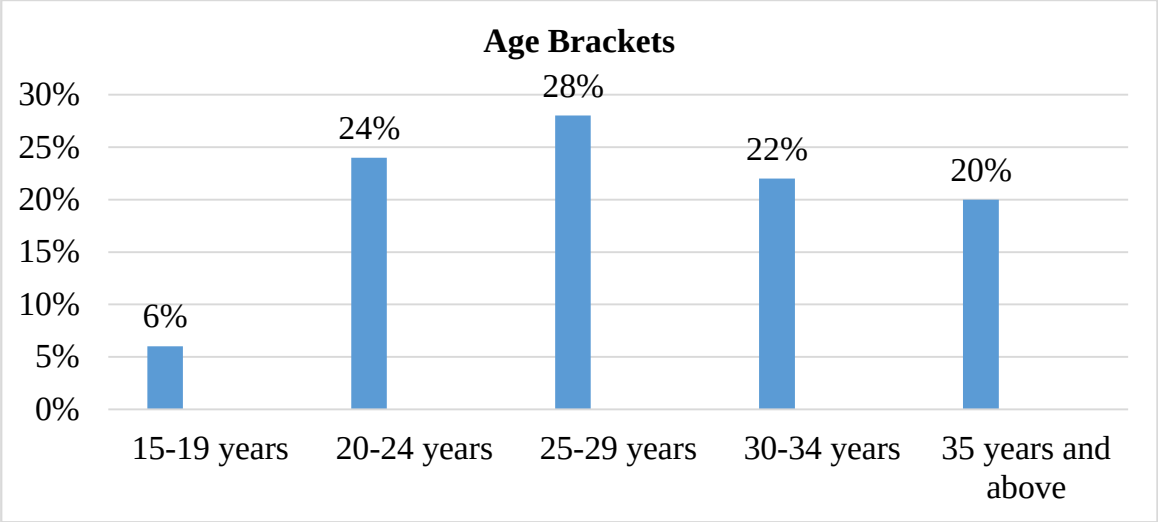
4.2 Background of the Respondents

In demographic aspects of the respondents, various issues were put into consideration in order to understand the respondents appropriately. Among the issues discussed in this section were age, marital status, education level and number of children. The background information points at the respondents and their suitability in answering the questions. The researcher found out that according to the literature written by Navaneethan and Dharmalingam (2002) that well-informed women are in a better position to receive healthcare services since they are able to comprehend the message taught.

4.2.1. Distribution of the Respondents by Age

The respondents were asked to state their age brackets. The figure 4.1 shows the age of various respondents.

Figure 4.1 Showing Age Brackets of the Respondents



Source: Researcher, 2017

From 4.1 indicates that majority of the respondents fell between the ages of 25-29, representing 28 percent of the study population. According to Reproductive health survey Kenya most women fall under the age 15- 24, the figures were relatively

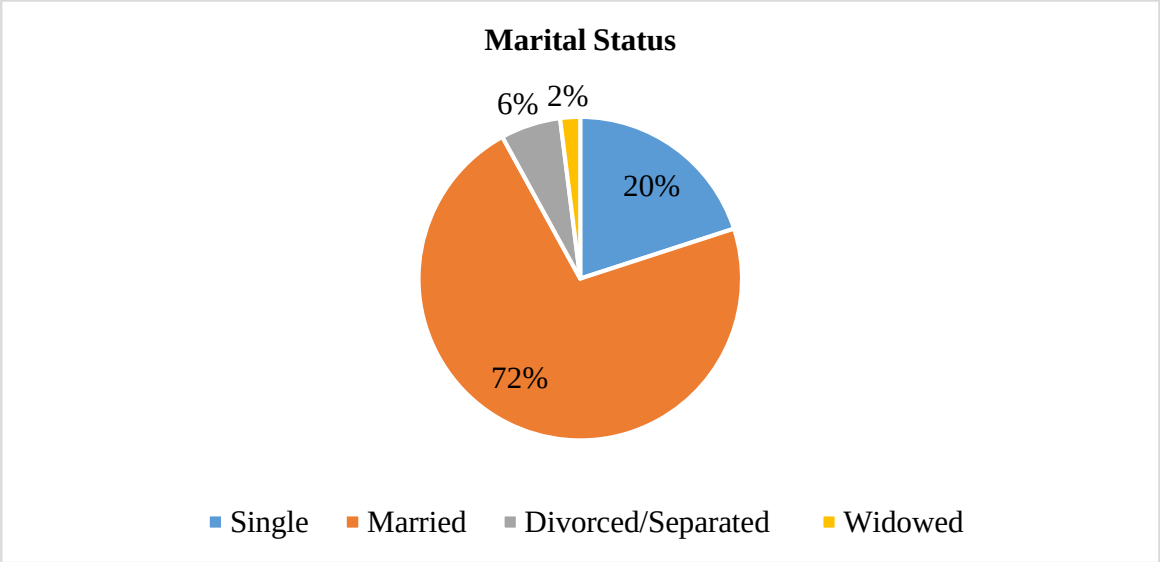
higher compared to the national average of 19.6 percent of women in the same age bracket (KDHS 2014). This was followed by women within the age cohorts of 20-24 at 24 percent and 30-34 at 22 percent respectively. Those above 35 years of age were represented by 20 percent while ages between 15 and 19 years were represented by 6 percent. From the study, almost 60 percent of the women of reproductive age are between the ages of 25-39 years, a slight difference from the data in the KDHS (2014) where majority of women are at 15-39 years.

According to Cameron and McCollum (1993) in literature review shows that pregnant women preferred direct interpersonal communication over mediated communication when obtaining information. Therefore the finding from the field was that Community health workers were preferred as the best mode of communication across all age groups, followed by television. Women aged between 25 and 29 years and above showed higher preference levels for community health workers as opposed to other modes of communication. The least preferred method for this group was posters where none of the respondents aged 29 and above seemed to prefer primarily using posters to get information.

4.2.2 Distribution of the Respondents by Marital Status

The respondents were requested to indicate their marital status. The findings are as presented in figure 4.2

Figure 4.2. Respondent's marital status



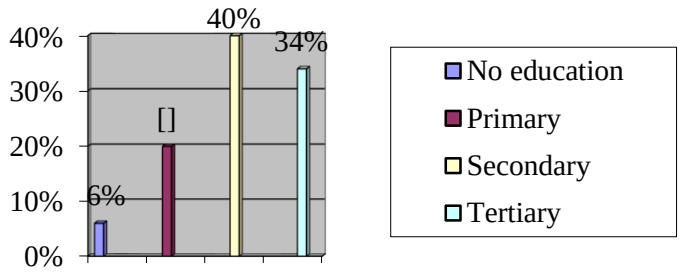
Source: Researcher 2017

Figure 4.2 indicates 72 percent of the respondents were married. Those who are single were 20 percent while divorced or separated were represented by 6 percent while the rest 2 percent were widowed. This implies that majority of the respondents were married.

The researcher sought to establish whether marital status of women seeking maternal health services had an impact on their source of information. Married women and single women predominantly depended on health workers for maternal health information while widowed women depended solely on friends and relatives. Divorced women did not depend on friends for information at all, instead preferring health workers, neighbors and relatives equally. The above pie chart reveals this significant finding that economic empowerment of many women is also linked with cultural practices those men can influence women decisions (Lawson et al, 2003).

4.2.3 Distribution of the Respondents Education

Figure 4.3. Respondent's Education Levels



Source: Researcher, 2017

The findings revealed that most of the respondents had attained secondary school education from the data analyzed. The tertiary education included having undergone a vocational training in a college or university. It is only 20 percent who had just attained a primary school education while it was only 6 percent who had not attained any form of education. This depicts that majority of the respondents had secondary school level education. This is evident by the economic activities they are engaged in. National statistics are in keeping with these findings, where 42.7 percent of women of reproductive age have attained at least a secondary education (KDHS 2014).

From the Health ministry in Nairobi County, the Nursing Officer in-charge had this to say on the women's literacy levels:

> "Majority of the women who visit the clinics have attained a minimum of primary education. The class 8 drop-outs are very many, more than secondary level educated mothers. Poverty is the worst challenge in ensuring that women advance in education. When they complete their schooling, they are married off. Others are not even able to complete their education. They even conceive before reaching the age of 18. This affects the number of women having attained secondary level of education and beyond." (Nursing Officer Number 1, 2017)

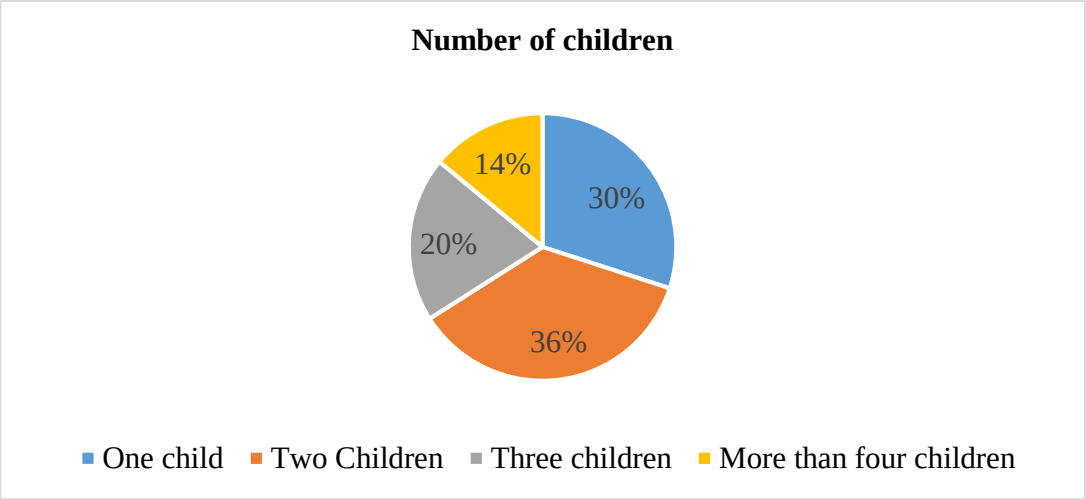
According to Yudell (2012) where he stated that public health communicator often attempt to persuade their audience to adopt a particular action especially if they are

educated. Most respondents preferred to be given health information by community health workers. Hence, revealing interpersonal mode of communication as the most preferred. When television was used to pass health information, it was preferred by women who had a college education, followed by those with secondary. The finding shows that the women with primary or no education did not prefer television because they could not clearly interpret and comprehend the information being delivered in a few minutes.

4.2.4 Significance of child bearing

The respondents were asked to state whether they have any children or not. If they had, they were supposed to indicate the number.

Figure 4.4 showing number of children per woman



Source: Researcher, 2017

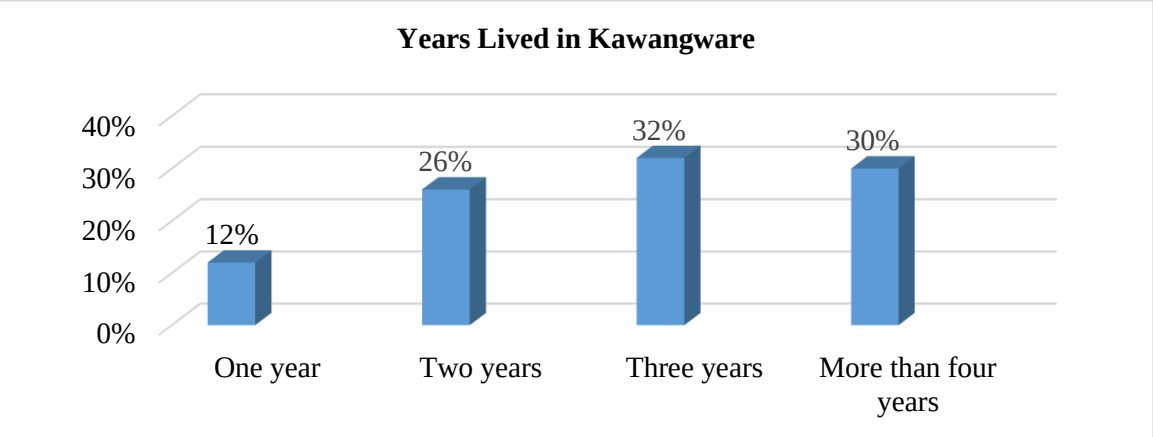
Most of the respondents, 66 percent had between 1-2 children. Those who had 3 children were represented by 20 percent while those who had more than four children were 14 percent of the respondents. From the study, total fertility rate was 1-2, compared to 3.9 as the national average (KDHS 2014).

The finding supported the theory of Reasoned Action where an individual's behavior is determined by their intention to engage in the behavior (Ajzen, 1980). According to this theory, a person's behavior is determined by its behavioral aim to accomplish it. The figure also helped the researcher to come up with a finding that the more the children the less the information the women needed since they had already learnt with from their previous babies.

4.2.5 Years lived in Kawangware

The respondents were asked to indicate the number of years they have lived in Kawangware. This was to guide the researcher on the objective One; to identify the communication strategies being used to promote awareness about the maternal health in Kawangware. The results were as shown in Figure 4.5

Figure 4.5 Years lived in Kawangware



Source: Researcher, 2017

It shows that 32 percent of the respondents have been living in Kawangware, for the last 3 years while 30 percent had lived in Kawangware for over 4 years. A larger number had stayed in Kawangware more than three years. This indicates that most of women were aware of the communication strategies that were being used for the last five years in Kawangware. The study further indicated that 26 percent of the

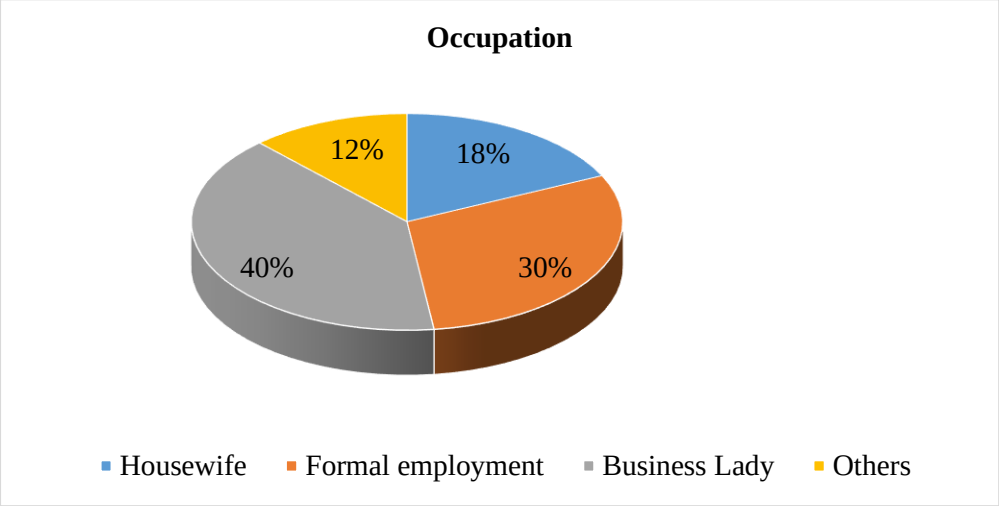
respondent had lived in the area for two years and the remaining 12 percent indicated that they have lived in Kawangware for a year.

The research agrees with Sheikh (2010) when mothers come to understand and embrace the importance of antenatal and immunization services they don't hesitate to return. Therefore, only a few may not have much knowledge on the strategies being used.

4.2.6 Respondent Occupation

The respondents were requested to indicate their occupation. The findings are as presented in figure 4.6

Figure 4.6 Respondent Occupation



Source: Researcher, 2017

Majority of the respondents, 40 percent, are business ladies followed by 30 percent who are in formal employment. The study further showed that 18% of the respondents were housewives and the remaining 12 percent had occupation in other areas such as Juakali and doing laundry/cleaning for other people to earn a living. The study showed that majority of the respondents was not in formal employment.

Hence, this helped the researcher understand the challenges they faced while seeking for maternal health information. It was noted that the women who were in self-employment and formal employment had no time to inquire more information or wait for clarification, since they had to go back to their business or work.

4.3 Knowledge on maternal health

4.3.1 Maternal health services Known by the Respondents

The study sought to determine various maternal health services the respondents know and they cited as follows.

Table 4.2 Maternal health services Known by the Respondents

Services	Frequency	Percentage distribution
Immunization	32	16
Family Planning	48	24
Antenatal	92	46
Postnatal	28	14
Total	200	100

Source: Researcher, 2017

The study indicated that immunization is one of the medical services sought in the clinics according to 16 percent of the respondents, 24 percent indicated family planning, 48 cited antenatal and 14 percent indicated postnatal.

These findings explain the responses earlier in the study where the women of reproductive age responded positively to whether they knew about aspects maternal

and child healthcare like family planning, antenatal care, immunizations, hospital deliveries and exclusive breastfeeding. Health Belief Model identifies with the change perceptions of susceptibility in order to move towards behavior change (Burke, 2010). Consequently, Individual Perceptions speak directly to the knowledge and beliefs that a person has about his behaviors and the outcomes they could have. Within the context of the HBM, perceived susceptibility examines the individual‘s opinions about how likely the behaviors they partake in are going to lead to a negative health outcome (Burke, 2010).

These are the four (table 4.2 above) aspects of maternal and child healthcare that formed the scope of this study in assessing the role of communication in maternal and child healthcare. Communicating these aspects to the women equips them with knowledge on them in order to make decisions that ultimately affect their healthcare outcomes (WHO 2011).

4.3.2 Source of information on the importance of attending the clinic

Table 4.3 Source of information on the importance of attending the clinic

Source of information	**Frequency**	**Percentage**
Community-health worker	72	36
Neighbor	28	14
Relatives	20	10
Friends	80	40
Total	**200**	**100**

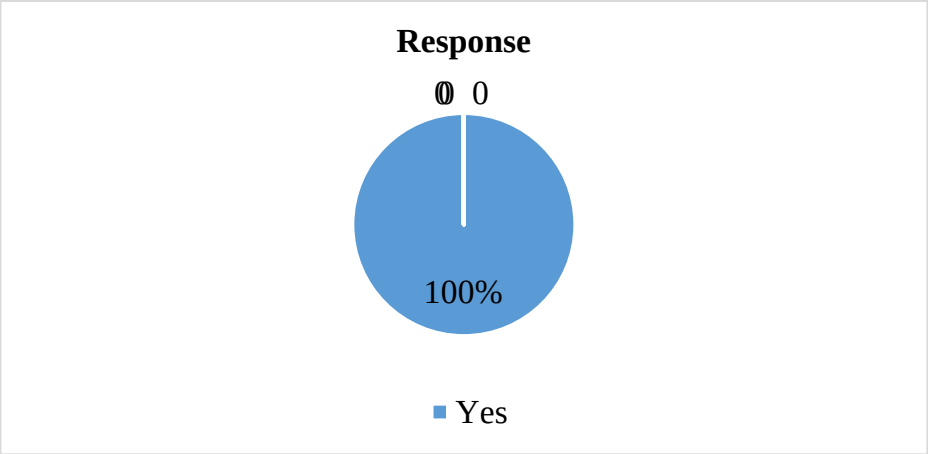
Source: Researcher, 2017

The results showed that majority of the respondents, 40 percent, learnt on the importance of visiting the clinic from their friends followed by community health worker as reported by 36 percent of the respondents. Other sources of information on

the importance of visiting the clinics were neighbors as represented by 14 percent and 10 percent respectively. The findings show that community health workers and friends formed the major sources of information on the importance of visiting the clinics.

Correlating mode of communication with future visits showed that communication of health messages had a positive impact on the likelihood of future visits. However, most women still preferred to be communicated to through health workers and to an extent, television, as opposed to flyers and posters. Those communicated to through health workers and televisions were more likely to visit a health facility in future compared to those who got information through other modes.

Figure 4.7 Intention to visit the clinic again in future



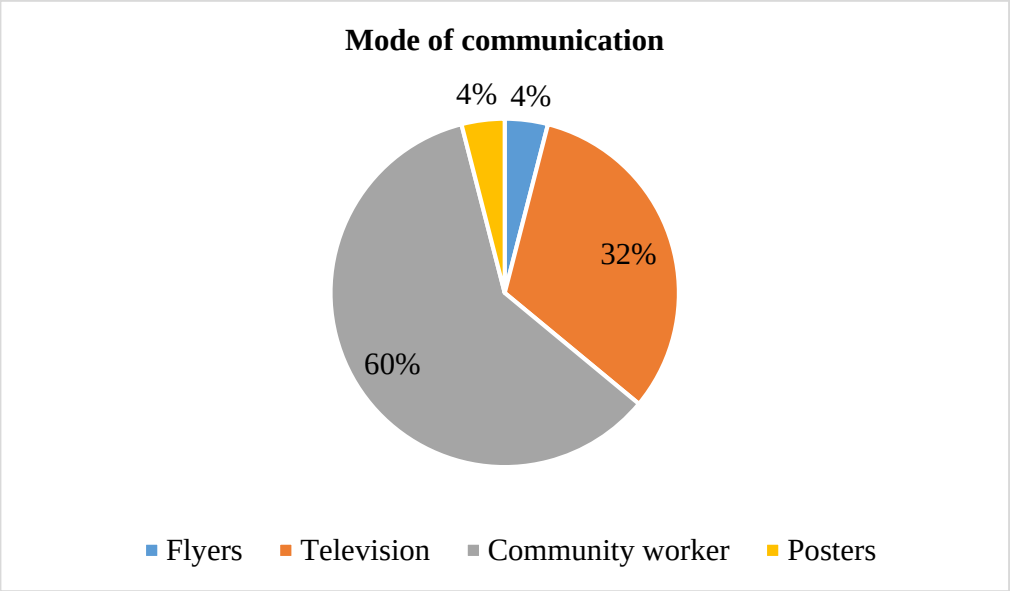
Source: Researcher, 2017

All the respondents indicated that they intended to visit the clinic again in future. Bousery (2009) indicates that the distance to reach health facility would determine if women will be able to come back to the health services. The findings show that most mothers, young women have known the importance of maternal health thus were ready to go back to the clinics to get more information. It is being recommended that

the information should be packaged in a grasping way that the women would understand better the importance on maternal health and seek to encourage the new mothers to go to hospital or clinic to be checked even with poor road infrastructure, lack of referral system and inadequate community mobilization.

4.4 Modes of communication used by the health care

Figure 4.8 Modes of communication used by the health care



Source: Research, 2017

The major mode of communication as cited by 60 percent of the respondents is the community health worker followed by television at 32 percent. Other modes include posters as depicted by 4 percent of the respondents and flyers as reported by 18% of the respondents.

Women who visited hospital or clinic more than four times got health messages through health workers as their preferred mode of communication followed by television. The same distribution is shown among women who visited hospital or clinic twice or thrice hence underlying the importance of interpersonal

communication and audiovisual communication. Least preferred were flyers and posters.

This was in contrast with what the healthcare workers and the Ministry of Health had to say on the channels of communication used. The nurses' view on this was;

> "The commonest channel used to communicate maternal and child healthcare is through radio, specifically vernacular radio stations. This is due to the socioeconomic dynamics of the women, most of whom would be home going about their daily chores, and their most accessible media channel being radio. Since most women were secondary school educated, access to print media in form of magazines and newspapers is limited. "However, the pediatrician was of the opinion that door-to-door campaigns by healthcare workers were a channel of communication from which the women get information. (Nursing Officer Number 2, 2017)

> "I believe that most women got their information from door-to-door campaigns run by healthcare workers, especially during specific campaigns, e.g. Polio campaigns, though this only interest affected women as opposed to all women of reproductive age." (Nursing Officer Number 3, 2017)

Karki (2008) getting awareness through campaign is no easy task. It takes many years of momentum from grassroots groups to catch the eye of major organizations and governments to secure such a proclamation. Its hard work, but the power to reach and teach the public is well worth it. This helps when a community worker who goes to talk to them because they already had an idea on what is needed or wanted.

4.4 Satisfaction against mode of communication

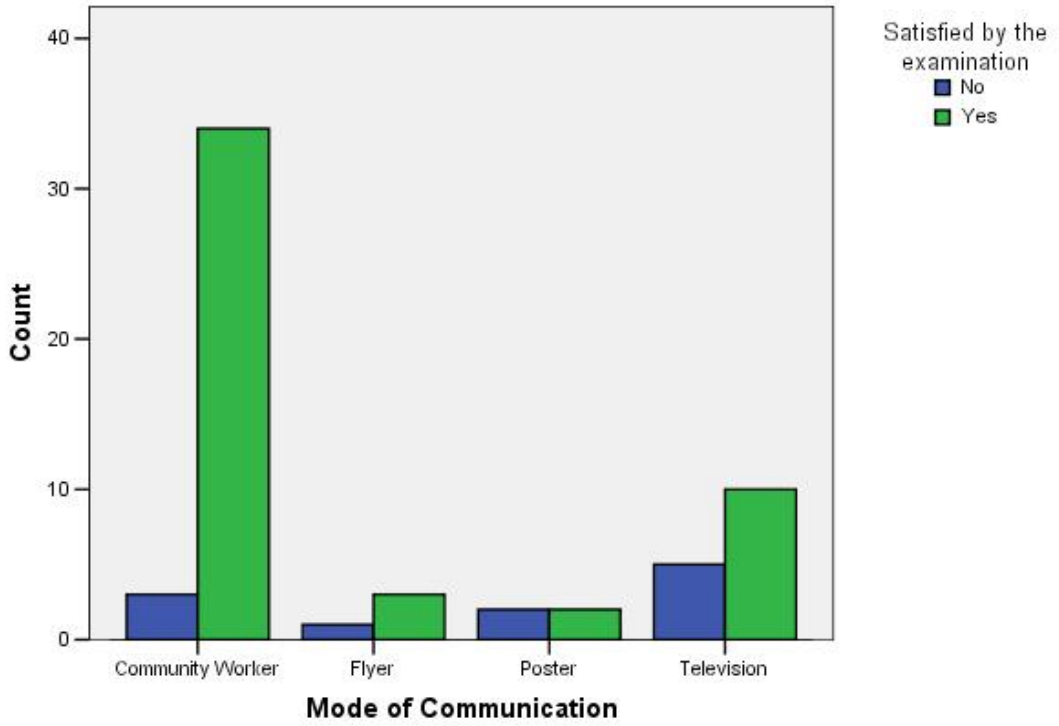
The level of satisfaction was higher among women who got information from community health workers compared to television, flyers and posters. The level of dissatisfaction with service was highest among those who depended on television as their source of maternal health information. The table and chart below show this

distribution and further emphasizes the importance of interpersonal communication in delivering of health messages.

Table 4.4 Satisfaction against mode of communication

		Satisfied by the examination		
		No	Yes	Total
Mode of Communication	Community Worker	3	34	37
	Flyer	1	3	4
	Poster	2	2	4
	Television	5	10	15
Total		11	49	60

Figure 4.9.The number that uses different modes of communication



Source: Researcher, 2017

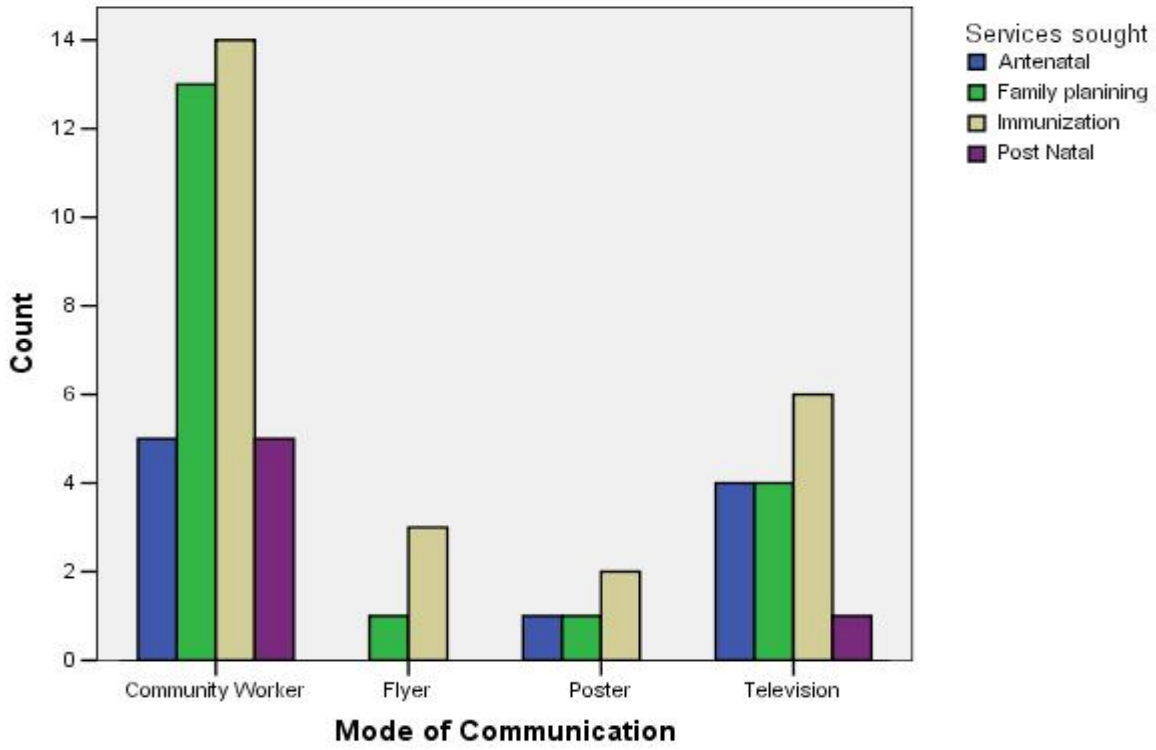
According to Goldsmith (1984) he said the picture illustration is important to transmit information to any person whether they can read on not. The above figure 4.9 shows finding that clarifies the importance of creating more appealing pictorials, flyers and posters those women would be able to attract their eyes. Colored pictorials and diagrams with fewer words should be used to help the women understand the message being sent without confusing them. Women preferred the community worker because all they had to do is to listen to what he or she says without further information.

Therefore the finding revealed that mode of communication should be more presentational that facilitates easy understanding of message without much wording.

4.5 Type of services

Community health workers had an influence on all the services sought from health facilities, further underpinning the role of interpersonal communication in maternal health service provision. Television, posters and flyers were least likely to influence women seeking post-natal care, with none of the respondents depending on flyers and posters for awareness on post-natal services.

Figure 4.10.The kind of services offered



Source: Researcher, 2017

The above graph illustrates that women had more information on immunization compared to all other maternal messages Family planning, Antenatal and Postnatal Immunization seemed to be the most familiar to women. This finding showed that women would care more of the child rather than themselves since the others were mostly a precaution.

4.7 Delivery at a health facility

Comparing the mode of communication to the likelihood of women delivering at a health facility revealed that community health workers had greater influence on the choice made by women followed by television. Below is a table and chart showing this distribution.

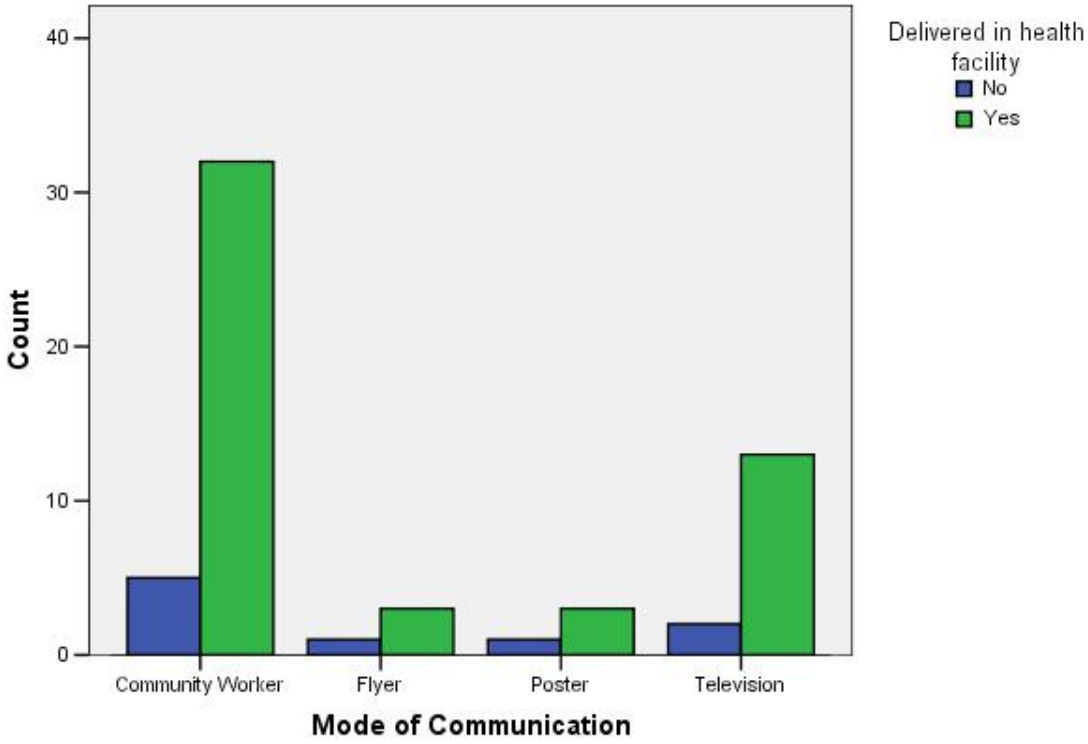
Table 4.5 ***Delivery at a health facility***

		Delivered in health facility		
		No	Yes	Total
Mode of Communication	Community Worker	5	32	37
	Flyer	1	3	4
	Poster	1	3	4
	Television	2	13	15
Total		9	51	60

Source: Researcher, 2017

The data was analyzed in figure 4.11, whereby it illustrate that women who were convinced by the community health worker to go and deliver in hospital were more than those who were convinced by the media. Interpersonal communication worked much better than the media communication.

Figure 4.11 The women who got information to deliver in hospital

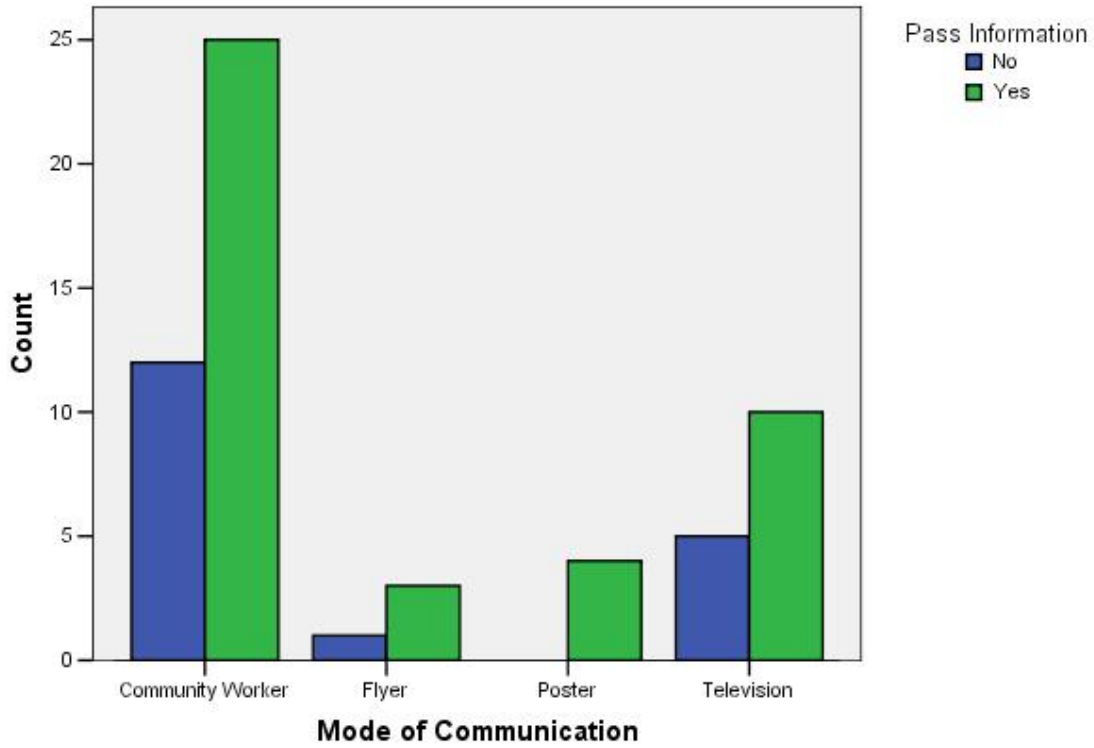


Source: Researcher, 2017

4.8 Passing information to other women

Women who get information on maternal health are likely to pass it over to their peers. However, according to this study, those educated by health workers and those who got health information from television were more likely to pass on this information compared to those who accessed information using other modes. Below is a chart showing this correlation.

Figure 4.12 Passing information

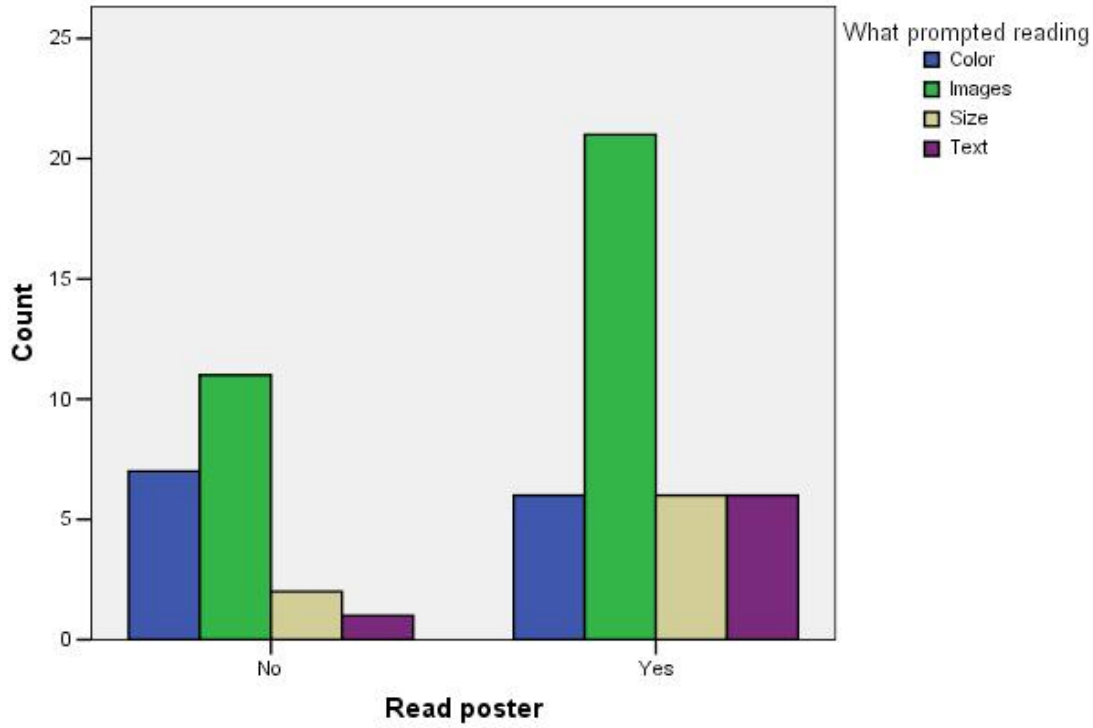


Source: Researcher, 2017

4.9 Improvement of posters as a mode of communication

Respondents were asked what had prompted them to read posters. Results showed that those who got maternal health information from posters were likely to be influenced more by the images and color as opposed to the textual information they contained. This shows that posters can be improved by making them more pictographic and colorful and therefore more appealing to the eye.

Figure 4.13 What prompted people to read



Source: Researcher, 2017

4.10 Source of information for the uneducated

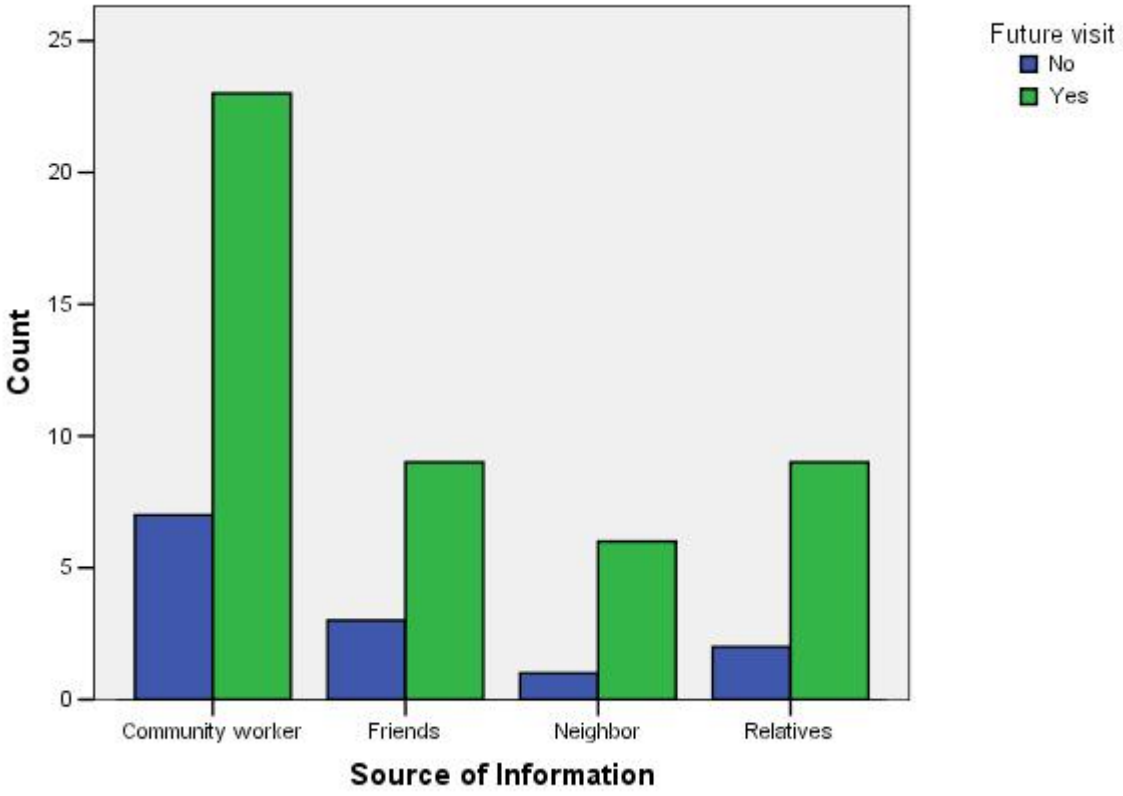
While all women preferred community health workers as their primary source of health information, uneducated women depended more on friends and relatives compared to educated women. The chart below shows this relationship.

4.11 Source of information correlated against number of visits

Women who got information through whatever source were most likely to revisit a health facility in future compared to those who didn't have any information on maternal health. However, community health workers as a source of information have a greater influence on the likelihood of future visits compared to other sources of information. From the results of this study, friends are more likely to influence

women not to visit a health facility in future more than any other source of information. The chart below emphasizes this finding.

Figure 4.14 who will go for future visit.

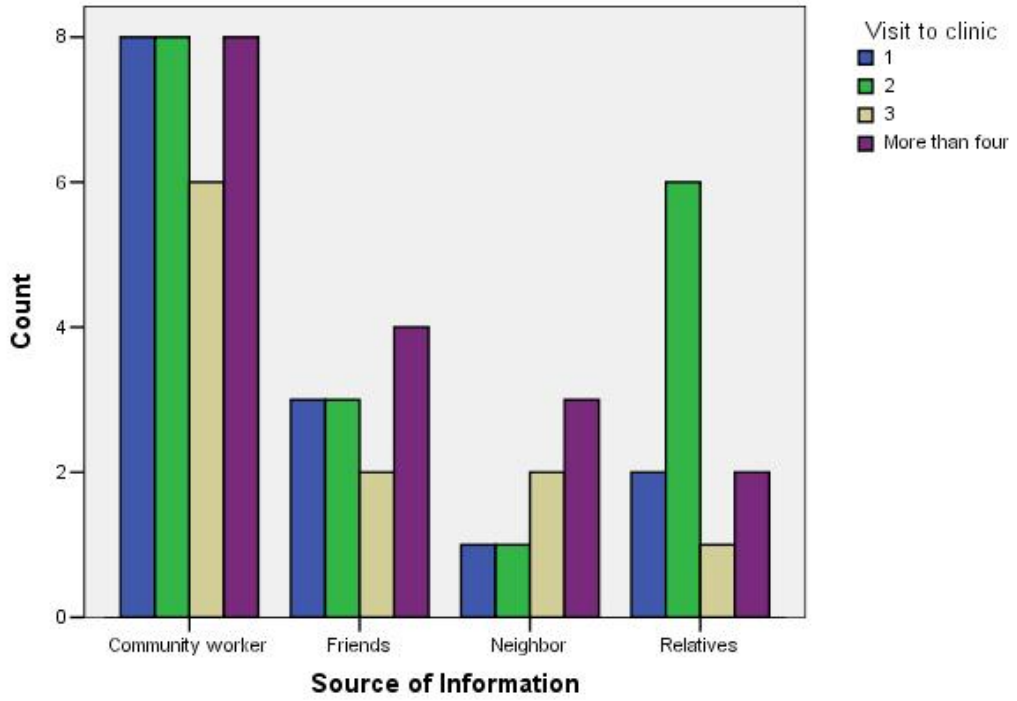


Source: Researcher, 2017

4.12 Influence of information source on number of visits

Community health workers are the leading source of information among women who had visited the clinic at least once, with repeat visits being higher too among women who had been educated on maternal health by community health workers. Incidentally, relatives showed greater influence among the cohort that had visited clinic twice. The chart below shows these findings.

Figure 4.15 Regular visit



Source: Researcher, 2017

4.13 Preference of source of information among different maternal age groups

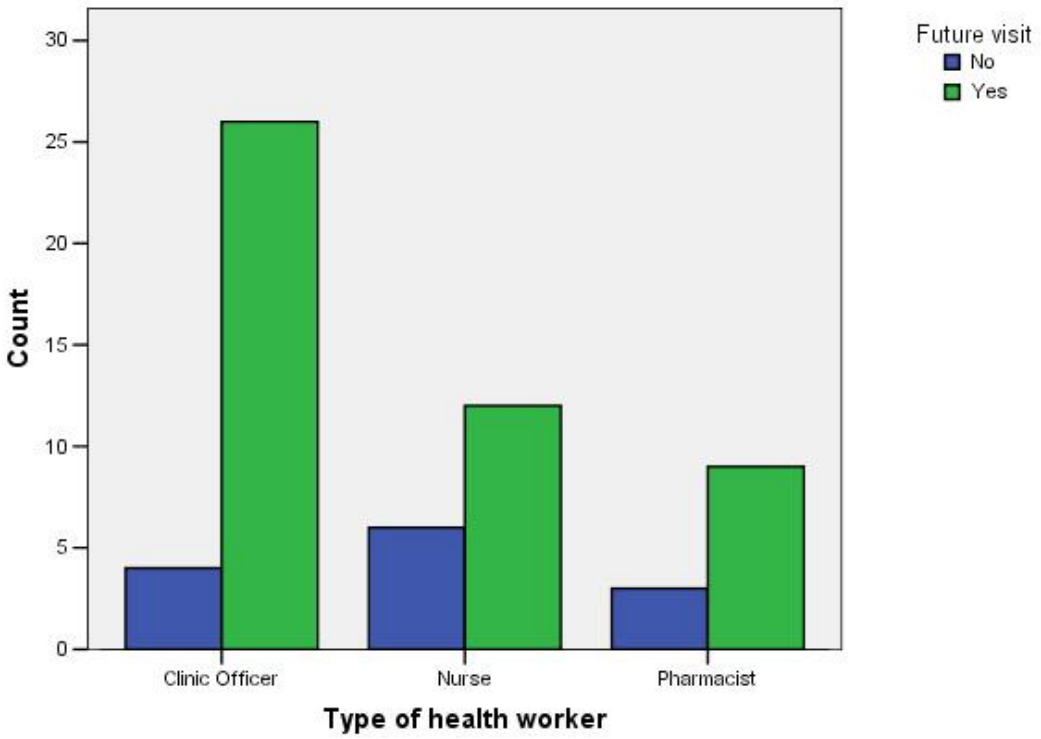
The community health worker remained the preferred source of information across all the age groups sampled. However, neighbors and relatives had significance influence on women aged above 35 years of age, compared to younger women. Interestingly, none of the teenage mothers sampled seemed to prefer friends, neighbors and relatives, instead putting their trust wholly in health workers.

4.14 Influence of different health workers on repeat visits

When attended to by clinical officers, most women were likely to visit clinic in future compared to those attended to by nurses and pharmacists. Of particular concern is the significant number of women served by nurses who appeared reluctant to visit clinic

in future, pointing to the fact that clinical officers and pharmacists were somehow more trusted by women seeking maternal health services.

Figure 4.16 Type of health worker



Source: Researcher, 2017

4.15 Influence of different health workers on passage of information to peers

Generally, information obtained from health workers was most likely to be passed on to peers, however, women attended to by nurses were least likely to pass on information obtained to their peers compared to those attended to by clinical officers and pharmacists. The mode of communication used by nurses could therefore be one the reasons contributing to this. Another reason could be the attitude of women to fellow women, considering that most nurses are women.

Magoma (2010) in the literature review noted that poor communication by the health provider during antenatal attendance lead to low hospital delivery. The findings showed that the initial interaction will determine the future coming of the women.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Overview

This chapter presents the summary, conclusions, implications and recommendations. Recommendations for proposed policy action and further research area have also been made. This is organized according to the study‘s objectives.

5.1 Summary of key findings

5.1.1 Communication strategies

The study established that Community health workers, Posters, Flyers and television were used to promote awareness were used to drive the maternal and health messages in Kawangware. According to Joseph (2010) communication strategies are how information is packaged and channeled and imparted by a sender to a receiver via a medium. The study also established that the communication strategies used to transmit message would be determined by the level of education. Whereby, the once that reached secondary education would not mind the use of illustration and pictorial on flyers or posters because they could interpret the information.

The literature further showed that there was real need to increase utilization of maternal health care, which was low universally. To do this, communication strategies needed to focus much more on understanding the cultural values that guide and determines what the people would be comfortable to read and discuss with service providers.

Communication strategies were needed to try to change attitudes and behaviors of women through counseling and interpersonal communication which is a very effective medium for communication Flay & Burton (2009)

5.2 Effects of communication strategies

5.2.1 Community health worker

The study established that Community health worker was very effective since it consisted of interpersonal communication through healthcare workers on one-on-one discussions with the women. Various aspects of face-to-face interpersonal communication make it more salient and effective e.g. non-verbal cues allows the communicator to gauge reception of the information in real time and they can therefore respond accordingly, not forgetting that dialogue can emerge, and hence one can easily be convinced of the message being delivered. The researcher also established that some of the hindrances to effective communication when the health worker does not speak the same language with the client. This leads to the loss of information leading to the client to go and seek information somewhere else.

5.2.2 Television

According to Evans & Ulasevich (2005) media has been recognized as powerful mechanisms to promote awareness and education of public issues and can probably influence decisions of individuals and change the behavior of the women. The study found out that 32 percent of women preferred to get information from the television as compared to the 60 percent chose to be taught by health worker. Hence, the research did not totally agree but other factors might have also hindered the outcome; Such as the illiteracy level, Social cultural values and the economic level of people living in Kawangware.

5.2.3 Posters

Fraser (2013) clarified that effective maternal and child health (MCH) practice requires skillfully combining a number of theoretical models and frameworks to

support systems addressing the health needs of women, children, and families. The study established that the Ministry of Health needs to make follow ups whenever useful information is printed on posters since this will ensure that the target audience actually receive the relevant information and incase the information wasn't received by a sample of women in reproductive age then it can be repackaged better.

5.2.4 Flyers

The Kenya National Bureau of Statistics(2010) showed that only 44 Percent of Kenyan women have done their secondary education. The study established that most women took the flyers but did not read them because of their level of education or they didn't have time to read the whole flyer and comprehend what message it had.

5.3 Challenges faced while promoting the maternal messages

5.3.1 Misrepresentation of Information

The study established that there existed misrepresentation of maternal health message. Further the study established that the way the media sends out maternal message it affects maternity services. This is in accordance to an article written by Otai(2013) from Kenya where she stated that "Women fear that if they accept free care they would be relinquishing their rights and would have to accept poor treatment'. The researcher noted that the fear is still there among the women who thought that media message had bad intensions that were supposed to harm them as compared to the rich who didn't need free maternal health service.

5.3.2 Distance to the clinics

Katumo (2015) points out that the distance of the health facility determines the chances of women to seek maternal health services. The study established that the women who lived further away from the clinics had fewer chances to come to

hospital. On the other hand women who did not utilize maternal care services had a low understanding of these issues. This shows a gap existed between use of maternal care services and the knowledge about using the maternal care.

5.3.3 Illiteracy

Though the study found that Kiswahili was most popular language in communication, vernacular radio stations were reported to be the most popular with the women, hence message delivery was in a language that the target audience could not comprehends best and hence the effectiveness in message delivery. The limitation however was that illiteracy affected how the women understood the messages. The effectiveness of information communicated was noted by the women‘s parity of 1-2 children which is below the national Total Fertility Rate of 3.9 as per KDHS (2014). The least communicated indictors of maternal and child healthcare was on antenatal care.

5.4 Ways to enhance communication among women

5.4.1 Raise awareness

The study established that Ministry of health and media need to raise awareness, the target audience should be clearly defined, and the information should be short and precise while they approach different platforms to inform people. The study found the use of appropriate channels creates an impact of health literacy. Italso found out that Women who were English proficient were able gather much evidence and information on maternal message and as well as explain to the friends.

The correlation analysis revealed that raising awareness was statistically important in influencing effective communication. These findings disagree with those of Cohen (2000) who noted that exposure to advertising promotes a significant effect to creating awareness to the women.

5.4.2 Train community health workers

The study established that Information about maternal health is changing on daily basis. The community health workers need to be going for a refresher course every other time. The finding suggested that the health workers should be taught how to communicate efficiently and effectively so that the can transmit messages well.

The correlation analysis revealed that Community health workers were confident on how they communicated to women and statistically significant in influencing effective communication. These findings agree with those of Gruning (1984) who examine the effectiveness of two way communication between two people to make the message effective.

5.4.3 Create patient-centered environments that stress the use of clear communications

Katumo (2013) points out that mother's attitude towards health facility is determined by the experience of the women with the health facility or what they observe other mothers going through during the maternal care. The researcher found out that most women didn't like the hospital because it didn't have privacy or a good environment to consult the health workers.

The correlation analysis revealed that women using maternal health service were positive and statistically significant in influencing effective communication for the future women. These findings agree with those of Lawson (2003) who stated that quality services are in relation to clients perception is to make services cost effective by meeting women health needs in appropriate ways and this reflect in the future use of the service.

5.5 Conclusion

Maternal and child health care is very important for the protection and reduction of maternal and child morbidity and mortality rates in the country. Communication of such information is also supposed to be timely and properly communicated in a language and mode that the recipient understands to ensure that women get the correct information. Simkhada (2006) research concluded that raising awareness using different channel communication would improve the uptake of maternal health care.

There are various tools of communication used. The effectiveness of such tools depends on how the recipient of the information given comprehends and responds to it, whether positively or negatively. These tools include interpersonal communication channels through healthcare workers or friends and relatives, mass media channels through TV and or print media like posters, flyers, brochures or any other printed material. The most effective mode of communication, as the study found was interpersonal communication through healthcare workers' interaction with the women in the clinics, hospital visits when sick and during door-to-door campaigns during specific campaigns. Other interpersonal means through relatives and friends were also popular.

Lastly, well understood information led to use of the same and sharing amongst various other women hence the information is spread amongst themselves and other immediate relatives and friends.

5.6 Recommendations

While the study appreciates the efforts applied to enhance communication in reducing maternal mortality rates in the country, there is much that needs to be done for improvement. From the discussions above, it was found out that most women

preferred a one-on-one engagement with the healthcare workers. There needs to be a paradigm shift from this because they can only be with health workers for limited periods of time and in hospital settings.

Ragupathy (2006) indicates that women need to start being educated about other credible channels of communication available and accessible to them. Due to the limited number of health workers per square kilometer other forms of media to communicate needs to be introduced by the Ministry of Health and the county governments. This will ensure wider coverage and accurate information dissemination to the target audience, who in this case are the women of reproductive age.

Majority of women cited healthcare workers as the most effective mode of information. These healthcare workers should get regular training through workshops and seminars on maternal and healthcare to ensure that they are up to date with their information. This ensures uniformity of information disseminated to all women not only in a county but across the country. These training should also encompass communication skills for healthcare workers so that they are better communicators and educators on maternal and child healthcare.

Finally, most clinics do not have a working health communication department to address the communication challenges and needs within the county. This needs to be established and set up as a conduit to implementing health communication policies in order to have improved outcomes on maternal and child healthcare.

5.4 Recommendations for further Research

Further studies should be conducted on the role of mass media on maternal health in referral hospitals in Kenya

This study also recommends further research on the impact communication through healthcare workers, in improving the maternal and child healthcare in Kenya.

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APPENDICES

APPENDIX I: QUESTIONNAIRE

My name is Jemima Kodero, a student of the University of Nairobi, currently doing a research on the communication strategies being used by health workers to deliver maternal health messages to women of reproductive age in Kawangware area of Dagoretti South. Your opinion will be highly appreciated and the answers you give will be used for purposes of research only.

Questionnaire to the ladies in the reproductive 15-49

Section A: General Information. (Kindly tick on one answer)

1. How old are you?
    a. 15 – 19
    b. 20 – 24
    c. 25 – 29
    d. 30 – 34
    e. 35 and above
2. What is your marital status?
    a. Single
    b. Married
    c. Divorced
    d. Widow
3. What is your level of Education?
    a. No education
    b. Primary

c. Secondary

d. College/ university

4. How many children do you have?

a. One

b. Two

c. Three

d. More than four

5. How long have you lived in Kawangware?

a. One year

b. Two years

c. Three years

d. More than Four years

6. What is your occupation?

a. Housewife

b. Formal employment

c. Business lady

d. Other (specify)_____

Section B: knowledge on maternal health. Kindly tick on one answer

7. Which kind of maternal health services do you know?

a. Immunization

b. Circumcision

c. Antenatal

d. Outpatient service

8. How many visits to the clinics have you attended?
    a. One
    b. Two
    c. Three
    d. More than four
9. From whom did you learn the importance of coming to the clinic?
    a. Community health worker
    b. Neighbor
    c. Relatives
    d. Friends
10. Do you intend to visit the clinic again in future?
    a. Yes
    b. No
11. In yes in question 10 above which services will you come for?
    a. Immunization
    b. Family planning
    c. Postnatal care
    d. Other (Specify)_____
12. Do you pass information you get on maternal and child health to your relatives and friends?
    a. Yes
    b. No

Section C: Modes of communication used by the health care

13. What mode of communication do you prefer to get information?

a. Flyers

b. Television

c. Community worker

d. Posters

14. Do you read Posters stuck on walls?

a. Yes

b. No

15. Which language are do you prefer the health worker to use?

a. Kiswahili

b. English

c. Other (Specify)_____

16. What would make you read a poster or newsletter?

a. Text

b. Color

c. Images

d. Size

17. Do you listen to the public campaign about health?

a. Yes

b. No

Section D: Challenges when sharing about maternal health

18. Who attends to you when you come for the clinic?

a. Clinic officer

b. Nurse

c. Pharmacist

d. Other(Specify) _____

19. How long does it take you reach the hospital?
    a. Less than an hour
    b. 1 hour
    c. 2 hours
20. How long do you wait to be attended to?
    a. 15 minutes
    b. 30 minutes
    c. 1hour
    d. More than one hour
21. What means of transport do you use to get to hospital?
    a. Walk
    b. Public transport
    c. Bicycle
    d. Private vehicle
22. Are you satisfied by the examination and check-up done by the health provider?
    a. Yes
    b. No
23. Are you satisfied with the attitude of the reception?
    a. Yes
    b. No

Section E: Improving communication about maternal health

24. What is your opinion of the health worker who attended to you?

    a. Excellent

    b. Very good

    c. Good

    d. Poor

    e. Very poor

25. What maternal services did you come to receive in this health facility?

    a. Ante natal

    b. Delivery

    c. Family planning

    d. Post natal care

    e. Immunization services

26. Did you deliver in a health facility?

    a. Yes

    b. No

27. Do you think the government has done enough on maternal health?

    a. Yes

    b. No

28. Rate your overall satisfaction of the communication skills in public hospital?

    a. Poor

    b. Fair

    c. Good

    d. Excellent

29. In which media should maternal health message be increased?

    a. Television
    b. Radio
    c. Newspaper
    d. Posters
    e. Flyers

30. Which kind of Health worker do you prefer?

    a. Male
    b. Female

Appendix II: INDEPTH INTERVIEW QUESTION

Section 1: Knowledge on maternal health?

1. List different methods you use to communicate to the reproductive age?
2. How do you help in creating awareness about maternal health?
3. Which is your preferable way to teach the reproductive age women?

Section 2: Modes of communication

4. What communication modes do you use to promote maternal and child health care? Kindly explain further

5. Which mode of communication are the women more familiar with? Explain further?

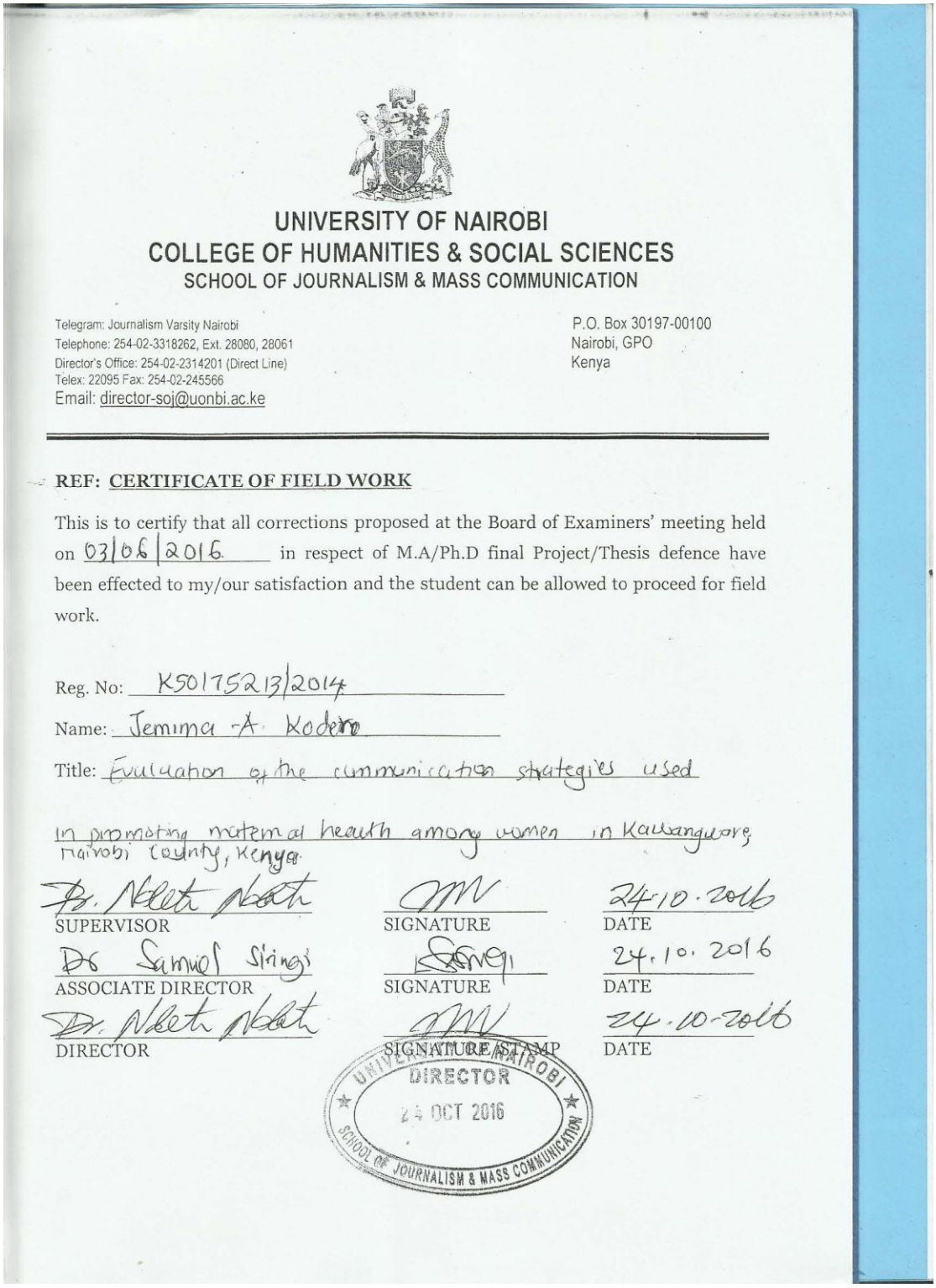
Section 3: Challenge when sharing about maternal health

6. Which age gap do you find challenging to communicate to?
    a. 15 – 19
    b. 20 – 24
    c. 25 – 29
    d. 30 – 34
    e. 35 and above
7. Give reason as to why you find there is a challenge when handling the age in Question six (6) above?
8. What are some of the challenges you face when trying to send maternal health messages?

Section 4: Enhancing communication

9. Explain what you require to improve communication of the maternal health messages?
10. Does a free communication tool improve the information on maternal health? If yes explain how?

Appendix III: CERTIFICATE OF FIELD WORK



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REF: CERTIFICATE OF FIELD WORK

This is to certify that all corrections proposed at the Board of Examiners' meeting held on 03/06/2016 in respect of M.A/Ph.D final Project/Thesis defence have been effected to my/our satisfaction and the student can be allowed to proceed for field work.

Reg. No: K50/75213/2014

Name: Jemima A. Kodero

Title: Evaluation of the communication strategies used in promoting maternal health among women in Kawangware, Nairobi County, Kenya.

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Dr Samuel Siringi		24.10.2016
ASSOCIATE DIRECTOR	SIGNATURE	DATE
Dr. Nkatha Kabeta		24-10-2016
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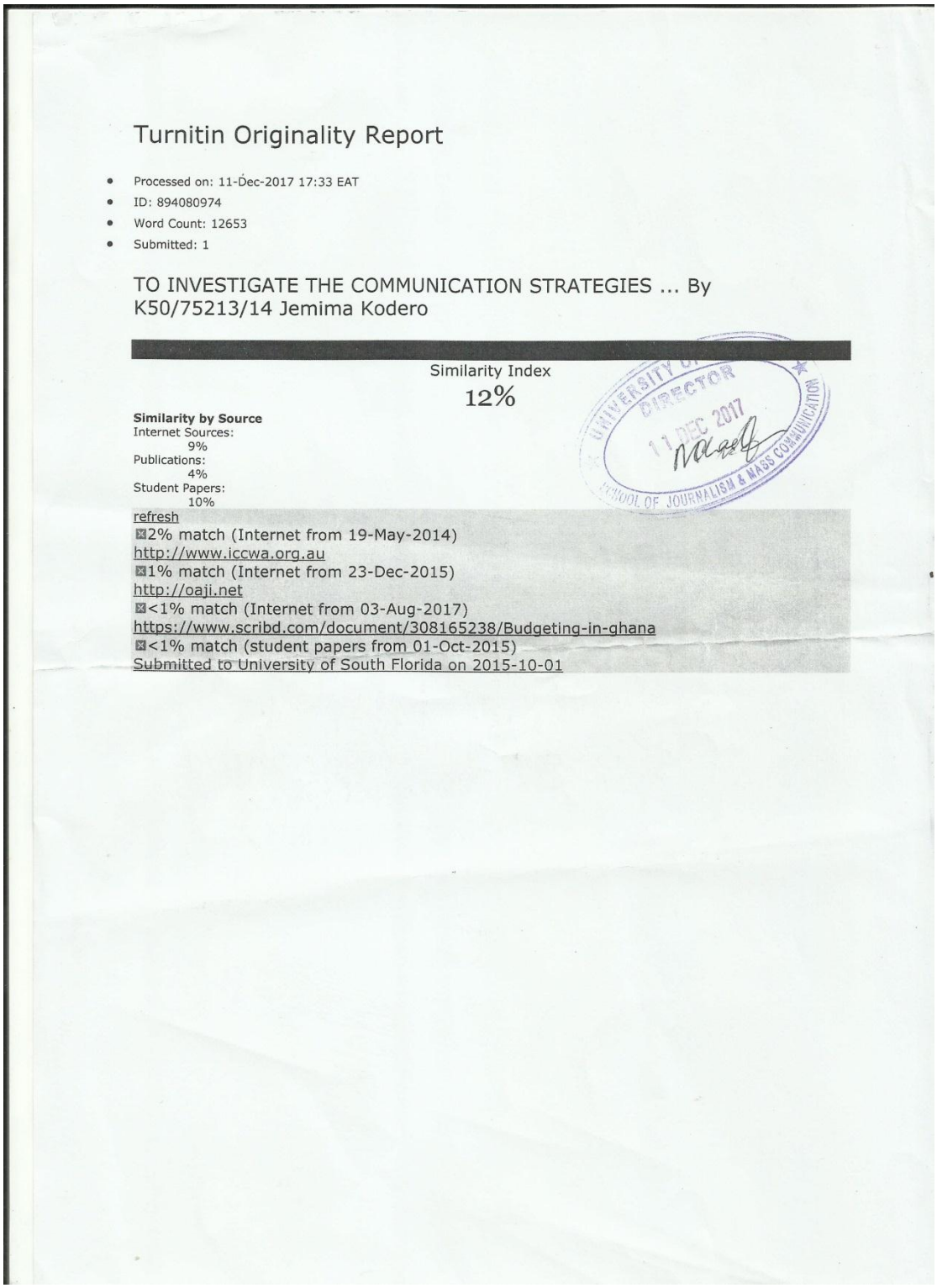

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This is to certify that all corrections proposed at the Board of Examiners meeting held on 24/10/2017 in respect of M.A/PhD. Project/Thesis defence have been effected to my/our satisfaction and the project/thesis can be allowed to proceed for binding.

Reg. No: K50/75213/2014.

Name: KADERO JEMIMA

Title: To investigate the communication strategies used in promoting maternal health among women in Kawangware, Nairobi county, Kenya.

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