THE USE OF INTERPERSONAL COMMUNICATION IN PROMOTING MATERNAL AND CHILD SURVIVAL IN WEST POKOT COUNTY, KENYA

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A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy (PhD) in Communication and Information studies in the School of Journalism and Mass Communication, University of Nairobi

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DECLARATION

I declare that this thesis is my original work and has not been submitted for award of a degree in any other university.

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Ting'aa, Simeon Lotulya **Date**

This thesis has been submitted to the University of Nairobi with our approval as the Supervisors.

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Dr. Samuel Siringi **Date**

DEDICATION

I dedicate this thesis to my beloved father, the late Por Ting'aa, in honour of his support during my initial journey of education. When the rest of my age-mates were roaming in the village of Topowon, my late father did all he could to ensure that I attended school.

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ABSTRACT

This study investigated the use of interpersonal communication in promoting maternal and child survival in West Pokot County, Kenya. Maternal and child mortality rate in West Pokot County has been above the country's average. The study sought to investigate the different forms of interpersonal communication that have been used by the health promoters to convey messages aimed at reducing maternal and child mortality levels. It also identified the factors that affect the choice of each form of interpersonal communication used in promoting maternal and child survival. The study further examined the perceptions of the community on the various forms of interpersonal communication used. A descriptive cross-sectional survey research design and adopted a mixed research methods approach were adopted. A sample of three hundred and ninety respondents was selected from the County through multi-stage sampling technique that include; cluster, simple random sampling and purposive sampling and additional qualitative data were collected using four key informant interviews and four focus group discussions. The qualitative data were analysed thematically while quantitative data were analysed using descriptive and inferential statistics using SPSS programme, then presented using a combination of narrative explanations, tables and graphs. The results from the study showed that face to face interpersonal communication was the most popularly used form of interpersonal communication at 75.4%, while the use of mobile telephone was only 14.1%. Moreover, from the study, government policies, health indicators, national campaigns and routine of the health workers were identified as the major factors that influenced the choice of the interpersonal forms used. The attitudes and perceptions of the community towards health workers were fairly rated at 53.8%. This study concludes that though technology has permeated every sphere of life, still face-to face interpersonal communication is supreme in a situation where action is required of reception of the message. The study recommends that the government should formulate a policy that incorporates the cultural aspects that encourage the upholding of proper upkeep of children and pregnant mothers should be identified and used during maternal and child survival campaigns. In addition the views of all the stakeholders should be sought and incorporated into programmes aimed at enhancing maternal and child survival campaigns. Again, messages should be designed and directed at health workers to improve their attitudes towards their clients.

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LIST OF ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

AMREF: African Medical & Research Foundation

ANC: Antenatal Care

BCC: Behaviour Change Communication

CBOs: Community-Based Organisations

CI: Confidence Interval

CHC: Community Health Committee

CHW/VS: Community Health Workers/Volunteers

CHEW: Community Health Extension Worker

CRA: Commission on Revenue Allocation

CSOs: Civil Society Organizations

Go K: Government of Kenya

IEC: Information Education Communication

INT: Insecticide-Treated Nets

FANC: Focused Antenatal Care

FGM: Female Genital Mutilation

FGD: Focused Group Discussion

HIV: Human Immunodeficiency Virus

KDHS: Kenya Demographic and Health Survey

KII: Key Informant Interview

KNBS: Kenya National Bureau of Statistics

MCH: Maternal and Child Health

MDGs: Millennium Development Goals

NGO: Non-Governmental Organisation

OR: Odds Ratio

SDA: Seventh Day Adventist

SGDs: Sustainable Development Goals

SMS: Short Message Service

SPSS: Statistical Package for Social Sciences

TBA: Traditional Birth Attendant

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

WHO: World Health Organisation

CHAPTER ONE
INTRODUCTION

1.1 Overview

This chapter outlines the background to the study, the statement of the problem and objectives of this study. It also provides the research questions, describes the significance, justification, scope, limitations of the study and the operationalisation of terms.

1.2 Background to the Study

Interpersonal communication is humanity's first way of communicating news or interacting with each other. It is still an important form of communication, especially useful when passing information and imparting knowledge to families, friends, neighbours and communities (Roy, 2005). Face-to-face conversations and oral forms of communication enable people to discuss issues in more detailed ways and to easily clarify issues. This is especially instrumental in confidential health issues or any ambiguous issues. These forms of communication provide clear statements of discussions and their outcome can be recorded and filed. Though online communication methods have revolutionised the flow of information by providing fast, cheap and efficient ways of interacting, interpersonal communication is still useful and relevant in contemporary society. Nevertheless, the strength of its usefulness has declined. One reason for this decline is that technology-mediated communication has provided a private forum for discussing even sensitive matters and connect with others who may have experienced similar health issues (Schiavo, 2007).

In the 1950s and 1960s, mass communication was considered a key ingredient in social development. Knowledge was by then thought to be the missing link in the development process. Mass media such as the radio, films and print were used to spread important development messages. Social development experts and extension agents would go on air on radio or use video and other mass media tools to demonstrate to people how to increase agricultural yields, have smaller families or how to live healthier lives. Communication flowed one way, that is, top-down.

The targeted group were mere recipients of the information (Melkote, 1991). There was little adoption on the messages by the target group and hence the strategy was evaluated and interpersonal communication was recommended for incorporation as part of the strategy of passing development and health messages.

In the 1970s, there was a drastic change in the approach to social development. This was because, from the evaluation done by researchers and administrators, there was little adoption of the services or products though knowledge was availed to the people (Rogers, 1973). During this period, there was great self-awareness among the people and hence there was a need for people to discuss, identify their needs and problems then decide on the plan of action. This marked a shift from top-to-bottom flow of information from government officials to bottom-up flow. In this regard, people needed to discuss together and agree before designing action to solve the identified problems. The need for information was the prerogative of the user at the grassroots level rather than authority at the top (Govender, 2010).

The change of communication strategy by government officials and social development agents from top-bottom to bottom-up did put emphasis on interpersonal communication. In this form of communication, people dialogue, identify their needs or problems, possible solutions and design actions to overcome the problems. This was the period when the participatory communication term was coined. This has been well elaborated by Melkote and Steeves (1990), who states:

> Communication constitutes an indispensable part of participatory approaches. If development is to have any relevancy to the people who need it most, it must start where the real needs and problems exist in rural areas, urban slums and other depressed sectors. People living in such peripheries must perceive their real needs and identify their real problems (P. 338).

Interpersonal communication involves individual interaction within a society and helps to reveal how people behave and communicate in a social system.

Govender (2010) explains that communication campaigns that are characterized by top-to-bottom flow of information and in which the target audiences are not involved in decision making, ownership or sharing of ideas and do not take the target group into account when designing the messages often fail to achieve the intended goals.

White, Nair and Ascort (2002) and Tufte and Mefalopus (2009) observe that participatory communication seems to yield better results than a linear form of communication popularly known as the top-down method. The reason is that participatory communication incorporates and involves the target community in the process of designing and implementation of social projects. In this way, participatory communication takes into consideration the cultural and other aspects that are important to the community.

According to Joram (2010), interpersonal communication is useful in situations where local actors need to be empowered and encouraged to take up initiatives that respond to local needs. Ndati (2011) adds that interpersonal communication is a crucial and fundamental phenomenon to human, and that no human endeavours can succeed or thrive without it. Dialogue is the defining quality of communication at a personal level. Paulo Freire (1970) passionately observes that dialogue must be established with the beneficiaries of any project, who he refers to as the oppressed. According to Freire (1970), dialogue:

> Implies that revolutionary leaders do not need to go to the people in order to bring them a message of salvation, but in order to come to know through dialogue with them, both their objective situation, the various levels of perception of themselves and of the World in which they exist. One cannot expect positive results from an education or political action programme which fails to respect the particular view of the World held by the people. Such as a programme constitutes cultural invasion, good intentions notwithstanding (P. 84).

Freire (1970) emphasises that in order for transformation to take place in any society, the oppressed or beneficiaries require a theory of transformation which assigns them a major role in the transformation process. He posits that through dialogue, people can discuss, identify and design a plan to solve the identified problem.

Dialogue is an important concept in communication that is aimed at behaviour change. It lifts dialogue from the casual talk to the urgent and serious discussion. In the context of community, a thorough dialogue and discussion of issues among members can promote decisions and action plans are laid down on how to arrive at the desired results (Freire, 1970).

1.2.1 Interpersonal Communication and Public Policy in Kenya

The Kenya government initiated the process of working towards achieving the Millennium Development Goals (MDGs) in 2002 (GOK, 2013). The initial process itself began earlier in September 2000, when 189 countries, including Kenya, adopted the Millennium declaration the main intention of which was to define a common vision for global development through the achievement of eight developmental goals by 2015. These set of eight goals were to: reduce abject poverty and hunger; reach universal primary level education, promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability, and develop a global partnership for development (GOK, 2013). Following the arrival of the 2015 deadline, MDGs were changed to Sustainable Development (SDGs) with all health related issues, including maternal and child health.

Apart from striving to achieve the SDGs, the Government is also endeavouring to realize the Kenya Vision 2030. This is a blueprint that aims at improving a number of services in which Kenya is lagging behind, including lowering infant and maternal mortality (GOK, 2017). In this blueprint the Kenya government expresses its commitment to revitalize the health sector by emphasising the promotion of preventive health care among its citizens. In this strategy, the missing link is on how this important government vision of promotion of health care can be achieved.

In order to realize this vision, holistic communication approach needs to be designed and incorporated into the campaigns in a bid to ensure that the disadvantaged groups like infants and expectant mothers are empowered to know why they should prioritize seeking health care services from health institutions.

In West Pokot County, several communication strategies which include interpersonal communication, folk media, mass media, have been developed and applied by the Kenya government and other stakeholders to address maternal and child health in the County. Though this has been done, West Pokot County still records high maternal and child mortality rates. The KDHS (2014) records that maternal mortality rate in West Pokot County stands at 488 per 100,000 live births while the average rate of the country is 362 per 100,000 live births (KDHS, 2014). In the child health care, the county is ranked 42 out of 47 counties in the country with 43.2% of children aged less than one year, having been fully immunized while the country average rate stands at 64.0% (CRA, 2013).

Communication strategies currently used in passing maternal and child survival messages include interpersonal communication, print media, mass media and folk media. Even with all these communication forms or strategies, the County still records low adherence as evidenced by the above statistics (KDHS, 2014; GOK, 2013; CRA, 2013).

In 2006, the government came up with the *Kenya essential package to the community; a strategy for the delivery of level one services* (MOH, 2017, GOK, 2006). The strategy seeks to empower Kenyan families and communities to identify initiatives to enhance their own health. It targeted to reach every household with health messages, especially messages on the health of children under five years who are normally vulnerable to various diseases and other related ailment.

The high maternal and child mortality rate in West Pokot County attests to lack of adherence of maternal and child health messages passed through non-interpersonal communication methods such radio, posters and other print and electronic media.

This study focused only on examining the use of interpersonal communication in the promotion of maternal and child survival.

1.3 Statement of the Problem

According to the Kenya Demographic and Health Survey (KDHS) (2014), only 26% of women in West Pokot County deliver at health facilities with the help of qualified medical personnel compared to the current country average of 62%. West Pokot County records 488 per every 100,000 live births against the country's average maternal mortality rate of 362 per 100,000 live births (KDHS, 2014).The government sought to reduce maternal deaths to 147 per 100, 000 live births by 2015, (GOK, 2013). However, the GOK (2013), states that the target of reducing the country average maternal mortality rate was not met instead, in some counties like West Pokot, still stands at 488.

Despite aggressive media campaigns in West Pokot County, questions remain as to why the county was still ranking low in key maternal and child survival indicators. It is on this basis that this study hypothesized that an increase in maternal and child mortality is a function of failure to communicate critical health messages. Consequently, the study sought to establish how effective interpersonal communication has been used to create awareness in the region and establish the success or failure of this mode of communication.

1.4 General Objective

The main objective of the study was to investigate how interpersonal communication has been used as a tool to reduce maternal and child mortality in West Pokot County.

1.4.1 Specific Objectives

The study was guided by the following research objectives:

i) To investigate forms of interpersonal communication that have been used by health promoters to convey messages aimed at reducing maternal and child mortality in West Pokot County

ii) To determine the factors that have influenced the choice of forms of interpersonal communication that have been used in promoting maternal and child survival in West Pokot County.

iii) To investigate the perceptions of the West Pokot community on the various forms of interpersonal communication used in passing messages aimed at reducing maternal and child mortality in West Pokot County.

1.4.2 Research Questions

The overall research question for this study was; how has interpersonal communication been used in the uptake of maternal and child survival messages in West Pokot County? The following three specific questions also guided the study:

1. Which forms of interpersonal communication have been used to reduce maternal and child mortality in West Pokot County?
2. What factors have influenced the choice of the forms of interpersonal communication used in communicating maternal and child survival messages?
3. What are the perceptions of the community on the various forms of interpersonal communication that have been used to reduce maternal and child mortality in West Pokot County?

1.5 Justification

Little research attention has been given to the effectiveness of various forms of interpersonal communication used on maternal and child promotion campaigns in West Pokot County. As such, there is lack of knowledge on factors causing high maternal and child mortality rate and for action to address health challenges facing the residents of this county. This study therefore aimed to fill this gap by providing knowledge on the current situation of maternal and child survival for attention of the government and other stakeholders. The study also sought to provide recommendations geared towards helping support the government effort of implementing vision 2030 and SDGs with the ultimate goal of attaining provision of health to all as per the current Constitution of Kenya 2010, (GoK, 2010).

1.6 Significance of the Study

First, the study is important because it avails data that can be used by both the County and national levels of government to identify strategies to reduce the high maternal and child mortality in the County. Second, it is hoped that the Kenya Government, Non-governmental Organizations (NGOs) and Community Based Organizations (CBOs) working in West Pokot County and other counties in Northern Kenya region will use the findings of this research in planning, designing and implementing more effective interventions in the region especially on maternal and child care. Third, the findings also give these agencies information and act as a pointer to the factors to consider in choosing interpersonal communication modes, in the maternal and child survival campaigns. Fourth, the findings of this study can also be resourceful for reference in future to academicians, scholars and researchers interested in understanding factors driving maternal and child mortality especially in marginal areas.

1.7 Scope of the Study

The study focused on the interpersonal communication used by the community health workers and other stakeholders in promoting maternal and child survival in West Pokot County. It targeted health workers, community members and government (Ministry of Health), and NGOs officials. The research was restricted to communication interventions, although it briefly captured the other aspects which were not communication related, but hinders adherence of maternal and child survival messages.

1.8 Limitations of the Study

The study relied on the narratives of the respondents of which there was no way of further validating. Second, some of the areas covered by this study had experienced insecurity from cattle rustlers from the neighbouring County of Turkana in the months before the study commenced. Due to this problem, the researcher and his assistants constantly cross-checked with security officers before carrying out the study in these areas which had been identified as insecure zones.

The researcher had to obtain clearance from the local security officers every time he went to the field. The researcher also had to constantly check for the safety of the field before every visit to collect the data. All this delayed the collection of the research data. Moreover, the researcher had to minimize probing the respondents and this may have slighted affected the details of data collection process.

1.9 Operationalisation of Terms

Antenatal Care (ANC): Care given to pregnant woman from the time of conception to the onset of labour pain or up to the time of giving birth.

Communication strategies: Plans and processes of sending health messages or information to the target community members.

Child: A young person between conception and 5 years.

Community: People who reside in villages.

Interpersonal communication: The exchange of information between two or more persons either through face to face interaction or by mediated means and geared towards influencing knowledge and skills.

Health Facility: A hospital or health centre offering maternal and child health services.

Mass media: Radio, TV, newspapers, postal means and magazines.

Maternal: Health of women during pregnancy, childbirth, and the postpartum period.

Maternal mortality: Death of mother caused by complications arising during pregnancy, delivery or after delivery.

CHAPTER TWO
LITERATURE REVIEW

2.1 Overview

This chapter presents a review of existing literature on interpersonal communication. It covers the global trends on maternal and child survival, various communication strategies used in health, which include interpersonal communication and participatory communication. It further discusses theories relevant to the study including behaviour change communication, theory of diffusion of innovation, theory of convergence and conceptual framework. The chapter finally identifies the research gaps that this study sought to fill.

2.2 Global Trends on Maternal and Child Survival

A total of 189 countries, including Kenya, have adopted MDGs now Sustainable Development Goals (SGDs), by September 2000. Most of these countries have defined and established various interventions to try and achieve the targeted goals (GOK, 2013). Among the goals that have received high attention has been maternal and child health. In 2013, it was reported that there was an improvement of maternal and child health care with a reduction in the number of maternal and child mortality rate worldwide. The report indicates that the number of women who die each year from causes related to pregnancy or child birth dropped from 543,000 deaths in 1990 to around 287,000 deaths in 2010 (WHO, 2013).

The WHO (2013) report attributes this improvement to campaign's effort and other support by various governments. Among the efforts by these governments and other stakeholders in health sectors include using various communication strategies targeting both the policy makers and communities to promote behaviour change. These agencies have used mass media, advocacy, celebrities, sport stars, religious and civic leaders to promote maternal and child health care in various countries worldwide, especially in the developing countries where it records high maternal and child mortality rate.

According to the WHO (2013), countdown profile reports, 30 countries, achieved reduction of maternal mortality rate of 50% between 1990 and 2010 while three countries of Equatorial Guinea, Nepal and Vietnam attained 75%. Over fifty countries reported reduced mortality rate during the period between 2000 and 2010, faster than during the previous decade.

In East Africa, maternal mortality rate has also improved with Uganda recording 310 per 100,000 live births, followed by Rwanda with 340, Kenya 362, Tanzania 460 while Burundi has 800 mortality rate per 100,000 live births. Regarding under five (5) child mortality rate, the report records improvement with Rwanda leading with 54 per 1000 births, Tanzania 68, Kenya 73, Uganda 96 and Burundi has 139 per 1000 births (UN, 2017, WHO, 2013; GOK, 2017).

In 2006, the Kenya government established a strategy to try and empower families, households and communities to be at the forefront in enhancing health. The strategy targeted every household with health messages, especially on the health of expectant mothers and children under five years who are normally vulnerable to various ailments. The government, through community strategy, aimed at prevention and management of common maternal and childhood illnesses at the community level with the main objective of attaining universal coverage of cost-effective child survival interventions and hence reduction of maternal and child mortality rate (MOH, 2007). Despite this campaign effort aimed at reducing maternal and child mortality rates, the statistics are still high as shown by a KDHS report of 2014.

West Pokot County has been recorded as one of the counties with the highest maternal mortality rate of 488 per 100, 000 live births (GOK, 2013). In child health, the County has recorded low immunization rate with 43.2% of children under one year, having fully undergone immunization as required (CRA, 2013). This poor state of affairs has come about despite spirited attempts to increase health education.

2.2.1 Maternal and Child Survival Messages in the Kenya Context

The Community Health Workers (CHWs) and the Health Workers based at health facilities across Kenya are charged with the responsibility of educating expectant mothers through interpersonal communication on key maternal and child survival messages. This is normally done by CHWs when they visit their respective households and at health facility during clinic days. In such occasions, the health workers at the health facility have sessions reserved for health education every clinic days for those community members who have gone to seek for Antenatal care (ANC) and immunization services (MOH, 2007). These maternal and child survival messages are passed by the health workers using different forms of interpersonal communication and these forms include one-on-one talks, small group discussions that have personal touch amongst the stakeholders like use of relevant examples. Other forms of interpersonal communication used include; lectures or teaching with demonstrations/use of teaching aids or pictures, counselling, video viewing coupled with discussions (MOH, 2014).

The Ministry of Health guidelines, (MOH 2017, MOH, 2007), outlines the following as the main maternal and child survival messages that should be passed to the community members by health workers:

- Identifying the early signs during pregnancy such as anaemia, swelling of legs, arms or face, spotting or vaginal bleeding or profuse or persistent bleeding after delivery, severe headaches or abdominal pains, severe or persistent vomiting, high fever, the water breaks before due time of delivery, convulsions and prolonged labour. Women who identify any of these signs are normally advised to quickly seek medical assistance from the nearest health facility that offers maternal and child health services.
- Encouraging pregnant women to attend ANC for at least four times during every pregnancy so that they are checked by a clinical officer, nurse or a doctor.
- Encourage all pregnant mothers to sleep under insecticide-treated nets (ITN) as pregnant women are susceptible to malaria which cause sickness for both the mother and unborn baby.

- Help pregnant women to prepare birth plan and organize resources in advance for getting skilled assistance from health facility during delivery.
- Recognize the following risk factors in pregnancy: an interval of less than two years since the previous birth, a woman who has had a previous premature birth or baby weighing less than 2 kilogrammes at birth, the woman who has had a previous difficulty during birth or through caesarean birth or a woman who has had a previous miscarriage or stillbirth.
- Approaches for preventing mother-child transmission of HIV.
- Motivate pregnant mothers to seek skilled assistance during birth.
- Encourage pregnant mothers to get immunized against tetanus.
- Immunize all new-born children against the preventable diseases.
- Ensure all births are notified and registered.
- Remember that a child health card is an important document that must be kept safely to monitor growth and immunization and other services to the child.
- Wash hands before feeding or breastfeeding, after cleaning the baby's stools or using toilet.
- Breastfeed the baby exclusively for six months.
- Follow instructions given at the health facility for each service.
- Remind community members that they should avoid physical abuse of women and the abuse during pregnancy is dangerous to the expectant mother and to the unborn baby.
- Encourage men to seek knowledge on reproductive health care.

Through the use of interpersonal communication, such knowledge and skills can be best disseminated to the target community. Subsequently, the following outcomes are expected: increase audience's knowledge and awareness of a health problem necessitating the need to seek for health solution, reinforcement of existing knowledge, attitude or behaviour, and promotion of uptake of medical services (MOH, 2014).

In the context of maternal and child survival, when the target audience understands the message, the indicators or the outcome include: the target individual ability of recognizing danger signs during pregnancy or after birth and act promptly by seeking medical attention or appropriate address, attendance of ANC for at least four times per pregnancy, delivery at health facility, taking new born child for immunization against preventable diseases (MOH, 2014; MOH, 2007).

2.3 Communication Strategies used on Maternal and Child Health in Kenya

In the early 1960s through to 1990s, many communication strategies were used to spread health messages throughout the world. These strategies used included social advertising, radio shows, posters, folk media performance and mobile films, among others. For example, in family planning, the extension agents' efforts were supplemented by these communication strategies to help bridge the knowledge gap and also to publicise the availability of contraceptive products and other health services (Rogers, 1973).

Another area where major communication campaign strategies or forms have been widely used, has been in HIV/AIDS prevention. Various communication strategies or forms have been used to disseminate information that may prevent risk behaviour and spread awareness that leads to the reduction of social stigma. Through these communication initiatives, awareness on HIV/AIDS increased and the social stigma attached to this disease reduced drastically (Melkote & Sleeves, 1991). Oriaso (2013) has carried out research on interpersonal communication among women from poor backgrounds in Rachuonyo North, Kenya. The researcher found that interpersonal communication was appropriate to this group of people because the approach encourages participatory involvement, social learning, instructional exchange, culture sensitivity and local creativity.

Various methods of communication are also utilized in sensitising people on the use of condoms to prevent STIs. In communicating health messages, programmes have also been initiated in the form of entertainment. In this approach, educational content is embedded in the entertainment programmes in mass media such as radio, television, video records and folk theatre. These educational programmes in these forms of entertainment have facilitated social change either directly or indirectly. These programmes present a unique kind of social communication whereby pro-social ideas are marketed as media products. People are entertained and at the same time people receive useful information on healthier living (Melkote & Sleeves, 1991).

These communication strategies have been criticised by many communication scholars that they lack participation from the target audience and have assumed that the power of communication to cause change is in the correct crafting of the content and in the adequate targeting of the audience (Tufte & Mefalopulos, 2009). The communication approach has shifted of late to participatory communication, which focuses on communication as a dialogical rather than linear communication. In linear communication approach, the emphasis was in the dissemination of information via the media to the target audience while in participatory communication, the emphasis is in dialogue-participatory.

Currently, technology has made it easier and faster to reach mass audiences, regardless of their location in the world. The Internet and mobile telephony have especially bolstered the communication process in Kenya and also around the world. The mass media has to embrace and adapt the new technology in order to remain relevant in our contemporary society. The traditional mass media have to change the way they collect, package and disseminate information. For example, media houses have to package information in the form of Short Message Service (SMS) and send via a mobile telephony to the subscribers in the form of breaking news. This is to the benefit of consumers as they will receive the message real time and even immediately without having to wait for new time or publication to come out.

Though the technology has revolutionized communication, there is still a need to blend the old forms of communication with the new ones. To achieve this, there is therefore a need to examine and integrate appropriately, the traditional media, the mass media and the new media to the benefits of the society. Use of all the communication channels will ensure that the target audiences receive the intended message faster and in an enriched format. The new technology has narrowed the knowledge gap. With about 89.10% of Kenyans owning mobile telephony (CCK, 2012), people can easily access information that is relevant to them.

2.3.1 Use of Interpersonal Communication in Maternal and Child Survival Campaigns

Interpersonal communication has been described as a process by which people exchange ideas, express emotions and concepts of the world through spoken and non-verbal messages, either face-to-face or mediated channels (Hartley, 1996). In other words, interpersonal communication entails dialogue or conversation that is personal, direct and intimate. It is an interaction between two people either through face to face or through mediated form (Schiavo, 2007). Mediated form is when a mechanical device mediates in an interpersonal exchange of messages between two or more people, whereby feedback is instantaneous and measured through responses (Roy, 2005, Schiavo, 2007). Many scholars agree that interpersonal communication is fundamental in life, that no human endeavours can thrive without it and that it is very important in situations where local actors (community) need to be empowered and encouraged to take up initiatives that address their needs (Ndati, 2011; Joram, 2010).

Interpersonal communication has been described as the most used and oldest form of health interventions (USAID, 2013). It may be understood better through the following four basic principles. Wood (2014) has come up with four (4) aspects of interpersonal communication. Wood further describes it as being inescapable, irreversible, complicated and contextual. On inescapable, it is acknowledged that in everyday life people are constantly communicating with each other not only in words but also through tone of voice, gestures, postures and facial expression.

In this process there is normally personal touch among interacting parties (MOH, 2014). Communication as a transaction process between a sender and a receiver has been known to include influence of others to take action upon understanding the message passed. It is observed that effective communication resides in how accurately the receiver interprets the message (AMREF, 2016). In the maternal and child survival campaigns, messages to be passed to the target groups are clearly passed and the audience are expected to response through an appropriate action (MOH, 2007).

Irreversibility for interpersonal communication means that once a person has spoken, it is impossible to turn back and reverse the statement. In the context of maternal and child survival messages, the health workers are expected to understand and be well versed with the key maternal and child survival messages in order to pass the correct information to their respective audience in order for the process to yield the expected results (MOH, 2007; MOH, 2014).

Complication of interpersonal communication may be found in words, as it may mean different things to different people. Therefore, communication between individuals is complicated by many factors in play (Wood, 2014). Many scholars and theorists have all agreed that there are six identity variables when people talk to each another. These variables include who each thinks they are, who each thinks the other person is, who each thinks the other person thinks the other, who the other person thinks they are, who the other person actually thinks the other is, and who the other person thinks the other thinks he/she is (Harley, 1996; Wood, 2014). Therefore, a communicator needs to minimize the possibilities for ambiguity and the bother of clarifications and ensure the messages sent and received are interpreted correctly. In the maternal and child survival context, the health workers who are tasked to pass the messages to the audience need to understand the variables and other factors in the target community in order to present accurate messages that will increase knowledge and awareness to the target audience in order to ultimately address maternal and child survival problem.

Wood (2014) asserts that interpersonal communication happens in a contextual framework, which include the following: psychological context which are normally in terms of moods and emotions. Depending on the emotional feelings of the sender, the audience will get an impact of the communication. In relational context, the familiarity that one has with the person he or she is communicating with influence also the process of communication. On the situational context, it points out that the engagement, influence where the communication is happening either in private or public. Cultural context has an effect on learned behaviours and norms of a particular people and different cultures communicate and interact differently. This need to be noted by the health workers who are carrying out maternal and child survival campaigns. Environmental context refers to the physical location of interaction e.g. classroom (Hartley, 1996; MOH, 2007; MOH, 2014; Wood, 2014).

In maternal and child survival the contexts through which messages in interpersonal communication pass are those arenas that enable exchange between persons to persons. These arenas include one-on-one communication as well as small group interactions like peer-to-peer, service provider-client, theatre, seminars, discussion groups, text messages, telephony, and social media. Interpersonal channels are interactive and can unpack complex information and personalized information which can build behavioural skills and increase self-efficacy and ultimately increase intentions to act (MOH, 2006; MOH, 2014).

2.3.2 Factors influencing the use of Interpersonal Communication in Promoting Maternal and Child Survival Messages in West Pokot County

The 2006 Ministry of Health strategy empowers and guide the CHWs/V on the strategies to deliver health messages to households within their respective communities and encourage them to seek health services from health facilities when in need and also ensure that they take their babies for immunisations while expectant mothers are to be encouraged to attend clinic at health facilities at least four times during the pregnancy period (GOK, 2006).

The community health workers were to act as catalysts by encouraging and mobilising community members to adhere to health messages, especially the pregnant mothers and children who are mostly vulnerable to diseases.

In Kenya, and in West Pokot County in particular, although the CHW/Vs have not undergone intensive training in the field of health, they have been trained to offer basic healthcare services like first aid and they work under the supervision of CHEWs who are normally trained public nurses and public health technicians. Though CHW/Vs have been trained to assist the community members with basic medical services, their main roles normally are to mobilise the community members to seek health services from health facilities whenever they are in need as well encourage pregnant women to attend antenatal clinics at health facilities.

According to a Ministry of Health Report (2007), community-based arenas and forums such as community dialogue, *barazas*, health celebration days, stakeholder forums, road shows, and community mobilization, rallies, and cultural events, are the main structures that provide arenas for presenting maternal and child survival messages through interpersonal communication. These fora provide an enabling environment, where various forms of interpersonal communication are utilized to present maternal and child survival messages effectively (MOH, 2007).

Again, these fora have been noted as ideal for the CHWs, health promoters and other campaigners of maternal and child survival, to present health messages and stimulate dialogue, motivate collective solutions, provision of social support, and feedback (MOH, 2014).

The guidelines and strategy for maternal and child survival campaigns notably use interpersonal communication as very important form that elicit positive response and its effectiveness; and like any other campaigns, the campaigners and the target audience have face-to-face interaction (MOH, 2014). At the village level, the CHWs visit the members of their respective households and they discuss the maternal and child survival messages face-to-face.

At their respective home visits, the CHWs ask the individuals to recall key messages shared during the previous visit and challenges if any that they might have encountered while implementing the messages.

During the interaction between the target individuals at households with the CHWs, discussions are normally held on a one-on-one basis (dialogue). In so doing, the transfer of knowledge and skills on maternal and child survival happens as the target audience are enabled to ask questions or seek clarifications on how to implement the messages. The increase of knowledge among the target individuals is expected to facilitate positive change at household levels. This increase in knowledge in turn leads to improvement or increase in the uptake of maternal and child health services offered at health facility (MOH, 2007; MOH, 2006).

In the community level, community meetings, commonly known as *barazas*, are organized by the assistant chief and village elders. They provide arenas for CHWs to educate the community on maternal and child survival using lectures, pictures and examples to motivate and encourage people to respond or adhere to maternal and child survival information. The MOH (2006) emphasizes interpersonal communication as a key method in imparting knowledge on maternal and child survival messages and to empower the community to live up to those messages.

The CHWs at the households and community levels are expected to educate and motivate the individuals to initiate and maintain positive uptake of maternal and child survival services at the care facility. Govender (2010) adds that people need their consciousness to be stimulated for them to act and in this process interpersonal communication is instrumental.

At the health facility, the health workers (clinical officers, nurse or public health officers) give health talks to the community members who attend clinic seeking for maternal and child health services, which are usually held on specific days of a week. In these talks, health workers present messages to the audience using lectures, teaching aids, examples, pictures, discussions and questions and answers forms of interactions.

The aim of these interaction sessions is to impart knowledge on maternal and child survival in order to ultimately increase uptake of the services at health facility and address any concerns of the target consumers of these services. Interpersonal communication takes several forms which include technology mediated, participatory discussions and motivational or catalyst talks.

2.3.3 Community perceptions on maternal and child survival messages

People's convictions on whether or not they are at risk for a disease or health problem influence the way they perceive the messages passed to them in a health campaigns. The community living in any geographical location think and perceive that there are benefits of acting on the messages they receive, the individuals will then tend to have positive perceptions and act according to the messages delivered to them (Glanz, 2005). Upon the receptions of maternal and child survival messages the target individuals must first understand the risk of non-adherence or non-compliance to the information they receive.

Perception of people in community are driven not by inner forces only, but also by external factors (World Bank, 2012). Human activity is known to be a product of interaction of individual and social factors. Environmental factors represent situational influences and the context in which behaviour is performed while personal factors include instinct, drives, traits and other individual motivational factors. The process of human behaviour may have intervening variables which may influence the process of change (Bandura, 1986; World Bank, 2012).

In maternal and child survival messages the target group are mostly expectant mothers which their perceptions and response are influenced by both environmental and personal factors which in turn drive them to act promptly and adhere to maternal and child survival messages like delivering at health facility, attendance of ANC and taking a new-born for preventive care. Therefore behaviour in this case is determined by an individual's attitude and subject norms-general social pressure. It is also determined by individuals' perceived behavioural control-individual's feeling of self-efficacy.

Maternal and child survival messages need to be continuously be passed to the target group until the target audience adopt and practice the expected behaviour that results in high delivery at health facilities and immunization of the new babies among other maternal and child survival messages.

In West Pokot County (study area), the social cultural factors seems to have a special role it plays in influencing maternal and child survival campaigns. The traditional indigenous knowledge passed through interpersonal communication from one generation to another tend to influence and shape positively and negatively maternal and child survival campaigns. In this connection therefore there was need for the maternal and child survival campaigners to study and familiarize themselves with the perceptions of the community on indigenous knowledge to be able to design and disseminate the messages to the target audience using appropriate communication channels in order to yield the desired results.

2.3.4 Technologically-mediated Interpersonal Communication

Interpersonal communication discussions would not be complete without acknowledging the impact of the Internet, video technology, telephone and other new media. These new forms of technology hugely influence interpersonal relationships in contemporary society. Currently, many interactions are mediated by technology and this include e-mail, phone calls, SMS, videoconferencing and social networks. This development has shaped the quality and implications of communications by depriving it of nonverbal expressions like facial expressions, gestures and other influences that are normally common in face-to-face encounters (Schiavo, 2009). When people rely on electronic media, they engage in the process of understanding and sharing common meanings (Bryman, 1990, 2004; Bryman & Lockridge, 2006; Schiavo, 2009).

In health, new media has been used effectively to convey maternal, child health care and other health-related messages. Schiavo (2007) notes that:

> In healthcare, technology mediated communications have provided a private forum to discuss sensitive matters, connect with others who may have experienced similar health issues, network, and learn about new medical solutions, among others.

> They have also affected provider-patient relationships. For example, some physicians may complain about the number of unnecessary questions and concerns that patients raise because of non-credible medical facts found on the internet. Yet the internet and other technology advances have improved the ability of patients and the general public to participate in person and public health decisions (P. 117).

Many scholars observe that even in cases of life threatening conditions such as HIV/AIDS, cancer among other terminal diseases, the use of the internet has increased the ability to overcome these maladies. The use of internet appears to have influenced the coping skills of people living with terminal illness by promoting individual empowerment, increasing social support and helping them help others (Reeves, 2000; Schiavo, 2007).

The influence of media technology on interpersonal communications and other aspects of health communication varies from population to population. It depends on accessibility of media as well preferences of these media among members of intended community. For example, new media or technology seem to be widely spread in developed countries than in many other countries in the developing world, where more face to face or one on one communications may still be dominant, more so in remote areas.

Reeves (2000) and Schiavo (2007) suggest that when using any form of technology to communicate health matters, it is important to remember and apply all general principles and values that pertain to interpersonal communications. In addition, they point out that gender, age, culture, ethnic and geographical factors as well as literacy levels still influence technology-mediated communications and hence should be considered in the process of communication (Reeves, 2000; Schiavo, 2007). Interpersonal communication mediated by technology has the ability to unpack complex information, personalized information, build behavioural skills, increase self-efficacy and can increase intension to act (MOH, 2014).

Research conducted recently shows that mobile phone intervention and sms-based interventions have successfully improved vaccination up-take in children.

It reveals that there was a statistically significant effect of mobile phone-based on improving immunization coverage and timelines in rural areas attributed to this initiative (Kazi, 2017)**.**

2.4 Linkage between interpersonal Communication and other forms of communication

While interpersonal communication involves exchange of ideas through spoken or either face-to face or mediated channels, on the other hand participatory communication is based on dialogue hence both forms allows for exchanging of information among parties, thus facilitating empowerment (Tufte & Mefalopulos, 2009). According to Cornish and Dunn (2009), both interpersonal communication and participatory communication have been known to have direct personal influence to the behaviour of human being than any other forms of communication. These two forms of communication ensure that the target local community do take part in creating and expressing their own ideas, thereby owning the process of communication (Cornish & Dunn, 2009).

The main objective of interpersonal communication and participatory communication are basically to improve the well-being of humanity, especially the poor. These two methods actively engages the stakeholders' through the information sharing, dialogue, consensus through the implementation or actions to the identified needs, up to the sharing of the benefit.

Participatory communication has largely been influenced by adult educationist Paulo Freire whose views on participatory grew out of his experience of living, working and reflecting, on his own words (White, Nair & Ascort, 2002). Freire's orientation towards participation stems from his critique of the existing system of extension education which he described as both paternalistic in its philosophy and non-participatory which he referred to as a banking concept of education. He expounded that knowledge was a finished entity, and not to be discovered in a dialogic encounter of the subjects. It was a given, packed and completed and people were mere passive receivers of this body of knowledge (Freire, 1970; White, Nair & Ascort, 2002).

In participatory communication the means of communication is handed over to the people themselves so that their voices can be heard.

Similarly, interpersonal communication has been greatly been influenced by Wood (Wood, 2014).These two forms of communication have been recorded to promote social transformation. The use of two approaches, tend to embrace horizontal communication such as stakeholder dialogue and consultation and bottom-up plus community media, creates spaces in which people can discuss and define their development and priorities, as well as give meaning to the issues affecting them (AMREF, 2016).

Mass communication and behavioural change communication are useful in themselves and in promoting pre-determined reforms. On the other hand, participatory communication has a greater potential to contribute to locally-owned reforms and sustainable change at various levels of the society.

Participatory communication has been equated to the participatory development in various ways, which include both adoption processes and interventions that generate conversations and cooperation (Tufte & Mefalopulos, 2009). It embraces the concept of empowerment and expression of voice of the beneficiaries and they are concerned with challenging power relations and promoting social change from the bottom-up. Interventions designed to include multiple components like education workshops combined with mass media campaigns, or theatre combined with community dialogue sessions, tend to effect better results than do single interventions (C-Change, 2009).

Communicating effectively entails understanding of the society and knowing how information is disseminated (Haselock, 2010). An understanding of the context and culture of a society is essential. Demand-driven projects are often more likely to succeed and to achieve local ownership of these factors are recognized and acknowledged. These require a communication approach that places more much emphasis on listening to local populations, acknowledging and choosing trusted ways of transmitting information.

The manner in which people approach and discuss issues or disseminate and process information greatly differs from one region to another and from one social group to another. Information initiatives process can counter unilateral perspectives and facilitate communal dialogue.

New media practices such as co-production, user-generated content are possible through social media and these developments have made significant contribution to diversification in voices. The information and communication products emerging from both developed and developing countries including the marginalised segments of populations such as women, children and ethnic minorities. These groups had often been absent from the media, in large part due to lack of access to editorial or managerial positions in media organizations.

Key considerations in participatory communication just like in interpersonal include: legitimacy or authority to speak on behalf of others? Are the marginalized groups within the community involved or represented? How can broad-based representation be achieved? (Cornwall & Coelho, 2007).While participation is considered a positive outcome in itself, it is also important to link these processes to mechanisms and institutions that can address the issues voiced by participants. In some communities, active participation in communication processes, collaboration, and increased respect for each other's ideas have contributed to improvement in the community (Harris, 2009; Martin & Wilmore, 2010).

In contribution by the mass media like radio on participatory, Brecht (1990) points out that radio can change its character from being a medium that is based on distribution system to a two-way communication system where dialogue can emerge.

> Radio could be the most powerful public communication system imaginable, a gigantic systems of channels… if it were capable not only of transmitting but of receiving, of making the listener not only hear but also speak, not isolating him but connecting him. This means the radio would have to give up being a purveyor and organize the listener as a purveyor (Brecht, 1990, p. 25).

Communication has become more important and complex in the current society and in development approaches hence focus on participation.

White, Nair and Ascort (2002) posit that a great number of participatory communication projects have been conducted and a number of useful reports have been compiled, analysed and lessons learned and embraced.

The challenge with this theory is in managing the decision making process with a large number of people involved, hence necessitating delay in trying to persuade all people to agree on what has already been agreed by others or inappropriate timing of participation. However, despite all these challenges the long term benefits of this method out weight these challenges.

The transfer of information has very important role in creating awareness on healthy behaviour and the benefits of the subsequent action. Many scholars agree that the behaviour change process begins at the right end by defining a specific health outcome to be achieved for example like the eradication of polio and then one proceed to define the specific ideal behaviours that will lead to this outcome like health workers vaccinating the clients and at-risk people come for vaccination. In this process communication approach will be at the centre in between the defined outcome and the identified problem.

Different types of communication interventions can be incorporated into behaviour change communication strategy; these include mass media like TV, radio, print channels public announcement, interpersonal communication for example spokesmen/women, testimonial and counselling. Others include informational materials like brochures, folk comics, posters, videos and audiocassettes distributed through small media channels folk media like local theatre, puppets and story tellers and interactive media such as internet.

Other forms of communication that have direct link with interpersonal communication is behaviour change communication, which is a strategy based on the formative research to understand the behavioural determinant that shapes the present behaviour and impede the adoption of new behaviours of the priority group. Interpersonal communication plays a powerful role in addressing barriers and shaping demand for adoption of preventive and promotional practice related to health. Internationally, there has been paradigm shift in the recent years from awareness creation, information education and communication (IEC) activities to strategic, evidence-based BCC strategies (USAID, 2013). This change has come about with the realization that an individual behaviour is influenced by socio-cultural and norms. Based on this, there is a need to mobilize communities in support of recommended behaviours along with integration of advocacy to influence policy and structural issues.

2.5 Theoretical Framework

Two theories guided this study, namely the Convergence Theory and Theory of Diffusion of Innovations. These theories provided a foundation into the inquiries in the use of interpersonal communication in promoting maternal and child survival.

2.5.1 Theory of Diffusion of Innovations

The Theory of Diffusion of Innovations was developed by Evert Rogers (Rogers, 1962, 1983, 1995, 2003). It explains how a new idea, concept or practice can spread within the community or from one society to another (Schiavo, 2007). This diffusion revolves around the circumstances that increase or decrease the rate of adoption of a new idea in a given culture. The Theory projects that the media and individual contacts influence opinions people hold. The diffusion of an idea or innovation has the following elements: (a) the innovation, which is any idea considered new by the recipient; (b) its communication through certain channels; (c) among members of a social system, and (d) over time (Rogers & Shoemaker, 1971). In this study, delivering at a health facility with the assistance of midwife was seen by expectant mothers as a new way (idea) compared to the old way where women delivered at home under the assistance of Traditional Birth Attendance (TBA).

The information flows through networks. The five adopter categories are: (1) innovators, (2) early adopters, (3) early majority, (4) late majority, and (5) laggards. These groups abide by a standard deviation-curve, with only a minority taking up an innovation at the start; early adopters making up for 13.5% a short time later, the early majority 34%, the late majority 34% and after some time finally the laggards make up for 16% (Melkote & Sleeves, 1991).

In the maternal and child survival campaigns, the CHWs and CHCs who are opinion leaders, can be motivated to influence change of behaviour in their respective villages by encouraging and ensuring that they adhere to the maternal and child survival messages so that community members can see and also do likewise-follow their example.

This theory has been used to accelerate the adoption of important health programmes that aim to change the behaviour of societal system. Secondly, many scholars have argued that the theory does not offer adequate construct to deal with collective adoption behaviours. The theory falls short of the context of networks and complexity of the society in terms of culture and other dimensions. It has been observed that diffusion of innovation in some situations may last over 15 years in one stage depending on context hence diffusion is not a straight line. Again, it has been said that diffusion may not be in sequential stages (Rogers, 2003). This analysis leaves a theoretical gap of participatory approach and seems un able to provide an account in complex situations with numerous variables hence in this study the convergence theory will fill this gap.

2.5.2 Convergence Theory

The Convergence Theory was very useful in giving an explanation on how information is exchanged and interpreted in a social system. It emphasizes the importance of information sharing, mutual understanding and mutual agreement on any collective action that would bring social change (Figueroa, Kincaid, Rani & Lewis, 2002).

The theory was developed by Lawrence Kancaid in 1979 to provide the general model of communication that would overcome the criticism and shortcomings on Shanon and Weaver's Mathematical Theory of Communication. Schiavo (2007) argues that convergence theory present communication as a sharing or exchange of information rather than one-way transmission. The theory was based on the perspective that an individual's perception and behaviour are influenced by the perceptions and behaviour of members of the same group (participatory).

This theory has contributed to redefining communication as a process in which all participants need to respect and take into account other people's feelings, emotions and beliefs. It has also highlighted the importance of social networks and key influential in defining the path to social change (Schiavo, 2007). White, Nair and Ascort (2002) aver that modernization hypothesized a convergence in which all societies would develop towards the same end point. This being the case, communication in support of these goals should be expected to vary from each country and not aim to copy the role played by communication from developed countries.

In short, this theory emphasizes information sharing, a process in which there is no sender or receiver, but everyone creates and shares information hence participation by all the members of the group. In this process, horizontal dialogue is encouraged and all the participants are equal with the main aim of reaching mutual agreement. This theory guided the researcher to identify the manner in which information sharing on the promotion of maternal and child survival has been handled in the study area.

2.5.3 The Conceptual Framework

Nachmias and Nachmias (2000) argue that conceptual frameworks are descriptive categories that are systematically placed in a broad structure of explicit propositions – statements of relationship between two or more empirical properties – which are to be accepted or rejected. These authors further explain that conceptual framework belongs to a higher level than a taxonomy because its propositions summarizes behaviours as well provide explanation and predictions for vast numbers of empirical observations.

In this study, the independent variables entailed the different forms of interpersonal communication, namely face to face, mobile phone, mediated by husbands, elders or local leaders. These forms of interpersonal communication are used to influence the attitude and behaviour of people to embrace maternal and child survival messages. There are intervening variables in between the independent variables and a dependent variable. The increase or decrease of maternal and child survival adherence depend on the influence of intervening variables by the independent variable (interpersonal Communication).

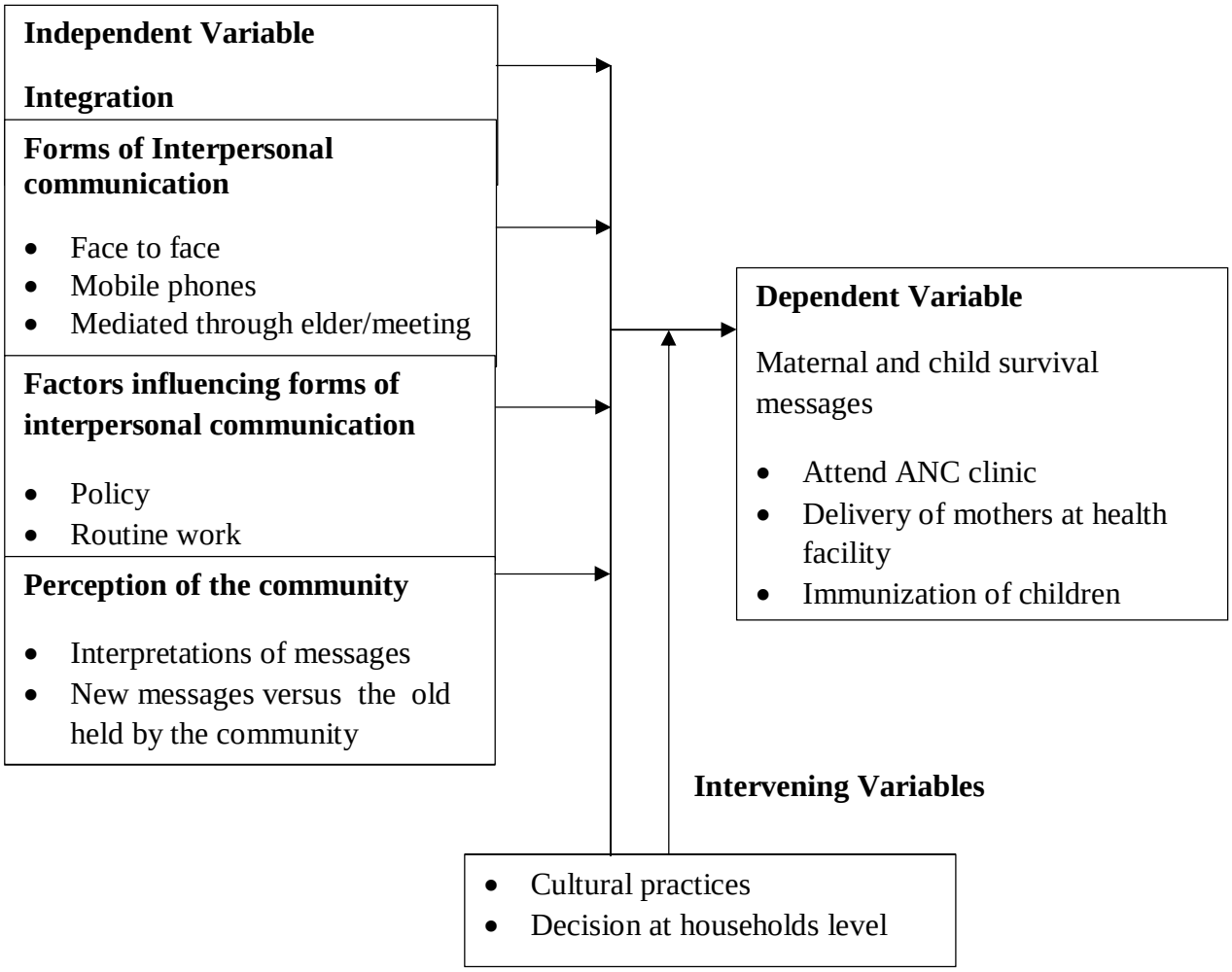

Figure 2.2 Conceptual Framework Model for the Study
Source*: Researcher, 2016*

The intervening variables are factors that the researcher hypothesized that it could affects the promotion of maternal and child survival in West Pokot County. These variables were confirmed during the study that indeed these factors shapes and influences the perceptions and actions of the community members.

Some of the intervening variables like cultural practices and decision at households cannot directly be influenced by interpersonal communication. However, interpersonal communication can be used to increase advocacy aimed at creating awareness on the need of identifying and upholding positive cultural aspects and discard the negative ones. Again through the use of interpersonal communication, advocacy can be used to create awareness and urge the every household member to provide the needed resources and support to the expectant mothers to comply and adhere to maternal and child survival messages (MOH, 2014).

2.6 Research Gaps

This study sought to describe the nature of interpersonal communication that is used by the health workers and community leaders to persuade the community members to increase uptake of maternal and child survival services in West Pokot County, in order to reduce high maternal and child mortality rate. The study also sought to identify the factors that influenced the choice of interpersonal communication used and the perceptions of the community on the interpersonal communication used to promote maternal and child survival. The main assumption made in the study was that currently community health workers and other stakeholders had not been using combination of various approaches and that they were not fully engaging the community in the planning, design and carrying out campaign on maternal and child survival programmes. Therefore, there was low response to or adoption of the messages passed to the community members as indicated by statistics from the Kenya Demographic Health Survey reports. Interpersonal communication was thus studied to see whether or not all the aspects such as the culture consideration and the changing habits of the target community have been incorporated into the health campaign initiatives in the study area.

Overall, the study assessed whether or not the campaigns considered relevance of the messages to the people who need it most – people who Melkote and Sleeves (1994) describe as the marginalized.

The reviewed literature showed that the involvement of community sometimes is limited; and in instances where alternative bottom-up communication strategies have been used, it has been criticized as lacking substance, thus has not fully been a vehicle of liberation as envision by its founder Paulo Freire (Freire, 1970). In participatory communication approach, several communication channels are supposed to be used to generate dialogue, to help people understand each other and identify their collective problems and suggestions for possible solutions (Melkote & Sleeves, 1994).

In this field of maternal and child survival promotion, interpersonal communication need re-examining before giving recommendations for consideration for improving the strategies for promoting reproductive health. In support of real change in this area, the researcher saw the need to investigate and interrogate factors in play in order to re-align all the communication interventions currently in place. The communication intervention in this field of maternal and child survival needed to be examined, more so the forms of transmitting information or techniques of passing the messages aimed at leading to solving the identified problem while paying attention to all other aspects like culture, needs and the habits of the community and get the involvement of the community on the subject and catch the magnitude of the community participation in the area of focus namely maternal and child survival.

In West Pokot County, available statistics show that interpersonal communication has not been used to the extent that the recipients of the messages have responded positively as expected. Therefore, there was need to study the forms of interpersonal communication that have been used and explain why these forms of communication have not been able to bring the desired change in the County.

2.7 Summary

The chapter has presented a review of existing literature. It began by first discussing the global trends in maternal and child survival followed by an examination of the maternal and child survival messages. The rest of the literature was reviewed under themes such as communication strategies used in maternal and child health, namely interpersonal communication, technology mediated, participatory communication, paraprofessional and catalysts. Moreover, two theories that guided the study namely convergence and diffusion of innovation together with conceptual framework for the study were discussed in this chapter. A summary of the research gaps was presented at the end of the chapter.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Overview

This chapter describes the research methodology employed in this study. It outlines the area of the study, research approach, study population, sampling, data collection instruments, techniques and procedures of data analysis. Finally, it narrates the ethical considerations observed in the study.

3.2 Philosophical Paradigm

Every research has a philosophical foundation. Jwan and Ong'ondo (2011) affirm that all researchers have a philosophical leaning and worldview (way of interpreting the world), which may not be explicit but still influence the research process. Researchers engage in research project with underlying assumptions. Hunt and Jared (2008) state that epistemological assumptions are necessary criteria and appropriate for evaluating knowledge claim.

In this study, the philosophical paradigm adopted was ontology-realism or relativism and epistemology-interpretivism-constructivism and positivism. Positivism, based on the realist ontology, helped the researcher to make direct and objective observations in order to understand the natural laws and relationships between research variables. Within the interpretivist-constructivist paradigm, the researcher was able to reason from particular responses in the study and draw conclusions that applied to the rest of the target population. Through this, the researcher was able to capture the reality on the interpersonal communication used in promoting maternal and child survival messages using multiple methods. Interpretivists-relative ontology assumes that reality was constructed subjectively through the meaning and understanding that one develops socially. It further assumes that one cannot separate themselves from what they know. The individual carrying out the investigation and the object being investigated are linked up together so that the investigators and their understanding of the world are central part of understanding of the world and themselves (Schutz, 1962).

Positivist assumptions and ontological assumptions aver that reality is external to the researcher; it is represented by the objects in the world. They further argue that reality has an independence from objects and can be seen by our senses and predicted (Lindsay, 2010). By use of these methods, the researcher maximized the overlap between ontological and axiological positions. Lichtman (2006) stresses that researchers should strive to capture reality by using multiple methods in various ways that reality would be approximated.

According to Audi (2000), the quantitative research paradigm has essentialist ontology, empiricist epistemology and either Aristotelian or applied axiology while qualitative research paradigm characteristically has anti-foundationalism ontology, a realist or idealist epistemology and applied or Aristotelian axiology. The realist epistemology in this paradigm gives rise to the constructivism research tradition and idealist epistemology which results in subjectivist tradition of inquiry. Anti-foundationalism subscribes to the view that all social phenomena are constructed and as such must be positioned in time, space and culture.

The philosophical assumption of this study was that interpersonal communication is more effective in addressing the identified problem. The linear communication model propounded by Shannon and Weaver (1949) advocates the notion of one-way communication. It suggests that any time during a conversation or communication between people, only one party is expressing information while the other party is exclusively absorbing the information-omnipotent source and passive receiver (Melkote, 1991).

Kincaid (1979) believes that the linear communication model was based on the misleading mathematical assumption that communication is one-way act rather than two ways. The model does not account for simultaneous interaction, transaction and feedback. Under normal conversations, it often entails both parties as active participants in sending and receiving information to each other (Kincaid, 1979). The linear communication model also suggests that the person sending the message is a powerful decision-making force while the receiver or listener is a powerless recipient.

On the other hand, participatory communication views communication as dialogue rather than just sending messages from a sender who is the source to just a passive receiver. As Servaes and Malikhao (2005) stress:

> I. The participatory model views ordinary people as the key agents of change and for this reason it focuses on their aspirations and strength. Local culture is respected.
> II. Participatory entails lifting up their spirits of a local community to take pride in its own culture, intellect and environment. Participatory also aims to educate and stimulate people to be active in self and communal improvements while maintaining ecology for future generations. Due to their local concentration participatory programs are, in fact not easily implemented nor are they highly controlled (P. 58).

This method sees communication as a dialogue whereby both the sender and the receiver learn from each other. It assumes that the receiver should not be considered merely as targets or members of an audience but rather as active participants. Though this method is tedious, the long term benefit is worth the investment. Freire 1970 sums it up thus:

> …the world of human beings is a world of communication. As a conscious being…the human acts and speaks on and about his reality which the mediation between him or her and other human beings who also act, think and speak (P. 137).

The Ministry of Health (2007) opines that if the health workers are well trained authorities in health issues, they will be able to use interpersonal communication and mass communication to sensitize the community on the benefits of adhering to maternal and child survival messages. This was the assumption that the researcher made in relation to the West Pokot County. One should not assume that the residents would just listen and adhere to the advice and messages of health workers without asking questions, raising concerns or engaging in dialogue.

Through the FDGs and KIIs held in West Pokot County, it was revealed that mass media, like radio, video, role play and road shows are important while announcing the programmes of the health campaigns and urging people to get more details in the health facilities.

The mass media, especially the community radio, was reported to be useful only while making announcements or creating awareness on any health problems like polio campaigns in the study area in the recent past. The health workers used these means to make announcements and urge people to go for immunizations at the nearby health facilities or at designated points. The other details about vaccinations were given at the health facility. At these facilities, health workers usually explain the reasons for the specific vaccinations being administered.

In West Pokot County, the mass media, especially community radio, has been used mostly to make announcements on any important health issues that needs thorough discussion and subsequent action or response. Face-to-face communication has proven more effective in discussing maternal and child survival issues and also for calling for response to health issues that need attention and action from the community members.

3.2.1 Reflexivity

A researcher's background and position affects what they choose to investigate, the angle of investigations, the methods, the purpose, the findings and communication of conclusions (Malterud, 2001). In this study, the experience and background of the researcher was insightful in collecting, interpreting and analysing the research data. The fact that the researcher was born and brought up in the research location, and had had a long work experience in this study site, focusing specifically on behaviour change communication, proved advantageous in collecting and analysing the data collected. Through this experience, the researcher already had insider information on where to locate the respondents and ask research questions and generate deeper insight and knowledge.

Scholars acknowledge that reflexivity cannot be underrated in identifying the strengths and limitations of a research, its location, its subjects, its process, its theoretical context, its data collection, analysis and the recognition that the construction of knowledge takes place in the world and not apart from it.

For example, Shacklock and Smyth (1998) suggest that by not acknowledging the interest implicit in a critical agenda for the research, or to assume value-free positions of neutrality, is to assume 'an obscene and dishonest position'. Similarly, Charmaz (2006) adds that through working with reflexive theory, the researcher allows the data to dictate the analysis and development of the research thereby promoting strong objectivity.

3.3 Research Site

The study was carried out in West Pokot County, one of the 47 counties in Kenya. The county is situated in the North Rift region along Kenya's western boundary with Uganda border. It borders Trans Nzoia County to the south and Elgeyo-Marakwet and Baringo counties to the South East and Turkana County to the North and North Eastern (GOK, 2013). The County has an area of about 9,169 square kilometres and its headquarters are at Kapenguria. It comprises four constituencies/sub-counties, namely West Pokot, Pokot central, North Pokot and Pokot South (County Government of West Pokot, 2013).

According to the 2009 Kenya Housing and Population Census, the County had a population of 512,690 and has an annual population growth rate of 5.09% (CRA, 2013). Currently, the population of the county is estimated at 613,231 peoples as per 2013 projections. This population consists of 313,746 males and 317,484 females giving a sex ratio of 100:101 (County Government of West Pokot, 2013).

The County is predominantly a pastoral area. This is because there is insufficient rain in most parts of the county to support farming activities. The county also has poorly developed infrastructure facilities apart from the Kitale-Lodwar road, which cuts through the County.

Figure 3. 1: Map of Kenya, showing location of West Pokot County, the research site

Source: Kenya National Bureau of Statistics (2010)

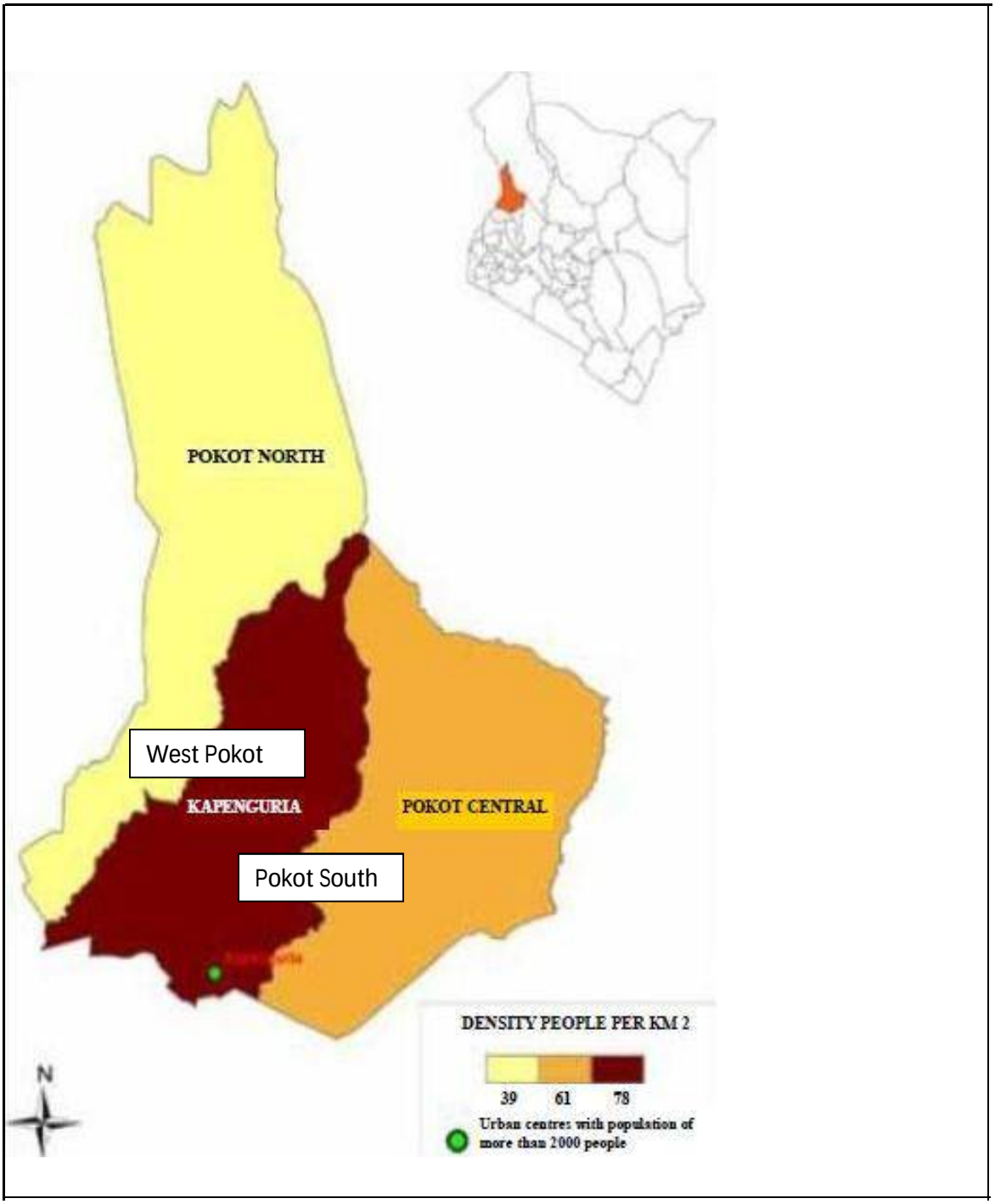

Figure 3. 2: Map of West Pokot County, sub-counties and density of population

Source: Kenya National Bureau of Statistics (2010)

3.4 Research Design

Kothari (2010) defines a research design as a conceptual structure or the blue print for the collection, measurement and analysis of data. It assists the researcher to set up a framework for a study. This research employed a cross-sectional research design in this study targeting to describe the state of affairs as it exists. Kombo and Tromp (2009) note that this design suits collection of information about people's attitude, opinions, habits or other social issues. According to Oso and Onen (2016), cross-sectional design describes and explains events as they are and involves collecting data from cross section of respondents chosen to represent a large population. This design was found appropriate for this study as it allowed the investigation of relationship among various variables as they interacting with each. Again, the design was relevant for this study as it helped explore attitude and opinions of resident of West Pokot County on the use of interpersonal communication in promoting maternal and child survival.

3.4.1 Research Approach

The study adopted a mixed methods research approach, where both quantitative and qualitative approach were used. By using both methods, the study benefited from the strengths of each, which helped to increase the reliability and validity of the results (Creswell, 2009). The quantitative approach builds directly on the results from qualitative phase in most cases and it gives a voice to the study participants and ensure that findings are grounded in participants' experiences (Wisdom & Creswell, 2013). Ndati (2011) and Nachmias and Nachmias (2001) concur that data produced by combined methods enhance validity and reliability of research findings and in addition confirming the findings through convergence of different perspectives.

3.4.2 Quantitative Approach

Through quantitative approach the research studied phenomena within their natural settings and described the situation of maternal and child survival campaign as it is in West Pokot County.

Abagi (1995) argues that a descriptive research attempts to describe what is in a social system such as a community living in particular area of research.

This approach was appropriate for this study because it provided a great deal of information, which was accurate (Kerlinger, 1983). In this approach, questionnaire was used to collect data from the respondents spread across Pokot South and Pokot Central Sub-Counties. Cohen and Manion (2000) note that the intention of a survey research is to gather data at a particular point in time and use it to describe the nature of existing conditions. This method was relevant to this study as the researcher was able to obtain information on the current situation on how interpersonal communication was being used in the study area to promote maternal and child survival.

3.4.2 Qualitative Approach

Qualitative research approach was also important for this study because it allowed the research to go beyond the statistical results obtained through quantitative and explore the community beliefs, attitude and interactions. The use of qualitative approach permitted an understanding on establish how participants interpreted their situations and related among they understood themselves, as explained by Jwan and Ong'ondo (2011). Qualitative data was obtained using key informant interviews and focus group discussions.

Through the mixed methods approach, the researcher was able to obtain information on the current situation and understand well on how interpersonal communication was being used in the study area, the perceptions and attitudes of the community in the use of interpersonal communication in promoting maternal and child survival.

3.5 Target Population

The study targeted the residents of West Pokot County in the two Sub-Counties of South and Central Pokot. Most of the respondents who were selected to participate in the study were aged 15-49, which are in the reproductive age (GOK, 2013).

The respondents for the survey comprised women who had children aged under five years, women who had had difficulty during child delivery (such as still births), expectant mothers, the Community Health Extension Workers (CHEWs), Community Health Workers (CHWs), and Community Health Committees (CHCs), who are also opinion leaders. Others included County Ministry of Health officials and coordinators/directors of non-governmental organizations working in the health sector in the County. These officials gave relevant information on how they had been using interpersonal communication in promoting maternal and child survival in the county. The total sample was drawn from a target population of 21,001 for the survey and 11,644 for FGDs and key informant interviews (See Table 3.1 and 3.2).

3.6 Sampling Procedure, Sampling Size, Sample Frame and Inclusion Criteria

Lenth (2001) suggests that while selecting samples researchers should ensure that the samples are of enough size to have scientific and statistical significance. Accordingly, a sample size is important for economic reasons, as an under-sized sample can be waste of resources for not having capability to produce useful results. Secondly, an over-sized sample requires more resources than are necessary.

3.6.1 Sampling Procedure

Multiple-stage sampling technique were employed in this study. First, cluster sampling technique was used to select the study area where the target population reside and this ensured that all the two sub-counties of West Pokot for the survey namely; Central and South Pokot Sub-County selected, all the four wards in each of the sub-county, were included and represented in the study. In each ward, it was further clustered into health facilities. Bailey (1994) states that the obvious advantage of cluster sampling is that it saves time and hence it is affordable.

This method was appropriate since this study covered an area with diverse geographical features and each with unique set ups, mode of lifestyles and challenges. This enriched the study and enabled the researcher to come up with comprehensive findings that reflect the true reality of the views of the respondents.

The researcher identified and mapped out the health facilities in each ward and administered the questions to the respondents during the clinic days which was held on a specific day of week in each health facility.

The following sampling procedures were used to select the respondents:

(i) Cluster Random Sampling

In the survey, the researcher selected a total of three hundred and ninety (390) respondents for the study. Through the cluster sampling procedure, the researcher allocated each of the two Sub-Counties, its appropriate percentage of the sample. During the data collection period the researcher visited each selected Sub-County and attended the days of the clinic. These clinic days were held on specific dates of the week in every health facility or mobile clinics for those who had no health facility within their area. Through cluster random sampling procedure, the researcher selected the respondents who filled the questionnaires from the respective health facilities in each ward.

The advantages of using the cluster random sampling included the fact that the researcher selected the respondents who attended a clinic that particular day of the clinic and were willing to participate in the study. In addition, this technique ensures that each member of the target population has an equal and independent chance of being included in the sample (Oso & Onen, 2016). Through a reconnaissance of the study site, the researcher found that some potential respondents who had been scheduled to come for the clinic did not turn up and in addition others were operating on tight schedules and do not have time for the interview. These findings prompted the researcher to opt for this sampling method.

(ii) Purposive Sampling

The respondents who participated in FDGs and key informant interviews were selected purposively on the basis of their experiences and knowledge on maternal and child survival. They were also purposively selected on the strength that they had ability of providing relevant information on the research objectives.

This method was used to select CHWs, CHCs, CHEWs, County government health and NGOs officials who participated in the study. The researcher booked appointments with the identified officials requesting for the interviews on the proposed day and time. One advantage of purposive sampling is that it enables the researcher to select information-rich cases for in-depth analysis (Jwan & Ong'ondo, 2011).

The number of all the respondents purposively selected to participate in the study came to 32 (see Table 3.2). Kombo and Tromp (2009) indicate that the main factor to consider in determining the sample size is the need to keep it manageable enough. Therefore, the researcher deemed this number sufficient to derive from it detailed data and save costs time and human resources.

3.6.2 Sampling Size

In determining the sample size for the survey, the researcher used the known number of 21,001 women with children under five years in the two Sub-Counties of West Pokot County, namely Central and South Pokot. These figures were obtained from the records of Sub-County hospital of each Sub-County in June 2016.

The formula that was used to calculate the sample size (mothers with children aged 0-5 years) was that by Yamane's formula as presented in Reid and Boore (1991). The Yamane formula assumes a normal distribution. Women with children under five years in the two selected sub-counties of West Pokot County was assumed to be normal in terms of the parameters under study in the interpretation of their experience and practice.

The Yamane formula was therefore considered suitable for determining an appropriate sample size as indicated below.

$$n = \frac{N}{1 + N(e)^2} = \frac{21001}{1 + 21001\ (0.05)^2} = 392$$

Where: n = the desired sample size, N = population size, e = the error of sampling.

The total number of respondents selected to participate in the study was thus three hundred and ninety-two (392).

3.6.3 Sampling Frame

Sampling frame is a complete listing of all the target population. The researcher compiled a list of all members of the target population totalling to 21,001. This comprised the sampling frame of the research. These figures were obtained from the records of Sub-County hospital of each Sub-County in June 2016. Zikmund and Babin (2012) emphasize that a sample frame must be representative of the population. The respondents selected from this sample frame participated in filling the questionnaire (see Table 3.1), FGDs and Key informant interviews (See Table 3.2).

Table 3.1: Summary Items of the Frame for the Survey

Sub-County	**Women with Babies under 5**	**Sample**	**% of Sample**
Central Pokot	10, 788	200	50%
South Pokot	10, 213	192	50%
Total	**21,001**	**392**	**100**

Source: Kapenguria County Referral Hospital, Sigor, and Kaibibich District Hospital in June 2016

Table 3.2: Sample frame for FGDs and Key informant Interviews

Sub-County	**CHWs**		**CHEW**		**CHCs**		**Expectant Women**		**Women who had had still births in the last year**		**NGOs officer**		**Health Policy makers**	
	T	**S**	**T**	**S**	**T**	**S**	**T**	**S**	**T**	**S**	**T**	**S**	**T**	**S**
Central Pokot	325	3	26	3	117	3	5238	2	71	1	6	2	14	2
South Pokot	300	3	24	3	108	3	5336	2	72	1	4	2	10	2
Total	**625**	**6**	**50**	**6**	**218**	**6**	**10574**	**4**	**143**	**2**	**10**	**4**	**24**	**4**

KEY: S = Sample (32), T = Total (11,644)
Source: Kapenguria County Referral Hospital, Sigor and Kaibibich District Hospital, June 2016.

The total number of respondents used in FDGs was twenty-eight (28) while for those who took part in key informant interviews was four (4), making a total of (thirty-two) 32 respondents.

3.6.4 Inclusion Criteria

For quantitative survey, women who resided in Central and South Pokot Sub-Counties of West Pokot County, with children under five years, and with the age bracket of 15-49 were eligible for inclusion in the study. For the qualitative study, FDGs and key informant interviews, CHWs, CHCs, CHEWs, expectant mothers, women who had had still births in less than a year, County government health officials and local NGO officials working in the health sector in West Pokot County were eligible to participate in the research.

3.7 Data Collection Methods and Instruments

The selected instruments for data collection for this study were questionnaire, interview schedules and FGD guides. Kombo and Tromp (2009) state that researchers should settle on instruments which provide high accuracy, general ability and explanatory power with low cost, rapid speed and a minimum of management demands with high administrative convenience.

3.7.1 Questionnaire

A total of three hundred and ninety two (392) respondents who were mothers with children aged zero to five (0-5) years and living in areas served by CHWs were selected using cluster sampling method. The researcher then administered questionnaires to the target respondents during clinic days in each sub-county. The filled-in questionnaires were then collected by the researcher, coded and analysed. The questionnaire collected data on perceptions and the forms of interpersonal communication used towards enhancing maternal and child survival messages in their respective areas. The data collected through questionnaires is quantifiable (Kombo & Tromp 2009). In this study, the questionnaire used was semi-structured, with both open-ended and close-ended questions (see Appendix 2).

The open- and closed-ended items, according to Kombo and Tromp (2009), help the researcher to obtain a complete and detailed understanding of the issue under research, which in this study was the use of interpersonal communication in promoting maternal and child survival in West Pokot County.

3.7.2 Focus Group Discussion

Four (4) FGDs were conducted, with the help of an FGD guide, with the selected CHWs, CHCs, CHEWs, County health officials, NGOs, officials, women who have had still birth in the last one year and expectant mothers. Jwan and Ong'ondo (2011) elucidate that FGDs tend to encourage participants to disclose attitude and behaviour they might not disclose during individual interviews. Again, FGDs bring out spontaneous reactions and ideas, hence help researchers understand how people feel or think about an issue, service or idea (Ferreira & Puth, 1988). According to Kombo and Tromp (2009), FGD should be composed of 6-10 individuals who possess characteristics relevant for the study (See Appendix 3). The four FGDs held had seven, six, eight and seven members each. Four (4) FGDs were held because by the time the interview reached 4th FGD, it had reached saturation and it had a lot repetition hence the researcher stopped. The challenges of bringing together the different individual members to make the group complete was a hard task and, in this process, one of the FGD meeting which had been planned had to be postponed due to lack of quorum hence inconveniencing other members who had planned to attend the meeting.

3.7.3 Key Informant Interview

The researcher conducted four key informant interviews using the interview schedule. The key informants interviewed included West Pokot head of health promotion, Community member who survived but lost her baby, County head of Public health and Coordinator for Community health workers in Pokot South and Central Pokot for ACF-Kenya. This method enables the researcher to probe for further information and thus obtain genuine and honest responses (Mugenda & Mugenda, 2009).

Jwan and Ong'ondo (2011) hold the view that in-depth interviews are intended to get to what a person who is a participant in research thinks, the attitude of that person or to expose a person's reasons for thinking in a certain way. This was important in this study, especially when the researcher was investigating the perceptions of the community members towards interpersonal communication and other strategies that have been used while carrying out maternal and child survival campaigns in the target area (see Appendix 4). This data was then categorized thematically and triangulated to enhance the study.

3.7.4 Document Analysis

Another instrument that supplemented primary data from the selected instruments was document review. Document analysis is a powerful source of data in qualitative research. Jwan and Ong'ondo (2011) argue that one of the very strong advantages of documents as sources of data in qualitative research is that they enhance the credibility of the study. The researcher visited the relevant Ministry of Health offices and offices of NGOs in the research location and requested for useful documents on the maternal and child survival campaigns.

Among the relevant documents that the researcher analysed included annual and quarterly reports of community health extension workers, NGO annual reports and County health officer's annual reports on the maternal and child health care in West Pokot County. These reports documented the communication strategies used by government and NGOs that work in the research site together with achievements obtained in the maternal and child survival campaigns.

The available documents in the study area of the maternal and child survival included records of maternal and child health, maternal and child survival campaign materials among other documents used by government and NGOs agencies operating in West Pokot County. Among the NGOs operating in West Pokot County in health sector whose documents and works (primary data) were reviewed included the World Vision, Kenya, Red Cross, Kenya, Action Against Hunger (ACF), Kenya and Population Service International, Kenya.

3.8 Data Collection Procedures

The researcher worked with ten (10) research assistants. All the assistants were university graduates and hailed from the Pokot community. They also resided in the Sub-Counties under study. These pre-qualifications helped to ensure accuracy in terms of the data collection. This also proved very useful to some local community members as the research assistants understood the local language and were able to accurately translate the questionnaires for those respondents who were not able to communicate fluently in either English or Kiswahili. Before the data collection started, the researcher trained the research assistants to be able to assist the illiterate and semi-literate respondents in filling the questionnaires. This ensured that none of the respondents was discriminated from participating in the study on the basis of their level of education. The filled questionnaires were sealed by the research assistants and delivered personally to the researcher.

3.8.1 Training of Research Assistants

The researcher recruited ten (10) research assistants consisting of eight men and two ladies who assisted the researcher to administer the researcher questionnaires, FGDs and KIIs to the respondents. They were first trained on the procedures to be followed while administering the questionnaires and the consent. The research assistants were all degree holders in social sciences and health sciences and were from the Pokot community and reside in the area of data collection.

This was an important aspect as the respondents in the study area are normally known to trust people they know and whom they may trace them in case of any incidence that might arise from the information they shared.

3.9 Data Analysis and Presentation

This being a mixed methods research, both quantitative and qualitative approaches were used for data analysis.

3.9.1 Quantitative Data Analysis

Quantitative data collected through the use of the questionnaires were examined thoroughly by the researcher while checking errors and addressing appropriately. The data entry was done in a database designed in Epidata V3.1 and part of the capturing process included assigning each questionnaire a reference number. Epidata was used to control the data entry errors as it has the capability of checking and controlling errors. The data was later exported to the Statistical Package for Social Science (SPSS version 20) for analysis. Descriptive statistics (frequencies, means and standard deviation) were used to summarize the data. Multiple binary logistic regression was used to identify significant predictors of choice of form of interpersonal communication at 95% confidence interval. Binary was used because the independent variable was dichotomous (e.g., either used face to face or not). Logistic regression was used to enable get the odds of using one form of communication by one group as compared to the other. All the results were considered significant at α=0.05. Findings were presented in form of tables, pie-charts and bar graphs.

3.9.2 Qualitative Data Analysis

The information from key informant interviews and focus group discussions was tape-recorded and transcribed in full text. After transcribing, the data were categorized into themes and analysed. Transcripts obtained from FGDs and key informants were identified by the researcher and grouped together, which then formed repeated ideas and later common themes.

The themes were obtained by examining the objectives and questions of the research. The qualitative data collected was then presented in narrative form, enriched with both reported and direct quotations from key informants and FDGs participants.

3.10 Validity and Reliability of Research Instruments

Validity and reliability of the data collection instruments were ascertained to give credence and faith in the results and conclusions of the study.

3.10.1 Validity of Research Instruments

The questionnaire, interview schedule and FGD guide that used in this study were designed and developed by the researcher. The instruments were later subjected to thorough appraisal by the researcher's student colleagues, university supervisors and other experts both in communication and in the field of research. The necessary adjustments were made accordingly before the instruments were piloted.

A test is valid if it measures what it claims to measure (Best, 1993). In this study, therefore, validity referred to the extent to which instruments accurately asked the intended questions and elicited responses envisioned in the research objectives. Kerlinger (1983) argues that for a research instrument to be considered valid, the content selected and included in the questions must be relevant to the variable being investigated. The researcher observed this principle to ensure correct results were obtained from the study. The researcher closely and constantly liaised with the university supervisors to ensure that the study was conducted as planned.

3.10.2 Reliability of Research Instruments and Data

Reliability is a measure of the degree to which a research instrument yields results after repeated trials. Reliability tells how well a test measures what it was supposed to measure. Tuckman (1978) says that one way to measure reliability is to give the same people the same test on more than one occasion and then compare each person's performance on both occasions.

In order to ascertain the reliability of the instrument, a pre-test technique was used. The sample for the pre-test comprised the community health workers and community members who were randomly sampled from Elgeyo-Marakwet County, Marakwet West sub-County, that had the same characteristics just like the respondents in the study area. This was to ensure that the research instruments were appropriate and accurate for the study.

Reliability was ensured by the use of sound recording devices and careful transcriptions of the collected data.

The recording equipment was first tested to ensure that the equipment was in good condition before using it in the field. Materials transcribed were constantly checked to ensure that the work was done as planned. In addition, the materials that were recorded were stored properly by the researcher and used for references during analysis.

3.11 Pilot testing of Research Instruments

The main study was preceded by a pilot test research conducted in July, 2016. Bailey (1994) emphasizes that the pre-test should be conducted in the same manner as the final study. The researcher ensured that these factors were considered. Pratt (2008) stresses that the main reason for testing tools or conducting a preliminary test of data collection tools and procedures is to identify and eliminate or make corrective changes or adjustments before actually collecting data from the target population.

The instruments for this study were piloted in the neighbouring county of Elgeyo-Marakwet, Marakwet West Sub-County. The respondents used had similar characteristics as those in the study area in terms of culture and geographical location. As pointed out earlier, the purpose of piloting the instruments in this context was to assess its clarity and the suitability of the items and language used. Items that were found to be inadequate were revised accordingly, as recommended by Mugenda and Mugenda (2009). The pilot study used twenty (20) respondents who were not among the final three hundred and ninety two (392) who participated in the main study, and Cronbach alpha test was done and coefficient value of 0.74 was achieved which showed the instrument was reliable. Additionally, one KII and one FDG were held to gauge the reliability of the qualitative data collection instruments.

The pilot study also benefited the researcher in the following ways: gaining practical experience in the use of research equipment, responses and scoring; determining the appropriateness and effectiveness of the research equipment and tools, and gaining experience in field of organization skills. Pilot testing also helped in identifying the best ways and strategies to administer the data collection instruments to the target respondents and to pre-empt the challenge of unreturned and uncompleted questionnaires.

The researcher withheld a fraction of the research assistants' honorary emolument till they submitted all the questionnaires before they were cleared. This was useful aspect as it helped researcher to receive all four hundred (400) questionnaires supplied hence 100% returned rate.

Teijlingen and Hundley (2001) emphasize that though pilot studies are crucial, it must be noted that conducting pilot does not guarantee success in the main study but it does enhance the likelihood. While conducting the pilot the respondents were asked to give comment on clarity, content and suitability of the language used. The researcher keenly analysed the responses and comments or observation given by the informants and keenly considered these responses. This tremendously improved and enhanced the data collecting instruments. Minor adjustments were done following the feedback from the respondents and upon thorough analysis of these results from the pre-test study. The results from the pre-test were also used to improve conceptual framework and methodology.

3.12 Ethical Considerations

After the approval of the final proposal, the researcher sought permission for field work by first presenting it before an examining panel at the University of Nairobi's School of Journalism. Upon passing the defence and carrying out corrections, certificate of field work was then issued, before the researcher applied for an official research permit from the National Council for Science and Technology (NCST) in the Ministry of Education, Science and Technology, which was granted (See Appendix 8).

The researcher then recruited the research assistants and trained them. Thereafter, the researcher made a pre-visit to the study sites and administered the questionnaire to the research teams to ensure they were fully familiarized with the content of the questionnaires and the study area. Additional permission was sought from the Ministry of Health, West Pokot County, Sub-Counties and respective local provincial administration in the Sub-Counties and at the locations and sub-locations levels where the research was conducted.

The researcher briefed the respondents on their role in the research before they were encouraged to participate in the study. The researcher also guided the research assistants and briefed them on how to assure the participants' confidentiality and that their names or the names of their institutions would not appear anywhere in the study, and that any information that they provided would only be used for academic purposes.

Again, the researcher and his assistants assured respondents of anonymity which intended to hide the identity of respondents for any vindication or reprisal by their respective supervisors in their respective organizations. This was an important aspect as lack of confidentiality and mishandling of the information provided may harm respondents physical or even psychological (Mugenda & Mugenda, 2009). The researcher sought the consent of the participants and ensured all were encouraged to participate voluntarily. Kombo and Tromp (2006) indicate that the researcher must maintain confidentiality at all times and obtain informed consent from any subjects used in the study. Participants were informed that participation was voluntary and they can withdraw from the study at any stage of the interview, if they so desire without any penalty. The researcher also took some few minutes before the start of the interview to reassure each and every one of them of all these aspects. Respondents were also accorded the opportunity to seek for clarifications and questions. The researcher sought permission from the relevant authority of all the health facilities under study to photocopy all the portion of the documents that may be required and other documents available for purposes of references of the study. The final report of the thesis was then subjected to plagiarism test before certificate of plagiarism issued. Finally certificate of corrections was issued upon carrying out all corrections that were proposed at board of examiners meeting.

3.13 Summary

This chapter has described the research methodology employed in the study, the research site, research design and research approach. The philosophical foundation and the reasons for aligning the study to the paradigm chosen have been discussed.

The study population and sampling procedure, data collection instruments and procedure, data analysis and presentation, piloting of the research instruments have also been described. The steps that were taken to ensure validity and reliability of research instruments were presented. The last part of the chapter presented the details of how ethical considerations for the study were ensured. The next chapter presents the research data, interpretation and discussions of findings.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Overview

This chapter provides the presentation, analysis and interpretation of the research data. The data analysis and interpretation focus on the following themes: socio-demographic characteristics of the community, place of child delivery, attendance of ANC clinic, means of transport to health facility, factors associated with choice of interpersonal communication used in promoting maternal and child survival, forms of interpersonal communication used in promoting maternal and child survival, and finally the perceptions of the community on the use of interpersonal communication in promoting maternal and child survival.

4.2 Response Rate

The research team administered the questionnaires and those with secondary level of education and above filled the questionnaires in the presence of researcher or assistant and clarifications were given where necessary. Out of the total sample of 392 respondents, 390 completed and returned the questionnaires administered to them. This represented a return rate of 99.5%.

4.3 Socio-demographic Characteristics

The study sought to document various socio-demographic characteristics of the respondents in relation to their responses on maternal and child survival messages using interpersonal communication approaches used.

The demographic parameters sought were: age, marital status, education level, distance between households and health facility, means of transport and cost of transport to health facility, knowledge of maternal and child survival services offered at health facility, religious affiliation and occupation. These parameters were investigated and presented in tables and interpreted appropriately.

4.3.1 Sub-County of the Respondents

The respondents were asked to indicate their sub-county of origin or residence. Of the 390 respondents, 200 were from Central Pokot while the other 190 were from South Pokot. This was an important factor in the study as each selected sub-counties has unique geographical characteristics which tend to influence the lifestyle of residents. These characteristics may also influence the forms of communication people use to pass information on maternal and child survival and the recipients of the messages as well. According to the GOK (2013), people living in South Pokot Sub-County are settled farmers who grow crops, and most of them have stable incomes. These factors could have an influence on the farmers' health seeking behaviour, as those with incomes can easily afford transport to health facilities and the required payment for health services.

On the other hand, the people residing in Central Pokot are mostly pastoralists and still practice nomadism (GOK, 2013). They constantly displace from one place to another in search of water and pasture. Therefore, their nomadic lifestyle equally influences their health seeking behaviour, especially delivery of new-borns at health facilities. Most of them have limited access to maternal and child survival messages, which are mostly disseminated at the health facilities. Majority of the residents in this area are low-income earners compared to those from South Pokot, and this also impedes their ability to seek maternal and child health services at health facilities (GOK, 2013).

4.3.2 Age of Respondents

Age of respondents was taken as very important variable in this study because it sheds light on the maturity and ability of the subjects to interpret the health care messages and take appropriate actions or response. Again, mature respondents, are able to conceptualise issues concerning maternal and child survival, and subsequently undertake corresponding decision and action appropriately. The findings on the ages of respondents were as presented in Table 4.1.

Table 4.1: Distribution of Respondents by Age

Age category	Frequency	Percentage (%)
Age-group		
15-20	39	10.0
21-25	102	26.2
26-30	129	33.1
31-35	70	17.9
36-40	40	10.3
41-45	9	2.3
46-49	1	0.3
Total	**390**	**100**

The findings in the Table 4.1 above show that, of 390 respondents 129 (33.1%) were aged between 26-30 years, 102 (26.2%) respondents were aged between 21-25 years. This clearly indicates that over 50% (231) respondents were of ages between 21 and 30 and only 10(2.6%) of respondents were aged between 41 to 49 years.

Going by the findings indicated in Table 4.1, women aged between 26 and 30 years were the majority. This group was considered to have rich experience on the latest issues on maternal and child survival, since they were in their active age of reproduction. Those below 20 years were 39(10.0%) respondents.

From the FGDs and KIIs, giving birth at such an early age disadvantages women and limits their chances of pursuing high education. This limits their chance of improving their income through stable employment in government agencies or non-governmental organisations. Women giving birth at such an age tend to overly rely on their spouses, or relatives, for most of their needs including fare to health facilities for ANC, immunizations and, or even for deliveries. Consequently, these women may at times abscond visits to the clinic for immunization or delivery at health facility, especially if the health facility is situated in far-off places.

4.3.3 Religious Affiliation

In this study, religious affiliation of the respondents was considered important since religious teachings and beliefs often influence decisions on marriage, maternal and child survival and other health issues. Table 4.2 presents the distribution of respondents according to their religious affiliation.

Table 4.2: Distribution of Religious Affiliation of Respondents

Religion	Frequency	Percentage (%)
Catholic	185	47.4
Protestant	157	40.3
SDA	21	5.4
African tradition	22	5.6
Other	5	1.3
Total	**390**	**100**

Source: Researcher (2016)

The Table 4.2 shows that majority of the respondents were Christians (88%), with 47.4% being Catholics and 40.3% being Protestants. The Seventh Day Adventist (SDA) and those who were affiliated to African Religious Traditions comprised 5.4% and 5.6%, respectively.

The above statistics correspond with the fact that Christianity is the most dominant religion in Kenya (representing up to 80% of the country's population). As one of the key informants stated:

> Religious affiliation has been known to influence how people seek maternal and child survival services. The two major religions in this area are Christians, namely Catholic and Protestant, who own health facilities and encourage their members to seek for maternal and child survival services in their respective health facilities (Personal Communication, KII 2, 2016).

Another key informant (KII 3) observed that some women who were affiliated to the traditional religious beliefs tended to delay in seeking maternal and child health

services. This finding reiterates that of Mondal (2009) who reports that those who subscribe to Catholic and protestant religions exhibit higher use of ANC and other child services than those who follow Traditional beliefs and other faiths.

4.3.4 Marital Status

The marital status of the respondents was equally sought in the study. This variable helps influence respondents' reaction to the maternal and child survival messages passed to them. In most African societies that are still largely patriarchal, decision-making on maternal and child survival in the homestead involves the participation of male members of the society because they are the heads of their respective households. This again is complex issue because in the Pokot community child bearing are normally women affairs and participation of men are minimal and this influence the whole process of seeking maternal and child health services. The distribution of respondents by their marital status is presented in Table 4.3.

Table 4.3: Marital Status of Respondents

Characteristic	Frequency	Percentage (%)
Married	330	84.6
Unmarried/Single	60	15.4
Total	**390**	**100**

Results from Table 4.3, indicate that majority (84.6%) of the sampled respondents were married while only 15.4% were unmarried. These findings corroborate those of Mekonnen and Mekonnen (2013) who posit that marital status is a determinant factor in the use of maternal and child health services.

4.3.5 Education Level of Respondents

Education is acknowledged worldwide as a powerful driver of social change in any society. Those with higher levels of education tend to adopt new ideas and innovation faster than those with low levels of education. In this regard, education of the respondents was seen as an important variable in this research.

A person's level of education has a bearing on the ability to understand, access and use healthcare information and messages. The findings on the level of education of the respondents were as presented in Table 4.4.

Table 4.4: Education Level of Respondents

Characteristic	Frequency	Percentage (%)
None	69	17.7
Primary	178	45.6
Secondary	77	19.7
Tertiary	66	16.9
Total	**390**	**100**

As shown in Table 4.4 above, out of the sampled 390 respondents about a half (45.6%) had primary school education while 17.7% reported that they had not gone to school or none level of education. Those who completed secondary education were 19.7% while those who had tertiary education were 16.9%.

From the results on Table 4.4, it is evident that majority (45.6%) of respondents interviewed had only primary level of education. These findings have an implication on uptake of information on promoting maternal and child survival messages.

The low level of education, negative cultural beliefs and traditions, poor economic status, distance between households and delay in decision-making contribute to low uptake of maternal and child survival messages. Again, the level of education has implications on other socio-economic opportunities like securing employment, access and understanding of maternal and child survival messages.

It has been noted that women with higher level of education have a higher likelihood of fulfilling requirements of uptake or adherence of maternal and child survival services as indicated by WHO (2004).

Women with high level of education have more capability to access, analyse and adhere to maternal and child survival messages than their counterparts with low education level. Indeed, in Vietnam, deliveries in health facilities are reportedly more common among highly educated women, employed or women with good economic conditions. Better education and economic empowerment also meant better access on awareness and utilization of information on maternal and child health care (Tran, 2012).

4.3.6 Education Level of Spouse

Due to the importance of the level of education of respondents on the uptake of maternal and child survival messages, it was important to find out the level of the respondent's spouse. As pointed out earlier, the education level of the spouse was hypothesised to be an important variable in this study. This was because education may act as an influencing factor in the access, understanding and uptake of maternal and child survival messages and subsequently utilizing maternal and child health services offered at health facility. The research findings on the education level of each respondent's spouse were as presented in Table 4.5.

Table 4.5: Education Level of Respondents' Spouses

Characteristic	Frequency	Percentage (%)
None	70	17.9
Primary	142	36.4
Secondary	103	26.4
Tertiary	75	19.2
Total	**390**	**100**

The results from the Table 4.5 indicate that about one-third (36.4%) of sampled respondents' spouse had primary level of education while 26.4% had secondary level education. It was also noted that 17.9% of the sampled respondents' spouses had never gone to school while 19.2% had attained tertiary level of education.

Evidently, there was not much educational difference between male and female members of society in the sub-counties of South and Central Pokot in West Pokot County as indicated in Table 4.4.

One, of the members of the FGD 4, who had been conducting health promotion in the county, argued thus:

> Spousal education level may influence the use and uptake of maternal and child survival messages. Education level enhances the capacity to access and analyse maternal and child survival messages that can be shared with a spouse. Sharing of these useful information and knowledge on promotion of maternal and child survival may enhance and encourage the spouses to see the importance of seeking for maternal and child survival services offered at health facility (Respondent 3, FGD4, 2016).

The spouse's level of education was noted and reported that the women whose husbands' have attained high education level have positive relationship on utilization of maternal and child survival services (Dairo & Owoyokun, 2010).

4.3.7 Respondents' Sources of Income

Respondents' source of income in this study was considered to be important variable as it helps to highlight the ability of respondents to pay for the fare (transport) and cost of service offered at health facility that is aimed at enhancing maternal and child survival.

The research findings on the respondents' sources of income were as presented in Table 4.6.

Table 4.6: Distribution of Respondents by their Sources of Income

Characteristic	Frequency	Percentage (%)
Government employee	42	10.8
Self employed	284	72.8
Other	64	16.4
Total	**390**	**100**

Table 4.6 above shows that majority (72.8%) of the respondents were self-employed while only 10.8% are employed by the government. The high number of women who are self-employed is explained by very low level of education of the respondents as shown in Table 4.6. The few who attained tertiary education were among the 10.5% who were employed by the government.

4.4 Place of Delivery of Latest Child

The place of delivery of the latest child was considered an important variable in this study. It highlighted the general situation of the study area in regard to the maternal and child survival. Moreover, it was conceived that the survival of the mother and the child depends on the place of birth. Moreover, it was assumed that a mother who delivers at a health facility has a high chance of survival in case of complications as the birth attendants are trained and more skilled to handle maternal challenges and there are always systems of referral in case of complications that requires special attendance during labour pain.

The findings on the place of delivery for the last child indicated that 221 (57%) delivered their latest child at home while 169 (43%) delivered at health facility (Figure 4.1).

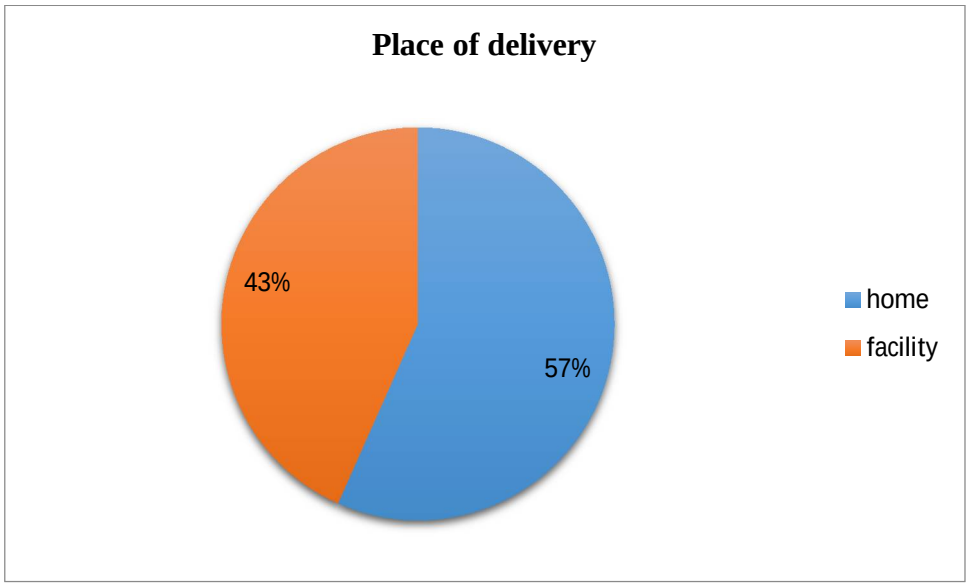

Figure 4.1: Place of Delivery of last child

The delivery at home was reportedly occasioned by various factors which include level of awareness on benefits of delivering at health facility, distance between households and health facility, poor road network, lack of transport and cultural factors. These findings are almost similar to those of KDHS (2014) in which West Pokot County was reported to have 26% of deliveries happening at health facilities while the rest were at home. This report ranks West Pokot County the fourth last County, Samburu County with 25% and Turkana County with 23% are ranked third and second last, respectively, while Wajir County is ranked last with 18% of deliveries taking place at health facility. Similarly, the KDHS (2014) report states that the Kirinyaga and Kiambu County are the leading Counties with the highest number of deliveries at health facility at 93% while Nyeri and Nairobi Counties are ranked second with 89% of deliveries happening at health facility.

Similarly, the KDHS (2010) indicates that West Pokot County has 18.1% of deliveries at health facilities hence from the record there has been an increasing trend towards embracing deliveries at health facility by the residents of this county of study.

In addition, there has been an increase in the number of health facilities and trained medical personnel in the County since the implementation of devolution in 2013. West Pokot County government had doubled the number of health facilities from 56 in 2013 to 114 with 96 of these facilities offering maternal and child survival service and other 56 outreaches offering maternal and child health services and this could be among the reasons that have led to enhanced uptake of maternal and child survival services including deliveries at the health facilities. The KII 3 revealed that the number of skilled medical staff have also increased from the previous 412 in 2013 to now about 750 officers. The contribution of delivery at health facility by expectant mothers cannot be underestimated as research conducted by Habibov and Fan (2014) in Azebaijan shows that women who delivered at healthcare facilities increases the probability of child survival by 18%.

Generally, these findings corroborate those of KDHS (2009), which report that the average of deliveries of babies in Kenya that took place at health facilities under the skilled birth attendants were recorded to be an average of 44.0%.

4.5 Source of Information on Antenatal Clinic (ANC) Services

The respondents were asked to indicate where they first learnt about the services offered during antenatal clinic. This variable sought to establish the sources from which the community members accessed information that create awareness and subsequently increase of uptake and utilization of maternal and child survival services. The results in Figure 4.2 below identify the sources of information on where residents first came to learn about service offered at ANC.

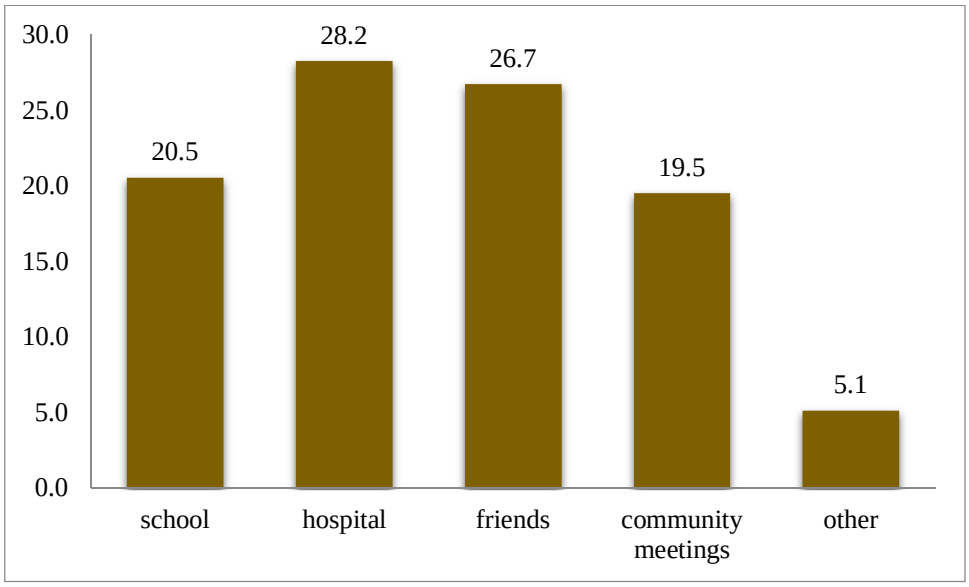

Figure 4.2: Source of information on ANC

Figure 4.2 reveals that a hundred and ten (28.2%) came to know about ANC services through the hospital, while one hundred and four of them (26.7%) through friends whereas eighty (20.5%) reported schools as the source where they first came know about services offered during ANC. When the respondents were asked about the services offered at ANC clinic, three hundred and thirty-five (88.8%) reported that they were aware of services offered at ANC and enumerated these services.

4.6 Frequency of Attending ANC

The respondents were asked to state the number of times they visited health facilities for ANC service before giving birth. This variable helped to show how women of reproductive age understand and respond to maternal and child survival messages passed to them by health workers. The findings on the times the respondents attended clinic during their latest child are captured in Figure 4.3.

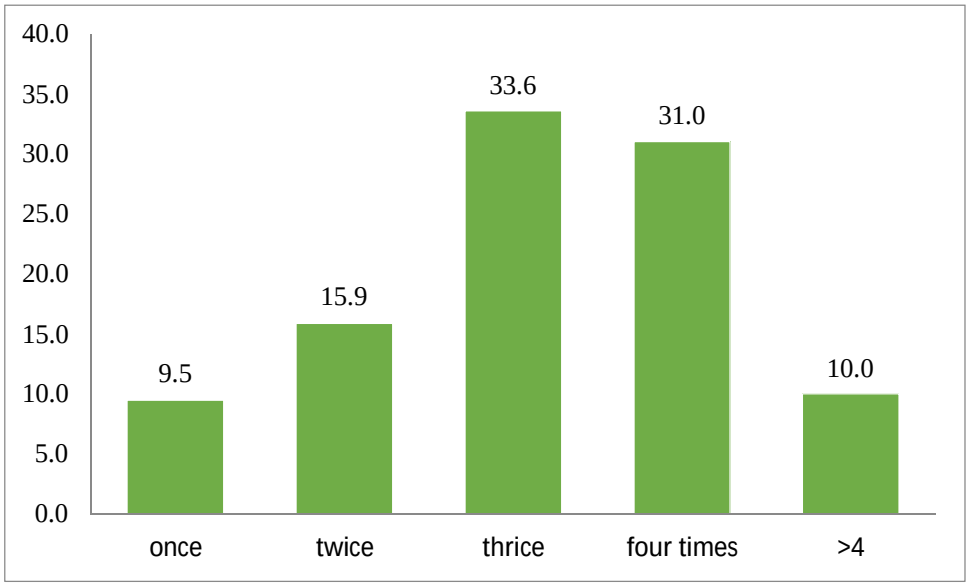

Figure 4.3: Times attended ANC

Figure 4.3 shows that a third of the respondents, 131 (33.6%), reported to have attended ANC 3 times, 121 (31.0%) four times while 39 (10%) had attended ANC more than four times. These findings show that about three-quarters (76.6%) of the respondents attended ANC clinics three times and above during the pregnancy of their latest child. The findings in Figure 4.3 also indicate that the higher the frequency of attending ANC, implies that the pregnant and lactating women have gotten the messages disseminated to them by the CHWS, and that they are responding to the information they obtain from the CHWs and at health facilities and this was evidence by their responses on attendance of ANC clinic hence uptake of the services offered.

4.7 Benefits of Attending ANC

The respondents were asked to state whether or not they were aware of the benefits of going for ANC services at health facility during pregnancy. This variable has a significant impact on the respondents and community at large desiring to seek for maternal and child survival services offered at ANC clinic. It was conceptualised that when people are aware of the benefit of the services offered at health facility they will put more effort to seek for those services offered during ANC clinic.

Therefore, it was noted that the more the community members understand the benefits of the services offered at health facilities, the more they normally respond and subsequently utilizing or desire uptake of maternal and child health services. The results on the respondents' awareness on the benefit of attending ANC clinic were as presented in Table 4.7.

Table 4.7: Benefits of Attending ANC

Benefit	Frequency	Percentage (%)
Helps in detecting complications during pregnancy	368	94.4
Helps in reducing maternal death	373	95.6
help in preventing diseases that may cause death	379	97.2
Ever missed attending ANC clinic	84	21.5

Table 4.7 shows that majority of the respondents reported that attending ANC helped in detecting complications during pregnancy, 368 (94.4%), helps in reducing maternal death, 373 (95.6%) and that it helps in preventing diseases that may cause death 379 (97.2%). On whether or not any of the respondents had ever missed ANC clinic only 84 (21.5%) reported to have ever done that.

4.8 Distance to the Nearest Health Facility Offering Maternal and Child Health Services

It was vital to establish the distance to the nearest health facility offering maternal and child health services in order to gain insight into the barriers that may hinder access and adoption of maternal and child survival messages in West Pokot County. The results of the study on this variable were as presented in Table 4.8.

Table 4.8: Distance to the Nearest Clinic offering Maternal and Child Health Services

Distance in Kilometres	Frequency	Percentage (%)
1-5	145	37.2
6-10	112	28.7
11-15	43	11.0
16-20	22	5.6
>20	68	17.4
Total	390	100.0

The research findings in Table 4.8 indicate that 145 (37.2%) of the respondents lived a distance of between 1Km to 5 Km while 68 (17.4%) of them revealed that the nearest clinic offering maternal and child health service was over 20 kilometres.

4.9 Means of Transport to the nearest Health Facility offering Maternal and Child Health

Means of transport to the nearest health facility offering maternal and child health services was considered a very important variable. It presented the means expectant mothers and those nursing babies use to reach health facility while seeking maternal and child health services. The respondents were asked to indicate the most frequent means of transport that they normally use to the nearest health facility when seeking maternal and child health services. The research findings of various means of transport to the nearest health facility were as presented in Table 4.9.

Table 4.9: Means of Transport to the Nearest Maternal and child Health facility

Item	Frequency	Percentage (%)
Walking	266	68.2
Motorcycle	112	28.7
Public Motor vehicle	12	3.1
Total	**390**	**100**

Table 4.9 shows that almost three-quarters, 266 (68.2%), of the respondents interviewed reported that they walked to the nearest clinic offering maternal and child health while 112 (28.7%) reported that they used motorcycles and only 12 (3.1%) respondents reported to use public motor vehicles to the nearest health facility.

4.10 The Cost of Transport to Health Facility

The cost of transport to the nearest health facility was considered as a variable that influences the adherence of attending ANC clinic for services offered at the health facility. Cost of transport could cause delay decision-making process over whether or not to visit the health facility for maternal and child health services.

Table 4.10: Cost of Transport to Health Facility

Item	Frequency	Percentages
Ksh 50-100	60	15.4
Kshs 101-200	138	35.4
Kshs 201-300	94	24.1
Kshs 301-500	56	14.4
Kshs >500	42	10.8
Total	**390**	**100**
Cannot easily afford transport	192	49.2

Findings in Table 4.10 indicates that 138 (35.4%) of the respondents reported used between Ksh.50 and Ksh.100 while 94 (24.1%) of them said they used between Ksh. 101 and Ksh.200. Only 42 (10.8%) of the respondents reported to use over Ksh.500.

About a half. 192 (49.2%) stated that they could not easily afford the cost of transport to the nearest health facility for maternal and child health services. The remaining 198 (50.8%) revealed that they could afford the cost of fare to the nearest health facility offering maternal and child health services.

4.11 Correlation of demographic characteristics and response to maternal and child survival messages

Socio-demographic characteristics were tested on their influence on response of maternal and child survival messages. Cross-tabulations were used to test the relationship between socio-demographic characteristics of respondents and their responses to maternal and child survival messages namely delivering at health facility and attendance of ANC clinic. Bivariate analysis test were conducted to test significance through the use of chi square statistics. Results of the analysis on chi-square statistics for each independent and dependent variable have been presented, interpreted and discussed in Table 4.10.and 4.11.

4.11.1 Correlation of socio-Demographic characteristics of the study respondents and the Place of delivery

The findings in Table 4.11 show the relationship between the socio demographic characteristics and place of the respondents.

Table 4.11: Demographics and Place of Delivery

Characteristic	Place of delivery		Chi-value	p-value
	Home	Facility		
Education level				
None	47 (68.1)	22 (31.9)		
Primary	107 (60.1)	71 (39.9)	64.277	<0.001
Secondary	21 (27.3)	56 (72.7)		
College /tertiary	6 (9.1)	60 (90.9)		
Age (years)				
<=25	67 (47.5)	74 (52.5)		
26-35	45 (34.9)	84 (65.1)	13.476	0.001
>35	70 (58.3)	50 (41.7)		
Married				0.481
Yes	147 (44.5)	183 (55.5)	0.603	
No	29 (48.3)	31 (51.7)		
Religion				
Christian (catholic)	75 (40.5)	110 (59.5)		<0.001
Christian (Protestant)	67 (42.7)	90 (57.3)	22.095	
Christian (SDA)	8 (38.1)	13 (61.9)		
African traditional	20 (90.9)	2 (9.1)		
Other	3m(60)	2 (40)		
Income	4000(3000,5000)	4000 (2000, 5000)	Z=0.33	0.974

There was a significant relationship between education level, age, religion and place of delivery. Proportion of those who delivered at the facility increased with an increase in the level of education (chi=64.277, p<0.001). Higher proportion of those aged 26-35 years (65.1%) delivered at the facility compared to 52.5% of those aged 25 years or less and also to 41.7% of those aged 35 years and above.

Smaller proportion of the African traditionalists (9.1%) delivered at the facility compared to other religions as in Table 4.11.

4.11.2 Correlation of socio-demographic characteristics of the respondents and the number of attendance of ANC clinic

In this section the researcher attempted to test whether a relationship exist between socio-demographic characteristics and number of attendance of ANC clinic. Table 4.13 present the results. In Table 4.13, it shows that there was a significant relationship between education level, religion and number of times attended ANC ($p<0.005$). The proportion of those who attended ANC more than 4 times increased with an increase in the level of education ($p<0.001$). Lower proportion of the Protestants attended ANC more than 4 times compared to other religions

Table 4.12: Demographics and ANC Attendance

Characteristic	**Times attended ANC**			**Chi-square**	**p-value**
	<4	4	>4		
Education level					
None	56 (81.1)	10 (14.5)	3 (4.3)		
Primary	115 (64.6)	46 (25.8)	17 (9.6)	61.033	<0.001
Secondary	34 (44.2)	31 (40.3)	12 (15.6)		
College /tertiary	15 (25.0)	31 (51.7)	14 (23.3)		
Age (years)					
<=25	83 (58.9)	41 (29.1)	17 (12.1)		
26-35	60 (46.5)	43 (33.3)	16 (12.4)	0.538	0.970
>35	72 (60.0)	36 (30.0)	12 (10.0)		
Married					
Yes	196 (59.4)	95 (28.8)	39 (11.8)	0.647	0.724
No	34(56.7)	17 (28.3)	9 (15.0)		
Religion					
Christian (catholic)	94 (50.8)	70 (37.8)	21 (11.4)		
Christian (Protestant)	100 (63.7)	43 (27.4)	14 (8.9)	20.753	<0.001
Christian (SDA)	9 (42.9)	6 (28.6)	6 (28.6)		
African traditional	18 (81.8)	2 (9.1)	2 (9.1)		
Other	3 (60)	1 (20)	1 (20)		
Income	4000 (3000, 5000)	4000 (2000, 5000)	2750 (2000, 4750)	2.970	0.226

4.12 Forms of Interpersonal Communication used in Promoting Maternal and Child Survival

The forms of interpersonal communication used in promoting maternal and child survival in this study was one of the most important factor as it is through those ways or forms that the community members learn about the importance of maternal and child survival messages. The forms of interpersonal communication were therefore seen as a critical variable in this study as it's avenues of access and uptake of maternal and child survival messages and subsequently utilization of these services. The research findings of the study on the forms of interpersonal communication used in promoting maternal and child survival messages were as presented in Figure 4.4.

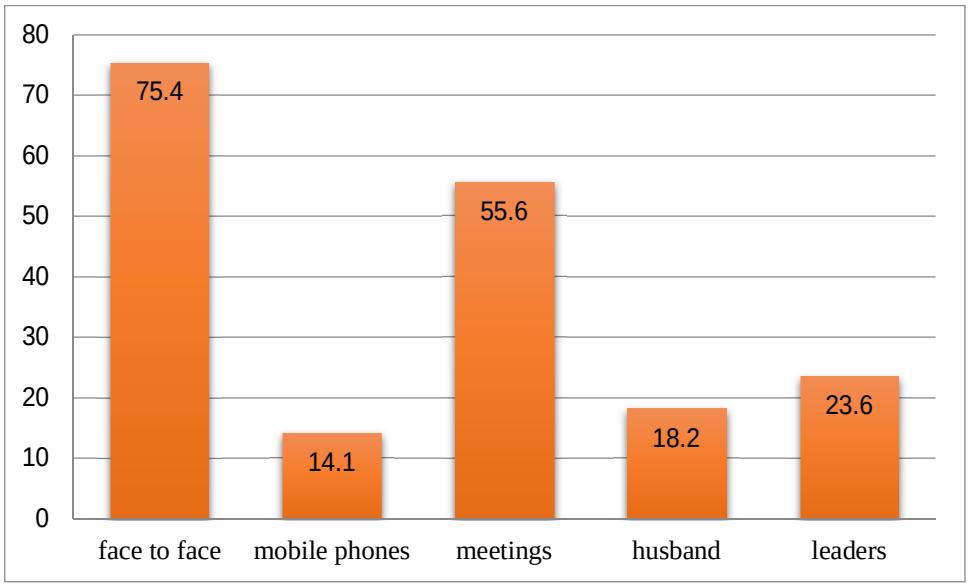

Figure 4.4: Forms of interpersonal communication used in promoting maternal and child survival

Figure 4.4 indicates that the most common forms of interpersonal communication used in promoting maternal and child survival were face to face 294 (75.4%), meetings 217 (55.6%) and use of leaders 92 (23.6%). The use of husband was rated second last at 71 (18.2%) while the use of mobile phones was rated last 55 (14.1%), respectively.

The interviews of with the key informants (KIIs) revealed that face-to-face form interpersonal communication was the most common and best form of interpersonal communication that have been used in promoting maternal and child survival campaigns. This was stated by KII 2 who had been carrying out health promotion campaigns in the County for several years:

> Interpersonal communication which always include; face-to-face, dialogue and health talks are the best and strong ways of handling sensitive health issues. Given that it is the best way it is also very expensive and time consuming (Personal Communication, KII 2, 2016).

Through KIIs and FGDs, it was further established that other forms of interpersonal communication that were commonly used included use of leaders, community dialogue, *Barazas*, health days, stakeholder forums, road shows community radio, text messages, mobile phone-calls and community mobilization, rallies, and cultural events.

The respondents further stated that the use of mobile phones had not been incorporated into the strategies used in reaching out to the community with maternal and child survival messages into by the government. The initiative of using mobile phones to boost the campaigns have not been adopted as the government has not developed software to be used by the community health workers (CHWs) as in other parts of the World. Mobile phones are usually used to send messages (SMS) to pregnant mothers and lactating ones and inform them of the clinic days. Mobile phones are also used by health workers to reach out to the lactating mothers to attend clinics by calling them at regular intervals. In Rwanda, for example, the health management information systems have been incorporated in various electronic health records and software programmes, web-based platform such as mobile phones (Musafili, 2015). Mobile phone technology resources have improved availability and quality health information systems needed for prevention, management and monitoring and evaluation of programmes through an alert system known as rapid short messages services-SMS (Musafili, 2015; WHO, 2013). This rapid SMS which is a mobile phone health system that particular country has implemented for the promotion of maternal and child survival since 2009 (Musafili, 2015).

The way this works is that pregnant women and children under five years are regularly monitored by the Community Health Workers (CHWs), who notify those who should be examined to present themselves to the nearest health facility by SMS. CHWs also report on monthly basis information related to case management of maternal and child health including any deaths at home. This could be attributed to the success of reduction of child mortality rate in Rwanda making it the leading country in East Africa region, in reduction of child mortality rate at 54 per 1000 births (WHO, 2013).

As shown in Figure 4.4, the use of mobile phone in West Pokot County is very low among the CHWs, standing at 14.1% and this could be attributed to lack of creation and implementation of mobile phone software programmes for CHWs and other health workers as in Rwanda. The monthly reporting of CHWs is still manual hence lack of accurate data that could aid in maternal and child survival campaigns.

4.13 Interpersonal Communication in Maternal and Child Survival Campaigns

The research findings in Figure 4.4 reveals that 75.4% of the respondents rated face to face as the most common form of interpersonal communication that has been used to the benefit of the target group followed by meetings with 55.6%, with the use of leaders at 23.6% while husbands were rated at 18.2% and the use of mobile was recorded as the least used form of interpersonal communication with only 14.1% of respondents acknowledging that this mode of communication has been used to their benefits.

These findings are in agreement with the suggestions given by the Kenya Ministry of Health (2014) that health workers should use face-to-face mode of interpersonal communication considering the complexity of health issues. It was also pointed out that the use of face-to-face form of interpersonal communication imparts knowledge and creation of awareness among the community members and this will in turn increase knowledge and influence perceptions, beliefs and attitudes and ultimately enhance possibility of driving community to prompt action (MOH, 2014).

Face-to-face interaction between the health workers and the clients coming for maternal and child health services at the health facility must always be preceded by health talks or health education as a norm. According to the FGDs 1 and 2 (Personal Communication, 2016) and KII 2 and 3 (Personal Communication, 2016), health facilities during the days set aside for maternal and child health clinics, maternal and child health education and sensitization are held first before the beginning of any other service. This forum provides arena for the health workers to discuss face-to-face with the mothers who in turn ask questions and seek for clarifications on issues related to maternal and child health.

Face-to-face health talks during the clinic days for ANC and immunizations services are one of the packages that has been stressed by MOH policy, that it must be offered during the clinic days according to KIIs and FGDs report.

According to Wambugu (2016), face-to-face communication enhances the synchronization of the brain, makes use of our native, in-born skills and abilities that digital platform does not. This was corroborated by the FGD 2 group member, who observed as follows:

> The most common interpersonal communication method used here is face-to-face talk; where the health workers assemble people and present to them maternal and child survival messages. This happens mostly in health facility where messages on services rendered at health facility are passed to the audiences who have attended the clinic during those particular days set aside for clinics. Another form which used is the community meeting popularly known as *barazas*, and here the Community Health Workers or Volunteers (CHW/Vs), have sessions of giving health talks or lectures to the community members.
>
> In line with Community Health Strategy, the community has been sub divided or segmented into units and the CHW/Vs are to take care of those units in terms of their health needs with the assistance of the CHEWs. When the CHW/Vs visit homes they pass maternal and child survival messages through face-to-face talks and sometimes when they visit markets or in a meeting where there are crowds, role plays or local drama or locally produced videos are also used to drive the important messages to the audience (Personal Communication, FGD2 member 4, 2016).

Again, it was revealed during KIIs and FGDs discussions that pictures are used for demonstrations. Information Education Communication (IEC), materials are also used to educate the public like the baby and mother pictures which are commonly used in the health facility. In addition, it was found that charts showing the effects of diseases like polio are used to educate the public and drive the message to the people that if they fail to take their babies for immunization as required, the target child may be affected by these diseases which could be have been prevented through immunizations.

The use of mobile phones was recorded to be the least used form of interpersonal communication with only 14.1% of respondents revealing that mobile phone has been used to their benefits. This corroborates the observations made by Schiavo (2007), that technology-mediated interpersonal communication are more widespread in developed countries than in many countries in the developing world, where more conventional ways of communications like word of mouth may still be dominant. KIIs and FGDs interviews held revealed that mobile phones were mainly used only when passing urgent messages like informing the clients the new changes on the information provided earlier like if the mobile clinic day for maternal and child health has been changed due to unavoidable circumstances, mobile phones are normally used by CHW/Vs to pass such messages to their respective households indicating the changes. Community radio is sometimes used to pass such messages to the target audience and also calling the others who heard the message to inform the target group.

The respondents who participated in the FGDs and KIIs discussions also elaborated that such forums were good for reinforcing knowledge and attitude and in addition provides an opportunity to refute myths and misconceptions on maternal and child health messages. They further pointed out that *Barazas* allowed for detailed discussions and seeking of clarifications on attitudes and cultural practices that are common in the community. The participants in FGDs again noted that this mode is suitable when there is need for quick or prompt action that requires the community to discuss and act collectively.

One the FGD member explained that,When the CHWs visit community meetings (Barazas) they discuss in details maternal and child survival messages through face-to-face and sometimes when they describe the situations that the local people can relate to and this is normally aimed at driving the important messages to the audience (FGD2 member 3, 2016).

There was need to establish the factors that are in play while choosing modes of interpersonal communication in promoting maternal and child survival in the study area.

Table 4.13 shows the findings on the factors associated with the choice of face to face mode of interpersonal communication.

Table 4.13: Factors associated with Choice of Face-to-Face mode of Interpersonal Communication

Factor	**Face-to-face**		**χ^2-value**	**p-value**
	Yes	**No**		
Age				
<=25	114(80.9)	27 (19.1)		
26-35	101 (78.3)	28 (21.7)	9.496	0.009
>35	103 (85.8)	17 (14.2)		
Married (Yes)	279 (82.1)	61 (17.9)	0.055	0.942
Education				
None	56(81.4)	13(18.6)		
Primary	143(80.3)	35(19.7)	0.225	0.973
Secondary	64(83.1)	13(16.9)		
Tertiary	55(83.3)	11(16.7)		
Religion				
Christian	301(82.9)	62(17.1)	7.109	0.016
Others	17(63)	10(37)		
Occupation				
Government employee	36(85.7)	6(14.3)		
Self employed	231(81.3)	53(18.7)	1.289	0.525
Others	54(84.4)	10(15.6)		

Age-group and religion were significantly associated with choice of face to face as a form of interpersonal communication used in promoting maternal and child survival. Majority of those above 35 years chose the use of face-to-face compared to those below 35 years. A higher proportion of Christians preferred face-to-face compared to other religions (82.9% versus 63%). Regression analysis indicated that those aged 26-35 years were almost 3 times more likely to choose face to face compared to those above 35 years (OR; 95% CI: 2.822; 1.388-5.739).

Similarly, Christians were almost 3 times more likely to choose face to face compared to other religions (OR; 95% CI: 2.801; 1.204-6.519). The Christians, namely Catholics, Protestants and SDAs, as shown in the findings on Table 4.12, were three times more likely to use face-to-face form of communication than any other religions. This point was elaborated by both the key informants and FGDs that Christians in that particular area normally met several times a week with the main services held on Sunday or Saturday. In these forums face-to-face form of interpersonal communication was always used to share Christian messages and any other important messages like maternal and child survival messages. During the FGD 1, one of the respondents noted that:

> We always use churches to make announcements and educate the community members on maternal and child survival messages. When we have church meetings in most cases sessions are reserved for health education which are mostly on maternal and child health, nutrition and general sanitations especially during the seasons when there are diseases outbreaks. The church meetings are important arenas where maternal and child survival messages are spread and key new issues passed to the members of the community. The churches have mid-week services normally held in the homes within villages (FGD1 respondent 2, 2016).

It was also revealed during FGDs discussions that the church forums are important avenues of spreading health messages including maternal and child health as some of the main churches namely Catholic and Evangelical Lutheran church have several health facilities in the study area. During their meetings, the church normally reserves sessions for health education.

Table 4.14: Factors Associated with Choice of Mobile Phones for passing maternal and child health messages

Factor	Mobile phones		χ2-value	p-value
	Yes	**No**		
Age				
<=25	121(85.8)	20(14.2)	4.183	0.124
26 -35	106(82.2)	23(17.8)		
>35	50(41.7)	70(58.3)		
Married (Yes)	57 (17.3)	275 (83.3)	3.845	0.050
Education				
None	56(81.2)	13(18.8)		
Primary	143(80.3)	35(19.7)	0.225	0.973
Secondary	64(83.1)	13(16.9)		
Tertiary	55(83.3)	11(16.7)		
Religion				
Christian	60(16.5)	303(83.5)	5.110	0.024
Others	0(0)	27(100)		
Occupation				
Government employee	20(47.6)	22(52.4)		
Self employed	35(12.3)	249(87.7)	38.713	<0.001
Others	7(10.9)	57(89.1)		

Religion, age-group and occupation were significantly associated with use of mobile phones as forms of interpersonal communication in promoting maternal and child survival ($p<0.05$). A higher proportion of those in South Sub-County acknowledged that mobile phone have been used to their benefit compared to those from Central (18.5 versus 11.5%). Higher proportion of government employees noted the mobile phones have been used to their benefits on maternal and child services compared to the self-employed and others (47.6% vis a vis 12.3% and 10.9%).

A higher proportion of those below 35 years indicated that mobile phones have been used to their benefits compared to those above 35 years. Higher proportion of Christians chose use of mobile phones compare to (0%) of the other religion. Regression analysis indicated that those in the South Pokot sub-county were almost 2 times more likely to choose the use of mobile phones to their benefits compared to those from Central (OR;95% CI: 1.986; 1.081-3.648). The married were 2 times more likely to choose to use mobile phones compared to the unmarried (OR; 95% CI: 2.353; 0.774-7.157). Government employees were almost 9 times more likely to choose use of mobile phones as source of maternal and child health messages compared to the unemployed (OR; 95% CI: 8.485; 2.880-24.994). The explanation on why those employed in government are more likely to use mobile phones than their self-employed counterparts, could be due to the affordability and also the strict schedule of their work of those employed group compared to those who are self-employed who have flexible time schedule.

4.14 Factors Influencing the Choice of Interpersonal Communication used in Promoting Maternal and Child Survival

In the Community Strategy Manual, the CHWs are tasked to visit their respective households and pass maternal and child health plus other important health issues. Each community health worker or volunteer has been allocated about 50 households where he or she is expected to visit these households and pass health messages and this is normally done through the use of face-to-face or one on one talk (MOH, 2007).

Through FGDs and KIIs discussions, other factors that influenced the choice of the interpersonal communication methods used included indicators, government policy and national campaigns. According to one participant in the FGD 2, on the choice of interpersonal communication:

> The health workers and CHW/Vs normally use various indicators which help them to identify the groups of people according to the region or villages and the levels on where they are on the adherence of maternal and child survival messages.

> Through assessing the situation, appropriate strategies identified and used in order to increase the adherence and or the number of people who need to respond positively to maternal and child survival messages and to urge those who are doing well in adherence to maternal and child health messages to continue with such spirit. If there is a drop in immunization for example, they analyse and use identified methods to call for an action from the specific target groups which include community and opinion leaders who can help spread the message during barazas/meetings, in order to enhance response and improve indicators in the affected area of their jurisdictions (Personal Communication, FGD2 respondent 2, 2016).

The above respondent further clarified that every health facility which offers maternal and child survival service daily but some have specific days of the week dedicated to maternal and child health services and this therefore requires that the messages to be shared during such week days have to be specific to the group (women with children and expectants). This was affirmed by other FGDs and KIIs as the true picture of what normally happens. During such sessions held at the health facility, the health workers use face-to-face, charts and other teaching aids within the facility to pass maternal and child health messages. On the understanding of the government policy with regard to maternal and child health message dissemination, KII 3 narrated as follows:

> Government policy especially on maternal and child survival are elaborate and clear to health workers, which require that before starting maternal and child services like immunization for expectant mothers and children, the health workers have to explain to the target persons the reasons for giving the services. The policy guides that people need to know the purpose of the immunization for them to complete all the series of immunization. The mothers needed to be guided during the clinic attendance on the returned date and the importance of the immunization taken and the one to be undertaken during the proposed returned date. Both FGDs and KIIs interviews confirmed that all the government and Faith based health facilities adhere to this government policy (KII 3, 2016).

The respondent also explained that during this health education sessions, face-to-face form of interpersonal communication is normally used to conduct the health education. The FGDs and KIIs held also disclosed that there are periodical campaigns by the national government on foreseeing the danger that require immunizations either of children under 5 years or expectant mothers.

One of the KIIs explained that in such a case the government normally planned and announced the massive campaigns spearheaded by the Ministry of Health officials. Moreover, all other stakeholders, including NGOs and local administration, were usually called upon to get involved in such program. During such specific campaigns, the messages to be passed to the audience are specific with a clear call for response. Various forms of interpersonal communication are used which include face-to-face talks, *barazas*, local leaders, use community radio, mobile phones, use of leaders and husbands.

Table 4.15: Factors associated with Choice of Meetings (*Barazas*)

Factor	Meetings (***Barazas***)		χ2-value	p-value
	Yes	**No**		
Age				
<=25	70 (49.6)	71 (50.4)		
26-35	66 (51.2)	63 (48.8)	7.499	0.024
>35	86 (71.7)	34 (28.3)		
Married (Yes)	208 (57.3)	112 (30.9)	20.169	<0.001
Education				
None	50 (72.5)	19 (27.5)		
Primary	108(60.7)	70(39.3)	14.563	0.002
Secondary	34(44.2)	43(55.8)		
Tertiary	32(48.5)	34(51.5)		
Religion				
Christian	203(55.9)	160(44.1)	9.694	0.002
Others	23(85.2)	4(14.8)		
Occupation				
Government employee	27(64.3)	15(35.7)	29.689	<0.001
Self employed	181(63.7)	103(36.3)		
Others	16(25.0)	48(75.0)		

Age-group, marital status, education, religion and occupation were significantly associated with the use of meetings as a form of interpersonal communication used in promoting maternal and child survival ($p<0.05$).

Table 4.16: Factors associated with Choice of Husband as Source of Information

Factor	Use of husband		$\chi 2$-value	p-value
	Yes	**No**		
Age				
<=25	30(21.3)	111(78.7)		
26-35	32(24.8)	97(75.2)	0.066	0.967
>35	25(20.8)	95(79.2)		
Married (Yes)	81(24.5)	249(75.5)	1.486	0.223
Education				
None	15(21.7)	54(78.3)		
Primary	30(16.9)	148(83.1)	3.608	0.307
Secondary	19(24.7)	58(75.3)		
Tertiary	20(30.3)	46(69.7)		
Religion				
Christian	87(24.0)	276(76.0)	1.037	0.308
Others	4(14.8)	23(85.2)		
Occupation				
Government employee	20(47.6)	22(52.4)	16.599	<0.001
Self employed	55(19.4)	229(80.6)		
Others	10(15.6)	54(84.4)		

Occupation was significantly associated with use of husbands as forms of interpersonal communication in promoting maternal and child survival ($p<0.05$). Higher proportion of those in Central chose the use of husbands compared to those from South (29.55 vs 16%).

A higher proportion of the government employees chose use of husbands compared to the self-employed and others (47.6% vs 19.4% and 15.6%). Regression analysis indicated that those from Central were almost 3 times more likely to choose husband compared to those from the south (OR; 95% CI: 2.572; 1.513-4.371). Government employees were 3 times more likely to choose husband compared to the unemployed (OR; 95% CI: 3.192; 1.304-7.816).

Table 4.17: Factors associated with Choice of Leaders

Factor	**Use of leaders**		**χ2-value**	**p-value**
	Yes	**No**		
Age				
<=25	59 (41.8)	82 (58.2)		
26-35	93 (72.1)	36 (27.9)	7.333	0.026
>35	53 (44.2)	67 (55.8)		
Married (Yes)	170 (50.6)	160 (49.4)	1.624	0.203
Education				
None	37(53.6)	32(46.4)		
Primary	85(47.8)	93(52.2)	3.299	0.348
Secondary	32(41.6)	45(58.4)		
Tertiary	36(54.5)	30(45.5)		
Religion				
Christian	180(49.6)	183(50.4)	0.268	0.605
Others	12(44.4)	15(55.6)		
Occupation				
Government employee	30(71.4)	12(28.6)		
Self employed	143(50.4)	141(49.6)	23.209	<0.001
Others	17(26.6)	47(73.4)		

Age-group and occupation were significantly associated with use of leaders as a form of interpersonal communication in promoting maternal and child survival ($p<0.05$).

Majority of the respondents from Central Sub-County 132(66%) chose the use of leaders as a form of interpersonal communication in promoting maternal and child survival compared to 62 (32.5%) from the South Pokot Sub-County. A higher proportion of those aged 26-35 years, 93 (72.1%), used leaders as a form of interpersonal communication in promoting maternal and child survival compared to 53 (44.2%) of those aged above 35 years. Majority of the government employees, 30(71.4%), chose use of leaders as a form of interpersonal communication used in promoting maternal and child survival compared to others 17(26.6%).

Those from Central Sub-County were almost 4 times more likely to choose use of leaders compared to those from South Pokot (OR; 95% CI: 3.847; 2.473-5.983). Government employees were 5 times more likely to choose use of leaders compared to the unemployed (OR; 95% CI: 5.345; 2 .094-13.642). This is because cultural practices which are normally spearheaded by the leaders is still stronger in Central Pokot than in South Pokot Sub-County.

Apart from the cultural factors and physical accessibility as stated by the respondents, there are other underlying issues. These were further expounded below through the discussions with KII 2.

> We also use public meetings (*barazas*) to pass maternal and child survival messages especially during campaigns like the one for the polio we had last month. We sent messages to the chiefs and assistant chiefs to announce the campaigns in their respective meetings and inform people about the places where immunization will be undertaken. In areas where we have CHW/Vs we sent them to *barazas* to make the announcements and to explain to the community the importance of responding to the call.
>
> Again, we also use churches to make announcement and educate on maternal and child survival messages. When we have church meetings, the leadership usually reserve sessions for health education topics such as maternal and child health, nutrition and general sanitation (KII 2, 2016).

Through the discussions held with FGDs and KIIs, it was further disclosed that the mediated communication like mobile phone and community radio (Kalya Radio), are only very important for passing messages or creating awareness on the purposes of the campaigns while face-to-face discussions, teaching and demonstration were seen by the community as ideals where action or adoption is required. This is in line with the observation by Schramm (1988), that the role of media in any communication scenario can be divided into three parts, i.e. to inform, to instruct and to participate.

- **To Inform**: for the development of the society, correct social, political and economic influence is the main criteria. This information should be both national and international. People should be aware of the areas or facts which hamper the development process.
- **To Instruct**: Mass literacy is an essential tool to development. This is possible by spreading basic skills among the people. Mass media plays an important role in this. Mass media can instruct people and educate them.
- **To Participate**: Voluntary and steady participation of the citizens of the country is necessary for its overall development. Such participation is possible in a liberal society (Schramm, 1988).

Such awareness is possible through debate and discussions. Discussions and debate help people to know the current issues, participate in health and developmental programmes and bring a change in the standard of living of the society. To sum up, employing an integrated approach, both interpersonal, technology mediated and mass communication fosters development and health awareness. Specifically, when it comes to community health issues, interpersonal communication and especially face to face is perhaps the hub. To change the behaviour of a certain community regarding health beliefs, interpersonal communication is the fundamental tool for progress. Following is an elaboration of nature and practices.

According to one of the key informants, the locality plays a critical role in the choice of interpersonal communication for maternal and child health. One of the members of FGD 3 noted that:

> The styles used while passing maternal and child survival messages, depends on the settings. For example, while at health facility, the health workers normally use pictures and other tools to pass the messages and even conduct demonstrations through face to face or even at times they use videos to pass the message because the training aids, IEC materials and time to educate are mostly available because those clinic days are reserved for that purpose by parties involved.
>
> Again, one on one or face-to-face communication is the most ideal especially when dealing with sensitive messages that require confidentiality like HIV/AIDS counselling. In other parts of West Pokot, IEC materials that are used have been translated to Pokot language. At times community dialogue and discussions are held on maternal and child survival, in a community or church meetings (FGD3 respondent 1, 2016).

According to Schiavo (2007), health communication is exchange, interchange information and two-way dialogue. A process for partnership and participation of that is based on two-way dialogue, where there is an interactive interchange of information, ideas, techniques and knowledge between senders and receivers of information on an equal footing, leads to improved understanding, shared knowledge, greater consensus, and identification of possible effective action. In summary, employing an integrated approach of using both interpersonal, technology mediated interpersonal and mass communication have been found to be in use in West Pokot County.

4.15 Rating of the Services and Attitudes of Health Workers while Offering Maternal and Child Survival Services by the Community Members

The respondents who were interviewed agreed that the general reception and attitude of the health workers at health facility and CHW/Vs on their approach including when offering health talk to pass maternal and child survival were rated as fairly good with a scoring of 53.8% and 54.6% respectively, as shown in Table 4.18.

The KIIs and FGDs explained that the interpersonal communication forms used are fairly good though it still need to be enriched and the time the health workers spent in giving health talks during the clinic days need to be increased. The respondents recommend for the use of various forms of interpersonal communication while offering maternal and child survival.

This proposed recommendation on multi-integral approach of interpersonal communication that may be used to deliver health messages has been recognized as important in creating and reinforcing individual and community behaviours (MOH, 2014).

Table 4.18: Rating of the Services and Attitudes of Health Workers while Offering Maternal and Child Survival Services

Services	Excellent	Good	Fair	Poor	Very poor	Mean (SD)
General reception	137(35.1)	210(53.8)	33(8.5)	8(2.1)	2(0.5)	1.79(0.7)
Attitudes of health workers personnel including CHWs on health talks/education	119(30.5)	213(54.6)	49(12.6)	5(1.3)	4(1.0)	1.84(0.7)
Availability of equipment/ injections	114(29.2)	149(38.2)	101(25.9)	18(4.6)	8(2.1)	2.12(0.9)

With regards to rating of antenatal care services offered at health facility during last visit, general reception was rated as good by 210 (53.8%) of the respondents, attitude of health workers, including CHWs, while offering health talks was rated good by 213 (54.6%) of the respondents while availability of equipment/injections was rated as excellent by 114 (29.2%) and good by 149 (38.2%) of the respondents. On average, general reception, attitude of medical personnel and availability of equipment/injections were rated as good (mean=2).

The attitudes of health workers at health facility though rated fairly good as shown in the findings in Table 4.18, at a score of 54.6%, the health workers were viewed by the community members to have negative attitude towards them and not caring much about their desire to be assisted while on their mission of seeking for maternal and child health care services and some of these health workers acknowledge that their attitude towards their patients are not up-to the required standard.

The KII 2 pointed out that:

> Concerning our attitude as health workers, we have not reached a level, where we see people coming to the health facility to seek for health services as our clients or customers and that they deserve the best from us. This is a big challenge and need to be addressed by the top management of health department in the county.
>
> When I speak straight on this issues that our attitude to our patients are still poor and wanting, my colleagues says I am being harsh on them. The attitude of the health workers in the facility is a stumbling block to the success of health service seekers in this county. We have a very good charter but that seems not to be adhered to by the health workers. The charter describes how a patient need to be served right from the arrival at the health facility till the time he or she leaves the facility but it is not being implemented accordingly (KII 2, 2016).

As revealed by KII 2, the general reception and attitude of the health workers including CHWs though fairly rated good, the heath workers themselves still acknowledge that much effort is needed to improve interpersonal communication and relationship amongst the two groups. The health workers pointed out that they have not reached a level equated to that of a shopkeeper who desire clients to be visiting him to buy products from his shop. According to both FGDs and KIIs interviews it was further revealed that clients at times when they came to the health facility to seek for the health services, the people who were supposed to receive and serve them joyful at times see like they are being bothered by these service seekers. One of the member of FGD 1 put it this way:

> The health workers need to be targeted with messages that are geared towards changing their attitude. Some health workers are rude and uncaring. They can even tell a patient that “enda mpaka kesho” (please come tomorrow) (Personal Communication, FGD1 respondent 4, 2016).

Messages need to be designed and targeted to change the attitude of the health workers especially those who are based at the health facility. According to both the FGDs and KIIs, addressing the attitude of the health workers would contribute towards improving the adherence of maternal and child survival messages. All the respondents agreed that there is need to address the attitude of the health workers towards the health seekers.

4.16 The Rating of the Antenatal Care Services Offered at Health Facility

The rating of the Antenatal care services offered at health facility was considered as an important variable as this provided an insight into the perceptions of the community on the various services offered to them by the health workers. The results on the rating of the community on these variables were as presented in Table 4.19.

Table 4.19: Rating the Antenatal Care Services offered at Health Facility

Services	Excellent	Good	Fair	Poor	Very poor	Mean (SD)
Palpation of the abdomen	150(38.5)	199(51.0)	26(6.7)	9(2.3)	6(1.5)	1.76(0.8)
Tetanus vaccination	198(50.8)	153(39.2)	31(7.9)	3(0.8)	5(1.3)	1.62(0.8)
Weight measurement/ Height taken	170(43.6)	189(48.5)	23(5.9)	4(1.0)	4(1.0)	1.67(0.7)
Delivery services	131(33.6)	171(43.8)	43(11.0)	34(8.7)	11(2.8)	2.04(1.0)
Immunization of new born	181(46.4)	162(41.5)	31(7.9)	9(2.3)	7(1.8)	1.71(0.8)
Health talk	123(31.5)	221(56.7)	30(7.7)	7(1.8)	9(2.3)	1.87(0.8)
Provision of treated bed nets	148(37.9)	175(44.9)	39(10.0)	18(4.6)	10(2.6)	1.89(0.9)
Iron supplement	180(46.2)	159(40.8)	28(7.2)	15(3.8)	8(2.0)	1.73(0.9)
Counselling on family planning options	130(33.3)	161(41.3)	49(12.6)	26(6.7)	24(6.2)	2.11(1.1)
Anti-malaria treatment	119(30.5)	195(50.0)	46(11.8)	17(4.4)	13(3.3)	1.98(0.9)
Registration of new born	173(44.4)	167(42.8)	27(6.9)	13(3.3)	10(2.6)	1.77(0.9)

More than half of the respondents rated Palpation of the abdomen and Health talk as good. Tetanus vaccination was rated as excellent by 198 (50.8%) of the respondents. On average the services were rated as good (Mean=2), as indicated in Table 4.19.

The respondents who were interviewed and who were also the beneficiaries of health service at health facilities agreed that the general reception and attitude of the health workers including their use of interpersonal communication while passing maternal and child survival messages were rated good with a scoring of 53.8% and 54.6%, respectively, as shown earlier in Table 4.18.

By looking at the results for both the services offered at health facility and the attitude of the health workers towards their clients, it was established that there is need for improvement. The health workers offering health talks at the health facility need to make their presentations interesting by using various forms of interpersonal communication while delivering the messages to make the presentations interesting. One of the FDG 3 members asserted that:

> The CHWs and health workers should be using combination of many methods to present health messages like using testimonials. For example, yesterday, a mother bleed to death on her way to health facility after delivery at home. Another one which we referred to a sub-county Referral Health Facility, because we detect that she had less blood but fortunately she delivered successful on the way to the referral health facility. This incidence may form a basis for explaining to the community the danger of delivering at home, where there is no skilled health professional. There is need to emphasize the risk of delivering at home by giving relevant examples that the community can identify with and relate to (Personal Communication, FGD3 respondent 3, 2016).

The rate of satisfaction of the health seekers influences their responds to the adherence of the maternal and child survival messages.

4.17 Men and Women's Attitudes towards Maternal and Child Survival Campaigns

The point of reference that women have put their attitude on the health workers are based on the tradition and culture of the society especially the place, the women occupy in the community and women's attitude in the context of their environment. A respondent member of FGD 2 said:

> Child bearing in this community is a woman affair, yet men in this same community are decision makers, and thus this complicates the issue of maternal and child survival promotion. We therefore need to change the current strategy and target men to be champions of the maternal and child survival promoters (FGD 2 respondent 3, 2016).

On the other hand, another group member of the same FGD 2 put it this way:

> Since decision-makers in this community are men while delivery of children are women affairs, there is therefore need to take cognizance of this fact that though child bearing and deliveries are women affairs, economic power and decision-making rest with men who are the heads of their respective households (FGD 2 respondent 5, 2016).

Through the FGDs, it was further revealed that men do regard maternal and child health as women issues and hardly do people see men accompanying women to the clinics for maternal and child health services unless when they are very sick. In addition, at the maternal and child health clinic, the environment seems to be created to fit women and no provision for men needs.

Such attitude and views by men tend to constraint the arguments of the participatory model, which stresses the importance of cultural identity of local communities and of democratization and participation at all levels, i.e. national, local and individual. It points to a strategy, not merely inclusive of, but largely emanating from, the traditional receivers (Servaes, 1995). The use of husband to pass maternal and child health messages was only recorded very low (second last in the ranking) at 22.8%, as shown in Figure 4.4. The FGDs and KIIs discussions held explained that socio-cultural practices could be the reason for the low use of this mode of interpersonal communication. One of the member of FGD 1 pointed out that the Pokot community has agreed that children issues are the main responsibility of women. The respondent put it this way:

> …in this community maternal and children issues are the prerogative of women. The maternal and child issues are the preserve of women. Wamama (women) seems to be active in children issues and it seems the community has universally agreed that is the sole responsibility of women (FGD1 respondent 6, 2016).

All the FGDs and KIIs agreed that men should be targeted with maternal and child survival messages as they play a key role of decision makers in their respective households. Again, men are the ones who have resources and targeting them would make positive significance change in the maternal and child survival issues.

On the perception of the health workers, the KII 3 stated that:

> In the maternal and child survival campaigns, in most cases, the health workers do have a negative perception about the community and these assumptions are wrong since it has been concluded at a certain level without looking into the details and the real issues.
>
> In any meeting among the Pokot community, health issues are discussed casually and those discussing it do so shallowly while the real issues are beneath (KII 3, 2016).

On the issues of behaviour of the health workers, it was disclosed that the community members are watching and relate what they say and what they are doing. In both the Focus group discussions and the key informant interviewees, the respondents particularly stressed that the community take time to think about the behaviour of health workers including the CHWs. KII 2 noted that:

> The community do watch the behaviour of the health workers and the elites in the community and are keen to observe what they are doing. Once they notice that they are not doing what they are advising them to do, they will not do what they say. For instance, if the CHWs or health workers are still using the TBAs to assist their wives to deliver instead of taking them to the skilled birth attendants at health facility, they ask why us. Behaviour of the elites in the community betrays the campaigns we are carrying out. When people see the elites and community leaders, they observe what they are doing and compare with what they are saying, it tends to discourage the local community. For instance, if a chief in a location is still circumcising his girls one will not take the message against female circumcision seriously. Preaching and not doing what you preach will not bring the desired results. We are demonstrating wrong things and we expect different results. Pokot want to see actions before you tell them to follow suit. As preachers of this gospel of maternal and child survival, we are supposed to be action-oriented people. Demonstration of behaviour by the elites in the community is enough testimony (KII 2, 2016).

On the other hand, Participants of the FGDs and various interview sessions further revealed that the CHWs are acting as a bridge between health facility and the community which was expected to improve the attitude, relations and interpersonal communication on the maternal and child survival campaigns.

The relationship between the health workers and community elites need to be strengthened and encouraged to get involved on the maternal and child survival campaigns. Messages targeting the opinion leaders from all the health units in the entire Pokot community should be incorporated in this maternal and child survival campaigns for this effort to bear much desired fruits.

Another aspect is making maternal and child health a common discourse in the community meetings or arenas. KII 3 said that:

> At the beginning of our meeting, maternal and child mortality rate is usually the main topic or amongst the important issues we normally discuss. The CHEWs introduces this topic and as a team we discuss. At the end of the meeting we plan to organize health education and community conversation sessions with our respective households and the community at large. We are the representatives of people in the village. Prior communication occurs between us before any health service reaches the people (KII 3, 2016).

It was also pointed out that it is important to have continuous maternal and child survival campaigns using available statistics and compare with that of those communities who are doing well as per WHO indicators till positive results are attained. KII 4 advised that:

> Dialogue among the community members should be initiated and this will lead the community to have a strategy to improve their health situation. The community should have a target and demand the elites in the community to do the same. In such a situation a community can pass a resolution on the requirements which should be adhered to by all including the elites in the community. There are a lot of activities which have been done on health promotion in this community especially on maternal and child survival. We are putting a lot of effort in the campaign and soon the fight will be won (KII 4, 2016).

On the perceptions of the community, one of the key informants who had been carrying out maternal and child survival promotion campaigns revealed that the members of the County had reached a level where they could analyse the messages and it was only on the side of responsiveness that they seemed to lag behind.

Generally, this maternal and child campaigns seemed to have raised mixed attitude especially when it touches on the communities' knowledge, beliefs and attitudes. The communication messages and interventions that are used by CHWs and health workers at the facility is reinforcing existing beliefs and social norms and in some cases establishing new beliefs, attitudes and social norms.

Taking a critical look at the current situation and listening to the FGDs and KIIs, it can be noted that women cannot do something without involving or getting the opinion or the interest of their respective husbands. Because of this, health extension workers are not effectively communicating to all the people who are partially involved which in

turn adversely affects the understanding and acceptance of new behaviours as well as revised gender perspectives. By not including all the gender concerns in the communication process was seen as part of problem why the maternal and child survival messages have not been acted upon. Including all the genders, addressing perceptions and continuous passing of maternal and child health messages will improve implementation of the messages passed to the target groups.

Additionally, when the community health strategy was formed, the concerned bodies did not take into considerations different genders and communication amongst these groups. Also the CHEWs and CHWs were not trained or oriented on creating awareness amongst different genders or how to bring on board different genders to participate and embrace maternal and child survival services.

Similar to the findings of this study, the research in Malawi also shows that social norms related to social identities have influence on health promotion and the cultural context which normally reveals a major disjuncture between the health program and the culture of the community (Sonia, 2010).

The community perception can be constructed to the ideas of Clarke who pointed that, the inclusive and participatory approach establishes active citizenship, a sense of empowerment, partnership, accountability and ownership. All of these concepts and attributes are linked and are complimentary. Without active citizenship and community participation, a sense of ownership over the development process cannot be achieved (Clarke, 2009).

In this study, it was observed that health extension programme or this community strategy does not make gender analysis in the context of participatory development before the program functionalize; gender analysis helps to understand how gender differences affect access to resources and the participation of all the genders in development activities.

Such an analysis could help to take appropriate measures to ensure that men are not excluded. Ideally, gender analysis should not be a separate participatory method but should be integral to all participatory methods.

4.18 Communities' Perception of CHWs and CHEWs

The effectiveness of interpersonal communication often relies on the perceptions of communicator's and reception's attitudes. This perception determines the power balance and communicative behaviour amongst these two groups. Therefore, when perception is affected negatively, it apparently affects the process of communication. From the discussions from both KIIs and FGDs, it emerged that the CHWs have made tremendous contributions as explained by KII 4 who narrates that:

> Despite the short comings, the CHW/Vs have made tremendous impact in the communities within West Pokot County. We have witnessed an increased number of people seeking for services at health facilities after we established 59 units and trained the CHW/Vs. Through this initiative, the immunization coverage has gone up, delivery at health facilities has increased. Again, through sensitization of this group, community members have come to understand that there are services one can seek from health facility even if one is not sick like maternal and child health services or family planning services. In the units covered by community health units, sanitations in the homes have improved and latrine coverage has also gone higher in such areas.
>
> There are a lot of adherences to maternal and child survival messages in the County. Tracing of maternal and child immunization defaulters have significantly improved in the areas covered by CHW/Vs services (KII 4, 2016).

With continuous campaigns of giving health talks and home visits by the CHWs, from the views of the community, there are be positive perception and improved linkage to the health facility which have led to improved adherence of maternal and child survival messages.

Though the CHWs have challenges of financial support by the government which it had been promised earlier by the government officials, there are evidenced of an increased adherence of health messages as a result of their effort as confirmed during FGDs and KIIs.

KII 1 explained it thus:

> The teachings of health workers are clear and well understood. What need to be added to their teachings are emphasis on delivery of expectant mothers at health facilities and importance of taking children to clinics to go through all the immunization processes. There is also need to incorporate the teaching with testimonies and life examples that people can relate with, in the community to emphasize the importance of mothers attending ANC clinic and taking children for immunization and delivery at health facilities. This is importance as someone like me who lost a child and almost passed on during labour pain will not forget or take for granted when anomaly is detected but will follow all the advice offered by the health experts. Had I paid attention to the advice I was offered at Sigor sub-county Hospital, things would not have gone the way it went till I lost my baby (KII1, 2016).

The community has been reported to uphold positive attitudes of the messages on maternal and child survival, presented to them by the CHWs and health workers based at health facility. KII 2 also noted that:

> In the health adoption process, it seems it follows the theory of diffusion of innovation by Everts Rogers, where we have early adopters, early and late majority and finally the laggards. I think in this case, the Pokot community is in the stage of laggards and now we are on the move and soon we will get to where majority are (KII 2, 2016).

Taking a critical look and analysing reports form KIIs and FGDs, it can be concluded that all the concerned parties including the government, community members, stakeholders like NGOs, churches, CHWs and health workers at health facility have made contribution towards the improvement of this sector of maternal and child survival and results are slowly showing up as there seem to be an increase of deliveries at health facility and immunization coverage going by the KDHS reports where in 2009, the report shows that 18.1% of deliveries occurred at health facility while in 2014, report shows of an increase to 26% (KDHS, 2009; KDHS, 2014).

Women from the community have positive attitude towards fellow women health workers who works at health facility in maternity section. As women in service, it was noted that they understand the challenge that women have to go through at home. It was pointed out during FGDs and KIIs, that maternal and child Health is strongly linked with women. The KII 1 observed that:

> There are people within this community who do not appreciate attending ANC clinic or delivering at health facility. Others fear being assisted by the male mid wife in health facility because like here at Chesta health facility, most of our health workers are male and normally conduct deliveries of women and unlike Traditional Birth Attendants (TBAs) who are women (KII1, 2016).

On the contrary to the community's perception through the FGDs, it was pointed out that by the fact the CHW/Vs were selected from the community where they are assigned to serve, have been seen as a plus for the maternal and child health campaigns. By being a member of a particular community where one serves, it was recorded that, that by itself was a strong motivator and encouragement as one will be seeing himself or herself making contribution in the community by supporting their relatives, their family members, and their neighbourhood. Moreover, language and cultural understanding is another very important aspect that gives this group an upper hand in their quest for service delivery. If someone from another ethnic group or a different area is deployed to serve in a certain community, cultural difference could emerge as a factor and this could make the work more difficult.

Being able to effectively communicate using the local language and in the context of that particular community has also been seen as very important and has led to the desired change of upholding maternal and child survival messages.

The leadership of community strategy in the county disclosed that they have been conducting analysis, when they observe that there have been two divergent thoughts between the community's perception and the local health workers.

The implementation of the community strategy is guided by the document or guideline provided by Ministry of Health (MOH, 2007) and implementers have to see that everything they do are in line with the guideline provided. One of the FGD 2 members suggested that:

> There is need to involve the target community on the preparation of such documents, he opined that; in policy development, the target community can be incorporated so that they can own the process of message development and dissemination (FGD 2 respondent 1, 2016).

4.19 The Role of the Community in Communication Process

The CHEWs and CHWs are placed to play an important role in enhancing the program' effectiveness with special contributions they have rendered to communities on maternal and child survival activities. The process of working with the community to enhance maternal and child survival campaigns have been critical and have been geared towards bringing all the stakeholders involved on the board within a given period of time (MOH, 2007).

The FGDs and KIIs, all pointed out that, the contributions from all the stakeholders were paramount to the success of maternal and child survival campaigns. They further recommended that the community members should be involved in the campaigns on maternal and child survival and that those who have enjoyed the benefits out of the campaigns should be recruited, encouraged and urged to get involved as the ambassadors of the program. Going by this observations, it was therefore concluded that the communication process by the community cannot be underestimated as the community members always learn from each other through discussions and sharing of experiences.

One member of FGD 1 observed that:

> One strategy that seem to work in this area is mother to mother support group which was introduced by ACF agency, a non-governmental organization which supports nutrition, maternal and child survival campaigns. This initiative targets to educate pregnant women and mothers with children who are under five years of age, on maternal and child survival programs. Through this initiative, women are empowered and encouraged by fellow women and urged to support fellow mothers within the community. The selection of the group members is based on the village, whereby people who live in the local geographical area team up to form one support group. Right now in this area surrounding Chesta Health Facility, we have five support groups from five villages. These groups support and assist each other, especially when a member is weak and in need. After one has had a baby they assist her to wean the baby after six months and during such time they make a visit and take food stuff for both the mother and the baby. Through this mother to mother support group, there has been an increase in the delivery of babies at our health facility here and adherence of maternal and child survival messages has increased tremendously (FGD1 respondent 1, 2016).

The FGD revealed that the mother to mother women group supplement the maternal and child messages passed to the community by health workers during the clinic days which include urging them to deliver at health facility. It was added that during such meetings (i.e. Mother to mother), women have sufficient time to discuss maternal and child survival issues in details. The FGD 2 member explained that the messages passed to the target audience during clinics are important. He added that:

> When expectant mothers come to the ANC clinic during our weekly clinic here at health facility we normally teach them how to take care of themselves during pregnancy, like birth plans, which is planning where to deliver and also post-partum services available after delivery.
>
> During this health talk or health education we teach about danger anger signs during pregnancy, which include severe headache, bleeding among other danger signs during pregnancy period. We ensure that all the women who attend the ANC clinic must understand why they should attend all the four sessions of the clinic during pregnancy but sometimes because they come when they are in their second or third trimester of their pregnancies they attend two or three times (FGD 2 respondent 4, 2016).

The CHWs and Community Health Committees (CHC) normally work together with the community in planning development process within the community.

On the other hand, from the FGDs perspective they pointed out that, the CHWs, CHC and health workers work together within the community in any project in the health facility like getting involved in constructing residential houses at the health facility so that the health workers are available 24/7 to provide services to the community. Constructing residential houses for the health workers within or near where they are working was seen as an important aspect as it creates favourable working conditions and saves the workers from spending their extra money and time. Getting involved in the work like construction of health facility or residential houses for health workers is seen as part of community participation and help to build relationships and link the community to the health facility.

This is different from the idea of Pretty (1995) that participation for material incentives that people participates by providing resources, for example labour, in return for food, cash or other material incentives.

Much on-farm research falls into this category, as farmers provide the fields but are not involved in the experimentation of the process of learning. It is very common to see this called participation; people have no stake in prolonging activities when the incentives end. Primarily the communities participate by being informed about what is going to happen or has already happened. Community's feedback is non- existent, and their participation is assessed through methods like hand counting and contribution to the discussion. This participation is similar to what Mefalopulos and Tufte (2009) refers to as participation by information or passive participation.

4.20 Strategies used in Enhancing Participation and Behaviour Change Communication

The perceptions of the community on the changing role and participation of the community in the health and development issues seem to be taking root in the county. There has been a lot of participation directed at enhancing participation of all the stakeholders including county government and other stakeholders.

From the FGDs and KIIs discussions held, it was evident that there seem to be growth in involvement of the community in health sector, geared towards behaviour change. KII 4 revealed that:

> We have had some partners who helped us succeed in health promotion activities. We are trying to educate our people on maternal and child survival including nutrition which is an important component of child survival. For example, in this county we have high stunt growth, which means for every ten Pokots, four of them are shorter than what their height ought to have been due to lack of proper nutrition's. Therefore, under this circumstance we have been educating our people on the benefits of having proper nutrition for their children. Sometimes we have been having advocacy directed to the governor and the County government so that they can allocate more funds to the health promotion activities because in the maternal and child health the county is still rated red going by the WHO methods of rating. The county government should see important things like immunization as a right of every child (KII 4, 2016).

Ministry of Health (MOH2017), suggests that in order to make the community strategy package effective and successful, the members of the target community must be involved starting from the planning stage through the implementation, monitoring and evaluation of the programme.

Nevertheless, before going into implementation, it was noted that there is a need to promote the programs and mobilize communities to act accordingly. It was reported through FGDs and KIIs that sensitization and orientation activities have been undertaken at public places including all the segment of the community among them farmers, women and youth associations, religious groups, business people, schools and civil society organizations and such initiatives seem to be raising the awareness on the maternal and child survival program. Many of the NGOs have combined efforts with government to raise awareness on the need for seeking health services from health facilities.

According to KII 2:

> In West Pokot, currently (2016), we have about five active partners in maternal and health care services namely; World Vision, Kenya, Red Cross, Kenya, ACF International, PSI Kenya and Experiential Marketing Agency. Together with these non-governmental Agencies, we normally use the existing systems of community Health workers to pass health messages especially maternal and child survival messages.
>
> Though this is the case, the entire system suffers from several challenges and setbacks like for now the community health workers are not supported as the government has failed to pay them and that's why they have of late been branded or labelled as volunteers so that they cannot ask for any payment for the work done (KII 2, 2016).

Additionally, through FGDs and KIIs, it was noted that, the CHWs were trained just once on the community participation. They added that since the focus of CHWS was mainly health promotion and preventions, there should be continuous training on mobilization of the community and how to get the community participate in all stage of health issues right from Planning, implementation, monitoring and evaluation and eventually sharing of the benefits of their work. Yoon (2000) argues that allowing people to participate in the implementation, evaluation and decision-making processes concerning the health communication strategy, will empower them to benefit and hence yield sustainable outcomes.

4.21 Communication Barriers in the Maternal and Child Survival Campaigns

There are several barriers that tend to influence the conveying of maternal and child survival messages and in turn impede the implementation of the program. These factors have then affected and provided lenses to the community on the way they perceive the maternal and child survival messages passed to them.

4.21.1 Harmful Traditional Practices applied on Children

The major causes of child and maternal mortality in Pokot community are lack of awareness on the part of parents about child health care, and means of preventing common child diseases. Harmful traditional practices that have existed for a long period of time in the society are and still applied on children and women.

The FGDs and KIIs interviews held acknowledged that early marriages and pregnancies among under 18 year's girls are still prevalent in the study area. Another very important aspect is the role of the Traditional Birth Attendants (TBAs), who have been noted by both the KIIs and FGDs as impediment to the maternal and child health campaigns as they still insist that they can still help to deliver expectant mothers at home. KII 3 stated as follows:

> There is need for targeting TBAs who have been giving false information to expectant mothers that health workers at health facilities are quick to resort or recommend for C. Section operations. Therefore, there is need to have clear messages to counter this notion as this is misleading and not true. This wrong perception has been identified as one of the barriers that hinder many women not to come here at health facility for deliveries (KII 3, 2016).

It was also added that early marriage practices could increase the girls' vulnerability to different problems. Forced and early marriages have been confirmed to be prevalent in the community and have been reported several times through community radio (Kalya Radio) which is located in Kapenguria town. It was confirmed through FGDs held that the most affected areas are lowland parts of the county mainly North and Central Pokot Sub-Counties. Although most people acknowledged the complications associated with early child bearing due to early marriages, the community members do not act to control such threat.

4.21.2 Socio-cultural Practices and Interpersonal Communication

There are number of negative cultural practices in West Pokot County that has been seen as hindrances to maternal and child survival campaigns. Through the FGDs and KIIs, it was pointed out that there are a number of expectant mothers and children who have died due to cultural practices that have delayed them from seeking for assistance from the health facility. It was observed through FGDs and KIIs that the community opts to take a patient to the nearby health facility when they have tried all means by using the traditional medicine, and other forms of traditional rituals.

A member of FGD 4, while making a comment on the delay to seek for health service, noted that:

> When they have exhausted all options and confirmed that they are unable to handle the situation, that's when they refer the case to health facility as the last option. Therefore, this is one of impediment especially on maternal and child survival because, we have observed that there is always a delay to bring expectant mother to health facility as in some cases the family members want the child to be delivered at home so that they perform traditional rituals related to a birth of a child (FGD 4 respondent 1, 2016).

On another aspect on the maternal and child health messages passed to the community through interpersonal communication, one members of FGD 1 pointed out that:

> Indigenous knowledge passed from generation to generation through word of mouth (face-to face) seem to be a barrier to the women deliveries at health facility. For example, there is a culture here that before a woman delivers, she has to go through a purification or cleansing ceremony called Parpara. In this ceremony, if a woman has had a sexual affair with another man beside her husband, she has to disclose so that her labour pain will be shortened. Most men would wish their wives deliver at home so that in case there was any another man who had sexual affairs with his wife, would be known and the culprit will have to pay a known fine which is usually two bulls (FGD1 respondent 2, 2016).

It was further observed that this could be part of the reasons why the County had low delivery of children at health facility. It was further disclosed during FGDs discussions that this cultural are aspects prevalent and are strong in the remote areas of West Pokot County where people still insists on performing traditional rituals unlike in urban areas of the county where people are no longer keen to keep traditional cultural practice.

KII 2, who has been carrying out maternal and child survival campaigns, disclosed that:

> During delivery when a woman experience prolonged labour pain they encourage the lady by reminding her of Pokot cultural saying like 'molokonye chepo mron" (a daughter of a real man don't cry under any circumstance). This is one of the powerful quotes used by the TBAs to encourage women to persevere under prolong labour pain instead referring them to health facility for assistance (KII 2, 2016).

Again, the health workers especially at health facility have been viewed with mixed views and reactions. Those who are keen in observing the community behaviour concludes that more efforts are needed in order to overcome the negative perceptions about the community as the community is not rigid as some people might think but at times the community has not been understood especially by the health campaigners. According to one of the member of FGD 4, a health worker:

> In the maternal and child survival campaigns, in most cases the health workers have been having a negative perception about the community and these assumptions are wrong because it has been concluded at a certain level without looking into the details and arriving at, after looking at and analysing the details of the issues. Our community is not like our neighbouring Turkana community who talk straight on any issue. It's not true to say that Pokot community *hawajui kwenda Hospitali ni faida* (seeking services at hospital is beneficial) but none has held dialogue with the community to understand the community and get to know underlying issues and correct it. I have been taking time and listening to the community members to understand them well before offering suggestions on how to address the identified problem (FGD 4 respondent 4, 2016).

During the FGDs discussions some CHWs who were members, disclosed that the community members in some parts of West Pokot county, still believe and uphold strongly negative cultural practices hence there is need to continue mounting campaigns targeting these segments of the community especially in areas where it is known that they still uphold strong socio-cultural practices that hinder adherence of maternal and child survival messages.

Members of the FGDs and KIIs recommended that the health workers, CHEWs and CHWs need continuous follow up and incorporation of local leaders to spearhead campaigns of urging the community to stop negative cultural traditions that impede maternal and child survival. It was further recommended that the community leaders needed further strengthening to empower them and equip them with the knowledge about risks of the expectant mother delivering at home and what need to be done to improve the situation. The risks and consequences of some negative practices needs to be addressed and that calls for collective involvement of the community with the help of the health workers.

It was further added that the community needed to be assisted to rethink about the situation of the maternal and child health in the community. In addition, that at various community level meetings, efforts need to be made to mobilize and use community arenas like *Barazas* and other gatherings to make maternal and child survival, an important issue of discussions.

In addition, it was agreed that the community should be explained to repeatedly and made to know the negative effects of cultural practices that touches on impediment of adhering to maternal and child survival messages.

Though there are many negative factors that impede maternal and child survival campaigns, there are also some positive cultural saying that emphasize taking care of the new born babies. One of the members of FGD 4, who said he had keenly observed Pokot community culture, revealed that:

> In this community there are sayings that may be used by health workers at health facility during health education and CHWs when they visit their respective households. Among the sayings that may be used include; "mambo chi nyo kimel kame" (a person whose mother took care of well), and this is normally in reference to proper upkeep of a child including giving of birth at health facility and ensuring a child undergoes through all the immunisation program as required (FGD4 respondent 2, 2016).

Besides, the above positive and negative cultural communication aspects that were disclosed during the interviews with FGDs and KIIs, the following other issues were also outlined as impediment to the maternal and child survival campaigns:

- **Facilities:** In this regard, CHWs put poor transportation and communication as the most key barriers to their work of carrying out the health promotion. They ascertained that they have not been supported with the emergency kits as promised during their selection, recruitment and orientation time. They added that even those who were given the kits, it has been exhausted long time ago and there has not been replenished since then.
- **Social mobilization skills:** The FGDs and KIIs, admitted that CHWs lack the training and are not well-developed or oriented on how to mobilize the community and present the health message to the community in an enriched format. As a result, they have not been able to mobilize the community to an extent that they respond to health messages appropriately especially in maternal and child survival whereby indicators like immunizations and delivery at health facility still rates low.
- They added that this limits their ability to establish instrumental rapport with their clients which is the most important prerequisite for social interaction and subsequent action.
- **Social influences and networks:** CHWs explained that there are no positive social environments that encourage their work. People's perception, attitude and value to their activities are declining as time goes by and even on their side as CHWs their motivation is very low. They pointed out that the support, they enjoyed first during the time when they were selected was very strong but this has since declined, because the motivation they were promised like financial support and working tools like first aids kits have not been provided to date. Generally, CHWs reported that the overall social environment is becoming boring for lack of the promises made earlier by the Ministry of Health officials.
- **Limited support from the leadership:** The leader of the program at county level who was one of the Key informants, explained that when the community strategy was first launched it had no budget support from the government. Therefore, the CHWs, as time went by became reluctant to commit themselves to their work due to the fact that this community strategy of offering health

> service at level one, which is at the households was just rolled out and no effort has been made since then to include it in the budget. It was promised by ministry of health officials initially that all CHWs will be supported financially and be supplied with First aid kits with continuous replenishment plan but since its initiation in 2007, no such support has been given. This has led the health leaders to brand the entire CHWs as volunteers (CHVs).

However, the local NGOs operating in the county seem to recognize the role of CHW/Vs in the community and sometimes they give them monetary support whenever they engage them, though there seem to be no standard or uniform support from these partners for CHWs.

4.22 Perception of the Community towards Propagating Health Messages

The Pokot community are known to be very suspicious towards any new initiative. When any programme that involves the community is rolled out, the community need to fully understand the programme for them to support it. A FGD 3 member put it this way:

> Pokot community is very complex and you cannot tell whether they have accepted your message or not. Last week, we were conducting research survey in this area on health issues affecting this community, then we went to a certain village and I went to the market while my colleagues went to the households nearby, then suddenly there were many people who came to the market centre. My colleagues who had gone to interview the respondents at the households reported that nobody was in the household to fill the questionnaires because they had gone to the market. I then asked the village elder to assemble the people at the market and when I asked them why they have ran from their homes to the market when people were coming to them for assistance. Most of them replied by stating that you people have come to us but we don't know what you want. They told us that we should have declared our mission first so that we know what you want from us (FGD 3 respondent 3, 2016).

Another sentiment from KII 4, asserts that Pokot community members have always been suspicious and takes long to accept any change. They are always looking for *wero ptio* (an example). They always ask who has done what you are telling us and succeeded and what is the magnitude of that success.

This culture influences the way the community perceive things hence culture cannot just be wished away and that was disclosed as part of the reason the community behave the way it does. On the maternal and child survival campaigns, it was noted that it has a lot of complexity and needed to be handled with a lot of care, because through the FGDS and KIIs, it was revealed that child bearing in Pokot community is a woman affair yet men are decision makers, making the issue a complex one.

Therefore, in order to influence the current state of maternal and child survival campaigns, there is therefore need to change the current strategy and target men and win them to embrace and accept to be champions of the maternal and child survival promoters.

In policy development, it was suggested by FGDs members that the target community may be incorporated so that they can own the process of message development and disseminations. One of the members of FGD 2 illustrated this point by give an example he witnessed and this is what he said:

> During the health promotion exercise we had in village, people were taught by the health workers to build latrine using available materials but people did not use it. When the health workers went to those households during assessment to find out how the project has benefited the households, in one of the household a mother who was in the house during the visit called out her son "telling him bring the key we open that toilet for *daktari* (health worker), so that he can see". The family did not use the toilet because it was for the health workers hence the need to incorporate them in the initial stage of designing the programme (Personal Communication, FGD2 respondent 1, 2016).

KIIs and FGDs disclosed further, that messages should be directed to the churches so that they could be empowered with maternal and child survival messages and encouraged to help pass these vital messages and asked to encourage the community to adhere to maternal and child survival messages. The FGDs and KIIs all agreed that the churches will easily embrace the messages as most of the churches in West Pokot county owns some health facilities hence it will be easy for these institutions to urge their respective members to adhere to maternal and child survival messages like attending ANC clinic and delivering their babies at health facilities.

It was also reported through FGDs discussion that another group that need to be targeted with maternal and child survival messages are women groups who have become popular because of their meetings and their table banking initiative hence the ring leaders could be targeted and won so that during their meetings, time be set aside for discussing maternal and child survival messages.

In addition, both the FGDs and KIIs emphasize that specific messages should be developed and targeted at the Traditional Birth Attendants (TBAs). They added that TBAs should be assigned and linked to the health facility and asked to be referral agents and motivated to the extent that they accept to play a role of encouraging to delivery their babies at health facility.

On other challenges like the distance between households and health facilities, it was disclosed that the county government has increased the number of health facility in the county. A member of FGD 4, which composed of County health leaders, pointed out that:

> West Pokot County has been marginalized by the previous government and currently we have only four sub-county Health facilities but though they have been upgraded by the county government, the services offered at these health facilities are on the state of health centres. The county government has increased the health centres but it lacks equipment and personnel (FGD4 respondent 5, 2016).

Through interview with county government officials, it was further revealed that the services offered at health facility has increased and services expanded. The health facilities in the county was increased from 56 health facilities in 2013 to now 114 in 2016 and out this 96 are offering maternal and child health services with 56 outreaches across the county.

4.23 Pregnant Mothers' Expectations of the CHWs and CHEWs

CHWs are primarily required to give primary health services by focusing on the individual households and are assisted by the CHEWs who supervise this group and support them to discharge their duties accordingly as expect in the guideline provided (MOH, 2006). MOH (2007) guidelines show that the primary goal of the programme mainly focusses on health promotion and prevention.

It was defined as: a package of basic and essential preventive and selected basic health services targeting households. Health Extension Programme (HEP) is similar to community strategy as in this concept it both focuses on households, at the community level, and it involves health facilitations. Through the guideline provided it can be understood that, the program should focus on preventive and promotion. In addition, a basic curative service of the most prevalent diseases was not incorporated in the programme.

The participants of this study indicated that clients are not getting access to curative health services as expected; even services on high impact diseases like malaria and diarrhoea were reported as inefficient or not offered at all by the CHWs.

Interviews and FGD sessions uncovered and noted that there is a gap between what people expect from CHW/Vs/CHEWs and what is being provided at household levels or what the initial program was meant to do and what is currently happening on the ground which are not matching. The community expects wholesome services like what is given at the health centres or dispensaries. Through FGDs and KIIs discussions, it was reported that CHWs roles are limited and are considered deficient in the delivery of basic curative health services like the treatment of the people affected by simple water borne diseases. It was further revealed that the beneficiaries are dissatisfied because of the gap in expectation which in turn affects and become hindrance to acceptance of the health messages by the community. One of the key informants said that the community served by the CHWs and CHEWs have mixed perception on their role in the community. KII 4 stated that:

> It is obvious that people do expect a lot from the CHWs and CHEWs. As these rural communities live far from the health facility, they need treatment for prevalent diseases like water borne diseases, malaria and diarrhoea. CHWs and the CHEWs are also expected by the community to render services like providing treatment but that's out of the scope for this group (Personal Communication, KII 4, 2016).

The respondents reported that they had been paying attention to the messages passed to them by these CHWs. These messages were passed to them through interpersonal communication.

However, most women believed that mid-wives at health facilities were quick to resort to taking women to theatre for operations as form of child delivery instead of waiting for the mother to push the baby till they are sure that there is no other alternative. As the KII 1 lamented:

> The community health workers who are supposed to be visiting homes and delivering health messages are few and as I can remember they came only once and taught us on how expectant mother should take care of herself during pregnancy, deliver at health facility and exclusive breastfeeding for six months after delivery, good nutrition both for the pregnant mother and baby, and maintaining general hygiene at home (Personal Communication, KII1, 2016).

Through the discussions with FGDs, it was clear that CHEWs and CHWs are responsible for addressing issues related to disease prevention but at times people demand curative service from them. It was suggested that trainings need to be given to selected CHWs and be supplied with first aid kits so that they can assist households where health facility are at a far distance. Currently, however, CHEWs provide treatment, but only of febrile diseases mostly malaria and other water disease like diarrhoea and that alone has been seen by the community as insufficient. They are thought to be in a position of addressing other diseases common in the community. It was further reported that there had been efforts to orient and train the CHWs and equip them with first aid kits but that has been done in only some few units and even the units that has been done, it is not sufficient hence there is still need of having continuous trainings and provision of first aid kits to equip them with sufficient skills.

During FGDs discussion, it was argued that people actually need extension workers to attend to the sick in the community. It was felt that sufficient work is not done as the main goal was to focus on the promotion of health and prevention aspects. Accordingly, it was suggested that some necessary tools/kits and empowerment are needed to enhance the capacity of CHWs to make them to respond to the basic health challenges like emergencies as expected by the clients.

The expectations of the people were also found to be different from place to place. Compared to less remote areas and more remote of West Pokot County, where there were higher expectations. Some of CHWs, working in remote areas, underscored that some even tend to call them 'Doctor' and expect higher level of medical services from them.

She said this was not surprising to her as she knew that people also used to call individuals who are known in those areas for customarily bringing drugs from urban areas (for sale to the people with profit) with the same name-*daktari* (Doctor). The researcher asked if the community was initially told who CHEWs are and what their distinct role was.

It was further found that exaggerated expectations was the consequence of high value and expert position of the CHWS/CHEWS. For this, the source of the problem could be traced to the time of initial orientation about CHEWs and the CHWs whereby the community where confused by the two in their respective roles and responsibility. In all cases the CHEWs were known trained public health technicians who have better understanding of health promotion and even administer drugs and inject drugs to their patients while the CHWs are community members who have interests on health issues and are assigned to some specific households to link them to nearby health facility for health services among these are maternal and child survival services.

A member of FGD 1 had this to say:

> First of all, the people have no clear understanding on who CHEWs and the CHWs are. The CHEWs are assigned here to provide primary health care (more so on prevention than curing), but the community has no clear image of the expectation. The problem is that sufficient orientation was not conducted and where it was provided it was done once during the initial process of launching the units. As a result of this inadequate orientation, the people have no clear knowledge of what a CHW and a CHEW are entitled to do. The community should have been told clearly what the primary purpose of the overall programme (FGD1 respondent 6, 2016).

One of the aspect on why the community members are not responding to the messages passed to them through various interpersonal communication by the CHWs, like delivery of babies at health facility, attending ANC clinic as required and taking babies for immunizations, it was revealed by both the KIIs and FGDs that there are still some factors that impede the community from responding. KII 1 answered this question as follows:

> There are people within this community who do not appreciate attending ANC clinic or delivering at health facility because of ignorance. Others fear being assisted by the male mid wife in health facility because like here at our health facility, most of our health workers are male and normally delivery women and unlike Traditional Birth Attendants (TBAs) who are women. Distance between the homes and health facility is also an impediment to the delivery at health facility and also bringing children for immunization as required. Because of distance some women deliver on their way to the health facility especially those from the highland up there and those from down there in the lowland.
>
> Sometimes those who have had prolonged labour pain are brought to the health facility and in some case others bleed to death before arriving at the health facility (KII1 respondent, 2016).

The FGD participants revealed further that people need from both the CHWs and CHEWs, are not only health education or campaigns but also direct medical assistance to the sick in terms of drugs and injections. Going through elementary and/or inefficient training and being only a form four school leavers; might be difficult for the CHWs to provide what a nurse or trained public health technician can provide.

Generally, through the interviews and FGD sessions, it was revealed that the gap between people's expectation and what the CHEWs are providing, created a greater dissatisfaction which contributed for the gradual perception and loss of acceptance in the community.

4.24 Factors Influencing the Trends of Maternal and Child Survival Campaigns

According to KDHS (2003, 2009, 2014), the factors that impede maternal and child survival adherence in Kenya include long distance to health facilities, poverty, shortages of personnel, inadequacies in the health care system, including lack of drugs. Through the analysis of KDHS reports, the Kenya Ministry of Health came up with

plans and strategies that focuses on promotion of individual and community health, in recognition that communities form the foundation of improving maternal and child survival. In order to achieve SDGS and Vision 2030, on maternal and child survival, the GoK has continually strives to improves access of health services and continues to strengthen the health systems and enhance the community strategy (MOH, 2008).

In the community strategy, the community health workers have continually been strengthened, especially on the communication strategy in order to increase the uptake of maternal and child health services (MOH, 2014). As shown in this study, the distance between the households and health facility offering maternal and child survival services is still a challenge as seen in Table 4.8. Again, 52% of the respondents revealed that they cannot afford the transport to the nearest health facility offering maternal and child health services as shown Table 4.10.

Studies conducted in other different parts of Africa and other developing countries in Asia have shown similar factors such as socio-economic status, accessibility to health care facilities and socio-cultural practices have been reported to be hindrances to message adherence on maternal and child survival (Wahab, 2004; Bockerhoof & Hewett, 2000).

Figure 4.2 shows the various arenas or avenues where members of the community came first to learn about maternal and child survival messages. This gives guidance to the policy makers and campaigners on vocal points that they need to focus on, to ensure that these messages reach the target group. As shown in Figure 4.2, hospitals top the list of the venues where the community first learnt about maternal and child survival messages at the rate of 28.7%, followed closely by friends with 28.5%. Others included schools at 21.4%, community meetings at 18.6% and other forums at 2.8%.

As shown in Figure 4.4, the strength of each form of interpersonal communication is shown and this information is rich and can guide the policy makers on the currently used form of interpersonal communication.

The community who have been beneficiaries of these maternal and child survival messages gave their response on the rating of various forms of interpersonal communication that has been used to their benefit. Face-to-face was rated as the most used form at the rate of 75.4%, followed by meeting at 56.6%. Others are leaders at 49.3%, while husband and mobile phones were rated at 22.8% and 14.1% respectively.

Maternal and child survival campaigns have been held with the main aim of focusing to overcome these factors that have been proved to hinder adherence of maternal and child survival messages. The indicators of adherence of maternal and child survival messages include; delivery at health facility, attendance of ANC, immunization of the babies as required, provision of proper nutrition both for the expectant mothers and the babies among other services offered at health facility offering maternal and child survival services.

Advocacy geared towards improving the quality of health care services and accessibility to health services have been directed to respective governments by the stakeholders while messages on overcoming social and cultural factors have been directed to the communities urging them to embrace maternal and child survival messages.

Studies conducted in Nepal and Ethiopia showed that interpersonal communication campaigns that involve the local women, urging and directing them to take charge of maternal and child survival health services seems to bear fruits (Laverack, 2006).

4.25 Summary

The findings from this chapter purposed to provide the general objective and to present, interpret and discuss the specific objectives of the study. The study began by presenting, interpreting and discussing the socio-demographic data on the ages of respondents, religious affiliation, marital status, education background of the respondents and their respective spouses, source of income of the respondents, place of delivery of the last child, sources of information on the services offered at Antenatal Care (ANC), frequency of ANC attendance, distance to the nearest health facility

offering maternal and child health services and then the means of transport to the nearest health facility offering maternal and child health services.

It discusses further in details, the forms of interpersonal communication used in promoting maternal and child survival. Through the findings from the study, it was revealed that 75.4% of the respondents acknowledged that face-to-face form of interpersonal communication has been used to the benefits of the respondents while only 14.1% acknowledged that mobile phone, as a form of interpersonal communication, has been used to their benefits and even on this, it was only used while passing on important messages on maternal and child survival issues or the changes on the days of attending clinic especially those who depend on mobile outreach clinics to receive maternal and child health services.

The chapter also presented and discussed the factors that influences the use of interpersonal communication in conveying maternal and child survival messages. These factors include; Ministry of Health community strategy which allocates the CHWs households and task them with responsibility of visiting their respective households and sharing health messages which mainly include maternal and child survival messages. Others factors include government policy which urges health workers based at health facilities to carry out health talks before administering ANC and immunisations services. Again, it was revealed that there are also periodic immunisations campaigns carried out by the government and other stakeholders and during these campaigns, different communication strategies are used.

The presentation of findings on the perception of the community on the use of interpersonal communication in promoting maternal and child survival messages were also covered. In this regard, it was found out that the attitude of the community towards the health workers including presentation of health talks/education was rated fairly at 53.8%.

The chapter also presents rating by the community on various ANC services, perceptions about CHWs and CHEWs, communication barriers, harmful tradition and socio-cultural applied to children. It further presents perception of the community towards propagating health messages and pregnant mothers' expectations. The chapter also discussed other relevant research studies done in developing countries with the main focus in Rwanda which has put a lot of emphasis on the incorporation of mobile technology to improve on maternal and child survival campaigns.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Overview

This chapter presents the summary, conclusion and recommendations. It begins with an over view of the study, the summary of the findings, conclusions of the study based on the research findings. Recommendations for both policy makers and practitioners are presented based on the findings of the study.

5.2 The General Overview of the Study

The purpose of this study was to find out the use of interpersonal communication in promoting maternal and child survival in West Pokot County in Kenya. The study was guided by three questions namely: Which forms of interpersonal communication have been used to convey messages aimed at reducing maternal and child mortality in West Pokot County? What factors have influenced the choice of the forms of interpersonal communication used in communicating maternal and child survival messages? What are the perceptions of the community on the various forms of interpersonal communication that have been used to reduce maternal and child mortality in West Pokot County? Three hundred and ninety (390) respondents from Central and South Pokot Sub-Counties were selected plus four key informants' interviewers and four Focus Group discussions which were held. Three hundred and ninety (390) questionnaires were filled and returned to the researcher for coding, analysis, interpretation and discussions and were triangulated with the results from FDGs and KIIs. From the results of the study, conclusion and recommendations to both the policy makers and practitioners were made.

5.3.1 Forms of interpersonal communication used by health promoters to convey maternal and child survival messages

The study showed that face to face was ranked the highest used form of interpersonal communication that have been used to the benefit of the target group with majority agreeing that this form has been used to their benefit, while mobile phones was rated the least used form of interpersonal communication.

The results therefore revealed that the use of mobile phone in West Pokot County is very low among the CHWs and this could be attributed to lack of creation and implementation of mobile phone software programmes for CHWs and other health workers. The monthly reporting of CHWs is still manual. This corroborates with the observations made by Schiavo (2007), that technology-mediated interpersonal communication are more widespread in developed countries than in many countries in the developing world, where more conventional ways of communications like word of mouth may still be dominant.

The respondents interviewed stated that mobile phones had not been incorporated by the government as the strategies of reaching the community with maternal and child survival messages. The initiative of using mobile phones to boost the campaigns have not been adopted as the government has not developed software to be used by the community health workers (CHWs) as in other parts of the World. Mobile phones are usually used to send messages (SMS) to pregnant mothers and lactating ones and inform them of the clinic days not as like in Rwanda.

In Rwanda, for example, the health management information systems have been incorporated in various electronic health records and software programmes, web-based platform such as mobile phones. Mobile phone technology resources have improved availability and quality health information systems needed for prevention, management and monitoring and evaluation of programmes through an alert system known as rapid short messages services-SMS (Musafili, 2015; WHO, 2013).

On the first sources of information on Antenatal Care (ANC), majority of the respondents indicated that their first source of information on ANC services were hospital followed by friends while others reported getting their first information from school and finally community meeting among other sources.

5.3.2 Factors that influence the choice of forms of interpersonal communication used in promoting maternal and child survival in West Pokot

On the factors that influence the use of interpersonal communication in conveying maternal and child survival, it was found out that government policies and guidelines, which urges the health workers at the health facilities to carry out maternal and child survival education, during or when offering maternal and child immunizations, and other services related to maternal and child health were noted among the important factors that influences the choice of forms of interpersonal communication used by the health workers to convey maternal and child health messages. Again, through the community health strategy guidelines, the CHW/Vs and CHEWs are tasked to move within their designated households and educate the members of the households on the need to adhere to maternal and child survival messages.

Another factor that was revealed by the respondents as having influence on the forms of interpersonal communication used was pointed out as periodical campaigns conducted by the national government from time to time on foreseeing danger that require immunizations of either that of children under 5 years or expectant mothers. One of the key informant explained that in such a case the government normally planned and announced the massive campaigns spearheaded by the Ministry of Health officials in conjunction with other government officials including local leaders like chiefs and their assistants.

5.3.3 Perceptions of the West Pokot community on the various forms of interpersonal communication in passing messages aimed at reducing maternal and child mortality in West Pokot County.

The KIIs and FGDs explained that the forms of interpersonal communication used are fairly good though it still need to be enriched and the time the health workers spent in giving health talks during the clinic days need to be increased.

The respondents suggest for the use of combinations of various forms of interpersonal communication while offering maternal and child survival talks. This proposal on the use of various forms of interpersonal communication to deliver health messages have also been recognized by ministry of health as important in creating and reinforcing individual and community behaviours (MOH, 2014).

The attitudes of health workers at health facility though rated good at a score rate of 53.8%, the health workers were viewed by the community members to have negative attitude towards them and not caring much about their desire to be assisted while on their mission of seeking for maternal and child health care services and some of these health workers acknowledge that their attitude towards their patients are not up-to the required standard.

The health workers pointed out that their attitude towards their clients is still low and that they have not reached a level equated to that of a shopkeeper who desire clients to be visiting him to buy products from his shop. According to both FGDs and KIIs interviews it was further revealed that clients at times when they came to the health facility to seek for the health services, the people who were supposed to receive and serve them joyful at times see like they are being bothered by these service seekers.

Messages need to be designed and targeted to change the attitude of the health workers especially those who are based at the health facility. According to both the FGDs and KIIs, addressing the attitude of the health workers would contribute towards improving the adherence of maternal and child survival messages. All the respondents agreed that there is need to address the attitude of the health workers towards the health seekers.

5.4 Conclusion

The summary of the major findings and discussions of the study according to the three objectives which initially formed the basis for the study are as follows; the study established that face-to-face interpersonal communication was found to be the most popular mode of conveying maternal and child survival messages while the mobile phone was rated the least used form of interpersonal communication.

On the factors that influence the use of interpersonal communication in conveying maternal and child survival, it was found that government policies and guidelines, which urges the health workers at the health facilities to carry out maternal and child survival education, during or when offering maternal and child immunizations, and other services was noted among the important factors that influences the choice of interpersonal communication forms. Secondly, through the community health strategy guidelines, the CHW/Vs and CHEWs are tasked to move within their designated households and educate the members of the households on the need to adhere to maternal and child survival messages.

It was further found that there are normally periodic maternal and child survival campaigns plans and led by the government and during such campaigns use of various combination of interpersonal communication among other strategies used to convey maternal and child survival campaigns. In addition, it was further revealed that there are health indicators which shows the progress on the adherence of maternal and child survival messages in the target areas. These health indicators are compared with the ideal situation as recommended by WHO standard and this factor guide the CHWs and health workers at their respective health facilities on the choice of interpersonal communication to be used to conveying maternal and child survival messages.

The perception of the community on the use of interpersonal communication in promoting maternal and child survival, was rated fairly well at 53.8% by the community members who are the beneficiaries of services offered by the health workers.

In final conclusion, the study found out that technology has permeated every sphere of life and has played a significant role in revolutionising communication strategies in general. But still, face-to-face interpersonal communication reigns supreme in a situation where action or behaviour change is required of the receptions. Psychologists assert that when two or more people talk to one another through face-to-face, their brains synchronise and collective action undertaken thereafter.

5.5 Recommendations

This study generated evidence to enable making of suggestions and recommendations on three areas, namely: formulation of the health policies that will target to enhance maternal and child survival and secondly, the recommendations for practitioners and finally, suggestions or recommendations for further research.

5.5.1 Recommendations on Policy

Based on the results of this research, the following recommendations are made for policy makers:

1. From the findings of this study, the major stakeholders in maternal and child survival, namely the national and county government together with non-governmental organizations working in health sector in the county of this study, should make deliberate efforts to formulate policies to guide the design and dissemination of maternal and child survival messages to promote women's reproductive health. The policy to be designed should take into considerations the current situations of the community and their inputs should also be sought in order to ensure that the policy should be inclusive of all the factors like cultural, current situation plus inputs of beneficiaries of this important services as this will enable the community to own all the process of maternal and child survival campaigns. This is because through this study, it emerged that in the current policy, it has not taken into considerations cultural factors, current situation and the input from the recipients of the services hence the gaps or limitations of the policy can be filled by the additions of these aspects in order to make the campaign yield the desired results.
2. The national and county governments should formulate policies that incorporate health management information systems with software programs that can be integrated into web-based and mobile technologies. These tools should be used by CHWs in prevention, management and monitoring of maternal and child health. This will assist the CHWs to notify and remind the respective clients on when to visit health facility for ANC and immunizations. Also, this format may be used by CHWs while filling monthly or quarterly report.

This is because through this study, it was made known that the mobile telephone has not be used to enhance the maternal and child survival campaigns as has been done in other developing countries like Rwanda to reduce maternal and child mortality rate.

3. The policy on health campaigns based on gender should be formulated to include both genders because this is likely to help develop men's awareness that might help communities find culturally appropriate ways to change existing beliefs, attitudes and social norms that restrict gender equity and equality. There is therefore need for development of the framework for communication that takes into consideration the gender-related factors that influence positively the upholding of maternal and child survival messages. The planning and execution of the health extension program should be based on identifiable purposes by the community members in order for them to be accepted and implemented as recommended. The results obtained from this study shows that the maternal and child health has been left to the women yet men are decision makers of their respective households and are economically endowed than women hence the need to have gender inclusive campaigns on maternal and child survival campaigns to achieve the desired results.

5.5.2 Recommendations for Practitioners

The following recommendations are made for practitioners or implementers of maternal and child survival campaigners:

1. On the basis of the established prevailing pattern of maternal and child survival messages, it is recommended that there should be deliberate effort for continuous creation of the awareness by national and county government together with NGOs working on health sector on importance of urging community members to adhere to maternal and child survival like the delivery at health facility under assistance of skilled birth attendance as this will reduce mortality and enhance maternal and child survival. The use of relevant, latest statistics should be used to improve adherence of maternal and child survival messages.

2. This is because as shown in figure 4.1 and also as indicated in KDHS (2014), majority of mothers deliver at home while minority deliver at health facilities in the study area.
3. It is recommended that the CHWs and health workers working at health facility while carrying out health education should identify positive cultural aspects of the community to be used in their own context to enhance maternal and child survival promotion. This is because through this study it was established that there are cultural practices that emphasize taking care of new born babies among the Pokot community and this can be identified and used to encourage proper child upkeep and expectant mothers in order to reduce mortality rate in the County.
4. It is recommended that messages be designed that targets the health workers working at health facilities in the county urging them to embrace positive reception towards their clients to encourage high turn up for maternal and child health services like ANC attendance, deliveries at facility and immunizations which will in turn be expected to enhance maternal and child survival in the area of study. As shown from the findings, the perceptions of the community who are beneficiaries of the health services were just rated fairly by the clients who are consumers of their services at health facilities hence that demonstrates that there is need for targeting the health workers to double their effort by improving their attitude and their services deliveries to their target clients.
5. Stakeholders' knowledge and views which include that of the community members and traditional birth attendants (TBAs) must be taken into considerations and incorporated into practice in order to enhance maternal and child survival. The findings from this study shows that the knowledge and views of all the stakeholders have not been harnessed to address the low response to maternal and child survival messages hence the need to take a critical look at this point and respond appropriately.

6. The findings from this research, KDHS and other research findings conducted in the area of study should be used as part of the important guidance while carrying out maternal and child survival campaigns to give clear picture of situations, the context of the area of operations like for example a sub-county or even the ward level on all the main indicators of maternal and child survival as prescribed by the WHO health indicators and this will give a clear picture of situation on the ground and appropriate plans and relevant communication strategies be incorporated in order to obtained the desirable results.

5.6 Suggestions for Further Research

1. This study used cross sectional survey design. Another one, could be recommended on longitudinal design to follow every significant change since the devolved system of government which has influenced the health administration with the provision of services devolved to the counties and national government handles policies.
2. Comparative study should be conducted on the interpersonal communication strategies used in promoting maternal and child survival in the counties with high deliveries at health facility and those with low deliveries at health facility The proposed study will be able to establish the communication strategies used by counties to urge their residents to respond positively yielding positive results so that the counties with low response to maternal and child survival messages could compare and borrow positive aspects from these counties.
3. More research should also be conducted to determine the extent to which communication has been used on health crisis management and the level of its effectiveness in the counties. This is because this study established that there frequent periodic health campaigns especially for maternal and child health that are normally carried out upon the government health officials at national level foresee danger like for example during the period of this research there was one on polio vaccine whereby the residents were urged to take the children who are under five years for immunization to ensure that their children are not affected by the outbreak of this preventable disease.

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APPENDICES

APPENDIX 1: INFORMED CONSENT FORM

Dear Respondent,

My name is **Simeon Ting'aa,** I am a PhD student at University of Nairobi, school of Journalism and Mass communication. I am carrying out research entitled ***The use of interpersonal communication in promoting maternal and child survival in West Pokot County, Kenya.*** I am collecting information from people living in this area about Maternal and Child Survival. This information will be used for academic purposes.

I would like to ask you some personal questions about maternal and child survival. If you agree to be interviewed, I will be asking you about your ideas and opinions on various aspects of promotion of maternal and child survival. There are no rights or wrong answers to the questions I will ask you. Your knowledge, opinions and experiences are important to me and so I kindly want you to be honest and truthful in answering the questions. The interview will take about 15 minutes. If you do not want to answer any question, you do not have to and you can stop the interview at any time.

I would like to take notes and pictures of the discussion. Your name will NOT be used in the notes. The notes will be kept safely and will be considered private and confidential. They will be used for this study only and the notes will be destroyed afterwards, and the pictures will form part of the appendices of this study report. If you have any questions after the interview, you may contact me on this number, ***0722476309)***.

CERTIFICATE OF CONSENT

I have understood the information provided to me. I have had the opportunity to ask questions and any question that have been asked have been answered to my satisfaction. I consent to participate as a respondent in this research.

Yes ☐

No ☐ Why? _____

_____ _____ _____

Name of interviewer **Signature** **Date**

APPENDIX 2: QUESTIONNAIRE

Questionnaire for the study on the use of interpersonal Communication in promoting Maternal and child Survival in West Pokot County, Kenya

Serial Number of Questionnaire ……

Site/ Sub County Number ……

PART A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Instructions: Please put a single tick **[✓]** where applicable

NO	QUESTIONS	CHOICES
1.	Your Sub Country:	1. Central Pokot ☐ 2. South Pokot ☐
2.	Your Age (in years):	1. <20Yrs ☐ 2. 21-25 Yrs ☐ 3. 26- 30 Yrs ☐ *4.* 31 -35 Yrs ☐ 5. 36 -40 Yrs ☐ 6. 41-45 Yrs ☐ 7. 46-49 Yrs ☐
3.	Are you married?	1. Yes ☐ **2.** No ☐
4.	What is your highest level of Education?	i. None ☐ ii. Primary ☐ iii. Secondary ☐ iv. College/University ☐
5.	What is your spouse's highest level of education?	i. None ☐ ii. Primary ☐ iii. Secondary ☐ **iv.** College/University ☐
6.	What is your Religious affiliation?	1. Christian (Catholic) ☐

		2. Christian (Protestant) ☐ 3. Christian (SDA) ☐ 4. Moslem ☐ 5. African Traditional Religion ☐ 6. Other _____ ☐
7.	What do you do for a living?	1. Government Employee/NGO ☐ 2.Self-employed ☐ 3. Other (Name) _____ ☐
8.	How much do you get from this activity on monthly basis?	
9.	Do you have other sources of income?	1. Yes ☐ 2. No ☐
		If No go to question **12**
10.	If Yes, which are these sources	_____
11.	How much do you earn from these other sources on monthly basis?	
PART B: MATERNAL AND CHILD RELATED QUESTIONS		
12.	Where you did deliver your last child?	1.Home ☐ 2. Health Facility ☐
13.	How you did first came to know about Antenatal clinic (ANC)?	1. School ☐ 2. Hospital ☐ 3. Through friends ☐ 4. Community meeting (baraza) ☐ 5. Other_____ ☐

14.	Are you aware of the services rendered at ANC?	1. Yes ☐ 2. No ☐ If No go to **16**
15.	If Yes, can you list these services	1. 2. 3.
16.	How many times did you attend antenatal clinic during your most recent pregnancy?	1 ☐ 2 ☐ 3 ☐ 4 ☐ >4 ☐
17	To your knowledge, does ANC attendance help in detecting complications during pregnancy?	1. Yes ☐ 2. No ☐
18	To your knowledge does ANC attendance help in reducing maternal death?	1. Yes ☐ 2. No ☐
19.	According to you, does taking your child to clinic help in preventing diseases that may cause death?	1. Yes ☐ 2. No ☐
20.	Have you ever missed taking your latest child to clinic for immunization as required?	1. Yes ☐ 2. No ☐ If No go to **22**
21.	If yes explain why?	_____ _____

PART C: COMMUNICATION AND OTHER FACTORS ON MATERNAL AND CHILD SURVIVAL			
22.	The following are forms of interpersonal communication used in promoting maternal and child survival, which ones are you aware of?	Forms of interpersonal communications. Tick the ones that you are aware of?	✓
		1. Face to face talk	
		2. Use of Mobile phone	
		3. Use of meeting (*Barazas*)	
		4. Use of husband	
		5. Use of leaders e.g. assist chiefs/Chiefs/Pastors	
23.	Among the above interpersonal communication list the ones that have been used to your benefit?	_____ _____	
24.	Do you have any suggestions on other forms of interpersonal communication which could be most suitable in this community? If yes which ones.		
25.	How far is the nearest clinic offering maternal service from your home?	1. 1 -5 kilometres ☐ 2. 6-10 kilometres ☐ 3. 11-15 Kilometres ☐ 4. 16-20 Kilometres ☐ 5. Above 20 Kilometres ☐	

<table>
<tr><td>26.</td><td>When visiting health facility during pregnancy or taking your child to clinic for immunization, what is the predominant means of transport you normally use?</td><td>1. Walking ☐
2. Motor Cycle (boda boda) ☐
3. Motor vehicle ☐</td></tr>
<tr><td>27.</td><td>If using paid means of transport, how much do you pay for a round trip?</td><td>1. Below Ksh. 50 ☐
2. Kshs.50-100 ☐
3. Ksh.100-200 ☐
4. Ksh. 200-300 ☐
5. Ksh.400-500 ☐
6. Above Kshs 500 ☐</td></tr>
<tr><td>28.</td><td>Can you easily afford to pay this fare</td><td>1. Yes ☐
2. No ☐</td></tr>
<tr><td>29.</td><td>How would you rate the following services offered at health facility during your last visit to the health facility in the area including health education? (1 = Excellent, 2=Good, 3= Fair, 4=Poor, 5 = Very Poor)</td><td>
<table>
<tr><th>Services</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th></tr>
<tr><td>General reception</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Attitude of medical personnel</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Availability of equipment’s/ injections</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>30.</td><td>In your own opinion how would you rate the following Antenatal care services offered at health facility when you visited in your last visit? (1 = Excellent, 2=Good, 3 = Fair, 4 = Poor, 5= Very Poor)</td><td>
<table>
<tr><th>Services</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th></tr>
<tr><td>Palpation of the abdomen</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Tetanus vaccination</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Weight measurement/ Height taken</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Delivery services</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
</table>

		Immunization of new born						
		Health talk						
		Provision of treated bed nets						
		Iron supplement						
		Counselling on family planning options						
		Anti-malaria treatment						
		Registration of new born						
31.	In your view does your culture influence (positive or negative) how people seek ANC service in this community?	1. Yes ☐ 2. No ☐ If No go to 33						
32.	If yes, explain your answer	_____						
33.	Does religion influence how you seek ANC?	1.Yes ☐ 2.No ☐						
34.	Explain your Answer	_____						

The End. Thank you for your Cooperation.

APPENDIX 3: FOCUS GROUP DISCUSSION GUIDE

1. What kind of interpersonal communication forms are used by health workers to promote maternal and child survival among the community members in this area?
2. How has interpersonal communication been used in promoting maternal and child survival in this area?
3. To what extend do you think the community members have changed their behaviour and attitude as a result of the messages targeted to them by health workers?
4. What factors normally influence the choice of the form of interpersonal communication that are used in maternal and child survival campaign in this area?
   a) What styles are normally used to deliver these messages?
   b) Do you know who initiate's or proposes these communication strategies that are being used in maternal and child survival campaign? Is the target community or their representative (s) involved in the designing of these strategies?
   c) What attitudes/perceptions do the community members have towards the interpersonal communication strategies that are currently being used to enhance and promote maternal and child survival messages in this region? What can you add as your opinion on the presentation of these communication strategies?
   d) What challenges or problems, have you noted on the current interpersonal or other communication strategies used?
5. In this area as it is shown by statistics, there is low adherence of maternal and child survival messages, according to you, where do you think the problem is?
   a) Do you think enough awareness has been done on maternal and child survival adherence?
   b) Where could be the disconnect between awareness and response to maternal and child survival messages?

c) Why are the community members in this area, been unable to transit or move from being knowledgeable on the importance of maternal and child survival to the practice?

6. Does indigenous knowledge passed on through interpersonal communication has any impact on maternal and child survival response?

7. What advices or suggestions regarding communication strategies can you give to the health workers and other stakeholders carrying out maternal and child survival campaigns in order to record high adherence of child survival messages?

APPENDIX 4: KEY INFORMANT INTERVIEW SCHEDULE

1. Explain to me briefly how maternal and child survival messages are passed to the community members in this area?
2. Do you think all the key groups in this community are targeted with maternal and child survival messages?
3. To what extend do you think, the forms of interpersonal communication used have changed the behaviour of mothers to adhere to maternal and child survival messages?
4. Do the local community members relate or identify with the interpersonal communication strategies used to enhance maternal and child survival in this area? What do you think can be added to enhance this campaign?
5. Can you briefly share your personal experiences that you think can help the uptake of maternal and child health care services in this area?
6. What recommendations in respect to communication can you give to those carrying out maternal and child health care campaigns that you think may increase responses from the community members?

APPENDIX 5: INTRODUCTORY LETTER FROM UNIVERSITY OF NAIROBI

Appendix 6: Letter from the University of Nairobi to NASCOSTI for permit request

UNIVERSITY OF NAIROBI
COLLEGE OF HUMANITIES & SOCIAL SCIENCES
School of Journalism & Mass Communication

Telegram: "Varsity" Nairobi
Telephone: 254-02-2229168, 318262 Ext. 28080 or 28061
Telex: 22095 Fax: 254-02-229168
E-mail: director-soj@uonbi.ac.ke

P.O. Box 30197
Nairobi,
Kenya.

Date: 3rd June, 2016

The Secretary/CEO
NACOSTI
Nairobi

RE: SIMEON, Ting'aa – K90/96407/2014

The above named is a registered PhD student in the School of Journalism & Mass Communication.

He needs to collect data in West Pokot County for his research project entitled, "The Use of Interpersonal Communication in Promoting Maternal and Child Survival in West Pokot County, Kenya".

We support his application for a research permit.

UNIVERSITY OF NAIROBI
DIRECTOR
03 JUN 2016
SCHOOL OF JOURNALISM & MASS COMMUNICATION

Ndung'u wa Munywe
for: Director
School of Journalism & Mass Communication

APPENDIX 6: LETTER OF RESEARCH AUTHORISATION FROM NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. NACOSTI/P/16/15516/12587

Date: 20th July, 2016

Simeon Lotulya Ting`aa
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"The use of interpersonal communication in promoting maternal and child survival in West Pokot County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **West Pokot County** for the period ending **19th July, 2017.**

You are advised to report to **the County Commissioner and the County Director of Education, West Pokot County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
West Pokot County.

The County Director of Education
West Pokot County.

APPENDIX 7: PERMIT FROM NACOSTI TO CONDUCT RESEARCH

THIS IS TO CERTIFY THAT:
MR. SIMEON LOTULYA TING`AA
of UNIVERSITY OF NAIROBI, 6823-30100
eldoret,has been permitted to conduct
research in *Westpokot County*

on the topic: *THE USE OF INTERPERSONAL COMMUNICATION IN PROMOTING MATERNAL AND CHILD SURVIVAL IN WEST POKOT COUNTY, KENYA*

for the period ending:
19th July,2017

Permit No : NACOSTI/P/16/15516/12587
Date Of Issue : 20th July,2016
Fee Recieved :Ksh 2000

.....
Applicant's Signature

.....
Director General
National Commission for Science, Technology & Innovation

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 10226

CONDITIONS: see back page

APPENDIX 8: WEST POKOT COUNTY COMMISSIONER'S LETTER

THE PRESIDENCY
MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT

Telegrams; DISTRICTER' Kapenguria
Telephone; kapenguria 054-62291
Radio call; kape 5ZRO

Office of the County Commissioner,
West Pokot County,
P.o. BOX 1,
KAPENGURIA.

Email: westpokotland@rocketmail.com

REF: OOP.CC.ADM.15/14VOL.I/61

26TH JULY, 2016

TO WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION
MR. SIMEON LOTULYA TING'AA

Reference is made to the Director General/CEO, National Commission for Science, Technology and innovation letter NO. NOCASTI/P/16/15516/12587 dated 20th July, 2016 on the underlined subject.

The above named who is a student at University of Nairobi, has been authorized to undertake a research on ***"The case of interpersonal communication in promoting material and child survival in Pokot West County,"*** for a period ending 19th July, 2017.

Please accord him your cooperation and the necessary assistance he may require while undertaking the exercise.

PP
(WILSON O. WANYANGA, MBS)
COUNTY COMMISSIONER
WEST POKOT COUNTY

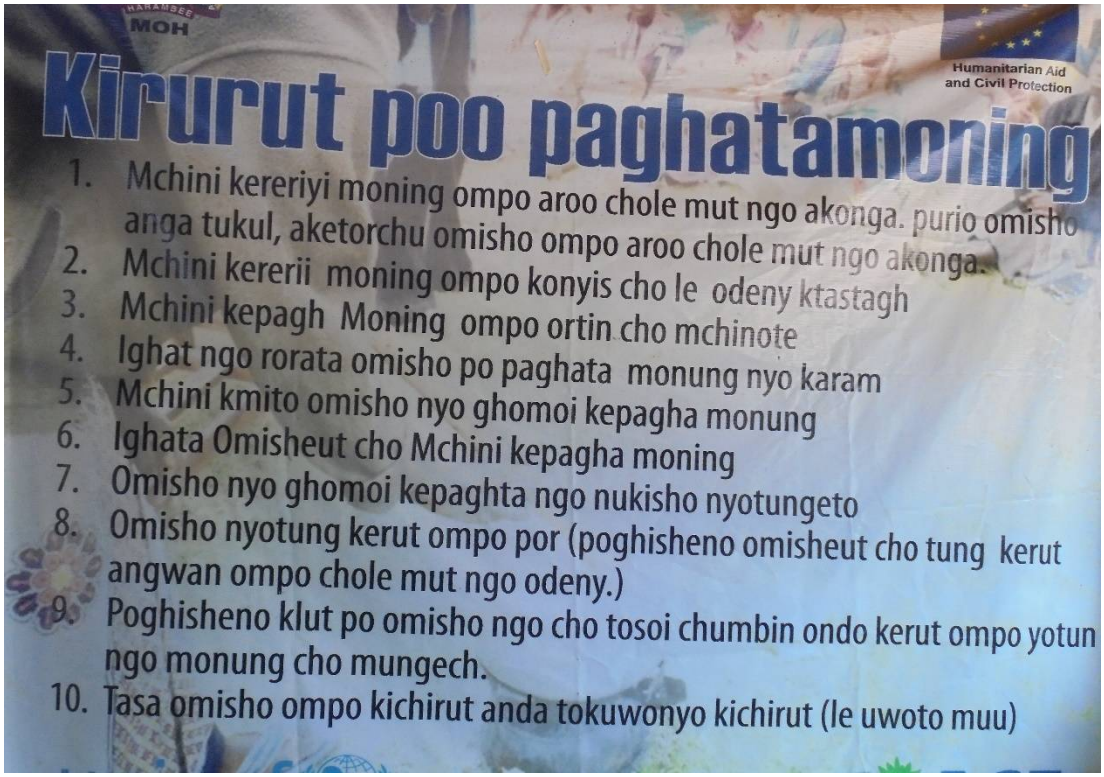
cc. The County Director of Education,
WEST POKOT COUNTY

APPENDIX 9: PHOTOGRAPHS

A nurse carrying out health talks at Sigor Sub-County Hospital on 4/10/16

New born being weighed at Chesta Health Centre on 3/10/2016

Beyond zero mobile clinic track stationed at Sigor Sub-County Hospital.



IEC Material written in Pokot language at Sigor Sub-County Hospital on 11/10/16