THE ROLE OF INTERPERSONAL COMMUNICATION IN THE USE OF FAMILY PLANNING METHODS AMONG WOMEN. A STUDY OF KAJIADO COUNTY

BY

OSEKO BOSIBORI REHEMA

K50 /68522/2011

A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS OF THE AWARD OF MASTERS DEGREE IN COMMUNICATION STUDIES AT THE UNIVERSITY OF NAIROBI, SCHOOL OF JOURNALISM AND MASS COMMUNICATION

NOVEMBER 2013

DECLARATION

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

OSEKO BOSIBORI REHEMA K50/68522/2011

Signature……. Date……

This project has been submitted for examination with my approval as the supervisor on behalf of the School of Journalism and Mass Communication University of Nairobi.

Supervisor: DR.NDETI NDATI

Signature…… Date……..

.

DEDICATION

To my Almighty God who in his ways made a way for me and made this possible when it seemed impossible to me.

ACKNOWLEDGEMENT

The success of this project lies heavily on the support from my parents Mr. Vernon Oseko and Mrs. Roseline Oseko who tirelessly supported me while I was working on this paper and for their unfailing love, trust and encouragement to pursue my studies. I also appreciate my siblings Derrick, Neldah, Allan and Dorcas who have been there for me all through. God bless you.

With love and affection, I highly appreciate my lovely son Brycen Onsongo who gave me courage to move on. God bless you.

I am grateful to my supervisor Dr.Ndeti Ndati who made the completion of this project possible. To all my lecturers at the school of journalism who equipped me with knowledge and skills, thank you.

I appreciate the services of my friend Isabel and family who supported me by taking care of my son to enable me devote time to my project work. God bless you abundantly.

To all respondents, who devoted time and made an appointment with me despite the busy schedule, may God bless their work and to all those who contributed to this work, do hereby accept my sincere gratitude.

Most of all I give glory and honor to the almighty God for bringing me this far and may he bless you all.

AMEN

ABSTRACT

This study sought to find out the role of interpersonal communication in the use of family planning among women in Kajiado County, The objectives of the study were. Investigating the role of interpersonal communication in creating awareness about family planning use, examining various forms of interpersonal communication used in creating awareness about family planning use, examining the frequency of use of family planning services and investigating the level of knowledge about family planning methods among women in Kajiado County.

The study used social cognitive theory and health belief model to explain behavior change in reproductive health .The-research utilized descriptive design so as to be able to collect data to describe a specific behavior of subjects under study as it occurred in the environment. The study used a purposive sampling technique to deliberately select a specific population for study. The study had a target population of women with reproductive age between 15-45 years, with a sample size of thirty six respondents. Twenty-five respondents used in-depth interviews, two groups each with five members in the focused group discussions and one respondent for key informant interview were used in data collection.

The findings of the study showed that, various communication channels such as broadcast media, print media and interpersonal communication were used in behavior change campaigns. However, various interpersonal communication channels were found to be the most effective method used by women in passing messages of contraceptive use. Although other communication channels were used, they were more commercial and advertorial unlike interpersonal communication which was more informative and

educative as it employed dialogue among women.The study recommended that for adequate use of contraceptives and achieving of vision 2030 and MDGs, various stakeholders as the government, media and development partners should engage in effective communication on reproductive health. Further, spousal communication should be enhanced and the media should involve itself in intense education programmes on family planning.

ACRONYMS

BCC-Behavior change communication

IPC-interpersonal communication

IEC-Information, education and communication

IUCD-Intrauterine contraceptive device

LAM-Lactational amenorrhea method

WHO-World health organization

SSA- Sub-Saharan Africa

USAID-United states agency for international development

HPI-Health policy initiative

MDGs-Millennium development goals

PSI-Population service international

CPR-Contraceptive prevalence rate

KDHS-Kenya demographic health survey

MLE-Measurement, learning and evaluation

HIV-Human immunodeficiency virus

AIDS-Acquired immune deficiency syndrome

GOK-Government of Kenya

UNFPA-United nations population fund

CBD-Community based distribution

TFR-Total fertility rate

CBS-Central bureau of statistics

FPA-Family planning association Kenya

FHOK-Family health options Kenya

MCH-Maternal child health

FP-Family planning

MSI-Marie stopes international

LAPMs-Long acting and permanent methods

STIs-Sexually transmitted infections

TABLE OF CONTENTS

FIGURES AND TABLES

CHAPTER ONE
INTRODUCTION

1.0 Background to the study

Reproductive health has been a challenge especially among women in Kenya and this is because of the poor indicators such as access to family planning services.

Family Planning refers to the control of number of children a woman can give birth to. This can be achieved by effectively using various methods of contraceptives such as: condoms, oral contraceptives, implants, injections, intrauterine contraceptive devices (IUCD) and female sterilization (hysterectomy), cervical cap, coitus interrupt, lactational amenorrhea method (LAM) among others.

Family planning involves behavior change and this can be achieved through information, education and communication (IEC) advocacy campaigns in the society, especially among women so as bring the awareness into use which is a challenge. This can help in access to information, safe, affordable, effective and acceptable methods of contraception. With the appropriate knowledge and information about the new behavior and its relevance, people are able to makes informed choices about their reproductive health.

Communication is an essential element in reproductive health. It basically motivates women to change from unhealthy behavior and practice a healthy behavior all through. In family planning, behavior change communication (BCC) is one of the programs or activities that can help people practice a healthy behavior by increasing awareness of reproductive health thus bringing about behaviors that improve the health status of women and related long term outcomes. It also motivates individuals to seek services and help them to successfully use their contraceptive method of choice.

BCC programs often use different communication channels such as interpersonal communication (IPC) for awareness by educating women contraceptive use and sexuality issues. It also builds on IEC and emphasizes that communication should be strategic and guided by systematic processes

and behavioral theories. Therefore for an individual to change to a healthy behavior there must be an influence of interpersonal relationships among individuals.

Interpersonal communication (IPC) involves a direct face to face relationship between the sender and the receiver of the message, who is in an interdependent relationship.IPC, involves both verbal and non-verbal communication and takes place between a respondent and a researcher.

There are various IPC communication channels that are involve in passing the message such as; telephones, one on one communication such as counseling, instruction and informal discussion groups between couples, friends and relatives.

Its closeness (its taking place now) and primacy (its taking place here) is characterized by a strong feedback component between individuals. Thus a very effective and efficient in health communication as it helps to influence, help, discover and share information among the individuals involved.

Therefore, interpersonal Communication can be categorized according to the number of participants involved.

a) ***Dyadic communication***-involves two people. Example, husband and wife.
b) ***Group communication***-involves three or more people. It is always done for the purpose of decision making or problem solving. It closely resembles IPC when there is a smaller number of people in a group. Example, a discussion group.
c) ***Public communication-***involves a large group of people with primarily one-way monologue style generating only minimal feedback. It is mainly aimed at sharing information and for persuasion. Example, public awareness education in a community environment.

IPC is the mostly preferred type of communication by individuals because it is more credible due to its face-to-face nature, permits dialogue (most participatory form of communication) and there is immediate response to the individual. Ideally, it is personalized to address the specific needs and concerns of family planning individuals thus assisting in decision making.

As IPC is one of the BCC interventions which include client- provider interaction and group presentation, it generates results which are measured by core indicators such as change in knowledge, attitudes, intentions and behavior (Babalola,S.,et al)

IPC can help to improve reproductive health which is necessary in achieving the Millennium Development Goals(MDGs) which were set to be achieved by 2015.Specifically,goal five which is, improving maternal health by achieving universal access to reproductive health whereby contraceptive prevalence rate and unmet family planning issues are to be addressed.
The use of contraceptive methods was high in Latin America and Asia and at the same time low in various parts of the world like Sub-Saharan Africa. For example, globally, in 1990 it was 54% and in 2012 it rose to 57%. In Africa it went from 23% to 24%, in Asia it remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67% (WHO, 2012).

There was a rapid population growth in developing countries due to high fertility rate hence high birth rates and low contraceptive prevalence rate and high but declining mortality rate. (Oyedokun, 2007).Therefore, there is an increase in number of people in need of health services. In Sub-Saharan Africa (SSA), the rate of population growth is one of the highest at 2.8 percent compared to the rest of the world (USAID/HPI 2007).

Therefore there is need for women to have access to safe and effective methods of fertility control and at the same time promotion of family planning through effective and efficient communication methods that will enable women in preventing unwanted pregnancy thus promoting healthy pregnancies.

There has been a parallel disparity in contraceptive use between the poor and the rich, educated and less educated among others. This has lead to highest wanted and unwanted fertility rates due to lack of access to the available services and awareness for family planning due to inadequate communication. This has led to high population growth rate which is likely to influence the Kenya`s economic development plan of Vision 2030.

Therefore, in order to achieve vision 2030, the unmet need for contraception must be fulfilled so as to slow the rapid population growth rate. This can be through carrying out intense education on women concerning reproductive health through IPC channels such as counseling. This will strengthen family planning services leading to improved maternal health and quality of life hence reducing poverty and improving financial stability enabling the government to invest in reproductive health.

According to the studies conducted by Population Service International (PSI) Kenya between late 2011 and early 2012, the Contraceptive Prevalence Rate (CPR) among married women in Kenya a decade ago, was at 46% and the unmet need for family planning at 24% due to the inadequate service provision and also lack of access to the same services.

Previous studies have also indicated that socio-economic and demographic factors such as education attainment, socio-economic status, place of residence, age, number of living children, accessibility to services as important to non-use and use of contraceptives in sub-Saharan Africa. (Kiragu and Zabin1995; Kyalo 1996; Tuonane 1999).Spousal communication is also a great contributing factor in contraceptive use among women as some men do not support family planning.

Communication has a stronger effect on contraceptive knowledge than attitude and behavior. Communication therefore may lead to family planning adoption among women as these decisions are likely influenced by individual-level factors while lack of it, may hinder decision making on contraception.

IPC is recognized as a community level model that influences behavior change together with other strategies such as subsidizing products and use of mass media for creating awareness.IPC helps in effective delivery of information to community members and it can be used as a strategy to move individuals from being knowledgeable about family planning to uptake of a method and continued practice of a new behavior (International conference on family planning, Addis Ababa-Ethiopia, 2013).

1.1 Family planning challenges

Contraceptive use among women is still low especially in the rural areas due to lack of education, lack of sufficient communication and poor economic status leading to a low level of awareness. This has greatly contributed to lack of knowledge about the family planning methods available hence, poor decision making when it comes to controlling reproduction. (MLE, 2011).

In the society, the poorest have the highest wanted and unwanted fertility rates as they are unable to access the right information and services in relation to family planning and maternal child health. Therefore, this greatly affects the economic growth which is slowed because of high

population (Kenya`s fertility transition, 2009).To curb the harmful effects of population growth, the family planning programmes should have two components: provision of family planning services and Information, Education and Communication(IEC) which involves providing information about the services, motivating women to adopt the practice as well as educating them about population problems and benefits of small families.IEC messages can be passed through IPC channels such as spousal communication, friends, relatives and counseling.

The family planning services have weakened over the past fifteen years as there is less attention paid to advocacy and resource allocation. This has led to less investment in availability and quality of a wide range of contraceptives especially the long-acting and permanent methods (Kenya`s fertility transition, 2009).

A study conducted by United States Agency International Development{USAID}core package final report indicated that, the attention of political leadership, the government and development partners shifted to HIV/AIDS programme at the expense of family planning. Thus, less resource allocation in terms of finance and less commitment in terms of offering family planning information and services. This has also reduced the national and international expertise available as it took the well trained reproductive health professionals to work in the HIV/AIDS programmes. (USAID, 2005)

Kenya is dependent on donor funding for family planning services but due to the withdrawal, there are commodity costs whereby, the recipients pay fees and this limits access to the services especially among the poor because of affordability hence limiting the client`s use of the services.(USAID, 2005)

In Kenya, there is a low contraceptive use and the high unmet need for family planning which have resulted in an increase in unintended pregnancies and high risk pregnancies which are associated with negative health consequences such as increased infant and maternal ill-health and also death (Adentuji 1998; Gipson et al., 2008).

1.2Benefits of family planning

According to the World Health Organization (WHO) fact sheet 351 of 2012, there are various benefits of family planning as discussed below.

Preventing health related risks

Family planning helps prevent health risks and helps a woman to make decisions concerning her reproductive life .It prevents unintended pregnancies and high risk pregnancies at the same time allowing spacing between births hence improving the health and well-being of a family.

By accessing the right family planning services, the need for unsafe abortion is also reduced. Too early or late pregnancies are avoided due to complication such as pregnancy-induced hypertension (high blood pressure) and uterine rapture respectively as they can lead to maternal death.

Reducing infant mortality rate

Infant mortality rate is caused by closely spaced and ill-timed pregnancies among women due to lack of proper family planning. There are also high chances of poor health among the infants born.

An analysis of family planning to the MDGs by Moreland and Talbird (2007) indicated that, satisfying the unmet need for family planning in Kenya could prevent 14,040 maternal deaths and 434,306 child deaths (GOK, 2007)

Enhancing education and empowering women

Family planning enables women to make the right decisions about child bearing, making it easier for them to achieve education and careers which can lead to employment hence increasing women`s earning power.

The parents are also able to invest in every child in terms of education and health due to right spacing, making it easier for children to access higher education and adopt a healthy lifestyle.

Slowing population rate

Family planning access is essential in reducing population growth rate of a country, because this has a great impact on the economy development. The government is able to invest hence, contributing to the economic growth of a country, reducing hunger, poverty and insecurity.

Wawire (2006) indicated that, high population n growth is associated with high illiteracy and low education levels hence making it difficult for the government to implement its programmes given the budget implications.

Preventing HIV/AIDS

By accessing family planning commodities such as condoms, there is reduction of unwanted pregnancies, illnesses and death associated with child birth, There is also prevention of spreading of sexually transmitted infections (STIs) including HIV/AIDS.

1.3 Problem statement

Contraceptive choice is a central element of quality of care in the provision of family planning services and an important dimension of women reproductive rights (Diaz et al.1999). Hence, proper understanding of contraceptive method choice is not only important for a woman but also for a country to realize its desired fertility impact on contraceptives practices.

According to the (USAID/HPI, 2007), women from the low socio-economic status groups are less likely to use the modern contraceptives compared to those from high social economic status group. For example, in 2003, 12 % of women from the low social economic status group used modern family planning methods compared to 45% of women from high social economic status group (GOK, 2003)

Population Service International (PSI), Kenya conducted a survey in 2007 to investigate family planning practices among women of 20-35 years of age with an aim of providing evidence for social marketing decision and measure various interventions and strategies used to help promote informed demand for modern methods of family planning. The study indicated that there was an improved use of contraceptives whereby, use of modern contraceptives doubled between 2001 and 2007(32.1% and 66.4%).The social marketing approach aimed at providing knowledge and promoting use of family planning services among women.

Further analyses of KDHS, 2001 revealed that, contraceptive use among women is a very dynamic process whereby, women can start and stop using contraceptives in response to changing circumstances such as their health environment hence, choosing of different methods

that suit them. Therefore, contraceptive prevalence and method mix, contraceptive use and method choice is as a result of decisions made by women.

IPC on the other hand focuses on communication processes in social, personal and family relationships with particular emphasis on reproductive health. Since IPC aims at shaping, sustaining and changing individuals in line with positive reproductive health behaviors, it's therefore important for the study to examine the role of IPC in the use of family planning methods among women in Kajiado county.

1.4 Study objectives

The objectives of this study are to:

1) Investigate the role of interpersonal communication in creating awareness about family planning use among women in Kajiado county.
2) Examine various forms of interpersonal communication used in creating awareness about family planning use among women in Kajiado county.
3) Examine the frequency of use of family planning services among women in Kajiado County.
4) Investigate the level of knowledge about family planning methods among women in Kajiado County.

1.5 Justification of the study

Family planning is an essential component of health among women as much these services are underutilized even when available. Therefore, there are various stakeholders who play a key role in ensuring provision and utilization of family planning services in our country.

This study will contribute to literature in the field of reproductive health as well as make recommendations on strategic IPC communication procedures on how increase uptake of contraceptives and also give the relevant information about family planning methods.

This study will also help to identify the attitudes and perceptions of the targeted women towards contraceptive use and its impacts and make recommendations on how to do away with such perceptions and attitudes among women. Therefore, the findings will help the health experts on

how to come up with behavior change communication (BCC) and IEC strategies that involve IPC that will help promoting positive reproductive health behaviors among women.

The government thorough the ministry of health can develop and effectively implement policies that will enable availability and access to the contraceptives. These laws should fulfill the goals of family planning. It can also allocate enough financial and human resources for improved services such as counseling as well as setting clear guidelines on pricing of contraceptives. Improving coordination with the donors for improved services and creating awareness.

The donors and development partners as WHO, USAID, UNFPA are fully entitled with provision of the services. Therefore, they are entitled to improving and advocating for policies that support access to contraceptives, increase funding and raise awareness through interpersonal communication, partner with the government for effective and efficient service delivery as well as coming up with advocacy campaigns for awareness.

Community based distribution (CBD) programs be revived so as to allow low cost contraception information and services to be accessed in the rural areas and peri-urban areas (Crinchton, 2008).This will also enhance community communication as well as community participation.

Women are the direct beneficiaries on FP use. Therefore, by gaining the required information and access about family planning methods, they are able to make informed decision about contraceptive use, contraceptive switch and family planning methods that suits them.

Public health facilities can provide free commodities such as condoms and create awareness of family planning to their clients through the IEC campaigns.

1.6. Definition of key terms

Behavior change communication-communication interventions focusing on individual, community and environmental influences on behavior that will have a positive impact on their health.

Information education and communication-these are strategies that are used to improve people's awareness and knowledge and to promote positive behaviors.

Interpersonal communication-refers to a face to face verbal or non-verbal exchange of information between two or more people.

Mass media-these are diversified media technologies that are intended to reach a large audience by mass communication.

Family planning-a process of limiting or spacing children by using contraceptives.

Contraceptive prevalence rate-proportion of women of reproductive age who are using who are using a particular contraceptive method at one point in time.

Mortality rate-a measure of number of deaths in a population**.**

Total fertility rate- number of children that could be born to a woman if she were to live to the end of her child bearing years in accordance with current age specific fertility rates.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section presents literature pertaining to studies which were conducted on the role of interpersonal communication and use of family planning among women. The review was discussed under various sub-topics: Interpersonal communication and family planning, overview of family planning trend, population and fertility trend, use of contraceptive methods, situational analysis of family planning in Kenya and the theoretical framework that linked the theoretical aspects with the practical components of the study.

2.1 Interpersonal communication and family planning

Communication activities were fundamental in virtually every family planning programme. They were used to promote the idea of family planning programs as well as specific contraceptive methods that were available and to locate locations where services and products were available. To pass on the message on contraceptive use, various communication channels were used. They included; interpersonal communication and mass media channels.

IPC and posters that carried educational messages were forms that were very useful for transmitting information and messages of family planning methods in small towns and villages where more advanced communication media lacked thus making IPC an essential component for transmission of reproductive health messages among women.

Interpersonal communication was also utilized by involving '*stratified users'* who were given material to distribute to their friends and members of their communities. Example: A successful household model could be used to communicate messages to their peers.

Literature reveals that, IPC has long been identified as an effective means of changing behavior. It was believed that, people are more likely to change their behavior when encouraged to do so by other individuals they know. Thus when individuals talked about mass media campaigns on reproductive health with others, the response they received, was important for decision making

on using or not using family planning. Thus, IPC was essential in reinforcing the positive impacts of mass media messages (Katz &Lazarsfeld, 1955).

Studies further discovered that, mass media may be an effective tool for motivating people to adopt family planning. However, it was argued that, following an exposure to mass media messages about family planning, IPC discussion about such messages was an important intermediate stage in the process of deciding to use or not to use contraception.IPC was to enhance the effects of exposure to media messages on contraceptive use behavior. Findings indicated that, those women who were exposed to media messages and discussed them with other people, were more likely to use contraceptives compared to those who did not discuss the messages (Syed Abdul & Jan, 2008).

Spousal communication was an example of IPC which was closely associated with family planning use after exposure to communication. There were communication assumptions that, communication lead to family planning use and vice versa. Importance of spousal communication was often emphasized in family planning programs and research and this was seen as the first step in a rational fertility decision-making process by analysts. Studies showed that, the amount of communication that takes place between spouses was positively associated with contraceptive use (Mona & Thomas, 2002).

It further revealed that, lack of communication about family planning, may be associated with misconceptions about a spouse's view on family planning which, in turn, may inhibit decision making. Behavior change interventions as IPC which intended to promote family planning, influenced psychosocial factors associated with spousal communication thus leading to family planning use (Mona & Thomas, 2002).

While media campaigns attempted to change behavior patterns, they could not universally lead to family planning adoption as these decisions were influenced by individual level factors. The effect of spousal communication on family planning use was mediated by the relative power of each spouse in the decision making process. This was related with a study in India that found that husbands were principal decision makers and initiators of discussion about family planning use (Mona & Thomas, 2002).

Therefore, spousal communication was a very important factor in the adoption of family planning method as it initiated change of behavioral factors like knowledge, motivation and attitudes towards family planning which in turn influences use of family planning. This was stimulated by both personal contact (IPC) and mass media communication.

Studies show that, family planning programs were used to reduce birth rate for stabilization of a population, at a level consistent with requirement of the national economy by generating universal knowledge about family planning method use.But even with high awareness about family planning methods,there existed a wide gap between knowledge and acceptance of family planning methods(West & Rodriguez, 1995).

2.2 Overview of family planning trends

Family planning programs occupy unusual place in the public policy arena. It is an essential services required in a reproductive life of every woman, as it virtually exists in every nation of the world. Reproductive health is the best remedy to address the consequences of high population growth rate in the world in order to maintain a healthy family as well as a healthy nation.

Worldwide, was estimated that, two hundred million women wanted to delay or avoid pregnancy but were not using safe or effective family planning methods due to lack of access, fear of the side effects or they think they will not get pregnant. This had led to unwanted pregnancies, maternal deaths and ill health. Access to contraceptives saved life, empowered women and also reduced infant mortality rate of 2.7 million every year (UNFPA, 2006).

The demand for contraceptive use was expected to rise by 40% in the next fifteen years because millions of young people were becoming sexually active. Therefore, to achieve the Millennium Development Goals the international community had to restore family planning both financially and politically (UNFPA, 2006).

Poverty was a great challenge in many countries and this had greatly contributed to high population growth. Most of Asia and Latin America had stabilized population growth due to the available national family planning programmes but still, the needs of the poor had been partially addressed. Ability to family plan was a recognized right among women but had not yet been

recognized among the poor. Example; among the developing countries, poorest women average six births compared to 3.2 births among the rich (UNFPA, 2006).

Sub-Saharan Africa (SSA) had the highest fertility level in the world, with an average total fertility rate (TFR) of 5.1 in 2009 (World Bank, 2011).Total fertility rates had declined over time in most regions but had steadily risen in some places or remained constant since 2000 in other countries.

In 2009, the contraceptive prevalence rate (CPR) in SSA was 21% compared to South Asia (51%), Caribbean and Latin America (75%) and East Asia (77%) (World Bank 2011).East Africa countries had shown an increase in contraceptive use compared to West and Central Africa but in Rwanda and Uganda, the fertility gap had widened since 2000 (Shaharan, Ahmed et al. 2010) indicating that, many women are had more children than they would prefer.

Fertility and future projected population was very high in Sub-Saharan Africa as compared to the rest of the world due to high levels of fertility and low contraceptive prevalence rate (WHO, 2011).As a result, SSA had the highest population growth rate among the developing countries in 2005-2010, an annual rate of 2.4%, compared with South Asia (1.4%) and Latin America (1.1%) (World Bank 2011).

The rise in population growth will hinder Africa from achieving the health and development goals if its population does not adopt effective and modern methods of contraception as compared to the rest of the world (WHO, 2011).

2.3 Population and fertility rate.

Owing to its high fertility and declining mortality, Kenya was characterized with a youthful population whereby 43% of the population was younger than fifteen years (CBS, 2006).This implied that, over three-fifths or twenty five million Kenyan`s in 2009, were less than twenty five years old. Therefore, a clear indication of challenges Kenya was facing in providing a safe, healthy and productive future.

Total fertility rate refer to the average number of children born by a woman over her lifetime. Through the demographic and health surveys that have been carried out regularly, there is a decline in the fertility rate reaching as low as 4.6 children per woman (KDHS, 2008/2009).

The survey further indicated that while the TFR declined from 4.9 children per woman in 2003 to 4.6 in 2008-2009, the decline was steeper in urban women (12%) compared to their rural counterparts at (4%).Overall the decline for urban women was from 3.3 to 2.9 and 5.4 to 5.2 for rural women.

Below is a summary of fertility trends.

Year	**1977/78**	**1989**	**1993**	**1998**	**1999(CENSUS)**	**2003**	**2008/2009**
TFR	**8.9**	**6.7**	**5.4**	**4.7**	**5.0**	**4.9**	**4.6**

(The first four surveys excluded North Eastern province and several northern districts in Eastern and Rift Valley provinces but the last two include the entire country.)

The survey findings further revealed that, rural areas recorded a higher fertility rate than women in the urban areas as indicated in the table below. This pattern is reflected in every age group and the difference increases with the age of the women, with the fertility of the rural women age 20 and older being about twice that of the urban women of the same age group. Fertility rate however, fall after age 39 in both rural and urban areas (KDHS, 2008-2009).

These differences in fertility among rural and urban women was due to various factors such as: The role played by educating women about population growth, lack of access to family planning resources and good health care among others (KDHS, 2008-2009)

The current fertility rate findings according to the KDHS, 2008-2009 was as presented in the table below.

Age group	Urban	Rural	Total
15-19	92	107	103
20-24	146	280	238
25-29	147	248	216
30-34	104	197	175
35-39	60	135	118
40-44	28	56	50
45-49	7	13	12

(The age specific fertility rates are per 1000 women)

There was a linear relationship between the level of contraceptive prevalence in a population and its current fertility. An increase of 15 percentage points in contraceptive prevalence was expected to yield a decline of about one child in the total fertility rate (Ross & Frankenberg, 1993).

2.4 Use of contraceptive methods

Knowledge about methods was essential for making decisions to initiate contraceptive use among women. Though the knowledge of family planning is universal, 95% of women age 15-49 know at least one method of family planning (KDHS, 2008-2009).

Contraceptive use was a determinant of the length of birth intervals and other reproductive health outcomes (Trussell et al., 1985).Knowledge of family planning methods is essential when making decisions about contraceptive to use (MLE, 2011).

Women were more familiar to modern methods (95%) than traditional methods (69%).89% of women knew about the most widely known modern method of contraception such as male condoms, injections and pills as these were the mostly used.

The least known method at 40% or less was lactational amenorrhoea method (LAM), male sterilization and emergency contraception. Around six in ten women had heard about female sterilization, the IUD, implants and female condoms and two-thirds had heard about rhythm methods while just under half had heard about withdrawal (KDHS, 2008-2009).

The contraceptive prevalence rate among the currently married women age 15-49 who were using family planning methods had increased. Less than half of currently married women (46%) were currently using some method of contraception an increase from 39 percent in 2003 while the proportion of women who wantd no more children had increased from 49 percent in 2003 to 54 percent in 2008-2009.Under-five mortality and infant mortality had also declined from 115 and 77 to 74 and 52 deaths per 1,000 live births in 2008-2009 respectively (KDHS, 2008-2009)

Below is a table showing trends in contraceptive use. (KDHS, 2008/2009)

Year	Percent
1978	7
1984	17
1989	27
1993	33
1998	39
2003	39
2008-2009	46

Rapid urbanization had led to an increased focus in use of family planning methods. Use of modern contraceptives had been an upward trend, with modern contraceptive method prevalence at 46.6% in 2008/09, from nearly 40% in 1998 and 2003, and 37.9% in 1993(MLE, 2011).

2.5 Situational analysis of family planning in Kenya.

Many studies had been conducted in regard to health issues and in particular, use of family planning services among women. These studies had taken various dimensions and among them, the ones reviewed below.

Kenya was one of the first African countries to develop a Population Policy and establish a Family Planning Programme as the main policy to reduce population growth rate (Koome et al., 2005; Ian et al., 2009)

In Kenya, family planning services were available in the 1950s by private doctors and Family Planning Association Kenya (FPA)now called Family Health Options Kenya(FHOK) in 1962.Family planning services were provided by the Ministry of Health in 1967 through the network of MCH/FP clinics. As the CBD programmes which were introduced in 1982 collapsed in the 1990s, the Marie Stopes International (MSI) in 1985 offered services through clinics and outreach strategies (Republic of Kenya, 1984).

The long acting and permanent methods (LAPMs) were strengthened in 1980s to mid 1990s and the condoms and pills in 1990s.A clear indication of the availability of various family planning methods at that time.

From mid-90s, the funding declined both from the donors and the government as the national family planning programme reduced. The community-based distribution(CBD) programmes that allowed information and services reach the rural areas, also declined and the IEC campaigns advocating for contraceptive use and small families also declined (Crinchton,2008).

The increase followed by a decrease in institutional commitments to family planning programmes, affected the stall, with the timing of these changes in commitments and corresponding programmes effort. It reflected the decline and stagnation in the fertility rate (Ian et al., 2009).

Due to rise in population growth, there was an indication that there could be challenges in reducing child mortality rate and improving maternal health, achieving universal primary education and combating HIV/AIDS and malaria among other diseases as part of the Millennium Development Goals (MDGs) (Health Policy Initiative, 2007).To address these, many SSA countries adopted use of family planning services.

The Kenya Demographic Health Survey (1998) was designed to provide information on levels and trends in family planning knowledge and use, infant and child mortality indicators. However, the impact of contraceptive use on women was left out as it further collected information on knowledge and behavior related to AIDS and other sexually transmitted diseases which helped them with information so as to estimate the contraceptive discontinuation rates (KDHS, 1998).

The KDHS survey further indicated that, knowledge and use of family planning is on the rise. It showed that 98% of all married women were able to cite at least one modern method of family planning. The most widely used contraceptives are injectables at 12%, pills at 9%, female sterilization at 6% and periodic abstinence at 6%,IUD 3%,condom 1% and Norplant at 1%.(KDHS,1998).The survey did not show the challenges involved while using these contraception methods among women.

An analysis of KDHS data indicated that, almost two-thirds of women who had ever used contraceptives before,chose short time methods at first use and the other quarter choose the traditional methods at first use. Use of sterilization at 4% while the long term methods at 7%.It further showed that when a woman made decisions on use of contraceptives, they chose a method that suit their needs. Older and high parity women and those who have got an ideal family size prefer long term methods and sterilization while the young and low parity women who have not yet got an ideal family size choose the short term methods (APHRC, 2001).

A study conducted by the KDHS 2008/2009 showed that, 26% of married women wanted to space or limit the number of children but were not using any contraceptive method hence a threat because of chances of high fertility rate and high population growth rate. It further indicated that, the difference in fertility among the rural and urban women was attributed by the role played by education which helped in creating awareness. Fertility levels were low when there was access to family planning resources, decent jobs among women and improved literacy levels (KDHS, 2008/2009).

The total fertility rate (TFR) refers to the average number of children born per woman according to the given fertility rate at each age. The study revealed that currently, the TFR is at 4.6 children per woman compared to the wanted fertility rate in Kenya which was at 3.4 children per woman. The gap between the wanted and observed fertility was greatest among the poor women living in rural areas with education level lower than secondary school. It was noted in the study that the government was planning to achieve a population growth rate of 2.4%per year through vision 2030 (KDHS, 2008/2009).

The KDHS of 2008 indicated that various factors such as level of income, level of education and wealth hindered women from accessing family planning services. The report further noted that low level of income contributed to low use of contraceptives.

It was estimated that about 60% of women with at least secondary education used contraceptives, compared to 40% with primary education and 14% with no education (Republic of Kenya, 2008).Only 43% of low income earners compared to 53% of income earners also used contraceptives.

The report of KDHS, 2008 indicated that modern methods of contraception such as injections were the commonly used at 39% compared to the traditional methods as periodic abstinence at 6%.It further showed that 53% of urban women were using contraceptives compared to their counterparts in the rural areas at 43%(Republic of Kenya, 2008).

A study was conducted within the city slums of Kenya to find out the level of contraceptive use and also find out factors that lead to the usage of these contraceptives. It was found out that 51% were using contraceptives mainly to avoid pregnancy and prevent sexually transmitted infections (STIs) while 49% were not using contraceptives because of infrequent sex, not married, pregnancy, lack of support from partners and desire for children. The study further revealed that the most commonly used contraception methods were condoms (35%), pills (33%), injection (19%) and IUD (4%) (Timothy et al., 2011).

This research further indicated that, use of family planning was highest among women aged between 20-39 compared to those below 20 years and above 39 years.49% of women who were using contraceptives were aged between 20-29 years, 41% were aged between 30-39 years but women who had 50 years and above were found not to be using any family planning method. The 4% and 6% using contraceptives were below 20 years and 40-49 years respectively. (Timothy et al., 2011).

A study was conducted using data collected in four national surveys between 1977 and 1993 to describe the differentials in contraceptive use and factors associated with contraceptive use. These factors were: *Socio-economic changes* which led to economic hardships hence people desire few children by using contraceptives, among women increased contraceptive use and also reduced fertility due to attainment of universal education which was critical for onset of fertility transition (Caldwell, 1980).

Prevalence in contraceptive use ranged from 18% of women with no education to 40% of women who have completed secondary education (Sinding, 1991).*Changes in cultural support of high fertility* whereby there was no longer demand for large families and married women used modern methods of family planning.

A study was conducted in Kenya to examine use of contraceptive methods among sexually active women aged 20-35 years. The study was aimed at providing social marketing decision for family

planning program and to help measure the effectiveness of various interventions and strategies used to promote informed demand for modern methods of family planning. This is because of the unmet need of family planning as reported in the KDHS, 2003 where 15.8% have the unmet need for family planning, 24.5% among the married and 2.7% among the unmarried women.

The study opted for some approaches such as supplying pills and injectibles, providing product support and information, developing information and education materials, mass media communication was used so as to increase demand for use. The study findings clearly indicated rise in usage of contraceptives when sufficient communication was involved (PSI/KENYA, 2007).

As revealed form the above analysis of family planning in Kenya, it is evident that various factors played a key role in adoption family planning. They include: Education level, income, communication, place of residence, accessibility and level of awareness.

IPC on the other hand was also influenced by various factors such as: socio-economic(ethnicity, education and occupation),demographic(age, age of marriage, duration of marriage and number of living children),cultural(religion, caste) and geographic(place of residence).These are influencing factors on the source of family planning information.IPC channels were also found to be the most influential source of family planning information to women in Kenya(Gathiti L., 1997)

2.6 Theoretical framework

The theoretical framework of a research project relates to the philosophical basis on which the research takes place, and forms the link between the theoretical aspects and practical components of the investigation undertaken.

Reproductive health often uses theories such as social learning theory recently changed to social cognitive theory, theory of reasoned action and health belief model have been applied in explaining, predicting and influencing behavior. But on this particular research, this study will use social cognitive theory as it is among the most frequently used for behavior change communication.

2.6.1 Social cognitive theory.

Cognitive theory is a learning theory of psychology that explains human behavior patterns by understanding the cognitive aspects, emotional aspects and aspects of behavior for understanding behavior change. Social cognitive theory is a subset of cognitive theory which focuses on ways in which people learn to model the behavior of others.

The social cognitive theory originated from social leaning theory, the work of Albert Bandura (1986).It was developed with an emphasis on the acquisition of social behaviors and continues to emphasize that learning occurs in a social context and much of what is learned is gained through observation.

It further states that, people can influence their own behavior in a purposeful, goal-oriented way (Bandura, 2001).Social cognitive theory also argues that, people can also through their self-reflection and self-regulatory processes exert pressure over their own outcomes and the environment more broadly unlike behaviorism that advocated a more rigorous form of environmental determinism. Therefore, social cognitive theory can also be referred to as an inter-personal level theory, which sees human behavior as forming under a triad of behavioral, personal and environment determinants.

This theory describes human behavior as a dynamic and an ongoing process in which personal, environment and human behavior all interact. That is a person`s ongoing functioning is a product of a continuous interaction between cognitive, behavioral and contextual factors. For instance, learning is shaped by the factors within the learning environment especially the reinforcements. At the same time learning can be affected by one`s one thoughts and self-beliefs and their interpretation of the learning context.

Social cognitive theory emphasizes on the acquisition of social behaviors in addition to the cognitive thought processes that influence human behavior and processes. It seeks to explain how behavior standards and norms are learned through an interaction of the individual and his environment, through the observation of others/vicarious learning.

This idea (vicarious learning) asserts that individuals can witness observed behaviors of others and then reproduce the same actions. As a result, individuals refrain from making mistakes and can perform behaviors better if they see individuals complete them successfully.

This theory refers to people as self-organizing, self-reflecting and self-regulating. According to Social cognitive theory, there are three main factors affect the likelihood that a person will change a health behavior: self-efficacy, goals and outcome expectancies (Bandura, 2001).

This theory will be used in this research to explain how people acquire and maintain certain behavioral patterns, while also providing the basis for intervention strategies such as using IPC which are essential in creating awareness about reproductive health. It will also be used to explain that, behavior change depends on factors as environment (social) as well as people(IPC) and behavior. Social environment refers to factors that affect a person's behavior such as family members, friends and colleagues which are different ways used in reproductive communication. It will further explain that cognitive/mental representations of the environment may affect a person's behavior such as a person's perception about an activity.

2.6.2 HEALTH BELIEF MODEL (HBM)

The Health Belief Model was developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels at the U.S Public Health Service in an attempt to understand 'the widespread failure of people to accept disease preventive or screening tests for the early detection of asymptomatic disease.' It was later applied to patients` responses to symptoms and compliance with prescribed medical regimens.

The Health Belief Model attempts to explain and predict health behaviors of individuals through examination of perceptions and attitudes, someone may have towards diseases and negative outcomes of certain actions. This model is used in health promotion to design intervention and prevention programmes. As the name implies, this theory deals with people's beliefs.

It further suggests that, a person`s belief in a personal threat of an illness or disease together with a person`s belief in the effectiveness of the recommended health behavior will predict the likelihood the person will adopt the behavior.

The Health Belief Model has been broadly used in predicting health-related behaviors, preventive health behaviors and also predicts health-promoting behavior thus, improving health behaviors.

This model has four major concepts that are necessary for behavior change as discussed below.

Perceived susceptibility-refers to a risk a person has to getting a particular health outcome. The greater the risk is of getting a certain medical condition, the more a person will engage in behaviors to decrease the risk.

Within the context of the Health Belief Model, perceived susceptibility examines a person`s opinion about how likely the behaviors they practice will likely lead to a negative health outcome. Example: a woman who does not use contraceptives. Lack of family planning has its own consequences but if an individual does not see the need of family planning then she has no reason of changing her behavior by using contraceptives.

One of the goals of Health Belief Model is to change perceptions of susceptibility in order to move towards behavior change. Therefore, interpersonal communication can used to understand how the perceptions are formed in order to dismiss any beliefs and also supply information that encourages a healthy action. Perceptions of susceptibility can be modified through communication by educating a person about the risk factors and dispelling cultural misperceptions around a condition.

Perceived severity-refers to how serious a situation or disease that a person is susceptible to and its potential consequences.

It assumes that people will take action to prevent or control ill-health behaviors if they regard themselves as susceptible to the condition. The Health Belief Model seeks to increase awareness of how serious the outcomes of behaviors can be in order to increase the quality of one`s life. Interpersonal communication is essential in engaging with people who already their behaviors have put them at risk thus inciting a positive healthy behavior.

Perceived benefits-refers to the positive consequences of adopting a behavior in order to reduce their susceptibility. An individual adopts a behavior that she thinks will decrease the chance of

getting a bad health behavior that she is susceptible to. This can be achieved by talking about the benefits through IPC by using the successful users as models to demonstrate the benefits of making a healthy choice.

Perceived barriers- barriers refer to obstacles that hinder an individual from adopting a new behavior. It also refers to consequences of continuing with the old behavior. They can be concrete and psychological. The perceived barriers determine adoption of a new behavior thus affecting a person's ability to take action. They include; affordability, accessibility of services, culture, side effects of contraceptives and lack of knowledge among others.

Supportive programming and consistent communication help in overcoming a person's perceived barriers. Incentive programmes can help individuals overcome concrete barriers like finances thus a very effective method through which information is passed to the targeted people.

The HBM model suggests that, for change in behavior to take place, the benefits must be weighed against the barriers in order to determine that taking an action will be worthwhile.

The HBM posits that people will take action to undergo a health prevention behavior when they are ready; they see it as beneficial; and the difficulty is not greater than what is to be gained. An individual`s belief in personal threat together with her belief in the effectiveness of the proposed behavior will predict the likelihood of the behavior.

Therefore, the Health Belief Model can be used in this study to explain that for an individual to engage in a healthy behavior, they must evaluate their perceptions of severity and susceptibility, benefits and barriers.

This model is useful in this study as it can be used to improve health by enabling individuals to make informed choices about their own health-related behavior. This can be through health professionals who educate them thus enabling them make informed choices regarding their own health behavior.

IPC can be used as a channel to produce a series of messages that target individuals' beliefs at various stages throughout the health belief model. Through IPC, people are informed and educated about negative behaviors and other factors that make them susceptible to conditions and also told about the positive effects of engaging in a healthy practice.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This section of the research was meant to introduce the context in which the study was carried out. It described various steps that were used in carrying out the study. The sections included: research site, study population, research design, sampling technique and sample size, data collection techniques as well as data analysis and presentation of the findings.

3.1 Research site

This study was conducted in Kajiado county, Ongata Rongai town. The study area was chosen because it was a diverse town with a cosmopolitan population. It was characterized with a population of mixed tribes and a representative town with people of different classes.

3.2 Study population

Population refers to the entire group of individuals who have a common observable characteristic (Mugenda & Mugenda, 2003).

The study`s targeted population comprised of women of a reproductive age between 15-45 years, who had used or were using contraceptives in Kajiado County, Ongata Rongai town because of the reasons discussed in the preceding section (research site).

3.3 Research design

Gay[7] defined descriptive research as a process of collecting data in order to test hypotheses or to answer questions concerning the current status of the subjects in the study (Mugenda & Mugenda, 2003)

This kind of design was used when the researcher wanted to describe a specific behavior of subjects under study as it occurred in the environment.

Therefore, this research used descriptive design to conduct the study because this kind of design attempted to describe possible behavior and attitudes of the study population in regard to the uses and impacts of family planning methods among women.

Descriptive design often involved use of extensive observation, note taking as well as in-depth narrative descriptions of small numbers of cases involved.

3.4 Sample size and sampling technique

3.4.1 Sample size

A sample is a subgroup that is carefully selected to be a representative of a whole population with the relevant characteristics (Mugenda & Mugenda, 2003).Gay suggested that, for descriptive studies, ten percent of the accessible population is representative(Gay, 1981).

Sample size in qualitative study does not really matter because the study was aiming at discovering a health trend in the society and the validity. Meaningfulness and insights generated from this study had more to do with information richness of the cases selected(WHO,1994).A qualitative study was designed to look beyond the percentages to gain an understanding of the respondents feelings, attitudes and viewpoints about a certain health trend in society hence use of smaller but highly targeted samples.

Therefore a sample size of twenty-five respondents was used for in-depth interviews, two groups each with five members in the focused group discussions and one respondent for key informant interview. This study had a sample size of thirty six respondents.

3.4.2 Sampling technique

Sampling refers to a process of selecting a number of individuals who represent a large group from which they were selected for study (Olive and Abel Mugenda, 2003)

This study used non-probability sampling to select its population for study. The individual participants were selected deliberately for their specific characteristics that were important because, a qualitative research focuses more on the information given by the respondents than generalization to a population.

The study selected its sample size using purposive sampling. This type allowed a researcher to use cases that had the required information with respect to objectives of the study.

This is a type of sampling in which decisions concerning the individuals to be included in the sample were taken by the researcher, based upon a variety of criteria which included specialist knowledge of the research issue or capacity and willingness to participate in the research. Through the selection of respondents, the researcher believed that the respondents will give in-depth information that will lead to achieving the study objectives.

3.5 Data collection techniques

3.5.1 Qualitative data

Qualitative research includes designs, techniques and measurements that that do not produce numerical data whereby, data is in form of words rather than numbers (Mugenda & Mugenda, 2003).

Qualitative approaches to data collection involve a direct interaction with individuals on a one to one basis or in a group. Though this method of data collection is time consuming, there is richness of data and a deep insight into the phenomena under study (Hancock Beverly, 2002).

This study used a range approaches for collecting data. They included use of in-depth interviews, key informant interviews and focused group discussions.

In-depth interviews were carried out with the aid of an interview schedule or guide which listed a set of questions to be used during the interview session. These set questions were meant to answer the study objectives of the study. This involved the researcher talking to participants focusing on the main issues in the study while recording and taking notes.

Key informant interviews were conducted with individuals who had specific knowledge or expertise as medical personnel on family planning.

Focused group discussions (FGD) involved an organized discussion with a selected group of women to gain information about their views and experiences about the contraceptive use and the role that interpersonal communication had on family planning.

3.6 Data analysis and presentation

Data analysis is a process of cleaning, coding and transforming the raw data for interpretation. With qualitative data analysis, text (transcripts from key informant interviews and focused group discussions) is the important feature that an analyst has to focus on.

Data was analyzed according to the themes (main findings) and various categories in the study and the findings were presented in a narrative form.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.0 Introduction

This section presents the findings of this research, based on the findings from the data collected.

4.1 Data presentation, discussion and interpretation.

Presentation of this research was done based on the key findings from the in-depth interviews, key informant interviews and the FGDs that were carried out during the study.

This study examined the use of contraceptive and its impacts among women. Respondents who were women were randomly picked in Ongata Rongai town and the response was quite good and adequate for a researcher to make generalizations to a wider population.

4.2 Analysis according to the study objectives.

4.2.1 Investigating the role of communication in creating awareness about family planning use among women in Kajiado County.

The findings of the research indicated that both interpersonal communication and media messages played a key role of education and awareness by giving women the right information about family planning use and the methods available.

This was effectively done through the communication channels which include: IPC (doctors, friends, relatives and husbands), radio, print media, and family planning related posters at the hospitals, billboards and television advertisements that educate the public about contraceptive use.

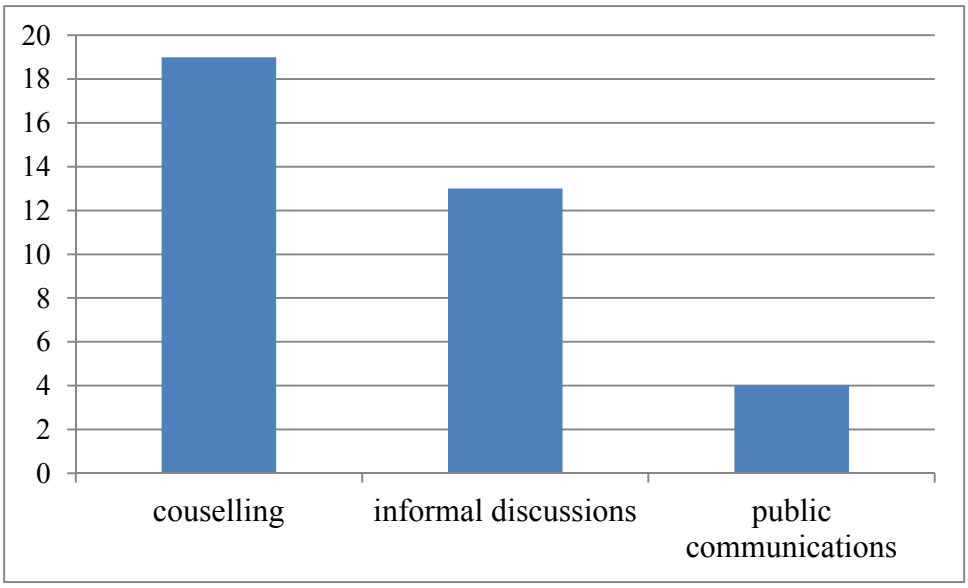
The interpersonal communication was through friends or relative and doctors who help the women with family planning information. This was done through discussions among women themselves whereby those who had used the services could help their colleagues in decision making about contraceptives use. At the hospitals, the doctors also helped through counseling

sessions thus educating women about family planning. This was mostly done when a woman had delivered whereby they were advised to use contraceptives after six weeks.

The findings showed that passing of information by 'word-of-mouth' was seen to be among the most effective communication channel for acquiring knowledge and promoting desired changes in behavior.

Therefore the findings of the study showed that, IPC was more educational compared to other mass media channels that were more commercial and advertorial.

4.2.2Examine the various forms of interpersonal communication used in creating awareness about contraceptive use



Findings from the study indicated that counseling, informal discussions and public communications were the only IPC channels used to pass a message about family planning use among the respondents that were interviewed.

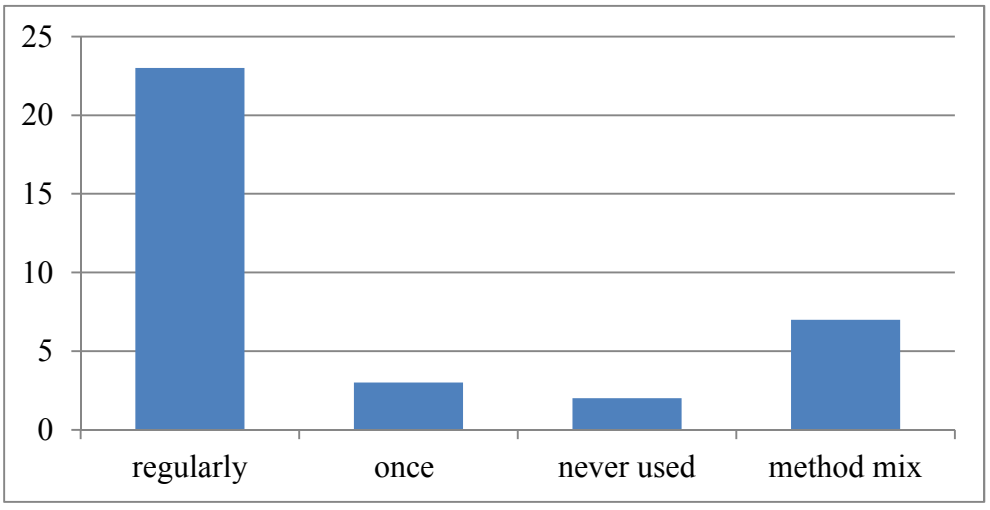
Counseling involved an expertise in medicine such as a doctor, informal discussions was among friends, relatives neighbors and couples while public communication involved a group of people such as public barazas, community rallies for awareness.

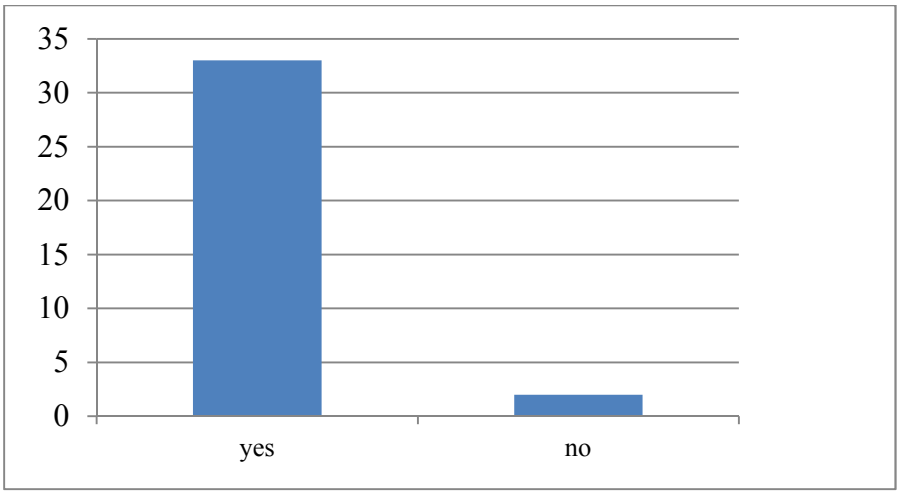
Different respondents utilized different communication method for family planning knowledge. Counseling which was widely used was at 53% followed by informal discussions at 36% and public communication at 11%.A clear indication of the most effective communication method used to the least communication method for used among women.

According to the study, doctors in reproductive health were particularly the most preferred source of information because of their adequate knowledge in that particular field. The respondents also attributed use of IPC through friends and relatives as the most used source for motivation to adopt family planning as it was seen to exert positive impact on reproductive behavior and couple communication was also seen as an additional way only if the husband approved use family planning because not all men were for the practice leading some women to practice family planning in privacy. The least utilized source was through public communication due to its rare nature.

Findings showed that dialogue among women provided accurate family planning information about safety and efficacy of family planning from personal testimonials which influenced perceptions of family planning acceptance as well as increasing positive outcome expectations and legitimizing female involvement in contraceptive use.

4.2.3 Examining the frequency of use of family planning services among women in Kajiado County.





The study findings indicated that the women from Ongata Rongai town were very much aware about family planning. This was because virtually all the respondents that were randomly interviewed said that they used contraceptives.

The findings showed that, 94% had used contraceptives while 6% had not used contraceptives before. Among those who had used contraceptives, 66% were regular users,9% used once,6% never used while 20% used different methods(method mix).

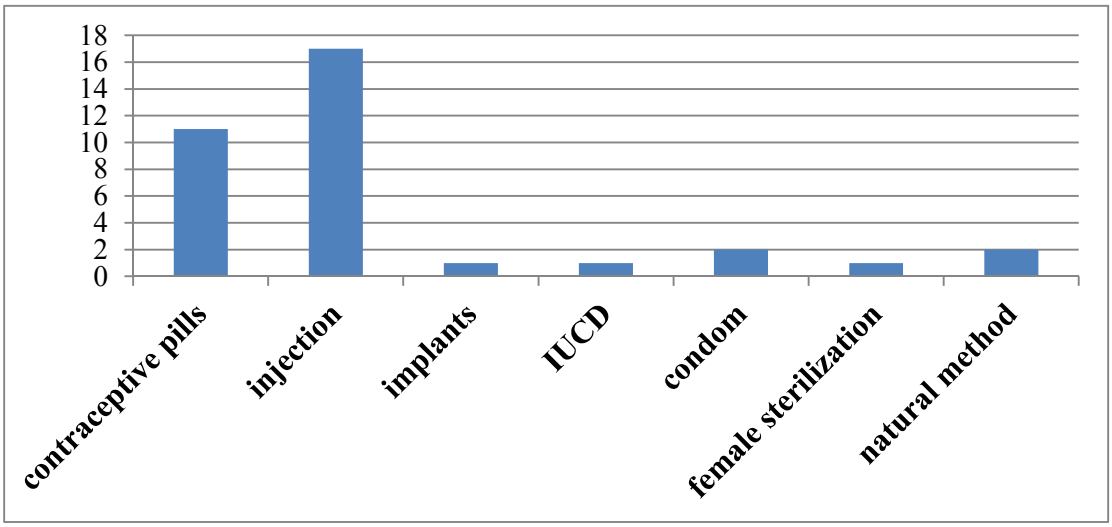
Among the respondents who were aware about family planning, most of them were regular users of contraceptives although others did not use a specific family planning method as they kept on changing from one method to another while others used a particular method once but due to the negative side effects they had to withdraw completely and opted not to use any method.

Also, some respondents did not use because the husbands did not approve. Therefore, spousal communication was an important precursor to the adoption of family planning methods among women.

The frequency of use was dependent on the contraceptive method that one used and exposure to communication channels that kept on educating women on the importance of behavior change as well as showing various contraceptive methods available. Due to the type of method, frequency of use among women differed. Example; after every three months for the injection, monthly for oral contraceptives, two or five years for the implants, twelve years for IUCD and a lifetime for female sterilization.

Therefore the respondents had good knowledge and access to family planning method according to the findings of the study, however, when the women had challenges while using the contraceptives leading to method mixing and total withdrawal.

4.2.4 Investigating the level of knowledge about family planning methods among women in Kajiado County.



The findings from this research showed that the respondents were aware of family planning methods as a variety of contraceptives were used as shown above. The respondents displayed knowledge of different family planning methods that they were aware of. They were conversant with the short term methods such as contraceptive pills and injections while others knew about the long term methods such implants and IUCD. The respondents were mostly aware of the short term method compared to the long term methods.

The injection was at 49%, contraceptive pill 31%, natural method 6%,female sterilization 3%,condom 6%,IUCD 3% and implants 3%.

The findings also indicated that a good number of respondents used pills and injection compared to other methods. Some respondents had used more than one method (switching) due to the negative health effects .This switching was mostly done between the contraceptive pills and injections. The use of IUCD and implants had a high continuation rate because so far there were no reported side effects from the respondents.

While conducting the study, the respondents were also able to bring out various reasons as to why they used contraceptives. They included; avoiding unwanted pregnancy, spacing children in order to able to provide for their basic need among them education and food, and also to have a manageable family.

The findings further revealed that, friends, relatives/family and doctors were the most common sources of information for women about family planning.

4.3 Findings from the focused group discussions.

According to the information gathered from FGDs, women were a bit knowledgeable about family planning although most of them got information from friends,family,experts such as doctors and through community groups that created awareness.

From the findings,the women did not have enough knowledge about the long term methods of family planning and how they are used compared to the short term methods such as contraceptive pills and injections which they were much aware of because they were often used hence when faced with problems; most women personally withdraw without consulting. Therefore, contraceptive prevalence and method mix, contraceptive use and method choice is as a result of decisions made by women. It was revealed that this was the case because, most of the people (friend, relatives, neighbors) they had engaged with approved of a particular family planning method because they had used it and could work out well without any effects.

The findings further revealed that some women did not engage in the practice because their partners/husbands did not support family planning due to cultural reasons, religious reasons and some were still clinging to the family planning taboos thus difficult for couple communication in such a set up leading to non-use of family planning among the women.

A good number of women were aware of the consequences of not using family planning and they clearly highlighted the benefits a clear indication that they were aware of family planning as much as they were faced with some health challenges.

4.4 Findings from the key informant interview

The study findings showed that, women after giving birth used contraceptives but others chose not to and others feared the side effects of family planning. Interpersonal communication was often used by doctors who counseled the women and taught them what family planning entails, its positive and negative benefits, different contraceptive methods available, how they are used and then the client was left to make a decision on use although the health workers emphasized on use.

While going for family planning, women are taught about family planning method giving out their negative and positive effects. A clear indication that before a woman settles on a method, she is already equipped with the necessary information from a counselor.

The findings indicated that the uptake of family planning was quiet good though not all women used family planning. Therefore, interpersonal communication had a positive impact on family planning knowledge, attitudes and behaviors because 70% of women used contraceptives compared to 30% who did not use family planning. The uptake of contraceptives had increased among the enlightened groups compared to other years.

Lastly, research showed that indeed IPC had a powerful impact on women's intention to use family planning as it was widely used among women unlike other channels like mass media which had less impact.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.0 Introduction

This section of the study gives a summary of the whole research as well as giving conclusion according to the study finding and also giving appropriate recommendations.

5.1 Research summary

Reproductive health should be a preference among all women in Kenya. From the study,family planning came along with its benefits such as preventing health related risks, reducing infant mortality rate, slowing the rate of population growth, empowering women among others. With these benefits at hand, if a woman embraced family planning, then the problems linked to family planning will be done away with.

In Kenya however, family planning was still a challenge that needed a solution by using behavior change communication (BCC).This was to be achieved through information, education and communication (IEC) advocacy campaigns which can aid in enlightening the women about the effective ways of controlling fertility and its benefits.

Family planning (FP) was a key development issue that impacted on the quality of lives of families, communities, and also broader society. Increased use of FP services lead to large improvements in the health of mothers and children, the status of women, and economic development of a country.

IPC was a critical element that aided in family planning use. It helped change sexual behavior among individual and to overcome myths and misconceptions about FP use. It also helped in having open discussion and dialogue in the community about the role of FP in safeguarding the health and wellbeing of our mothers and children.

For effective IPC,findings showed that, spreading practical information about family planning use was mostly done by those women who had used FP and it was successful thus encouraged other women to engage in the practice.

From the literature, it was evident that there was need to increase the level of awareness on FP use through various activities that could lead to behavior change and adoption of family planning measures by women. Therefore, IEC Strategies were needed that linked IEC to behavior change that could be achieved through interpersonal communication – especially by providers and front-line workers –with specific messages that could meet the information about reproductive health of women.

The literature further showed that there was real need to increase utilization of key reproductive health services, which was low everywhere. To do this, communication strategies needed to focus much more on understanding the socio-cultural values that guide people's, including service providers', attitudes and behaviors; and on deepening their knowledge as to what reproductive and sexual health is, what determines it, and how it can be achieved. Communication strategies were needed to attempt to change attitudes and behaviors of women through counseling and interpersonal communication which is a very effective medium for communication.

According to the various studies conducted in Kenya about contraceptive use, it was also evident that, there was still a high unmet need for family planning at 24% while the contraceptive prevalence rate at 46% hence posing a challenge about reproductive health.

There were also various factors that determined the use and non-use of contraceptives such as: education attainment, socio-economic status, place of residence, age, number of living children and accessibility to services. Family planning uptake was low among women living in rural areas compared to their urban counterparts. Lack of education and poor economic status also lead to low level of awareness among women. This greatly contributed to lack of knowledge about the family planning methods available hence, poor decision making when it comes to controlling reproduction.

From the study there were various methods that were used by women to plan their families. For example; three-quarter of women who had ever used contraceptives before chose short time methods at first use and the other quarter choose between the long term methods and the traditional methods at first use.

A good percentage of women preferred using short term method unlike the long term methods. It further showed that, a woman made decisions on use of contraceptives that suit their needs.

Older and high parity women and those who have got an ideal family size prefer long term methods and sterilization while the young and low parity women who have not yet got an ideal family size choose the short term methods.

The study also indicated that, the TFR was at 4.6 children per woman compared to the wanted fertility rate in Kenya which 3.4 children per woman an indication that still the fertility rate in Kenya was wanting. The gap between the wanted and observed fertility was greatest among the poor women living in rural areas with education level lower than secondary school.

This study further indicated that use of contraceptives use was a very dynamic process in that some users practiced family planning regularly while others stopped using or changed to a different method due to various challenges they faced.

To make this study a success, women from Kajiado county who had the required characteristics for the study were randomly selected as long as they yielded important and relevant data towards this research. The study targeted reproductive women between the age of 15-45 years who were using contraceptives or had used contraceptives before.

The research used key informant interviews, in-depth interviews and focused group discussions as methods for collecting data. The targeted population was interviewed while focusing on the study objectives of the research.

The study findings indicated that passing of information by 'word-of-mouth' was seen to be among the most effective communication channel for acquiring knowledge and promoting desired changes in behavior. The FP information was necessary among women to help in decision making about contraceptive use.

The study further revealed that, counseling, informal discussions and public communications were the only IPC channels used to pass a message about family planning use. Counseling involved an expertise in medicine such as a doctor, informal discussions was among friends, relatives neighbors and couples while public communication involved a group of people such as public barazas, community rallies for awareness.

The study indicated that the women were very much aware about family planning.94% had used contraceptives while 6% had not used contraceptives before. Among those who had used

contraceptives, 66% were regular users,9% used once,6% never used while 20% used different methods(method mix).Also, spouse communication was an important precursor to the adoption of family planning methods among women. It further revealed that there was a significant relationship between respondent's level of awareness to family planning and their use of contraceptives

The findings further showed that, the respondents were aware of family planning methods as they had used variety of contraceptives. The respondents displayed knowledge of different family planning methods that they were aware of. They were conversant with the short term methods such as contraceptive pills and injections while others knew about the long term methods such implants and IUCD.The use of different methods were as follows: Injection 49%,contraceptive pill 31%,natural method 6%,female sterilization 3%,condom 6%,IUCD 3% and implants 3%.

Lastly, health communication campaigns that involved IPC were well utilized among the women thus, creating awareness on family planning use and promoting positive behavior among women.

5.2 Study limitations

The study was faced by several challenges. The target population was too busy and difficult to access. This made the researcher to be dependent on those respondents who were willing to cooperate to give out the required information.

It was time consuming as it was difficult to get the willing respondents to participate in the interview.

Conducting the research using English was challenging as some respondents were not well conversant with the language thus leading to change of language mostly to Kiswahili. The respondents were not willing to give out information because they regarded FP discussion as a personal issue thus it became very difficult interviewing them as they were not ready to reveal what they knew about the practice.

Some feared that their identity could not be protected because they were giving out sensitive information. They only promised to share the information if their identity and privacy was protected.

5.3 Conclusion and recommendation

In Kenya, family planning has an effect towards population control. However, this can be dealt with if every woman decides to be responsible. This can be achieved through using the appropriate method of communication such as IPC to help educate women about practicing FP use thus get rid of negative reproductive behaviors among the women.

There were wide differentials in contraceptive use among the interviewed respondents. There was a low level of unmet need for family planning and a great percentage of women who practiced family planning were more familiar with short-term methods unlike the proportion of contraceptive users that used longer-lasting methods such as IUCD, sterilization, and implants.

This study also provided essential information on family planning and related reproductive health issues such as impacts of family planning, giving sufficient information about the FP use and articulated in detail the challenges that must be addressed as well as priority issues that needed further study. They included, educating the public about the long term methods and ways in which the health sector can help women to minimize the negative health consequences.

Therefore, in order to enhance the uptake of family planning so as to meet Kenya's Vision 2030 and also achieve the MDGs, the government should support family planning education at both household and community level. This could be undertaken through various communication channels.

Women should also be encouraged to use contraceptives as this enhanced continuous promotion of family planning services and the government also plan of subsidizing their products. This is expected to contribute positively towards enhancing awareness of family planning services and the benefits and addressing the side effects.
Spousal communication should also be emphasized as one of the strategies for increasing awareness of family planning use among those families that men do not approve FP.

The Ministry of Health in collaboration with the development partners involved in the provision of family planning services need to enhance counseling of women in line with FP use. In the end,

this will contribute positively towards a reduction in the total fertility rate as well as decline in population growth rate.

The community should be involved in designing and guiding BCC programs, so that the programs are more capable of addressing the community's concerns and needs. Also, the community strengthens its capacity to identify and address health and social problems.

The study findings re-echo the point of, raising the need for more efforts to make family planning use more widespread among all women in through a combination of interpersonal communication interventions and mass media campaigns so as to reach measurable impact on reproductive health.IPC such as peer education and promotion of contraceptive use by providers as well as health workers, can have a significant impact on contraceptive use

As much as IPC has been seen as an integral component in family planning through direct influence on a woman's intention on contraceptive use further research need to be carried out on the magnitude and quality of impact that mass media and IPC have on promoting behavior change.

REFERENCES

Adetunji J. 1998. Unintended Childbearing in Developing Countries: Levels, Trends, and Determinants. DHS Analytical Reports No. 8. Calverton, MD: Macro International.

African Population and Health Research Centre (APHRC) (2001) *Contraceptive Use Dynamics In Kenya Further Analysis Of Demographic And Health Survey (DHS) Data,* Macro International Inc Calverton, Maryland USA

African Population and Health Research Centre (APHRC) and the Woodrow Wilson Centre – Washington, DC. July 2011.

Babalola, S., Vondrasek, C., Brown, J. & Trao,R. 2001.'*The impact of a regional family planning promotion initiative in West Africa: Evidence from Cameroon*."International family planning perspectives 27:4.

Bandura, A. (1986).*Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (2001).*Social cognitive theory: An agentic perspective*. Annual Review of Psychology, 52, 1-26.

Becker, Howard and Geer, Blanche (1982) '*Participant Observation: The Analysis of Qualitative Field Data' in Burgess,* Robert (ed.) Field Research: A Sourcebook and Field Manual London: Allen & Unwin.

Central Bureau of Statistics (CBS). 2006. *Revised population projections for Kenya: 2000-2010*.Nairobi: CBS.

Conner. & Norman (1996). *Predicting Health Behavior. Search and practice with social cognition models.* Open University Press: Ballmore: Buckingham.

Crichton, J., (2008) "*Changing Fortunes: Analysis of Fluctuating Policy Space for Family Planning in Kenya",* Health Policy and Planning, Vol. 23, No. 5: 339-350.

Diaz M., R.Simmons, J.Diaz, C.Gonzalez, M.Yolanda and D.Bossemeyer.1999. `*Expanding contraceptive choice: Findings from Brazil-Studies in family planning* 30(1)1-16.

Fotso JC, Kizito P, Guilkey D, Vane L, Wamukoya M. *Levels, Trends, and Differentials in Family Planning and Reproductive Health Indicators in Urban Kenya.* Chapel Hill, NC:

Gay, L.R., 1981.*Educational Research: Competencies for analysis and application*.Charcles E. Mairill Publishing Company A.Bell&Howell Company.Collumbus, Toronto, London.

Gipson JD, Koenig MA, Hindin M. 2008. *The effects of unintended pregnancy on health outcomes*: a review of the literature. Studies in Family Planning 39(1): 18-38.
Hancock, Beverley. Trent *Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Research*. Trent Focus, 1998.

Health Policy Initiatives (HPI). (2007). Task Order 1. *Inequalities in the Use of Family Planning and Reproductive Health Services: Implications for Policies and Programs,* Washington DC, Futures Group International.

Ian Askew, Alex Ezeh, John Bongaarts and John Townsend. 2009. *Kenya's Fertility Transition: Trends, Determinants and Implications for Policy and Programmes.* Population Council. Nairobi

International conference of family planning, Addis Ababa-Ethiopia, 2013.

Katz, lazarsfeld, P.F 1955.*Personal influence.* Glencoe, IL: Free press.

Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro

Kiragu k.,and L.S Zabin 1995 "*Contraceptive use among high school students in Kenya*" international family planning perspectives 21:108-113.

Koome P. D. Nturibi and G. Kichamu (2005), *The Effect of Declining Family Planning IEC Efforts on Contraceptive Behavior,* Working Paper No. 7, Nairobi, Kenya: National Coordinating Agency for Population and Development, Nairobi

Kyalo M.M. 1996 *Determinants of contraceptive use in Kenya*.MA Thesis.P.S.R.I., University of Nairobi, Kenya.

Magadi, M. A. and Curtis, S., (2003) "*Trends and Determinants of Contraceptive Method Choice in Kenya"* Studies in Family Planning 34(3):149-159

Measurement, Learning and Evaluation (MLE) Project & National Coordinating Agency for Population and Development (NCAPD). 2011. Family *Planning and Reproductive Health in Urban Kenya*: Levels, Trends and Differentials. Chapel Hill, NC.

Mona.S. and Thomas.W. 2002. Spousal *communication and family planning adoption; Effects of a radio drama serial in Nepal.* International family planning perspectives vol.28 No.1.

Mugenda, O. M and A. G. Mugenda (2003) *Research Methods*: Qualitative and Quantitative Approaches, Nairobi; ACTS Press

Oyedokun A. O., (2007), *Determinants of Contraceptive Usage*: Lessons from Women in Osun State, Nigeria, Journal of Humanities and Social Science, Volume 1, Issue 2

Republic of Kenya (2003b), *Demographic Health Survey of 2003,* Nairobi: Government Printer

PSI/KENYA: *Use of modern contraceptive methods among sexually active women aged 20-35 years*; social marketing research series.

Republic of Kenya (1984), *Kenya Contraceptive Prevalence Survey 1984*. First Report. Ministry of Planning and National Development. Contraceptive Prevalence Survey Programme, Nairobi, Government Printer

Rosenstock, I.M., Strecher, V.J., Becker, M.H., 1998 '*Social learning theory and health belief model*'. Health Education and Behavior 15(2):175-183

Ross JA, Frankenberg E. *Findings from Two Decades of Family Planning Research*. New York: The Population Council; 1993.

Schunk D. (2001).*Social cognitive theory and self-regulated learning*. In B.Zimmerman and Schunk D. (Eds.), Self-regulated learning and academic achievement: Theoretical perspectives (2nd ed.)Mahwah, NJ: Erlbaum.

Sinding, Steven. 1991."*The Demographic Transition in Kenya*: A Portent for Africa?" Distinguished Lecture Series on International Health, School of Public Health, University of North Carolina, Chapel Hill. 28 February

Syed A.S & Jan.M. 2008. '*Contextual domain of interpersonal communication'* Global Media Journal vol.1.

Timothy, C.O., 2011.*Contraceptive use among women of reproductive age in Kenya's city slums*: International Journal of Business and Social Science. Volume 2 No. 1

Tuonane. M. (1999): *Patterns of contraceptive behavior and the delivery of family planning services in Lesotho* PhD Thesis, university of Southampton

USAID/HPI (2007), *Achieving Equity for the Poor in Kenya: Understanding Level of Inequities and Barriers to Family Planning Services*, Washington D.C.

Wawire, N.H.W. (2006), Determinants of Tax Revenue in Kenya, PhD Dissertation, Kenyatta University, Nairobi

West off, Charles F. and German Rodriguez. 1995. "*The mass media and family planning in Kenya,"* International Family Planning Perspectives 21, no. 1: 26-31

APPENDIX I

INTERVIEW GUIDE

UNIVERSITY OF NAIROBI

SCHOOL OF JOURNALISM

My name is ***REHEMA BOSIBORI OSEKO*** a student at the University of Nairobi, undertaking a masters degree course in journalism and mass communication. As part of the fulfillment of my studies, I am undertaking a research project to examine the use of contraceptives among women and its impact among women in Kajiado County.

The findings of this research will be used for academic purposes only. You will also be provided with a copy of the final report upon request.

QUESTIONS:

1) What is family planning?

   ……..…

   ……

2) What is interpersonal communication?

   .....

   .....

3) Have you ever used any family planning method?

   ……

4) What are the different types of IPC that are useful in creating awareness about family planning use?

   ……

   ……

5) What is the role of IPC in creating awareness on FP use among women?

   ……

   ……

6) How often (many times) do you use family planning services?

……

7) How do you access family planning services?

……

……