

**AN ASSESSMENT OF FAMILY PLANNING COMMUNICATION APPROACHES IN  
NIGERIAN URBAN REPRODUCTIVE HEALTH INITIATIVE (NURHI) IN KADUNA,  
NIGERIA**

**BY**

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## **DECLARATION**

I hereby declare that this dissertationentitled **An Assessment of Family Planning Communication Approaches in Nigerian Urban Reproductive Health Initiative (NURHI) in Kaduna State** was written by me in the **Department of Theatre and Performing Arts**, under the supervision ofDr. Emmanuel Jegede and Prof. M.I. Umar-Buratai. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation has been previously presented for another degree or diploma at this or any other Institution.

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**DIMKA, KidelmwaNazin**

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**Date**

## CERTIFICATION

This dissertation entitled **An Assessment of Family Planning Communication Approaches in Nigerian Urban Reproductive Health Initiative (NURHI) in Kaduna, Nigeria** meets the regulations governing the award of the degree of Master of Arts in Development Communication of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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## **DEDICATION**

This dissertation is dedicated to my Father and Mother, Mr. and Mrs. NazinChingtok, and also to my siblings, Ripkang, Shangni, Endang, Rotdung and Korit for always being there for me.

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## **ABSTRACT**

The low rate of adoption of modern family methods has long been a bone of contention in Nigeria and especially resisted in Northern Nigeria. Despite huge sums of monies expended in order to enlighten the populace on the need for family planning, the use and access of family planning services has remained relatively low. This apathy by the populace is not unconnected to the fact that the communication approaches that were used have not answered nor conformed to the people's cultural and religious beliefs. Furthermore, the people's opinions were not sought. The method of the flow of communication was one-dimensional: top to bottom. The Nigerian Urban Reproductive Health Initiative (NURHI) is an organization that aims to increase the demand for modern family planning methods. In order to achieve this, the organization embarked upon a systematic and strategic means of communication. This study therefore sought to review NURHI's communication approaches via the use of the Questionnaire, Focus Group Discussion and In Depth Interview with the view to assess the success and or otherwise of the communication approaches and also bring to the fore the need for participatory communication that can lead to sustainable development. One of the findings of this research was the need for intensified participatory communication approaches and not only the use of media as means of communication. This is because, the fear of side effects of modern family planning methods, the need to nurture children and cultural and religious biases are still barriers to accessing modern family planning methods. Thus there is a need for an unconventional approach to attaining sustainable development.

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## CHAPTER ONE: GENERAL INTRODUCTION

### 1.0 Introduction

Reproductive freedom is critical to a whole range of issues. If we cannot take charge of this most personal aspect of our lives, we cannot take care of anything. It should not be seen as a privilege or as a benefit, but a fundamental human right (F. Wattleton, 2011:6).

The term development has over the years evolved to mean different things to different individuals and groups. While some view development as economic growth or rise in Gross Domestic Product (GDP), others view it as a comprehensive growth or rise in an individual's life resulting in a total well being of a person's life. (Ideas for Development 2005:186).

In trying to increase the total well being of an individual, it has been deduced that reproductive health is a fundamental aspect of one's well being. This is because it is linked to one's emotional and physical needs. According to the *Reproductive Health Journal*, reproductive health is defined 'as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. (<http://www.reproductive-health-journal.com/about/faq/whatis>). Having good reproductive health implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.

With the high rate of maternal and child mortality, high poverty rate, death from Malaria and Human Immuno Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), many conferences have been held to debate and proffer solutions to such problems. The International Conference on Population and Development (ICPD), 1994 which had a Programme of Action aimed at empowering women and providing them with more choices through expanded access to education and health services, skill development and employment. The ICPD also aimed to

empower women through ensuring that they were fully involved in policy- and decision-making processes at all levels. One of the primary goals of the Programme of Action was to make family planning universally available by 2015 as part of a broadened approach to reproductive health and rights. It also addresses issues pertaining to population and includes goals to further reduce levels of infant, child and maternal mortality. This is because population, maternal child health and mortality are all dependent on Sexual Reproductive Health.

Based on the global political reaffirmation of the ICPD agenda, reproductive rights, including universal access to reproductive health through their life cycle, are now considered a human right for all people. The term reproductive right has been further explained in the Beijing Platform for Action (BPFA1995) and the International Conference on Population and Development ICPD (2005) documents as:

Certain human rights recognized in the National and international legal and human rights documents and other consensus documents including the basic rights of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so, the right to attain the highest standard of sexual and reproductive health: the rights to make decision concerning reproduction free of discrimination, coercion and violence. (Cited in Gbadamosi Olaide, 2012, *Reproductive Health and Right*, pg 2)

Therefore, family planning is now understood within the broader framework of reproductive health and rights and not just as a population control instrument. This led to many countries adopting the ICPD policies and implementing reproductive policies in their countries.

Although there has been considerable progress since the ICPD, especially in terms of reproductive health, millions of people – mostly disadvantaged women and adolescents, still lack access to information and services as it pertains to reproductive health. In developing countries, about 201 million married women lack access to modern contraceptives. There are about 340 million new cases of sexually transmitted infections (STIs) each year and 6,000 young people are

infected with HIV every day, (United Nations Programme of Action, 1994). Also, the document reveals that millions of women and adolescent girls continue to suffer from death and disabilities during pregnancy and childbirth.

Reproductive health is seen as an intrinsic part of development. Indeed if the reproductive health of a people is improved then there will be a higher capacity for productivity that will enable people to live satisfying and fulfilled lives. With the realization that development is neither static nor about economic growth alone, but rather a process of involving and empowering the people, there led to the development of various theories that are aimed at involving the people that will lead to people's empowerment. This led to the growth of what is now called development support channels or development communication. Development communication, though diverse in nature, has grown from just providing information through mass media to involving the people and due to its important and dynamic features, it can be applied to a myriad of social and behavioural issues that will lead to people being empowered and ultimately lead to sustainable development.

Although people's perception of reproductive health is faced with a myriad of challenges, it is gradually accepted as a necessary aspect of life especially in terms of population growth of Nations. In 1979, China as a result of its population boom enacted a National Policy that limits the number of children that a couple can have to one. In Nigeria, former President Goodluck Jonathan on 26<sup>th</sup> June, 2012 while inaugurating the newly constituted National Population Commission board said the government was contemplating a legislation to control population growth (The Nation Newspaper 27<sup>th</sup> June, 2013). After the news broke, there was a lot of outcry especially as it pertained to people's beliefs.

Reproductive health is not just about population control but it also entails family planning. Thus, men and women are informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

Reproductive health is usually seen as a woman's sole prerogative. Ladan (2003) posited that the state of a woman's health is very important in order to bring about a reduction in "maternal mortality and morbidity and their impacts on infant mortality" (Review of Existing Reproductive Rights and Health in Nigeria:2003). In the consideration of reproductive health of women, certain indices readily come to mind, like family planning, abortion, sexually transmitted diseases including HIV/AIDS, premature and early marriage, safe motherhood comprising pre and post natal care. Other issues include safe sex and gender equality, sexual dysfunction in women such as infertility, female genital mutilation, marital rape, other sexual violence against women, and reproductive health problems associated with menopause. All of these are sexual and reproductive issues which women usually face or are at the receiving end, which explains why reproductive health is mostly viewed as a problem associated with women. Ladan in his paper Review of Existing Reproductive Health Policies and Legislation in Nigeria:(2006: 26) explains further that:

In Nigeria, and indeed most African countries however, the reality is that, women's rights to the enjoyment of highest standard of health is highly jeopardized and threatened by many legal social, religious and cultural impediments. In consequence thereof most Nigerian women; especially in the rural areas have suffered incessant violations of their health and reproductive rights. This unfortunately persists despite the fact that a plethora of laws have been put in place at both the National, regional and international levels targeting quality reproductive rights of women.

Reproductive and health rights are of paramount importance as a vital aspect of general health. It is a central feature of human development as it reflects health at childhood, adolescent and

adulthood. The mismanagement of the reproductive health of an individual whether male or female, affects the health of the next generation. Although reproductive health is a universal concern, it is of special importance to women especially in their reproductive years. The health of a newborn is largely determined by the state of its mother's health which includes nutritional status and her access to healthcare services.

Reproductive health is highly connected to many of young people's issues such as completing education, finding employment, securing their economic position, making secure relationships and eventually founding a family of their own. Reproductive health is an important component of general health; it is a prerequisite for social economic and human development. This is because since human energy and creativity are the driving forces of development, the highest attainable level of health is essential because of social and economic reasons ().

With the high incidences of maternal mortality especially in developing countries, there is an urgent need for increased investments in Sexual Reproductive Health (SRH) information and particularly the most vulnerable as:

- i. Poor SRH accounts for an estimated one third of the global burden of illness and early death among women of reproductive age (UNDP. Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. Berstein, Millennium Project, 2006)
- ii. About 201 million married women in developing countries still have an unmet need for modern contraceptives. Data from 94 national surveys indicate that the unmet contraceptives need among sexually active adolescents is more than two times higher than among married women. In sub Saharan Africa for example, as many as 46 % of women face this problem. Globally 37 countries have an unmet need for family planning

that is greater than 20% and 24 countries have a prevalence rate for modern methods that is less than 10% (UNFPA and the UN Population Division. 2008)

Couples and individuals need access to improved SRH information and services to be able to participate in the social development and economic life of their countries as well as for improved quality of life. Many organizations believe that the realizations of reproductive rights through improvements in SRH is a necessary condition to achieve poverty reduction at both household and macro levels. The influence of reproductive rights on population dynamics such as fertility, mortality and age structure and their influence on social and economic development support a strong argument for policymaking on poverty reduction to increase in reproductive investments. Nigeria, for example, with a Maternal Mortality Ratio (MMR) of 800 per 100,000 live births (UNDP Report on Reproductive Health 2008), still has an extremely high maternal mortality ratio, one of the main indicators of the state of reproductive health in the country.

## **1.1 Background to the Study**

Nigeria is a country with One Hundred and Sixty Seven Million People (Nigerian Population Commission). It is viewed as one of the foremost African countries with the fastest rate of economic growth. Despite this positive assessment, this does not necessarily translate into a total wellbeing in the life of an average Nigerian. Many development workers argue that several indicators noted in the life of a Nigerian show that the economic growth of the Nation is yet to impact positively on the life of the Citizens. Foremost among these indicators is the totally unacceptable high maternal mortality in the Country. A major development and health challenge in Nigeria is the high level of maternal deaths arising from complications related to pregnancy and childbirth. The current maternal mortality ratio is estimated to be 800/100, 00 live births

thereby contributing approximately 10% of the global burden of maternal deaths.(UNDP Report on Reproductive Health 2008)

Over the years in Nigeria and indeed developing countries, it has been determined that various reasons account for this high rate of maternal mortality. These issues range from cultural and socio economic reasons, mal-nutrition and inadequate access to and use of reproductive health, inadequate birth attendants, live birth without the assistance of skilled birth attendants and doctors. Also key to the high prevalence of maternal mortality is the inadequate knowledge and access to reproductive health. According to the World Health Organization (WHO) "Reproductive Health accounts for the 20% of the global burden of ill health for women, and 14% for men" (Reproductive Health Strategy – World Health Organization 2008).

The steady death toll of women during childbirth led to the listing of one of the Millennium Development Goals as improving maternal mortality. The Millennium Development Goal is a strategy document which is aimed at prompting actions from federal and states government to ensure that policies, infrastructure and enlightenment are carried out to ensure the development of the developing world especially in terms of the standard and quality of life of its populace. Achieving universal access to reproductive health is one of the two targets of Goal 5 – Improving Maternal Health. To monitor global progress towards the achievement of this target, the United Nations has agreed on the following indicators:

5.3: Contraceptive prevalence rate.

5.4: Adolescent birth rate.

5.5: Antenatal care coverage.

5.6: Unmet need for family planning(United Nations2008 Millennium Development Goals, <http://www.un.org/millenniumgoals>).



With the high rate of maternal mortality, experts believe that maternal health conditions can only be improved by a three-stage program:

- Child spacing by self-determination of periods between the childbirths.
- Professional care during pregnancy and childbirth.
- Timely access to hospitals where complications can be treated by Caesarean cut (WHO factsheet, 2008).

It is however important to note that the above stages will be unachievable and futile without effective adequate communication. Effective communication with the participation of the people will serve to empower them with the right information, clearing misconception and perceptions, and drawing upon their knowledge and inherent wisdom to bring about a reduction of maternal and child health in their families and communities at large.

Despite the several benefits embedded in good reproductive health, many factors however hamper the promotion, use and access to good reproductive health services. The challenges to the protection of reproductive health rights on the other hand include lack of awareness, lack of political will, poverty, religious and cultural beliefs.

Another vital area of challenge to Reproductive Health is communication. Many governments, organizations and Non Governmental Organizations embark on campaigns aimed at promoting reproductive health rights but instead of an increase of people accessing reproductive care, it rather pushed them away because it did not reflect their cultures, traditions and religions. This was as a result of ineffective communication with the people to understand their perceptions, environment and cultural and religious knowledge and belief about reproductive health.

With the use of the Diffusion Theory of communication where information was passed to the people with the hope that the messages embedded in the information will be adopted by the people, it turned out to be less effective. This was because the communication model was a one way linear communication. The people whose development was needed were not involved in the communication but were rather passive receivers and stakeholders. Thus the improper use of communication exacerbated the people's resistance to accessing of reproductive health methods.

With the evolving nature of communication in the 21<sup>st</sup> century, an apt definition as captured by Em Griffin in his book *A First Look at Communication Theory* (2011), is that "Communication is the relational process of creating and interpreting messages that elicit a response". This definition clearly explains that a process is surely needed for effective communication. Griffin tried to make the point that until there is a process which results in a response between parties, communication has not taken place. This response of course can be discussion between audiences.

In trying to ensure that there is a process of communication many communication experts have tried to develop processes or a medium in which communication can take place. One among such is participation. *Development Communication Source book* (2008) describes the benefits of participation as such:

The adoption of two-way communication to involve stakeholders as partners in the problem-analysis and problem-solving processes of development initiatives, rather than treating them as mere receivers of information, is fundamental for making changes effective and sustainable. (pg 16)

It is thought that when there is participation, it is able to bring about a response in communication swiftly, efficiently and sustainably. It is however apt to note that there are different forms of participation. One of such forms is partial participation; where individuals are asked questions or for their inputs but the ultimate power remains with the experts.

In 1988, the Federal Government of Nigeria embarked upon a campaign for the Nigerian people with the aim of bringing about the reduction in the number of children one has. This was an attempt at curtailing population explosion. Also, the policy was embarked upon in order to serve as a basis for population planning. Thus it embarked on mass media campaign providing information and messages, and promoting family planning. Even though, the campaign was widely reached, there were some resistance to the information and messages especially in the Northern Region of the country. Foremost among this was the involvement of foreign organizations in the implementation of the campaign. There has always been a suspicion when the West is involved in campaigns especially in terms of population. In the report *Child Spacing Attitude in Northern Nigeria*, it was noted that issues pertaining to population and child spacing was viewed as “just an American propaganda to reduce the population of Moslems in the world so that they can conquer the world...” This view perhaps still persists and thus the low adoption of family planning messages/campaigns in Northern Nigeria.

Culture and religion also play vital roles especially for the Northern Muslims in Nigeria. Enang and Ushie (2012) noted that there was a boycott in some parts of the country against polio immunization in the early 2000s. The cultural and religious belief that the polio vaccine was contaminated with anti-fertility drugs so that young girls would be unable to reproduce affected the exercise. This point was reiterated by Dike (2004) who explained that Islamic northern Nigeria refused government vaccines imported from the western world alleging that the vaccines were laced with other deadly poisons meant to depopulate the Muslim community in Nigeria as part of a war against terrorism. This is a case in point for the 1988 family planning communication campaign which did not take into cognizance the people’s cultural, traditional and religious belief before embarking on the media campaign. This led to rejection of messages

by the people who also physically tore down posters in some parts of the Northern States(Enang and Ushie 2012).

In an attempt to promote the benefits of accessing reproductive health by the Nigerian government to its people, the Government embarked upon a National campaign that was targeted at providing information to the public. The communication was modeled upon the Sender – Message – Channel – Receiver (SMCR) model. The mass media was used to provide information to the public with the hope that the information embedded in the messages will serve to encourage behaviours and attitudinal change. This however was not successful because of its linear mode of operation and also the inability of the campaign to involve the people in assessing and addressing perception, religious and traditional concerns harboured by the people.

With the afore-mentioned problems of reproductive health, it is obvious that there is a need for a behavioural change amongst the populace. If indeed progress needs to be made in ensuring that the reproductive health rights is being accessed by Nigerians, there is a need to review the communication strategies that will address issues that lead to barriers against and resistance of family planning. This can be done through participatory methods of communication. Participation is needed in communication for various reasons foremost among such is that the people will be able to be involved not just by being passive or by being asked questions but to be involved in a two-way communication on what are their thoughts, perceptions, cultural, traditional and religious beliefs on reproductive health. Also important is for them to come up with reasons and an understanding on why they need to access family planning.

With this in mind, the Nigerian Urban Reproductive Health Initiative (NURHI) embarked on a campaign that was aimed at increasing the access and use of family planning methods by

the public. The project started in 2009 and is being implemented in select cities of the federation with various communication strategies constitutes the focus of this study.

The Nigerian Urban Reproductive Health Initiative (NURHI) is a Non Governmental Organization that is funded by the Bill and Melinda Gates Foundation. With project duration of 2009 – 2014, NURHI was funded to reduce supply and demand barriers to the use of family planning services in urban Nigeria. Tasked with increasing contraceptive prevalence rate by 20 percentage points, NURHI aims to harness the potential of Nigeria's dynamic services and healthful lifestyles now, before pressures on the urban health infrastructures lead to systems overload and breakdown. The programme brings together private and public sector resources to strengthen the delivery of family health services while gradually increasing demand for such services across project sites. The project is focused on six urban centres – Abuja, Benin City, Ibadan, Ilorin, Kaduna and Zaria. NURHI is developing workable approaches that will provide rapid scale –up models for other urban areas in Nigeria and the African continent. (Nigeria Urban Reproductive Health Survey 2011:5).

The objectives of NURHI include:

- Develop cost effective interventions for integrating quality planning with maternal and new born health, HIV and AIDS, post partum and post abortion care programmes.
- Improve the quality of family planning services for the urban poor with emphasis on high volume clinical settings.
- Test novel public – private partnerships and innovative private-sector approaches to increase access to and use of family planning by the urban poor.
- Develop interventions for creating demand for and sustaining use of contraceptives among marginalized urban populations.

- Increase funding and financial mechanisms and a supportive policy environment for ensuring access to family planning supplies and services for the urban poor.

By reaching urban women with the greatest need, this comprehensive strategy is expected to increase contraceptive use among women in urban and pre-urban areas and potentially to diffuse to rural areas to which urban women are linked. (Nigeria Urban Reproductive Health Survey 2011).

The accomplishments of NURHI so far include:

- Joint advocacy efforts resulted in Federal Ministry of Health's National Policy announcement on availability of free contraceptive commodities in all states. Commodities continue to be available free of charge at all public health facilities including primary health centres.
- NURHI engages prominent religious and traditional leaders who in turn have publicly endorsed family planning/child spacing, encouraging Nigerian men and women to find a method that will help them care for their desired family size and protect each mother's health.
- 'Know. Talk. Go' mass media campaign encourages Nigerians to 'Know' about family planning, 'Talk' to their partner about family planning and 'Go' for services. This Multi channel campaign includes a radio drama for youth, television and radio spots, and posters, billboards and promotional items for community members.
- A novel public-private partnership, the Family Planning Providers Network (FPPN) was developed as an innovative approach to connect all family planning providers in Nigeria- clinical and non clinical as well as public and private. ([www.nurhi.org](http://www.nurhi.org)).

In view of the above, this study is therefore structured to assess the performance of NURHI in terms of its communication use for intervention in Kaduna, Nigeria.

## **1.2 Statement of the Research Problem**

The adoption of family planning methods has been low in developing countries in Africa. In Northern Nigeria especially there has been persistent resistance of family planning methods. This is perhaps because of the dominance of religion and religious beliefs namely Islam and Christianity which are both against the practice of family planning. However, there are other cultural and traditional practices which also hinder the free adoption of modern family planning methods.

In an attempt to promote the adoption of modern family planning methods in Nigeria, the Federal Government had promulgated policies for example the 1988 Reproductive health policy which promotes one, husband, one wife and four children. Furthermore, the Federal Government open the door to Non Governmental Organizations such as the Planned Parenthood Federation of Nigeria (PPFN), Society for Family Health (SFH), United Nations Children Fund (UNICEF) and Nigerian Urban Reproductive Health Initiative (NURHI) to also contribute their quota in ensuring that people were enlightened about the benefits of accessing modern family planning methods. Despite, these efforts and the huge monies spent, there is still low acceptance of family planning. Beyond religious and cultural considerations, the problem of family planning has remained persistent which begged the question: is the problem with the planning, programme design, programme implementation or the communication approaches?

The focus of this study is to examine the communication approaches of NURHI in its use of family planning communication approaches and investigate if these communication

approaches has addressed the people's religious and traditional beliefs and attitude in ensuring sustainable healthy living especially among women.

### **1.3 Aim of the Study**

The aim of the study is to assess NURHI's communication approaches in order to enhance and strengthen the family planning initiative in Nigeria through a proper and effective deployment of efficient communication approaches.

### **1.4 Objectives**

The objectives of this research are:

- i. Analyse the various communication approaches deployed by NURHI for effective and accessible family planning.
- ii. Investigate the experiences and perception of the people about the campaign by NURHI on family planning approaches.
- iii. Determine barriers associated with modern family planning and their attendant implications for development.
- iv. Articulate a way forward on how effective communication use can achieve a higher impact on reproductive health issues especially on family planning in Nigeria.

### **1.5 Research Questions**

1. What communication models have been used by NURHI to address reproductive health?
2. What are the peoples' experiences and perception about NURHI's Communication approaches?
3. What are the specific barriers in the access and promotion of family planning?



4. What specific advantages can be derived from the use of participatory communication for the target audience in reproductive access at the individual and community level?

## **1.6 Justification for the Study**

With the high maternal and child mortality rate in Nigeria there has been the need for an increased awareness on accessible family planning information as a plan in the reduction of maternal and child mortality rate. It is opined that child spacing will provide the necessary time for a mother to heal and regain her health which will ensure that her life and the life of her new born child is secured. Despite the various communication strategies adopted by the Federal Government, and Non Governmental Organizations, there is still low demand for family planning methods, resulting in high mortality rate.

This study is therefore necessary as it explores and investigates whether the communication approaches deployed by NURHI will improve the knowledge, attitude and acceptance of family planning methods. It is believed that the study will provide insight into how barriers to family planning can be properly handled and the communication approaches that can be deployed to arrive at effective realization of family planning and healthy living among women in Nigeria.

## **1.7 Scope and Limitation of the Study**

The research scope encompasses the assessment of specific communication approaches currently utilised by NURHI in addressing family planning in Kaduna. The study is limited to Kaduna metropolis alone with a focus on Kaduna North and Kaduna South. The reason for the choice of these study areas is premised on the fact that they are located in Northern Nigeria which is a region that has a high number of resistance to modern family planning methods.

## **CHAPTER TWO: REVIEW OF RELATED LITERATURE**

### **2.0 Introduction**

The issues that pertain to reproductive health are numerous. Many scholars have provided discourse and offered solutions to address barriers to the adoption of positive behaviours that will ensure the continued health of individuals, communities and Nations at large. This chapter therefore is aimed at providing a general outlook on the positions of these scholars in today's communication situations in Nigeria.

### **2.1 Health Communication**

Communication is as old as time and plays a vital role in our interaction with one another as human beings. Communication refers to the transmission or exchange of information and implies the sharing of meaning among those who are communicating. It serves various purposes which include, initiating actions, making known needs and requirements, exchange of information, ideas, attitudes and beliefs, engendering understanding, and establishing and maintaining relations (U.S. Office of Disease Prevention and Health Promotion, 2004).

According to Rimala and Labrinski (2009), there are three important intervention considerations that emerge regarding communication. The first is the realization that communication interventions do not fall into a social vacuum. Rather, information is received and processed through individual and social prisms that not only determine what people encounter but also the meaning that they derive from the communication which can also be known as selective perception depending upon factors at both the individual (prior experience, efficacy beliefs, knowledge, etc.) and the macro-social (interpersonal relationships, cultural patterns, social norms) levels.

Noting that communication is a dynamic process in which sources and receivers of information continuously interchange their roles, in the sphere of healthcare it is better appreciated as health communication and it can take many forms, both written and verbal, using traditional outlets and new media outlets. In this light, health communication has been defined as referring to any type of human communication whose content is concerned with health (Rogers, 1996). McGinnis and Foege (1993) expounds further on the uniqueness of Health Communication:

Health communication, in its various applications, offers a potentially important approach to a better informed and presumably healthier population by focusing on the behavioral aspects of risk factors, such as diet, smoking, alcohol use, sedentary lifestyle, and sexual behavior. (McGinnis and Foege, 1993: 59).

Furthermore, Richard K Thomas in his book "Health Communication" (2006:2) posits the role of health communication in an ever changing world especially in disease prevention and also healthy lifestyle promotion.

Health communication encompasses the study and use of communication strategies to inform and influence individual and community knowledge, attitudes and practices (KAP) with regard to health and healthcare. The field represents the interface between communication and health and is increasingly recognized as a necessary element for improving both personal and public health. Health communication can contribute to all aspects of disease prevention and health promotion.

There are various definitions of health communication from different perspectives. One of such is the definition by The Healthy People (2010) which sees health communication as the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. It also goes on to add that the scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community.

Sciavo (2007) sees Health Communication from a scholarly point of view as a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policy makers and the public to champion, introduce, adopt, or sustain a behaviour, practice or policy that will ultimately improve health outcomes.

Cline (2003) on the other hand sees it as an area of theory, research and practice related to understanding and influencing the interdependence of communication (symbolic interaction in the forms of messages and meanings) and health related beliefs, behaviours and outcomes. This is also a scholarly definition but the substance remains the same. It is what runs through all the definitions and this substance is 'influence' which can only be achieved through communication.

Communication is what would influence the people to adopt any form of health practice introduced to them. All the definitions do not mention the use of force or deceit. The definitions tell us that what must be used is communication which means we must be able to effectively communicate health communication for better outcomes.

According to a Definition of Wellness, (Accessed 2013), health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. It advises the use of the mass and multimedia and other technological innovations to disseminate useful health information to the public, increase awareness of specific aspects of individual and collective health as well as importance of health in development.

There is however, a contrary view to health communication. Lupton (1994) critiques some of the foundational issues that underlie it. She argues that communication in the health context is traditionally conceptualized as a top-down approach, with communication flowing from the centre of authority to peripheral locations. It is what she refers to as 'the critical

perspective that determines the relationship between the bourgeoisie and subaltern classes'. Power is central to how problems are defined and how solutions are framed (Mody, 2000; Wilkins & Mody, 2001). Campaigns, critical theorists argue, are dictated by the capacity of those with power to "select and frame social conditions and groups as problematic, legitimizing particular approaches to their resolution and not others".

According to Foss & Griffin (1995), Health communication has its primary objective of persuasion which is based on a desire for control and domination. This 'persuasion' is what was mentioned earlier in the various definitions which looked at health communication as the art and technique of informing, influencing, and motivating people. Notwithstanding, health communication is directed towards improving the health status of individuals and populations which is undeniably the truth and this is why it must be taken seriously. It is important to note that communication on health is not enough but effective health communication is the key for successes in Health communication.

Effective communication should not only entail using mass media to disseminate information but should also include interpersonal communication and being sensitive to cultural, religious and traditional values for it to be effective and sustainable. Even though the mass media is a medium whereby more people can be reached with messages at a single time, cognizance should be given to reaching people through a process that will ensure that they are deeply rooted and if possible, develop messages. These messages can then be disseminated and using the media which serves as enforcers or reminders.

In trying to communicate health issues, much of modern culture is transmitted by the mass and multi-media which has both positive and negative implications for health. Several

researches have shown that theory-driven mediated health promotion programming can put health on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy lifestyles.

Health Communication encompasses several areas including edutainment, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can also be said to take many forms which can be from mass and multimedia communications to traditional and culture-specific communication such as storytelling, theatre, songs and dance. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas, television shows, documentaries, among others and advances in communication media, especially in the multimedia as new information technology continue to improve access to health information.

In Health Communication, there is a need to take into cognizance various factors among which is the population, religious belief, age, parent, child, background of the people the health communication is talking to. This is because the various mentioned issues provide a different baseline and need a different approach for communicating health issues.

Another significant area that Developmental organizations need to note when communicating health issues is the Visual Health Communication. In many societies especially in developing Africa, there are individuals and communities who are not literate. Therefore for these individuals, there is a need to provide pictures (pictograms) that are culturally appropriate that will pass across the right message.

Health related visuals have been studied almost exclusively as part of a broadercommunicative intervention, in which they accompany, support or clarify textin

information leaflets, billboards, and different types of spoken health messages. This reflects the current practice of using visuals in health communication and at the same time shows the insufficiency of standalone visuals as carriers of complex health messages. A review by Houts shows that visuals appear to be beneficial in promoting attention, understanding and adherence, especially in situations in which formal (verbal) literacy is problematic in health communication (Houts, 2006). Instructive health visuals have been found effective in improving the recall of spoken instructions (Houts 1998; Houts 2001; Kools 2007; Kripalani 2007; Ngoh and Shepherd 1997), as well as in supporting task execution (Kools, 2007). Informative health visuals improve comprehension of written information (Brotherstone 2006; Campbell 2004; Hameen-Anttila 2004; 1992). Photo-novelas and comics make written health messages more attractive and they enhance compliance (Cabrera 2002).

However, it has been argued that even though the benefits of using pictograms are monumental, they cannot stand alone especially in health messages. This is because some health messages are complex to convey by using pictures and therefore in order to prevent misrepresentation of images and symbols, developmental agencies when communicating health issues, need to have a double strategy of not just using pictures but backing it with oral discussions especially with non-literate audience

## **2.2 Health Communication, Health Promotion and Health Education**

Health communication can be viewed as approaches that seek to persuade or motivate people to change their behavior in order to improve their health. Health communication is pertinent because as a society grows, it becomes more diverse and prone to health issues. Thus health communication provides an important approach to a better informed and healthier population by focusing on the behavioral aspects of risk factors, such as diet, smoking, alcohol

use, sedentary lifestyle, and sexual behavior (McGinnis and Foege, 1993). When communicating for public health, it is important to ensure that it is directed and addressed at different levels. In the book *Theory at a Glance* (2005:29) by the United States Department of Health and Human Service, posits that:

Public health communications should represent an ecological perspective and foster multilevel strategies, such as tailored messages at the individual level, targeted messages at the group level, social marketing at the community level, media advocacy at the policy level, and mass media campaigns at the population level. Public health communications can increase knowledge and awareness of a health issue; influence perceptions, beliefs, and attitudes that factor into social norms; prompt action; demonstrate or illustrate healthy skills; increase support for services; debunk misconceptions; and strengthen organizational relations.

In general, health promotion is any event, process or activity that facilitates the protection or improvement of the health status of individuals, groups, communities or populations (Marks et al., 2000). Its main objectives are to prolong life or to improve the quality of life. As Bennett and Murphy (1997) pointed out, health promotion is premised on the understanding that the behaviours in which we engage, and the circumstances in which we live, impact on our health. Health outcomes that are relevant to health promotion are increasingly recognized to result from a complex interaction between biological, social, environmental and psychological factors. In line with this, the World Health Organization (WHO) has identified the need for a multiple approach to health promotion which acknowledges the important role that the environment and public policy play in relation to health.

Health promotion and education can take place in schools and also the workplace. Whether it occurs in schools, the workplace or elsewhere, health promotion is the product of health education and health public policy (Tones, 1998). Health education is any intentional activity which is designed to achieve health or illness-related learning, that is, some relatively



permanent change in an individual's capability or disposition. Effective health education can have many significant positive effects. It produces a change in knowledge and understanding or ways of thinking and thus influence or clarify values. Furthermore, health education can bring about some shifts in beliefs or attitudes and facilitate the learning of new skills; and, importantly lead to desired changes in behaviour or lifestyle (Tones and Tilford, 2001). Clearly, effective communication is key to effective health education. There are numerous ways in which effective health communication can occur. Most common are via written Patient Information Leaflets, product labeling, the Internet, and media campaigns.

### **2.3 Strategies for Health Communication**

Many countries today have focused their attention on primary prevention activities through the modification of lifestyle factors that account for the greatest share of the burden of disease (e.g. smoking, excess alcohol, poor diet and risky sexual behaviour). Key methods that have been used to address these include health education, fiscal and legislative measures such as increased tax on cigarettes and alcohol, and compulsory wearing of seatbelts in cars and environmental changes such as the introduction of airbags into cars, and the removal of asbestos from old buildings. Interestingly, comparisons of the effectiveness of public health strategies that have used education/persuasion with those that have used financial or legal changes have shown the latter to be far more effective (Stroebe, 2000). Clearly, it is difficult to apply financial and legal sanctions to many aspects of unhealthy living. Marks (2000) outlined three main strategies or approaches to health promotion. These are the Behavioural Change approach, the Selfempowerment approach, and the Collective Action approach.

#### **2.3.0 The Behavioural Change Approach**

The key objective of this approach is to bring about changes in the behaviour of individuals through changing their cognitions (thoughts and beliefs). This typically requires increasing people's knowledge about the causes of health and illness through the provision of information about health risks and hazards. The Behavioural Change Approach is based on the assumption that people are rational decision makers and that their health behaviours are informed by their thoughts and beliefs. According to Buchanan, there are four strategies in influencing people to change their behavior. These include behaviorist conditioning, through 'rewards' and 'punishment'; communicative persuasion, through subliminal information or 'scare' campaigns; group pressure, through 'meeting strategies' where people are influenced to abstain from certain kinds of behavior; and direct instrumental power, through prohibitions or authority (Buchanan, 2000: 35). When implementing behavior change, theories like social marketing and health belief model have been used to reinforce and promote behavioural change in health issues.

Limitations of this approach include its focus on the cognitions of individuals, its failure to take sufficient account of individual differences, and the fact that it has not had much success in targeting important socio-economic causes of ill health.

### **2.3.1 The Self-Empowerment Approach**

According to Tengland (2008:59), the word 'empowerment' has two distinct meanings, one refers to a state of the individual, group or community and a goal to be achieved in empowerment projects, and the other refers to the process or means to attain the goals (empowerment in the first sense) are sought.

Empowerment as a process is about letting the client, group or community have as much control as possible over the change processes they are involved in (Rogers, 1961; Freire, 1972; Tengland, 2008; Laverack, 2009). The people therefore, are expected to actively participate in the

problem formulation, proffer solutions to the problems and initiate the actions that are needed to solve them. As distinct from the behavior-change approach, which primarily relies on cognitive or behavioral psychology, the empowerment approach is based on humanist–existentialist ideas about human nature. One difference is that the empowerment approach emphasizes that the individuals themselves have the (internal) means to change and develop in a positive direction. Given psychological conditions that include empathic listening, nonjudgmental attitudes, ensuring genuine participation on the part of the professionals and enabling dialogical conditions, as well as external opportunities, the main objective of this approach is to empower people to make healthy choices so that they can increase control over their physical, social and internal environments. This is mostly done through participatory learning.

Health promotion and the wider public techniques such as group work, counseling and social skills training are based on the assumption that power is a universal resource that can be used by everyone. However, a limitation is that it seems to ignore systematic inequalities that are known to exist with regard to access to material and psychological resources. Like the previous approach, the Self-Empowerment Approach has also been criticized for focusing on the individual as ‘the target for change’ and it’s also a very slow process.

### **2.3.2 The Collective Action Approach**

The main aim of this third approach to health promotion is to improve public health by addressing the important socio-economic and environmental determinants of health. Specifically, the key objective is to modify the relevant social, economic and physical structures that generate ill health. In order to achieve this, however, individuals must act collectively to improve their social and physical environments. The Collective Action Approach is therefore based on the assumption that individuals share sufficient interests to allow them to act in the necessary

collective way. As should be apparent, this third approach is more 'political' than the other two approaches and, to be effective, can require significant resources.

Clearly, effective communication is central to all three approaches. However, the particular way in which it is applied will differ according to which approach is taken. Thus, the content of the message, and the way in which it is presented, will differ according to whether the main aim of the activity is to change individual behaviour, empower people, or to address major socioeconomic and environmental determinants of health. An important point to note is that communication in all cases involves more than simply getting a message across. Rather, it involves building relationships and empowering people so that they can make appropriate health-related choices and decisions (Katz, 2000).

Other strategies used for health communication include the use of information leaflets, the media and the Internet. However, these strategies have been criticized as providing incomplete messages and not being understood by the general audience as against a target audience. Increasingly, health improvement activities are taking advantage of digital technologies, such as CD-ROM and the World Wide Web, that can target audiences, tailor messages, and engage people in interactive, ongoing exchanges about health. As population-based approaches to healthcare have become more common, the role of health communication has expanded. Community-centered prevention shifts attention from the individual to group-level change and emphasizes the empowerment of individuals and communities to effect change on multiple levels. Health communication has become an accepted tool for promoting public health. Health communication principles are often used today for various disease prevention and control strategies including advocacy for health issues, marketing health plans and products, educating patients about medical care or treatment choices, and educating consumers about healthcare

quality issues. At the same time, the availability of new technologies and computer-based media is expanding access to health information and raising questions about equality of access, accuracy of information, and effective use of these new tools.

The many roles that health communication can play have been highlighted by the Centers for Disease Control and Prevention (2008). These roles include: increase knowledge and awareness of a health issue, problem, or solution; influence perceptions, beliefs, attitudes, and social norms; prompt action demonstrate or illustrate skills; show the benefit of behavior change; increase demand for health services; reinforce knowledge, attitudes, and behavior; refute myths and misconceptions; Help coalesce organizational relationships and advocate for a health issue or a population group.

#### **2.4 Origin of Reproductive Health Right**

In 1945, the United Nations Charter made declarations related to reproductive health rights even though the charter did not define the rights. In 1974, the United Nations population Plan of Action reaffirms the right to reproductive decision making at the World Population Conference held in Bucharest, Romania. In 1975, the International Women's year Conference which held in Mexico also asserted the right to reproductive health and choice in notion of bodily integrity and control. From 1976-1986, the overriding importance of reproductive rights was emphasized in the Convention of the Elimination of Discrimination against Women (CEDAW). This was followed by the Universal Declaration of Human Rights (UDHR) of 1948, the International Covenant for Civil and Political Rights (ICCPR) of 1966, the African Charter on Human and People's rights of 1981 and the International Conference on Population and Development (ICPD) of 1994. Further, the Cairo Programme of Action was adopted in 1994 at

the International Conference on Population and Development (ICPD). All these led to the recognition of reproductive and sexual health as a matter of social justice.

After the International Conference on Population and Development (ICPD) held in Cairo in 1994 which saw to a shift in the focus of population programmes and underscored the need to meet the reproductive health needs of individuals and couples throughout their life cycle as a key approach to improving quality of lives of people and stabilizing the world population, Nigeria, amongst the over 180 countries represented at the conference, approved the programme of action that was resolved at the International Conference on Population and Development (ICPD). Nigeria therefore, committed herself to the adopting of the reproductive health concept and the achievement of the ICPD targets of the health and development of her citizenry. It was this meeting that led to a reproductive health policy by the Federal Ministry of Health in 2001. The policy was developed through a 'highly consultative process involving various groups of stakeholders at various levels and thus represents the aspirations of the peoples and governments of Nigeria to achieve an improved reproductive health status' (Federal Ministry of Health: Reproductive Health Policy, 2001).

As defined at the International Conference on Population and Development (ICPD), reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system. The reproductive health care covers wide range of services which are defined in the programme of action: family planning counselling, information, education, communication and services, education and services for prenatal care, safe delivery and post natal care, and infant and women's health care. It also includes the prevention and treatment of infertility, prevention and treatment of infections, sexually transmitted diseases including HIV/AIDS, breast cancer and

cancers of the reproductive system and other reproductive health conditions and active discouragement of harmful traditional practices such as female genital mutilation (ICPD Programme of Action, 1994).

Nigeria therefore became bound by these declarations by becoming signatories to these international declarations. Nigeria and indeed other African countries committed themselves to achieve the targets set out in the ICPD Programme of action in September 1997 and committed themselves to implement the reproductive health concept for the next twenty years. The regional vision is that within the next twenty five years all people of the African region should enjoy an improved quality of life through a significant reduction of maternal and neonatal morbidity and mortality, unwanted pregnancy and sexually transmitted infections including mother to child transmission of HIV and through the elimination of harmful practices and sexual violence.

## **2.5 The Reproductive Health/Family Planning Situation in Nigeria**

The Nigerian Government, first got involved in Reproductive Health especially as regards with family planning in 1988. With a very high fertility rate amongst Nigerians, especially in the 1980's, there was a need for a population policy that will guide the country in its developmental projects. Therefore in 1988, the Federal Government of Nigeria formulated the National Policy on Population with the main objective of reducing the National fertility rate (National policy in population for development, unity, progress and self reliance, Lagos; Federal Ministry of Health, 1988). A family planning programme which focuses on increasing contraceptive use was the main strategy for reducing the high fertility rate. The target of the 1988 population policy was to reduce the number of children from 6 by 1990 to 4 per 1 family.

Fertility rate in Nigeria has remained consistently high overtime. Total fertility rate for 2003 is 5.7 children per woman (4.9 for urban and 6.1 for rural areas), which is higher than the

1999 demographic and health survey rate of 5.2. Current crude birth rate is 41.9 per 1,000 populations. On the other hand, family planning utilization in Nigeria despite many decades of programme implementation, improvement in practice has been much slow (Adesegun, 2004). Reproductive health has widely been interpreted to focus more specifically on providing access and choice in family planning.

The World Health Organization (WHO, 2000) maintained that family planning couples and individuals should decide freely the spacing of their children, and to have the information and means to do so. The right of couples and individuals to make decisions about family size and spacing and about which contraceptives will be used without being coerced or otherwise being subjected to violence and other outside pressures to behave in ways contrary to what they could like is very important in ensuring that there is sustenance in such decision making.

According to Nigeria Survey of Health Services (1988), recognizing the social and economic needs and costs of rapidly growing population, the Federal Republic of Nigeria adopted a population policy in 1988. The target of the National Policy on Population is to reduce the number of births per women from 6 in 1990 to 4 by the year 2000.

The flaws of the 1988 population policy are quite many. First of all the population policy was developed at the time when the foreign scene was concerned with the population growth rate of Nigerians. This immediately gave Nigerians the feeling that the West were trying to reduce their population for financial gains. That the West were part of the campaign also did not help the cause as people especially the Northerners have always viewed the West with suspicions.

Another major issue of this population policy is the communication strategy. The communication strategy was based upon reducing the number of children that one has. This goes against the tandem of religious and cultural belief. So even though there was wide knowledge of



the new family planning methods. It did not transcend to high usage of the methods or the sustenance of the use of family planning methods.

Despite almost two decades of efforts to promote the use of modern contraceptives in Nigeria, family planning programmes have had no appreciable impact on fertility (Traditional Fertility Regulation among the Yoruba of South Western Nigeria; A study of Prevalence Attitudes, Practice and Methods. Musa K Junadu, S.O Olusi and Bade Ajuwon). Recent Demographic and Health surveys indicate that the prevalence of modern contraceptives in the country is low, at around 3.5 per cent while the total fertility rate remains high at 5.9 per cent per woman (DHS 1990).

By 1990, only 6 per cent of married women used contraceptives. It was also found that contraceptive use among unmarried females was 13 per cent. It was discovered that females who were educated and lived in the southwest had a higher level of modern contraceptive usage than educated females and women in the North. When asked what their sources of accessing family planning methods were, 47 per cent said private.

With the development of the Reproductive health rights, there was a need for Nigeria to develop its own reproductive health right strategy. The broad aim of the current Nigeria Reproductive Health policy is that of stimulating an enabling environment that will promote universal access to comprehensive sexual and reproductive health services that meet the changing reproductive health needs throughout the life cycle of individuals and couples (Federal Ministry of Health 2010). The Nigerian Reproductive health policy is set within the framework of the national health policy which upholds primary healthcare (PHC) as the key to improving the health of men, women, adolescents and children at all levels. Thus the reproductive health policy developed the following policy objectives at the end of the year 2006:

- To reduce maternal morbidity and mortality resulting from pregnancy and childbirth by 50 per cent.
- To reduce prenatal and neonatal morbidity and mortality by 30 percent.
- To reduce the level of unwanted pregnancies in all women of reproductive age (15-49 years) by 50 per cent.
- To reduce the incidence and prevalence of sexually transmitted infections including the transmission of HIV infection.
- To eliminate all forms of gender –based violence and other practices that are harmful to the health of women and children.
- To reduce gender imbalance in availability of reproductive health services.
- To reduce the incidence of reproductive cancers and other non communicable disease.
- To increase knowledge of reproductive biology and promote responsible behaviours - to prevent unwanted pregnancy and STI's /HIV/AIDS.
- To reduce the prevalence of infertility and provide adoption services for infertile couples.
- To increase the involvement of men in reproductive health issues.
- To promote research on reproductive health issues(The Nigerian Reproductive Health Policy: 2006).

Reproductive health as a wholesome issue is one that might be new to Nigerians. One major way of practicing family planning could be said to be marrying more than one wife. So that as one is pregnant and gives birth, sexual activity is not practiced and the man moves on to the next wife. One other method of practicing family planning is breastfeeding. It is assumed that a breastfeeding woman cannot become pregnant, thus, women breastfeed their children for longer periods in an attempt to prevent pregnancy. In the Southwest region of the country, there have

been cases of women eating specific vegetables, or putting on special 'jigida' or waist beads that are thought to prevent pregnancies.

Cultural and Religious Beliefs in Family Services Compass/USAID, (2005) affirmed the above. It was noted in their research that before the advent of scientific methods of family planning, our forefathers were aware of the need for child spacing. Traditional medicine men have prescribed, and operated some traditional method of family planning. The most recent surveys in Nigeria demonstrated the importance of post-partum abstinence for fertility regulation particularly child spacing (Lesthaeche, et al 2005). Polygamy (the practice of having more than one wife,) has also been important as a traditional means of controlling fertility. Polygamy can reinforce effects of the post-partum abstinence by providing the husband with another sexual outlet thereby decreasing the chances that the abstinence will be violated and sexual relations resumed prematurely (Waife, 2000).

Many of these practices, especially post-partum abstinence, were important in the past than today. A recent Nigerian survey revealed a marked difference between wealthy urban women and poor urban or rural women in the duration of post-partum abstinence (Caldwell, 2001). Women of higher socio-economic status tend to adopt modern contraceptives and so rely less on abstinence than did women of lower status. Other methods here are the calendar (rhythm), withdrawal method and lactation amenorrhea (Caldwell, 2001).

Some traditional methods of family planning are: a) The arm/waist band worn round the women's arm or waist. b) Incantation parchment: worn by the women before or during intercourse. c) Leopard skull scares away children, since they are afraid of it, therefore its use to prevent pregnancy. d) Scarification marks, black powder applied every 3 months on incision on the vagina of women. This powder is prepared from the used burnt menstrual cloth of the women

and when the powder is applied, it is assumed that this prevents ovulation (Compass/USAID, 2005). e) Wooden doll is placed under the pillow during coitus. It is assumed that the spirit of the wooden doll will prevent pregnancy. f) Locked throughout the period the couple does not want pregnancy (Labaran, 2001) g) Potash: Potassium sulphate dissolved in water to be taken immediately after coitus.

## **2.6 Barriers to the Use of Family Planning**

The barriers to family planning are seen as extending beyond factors operating at the individual and household levels, to include characteristics of the social, religious and cultural environment and the health service infrastructure method. The health behaviour of individuals is often mediated by community beliefs and norms, such that individual behaviour is influenced by community perceptions of individual actions. Although individual demographic and socio-economic factors may shape an individual's desire and ability to use a service, the cultural environment in which an individual lives exerts a strong influence on the extent to which these factors actually lead to service utilization (Stephenson, 2004). A recent survey in Nigeria (Lesthaeghe, 2005) showed that about 80% of married couples knew of some form of modern conception but only 10 per cent actually practiced it.

The term family planning is an awkward one and goes against the cultural and indeed religious belief that man was meant to procreate, so trying to stop one from giving birth is a taboo and unheard of especially through so called extreme measures of taking pills and other measures. With western civilization, the term became quite popular in the 1980's in Nigeria as a result of the national population policy and the media campaign that promoted the benefits of one not having too many children. This campaign came at the heels of the West stating that Nigeria had a very high population growth rate. The campaign was also sponsored by the John

Hopkins University; this heralded the many problems encountered during the media campaign. The campaign made use of the media in providing information about family planning; the logo was also used as a visual reminder to the public on the National family planning. A major problem with the family planning campaign was the mistrust by Nigerians and indeed Northern Nigeria populace that the campaign is sponsored by the West and in this case International Agencies.

Elisha P. Renne (1996) in her article 'Perceptions of Population Policy, Development and Family Planning Programs in Northern Nigeria' noted that she went to Zaria city to conduct a research on family planning. After conducting interviews, she and her assistant gave the women maggi cubes as a sign of appreciation. Rumours immediately started that the seasoning cubes were laced with family planning elements with the intention of making them less fertile. On making enquiries she was notified that the Hausa culture does not understand what a thank you gift means. During the period of this research, she was told that one does something for the sake of the person otherwise known as "mutunchi", thus giving the cubes was bound to raise suspicions as the Hausa culture does not recognize thank you gifts. Not only were there rumours of the seasoning cubes, it was said that the researcher had gone further to take Hausa traditional medicines to the United States with the aim of lacing it with family planning drugs. Elisha also went further to state that after discussing with an Islamic scholar she was told that 'there is a vigorous campaign by youth and religious organizations about this family planning (because they think) that it is an American project that would be used to eliminate Muslims.

The above summary of Elisha's experiences and findings, sum up the key issues and barriers of Northerners in Nigeria in terms of attitude and behaviour as regards family planning which needs to be addressed by using a communication strategy especially in Northern Nigeria.

First among such is the top – down approach. Northern Nigerians are very suspicious about the United States of America and indeed the West about its reasons for funding such projects. No matter how laudable the idea, as long as it is viewed by the people as external, the question always asked is what do they (the West) have to gain from it? Thus, the distrust about such a delicate issue as family planning persists.

A second issue that needs to be addressed is the culture of the people. What are the cultural and traditional values of a people? Another question to be asked is, do the people understand why their traditional methods of family planning do not work. Until the public understand and agree that their traditional methods aren't very effective for family planning or that the health of the mother and child are at risk, they may not be susceptible to the health communication. Unless this is understood and addressed no communication strategy or media campaign can be successful talk more of being sustainable.

Religion is another factor that needs to be considered when family planning is being discussed. For Northern Nigerians, they are being governed by their religious beliefs, thus they must understand and believe that whatever is being communicated does not go against their religious beliefs. Nigerians being the dynamic people they are, are very determined especially in religious issues, there is therefore a need to always make sure that whatever communication strategy being embarked upon meets the above specification before it is exposed to the people.

Pathfinder International's Reproductive Health/Family planning service delivery project was funded by Lucille and David Packard foundation. It was aimed at improving the reproductive health status of adults and adolescents in Northern Nigeria and to increase the utilization of services through a network of public and private sector facilities and community based providers. At its third phase, Pathfinder International conducted a survey that was aimed at

informing the implementation of its future interventions in six states of Northern Nigeria including the federal capital territory, Abuja. Its findings were published in the Journal: Reproductive Health Knowledge and Practices in Northern Nigeria: Challenging Misconceptions 2006.

In the above survey, its key findings include the knowledge that barriers to the use of Family Planning for child spacing include religious and cultural concerns and a fear that family planning may interfere with future conception. It was also discovered that there is a good understanding of the concept of child spacing and acceptance of the concept is generally growing. It was noted that there are wide variations in the level of awareness about HIV/AIDS. For example knowledge of HIV/AIDS is higher among male youth than female youth. It has been a well known fact that the Northern part of the country (who are mostly Muslims) have been opposed to issues that relate to Reproductive Health especially family planning. That it is still a predominant issue is no news since the very first population and family planning campaign in 1988.

Another issue discovered during this survey is that parent to child or spousal communication of Reproductive Health is generally challenged. This stems from the parents being shy to discuss with their children about family planning methods as it will seem to be a license to engage in premarital sex. Here also, the factor of culture is also a huge issue. For spousal communication, it was observed that the women who bring up such issues such as family planning be as a method are seen to engage in extra marital affairs. Also decision making is firmly rooted with the males and thus the females neither find it difficult to brooch such conversations nor determine if it can be used. Njikam (1994: 24) pointed out that Nigeria is a patriarchal society thus, the role of women in reproductive health is limited.

The role of male-dominated culture in shaping maternal health conditions and outcomes among individuals in sub-Saharan Africa. .. is over 60 percent of the populations and because Africa is rural based, cultural norms and practices still exert a strong influence on reproductive health care, especially in relation to pregnancy, delivery and child rearing. The implication is that women's contributions to maternal health are limited.

The health behaviour of individuals is often mediated by community beliefs and norms such that individual behaviour is influenced by community perceptions of individual actions. Although individual demographic and socio-economic factors may shape an individual's desire and ability to use a service, the cultural environment in which an individual lives exerts a strong influence on the extent to which these factors actually lead to service utilization (Stephenson, 2004).

Sir Francis Bacon as quoted by Anderson, R. E. (1990: 42) adds: "Men commonly feel according to their inclinations, speak and think according to their learning and imbibed opinions, but generally act according to custom".

## **2.7 The Need to Practice Family Planning**

With maternal and child mortality at a high rate, there is a need to understand and find out the underlying causes of this mortality. Ni and Rossignol (1994) in a community – based maternal mortality surveillance study in Sichuan, China assessed the impact of family planning status on maternal mortality. They found that the leading causes of death for both planned and unplanned pregnancies were the same: hemorrhage, post partum infection, pregnancy – induced hypertension, cardiac diseases and pulmonary diseases. As among women with 'planned' pregnancies, about 40 per cent of maternal death among women with 'unplanned' pregnancies occurred at home, and 20 per cent occurred en route to a hospital. After controlling for the confounding effects of gravity and education, with additional control for the effect of pre natal



care visits the study indicated that women with ‘unplanned’ pregnancies have a higher risk of maternal death, which is only partially attributed to less prenatal care.

Lawoyin (2007) carried out a cross – sectional, community – based study to assess men’s perception of maternal mortality in Nigeria and found that efforts were required to improve men’s attitudes and knowledge in order to make them active participants in the fight to reduce maternal mortality. Maternal deaths in this study were blamed on healthcare workers not being skilled enough, financial barriers, failure to use family planning, emergency, ante natal and delivery care services. Factors associated with knowledge and attitude to preventing maternal mortality are discussed. Healthcare reforms must be coupled with socio- economic improvements and efforts made to improve men’s attitudes and knowledge in such a way as to make them active stakeholders, more supportive of preventing maternal mortality.

Shah and Say (2007), reproductive health researchers with the WHO produced a paper on maternal Mortality and maternity care. The authors showed that countries with high mortality ratios shared problems of high fertility and unplanned pregnancies, poor health infrastructure and low availability of health personnel.

Mojekwu and Ibekwe (2012) in their study, maternal mortality in Nigeria: examination of intervention methods, found out that delivery by a skilled health professional and educational attainment of women had more effect on maternal mortality than other factors. This they found out through the use of simultaneous multiple regressions on fourteen variables for maternal mortality modeling in Nigeria. Stepwise regression was then applied to identify from among the fourteen variables, the major determinant factors that appear to affect maternal mortality ratio more than others.

Other unfavourable characteristics of reproduction in Nigeria continue unabated: early marriage, early teenage pregnancy, low contraceptive usage, high fertility rate and huge fatalities from induced and unsafe illegal abortions. (Brabin L, Kemp J, Obunge O.K . Reproductive tract infections and abortions among adolescent girls in rural Nigeria. Lancet 1994; 344:300-4). In 1994 the overall contraceptive prevalence rate among Nigerian women was not more than 6% and many high risk women especially adolescents were not using contraceptives.

## **2.8 Theoretical Framework**

Strategic Communication is increasingly being recognized as an essential element of any successful health, social or development programme. When properly implemented, communication results in sustained change in policy, social norms and behaviours. Communication is also essential in overcoming barriers to access to services or generating demand for such services. Within the context of reproductive health, communication has been seen as an important input into tackling sexual and reproductive health issues including deteriorating indicators, unmet need for reproductive health, poor utilization of available services as well as weak dissemination of existing policies and guidelines on reproductive health to the lower levels. Thus, the theoretical framework for this study will be based upon the participatory communication theory.

### **2.8.1 Participatory Communication**

The theory which this study is based upon is the participatory theory of communication by Paulo Friere. The participatory approach emerged as an alternative to linear communication approaches. It is an emerging paradigm that is consistently growing in development circles. It is believed that by increasing people's participation, the more the people will be empowered. Its

goal is to empower local communities to manage their own development and be the key agents of their own development. According to Nair and White (1993), participatory communication opens up dialogue between both the receiver and the sender, thinking constructively about the situation, identifying developmental needs and problems, deciding what is needed to improve a situation and acting upon it.

Participatory approach is hinged on the fact that development is inherent among the public and that by communication, self reliance and independence and wisdom of the people will be depended upon that will lead to empowerment and ultimately leading to sustainable development. Common features of participation are the emphasis on people, the endogenous vision of development, and the attention to power and rights issues. This is because before now, development efforts have been focused on other activities at the detriment of involving the people in the development process. Thus, participatory communication is aimed at bridging that gap.

During the Rockefeller process communication for social change was described as:

“a process of public and private dialogue through which people themselves define who they are, what they need and how to get what they need in order to improve their own lives. It utilizes dialogue that leads to collective problem identification, decision making, and community-based implementation of solutions to development issues ([www.communicationforsocialchange.org](http://www.communicationforsocialchange.org)).

This definition literally gives the power of decision making to the people thereby empowering them. It is pertinent to note at this point that there are various types of participation. The World Bank (1995) identified four types of participation: information sharing, consultation, collaboration, and empowerment. Information sharing and consultation are considered low-level forms of participation. Mefalopoulos (2003) further classifies and describes the different forms of participation. He opines that passive participation is when stakeholders attend meetings to be informed; participation by consultation, when stakeholders are consulted but the decision making

rests in the hands of the experts; functional participation, when stakeholders are allowed to have some input, although not necessarily from the beginning of the process and not in equal partnership; and finally empowered participation, when relevant stakeholders take part throughout the whole cycle of the development initiative and have an equal influence on the decision-making process.

The benefits of participatory communication far outweigh the disadvantages in the use of participatory communication in any developmental project. Foremost among the benefits of the use of participatory communication is that community members will be empowered to take ownership of projects in their localities, thus ensuring the sustainability of the project. Furthermore, because the people are involved in a two way communication flow process, it lends credibility to a project because it takes into cognizance, the peoples culture and traditional values

This theory is very important because with full participation however will fully empower the people which lead to behavioural change and sustainability of projects. The World Bank (2005: 97) captures the benefits of participatory communication thus:

To be genuinely participatory and truly effective, communication should occur among all parties affected, ensuring all have similar opportunities to influence the outcome of the initiative. Optimally participatory communication would be part of the whole project process, from beginning to end. Since this approach promotes the active involvement of stakeholders in investigating options and shaping decisions regarding development objectives, participatory communication also facilitates empowerment. In this way, the effects go beyond the project boundaries, spilling into the wider social and political dimensions.

Critics of participatory communication will state that it is very expensive, slow and time consuming. Although this is true, when the cost of its being expensive and slow is placed side by side with the assured sustainability of a project, indeed, the use of participatory communication is worth the wait.

The participatory communication theory is adopted as the theoretical framework because it is a versatile field and can be used in diverse spheres. Furthermore, participatory communication provides opportunity for a dialogic communication, thus enhancing and providing the people with the opportunity to use their inherent wisdom in order to bring about ways in which they can participate thereby ensuring that the developmental project is sustainable.

## **CHAPTER THREE: METHODOLOGY**

### **3.0 Introduction**

This research is aimed at assessing the communication approaches employed by the Nigerian Urban Reproductive Health Initiative (NURHI). The Nigerian Urban Reproductive Health Initiative (NURHI) has for over three years employed various communication approaches in order to ensure that there is a positive behavioural change in people.

In Kaduna metropolis, NURHI's activities have been limited to two Local Government Areas. They are Kaduna North and Kaduna South Local Government Areas. Thus, the researcher limited the research to these two locations. This is because the Northern region has always been at the forefront of the resistance to family planning especially as a result of culture, traditions and religion. Thus these two locations constitute the focal point of the study in order to determine if issues pertaining to attitudes and behaviours have been effectively addressed by NURHI to ensure sustainability of the use of modern family planning methods.

### **3.1 Research Design**

This research adopted the mixed survey method of research. According to Asika (2002), 'survey research focuses on population or the universe'. A research design constitutes the planning, conceptual structure of the research type of approach adopted for a research. It encapsulates the measurement of variables, collection and also analysis of data. Thus, this research adopted the qualitative and quantitative research tools.

Qualitative research aims to understand aspects of a people's social life and is generated usually by words. This is against the quantitative tool which is generated in numbers and percentages. Furthermore, Qualitative research is being used for health studies, academic research, market research and stakeholder consultation. It is based upon exploring issues,

understanding phenomena and answering questions by analyzing and making sense of unstructured data. Qualitative research is designed to reveal a target audience range of behaviour and perceptions that drive it. It uses in depth studies of small groups of people to guide and support the construction of hypotheses. The results of qualitative research are descriptive rather than predictive.

According to Qualitative Research Consultants Association (2014), qualitative research contributes rich and insightful results by:

- Creating a synergy among respondents, as they build on each other's comments and ideas.
- The nature of interview or tool of qualitative research engages respondents more.
- It provides an ample opportunity to probe by enabling the researcher to reach beyond initial responses and rationales.
- It also provides an opportunity to observe record and interpret non verbal communication as part of a respondents feedback which is valuable during interviews or discussion and during analysis (<http://www.qrca.org/?page=whatisqualresearch>).

The use of the quantitative tool was adopted in order to generate data that was used to give factual statistics about people's opinion and action. Aliaga and Gunderson (2000) describe quantitative research as:

Explaining phenomena by collecting numerical data that are analysed using mathematical based methods.

The quantitative tool was used to measure the quantity and amount. This helped the study to numerically analyse the responses based upon the number of the respondents for each question

in percentages. This is with the aim of formulating facts and uncovering patterns in order to further understand the research population.

### **3.2 Study Population**

The study population comprises of the total number of people and places selected that have similar characteristics in which the study was carried out. The research was conducted in UnguwanRimi which is a locality in Kaduna North and Barnawa a locality in Kaduna South. According to the National Population Commission (2006), the population of UnguwanRimi is 83743 while in Barnawa the total population is 51920. Going by the estimated growth rate of Nigerian communities in Kaduna state which is calculated at 3% annually, the 2014 population size was arrived at through the multiplication of the previous population size by 3 and dividing it by 100. The answer is multiplied by 8 which represent the distance of time from the last conducted population census. This gave an approximate result of 106, 084 people in 2014 for UnguwanRimi while 65,771 people in Barnawa communities respectively.

### **3.3 Sample Size**

A sample size is a selected group from a population which is considered an adequate representation of the whole population. In order to arrive at a sample size, this research used the Meyer's Formulae (1973). Therefore, when the total sum of UnguwanRimi inhabitants (106, 084) and total sum of Barnawa inhabitants (65, 771) was added, the total sum of inhabitants was about 171,855. Therefore, through the use of Meyer's formula, the sample size was pegged at 384.

Under the aegis of the qualitative research paradigm, simple random sampling technique was used to select the population. Since there is no identified group of audience, simple random sampling technique helps to recognize a representative sample of the population (Anderson,



1998). Purposive sampling, a form of non-probability sampling in which decisions concerning the population to be included in the sample are taken by the researcher based on reasons which may include specialist knowledge of the research issue or capacity and willingness to participate in the research was used.

### **3.4 Instruments for Data Collection**

The study used four tools in order to generate data for analysis:

- i. Questionnaire
- ii. Documentary Observation
- iii. Focus Group Discussion
- iv. In-depth Interview

#### **3.4.0 Questionnaire**

A questionnaire is a series of questions asked to individuals to obtain statistically useful information about a given topic. A questionnaire provides an instrument by which people can give direct information or answer about a question which can be used to make factual statements about specific people or even an entire population. This quantitative tool was used to determine respondents agreement or otherwise about specific questions. The questionnaire was developed in an easy to understand manner so that respondents can agree or otherwise, state the level of intensity or list certain issues that make them react in certain ways.

Ujo (2000:97) asserts that ‘the questionnaire uses straight forward questions to obtain information on distribution to a group of people or population in relation to factors such as state, qualification, age, gender’. In view of this therefore, four hundred self-completion copies of the questionnaire were distributed among the sampled population. Here, purposive sampling was used to distribute the copies of the questionnaire among the respondents.

The copies of the questionnaire were administered to respondents face to face and some were given at places of employment. The face to face administering was done in order to ensure that respondents both literate and non literate were carried along.

### **3.4.1 Documentary Observation**

Existing records provide insight into activities that cannot be observed because they have occurred a long time ago and are therefore used to prove that such activities have been carried out. The NURHI communication approaches were implemented in phases and thus by the time this study was carried out some of the phases had already occurred. Therefore, the researcher requested for documents which provided more insight into the project.

The documentary records include records of census and vital statistics reports and newspaper archives. Other materials include electronic and hard copy materials and communiqués, video and audio materials, photographs, Information, Education and Communication materials (IEC), newspaper adverts, billboards and below the line advertising instruments.

This instrument is very important in this study because it validates the claims made by NURHI and also augments the findings of the research. It further improved the quality of this study.

### **3.4.2 Focus Group Discussion**

A focus group discussion is a semi-structured discussion with 8–12 participants led by a facilitator who follows an outline and manages group discussions with the proceedings being recorded.

The points for the discussion among the focus groups were taken from the materials gotten from the primary and secondary sources regarding the NURHI Project in selected project

locations. The design of the discussion guides and formats was carried out in such a way that the language of communication was Hausa language. This was because the participants were comfortable discussing in the language. The focus group discussion enabled the researcher to get information that further validated other information gotten from the use of questionnaire. It further helped the researcher understand and get more detailed information on stakeholder's attitudes, behavior and people's opinions of the NURHI's Project.

Two groups of focus group discussion one in each case study site, made up of 8 respondents each were involved in the discussion. The discussion was held for not more than 45 minutes.

### **3.4.3 Key Informant Interview**

A key informant interview (KII) is a method of collating information from seasoned experts or individuals in a chosen field of study. The KII was aimed at bringing to the fore information that might otherwise not be uncovered about the implementation of a project. It consists of an Interviewer and an interviewee. In-depth interview makes for the most comprehensive evaluation that one can achieve and that is gathered over time. Questions for the in-depth interview were designed after reading through the project design and other relevant documents of the project.

For the purpose of this study, two members of NURHI staff resident in Kaduna were interviewed. The staff had a cumulative experience of six years working on the NURHI project. In-depth interviews were conducted with the State Coordinator and the Demand Generation Officer in Kaduna. This provided an ample opportunity to get detailed information and explore issues about the project. It also served as a means of providing credibility not only to the questionnaires but also on the information obtained from the project location.

### **3.5 Research Instruments**

The study followed a cross-sectional survey design and employed the qualitative and quantitative data collection techniques namely: Focus Group Discussion (FGDs), TV, Radio Newspaper adverts and below the line advertising, documentary observation, questionnaire and In-depth Interview to gather the required information. Data was obtained from primary and secondary data sources. The primary source of data for this work were responses to questionnaire/interview questions, Focus Group discussions and Documentary observation, while the secondary source of data comes mainly from books, journals and the internet among others.

### **3.6 Sources of Data Collection**

#### **3.6.0 Primary Source**

The primary sources of data were the questionnaire, the key informant interview and the focus group discussion. These primary data provided the raw data upon which findings and conclusions were drawn.

#### **3.6.1 Secondary Source**

The researcher collated information from the internet, books, journals, reports and newspapers. The data collated provided the introduction and background of the study, the research problem and also provided the theoretical framework upon which this study was anchored upon. Furthermore, the information garnered from these secondary sources was used to review related literature in the study.

### **3.7 Procedure for Analysis**

After collecting the data, it was transcribed and analyzed. The interviews conducted on key informants were analyzed and provided a theoretical background upon which NURHI's activities and communication approaches were used and based upon. It also documents the media

and various forms which NURHI had used to inform the public to achieve their set goals and objectives.

After having set the background, the narrative was analyzed in order to bring to the fore emerging themes on the sample populations' recognition and acceptability of messages of NURHI. The narrative took into account their observations of NURHI's project and how effective the medium of communication has been. Thus both the quantitative and qualitative methods were synthesized and used in order to come to a logical discussion and conclusion of findings.

In attempting to assess the Communication Strategy of Nigerian Urban Reproductive Health Initiative (NURHI), especially in terms of its sustainability as a project, the study tries to buttress the fact that the success of any communication is determined by unequivocally involving the people in full communication that will ensure sustainability of the project.

## **CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS**

### **4.0 Introduction**

This chapter captures the findings and analysis derived from the data collected using both qualitative and quantitative methods of research. The research instruments used were the Questionnaire, the key Informant Interview (KII), the Focus Group Discussion and Documentary Observation.

The researcher conducted two Focus Group Discussion sessions in selected communities within Kaduna North and Kaduna South Local Government Areas. A total of 16 people were involved in the discussions. 384 responses to questionnaire were received from 400 copies of questionnaire administered in UnguwanRimi community in Kaduna North Local Government Area and Barnawa in Kaduna South Local Government Area.

Two key informant interviews were held with members of staff of the Nigerian Urban Health Initiative (NURHI). The staff had been with the organization since the project commenced in 2011. One person interviewed was the Kaduna State Coordinator of NURHI while another was the Demand Generation Officer. The researcher was also given access to the various communication tools employed by the organization in its implementation of the project. These include, radio and television jingles, posters, handbills and radio magazine programmes. These have been critically observed and discussed under documentary observation.

The analysis in this chapter is divided into six sections – sections A, B, C, D, E and F. The first section (A) represents the demographic characteristics of the respondents while the

remaining sections (B, C, D, E and F) focus on the objectives of the study which were indicated in the study.

#### 4.1 Data Presentation, Results and Analysis

##### 4.1.0 Section A: Demographic Characteristics of the Respondents

**Table 1: Distribution of Respondents by Sex**

Variable	Frequency	Percentages
Male	125	33 %
Female	259	67. %
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

Table 1 represents the total number of people who participated in the questionnaire survey. The cumulative sum of 384 copies of questionnaire were filled and returned to the researcher from a total of 400 copies questionnaire that were distributed in UnguwanRimi community (representing Kaduna North) and Barnawa community (representing Kaduna South) of the case study sites.

The table above indicates that 125 respondents, representing **33%** were male while 259 of the respondents, representing **67%** were female. Majority of the respondents therefore were females. This is an indication that women were usually the ones who are more involved in discussions as it pertains to reproductive health because they are usually the ones who are affected by the consequences of poor reproductive health issues. It also shows that during interactive sessions of communication through the use of community mobilizers embarked upon

by NURHI, majority of those involved are women. This is because women are almost always found at home as a result of gender roles and/or religious reasons, while the men are at their respective businesses or work places.

However, this gender disparity does not reflect any bias against NURHI because they have used multiple approaches during the implementation of their communication strategy.

**Table 2: Distribution of Respondents by Marital Status**

<b>Variable</b>	<b>Frequency</b>	<b>Percentages</b>
<b>Singles</b>	83	22%
<b>Married</b>	248	65%
<b>Divorced</b>	17	4%
<b>Widowed</b>	36	9%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

This table shows the distribution of respondents by marital status. There are 248 respondents, representing 65% of the survey size who are married. The singles are 83 representing 22% while the divorced and widowed are represented by 4% and 9% of the survey respectively. This is an indication that all marital statuses were represented in the survey so as to collate their perceptions about NURHI's communication approaches and how it has (if any) changed their perceptions towards family planning.



**Table 3: Distribution of Respondents by Age Bracket**

<b>Variable</b>	<b>Frequency</b>	<b>Percentages</b>
<b>15 – 20</b>	26	6%
<b>21 – 25</b>	48	13%
<b>26 – 30</b>	83	22%
<b>31 – 35</b>	107	28%
<b>36 – 40</b>	47	12%
<b>41 – and above</b>	73	19%
<b>Total</b>	384	100%

Source: Field Survey 2014

The above table presents the age grouping of the respondents. The essence of this table is to indicate the ages of respondents. This is to ensure that women of different child bearing ages are duly represented. The highest is the 31 – 35 age group with 28% of the selected communities. Also the 26 – 30 age group had 83 respondents representing 22% of the respondents. There are also the 21 – 25 age group and the 15 – 20 age group representing 13% and 6% respectively of the respondents.

**Table 4: Distribution of Respondents by Educational Status (From UnguwanRimi and Barnawa Communities in Kaduna North and Kaduna South LGAs)**

<b>Variable</b>	<b>Frequency</b>	<b>Percentages</b>
<b>Primary School</b>	32	8%
<b>Secondary School</b>	83	22%
<b>University</b>	105	27%
<b>HND/OND/NCE</b>	90	23%
<b>Quranic School</b>	42	11%
<b>None</b>	32	8%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

The table 4 indicates the educational qualification of the respondents. This shows that the research was all inclusive. It further shows that the questionnaire survey participants, irrespective of their educational background, were exposed to the family planning messages, thus were aware of NURHI's communication approaches. 8% of the respondents had stopped schooling at primary school level while 22% of the respondents had concluded their secondary school. 27% had their certificates from the university. Also, 23% had their HND/OND/NCE certificates while 11% had only Quranic training. About 8% of the respondents had no formal or religious training.

#### 4.1.1 Section B: NURHI's Communication Approaches in Addressing Reproductive Health

**Table 5: Respondents Responses on What Medium they could recall hearing the messages of Family Planning?**

Variable	Frequency	Percentage
Television	137	36%
Radio	71	19%
Newspaper	28	7 %
Community Mobilizer	40	10 %
Hospital staff	60	16 %
Other	4	1 %
None	44	11%
<b>Total</b>	<b>384</b>	<b>100 %</b>

Source: Field Survey 2014

Table 5 is the representation of respondents who were sampled using the questionnaire in selected communities on the various communication tools. It samples the respondents' awareness on the various communication activities that NURHI has embarked upon.

The above table shows the various media tools which the campaign employed in order to reach out to the target audience with messages. It shows that 137 respondents, representing 36% of respondents have heard and or seen the adverts via the television. The Key informant interview with the Generation Demand Officer, Mr. Aliyu Baba, confirms that indeed NURHI has invested heavily on Television Jingles. He added that:

We placed Television jingles on major Television stations in the state. This is with the aim of providing enlightenment to the populace. We used popular Hausa actors and actresses and also used themes that people can easily relate with such as wedding and naming ceremonies. This is because these occasions provide us with the opportunity to think and start planning ones family. (KII, Demand Generation Officer NURHI, 10/ 09/ 2014).

19 %, representing 71 respondents attributed their knowledge of NURHI's campaign to jingles heard on the radio. This is an indication that the radio Magazine programme and the radio jingles were able to reach some of the targeted audience with family planning messages. As discussed during Key Informant Interview with Mallam Kabir Mohammed (the State Coordinator NURHI) and also through documentary observation, the jingles were produced in Hausa and Pidgin languages and also broadcast on major radio stations within Kaduna State. Furthermore, the radio programme was designed with a feedback segment where the audience can send in questions that will be answered during the programme.

As seen in Table 5 above, 16% of the respondents acknowledged that they have heard about family planning via interaction with hospital staff and 10% believe they heard it as a result of interaction with community mobilizers. Many women in the focus group discussion corroborated and provided reasons why this is so. They explained that they get informed about family planning at their primary healthcare facilities.

When we go for antenatal check up in the hospital or clinics, the nurses there always talk to us about family planning. They tell us to consider spacing our children so that we can rest. You know rest is very good for a woman after she has given birth. (Focus Group Discussion, Respondent 11/ 09/ 2014, UnguwanRimi).

The response above indicates that interpersonal communication can be a very important tool in providing discourse on behavioural issues. Furthermore, the NURHI Demand Generation Officer corroborated the views on the various communication activities which the organization has embarked upon in order to disseminate information about the need for the usage of family planning methods. Mr Aliyu Baba explained that:

We have engaged community mobilizers who were sourced from traditional and religious leaders in each community. These individuals were trained and given the responsibility of

entering their communities and engaging in discussions with members of their communities. (KII, Demand Generation Officer NURHI, 10/ 09/ 2014).

This action was to encourage participation in the discussion on family planning. These volunteers served as a means of mobilizing community members, providing information on family planning and urging them to visit the nearest primary healthcare centre for more information and access to family planning services. The activities of these community mobilizers were backed by the hospital staff (Nurses) who have been co- opted into the NURHI project to aid dissemination of information.

While 1%, representing 4 respondents agreed that they heard NURHI's campaign via other methods, 11%, representing 44 respondents said they have never heard of NURHI's communication approaches from any medium. Indeed, foremost amongst other activities embarked upon was advocacy. Many religious and traditional leaders were involved from the onset of the programme. They were involved in discussions about what family planning really meant and how they could be involved in helping their subjects to be enlightened about and be more susceptible to messages on family planning. The traditional and religious leaders provided a candidate who will act as a volunteer to the project and be involved in all aspects of the campaign. This was with the aim of using a community member as against using an outsider so that the people will be more accessible and receptive to family planning messages. The leaders' meetings were recorded and transmitted via the radio for the listeners. The leaders were also invited for discussion programmes where they answered questions from the public via a phone-in programme.

There was also a heavy dependence on information, education and communication materials. They were in form of stickers, wrist bands, frequently asked questions flyers and also

below the line products like T-shirts, traffic jackets, among others. All of these were to serve as re-enforcers of messages and to help in stimulating discussion amongst the populace. This is an indication that although advocacy is paramount in any communication campaign, community members do not easily remember what impact it had on them. This might not be unrelated to the fact that the flow of information was one dimensional: from top to bottom. So also, the below-the-line products were not easily remembered by the populace, thus implying that it had little or no effect on them.

**Table 6. Respondents Responses on Which Medium of Communication had the highest Impact on them**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Television</b>	77	27%
<b>Radio</b>	58	20%
<b>Newspaper</b>	6	2%
<b>Interpersonal communication</b>	140	36 %
<b>None</b>	43	15 %
<b>Total</b>	<b>384</b>	<b>100 %</b>

Source: Field Survey 2014

When respondents were asked which of the tools had the highest impact on them, 36% of them said it was interpersonal communication. This was followed by 27% of the respondents who agree that the television adverts had more impact on them than any other media used. Newspaper as a medium of communication had 2% while 15% of the respondents opined that none of the media had any impact on them. That 36% of respondents felt that interpersonal communication had more effect on them is an indication that participatory communication is almost always the best medium of communication for health communication.

During the focus group discussion, majority of the women explained further that interpersonal communication provided them with the opportunity to express their thoughts and opinions and also to be answered by someone immediately. The women said that one-on-one interaction helped them to come up with positive opinions about family planning on the spot and to start mapping out ways by which they can approach their husbands and discuss on why and when they could start accessing the family planning services.

**Section C: Peoples experiences and perceptions about the campaign by NURHI and to what extent have they been involved in the communication process**

**Table 7: To what extent would you agree that NURHI’s messages have changed your perception in order to adopt Family Planning?**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Strongly agree that NURHI’s messages have made me adopt modern family planning methods</b>	81	21%
<b>Agree that NURHI’s messages have made me adopt modern family planning methods</b>	68	18%
<b>Strongly disagree that NURHI’s messages have made me adopt modern family planning methods</b>	155	40%
<b>Disagree that NURHI’s messages have made me adopt modern family planning methods</b>	80	20%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

Table 7 above represents the level of change that has been experienced by respondents after hearing messages about the need for planning one’s family. About 40% of the respondents

feel that they have not experienced any level of change in their perception about family planning after being exposed to NURHI's communication messages. About 18% representing 68 respondents agree that after hearing the messages it led them to take action by adopting modern family methods. So also, 20 % representing 80 respondents were of the opinion that NURHI's communication messages did not have any positive impact that could lead to behavioural change. This means that there is still a high level of mental or personal resistance to the importance and adoption of family planning as a method of spacing ones family to secure the health of mother and baby and also for a better life for the entire family.

**Table 8: To What Extent would you agree that the people were involved in the communication process?**

**The extent of the public involvement in family planning messages**

<b>Description</b>	<b>Frequency</b>	<b>Percentage</b>
<b>To a large extent, the public were involved in the communication process from the initial stages</b>	37	10%
<b>To some extent, the public were only involved in the communication process when messages are being tested/ introduced</b>	55	14%
<b>No, the public were not involved in the communication process from the initial stage</b>	247	64%
<b>To a limited extent the public were not involved in the communication process from the initial process</b>	45	12%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

The above table contains the items used to answer question 4 of the research. It emerges that the public were not properly involved in the development of the family planning messages. This



is evident from the findings as 247 respondents, representing 64% who indicated that they were not involved in the communication process. The public were involved in the communication process at the initial process only through the consultative form of participation. According to Mr. Aliyu Baba, he said

...what we did was to organize discussion sessions with selected individuals for example; we involved the religious leaders in discussions regarding family planning. We got their views and opinion on what the Bible or the Quran says about family planning. We also got traditional leaders to select individuals in their communities who will serve as Community mobilizers in their various communities... (In depth interview with MrAliyu Baba, 10 / 09/ 2014 Demand Generation officer, NURHI).

This means they were only asked questions on what their perceptions were in the baseline study. This was used to determine the type of words to be used that people will relate to in terms of family planning. Also, the people's religious and traditional leaders were also heavily depended upon to wield their influence on the people's belief, since the leaders are trusted both in terms of their knowledge on religious issues and also their integrity in leading the people aright. The people were also involved during the pre testing of the messages to ensure that the messages did not offend anyone's sensibility. They were also involved by providing them with opportunities to ask questions during phone in programmes on radio programmes.

We also provided avenues where the people could participate in our programmes. For example, we had a radio phone in programme where religious leaders are interviewed on radio and the general public can phone-in with questions where the leaders can respond to such questions. We also had a pre testing of our communication materials where some individuals were shown the materials and their observations about the materials were observed and then further inserted to produce the final copies of the communication materials. (In depth interview with MrAliyu Baba, 10 / 09/ 2014 Demand Generation Officer, NURHI).

From the above, the question was not that of a lack of participation but rather, the level of participation. As seen here, it is consultative type of participation with emphasis on

consultation and gathering of information from the public and also influencing their decisions. The consultation is based on a very limited few percentage who were opportune to be asked what their views were and then imposed on the rest of the public. Also very few percentage of people were involved in the pre testing and still fewer percentage involved during phone in programmes. Thus the level of involvement in the communication process is limited.

**Section D: Determine the Level of Cultural and Religious Barriers Associated with NURHI and their attendant implications for development**

**Table 9: Distribution of Respondents on what can hinder respondents from adopting family planning?**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Religious beliefs</b>	38	10%
<b>Family frowns upon Family Planning</b>	32	8%
<b>Family planning makes one fat</b>	50	13%
<b>Family planning causes infertility</b>	80	21%
<b>Lack of Funds</b>	8	2%
<b>No easy Access to Family Planning methods</b>	8	2%
<b>Uncertain negative effects of modern family planning methods</b>	61	16%
<b>Inadequate knowledge of Family planning</b>	25	7%
<b>Neutral</b>	12	3%
<b>None</b>	70	18%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

The above are indicators of the people’s fears and their perceived barriers and perception of family planning. While 21% of the respondents were afraid that family planning causes infertility, 18% of the respondents also felt there was no barrier for them in accessing family planning methods. Second amongst their fears is that using modern family planning methods has uncertain negative effect. Respondents who perceived that they do not have adequate knowledge of family planning were pegged at 7% of total sampled population. This indicates that many respondents are aware of various modern family planning methods.

Upon further investigation in Focus Group Discussions, respondents corroborated that the uncertain negative effects include, bleeding, irregular menstruations or the belief that modern family methods might hinder a woman from getting pregnant immediately after stopping the use of some modern contraception.

**Table 10: Distribution of Respondents on Reasons for not accessing modern Family Planning methods**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>I have a natural Family Planning in my system</b>	11	3%
<b>I am not interested</b>	70	18%
<b>I do not have enough children yet</b>	20	5%
<b>My spouse doesn’t want it</b>	50	13%
<b>Am single, not married</b>	35	9%
<b>I will practice but not yet</b>	20	5%
<b>I use other methods like withdrawal method, breastfeeding and safe period</b>	38	10%
<b>I am afraid of complications like infertility</b>	68	18%
<b>No response</b>	72	19%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

The table above provides various reasons given by respondents on why they have not accessed family planning services. The respondents who did not answer the question on why they are not using modern family planning methods represent 19% of the sample population. This indicates apathy or respondents not motivated or convinced about the use of modern family planning methods as a means of contraception. Also, 18% of the sample population clearly said they were not interested in using modern family planning methods. About 10 % said they used other natural methods like withdrawal method, breastfeeding and safe period as their own means of family planning. From this, it is obvious that there is apathy in terms of the use of modern contraception as a means of family planning. Thus, there is a need for effective sustainable communication to create awareness about other benefits of modern family planning methods.

**Table 11: Respondents’ Responses about Knowledge of NURHI’s Communication Campaign on Family Planning?**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Yes</b>	267	70%
<b>No</b>	97	25%
<b>Not Sure</b>	20	5%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Field Survey 2014

This table above provides an analysis of the spread of NURHI’s campaign. It shows that 70% of the respondents have heard about messages on family planning, child spacing and its benefits on the health of the mother, child and family as a whole. This indicates that the campaign has been successful in terms of its reach to the intended target audience.

During Focus Group Discussion sessions, when respondents were asked if they have heard of NURHI they said no. Also when asked if they know the slogan “Get it together” of

NURHI, they replied in the negative. However, when the logo of NURHI and some of the Television jingles were shown to the respondents, they all agreed that they had seen the advertisements on Television, heard it on Radio, had seen the community mobilizers of NURHI and also billboards and flyers on street corners and major roads in the state. This is an indication that many people have been exposed to the communication messages as implemented by NURHI.

**Table 12: Distribution of Respondents on Perceptions of NURHI’s Campaign on if it had Addressed their Cultural, Social, Religious and Traditional Beliefs on Family Planning?**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Yes</b>	122	32%
<b>No</b>	262	68%
<b>Total</b>	<b>384</b>	<b>100 %</b>

Source: Field Survey 2014

When the respondents were asked if the adverts on radio and TV jingles, radio serial magazine programmes, IEC materials, below the line adverts had addressed all their perceptions about family planning, a higher percentage of 68% said No. This meant that the respondents still have reservations about family planning that has not been addressed by the campaign.

The Focus Group Discussants went further to say that they felt that the family planning messages addressed their perceptions on child spacing in terms of showing the benefit of child spacing because it helps the women to rest in-between children and also for the children to be grown to a certain age, thus not needing too much care and attention before they get pregnant again. They also spoke about the benefits of child spacing especially as a tool that can help them grow their petty business trade before getting pregnant again.

Yes of course... as a woman you will rest. Who doesn't want rest? Your children will get good care and look fine and so also the mother. You will have opportunity to do other things before the next child comes. (FGD interview, AminaTozali, UnguwanRimi, Kaduna North)

**Table 13: Distribution of Respondents on taking positive action after being Exposed to NURHI's Communication Messages**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Yes</b>	147	38%
<b>No</b>	237	62%
<b>Total</b>	<b>384</b>	<b>100 %</b>

Source: Field Survey 2014

The main aim of NURHI's campaign is to ensure an increase in demand through the use of modern family planning methods. However about 62% replied in the negative that they have not started using family planning methods. That is almost as twice as the percentage of people who have started using family planning and child spacing methods. This is an indication that although the communication campaign has been robust and has had a wider reach, but it has not been able to result in a higher number of the populace taking the necessary action in order to avail themselves of family planning services.

## Section E: How participatory communication can be used to achieve a Higher Impact on Reproductive Health Issues in Nigeria

**Table 14: Distribution of Respondents on What Medium would they prefer to be used in communicating Family Planning messages?**

Variable	Frequency	Percentage
<b>Interpersonal Communication</b>	181	47%
<b>Television</b>	87	22%
<b>Radio</b>	100	26 %
<b>Newspaper</b>	16	5 %
<b>Total</b>	<b>384</b>	<b>100 %</b>

**Source: Field Survey 2014**

Taking a look at table 13, majority of respondents represent 181, and 47% of the respondents attest that they would prefer being communicated to via the use of interpersonal communication. 87 respondents, representing 22% of the respondents would prefer the medium of communication to be television while 100 respondents, representing 26% of respondents would prefer the radio as a means of communication.

The Focus Group Discussion on this topic corroborates the point that many respondents would prefer interpersonal communication. This is because talking with someone who is knowledgeable about the topic would provide the opportunity for questions, fears and thoughts to be listened to about the topic.

### **4.2 Discussion of Findings**

Health communication is a delicate area that needs to be handled with utmost caution during implementation. This is because when communicating for health, people's beliefs,

culture, attitude and behaviours all come into play when health issues are being addressed. This is why Health Communication needs to address multiple layers of people's beliefs before an impact can be made.

As established earlier in the literature review, acceptance of family planning messages in Northern Nigeria has long been resisted which has necessitated the intervention by NURHI. In trying to answer the first objective of the study which is to identify and analyze the various communication approaches employed by NURHI and determine how effective they have been, the communication approaches used by NURHI in order to promote health communication have been multidimensional. They have used advocacy, interpersonal communication and Community Mobilizers and Health personnel, the use of the Media (Television and radio jingles and also radio magazine programmes) This is consistent with the views of Rimal (2009) who opined that, communication interventions do not fall into a social vacuum but rather, information is received and processed through individual and social prisms. Mr. Kabir Mohammed, the State Coordinator of NURHI, Kaduna in an interview said:

Advocacy is very paramount in communication such as this. This is why Traditional and Religious leaders were relied upon in other to ensure that our communication messages were accepted by their subjects. Because we involved these individuals, community members were more susceptible in listening to our messages and also accepting them by accessing family planning services. Also, we have used community mobilizers who are selected volunteers in various communities to help drive the messages right to the door step of community members. Because these are individuals that are known and recognised in their communities, they are credible sources which community members can relate with. We have also embarked on a partnership with Nurses at Primary Healthcare Centres. They are trained in order to reaffirm family planning messages to patients who are in need of such information. (In depth interview with Mr Kabir Mohammed, 10 / 09/ 2014 State Coordinator, NURHI).

The effort of NURHI in this regard can be reaffirmed in table 5, where 36% of respondents acknowledged having been informed and are aware of NURHI's communication



campaign via the Television. Furthermore, 19% of respondents concurred that they heard the messages through the radio. This is an indication that the media is still a veritable tool in dispersing information to the public. Another medium that the respondents recalled hearing messages about family planning was interpersonal communication: Hospital staff and community mobilizers with 16% and 10% respectively. This is an indication that interpersonal communication has a role in ensuring that people are reached with the necessary information.

The role of interpersonal information is further buttressed with the findings on the field where 36% of the respondents believe that interpersonal communication had the most impact on them. This is an indication that there is a need to focus a lot more energy on activities that are centered on participatory communication, where there will be a two way flow of communication so that much impact could be had on target audience. Also, the use of the television as a medium of communication was believed to have had impact on respondents as 27% of them acquiesced that it had an impact on them. However, about 15% of respondents were of the opinion that none of the medium used had any impact on them. This further prove the need for participatory communication. This is because participatory communication engages a people through a process of self awareness through dialogue and the exchange of information, mental and emotional feeling. This therefore, reduces the risk of apathy amongst the populace.

In achieving the second objective of this study, which is to investigate the experiences and perception of the people about the campaign by NURHI and to what extent the people were involved, it was discovered from the findings on the field that after being exposed to the messages on family planning, 40% of the respondents strongly disagree that the messages had made them adopt modern family planning. This implies that there wasn't any positive behavior change. So also, 21% of the respondents strongly agree that NURHI's messages had made them

adopt family planning methods. This is an indication that although NURHI's communication messages had an impact on some of the respondents, there are still a higher number of people who are still yet unaffected by their messages.

According to findings in table 8, 247 respondents, representing 64% of total respondents strongly disagree that they were involved in the communication process. The respondents do not believe that they were involved in the communication process. This indicates that the flow of communication was mostly one dimensional with the people at the bottom receiving the information. This also could explain the high level of apathy experienced by the people despite being exposed to family planning messages.

From the research findings, 68% of the respondents were of the opinion that the communication messages have not addressed their cultural, religious and personal bias against modern family planning. This provides one explanation on why many of the respondents have not accessed family planning services. This finding corroborates Stephenson(2004) exposition that although individual demographic and socio-economic factors may shape an individual's desire and ability to use a service, the cultural environment in which an individual lives exerts a strong influence on the extent to which these factors actually lead to service utilization.

The researcher in this study tried to find out if there was any reason why respondents couldn't adopt family planning. 18% of the respondents noted that there wasn't anything that could hinder them from accessing family planning services. Also, 21% of the respondents were of the belief that family planning causes infertility. About 16% of them cited the uncertain negative effects of modern family planning methods, 13% cited the reason that family planning makes one fat while 10% of the respondents cited religious belief as a reason that hinders from accessing family planning services. This finding goes to show that the people did not have any

negative misgivings about NURHI or their messages but rather have misgivings about the effect of the use of family planning on their health. That people's religious beliefs was pegged at 10% of total respondents who think that their religious beliefs could hinder them from accessing family planning services could be attributed to the project using the religious and traditional leaders from the onset of the project. According to the State Coordinator of NURHI in Kaduna state, MallamKabir, he said they have not had any resistance whatsoever based on religion or traditions. Individuals during the FGD sessions corroborated this. They noted that the advertisements and also the use of actors from the Hausa film industry were appropriate. They further added that the use of the actors did not make them feel that only prostitutes or immoral people use family planning but rather it aided the believability of family planning. The respondents also said that family planning is now gaining acceptance not only as a result of a changing world but because NURHIs messages promoted family planning as a means of ensuring the health of mother and baby. The Focus Group Discussions also revealed that the people though did not have any misgivings about NURHIs' messages but added that women were more afraid of uncertain negative effects of modern family methods.

Furthermore, Adamu (1999) stated that other barriers to access to Sexual Reproductive Health services include social taboos. Sex and sexuality issues are taboos in many cultures and perceived stigma and embarrassment can lead to a reluctance to discuss and address sexual health issues. In trying to promote discussions between spouses, peers, mothers to their children, the communication campaign attempted to use specific themes in the projection of family and that is the use of weddings and naming ceremonies as focal points for discussions of family planning. Some certain jingles were set during weddings and naming ceremonies in order to serve as reminders to the public so that they will in real life use these opportunities to think about

and to create discourse on such issues. The use of folklores and other traditional ways such as storytelling, dramas, riddles and songs that will suit the people's culture and tradition can be used for effective and sustainable communication. This recommendation comes on the basis of the FGD sessions. When the participants were shown the Television jingle of a testimonial by a woman on the effect modern family planning had on her, it resonated deeply with the participants. They especially noted that they liked her composure, her looks and also what she was talking about. This might not be unconnected to the fact that it was something they could relate with i.e. the story telling. This goes to show that a peoples' culture and tradition can be used to bring about positive behavioural change. Aside from storytelling, theatre performances and theatre for development are activities that can also be used as tools for participatory communication.

So looking at Table 9 which shows that majority of the respondents believe that their cultural and traditional inhibitions were not answered by NURHI, vis-a-vis Table 7 which provides reasons why women do not access family planning methods, it can be deduced that despite being exposed to the messages on family planning, majority of the respondents still have inhibitions that pertains to cultural, traditional and belief system in accessing family planning. This finding corroborates earlier findings that the effects of modern family planning on users are paramount in the respondents' minds and thus needs to be addressed. This answers the third objective of the study which is to determine the level of cultural and religious barriers associated with NURHI and their attendant implications for development

Despite the increase in awareness on the need for family planning methods, it is obvious that more needs to be done. This is especially in the area of participatory communication as against consultative form of participation which answers the fourth objective of the study which

is to articulate a way forward on how effective communication use can achieve a higher impact on reproductive health issues in Nigeria.

During the research process, it was observed that although there was a wide recognition of the project especially in terms of Television and Radio jingles and other IEC materials, there is still a lot of apathy among individuals about the use of modern contraceptives. Also among the individuals sampled via the use of questionnaire and during Focus Group Discussions, it was agreed that the interpersonal sessions they had with health officials at hospitals had a lot of effect on them. This according to them was because it provided them with the opportunity to discuss family planning issues with health officials. The fact that someone listened to them also appealed to the respondents. Thus, they viewed the communication process as effective. The respondents' opinion on how they felt and responded to the interpersonal communication shows that indeed participatory tool in communication is very effective and can also lead to sustainable development.

An example of the potential of participatory communication was noted by the researcher during the research processes. The researcher during the focus group discussion noticed a woman who was very passionate about NURHI's messages on family planning. On further questioning, it was discovered that the woman's husband has been involved in the development and pre-testing of messages. Thus he became a strong advocate for family planning. The woman by association must have also benefitted from her husband's participation and thus by proxy she became an advocate for family planning.

During this research, it was noticed that there was a lot of apathy by women on issues that pertain to family planning. Even though the women had heard of the family planning messages, and had even discussed with friends and husbands about family planning but they are

still not interested for no apparent reason. This is why the researcher is advocating for the use of more participatory methods to physically and mentally engage such people in a process that will force them to have a rethink about their actions and why they need to adopt family planning messages.

## CHAPTER FIVE

### SUMMARY, RECOMMENDATIONS AND CONCLUSION

#### 5.0 Summary

This research is centered on the challenge of effective communication in advocating for the adoption of family planning. This was as a result of the poor acceptance of family planning messages in the past which was as a result of its top – down approach and lack of messages appropriate to the people’s religion and tradition. The study stressed the fact that huge amount of money and manpower and resources have been wasted in an overdependence on the media as a focal medium of communication with the hope that diffusion of messages will bring about the necessary change in behaviour and the adoption of family planning messages. This strategy was deemed ineffective as evidenced to the poor adoption rate. With the coming of The Nigerian Urban Reproductive Health Initiative (NURHI) as an NGO with the aim of improving and increasing the demand to the access of family planning methods, this study therefore explores communication approaches explored by the organization for sustainable development.

The theoretical framework was hinged on the participatory communication theory. This was to provide an alternative means of communication whereby development can be made sustainable. The quantitative and qualitative methods were used by the researcher. The primary respondents of the study were composed of 384 respondents and stakeholders located in Kaduna North and South. Two of the project staff of NURHI were interviewed and also two focus group discussion sessions were held in order to generate data. For effective analysis and interpretation of data, the researcher used descriptive and z-test statistical tools along with Percentage Distribution and Ranking to make logical discussions of data generated.

## 5.1 Key Findings

Based upon the responses gotten on the field on the communication approaches employed by NURHI and its attendant implication for sustainable development, the following key findings emerged.

- i. NURHI's communication approaches though widely robust, has not effectively resulted in a higher level of acceptance of family planning by the populace.
- ii. There is still a large apathy by people in accessing family planning services. This apathy still stems from traditional, religious and cultural beliefs.
- iii. Aside from biases as a result of traditional, cultural and religious hindrances to the acceptance of family planning, the messages have not handled issues that pertain to the fears of the negative effect of modern family methods.
- iv. The study also discovered that the people would prefer being communicated to using interpersonal means as against the use of the media.
- v. The study also shows that the use of Television and Radio has a greater level of impact than the use of billboards and other below-the line products.
- vi. Community mobilizers and the use of hospital staff as a means of educating and enlightening the public is a very important tool of communication that is successful and widely accepted.
- vii. NURHI should intensify efforts and build on increasing the level of participation by the public through the use of participatory methods such as Theatre for development and Participatory and Learning Action tools.



## **5.2 Conclusion**

From the findings of this study on assessing NURHI's communication approaches on family planning, it has been established that the communication approaches being implemented has been widely recognized. Many women have been exposed to the messages via various mediums: television, radio, community mobilizers, hospital staff, newspapers and below the line advertising. Furthermore, the use of traditional/religious leaders has served to bring about the increased acceptance of family planning.

However, despite the increased awareness about the benefits of family planning, there is still a lot of apathy and the adoption rate is still low. This is because there are still reservations pertaining to not only traditional/religious values but also to the people's perception on the uncertain negative effects of the use of family planning. Moreover, from these findings it has been deduced that the public tend towards interpersonal as a better alternative for communication.

Thus, even though the communication approaches of NURHI is good, this study concludes that the repositioning of the approaches via the use of participatory communication is necessary. Participatory communication will ensure a two - way flow of communication and also bring the people to a personal state of realization which comes from oneself and thus, reduce people's apathy and thereby ensure sustainable development.

### 5.3 Recommendations

In view of the above findings, this study recommends the following:

- i. NURHI should intensify efforts and build on increasing the level of participation by the public through the use of participatory methods such as Theatre for development and Participatory and Learning Action tools.
- ii. This research work strongly advocates the use of cultural forms of communication. These include folk songs, local poetry and drama. These strategies should be utilized in a participatory way to illustrate the benefits inherent in the practice of family planning for easy adoption. They should be used to cater for local situations and response from the audience. These media are especially useful where literacy levels are low. By involving local people in preparing the plot of a play, agents can stimulate the process of problem analysis and proffering solutions which is a fundamental part of the evoking ones thought process and bring about discourse that can lead to behaviour change.
- iii. Messages about family planning should also address the public's fear that the use of modern family planning methods does not lead to infertility or have other negative effects on the user.
- iv. Furthermore, this study commends the use of the television and radio as a medium of communication and should be intensified vis-a-vis participatory communication.
- v. The use of community mobilizers and hospital staff has also been seen as effective thereby needs to be re-evaluated and properly developed in order to be more effective and sustainable.

- vi. There is also the need for expanding NURHI's reach to hinterlands and rural areas

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## **INTERVIEWS**

,  
Mallam Kabir Mohammed State Coordinator, Nigerian Urban Reproductive Health Initiative,  
Kaduna, 1<sup>st</sup> September, 2014

Mr. Aliyu Baba, Demand Generation Officer, Nigerian Urban Reproductive Health initiative,  
Kaduna 1<sup>st</sup> September, 2014

Focus Group Discussions with females in Kaduna North LGA  
Focus Group Discussions with Females in Kaduna South LGA

## **APPENDIX I:**

### **QUESTIONNAIRE FOR MEMBERS OF UNGUWAN RIMI AND BARNAWA DISTRICTS IN KADUNA NORTH AND KADUNA SOUTH LOCAL GOVERNMENT AREAS**

This set of questions are intended to help this Researcher, DimkaKidelmwaNazin collect relevant information on a research topic: **An Assessment of Communication Approaches in Nigerian Urban Reproductive Health Initiative (NURHI) IN Kaduna, Nigeria** for a Master Dissertation in Development Communication, Department of Theatre and Performing Arts, Ahmadu Bello University, Zaria.

Please note that whatever information you will give will be confidential and will not be used for any reasons except for research purposes.

Please tick the appropriate answer. Thank you.

#### **A. DEMOGRAPHICS**

- 1) Age bracket  
(a) 15 - 20 (b) 21 - 25 (c) 26 - 30 (d) 31 - 35 (e) 36 - 40 (f) 41 and above
- 2) Sex  
(a) Male (b) Female
- 3) Marital Status  
(a) Single (b) Married (c) Divorced (d) Widowed
- 4) Religion  
(a) Christian (b) Muslim
- 5) Educational Status  
(a) Primary School (b) Secondary School (c) University (d) HND/OND (e) Quranic  
(f) None
- 6) Number of Children  
(a) 1 (b) 2 (c) 3 (d) 4 (e) 5 and above (f) None

**B. INVESTIGATE AND DETERMINE OTHER CULTURAL AND RELIGIOUS BARRIERS ASSOCIATED WITH FAMILY PLANNING AND THEIR ATTENDANT IMPLICATIONS FOR DEVELOPMENT**

- 7) What religious or traditional methods of family planning do you use?  
(a) Breast feeding (b) Polygamy (c) Menstrual cycle (d) Abstinence (e) Others (f) none
- 8) What are your feelings and belief about modern family planning?  
(a) Religious (b) Family frowns upon it (c) Makes one fat (d) Causes infertility
- 9) Which of the modern family planning methods do you use?  
(a) Condoms (b) Female Condoms (c) IUD (d) pills (e) Injection (f) Others (g) None

**C. IDENTIFY AND ANALYSE THE VARIOUS COMMUNICATION STRATEGIES EMPLOYED BY NURHI**

- 10) Have you heard of the child spacing campaign 'Get it together'/ 'Ko Kun Gane'?  
(a) Yes (b) None (c) Not sure
- 11) Can you remember where you heard messages about 'Get it together' / 'Ko Kun Gane'?  
(a) TV (b) Radio (c) A staff of the project told you about it (d) Hospital (e) All (f) None
- 12) Of the above, which of the messages do you remember or had the most impact on you?  
(a) TV (b) Radio (c) Interpersonal communication (d) None

**D. INVESTIGATE AND DETERMINE OTHER CULTURAL AND RELIGIOUS BARRIERS ASSOCIATED WITH NURHI AND THEIR ATTENDANT IMPLICATIONS FOR DEVELOPMENT**

- 13) Do you agree with NURHI's messages?  
(a) Yes (b) No (c) Not sure
- 14) Do you think NURHI's messages has addressed all your perceptions whether cultural, social, religious and traditional belief and thinking on family planning?  
(a) Yes (b) No (c) Not really (d) Indifferent

- 15) Do you think the messages were culturally appropriate?  
(a) Strongly Agree (b) Agree (c) Strongly Disagree (d) Disagree
- 16) Have you as a result of the adverts engaged in conversations about child spacing with your friends, husbands and or wives?  
(a) Yes (b) No
- 17) Have you as a result of the adverts started using family planning methods?  
(a) Yes (b) No

**D. SHOW THAT PARTICIPATORY COMMUNICATION IS NECESSARY FOR SUSTAINABLE DEVELOPMENT**

- 18) To what extent were you involved in the development / creation of the family planning messages?  
(a) Strongly Agree (b) Agree (c) Strongly Disagree (d) Disagree
- 19) To what extent has NURHIs messages changed your perception about family planning?  
(a) Strongly Agree (b) Agree (c) Strongly Disagree (d) Disagree
- 20) To what extent have you adopted the messages of family planning?  
(a) Strongly Agree (b) Agree (c) Strongly Disagree (d) Disagree
- 22) Considering the issue of family planning and also your cultural, traditional and religious beliefs, which medium would you most prefer to be communicated with?  
(a) TV (b) Radio (c) Newspaper (d) Interpersonal communication (e) None

## **APPENDIX II**

### **CHECKLIST FOR KEY INFORMANT INTERVIEW (KII)**

#### **Introduction**

**I am DimkaKidelmwaNazin a Master Student in Development Communication with the Department of Theatre and Performing Arts, Faculty of Arts, Ahmadu Bello University, Zaria.**

**I am researching on the topic:An Assessment of CommunicationApproaches in Nigerian Urban Reproductive Health Initiative (NURHI) IN Kaduna, Nigeria. This interview will be recorded (voice) and photographs will be taken during the session as part of the research data collection process.**

#### **Section A**

**The Demand Generation Officer, Nigerian Urban Reproductive Health Initiative (NURHI), Kaduna**

1. Could you please tell us about yourself
2. Could you give us a brief history of NURHI
3. What are the communication approaches employed by the people?
4. Since the beginning of the project, has the organization faced any resistance from the people?
5. To what extent would you say that the people were involved in the development of the communication messages?
6. Has the organization faced any resistance from the people?
7. Do you think the communication approaches used have been effective?

**Section B**

**The State Coordinator, Nigerian Urban Reproductive Health Initiative (NURHI), Kaduna**

1. Could you please introduce yourself?
2. What Communication Theory was the Campaign built upon?

**Interview Record**

**Key Informant: Prof., Dr., Mr., Mrs:-----**

**Area of Specialization: -----**

**Years of Experience:-----**

**Sex:-----**

**Date of Interview:-----**

**Duration: -----**

**Venue:-----**

**Interviewer:-----**

## **APPENDIX III**

### **CHECKLIST FOR FOCUS GROUP DISCUSSION**

**I am DimkaKidelmwaNazin a Master Student in Development Communication with the Department of Theatre and Performing Arts, Faculty of Arts, Ahmadu Bello University, Zaria.**

**I am researching on the topic:An Assessment of CommunicationApproaches in Nigerian Urban Reproductive Health Initiative (NURHI) IN Kaduna, Nigeria. This interview will be recorded (voice) and photographs will be taken during the session as part of the research data collection process.**

- 1. Have you heard about the Nigerian Urban Reproductive Health Initiative family planning communication campaign?**
- 2. What medium can you recall hearing the messages?**
- 3. Can you tell me one of the jingles you have seen/heard?**
- 4. Of the different medium you have heard the messages, which of them do you prefer?**
- 5. Why do you prefer it?**
- 6. Do you think the messages have answered your cultural and traditional values**
- 7. Have you as a result of the messages started using modern family planning methods**
- 8. Lets watch this video. What do you think about it?**



## **APPENDIX IV**

### **KEY INFORMANT INTERVIEWS**

#### **A. Responses from Mr. Aliyu Baba Demand Generation Officer, Nigerian Urban Reproductive Health Initiative (NURHI) Kaduna State**

My name is Aliyu Baba and am the Demand Generation Officer of NURHI. The project was initiated in 2011 and is being sponsored by the David and Lucille Packard Foundation. We were established with the aim of increasing the demand for and the use of modern family planning methods. We are in operation in selected cities of the federation among which is Kaduna, Zaria, Ilorin, Ibadan and Abuja.

In order to achieve our set goals and objective we have been able to use various methods. Before we began the project, we had a baseline study. This is to get peoples views and opinions about family planning. What are their dislikes and their likes: what kind of messages will they like to see. What kind of words will they prefer to be used when communicating about family planning? This base line study really helped us. It was based on the findings of this baseline study that we opted to use the words child spacing instead of family planning. This is because the people interviewed said they prefer the former words as against the latter.

Secondly, what we did was to organize discussion sessions with selected individuals from example; we involved the religious leaders in discussions regarding family planning. We got their views and opinion on what the Bible or the Quran says about family planning. We also got traditional leaders to select individuals in their communities who will serve as Community mobilizers in their various communities. We have held advocacy meetings with religious and traditional leaders. These meetings was with the aim of involving them in the process so as to get them to accept and agree that the use of modern family planning methods does not go against

their religious and traditional beliefs. This is very important because they are the gate keepers of these communities and without their approval we would have encountered many issues during the implementation of our programmes.

We placed Television jingles on major Television stations in the state. This is with the aim of providing enlightenment to the populace. We used popular Hausa actors and actresses and also used themes that people can easily relate with such as wedding and naming ceremonies. This is because these occasions provide us with the opportunity to think and start planning ones family.

We have engaged community mobilizers who were sourced from traditional and religious leaders in each community. These individuals were trained and given the responsibility of entering their communities and engaging in discussions with members of their communities. We also provided avenues where the people can participate in our programmes.

Well... we have engaged the people in some ways. For example we had a radio phone in programme where religious leaders are interviewed on radio and the general public can phone-in with questions where the leaders can respond to such questions. We also had a pre testing of our communication materials where some individuals were shown the materials and their observations about the materials were observed and then further inserted to produce the final copies of the communication materials.

We haven't faced any resistance per se. The only issue we ever had was when we pre tested some of the communication materials. When we showed it to some people they said that the women we used in the communication materials who are actresses said of course they will promote family planning because they are actresses. That is the only issue we ever had.

I would say that our communication strategy has been effective. This is because we have used various mediums and we therefore we have had a wide reach in getting information to the public. Also, at the hospitals, you know we partner with hospitals in order to make family planning methods easily accessible to the women. All of this have led to an increase of 15.9 % in demand of family planning services in Kaduna State.

**B. Responses from Mallam Kabir Mohammed State Coordinator, Nigerian Urban Reproductive Health Initiative (NURHI) Kaduna State**

My name is Kabir Mohammed and I am the State Coordinator, Nigerian Urban Reproductive Health Initiative, Kaduna. The theoretical framework of the campaign is based upon the ideation theory. The ideation theory refers to new ways of thinking of social interaction in local, culturally homogenous communities. The ideation theory is used in strategic behaviour communications in order to identify and influence ideational elements which include attitudes, knowledge, self efficacy, social and peer approval and other factors that can affect and determine health behaviour. The key premise of this theory is that the more elements that apply to someone, the greater probability that they will adopt a healthy behaviour and in this case family planning. Seeing that religion, ones belief and what one says about ones decision about family planning matters in the adoption of the family planning messages, The campaign set out to systematically breakdown these barriers. It is in order to break down these barriers that religious and traditional leaders, the use of community mobilisers and health officers at hospitals. Advocacy is very paramount in communication such as this. This is why Traditional and Religious leaders were relied upon in other to ensure that our communication messages were accepted by their subjects. Because we involved these individuals, community members were more susceptible in listening

to our messages and also accepting them by assessing family planning services. Also, we have used community mobilizers who are selected volunteers in various communities to help drive the messages right to the door step of community members. Because these are individuals that are known and recognised in their communities, they are credible sources which community members can relate with. We have also embarked on a partnership with Nurses at Primary Healthcare Centres. They are trained in order to reaffirm family planning messages to patients who are in need of such information.

## APPENDIX V

### FOCUS GROUP DISCUSSION

#### A. Focus Group Discussion with women in UnguwanRimi (Kaduna North Local Government Area)

After you showed us these pictures I recognize their logo. Yes we have seen their messages. We saw it on Television, Heard it on radio. Some people have come to our community to talk to us about it and give us leaflets and also when we go to the hospital especially those of us that are pregnant, the nurses talk to us about modern family planning methods. When we go for antenatal check up in the hospital or clinics, the nurses there always talk to us about family planning. They tell us to consider spacing our children so that we can rest. You know rest is very good for a woman after she has given birth. Yes of course... you see as a woman you will rest. Who doesn't want rest? Your children will get good care and look fine and so also the mother. You will have opportunity to do other things before the next child comes.

I remember the one where they are in a saloon and they were talking about child spacing to a new bride. I also remember the one that a man was talking in a barbershop about child spacing. Honestly I prefer the one where they talk to us face to face. This is because there is room for us to exchange information. I can ask questions and they can immediately answer me. Also when we talk we can talk about issues like how to raise the discussion with our husbands.

Well... it has answered some of our questions and thoughts but you know the issue of family planning has a lot of issues. You know when one starts doing the family planning it reacts differently to every woman. Some people are afraid that when they want to start

having children after using family planning methods, they will find it difficult. Some people even prefer the traditional methods like breastfeeding and other methods to help prevent them from getting pregnant. And you know sometimes the husband, mother in law and other family members frown about using modern family planning methods. I know a woman who said that her husband said he has cursed any of his wives who will go behind his back and do any family planning method. So you see there are still a lot of issues. However, these messages are okay because they are promoting the health of mother and child

We have seen this advert plenty several times on Television. I like the way the woman looks: she looks respectable and well mannered so I believe that what she is saying is true. Even though they use actors in their advert it's okay. We don't feel any bias because of this. This is the way the world works now. They are just trying to show us the benefits of child spacing.

## APPENDIX VI

### PHOTO-SHOTS/ FIELD SURVEY



Interview with Mr. Aliyu Baba. Demand Generation Officer, NURHI, Kaduna



Focus Group Discussion Session with women in UnguwanRimi (Kaduna North Local Government Area)



Focus Group Discussion session with women in Barnawa (Kaduna South Local Government Area)



Some Documentary observation of some below the line communication materials





NURHI's Stickers placed on Bike



NURHI posters placed at strategic locations in Kaduna UnguwanRimi