

AN ASSESSMENT OF COMMUNICATION STRATEGIES FOR FAMILY  
PLANNING PROMOTION IN NIGER REPUBLIC

BY  
DJIBO OUMAROU  
B.Sc (ENSP-Niamey)  
PGDMC (ABU-Zaria)  
M.Sc/Soc-Sci/2635/2011-2012

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Department of Mass Communication  
Faculty of Social Sciences  
Ahmadu Bello University, Zaria – Nigeria

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## DECLARATION

I hereby declare that the work in this thesis titled “An Assessment of Communication Strategies for Family Planning Promotion in Niger Republic” was conducted by me in the Department of Mass Communication, Faculty of Social Sciences, Ahmadu Bello University, Zaria, under the supervision of Dr Suleiman Salau and Mr. Cosmos Ikechukwu Eze.

The information derived from the literature has been appropriately acknowledged. No part of this work has been presented for another degree or diploma in any institution.

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Djibo Oumarou

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Signature

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Date

## CERTIFICATION

This Thesis titled AN ASSESSMENT OF COMMUNICATION STRATEGIES FOR FAMILY PLANNING PROMOTION IN NIGER REPUBLIC meets regulations and a standard governing the award of the degree of Master of Science (M.Sc) in Mass Communication of the Ahmadu Bello University, Zaria and it is approved for its contribution to knowledge and literary presentation.

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Djibo Oumarou

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Suleiman Salau  
Chairman Supervisory Committee

\_\_\_\_\_  
SignatureDate

\_\_\_\_\_  
Mr. Cosmos. I. Eze  
Member Supervisory Committee

\_\_\_\_\_  
SignatureDate

\_\_\_\_\_  
Dr Mahmud. M. Umar  
Head, Department of Mass Communication

\_\_\_\_\_  
SignatureDate

\_\_\_\_\_  
Professor Adamu. Zoka Hassan  
Dean, School of Postgraduate Studies

\_\_\_\_\_  
SignatureDate

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## TABLE OF CONTENTS

PAGE TITLE .....	i
DECLARATION .....	ii
CERTIFICATION .....	iii
ACKNOWLEDGEMENTS .....	iii
LIST OF FIGURES .....	viii
LIST OF TABLES .....	ix
LIST OF APPENDICES .....	x
LIST OF ABBREVIATIONS AND ACRONYMS .....	xi
ABSTRACT.....	xiii
CHAPTER ONE:INTRODUCTION.....	1
1.1 Background to the Study.....	1
1.1.1 Maradi profile.....	5
1.2 Statement of the Problem .....	6
1.3 Research Questions: .....	7
1.4 Aim of the Study: .....	8
1.5 Objectives.....	8
1.6 Significance.....	8
1.7 Scope of the Study.....	9
1.8 Operational Definition of Terms .....	10
CHAPTER TWO:LITERATURE REVIEW AND THEORETICAL FRAMEWORK.....	11
2.1 Introduction .....	11
2.2. An Overview of Family Planning .....	12
2.2.1. Health Benefits of Family Planning .....	14
2.2.2. Family Planning Policies and Programmes.....	15
2.2.3. Factors Influencing Family Planning Communication in Maradi State.....	16
2.2.4. Role of Islamic leaders as sources of information on family planning .....	18
2.2.5. Advocacy and Communication for Behaviour and Social Change .....	18
2.3. Health Communication Strategies.....	22
2.3.1. Role of Communication in Family Planning Promotion.....	22

2.3.2. Health Communication and Family Planning initiatives in Niger Republic.....	24
2.3.3. Health Communication and Mass Media .....	25
2.4. Theoretical Framework .....	27
2.4.1 Health Belief Model (HBM): .....	27
CHAPTER THREE:RESEARCH METHODOLOGY .....	31
3.1 Introduction .....	31
3.2 Research Design.....	33
3.2.1 Survey.....	33
3.3 Population.....	33
3.4 Sampling Technique:.....	33
3.5 Sample Size.....	34
3.6 Method of Data Collection.....	37
3.7 Instruments of Data Collection: .....	38
3.8 Validity and Reliability .....	39
3.8.1 Validity:.....	39
3.8.2 Reliability: .....	39
3.9 Method of Data Analysis: .....	40
CHAPTER FOUR:DATA PRESENTATION, INTERPRETATION AND ANALYSIS .....	41
4.1 Introduction .....	41
4.2. Presentation and Interpretation of Data.....	42
4.2.1. Identity of the respondents .....	42
4.2.2. Knowledge, Attitude and Practice about Family Planning Communication Strategies .....	46
4.2.3. Sources of Information.....	51
4.2.4. Communication Skill and use of Media Materials.....	53
4.2.5. Observation Guide Data Analysis .....	56
4.2.6: Focus Group Discussion Data Analysis .....	58
4.2.7. Key Informant Interview Data Analysis .....	60
4.3 Discussion of Findings .....	61
4.4 Summary of Major Findings .....	72
CHAPTER FIVE:SUMMARY, CONCLUSION AND RECOMMENDATIONS.....	73
5.1 Introduction .....	73

5.2 Summary of Chapters.....	73
5.3 Conclusion.....	75
5.4 Contributions to knowledge .....	75
5.5: Recommendations .....	76
5.6: Suggestion for Further Study .....	77
REFERNCES .....	78
APPENDICES .....	83

## **LIST OF FIGURES**

Figure 4. 1: Distribution of respondents by age group .....	42
Figure 4.2: Distribution of respondents by educational level .....	43
Figure 4. 3: Distribution of respondents by marital status.....	44
Figure 4. 4: Classification of the respondents by their opinion on F.P providers' attitude .....	50
Figure 4.5: Distribution of respondents by their opinion about FP information .....	54
Figure 4. 6: Classification of respondents by their degree of understanding FP messages .....	56

## LIST OF TABLES

Table 3. 1: Sample size of estimated WRAS by District Health Centres in Maradi state .....	35
Table 3. 2: Sample size of the estimated WRAs by Integrated Health Centres.....	36
Table 4. 1: Distribution of respondents by religion .....	43
Table 4. 2: Distribution of respondents with co-wives.....	44
Table 4. 3: Distribution of respondents by F.P users and non-users.....	45
Table 4. 4: Distribution of respondents by the number of their children.....	46
Table 4. 5: Distribution of respondents by their understanding of what Family planning is?.....	47
Table 4. 6: Distribution of respondents by knowledge of location of family planning units .....	47
Table 4. 7: Classification of respondents by knowledge of family planning benefits .....	48
Table 4. 8: Distribution of respondents by reasons why people visit a family planning service? ..	49
Table 4. 9: Classification of current F.P users by their satisfaction with the methods.....	49
Table 4.10: Respondents' views on family planning providers' attitudes.....	51
Table 4. 11: Classification of respondents by sources of information.....	51
Table 4. 12: Distribution of respondents by sources of Information during the last 3 months ....	52
Table 4. 13: Distribution of respondents by media influence .....	52
Table 4. 14: Distribution of respondents by ownership of media equipment.....	53
Table 4. 15: Distribution of respondents by information availability.....	53
Table 4.16: Distribution of respondents' view by Integrated Health Centres .....	55
Table 4. 17: Distribution of family planning methods available in the sites .....	57
Table 4. 18: Distribution of family planning communication materials available in the centre ..	57
Table 4. 19: Family planning materials available in FP units visited and frequencies of users ...	58
Table 4. 20: Mean Score of family planning Communication materials? .....	62
Table 4. 21: People's familiarity with family planning messages or methods .....	64

## **LIST OF APPENDICES**

Appendix A: Questionnaires addressed to the respondents

Appendix B: In depth interview guide

Appendix C: Observation guide

Appendix D: Focus group discussion guide

Appendix E: Autorisation de Recherche du MSP (Letter of introduction by Health Minister)

Appendix F: Map of Maradi Metropolis

Appendix G: Samples of Family Panning Products

## LIST OF ABBREVIATIONS AND ACRONYMS

**ACTN:** Niger Republic Traditional Rulers Association

**AIDS:** Acquired Immune Deficiency Syndrome

**ANBEF:** Niger Association for family better life

**ANIMAS- SUTURA:** Niger Association for Social Marketing

**BCC:** Behaviour Change Communication

**BSC:** Behaviour and Social Change

**CMAW:** Currently Married Adolescent Women

**CBSC:** Communication for Behavioural and Social Change

**CONIPRAT:** Niger Association against Traditional Bad Practices,

**DHC:** District Health Centers (Local Government Level)

**DHS:** Demographic and Health Surveys

**DRP/PF/PE-MI:** Direction Regionale de la Population, de la Promotion de la Femme et de la Protection de l'Enfant-Maradi (Maradi Regional Direction of Population, Women Affairs and Child Protection)

**DRSP:** Direction Régionale de la Santé Publique (State Direction of Public Health)

**FPC:** Family Planning Communication

**FPSP:** Family Planning Service Providers

**HIV:** Human immunization Virus

**IEC:** Information, Education, and Communication

**IHC:** Integrated Health Centers

**IHHC:** Integrated and Holistic Health Communication

**IUCD:** Intra Uterine Contraceptive Devices

**MP/PF/PE:** Ministry of Population, Women Promotion and Child Protection

**MSP:** Ministry of Public Health

**NFHS:** National Family Health Survey

**NFPDP:** Niger Family Health and Demography Project

**ORTN:** Niger Republic Radio and Television Office

**PMTCT:** Prevention of Mother to Child Transmission

**PRB:** Population Reference Bureau.

**ProAg:** Project Agreement

**SBCC:** Social and Behavior Change Communication

**TFR:** Total Fertility Rate

**UN:** United Nations

**UNFPA:** United Nations Fund for Population Affairs

**UNICEF:** United Nations International Children's Education Fund

**USA:** United States of America

**USAID:** United States Agency for International Development

**WHO:** World Health Organization

**WRAs:** Women of Reproductive Age

**VVF:** Vesico-Vaginal Fistula

## ABSTRACT

The study investigated communication strategies influencing the promotion of family planning in Maradi State. Four research questions were asked and four objectives were formulated. The research design adopted was survey combined with focus group discussion, observation guide and In-dept Interview. A sample of six hundred and five (605) respondents among women of reproductive age between 15-45, were selected from seven local government areas including Maradi Metropolis using multistage sampling technique. Questionnaire was used to collect information from the subjects. Mean score statistics and Standard Deviation were used for the purpose of data analysis. Checklists for observation were also used as instruments to collect data. The findings revealed that inadequate family planning messages caused problems of misunderstanding the benefits of family planning. These problems might be due to inappropriate methods being used to communicate with people. The conclusion drawn from the findings of this study show an important knowledge gap exists with respect to family planning benefits. The analysis of the data revealed that respondents were of the opinion that communication channels have significant impact on the population and face to face communication is considered as the best strategy in promoting family planning in Maradi State. The main recommendation from this study is for the State Health-Director to organize job-training, workshops and seminars at interval for health workers on family planning. Communication messages should also be edited locally and not at national level as it is know. The establishment of a family planning communication audit should be conducted in Maradi State. National, regional and community radio and television stations should conduct discussions that will help women to understand their reproductive life, rationalize work and shift emphasis from funding to report family planning communication activities. Religious and traditional leaders (Imams, Pastors and chiefs) should have regular communication with their followers on the need for family planning as stated in their engagement protocol held with the UNFPA.

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the Study

For most health issues, the main goal of learning is to be able to communicate. Thompson (1994: 30) notes that: “it is through communication that people send and receive messages effectively and negotiate meaning.” Nowadays, how to communicate effectively in health matters becomes much more important than reading and writing. As a result, communication strategies have turned into a crucial topic for all health workers. Recognizing the urgent need for family planning and the increasingly important role of communication in family planning programmes, The United States Agency for International Development (USAID) began, as early as the 1970s to address communication issues. A lot of strategies were implemented including: risk communication, persuasive or behavioural communication, media advocacy, entertainment education, interactive health communication, development communication and participatory communication.

The ability to communicate is essential to the success of any undertaking and an important family planning factor in the achievement of its objectives. We have entered an age of knowledge and the key to accessing and harnessing that knowledge lies in the ability to communicate. Therefore, a successful communications strategy will enhance considerably, the value of family planning programmes in Niger Republic in general and in Maradi State in particular. But sometime, the family planning communication message contents delivered by health workers are not effective.

Health Communication is “the means by which information about health is imparted and shared with other people” (Northouse, 1998). Put more formally, it is the “transfer of health information between a source and one or more receivers; a process of sharing meanings, using a set of common rules” (Northouse, 1998). To deal with health issues, we communicate information in many different ways. Frequently, it is done through spoken language in radio, television through traditional rulers, religious leaders and/or social mobilizers. We disseminate also the same information in a written language through newspapers, leaflets, journals, magazines and bulletins, but non-verbal communication also plays a significant role in our interactions especially when we are sending health message to people in face to face communication. Thus, our body posture, our expressions and even the clothes we wear also contribute to the messages that we give out.

Effective communication is central to our ability to promote family planning as communicators in the society. Communication is the key aspect of all relationships between family planning service providers and family planning users and/or non users, whether these occur in family, educational, work or social settings. Indeed, when such relationships break down or become stressful, the central complaint frequently relates to poor communication.

The area of healthcare is no exception. Communication problems can occur at many different levels. So, effective communication is now generally acknowledged to be central to effective healthcare. It is no longer seen as an add-on extra; rather it is recognized by many as being at the heart of patient care, playing a pivotal role. As Kreps (2003), noted: “Communication is pervasive in creating, gathering and sharing health information. It is a central human process that enables individual and collective adaptation to health risks at many different levels”. For

example, a significant event in relation to health communication in the United Kingdom was the publication of the Patients' Charter which informed patients that they had a right to be given a clear explanation of any treatment proposed, including any risks involved and alternatives to the recommended treatment. At about the same time, an international conference on health communication produced the 'Toronto Consensus Statement' on the relationship between communication practices and health outcomes (Simpson. 1991).

The statement made eight key points:

- Communication problems in medical practice are important and common;
- Patient anxiety and dissatisfaction are related to uncertainty and lack of information, explanation and feedback;
- Doctors often misperceive the amount and type of information that patients want to receive;
- Improved quality of clinical communication is related to positive health outcomes;
- Explaining and understanding patient concerns, even when they cannot be resolved, results in a fall in anxiety;
- A greater participation by the patient in the encounter improves satisfaction, compliance and treatment outcomes;
- The level of psychological distress in patients with serious illness is less when they perceive themselves to have received adequate information;
- Beneficial clinical communications is routinely possible in clinical practice and can be achieved during normal clinical encounters, without unduly prolonging them, provided that the clinician has learned the relevant techniques.

Now, there is a substantial body of evidence to show that healthcare providers who communicate well with patients are more likely to secure positive outcomes for patients, themselves and others. Thus, “they are more likely to make more accurate and comprehensive diagnoses, to detect emotional distress in patients, to have patients who are more satisfied with their care and less anxious, and who agree with and follow the advice given” (Lloyd and Bor, 1996).

In addition, “patients who are dealt with by professionals with good communication skills have been shown to have improved health indices and recovery rates” (Davis and Fallow field, 1994). Thus, in what is now cited as a classic series of studies by Greenfield (1985), informing and involving patients in their cases led to significant reductions in blood pressure and improvement in diabetic control that were comparable with the introduction of a new drug.

About health communication in the New Media Landscape, technology and communication systems may enable disruptive innovations and creative solutions that can be brought to bear on many challenging health care problems. The availability of information at the optimal time and place may better inform lifestyle choices, promote preventive healthcare, improve interdisciplinary coordination of care, and enable more informed selection of health care providers and services

As mentioned earlier, many of the communications involve the use of language (either spoken or written). It is health workers’ capacity for these forms of language that distinguishes them from their audience. Indeed, it has been suggested that non-verbal elements account for over 80 per cent of the content or meaning that is conveyed in face-to-face interactions. In most situations, effective communication depends on the appropriate and simultaneous use of both verbal and non-verbal channels. This is so natural that, even on the telephone, people tend automatically to

use all sorts of gestures that cannot be seen by the person at the other end of the line (GTZ, 2006). It distinguishes between intrapersonal (i.e. within person) and interpersonal (i.e. between person) communication, with the former being used for such activities as reflection, problem solving and self-evaluation, whereas the latter involves interacting with others.

### **1.1.1 Maradi profile**

Maradi is the third largest city in Niger Republic and it is the commercial centre of the country. It is located in the South-Centre of Niger territory between the parallel 13° 16' 26" North and the Meridian 6° 16' East (DRP/PF/PE, 2009). It is limited in the East by Zinder region; in the West by Tahoua region; in the North by the regions of Agadez and Tahoua, in the South by the federal Republic of Nigeria. Maradi State has 41,796 square kilometers (about 3% of the national territory). The land square is divided into: agricultural zone (71, 5%), pastoral zone (25%) and forestry zone with 3, 5% (DRP/PF/PE, 2009).

### **Communication channels in Maradi State**

The Niger Republic press is governed by Ordinance No. 99-67 of 20<sup>th</sup> December 1999 (Illia, 2007). Maradi State has several communication channels. These are:

- **Printing papers**

There are 2 private French-language printing papers (Garkuwa and le Gardien). Both of them are fortnightly papers.

- **Public and private Televisions**

Four (4) private television channels and 1 public TV currently broadcast in Maradi State. These are: TV Ténére, TV Duniya, TV Canal 3, TV Niger 24 and the public television called “Tele Sahel”. With limited means of production, the private TV cover their schedules with shows imported, cheap and low quality which content is often not adapted to local realities.

## **Public and private Radios**

Radio stations broadcast their programmes in French as well as local languages, including Hausa. These private radio stations (Garkuwa FM, AMA FM, Anfani FM, Dunya FM, Saraounia FM and Tenere FM), generally are more critical of government actions than is the public radio (La Voix du Sahel). According to Marie (1996), “la Voix du Sahel “or the Voice of Sahel had a large coverage in the audio area in Maradi State.

## **Community radios**

Community radios have emerged in Maradi State in 2001. To date, 6 community radio stations are scattered throughout the State. These are: Radio Anur (Mayahi), Radio Ayiwa Kai (Gazaoua), Radio Tchinchia (Souloulou), Radio Gabi (Gabi), Radio Bermo (Bermo) and Radio Tessaoua (Tessaoua).

## **1.2 Statement of the Problem**

In the past 26 years, traditional family planning methods were used by minority of women in Maradi State. It was later, in August 1988 when Niger Family Health and Demography Project (NFHDP) started that modern family planning methods were introduced. Along the years, there has been an increase in the use of communication channels to spread health-related information such as family planning promotion.

However, such communication channels (leaflet, radio and television) are often used by health workers and other ‘non-official sources’ to disseminate family planning information and the reliability of some of those has been called into question. A variety of communication strategies has been implemented by health workers ranging from family planning promotion campaigns, traditional rulers, religious leaders, Information Education and Communication (IEC) leaflet,

radio and television and other communication channels to promote general awareness, to community mobilization activities and interpersonal communication.

Despite these, evidences emerging between 2005 and 2011 show a weak utilization of family planning in Maradi State. It was recorded 4% in 2005 at state level while in Maradi Metropolis it was 5% (Chaïbou, 2007). In 2011, family planning ratio in Maradi State recorded 6.75% whereas the expected national objective was 23% (DRSP/MI, 2011). With this, there seem to be a problem with the way family planning was being provided, hence, the need to identify and explain some of the possible causes of the problem. For example, people think that contraception pills give *Cancer* and practicing family planning is against their religion. Therefore, with the observed negative trend, there is need to assess the effectiveness of communication strategies used in promoting family planning in Maradi State.

### **1.3 Research Questions:**

The following research questions will be answered:

1. What are the communication strategies used by health workers to promote family planning in Maradi State?
2. How familiar are the people with the communication strategies and/or family planning products in Maradi State?
3. What are the challenges communicating with the people on family planning in Maradi State?
4. How do people perceive family planning communication messages delivered by health workers in Maradi State?

#### **1.4 Aim of the Study:**

The aim of this study is to assess the effectiveness of communication strategies for family planning promotion in Maradi State.

#### **1.5 Objectives**

To achieve the purpose of this study, the following research objectives are stated:

1. Identify the communication strategies used by health workers to promote family planning in Maradi State
2. Identify the people's familiarity with family planning communication strategies and product
3. Identify the challenges of communicating with people on family planning
4. Determine peoples' perception on family planning communication messages delivered by health workers in Maradi State.

#### **1.6 Significance**

Some works (Maman, 2004 and Souley, 2005 in Chaibou, 2007) have been done on family planning services and its challenges in Maradi State but they have been limited to adult women, married people in specific areas. However, none of these studies has focused specifically on the entire state and none focused on both sexes. This study is meant to help assess the communication strategies of contraceptive and family planning services need for couples (young and old) in Maradi State and their difficulties in communicating with family planning providers or services. The outcome of the study will enable people to identify services need them with respect to good family planning communication and services.

The study will also provide information on the level of awareness; utilization and difficulty that people may be having in accessing reproductive health services. It helps to assess the quality of communication strategies and information that people are having on contraceptives which often shape their attitude toward its use. The study helps to identify the need of Maradi people regarding their sexual health. The result of the study could also assist the Ministry of Public Health (MSP) and the Ministry of Population, Woman Promotion and Child Protection (MP/PF/PE) on how to structure policies and strategies on health programme for people. It will also help the Ministry of National Education (MEN) in developing an appropriate reproductive health/sex education curriculum for schools which can by extension, reduce unwanted pregnancy among school children and in the long term, prevent Vesico-Vaginal Fistula (VVF).

### **1.7 Scope of the Study**

This study was to be conducted in Maradi State of Niger Republic during three months (October, November and December 2012). It covered all the seven (7) local government areas including Maradi Metropolis. The target population of the survey was Women of Reproductive Age (WRAs) between 15-45 years old in Maradi State distributed into the seven areas, namely, Aguié, Dakoro, GuidanRoumji, Madarounfa, Maradi Metropolis, Mayahi and Tessaoua. The region is composed of seven Districts Health Centres (DHC), one regional hospital (based in Maradi Metropolis), 125 Integrated Health Centres (IHC) and 8 pharmacies (public and private). In addition, there are also many private clinics run by private physicians that provide family planning services in the region.

The target audiences in this study are individuals and groups at the state level, but it could also concern national or international level with whom the research is seeking to develop a synergy

and to share information on family planning promotion. Thus, the local communities, state agents, funding agencies, or researchers are all involved. Because each target group has specific characteristics and is faced with different problems or situations, a specific communication strategy is needed for each.

### **1.8 Operational Definition of Terms**

*Assessment:* It is the process of gathering and discussing information (on family planning) from multiple and diverse sources in order to develop a deep understanding of what people know, understand, and can do with their knowledge as a result of their educational experiences.

*Communication strategy:* In this study, communication strategies are the synchronization of communication actions, images and worlds to achieve a desired effect in promoting family planning in Maradi State

*Family planning:* Family planning means planning when and how many children to have and how to prevent unwanted pregnancy. It also means working out a plan with partner on how to deal with procreation within the context of a sexual relationship. For the purpose of this work, we define family planning as “having children that are planned for and not children conceived by accident”.

## CHAPTER TWO

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 2.1 Introduction

This literature review focused on communication strategies for promoting family planning in general, with particular interest in Maradi State of Niger Republic. In a comparative study on the media in Niger Republic and Nigeria, Salau (2011:334) observed that “In spite of the encouraging media scene and the seeming liberal regulatory environment, it is not all roses for especially, the press in Niger Republic”

Okigbo (2004: 5) traced the challenges of human communication by saying that: “Human beings so devoid of true emotions and so destitute of honest experiences communication in the most artificial manner”. Communication strategies (CS) have been at the forefront in family planning campaigns all over the world. Specifically, in Niger Republic from August 1988 to August 2012, WHO Communication strategies experts provided technical assistance to the Ministry of Public Health (MPH), Ministry of Population, Women Promotion and Child Protection (MP/PF/PE) and the Ministry of National Education (MEN) to develop a national communication campaign to promote family planning in the country.

The literature review included also a search for qualitative and quantitative peer-reviewed journal, articles, full research reports, summary reports, policy documents, guidelines, books and websites. These documents touched on a variety of communication issues, including: strategies for Prevention of Mother to Child Transmission (PMTCT) communication, a rights-based approach to family planning counseling, family-centered communication, mass media communication and the Family Planning Communication (FPC) policy to appropriate

stakeholders. Some studies have tried to identify reasons why certain countries in the world in general and in Niger Republic in particular underwent fertility decline whereas others did not. This review gives also an overview of religious' views in support for or against family planning with modern contraceptive.

## **2.2. An Overview of Family Planning**

Rhonda (2009) was of the view that: “the widespread adoption of family planning represents one of the most dramatic changes of the 20<sup>th</sup> century”. The growing use of contraceptives around the world has given couples the ability to choose the number and spacing of their children and has had tremendous life saving benefits. Yet, despite these impressive gains, contraceptive use is still low and the need for contraception high in some of the world’s poorest and most populous places.

The World Health Organization (2006), while tracing trend in poverty reduction noticed that “seemingly self-evident to many non-economists, is the idea that rapid growth in a population” (usually defined as an annual increase of 2% or more, equivalent to a doubling of population size every 36 years) “can only exacerbate the issue of poverty”, especially in countries where under employment is already high or where food security is a major concern (WHO, 2006).

Furthermore, in stagnant economies, the notion is undeniable that population growth inevitably boosts the number of poor people as has happened in sub-Saharan Africa where the estimated number of individuals living on less than a dollar a day rose from 164 million in 1981 to 316 million in 2001. Nevertheless, estimation of the effect of demographic factors on economic

welfare has proved elusive, partly because poverty reduction is also affected by many other powerful forces.

Paradoxically, during the heyday of international investment in family planning in the 1980s, the prevailing view on the demographic-economic relation among economists was cautious bordering on neutrality (WHO, 2006). Since that time, evidence has become more affirmative on the benefit of reductions in fertility and population growth. Elucidation of the link between household poverty and child bearing has also proved contentious. Existence of a strong correlation is not in doubt. Both ideas are profoundly mistaken. Family-planning promotion has succeeded in very poor countries and much of the fertility difference between rich and poor populations stems not from the application of reproductive choice but from the absence of such an option for the poor. Unmet need for contraception and unwanted child bearing are invariably higher for poor couples than for wealthy individuals, as will be shown later.

According to Greene (World Bank 2005), Niger Republic is one of the poorest and least literate countries in the world. It is also one of 12 nations whose population is expected to triple (or more) in size by 2050. Since the 1960s, the population of Niger Republic has already tripled, whereas its arable rain-fed land area has declined by half as a result of drought. The present situation is dire. In the 1990s, grain production was 15% lower than needed and in 2005 a famine was averted only by international food relief (World Bank, 2005).

The consequences of continued rapid population growth are potentially catastrophic. Prospects for future food sufficiency are especially bleak. It is on the record that the fertility rate in Niger Republic remains unchanged and is one of the highest in the world. Contraceptive use is very

low and is predominantly for spacing children rather than limiting family size. Only 17% of women in Niger Republic have an unmet need for family planning and, of these, 56% do not intend to use modern contraception in the future. Child mortality remains very high with more than a quarter of children dying by age 5 years (World Bank, 2005). In addition, women aged 30–39 years, on average, have more than four surviving children but over 90% with four children want more.

### **2.2.1. Health Benefits of Family Planning**

By contrast with the complicated links between fertility, population growth and poverty, the benefits of family planning for the survival and mothers and children's health are fairly straightforward (WHO, 2006). In 2000, about 90% of global abortion-related and 20% of obstetric-related mortality and morbidity could have been averted by use of effective contraception by women wishing to postpone or cease further childbearing. A total of 150 000 maternal deaths (representing 32% of all such deaths) could have been prevented with high cost-effectiveness, with much of this benefit reaped in Africa and Asia.

World Bank (2010) posits that family planning also brings large potential health and survival benefits for children, mainly as a result of wider intervals between births. Findings of studies in both rich and poor countries show that conceptions taking place within 18 months of a previous live birth are at greater risk of fetal death, low birth weight, prematurity, and being of small size for gestational age. The mechanisms underlying this association are thought to include postpartum nutritional depletion, especially folate deficiency. Examination of the association between birth interval length and infant and child mortality in developing countries has been dominated by two major sources of evidence: cross-sectional surveys undertaken under the auspices of the Demographic and Health Surveys (DHS).

A conservative view of this evidence suggests that about 1 million of the 11 million deaths per year of children younger than 5 years could be averted by elimination of inter birth intervals of less than 2 years. Effective use of postpartum (and post abortion) family planning is the most obvious way in which progress towards this ideal could be achieved. Family planning is one of the most cost-effective ways of reducing infant and child mortality and this contribution has been overlooked too often on this topic.

### **2.2.2. Family Planning Policies and Programmes**

One study compares Kenya, where total fertility fell about 40 percent between 1980 and 2000, with neighbouring Uganda, where fertility declined by 10 percent. It finds that both economic development and a strong national family planning programmes were associated with lower fertility in Kenya (Blacker, 2005).

Also, a comparative analysis of Zimbabwe, where the fertility rate fell more rapidly than in Zambia, reveals that a strong family planning programme in Zimbabwe backed by high level political commitment and institutional and financial stability were key ingredients of success (Lee, 1998). Emerging evidence from Rwanda suggests that major strides in improving family planning uptake can be made if political commitment exists. African governments were reluctant to institute effective family planning programmes; political support for family planning in the public sector was weak throughout the continent. Africa has lagged other regions on fertility decline because family planning programmes were introduced relatively late in the continent (it was introduced in Niger republic in 1988). Family planning programmes in Africa are not as strong or as old as those in other parts of the world, but as the experience of many African countries reveals, if strong and high-quality family planning programmes are developed, people will use them and fertility will decline (Mbacke 1994).

Relatively better progress on family planning indicators in Eastern Africa compared to Western Africa has been attributed to stronger family planning efforts that ensured wider availability of modern contraceptive methods (Cleland, Ndugwa, and Zulu 2011). Family planning utilization in Niger Republic is weak as well as programmes in African region have been weak overall, but some encouraging progress in programme implementation began to emerge many years back. For instance, a study on family planning programme effort finds that the greatest improvement among all regions of the world between 1982 and 1989 occurred in Sub-Saharan Africa, where there was a sharp increase in family planning programme effort indicators, albeit from a low base (Mauldin and Ross 1991). Policy-level support in countries in which strong commitments existed translated into successful national family planning programmes.

A few countries have tried community-based distribution of contraceptives to extend family planning to hard to-reach populations, particularly in rural areas. Community depots, mobile clinics, women's groups, and both paid and volunteer village health workers are some modes of service delivery used by such programmes. Countries such as Ghana, Kenya, Nigeria, and Zimbabwe have implemented large community-based distribution programmes at the national level. Although conclusive evidence on the effectiveness of such programmes is not available, these programmes provide good examples of successful bottom-up approaches that have been applied in the region (Phillips, Greene, and Jackson 1999).

### **2.2.3. Factors Influencing Family Planning Communication in Maradi State**

According to the National Demographic and Health Survey in Niger, Maradi State is the most populous state in Niger Republic (INS, 2012). Contraception is mainly addressed in this state in the context of marriage and family in Islam. So, as a social system, culture and civilization, Islam

considers the family the basic unit of the society. The Quran (Islam's holy book) is their primary source of Islamic law or *Shariah*. Therefore, any important purpose of family life derives from the holy book. From the Islamic point of view, when procreation takes place, it should support and endorse tranquility rather than disrupt it. This view (Islam and family planning), written by late Abdel Rahim (Abdel-Rahim, 2000) gives an overview of Muslim countries' policies on and support for family planning and modern contraception. It reviews Islamic jurisprudence and justifications for sanctioning family planning, drawing from family planning in the legacy of Islam.

However there are some justifications for contraception in Islam which states that for Muslims, *Shariah* is the "Divine Law"; by virtue of its acceptance, a person becomes a Muslim, although he or she may not be able to realize all of its teachings or follow all of its commands. For believers, *Shariah* is the guide of human action that encompasses every facet of human life. Thus, Islam is a religion that provides guidance for worship as well as a social system for Muslims' public and private lives. Some Muslims question the economic justification for family planning on the grounds that it contradicts the Islamic beliefs of *tawakkul* (reliance on God) and *rizq* (provision by God). Regarding the health justification of family planning, Abdel Rahim (2000), wrote: "Warding off the risks posed to the health of mothers and children by additional pregnancies is the most common reason for accepting contraception in Islamic jurisprudence".

Identifying the opposition to family planning, a number of non users oppose family planning and contraceptive use generally on two grounds. Firstly, they believe that withdrawal or any practice that prevents pregnancy is infanticide, which is repeatedly condemned and prohibited in the

Quran. Secondly, the opponents of family planning, believe that the larger the number of Muslims and the higher their population growth rate, the greater their power will increase.

#### **2.2.4 Role of Islamic leaders as sources of information on family planning**

Maradi State is the most populous in term of population and 99% are Muslims (Kourgueni, /2013). So, Islamic leaders can play an important role in promoting family planning in the state because, Islam per se, is not incompatible with family planning. In this community, many people, both men and women are aware of Islamic verses on lactational amenorrhea, about which the **Qur'an** says: *“And mothers shall suckle their children two full years for those who wish to complete breast-feeding.”* (al-Baqara-Sura 2: 233)

These Islamic leaders must explain to their followers or members that the use of contraception is accepted for spacing of pregnancies, but not for planning the number of pregnancies and children. This is a common idea among men and women, many of whom regard children as gifts of God. In the present context, *“Malam”* may be the unique person who can convince people to accept modern contraception.

#### **2.2.5. Advocacy and Communication for Behaviour and Social Change**

This section reviews and elucidates the role of advocacy and communication for behaviour and social change in family planning.

##### **2.2.5.1 Advocacy for Family Planning Promotion**

Quite a number of scholars concur that advocacy is very important within the field of health communication as it is a prerequisite or component of most behaviour change effect (Karl. and Alkalay 2001). Whenever change need to occur, advocacy has a responsibility there. More so, if health communication is recognized as “a multi faceted approach to reach different audiences

and share health- related information (Schiavo, 2007), then advocacy is definitely one of the approaches of health communication as it provides support, influence public opinion, and bring issues up to decision making level (Pervanta, 2011). Sharma recognizes advocacy as speaking up, drawing a community's attention to an important issue, and directing decision makers towards a solution. To him, advocacy is all about pleading for, defending or recommending an idea before other people.

#### **2.2.5.2 Advocacy for Change:**

Successful Information-Education and Communication (IEC) combines activities targeted at changing behaviour with advocacy to change attitude and the social environment, for example, seeking the support of community and opinion leaders for changing the social factors that contribute to problems or prevent people changing to more healthy behavior. IEC is more likely to achieve its objectives if the target audience participates in planning, implementing, monitoring and evaluating activities, and as a result, more culturally sensitive and appropriate approaches are used. A participatory approach should be used in the design and development of messages and in the choice of media. The wider the range of approaches used, the greater the chances of reaching the broadest range of people, for example, using radio, printed materials and drama makes it possible to reach urban and rural, and literate and less literate audiences, Mass media can be useful in raising public awareness but less useful in changing public behavior.

Guy(WHO, 2008)states that,for an effective advocacy campaign, evidence should be used in support of making arguments. For instance, advocacy that uses health economics data looks beyond the impact of health conditions alone (burden of disease data) to the impact on educational development, economic output, national development and even human rights.

Through multiple regression analysis – among other tools – it is possible to identify causal links between a problem and its social impact. To Guy, the data on economic and social impact due to a disease could be used to develop a basic document such as a comprehensive situational analysis report that addresses the above mentioned questions related to the issue. From this report, depending on the audience for the advocacy strategy (community members, local leaders, regional leaders, and national policy makers) the information that directly relates to the situation should be used. Also, the document is useful in producing informational material such as pamphlets, press releases, TV or radio spots or even documentaries.

In general, advocacy can be differentiated based on audiences and approaches into:

- Policy advocacy: Uses data and approaches to advocate to senior politicians and administrators about the impact of the issue at the national level, and the need for action.
- Programme advocacy: Used at the local, community level to convince opinion leaders about the need for local action. For instance, in the case of mobilizing religious leaders in communities for family planning, or in the case of religious leaders interpreting faith-based texts in the light of children and women's rights.
- Multi-channel Advocacy: Media advocacy: Conducting workshops for Journalists Association to advocate for greater understanding and instilling a sense of urgency among the journalists

### **2.2.5.3 Communication for Social and Behavioural Change (CSBC)**

Depending on the programming context, CSBC can begin at different levels. Within the new development paradigm, the discourse of “behaviour change” is linked to “social change”. While behaviour change implies individual level change; social change seeks to create an enabling and

favourable environment for change (Arvind, 2005). Yet a more detailed definition of social change within and among international development agencies is still being debated. The following definition of social change is offered to stimulate thinking and debate within UNICEF and among partner organizations (UNICEF, 2005).

### **Behaviour Development and Social Change**

Behaviour development and social change draws the concept of positive deviance which demonstrates how positive behaviour by a few individuals in the community who do things differently than others can eventually lead to far-reaching changes within the community.

Jerry (2005) observes that:

The positive deviance inquiry capitalizes on existing local knowledge and builds on it to tackle health and development problems. Positive deviance principles have been implemented in Africa to reduce incidence of the traditional practice of female genital mutilation. Similarly, within the context of HIV prevention among young people, youth who practice abstinence or monogamy despite peer pressure, are used as positive deviants to influence their community of peers.

As the positive deviant behaviour is practiced by families that share a similar cultural background with others in the community, it makes the adoption of these behaviours relatively easier. Communication is also more effective when using local idioms that are more culturally proximate to the audience to acquire an effective behaviour change; the people's cultural background should be taken into consideration.

President Museveni of Uganda demonstrates it through the story of a village mobilizing its people to act against AIDS by using the parable of "shouting loudly when a lion comes to a village" (UNICEF, 2005). When leading his country's national response, he noted the following

while addressing his fellow African heads of state:

“When the lion comes to your village you don’t make a small shout. You make a very large shout. And you shout and shout and shout and shout. Further, the village chief [implying the top political, civic, and religious leaders] has the responsibility to shout the loudest. So when I learned about the impact of HIV on my country, as the head of state, it became my responsibility to shout the loudest”.

## **Entertainment-Education**

Some scholars call it (Entertainment-Education)“the Viagra of communication for Behavioural and Social Change”(BSC). It is a planned entertainment education (EE) initiative which diffuses information on family planning techniques to couples and especially women. However, the widespread interest in the use of EE in family planning promotion:

- Plays a critical role as the frontline community health volunteer, along with the community mobilization and participation;
- Involves community leaders, CBOs and local government institutions
- Collaboration with workers from programmes such as micro-credit and education
- Rewards volunteers for their efforts by providing access to a revolving fund for treatment and public recognition of volunteers served as a significant incentive
- .Underscores the multi-layered communication strategy by a strong community mobilization initiative focusing on the hard-to-reach low-performing areas.

## **2.3. Health Communication Strategies**

### **2.3.1. Role of Communication in Family Planning Promotion**

Today, models of information transmission and persuasion tend to dominate the design of strategic communication in the field of health. Communication from this perspective can involve

delivering a predetermined message to a particular group of individuals in an attempt to persuade them to behave in a desired way.

John Hopkins University (2009) uses a strategic communication approach that combines different modes (for instance, mass media, community messaging, interpersonal communication and advocacy) to bring about behavioral and social change. A strategic approach recognizes that in order to influence change, communication needs to operate at multiple levels: societal, community, social network and individual. To this end, John Hopkins University (JHU) adopts a conceptual framework based on the social ecology model. As noted in the John Hopkins University (2008–2009) strategic plan for Programme in South Africa:

Change at one level may be facilitated or obstructed by another level. For example, a woman may choose to make use of prevention-of-mother-to-child-transmission services such as formula feeding. However, this may be impacted upon if her partner is aware and supportive of her status and thereby enables the use of formula feed, or where formula feeding may be culturally regarded as not being appropriate this may also impede usage.

This approach is also criticized for promoting a paternalistic view of development. For example, such approaches implicitly assume that the knowledge of the organization/agency/ government developing the message is always right, while those receiving the message are assumed to be ignorant. What is needed in the context of family planning is an approach to communication that takes seriously the social context in which people negotiate their lives and that recognizes the need for long-term and sustained efforts that engage local communities in the development of contextually relevant and appropriate responses. Such an approach promotes collective discussion and debate in addition to individual reflection and self-awareness and simultaneously attempts to address social, cultural, economic and political factors.

### **2.3.2. Health Communication and Family Planning initiatives in Niger Republic**

National family planning using Information, Education, and Communication (IEC) campaigns were introduced in Niger republic in 1988 (Baron, 1989). The emphasis of the family planning programme in its first aspect was on clinic and field-based counseling training. A large number of trainers were trained in contraceptive methods and employed part-time to provide family planning methods to village households. These trainers were not trained in communication and in how to motivate clients to adopt contraception.

Lonna (1994) confirmed this statement by saying that:

Health workers had not been trained in interpersonal communication and did not know how to communicate information to mothers. In focus groups, mothers said that negative behavior of health workers in other health services, particularly maternity services, was a major barrier to their seeking health services of any kind, including children's vaccinations, family planning...

Specific training in Information, Education, and Communication (IEC) consisted in training of a few selected workers outside the country. An IEC curriculum has been developed which was used in Dosso State of Niger Republic. Due to the fact that the training in Dosso was given simultaneously with family planning evaluation, it was not possible to review the curriculum. This is because, it was too early to evaluate what additional training in Information, Education, and Communication is needed, since, so few have been trained in IEC. In addition, the state family planning programmes included some training in IEC, focused on giving counseling and small group talks. It should be noted that in order to provide effective IEC to the entire population, it is necessary to train both male and female personnel specifically in that area.

According to Nouhou (2011), in 2007, in Niger Republic, a national strategic plan for IEC was implemented from 2007-2010 where a multi-media communication campaign was implemented.

This campaign used media materials (radio, television, films, billboards, posters, and leaflets) and interpersonal communication interventions (motivational meetings and folk song programmes) to increase awareness and knowledge about family planning for couples in urban and rural areas, trade union council chairmen, teachers, and religious leaders.

The Ministry of social welfare, education, agriculture and Labor supported the population policy programme with several non-governmental organizations (NGOs). During 2012, the focus of the population programme was on improving awareness about family planning methods and moving the population toward positive attitudes about family planning. It also promoted adoption of contraceptive methods through community radio. Family planning field workers were trained in interpersonal communication. Project cycles and the inevitable changes in staff and leadership within Health staff of Niger Republic include the creation of continuity challenges in shifting paradigms that require longer term horizons and planning. Some leaders had meanwhile begun to take the first steps to promote education about contraception and even early family planning services. With the plan in hand and its objectives clarified, the machinery of the new programme had to be set up. It needed to provide good information and services to the entire population.

### **2.3.3. Health Communication and Mass Media**

However, health communication may also occur in other settings. It is often necessary to impart information to the wider public in order to reach mass audiences, such as in public health campaign, as well as health campaigns which require different communication skills and strategies, health communication does not always involve sharing information with others, however, it can involve communication that takes place solely within a person, through the use of processes such as reflection. Thus, in many everyday situations, we need to solve problems by

thinking through alternative courses of action, or we need to monitor the results of our interactions with others.

Broadcasting has come to mean the communication of news, instruction and entertainment by radio or television. Oral skills, both speaking and listening, are at the very foundation of literacy. According to Oladeji (2008), communication and decision making play a vital role in ensuring informed choice of family planning and reproductive health behaviour. It was for Rimal (2002), to conclude that effective communication and decision making allows people to seek what is best for their own health and to exercise their right to good quality health care.

In Niger Republic's urban areas, the mass media, especially radio and television have been quite effective in creating family planning awareness. Perhaps, this could be related to the fact that urban dwellers have greater access to the mass media. A survey conducted in a neighbouring country (Nigeria) in 1996 on predominant urban areas, about 90% of all urban house-holds have radio sets and about 60% own television sets (IEC, July 1996) and the likelihood that people living in urban areas would readily have access to family planning information as purveyed through radio and television media is high.

Narzary (2009), while examining the knowledge and practice of family planning methods among the Currently Married Adolescent Women (CMAW) in India, observed that exposure to mass media play a significant role in family planning matters. Similarly, Obaid (2006) and Abd El-Aziz (2006) have also identified radio and television media as effective instruments in family planning education in Jordan and Egypt respectively. Attitude formation and attitude modification precede behavioral change or modification for the achievement of the desired goals. For a modification of attitude and behavior, an effective communication must be presented and

articulated before there can be any useful mobilization. However, when communicating with the rural people, the problem of the appropriate medium to be used arises.

In some of the above studies, attitudes and methods towards family planning are some of the factors that affect family planning achievement but how these factors affect achievement has not been fully explained. The literature reviewed so far, has not given some insights into the effects of communication channels and this is some implication of the present study. Nomaou, Johoa and Dangana (in EDSN-MICS IV2012) discovered that: in Maradi State 7.3% watch TV once a week while 42.2% listen to radio once a week too. These were respectively 9.8% and 48.1% among men. Their data is different from the aim of this study which is an assessment of communication strategies to promoting family planning in Niger Republic with Maradi in particular.

## **2.4. Theoretical Framework**

This section examines the theoretical framework upon which this study is located. The Health Belief Model (HBM) has been embraced for this study because it is becoming a prolific framework for explaining and predicting preventive health care. That is why many scholars argue that: “we cannot emphasize on communication strategies without bringing out related theories” (Rimer, 2005). This section introduces the HBM and reviews its origin, perspectives and contribution to communications research. Hence, the importance of selecting appropriate theories to develop correct strategies

### **2.4.1 Health Belief Model (HBM):**

#### **2.4.1.1 The origins of HBM**

The frustration as to why the public was not responding to federal government (United States of America) offerings of free health prevention programmes in the 1950s sparked the research of three psychologists, Irwin Rosenstock, Godfrey Hochbaum and Stephen Kegels (Burns, 1992; Mikhail, 1981). As Hochbaum (1958) stated, “Although the public stands to gain most from the success of health programmes, its willingness to participate has all too often been disappointing, in spite of well-organized attempts to arouse popular interest and to make participation easy” (Hochbaum, 1958:1). HBM was developed as a result of their (Rosenstock, Hochbaum and Kegels) endeavor to resolve this. This assistance and subsequent research was funded by the U.S. Public Health Service in response to epidemics of tuberculosis and polio (Hochbaum, 1958; Rosenstock, Derry berry, & Carriger, 1959).

The Health Belief Model was one of the first theories of health behavior and remains one of the most widely recognized in the field. The pioneers theorized that people’s beliefs about whether or not they were susceptible to disease, and their perceptions of the benefits of trying to avoid it, influenced their readiness to act. In ensuing years, researchers expanded upon this theory, eventually concluding that six main constructs influence people’s decisions about whether to take action to prevent screenfor, and control illness. They argued that people are ready to act if they:

- Believe they are susceptible to the condition (perceived susceptibility)
- Believe the condition has serious consequences (perceived severity)
- Believe taking action would reduce their susceptibility to the condition or its severity (perceived benefits)
- Believe cost of taking action (perceived barriers) are outweighed by the benefits

- Are exposed to factors that prompt action (e.g., a television ad or a reminder from one's physician to get a mammogram) (cue to action)
- Are confident in their ability to successfully perform an action (self-efficacy)

Since health motivation is its central focus, the HBM is a good fit for addressing problem behaviours that evoke health concerns (e.g., high-risk sexual behaviour and the possibility of contracting HIV). Together, the six constructs of the HBM provide a useful framework for designing both short-term and long-term behaviour change strategies. When applying the HBM to planning health programmes especially family planning, practitioners should ground their efforts in an understanding of how susceptible the target population feels to family planning problem, whether they believe it is serious, and whether they believe action can reduce the threat at an acceptable cost. Attempting to effect changes in these factors is rarely as simple as it may appear.

#### **2.4.1.2 The relevance of HBM to the study:**

The advantage of HBM is that it can be used for print materials, reminder letters or pill calendars to encourage people to consistently follow their health workers' recommendations (cues to action). Its successes can make behaviour change at many levels (Individual, family and groups). The value of the HBM to communication scholars is its ability to operationalize research. It offers a framework to conceptualize and measure variables. The measured HBM factors are then able to determine the effectiveness of health messages especially in family planning. For example, did the message increase or decrease perceived susceptibility? If increase is shown, individuals will more likely be motivated to change health behaviour. The HBM theory is appropriate, because such is the case with determining the health beliefs of an audience following a health related programme.

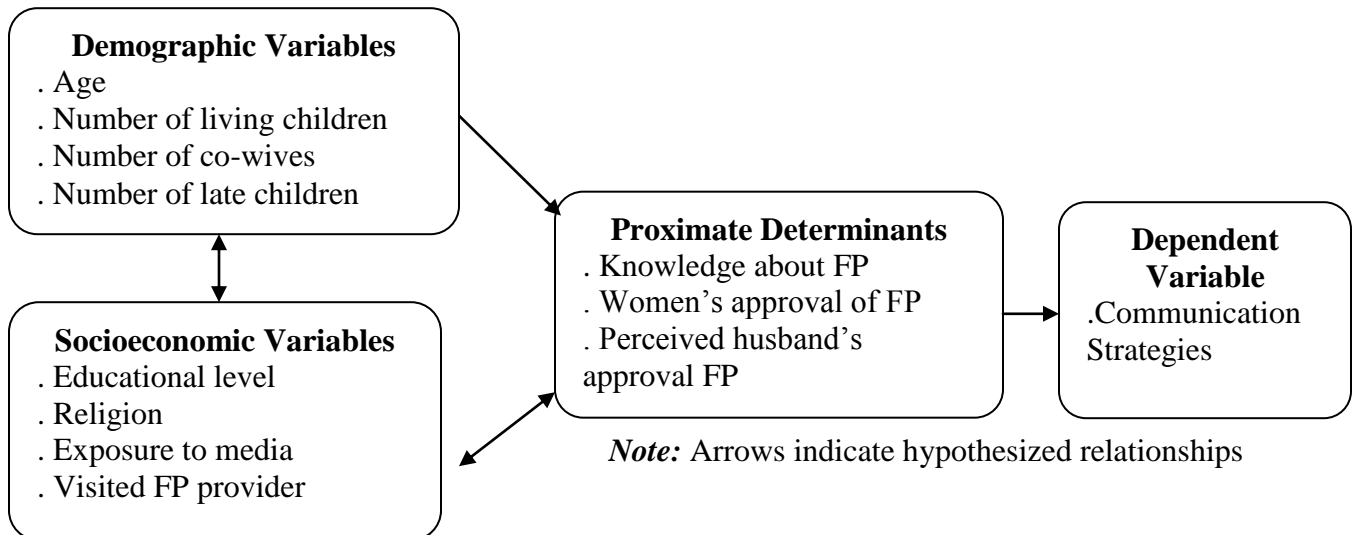
#### **2.4.1.3 Criticism of Health Belief Model**

The Health Belief Model is not in itself clearly or adequately specified, and the available evidence indicates that in practice its application appears to be inadequate for such purposes. Further, although the HBM may be used to derive information that may then prompt interventions designed to change health beliefs and behaviours, using the model itself cannot inform decision making as to how such interventions might best be structured. The HBM is characterized by a lack of adequate combinatorial rules and inconsistent application according to Yarbrough and Braden (NICE, 2007). Its main components have weak effect sizes, and its predictive capacity is limited as compared to that of other social cognition models (Harrison 1992 in NICE 2007, Zimmerman and Vernberg (NICE, 2007)

The task of HBM theory in the study is to understand health behaviour and to transform knowledge about behaviour and believes into effective communication strategies for family planning enhancement (Rosenstock, 1990). Research in health education and health behaviour ultimately will be judged by its contributions to improve the health of the people in Maradi State

#### 2.4.1.4 Conceptual framework

Independent variable (Family Planning)



## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Introduction

Given the nature of the study, it is appropriate to use a research method that assures more access to health workers and people in Maradi State. For this reason, *Triangulation* was used as a mixed method. Survey, Focus Group Discussion (FGD) and In-depth interview were considered the most appropriate approaches to execute this study. Patton (2001:247) advocates the use of triangulation by stating that “triangulation strengthens a study by combining methods”. This can mean using several kinds of methods or data, including using both quantitative and qualitative approaches.

- **The survey:**

For this study, the research assistants were divided into three teams, each consisting of two interviewers and one supervisor. Two teams were assigned to cover three district health centres each and the third team covered the remaining one. The members stayed in the field during the whole duration of the survey. The supervisors coordinated and monitored fieldwork and gave report directly to the researcher in charge of data collection.

- **Focus Group Discussion (FGD):**

The FGDs for this study were conducted for two purposes:

- To find out how certain message concepts are perceived or understood by the prospective respondents of the study;
- To generate additional and more detailed information that could enrich, validate, or clarify survey findings, particularly on the impact of family planning on the lives of women.

One round of FGDs was conducted after the survey. One Pre-survey FGDs were conducted to establish realistic and objective measures of psycho-social indicators, like "quality family planning messages," "self-esteem" and "health workers-image." It covered two categories of women (women who have had more than 10 children and women who have 3 or less children). The results were used as bases for operationally defining the psychosocial variables and in the formulation of the survey instruments. On the other hand, the post-survey FGD was used to generate perceptions and views of other women (non respondents, members of women's groups, etc.), men (husbands of women of reproductive age), and FP service providers on the effect of family planning on the lives of women they know.

The FGD results were expected to shed light on the variations of the women's family planning experiences and responses to these, with respect to residence (rural-urban); education (educated-uneducated); employment status (employed-unemployed) and other relevant factors. Trained facilitators conducted the FGD after being trained on how to open, moderate, probe, and facilitate group interaction. FGD simulations were conducted to provide facilitators practice before actual fieldwork. Each FGD group had at least eight to ten participants who sat in circular fashion to facilitate group interaction. The discussion started with an explanation of the objective of the FGD by the facilitators, who encouraged the participants to express their views openly and freely to comment and/or ask questions on the subject being discussed. A note taker and a tape recorder were used to document the FGD proceedings.

- **In-depth interviews:**

The in-depth interviews were conducted after the survey. The women's groups and NGOs represented in the in-depth interviews, concerned women operating in the urban areas and

involved in family planning or any reproductive health initiatives. The male key informants in each district health centre were husbands of family planning users and husband of a non-user who agreed to share their ideas.

## **3.2 Research Design**

### **3.2.1 Survey**

Survey design was used in this study. In addition, qualitative approaches, particularly, key informant interviews and focus group discussion have been used, both to supplement and complement the survey findings. The survey involved face-to-face interview with respondents randomly selected among Women of Reproductive Ages (WRAs) in 7 Local Government Areas (LGA), whose age ranged from 15-45 years (less than 15 if married). Key informant interviews and focus group discussions were conducted to generate qualitative information expected to aid and also to validate and further enrich the survey findings.

### **3.3 Population**

The target population of the survey were women of reproductive age (15-45 years old) in Maradi State distributed in the seven LGAs including Maradi Metropolis: (Aguie, Dakoro, GuidanRoumji, Madarounfa, Maradi metropolis, Mayahi and Tessaoua).

### **3.4 Sampling Technique:**

In this study, multistage sampling technique was used. According to Corlien and Indra (2000), in a very large and diverse population, sampling may be done in two or more stages. This is often the case of community based-studies in which people to be interviewed are from different

villages and the villages have to be chosen from different areas. The areas were stratified into seven groups, based on their population size and/or number of health centres.

From each district health centre, samples of integrated health centres were randomly picked to represent the stratum. Group I Aguié LGA; Group II consisted Dakoro LGA; Group III GuidanRoumji; Group IV Madarounfa LGA; Group V Maradi Metropolis; Group VI Mayahi LGA and Group VII concerned Tessaoua LGA.

Data from DRSP/MI (2011), estimates that the number of WRAs constitutes approximately 21.25% of the total population. With reference to the 2011 population (3,117,810) of the state, the total number of WRAs was estimated to be about:

$$\frac{3,117,810 \times 21.25017}{100} = 662,540$$

So, our study population was 662,540 women of procreative ages

### 3.5 Sample Size

The sampling procedures followed are described by the formula used by Parel, (1985) in Fely, 1998.

$$n = Z^2 \frac{(pq)}{e^2}$$

Where:

**n** = sample size

**Z** = the Z-value at the 95 percent confidence level adopted (1.96)

**p** = the proportion of the population who are FP users (6.75%)

**q** = (1-p)

**e** = the tolerable/missible sampling error for the confidence level adopted (2%)

Therefore:

$$n = (1.96 \times 1.96) \frac{0.0675 (1 - 0.0675)}{(0.02 \times 0.02)} = 604.51$$

A sample size of **605** respondents for the whole region was obtained. The sample size of each LGAs or district health centres was obtained proportionally according to their estimated number of women of reproductive ages (WRAs).

The following table 3.1 shows the distribution by district health centers.

**Table 3.1:** Sample size of estimated WRAS by District Health Centres in Maradi state

S/N	District Health Centres	Estimated N. of WRAs (m)	Sample Size (n)
1	AGUIE	84,368	77
2	DAKORO	121,267	110
3	GUIDAN ROUMJI	105,712	97
4	MADAROUNFA	87,366	80
5	MARADI METROPOLIS	49,960	46
6	MAYAHI	118,091	108
7	TESSAOUA	95,776	87
<b>TOTAL</b>	<b>7</b>	<b>(z) 662,540</b>	<b>(y) 605</b>

It was very difficult or impossible in this study to take a simple random sample of villages because of logistical difficulties and where people are scattered over large geographical areas. So, cluster sampling was used to determine the villages to be used in the study. Simple random was used to determine the IHC. Therefore, 31 out of 125 IHC (or 25%) were covered in the survey; the study proceeded as follows in table 3.2

**Table 3.2:** Sample size of the estimated WRAs by Integrated Health Centres

S/N	DISTRICTS HEALTH.C	I.H.C	Estimated N. of WRAs (m)	Sample Size
1	AGUIE (4)	CSI AGUIÉ	12 803	32
		CSI DEBI	2 916	07
		CSI GAZAOUA	6 809	17
		CSI TCHADOUA	8 110	21
		<b>S/TOTAL 1</b>	<b>30 638</b>	<b>77</b>
2	DAKORO (5)	CSI AJEKORIA	10 903	25
		CSI DAKORO	12 399	28
		CSI KORNAKA	6 769	15
		CSI SABON MACHI	8 833	20
		CSI MAIYARA	9 790	22
		<b>S/TOTAL 2</b>	<b>48 694</b>	<b>110</b>
3	GUIDAN ROUMJI (4)	CSI TCHADAKORI	9 730	21
		CSI EL KOLTA	4 096	09
		CSI G/ROUMDJI	13 709	30
		CSI TIBIRI	17 093	37
		<b>S/TOTAL 3</b>	<b>44 628</b>	<b>97</b>
4	MADAROUNFA (5)	CSI DAN ISSA	13 461	31
		CSI DANJA	1 449	03
		CSI DJIRATAWA	4 490	10
		CSI MADAROUNFA	6 425	15
		CSI SAFO	8 875	21
		<b>S/TOTAL 4</b>	<b>34 700</b>	<b>80</b>
5	C. U/MARADI (2)	CSI 17 PORTES	11 439	25
		CSI PLACE DU CHEF	9 539	21
		<b>S/TOTAL 5</b>	<b>20 978</b>	<b>46</b>
		CSI GUIDAN TAWAYE	2 689	08
		CSI JAN TOUDOU	3 718	12
6	MAYAHY (6)	CSI KANEMBAKACHE	8 169	25
		CSI KORE HABJIA	4 223	13
		CSI MAYAHI	9 956	31
		CSI SARKIN HAUSA	6 219	19
		<b>S/TOTAL 6</b>	<b>34 974</b>	<b>108</b>
		CSI BAOUDETA	5 696	14
7	TESSAOUA (5)	CSI GUIDAN ZIGAO	2 663	06
		CSI GUINDAWA	14 677	36
		CSI KOONA	4 686	11
		CSI MAÏJIRGUI	8 176	20
		<b>S/TOTAL 7</b>	<b>35 898</b>	<b>87</b>
<b>TOTAL</b>		<b>31</b>	<b>243 738</b>	<b>605</b>

### 3.6 Method of Data Collection

#### *Drawing of survey sample*

- The first stage of sampling involved the selection of district health centres (DHC). The seven DHCs constituted our seven LGAs in which the study was conducted. From each DHC, a sample of Integrated Health Centers (IHC) was drawn using simple random sampling.
- Stage two involved the drawing of sample villages. From each sample IHC, two sample villages were selected through “cluster sampling” because of logistical difficulties (people are scattered over a large area). Therefore, the villages were stratified into geographical classifications, namely; urban and rural. In MaradiMetropolis, instead of village sample, we had samples of quarters.
- In stage three, the sample of respondents was selected through random sampling. The sample of WRAs was drawn in the final stage. The required sample size for each IHC was proportionally allocated to the sample of DHC and the DHC sample proportionately allocated according to the sample size of the entire study population which constitutes 605.

The following procedure was performed in selecting the respondents:

- In each sample village, a number of respondents were selected;
- Then, we went to the center of the village;
- Chose a direction in a random way,
- Walked in the chosen direction and selected every third or fourth compound depending on the size of the village until had the number required was obtained. When boundary of the village was reached and the number was not obtained, the researcher returned to the centre of the village again, walk in the opposite direction and continue to select the sample in the same way until got the exact number needed was obtained. When there was nobody in a chosen household, the next nearest one was chosen.

***Selection of focus group discussion participants:***

The FGD participants were purposively selected. Nine sessions were organized after the questionnaire administration, one in each sample DHC and two in two selected integrated health rural health centres. It regrouped women's groups in NGOs, non-respondent women and men. Eight to ten participants per FGD were predetermined and invited to attend the group discussion.

***Selection of key informants for in-depth interview:***

The key informants for the in-depth interviews were purposively selected from FP service providers (both private and public), members of women's groups and members of non-government organizations (NGO), traditional rulers and religious leaders involved in family planning and reproductive health initiatives, and some husbands of FP users as well as those of non-FP users. The FP service providers that were selected had provided family planning services in the last six months prior to the survey. Services include counseling, provision or distribution of family planning supplies, motivation and/or referral of WRAs, insertion of IUD, administration of injection, or ligation.

**3.7 Instruments of Data Collection:**

A structured questionnaire was used in the survey of WRAs. The survey questionnaire consisted of two general parts: the bio-data and the second based on the core issues of the study. The preparation of the questions was guided by the study objectives, operationalized variables and identified indicators. Since interviews were done in the dialect of the respondents, the survey instruments first were formulated in English and then translated to French by the researcher. After that, a two-way translation was conducted. A native speaker (who speaks Hausa and French) translated the original French version to Hausa; then back-translated the dialect version

to French. The original and the translated English version were compared and doubtful and ambiguous items were revised.

### **3.8 Validity and Reliability**

#### **3.8.1 Validity:**

For validation purposes, the survey questionnaire was referred to other specialists in public health (especially family planning, gender and reproductive health) and social science researchers. It was also presented for review and approval by the supervisors. The instruments were then field-tested (pilot) on 20 WRAs who were not part of the study sample. Questions consistently skipped or not completely answered in the pre-test were improved upon.

#### **3.8.2 Reliability:**

For quality control, the following activities/strategies were undertaken to ensure data quality:

- Training of interviewers,
- Preparation and use of instruction sheet for the interview,
- Close supervision and monitoring of data collection.

One unique component of the data collection phase of this study was the dissemination of referral information to all the study respondents. This information contained a number of organizations/offices/agencies where the respondents could go for help, especially for problems involving family planning.

#### ***Recruitment of interviewers:***

Interviewers were recruited based on certain criteria, such as:

- a) Junior Secondary School (JSS3) Certificate,

- b) Health research background (but not compulsory), and
- c) Fluency in the dialect of the respondents (at least speaks French and Hausa language).

### **3.9 Method of Data Analysis:**

The quantitative data was computer-processed using the *Epi-info 3.5.1* software. A coding sheet was prepared to guide data processing. Completed in-depth interviews and FGD documents--tape recorded FGD proceedings and documenters' notes were transcribed, summarized and categorized. Categories of responses of the FGD participants' views and perceptions were also prepared based on commonality/variations of content. Data analysis involved descriptive association. To describe the respondents' general characteristics, such as their socio-demographic characteristics, family planning practices, family planning experience and their perceptions regarding the economic, social and psychological consequences of family planning on their lives, percentage distributions were used together with an appropriate measure of central tendency depending on the level of measurement of the statistical variable.

Appropriate tests for association were used to ascertain if family planning practice, methods used, quality of family planning services received and selected antecedent variables, such as education of the women. The qualitative data generated through in-depth interviews and FGDs were summarized and analyzed in relation to the survey findings. The qualitative data were used mainly for description.

#### ***Information dissemination and research utilization:***

The information dissemination activity of the study was a continuous process. From conceptualization to completion of the study, information about its objectives, processes, and progress of activities and results were being continuously disseminated.

## CHAPTER FOUR

### DATA PRESENTATION, INTERPRETATION AND ANALYSIS

#### 4.1 Introduction

An essential practice for assessing family planning communication strategies in Maradi State of Niger Republic is the identification of the routines of family planning activities and events that occur regularly for health workers, women and families at home and in their community. Here, the researcher analyzed information on family planning services, what health services providers do for women and how health workers were engaged in their everyday family planning communication activities. In this chapter, four different sets of data were analyzed. This chapter is structured along research questions and objectives

The first set of data concern respondents' view of family planning activities in the different localities of the survey. The second set of data focused on family planning health centres and workers through an observation done during family planning activities. The third one is based on focus group discussion with men and women on the importance of communication sources to promote family planning. In the fourth set of data, the role and contribution of certain NGOs and International organizations were analyzed.

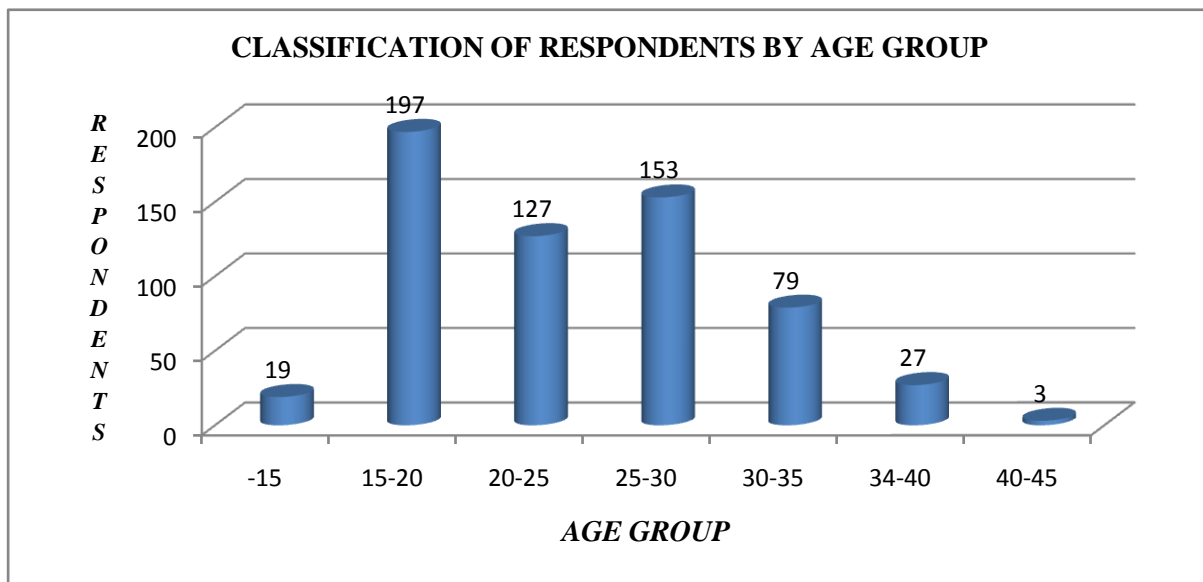
Attitude, perceptions and knowledge of the respondents on family planning communication strategies were assessed on the basis of what they know about family planning and then what they think of family planning service providers. The health workers' performance was assessed through the fourth and fifth part of the questionnaire.. The total numbers of respondents included in the survey from the selected quarters and villages were 605. Among health service

providers, the analysis was based on 34 family planning units. Five key organizations were also covered by the analysis; followed by 9 focus group discussion sessions constituting 84 members.

## 4.2. Presentation and Interpretation of Data

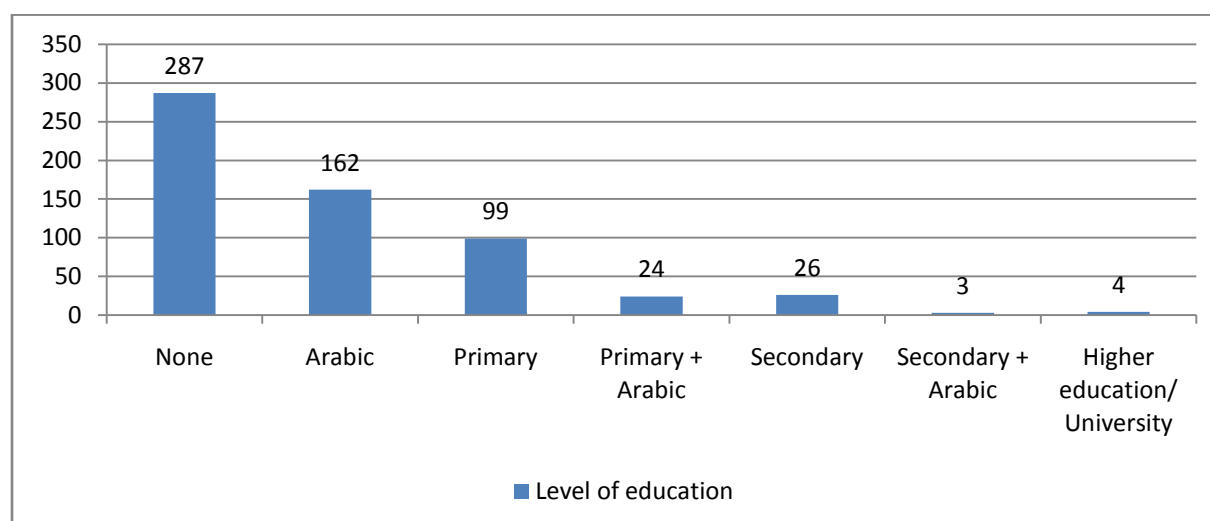
### 4.2.1. Identity of the respondents

**Figure 4.1:** Distribution of respondents by age group



The figure 4.1 shows some variation in respondents' age. Women within reproductive ages constituted highest group among women within age group 15-20 (32.6 percent), this declines to 0.5 percent among women between age 40-45 and varies little after age 25. The notable remark is among the youngest group of women (-15) where this group constitutes 3.1%. In this study, the minimum age of the respondents is 13 years old and the maximum age is 42 while the mean age is 24 years.

**Figure 4.2:** Distribution of respondents by educational level



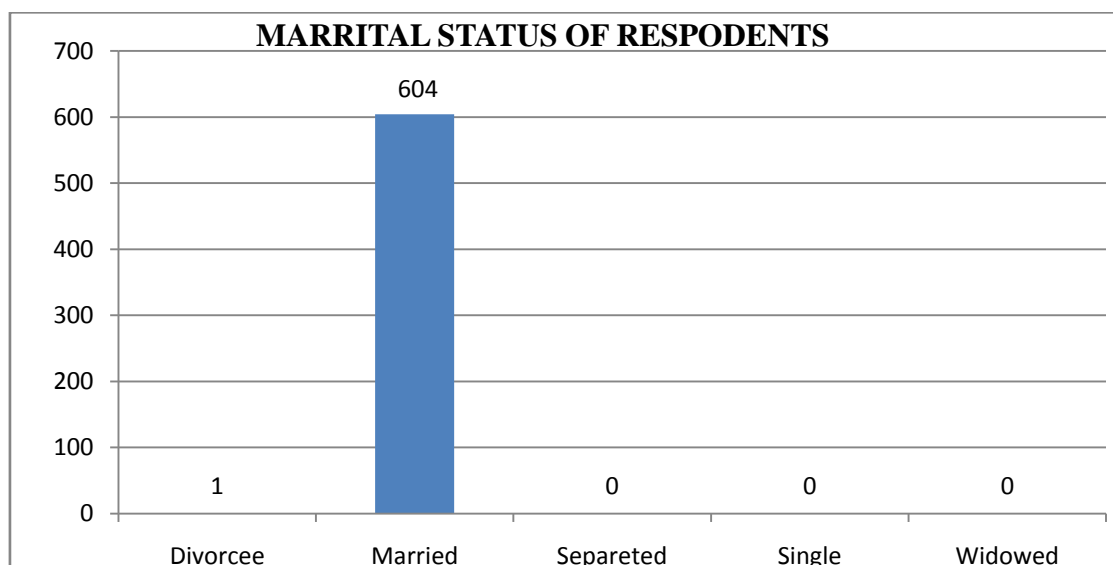
In the educational angle, 47.4% of the respondents had no formal education. The educated women accounted for 52.6% among the respondents. It is only in Arabic education that majority of them have some education as indicated in the figure. This will be discussed later because it is one of the major problems in promoting family planning in the study. The important point here is that, all educational levels, were included in the study. The distribution of respondents by their religion is represented in table 4.1.

**Table 4.1:** Distribution of respondents by religion

Religion	Frequency	Percent	Cum percent
Christianity	6	1.0%	1.0%
Islam	599	99.0%	100.0%
<b>Total</b>	<b>605</b>	<b>100.0%</b>	<b>100.0%</b>

Here, the data show that among the total number of respondents(99% of the sample) are Muslims. This was not a surprise because the study was conducted in an Islamic country with between 98 to 99 percent Muslim population.

**Figure 4.3:** Distribution of respondents by marital status



Among the 605 respondents in the study, married women constituted almost the entire population with (99%) of the respondents. At least only one divorced woman was interviewed during the survey.

**Table 4. 2:** Distribution of respondents with co-wives

4.1. Are you the only wife	4. Marital Status					Total
	Divorcee*	Married	Single	Separated	Widowed	
Yes	0	395	0	0	0	<b>395</b>
No	1	209	0	0	0	<b>210</b>
<b>Total</b>	<b>1</b>	<b>604</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>605</b>

The data shows that many husbands have one wife in Maradi State (65.4%). But the polygamy is also significant, because 34.6% of the respondents said that they have co-wives as shown in the table.

**Table 4. 3:** Distribution of respondents by F.P users and non-users

<b>11. Are you currently using family planning method?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
Yes	72	11.9%	11.9%
No	533	88.1%	100.0%
Total	605	100.0%	100.0%

Table 4.3 present the percentage of women who are currently using contraceptive methods (11.9%). The most important reasons for non-use of contraceptives identified by the women are fertility reasons, related to Islamic principles and other rumours. According to the study, women who do not use family planning contraceptives were above 88%, which reflects the weak utilization of family planning practice in Maradi state (6.75% in 2011)

**Table 4. 4:** Distribution of respondents by the number of their children

<b>4.2. How many children do you have?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
0	21	3.5%	3.5%
1	68	11.2%	14.7%
2	91	15.0%	29.7%
3	109	18.0%	47.7%
4	79	13.1%	60.8%
5	72	11.9%	72.7%
6	54	8.9%	81.6%
7	39	6.4%	88.0%
8	38	6.3%	94.3%
9	14	2.3%	96.6%
10	8	1.3%	97.9%
11	5	0.8%	98.7%
12	6	1.0%	99.7%
13	1	0.2%	99.9%
<b>Total</b>	<b>605</b>	<b>100.0%</b>	<b>100%</b>

Referring to the table, it can be calculated that a total number of 2500 children. Related to this, the total fertility rate is four children per woman. The expected number per woman during her reproductive life in Niger Republic is 7.1 children. Among the 2 500 children, 2 189 are alive.

#### **4.2.2. Knowledge, Attitude and Practice about Family Planning Communication Strategies**

Knowledge, attitude and practice of women were examined by considering some selected variables: women's knowledge about family planning, whether they ever used family planning methods or not and women's and husbands' opinion of family planning.

**Table 4. 5:** Distribution of respondents by their understanding of what Family planning is?

<b>6. What is family planning?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
1. Allows pregnancies to be wanted	236	39.0%	39.0%
2. Improves the health of families	284	46.9%	86.0%
3. Limitation of child birth	9	1.5%	87.4%
4. Promotes responsible behaviour	38	6.3%	93.7%
5. Promotes the well-being of families	19	3.1%	96.9%
6. Reduces expenditure of the families	19	3.1%	100.0%
<b>Total</b>	<b>605</b>	<b>100.0%</b>	<b>100.0%</b>

By the proposed definitions, women who have no knowledge of family planning do choose answer No 3. The “Good answers” were 1-2 and accounted for 86%, “The approximated answers” (4, 5, and 6) had only 12.5%. The frequency of those who do not know what family planning is in this study was 9 equivalent to 1.5%.

**Table 4. 6:** Distribution of respondents by knowledge of location of family planning units

<b>7. Where the family planning unit located in your locality</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
1. Public Health centers	417	68.9%	68.9%
2. Private Health centers	1	0.2%	69.1%
3. Hospital	0	0.0%	69.1%
4. Pharmacies	2	0.3%	69.4%
5. N <sup>o</sup> 1 and 2	55	9.1%	78.5%
6. N <sup>o</sup> 1 and 4	130	21.5%	100.0%
7. Other	0	0.0%	100.0%
<b>TOTAL</b>	<b>605</b>	<b>100.0%</b>	

Government owned health centres were well known as family planning units. 68.9% of the respondents knew that public health services offer family planning activities, while 0.2% knew that they can also get the same service in private health centres. What respondents think about family planning benefits is presented by frequencies and percentage in table 4.7

**Table 4. 7:** Classification of respondents by knowledge of family planning benefits

<b>8. What are the benefits of family planning?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
Birth control	515	85.1%	85.1%
Pregnancy testing & counseling	90	14.9%	100.0%
Total	605	100.0%	100.0%

Identifying the major benefit of contraceptives was addressed through two main questions: birth control and pregnancy testing & counseling. But, there could be other numerous benefits that women can gain from using contraceptives. Majority of the respondents (85.1%) agreed that the overall benefit of family planning is to encourage birth control.

**Table 4. 8:** Distribution of respondents by reasons why people visit a family planning service?

<b>9. Why do people visit or see a family planning service provider?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
1. To get counseling about family planning methods	383	63.3%	63.3%
2. To discontinue a family planning method	00	0.0%	63.3%
3. To be resupplied with contraceptives	98	16.2%	79.5%
4. To change a family planning method	4	0.7%	80.2%
5. To deal with side effects	14	2.3%	82.5%
6. N <sup>o</sup> 1 and 3	97	16.0%	98.5%
7. N <sup>o</sup> 1 -3 and 4	8	1.3%	99.8%
8. Other	1	0.2%	100.0%
<b>Total</b>	<b>605</b>	<b>100.0%</b>	

This table shows that none of the respondents think that it is important to see the family planning provider to discontinue a family planning method when a user needs a new pregnancy. This means that, a user could stop a method at any time, especially if she has problems with it. One of the respondents said that women could also visit a family planning unit for sterility problems. So sterility is also an important key point of reproductive health services.

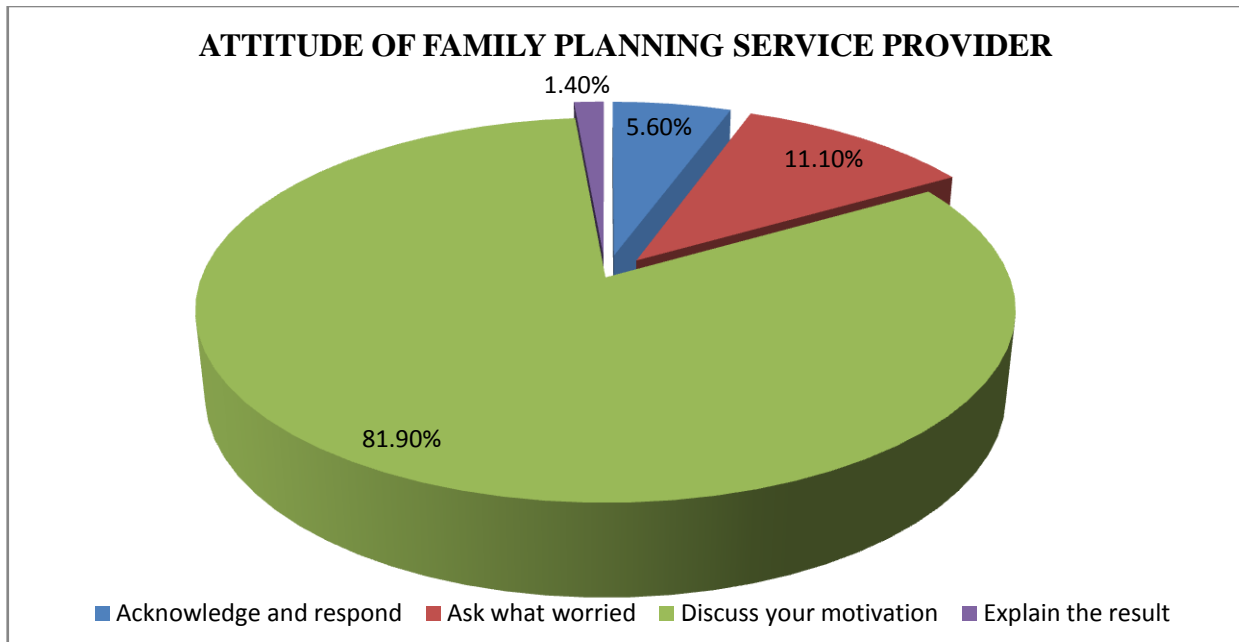
**Table 4. 9:** Classification of current family planning users by their satisfaction with the methods

<b>13. Are you satisfied with your current family planning method?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
Yes	70	97.2%	97.2%
No	2	2.8%	100.0%
Total	72	100.0%	100.0%

The effectiveness of family planning methods when correctly used was acknowledged by the respondents in this table. 97.2% are satisfied with their methods. So, the reason why nonusers do

not use family planning methods is not probably related to the doubt on the efficacy of the method. This could be supported by the view of current users who state that their methods are “sure” between: 88% to 99%.

**Figure 4.4:** Classification of the respondents by their opinion on F.P providers’ attitude



The analysis was done only for women who were currently using contraceptives. The study also highlighted major attitudes that the service providers must observe when receiving a client. The study shows that 5.60% of the respondents are of the view that service providers do not acknowledge or respond to them appropriately

**Table 4.10:** Respondents' views on family planning providers' attitudes

During the consultation, did the service provider:	Responses				Total
	Yes	%	No	%	
18.1 Treat you politely?	68	94.44	4	5.66	72
18.2 Speak clearly?	64	88.88	8	11.12	72
18.3 Use words which you understand?	72	100	0	0	72
18.4 Listen attentively to you?	60	83.33	12	16.67	72

As indicated in the table, family planning users were not comfortable and claimed that health workers did not treat them well (5.66%) and did not attentively listen to them too (16.67%).

#### 4.2.3. Sources of Information

**Table 4. 11:** Classification of respondents by sources of information

Sources of information	Responses				Total
	Yes	%	No	%	
Radio programmes	543	89.75	62	10.25	605
Television spots or programmes	228	22.90	377	87.10	605
Drama or folk songs	38	6.28	567	93.72	605
Flip books	0	0	605	100	605
Organized talks	21	3.47	584	96.53	605
Page volt	14	2.31	591	97.69	605
Posters	11	1.81	594	98.19	605

The answers given by the respondents show that radio was chosen as the most powerful channel in giving information. It was cited by every respondent as the first medium before any other channel.

**Table 4. 12:** Distribution of respondents by sources of Information during the last 3 months

<b>22. Have you heard about family planning on radio or television in the last 3 months?</b>	<b>Radio</b>		<b>Television</b>		<b>Radio and Television</b>	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	44	7.3%	15	2.5%	8	1.32%
No	561	92.7%	590	97.5%	597	98.68%
<b>Total</b>	<b>605</b>	<b>100.0%</b>	<b>605</b>	<b>100%</b>	<b>605</b>	<b>100%</b>

Depending on the data in the table, family planning communication programmes was not provided in the last three months before the survey (October, November and December 2012) on radio and TV programmes in Maradi state. In the table, the percentage of radio listeners accounted for 7, 3%. These media, the data show covered public, private and community radio and television stations that broadcast in Maradi state during the period (October, November and December 2012) of the survey.

**Table 4. 13:** Distribution of respondents by media influence

<b>21. Which of these sources is the most influential to you?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
Radio programmes and health agents	374	61.8%	61.8%
Television spots and health agents	203	33.6%	95.4%
Radio and Television spots or programmes	27	4.5%	99.9%
Social mobilizers	1	0.1%	100.0%
Organized talks	0	0%	100.0%
Dramas or folk songs	0	0%	100.0%
Posters	0	0%	100.0%
Flipbooks	0	0%	100.0%
<b>Total</b>	<b>605</b>	<b>100.0%</b>	

The data here show that radio remains the most influential channel according to the sample, constituting 61.8% of respondents. This was confirmed in the following table 4.14 where a lot of respondents were radio owners and listeners

**Table 4. 14:** Distribution of respondents by ownership of media equipment

<b>24. Do you have one or more of the following?</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
Radio	480	79.3%	79.3%
Radio and TV	72	11.9%	91.2%
TV	15	2.5%	93.7%
TV and DVD	1	0.2%	93.9%
DVD Reader	3	0.5%	94.4%
Radio, TV and Digital Versatile Disc	13	2.1%	96.5%
None	21	3.5%	100.0%
<b>TOTAL</b>	<b>605</b>	<b>100.0%</b>	<b>100.0%</b>

As indicated in the table, 79.3% of the respondents owned radio sets to listen to information or other programmes in their day-to-day life.

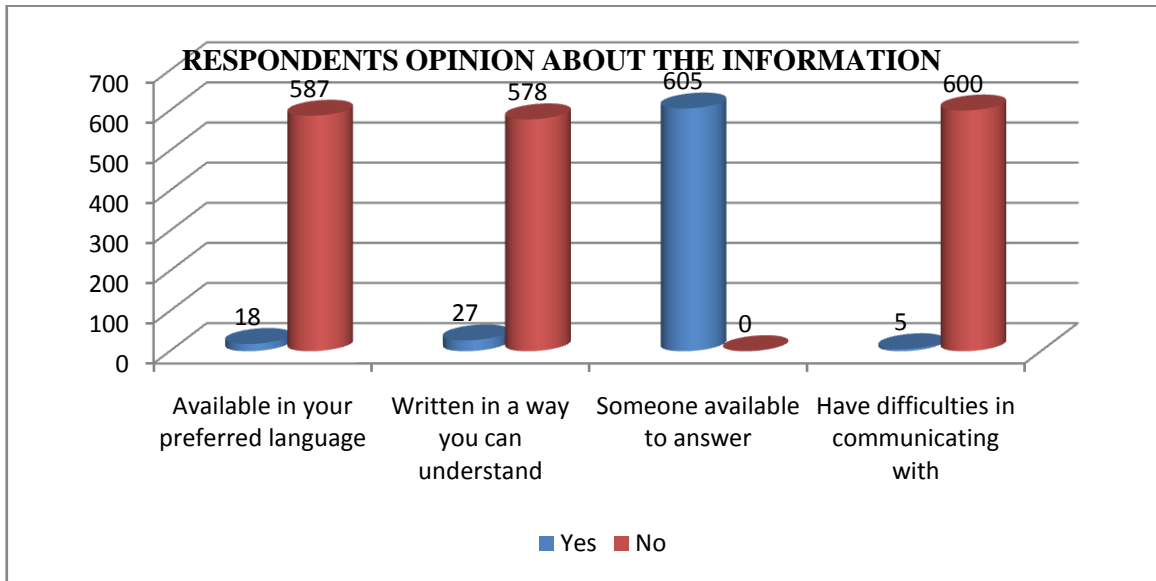
#### **4.2.4: Communication Skill and use of Media Materials**

**Table 4. 15:** Distribution of respondents by information availability

<b>25. Is there family planning information available to you</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cum percent</b>
Yes	587	97.0%	97.0%
No	18	3.0%	100.0%
Total	605	100.0%	100.0%

The table revealed that there was family planning information available in majority of health centres (pasted somewhere in the unit). This availability was confirmed by 97% but it was revealed that even if this information exists, respondents don't do have access to it or did not understand the meaning. This is shown in the next figure 4.5

**Figure 4.5:** Distribution of respondents by their opinion about FP information



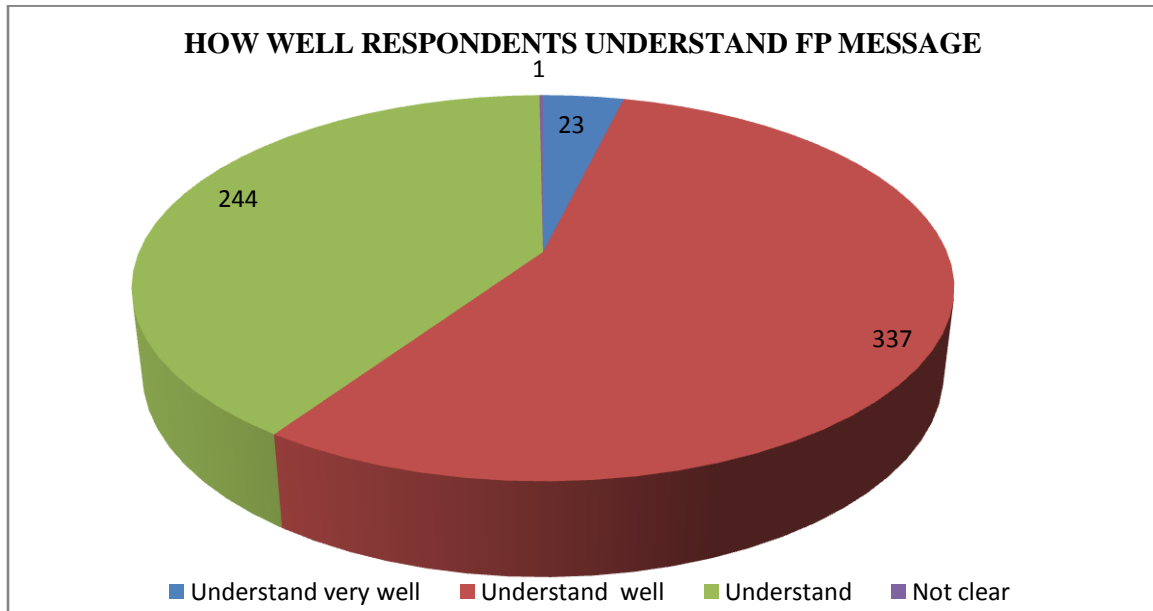
In the figure, there is a predominance of « NO » except for the « availability of health workers to answer to their preoccupation ». It was shown in the figure that 95.5% of the respondents said that information was available to them but not written in a way they can understand it, while 97% notified that it was not available in their preferred language.

**Table 4.16:** Distribution of respondents' view about the most influential communication source

INTEGRATED HEALTH CENTRES	WHICH SOURCE IS THE MOST INFLUENTIAL TO YOU?								TOTAL	
	TV		RADIO		NEWSPAPERS		TV & RADIO			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
CSI AGUIÉ	15	2.5	8	1.3	1	0.2	8	1.3	32	5.3
CSI DEBI	4	0.7	3	0.5	0	0.0	0	0.0	7	1.2
CSI GAZAOUA	8	1.3	4	0.7	0	0.0	5	0.8	17	2.8
CSI TCHADOUA	10	1.7	5	0.8	0	0.0	6	1.0	21	3.5
CSI AJEKORIA	7	1.2	11	1.8	0	0.0	7	1.2	25	4.1
CSI DAKORO	15	2.5	4	0.7	1	0.2	8	1.3	28	4.6
CSI KORNAKA	8	1.3	5	0.8	0	0.0	2	0.3	15	2.5
CSI SABON MACHI	5	0.8	10	1.7	0	0.0	5	0.8	20	3.3
CSI MAIYARA	3	0.5	16	2.6	0	0.0	3	0.5	22	3.6
CSI TCHADAKORI	6	1.0	13	2.1	0	0.0	2	0.3	21	3.5
CSI EL KOLTA	1	0.2	8	1.3	0	0.0	0	0.0	9	1.5
CSI G/ROUMDJI	14	2.3	8	1.3	2	0.3	6	1.0	30	5.0
CSI TIBIRI	14	2.3	11	1.8	2	0.3	10	1.7	37	6.1
CSI DAN ISSA	6	1.0	14	2.3	0	0.0	11	1.8	31	5.1
CSI DANJA	0	0.0	3	0.5	0	0.0	0	0.0	3	0.5
CSI DJIRATAWA	1	0.2	9	1.5	0	0.0	0	0.0	10	1.7
CSI MADAROUNFA	10	1.7	3	0.5	0	0.0	2	0.3	15	2.5
CSI SAFO	3	0.5	15	2.5	0	0.0	3	0.5	21	3.5
CSI 17 PORTES	20	3.3	2	0.3	1	0.2	2	0.3	25	4.1
CSI PLACE DU CHEF	14	2.3	1	0.2	0	0.0	6	1.0	21	3.5
CSI GUIDAN TAWAYE	0	0.0	8	1.3	0	0.0	0	0.0	8	1.3
CSI JAN TOUDOU	0	0.0	9	1.5	0	0.0	3	0.5	12	2.0
CSI KANEMBAKACHE	10	1.7	7	1.2	0	0.0	8	1.3	25	4.1
CSI KORE HABJIA	2	0.3	7	1.2	0	0.0	4	0.7	13	2.1
CSI MAYAHI	18	3.0	6	1.0	0	0.0	7	1.2	31	5.1
CSI SARKIN HAUSA	5	0.8	9	1.5	0	0.0	5	0.8	19	3.1
CSI BAOUDETA	0	0.0	13	2.1	0	0.0	1	0.2	14	2.3
CSI GUIDAN ZIGAO	0	0.0	6	1.0	0	0.0	0	0.0	6	1.0
CSI GUINDAWA	17	2.8	6	1.0	2	0.3	11	1.8	36	6.0
CSI KOONA	1	0.2	10	1.7	0	0.0	0	0.0	11	1.8
CSI MAÏJIRGUI	7	1.2	12	2.0	0	0.0	1	0.2	20	3.3
TOTAL	224	37.0	246	40.7	9	1.5	126	20.8	605	100.0

In this table, the most influential communication channel is radio, quoted by 40.7% of the respondents while TV recorded 37.0%. Referring to the answers collected by health centre, TV came first with 3.3% in CSI 17 Portes of Maradi Metropolis.

**Figure 4.6:** Classification of respondents by their degree of understanding FP messages



Data in the figure above (Figure 4. 2), show that 3.3% (23/605) of the respondents understand family planning messages very well, where those who just understand what it means represent 40.3% (244/605). These findings are explained more in the study research questions.

#### 4.2.5 Observation Guide Data Analysis

In determining the quality of family planning services, the family planning providers play a critical role. Their (providers) ability in communicating with users determines largely whether a client chooses or has an appropriate method and can use it competently. The information gathered about providers' strengths and weaknesses can be used to improve services for client. During this study, it was observed that service providers were worried about the research results of their evaluation, because they think that it will be reported to their superiors, but, as indicated in the research observation guide, all data will be kept confidential and that no name of workers will be mentioned in the survey report except with his/her permission.

**Table 4. 17:** Distribution of family planning methods available in the sites

Types of methods	2.1 Are the following family planning methods available on this service?				
	Yes	%	No	%	Total
Pills	34	100	0	0	34
Tubal ligation	0	0	34	100	34
Injection	33	97.05	1	2.95	34
Vasectomy	0	0	34	100	34
IUCD	18	52.94	16	47.06	34
Norplant/Jadelle	24	70.58	10	29.42	34
Foam	1	2.95	33	97.05	34
Natural Family Planning	18	52.94	16	47.06	34
Diaphragm	0	0	34	100	34
Lactation Amenorrhea	26	76.47	8	23.53	34
Condom	22	64.70	12	35.30	34

The family planning service delivery sites visited during the survey to collect data regarding to the methods, show non-availability of several methods in Maradi State family planning centres. Only two major methods were permanently available: Pills accounted for 100% and injection 99%.

**Table 4. 18:** Distribution of family planning communication materials available in the centre

Types of communication materials	3.1 Do the centres have any of the following family planning communication materials?				
	Yes	%	No	%	Total
Flip book	4	11.76	30	88.24	34
Leaflet	4	11.76	30	88.24	34
Poster	25	73.52	9	26.48	34
Contraceptive samples	34	100	0	0	34
Anatomical models	29	85.29	5	14.71	34
Audio, video tape and films	9	26.47	24	73.53	34
Page volte	24	70.58	10	29.42	34

The availability and use of communication materials during family planning consultations could help in information, education and communication (IEC). Apart from the general counseling

communication materials (contraceptive samples and anatomical models), the data show a lack of information materials in all the centres visited. Even those that existed, they were not being used properly as shown in table 4.18 below

**Table 4. 19:** Family planning materials available in FP units visited and frequencies of users

Types of communication material	3.2 How often each material available is used at this site?			
	Daily	At least once a week	A least once a month	Less than once a month
Flip chart	0/34	1/34	3/34	0/34
Leaflet	3/34	1/34	0/34	0/34
Poster	21/34	2/34	1/34	1/34
Contraceptive samples	34/34	0/34	0/34	0/34
Anatomical models	29/34	0/34	0/34	0/34
Audio tape video and films	3/34	6/34	0/34	0/34
Page volte	1/34	23/34	0/34	0/34

The data showed that these materials were available in 66.6% of the centres. Even if, the service providers decide to use them daily or at least once a week, the permanent communication materials (contraceptives samples and anatomic models) and other materials are still not available. Audio, video-cassette and films which must be used daily, were used by health workers in many centres at least once a week. Therefore, consistent and standard use of these communication materials must be applied.

#### **4.2.6: Focus Group Discussion Data Analysis**

Focus group discussion was used to gather information from other members of the survey as defined in the research methodology. FGD was combined with other methods such as questionnaire, observation guide and Key Informant Interview. The FGD data analysis consisted of examining, categorizing and tabulating the “results” collected during the focus group.

Examining the data collected, 66.6% of the participants in the FGD were women. The mean group participant was 9 per group. The time allocated to each group varies from 13 minutes (fewest) to 36 minutes (highest). The mean time spent by the group was 22 minutes. An audio tape-recorder was used occasionally because of lack of batteries in some villages. The tapes were transcribed for more details. The notes from the FGD were focused on three main points:

- Respondents' need to have an interpreter in the clinic?
- How well did the respondents understand what health workers were telling them?
- The information provided to the respondent, was it in their preferred language?

Firstly, data collected indicated that the participants in the FGD did not need an interpreter in the clinic, because generally, health workers who work in the locality speak at least the main local language (Hausa). Individual responses indicated that speaking the local language is not the problem but how they transmit it so that people understand the message.

Secondly, the participants in the FGD could understand what they were being told orally by nurses, but most of the information about family planning was written in French, which is not appropriate for them.

Finally, the answer to the question "The information provided to the respondents was it in their preferred language? It was answered with total agreement by the participants that, information was not provided in their preferred language (See figure 4.5). It was resolved in the focus group data that the participants needed similar group discussion to be organized at least once a month for the benefit of the population.

#### **4.2.7: Key Informant Interview Data Analysis**

Data analysis was predominantly descriptive. Notes from telephone interviews and site visit discussions were done. The researcher focused the Key Informant Interview on seven different key sources operating in Maradi State. These were: UNFPA, UNICEF, CONIPRAT, ANBEF, ANIMAS-SUTURA, MSF and ACTN. All the key informants stated that: training of health workers is more likely to be prioritized according to the policies in place, that outline specific performance expectations with regard to family reproductive health in general and family planning practice and service delivery in particular.

The questions discussed their strategic planning efforts in ensuring better family planning promotion in Maradi state especially in the reproductive health domain. One programme of ANIMAS-SUTURA described was a strategic family planning effort to reduce health disparities through their HIV/AIDS sensitization campaign. All these mentioned structures provide support to family planning through forum, sensitization and social mobilization campaign. Their programmes also improve the provider-patient interaction and address barriers to care such as cultural ideology.

For this reason, the UNFPA, held a forum in Niamey (Capital) with traditional rulers on November 24<sup>th</sup>, 2012 to promote reproductive health in all Niger Republic's families. On reasons that make it difficult to implement their communication strategies, all the key informants noted that:

- Locating services geographically such that they could be accessible and available to the population is not easy;

- The most commonly mentioned state in relation to communication problem was Maradi state;
- In addition, people of Maradi state always think that something must be given to them before asking for any services from them;
- Also, the high rate of malnutrition in Maradi state which need a lot of effort by staff, health workers, NGO, International Organizations, women groups... to tackle the matter. To paraphrase a traditional ruler who stated that: *“Maradi is like the Printer called ‘3 in 1’”*.

### **4.3 Discussion of Findings**

The study demonstrates key issues in respect of communication strategies in family planning among women of reproductive age in Maradi state of Niger Republic. Four research questions were asked in the study, namely:

#### **Research question one (1):**

- What are the communication strategies used by health workers to promote family planning in Maradi State?

Communication strategies were assessed along the respective communication materials used for family planning promotion by health workers in the respective family planning units visited in Maradi State. Other elements were managed and posed to both service providers and respondents to compare and establish possible differences in having family planning communication materials in the seven district health centres. It is remarkable that the mean score for each item is therefore set at 1.000 while score lower than 1.0000 would imply not having enough

communication material. The mean score availability of family planning communication materials in the 34 family planning centres were represented as follow:

**Table 4.20:** Mean Score of family planning Communication materials?

<b>The following F.P Communication materials are they available?</b>	<b>Number of Centres</b>	<b>Frequency</b>	<b>Mean</b>	<b>Variance</b>	<b>StdDev</b>
1. Posters	34	25	.7353	.2005	.4478
2. Page volts	34	24	.7059	.2139	.4625
3. Contraceptive samples	34	34	1.0000	.0000	.0000
4. Anatomical models	34	29	.8529	.1292	.3595
5. Audio/Video Tapes	34	9	.2647	.2005	.4478
6. Leaflets	34	4	.1176	.1070	.3270

Availability of family planning communication materials in the 34 family planning centres visited in Maradi state reveals that:

- In item N°5, there is a critical unavailability of audio/video Tapes (Mean = 0.2647). Furthermore, the availability of leaflets in item N°6 is still similar to the item N°5 (Mean = 0.1176).
- The mean score for items 3, 4, in the table revealed a complete positive availability of family planning counseling materials (contraceptive samples and anatomic models). This proved that there are at least some communication materials for counseling. It could be stated that service providers were of the opinion that with possession of these communication materials, they can perform better family planning promotion.
- In the remaining items (1, 2) the availability of posters and page volts is almost good because their score were closed to the study mean which is 1.000. Their mean scores are respectively 0.7353 and 0.7059 (see table 4.19).

According to the data collected, none of the family planning services had a regular communication programme. Radio and video cassettes, considered as a significant factor, were not regularly used anywhere in all the 34 family planning units visited. It can be stated that communication materials used by health workers generally are not effective. So, in this study, the most effective communication strategy is face-to-face communication

***Research question two (2):***

- How familiar are the people with family planning communication strategies and/or family planning products in Maradi State?

To answer this question, the recorded number of family planning users and non users were computed with the mean as indicated in table 4.20. It was considered here that all respondents should reply “**Yes**” to the question “have you heard about family planning?” For the family planning location, all users must tick (in the questionnaire) the 4 proposed answers, while non users can at least tick 2.

About the benefit, it was specified in the study to choose “Birth control” for all users and nonusers. To the question “why people visit Family planning service provider”, all users should tick the entire item while non users can stop at item “Be resupplied, counseling, and side effects”. All respondents’ good response got 1 mark

**Table 4. 21:** People’s familiarity with family planning messages or methods

Type of users	Hear about FP	Advantages/ benefit of FP	Location of FP unit	Why people visit FP unit
	<i>Mean</i>	<i>Mean</i>	<i>Mean</i>	<i>Mean</i>
1. Family planning currently users	1.00	0.81	1.00	0.69
2. Family planning non users	1.00	0.85	0.80	0.80

The analysis shows that there was almost no difference between family planning current-users and non-users in their familiarity with family planning activities. The observation here implied that, the family planning current-users were more familiar with family planning information. The reason of non-users could be attributed to the fact that, they had doubt on family planning related to their cultural consideration. These beliefs are important in determining the goals people set. An individual’s view on what is important and how they place themselves in context of a situation determines their success or failure of obtaining a goal (Hochbaum, 1958).

***Research question three (3):***

- What are the challenges communicating with the people on family planning in Maradi State?

This question was answered in the mean score of family planning users and non users’ views. In the analysis, only the respondents who answered **yes** to the question “Is there family planning information available to you?” were analyzed. The data are presented in figure 4.5. It was indicated that health workers were always ready to receive clients, but the way their messages or information on family planning were reaching the audience was not transmitted in people’s preferred language or written in a way they can understand it.

This was attributed in this study to the respondents’ low level of education shown in figure 4.2

***Research question three (4):***

- How do people perceive family planning communication messages delivered by health workers in Maradi State?

The variable used in this context was based on people's perception about how health workers use their communication strategies. The analysis (figure 4.6) revealed that people understood what health workers were telling them, but even if they understand what they were told, most of them did not agree or applied it. That is why permanent relationship between providers and their clients must be maintained. The research theoretical framework (HBM) can be and *are* useful, because it enrich, inform and complement the messages of health promotion and education in the present study.

Communication messages were not always delivered by professional health communicators, which brought a lot of misunderstanding and/or misinterpretation. For example these are some messages used to promote family planning:

1. Family planning helps to take care of the family
2. Family planning allows economic grows
3. Family planning brings happiness in the family
4. Family planning saves the life of women and children

All these messages can have negative effects. For instance, the fourth one can be interpreted (by husbands) as if, family planning can just helps mother and her children. Further more, people of Maradi State will never accept that family planning is the basic source of economic grows (message No 2), because originally, the state is considered as the centre of commerce of the country. So, they believe that there is no relationship between "family planning and economic grows" and "everything comes from Allah".

Using the assessment of communication strategies for family planning promotion in Maradi State, it can be argued that communication strategies are determinants and can influence people's life vis-à-vis family planning.

Hargie (2004:2) said:

Information is fundamental to choice and making informed decisions. Without information, there is no choice. Information helps knowledge and understanding. It gives patients the power and confidence to engage as partners with their health service providers

Among the objectives of this study was the determination of the extent to which certain variables like (marital status, level of education, media channels) could promote or influence controversies about family planning in some selected health centres and villages within Maradi State in Niger Republic. So, communicating in family planning requires the consideration of some cultural values. For example, when one is attempting to overcome women's personal barriers to obtaining modern family planning methods the HBM may be useful.

Festus (in Okigbo, 2004: 7) stated that: "Communication is a neutral instrument, whether one speaks of radio, telephone, television, computer, or physical interaction. How we say what is that we say and what we do with our own values in the saying of what we say dictates the alignment with cultural and personal benefits".

From the analysis of the data collected on personal opinion of respondents in the two selected locations (urban and rural), the observation was that respondents' location has a significant influence on people, especially in the rural areas. In some cases, the environment is "the teacher of people". This finding is consistent with the views of Juliann (2008), where it was reported

that: “observations can enhance the identification of routines and activities by observing the environment where the people live, learn and play. He recommended that service providers should look for familiar and preferred materials according to the areas”.

In a similar report, Ricardo and Wendy (2004) discovered that the locality was found to influence respondents’ attitude and practice. The authors opined that communication works best when it is planned locally and if it is based on research into the local knowledge, attitudes and habits of the people with whom one wants to communicate. Thus, in this study, one of the consequences of the low rate of family planning utilization was the poor consideration of people’s localization (zone) by health workers in their communication strategies in Maradi State. In two statements, John (2004:1) said that: “General practitioners and practice nurses are often best placed to offer good contraceptive advice because they know already the patient’s health and family circumstance”. Then, concerning the relative effectiveness of available methods, John (2004:6) argued that: “Good result depends on a couple-based, individualized approach. Contraception is very much about choosing ‘horses for courses’”

Another objective was to identify the communication strategies used by health workers to promote family planning in Maradi State. Communication strategies were developed in response to the above context of family planning. A range of communication materials and products in different health centres and community media were developed to enable people adopt the practice of family planning in Maradi State specifically.

The finding has shown a significant lack of materials available in many centres visited. Thus, apart from the general counseling materials (contraceptive samples and the anatomical models), there is a lack of information materials in all the centres visited. The research findings show that

the communication materials available were not regularly used by family planning service providers in some health centres visited.

A way to achieve this objective is to make people (users and non users) be in partnership and in continuous contact with communication materials. According to Rogers (2003), there are five qualities which can determine between 49 and 87 percent of the variation in the adoption of a communication product: the advantage, the compatibility with existing value, simplicity and ease of use, its trialability and observation result.

One key objective of the study was to identify people's familiarity with family planning communication strategies and products. The result has shown that health agents were chosen as first source of information followed by radio and TV programmes, that radio and TV programmes have influence on viewers and listeners in the selected areas. It was found that the respondents prefer different communication channels and this preference vary across districts and local areas. However, some common patterns do exist. The field work confirmed that the respondents preferred the national station because the community radio stations could not reach their locality or have a poor signal. Respondents put more trust on the formal official radio (*Voix du Sahel*) and they favor especially educational radio and television programmes. Communication channels have to do more in Maradi State because it has the low prevalence (7%) of family planning (Hassane and Nomaou, 2012)

With respect to the respondents' view, media exposure is very significant. Among respondents who were currently using family planning, 90.3 percent said that they have heard about family planning on radio or television. It has been argued that the mass media, especially radio and

television, have been quite effective in creating family planning awareness in urban Nigeria (Osakue, 2010). Apparently, in this study the accessible family planning messages come from radio and television channels. It is not to be denied that the mass media have, and always have had, an important role in communication. However, the family planning and communication studies reviewed here suggest that the assets and liabilities of the traditional approach should be considered.

When the respondents were asked if the message or information available to them were in their preferred languages” their response was no. Thus, it was discovered in this study that 61.8% think that radio could have more influence on them. This was proved in table 4.14 where 79.3% indicated they own radio sets. The result revealed also that radio and television can have direct impact on people today. Broadcasting has come to mean the communication of news, instruction and entertainment by radio or television. People preferred language in this study was first Hausa. Salau (2011:327) support that by saying:”In fact the Hausa constitute 56 % of the country’s population and, of course, Hausa language is widely spoken”.

This attaches credence to the view of Piotrow (in Osakue, 2010) that the spread of television and radio, the rise of an independent press, and increasing literacy rates in many countries offer new opportunities for family planners and other health care organizations to inform the public and reach opinion leaders. Communication is central to our everyday functioning and can be the very essence of the human condition (Hargie, 2004). The answers to this question can also have an effect on the extent to which communication is seen as an integrated part of health workers’ activities. However, in this study, the respondents’ listenership to radio programmes was far

more than their viewership of television programmes with regard to family planning and related matters.

The fourth question of the study is “How do people perceive family planning messages delivered by health workers in Maradi State?” The result for the above objective is linked to the centrality of communication in health. The objective was based on women’s educational level and their preferred language. Educated women (secondary and university) were significantly more likely to understand very well the message than women who have Arabic or primary education. Fortunately, educated women practice child spacing than women with at least primary level. As should already be becoming clear, effective communication is central to our ability to function as members of a society.

Regardless of the communication materials or family planning information that were available, the messages were not reaching the audience in their preferred language or writing in a way they can understand. Therefore, an increase in communication messages increases the number of audiences and the number of family planning users. Nancy (2001), argued that a lack of participation may lead to decisions being overruled, delayed, challenged, or questioned by either internal or external stakeholders. Nancy (2001), further states that mismanagement of time and missed deadlines can result in lost opportunities, decreased impact of the project and greater stress in partner relationships.

Furthermore, the same result was reflected in the focus group discussion where the participants did not prefer having the discussion in French language, although French is the official language. The economic factor is also a handicap for media houses to promote family planning in the

country. In support of this, Salau (2011:333) saw it as a result of the poor economic situation of the environment, a dearth of advertising revenue which has been a major headache of these private stations.

### **Challenges and gaps of family planning messages acceptability**

Factors preventing people from using contraceptives are generally culture or rumours. Traditionally or culturally, sons stay in the family home when they get married, whereas daughters go to live in the home of their in-laws. For example, a married woman is likely to be under constant pressure from her husband or her in-laws to deliver a son. During the FGD, the participants were asked to list rumours, misconceptions and obstacles to family planning. Many responses indicated the belief that “pills cause mental disease,” some mentioned the belief that “pills can cause infertility or Cancer” and others mentioned that contraceptive injections can increase or decrease bleeding. In addition, people also think that condom can reduce the sexual pleasure. During the study survey, the researcher has observed a current family planning user telling the midwife that her mother-in-law said “if she uses family planning; it will make her sick and cause severe illness and death”.

More over, inadequate messages caused problems of misunderstanding. For example there is a family planning poster on which there is a picture of man with pregnancy. Such picture cannot facilitate the promotion of family planning in an area where 99% are Muslim. So, poor family planning communication messages may be the basic problem in Maradi State. These problems might be due to inappropriate methods being used to communicate with people. Health workers had not been trained in interpersonal communication and did not know how to communicate information to mothers. They also did not show mothers respect. In focus groups, mothers said

that negative behaviour of health workers in other health services, particularly maternity services, was a major barrier to their seeking health services of any kind, including family planning, children's vaccinations.

#### **4.4 Summary of Major Findings**

The findings from the analyzed data are summarized below:

1. Radio and TV are the most influential communication sources which can play a major role to promote family planning in Maradi State;
2. The educational level of respondents has effects on their degree of understanding of family planning messages in Maradi State of Niger Republic;
3. Islamic leaders (Malams) have a an important role to play in promotion family planning in Maradi State in face to face communication with their people.
4. The marital status has very significant effect in adopting and promoting family planning in Maradi, Niger Republic, that marital status affects the effectiveness of family planning communication strategies.
5. Qualification of health workers in general and family planning providers in particular, enhances their ability to manage the users.
6. The availability and effective use of family planning communication materials were not adequate in health centres in Maradi State.

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter highlights the summary of the chapter of this study. It also highlights the conclusion of investigation into the influence of communication strategies in improving family planning methods within MaradiState in Niger Republic. In this regard too, the chapter includes recommendations on steps towards improving the knowledge of people and family planning providers in Maradi State.

#### **5.2 Summary of Chapters**

Aspects included in this study were family planning, NGOs' participation and people's opinion on family planning providers. The study further aim at: assessing the effectiveness of communication strategies in promoting family planning in Maradi State.

To answer the study objectives and research questions, three sets of data were analyzed from responses to questionnaires administrated to 605 Women of Reproductive Age, in addition to interview of 7 key informants and 9 different groups for focus group discussion. Also, 34 family planning services and/or providers were observed.

The study areas and the survey sample of the 605 respondents were selected using multi-stage sampling. The survey questionnaire, the FGD, observation guide and a Key Informant Interview were prepared and finalized in close consultation with the research supervisors. The instruments were translated into the official language (French) of the study participants. The study was structured into chapters for effective assessment of the objectives. Chapter one of the studygave an insight to the background and purpose of the study. This chapter also included the statement

of the problem and the research questions. Other aspects of the chapter were the basic assumption, significance of the study, scope and delimitation.

In chapter two, related literature to the study was reviewed. The research methodology was given in chapter three. This chapter was made up of the research design, the population of the study and the sampling procedure. The sampling technique used in selecting the population size was also given within chapter three along with the instruments for data collection. Chapter (3) also contains validity and reliability of the instrument and the method for the statistical analysis of data collected for the study.

The statistical analysis and interpretation of findings from the obtained data were presented in chapter 4. It consisted of the description of the provision of answers to the research questions. The fifth chapter of this study concerns the summary, conclusion and the interpretation. The study has four research questions that were answered as follow:

Looking at the communication strategies under consideration in promoting family planning, majority of the strategies were found to be very useful and appropriate. The family planning current-users and non users received family planning information from health workers, neighbors, social mobilizers and media channels. Availability and utilization of communication messages were not always done in a way that people (with low educational level) could understand the message as it was indicated in the study. A large number of respondents were not currently using family planning and fewer reported that messages never reach them or the messages were not understandable.

### **5.3 Conclusion**

To sum up, family planning communication strategies remain an important element in promoting family planning in Niger Republic in general and Maradi State in particular. Health workers can play a major role in conveying communication strategies (messages) to people (couple) and thereby assisting people to practice family planning. The analysis of the data revealed that respondents were of the opinion that communication channels have significant impact on the population. So, face to face communication is considered the best in promoting family planning in Maradi State. It was also observed that for any new family planning user to adopt a method, this user needs good counseling. The religion (Islam) has a significant impact in the adoption of family planning in Niger Republic. The study shows that an important knowledge gap exists with respect to family planning benefits. Along with the identified barriers, it reflects opportunities for holistic communication interventions that will touch gender education and religion in family planning. People with Islamic education in the study constituted the highest number of the respondents (99%). In this regard, there is the need to identify group-specific characteristics including experiences and perceptions. In fact, only permanent (long term) sensitization of people could help to promote family planning in Maradi State. In accordance with this conclusion, the study highlights some recommendations.

### **5.4 Contributions to knowledge**

1. The study identified important communication knowledge gaps that exist with respect to uptake family planning benefits among families in Maradi State of Niger Republic;
2. The study also identified the barriers revolving round religious beliefs that negatively affect participation in family planning among families in Maradi State and how communication can be used to address such religious barriers.

## **5.5: Recommendations**

Having studied the communication strategies and factors influencing family planning promotion among women of reproductive age in Maradi State, the following recommendations are made:

1. The State Health-Director should organize job training workshop and seminars at interval for health workers on family planning. Communication messages should also be edited locally and not at national level as it is know.
2. Health workers in Maradi State should continue to encourage people to visit family planning service providers/units so as to enlighten the people on various family planning choices that will meet their needs;
3. Religious and traditional leaders (Imams and chiefs) should have regular communication (meeting, ceremonies, mosque...) with their followers on the need for family planning. The Niger Republic government should provide sufficient communication materials on family planning to service providers and the population;
4. To reach a wider audience, the use of local and or regional broadcast media (Radio and TV) in promoting family planning should be maximized. Community radios and television programmes should be aired regular programmes on family planning.
5. National radio and television stations should also conduct discussions that will help women to understand their reproductive life, rationalize work and shift emphasis from funding to report family planning communication activities;
6. Hence, a health communication audit and an inventory of all existing communication materials to determine their direct related objectives should be undertaken, a logical framework process for developing new materials should be established and approaches which will take care of people's consideration should be adopted.

### **5.6: Suggestion for Further Study**

This study assessed the effectiveness of communication strategies for family planning promotion in Maradi State. As every research has some limits, this one cannot be an exception. Further researches can investigate the prospect of better communication activities in family planning in the same area. It could be of academic interest and it is helpful to extend this investigation on the social influence of media about family planning in Niger Republic

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# **APPENDICES**

**INSTRUMENT FOR RESPONDENTS**

**Madam,**

This research, *“An Assessment of Communication Strategies for Family Planning Promotion in Niger Republic: A Case Study of Some families in Maradi State”*. It is strictly for academic purpose and it is in partial fulfillment of the requirements for an award of M.Sc in Mass Communication. The response obtained from you shall be treated confidentially.

Thank you.

**I. IDENTIFICATION**

Name of quarter or village: ..... Name health centre: ..... Name of District...

01 Age (in years)? \_\_ \_\_

02 Level of education:

0 = None, 1 = Arabic 2 = Primary, 3 = Secondary, 4 = Higher education/university

03. Religion? 1= Christian, 2 = Muslim

04. Marital status:

0 = Single, 1 = Married, 2 = Divorcee, 3 = Separated, 4 = Widowed

(If the answer is 1, continue to question 4.1 Otherwise, skip to question 05).

4.1. Are you the only wife? 0 = No 1 = Yes

4.2 How many children do you have? \_\_\_\_\_

**II. KNOWLEDGE ON FAMILY PLANNING**

05. Have you heard of family planning? 0 = No 1 = Yes

06. What is family planning? (Only one response is allowed)

1 = Family Planning improves the health of men, women and children

2 = Promotes responsible behaviour.

3 = Promotes the well-being of families

4 = Reduces expenditures for high risk and planned when couple are infant care

5 = Allows pregnancies to be wanted and planned and when couple are best able to care for

new

6 = Limitation of child birth

7= Other ....

07. Where the family planning unit located in your locality? (Tick as many as possible)

1 = Public Health centres

2 = Private Health centres

3 = Hospital

4 = Pharmacies

5 = Other location ....

08. What are the benefits of family planning? (Only one response is allowed)

1 = Pregnancy testing & counseling

2 = Male and female birth control

3= Other .....

### **III. ATTITUDES AND PRACTICE ON FAMILY PLANNING**

09. Why do people visit or see a family planning service provider?

1 = To get counseling about family planning methods

2 = To discontinue a family planning method

3 = To be resupplied with contraceptives

4 = To change a family planning method

5 = To deal with side effects

6 = Other:

10. Did you use a family planning method before? 0 = No 1 = Yes

11. Are you currently using family planning method? 0 = No 1 = Yes (*If no, skip to N.14*).

- 12. Have you had any problems with your current family planning method? 0 = No 1 = Yes
- 13. Are you satisfied with your current family planning method? 0 = No 1 = Yes
- 14. Do you plan to have more children? 0 = No 1 = Yes
- 15. What about your medical history? .....
- 16. Do you breastfeed? 0 = No 1 = Yes 9 = NA
- 17. During the consultation did the service provider:
  - 17.1. Discuss your motivation for seeking services? 0 = No 1 = Yes
  - 17.2. Ask what worried you about using a modern family planning method? 0 = No 1 = Yes
  - 17.3. Acknowledge and respond to your concerns, if any? 0 = No 1 = Yes 9 = NA
  - 17.4. Explain the results of your physical examination? 0 = No 1 = Yes 9 = NA

**IV. COMMUNICATION SKILLS AND USE OF MATERIALS**

- 18. During the consultation did the service provider: (Multiple responses possible)
  - 18.1 Treat you politely? 0 = No 1 = Yes
  - 18.2 Speak clearly? 0 = No 1 = Yes
  - 18.3 Use words which you understood? 0 = No 1 = Yes
  - 18.4 Listen attentively? 0 = No 1 = Yes
- 19. Did the service provider use any of the following materials?
  - 19.1 Flip books 0 = No 1 = Yes
  - 19.2 Leaflets 0 = No 1 = Yes
  - 19.3 Posters 0 = No 1 = Yes
  - 19.4 Contraceptive samples 0 = No 1 = Yes
  - 19.5 Other items: -----
- 20. Have you heard about family planning in the following media sources? (Multiple responses possible)

20.1 Radio programmes 0 = No 1 = Yes

20.2 Television spots or programmes 0 = No 1 = Yes

20.3 Posters 0 = No 1 = Yes

20.4 Organized talks 0 = No 1 = Yes

20.5 Newspaper articles 0 = No 1 = Yes

20.6 Booklets or leaflets 0 = No 1 = Yes

20.7 Dramas or folk songs? 0 = No 1 = Yes

20.8 Other media: 0 = No 1 = Yes

21. Which of these sources is/was the most influential to you? -----

(Write number on the line from one of the lists above.)

22. Have you heard about family planning on radio for the last 3 months? 0 = No 1 = Yes

23. Have you heard the programme on TV for the last 3 months? 0 = No 1 = Yes

24. Do you have one or more of the following?

1= Radio, 2= TV, 3 = DVD / CD reader, 4 = other: .....

**V. Implementing communication strategies for family planning: language**

25. Is there family planning information available to you (e.g. posted in the clinic or in the waiting room)? 0 = No 1 = Yes

- Is it written in a way that you can understand it? 0 = No 1 = Yes
- Is it available in your preferred language? 0 = No 1 = Yes
- Is there someone available to answer any questions you might have? 0 = No 1 = Yes
- Did you have difficulties communicating with health workers? 0 = No 1 = Yes
- How well did you understand what the nurses or doctors were telling you?

1= Understood very well, 2= Understood well, 3= Understood 4= not Understood clearly

26. Do you feel you can communicate well during your appointments? 0 = No 1 = Yes

• If no, what makes it difficult? .....

.....

.....

• What would make it easier to communicate with health workers? .....

.....

.....

.....

**VI. PERCEPTIONS**

27. Would you recommend anybody to visit a family planning provider? 0 = No 1 = Yes

28. What are /is the need(s) for communication strategies to promote family planning in Maradi State?

.....

.....

.....

## Informant Interview Guide

### Introduction

Thank you for agreeing to participate in this interview. My name is \_\_\_\_\_ and I am working on the topic: *“An Assessment of Communication Strategies for Family Planning Promotion in Niger republic: A Case Study of Some families in Maradi State”*. It is strictly for academic purpose and it is in partial fulfillment of the requirement for an award of M.Sc. in Mass Communication.

#### I. IDENTITY:

1. Gender:

1 = Male 2 = Female

2. Language of interview: -----

3. Type of interviewee:

- Government official: 0 = No 1 = Yes
- Project staff: 0 = No 1 = Yes (If yes, which organization)
- Potential women participant: 0 = No 1 = Yes
- Outsider: 0 = No 1 = Yes
- Health worker 0 = No 1 = Yes (If yes, continue with question 4, if not skip to question 5)

4. Registered nurse 0 = No 1 = Yes  
Enrolled nurse 0 = No 1 = Yes

Medical doctor 0 = No 1 = Yes  
Midwife 0 = No 1 = Yes

#### II. OUTREACH / HEALTH COMMUNICATION

5. Is Reproductive Health (RH) one of the questions that your department / organization focus its activities? 0 = No 1 = Yes

6. (IF YES) On which aspect of reproductive health have you worn your communications activities during the past 2 years? (Multiple answers are possible)

- a) Family Planning 0 = No 1 = Yes
- b) Prenatal Care 0 = No 1 = Yes
- c) Emergency Obstetric Care 0 = No 1 = Yes
- d) Adolescent Sexual Health 0 = No 1 = Yes
- e) Other (specify).....

7. What are the specific actions you have taken in the context of reproductive health?

8. What are the different templates that you use as part of your communication activities on reproductive health since 2011?
9. What are the specific reasons that led to the implementation of your communication activities to promote family planning in the Maradi region?
10. What difficulties (if there are any) have you encountered or do you encounter in using your strategies / activities about family planning in the Maradi State?
11. What is the effectiveness or outcome of your communication strategies for family planning intervention in your area or on your target group?
12. . Tell us about the weaknesses (if there are any)
13. Please, can you suggest or recommend solutions for a more useful communication strategy for family planning in your areas of operation or in the Maradi region?

*Thank you very much for your time.*

**FAMILY PLANNING CENTERS' OBSERVATION GUIDE**

**I. Identification**

1.1 Name of the site: .....

1.2 Name of the health centre: .....

1.3 Name of district health centre: .....

**II. Family Planning Centre**

2.1 Are the following family planning methods **ever** available at this site?

- Pill 0 = No 1 = Yes
- Tubal ligation 0 = No 1 = Yes
- Injectable 0 = No 1 = Yes
- Vasectomy 0 = No 1 = Yes
- IUD 0 = No 1 = Yes
- Norplant/Jadelle 0 = No 1 = Yes
- Foam 0 = No 1 = Yes
- Natural Family Planning 0 = No 1 = Yes
- Diaphragm 0 = No 1 = Yes
- Lactation amenorrhea 0 = No 1 = Yes
- Condom 0 = No 1 = Yes
- Page volte 0 = No 1 = Yes

**III. Materials Available in Family Planning**

3.1 Do the centers have any of the following family planning materials?

- Flip books 0 = No 1 = Yes
- Leaflets 0 = No 1 = Yes

- Posters            0 = No 1 = Yes
- Contraceptive samples            0 = No 1 = Yes
- Anatomical models            0 = No 1 = Yes
- Audiotapes, videotapes, or films            0 = No 1 = Yes
- Page volte            0 = No 1 = Yes

3.2 How often is each material available at this site?

1 = every day

2 = At least once a week

3 = At least once a month

4 = Less than once a month

- Flip books            \_\_\_\_\_
- Leaflets            \_\_\_\_\_
- Posters            \_\_\_\_\_
- Contraceptive samples \_\_\_\_\_
- Audiotapes, videotapes, or films \_\_\_\_\_
- Page volte            0 = No 1 = Yes

**GUIDE FOR FOCUS GROUP DISCUSSION (FGD)**

No of Group Interviewed: -----		Date: -----/-----/ 2012	
Site: -----		Time discussion started: -----	Time ended: -----
Participant summary:	No. of women:	No. of men	Total No.:
	-----	-----	-----
Name(s) of Facilitator(s):-----			

**Introduction**

- Introduce moderators, translators, record keeper (s)
- Introduce topic: Communication strategies for Family Planning (FP) in your locality
- First, I would like to ask you some general questions about the topic (Communication Strategies for family planning):

1. How many of you prefer to receive FP services in a language other than French? \_\_\_\_\_
2. Has anyone here ever needed an interpreter in this clinic? \_\_\_\_\_
3. What was your experience using the interpreter? \_\_\_\_\_

4. For those of you that needed an interpreter but did not have one, how did you communicate during your visit? \_\_\_\_\_
5. How well did you understand what the nurses, midwives or doctors were telling you?
6. Was there information provided to you in your preferred language? \_\_\_\_\_
7. How comfortable are you using family members or friends to interpret during clinic visits?
8. Before we finish, I would like to hear what you think would make communicating for FP at this clinic/IHC more effective?

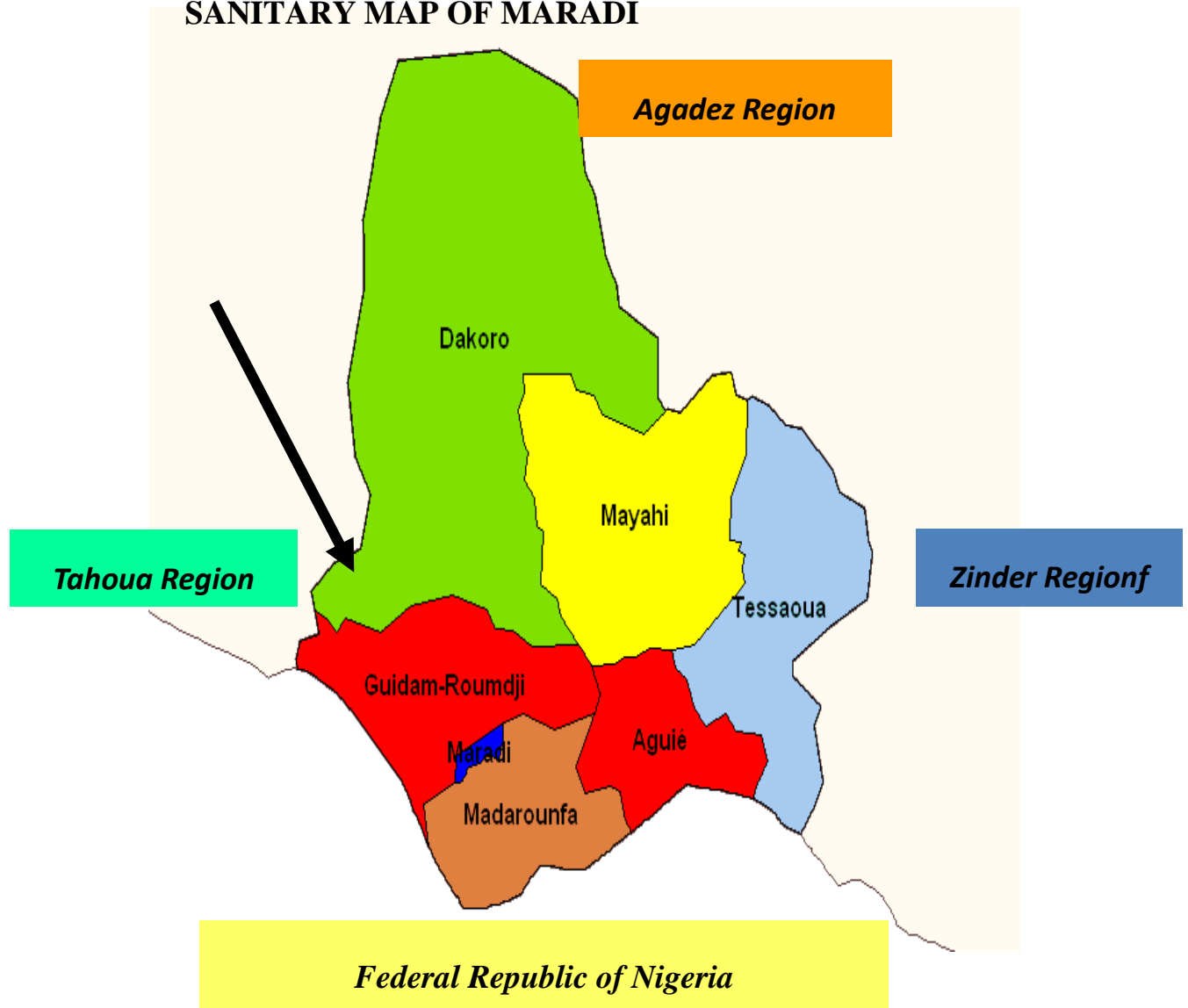
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-----

What do you think about the subjects we have discussed?

-----  
-----  
-----  
-----

*END:* Thank you all for your time and ideas. This has been extremely helpful. As I said in the beginning, the purpose of this discussion was to help me learn about what people need here for better communication strategies to promote family planning in Maradi State.

**SANITARY MAP OF MARADI**





# Family Planning