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The contribution of interactive communication to the improvement of maternal healthcare services in Migori County, Kenya

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Abstract: The contribution of interactive communication in promoting maternal healthcare services are missing in the county's healthcare literature thus leading to higher levels of morbidity and mortality in Migori County. The study therefore achieved the following objectives: it established the influence of face-to-face interactions in promoting maternal health services in Migori County, and it also investigated the role of support group discussion in the uptake of maternal health services in Migori County. The health belief model and the elaboration likelihood models were used to underpin the study. A cross-sectional research design was used with a mixed research method approach. The study targeted a sample size of three hundred and ninety-eight (398) respondents. Sampling techniques used included cluster, systematic random sampling and purposive sampling. The study collected both primary and secondary data. The research instruments used in this study to collect data were questionnaires and key informant interview schedules. The results were done with the help of Microsoft Office Excel and the Statistics Package for Social Sciences (SPSS v25). The results were presented using a combination of narrative explanations, tables, and graphs. The validity and reliability of the instrument were determined through a pre-test and expert opinion to determine whether it addressed all relevant aspects of the variables. The study findings indicate that face-to-face interaction has the most significant influence on promoting maternal healthcare services in Migori County. The study recommends that the county government of Migori should employ more health workers to facilitate support for the use of face-to-face communication.

Keywords – Interpersonal communication, Maternal healthcare, Face to face communication, Maternal mortality, Support group discussion

1. INTRODUCTION

Interpersonal communication, or IPC, is the process of communicating meanings, emotions, and information to and from individuals in person or through technology, both audibly and nonverbally (Hartley, 2012). On the other hand, private, intimate, and specific communication occurs during dialogue or discussion (Schiavo, 2013). It is the sharing of information between two individuals. This kind of involvement is essential and very beneficial when sharing information and teaching neighbors, families, communities, and friends (Ting'aa, 2018). Talking to someone face-to-

face and verbally facilitates a more thorough discussion and helps clarify things more clearly, which is why it's crucial when discussing private health problems. IPC, when used with communication technology, makes clear reporting possible. IPC as a communication tool allows for the unambiguous reporting of conversations and the recording of health issue outcomes (Ting'aa, 2018).

However, with the availability of rapid, simple, and affordable networking solutions, recent technological advancements have completely changed the way information is shared. Face-to-face interactions are still very important in today's world, so it's important to incorporate both established and new communication methods (Schiavo, 2013). This means that a review and integration of new, traditional, and mainstream media are necessary to better society. Social structures and interpersonal interactions have a critical role in shaping African women's decisions regarding their reproductive health. According to Mary (2017), this is one of the most widely used techniques in sensitization campaigns aimed at reducing Kenya's maternal death rate. Interpersonal communication needs to be effective for patients and healthcare providers to build healthy connections. Improving patient satisfaction, treatment acceptability, and health outcomes all depend heavily on interpersonal communication between medical professionals and patients. Patients are more satisfied with the care they receive and are more likely to adhere to treatment recommendations when they have a thorough awareness of the nature of their illnesses and treatments and a strong belief in the professionalism of the healthcare practitioners (USAID, 2013).

Additionally, it guarantees that all participants have constructive communication with one another and comprehend the content being shared completely. Patients' actions, such as establishing a good relationship by refraining from being impolite or yelling, bridging social divides, and promoting two-way conversation, can improve the effectiveness of communication between healthcare practitioners and patients. Using both verbal and nonverbal cues to communicate effectively, maintaining a happy mood when interacting with patients, and giving them adequate time to share their medical histories are additional useful tactics (Madula, 2018). Poor patient care results from healthcare practitioners and patients not using IPCs appropriately. Proper communication between patients and healthcare providers is essential to guaranteeing the appropriate delivery of maternal services. Patients and healthcare professionals can connect therapeutically thanks to this communication as well as knowledge (USAID, 2013).

Consequently, establishing a good rapport between the two parties is crucial in encouraging expectant mothers to use maternity care at medical facilities. Only through efficient interpersonal communication can the health sector push for increased financing and effectively promote maternal health, including family planning services. Achieving universal access to reproductive health by 2015 and reducing the maternal death and morbidity ratio by three-quarters between 1990 and 2015 are the objectives of the fifth Millennium Development Goal. The number of births attended by trained medical professionals, the prevalence of contraceptives, the number of unmet family planning needs, the antenatal care coverage rate, the adolescent birth rate, and the maternal mortality ratio are some of the indicators used to determine the gains in maternal health (Mungai, 2015). To achieve optimal maternal health, it is necessary to provide high-quality reproductive health care and a range of timely interventions that enable women to give birth safely and adjust to motherhood smoothly. If the objectives were not met, there would be a great number of preventable deaths annually, serving as a sombre reminder of the low status that women bear in some communities.

It is extremely difficult to define maternal mortality brought on by problems connected to pregnancy. Approximating the numbers is hard because organised deception is widespread (Mungai, 2015). MDG 5 has advanced, as evidenced by improved maternity and reproductive health care provided to women across all regions and trend statistics showing a decline in maternal morbidity and mortality. Maternal death in Kenya has gradually decreased over the past ten years, with the ratio falling from 432 in 2010 to 342 in 2017. Regardless of the government's Ministry of Health's numerous health campaign activities aimed at addressing maternal healthcare, Under the leadership of former Kenyan President Uhuru Kenyatta, the government abolished maternity fees at public hospitals and clinics on June 1, 2013. This action decreased the frequency of maternal fatalities and made maternity services

available to all pregnant mothers. In contast, Migori County has one of Kenya's lowest maternal survival rates. The county now has a maternal mortality ratio (MMR) of 673 deaths per 100,000 live births. There is a need for a context-specific strategy to reduce rural Kenya's persistently high maternal mortality rate to meet the Sustainable Development Goal, which aims to reduce the world's pregnancy rate to below 70 per 100-,000 live births, this is far too high (Masaba, 2023).

The majority of hospitals and dispensaries in Migori County, particularly those located in rural areas, function without the most basic amenities, like clean water, electricity, and medical equipment. According to Cheptum (2014), the majority of these clinics are not even equipped to perform caesarean section procedures. Furthermore, because maternal healthcare is generally inadequate, particularly for appropriate prenatal and delivery care, rates of maternal mortality, newborn mortality, neonatal deaths, and morbidity remain high (Banke, 2017). Globally, the SubSaharan African region has the highest number of maternal deaths, with a ratio of 546 maternal deaths per 100,000 live births, or around 201,000 maternal deaths each year. This accounts for almost two-thirds of all maternal deaths worldwide each year (Nnadi, 2022).

In comparison to Sustainable Development Goal number five, which aims to guarantee a reduction in the worldwide maternal mortality rate to less than 70 per 100,000 live births by 2030, the current incidence of maternal death is extremely high . "Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" is the definition given by the World Health Organisation (WHO, 2015). In 2017, there were about 293,000 maternal deaths and postpartum deaths worldwide. The lives of pregnant women were complicated since the bulk of the deaths, or 94%, might have been avoided because they happened in low-resource settings (WHO, 2019). Maternal problems claim the lives of about 450,000 women worldwide each year. Sub-Saharan Africa accounts for half of all maternal deaths worldwide. Around 85% (253,000) of maternal deaths worldwide in 2017 occurred in Sub-Saharan Africa in addition to Southern Asia (WHO, 2015). Only in Sub-Saharan Africa were 33% (195,000) of maternal deaths recorded in that year.

Pregnancy-related complications, obstetric complications, unsafe abortions, childbirth, and other problems such as obstructed labour, infection, severe bleeding, and hypertensive disorders are the main causes of mother mortality. Differences in the quality of care received by mothers result in differences in the health outcomes of mothers and newborns. The fact that some of Kenya's poorest counties, like Migori, have the worst rates of maternal mortality in the nation lends credence to this (Cheptum, 2014). WHO reports that a shortage of qualified healthcare providers causes women in South Asia and Sub-Saharan Africa's rural areas to get subpar medical care. Furthermore, one of the things inhibiting women from seeking or receiving medical treatment during pregnancy and childbirth is a lack of knowledge (WHO, 2015). Certain difficulties and issues associated with pregnancy can be addressed by improved communication between patients and healthcare professionals.

A single strategy to address maternal and pregnancy-related difficulties is to educate women of reproductive age to seek out maternal healthcare services. Reducing maternal mortality is a universal health objective. In order to convince pregnant women to give birth in accordance with government policies, healthcare providers must make sure that they use interpersonal communication in their health treatments (Ting'aa, 2018). Utilising maternal health services can be encouraged by women's use of interpersonal communication techniques such as face-to-face interactions, support group discussions, and mediated interpersonal communication. Through the use of modern technology, interpersonal communication campaigns can effectively increase awareness of maternal healthcare by sharing information about it across national borders.

A long-term solution is offered by interpersonal communication, which fosters understanding across various public and health sector players. In order to reach out to a variety of audiences and share health-related and maternal care information, it is then integrated into the field of motherhood and health to provide a multidisciplinary and multifaceted approach. The ultimate goal is to persuade policymakers and healthcare professionals to champion social change and behavioural modification in order to achieve the set goals and bjectives. (Schiavo, 2013).

2. LITERATURE SURVEY

2.1. In-person communication to promote maternal healthcare services

The process of exchanging meanings, emotions, and information both vocally and nonverbally with people in person or via technology is known as interpersonal communication, or IPC (Hartley, 2012). In contrast, direct, personal, and intimate communication takes place through dialogues or discussions (Schiavo, 2013). The mediated type of interpersonal communication is one in which two or more people exchange messages with one another through the use of mechanical equipment; feedback is immediate and based on the replies one receives. The majority of scholars argue that IPC is essential to human survival and that no person can prosper without it; for this reason, it is useful when local actors in the community need motivation and empowerment to take action and take care of their needs.

According to USAID (2015), interpersonal communication is the most widely utilised type of communication and is also regarded as the oldest. It can be described in greater detail by following the four main recommendations made by Ting'aa (2018). Complicated, unavoidable, contextual, and irreversible are the four basic tenets of interpersonal communication. People talk with one another all day long; therefore, interpersonal communication is unavoidable. Interpersonal communication involves the use of gestures, voices, postures, and facial expressions in addition to words (MOH, 2014). As a result, when people connect with one another, they typically make physical contact during the process of interpersonal communication. According to the IPC, once a word is spoken, it cannot be taken back, and no statement can be undone. This is known as irreversibility. Healthcare professionals who are distributing messages about maternal health must possess a thorough awareness of the most important messages pertaining to maternal healthcare. This will ensure that the information is accurately conveyed to the target audiences and yields the desired outcomes (MOH, 2014). People's ability to interpret words differently is the only way that interpersonal communication may become more complex through language.

As a result, IPC may be complicated due to a multitude of communication-related aspects. Many academics and thinkers concur that there are important factors to consider when individuals communicate with one another. These include the identities that each person believes themselves to be, the identities that each believes the other to be, the identities that each believes themselves to be, the identities that each believes another to be, and the identities that each truly believes the other to be. It appears that in order for their communications to be correctly understood and accepted, communicators must reduce the likelihood of ambiguity and the necessity of clarifying their claims (Ting'aa, 2018). Healthcare professionals who are tasked with communicating with the public in situations involving mothers and children must be aware of the unique characteristics of the target community in order to deliver the appropriate information and raise awareness among the audience about the issues surrounding women and child survival.

A psychological context that typically deals with emotions and moods is one of the contextual frameworks in which interpersonal communication takes place. The effect of communication and the information being shared is experienced by the audience based on the sender's emotional state. Intimate ties help people understand one another better than they do not; hence, familiarity between the speaker and the listener has an impact on communication in relational contexts. (Ting'aa, 2018). Situational contexts confirm that communication takes place in both public and private settings and that involvement affects the environment in which it occurs. In addition, learning behaviours and individual norms are influenced by cultural environments. It's because people from various cultural backgrounds interact and communicate in unique ways. Notably, healthcare professionals involved in campaigns for mother and child health and survival need to recognize the importance of interpersonal communication in reaching their objectives. The actual setting where communication takes place, like a classroom, is another example of an environmental context.

Numerous studies carried out in affluent nations demonstrate that improved service quality is contingent upon the efficacy of interpersonal communication, which is reinforced in health professional education (USAID, 2013). According to research, with the right instruction and follow-ups, health counselling abilities, patient-provider interactions, and communication all improve. The different outpatient clinics, which are located in pharmacies,

health centres, and hospitals, are frequently the first places where moms and children interact with medical professionals. Therefore, one of the best ways to promote health is to set up clinics just for moms. Maternal and Child Health (MCH) clinics offer a wide range of preventative treatments as well as some basic therapeutic therapy for ill mothers. These services are crucial to the healthcare industry in general.

In order to guarantee a good interpersonal connection in the hospital, moms and healthcare professionals must form a partnership and a two-way channel of communication that fosters a caring environment (Korir, 2015). Patient satisfaction and healthcare provider-patient communication are frequently linked; this can be attained by remembering information, adhering to routine clinical visits, and keeping appointments. This means that developing one's capacity for effective communication and for selecting the most appropriate messages to spread are equally essential. Observational techniques and the use of different interpersonal communication principles are essential to developing good interpersonal skills (Teresa, 1994). It is not reasonable to believe that good communication comes naturally. It is inevitable that the patient and the healthcare professional will come from different socioeconomic and cultural backgrounds, even if they both reside in the same area and speak the same language. Obstetricians may encounter difficulties during labour, such as a lack of privacy in their interactions with medical staff.

The content of interpersonal communications is tailored to the patient's educational background, level of comprehension of technical information, proposed treatment plan, and interactions with other medical professionals. Women are better able to comprehend their health issues and available treatment options when interpersonal communication styles and content are used effectively. IPC is a diagnostic communication utilized in problem solving since it establishes information to determine diagnosis and treatment. Additionally, it helps women who are ready to have children understand their options for family planning, prenatal visits, delivery, and postpartum care. In order to guarantee positive patient-physician interactions, clinicians need to possess appropriate consultation skills that facilitate communication. Patients use their medical contacts as a means of expressing discontent when there is ineffective communication.

It is confirmed that all patient behaviours have communicative meanings and messages since all actions have the ability to send messages. According to Teresa (1994), there are two ways in which non-verbal communication can be conveyed: vocal and non-vocal.

2.2. Support group discussions in maternal health services

Support groups are formed to provide emotional support and information to those who have a shared concern. They are frequently facilitated by professionals and tied to a social agency or a larger formal group. Individuals who are not serviced by the organisation are frequently denied membership (Kurts, 1997). Behavioural and cultural change are subservient to the purpose of emotional support; education meetings are relatively unstructured; and the group programme is unlikely to promote an ideology. There are no fees or dues charged by support groups. Support groups use a number of techniques, some of which focus on behavioural issues and symptoms (such as pain and fatigue), while others focus on emotional expression. The majority of these support programmes are structured and short-term, including components such as information delivery, emotional and social support, stress management measures based on the cognitive-behavioural approach, and relaxation technique training. Aside from individual therapy, group therapies can address pregnancy-related difficulties, allowing patients to obtain emotional support from other patients who have had similar experiences and utilise these experiences to buffer their fear of dying and the unknown future (Weis, 2003).

In Kenya, community health workers (CHWs) and health workers stationed at various health institutions are responsible for informing expectant mothers about key maternal and child survival messages via interpersonal communication. CHWs often do this when they visit clients's homes and the health institution during clinic days. On these occasions, the institution's medical staff schedules health education workshops for women who have come in for ANC and child immunisation services (MOH, 2007). Health practitioners deliver these maternal health messages to stakeholders through one-on-one talks and intimate small group discussions, as well as the use of relevant

examples. Other ways of interpersonal communication include teaching or lecturing with examples, using visual aids or graphics, counselling, and watching films while conversing.

It is widely acknowledged that becoming a parent is a stressful time, and many women report feeling isolated and lonely when raising a child (GOK, 2010). A growing body of research shows that social support is critical for improving mother confidence and optimising parenting abilities, as new mothers increasingly lack access to broad social networks. Programme administrators are interested in measures that foster peer support. Such groups are helpful not only for patients but also for their wives and other family members in easing the cancer-related distress (Weis, 2003). Empirical research shows that peer support, which involves contacts between people who have similar experiences, is a very effective and critical technique for retaining breastfeeding and aiding new families in transitioning to parenthood. Women in similar life situations can encourage one another by sharing their tales, which helps them cope with their own experiences and aid others.

Instead of forming entirely new groups, mobilisation efforts should focus on discovering and recruiting women from existing community groups in order to maximise their efficacy and durability. It is best to select organisations based on their interest in maternal health. We may leverage women's organisations that already meet on a regular basis to gain access to long-term, continuous channels for disseminating information about support groups. Numerous studies undertaken in industrialised countries have looked into the effect of support networks on health-seeking behaviour and the use of maternal health care during the parenting stage. The findings indicate that friends, family, and partners can have a major influence on health-seeking behaviour.

Family is a significant component of care access, according to numerous studies that have qualitatively examined the relationship between social support and maternal healthcare access in developing countries. However, very few, if any, studies have examined the idea that, in contexts in developed nations, maternal health care seeking behaviour could be related to network characteristics from a qualitative perspective. There is a comparison of three different kinds of variables: network characteristics, demographic factors, and interpersonal communication. This enables us to comprehend the relationship between pregnancy-related outcomes and network properties and communication within this relationship. The second hypothesis states that there will be a positive correlation between pregnancy-related outcomes and variables related to age, marital status, education, religion, and communication language (Dougherty, 2018).

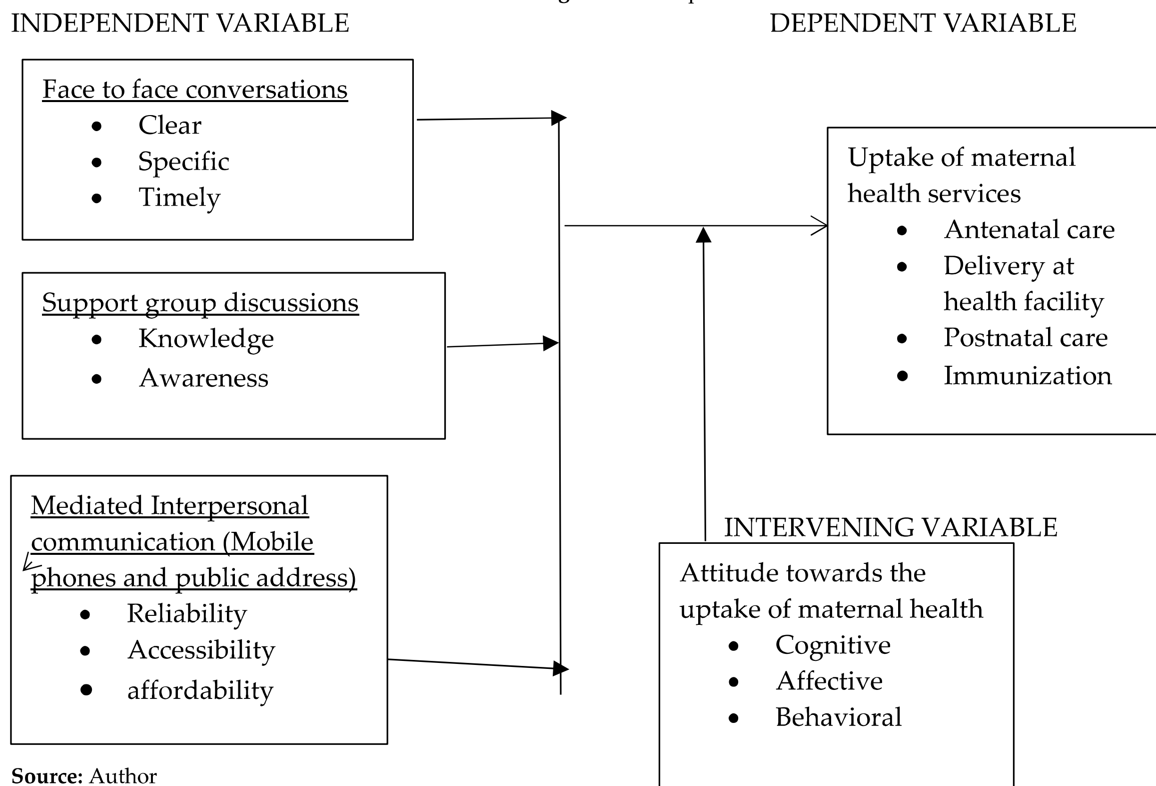
It goes without saying that women who discuss prenatal care frequently will take advantage of services. Additionally, women who report obtaining information and advice will be more likely to use services than those who do not. By sharing knowledge, women can have a better understanding of when and how to access prenatal and postnatal care services. In Germany, support groups are developed in outpatient programs and rehabilitation centers. They are vital to the palliative and supportive care provided to cancer patients. Structured group therapy has been demonstrated in numerous empirical studies to enhance psychological well-being, lessen anxiety and despair, and enhance quality of life, coping mechanisms, and mental health in cancer patients. Although beneficial effects on survival have been suggested, they have not yet been validated (Weis 2003).

3. PROBLEM STATEMENT

In the face of the county’s best efforts to support maternal healthcare, most mothers are unable to become maternal health literate due to inappropriate use of interpersonal communication to provide maternal health information. Lack of access to sufficient and reliable maternal healthcare information has an impact on how often mothers use maternal health services. Higher rates of morbidity and mortality in Migori County result from this, hence the impact on the execution of maternal health initiatives. The county government has implemented a number of initiatives to address issues related to maternal health; yet, the maternal death rate in the area is 673 per 100,000 live births, whereas the national average is 342 per 100,000 live births (Cheptum, 2014). Additionally, Migori is one of the 15 Kenyan regions that accounts for 60% of the country's maternal death rate. It is therefore evident that the County of Migori has seen an increase in mortality and morbidity. Importantly, receiving maternity care in a medical facility may not always

mean that this issue will be resolved. Maternal health care is a critical area of focus in the health sector because a decline in the usage of these services results in an increase in maternal fatalities. The number of women giving birth at home, where there is no access to professional care, can rise as a result of low usage of maternal health care services. Thus, it is imperative to affect behaviour change. Interactive communication can be used to achieve this, as it is utilised to advance maternal health care and foster awareness and long-term solutions among the public and stakeholders in the health sector.

Figure 1: Conceptual framework



Source: Author

4. RESEARCH METHODOLOGY OR METHODS

4.1. Method

In order to provide a more thorough explanation of the research subject under investigation, the study employed two research methodologies, utilizing both qualitative and quantitative approaches to data gathering (Truck, 2014). In addition to avoiding the drawbacks and challenges associated with a single study approach, the researcher intended to gain a deeper understanding of the issues under investigation by combining both qualitative and quantitative approaches and linking disparate views, contradictions, and fresh perspectives. This also aids in the validation of findings. The survey method used in quantitative data collection is a structured questionnaire that was administered to 398 women of reproductive age visiting the Rongo and Migori sub county hospitals.

With a questionnaire, the researcher could easily collect a large amount of information from a large number of people at relatively low cost and within a short period of time. Interviews with 20 key informants were used to gather qualitative information. The Rongo and Migori subcounty hospitals' nurses, clinical officers, physicians, and other health authorities who worked on the designated clinic days were among the key informants who were interviewed. The approach ensures that the responses are honest by allowing the researcher to easily elicit more information from the respondents (Sekaran, 2005). Key informant interviews should show respondents' opinions and attitudes, as well as the things that influence their thinking in certain ways (Ong'ondo & Jwan, 2011).

4.2. Design

This study employed a cross-sectional study design to describe the current situation and investigate how interpersonal communication contributes to better maternal health services in Migori County. The approach worked well for this research topic because it facilitated the analysis of the relationship between maternal health service uptake and interpersonal communication.

4.3. Participants

For the survey, a sample population of 129,049 people was selected to become the study population. The survey included 63,694 women overall and 65,329 women from the Rongo subcounty. The study's main focus was on reproductive-age women who visited MCH clinics, as well as MCH staff members at Rongo-Sub-County Hospital and Migori, such as nurses and doctors. The study population was obtained by taking into account that Suna East sub-county has a population of 9.4% and Rongo town has the largest urban centre in Migori county, with a population of 14.6% of the county total. As such, a subset of participants is chosen from the population; this subset may be small, yet it serves as a sufficient representation of the population. Yamane's (1967) formula was used to recalibrate the study's sample size.

In which case: n= Sample size,

N = The size of the population

e = precision level.

Using e = 5% and a 95% confidence level

n = N/(1+N⟦(e)⟧^2)

n = 129,049/(1 + 129,049⟦(0.05)⟧^2)

n = 398.

Thus, the study used 398 respondents. 398 respondents from all of the health facilities under study were obtained by applying Yamane's formula for sample size with an error of 5% and a confidence level of 95%, with a target population of 129,049 (KDHS, 2019). According to the Krejcie and Morgan (1970) chart, a sample size of 391 is adequate when the target population is between 20,000 and 30,000. Therefore, this sample size is appropriate.

5. DATA ANALYSIS AND DISCUSSIONS

Tables and charts were used for the data analysis and tabulation process. The surveys were coded using both descriptive and inferential statistical methodologies and techniques in order to analyse the quantitative data. The analysis of qualitative data involved recording the procedures used to gather the data, classifying and organising each concept, creating connections between concepts to show how they relate to one another, looking at competing theories to support the data, and finally presenting the accounts of the information that was gathered. The reporting of findings, often referred to as representing the narratives of the information gathered, and the data corroboration through alternate explanation exploration are other steps in the process. Writing a narrative report, including quotes from important sources, came next.

Table 1: Language of communication during interaction with the health care providers

Communication Language	N	Response (%)	Cases (%)
Swahili Language	132	46.3	84.9
Other vernacular language	81	28.4	52.0
English Language	73	25.4	46.5
Total	**286**	**100**	**183.4**

Source: Author

According to Table 1, the majority of respondents said that they preferred speaking in Kiswahili for communication. Of the respondents, 46% spoke Kiswahili, 28.1 percent spoke vernacular English, and 25.4% spoke their preferred form of English. They all got the message of mother-and-child survival, despite the language choice. Therefore, the

results suggest that healthcare workers should speak a variety of languages to facilitate communication in order to reach the majority of individuals regarding maternal health information. Employers in the healthcare industry should think about hiring staff members who are conversant in the local tongue.

Table 2: How healthcare providers communicate with women at MCH/ANC?

Healthcare providers communication with participants	Frequency (N)	Percent (%)
Support group discussions	107	37.4
Face-to-face conversations	125	43.7
Through husband	14	4.9
Through other mothers	12	4.2
Posters/billboards	5	1.7
Public address	6	2.1
Door to door campaigns	4	1.4
Others	13	4.5
Total	**286**	**100.0**

Source: Author

The results show that most healthcare professionals have in-person interactions. 125 (43.7%) face-to-face interactions, 107 (37%), support group discussions, 14 (4.9%) through the spouse, 12 (4.2%) through other moms, 5 (1.7%) through posters and billboards, 6 (2.1%) through public addresses, 4 (1.4%) through door-to-door campaigns, and 13 (4.5%) through other formats were noted. This showed that in-person conversations were more beneficial to the majority of respondents than other types of communication.

Based on the qualitative data and the interviews, KII 1 clarified that face-to-face interactions are the primary means of educating women who attend the institution during MCH clinics on maternal health issues. During these sessions, counselling and assistance on managing postpartum depression are also given to first-time mothers. Women are more likely to use further maternal health services and visit the following clinic if they are satisfied with the information we provide them during these consultations.

Table 3: Influence of Face-To-Face Interaction in promoting maternal healthcare service

Influence	Frequency (Yes)	No	X^2	p-value
Time				
< 15 min	115 (80.4)	11 (8.4)		
16 – 30 min	101 (67.2)	10 (17.2)	9.33	0.006
31 – 60 min	121 (88.4)	12 (18.4)		
>61 min	105 (88.2)	15 (28.2)		
Conversation				
All the time	36 (80.4)	9 (18.4)		
When necessary	127 (67.2)	10 (17.7)		
When there is time	121 (88.4)	20 (16.4)	1.289	0.013
Not at all	15 (88.2)	15 (28.2)		
Importance of Information				
Yes	201 (82.7)	10 (56)		
No	19 (45)	63 (19)	7.551	0.005

Source: Author

Table 3 also illustrates when the conversation was engaged. The findings showed that most information was rendered to the mothers face-to-face when there was enough time since most health care workers have busy schedules. Therefore, initiating a face-to-face conversation when there is time had a majority compared to all the time, when necessary, and not at all variables, respectively (88.4%, 80.4%, 67.2%, and 88.2%). Additionally, most of the respondents found the information rendered face-to-face useful. 82.7% of the respondents said the information was important to them. Additionally, the qualitative data clearly shows that face-to-face interactions were the most favoured method of interpersonal communication between healthcare personnel and women at MCH. Women talked with the MCH practitioners face-to-face for longer periods of time.

KII4 The World Health Organisation's interpersonal communication policy has had a bigger impact on the delivery and uptake of maternal health care in this facility than it did before. The rate of maternal fatalities and morbidities has declined, as has the number of women utilising these maternal health services. In light of this development, it is imperative that women utilising the facility receive reliable, affordable, and timely medical care. MCH professionals ought to strive towards enhancing their interpersonal communication skills as a means of favourably influencing clients' faith in the formal healthcare system. This is due to the fact that these abilities are critical to raising the level of customer satisfaction with the qualifications of healthcare professionals during in-person interactions related to the delivery of maternal health services.

Furthermore, the majority of respondents thought the information provided in person was helpful. 82.7% of those surveyed stated they found the information to be significant. In order to lower maternal mortality rates, the respondents supported the idea of speaking with mothers face-to-face about maternal health issues. The data collected clearly shows that face-to-face interactions were the most favoured method of interpersonal communication between healthcare personnel and women at MCH. Women talked with the MCH practitioners face-to-face for longer periods of time.

These seminars provided women and health professionals with an opportunity to ask questions about issues related to maternal healthcare. In one-on-one talks, the women reported feeling more at ease and confident enough to confide in the healthcare provider. One-on-one interviews facilitate the acquisition of thorough information about the mother's illnesses. While everyone participating in these discussions can hear what is being said, they can also read important cues from one another's body language and facial expressions, which aids in understanding the meaning of what is being said. All five KIIs agreed that face-to-face communication was the most effective and fruitful method of interpersonal exchange in MCH clinics.

KII 5 Most of the women who work at MCH clinics prefer face-to-face contact since they are more at ease and comfortable asking questions in these kinds of environments. During these sessions, they also open up and discuss in-depth personal health concerns with us. We also furnish them with timely feedback and clarifications on complex health issues. These are lengthy conversations, but women leave the institution when they are satisfied with the treatment they receive and feel positively about using maternal health services.

Effective maternal service delivery necessitates face-to-face communication. It takes skill and good communication to develop a therapeutic relationship between a patient and a healthcare professional.

KII 6 noted that many women would rather receive more detailed information about their health conditions in a face-to-face chat than receive concise summaries and instructions. Expectant moms are more likely to give birth in a medical facility if they are happy with the way MCH clinic healthcare staff engage with them.

KII 2 After providing women with maternal health services on the days designated for the clinics, we engage in group discussions aimed at sensitization. The experiences of other women in these forums provide them with encouragement. In addition to learning how to breastfeed their babies exclusively, first-time moms who are accompanied by their partners are typically instructed on the best family planning options.

Face-to-face communication is essential to efficiently providing maternal services. It takes skill and skillful use of face-to-face communication for a healthcare provider and patient to develop a therapeutic relationship. Therefore, promoting the use of maternal services by expectant mothers at a health facility remains contingent upon the health professionals' favourable rapport with these women.

Nonverbal cues are often employed in addition to spoken words, which is a big issue for face-to-face communication. Social conventions and cultural practices have a distinct influence on many aspects of nonverbal communication. Particularly when it comes to those of the opposite sex, direct eye contact, for example, might be

interpreted as unsuitable or hostile in some cultures, but it can also be interpreted as a sign of respect and consideration from others. According to KII 7, in certain cultures, touching the patient's hand or arm during a talk is considered highly inappropriate, but in others, it is perceived as a sign of affection.

KII7 Health practitioners utilise physical contact, such as touch, to assess a pregnant mother's readiness for delivery and labour and to ascertain the baby's position during a physical examination. Some moms feel guarded, especially if they are being examined by a male nurse or physician. Both the mother and the infant may be put in danger by this.Easy actions that convey a positive message and achieve the intended outcome include smiling and leaning in to listen to the patient. Messages are conveyed through all nonverbal communication.

The findings of this study are also consistent with a study by Ting'aa (2018), which discovered that face-to-face communication was the most prevalent and successful form of interpersonal communication for supporting campaigns for mother and child survival. These findings also corroborate those of Korir (2015), who discovered that one-on-one interactions with medical experts were the most effective means of communication for providing mother-and-child healthcare. These findings corroborate the Ministry of Health's recommendations, which emphasise that health professionals should speak with patients face-to-face due to the complexity of health issues. Furthermore, it highlights the generation and transfer of knowledge that occurs when using the face-to-face version of IPC.

These results support the Ministry of Health's assertion that, in addition to instruction, in-person interactions have an impact on people's perceptions, beliefs, and attitudes, which in turn affect behavior. (MOH, 2014). These results also support the findings of Korir (2015), which indicate that during their MCH clinics, the majority of women favoured direct interpersonal conversation over mediated communication.

Table 4: Role of support group discussions in the uptake of maternal health services

Influence	**Support group Discussion**			
	Yes	**No**	**X^2**	**p-value**
Safe delivery				
Attending ANC clinic	110 (65.4)	9 (18.4)		
Family and friends	99 (40.2)	45 (17.2)	9.81	0.016
Healthcare providers	99 (83.4)	10 (18.4)		
Home	100 (64.2)	11 (18.2)		
Know contraceptive method				
Attending ANC clinic	44 (70.4)	9 (8.4)		
Partners	112 (77.2)	19 (7.7)		
Healthcare providers	73 (68.4)	26 (6.4)	7.286	0.001
Other women	19 (48.2)	15 (8.2)		
Billboards, newsletter, internet	11 (21.9)	23 (9.3)		

Source: Author

The findings from Table 4 indicated that information on safe delivery and knowledge on contraceptive methods were offered to mothers through support discussions. Mothers obtained information on safe deliveries from different intermediaries, such as attending an ANC clinic, family and friends, healthcare providers, and at home. The majority obtained information on safe delivery from health care providers as compared to other sources; the respondents presented (83.4%), attending an ANC clinic recorded (65.4%), discussions from home recorded (64.2%), healthcare providers recorded (64.2%), and the least was discussions conducted from family and friends, which registered (40.2%) of the respondents.

Knowledge of contraceptives was obtained through attending ANC clinics, partners, healthcare providers, women, billboards, newsletters, and the internet. Most of the information was derived from partners.77.2% of the respondents received information on contraceptives from their partners, 70.4% got information through attending an ANC clinic, 68.4% acquired knowledge through healthcare providers, information from other women was 48.2%,

and the least percentage was recorded from respondents getting information from billboards, newsletters, and the internet. It was revealed during talks with KII 2 that moms were provided with knowledge on contraceptives and safe delivery practices through support group talks conducted at MCH clinics. She said,

KII 2: After women get maternal health treatments on the days set aside for maternal health clinics, sensitization is carried out through group talks. In these forums, they find solace in the experiences of other women. First-time mothers also receive training on exclusive breastfeeding in addition to guidance on family planning options.

It is mandatory for healthcare providers to provide health discussions or health education to moms who visit the institution for ANC after they have chats with them. According to MOH (2014), once moms receive maternal health treatments, maternity health education and sensitization are conducted on the days set out for maternal health clinics. Mothers can interact with doctors in person, exchange experiences with other mothers, ask straightforward questions, and receive clear answers through these forums. First-time mothers are accompanied by their partners, who come to inquire about the health of their loved ones and, at the same time, provide social and psychological support.

On days set aside for maternal health clinics, health facilities host maternal health education and sensitization events. According to KII 3, the morning delivery of maternal health care is followed by the afternoon session. According to key informants, this forum provides a face-to-face conversation space between MCH professionals and mothers, who then raise questions and seek clarifications on issues related to maternal health.

KII 3: Family planning and ANC services, among other packages, must be offered during clinic days through in-person health consultations, according to MOH policy.

These findings are in line with MOH (2007), which demonstrated how nurses informed mothers during support group sessions held in medical institutions. Moreover, KIIs state that the facilitated support group talks that inform, educate, and counsel women on topics related to maternal health during MCH clinics are very successful because some women came with partners who had some prior knowledge about using contraceptives; while this took a considerable amount of time, it was easier to encourage these women to use the contraceptives. Women with medical difficulties, according to KII 4, receive treatment and attention in the morning, and clients and patients receive health education in the afternoon. One of them even went so far as to post a daily schedule of health seminars.

KII 4 Given the high demands placed on us as maternal health professionals, our overworked status, and the fact that even our clients are eager to return home, it can be difficult to start each day with medication and conclude it with health conversations reserved for these clinics.

The awareness of a partner about contraceptives may have an impact on the use of maternal health services. Their ability to access and assess maternal health messages that they can share with their partner is enhanced by their level of awareness regarding contraception.

One of the KII 6 who was supposed to give a health lecture that day said,
KII6 By sharing this useful information and knowledge, the spouses' comprehension of the benefits of utilising the maternal health care offered by the medical facility may be enhanced and encouraged. These findings align with the findings of MOH (2007), which demonstrated that nurses educated mothers during group discussions held in hospitals.

6. RESEARCH IMPLICATIONS

The study will help decision-makers make sure that the best interpersonal communication tools are created for county governments. Informed about how healthcare providers engage and communicate with women, this study will benefit those involved in the health sector by improving maternal health. Researchers, scholars, and academicians interested in learning more about the role of interpersonal communication in promoting maternal health services will find the study's conclusions to be useful resources for future reference.

7. CONTRIBUTIONS TO SCIENTIFIC COMMUNITY AND FUTURE RESEARCH

This study has demonstrated the potential benefits of interpersonal communication in sustainable development by serving as a tool for behaviour modification. Nevertheless, in order to increase the uptake of maternal services at Migori County's health facilities, there needs to be strong advocacy for the use of mediated interpersonal communication.

8. CONCLUSION

The study found that women preferred face-to-face interactions over other forms of information gathering and that this preference had the greatest influence on the promotion of maternity healthcare services in Migori County. A face-to-face chat is essential to collecting thorough information regarding the mother's symptoms. While everyone participating in these conversations can hear what is being said, they can also see important cues such as body language and facial expressions, which aid in understanding the meaning of the words being spoken. The results show that Migori County women have not prioritised talking about pregnancy-related difficulties with other family members or with each other. Because they received services prior to taking part in a support group discussion at a medical facility, women would only have learned about these maternal health services through the communication of health professionals. Women were also urged to engage in developmental and health activities in order to enhance the utilisation of maternal health services. During MCH clinics, support group talks on issues including breastfeeding, safe delivery practices, and contraception techniques were held at the health center. The study found that discussions about maternal health care were also quite popular in support groups.

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REFERENCES

Banke-Thomas, A., Banke-Thomas, O., Kivuvani, M., & Ameh, C. A. (2017). Maternal health services utilisation by Kenyan adolescent mothers: analysis of the demographic health survey 2014. *Sexual & Reproductive Healthcare*, *12*, 37-46.

Cheptum, J. J., Gitonga, M. M., Mutua, E. M., Mukui, S. J., Ndambuki, J. M., & Koima, W. J. (2014). Barriers to access and utilization of maternal and infant health services in Migori, Kenya.

Doherty, J., Brosnan, M., & Sheehy, L. (2021). Changes in care in the fourth trimester in Ireland: 2010–2020. *British Journal of Midwifery*, *29*(12), 683-691.

Hartley, J. (2012). *Communication, cultural and media studies: The key concepts*. Routledge.

Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. *Educational and psychological measurement*, *30*(3), 607-610.

Kurts, L. F. (1997). Self help and support groups. In *A hand book for practioners/authers* (34). Sage Publication.

Marcy, H., &. (2017). Health medicine and Nursing practice. *International journal* (1), 1-13. doi:25200852 *Health*, *15*, 487- 498. Retrieved from https:/doi.org/10.2147/IJWH.5396257

Masaba, B. B., & Mmusi-Phetoe, R. (2023). A strategy for reducing Maternal mortality in Rural Kenya. *International journal of women's Health.15,487- 498.https:/doi.org/10.2147/IJWH.5396257*

MOH. (2007). Community implimentation Guidelines; Key health messages for level 1 of the Kenya essential package for Health. *Amanual for community extension wokers*.

Mungai, S. (2015). *Determinants of maternal health care services in Kenya* (Doctoral dissertation, University of Nairobi).

Nnadi, C. I., Onu, J., Nwankwo, C. E., & Nwankwo, I. U. (2022). Maternal mortality and economic development in Sub-Saharan Africa. *African Social Science and Humanities Journal*, *3*(4), 161-169.

Jwan, J. O., & Ong'ondo, C. O. (2011). *Qualitative Research: An Introduction to Principles and Techniques.* Eldoret: Moi University Press.

Schiavo, R. (2013). *Health communication: From theory to practice* (217). John Wiley & Sons.

Sekaran, U. (2005). Research methods: Qualitative and Qualitative Approaches.

Ting'aa, S. L. (2018). *The use of interpersonal communication in promoting maternal and child survival in West Pokot County.* Doctorial Desertation, University of Nairobi.

Truck, E. (2014). *Place in research:Theory,Methodology and Methods* (1st ed.). Routledge. doi:104324/9781315764849

USAID. (2013). *Social and Behaviour change communication:Training for information,Education and communication officers.* New Delhi: IHBP.

Weis, J. (2003). Support groups for cancer patients. *Support care cancer, 11*, 763-768. doi:10.1007/500520-003

World Health Organization. (2015). *WHO recommendations on health promotion interventions for maternal and newborn health 2015*. World Health Organization.