

THE UNIVERSITY OF ZAMBIA
SCHOOL OF EDUCATION
DEPARTMENT OF LIBRARY AND INFORMATION SCIENCE

LIS 4014 RESEARCH PROPOSAL

TOPIC: PERCEPTIONS OF PEOPLE ON THE DISSEMINATION OF INFORMATION ON CHOLERA BY THE MINISTRY OF HEALTH. CASE STUDY: KANYAMA COMPOUND.

NAMES	COMPUTER NUMBERS
WENDY NTEMBELWA	14099594
ROBINAH MGOE	14100835
ZAMIWA CHIMIKO	14101033
MAINZA MAAMBO	14008670

SUPERVISOR: MRS. MWILA

**PERCEPTIONS OF PEOPLE ON THE DISSEMINATION OF INFORMATION ON
CHOLERA BY THE MINISTRY OF HEALTH. CASE STUDY: KANYAMA
COMPOUND.**

BY

NTEMBELWA WENDY

MGODE ROBINAH

ZAMIWA CHIMIKO

MAINZA MAAMBO

**THESIS SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A BACHELOR OF
ARTS DEGREE IN LIBRARY AND INFORMATION STUDIES**

THE UNIVERSITY OF ZAMBIA

LUSAKA

2018.

ACRONYMS

WHO	World Health Organization
UNICEF	United Nations International Children's Emergency Fund
NWASCO	National Water Supply and Sanitation Council
ICTs	Information and Communication Technologies

DECLARATION

We (Wendy Ntembelwa, Robinah Mgode, Zamiwa Chimiko and Mainza Maambo), do hereby declare that this Research Report is our original work. It has not been submitted before to any university or college for the award of a degree or diploma of any kind.

Name

Signature

.....

.....

.....

.....

.....

.....

.....

.....

DEDICATION

We dedicate this research report to our parents and guardians, brothers and sisters for their tireless support and motivation in our academic.

APPROVAL

This report was approved as a partial fulfilment of the requirement for the award of a Bachelor's Degree of Library and Information Science by the University of Zambia. Works drawn from other sources has been acknowledged.

Supervisor's Name

Supervisor's Signature

Date

ACKNOWLEDGEMENTS

This research has been made a reality by the help of many people. We are greatly indebted to the following:

In the first place, we wish to extend our sincere gratitude to our supervisor of this research Mrs Mwila, for her tireless dedication and educative comments and advice throughout the study. She gave us confidence even when we felt like we did not know what we were doing. Our special thanks also go to our parents and guardians for their financial support and encouragement during data collection exercise and writing the report. Above all, we thank our Almighty God for all his providences and endless care which enabled us to finish our research in good health and in good faith.

ABSTRACT

The purpose of this study was to investigate the perceptions of people on the dissemination of information on cholera by the ministry of Health. In the study, specific objectives were; to assess the knowledge levels people of Kanyama have on Cholera. To investigate the methods the Ministry of Health is using to disseminate information on Cholera. To assess the challenges the people of Kanyama face in accessing information on Cholera

The research was a case study of Kanyama Compound. The study sample population was 50 respondents. The simple random sampling was used in the collection of data. Information was collected from respondents by using the structured questionnaires. The data obtained was coded and computed using the Microsoft word excel and analysed using descriptive statistics which transposed it into bar charts, pie charts and tables. The analysed data was then presented quantitatively in forms of tables, bar charts and pie charts.

In line with the first objective which was to assess the knowledge levels people of Kanyama have on cholera, the findings of the study revealed that more than 60% of the residents are aware of the causes of cholera and its symptoms and 40% of the residents require more sensitization and education on the causes of cholera and the symptoms of cholera because they were able to disagree with some major causes of cholera such as poor sanitation, eating contaminated food and drinking contaminated water. They also disagreed that severe diarrhea and excessive vomiting are symptoms of cholera. The respondent's knowledge about cholera in Kanyama needs be improved based on the study's results; there was a group of people who did not have full information about cholera.

The study also reviewed some of the methods the ministry of Health use to disseminate information on cholera which includes, radio, newspapers, TV, mobile phones, posters, internet and brochure.

Additionally, it was revealed in the study that the challenges people of Kanyama face in accessing information on cholera are; language barrier, shortage of radios and televisions among the members, lack of the best platform for accessing information on cholera and inconsistency of the messages received on cholera.

Contents

ACRONYMS	3
DECLARATION	4
DEDICATION	5
APPROVAL.....	6
ACKNOWLEDGEMENTS.....	7
ABSTRACT	8
The purpose of this study was to investigate the perceptions of people on the dissemination of information on cholera by the ministry of Health. In the study, specific objectives were; to assess the knowledge levels people of Kanyama have on Cholera. To investigate the methods the Ministry of Health is using to disseminate information on Cholera. To assess the challenges the people of Kanyama face in accessing information on Cholera.....	
CHAPTER ONE: INTRODUCTION	12
1.0 Introduction.....	12
Background	13
1.2 Statement of the Problem.....	15
1.3.0 General Objective	16
Specific Objectives	16
Research Questions	16
1.4 Significance of the Problem.....	16
1.5 Ethical Considerations.....	17
1.6 Definition of Key Terms.....	17
1.7 Summary of Chapter One.....	18
CHAPTER TWO: LITERATURE REVIEW.....	18
2.0 Introduction.....	18
2.1 Knowledge Levels	19
2.2 Methods of Health Information Dissemination.....	20
2.3 Challenges in accessing information.....	22
CHAPTER THREE: RESEARCH METHODOLOGY	25
3.0 Introduction.....	25

3.1 Research Design.....	25
3.2 Target Population	26
3.2.1 Target Group 1.....	26
3.2.2 Target Group 2.....	26
3.3. Sample.....	26
3.4 Data Collection	27
3.4.1 Primary data	27
3.4.2 Secondary data	27
3.5 Research Site	27
3.6 Data Collection Tools	27
3.6.1 Questionnaire	27
3.6.2 Interview Guide.....	28
3.7 Validity of the Research Instrument	28
3.8 Ethical Considerations.....	28
3.9 Data Analysis	28
3.10 Summary	29
CHAPTER FOUR: PRESENTATION OF FINDINGS.....	29
4.0 Introduction.....	29
4.1 Background information	29
4.2 The knowledge levels the people of Kanyama have on Cholera.....	30
4.3 The methods which the Ministry of Health use to disseminate information on Cholera in Kanyama	30
4.4 Challenges the people of Kanyama face in accessing information on Cholera.....	32
4.5 Summary	33
CHAPTER FIVE: DISCUSSION OF THE FINDINGS.....	33
INTRODUCTION	33
5.1 Knowledge levels people of Kanyama have on Cholera	33
4.2 The methods which the Ministry of Health use to disseminate information on Cholera in Kanyama.	35
5.4 Challenges the people of Kanyama face in accessing information on Cholera.....	36
5.5 Summary	38
CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS.....	38

Introduction	38
Conclusions	38
Recommendations.....	40
BIBLIOGRAPHY	41
WORK PLAN	44
BUDGET.....	46

Activity A: Literature Review				
S/N	ITEM	QUANTITY	UNIT PRICE	COST (K)
1	Notepad	4	10	40
2	Pens	4	2	8
3	Internet Fees	180 mins	2/min	360
4	Transport from school to Information Centers		Lump sum	200
		Sub-total		608
Activity B: Draft Proposal				
5	Ream of paper	1	45	45
6	Printing of draft proposal	26 pages	1	26
		Sub-total		71
Activity C: Questionnaire				
8	Printing of questionnaire and Interview guide	5 pages	1	5
9	Photocopying Questionnaires	5 pages x 35	0.5	87.5
		Sub-total		92.5
Activity D: Fieldwork				
10	Ream of paper	1	45	45
		Sub-total		45
Activity E: Data Analysis and Draft Report				
11	Ream of paper	1	45	45
12	Printing draft report	60 pages	1	60
		Sub-total		105
Activity F: Final Report				
13	Printing final report	60 pages	1	60
14	Photocopying Final report	120 pages	0.5	60
15	Binding reports	2	10	20
		Sub-total		140
		GRAND TOTAL	K	1,061.50

.....	46
APPENDICES.....	47
APPENDIX I: QUESTIONNAIRE FOR THE PEOPLE OF KANYAMA COMPOUND.....	47
APPENDIX II: INTERVIEW GUIDE FOR OFFICIALS FROM LUSAKA DISTRICT OFFICE AND LUSAKA PROVINCE HEALTH OFFICE.....	53

CHAPTER ONE: INTRODUCTION

1.0 Introduction

A healthy nation is a wealthy nation. Provision of safe water and sanitation is the start of development. Cholera is an acute intestinal diarrheal disease that can lead to death if untreated. It is transmitted through the faecal-oral route, usually through consumption of contaminated water or food and is closely linked to adequate access to clean water and sanitation facilities (Kaper et al, 1995). It has been estimated that each year, 1.3-4.0 million cases of cholera, and 21 000-143 000 deaths worldwide due to Cholera. Yet, most of these go unreported due to poor monitoring and fear of impact and tourism. Most of these infected will have mild or symptoms and can successful with oral rehydration solution. In as much as the Ministry Of Health may put measures in place to prevent cholera, it is of great importance for people to have information on how to prevent the disease.

Cases of cholera often present with mild symptoms, although some patients experience profuse watery diarrhea and vomiting. Due to the short incubation period of the bacterium, however, severe cases that are left untreated experience a massive loss of bodily fluids, which can quickly provoke dehydration, hypovolemic shock and eventual death. The disease is easily treated with oral rehydration therapy, and antibiotics are required for critical cases (Centers for Disease Control and Prevention 2013).

The magnitude and frequency of cholera outbreaks in Zambia is most likely to continue if more attention is paid on case management than on preventive measures. Therefore, it is widely believed that dissemination of health information plays a vital role in the prevention of infectious diseases such as cholera and should always be the first measure to preventing the epidemic. In Zambia, the continuous outbreak can be attributed to the possibility that the Ministry of Health has not been effective in disseminating information to the people on cholera prevalence and prevention.

As alluded to, cholera epidemic is accelerated by poor sanitation, contaminated food, contaminated water, negative and poor practice of unhygienic life styles of living. Unfortunately, due to lack of access to adequate information on the subject matter, very few people realize that cholera outbreak is accelerated by the above mentioned factors. For this reason, dissemination of information on the measures that can be applied to prevent recurrences of cholera is vital.

Researchers estimate that there are roughly 1.3 to 4 million cases, and 21000 to 143 00 deaths world wide due to cholera. It remains a global threat to public health and is an indication of inequality and lack of social development.

This study therefore focuses on investigating the perceptions of people of Kanyama compound on the of the Ministry of Health in disseminating information on cholera, assess the methods through which the Ministry disseminate information on cholera and the challenges the people of Kanyama face in accessing such information.

Background

Kanyama is one of the largest communities in Lusaka. It is located on the west side of the city center. It is one of the areas that experiences many problems such as flooding, the growth of houses in the area sometimes called mushrooming and how these have added to the problems of flooding and poor sanitation of homes and pit latrines (toilets), water borne diseases such as bilharzias, diarrhoea, cholera and malaria due to stagnant water.

The disease can affect both adults and children (WHO, 2004). About 20% of those individuals who are affected experience acute watery diarrhea and 10 to 20% of persons infected develop

both watery stools and vomiting. The case fertility rate may reach 30 to 50% if not promptly treated, but can be reduced to 1% if treated promptly (Barua, 1972). Treatment of cholera is basically by rehydration, thus by replacing the salt and the fluid lost (WHO, 2004). Up to 80% of cases can be successfully treated with oral rehydration salts. However, very severe dehydrated cases of cholera require the administration of intravenous fluids. Such patients also require antibiotics to diminish the duration of diarrhea, reduce the volume of rehydration needed and also shorten the duration of *Vibrio Cholerae* excretion (Ghana Health Service, 2010).

The coming of the rainy season, coupled with inadequate water supply and sanitation increases the risk of outbreaks in Lusaka and other parts of the country. The cholera outbreak initially started in the Chipata sub-district and spread to Kanyama sub-district around October 2017. The outbreak has spread from the urban townships on the Western side of Lusaka city to the Eastern with a new case reported in Chelston sub-district. As of December, the affected sub districts include Chipata, Kanyama, Chawama, Matero, Chilenje and Chelston. Sixty two cases were receiving treatment in Cholera Treatment Centres in Chipata, Bauleni and Matero. One third of the cases were children under five years old and two thirds are persons five years and older. A total of 282 Rapid Diagnostic Tests were performed, of which 230 were positive for *Vibrio cholerae* of 310 culture tests, 53 were positive for *Vibrio cholerae* (48 from chipata, four from Kanyama and one from Bauleni) Water quality monitoring is ongoing in all sub-districts, with intensified activity in Kanyama, Matero and Chipata. The results so far show that nearly 42% of tested water sources are contaminated with either Faecal coliforms. (WHO, 2011)

While government spending on water and sanitation has declined in recent years, from \$147 million in 2013 to just \$27 million in 2016, the sector has become a priority for international partners. Since 2013, Zambia has received \$80-85 million annually in official development assistance towards the sector. However, there is still a significant funding gap. A World Bank analysis from 2016 estimates that Zambia would need to invest \$385 million per year in order to meet the 2030 sustainable development goals in terms of universal access to water, sanitation, and hygiene. (NWASCO, 2016),

Ever since the beginning of extensive use of ICTs by local people due to the ever improving technological advancements and high ICT dependence in this generation, the Ministry of health has collaborated with various stakeholders in an attempt to definitively clear out cholera in the

country by sensitizing the public on cholera awareness issues. One such collaboration is between the ministry and the World Health Organization (WHO). The two together with other partners have been making attempts to control these recurring outbreaks of the epidemic (Bwalya, 2010)

With this collaboration on awareness set, it has seen the full engagement of different sectors which include: other government ministries and departments; defence forces; the private sector; the United Nations; Non-governmental organizations; faith-based organizations and the media institutions. Support has come in form of deployment of volunteers to conduct health education in health centres and public arenas, cleaning up the city through garbage collection, provision of clean water to the communities, donation of chlorine, provision of transport facilities to support community mobilization including space in newspapers and airtime on radio and television for public information and education on the epidemic, awareness and sensitization campaigns and how best to prevent it. Cholera Outbreak Guidelines and standard operating procedures have been updated and shared with health workers, so that they too can share with people who visit these health centres. However, the outbreak of cholera has continued to be recorded despite all the efforts by the Ministry of Health and other cooperating partners to sensitize people about it. Therefore, this study seeks to investigate people's perceptions on the effective dissemination of information on cholera.

1.2 Statement of the Problem

Cases of cholera have for a long time been the cause of panic and distress among the Zambians citizens, as it has been the cause of many health related illnesses and in some cases, death amongst the local people especially those living in high density informal settlement areas, (Ministry of Local Government and Housing, 2015) in this case Kanyama constituency. From the period after independence to the early 90's, the ministry could not overly sensitize the general public in due time on how best they could prevent an outbreak of the disease because of limitations in reaching out to the people and a lack in ICTs like mobile phones, radio sets, television sets, computers and the internet in two thirds of most Zambian homes at the time. In the recent past, ministry of health has intensified the awareness programs using different platforms and media's including new technology.

Despite all these awareness and prevention attempts, little seems to have been achieved. This is because the public is mostly made aware almost only after cases of the disease arise, which in

most cases is during the rainy season as it is during this period that cases of cholera arise. Because of this seemingly periodic awareness, people tend to forget prevention measures such that by the time new cases begin to arise, most symptoms are treated lightly and as such begin to manifest and grow into the full epidemic, only then is the issue treated with utmost urgency and importance (Harrison, 2007)

Because of this slack in constant awareness, this study therefore, is aimed at investigating the perception of people on the effective dissemination of information on cholera by the ministry of health.

1.3.0 General Objective

To investigate the perceptions of people on the effective dissemination of information on Cholera by the Ministry Of Health

Specific Objectives

1. To assess the knowledge levels the people of Kanyama have on Cholera
2. To investigate the methods the Ministry of Health is using to disseminate information on Cholera
3. To assess the challenges the people of Kanyama face in accessing information on Cholera

Research Questions

1. What are the knowledge levels the people of Kanyama have on Cholera?
2. What methods is the Ministry of Health using to disseminate information on Cholera?
3. What are the challenges the people of Kanyama face trying to access information on Cholera?

1.4 Significance of the Problem

The possible results of this study on the perceptions of people on the dissemination of information on Cholera by the Ministry Of Health will be used by the Lusaka City Council, Lusaka District and Provincial Health Office and other stakeholders to formulate policies and guidelines for the local community, neighbouring places and other relevant authorities on environmental health to prevent outbreaks of Cholera and its management in Kanyama compound. It will also help stakeholders in planning and formulating future policies with regards to cholera as well as help non - governmental organizations who are interested in disease control

activities draw their future policies. As a result of assessing potential gaps in knowledge levels, methods of health information dissemination and challenges faced in accessing information on cholera by the people of Kanyama compound, appropriate policies and timely public health interventions can be implemented to limit or prevent cholera, ensuring an improved quality of life and reducing the social and economic trauma of cholera on the community. Furthermore, this study serves as a partial fulfilment for the award of Bachelor of Library and Information Science.

1.5 Ethical Considerations

Ethics in research helps researchers to behave in a way that protects the rights of individuals, environments and communities. If researchers fail to observe ethics, they contribute to long term harm on respondents which will affect future researchers negatively. Ethical behaviour helps to build trust between researchers and their respondents. Therefore, this research will respect autonomy of respondents, avoid harm and maintain maximum confidentiality. Permission will be sought from all participants/respondents before they are interviewed or have a questionnaire administered to them. This will ensure freedom of expression, and that nothing is said or written other than what they know or believe in. At the sites where permission will be granted, the expected respondents will be briefed about the procedures to be used, and the value of research. To maintain confidentiality, participants will be assured that no names will be used on the interview schedules and questionnaires; serial numbers will be used instead. In this manner, all participants' details will be treated anonymously. They will be also assured that data to be collected will not be disclosed to others persons, and that the data will be only be used for academic purpose.

To ensure that respondents programs are not interrupted, interview schedules and questionnaires will be administered at the respondents' convenience. Appointments will be made advance with respondents so that they can choose their own convenient times. Finally, the researcher will at all cost be responsible for any of the consequences regarding research process.

1.6 Definition of Key Terms

Cholera: Cholera is an infectious disease that causes severe watery diarrhoea, which can lead to dehydration and even death if untreated. It is caused by eating food or drinking water contaminated with a bacterium called *Vibrio Cholera* (WHO, 2009).

Perception: Perceptions are a way in which something is regarded, understood or interpreted or the ability to see, hear or become aware of something through the senses (Anasi, 2012).

Information: Information is any entity or form that resolves uncertainty or provides the answer to a question of some kind (Cutilli, 2010).

Dissemination: According to Merriam Webster Dictionary (1828), dissemination is the act or process of spreading something.

1.7 Summary of Chapter One

Cholera outbreaks continue to be a problem of public health, given that they cause great human, social and economic losses. The WHO's data indicates a concerning increase in the number of Cholera cases worldwide since the beginning of the 20th century. Despite measures being put in place to prevent Cholera, the disease has continued to affect people worldwide.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter presents the literature review for the study. The main purpose of literature review is to enable the researcher to understand the topic in a way that permits a clear formulation of the problem under study. The aim of conducting a literature review was to get background information related to the topic under discussion and gain knowledge in the field of use studies using citation analysis, including vocabulary, theories, key variable and methodologies applied by the expert prior to this research. Gall and Borg (1996) state that literature review plays a role in delimiting the research problem, seeking new lines of inquiry, avoiding fruitless approaches, gaining methodological insights, identifying recommendations for further research as well as

seeking support for their theories and major concepts in the area of study. According to Blaxter (2008: 120), literature review helps to place one's research in the context of what has already been done, allowing comparison to be made and providing a framework for further research.

2.1 Knowledge Levels

Knowledge is fact, information, skills and understanding that people have gained through learning and experience in the prevention and control of cholera. Despite numerous information written on cholera, globally, regionally and nationally, cholera still persists in many parts of the world. Currently, it has affected more than 100 countries worldwide. It is highly fatal and usually occurs in epidemic proportions in many countries. It is a serious acute intestinal infection that is caused by a germ called *Vibrio cholera* (WHO, 1998). An individual can die within a few hours after contracting the *Vibrio cholera* if medical attention is not received on time.

Zambia experienced two major outbreaks of cholera in the recent past years. The first epidemic was from 1980 to 1981 and covered two provinces, Northern and Luapula Provinces. The second outbreak was from 1990 to 1991. Both epidemics claimed loss of lives. Unfortunately, very few people realized that cholera incidence is accelerated by poor sanitation; unhygienic practices, methods of living and drinking contaminated water or eating contaminated food (Chitanda, 1996). In all the studies carried out it was discovered that people had little knowledge with regards to cholera or eating contaminated food (Chitanda, 1996). In all the studies carried out it was discovered that people had little knowledge with regards to cholera.

Results of a study by (Quick et al) suggest that acquiring behavioral information of a community is an important strategy in the control of cholera. Results of a study in Tanzania indicate very poor prevention practices in spite of high levels of correct knowledge (85%) of and positive attitude (97%) toward cholera (Mpazi, 2005). Another study identified that incorrect information, poor commitment of health staff to the community, and cultural factors were contributors to poor reporting of cholera cases (Chingayipe, 2008).

A study carried out in Cameroon indicated a great handicap in information flow during and prior to the cholera outbreak (Njoh, 2010). UNICEF (2012) mentioned responding to cholera emergency through interpersonal communication reaching about 245,000 people and one million were reached with priority behaviour change messages through radio and television programs

focussing on disease recognition, treatment seeking practices, and good hygiene practice. UNICEF however, asserted that implementing certain interventions in high-risk groups with poor knowledge of and attitudes toward cholera may not be appropriate. It is therefore important to understand the current levels of knowledge, attitudes, and practices of a given community to implement campaign programs and other preventive measures (UNICEF, 2012)

The World Health Organization (2004), indicated that cultural concepts of illness and how to treat and prevent it cannot be over looked because, it has practical implications for behavior, public health, and disease control that need to be considered (WHO,2004).

According to WHO (2000), health education should continue throughout the year with intensification before the cholera season. As mentioned by WHO (2000), most of the educational messages are technically good, but difficult to implement. WHO (2004), cited that if soap for hand or chemicals for water treatment are not available, alternative solutions should be recommended to ensure basic hygiene practices to limit cholera transmission. Lime juice added to water, beverages or other foods have the ability to inactivate *Vibrio Cholerae* (WHO, 2000). Also, WHO cited that it would be necessary to organize focus group discussions to identify gaps in knowledge and the kind of reinforcement needed in cholera periods in high risk communities, checking to see whether soap and chemicals to treat water are available and affordable is another important thing recommended to do during these periods (WHO, 2000)

2.2 Methods of Health Information Dissemination

Einarsdóttir, Passa & Gunnlaugsson, (2001) conducted a study to explore local ideas about cholera and the dissemination or spreading of official health educational messages for cholera prevention and to assess whether such messages contributed to changed behaviour in the population in Guinea Bissau. The findings of the study revealed that local preventive rituals performed contributed significantly to the awareness of the epidemic. Radio and word-of-mouth communication are regarded as the most important sources of information on cholera; however, posters and television did not effectively get to the population. Omogor (2013) also conducted a similar study in Nigeria to explore the channels of health information acquisition and dissemination among rural dwellers. The descriptive research approach was employed in the study. It revealed that town-criers, marketplaces, socio-political meetings, traditional festival,

lecture and exhibition, television, radio, and newspapers are vehicles of information that are used to get and distribute health information among rural inhabitants.

Johnson & Meischke (1991) identified two main sources of health related information, namely interpersonal and mass media sources. The interpersonal sources of health information include doctors, nurses, family and friends, health groups, voluntary organisations, and other professions allied to medicine. These face-to-face information channels are preferred for information dissemination and the teaching of complex skills that need two-way communications between individuals (Parrott, 2004). The mass media sources include TV, radio, posters, books, magazines and newspapers, videos and the internet. In the view of Mills and Sullivan (2000) and Parrott (2004), media related sources normally offer broad coverage so that communicated messages reach a vast number of the target audience quickly and frequently.

Petro and Clark (1984), maintain that sources of information are best understood and regarded as sources by individuals in an attempt to respond to their questions. They use them to instantly satisfy their information needs or to answer questions about their own health or the health of someone who is important to them (Pietro & Clark, 1984). People's use of information sources is dependent on their socio-economic and demographic characteristics. Cutilli (2010) and Gombeski et al. (1982), for example, have shown that individuals who have high literacy level access health information from written sources such as newspapers, magazines, books, and brochures whereas those with low literacy level access health information from television and radio and other interpersonal sources. Furthermore, individuals who consult multiple sources have greater chances of getting necessary information for making decisions about their own health than those who depend on a single source.

Beyond the variety of sources of health information, individual's health information seeking behaviour has also been of great research interest in many countries. Most studies of health information have examined how individuals seek and obtain information about health and illness. For example, Spadaro (2003) investigated the source of health information for European Union citizens and discovered that the majority of Europeans use health professionals (pharmacists, doctors, etc.) as their primary sources of health information. A similar study conducted in the United States showed that doctors, nurses, and other health professionals were selected as the primary source of health information by a greater percentage of the population.

Connell & Crawford's 1988 research involving two Pennsylvania counties and investigating how residents' age and gender influenced their attainment of health information noted that the youngest and oldest age groups received and preferred printed materials as their primary sources on health information whereas the middle age groups preferred television. Printed materials were also cited as the most regularly mentioned sources of health information for women, while no particular health information source was predominant for men (Connell & Crawford, 1988). Still, both the European and US studies demonstrate that citizens from both regions seek most health information from interpersonal sources.

Shikawa & Yano (2008), in their systematic review disclosed that most people only use their physicians as a medium for information without conferring with other media as data supplements. Similarly, Koo, Krass & Aslani (2006) add that adult patients with low health literacy, who are suffering from rheumatic pain or other health-related illnesses, show no interest in seeking written information on medicine. Regarding information of individuals concerning their health from either personal or professional sources, Kutner, Greenberg & Paulsen (2006) aver that individuals with basic or low health literacy tend to employ radio, television, and healthcare professionals but people with higher level of health literacy use print sources such as health brochures, newspapers, books and magazines for health information.

Anasi, (2012) investigates the dissemination and spread of health data in Africa and demonstrates that numerous African nations use distinctive techniques and channels to disperse health information to most communities. While print, broadcast and other group channels have been generally utilized as a method of sharing health information and advancing different sorts of health issues; oral communication is also used in the dissemination of health information in numerous African nations. Besides utilizing normal speech, health messages are also conveyed as melodies, shows, stories, and talks (Anasi, 2012). In some rural African towns, town messengers as well as group and religious leaders also disperse health information. In addition, religious and global philanthropic associations join in the generation and sharing of health information (Anasi, 2012).

2.3 Challenges in accessing information

Information is an indispensable contributor to good health outcomes, and a critical element of well-functioning health systems. For this reasons, universal access to health information is a

prerequisite for achieving the Sustainable Development Goals. Further, it is important to note that, for information to be used, it must be available, accessible, usable, and absorbed by the recipients of the information

However, communities in Zambia face several health-related challenges including limited healthcare facilities and poor health information provision particularly on cholera that make access to health care and health facilities difficult.

Empirical evidence on the challenges facing people in some areas in accessing health information have been carried out in different countries. These studies found that the main barriers to access to information by people in most African countries include language, timing of messages, mobile network fluctuations, medium through which information is disseminated, lack of financial incentives, geographical, organizational, personal, economic, educational status and time (Andualem et al, 2013).

Research undertaken by Sokey and Adisah-Atta (2007) in Ghana revealed that the majority of the respondents had challenges in accessing health information due to a language barrier. This implies that greater majority of the respondents (88.9%) had difficulties in accessing health information due to language problems. It also revealed that people face difficulties in accessing health information due to poor/unreliable information infrastructure from agencies and government institutions. The study also indicated that people face difficulties in accessing health information due to factors such as not having mobile phones to access health information, not having televisions to watch health programs and not having any form of the recent emerging technologies.

In a cross-sectional quantitative study by Andualem et al. (2013), the majority of the respondents acknowledged the need for health information to their normal activities. About 54.0% of respondents did not have access to health information. Only 42.8% of respondents had access to health information on the Internet. The following are considered as important barriers to information accessibility: geographical, organizational, personal, economic, educational status and time. The study revealed that barriers to access to health information by people in the Edo State of Nigeria were illiteracy and language. A systematic literature review conducted by Déglise et al. (2012) on the use of the SMS feature for disease prevention in developing

countries such as India, Kenya, and South Africa, identified main barriers to health information as language, timing of messages, mobile network fluctuations, lack of financial incentives and data privacy.

Haynes (2001) also sums up challenges to access health information based on socio-economic factors and name one factor as 'technological divide'. In addition, Ojo (2006) states that a high level of illiteracy, poverty and absence of basic infrastructure prevents most people from adopting most new media device for accessing health information.

Finally, Mtega and Ronald (2013) also investigated the factors influencing accessibility of health information services in Tanzania. Categorically, the study revealed the kinds of information services provided in rural areas, identified the sources of information used by people and determined the hindrances to accessibility of health information services in some areas in Tanzania. It was found that there were several health information sources used in some areas starting from simple face-to-face communication to modern interactive ICTs including the mobile phones. Even though there are a considerable number of sources of health information available, several factors limited the accessibility of health information services in some areas. Findings of the study show that high illiteracy levels, poor/unreliable information infrastructure, low income, absence of electricity and high cost of ICTs have negatively affected the accessibility of health information services in different areas. The usage of technical languages in repackaging information, inadequacy of time to access information as well as geographical isolation also served as barriers to accessing of health information services in some areas. However, irrespective of the challenges communities go through in accessing health information in Zambia, little attention has been paid to them by scholars. There is little or no research on the challenges people face in accessing health information on cholera in Zambia. Therefore, the above has prompted this study to assess the challenges people of Kalingalinga face in accessing information on cholera.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes the methods and procedures that will guide the research. It includes research design, data collection methods, location of the study, target population, sampling techniques and sample size, research instruments, validity and reliability of the research instruments, data collection procedures, data analysis and logistical and budgeting and ethical considerations.

3.1 Research Design

A research design is a systematic plan to study a scientific problem. Bryan (2008) defines a research design as the planning of the scientific research from the first step to the last step. Research designs are used to collect, analyse and interpret data using either quantitative or qualitative methods.

The quantitative tradition provides qualities of validity, reliability, objectivity and generalizability to a study, the qualitative method ensures the achievement of a holistic view of the phenomenon by exploring meanings, feelings, experiences and perceptions (Tashakkori and Teddlie, 2003). The greater focus given to the qualitative method was to allow the researcher to freely interact with the participants in a manner that might have led to a clear understanding of the management of education in orphanage schools.

A case study design was adopted in this study. According to Rangaih (2012), a case study is an all-inclusive research method that uses sources of evidence to analyse or evaluate specific phenomenon. Based on this definition, the study used a case study design as it allowed in depth study on the orphanage schools. The study employed qualitative approaches in order to convert the data that was collected. The study opted to use this method while taking into consideration the nature of the research at hand. This study mainly deploys qualitative methods of data collection. This gave an opportunity to use multiple sources of evidence which increased validity and reliability in the findings. A case study was helpful to facilitate an in-depth analysis of the findings and logical explanations but also help in yielding qualitative data.

3.2 Target Population

3.2.1 Target Group 1

The first target group is residents of Kanyama Compound. These residents are believed to be the major victims of outbreaks of cholera and therefore they are the main stakeholders of this research. Residents of either sex will be randomly selected and interviewed.

3.2.2 Target Group 2

This study will also target stakeholders from Lusaka District Health Office and Lusaka Province Health Office. Stakeholders from these offices are targeted because they are the ones responsible for the dissemination of health information in the district and province respectively. Therefore, it's important to include them in the research as they are the ones responsible for choosing the media through which information is disseminated, in what format and at what time. This group will be purposively sampled in accordance with their expertise held.

3.3. Sample

A total of 50 respondents were selected for this study as the sample.

3.4 Data Collection

3.4.1 Primary data

Primary data will be collected in this research. This type of data is rich in fresh information that is prevailing on the ground. With this study being a qualitative study, literally the whole research is based on this type of data. The researchers will go in the field to collect this type of information which seeks to directly answer the objectives of the research before making generalizations. This type of data will be collected directly from first-hand experience and it will be obtained by following scientific procedures which the study seeks to follow.

3.4.2 Secondary data

Secondary data is data that has been collected by other investigators in connection with other research problems or as part of the usual collection of social data as in the case of population census. This is second hand data or at least once removed from the original event such as a summary of important statistics, newspaper column based on an eyewitness account (Neil, 2004). Thus, secondary data available on perceptions of people on the dissemination of information on cholera by the Ministry of Health will be used and analyzed in this research to get the general overview of the topic. Reports, journals, books and other documents as well as the internet will be used to get data for this research, thus providing background information. This data will be both supplementary and supportive in nature and provide a framework within which primary data will be collected.

3.5 Research Site

The study will be conducted in Kanyama Compound of Lusaka, Zambia. Kanyama compound is a highly density populated shanty compound which usually records high prevalence of cholera and recently recorded the highest number of cholera cases in the last outbreak. Therefore, getting a sample from this compound will correctly represent the target population.

3.6 Data Collection Tools

3.6.1 Questionnaire

The study will use administered questionnaires as the main data collection tool. To ensure that data collected is mostly qualitative, the questionnaire will mostly comprise of open-ended questions with only a few closed ended questions. Usage of administered questionnaires is

justified because the target population comprise of people with the level of literacy highly uncertain.

3.6.2 Interview Guide

The interview guide will be used by the study to supplement questionnaire findings as it will provide additional information to findings from target group 1. It will be used to collect data from all stakeholders from target group 2. This tool will help to extensively capture the views of these stakeholders who are directly involved in the dissemination of health information.

3.7 Validity of the Research Instrument

Validity refers to the degree to which evidence supports any inferences the researcher makes based on the data he/she collects using a particular instrument. It is the inferences about the specific uses of an instrument that are validated, not the instrument itself where the inferences should be appropriate, meaningful, correct and useful (Fraenkel and Wallen, 2009).

3.8 Ethical Considerations

This research was conducted only for academic purposes and hence, all participants were assured of total and maximum confidentiality. All participants were not asked to write their names on interview guide or say their names in the interviews as this may disclose identity. The information collected was highly secured.

3.9 Data Analysis

Data analysis in this study was be done manually through the use of thematic analysis. Analysis for the questionnaires will be done by first, grouping together the types of questions that will be open ended. The data from the interview guides and the questionnaire was analysed by coding and grouping the emerging themes. Lloyd and Blanc (1996) suggest that in analysing qualitative data, the initial task is to find concepts that help “make sense of what is going on”. The closed ended questions will be coded and then analyzed using descriptive statistics. Open ended questions with similar responses will be grouped together so as to get the general view of the respondents and those with different views will also be grouped accordingly and analyzed using content analysis. The same procedure for open ended questions will be followed for the data collected from the interviews that will be conducted to the stakeholders in target group. The researcher therefore extracted categories of data with similar meanings. The data collected was

coded into conceptual categories of data and constant comparative analysis was used to generate concepts by coding and analysing.

3.10 Summary

The research methodology of this study focused on components which include the research design, the target population, sample size, sampling procedures, data collection instruments, data analysis and ethical consideration. The two data collection instruments that were used in the study are the interview guide and questionnaire.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.0 Introduction

The information presented in this chapter is the findings of the study based on responses acquired from questionnaires administered to members of Kanyama community in Lusaka district. A total of 50 questionnaires were administered to the members and all were collected back. This means that we are working with the total population of 50 giving us 100%. The objectives of the study were:

1. To assess the knowledge levels the people of Kanyama have on Cholera
2. To investigate the methods the Ministry of Health is using to disseminate information on Cholera.
3. To assess the challenges the people of Kanyama face in accessing information on Cholera.

4.1 Background information

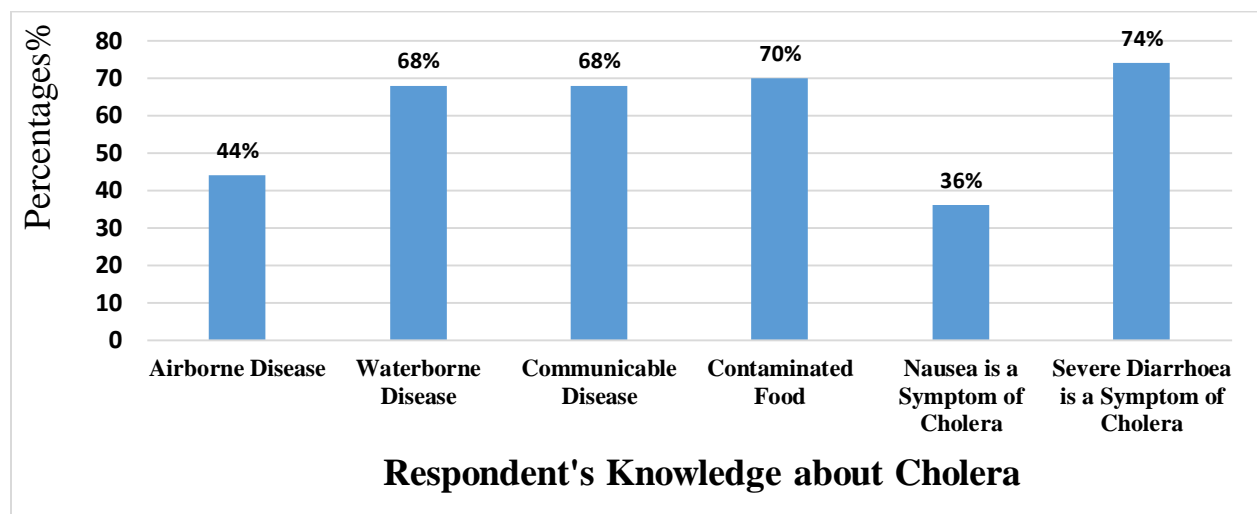
The study had a total of 50 participants of which 22 (44%) were males and 28 (56%) were females. Their educational background was that, 17 (34%) respondents attained primary level

of education, 11 (22%) respondents attained secondary level of education, 4 (8%) respondents attained tertiary level of education and 18 (36%) respondents never went to school.

4.2 The knowledge levels the people of Kanyama have on Cholera.

The first objective of the study was to assess the knowledge levels the people of Kanyama have on Cholera. When respondents were asked to select yes or no to options of causes of cholera and symptoms of cholera, the responses are presented in the figure below.

Figure 4.2 below shows the knowledge levels people of Kanyama have on cholera as heard from the respondents.



In the figure 4.2 above, the findings of the study shows that, 22 (44%) of the total respondents agreed that cholera is airborne disease. Secondly, 34 (68%) of the total respondents agreed with a yes that cholera is a water borne disease. Further, 34 (68%) total respondents again agreed that cholera is a communicable disease. In the same vein, 35 (70%) of the total respondents agreed that cholera is caused by eating contaminated food. Additionally, 18 (36%) of the total respondents agreed that nausea is a symptom of cholera and 37 (74%) of the total respondents agreed that severe diarrhoea is a symptom of cholera.

4.3 The methods which the Ministry of Health use to disseminate information on Cholera in Kanyama.

The second objective of the study to investigate the methods the Ministry of Health is use to disseminate information on Cholera. When respondents were asked to select options on the methods the Ministry of Health use to disseminate information on Cholera, the findings are presented below:

Figure 4.3 below show the methods which the Ministry of Health use to disseminate information on Cholera in Kanyama in percentages.

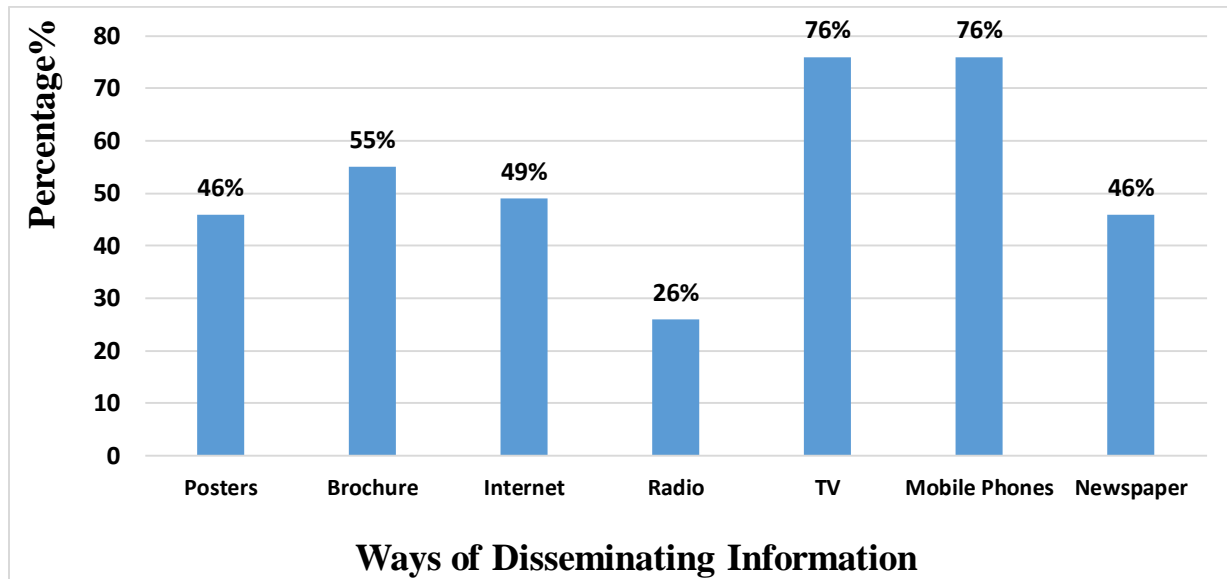


Figure 4.3 above show that the methods which the ministry of health use to disseminate information on cholera in Kanyama are; 23 (46%) of the total respondents agreed that radio is one of the method being used. Secondly, the findings reveals that 38 (76%) of the total respondents agreed that mobile phones are also used to disseminate information on cholera by the ministry of health through text messages in conjunction with all network providers. Further, the findings also revealed that 38 (76%) of the total respondents agreed that a televisions (TV) is also one of the major method the ministry health use to disseminate information on cholera in Kanyama compound. In the study, it was also revealed that 23 (46%) of the total respondents agreed that newspapers are also used in the dissemination of information on cholera in Kanyama area. Further, the findings of the study revealed that 25 (49%) of the total respondents agreed that internet also is one of the method the ministry of health use to disseminate information on cholera in Kanyama compound. Lastly, the study revealed that 13 (26%) of the total respondents

agreed that a radio is one of the method the ministry of health use to disseminate information on cholera in Kanyama compound.

4.4 Challenges the people of Kanyama face in accessing information on Cholera

The third objective of the study was to assess the challenges the people of Kanyama face in accessing information on Cholera. When the respondents were asked to select on the options on challenges they face in accessing information on Cholera, the findings are presented below:

Figure 4.4 show the challenges that people of Kanyama face in accessing information on Cholera in percentages.

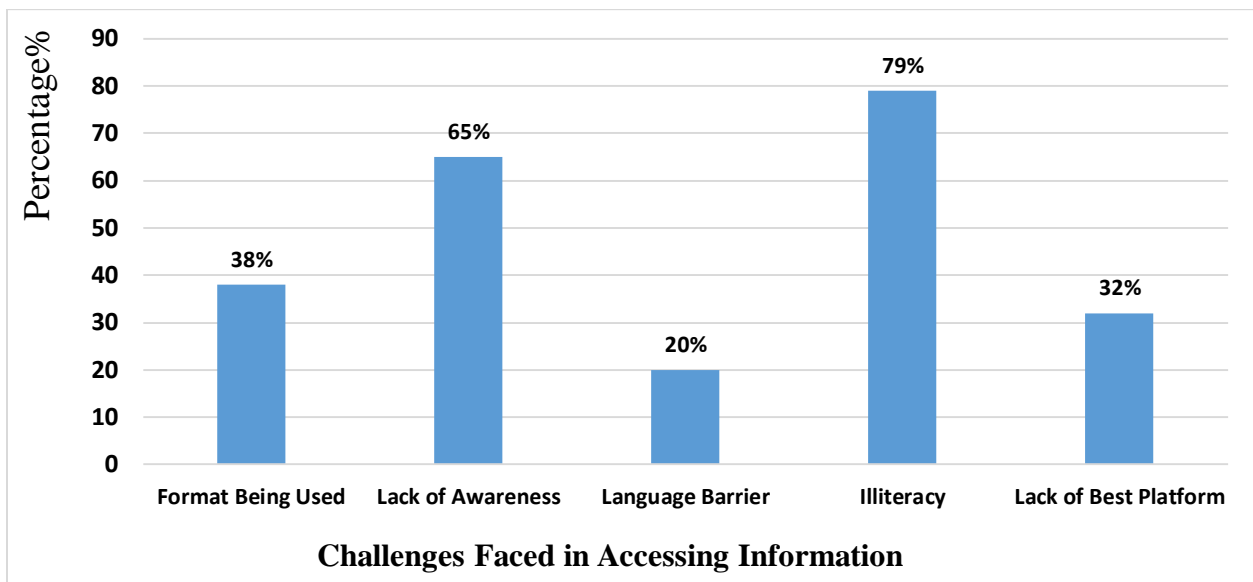


Figure 4.4 above show that the challenges people of Kanyama face in accessing information on cholera are; 40 (79%) of the total respondents agreed that illiteracy among members of the community is a challenge in accessing information on cholera. Further, the findings revealed that 19 (38%) of the total respondents agreed that format used in delivering information on cholera is a challenge in accessing information. In the study, it was also revealed that 10 (20%) of the total respondents agreed that language is a barrier in accessing information on cholera because mostly information is delivered in English of which people understand Nyanja and Bemba. The study also revealed that 33 (65%) of the total respondents agreed that lack of awareness is also a challenge in accessing information on cholera because certain information is not communicated

consistently. The best platform for receiving information on cholera (18%) and format being used (8%).

4.5 Summary

This chapter has presented the findings of the study in-line with three objectives of the study.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

INTRODUCTION

This chapter will present a discussion of findings presented in chapter four on perceptions of people on the dissemination of information on cholera by the ministry of health. Therefore, the discussion of the findings will be based on the three objectives of the study which are; to assess the knowledge levels the people of Kanyama have on Cholera, to investigate the methods the Ministry of Health is using to disseminate information on Cholera, to assess the challenges the people of Kanyama face in accessing information on Cholera.

5.1 Knowledge levels people of Kanyama have on Cholera

From the findings in figure 4.1, it was revealed that (44%) of the total respondents agreed that cholera is an airborne disease. This means that less than half of the population have the knowledge on cholera in relation to air. This 44% of the total population do not have information on cholera in relation to air as a result, they may not necessarily understand what has caused cholera in the community and they cannot find relevant measures to the problem.

From figure 4.1, it was revealed that (68%) of the total respondents agreed that cholera is a water borne disease. The interpretation of this is that, a good number of the population in Kanyama are aware that cholera virus can be transmitted in water. They understand cholera can be caused by using contaminated water. The implication is that, the majority in the community will treat water with chlorine and boil it before using it. Only a small number of the population do not know that cholera is waterborne disease.

Further, it was found that (68%) of the total respondents agreed that cholera is a communicable disease. This means that the members of the community understand that they can contact the

disease through exchange of body fluids among themselves. Only a small number of the population do not know that cholera is a communicable disease and is as a result of not understanding the meaning of the word communicable.

In the study, it was found that (70%) of the total respondents agreed that cholera is caused by eating contaminated food. This means that people in the area, people have basic knowledge on the causes of cholera and are likely to protect themselves from eating uncovered foods which have a high percentage of carrying a cholera virus. Only a small number of the population do not know that cholera can be caused by eating contaminated food.

Additionally, (36%) of the total respondents agreed that nausea is a symptom of cholera. The interpretation is that, less than half of the population know that nausea is a symptom of cholera and the majority do not know. The implication is that someone can be infected with cholera and show the symptom of nausea but people cannot tell until they seek medical attention.

Further, the findings of the study revealed that (74%) of the total respondents agreed that severe diarrhoea is a symptom of cholera. This shows that there is positive understanding of the symptom by the members of the community and medical attention can be accessed whenever that behaviour is seen in the community.

In line with the findings of the study, Chitanda (1996) stated that Zambia experienced two major outbreaks of cholera in the recent past years. The first epidemic was from 1980 to 1981 and covered two provinces, Northern and Luapula Provinces. The second outbreak was from 1990 to 1991. Unfortunately, very few people realized that cholera incidence is accelerated by poor sanitation; unhygienic practices methods of living and drinking contaminated water or eating contaminated food. In all the studies carried out, it was discovered that people had little knowledge with regards to the causes of cholera and symptoms of cholera (Chitanda, 1996). Up to date, it is still clear that the outbreak of cholera which Zambia experienced recently in 2017 and 2018 was caused by similar earlier mentioned causes of cholera which are as a result of people's lack of knowledge on the causes of cholera.

4.2 The methods which the Ministry of Health use to disseminate information on Cholera in Kanyama.

The second objective of the study was to investigate the methods the Ministry of Health is using to disseminate information on Cholera. In line with this objective, the findings of the study revealed that the methods which the Ministry of Health use to disseminate information on Cholera in Kanyama are: firstly, in figure 4.2 in the preceding chapter, (46%) of the total respondents agreed that radio is one of the method being used by the ministry of health in disseminating information on cholera. The radio is one of the most common devices used to get information and the majority of the people in the community have access to the radio. The interpretation is that nearly half of the population receive information on the radio concerning cholera. The other half who did not agree is because they do not have radios making it impossible for them to access information on the radio.

Secondly, the findings reveals that (76%) of the total respondents agreed that mobile phones are also used to disseminate information on cholera by the ministry of health through text messages in conjunction with all network providers. The ministry of health work with the telecom companies such as MTN which help to facilitate the sending of health message to the people. The response show that the majority have access to mobile phones and they have had access to health messages from mobile phones.

Further, the findings also revealed that (76%) of the total respondents agreed that television (TV) is also one of the major methods the ministry of health use to disseminate information on cholera in Kanyama compound. The meaning of this is that, a lot of people have access to televisions and they receive information on cholera on the TV through various health messages that are presented on the television. Only few have no access to TVs in Kanyama compound.

In the study, it was also revealed that (46%) of the total respondents agreed that newspapers are also used in the dissemination of information on cholera in Kanyama area. The interpretation of this is that, nearly half of the population have access to newspapers in the community and members are able to access information on cholera through newspapers. Therefore, half of the respondents who have no access to newspapers are those who are illiterate and cannot read.

Further, the findings of the study revealed that (49%) of the total respondents agreed that internet also is one of the method the ministry of health use to disseminate information on

cholera in Kanyama compound. This means that at least half of the respondents have access to internet and messages of cholera are all over the internet giving them more opportunity to learn more about cholera.

In line with the findings of the study, Passa & Gunnlaugsson, (2001) found that, radio and word-of-mouth communication are regarded as the most important sources of information on cholera, however, posters and television did not effectively get to the population. Omogor (2013) also conducted a similar study in Nigeria to explore the channels of health information acquisition and dissemination among rural dwellers. It revealed that town-criers, marketplaces, socio-political meetings, traditional festival, lecture and exhibition, television, radio, and newspapers are vehicles of information that are used to get and distribute health information among rural inhabitants.

Also Johnson & Meischke (1991) identified two main sources of health related information, namely interpersonal and mass media sources. The interpersonal sources of health information include doctors, nurses, family and friends, health groups, voluntary organisations, and other professions allied to medicine. These face-to-face information channels are preferred for information dissemination and the teaching of complex skills that need two-way communications between individuals (Parrott, 2004). The mass media sources include TV, radio, posters, books, magazines and newspapers, videos and the internet. In the view of Mills and Sullivan (2000) and Parrott (2004), media related sources normally offer broad coverage so that communicated messages reach a vast number of the target audience quickly and frequently.

5.4 Challenges the people of Kanyama face in accessing information on Cholera

The third and last objective was to assess the challenges the people of Kanyama face in accessing information on Cholera. According to figure 4.4 in the preceding chapter, the challenges that people of Kanyama face in accessing information on Cholera: firstly, (79%) of the total respondents revealed that illiteracy among members of the community is a challenge in accessing information on cholera. Those people who cannot read cannot access the information which can be written in posters and brochures and fail to get the message which is communicated to them. It becomes difficult for people who are in this category to participate in the fight against cholera

Further, the findings revealed that (38%) of the total respondents revealed that format used in delivering information on cholera is a challenge in accessing information. The study revealed that the format used to communicate the message was not favourable to cater the entire population. There are some people in the community who may not have access to these devices which the ministry use to disseminate the information to the public.

In the study, it was also revealed that (20%) of the total respondents agreed that language is a barrier in accessing information on cholera. The study results revealed that the common language which is used especially on internet, mobile phone and TV is English and some people cannot understand the language. This has led communication to be one of the challenges faced by the community members and prefer the message to be delivered in Nyanja and Bemba.

The study also revealed that (65%) of the total respondents agreed that lack of awareness is also a challenge in accessing information on cholera because certain information is not communicated consistently.

In line with the findings of the study, UNICEF (2012) mentioned responding to cholera emergency in Cameroon through interpersonal communication reaching about 245,000 people and one million were reached with priority behaviour change messages through radio and television programs focussing on disease recognition, treatment seeking practices, and good hygiene practice. UNICEF however, asserted that implementing certain interventions in high-risk groups with poor knowledge of and attitudes toward cholera may not be appropriate as well as to those who do have radios and televisions. They further added that language should also be localised because of various educational backgrounds in order to include those who are illiterate because they are the perpetrators of the problem.

In line with the findings, the WHO (2000), added that most of the educational messages are technically good, but difficult to implement. WHO (2004), cited that if soap for hand or chemicals for water treatment are not available, alternative solutions should be recommended to ensure basic hygiene practices to limit cholera transmission. Lime juice added to water, beverages or other foods have the ability to inactivate *Vibrio Cholerae* (WHO, 2000). Also, WHO cited that it would be necessary to organize focus group discussions to identify gaps in knowledge and the kind of reinforcement needed in cholera periods in high risk communities,

checking to see whether soap and chemicals to treat water are available and affordable is another important thing recommended to do during these periods (WHO, 2000)

5.5 Summary

This chapter has discussed the findings of the study on the perceptions of people on the effective dissemination of information on Cholera by the Ministry Of Health. It has highlighted the level of knowledge of the people of Kanyama about cholera, the methods which are used by the Ministry of health in disseminating information and the challenges faced by the member of the community in accessing the health information on cholera. The finding of the study has further been linked to the literature review of the study.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

Introduction

The aim of the study was to investigate the perceptions of people on the effective dissemination of information on Cholera by the Ministry Of Health in Kanyama compound. This chapter attempts to answer the research questions based on the findings. It will further draw conclusions from the main findings generated in chapter four and then make conclusions.

Conclusions

The study was set to investigate the perceptions of the people on the dissemination of information on cholera by the Ministry of Health.

The results indicates that the knowledge levels the people of Kanyama have on Cholera as follows; According to the findings in figure 4.2 (a) 22 (44%) respondents revealed that cholera is an airborne disease while 28 (56%) respondents said cholera is not an airborne disease. The explanation which was given by the respondents is based on the rate at which it spread. The study established that despite some people having the knowledge about cholera, there people in the community who don't know how cholera can be transmitted from one person to the other. The percentage difference between the two responses is 12% and (b), 34 (68%) respondents revealed that cholera is a water borne disease while 16 (32%) respondents said that cholera is not an airborne disease. The respondents knowledge about cholera in Kanyama needs be improved based on the study's results there is group of people who do not have full information about cholera. The average percentage difference between those who said that cholera is water borne

disease and is not a waterborne disease is 36 %. The findings of figure 4.2 (a) and (b) revealed that the majority of the respondents indicated that cholera is a water borne disease but not an air borne disease.

According to figure 4.3 (a) 34 (68 %) respondents revealed that cholera is a communicable disease while 16 (32 %) respondents said that cholera is not a communicable disease and in figure 4.3 (b) it was established that 35 (70%) respondents said cholera is caused by eating contaminated food while 15(30%) respondents said cholera cannot be caused by eating contaminated food. The major findings of the study are that the majority of the people who were interviewed provided the positive knowledge about causes of cholera and how it is transmitted. Only few people did not know how cholera is transmitted and the causes of cholera.

The study revealed that, according to figure 4.4 (a), (18%) that 14 respondents revealed that nausea is one of the symptoms of cholera and 32 of the respondents said that nausea is not a symptom of cholera. Further Figure 4.4 (b) reveal 37 respondents revealed that severe diarrhoea is one of the symptoms of cholera while 13 respondents said that severe diarrhoea is not a symptom of cholera.

The study highlighted that the methods that the Ministry of Health is using to disseminate information on Cholera were: The second objective of the study was to investigate the methods the Ministry of Health is using to disseminate information on Cholera. In with this objective, the findings of the study revealed that the methods which the Ministry of Health use to disseminate information on Cholera in Kanyama are: radio (26%), mobile phones (18%), TV (20%), newspaper (16%), posters (14%), brochure (4%) and internet (2%). It was established that the most common methods which the Ministry of Health use to disseminate information on Cholera in Kanyama is the radio. Most members of the community in the compound receive health messages through the radio. The radio is one of the most common devices used to get information and the majority of the people in the community have access to the radio. The study further established that mobile phones are also used in the transmission of the health messages. The ministry of health work with the telecom companies such as Airtel which health to facilitate the sending of health message to the people. The study highlighted that TV, newspaper and

posters are other Medias of communication which are used to disseminate information by the ministry of health. The result also revealed that brochures and internet are also used to disseminate health information to the people of Kanyama.

It was eminent from the result that the challenges the people of Kanyama face trying to access information on Cholera were as follows: According to figure 4.6 in chapter four the challenges that people of Kanyama face in accessing information on Cholera in percentages are: high levels of illiteracy (30%), language barrier (20%), lack of awareness (24%), best platform for receiving information on cholera (18%) and format being used (8%). The finding of the study revealed that illiteracy is the major challenge which has negatively affected the people of Kanyama in accessing information on cholera. Those people who cannot read and access the information which can be written in posters and brochures fail to get the message which is communicated to them. It becomes difficult for people who are in this category to participate in the fight against cholera. Lack of awareness and language are other challenges which people are facing in accessing information about cholera. The study results revealed that the common language which is used especially on internet, mobile phone and TV is English and some people cannot understand the language. This has led to barrier to communication as one of the challenges faced by the community member. It was further revealed that the format used to communicate the message is not favourable to cater the entire population. There some people in the community who may not have access to these devices which the ministry use to disseminate the information.

Recommendations

- It is recommended that the health information which is disseminated through the TV, Internet and Brochures should also be prepared in the local languages.
- Members of the community should also be encouraged and assisted to actively participate in the design and implementation of cholera awareness programmes.
- Families must be assisted in determining what is going on in their household which can lead to cholera outbreak and tremendous restructuring, rethinking, shift the culture in the community and the culture we have at approaching the problem.
- The government should establish community health education centres where members of the community can access the information regarding cholera and other diseases.

- The government should come up with literacy programmes which will help in reducing the literacy levels in the community.
- Health education programmes should receive direct funds from the government and nongovernmental organisation.

BIBLIOGRAPHY

Anasi, S. N. 2012. *Access to and dissemination of health information in Africa: The Patient and the public.* Journal of Hospital Librarianship, 12(2), 120-134.

Blaxter Aktin, 2008. *Role of literature review.* Sage, London.

Bless, C. and P. Achola, *Fundamentals of social Research Methods; An African Perspective.*

Bwalya Kelvin Joseph.2010 *E-government Adoption Landscape Zambia: Context, Issues and Challenges* Integrated Series in Information Systems

Centre for Disease Control and Prevention.2002. *Weekly Epidemiological Record. Cholera*,257-68

Chingayipe EM: *Factors affecting cholera case detection by the communities in Chiradzulu district.* Master's dissertation. University of Malawi, College of Medicine, Environmental Health;2008.<http://www.medcol.mw/mpH/dissertations/intake%202005/Elizabeth%20Chingayipe.pdf>.

Chitanda, R. (1996), *Cholera Control Manual for Health Promoters*, Lusaka

Connell, C. M. & Crawford, C. O. (1988). *How people obtain their health information—a survey in two Pennsylvania counties*. Public Health Reports, 103(2), 189.

Cutilli, C. C. (2010). *Seeking health information: what sources do your patients use?*. Orthopaedic nursing, 29(3), 214-219.

Echenberg, M. (2011). *Africa in the Time of Cholera: A History of Pandemics from 1817 to the present*. New York, NY, USA: Cambridge University Press.

Einarsdóttir, J., Passa, A., & Gunnlaugsson, G. (2001). *Health education and cholera in rural*

Gall K. and Borg M., 1996. *Purpose of a literature review*. Thousand Oaks, CA: Sage Publications.

Guinea-Bissau. *International journal of infectious diseases*, 5(3), 133-138.

Johnson, J. D. & Meischke, H. (1991). *Women's preferences for cancer information from specific communication channels*. American Behavioral Scientist, 34(6), 742-755.

Kaper et al 1995. *Cholera*. Clinical Microbiology Reviews 8 (1):48-86

Kasoka .P. (2003).: *A Study on Knowledge, Attitude and Practices as Factors Contributing to Recurrences of Cholera in Kabwe*, School of Medicine Department of Nursing Sciences, Lusaka, Zambia

Koo, M., Krass, I. & Aslani, P. (2006). *Enhancing patient education about medicines: factors influencing reading and seeking of written medicine information*. Health Expectations, 9(2), 174-187.

Merriam Webster Dictionary, 1828

Mills S. and Sullivan T., 2000. *Role of Social Media on Information Accessibility*. New

Ministry of Local Government and Housing. 2015 Government of the Republic of Zambia, *National urban and peri urban sanitation strategy (2015-2030)*. Lusaka, Zambia: Government of the Republic of Zambia, Ministry of Local Government and Housing.

Mpazi VM, Mnyika KS: *Knowledge, attitudes and practices regarding cholera outbreaks in Ilala Municipality of Dar Es Salaam region, Tanzania*. East Afr J Public Health Volume 2005, 2:6–11.

NWASCO (2016), Urban and Peri-urban Water Supply and Sanitation Sector Report

Parrott, R. (2004). *Emphasizing —communication in health communication*. Journal of Communication, 54(4), 751-78 Sandra Harrison. 2007 “Health Communication Design: an innovative MA at Coventry University”, Journal of Visual Communication in Medicine.

Petro C. and Clark J., 1984. *Health communication in the new media landscape*. New York, NY: Springer.

Quick RE, Gerber ML, Palacios AM, Beingoleat L, Vargas R, Mujica O, MD, Seminario L, Smithwick EB, Tauxe RV: *Using a knowledge, attitudes and practices survey to supplement findings of an outbreak investigation: cholera prevention measures during the 1991 epidemic in Peru*. Int J Epidemiol 1996, 25(4):872–878.

Sasaki, S, H Suzuki, K Igarashi, B Chapula and P Mulenga, 2008. *Spatial Analysis of Risk Factor of Cholera Outbreak for 2003-2004 in a Peri-urban Area of Lusaka, Zambia*, The American journal of tropical and medicine and hygiene. 79;4 Spadaro, R. (2003). European Union citizens and sources of information about health. European Union Research Group.

WHO, 1998. Tropical Disease Bulletin, Journal Volume 78, No 1871998.

WHO, 2009. *Global Alert and Response on Cholera Outbreaks*. World Health Organization: Cholera, 2009. Wkly Epidemiol Rec 2010, 85(31):293–308.

World Health Organization, 2004. *Cholera: mechanism for control and prevention*.

World Health Organization: *WHO Technical Working Group on creation of an oral cholera vaccine stockpile*. Geneva; 2012

[http://apps.who.int/iris/bitstream/10665/75240/1/WHO_HSE_PED_2012_2_eng.pdf].

York: Academic Press.

WORK PLAN

S/N	ACTIVITY	DESCRIPTION	DURATION (March to November)									
			M	A	M	J	J	A	S	O	N	
1	Research Topic Formulation	This will involve identifying a research problem, refining it into a research topic, discussing topic with supervisor. Once approved by supervisor the topic will be submitted for filling.										
2	Secondary Data Collection	This will involve the collection, compilation and reviewing of information from the internet and various books from previous studies relevant to the research topic.										

BUDGET

Activity A: Literature Review				
S/N	ITEM	QUANTITY	UNIT PRICE	COST (K)
1	Notepad	4	10	40
2	Pens	4	2	8
3	Internet Fees	180 mins	2/min	360
4	Transport from school to Information Centers		Lump sum	200
		Sub-total		608
Activity B: Draft Proposal				
5	Ream of paper	1	45	45
6	Printing of draft proposal	26 pages	1	26
		Sub-total		71
Activity C: Questionnaire				
8	Printing of questionnaire and Interview guide	5 pages	1	5
9	Photocopying Questionnaires	5 pages x 35	0.5	87.5
		Sub-total		92.5
Activity D: Fieldwork				
10	Ream of paper	1	45	45
		Sub-total		45
Activity E: Data Analysis and Draft Report				
11	Ream of paper	1	45	45
12	Printing draft report	60 pages	1	60
		Sub-total		105
Activity F: Final Report				
13	Printing final report	60 pages	1	60
14	Photocopying Final report	120 pages	0.5	60
15	Binding reports	2	10	20
		Sub-total		140
		GRAND TOTAL	K	1,061.50

APPENDICES

APPENDIX I: QUESTIONNAIRE FOR THE PEOPLE OF KANYAMA COMPOUND

THE UNIVERSITY OF ZAMBIA

SCHOOL OF EDUCATION

DEPARTMENT OF LIBRABRY AND INFORMATION SCIENCE

LIS 4014 QUESTIONNAIRE FOR THE PEOPLE OF KANYAMA COMPOUND.

**TOPIC: PERCEPTIONS OF PEOPLE ON THE DISSEMINATION OF
INFORMATION ON CHOLERA BY THE MINISTRY OF HEALTH.
CASE STUDY: KANYAMA COMPOUND**

Dear Respondent,

We are fourth (4th) year students at the University of Zambia in the School of Education. We are conducting a research on “PERCEPTIONS OF PEOPLE ON THE DISSEMINATION OF INFORMATION ON CHOLERA BY THE MINISTRY OF HEALTH. CASE STUDY: KANYAMA COMPOUND”.

With reference to the above subject, you have been randomly selected to participate in this research. Please note that your views will also represent those that have not been selected in this study. Rest assured that the data being solicited will be purely for academic purposes and will be treated with maximum confidentiality. Your co-operation will be highly appreciated.

INSTRUCTIONS FOR RESPONDENTS

1. **Do not** indicate your name on the questionnaire.
2. Tick [√] or write down the appropriate answer in the answer spaces provided.
3. Please try as much as possible to answer all the questions that apply to you.

SECTION A: BACKGROUND INFORMATION

**OFFICIAL
USE ONLY**

1. What was your age on your last birthday.....?

2. What is your sex?

(a) Male []

(b) Female []

3. What is your highest level of education attained?

(a) Primary Level []

(b) Secondary Level []

(c) Tertiary Level []

(d) Never went to School []

SECTION B: KNOWLEDGE LEVELS OF PEOPLE ON CHOLERA

4. Cholera is an?

<i>Tick on your response</i>		YES	NO
a).	Airborne Disease		
b).	Water borne Disease		
c).	Communicable Disease		

d). Others specify.....

.....
.....

5. What are some of the causes of Cholera?

<i>Tick on your response</i>		YES	NO
a).	Eating contaminated food		
b).	Poor sanitation		
d).	Poor hygiene		

e) Others specify

.....

.....

.....

6. What are some of the symptoms of Cholera?

<i>Tick on your response</i>		YES	NO
a).	Vomiting		
b).	Severe Diarrhoea		
c).	Sweating		
d).	Dehydration		

f) Others specify

.....

.....

.....

7. How can Cholera be prevented?

<i>Tick on your response</i>		YES	NO
a).	Treating drinking water		
b).	Washing hands before eating and after using the toilet		
c).	Keeping the environment clean		

e) Others specify

.....
.....
.....

**SECTION C: THE METHODS USED BY MINISTRY OF HEALTH TO
DISSEMINATE INFORMATION ON CHOLERA.**

8. What platforms have you ever heard or received information on Cholera?

<i>Tick on your response</i>		YES	NO
a).	Radio		
b).	TV		
c).	Mobile Phone		
d).	Newspaper		
e).	Poster		
f).	Door to door sensitization		
g).	Internet		
h).	Social Media (Facebook, Whatsapp, Bulk Systems Management Server)		

i). Others Specify.....
.....

9. Was the information helpful in the prevention of Cholera?

(a) Yes []

(b) No []

10. What do you think is the best platform through which you can receive information on cholera?

.....
.....
.....

SECTION D: THE CHALLENGES PEOPLE FACE IN ACCESSING INFORMATION ON CHOLERA

11. What challenges do you face in accessing information on Cholera?

<i>Tick on your response</i>		YES	NO
a).	Language barrier		
b).	Format being used		
c).	Lack of awareness		
d).	Illiteracy		

e) Others specify

.....
.....
.....

12. What measures would you suggest which would best help in mitigating the challenges in accessing information on cholera?

.....
.....
.....
.....
.....
.....
.....
.....
.....

.....

.....

.....

.....

.....

THANK YOU FOR YOUR COOPERATION.

**APPENDIX II: INTERVIEW GUIDE FOR OFFICIALS FROM LUSAKA DISTRICT
HEALTH OFFICE AND LUSAKA PROVINCE HEALTH OFFICE**

**TOPIC: PERCEPTIONS OF PEOPLE ON THE DISSEMINATION OF INFORMATION
ON CHOLERA BY THE MINISTRY OF HEALTH. CASE STUDY: KANYAMA
COMPOUND.**

Date of interview.....

Name of department.....

Position held by interviewee.....

Questions

- 1) What preventive measures are in place against the outbreak of cholera?
- 2) What methods do you use to disseminate information on cholera to the people of Kanyama?
- 3) Do you think the methods you use are appropriate and people easily access information?
Why?
- 4) Are there any challenges that you face in accessing information on cholera?
- 5) Do you think people of Kanyama are knowledgeable enough on cholera?
- 6) Do you think lack of access to information on cholera is a major contributing factor to its outbreak?
- 7) Anything else you would like to add on?