THE UNIVERSITY OF ZAMBIA

DEPARTMENT OF MASS COMMUNICATION

PARTICIPATORY DEVELOPMENT COMMUNICATION: A CASE STUDY OF KAFUE DISTRICT HOSPITAL

PRESENTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF MASTER OF COMMUNICATION FOR DEVELOPMENT

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DEDICATION

To a life lived in not a moment of perpetual dirges, sung amidst the cries of agony
A life has been lived and lived it remains to be. With gratitude in my heart, I dedicate this work to my parents, brothers and sisters, and providentially, without the array self-pity, Limpo and Namasiku, who have summoned the best of love beyond telling, amidst a dark night of despair.

PARTICIPATORY DEVELOPMENT COMMUNICATION: A CASE STUDY OF THE CONSTRUCTION OF KAFUE DISTRICT HOSPITAL

BY

John-Eudes Lengwe Kunda

Submitted to the University of Zambia In partial Fulfilment of the Requirements of the degree of master of communications for development (MCD).

THE UNIVERSITY OF ZAMBIA
LUSAKA
APRIL, 2006

DECLARATION

I, JOHN EUDES LENGWE KUNDA,
Solemnly declare that this practical attachment Report has not been submitted for a Degree in this or any other University.

Signed: _____

Date: 31/05/2006

Supervisor: _____

Date: 01-06-06

APPROVAL

This practical Attachment Report of JOHN EUDES LENGWE KUNDA is approved as partial fulfilment of the requirements for the award of Master of Communication for Development (MCD) Degree of the University of Zambia.

Supervisor: KENNY MAKUNGU

Signature: [signature]

Date 01 - 06 - 06

LIST OF ABBREVIATIONS

ANC	African National Congress
BCC	Behaviour Change Communication
CSO	Central Statistical Offices
DRC	Democratic Republic of Congo
HDP	Health and Development policy
HIV	Human Immuno Deficiency Virus
AIDS	Advanced Immuno Deficiency Syndrome
KDHDC	Kafue District Health Development Committee
KDHMB	Kafue District Health Management Board
KTZ	Kafue Textiles of Zambia
NCZ	Nitrogen Chemicals of Zambia
PRSP	Poverty Reduction Strategy Paper
SAP	Structural Adjustment Program
SPSS	Statistical Package for Social Sciences
TNDP	Transitional National Development Program
UNICEF	United Nations Children's' Emergency Fund
UNIP	United Nations Independent Party
US	United States
SRP	Social Recovery Program
ZAMSIF	Zambia Social Investment Fund
ZDHS	Zambia

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO KAFUE DISTRICT HOSPITAL

Introduction

The development of participatory development communication is rooted in the understanding that development is not merely a gift to be given to the exclusion of intended beneficiaries. The people for whom development is intended must be seen as integral architects in the construction of their own destiny vis-à-vis development, be it social, economic or political. The development of the people depends largely on how the people are involved in the process. It is the "*how*" question that brings to the fore this participatory development communication paradigm which is key to power-sharing, decision-making and appropriation of accruing benefits. Yoon (2004) has captured this history lucidly:

> *The roots of participatory approaches in development communication can be found in the early years of the 1970s when many people in the development community began to question the top-down approach of development dominant in the 1950s and 60s which targeted the economic growth of countries as its main goal. Also, for the first time development communication was no longer in the exclusive domain of the professionals. Participatory communication, in the ideal situation, is practised spontaneously by the people without mediation. It was ideally the by-product o f participatory processes and participatory communities.*

This is the vision that this paper embraces. This case is articulated in the particular case of the construction of Kafue District Hospital. The case has been analysed with a bias to the nature and functionality of the communication process involved so as to establish

linkages between varying variables. The paper has investigated with respect to this particular case the importance of development communication, its nature and utility.

Data has been collected by the researcher and some research assistants in order to understand the central question of investigation. Analyses and recommendations have been made based on the findings and the interpretations of the data revelatory of experiences accruing in the community under investigation.

1.1. Background Information

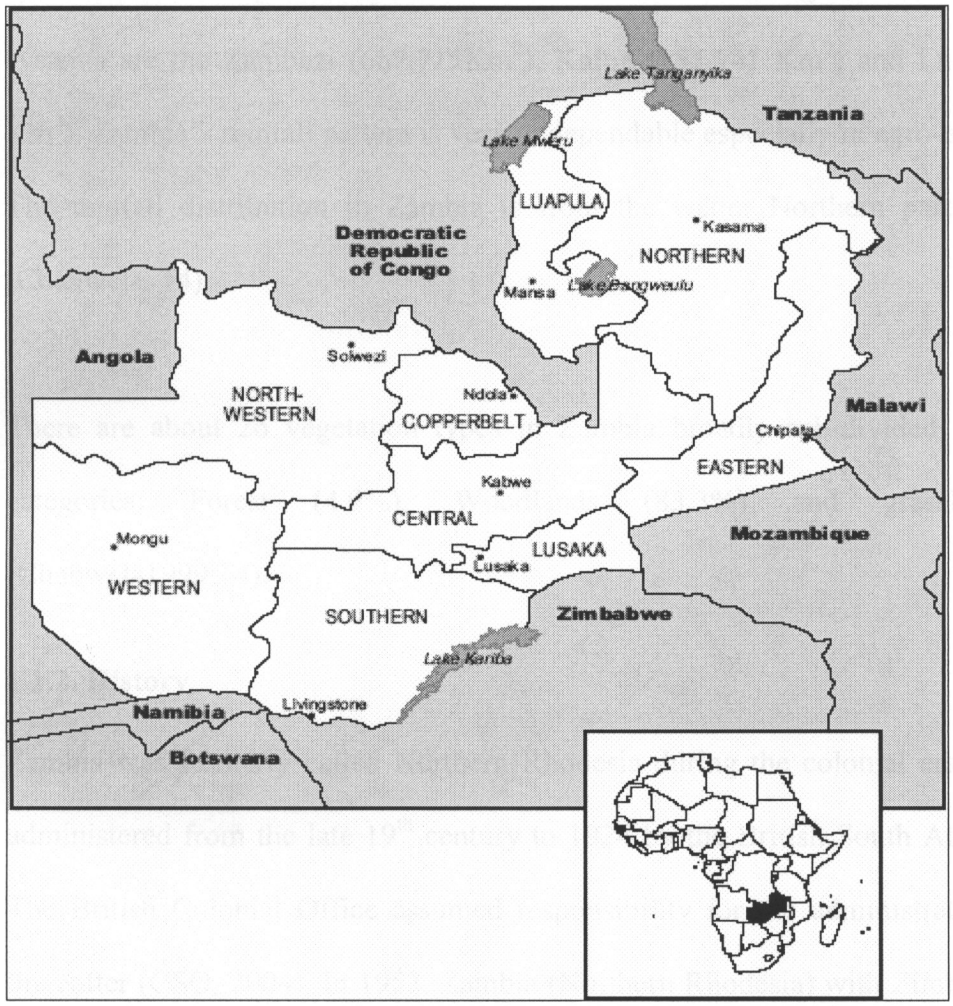
At independence in 1964, Zambia was one of the most prosperous countries in Africa. Its population, estimated at 9.9 million as at 2000, has, over the years witnessed deterioration in its standard of living arising from the decline in the country's economic performance. This is attributed to oil price-shocks of the 1970s, and the decline in revenues from copper. These variables are exacerbated by the physical location of the country. Transport costs being a major factor. Despite economic reforms in the 1980s and 1990s, the country continues to face the challenge of growing and diversifying its economy, while simultaneously addressing widespread and worsening poverty levels (Ministry of Finance and National Planning, May 2004). Zambia's physical location is both a gift and a challenge. It suffers a number of geographical impediments to economic competitiveness with its neighbours, yet at the same time it enjoys an abundance of resources that would stimulate growth.

1.1.1 Geography of Zambia

Zambia is a landlocked country sharing boundaries with eight neighbouring countries namely, Botswana and Namibia to the south west, Zimbabwe to the south, Mozambique

to the south east, Angola to the west, Democratic Republic of Congo to the north, Malawi to the east, United Republic of Tanzania to north east. (Refer to Fig. 1). This physical location has a bearing on the country's political institutions, agriculture, and tourism, hydropower, and industry and transport networks. Zambia has a zero maritime and coastline claim which has adverse implications for economic growth in terms of access to export and import markets beyond the boundaries of the sub-region. The total area of Zambia is 752,972 km^2. It is dominated by the plateau system with an elevation ranging between 900-1500 meters (Chabwela, 1999:14). It is commonly drained by the Congo-Zambezi watersheds. The climate is generally sub-tropical. The vegetation is dominated by woodland savannah not withstanding inherent variations. The main natural resource of the country is land which covers about 75.3 million hectares of which 920,000 is covered by water bodies such as swamps, lakes, and rivers. It is estimated that only 24% of the land is arable of which only 11% is cultivated annually.

Figure 1: Map of Zambia



Source: ZDHS 2001-2002

Soils in many ways are a result of climate, that is, a combination of humus and fragmented rock (Stringer, 1966:9) Zambian soils are characterised by eight general soil groups, and their formation is based on climatic factors, parent rock material, topography,

vegetation, organisms and land use. The most common of these soils being ferrallitic soils and the Barotse sands (Chabwela, 1999:14)

There are two hydrological systems in Zambia; the Congo system supporting the Chambeshi, Bangweulu, Luapula, Lake Mweru-wantipa wetlands, and the Zambezi system which comprises the Zambezi, Kafue and the Luangwa rivers. The main river systems are the Zambezi (667,715Km^2), Kafue (155,141 Km^2) and Luangwa (147,472 Km^2). Zambia's rainfall pattern is very undependable especially in agro-ecological zones. The rainfall distribution in Zambia is from the wetter Northern part of the country (Chabwela, 14).

There are about 26 vegetation types in Zambia broadly sub-divided into three basic categories: Forest (4.9%), Woodlands (83.3%) and grasslands (11.8%) (Chabwela1999:14).

1.1.2. History

Zambia was formerly called Northern Rhodesia during the colonial era. This area was administered from the late 19th century to 1924 by the British South African Company. The British Colonial Office assumed responsibility for the administration of this area thereafter (CSO, 2004). In 1953, Zambia (Northern Rhodesia) with Zimbabwe (Southern Rhodesia) joined Malawi (Nyasaland) to form a Federation. This federation lasted for ten years as it broke apart in 1963. The country got its independence from the British rule on October 24, 1964. From independence, the country assumed multi-party politics and was ruled by United Nations Independence Party (UNIP) and the African National Congress (ANC) was in opposition. Zambia became a one party participatory democracy in 1973

when Kenneth Kaunda and Harry Nkumbula who were leaders of the two political parties singed the Choma declaration. In December 1990, Zambia reverted to multi-party system and the newly introduced Movement for Multi-party Democracy (MMD) became the ruling party.

1.1.3. Social Characteristics

There are 73 officially recognised ethno-linguistic groups in Zambia. Each has a distinct culture and customs that influence its world-view. The major ones are Bemba, Kaonde, Lozi, Lunda, Luvale, Nyanja and Tonga. English is the official language. These major languages are loosely distributed according to the nine provinces of the country: The Bemba are primarily in Northern and Luapula provinces, the Kaonde, Luvale and the Lunda in the North-Western Province, the Lozi in western province, the Tongas inhabit the southern province, the Nyanja are in Eastern and some parts of Central Province (CSO, 2003).

1.1.4. Particular Factors Affecting Economic Situation

Zambia is ranked amongst the poorest of the least developed countries. The economy of the country has been on the decline since the mid-seventies. This decline has given rise to increasing poverty levels. Central Statistical Offices' Living Conditions Monitoring Survey of 2002/3 shows that 67% of the population fall below the poverty line; the poverty levels are higher in rural areas (74%) compared to urban areas (52%) (CSO, 2002-2003).

The economic quagmire of the country is attributed to the historical practice of nationalisation and centralised development of the economy in which most of the consumer goods and agricultural inputs were subsidised and prices of goods controlled (Chabwela, 1999). Serious shortage of foreign exchange, over reliance on copper, high foreign debt servicing, structural adjustment programs, high redundancies, and excessive public sector participation are amongst the factors blamed for this state of economic quagmire. In addition to the identified variables that could have led to the underdevelopment of Zambia, there are geographical factors that did exacerbate the economic degradation. The geography of poverty in Zambia shows that it significantly affects rural areas due to their geographic isolation or remoteness (Alwang Jeffrey and Paul B. Siegel, 1994).

1.1.5. Over-reliance on copper

The Zambian economy has comparative geographic advantage of copper deposits, cobalt, gold, diamonds, Zinc, gemstones, coal, and a number of agro and industrial minerals. What is noticed is the over dependence on mining copper and cobalt on a large scale. "The mining and refining of copper constitutes by far the largest industry in the country and is concentrated in the cities of the copperbelt" (www.infoplease.com/ce6/world). This industry can develop and contribute to national growth if these other resources are invested into. The TNDP shows optimism on mining as;

> *It provides critically needed inputs for agriculture and agro-chemicals, industrial manufacturing of a wide variety of products e.g. ceramics, paint manufacture, the electricity industry, essential raw materials for the building industry, and for road and telecommunication infrastructure. Clearly, the predominant superstructure of economic development is built upon mining and its products. In this regard, the actual contribution of mining to wealth creation in the economy through employment creation,*

income generation, and stimulation of industrialisation and infrastructure development. (TNDP, 71)

The Zambian economy has been considered a mono economy heavily dependent on copper. Even during the federation (1953-1963), mining was the single factor in development which provided the largest percentage of export earnings for the federation. This over-reliance on copper created inertia in expanding economic diversity in the country. It is in this sense that copper is seen as a gift and the same time a limiting factor. Revenue collected from this industry was enormous, but little attention was paid to its wasting nature despite early warnings that came as early as 1960 (Gardner 1961:5).

In order to redress this situation of poverty in 1980s, Zambia started the first phase of the implementation of the Structural Adjustment Program (SAP). The pace of these reforms was accelerated in the 1990s during the reign of the MMD. This period saw the closure of many government institutions that were deemed a drain on the national economy, hence their privatisation or closure. (CSO, 2003:2) Kafue district was negatively affected by this adjustment program which affected the main industries of the area. Most of the people who were in employment were retrenched, on forced leave or unpaid over extended periods of time.

Although copper remains the pillar of the Zambian economy, efforts are being made to diversity the economy in order to improve the other viable or promising areas like

agriculture. A transitional development plan is envisioned which is taking care of this diversification process:

> *Thus, the TNDP considers the agricultural sector as one of the engines of economic growth that is required to create employment and reduce poverty. In view of the multiplier effects that the agriculture sector has on the economy, the TNDP sees the restoration of its high and sustained growth as constituting a critical step for reducing poverty. (TNDP, 49).*

Zambia economic growth ultimately will only result from heavy investment in the agriculture industry. There is inherent promise in the following picture,

> *"Some 85% of Zambians work the country's relatively infertile soil as subsistence farmers; commercial agriculture is mostly confined to a small number of large farms. The leading crops are corn, sorghum, rice, peanuts, sunflower seeds, tobacco, sugarcane, and cotton. Cattle and other livestock are raised. There is a small fishing industry."*
> *www.Infoplease.com/ce6/world*

This economic background shapes the argument of this paper that participatory development does not depend on the enhanced affluence accruing in a community. As in the case of Kafue, despite the economic state, people were mobilised to embark on a project that was to support their health.

1.2. Kafue District And Background To Hospital Construction

To better locate the analysis of the project, a macro context of the district placed in the micro-context of the specific construction boundaries.

Kafue district is located 35 Km south of Lusaka province. It covers an area of 9,396 Sq.Km. As of 2000, its population was 9,723 with 2,239 households covering 11% of the total population of Lusaka (CSO 2004:24).

1.2.1. Language of communication

Kafue district has multiple linguistic tendencies as it depicts a variety of languages spoken: Tonga, Bemba, Nyanja, Soli, Gowa, Lenje, Kaonde, Lozi, Chewa, Nsenga, Ngoni, Nyanja, Chikunda, Mambwe, Namwanga, Tumbuka, and English. Of these languages, Nyanja (40.5%), Tonga (16.1%) and Bemba (12.9%) of the total population are predominant ((CSO 2004). These three languages, therefore, form the core of the language that can be context-specific in Kafue district without disregard to other obtaining languages. They form the most applicable means of communication to the people on whatever subject-matter one intends to sell to the community.

1.1.2. Health

Kafue district which is the area under the consideration of this paper falls within the macro-context of Lusaka province. Lusaka province has 100 hospitals of which 82 are government owned, 14 private, while 4 are mission hospitals. Kafue district has 17 hospitals which are government owned, 1 mission owned, and 7 privately owned. The 24 hospitals of Kafue have a total of 89 beds and 34 cots. This shows a lack of medical facilities for Kafue to cater for the named population (CSO 2004). Lusaka shows the highest prevalence rates of HIV/AIDS of 22 percent in the population aged 15-49 for the females and 15-59 years for the males (CSO 2004:3). Kafue has a fair share of this malaise (about 24 percent) (CSO 2004:4). As such the need for a hospital to deal with increasing clinical cases was critical. Health is a priority agenda in Zambia. The country has largely experienced poor investment in the area of health. Kafue district is a point in case. A sizeable population has lived in the area without a major hospital to meet their health demands till 1998 when the idea to build a community hospital began to be

realised. The desperate need for a hospital could not have been far from the following observation:

> *Villagers in Kafue constituency have called on the government to help them extend their clinic by constructing a maternity block. According to some residents of Chaledzera village, the Masstock Kambale clinic cannot cater for all the surrounding villagers. The clinic which was built under self help with some assistance from the Government, Masstock Africa Limited and the Irish aid was not fully completed. The residents expressed appreciation to the government for responding positively to their need but said there was need to up-grade the clinic in order to make it efficient for about 5,000 people within the catchment area. Senior Headman Chaledzera told the Mail that although the staff at the clinic were trying their best to serve the community, the clinic usually lacked drugs. The headman said the only alternative was Mutendere Hospital in Chirundu district which was over 25 Kilometers away. He said pregnant women struggle to go to the hospital while others have no option but to give birth in their houses. The lucky ones, he said were driven to the hospital on wheelbarrows (Hoppenbrouwer, 1999)*

The necessity of the hospital was a foregone conclusion, yet the means to its construction was a question that remained silently imprinted on the minds of most the people till this material year (1997) when the community decided not to wait on external help but contribute what they could to see the hospital erected.

1.2.3. Economy

Kafue district has, for its industries inter alias, Kafue Textiles of Zambia (KTZ), Nitrogen Chemicals of Zambia (NCZ), Railway Systems, Zambia Concrete and Bata Shoe Company. These are supplemented by private businesses. Fishing is another notable activity in the areas lying along the Kafue river of Kafue district. Farming is also an activity that preoccupies rural communities of the district. The district has nonetheless suffered from the effects of the structural adjustment programmes as effected in the early

1990s. This led to the closure of the Nitrogen chemicals of Zambia, and low production levels at KTZ.

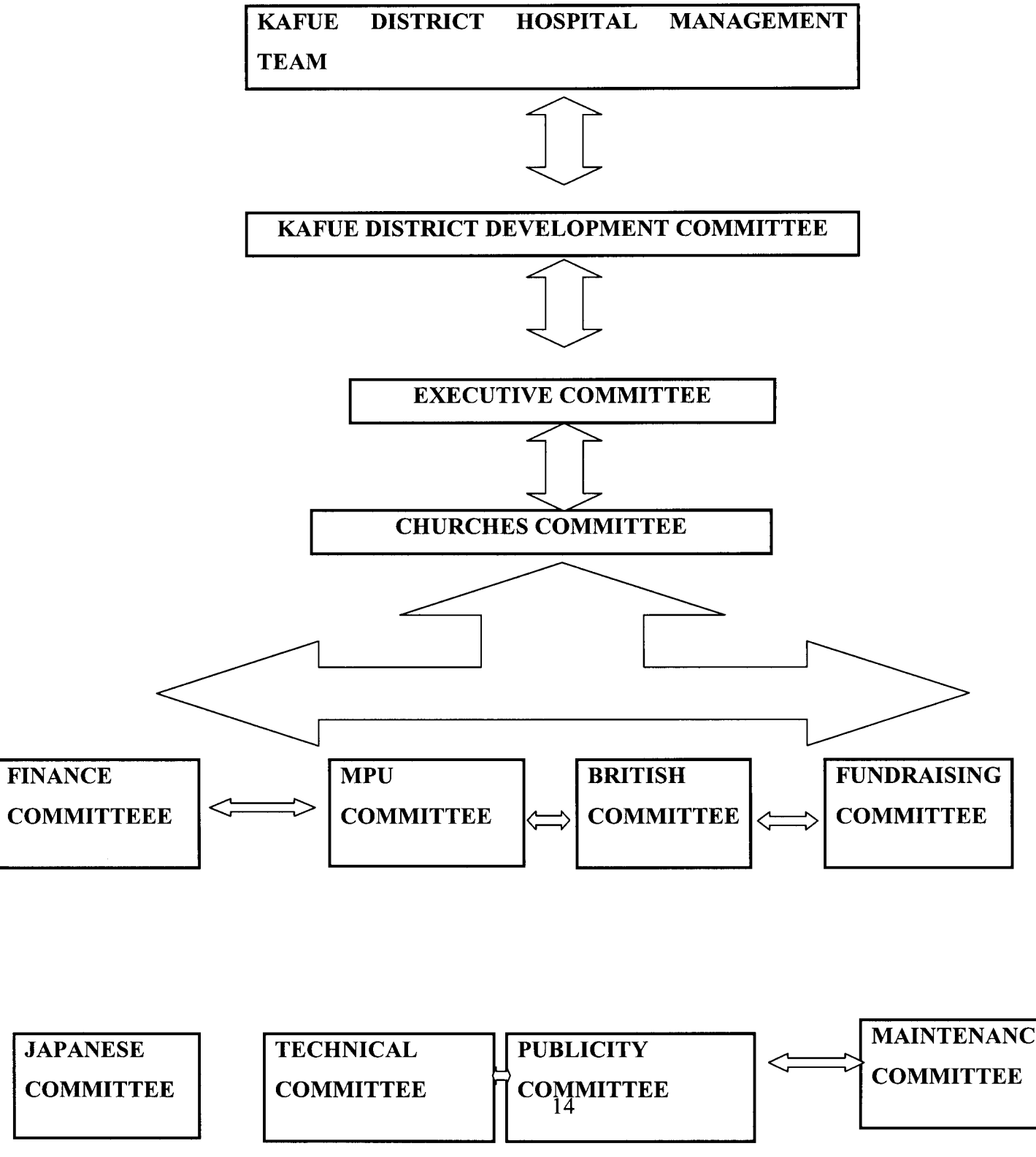
1.2.4. Religion

There are many Christian denominations viz. Jehovah Witnesses, Seventh Day Adventists, Roman Catholic, Dutch Reformed Church, Baptist Church, Apostolic church, Pentecostal and evangelical movements. There are also Islamic and Hindu communities. These communities were important because they formed the central areas of information dissemination which then filtered to other segments of the community.

1.3. Kafue District Hospital Development Committee

The formation of the District development committee dates back to September, 1997 under the theme, "Together It is Possible". Its task was to pioneer and head the construction of the Kafue district hospital. It was constituted to organize different interest groups. The Kafue District Hospital Development Committee (KDHDC) is a legal entity registered under the society's act of Zambian laws. The need for a hospital in Kafue was felt and unsuccessful attempts at construction were made as far back as 1972. The committee formed the Kafue district churches coordinating committee to coordinate its activities. Dr. Dyness Kasungami notes that the need for a churches committee was identified to provide a link to the ordinary members of the community (Kasungami, 2006). In order to complete its task, various committees were put in place with respect obtaining responsibilities. The following were the committees that fell under the Kafue district development committee:

1.4. Structure of the Organisation



CHAPTER TWO

Practical Attachment Problem

This chapter explores the central question of investigation which is the communication processes involved in the construction of Kafue District Hospital. The approach taken is a historical study since the hospital is already completed.

2.1. Statement of the Problem

Kafue District with its population relies for its health needs on the enumerated health facilities. For instance, between the town area of Kafue District there is no hospital within immediate reach that would meet the health needs of the community adequately. This meant that for major clinical cases, Kafue Histrict had to rely on Mtendere mission hospital in Chirundu or University Teaching Hospital in Lusaka. This led to experiences of inadequate health provision and sometimes loss of life due to the distances ensuing in seeking urgent medical attention. It is within this context that this project was embarked on. However, the community of Kafue District experienced the closure of KTZ and NCZ, the major sources of income of the majority of the residents. Most of them were retrenched or were underpaid for a number of months. NCZ is only being revamped now, i.e. the year 2005. Within this background of economic struggle, how was the community mobilised to engage in such a mammoth project. What communication strategies were employed to persuade the community to take on the project?

This study was designed to investigate the role of communication in mobilising communities in their development. Kafue District Community was used as a case study.

The study also sought to investigate the level of community involvement and the types of participation ensuing in this development. The facilitation role of donors and leaders were also being investigated.

2.2. Rationale of the Problem

There has been a shift in Zambia from mere provision of services, especially development projects, from a top-down paradigm to a more collaborative one. The latter seeks to engage the intended beneficiaries into the process of their own development. The work done by the Zambia Social Investment Fund (ZAMSIF) and their intention to allow communities to make a contribution to their own projects was a cardinal step in the direction of participatory development. It is however, difficult to mobilise people if proper participatory communication skills are lacking. At the heart of mobilisation is communication whose failure would stamp a mark on the fate of a given project. The people need to feel a part of the process of planning, implementation, and eventual evaluation of the projects that are aimed to expand the capabilities of the people.

> *Effective implementation of programmes requires the involvement of the community in project identification, planning, and implementation. This participation would encourage sustainable management and use of resources that would in turn ensure poverty reduction.* (Ministry of Finance and National Planning, 2002-2004: 69)

This quest for the involvement of intended beneficiaries in projects that are targeted at human development i.e. the expanding the people's capabilities and *ipso facto* their choices for a meaningful life would be a vain pursuit without participatory communication for development. This kind of communication gives them a sense of belonging, hence, feeling respected and affirmed. It is in this vein that this paper locates

the problem within the *participatory communication paradigm* as pivotal to any development mobilisation seeking to embrace and share the echelons of power, control and decision-making with the intended beneficiaries. Recent research has moved from a top-down, master to slave model to a more participatory approach that guarantees success and sustainability.

The Poverty Reduction Strategy Paper (PRSP) is apt in support of the need for the involvement of communities in their development Ministry of Finance and National Planning, 2002-2004). Projects that do not accommodate intended beneficiaries in the whole process are likely to meet with failure. The people need to make decisions as to the control of the project and the anticipated benefits resulting there from. This practical attachment is to the community development committee which was responsible for the mobilisation of the community to embark on the project. The choice of the committee was to facilitate first hand information on the processes and communication strategies used in the project.

2.3. Objectives of the Study

1. To investigate the type(s) of communication techniques used to mobilise the people of Kafue
2. To investigate the role played by the community in developing the hospital
3. To investigate the level of community participation in developing the hospital
4. To investigate the facilitation role of the donors and community leaders in the Kafue district hospital project

2.4. Research Questions

1. What communication strategies were used to mobilise the community in this project?
2. What types of communication campaign strategies were involved in persuading the community to participate in the project?
3. What type(s) of participation were involved in this project?
4. How did the donors facilitate the project?
5. How did the local/community leaders facilitate the project?

CHAPTER THREE

METHODOLOGY

This research report based its findings on a case study of the construction of the hospital. The practical tools of research used **triangulation** i.e. it combined both **quantitative** and **qualitative** methods of research. This gave the student an in-depth comprehension of the factors under research.

3.1. Research Setting

This research covered the district of Kafue. The compounds and residential areas covered were selected as noted in research methods. The role of donors was ciphered from minutes, brochures, and in-depth interviews with leaders of the community. This was done because most of the people responsible for the project were not available and neither were the records.

3.3. Research Methods

The research methods employed in this research for objectives 1-3 was a household survey. This embraced subjects of the community who were randomly selected to provide their view about how they came to know about the project and the contributions made thereto. This led us to seek an understanding as to the type(s) of communication strategies used to inform and mobilise the community for this particular project. This survey used closed questionnaires. The respondents were randomly picked from three compounds in Kafue amongst which subjects to be studied chosen using systematic **random sampling**. This helped to get a representative view due to the variety of

characteristics in the community of Kafue district. Objective 4 was met through **in-depth interviews of community leaders and donors**.

The research targeted all the donor representatives who were interviewed to give the kinds of campaigns carried out in bringing the community together and embark on the hospital project. Community leaders identified and clustered according to the community they represented. This is due to the variety of communities that contributed to the construction of the hospital viz. churches (of varying denominations), NGOs, Community groups, business houses, sports clubs, youth groups. Then a random sample was picked of these leaders to provide insights into the role of community leaders in disseminating the information and consequently bringing the community together to collectively work on the project.

3.4. Sample Size

The population of Kafue town, which was used as the sampling frame, is estimated at 9,349. The sample size of the respondents, excluding facilitators and donor representatives was 151.

3.5. Documentary Evidence

The hospital has a registry department where records and documents are kept. It was however discovered that most of the documentation relating to the hospital has not been kept in the registry of the hospital or any other chosen department. Individuals keep most of the records to-date. The minutes and documentation related to the projects planning, implementation and evaluation are not kept anywhere in the main hospital or in the district offices. These include; minutes of meetings held, correspondence, and

memoranda and reports. Some minutes of the project processes in the community have been kept by individuals who were in community committees. It proved difficult to locate these individuals since they had no central point of reference. The student did, however manage to locate some notes from some individuals. The chairperson of the executive committee also indicated reluctance at releasing some minutes for study for they were considered committee property. The data that was kept by some individuals who have been members of committees was analysed to support the findings of the survey and in-depth interviews.

3.6. Data Collection Methods

Data was collected basically using questionnaires administered to the selected samples. The student carried out structured interviews and filled-out questionnaires. In-depth interviews were conducted with some leaders of the community who were in the facilitating team. A total of 151 households were systematically picked out of a total of 2474 households. Every 17^{th} house was targeted. As of the leaders, simple random selection was used and those picked were interviewed extensively.

3.7. Data Analysis

Firstly, data from in-depth interviews was assessed, coded and analysed. Categories were created representative of the objectives of the study and accordingly coded for easy analysis. Secondly, data collected through structured interviews was (closed ended questions) analysed quantitatively using the Statistical Package For Social Sciences (SPSS) and Epi Info. These are computer software that analyse quantitative data

providing percentages, cross tabulations, frequencies, tables, diagrams for easy analysis and interpretation of data.

3.7. Study Limitations

It was difficult to access archival data as most of it was not filed in a central location for reference or public access. The student however was able to access some documents from individuals who were instrumental in the process of constructing the hospital. The student experienced difficulties in terms of transport and costs. Mortality of subjects, i.e. some of the prominent individuals who were saliently involved in project designing have since permanently moved either to other areas within Zambia or have gone abroad. The population of Kafue is depended on the 2000 census data provided by the Central Statistical Office availing the student a limitation in accurately determining the current sampling frame. It was also difficult to interview donors who were involved in the projects as most of them have either moved or the institution has wound up as in the case of MPU. It has been replaced by ZAMSIF but the latter has not kept record of the Kafue project in its books.

CHAPTER FOUR

CONCEPTUAL FRAMEWORK

In this section, concepts related to this study topic are defined and explored to provide a basis for our presentation. This vantage point includes a clear understanding of the concepts of our study including; communication, participation and development as they relate to the central question of investigation.

4.1.Conceptual and Operational Definitions

4.1.1. Communication

Communication is defined variously. Communication is herein understood as an exchange of meaning expressed in verbal and non-verbal gestures. Communication is herein understood in the words of Bella Mody as shared meaning i.e. communication has occurred when parties to a communication process hold meaning in common (Mody, 2003:41). This happens when the message that the sender wanted to send relates to the meaning the audience receives. Mody further articulates, "The degree of communication achieved is a function of the relevance of the topic to a particular audience and the appropriateness of the treatment/presentation/form of the information (i.e., to what degree it facilitates processing by the audience." (Mody, 2003:42)

However our discussion is within the micro-context of interpersonal communication. This form embraces a web and linkages of interrelatedness wherein information is disseminated in an informal way. It is also within the interests of this presentation to look at public address as a part of the process of community mobilisation. The following are

some of the definitions and sense in which terms and key words are used in this presentation:

4.1.1.1. **Mass Media**: Mass refers to an audience that is large, anonymous, heterogeneous, This means that the audience being addressed is simultaneous receiving the message, while remaining unknown to source, and the characteristics of the audience are heterogeneous i.e. demographically, and psychographically; whereas media refers to the means used to communicate a message. This may encompasses: Electronic in which are; radio, television, internet whereas; Print embraces, newspapers, books, booklets, magazines, insofar as they are communicated from one source to a large homogeneous and anonymous audience.

4.1.1.2. **Communication**: is the process of sending a message from a source to an audience or receiver. There are many forms of communication. These include;

1. Interpersonal Communication- This is the exchange of meaning between two individuals. This kind of communication is the most common underlies various forms of social intercourse. Since it is usually within immediate reach, feedback is usually immediate (Infante 1997).
2. **Intra-personal communication**-is when an individual communicates within himself. He encodes the message and decodes it him/herself.
3. **Intercultural communication** is done between individuals of different cultures. This entails breaking down cultural barriers that may distort the exchange of meaning.

4. **Organisational communication** which is done within or between organisations.
5. **Public communication** is when a speaker is addressing a public audience like addressing a crusade or public campaign.
6. **Family communication** is the one done between family members.
7. **Health communication** is the one involving health providers and health receivers. It may be between health experts and their patients or the community on areas of concern specific to the field.
8. **Political communication** involves the governance component of public affairs. The running of the government and its inherent dynamics.

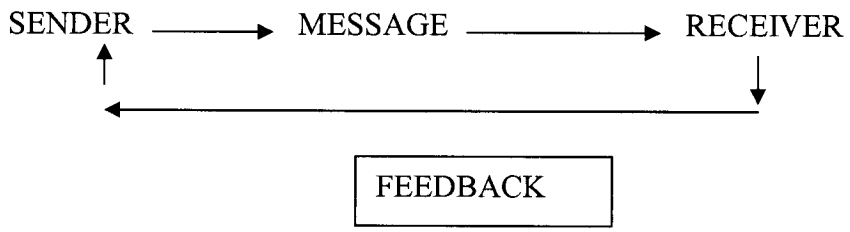
4.1.1.3.Effects: These are being defined as the results, whether emotional, psychological or physical, that are caused by a particular stimulus. It may take on two forms:

- Intended: This is a deliberately desired goal that a source of a message seeks to see in the intended audience. For instance in selling a product like mealie-meal the advert screened or aired on radio may have the desired effect of getting people to buy the product.
- Unintended: This refers to the indirect effects of what is communicated. That is, for instance, the message that is sent may have its desired effect, but may also alarm people. In other words, this may be called a dysfunction of the media. These effects may be:
  - Short-term or Long term: some effects of the media may be short-term by which is meant short-range effects which may not necessarily lead to

behaviour change whereas long-term effects will affect the beliefs, knowledge and practices of the audience. Some of these effects may be long-term or short-term.

There are a number of models of communication. The one in Figure 2 is a basic model. It presupposes a sender or source of the message, a message which is the content of what the source intends to communicate to the audience. The latter defines the receiver or recipients of the message. Feedback is the reaction given by receiver of having received the message. It may be immediate or delayed depending on the context and mode of transmission used.

Figure 2: Basic Communication Model



According to Bella Mody, communication means shared meaning i.e. communication has occurred when parties to a communication process hold meaning in common (Mody, 2003:41). This happens when the message that sender wanted to send relates to the meaning the audience receives. Mody further articulates,

"The degree of communication achieved is a function of the relevance of the topic to a particular audience and the appropriateness of the treatment/presentation/form of the information (i.e., to what degree it facilitates processing by the audience." (Mody, 2003:42) This is the sense in which this study wishes to understand communication. In

any project, for it to claim success, there is need to share the same frame of meaning so as to move at the same pace with a similar understanding. Power sharing in decision-making would be mockery if meaning of what is intended in a development venture is not commonly shared between the benefactor and the intended beneficiary. Communication designs for development must allow the audience to be both architects and recipients of the message i.e., the source and at the same time the receivers.

There are, however, various models of communication that have been defined. For us to better appreciate the approach of this presentation there is need to have an overview of basic models and how they operate. Most of these models were basically a one way, stimulus-response model. Information has been viewed as one way. The audience was perceived as passive recipients of information.

4.2. Two-Step Theory

Two-step Flow - the term used by Katz and Lazarsfeld to describe their observation that media messages flow from the media to opinion leaders to the rest of the audience. The important point is that their research demonstrated that media effects are mediated by the pattern of our social contacts. They concluded that the media have limited effects.

Katz and Lazarsfeld (1955) stated that "...many variables intervene to modify the effect of messages on audience response..." (Infante, 361) This theory evolved from a research on elections campaign wherein it was discovered that confounding variables of personal informal contacts. These contacts were identified as sources information and ones usually exposed to the media.

The theory *in se* states that information moves in two distinct steps i.e. people who pay close attention to mass media (attenders) receive information and they in turn pass it on

to those who are less exposed to mass media through interpersonal communication (360, Infante). This information is nuanced with own interpretations of information in addition to receive personal meaning is added. These play an influential role in attitudes and behaviour. Opinion leaders are also seen as active information seekers and the audience is assigned a passive role (362, Infante).

4.3. The Two-Step Flow Model

Figure 3: The Two-Step Flow Model

The two step flow of communication hypothesis was first introduced by Elihu Katz and Paul Lazarsfeld, who recognised that the magic bullet theory exaggerated the effects of mass media on the audience. They stated that the magic bullet theory lacked the powere of prediction and explanation. Research on an election of peoples' voting intentions discovered that the media did not have the direct influence attributed to it. The message usually went through other informal personal contacts who were mentioned in the research more than newspapers, radios, or Television. Others in response reported having received information from other people who were had received information directly from the mass media (Infante 1997: 361). This led Katz and Lazarsfeld to develop the **two-step flow theory** which stated that,

> *...information from the mass media moves in two distinct stages. First, individuals who pay close attention (are frequent "attenders") to the mass media and its messages receive the information... These individuals, called* ***opinion leaders****, are generally well-informed people who pass information along to others through informal, interpersonal communication. Opinion leaders also pass own their own interpretations in addition to the actual media content.* (Infante 1997: 361)

These opinion leaders are known to be quite influential in getting people to change their attitudes and behaviours and fairly similar to the people they influence. This theory has also received a fair share of criticism. One of the main criticism is that it supposes that opinion leaders are primarily active information seekers whereas their audience is deemed passive. Some opinion leaders have been identified as passive recipients of media information (Infante 1997: 362). Others have argued that information does not flow only on a two-step frame, there are multiple processes involved in media dissemination and audience behaviour. This has led to the development of the multi-step flow theory of mass communication.

4.4. MULTI-FLOW STEP THEORY

This is generally used to describe diffusion of innovations by which is indicated in common reference to the process of taking up of technological innovations within a given population (McQuail, 2005). By innovation is meant a new idea, technology, or habit of doing things. This theory in addition to the two-step theory adds that people who influence others are themselves usually influenced by others in the same topic area resulting in an exchange. Opinion leaders are thus both recipients of influence and disseminators hence the emergence of the multi-step flow.

There are a number of steps involved in the diffusion of innovations:

1. Awareness creation stage is the time when the community is being introducted to the innovation.

2. interest stage: There is interest shown in the innovation and a desire to understand it further is pursued.

3. Assessment stage is the time when a small group of members of the community take time to study the innovation and assess its relevance to the community.

4. Trial Stage attempts to apply the innovation to their life pattern.

5. Adoption stage is the adoption or rejection of the innovation and it becomes or does not become a part of the community process on a large scale.

In this field of the diffusion of innovations,

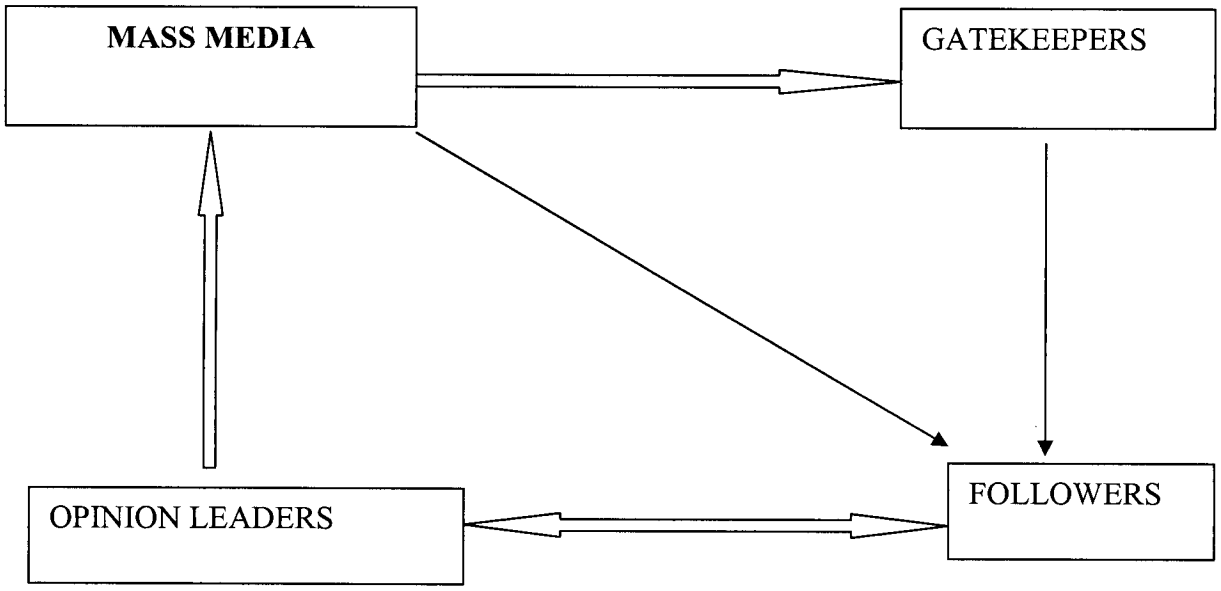
> *...much research data was gathered which tended to show that information about innovations was communicated by the mass media and extension agents to opinion leaders among relevant recipients, and from them to others in the social system (Rogers, 1962)*

There are key players involved in this process: Identified in the diffusion of innovations are the change agents and gate-keepers. The former are the professionally trained people in the field of development or its related, whilst the latter embrace people who function in a 'local editorial framework'. The Gate-keeper is the one who selects what goes in or what stays out of the media. The flow of information takes into consideration other individuals in the community who are deemed cardinal to the process. There are informal processes of information dissemination at community levels that are formed out of convention and through a long process of socialisation. The local people are key to understanding these processes. They understand the best way to articulate and transmit messages in a language that can be understood by the community. They can easily read the pulse of the community. Yoon observes,

there is increasing awareness that it may be just as important, or even more important for the communicators to be trained in the indigenous communication methods of the people so that they can participate effectively in the communications systems of the community. A view has emerged that truly participatory communication is the "natural" communication of the people. It is everyday communication which nourishes the identity of the people as a community. Such communication skills are learnt over a lifetime and are probably difficult to acquire if one were an "outsider".

4.5. MULTI-FLOW STEP MODEL

Figure 4: Multi-Flow Step Model



4.6. Development

This implies a state of bringing out possibilities into actual states that are relevant to a particular situation, group of people, or organisms. In this paper, development is understood as allowing people to improve their own lives, both individual and corporate, to be in control of their means of survival and ultimately have a grip on the shape of their destiny. The particular tone that we take is that development must be sustainable. The

people must take hold of development initiatives if they are to benefit the immediate generation as well as embrace the needs of future generations. Various definitions of development have been articulated. Francis Kasoma defines development as:

> *... the improvement in human life condition at individual and societal levels which is achieved through desirable but fluctuating changes or adjustments in the environment, (Kasoma, 1994:403).*

What is noted in this definition is that development is not merely defined in economic terms. It is integral as it embraces the whole of human life. Development processes in institutions and structures of society without improvement in the welfare of the people would not meet the above definition because the human person is at the heart of the development process. The human element is a *conditio sine qua non* factor to understanding the concept of development. It entails that the economic, social, health and educational needs of individuals are considered. Melkote advances what has been missing in the dominant development paradigm:

> *Missing in this definition was the need for a more broad-based definition of development. Any discussion of development must include the physical, mental, social,, cultural, and spiritual development of an individual in an atmosphere free from coercion or dependency (Melkote, 1991:189)*

It is therefore fair to understand development as an integral interaction between an individual and the environmental factors that lead to the natural pursuit of happiness and a good life for all. This cannot merely be given by external provision of necessities without due empowerment of the subject of development. Chairman Mao had aptly noted when he stated the need to teach an individual how to fish than actually providing him/her with food. The opposite seems to have been the approach of the industrialised West, that all that third world countries needed is the reception of mass technological

support that would necessarily lead to mass production hence the eradication of poverty and underdevelopment. The words of US President Harry S. Truman are a case in point:

> *More than half of the people of the world are living in conditions approaching misery. Their food is inadequate. They are victims of disease. Their economic life is primitive and stagnant. Their poverty is a threat both to them and to more prosperous areas. For the first time in history, humans possesses the knowledge and skill to relieve the suffering of these people (Daniels, 1951:10-11)*

It has been thought that helping the third world to develop is to avail them western advances in the arena of technology, health, agriculture and economics. This trend neglects the essential traits of uniqueness that are enshrined in other people's world-views and rate of progression. Intended beneficiaries of developmental initiatives must be involved in the strategic tasks of information gathering, analysis, decision-making, implementation and capacity-building, and monitoring and evaluation.

4.7. Participation

There is a general agreement that development should be people-centered. It should lead to the empowerment of the target populations. Marginalisation of the subjects of development initiatives leads to lack of sustainability. Jonsson notes that "...people who are poor should no longer be seen as passive beneficiaries of transfers of services and commodities, but rather be recognised as key actors of their own development." (2003:3). It is difficult to establish a universal definition of participation. It is equally difficult to identify it as an 'actual social reality.' David Marsden (1990) states that there are various definitions of participation which have been advanced;

> *Participation means...in its broadest sense, to sensitise people and, thus to increase the receptivity and ability of rural people to respond to development programmes, as well as to encourage local initiatives." (19)*

The view of this presentation is congruent to;

> *"With regard to rural development... participation includes people's involvement in decision-making processes, in implementing programmes ... their sharing in the benefits of development programmes, and their involvement in efforts to evaluate such programmes." (19)*

At the heart of participation in development initiatives is the question of power, control and benefits. Inherent herein is the question of decision-making and benefit distribution. What is noticed in the Kafue project is the understanding that,

> *"Community involvement means that people, who have both the right and the duty to participate in solving their own health problems , have greater responsibilities in assessing the health needs, mobilising local resources and suggesting new solutions, as well as creating and maintain local organisations." (19)*

This definition is critical for vital project articulation and implementation. At the heart of development is the question of power and benefits. This anchors the nerve-centre of participation, that is, respect for the people and their capabilities. The need for participation may not easily embrace a reasonable habit of clearly designed, blue-print projects that are cost-effective in the immediate time. Sustainability of a project demands the felt-identification of the intended beneficiaries with the project. This, in turn, is relevant for it to ensure long-lasting support and protection of the project.

The people of Kafue saw the need as a result of having distant hospitals, a situation unpropitious to their health needs. The decision to embark on the Hospital project was a felt-need that the community urgently needed to address. In this presentation, participation is taken to mean 'to take part' or 'to have a share'. The scope of this paper

understands participation as involving people in the act(s) of personal as well as corporate development. Innocenti Global Seminar aptly summarises this perspective,

> *Participation is the process of empowerment-the enhancement of people's individual and collective capability to improve their own lives and to take greater control over their own destiny... It is a process in which all intended beneficiaries organise themselves in groups to solve problems they have in common, gaining access to information and resources they need, and learning to manage them effectively (12).*

This means that the intended beneficiaries own the project and see it as a vital component of their quest for survival. Participation is to be seen as both a means and an end. There is both a teleological and the deontological dimension, the former focuses on the benefits realisable from the project whereas the later looks at the process as a growth- inducing and empowering tool. The United Nations Economic Commission for Africa says,

> *In our view, popular participation is both a means and an end. As an instrument of development, popular participation provides the driving force for determination of people-based development processes and willingness by the people to undertake sacrifices and expend their social energies for its execution. As an end in itself, popular participation is the fundamental right of the people to fully and effectively participate in the determination of the decisions which affect their lives at all levels and at all times. (Makumbe 1996 : 5)*

The intended beneficiaries would have learned from the process vital skills for survival and general well-being. Greater self-confidence, strengthened self-image, with a fired-up desire to willingly participate in future projects for their own best interests.

There are however a number of approaches to development that have been developed by scholars and the following is a brief description of some of them:

4.8. Empowerment:

In this theory, the responsibility of putting up a project is put in the hands of the intended beneficiaries, whereas facilitation of the project is in the hands of the benefactors. Empowerment herein is defined as enabling people acquire the capacity to significantly control their lives through increased capacity for decision-making.

The concept of empowerment espoused in this paper follows Ugbomeh (2001:291) who says that a person is empowered:

> *When the person grows in the subjective sense of feeling able to do things hitherto out of reach, when a person develops the ability to do things which were not previously within the person's competence, and when doors of opportunity, which were hitherto closed, swing open to allow access to information, influence and opportunity.*

4.9 "Small is beautiful" or Comparative advantage

This theory developed by Schumacher (1973) advances that development has to be planned and executed at a micro-level i.e. at a small scale level. It is to take on the ethos (this includes their attitudes, world-views, beliefs, customs, rites, taboos) of the people and their aspirations. Developers must not invade local people with pre-conceived 'roadmaps' for development, but consider the people and embrace them in their reality. "No development program, however, grand, can succeed unless the local people are willing to accept it and make an effort to participate." (Makumbe 1996:12).

4.10. Two-Plus-Two-Equals-Five (CONVERGENCE AND SYNERGE)

This theory applauds the involvement of local communities in development to supplement insufficient resources. Herein, the community realises much more than the

investment due to the combined efforts of the community hence the theory, two plus two equals five. Related to developing countries, these will identify their own local needs within their own contexts and give meaningful and effective solutions to their living milieu. John Mw. Makumbe aptly says,

> *Beneficiary participation tends to result in the mobilisation of greater resources and therefore the accomplishment of more with the same budget. This means that beneficiary participation can enhance efficiency in resource use for development. For example, rural labour is usually grossly under-utilised. Beneficiary participation will facilitate better and increased use of such labour and local knowledge thereby reducing project costs. (Makumbe 1996:18))*

4.11. Social learning Perspective

Participation is a learning process through which participants become self-reliant subjects. It is necessary for capacity building and enhanced decision-making. People will have been given the capacity to solve their own problems as they encounter them. They need not wait for handouts. They become independent and innovative. The process may be flawed with errors and mistakes, but these are huddles that facilitate the process rather than hinder it as the Chewa people of Zambia say *"Kote-kote ni wa njira kwalinga mtima ndi komweko."* – 'however the flaws, people get to their willed-destinations.'

4.12. Humanist Perspective:

In development endeavours, people matter, hence a human face must be given to development. Purpose, mutual agreement and trust, commitment and legitimacy can foster and motivate participation. Paulo Freire stands out as one of the proponents of this approach in which he advocates that "...any reshaping of the development process should begin not only ascertaining the peoples' basic needs (which they themselves should rediscover, redefine) but also by using the knowledge the people have about how to

respond to those needs." (Freire & Faundez, 1989:88). Participation of local communities in development projects is cardinal if the project is to succeed and have long term benefits to the community. The SRP which

> *...operates on the premise that community participation is the corner-stone for development. Communities participate in projects if they feel capable of doing so. Early in the life of SRP, several factors were identified which influence the quality and extent of community participation. Communities are more likely to participate if: they are well-informed, well-organised and have good leaders; the project meets a felt need; the contribution is appropriate and relatively easy for them to provide; they feel a sense of responsibility and ownership; they are given the opportunity to influence decisions which affect them; and there are visible benefits.*

4.13. Facilitation

Facilitation of projects takes on different forms. Herein, it is being discussed as a process of availing a community the opportunity to take charge of their own situation and build capacities that widen their choice-possibilities. The process of facilitating a project is cardinal because it determines where the power for decision-making lies. It is the nerve centre of the project. Japan gave Kafue District Hospital Development Committee$33,890 to the project in 98-99/8. Their vision regarding development projects is that,

> *In considering aid to a developing country, Japan takes into account each recipient country's priorities, its economy and the existing bilateral relations. It also attaches importance to the concept of "ownership" and the country's self help efforts towards economic take off. Accordingly, the Japanese Government promotes a community-based approach in development planning, and implements its aid programme with a view to ensuring the efficient and fair distribution of resources with the emphasis on capacity building and technology transfer. (http://www.zm.emb-japan.go.jp/relation.html)*

The World Bank validates this position with their own view in which,

> *District staff and regional officers facilitate community meetings so that all community members are given the opportunity to participate in decision-making and all community members have access to information. Projects Implementation and Maintenance Manuals have also been developed to assist communities manage their resources and improve the technical quality of their projects* (Oakley & Marsden (1990).

District staff and regional officers facilitate community meetings so that all community members are given the *opportunity to participate in decision-making and all community members have access to information*. Projects Implementation and Maintenance Manuals have also been developed to assist communities manage their resources and improve the technical quality of their projects (Barkworth). Without information, the community cannot take full responsibility because knowledge is essential to any deliberate social involvement. Facilitators of projects are the ones to provide leadership in information dissemination and guidance. Yet the problem of communication resulting in poor relationship with donors is evident:

> *Coordination between donors involved in district planning and community-based development and a sharing of lessons learned is generally poor. This poses a risk to the community-based approach to development that is easily undermined by interventions that support a 'handout' approach (Barkworth)*

CHAPTER FIVE

Literature Review

In this review, this paper looks at a number of publications addressing the need for participatory approach to communication for persuasion of communities towards meeting desired objectives. Prominence is however given to two; the Journal of Health Communication and Everett Rogers' Diffusion of Innovations (1983).

In the journal of health communication, human communication is seen as the relationship between public health and various social indicators whose result has come to be called "social determinants of health". The central predictive factor being social connectedness (Ratzan 2004:167). Public health communication is dependent on strong cohesion, specifically the way people communicate, network and trust one another. The definition of social connectedness defines external relationships within a given community or society (Ratzan 2004:168). Ratzan in exploring social relationships and how they interact relates the concept of "social capital" which embraces features of a social life-networks, norms, and trust that enable participants to act together more effectively as they pursue common objectives (2004:169). The need to involve target beneficiaries in communication initiatives is not by Rudd a condition in the success of health campaigns (Rudd, 2004:2005).

Everett Rodgers in his book 'Diffusion of Innovations' (1983) discusses the diffusion of an innovation within a social system over time. Though this work was primarily dealing with technological ideas, practices or beliefs related thereto, it advances a collaborative effort in the process of communication. He argues that the social and communication

structure of a system facilitates or impedes the diffusion of innovation in the system. Communication amongst homophilous individuals easier, i.e. that is communication obtaining amongst individuals who are similar in attributes like education level, values beliefs and social status. He also argues for heterophilous relationships as facilitating diffusion. This means that change agents or advocates of change be higher in attributes like education or technological language for them to diffuse knowledge to the intended beneficiaries. Rodgers also articulates a number of qualities that are seen as critical to the adoption or rejection of an innovation. These are relative advantage, compatibility, triability, observability. He notes that a project that satisfies these characteristics is likely to diffuse through a social system with relative ease.

In view of the growing importance of Participatory communication in human development projects, literature is diverse in addressing this question of participatory communication, defined as involvement in all phases, the design, development, implementation and evaluation of a project intended for assisting intended beneficiaries in their development. It is contended that Participatory communication, two-way dialogical communication, including group discussion, is the most appropriate option for involving intended beneficiaries in development programs. In dealing with the current situation affecting the health of these communities, the majority of Kafue district participants favoured a two step flow of communication in the process of community intervention of constructing a hospital.

Over the decades, there has been an increasing shift towards the use of *participatory communication* in sectors of human development as in health development programs. It is

believed that participatory communication may enhance the likelihood of program's success by stimulating two-way communication in the program—a process which is not always inherent in the modernization, and dependency paradigms of development communication. The modernization and dependency paradigms of development communication in this context mean a one-way, top-down, transmission of information that dominates the communication process in the development program.

The rationale behind participatory communication is that it involves "audiences" (people/communities) in "dialogue, collaboration, and group decision making" and considers them as the "ultimate and perhaps the most important beneficiary of development communication policies and planning". As a result, with the help of dialogical interactions with audiences, such communications can address a whole range of social, cultural, political, economic, and environmental issues affecting people's lives. In reaching the targeted audience, it is always cardinal to involve influential men and women in the community (opinion leaders). These are people held in high esteem and are likely to contribute to the dissemination of the message to the audience in order to persuade them for action. This is important because more often than not, these people are aware of the symbols of communication within the domains. Their language is likely to meet the target of accuracy, effectiveness and efficiency due to their comparative advantage in understanding their community. They understand the how, why and the when of transmitting the message for a projected purpose. The following Ghanaian case is a validating point:

> *This approach has helped to One of the innovations introduced by both projects in Ghana has been the inclusion of traditional rulers in the*

planning process. Chiefs and elders were individually contacted during the pre-planning stage to discuss and explain the modalities of the process and in both cases were part of the training and planning process. Apart from the chiefs participating in all subsequent meetings, they also played the role of mobilising the communities to attend these meetings. The participatory methodologies (including use of livelihoods analysis) have also enabled the full participation of disadvantaged groups including women. (John Cofie Agamah)

The working group on Reproductive Health and Family Planning gave a report on a meeting which was held to look at "Changing Communication Strategies for Reproductive Health and Rights (December 10-11, 1997). In this report the necessity of participatory communication for development is aptly underlined:

The approach used by International Planned Parenthood Federation (IPPF)-Western Hemisphere in the Caribbean, the increasing use in communities throughout the world of the Stepping Stones methodology, and the examples of other approaches to community mobilization reveal that participatory communication strategies are essential to understanding and building on people's own sense of the interconnectedness of sexual and reproductive health with other areas of their lives. Such approaches also are critical to the integrity and sustainability of efforts aimed at behaviour change. (HDPP, 1998)

In the field of health communication, an attempt has been made to engage the audience in the design and implementation of strategies that recognise their worth . This is viewed as critical to the success of health or related campaigns. It is also believed to support long-term behaviour change. Elaine Murphy notes;

Communication strategies have evolved to focus more on the receiver- rather than the sender- as the center of communications, and the new terminology, behaviour change communication (BCC) reflects this shift. BCC recognises individuals within the intended audience as active, rather than passive, receivers of information and messages, who act on messages only if they are seen as advantageous or useful? Often, such strategies rely on trusted sources to convey health messages. If a receiver identifies

with the sender s/he is more likely to be convinced that the message is relevant to her/his own life. (HDPP, 1998)

In Zambia this method has been used to fight the HIV/Aids pandemic especially amongst the youth. This is in realizing that participatory communication is important in campaigns against HIV/AIDS. Minister Gladys Nyirongo, Zambia's minister of sport, youth and child development, recently spoke at a UNICEF-Zambia workshop on communication for social change at which the Consortium's Denise Gray-Felder and consultant Ailish Byrne worked with local community leaders on using and monitoring the communication for social change process. www.communicationforsocialchange.org) In the fight against HIV/AIDS the approach has attempted to make the campaigns participatory. Knowledge is diffused through the community through networking. This has been especially so in Peer education.

One of the most important lessons learned throughout the Peer Education Programme is the importance of networking, so that everyone in the community knows what the programme is about. It is vital to cultivate connections with all leaders in the community http://www.worldbank.org/afr/findings/english/find137.htm

Participatory communication in communities to succeed has to involve local leadership i.e. people of considerable influence and respect within communities. They may be chiefs, Pastors, Priests, community elders and all others who are in positions of influence either formally or informally and are considered as such by the community. An attempt to involve chiefs in the transmission of messages of HIV/AIDS campaigns has been applauded as a possible area of great influence. The World Bank documents that

...traditional leaders can play a major role in strengthening the local response to AIDS. In Zambia's Southern Province the Peer Education Programme of the Anti-AIDS Project has been able to turn the tide by

involving chiefs, taking advantage of traditional leaders' roles and influence.

In the area of development, the Social Recovery Project (SRP) supports small, simple and locally-generated community-based projects that improve infrastructure and service delivery to the poor during the adjustment period in Zambia. Communities themselves prioritise their needs, identify solutions, organise themselves, contribute in cash and kind and initiate activities that provide solutions to their problems.

CHAPTER SIX

FINDINGS AND DISCUSSION

This report analyses, interprets the data and discusses the findings in the context of the objectives set out in this set. i.e. to understand the dynamics involved in knowledge dissemination and community mobilisation.

6.1. Household interviews

The household interviews covered a number of topics and these include:

6.1.1. Knowledge of construction

As about the construction of the hospital, 66% of the 140 people who responded to the question on knowledge, were aware of the project from its inception against 34% who were not. This signifies massive knowledge dissemination within the community via the appropriate media. The people of Kafue were communicated to about the project from the very beginning accounting for high turn out rate.

Table 1: Knowledge of construction

Construction knowledge	Freq.	Percent
Yes	92	65.71
No	48	34.29
Total	**140**	**100.00**

6.1.2. Channel of Communication

In community mobilization, the committee responsible for the construction of the hospital used the following media; radio, TV, community networks (interpersonal communication), and also church's public address and group media. Of the individuals who learnt about the construction of the hospital 58% indicated that they came to know of the project through the church. Thirty-six percent learnt of the project through the community's interpersonal networks. Television and Radio accounted only for about 6% of the individuals who knew about the project through these media. Community awareness in Kafue district depends much on the church and community networks. The two form the platform upon which messages critical to the life of the community are disseminated.

Table 2: Channel of communication

Channel	Freq.	Percent.
Radio	3	3.33
TV	2	2.22
Community	33	36.67
Church	52	57.78
Total	**90**	**100.00**

6.1.3. Participation in the construction

Of the 92 who knew about the project, 64 participated against 27 this represents 70% of those who participated against 30% who did not. This indicates that the majority of the members of the community participated in the project.

Table 3: Participation in the construction

Participation	Freq.	Percent
Yes	64	70.33
No	27	29.67
Total	**91**	**100.00**

Of those who participated, 90% felt fulfilled and didn't forced into participating as the table below shows. A percentage of individuals felt forced into the project.

Table 4: Freedom of participation

Freedom	Freq.	Percent
Happy	47	73.44
Forced	1	1.56
Honoured	7	10.94
Nothing	4	6.25
Fine	5	7.81
Total	**64**	**100.00**

6.1.4. Sustained Involvement

As the project is still going on in some of its parts, only a few individuals are still involved. 41% as against 59% are still involved in the on-going works of the project. For a number of people they were involved insofar as the construction of the hospital was going on. The official hand over of the project signalled an end to the process. This means that information flow to the community has not continued on the same scale as before.

Table 5: Sustained involvement

Current participation	Freq.	Percent
Yes	26	41.27
No	37	58.73
Total	**63**	**100.00**

6.1.5. Knowledge of Organizers and leaders

Organizers of the were considered as coming from the church, 55% followed by the community, 34% and lastly NGOs,12%.

Table 6: Project Organizer

Organizer	Freq.	Percent
NGO	10	11.63
Church	47	54.65
Community	29	33.72
Total	**86**	**100.00**

This shows that most of the community members believed that the leadership of the project was centered around the church.

The church was the center of activity and church leaders were recognized as the appropriate instruments in the mobilization of community participation. This proved effective as most respondents report receiving information firstly from the church and from within the community. The formation of the churches committee was a cardinal step in communication and community mobilization. This committee was composed of pastors, priests, deacons of various Christian communities in Kafue. The level of awareness of the leaders and where they came from was proportionately higher as shown in the table below:

Table 7: Knowledge of leaders

Knowledge of leaders	Freq.	Percent
Yes	57	64.77
No	31	35.23
Total	**88**	**100.00**

6.1.6. Trust of leadership

Another reason for the success of the project is the trust that members of the community had in the leadership. The table. below shows that 89% as against 11% trust their leaders. This probably accounts for the response of the community when called upon to work on the project.

Table 8: Trust of leadership

Trust of leadership	Freq.	Percent
Yes	74	89.16
No	9	10.84
Total	**83**	**100.00**

6.1.7. Community Language

The main language of communication used in interpersonal communication in Kafue district is Nyanja,52% followed by English. These are also the languages that were predominantly used in communicating to the community.

Table 9: Main Language of communication

Language	Freq.	Percent
English	31	38.27
Nyanja	42	51.85
Bemba	7	8.64
Tonga	1	1.23
Total	**81**	**100.00**

During the construction, Nyanja was used by 59% of the respondents. English was used by 31% and Bemba by 7%.

Table 10: Language used during project

Language	Freq.	Percent
Nyanja	81	59.12
English	42	30.66
Bemba	10	7.30
Tonga	2	1.46
other	2	1.46
Total	**137**	**100.00**

6.1.9. Education

The levels of education of the respondents are shown in tables 11 and 12 below. Table 11 shows that 93% of the respondents have been to school against 6% who have not been to school. Table 12 shows that sixty four percent of those who have been to school have reached secondary school, 27% Tertiary and 6%, primary school. The choice of the language was consonant with the community level of language familiarity presenting a high rate of communication efficacy.

Table 11: Respondents who have been to school

Been to school	Freq.	Percent
Yes	129	93.48
No	9	6.52
Total	**138**	**100.00**

Table 12: Level of education completed

Education level	Freq.	Percent
Primary	12	9.38
Secondary	82	64.06
Tertiary	34	26.56
Total	**128**	**100.00**

6.1.10. Participation in working on site

Working on site was done on a schedule basis. There was a time-table which was followed by varying communities as outlined by the executive committee. This is the reason as to why working on site has 52% for rarely and 34% for often. Only 14% of the respondents indicated having worked on the project full-time. Work was evenly distributed giving the various communities breaks in between assignments. This gave morale to the members of the community.

Table 13: Participation in working on site

Participation level	Freq.	Percent
Often	27	34.18
Rare	41	51.90
Full-time	11	13.92
Total	**79**	**100.00**

6.1.11. Necessity of Project

The other reason for the success of the project was the necessity of the construction. For the community of Kafue this was an area of great urgency. It was a felt-need. Ninety-two percent of the respondents felt that the construction of the hospital was a need which was long overdue as against 8% who felt that it was not necessary.

Table 14: Necessity of the project

Necessity	Freq.	Percent
Yes	83	92.22
No	7	7.78
Total	**90**	**100.00**

A number of reasons were given for the necessity of the hospital amongst which are: saving life, Lusaka was too far for most respondents, it was costly for most families to nurse patients, and others felt the population of Kafue had grown. Forty-seven percent felt the variable of distance was a major reason for the necessity of the hospital against saving life. This means that the urgency of the hospital was strongly felt. The people had also experienced the harness of having had to travel to Lusaka to nurse their sick relatives or to take critically ill-patients. The idea of the project came in handy and coupled with the above enumerated variables, the project received overwhelming support

Table 15: Reason for necessity of Project

Reason for necessity	Freq.	Percent
Save Life	27	32.14
Distance to Lusaka	47	55.95
Population growth	3	3.57
Costs	7	8.33
Total	**84**	**100.00**

6.1.12. Knowledge of source of funding

As for the source of funding, 48% noted donors as the main source of funding, 32% indicated the church, 10% MPU, 10% Community. Knowledge about the actual donors of funds for the project was not effectively communicated. It was clear to the leaders and a few other individuals as to the actual source of funding. As to the general community, it sufficed to know that there were donors involved in the project.

Table 1: 6Knowledge of source of funding

Source of funding	Freq.	Percent
Local	5	5.88
Donor	41	48.24
Church	18	21.18
NGOs	1	1.18
MPU	10	11.76
Community	10	11.76
Total	**85**	**100.00**

6.1.13. Property Protection

True to its description, the district hospital is a community hospital as many respondents identified with the project. Asked as to what they would do if they found somebody stealing or vandalizing any aspect of the hospital, 52% said they would report to authorities, 23% would arrest the culprit, 16% would advise the culprits, while 9% felt they would beat-up the culprits. The indication is that the community, having been involved in the project is likely to protect it against vandalism. It is a project arising from amongst them and anyone who vandalizes it offends the community.

Table 17: Property Protection

Protection action	Freq.	Percent
Arrest	21	23.33
Beat up	8	8.89
Report to authorities	47	52.22
Advise	14	15.56
Total	**90**	**100.00**

6.1.12. Project Comment

Most respondents expressed feelings about the lack of enough doctors, less government support and the need for the hospital to provide employment for the members of the local community.

6.1.13. Table 18: Project Comment

Comment	Freq.	Percent
Doctors not enough	34	43.04
No GVT support	26	32.91
Provide Employment	11	13.92
Other	8	10.13
Total	**79**	**100.00**

6.2. In-Depth Interviews

The construction of the hospital was considered a landmark success (Kasungami,2006). It was a miracle that emerged from the community (Chapeshamano, 2006). In terms of community mobilisation, leaders interviewed all indicated that the appropriate choice for community mobilisation was the church. It was seen as the central place of information dissemination that would also filter to the rest of the community. Schools and business houses were also used in community mobilisation (Antonio, 2006)

In communicating to the community, the church was used as the main stage. The language used included Nyanja, English, bemba, Tonga. Bill-boards were erected and business houses were encouraged to advertise on them (Hodgkison M.P. Advetising Space On Kafue Hospital Billboard, Letter to BP. 18/01/2001. Radio and Television were also used to communicate about the project and the progress inherent. Posters, Drama, Choirs, were used to raise community awareness. Brochures were prepared to communicate project progress. The committee had a publicity sub-committee that would plan the various media for community awareness and donor awareness. Included in the identified media were, Radio phoenix, ZNBC, bill-boards, bronchures (Minutes,1999). Newspapers were used to publicise the hospital and solicit support (Ilunga Juliet, National Mirror, 4th March, 4-10.2000). Newspapers were also used to create community awareness and unveil project progress(Nondo Bwalya, Times of Zambia, January, 7, 2001). Reports on possible donor funding was also carried in Newspapers (Siwisha Brian, Zambia Daily Mail, 30th March,2002). The post newspaper also carried a story on the donation by the british envoy, Thomas Young (Post, Britain Donates 66,000 pounds, 30th March,2002).

As with donors most of them used to visit the project site in order to see the progress of the construction. Those that had specific areas of construction would come and monitor their area of sponsorship. MPU used to visit the site almost every month. They kept monitoring the project and asking about reports and what was obtaining on the ground (Chapeshamano, 2006). Donors had specific areas that their money was to be used for. The following is an outline of the arrangement:

- Italian community/local community-crushed stones and sand
- MPU-Utility blocks
- British High Commission-Maternity and Female wards
- Japanese embassy-Children and Male wards
- Italian community/Kafue community- Children and Male wards
- Just A Drop(UK)- Water Tanks and two borehole pumps
- Catholic Diocese of Milan-Chapel
- Italian Donors-Car Park Surfacing
- Italian Donors/British Embassy-Walkways
- Italian Donors- Medical Equipment
- Aroma Stars-Cash
- Constituency Development Fund
- Individuals

Most of the local donors fell under the local effort contribution. Reports of financial utilisation were printed on brochures for publication. This ensured that open accountability was observed.

6.3 Summary of Conclusions and Recommendations

Communication Channels

The community of Kafue has a community set-up that finds communication easily filtering through the community via prominent areas of interaction like the church and business houses. Its primary source of information about community projects is primarily from within the community.i.e. interpersonal communication. The churches' are a central pillar in the dissemination of information in the community. Mass media i.e. radio, newpapers, television; may be used only to reinforce messages that are designed and communicated by and within the community. In the findings of this report mass media did not come out as a major source of information.

Language of Communication

Nyanja is the language of the community. Despite the community being of a mixed nature in terms of tribe and language, the Kafue community uses Nyanja as a language of daily social interaction. English is also a language that is easily understood by the majority of community members. This is consistent with the educational profile of the community. It is therefore easier to community to the community using English and Nyanja.

Trust of Community Leaders

The level of trust invested in the leadership of the community in Kafue accounts for the higher levels of community participation. When leaders are deemed trustworthy community members find it easier to relate to the messages that are communicated to

them. This comes out as a strong point of the leadership of the project. The use of the church also added credibility to the trust factor.

Donor Support

Donors had specific responsibilities on site. This also led to the creation of committees relating to the specific task. This made work easier for the executive committee for specific tasks were allocated to specific committees. Liaising with donors also was easy as a specific committee gave regular reports on how the money from a specific donor was used. Interaction between donors and committee members was also a good point as it gave confidence to the donors of the various aspects of the project. It was, however to located specific donors who had a long standing working relationship with the community. The main donor at the heart of the project was micro project which suffered experimental mortality by the time of the research. It had wound up its activities and some of its activities were being taken over by ZAMSIF. Knowledge of the existence of document files was non-existence as people contacted at ZAMSIF offices both at Kabendekela House and CSO building expressed ignorance at the exact location documents.

Facilitation

Leaders from the different levels of organisation acknowledged the need to identify local leadership and incorporate them in the overall structure of the project. From inception, the DHMT recognised the need to involve community leadership in mobilising the people for the project. As the research indicates most of the people did not know the leaders

individually but somehow they did follow the instructions that were sent to the community. Leaders picked from the community included, church leaders, businessmen and local men and women from various communities. Messages about the project were not sent directly to the community from the executive committee or DHMT. Those close in contact with the community were tasked to deal with the disemmination of messages to the grassroots. It is this participatory dimension that rendered project organisers more of facilitators of the construction process.

Documentation

It is the recommendation of this research that a central unit where all files pertaining to the construction of the hospital would be kept. This could be located either in the registry of the hospital or at the district hospital offices. These documents are important for individuals or institutions that may seek to embark on projects of an ambitious nature like the Kafue project. Documentation of the processes involved in the construction of the hospital can be used by future and current generations for monitoring and evaluation variables that may explain project success or failure. The success of the project is a historical lesson of success. It can be used for many other community based projects. It is, therefore, critical that reports and accounts ensuing in the project are well-documented.

APPENDICES

APPENDIX 1: INDIVIDUAL QUESTIONNAIRE

Q no.	Question	Response	Skip to
1.	How old are you?	[|]	
2.	SEX	Male.....1 Female.....2	
3.	What is your marital status?	Married.....1 Separated.....2 Divorced.....3 Widowed.....4 Never married.....5	
4.	What is your main language of communication?	Nyanja.....1 English.....2	
5.	What is the size of your household?	[|]	
6.	Have you ever been to school	Yes.....1 No.....2	→ Q8
7.	What level of education have you reached?	Primary.....1 Secondary.....2 Tertiary.....3	
8.	What is your employment status	Employed.....1 Retrenched.....2 Retired .....3 Self employed .....4 None.....5	
9.	Did you know about the construction of the hospital	Yes.....1 No.....2	→ Q11
10.	How did you know about the project?	Radio.....1 TV..... 2 Community.....3 Church.....4	
11.	Did you take part in the project?	Yes.....1 No.....2	→ Q14
12.	How did you feel taking part in the project?	Happy .....1 Forced .....2 Honoured.....3 Nothing.....4 Fine.....5	
13	Are you still involved in the project in any way?	Yes.....1 No.....2	
14.	Who organized the project?	NGO .....1 Church .....2 Community..... 3	

15.	Do you know who the leaders of the project were?	Yes.....1 No.....2	
16.	Where did the leaders in the project come from?	NGO .....1 Church .....2 Business Houses 3	
17.	Did you trust your leaders?	Yes.....1 No 2	
18.	What language did you use in communicating?	English.....1 Nyanja.....2 Bemba.....3 Tonga.....4	
19.	How often did you work on site?	Often.....1 Rarely.....2 Full-time.....3	
20.	Do you think it was necessary to build the hospital in this area?	Yes.....1 No.....2	→ Q22
21.	Why do you think it was necessary?	Save lives.....1 Distance to Lusaka.....2 Population Growth.....3 Save costs.....4	
22.	Where did the money for building the hospital come from?	Local People..... 1 Donors .....2 Church .....3 NGOs .....4 Micro project.....5 Community.....6	
23.	What would you do if you found somebody stealing property at the hospital?	Arrest him/her .....1 Beat him/her..... 2 Report to authorities.....3 Advise.....4	
24.	Would you like to say something about the Project and its relationship to the community?	Doctors not enough.....1 Less Gvt support.....2 Provided employment...3	

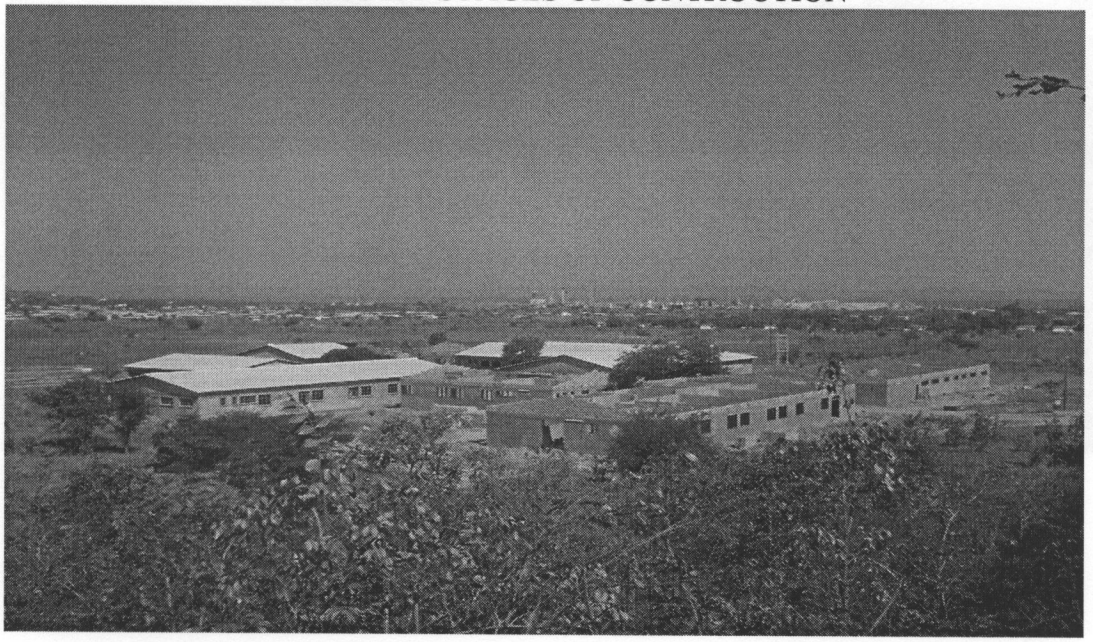
APPENDIX 2: QUESTIONNAIRE FOR DONORS

1.	Name of Organization		
2.	Representative:		
3.	Capacity:		
4.	How did you know about the project?	Letter for help.....1 Heard about it.....2 Read about it.....3 Other [Specify].....4	
5.	Who approached you for help?	Committee Members.....1 Leaders.....2 Other officials [Specify]	
6.	Why did you decide to support the project?	Sounded Credible.....1 Community Involvement 2	

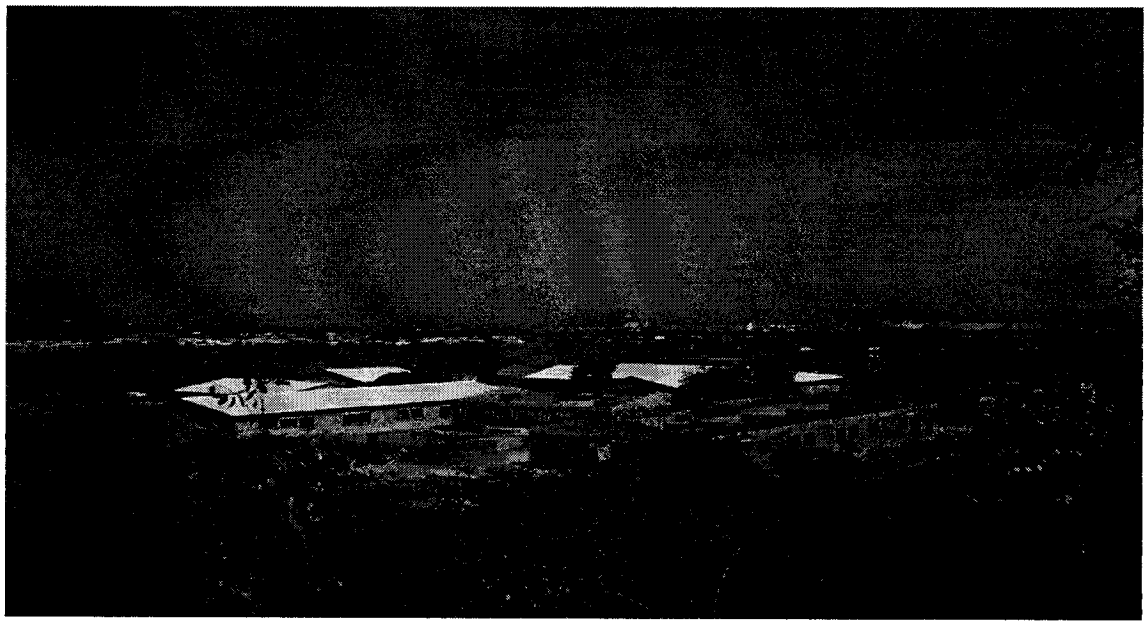
APPENDIX 3: PICTURES OF PROJECT

PICTURE 1: BILLBOARD

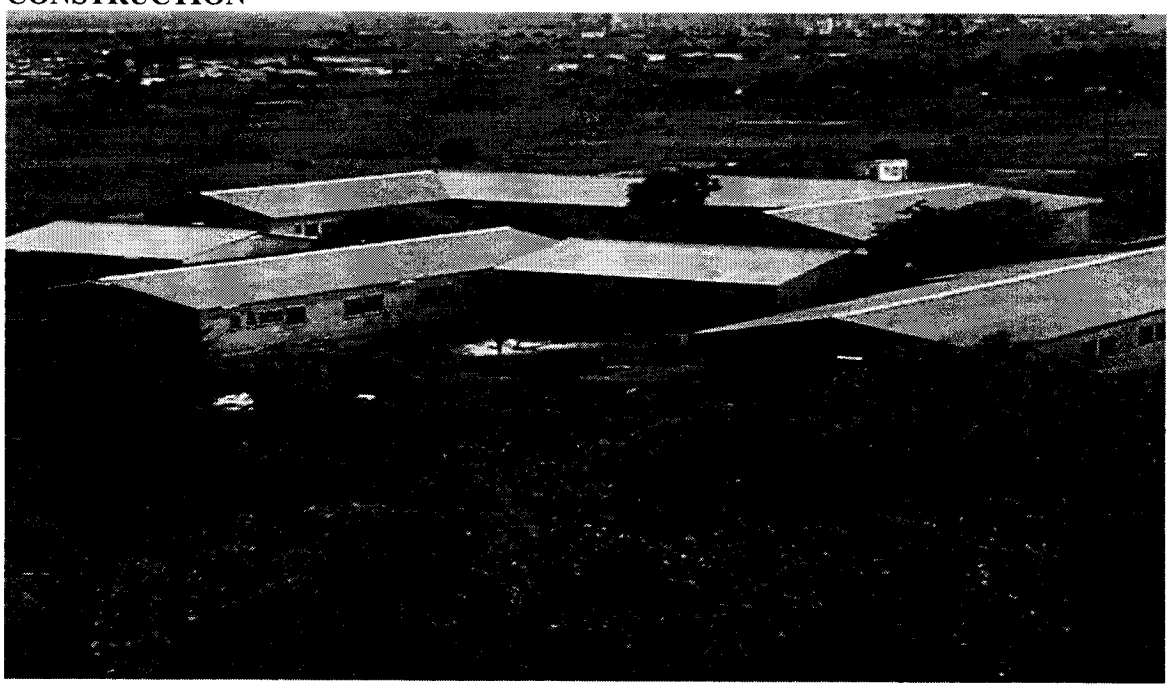
PICTURE 2: VIEW OF EARLY STAGES OF CONTRUCTION



PICTURE 2: SITE OF CONTRUCTION



PICTURE 3: SITE OF HOSPITAL CONSTRUCTION

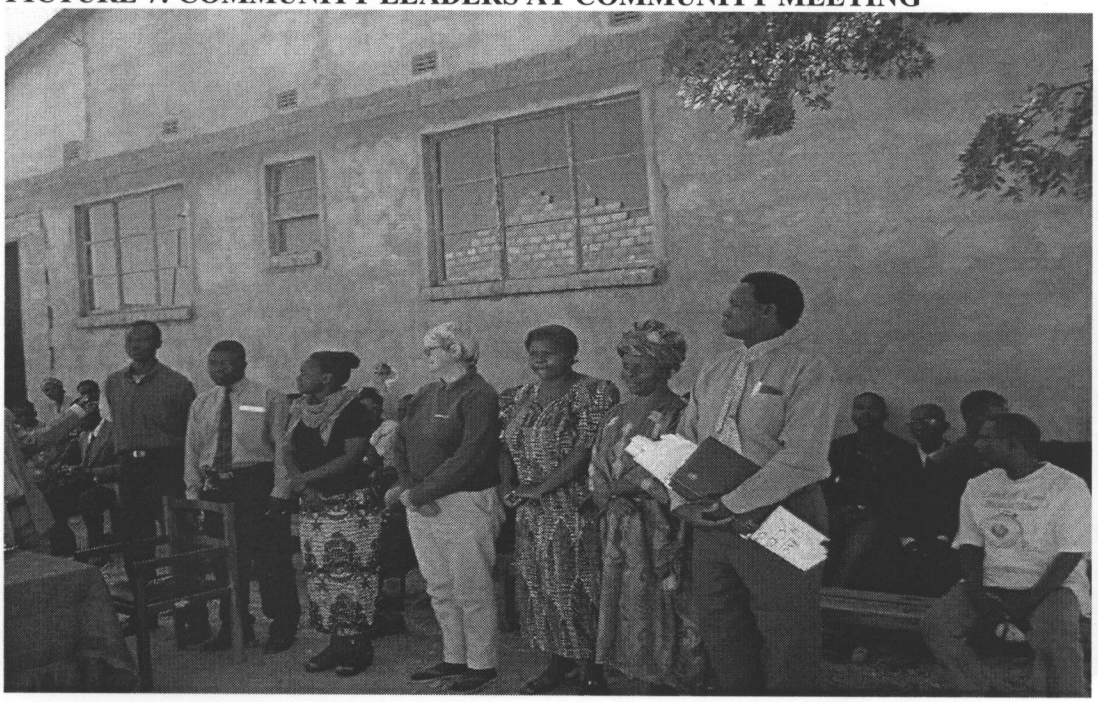


PICTURE 4: CHURCH CHOIR ON SITE

PICTURE 5: PART OF COMMUNITY AUDIENCE DURING CAMPAIGN

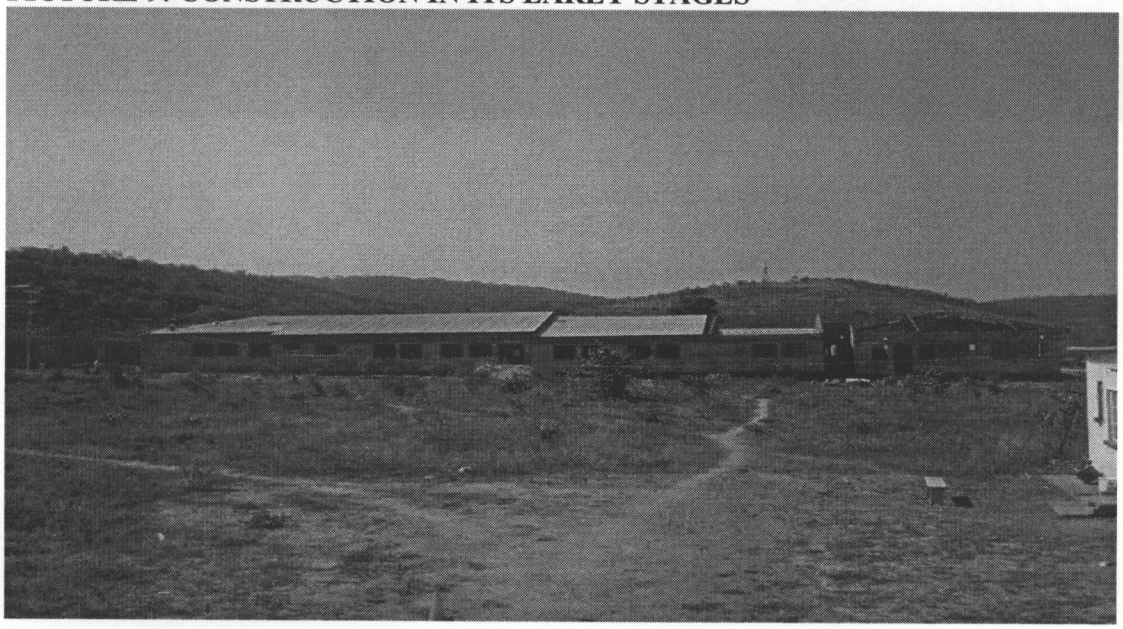
PICTURE 6: YOUTH DANCE TROUP

PICTURE 7: COMMUNITY LEADERS AT COMMUNITY MEETING

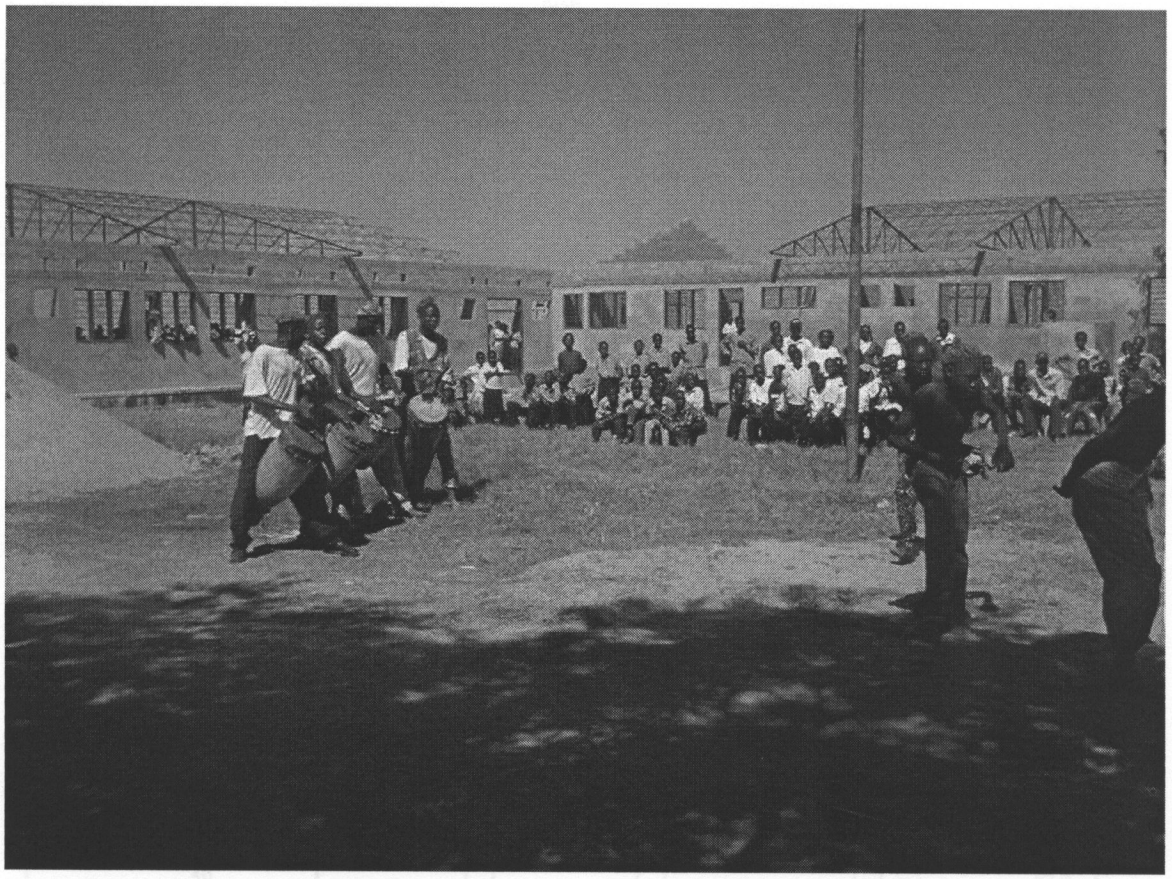


PICTURE 8: A CHURCH YOUTH CHOIR ON SITE

PICTURE 9: CONSTRUCTION IN ITS EARLY STAGES



PICTURE 10: COMMUNITY DANCE TROUPE INVOLVED IN AWARENESS CREATION AND FUNDRAISING.



APPENDIX 4: List of SPSS Tables.

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	16	2	1.3	1.5	1.5
	17	2	1.3	1.5	2.9
	18	2	1.3	1.5	4.4
	19	4	2.6	2.9	7.3
	20	1	.7	.7	8.0
	21	4	2.6	2.9	10.9
	22	7	4.6	5.1	16.1
	23	5	3.3	3.6	19.7
	24	1	.7	.7	20.4
	25	6	4.0	4.4	24.8
	26	3	2.0	2.2	27.0
	27	1	.7	.7	27.7
	28	6	4.0	4.4	32.1
	29	5	3.3	3.6	35.8
	30	6	4.0	4.4	40.1
	32	6	4.0	4.4	44.5
	33	3	2.0	2.2	46.7
	35	4	2.6	2.9	49.6
	37	4	2.6	2.9	52.6
	38	4	2.6	2.9	55.5
	39	4	2.6	2.9	58.4
	40	4	2.6	2.9	61.3
	41	6	4.0	4.4	65.7
	42	7	4.6	5.1	70.8
	43	8	5.3	5.8	76.6
	44	3	2.0	2.2	78.8
	45	5	3.3	3.6	82.5
	46	1	.7	.7	83.2
	47	1	.7	.7	83.9
	48	3	2.0	2.2	86.1
	50	3	2.0	2.2	88.3
	52	3	2.0	2.2	90.5
	53	1	.7	.7	91.2
	54	2	1.3	1.5	92.7
	55	3	2.0	2.2	94.9
	56	1	.7	.7	95.6
	57	1	.7	.7	96.4
	59	1	.7	.7	97.1
	61	1	.7	.7	97.8
	65	3	2.0	2.2	100.0
	Total	137	90.7	100.0	
Missing	System	14	9.3		
Total		151	100.0		

{male}1,{female}2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	70	46.4	50.7	50.7
	2	68	45.0	49.3	100.0
	Total	138	91.4	100.0	
Missing	System	13	8.6		
Total		151	100.0		

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	16	2	1.3	1.5	1.5
	17	2	1.3	1.5	2.9
	18	2	1.3	1.5	4.4
	19	4	2.6	2.9	7.3
	20	1	.7	.7	8.0
	21	4	2.6	2.9	10.9
	22	7	4.6	5.1	16.1
	23	5	3.3	3.6	19.7
	24	1	.7	.7	20.4
	25	6	4.0	4.4	24.8
	26	3	2.0	2.2	27.0
	27	1	.7	.7	27.7
	28	6	4.0	4.4	32.1
	29	5	3.3	3.6	35.8
	30	6	4.0	4.4	40.1
	32	6	4.0	4.4	44.5
	33	3	2.0	2.2	46.7
	35	4	2.6	2.9	49.6
	37	4	2.6	2.9	52.6
	38	4	2.6	2.9	55.5
	39	4	2.6	2.9	58.4
	40	4	2.6	2.9	61.3
	41	6	4.0	4.4	65.7
	42	7	4.6	5.1	70.8
	43	8	5.3	5.8	76.6
	44	3	2.0	2.2	78.8
	45	5	3.3	3.6	82.5
	46	1	.7	.7	83.2
	47	1	.7	.7	83.9
	48	3	2.0	2.2	86.1
	50	3	2.0	2.2	88.3
	52	3	2.0	2.2	90.5
	53	1	.7	.7	91.2
	54	2	1.3	1.5	92.7
	55	3	2.0	2.2	94.9
	56	1	.7	.7	95.6
	57	1	.7	.7	96.4
	59	1	.7	.7	97.1
	61	1	.7	.7	97.8
	65	3	2.0	2.2	100.0
	Total	137	90.7	100.0	
Missing	System	14	9.3		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	70	46.4	50.7	50.7
	female	68	45.0	49.3	100.0
	Total	138	91.4	100.0	
Missing	System	13	8.6		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	married	80	53.0	57.1	57.1
	Separated	8	5.3	5.7	62.9
	Divorced	3	2.0	2.1	65.0
	widowed	6	4.0	4.3	69.3
	Single	43	28.5	30.7	100.0
	Total	140	92.7	100.0	
Missing	System	11	7.3		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nyanja	81	53.6	59.1	59.1
	English	42	27.8	30.7	89.8
	Bemba	10	6.6	7.3	97.1
	Tonga	2	1.3	1.5	98.5
	Other	2	1.3	1.5	100.0
	Total	137	90.7	100.0	
Missing	System	14	9.3		
Total		151	100.0		

OTHERLAN

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		149	98.7	98.7	98.7
	LOZI	1	.7	.7	99.3
	TONGA	1	.7	.7	100.0
	Total	151	100.0	100.0	

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nyanja	81	53.6	59.1	59.1
	English	42	27.8	30.7	89.8
	Bemba	10	6.6	7.3	97.1
	Tonga	2	1.3	1.5	98.5
	other	2	1.3	1.5	100.0
	Total	137	90.7	100.0	
Missing	System	14	9.3		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	129	85.4	93.5	93.5
	No	9	6.0	6.5	100.0
	Total	138	91.4	100.0	
Missing	System	13	8.6		
Total		151	100.0		

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		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	12	7.9	9.4	9.4
	Secondary	82	54.3	64.1	73.4
	Tertiary	34	22.5	26.6	100.0
	Total	128	84.8	100.0	
Missing	System	23	15.2		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employed	54	35.8	39.1	39.1
	Retirecned	6	4.0	4.3	43.5
	Retired	12	7.9	8.7	52.2
	Self employed	22	14.6	15.9	68.1
	Non	44	29.1	31.9	100.0
	Total	138	91.4	100.0	
Missing	System	13	8.6		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	92	60.9	65.7	65.7
	No	48	31.8	34.3	100.0
	Total	140	92.7	100.0	
Missing	System	11	7.3		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Radio	3	2.0	3.3	3.3
	Tv	2	1.3	2.2	5.6
	Community	33	21.9	36.7	42.2
	Church	52	34.4	57.8	100.0
	Total	90	59.6	100.0	
Missing	System	61	40.4		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	64	42.4	70.3	70.3
	No	27	17.9	29.7	100.0
	Total	91	60.3	100.0	
Missing	System	60	39.7		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Happy	47	31.1	73.4	73.4
	Forced	1	.7	1.6	75.0
	Honoured	7	4.6	10.9	85.9
	Not satisfied	4	2.6	6.3	92.2
	Fine	5	3.3	7.8	100.0
	Total	64	42.4	100.0	
Missing	System	87	57.6		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	26	17.2	41.3	41.3
	No	37	24.5	58.7	100.0
	Total	63	41.7	100.0	
Missing	System	88	58.3		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NGO	10	6.6	11.6	11.6
	Church	47	31.1	54.7	66.3
	Community	29	19.2	33.7	100.0
	Total	86	57.0	100.0	
Missing	System	65	43.0		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	57	37.7	64.8	64.8
	No	31	20.5	35.2	100.0
	Total	88	58.3	100.0	
Missing	System	63	41.7		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NGO	16	10.6	20.0	20.0
	Church	58	38.4	72.5	92.5
	Business houese	6	4.0	7.5	100.0
	Total	80	53.0	100.0	
Missing	System	71	47.0		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	74	49.0	89.2	89.2
	No	9	6.0	10.8	100.0
	Total	83	55.0	100.0	
Missing	System	68	45.0		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	English	31	20.5	38.3	38.3
	Nyanja	42	27.8	51.9	90.1
	Bemba	7	4.6	8.6	98.8
	Tonga	1	.7	1.2	100.0
	Total	81	53.6	100.0	
Missing	System	70	46.4		
Total		151	100.0		

OTHERLA1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		142	94.0	94.0	94.0
	BEMBA	3	2.0	2.0	96.0
	ENGLISH	1	.7	.7	96.7
	NYANJA	3	2.0	2.0	98.7
	TONGA	2	1.3	1.3	100.0
	Total	151	100.0	100.0	

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	27	17.9	34.2	34.2
	Rare	41	27.2	51.9	86.1
	Full-time	11	7.3	13.9	100.0
	Total	79	52.3	100.0	
Missing	System	72	47.7		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	83	55.0	92.2	92.2
	No	7	4.6	7.8	100.0
	Total	90	59.6	100.0	
Missing	System	61	40.4		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Saved lives	27	17.9	32.1	32.1
	Distance	47	31.1	56.0	88.1
	Population growth	3	2.0	3.6	91.7
	Costs	7	4.6	8.3	100.0
	Total	84	55.6	100.0	
Missing	System	67	44.4		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Local Populaton	5	3.3	5.9	5.9
	Donors	41	27.2	48.2	54.1
	Church	18	11.9	21.2	75.3
	NGO	1	.7	1.2	76.5
	Microproject	10	6.6	11.8	88.2
	Community	10	6.6	11.8	100.0
	Total	85	56.3	100.0	
Missing	System	66	43.7		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Arrest	21	13.9	23.3	23.3
	Beat	8	5.3	8.9	32.2
	Report to authority	47	31.1	52.2	84.4
	Advise	14	9.3	15.6	100.0
	Total	90	59.6	100.0	
Missing	System	61	40.4		
Total		151	100.0		

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Doctors	34	22.5	43.0	43.0
	Government	26	17.2	32.9	75.9
	Employed	11	7.3	13.9	89.9
	Other	8	5.3	10.1	100.0
	Total	79	52.3	100.0	
Missing	System	72	47.7		
Total		151	100.0		

Project Comments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		126	83.4	83.4	83.4
	Air conditioning needed	1	.7	.7	84.1
	beneficial to the community	1	.7	.7	84.8
	Building remaining wards	1	.7	.7	85.4
	Clinical consultation is slow	1	.7	.7	86.1
	Complete hospital	1	.7	.7	86.8
	Doctors and nurses not serious	1	.7	.7	87.4
	Enjoying the hospital	1	.7	.7	88.1
	Expensive since we contributed	1	.7	.7	88.7
	Extend hospital	1	.7	.7	89.4
	Extension	2	1.3	1.3	90.7
	Helpful to the community	1	.7	.7	91.4
	Houses for nurses	1	.7	.7	92.1
	Improve the clinic	1	.7	.7	92.7
	Lack of interest from NGOs	1	.7	.7	93.4
	Less care by nurses	1	.7	.7	94.0
	More doctors. Gvt. support	1	.7	.7	94.7
	more rooms.Equipment not enough. few wor	1	.7	.7	95.4
	Mother's shelter	1	.7	.7	96.0
	need more seats and benches for nursing	1	.7	.7	96.7
	No necessary equipment	1	.7	.7	97.4
	Project not finished	1	.7	.7	98.0
	Provide airconditioners	1	.7	.7	98.7
	Provide employment for local people	1	.7	.7	99.3
	Reduce costs	1	.7	.7	100.0
	Total	151	100.0	100.0	

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