

**COMMUNICATION STRATEGIES TAKEN BY THE CHURCHES  
HEALTH ASSOCIATION OF ZAMBIA IN ITS EFFORTS TO  
FACILITATE PEOPLE'S HEALTH AND DEVELOPMENT**

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**By**

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Submitted in partial fulfilment of the requirements for the degree of Master of  
Communication for Development offered by the Department of Mass Communication,  
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## Declaration

I declare that this dissertation, which I submit for the degree in Master of Communication for Development (MCD) at the School of Humanities and Social Sciences, University of Zambia, is my own work and has not previously been submitted for other degree or diploma purposes at any other institution.

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## **Dedication**

To my both late parents: mum Margaret Chilambwe Mutashala and Dad Peter Kapembwa Mutashala who prayed and supported me during the period I was caught up in the academic drudgery and turmoil. May God richly bless you for the sacrifice you made and the love you have for me.

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## **Abstract**

This paper aims at contributing towards the study of Communication strategies taken by the Churches Health Association of Zambia – (CHAZ) - in its efforts to facilitate people's health and development.

Results show that CHAZ is doing everything possible to reach out to the country side.

In order to contribute towards lowering of disease infection levels in Zambia, it is recommended that the Government should strengthen the education system for girls and women alongside other essential services such as primary health care and reproductive health services. It is also important that Churches Health Association of Zambia and other stakeholders combine efforts with Government in disease reduction.

## Acronyms

AIDS.....	Acquired Immunal Deficiency Syndrome
CIME.....	Communication, Information, Media and Education
CHAZ.....	Churches Health Association of Zambia
FAO.....	Food and Agriculture Organization
HBC.....	Home Based Care
HBM.....	Health Belief Model
HIV.....	Human Immune Virus
MCD.....	Master of Communication for Development
MoH.....	Ministry of Health
NGO.....	Non-Governmental Organizations
OVC.....	Orphans and Vulnerable Children
PRCA.....	Participatory Rural Communication Appraisal
SPSS.....	Statistical Package for Social Sciences
UNICEF.....	United Nations International Children Emergency Fund
WCC.....	World Council of Churches
WHO.....	World Health Organization
ZNBC.....	Zambia National Broadcasting Cooperation

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## **CHAPTER ONE**

### **BACKGROUND AND INTRODUCTION**

#### **1.0 Introduction**

The following is the report of a research study carried out to appraise the efforts the Churches Health Association of Zambia (CHAZ) is making towards human development through the use of certain communication strategies. CHAZ conducts Campaigns on Malaria, TB and HIV/AIDS in Zambia. The attachment has been in partial fulfilment of the award of the Master of Communication for Development (MCD) offered by the Department of Mass Communication of the University Of Zambia (UNZA). The research particularly covers Churches Health Association of Zambia Headquarters in Lusaka. Chapter one includes the Background, the statement of the problem, rationale and the objectives of the study.

#### **1.1 Problem Background**

Africa, South of the Sahara was, at the time of writing, the epicentre of the HIV/AIDS pandemic. The disease together with Malaria is one of root causes of suffering in the region where Zambia is situated. When one speaks of Human development, it simply means helping people in subsistence straits to gain more control over their basic needs. Health is a key element without which development is very difficult to attain if not impossible. As a fundamental human right, it is a prerequisite for the full enjoyment of all other human rights. As the World Health Organization asserts:

“...for development to be substantial, health and economic Growth must be mutually reinforcing. Health is an essential prerequisite as well as outcome of sound Development policies..... “(WHO, 1998)

Health care services in developing countries such as Zambia were, at the time of writing, faced by many difficulties. There were, at the time of writing, two major constraints involved, namely; increased population and poverty. These two factors were often very closely interrelated since the inability to pay for health services limits the access to health care for the majority poor who are the most vulnerable to disease. The prevailing economic slump in most African countries, Zambia included means that governments were finding it difficult to fulfil their responsibility of providing adequate, affordable health services to their citizens.

The church is thought to provide about 35 percent of health care services in Africa (Asante, 1998: 59.). The faith-based health institutions help to fill in the gap left by the government and 'profit-motivated' care providers by making health care services accessible and affordable to even the least able in the society.

Health Service does not answer all questions or solve all the problems of human suffering, but tries to play as a key element without which many lives of suffering people could be lost.

Food, cloth, shelter and above all health were a fundamental human right. Health Service plays as a prerequisite for the full enjoyment of all other human rights. The focus of FAO, WHO and UNICEF, is all about retrieving people from poverty, disasters and perpetual suffering. Health has been regarded as priority issue also by the Zambian government.

## **1.2 Zambia's Profile**

Many years ago, on the ancient land now called Zambia, mankind's ancestors lived. Economic and cultural activity flourished in this resource rich environment for centuries prior to the European exploitation. Once known as Northern Rhodesia, Zambia was controlled by the South Africa Company from 1891 until its takeover by the United Kingdom in 1923. After many years of struggle with the British, independence was secured in 1964, and the name was officially changed to Zambia. The name Zambia

comes from River Zambezi.

Located south of the Equator, Zambia is in both the eastern and southern hemispheres. This landlocked country is positioned in southern Africa, and bordered by the countries of Botswana, Angola, Namibia, The Democratic Republic of Congo, Tanzania, Malawi, Mozambique and Zimbabwe. Zambia's area is estimated to be about 752,614 sq km (270,586 sq miles). Land is divided in 9 provinces: Central, Copper belt, Eastern, Luapula, Lusaka, Northern, North-Western, Southern and Western provinces.

On physical features, most of the country consists of a wide plateau, with some scattered mountains in the north and central. The major river system formed by the Zambezi and its tributaries (the Luangwa and Kafue Rivers), cuts into the plateau forming deep valleys and waterfalls. Major lakes include Bangweulu, Mweru and Tanganyika.

### **1.2.1 Population**

The population of Zambia is about 11 million (UN, 2005). This has been projected to reach 18.5 million people by the year 2025. The population has been growing steadily from 5.7 in 1980 to 7.8 in 1990 and 10.3 in the year 2000. The population density has increased from 7.5 people per square kilometre in 1980 to 10.4 in 1990 and 13.7 in 2005. In Lusaka (capital city), almost half of the housing is shanty town which hosts the incumbent problems of lack of safe water and poor health facilities. With population increasing so fast in urban areas, there is also danger of disease spreading much faster. According to Malthus, there is a very strong connection between Population density and the quick spread of disease in a given area. Diseases such as TB, Malaria and HIV/AIDS were easily spread in an area where people live close to one another in big numbers. Malthus argued that human beings have a basic instinct to reproduce. He postulated that populations would grow exponentially unless kept in control by "balances" and "checks". These, according to him, were direct causes of mortality such as famine, droughts and preventive measures such as moral constraints, abstinence and celibacy. Malthus called for individual or family behavioural responses to curtail fertility if the positive check of high mortality and less disease was to be checked.

The life expectancy at birth in Zambia is placed at 37.5 years. The country's annual population growth rate is about 2.9 percent. The country is landlocked and sparsely populated by more than 70 ethnic groups, many of them Bantu-speaking. Major languages include English (official), Bemba, Lozi, Nyanja and Tonga. Major religions include Christianity, indigenous beliefs, Hinduism and Islam. With an estimated per capita income of about \$320 in 1999, Zambia is one of the poorest countries in sub-Saharan Africa.

The World Bank calls women's education as the single most influential investment that can be made in the developing world as it does not only foster economic growth but also promote smaller families, increase modern contraceptive use, and improve child health.

Education is strongly related to fertility in most countries, but the form and size of the relationship vary considerably. Women with seven years or more of schooling marry, on average nearly four years later and will thus bear 3.9 children while women with no schooling will bear nearly 6.9 on average. The educated women will have about 25 percentage points higher contraceptive use and breast-feed their children eight months less than women with no education. Unlike fertility itself, these fertility determinants nearly always show a monotonic relation with number of years of education

Education is the single most important determinant of both age at marriage and age at first birth in Middle East and North African (MENA) countries, since women in the region tend to give birth soon after marriage. It has also been found that in a number of less developed countries, women with no education have about twice the number of children as women with 10 or more years of school. Steep fertility declines often occur among women who have seven or more years of school. In addition, higher education levels were associated with better family planning. As more children survive, families reduce the number of children they have. Desired family sizes decline, a process helped by the ready availability of contraceptives. So, over time, lower infant and child mortality plays a major role in falling fertility rates. Community or aggregate level education has

also been found to have a significant depressing effect on women's birth-rates, taking into consideration factors such as urbanisation and her own education.

### **1.2.2 Economy**

The country's economy was un-diversified, and exhibited heavy dependence on mineral resources and exports, in particular copper, which generated over 50 percent of the foreign exchange earnings of the country. Over the last three decades, the structure of the economy and composition of output changed perceptibly. The share of agriculture in the economy increased from around 15 percent in the 1970s to about 21 percent in the 1990s: manufacturing from 16 percent to 21 percent: services from 35 percent to 40 percent: and energy from 2.4 percent to 2.8 percent.

On the other hand, the share of mining had declined from 24 percent to about 11 percent and that of construction from 7.3 percent to about 4.5 percent. As of 2000, nearly half of the Gross Domestic Product (GDP) came from services, about 27 percent from agriculture, and about 13 percent from manufacturing. Mining contributed only about 3 percent of GDP. The health status as reflected by some indicators has also been deteriorating over the years. The Maternal Mortality Ratio for Zambia has been 729 per 100,000 and the Under-Five Mortality Rate and Infant Mortality Rate now stand at 168 and 95 per 1000, respectively.

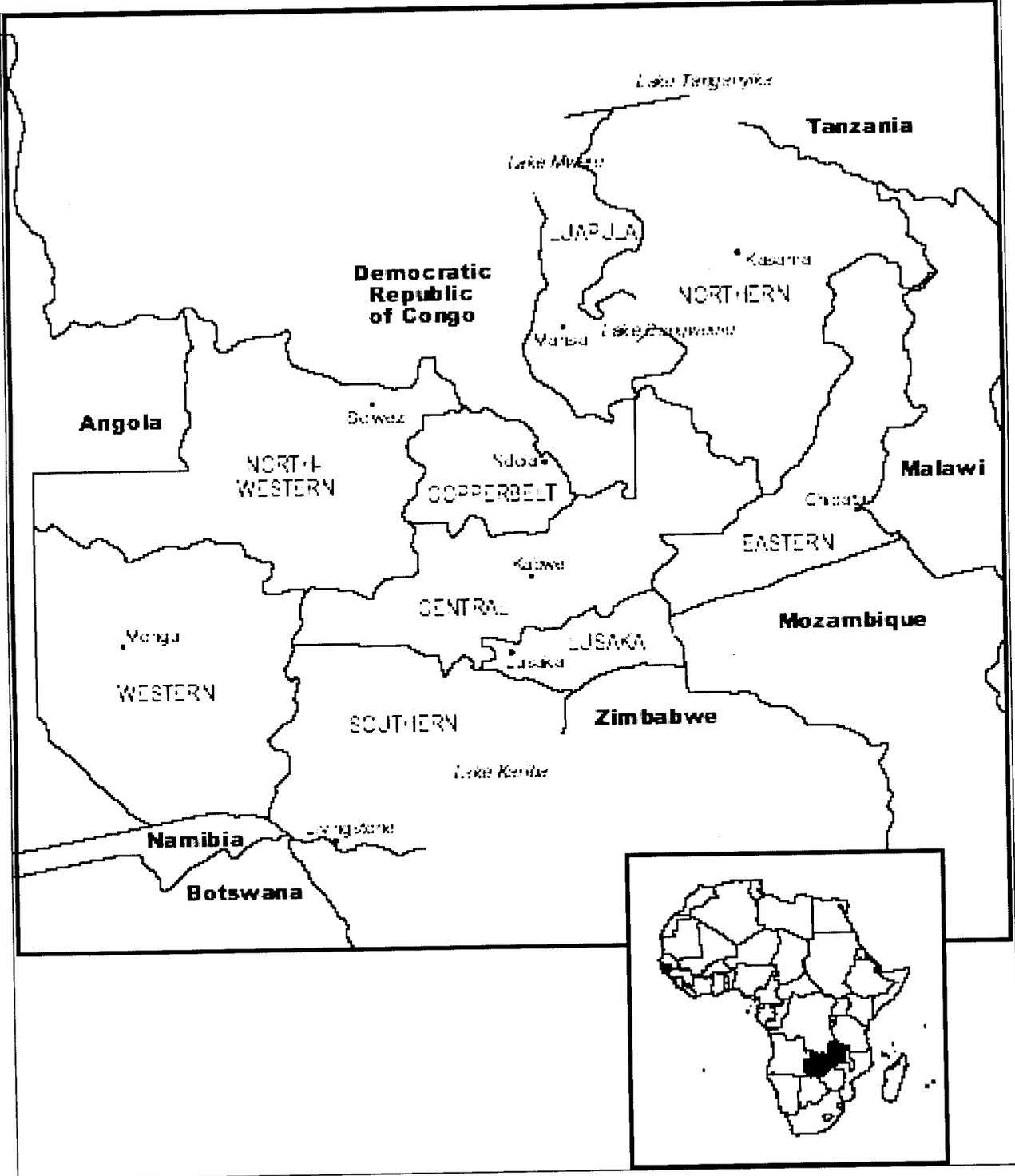
It has some spectacular scenery, including the Victoria Falls along the Zambezi River, the Bangweulu swamps and the Luangwa river valley. Victoria Falls and the abundant and varied wildlife attract many visitors, making tourism another important income earner.

In the late 1960s Zambia was the third largest copper miner, after the US and the Soviet Union. World copper prices collapsed in 1975 with devastating effects on the economy. Even so, copper accounted for most of Zambia's foreign earnings and there is optimism about the future of the industry, which was privatized in the 1990s. The government also embarked on expanded agriculture so that it becomes another important economic sector. At the time of writing HIV/AIDS was blamed for decimating the cream of Zambia's

professionals including engineers and politicians. Malaria also was a major problem in Zambia. Many Zambians lived below the World Bank poverty threshold of \$ 1, (One American dollar) a day.

Further as the study is undertaken State-run radio and television services dominate Zambia's broadcasting scene. The press was comprised of *Zambia Daily mail* and the *Times of Zambia* (both state-owned). Private press includes *The Post*, *Monitor*, the *Weekly Angel* and the *National Mirror* which is owned by the church. As regards private and church owned radio stations, these included QFM (Lusaka music station) Radio Phoenix, Radio Icengelo, Breeze FM, Yatsani Radio, and Radio Choice. Others were Radio Mano in Kasama, Radio Maria in Chipata, and Radio Yangeni in Mansa and Radio Liseli in Mongu.

Figure 1: Map of Zambia



Source: ZDHS 2001-2002

### 1.3 Zambia's Health services

Health has been regarded as a priority issue by the Zambian government. There can not be development without health services. The provision of health services should meet the basic needs of the Zambian population.

Health care as a public facility is regarded as the government's responsibility. From the time of independence in 1964, the state has been the main provider of health care services to the Zambian citizens.

When Zambia got independent, health care services were free. But due to the rapid growth of population in Zambia, the Ministry of Health (MoH) has not managed to provide adequately the demand of services. There have been a lot of private institutions and churches helping in health services in Zambia. The government has also changed policies. There has been an introduction of user fees in all health services with an exception of the under fives and the above 65yr olds.

**Table 1: Socio-economic and demographic profile of Zambia**

Variable	Figure
Mid year 2005 population	11 Million
Rate of natural increase	2.9
Infant Mortality Rate	95 per 1000
Total fertility rate	5.9
Life expectancy at birth (Total)	37.5
Life expectancy at birth (Male)	37.5
Life expectancy at birth (Female)	37
Births	43 per 1000 population
Deaths	21 per 1000 population

Source: PRB 2003

## **1.4 Institution Profile of the Churches Association of Zambia (CHAZ)**

The Churches Health Association of Zambia (CHAZ) was created in 1970 as an umbrella organization to represent work done by church administered (or mission) health institutions in Zambia. Prior to 1970, the Medical Committees of the Christian Council of Zambia and the Catholic Bishops Conference met regularly since 1950 to discuss matters of common interest and adopt common positions in dialogue with the government.

With the assistance of the Christian Medical Commission of the World Council of Churches it was decided that one organ is created to represent and provide support to all church administered health institutions in the country. There were, at the time of writing, 129 health institutions and community based church organizations affiliated to CHAZ representing 16 different churches and church organizations.

Together these institutions were responsible for more than 50% of formal health services in the rural areas of Zambia and about 30% of health care in the country as a whole.

### **1.4.1 Governing Structure**

The Annual Council is the main governing body of CHAZ. The Council consists of representatives of all member institutions and churches of CHAZ. It meets once a year and determines the organization's policies and amends the constitution. It is the Council that also elects the CHAZ Board and Advisory Committees. The CHAZ Board supervises the day-to-day functioning of the Association and the Secretariat. The CHAZ Board carries out responsibilities and makes decisions on behalf of the Annual Council during the year. The meetings of the CHAZ Board take place bimonthly. There were Advisory Committees also elected at the Annual Council. Advisory Committees advise and give other forms of assistance to the Executive Committee, Annual Council and Secretariat on various aspects of the business of CHAZ. At the time of writing, there were four Advisory Committees namely, Finance Advisory Committee, Primary Health Care Committee, Health Planning Advisory Committee, Pharmaceutical Services Advisory Committee and AIDS Advisory Committee.

Advisory Committees also meet bimonthly, preceding the CHAZ Board meeting. At the time of writing The CHAZ Secretariat had been the main implementing agency, which carried out the day-to-day functions of the Association. The Secretariat had full time staff in the various categories such as professionals, administrative and supportive. The Secretariat was based at CHAZ House in Lusaka. The Executive Director who was responsible to the CHAZ Board headed the Secretariat.

#### **1.4.2 The Role of CHAZ**

CHAZ fulfils the role of a facilitator in the provision of health services in the country. Member church institutions implement health services and programmes. CHAZ provides support and representation to enable each member institution to provide adequate and effective services.

#### **1.4.3 Mission Statement:**

The mission of CHAZ is to represent and provide assistance to church related health institutions and programmes to improve health in Zambia.

#### **1.4.4 Objectives:**

1. To assist members develop the best possible level of health care.
2. To provide one proactive voice for members in dialogue with Ministry of Health, and allocation of national health resources.
3. To provide and/or facilitate technical, administrative and logistical support to members as required
4. To provide training, assist members develop training programmes and to co-ordinate government recognized training programmes in collaboration with the Ministry of Health and other relevant agencies.
5. To provide a forum for communication and exchange of ideas, information and experiences in the provision of health services.

6. To assist members evaluate and monitor health programmes.
7. To promote co-operation and collaboration between members and with Ministry of Health.
8. To assist churches in formulating appropriate policies and plans with regard to health issues.
9. To assist members in the procurement of pharmaceuticals and other medical supplies

The functions of CHAZ can be broadly classified into three categories, namely, representation, technical assistance and logistical support. CHAZ employs a number of strategies to fulfil these functions.

Ownership Church health institutions were established and were owned by church organizations working in Zambia. The churches control these institutions in the same way that any other private institution would be owned and controlled. However, although church health institutions were "privately" owned, they exist to provide public health services in exactly the same way that government health institutions do. Therefore, although church health institutions were privately owned, they exist in the public interest and provide public service. Each of the church administered health institutions functions as an autonomous entity. Routine functions were the responsibility of the local management. Priorities were identified: strategies and plans developed, budgets made and activities were also often implemented by the institutions.

Church health institutions were founded primarily on Christian commission to not only preach the word of God to people but also to address their health and other basic needs. The continued existence of mission hospitals today is still to a large extent driven by that same religious conviction. Most of these institutions see their role as a direct response to the call of God to express His love and compassion through care for the sick and dying.

Some workers in these institutions may be ready to make many personal sacrifices in order to accomplish what they perceive as God's high calling for them.

#### **1.4.5 Services provided by CHAZ.**

Among the major functions CHAZ has performed is that of representing the interest of member institutions to the government through the Ministry of Health. This is important because government policy does affect the operation of church health institutions. It is necessary that the views of church institutions were taken into account when developing policies and that the institutions clearly understand government policy. In addition, church health institutions depend on support from government through grants and secondment of personnel. CHAZ holds regular meetings with the Ministry of Health. Representatives of CHAZ often were invited to sit on various national policy and implementation committees such as the National AIDS Council, General Nursing Council, Medical Council of Zambia and Pharmacy and Poisons Board.

#### **1.4.6 Health Programmes**

1. The CHAZ AIDS Care and Prevention programme was developed in 1987 as a response to the growing problem of HIV/AIDS in the country. The programme concentrated on promoting educational activities in rural areas to achieve prevention of HIV transmission and development of home based care. The control of sexually transmitted diseases is another important component of the AIDS programme.
2. The TB programme is focused mainly on the promotion of Directly Observed Treatment Therapy (DOTT) and improvement of skills of the laboratory and health facility staff to diagnose and manage TB.
3. The malaria control programme ensures the promotion of Insecticide treated bed nets focusing on pregnant women and children under-five.

4. There is also a Primary Eye Care program, which focuses on the primary prevention of eye diseases and management of cataracts in rural areas
5. The Primary Health Care programme administered by CHAZ has aimed at providing assistance to members in implementing PHC activities. Activities that have been supported have included the training of community health workers (CHW) and traditional birth attendants (TBA), immunizations, nutrition rehabilitation, micronutrient supplementation and family planning. CHAZ provides funds and other requisites to support these activities.

#### **1.4.7 Pharmaceutical Program**

The other programme undertaken by CHAZ is that of support to member institutions through provision of drugs. The drugs come to CHAZ mainly as donations from agencies overseas. CHAZ distributes these drugs to member institutions with only a minimal handling charge. The availability of donated drugs has in the past been rather irregular and not always the most necessary items. A drug store is now in place and a drug revolving fund has been secured, this will solicit, procure, store and make available essential drugs to members and government health institutions at reasonable cost. CHAZ promotes rational drug use at member institutions and supports by training various cadres of health workers in management of pharmaceuticals

#### **1.4.8 Institutional Support, Planning and Development**

CHAZ assists member institutions in areas of planning and management of health facilities. Included here are issues in human resource development, health financing, and development of physical infrastructure, health systems research, and health information system. This department plays a pivotal role as the main administrative and information link between CHAZ and church health institutions. Capacity building for workers in member institutions is one major function of this department. This department also



The twentieth century was a period of extraordinary growth, progress and prosperity for many people. Yet it also brought with it increasing fragmentation, marginalization, and growing disparity between the rich and the poor, the knowledgeable and the ignorant masses. Developmental projects, for example, have been imposed on the people without much consultation.

Many Non Governmental Organizations have been challenged so that they start involving people in their developmental interventions. The changing nature of the world created a compelling need for change in CHAZ strategies. These complex global realities compel CHAZ to re-envision its role and responsibilities in the twenty-first century by developing new strategies, expanded partnerships, effective technologies, and greater resources, an internal working environment that can more effectively respond to the changing world.

The challenge is that participation must be dialogic and transactional, and that development communicators have a role in facilitating the spread of new philosophies and concepts through all stages of the development process.

It is this understanding that leads to a need for the research in this field. With participatory communication, developmental projects will transform the world to cherish and uphold the sacredness and dignity of every person and indeed respect local people's contribution, hence making all projects lasting longer for the benefit of all.

## **1.6 Rationale**

The purpose of the attachment has been to investigate how this development oriented Association makes use of communication Strategies in its functions and processes in order to facilitate human development within its sphere of operation. CHAZ which serves as the host organization for the attachment has been selected as a suitable organization for purpose of the attachment because of the following reasons:

- a. Its field of operation, health, is an important element of sustainable human development. Emphasis is on caring for the sick.
- b. The Organization's professed mission of providing quality Health Services equitably for the needy indicates commitment to the achievement of Human development, and
- c. CHAZ as an umbrella body serves a number of individual units and therefore provides the opportunity of observing, networking, co-coordinating, facilitation and advocacy functions.

### **1.7 Objective of the study**

At the end of the study, the researcher will have to realize the following objectives:

1. Review various communication strategies employed by CHAZ in integrating development intervention in fighting disease and identify gaps and provide recommendations.
2. Find out the impact of the same CHAZ programmes have on the targeted beneficiaries.
3. Determine how the existing communication development strategies have assisted in achieving the desired impact.
4. Propose how recommended strategies would help achieve more significant impact. (Consider both positive & negative impacts)
5. Observe and learn about communication patterns and techniques used by the Association in fighting disease.
6. Assess the communication technology and communication capacity of the Association, as well as see if these are adequate to meet the needs of the organization, and
7. Examine/observe CHAZ's networking, co-ordination and advocacy activities in relation to fighting disease.

## CHAPTER TWO

### METHODOLOGY

#### 2.0 Introduction

This chapter describes the research setting, the research questions, and sampling. It also includes how the data has been collected, organized and analyzed. The emphasis during the attachment to CHAZ was placed on both the experiential and the theoretical learning. The study, therefore, did seek to test out a set of predetermined hypothesis and attempted to explore the usefulness of the principles of Development Communication through the analysis of current practice.

In any case, a qualitative approach was thought to be most suited and the following data collection methods were employed: observation, focus group discussion, documentary evidence, field study and in-depth interviews. As regards quantitative survey, likert scaling or summated rating approach method was used.

#### 2.1 Research Questions

CHAZ conducts campaigns on Malaria, TB and HIV/AIDS.

The following research questions helped the researcher do work properly:-

1. What were CHAZ's direct role in the health campaigns?
2. What were the policies towards the proxy/partners, and who were these partners?
3. How do CHAZ and its proxies/partners communicate?
4. What were the major concerns as regards Disease, policies and Nature of communication?
5. What were the successes and failures of efforts of the communication campaigns?
6. What were the impacts on the beneficiaries (Both negative and positive)?
7. To what extent were the beneficiaries involved in all activities?

## **2.2 Data collection Methods**

The following methods were employed:-

### **2.2.1 Participant observations**

The researcher took active participation in the activities of CHAZ. These included some works in the programs, assisting in the day to day duties and even joined the staff in their sessions and the twice a week devotions. It was also felt necessary that the researcher mixes with other members of staff in other departments. A daily record was done for the activities and observations.

### **2.2.2 Focus group discussions (FGDs)**

Participants in the FGDs were selected on the basis of their availability and willingness to participate in the discussion. But selection was based on some socio-demographics for eligibility. There were 2 FGDs that were conducted and these were of two categories. One group was comprised of 8 CHAZ members while the other group was comprised of 12 non CHAZ respondents. The non CHAZ was comprised of 10 members from Beneficiary organisations and 2 from the service providers also known as proxies.

### **2.2.3 Review of Documentary evidence**

Documentary examination is a method that is useful because it provides confirmatory evidence and strengthens the credibility of results of interviews and observation. In the attachment, this involved examining a variety of documents including minutes of meetings, project proposals, concept papers, official correspondence, brochures, seminars and workshop reports, and any other documentary evidence available relating to the Association and its activities.

#### **2.2.4 Quantitative survey**

The quantitative survey method was used with a sample of 100 respondents drawn from CHAZ and its member organisations. This quantitative study has been carried out in this study and has helped to rate the strength of the attitude and belief for particular items.

#### **2.2.5 In-depth interviews**

In-depth interviews were carried out with key informants in the organization, that is, the Executive Director, the Development and project managers, the programme Managers and the information officer. These interviews were semi-structured and the student used a question guide (on Appendix). The student had also some time to talk to the support and subordinate staff to gain an insight on the organizations functioning. The student used unstructured discussions and casual chats.

### **2.3 Sampling Procedure for Quantitative Survey**

The researcher prepared a Hundred (100) questionnaires in total. There were 10 questionnaires for all the CHAZ staff at Head Office involved in communication. He also had 90 questionnaires which were distributed among all the 10 sub-recipients and the 8 proxies through out CHAZ catchments. These represent the 129 health centres countries wide which were under CHAZ. The sub-recipients include, the Christian Council of Zambia (CCZ), the Evangelical Fellowship of Zambia EFZ), the Coptic Church and the Young Women Christian Association (YWCA). Others include the Expanded Church Response, Chilanga Hospice, and ZINGO in Kalundu, Youth Alive Zambia, Digital Business Associates (DBA), and the Nyampande Orphanage.

The service organizations or proxies include Yatsani Radio, Yatsani Television, UNZA Radio, Zambia National Broadcasting Co-operation (ZNBC), 5FM, Radio Maria, Breeze FM, Lyambani Radio, and Radio Liseli in Mongu. Questionnaires have been administered using one of the non-probabilistic sampling methods, the systematic random



**Table 3: Names of Service Providers and Questionnaires.**

<b>Name of Service Provider</b>	<b>Number of respondents</b>
Yatsani Radio	3
Yatsani Television	3
UNZA Radio	3
Zambia Broadcasting Corporation (ZNBC),	2
5FM	1
Radio Maria	2
Breeze FM	1
Lyambani Radio	1
Radio Liseli in Mongu	2
<b>TOTAL NUMBER OF RESPONDENTS FROM PROXIES</b>	<b>18</b>

Participants in the FGD were selected on the basis of their availability and willingness to participate in the discussion. But selection was based on some socio-demographics for eligibility. FDG involved no more than 30 people. Three FGDs consisting of 10 people each were conducted during the research period, and this was within the 100 people targeted.

#### **2.4 Sampling Size**

The sample size for the questionnaire was about 100. During the survey there was no deliberate effort to be made to consider gender representation, as the type of sampling used was the convenience sampling, with the main concern being representation of organizations.

## **2.5 Data Gathering**

The questionnaire was used to gather the data from the people during the quantitative survey.

## **2.6 Data Analysis**

Data was collected, organized, examined and reviewed using both quantitative and qualitative analyses. Data from the quantitative design has been coded and entered into the computer using the statistical package for social sciences (SPSS). It has been analyzed in terms of percentages, frequencies and other characteristics.

Data from FGDs was also analysed and examined to draw out responses and opinions about the communication strategies available and how people participate in the whole exercise.

## **CHAPTER THREE**

### **CONCEPTUAL AND THEORETICAL FRAMEWORK**

#### **3.0 Introduction**

The chapter looks at the conceptual framework of the main issues tackled in this report. The concepts were taken from development communication, a multi-disciplinary field, that is, a synthesis of the disciplines of communication and development.

#### **3.1 Conceptual and Operational definitions**

##### **3.1.1 Relief**

According to the web definition, relief is the provision of assistance or intervention during or immediately after a disaster to meet the life presentation and basic subsistence needs of those people affected. It can be of an immediate, short-term, or protracted duration. ([www.inverstorwords.com/4201/research.html](http://www.inverstorwords.com/4201/research.html)).

##### **3.1.2 Participation**

Wikipedia free encyclopaedia defines participation as a process through which stakeholders influence and share control over development initiatives and the decisions and resources which affect them. In order to establish a participatory planning process, project designers must first identify those who should be involved in the process, or the stakeholders ([wikipedia.or/wiki/Wikipedia](http://wikipedia.or/wiki/Wikipedia)).

The stakeholder include the poor because the main objective is to reduce poverty, those to be directly affected (either positively or negatively) by a proposed project, governments and government organizations responsible for devising and implementing public policies and programs, those indirectly involve or affected such as NGOs or

private sector organizations with an interest in outcomes and the funding management, staff, and shareholders who have their own objectives, policies and institutional responsibilities.

### **3.1.3 Participatory Stance**

These were some of the important points considered on participation:

a). To establish meaningful participation is essential for project planner to take themselves out of the external expert role to place themselves within the local social system and demonstrate a willingness to learn from the other key stakeholders in preparing a project.

b). specifically project planner should work collaboratively with other stakeholder to carry out the steps required for preparing, implementing and evaluating a project. The key characteristic of a participatory approach is the collaborative stance the project sponsors and designers take so that stakeholder influence and share control over the decisions that were made.

Participatory approaches contribute to put decision-making in the hands of the people. It also consolidates the capability of communities to confront their own ideas about development with development planners and technical staff. Within the community itself, it favours the strengthening of an internal democratic process. Especially in communities that have been marginalized, repressed or simply neglected during decades, participatory communication contributes to install cultural pride and self-esteem. It reinforces the social tissue through the strengthening of local and indigenous forms of organization. It protects tradition and cultural values, while facilitating the integration of new elements. Finally, while asserting that there cannot exist a universal model applicable to all situations, the author emphasizes some of the issues that distinguish participatory communication from other development communication strategies in search of social change:

- (1) Horizontal vs. Vertical. People as dynamic actors, actively participating in the process of social change and in control of the communication tools and contents, rather than people perceived as passive receivers of information and behaviour instructions, while others make decisions on their lives.
- (2) Process vs. Campaign: people taking in hand their own future through a process of dialogue and democratic participation in planning communication activities: rather than expensive, unsustainable top-down campaigns that help to mobilize but not to build a capacity to respond from the community level to the needs of change.
- (3) Long-term vs. Short-term. Communication and development in general is conceived as a long-term process which needs to be appropriated by the people: rather than short-term planning, which is seldom sensitive to the cultural environment and mostly concerned with showing “results” for evaluations external to the community.
- (4) Collective vs. Individual. Urban or rural communities acting collectively in the interest of the majority, preventing the risk of losing power to a few rather than people targeted individually, detached from their community and from the communal forms of decision-making.
- (5) With vs. For. Researching, designing and disseminating messages with participation: rather than designing, pre-testing, launching and evaluating messages that were conceived for the community, and remain external to it.
- (6) Specific vs. Massive. The communication process adapted to each community or social group in terms of content, language, culture and media. Rather than the tendency to use the same techniques, the same media and the same messages in diverse cultural settings and for different social sectors of society.
- (7) People’s needs vs. Donor’s musts. Community-based dialogue and communication tools to help identify, define and discriminate between the felt needs and the real needs: rather than donor-driven communication initiatives based on donor needs (family planning, for example).
- (8) Ownership vs. Access. A communication process that is owned by the people to provide equal opportunities to the community: rather than access that is

conditional by social, political or religious factors.

- (9) **Consciousness vs. Persuasion.** A process of raising consciousness and deep understanding about social reality, problems and solutions: rather than persuasion for short-term behavioural changes that were only sustainable with continuous campaigns.

### **3.1.4 The Four Ways of Chin Saik Yoon**

He discusses generally, four different ways of participation, in most development projects claiming to be participatory in nature. They are as outlined below:-

1. **Participation in Implementation:**  
People are actively encouraged and mobilized to take part in the actualization of projects. They are given certain responsibilities and set certain tasks or required to contribute specified resources.
2. **Participation in Evaluation:**  
Upon completion of a project, people are invited to critique the success or failure of it.
3. **Participation in Benefit:**  
People take part in enjoying the fruits of a project: this may be water from a hand-pump, medical care by a “bare-foot doctor”, a truck to transport produce to market, or village meetings in the new community hall.
4. **Participation in Decision-Making:**  
People initiative, discuss, conceptualize and plan activities they will all do as a community. Some of this may be related to more common development areas such as building schools or applying for land tenure. Others may be more political, such as removing corrupt officials, supporting parliamentary candidates, or resisting pressures from the elites. Yet others may be cultural or religious in

nature-organizing a traditional feast, prayers for an end to the drought, and a big party just to have a good time.

### **3.1.5 Development**

According to Brundland commission, 1987, Development is the advancement of the management and use of natural resources to satisfy human needs and improve the quality of human life. For development to be sustainable it must take account or social and ecological factors, as well as economic ones, of the living and non-living resource base, and of the long-term and short-term advantages and disadvantages of alternative actions.

### **3.1.6 Sustainable Development**

This meets the needs of the present without compromising the ability of future generations to meet their own needs. it contains within it two key concepts, the concepts of "needs", in particular the essential needs of the world's poor, to which overriding priority should be given, and the idea of limitations imposed by the state of technology and social organization on the environment's ability to meet present and the future needs (Brundtland Commission, 1987). Sustainable development is based on socio-cultural development, political stability and decorum, economic growth and ecosystem protection, which all relate to disaster risk reduction.

### **3.1.7 Communication**

Communication is the process of exchanging information and ideas. An active process, it involves encoding, transmitting, and decoding intended messages. There are many means of communication and many different language systems. Speech and language is only a portion of communication. Other aspects of communication may enhance or even eclipse the linguistic code.

These aspects are paralinguistic, non-linguistic, and metalinguistic. Paralinguistic

mechanisms signal attitude or emotion and include intonation, stress, rate of delivery, and pause or hesitation. Non-linguistic clues include gestures, body posture, facial expression, eye contact, head and body movement, and physical distance. Metalinguistic cues signal the status of communication based on our intuitions about the acceptability of utterances, in other words, metalinguistic skill enable us to talk about language, analyze it, think about it, separate it from context and judge it.

### **3.2 Main Theories and the Study**

There will be a few main theories mentioned here and how they apply to the study.

#### **3.2.1 Multi-step Flow of Communication Theory**

The two step flow of communication hypothesis was first introduced by Paul Lazarsfeld, Nernard Berelson, and Hazel Gaudet in the People's Choice, in 1944 study focused on the process of decision making during a Presidential election campaign. These researchers expected to find empirical support for the direct influence of media messages on voting intentions. They were surprised to discover, however, that informal, personal contacts were mentioned for more frequently than exposure to radio or newspaper as sources of influence on voting behaviour. Armed with this data, Katz and Lazarsfeld developed the two-step flow theory of mass communication.

This theory asserts that information from the media moves in two distinct stages. First, individuals (opinion leaders) who pay close attention to the mass media and its messages receive the information. Opinion leaders pass on their own interpretations in addition to the actual media content. The term 'personal influence' was coined to refer to the process intervening between the media's direct message and the audience's ultimate reaction to that message. Opinion leaders are quite influential in getting people to change their attitudes and behaviours and are quite similar to those they influence. The two-step flow theory has improved people's understanding of how the mass media influence decision making. The theory refined the ability to predict the influence of media messages on

audience behaviour, and it helped explain why certain media campaigns may have failed to alter audience attitudes and behaviours.

The two-step flow theory gave way to the multi-step flow theory of mass communication or diffusion of innovation theory (Katz and Lazarsfeld, 1955). Opinion leadership theory stems from the two-step flow model of communication. Over the years, the two-step flow has slowly evolved into multi-step flow. The two-step flow model rests on the belief that there are people who act as opinion leaders that selectively consume media in their area of expertise and then disseminate the ideas among opinion-seeking members of a group.

Through diffusion, the message is altered somewhat by the beliefs of the opinion leader. In turn, group members are influenced by this communication in some manner. Finally, opinion leadership theory has implications for advertising and marketing. By targeting opinion leaders, advertisers can more effectively and more rapidly communicate product information to their target consumers

This theory somehow applies to this study. Some people think that what is said on the media is reaching the people without difficulties. It must be understood that many people are only told by other and never listen to the media at all.

In any community there are people who are known as influentials. Regularly, reports and studies are performed in an attempt to unlock the secret to reaching these influentials. What has the term "influential" come to describe?

According to Daine Crispell, these people are the "thought leaders" and "pioneer consumers". "Influentials are better educated and more affluent than the average citizen, but it is their interest in the world around them and their belief that they can make a difference that makes them influential (Crsipel, 1989)." The idea remains that the most efficient media is word-of-mouth, and it is by reaching the influential with other forms of media that this word-of-mouth is generated. This study has interest in the extent to which CHAZ use this theory in the dissemination of the information.

### 3.2.2 Agenda – setting theory

Agenda-setting is the creation of public awareness and concern of salient issues by the news media. The Agenda-setting theory's central axiom is salience transfer, in other words, the mass media have the ability to transfer importance of items on their mass agendas to the public agendas. Media agenda is the set of issues addressed by media sources and public agenda is the issues the public consider important (Miller 2005).

In 1963 Bernard Cohen stated, that the press may not be successful much of the time in, 'telling people what to think, but it is stunningly successful in telling its readers what to think about', (Griffin, 2006).

The Agenda-setting theory was introduced in 1972 by two scholars, Maxwell McCombs and Donald Shaw. The two scholars studied the role of the media in 1968 presidential campaign in Chapel Hill, North Carolina and found that the media influenced the public on what issues to think about. The study was groundbreaking and has been influential in the field of communication.

The theory explains the correlation between the rate at which media cover a story and the extent that people think that this story is important. As pointed out earlier in the work of Bernard Cohen, The Agenda-Setting Theory says the media (mainly the news media) aren't always successful at telling us what to think, but they are quite successful at telling us what to think about. McCombs, M., & Shaw, D.L. (1972).

Here may lie the most important effect of mass communication its ability to mentally order and organize our world for us. In short, the mass media may not be successful in telling us what to think, but they are stunningly successful in telling us what to think about. Shaw & McCombs, 1977

This theory is good at explaining why people with similar media exposure place

importance on the same issues. Although different people may feel differently about the issue at hand, most people feel the same issues are important.

The Agenda-Setting Theory comes from a scientific perspective, because it predicts that if people were exposed to the same media, they will place importance on the same issues. According to Chaffee & Berger's 1997 criteria for scientific theories, Agenda-Setting is a good theory, because:

- 1 It has explanatory power because it explains why most people prioritize the same issues as important:
- 2 It has predictive power because it predicts that if people were exposed to the same media, they will feel the same issues are important:
- 3 It is parsimonious because it isn't complex, and it is easy to understand:
- 4 It can be proven false. If people aren't exposed to the same media, they won't feel the same issues are important:
- 5 It's meta-theoretical assumptions are balanced on the scientific side:
- 6 It is a springboard for further research: and,
- 7 It has organizing power because it helps organize existing knowledge of media effects.

CHAZ and its partners make good use of mass media and hence the special concern with this theory in this study.

### **3.2.3. Cultivation Theory**

The cultivation theory got its start with the cultivation hypothesis, created by George Gerbner 1976, which states attempts to understand how "heavy exposure to cultural imagery will shape a viewer's concept of reality" (Pierce 1982). Stemming directly from his work on the Cultural Indicators Research Project, Gerbner used the cultural analysis research strategy to cumulate his theory on television cultivation.

Essentially, the theory states that heavy exposure to mass media, namely television, creates and cultivates attitudes more consistent with a media conjured version of reality

than with what actual reality is. The cultivation theory asserts that heavy viewers' attitudes are cultivated primarily by what they watch on television. Gerbner views this television world as "not a window on or reflection of the world, but a world in itself" (McQuail 100). This created version of the world entices heavy viewers to make assumptions about violence, people, places, and other fictionalized events which do not hold true to real life events.

Here, television acts as a socializing agent that educates viewers on a separate version of reality. The concrete base behind the cultivation theory states that viewers tend to have more faith in the television version of reality the more they watch television. We must realize that light viewing of television events tend not to shape an entirely separate reality. Thus, the focus of study is on heavy viewers. Light viewers may have more outlets and sources to influence their version of reality than heavy viewers whose main source of information serves to be the television programming.

In order for cultivations theorists to prove their ideas, they must continually conduct research to demonstrate television's effects. Through a technique called cultivation analysis, involving the correlation of television content with data accumulated from surveyed audience members, the "TV world" is characterized (Chandler, 1977). Here, theorists attempt to prove how violence, among other characteristics (love, infidelity, cheating, etc.) is more prevalent in the TV world than in the "real world." An example furthering this idea is that the TV world dramatically overemphasizes the prevalence of law enforcement jobs in the real world (Chandler, 1977).

Theorists try to prove ideas surrounding the occurrence of violence. One study shows instances where a heavy viewing child believes it is okay for him to be hit if he has it coming to him (Kenny, 1983). Other factors in cultivation analysis studies include an increased fear of walking alone at night, and a mistrust of people in general (Kenny, 1983).

Another cultivation theorist, Leonard Enron, too attempts to prove the effects of television on viewers. By following a group of third graders in suburban New York, he

learned that the more violent the TV watched, the more aggressive the children were in school. He returned again when they were nineteen and then again at age thirty. Both times, the previously troubled youngsters revealed problems in marriages and with the law (Phillips, 1992). In fact, in a 1993 conference of the National Council for Families and Television, Eron estimated that 10% of violence in the US can be directly attributed to viewing of television (Stossel).

Cultivation theorists focus on trends of heavy viewing over a long period of time rather than placing the focus on singular events. This type of long-term exposure is bound to create an impression among viewers. Gerber's theory asserts that most often, heavy viewers tend to be men and those of lower income brackets. One particular survey on this group revealed that 25% of them showed "what life is really like" and that 40% of them professed to learn a lot from the television (Stossel)

In a positive sense, CHAZ and its partners make good use of mass media and hence the special concern with this theory in this study.

#### **3.2.4 Beebe and Masterson's Constellation Model**

Beebe and Masterson's Constellation Model builds from a systems perspective and states that in order for a group to be successful it must consider all possible sender, receiver, and message variables which occur in a small group. The model posits that there is a relationship between communication, leadership, goals, norms, roles, cohesiveness, and situation. Each must be analyzed to determine group effectiveness (Steven A. Beebe and John T. Masterson, 1997).

Beebe and Masterson's Constellation model explains that in a group there is a strong relationship between seven aspects of communication and group overall effectiveness. This theory also explains that attention must be paid to all communicators in the group, including the senders and receivers of the messages.

CHAZ tries to engage a few of the ideas from this theory. Given the fact that each group member organisation of CHAZ has the free will to take on certain roles and adopt certain

communication styles leads to the conclusion that there is no determinism in this theory. This therefore means that, The Constellation Model is an informative theory about group communication and is consistent with the belief that group normality and group function is highly determined by the amount of skill present in terms of communication by its members.

Beebe and Masterson's Constellation Model clearly demonstrates how a member of a group can affect others in the group based on his or her communication skills. The interconnectedness of the communication traits is vital in the effectiveness of a group member, and the awareness of this fact that Beebe and Masterson portray is very informative from a communicative standpoint. CHAZ sometimes makes use of this advantage during different meetings.

People, who were HIV positive for example, will upon meeting for the first time discuss their communication skills and what they can contribute to their group. Each member listens intently to the others who share in order to find out what areas were strong within the group. Following this event, one member, could inform the entire group of their strengths and weaknesses, and the amount of participation each member must invest in the group in order for it to function properly and effectively. This is important because CHAZ is dealing with the people that were living with AIDS.

### **3.2.5 Dramatism**

Kenneth Burke, 1968 says that Dramatism claims that the communicator must act as if he or she were an actor in a drama, where they were trying to get the audience to accept their view of reality as true. The communicator must try to identify with the audience members through various means to gain acceptance. When a communicator stands to give a speech, they have to get the audience to see eye to eye with them before they will ever be able to get their point across. A politician hopefully will believe in the things he is saying, but even if he doesn't, he can make the audience love him by speaking about things that were important to them.

There are five central elements of the human drama, which coincide with the audience. These are: Act/Response, Scene/Situation, Agent/Subject, Agency/Stimulus, and Purpose/Target. Burke believes it is people's nature to create, use, and abuse language.

CHAZ must act in certain ways to appeal to the audience, and beneficiaries should make sure they do not lose sight of what their own values were. CHAZ must also change the ways of approach according to the audience and present situation. Any the communicator must not focus on one way of thinking.

### **3.2.6 Functional Perspective**

Functional Perspective claims that there are four functions for effective decision making which include an analysis of the problem, goal setting, identification of alternatives, and an evaluation of positive and negative characteristics, all of which are equally important ((Randy Hirokawa & Dennis Gouran 1983). This theory is very good in guiding groups through different types of communication. The theory stresses all four functions as being important.

This theory is value-neutral because there is a four- step system that groups follow to rationalize their communication, regardless of their original values. In order to communicate effectively CHAZ will need to follow some of the outlined steps by this theory. By following the four functions, effective decision can be made. The functions do not need to be prioritized because they are all important to fulfilling group needs.

## CHAPTER FOUR

### LITERATURE REVIEW

#### 4.0 Introduction

In this chapter, the researcher looks at the past research work, studies and findings that have been done by others in the field of Health Communication, in the world at large, in Africa, and indeed in Zambia in particular. There are numerous studies, concerning Health Communications.

The Church is regarded as an institution that stands in solidarity with the most vulnerable members of society – the poor, the widowed, and the sick. In many countries the church has even played a role in championing the cause for democracy. There are also campaigns for justice and peace so that the world people live in becomes a new society of love and equality.

The following frameworks contribute to the general context of this study.

#### 4.1 World Council of Churches (WCC)

One very important organ that strongly helps the Church is the World Council of Churches (WCC). In the 5<sup>th</sup> Assembly held in Nairobi Kenya in 1975, the participants of the WCC resolved that the main focus of ecumenical work should be to assist churches to manifest, in their styles of life and organizational structures, their solidarity with the poor. The World Council of Churches defines the poor as:

Those that are not able to satisfy the basic  
Human needs such as food, housing, education,  
Health, jobs, and social participation.”  
(WCC, 1975: 3, 4)

At the same assembly meeting the participants resolved that the main focus of ecumenical work should be to assist churches and their constituency to manifest in their theological outlook, styles of life and organizational structures their solidarity with the struggle of the poor.

The Christian definition of 'development' is people-centred. In the 1991, a seminar for Christian communicators held in Namibia on Communication, Human Dignity and People's Rights in Africa, acknowledged that all churches in Africa should have among their agenda and mission the notion of-

Encouraging the evolution of a Christian understanding development, which as Christianity itself, is people-centred and providing appropriate communication models and structures to support development (WCC, 1980: 3).

The Christian community is at its very core a healing community as "compassion for the sick was an important and visible part of Jesus' life and salvific mission, and one he expressly charged his disciples to emulate in all times and places (Asante, 1998: 1). For a long time, health care has been integral to Christian mission and many of the oldest health facilities in developing countries were established by the church. The Church not only has the motivation for holistic health care in the footsteps of its founder (Jesus), but it also has the reach, according to Sande (1998). He adds:

More than any other institution or organisation the church has the widest and deepest penetration of the community, and necessarily so because the mission of the church is to the individual, to the family, to the congregation and to the community.... The congregation or the local church is to be found across the whole spectrum of humanity in the bright city lights in the slums across the high way and in the deep of jungles where no road exist...(Sande, 1998: 26)

In the health circles too, the importance of the people's well-being is also placed at the centre of human development. It is believed that poverty eradication and health were the

key to development. At an inaugural address at the World Health assembly in May 1998, Dr Gro Harlem Brundtland noted: "We must speak out for health in development, bringing health to the core of the development agenda. That is where it belongs, as the key to poverty reduction and development underpinned by the values of equity, human dignity and human rights. (CHAZ, 1998d: 1).

With this in mind it is important for Christian health care providers to put in place a sustainable system that will be able to serve all members of communities. A study was conducted in 1997-98 by Kofi Asante of WCC on the sustainability of church hospitals in developing countries. This study covered 43 church-related health institutions in 11 countries in Africa and Asia.

Asante notes that in most of the less industrialized countries churches are by far the most significant voluntary contributors to the National Health Service. Whereas some governments allocate the totality of the health budget to the ministry of health, others give limited help to churches involved in providing health services. The reason given for the low-level in government assistance to churches is that they will receive funds from "somewhere" (Asante, 1998: 53).

CHAZ is operating in an environment like the one described by Asante. Although there was some government assistance in the past, this has gradually dwindled to nothing. Donor funding that the Association enjoyed in the past has not always been compatible with the ideas of sustainability and self-reliance. The way forward has been identified as maintaining or developing new partnerships with donors and communities, both in the countries and overseas, in the care of the poor. This focuses on the poor that necessitates extra efforts in fund-raising, given that the poorer sectors of the population were unable to meet the cost of their own health care.

Asante confirms this responsibility and says:

Church institutions have to combine a commitment to serving the poor with the

provision of high-quality services. These somewhat conflicting objectives inevitably involve them in difficult choices and mean that fund-raising will be needed to pay for care of the poor. The economic situation in most developing countries implies that this need will continue into the foreseeable future. (Asante, 1998: 57).

The main problem being faced by research to be conducted in the area of the sustainable church health care services is the availability of statistical data on the number and types of institutions.

Asante laments the non-existence of readily available lists of church-related hospitals world wide that made it difficult to identify a statistical universe from which to draw a watertight random sample for his study. However, his study still constitutes a sound basis for future interventions in church hospitals that were having problems with sustainability (Asante, 1998: passim).

## **4.2 Speaking of Health**

This is a Book that has been written by a Committee on Communication for Behaviour Change in the 21st Century, Improving the Health of Diverse Populations, Board on Neuroscience and Behavioural Health. They were trying to analyse how to communicate the language of good health so that it is uniformly received-and accepted-by people from different cultures and backgrounds.

Public health communicators and health professionals face dilemmas every day. Speaking of Health looks at the challenges of delivering important messages to different audiences. Using case studies in the areas of diabetes, mammography, and mass communication campaigns, it examines the ways in which messages must be adapted to the unique informational needs of their audiences if they were to have any real impact. Speaking of Health looks at basic theories of communication and behaviour change and focuses on where they apply and where they don't.

By suggesting creative strategies and guidelines for speaking to diverse audiences now and in the future, the Institute of Medicine seeks to take health communication into the future, in an age where people were inundated by multiple messages every day. <http://www.nap.edu/catalog/10018.html>

Clear evidence from the Centres for Disease Control and Prevention, the National Institutes of Health, the Institute of Medicine, and other agencies that collect data on health behaviours and outcomes shows that significant health disparities continue to exist across diverse populations, despite efforts to reduce or eliminate those disparities. (National Academy of Science, 2002). This problem is likely to grow if predictions of increasing social and cultural diversity over the next 50 years were correct. If effective actions were not taken, this increasing diversity could lead to a disproportionate rise in populations who have poorer health outcomes. Given the likely growth in diversity, communication interventions to affect health behaviour were an increasingly important strategy for improving the health of people in the world.

There is little evidence of the differential effects of these programs according to diversity subgroups. As a result, money and time were spent without knowing when a common format would suffice, or when a variety of targeted or even tailored interventions would be more appropriate. Given the likely growth in diversity, there is an urgent need now to enhance people's current understanding of the dynamics of health communication to achieve the greatest impact for the most people. This volume has been the product of the Committee on Communication for Behaviour Change in the 21st Century: Improving the Health of Diverse Populations, established by the Institute of Medicine in 1999. It focuses on those programs that involve some use of communication technology and have incorporated the transmission or exchange of messages within interventions designed to influence behaviour to improve health. Programs exclusively involving interpersonal communication, such as between physician and patient, were not the focus: interventions that include other elements along with communication technology were considered. The charge to the committee was to

- (1) review existing theory and research applications in health communication and health behaviour change, especially as they relate to culturally diverse populations, and define research areas that would benefit from expanded or new research efforts:
- (2) consider up to three specific examples of health communication interventions to evaluate whether and how those strategies affect culturally diverse groups: and
- (3) recommend how health communication strategies may be designed and implemented to help achieve sustained gains in public health across cultural groups. The committee included experts in anthropology, psychology, mental health, cancer prevention and control, health behaviour change and theory, communication and the media, social marketing, and public health (National Academy of Sciences, 2002).

The same book continues to say that theories of behaviour change and communication have an important place in the construction of communication programs in general and for diverse populations. The committee encourages program developers and implementers to use these theories in a more consistent and aggressive way in developing implementation plans for health communication interventions. Additional research is needed about the translational process of moving from theory to implementation. The committee recommended that more attention be given to how theories were translated into effective practice and implemented in health communication interventions: that is, how the theoretical principles were applied in practice. One approach might employ case studies that document specific interventions and include discussions of the operational difficulties of translating theory into practice.

As regards Ethics, respecting an individual's autonomy to make choices, maximizing benefit, avoiding harm, and treating groups and individuals justly and equitably are core ethical principles. These principles are easily endorsed, but not always easily achieved. Implementing ethical principles can be complicated by the developers' needs to consider tradeoffs among efficiency, cost, and improving the health of the most in need versus

benefiting a broader range of persons. Sometimes these choices have to be made under conditions of uncertainty, either in terms of uncertainty about the scientific support for an intervention or uncertainty about the effect of the intervention. Some communication strategies come into conflict when trying to secure benefit for one segment of the population versus another. This risk may be heightened in the context of reaching heterogeneous audiences with a common message. There is always the opportunity for unintended consequences to occur (e.g. confusion, unwarranted anxiety), even with the most well-intentioned and well-executed health communication interventions. Some of these concerns can be minimized through close cooperation with the groups whose health care one hopes to improve.

#### **4.2.1 Components of a Successful Program**

Many successful communication programs have been reported in the literature. A review of these can be found in Chapters 3 and 4. The committee finds that these programs have met certain conditions, and that these conditions should serve as a guide for future program development. These conditions include a strong science base for recommended behaviours, a realistic possibility that recommendations can be implemented by the population, coordination with other programs addressing related issues, enough resources available for the development and particularly the transmission of messages so that the intended audience sees them at needed frequency, and often the resources to maintain the campaign over time if the pace of change is slow.

#### **4.2.2 Towards a new definition of Diversity**

Diversity is frequently defined for policy and research purposes by broad social and demographic categories such as race, ethnicity, socioeconomic status, age, and gender. Although these categories may have important political relevance, there is usually as much heterogeneity with regard to behaviour and its determinants within a specified group as between groups. The committee argues that communication programs need to focus on other, more meaningful ways of describing heterogeneity. Specifically, they should focus on cultural process, on understanding the life experiences of the

communities and individuals being served, and on the socio-cultural environment of individuals within the populations to be reached.

There are multiple dimensions to be considered, ranging from economic contexts and community resources such as access to health services to commonly held attitudes, norms, efficacy beliefs, and practices pertinent to the health issue in question. The committee recommends that policy makers and program planners continue to use demographic factors to understand whether health benefits were equally distributed and to identify inter-group differences.

Where there were existing disparities, it will be important to monitor trends in gap opening and closing according to these categories. At the same time, program planners need to recognize that other measures such as life experiences and cultural processes were needed to understand within-group variations and to understand their association with health behaviours. Actual planning of health communication programs rarely will be well served by an assumption of homogeneity within any of these categories. This may also require efforts to more systematically educate policy makers about the relevant domains of diversity for purposes of communication interventions (Ibid, 2002).

#### **4.2.3 Infrastructure Needs**

The field of public health communication relies on contributions of many disciplines. Skilled communicators and intervention developers are central to successful communication programs, but they depend on expertise from many other fields. Public health communication requires theories about behaviour and behaviour change: deep understanding of audiences, their cultural experience, and their social and structural circumstances: and understanding of the health infrastructure around the health concern and its medical nature. Increasingly, public health communication requires technical expertise with new technologies and medical knowledge about health problems.

Some programs also need the expertise of marketers, and others need informatics expertise. If advances were to be made in communication for diverse populations, the field of public health communication should be strengthened. This requires not only

investment in research and training, but the active participation and collaboration of people from many disciplines. Interdisciplinary teams to design and implement communication strategies in diverse populations should be encouraged by funding agencies. National campaigns to address major health priorities require the mustering of substantial resources and, often, coordinated efforts of multiple agencies, if national audiences were to be reached and effects were to be sustained over time. They cannot be undertaken successfully without such commitment. A national strategy and infrastructure for prioritizing and implementing such large scale campaigns were needed.

<http://www//books.nap.edu/catalog>.

### **4.3 Education and Health**

The World Bank calls women's education as the single most influential investment that can be made in the developing world as it does not only foster economic growth but also promote smaller families, increase modern contraceptive use, and improve child health. Education is strongly related to fertility in most countries, but the form and size of the relationship vary considerably. Women with seven years or more of schooling marry, on average nearly four years later and will thus bear 3.9 children while women with no schooling will bear nearly 6.9 on average. The educated women will have about 25 percentage points higher contraceptive use and breast-feed their children eight months less than women with no education. Unlike fertility itself, these fertility determinants nearly always show a monotonic relation with number of years of education.

Education is the single most important determinant of both age at marriage and age at first birth in Middle East and North African (MENA) countries, since women in the region tend to give birth soon after marriage. It has also been found that in a number of less developed countries, women with no education have about twice the number of children as women with 10 or more years of school. Steep fertility declines often occur among women who have seven or more years of school.

In addition, higher education levels were associated with better family planning. As more children survive, families reduce the number of children they have. Desired family sizes decline, a process helped by the ready availability of contraceptives. So, over time, lower infant and child mortality plays a major role in falling fertility rates. Community or aggregate level education has also been found to have a significant depressing effect on women's birth-rates, taking into consideration factors such as urbanisation and her own education.

#### 4.4 Upfront

"Upfront" was, at the time of writing, a magazine created by The New York Times that contains articles written with the teenage demographic in mind focusing on Health Communications in general. Current events topics were typically discussed, and the majority of advertisements contained within the magazine were designed to appeal to teenagers. It is a bi-monthly journal. (Wikipedia encyclopaedia).

From Volume 7, Number 3 of May-June 2003, Global epidemiological trends reveal that mortality from lifestyle-related diseases in Western and other industrialised nations has been declining while the converse is true in developing nations and in various Newly Independent States of the Former Soviet Union. It commissioned a TV series that featured the scientific basis for the lifestyle and disease connection. The series differentiated fact from fallacy, and suggested practical ways to lower the risk of heart disease, certain cancers, and other major lifestyle related disabilities by tracking four families through the cycle of a year and their efforts to live healthier lives.

In the first article of this issue, a study by Chew and her colleagues reports the impact of this TV series on health knowledge and the key factors of the health belief model (HBM) that have led to health behaviour in Poland (exercising, losing weight, changing eating habits, and not smoking/quitting smoking). The HBM examines five basic factors influencing disease prevention behaviours: perceived susceptibility of getting the disease or being harmed: perceived seriousness of the consequences of the disease, such as a disability: perceived benefits of the recommended behaviour, such as feeling healthier:

perceived barriers to the suggested actions, such as cost: and finally, cues to action, such as a physician's advice or TV program. Benefits and barriers combined to form efficacy. Data from a post - test comparison field study with 151 viewers and 146 nonviewers, analyzed with hierarchical regression, showed stronger support for efficacy, susceptibility, seriousness, and salience (interest in good health) in their contribution towards health behaviour among TV viewers compared to nonviewers.

Cues to action variables (including TV viewing) and health knowledge boosted efficacy among viewers. Without the advantage of receiving health information from the TV series, nonviewers relied on their basic disease fears on the one hand, and interest in good health on the other to take steps towards becoming healthier. The researchers concluded that a health promoting TV series can increase health knowledge and enhance health beliefs, which in turn contribute to healthy behaviours. Study limitations included social desirability response bias and memory dependence, which may characterize self-reported measures. In addition, self - selection bias may be present among the program viewers. Finally, the results were derived from more demographically upscale participants and may not be generalisable to the larger Polish population. Chew, F., Palmer, S., Slonka, (2002)

The final article of this issue broadly uses the language and concepts of public relations to analyze the global AIDS/HIV phenomenon at three levels.

First, it applies models of public relations practice to analyze power differentials between various stakeholders (publics) involved in the pandemic. This part of the analysis shows that those who were most impacted by the pandemic at the everyday level were least empowered to shape rhetoric and policy on global AIDS/HIV.

The next level of analysis draws upon international and intercultural public relations research. Literature in this area teaches us that when it comes to practicing public relations across cultures and national borders, practitioners should avoid working against local conceptualizations of how public relation is understood and practiced. Similarly, in

the case of global AIDS/HIV, public relations efforts and prevention campaigns should be sensitive to local and cultural interpretations of the epidemic.

Third, in public relations, the manner in which an issue is framed through the news media can shape the responses and opinions of significant stakeholders, thereby influencing future signification and courses of action. Therefore, it is important to understand how news about global AIDS/HIV gets created, and how various stakeholders respond to these news representations. In order to understand this, reporters who cover AIDS/HIV at four leading transnational wire services were interviewed. In order to understand how various publics interpret news, two groups of stakeholders (people living with AIDS/HIV or engaged in AIDS/HIV related work, and policy makers working at the global level) were interviewed. These interviews resulted in a data set of narratives that were qualitatively coded and analyzed.

The main finding from the reporters' narratives was that the global AIDS/HIV story has lost its spike and become routine. Therefore it is hard to keep it on the news agenda. People living with AIDS/HIV or engaged in work that relates to AIDS/HIV were mostly of the opinion that global representations were simplistic and do not adequately include the voices and experiences of those intimately affected by the pandemic. The policy makers were of the opinion that coverage is mostly uncritical and that enough attention is not paid to prevention issues.

The author concludes that AIDS/HIV is a polycultural phenomenon that involves the agendas, interactions and interpretations of various cultural groups/stakeholders. In this sense, it is also an intercultural as well as public relations phenomenon. Hence, those individuals who operate at boundary spanning transition nodes along the global/local continuum, and the (intra as well as inter) dimensions that connect different cultural groups/stakeholders play a crucial communicative relationship building role that requires cultural sensitivity and open minded creativity, initiative, superior leadership qualities and a finely balanced understanding of the top - down and ground up intersections and subjectivities of AIDS/HIV communication. Bardhan, on Global AIDS/HIV, (2002).

#### **4.5 International Conference on Gender and Health *September 2002***

The International Conference on Gender and Health which was held in Vienna, Austria from September 16-18, 2002, was aimed at promoting the integration of the gender perspective in the health care field and in health sciences, and at stimulating collaboration between researchers, practitioners, and policy makers. The main objectives of the conference included examining sex differences in health status, diagnostic and health care delivery, discussing the relationship between sex role stereotypes and clinical judgment. It critically examined the current systems and structures for health care services in women's and men's health, and identified effective models for health care delivery.

The International Conference on Communication in Healthcare 2002 is the first international conference organized by the newly formed European Association for Communication in Healthcare(EACH), in partnership with: The Program in Communication and Medicine, North western University, Chicago, the Netherlands Institute for Health Services Research, The Forum on Communication in Healthcare of the Royal Society of Medicine, and the Oxford Institute for Ethics and Communication in Health Care Practice. The conference was held at the University of Warwick, UK September 18-20, 2000. The aim of the conference was to bring together teachers, researchers, consumers, policy makers, and practitioners interested in all aspects of communication in healthcare, to create networks, to share new work and new ideas, and to provide an enjoyable and motivating experience for all participants.  
<http://www.each2002.com>

The other one was the 88th Annual Meeting of the National Communication Association, "Communication in Action", held November 21-24, 2002 in New Orleans, Louisiana. The conference included a seminar series on a variety of topics. One example is HIV/AIDS, STDs & Sexual Behaviour: Conversations Leading to Action led by Stuart Schrader, Indiana University-Purdue University, Indianapolis, and Thomas Steinfatt, University of Miami. The seminar intended to foster a dialogue that centres on how study within this topic area can positively contribute to other applied communication and/or

health communication scholarship. Brief position papers were requested from participants who wish to contribute to the seminar. Submissions may address any issue related to HIV/AIDS, STDs, or sexual behaviour. <http://www.natcom.org/convention/>.

#### **4.6 Internet Sources**

“An Extraordinary Opportunity : Cancer Communications” is a new 10-minute video featuring The Communications Opportunity Leadership Team (COLT) members sharing their views on the importance of the Extraordinary Opportunity in Cancer Communications (EOCC). The video emphasizes the research potential in cancer communications.

## CHAPTER FIVE

### DATA ANALYSIS AND RESULTS

#### 5.0 Introduction

This chapter presents the findings of the study for both the quantitative and the qualitative designs. The presentation of the findings is in two parts. Firstly, there were the quantitative design results and secondly, the findings from the focus group discussion.

The main findings at CHAZ can be summarised as follows:

1. The organisation has good communication within the system,
2. Modern network links,
3. A clear understanding about the Secretariat's mandate and
4. Adequate personnel for tasks to be accomplished.

All these issues influence and are influenced by the communication capacity of the association.

#### 5.1 Study findings

The SPSS has been used for analysing all quantitative data. Data was collected using a questionnaire. As mentioned earlier, a total of one hundred questionnaires were administered. 10 questionnaires were given to the members of CHAZ that were very involved in communication matters of the Association. These questionnaires have been analysed separately. The other 90 which were given to other organizations have also been separately analysed.

Participants in the Focus Group Discussion were selected on the basis of their availability and willingness to participate in the discussion. But selection was based on some socio-demographics for eligibility. Two FGDs consisting of 10 people each were conducted during the research period.

### 5.1.1 Characteristics of Respondents at CHAZ Head Office

Below are the characteristics of the respondents at CHAZ. As can be observed from the table below, out of the 10 respondents, 8 were female while 2 were male. The results show that there were more females dealing with communication matters at CHAZ than males. The information office, in fact, has a female officer as head.

**Table 4: Sex of respondents**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid male	2	20.0	20.0	20.0
Female	8	80.0	80.0	100.0
Total	10	100.0	100.0	

The age range of the respondents at CHAZ was between 31 years and 50 years. Results indicate that the higher percentage is that of those between 31 and 40 years (60%)

**Table 5: Age of respondents**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid between 31 and 40 yrs	6	60.0	60.0	60.0
between 41 and 50yrs	4	40.0	40.0	100.0
Total	10	100.0	100.0	

In terms of education, all the respondents at CHAZ have attained tertiary education. The quantitative study at CHAZ therefore dealt with people who were literate enough to understand some concepts and to analyse situations.

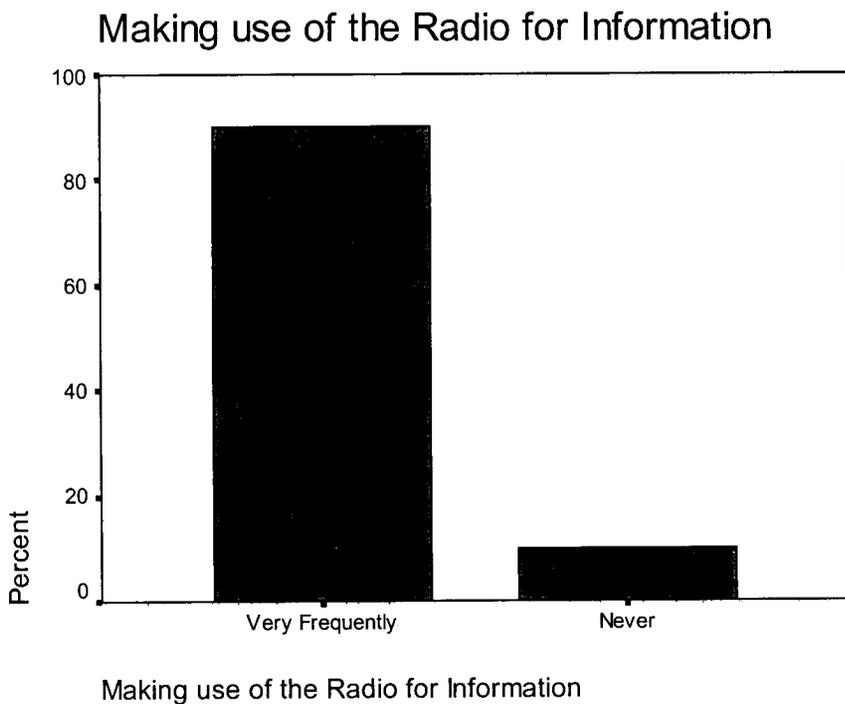
### 5.1.2 Use of the Television

Surprisingly, 100% of the respondents at CHAZ identified the television as one medium frequently used. Most of the information given about TB, Malaria and HIV/AIDS is frequently by the TV.

### 5.1.3 Use of Radio as communication medium

Radio as a communication medium to disseminate health information is also used frequently by as much as 90 percent of the respondents at CHAZ. Only 1% constituted those who never use the radio.

**Figure 3: making use of the Radio**



### 5.1.4 Use of Print media

Regarding the print media such as the Newspaper, the magazines, the brochure and pamphlets, generally a higher percentage constituted those who said they use them frequently at CHAZ.

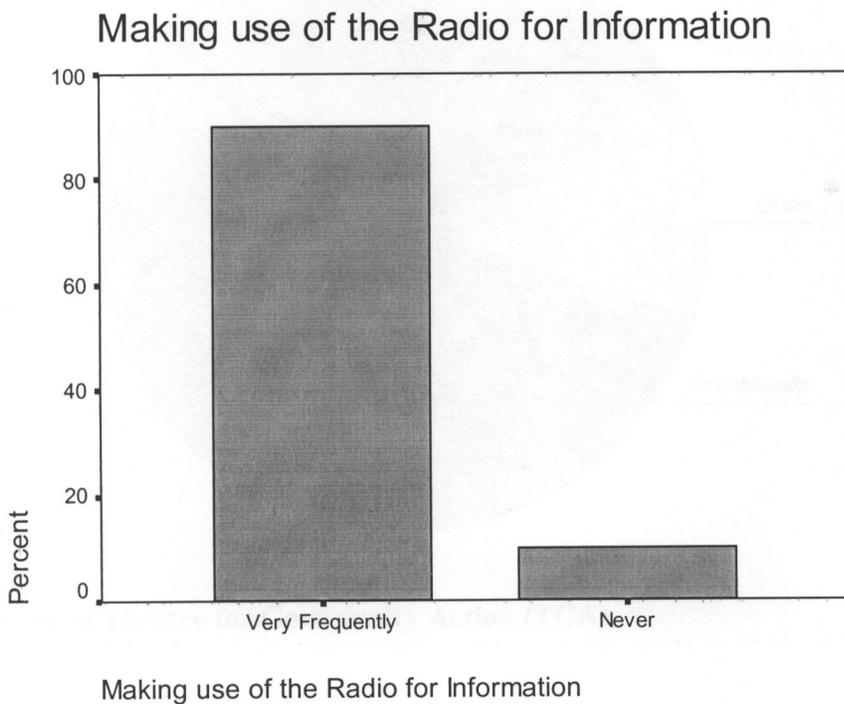
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### 5.1.4 Use of Print media

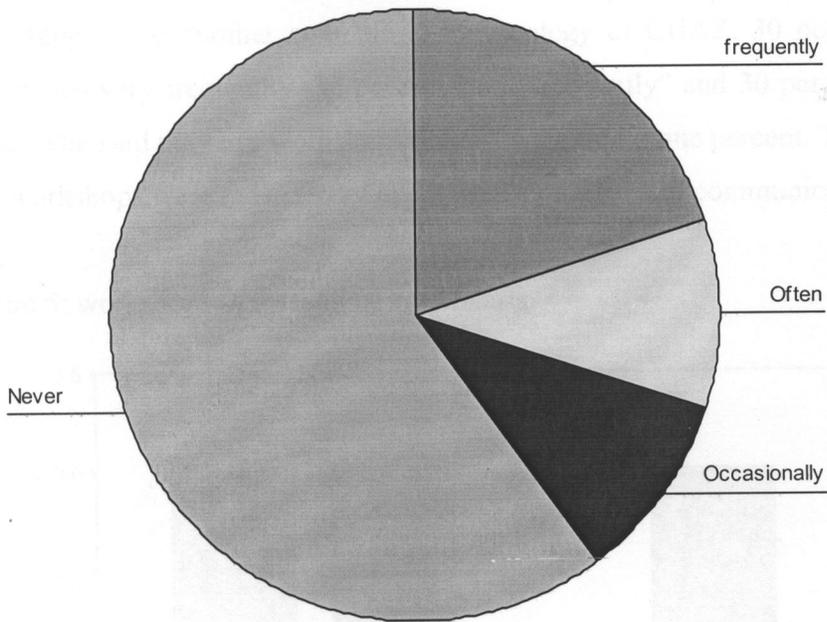
Regarding the print media such as the Newspaper, the magazines, the brochure and pamphlets, generally a higher percentage constituted those who said they use them frequently at CHAZ.

### 5.1.5 Use of the Internet

As for the internet, 60 percent said they never use the internet for communication at all. Those who said they use the internet "often" and those who said they use it "occasionally" constituted 10 percent each while those who said they use it "frequently" constituted over 20 percent.

**Figure 4: Internet in disseminating information**

### Internet in disseminating Malaria, TB and HIV/AIDS?



### 5.1.6 Use of Theatre for Community Action (TCA)

Regarding Theatre for Community Action (TCA), CHAZ respondents had very mixed responses possibly due to the fact that they were from different portfolios with different programmes and methods. 30 percent said they use the TCA frequently while 20 percent said very frequently. Those who said they use TCA often constituted 4 percent while those who said never constituted only 1 percent.

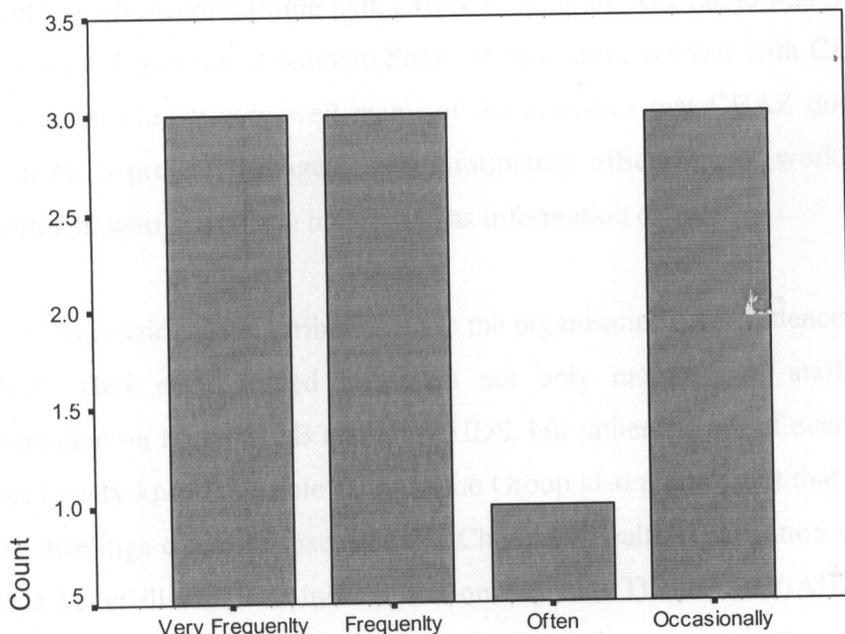
**Table 6: Theatre for Community Action**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very	2	20.0	20.0	20.0
	Frequently	3	30.0	30.0	50.0
	Frequently	4	40.0	40.0	90.0
	Often	1	10.0	10.0	100.0
	Never				
	Total	10	100.0	100.0	

**5.1.7 Use of the Workshops**

Workshops were another communication strategy of CHAZ. 30 percent said they use workshops very frequently. 30 percent said "frequently" and 30 percent "occasionally". Those who said they use workshops "often" were under one percent. This is an indication that workshops were indeed very much used as a means of communication by CHAZ.

Figure 5: workshops in disseminating Malaria



Workshops in disseminating Malaria, TB and HIV/AIDS?

### **5.1.8 Age of respondents \* Period of working with CHAZ Cross tabulation.**

It was noted that the older the respondents at CHAZ the fewer the years they have spent with the association. These people represent a mature generation of those who worked elsewhere before joining CHAZ.

### **5.1.9 Serious Health Problems against the age of the respondents Cross tabulation**

The table below indicates the percentage of the answers given from the respondents at CHAZ about what they consider to be the serious health problems. As can be noted, a higher percent of the respondents that said that it is actually HIV/AIDS that is the problem.

### **5.2 Focus Group Discussion Findings among CHAZ respondents**

The second part of the findings is from the Focus Group Discussions. One FDG was conducted at CHAZ and this was comprised of 8 members, comprising of the workers/volunteers who were fulltime with CHAZ secretariat. Age range was from 30 to 55 years. There were 4 men and 4 women. Some of them have worked with CHAZ for as long as 15 years and knew very well many of the activities that CHAZ does. There was one volunteer, 5 project managers, one information officer and 1 worker in the accounts department who previously had served as information officer.

The officers said they contribute a lot to the organisation and influence decisions made by CHAZ. They even argued that it is not only members of staff who disseminate information on Malaria, TB and HIV/AIDS, but rather the job of everyone at CHAZ and indeed every knowledgeable person. The Group also pointed out that several times there were meetings called to discuss ways Churches Health Association of Zambia (CHAZ) would better disseminate information on Malaria, TB and HIV/AIDS. These meetings were very participatory, the group said. Each member present in the meeting is allowed to contribute ideas.

On relationships with other organizations, the CHAZ group said that all is fine and smooth. Communication is excellent and the annual general meetings with all other organisations go on very well. The monitoring and evaluation also goes on very well, except that sometimes the association lacks personnel.

Radio and Television were, according to FGD, the most efficient and effective media used by CHAZ to disseminate information. There were, however, a few problems regarding Churches Health Association of Zambia (CHAZ) in their communication strategies to combat Malaria, TB and HIV/AIDS. These included insufficient personnel, funding, and vastness of the catchments.

Communication between members is not a big problem because they would use phones, emails and radio or Television announcements. However, sometimes it is a problem because of the vastness of the country. A few of the communication media were pointed out to be the most used ones. The group said CHAZ usually uses radio, TV, billboards, newspapers, magazines, brochures, posters and meetings. They also said that there is a very good cooperation between CHAZ and other organizations.

### **5.3 Characteristics of Respondents from Member Organisations**

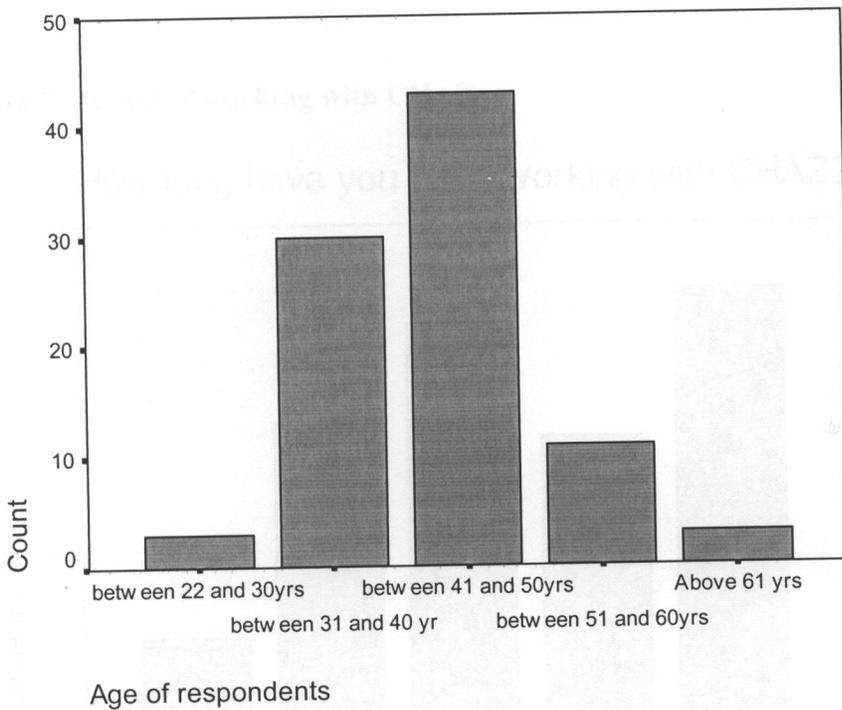
As can be observed from the table below, out of the 90 respondents, 41 were females while 49 were males. The results show that there were slightly more males interviewed than females.

**Table 7: Sex of respondents**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid male	49	54.4	54.4	54.4
Female	41	45.6	45.6	100.0
Total	90	100.0	100.0	

The age range of the respondents was between 22 years and 60 years. Results indicate that 3 of the respondents, however, were above 61 years. The graph for age distribution is given below:

**Figure 6: Age of Respondents**



3.3 percent constituted those who were between 22 and 30 years. 33.3 percent were between 31 and 40 years while 47.8 constituted those between 41 and 50 years. 12.2 were between 51 and 60 years while 3.3 were for those above 61 years.

### **5.3.2 Use of communication media**

On how much CHAZ makes use of the communication media in disseminating information about Malaria, TB and HIV/AIDS information, the following answers were given. Regarding the television the results show that 41 percent of the 90 respondents constituted those who said that the television is never used at all to disseminate the information. This explains two factors: firstly, most of the beneficiaries were in the rural areas of Zambia where the television is not watched. Secondly, it shows that not so many people can afford to buy the television. Only 13% said they get the information from the TV very frequently, otherwise, they get most of the information about TB, Malaria and HIV/AIDS frequently from other sources and not television.

### **5.3.4 Use of Print media**

Regarding the print media such as the newspaper, the magazines, the brochure and pamphlets, generally a higher percentage constituted those who said they use them frequently. This was followed by those who said they use them very frequently. 43% of the 90 respondents said that they use the newspaper frequently while 25 percent said very frequently. Those who said they use the newspaper often, constituted 19 percent while those who said occasionally constituted 13 percent.

Regarding the magazines, 41 percent said they use them frequently while 18 percent said very frequently. Those who said they use the magazines often, constituted 19 percent while those who said occasionally constituted 18 percent. Only 4 percent said they never use them. For the Brochure and pamphlets, 34 percent said they use them frequently while 29 percent said often. Those who said they use the brochures and pamphlets very frequently constituted 26 percent while those who said occasionally were only 11 percent.

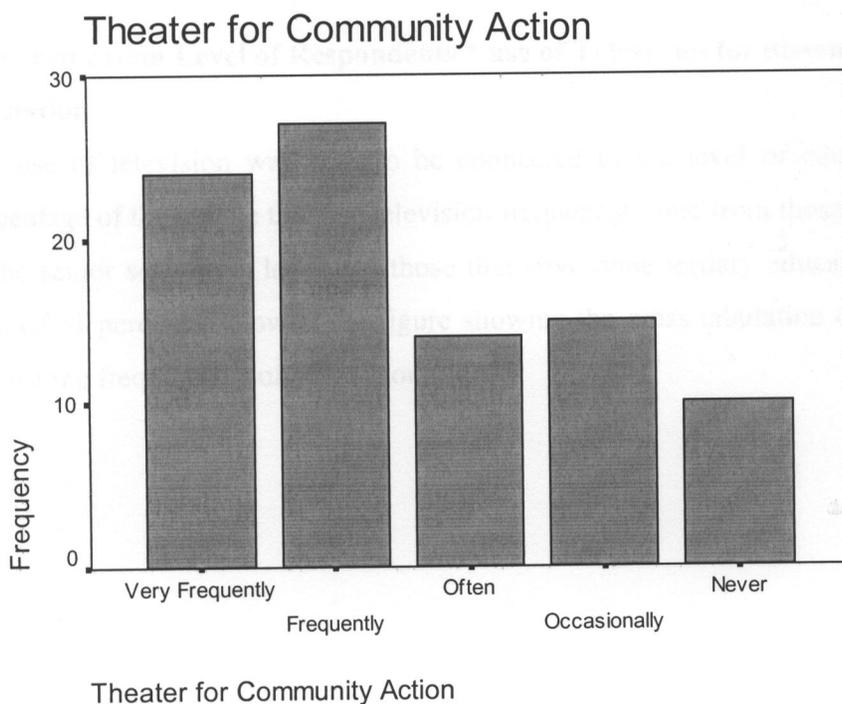
### 5.3.5 Use of the Internet

As for the internet, 43 percent said they use the internet frequently while 25 percent said very frequently. Those who said they use the internet often constituted 26 percent while those who said occasionally and never constituted 3 percent each.

### 5.3.6 Use of Theatre for Community Action (TCA)

Regarding Theatre for Community Action (TCA), figure 3 has the details of the percentages. A total of 89 percent said they use the TCA and only 11 percent said they never use it at all. The graph below illustrates the details:

**Figure 8: Theatre for Community Action**



### 5.3.7 Use of the Workshops

Workshops too were a communication strategy of the organisations that work with CHAZ. After conducting a survey, the following results indicate how often the 90 respondents use workshops: 23 percent constituted those who said very frequently. 33

percent said frequently and 38 percent said often. The positive percentage together comes to 94.

This is an indication that workshops were indeed very much used as a means of communication.

### **5.3.8 Age of respondents \* Period of working with CHAZ and other organizations Cross tabulation.**

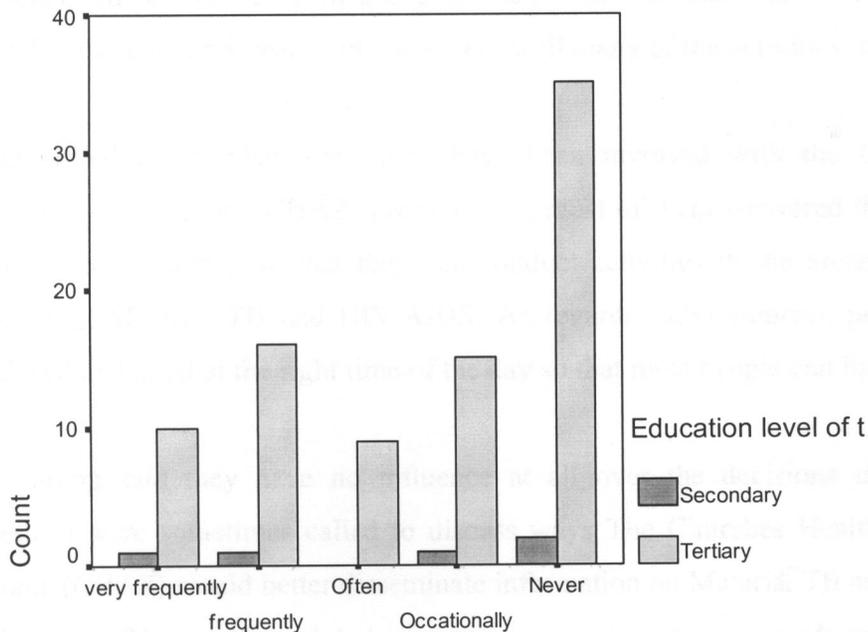
In some of the cross tabulations taken, it was noted that the partner organizations have more people aged between 31 and 50 years who have spent between 6 and 9 years in their respective places of work. These people represent a mature generation. It has been analysed that this age group represented 67 percent.

### **5.3.9. Education Level of Respondents \* use of Television for dissemination Cross tabulation**

The use of television was seen to be connected to the level of education. A higher percentage of the people that use television frequently came from those that have gone up to the senior secondary level and those that have done tertiary education. They make a total of 51 percent. Below is the figure showing the cross tabulation of education levels against the frequent use of Television.

**Figure 9: Education Level and Television**

Count



How much use do you make of the Television in disseminating Ma

**5.3.10. Education Level of Respondents \* Frequent use of radio and newspapers**

**Cross tabulation**

Very similar percentages have been reflected in the frequent use of radio and the newspapers for dissemination of health communication.

**5.4 Focus Group Discussion from other Organisations**

This FDG was the second to be conducted. The group was comprised of 10 respondents. This was comprised of 10 members from beneficiary organisations. The FGD targeted two sub-recipients from the Christian Council of Zambia (CCZ), two from the Evangelical Fellowship of Zambia (EFZ), three from the Coptic Church and one from the Young Women Christian Association (YWCA). The other two came from the Youth Alive Zambia and Nyampande Orphanage.

The two service organizations that provided the personnel were Yatsani Radio and Zambia Broadcasting Corporation (ZNBC), one person each. The range was from 28 to 47 years. There were 10 men and 2 women. Some of them have been partners with CHAZ for as long as 8 years and know very well many of the activities that CHAZ does.

When asked as to what ways they have been involved with the Churches Health Association of Zambia (CHAZ) Programmes, most of them answered that they get help in the form of money so that they can conduct activities in the areas of treating and controlling Malaria, TB and HIV/AIDS. As regards radio stations, programmes were produced and aired at the right time of the day so that most people can listen to them.

This group said they have no influence at all over the decisions made by CHAZ. Meetings were sometimes called to discuss ways The Churches Health Association of Zambia (CHAZ) would better disseminate information on Malaria, TB and HIV/AIDS on radio or TV. This group said that everything was well arranged in advance before CHAZ approaches them for a programme, and that there is cooperation between and CHAZ and themselves.

## CHAPTER SIX

### DISCUSSION OF FINDINGS

#### 6.0 Introduction

In this chapter, most of the findings were discussed and a personal view is given. As stated at the outset, the objectives of the practical attachment at CHAZ were to observe and assess through experiential learning:

- (i) The communication patterns and techniques used at CHAZ in the fight against Malaria, TB and HIV/AIDS
- (ii) The communication strategies and capacity of the Secretariat CHAZ in the fight against Malaria, TB and HIV/AIDS

#### 6.1 Analysis of CHAZ's environment

An association is a body made up of individuals or organisations sharing strong common interests which may be financial, professional, social, cultural or intellectual. The function of such a body is to advance the collective interests of its members. CHAZ is an association for Christian health care providers in Zambia. CHAZ's secretariat may be described as the focal organisation or the co-coordinating agency which advances the interests of the Association's members (i.e., Christian health facilities and Churches) through interaction with other players within the Zambian health sector. These other players that belong to CHAZ's environment were partners/donors, the Government, and organizations offering complementary or competing services. CHAZ can be termed as a professional body that bands together churches health care providers in Zambia. The Association's functions include advocacy, capacity building, training and networking, not forgetting of course, the role CHAZ plays in fighting TB, Malaria and HIV/AIDS.

## **6.2 Issues of Gender, Age and Education at CHAZ.**

The CHAZ secretariat is very gender sensitive. There is no office at CHAZ that does not have a female or one without a male member. When it came to focus group discussions, both sexes were equally represented.

Regarding the issue of age, CHAZ has a generally youthful age group. A higher percentage of the respondents also is less than 55 years: therefore it is a younger generation that was interviewed.

All the members of staff at CHAZ were highly educated up to tertiary level. The quantitative study therefore dealt with people who were literate enough to understand concepts and to analyse issues and situations.

## **6.3. CHAZ's contribution to human development**

Health and development go hand in hand. CHAZ is an important actor in the Zambian health sector. The association provides a significant percentage of the country's health care services. As a Christian association, its affiliated health facilities provide health services that were distinct from those given by state and private/commercial facilities.

The main difference is that church-run facilities which were non-profit installations and, therefore, ensure that even economically constrained individuals and communities have access to health services. 'Wilcox et al (1989) confirm the importance of non-profit organisations in a society's development when they wrote:

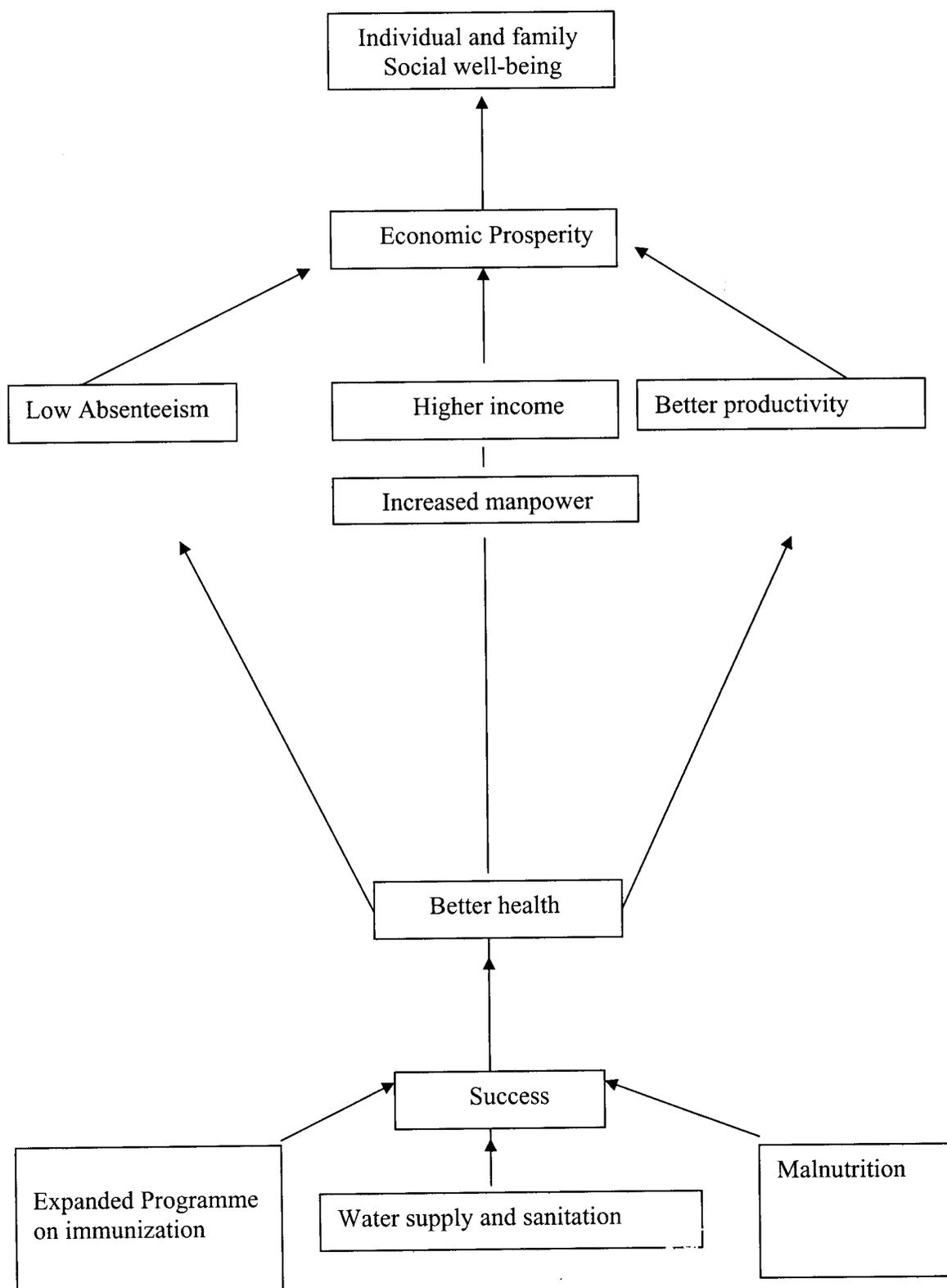
"Much of society's effort to enrich contemporary life and to improve individuals well being is carried out by non-profit Organisations that depend upon volunteer help and financing... social service, cultural, medical, educational and religious Organisations exist to improve the human life condition." (Wilcox et al., 1989: 447).

CHAZ also advocates a holistic approach to health care, that is, one that encompasses the concept of well-being. It is the preventive strategies which assure the consideration of individual and community social welfare by focusing on aspects of social well-being such as:

- a. Nutrition,
- b. Clean water supply,
- c. Immunisation,
- d. Family planning and,
- e. General living conditions, e.g. environmental, occupational and domestic factors.

The services provided by CHAZ were important since this kind of holistic health is essential to the achievement of sustainable development within any country. Mohith and Beyene (1984) clearly illustrate this argument in the schematic outline shown in Figure 13 on the following page.

Figure 10: Health and Human Development (Source: Mohith/ Beyene 1990)



CHAZ health facilities mirror Mohith and Beyene's perception of health through their collective mission of providing holistic health care. One needs to point out that there is a timely shift in the understanding of health by the Secretariat and member units and Churches as a state of wholeness in all encompassing dimensions of life, and not simply absence of disease. The understanding of health must govern how it has to be taken care of, particularly in the context of the Church. The Church has many opportunities to promote wholeness among individuals, families and communities beyond medical facilities.

The Christian character of CHAZ enables it to have, as apriority, the well-being of the society. Through the churches, the association is able to provide an appropriate network structure that reaches the grassroots of the community. Note that the Church has a network that goes down to individual households, congregations and communities and is, therefore, well-placed to facilitate a community-based approach and which builds on people's own initiative, resources and agenda.

#### **6.4. Discussion of Communication Strategies**

The above discussion underlines the importance of the services provided by CHAZ. The activities of one facility alone were not enough to make a significant impact on the development of the country. Concrete efforts were therefore more effective in assisting toward the goal of better health and well-being in the nation. In order to do this CHAZ needs to maintain a strong network, and networking links with its members, i.e., there must be very good communication strategies in place.

According to Weick's Organizational Information Theory (1979), communication is a crucial means by which organisation occurs. The free flow of information within a system is the key to establishing strong relationships. In the case of CHAZ's organisation set, the Secretariat needs to maintain constant communication with the Association's members in order to ensure that there is free flow of information within the system. If the Association is considered as being a network, then the Secretariat is the focal

organisation and, therefore, the hub of the network. CHAZ is a large network. There were, at the time of writing, 129 health institutions and community based church organizations affiliated to it representing 16 different churches and church organizations.

Together these institutions were responsible for more than 50% of formal health services in the rural areas of Zambia and about 30% of health care in the country as a whole (CHAZ,2005).

The strategies set up to facilitate communication flow within the association were the focus on the use of both print and the broadcasting media. These include the T.V, radio, newspapers magazines, internet, brochures, pamphlets and posters. Others were the Theatre for Community Action (TCA), workshops, testimonies, health talk, dialogue, Peer Education and meetings. CHAZ is always successfully using these strategies to reach out to the beneficiaries in Zambia.

The researcher learnt that to enable the secretariat fulfil its responsibilities to the members of the association, CHAZ has realized the importance of developing the Secretariat communication. To this effect, CHAZ has established a Communication/information centre. There has been a strong emphasis on electronic communication and information technology that will allow the Association to communicate faster and more efficiently. The CHAZ secretariat has invested in electronic communication technology to enhance its networking capacity through investment in the area of information technology. This has been done by purchasing new computers for the Secretariat, updating the existing ones, and then networking all computers on local and wide area networks (i.e. LAN and WAN). This has established internet and e-mail facilities for the Secretariat. At the secretariat level, this is important because the Secretariat has trained its staff to use the new hardware and software that has been purchased. This has been done through on-job training and workshops conducted both in-house and out-house. At the association level, the technology does not translate as relevant technology since many of the rural members do not have computers, and therefore not connected to internet and e-mail services. A few of

CHAZ's larger members, mainly the hospitals, do have compatible technology. However, the majority of the Association's members, particularly those in rural and poverty-stricken areas, were not even connected to telephone services. Consequently the information technology which the Secretariat has invested in will not be an effective networking tool until a majority of members have attained the same/compatible technology to enable effective interfacing. This is an important consideration for interactive media because such media can only become effective when most of the members within that system have adopted the same technology.

Networking implies interactivity and, therefore, it should facilitate mutual discourse among the parties involved. Rogers' (1995) explanation of critical mass in the adoption of interactive technology, underlines the interdependence that exists in adoption decisions of members of a system in order to make interactive media self-sustaining.

He stated:

The critical mass occurs at the point at which enough individuals have adopted an innovation so that the innovation's further rate of adoption becomes self-sustaining. The interactive innovation is of little use to an adopting individual unless other individuals with whom the adopter wishes to communicate also adopt. Thus a critical mass of individuals must adopt an interactive communication technology before it has utility for the average individual in the system (Rogers, 1995: 313).

The technology that CHAZ has invested in has not yet achieved critical mass in terms of adoption within the Association's internal system. Although the new technology has enabled the Secretariat to interact more easily with organisations in its environment, such as partners and donors, it has not been very successful in terms of serving as an internal networking tool for the Association. It will only become so if a larger portion of its members were able to invest in the same technology and train their staff to be able to use it.

CHAZ has invested in a quarterly publication, *CHAZ Information News Letter*, as a second strategy and networking tool. This second networking tool is cheaper and, therefore, more easily accessed by the members of the Association than e-mail and internet services. The Secretariat has the staff capacity to produce this particular medium and is also at times relying heavily on external experts. The network newsletter is also faced with the problem of distribution and this means that the end-users (i.e. the association members) have the ability to use the medium some of them do not have access to it.

### **6.5. Role of the CHAZ Secretariat**

As stated earlier it has been identified that the Secretariat is the focal organisation of the CHAZ network. The central positioning of the Secretariat establishes it as the co-ordinating centre. The role of the CHAZ secretariat has changed several times during the association's history and its renewed mandate focuses facilitation through activities of advocacy, training and capacity building. It is important for a focal organisation, which co-ordinates the activities of other organisations, to have the staff capacity to carry out this function.

During the attachment period the secretariat had 25 employees as its staff team, whereas the membership they served was at 326. It was noted that the Secretariat's facilitation activities were performed by the Executive Director's office, the Institutional Development Department and the Programmes Department with logistical, administrative and accounting support from the Finance and Administration Department. This means that less than half of the staff performed tasks that were directly related to the Secretariat's facilitative role, while the rest provided supportive functions.

**Table 8: Secretariat staff tasks allocation: Source, CHAZ 2006**

Secretariat functions/tasks	Staff
1. Advocacy, capacity building,	<ul style="list-style-type: none"> <li>• Executive Director</li> <li>• Institutional Development Manager</li> <li>• HCTS Officer</li> <li>• MIS Officer</li> <li>• Technical Training Officer</li> </ul>
2. Accounting and logistical support	<ul style="list-style-type: none"> <li>• Accountant</li> <li>• Accounts Assistant</li> <li>• Driver/mechanic</li> <li>• Messenger</li> </ul>
3. Administrative and secretarial support	<ul style="list-style-type: none"> <li>• Executive Secretary</li> <li>• Secretary</li> <li>• Receptionist/typist</li> </ul>
4. Subordinate support staff	<ul style="list-style-type: none"> <li>• Security guard</li> <li>• Cleaner/messenger</li> </ul>

A major problem identified by the student, was that of role overload. The staff members most severely affected by this problem were management, the field officers and the accounting staff. The main issue of concern here is that these staff were the key actors enabling the Secretariat to carry out its functions.

## CHAPTER SEVEN

### CONCLUSION AND RECOMMENDATION

#### 7.0 Introduction

There are two parts in this Chapter. Firstly, a few insights are mentioned and summarised. Secondly, there are recommendations for a few interventions that CHAZ needs to undertake so as to reach out to the beneficiaries country wide.

#### 7.1 Conclusion

This research report has explored the various communication strategies taken by the Churches Health Association of Zambia (CHAZ) in its efforts to facilitate people's health and development. The extent to which each independent variable influences communication has been explored in the work. From the results that were obtained from the quantitative as well as the qualitative survey, it has been seen that CHAZ is using various communication strategies in order to facilitate the health and development of the people of Zambia. The radio and Television programmes were some of the strategies CHAZ was using. There is still conviction that radio remains the most popular, accessible, and cost-effective means of communication for rural people. Radio can overcome the barriers of distance, illiteracy and language diversity better than any other medium (R. Del Castello, 1996). This is the reason why CHAZ uses radio and television.

With the surge in numbers of community radio stations on the one hand, and decentralization of capital city-based networks to include regional and local stations on the other, the development of radio communication appears to be under way.

The findings showed that rural organisations were less likely to use the television than urban ones. This is probably because urban organisations and beneficiaries have better

access to these facilities and therefore get quick information, health care services, and even recreation facilities. The respondents' educational level showed a significant association with the understanding of the issues that were being discussed.

The human development report recognises that education affects all types of human development outcomes. More than just a source of knowledge, education promotes better hygiene and increases the use of health services. They will learn about safe water and adequate sanitation and these will determine health outcomes. By reducing infectious diseases, they improve children's nutritional status and increase their learning abilities. Together such interventions contribute to a health transition - from having communicable diseases account for most of a country's disease burden to having chronic diseases as the main source. This notion of synergies among social investments is central to reducing hunger, malnutrition, disease and illiteracy—and to advancing human capabilities.

The results of the study should, however, be interpreted with caution as there were many other unexplored factors that contribute relatively to CHAZ's success in its programmes.

## **7.2 Recommendations**

Having looked at the communication strategies taken by the Churches Health Association of Zambia, the following were recommended in order to do even more in enhancing health and development: -

### **7.2.1. CHAZ must continue instituting participatory communication**

Participation of the beneficiaries of an intervention avoids the assumption that the change agent's way or logic is correct, universal and applicable to all. Before any programme is instituted the community must be involved in problem identification and definition. They should be able to help identify alternative solutions to the problem of TB, Malaria and HIV/AIDS: and come up with strategies to resolve the problem.

## **7.2.2 Develop more Policies**

CHAZ must work hand in hand with the Government of the Republic of Zambia to develop policies that can successfully favour such associations as CHAZ so that more people can benefit and enhance quality of life.

## **7.2.3. Make an extra effort to help government so that Education is more accessible**

CHAZ together with the Government also need to make an extra effort to ensure that education is more accessible to low-income families and rural populations, with special attention to the quality of the education provided and the need for girls to complete school. Richer countries both inside and outside the region are encouraged to help resource-poor countries improve their educational systems and collect data on their progress. Improving access to and the quality of education is the most rewarding investment a country can make. This will accelerate the country's economic and social development by enhancing human capital, slowing population growth, and alleviating poverty.

## **7.2.4 Undertake Community Analysis**

The starting point for any community-based activity is to get to know the community. It is important to have a profile of the community in order to identify any special features, which will affect the success of the programme. In any community there will be some individuals with special influence. It is important to find out who the opinion leaders are and what they think are the needs of the community. CHAZ should continue facilitating the undertaking of community analysis as it embarks on its programmes. Communication in this case should take the audience's perspective.

## **7.2.5 CHAZ should continue facilitating or commissioning research**

Research will help in providing detailed information on issues of TB, Malaria and HIV/AIDS as well as behaviour change.

### **7.2.6 Emphasis on services to women**

CHAZ should in addition provide and emphasise other equally important services to women and their families such as primary healthcare and reproductive health services, and developmental programmes like the provision of adequate housing, employment and so on. This will ultimately improve women's welfare thereby sustaining human development in the country.

### **7.2.7 Publicise the Programmes in community Media**

Publicising service does not only make people aware of the services being provided but serves as its main purpose to attract people to the service. The "school of the air" is a very popular variation of using media such as the radio for distance education. This can be used to fuse in CHAZ programmes on community media so as to reach out to many. These contribute to people's advance in Knowledge, Attitudes, and Practices (KAP). Community media were most of the time community focused, and the national mass media is nationally focused, but surely they were serving the same purpose, namely educating, informing and helping in fostering development. Taonga Market teaches basic education to Zambia's out-of-school children, grades 1-5, throughout the country. The success of the series demonstrated that media like radio can be an effective tool to mitigate the impact of TB, Malaria and HIV/AIDS.

### **7.2.8 Invest in Communication Technology**

Investment in technology, particularly in costly technology, should take in consideration the relevance of the technology to its end users. Communication technology invested in must not intend ultimately for the benefit of the Secretariat but rather for the association's members, careful, of course, to guard against the prevailing tendency in developing countries of investing in communication technology that is costly but not very relevant to their situations. CHAZ, therefore, needs to make the information/communication technology that it has at its Secretariat, relevant to the needs of the association by making

it accessible, affordable and reliable. This may be done by building up the technology capacity at the member facilities that corresponds with the capacity at the Secretariat. Efforts should also be made to improving the distribution of the newsletter so as to make the medium available to all members.

#### **7.2.9 Involve other Organisations or Stakeholders**

It was very clear that other organisations needed to be involved in the dissemination of TB, Malaria and HIV/AIDS information and education in Zambia. Networking and collaboration in community programmes has a synergic effect. It is generally acceptable that collaboration leads to reduction in costs by avoiding duplication of efforts. It also creates opportunities for multiple points of view and may contribute to quality programming. It was clearly established that CHAZ could not do everything and therefore needed other organisations to collaborate with especially in community outreach activities such as drama, TCA, sport, community talks and other community activities.

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Appendix

**QUESTIONNAIRE FOR CHURCHES HEALTH ASSOCIATION OF ZAMBIA  
(CHAZ) WORKERS INVOLVED IN COMMUNICATIONS AND THE SUB-  
RECEPIENTS IN ZAMBIA**

Name of the Organisation.....

**Kindly answer the following questions. Simply tick what is applicable.**

**Section A**

**Identification**

**1. Sex**

1. Male

2. Female

**2. For how long have you been working with CHAZ?**

1. Less than 1 Year

2. 2- 5 Years

3. 6- 9 Years

4. 10- 13 Years

5. above 13 Years

**3. Age of the Respondent:**

1. 21 yrs

2. between 22 and 30yrs

3. between 31 and 40yrs

4. between 41 and 50yr

5. between 51 and 60yrs

6. above 61yrs

**4. Education level of the Respondents**

1. Primary

2. Secondary

3. Tertiary

**Section B****Communication Strategies****How much use do you make of them? following in disseminating Malaria, TB and HIV/AIDS information**

	<b>1. Very Frequently</b>	<b>2. Frequently</b>	<b>3. Often</b>	<b>4. Occasionally</b>	<b>5. Never</b>
<b>5. T.V</b>					
<b>6. Radio</b>					
<b>7. Newspapers</b>					
<b>8. Magazines</b>					
<b>9. Internet</b>					
<b>10. Brochures, Pamphlets and Posters</b>					
<b>11. Theatre for Community Action (TCA)</b>					
<b>12 Workshops</b>					
<b>13. Testimonies</b>					
<b>14. Health Talks</b>					
<b>15. Dialogue</b>					
<b>16. Peer Education</b>					
<b>17. Meetings</b>					
<b>18. Others, (Please specify).....</b>					

From your experience, how fast/ quick is the following medium in disseminating Malaria, TB and HIV/AIDS information to reach the people.

	1. Very Fast	2. Fast	3. Slow	4. Very Slow
19. T.V				
20. Radio				
21. Newspaper				
22. Magazines				
23. Internet Brochures, Pamphlets and Posters				
24. Other People				

25. Basing on Communication Strategies you use, has there been a reduction of Malaria, TB and HIV/AIDS infections?

- 1. Yes
- 2. No
- 3. I am not sure

26. Have you encountered different approaches and angles to stimulate discussion around the problem?

- 1. Yes
- 2. No

27. Has there been a contribution on the Development of the country due to your existing communication strategies?

- 1. Yes
- 2. No
- 3. I am not sure

Where CHAZ is the Producer please answer the following questions by circling

MEDIA	TARGET AUDIENCE
38. News Letter	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
39. T.V	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
40. Radio	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
41. Newspaper	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
42. Magazines	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
43. Internet Brochures,	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
44. Pamphlets and Posters-	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
45. Other People	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above
46. TCA	1. Youths 2. Adults 3. Service providers 4. persons with Disabilities 5. All of the above

47. Do you have a resource centre for Information, Education and Communication materials?

- 1. Yes
- 2. No

48. Which problems/ challenges/ issues do you face in your communication approach?

1. Organizational,

specify.....

.....  
.....

**2. Transport ,**  
specify.....  
.....  
.....

**3. Financial,**  
specify.....  
.....  
.....

**4. Staffing,**  
specify.....  
.....  
.....

**5. Others (Please**  
**Specify).....**  
.....

**49. Do you have any individual beneficiaries of CHAZ, other than organizations?**

- 1. Yes
- 2. No

**50. What are the serious health problems of the people you are dealing with?**

- 1. Sexually Transmitted Infections
- 2. HIV/AIDS
- 3. Malaria
- 4. Drug Abuse
- 5. Tuberculosis

**51. Have you addressed and identified the concerns?**

- 1. Yes
- 2. No

**52. How good is Communication from CHAZ to other Organisations?**

- 1. Excellent**
- 2. Very adequate**
- 3. Adequate**
- 4. Fairly adequate**
- 5. Inadequate**
- 6. Very inadequate**

**53. How good do you think is CHAZ's awareness of activities on the ground?**

- 1. Very aware**
- 2. Aware**
- 3. Moderately aware**
- 4. Not aware**

**54. What do you think is the focus of CHAZ Activities?**

- 1. Behaviour Change**
- 2. HIV/AIDS**
- 3. Youth Unemployment**
- 4. General health**

**55. Does the Educational Information from CHAZ help prevent disease?**

- 1. Yes**
- 2. No**
- 3. Not Sure**

**56. How does CHAZ contribute to other Organisations?**

- 1. Very enough**
- 2. Enough**
- 3. Moderately enough**
- 4. Not Enough**
- 5. Very little**

**57. In your opinion which of the following is the Best media for disseminating information?**

- 1. Radio**
- 2. Television**

**3. Newspaper**

**4. Brochures**

**5. Internet**

**58. How does your Organisation Participate in CHAZ's Programmes?**

**1. Very adequate**

**2. Adequate**

**3. Fairly adequate**

**4. Inadequate**

**5. Very inadequate**

**59. How would you rate the communication strategies from CHAZ?**

**1. Very good**

**2. Good**

**3. Fairly good**

**4. Poor**

**5. Very poor**

**60. Would you Recommend CHAZ as one best Association to belong to?**

**1. Yes**

**2. No**

**3. Not sure**

**61. In your opinion, How Successful are the programmes of CHAZ?**

**1. Very successful**

**2. Successful**

**3. Moderate**

**4. Unsuccessful**

**5. Totally unsuccessful**

**62. Does CHAZ Monitor and evaluate your programmes?**

**1. Yes**

**2. No**

**63. Is a framework provided for working with CHAZ?**

**1. Yes 2. No**

**IN- DEPTH INTERVIEW QUESTIONNAIRES (CHURCHES HEALTH  
ASSOCIATION OF ZAMBIA (CHAZ) WORKERS/ VOLUNTEERS AND OTHER  
RELEVANT ORGANISATIONS)**

1. In what ways have you been involved with thee Churches Health Association of Zambia (CHAZ) Programmes?
2. For how long have you been involved in Churches Health Association of Zambia (CHAZ) activities?
3. Have you been involved in Churches Health Association of Zambia (CHAZ) Project Management Structures?
4. If yes, how long have you served in Churches Health Association of Zambia (CHAZ) Management?
5. Are you in any way able to influence decision made by CHAZ
6. Some people say that it is not only members of staff who disseminate information on Malaria, TB and HIV/AIDS. What is your view?
7. Are there any meetings called to discuss ways Churches Health Association of Zambia (CHAZ) would better disseminate information on Malaria, TB and HIV/AIDS?
8. If they have been, how effective do you think they have been? Are the meetings participatory?
9. Are there meetings or workshops held at Churches Health Association of Zambia (CHAZ) to sensitize workers/ volunteers on how to fight Malaria, TB and HIV/AIDS? Have they been participatory?

10. In your view, is the approach used by Churches Health Association of Zambia (CHAZ) to disseminate information on Malaria, TB and HIV/AIDS effective?
11. If it is effective, what do you mean?
12. How has been the relationship between Churches Health Association of Zambia (CHAZ) and other organizations, involved in combating Malaria, TB and HIV/AIDS?
13. Has there been any monitoring and evaluation on funded projects in these organizations?
14. Which types of media do those funded organizations use (if any)?
15. What are the weaknesses for Churches Health Association of Zambia (CHAZ) in their communication strategies to combat Malaria, TB and HIV/AIDS?
16. What are the strengths of Churches Health Association of Zambia (CHAZ) in their communication strategies?
17. What is your view of the way you receive and send information at Churches Health Association of Zambia (CHAZ)?
18. How does CHAZ use any of the following communication strategies to disseminate Malaria, TB and HIV/ AIDS information?
1. Radio, 2. TV, 3. Billboards, 4. Newspapers, 5. Magazines,
  6. Brochures, 7. Posters, 8. Meetings.
19. To what extent is there make of research from the field?
20. How much collaboration is there with other organizations doing similar work?
21. How do you co-operate?