

GHANA INSTITUTE OF JOURNALISM

COMMUNICATING HEALTH ISSUES TO THE RURAL FOLKS: THE
ROLE OF THE COMMUNITY INFORMATION CENTRE. A STUDY OF
THE EMMANUEL INFORMATION CENTRE IN OFOASE IN THE
ASANTE-AKIM SOUTH DISTRICT.

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DECLARATION

STUDENT'S DECLARATION

I, Dominic Prempeh, declare that this dissertation, with the exception of quotations and references contained in published books which have all been identified and acknowledged, is entirely my own original work, and that it has not been submitted, either in part or in whole, for another degree elsewhere.

SIGNATURE: .....

DATE: 30/10/15.....

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and submission of this dissertation was supervised in accordance with the guidelines for writing thesis laid down by the Ghana Institute of Journalism.

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DEDICATION

I dedicate this research to my uncle, Mr. Charles K. Brefo, my aunt Grace Agyare and my friend George Opoku Adu.

ABSTRACT

It is believed that Community Information Centres have come to stay. In their duty of informing, educating and entertaining the local people, plentiful of these Community Information Centres have been communicating health in their various communities. This study was done to assess how Community Information Centres communicate health issues to the rural Ghanaian. The findings did show that Emmanuel Information Centre, the facility chosen for the study, follows some of the theoretical underpinnings (Media Advocacy Theory, Agenda Setting Theory, and Diffusion of Innovation Theory) reviewed under the study. The hard fact is that the communal people that are the recipients of this health communication are not involved in the communication process and the health programmes that are communicated to them. Another fact that came to bare is that Community Information Centres, with emphasis on Emmanuel Information Centre, make noise and create a sort of nuisance to the communal populace.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CFSC	Communication for Social Change
CIC	Community Information Centre
CMC	Community Multimedia Centre
GDHS	Ghana Demographic and Health Survey
GIFEC	Ghana Investment Fund for Electronic Communications
HIV	Human Immune Virus
ICT	Information and Communication Technology
IMCFSC	Integrated Model of Communication for Social Change
JHS	Junior High School
LDCs	Least Developed Countries
MC	Master of Ceremonies
MDGs	Millennium Development Goals
SHS	Senior High School
UNESCO	United Nations Educational Scientific and Cultural Organization
UNMD	United Nations Millennium Development
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Information dissemination in the communal Ghanaian society was normally done through the gong-gong beater years ago. That form of communication lacked the feedback approach that communication entails. Radio, Television, Newspapers and the internet came in to give a modern trend to information dissemination. These media forms also came with their peculiar flaws of being 'urban biased' in ownership, programming, content, and location. Community Media, the supposed remedy to fill the urban-rural gap of information dissemination in Ghana, has not been generally effective. This is due to its fewness in the country. Community information dissemination centres, popularly known in Ghana as 'Information Centres', have been the new occurrence in information dissemination in the localities of Ghana. It is believed that these Information Centres have come to fill the gap created as a result of the urban-bias of the Ghanaian media. It is also assumed that these Information Centres will replace the erstwhile gong-gong beating in the various communities.

I, therefore, decided to embark on this study to look at how the information dissemination centres in Ghanaian communities, especially the ones in the rural areas and emphasizing on 'Emmanuel Information Centre' in Ofoase, communicate information on health issues to the local people.

1.1 Background to the Study

Sicknesses and health related issues have been a worry to every government of developing nations and its people. "...the pattern of disease in Ghana demonstrates a preponderance of communicable diseases, under-nutrition, and poor reproductive health" (Ghana E-Health Strategy, 2010:15). Morbidity and mortality of these sicknesses are always high because of the poverty rate of the people and their inability to access a good standard of living. Preventable and curable diseases also affect the people due to their inability to access health information in any form. Access to information on health issues would drastically reduce sicknesses such as malaria, diarrhoea and pneumonia (Ghana E-Health Strategy, 2010). It is therefore not surprising that global Health communication has been very massive in recent years. More organizations (Governmental, Non-Governmental and inter-governmental) and personalities (Bill Gates, Jimmy Carter) have currently involved themselves in communicating health issues and providing health care to the citizens of less endowed countries including Ghana. The above indications buttress the point that healthcare is prominent in the empowerment of the human race as explained by themes 4 (Reducing child mortality), 5 (Improving maternal health), and 6 (Combating HIV/AIDS, malaria

and other diseases) of the Millennium Development Goals (United Nations Millennium Development Summit, 2000). And, for a society to be healthy, it needs to get accurate information on health issues and use that information for the wellbeing of the people (Stetson & Davis, 1999).

Health communication research, therefore, is to identify and address more effective communication strategies to improve the overall health of society (Stacks & Salween, 2008). However, most of the health communication and other development programmes are urban biased. The urban audience is targeted due to the commercialization of the media as a result of the media's reliance on adverts and commercials for survival. And these adverts and commercials come from and are patronized by the urban centres (McMichael, 2012). The 2014 Ghana Demographic and Health Survey (2014) explain that the urban dwellers, especially women, are knowledgeable about HIV prevention methods than their rural counterparts; an outcome of the urban-centeredness of the Ghanaian media outfits. The rural population therefore suffer the effect of what Ugboajah (1972) called the umbrella of mass media dysfunction. The model explains that educated elite and urban rich have full access to the mass media. The suburban population enjoy less so. But, the urban-poor and rural populations have very little or no access to the mass media at all. They are virtually cut-off from profitably engaging in media communication. This mass media dysfunction led to the quest for a decentralized and pluralised media system to allow even-handedness in national communication affairs.

The basic aim of decentralizing the media terrain: reaching the relegated communities and abandoned people, has also not been very effective (Hoffman & Metzroth, 2010). Locally, it is speculated that the Information Services Department and the National Commission for Civic Education vans from the Metropolitan, Municipal and District Assemblies that disseminate information to the rural communities reach these communities at mid-morning whence almost the entire communal citizenry have gone to their various farms. This bereft the vulnerable rural Ghanaian, who is the neediest in accessing information through any means, the affordable interventions and means that would enhance their knowledge on health issues.

The introduction of Community media was purposely to fill the communication gap. Despite the efforts by community radio to enhance access to information by the rural Ghanaian dweller (Abbey-Mensah, 2006), not everyone in the countryside has access to this health information (Ghana E-Health Strategy, 2010). And such is the fate of the inhabitants of Ofoase in the Asante Akim South District of the Ashanti region. The inaccessibility of the Ofoase inhabitants to health information through the media is due to two main reasons. Firstly, the inhabitants of Ofoase, a community in a highly dense African forest, are predominantly farmers. They therefore go to farm as early as dawn and come at dusk. This agrarian lifestyle denies the people from accessing information and other development programmes, which are mostly disseminated in the day time, on radio and television (National Population and Housing Census, 2010). The second

factor is that the district in which Ofoase is (Asante-Akim South District) does not have any local television or radio facility, whether commercial or communal. The district therefore relies on the radio stations in the other districts and the Kumasi metropolis for information. This makes vital information eludes them due to the fact that though the signals of these radio and television stations are received in Ofoase, their programmes are not for the rural poor. The health programmes presented by such media houses target the immediate consumers (urban listeners) who are metropolitan elites and middle-classed municipal and urban dwellers. Such situations make it very essential for the introduction of a communication facility that would create platforms for the rural poor to also access information (The Broadcasting Bill, 2014).

It is therefore generally believed that the reliable alternative to access information on health issues, and any other issues, by the people of Ofoase, and for that matter plentiful of the rural communities in the district and Ghana as a whole, is through the Community Information Centres. These Information Centres, arguably the most popular of information dissemination outfits in Ghana currently, are found everywhere in the country: the market square, lorry parks, city centres, and rural areas, among other places. And to De-graft Fokuo, the District Chief Executive of the Asante Akim South District, these Information Centres are, presumably, the fastest growing communication channel in the Ghana.

Hence, with information dissemination to the local Ghanaian taking a new turn through the Community Information Centres, it is very necessary to study these facilities as they communicate especially health issues which are technical.

1.2 Profile of Ofoase

Ofoase is in the Asante-Akim South District (the gateway to the Ashanti region through the Accra-Kumasi highway) of the Ashanti Region. The District is located at the eastern part of Ashanti with its eastern boarder forming part of the boundary dividing Ashanti and Eastern Regions. The District also shares boundaries on the North and North-West with Asante Akim North Municipal and Kwahu South District on the West. On the South-West lies Bosome Freho District and on the South-East is Birim North District in the Eastern Region. Juaso is the Capital (ghanadistricts.gov).

Ofoase is located South-West of Juaso. It is about Forty-minute drive from Juaso. It has 4,221 inhabitants (GDHS, 2014). It has a senior high school; about six basic schools, a police station, and a banking agency. Friday is the market day. It has tarred road linking Juaso. The inhabitants drink from deep-well hand-pump taps. The Ofoase populace are predominantly farmers, especially subsistence. They also cultivate cash crops like cacao, oil palm, citrus, and rice. They therefore go to farm as early as dawn and return at dusk; especially during the planting and harvesting seasons. The people are largely Akans with the Ashanti dominating.

Other tribes as the Akwapim and a cluster of tribes from Northern Ghana also inhabit the community. Almost everybody speaks the Asante-twi dialect. Christianity dominates the other religions; with a mixture of both orthodox and charismatic churches as well as prayer groups scattered all around the community. There are also a collection of Muslims who are predominantly settlers from Northern Ghana. African Traditional Religious groups also inhabit Ofoase with few Fetish Shrines and fetish priests. Politically, it is a zonal-council capital with some other communities under its jurisdiction. Traditionally, the Ofoase royal stool is a paramount stool under the Asante Royal Stool. It therefore has a Traditional Council of Chiefs. Customarily, it is a taboo to go to farm on Tuesdays. The citizens therefore use Tuesdays to rest and do communal activities. In health and health-care issues, Ofoase is in level 'A' under the three-tier primary health care system. Level 'A' is the community level consisting of traditional healers, chemical sellers and community clinic. Ofoase has a community health centre with a medical assistant, six nurses, and a midwife. Herbal medicine and traditional healers are rampant in the community. The community has one information dissemination facility (Emmanuel Information Centre) that broadcasts information to the whole community through public address systems mounted on long erected poles at strategic places to reach every home.

1.3 Profile of Emmanuel Community Information Centre

Emmanuel Community Information Centre is situated closer to the Ofoase funeral grounds. It was established by Elder John Kwadwo Darko, an elder of the local

Church of Pentecost and a farmer, in September, 2010; after getting approval from the Information Services Department of the Asante-Akim South District Assembly and the Unit Committee of Ofoase. The main aim of setting up the centre was to spread Christianity through dawn preaching. The other objective was information dissemination to the Ofoase populace. This includes communal and individual announcements, relaying vital information from government or the district Assembly to the community, organizing the citizens for communal activities, and any other information that will be relevant to the Ofoase citizens. The Emmanuel information centre has one sound amplifier, two microphones, one cassette tape recorder, one compact disc player, two each horned-speakers erected on a seven-meter pole with each speaker facing the four directions of the community at four locations that make it possible for almost all the people to hear sounds from the facility.

Due to the problems elaborated in paragraph eight of the Background (the agrarian life of the Ofoase inhabitants making them not able to actively listen to radio, and the unsuitability of plentiful radio and television programmes to the Ofoase populace), Elder Darko, as he is popular called, with the support of the Ofoase Unit Committee decided to use Emmanuel information centre to fill the information gap; especially in governance, health and sanitation issues. Elder Darko therefore designed health programmes that are broadcast to the citizens. These broadcasts are generally done by himself, and a volunteer, Kankam Abel,

popularly called M.C. Bonty, a high-school graduate teaching in a private basic school and a popular 'Master of Ceremonies' in the Ofoase community.

Emmanuel information centre is financed solely by Elder Darko. Additional funds come from 'token' charges that the people pay for using the facility to advertise their products or services and make announcements (funerals, outdoorings or marriage ceremonies, or announcing the loss of a property or livestock). Announcement done for or on behalf of the community is free.

Sanitation issues that are usually discussed by Emmanuel Information Centre are that of the community refuse dump, communal farm routes, the conditions at the pipe-stands, and general sanitary conditions. Health issues discussed are usually preventive health-care systems, especially on everyday diseases and common infections like malaria, cholera, sexually transmitted infections and snake bite, among others. Mobile phone numbers are made available for prospective call-ins. The health and sanitation programmes are broadcast on Tuesdays (morning and evening), Fridays (evening), and Sundays (evening) mainly from the studios of the Centre.

The three most popular health and sanitation programmes that are broadcast by the Emmanuel information centre are explained below.

❖ *'Me man nti' (For the sake of my land)*

'Me man nti' was designed to replace the olden-day gong-gong beater who reminded the citizenry of a communal activity or sensitized the people on the upsurge of an epidemic in the community. It is presented on Tuesdays from 5.30am to 7.30am. It starts with inspiring words that incite patriotism among the citizenry and encourage them to partake in communal activities. The speaker normally talks about patriotic people and heroic deeds that have helped promote development in Ghana and the world as a whole. 'Me man nti' is usually presented by Kankam Abel. Discussions are done on the state of the community in terms of sanitation and health; and communal leaders are sometimes invited to help in the discussion. Details of the communal task(s) of the day, which starts from 9am, are given in the course of the program.

❖ *'W'apom te sen? (How is your health?)*

Broadcast at 7pm-8pm on Tuesdays, and 4:30pm -5:30pm on Fridays, 'W'apom te sen?' is normally presented by an invited resource person. It was purposely designed to disseminate health issues to the Ofoase people, especially educating the people on health issues. Some of the resource personalities who normally present this programme include the 'Medical Assistant' and/or the midwife of the Ofoase Health Centre', or 'established' traditional and herbal practitioners. Health issues usually discussed on 'W'apom te sen?' include preventive and alternative health care, alternative medicine, healthy living and general health conditions.

❖ *'Wo haw ne sen?' (What is your problem?)*

'Wo haw ne sen?' is purely a call-in programme. It is an on-air consultative programme that allows the Medical Assistant or the health expert present to advise or prescribe measures to individuals in the community that call in to the studios to express their health conditions. It is presented by the Medical Assistant or any of the health workers in the community health centre depending on availability; and assisted by Kankam Abel. It is presented on Sundays from 6:00pm to 7:00pm. Lately, most health cases that people call in to get information on *'wo haw ne sen?'* are the ones that shy patients from the hospitals and health centres like sexual infections, sexual weakness, piles, etc. People with health cases that are deemed critical by the Medical Assistant are advised to visit the health centre for proper consultation and diagnoses. *'Wo haw ne sen?'* has been touted by the community people as one of the most simplest avenues to discuss one's health ailment with a medical expert.

Despite the regular time allotted to communicating these Health programmes, programmes do not always follow any strict and orderly arrangement as the radio or television stations do. Programme content and schedules might alter or might even cease due to factors like the unavailability of a resource person; the unavailability or inactivity of the two workers due to illness, tiredness or even apathy; hydro-electric power offs; breakdown of equipment(s); the on-going of a popular communal programme like church crusades or funerals; heavy rainfall (that would either destroy the cables connected to the public address system

erected at strategic places, or hit hard on the roofs of individual houses that would compromise listening); broadcasting of a national programme on television and radio; among other problems. These affect the regularity of programmes.

Emmanuel Information Centre also does a little inter-personal and house-to-house health communication. This involves visiting individuals in their various homes to disseminate health information and ascertain issues that affect people. The direct communication also involves organizing communal gatherings for experts to disseminate health information through demonstrations and other methods of health communication.

Herbal medicine practitioners also promote their services and products through Emmanuel Information Centre. Some of the herbal products that are normally promoted include '*dahiada*' (ointment), '*wo bête wo kaka nka*' (tooth-ache cream), '*kanfo yehowa*' (blood tonic), '*yaabodonkuaa*' (balm), '*kaakyire samina*' (soap), '*nyame akwan ma abotoyamu*' (cream), '*akatoakatoa*' (cream for sexually transmitted infections among females), and '*obaatanpa*' (cream). These products are very popular in the community. Plentiful of these herbal products are those that alleviate pains. Almost all of the herbal products do not have the seal of license of the Food and Drugs Authority, the Ghana Standards Authority, or the Centre for the Scientific Research into Plant Medicine. Traditional healers who promote their spiritual prowess and herbal potency through the information centre

are not also registered with or licensed by any organization or body. All these people (advertisers and promoters) pay a token to the centre to help run the place.

To the Ofoase inhabitants, Emmanuel information centre is their 'locally-made media' facility that meets their demands.

1.4 Statement of Problem

It is evident that people still strive to access information on health issues. This is apparent in how people struggle to deal with preventive diseases like cholera and malaria (Ghana Health Digest, 2004). Research shows that not even all the educated and urbanized Ghanaians that have access to a lot of information have access to health information (Ardayfio, 2010). And it is again posited that Ghanaians, especially those between the ages of 15-19, are less knowledgeable about health prevention methods (GDHS, 2014).

The media, in its quest to educate the national population, has also not been very effective. This is due to problems like bias in target audience, programme content, and location of facility, among others. Most media programmes suit the upper and the middle class urban settlers. The rural and the urban poor are left out in the choosing of audience in programming (Sparks, 2007). The demographic patterns of urban and rural settlements as shown by the 2010 population and housing

census done by the statistical service authority of Ghana buttress this urban bias by explaining that policy implementation by successive governments of Ghana, even on decentralization, is urban biased. McMichael (2012) also identifies and elaborates on the urban bias in the location of media organizations, programming, content, and dissemination of information in the state. He believes that both the Public and Commercial media companies are guilty of this.

Sparks (2007) posits that this urban bias has come about because the supposed 'independent media' in the developing countries are not that independent. He sees three control mechanisms (the direct control, the indirect control, and the imperialist control) that regulates and direct the media in the developing countries. This makes programmes of the media in developing countries unsuitable to the ordinary receiver; and does not address the needs of the local people. To Hachten (2004), the world's poor nations would love to use the modern media used by all other nations to communicate health issues; but these poor nations lack the economic and social infrastructure to utilize and maintain them. He believes that the new media is costly to purchase and maintain. The multi-national companies and individuals that can provide these infrastructure and equipment consequently control the media. To him, that is the reason why efforts to promote and partake in effective community development through the media has not been effective.

Karikari (2000), argues for the strong presence of community media, in the absence or ineffectiveness (though present) of the public and commercial media. To him, the community media is more participatory and addresses the needs and desires of the communal Ghanaian. He explains that the community media brings all the citizenry on board to uncover a problem, find a solution, and collectively solve that problem. However, community media too has its peculiar challenges in the Ghanaian media terrain. This emanates from the fact that there are few community media stations in the country; and there are even some facilities that started as community media but diverted to commercial in terms of programme design and content. The shift in focus is due to stiff competition with the public and commercial forms of media. The cost of operation (securing frequency and equipment, maintenance, and allowances to volunteers) makes it very hard for the efficient and effective work of the community media with its desire to reach the local masses (Larweh, 2015).

It is argued, rather controversially, by the communal masses, that the insurrection of a new system of communication in the Ghanaian media terrain — the Community Information Centres — can fill the gap created by the urban-bias of the Ghanaian media and also to replace the erstwhile gong-gong in the various communities. To Elder Darko (2015), the owner of Emmanuel Information Centre in Ofoase, Community Information Centres are the best alternative and cost effective option to enhance efforts at effective community outreach and development in Ghana. This assertion is buttressed by Tabing (2000) who

explains that this new form of community media is relatively small, has a 'real' community ownership and control, has non-profit aim, run on low cost, has a two-way communication process (interactive) with a proper and an effective feedback mechanism, autonomous, has a limited coverage and relatively smaller audience (usually a section or sometimes a whole community), uses indigenous machines and resources, reflects community needs and interests, involves community members, and preserves local culture. Also, it is assumed that the volunteers that work in these information centres know the what, when, where, how, and who to communicate to in their communication process.

With the new development of Ghanaian communities relying on Community Information Centres for information, health issues should be paramount. This is due to such reasons as the inadequacy, and sometimes, absence of proper and adequate health professionals, lack of health care infrastructure, and inept health education and health sensitization to the communal dwellers. In places where these health facilities do exist, the agrarian lifestyle of the people absorbs majority of them from accessing these health functionalities (Ghana Health Digest, 2004).

Of concern is the fact that many of these information centres, irrespective of orientation, are the only, in most often times, available sources of accessing information on health issues in the rural Ghanaian communities. Thus, the rural populace, irrespective of the level of education attained or social status, still resort

to this non-traditional means of obtaining information on health issues (Abissath, 2011; Ayanore, 2011).

The fact that people in rural Ghana need information on health issues (Ghana E-Health Strategy, 2010), and the assertion that the Community Information Centre is currently the newest and presumably the best option to reach the rural Ghanaian with health information (Abissath, 2011) raises the question of whether accurate health information are been acceptably communicated to the rural Ghanaian through the Community Information Centres (Gbaa-Faakye, 2010).

1.5 Research Objectives

The characteristic rural Ghanaian is devoid of information in relation to the urban dweller. Media organizations tend to focus on the urban centres due to possible source of advertisement and funding. The Community Information Centre has come to stay in communicating information, especially on health.

The general objective of this study is to assess how Community Information Centres communicate health issues to the rural Ghanaian.

The specific objectives of my study are to:

1. Discover the sources of information on health issues that are disseminated by Emmanuel Information Centre to the Ofoase populace.

2. Ascertain the type of health issues that Emmanuel Information Centre communicates to the Ofoase populace.
3. Examine the process of communicating health issues to the rural folks of Ofoase by Emmanuel Information Centre.
4. Examine how the Emmanuel Information Centre involves the Ofoase populace in communicating health issues.
5. Assess the monitoring of health communication by Emmanuel Information Centre.
6. Examine the effect of communicating health issues to the Ofoase populace through Emmanuel Information Centre.
7. Assess the overall importance of Community Information Centres in communicating health information to rural Ghanaians.

1.6 Research Questions

A study is done to get answers to a particular phenomenon. Questions are asked to solicit for responses that would be used to achieve the objectives of the study.

The general questions that I used to get answers to fulfil my research objectives are the following.

1. Where does Emmanuel Information Centre get information in its role to communicate health to the Ofoase citizens?

2. What are the health issues that the Emmanuel Information Centre communicates to the people of Ofoase?
3. How does Emmanuel Information Centre communicate health issues to the Ofoase populace?
4. How does Emmanuel Information Centre involve the Ofoase people in its health communication programmes?
5. Who oversees the work of Emmanuel Information Centre in communicating health issues to the Ofoase people?
6. How has Emmanuel Information Centre helped in promoting the health of Ofoase people?
7. Is Health Education and Communication by Community Information Centres necessary in Ghana?

1.7 Research Significance

This study has the following significance;

1. The study helped in discovering the sources and supply of information on health issues that are disseminated by Community Information Centres to the rural Ghanaian.
2. The findings helped in ascertaining the type of health issues that Information Centres in Ghana communicate to the rural populace.
3. The findings of the study will help Health-communication authorities to assess health communication to rural folks by Information Centres.

4. The outcome will also help stakeholders to know the effect of communicating health issues to rural Ghanaians through Information Centres.
5. The study has been another platform to assess the Community Information Centres in their role of communicating health issues to the rural Ghanaian.
6. The findings will help redirect national focus and attention on the Community Information Centres and make necessary policies to project them.

1.8 Scope of the Study

The scope of the study is the Emmanuel Information Centre and how it communicates information to the Ofoase Community in the Asante Akim South District in the Ashanti Region of Ghana. I did this study to examine, generally, how information on health issues is communicated to the rural Ghanaian settler. This is as a result of the vulnerability of the rural Ghanaian dweller in assessing the value, or not, of information given to them by any person through any medium. I also used the study to assess the sources of information on health issues that are disseminated by Emmanuel Information Centre to the Ofoase populace; examine the processes of communicating health issues to the rural folks of Ofoase by Emmanuel Information Centre; ascertain the type of health issues the Emmanuel Information Centre communicates to the Ofoase populace; examine the effect of communicating health issues to the Ofoase populace

through the Emmanuel Information Centre; and assess the overall importance of Community Information Centres in communicating health information.

1.9 Limitations

The limitations of the study are the adjoining communities around Ofoase that do not have access to the Emmanuel Information Centre. They include communities like Dickson, Yaw Bronya and Gyankobaa. Other limitations to my study are the other issues (religious, cultural, political, etc.), other than health issues, that are communicated to the Ofoase inhabitants through Emmanuel information centre that were not paramount to me and thus did not surface in the study.

1.10 Problems Associated with the Study

The major problem associated with this study was limited timeframe. The time used for the administration of the questionnaire and interviews was relatively short. This led to the cutting of the number of respondents to the questionnaire which affected the outcome of the study. Financial commitment in terms of printing of questionnaire as well as the transportation fares to and from the study population (Ofoase) also posed certain difficulties.

Again, the interpretation of questionnaire to respondents in the Asante-twi dialect was another problem. Certain technical words, like media, which cannot be

explained with a single word, became very problematic to explain; even though pre-testing was done to alleviate such problems. It needed different explanations to different category of respondents at different times. In addition, it was very hard to persuade some of the sampled population to respond to the questionnaires; especially the aged and those whose educational level are low. This emanated from the fact that it is their belief that any research or study done amongst them is the government's 'smart' way of knowing their location so as to tax them. Some respondents decided, due to this factor, to give limited information especially to the open-ended questions.

1.11 Operational Definition of Terms

For the purpose of this study, the following terminologies are defined as follows:

Communication: dissemination of information to people. This takes the form of studio discussion, one-on-one interactions, and communal gathering.

Community: The community is the inhabitants of Ofoase.

Media: Information dissemination facility.

Community Media: A communication facility that is in the community, for the community, about the community and by the community" (Tabing 2000: 75). A community media, thus, entails any information dissemination facility that allows communal people to access information.

Community Information Centre: An information dissemination facility (different from the original Community Information Centres established by Government that concentrates on ICT training, and giving information to communal people through the internet) that disseminates information from a central place (studio) with public address system erected at strategic areas in Ofoase to reach inhabitants in their homes. The erected public address system is connected by wires from a sound amplifier in the information centre.

Health issues: Issues related to health, healthcare and promotion, and sanitation.

Health communication: Dissemination of information on health issues.

1.12 Chapter Organization

The study will be put under five chapters and it will follow the following pattern;

Chapter One

Chapter one is the introduction. This chapter has the Introduction to the chapter, background to the study, Profile of Ofoase, Profile of Emmanuel Information Centre, problem statement, research objectives, research questions, significance of the study, scope and limitation of the study, problems associated with the study, definition of terms, and chapter organization of the study.

Chapter Two

Chapter two presents the literature review. Literature themes that were reviewed in relation to the study are Communication; Health; Health Communication; Rural Life; Community Media; Community Information Centre; and Communication for Social Change. Theoretical framework — ‘Media Advocacy Theory’; ‘Participatory Theory’; ‘Agenda Setting Theory’; and ‘Diffusion of Innovation Theory’ were discussed.

Chapter Three

Chapter three expresses the methodology used for data collection and analysis in the study. It has the introduction, type of study/ design, study location/area, source of data for the study, study population, sampling, sample size, sampling method, data validity and reliability, data collection techniques/methods and tools, pre-testing, and methods/techniques of data processing/analysis.

Chapter Four

Chapter four presents the results/findings which includes data analysis and interpretation.

Chapter Five

The chapter five presents discussion of findings, summary, conclusion and recommendations of the study.

References, Appendices and other relevant information are given at the end pages.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 LITERATURE REVIEW

2.1.0 Introduction

Various studies have been done on health communication and community media by different researchers. Some of the topics reviewed under this study are Communication, Health, Health Communication, Communal living, Community Media, Community Information Centres, and Communication for Social Change.

2.1.1 Communication

Communication formerly assumed a primary function of information dissemination and persuasion. It used the one-way, linear process of source-to-receiver(s); usually for the purpose of having an effect on individual receiver(s). Feedback was infused into the linear communication process and these models became 'knowledge of effects'. Communication based on dialogue, equitable participation, local ownership, empowerment, and social change

evolved in the 1990s; and provided stronger decentralization of authority and increased access to new forms of communication and technology (Díaz Bordenave, 1998).

Communication denotes a shared experience (Ansu-Kyeremeh, 1998). And because sharing involves a group, it is always important to involve everyone in a given community in the communication of a development programme like health. Local people must therefore be encouraged to involve themselves in the development process of their communities. They should be involved in all the phases of the development process: planning, designing and the delivery stages (Melkote & Steeves, 2001). Agunga (1997: 11) actually sees communication as synonymous to development as he quotes “development or more broadly, social change is a communication activity”. It is therefore clear that through communication, a society projects its ideals, objectives, and usages and traditions collectively. Opoku-Amankwa (1998) supports this by elaborating that communications breeds an effective channel for a group of people to achieve the common goal through collective solution of social issues.

To Figueroa, et al, (2002), communication can originate from a third source such as television or radio, or a person or institution. And, they believe that information emanating from the media to the citizenry is highly received due to people’s trust in the media as a credible source of information. They explain that the media in

their communication role should interpret and reinterpret issues until a sufficient degree of mutual understanding and agreement has been reached for collective action to take place. That would allow the development communication process to be efficient, effective and appreciated.

In the communication process, “‘Information’ is preferred over the term ‘message’ to allow for both verbal and nonverbal information, unintended as well as intended information. For example, if women suddenly show up at a community meeting for the first time, this action by itself conveys information that can be stronger than all of the verbal comments made about ‘allowing women to participate’” Figueroa, et al, (2002: 4).

UNESCO (1965: i) summarizes the importance of communication in health development by stating that “Effective communication with rural people and their active participation in the life of their country are essential for all developing societies”.

2.1.2 Health

Health plays a vital role in human life. No one can enjoy the social order in bad health. A society that rejects the health needs of its people risks losing its human resource. Various Governments of developing countries have hugely invested in

improving public health measures (safe drinking water, sanitation, and mass immunizations), training medical personnel, building clinics and hospitals, providing medical care and improving access to medical care (WHO, 2012)

36 million deaths each year are caused by non-communicable diseases such as cardiovascular disease, cancer, diabetes and chronic lung diseases. This is almost two-thirds of the estimated 56 million deaths each year worldwide. Tuberculosis (TB) is second only to HIV/AIDS as the greatest killer worldwide due to a single infectious agent. 1.6 million people still die from pneumococcal diseases every year, making it the number one vaccine-preventable cause of death worldwide. Malaria causes some 225 million acute illnesses and over 780,000 deaths, annually. These statistics buttress the cries that about one billion people lack access to health care systems in the world (WHO, 2010).

Rural areas in developing countries are the hard-hit with avalanche of health problems. This is due to factors like extreme poverty; non-availability of health information; inaccessibility of health-care and lack of routine medical check-up (GDHS, 2014); and the agrarian lifestyle that always keep the people in their farms and bars them from taking interest in their health. The desire to reduce the incidence of health problems will require changing people's behaviours and lifestyles. Local people need to be educated and sensitized on lifestyle choices that will enhance their health.

The MDGs 4 (Reduce child mortality), 5 (Improve maternal health), and 6 (Combat HIV/AIDS, malaria and other diseases) also emphasize on how to address the general health and welfare issues of the world (UNMD Summit, 2000). Without health the good life envisaged by all would never be achieved. Health therefore plays an important role in the achievement of sustainable development for living.

2.1.3 Health Communication

The International Communication Association officially recognized health communication in 1975. Communication can be trimmed to concentrate on disseminating health and health related information. This emanates from the fact that health communication is very pivotal in worldwide health promotion (WHO, 2012). Health communication research identifies and provides better and more effective communication strategies to improve the overall health of society (Stacks & Salween, 2008). To Kahlenberg (2012: 31) “the field of health communication generally explores communication processes that inform and influence our health and healthcare”.

Kumbuor (cited in the Ghana E-health Strategy, 2010: 4) believes that “... the need for a faster and effective way to generate knowledge, share knowledge and translate knowledge into effective and affordable interventions and strategies that make health care accessible to the most needy and vulnerable people in our

societies is urgently needed”. This reflects one of the purposes of disseminating health information: to influence personal health choices by improving health literacy. Research posits how behavioural and social factors determine most diseases. Research also indicates that health promotion programmes should address these factors to ‘create health’ (Smedley & Syme, 2000; WHO, 2012).

To Frey et al. (1996: 110), health communication should work towards the achievement of ‘the social justice’ with the social justice defined as “the engagement with and advocacy for those in our society who are economically, socially, politically, and/or culturally under-resourced”. Snyder et al. (2004) affirms Frey and others position by explaining that the societal good should be the end product of every health communication programme. Health communication aims at increasing audience knowledge and awareness of a health issue, influencing behaviours and attitudes towards a health issue, demonstrating healthy practices, establishing the benefits of behaviour changes to public health outcomes, promoting a particular health issue or policy, intensifying the demand or support for health services, and arguing against misconceptions about health, etc. (Frey et al., 1996; Hesse & Schneiderman, 2007; WHO, 2012).

Stacks & Salween (2008) state that, the internet, educational materials (hand-outs, games, etc.), guidance and counselling, the media, and communication toolkits are some of the tools for health communication. They assert that these

tools, including other relatively important tools, help the health communicator to reach the masses in a more efficient and effective way. To health communication experts, creating a health message or adopting and modifying health message to suit particular audience and conditions, understanding the audience for which the information is tailored, gathering tools needed for the communication, and audience segmentation are some strategies of health communication. Methods of health communication encompass campaigns, media advocacy, new technologies, and interpersonal communication.

Hachten (2004) however believes that the efforts to promote and partake in effective community health communication through the media have not being effective because the new media is costly to purchase and maintain by the world's poor nations. Thus the dream of poor nations to use the modern media that is used by all other nations to communicate health issues is becoming a mirage. Though research shows that health communication efforts to educate, motivate and support people to make healthy changes have shown uneven results (Neuhauser & Kreps, 2010; Snyder et al., 2004) there is ample evidence that health communication, if procedurally done and designed with the close participation of the intended beneficiaries and stakeholders, is successful and brings positive effect (Hesse & Schneiderman, 2007; Neuhauser, 2001).

Health communication uses public and private volunteers and professionals that conduct communication research, develop successful and repeatable campaigns for health promotion and advocacy, and evaluate how effective these strategies have been for future campaigns. “In Health Communication, we critically examine how corporate media control may have an adverse effect on health as it oftentimes functions to preserve the status quo” (Kahlenberg, 2012: 33). Clear communication is essential to successful public health practice at every level of the ecological model; intrapersonal, interpersonal, group, organizational, and societal. In each instance of health communication, there must be careful deliberation concerning the appropriate channel for messages to best reach the target audience. Ranging from face-to-face interactions to television, internet, and other forms of mass media the potential media are ever changing. The research of health communication surrounds the development of effective messages about health, the dissemination of health-related information through broadcast, print, and electronic media, and the role of inter personal relationships in health communication. At the core of all the communication are the idea of and the emphasis on health (Stacks & Salween, 2008).

2.1.4 Rural Living

The 2010 demographic census expressed that the percentage of rural population and impoverished communities in Ghana is higher than the percentage of the urban communities and population.

This rural population suffers from a high rate of illiteracy and absence of social amenities like pipe-borne water, electricity and good roads. In many of these rural areas there are schools, but school buildings are generally below standard and lack such amenities as libraries, gymnasias, desks and such teaching tools as audio-visuals, radio and television. The schools are poorly staffed and equipped. Majority of the men are farmers, who live on subsistence agriculture; and majority of women are very small scale traders. Politically, rural communities are on the outskirts of the mainstream and are used by the political elite as tools to gain political power, but forgotten as soon as the politicians have gained their desired power. What they frequently get are socio-economic promises for improvement of their communities; but these promises are hardly ever kept, creating a feeling of perpetual frustration and fatalism....Everyday, they face the psychological mortification of seeing wealth and affluence a stone-throw away while they themselves live in abject poverty. (Moemeka, 2009: 33,34).

The rural population do not fully enjoy the mass media and the social order in general as their counterparts in the urban centres. The peasant rural poor usually

have very little or no access at all to the mass media. With poor education and lack of skilled knowledge, the rural citizens therefore go in search of work and better livelihood in the urban centre; and this puts intense pressure on the socio-economic facilities in the urban centres. Moemeka (2009) therefore believes that the socio-economic, environmental and communication handicaps facing the rural communities make it more essential and meaningful to develop these rural communities. He explains that it is in developing these impoverished rural communities that their urban counterparts would be free.

Moemeka (2009: 34) further iterates that “any action taken to reduce or eliminate the problems of these rural populations is action taken towards fostering development in the rural area and towards relieving the burden of poverty and underdevelopment on national development. And the most important action would seem to be setting up an interactive communication system in order to build understanding and create active participation”.

2.1.5 Community Media

“A communication facility that is in the community, for the community, about the community and by the community” (Tabing 2000: 75). A community media, thus, entails any information dissemination outlet that allows communal people to access information. To Karikari (2000: 47), ‘community media’ are defined as “those that are devoted to the social, political and cultural interests and aspirations

of identifiable groups resident in particular geographical areas within a country or within its provinces; and/or sharing common specific social, economic, cultural or political experiences and interests. This community, however, refers to those that are: geographically physically remote from centres of governmental and economic decision-making and development; economically deprived or poor; culturally marginalised or alienated from dominant cultures; socially subordinated and or discriminated against or persecuted; or politically victimised or disempowered”.

Essandoh (2006) believes that community media is the platform that informs the communal people and allows them to participate in the development process. Community media should therefore be integrated into the community it finds itself — in order to have in-depth knowledge of the issues affecting the people and help find solutions to those issues. Integrating the media into the community involves the media involving itself with the communal struggle and being part of the solution seekers.

Presumably, community media is one of the most effective (and not very costly) means of health communication, especially in rural communities. Community media also creates the platform for social participation, of information and advice on literacy, health, child care, improved agricultural methods, vocational training and protection of the environment.

UNESCO has helped in promoting Community Multimedia Centres (CMCs) that aim to integrate Community Radio and Tele-centres in multipurpose communities since 1996. The CMC assists Least Developed Countries (LDCs) with information, communication and knowledge with the aim of improving lives through an approach that is cost-effective, country differentiated and empowerment- oriented (Tabing, 2000).

Community media depicts some characteristics, according to Tabing (2000). These characteristics include being relatively small; having a community ownership and control; being established with a non-profit making aim; run the facility at a low cost: having a two-way communication process (being interactive); being autonomous; having a limited coverage; using indigenous machines and resources; having programmes that reflect community needs and interests; and preserving local culture and tradition.

2.1.6 Community Information Centres

To GIFEC (2015), among the roles of Community information centres include

1. Supporting economic activities in the rural areas by providing ready information on marketing, production practices, extension services, credit facilities, etc.;
2. Addressing community information needs and enhance national integration;

3. Provision of ICT and other avenues to disseminate developmental information particularly on health, agriculture, environment and local government & rural communities;
4. Providing the platform for grass-root education on communal and national issues; and
5. Providing public communication and education support for community based development organizations.

In evaluating community information centres in Dodowa and Saltpond, Abisath (2011) agreed that despite the challenges faced by these Information centres, they are still on course doing their best in educating, entertaining and informing their audiences in their catchment areas. ICT and equipment were defined as the major problems confronting the efficient and effective delivery of the Zebilla Community Information Centre by Ayanore (2011).

Currently, 120 CICs have been constructed nationwide covering 99 Districts/Municipalities. Under a cost-sharing agreement between the Ministry of Communications and the United Nation Development Programme, 92 CICs have been equipped with network infrastructure and trained Centre Managers, making them operational. Work on equipping 26 Community Information Centres is in progress (GIFEC, 2015).

For Information Centres to be effective in the society, Schramm (1964: 123) explains their existence, function, and mandate better as:

...they should be as local as possible. Their programmes should originate no farther than necessary from their audiences; the programs should be prepared by persons who understand the culture to which they are speaking, and means should be available for the audiences to report back to the media.

2.1.7 Communication for Social Change

“The guiding philosophy of Communication for Social Change can readily be traced to the work of Paulo Freire (1970), the Brazilian educator who conceived of communication as dialogue and participation for the purpose of creating cultural identity, trust, commitment, ownership and empowerment (in today’s term)” (Figueroa, et al, 2002: 2). The Integrated Model of Communication for Social Change (IMCFSC) (cited in Figueroa, et al, 2002: 5) describes Communication for Social Change as “an iterative process where ‘community dialogue’ and ‘collective action’ work together to produce social change in a community that improves the health and welfare of all of its members”. This depicts that social change is ingrained in communication; and can occur through various processes including externally generated change, individual behaviour change, social influence, community dialogue and collective action. And for change to happen in the community it needs some catalyst that will trigger it.

These catalyst are stated by the IMCFSC as an internal stimulus, a change agent, an innovation, an effective collective policy, availability of technology, and the ever presence of the Media (Figuroa, et al, 2002).

Denise Gray-Felder (cited in Figuroa, et al, 2002: i) writes that

As we looked at the CFSC process, we knew that a big question remained: how do we know when communication for social change is working? Traditionally, when measuring communication effectiveness, professionals focus on end-products or outcomes. How many people viewed a public service announcement? How much newspaper coverage was generated? What is the level of message retention? Yet, Communication for social change is valued as a process in and of itself. The act of community problem identification, group decision making, action planning, collective action and implementation are critical to how a community grapples with a serious issue. When a village or group uses the communication for social-change process to address a critical issue they have already affected positive outcomes. They have shown people how to think critically at a group level, they have worked together to identify problems and to come up with solutions.

Díaz Bordenave (1998) posits that the social change process starts with the 'identification of a problem'. Then, if community dialogue and collective action are implemented systemically, there would be not only an improvement in the health status of the members of the community in question, but also an increase in the community's sense of collective self-efficacy, a sense of ownership, some level of social cohesion, and a collective capacity. For communication to effect social change, a common platform for dialogue should be available. Information should emanate from a common trusted source to the community in general. This platform promotes the local history, culture, identity, indigenous lifestyle, and even the religion of a group of people.

One basic component of social change communication is the usage of channels and themes that suit the needs and wishes of the target audience and address their questions. These channels include media facilities like community information centres; and they communicate on themes such as health that suits the agrarian lifestyle of a communal people.

2.2 THEORETICAL FRAMEWORK

2.2.0 Introduction

This chapter presents the Theoretical framework under which the study was done. Theories like 'Media Advocacy Theory'; 'Participatory Theory'; 'Agenda Setting Theory'; and Diffusion of Innovation Theory are reviewed.

2.2.1 Media Advocacy Theory

Media advocacy is the strategic use of the mass media to advance social or public policy initiatives. Media advocacy aims at stimulating debate and promoting responsible portrayals and coverage of health issues. One basic requirement of Media Advocacy is the mobilization of resources and groups to promote and enhance certain issues and policies to change public opinion and decisions in the society. It also involves organizing and disseminating information through various interpersonal and media channels (Wallack et al 1993). Social Advocacy, thus, buttresses the political and social acceptance of certain pressing societal issues. It generally complements the struggles of humanity; and helps find solutions to societal negatives.

Melkote (1991) believes that the media transmit information to produce societal changes. This leads to the media influencing certain decisions and behaviours of

the people in a particular community. The advocacy stands on affecting the public debate about public health. It thus locates problems in the society and promotes a collective solution to those problems. To Holder and Treno (1997), media advocacy approaches health not as a personal issue but as a matter of social justice. It campaigns for changes in the social environment that legitimize certain behaviours and decisions in the society. Media advocacy posits that social interventions should target societal problems and conditions. Such interventions entail the process of changing conditions and redressing social inequalities. The interventions do not persuade individuals about the benefits of certain lifestyles and behaviour change but advocates for a collective change. And, because health is a matter of social justice, media advocacy theory focuses on providing information to change individual behaviour in order to access a better health care by people (Brawley and Martinez-Brawley, 1999).

Glanz and Rimer (1995) differentiate media advocacy from social marketing. To them, social marketing has an individualistic, behaviourist approach to health and social problems and therefore narrows interventions to public information campaigns. Yet, media advocacy champions a community-level model of intervention in health issues. They summarize their stand with the fact that community organization helps communal groups to identify common problems or goals, marshal resources, develop strategies and implement them for the benefit of the whole community. This feat, to them, can be well achieved by the active communal advocacy through the media.

Media advocacy emphasizes on communal control in transforming their environments. Melkote (1991) explains that the advocacy is not solely concerned with media actions. He agrees that health problems are primarily engrained in power inequalities. Thus, he expresses that there should be a dual strategy to build power that includes the formation of coalitions and grassroots actions coupled with media actions and lobbying.

It is therefore clear that communities need some institutions to promote some plan that will enhance a collective solution to social problems. Such institutions target the whole community; not individuals or behaviours. And the media taking it upon itself to promote and enhance this collective social action is referred to as media advocacy.

2.2.1.1 Relevance of Media Advocacy Theory to this Study

Media Advocacy Theory explains that social interventions should target societal problems and conditions. Such interventions entail the process of changing conditions and redressing social inequalities; and that the media should play the frontline role in promoting and solving of social issues. This study looked at the role of Emmanuel Information centre in communicating health issues to the Ofoase people. Using health education, health information dissemination and other health promotion activities communicated by Emmanuel Information Centre to the citizens of Ofoase as milieu, this study was done to confirm, or not, whether

Emmanuel Information Centre actually advocates for the Ofoase citizens.

2.2.2 Participatory Communication

Communication denotes a shared experience (Ansu-Kyeremeh, 1998). And because sharing involves a group, it is always important to involve everyone in a given community in the communication of development programmes like health. Local people must, therefore, be encouraged to involve themselves in the development process of their communities. They should be involved in all the phases of the development process: planning, designing and the delivery stages (Melkote & Steeves, 2001). Participating in the development programmes of one's community makes one strongly become part of the claim of ownership of the said projects. To Karikari (2000), the community media is more participatory and addresses the needs and desires of the communal Ghanaian.

Moemeka (1987) sees participatory communication as serving, among others, the following roles; determining the needs of the people; allowing interaction; preservation of local culture; relevant information dissemination; promoting societal development projects and policies; and awareness creation. As Denise Gray-Felder (cited in Figueroa, et al, 2002: i) explained that his professional and volunteer activities have taught him the power of collective action. He believes that "as one person can move a mountain, a well-intentioned, well-prepared group can also build a mountain". Participatory communication therefore excels on

collective action. To Minkler and Wallerstein (2008), to design a vibrant health communication and health promotion programmes, one should include community participation. That is, bringing all the community members on board the programme. The community members know what the problem is, how the problem is, where it can be found, who has that problem, and when it can actually be found.

Empowerment of the people is believed to be one major outcome of participatory communication. The abolition of certain practices, which can be done through empowerment of the people, can be achieved through participatory communication. Through such empowerments, a group of people can achieve modernization (Szalvai, 2009). Communication therefore empowers people through their active involvement in the development programmes and projects within their communities. Participatory communication also helps people to work in groups and imbibe the spirit of collectivism among people. To Mefalopulos (2002: 836), "People's capability and opportunities to shape their own destiny is an ideal supported by virtually everybody, including the decision-makers at the highest level. Still, most people around the world do not have this option". For a group of people to be empowered, therefore, the communication gap created by the urban bias should be closed. And this is done by enhancing local media and communication instruments to function in bringing all on board (Hesse & Schneiderman, 2007).

Development and empowerment through participatory communication all stand on access: access to information (Opoku Amankwa, 1998). And a free and true access can be achieved through the decentralization and liberation of the media that any group of people would have a mouthpiece to share their voices and opinions; and also get a favourable platform for individual as well as group empowerment (Karikari, 2000)

(Moemeka, 1996: 149-150) sums the participatory theory with the following,

No broadcasting organization can truly claim to be effectively reflecting the community it serves, unless it properly knows that community and appreciates its problems, aspirations and expectations. Properly knowing a community involves (a) entering into the unique socio-cultural contexts that obtain in the community as a whole, and (b) involving the different categories of citizens actively in its activities. These two factors are imperative for correctly reflecting the community in programming. This is particularly important with regard to marginalized populations. The first unwritten law of Development Communication is "know your audience". Involving rural and urban poor citizens in broadcasting activities, to be meaningful and effective, must be predicated on substantial general and specific knowledge of their environment and socio-cultural realities. Such engagement also needs to be organized and coordinated, either on the basis of

location (citizens groups and broadcast personnel discussing and finding solutions to the different problems of the same locality), or on the basis of specific problems (the discussion and solution attempts focusing on each problem affecting, not only one locality, but a group of localities). Either way, the people should be as involved in program activities (selection, planning, production, presentation and evaluation) as broadcast personnel should be involved in community activities (group meetings, social activities, games, etc.). Such interactive relationship helps build up confidence in broadcasting as a social institution and increases knowledge and a sense of self-worth in the people.... Information is not only knowledge; it is also power. The more there are rural and urban poor who are well-informed, the more there would be those who can understand the potentials of broadcasting and the more those who can demand the utilization of broadcasting facilities to meet their authentic development needs.

2.2.2.1 Relevance of Participatory Communication to this Study

This study seeks to analyse if there is the involvement of Ofoase community members by the Emmanuel Information Centre in the establishment, management, drafting, development and production of programmes. It also seeks to know if there is access to information through participation of the local

citizenry, education and enlightenment of the local illiterate, and capacity building of the local human resources.

Summarily, this study is to attest to the fact that Emmanuel information centre is practicing the participatory paradigm, which is the backbone of community media in addressing the health needs of the Ofoase community and its people.

2.2.3 Agenda Setting Theory

The Agenda Setting Theory, as explained by Severin and Tankard (1979), is the selection of a topic or issue and promoting it to be the most ^{sought} sort after information among the people. The media in choosing which topic to headline the news of the day looks at issues like society, the needs of the people, among others before setting the agenda to project the most pressing themes. The agenda setting always centres on topical issues like health and health related issues, development issues, grass-root politics and other societal issues.

Under the agenda setting theory, the media takes the pivotal role in raising issues that need to be discussed and putting pressure on decision-makers. It projects topical societal issues at particular times and seasons. To Melkote (1991), the media, in setting the agenda, should prioritize the pressing social issues that need to be addressed instantly. He emphasises that the issues that if unattended to can

cause the whole society are the ones to always prioritize when setting the agenda. The 2014 Ghana Demographic and Health Survey (GDHS) supports this claim with a research finding that one landmark outcome of the urban media outfits' role in setting the agenda is the current state of the urban dwellers being more knowledgeable in health issues than their rural counterparts.

Stetson and Davis (1999) explain that in not-too-urbanized or agrarian communities primary health care should be one of the main issues to publicize in the agenda setting theory. To them, a society that relegates health issues dreads facing dire consequences in addressing social issues. McMichael (2012) also emphasises this position by explaining that due to the urban bias in the location of media organizations, programming, content, and dissemination of information in the state, community media facilities should identify and project issues affecting them on their platforms.

Agenda setting can simply mean let us tell our own story; with the pressing issue(s) headlining the rest. The media, in addressing such pressing issue(s) should have adequate knowledge of the people, community and issue(s) it is dealing with. This makes the media more proactive and effective and putting to the fore a really communally-affecting situation that needs a remedy. Griffin (1991) explains that the agenda being set is the one that reflects the cries of the

citizens; and the ones, which being known and addressed, would solve the needs of a group of people.

2.2.3.1 Relevance of Agenda Setting Theory to the Study

The linkage of this study and the Agenda Setting theory is that the theory will help to assess how the Emmanuel Information centre— being the only information dissemination outlet in Ofoase and most of the Ofoase population depend on it for education, information and entertainment— sets the agenda in programming, content and delivery of health issues to the people of Ofoase. The results of this study will help juxtapose the health communication of Emmanuel Information Centre in Ofoase to Agenda Setting Theory to see if the Information Centre is really promoting the health priorities of the Ofoase citizens.

2.2.4 Diffusion of Innovation Theory

Diffusion of innovation as elaborated by Rogers (1962; 1983) is one of the most influential theories of modernization and one of the strongest models of development communication. Rogers wanted to understand how new behaviours were adopted by people. He posited five stages through which an individual passes through in the adoption of innovations after a reviewing of about 500 studies in the early 1960's. These stages are awareness, knowledge and interest, decision, trial, and adoption/rejection. A group of people should be made aware of a situation or issue affecting them. They should then be influenced to have interest

in the issue by giving an insight into it. These group should be helped in deciding on what to do, how to do it, when and where to do it, and who should do it. The trial stage is when measures decided on to be used in addressing the communal issue are actually used. The success of the methods and processes would lead to their acceptance and adoption; and the failure of the methods and procedures for addressing the issues will lead to their rejection by the people.

Diffusing health innovation and practices emphasizes knowledge transmission and acquisition as well as changes in knowledge, attitudes and beliefs. Stetson & Davis (1999) buttress this position by explaining that technocrats and experts who have gained knowledge in health issues should communicate them to the 'naïve' communal people. According to Rogers, development communication is a process: a systematic transfer of an idea from a source to a receiver to change behaviour. The underlying principle here is to change the receiver's knowledge of some idea, create or change his attitude toward the idea, or persuade him to adopt the idea as part of his regular behaviour. Health communication therefore transfers health issues from a source to a receiver with the intention of changing behaviours. Here, there is the alteration of already known knowledge and accepting a new one through persuasion (Rogers 1962).

One important finding of diffusion of innovation communication research was that what motivate change are not economics or politics but communication and

culture. This is what the studies by Rogers on how farmers adopted new methods showed. Such studies were particularly influential because a substantial amount of early efforts targeted agricultural development in the Third World (Rogers 1983). Other applications targeted literacy programs and health issues, mainly family planning and nutrition. To Katz and Lazarsfeld (1955), one crucial phenomenon in channelling and shaping opinion is interpersonal relations. The person channelling ideas and shaping opinions of other communal folks should be able to integrate with the communal people so as to diffuse what is in him/her.

2.2.4.1 Relevance of the Diffusion of Innovation Theory to this Study

The relevance of the 'Diffusion of Innovation theory' to this study is that I wanted to assess whether Emmanuel Information Centre in Ofoase transfers ideas on health issues to the Ofoase populace through programmes it does; and the re-diffusion of health programmes done on other media platforms.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

The Methodology sums up the various processes and methods that were used in collecting and collating data. The methodology, to Nsikan & Uwem (2014: 465), is “the outline of the steps and procedures used in conducting a survey research”. It can be explained as a set of methods and principles adopted in carrying out a particular activity. It involves many sets and stages before the task can be accomplished. The various units that make up the research methodology (Research Design; Sources of data; Study Area; Population of the Study; Sample Size and Sampling Procedure; Data Collection procedure and pre-testing; and Data Analysis) in a survey are examined as follows:

3.1 Research Design

Nsikan & Uwem (2014, 466) explains a research design as “the technique of investigation adopted by the researcher to find out the facts that were hither to unknown or bleak”. The research design helps the researcher to achieve the purpose, goal or objectives of a study. Wimmer & Dominic (2006: 179) explains

that the research methods "... allow researchers to examine the interrelationships among variables and to develop explanatory inferences". It uses either qualitative or quantitative method or can combine the two; depending on the nature of the study.

Under this study, I used a combination of Quantitative and Qualitative methods in the research design. This was to give chances to both observation and statistics. Availability of a sample population in terms of access and time were considered in designing the method for this study.

3.2 Sources of data

Data for this study were gathered from two basic sources: the primary and the secondary sources. The primary sources of data were the questionnaire and interviews done on the field. The secondary sources were books, journals, speeches, etc. from authorities.

3.3 Study Area

The study was done in Ofoase in the Asante Akim South District of the Ashanti Region. Ofoase is situated South West and about Forty minutes' drive from Juaso, the district capital. It has 4,221 inhabitants (GDHS, 2014). It has a senior high school; seven basic schools, a police station, and a banking agency. The Ofoase

inhabitants are predominantly farmers, especially subsistence. They also cultivate cash crops like cacao, oil palm, citrus, and rice. They therefore go to farm as early as dawn and return at dusk; especially during the planting and harvesting seasons. The people are largely Akans with the Ashanti dominating. Other tribes as the Akwapim and a cluster of tribes from Northern Ghana also inhabit the community. Almost everybody speaks the Asante-twi dialect. The main reason for choosing Ofoase as my study area is that, it has one of the emerging sources of information dissemination centres that communicate information to the communal Ghanaian.

3.4 Research Population

As explained by Agyedu et al. (1999) the population of a study is the complete set of individuals (subjects), objects or events having common observable characteristics in which the researcher is interested. The population of my study is the Ofoase Community members above 16 years. I chose this population on the basis of appreciation of information.

3.5 Sampling Procedure and Sample Size

Osuala (2007: 114) defines sampling as “taking any portion of a population or universe as representative of that population or universe”. Sampling becomes important when the population of the study is too large for a complete census to be taken. To Frey and Cissna (2009), a sample denotes a selected subgroup of the

total population. The sample makes a research effective and plausible; and provides a reliable generalization of the findings. Nsikan & Uwem (2014) posit that the sample size depends on specific facts and circumstances of the study such as the population size, the study time frame, available funds and manpower for the study. Best and Kahn (1989) assert that the sample size is a matter of convenience and applicability.

The selection of Emmanuel information centre was purposive. This was to select an institution that represents the new trend of communal information dissemination in Ghana; and it is also the only avenue for the access of information by the Ofoase populace, marketing of health products; and mobilization of the Ofoase people for health-related issues. And, the selection of the participants (16 years and above) too was purposive: based on maturity and discernment.

Under the quantitative design, due to time limitation and financial constraints, the sample size of this study were 150 people; with ages from 16 years and above. The size was achieved using the simple random probability sampling. This technique gives every member of the study population the chance of been included in the study.

Other six (6) participants were purposively selected to give their professional, technical or personal opinions on the work of Emmanuel Information Centre. The five participants are:

1. The owner of Emmanuel Information Centre. He was chosen to be interviewed on the objectives for setting up the communication facility, managing the facility, communicating health through the facility, and problems that he faces in the management and health communication process.
2. Three Authorities — Two Political (The District Chief Executive of the Asante-Akim South District Assembly and The Assembly Member for the Ofoase Electoral Area) and One Traditional (A member of the Ofoase Traditional Council) — were chosen to get the political and institutional notion on Information Centres in the District and Ofoase in particular.
3. The Medical Assistant of the Ofoase Community Health Centre. The aim was to get the professional views on how the Emmanuel Information Centre helps, or otherwise, in communicating health information to the Ofoase people.
4. One herbal practitioner who patronizes Emmanuel Information Centre in advertising his or her products. He was randomly selected based on convenience. This is to know how effective the Emmanuel Information Centre is in promoting local medicine to the Ofoase populace.

3.6 Validity and Reliability

In the construction of questionnaire, validity and reliability were the two important considerations that were taken. Colin Phelan and Julie Wren (2005-06) explained reliability as “the degree to which an assessment tool produces stable and consistent results”. Thus, reliability is the degree of a research instrument (a test, questionnaire, an interview schedule, or an observation scheme) to measure a subject or variable at different occasions; and all the occasions give similar results, consistently. Validity, to Colin Phelan and Julie Wren (2005-06), is “how well a test (questionnaire, an interview schedule) measures what it is supposed to measure”. The validity and reliability of my study depended on the appropriateness of the instruments used to measure the variables.

3.7 PROCEDURE FOR DATA COLLECTION

3.7.1 Data Collection Tools

In using the quantitative method of data collection, a structured questionnaire was used. Study participants responded to a self-administered or interviewer-administrated structured anonymous questionnaire relating to socio-demographic information regarding the access, awareness, knowledge, attitude, practice, and relevance of the information about Health issues that are communicated by Emmanuel Information Centre. The questionnaire included both open-ended and close-ended questions. The closed-ended questions sought for specific responses.

And the open-ended questions allowed the respondents to adequately express themselves and add some relevant information on some of the issues that were raised in the questionnaire.

Under the qualitative technique, which Straus and Carbin (cited in Hoepfl 1997:2) define as “any kind of research that produces findings not arrived at by means of statistical procedures or other kinds of quantification”; structured interviews were the tools used for data collection. Doing interviews buttresses Neuman’s (1997: 206) assertion that “interviews are acceptable kind of sampling for special situations”.

3.7.2 Pre-testing

The data collection instrument was pre-tested on fifteen (15) people in Asankare. Pretesting was done to mainly determine the clarity, including the content validity, of the questions and also to reveal any problem that may be encountered in the main study. Asankare was chosen for the pre-testing because it has similar characteristics with Ofoase which was chosen for the study. The data collection technique was thus fine-tuned before the actual data collection for the study was initiated.

3.7.3 Data Collection Techniques/Method

Before administering the questionnaire, permission was sought from both the traditional and political authorities of Ofoase. Persons were then approached by the researcher in their homes. The purpose of the research and the non-compulsory nature of the survey were explained; and the confidentiality of answers given by respondents was assured. Questionnaires were administered to persons that consented to take part in the research as respondents. The literates (respondents who could read, decipher and write in English) used the self-administered technique. The questionnaires were then collected after filling. Portions of the questionnaires were explained for better understanding. The interviewer-administered technique of questionnaire administration was used to solicit responses from the illiterates (respondents who could not read, decipher, and write in English). Here I explained every question in 'twi' for their understanding and translated their answers in English. I addressed any question from the respondents regarding their right as research participants. My mobile phone number and address were also made available to the respondents.

In conducting the whole research, I made sure informed consent, privacy, and confidentiality were ensured. Data quality was ensured by pre-testing of data collection instruments, checking of completed questionnaire, re-interviewing, questionnaire editing, data cleaning and validation which included the cross checking of already entered data.

3.8 Data Processing and Analysis

Both quantitative and qualitative methods of data analysis were used to analyse the data collected. To Saunders et al. (2009), it is very important for the researcher to record, arrange the data and then apply various descriptive and inferential statistics to explain the data and to draw inferences. Field data was coded to facilitate the processing of data captured. Microsoft Excel 2010 was used to obtain frequencies for the various responses and tables and different charts were used to analyse the data. The conclusions of this study were therefore drawn from the analysed data.

CHAPTER FOUR

RESULTS/FINDINGS

4.0 Introduction

This study was embarked on to ascertain how Community Information Dissemination Centres Communicate Health Issues to the Rural Folks; concentrating on Emmanuel Information Centre in Ofoase in the Asante-Akim South District of the Ashanti Region.

Out of the 150 questionnaire sent out, 142 responded questionnaires were retrieved. This depicts a high return rate (95%) of the instrument.

This chapter presents the data collected and analyses the results that came out. The data is presented in three sections; sections A, B, and C. Section A focuses on the Bio-Data of the respondents. It analyses respondents' sex (gender), age, educational background, and occupation as at the time the data was collected. Section B deals with the analysis of the research questions that were raised for the study. Section C summarizes the interview responses from respondents.

4.1 Section A: Bio Data of Respondents

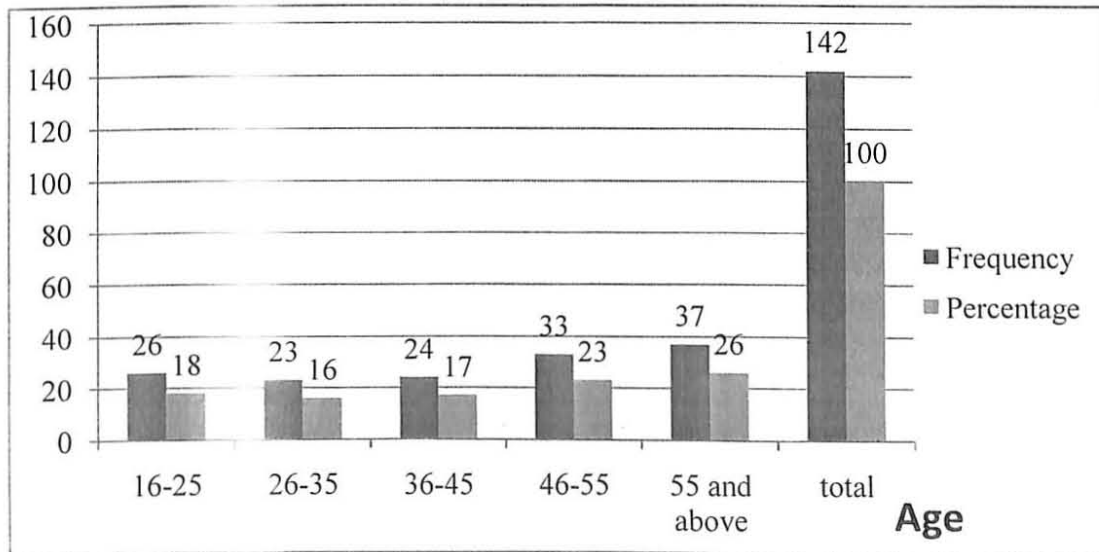
Table 1: Sex Distribution of Respondents of the Research Questionnaire

Gender	Frequency	Percentage
Male	66	46
Female	76	54
Total	142	100

(Source: Field Data, 2015)

Table 1 demonstrates that there were 66 male respondents, forming 46% and 76 female respondents making 54% of the total questionnaire retrieved (142).

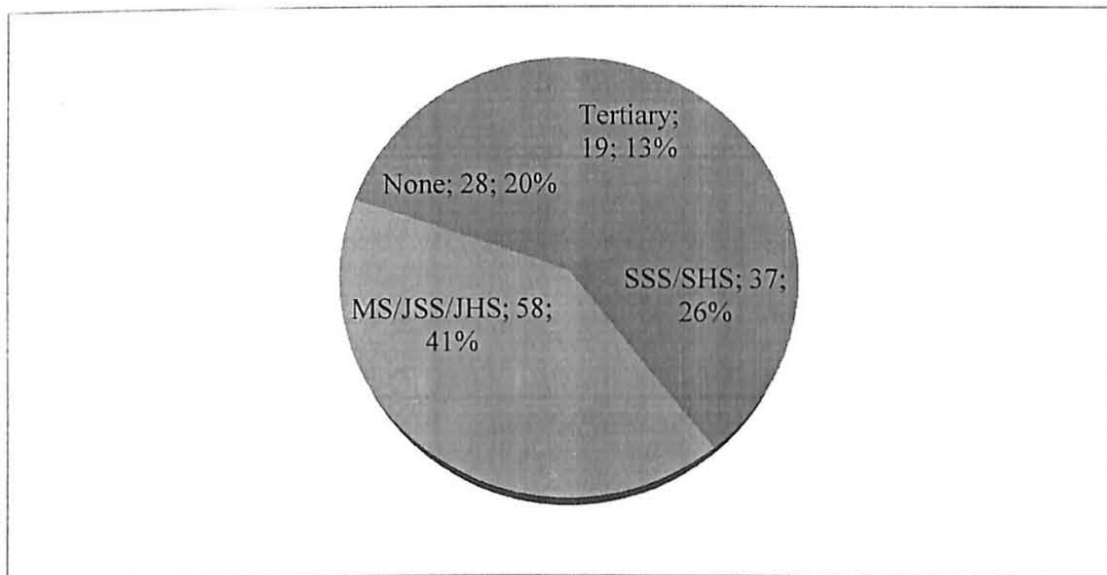
Chart 1: Age Distribution of Respondents of the Research Questions



(Source: Field Data, 2015)

As indicated in Chart 1, respondents between the ages of 16-25 were 26 amounting to 18% of the total number of responses retrieved. Respondents Aged 26-35 were 23, which is 16% of the total data. 24 respondents with a percentage of 17% were between the ages 36-45. Out of the 142, respondents between the ages 46-55 were 33, which was 23%. And respondents of 55 years and above were 37, which amounts to 26% of the total respondents.

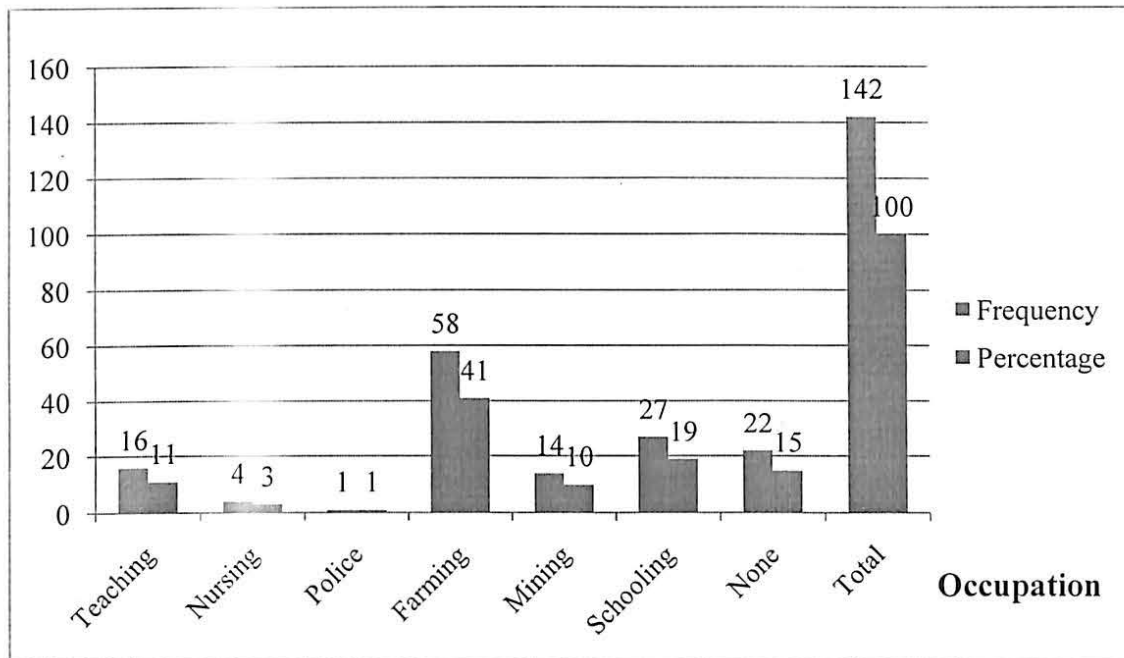
Chart 2: Highest Educational Level Achieved by Respondents to the Research Questions



Source: Field Data, 2015

Chart 2 denotes that 19 respondents representing 13% have completed Tertiary education. 37, representing 26% respondents have completed Senior Secondary School. Respondents who have completed Junior Secondary or Middle School were 58, which represent 41% of the total respondents. Lastly, 28 respondents representing 20% have no education.

Chart 3: Distribution of Respondents by Occupation



Source: Field Data, 2015

Chart 3 denotes that 16, representing 11% of the total respondents were teachers. 4, signifying 3% of the respondents were nurses. There was 1 police respondent representing 1%. Farmers were 58 representing 41% and miners were 14 representing 10%. 27 respondents were students, representing 19%; and 22 respondents that represents 15% said they were unemployed.

4.2 Section B: Distribution of Responses to Research questions that were raised for the study.

4.2.1 Objective 1: Source(s) of Health Information to the Ofoase citizens

Research Question 1: Where do you get your information on health issues?

Some of the responses given to the question of ‘source(s) of information to respondents’ are given below

- i. Radio
- ii. Information Centre
- iii. Clinic

Research Question 2: Do you recognize Emmanuel Information Centre as a Health Communication Avenue?

Table 2: Distribution of responses to the recognition of Emmanuel information Centre as a Health Communication Avenue

Responses	Frequency	Percentage
Yes	131	92
Uncertain	11	8
No	0	0
Total	142	100

Source: Field Data, 2015

Table 2 shows that 131 respondents, representing 92% of the total respondents, recognize Emmanuel information centre as a medium of Health communication. 11 respondents, symbolizing 8% were uncertain; and none of the respondents said he/she does not recognize Emmanuel Information Centre as a medium of health communication.

Research Question 3: How often do you patronize Emmanuel Information centre's health programmes?

Table 3: Distribution of responses to how often respondents patronize Emmanuel Information Centre's health programmes

Responses	Frequency	Percentage
Very Often	21	15
Often	96	68
Once in a while	25	18
Never	0	0
Total	142	100

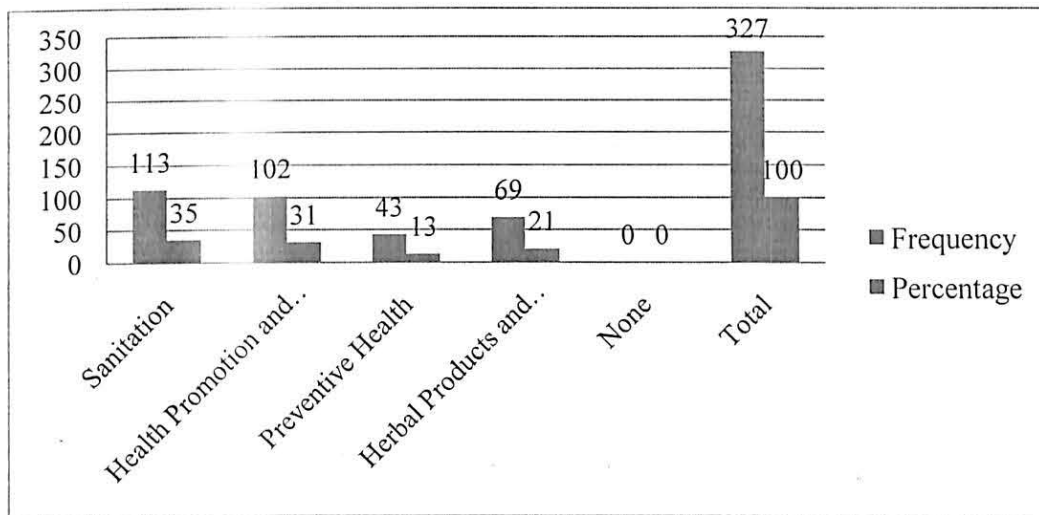
Source: Field Data, 2015

Table 3 shows that respondents who responded that they very often listen to Emmanuel Information Centre were 21, representing 15% of the total respondents. 96, representing 68% of the respondents said they often listen to the centre's health programmes. Whilst 25 of the respondents, signifying 18%, said they once in a while listen to the health programmes of the Emmanuel Information Centre, none of the respondents said they have never listened to the centre's health programmes.

4.2.2 Objective 2: Health issues that Emmanuel Information Centre communicates to the Ofoase populace.

Research Question 4: What health issue(s) do you know Emmanuel Information Centre communicate to the Ofoase people?

Chart 4: Distribution of responses to the health issue(s) that respondents do know Emmanuel Information centre communicate to the Ofoase people



Source: Field Data, 2015

The Research question allowed for respondents to choose more than one options. Thus the Frequency of the responses to this Research Question is higher than the usual Frequency (total number of respondents for the Questionnaire). The frequency for this question, therefore, is 327. Chart 4 therefore shows that, 113 respondents, representing 35% of the total respondents said they know Emmanuel Information Centre communicates sanitation issues. 102, signifying 31% of

respondents also know that Emmanuel Information Centre communicates health promotion and education. Preventive health accrued 43 responses, signifying 13%. 69 respondents, representing 21% responded that Emmanuel Information Centre communicates products and services concerning health. No respondent responded that Emmanuel information centre communicates nothing on health issues to Ofoase citizens.

Research Question 5: Which of the health issues do you usually listen to?

Table 4: Distribution of responses to the health issues that respondents do usually listen to

Responses	Frequency	Percentage
Sanitation	96	34
Preventive Health	91	32
Health Promotion and Education	40	14
Health Products and Services	55	20
None	0	0
Total	282	100

Source: Field Data, 2015

This Research question also allowed for respondents to choose more than one options. The response frequency for this research question is 282. Thus, table 4 explains that whilst 96 respondents, signifying 34% said they listen to the Sanitation issues communicated by Emmanuel Information Centre, 91, representing 32% respondents said they listen to Preventive Health issues. 40 respondents which represent 14% said they listen to Health Promotion and Education, 55, signifying 20% also said they listen to the communication of Health Products and Services by Emmanuel Information Centre. However, none of the represents said they do not listen to any of the health issues communicated by Emmanuel Information Centre.

Research Question 6: Do the health issues communicated by Emmanuel Information Centre address your health problems?

Table 5: Distribution of responses to whether the health issues communicated by Emmanuel Information Centre address the health problems of respondents

Responses	Frequency	Percentage
Yes	84	59
No	20	14
Uncertain	38	27
Total	142	100

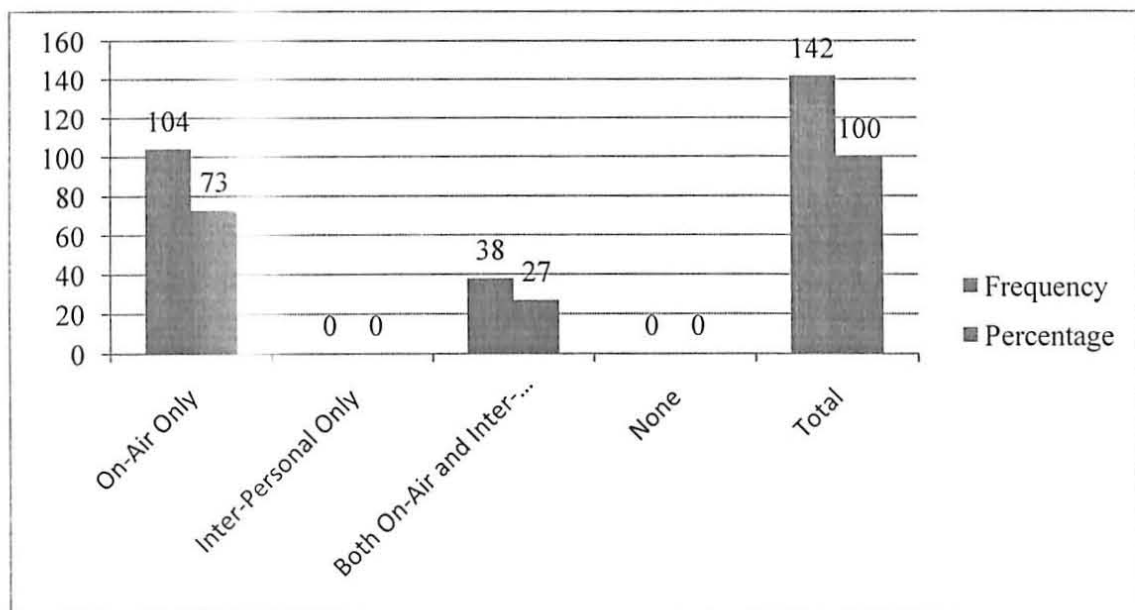
Source: Field Data, 2015

Table 5 indicates that 84 respondents, representing 59% believed that Emmanuel Information Centre address their health problems through its health communication. 38 respondents, indicating 27% were uncertain whether the communication of health issues by Emmanuel Information Centre addresses their health problems. And, 20 of the respondents, representing 14% believed Emmanuel Information Centre's health communication in no way addresses their health problems.

4.2.3 Objective 3: Process of communicating health issues to the rural folks of Ofoase by Emmanuel Information Centre.

Research Question 7: How does Emmanuel Information Centre communicate health issues to Ofoase people?

Chart 5: Distribution of responses to how Emmanuel Information Centre communicates health issues to Ofoase people



Source: Field Data, 2015

Chart 5 shows that 104 respondents, signifying 73%, says Emmanuel Information Centre communicates to them through programmes done and disseminated from the studios of Emmanuel Information Centre. 38 of the respondents, representing 27% said communication was through both On-Air and Inter-Personal Mediums.

None of the respondents believed that Emmanuel Information Centre communicates to them through Inter-Personal medium only.

Research Question 8: Do you understand the health issues communicated to you by Emmanuel Information Centre?

Table 6: Distribution of responses to respondents' understanding of the health issues communicated by Emmanuel Information Centre

Responses	Frequency	Percentage
Yes	93	65
No	38	27
Uncertain	11	8
Total	142	100

Source: Field Data, 2015

In Table 6, Whilst 93 respondents, representing 65% answered 'Yes' to whether they understand the health issues communicated to them by the Emmanuel Information Centre; 38 respondents, representing 27% answered 'No'. And, 11 respondents, signifying 8% were uncertain whether they understand the health issues communicated by the Emmanuel Information Centre.

Research Question 9: Do you like the days and hours such programmes are communicated?

Table 7: Distribution of responses to whether respondents like the time(s) that health programmes are communicated

Responses	Frequency	Percentage
Yes	94	66
No	15	11
Uncertain	33	23
Total	142	100

Source: Field Data, 2015

Table 7 shows that 94 respondents, signifying 66% said they like the times that Emmanuel Information Centre communicates health issues in Ofoase. 15 of the respondents, representing 11% responded no; and 33 respondents, signifying 23% were uncertain.

Research Question 10: How would you rate the person(s) that discuss health issues on Emmanuel Information Centre?

Table 8: Distribution of responses to how respondents rate the person(s) that discuss health issues on Emmanuel Information Centre

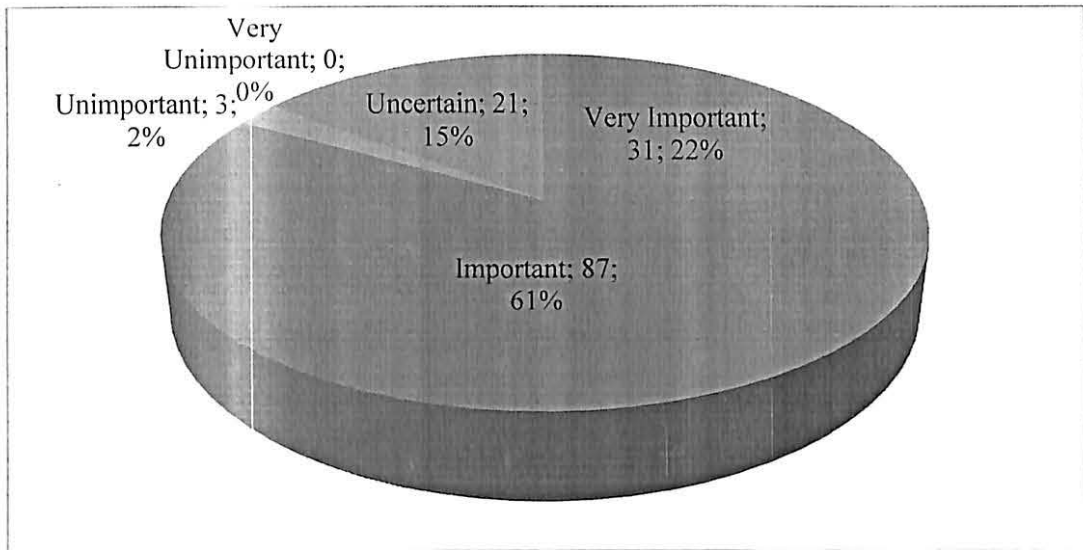
Responses	Frequency	Percentage
Very Insightful	13	9
Insightful	102	72
Naive	2	1
Very Naïve	0	0
Uncertain	25	18
Total	142	100

Source: Field Data, 2015

Table 8 denotes that 13 respondents, representing 9% see the persons who work at Emmanuel Information Centre as very insightful. 102, also representing 72% also see the communicators as insightful. Whilst 2 respondents, signifying 1% said the communicators are naïve, none of them said the communicators are very naïve. And, 25 respondents, representing 18% were uncertain about their response.

Research Question 11: How would you rate the Health issues that Emmanuel Information Centre communicates to Ofoase people?

Chart 6: Distribution of responses to how respondents rate the Health issues that Emmanuel Information Centre communicates to Ofoase



Source: Field Data, 2015

Chart 6 depicts that 31 respondents, demonstrating 22% believed the health programmes communicated by Emmanuel information centre are very important. 87 respondents, signifying 61% said the Health issues were important. 3 respondents representing 2% said those programmes are not important. The very unimportant response option had nobody to support. And, 21 respondents, representing 15% of the total, were uncertain with their answer.

Research Question 12: Any comment on the process of communicating health issues by Emmanuel Information centre?

Some of the comments given by respondents to Research Question 12 are the following,

1. The Facility should always let health experts do the communication.
2. The Facility should do more house-to-house (inter-personal) communication.
3. The communicators over emphasize health issues, sometimes making them nuisance.

4.2.4 Objective 4: How Emmanuel Information Centre involves the Ofoase populace in communicating health issues.

Research Question 13: Have you ever been involved in the communication of health issues by Emmanuel Information Centre?

Table 9: Responses distribution to whether respondents have ever been involved in the communication of health issues by Emmanuel Information

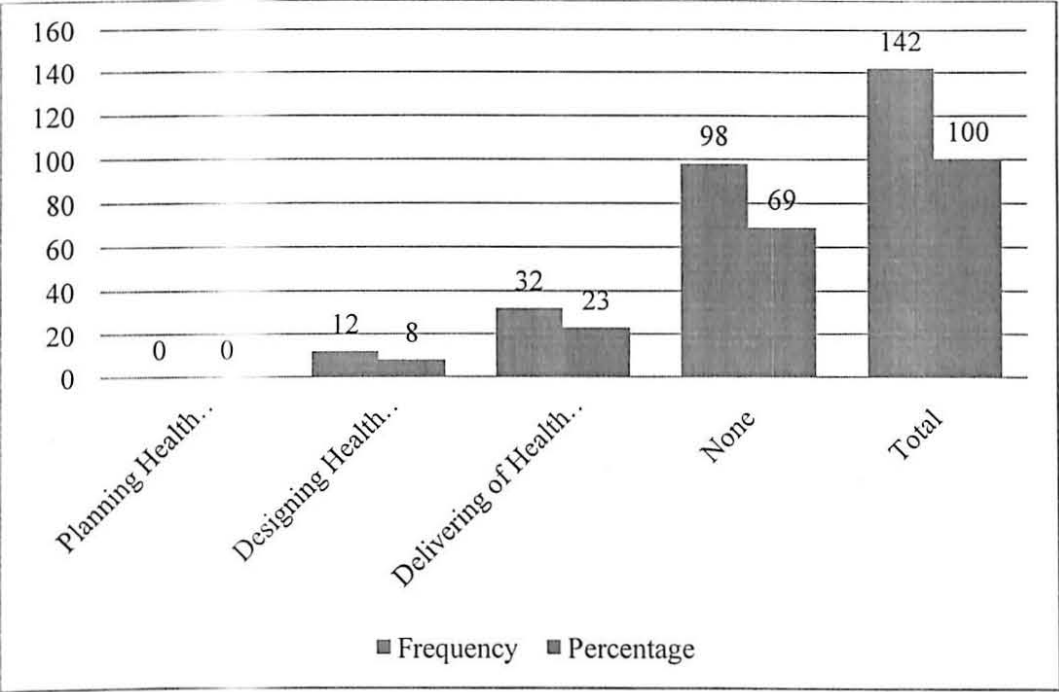
Responses	Frequency	Percentage
Yes	44	31
No	95	67
Uncertain	3	2
Total	142	100

Source: Field Data, 2015

In Table 9, respondents who said they have ever been involved in the communication of health issues by Emmanuel Information Centre were 44, representing 31%. 95 respondents, representing 67% said they have never been involved in the communication of health issues by Emmanuel Information Centre. And, 3 respondents, representing 2% were uncertain with their responses.

Research Question 14: How does Emmanuel information Centre involve you in communicating health issues? Through,

Chart7: Response distribution to how Emmanuel information Centre involves respondents in communicating health issues



Source: Field Data, 2015

Chart 7 reveals that none of the respondents agreed that Emmanuel Information Centre involves them in the Planning of health communication. Whilst 12 people, representing 8% of the respondents said they are involved in the Health Designing process, 32, signifying 23% agreed they are involved in the Health delivery process. 98 respondents, representing 69% said they have never been involved in any of the health communication process of Emmanuel Information Centre.

Research Question 15: In which of the health issues are you involved in by Emmanuel Information Centre in its health communication process?

Table 10: Response distribution to the health issues that respondents are involved in by Emmanuel Information Centre in its health communication

Responses	Frequency	Percentage
Sanitation	44	22
Health Education and Promotion	31	16
Preventive Health	23	12
Health Products and Services	0	0
None	98	50
Total	196	100

Source: Field Data, 2015

This Research question also allowed for respondents to choose more than one options. The response frequency for this research question is 196. 44 respondents, representing 22% said they are involved in communicating Sanitation issues. 31, signifying 16% respondents said their involvement is in Health Education and Promotion. 23, representing 12% responded that they are involved Preventive Health Communication. Nobody, representing 0% said he or she is involved in communicating Health Products and Services. And, 98, representing 50%,

responded that they have never been involved in communicating any of the health issues raised in the research question.

Research Question 16: Are you satisfied with the level of involvement of the community folks in the health communication by Emmanuel information Centre?

Table 11: Distribution of responses to the satisfaction of respondents with the level of involvement of the community folks in the health communication by Emmanuel information Centre

Responses	Frequency	Percentage
Yes	21	15
Uncertain	14	10
No	107	75
Total	142	100

Source: Field Data, 2015

In table 11, 21 respondents, representing 15% of the total responses said they are satisfied with the level of their involvement in communicating health by Emmanuel Information Centre. 14 respondents, representing 10% were uncertain with their responses. And, 107, signifying 75% said they are not satisfied with

their involvement level by Emmanuel Information Centre in communicating Health Issues to the Ofoase populace.

Research Question 17: Does Emmanuel Information Centre seek for feedback for health issues communicated to the Ofoase citizens?

Table 12: Distribution of responses to whether Emmanuel Information Centre seek for feedback for health issues communicated to the Ofoase citizens

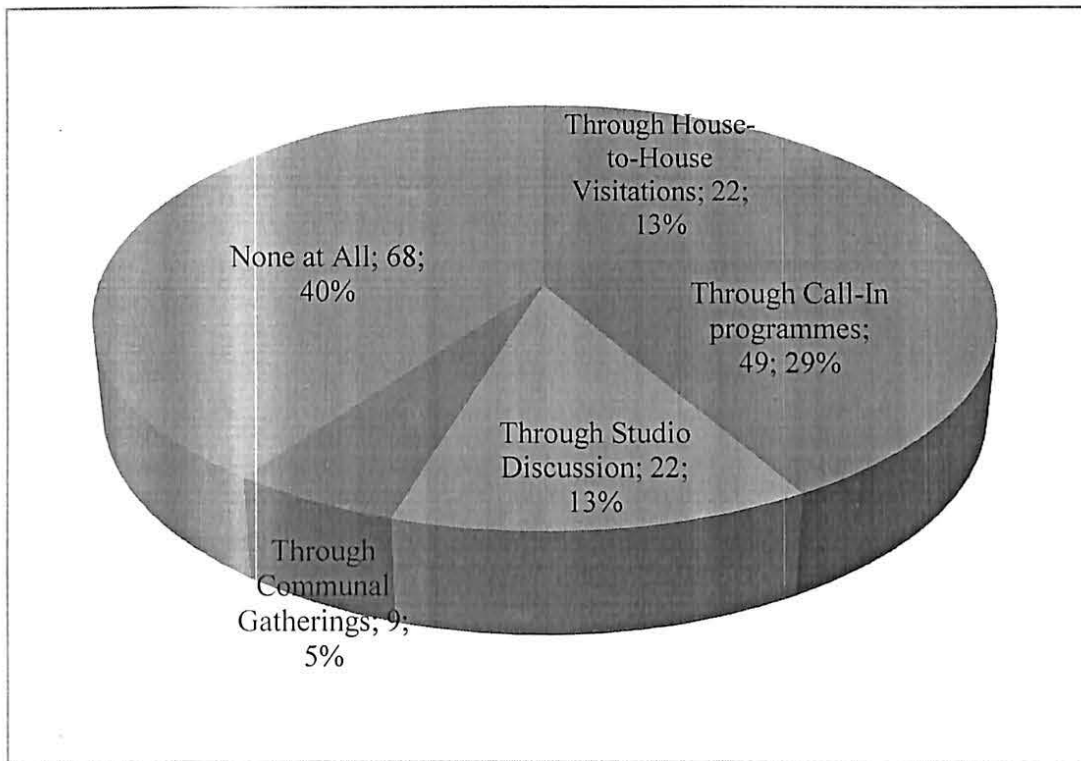
Responses	Frequency	Percentage
Yes	49	35
No	60	42
Uncertain	33	23
Total	142	100

Source: Field Data, 2015

Table 12 depicts that 49 respondents, representing 35% responded that Emmanuel Information Centre seeks for the feedback of the health communication done in Ofoase. 60 respondents, representing 42% answered no to whether Emmanuel Information Centre seeks for the feedback of health issues communicated. 33 respondents, denoting 23% were uncertain with their responses.

Research Question 18: How does Emmanuel Information Centre solicit for feedback from the people it has communicated health issues to?

Chart 8: Distribution of responses to how Emmanuel Information Centre solicit for feedback from the people it has communicated health issues to.



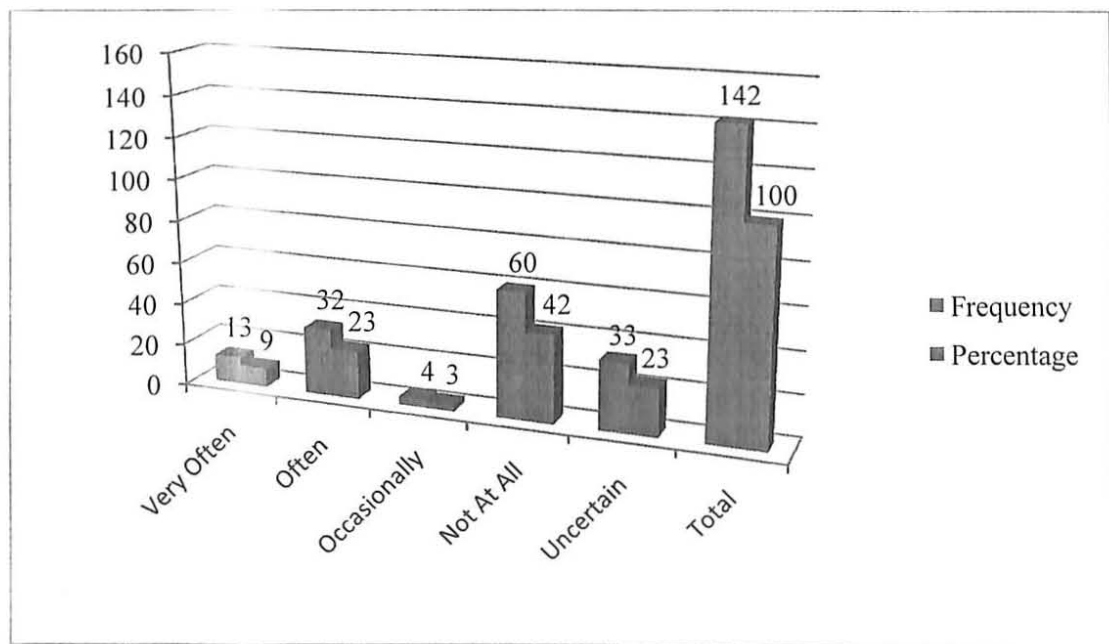
Source: Field Data, 2015

This Research question allowed respondents to choose more than one options. The response frequency for this research question was 170. 22 respondents, representing 13% said Emmanuel Information Centre uses House-to-House visitations to get its feedback for health issues already communicated to the Ofoase citizens. 49 respondents, signifying 29% said Emmanuel Information Centre solicit feedback from them through allowing them to call-in to programmes to express their experience. Another 22 respondents, representing

13% said their feedback medium is through inviting them to the studio of Emmanuel Information to discuss their experience. 9, representing 5% of the total (170) respondents said Emmanuel Information Centre uses communal gathering to get its feedback from them. 68 respondents, representing 40% believed Emmanuel Information Centre does not use any medium to get feedback for health issues communicated.

Research Question 19: How often does the Emmanuel Information Centre solicits for feedback?

Chart 9: Distribution of responses to how often the Emmanuel Information Centre solicits for feedback



Source: Field Data, 2015

Chart 9 shows that 13 respondents, signifying 9% of the total respondents, said Emmanuel Information Centre's feedback programmes to health issues communicated to Ofoase citizens is very often. 32, representing 23% said the feedback programmes are often. 4 respondents, denoting 3% believed the feedback programmes are occasionally. 60, signifying 42% replied that no programme is done to solicit for feedback for health issues communicated by Emmanuel Information Centre in Ofoase. And, 33, representing 23% of the respondents were uncertain with their responses.

4.2.5 Objective 5: Monitoring of the Health Communications of Emmanuel Information Centre.

Research Question 20: Are you involved in the official monitoring and evaluation of the activities and programmes of Emmanuel Information Centre?

Table 13: Distribution of responses to whether respondents are involved in the official monitoring and evaluation of the activities and programmes of Emmanuel Information Centre

Responses	Frequency	Percentage
Yes	0	0
No	142	100
Uncertain	0	0
Total	142	100

Source: Field Data, 2015

Table 13 denotes that, all the 142 respondents, representing 100% said they are not involved in the monitoring and evaluation of the activities and programmes of Emmanuel Information Centre.

4.2.6 Objective 6: Effect(s) of communicating health issues to the Ofoase populace through the Emmanuel Information Centre.

Research Question 21: What has changed in your life since Emmanuel Information Centre started the health communication in Ofoase?

Table 14: Distribution of responses to whether there is a change in respondents' life since Emmanuel Information Centre started the health communication in Ofoase

Responses	Frequency	Percentage
I now understand the Causes and Effects of some Diseases	98	32
I now know and can apply basic preventive health care practices	73	23
I now appreciate and practice Sanitation good measures	97	31
I have not seen any impact in my life	24	8
Uncertain	17	6
Total	309	100

Source: Field Data, 2015

Respondents had the freewill to choose more than one option under this question. The total frequency for response was 309. Table 14 shows that out of the total number of responses (309), 98, representing 32% responded that they now understand the causes and effects of some diseases by receiving Emmanuel Information Centre's health communication. 73 respondents, signifying 23%, said that they now know and can apply basic preventive health care practices. 97, amounting to 31% of the total respondents, said that they now appreciate and practice good sanitation measures. Respondents who believed they have not seen

any effect in their lives since receiving Emmanuel Information Centre's health communication were 24, representing 8%. 17 respondents, signifying 6% were uncertain with their responses.

4.2.7 Objective 7: The overall importance of Community Information Centres in communicating health information.

Research Question 22: How would you rate the overall performance of Emmanuel Information Centre in its health communication programme?

Table 15: Distribution of responses to how respondents rate the overall performance of Emmanuel Information Centre in its health communication

Responses	Frequency	Percentage
Very High	17	12
High	45	32
Average	56	39
Poor	4	3
Very Poor	0	0
Uncertain	20	14
Total	142	100

Source: Field Data, 2015

Table 15 shows that 17 respondents, representing 12%, rated Emmanuel Information Centre very high in its health communication. 45, representing 32% respondents rated Emmanuel Information Centre High in its performance. 56, signifying 39%, responses said the performance of Emmanuel Information Centre was average. 4 respondents, amounting to 3%, believed Emmanuel Information Centre's performance is poor. None responded to the very poor option. And, 20 respondents, signifying 14% were uncertain with their responses.

Research Question 23: Would you recommend Health Communication to other Information Dissemination Centres in other communities in the country?

Table 16: Distribution to responses to whether respondents would recommend Health Communication to other Information Dissemination Centres in other communities in the country

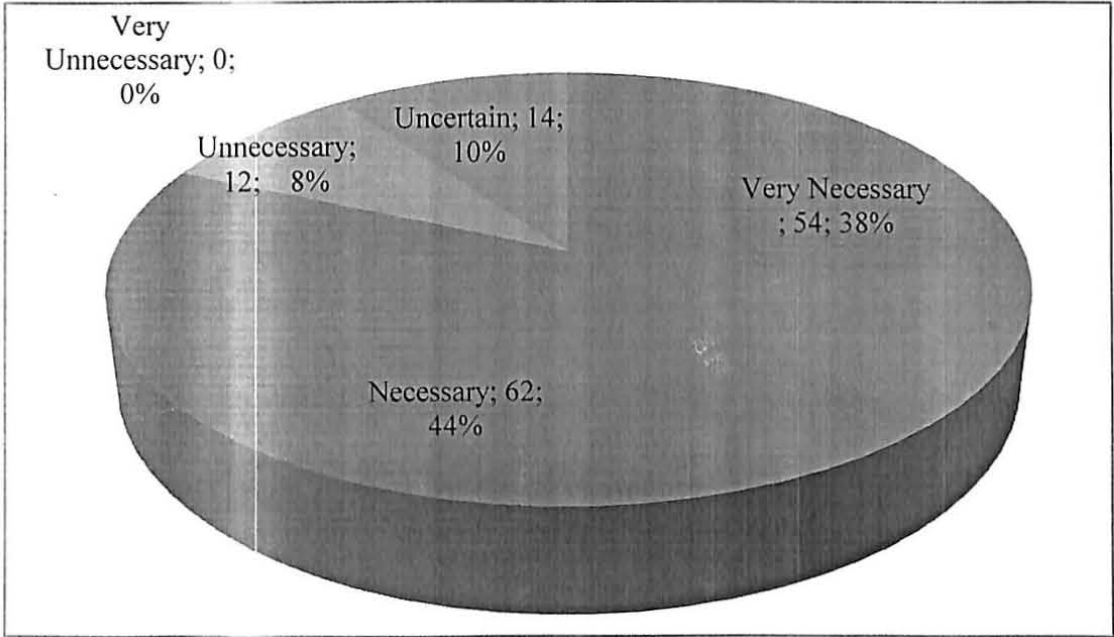
Responses	Frequency	Percentage
Yes	92	65
No	9	6
Uncertain	41	29
Total	142	100

Source: Field Data, 2015

In table 16, 92 respondents, representing 65%, responded that they will recommend Health communication as done by Emmanuel Information Centre in Ofoase to other Information Dissemination Centres in Other communities in Ghana. 9 respondents, representing 6%, replied with no. and, 41 respondents, signifying 29% were uncertain whether they would recommend, or not, health communication as done by Emmanuel Information Centre to other Information Dissemination Centres in other communities in Ghana.

Research Question 24: What is your impression of Community Information Centres in projecting Health Communication in Ghana?

Chart 10: Distribution of responses to respondents' impression of Community Information Centres in projecting Health Communication in Ghana



Source: Field Data, 2015

Chart 10 explains that 54 respondents, representing 38% of the total respondents said helping to promote Health Communication by Information Dissemination Centres in Ghana is very necessary. 62 respondents, representing 44% believed it is necessary. 12 respondents, representing 8% said it is unnecessary. None of the respondents responded that it is unnecessary. 14 respondents, representing, 10% were uncertain with their responses.

4.3 Section C: Summary of the Interview Responses

4.3.0 Introduction

The Owner of Emmanuel Information Centre is respondent 'A'. The District Chief Executive of the Asante Akim South District is Respondent 'B'. The Assembly Member for the Ofoase Electoral Area is respondent 'C'. The Sub-Chief and Member of the Traditional Council is respondent 'D'. The Medical Assistant of the Ofoase Health Centre is respondent 'E'. The Herbal Product seller who advertise her products at the Emmanuel Information Centre is respondent 'F'.

4.3.1 Interview Objective 1: Acceptability of Emmanuel Information Centre as a Medium of Communication.

All the respondents replied that they highly accept Community Information Centres as channels of communication to people.

4.3.2 Interview Objective 2: Sources of information on health issues that are disseminated by Emmanuel Information Centre to the Ofoase populace.

Respondent 'A' said that he gets his Information on Health Issues from radio and television programmes, and also from the Medical Assistant at the Ofoase Health Centre. Respondents 'B', 'C', 'D' and 'F' said they do not feed the Emmanuel

Information Centre with any Health Information. Respondent 'E' replied that he sometimes relays important health messages to the Centre to disseminate.

4.3.3 Interview Objective 3: Type of Health Information that Emmanuel Information Centre Communicates to Ofoase citizenry.

Respondent 'A' replied that he communicates issues in preventive health, especially on cholera, and recently Ebola, and also buttresses on environmental cleanliness. Respondents 'C', 'D' and 'E' supported respondent 'A'. All of them believed that it is always Emmanuel Information Centre sets the agenda on which health issue to project.

4.3.4 Interview Objective 4: The Process of communicating Health Issues to the Ofoase Population

Respondent 'A' said they disseminate health information through studio discussion; yet, sometimes organize communal gathering to discuss health issues affecting the community. He also stated that once in a while, with the help of the health centre, they do house to house outreach programmes. They do the communication in the 'Asante-Twi' dialect. He stated Tuesdays (morning and evening), Fridays (evening), and Sundays (evenings) as the days and times that the health programmes are communicated. Respondents 'C', 'D' and 'E' opined that the studio discussions outweighs the communal gathering and inter-personal processes.

4.3.5 Interview Objective 5: Community involvement and cooperation with Authorities

Respondent 'A' replied that they do involve the citizens of Ofoase in a few of their health communication programmes. But do not necessarily involve the Local Authority or Traditional Council members. Respondent 'E' is often involved in their communication process, especially in preventive health issues. And the feedback mechanism is through call in to programmes; and once in a while, with the help of the Health Centre, they visit individual homes to check on the usage, or not, of health tips they had disseminated. Respondents 'B', 'C', 'D' explained that they are not involved in the health communication programmes. Respondent 'F' said that she is occasionally involved in health communication programmes especially in herbal medicine and traditional practice.

4.3.6 Interview Objective 6: Monitoring of the Health Programmes communicated by Emmanuel Information Centre.

All the respondents replied that it is the District Assembly through the Information Services Authority monitors the Emmanuel Information Centre. Respondent 'B' stated that the Assembly has a task force that should have monitored the works of the Information Centres; yet, financial and logistic constraints restrict them from effectively doing that. Respondent 'C' and 'D' replied that they also monitor especially the adverts of products on the Centre.

4.3.7 Interview Objective 7: Effect of health Communication in the lives of Ofoase people

Respondent 'A' said that "there is attitudinal change in the dumping of refuse. People used to haphazardly dispose of refuse. But now, everybody goes to the central dumping area. Secondly, people now understand and apply preventive measures to some common disease like malaria. Thirdly, the citizens now attend health centre a lot compared to those days that they loved using traditional medicine". Respondents 'C', 'D', 'E' and 'F' responded that they have also seen some changes in the communal people especially in sanitation issues.

4.3.8 Interview Objective 8: The overall importance of community information centres in communicating health information.

Respondent 'A' believed that Emmanuel Information Centre is doing well in communicating Health to the Ofoase. He quoted "...on the scale of 10, I will not hesitate to give my team mark of 7". He responded that he shall recommend such health communication programmes to other Information Centres elsewhere in the District and the Country as a whole. Respondent 'B' believed "Information Centres are the newest way of reaching the whole community at the right time". He would rather rate their overall performance 5 out of 10; in that, even though these Information Centres are helping the State and the media with information dissemination, they should get professional by training themselves in journalism. To him, he would recommend health programmes to Information Centres that

have enlightened and educated people to handle the communication process. Respondents 'C' and 'D' replied that the Emmanuel Information Centre is their local media facility. To respondent 'D', "though the communicators are not all-knowing and professionals, they are the best hands we have for now", he rather believed Government should train communicators using the Information Centres to be abreast with issues and modern technologies. Respondent 'E' said that "Ghana has a lot of rural areas dominated by farmers. The best way to get to these farmers is to use the information centres. I just hope they would be well-equipped to efficiently and effectively do the work of communal communicator." To respondent 'F' Information Centres have given local businesses and herbal medicine a boost and a platform to reach the masses instantly. She stated that "I wished all Information Centres in Ghana can dedicate some of their time to educate their people on local medicine and traditional health-care as a better alternative to the mainstream medicine".

4.3.9 Interview Objective 9: Any other issue concerning information centres

One concern cut across: the issue of noise making. All the other respondents apart from respondent 'A' said Information Centres make a lot of noise. Respondent 'B' noted that

...there have been a lot of complaints in my office about the irking nature of these Information Centres. Some are even alleged to

have opened their volumes higher at late night. Others too would not allow their community members to even listen to radio or watch television, especially those staying close to their erected speakers. And the case worsens in communities with more than one Information Centres.... Their mandate is to educate and inform their people; not to kill their ears with unnecessary noise.

But, respondent 'A' believed Information Centres do not make noise. He said that it is those people who are not enthused with their involvement in the communal communication that are "endeavouring to give them a bad name in the quest to hang them".

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses the findings of the study. The study investigated how Information Centres in Ghana communicate health issues to the rural folks with emphasis on Emmanuel Information Centre in Ofoase in the Asante-Akim South District of the Ashanti Region. This chapter therefore summarizes the findings in relation to the Objectives set for the study, discusses the findings in relation to related Theories reviewed in Chapter 2 of the study, draw conclusions and make necessary recommendations to managers and stakeholders of Information Centres; and finally suggest possible research areas under Information Centres to future researchers.

5.1 Summary of Findings

The analysis of the data collected proved the following;

5.1.1 Research Objective 1: Discover the sources of information on health issues that are disseminated by Emmanuel Information Centre to the Ofoase populace.

The study showed that Emmanuel Information Centre gets the information on health issues that it communicates to the Ofoase people from Radio and Television programmes and from the Medical Assistant at the Health Centre. It also showed that rural people rely on the Media and their respective health centres for health information; and thus rely massively on Emmanuel Information Centre for health information.

5.1.2 Research Objective 2: Ascertain the type of health issues that Emmanuel Information Centre communicates to the Ofoase populace.

The study showed that keen interest in the health programmes of Emmanuel Information Centre helps address a number of their health issues. This emanates from the high rate of knowledge and listenership of the sanitation, health promotion and education, Preventive Health, and Herbal products by the citizens in Ofoase.

5.1.3 Research Objective 3: Examine the process of communicating health issues to the rural folks of Ofoase by Emmanuel Information Centre.

It was revealed that Emmanuel Information Centre relies hugely on studio production to disseminate health information in Ofoase; though they occasionally do inter-personal communication. The Ofoase citizens agreed that they appreciate the health programmes of Emmanuel Information Centre because the communicators are insightful; and the times that these programmes are communicated to them are favourable.

5.1.4 Research Objective 4: Examine how the Emmanuel Information Centre involves the Ofoase populace in communicating health issues.

The study showed that, the level of involvement of the Ofoase citizenry in health communication by Emmanuel Information Centre is very low. Only the Health Assistant (often times) and a handful of respondents (occasionally) to the Questionnaire said they were involved in the health communication of Emmanuel Information Centre.

5.1.5 Research Objective 5: Assess the monitoring of the health communication programmes done by Emmanuel Information Centre.

Responses to the question to the fulfilment of Research Objective 5 showed that monitoring of activities of information centres in the District is bad. There is

virtually no official monitoring on the part of the citizens who are direct beneficiaries of the health programmes that Emmanuel Information Centre communicates to them. The interview with the District Chief Executive revealed that, even the District Task Force in charge of monitoring is not effective due to resource and financial lapses.

5.1.6 Research Objective 6: Examine the effect of communicating health issues to the Ofoase populace through the Emmanuel Information Centre.

There was a high positive response to objective 6. Responses revealed that the health communication of Emmanuel Information Centre has a greater positive impact on the lives of the people. To them, disease prevention through attitudinal change has been effective through the communication of health programmes by Emmanuel Information Centre.

5.1.7 Research Objective 7: Assess the overall importance of Community Information Centres in communicating health information to rural Ghanaians.

Various responses denote that spreading health communication across the rural communities of Ghana through Community Information Centres is essential. This is seen in the massive high rating of Emmanuel Information Centre in its Health Communication task to Ofoase citizenry, a rural setup.

5.2 Discussion of Findings

5.2.0 Introduction

In studying Emmanuel Information Centre in its Health Communication, I used theoretical underpinnings. The underlying discussions reveal whether Emmanuel Information Centre works according to these Theories of Health Communication.

5.2.1 The Study in Relation to Media Advocacy Theory

Under the ‘Media Advocacy Theory’, it was revealed that Emmanuel Information Centre has been a strong advocate of good health and a better health care among the agrarian rural citizens of Ofoase. Emmanuel Information Centre does the advocacy through stimulating debate and promoting responsible portrayals and coverage of health issues. It also mobilizes resources and groups to promote and enhance certain issues and policies to change public opinion, social attitude and decisions in the Ofoase community. It does the advocacy also through organizing and disseminating information through various interpersonal and media channels.

5.2.2 The Study in Relation to Participatory Theory

With the ‘Participatory Theory’, it was discovered that the level of involvement of the Ofoase people in the health communication by Emmanuel Information Centre is very low. Feedback, which allows a facility to assess its progress in the

communication process, is very low. The citizens therefore are, more or less, passive participants of the health communication designed for them. They population, as showed by the responses, are relegated from the monitoring and control of the facility and programmes that are supposed to alter their way of life. It is therefore evident that much is desired by Emmanuel Information Centre in its health communication to the Ofoase populace in relation to the Participatory theory.

5.2.3 The Study in Relation to Agenda Setting Theory

‘Agenda Setting Theory’ denotes the media taking the pivotal role in raising issues that need to be discussed and putting pressure on decision-makers. Emmanuel Information Centre scored higher marks under this theory. The communication facility has been setting the health agenda in the community: by organizing thematic health programmes in Ofoase. Due to rural and agrarian lifestyle of the Ofoase populace, Emmanuel Information Centre sets the agenda on health issues that have direct impact on the people. These include preventive health care, sanitation issues, and promotion of healthy life, among others.

5.2.4 The Study in Relation to Diffusion of Innovation Theory

And, with regards to ‘Diffusion of Innovation Theory’ the communication of health innovation and practices emphasizing on knowledge transmission and acquisition as well as changes in knowledge, attitudes and beliefs by Emmanuel

Information Centre was paramount; as the study revealed. Various interviews depicted that Emmanuel Information Centre communicated to the Ofoase people the awareness, knowledge and interest, decision, trial, and adoption/rejection of health issues and programmes. According to Rogers (1962), development communication is a process: a systematic transfer of an idea from a source to a receiver to change behaviour. The underlying principle here is to change the receiver's knowledge of some idea, create or change his attitude toward the idea, or persuade him to adopt the idea as part of his regular behaviour. Health communication therefore transfers health issues from a source to a receiver with the intention of changing behaviours. And the study did show that Emmanuel Information Centre is in sync with the Theory in its health communication to the Ofoase Populace.

5.3 Conclusion

It has been established by this study that Community Information Centres have come to stay. And in their quest for perpetual existence have added to their numerous themes a very technical field in development communication (Health Communication). The study showed that Emmanuel Information Centre is actually communicating health issues to the Ofoase community and it is having a positive impact on them. The hard fact is that these Local people are not involved in the communication process and programmes that are communicated to them. Another fact that came to bare is that Emmanuel Information Centre makes noise and create a sort of nuisance to the Ofoase populace.

5.4 Recommendations

1. Community Information Centres should involve the local people in the communication of health programmes.
2. Community Information Centres should do more house-to-house (inter-personal) communication.
3. The communicators using Information Centres should not over emphasize health issues; but explain issues and medicine as they really are.
4. Government and Funding Agencies should promote Community Information Centres in their health communication.
5. Government should make funds available for the monitoring and control teams to Information Centres in Ghana to help facilitate their work.
6. Community Information Centres should be monitored effectively to put them on their toes in their task.
7. Government, and District Assemblies, should actively use the noise-control laws to control the volumes of Community Information Centres.
8. Community Information Centres should check the legitimacy of Herbal Products that are promoted by their facilities. These products should be registered by the various regulatory and licensing authorities.
9. Government should train volunteers working in Information Centres on Health communication.

5.5 Suggestions for Further Research

With the findings of the study, the following suggestions are made for further research

1. Communicating health issues to the rural folks: the role of Community Information Centres. A study of Community Information Centres in other Communities in Ghana.
2. Involving the recipients of health communication by Community Information Centres in Ghana.
3. Promoting Health Insurance policies in communities through Community Information Centres.
4. Control and Monitoring of Community Information Centres in Ghana.

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APPENDIX 'A'

QUESTIONS FOR THE RESPONDENTS FOR QUANTITATIVE DATA

GHANA INSTITUTE OF JOURNALISM

These are Research Questions designed to solicit for information to fulfil the objectives of a Study with the topic 'Communicating Health Issues to the Rural Folks: The Role of the Community Information Dissemination Centre. A Study of Emmanuel Information Centre in Ofoase in the Asante-Akim South District'.

This questionnaire is strictly for academic purposes only; and any information given is highly confidential. I am very grateful for your time and cooperation.

Kindly tick (✓) the appropriate option box unless otherwise stated.

SECTION A

Bio-Data

1. Sex:

a. Male [] b. Female []

2. Age (years)

- a. 16-25 [] c. 36-45 []
- b. 26-35 [] d. 46-55 [] e. 56 and above []

3. Highest Educational Qualification?

- a. Tertiary [] c. MS/JSS/JHS []
- b. SSS/SHS [] d. None []

4. Occupation:

SECTION B

I. Source(s) of health information to the Ofoase citizens

5. Where do you get your information on health issues?

(You can write more than one source)

.....

6. Do you recognize Emmanuel information centre as a Health Communication Avenue?

- a. Yes [] b. No [] c. Uncertain []

7. How often do you patronize Emmanuel Information centre's health programmes?

- a. Very Often [] b. Often [] c. Once in a while []

d. Never []

III. Process of communicating health issues to the rural folks of Ofoase by Emmanuel information centre.

11. How does Emmanuel Information centre communicate health issues to Ofoase people?

- a. On-air only [] c. Both On-Air and inter-personal []
b. Inter-personal only [] d. none []

12. Do you understand the health issues communicated to you by Emmanuel Information Centre?

- a. Yes [] b. No [] c. Uncertain []

13. Do you like the Days and Hours such programmes are communicated?

- A. Yes [] b. No [] c. Uncertain []

14. How would you rate the person(s) that discuss health issues on Emmanuel Information Centre?

- a. Very Insightful [] d. Very Naïve []
b. Insightful [] e. Uncertain []
c. Naive []

15. How would u rate the Health issues that Emmanuel Information Centre communicates to Ofoase people?

- a. Very Important [] b. Important []

c. Not Important []

d. Very Unimportant []

e. Uncertain []

16. Any comment on the process of communicating health issues by Emmanuel Information centre?

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IV. How Emmanuel information Centre involves the Ofoase populace in communicating health issues.

17. Have you ever been involved in the communication of health issues by Emmanuel Information Centre?

a. Yes []

b. No []

c. Uncertain []

18. How does Emmanuel information Centre involve you in communicating health issues? Through, *(You can tick more than one option)*

a. Planning of health communication []

b. Designing of Health Communication []

c. Delivery of Health Communication []

d. None []

23. How often does the Emmanuel Information Centre solicit for feedback?

a. Very Often [] b. Often [] c. Occasionally []

d. Uncertain []

V. Monitoring of the Health Communications of Emmanuel Information Centre.

24 Are you involved in the official monitoring and evaluation of the activities and programmes of Emmanuel Information Centre?

a. Yes [] b. No [] c. Uncertain []

VI. Effect(s) of communicating health issues to the Ofoase populace through the Emmanuel information Centre.

25. What has changed in your life since Emmanuel Information Centre started the health communication in Ofoase?

a. I now understand the Causes and Effects of some Diseases []

b. I now know and can apply basic preventive health care practices []

c. I now appreciate and practice Sanitation good measures []

d. I have not seen any impact in my life []

e. Uncertain []

VII. The overall importance of community information centres in communicating health information.

26. How would you rate the overall performance of Emmanuel info Centre in its health communication programmes?

- a. Very High [] c. Average [] e. Very Poor []
b. High [] d. Poor [] f. Uncertain []

27. Would you recommend Health Communication to other Information Dissemination Centres in other communities in the country?

- a. Yes [] b. No [] c. Uncertain []

28. What is your impression of Community Information Centres in projecting Health Communication in Ghana?

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APPENDIX 'B'

INTERVIEW QUESTIONS FOR THE PURPOSIVE RESPONSES

GHANA INSTITUTE OF JOURNALISM

These are Research Questions designed to solicit for information to fulfil the objectives of a Study with the topic 'Communicating Health Issues to the Rural Folks: The Role of the Community Information Centre. A Study of Emmanuel Information Centre in Ofoase in the Asante-Akim District'. You were purposely selected to give your view on the role of Information Centres in communicating Health Issues.

This interview is strictly for academic purposes only; and information given is highly confidential. I am very grateful for your time and cooperation.

1. Acceptability of Emmanuel Information Centre as a Medium of Communication.

1. Do you recognize Emmanuel Information Centre as a Channel of Communication?

2. Discover the sources of information on health issues that are disseminated by Emmanuel Information Centre to the Ofoase populace.

2. Does outfit help the information centres with information?
3. What type of information do you relay to information centres?
4. Does your outfit give information to the Information Centres?

3. Ascertain the type of health issues that Emmanuel Information Centre communicates to the Ofoase populace.

5. What type of health issues does the Emmanuel Information Centre communicate to the Ofoase populace?

4. Examine the process of communicating health issues to the rural folks of Ofoase by Emmanuel Information Centre

6. How does Emmanuel Information centre communicate health issues to Ofoase people?
7. Do you understand the health issues communicated to you by Emmanuel Information Centre?
8. Do you like the time(s) such programmes are communicated?
9. How would you rate the person(s) that discuss health issues on Emmanuel Information Centre?

10. How would you rate the Health issues that Emmanuel Information Centre communicates to Ofoase people?

5. How Emmanuel information Centre involves the Ofoase populace in communicating health issues.

11. Have you ever been involved in the communication of health issues by Emmanuel Information Centre?

12. How does Emmanuel information Centre involve you in communicating health issues?

13. In which of the health issues are you involved in by Emmanuel Information Centre in its health communication process?

14. How does Emmanuel Information Centre solicit for feedback from the people it has communicated health issues to?

6. Monitoring of the Health Communications of Emmanuel Information Centre

15. How are you involved in the official monitoring and evaluation of the activities and programmes of Emmanuel Information Centre?

7. Effect(s) of communicating health issues to the Ofoase populace through the Emmanuel information Centre.

16. What changes have you observed since Emmanuel Information Centre started the health communication in Ofoase?

8. The overall importance of community information centres in communicating health information.

17. How would you rate the overall performance of Emmanuel info Centre in its health communication programmes?

18. Would you recommend Health Communication to other Information Dissemination Centres in other communities in the country?

19. What is your impression of Community Information Centres in projecting Health Communication in Ghana?

8. Any other issue on information centres

20. What other issues would you like to share about information centres?