

Sources and Channels Rural Communities Use to Access and Use Health Information on Schistosomiasis in Ukerewe District, Tanzania

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Abstract

The main objective of this study was to assess sources and channels rural communities use to access health information on Schistosomiasis in Ukerewe District, Tanzania. The study adopted a convergent parallel design. The sample size for this study was 399. Multistage sampling was used to select 399 respondents, and purposive sampling was used to select 7 key informants. Interviews, focus groups, and questionnaires were used to collect data. SPSS version 29 was used for quantitative data analysis, while NVivo software version 9 was used to analyse qualitative data thematically. The findings indicate rural communities frequently access and use information on schistosomiasis through informal sources, such as family members, friends/peers, vijiwe vya kahawa, religious leaders, and village/local leaders. The study findings further revealed that the factors influencing their choice of information sources were ease of access, affordability, and availability. The findings further suggested that rural residents prefer information sources that do not require technical skills to use, are low-cost and are consistently accessible. Based on the findings, the study concludes that rural communities have diverse and unmet health information needs, driven by the use of informal sources that may provide misleading information. The study further concludes that these sources and channels are ineffective at disseminating information to rural communities. The study recommends that the government allocate sufficient funds to print and distribute leaflets, posters, and brochures to community members. The study further

recommends that the government should establish medical libraries, expand internet access and improve mobile networks in rural areas.

Keywords: *Health Information, Health Information Sources, Rural communities, schistosomiasis, and Tanzania.*

Introduction

Access to accurate, relevant, and timely health information among rural communities is crucial to improving health outcomes by empowering them with public health awareness, self-care, disease management, and the promotion and adoption of preventive behaviours, and better decision-making about their health and well-being (Heaton-Shrestha et al. 2023). Protecting a population's health, such as through the control, prevention and proper management of disease, significantly relies on the accessibility and use of reliable health information (Royston et al, 2020). Inadequate access to and use of health information and knowledge hinder rural residents from eliminating and combating diseases, including schistosomiasis, thereby increasing their prevalence (Feng et al., 2023).

Limited access to and use of health information have become a global health concern, restricting people's ability to obtain relevant, accurate, and timely health information. People in many parts of the world struggle to access and use health information (Royston et al. 2020). Furthermore, Bouh et al. (2024) reported that about 3.5 billion people worldwide have limited access to and use of health information services. However, the situation is worse in developing countries, where high illiteracy rates, limited health information infrastructure, limited health information literacy, internet access issues, and limited access to health education are common (Bagherian & Sattari, 2022). In Tanzania, particularly in Ukerewe district, studies by Mazigo et al. (2019, 2021, 2022,

2024) and Mbugi et al. (2024) reported a serious problem of the highest prevalence of schistosomiasis among community members. The district has the highest prevalence of schistosomiasis (53%) of all the districts in the country.

Despite the efforts and initiatives made by the Government of Tanzania to promote and improve the provision of health information services to community members through various channels, including Mobile health Apps, health education, health facilities, mobile health clinics, hospitals' noticeboards, and tele-health services, to improve health outcomes, control disease, and prevent disease transmission, Ukerewe district still has the highest prevalence of schistosomiasis, making it the country's leading district (Mbugi et al. 2024). The current study, therefore, sought to assess sources and channels rural communities use to access and use health information on Schistosomiasis in Ukerewe district. Understanding these sources and channels was essential for improving the strategies for the provision of health information services and ultimately combating and eliminating the disease.

Objectives of the Study

The main objective of this study was to assess sources and channels rural communities use to access and use schistosomiasis information in Ukerewe district. Specifically, the current study was guided by the following specific objectives:

- 1) To examine the frequently used sources and channels to access schistosomiasis information among rural communities in Ukerewe district.

- 2) To assess the effectiveness of the available sources and channels in facilitating access to schistosomiasis information among rural communities in Ukerewe district.
- 3) To investigate the factors influencing the choice of health information sources and channels among rural communities in Ukerewe district.

Literature Review

Sources and Channels of Health Information

Health information is fundamental to raising public health awareness, leading to improved health outcomes and behavioural change within the community. Access to and use of health information empower community members to make informed decisions about their own health and that of their families (Adeyemo et al. 2025). According to Yehula et al. (2023), rural community members access health information on schistosomiasis prevention through sources such as radio, television, and community health education programs, thereby improving their knowledge, attitudes, skills, and practices regarding its prevention and control. Yehula added that access to and use of health information are essential protective and preventive measures against disease. To access and use health information, individuals should be able to seek, understand, apply and appraise health information sources effectively. Maha et al. (2024) argued that rural communities access health information on schistosomiasis prevention through digital technologies, including telehealth, mobile health applications and health education programs. Another study by Mulopo & Chimbari (2021) argued that rural communities were provided with health information on schistosomiasis prevention through health education programs by placing much emphasis on hygiene and sanitation.

Makau-barasa et al., (2023) reported that mass media (TV, radio, and newspapers) are used to disseminate health information on schistosomiasis prevention to rural communities. The findings further suggested that providing health information about schistosomiasis may result in behavioural change in the population. Anyolitho et al. (2024) indicated that health workers were used to disseminate schistosomiasis-related information, even though they faced challenges in delivering outreach services to rural communities, including limited resources, larger coverage areas, transportation issues, and a lack of motivation.

Santos et al. (2023) suggested that most rural community members had low levels of education, which hindered their access to health information from reliable sources. Additionally, the study reported limited health education, characterised by inadequate numbers of community health workers in the area. Another study conducted by Reigl et al., (2025) in rural Uganda found that health information on schistosomiasis prevention is provided to rural communities through various sources, including community radio, community volunteers, local leaders, trained village health team members, teachers, and community health workers at government health facilities. Moreover, the study revealed that eliminating schistosomiasis prevalence in rural communities requires serious interventions, such as community health education and the dissemination of health information on schistosomiasis prevention to raise awareness among community members (Anyolitho et al., 2024).

Effectiveness of Information Sources and Channels in Improving Access to Health Information

A study by Yohana et al. (2022) on Assessment of Knowledge, Attitude and Practice on Schistosomiasis in Zanzibar reported that schools, mass media (radio, TV and newspapers), hospitals, special trainings and families were the effective health information sources and channels used by community members to access information and knowledge on schistosomiasis. Another study by Ssali et al. (2021) in Uganda, suggested that the main and reliable sources and channels of information on schistosomiasis were health workers, village health teams, radio and TV programs and teachers. The sources were reliable, accurate, and effective in disseminating health information. Additionally, Yehula et al. (2023) found that rural community members access health information on schistosomiasis prevention, modes of transmission and its symptoms through sources such as radio, television, and community health education programs.

Mindu et al. (2020), on the other hand, revealed that the effective sources and channels of information on schistosomiasis were edutainment and infographics. These sources were reliable and accurate, and schoolchildren used them to access information to prevent themselves from contracting schistosomiasis. Another study by Anyolitho et al. (2024) in Kenya revealed that community members access information on schistosomiasis through health workers and healthcare facilities. These sources and channels were reported to be reliable and accurate, making information available at the community level.

Factors for Choosing Health Information Sources

Numerous factors can influence rural communities' selection of health information sources. Almaazmi et al. (2023) mentioned that health information needs, trustworthiness, sociodemographic status, rural community members, credibility, and intention play a significant

role in choosing information sources and channels. Information needs drive people to seek out information. If the socio-economic status of community members is poor, it can affect their selection of the sources. Another study by Obaremi & Olatokun (2022) in Nigeria indicates that, in rural areas, community members' choice of information sources primarily depended on ease of access, affordability, and the reliability of the sources in meeting their information needs. Additionally, the study by Quartey et al. (2025) in Ghana found that trust in sources and easy access to health information were the main factors in selecting health information sources, including family and friends, health professionals, the media, and the internet.

Theoretical Framework

The current study was guided by Wilson's Model of Information-seeking Behaviour. According to Ugbala et al. (2022), Wilson's model of information-seeking behaviour was coined by Thomas Wilson in 1999. The current study draws on Wilson's (1999) model of information-seeking behaviour as the most relevant since its key assumption aligns with all the study objectives, providing a clear lens on how rural communities use information sources to access and use health information on schistosomiasis (Kundu, 2022; Patel & Oza, 2021). The key assumptions of this model include: information-seeking behaviour, information use, information needs, information communication and intervening variables. The construct of information communication aligns with all objectives, including the sources and channels, the frequency of source access and use, and the factors influencing the choice of information sources, providing a strong theoretical foundation for explaining how rural communities can access information on schistosomiasis through various information sources. The Wilson's model emphasises that rural communities can access

information on schistosomiasis through various sources, such as community meetings, posters, radio, community health workers, libraries and information centres.

Methodology

The current study adopted a convergent parallel design to assess the sources and channels rural communities use to access and use health information on schistosomiasis in Ukerewe district. The target population of this study was rural communities. Purposive sampling was adopted to select Ukerewe district and 7 wards, including Muriti, Murutunguru, Ngoma, Kagunguli, Bukindo, Kakukuru and Namagondo. In contrast, multistage sampling was used to select 399 respondents, ensuring that every member of the population had an equal chance of being selected. The main data collection methods were questionnaires, interviews, and focus group discussions. SPSS version 29 was used to analyse quantitative data using descriptive analysis, while NVivo software version 9 was used to analyse qualitative data thematically.

Findings and Discussion

Sources and Channels of Health Information Consulted

The findings in Table 1 reveal that out of 399 respondents, 315 (79%) access schistosomiasis information through community health workers, 192 (48%) health professionals, 247 (62%) village/local leaders, 227 (57%) religious leaders, 379 (95%) family members, 343 (86%) community meetings, 327 (82%) friends/peers and 191 (48%) hospitals' notice boards.

Table 1: Sources and Channels of Health Information Consulted

Health Information Sources and Channels Consulted	Frequency (N=399)			
	Very Frequently	Frequently	Rarely	Never
Family Members	379 (95%)	4 (1%)	12 (3%)	4 (1%)
Healthcare Professionals	68 (17%)	192 (48%)	100 (25%)	28 (7%)
Village/Local Leaders	56 (14%)	247 (62%)	60 (15%)	36 (9%)
Religious Leaders.	227 (57%)	96 (24%)	32 (8%)	24 (6%)
Community Health Workers	28 (7%)	315 (79%)	16 (4%)	40 (10%)
Friends/Peers	327 (82%)	44 (11%)	12 (3%)	16 (4%)
Medical Libraries/Information Centres	12 (3%)	8 (2%)	8 (2%)	371 (93%)
Radio Programme	128 (32%)	36 (9%)	168 (42%)	67 (17%)
TV Programmes	88 (22%)	28 (7%)	60 (15%)	203 (51%)
Internet	4 (1%)	8 (2%)	12 (3%)	375 (94%)
Mobile Health SMS	12 (3%)	16 (4%)	8 (2%)	363 (91%)
Hospitals Noticeboards	191 (48%)	52 (13%)	60 (15%)	96 (24%)
Mobile Health Apps	8 (2%)	16 (4%)	12 (3%)	363 (91%)
Printed materials (posters, brochures)	20 (5%)	60 (15%)	211 (53%)	108 (27%)
Community Meetings	343 (86%)	20 (5%)	28 (7%)	8 (2%)
Public Announcements (e.g., Loudspeakers)	12 (3%)	108 (27%)	235 (59%)	44 (11%)
Government Publications	16 (4%)	60 (15%)	311 (78%)	12 (3%)

Source: Field Data (2026)

Moreover, other formal sources and channels, including medical libraries/information centres, the internet, mobile health SMS, mobile health Apps, government publications, TV programmes, and radio programmes, were never consulted by rural communities to obtain information on schistosomiasis. The findings of the current study indicate that the majority of respondents never used libraries as information sources, likely because there are none within the district. Additionally, internet and mobile health Apps were never used to access health information; instead, most rural communities mainly used informal sources, such as friends/peers, vijiwe vya kahawa, family members, local leaders and religious leaders.

The study findings revealed that the majority of respondents, 375 (94%), and 371 (93%) respectively, never used medical libraries/information centres and the internet as their main sources and channels of information, probably because there is no medical or district library and poor internet access and mobile networks in Ukerewe district. Additionally, the results further suggested that the majority of rural community members never used mobile health Apps, mobile health SMS, television, or radio programs; therefore, they relied on informal sources, including family members, religious leaders, friends/peers, local leaders, community meetings, and home visits by community health workers. In contrast, others used hospitals' noticeboards and healthcare professionals as sources of health information and as channels for accessing information on schistosomiasis in the study area. This is probably due to inadequate infrastructure and the poor socio-economic status of rural communities in the district.

These results align with those from interviews and focus groups. During the interview with community health workers, one of them had this to say:

“...Okay, here in this community, we normally disseminate health information through various ways, including home visits and community meetings. Sometimes, we distribute posters, leaflets and brochures to community members and educate them about preventive measures of diseases...” (Community Health Worker 1, 2026).

Another one commented that:

“...In fact, we occasionally disseminate health information to rural communities through posters. But we mainly rely on community meetings, home visits, and other community gatherings such as VICOBA meetings and Vijiwe vya kahawa...” (Community Health Worker 2, 2026).

Vijiwe vya kahawa refer to places where people in the community tend to meet after work, usually in the evening, to drink coffee and ginger while telling stories. Therefore, community health

workers use these platforms to disseminate health information and education to rural community members. Another community health worker added that:

“... Well, actually, we normally disseminate health information to rural communities through many ways, such as home visits, community meetings, and through distributing brochures, posters, and leaflets when available ...” (Community Health Worker 3, 2026).

Another community health worker during the interview had this to say:

“... Personally, I disseminate health information to rural communities by visiting them at their homes, I also use community meetings and VICOPA meetings to provide them with health education and information ...” (Community Health Worker 4, 2026).

The findings from the FGD held in Murutunguru ward, comprising eight (8) discussants, including four (3) doctors and four (5) nurses. All eight (8) discussants reported that health professionals disseminate health information to rural communities through health centres’ notice boards and outreach programs in collaboration with community health workers. One doctor had the following to say:

“... Actually, at our health centre, we normally distribute health information and education to the residents through the health centre’s notice boards ...” (Doctor 1, 2026).

Additionally, the findings from the focus group discussion held in Muriti ward, which had eight (8) discussants, including five (5) nurses and three (3) doctors. All of them divulged that they disseminate health information to community members through collaboration with community health workers. One nurse commented:

“... We collaborate with community health workers in providing health information and education to rural communities. We normally conduct community outreach services to deliver information about schistosomiasis treatment and distribution of medicine to the infected ones ...” (Nurse 1, 2026).

Another focus group discussion carried out at Namagondo ward, which had also eight (8) participants, involving six (6) nurses and two (2) doctors, revealed that nurses and doctors rarely disseminate health information to rural communities. During the discussion, one nurse commented that:

“... Well, here at our health centre we distribute health information to rural residents through various ways, including the health centre’s notice board and outreach programs in collaboration with community health workers by distributing posters, leaflets, and brochures...” (Nurse 2, 2026).

The results of this study imply that the majority of rural community members in Ukerewe district mainly rely on informal channels, including community meetings, home visits, and other gatherings like *vijiwe vya kahawa*, religious leaders, village/local leaders, family members, and friends/peers to obtain health information, which may dilute the knowledge and information leading to some misconceptions. Rural communities access health information through such channels probably because of their convenience, easy availability and accessibility, affordability, and the modes of delivering information to community members. On the other hand, the study results imply that disseminating schistosomiasis information through formal channels such as health centres’ noticeboards is ineffective, as the residents who can access it through this channel are only those who visit the health centres to seek treatment. Healthcare professionals rarely use print channels, including posters, leaflets and brochures, to distribute health information to rural residents through outreach programs due to limited printing budgets. The study results imply that rural communities in Ukerewe district mainly access health information from sources and channels, including community health workers through home visits, community meetings, and other community gatherings such as VICOBA meetings and *vijiwe vya kahawa*; village/local leaders; friends/peers; religious leaders; and family members. These results imply that rural communities

access health information through such channels and sources, probably because of their convenience, easy availability, affordability and the way information is delivered to community members. Conversely, information sources such as health professionals and hospitals' noticeboards were less frequently used to provide information, while other sources, such as the internet, medical libraries, mobile health SMS and mobile health Apps were never consulted. This situation is probably due to poor information infrastructure, limited access to formal sources, high levels of illiteracy, a lack of awareness of suitable sources and channels and low levels of education among community members. In Ukerewe district, community health workers were the most frequently consulted sources of health information and the most commonly used channels. However, they mainly provided other types of health information, rather than information on schistosomiasis.

The results of this study are similar to those of several studies carried out in Africa. For instance, a study by Ssali et al. (2021) in Uganda reported that rural residents access information about schistosomiasis through the village health team (VHT), especially when VHT members travel to deliver drugs to infected residents. Additionally, health charts on schistosomiasis were displayed in government hospitals to disseminate information to rural community members. Healthcare professionals distribute schistosomiasis information, treatments in particular, to community members through home visits, especially when they go to give drugs to infected people. Another study by Khamis & Sylvester (2024) in Zanzibar supported the argument that rural communities access information about schistosomiasis through village meetings and community health education campaigns. These platforms are effective in disseminating health education at the community level. Anyolitho et al. (2024) reported that rural communities in Uganda access health

information on schistosomiasis through channels such as community meetings, village health team (community volunteers), local leaders, health workers and community radios.

Another study by Reigl et al., (2025) in Uganda, also revealed that rural communities access health information on schistosomiasis through healthcare professionals, community health workers, parents, school teachers, friends and radio programmes. Additionally, the study's findings are similar to those of Addo et al. (2024), who reported that rural communities in Ghana access health information through public health workers, family members, friends/peers, and mass media. Additionally, Anyolitho et al., (2024) in Uganda supported the argument that in rural areas where schistosomiasis is prevalent, health information is disseminated through posters, radio, community meetings, and community health workers. Moreover, Obaremi & Olatokun (2022) supported the findings by suggesting that rural communities access health information through various sources, such as community health workers, traditional healers, traditional birth attendants, town criers, posters, family members, and friends/peers.

Effectiveness of Information Sources and Channels in Improving Access to Schistosomiasis Information

The study findings in Table 2 show that, among 399 respondents, 295 (74%) indicated that friends/peers were effective in providing information about schistosomiasis, followed by 267 (67%) family members. Furthermore, 251 (63%) respondents mentioned religious leaders as an effective source for disseminating schistosomiasis information, 247 (62%) mentioned community health workers, and 235 (59%) respondents reported that village and local leaders were effective

in disseminating schistosomiasis information. On the other hand, very few respondents (28, 7%) mentioned the internet as their source of information on schistosomiasis.

Table 2: *Effectiveness of Information Sources and Channels*

Statement	Agreement Scale (N=399)				
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Religious leaders play an important role in disseminating schistosomiasis information in the community	20 (5%)	251 (63%)	12 (3%)	84 (21%)	32 (8%)
Friends and peers are important sources of schistosomiasis information in my community	24 (6%)	295 (74%)	28 (7%)	44 (11%)	8 (2%)
Community health workers provide understandable health information	52 (13%)	247 (62%)	36 (9%)	44 (11%)	20 (5%)
Village and local leaders effectively communicate schistosomiasis information to community members	48 (12%)	235 (59%)	28 (7%)	76 (19%)	12 (3%)
Radio and TV programs provide us with timely health information	40 (10%)	76 (19%)	48 (12%)	227 (57%)	8 (2%)
Family members frequently share schistosomiasis-related information among themselves	56 (14%)	267 (67%)	28 (7%)	40 (10%)	8 (2%)
The internet provides us with timely health information	28 (7%)	72 (18%)	44 (11%)	223 (56%)	32 (8%)
Libraries and information centres disseminate us schistosomiasis-related information	68 (17%)	32 (8%)	28 (7%)	251 (63%)	20 (5%)

Source: *Field Data (2026)*

Moreover, 76 (19%) reported Radio and TV programs, while 68 (17%) respondents mentioned libraries and information centres as effective sources of information on schistosomiasis. The findings in Table 2 below indicate that rural communities in the study area depend on interpersonal information sources and channels, such as family members, friends/peers, religious leaders, and

village and local leaders, as their effective sources for accessing information on schistosomiasis. Community health workers were also reported to be effective at disseminating health information at the community level. However, they were reported to disseminate general health information, while information on schistosomiasis was neglected.

These findings are consistent with those from interviews with community health workers, who reported disseminating health information at the community level through community meetings and home visits. However, the findings indicated that they actually disseminate health information on other topics, including sexual and reproductive health, maternal and child health, and malaria, rather than on schistosomiasis. One CHW from Namagondo ward had this to comment:

“...Actually, I disseminate health information in this community, specifically on other topics, including Malaria, sexual and reproductive health. Honestly, I have never disseminated information on schistosomiasis because in this area there is no project for schistosomiasis despite being chronic ...” (Community Health Worker 5, 2026).

Another community health worker from Kagunguli ward had this to say:

“...Well, it’s true that we (CHWs) disseminate health information to community members through home visits and community meetings, but actually we have never been trained on how to find and evaluate information we provide to rural community members...” (Community Health Worker 6, 2026).

The findings from the FGD held in Bukindo ward, including eight (8) discussants, including two (2) doctors and six (6) nurses. All eight (8) discussants reported that the only schistosomiasis information disseminated to rural communities is on treatment. During the discussion, one doctor commented:

“...Basically, we disseminate information on schistosomiasis, specifically on treatment to infected individuals in the community through Mass Drug Administration campaigns ...” (Doctor 2, 2026).

The findings of this study imply that community health workers were reported to be effective information sources. However, they provided general health information to rural communities, while CHWs found information on schistosomiasis inaccessible because they prioritised other health topics. Additionally, community health workers reported that, despite being information providers, they are unaware of how or where to find, and evaluate the health information they provide. This implies that community health workers were effective in disseminating information to the rural community; however, the information and health education provided are questionable. Additionally, the findings indicate that rural communities in the study area depend on interpersonal information sources and channels, such as family members, friends/peers, religious leaders, and village and local leaders, as their effective sources for accessing information on schistosomiasis. This implies that these interpersonal sources are effective in making information on schistosomiasis accessible to rural communities. However, its relevance, accuracy and appropriateness are doubtful.

The results of this study are similar to those of several studies worldwide. For instance, a study by Yohana et al. (2022) in Zanzibar identified special training, schools, families, and hospitals' noticeboards as effective sources and channels used by community members to access knowledge and information about schistosomiasis in the study area. Additionally, the findings of the current study align with those of Mulopo & Chimbari (2021), who reported that friends/peers, family members, and local leaders were mentioned as effective sources and channels community members used to access information on schistosomiasis.

Furthermore, the study's findings corroborate those of Ssali et al. (2021) in Uganda, who found that the main and reliable sources and channels of information on schistosomiasis were health workers, village health teams, radio and TV programs and teachers.

Factors for Choosing the Information Sources

The study findings in Table 3 show that out of 399 respondents, 315 (79%) preferred the affordability of the sources, 247 (62%) sources' reliability, 271 (68%) sources' closeness, and 245 (61%) revealed the format of the sources to be important factors for selecting the sources. Additionally, 319 (80%) reported ease of use of the source, 269 (67%) reported that their choice of information sources was based on the availability of the sources, and 287 (72%) indicated language familiarity as an important factor in choosing information sources. See Table 3 below.

Table 3: Factors for Choosing the Information Sources

Factors for Choosing the Sources	Very Important		Important		Moderate Important		Not Important	
	F	%	F	%	F	%	F	%
Ease of use	319	80%	48	12%	24	6%	8	2%
Affordability of the sources	315	79%	26	7%	39	10%	19	4%
Source's reliability	247	62%	84	21%	56	14%	12	3%
Sources' closeness to my place of residence	271	68%	104	26%	24	6%	-	-
Format of the source	245	61%	99	25%	42	11%	13	3%
Language familiarity of the sources	76	19%	287	72%	16	4%	20	5%
Availability of the sources	269	67%	87	22%	43	11%	-	-

Source: Field Data (2026)

The findings of the current study imply that the use of information sources among rural communities largely depends on their ease of access, affordability, and availability. Rural residents prefer information sources that do not require technical skills to use, are low-cost and are consistently accessible. The choice of these information sources is probably because of the poor socio-economic status of rural communities, since the majority of them have low levels of education, low-income levels and live in extreme poverty, they cannot afford to use other formal information sources such as internet, medical libraries, databases, websites, instead, they mainly rely on the sources that are free of charge, accessible to them geographically, in a language they understand and easy to use.

The findings of this study are similar to those of several studies carried out worldwide. For instance, the study findings are similar to those of Liu, (2023), who revealed that in rural areas, one of the factors for the selection of information sources is availability and accessibility of the information sources to the community members, of which sources such as search engines, family members and friends were more accessible. Another study by Obaremi & Olatokun (2022) in Nigeria also supported the argument that in rural areas, the choice of information sources among community members primarily depended on ease of access, affordability and the reliability of the sources in meeting their information needs. Additionally, the findings of the current study comply with the study by Quartey et al. (2025) in Ghana, who asserted that trust of the sources and easy access to health information were the main factors for the selection of the health information sources, including family and friends, health professionals, media and internet. On the other hand, Reyes et al. (2026) reported that trust in the source, geographical proximity, affordability, language familiarity, and the quality of communication are the main factors influencing the choice of sources among the community members in rural areas.

Conclusions and Recommendations

The study concludes that the majority of rural communities in Ukerewe district struggle to meet their information needs due to limited access to and use of information on schistosomiasis. They did not access health information on schistosomiasis from formal sources, such as the internet, medical libraries, mobile health applications, and telehealth services, were not adequately used by rural communities to obtain health information due to high illiteracy rates, limited information infrastructure, and the cost of the sources, as a result, they rely on informal sources, including family members, *vijiwe vya kahawa*, friends/peers, religious leaders, and village/local leaders, which may provide misleading information. Formal information sources. The study further concludes that the information needs of rural communities are largely unmet, as health information services in the district are inadequate. To improve accessibility of schistosomiasis information to rural communities, the study therefore recommends that rural communities should proactively seek out community health workers for information on disease prevention and control, modes of transmission, and diagnosis, rather than waiting for home visits. The study recommends that the government allocate sufficient funds to print and distribute leaflets, posters, and brochures to community members. It is further recommended that the government should establish medical libraries in rural districts, such as Ukerewe, to provide community-level access to health information resources and services. Moreover, ICT infrastructure should also be strengthened to bridge the digital divide by investing in telecommunications to expand internet access and improve mobile networks in rural areas.

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