UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF COMMUNITY MEDICINE

HEALTH STAFF'S KNOWLEDGE ATTITUDE AND PRACTICE OF THE HEALTH REFORMS
"A COMPARATIVE STUDY"

THESIS
SAK
1995

BY

BEATRICE KUTEMBA SAKUNGO

UNZA 1995
UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF COMMUNITY MEDICINE

HEALTH STAFF'S KNOWLEDGE ATTITUDE AND PRACTICE
OF THE HEALTH REFORMS
"A COMPARATIVE STUDY"

BY

BEATRICE KUTEMBA SAKUNGO
ZRN (1985) Kitwe
BSc Nursing (1991) UNZA, Lusaka

A Thesis submitted to the School of Medicine, Department of Community Medicine in partial fulfilment for the Master of Public Health Degree.

Lusaka, Zambia December 1995
DECLARATION

I hereby declare that the work presented in this study for a Master of Public Health degree has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

Signed: [Signature]

Candidate

Approved by: [Signature]

Supervisor
STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated and acknowledged in the paper and references.

Signed: [Signature] (candidate)
DEDICATION

This study is affectionately dedicated to my husband Chitambala M Chikotola and my children Kahana, Lukayi and Kalumbu for their love, understanding, support, encouragement and prayers during the time I was doing this work. I also remember my heavenly Father and the Lord Jesus Christ for the good health enjoyed and the direction given unto me throughout my study.
APPROVAL

This dissertation of Beatrice Kutemba Sakungo has been approved as fulfilling the requirements for the award of the degree of Masters of Public Health by the University of Zambia.

Signature:  

Date: 2.9.96
ABSTRACT

Objective: The objective was to determine whether the health staff understand what the health reforms are all about and whether they have accepted them and are practising in line with what has been stipulated in the guidelines.

Design: This was a descriptive comparative study which compared the urban and rural provinces to ascertain the relationships between staffs' knowledge, attitude and practice of the health reforms.

Setting: The study was carried out in the NorthWestern and Copper belt Provinces of Zambia. A total of ten Health Institutions were studied and these comprised of Government hospitals, Mission Hospitals and Health centres.

Subjects: A total of 238 health workers were studied and these comprised 15 Doctors, 147 Nurses, 41 Paramedical and 35 Clerks and Cashiers.

Sampling Method: A stratified sampling method was used for the Provinces and Districts as well as Health Institutions where pieces of paper with names written and randomly picked were used. Health staff were sampled randomly using a sampling frame. Proportions of the various cadres were got by using the sampling fraction of \( f = \frac{n}{N} \).

Results: The study reveals that there is poor dissemination of information from top to the bottom line and is concentrated more in the rural areas than urban. This has also affected all staff cadres with at least 32% and 28% of the 238 rating it as being very poor and poor respectively. This poor dissemination of information has been attributed to the use of ineffective channels of communication namely radio, TV., newspapers/bulletins, poor road networks and poor postal services. The supervisor, seminar/workshop and circular channels proved to be effective with the majority of those who used them supporting the reforms. Unfortunately, these channels are underutilised.

The attitude of staff varied with circumstances, like things that affect their work directly e.g. fear of added responsibility (52%) and being answerable to patients (39%) brought about a bad attitude towards the reforms and lack of support for the reforms.

The introduction of user fees however was associated with improved supply of drugs, working environment, implementation of programmes and not salaries and bonuses, showing a positive
attitude in this area. Majority(76%) did not have guidelines hence felt insecure about their practice. Nevertheless, majority did seem to understand the exemption policy with for example only 16 out of 148 saying they charged underfives.

Even though there is poor dissemination of information, most of the staff know that the reforms are about decentralisation of power to the Districts, Community/Private sector participation in the provision of health care and that the introduction of fees is to improve health services.

**Conclusion:** Even though the staff feel that dissemination of information is poor, they do understand some areas of the reforms quite well. Their attitude did vary and the practice is good for the majority. But it is evident that guidelines and supervisor, seminar/workshop communication is very important in improving the understanding of staff. However more educational work is needed to cover those who still lack knowledge and whose attitude and practice is still bad especially in the rural province which seem to be marginalized in all areas of reform information.
ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to all those who rendered help to me in any form through out my study. However, special acknowledgements go to the following people and institutions: Ministry of Health and UTH Board of Management respectively who allowed me to undertake this course and my sponsors; the Directorate of Human Resources Development Special thanks go to the Senior Programme Officer (Health) Dr. Anders Nordstrom of SIDA and the entire Swedish Embassy for the additional funding towards completion of this study.

I also wish to thank the Health Management Teams in Zambezi, Solwezi and Ndola for their moral support and provision of transport to the various study sites. The Nursing Services Manager and her Deputy and the Sisters in Charge of Ndola, Solwezi and Nursing Officer of Zambezi District Hospital, Medical Officer and Sister in Charge at Mpongwe Mission Hospital for the help rendered in terms of orientation to their institutions, organising their staff and distributing and collection of questionnaires. I would also like to gratefully acknowledge Pro Peter Simms whose tireless supervision has led to the completion of this study.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration</td>
<td>i</td>
</tr>
<tr>
<td>Statement</td>
<td>ii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iii</td>
</tr>
<tr>
<td>Approval</td>
<td>iv</td>
</tr>
<tr>
<td>Abstract</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td>List of Figures</td>
<td>viii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>ix</td>
</tr>
<tr>
<td>Chapter 1: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Background</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Statement of the Problem</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Literature review</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Hypothesis</td>
<td>8</td>
</tr>
<tr>
<td>1.5 Definition of terms</td>
<td>9</td>
</tr>
<tr>
<td>Chapter 2: Objectives of the Study</td>
<td>10</td>
</tr>
<tr>
<td>2.1 General objectives</td>
<td>10</td>
</tr>
<tr>
<td>2.2 Specific objectives</td>
<td>10</td>
</tr>
<tr>
<td>Chapter 3: Methodology</td>
<td>11</td>
</tr>
<tr>
<td>Chapter 4: Results of the Study</td>
<td>15</td>
</tr>
<tr>
<td>Chapter 5: Discussion</td>
<td>28</td>
</tr>
<tr>
<td>Chapter 6: Conclusions and Recommendations</td>
<td>33</td>
</tr>
<tr>
<td>6.1 Conclusion</td>
<td>33</td>
</tr>
<tr>
<td>6.2 Hypothesis Testing</td>
<td>34</td>
</tr>
<tr>
<td>6.3 Limitations of the Study</td>
<td>36</td>
</tr>
<tr>
<td>6.4 Recommendations</td>
<td>37</td>
</tr>
<tr>
<td>Bibliography</td>
<td>38</td>
</tr>
<tr>
<td>Annexes</td>
<td></td>
</tr>
<tr>
<td>Annex 1: Variables</td>
<td></td>
</tr>
<tr>
<td>Annex 2: Important observation</td>
<td></td>
</tr>
<tr>
<td>Annex 3: Questionnaire</td>
<td></td>
</tr>
<tr>
<td>Annex 4: Focus group discussion questions</td>
<td></td>
</tr>
<tr>
<td>Annex 5: Letters of permission</td>
<td></td>
</tr>
<tr>
<td>Annex 6: Approval letter from Ethical Committee</td>
<td></td>
</tr>
<tr>
<td>Annex 7: Budget</td>
<td></td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1 Breakdown of Health Institutions 14
Figure 2 Factors affecting Knowledge, Attitude and Practice of Staff 32
LIST OF TABLES

Table 1: Characteristics of the Sample .................................................. 16
Table 2: Information Dissemination ......................................................... 17
Table 3: Type of Institution by Information Dissemination ....................... 17
Table 4: Channel of Communication ....................................................... 18
Table 5: Seminar/Workshop by Province ............................................... 20
Table 6: Support of Reforms by seminar/workshop Rural Province .......... 22
Table 7: Fear of job Security and support of Reforms-Rural Province ....... 22
Table 8: Insecurity by Guidelines ......................................................... 23
Table 9: Guidelines by Place of Work ..................................................... 24
Table 10: Guidelines by having detailed information on exemptions ....... 25
Table 11: Guidelines by Cadre .............................................................. 26
Table 12: Making implementation of reforms Successful ......................... 27
CHAPTER 1

1.0 INTRODUCTION

1.1 Background Information

Health reform is in process in many countries worldwide. Common to most countries is a concern that the scale of government spending on health is at a level which is not sustainable and Zambia is no exception.

Zambia is a land locked country covering an area of 752,600sq Km with a population of about 8.09 million (1990 census) and is situated in Central Africa. The Country constitutes nine Provinces. The communication link is best in the urban areas and on the line of rail. The rural areas are quite often disadvantaged because of the poor dissemination of information which is due to the prevailing bad roads, poor radio reception, lack of television services in some areas and lack of newspapers.

Health care in Zambia is provided by the government and private institutions, churches, armed forces and traditional practitioners. Of all these, the government is the principle provider of health care through a wide network of hospitals and health centres. Since independence in 1964, the government has followed its commitment of providing free medical services for the entire nation. This has had an effect on the people of Zambia to think that the provision of health care is solely a responsibility of the government.

From the 70's through the 80's however, Zambia has experienced a serious economic decline with a reduction in the health budget resulting in a deterioration of health services. In consequence there have been shortages of staff, equipment, drugs, supplies, erosion of the infrastructure and failure to build new hospitals to meet the growing population.

To reverse this situation, the government found it necessary to have a new health vision. Hence the health reforms were designed to allow people to

---

1 “Experiences with Primary Health Care in Zambia:” Public Health In Action, No. 2 WHO, 1994
assume responsibility for their own health and in return acquire better health services. Instructions on the running of the new health service have been disseminated with emphasis on decentralisation of power to the districts and promotion of bottom-up planning.

Goals have been established to guide both the providers and the consumers of health namely:

1) Helping Zambians live a long, happy and productive life
2) Reduce infant and young child death rates
3) Promote women's health, reduce deaths during pregnancy
4) Reduce population growth rate through accessible and affordable family planning services
5) Reduce common illness like malaria, diarrhoea, tuberculosis, STD's and HIV
6) Provide safe water and good sanitation to a larger proportion of the population

Institutional and financial restructuring requires the establishment of District Health Boards, Hospital Boards at referral hospitals and area Boards. Suggested options for financing health are pre-payment schemes, user fees (cost recovery and cost sharing) and compulsory or private health insurance\(^2\).

Exemptions have been made for certain target groups, diseases and services e.g Ante-natal care, Children under five and adults over 65 years, Counselling and health education, the treatment for chronic conditions e.g asthma, tuberculosis, hypertension and diabetes, contact tracing for TB and STD and treatment during epidemics e.g cholera, dysentery, measles and meningitis are free\(^3\).

1.2 Statement of the Problem
The Zambian health reforms have come into being with commitment by the Government to provide better management for quality health care based on good leadership, accountability and provider/consumer/private sector partnership.

---

\(^2\) Ministry of Health, *National Health Policies and strategies (Health Reforms)*, 1992

Recent debates in our press and among the public indicate problems of knowledge, attitude and practice. Ministry of Health staff feel implementation is being done correctly and adequate information passed on. Their subordinates on the other hand feel it is being hurried, hence the misunderstandings that are existing between them.

This misunderstanding has been very evident in that the media has reported instances where mothers with children under five have been turned away from health institutions because they are neither members of the scheme nor have no money to pay for the child. Television of Zambia one day showed a mother with an under five year child being turned away because the mother was not a member of the scheme. On the same programme at the same clinic, the Sister in Charge understood the exemption policy but not the junior nurses. Similarly, Katondwe mission hospital in its progress report published in the "Health Reform News Bulletin" of July-September, 1994 indicated that they were charging medical fees for under five children. Kasama General Hospital is yet another institution which revealed that exemption from paying applied only to under five children and adults over 65 years only. Thus shows that there are irregularities in the implementation of the reforms compared with the stipulated guidelines.

Civil service bureaucracy may be another factor in causing these uncertainties where critical circulars are not available. The absence of a circular can therefore prevent prompt action and stifle initiatives or hinder new changes occurring. Nevertheless, most people prefer things as they are and do not welcome changes easily. This natural resistance to change can constitute a serious barrier to communication. This is so because a message which brings change is usually received with suspicion and the listener tends to filter and reject new ideas which conflict with what he/she already believes in. Sometimes this filter works so efficiently that in reality he does not hear at all.

On the part of the health staff, the reforms can be seen as something that will disturb the equilibrium of the current state of affairs in that it can threaten

---

6. Times of Zambia, No. 9147, April, 1996
7. Haimann T, Supervisory Management for Health Care Institutions, The Catholic Hospital Association, St Louis, 1963
their job security, job status and rewards. Sometimes they may fear added responsibility. Others may consider the introduction of user fees as a way of making more money for their institution in order to better their working conditions, perhaps in terms of bonuses or buying of new vehicles. All these feelings can lead to the development of either positive or negative attitudes towards the health reforms and depending on how the message is understood and perceived, ensuing practice can be wrong.

Do these problems reflect lack of knowledge on the part of staff or other factors like resistance to change or financial anxiety? This study sought to find out the level of knowledge of staff about the health reforms. It also tried to find out if there are any differences in knowledge, attitude and practice of health staff between rural and urban province.

1.3 Literature Review
Reforming a health system in a way that would have a significant impact on the management of the health sector both in terms of human, infrastructure and financial resources involves the resolution of complex technical elements. Some leaders who are charged with the management of the reform process are not adequately prepared educationally to handle this social-political process in terms of analysis and implementation strategies. This has also affected the general public. Due to such problems, the health policies have been rejected at various levels and by ordinary people, politicians and health workers. This is supported by Gill W and Gilson L who argue that the recent health reforms are likely to fail because many health policies wrongly focus their attention on the content of the reform and neglect the actors involved in the policy reform at all levels producing conflicts and uncertainty.

To launch any new process, there is need for those who are to be involved to be aware of it. It is more likely that such awareness exists at the top management than at the bottom. Education therefore is a predominant feature of the managerial reform process because it enables people to realise their own capacities to help themselves and learn to guide their own process of

---

orientation in the direction of a desired future. Mobilisation of the public and professionals can create a collective will for change. This collective will requires an open and a two way communication system among the people, institutions and organisations that have to work together. It is important that vertical and horizontal liaisons be established with consultative platforms at all levels so as to permit intersectoral action. Providers of health are naturally bound to have strong feelings towards the health reforms hence the different perceptions. Some of them think that this is a means of raising their income. Others are uncertain about the new change and have portrayed some resentment due to the fact that its success has been doubted. A study in Papua New Guinea on user charges revealed that lack of policy framework or practical guidelines on cost recovery, resulted in the workers using the fees as fiscal tools, rather than furthering the reform process. This clearly indicates that proper and effective dissemination of information is vital if change has to be implemented in a desired manner. This is further revealed in a report by a working group in Botswana which reported that use of information media helps in raising levels of awareness and knowledge, gaining social acceptance and support, clarifying misconception, misinterpretation and misinformation. This means that new information needs to be disseminated through the media as well.

Deeny James in his article "conflict in Health Systems" reveals the importance of good communication at all levels if a successful structuring, functioning and development of the health system is to be achieved. Schrifvers in reviewing the decentralisation process of the Netherlands' health services found that knowledge about implementation of the reform seemed to be confined to the spokesmen or women of the regional participating body. The groups under them were not well informed and yet these had a role to play in the newly designed procedures. The same applied to the administrative staff in the provinces and districts.

---

A study conducted in Zambia by Kalyalya D, reaffirms that the problems experienced elsewhere are also in Zambia. This study states that in virtually all areas visited, health personnel at district levels have received the policy on user fees as a directive from the Ministry of Health. Information on the same policy was relayed also on radio, television and in the print media which are not accessible to all Zambians. The lack of communication is not only between the ministry and district level but also intra- district and dialogue between the district authority and clinic staff is generally poor\textsuperscript{14}.

Zulu A, in a KAP study covering Lusaka Urban Clinics and the University Teaching Hospital revealed that out of the total population 100 health workers less than a quarter were knowledgeable of the health reforms. Nevertheless, 58\% of those without knowledge had a positive attitude towards the reforms and this was attributed to the changes that are taking place in the health institutions like clean environment, enough supplies and bed linen etc.\textsuperscript{15}

The poor communication on the reforms was confirmed recently by a Parliamentary Committee on Social Services team which expressed reservations with the way policy issues were being implemented. They said that the Ministry of Health was not providing information to Health Management Boards about the latest developments in the health sector. The Ministry, they advised needed to ensure that all policy issues are disseminated and understood by all Health Boards so as to make them be aware of what is expected of them.\textsuperscript{16}

Similarly, a study conducted by Booth et al on the social impact of and responses to cost recovery in basic services( Health and Education) in poor Communities in Zambia reveals that at Ndola hospital, apart from those in senior positions, hospital staff feel that they have not been consulted or are not sufficiently briefed on the prepayment scheme, hence were not in the position to educate patients on the scheme. It was also found that information at Lewanika hospital was restricted to senior staff and doctors who attend

\textsuperscript{14} Kalyalya D, " User fees in Health Sector", Policy, Practice and Perceptions, Lusaka, 1990

\textsuperscript{15} Zulu A, KAP., Health reforms UTH and Lusaka Urban Clinics, UNZA.,1995

\textsuperscript{16} Times of Zambia,No.9345, November, 1995
seminars on the subject. The study reports that there were some variations on
the administration of user fees. A mission hospital (Mtendere) in a rural area
applies a sympathetic policy towards treating people with no money by asking
them to pay perhaps during their next visit when they have money. Jumbe
another mission hospital has made steps to publicise the rationale for its
charges hence the good reception of cost sharing issues by the villagers. It was
also noted that at Ndola Central Hospital, 10% of the income from user fees
had been channelled to staff bonuses. In some clinics the money was used to
pay for tea snacks and buying of new uniforms for the staff.

Despite the Ministry guidelines which stipulates the categories of those
exempted from paying for treatment, there are still cases of people being sent
away. Thus at Lewanika hospital, a boy with acute malaria who was denied
treatment because he did not have K300 for registration was brought back dead
two hours later\textsuperscript{17}. This in essence negates the objectives of providing health to
all. The above sad story can also be attributed to several reasons like staff
having a material interest in the user fees hence making sure that as many
people as possible are made to pay. Another reason could be that, staff
assigned to deal with the registration of out-patients are not medically qualified
to make the sort of discriminations that the policy requires. There seems also
to be a considerable information gap between the senior administrators and
medical staff who understand the principles and their subordinates who have to
apply them. This was noted by the Parliamentary committee.\textsuperscript{18}

Health policy makers in developing countries and officials of the international
donor community often face a number of difficult challenges in pursuing the
agendas for change. This is so because "virtually every country has interest
groups who will resist health policy reforms. Health workers will object to the
change that threaten their job security, income levels and degree of professional
autonomy. Also political and financial elites and organised labour groups will
almost always block the efforts of the reforms".\textsuperscript{19}

\textsuperscript{17} Booth et al.,\textit{Coping with Cost Recovery In Basic Services
(Health and Education) In Poor Communities
in Zambia, Lusaka, 1993

\textsuperscript{18} Op cit, Times of Zambia

\textsuperscript{19} World Health Forum: An International Journal of Health Developemnt, WHO., 1994,
Vol 15, No. 4
Ndiaye J. M in his analysis of the decentralisation of health services in Senegal, reported that the process met with several obstacles two of them, being opposition from health workers and lack of personnel to implement the reforms. Because of this, an intensive campaign was undertaken to create awareness. Training of health personnel and members of health committees became a priority activity of the Ministry of Health 20.

Similarly, Vaugue J.P states that after finance, personnel is the next most important source of difficulties when implementing reforms. The writer goes on to say that health workers especially doctors and nurses tend to have a strong resistance to change when placed under the direction of non health professionals and people who lack managerial skills hence creating professional opposition.21. This is confirmed in an article in the Times of Zambia which pointed out that the present calibre of management teams especially in the rural areas proves to be a "recipe for mismanagement " because the Chief Executives are not aware of the national health policies.22

1.4 Hypothesis
1. Lack of understanding of the health reforms by health workers has led to non acceptance of the reforms.
2. Poor communication across the health service on issues concerning health reforms has led to poor attitude and practice.

1.5 Operational Definition of Terms
1. Health Reform: New things introduced in the health sector
2. Health staff: Doctors, Nurses, Paramedicals and Administrative staff like clerks and cashiers.
3. Knowledge: Understanding and working according to the objectives of the health reforms.
4. Attitude: Acceptance and Non acceptance of the reforms

22 Op cit, Times of Zambia
5. **Practice:** Being able to carry out the principles outlined in the health reforms.

6. **Resistance to change:** Not wanting to carry out the new things introduced in the health sector correctly.

7. **Managerial skills:** Supervisors being able to teach the health staff regarding the reforms, helping them understand the guidelines and follow them.

8. **Rural setting:** A place which is not along the line of rail

9. **Urban setting:** A Place found along the line of rail.
CHAPTER 2

2.0 OBJECTIVES OF THE STUDY.

2.1 General Objective.
To determine whether health staff understand the purpose of the health reforms, whether they have accepted them and are practising them correctly.

2.2 Specific Objectives.

2.2.1 To examine the level of understanding of the health reforms by health staff.
2.2.2 To examine the relationship between the managerial skills and practice of health staff.
2.2.3 To establish whether all health staff have been given guidelines to follow and are working accordingly.
2.2.4 To determine the relationship between distance and information dissemination.
2.2.5 To ascertain whether there is political interference and whether it has any impact on the implementation process by health staff.
2.2.6 To determine whether channels of communication are effective and have any effect on staff’s awareness of the reforms.
2.2.7 To determine whether there is resistance on the part of health staff to the new changes.
2.2.8 To assess if fear of job security has a bearing on staff practice of the reforms.
CHAPTER 3

3.0 METHODOLOGY

3.1 Study Type:
This was a descriptive comparative study which compared an urban province with a rural one to ascertain the relationships of staff’s knowledge, attitude and practice of the health reforms.

3.2 Study Sites:
This study was conducted in the North Western and Copper Belt provinces of Zambia (see maps next pages). Zambezi and Solwezi were covered in North western province while Ndola urban and Rural were covered in the Copper Belt province. A total of 10 health institutions were covered and among these were 3 government hospitals, 2 mission hospitals, 2 urban clinics, and 3 rural health centres (see figure 1).

3.3 Sample:
The study population was composed of health staff drawn from the sampled health institutions and these comprised of Doctors, Nurses, Paramedicals, Clerks and Cashiers. A total of 15 Doctors, 147 Nurses, 41 Paramedicals and 35 Clerks/Cashiers were interviewed.

3.4 Sampling Method:
A stratified sampling method was used for the provinces and districts where pieces of paper with names written on them were put in a box and then randomly picked. The same method was used for the hospitals and health centres. Health staff were sampled by use of a sampling frame and the sampling fraction formula of \( f = \frac{n}{N} \). The total of each cadre of staff was then multiplied by the sampling fraction to obtain the proportions and this was the number that was finally used in the study. E.g. To obtain the proportion \( s \) at Ndola Board of Management, this is how it was found:
Total population = 486 (52 doctors, 338 Nurses, 39 Paramedical, 57 Clerks/Cashiers)
Sample needed = 100
sampling fraction = \( f = \frac{n+N}{N} = 100+486 = 0.205 \)

Proportions thus were
Doctors 52 \times 0.205 = 11
Nurses 338 \times 0.205 = 69
Paramedical 39 \times 0.205 = 8
Clerks/Cashiers 57 \times 0.205 = 12
Total = 100

3.5 Sample size:
The original sample size was 260 which was arrived at by using an anticipated population of 60% confidence interval of 90% with an absolute precision of 55% to 65% allowing for 5% points for errors. by use of the statistical table, the above sample was obtained (A model by S. K Lwanga and S. Leemeshow). After the data was collected only 238 were interviewed owing to losses or non return of 22 questionnaires. The original sample was further broken down as shown below:

<table>
<thead>
<tr>
<th>Urban and Rural Provinces (260)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural Province</strong></td>
</tr>
<tr>
<td>130</td>
</tr>
<tr>
<td>Government Hospitals</td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>50 Zambezi District hosp /50 Solwezi General Hosp</td>
</tr>
<tr>
<td>Mission Hospital 10 (chitokoloki)</td>
</tr>
<tr>
<td>Health Centres 20</td>
</tr>
<tr>
<td>-Mpidi 2</td>
</tr>
<tr>
<td>-Mukandakunda 3</td>
</tr>
<tr>
<td>-Solwezi Urban 15</td>
</tr>
</tbody>
</table>

The break down of the rural province into two districts and the variations in the numbers for the mission hospitals and health centres was mainly due to poor staffing levels prevailing in the rural areas.
3.6 Data Collection:
Data collection was done over a period of one month. Permission to carry out the study was obtained from the Ministry and the sampled institutions. Before going into the field a pre test of the questionnaire was done upon which some adjustments were made. Data was obtained through the use of a structured self administered questionnaire, observations, patient records and focus group discussions with mothers and staff to obtain more information on practice of staff.

3.7 Data Processing and Analysis:
This was done by the use of EPI Info programme. the Chi square test was the major test used to compare the relationships between the various variables.

3.8 Ethical Considerations:
Being a self administered questionnaire, the subjects had a choice to either answer or not hence their participation willingly. No names were attached to the questionnaires for the sake of anonymity. The research proposal was also approved by research and ethics committee.
**Figure 1: Study Sites**

<table>
<thead>
<tr>
<th>PROVINCES</th>
<th>North-western Province</th>
<th>Copper belt Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zambezi</td>
<td>Zambezi D. Hospital</td>
<td>Mpongwe Mission Hospital</td>
</tr>
<tr>
<td></td>
<td>Chitokoloki Mission Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mukandakunda Health Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mpidi Rural Health Centre</td>
<td></td>
</tr>
<tr>
<td>Solwezi</td>
<td>Solwezi G. Hospital</td>
<td>Ndola Rural</td>
</tr>
<tr>
<td></td>
<td>Solwezi Urban Clinic</td>
<td>Mpongwe Mission Hospital</td>
</tr>
<tr>
<td>Ndola Urban</td>
<td>Ndola Board of Mgt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lubuto Urban Health Centre</td>
<td></td>
</tr>
<tr>
<td>Ndola Rural</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 4

4.0: RESULTS OF STUDY

4.1: Characteristics of the Sample

The 238 subjects in this study were health personnel working in various health institutions in the Copper belt and NorthWestern Provinces of Zambia. Table 1 shows a frequency distribution of their age, sex, marital status, educational background, qualifications and length of service.

Of the total sample, 152 (63.9%) were females and 86(36.1%) males. The mean age of the respondents was 34 years with the majority 125(52.5%) being in the age group of 30 to 39 years and the least 6(2.5%) in the 50 to 59 age group. In terms of marital status, 159(66.8%) were married, 64(26.9%) were single, 6(2.5%) divorced and 9(3.8%) were widows.

In terms of cadres, there were 15(6.3%) Doctors, 147(61.8%) Nurses, 41(17.2%) Paramedics and 35(14.7%) Clerks/Cashiers. Majority 75(31.5%) of the respondents had been in service within the range of 5 to 10 years and the least 21(8.8%) had been in service for 20 years and above. The educational level of the majority 220(92.4%) was secondary school and 18(7.6%) university. There were non in the primary school bracket.


<table>
<thead>
<tr>
<th>Variable</th>
<th>frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>86</td>
<td>31.1</td>
</tr>
<tr>
<td>Female</td>
<td>152</td>
<td>63.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>238</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>159</td>
<td>66.8</td>
</tr>
<tr>
<td>Single</td>
<td>64</td>
<td>26.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>238</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 to 29</td>
<td>65</td>
<td>27.3</td>
</tr>
<tr>
<td>30 to 39</td>
<td>125</td>
<td>52.5</td>
</tr>
<tr>
<td>40 to 49</td>
<td>42</td>
<td>17.6</td>
</tr>
<tr>
<td>50 to 59</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>238</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>220</td>
<td>92.4</td>
</tr>
<tr>
<td>University</td>
<td>18</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>238</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>Length of Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 yrs</td>
<td>67</td>
<td>28.2</td>
</tr>
<tr>
<td>5 to 10</td>
<td>75</td>
<td>31.5</td>
</tr>
<tr>
<td>11 to 15</td>
<td>49</td>
<td>20.6</td>
</tr>
<tr>
<td>16 to 20</td>
<td>26</td>
<td>10.9</td>
</tr>
<tr>
<td>20 +</td>
<td>21</td>
<td>8.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>238</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Knowledge**

Out of the 238 respondents, 77(32.4%) said that information dissemination by top management to subordinates was very poor. Those who said it was very
good were only 18 (7.6%) and this was rated the least as shown in table 2 below

Table 2: Information dissemination

<table>
<thead>
<tr>
<th>Information Dissemination</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Good</td>
<td>18</td>
<td>7.6</td>
</tr>
<tr>
<td>Good</td>
<td>67</td>
<td>28.2</td>
</tr>
<tr>
<td>Poor</td>
<td>68</td>
<td>28.2</td>
</tr>
<tr>
<td>Very Poor</td>
<td>77</td>
<td>32.4</td>
</tr>
<tr>
<td>Total</td>
<td>238</td>
<td>100</td>
</tr>
</tbody>
</table>

Majority of those who rated information dissemination as good and very good were from the mission hospital in the urban province. This was deduced from the comparisons made of a mission and a government hospital. Nevertheless, these same results seem to apply to the entire province. The rates in the mission hospital were 6% for very good, 15% for good, 7.3% for poor and a zero response for very poor. In all there were 19 respondents. In the government hospital however, only 7.3% out of the total respondents of 49 said information dissemination was good. The rest rated it as being poor and very poor, i.e. 27% and 38% respectively. The P value of 0.00000052 reveals a relationship between type of institution and information dissemination (see table below)

Table 3: Type of Institution by Information dissemination

<table>
<thead>
<tr>
<th>Institution</th>
<th>Very good</th>
<th>Good</th>
<th>Poor</th>
<th>VeryPoor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mpongwe Mission</td>
<td>4 (6%)</td>
<td>10 (15%)</td>
<td>5 (73%)</td>
<td>0</td>
<td>19 (28%)</td>
</tr>
<tr>
<td>Zambezi D. Hospital Govt</td>
<td>0</td>
<td>5 (7%)</td>
<td>18 (27%)</td>
<td>26 (38%)</td>
<td>49 (72%)</td>
</tr>
<tr>
<td>Total</td>
<td>4 (6%)</td>
<td>15 (22%)</td>
<td>23 (34%)</td>
<td>26 (38%)</td>
<td>68 (100%)</td>
</tr>
</tbody>
</table>

Chi square 32.01: degree of freedom 3, P Value of 0.00000052

As regards the issue of what the health reform is all about, the majority of the respondents associated it with the decentralisation of power to the districts,
community participation in the provision of health care and fees for health services. Rated highest was community participation by 70% of the respondents, decentralisation of power by 66% and introduction of fees by 52%. These percentages bring out the fact that there are still some health workers who do not understand what the health reform is.

Furthermore, respondents felt that living within Lusaka, belonging to a particular professional group, the type of unit one worked in and the communication channel used were determinants of good information dissemination. Those supporting this notion constituted 38.7%, 45.8%, 53.8% and 69.3% respectively. Rated highest was the type of channel used. However there were those who disputed the above notion and rates were 30.7%, 56%, 45%, and 21% respectively. Out of a total of 238 respondents majority of those who supported the notion were from the rural province. Besides this, the respondents also agreed to having received information about health reforms through the radio, television, newspapers, bulletins, circulars, seminar/workshop, friends and supervisors as shown in the table below.

**Table 4: Channels of communication**

<table>
<thead>
<tr>
<th>Channel</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>158 (81%)</td>
<td>36 (19%)</td>
<td>194</td>
</tr>
<tr>
<td>Television</td>
<td>148 (75%)</td>
<td>50 (25%)</td>
<td>198</td>
</tr>
<tr>
<td>News papers</td>
<td>123 (66%)</td>
<td>63 (34%)</td>
<td>186</td>
</tr>
<tr>
<td>News bulletin</td>
<td>112 (62%)</td>
<td>70 (38%)</td>
<td>182</td>
</tr>
<tr>
<td>Circulars</td>
<td>109 (59%)</td>
<td>75 (41%)</td>
<td>184</td>
</tr>
<tr>
<td>Supervisors</td>
<td>82 (47%)</td>
<td>92 (53%)</td>
<td>174</td>
</tr>
<tr>
<td>Seminar/workshop</td>
<td>91 (47%)</td>
<td>101 (53%)</td>
<td>192</td>
</tr>
<tr>
<td>Friends</td>
<td>94 (53%)</td>
<td>84 (47%)</td>
<td>178</td>
</tr>
</tbody>
</table>

The total responses were quite evident under the supervisor channel accounting for 53% of the 174, while the seminar/workshop channel accounted for 53% out of 192. This shows that a good number of supervisors are not providing their subordinates with information on health reforms nor giving them opportunities of attending seminars and workshops where they can receive information on reforms.
Table 5: Channel of communication by Knowledge of User fees.

<table>
<thead>
<tr>
<th>Channel</th>
<th>Knowledge of User Fees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Circular</td>
<td>54</td>
<td>49</td>
</tr>
<tr>
<td>Seminar/workshop</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Supervisor</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>Friend</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>Radio</td>
<td>51</td>
<td>93</td>
</tr>
<tr>
<td>Television</td>
<td>53</td>
<td>85</td>
</tr>
<tr>
<td>Newspapers</td>
<td>51</td>
<td>66</td>
</tr>
<tr>
<td>News bulletins</td>
<td>50</td>
<td>57</td>
</tr>
</tbody>
</table>

The circular and supervisor channels are more effective in information dissemination as the above table shows. The reason being that, the civil servant is used to acting efficiently on circulars that come from top management. This is so because the bureaucracy believes in written and circulated information which is taken as the "gospel" truth. The supervisor channel on the other hand is effective in that, there is a face to face communication which allows the listener to seek immediate clarifications. On the other hand the circular though does not provide any face to face communication situation, to a civil servant it represents final instruction which should be obeyed, hence the reasons why the majority of those who received information through these two channels had knowledge of the user fees.

However, the most used channels i.e radio, television, newspapers, news bulletins are not very effective as has been revealed in this study. The majority of those respondents who received information through these channels had no knowledge of the user fees. This is worse in the rural areas where communication link is very poor.

The results also revealed that majority of the respondents 54(28%) who had attended seminars/workshops were from the urban province. This shows that there is a correlation between place of residence/work and attending seminar/ workshops( see table 6 )
Table 6: Seminar/Workshop by Province

<table>
<thead>
<tr>
<th>Seminar/Workshop</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>54 (28%)</td>
<td>37 (19%)</td>
<td>91 (47%)</td>
</tr>
<tr>
<td>No</td>
<td>37 (19%)</td>
<td>64 (34%)</td>
<td>101 (53%)</td>
</tr>
<tr>
<td>Total</td>
<td>91 (47%)</td>
<td>101 (53%)</td>
<td>192 (100%)</td>
</tr>
</tbody>
</table>

Information sharing by supervisors was also compared to the various cadres of staff. The results revealed that no one cadre surpassed the other in getting information from their supervisors. Of all the responses, 4 out of 12 doctors, 56 out of 110 nurses, 15 out 32 paramedicals and 7 out of 20 clerks/cashiers got information from their supervisors.

Attitude

Rating and support of the Reforms
In terms of rating and supporting of reforms, 180(76%) of the 238 respondents said the health reforms were good, 41(17%) said they were bad with non response of 17(7%). Of these 170(71.4%) were in full support of the reforms and the majority 94(55%) were from the urban province with 76(44.7%) from the rural province.

Threat to Present Job
There were some respondents who felt that their jobs were threatened by the reforms. Reasons given were varied and included being answerable to patients which accounted for 92(38.7%) responses out of 212, added responsibility 124(52.1%) responses. Majority of those who feared job security were from the rural province. However, demotions, failure to get another job following a transfer or job losses were not a threat as was stated by 64.3%, 50.4% and 34.9% of the respondents respectively.
Fees
The introduction of fees in the institutions was associated with improvements in the following areas: Working environment, supply of drugs and implementation of health programmes. These were supported by rates of 55%, 54.6% and 42.9% respectively. Those rated not to improve despite the introduction of fees were salaries with a No response rate of 70.6% and staffing with only 55%.

<table>
<thead>
<tr>
<th>Support reforms</th>
<th>Seminar/</th>
<th>Workshop</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attended</td>
<td>Not attended</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>34 (34%)</td>
<td>34 (35%)</td>
<td>68(69%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (1%)</td>
<td>10 (10%)</td>
<td>11(11%)</td>
</tr>
<tr>
<td>Do not Know</td>
<td>2 (2%)</td>
<td>18 (18%)</td>
<td>20(20%)</td>
</tr>
<tr>
<td>Total</td>
<td>37(37%)</td>
<td>62(63%)</td>
<td>99(100)%</td>
</tr>
</tbody>
</table>

Of the 68 who supported the reforms in the rural province, 34% had a chance of attending a seminar and the other 34% had not. Of the 11 who did not support the reforms, only 1(1%) had attended a seminar while the rest 10(10%) had not. The P value above shows that there is a relationship between attending a seminar and supporting the reforms. In the urban province, out of 79 respondents who supported the reforms, 62% had attended a seminar and only 35% had not. Out of the 5 who did not support the reforms, 3(60%) had attended a seminar and 2(40%) had not. The P value of 0.09340113 showed no relationship between attending a seminar and supporting the reforms in the urban province.

<table>
<thead>
<tr>
<th>Fear job security</th>
<th>Yes</th>
<th>No</th>
<th>Do Not Know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4 (5%)</td>
<td>12 (14%)</td>
<td>19 (21%)</td>
<td>35(35%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (3%)</td>
<td>2 (2%)</td>
<td>36 (40%)</td>
<td>39(44%)</td>
</tr>
<tr>
<td>Do not Know</td>
<td>10 (11%)</td>
<td>1 (1%)</td>
<td>4 (5%)</td>
<td>15(17%)</td>
</tr>
<tr>
<td>Total</td>
<td>17(19%)</td>
<td>15(17%)</td>
<td>57(66%)</td>
<td>89(100%)</td>
</tr>
</tbody>
</table>

*Chi square 38.9, degree of freedom 4, P value 0.00000007*

Of the 35 respondents who had fear of their job security, in the rural province only 4 (5%) supported the reforms while 12 (21%) did not and 19 had the fear but did not know whether to support or not. Out of the 39 respondents who
did not have fear, only 3 (3%) supported the reforms while 2 (2%) did not. The majority 34 (57.8%) did not know whether to support the reforms or not. Results of the urban province showed a similar trend in that out of the 30 who had fear only 5 (16.7%) supported the reforms. The rest, 24(80%) did not support the reforms. This shows that there is a relationship between fear of job security and not supporting the reforms.

The respondents who did not support the reforms gave reasons for this. These reasons were that of unqualified junior staff being in authority. This is very true in that no senior person can allow himself to be answerable to a junior staff. This leads to clashes and poor reception of instruction good as they may be. The other reason given was that of monetary gains by the top management. This stems from the many seminars/workshops that these people attend showing some element of selfishness and thus leading to others thinking there was some monetary gains. Others have claimed not to have seen any differences and have said the poor are being marginalised. However, in everything one finds a section of positive thinkers. The positive ones are those who are supporting the reforms. Their support is due to the fact that they have seen some improvements, local hospitals being able to set their own priorities, getting certain allowances, being able to make their own budgets and able to buy supplies and food for patients when needed. This to them is a good thing thus their support for the health reforms. Those who could not say whether to support the reform or not said so because of not having any knowledge of the reforms.

Table 9: Security by Guidelines

<table>
<thead>
<tr>
<th>Insecurity</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15  (9%)</td>
<td>49 (28%)</td>
<td>64(37%)</td>
</tr>
<tr>
<td>No</td>
<td>29 (16%)</td>
<td>51 (29%)</td>
<td>80(45%)</td>
</tr>
<tr>
<td>Do not Know</td>
<td>3 (2%)</td>
<td>29 (16%)</td>
<td>32(18%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47(27%)</strong></td>
<td><strong>129(73%)</strong></td>
<td><strong>176(100%)</strong></td>
</tr>
</tbody>
</table>

*Chi square 8.98, degree of freedom 2, P value 0.01120450*

Of the 64 respondents, majority of them 49(28%) did not have guidelines and were insecure about their jobs. Similarly, the 15 (9%) who had guidelines also felt insecure. Among the 80 who did not feel insecure, 51 (29%) had no guidelines while 29 (16%) had. This definitely reveals that there is a
relationship between not having guidelines and feeling insecure. There was also a relationship between having added responsibilities and not supporting the reforms. In fact out of 24 with no support for the reforms, 46% had fear of added responsibility, 2% did not and the remaining 25% did not know. There was yet another 42% out of 24 responses who feared being answerable to patients, 33% had no fear and the remaining 25% did not know.

Practice

Guidelines

Of the 238 respondents, 169 (71%) said they had not been given guidelines on how to carry out the new changes. The respondents felt that lack of guidelines has led to:

1. Not having proper instructions on how to do things.
2. Being prone to making mistakes.
3. Conflicts between supervisors and subordinates and even between clients.
4. Lack of confidence when practicing hence not rendering better and up to date health services which in turn has led to inconveniences to both staff and clients.

Charges.

For those people who are not exempted from charges but have no money to pay, the majority 132 out of 148 responses said they would not send them away but treat them and perhaps ask them to pay later. Only 16 said they would send them away. Nevertheless, some individuals still felt that they would treat them free of charge. As for the Social Welfare Department, 42 out of 138 responses said they would refer them to the department, while 96 said they would not. In the case of an under five child whose parents are not members of the hospital scheme, 181 (76.1%) out of 197 said they would treat the child free of charge. Only 16 (6.7%) said they would send the child away. There was however no difference between rural and urban provinces. In that out of the 196 responses, 93 were from rural and 87 from urban. These said they would offer free treatment. Only 9 in the urban and 7 in the rural who said they would not treat the child. In case of outbreaks, 97 and 87 in urban and rural respectively out of the 204 responses said they would exempt them from paying. Only 9 and 11 respectively said they would send them away if they had no money to pay. A similar trend was observed over the other conditions under
which there are exemptions with a majority saying they would not charge for such services.

Table 10: Guidelines by Place of Work

<table>
<thead>
<tr>
<th>Place</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mpongwe Mission (urban province)</td>
<td>10</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Zanbezi D Hospital (rural Province)</td>
<td>8</td>
<td>41</td>
<td>49</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>49</td>
<td>67</td>
</tr>
</tbody>
</table>

*Chi square 10.31, 95% ci 1.65-25.11, odds ration 6.41, P value 0.00132258*

Of the 18 respondents with guidelines (see table 10), the majority 10 were from the Mission hospital. Only 8 from a government hospital had guidelines and of those with no guidelines, 8 were from the Mission hospital while the majority were from the government hospital. This shows that there is a relationship between belonging to a particular institution and having guidelines. This also shows that, the government is not bothered about guidelines and it is not strange that many people prefer Mission hospitals to government ones because the staff in these institutions are confident of what they are doing due to the availability of guidelines.

Similar results were observed when reviewing under five charges under the same institutions. All the 6 who admitted that they charged were from the rural province and government hospital. Of these 3 were nurses and the other 3 were paramedicals. No health worker admitted charging under five children in the mission hospital. Out of the 63 respondents who did not charge, 32% were from mission hospital while 68% were from government hospital. There was actually no relationship between place of work or mission and government hospital and charging under five children, the same applied to the urban and rural province.

Table 11: Guidelines by Province

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Province</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>Rural</td>
<td>41</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Rural</td>
<td>76</td>
<td>169</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>110</td>
<td>229</td>
</tr>
</tbody>
</table>

The results showed that the majority of those who had guidelines were from the urban province with 41 out of 60 and 19 out of 60 from the rural province. Those without guidelines were 169 and of these, 93 were from the rural province and 76 from the urban. The P value of 0.00131581 showed that there
was a relationship between belonging to a particular province and having guidelines.

**Table 12: Guidelines by Having detailed information of Exemption Policy**

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td>No</td>
<td>48</td>
<td>108</td>
<td>156</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>121</td>
<td>210</td>
</tr>
</tbody>
</table>

Odds ratio 7.10, 95% ci 3.33-15.66, Chi square 33.50, P value of 0.00000001

Of the 210 respondents, 54 agreed to having guidelines with 20% agreed to having a detailed explanation on the exemption policy and 6% did not have. Of those without guidelines, 23% had a detailed explanation on the policy, while the majority 51% did not have. The P value of 0.00000001 confirmed a correlation between having guidelines and receiving a detailed explanation of the exemption policy. These results reveal that there is no relationship between having guidelines and belonging to a particular cadre of staff. This shown in the table below.

**Table 13: Guidelines by Staff Cadre**

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Doctor</th>
<th>Nurse</th>
<th>Paramedic</th>
<th>clerk/cashier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2(13.3%)</td>
<td>35(25%)</td>
<td>11(27%)</td>
<td>12(36%)</td>
</tr>
<tr>
<td>No</td>
<td>13(86.7%)</td>
<td>105(75%)</td>
<td>30(73%)</td>
<td>21(64%)</td>
</tr>
<tr>
<td>Total</td>
<td>15(100%)</td>
<td>140(100%)</td>
<td>41(100%)</td>
<td>33(100%)</td>
</tr>
</tbody>
</table>

Chi square 3.16, Degree of freedom 3, P value 0.3676228

Out of 229 respondents, 60 had guidelines and 169 did not have. Of those who had, 13.3% were Doctors, 23% Nurses and 27% Paramedics and 36% clerks/cashiers. Those who did not have guidelines constituted 86.7% of the Doctors, 75% Nurses, 73% Paramedics and 64 Clerks/cashiers.

**Politics**

Out of the 238 respondents, 73 (30.7%) had no interest in politics while 165 (69.3%) had an interest. On whether politics interfered with the implementation of the reforms, majority 108(45.4%) said it did because politicians may tell their electorates different things at different times. The majority also felt that criticisms from and belonging to opposition parties had no bearing on the implementation of the reforms. Those who said No were 98 (41.2%) and 111 (46.6%) respectively. Those who said Yes were 56 (23.5%) and 32 (13.4%) respectively.
There was however no much difference between the rural and urban in terms of having interest in politics. On average the responses were 50% for each province.

Use of Money

Table 14: Use of money by Province

<table>
<thead>
<tr>
<th>Use of Money</th>
<th>Province</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staff Bonuses</td>
<td></td>
<td>20</td>
<td>46</td>
<td>57</td>
<td>37</td>
</tr>
<tr>
<td>Renovations</td>
<td></td>
<td>29</td>
<td>34</td>
<td>42</td>
<td>49</td>
</tr>
<tr>
<td>Buying Supplies</td>
<td></td>
<td>47</td>
<td>23</td>
<td>50</td>
<td>33</td>
</tr>
<tr>
<td>Buying staff uniforms</td>
<td></td>
<td>10</td>
<td>53</td>
<td>7</td>
<td>78</td>
</tr>
<tr>
<td>Send to Ministry Fund</td>
<td></td>
<td>10</td>
<td>46</td>
<td>6</td>
<td>76</td>
</tr>
</tbody>
</table>

Concerning the use of money collected from user fees, the majority i.e more than 50% of the respondents attributed it to the buying of supplies. Less than 50% attributed it to staff bonuses, and renovations. Very few respondents attributed it to buying staff uniforms which supported by 17 out of 148 responses and sending it to the Ministry of Health central fund was attributed by 17 out of 148 responses.

Table 15: Making implementation Of reforms successful

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate training</td>
<td>52 (22%)</td>
<td>33 (14%)</td>
<td>85 (36%)</td>
</tr>
<tr>
<td>Qualified Management</td>
<td>14 (6%)</td>
<td>1 (1%)</td>
<td>15 (7%)</td>
</tr>
<tr>
<td>Improve Communication</td>
<td>34 (14%)</td>
<td>40 (17%)</td>
<td>74 (31%)</td>
</tr>
<tr>
<td>Team work amongst Staff</td>
<td>8 (3%)</td>
<td>13 (5%)</td>
<td>21 (13%)</td>
</tr>
<tr>
<td>Financial accountability</td>
<td>10 (4%)</td>
<td>5 (2%)</td>
<td>15 (6%)</td>
</tr>
<tr>
<td>Increase Funding</td>
<td>17 (7%)</td>
<td>11 (5%)</td>
<td>28 (12%)</td>
</tr>
<tr>
<td>Total</td>
<td>135 (56%)</td>
<td>103 (44%)</td>
<td>238 (100%)</td>
</tr>
</tbody>
</table>

Out of the 85 respondents who felt adequate training should be given to all staff, the majority 52 (22%) were from the rural province, while 33 (14%) came from the urban province. The rural respondents 14 (6%) felt that qualified staff should make up the management teams. 34 (14%) of rural respondents
and 40 (17%) of urban felt that one communication system should be improved. 8 (38%) and 13 (5%) from both rural and urban respectively said teamwork should be promoted amongst staff. 10 (4%) in rural and 5 (2%) in urban felt there should be financial accountability. Of those who felt government should improve funding, 17 (7%) were from rural and 11 (5%) from urban.
CHAPTER 5

5.0 Discussions

5.1 Discussion of Results
This study was aimed at finding out the knowledge, attitude and practice of health staff under the umbrella of the health reforms. Some factors identified as having an effect on the above were the following:

- Political interference
- Poor information dissemination
- Lack of managerial skills
- Lack of guidelines
- Distance from initiators of the reforms (MOH)
- Poor communication channels
- Fear of job security
- Resistance to change

The study revealed that dissemination of information from top management is very poor. This is due to the various factors mentioned like:

Types of Channels Used
It has been revealed that members of staff who received circulars, attended seminars and got information through supervisors were more knowledgeable of the user fees than those who got information through the radio, TV., newspapers/bulletins and friends. This can be further attributed to the two way communication and the one way communication being used in the two subgroups respectively. In the case of seminar/workshops and getting information through supervisors, the two way system of communication can iron out misunderstandings and further create some motivation to learn on the part of the health staff. The majority of those who did not attend seminars were from the rural province and this was also rated the highest as having problems among the various channels of communication. This could be the reason why information dissemination was rated very poor. This finding in fact corresponds with what was stated by Shrifver, saying that knowledge about the reforms in most cases is confined to the top in the regional participating bodies.

Channels like radio, television, newspapers etc., seem to be less effective probably because they are a one way type of communication and furthermore, there is a likelihood of people
not being able to or having no interest in using these channels. Moreover the study again reveals that poor radio/ television reception, lack of television, poor road network, lack of newspapers etc. are factors associated with less effectiveness of the mentioned channels. These results are supported by Kalyalya’s study which revealed that the use of the above channels were not effective because they are not accessible to all Zambians and this contributed largely to the poor communication link which is in existence at the moment. Improvement in the communication systems was rated the second highest after staff training by respondents to ensure a successful reform process. The bureaucratic process e.g circulars can be helpful and certainly those who received such circulars were more knowledgeable.

The type of institution one operated from was also another factor determining information dissemination. The mission hospital rated it as being very good as compared to government hospital which rated it as poor. This shows that the communication platform is better in mission hospitals than in government hospitals a reflection of what happened at Jumbe mission hospital where steps were taken to publicise the rationale for its charging and hence the good reception of cost sharing issues by staff and clients. It is bad in government hospitals because of the bureaucracy where the main document of information is a circular and because of poor road network and postal services in the rural province coupled with lack of training and sharing of information by supervisors, information dissemination on health reforms has been poor.

Distance from initiators of the reforms has also had an effect on information dissemination as has been revealed by some respondents who said that those living within Lusaka stood a better chance of knowing issues pertaining to the reforms than those in the rural areas. This again can be confirmed by the number of people from the rural province who have attended seminars. The other problem of poor information dissemination was attributed to poor channels of communication and even poor managerial skills on the part of supervisors who are unqualified as stated by some or who are not just sharing information with their subordinates. This is supported by the Parliamentary committee on Social services which revealed that the Ministry of Health was not providing information to Health Management Boards on the latest developments in the health sector and that there was a considerable information gap between the senior administrators and medical staff who are supposed to apply the principles. The results however do not reveal any variation in information received from supervisors among different staff groups.
The introduction of user fees was found to be associated with improvements in the working environment, supply of drugs and implementation of health programmes hitherto abandoned due to poor funding. Very few of the respondents consider it as a way of improving their salaries and staff bonuses. This in itself proves that, the staff are not money conscious. This was also supported by the mothers during focus group discussions who denied paying for the services stipulated under the exemption policy. They also said that the introduction of user fees had brought about changes in terms of linen provision, food, drugs and clean environment. The only thing they were not happy with was the shortage of staff which they felt led to health workers failing to cope with the work load. They also complained of the lack of refunds when medicines are out of stock and the patient is asked to buy on his/her own despite having paid money already.

With every new thing there is bound to be some fear in terms of job security. The majority of those with fear of job security, did not support the reforms which is obvious. Their main fear is having added responsibility and being answerable to patients. Owing to the increasing population, coupled with the advent of new diseases, Zambian health workers have been experiencing heavy workload. This coupled with poor salaries and conditions of service, have made them develop a very poor attitude towards their work. Therefore, added responsibility and being answerable to patients has worsened the already existing situation. Perhaps, this explains why some staff did not support the reforms.

It has also been revealed that most of those who did not have guidelines, did not actually support the reforms. This is due to staff not knowing what to do and hence being subjected to making a lot of mistakes as has been discovered that some staff do charge or send away under five children whose parents have no money to pay. Various reasons were also given by the staff as to why they did not support the reforms such as having unqualified junior staff being in authority and only those in teams benefiting both in terms of knowledge and monetary. The issue of unqualified staff is very serious and was also raised by a Parliamentary committee team which pointed out that the present calibre of management teams especially in the rural areas was a "recipe for mismanagement".

Comparisons of mission and government hospitals showed that in Zambezi only 8 out of 49 had guidelines and felt in-secure. This proves why the majority who feared about their job security and did not support the reforms were from the rural province. Despite lack of guidelines, and poor dissemination of information to some health staff, majority of the respondents did not charge for the services exempted. Some respondents also felt that
political interference had an effect on their practice or the implementation of the reforms as a whole. This interference was attributed to decisions being made by politicians, who sometimes stop them from doing things that have been stipulated in the reform document so as to gain political leverage. This ties in with what was brought out in the literature review that political, financial elites and organised labour groups almost always block the efforts of the reforms any where.

The suggestions given by respondents into making the reforms a success ties in with what has been revealed in this study i.e. lack of knowledge due to poor dissemination of information. The respondents suggest that adequate training be offered to all staff, have qualified staff to run management teams and improve the communication system. Promotion of team work has also been suggested and this is very important if anything has to succeed. Financial accountability and increased funding from the government were yet other suggestions.

An important observation made and supported by the mothers was shortage of staff, this was quite evident in the rural province. Implementation of the reform actually requires people to do it. If the situation in the rural areas does not improve the problems revealed in this study will continue.

On the whole, despite poor information dissemination, some health workers are aware of the reforms and are knowledgeable. Their practice is also good but there is need for more training and improved information dissemination to improve the practice of those who are ignorant. The attitude varies with circumstances. These vary in terms of how they affect the health worker e.g. having added responsibilities and being answerable to patients now that they are paying for the services. Figure 3 conclusively shows some of the factors observed in this study that determine staffs' knowledge, attitude and practice.
Figure 3 Factors affecting Knowledge, attitude and practice of staff:

- Poor Administration
- Lack of guidelines
- Political Interference

- PRACTICE
- KNOWLEDGE
- ATTITUDE

- Poor Channels
- Added Responsibility Answerable to patients
- Distance from MOH
- Resistance to Change
- Lack of Information
- Lack of training
CHAPTER 6

6.0 Conclusions and Recommendations

6.1 Conclusions:
The results of this study show that even though the health staff are aware of the reforms, the level of knowledge and understanding of some is very poor hence having no knowledge on some of the issues in the reforms.

The factors identified earlier on like political interference, information dissemination, communication channels, managerial skills, distance from initiators, fear of job security and resistance to change have an effect on the knowledge, attitude and practice of the health staff regarding the health reforms. It appears that the effective channels are not used as revealed in the study. These channels i.e. seminars, supervisors and circulars should be utilised especially in the rural areas. These are the channels that have proved very effective in the study. The other channels though useful have problems in terms of poor or no reception at all and lack of news papers/bulletins in rural areas makes them ineffective. The above, have adversely contributed to the poor dissemination of information. There has also been disparities between urban and rural province in that the urban is more favoured in terms of information dissemination which is obvious. It is therefore important to note that different channels of information should be applied for different areas.

The reforms are bound to fail if there is no team work amongst the staff. Those in management teams should make sure that they work hand in hand with other members of staff. The idea for all is to see the reforms achieve their objectives and thus need for team work. Financial accountability should also be emphasised. It is important that those responsible for the collection of money should account for every coin collected. Problem of collection and accountability can cause suspicion of misuse. Without financial accountability, the idea of financial independence will not be achieved. The government should also increase funding and improve salaries and conditions of service if the programme has to run successfully and if health staff are to be motivated to do their work. Improved funding will enable the hospitals to have the requirements readily available. Staff levels also is a very serious issue that came out of the study. The objectives of the reforms among others is to provide very efficient and effective health care to all, but when you look at staff levels especially in the rural province you wonder whether this will be
achieved. These are areas where the majority of our people are staying and yet you find very few staff manning institutions. There is need to improve upon this. If there are problems of retaining staff in rural areas, the Ministry should introduce some type of bonus to rural health staff or rural experiences to all cadres before being allowed to work in the urban areas.

It can be concluded that the irregularities in the exemption policies could be attributed to poor information dissemination. On the whole, in the area of charges, the attitude and practice has been found to be good in the majority of cases though there are still some with bad attitude and practice. With good information dissemination and training these can be improved.

6.2 Hypothesis Testing
The hypothesis testing was based on Chi square calculations. I had three hypothesis thus tested below:

Hypothesis 1
Ho: Poor communication has led to poor attitude of the health reforms.
Hi: Poor communication has not led to poor attitude of the health reforms.

Information dissemination by Support of the reforms

<table>
<thead>
<tr>
<th>Information dissemination</th>
<th>Support of Reform</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Good</td>
<td>73</td>
<td>5</td>
</tr>
<tr>
<td>Poor</td>
<td>91</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>164</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

Using significance level of 0.05 and degree of freedom of 1, the chi square test proved that there is a relationship between poor communication and poor attitude towards the health reforms.

Hypothesis 2
Ho: Poor communication has led to poor practice of health reforms
Hi: Poor communication has not led to poor practice of health reforms
### Information dissemination by Underfive charges

<table>
<thead>
<tr>
<th>Information dissemination</th>
<th>Underfive</th>
<th>Charges</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>6</td>
<td>78</td>
<td>84</td>
</tr>
<tr>
<td>Poor</td>
<td>12</td>
<td>130</td>
<td>142</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>208</td>
<td>226</td>
</tr>
</tbody>
</table>

At a significance level of 0.05 and degree of freedom of 1, the chi square test reveals a relationship between poor communication and poor practice of the health reforms.

**Hypothesis 3**

**Ho:** Lack of understanding of health reforms has led to non acceptance of the reforms

**Hi:** Lack of understanding of health reforms has not led to non acceptance of the reforms

### Community participation response by support of reforms

<table>
<thead>
<tr>
<th>Community participation response</th>
<th>Support of Reforms</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Agree</td>
<td>133</td>
<td>17</td>
</tr>
<tr>
<td>Disagree</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>26</td>
</tr>
</tbody>
</table>

Using significance level of 0.05 and degree of freedom of 1, the chi square test on pooled data reveals a relationship between lack of understanding of health reforms and non acceptance of the reforms.

6.3 **Limitations of the Study:**

Transport was the major limiting factor especially in the rural areas. since long distances had to be covered to reach various health centres. Some days were wasted whenever transport was not readily available. Again, owing to the expenses encountered in securing fuel for transport, I could not make second trips to collect questionnaires not completed in the first instance.

It is also a factor to consider that this study looked at two provinces out of the nine in Zambia which may mean that the findings cannot be generalised. However the findings are worth considering in terms of improving the operations of the reforms.
6.4 Recommendations

Out of the results of this study, I make the following recommendations:
1. The Ministry of Health should reconsider using circulars, seminars workshops and supervisors as major channels of disseminating information.
2. Start a re education programme for staff on issues concerning the reforms.
3. Consider placing qualified staff to run districts to avoid conflict and negative attitudes towards the reforms.
4. Improve staffing levels especially in the rural areas and as a way of over coming added responsibilities.
5. Politicians should be seen to support the reforms through and through and not just during meetings with officials but change when people query them.
6. Seminars/ workshops should be open to every one.
7. A larger study covering the entire country will be necessary so as to evaluate the knowledge, attitude,practice of staff and also the implementation of the reforms.
BIBLIOGRAPHY

1. Booth et al., "Coping with Cost Recovery In Basic Services (Health and Education) In Poor Communities in Zambia," Lusaka, 1993

Journals and Newspapers

17. Times of Zambia, No. 9345, November, 1995
19. Times of Zambia, No. 9147, April, 1995
ANNEX 1

VARIABLES

Political interference

Guidelines

Managerial skills

Knowledge, attitude, and practice of health staff concerning health reforms

Distance from the initiators

Fear of job security

Communication channels (road, radio, TV, papers)

Resistance to change

Information dissemination
IMPORTANT OBSERVATIONS
An important observation was made during the period of the study which seemed to affect both the rural and urban provinces though it was more evident in the rural area.

There seemed to be a lot of misunderstandings between health management teams and the health workers especially over the issue of money and attending seminars/workshops where the health workers felt that it was the top management benefitting.

There was also the issue of authority especially in the rural province where those in authority were being rejected because the health staff more especially the doctors felt they were juniors and on top of that, unqualified.

Another problem was over supplies to the hospital as observed in one hospital where it was felt that they should be allowed to make their own budgets and buy their own supplies since they had better knowledge of what they required.

After observing the above problems, meetings were held with the management teams in the rural province and the following were said to be the problems being encountered:
1. Allocations not being granted on time hence the delays in carrying out the action plan.
2. Shortage of staff which has a bearing on proper dissemination of services and hence poor practice due to work loads.
3. Resistance to change where the health staff perceive them as using the money.
4. Political interference, where in certain instances politicians have gone to the extent of telling their electorates that they are not supposed to make any payments and accused health workers of stealing money from people.
5. Poor incentives which has led to workers being demotivated.
6. Problems of fuel- hence interruptions in the programmes. It became very difficult to convince them that certain things were not catered for by fundings e.g buying soft drinks when having meetings. It was suggested that people from the ministry should make an effort to visit the different institutions to explain the financial aspects. Perhaps people would believe if it came from the 'Horse's mouth'

There were however some positive aspects like:
- Being able to set their own priorities
- There is timely intervention in cases of crises.
- Things were easy to get.
- There is community participation especially now that there are committees which include the local people.
University of Zambia,
School of Medicine
Department of community Medicine
Dear Respondent,
The questionnaire you are about to answer is seeking information on your knowledge, attitude, practice of the health reforms. Kindly answer the questions by making a tick (✓) or filling the blank spaces provided truthfully and concise. The information provided will be treated in strictest confidence. No names should attached to the questionnaire.

A) Demographic Data:
1. Age ______ years
2. Sex Male (__) Female (__)
3. Marital Status: Married (__)
   Single (___)
   Divorced (___)
   Widowed (___)
   Other ,state _______________
4. Educational Background
   Primary (___)
   Secondary (___)
   University (___)
5. What is your Qualification
   Doctor (___)
   Nurse (___)
   Paramedical (___)
   Administrative( Clerks, Cashiers) (___)
6. What is your present job ____________________________
7. How long have been in service
   Less than 5 years (___)
   5 to 10 years (___)
   11 to 15 years (___)
   16 to 20 years (___)
   20 years plus (___)

B) Knowledge
8. Health reforms are all about

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralisation of power to the Districts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction of fees for health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community participation in provision of health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private sector participation in the provision of health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A profit making venture for health institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A political change which has emerged with MMD government</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A change aimed at improving the quality of health care and quality of life for every Zambian</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Listed below are channels of communications. Through which ones have you been able to get information about health reforms

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td></td>
</tr>
<tr>
<td>Television</td>
<td></td>
</tr>
<tr>
<td>Newspapers</td>
<td></td>
</tr>
<tr>
<td>News bulletin</td>
<td></td>
</tr>
<tr>
<td>Circular</td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
</tr>
<tr>
<td>Seminar/workshop</td>
<td></td>
</tr>
<tr>
<td>Friend/CO Worker</td>
<td></td>
</tr>
</tbody>
</table>

10. Do you have problems in getting information through the various means listed above

YES (___)

NO (___)

If Yes, what problems

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor radio reception</td>
<td></td>
</tr>
<tr>
<td>Poor TV reception</td>
<td></td>
</tr>
</tbody>
</table>
No TV reception ( ) ( )
Poor road network ( ) ( )
Lack of newspapers ( ) ( )
Poor postal services ( ) ( )
Supervisors not sharing information ( ) ( )
Seminars/workshops being attended by managers only ( ) ( )

11. Have you had detailed explanation of the health reforms concerning

   YES          NO
   Exemption policy ( ) ( )
   Use of Social Welfare Dept ( ) ( )
   User fees ( ) ( )
   Insurance scheme ( ) ( )
   Pre-payment ( ) ( )
   Restructuring decentralisation ( ) ( )
   Collection and use of money ( ) ( )
   How to enhance community participation ( ) ( )

12. What is your opinion concerning the dissemination of information from top management to subordinates

   YES          NO
   Very Good ( ) ( )
   Good ( ) ( )
   Very Poor ( ) ( )
   Poor ( ) ( )

13. Do you think the factors listed below determine the effectiveness of information dissemination

   YES          NO          DO NOT KNOW
   Living within Lusaka ( ) ( ) ( )
   Professional group (e.g. Doctor/Nurse) ( ) ( ) ( )
   Type of unit one works in (e.g. big hospital, RHC etc.) ( ) ( ) ( )
   Type of communication channel used e.g. TV, Radio, circulars ( ) ( ) ( )

C) Practice
14. Have you been given any guidelines on how to carry out the new changes brought about by the health reforms?
   YES ( ) go to 16
   NO ( )

15 Do you think lack of guidelines have an effect on your practice?
   YES ( )
   NO ( )
   Explain ________________________________

16. What do you do to patients who are eligible to pay but have no money?

   YES  NO
   Send the away ( ) ( )
   Treat them free of charge ( ) ( )
   Treat them and ask them to pay later ( ) ( )
   Refer them to dept of Social welfare without treatment ( ) ( )
   Other/ state ________________________________

17. What do you do in cases where a parent who is not a member of your scheme who brings a sick under five child to, your institution and has no money

   YES  NO
   Treat the child free of charge ( ) ( )
   Send the child away ( ) ( )
   Treat the child and payment later ( ) ( )
   Send them to social welfare dept ( ) ( )

18. What do you do with people who do not know their ages and have come for treatment

   YES  NO
   Estimate age by physical assessment and treat ( ) ( )
   Assess their age by use of some important events that occurred at the time of birth and treat ( ) ( )
   Treat them ( ) ( )
   Send them away ( ) ( )

19. In case of an out break, what do you do to those suffering from the disease?

   YES  NO
   Exempt them from paying ( ) ( )
   Make them pay for the services ( ) ( )

20. Do you charge for the services/ ages/ diseases listed below?
YES  NO

Under five children (  ) (  )
Adults over 65 years old (  ) (  )
Ante natal services (  ) (  )
Under five clinic services (  ) (  )
Health education and counselling (  ) (  )
Treatment of chronic diseases e.g. TB., (  ) (  )
Hypertension, Diabetes mellitus etc., (  ) (  )
Contact tracing of people with TB.,and screening (  ) (  )
for STD (  ) (  )
Treatment during epidemics e.g. Cholera (  ) (  )

21. What do you do with the money collected from patients?

YES  NO

Use it for staff bonuses (  ) (  )
Buy staff uniforms (  ) (  )
Make institutional renovations (  ) (  )
Send to the central fund(MOH) (  ) (  )
Buy equipment, supplies (  ) (  )
   drugs for the institution (  ) (  )
Other, state (  ) (  )

22. Are you interested in politics?

YES (  )
NO (  )

If yes which party do you support?

MMD (  )
UNIP (  )
NP (  )
Others, state

23. In your opinion, do you think the factors listed below have an interfered with the way you implement the reforms?

YES  NO  DO NOT KNOW

Decisions being made by top (  ) (  ) (  )
politicians(e.g. Minister)
Criticisms from opposition parties (  ) (  ) (  )
Belonging to the opposition party(self) (  ) (  ) (  )

D) Attitude
24. In your own opinion, what do you think of the reforms?
   Good ( )
   Bad ( )
   Do not know ( )

25. Are you for the reforms?
   Yes ( )
   No ( )
   Do not know ( )

Support your answer ____________________________

26. Does the health reforms threaten your present job in terms of

<table>
<thead>
<tr>
<th>Demotion</th>
<th>YES</th>
<th>NO</th>
<th>DO NOT KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not getting a job when transferred to another town</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Being answerable to patients for services rendered</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Having added responsibility to your present work hence workload</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Insecurity in terms of job loss i.e. being fired easily</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Other, state</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. Do you think that the introduction of fees in your institution will improve:

<table>
<thead>
<tr>
<th>Your salaries</th>
<th>YES</th>
<th>NO</th>
<th>DO NOT KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your working environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The supply of drugs and other material resources</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of health programme</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Other, state</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
28. What in your opinion should be done to make the implementation of the health reforms successful?


End of questionnaire

Thank you very much and may God Bless you!
LIST OF QUESTIONS.
FOCUS GROUP DISCUSSIONS

TARGET GROUP: MOTHERS

1. Have you noticed any changes with regards the health care delivery of this institution now?
   What are these changes?
2. Are you supplied with information on the health reforms and its benefits?
   What kind of information are you being given?
3. Are you aware that there are provisions of exemptions?
   What falls under these exemptions?
4. Have you at some occasion been sent away without treatment due to lack of money?
   What was your reaction and what move did you take?
5. How do you rate the quality of care being offered now?
   Are there any changes?
6. How would you like the staff to conduct their practice as regards the new changes of health reforms?
5 October 1995

The Provincial Medical Officer
North-Western Province
OLWEZI.

Dear Sir

RE: Conducting of Research Study by Beatrice K. Sakungo

I wish to introduce to you the above named Post-Graduate Student in the School of Medicine, Department of Community Medicine, UNZA who is currently doing a Masters of Public Health Degree Programme.

Please be informed that the said person, has been granted permission by this office to conduct a study in the "knowledge, attitude and practice" of the health staff regarding the Health Reforms.

Your Province is among those selected as study sites and I will be grateful if you will render her all the necessary assistance to help her carry out the said research study.

Thanking you in anticipation for your usual cooperation.

Yours sincerely

V. Musoye
Chief Health Planner
for/PERMANENT SECRETARY
MINISTRY OF HEALTH
The Provincial Medical Officer
Copperbelt Province
DOLA.

Dear Sir

RE: CONDUCTING OF RESEARCH STUDY BY BEATRICE K. SAKUNGO

I wish to introduce to you the above named Post-Graduate Student in the School of Medicine, Department of Community Medicine, UNZA who is currently doing a Masters of Public Health Degree Programme.

Please be informed that the said person, has been granted permission by this office conduct a study in the "knowledge, attitude and practice" of the health staff regarding the health Reforms.

Your Province is among those selected as study sites and I will be grateful if you will render her all the necessary assistance to help her carry out the said research study.

Thanking you in anticipation for your usual cooperation.

Yours sincerely

V. Muscwe
Chief Health Planner
for/PERMANENT SECRETARY
MINISTRY OF HEALTH

The District Health Director
Ndola Urban Health Board
NDOLA.

The Medical Officer - In-charge
Mpongwe Mission Hospital
University of Zambia  
School of Medicine  
Dept. of Community Medicine  
P. O. Box 50110  
Lusaka  

2nd October, 1995  

Dear Sir/Madam,  

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY  

I am a Postgraduate Student, undertaking a masters of Public Health Degree at the above mentioned institution.  

As part of the requirement to complete my studies, I have to do a thesis and in this case on the knowledge, attitude and practice of the health staff regarding the health reforms.  

I am hereby asking for permission to carry out the said study in your institution which is among the selected study sites. Please find attached a supportive letter from the office of the Permanent Secretary, Ministry of Health.  

I will be very grateful if you consider my request.  

Yours faithfully,  

Beatrice K. Sakungo  
encl...
19th October, 1995

Beatrice K Sakungo,
MPH Student
Dept. of Community Medicine
LUSAKA

Dear Mrs Sakungo,

RE: HEALTH STAFF’S KNOWLEDGE, ATTITUDE AND PRACTICE TO THE HEALTH REFORMS IN AN URBAN AND RURAL SETTING OF ZAMBIA (A COMPARATIVE STUDY)

Your proposal was submitted to the Research and Ethics Committee and was accepted, subject to inclusion of Data Collection Techniques in your proposal.

The Committee wishes you success completion of your study.

Yours Sincerely

[Signature]

Dr K S Baboo
CHAIRMAN,
RESEARCH & ETHICS COMMITTEE
UNIVERSITY OF ZAMBIA

cc: Associate Professor, Peter Sims
    Assistant Dean (PG)
    Head, Dept. of Comm. Medicine
    MPH Co-ordinator, Dr N W Chitalu

/ fh
<table>
<thead>
<tr>
<th>ITEM</th>
<th>QUANTITY</th>
<th>UNIT COST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Subtotal**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>QUANTITY</th>
<th>UNIT COST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STATIONARY**

- Bin Tying Services
- Stencils
- Duplication Paper

**TRANSPORT**

- Local Transport
- Zambezi to Luaka
- Ndola to Zambezi
- Luaka to Ndola by Road

**Computer Services**

- Photocopying Fashion Report
- Discussion Group Report
- Photocopying Focus Group
- Duplication Services

**Typing Services**

- Typing Final Report
- Typing Discussion Group
- Typing Focus Group
- Typing Questionnaire

**Researcher - Subsistence**

- Allowance

**TOTAL**

- 50,000 pages x 10 copies
- 5,000 copies x 50 pages
- 1,000 copies x 1 page
- 45,000 copies x 5 pages
- 50 pages
- 1,000 copies x 1 page
- 1,000 copies x 1 page
- 5 pages
- 30 days
- 1,000 copies x 1 page
- 1,000 copies x 1 page
- 20,000 nights
- 700/000/000
- 1,000/000/000
- 9,000/000/000
- 7,000/000/000
- 9,000/000/000
- 6,000/000/000
- 1,000/000/000
- 300/000/000
- 100/000/000
- 100/000/000
- 30/000/000
- 1,000/000/000
- 2,000/000/000
- 1,000/000/000
- 1,000/000/000
- 1,000/000/000
- 60,000.00
- 18,000.00
- 12,000.00
- 6,000.00
- 84,000.00
- 50,000.00
- 45,000.00
- 50,000.00
- 600,000.00

**UNIT**

- Copy
- Box
- Room
- Room

**COPY**

- 10 copies
- 1 box
- 3 rooms
- 3 rooms

**SUBTOTAL**

- 30 days
- 1 trip
- 1 trip
- 1 trip

**96,000.00**
<table>
<thead>
<tr>
<th>Balance</th>
<th>Fundings Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>602,000.00</td>
<td></td>
</tr>
<tr>
<td>500,000.00</td>
<td></td>
</tr>
<tr>
<td>1,102,500.00</td>
<td></td>
</tr>
<tr>
<td>52,500.00</td>
<td></td>
</tr>
<tr>
<td>1,050,000.00</td>
<td></td>
</tr>
<tr>
<td>30,000.00</td>
<td></td>
</tr>
</tbody>
</table>

GRAND TOTAL:

5 crates

6,000/each