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# PART I

## THE HUMAN FACTOR



## Introduction to the human factor

In the preceding chapter we set the stage for what is to follow in this dissertation. The debate on the African state and the concept of neo-patrimonialism were explored, and a justification was given for focussing on the object of study: Zambia and particularly its health sector. Now, as was discussed in the theoretical framework, we will zoom in on the human factor that drives the Zambian health sector. In the chapters that will make up this part of this dissertation, we will look at the ‘shop-floor level’<sup>1</sup> of the Zambian health sector by examining the primary element that makes the health sector or any bureaucracy tick: Its workforce. This means looking at the strategies and behaviour of health workers: Doctors, nurses, administrators, and other staff required to deliver the outcomes envisaged for the health system. We will, however, not only look at them as professionals, but rather as part of the socio-economic context within which they live. It is hoped that this will provide the insights needed to make sense of the historical, bureaucratic, and political processes analysed in greater depth in the next part of this dissertation. We will thus attempt to take a good look beyond the façades of the State and the sector at the human factor of the Zambian health system.

As mentioned in the section ‘Zooming into the human factor’ of Chapter 1, the neo-patrimonial paradigm makes assumptions about human behaviour. As such, the neo-patrimonial paradigm suggests that in African bureaucracies there is little distinction between the public and private roles of those individuals holding a position. For the Zimbabwean health sector in the 1990s, one researcher drew the following bold conclusion:

Health institutions and professions are based on rational-legal principles, but the behaviour of most of the health workers is underpinned by pre-industrial cultural values, such as valuing kinship over public interest. This gives rise to patrimonialism and other behaviours which are incompatible with professionalism as perceived from an Anglo-American perspective.<sup>2</sup>

This statement represents well the dichotomous presumptions of the neo-patrimonial paradigm. It equates pre-industrial cultural values with patrimonialism and contrasts them with professionalism, which is implicitly labelled as a Western cultural value. A similar conclusion on the behaviour of health workers was drawn by Aitken in her analysis of the district health system in Nepal. She concluded that in contrast to the official theory, which sees the delivery of health services to the community as the

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<sup>1</sup> Anders, ‘Civil servants’.

<sup>2</sup> Mutizwa-Mangiza, D., *The impact of health sector reform on public sector health worker motivation in Zimbabwe* (Bethesda, 1998), 25.

purpose of the health system and its staff, implicit theory sees the provision of jobs and income to those within the system as its primary task. Whereas she does not directly employ the concepts of rational-legalism versus patrimonialism, she does evoke the well-known image of a façade by stating that many actions within the system that are phrased in terms of official theory have become ritualised and meaningless, as procedures have been manipulated to serve the implicit theory.<sup>3</sup>

In the next chapter we will explore the narratives presented by health workers to explore the factors that drive them and their behaviour. Indeed, we will see confusion between official theory and more implicit motivators. At a later stage we will further explore such conclusions to see to what extent they hold against the empirical reality of contemporary Zambian health workers. Is the pursuit of jobs and income indeed implicitly the primary goal for those in the health sector? Is this goal underpinned by ‘pre-industrial values’ and patrimonial behaviour? Is the official theory of delivering health care to the population inconsequential in the face of the true motives of health workers?

We will, however, begin this exploration with an example of a health worker and his account of some difficulties he has encountered both getting to work and being at work. This will familiarise us with some of the issues that are at play in health workers’ careers and at their place of work. The case is the anonymised account of a health worker I encountered a number of times. I interviewed him, spoke with his colleagues, and interacted socially with him while we bought each other beers. In addition, I observed the intervention on his behalf by a senior health official. The case presented is limited by the meagre information I was able to gather. Undoubtedly, some statements or even actions of those involved cannot simply be taken at face value: They are essentially aimed at self-justification, presenting an optimal picture of one’s self. Nevertheless, this illustrative example will reveal issues relevant to the work and life-world of health workers and present the desires and ambitions expressed by them.

#### The case of Ashley Mwansa<sup>4</sup>

When I first met Ashley in April 2008, he was working at a zonal health centre, together with a midwife, support staff, and two young clinical officers. The clinical officer-in-charge, Anton Chanda, was only twenty-five years old, but it was already the second health centre that he had headed. Both young men had only recently been transferred to this clinic. They recounted that they were facing some difficulties. There was no staff accommodation available at the health centre, so they had to walk four kilometres to a house they had to share. Moreover, Ashley had not been put on the government payroll even though he had been posted here five months earlier. This meant that he had had to leave his wife and three children behind in a small town in a neighbouring district. Over a beer, he told me that he was not sure how long he would remain working in the health sector. What kept him there was Anton and the other young clinical officer, who despite their age were doing good work.<sup>5</sup>

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<sup>3</sup> Aitken, J.M., ‘Voices from the inside: Managing district health services in Nepal’. *International Journal of Health, Planning and Management*, 9 (1994): 309-340.

<sup>4</sup> So as to protect the privacy of respondents, all the names presented below are fictitious.

<sup>5</sup> ML0804/15.

Ashley was a Zambian enrolled nurse.<sup>6</sup> Although he was already in his mid-thirties, he had graduated from St. Paul's school of nursing only in 2006. Ashley told me that his father and mother had not been married to each other. His mother came from North-Western Province and his father originally came from Kaputa District in Northern Province. He explained that he had never known his father, who was working for the Ministry of Finance in Lusaka. His father had another family there and had passed away in 1994. Ashley said that he would have liked to get into contact with his father's family, but suggested that he did not know how. His mother had brought him up in Solwezi, North-Western Province, until she followed a man to Luapula Province, a man whom she had met and later married. Ashley said his stepfather was a nursing officer with the district council and retired in 1993. He recalled that his mother was able to support him through secondary school, but that there was not enough money for further schooling. In the meanwhile, he had married a girl he met at school and started his own family. He supported the family by practising small-scale agriculture. In fact, he claimed, he even managed to save money for further schooling. The plan had initially been to send his wife to nursing school. But she had told him, "No, you go". "I have a good wife", he proudly told me in a bar for all to hear. Later he explained that this decision was based on the fact that his wife's school results were not good enough. In order to have a good chance of being admitted to nursing school, she would have to re-sit mathematics. That would take a long time and perhaps she would not pass.<sup>7</sup>

Learning that Ashley had not been put on the payroll in the five months since having been posted was surprising. In recent years, payroll management had been partially decentralised to districts. The manager administration of a district health office would have to go to Lusaka with 'inputs' – a list of changes to be made to the payroll – and submit these to the Ministry of Finance. In an interview with the manager administration in question, when he was asked if there were problems placing people on the payroll, he was very vague and evasive in his response. He said it was not a problem to put people on the payroll. "You just go to Lusaka with the 'inputs'". He did, however, suggest that it was difficult to get hold of people at the human resources directorate at Ndeke House<sup>8</sup> because there were so many people waiting.<sup>9</sup>

A week after speaking with Ashley, I ran into him at the district health office in the neighbouring district. I happened to be there with a team from the provincial health office who were conducting a performance assessment. When asked, Ashley indicated he had come to fax his appointment letter to Lusaka, and he had to travel to this place as there was no fax machine in his home district. The manager administration was in Lusaka and needed this letter to put him on the payroll. After having said goodbye to Ashley, I asked the human resource manager from the province if she was familiar with this case. It turned out she was and appeared surprised that Ashley had had to come all this way to fax his appointment letter. She then went to her boss, the provincial health director, and told him of what she had just learned. She had earlier told me she does not understand why this procedure is a problem for the manager administration. "He goes to

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<sup>6</sup> An enrolled nurse is lower in the hierarchy of the health sector than a registered nurse, owing to the shorter training programme. See Annex IV for a list of professional cadres in the Zambian health sector.

<sup>7</sup> ML0804/15 and ML0811/14.

<sup>8</sup> Ndeke House is the modern, multi-storey building in which the Ministry of Health is housed. Formerly, the building housed the Central Board of Health.

<sup>9</sup> ML0804/17.

Lusaka often, but probably to do other business. He does not even go past the provincial health office on his way ... It should be simple, but perhaps it is because he is a nurse. He is forced to do these things even though he does not understand them”.<sup>10</sup>

The provincial health director then grabbed his mobile phone, found the manager administration’s number, and called him. It seemed that this issue had come up when the team from the province visited earlier in the week. Also, the manager administration had been told how to prepare himself for the task of putting people on the payroll. “Why haven’t you brought the letter”, the director asked the manager administration. “Why are you rushing to Lusaka for reasons known only to yourself without preparing yourself properly? You are just chasing allowances while others are suffering. This young man travelled (here) to fax this letter. Do you realise the cost you are adding? This just reflects the shoddy work you have been doing. I’m sorry if I sound harsh, but if I hear one more thing like this, I’ll remove you from your post”. After hanging up he muttered under his breath, “No wonder they hate (the district health director)”.<sup>11</sup>

In November of that same year I visited Ashley again. I had learned that both he and Anton had moved to a different health centre. Because of the accommodation issue, Ashley had gone to the district health office to insist on a transfer. He was not able to bring his family over and he had been maintaining two households. So some four months earlier he was moved from the zonal health centre to become the in-charge<sup>12</sup> at this improved health post where he would work together with one classified daily employee (CDE), an older gentleman who cleaned, guarded, and assisted in carrying out the duties at the clinic. The health post that Ashley was running was just a small facility that had been recently opened. His predecessor, also a male nurse, had gone on study-leave to upgrade from an enrolled nurse to a registered nurse. Anton had also left the health centre where I had found them in April. After Ashley had been transferred, Anton had gone to the district health office to say, “If you transfer Ashley, then I am leaving”. They thought he was joking, but then he arranged a transfer back to the district where he used to work. He went back to the same health centre where he was in-charge before, to take up the same position.<sup>13</sup>

Ashley had since been put on the payroll. He received his back pay, which had allowed him to furnish the two-bedroom staff house that his family now occupies. In April he had been informed by someone that the provincial health director was in the district. He had then gone to the human resource manager to explain his problem. The human resource manager in turn took it up with the provincial health director. Then, after faxing the letter to Lusaka, the problem was soon resolved and since May he had been receiving his salary. However, Ashley suspected this issue has caused enmity between the manager administration and himself: They were not on good terms. The manager administration appears to think that what Ashley did, complaining to the provincial health director, was wrong. He had since been telling people in the district bad things about Ashley. This led Ashley to consider that people in the district now think he is a troublemaker. If he presented problems to the district now, they would be overlooked: The district would not help. He was currently thinking about complaining to the provincial health director to ask for a transfer out of the district. According to

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<sup>10</sup> Field notes VW06.

<sup>11</sup> Field notes VW06.

<sup>12</sup> The officer-in-charge of a clinic or department is commonly referred to as the in-charge.

<sup>13</sup> ML0811/14 and ML0811/08.

Ashley's friend Anton, however, there had already been a soured relation between the manager administration and Ashley before this incident.

When asked what type of problems he had presented to the district, Ashley mentioned that in the health centre where he was posted before he had been beaten. He was on night duty when a man arrived looking for his wife. His child was ill and had been admitted. The man went in to the ward and then came out and started beating Ashley. "I didn't retaliate. That is against our ethics". Ashley cannot give an explanation why he was beaten. He suggested that when he came for night duty, he just found the child there. When asked if something had gone wrong, he denied this. The only explanation he could give was that the father had probably been smoking *dagga*.<sup>14</sup> Ashley suggested that he had brought the case to court, but has since decided to drop the case after the man's relatives pleaded and he decided to forgive him. According to Ashley, the district did not know how the case was doing; he felt that at the district health office they were not concerned.

Another issue in which the district health office, in Ashley's view, had not supported him concerned the family of the nurse who was previously in charge at the health post. While the nurse was on study leave, his family still had the right to be accommodated in his staff house. Now, "the family behave as if they are workers at the clinic and the man even instructs them to insult me". When Ashley arrived at the clinic, there were no bicycles there. During performance assessment, "the district asked us why we were not doing much on IMCI" (integrated management of children's illnesses). He had answered that they did not have the bicycles needed for the outreach activities. The officials from the district then informed him that not too long ago bicycles had been delivered to the clinic. Ashley then learned from his colleague, the CDE, that the bicycles were kept at the home of the last in-charge. When they went to remove the bicycles to bring them to the clinic where they belong, the wife of the former in-charge phoned her husband. Ashley's predecessor accused him of not knowing the regulations, and that he, the former officer-in-charge, had opened the clinic and that was why he was given the bicycles. Later, the family just came into the clinic to take the bicycles. "I don't know why they behave like that", Ashley exclaimed. "The family and the clinic are separate". He has reported the issue to the district, but they have not done anything to help. The issue affects even Ashley's own family. They are also insulted by his predecessor's family, who live in the adjacent staff house. The family have never encountered something like this before. At their previous home they got along well with their neighbours. After the district had failed to do anything about this issue, Ashley told his Neighbourhood Health Committee that he was planning to leave. The community, however, asked him not to go, promising that they would go to the district to talk to them.<sup>15</sup>

Ashley's friend Anton also reported that he had the impression that he was not supported enough by the district health office in the district he left. At the health centre where he was in charge, they were running a clinic dispensing anti-retroviral AIDS treatment. They wanted to set up a mobile clinic to follow up patients who were put on anti-retrovirals, but the district could not come up with the funds. Also, once he wanted to send blood samples for testing at the nearest hospital in the adjacent district. "They took three months and they still didn't deliver". When he went to complain about this, he was told, "We have been here for a long time. You have just been here for a few

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<sup>14</sup> Cannabis.

<sup>15</sup> ML0811/14.



months. You can't tell us how to run the district".<sup>16</sup> Separately, concerning the same issue, Ashley told me, "They fail to find money for fuel to follow up people on ARTs (anti-retroviral treatment), but they find fuel to go to Mansa to do their business. You know with ARTs we're not helping people; we're killing them. They are interested in how many people we start on ART, but we don't have means to follow up. They could move or be anywhere". As a further illustration of the management problems in the district, he listed the people who have left the district. "That must show we have a problem".

When asked if he still had job satisfaction, he replied that he felt very little enjoyment in the work. This health post was, he argued, running like a larger health centre. A health post should just operate from 08.00 until 16.00, but here they would even admit patients. "We work throughout the day and at night there are emergencies. I only enjoy my due: My salary. The workload is very heavy". Nevertheless, when prompted, he also admitted that there was gratitude from patients. Some come with gifts such as cassava. "Usually I don't allow that", he added. "In your country people might just offer a gift, but here that is different. Here they might give that to be favoured when you treat them". Then he recounted how once when he was just about to travel, a difficult maternity case came and he had to delay his travels. He called an ambulance and accompanied the patient before he proceeded. Then when he returned, her family came to thank him and offer praise. "That does give enjoyment". In fact, it is one thing that motivated him to become a nurse. Once Ashley's son received a burn and he brought him to a clinic. There a health worker treated the child. That inspired Ashley to want to deliver services, he claimed.<sup>17</sup>

When chatting over a beer, Ashley suggested that many people in the district management were not qualified for the positions they hold. The manager administration was trained as a midwife with little training in management and administration. Earlier I had learned from the manager administration himself that he had been a nurse who trained as a midwife in the early 1980s. Besides a few years working as a tutor at a nearby nursing school, he had spent most of his time working at rural health centres. He came to the district seven years ago, and after having worked as a health centre in-charge, he was made to act as a manager administration three years earlier. Now he was waiting for his retirement in two years' time. Ashley then indicated that another member of the district management team was in service for just a short time before joining the district office. People such as this are afraid to speak out in support of those below them. They are insecure about their positions, so they stay quiet. He added that the district health director shows no concern for his workforce. He never comes to clinics, only to do his own business or if some staff member has to drop something off. Ashley was told that the previous director would just stop by to see how people are doing and if their family is well. Also he complained that "when you pass by the district health office, you're not a welcome guest, but an intruder ... If you come with an issue, people do not take responsibility but push it to a colleague".<sup>18</sup>

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<sup>16</sup> ML0811/08.

<sup>17</sup> ML0811/14.

<sup>18</sup> ML0811/14.

## What does this case suggest?

Ashley's story has been related to identify some issues that will feature in the following chapters. It is the story of a young man who has dealt with poverty and adversity on his way towards joining the Zambian health service and who apparently struggled to get to grips with the reality of being employed in the health sector. It was interesting to note how Ashley claimed to have been working on the land to raise money for feeding his family as well as to send his wife or himself to college. He, like many other Zambians, was born into a situation in which it could not be taken for granted that there would be funds to send him through school. However, he apparently persevered and reached his goal of educating himself. We will examine the accounts of other health workers to get an impression of the socio-economic backgrounds of those entering the health sector in Chapter 3. We will see how, through the collective effort of parents, relatives, and the individuals themselves, they manage to go through school to get the qualifications needed to start off in the health sector.

Also striking in this account is the ambivalence that is suggested by Ashley's motivation for being a health worker. Apparently he had tried to send his wife to college, but as his chances for being accepted were higher than hers, or so he claimed, they had decided on his becoming a nurse. He, however, juxtaposed this motivation with an account of how he was inspired when his child was helped by a health worker. This raises questions about the motivations of health workers. Is it a strong intrinsic motivation, a passion, or a calling that leads young men and women to become a nurse or a doctor, or are they just looking for a job? This is an issue that we will examine further in Chapter 3. Equally, the difficulties recalled by Ashley about his working conditions conjure up an ambiguous picture about his job satisfaction and motivation. On the one hand, he claimed that he was motivated by the gratitude offered by patients and their relatives. On the other hand, after having finished a litany of the difficulties he encountered, he resigned himself in the statement, "I only enjoy my due: My salary."

As Ashley and Anton were posted, they were confronted with hardships that affected their private lives. Living conditions were, according to the two young men, not up to standard. There was no accommodation that would allow Ashley to be joined by his family, and he did not receive his salary for the first months of his posting – apparently owing to the incompetence of people at the district health office. Moreover, there were issues in the working relation Ashley and Anton had with the district health office, which made them dissatisfied. It was striking how they both showed their agency in securing a transfer elsewhere, which apparently was not very difficult. This agency or power of health workers vis-à-vis the bureaucracy that tries to manage them is remarkable. We will explore accounts of health workers on the transfers and the postings they have undergone within their career in Chapters 3 and 4 to get an idea of their perspectives and how this agency can be explained.

In the account presented above, there are various instances where the public interest, namely offering effective and efficient health services, and private interests do not converge and can even conflict. The understandable preoccupation of Ashley and Anton with their living conditions already suggests as much. Most illustrative in this regard, however, is the account Ashley gave of the attitudes of his predecessor and the predecessor's family to the bicycles that were given to the clinic to conduct outreach activities. This account clearly shows the confusion between the public and private spheres of a health worker, which is so familiar to the neo-patrimonial paradigm. It shows that in the behaviour of Ashley's predecessor, there is no separation made be-

tween what is public, the property of the health post, and his own private social realm. The predecessor is even so brash as to use rational-legal discourse to defend his actions, accusing Ashley of not knowing the regulations. On the other hand, Ashley's account of this incident also suggests that the instrumentalisation of one's position to personalise public resources is not uncontested. He denounces the invasion of the public sphere of the clinic by his predecessor's family. Of course, Ashley's true views in this situation might remain closely guarded in his heart and mind. A cynic might suggest that he removed the bicycles to use them for his own private interests. At the same time, the exclamation, "The family and the clinic are separate", reflects the rational-legal values inherent to bureaucracy. This anecdote thus suggests that the borders between public and private are the subject of contestation on the shop-floor of the health sector. From the perspective of the predecessor, one could argue that in this micro-example there is no emancipation of the state from society. Judging from the outcome of this particular struggle, however, in that the bicycles have been taken away from the family, the distinction between what is of the state and what is of society has indeed been defined in practice.

This public-private confusion also came to the fore in the light this example shone on the practice of human resource management. Apparently the process of putting someone on the payroll was not as straightforward as it appeared. Were the problems encountered merely due to the incompetence of the manager administration involved, or because this official allowed private interests prevail over his official duty? The provincial health director's explanations suggest that both incompetence and the pursuit of private interests can be at play. He stated that this was shoddy work, caused by the manager administration's "rushing to Lusaka for reasons known only to (him)self" and "just chasing allowances", while at the same time arguing that he is a nurse who is made to do things he does not understand. In fact, according to Ashley's accusations against those at the district health office, it is a trend that officials there are under-qualified and thus not responsive to the problems faced in the district. When Anton and Ashley point out these problems – or even worse, Ashley complains to his boss' superior – they incur the district officials' wrath for their disloyalty. As we will see later in this dissertation, this contributes to the argument that managing loyalty is more important than managing performance in a neo-patrimonial context.

While Ashley's story is inherently specific – specific to his context, his personal experiences, and his individual perspectives, values, and character – it does provide an insight into the reality of a health worker. It shines a light on the spatial mobility of health workers, being sent by a bureaucracy from one place to another to deliver services, though many such as Ashley and Anton manage to influence this process so as to align this public objective to their personal goals. It also shines a light on health workers' social mobility, having struggled out of poverty on to a path that will allow them to further improve their lives and those of their families. We will now examine other health workers' accounts to further flesh out these arguments.