Beyond the façade : instrumentalisation of the Zambian health sector

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Getting (down) to work

Having been introduced to the lives and careers of health workers from their own accounts through the analysis of Ashley's story, let us now discuss the issues confronting health workers in their career paths. We will begin by examining how health workers have started off in the health sector. First, we will look at why health workers chose a career in the health sector. What are the motivations that they recount when describing why they became a health professional? As was asked earlier, are health workers intrinsically motivated to work specifically in health or is it simply a path like many others to secure a livelihood? Subsequently, we will explore how they had been able to reach the health sector through schooling and earning qualifications. As it will appear, this is not a purely individual achievement based on someone's talents, but more of a collective pursuit. We will thus examine the socio-economic environment of the health worker by asking who pushed them through school and, as such, onto a middle-class road that may lead them out of poverty. Is the health sector an avenue for upward social mobility?

The following section of this chapter will deal with health workers' pursuit of qualifications. Having been put through school, most working in the health sector will need further qualifications in order to get a job in health. We will see what the competition for scarce education opportunities can lead to, when we examine health workers' recollections of getting into college. In the subsequent part of this chapter, the argument on scarcity is reversed, however. In that section it appears that health workers themselves have become scarce commodities on the market of jobs in the government health system. We will see that this empowers health workers in their negotiation with the system that places them across the vast map of health centres, hospitals, and health offices throughout the country. We will thus be introduced to the great spatial mobility involved in working in the health sector and the agency of health workers in determining their fate. This chapter will conclude with a look forward to issues of how the health system manages its labour force, when we deal with the stories of health workers who are forced to move by disciplinary transfers. How does a system deal with deviant employees, when they are empowered by being a scarce commodity?

In this chapter and the subsequent ones dealing with the human factor, arguments made will be illustrated by and based on extracts from interviews with health workers. Before beginning, a note should be made again about the validity of some statements. People's perspectives will be presented which need not be reflective of the truth as others perceive it. Their interests, their values, and their conceptions of the interviewer are likely to have influenced what they chose to relate and what not. Nevertheless, by

critically analysing their accounts and by placing them next to others' accounts, we should learn of issues, factors, and values influencing health workers' behaviour.

Struggling out of poverty

For an average Zambian, getting a job essentially means an escape from poverty. According to Zambian government statistics, only 17 per cent of working Zambians are in paid employment.[1] A job in the government health sector is one of the limited opportunities that provide an alternative to the default livelihoods of most Zambians: Subsistence agriculture, informal urban work, and dependence on relatives. Some health workers may profess lofty goals and motives behind their career choice, but a broader sample of health workers' career motivations reveals much ambivalence. Health workers often became health workers by chance: They were presented with a lucky opportunity, having limited alternatives. Nursing or medicine is thus generally seen as a job rather than a vocation.[2]

When talking to health workers about their profession and careers, one hears different explanations from different individuals as to why they became a nurse, a doctor or, for instance, a physiotherapist. Some put forward high and lofty motives, presenting themselves as selfless and idealistic. Various people claim to have chosen a job in the health sector "just to serve the people".[3] Some call it a passion or a calling, "to help people who are suffering", or to "care for patients". A number of people recount having had a suffering family member when they were young; others recall an experience when they were young and were treated by health workers. One nurse put is as follows: "When I was younger, I got sick, and I admired the nurses I saw, so that's where I got the idea".[4] Another health worker, whom we will call Mr. Zulu, remembers that he had once gone to an urban clinic. The only health workers there had fallen ill, so people were sent away; only the most urgent cases were seen to. He still remembers the look of desperation on people's faces; he felt he had to assist.[5]

It would be cynical to bluntly dismiss these representations of people's motives as insincere. On the other hand, it is important to bear in mind that in interviews many will want to present themselves in the best light. Moreover, such idealistic, altruistic motives are just one factor among many that influence one's career choice. A more complete palette of responses on why they chose their profession provides more ambivalence. Some are very frank in explaining the banality behind their decision to work in health. One nurse said, "It's a calling. My father wanted me to be a teacher. But I just loved the white uniform".[6] For some it was a calculated decision, focussed very much on the financial motivators that came with the profession. A male nurse admitted that to him the Ministry of Health "seemed like a good employer, with the possibilities for work-

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1 CSO (2005) Labour Force Survey 2005 – Summary Report; http://www.zamstats.gov.zm/nada/ddibrowser/?section=reports&id=32 (accessed on 9 February 2009). The self-employed make up 43 per cent, unpaid family labour 38 per cent, and employers 1 per cent of employed Zambians.

2 Weberian's, A., idealised notion of rational-legal bureaucracy assumes, however, that a position in the civil service is a vocation (*Beruf*), characterised by duty (*Pflicht*), thus presuming that private interests are made subservient to the public good. See Weber, 'Bureaucracy', 51.

3 PB0811/19, LB0809/19, LB0809/21, PB0810/02, and PB0810/08.

4 PB0810/08.

5 ML0811/15.

6 PB0810/07.

shops and allowances".[7] Another interviewee, Mr. Phiri, wanted to study medicine. However, he did not get into medical school because of financial constraints. Still, he wanted to do something in the medical field but was discouraged from becoming a clinical officer "because it is a Zambian programme and difficult to go out of the country with that diploma".[8] So instead, Mr. Phiri settled for becoming a physiotherapist.

For some, a career in health care was not a decision born out of deep passions or convictions; rather it was a second or third choice, influenced by social considerations. One doctor explained how as a child he wanted to become a pilot. But, "all my friends went to medical school, and I had been with them since primary school, and I also went to medical school with them ... It wasn't peer pressure, we just got in as a gang".[9] As indicated by this example, someone's social environment plays a large part in their career choice. Sometimes this is blunt parental pressure, based on engendered norms. A young nurse argued that she had no choice in deciding on a career. After school she had wanted to go into engineering or something similar, perhaps with computers. Her father objected, saying, "if you do what men do, what will men do?" One day she woke up and her father told her, "there are interviews today at St Paul's; you should go there". He had already signed her up. She did not want to go, but she went to please her father. The interview went well and a few months later she was accepted into nursing school to become an enrolled nurse. She reflected, "maybe this is what God wants me to do".[10]

But apart from blunt pressure, relatives can also be of indirect influence – for instance, by being a positive or a negative example. The male nurse cited earlier, who reckoned the Ministry of Health would be a good employer, grew up with an uncle who was a teacher. However, seeing the problems that teachers face, he decided to do something else.[11] Others were inspired or convinced by role models, either doctors or nurses encountered when they went to hospital or family members who themselves worked in the health sector. Having a relative working for the Ministry of Health, however, can be more than merely an inspiration. One environmental health technician who has climbed up to hold a senior position in a district health office mentioned that the fact that his father was a health inspector was an important factor in his career choice: He was emulating what his father had done. However, when prompted, he admitted that having a relative in the health sector made it easier for people to be "pushed into college" by these relatives.[12] In other words, it is not only inspirational but also instrumental.

Of course, it is important to take into consideration that it is not always that a young person can just become what he or she chooses to be. This is true anywhere but more so in a country such as Zambia, where even among the emergent middle-class, resources and possibilities are constrained. A choice of studies is very much influenced by the employment possibilities a country has to offer. One man in his late forties remembered that he was encouraged by a cousin, who was a nurse herself, to try to go into nursing. "You can also be something other than a teacher or a miner", she had said,[13] referring to

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[7] PB0811/23.
[8] PB0811/26.
[9] PB0812/11.
[10] LB0809/23.
[11] PB0811/23.
[12] LB0809/03.
[13] PB0809/02.

two of the most common avenues in Zambian history for a career in formal employment. Similarly, a career in health is such an avenue. If one manages to get accepted into a health-related college or into medical school, one is virtually guaranteed (provided you complete the programme) a job for life.

Getting into medical school, nursing school, the clinical officers' programme at Chainama College, or another health-related programme could thus mean the difference between lifetime employment and struggling to get by in informal employment or small-scale agriculture. This can be illustrated by the account of a doctor, whose father was a spray painter at an engineering company in Lusaka. He remembered what the chances offered by education meant to him. He recounted that his parents tried their best to provide their love and care to him, but it was difficult to see him through secondary school. His parents were living in a compound[14] on one side of Lusaka. He had to walk many kilometres to go to school on the other side of town in the industrial boots his father brought home from work. Even his teachers mocked him for the boots he wore because his parents could not afford other shoes. Later, his parents sent him to live with an uncle in a compound closer to school. Years later, he related, he was at school with a focus. On his locker he wrote "target UNZA".[15] Then, in Grade 12 as he sat for his final exams, he thought to himself, "This is the time." He sat with tears in his eyes, thinking, "If I succeed I can go to university, become better, and help improve my family. Otherwise we will remain in this poverty." He passed his tests with good results and was able to go to medical school. He spent all seven years of his doctors' training on a public bursary. He did not repeat a single year. "Public investment produced me". He had been motivated to succeed.[16] On the one hand, this account is evidently a story aimed at glorifying the one who tells it by portraying himself as a focussed, hard worker who knows his duties to his family and his country. Besides that, however, this story also clearly presents a key motivator for people's efforts to educate themselves and seek employment: Namely, to get themselves and their families out of poverty.

Resources of course are a constraining factor. This need apply not only to the necessary fees[17] that might be required for a specific educational institution, but also to the economic difficulties in getting a quality education to allow access to tertiary education. Mr. Phiri, who had failed to become a doctor and in the end became a physiotherapist, said that he had not achieved his goal because of financial constraints.[18] A male nurse who graduated in the mid-1990s provided a similar account; he recounted that initially he had wanted to do mechanics, but he had no money for college, so he applied for nursing, which was a free course at the time. Since then, however, he claimed that he had grown to like his profession "because it is life-saving and because you receive a lot of blessings".[19]

Being able to afford an education, however, is not enough to automatically get into school. Some did not get the grades to allow them to study what they wanted. In the Zambian education system, school results not only influence the possibility of getting into a college or university but also in which field of studies. The Mr. Zulu referred to

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[14] In the Zambian context, a compound refers to a high-density suburban area, where the lower and lower-middle class urban population lives.

[15] University of Zambia.

[16] ML0812/03.

[17] Both formal and informal fees, which we will examine further later.

[18] PB0811/26.

[19] PB0811/24.

above related that he had been accepted to university. He had initially been inspired to study engineering, but the results of his entrance exam simply were not good enough. Instead, he was assigned to do library studies. As this did not interest him, he decided to study to become a clinical officer instead. It was, he said, not much of a problem to get into Chainama because he had achieved good results in school.[20] Others told of wives, daughters, nieces, or brothers who have completed Grade 12 but have had to re-sit certain subjects to get into college and who are in the meantime working in the house, on the field, and/or in other informal employment.[21] As we will see later in this chapter, health workers' accounts of the paths they took to and through their careers point towards the conclusion that qualifications and good marks matter. However, in order to get these qualifications, a child has to grow up in a social environment in which the resources are available to study.

Who pushed you through school?

For almost all the people interviewed, getting to and through college was a financial struggle, both for themselves and their families. Nominally, primary education is free in Zambia, but the same does not apply to the entire route one has to take to qualifying as a professional. In the Kaunda era, most public education had been free, but structural adjustment had put an end to this as it was considered financially unsustainable. President Mwanawasa had, in turn, in an election year and under the shadow of donor-policies advocating universal access to education, announced the popular decision to scrap primary school fees. Moreover, quality is a serious concern with respect to Zambian education. While remarkable progress has been made in the state-run education sector in raising statistics for children in schools,[22] many Zambians who can afford it turn to private schools to educate their children. Public schools are often considered below standard. Nevertheless, getting a child educated to the extent that she can be accepted to a university is very costly. It involves – among other things – fees, school uniforms and materials, food, clothing, accommodation, and transport costs, as well as the opportunity costs of not being able to engage in informal labour while studying. Bearing these costs is not only an individual venture, depending on one's own talents and resources, but also on one's social capital; relatives' abilities and preparedness to support a child's educational career. Considering these costs, the motivation interviewees have expressed for education in their accounts is overwhelming. As will be seen in later sections, this applies not only to their own initial education but also their further education and the education of their children and relatives.

Parents commonly played a large role in pushing future health workers through school. A very senior nursing officer in a provincial hospital spoke of how his parents in Mwinilunga in the North-Western Province of Zambia had, as "subsistence farmers", grown pineapples to educate all their 12 children up to Grade 12 level, and some beyond.[23] Out of 54 people interviewed and who spoke about their parents' work or

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[20] ML0811/15.

[21] For instance, PB0810/02, PB0810/12, PB0810/17, PB0810/20, and ML0810/09.

[22] Net enrolment rates increased between 1990 and 2006 from 71 per cent to 96 per cent for boys and from 69 per cent to 98 per cent for girls. The percentage of children completing Grade 7, meanwhile, grew from 71 per cent to 91 per cent for boys and from 57 per cent to 79 per cent for girls. UNDP, *MDG progress report 2008* (Lusaka, 2008).

[23] One can note that this was in the early Kaunda-era, when school fees were not an issue.

profession, just over 20 per cent indicated that at least one of their parents had been or were "just farmers", usually peasant farmers or subsistence farmers. Evidently, more had parents who had been working in formal employment. Just under a third of these respondents had at least one parent (usually the father) working for the government and about the same proportion of respondents had a parent working in mining. These figures can be a bit confused, as parents often resorted to farming after retirement, and generally many Zambians farm in addition to their day-job. One young clinical officer, for example, mentioned that his father is a farmer on the plateau in Luapula. "Not on a large scale, but he's got herds of cattle". The father also grows a hectare of maize, a hectare of beans, a hectare of groundnuts, and some cassava. The respondent, however, then mentioned that his father used to be a miner in Mufulira on the Copperbelt before retiring and moving to Luapula. Originally the father had come from Northern Province but settled in the district where his wife came from, before moving to another district in the same province where he could get land for farming.[24] For health workers it is also a common pattern to farm next to formal employment and after one retires, as we will see in Chapter 5.

Whereas the figures presented above might lack statistical rigour or statistical significance, they do give an impression of the social backgrounds of health workers. Apparently, a majority of health workers have parents in formal employment. While it certainly happens that the children of peasant farmers manage to complete school and college and then join the ranks of the lucky few with permanent jobs, the larger part of the health workers we encountered were at least the second generation of people in formal employment. This thus points towards a process of class formation, in which it is more difficult for the offspring of peasant farmers to progress to being employed in the government health sector than it is for the offspring of those already in formal employment to also gain the qualifications needed for a government job.

It is striking to note the number of sons and daughters of miners encountered among health workers interviewed. Not only did almost a third of our respondents, such as the clinical officer mentioned above, have fathers who had been miners, but others had grown up on the Copperbelt with parents who were not directly involved in mining[25]. This is perhaps not so surprising, considering the extent to which the mining sector dominates Zambia's formal economy. It is, however, an interesting finding in light of the gloomy picture painted by Ferguson about retiring miners on the Zambian Copperbelt. He described how miners, in the shadow of a collapsing mining sector, went 'back' to rural areas to retire. If they were lucky, they would have the social and cultural assets to maintain relations with their rural allies and resume the life of a villager. If they were unlucky, however, they would be condemned to social isolation and poverty as they had failed to maintain what Ferguson calls a localist cultural style that does not offend rural values. In short, Ferguson paints a picture of a retirement of failed modernity for some Zambian mineworkers in the 1990s.[26] It is then interesting to see 'their children' a good decade later, in whose education their mining fathers had invested. They are holding a

[24] ML0811/08.

[25] Some had parents who were teachers or other government workers on the Copperbelt, and numerous respondents had brothers, uncles, or sons working in the mines.

[26] Ferguson, *Expectations*, 123-165.

job – perhaps 'struggling financially' but still making a decent livelihood out of formal employment.[27]

It is also striking to note how many respondents were sons and daughters of government workers. This was roughly equal to the number of miners' offspring. This number includes those whose parents were teachers or nurses. One respondent described how his father was one of the first African teachers, in fact one of the first Africans with A-levels. He went on to work at the Ministry of Education as an under-secretary.[28] Another respondent's father was a medical assistant, which was the highest a black man could become in the colonial health sector. He rose to the rank of a provincial medical assistant before retiring.[29] Others had parents with more modest careers, but nevertheless these individuals are the second generation (at least) of those in government employment. This is of course not surprising since the state is the largest employer in Zambia, as is the case in most African countries. It does, however, add to the argument that public employment contributes to forming an emergent middle-class. In fact, one could consider these as the direct descendants of what the Zambian historian Chipungu describes as the 'boma-class', those who made careers in the native administrations of the colonial era and through their accumulation and enterprise began to form a distinct class.[30]

Of course, someone's account of his father's or mother's line of work is only a weak indicator of the ease of getting a good education. It says little about their parents' other financial obligations, other sources of income, or the circumstances that influenced their lives and careers. Family histories are pocked and scarred by deaths, divorces, and other influential events. Some respondents had elderly parents to care for; some had mothers and fathers that were still professionally active; others' parents were active and productive retirees. At least as many, however, were orphans or partially orphaned, which is not surprising taking into account the ravages of AIDS. In many personal histories, other relatives such as aunts, uncles, or siblings played an important role in supporting someone's education. For example, one health worker, Mr. Chipumbu, described how he grew up in Chingola, on the Copperbelt. There he went to primary school. Then, in Grade 7, his father, who had been a miner, passed away. He then moved with his uncle to Northern Province to the town of Luwingu. Later he went to boarding school in Mbala, also in Northern Province. The uncle, who had been posted in Northern Province as teacher, had himself had been supported by Mr. Chipumbu's parents until the father died. Taking the young son of Mr. Chipumbu and educating him was his way of repaying their hospitality.[31] Another health worker, Mr Tembo, came from Eastern Province, where his parents were subsistence farmers. His father died when he was very young. Initially, his schooling was sponsored by his uncles; later, a brother (who was actually a cousin "who grew up at mum's home") took over sponsoring him. He had managed to get a job with an NGO in Lusaka and later started working with UNICEF. Mr. Tembo's sister was not as fortunate as him and another brother, who had since

[27] Of course, our limited sample does not include the accounts of miners' children who may have ended up as destitute subsistence farmers. These tentative conclusions should thus be considered cautiously. This may provide, however, a tangent point for further research into social mobility and class formation in contemporary Zambia.

[28] ML0810/02.

[29] ML0811/02.

[30] Chipungu, 'Accumulation'.

[31] LB0809/07.

become a teacher. The sister just did Grade 5 as the uncles had refused to sponsor a girl.[32]

From these health workers' accounts we can thus see that luck and circumstance had a large role to play in getting them educated. The people interviewed in this research were those who succeeded (in part) in getting qualified and getting a job. Beyond them there must be many more who failed. Nevertheless, the determination and perseverance demonstrated by these health workers is inspiring and is testament to the extent to which educational qualifications are important tools for struggling out of poverty.

Qualifications matter

Notwithstanding the struggle involved in completing secondary school, this is not enough to qualify as a health worker or to get a job in the government health sector. Following the logic of patrimonialism, one would assume that people's recruitment to a job in the Zambian health sector would be in large part a 'reward for (a) personal connection with personal leaders" rather than as the result of 'competitive processes that judge their merit and expertise".[33] Strikingly, however, from health workers' accounts about themselves and others, it appears that qualifications – which are attributes of processes – that judge merit and competence do matter, or are indeed essential. The health sector is characterised by the fact that various specific specialised cadres are employed, such as nurses, clinical officers, physiotherapists, environmental health technicians, and doctors. Without the prerequisite qualifications, one has next to no chance of getting a job in such a specialised profession, regardless of one's family connections. At the same time, as we shall see, personal connections play an important part in determining access to qualifications, which are a scarce and prized resource.

Of course, in terms of the importance of qualifications there are differences between the 'qualified' cadres such as doctors and nurses and those less educated such as cleaners, watchmen, or office orderlies. In the Zambian health sector such 'un-qualified' staff are often called classified daily employees (CDEs). Some, especially at rural health centres, merely have a few years of secondary school, while others are school leavers. It is possible that among such groups personal connections can play a role in getting access to a job. When qualifications are less of a distinctive factor between two candidates for a job, other criteria might become more important. In fact, jobs for which minimal qualifications are needed are ideal instruments for clientalism.[34] Notwithstanding the opportunities that exist for clientalism, it equally appeared in the fieldwork for this research that for these cadres, qualifications can be also be relevant. This combination of both personal connections and formal qualification appeared to have been instrumental in the account casually offered by a security guard. While waiting for a medical superintendent to arrive at a district hospital, I was chatting with a watchman. He told me that he had previously been working as a guard for the electricity company in Lusaka. One night the facility he was guarding had been robbed by armed thieves,

[32] ML0811/17.

[33] See Brinkerhoff & Goldsmith, *Clientalism.*

[34] For instance, Anders, 'Civil Servants', 86-87 explained how the Civil Service Reform Programme in Malawi specifically targeted support staff for retrenchment, as there was a significant overstaffing of the lower ranks of the civil service. However, he also suggested that following the retrenchments that were part of this programme, many support staff were rehired in response to social pressure felt by superior officers, who related to the support staff as Bwanas (masters or patrons).

who took some vehicles. The company suspected the guards of colluding and withheld his pay. This prompted him to resign and to move somewhere away from Lusaka, where the job of being a watchman would be less risky. On his way to his ‘home village’, he stopped at some relatives in the town where I met him. His relatives had informed him that the hospital was looking for a guard. Because he had a guard certificate, which he had obtained from the police, he was hired. He mentioned that four out of six guards at that hospital were qualified.[35] The personal connection this guard had to ‘relatives’ apparently was important as a source of information about a job opportunity. Possibly it was also useful as a recommendation for the guard. However, it appeared to be little more important than the fact that this respondent was a qualified and experienced guard.

For others working for the health sector, however, such as pharmacy technologists, nurses, and clinical officers, a certificate and preferably a diploma or even a degree is required – as official proof of qualification as a result of attending a formal education programme. For many Zambians, even those who have managed to complete secondary school, this is difficult to manage. In casual contacts in Zambian towns or cities, one comes across numerous young people working in informal jobs, as waiters or shop assistants or apparently idling on the street, who tell you that they completed school and are hoping and trying to save up for college or to be accepted on a government bursary. Some are trying to improve their school results by re-sitting examinations, or are writing applications and waiting for responses, while others again are saving up or looking for relatives to sponsor them. We can recall the example of Ashley, who only at the beginning of his thirties, while sustaining a family, had managed to raise enough money by ‘digging his field’ to pay for college for either his wife or himself.

Some respondents matter-of-factly told us that getting into college was not difficult, though others painted a different picture. Again, lack of financial resources proves to be a barrier for education. One frank and outspoken young nurse, whom we shall call Tom Chansa, shone light on an issue which many other respondents chose to ignore. He recounted that he originally came from Kasama in Northern Province, but he grew up in Kabwe with an uncle who was a miner. Then, to Tom’s detriment, the mines closed and his uncle was out of a job. Tom had been supported to complete secondary school, but for college he was on his own. Fortunately, he managed to get a job at a Chinese garment company that assembled and sold clothes. With this he managed to raise funds for school. He had never thought of going into health, but his aunt was a nurse and advised him to do nursing. This, according to him, corresponded with his desire to help people. Besides, a friend of his went into nursing, which for him dispelled any stigma possibly associated with a male working in what could be seen as a female profession. Tom just applied across the board to a number of nursing schools. He received two invitations. For him it was a matter of first come, first served. He went to interviews at both schools and was accepted at both. The cost was about the same, but one school was three years, while the other lasted two. At the time he did not know the difference between becoming a registered nurse and an enrolled nurse. His aunt advised him that it would be better to go for registered nursing, so he did. After more than a year, however, he realised that the money he had raised was not enough for his out of pocket expenditures, buying small things, and enjoying himself. Fortunately, a United-Nations agency, UNFPA, was offering sponsorship for nursing students on the condition that

[35] ML0706/18.

one would be bonded in a specific province. He was thus sponsored for the last year of his programme.

So far, Tom's story did not seem remarkable: Yet another story of lack of resources, adversity, and perseverance as the key to success.[36] Then, however, we began talking about Tom's ambitions for further education. This sketched the reality of the importance of personal connections in accessing education. "I would prefer post basic (training), maybe to become a lecturer, but there is only UNZA and there you have to know somebody". When I asked if he meant that you have to know someone to get into college, he gave the example of his own nursing school. "At (my nursing school), of the ten male students in my year, eight had relatives in the system. Just me and someone else didn't. We were just there because I was first in the interviews and he was second. So number three and four were rejected because they didn't have relatives in the system. It is people from the nursing school and people who decide on the list of people to be accepted. They just consider relatives". Asked what he thought about this, he said that he did not like it, especially considering "us that don't have anyone to push us". He then went on to describe the impact of this practice: "Out of the 40 people in my year just 32 made it. The rest were expelled or failed. These are the ones that were there through uncles. Academically they don't do well; they have no interest for their studies".[37]

Others gave comparable accounts and went further by attesting that bribery can occur in such situations. From a casual chat with a student nurse, my research assistant reported a similar story. "It's a fifty-fifty game. You can come in in a fair way, but otherwise you either know somebody or you pay somebody. It's a problem. I applied (at another nursing school than the one where she was at the time) and my friend did as well. She was asked pay one million Kwacha (€ 192),[38] and she paid seven hundred (thousand, €135) because that was all she had". Then the student nurse recounted that she was also asked to pay something. "But I was very confident that I would get in because I had all these ideas about nursing so I didn't pay. When I didn't get in, (the friend) laughed at me. I was very disappointed, but I thought that God might have other plans with me". She went on to indicate that, at other colleges, "it's even worse". At one college an administration officer had been arrested because he had helped a number of people into college. It seemed he had been doing it for some years. She mentioned that the 10 to 20 students concerned were expelled. "They are making an effort to make the system transparent, but it's poverty that makes people do these things. It's selfishness; people never have enough". On the extent of this happening, she estimated, "In general, 50 per cent of the people are admitted this way: There are many ways to skin a rat".[39]

Another contact suggested how this had affected him. "I didn't get into UNZA because of the corruption", he said. "Rich people really want their kids to go to university, so they are willing to pay for it. The high officials just let everyone do the application and interview, but in the end they just pick those with the right relatives or those who

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[36] In fact, the personal adversity faced by Tom, with his uncle losing his job as a miner as a result of the economic crisis of the late twentieth century, resonates with the Zambia that is described in Ferguson, *Expectations*. However, the outcome of this particular story – namely that the respondent ends off with a better chance at success and the benefits of modernity – diverges from the accounts of Ferguson's own respondents.

[37] ML0811/12.

[38] Currency calculations are based on the approximate exchange rate at the time of the interview (€ 1 = ZMK 5,200 is generally taken) or at the historical moment where relevant. Historical exchange rates derived from www.gocurrency.com.

[39] PB0811/36.

have paid. They ask around one million, because there are many people who are willing to pay. Maybe there are a few who get in based on their qualities, but most get in with money or relatives. I got into (a different instruction, referred to by the previous respondent as being 'even worse') because it is a little less corrupt than UNZA".[40]

Yet another respondent even went as far as describing the possible mechanics of the process: "They just let you do the interview, but then they let you come over and pay, and they don't tell you that you will have to do the aptitude test. They just let you get into a room and then suddenly you have to do the test. It's difficult to get in, except for when you come from a rich family. It's like a conspiracy". He went on to say, "One of the officials would meet some applicants in one of the lodges in town, and then he would talk to them, seeing if they could do anything for him. That way, he could still change the marks for the ones that he would like to have as students but didn't do well." This, by his account, need not have negative consequences. "A girl I know is the daughter of a man who works for GNC (the General Nursing Council), and he marks the aptitude test for (a certain nursing school) ... She got in, and she turned out to be intelligent; she was the best in the year in surgical and medical". He philosophically reflects that this is just the way the world is: "Money and intelligence are both forms of power, and you just need one of those forms of power to get in".[41]

Of course these accounts are subjective and it is all but impossible to prove their general validity. Assuming that bribery and nepotism do occur in the selection process for accepting students into college or university, it is not possible on the basis of such accounts to accurately reflect on the prevalence of its occurrence. Nevertheless, an account from another angle certainly lends credence to the assumption that it is widely prevalent. A respondent, who at the time was working in one of the colleges referred to above, conceded that the college indeed receives and responds to 'special requests' from directors or others with influence in the ministry. He did, however, stress that students do have to meet the minimal criteria for admission. They must, for instance, have completed secondary school and they have to come for interviews. He illustrated this with a rather shocking example. A few years before, the former permanent secretary, who had been sentenced to five years hard labour for corruption, was said to have managed to push his niece to the college, despite the fact that he had been convicted for corruption. In the subsequent year, she turned out to be failing dismally. She was then sent away from college and her uncle understood and accepted the fact. Finally, our respondent claimed that, paradoxically, this phenomenon can even be in the school's interest. If the nephew of a director, for instance, goes to the school and complains to their relative about the conditions at the school, perhaps the school will get more resources to improve conditions.[42]

It thus appears from the previous accounts that access to the scarce opportunities to achieve qualifications is manipulated to serve the private interests of some of those who control this access. On the other hand, the same accounts also show that it is neither ubiquitous nor fully accepted as legitimate. In particular, from those who do not benefit

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[40] PB0811/34. Of course, this testimony is speculative and cannot be taken as a complete reflection of the reality of the application process at the University of Zambia. In part, it is possibly an external justification of the respondent's failure to be accepted. At the same time, it does illustrate perceptions that exist about the fairness of processes that have been designed to be rational-legal. It also illustrates the use of allegations of corruption to challenge the equity of such processes in practice.

[41] PB0811/35.

[42] ML0809/05.

you can hear moral condemnation: It benefits the rich and is unfair to those who do not 'know someone'. The fact that this is not an issue many care to talk about also implies the practice is not considered socially to be virtuous or acceptable. Considering the account that "they are making an effort to make the system transparent", one could even go as far as concluding that this practice is being actively contested. In addition, it can be deduced from Tom's story and the account of the person working at the college, that some who are completely unfit to qualify as a nurse (or another health worker) do not get through the system, regardless of money or connections. Nevertheless, such corrupt practices are part of Zambian reality. A formal competitive process based on merit is thus instrumentalised by private interests based on personal connections or money. This resonates with the neo-patrimonial paradigm. However, it is important to note that these private interests merely manipulate the formal process and adapt to formal demands; they do not eclipse or obliterate formal institutions. Such accounts of nepotism and bribery in deciding access exemplify the instrumentalisation of order. Nevertheless, despite the efficiency losses and equity issues that come with this reality, the bottom line remains that one must obtain qualifications to occupy a professional post. In other words, in the Zambian health sector, qualifications matter.

A first posting

Now, having seen our health workers through college, let us look at the first professional encounter between a health worker and the health system: The first posting. This topic is relevant for our analysis of neo-patrimonialism in the health sector as it touches on a conflict between personal interests and the public interests of a system. It also deals with the relative power of health workers to determine their own spatial mobility; and this power or influence is significant. Whereas obtaining access to scarce opportunities for professional qualifications was a struggle for aspiring health workers, once they qualify this situation is reversed. Then *they* become the scarce resource, giving them significant leverage over the system.[43] In 2005, in total there were some 23,000 people working in the health sector, out of which roughly 12,000 were 'professional staff' (that is, qualified health workers as opposed to support staff). This contrasts with a recommended establishment of 49,360 positions (39,360 for 'professional staff').[44] In rural areas, health workers' scarcity is particularly pronounced, with many rural health centres with one or even no qualified staff. In subsequent accounts by health workers of their career paths, we will hear their perceptions on working in rural areas and gain an insight into the agency they have to escape from working in rural areas. As such, we will see how a seemingly structural phenomenon, the geographical allocation of human resources, is in essence a result of human agency and the power of individuals to decide for themselves.[45]

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[43] Then they become the insiders in the limited access order. See North, D.C. *et al.*, *Violence and social orders* (New York, 2009).

[44] MoH (2005), National Health Strategic Plan 2006-2011. Of course, that is not to say that government had allocated the funds for so many workers. In 2006 the structure that was approved by the treasury amounted to 26,088 people, while the ministry has been authorised by Cabinet Office is let this grow to 51,414 in subsequent years (MoH, 2008: Ministry of Health Quarterly; issue no. 1).

[45] Kalumba's, K. thesis 'The practice of health care reform in Zambia' (unpublished PhD thesis, University of Toronto, 1988), which will be discussed later, makes claims about geographically inequitable allocation of resources in the Zambian health sector being the result of a discursive policy

To get a feeling for the issues a young graduate can face on their first posting in the health sector, let us hear the account of a Mr. Zimba. He graduated as a clinical officer in 1991. Before his studies at Chainama in Lusaka, he grew up in Livingstone. His father had come from Eastern Province and had been working in a textile company. Mr. Zimba's mother was an Ndebele from Zimbabwe. At his graduation, he and his fellow graduates were allowed to express a preference for two provinces where they could be placed. Mr. Zimba was posted to a very remote clinic on the plateau in Luapula. He felt bad; his two choices had been to be posted in either Southern or in Central Province. The four years he spent at this rural health centre were very challenging. "There was no road. You sometimes even had to move by canoe. There were no shops, so if you forgot to pack something, you were stuck. It would take four to five, or even six hours to cycle to the boma to collect salaries". He recalls that it took all his passion to motivate him to stay there, not money. Imagine, moving from Livingstone, the tourist capital of Zambia, to the bush. "I thought, God must be trying to teach me something".

Mr. Zimba found the community very difficult to handle. "There was no community participation". Once the VIP (ventilated improved pit-latrine) of the clinic collapsed. He called a community meeting to ask them to help rehabilitate it. However, they refused; only if they were paid would they help. "There was no partnership". Coming from Livingstone, where Lozi is the lingua franca, and from a mixed Chewa-Ndebele marriage, he had difficulties with the language. Lozi is not at all compatible with Bemba, and the urban Bemba words he had picked up in Livingstone turned out to be insulting or degrading. At the clinic, he would be explaining something and people would laugh or tell him "that word is an insult". The local chief was not at all friendly. He would constantly insist that Mr. Zimba gave gifts such as bottles of kachasu.[46] If Mr. Zimba failed to give a bottle for lack of money, the chief would insult him and threaten him with witchcraft. Being a Pentecostal, however, he claimed the witchcraft did not harm him. "I know my God; it's impossible to bewitch me!"

A further problem for Mr. Zimba was that social life in the village was boring. To this day he does not drink alcohol, so after finishing work he went straight home. The only time he could really breathe was when he was cycling to the boma. Fortunately, he had befriended some teachers with whom he started a literacy club to teach villagers to read and write. Besides that, he had a small project cultivating some of the fertile soil of the plateau. The medical work, however, Mr. Zimba found very satisfying. The community had never had someone young and newly qualified at the clinic before; it had usually been officers later in their careers who were less active. The job brought a lot of responsibility; he does not remember ever having referred a case. He did everything himself, even cases that would normally be treated in an operating theatre. Eventually, however, because of the problems he had with the chief, he requested a transfer. He could not continue like that. It was no problem to convince the district health office to give him a transfer. A friend from the Ministry of Agriculture, who stayed in the same village, even testified on Mr. Zimba's behalf.[47]

Mr. Zimba's case provides insight into the issues facing a young graduate from town who gets posted to a part of Zambia they are not all that familiar with. As we saw in a previous section, a considerable number of health workers we spoke to grew up on the

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strategy of 'down-classing'. In my dissertation, however, I argue that it is more the result of individual agency: People choosing and scheming to work closer to the socio-economic centre of a country.

[46] A local, home-distilled spirit, sometimes erroneously referred to as a brew or beer.

[47] ML0811/15.

Copperbelt, while some others grew up in Lusaka or other towns. Many were thus progeny of an emergent, urban middle-class. This is thus the account of a clash of cultures within contemporary Zambian society – a clash, if you will, between expectations of modernity and the claims of rural localism.[48]

It is also an account of the struggle between a system and the individuals that are required to make the system work. The outcome of this struggle is inherently personal and context-specific. As we will see below, there are many variations in the career paths recounted by health workers and the influence they had over their fate. Mr. Zimba and other respondents had been given some influence over where they would be placed, although in Mr. Zimba's case this was not honoured. Others claim to have had no influence on their posting. They were "just posted". It is part of the public service ethos that a public servant should be prepared to 'work anywhere'. In fact, the *Terms and Conditions of Service for the Public Service* states that an officer may be transferred to any duty station where his or her services are required.[49] It seems that in the Kaunda era, it was a deliberate policy to post civil servants to parts of the country from which they did not originate. This would help the process of fostering "One Zambia, one nation". One enrolled nurse, after graduating in 1988, was posted to a rural health centre in a remote part of Luapula. He would have liked to return to the Copperbelt, where he had been brought up and where it was familiar. He explained, however, that during nursing school he had signed a form that he could work anywhere. Therefore, he could not object to his posting. "They were forcing the students to go where is need". His objections did not yield any results. "They said, you have no right to complain".[50]

Some just accepted this fate. An environmental health technician who also grew up on the Copperbelt received his first posting in Western Province in the early 1980s. He was not happy. "I wanted to go back to the Copperbelt. But I got used and things became normal; now I realise my thinking was just too childish". In fact, he remained working in Western Province at various clinics and even married a Lozi wife, despite being a Bemba speaker. Only after more than seven years did he request a transfer to his "homeland".[51] A nurse from Eastern Province, who had grown up in Kabwe, was posted to a rural clinic. She remembered, "I was not happy; I was born in town, and it was my first time to go to a rural area. First it was hard, but then I got used."

Yet others did not even consider a rural posting as problematic. For example, consider Mr. Pande, a clinical officer who since 1987 has served in rural health clinics. He

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[48] It is thus similar to the tension described by Ferguson when he deals with his retiring mineworkers (Ferguson, *Expectations*) or the description of the return of Paddy the townsman in N. Long, *Social change and the individual: A study of the social and religious responses to innovation in a Zambian rural community* (Manchester, 1968). What is striking, however, in this account and others like it is the lack of willingness to submit to local rural claims and realities. In this fieldwork, numerous such narratives emerged about the relation between health workers with an urban, cosmopolitan orientation and localised, rural communities. While it is beyond the scope of this research, such encounters could provide interesting objects of research, providing insight into how the state is socially constructed and renegotiated at the local level in the periphery of the state-run health sector. As the perspectives of local communities have not been collected, further analysis of such narratives is not appropriate here.

[49] Terms and Conditions of Service for the Public Service, Chapter II No. 29(a).

[50] PB0809/02.

[51] This account thus presented an idyllic picture resonating with Kaunda's nationalist, 'one Zambia, one nation' discourse. "I got surprised; in each tribe people differ". He claims his wife's relatives and his have accepted: "When they visit they are free with my family". This account, however, glosses over any difficulties that may have arisen for our respondent in Western Province, which may have driven him to 'struggle' for arranging a transfer back to Luapula. LB0809/07.

was the first-born of peasant farmers. When he was sent to a remote rural health centre, he "just accepted the posting; I was praying for helping people". In fact, he even wanted to go to such a place despite coming from elsewhere, because he thought it would be cheap to look after relatives at a place like that.[52] Apparently, for some like Mr. Pande, being posted to rural areas was preferable as it fitted with their goals and strategies.

Others demonstrated more reluctance to accept their posting. Another health worker, who grew up in Kitwe on the Copperbelt, took a bit more convincing to move to a provincial capital. "It was quite shocking. I had been expecting to be posted in Kitwe, but they saw a shortage in Mansa. I was looking at a place that I had never been, and I had heard some negative stories about Mansa. I would be coming on my own; I had no friends or family there. I tried to object, but they said, 'we don't want people to be concentrated'. They were also looking at hard-to-reach places. This helped to convince me because in the end, the issue was not where I would be going, but if I could contribute to people's health. I shared my story with an old friend who had been to Mansa, and he said: You can still make the best out of it".[53]

Yet other health workers were effective in their opposition to a posting. One clinical officer was able to convince decision-makers of the fact that his family responsibilities required him to be posted somewhere different from what was intended. After he graduated, he was posted in Chipata in Eastern Province. However, he felt he needed to work somewhere closer to his family as it would be very expensive to work in Chipata and from there support his relatives in Luapula. So he convinced officials that he was the breadwinner and that he could not go to Eastern Province. "I just explained, and back then there were few students; they didn't want them frustrated". He does not remember who he convinced at the ministry, "but if you tell someone the truth, you can touch someone's heart".[54] Of course it might have been easier to arrange a posting near his relatives in Luapula than it would have been in Kampala or Ndola, for example. However, others did manage to arrange postings in town – for instance, a nurse who in 1993 was posted to Mbereshi Mission Hospital in Luapula obviously realised how scarce and valuable she was to the system. She recalled, "I didn't like the bush. I was very young. I said, if you won't post me to Mansa, I'll stop". She got her way and was posted from the mission hospital to the general hospital.[55] To show how relative individual preferences are, someone else considered himself fortunate to be placed at the same mission hospital rather than a rural health centre. This nurse grew up in Solwezi, the capital of North-Western Province, and was placed at a clinic in a remote part of Luapula. He refused, saying that he would already be covering a long distance to visit his family. He preferred to stay in a hospital at least and was posted to Mbereshi Hospital instead.[56]

Many of the preceding accounts are from those who were working in a rural province when we interviewed them. Some of these respondents had managed to negotiate a position at a specific rural posting they desired or perhaps a slightly less remote place. There were, however, according to our respondents also health workers who had avoided being posted in rural areas entirely. One nurse reported, "When we were posted after graduating, there were three of us who were posted to Luapula, but I was the only

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[52] PB0811/16.
[53] PB0809/04.
[54] LB0809/19.
[55] PB0811/28.
[56] PB0811/24.

one going. The other two went to work in a private clinic and in South Africa instead. I did go to St Paul's, because I thought that maybe I could reduce the diseases. I developed an interest in public health".[57] The male nurse Tom, whose candid accounts were presented earlier, also had something to say about how others could deal with undesirable postings. "Posting is fairly straightforward. But when you get a letter, that is only tentative. Then people on an individual basis go and complain. They argue why they can't go to where they are posted. And maybe someone will squeeze them in somewhere. In my class only four have gone where they were posted". The ones who had refused their postings were then employed by other districts. When I asked Tom if people actually pay in such cases, he said, "Bribery is done between individuals, so I can't say if it happens a lot. But Zambians have developed a funny language for it. They might say. 'Here's some money for a drink'. Or 'let's go and have a drink' and they keep buying beers. Or when you're on a bus, they will pay for you. Then someone will remember, 'he helped me with something', and do something back. Only very few people actually bring brown envelopes".[58]

It appears thus that the interaction between a health worker and the human resource system is one of negotiation. A health worker's scarcity improves his negotiating position. The formal procedure is relatively straightforward and follows a bureaucratic rationale; it is blind to the specific circumstances of an individual. However, if someone has a specific wish or intent to deviate from these formal procedures, it appears that there are possibilities to do so. Apparently in some cases, simple lobbying – or as one respondent indicated, telling the truth so you can "touch someone's heart" – might suffice. However, it also appears that if one wants something more desirable, the process of negotiation might require a material transaction, though not necessarily in the form of a 'brown envelope'.

Transfers

Health workers' career trajectories are marked by considerable movement through the system; more often than not this is a matter of spatial mobility whereby they moved throughout Zambia. After a first posting, health workers will generally continue to experience various transfers, and from their accounts the logic behind these at times seems vague or arbitrary. In reality, however, these decisions are the result of the obscure, complex interplay between personal and organisational objectives. As we will see below, at times health workers ask to be moved elsewhere; at times it is because the system needs them elsewhere or simply moving them is the solution to problems at their work place. These decisions, of course, become a matter of negotiation and are influenced by the covert or overt interests of those involved. As we will see again later, this leads to the risk of informal interests and logics of individuals superseding the public interests or the interests of the health sector.

In the past there was a deliberate policy of transferring people throughout the health sector. In other departments than health this policy still seems to the practice; under the Ministry of Finance, it is routine that accountants get 'shifted' every five years, an accountant told me.[59] The formal rationale behind this policy is that people might become too connected to the community or too de-linked from the formal objectives of

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[57] PB0810/15.
[58] ML0811/12.
[59] ML0809/12.

the system if they 'overstay', as it is called in the discourse of Zambian public servants. One health official, for instance, gave an explanation for a reshuffle of a number of district health directors in a certain province: "Some people had overstayed and lost touch with the way things were going".[60] He explained that they had become unresponsive to certain problems, which were gradually considered normal. A medical superintendent and his hospital administrator also once explained this formal organisational logic of transferring people. They said that if someone was be in the same post too long, "they become undisciplined" and "known to the community". If, for instance, a nurse has ties with a patient, she might even insist that a doctor drops his other work and attends to the patient.[61] While in my understanding of this account I was confused whether they thought the greater sin was the fact that a nurse told the doctor what to do or that some patients were offered preferential treatment at the nurse's behest, it is clear that they felt that in such a situation a transfer was in order. At the same time, this bureaucratic logic was also echoed by a health worker himself. He explained that you perform better if you move from time to time. He cited the example of police officers: "If people get used you, then you can't arrest them". For health workers, he explained that if you get too well known to the community, "the ladies who come to deliver, they become shy and they don't come anymore".[62] It is thus clear that from an organisational viewpoint, transfers are an instrument for ensuring that one's loyalties lie with the organisation, and people do not get the chance to build social relations in their work environment that will threaten the organisation's formal goals.[63]

In recent years, however, owing to the reorganisations linked to the health reforms – which will receive ample attention in later stages of this dissertation – the practice of periodically transferring health workers was disrupted. One nurse explained that he had not been able to go to the Copperbelt as he had wanted. He explained: "Between 1992 and 1994, all transfers out of the province were banned, but they also feared that we would run away. They said that we could only leave if we found someone to replace us".[64] As part of the health reforms, autonomous district health boards and hospital boards were formed which were delegated the responsibility to attract and retain staff. For certain positions, they advertised vacancies, held interviews, and appointed people. One former manager administration who had been hired this way reported that he had stayed in the same position in the same district for nine years. He overstayed, because the boards were given autonomy in 1995 and therefore he was not transferable unless the Central Board of Health in Lusaka and the employee would both agree. Certain district management teams in this period actively tried to recruit health workers to their district, even by 'poaching' staff from other districts. Districts also tried to distribute health workers within their district. For the rest, movement from the district and especially out of the province was restricted. At the time of conducting this fieldwork, a new restructuring exercise[65] was ongoing and again transfers out of the province were banned. This thus reduced the spatial mobility that had been the norm earlier. Hospitals

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[60] ML0811/17.
[61] ML0706/36.
[62] LB0809/07.
[63] In the diplomatic service and formerly the colonial service, regular transfers were similarly seen as a way to prevent someone from 'going native' and losing touch with official interests.
[64] PB0809/02.
[65] This was linked to the abolition of the Central Board and the autonomous district and hospital boards, which will be discussed further in later chapters.

and districts could only replace staff that left. Formally, the only ways to leave were by either by resigning or if one was a married woman.

In women's accounts of their career paths, 'following your husband' is a very common phenomenon. One nurse spoke of her first posting as an enrolled nurse in North-Western Province. For her, language was a problem as she did not speak Luvale. She recounted that she had not been able to avoid being posted there because at the time she was not yet married. After seven months, however, she was transferred to a mission hospital in Luapula. In the meantime, she had gotten married and she could show her marriage certificate. Her husband was a teacher in Luapula, whom she thus followed. It was easier for her to be working in Luapula, because now she could use her mother tongue Bemba again.[66] This formal arrangement, which incidentally does not apply to men following their wives, generally applies to public service workers. We spoke to health workers married, for example, to teachers, employees of the Ministry of Finance or Agriculture, and also to health workers married to other health workers. In fact, it is not unheard of to see a married couple running a health centre together.[67] In one clinic, we noted that this had a distinct impact on staff composition. Whereas most rural health centres are lucky to have two or more qualified health workers, this one had one environmental health technologist in charge and three nurses. One nurse was married to a local teacher, and two nurses were married to each other.[68]

In various accounts, health workers had left to join their husbands in Lusaka or the Copperbelt, thus adding to the skewed distribution of health workers. It seems, however, that in recent years it has become more difficult to 'follow your husband'. One health worker in charge of an urban clinic reported that, a few years ago, "it was easier to follow your husband, because nowadays you have to apply and then you have to wait for a place. Transfers are a problem now. For example, here at (our) clinic, we got one nurse whose husband is in Lusaka. She is trying to go to Lusaka as well, and she had been given a place in Chainama but in the end she couldn't go there. In this world of HIV/AIDS, it is a very bad thing to keep couples away from each other".[69] A newly posted nurse, whom I encountered at a provincial health office patiently and glumly waiting to be attended to, told a passer-by that her husband was still in Lusaka. At the Ministry of Health they had told her to choose between a career and marriage.[70] This young lady was thus caught in the negotiation between her own interests and those of the system. As we shall see, within such negotiations there are opportunities and incentives for people to successfully defend their own interests; there is scope for lobbying for a desired transfer.

Lobbying for a transfer

From their perspective, there are various reasons for health workers to request a transfer from their current posting. From the accounts offered by health workers, it is often difficult to determine which factor is decisive or to uncover the hidden motives besides those readily proffered. By and large there are two general categories of reasons given to justify a transfer. First, there are motives related to the working atmosphere, such as

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[66] LB0809/16.
[67] In both cases I encountered, the husband was officially in-charge.
[68] LB0809/13, LB0809/18.
[69] LB0809/16.
[70] ML0809/16.

the facilities and relations with superiors and colleagues; then there are socio-economic reasons related to health workers' private situation. Such issues can include family considerations, such as proximity of children's schooling or a spouse's work, living conditions, or the possibility to supplement one's livelihood by moonlighting or farming. As indicated by the skewed distribution of staff in the health sector described above, there is a general preference for transfers to urban areas over rural areas. Some respondents mentioned, for instance, that in towns they would be closer to stores or Internet or the other trappings of middle-class modernity. Other respondents, however, explicitly remarked they would prefer to remain in rural areas because of the cost of living and the quietness of rural life.

Both in the case of Mr. Zimba above as well as of Ashley and Anton, we saw how living and social conditions can be unfavourable to health workers in some places, which can drive them to take action. Lack of proper accommodation was an issue for Anton and Ashley. They had to walk four kilometres to a house they had to share. Ashley could not bring his family to join him and had to maintain two households because of this. Anton also complained to me that from the place where they were posted, "the distance from the market was very big". He had to go to a town two districts further, travelling more than 150 kilometres, in order to collect his salary. So after his friend and colleague Ashley had arranged a transfer, he did too as things there were not working according to expectation. He thus went to the people at the district health office in the district where he had been posted earlier. He talked to them and "then (he) had to come to process the papers".[71] The management team of the district he left were not happy to see him go. Anton had been running a recently opened anti-retroviral clinic and the district was already understaffed. Anton, however, had already arranged the transfer to a district where they were happy to see him return. Then when Anton had arranged a vehicle "to pick his things" to move them to his new location, he passed by the health post where Ashley had been posted to say goodbye. Coincidently, the planning manager of the district was there. Ashley recounted how the planning manager said, "How come you come by to say goodbye to (Ashley), but you don't come to the district to say that you're going?" Anton was said to retort "I did come, but you didn't listen". Then, according to Ashley, "He put his chin up and left".[72] Obviously, Anton's concerns about his living conditions were interlinked with his disaffection with the management of the district health service. Most importantly, however, he had an alternative, which empowered him.

These stories strengthen the argument that owing to their scarcity, health workers have a certain power over their own careers, which can challenge the power of the bureaucracy which aims to control them as valuable human resources. To elaborate this argument, let us look further at the conditions under which people can be transferred and can arrange transfers. In two cases, we came across accounts of health officials picking up on the fact that health workers were de-motivated at a rural clinic and apparently felt that the system did not use them to capacity. One health worker spoke of how he was at a workshop and met someone working for the ministry in Lusaka. The health worker mentioned to the official that he was wasting his time at the remote clinic where he was posted and that he wanted to move. Following that, he was transferred to a less remote health centre in the district. He recalled that moving was a relief because he was starting to get into an argument with the district, partly because the district was

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[71] ML0811/08.

[72] ML0811/14.

not delivering on promises regarding transport. They were promised motorbikes, but these never came. He felt that the place where he was "was more like a punishment".[73] Another health worker was visited at his clinic. One day, he recalled, provincial health officers came by during lunch, and there were no patients there. They said that the health worker was being under-utilised and that it would be better for him to work in a busy centre. The gentleman was told to put this in writing and the province acted on it. "They sent me a vehicle and picked me up. I had no objections; I agreed because I was only doing some community work. I was happy to go and practice my profession".[74] Although from these accounts one cannot get a complete sense of the decisions made and the factors at play,[75] it is clear that these respondents had a desire to leave. In order to achieve their goal, they may well have used the arguments that they were being under-utilised to the detriment of the system. It seems fair to consider the subjective experience on the part of health workers that they are suffering from rural hardship (that is, being isolated and far from town life), which we have seen above and will encounter in later stories, to be legitimate. On the other hand, one can also wonder whether simply transferring health workers away is the best option for the health system, rather than investing in the possibilities for the health workers to be effectively utilised in serving the needs of rural communities. This is an issue that we will pursue later.

Family matters have, as we have seen a few times already, an important influence on health workers' posting preferences. One nurse told my research assistant that she had only worked for about a month in her present station. She had received a transfer to this clinic, which was closer to her parents, who lived in a nearby district. Her father, who used to be a miner, had had an accident and was no longer able to take care of himself. As the eldest in the family, the nurse had taken responsibility and asked for a transfer.[76] Let us also recall the nurse whose family was in Solwezi and who, after influencing his initial placement, was posted to Mbereshi Mission Hospital. After two and a half years he still felt the distance to Solwezi was too long and requested a transfer. He was subsequently posted to Mansa, which is a few hundred kilometres closer.[77] Another respondent even lobbied her way from Lusaka to a remote province, as she wanted to be closer to her widowed mother. The nurse wanted to assist her mother in building a house. From her current location, she could easily bring cement and other building materials to her mother's home. She also wanted a change of place. She said that getting the transfer was easier for her because she had a brother working at Cabinet Office in Lusaka.[78] Someone else, however, said that in general it is much easier to get a transfer from town to a more rural place, than the other way around. Without that brother at Cabinet Office, this lady might well have secured her transfer anyway, though it might have taken longer.

The formal route to getting a transfer process is a long one, as yet another health worker casually recounted. He was planning to leave Luapula for Central Province because of family issues. He had assumed a position of responsibility in his family. "The chair(man) of my relatives died. I am now the administrator for three different

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73 LB0809/13.

74 PB0811/21.

75 It is conceivable that in these situations private interests played a bigger role than the professional arguments put forward by the respondents. These latter arguments, however, are perhaps more acceptable discourse to present to a foreign researcher with a notebook.

76 PB0811/06.

77 LB0809/19.

78 PB0810/07.

families. I need to be there to get the rentals. Kabwe already agreed, and I'm cleared by district health office and the provincial health office. Now all that remains is getting permission from Ndeke House, after the Cabinet (Office) works on it".[79] One has to convince a number of people in that chain to agree with a transfer, although there are apparently short cuts. One man reported that his wife was working for a bank. So he went to the ministry in Lusaka to see if there was a vacancy somewhere where that bank had a branch, and there was one in Luapula. He had heard negative stories about Luapula, but, being from an area where fish is traditionally eaten a lot, he thought, "There is a lot of fish; I'll come and enjoy. As long as there are patients, it's ok". He came to Mansa in 1996. He remembered that back then, the boards had not started and the transfers were handled by headquarters. So he went there and talked to the chief nursing officer. It appeared as if she would not grant him the transfer, but "deep down her heart she had said yes" because a week later he received a letter with the transfer.[80]

Often the process of arranging a transfer is not easy. As we saw, reorganisations have impacted on the routine practice of transferring staff. In addition, the scarcity of health workers provides a strong incentive to the system to raise barriers to prevent people from leaving. Concerning this, one respondent said, "You have to fight real hard to get a transfer because of staff shortages. My colleague had to fight really hard. He is now in Kabwe".[81] One district health officer recounted that he was once transferred to the most remote part of the province. He "wasn't happy" about that so he contested the decision and wrote a letter to the boss at the provincial health office. He argued that he had already worked in that district and therefore had served his time in a remote area. Six months later he was then transferred to the provincial hospital, to work under a former colleague. "The hospital was like a punishment" as he was "put under someone junior so that you get depressed". Later, for reasons he did not mention, the provincial health office reconsidered and moved him to the district health office. When he was asked if that means that one has to lobby, he replied. "Lobby? Yes, sometimes you have to fight for your rights".[82]

Another officer took his protests literally to the highest level. In 1988 he was transferred from a provincial capital to a very remote district. At first he had resisted moving there, but the provincial health director had convinced him, promising that he would be able to return after the retirement of another officer. The next two years he stayed at that remote district. Then it turned out that someone else had been posted to the job he was promised. In the meantime, the provincial health director had left and his successor had given the job to someone else. The officer complained about this; there was a lot of writing. He even went to see President Kaunda, who issued a directive, and he eventually got promoted and went to another district. During his career this man resigned three times, but each time he was called back and he returned. "I wouldn't like to disappoint the boss".[83] In yet another case an enrolled nurse was posted to be in charge of a remote health centre. He did not want to stay, however, but according to him the district health office saw that he was doing a good job and asked the provincial health office to keep him there. "I wasn't ready to accept at first. I wouldn't be helping my children by going to (that district)". He made an agreement with the district and the province, how-

[79] PB0811/16.
[80] LB0809/21.
[81] PB0811/02.
[82] LB0809/02.
[83] LB0809/03.

ever, that he could leave his children in school in the provincial capital and that the office would pay for the house they lived in. In the end, however, "they only paid it for three months, and I have been paying for the house from my own salary the rest of the time". He remained at the remote health centre for three years. Again he resolved to leave the district but the district health director refused to sign the papers that would enable him to leave. Then, during a performance assessment visit, he talked with the most senior health official in the province and told him about the situation: "This is the way I'm being treated". So he went to the provincial health office and the director signed the papers so he could return to a post closer to town.[84]

As is common in processes of negotiation, the struggle over transfers is a process of give and take, and at times compromises are reached that are acceptable to both sides. An enrolled nurse reflected on the many transfers he had had in his long career. Most memorable was a transfer he once made from an urban clinic to a rural area. The rural clinic had been left without qualified staff after the person who was working there had been "beaten by the community". The nurse did not want to leave the urban clinic. "It was the first urban centre for me; I would enjoy". Besides, he was building a house. "I resisted a bit before going there, but a doctor pleaded with me. He said, you simply have to go there". At the end a compromise was found. "When they transferred me away ... they gave me two months to finish building my house. I did it. What else could I have done? I got help with moving". Years later he looked back on this and other postings with mixed feelings. "Most transfers have been prompt. Even if I plead, they also plead. Some day they will send me into hot soup. What if I had failed to settle in (the rural centre)?"[85]

The previous accounts indicate that there is a seemingly constant struggle between health workers and the health system. Health workers want to assert what they consider to be their rights, fighting for their interests. At times, officers in the health system try to be firm in enforcing the interests of the system – that is, to have an appropriate distribution. Sometimes they are convincing; some times they make deals to persuade health workers. But in a number of cases we have seen above, they managed to be convinced by the arguments and circumstances put forward or they were over-ruled by someone more susceptible to such arguments with more influence in the system. In short, despite the fact that some health workers in their accounts make a transfer sound matter-of-fact and others evoke images of powerlessness against a system in which they are trapped, there seems to be a good deal of influence and agency that health workers have over their fate. However, it is good to remind ourselves that this need not always be the case. This came to the fore in what one clinical officer, who made it to hospital official level in Lusaka, said about ending his rural posting: "I worked there for two years, but I had to run away. *They forget about you.* I resigned and applied at UTH in 1987, because friends had told me they were recruiting".[86]

Let us look at the account of one lady in an extremely remote location, who was nearly 'forgotten about'. After graduating and working at a mission hospital and later a rural health centre, she requested a posting to Kilwa Island in Lake Mweru, which is nearer to Congo than to the Zambian mainland. She said she had wanted to go there because the health centre there had no qualified staff at all and she wanted to assist. She planned to go there for six months. "I got used there, and I forgot to ask for a transfer

[84] PB0811/24.
[85] PB0811/14.
[86] PB0812/01.

from the island. I was just staying with the villagers. Then, after four years my thatched house collapsed, and I had no accommodation anymore. I went to the (district health office) to ask for a transfer back to St Paul's, and they came to inspect my house on the island. When they saw it had indeed collapsed, they transferred me".[87] It thus appears that there is a good reason that people look out for their own interest and lobby decision-makers for favourable postings; if they do not, they risk being 'forgotten about'. Now, having examined the influence health workers have in soliciting a transfer, let us look at what they have to say about situations in which people are forced to move.

Disciplinary transfers

Transfers are not only initiated by health workers themselves, but are also an instrument for management to deal with problems at the workplace. In fact, it even appears that it is one of the few tools at the disposal of management to discipline people, as culture, procedures, and the scarcity of health workers appear to make other measures difficult to apply.

Most people do not like to talk about their own failures, especially not to a strange outsider with a notebook. It is thus difficult to expect someone to talk about having been fired or having received a disciplinary transfer. One respondent, when asked about why he was transferred from one place to the other, was very cryptic. "Witchcraft becomes difficult to prove. The headman created a transfer. It was not for the rest of the community, but he said there was a quarrel between me and a colleague. We couldn't argue against it. We had fear. The district office never came to our place, but we found a letter of transfer".[88] He was not prepared to elaborate more on this issue. The colleague in question, whom we had interviewed before we learnt of his involvement in this case, did not even touch on this transfer when we spoke to him.[89] Later, however, I read the minutes of a human resource meeting in which this matter was discussed. According to the minutes, the headman had indeed reported to the district director of health that the two officers fought while on duty in the rural health centre. The two officers had been asked to write letters to exculpate themselves, which they did. The minutes then announced that, 'In accordance with *Terms and Conditions of Service for the Public Service*, Chapter IV No. 54, requires officers to maintain the highest standard of conduct, efficiency and personal behaviour. Fighting while on duty warrants a written Final Warning". The management then decided to write the officers final warning letters and transferred them to different centres.[90]

This description is of course very sketchy and its accounts conceal a whole complex of social relations, incidents, and human reactions. It is unfortunate that I have not been able to construct a more revealing picture of this incident. It could have involved a simple work dispute between colleagues that attracted unwelcome attention from the community. Alternatively, it could have been the result of deeper, perhaps more sinister conflicts. A situation may have arisen similar to the one which faced Mr. Zimba and his unfriendly chief. On the basis of the little we know, however, it would be careless to speculate about what actually occurred. Nevertheless, this account does highlight the difficulty of revealing the reality of labour conflicts and attempts to discipline staff.

[87] PB0811/11.
[88] LB0809/07.
[89] LB0809/19.
[90] Field notes.

Moreover, it shows that on occasion, complaints about health workers' conduct lead to the proverbial book being thrown at them – in this case the *Terms and Conditions of Service for the Public Service*. It also shows a preferred instrument for disciplining: Transferring the alleged wrongdoer.

Various respondents spoke about predecessors or other colleagues having been transferred because they were creating problems at their place of work. In one case, a senior enrolled nurse explained one of his transfers. A colleague was transferred away from a clinic. Someone at yet another clinic replaced him and the respondent had to fill that gap. He explained that the colleague had cheated on his wife after she had fallen ill and was hospitalised. This angered the community, "partly because one of the women involved was a married woman". The chief then reported to the district health office and the man was transferred.[91] Another health worker spoke of how he filled a vacancy caused by the transfer of a predecessor who "did not associate well with the community; there were a lot of problems". He explained: "The previous officer was drinking a lot of the local beer and smoking. When he was drunk he was provoking, and he wanted to fight".[92] Another account shines some light on the routes that communities can take to have someone removed. The community living around a certain clinic had gone to the community radio station in the nearby town to complain about the new officer there; they wanted him removed. They had also gone to the district health office, but there they were told that they had not followed the right procedure. Instead, they were to resolve the issue through the neighbourhood health committee.[93] In a different instance, this procedure was indeed followed. A nurse spoke of a clinic where a maternal death occurred. The responsible officer had been away at a workshop. When he returned, the community threatened to give him a beating. In the end, the community, through the Neighbourhood Health Committee, passed a vote of no confidence, and the district transferred the officer.[94]

Transfers appear to be the easiest way of dealing with people who are misbehaving. An expatriate technical advisor interviewed argued that rather than deal with a difficult case, people prefer to just move the problem elsewhere.[95] This was echoed by a human resource officer who cited a case that I had previously heard of from others. In a district in Western Province a doctor "suffered from drunkenness". [96] He was often absent and would insult people who needed help. Then, following complaints by the community, he was transferred to the Chainama Psychiatric Hospital in Lusaka. His former boss explained that alcoholism is a disease and that at Chainama there would be people who could care for him.[97] In the same province, I came across complaints of other doctors misbehaving. One respondent indicated that in one hospital some doctors are occasionally absent and that others have to cover when they are off drinking to counter the boredom of living in a provincial town.[98] Another respondent accused these doctors of boycotting the out-patient department. They refuse to hand in their work schedules. This respondent suspected that this might be connected to their receiving patients at home for a fee. It was also said that the hospital director responsible did not have the authority

[91] PB0811/14.
[92] PB0811/24.
[93] PB0811/24.
[94] PB0811/24.
[95] ML0809/05, ML0804/01.
[96] ML0607/12.
[97] ML0706/17.
[98] ML0607/13.

and seniority to discipline his peers. [99] In the judgement of one of these respondents, this is because it is not in the nature of "us Zambians" to openly criticise and confront one another.[100] Another explanation given was that this director had local roots and the local royal establishment had insisted on a local filling this important post, regardless of his professional experience. Thus, owing to his youth and relative inexperience, he did not have the clout to discipline older doctors, despite the fact that, according to others, he genuinely tried to manage the hospital as well as he could.[101]

A number of managers or former managers I spoke to agreed that in the civil service it is extremely difficult to discipline workers. One former manager recounted that once a driver in her district repeatedly used the ambulance to transport maize. She sent him back, but it finally took two years to get him off the payroll. The case had to go from one level to another, following the 'civil service route'. During the process, she encountered threats and intimidation as well as people at higher levels asking if she was sure she wanted to proceed with firing the driver, as it would be hard on the relatives.[102] According to some, this process has become even more cumbersome due to recent reforms and the dissolution of the health boards. An manager administration at the district level said, "Under the board we felt a sense of responsibility. We had the power to hire and fire. Now we can just advise. If people misbehave, we can't fire them". He explained that a recommendation has to go from the district health office to the provincial health office to the office of the provincial permanent secretary to the ministry headquarters to the public service management division of the Cabinet Office. He gave the example of "when a general worker steals drugs, you can recommend (firing him). Six months later he is still drawing a full salary. Before PSMD (the Public Service Management Division of Cabinet Office) decides, it can be three years later". He indicated that this leaves him and his colleagues with little authority: "They even call us toothless; managers by name only".[103] Another human resource manager, this time at a large hospital, agreed that it had become more difficult to discipline staff since the health boards had been abolished. "Under the board, the board could institute a disciplinary case. The executive director would sign and that was the end of it. As a last resort, someone could approach the courts. Now it has to go through the system up to the Public Service Commission. That can take two years up to three years". He did add, however, that "when someone deserts and does not show up for work, pay can be withheld. That works well". In fact, as I was interviewing him, a phone call came from the internal audit department. They asked about a dismissed worker who was still on the payroll. The respondent indicated that the case had come up at the last disciplinary meeting. He cross-checked with his colleagues at human resources and made sure that no payment would be made. He then called back to internal auditors to confirm when the person in question last had a working day.[104]

From the preceding, it has become clear that there can be various factors that make it difficult to mete out discipline to erring health workers. The bureaucratic process is long and cumbersome. In such situations, it seems easier to simply move the problem by transferring someone than to tackle the root causes. Another element can be seen to

[99] ML0607/15.
[100] ML0607/13.
[101] ML0804/02.
[102] ML0706/13.
[103] ML0810/07.
[104] ML0810/09.

emanate from the cultural values of those who are in charge of disciplining staff. Disciplining implies open confrontation and criticism, and people may feel that this may not be appropriate in a society that prides itself on evading conflict and striving for consensus. Moreover, the consequences of the ultimate penalty of disciplining human resources affect not only the worker himself but also the family and relatives dependent on him.[105] One could thus argue that traditional solidarity conflicts with a need to mete out punishment. However, when I put this dilemma to a former Cabinet Office employee with whom I was chatting in a pub, he agreed that this solidarity impacts on the willingness to discipline staff, but he considered this wrong as people should be motivated to perform and deliver services.[106] Another factor that can be argued to play a role in hampering the disciplining of staff can be found in the argument that has come to the fore throughout this section, namely the fact that qualified staff is scarce. The health sector has many vacancies to fill; and relative to the need, supply is low. This scarcity makes it difficult for the health system to lay off staff that are not performing or underperforming. Instead, it is easier to simply reshuffle staff by transferring them.

The consequence of the difficulty in disciplining staff discussed above is that it is thus difficult to manage performance in this setting. Is this an issue of neo-patrimonialism in that rational-legal logic conflicts with traditional 'patrimonial' values? The argument of solidarity and affection, in which the social consequences of firing someone are given such value, would suggest so. The lobbying and the influencing that we have seen impact on the cumbersome rational-legal bureaucratic process of dismissing someone also points towards the impact of clientalism. At the same time, the consideration on the part of a manager not to want to risk losing scarce staff and to take rather the more efficient route of transferring a wrongdoer – as opposed to going down the cumbersome route of laying him off – can be considered to be in line with the rational-legal value of efficiency. In other words, while this dilemma is reflective of the neo-patrimonial paradigm, the attempt to label considerations remains problematic.

Conclusions

In this chapter we have embarked on a journey in which we saw our health workers join the health sector and negotiate considerable spatial distances, being transferred from place to place. It was not, however, a story only of spatial mobility, but also of social mobility. The first section of this chapter suggested that there is an element of intrinsic motivation for becoming a health worker. Some did so to be able to care for others; they considered working in the health sector a vocation in the Weberian sense. However, it appeared that the motivation to get a job in a context in which jobs are scarce was at least as important. Getting to and through college in the pursuit of prized qualifications was an endeavour that could spell the difference between the life of most Zambians, surviving in informal employment or semi-subsistence agriculture, and the relative independence and security of paid employment for life (or more specifically, until retirement). A career in the health sector can thus be seen as a livelihood strategy for those involved that will to an extent emancipate them from the traditional peasant economy.

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[105] As we saw above in the account of respondent ML0706/13.

[106] ML0706/36. This of course is the official view one would expect to hear from someone who would like to come across as a professional.

It appeared that this route through education into formal employment is a social effort. We saw how the pursuit of qualifications, passing through school and college, was partly made possible by the contributions of others. Not only parents, but also aunts, uncles, and siblings featured among those who have pushed our health workers through school. In Chapter 5 we will see the relativity of the emancipation and independence that comes from the process of qualifying for a job. In return for the social support they received, health workers face claims from their social environment for similar support. In this chapter above, however, we saw that the children of those in formal employment appeared more likely to qualify as professionals in the health sector that those from peasant backgrounds. It can thus be argued that this process of striving for qualifications and obtaining paid employment in the health sector is an avenue for upward mobility and, as such, an important contributor to the process of class formation in contemporary Zambia.

The importance placed on qualifications resulting from formal education was more than evident in health workers' accounts. The path from secondary school into college transformed them from an outsider into an insider within the state-run health system. In other words, from being a contender for scarce training opportunities, they became a qualified professional and thus a scarce asset themselves. As we saw, this scarcity gives health workers considerable agency vis-à-vis the management of the health sector, which depends on them for its existence and performance. As a consequence, in their negotiation with the system about issues such as posting and placement, they have opportunities to realise their private preferences. As such, some of our respondents or their colleagues were empowered enough to resist being posted to a location which they considered not to serve their interests. We also saw how people can influence the system to provide them a better alternative. Some respondents, however, were less assertive or more accepting of their fate, remaining in more remote locations at the lower rungs of the system, a fact pointing to the variations in agency between individuals. The aggregate result of the influence individuals have on posting decisions can, however, conflict with the public interest. This is illustrated by the skewed distribution of health workers at the expense of more remote parts of the country. Health workers' ability to influence posting decisions means that such decisions are not as neutral and impersonal as ideal-typical bureaucratic decisions.

The pursuit of qualifications also poses a challenge to more extreme conceptions of neo-patrimonialism. The logic of qualifications as an indicator of merit being the primary criterion for eligibility to a professional position in the health sector appears uncontested. This does not correspond with the patrimonial logic that appointment to an office depends on personal connections to a patron. In the situation in which qualified candidates are scare in relation to the available positions, personal connections are thus less relevant for getting a job. However, when this scarcity is reversed, as in the case of competition for scarce education opportunities – or as we will see in Chapter 4, training opportunities – there are more incentives for manipulating application procedures for private gain. This was illustrated by the frank accusations of nepotism and bribery encountered in this chapter. These convincing accounts can be seen to support the neo-patrimonial paradigm. It also seems as if, in these accounts, complicity with such practices was less unavoidable or acceptable than some might suggest. Rather, this manipulation appeared to be more subtle than one might expect. As one respondent said, "Only very few people actually bring brown envelopes". Such informal strategies merely manipulate rational-legal application processes rather than replace them. This

supports the argument that we should not negate the value of rational-legal logic in neo-patrimonial settings – or in this case: Qualifications do matter. In short, there is no simple answer to the question whether it is either merit or personal connections that make someone successful when joining the health sector.

In the last part of this chapter, we were confronted with situations in which people were transferred owing to problems or misconduct. It appeared from various accounts that transferring staff is a more convenient solution for errant staff than dismissing them. The arguments put forward to explain this varied. On the one hand, it appears to be a reaction to a cumbersome bureaucratic process. On the other hand, severe, impersonal disciplining can be considered to be at odds with traditional values of solidarity and affection. While this dilemma is reminiscent of the notion of neo-patrimonialism, labelling such considerations as patrimonial is less straightforward. Nevertheless, it does appear that this dilemma makes the management of performance problematic and that personal considerations weigh heavily on a decision that in ideal-typical rational-legal logic should be a neutral, impersonal decision. As we will see later, managing loyalty appears to be more important than managing performance in a neo-patrimonial context. The importance of loyalty as a consideration in promotion decisions will come to the fore in the next chapter, in which we will examine health worker prospects for career advancement. Let us therefore now look ahead in the same way that health workers tend to do after having entered the sector. Let us look at their possibilities for forging ahead.