Cover Page

Universiteit Leiden

The handle http://hdl.handle.net/1887/18587 holds various files of this Leiden University dissertation.

Author: Leenstra, Melle
Title: Beyond the façade : instrumentalisation of the Zambian health sector
Issue Date: 2012-03-14

4

Forging ahead

In the previous chapter we saw our health workers through school and college and saw them join the health sector. There it already became apparent that attaining qualifications plays an important role in realising the ambitions of upward mobility. In this chapter, we will continue following these career paths to examine how health workers attempt to forge ahead within the sector. We will again examine whether merit or personal connections are the key to professional advancement. In addition to looking at those who get extra qualifications by further specialising in their field, this chapter will look at health workers who depart from a specialised professional career path and retrain to be able to enter management positions. We will see that in doing so they are pursuing more power and influence, but there are also financial incentives. Again, from health workers' accounts of their quest for further qualifications, we will see a strong sense of agency: People taking charge of their own destinies. We will examine what this means for them, but also what this means for the health system itself. Is the sector served by this upward mobility and the pursuit for further advancement? Also, does the system offer room for people to chart out their paths or does it rather challenge and block them? In other words, we will explore a possible tension between private interests for self-advancement and the official objectives of the health sector.

In the next section, this chapter will discuss an important goal of this quest for further qualifications: Promotion. Promotions are an interesting subject from the neo-patrimonial perspective. It is assumed that in a patrimonial context, people are not appointed on the basis of merit but on the basis of loyalty to or dependence on a superior, in a patron-client relationship. In this chapter we will examine what people themselves, as well as others, have to say about such promotions. Are promotions based on merit and sought-after qualifications, or do other, more personalised factors indeed play a role?

Finally, this chapter will take a look at a particular cadre in the health sector: The doctors. In neo-patrimonial theory, much emphasis is placed on the vertical linkages between patrons and clients. It is suggested that horizontal linkages, such as class and professional distinctions, are less relevant for African power relations than vertical

ethnic- or identity-based linkages.[1] The section titled 'It's a docs' world' will examine whether this assertion holds in the Zambian health sector. As such, we will gain insight into 'who's the boss' in the Zambian health sector.

Further education

Picking up the stories health workers presented on their careers, let us address an important issue in health workers' social mobility: Further education. When speaking to bright, young health workers – or in fact, nearly any young professional Zambian – they seem have a clear goal in mind. They aim to 'upgrade themselves' by getting further qualifications, in order to climb the professional ladder or improve their chances in the labour market. This can be pointedly illustrated by the example of John Mwewa, a miner's son who became a nurse tutor. He had wanted to become a doctor but failed to get into medical school. Instead, he applied for registered nursing. At a mission hospital that also served as a nursing school, he had worked himself upwards to become a senior nurse and later a clinical instructor. But he wanted to go further. Having signed up for midwifery, he had also applied to a bachelor programme in nursing at the university. After studying midwifery for a year, he was accepted to the University of Zambia, where he completed his programme. With this he qualified to become a nurse tutor. John's wife, whom he met at nursing school, is an enrolled nurse and was on leave studying pharmacy.[2] This example suggests that the exact field of work – nursing, lecturing, midwifery, or pharmacy – is secondary to a primary goal: Getting ahead. This, we will see, is a recurrent theme in the following sections.[3]

Supporting further education of public servants is an active policy of the Zambian public sector. This is unsurprising considering the fact that qualified Zambian health workers have been extremely scarce throughout the history of the Zambian health sector.[4] This was even more striking in the early years of Zambian independence, as is illustrated by the account of a retired medical doctor and public health official. He was one of four black Zambians among thirteen medical students who graduated in the second batch of doctors trained at the school of medicine in Lusaka. After working at the UTH for two years, he was set to go abroad to help Mozambique, to where most Portuguese doctors had fled Zambia after independence. This support was an act of solidarity by Kaunda for his comrade Samora Machel, despite the fact that Zambia was only marginally better-endowed with doctors itself. The director for medical services and presidential physician at the time,[5] however, asked him to go to the Kitwe City Council, as the expatriate medical officer there had left. The respondent said that he had argued that he was not qualified, not having studied public health. He was promised, however, that if he accepted he would be sent for a masters' degree in public health. So after spending two months in Kitwe, he went to study in the UK for a year. Then, after

---

1 See for instance, Chabal & Daloz, *Africa*, 20.

2 LB0809/06.

3 A point also made when examining why health workers chose the health sector in the previous chapter.

4 In fact, human resource development, i.e. training, has long been a higher priority than human resource management, which focuses on staff performance. This can be deduced from descriptions of the early years of the Zambian health sector in Kalumba, 'The practice', and also more contemporary planning documents such as MoH 2001, National 10-year Human Resource Plan for the Public Health Sector.

5 He was a Nigerian, which further illustrates the scarcity of Zambian doctors at the time.

another four years in Kitwe, he went to the US for a doctorate in Public Health, with a Swedish scholarship.[6]

Many respondents have profited from government support in the pursuit of their qualifications. One laboratory technician reported that he had first qualified for a job in the health sector after following a certificate course.[7] After five years of work, he went on study leave to pursue a diploma in bio-medical sciences. He claimed it was not difficult to arrange study leave, as it was pre-arranged when he did his certificate course. Furthermore, the three years he spent pursuing a diploma did not cost him anything, as government paid for it. This sponsorship, however, did come with the obligation spelled out by a 'bonding letter', meaning that he would have to spend at least two more years in his current post after qualifying.[8]

The investment made by government in further education of its workers is a definite incentive for people to join government service. The question is, however, whether this will keep them working for the government that sponsored them.[9] A pharmacist in his late twenties recounted that he had received a 75 per cent bursary from the government to support him at university. However, when his uncle who supported him died, this was scaled up to one hundred per cent. He said that he would like to continue working for the government because government had educated him. He was planning to go for a master's degree soon to further his education. As he had spent almost three years in government service, he would be permitted to go. He also expected the Ministry of Health to sponsor this. He summarised his gratitude to government by saying, "The government sponsored me; they sent me to school. So I'll work for government". Later in the conversation, however, this resolve suddenly appeared less firm. "But maybe until a better offer comes around". Apologetically, he added, "We cannot run away from the salaries".[10] This ambivalence about paying back the government for the investment made in one's education was echoed in the words of another health worker. "The government pays the lowest salaries. In the private sector it is much better, but in the government the possibilities for education are much better. Job security is also higher in the government. I intend to remain working for the government, but if something comes along ...".[11]

Some health workers are less fortunate than others in accessing possibilities for further education. Because access is limited, it is contested, in much the same way as we saw when discussing chances of getting into college. One enrolled nurse mentioned that she had been trying for quite some time to be accepted into a college, to be 'upgraded' as a registered nurse. She explained her failure by stating that, especially in rural areas, one can apply several times without being picked. Part of the problem is that it is difficult to hear on which dates one can apply, and that the district only sponsors an applicant once. The rest of the time an applicant has to pay for transport costs herself. The district health office will then only support someone financially after he or she has

---

6 ML0811/02.

7 Zambian colleges such as Chainama or Evelyn Hone offer certificates and diplomas to represent one's qualifications, and together with bachelors' and masters' degrees these reflect an ascending order of qualifications.

8 After that, he was considering moving from the government sector. "I'm not all that comfortable. This is a government set-up: NGOs are performing much better … We're not making our ends meet. I've got friends working for NGOs who are earning five times more than I do". PB0810/01.

9 Despite the lofty words some may offer in response to an interviewer's questions.

10 PB0810/03.

11 PB0810/17.

been accepted to college. The nurse found it very frustrating not to be accepted to a college. “How are we going to improve? If you have that plan, you should be able to go to school. Now we are growing old without upgrading”.[12] Some health workers are resigned to the fact that it is too late for them to further their education. “As years went by, my interest was thinning and when the family grew it became more difficult as well”.[13]

The complaint that it is more difficult for people in rural areas to get into colleges is often heard. During a focus group discussion in a rural provincial capital, participants mentioned that people ‘along the line of rail’ (those closer to colleges) have first-hand information about a selection procedure and thus it is easier to apply and get picked.[14] It is very likely that this is indeed a complicating factor in seeking further education. Nevertheless, some respondents gave the impression that policies aimed at enhancing access to people in rural areas had some impact. One nurse, who had gone for midwifery, said. “The government wanted to give a chance to rural areas, so I was lucky”.[15] In fact, chatting to a young nurse on the Copperbelt, I was told that he was even considering applying for a transfer to Mansa as people in rural provinces had more chance to go for further education.[16] This argument was, however, contested by a participant in a focus group discussion who conceded, “The policies are there, but not put in practice”, claiming that if someone from a “higher office brings a person”, then that person would be more likely to be accepted than someone from a rural area.[17]

As was the case with getting into colleges, allegations of unfair clientalism are rife in discussions of further education. “The time you go for interviews, someone else is already selected. The people who get selected might have relatives there; they might have some people backing them. Also, the people who are selecting, only select those who are a new entry; there is no gratitude for the years spent in service”.[18] Another respondent was more specific with an allegation of clientalism. He said that he had attempted to get into registered nursing twice. In addition to himself, there was one other from the same hospital who wanted to go. Eventually, the other one was picked by the nursing school. “The nursing officer (at his hospital) favoured someone from her own church, and she communicated about this with (the nursing school). The other one didn’t even have all the qualifications. He didn’t have the required maths ... It was not easy for me; I saw that I didn’t get the chance even though I was hard-working”.[19]

Other respondents stress issues of prior qualifications as the source of their difficulties in getting accepted for further education. One young enrolled nurse told us she would definitely like to become a registered nurse. First, however, she would have to improve her high-school grades for science and biology; then it would be easier. She had wanted to get into registered nurse school for the last three years. She even tried to re-sit biology once before, but the attempt was not good enough. Then she got pregnant and had to wait. As her daughter was a year and seven months old when we spoke to

---

12 LB0809/18.
13 PB0811/09.
14 FG0811/02.
15 PB0811/15.
16 ML0810/11.
17 FG0811/01.
18 LB0809/19.
19 PB0811/24. This account illustrates that clientalism is not merely an issue of favouring relatives or people from the same ethnic group; other contemporary social relations, such as membership of the same church, also play a role.

her, she could start working on her grades again. She mentioned that she was taking private lessons, though it was a difficult combination to work and study: "your mind is divided". After qualifying, she said she could choose between a private and a public school, though private schools mean paying "big money". In both cases, however, one can get study leave.[20] Another nurse said that this strategy of re-sitting secondary school exams had been successful for her. She said she had tried to get into registered nursing many times, but had not been accepted. Then she was accepted for midwifery. As this was her second choice and she still preferred registered nursing, she decided to re-sit her mathematics. As she passed these exams, she now has "a better shot at getting into" registered nursing. Still, she wants to re-sit mathematics again to improve further. She explained: "Promotion depends on yourself; you have to advance. The young ones are becoming better off, so you have to study from time to time".[21]

The pattern shown by the previous respondent and also by Mr. Mwewa, the nurse tutor presented at the beginning of this section, appears to be common. Some people bet on various horses to increase their chances of 'improving themselves'. One young enrolled nurse revealed his ambitions: "By God's grace, I can continue my education. I already applied to Evelyn Hone, to study pharmacy. As a back-up I also applied to the Lusaka Institute of Nursing to become a registered nurse, but I would prefer pharmacy. In ten years I want to have a degree, either via nursing or pharmacy. My focus is just to have a degree, and I am pretty sure I can do it".[22] Not only does this account illustrate the strong sense of upward mobility that we have encountered a number of times already, it also shows a tendency towards what we can call 'stacking qualifications'. One could even describe some Zambian professionals as 'serial students', who appear to have embarked on a seemingly indiscriminate quest of qualifications in order to enter more lucrative career paths.

One registered nurse's account of her career and the qualifications she tried to get is illustrative for this stacking of qualifications and changing career paths. After graduating, she started working in a rural health centre in a very remote part of the country. Although she was not trained as a midwife, she conducted many deliveries. Then the Central Board of Health began hiring people for the district health management team. At the time, the Netherlands was supporting a district health management course in Kabwe, to train people for the new management responsibilities that resulted from the health reform process. The top three managers in each district were appointed to follow this higher diploma course, including our respondent. After qualifying for her management job, she returned to the district for a further four years. Then she applied for a nursing degree at UNZA. She claims that, based on her health management diploma, she was accepted. The district, however, wanted to support her only for management courses as she was part of the management, rather than for a further clinical specialisation. Therefore, after six months her sponsorship was cut. She then decided to go back into nursing as there were rumours that the Central Board of Health would be abolished and she was afraid her management position would be given to someone else. After leaving UNZA, she had applied for a job in Lusaka, but the province she came from did not clear her for a transfer to Lusaka. She then went to work at the provincial hospital. In the meantime, she had secured sponsorship from the African Development Bank, with which she could go back to university to pursue a nursing degree. This, she said,

[20] LB0809/23.
[21] PB0810/08.
[22] PB0810/17.

was due to her extensive rural experience. However, in her third year she got stuck. She failed a course in physiology, re-sat the exam and failed again, and was then excluded from the studies. If she wanted to retry she would have to start again from the first year. She then returned to the provincial hospital, where she continued working in the wards and the out-patient department. At a certain point she briefly worked as a lecturer at the nearby nursing school as she had nearly attained a degree in nursing, but the principle nursing officer transferred her back to the hospital because she did not have her papers. "I would prefer working as a lecturer", she said. "My interest was to teach students. Also there is a financial incentive: The salary is the same, but the lecturers are getting 250,000 every month for teaching and 250,000 for upkeep, so there is a 500,000 difference".[23] This nurse thus had a varied career, from working at a rural health centre, dealing with deliveries and primary health care, before she shifted to management. Then she went 'back' to hospital nursing and lecturing. This account does not shine light on the entire range of motives this health worker might have had for changing tack so many times.[24] However, one is led to wonder whether it was indeed the personal interest and motivation for a specific job that were the decisive factors for going into nursing, management, or tutoring. Alternatively, the financial incentives that came with each job and a desire to secure her livelihood may have been decisive. One could also seriously doubt how efficient it is for public money to be spent training and re-training this individual. It does appear that management at a certain point tried to curb this nurse's desire to stack qualifications, when she decided to pursue a university degree in nursing while being a manager. In the end, however, it appears that neither her own ambitions to be a tutor with a degree nor the management's desire to retain her as a manager prevailed. Finally, a picture emerges from such accounts that health workers constantly pursue strategies to find new opportunities for both improving and securing their livelihoods. These strategies appear to attempt to keep options open and seize opportunities that pass by, rather than focussing on a specific career trajectory. As we will see later, this relates to focus not only within one's professional career but also beyond one's formal job.

Moving into management

The move from clinical work into management is a common pattern in health workers' accounts. In part, this is a result of the organisational changes the health sector has been undergoing over the last decades. During the implementation of the health reforms, considerable responsibilities were delegated to the district level. That created numerous management posts that needed to be filled, as we saw in the case of the registered nurse above. Environmental health technologists, nurses, and clinical officers were often given workshops, training courses, and the district health management course mentioned above to prepare them for their new tasks, in addition to learning on the job. At times this allowed capable and experienced health workers to climb up and share their practical experience as managers. Equally, at times it meant that health workers that were not really suited for management (as we saw in the case of Ashley and Anton's manager administration) land in a position of power and influence. The suitability of

[23] PB0810/15. ZMK 500,000 equalled € 90 at the time of interviewing.

[24] There may have been personal issues or conflict at the workplace, which may not have been deemed fit to mention in an interview.

this group of health workers for management positions, however, is contested, as we will see later.[25]

In addition to this group who were raised into management en-masse owing to structural changes, there are also health workers who have re-educated themselves into management at their own initiative. Take for instance Mr. Mtonga, who had grown up in Lusaka, was trained as an environmental health technologist, and was initially posted in a very remote rural area. "That posting was a bad experience", he remembered when narrating his story. In Lusaka he had been used to things like electricity, while at his centre "there was nothing". After a year, the district noticed that he was depressed and they transferred him to what would shortly be the newly created district of Chiengi. At Mununga, his new location, he recalled that there was a Peace Corps project that was building a new health centre. At the time, during the run-up to the 1996 elections, the deputy minister of health, Katele Kalumba, was standing against a local politician for the parliamentary seat.[26] In the course of the campaign struggle, those in power considered the sourcing of funds to build the health centre was in a sense campaigning for the opposition. Together with the Peace Corps volunteers, Mr. Mtonga was transferred elsewhere.

After three more years working as an environmental health technologist at a different health centre, Mr. Mtonga decided to study human resource management. He claimed that the main reason for this change of career was that, as an environmental health technologist, he "experienced a lot of noise". The work was antagonistic to the community; he was mainly inspecting premises or bars and threatening to close them down if health circumstances did not improve. "The communities were somewhat primitive; they didn't want to see me. They would say 'ah, the inspectors have come!'". They even threatened him with witchcraft. In the beginning, he believed in it, but later he could not see how it would work. "Someone would say they had a charm, but it was just a wooden plank carved up". It did not affect him. What did affect him though was the fact that the ministry did not approve of him studying human resource management. Mr. Mtonga was not clear on the reasons for this, but he recounted that he then decided to support himself. Three years later he had finished a diploma course in Lusaka. Since then he had worked as an manager administration at the district level. At the time we spoke to him, however, he still did not seem satisfied with his qualifications. He was studying development studies, through a long-distance programme. Two more years of effort would get him his bachelor's degree.[27] But he had set his sights further than that. He hoped that in 2011 he would then be able to start a master's programme.[28] One can assume that Mr. Mtonga figured that a degree in development studies, together with his experience, would make him a good candidate for a job with an NGO.

---

[25] This emerged particularly during the restructuring process that followed the abolition of the boards, when the aim was to hire people with degrees in management to fill management positions rather than health staff with management diplomas or certificates.

[26] According to the Zambian historian Musambachime, there was quite some disappointment with the Shila people of Mununga, who now found themselves split between Chiengi and Nchelenge, from which Chiengi had been split off. They would prefer a district to be established in the Kalunwishi area. Instead, the *boma* was created near Puta, seat of the Bwile royal establishment (Musambachime, personal communication). The episode described here fits well with this expert's account of the local political context, as well as the section 'Building Katele's Kingdom' in Chapter 8.

[27] He found combining study and a full-time job very busy. He claimed that when necessary, he got up at one in the morning to do his homework and then started working at eight a.m.

[28] LB0809/02.

During my fieldwork, I encountered at least two other health workers who decided to retrain themselves to become human resource managers. One, once he was in possession of the appropriate qualifications, made his way to a senior post at the ministry headquarters. He had started out as a clinical officer. After graduating from Chainama, he was posted to a remote part of North-Western Province. As we have seen before in other cases, he was very unhappy. Then, one day when he was back in Lusaka for training, he told the ministry that he refused to return to his post. He recounted that to hold on to him the ministry posted him to a major hospital on the Copperbelt. As time progressed and he continued working as a clinical officer, he decided to continue studying. He went on to finish a degree in public administration at UNZA. He then returned as a human resource officer to the hospital where he had been working. Later, the restructuring process put a strain on the human resources directorate in Lusaka, which was allegedly understaffed in both numerical as well as qualitative terms. He was asked to help out at Ndeke House from time to time: Looking at submissions, checking, counter-checking, and verifying. After a few months, he was appointed to a fixed position.[29]

Another Chainama graduate was trained as a psychiatric clinical officer. He had wanted to be posted to a rural district. Once, he recounted, he had the possibility to become the AIDS expert at the district health office. However, his supervisor refused, saying that he was too valuable as a psychiatric clinical officer. The respondent claimed he had the feeling he lost out then, as the person who did get the job reportedly ended up working for a good NGO. Later, after having done a training course in the field of counselling, he was requested to open a counselling unit at the central hospital. Then, as the hospital board was established, there were vacancies in administration. The director then moved him, and the board appointed him as a hospital administrator. When he started as an administrator, he had hoped that the hospital would have a career development plan for him, but it seemed otherwise. He applied and had been accepted to a diploma course in human resources three times. However, only on the fourth acceptance did the ministry decide to sponsor him. Then, because the boards were being dissolved, a vacancy opened up for him at his old hospital as acting human resource manager. The former human resource manager had been on a board contract but reverted to the old civil service conditions of service. His fuel allowance was stopped and electricity and water were no longer paid, so he had left to join the Roads Development Agency. The respondent claimed that he had no regrets that he had left his old profession. “When you are a clinical officer, your movement is limited. You can become senior or chief (clinical officer), unless you branch off”. He wanted to go further, however. He claimed it was not from a financial perspective but from a professional perspective. He argued that when he changed into administration, he only went up 4000 Kwacha in salary.[30] While I have no specific evidence to deny this claim, it might not be the entire truth. Those in management (including human resource management) positions are generally known to have more access to workshops, field trips, and other opportunities to receive additional allowances. It is thus likely that, at least more recently in his career, he has profited from the material benefits of management. Apparently, our respondent did not consider it virtuous to admit such financial motivations. Furthermore, the position of human resource manager creates power and influence, since one decides over the fate of others, whether they can access training, qualify for promotions or allowances, and so on. The neo-patrimonial paradigm would suggest that such a gatekeeper function could

[29] ML0809/14.

[30] ML0810/09. ZMK 4,000 equalled about € 0.75 at the time of interviewing.

provide opportunities to abuse one's influence for some personal gain, either in payment or favours. We can in no way claim that this respondent has indeed instrumentalised his position in such a way. If it were the case, however, this would of course be an issue best left unspoken for this respondent.

It is interesting to note that in some of the stories above there was a disconnect between what a health worker considered appropriate further education and what was considered appropriate in view of the greater good of the state-run health system. As we have seen before, however, some health workers demonstrate considerable agency in pursuing their interests. That this can even lead to what can be safely called manipulation can be seen in the following account of yet another clinical officer who turned human resource manager. We heard a quotation from him in the previous chapter, when he ran away from a rural posting to Lusaka so as not to be "forgotten about". After four years of having worked at a very large hospital, he was sent to Australia on a scholarship. He admitted that these scholarships were given only for courses that are not found locally. "I was supposed to go and study occupational therapy, and when I went there I took some orientation courses". However, then he followed courses in the field of human resource management instead, for which he eventually got permission because there were people with diplomas in this field but no degrees. "When I came back, I had problems with my transfer from clinical officer to human resource manager. My colleagues didn't want me to come to administration. No one had a degree in human resource management there; maybe they were scared for their positions. The person who had recommended me had already left when I returned from Australia in 1999. The managing director helped, and people who were making a lot of noise were transferred".[31] This enterprising career hunter, in his frank account, shone light on the process of seizing opportunities and even bending rules in his quest to get valued qualifications. When the system tries to block such people, some might concede and accept their fate; others might look for alternative paths to further themselves; and the most brash might simply try to overbear the system and present people with foregone conclusions, as we saw in the case above. This account also shines light on transfers as an instrument for dealing with "people who make a lot of noise". And while the social relations behind this account remain obscure, it also suggests a process of gaining allies to defend one's interest. One can only speculate, however, whether such social allies would need to be repaid with favours or loyalty.

Training your way out of the bush

Having argued extensively the importance that Zambian health professionals place on the quest for qualifications, let us now look at the sometimes perverse effects that these laudable individual efforts[32] can have on the formal objectives of the health system: The public interest. Earlier we have questioned whether it was an efficient use of resources for a nurse to change career paths several times in a seemingly haphazard manner. In yet another example, we will see a health worker over-qualifying himself for his current job and apparently spending more time training than actually working. A supervisor in the laboratory of a provincial hospital had made his entrance into the health sector with a certificate in laboratory technology. After a year and eight months working at a mission hospital, he was admitted to a college in Lusaka for a diploma course in bio-medical

[31] PB0812/01.

[32] Or collective efforts focussed on a particular individual.

sciences. The mission hospital had given him transport money and helped him arrange paid study leave, before he had served the regulatory two full years. Perhaps this was influenced by the value that qualified laboratory technologists have, owing to their scarcity and the enormous extra workload the sector has experienced from the massive roll-out of anti-retroviral treatment for people living with AIDS and the diagnostic tests this involves.

This respondent described his experience working in these conditions. The previous person in charge had left the laboratory he worked in somewhat dirty, so he had cleaned it up to standard. When he arrived there, three staff members had just left, while the laboratory catered for three districts. “I was working twenty-four hours. That place taught me about hard work. If you are alone, you are forced to process the work whether you like it or not. If patients come, you can't send them away”. He claims that this made him hard-working. As an after-thought, he said about his current workplace, “Here it is a bit different”. After another few years he went on study leave again, this time for a degree in bio-medical sciences. When he came back from his studies, however, he could not remain at the mission hospital. “It was tough when I told them I would leave. They realised a bit late that I would leave a gap. Still now I haven't been replaced there. But after completing my degree, my position does not exist there”, as he has been too highly qualified. “So the province transferred me here; otherwise, someone might have hooked me. I would have loved to stay; they even built me a house”.[33] This is a clear example of someone training himself out of a job in a context in which an even moderately trained laboratory technician would be invaluable. Fortunately, in this case the respondent resisted the opportunity to go elsewhere where his qualifications would be welcome. Also, he was not completely re-retrained, as we have seen before. However, this case did show how, by constantly increasing their qualifications, health workers can be seen to train themselves out of the bush – and possibly out of the country.

It is evident that certain high-tech skills may not be very useful in rural areas or even less-equipped hospitals. In the words of a surgeon in Lusaka, “When you’re trained in a particular field, you find you won’t be very useful. You don’t have the back-up; your training is a complete waste of time. I’ll give you an example. I went to Tokyo to study bypass surgery, and I can’t do that in a rural area. A surgery like that needs other surgeons, as well as trained nurses, etc. A training like this becomes completely useless in a rural area”.[34] Similarly, a degree-holder in charge of a laboratory in a provincial hospital said that, before, one had to go outside the country for a university degree, but in 2002 the University of Zambia began a degree course. He had recently returned with a degree. The programme had given him new insights about the changes in the profession and in immunology. His professor had told him that he had to do research now, although his hospital is not running appropriate research programmes. “I am being under-utilised”, he complained. “I need a bigger hospital like Kitwe or UTH, but the government wants every lab in the country to be run by someone with a university degree”. For the time being, he is not going anywhere, however. “I have a two-year bonding contract, and after that I have three years until retirement. Then I can start working for the private sector”.[35] This account is echoed by a younger laboratory technician. He reported that since returning from his diploma course, he can use new technologies for examining, for instance, liver and kidney conditions. He can diagnose more

[33] LB0809/22.
[34] PB0812/11.
[35] PB0811/01.

accurately now, but he is annoyed that he does not have certain equipment: "I have the knowledge, but I cannot do certain things. In five or ten years, my knowledge will be gone. Management is well aware of these problems, but there is nothing that can be done about it". In the meanwhile, he wants to further his studies and get a bachelor's degree. He is not sure if he will remain working for the government: "I'm not all that comfortable. This is a government set-up; NGOs are performing much better". When asked, he mentioned that his main argument is that "what you get at the end of the month is what scares people: We're not making our ends meet. I've got friends working for NGOs who are earning five times more than I do".[36]

Not all health workers seem so intent on 'looking for greener pastures' after getting qualified, however. One doctor who was trained in Russia and was working in Lusaka said, "The MoH should be flexible with staff. I would go to a rural area; I haven't seen much of rural Zambia. It also leaves you a much better doctor. You are exposed to so many conditions. Here you become so focused, you forget other departments". While in his profession the training opportunities are limited, he did not appear anxious to seek his fortune abroad. "I would like to leave the country for postgraduate research, but I would like to come back to Zambia afterwards. In UTH, only the postgraduate studies in surgery are recognised internationally. I want to be exposed to the latest developments in technology. But the need for doctors is so big here that I would feel guilty working somewhere else, making some huge salary".[37] The question is, however, whether he would indeed be so steadfast if, as was mentioned by others, 'something comes along ...'.

It is clear that in the Zambian sector there is a strong tide of health workers ebbing away from the rural areas where they are much needed.[38] As we have seen from the preceding, this is to a large extent the result of individuals fulfilling their ambitions of upward mobility. As we have also seen, this is partly driven by financial incentives, but also by a pursuit of status as well as the desire for professional satisfaction: being able to do what you are trained for. Another factor we have encountered in numerous examples above is that the reality of life and work in rural areas is at odds with the expectations a professional has of living a middle-class life. The discourse of the human resource crisis in health sees this phenomenon as problematic, which is understandable viewed from the perspective of the public good. From the perspective of the health worker, it is not problematic *per se* and is morally justified. Another mitigating argument is that at higher levels in the system, appropriately qualified staff are also needed. Nevertheless, it is evident that the result of this accumulation of individual endeavour has negative consequences for an efficient and equitable distribution of human resources. This clashes with the perspective of serving the public interest.

However, as we can see from health workers' accounts, the bureaucracy does try to deal with these efficiency and equity issues. We have already heard stories that mentioned that health workers were bonded. This is a useful quid pro quo: Government sponsors your training and a district or institution facilitates the training; in return, the health worker is obliged to stay at a particular clinic for a certain period. There is also, as we have seen earlier, a rule in practice (though we saw in that example that the rule

---

36 PB0810/01.

37 PB0812/04.

38 See for example Toyoshi-Hamada, N., 'Zambian'; and P. Boone, 'In search of greener pastures; Motivatie en braindrain van gezondheidswerkers in Zambia' (unpublished MA thesis, University of Groningen, 2009).

was not followed) that after having gone on study leave, one has to wait a period of two years before going on study leave again. And for doctors it is said that after an internship and before being allowed to go for post-basic education, they should go through a period of mandatory rural posting, though it is unclear to what degree this is implemented. As we have also seen, at times health workers are blocked in attempts to go for extra training. One former enrolled nurse, who had already been upgraded to registered nurse, said that he had wanted to go for midwifery, but that the district did not allow him. They argued that staffing levels did not allow for this. They also said that he had not put it in the action plan. At his next posting, however, the health centre was supportive and he went for his midwifery. At the time my research assistant interviewed him, he had recently applied for a degree course in post-basic nursing and was still waiting for the reply. He reflected that his recommendations are good, but that there is high competition.[39] This account shines light on the way study leave and courses have to be planned and the bureaucratic process of recommendations and approval. While such bureaucratic processes are open to social influence and possible manipulation, they do show an attempt by the health system to get a grip on people's training ambitions and efforts, to promote a more equitable distribution of health workers.

The struggle and the negotiation involved in accessing the privilege of going on study leave is illustrated by the following example. A physiotherapist did his diploma course at Evelyn Hone, and after graduating he was posted to a hospital in a rural provincial capital. He had never been out of the Copperbelt and Lusaka before, so he was in some trepidation about it. He had the opportunity to go and see the working environment during a six-month probation period. After that period, he decided it was alright to stay there. What he claimed had helped him in this decision was the fact that the hospital promised to send him back to school later on. Then, after two and a half years the hospital sent him to UNZA, as promised, where he studied physiotherapy. During his training at UNZA, he was sponsored by the ministry and the hospital. He received a bonding contract for three more years at the hospital. After those three years he wants to go for his master's degree. While his previous experiences were good, he did not seem confident about his future training, "It is quite difficult to get in. Only doctors get their masters. For doctors it's easier; after two years of rural experience they automatically get back to school. It is discrimination; it is not fair. For physiotherapy the boss has to endorse before the Ministry of Health considers master's". But he is anxious whether this boss, the executive director, as a doctor will treat him fairly. "He has a certain orientation about doctors".[40] This is thus a struggle between health workers and the bureaucracy, in which we have to take into account that it is also the decision-makers themselves who struggle for their own access to qualifications and upgrading.

Let us end this section, however, with accounts that do not necessarily imply a divergence of public and private interest: The stories from two young men whose strategies for forging ahead will leave their current work benefiting from their skills – for a short while still at least. But in their long-term planning, the sky is the limit. A young pharmacy technologist explained how he wanted to use the provincial town where he is currently posted 'as a training ground'. He wanted to go back soon to school and upgrade himself with a diploma course. After that, he would like to go to campus. He said he expected to do this while using his current town of residence as a base; therefore, he reckoned that he would stay there for the next six or seven years. "I am looking

[39] PB0811/33.
[40] LB0809/20.

at the vision that I have. Being a young man, and having a lot cut out for me, I don't think I should miss that opportunity". He thought it would not be difficult to get into a diploma course: "I have a basis, I don't expect much restrictions, and they know us from the certificate course; they know my behaviour in school is good. Also, this time I will get help from the government for the expenses, because I'm in government service now". In ten years, he saw himself going for a PhD, as he would very much like to do scientific research. He also expressed that he would like to go into business and have his own pharmaceutical company. For that, he would like to go out of the country as well, to see how people in other cultures are dealing with the challenges they face. "If you are somewhere for a long time, you don't see the need for improvement; but if you see other cultures, this can help you. But the most important thing is that I arrive where I want to arrive".[41]

Another young man described the difficulties of living in a rural area: Witchcraft, rumours, and electricity "can just go off anyhow". "And a big problem is relish. There's just fish. Every day there's fish". And even when he buys something else, such as beef and keeps it in the fridge, the electricity goes off and it spoils. He looked at his friends who refused to go for rural postings and are working in clinics connected to the mines. "I'm just the black sheep for staying in a rural health centre". He reflected, however, that after working there for a while he would have a better chance of getting further education. "Here we are few, so the chance of getting sent is bigger. And if I don't get sponsorship, here I can save money for my schooling". Even though he is not originally from the province where he is posted, he sees himself staying there for a while. Neither does he want to go abroad: "I want to build houses".[42]

Who's the boss?

In previous sections we have seen how health workers chase possibilities to get qualifications in their bid to forge ahead and improve themselves and possibly move into management. In this section, we will look at how people are promoted to more senior positions. Again, through talking to people, it is very difficult to get a true sense for all the factors that played a role in a specific promotion decision and to determine which factors were of overriding or significant importance. Nevertheless, we can identify certain patterns that are seen to play a role, by analysing the accounts of health workers of themselves and others.

When asked why they were promoted, many respondents point out that they were qualified or that they have the capabilities. One official answered, "Because I am a performer". He indicated that, in his judgement, 98 per cent of the reasons for getting opportunities "is based on your performance, and 2 per cent is who you know". He added that it is "difficult for others; some of my classmates, even to this day, failed to get a promotion".[43] Another respondent, who made it up to principal nursing officer, said, "I'm not sure why they picked me. Maybe I just had what it took. But I haven't let them down".[44] A former principal clinical officer thought the reason for his promotion was that he is a "very efficient worker".[45] And a stores officer, who started out as a

[41] PB0809/04.
[42] ML0811/12.
[43] LB0809/03.
[44] LB0809/21.
[45] PB0811/10.

garden boy, said, "The management determined my upgrade. They have to see your performance, and then they write to you with a transfer. The performance should pave the way for an employee".[46] Of course, these accounts in part reflect a discourse of self-justification: Representations of people wanting to shine a positive light on themselves. It is safe to say that they are not a precise and complete reflection of the considerations in the actual decision-making process.[47] On the other hand, one could equally argue that they say something about a shared ideal in the public service: Someone gets promoted on the basis of performance, of merit.

In various cases, promotion did not seem much of a contentious issue due to the scarcity of qualified staff. This was especially so in the earlier years of the Zambian health sector, as we saw in the case of the doctor who, when he was young and in-experienced, went to work for the Kitwe City Council and who was, *en passant*, sent abroad to get the required qualifications.[48] At the time, many positions in the sector were filled by expatriates, some of whom were anxious to leave. One former public health officer described how he took over from an expatriate who had left in such a hurry that there was no smooth handover. Coming from a posting in Eastern Province, where he had taken over from one expatriate, he had arrived in Lusaka for a placement at the ministry headquarters. As he arrived he was told not to unpack as the provincial health inspector on the Copperbelt had resigned and there was a vacancy that needed filling. At the time there was an active policy of Zambianisation, aimed at replacing expatriates with indigenous Zambians.[49] According to our respondent, some expatriates were not anxious to leave as they had their families in Zambia and were oriented towards Africa.[50] Others, however, were, no doubt influenced by the economic crisis that had set in in the 1970s and was gradually eroding Zambia's capacity to pay civil servants internationally competitive salaries. At any rate, in this situation it is understandable that anyone who was qualified or even partially qualified could make very rapid career advances. In many cases, especially in more remote locations, this situation still holds. In part this is because of the new cadres and new positions that have been created in the course of time. One nurse described how, on arrival at a mission hospital, she was immediately put in charge of the children and maternity ward, as she was properly qualified, albeit in-experienced. "It was a challenge but it also brought confidence in my training that I was well prepared for it".[51] But even a senior doctor who was head of the department of medicine at a major hospital commented on his becoming head of the department: "There are very few people in the department; it was not very competitive. The previous head of department was promoted; he is now the MD (managing director), and that's how I became the head".[52]

One account shone some light on the process of selecting a candidate when a vacancy emerged. It may be interesting to note that this case refers to a cadre that is relatively new in the sector, that of health information officer. This cadre has become increasingly essential to the health management system due to donors' demands for health and service-delivery data. The respondent had trained as a public health officer.

---

46 PB0810/02.
47 We will more closely scrutinise the case of one of these respondents later.
48 ML0811/02.
49 See for instance Lungu, G.F.,'Africanization and the merit principle in the Zambian public service'. *Journal of Administration Overseas*, 19: 2 (1980), 88-99.
50 ML0810/06.
51 PB0811/08.
52 PB0812/12.

Then, after having worked at a rural health centre for five years, he was transferred to the district health office. He claimed that it was not his own initiative to move from the rural centre. He did not have any problems with living in the bush, having grown up in a typical village. He had taken care of cattle and helped with farming when he was young. Rather, he had some problems managing his own small household; however, he held the principle: "If the community can do it, I can too". He remembered that he was interacting well with the community. It was just important to stick to agreements and to keep the trust of the community. He did remember some problems, however. A clinical officer, his boss at the centre, felt that as the person in charge he did not need to go on outreach programmes or organise neighbourhood health committee meetings. The respondent claimed the clinical officer felt that "he had grown up". Fortunately, after nine months he retired. When the respondent himself left the clinic, he claimed the "programmes were running typical". After five years he was shifted. As mentioned, it was not on his initiative. Rather, according to him the district health management team saw that he could contribute. He was made responsible for running the information department at the district level. He remembered that it was great to realise he was doing well and to get a more responsible position. In the next six years he was also sent to another district to hold the same job. Meanwhile, he was trained for the job he had initially held without the proper qualifications and got a certificate in integrated management of information systems. Then the person holding a similar position, but at the provincial level, went abroad for his studies. The provincial health director then reportedly asked the ministry headquarters to identify a replacement. On a tip from the predecessor, our respondent was appointed, though because of the abolition of the Central Board of Health and the restructuring he has still not been confirmed in his post for the last two years.

Through our respondent's account of what his work entails, we can also get a view of his erstwhile colleagues at other districts who thus indirectly were his competitors for his current job. He claimed that there are big variations in their competence: Some are computer literate while others just know the basics. In addition, in three districts the health information officers are on study leave to get their qualifications. He denied that these colleagues had negative work attitudes, though his further account did illustrate two such examples. To get reports from one district, he mentioned, he always had to phone, knock, or even threaten before a report came. The colleague really needed a talking to or some form of discipline, so our respondent influenced the provincial director to write a 'charge letter', an official notification that the colleague had violated applicable rules. The director did so and there was a marked improvement in the way reports were submitted. In another district, information was also not forthcoming. Again he influenced the director to write a letter, this time to the district director. "When things get out of hand sometimes you need a strong approach". From interacting with this respondent, I got the impression of a sharp and dedicated professional. When supervising staff at clinics, he took the time to teach and explain why demands for information from the centre are needed and how clinics themselves can benefit from collecting health information. In the explanation of the project he had launched to tackle his main professional problems – timeliness and completeness of reports and data quality – he also gave an impression of professional competence. He instituted two-day periodic meetings with the district health information officers in the province to go through the reports together. By doing peer assessment, they could also tackle quality issues by identifying errors. To ensure completeness, they would identify gaps in information from districts and carry

out technical support to the districts and centres who need it. It is paradoxical that in the case of this apparently competent officer, it was not certain that he will remain in his position after the restructuring. His certificate did not formally qualify him for the position he is holding. If a recent graduate with a degree in information technology comes along, he might lose out and have to revert to his old job at the district. Alternatively, he might decide to take up the job offers from NGOs and international organisations which he had earlier rejected.[53] Regardless of his apparent competence and despite the fact that he could be quite critical of issues further afield, he was careful not to address sensitive issues close to the office in which he worked.

The previous example has described a situation in which a vacancy emerged, in this case when someone moved on to 'greener pastures'. As in earlier anecdotes, there were few qualified candidates around to fill the gap. Apparently, a bright young man was picked and thrown into the proverbial deep end to learn on the job. Then, in the course of time, he was sent for a course to train him into the job he was holding. In this case it seemed that the sector could have gotten a far worse deal and some one far less competent for the job.

Perhaps more interesting than situations in which there are few qualified candidates are situations in which there is more competition for a position. Personal accounts in which a respondent reveals that more factors were decisive than his performance, competence, or qualifications are understandably rare. Presenting anything other than the ideal formal factors might draw suspicions of less legitimate factors being of influence in one's promotion. One enrolled nurse gave an account that does illustrate that having a good personal relation with one's boss helps getting a more senior position, even if you are not sufficiently qualified. He mentioned how he became the person in charge of a certain department in the hospital, although he had not trained further than enrolled nurse. "There were many applicants", he said, but because he had worked extensively with the executive director in the high-cost ward[54] and the director had confidence in him, he was selected for the position.[55]

We will return later to this issue of social relations in the context of appointments. But let us first examine how the matter of qualification plays out in determining who is in charge of a centre or a ward. In a specific hospital department, there was a clinical officer heading the department and an enrolled nurse in charge of the ward, as there was no registered nurse. An enrolled nurse recounted that he had been in charge of the ward from 2002 to 2006. "But then" he said, "the administration wanted us to swap, so that everyone could have the power for some period of time". Since then the role of being in charge was passed first to a male enrolled nurse and later to a female colleague. "This caused some difficulties between the members of staff. Now (the female enrolled nurse) is in charge, but even then, the CO (clinical officer) thinks he is in charge of all of us. Sometimes there is disrespect between us".[56] The clinical officer himself pointed out that he had become head of the department because of his qualifications as clinical officer. He mentioned that the enrolled nurse who had become in charge of the ward after our first respondent had been upset after being replaced as the in-charge. He had even requested a transfer because of the matter.[57] According to a colleague, he had to

---

53 ML0811/17.
54 This is a ward in a public hospital in which a patient pays extra for better quality treatment.
55 PB0809/02.
56 PB0811/02.
57 PB0811/10.

fight really hard but succeeded and moved to Kabwe.[58] The clinical officer reflected, "Someone is demoralised. Even though it doesn't make a difference in income, it is nice to be in charge, and when it is taken away, this is demoralising. It would be better if we had a registered nurse to be in charge all the time".[59] This account shows how the hospital management in this situation apparently rotated the authority of being in charge in an attempt at fairness. Nevertheless, it can bring conflict and disgruntlement. It also shows, however, how qualifications can be used to resolve disputes as to 'who's the boss'.

In other cases, however, using qualifications to decide who is in charge seems not to be uniformly applied, nor is it uncontested. Let us recall Anton, whom we encountered before. Despite his young age, this clinical officer had quite a track record of being in charge. He had been in charge of a rural health centre that was referred to as a zonal health centre. Although it had only three qualified and two unqualified staff, less than ideally recommended for a normal rural health centre, the clinic did have a rare ambulance. The previous clinical officer had requested a transfer after a conflict with the community. Then Anton had been posted in a different district. At that centre a midwife was in charge. Anton claimed that after he had been at the centre for two months, a letter arrived from the district health office putting Anton in charge. Anton claimed that the district said that there had been administrative errors.[60] Ashley confirmed that this letter indicated the faults of the former person in charge.[61] Then, after deciding to leave and return to the clinic where he was previously posted, Anton again became in charge. This meant that the environmental health technologist who had been in charge while Anton was away was again replaced. Anton admitted that there was some difficulty for the colleague to accept that he was not in charge anymore – especially considering that Anton had only been in service for 2 years, while the colleague had been in service for 22 years. Anton claimed that he was just put in this situation as a leader. To deal with the situation, he said he just had to humble himself: Show humility and discuss things.[62] From the words of an old nurse, who was working on contract at the clinic, I got the impression that this was indeed what Anton did. "Once you explain, he can understand. He's my boss". When asked why, she simply responded: "He's lucky".[63] The man who had been replaced as the person in charge was indeed disappointed and seemed to externalise the cause of the problem. "That is the system of the ministry. I don't understand. It's somehow frustrating. I have a lot of experience, a lot of ideas". According to him, the reason that Anton is the boss is because he is dealing with clinical work, while he often has to leave the clinic for outreach.[64]

Anton's friend Ashley put the fact that Anton was in charge simply down to the fact that he is a clinical officer. "According to the code of conduct, a CO is superior. But you should look at what is on the ground. There is theory but also practical knowledge and experience. It also may lower performance for some people. They may not show it, but being levelled lower than someone with less service years can become frustrating".[65] In one of our focus group discussions this frustration also came to the fore. The respond-

[58] PB0811/02.
[59] PB0811/10.
[60] ML0804/18.
[61] ML0804/15.
[62] ML0811/08.
[63] ML0811/09.
[64] ML0811/10.
[65] ML0811/14.

ents were unanimous in their verdict that it is not fair when a registered nurse with limited experience is brought in and is automatically put in charge. They felt that "if you serve long, then you deserve a promotion. It's better to automatically make a promotion after a number of years". One participant remembered that in the past the Ministry of Health promoted people, before the boards came. "You were just promoted based on years of service". These responses are very understandable in view of the fact that most participants in this group were more mature enrolled nurses.[66] It does indicate, however, a social tension in this system. In the past and also in African tradition, age and seniority were important factors in someone's social standing. As qualifications have now become so desirable, obtainable, and real (though not always decisive) factors in someone's placement and promotion, the relative value of age has declined. It is thus not uncommon to see what traditionally can be considered youths now in charge of their elders, and even (though this is less common) young women in charge of older men.

A clash over who is the boss can even come to blows in physical terms. One clinical officer remembered such an incident. "Some friends, they always go for entertainment, and they drink beer and quarrel amongst themselves". He recounted that, "about ten years ago, there were two officers, working together in a clinic, and when they went out they were both calling themselves the in-charge. It created confusion in the community and amongst the staff in the health centre". The respondent explained that when a health centre was starting up, an environmental health technician would be the first to be posted; they were the forerunners. After some time, a nurse and a clinical officer would follow him. As we saw above, in general the clinical officer would be made in-charge. In this case the environmental health technician had also arrived first and considered himself in charge. On the basis of his profession, the clinical officer did the same. The respondent concluded, "I was told to go and (sort out the problem), together with a DHO (district health office) officer. We gave them a job description". The respondent himself was promoted to senior clinical officer in 1996 and principal clinical officer in 2000. "We were applying for promotions. The public service looked at who had served longer. We were several (people with similar years of service) but I was chosen. I don't know why; we just handed in our papers, and they looked at it. I don't know the criteria". He stated that he thinks promotions are important: "You feel demoralised if you don't get up, you may even think of quitting".[67]

One respondent, who was no longer working as a government doctor, was a bit more revealing, even frank in his explanation of how promotions can work. He was once working as an acting district director of health in Southern Province, as the person holding the position was abroad pursuing a master's degree in public health. One frustration was the politics involved in holding such a position. "Working in a district has a lot of politics. When bigwigs come, they expect you to be there". He referred to politicians who request transport when they come to the district. Another frustration he recounted was that being in a more rural district gives little opportunity for promotion. "The way to get higher is through the province and it is mostly the junior guys in Livingstone (the provincial capital) who get those positions". He explained these 'junior guys' would be physically and thus socially nearest to the provincial health director. He admitted that there is an element of politics there. "The PHD can appoint or suggest

[66] FG0811/01.
[67] PB0810/12.

people".[68] He said in conclusion: "One has to be obedient to get a position".[69] It is striking that in this account, rather than what one might expect when thinking along the lines of the neo-patrimonial paradigm, it is not ethnicity or family relations that are stressed, but simply obedience and physical proximity. On the other hand, the account neither excludes such familial nor ethnic relations. It certainly does point to the obvious: That informal relationships are an important factor in promotion decisions.

The importance of informal relations as a factor in promotion decisions also becomes evident in the example of one Mr. Banda, which has been pieced together from various accounts. We have earlier quoted Mr. Banda saying that 98 per cent of the reasons for getting opportunities "is based on your performance, and 2 per cent is who you know". From other accounts, it appeared that 'who you know' may have been a bigger factor in Mr. Banda's career that he suggested. In a certain district, Mr. Banda had been appointed as acting director of health. Besides his two-year certificate course, he had followed various other training, even abroad. In an interview, he prided himself on these trainings.[70] They did not lead, however, to further academic qualifications. He was made acting director while his predecessor was on sick leave and he has since retired. A former colleague did not agree with this posting. She indicated that Mr. Banda had only two years of training and a certificate. There were people who were more qualified. Her explanation was that "less qualified people get hand-picked by the person who is there, because maybe they are less difficult. Those who are less qualified will then accept everything and be pushed around. (They) will be insecure and become hostile to programme officers".[71] An account by someone else, a doctor with no conceivable interest in the position himself, corresponded with and elaborated on this account. He mentioned that Mr. Banda's predecessor had been a nurse. When she received her retirement letter, another letter had already been prepared to appoint a doctor to take over as district director of health. Then, however, he claims that Mr. Banda went and had a talk with the provincial health director, saying that he would retire soon and asking if he could be appointed to act in the position in the meanwhile. This respondent argued that the provincial health director "just likes to surround himself with 'yes people'", people who are not too critical and who do not disagree with the director. He put this down to the fact that people who are district health directors and who are just nurses or environmental health technicians "just worship doctors" and, he added, "for the one who is worshiped, this is also nice".[72]

This image of a boss surrounding himself with cronies was also sketched in another context. Over a beer, a medical doctor complained about a director at the ministry headquarters. The criticism was that the director does not take criticism and just surrounds himself with loyalists. Our respondent remembered how this person was previously a district director of health at a time when he himself was working in a hospital in the same district. At that hospital there was a foreign doctor who had made a bad mistake in handling a patient. Our respondent had reported this to the medical superintendent of the hospital, who did not take action. Then he complained to the ministry headquarters,

---

[68] The procedure is that a provincial health director can recommend someone to fill a vacancy to the central ministry, and eventually, Cabinet Office and the public service committee have to approve this.

[69] ML0706/11.

[70] LB0809/03.

[71] ML0811/16.

[72] ML0812/03.

following which action was taken and our respondent was even asked to review the case. Subsequently, the district director of health heard about it and concluded that our respondent could not remain at that hospital. He was then promoted to the position of medical superintendent in a remote district hospital. While our respondent admitted it was a promotion, he claimed he was in effect removed for being too critical.[73] In yet another account, an official recounted how at a certain district, people were not forthcoming in answering a request for information. When colleagues complained to their boss about the director of this district, he reportedly said: "There is no problem; he is working". Our respondent argued that the district director is "from the same village" as the provincial director. "Some people are very good at talking. They might be favourites of the boss (who are) not doing well. But if they are his good boys or good girls, he won't be tough on them".[74]

Having people who may not be competent in a position may be useful for a superior who wants to have control over his officers, by having their loyalty because they depend on him for their job security. This is likely to have a negative impact on those working under them. In our discussion of the case of Ashley and Anton, we already saw the behaviour of one such official. The manager administration was an enrolled nurse, who trained to become a midwife and then landed a job in management. However, when Ashley and Anton made suggestions about how their work could be improved, they were told, "We have been here for a long time. You have just been here for a few months. You can't tell us how to run the district". And when Ashley had lobbied his own cause with the provincial health director, thus revealing the manager administration's incompetence, this earned Ashley his enmity and earned him a reputation as a troublemaker in the district.[75]

The above section has indicated that while qualifications matter – especially when qualified staff are scarce – in situations when there is more competition for a position, other factors can enter into play. Various accounts have suggested that bosses in certain cases prefer to surround themselves with uncritical loyalists who are insecure about their position. Having a boss who forgives them their incompetence, as long as they are 'his good boys and girls', may mean that those occupying a position are not the most suitable. In turn, this insecurity would reinforce intolerance to criticism or good performance below them as it would be perceived as a threat.

Such allegations resonate with perspectives stressing patrimonial aspects of the African state. They also resonate with Gerhard Anders' study of Malawian civil servants. He sketched a parallel order of informal office mores that operated next to the official rules and regulations. Rather than harbouring a sense of loyalty to an abstract state, Anders' civil servants feel loyalty to colleagues and superiors. The core of the moral principles underlying this parallel order is, in this perspective, the principle of "respect for the boss". These informal rules are "a very vague set of generally accepted principles open to negotiation and not known by uninitiated outsiders".[76] Moreover, as official rules may be unclear and contradictory, a gap exists between daily practice and official regulations. This, Anders argues, gives further legitimacy to the parallel system of office mores. The personal relationships in the Malawian civil service was based on two factors: The asymmetric patron-client relationship and mutual indebtedness. By offering

[73] ML0812/06.
[74] ML0811/16.
[75] ML0811/14.
[76] Anders, 'Civil servants', 207.

favours and overlooking transgressions such as illicit, corrupt acts, colleagues could maintain control over one another. While for some, such as young idealistic civil servants, the result of this social control – a culture of corruption and low motivation – may be vexing, few would openly oppose it as this would lead to social isolation, according to Anders. Those who would violate office principles would risk resistance or revenge, for instance by seeing promotion opportunities pass one by or by facing corruption allegations. A former donor official who had himself worked in the Zambian health sector had a similar impression of the Zambian health sector. He claimed it was a patronage system. He had the impression that people entering the system would be co-opted to be part of a conspiracy of silence. He claimed that one would be offered favours and perks which would contravene regulations, and if someone spoke out on abuses of the system, they would be blackmailed with their own vices. This situation, he insisted, caused many inefficiencies, hampered performance, and impeded change.[77]

This image of how things work and the allegations it is based on are very difficult to prove. Any description of the informal 'office mores', such as the one presented by Anders, is based on conflicting accounts, speculation, and innuendo. The same applies to the accounts of, for instance, Mr. Banda's promotion and other allegations of bosses surrounding themselves with incompetent yet loyal cronies. Such accounts may be influenced to an extent by jealousy at others' career successes and by attempts to cognitively find explanations for one's own lack of successes. Nevertheless, these allegations form a part of reality as those involved perceive and narrate it. As such, it becomes part of people's understanding of how things work, and it also influences how they themselves might act in a given situation. If personal relations based on loyalty or clientalism play a prominent part in how people explain how things work, it must indeed be a part of reality. At the same time, however, it has become evident how qualifications matter, how they are prized as a means of improving one's chances at a better life and a more secure livelihood. We also saw the importance qualifications played in determining access to jobs and promotion. This demonstrates that this rational arrangement of determining merit by whether someone has passed a course and attained a diploma or degree indeed has value. This thus confirms that in the Zambian health sector both meritocracy and clientalism co-exist as parts of the same reality as logics determining placement and promotion. This conclusion supports the notion of neo-patrimonialism as a hybrid of these two logics, in which rational-legal logic and patrimonialism are interwoven. This makes the formal bureaucratic reality less of a façade but more of structure or scaffolding in which opportunities for patrimonial behaviour exist.

It's a docs' world

Having examined allegations of clientalism in the health sector and having concluded that that is merely one side of the neo-patrimonial coin in a situation in which qualifications matter, let us investigate a different allegation of a patronage system within the health sector. We will examine a situation in which qualifications, rather than simply familial, ethnic, or political relations, are instrumental in determining whether or not one has access to the 'patronage' system involved. This may seem paradoxical, yet fits with the conclusion above that in a neo-patrimonial context rational-legal arrangements

[77] ML0X13/01.

are not merely façade but a structure around which patrimonial behaviour takes place. For this, we will take a side-step away from health workers' career paths by looking at a special cadre within the health sector: doctors. These cadres form an elite within the health system. Entry into this elite is determined by the merit derived from doctors having studied at least seven years to get the qualifications required.[78] Rising within the system, however, is again determined by factors other than mere merit, as we have seen earlier.

After an interview, Mr. Mulenga, the clinical officer in charge of an improved health post, showed me around his facility. The clinic, which is not equipped with a ward for in-patients, looked clean and orderly. Plastic drug jars were lined up on the shelves in the drug storeroom; exercise books, acting as patients' registers, filled up two shelves in the screening room; a desk with a few stacked-up registers and log books, office equipment, and jars of drugs appeared ready for business. The post had been opened only half a year earlier by the minister himself. Mr. Mulenga had taken that opportunity to tell the minister about his biggest concern. Although this health post had been designed for out-patients as well as being a base for conducting outreach activities in the community, it had not been endowed with a motorcycle. There was also no borehole at their facility for drawing water yet. The minister promised that these issues would be addressed. When asked whether the minister is open and approachable, Mr. Mulenga replied, "He is approachable, but in the implementation he just favours doctors". When asked what he meant, he indicated that conditions of service for doctors had been improving, but other cadres were overlooked.[79]

While drinking a beer with another health worker, the same theme came to the fore. This former clinical officer, having since obtained a university degree and working as a human resource specialist, also complained that the benefits for doctors were incomparable with those of other health workers. "Patronage is very much there in the health sector," he told me. The signs are clear. "The minister is a doctor, the deputy minister is a doctor, the PS (permanent secretary) is a doctor, and four out of six directors at Ndeke House".[80]

A survey of salaries and incomes of health workers in sub-Saharan Africa by McCoy *et al.* presents data for various countries. From this, one can learn that in Zambia, doctors earn more than four times as much as nurses. This difference is markedly higher than in Ghana (the only other country in this study for which comparable data are presented), where doctors earn three times as much as nurses. Studying the Zambia civil service salary scales for 2008 and adjusting them with the 15% increase that all civil servants received in May 2008,[81] teaches us that the lowest-rank doctor, for instance an intern (a junior resident doctor at the UTH), earns a gross salary of 4.1 million Kwacha per month, compared with 1.5 million Kwacha for the lowest-grade nurse, for example an enrolled nurse in the male ward at Mansa General Hospital.[82] In take-home salary,

---

78 Seven years is the length of time it takes for doctors to be trained at the Medical School of the University of Zambia.

79 LB0809/19.

80 ML0809/14.

81 PSMD Circulars No. B.5 and B.8 of 2008.

82 This disparity is to an extent lessened by the fact that the Zambian PAYE (pay-as-you-earn) income-tax system is progressive, which means that the richest pay more. This progressive tax system is not only a relic of Kaunda's humanist-socialist policies, but was even reinforced in 2007.

the intern at UTH thus earns 3.1 million Kwacha per month, while the nurse in Mansa gets 1.2 million Kwacha. Notwithstanding the equalising influence of Zambia's tax-regime, other factors inherent to the health sector have reduced equity in incomes among the health workforce, in favour of doctors. It is well known that a significant proportion of civil servants' incomes in Africa is made up of allowances. Attending workshops and conducting field visits, people earn subsistence allowances and meal allowances. Housing allowance is also paid. Besides this and various other allowances – such as funeral grants, uniform upkeep allowance, tool allowance, and commuted night-duty allowance,[83] when relevant – there is an allowance that is given to doctors only: On-call allowance. This is a standard monthly payment to doctors to compensate them for the fact that they can be called to perform emergency interventions, regardless of how often they actually conduct rounds.

This on-call allowance involves very significant sums of money. As of July 2008, the on-call allowance for medical doctors was increased from 2.6 million to 3 million Kwacha for the lower and medium grades of doctors, and from 3 million to 3.4 million Kwacha for the most senior doctors (senior registrars and consultants). This payment alone is at least two and a half times the base monthly salary of our nurse in Mansa, who earns 1.2 million Kwacha.[84]

But it seems that many doctors in management and administration receive on-call allowances while they rarely or never make calls. One informant explained the workings of on-call allowance. During one of my interviews, I asked a medical doctor working as a district health director whether he missed doing clinical work, as he was currently holding a managerial position. He indicated that he did occasionally do rounds or helped out in the district hospital when it was busy.[85] Shortly afterwards, in an informal setting, I told the medical superintendent of the local district hospital that I had heard the district health director occasionally helped out. He looked surprised, told me he did not, and concluded that he probably had said that to be entitled to receive on-call allowance.[86] In another district, a very frank planning manager, frustrated by doctors as managers, told me, "We need doctors in wards. When a doctor is needed, he may be in a meeting or a workshop. They get on-call allowance, but are not offering service".[87] He and other informants claimed that even doctors who are managers or administrators at Ndeke House receive on-call allowance. While this is not formally illegal, it is clear that this measure does not serve its nominal function, namely to compensate doctors for the inconvenience of being prepared to respond to emergencies.[88] One could thus arguably call this misapplication of funds.

Besides a difference in income, there is also a difference in status between doctors and other health workers. As in many countries, a doctor's title is rarely forgotten when

---

82 At that time, the tax system was made even more progressive. This is likely to have been a reaction by the MMD governments to Michael Sata's campaign in the 2006 elections, where his campaign for lower taxes and 'more money in your pockets' appealed to working-class Zambians.

83 PSMD Circular No. B.7 of 2003.

84 PSMD Circular Minute No. 2. of 2008.

85 ML0706/17.

86 ML0706/36.

87 ML0811/15.

88 While the PSMD Circulars and the *Terms and conditions of service for the public service* that were available to me did not spell out the way in which on-call allowance is administered, the above is my understanding after speaking with various informants.

addressing him.[89] The social standing of doctors was also exemplified by one of my informants when he explained why he chose to be a doctor. Initially he had wanted to become an engineer. Then, however, he had a chat with an uncle. The uncle said that in his long life he had never seen a poor doctor, while he had seen many poor engineers. He had never seen a dirty doctor, while he had seen many dirty engineers.[90] One can assume that, in the collective memory of Zambians, doctors historically took a special place when in the colonial period they stepped into the spiritual realm of *sangomas* and other traditional healers carrying powerful *white-man's* or modern medicine. In fact, with only three indigenous Zambian doctors at the time of independence and considering that a African could for a long time not aspire to a higher position than medical assistant,[91] it is no surprise that doctors still are considered special.

Doctors' status is demonstrated not just in terms of income or by occupying an honorific position. Organisationally, doctors also occupy a special place within the health sector. All doctors (and pharmacists), from the moment they appear on the government payroll as junior resident doctors or interns, occupy management scales.[92] For all other medical personnel, only the top three out of eleven scales, are management scales. Those in management scales, such as doctors, are not unionised. This was explained by one doctor as follows: "Doctors are officially part of management. They should come up with solutions for problems. So they should be the last to complain: The head should not protest; the head should offer guidance. Doctors do not have a legal platform for defending their interests. They should rely on the same union that they don't belong to. The Resident Doctors Association (RDA) has no legal authority for collective bargaining. (Formally) they never engage with government: They advocate".[93] For other health workers, the Civil Service Union or the Health Workers Union bargain with government over working conditions. Doctors, however, do meet with the minister in management meetings, but that is what my respondent euphemistically called consultation or advocacy rather than bargaining.

Being in management scales also means that doctors tend to dominate management positions. At one mission hospital, which was still served by resident missionaries (expatriates), I met a Zambian hospital director who by his own account is the only non-doctor serving in such a position. He indicated that it does create some resistance from doctors.[94] If not for the fact that he was working in a mission setting, which has some managerial autonomy, he would probably not be holding this position.[95] Normally, in small hospitals, a doctor – even if there is only one – is automatically the director or medical superintendent, and thus involved in considerable administrative responsibilities. In mission hospitals, hospital administrators can play an important role with commensurate status, by the grace of being attached to the church or the mission. At times, it is vexing for health workers posted by government to be, as they see it, bossed around by Catholic sisters whom they perceive as being less qualified, but who have the church behind them. However, in the formal structure as well as in common practice,

---

89 In Zambia among colleagues this is often shortened to a familiar 'Doc'.
90 ML0812/03.
91 ML0811/02.
92 ML0810/09, and ML0812/03.
93 ML0812/03.
94 ML0607/20.
95 In fact, in the restructuring this looks set to change: The approved establishment MoH (2007) shows the same management structure as other similarly sized hospitals: A head of clinical care, a medical superintendent, and a senior hospital administrator at a far lower rank.

doctors are the boss. To illustrate this point, a medical superintendent in a provincial hospital holds the highest medial doctors' scale (MDS01), whereas a senior hospital administrator is given a medium-rank general service scale (GSS06). This corresponds to a net base salary of 5.3 million Kwacha per month and 2.2 million Kwacha per month, respectively.[96]

The process of restructuring has not only confirmed this exclusive position for doctors in management: It has even strengthened it. This is most apparent from the fact that the position of district health director has been abolished and replaced by a district medical officer, a situation which is as things were before the health reforms of the 1990s. According to the report of a presentation by an official involved with the Health Reforms in 1994, the position of district medical officer was first introduced in 1982 but had since never been formally elaborated. De facto, the district medical officer was responsible for the management of a district hospital where he was posted. According to this account, the health reforms were yet to bring further clarity to the role of a district medical officer. In 1994 a new position was created, that of district director of health, who from 1995 onward would take over the financial and administrative responsibilities of the district medical officers.[97] In practice, as is seen from the stories and career histories of various health workers interviewed, these were often environmental health technicians or clinical officers, and sometimes nurses or midwives. To prepare them for the roles they carried out, they were trained, through various workshops, but also by the district health management course at Kabwe. However, a number of young Zambian doctors were also recruited to fulfil such positions, though this was less common in the most remote rural areas.

It might be instructive to view this policy change in the 1990s in light of the fact that at that time there were very few Zambian doctors available (or prepared) to serve in rural areas. In many cases, district medical officers were expatriates. In fact, a decade earlier none of them were Zambian.[98] The shift towards moving management responsibilities, and thus power, from expatriate doctors to Zambian non-doctors can be seen as a logical extension of the rationale of Zambianisation, which had been a major theme in Zambian public service since independence. Or to put it in cruder terms, it secured access to the power and benefits of management for a considerable number of Zambians. A decade later, anything other than a Zambianised district health management is inconceivable. Moreover, more doctors are available and willing to serve in districts, especially with the doctors' rural retention scheme in place (as discussed in Chapter 10). In the process of restructuring following the dissolution of the Central Board of Health, it has been deemed that the management of the district health system, which as we know is central to this system, should in principle be in the hands of a qualified medical doctor.

In interviews, I encountered various sides to this argument. One high-ranking doctor in a provincial hospital[99] bemoaned the fact that in certain provinces hardly any district health directors are doctors. In his view, nurses or environmental health technicians are

---

96 At entry level, without allowances.

97 MFA (1996), Verslag APO Dienstreis Zambia: EKN files ISN 2266.

98 Kalumba, K., *Towards an equity-oriented policy of decentralization in health systems under conditions of turbulence: The case of Zambia* (Geneva, 1997).

99 Who, or so unconfirmed rumours said, had tried to get a position as district health director and lost out to a non-doctor. This position was given instead to an environmental health technician, who would be less outspoken and less likely to challenge his superior.

not qualified enough for the complex public health role they have to fulfil. Doctors, on the other hand, have gone through seven years of training and, in addition, often hold masters' degrees in public health. He mentioned that in a province such as Luapula, where until recently none of the district health directors were doctors, the maternal mortality figures were far higher than in Southern Province, where most district health directors are doctors.[100] Another doctor holding a senior management position also made the argument of doctors being more qualified. He added that he had studied public health, which he considered to be "political medicine". "I've gone beyond clinical medicine. I am in charge of AIDS and TB-programmes. You need a technical background for that". He went on to compare it to generals, who are soldiers sitting in the office making battle plans.[101]

On the other side of the argument, one can find those who have climbed up through the system and see a threat of losing career possibilities or even being posted back into clinical positions. Mr. Zulu, a planning manager serving under a doctor working as a district health director, said about the decision to make a district medical officer the head of a district health office: "Things are going back to how it used to be: A doctor on top because those are people with respect. Now they want to put all our doctors in management, leaving only Congolese doctors in the rural hospitals. In the whole province, it's just Congolese. Some don't even have work permits. Zambians are just in districts (district health offices). In most rural districts there is even not much work for them. You don't need to study seven years, just to be able to sign checks and go to meetings". He added that maybe for larger districts or provincial towns it is fine to have a doctor as a district health director, but not in rural ones.[102]

People like Mr. Zulu stress that academic qualifications alone are not enough to make someone competent, as these are no substitute for experience. Some qualifications even mean that doctors are perhaps not even properly qualified. In Mr. Zulu's words, "Doctors are not trained at primary health care. No doctor has ever worked at a rural health centre. Some might have MPHs (masters' degrees in public health), but public health is different from primary health care. Also being trained in something is different from actual working experience". In explaining the importance of primary health, he invoked the vision of the health reforms, which were based on the concept of primary health care. This centred on how to fund the disease burden, based on equity. He added, "That means you have to understand programmes and partnership. These doctors don't understand that".[103] Moreover, various people in Mr. Zulu's position are keen to list the workshops and training programmes they followed. One former nurse, who had made it up to human resource specialist, even complained, "they are throwing away our papers".[104] By this she meant that in the restructuring process, university degrees are valued over in-service training.

As we saw, the argument has two sides. Both make sense from a rational perspective, but then again both points of view reflect the interests of those expressing them. A doctor will obviously argue that his seven years of training and the barriers that there are to get into medical school (that is, the fact that they need good secondary school grades) naturally make him a better candidate. On the other hand, someone who climb-

[100] LB0809/01.
[101] ML0809/16.
[102] ML0811/15.
[103] ML0811/15.
[104] ML0811/16.

ed up the rungs of the district health service will stress the importance of experience and in-service training. In other words, you stand where you sit. The discussion, however, does illustrate (yet again) the importance that is placed on qualifications, though this can be at odds with experience and need not reflect competence. It also shows how managerial positions are coveted and contested and that doctors use their power to claim senior management positions.

It is not automatically the case that doctors actually and necessarily prefer administrative over clinical work. When arranging permission to interview people at a central hospital on the Copperbelt, I ran into a senior doctor who had to sign my permission letter. When I asked if perhaps I could interview him, he sighed in an exasperated way, "No, I don't have much time. That's what you get when you have to combine your clinical work with administration: You get torn apart".[105] It goes without saying, however, that the authority and status that come with managerial positions, with being closer to the top of the bureaucratic pyramid, is appealing to doctors. Beyond the salaries, which already are favourable to doctors, the access to workshops, meetings, and domestic and foreign trips also add a financial incentive. This is in addition to the more illicit ways of amassing wealth and power through clientalism and corruption, which the paradigm of neo-patrimonialism presumes to be opened up to office holders.

So, how have doctors as a group attained the influence to shape the formal rules of the game to their advantage? The fact that doctors are not unionised is not to say that doctors never engage in industrial action. From the media analysis conducted for this research, one can determine an entire string of doctors' strikes throughout the 1990s. This culminated in massive strikes (described in Chapter 9) at the end of the decade as a precursor to the anti-third term campaign. This episode of public unrest marked an absolute low-point in President Chiluba's popularity. The government's reaction was usually a threatening one. Ministers told doctors that they would be fired if they did not resume work. In 2000, hundreds were indeed laid off and at the same time deregistered as doctors by the Medial Council of Zambia. One respondent who was one of the leaders of the Resident Doctors' Association at the time was indeed fired and deregistered. He then started working in the private sector for the next two years, but only after he paid a fine of half a million Kwacha (roughly equal to € 190 at the time) to the Medical Council. In his words, "the instruments of government were used to mete out punishment".[106] Two other informants had also been active in strike action as organisers of the Resident Doctors' Association at different times in the 1990s. They were both posted in far-flung rural areas as a consequence: One in Zambezi district in North-West Zambia on the border with Angola, the other at a mission hospital in Southern Province a good distance off the line-of-rail.[107] One former senior official at the Ministry of Health admitted that indeed young doctors who displeased government with political actions and who were not in the position to opt to go abroad for work or study would be sent for rural postings. He also admitted that this gave the practice of mandatory rural posting, intended to familiarise young doctors with rural realities, a bad name.[108]

While these doctors who asserted their rights were indeed punished for their dissent, in the long-run their careers were not irreparably damaged. One of the three informants ended up in a high position at an important NGO, one obtained a high and influential

[105] ML0810/12.
[106] ML0812/03.
[107] ML0706/05, LB0809/01.
[108] ML0811/02.

position at ministry headquarters, and the third became the executive director of a second-level hospital. One can expect, however, that it has conditioned them to be wary of being too critical or openly venting dissent. As such, the reaction to striking doctors was part of the strategy of managing loyalty. On the other hand, the government has equally learned the power doctors have. The doctor who was active in the strike of 1999 looked back in the following way: "Time revealed that we were right. We had the right to protest. It has raised awareness. In time they learnt never to take doctors ..." Then he corrected his slip, "never to take *health workers* for granted". When I pointed out his slip, he admitted that it is true that attention has been more focussed on doctors and that this was the downside of the protests. In fact, the gap between doctors and others had widened. He added: "We were campaigning for better conditions of service and doctors did benefit. There is a fear of doctors. Conditions of service have never been the same. Then we couldn't get loans; now we are creditworthy. Salaries have gone up since; on-call allowance is up and continues to rise".[109]

These strikes have thus instilled a fear in politicians that doctors could walk away if disgruntled, not only through strike action but also by searching for greener pastures. Doctors are scarce and are trained at the public cost. Despite not being unionised, doctors are extremely well represented in management, and ministers hear doctors' complaints and when possible address their concerns. The fact that, for much of the Mwanawasa era, the minister and his deputy were doctors must have been a factor adding to doctors' privileged positions. As the doctor cited above put it, "Having a doctor as a minister works better for MoH. Their understanding of issues is deeper. That is a big advantage". He did admit, however, that the disadvantage is that they might be biased towards doctors' welfare, to the expense of other cadres.[110]

Doctors' privileged position is not only manifest in the formal organisational structure and reward system of the health sector; it also appears that doctors form an informal network of acquaintances and are informally awarded priority over others. A former doctor, who has since moved to a development agency, mentioned that after her internships she was working at a large hospital on the Copperbelt. She felt, however, that she could learn more if she was working at a lower level in the system, closer to the community. The hospital refused to let her go, however, so she went to a doctor she knew who was working as a senior official in the ministry. It took a lot of informal influence and overcoming a number of bureaucratic barriers, but at the end of the day she was posted to a district and after two months she was on the payroll in her new capacity. She told to me that she was lucky to be a doctor as they are considered a priority.[111] A similar story was also related by another doctor who, when I spoke with him, was working as a district health director. He was also working in a large Copperbelt hospital. He felt the job was routine and was looking for a new challenge. Again, the hospital did not want to let him go. So he called someone who was his senior in medical school and held a management role in the Central Board of Health. He claims he was offered a choice of a number of positions and chose a far-flung location for the adventure. There he replaced an environmental health technician as district health director.[112]

---

[109] ML0812/03.
[110] ML0812/03.
[111] ML0706/13.
[112] ML0706/17.

When chatting informally with health workers, it struck me how, particularly among doctors, people have a good sense of who is who. This is not surprising as the number of doctors in the health sector was rather limited, with some 650 doctors working in the sector in 2005. If this was narrowed down to the Zambian doctors working in the government system, it would be even more meagre. This is likely to have something to do with the fact that there is only one medical school in Zambia, with an intake of some seventy students per year.[113] Combined with the absolute scarcity of doctors, it is safe to say that doctors form an elite network that has the power and influence to advocate effectively for the interests of the group and allow members to serve effectively their private interests.

Conclusions

In the preceding pages, we have sketched the factors that play a role in moving up the hierarchical ladder in the Zambian health sector. It has been striking to see how qualifications have been prominent in the way in which people talked about getting ahead; it is clear that people value further education as a means for professional advancement. The extent to which government invests in further education, by offering paid study leave, by suffering existing vacancies while officers are on study leave, and by sponsoring some staff and subsidising government schools is enormous. This is understandable considering the historical scarcity of qualified health workers. Again, as we have seen in the previous chapter, as opportunities for further education are scarce, positions are contested. This leads to disgruntlement amongst those who fail to access further education. To an extent, people consider prior qualifications and school results to be the key to accessing education – hence people's willingness to re-sit secondary school exams. On the other hand, those who miss out put this down to unfairness in the system, blaming advantages for those in urban areas or blaming clientalism and nepotism.

It remains evident that qualifications are prized. One can see this in the manner in which some respondents continue to stack qualifications. At times, this constitutes a logical career progression, but equally it can seem rather random or arbitrary: It depends on which opportunity for further education they can secure. The tendency to change one's professional path raises questions again about the motivation driving people professionally: Is it primarily an extrinsic money-oriented motivator that drives people's decisions? Moreover, it raises questions about whether individual ambitions to forge ahead, subsidised by government, are in fact in the public interest, in the interest of the public health sector. Of course, considering the scarcity of qualified health workers, public investment in training is logical. On the other hand, the health workers whose accounts we have examined are well aware of the fact that through further education their labour-market value increases. While in their accounts one hears some gratitude to government for the public investment that qualified them, they are also well aware of the fact that this increases their chances of employment in the private sector or possibly abroad. Moreover, as we have seen, going for further education provides a professional with skills and knowledge that are only of limited usefulness in most parts of the Zambian health sector. Some may in fact be training themselves out of the bush and even out of the country. The pursuit of upward mobility by individuals within the sector

[113] MoH (2006), Human Resource for Health Strategic Plan 2006-2010.

can thus be seen to increase the skewed distribution of human resources within the sector.

This is not to say, however, that the health system does not react to this potential divergence between private and public interests. People wanting to go for further education have to make sure their plans are taken along in the annual planning process, they are recommended by their bosses, and this is approved at higher bureaucratic strata, to try to rationalise in-service education. In addition, some health workers are coaxed to come and work in more remote or less popular posts with the prospect of being supported to go for further training after a certain period. Those who are educated at the public expense may also receive bonding letters requiring their service for a specific period of time. Failure to adhere to such bonding requirements risks losing pension benefits. In short, one can conclude that there is a struggle between health workers and the health system over whether one can access further training opportunities. This struggle represents a tension between private interests for self-advancement and the official objectives of the health sector.

Having discussed the quest for qualifications, let us now turn to the issue of professional advancement. We have seen how some health workers on their own initiative retrained to qualify for management positions. We examined the accounts of three clinical officers who became human resource managers. While arguably it is valuable for the health sector to have human resource managers with the experience of working within the sector itself, one can debate whether it is worth losing scarce qualified curative staff such as clinical officers. From an individual perspective, however, it is understandable, as apparently there are benefits to being in management positions that are not experienced in the wards or in rural health centres. These can be benefits in terms of influence, power, and financial gains.

When assessing the factors that played a role in people being appointed to more senior positions, we saw that in people's own accounts qualifications and performance featured prominently, as can be expected. However, looking beyond such discursive justifications, we saw a difference between situations in which the scarcity of qualified staff meant little competition and other situations, especially those concerning positions of authority where there were more aspiring candidates. In situations in which positions were more contested, it appeared that, at least in people's perceptions, issues of obedience and loyalty are an important explanatory factor for promotions. Being outspoken or critical, one can be considered as 'a troublemaker'. These people may then be transferred elsewhere. As we have discussed, accounts of directors who surround themselves with 'good boys and girls' and who consider those who are critical as a threat point towards a strategy of managing loyalty. This resonates with images conjured within the neo-patrimonial paradigm and accusations of African bureaucracies being patronage systems. However, again we can conclude that it is not clear-cut whether personal factors or issues such as merit or performance are of primary importance in someone's professional advancement.

In the last section of this chapter we took what may have appeared as a side-step, by looking in some detail at the privileged and influential position occupied by doctors in managing and shaping the health sector. We saw how, in the views of other health workers, there was a feeling that there was an unfair bias towards doctors in the sector. One respondent even described it as patronage. It was pointed out that most of the senior management positions and at times the political leaders of the sector were doctors. Indeed, in our analysis we saw that the advantage that doctors enjoy over others in

terms of salary levels is further increased by the use of on-call allowances, allowances paid in some cases that one could call dubious. This illustrates the privileged position doctors occupy in the sector. Moreover, doctors automatically occupy management scales and thus qualify for the most senior managerial positions in hospitals, districts, provinces, and the ministry headquarters. In the recent restructuring of the health sector, doctors' hierarchical seniority was reinforced by transforming district health directors into district medical officers and demanding medical qualifications as a prerequisite.

There are various sides to the argument justifying or contesting doctors' dominance in the health sector. This was reflected in the accounts and opinions of the respondents, depending on which side of the fence they sat. On the one hand, doctors assert that due to the qualifications they possess they are simply the most competent to manage the sector. They better understand the technical aspects of public health needed to formulate a policy response and its implementation. Conversely, people question whether the highly technical and clinical training doctors receive prepares them for the management of people and resources in a bureaucratic and political environment. These respondents are more likely to argue that experience and on-the-job training are more valuable qualities. Finally, there is an efficiency argument to be made about doctors' heavy involvement in management. Can a country in which medical professionals are so scarce afford to have them occupy so much of their scarce time on management and administration?

Regardless of how one might judge doctors' dominance in the sector, it is an important conclusion for this section that doctors as a professional group, and also as an informal network of acquaintances, have extraordinary power and influence within the health sector. Doctors' are empowered by their scarcity and ability to withhold labour. Moreover, they occupy most positions of power, thus controlling many of the financial and human resources in the sector. This conclusion is remarkable as it challenges or at least nuances certain tenets of the neo-patrimonial paradigm. It is assumed that in neo-patrimonial settings vertical patron-client relations are more dominant than horizontal cleavages such as class or professional distinctions. In the context of the Zambian health sector, it is evident that doctors' qualifications are a real factor in determining the structure of power and authority. Entrance into this privileged group is essentially based on merit, as one is required to successfully complete medical school. While informal contacts arguably do play a role in getting into medical school and in further career advancement, the process of qualification is of primary importance.

The accounts presented in this chapter and the patterns emerging from them pose serious challenges to the neo-patrimonial paradigm. Central to this chapter was a conflict between an individual's interests in further advancement and the public need for an equitable and cost-effective distribution of human resources. This is a clash between public and private interests, reminiscent of the public–private confusion central to neo-patrimonialism. However, can one call the pursuit of qualifications and professional advancement patrimonial? This pursuit is in no way reminiscent of the imagined traditional patterns of gaining advancement through loyalty and personal affection. However, if one projected a rationality on this quest for qualifications as a means of accessing prebendal positions of power and wealth, one could stretch the concept of patrimonialism to cover such behaviour. Many of the health workers featuring in the accounts above do not appear to be passive clients dependent on their patrons. Rather, empowered by their scarcity as qualified health workers, they display an agency and a mobility that allows many of them to seize and even manipulate opportunities. At the

same time, we also saw patterns in which office holders with decision-making power selected people who were under-qualified, to take up key positions below them. It can be assumed that this would indeed foster a certain measure of dependence and personal loyalty towards themselves in a patron-client relationship. Thus, while it is evident that the human resource structure in the Zambian health sector is primarily governed by the rational-legal principle of qualifications, this forms an arena in which agents can instrumentalise this reality and seize opportunities to further their private interests. This includes creating opportunities to forge patron-client relationships. However, the most striking feature of the Zambian health sector is that one of the most powerful social networks in the sector is an institutionalised patronage system that is firmly rooted in the rational-legal principle of qualifications: The dominance of doctors.

In this chapter we have followed our health workers further into the sector to see the factors involved in getting a position of authority, which also means a better income. In this quest to forge ahead, we have seen indications of health workers' behaviour and perspectives in pursuit of their private interests. Let us now continue following the accounts of our health workers, to further examine their private interests by looking at how their careers fit into their broader life-world. What financial imperatives motivate them to struggle for qualifications and further professional advancement?