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Author: Leenstra, Melle
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"We're struggling financially": Competing claims

In the preceding chapters it was argued that securing a steady job with a steady income was an important motivator for people to join the health sector, as we saw in Chapter 3. We saw that completing college, qualifying, and subsequently landing on the government payroll can be the difference between employment 'for life' and working in the informal sector or in small-scale agriculture. While health workers are fortunate when compared with the rest of the population, when speaking to health workers it is very common to hear them complain about the 'peanuts' they get paid. One enrolled nurse, Mr. Musonda, sympathetically formulated it thus: "I declared myself a volunteer in June 1996 ... Because of the conditions of service, if you work in a (rural health centre) you can't be motivated by the money, so you need to find another reason to attend to your patients".[1] Even doctors who, as we will see later, are much better off than other health workers feel they should be earning more: "Money is never enough, right? But I cannot complain, although with hours and risks it should be much higher. Doctors are least paid amongst professionals but exposed to more than bankers".[2]

In this chapter we will analyse health workers' assertion that they do not earn enough. We will look at the competing claims that they encounter from society, which might explain why they present themselves as 'struggling financially'. We will also look at health workers' strategies for 'working beyond the payslip' and supplementing their income from other sources. We will then examine how this quest to make ends meet may impact on the system that employs them. Do the social and economic pressures facing health workers explain patrimonial behaviours?[3]

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1 PB0811/14.

2 PB0812/04.

3 Note: The aim here is to understand, not to judge or to justify.

Salary and allowances

First let us get an impression of what health workers actually earn and what are the basic costs of living. Let us take, for instance, three people working in the health sector and see what they are earning in terms of salary. One is Mr. Musonda, the enrolled nurse working at a rural health centre, who calls himself a volunteer. Another is Brixton Mutale, a district stores' officer, who worked himself up from garden boy, then worked as a registry clerk in the personnel department, and who is now following a distance-learning course to qualify himself for his current position. The last is Dr. Chisa, a doctor still doing his internships at the UTH in Lusaka. As a net base salary, Mr. Musonda earns about 1.1 million Kwacha, and Dr. Chisa earns 3.6 million Kwacha. Brixton, if he was paid according to the position he is occupying would earn about 1 million Kwacha; however, even though he has been working as a stores' officer, he has not been confirmed in this position, probably owing to the abolition of the boards and the ensuing restructuring, and also because he has not yet attained the appropriate qualifications. In the meantime, he is earning an estimated 720,000 Kwacha.[4]

In Zambia, base salaries present only a modest part of the income a government employee gets from their day job. A further part of the income is furnished by a complex of allowances which are difficult to fathom. Some of these allowances are monthly entitlements; others are incidental. An important monthly allowance is housing allowance. Even though the *Terms and Conditions of Service for the Public Service* from 2003[5] makes no mention of housing allowance, such an allowance is received by all those who are on the government payroll. According to a complex collection of circulars from Cabinet Office, general workers, including Brixton, receive 110,000[6] Kwatcha per month; a nurse such as Mr. Musonda is entitled to 200,000;[7] and junior doctors such as Dr. Chisa get 570,000.[8] Previously, people who had received a housing loan from the government or had bought a house under Chiluba's housing empowerment scheme received a considerably lower 'owner-occupier' allowance, but this has since been reversed. Now people who get accommodation provided by government have to pay the government a token rent of 7 to 12 per cent of their housing allowance, depending on the standing of the neighbourhood.[9] Another allowance that is a fixed monthly amount is on-call allowance, which is specific to doctors only and is a considerable contribution to their income. Earlier we have discussed this discrepancy between doctors and others in the health sector at length (Chapter 4). This means that Dr. Chisa gets another 2.6 million Kwacha added to his gross salary.[10] Doctors and nurses can also get a monthly uniform upkeep allowance of 35,000 Kwacha and tool allowance of 20,000.[11]

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[4] Refer to Table 5.1 for a full comparison of incomes and their euro equivalent

[5] Which one senior official referred to as our Bible or Koran, while later admitting, "We are all sinners".

[6] PSMD Circular No. B.16 of 2008.

[7] PSMD Circular No. B.8 of 2008.

[8] PSMD Circular No. B.5 of 2008.

[9] In the more up-market 'low-density' neighbourhoods, this is 12 per cent, and in 'medium- and high-density' neighbourhoods this is 10 per cent and 7 per cent respectively.

[10] PSMD Circular Minute No. 2. of 2008.

[11] PSMD Circular No. B.7. of 2003. While I was informed this was the applicable circular, these amounts may have been revised upwards, judging by a nurse's account that she received ZMK 40,000 in uniform allowance.

As mentioned in Chapter 4 and to be examined more closely in Chapter 9, there is a health workers' retention scheme, which came about as a result of a donor initiative. To certain cadres – initially only doctors in rural districts, but later also nurse tutors and even some lower cadres in the most remote health centres in rural districts – a rural hardship allowance is provided, and depending on their rank they can receive other perks such as an education allowance for school-going children, house loans, vehicle loans, and so forth. Besides this donor-funded health workers' retention scheme comprising a hardship allowance, there is also a government provision for rural hardship allowance, which also applied to cadres in other sectors. Recently this arrangement was adjusted so that it targets centres at a given distance from such amenities such as shops, banks, and petrol stations. Officers working at such rural locations are then entitled to an extra 20 per cent of their salary, while those at stations considered remote (even more inaccessible) receive 25 per cent extra.[12] This change in this arrangement has meant that some who had previously profited from this allowance later missed out. Or to put it in the words of one nurse, working at a reasonably well-staffed health centre along a tarmac road at no more than thirty kilometres from the provincial capital: "They removed rural hardship allowance, which was boosting us".[13] Assuming that Mr. Musonda's clinic is far enough away from basic amenities, he also receives rural hardship allowance. At his salary, this means roughly an extra 290,000 Kwacha per month.

In addition to monthly allowances there are incidental allowances connected to the activities that various cadres conduct during their work. Those health workers at hospitals or larger clinics that have night duty can receive a commuted night-duty allowance of 30,000 Kwacha. Staff at rural health centres are to conduct outreach activities, for instance for the immunisation of children. For these activities they are entitled to allowances. Moreover, for workshops and training, and for certain meetings, field visits, and other incidental activities, government employees are entitled to transport allowance, subsistence allowances of between 140,000 Kwacha and 165,000 Kwacha, and/or meal allowances of 50,000 Kwacha per meal. Considering the fact that, especially if someone spends wisely, actual costs can be lower than the allowance given, this provides a potential extra something to bring home. For instance, a local meal[14] at an eatery next to Cabinet Office in Lusaka cost me 17,500 Kwacha, whereas for the allowance of 50,000 one could eat at a much more up-market restaurant. The fact that people try to earn on allowances is also reflected by something a district director of health jokingly admonished the participants at a workshop: "Travel safely. You all have been given transport allowance to get home, so don't let me catch you hitching rides on bikes or balancing on overloaded trucks".[15]

Of course, these allowances are not always paid promptly or equitably. One health worker mentioned that while in his current district allowances are paid on time, at the district where he was previously it "was terrible": Allowances were rarely paid on time, if at all. "Because of that, people wouldn't go on outreach any more, and the immunisation numbers are very low. People are de-motivated. You would be spending time on outreach without knowing if you will get the allowances. I also stopped going when the allowances stopped. The allowances started piling; on paper I had a lot of money".[16]

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[12] PSMD Circular No. B.2 of 2008.
[13] LB0809/18.
[14] Consisting of *nshima* (stiff maize porridge), village chicken, two vegetables, and a soft drink.
[15] ML0804/23.
[16] PB0811/33.

A colleague echoed this: "When I was in (another district), we used to get our allowances only after six or seven months. This affected the work, because the (outreach) work is very involving, and when you don't get paid for it you get frustrated. You develop an attitude towards the patient that is not good".[17] These examples not only reflect the fact that allowances can apparently be paid irregularly, but also that people strongly perceive them not only as incentives but as entitlements: If they are not paid, some will refuse to do their work.

Some workers lack the possibility to carry out activities that earn allowances. Brixton, for instance, hid a complaint in the positive attitude that he presented: "I like working for the Ministry of Health, but I'm being denied of certain enjoyments. I don't get the tasks with which I can get an allowance, such as night duty or missing lunch. But my vision is that I perform, and that I enjoy work".[18] Furthermore, the number of workshops one can follow is not equitably distributed. The following remarks, recorded from a nurse, hint at the lack of transparency and the sense of unfairness people perceive in being picked to go for workshops. "Administration picks you; you can't apply. It's unfair who gets picked. Everybody wants to learn something. Administration should look into that more carefully. People pick themselves, leaving the ones who work in the wards with the patients".[19] This allocation, in part, depends on the different cadres. "There is a lot of extra knowledge in workshops. It depends on the profession how many chances one gets to attend a workshop: There are many for the lab and much fewer for nurses. In the lab, most of the colleagues have attended workshops".[20] A theatre nurse also felt her department was left out: "We are like forgotten. You can only go when you talk too much, so they remember you. For example, PMTCT[21] training is important for us, but they forget that. They forget that we are very vulnerable for HIV in theatre. You keep going and talking to management, but most of the theatre staff have only been to one workshop".[22] From this account one can deduce, as we have seen earlier, that those who are assertive have a better chance of getting what they want.[23] At rural clinics, however, the problem of understaffing can have a positive side, as one in-charge mentioned. "When there is a workshop, I don't have to decide who's going, because I'm just alone".[24]

Again, as we have seen when discussing the access to college or promotions, access to workshops generating allowances is scarce and prized, and decisions about who can attend can thus be a source of power. As these opportunities are contested, this can equally feed suggestions of patronage. A dentist whom I met at a workshop in Lusaka told me that there is "a certain clique" at the provincial health office, which shares workshops, and that workshops are desirable because they "bring money".[25] It is widely acknowledged that management and administration positions give greater access to

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17 PB0811/24.
18 PB0810/02.
19 PB0810/17.
20 PB0811/01.
21 Prevention of Mother to Child Transmission (of HIV).
22 PB0811/28.
23 One might also question the need for a theatre nurse to have PMTCT. Possibly this was a slip with the respondent, meaning another course aimed at prevention of HIV transmission in the workplace; alternatively, it might signal the extrinsic financial motivation attached to any workshop regardless of the subject matter.
24 PB0811/24.
25 ML0706/06.

workshops and other allowance-generating activities.[26] As one former manager reflected on her time in management: "It was a very good experience. I learned a lot about planning. I learned supervision, administration, et cetera, and got the chance to attend workshops". A district health director admitted that he himself could be biased when he decides who goes for training. He mentioned that he could bypass those who are disrespectful or not loyal: Those who insult management.[27] In other words, as these scarce opportunities for workshops and training are contested, such perks can be used as tools for managing loyalty.

Later in this chapter we will again turn to the struggle for access to scarce opportunities for allowances and the impact the incentives involved have on health worker behaviour. The aim of this section, however, is to illustrate the importance of allowances in the build-up of health workers' income. This was well illustrated by the account of an accountant at a provincial health office. He was previously a board employee. He claimed that the restructuring following the dissolution of the Central Board of Health has caused a lot of confusion and has affected him personally. Although the board had been dissolved two years before I interviewed him, he had still not been put on the government payroll. He was told he had to wait until the restructuring was over, which was expected to be six months later. In the meanwhile, he said that he was paid from the provincial health office's operational funds and had seen his income fall by about sixty percent. Nevertheless, he said he was satisfied with his work. For his work, he travels a lot and he stays in places where he never imagined he would stay, such as the luxury hotel, InterContinental Lusaka. "There is a lot of capacity-building. We learn a lot. Workshops are there". The ambiguity as to the exact benefit of workshops – is it as a source of knowledge or as a source of income? – was heightened when the respondent said about such allowances: "That's what supports me".[28]

Table 5.1 Health workers' incomes

	gross salary	housing allowance	on-call and rural hardship	net total[29]	euro[30]
Brixton	942,138	110,000		804,103	155
Mr. Musonda	1,467,065	186,000	293,413	1,439,285	277
Dr. Chisa	5,040,436	570,000	2,600,000	5,613,534	1,080

With the complex of various incidental allowances, it is difficult to piece together what the average health worker earns in allowances, or even what a particular health worker receives. Notwithstanding the importance of these sources of additional income to our presentation of workers' take-home pay, this presentation disregards such allowances, as a matter of convenience. We have incorporated only substantive allowances, such as housing allowance and Dr. Chisa's on-call allowance. We have also assumed that Mr. Musonda gets rural hardship allowance. While this table might provide an illustrative account of what health workers 'get out of their work financially', it is truly

26 Toyoshi-Hamada, 'Zambian'.
27 ML0706/17.
28 ML0809/12.
29 After deducting PAYE income tax and pension payments.
30 At €1 = ZMK 5,200.

instructive only if we can also see this in relation to the cost of living. This we will examine below.

The cost of living

Estimating the cost of living for health workers is an arbitrary task, inherently subjective to an individual's specific desires and context. Also, quoting Dr. Chisa, "Money is never enough, right?"[31] In macro-economic comparisons, average incomes between countries are often corrected for purchasing-power parity, taking into account what a dollar can buy in a specific country. Perhaps more illustrative for our interest is a monthly exercise carried out by an NGO in Lusaka, which contributes to public debates on poverty in Zambia. This organisation, headed by an American Jesuit priest, carries the intriguing name Jesuit Centre for Theological Reflection. Every month, they calculate the cost of a basic needs' basket for a family of six (Table 5.2). Average prices for basic commodities are collected at a number of retail outlets in Lusaka. In the calculation for September 2008, it was projected that a food-basket, composed of the essentials such as mealie-meal,[32] relish,[33] vegetables, and so on would cost a family of six a total of 656,600 Kwacha. Non-food items in the basket included rent, utilities, and cleaning products. They brought the basic needs' basket to a total of 1,828,100 Kwacha, which at the time was equal to €352.

While the above is a fair representation of the costs a nurse in Lusaka, and also Dr. Chisa, will face, for Brixton or Mr. Musonda things may be different. In provincial or district towns, foodstuffs may be slightly less expensive, whereas manufactured goods might be somewhat more costly. Moreover, as we will discuss later, particularly in the most rural areas many professionals also do some farming on the side, particularly for their own consumption. A further and more substantial difference is the cost of housing. Most health workers at health centres are accommodated in staff houses provided by government. While they get a token amount deducted from their housing allowance, it does provide a significant adjustment to their basic needs' basket. Nevertheless, depending on the cost of their housing, for nurses such as Mr. Musonda or his various fellow nurses, the basic needs' package is either slightly above or slightly below the cost of their basic needs. For people-support staff such as Brixton, the basic needs' package is slightly higher than what they bring home on their payslip. However, this does not even take into account the other costs they might have or chose to face. In the following sections we will see what expenditures health workers face beyond these basic needs.

Educating your children

On arrival at a rural health centre to conduct interviews, my research assistant Paulien and I found the in-charge occupied with screening patients. He asked us to wait half an hour before he could attend to us. We asked a lady who was attentively watching us wander around the clinic if she worked there. When she affirmed that she did, we asked her if we could interview her. She brought us to a desk in a nice-looking maternity wing built with NGO support, which was not being used at that moment. Then she went off and walked back with another lady, who looked old and emaciated and was dressed in a

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[31] PB0812/04.

[32] The maize meal which is made into the staple food, *nshima.*

[33] The main accompaniment to *nshima*, such as meat or *kapenta* (small dried fish).

chitenge[34] wraparound and a simple shirt. She greeted us traditionally in Bemba and sat down next to her companion. When we learned that she was a colleague, we asked if she minded if we interviewed her separately. We then interviewed the first lady, who turned our to be a recently recruited community volunteer and had few stories that we could elicit from her. To our surprise, the other lady, whom we shall call Mrs. Mwaanga, had a much more interesting story, which she shared in articulate English. She had looked very much the typical local villager, but it appeared that she originally came from Southern Province and had worked at a number of clinics in Luapula as a cleaner since the 1970s.

Table 5.2 Basic needs basket

JCTR *BASIC NEEDS BASKET*: LUSAKA

September 2008

(A) COST OF BASIC FOOD ITEMS FOR A FAMILY OF SIX IN LUSAKA

Commodity	Kwacha	Quantity	Total	
Mealie meal (breakfast)	50,700	3 x 25 Kg bags	152,100	
Beans	11,000	2 Kgs	22,000	
Kapenta (Siavonga)	41,300	2 Kgs	82,600	
Dry Fish	53,300	1 Kg	53,300	
Meat (mixed cut)	17,700	4 Kgs	70,800	
Eggs	5,700	2 Units	11,400	
Vegetables (greens)	3,200	7.5 Kgs	24,000	
Tomato	3,700	4 Kgs	14,800	
Onion	3,500	4 Kgs	14,000	
Milk (fresh)	9,100	1 x 2 litres	9,100	
Cooking oil	25,300	2 x 2 litres	50,600	
Bread	3,400	1 loaf/day	102,000	
Sugar	5,300	8 Kgs	42,400	
Salt	2,200	1 Kg	2,200	
Tea (leaves)	5,300	1 x 500 g	5,300	
Sub-total				**K656, 600**
(B) COST OF ESSENTIAL NON-FOOD ITEMS				
Charcoal	55,000	2 x 90 Kg bags	110,000	
Soap (Lifebuoy)	1,800	10 tablets	18,000	
Wash soap (Boom)	3,100	4 x 400 g	12,400	
Jelly (e.g., Vaseline)	6,700	1 x 500 ml	6,700	
Electricity (medium density)	125,000		125,000	
Water & Sanitation (med - fixed)	99,400		99,400	
Housing (medium density)	800,000		800,000	
Sub-total				**K1, 171,500**
Total for *Basic Needs Basket*				**K1, 828,100**

Mrs. Mwaanga had followed her mother, who had worked as a matron at a teaching college in Mansa, to Luapula. When she was looking for a job, she applied at the hospital, before being transferred to the clinic where we spoke to her. There she had met her husband, whom she had since divorced. Then, after 13 years she was transferred again, which she explained simply by saying that she had ‘overstayed’. At the end of the 1990s she was ‘pruned’, retrenched together with many other casual employees. She then received a retrenchment package, which she put in the bank. In 2001 she was again employed at the clinic where she is now, this time on a contract with the district health office. “I wasn’t too old to stop working, so I re-applied”. The reason she chose to come

[34] A traditional garment for women: A piece of batik cloth wrapped around the waist, chest, head or used as a sling for carrying infants.

back to this location where her ex-husband came from was that before she had been transferred, she had already bought a house there. She also did some farming, selling some cassava and ground nuts. About living as a Tonga among the Bemba, she said she sometimes had "difficulties, but when I explain our customs, it is ok, they understand". Witchcraft was not a problem, she said, being a member of the United Church of Zambia: "I just pray". A difficulty was that her relatives do not come to visit her in Luapula. "They say it is too far. They're not happy with me staying here. They can't visit me when I fall ill." Indeed, Mrs. Mwaanga looked as if she had been struggling with serious illness. While it remained unspoken, it would not have surprised me if her emaciated appearance was a sign of her struggling with full-blown AIDS.

The reason for telling Mrs. Mwaanga's story here in this section is that there was one issue which she talked about with a particular passion and an occasional glint of pride. The money she had put in the bank after having been 'pruned' was used mainly to put all her six children through school. All children had in fact completed secondary school or were set to do so. The youngest was still at boarding school elsewhere in the province, quite a distance away. The next one was a tailor in Ndola, who she said "is doing well". The same pride, however, she could not show for her youngest daughter. She "refused to do anything", Mrs. Mwaanga told us. Now the daughter was married to a driver in a nearby town where the Pedicle Road crosses into the Congo on its way to the Copperbelt. With clear disapproval, Mrs. Mwaanga added that the daughter was "just staying and doing nothing". Another daughter had tried to study to become a teacher but she had failed twice. Now she was in Kitwe looking for another course to try. Mrs. Mwaanga's second-born had apparently been more successful in getting further education and was working as an electrician for the Ministry of Health in Itezhi-Tezhi in Southern Province. Finally, Mrs. Mwaanga's first-born was the key to her retirement in a year's time. He was in Mrs. Mwaanga's home village in Choma district, farming and keeping cattle. He was also taking care of his mother's two cows and two bulls, which Mrs. Mwaanga had already bought. She had also already bought a plough she found standing idle in her current place of residence. Bembas, she claimed, do not know how to use them. She sent it with one of her children to Southern Province. In a year she would sell her house and "live with mum", who is getting old in Livingstone, before buying a house near her son in the village.[35]

Mrs. Mwaanga's story illustrates to what extent Zambians (perhaps particularly women) will go to ensure that their children have the chance to do well in life, by putting them through school. While from her account one can conclude that only one, possibly two, of her children had completed some tertiary education, by and large she gave the impression that most were "doing well". For Mrs. Mwaanga's meagre pay-check, this must have been quite a strain. Estimating her pay-check, she picks up only 480,000 Kwacha (€92) per month, as she probably does not receive extra allowances, being on contract and thus not on the government payroll. Apparently, the lump-sum pay-out she had received when government was 'down-scaling' the public service was of significant help. Ironically, Mrs. Mwaanga and her children appear to have been beneficiaries of structural adjustment. Getting back to our argument, however, nearly all our respondents were spending a significant amount of money and effort educating their children. This also came to the fore in another situation I came across.

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[35] LB0809/08.

At an office, somewhere in the Zambian health system, there was a quite elderly office orderly walking around. He would shuffle around with piles of paper, apparently looking around absent-mindedly. One of his colleagues told me that he was over sixty-five and should have retired already. She indicated that because of the confusion surrounding the restructuring, he was still around. His retirement had not been automatically processed by Lusaka, and although he was old and had trouble seeing and hearing, he was still at the office every morning at six to prepare the office for a day's work.[36] Later, another colleague explained that this gentleman had two wives and six children with each. Soon he would retire, as his last child would finish school. According to his colleague, he had continued working past the normal retirement age of 55 to 'finish' educating his children.[37]

Owing to economic circumstances, some fail to give all their children equal opportunities to access education. One health worker reported having had ten children with his wife, of whom three had since passed away. He and his wife had managed to school their children, with two girls becoming teachers, one son a miner, and another son a driver. Nevertheless, some of these children did not go as far as they might have. In 1998, however, the family had a lucky break of sorts. Our respondent's wife had been working as a classified employee at a clinic but was retrenched, in much the same way as Mrs. Mwaanga. With this lump sum, our respondent and his wife were able to sponsor one of their younger sons through university. Now he is a public relations officer at the refinery in Ndola.[38]

As mentioned in an earlier section, primary public education in Zambia is nominally free. Government also issues bursaries and subsidises many institutions of higher learning. Nevertheless, educating children remains costly. In the basic needs' basket exercise, under the heading 'some additional costs', schooling costs for secondary schools in Lusaka are listed. Fees and PTA-contributions for Grades 8 and 9 are quoted at 252,000 to 380,000 Kwacha per year, and for Grades 10 to 12 at 465,000 to 600,000 Kwacha per year, with school uniforms quoted at between 75,000 and 180,000 Kwacha per year. Of course, there are variations between public and private schools, and some of our respondents admitted to sending their children to "expensive private schools" no doubt because that would improve the chances of their children being successful.

In Zambia, families are traditionally large, with women on average having 6.2 children in their life.[39] This thus poses considerable costs. One clinical officer mentioned that he had seven children, out of which five were in boarding school. "Our vision is to get our children into college ... We need our children to be independent". In addition to his work, this clinical officer has various projects to raise money for school fees[40] (a topic we will elaborate on later). While on average families can be large, in practice families are very varied in structure. In the Christian Nation Zambia,[41] where the picture of a nuclear family is at times idealised, it might be tempting to look at families through the nuclear lens of one man, one woman, and their children. In practice, however, this ideal

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36 ML0804/08.

37 ML0809/10.

38 PB0810/12.

39 ZDHS 2007.

40 LB0809/19.

41 Zambia is perhaps the only country in the world that is constitutionally defined as a Christian Nation. The declaration of Zambia as a Christian Nation has been cause for vehement debate. See for instance Hinfelaar, M., 'Debates on the secular in Zambia: The Catholic church response to scientific socialism and Christian nation (1976-2006)'. In: Englund, H., ed., *Christianity and public culture* (forthcoming).

rarely holds. One wise retiree whom I interviewed re-impressed this point on me. When I asked, "How many children do you have?", he told me that that was the wrong question to ask in Zambia. Instead I was supposed to ask, "How many children do you have with your wife?", because God knows how many children a man has elsewhere.[42]

Traditionally, describing the family structures of Zambians and other 'research objects' has been a favoured pastime for anthropologists. Using their concepts and typologies in contemporary Zambia may not create clarity but rather illustrates the complexity of family arrangements. Nevertheless, it can be said simplistically that in the past many Zambians lived together with people from their lineage. Among many ethnic groups in Zambia, including most in Luapula, these were matrilineal lineages, meaning that heritage was determined through the line of the mother, as opposed to patrilineal, which was the norm among for instance the Lozi and the Ngoni. Some ethnic groups described by anthropologists were further labelled 'matrilocal', which means that husbands move in with their in-laws, as opposed to wives moving in with theirs, which may be common elsewhere. As anthropologists began describing real and imagined processes of modernisation, in some parts of Zambia such as Luapula an interesting topic of discussion was whether, under the influence of Christianity, colonialism, and capitalism, matrilineal extended family relations were giving way to more nuclear family structures that were more patriarchal and patrilineal.[43] In this research, we did not primarily delve into family structures, nor do we attempt to classify them. We did encounter many family arrangements of health workers. Some were widowed, some were divorced, and some were unmarried women with children. We also met men with multiple wives,[44] with children living in different households, divorced men with new families, or widowers whose new wives cared for their husband's children as well as their own. Some individuals had split their households because of their jobs. One senior nurse had two of his children with him in Luapula, while his wife was living with the two youngest on the Copperbelt, where she had a managerial job in a bank.[45] Others serving in rural stations had a house in town where their children were staying to go to school; one of the older children or another relative would take care of the others.[46]

When listening to people's accounts, the distances over which family members can be spread are striking. In the quest for quality education, many children find themselves going to school at some distance from their parents, at boarding school, or with relatives. This is very consistent with a clear pattern in Zambian history, namely the strong tradition of labour migration and the spatially complex social relations this has resulted in. Schooling children away from home, however, does not necessarily absolve parents of costs involved in schooling; it can even make it more costly. One nurse worked together with her husband at a clinic. Together they had five children. The first-born was working on the Copperbelt; the rest were in boarding school. She claimed they managed to school their children, although that may mean they fail to achieve other things. "The money is not enough, but we save for the children. We send them to school even if we suffer".[47]

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[42] ML0811/02.

[43] Poewe, K.O., *Religion, kinship, and economy in Luapula, Zambia* (Lewiston, 1989). This discussion is also dealt with in J. Gould, *Luapula: Dependence or development?* (Helsinki, 1989).

[44] Some in common-law marriages, others in formal marriages.

[45] LB0809/21.

[46] LB0809/09, LB0809/10.

[47] LB0809/09, LB0809/10.

In the next section, we will look at the great importance of relatives and dependants in the lives of contemporary Zambians, and the financial costs this implies for those with jobs. While it is wrong to deny the importance of the extended family, neither is it right to minimise the significance of the idea of the nuclear family in the accounts of some health workers. When I was giving a lift to a health worker who had just come from a different district from his own, and where he was acting as a peer-assessor in that district's performance assessment, we were talking about his career history and family situation. He told me that his father had been an office orderly for the council in Kitwe. Then his father passed away and his mother took the family back to their village in Eastern Province. They had not been farming in town, but now his mother said they would have to work together as a family. Of his five siblings, two had since passed away; the others were getting by. One is a mechanic; another works for a factory in Kabwe. He himself went to Chainama college to study public health and he is working at a district health office. He mentioned that his wife was a high-school teacher. Together they farm; he has a heart for farming as he comes from a farming family. Last year they cultivated two hectares of maize and two *lima*[48] of groundnuts. They harvested two-hundred and fifty kilo-bags of maize but the groundnuts did not do well. This year he and his wife decided to cultivate less; they decided to better share their labour. They both worked during the day; then they would go to work the land together. After they came back, she would go prepare food while he would sit and relax. He did not know why he would do that, but he appeared to consider acting differently, adding, "It is important to be a good husband". He said that he and his wife had three children, two girls and boy between the ages of twelve and one. "But that is enough". He and his wife decided not to have more children. When I asked why, he explained, "We made an analysis". Both of them come from large families and there was not enough money "to bring us far". With three children it should be easier to send them to university. "That is our goal." From this account it becomes clear that this particular respondent sees his marriage to a fellow professional as a partnership. While, by his admission, typical patterns of a division of labour do slip into the relationship, he appeared resolved to share labour better. He also professed the intention not to have more than three children so as to be able to give them a better life.[49] In short, with his account our respondent sketched the ideal of a small nuclear family, indicating there is an element of personal choice in determining one's household structure and the burden this implies. Although one cannot assume this respondent's account to be the norm in Zambia, it does suggest that for some[50] professionals the ideal a nuclear family correlates with middle-class life.

Despite the professed ideal of a nuclear family representing the concept of 'modernity', in practice most health workers also face the burden of educating children born to their relatives. A nurse tutor we spoke to had one child with his wife, who is a nurse studying to become a pharmacist. He claimed that he would like to have one more child, but no more. This is because he already also had to take care of three nieces from his side of the family. Their parents had died and he took responsibility for caring for these three girls. His other siblings have also taken in orphaned relatives, but being the eldest he has taken in most.[51]

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[48] A *lima* is an area measurement commonly used in Zambia and equal to a quarter hectare.
[49] ML0811/07.
[50] It needs to be explicitly emphasised that it is unclear to which extent this is common.
[51] LB0809/06.

Having to care for other children competes with the schooling one can give one's own children. Another public health official, living in a provincial town, gave an account reflecting this. He said that he had three children, as well as caring for two children of his late brother. Educating the children was "a struggle; it hasn't been easy". He is sending the children to a private school and recently the rates for next year have been increased. For his own children, he will be paying 600,000 Kwacha per term per year; for his two other children, 300,000 and 350,000 Kwacha. Although we did not discuss this further, apparently he discriminated between his own children and dependants from the extended family, placing more importance on the education of his own children than that of his dependent relatives.[52]

One respondent even explicitly said that educating his own children had priority over caring for dependants. He recounted that he had five children, three with his first wife, a nurse who had since passed away. The eldest, a daughter, had become a nurse; the second-born was in university; and his twin sister was at home hoping to be accepted to college. The two youngest children, whom he had with his second wife, also a nurse, were still in school. He mentioned that currently he had no dependants living with him. "Relatives don't have our vision, which is to get your children educated. Therefore, relatives can pose problems". He made this statement more concrete by describing the case of a girl he sponsored from his wife's side of the family, who went to boarding school. There she "didn't take her education seriously and got engaged in extra-curricular activities". He explained that she got pregnant and dropped out. "It was one thing to have one dependant, but I didn't like getting another one from her. She ran off to her family and she avoided us from that time". Now, our respondent stated, he and his wife are only prepared to support dependants who live with them from an early age, so they can teach them their own values. He concluded, "My own relatives have to accept what I put in. Education is the only inheritance that I can give my children".[53]

In this section we examined both the costs of educating children and the drive of health workers to willingly bear these costs. We have also seen that while actual family sizes, structures, and compositions vary, in part reflective of how this might have been traditionally, some might tend to strive for more compact nuclear families in line with the costs of raising a family as a professional in contemporary Zambia. From these accounts it becomes clear that the theme that has permeated this chapter on the human factor, the drive to forge ahead to improve yourself by striving for qualifications, is also transposed onto the next generation. Implicitly or explicitly, most of the health workers we spoke to shared this 'vision' of educating their children.

Relatives and dependents

Nearly all health workers that we spoke to had to care for at least some family members. Often this involved orphans: Siblings, cousins, or nephews and nieces whose parents had died. Although this was not necessarily the case in all instances encountered, there is no doubt that the AIDS pandemic placed an enormous extra burden on many of our health workers. Let us take the case of Brixton, for example. As we remember, he began working as a garden boy for a health office. He got this job after having completed Grade 12. In the course of the years, he had worked his way up to district stores officer, although he had not been confirmed in this position. We saw that he was still earning

[52] ML0811/17.
[53] LB0809/17.

the salary of a registry clerk, bringing home 800,000 Kwacha (€ 155). This was less than would cover the basic needs of a family of six in Lusaka. Brixton who was 35 years old. He said he and his wife had four children. His latest had just been born as he was interviewed, so he indeed had a family of six. Fortunately, Brixton was not living in Lusaka but in a provincial town, which might have made the cost of living a bit lower. However, a family of six was not all that he had to care for. In the interview Brixton revealed that besides his own family he was supporting 13 family members. His twenty-eight-year old niece and her two children, his wife's brother, his mother-in-law, and a divorced sister and her three children were among the people living at his house. Four of these are in school, plus two of his own children. "People come and go," he explained, "but I never have less than ten family members living with me. They follow me because there is too much poverty. I cannot chase them away". In 1996 his parents died and Brixton's two older brothers also passed away. Because of this, he explained, "Those who were still there, they came to see me since they had no one to look after them". He is also the only one around with a reliable job. "In my family, there is only one who has attended school. I cannot chase them away because they have nothing. I cannot run from that responsibility, even if it is a drawback". Brixton's wife was not working. She only made it up to Grade 9. Brixton claimed he took her back to school so that in the future she could supplement the family's income. She had finished now, but still had to re-sit some subjects. "We still have a long way to go".

No matter how depressing this account may sound, Brixton has his eyes set firmly on the future. He was following a long-distance course in supply-chain management with a UK-based organisation. After passing the next module, he would qualify for the position he was holding, thus increasing his salary to 1.1 million Kwacha. Each module of this programme was costing Brixton an estimated 337,000 Kwacha.[54] "I starve my family and myself to pay. But when I make it, I can work and serve my people and serve the nation ... I'm so eager, but I don't have sponsors. The family has come to understand that the only way to proceed is through study".[55] This account yet again exemplifies the sense of upward mobility, as well as the sacrifices made to secure further qualifications, that we have seen in previous chapters. This young man has seen a lot but still is very determined to better himself and his family. Besides ambition and sacrifices, this account also shows the burden that poor relatives can pose for someone lucky enough to have a job, especially if he is one of the few in their family.

Having dependent relatives seems unavoidable for most of our respondents. Brixton indicated that he could not run from his responsibility of caring for those family members who have nothing. Another respondent, an official working in Luapula, had most of his relatives in Eastern Province, though a brother-in-law and a junior sister were living with him. He considered the responsibility of attending to visiting relatives unavoidable. When asked if he could not send relatives away, he seemed a little taken aback. "That is unethical," he replied. "You can't leave your people who are suffering".[56] In another case, a doctor in a senior management position, who had stated he had struggled out of poverty to be able to "become better and help improve my family", passionately made an argument for the moral virtue of the extended family. "There is something good about us:" he said, "the extended family. We recognise that a child belongs to all of us.

[54] The course cost £55 per module, which at the time equalled about €70.

[55] PB0810/02.

[56] ML0809/11.

It is very helpful to cushion gaps. It is strength. We should not nuclearise".[57] A clinical officer, who described himself as not being "from a wealthy family", whose father is a village headmen and most of whose family are subsistence farmers, does not consider being a medical professional in such a family much of a problem. "When our family members come by, we just take them to the farm; we have enough food there for everyone. In Africa, we help each other".[58]

This is not to say, however, that claims from relatives do not pose problems. One retired public health official said, "There are very many claims from relatives. Traditionally, we say that a child belongs to his parents during and after life. It is often misunderstood," he said, adding that it is not necessarily malicious, but that it can lead to property-grabbing, a practice of which he does not approve. "In our society, when someone leaves a will, people will grab it, tear it up and burn it and then discuss the division (of the inheritance)". In the wake of President Mwanawasa's death, he drew a parallel with current events. "Mwanawasa knew that as a lawyer and that is why he left a video will".[59] A nurse interviewed gave an account of just such a situation. Her husband had been a miner on the Copperbelt. When their two daughters were just starting school, her husband died in a mining accident. Shortly after, her husband's relatives took the house the family was living in and even some money and the package that was offered after the husband's death. Fortunately the family was able to survive on her salary and were even offered a council house because of the ordeal. She looked back on it relatively mildly, saying, "His relatives seem to come to their senses now; they send me the rent of that house when they feel like it".[60] For another health worker, this meant a spilt with his relatives. He had grown up on the Copperbelt. When his father was alive they had contact with people from their home village in Eastern Province. Even the chief visited them. When his father passed away, the relatives came. Because of the conflict that ensued, he said he never went back to his home village.[61]

Others also considered claims from relatives to be a nuisance. A laboratory technician mentioned that his relatives live nearby, near the town where he is posted. "Somehow it is not good to live too close to your relatives. They trouble you a lot, unless they are also independent". He indicated that the relatives have financial concerns: Sometimes they ask for money, sometimes they need clothes and other basics. This is worse for him because he is the only one with a good job in the area. He mentioned he had three sisters who are married nearby. "Their husbands don't have good jobs. They bring trouble. Even my wife is troubled".[62] One accountant claimed he does not let himself be distracted too much by his relatives as he has a (nuclear) family to support. Having grown up on the Copperbelt, his own relatives were in Eastern Province. His wife, however, was local to the town where they were staying. Of them he said, "You try to avoid them. They can distract you by needing support, they want money, invite you into family activities, visit without knocking, ask for money for someone in hospital, for transport". He claimed that he manages to keep them at bay by indicating that he is not their relative. He alluded to the fact that for his wife this might be more difficult though. "There are those who are closer and those who are not so

[57] ML0812/03.
[58] PB0810/12.
[59] ML0811/02.
[60] PB0811/06.
[61] LB0809/12.
[62] LB0809/22.

close". But in the end, he said, his wife depends on him and has to follow what he decides.[63] This respondent gave the impression that he is very much in control of the situation. Others also gave that impression. One said that although he lived close to his relatives, being in the same province, "they are all independent". He thus does not need to support them much, "unless I feel like giving".[64] Yet others did acknowledge a burden from relatives but, like Brixton, felt they could not avoid it. One health worker mentioned that he and his younger brother, who was a teacher, were the only ones in the family with formal employment. "Most of the burden is for us. My budget is disturbed; things plunge in". But he conceded, "It is difficult to isolate yourself. I have been brought up by an uncle and this is a reason for me to look after others as well".[65]

Despite there being a social sense of moral obligation to respond to relatives' requests for assistance, this is not as unavoidable as it may be portrayed. There seems to be considerable agency for people in deciding the extent to which they support relatives. Some actively choose to do their duty, while other relatives are shirk their responsibilities. A nurse said, "Right now I only have one dependent, a boy who is my late brother's son, and then I'm also supporting one who is in Grade 12. But I have brought up a lot of dependants, many. I am the only one caring for dependants, maybe because I am the only woman in the family. Men don't really care for relatives; my older brothers are just caring for their own children. But I do it out of love for people; you cannot just leave them".[66] Other respondents weigh what they can be involved in and what not. One nurse implied that she and her husband carefully consider requests for assistance. "With dependents, it depends on how you as a couple handle them. We look at the most important things, and we help them out with those important things".[67] A senior official posted in his home province replied that working close to your relatives is a "mixed grill". On the one hand, being away from home means fewer disturbances by family members. On the other hand, with aging parents there is much more one can do if one is closer. However, he stated, "It is a question of managing family issues. Through dialogue you make them understand the position you are in and that you cannot get involved in certain family matters".[68] Yet another respondent illustrated that dealing with claims from relatives is a subtle practice. He admitted that relatives can be difficult. They can trouble you with complaints and at times want assistance. The respondent added that sometimes he needs to get involved in settling disputed between relatives. Moreover, besides his own children, he is schooling two dependants. But he admitted that sometime he 'technically ignores' requests, not by bluntly refusing them but by not following through. "I know the way to do that", he added. He suggested, however, that doing this incorrectly poses risks: "When you are closer to your relatives and if you don't use the right approach, they can make your name bad".[69]

The philosophical doctor we quoted above, who was very clear about the moral virtue of the extended family, also indicated that "there should be limits; otherwise, the poverty of your brother can transform you into a poor man". This in his view was not something to avoid but to deal with. "Still, you should help and not complain". One

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63 ML0809/12.
64 PB0809/03.
65 PB0811/33.
66 PB0811/08.
67 PB0810/09.
68 ML0804/12.
69 ML0811/10.

does not have to offend when setting these limits. He explained how one should offer support. "If he is a minor, support him and educate him. If he is an adult, support him to find employment". If he does not find employment, find other ways of gradually making the dependant independent. "Sit down with your brother to discuss him moving out. Tell him 'I will pay rent for let's say six months and then you will start paying'. Or you help him go to a driving school and get a driving licence, so that he can drive a taxi. Offer a starting point to become independent". He admits that sometimes this is not so easy. There is sometimes abuse, and according to our respondent, often it is the one doing well who ends up being abused. "The recipient might end up spending money on beer or on a *ka*-phone. Such recipients can be abusive". He concluded his argument with an apt metaphor revealing his medical training. "There is a difference between a symbiotic relationship and a parasitic relationship. A parasitic relationship ends up killing both".[70]

This opinion on supporting dependants with the aim of making them independent, so eloquently aired by the previous respondent, was repeated by others. One health worker, who had moved to the other side of the country for his job, said that most of his siblings were peasant farmers. They had been happy when they saw him leave to work elsewhere as he sent money to his family to support them. But he showed that he would prefer them to become more independent. "I have been pushing them to finish their education, but they think they are too old now".[71] A different health worker said, "I got my brother a piece of land outside Mansa for cultivating, so he can start supporting his own family".[72] Yet another said that he paid for his three cousins to go to school. "I keep on encouraging them to educate themselves. Education gives a basis for life".[73] And education leads to independence, as yet another health worker implied. He revealed that in addition to the two nephews his family and he are supporting, they used to support a niece of his. "But she is a teacher now and doesn't need support anymore".[74] That this takes the pressure off was indicated by a nurse: "Most of my relatives are independent. They have all learned to work. My hometown is near, and I have relatives there, but they don't come by unless they really need to. So when they come, I know they are in real need of assistance, and if I have the means, I help them".[75]

One respondent gave an account of how he dealt with a dependency that had grown parasitic. He mentioned he had one dependant staying with him, a younger brother. His wife, who was living elsewhere for her job, had five. This respondent explained that he was brought up in an extended family himself and has fond memories of that. He missed the drama of staying as a family: Recalling things from earlier times and really knowing each other. Now, as he was living at quite a distance from most of his relatives, he admitted he was not contributing much to the family. "Those that are near have a bigger burden and responsibility". While for him the expenses are less, he does feel his relatives are being deprived of the benefit. "You just send something once in a while". He went on to explain, however, that with his younger brother things have not worked. "Let him be. Let me not bother him; he doesn't like to work. He just wants to play. He just can't take care of himself. I could think of maybe buying a car, which he can use as a

[70] ML0812/03.
[71] PB0811/24.
[72] PB0811/23.
[73] PB0810/03.
[74] PB0810/18.
[75] PB0810/11.

taxi, but that wouldn't work. I have a shop, and I tried that with him several times, but then I would find empty shelves and books that weren't correct. He decided not to take care of himself. If he was extended family, I wouldn't keep him".[76]

A recurring theme in people's accounts of relations with relatives is that of distance. In his study of civil servants in Malawi, Gerhard Anders described how his informants "experienced a tension between their dream of material wealth for their own nuclear family and the numerous demands on their resources by kinfolk". As we have seen above, while there is a tension and an ambivalence, Anders argues that there need not be a contradiction between individual aspirations and kinship obligations.[77] Instead, people try to deal with both. One strategy that Anders described was that after retirement, civil servants move to "neutral ground" at a "safe distance" from their relatives. As such, they translate a social distance into a spatial distance. In the accounts, we saw similar strategies. While we will come back to our respondents' preparations for retirement later, below are a number of illustrations of how health workers take the issue of distance from relatives into account in their decisions on where to be placed.

In an earlier section on placements and transfers, a number of accounts were presented on health workers who chose to be posted close to specific family members. Often people wanted to be close to their parents to help them in illness or old age. Having said that, numerous respondents attested to a more or less pronounced inclination to put a safe distance between themselves and their relatives. During a trip to Western Province, I spoke with a man who previously was posted in North-Western Province. He said he had been doing well running a mobile eye-clinic, for which he was specially trained in Malawi as one of the first Zambians. At a certain point in time, the ministry wanted to transfer him back to his home province of Western Province. He had refused. He suggested that he did not want to be close to his relatives. After the ministry told him for the third time that they wanted to transfer him, because he had overstayed in Solwezi, he finally conceded. He went back to Western Province. When I asked if it indeed was so bad, he sighed: "Yes, I'm running a boarding school". He told me that his relatives come from a nearby district, asking for assistance. Sometimes they come with genuine cases and he struggles to manage. "It is difficult for village people to understand," he concluded.[78] A colleague of his proudly wore a broad ivory bangle. He explained that this indicated that he was a headman in his home village in Southern Province. When I asked if he would not prefer to be closer to home, he said no. At home there would be relatives nearby; at the place where he was, at least he could work with few disturbances.[79] This was echoed by a number of other respondents: "You do better if you're working in another place" than the one where your relatives live.

The ambivalence remains: Creating or maintaining distance between a professional and his or her family members does not imply severing the ties with these family members. Let us go back, for instance, to that nurse who came from Solwezi and was transferred to Mbereshi to reduce the travelling time to his family in North-Western Province. As he was interviewed 12 years after his initial posting, he did not consider going back to Solwezi an option for him yet. He explained that would mean that he would then be closer to his relatives and he would get a lot of pressure from them. "I might not advance if I go back, because of that. Maybe I will go back in two or three

76 LB0809/21.
77 Anders, 'Civil servants', 154-155.
78 ML0706/24.
79 ML0706/29.

years, but not yet because I haven't yet bought a lot of things for the home. I need to lay a very good foundation and get some capital". Obviously, being close to his family would be such a financial drain that he could not spend money on other things. He mentioned buying things for the house, but there were also other projects he had running. Currently, he was farming on one or two hectares; in the previous year he had made four and a half million Kwacha selling maize. He said that he did not have any other business at the moment, though he admitted having some money in the bank. For this, he had some plans; maybe he would use it for poultry-farming. Having relatives close would obviously compete with these plans and prevent him from advancing. That is not to say, however, that he does nothing for his relatives. Later he mentioned that his parents had passed away, which left him to support some family members. Staying with him were his brother, with his wife and two children, and his sister, with her husband and three children. "You have to be experienced financially. A big family against (the budget of) one person is really hard".[80]

On one hand, it is evident that spatial distance can buffer people from claims from the extended family. As one respondent put it, if he moves, relatives need to pay for transport, whereas now they can just walk to his place. On the other hand, despite distances, one may find it difficult to isolate one's self. One respondent, who was working in a remote rural district, mentioned that his relatives are all in Lusaka. According to him, he is the only brother in a family of five surviving children. Two of his sisters are working; two are unemployed. The latter two, according to the respondent, are in trouble financially. When asked if he is not safe from disturbances being so far away from his relatives, he held up his mobile phone with a look of resignation. He claimed that still they could find him to ask support; he received a lot of text messages: "We have debts. Send us so much". When he has money, he said, he sends some.[81]

In this section we examined the burden and the claims of the extended family on people holding jobs. As we saw, there is a lot of ambivalence in people's assessment of this burden. On the one hand, there is a sense of pride in the virtuousness of valuing the extended family. There is a sense that this solidarity is at the core of an 'African identity'. As one respondent said, "in Africa, we help each other". On the other hand, some respondents complain of the burden this imposes and actively try to deal with claims. Some refuse or ignore claims, others use the special mobility inherent in the Zambian public service to their advantage by creating a distance from their relatives to decrease the claims they face. Whereas very few of the people we have encountered found it either possible or desirable to wholly withdraw from kinship obligations, it was seen as competing with other aspirations that our respondents may have held – not least, the dream of a 'modern middle-class life', with all the material comforts that this implies. As was also suggested by the tentative conclusion on smaller nuclear families, it appears as if our health workers are in the process of reforming and renegotiating culture. In this process, conceptions of what is traditional are an important resource, but they are by no means the sole determinant of this process. Someone's sense of their current and aspired-to economic situation is also of influence – just as are, perhaps, concepts of modernity and the desires associated with a middle-class life. In the next section, we will further explore such aspirations to modernity.

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[80] PB0811/23.
[81] ML0811/15.

The material trappings of middle-class life

Having looked at the basic costs of living as well as having gained an impression of extra claims being placed on health workers by family and dependants, let us go on to examine the things health workers aspire to spend their money on. In his study of mineworkers on the Copperbelt, James Ferguson, distinguishes two cultural styles: The cosmopolitan and the localist styles. Part of his argument is that the people he studied had different consumption or investment options, which are perhaps not mutually exclusive but certainly depend on how an individual chooses to prioritise his expenditure. Either one can invest in smart clothes, electronic gadgets, and bottled beer to reinforce one's cosmopolitan style or one can prioritise investing in social capital, by remitting to relatives and caring for dependants. This last fitted with what Ferguson called a localist style, which allowed some of his mineworkers to have a relatively safe retirement. In this section, we will examine some patterns of consumption related to what Ferguson terms this cosmopolitan cultural style, having already looked at dependants' claims.

When talking to a medical doctor in his early thirties, who had been posted in a remote rural district as district director of health, my respondent sketched why it was difficult to get doctors such as himself to work in rural areas. He explained that there were few opportunities to take his wife for a pizza or his children for ice-cream. He also openly wondered whether the salary he received was empowering him enough, as he had to pay "big taxes" to government and educate his children well. He also admitted he wanted to be able to buy "small things" such as a nice pen, a nice shirt, and a nice perfume. Judging from his attire and the nice-looking pen he was handling, he did not deny himself these small luxuries.[82] This frank admission shows how this respondent was stuck between very different worlds. On the one hand, when comparing him with the average Zambian, these "small things" might be extreme luxuries. On the other hand, when comparing himself with siblings studying abroad, study mates who had left for 'greener pastures' or even the PhD researcher interviewing him, these luxuries again become "small things" that should indeed be obtainable for a qualified professional. Moreover, with his statement, our respondent shone light on some important symbols of success, the visible material possessions that display to the world that one has made it.

Perhaps one of the most potent status symbols is the possession of a 'vehicle', as motorcars or light-trucks are often referred to in contemporary Zambia. In fact, as I myself drove a battered pickup-truck, its merits – who owned it and what I would do with it when I came to leave Zambia – were subjects commonly raised in casual conversation with health workers and others.[83] Undoubtedly, this vehicle was used to socially categorise me in the conceptions they had of me. On the one hand, vehicles have an important functional aspect. As we have seen, the spatial distances that Zambians traverse are enormous. It is not uncommon for relatives to have to travel over a thousand kilometres to meet. Furthermore, the major commercial centres and the bureaucratic centres, such as the ministry headquarters in Lusaka, lie at hundreds of kilometres from most parts of the more remote provinces such as Luapula, Western, North-Western and Eastern Provinces. To arrange things and conduct 'business', Zambian health workers need to be mobile. Possession of a motor vehicle of course sig-

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[82] ML0804/23.

[83] This perhaps was only surpassed by the interest raised by my small netbook computer, which commonly drew the comment: "That is a very portable computer".

nificantly reduces the difficulty of traversing these distances, albeit at a tremendous cost. On the other hand, the desirability of a vehicle goes beyond its functional value, and it can be a measure of economic and professional success. One respondent mentioned that he was contemplating moving to ‘greener pastures’, with the argument, “You see other people driving, and sending their children to good schools ...”.[84] A laboratory technician also argued that it was in his view unfair that nurse tutors benefit from the health workers’ retention scheme while he did not, illustrating it with the argument that “they drive, but I can’t afford to”.[85] Finally, when conducting a focus-group discussion and discussing the issue of becoming successful in the health sector. one participant compared himself with “people driving big cars”, to show that he does not consider himself successful.[86] Being able to afford to drive a vehicle could be seen as a dividing line across the emerging middle-class. Four-wheel drive vehicles are among the most desired cars for Zambians. On the streets of Lusaka, luxury saloons look dull in the shadow of the many luxury SUVs that overtake them. In part, these vehicles are functional, considering the conditions of the unpaved roads in much of Zambia. Another functionality could be the need to occasionally visit the farm. This functionality, however, does not fully explain all the spotless four-by-fours plying the roads in Lusaka and the Copperbelt, or gracing most of the executive parking spaces in front of Ndeke House.

Figure 5.1 Vehicles at Ndeke House

That is not to say that all those with vehicles have actually already earned the money to buy vehicles. One of the conditions of service for senior civil servants is that they can access car loans. In part, this is an arrangement of the health workers’ retention scheme referred to earlier, but there is also a car-loan scheme provided to civil servants across

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[84] PB0811/33.
[85] LB0809/22.
[86] FG0811/02.

the public service. Various respondents, however, complain about the accessibility of this scheme. One nurse in a provincial town complained that in Lusaka people could get car loans "but here you can't".[87] Another health worker complained about the tough conditions for car loans and house loans, implying that only those in Lusaka could attend the meetings where the criteria were explained. He even went so far as suggesting that once one would get the information, the scheme would be revised.[88] While it goes too far here to assess these claims of unfairness, it is sufficient to state that owning a car is a desired good that some health workers can just afford, while for others it is out of reach. Indeed, when going round ministries in Lusaka, one can see civil servants getting into various vehicles with private registrations. Some are donated by donor agencies, others are 'personal-to-holder' vehicles which come with a position, while many are second-hand cars imported from Japan, either paid for by a car loan or through other means.

Other material possessions can also be seen as 'must haves' for someone who has arrived in the middle-class. Let us also recall the respondent who indicated that he was not ready to go back to Solwezi. He argued that he had not "yet bought a lot of things for the home".[89] The account of another health worker gives us an insight into what things he might have meant. This public health officer had been posted to a rural health centre after graduation in 1997. At this time, due to ongoing reforms there were problems putting him on the payroll. According to our respondent, during the first two years of his posting he was receiving no salary whatsoever; instead, he was depending on the allowances that he received for outreach activities to survive. Then when he finally was put on the payroll, he received two years of back-pay. To my question concerning what he spent this on, he replied that he bought household appliances, beds, mattresses, and a sofa, and he sent some money to his relatives.[90] Ashley had also received several months of back pay, after finally having been put on the payroll. He also said he had spent this money on furnishings, and indeed when I was invited into his house, it looked well-furnished, his living room lined with large and comfortable sofas and armchairs. It still, however, lacked a television set, which Anton had and which took up a place of prominence in other health workers' living rooms I visited, sometimes accompanied by DVD-players, video recorders, or satellite receivers. Of course, these modern conveniences require electricity; hence the frequent complaints from health workers about the lack of electricity at rural stations. One health worker during an interview proudly talked about his solar panels and his generator.[91] At Ashley's clinic, electricity was lacking, as the health post had not yet been linked up to the national grid. The clinic also did not have solar panels, while the former in-charge, who was away on study leave, did have a solar panel connected to his staff house.

Logically, being able to afford these modern conveniences competes with other expenditures. This was aptly illustrated with the dilemma one young man shared with Paulien, my research assistant, whom he had invited to dinner. In the house which this bachelor shared with a friend, he had a television with a DStv-receiver. DStv is a satellite television service provided by a South-African company, which broadcasts mainly international and South-African content. Some of the content, however, specifically

[87] PB0810/20.
[88] PB0811/26.
[89] PB0811/24.
[90] ML0811/07.
[91] LB0809/12.

targets the Anglophone part of the continent, particularly with Nigerian drama. Another type of content that in my observation is particularly popular in Zambia is sports, with especially the UK's Premier League matches drawing considerable enthusiasm. It is not surprising that a DStv subscription is particularly desirable for someone with a cosmopolitan orientation, such as our informant. His dilemma, however, was the cost of the monthly subscription. He said he paid 350,000 Kwacha per month for this, which he admitted was as much as his monthly rent.[92]

Satellite television is one more technology within reach for the emerging Zambian middle-class that serves to make the world become smaller. With its images of a consumer lifestyle in South Africa, Europe, and America, it presents images of what life could be if you forge ahead. This is reinforced by another relatively new phenomenon in Zambia, the spread of the South-African supermarket chain, Shoprite, over the country, with at least one branch in every province. This has brought food and non-food consumables physically closer to many. For the poorest in Zambia, many of the products are still unobtainable. For others, such as our health workers, it significantly broadens the range of consumer options. Walking through a Shoprite branch in a provincial town one can see this contrast. Workmen with a single bottle of water and old ladies in *chitenge* with a single loaf of bread queue up with professionals doing the weekly shopping, emptying out their trolleys onto the conveyer belt.

Another relatively recent commodity in Zambia is what is now the seemingly ubiquitous mobile phone. As we have seen, the spatial distances involved in a Zambian health worker's life world are substantial. Mobile phones cut these distances considerably. Nowadays relatives, friends, business partners, and colleagues are considerably closer in a virtual sense. This means that official tasks and business deals can more easily be arranged. It also means, as we have seen above, that social claims can be more easily expressed over a distance. Of course, as with vehicles, besides the functional side of mobile phones there is also the aspect of status. In price, phones vary from the most basic phones costing around 200,000 Kwacha to the more desirable luxury phones with catchy ring-tones, photo-imaging options, and many other extras. In my own observation, it appeared that most middle-ranking and senior officials carried more flashy phones than the almost embarrassingly modest phone I carried during my fieldwork.

In the preceding section, we have had a glimpse of the consumptive expenditures that go beyond the basic needs' package that was presented earlier. Depending both on someone's socio-economic standing (partly corresponding with one's professional standing) and also on one's personal preferences, there are huge variations in how much someone wants or can afford to spend on such luxuries. At the lower rungs of the health sector, including some qualified staff at rural health centres but mainly classified employees and other support staff, one would be likely to see people corresponding more with the image of Ferguson's localist style. However, the higher up the professional ranks and the closer to the urban centres one looks, the more likely it is for one to see the trappings of the cosmopolitan style such as smart suits, flashy phones, and luxury four-wheel drive vehicles.

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[92] PB personal communication.

Working beyond the payslip

Adding up the basic needs' package required for simple survival and the costs of other desired expenditures creates a huge financial burden for our health workers. They bear the costs of putting their children through school, of supporting elderly relatives and worse-off siblings, of schooling their relatives' children and orphans, as well as the costs of a comfortable modern life. Considering this burden and offsetting it against the salaries earned by health workers, one can understand that doctor who said, "money is never enough, right?" From this perspective, it is thus not surprising that so many of our respondents had secondary sources of income from, as one respondent put it, "working beyond the payslip".[93]

During an interview, Mrs. Tembo – who had started off as a nurse, gone on to midwifery, and later gone to work at a district health office – stated that she was only earning 1.6 million Kwacha (€ 308). "We're struggling financially", she exclaimed. However, when we were piecing together what we learned from the interview and what my research assistant learned when visiting her farm, a different picture emerged entirely. Our respondent, who was originally from Western Province, was married to a man from Eastern Province. They had been working throughout Luapula Province. He had made a career in the education service, while she 'followed him' from one job in the health sector to another. They had a farm just outside of town that covered one hundred hectares. In the previous year, Mrs. Tembo claimed she had only cultivated one hectare of maize. From her harvest, she sold over a hundred fifty-kilogram bags to the Food Reserve Authority.[94] This raised five million Kwatcha, while her costs were two million. For the next year, Mrs. Tembo said she was planning to cultivate two or three hectares of maize, while her husband would only cultivate one. He would rather be concentrating on a guest-house he was building in town. According to our respondent, her husband reckoned that tourism in Luapula would grow in the near future, so they should focus on that first. At the time of the interview, the guest-house was said to be underway, at concrete-foundations' level, and the complex was expected to have 15 chalets.

Mrs. Tembo also mentioned that they grew some vegetables, which they usually sold directly to local schools. They had some banana plants that had not been doing well and were also trying to grow pineapples. In terms of livestock, they owned 10 head of cattle, including a pair of trained plough oxen as well as 50 mature goats and 14 kids. Moreover, they had begun rearing pigs. At the moment, they had one pigsty with 21 pigs, but according to Mrs. Tembo, they were thinking of building another pigsty. Our respondent was already calculating that with Christmas coming, these pigs should sell for about 450,000 Kwacha (€ 87) each. In addition, the farm had 20 modern beehives collecting honey. The family had 3 local 'boys' working on the farm. Two of them had done two years of agricultural college. When asked why they did not have relatives working on the farm, Mrs. Tembo indicated that they might feel that "you throw them in the bush while you are enjoying yourself in town. You can then find that they do not do a good job". Of course, the family also worked on the land. They had two nieces living with them from his side of the family and one from hers. She mentioned that even though one is Lozi and the other an Easterner, they get along very well. The girls had both completed school. One, who was an orphan, stayed with the family while the other went back after having helped sow the new crop. The family also had four sons. Their

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[93] PB0811/02.

[94] The government's marketing board for food crops, particularly maize.

eldest had just completed school and was planning to go to medical school. When asked whether it would be difficult to get into medical school, he answered that he did not expect so. As a further indicator of how well the household was managing, they apparently owned two houses. One was bought when the family was still living in another district town and Chiluba's government was selling off houses to the sitting tenants. That house was now being rented out. The spacious house, in what must have been a low- or medium-density suburb where we interviewed this enterprising health worker, was bought when the house was still being built. Mrs. Tembo and her husband had since completed it and furnished it with various modern conveniences. On the property, one could see two cars and a motorcycle belonging to the family.[95] Mrs. Tembo thus had quite a commercial venture going, which she had built up together with her husband and family next to her long career in the health sector. This did not necessarily evoke an image of someone who was in her own words 'struggling financially'. However, considering the plans she and her husband had yet to realise, such as building a guesthouse, a new pigsty, possibly buying a tractor, and seeing their firstborn through medical school, admittedly one can concede that they face a financial balancing act. As that doctor said, "money is never enough".

When speaking to people about their economic activities, it is difficult to get a complete account of what they are involved in or of the viability and profitability of their ventures. Some may want to minimise their secondary economic activities as this could be seen to conflict with their day-job. Others might exaggerate their activities to make them appear successful. Also, as in the case of Mrs. Tembo and her husband, it may be unclear how far a respondent's ownership of a venture goes and to what extent it is shared with her husband or other household members. In the previous account, we were able to verify certain parts of the account with direct observation, but at times a respondent's word is all we have. Nevertheless, such accounts do provide an insight into the fact that health workers' economic activities are not limited to their role as a professional, but can go well beyond that. The example that was presented above is not necessarily typical, not least in the scale of the activities and the apparent success of these entrepreneurs-cum-professionals. Nevertheless, it does shine light on part of a public official's life that is often left untouched. Let us go on to examine other accounts of health workers activities 'beyond the payslip'.

As appeared from accounts presented above and used to argue other issues, many Zambians are farmers. Whereas a few respondents replied that they were not engaged in farming and only survived on their Ministry of Health income, these were a definite minority. Others consider it only natural that they should farm. As one nurse put it, "you can't let the wet season pass by just like that".[96] Some indicated that they do some farming but only for their own consumption. Some may sell surplus maize, cassava, or other crops either locally or to the FRA. One respondent admitted that his farming "doesn't give a lot of profit but it helps to sustain the family".[97] Often this farming is not a very large affair. For example, one clinical officer claimed to have collected about eighty bags of fifty kilograms of maize.[98] If he had sold these to the FRA in the 2008

[95] ML0811/16.
[96] PB0809/02.
[97] PB0809/03.
[98] LB0809/19 .

season, they would have fetched about 3.6 million,[99] not taking into account his input costs including the effort he and his family put into it. Considering the three million Kwacha profit Mrs. Tembo claimed to have earned from her hundred bags, one can assume that for a health worker taking home a bit over a million per month, this is a nice extra, either in cash or in saving on a family's own consumption. According to the basic food basket, a family of six spend around 150,000 Kwacha on seventy five kilos of maize meal. Thus, these eighty bags could last a family of six for 53 months. Excluding the cost of milling, this would hypothetically save them about eight million Kwacha.

One might expect that farming is an economic activity that is limited to those in villages. Anecdotal evidence from our accounts, however, suggests that this is not necessarily the case. Various respondents indicated that they had farmed or were farming from provincial or district towns, such as Mrs. Tembo. Another respondent, a nurse in-charge of an urban clinic in a provincial town, mentioned that she had a farm 54 kilometres out of town, from which she had collected 82 bags of maize in the previous year, and hoped to have more next year. She claimed that at the weekends she went to the farm, right after leaving work. She would then supervise the workers and return home on Sunday. She indicated that the workers were people from the area near the farm, but that during the week her nephew also supervised.[100] Two other accounts further illustrate not only that urbanites can be involved in farming, but also that farming by people working in the health sector can be larger-scale affairs. One driver for the ministry headquarters told me that outside Lusaka he had a 13-hectare farm. On this he had two diesel pumps to irrigate his vegetable production. He mentioned that he would sell tomatoes and other vegetables in the city. Considering the proceeds of irrigated vegetable production per hectare, this might yet be a reasonably lucrative addition to his drivers' income.[101]

Another Lusaka-based professional working in the health sector gave a similar account. She was a nurse tutor, whose husband was working at the Ministry of Finance. They both came from Western Province. Somewhere in their home province, they had twenty hectares of land in a 'resettlement scheme'. She said that this scheme provided land to civil servants who could not farm in their home village. Last year, the respondent said she had grown a thousand bags of maize. She did not sell these to the FRA, but to two different private buyers that had offered better prices. At an assumed price of 50,000 Kwacha, that would mean proceeds of fifty million Kwacha (€9,600), of course not taking into account the considerable costs she must have borne. She said that she travelled to the farm at weekends, but was planning to take vacation leave during the rainy season to plant a new crop. She had already had a hundred bags of fertiliser, bought from a private trader, delivered. She suggested that she was looking into further investing in the venture, as the tractor they had was 'a non-runner'. A new tractor and a plough would help her much. Soon she and her husband would retire and then, she indicated, they would settle on the farm.[102] Another health worker, an environmental health technician, had mentioned that he had two farms of 10 and 12 hectares respectively. He claimed he had already planted some 200 oil palms, both a traditional

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99 This was initially 45,000 Kwatcha, although a higher price was announced halfway through the process of buying the maize as the election campaigns had gotten into swing.

100 LB0809/16.

101 ML0809/15.

102 ML0810/04.

crop for home consumption and a potentially lucrative cash crop with the emergence of bio-fuels. He mentioned that he was even speaking to the chief, a friend of his, about the purchase of 200 hectares of land for planting oil palm.[103] In short, professionals can not only be entrepreneurs in traditional sectors but can also be early adopters of non-traditional crops and technologies.

In addition to growing crops, rearing poultry is a niche that various respondents claimed that they or their partners had found. This is not unsurprising, considering the economic growth in previous years with a corresponding growth of the consumption of meat, a relative luxury item. One health official mentioned that his wife is now a housewife, but she also used to work in the health sector. She was trained as a maternal health assistant, but in 2001, when the new government had reportedly decreased the number of staff on the government wage bill, she was made redundant. Our respondent said that with the package she received, she started a small business raising chickens. He claims she had from one to two hundred chickens, which he still referred to as "a very small business".[104] Another public health official was rearing chickens in Western Province, where she was posted. She was planning to retire in Kabwe, where she would expand the business.[105] Another health worker used to rear broiler chickens at the place where he was previously posted. However, in the few months since having been transferred, he claimed not to have been able to start something new. He claimed that he was still "looking for a good idea: A niche". If he had one, he might open some kind of a store.[106]

As we saw in this previous account, the high mobility inherent to the health sector, where one can be placed where one's 'services are needed' can possibly disrupt people's private projects. One health official recounted how he had been caught up in a reshuffle in which various senior district health managers had been shifted from one part of the province to another. From a professional perspective, he was not happy about it. In his view, it has destroyed teamwork to put people who were all strangers together. The first six months things did not go well in the district, he stated; a few months later they still were learning. Privately, he was also not happy with the move. At his current post, accommodation was a problem for him. At his previous post, he claims he had started settling down. He had begun projects that were "only quarter way" when he was moved. This included building a house and developing a farm; he made investments, he claimed. Whereas previously he used to grow his own food, now he was forced to buy food in shops. At his current location, he claimed there was little possibility for farming. Farms were on the plateau, far from the *boma,* because in the valley land was not fertile. Soon, however, he admitted that he would take leave to cultivate his farm; then he could also work on finishing the house.[107] Another health official had bought land at his previous posting to build a private nursing school. When he was moved to a new town, he had to put these plans on hold. He claimed that he "he hasn't trusted anyone yet" to build the school for him, though he suggested that he had talked to the pastor of his church, who might be able to supervise the project.[108] For others, changing one's work location may actually partly depend on their business success. One health worker stated

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[103] ML0811/10.
[104] LB0809/02.
[105] ML0706/33.
[106] LB0809/06.
[107] ML0811/15.
[108] LB0809/04.

that he would like to continue working in the town where he was posted, because he claimed to see business opportunities there – not only in his own profession, but also in the mining and in other fields. Still, he had not yet decided whether to build a house. First he wanted to see if his business plans would work out. “It is tricky, tricky, tricky. What makes a person leave a place is when you don’t generate money,” he argued.[109]

Of course, not all business ventures are in fact a success. One health worker had also been transferred to a different district. There he still had a farm, but he claimed that after he left, it had been mismanaged by the hired workers. He had also planted sweet bananas there, but again these had not been performing well. This he also attributed to the lack of care from the workers. Now, he suggested, he would focus on his current location. He already had plots of land, a hectare for farming and a plot to build a house.[110] Another respondent mentioned he had a business raising ‘layers’ (chickens producing eggs), which had failed to do well. He put this down to the fact that the person he had hired to manage the business did not do a good job. He claimed that he was intending to restart the business on the plot he had bought to build a house. The plot had been bought from a colleague who our respondent claimed had gotten into financial problems. Possibly, our respondent considered, he could even put up three houses as the plot was big enough. Unfortunately, putting up structures on the plot had been delayed because of other expenditures, such as school fees, rent, and support for his mother.[111] Another health worker was currently building a second house and doing some farming, while his wife was running a tailoring shop, which he claimed was doing fine. He added that he and his wife also used to own a cleaning company, which had two employees. They have since abandoned it, however, which our respondent attributed to the fact that the town where he is based was not big enough to sustain the business.[112] These accounts are illustrative of a trial-and-error approach to business on the part these part-time entrepreneurs. They place a number of arrows on their bow and try to see which ones hit the target, hoping that one will hit the bull’s-eye. One respondent suggested a conscious strategy of honing one’s business skills. He mentioned that he had a small shop at the market. He would like to expand his business, but he admitted capital was a constraint. Nevertheless, he felt it important to practise at doing business before retirement. “You have to develop the skills”. He said he had seen people go into business after retirement and failing because they did not have the experience.[113]

In addition to farming, livestock rearing, and owning a store, various health workers or their spouses were involved in petty trade. Some would buy *chitenge* materials from Congolese traders, selling them in commercial centres along the ‘line-of-rail’.[114] Others would buy second-hand clothes or other goods in, for instance, Lusaka and the Copperbelt, selling them to villages, sometimes on credit.[115] One health worker along Lake Mweru said that from time to time he transported and sold dried fish on the Copperbelt,[116] the trade described by Gordon in his study of the Luapula-Mweru fishery.[117]

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[109] PB0810/14.
[110] PB0811/33.
[111] ML0811/17.
[112] PB0809/03.
[113] LB0809/21.
[114] PB0810/15.
[115] ML0811/18.
[116] ML0811/11.
[117] Gordon, D.M., *Nachituti’s gift: Economy, society, and environment in central Africa* (Madison, 2006).

Beyond these more traditional economical activities, however, some health professionals would venture into more contemporary market niches. As I was interviewing an official at the Ministry of Health, he received a phone call. From the ensuing conversation and the respondent's explanation, I learned that a truck carrying goods for him had some problems crossing the border into Zambia. He later explained that he and his wife had a business. In school he had learned woodcraft and metalworking and with these skills they had started building furniture. He said he had designed and produced metal beds that could be taken apart and easily carried, which he delivered to the armed forces as equipment for Zambian contributions to peace missions. He also said that he was working on a hire-lease scheme of furniture for students at police colleges, for which he imported furniture into Zambia.[118] In short, from his account it seemed that his business had over the course of time expanded following opportunities he encountered. In another case, an accountant explained he had a business centre in town, run by his wife. They offered copying, typing, and word processing services, in addition to selling supplies. Two employees were working at the business centre, including his niece. They had stopped offering Internet because of problems with viruses. Informally, this respondent admitted that he could use his regular visits to Lusaka for his work to arrange things for his business.

Some health workers used the skills and experience gained during their training and in their day-job as a basis for their business. A doctor mentioned that he had a small company, which he and some colleagues run to provide training and consultancy. As an example of the services offered, he explained that they would, for instance, offer talks about AIDS at functions organised by, for example, a commercial bank or a newspaper.[119] Another professional also considered using the knowledge from his profession for his private business. A radiographer at a provincial hospital mentioned considering opening up a private practice. He claimed that for five to six thousand US dollars he could buy a second-hand ultrasound machine on-line. With this, he argued, he could determine the sex of unborn children for a fee. This service he claimed was not offered in the government public health set-up and he calculated how profitable it could be. The money needed to buy a machine, he claimed, was not a problem for him.[120]

In these examples, private business interests may continue where one's formal work stops. From these accounts we cannot, however, see how this boundary is maintained. Sometimes health workers benefit from opportunities presented by their day-job, such as the accountant using business trips to also pursue his private affairs. Potentially, this can give rise to conflicts of interests: A neo-patrimonial blurring of the public and the private. Such conflicts of interest between private and official business will be discussed later in this chapter, but let us now look at other jobs 'on the side'. In his dissertation, Anders referred to this as moonlighting. Whereas moonlighting by civil servants may have a negative connotation, in Zambia it is legal and acceptable to have multiple jobs as a civil servant,[121] as long as there is no conflict of interest between official and private activities.[122]

In addition to engaging in farming or business, some health workers work extra jobs. When visiting two private clinics in a provincial town, on both occasions the owners

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[118] ML0706/37.
[119] ML0812/03.
[120] PB0810/14.
[121] *Times of Zambia*, 'You're free docs told', 18 November 1991.
[122] ML0812/03.

admitted that their staff were nurses and clinical officers working at local government clinics or in the hospital. One even advertised his business by telling me that the part-time nurses at his clinic were charming and had a better attitude there than at their day-jobs.[123] In hospitals also, some health workers related how they worked part-time, referring to working extra shifts in other wards. One nurse said that she does part-time work in other wards occasionally. She claimed that this practice had been set up due to the shortages of manpower. She explained that you had to book extra time in advance through the nursing officer; then you could work extra shifts for extra money. The nurse admitted that she did do this sometimes, "but not very often because I also need to rest".[124] Even a doctor in Lusaka, who had moved back from living in Scotland, mentioned that previously he was working part-time at the hospital, though he had stopped five years earlier. He claimed that his children had wanted to continue the same type of life as they had in Scotland, "so I had to work hard and add some part-time work to my income. Now they have grown and I don't need to work part-time anymore".[125]

Yet others had jobs with international organisations or NGOs. One psychiatric nurse said he was a part-time radio presenter, at times doing programmes sponsored by NGOs. He claimed he did not get a regular salary for this, though: "If they feel like paying me, they do. I do get a bonus based on the money I bring in for the station by working for sponsored programmes. It is not a salary as such, more like a motivation fee". In addition, he had been trained as a psycho-social counsellor by a UN-agency. He mentioned he occasionally worked for NGOs such as KARA Counselling in Lusaka or UN-agencies. He mentioned that he was sometimes hired as a counsellor and sometimes as a trainer for courses of up to 12 days. In those cases, he claimed, he would have to arrange with his colleagues that he could be away from work.[126]

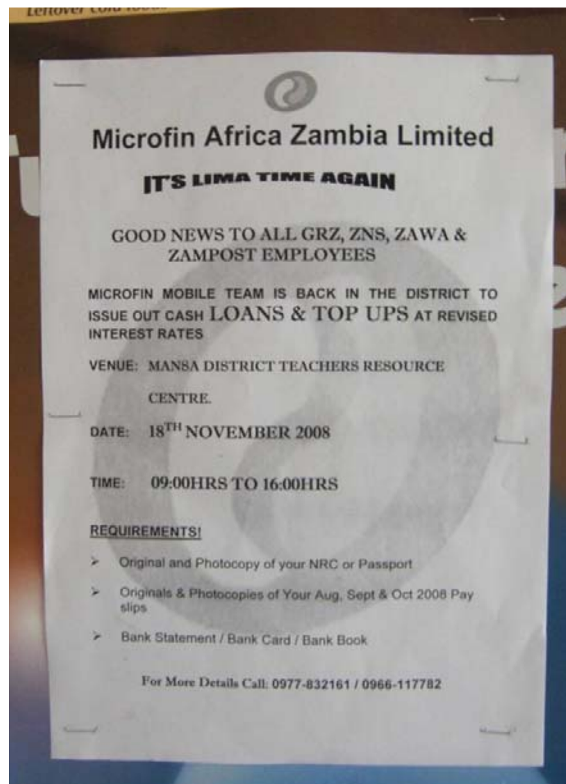
From many of the previous examples of health workers working beyond the payslip, we can deduce that such business can be a social affair. For many, their spouses or others in their household are involved. Disentangling the social network behind commercial ventures in contemporary Zambia can at times be quite complex, as Ferguson learned in his description of a retired mine worker, who had become involved in his family business by the time Ferguson visited him.[127] The accounts collected in this research do not delve deeply into the social arrangements behind these businesses. It is clear, however, that a household's livelihood portfolio is filled with various income-generating and investment opportunities. A day-job in the health sector is but one of these livelihood ventures. At the same time, such a job provided a steady, dependable source of income, which can be invested in other livelihood ventures. On the other hand, having regular salaries from their day-jobs offers capital to invest into business ventures. In fact, there are various companies that offer credit products specifically aimed at civil servants, in which their employment serves as security (see Figure 5.2). One of the aims of the livelihoods' strategies presented by our health workers is to accumulate wealth in order to prepare for the future. Considering that Zambian civil servants normally retire at fifty-five years, this is a future that comes soon.

[123] ML0811/18.
[124] PB0810/19.
[125] PB0812/12.
[126] PB0811/02.
[127] Ferguson, *Expectations*, 158-164.

Preparing for the future

In this section we will follow health workers until the end of their career in health: Retirement. But as we will see, this is by no means the end of their working lives. Before discussing pensions – how government provides for their retirement – and before discussing the ventures they might engage in after retirement, let us first examine a private strategy for amassing wealth for later years: Investing in real estate. This is a venture which we will see not only cuts a household expenditures by saving on rent, but is also a striking part of health workers' preparations for the future. This strategy for accumulating wealth has also been stimulated by government, particularly under Chiluba in the run-up to the 1996 elections, as we saw earlier in the case of Mrs. Tembo.

Figure 5.2 Advertisement at Provincial Health Office



Housing and accommodation feature prominently in the accounts of health workers. We have seen in the example of Ashley and Anton how lack of accommodation can be a cause of disaffection among health workers. For many health workers there is institutional housing for which they, as we have seen, need to pay only a modest fee. Other health workers indicated in interviews that they were renting. At times the rent was higher than what they received as housing allowance. One nurse in a provincial town, for instance, mentioned that she received 200,000 Kwacha in housing allowance while she was paying 250,000 in rent.[128] Another was living in a house in a medium-density[129]

[128] PB0810/09.

neighbourhood. With the same 200,000 housing allowance, she claimed that she and her husband paid a million Kwacha in rent.[130] From this, it is easily understood that some would prefer to build a house to cut their rent expenditures, unless for instance they are not sure they would like to remain posted at their current location. This was the case for another nurse, though that is not to say she was not keen to own houses. She was not interested in building a house at her present location. She and her husband are renting a four-bedroom house for 700,000 Kwacha. She did add, however, that they had two houses elsewhere. They had one in Lusaka, where her children were living. With her husband she had one son going to college there and she had two stepdaughters, who were both married. The other house was in Kabwe, where they had previously been working. That one, she said, was being rented out to cover the rent they were currently paying. "If I had a way," she added, "I would buy each child a house".[131]

As we have seen before in passing accounts, various respondents were living in institutional houses, while they had other houses in which their children lived in town. One nurse, who was working with her husband at a rural health centre, stated that they were building a house in town. They already had a plot. To argue the rationale of building a house, she said, "There's death," explaining that when they die they could leave the house to the children. Also if they were transferred, they could rent it out, or when retired they could come back to the house.[132] For some, however, building houses appeared more of a commercial venture. One clinical officer staying at a rural health post said he was building a house in town, which was almost complete. He claimed it was a bigger house than the two-bedroom staff house he was living is. To finish it, he said, he just needed to wait until he had saved the money to finish the floor and to put in the electrical wiring. The prospective landlord added that he wanted to furnish the house nicely, so that "*ma*-bosses, or people like you, can rent it for big cash".[133] As an illustration of real estate investment on a slightly larger scale, we can take another account. As I was waiting at a certain health office, I spoke with someone else who was waiting around. He mentioned that he was working for the Ministry of Works and Supplies. In his free time, however, he explained that he carried out private jobs with colleagues. This was the reason, he claimed, he was spending part of his free Monday morning waiting for a certain doctor. The doctor, while my conversation partner and others waited, was busily engaged. It appeared that he was building apartment flats in town. The man from the Ministry of Works and Supplies was constructing the tarred driveway on the property and needed to consult the doctor about that.[134]

While it is impossible from our accounts to get a picture of the full extent to which health workers construct houses, it seems evident that this building activity is significant. Depending on their phase in life, many respondents had one or more houses in their possession. The empowerment scheme that the government implemented in the mid-1990s, selling government houses to the sitting occupants, judging from some respondents' accounts definitely contributed to this endeavour. In any case, it is clear that building and owning real estate is a lucrative objective for Zambians who can afford it.

[129] Middle-class.
[130] PB0810/11.
[131] PB0809/05.
[132] LB0809/10.
[133] LB0809/19. The respondent used the Bantu prefix *ma* in his English.
[134] ML0811/23. The wife of this doctor, herself a doctor, confirmed in a separate interview that they were building flats. PB0811/25.

Not only are they saving on paying rent, generating extra income, and thinking of their children's inheritance, they are also accumulating wealth which can later be used for financing business ventures or other expenditures. These health workers are following a common pattern in a country where the construction business has been growing steadily. Between 1999 and 2005, for instance, construction in Zambia grew at an average rate of 15 per cent per year.[135] Moreover, by accumulating wealth through real estate, they are laying a stable basis for retirement.

Here this section moves on to examine what retirement from government service means for our health workers. In Zambia, the retirement age is fifty-five. However, rather than being the end of someone's working life, it seems that retirement for many is merely the continuation of one's economic life based on a portfolio of different livelihood ventures. When retiring, civil servants can choose to get about half of their pension as a lump-sum, leaving a small additional monthly pension. Historically, these pension payouts have not been worth that much while the Zambian economy was going through the economic crisis of the 1980s and 1990s. As people were waiting years to receive their packages, inflation steadily eroded the real value of these payouts.[136] What was left of the residual pension was often less that the postage costs required to mail the pensions to the recipients, as the pensions were not adjusted to inflation.[137] In the mid-1990s, a national pension scheme was set up, following an act of Parliament reforming the various pension schemes and establishing the National Pension Scheme Authority (NAPSA). This meant that all those in formal employment were entitled to a pension. A fellow researcher told me an anecdote from one of his respondents, who had worked in the health sector for 34 years until his retirement in 2003 or 2004. Under the previous pension scheme, he had paid his pension contribution for 27 years, and he then paid 7 years to NAPSA. When he was awarded his pension, the former Civil Servants Pension Fund allegedly paid him 6 million Kwacha, whereas NAPSA paid him 11 million.[138] This anecdote suggests what one might assume: In the favourable macro-economic climate that Zambia has seen in most of the first decade of the millennium, lower inflation has protected the value of pensions in recent years. It may also indicate that since the reforms initiated in the Chiluba era, pensions are in fact better managed. Nevertheless, it is clear that historically Zambian professionals had been used to heavily eroded pension packages. Moreover, the current generation of retirees will still have built up much of their pensions before the establishment of NAPSA. It is thus understandable that Zambians have learned to adopt strategies preparing them for a retirement in which they would have to remain economically active.

When he was being interviewed, one health worker said he was nearing the date of his retirement. He had been due to retire earlier, but this was delayed due to bureaucratic issues. Now he was waiting for the letter and presumably the package that went with it. He said that he had already finished two houses, and he was set to complete a third. Perhaps he would even build one or two more houses, he went on, "for the children, when we say goodbye". After retirement, he said, he would try to improve pro-

[135] National Council for Construction, quoted by *Xinhua*, 17 July 17 2006, 'Zambia's construction industry records highest growth'. Source: http://english.peopledaily.com.cn/200607/17/eng20060717_283904.html (accessed 19 February 2009).

[136] See Table 1.2 in Chapter 1.

[137] Queisser, M., C. Bailey & J. Woodall, *Reforming pensions in Zambia* (Washington, 1997).

[138] Daniel Reijer, personal communication, February 2009.

duction on his farm, as currently it was producing below capacity. He was also planning to start a hardware business. He had already applied for a loan, having filled in the paperwork, and now he was just waiting for the finances.[139] A nurse admitted that she still had seven or eight years to go before retirement. Nevertheless, she was already thinking about it. "I have been encouraged by my husband to do something after retirement. He says, 'You are a nurse and I am a lab tech, so let's open a surgery together'. But I don't have an interest in that: I like farming. But my husband says, 'One day you'll be old and then you cannot farm anymore, so it is better to improve your career'".[140]

Others did in fact choose to do something after retirement that was close to their old profession. One elderly man, the owner of a private clinic who had presented himself as a doctor, was in fact a retired clinical officer.[141] Another respondent, a pharmacy technologist, said he had been considering opening a drugstore after retirement. He claimed he had specially chosen to be transferred from a hospital pharmacy to a district pharmacy as that extra experience could help him with a drugstore. He admitted that he had even wanted to groom his son to be a pharmacist. Then that he could register the pharmacy in his son's name and run it himself. He could not do that on his own as he is merely a pharmacy technologist rather than a proper pharmacist. The son, however, had chosen to pursue a different field of studies and the father decided not to force him to do his will. As an alternative to opening a drugstore, our respondent indicated that he could stay on as a pharmacy technologist working for a district, as there are shortages for trained people in such posts.[142]

Staying on after retirement is a phenomenon that was encountered frequently in interviews. Various respondents who were still working had already retired from government service. However, to cover the manpower shortages, they were continuing to work on a contract. One psychiatric clinical officer said that he had retired in 2000. "I didn't want to come back after retirement," he recounted, "but the executive director came to see me. He told me I was the only one who was qualified and that the patients were suffering without a clinical officer. I thought I could do it because of my care for the patients".[143] Besides the lofty motivation presented by this respondent, of course there are also basic financial motives to continue working. One clinical officer had graduated and started work in 1966. Then in 1991 he retired at the age of fifty-five. He said that he used his retirement package to buy a house. Nine years later he applied for a contract on the Copperbelt. He said that his children had started going to college. "Life was getting harder and harder for me and my children, both because of the schools and because of the financial crisis". While his wife was still living in Luapula, he went to the Copperbelt, to have a "change in environment". The cost of keeping two homes, however, made him move back to Luapula after a year. "I got very little; I had to divide 500,000 between the homes and I was remaining with nothing". Then, however, he started working in the place where his wife lived until 2004. Then he stayed at home for a further two years until he again got a new contract because his children were still in college.[144] This practice of taking people who have retired to work on contract can be

[139] PB0810/12.
[140] PB0811/09.
[141] LB0809/05.
[142] LB0809/17.
[143] PB0811/10.
[144] PB0811/30.

seen as a pragmatic way of coping with the tremendous shortages of staff which the health sector is facing. Some of these health workers are indeed still active and have a wealth of valuable experience to contribute. However, interviewing some elderly health workers on contract also provided a different view. One retired nurse I interviewed appeared dull, old, and tired. She could not manage to give a clear account of her career, mixing up decades and giving vague and minimal answers. After the interview, she resumed sitting in front of the clinic on a bench, waiting and eating a mango.[145] Her boss, the clinical officer in-charge, also did not appear too impressed with her performance, indicating she was not very active, but old and tired.[146] However, in a sector where human resources are scarce, perhaps 'beggars can't be choosers' and the sector should be happy with what they can get.

Now let us now examine where health workers plan on settling after retirement, after having spent a mobile career and being moved from place to place. A respondent said that he wanted to return to the province he came from, as he was a headman. He said that his relatives had followed him to where he was. His social responsibilities would thus draw him back to the village.[147] Sometimes this decision is not as easy for married couples. From the separate interviews of a man and his wife working in the health sector, we learned that they had different views on this issue. The man, who still had three to four years to go before he retired, announced that he would start a business trading general merchandise after retirement. He reflected that one day he might move back to Eastern Province, where he came from originally. He argued that his relatives missed him, wishing he was back home.[148] His wife mentioned that she still had seven years before retirement. She indicated, however, that when her husband retired, "we can just go" from the rural health centre they were managing together. She did not, however, share his dream of one day going back to Eastern Province. The province where they currently lived was familiar to the children, she argued. Moreover, the family was building a house in town. She claimed that it would bring problems if they went home. "Relatives will think we have a lot of money and they will depend on us. If we visit, we bring them things and they can come and visit us and we give them what they need. But when you have money, that can bring conflicts. In Africa we are superstitious; there can be witchcraft".[149]

Other health workers claimed that they and their partners had clear plans on where to settle. One district health official, whom I met at a workshop, told me that although he was working in a rural part of the Copperbelt, he was originally from Western Province, while his wife was from Eastern Province. He said he was planning to retire halfway between his relatives and his wife's relatives in Central Province. He explicitly said he did not want to retire in Eastern Province, as being too close to your wife's relatives brought nothing but trouble.[150] A nurse gave a similar account. She was from Eastern Province, having grown up in Kabwe, and her husband was a teacher from Serenje district in Central Province. After her retirement, she said, she would like to go back to Kabwe, explaining that "for our retirement we want to choose a neutral place, without

[145] ML0811/09.
[146] ML0811/08.
[147] PB0811/01.
[148] LB0809/09.
[149] LB0809/10.
[150] ML0804/13.

relatives".[151] In other words, while other health workers may have had other plans, these health workers were intent on maintaining a distance. Their careers had allowed them to accumulate capital. Moreover, they may have failed to continue investing in social capital, 'back in the village'. Deciding to go back to the village could confront them with rural jealousy and witchcraft, risking all that they had worked so hard to accumulate. As such, distance could help them to guarantee the emancipation that their jobs had brought.

This brings us to the end of our journey following the career paths of health workers that has stretched over the preceding chapters. In the preceding sections, we have witnessed health workers as rational economic actors. If they have the social and economic assets, and of course the appropriate competencies, they have the possibility to balance a broad array of necessary, desired, and demanded expenditures against a salary, allowances, and a number of extra sources of income, all this with an eye on their own future in retirement, and also the futures of their children. It is evident that along this journey, one can see much struggle: Up the rungs of the education ladder, out of poverty, against a system that might want to post a health worker where he would not like to be posted, a struggle to make ends meet and to care for others without forgetting your own future. In spite of these struggles, the preceding does not reflect the sense of doom evoked in Ferguson's study of retiring mine workers in the early 1990s. In part, this is because Ferguson ended his analysis at the mineworkers themselves, without taking into account their children, some of whose accounts were presented above. For the mineworkers themselves, their expectations of modernity might have suffered a hard blow; it is not evident that the same necessarily applies to their children. On the other hand, more relevant is the fact that the economic climate in the decade that separates his account from this one has markedly improved, impacting particularly on the group of people followed in this dissertation. While it is very likely that these economic conditions influence behaviour, some patterns of behaviour may be enduring, not least because of the risk of economic conditions again deteriorating, for instance as a result of the global economic crisis following the credit crunch of 2007–8. In the last part of this chapter, we will make an attempt to analyse health workers' behaviour as a result of the economic and social pressures they face.

Stealing government's time, and ...?

In the previous sections, we have been looking at various competing claims on health workers' limited, but varying sources of income. Many respondents had different ideas and saw various opportunities to make extra money. At times, they claimed that they did not have enough capital for further investment. In this section, we will see what these economic pressures may drive them to besides the more straightforward economic activities presented above.

It is not only money that limits health workers' possibilities to do better. Another important factor is the scarcity of time health workers have in which to earn extra income. Above we saw accounts of people who did not have time to supervise their businesses, causing them to fail. Time is especially scarce since health workers are already holding down what are officially full-time jobs. Some respondents have stressed how they do farming at the weekends and attend to their studies or other business before

[151] PB0810/04.

and after work. Of course, civil servants are formally required to be 'present on duty during the whole period of the normal working hours', or so the *Terms and Conditions for the Public Service* reads.[152] Failure to comply with this constitutes misconduct. This was also reflected in the words of a doctor who, when asked about his business activities, said that "existing laws allow for private enterprise on the part of public servants. But your private enterprise must not interfere with your work". He stressed that there must be a clear and transparent delineation between official and private work.[153] It would be naïve, however, to simply take such statements at face value and assume that these rules are representative of general practice. If people work on their own projects during the boss's time, one cannot expect them to bluntly admit it and thus incriminate themselves. On the other hand, it would also be too cynical to casually dismiss statements by respondents that they separate public from private business. Suffice it to say that there is both a real and a potential tension in keeping a balance between a day-job and secondary activities. This was illustrated when we asked the participants to a focus-group discussion on how one can become successful in the health sector. One participant stated, "by stealing government's time", causing hilarity among the other participants. A colleague chipped in, "he has a point there", adding that people steal government time (as opposed to money) by taking time off to attend to other business. "Maybe you come at nine, knock off at eleven and then go back at fifteen. It's very difficult to run a business next to work".[154]

This assertion by our focus group participant, as well as the way in which his colleagues perhaps embarrassedly supported it, suggests that this may indeed be common practice. The assumption on the part of the provincial officials intervening on Ashley's behalf (in Chapter 2), that the manager administration was just rushing after his own business, also suggests the same. This research did not set out to determine to what extent people actually steal government's time, though as a researcher I did remain attentive to picking up accounts or behaviour suggesting such. While interviewing people or waiting for them, I have observed some receiving calls that may have been related to business rather than work; I found them out of the office or coming in later; I waited and chatted with people waiting for health workers for other than official business; and I have seen them surfing the Internet for possibilities for further education or second-hand Japanese cars[155]. In such situations, it might have been easy to speculate or assume; it was more difficult to contextualise these fragments, make full sense of them, or verify suspicions. In part, this was influenced by a desire not to appear too snooping or nosey, potentially offending people or jeopardising good relations needed for further research. Nevertheless, having seen how normal it is to work beyond the payslip, having got a sense of the claims on health workers' limited money and time, and having heard accounts suggesting the prevalence of such behaviour, it is safe to assume that there are incentives driving people to consider stealing government's time, despite the fact that this is against regulations.

The same may be said about stealing more than government time: Stealing government resources. In a Transparency International country study of Zambia, poor conditions of service were first among a list of factors presented as causing corruption. It is

[152] Chapter IV, Article 58(a).
[153] ML0812/03.
[154] FGD0811/02.
[155] The number of cases when calls, visitors, or time out of the office was clearly official was markedly greater, however.

argued that these poor conditions of service 'fuel corruption as the public service workers strive to survive in a harsh economic environment'.[156] This argument that low salaries are instrumental in people benefiting from government beyond what is legally accepted also features prominently in casual conversation. Having examined the accounts and the situations of contemporary health workers, it is clear that it is a struggle to balance all of one's desires, ambitions, and the claims and demands one is facing. However, having also compared the figures of the basic needs' basket with salaries and allowances, it appears that this struggle is not that of basic survival. Nevertheless, for a long time it had been the case that the real value of civil service salaries had plummeted from what in the early years of Independence was a good salary allowing for a modern middle-class life. Amidst the *permanent* economic crisis Zambia underwent, those on the government payroll must have developed strategies for 'striving to survive in a harsh economic environment'. Possibly such survival strategies have endured to sate the needs, ambitions, and desires of some of those health workers whom we saw 'struggling financially'.[157]

The argument of linking corruption to poor conditions of service was used above to explain the stealing of government resources. Such arguments, however, can also be used as an excuse to justify their behaviour by those involved in such theft. Basic survival might justify issues that may otherwise be considered morally deviant. Let us examine, however, indications of the theft of government resources in the Zambian health sector from health workers' accounts. Let us start by presenting an account that empathically does not subscribe to the justification of theft with the survival argument. This will allow us to argue that while theft is prevalent, it is not as ubiquitous or uncontested as exaggerated views of neo-patrimonialism may assume. A senior officer at a hospital said that once he had gone to a workshop. He explained that the organiser, presumably a foreigner, had access to the participants' payslips. The organiser had asked, "How do you survive? You are starving or you are all thieves". Our respondent still looked a bit taken aback by the argument, saying, "But we just survive by the grace of God. If everybody would pinch, there would be nothing left. Health workers are putting in everything".[158]

In spite of this striking account, pilfering of government resources does occur in the Zambian health sector. However, it is nearly impossible to determine to what extent it occurs. Newspaper stories occasionally report on health workers caught stealing. One such article reported that two senior health workers at the district hospital in Mazabuka were suspended while they were being investigated for theft and misappropriation. They were alleged to have been connected to the disappearance of fifty bed-sheets and for failing to account for excessive fuel tanked at a petrol station. They were also suspected to have stolen medical fees, which had been collected but not yet lodged in the bank. The article quoted the manager administration of the district health office, who reported that these anomalies had been discovered by an ad hoc committee established to look

[156] Chanda, A., *New anti-corruption governments: The challenge of delivery, Zambia a case study* (Nairobi, 2004), 15.
[157] If the actual historical prevalence could ever be measured, this might give an insightful quantitative analysis.
[158] LB0809/21.

into the disappearance of the bed-sheets. In an article half a year later, it appeared the duo were due to face court.[159]

From health workers' accounts also, there are indications that pilfering occurs and attempts are made to deal with this. A human resource officer who had previously been working at a large hospital reported that he had been involved in dismissing someone working in catering for having stolen two chickens, suggesting this was not the person's first offence.[160] A provincial pharmacy expert explained how she would audit district and hospital pharmacies to prevent stealing of drugs. She explained that there is one trick which people may attempt: To put good drugs between expired drugs due to be destroyed, the good drugs then being removed before destruction to be sold.[161] Finally, a provincial human resource officer spoke of how someone at a district health office was supposed to pay electricity bills. Instead, the human resource officer claimed, he had "chewed the money". Subsequently, he was suspended without pay for three months. Also, someone at a nursing school was reported to have "chewed twenty million" Kwacha.[162] When I wanted to further delve into these two cases for more detail, this was politely refused.

The issue of pilfering also came up during a performance assessment visit to a rural health clinic, which I witnessed. The team, consisting of officials from the provincial and the district health office, had noticed that there were stock-outs in the storages of drugs. A district official said that people from the clinic passed the district pharmacy weekly to pick up consignments of drugs, yet there were still stock-outs. The team leader then advised the man from the district to carry out an audit to see if pilfering took place or whether it was an issue of bad stores' management. He then told the in-charge of the clinic to be careful and monitor how the clinic managed drugs. Drugs, he said, are the most expensive resource in health centres, and the DRC (Congo) is very close by. He also cautioned that the health centre is dealing with volunteers and classified employees and that one must be suspicious of everyone. The team leader then spoke of a health centre in another district where they found drugs missing. There it appeared that a classified employee was married to a businessman. Moreover, he recounted a story of when he himself had been working in a mission hospital in Eastern Province. At that time, there were frequent stock-outs of chloroquine.[163] One day he decided to take care of issuing chloroquine himself, and it appeared there were enough drugs for the caseloads they encountered. It then appeared, or so the official recounted, that a classified employee had been giving chloroquine tablets to relatives who passed by, as if they were groundnuts.

As the performance assessment team was driving away, this issue was being discussed. I got the impression that the in-charge was being suspected. A district official said that the in-charge's wife was living elsewhere, where she was working as a teacher. Every Thursday or Friday, before going to his wife for the weekend, the in-charge would pass by to collect drugs at the district health office. It seemed that he was retired and continued to work on contract.[164] When I visited the clinic several months later, the

[159] *Post*, 'Mazabuka health workers on forced leave', 28 April 2008; *Post,* 'Mazabuka health workers due in court', November 2008.
[160] ML0810/09.
[161] ML0607/17.
[162] ML0804/08.
[163] A first-line drug previously used for treating malaria.
[164] Field notes VW06.

in-charge was still working there. He told me that he was continuing to work beyond retirement to help educate his children. When I raised the issue of drugs, he said that he occasionally received technical support for dealing with stock management. I did not get a picture of the extent to which this issue was followed up, not having prodded him further on the issue.[165] Instead, speaking to a young nurse who had joined the in-charge at the clinic since I my last visit, some complaints about drug management at the district surfaced. The young nurse, who seemed to have taken charge of administrative issues such as drug management, complained that "when we order drugs, we go there with our book showing what we need. Then there is no vehicle. It can then take a week and when they do come they don't have all the things you need. They just pick some things and give it without looking what you really need. It can be that there are shortages, but basically it is more a transport issue".[166]

These accounts presented above are extremely anecdotal and fragmentary. The behaviour of both those complicit and those in positions of responsibility make it difficult to get a full perspective on how widespread such cases are. It is clear that theft is a crime, and the fact that people are in certain cases prosecuted indicates that it is punishable crime. Thus, if people are involved in theft, there is no reason for them to incriminate themselves; on the contrary, they evidently have incentives to conceal such behaviour. For officials dealing with such cases, too much openness, and possible publicity, would cause embarrassment. They would thus prefer not to give public attention to such cases. On the one hand, this is logical behaviour for bureaucracies anywhere. On the other hand, the lack of openness encountered while investigating such issues, combined with rumours among those outside the sector, may equally fuel conjecture about whether stealing of government resources is rampant and an inherent part of the system. Those who are part of the system would then share complicity by keeping quiet on specific cases of theft. If one followed this line of reasoning further, as Anders did in his study on Malawi, one could assert that those who are caught are lower in the bureaucratic hierarchy or those who violate the 'office mores'. Such office mores require people to keep quiet about this conspiracy of 'democratised appropriation'.[167] On the basis of the information gathered in this research, it is impossible to either verify or falsify such theories. What we do know is that there is great economic pressure on health workers and sating their needs, ambitions, and desires is an enormous struggle. Especially when people have been adversely struck by unexpected loss or have accumulated debts to settle the claims they face, they might be tempted to look for a 'lucky break'. We have also seen the ambitious manner in which many try to forge ahead. It is thus quite possible that some might use their assertiveness to create an opportunity to make extra profit from the system that is sustaining them.

Having examined possible economic motivators for stealing government resources, the questions arise as to how wide or narrow the margins are within which one can steal and what the chance is of doing it with impunity. This depends in large part on the systems in place to prevent this and to deal with it. It also depends on the extent to which the formal organisational culture is able to influence people to follow civil servants' codes. We saw above that systems are in place to sanction devious behaviour. We saw that at times these are indeed applied by suspending or transferring staff. At the

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165 ML0811/11.

166 ML0811/12.

167 Anders, 'Civil servants'. One could also compare this, as one former donor official did, to the *omertà* of the mafia: An unwritten vow of silence about illicit behaviour. ML0X13/01.

same time, we saw in Chapter 4 that there is an ambiguity in the way in which such sanctions are applied. Moreover, there is a large measure of impunity enjoyed when it comes to dealing with grand corruption, as we shall see in the next part of this dissertation, in which some such cases will be examined. This may then feed a certain resignation at lower levels of the system when enforcing public service ethics.

Conclusions

This chapter examined the claims by health workers that they were "struggling financially", as "money is never enough, right?" The claims that are made on health workers, by themselves and by their social environment, are very considerable. The fact that many of them have struggled out of poverty and others have kept absolute poverty at bay does little to lighten this load. In fact, especially in environments in which the health worker is one of the few with a good job, they are seen as a potential source of support by their relatives. Responding to these claims is usually presented as virtuous and normal, though it may be considered a burden. It is illuminating, however, to see that these claims are neither unavoidable nor uncontested. The spatial mobility that characterises most health workers' careers is used by some to maintain or create a social distance between them and their relatives, with the aim or consequence of lessening the social burden. Some also choose for retirement a safe distance from relatives, to enjoy the legacy of their working life. People also negotiate with relatives directly and through their deeds. While trying not to strain or sever relations, they attempt to minimise the burden. Some health workers declare their desires and their aims to be to try to help dependants become independent, not least by stimulating them and supporting them to attain qualifications. The relations between health workers and their less fortunate family and relatives can, in large part, be seen as solidarity, as repaying the previous generation for what one has received, or as repaying this hereditary debt to one's children. They can also be seen as a strategy of hedging oneself against future insecurities by investing in social capital. However, one can also see in the behaviour of some professionals a tendency towards personal emancipation. This could be the emancipation that is part of Zambia's process of class formation, emancipation through joining Zambia's emerging middle-class – or, if one prefers, the continuation of Zambia's tradition of the *boma*-class.

Emancipation from one's former social environment is certainly not a clear rupture, nor is it necessarily based on conscious rational decisions. Rather, it can be a process in which people drift away from their kin, in part as a consequence of the investment decisions they might make. As was argued in this chapter, investing in social capital may coincide with buying a house, schooling one's children, or buying a TV, a car, a nice pen, a nice shirt, or a nice perfume. At the same time, such expenditures also compete with family requirements, as health workers' means of meeting both sets of claims are scarce. Some people may fall short of relatives' expectations of what is necessary to maintain the relationship. Others may gradually feel the social distance becoming too great for the relation to be considered significant. Nevertheless, regardless of the precise dynamics of emancipation or the extent to which such vertical ties continue to be maintained, it is clear that many health workers have made investments that benefit not only themselves but also others in their social context. The most significant of these investments is perhaps the investment in human capital: Investing in the education of the next generation to allow them a similar opportunity to forge ahead.

In addition, in this chapter we have seen how health workers are also entrepreneurs. Beyond their jobs, they invest their labour and resources in other productive ventures, including producing food and cash-crops, delivering various private medical and other services, and investing in construction and trade. It is of course impossible from this qualitative research to estimate the economic impact of these productive activities beyond the payslip. However, from a workforce of several tens of thousands, this does appear to be a welcome contribution to Zambia's national income. Perhaps one could even with some validity argue that public health sector employment, together with similar contributions on the part of those employed in the various other sectors of the public service, has made a significant contribution towards achieving the goal of the Zambian Fifth National Development Plan, namely broad-based employment and wealth creation.

Of course these livelihood ventures beyond the payslip are secondary to the official objectives of the health sector. The public interests health workers are intended to serve deal with providing access to affordable preventative and curative health services. At the end of this chapter we have examined how the ambition and opportunism health workers displayed in pursuit of their private (and familial) livelihood strategies may not only distract them from but also undermine the public interest. As health workers themselves put it, one way of successfully pursuing such livelihood strategies is by 'stealing government's time'. It thus appeared to be a practice for some to violate the rational-legal ethics of the public service, which distinguish the private from the public realm. As we saw, this appropriation of government resources was at times even extended to other resources beyond time. In other words, there is indeed a link between the social and economic pressures facing health workers and patrimonial behaviours. However, this explanation is emphatically not a justification. As we saw in previous chapters, behaviour that can be labelled patrimonial, such as theft, may in health workers' accounts have been resignedly accepted as being prevalent, but it was not universally condoned. Moreover, there were systems and arrangements in place to prevent and punish such behaviour. However, such systems appear to have a questionable impact. Moreover, there is arguably a sense of democratisation of corruption, as grand corruption appears to go unpunished (as we shall see in later chapters).

Our health workers are thus caught between different forces. On the one hand, as is evident from their discourse, the ethics and morality in which they have been socialised denounce opportunistic behaviour at the public expense. Others may take offence at selfish profiting as it may affect opportunities for them. There is also a latent threat that deviant behaviour may be punished. On the other hand, there are strong pressures and ambitions facing health workers to accumulate, invest, and consume, which are likely to outstrip their income. Moreover, there may be an office culture of impunity starting at the top, which may give people a sense that they can get away with stealing government's time and resources; at the very least, there is a sense of resignation that others get away with it. In the preceding chapters, we have highlighted health workers' relative agency. We have also shown that there is wide variation in the choices health workers make and the preferences they hold. Within the context sketched above, there is also a choice for health workers: To what extent they want to conform to rational-legal rules and expectations or to manipulate them, bend them, or violate them. There is no way to generalise about what an average health worker will do. However, as one young respondent suggested: "It's a fifty-fifty game ... There are many ways to skin a rat".