9

Health reforms grind to a halt

In this chapter we describe how the momentum of the health reforms appears to have dissipated. This chapter shows that not only donors are factors of importance in this arena, but also health workers' collective interests. At the same time, we will see the failure of a minister to effectively shape the health reforms to suit her own aims.

The structural changes resulting from the implementation of the health reforms were perceived by health workers as being a threat to their conditions of service, particularly their job security and their pension rights. Consequently, the labour unions used the formal means provided by the judicial system to challenge the health reforms. The courts sent the Ministry of Health, headed by Kalumba, back to the drawing board to provide better guarantees to health workers. Kalumba, however, had by this time become mired in public controversy linked to the unrest the health reforms had generated. Having been moved to another ministry, he was no longer able to rescue the reform process. This effective challenge by the trade unions shows how group interests blocked the reform process, thus refuting arguments that in neo-patrimonial contexts horizontal social linkages lack influence.

Kalumba, who had lost his position owing to his failure to reconcile his loyalty to his constituency with loyalty to his superiors, was succeeded by Zambia's first lady professor, Nkandu Luo. Luo, a micro-biologist was more of a micro-manager than the political strategist some of her predecessors were. Having inherited a major corruption scandal, she became embroiled in a conflict with donors, which led to a breach of trust between the donor community and her ministry. This struggle for control related to an episode in which the process of out-sourcing the management of the drug distribution company was apparently instrumentalised to the benefit of a criminal organisation, in return for financial support to the MMD's re-election.

Luo's abrasive style not only alienated donors, it also set various cadres of health workers against her. By asserting her authority, she appeared to be trying to regain some of the power the position of Minister of Health had lost owing to the reforms. In doing so, she echoed the discourse of the Mahler report that too much emphasis had been placed on systems instead of health care. She effectively disrupted the health reform process by disbanding individual district health boards and banning workshops. However, she was not able to reshape the balance of power in the sector. In fact, having alienated the donors, she in effect strengthened the Central Board of Health, as donors opted to exert their influence by bypassing the ministry to work directly with the Central Board. This thus signifies a counterproductive attempt by Luo to manipulate the health reform process to her own ends.

Health workers' disgruntlement further flared under Luo's tenure as she got mired in public controversy. Soon she would be shifted from the ministry, but not before taking the opportunity to preside over the organisation of an international AIDS conference, which was marked by irregularities and corruption, representative of the large-scale looting characterising the last years of the Chiluba regime. Even though donors had bypassed the ministry, ministry officials nevertheless found a means to siphon off resources for other ends. The labour unrest with which Luo was confronted further escalated under a succession of ministers who followed her. Doctors' and other health workers' claims for better entitlements gradually generated broader public support and were translated into protests against the failings of Chiluba's government in general. Donors meanwhile insulated themselves from this chaos dominating the health sector. They continued their support to the sector through the Central Board of Health, further strengthening its capacity as a rational-legal enclave in a neo-patrimonial context. Around this time they also agreed on a memorandum of understanding which would provide the basis for further harmonised support for the sector for the next five years. Health workers finally effectively used their power to disrupt the operation of the sector and cause disorder to strengthen their claims for better entitlement. Thus, besides private and political interests, professional interests had also been effective in instrumentalising the health sector for its collective ends.

Human resource trouble

The de-linkage process in which health workers would be transferred from the civil service to employment under the boards on a contract basis turned out to be the Achilles' heel of the health reforms. This hit a raw nerve of anxiety and led to opposition from those representing health workers' interests. This process of transferring the authority over personnel management to the boards meant that health workers would lose their permanent and pensionable civil service status in exchange for three-year contracts with higher salaries. Although some staff reportedly welcomed the expectation of higher salaries and better job satisfaction associated with working with better-motivated colleagues, others were concerned about their pensions and end-of-service benefits.[1]

The de-linkage process was set against the background of wider public sector reforms that had the goal of trimming down the public workforce. Throughout the public sector there had been retrenchments to weed out unproductive staff and redistribute personnel from towns to more remote areas.[2] According to an observer working for a non-governmental organisation, in most retrenchment processes redundant staff would normally get a retrenchment package. In the context of the economic instability witnessed in Zambia at the time, this would provide a considerable sum for consumption and investment. However, a statutory instrument had been presented to Parliament, which would absolve the government of the responsibility to pay termination of retrenchment packages. It was argued that there were sufficient jobs in the sector, albeit not always in town. As many health workers were reluctant to move to rural areas, the lack of a retrenchment package limited opportunities to work elsewhere. Many health

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1 Gerritsen, M., 'Key-actors in the Zambian health reforms' (unpublished term essay, London School of Hygiene and Tropical Medicine, 1998).

2 Bennett, 'Health'.

workers thus felt cheated and demotivated. This in turn further compromised the quality of care.[3]

This anxiety and the perceived threats to health workers' interests were taken up by two major public service unions. They took the ministry to court, calling for a review by the High Court of the statutory instrument that would allow for de-linkage of staff to the boards. The unions claimed that they had not agreed on de-linkage. They expressed concern that their members would no longer fall under the conditions of service they had negotiated with government. Another complaint was that the ministry had threatened to withhold funds to hospitals and districts that did not proceed with the de-linkage process.[4] Various people involved in the process or observers from within the sector suggested that the unions were essentially motivated by their organisational interest rather than their members' needs. De-linkage of health staff from the public service would mean that the civil service union would lose a considerable number of its members as well as their contribution fees.[5] One district health manager even considered the possibility that union members might have been bribed to support the case.[6] Regardless of the unions' true intentions, they were effective in delivering a legal blow to the health reforms, though perhaps not a definitive one.

Kalumba later admitted in an interview that he had realised too late how health workers had the capacity to resist change, while the reforms had presumed they would be the agents of change. Even if they technically understood the reforms, their perceptions of their individual and collective interests impacted on the process. Especially lower in the hierarchy, people felt more threatened by the prospect of change. Kalumba felt that nurses in particular were critically vulnerable to unionised politics. They argued and fought against de-linkage even though the de-linkage process had been strategically designed to improve their conditions of service. That would not have been possible if the boards remained part of the civil service, Kalumba argued.[7]

Apparently, at the time, Kalumba had also had the perception that health workers did not sufficiently understand that de-linkage would be to their benefit. He announced to the *Post* that he had been on a countrywide tour to explain the process and remove health workers' concerns.[8] A media report of the confrontation between Kalumba and health workers, however, did not suggest improved understanding *per se*. From a report of a meeting in Livingstone printed below (Box 9.1), it appeared that at least the journalist did not fully understand all of Kalumba's explication. This was particularly the case when he was discussing traditional views on sexuality, making reference to more cosmopolitan images of topless sunbathing, leaving some of the audience embarrassed. Apparently, the intellectual Kalumba did not always strike the right, locally sensitive cultural chord. In his defence of de-linkage and the reforms, the article gave the impression that he was evasive. By dwelling on a technical lecture about maternal

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3 Munro, M., 'Health sector reform in Zambia: Benefits and constraints for service delivery'. In: Johnston, T. *et al.*, eds., *Report of the meeting on the implications of health sector reform on reproductive health and rights* (Washington, 1998).

4 *Post*, 'CSUZ seeks judicial review', 11 August 1997.

5 Perhaps this allegation fit well into the discourse of these observers, as they each took the professional perspective that de-linkage would benefit health workers and the sector at large Gerritsen, 'Key-actors'; ML0706/03, ML0811/15, ML0706/04.

6 ML0811/15.

7 ML0812/01.

8 *Post*, 'CSUZ seeks judicial review', 11 August 1997.

Box 9.1 "Kalumba disappoints Livingstone health workers"

Kalumba disappoints Livingstone health workers

The Post, August 18, 1997
By Ruth Banda, Lusaka

Livingstone workers who were expecting health minister Katele Kalumba to clarify their de-linkage from the public service were on Friday disappointed when he refused to discuss the subject.

Kalumba told Livingstone workers to seek de-linkage clarifications from their employers and went on to address them on professionalism.

Kalumba, addressing more than 200 health workers in Livingstone on Friday, said "professionalism is a paper licensed by law to practice".

From talking about professional, the minister then switched to high maternal mortality rate He said the high maternal mortality rate was due to heavy workloads, limited access to health services, inadequate diet and rest.

Kalumba then spent two hours talking about sex and how breasts are so exposed in beaches whilst breastfeeding mothers here in Zambia hide them from their babies.

This made some of the people in the meeting bow down their heads in embarrassment while some walked out of the hall which the minister noticed and remarked: "Don't worry they are going to answer the call of nature. This hall is protected by the Holy Spirit."

A clinical officer, Renford Nkunika, from Livingstone General Hospital brought the minister into the right topic when he asked him what will happen to the clinical officers and Zambia Enrolled Nurses who were phased out on the document carrying proposals of Livingstone Hospital Management Board establishment.

The minister referred the question to the executive director of the hospital Dr. Elicho Bwalya who answered that the clinical officers will be transferred to run district health centres.

The minister added that ZEN will not lose their jobs but will be re-trained into registered nurses.

The meeting unanimously demanded that they be paid their packages before joining boards.

The minister answered that anyone who won't join the board will be handed back to the public service commission and that any worker will be free to go to the Pensions Board to demand for their gratuity of which the board will only pay back the employees contribution unless where the worker has reached the age of 55.

Clinical officer Emmanuel Nkatya said that life expectancy is 46 whilst retirement age is 55, meaning that most workers will lose their money as they would want to retire when they are still young and energetic.

Kalumba charged that low life expectancy must be a challenge as the health policy says people should prolong their lives.

"Our friends in Japan are fighting to reach 100 years whilst I am losing a lot of doctors and nurses due to the scourge of AIDS," he said.

One of the unsatisfied workers asked the minister to allow the Public Service Commission who are their employers and the Pensions Board who are in charge of their gratuity to address them.

"I am here advocating for my health board. You are free to call others to explain to you," Kalumba said.

Source: The Post, August 18, 1997.

health, he certainly did not appear to go out of his way to address health workers' concerns. Perhaps he was struck by the vehemence of opposition to his grand ideas.

Despite Kalumba's attempts to explain the health reforms, the opposition presented by the unions' litigation was a serious blow to the credibility of the reforms. The court ruled in favour of the unions' request for a judicial review of the reforms. When Kalumba showed a lack of progress in complying with the previous judgment, the unions tried to have him cited for contempt. The court, however, struck off the unions' application.[9] In the court of public opinion, however, Kalumba had a tougher trial. Within a period of two weeks at least three opinion pieces seriously criticised the reforms. The first, a satire piece on the health reforms by Roy Clarke,[10] was published

[9] *Times of Zambia*, 'Unions' Application Struck Off', 9 October 1997.

[10] Who would later get international media attention by facing expulsion for a satirical piece on Mwanawasa, before being cleared by the courts.

in the *Post*. It depicted an interview with Bulkele Bukalamba, the Minister for Health Reforms. In response to a question about rising infant mortality, Minister Bukalamba argued that infant mortality was indeed rising, as in fact it was the result of a successful government policy to reduce the number of dependents per wage-earner from fifteen to five. "Under our policy of Health Deforms, funded by the Global Bank, we have successfully increased the child death rate by diarrhoea, measles and malaria. Child deaths are now running at 50,000 per year! Washington is delighted!"[11]

This was followed by a venomous piece by a columnist who ridiculed Kalumba's recent appointment as a special advisor for health issues to World Bank president Wolfensohn. She sarcastically argued that the only way he could achieve this was if he indeed attained 'zero infant mortality', in reference to Clarke's satire piece. This in her view would 'earn Katele Kalumba and Zambia first prize in implementing Dr Mengeles Nazi Medical reforms to abolish the weak, destitute, poor of Zambia'. Based on field level impressions from working for an NGO, she drew a distressing picture of human suffering, of a mother carrying her fifteen-year old son to a clinic. Meanwhile, she claimed, ambulances were busy ferrying family and relatives and transporting 'game meat or even a cache of psychotropic substances'. She also accused the Central Board of planning to create hospitals for tourists and investors, rather than providing care for the people.[12] The last opinion piece in this series was a letter from a reader commending Clarke on his satire piece. He contended that the health reforms were indeed not working, judging from the worsening indicators, despite the vehicles bought by the ministry, the upgrading of health centres, and recruitment of expatriate doctors.[13] Of course, these three opinion pieces lacked nuance and used hyperboles to convey their criticism. They are also reflective of the discourse used by Zambian activists and their advocates abroad, which put much of the blame for the social conditions ordinary Zambians were facing on the World Bank and the reforms they had been advocating since structural adjustment. Equally, they conveyed a growing sense of cynicism among the public concerning the impact of health reforms, while at the same time one could see people in the sector looking out for themselves. Moreover, as Kalumba had personally been promoting the health reforms, he was personally attacked for the health reforms' perceived failure, thus tarnishing his image as a 'golden boy' of Zambian politics.

Returning to the de-linkage process, the court-case itself did not block the process as it merely called for a judicial review to see if the statutory instrument allowing for de-linkage contravened other legislation. Nevertheless, in effect it did lead to the blocking of the de-linkage process as it became clear that staff could only be de-linked if civil service contracts were properly dissolved, meaning that terminal benefits were paid. This would be a costly venture. According to later estimates, this would have cost 400 billion Kwacha.[14] At a certain point, it was decided to indeed offer voluntary separation packages to facilitate the de-linkage process. This led to a significant exodus of staff, with over 1,400 professional health workers being lost from the sector.[15] This controversial and costly process was, however, finally halted after Kalumba's time in the ministry had come to an end.[16]

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11 Clarke, R., 'Health reforms'. *Post*, 9 October 1997.
12 Sichone, L., 'Medical reforms'. *Post*, 13 October 1997.
13 *Post*, 'Health Reforms not working', Letter to the Editor, 20 October 1997.
14 Koot & Inambao, *Institutional*, 32. This was roughly € 67 million.
15 MoH, 'Mid-Term Review' (Lusaka, 2004), 98.
16 Munro, 'Health', 41.

Luo takes over

In his last period at the ministry, Katele Kalumba was not as effective as when he had been the deputy. According to a former donor representative, during that final period he tended to micro-manage things.[17] By then a new political figure had entered the health sector who would become effective in taking over Kalumba's job at health. In the 1996 elections, Nkandu Luo, professor of micro-biology at the University of Zambia, was elected to Parliament. According to Kalumba, she had been picked as a parliamentary candidate because Chiluba had wanted to rehabilitate the family of a certain politician, Chibesa Kankasa, who had been influential in the Kaunda era.[18] Luo, a relative of *Mama* Kankasa, was thus selected to stand as an MMD parliamentary candidate in Mandevu constituency in Lusaka. As she was highly qualified in a medically related field, being Zambia's first woman professor,[19] a post of deputy minister of health seemed logical. Nevertheless, her posting at health, especially later as a full Cabinet minister, became so controversial in many areas that it can hardly be considered to have been a success for the sector.

Prior to becoming deputy minister, Luo had been a lecturer and researcher at the university and had headed laboratory services at the UTH. She was also involved in non-governmental activities in the field of AIDS prevention. Together with Kawimbe and Kalumba, she had been a member of the MMD health committee around the time of the 1991 elections. Nevertheless, she was not supportive of the reform efforts, but was rather more concerned about clinical care, which seemed to have been neglected during the early stages of reform. This concern did not so much come to the fore at the time when she was deputy minister. One researcher and former technical advisor described her as having had a low profile at that time.[20] Naturally, this became different when she became minister. One former health official claimed that Luo had borne a grudge against Kalumba, as Kawimbe and he had earlier blocked her appointment as dean of the Medical School. This had motivated her to do what she could to dislodge Kalumba. The respondent even went so far as to suggest that Luo had been successful in getting Kalumba out because she had been Chiluba's lover. He said that Kalumba himself had told him it was 'bottom power' which removed him from health.[21] Of course, it is unclear to what extent this rumour reflects reality. Perhaps this was an example of masculine discourse refusing to acknowledge that a woman could get ahead by merit rather than by sexuality.

Regardless of whether these rumours were accurate, this will not have been the only factor that led to Kalumba's replacement as minister. We saw that in his last year as minister, he had attracted public controversy tarnishing his image. Although he too suggested that Luo had been seen lobbying at State House, Kalumba explained that in his view the reason he had been moved from health was that he had fallen foul of vice-president Christon Tembo. In February 1998, floods had hit Kalumba's constituency. Kalumba publicly accused the disaster relief committee of complacency in responding to the emergency by offering food-relief. He also mentioned that visits to the area,

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17 ML0810/01.
18 ML0706/04.
19 Zambia News Online, 'Zambian women wrangle over women's day', 14 March 1997: http://www.africa.upenn.edu/Newsletters/zno14.html (accessed 27 May 2009); and *Post*, 'My marriage has failed because I am a high flyer, reveals Prof. Luo', 1 June 2001.
20 Lake *et al.*, *Analyzing*, 53 and 126.
21 ML0811/02.

including one by Tembo, who as vice-president was responsible for disaster relief, had yielded nothing.[22] According to Kalumba, Sata had used this as pretext for allying with Tembo to get rid of Kalumba. In March, Kalumba was transferred to the Ministry of Tourism, which he considered a demotion.[23] However, within months he was again moved, this time to the Ministry of Home Affairs, and later again even to Finance, suggesting that he had not permanently fallen from grace.[24]

Opinions of Luo as a minister vary, though those with a stake in the health reforms say she did little to further the reforms. Kalumba said she was a good micro-biologist, but a bad manager. He claimed that she had started dismantling the reforms. Her preoccupation had been to get back control of the ministry following the establishment of the more independent Central Board. This was exemplified by her decision to physically move the ministry headquarters from Woodgate House in the centre of Lusaka to Ndeke House, where the Central Board had its offices. Her leadership style was also abrasive, acting in a directive rather than a consultative way. Kalumba said that she had difficulties with professional identities, implying that she did not get along well with doctors. She would put down colleagues, thus demotivating them and driving them away.[25] Others echoed this impression. A former ministry official who had not directly worked with Luo himself admitted that as a woman in a ministry dominated by doctors, Luo had not been well received. Having come from a laboratory background, she wanted to prove to doctors that she was on top; as a result, she gave the impression of being arrogant.[26]

Some people who had interacted with her on a personal level were mild in their assessment of Luo as a person, though admitting the damage she did to the reforms. One health worker who had received a prize from Luo for his performance in a course remembered Luo as a strict and action-oriented minister 'like Sata'. He found her principled, wanting to see things being done.[27] A former donor representative felt that in her heart Luo was a good person. When she started as minister, she had invited him for an informal conversation to get his views on various issues. At such moments, she was very friendly. However, as soon as she was with more than two people she started acting bossy and directive, at times ranting and shouting. She also looked at the sector like a micro-biologist wanting to control details. As a consequence, she threatened to halt the decentralisation and considered the Central Board too independent.[28] A medical doctor who had attended an international conference with Luo found her a vibrant and determined minister. She had wanted to put more emphasis on aspects of the system that were neglected, such as service delivery and hospitals. However, with respect to the reforms, Luo was seen as reactionary, which led to the undoing of some reforms.[29]

Luo herself, in an interview later, denied being opposed to the reforms *per se*. She believed the initial vision had been correct in addressing people's health through primary health care – particularly in the face of epidemics such as cholera, AIDS, and the outbreak of bubonic plague that she would successfully face during her time in

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22 *Times of Zambia*, 'Deep sounds further flooding alarm', 17 February 1998.
23 ML0812/01.
24 Lake *et al.*, *Analyzing*, 53
25 ML0812/01.
26 ML0810/06.
27 ML0811/18.
28 ML0810/01.
29 ML0706/13.

office. Instead, she felt the need for a reform within a reform.[30] Indeed, Luo felt that too much emphasis had been placed on developing systems rather than on delivering services. She seemed to share the impression also suggested by the Mahler report: That there had previously been a concentration on administrative and management procedures, neglecting issues of, and information on, output and impact of service delivery.[31] In fact, in a speech to donors, Luo stated that "priorities will shift from the invisible to the visible, from structures to services, and from development to delivery".[32] In a later, joint donor-government mission to appraise the sector, this was termed a 'paradigm shift from systems development to services delivery'.[33] In essence Luo held similar concerns to donors: There was a need to show results on the ground and to consolidate existing reforms rather than to implement new initiatives. However, in the implementation of these views, unfortunately Luo got caught up in confusion, conflicts, and other political distractions.

During the first three months of her tenure, Luo called for a total ban on capacity-building workshops and training. After this period, the policy of discouraging workshops remained.[34] The rationale behind this was clear and reflected a valid criticism of the workshop and allowance culture in Zambian public service. To this day, many health workers are frequently away from their posts following workshops, driven by the incentives offered by allowances. At the micro-level this can be a real disruption of service delivery. On the other hand, this decision also slowed down the implementation of reform initiatives, such as the roll-out of various guidelines, for instance on cost sharing. Policy processes, such as the completion of the draft health financing policy which was almost completed, were also discontinued, while the de-linkage was halted. Luo, however, did undertake a review of all structures that had been put in place, such as the Central Board, regional offices, and health boards.[35] She felt these had been designed by 'a lot of technical thinking not connected to reality'. Again, too much emphasis had been placed on financial management rather than actual health care.[36] We will later examine to what organisational changes these reviews led.

As was the case with earlier ministers, in her few months as a minister, Luo came up against the power of the health workers' vested interests. At a meeting of health workers in Livingstone, she called on them to leave general unions as these did not directly relate to their professions. Apparently, this was an attack against the two unions who had blocked the de-linkage process by calling for a judicial review. This quickly prompted representatives of the union to react fiercely. One said, "If professor (Luo) goes ahead to interfere with the individual and collective rights of our members, we will be forced to teach her a lesson she will never forget .... While we understand and appreciate how excited the professor is for being appointed a full Cabinet minister, she should be cautioned against having a wrong impression that she personally owns the workers in the Ministry of Health".[37]

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30 ML0804/05.
31 Lake & Musumali, 'Zambia', 260.
32 Luo's speech at a co-operating partners meeting, Lusaka, August 1998, cited in Lake and Musumali, 'Zambia', 261.
33 MoH, Joint identification and formulation mission for Zambia' (Lusaka, 2000), 1.
34 Lake *et al*., *Analyzing*, 129.
35 Lake *et al*., *Analyzing*, 129.
36 ML0804/05.
37 *Post*, 'Moonde warns Luo', 2 April 1998, and 'Now NUPSW warns Luo', 3 April 1998.

A few months later she would also have direct run-ins with her staff. In May 1998 the Resident Doctors Association called for better conditions of service for Zambian doctors. They felt that doctors were permanently placed on-call, while not getting enough for the extra hours worked. They also asserted that compared with certain expatriate doctors who were equally qualified, they earned far less for the same work. "What we want is equal pay for equal work ... I know that the Minister of Health Professor Nkandu Luo has said we should give priority to patients but we should also be paid for the work", a representative of the association was quoted as saying.[38] Shortly afterwards, a circular on on-call allowances caused anxiety among doctors. Doctors were reported to have 'threatened to withdraw labour since it was these allowances that kept them in Government (service)'. Luo, however, clarified to the media that her ministry had no intention of removing these allowances, although she admitted she did want to streamline the arrangement "so that it gave the best benefit to the communities". For instance, doctors who were on-call would have to be at a specific location rather than having to be searched for.[39]

Regardless of these clarifications, health workers remained fearful of the suspension of on-call allowances. Obviously, they felt that the conditions of this 'entitlement' should be *more* beneficial to them rather than more stringent. The same day, the doctors at the UTH downed their tools. According to the hospital director, even emergency cases were not seen to and death certificates were not signed. In response, Luo rushed to add that the previous circular on on-call allowances had been unclear and incorrect and that a new one had been issued calling for a mere streamlining of the allowance.[40] Doctors, however, were not impressed by Luo's clarifications and attempt to avert a strike, saying that she was 'spoiling for a fight'. They also added other issues to their demands, drawing attention to outstanding issues from the last time they had called a strike two years earlier, such as the issue of accommodation and conditions of service. They also undertook to bypass Luo by going directly to Cabinet Office, as Luo had not consulted them.[41] The strike subsequently continued and spread to other hospitals, while the ministry did not seem eager to meet with doctors' representatives.[42] Then the ministry asked heath workers for a three-month grace period to attempt to meet health workers' demands, to which a health workers' union threatened that if demands were not met within a month they would go on strike.[43] Then, as government was posturing about preparing legislation to ban health workers from striking,[44] further strike action appeared to have been postponed, at least for the moment.

In addition to clashing with health workers, Luo also clashed with donors. While donors had in part been happy with Luo's intentions to focus on service delivery and the quality of health care, there was also concern that she was less committed to the reforms. In April 1998, a Zambian–Danish annual consultation meeting was held, at which Denmark announced its suspension of contributions to the district basket. They also announced, however, that they would be prepared to continue their support if a list of 14 'relative conditions' were met. The first of these conditions perhaps illustrated the

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38 *Times of Zambia*, 'Doctors want equal pay for equal work', 18 May 1998.
39 *Times of Zambia*, 'Doctors overtime perks stay, says Luo', 26 May 1998.
40 *Times of Zambia*, 'UTH doctors down tools', 27 May 1998.
41 *Post*, 'UTH operations in disarray', 27 May 1998.
42 *Times of Zambia*, 'Kitwe docs join strike', 29 May 1998; *Post*, 'UTH doctors' strike enters day three', 29 May 1998; and *Times of Zambia*, 'Doctors body battles to meet State', 2 June 1998.
43 *Post*, 'UTH workers reject govt's "3 months grace period"', 9 June 1998.
44 *Times of Zambia*, 'ZCTU slams State for punitive law', 2 July 1998.

key to their concerns, namely that the ministry would guarantee the future autonomy of the Central Board. Other conditions referred to financial and administrative management, the transfer of staff responsibilities and equipment to the Central Board, and estimation of the cost of the de-linkage process.[45] While official Danish reports on the issue were extremely formal, sterile, and impersonal, according to a Dutch donor representative these discussions became quite personal and erupted into a 'shouting match'. Conflict between donors and Minister Luo would, however, only get worse. This conflict spread to most of the donor community, as a skeleton emerged from the bureaucratic closet Luo had inherited.

Criminalisation of the Zambian health sector

The case of Medical Stores Limited would explode and disrupt donor–government relations in the health sector for years to come. Although we will not dwell on this in this dissertation, the narrative fully reflects the worst of the criminalisation of the African state that analysts had focussed their attention on at the end of the twentieth century. Rather than an analysis of public administration, the episode we will now explore had elements more befitting a political thriller, such as arms' dealing, former apartheid-era spies, an Italian mafia connection, and even, indirectly, the assassination of a European head of government.[46] In this section we will not describe the complex criminal networks behind the façade of health policies and the discourse of donor–government dialogue, but rather concentrate on how policies and administrative processes were instrumentalised for political, personal, and even criminal gain.

As we recall, by the time of Sata's tenure at the Ministry of Health, Medical Stores had become a prime object of donors' concern. Medical Stores was a parastatal company, with the Ministries of Finance and Health as shareholders, responsible for procuring, distributing, and even producing drugs. During Sata's tenure, accusations of political appointments and corruption involving Medical Stores hit the media. Reports of drug shortages had also become common, and there were accusations of mismanagement within the parastatal.[47] As the erratic supply of drugs jeopardised service delivery as well as the public's perception of the health reforms, donors had urged that Medical Stores be privatised, an idea fully consistent with the prevailing policies of structural adjustment. As mentioned before, Sata had been opposed to such a privatisation, refusing to bow to "donor benchmarks". The argument he put forward was that Medical Stores provided an essential service by distributing drugs to remote areas.

Gradually, full privatisation was postponed as an option for Medical Stores. Instead, in July 1997 after Kalumba had taken over the ministry from Sata, Cabinet took the decision to restructure Medical Stores into an essential drugs and medical supply stores. Shortly afterwards, a consultancy study was carried out to examine options for Medical Stores. One option was to contract out all services to a private party; another was to dissolve the existing Medical Stores and establish new essential drugstores; and the third option was to restructure Medical Stores. Donors and the ministry reportedly agreed upon the option to restructure, which had been recommended by the consultants. This would mean a significant down-sizing of Medical Stores from some 200 to less

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45 Danida, technical review de-briefing note, December 1998. ISN 5120.

46 See Leenstra, M. (forthcoming), 'The dark side of the moon: Real life Zambian stories ignored by official discourse'. Paper to be presented at a *Journal for Southern African Studies* seminar.

47 *Post*, 'Sata, Katele in drugs dispute', 6 January 1995.

than 50 staff, as well as revitalisation and recapitalisation. Donors would support this process and establish a drugs' and supplies' fund, pledging over a million US dollars in support. Only when the company became viable would privatisation become the objective again.[48]

However, early in 1998, Kalumba rejected previous agreements on restructuring Medical Stores and let a private company carry out a 'diligence study'. This was done without consulting with donors or sharing either the terms of reference or the findings with donors and those within the health sector who had hitherto been involved. This study recommended that rather than restructuring Medical Stores, its operations should be contracted out to a private company. Reluctantly, donors accepted this option and agreed with the ministry that the management of Medical Stores would be contracted out under a transparent process of international competitive bidding. In March of 1998, donors discovered that a tender procedure had been held for the contracting out of the management of Medical Stores and that a company named GMR had won the tender.[49] Further investigation of the process sparked serious concerns among donors. In letters addressed to the ministry, donors led by the Swedish and the British clearly asserted that the tender process and the contract drafted between the ministry and GMR were unacceptable to donors.[50]

The first point of criticism about the tender process was that the 'diligence study' carried out to advise the ministry on how to deal with Medical Stores had been performed by a consultant who also represented GMR during the bidding. Also the tender that had been 'floated' to 14 international and 8 national companies by the national tender board had no pre-qualification phase to allow potential bidders to inform themselves about the process. Moreover, the period in which interested companies could submit their proposals was extremely short. Whereas standard practice, according to the Zambian government's own guidelines, was to allow for an eight-week period, in this case only four weeks were given. This meant that unless a firm had anticipated the tender before its formal announcement, it would have had insufficient time to prepare for submitting a good proposal. Clearly, this was an advantage that GMR had over other companies. Donor concerns also extended to the conditions of the contract, which were disadvantageous to the Zambian government. There was no performance clause in the draft contract stipulating what could be expected from GMR, whereas GMR was guaranteed a turnover of 10 million US dollars and would get a commission of 15 per cent of the value of the goods distributed.[51]

As the government did little to address donors concerns, donors formulated a coordinated response – initially on the level of health experts, although later also at the 'political level', meaning that ambassadors and the British High Commissioner were involved. Following a donor meeting, the Swedish ambassador and her British counterpart had a tense meeting with Minister Luo. In reaction to a statement in which donors' concerns were outlined, she emotionally accused donors of pursuing a merry-go-round of issues. While some donors were telling her to get on with the job, now she was confronted with a dictatorship of donors lined up against her. This was just one of the areas of criticism. Everything she did seemed to be wrong. If donors felt so strongly about the

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48 Background notes on Medical Stores, September 1998. (EKN files, ISN 5066); and ML0810/01.
49 Background notes on Medical Stores, September 1998. (EKN files, ISN 5066).
50 Letter Swedish Embassy Lusaka to PS MoH Bulaya (EKN files, ISN 5066).
51 Letter Swedish Embassy Lusaka to PS MoH Bulaya, including background notes. (EKN files, ISN 5066).

issue of Medical Stores, they should forget so-called cooperation. She complained she had met the Swedish and the British numerous times over the issue, wondering how long they would go on about it. She concluded that her concern was the health of millions of Zambians, implying that donors concerns were different. The donor representatives then reacted by saying that the minister had no monopoly of concern about the health of ten million Zambians. Donor agencies would not be involved in health care if that were the case. Moreover, the British High Commissioner was surprised by accusations of a merry-go-round of issues and a dictatorship of donors. He defended donors' position by asserting that the donors had based themselves on agreements with government about transparent and competitive bidding and that in this case neither local nor international procurement rules had been followed. Luo maintained that donors were 'ganging up' on her by meeting on these issues without representation from the ministry. She indicated that Cabinet would take a decision on this issue. If Cabinet approved the contract with GMR, donors would merely be informed. If there was room for further discussion, donors 'should be prepared to quote chapter and verse'.[52]

Indeed, a month later, despite donor concerns a contract was signed between GMR's managing director Leonardo Mordini and the Zambian government, represented by the permanent secretaries of the Ministries of Finance and Health. Donor representatives appeared powerless on this issue. A Dutch donor representative admitted that a cloud of mystery surrounded the issue and that donors only gradually learned about certain details. Some colleagues were startled and intimidated by the issue, fearing that their phones were tapped. "We knew too much, but a lot we couldn't prove".[53] Some donor representatives, however, did informally piece together some details about GMR's reputation. It emerged that this was not only a case of non-transparent procurement, but also apparently a more sinister case of international organised crime. The historian Stephen Ellis had in 1996 written an article detailing GMR's history, tracing it to a company set up as a vehicle for an Italian entrepreneur based in the Seychelles. The company, which eventually set up a South African branch run by apartheid-era secret operatives, was allegedly mixed up in sanctions-busting, gun smuggling, and a coup attempt in the Seychelles.[54] In the period GMR was running Medical Stores, there were indications that Medical Stores' logistical capacity was used for the guns-for-diamond trade with Angola and possibly the DRC.[55] However fascinating, this murky part of Zambia's contemporary history would remain outside of the official discourse on the health sector – though as we will see later, it did significantly affect donors' attitude to the Zambian health sector.

Unknown to donors, however, this case had its roots in the Chiluba regime's quest for political survival. The path leading up to the contracting of GMR happened before Luo took over from Kalumba in March 1999. Kalumba gave the order for the 'due diligence study', and his permanent secretary, Bulaya, would have had a major role in this. This is also apparent from the account of a former ministry official. He claimed that following the elections of 1996, the permanent secretary at the time, Bulaya's predecessor, was unexpectedly retired in the national interest. This meant he was honourably discharged by the President, after which he got a job for the World Bank in

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52 Report of a meeting between Luo and donor representatives (EKN files, ISN 5066).
53 ML0810/01.
54 Ellis, S., 'Africa and international corruption: The strange case of South Africa and Seychelles'. *African Affairs*, 95 (1996), 379.
55 The background to this scandal will be dealt with in Leenstra, 'The dark'.

Lesotho. It appeared, however, that President Chiluba had personally insisted on this removal and that Kalumba had accepted it. The reason seemed to be that a certain company had supported the MMD during the elections and in return wanted the contract for exploiting Medical Stores.[56] The retired permanent secretary was seen as a man of integrity. One former colleague suggested that he was the last permanent secretary who followed systems correctly, as after him it became a free-for-all.[57] Indeed, the incoming man, Kashiwa Bulaya, was to spark much controversy. He became known as 'Quick Silver' for the money he controlled and as a 'banker for the MMD'.[58] As we will see later, he apparently played this role in subsequent elections and would later be sentenced to five years' hard labour for corruption in his role as permanent secretary. One colleague remembered, "Bulaya had nerves of steel. He wouldn't think twice before he did anything". After Bulaya became permanent secretary, "He succumbed to problems. He was knowledgeable, and politically, socialist inclined, but he was overpowered and took advantage. He gave favours and took his reward".[59] Thus, with Bulaya as controlling officer of the ministry, GMR could be given the chance to profit from illicit opportunities in exchange for support to Chiluba's regime.

The case of Medical Stores was thus more than the instrumentalisation of procedures for private and criminal gains, though this certainly played a part. Significantly, this case served the interests of regime survival. This strategy of regime survival, however, came at a cost as the scheme emerged from the shadows in which it was hatched, a cost which impacted on relations between the donors and the government and left the health reform process in limbo.

Muddling through

As we saw above, due to their involvement in the health sector, donors had picked up on the dubious selection of GMR as the contracting party for managing Medical Stores. They had also seriously confronted the Zambian government over the issue. The Danes suspended their contributions to the sector, as did the Swedes. The British, meanwhile, appeared even less inclined to join the district basket than before. The Dutch also considered ending their support to the health sector. The Netherlands Embassy's health advisor, however, strongly opposed this decision. He felt that they should continue supporting the district basket, as without money, districts would be making plans in vain. In fact, he even argued in hindsight that in the context of a minister hostile to reforms and deteriorated relations between donors and the ministry, the district basket saved the decentralisation of power to districts. Donors' reaction to the row over Medical Stores was therefore not unambivalent, with some donors taking serious actions and others – in the words of this donor representative – burying their heads in the sand.[60]

This ambivalence becomes clear in a Dutch report from September 1998, presenting arguments as to why support to the health sector in Zambia should be continued. At the time, the Netherlands was re-evaluating its development programme, focussing on a smaller number of partner countries and selecting a limited number of sectors per

[56] ML0811/03.
[57] ML0810/06.
[58] ML081005, ML0706/37.
[59] ML0811/02.
[60] ML0810/01.

country to further focus support. The organising principle for this exercise was the implementation of the sector-wide approach, which would aim to support a recipient governments' poverty-reduction policies at a macro-level, rather than implement donor projects and fielding technical assistance at a micro-level. The striking part of this report, however, is that only the faintest reference is made to the difficulties the health reforms were experiencing at the time, with no allusion to the row that was brewing over Medical Stores. As such, the paper is an interesting example of how donor agencies use their own policy discourse to create a façade to sanitise issues of personality, conflict, abuse, and failure.

The paper began by describing the principles of Dutch health-sector policy for development cooperation at the time, which took an integrated approach to strengthening basic health care from a curative and preventative perspective. A link was also drawn to international agreements on health care as well as a recent pronouncement of the Dutch Minister for Development Cooperation to support social sectors with twenty per cent of the aid budget. The paper went on to describe the health situation in Zambia on the basis of health indicators, which were considered to be poor and showing little improvement, especially in the face of the AIDS epidemic. These poor indicators were seen as the reason health reforms had been implemented, following the collapse of the system of free health care at the end of the 1980s. The reforms were subsequently presented as innovative policy. In reference to the problems donors were at that time encountering with Minister Luo, the paper argued: 'The implementation of the reforms is a process of trial and error, but despite the recent problems the policy is still standing'. Details of these 'recent problems' were, however, not given. To argue that the reforms still had a positive impact, the paper stated that the strategic plan was still used as the basis for these policies and that 'the decentralisation of authorities to districts is a positive affair, which can never be fully reversed'. It was also argued that the health reforms had created a sector that fitted with the available capacity and recourses, arguing that it was by no means a 'white elephant'. Other positive results named were the improvement of capacity at district level, the 'relatively' transparent planning and implementation system, and the monitoring and evaluation tools of HMIS and FAMS. In fact, it was argued that the health reforms were seen as a 'good practice' and were used as an example for reforms in other countries. On the negative side, however, the report mentioned that total government and donor funding were insufficient to deliver the essential packages of care, leading the authors to argue for an expansion of the long-term commitment of donors and the government to supporting a 'sector-wide approach'.

Subsequently, the paper argued that the Netherlands had a 'comparative advantage' in their involvement in the health sector. The long experience in Zambian health care was credited as giving the Netherlands good insight into what happens in the sector at all levels and not just at the central level, as was the case for other donors. This allowed for a pragmatic and informed contribution to dialogue with government on the health reforms. As a case in point, the primary health care programme in Western Province was cited as an important source of experience and innovations. For example, the development of monitoring systems, the design of the district basket fund, and the development of a district health management course, which was supported by the Dutch, were considered to have drawn on experiences from Western Province. It was also argued that despite questions about their relevance to development, the Dutch technical experts were considered to contribute to the implementation of the health reforms. Strikingly, the paper listed comparative advantages in the health sector which were derived from

precisely those activities the Dutch were in the process of abandoning in pursuit of the new mode of working: The sector-wide approach. In conclusion, this paper argued that despite concerns about the progress of the health reforms (which again were not substantiated), there were ample arguments to continue the Dutch support to the health sector.[61]

Of course, it is clear that the purpose of this report was to legitimate Dutch involvement in the health sector. This goal would not be served by emphasising the relational problems between donors and the government, a decline in the minister's commitment to reform, or especially the suspicions of illicit practices. Instead, a discursive pattern that is common to development cooperation was presented. Simplified, this can be read as follows: The problems are big; there are promising policies in place to solve these problems; the main thing needed is money to cover the financial gap between intentions and available resources. In other words, despite the problems the health reforms were facing, there was a strong motivation inherent to those working in donor bureaucracies to continue being involved in the health sector. On the other hand, owing to a lack of confidence in the ministry, donor contributions to the district basket dropped to just 57 per cent of what had been pledged, whereas in previous years this had been around 80 per cent.[62]

The next few years would see particular donor interest in the operation of the Central Board of Health. A consultant later reported that during this period, donors had become more focused on the Central Board and had established firm working relations, by means of which they could disburse funds under their own conditions for procurement, accounting, and reporting.[63] However, doing this required further strengthening of the Board. One health advisor remembered that the Central Board was a good idea on paper, and ideas developed in the Central Board on, for example decentralisation or performance-based management, were promising. However, he recalled that staffing of the Board was not in line with reality. Salaries for existing staff had been increased, which made it difficult budget-wise to recruit new staff for functions such as procurement, planning, and monitoring and evaluation.[64] Other donors shared these concerns. As we saw above, the Danes made the autonomy and the proper functioning of the Central Board a prerequisite for continued support. However, apparently from within the sector also, there was an incentive to reorganise the Central Board. In a report on the restructuring of the Central Board of Health, the criticism we saw coming from Professor Luo earlier was presented as the rationale for this restructuring. 'Lower than expected individual quality health programme outputs have led many individuals and communities to question health sector reform in general and the role of CBoH in particular. Mid-1998, in response to community concern and personal visits to most parts of the health system, the Minister of Health appointed a MoH-CBoH Joint Task Force to review the mandate and organisation of the Central Board of Health".[65] As this report was authored by the Central Board, and considering Luo's sensitivity to the role played by donors, it is possible that the presentation of this rationale appeared to be a

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61 Paper putting forward arguments for the decisions to continue support to the health sector in Zambia and Malawi (EKN files, ISN 4966).
62 Chansa *et al.*, 'Exploring', 248.
63 Koot & Inambao, *Institutional*, 15.
64 ML0810/01.
65 CBoH, 'Report of the restructuring of the Central Board of Health' (Lusaka, 1999), 3.

more palatable representation for the political leadership than acknowledging the influence of the donor pressure to beef up the Central Board.

In the restructuring report, the Central Board was described as an 'agent' of the ministry and was made responsible for implementation. As it had no health-care providing staff itself, it contracted these services from management boards. It was also mandated with advisory and supervisory tasks and also with the responsibility to set standards and financial objectives, and to provide technical support. The most significant element of this restructuring report is that it reversed the establishment of regional offices which had been insisted on by Kalumba. Instead, provincial health offices were re-established as a decentralised part of the Central Board. The rationale presented for this was that it would be more effective and efficient to manage health care as close to the delivery point as possible. It was also argued that the province was a key organisational level in other ministries. The fact that this would create provincial-director positions with associated staff, providing lucrative new appointment opportunities, was not explicitly mentioned. Another area of focus for the restructuring was the strengthening of the financial management functions of the Board. Various financial management functions would be merged into one financial unit. In total, the report suggested forming four directorates and three units. This included a Directorate of Technical Support Services, which had management responsibility over the provincial offices, one for Clinical Care and Diagnostic Services, one for Public Health and Research, and a Directorate of Human Resource and Health Planning. In addition to a finance unit, there would be an administrative and an internal audit unit. In total, the structure catered for 221 positions, of which 95 were to be at Ndeke House.[66] In subsequent drafts of this report, which would finally be approved by Cabinet in 2000, the Malaria Control Centre was also added to the Central Board. As such, the total establishment came to 266, of which 122 positions were at Ndeke House.[67]

While the Central Board was being restructured, a similar process was set up for the ministry headquarters, though this process was reportedly very slow. While a revised structure was proposed in 1999, it took until 2002 before the restructuring was completed, resulting in an establishment of 88 members of staff.[68] A consultant later concluded that for certain functions for the ministry, no rationale had been provided in the restructuring report. It also appeared that rather than reflecting the ministry headquarters' new roles since the establishment of the Central Board of Health, old organisational structures had been followed. As such, there were units for procurement, accounts, and internal audit, while the Central Board had similar units to support service delivery.[69] This could be seen as a duplication of functions. Moreover, some units at headquarters, such as the procurement unit, were reportedly not fulfilling their functions, owing to understaffing and lack of equipment. As a consequence, the Central Board and other technical units carried out procurement activities. According to a review mission in 2000, donor concerns on cost-effectiveness and transparency in procurement were partly justified, and executive procurement should be shifted to the Central Board. Nevertheless, the ministry retained final responsibility for procurement and continued to be at the centre of procurement decisions.[70] We will later examine an

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66 CBoH, 'Report of the restructuring of the central board of health', May 1999.
67 Koot & Inambao, *Institutional*, 25.
68 *Ibid.* 14.
69 *Ibid.* 25-26.
70 MoH, *JIF*, vol. I, 23.

instance in which the ministry's procurement system was abused by Bulaya in a corruption scandal that would attract wide-spread public attention. Donors in part added to this duplication, as the Netherlands continued to allow the rural health kits which they funded be procured through the ministry, even after Sweden had discontinued its support over the Medical Stores' issue, and others channelled their equipment through other procurement channels such as the Central Board.

In addition to procurement, there were other areas where the ministry seemed reluctant to transfer control. As we saw in Chapter 8, the Health Services Act of 1995 had provided for a management board for the Central Board of Health. This board would advise on policy issues. However, after board members had been appointed in 1996, the board was dissolved after its term ended and its members were not reappointed in 1998. Instead, the new structure of the ministry set out to consolidate its role as the policy-making organ of the sector, for instance by providing for a director of health policy.[71] This is consistent with the impression given of Luo's tenure at the ministry: She strived to take back power for the ministry, which had been lost in the original health reforms. This impression is strengthened by accounts of her treatment of district health boards during her tours of the country. Various people interviewed remembered that Luo would go around the country dissolving boards without appointing new ones. A fellow traveller on a bus to Mongu, for instance, told me he had been the member of a district health board. During the visit by Luo, the board had advocated that a new district hospital be opened in Mongu apart from the provincial hospital. Luo had reacted fiercely that the board should first make sure their existing hospital was functioning, as currently that hospital was filthy. Then, on the way to the airport, she had signed an order to dissolve the board, without prior consultation or notification. It thus appears that, as relations between donors and the ministry had become acrimonious and while donors were turning to the Central Board to continue their programmes, the ministry was reclaiming its sources of power or debilitating the popular structures that could pose a rival authority.

On the other hand, beyond power issues, some criticism of the functioning of district health boards arguably had a technical validity. Experiences with district health boards were mixed. The former Mongu board member, referred to above, admitted that board members were not always extremely knowledgeable, which led to difficulties with doctors, who would consider board members laymen. One former district health director from a peri-urban district, however, looked back more favourably on her board. After a previous board had been dissolved as a result of political influence of the local Member of Parliament, who was also a medical doctor, a later, newly appointed board was competent and supportive. A colleague also remembered he had a board that functioned extremely well. It held influential people who could help the district arrange issues. Other health managers were less impressed with their board. One agreed that, especially in the beginning, many boards had members who were "apparently ignorant". He suggested that many were there mainly "for allowances or something". Board members apparently had little concept of what they were supposed to do, not having been well oriented towards their responsibilities, as, at least in the beginning, there were no workshops for board members. Another district director of health suggested that the board members coming from the community did not understand how doctors work. In addition, "they weren't progressive". He recounted that the chairman was not 'timely' and

[71] MoH, *JIF*, vol. II sect. 8.2.

demanded to use the district's transport, which was meant for the doctors' duties.[72] He also suggested that local politics were involved in the selection of appointees to the board. Yet another doctor interviewed had a similar opinion: The Central Board had not done its groundwork on how to appoint boards and what qualifications were required. "I could have gotten my brother in (the board) with only a six-week crash course ... Then how do you expect a system to tick?"

Indeed, in August 2000 new guidelines were issued for the selection and appointment of board members as well as a handbook for board members to guide them in their tasks. Bulaya's foreword admitted earlier 'challenges'. 'The first crop of boards has lived their full life, each with its own accomplishments and challenges. It is time now to put in place new boards with a fresh mandate'. With reference to Luo's motto he added, 'These boards should move the reform process from the invisible to the visible, having learnt from the challenges of yesteryears'.[73] These guidelines stipulated that board members should include community leaders, skilled community members, representatives of churches, and local health committee members and that they should be able to communicate in English. On the other hand, the district administrator, a controversial semi-political cadre instituted by Chiluba, would have a central role in selecting candidates and submitting them to the Ministry of Health through the provincial permanent secretary. While such a formal process could add objectivity to the process, it also formalised the political influence on the appointments.

Luo's ad hoc dismissal of the boards, as well as her tendency to reassert the minister's power, may thus well have been influenced by genuine concern over the capacity of boards and the integrity of members. It is thus difficult in this case to clearly distinguish technical interests: concerns about effectiveness and efficiency from what could be regarded as patrimonial interests or behaviours. Both Luo's attempts to personally control boards by dismissing those that displeased her and her ministry's attempts to take back relinquished powers can be phrased as patrimonial endeavours. These behaviours reflect both the autocratic leadership style and the centralising tendency associated with patrimonialism. On the other hand, these behaviours can also be seen in terms of strengthening rational-legal control, as boards were apparently prone to local politics and abuse of authority for private interests – in short, patrimonial behaviour. Nevertheless, regardless of the rationale behind the decisions taken, the result of the ministry's challenge against the loss of its powers would prove to be a burden on the sector: While the reforms had intended a purchaser-provider split to enhance efficiency, a less-than-efficient system of two partially parallel structures had been created instead. In this period, the seeds were thus sown for subsequent criticism of the health reforms, which would lead to the dissolution of the Central Board in 2006.

Exit Luo

As the proposals to restructure the Central Board of Health were waiting for Cabinet approval, Luo was moved from the Ministry of Health to the Ministry of Transport in November 1999.[74] Kalumba suggested that Chiluba by then realised the negative impact

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[72] Yet another doctor argued that board members would request free and preferential treatment at the hospital.

[73] Ministry of Health, 'Guidelines for selection and appointment of board members to the health boards', August 2000.

[74] Panafrican News Agency, 'Chiluba reshuffles cabinet', 10 November 1999.

Luo was having on the health reforms.[75] No doubt the acrimony between her and donors had reached the president. But other factors are also likely to have played a role. During her tenure, Luo had attracted public controversy. In addition to going round the country to dismiss boards, it was alleged, "(s)he moved in the night and when she found nurses sleeping she fired them".[76] Her aloof and authoritarian attitude vexed health workers and made headlines. At the end of May 1999 health workers at the UTH had been striking and staging a 'go-slow' as they demanded to be paid allowances due since January. The negative consequences of the partial de-linkage were also showing themselves. While health workers under the ministry had received salary increments of around 33 per cent, those employed by hospital boards were expecting similar raises.[77] A few days later the General Nursing Council threatened that nurses who did not get back to work could be de-registered. Obviously, the powers sought by ministers and the Medical Council through new legislation during earlier episodes of labour unrest had now been granted. When Luo visited the hospital a week after the unrest had broken out, health workers were expectant, chanting "*ndalama za bwela*" ("money has come"). When Luo snubbed them, however, by refusing to address them, the crowd reportedly became rowdy, shouting that Luo had failed.[78] A similar incident had transpired a day earlier when Chiluba himself visited the UTH and he too was jeered for refusing to address disgruntled health workers.[79]

Luo also frustrated doctors when she announced a change in the system for prescribing drugs. This would entail new prescription pads and stamps making it impossible for doctors and clinical officers to prescribe drugs outside their places of work. The rationale was that some medical practitioners took advantage of flaws in the existing system to divert government-procured drugs 'for their own selfish needs'.[80] This proposal, however, was rejected by doctors, who, besides practical objections, felt that using the pads was tantamount to admitting that medical practitioners pilfered drugs.[81] At the same time, another controversy had erupted when the director of the UTH confirmed a directive issued by Luo to ban relatives from wards outside of visiting hours, to avoid crowding. This would not have been controversial were it not that in Zambian hospital wards the tradition had developed of relatives caring for patients, as understaffing meant nurses were unable or unwilling to perform these tasks.[82] Ironically enough, months earlier Luo had been publicly criticised for asserting that government was not obliged to feed patients, as some hospitals were cutting down on patients' meals to reduce costs.[83] Luo, however, defended her ban on relatives in wards, saying that it was prompted by doctors' and nurses' indiscipline. She claimed that patients were not properly cared for by hospital staff as the staff would be sleeping to recover from working in private clinics. The only problem the health sector was facing, she suggested, was that staff were resistant to change. In the same article she defended her new prescription

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75 ML0706/04.
76 ML0706/11.
77 *Post*, 'Nkandu Luo Angers Striking UTH Workers', 3 June 1999 and 'Workers disrupt UTH operations', 27 May 1999.
78 *Post*, 'Nkandu Luo Angers Striking UTH Workers', 3 June 1999 and *Times of Zambia*, 'Luo snubs UTH strikers', 3 June 1999.
79 *Post*, 'Chiluba jeered', 2 June 1999.
80 *Times of Zambia*, 'Ministry "cages" doctors', 30 July 1999.
81 *Post*, 'Doctors reject Luo's pads', 16 August 1999.
82 *Times of Zambia*, 'UTH ban stays', 1 August 1999.
83 *Post*, 'Luo's decision to stop feeding patients appalls', 26 February 1999.

policy despite resistance from staff.[84] Shortly afterwards, the ban on relatives in wards turned into a huge embarrassment for Luo. As the director of the UTH, a confidante of Luo, patrolled the wards to enforce Luo's dictate, she was alleged to have kicked and slapped the mother of a one-year old baby who was sleeping on the floor beside her baby's cot.[85] Columnists and readers wrote appalled pieces in *The Post*. One public letter submitted to *The Post* drew a parallel between the way Luo had issued the directive on a new prescription system and the ban on relatives in wards, saying that the common denominator in these issues was 'a lack of communication whose foundation is a total disrespect for other people'. Luo was accused of harbouring an 'I am clever, you are stupid' attitude. As such, the anonymous commentator argued, Luo and the hospital director disqualified themselves for public service.[86] Again, it appears that despite Luo's declared intentions to oppose abuse and indiscipline (in short patrimonial practices), her autocratic leadership style not only made her ineffective by alienating stake holders, but arguably also revealed her own autocratic, patrimonial tendencies.

Before Luo was removed from health, she had one more opportunity to shine. In September 1999, Zambia hosted the international conference on AIDS in Africa (ICASA). Luo had been appointed to head a Cabinet committee to organise the international conference.[87] The conference was to be a grand affair. Fourteen-hundred foreign delegates and 1,600 Zambians were expected to attend the conference in Mulungushi Conference Centre and side-events at other locations. Seven-hundred million Kwacha (€ 280,000 at the time) had been budgeted to renovate conference locations and 5,000 conference bags and badges had been procured. The theme of the conference was 'Looking into the future: Setting priorities for HIV/AIDS in Africa'.[88] Of course, many important things were discussed at the conference. Luo took the opportunity to draw on yet another controversy surrounding her to make a valid statement on sexual behaviour and AIDS. She dismissed the notion that casual and forced sex were caused by the way a woman is dressed. The media quoted her as saying, "I want to say it now although I am on camera, that African men should understand that one does not control sex from the trousers but from the head. I like the way I dress, it is controversial, but I like ... that is the way I am".[89] Indeed, female ministers' attire had in recent years been a public and parliamentary point of discussion, as both Luo and Finance Minister Nawakwi had been blocked from addressing Parliament, wearing a mini-skirt and trousers respectively.[90]

In addition to the content discussed, the conference also drew attention to issues of budgeting and management. A *Post* columnist described the conference, pointing out that far fewer delegates had come than the number of conference bags that had been prepared. She also described how various renovations had not been completed and contracted workers had not been paid.[91] A report circulating among embassies dealing with corruption allegations in the ministry concluded that in the tender for bags, badges, and other conference paraphernalia, a billion Kwacha (€ 400,000) had been held back by two senior officials. One of these senior officials, who had reportedly invested his share of the loot in a car import company, was also involved in another case together with

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84 *Times of Zambia*, 'UTH ban: Luo heaps blame on docs, nurses', 14 August 1999.
85 *Post*, 'UTH director "slaps sick baby's mother"', 12 August 1999.
86 *Post*, 'Political watch: Health reforms', 16 August 1999 and 'Postbag: Prescriptions', 26 August 1999.
87 *Times of Zambia*, 'Icasa Cabinet committee picked', 5 August 1999.
88 *Times of Zambia*, 'ICASA: Eight days to go', 7 September 1999.
89 Panafrican News Agency, 'Minister defends women's libertine attire', 16 September 1999.
90 *Post*, 'Luo's mini defended', 6 April 1998.
91 *Post*, 'Political watch: ICASA delegations', 27 September 1999.

Bulaya and Luo. In that case, the three split close to a billion Kwacha siphoned off from a tender for HIV/AIDS-related drugs destined for the National AIDS Programme.[92] Six years later a report was issued to Parliament concluding that 13 billion Kwacha spent on the conference had not been accounted for. Eighty million Kwacha had been issued to a car dealer for a transaction that was never effected. For expenditures worth more than a quarter of a billion Kwacha, no expenditure returns were available and no decision had been taken over a special account holding a balance of a similar amount of money. Moreover, according to the article detailing this report to the House of Assembly, '(t)he House also heard how a controlling officer at the Ministry of Health the then Dr. Kashiwa Bulaya was excluded on the ad hoc committee appointed to oversee the success of the conference saying the donors suggested so because they had no confidence in the officer'.[93] Thus, unfortunately, despite Bulaya having been excluded from involvement under donor pressure, the conference had not escaped the controversy of fraud and lack of transparency. Two months after the conference, Luo was moved to the Ministry of Transport. A media report suggested that her transfer was attributed to the 'alleged shoddy preparations for the conference', which resulted in accommodation for delegates not having been completed two months later.[94] There is, however, no reason to believe that anyone was ever prosecuted for this case of plunder.

Luo was replaced by Commerce Minister David Mpamba, an accountant without medical experience.[95] Previous to his posting at commerce, he had served as Information Minister and was the elected Member of Parliament for Nangoma in Central Province. Mpamba would be one of three ministers to occupy health during the last two years of the Chiluba regime, spending only a year in the job before being transferred to Tourism in November 2000. There he would spend only three weeks before again being moved to Commerce.[96] In Mpamba's first month as a minister, it appeared as if steps would be taken to clear up the confused situation following the failed de-linkage process. Cabinet had approved restructuring plans and all posts in the ministry and the Central Board would be declared vacant and be re-advertised in the next year. Reportedly, an agreement had been reached with unions on the de-linkage. A statutory instrument was also passed to allow civil servants to be seconded to health boards on three-year contracts. As such, a dual employment situation was formalised, with civil servants and board employees working side by side, which would later be an argument for dissolving the Central Board, Moreover, Mpamba indicated that when civil servants were seconded to boards, they would 'carry the same conditions of service'.[97] This prompted the health workers' union to react with concern. A union representative argued that the boards had the right to set their own conditions of service. That implied that having civil servants move with their existing conditions would lead to two different standards in practice, with board employees having better conditions of service. With a sense of premonition, he concluded that this was bound to create problems.[98]

At the same time, a new spate of strikes had started. A strike by junior doctors at the UTH would grow into the most severe labour unrest the health sector had seen to date,

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92 'Report on high level corruption in the ministry of health' (EKN files, ISN 5066).
93 *Times of Zambia*, 'K13 Billion Icasa cash not accounted for, Reveals Report', 23 November 2002.
94 Panafrican News Agency, 'Chiluba Reshuffles Cabinet', 10 November 1999.
95 African Eye News Service, 'Zambian president surprises with cabinet reshuffle', 10 November 1999.
96 *Times of Zambia*, 'President cracks whip, Minister Mulongoti Dropped', 18 December 2000.
97 *Times of Zambia*, 'Ministry of Health posts up for grabs', 17 December 1999.
98 *Times of Zambia*, 'Don't impose conditions on board workers', 22 December 1999.

which was referred to in Chapter 5. According to the hospital's executive director, the doctors had only demanded extra on-call allowances, which she argued were not due. The full list of concerns put forward, however, not only included entitlements such as accommodation, salaries, allowances, and transport, but also broader concerns linked to hospital conditions, such as shortages of drugs and supplies, nursing staff and support staff, and limited laboratory facilities.[99] Then, several weeks later in early January 2000, as the strike had spread to health workers in most major hospitals and was also spreading to senior doctors, government backed up their threats to use their legal power against doctors: 300 junior doctors were suspended and banned from leaving the country.[100] Meanwhile, the ministry prepared to bring in more Cuban doctors to fill the shortage caused by firing the junior doctors,[101] further vexing Zambian doctors who felt they were disadvantaged compared with expatriate doctors.

Health workers were slowly gathering broader public support for their strikes. Medical students, civil society activists, and even Catholic nuns joined the protests. Catholic bishops, trade unions, and other civil society groups voiced their support for the health workers who were protesting for better health care conditions. *The Post* wrote several editorials on the strike and published several concerned citizens' letters in support of health workers. The issue also became political as it was debated in Parliament, and opposition cadres joined the protests. At times, it seemed that the protests were aimed at the Chiluba regime in general instead of merely targeting health issues. Over the months that the strikes lasted, the police regularly blocked protests, protestors clashed with riot police, and protestors were arrested. The government even called in the support of regional governments by working on a protocol to prevent dismissed Zambian doctors from working in neighbouring countries. [102]

Although meetings were agreed upon and held, it took the ministry many months to resolve the labour unrest. The government's reaction to strikers' demands was again a mixture of repression and appeasement. Minister Mpamba said government was trying to find funds to improve conditions of service but that doctors could not profit in isolation from other staff. "If we only improve conditions of service for doctors we will create a crisis because the nurses and other workers including cleaners will be up in arms".[103] As Mpamba accused doctors of demanding salaries of five million Kwacha, doctors reacted angrily. A junior doctors' representative denounced this as "a very feeble propaganda attempt at dissuading the public from the main issues affecting the quality of health care at Zambian public hospitals".[104] Obviously, the question of whether private interests or public concern were at stake in the strikes was very much contested and with it the moral legitimacy of the protests. At the same time, doctors

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99 *Times of Zambia*, 'UTH doctors strike', 22 December 1999.

100 *Times of Zambia*, '300 striking docs banned', 3 January 2000 and Panafrican News Agency, 'Health crisis deepens as Zambia sacks 300 Junior Doctors', 5 January 2000.

101 *Post*, 'Government is considering bringing in more Cuban doctors', 28 January 2000.

102 See for instance: Panafrican News Agency, 'Zambia police stop students from protesting', 8 January 2000; *Post*, 'Catholic bishops back doctors strike', 31 January 2000; *Post*, 'Find solution to doctors' strike', 5 January 2000; *Times of Zambia*, 'Private member's motion on doctors shot down', 24 February 2000; Panafrican News Agency, 'Police and opposition supporters clash over sacked doctors', 13 January 2000; *Times of Zambia*, 'Striking junior doctors denied demo permit', 27 April 2000; *Post*, 'Cops arrest 83 junior doctors', 28 April 2000; *Times of Zambia*, 'Doctors Squeezed', 11 March 2000.

103 *Times of Zambia*, 'Government lays cards on table', 22 April 2000.

104 *Post*, 'Doctors accuse Mpamba of lying', 10 May 2000.

bemoaned the difference in pay between expatriate doctors and Zambians as government brought in 39 Chinese doctors to work at hospitals throughout the country. Doctors reacted that it would be a bad policy to favour foreigners over citizens, as this would not improve Zambia's health care delivery.[105] Meanwhile, Mpamba admitted that various doctors who had been fired had gone abroad, although the possibility of going to neighbouring countries had been blocked.[106]

By August some of the doctors had gone back to work, while fifty doctors had let for 'greener pastures'. [107] However, the matter would not be fully resolved during Mpamba's tenure at health. It was not until former Commerce Minister and former UNIP-stalwart Kavindele assumed office and early in the election year offered pay rises between 15 and 155 per cent to health workers that doctors appeared at least moderately content. While nurses' salaries would improve from 120,000 to 300,000 Kwacha, doctors would earn a minimum of 1.5 million Kwacha[108] per month. The rationale offered was that this would help stem the brain drain of emigrating Zambian doctors and nurses.[109] For similar reasons Kavindele had halted the voluntary separation scheme, saying, "We cannot continue to educate our people for other countries".[110] The pay rise offered to health workers was admittedly made possible owing to renewed donor support. Kavindele stressed that government had impressed on donors that support should include attention to human resource development and retention of health workers.

Donor confidence in the health sector had indeed been somewhat restored since Luo left the ministry. In November 1999, a memorandum of understanding was signed, a remarkable agreement marking Mpamba's time as a minister and leading to further development of the mode of cooperation between the government health sector and donors. Following extensive consultations, 13 donors[111] out of the 15 active in the health sector signed this legally non-binding document, which stipulated the way donors and the government should cooperate. The memorandum of understanding presented guidelines and an institutional framework on which this co-operation would be based and designated common systems for planning, reporting, disbursement, accounting, auditing, and procurement that ideally all partners should use. Central to this cooperation would be the ministry's own national strategic health plan, and various forums were identified in which donors and government would discuss issues related to these areas. The document also made it clear that the preferred means of channelling monetary support to the sector was through the district basket and other baskets that would be established. As we saw before, this type of 'on-budget' support was significant as it bundled the resources available for the ministry to implement the strategic plan, with the assumption that this would increase efficiency and effectiveness. One notable condition was placed on budgetary allocations. The memorandum spelled out that sixty per cent of donor contributions should be used at the district level and that fifty per cent of the government's own resources should be spent at that level.[112] This memorandum thus

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[105] *Post*, 'Government deploys Chinese doctors at UTH', 19 April 2000.
[106] *Times of Zambia*, 'Government lays cards on table', 22 April 2000.
[107] *Post*, 'Government, Striking docs resolve impasse', 28 August 2000.
[108] About € 600.
[109] *Times of Zambia*, 'Doctors, nurses win pay rise', 2 April 2001.
[110] *Post*, 'Docs, state impasse to be resolved soon', 27 December 2000.
[111] DANIDA, DFID, Ireland, SIDA, EU, Netherlands, USAID, UNICEF, World Bank, UNFPA, UNDP, WFP and WHO. Japan and Canada did not sign the memorandum of understanding. Chansa, 'A critical', 31 and 61.
[112] *Ibid*.

signified a further formal step in the mode development of donor–government cooperation, or what at the time was known as the sector-wide approach. While this memorandum was symbolically important to signify donors' and the government's mutual commitment, in reality for some donors it was little more than a declaration of intent. By 2003 only 9 of the 13 participating donors had actually contributed to the baskets.

The memorandum of understanding led to a process of several further documents being produced. The memorandum of understanding called for a joint identification and formulation mission which would chart the problems the sector was facing, as a basis for drafting a new national health strategic plan for 2001–5. Chansa, in an analysis of the sector-wide approach in the Zambian health sector, quoted donor representatives to indicate that donors had not been comfortable with earlier national health strategic plans, but that due to increased involvement in this process it was felt that this plan had been developed with the confidence from most donors. The apparent result of donor cooperation in the formulation of the national health strategic plan was that this third strategic plan was more systematic and specific in its listing of objectives, strategies, and expected outputs than previous plans. In this new plan, basic health care packages remained an important planning tool, though they were in need of revising and further implementation. One notable strategic objective of the plan related to the sector-wide approach. It was envisioned that within five years the district basket would be transformed into a broader health-sector basket. This was closely connected to the idea that earlier health reform policies had ignored the role of hospitals as an essential link in the referral system. As such, the plan aimed at reforming the hospital sector on the basis of basic health care packages that would be formulated for this level. This would allow for 'right sizing' of hospitals. Another example of the renewed focus on hospitals was that the financial and administrative management system would now be rolled out on this level. A minor but notable element of this plan was that yet another element of previous plans was abandoned as it was not feasible. The plan to build, equip, and staff thousands of health posts, which had featured prominently in the national health plan of 1995-2000, was now deemed not to be possible 'under the resource envelope' of this strategic plan. With regards to human resources, the plan would focus on planning human resource development in line with the needs of the basic package. Emphasis was also placed on resolving outstanding issues from the de-linkage process and on issues of staff retention.

In response to the strategic plan, a small group of donors – the British, the Danes, and the European Commission – carried out a joint appraisal of the strategic plan. This document stands out from most health sector documents, particularly those produced by the government or jointly by government and donors, in that it contained a critical assessment of what had been achieved and the challenges that still lay before the sector. Moreover, problems were also attributed to management issues at the ministry, rather than being seen as the result of external factors. In analysing the achievements and challenges of service delivery, the glass was seen as being half empty rather than half full. The only achievement of the health reforms that was not qualified with points for further attention was that there was a more capable and decentralised authority to manage health services. Participatory structures had admittedly been created, but were deemed to need further strengthening to become more effective. Resources had been shifted to the district level, although the report noted that this shift was based more on estimates of allocations than what was actually spent at district level. Furthermore, whereas the concept of the basic health care package had been developed in the pre-

vailing economic context, this was deemed to be unaffordable. Finally, the mission found that the purchaser-provider spilt had occurred theoretically, but the provider was not considered to be fully empowered to provide services or to be fully accountable.

The joint appraisal mission also summarised the problems the sector was facing. First of all, it concluded that the overall socio-economic environment was not conducive to achieving great progress in improving people's health status, due to poverty and AIDS. More specifically for the health sector, the document concluded that the health reforms had yet to show a substantial improvement in service delivery, again echoing the point put forward by Luo. Many groups of the population remained with insufficient access to quality health services, as resources remained inequitably distributed geographically. In addition, the decentralised authority to manage health services was deemed incomplete as districts still lacked authority over human resource management and lacked resources for buying drugs and supplies. Moreover, support systems such as procurement and financial systems were deemed to lack effectiveness and transparency, while technical support to deal with specific health priorities was insufficient. Finally, the donors also criticised the fact that the Ministry of Health lacked control, owing to its dependency on donors, and remarked that the paradigm shift from project support to sector support was only partial. In order to manage these problems, the donors formulated a list of conditions that needed to be met in return for donors' contributions. It is striking that all these conditions referred to processes within the sector rather than to the results of service delivery. It thus appears as if donors' shift away from their own projects towards sector support gave them a greater involvement in the day-to-day management of the sector, while the presented aim of the sector-wide approach was to increase government's 'ownership'.

Other donors were not directly involved in this joint appraisal. Some donors were unable or unwilling to compromise on their own appraisal processes. In the case of the Netherlands, however, this was due to the fact that they had already conducted their own appraisal of their support to the health sector. This appraisal formed the basis for repackaging various individual projects into one sector-support programme for an unprecedented six-year period. From the perspective of the embassy, which managed this programme, this was a big step forward as it reduced the administrative burden of administrating various small programmes with shorter programme cycles, and it also insulated the health-sector support programme from the ever-shifting policy priorities at headquarters' level. For the embassy's counterparts in the ministry, it was also a step ahead as it signalled the Dutch commitment to Zambian systems rather than the parallel support given in the primary health care programme in Western Province, which had been finalised by 1998. To the great surprise of the health adviser at the embassy at the time, and to the embarrassment of some of his Zambian counterparts, Mpamba seemed not to realise the golden opportunity that this six-year support programme presented.[113]

Kavindele's tenure at the Ministry of Health was even shorter than those of any of his predecessors. Kavindele was a UNIP die-hard and member of its central committee when in the run-up to the multi-party elections he tried to replace Kaunda as UNIP leader. It was not until after the 1996 elections that he eventually joined the new ruling party.[114] Then, after having served as Minister of Science and Technology for a few months and as Minister of Commerce, he was fired by Chiluba in September 1998. According to Kavindele, he had differed with Chiluba over the taxation of Coca-Cola,

[113] ML0810/01.
[114] *Post*, 'I'm the right man for President – Kavindele', 23 July 2001.

proposing to ease the burden on the company to prevent mass lay-offs. According to an opposition politician, this showed that 'anyone who served the interests of the people and not President Chiluba risked losing his job'.[115] Then, in November 2001, Kavindele surprisingly 'bounced back' into Cabinet, taking up the Ministry of Health.[116] Kavindele was also a businessman, having amassed considerable wealth and declaring total assets of 11 billion Kwacha (€ 5.85 million) in 1998. According to Kalumba, Kavindele had also been mainly interested in the business side of health, though these accusations were not substantiated. Barely a year after assuming the health portfolio, however, Kavindele was promoted to vice-president in May 2001, as Chiluba was fighting dissidents within his own party in an attempt to ensure a third term as president.[117]

Owing to the brevity of his tenure at the health ministry, Kavindele failed to put much of a stamp on policy at the ministry. However, archive material does shine light on two meetings between donors and Kavindele in January 2001, in which a number of practical issues were discussed and also the issue of Medical Stores. From the minutes of these meetings it becomes clear that government was still not prepared to cancel the contract with Medical Stores, while donors were looking for alternatives to distribute drugs. At the time, serious consideration was given to by-pass Medical Stores by establishing a parallel distribution system through the Churches Medical Association. Kavindele seemed inclined to accept this decision, although he stressed that it was controversial and emotive within the ministry. Donors, however, would have to foot the bill for a parallel system. The minister also confirmed that in future the responsibility for preparing and approving drug tenders would be shifted from the ministry to the Central Board, in response to donor concerns. A final point mentioned in one of the minutes concerned staff changes of unnamed senior officials. It suggested that the minister had 'pushed for change', but that this would be difficult 'considering the political connections and activities of some officials'. It appears that donors were inclined to solve not only the issue of Medical Stores but also the issue of Bulaya, as was also suggested by his exclusion from the ICASA organising committee.[118]

After Kavindele left the ministry, the last months of Chiluba's regime passed with Levison Mumba at the helm of the ministry. Mumba had been a backbencher from Eastern Province, who had attracted attention by being accused by Sata of being opposed to Chiluba's plans for securing a third term. Shortly afterwards, he had been recruited by Chiluba to lobby on his behalf among Eastern chiefs. This loyalty was soon rewarded when Mumba was appointed as provincial minister in March 2001. A few months later, as Kavindele was promoted to vice-president in May, Mumba became Minister of Health. Mumba's tenure, however, made little impression on those in the health sector, other than what would emerge after his tenure. Various officials strained to remember him, owing to the number of changes in ministers at that time. One former official claimed he was invisible at the ministry. Be that as it may, it can be assumed that in the last half of 2001 all eyes were on the third-term debates and on what would happen in the elections that would come to Zambia at the end of the year. Would this lead to a change of power or an extension of Chiluba's disappointing regime? In other

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[115] *Post*, 'I differed with Chiluba, says Kavindele', 22 September 1998.

[116] He was reportedly 'the first MP to bounce back in cabinet since the dawn of the third republic'. *Times of Zambia*, 'Kavindele bounces back in cabinet', 22 November 2000.

[117] *Post*, 'Kavindele Appointed Vice-President', 5 June 2001.

[118] Minutes of the meetings between Honourable Minister of Health Mr. E. Kavindele and cooperating partners, 11 and 30 January 2001 (EKN files, ISN 5066).

words, after these elections would Zambia and its health sector get a new deal, or would it be business as usual for those with political connections.

Conclusions

This chapter traced the events leading to stagnation of the health reform process. Key to this stagnation was the failure to de-link health workers from the civil service. Unions effectively challenged this process in court. While proponents of the health reforms have tried to de-legitimise the unions by alleging that they were afraid to lose membership or by claiming they were bribed, the fact is that they were effective in articulating health workers' anxiety about their livelihood security. The effective role played by the unions conflicts with the view that in neo-patrimonial settings horizontally linked groups lack relevance. These events are also somewhat at odds with Rakner's conclusions that domestic interest groups were marginalised in the Zambian reform process. Indeed, while the unions did not appear to have been taken seriously in earlier stages of the health reform process, collectively health workers eventually managed to effectively block the process of de-linkage and thus de-rail the health reform process. At the same time, however, we can also attribute a patrimonial logic to this challenge to the de-linkage process. Moving people from civil service employment to three-year performance contracts managed by an autonomous agency can be seen to conflict with the logic of a state patronage system. Under state patronage, as long as one does not air dissent or disloyalty, issues of performance are not enforced. As managing loyalty appears a greater priority than managing performance, the political system likely had as much vested interest in the status quo as health workers who apparently prioritised livelihood security.

The court challenge to the de-linkage process need not have been conclusive. However, it is evident that after this blow, the health sector no longer had the leadership to keep the reforms on course as Kalumba soon lost his position of stewardship over the sector. His successor Luo was made of different leadership material. She had different priorities and intentions. Moreover, she appeared to lack the performative capacity to broker between various interest groups. Instead, her style estranged herself from various domestic and international constituencies. Part of the challenges faced by Luo came from gender power relations within the health sector. To generalise, one could say that the power structure depended on male doctors and (at a lower level) clinical officers in positions of authority, while mainly female nurses played more subservient roles. For a woman who unabashedly flaunted her femininity it may have been difficult to challenge the gendered expectations of leadership.

In this chapter we were also confronted with the criminalisation of the health sector. The case of Medical Stores linked the health sector to the world of international organised crime. This case of grand corruption also linked some of the protagonists in the health sector with the social network making up Chiluba's matrix of plunder.[119] The case illustrated the instrumentalisation of health sector institutions for private and criminal interests. At the same time, we also saw that this served political interests, as

[119] On Chiluba's Matrix as a social affair, see Leenstra, 'Dark', for a social network analysis in the MLS/GMR case and J.K. van Donge, 'The plundering of Zambian resources by Frederick Chiluba and his friends: A case study of the interaction between national politics and the international drive towards good governance'. *African Affairs*, 108: 430 (2009).

granting the management of Medical Stores to GMR was obviously a return favour for campaign funding in the 1996 elections.[120]

The episodes described in this chapter had serious repercussions for relations with donors. Donors had invested heavily in the health reforms; their stagnation thus harmed their interests. Moreover, donor confidence in the intent and integrity of the Ministry of Health was damaged by the Medical Stores' saga. We saw how Luo's lack of performative capacity rather escalated this crisis, one that was not of her own making, than defused it. This turn of events impacted on donors' ambiguous strategy towards the health sector. While there was some posturing and the overall level of funding declined, donors worked from the status quo to save certain benefits of the reforms. They focussed their funding and attention on the Central Board of Health, while by and large bypassing the ministry. Meanwhile, the ministry was loath to cede control over certain functions that had been built up at Central Board, which contributed to parallel system and inefficiencies. This situation would later contribute to the rational-legal argument that would be used to abolish the boards, as we shall see in the next chapter. Donors' ability to shape the status quo as well as the modalities of working with the health sector were increased when Luo was succeeded by less-involved ministers. In this near absence of political leadership, donors codified their relations with the sector in a memorandum of understanding, embellished by the rhetoric of ownership. At the same time, this modus *operandi* was strongly linked to the Central Board of Health as a politically isolated parallel system within a context of neo-patrimonialism and political turbulence.

It is striking how donors preoccupations in the sector at this time appeared disconnected from the political turbulence affecting the health sector and the country at large. In this chapter, we saw the labour unrest, encountered throughout this narrative of the health sector, at its most intense. On the one hand, this unrest, owing to the public support it generated, was translated into challenging the legitimacy of the Chiluba regime. On the other hand, it also appeared as an arena for renegotiating the pact between the state patronage system and health workers. Health workers' loyalty was at stake as they aired their discontent and dissent, underlined by the credible threat of withdrawing from the health sector (and moving to greener pastures). The political system, meanwhile, attempted to discipline striking doctors by firing and deregistering them and bringing in expatriate doctors. This strategy to discipline those guilty of airing their dissent further underlined the argument on the importance of managing loyalty. At the end, as we saw in Chapter 5, the pact between health workers, particularly doctors, and the state was again sealed. Health workers' loyalty, or at least an absence of dissent, was restored with promises of better entitlements. Moreover, the proposals Luo had made of linking allowances to performance were off the table for the foreseeable future.

[120] This case thus differs from Van Donge's conclusion on Chiluba's alleged corruption that this was mere theft as it did not possess political rationality (Van Donge, 'The plundering').