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Political distractions for the health reforms

We now move on to describe the period in which the health reform process reached its conceptual and operational zenith. Paradoxically, however, the instrumentalisation of the reforms for personal and political gain also seems most prevalent in this phase. This period is very much coloured by Michael Sata's tenure at the ministry; he was a mover and shaker in Zambian politics, whose earlier reputation of political dealing and fixing followed him into the health sector as soon as he was appointed. Kalumba, who remained deputy minister of health, played a supportive and complementary role to Sata, studying his strategies and later defeating Sata in the quest for control of the health sector.

This chapter zooms in on several workshops as arenas in which donors and government representatives jointly negotiated policies and exchanged discourse. In one of these workshops, Katele Kalumba demonstrated his performative competence in dealing with donors. He used a discourse which was very appealing to donors to convince them to buy into the health reform process. He apparently also persuaded donors to channel their funds directly through Zambian government systems rather than through their own projects. This workshop also revealed that conflicts between donors about their competing approaches were played out at the national level, which further strengthened the argument for donors to follow Zambian plans and systems. At the same time, donors claimed a role in creating systems to operationalise the health reforms. In technical workshops, they contributed to shaping rational-legal arrangements, such as a financial and administrative management system that would mitigate the fiduciary risks of putting their funds into a Zambian basket rather than through their own projects.

This chapter also describes Sata's role in shaping the formal institutional set-up of the health sector and its power structure. He was confronted with a draft legislative framework to formalise and underpin the health reforms. This draft law would lead to an erosion of the power of the minister as it would create a semi-autonomous body responsible for health policy implementation, the Central Board of Health. Moreover, it would devolve authority and control of resources to the district level. In a bid to

minimise this loss of power, Sata used his position as minister to alter the proposed legislation by insisting that the minister himself appointed all the district health boards and the leadership of the Central Board of Health. In doing so, Sata constructed a political base, which would be used not only to mobilise support for the MMD's re-election but also to generate loyalty to himself. Thus, Sata was able to generate political gain for the party in the short-term and a boost to his own political reputation in the longer term, albeit at the expense of the institutionalised power of the position of the Ministry of Health. This further illustrates the argument promoted in this dissertation that in a neo-patrimonial set-up, the instrumentalisation of order is at least as relevant as the instrumentalisation of disorder.[1]

But it was not only Sata who exploited the opportunities provided by a political position overseeing the health reforms. Kalumba especially, as the midwife of the health reforms who had mobilised significant donor support for the health sector, benefited from the boost to his political reputation. This allowed him to join Sata in mobilising public support for the MMD's re-election. In doing so, however, he also created a personal power base. Kalumba's rising political fortune is best illustrated by the fact that he had used his political capital to lobby for the creation of a new district in his home area, where he would be elected as a Member of Parliament in 1996; this act of creating a new district, with the associated job creation and infrastructure development, is perhaps one of the most striking examples of contemporary African political patronage.

This chapter ends by taking stock of the results of the health reforms hitherto. In the later days of the tenure of Kalumba as Minister of Health – he went on to replace, or perhaps displace, Sata – a mid-term review mission was fielded by the donor community, under the leadership of Professor Mahler of the World Health Organization. This review showed the benefits and shortcomings of the health reform process, but was much less explicit about the instrumentalisation that the process had undergone. The mission found that the health reforms had achieved progress in developing accountability systems for the health sector. The area where the reforms had made the most significant progress, however, was in the decentralisation of authority to district level, together with the direct allocation of funds to district level through the district basket fund. The health reforms had thus succeeded in significantly altering the way power and control was structured in the health sector, despite the instrumentalisation by Sata and others. At the same time, the review also hinted at instrumentalisation of the reforms at lower levels. This can be deduced from the conclusion that the reforms had led to the creation of new elites at local level by creating and staffing structures with resources and authority at district level. Finally, the report provided an argument to Kalumba's successor, who opposed the health reforms, that perhaps too much attention had gone into developing systems at the expense of improving health care. This chapter thus demonstrates that the long-term transformation of the power structure in the health sector generated short-term political benefits for the regime as well as consolidating the political power and reputation of Kalumba and Sata.

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[1] Refer to the theoretical framework and the conclusions for more on the instrumentalisation of disorder.

New leadership

Many Zambians, health workers, taxi-drivers, barmen, and other normal Zambians remember Michael Sata as the best Minister of Health Zambia has ever had. During the 2008 election campaign, I was sitting at a hotel chatting to the barman. I asked him about his views on the elections. Being in Northern Province near Mpika district, Sata's traditional home area, I was not surprised to learn that the young man would vote for Sata. When I asked why, he told a tale about Sata as Minister of Health. It was told in such detail one might almost think he had been there; it was a fine contemporary example of the African oral tradition, a tale that had obviously been told and retold many times. He related how Sata had once travelled to a hospital clinic in Eastern Province at night. He had disguised himself with a coat and a hat and joined other patients in the waiting room. There he noticed how the nurses lazed and were rude to patients. When he got up to approach the nurses, they shouted at him, telling him to get in line and wait his turn. Sata then took off his disguise and told off the staff, firing them there and then.[2]

Some individuals within the health sector also retained positive memories of Sata's time at the ministry. For instance, a former senior ministry official, who had since moved to a faith-based organisation, said that Sata had been an experienced hand in government 'and he gave us a glimpse of how things worked. At times he was unpredictable, but he introduced some good things. He really cleaned up the place. He introduced incentives[3] for cadres, who really benefited. Doctors were picked up for work, nurses got good new uniforms. He didn't rock the boat. He wasn't bureaucratic but a man of action, a practical man, who worked well with professionals who took the decisions'.[4] This is also an image that Sata himself attempts to cultivate. According to his party's website, he was an action man who brought 'sanity to the health sector' and who worked well with technocrats.[5]

Others, though, paint a different picture. One former donor representative remembered him as a "mad man".[6] A former senior official at the ministry said, "They call him a man of action, but sometimes the actions were very destructive. He was an unguided missile. If it was launched from your side, it could be safe; but if you were unlucky, it could damage you".[7] We will later evaluate what he did for the health sector. At the moment, it suffices to state he was a controversial figure, who brought controversies with him the moment he came to the Ministry of Health.

On 12 January 1994, the same day that the newspapers announced Michael Sata's appointment as Minister of Health,[8] they reported on further developments in one of the corruption cases haunting him. The article indicated that the Anti-Corruption Commission had recommended that the Director of Public Prosecutions (DPP) bring Sata to court on charges that in the position Minister of Local Government, which he held before moving to Health, he had deposited more than a billion Kwacha into a bank in

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2 Unfortunately, this informal interview went undocumented. This representation is therefore lacking in the colourful detail and expressively acted-out dialogues with which the tale was told.

3 In common usage in the Zambian health sector, *incentives* refer to financial remuneration, underlining the argument about extrinsic motivation made before.

4 ML0810/06.

5 Patriotic Front website: http://www.pf-zambia.com/michael_sata.html (accessed in June 2007).

6 ML0810/13.

7 ML0811/02.

8 *Times of Zambia*, 'Cabinet shuffled', 12 January 1994.

which he had shares. Contrary to legal requirements, he had not disclosed this interest, and in doing so, government lost out on higher interest that could have been earned elsewhere. Sata was never prosecuted, however, as the attorney dropped the charges because this would be against 'public policy', an argument that was not elaborated upon.[9] It appeared that the case was dropped because the penalty Sata would face for this abuse of office would be only fifty Kwacha, for which it was not considered worth prosecuting him.[10] The report of the Anti-Corruption Commission detailed this case and others against ministers in the first few years of the MMD government.[11] It is notable that Sata featured twice in the report. Another issue he was involved in was ordering the water company to make a special delivery of water to his residence, thereby upsetting its normal schedule, though this was not considered grave enough to pursue.[12]

Barely a few months into Sata's tenure with responsibility for the health portfolio, at the end of February, the *Weekly Post* published a profile article on Sata, as he was again probed for corruption. The profile had the ominous title, 'A snake in the grass roots'. Sata was described as having been a police constable, who in the 1960s quit his job to become a trade unionist. The article suggested that this demonstrated his early political aspirations, as the labour movement was seen as a gateway for African nationalists to enter into politics. Later he had teamed up with a foreign businessman to build houses in what was to become Lusaka's Avondale residential area. After the business partner was deported under obscure circumstances, Sata was left with an investment 'that would help him transform from a failed policeman into a minor tycoon'. Later Sata served as Governor of Lusaka. The *Post*'s profile article suggested that at this time he served as Kaunda's right-hand man and 'the UNIP vigilante par excellence, bullying frightened citizens into a reluctant worship of the president'. As governor, he would force market women to close their shops every time Kaunda was travelling so that they could dance for him at the airport. As the Kaunda era drew to a close, Sata was one of the later UNIP politicians who crossed over to the new MMD, preferring to sit on the fence until Kaunda fired him for treachery in January 1991. Then, under the MMD government, Sata proved himself as a good organiser and a mover and shaker. The article recalled that two years earlier, Chiluba had confirmed that the Anti-Corruption Commission was investigating Sata for criminal dealings, but at the same time admitting that he could never drop Sata, who was a 'good grass roots' organiser'. To complete this characterisation of Sata, the article claimed that 'Sata certainly is a riotous character. His coarse blustering ways and rude domineering style cost him dearly in his social life'. Perhaps more to his credit, the article stated, 'He also is a generous man – after a fashion. Usually he is only too glad to oblige. He will readily use his political muscle to help one get, say, a council flat – even if it is against regulations'.[13]

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9 *Times of Zambia*, 'Attorney saved Cobra', 12 January 1994.

10 Matenga, G.R., *Corruption: Is it endemic in Zambia?* (Lusaka, 1998). This handling was also condemned in Levy Mwanawasa's resignation statement in *Times of Zambia*, 3 July 1994.

11 Action was taken only against one minister, the Minister of Works and Supplies, Ephraim Chibwe, who was accused of irregular purchases for State House. He was dropped from the Cabinet and the MMD electoral list. The new MMD candidate for his Chienge constituency was Katele Kalumba.

12 Anti-Corruption Commission (undated), Reports on Suspected Corrupt Practices involving Ministers, Submitted to the President by the ACC since November 1991. EKN files ISN 2292.

13 *The Weekly Post*, 'A snake in the grassroots', 22 February 1994.

A few days earlier, the *Post*[14] had reported that once again the Anti-Corruption Commission had begun investigating Sata. Although he had been at the ministry for less than only two months, he was alleged to have ordered the parastatal drug procurement and supplying company, Medical Stores, to pay rent for his private office at Farmers' House, in downtown Lusaka. He was also said to have named a friend as the sole buying agent for medical supplies on behalf of Medical Stores. Sata, in turn, accused the Anti-Corruption Committee of organising a vendetta against him, having planted agents in his surroundings.[15] Then, a few weeks later, the *Post* published accusations that the director at Medical Stores had hired a number of MMD cadres in return for the facilitation of an appointment to meet Chiluba at State House. These party cadres, who had no more than secondary-school qualifications, were employed in the security department and as a receptionist. The paper also reported that the director at Medical Stores had since then been replaced, having previously resisted previous attempts by Sata to appoint two senior officers there.[16] The *Post's* editorial in this edition of the paper was outraged by this scandalous example of political patronage. This behaviour reflected that Chiluba had failed to de-link the ruling party from the government and was reminiscent of the old UNIP-era slogan: 'It pays to belong to UNIP'.

Sata's alleged corruption did not go unchallenged. Several months later, as the investigations into the allegations of corruption at Medical Stores had drawn to a close, the DPP ordered the Anti-Corruption Commission to arrest Sata.[17] Sata promptly reacted in a characteristically brazen manner, taunting the Anti-Corruption Commission to go ahead and arrest him if they had any evidence. He then charged that there was a conspiracy on the part of the Minister of Justice Sondashi and Vice-President Mwanawasa to frame him. Sondashi, he claimed, had pressured the DPP to order his arrest. After he was arrested, Sata continued, Mwanawasa and Sondashi, both being lawyers, should lead the prosecution against him, so that he could produce documents showing their complicity in framing him. He alleged that he had proof that the former director of Medical Stores, an unnamed permanent secretary, Mwanawasa, and Sondashi had met at Mwanawasa's office to plot Sata's victimisation. In the same article, however, the DPP called on the Anti-Corruption Commission to close the case against Sata, as the key witness testifying against Sata had since been charged with a very serious offence, thus rendering the evidence against Sata inadmissible due to the witness's lack of credibility. Consequently, there was not enough evidence to successfully prosecute Sata.

This prompted both Mwanawasa and Sondashi to resign from government two days later. Following his resignation, Mwanawasa issued a detailed statement subsequently published in the media. In this statement he claimed that part of the reason he had resigned was that there was inconsistency between his role as vice-president and the tools at his disposal, explaining that he had spoken out on issues of good governance, reprimanding colleagues and party members, only to be contradicted and challenged by his colleague ministers. He then went on to describe his role in facilitating the case against Sata over his abuse of office. He confirmed that he had been approached by the director of Medical Stores, who made the allegation that Sata had ordered him to pay the rent of his private offices from the Medical Stores' account. He also told Mwana-

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[14] Which still called itself *The Weekly Post* although its frequency of publication had been increased to several editions per week.

[15] *The Weekly Post*, 'Sata is probed for corruption again', 18 February 1994.

[16] *The Weekly Post*, 'MMD jobs shock at Medical Stores', 4 March 1994.

[17] *Times of Zambia*, 'Arrest Sata – DPP', 29 June 1994.

wasa that Sata had directed him to employ one of Sata's relatives as a technician at Medical Stores, as well as another man as general manager. Mwanawasa then explained that in his role of vice-president, and at the time even as acting president, he referred the case to the Anti-Corruption Commission. After it appeared that no action was taken, he consulted the Minister of Legal Affairs, Sondashi, with whom he heard the former director of Medical Stores in the presence of the permanent secretary of Health, who had witnessed Sata issuing the order to pay for his rent from the funds of Medical Stores. Later, as we have seen, the DPP ordered Sata's arrest and subsequently retracted this order, which Mwanawasa claimed left him aghast. After suggesting that the DPP had acted impartially, he concluded by suggesting that Chiluba had considered firing Sondashi rather than Sata for washing dirty linen in public.[18] Echoing the analysis put forward in the *Post's* profile of Sata, Mwanawasa thus suggested that though corrupt, Sata had been retained by Chiluba as he was considered untouchable and indispensable.[19] Days later the *Post* published accusations of Sata influencing the Lusaka town clerk[20] to arrange a high-cost house for the DPP to induce him to drop charges against Sata.[21] The lack of follow-up applied to these substantial suspicions of corrupt behaviour supports the argument of impunity for political leaders, put forward at the end of Chapter 5.

Health reforms continue

In the meanwhile, as Sata was settling into his new job as Minister of Health, the health reform process was continuing, with Kalumba chairing a five-day appraisal workshop for donors to discuss the Strategic Health Investment Plan 1994-1999, which would later evolve into the National Health Strategic Plan 1995-1999 (referred to at the beginning of this Health Section of the dissertation).[22] Shortly after the meeting, the *Times* ran a special focus article reporting on the meeting and introducing the health reforms to the public. It reported that representatives of the ministry, including the minister, deputy minister, and permanent secretary, met with four bilateral donors and five international organisations for a five-day workshop at Siavonga, a resort town on Lake Kariba. Donors were reported to have presented a joint statement that stressed their firm commitment to supporting the reforms, 'based on the very positive results in the field in a very short time'. These results were reflected in donors' observation that health staff at district level had been 'empowered and are taking charge of service delivery in their districts, resulting in improved morale and commitment to better health'. The media report drew the conclusion that this commitment was demonstrated by donors' pledges of over 150 million US dollars for a period of four years to support the activities in the strategic plan. The article then proceeded by introducing various elements of the reforms and of the strategic plan, as well as 'the vision' of the reforms. Finally, it quoted Katele Kalumba presenting an argument he was wont to articulate.[23] He admitted that there was still far to go before this vision would be attained and that people felt that there was too much planning already. 'In my own empirical assessment

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18 If you will, for violating the vow of silence about corruption.
19 Mwanawasa, 'Resignation statement'. *Times of Zambia*, 3 July 1994.
20 Whom he had hired as Governor of Lusaka and who later became the treasurer of the patriotic front.
21 *Post*, 'Sata accused of helping DPP in acquiring a house', 8 July 1994.
22 See Annex I.
23 See Annex I.

of Zambia's health reform history, planning outputs have far exceeded services reaching the people. This strategic plan should not be allowed to fail'.[24]

A report by a Dutch delegate, however, indicated that donors had more reservations than this article in the state media would suggest. The delegate reported that the plan presented was still far from complete and that from the Zambian side more energy would have to be invested before one could consider this a plan that was acceptable to all donors. The report indicated that the original aim of this workshop had been to give the World Bank an impression of the progress made with the health reform process, as the World Bank was at that time preparing a 30 million US dollar loan for the health sector. However, the inclusion of other donors in the workshop reportedly led to very lively discussions. A striking issue of discussion regarded the packages of care (what would later be known as the 'essential care package'). After World Bank missions had recommended that the ministry look closer at 'designing an affordable Zambian car',[25] the HRIT had spent much energy on a so-called 'packaging exercise'. They had meticulously tried to quantify the packages of services to be delivered at various levels. After calculating the costs of these packages, it would be determined if they were affordable; if not, the package would be reformulated. However, after months of calculations and consultations, the process had not yet resulted in presentable packages. Other donors had suggested that the HRIT should not follow such a detailed approach, quantifying and costing individual actions on the level of health workers. Instead, the joint donor statement suggested that the HRIT should focus on describing packages for key health problems for which districts would get technical support for implementing. Other donors' critiques placed the World Bank in a difficult position, as it would lose face if it now advised the ministry to drop a time-consuming methodology that it had instigated.[26]

Another issue that came to the fore was the heavy burden placed on district health management teams to comply with the conditions set by the HRIT and the Danish project on planning, budgeting, and reporting. It was suggested that districts be offered breathing space so that they could focus more on service delivery rather than merely on paperwork. This was an issue that was compounded by the fact that in Western Province districts, in addition to having to adhere to the government's own and Danish requirements, they also had to adhere to the requirements set in the Dutch Primary Health Care Programme. Besides these considerations of administrative burdens, the political leadership found equity considerations important in determining the allocations to districts. A problem for them was the fact that some districts received significantly higher allocations as they received donor support in addition to government support, notably the districts in Western Province receiving Dutch support. There was thus an impetus to come to a unified disbursement system with a unified financial reporting system, in addition to the necessity for a further refinement of the allocation mechanism to ensure equity. This resulted in the special attention that in subsequent years would be placed on developing a financial management and administration system. A step in this process that was reported at Siavonga was to send a mission to Zambia in June 1994, comprising headquarters' representatives of the seven donor agencies involved.[27]

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[24] *Times of Zambia*, 'Health plan, from vision to reality', 19 May 1994.
[25] See Annex I for more on the metaphor of the Cadillac.
[26] Communication RNE to DGIS on the Strategic Health Investment Plan 1994-1999 (EKN files, ISN 3204)
[27] *Ibid*.

An appraisal report from the World Bank staff, which presented the proposal for the World Bank's loan referred to above, also shone light on this workshop in Siavonga and how it contributed to creating a new way of working between donors and the government. This report emphasised the role Zambian leadership played in shaping these relations by, for example, using excerpts from speeches.[28] A special place was given to Kalumba's speech at the Siavonga workshop, presented in Box 8.1, which served to convince donors to buy into the joint endeavour of health reform, an endeavour which may have seemed like a path with an uncertain future.[29] This speech was also presented by Kalumba himself, in an article which he wrote to present the reforms to an international audience.[30]

Box 8.1 Health reform: A Zulu healer's tragedy

"An anthropologist documented the Zulu healer's method of proving success with cases of epilepsy: to have the patient dive into a river known to be infested with crocodiles and lethal snakes completely nude, early on a morning during the coldest part of the year, and hold his breath as long as possible. If he came up alive, he would b cured of epilepsy. There are no records to show how many survived the ritual to tell the story!

We in Zambia are trying to avoid a Zulu healer's tragedy of the past. We all need a real success story in Health Reform, consistent with a vision of health that moves away from orthodoxy … or more of the same thing. Work with us to provide environments that are conducive to health; help out people learn the art of being well; and provide a basic package of health care for all. We want to be able to spend less on drugs, less on expensive technology; less on super-specialists with long credentials whose value is only acknowledged by editors of professional journals. We want cost-effective, quality-assured health, centred around the needs and resource possibilities of the family. This vision we have defined. This vision we share with you. This vision, we learn, is now being shared by many the world over. Somewhere it must succeed. That place is here …

You cannot walk away from Zambia's reform effort saying, 'We helped Zambia dive into the river of comprehensive Health Reforms … and those chaps were courageous, but Zambia's infant mortality rate has become worse; its infrastructure remains unfixed; its drug supplies still inadequate; its epidemics uncontrolled, etc'. There is no taxpayer in Europe, Japan America or member country of multilateral agencies who wants to hear that kind of 'success' story. Our fate is your fate too; we are in this boat together. We have gone too far together not to share in the common cause for real success – and not one measured by the volume of documents we collectively produce."

Source: Hon. Deputy Minister, Dr. Katele Kalumba. Speech at MoH Appraisal Workshop, April 1994.

If we analyse the content of this speech we get the impression not only of an eloquent presentation, but also a well-crafted piece of oratory aimed at convincing donors to open their purses and invest in Kalumba's political project of health reforms. This excerpt contains many elements that would appeal to donor agency representatives. The metaphor, taken from Africa's traditional past, adds a certain *couleur locale* to an international discourse of public health. In the mouth of the speaker, an African in-

[28] Though it is unfair to deny this role, at times it seems as if the report manipulated reality by downplaying the role of donors such as the World Bank and highlighting their ideas when they are reflected in the words of Zambian politicians. This is most extreme in their attribution of the Cadillac metaphor to a speech by Sata (referred to earlier), when Kalumba (who is not too modest to take credit for any achievement) puts its provenance in a World Bank mission one and a half years earlier.

[29] World Bank (1994), *Staff appraisal report*.

[30] Kalumba, K. (1997), *Towards*; World Bank (1994).

tellectual, it would lend weight to the idea that these reforms were indigenous Zambian reforms, rather than ones imposed by international agencies or Northern donors. Equally, it would also appeal to international public health experts, as it portrays traditional medicine as irrational – and possibly dangerous to the patient – thereby confirming their convictions that reinforcing modern medicine in Africa was indeed a worthwhile pursuit. The speech also aptly summarises the vision of the reforms in a manner that fits with representations of a health care system as held in the international discourse of public health care, an emphasis on health education, appropriate technology, and affordability, rather than the high-tech, high-cost, and high-status pursuits of 'super-specialists' and other orthodox medical professionals – such as Boniface Kawimbe and the senior medical professionals he represented. Finally, Kalumba in his speech cleverly combines the idea of taking risk, which is something donor bureaucrats are loath to do, with the need of reaching tangible results and success stories, which is something donor-bureaucrats are under pressure from their headquarters to pursue. He does this by invoking the idea of Northern taxpayers' expectations, in a way donor representatives are likely to do, therefore suggesting to donor representatives that he knows and appreciates donors' preoccupations and that it is in their interests to take a risk and launch into the river of health reforms in the same boat as the Zambian reformers are taking. Considering that this eloquent and colourful piece of discourse was presented in the World Bank staff assessment, this piece of discourse may have served the bank staff's own interest of getting approval for a loan from their executive board.

In addition to illustrating how a Zambian political actor attempted to seduce donors into giving support, the report also presented the advances made in donor coordination, which in later development jargon was to be known as 'alignment with government systems. The report suggests this trend was also significantly influenced by the political leadership of the Ministry of Health, notably in the person of Kalumba. A notable development in coordination between donors and the government was, or so the report suggested, the intention of using the strategic plan discussed in Siavonga as the framework for all donor contributions to the health sector. Having the opportunity to discuss and give input to the plan, donors would then have to ensure their support fitted into the agreed strategic plan, which would be complemented with an annually updated five-year investment plan. Further, the development of the district basket was notable in that it contributed directly to the recurrent costs of the government's service delivery system. For this, donors would use common planning, budgeting, disbursement, and accounting systems. The report states that this way of working departed significantly from donors' traditional way of working, in that it not only contributed to recurrent costs but that districts would be unaware (and would thus not have to account for) which Kwacha came from which donor.[31]

The World Bank report, as has been suggested above, put significant emphasis on the Zambian ownership of the reforms, as well as the changes in donor government relations. Two other citations were taken from Kalumba's speech as textbox illustrations for the report, which demonstrate this point. One quote, which was further emphasised with the heading, 'It's Zambia's Plan', indeed highlights Zambian conceptual ownership, though implicitly acknowledging convergence in Zambian and donor discourse. Kalumba said, 'The approach to this exercise of strategic planning reflects the working philosophy of some of your organisations, but the logic of what the Plan contains

[31] World Bank, *Staff appraisal*, 18.

reflects the originality of Zambian reform. Both the concepts of the Strategic Plan and of a basic package of health services were defined in the MMD's Policy Framework paper!' Of course, there is a clear logic both in Kalumba's assertion of his intellectual ownership of at least part of the reforms and in the World Bank's presentation of these arguments. Kalumba was working on getting credit for his achievements, and the bank's staff was eager not to be seen as a prescriptive bully (a reputation that structural adjustment had understandably given them). In particular, Kalumba's claim on the intellectual ownership of the concept of care packages illustrates the instrumentalism of the World Bank in presenting this quote. As the Dutch report of the workshop recorded, there was a discussion among donors about the feasibility of the package approach that was pushed by the World Bank. Presenting it as a Zambian idea, the World Bank appears to try to minimise its role in forcing the controversial decision. A cynic might assert that Kalumba merely bounced back the discourse that donors would be eager to hear. On the other hand, seeing the development in Kalumba's thinking on health reform over time, as we have done, it certainly reflects an influence of, and adaptation to, donor discourses, but it also suggests a certain originality and consistency. Rather than assuming the cynical view, it would be more correct to conclude a convergence of discourse and mutual adaptation between policy makers and donors.

The argument that there was mutual adaptation and a two-way flow of influence is supported by a quotation presented in which Kalumba urges donors to align with and contribute to the strategic plan. This illustrates his assertiveness and his efforts to set conditions on donors rather than simply accepting theirs. "We want to encourage you as our cooperating partners to buy into our National Strategic Plan", he said. "We want your input into the design but then we will discourage parallel vertical programmes which operate outside the national programme that is being designed. We invite you to transcend the temptation that you take only that which you can individually label: 'Made in the Republic of Luampungu'. Donor community funding should be seen in the context of complementing the Zambian effort not the other way around". Again, Kalumba went beyond the expected courtesies of a speech addressing donors and showed his insight into the factors influencing donor behaviour. He even criticised aspects of such behaviour, namely flag-planting and the quest for visibility. Considering the fact that one is still likely to see labels such as 'From the American People' or various other donor acronyms on equipment in the health sector, such criticism is still valid today. However, considering the way some donors received the criticism Kalumba articulated here and acted on it in subsequent decisions regarding their health sector activities demonstrates that this was not mere rhetoric. For example, we saw both in the report of the Dutch delegate to this Siavonga workshop and in the incident between the HRIT and doctors in Mongu that there was a consistent pressure on the Dutch to fit their programme into the government framework.

Following the functional decentralisation of planning and budgeting functions to districts, and their 'empowerment' through training and direct grants in the period leading up to the workshop in Siavonga, the process of supporting this new district level required further steps to be taken. As we saw, initially the HRIT had undertaken capacity-building and technical support. However, already in 1993 the intention had been to gradually shift this responsibility to the provincial level, while the HRIT would focus on supporting the process and the reorganisation of the ministry at the central level.[32] To

[32] Report RNE to DGIS, 1 July 1993 on donor coordination health (EKN files, ISN 3204).

prepare the provinces for this supportive role, considerable work was yet to be done. According to a proposal document for provincial capacity-building intended to solicit donor funding, historically there had been considerable lack of clarity about the functions of the offices of the provincial medical officer. The last document on these offices dated from 1968, more than a quarter of a century earlier. Officially, provincial offices were the representatives of the central ministry, but there were various perceptions of what this meant. Programme officers within the office were answerable to the managers of vertical programmes at the central level, and the provincial medical officer had little authority over them. This unclear situation was described as leaving staff uncertain, demotivated, and with inappropriate attitudes. At the same time, there was little teamwork and lack of competency for supporting and supervising districts.

In August 1994 a workshop had been held with members from provincial health management teams and a working group on provincial capacity-building, consisting of three representatives of the ministry, two provincial medical officers, one member of the HRIT, and four technical advisors. Two of these advisors were the Dutch primary health care advisors from Western and Northern provinces, one a Dane with the HRIT, and one a Dutch-funded Tanzanian who advised on primary health care within the ministry. The document that resulted from this workshop summarised the functions of the provincial health management team as 'discharging supportive technical supervision, effective training based on identified priorities, health administration/logistic support and promotion of interventions and exchange of experiences'. The document went on to define a range of detailed roles, an ideal organisational structure, and action plans for building capacity at this level.

One important action in the proposal was to restructure provincial medical offices into regional offices. If we recall, the policies and strategies from 1991 had called for regional health advisors, and the later version of the national strategic plan from 1996 had talked about four regional health offices. This document, however, remained vague about what this change to a regional health office entailed, besides offering descriptions of their roles and structure.[33] One working-group participant remembered that there had been extensive discussions. Katele Kalumba had wanted to get rid of the provincial level completely, as it would be likely to interfere with the development of districts, being loath to transfer their authority over financial management and human resource management. Others had been worried that supervising and coordinating 58 districts from the centre would be unmanageable. In his role as deputy minister, Kalumba had not been able to win this argument. This working group thus developed proposals for nine smaller provincial offices aimed at supporting the districts.[34] Shortly after Kalumba became a full minister in May 1996, the decision was taken to indeed go from nine provincial offices to four regional ones.[35] Another concrete action that was proposed in this plan was to improve the financial and management skills and develop financial and administrative management systems (FAMS) at the provincial level, together with a separate FAMS-working group and the HRIT.

These FAMS were also an area that would get considerable attention in the years of Sata's tenure at the ministry. In June 1994 the mission of donor headquarters' staff referred to above was indeed held. This joint mission of financial controllers at donor

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[33] MoH, 'Report of a workshop on the functions of provincial health management teams' (Lusaka, 1994).
[34] ML0905/01.
[35] MoH, *NHSP*, 95-99, draft 3.

agency headquarters attended a seminar with, and at the invitation of, the ministry and the HRIT. The purpose of this seminar was, according to a document reporting on a later FAMS workshop, 'to provide technical support in the process of developing a unified system for disbursement, accounting and reporting of external and GRZ (Zambian government) funds to the Ministry of Health'. Following the recommendations of this joint mission and discussions within the ministry, the HRIT contracted an American consultancy company, which issued a detailed report with recommendations of improvements to financial and administrative routines, procedures, and forms used at various levels in the Zambian health system. This led to a workshop held in Livingstone in February 1995. The participants at this workshop included ministry staff at various institutional levels and a special FAMS' working group. This group included some of the representatives of the HRIT, the ministry, and technical advisors who were also involved in processes such as the district and provincial capacity-building described earlier. The content of this workshop was extremely technical and it led to numerous concrete outputs. Participants discussed accounting, record-keeping, financial reporting, stores, and medical record-keeping procedures and contributed to the formulation of formats and forms for these various areas.[36] This contributed to revising and developing the various systems that the heath sector uses today. A subsequent step was the implementation of these systems. Stationary kits and guideline manuals were prepared for distribution to the districts. It had been decided that the system would be piloted in Western Province. This and the fact that two Dutch technical advisors had been involved in designing the system would assure Dutch commitment to Zambian financial management systems. Furthermore, using Western Province as a testing ground gave relevance to the Dutch Primary Health Care Programme as a field laboratory for the health reforms, a role which would also be played in designing a Health Management Information System (HMIS). The Dutch had also commissioned a report by an accounting firm on the FAMS as a basis for deciding whether it too would directly contribute to the district basket.[37]

Beyond such technical issues aimed at strengthening rational-legal systems, one major political struggle was significant in Sata's years at health. This struggle involved fundamental issues of power involved in the process of drafting and deciding on the legislative framework for these reforms. These discussions would eventually, after a heavily contested process, result in the National Health Services Act of 1995. A number of the architects of the reforms and participants in its implementation argued that Sata played a crucial role in the process to arrive at the final act.[38] His main preoccupation, however, appeared to be to resist any change that would limit his own powers as minister. Instead, he succeeded in consolidating his power of appointment and control, thus creating a loyal power base which could be used for his political objectives. Such a strategy is wholly consistent with the idea of patrimonial instrumentalisation of a rational-legal process.

As we recall, originally the health reform documents, the MMD policy framework paper and the policies and strategies from 1991, had called for a National Health Council. This would be an advisory body chaired by the vice-president. This body would have a guiding role towards the ministry, which would retain executive authority. According to a former ministry official and co-architect of the reforms, Sata had op-

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36 HRIT, FAMS report from a planning workshop held in Livingstone, February 1995 (Lusaka, 1995).
37 Report on donor coordination from RNE to DGIS, 20 June 1995 (EKN files, ISN 3204).
38 ML0812/01, ML0706/03, ML0811/02, ML0810/01.

posed this idea of a National Health Council to advise the minister. "He wanted no one above him".[39] An argument against the council would be that there would be no legal-institutional precedent for such a council. Kalumba was then said to have gone to the Public Health Ordinance of 1930, which he had studied during his doctoral research. It seemed that this colonial-era document had instituted a central health board. Although it had apparently never fully functioned, and in fact in Kalumba's dissertation no mention is made of it,[40] legally it still existed.[41] A central board, moreover, provided a solution to another problem reformers had run into. As mentioned before, early attempts at drawing up a blueprint to improve the conditions of service of health staff had been rejected by the Cabinet as this would not be possible within the public service. Creating a central board of health apart from the public service could overcome this problem if staff were employed by this autonomous agency rather than the civil service.[42]

The exact conceptual origins of the Central Board have caused some debate among observers. A consultants' report from 2004 states, 'The CBoH has been modelled along the functions of the Swedish National Board of Health and Welfare, and the functions in the Health Services Act 1995 coincide largely with the Swedish Board'.[43] This is interpreted by some as meaning the board was an idea proposed by Swedish technical advisors and consultants.[44] One observer working outside the government health sector asserted this was the case, as he had overheard a discussion between Swedish consultants and ministry staff on this issue in a hotel lobby in Lusaka. The architects of the reform, however, vehemently deny that the idea was originally Swedish, while they admit that for the implementation of the idea the architects closely studied the Swedish model and that Swedes were brought in to advise. Considering eye-witnesses' narrative of Sata's objection to a council, the institution of a board in colonial times, the desire to de-link staff to provide for better conditions, and the admission that Swedes were indeed involved in designing and implementing the idea, this later version of events seems more plausible than the blanket contestation by less-informed observers that the board was a completely Swedish idea.

Thus, a working group supported by a number of technical advisers, including the two Dutch primary health care advisors, and taking into account Swedish technical advice, developed draft legislation with a view to creating a Central Board of Health. This again ran into Sata's objections. The draft had stipulated that the board's director-general would be appointed by Parliament. One former senior official argued that this was to make the board more autonomous, as it would give more security of tenure to the director-general.[45] In this way it was implied that the director and his board would not be subject to the minister's schemes, as we have seen in Kawimbe's attempts to appoint senior management at the country's biggest hospital and in Sata's recent changes of management at the Medical Stores. Further, another official claimed that Sata was opposed to the de-linkage as this meant he would lose control over large numbers of

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39 The idea that the council would be chaired by the vice-president must have been even more vexing to Sata, considering the troubles he was having with vice-president Mwanawasa in the first half of 1994.

40 Kalumba merely mentions that this Public Health Ordinance had defined health authorities in the territory. Kalumba, 'The practice', 76.

41 ML0706/03.

42 ML0811/02.

43 Koot, J. & A. Inambao, *Institutional and organisational appraisal, Ministry of Health* (Lusaka, 2004) – unpublished.

44 In an interview with Kalumba, this was a major point of his critique of the report in question.

45 ML0811/02.

health workers and other staff.[46] Kalumba said that Sata had also objected to linking district boards to the district councils of local government. Subsequently, the draft act was amended many times, with the result that, in Kalumba's words, Sata 'created a eunuch'.[47]

From other sources also we can learn that Sata had blocked earlier drafts of the 1995 Act at various times to resist losing patronage power. In February 1995 the Dutch ambassador reported to his Minister for Development Cooperation that Sata was increasingly asserting his influence over the reforms. This influence the ambassador 'unfortunately could not always judge positively'. Sata had again postponed the adoption of the draft health act, this time by telling Parliament that a commission would review the health reforms. While the ambassador was not in principle opposed to critically reflecting on what had been achieved, he doubted Sata's good intentions based on the recent scandals Sata had been involved in. The first case referred to continued rows over Medical Stores, where Sata had placed a protégé after removing her predecessor for refusing to cooperate in allocating money to Sata's personal expenses. At the time, there were serious concerns over the purchase of inappropriate medicines by the central Medical Stores to supply hospitals. The other example cited concerned labour unrest at Ndola Central Hospital. A number of junior doctors had gone on strike to call for the removal of senior staff. This had forced Sata to suspend the director – a relative of his – and replace him with a confidant of his from Lusaka. Moreover, the junior doctors had made allegations over the procurement of curtains, in which a brother of Sata was involved. The third reason the ambassador had for distrusting Sata's intentions was his insistent refusal to send the draft act to Parliament. The ambassador put this down to the fact that the bill would significantly weaken the central ministry and its political leadership in favour of the districts. Since Sata was seen as wanting to control many issues himself, even to the smallest detail, this would be a considerable erosion of his power base. This had led to considerable concern among the group of donors. The ambassador reported that a mission from the World Bank had put considerable pressure on Sata to place the draft act before parliament. This had prompted Sata to go forward, while altering the draft so that he, the minister, would have the power to appoint the director-general of the board. Nevertheless, the future of the bill still remained uncertain.[48]

This conflict between donors and Sata over the health act did not go unnoticed by the public. A month after the Dutch report to headquarters, the media reported on the discussions over the act. The *Times of Zambia* reported that the draft bill would cut the minister's power, as the director of the Central Board was to be appointed by the president from three candidates, subject to ratification by Parliament. The article also reported on the 'disappointment' of donors at the fact that the bill had not been presented to parliament. Denmark had suspended 31 million US dollars earmarked for supporting the health reforms, while Sweden was reluctant to offer its proposed contribution of 25 million US dollars. The Netherlands and the United States were also reportedly concerned about the delays. Sata coldly ignored the protests in the media, however, saying he had not received any official correspondence on the matter.[49]

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46 ML0706/03.
47 ML0706/04.
48 Communication RNE to Netherlands Minister for Development Cooperation, 2 February 1995. (EKN Files, ISN 1701).
49 *Times of Zambia*, 'Bill cuts health minister's power', 29 March 1995.

By the end of May of that year, the Cabinet agreed to send the bill to parliament. They did, however, object about the lack of linkage between local government and the district health boards. As a concession, Sata, who had to defend the bill in Cabinet, agreed that district councils would have to approve district health boards' annual plans and would be informed of progress on a quarterly basis.[50] In September, the National Health Services Act of 1995 was finally passed, although it was not gazetted until six months later.[51] The final bill had undergone significant changes in Sata's favour, although it still made the de-linkage that he was opposed to possible. In the final version of the act, the minister appointed the director-general of the Central Board after consultation with the representatives on the board. Of the 16 members of the board, the minister could appoint 7. The other 9 included the dean of the Medical School, representatives of the Medical Association and the Traditional Healers Association, and representatives of the Attorney-General and the Ministry of Local Government.[52] However, considering that the minister had an influence in the appointment of some of these 9, such as the chairpersons of the Medical Council and the Nursing Council, one could argue that the minister through his appointments had control over the board.

Sata also saw benefits in other areas in consequence of the health act. A participant in the working group which prepared the act remembered that it had been decided that the ministry would appoint a third of the members of the district health board. Kalumba had been slightly panicked at the prospect of Sata appointing these.[53] Kalumba himself admitted that he had never considered the power base formed by these district health boards until he had seen Sata's insistence on signing each and every one of the appointment letters to the boards around the country.[54] We will later see the political use that Sata, and possibly also Kalumba, would make out of this newly created political support base.

The passing of the health act by no means meant an end to the confrontation between Sata and donors. Later in the year, Sata was reported rejecting donor demands in the media. After an annual consultative review with donors, he railed at what he called "donor benchmarks" to privatise the Medical Stores. Donors had claimed that this would improve procurement procedures and that they were under pressure from their governments to account for how funds were spent. Sata, however, asserted that this would kill the health reforms and that in the financial sector it had been seen that benchmarks do not work.[55] The controversy over Medical Stores, which had dogged Sata since the start of his posting at health, would develop into something even more sinister, a case which will be given ample attention later.

Building Katele's kingdom

For Katele Kalumba, Sata's tenure at the Ministry of Health led to the worst moments in the health reforms. It is clear that Kalumba considered the health reforms a matter of personal pride. He took an active role not only in designing the reforms but also in

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50 Communication RNE to DGIS on donor coordination in the health sector, 20 June 1995 (EKN files, ISN 3204).
51 Mahler *et al., Independent*, 9.
52 National Health Services Act No. 22 of 1995, 222.
53 ML0810/01.
54 ML0706/04.
55 *Times of Zambia*, 'Sata rejects donor demands', 28 October 1995.

selling them to various audiences. Numerous media articles explaining the health reforms to the public extensively quoted Kalumba. As we have seen earlier, Kalumba also played a key role in engaging donors in their support for the reforms. His public profile was far more pronounced than any subsequent deputy minister of health. Seeing Sata mess around with his own prestige project will have been a threat to Kalumba. He said that after Kawimbe, with Sata 'a politician had been brought in', as 'health was seen as an instrument for winning political power'.[56] He did not suggest, however, that the same applied to himself.

One observer of the health sector informally told me about the politics of health reform over lunch in an Indian restaurant which was frequented by Chiluba and his cronies in the later years of his presidency, where they would come to drink Blue Label whisky. He said that both Sata and Kalumba had used the structures created in the health reforms as a patronage machine for the MMD in the run-up to the 1996 elections. Vehicles belonging to the health ministry were used to transport district health board members and local health officials to party conferences. As many of these people owed loyalty to Sata or Kalumba for their appointments, they could influence them to rally for the party – and for themselves. Meanwhile, they would use the flying doctor service to travel the country doing political footwork for the MMD. An article by a Zambian organisation involved in socio-economic health research provided further insight into the politicisation of health structures. This article looked at the development of local planning in the health sector and as such studied health centre committees that had been formed to get the community's input. The article quoted an opposition councillor's impressions of the committee: "As area councillor from the opposition, I am heavily sidelined by the HCC (Health Centre Committee). They have brought a lot of politics. They think and say that all programmes in this area must be initiated and run by the ruling party without looking at their abilities to perform. The HCC members here have closed up against me. They don't consider me as their civic leader. I have always been open but they don't want me to associate with them just because I am not from the ruling party". On the basis of other impressions also, the article concluded that the health reforms had become viewed as a project that was owned by the ruling party. Moreover, as expectations of the process with the associated donor funding grew, other parties were systematically discouraged from being involved in the process at local levels.[57]

Two interviewees gave another illustration of ruling-party politics in the health sector around the time of the 1996 elections. One former government health worker said that a few months before the elections he had been posted as a senior member of the district health management team in a certain district. At that time there was a nurse at the local rural stage-two health centre who was "a very staunch MMD-supporter". She had wanted to become the in-charge of the facility, although according to the establishment,[58] the in-charge should have been a registered nurse. She had tried to use her political influence to assert the claim, but our respondent refused because, according to the establishment, she was not properly qualified. She then went to the provincial MMD chairman and the case was discussed in political meetings. The respondent was accused of belonging to the new opposition party, recently established by Dean Mung'omba.

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[56] ML0706/04.

[57] Ngulube, T.J. *et al.*, *Planning and budgeting for primary health care in Zambia: A policy analysis* (Lusaka, 2005).

[58] The organogram indicating which cadre take up which positions in the structure.

The former district health manager, however, claimed he was not even active in politics, but was still visited by an officer of the Office of the President (the intelligence service) who asked him about the vacancy and why he had not posted that specific candidate. Then the provincial health director intervened in support of the respondent and prevented him from being sent to a rural health centre; instead, he was re-posted to the health management team in a different district. "He knew that I was a Christian and had no political duties".[59] Another respondent's account suggested that this issue was not just simply a party-political one. She had, as a registered nurse, been in charge of the stage-two clinic in question. She had been made signatory of a German-funded project at the clinic. Around election time, however, other people at the district had wanted to become signatories themselves, "to be able to chew the money". She, the previous respondent, and three others were removed to make it easier to get access to the project. She remembered that her letter was "written in a nice way, but it was political". Her husband, who was also in government service, was transferred elsewhere so she had to follow. Subsequently, the project was terminated.[60]

Figure 8.1 Political graffiti, Chiengi district

The telling of these anecdotes from the local level is not meant to suggest a direct connection between these anecdotes and the rumours cited above of the political behaviour of key individuals in our narrative; there is no evidence to support such a suggestion. These anecdotes are merely intended to illustrate the prevailing impression that in the run-up to the 1996 elections, when Chiluba was fighting for re-election, the distinction between the government and the party was blurred and that this also affected the health sector. In Chapter 10 we will examine witness testimony on the 2001 elections, which will again illustrate this phenomenon. In this context, Kalumba's assertion that Sata used the reforms for political mileage seems convincing. However, the path Kalumba's own political career took suggests this might not have been unique to Sata.

[59] ML0811/18.
[60] ML0811/16.

When Kalumba became a deputy minister, he had been appointed as a nominated Member of Parliament rather than having been elected in a constituency in his own right. However, in the 1996 elections, he stood as a candidate in the constituency of Chienge in the very north of Luapula, bordering on the Congo and Lake Mweru. The previous Member of Parliament for this constituency had been fired as Minister of Works and Supplies after an investigation by the Anti-Corruption Commission.[61] Although he was never prosecuted, it can be deduced that he did not have the political clout to survive these incriminations. Kalumba, on the other hand, must have gained considerable political credit for the progress made in the health reforms, not least for the donor interest it generated, but also for the political mobilisation that the district health structures could be used for. Regardless of the dynamics between Kalumba and the political leadership of Chiluba's regime, it appears that locally Kalumba had mobilised considerable support as a parliamentary candidate. We can recall that Kalumba had a matrilineal connection to the Bwile Royal Establishment. In fact, chief Puta of the Bwile people was commonly referred to as Kalumba's uncle in the media.[62] In addition to relationships, Katele had by the time of the elections in November 1996 influenced a political decision that was a direct and immediate benefit to the people of Chienge.

In 1996 the local government act had been revised, allowing for the creation of several new districts in the run-up to the elections. Whereas there were previously 58 districts, there would now be 72. Chienge had hitherto been a sub-district of Nchelenge, but after a 'quiet but effective lobby' by Kalumba, by October 1996 it had been decided to make it a separate district. Then in December, after having been newly elected, he together with a trusted associate from the Ministry of Health and other government officials witnessed the inauguration of the council chairman of the newly established district.[63] Creating a new district was not merely an administrative action, but it was followed by considerable investment in the area to create the needed administrative infrastructure. A district council building would need to be constructed, as well as local departments for ministries such as agriculture, education, and health. This meant extra employment opportunities for locals, and it also meant people from outside the district coming in to spend part of their government salaries in the district. When asked why Chienge had been created as a separate district, a district health official who had been working in the area in 1996 said that there were a lot of political issues involved but that "basically Katele Kalumba was creating employment by demarcating Chienge".[64] Kalumba's enterprise of securing his own power base is a interesting example of patronage politics, as he created benefits such as jobs not for individuals *per se* but for the people of his 'home village'. In subsequent years, he would continue to serve the

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61 Matenga, *Corruption*; and *Times of Zambia*, 'Attorney saved Cobra', 12 January 1994.

62 *Post*, 'Police arrest Katele', 15 January 2003; and 'Kalumba Shouldn't Force Me to Support MMD', 28 October 2004. It is unclear whether this is a biological relation with this specific chief, who has since died, or a 'perpetual' socio-cultural relation to whomever holds the chieftaincy, or both.

63 This information had been taken from an un-referenced article on wikipedia.org (http://en.wikipedia.org/wiki/Luapula_Province_border_dispute accessed 3 December 2008]). In personal communication, however, the Zambian historian and former ambassador to the UN, Prof. Mwelwa Musambachime, an expert in the history of Northern Luapula, indicated that he had no evidence to doubt what is reported in the Wikipedia article. In fact, he added that Kalumba, through his father's lineage, is related to the chief Munuga of the Shila Royal Establishment, which centres around the town of Mununga in the Kalunwishi area, a rival population centre to Puta within Chienge. He also stated that in local politics the people from the latter area were disappointed to have the *boma*, the administrative centre of the district, nearer to Puta.

64 ML0811/21.

interests of his rural home and political power base. As shown in Figure 8.1, political graffiti in his constituency urges people to 'Vote Kaka Wesu the Developer'.[65] Many in his home province informally credited Kalumba with building schools and clinics and particularly with connecting Chienge to the national electric grid. This support even continued when his electorate's presidential preferences shifted away from Kalumba's MMD and towards Sata. It thus becomes clear that besides being an academic and a technocratic deputy minister, Kalumba was also a political entrepreneur who looked for and seized opportunities to further his own political ambitions, despite his own attempts to present himself as merely a technocrat who reluctantly found himself in politics.[66]

Within the Ministry of Health, Kalumba also managed to strengthen his own position. While Kalumba may have been irked by the disruptions Sata caused to his reform process, donors' concerns about the progress in the health reforms must have been a huge boon to Kalumba, in view of their rivalry. Kalumba has been eager to present a negative image of Sata's time at the Ministry of Health, even more than a decade later.[67] Sata in an interview equally downplayed Kalumba's profile as a reformer. He claimed that he was the one who politically directed the reformers within the ministry, while Kalumba was just trying to "highjack the limelight.". He also suggested that Kalumba was very much influenced by donors, saying "the young man was a conduit for his masters' voice: The donor community". At the same time, Sata claimed Kalumba was "trying to be a good boy with the president".[68]

Indeed, it was a combination of these two factors – Kalumba's relations with donors and Chiluba – that led to Sata being off-staged in the health sector. Kalumba suggested in an interview that because of Sata's undermining of the health reforms, cooperating partners were beginning to backtrack. He gave the examples that Sweden was not keen to move and that the Americans did not want to join the district basket over related issues. Indicators (of performance), he added, were slowing. Kalumba admitted that he had convinced Chiluba of the threat and that the ministry had to deliver. Then in May 1996, ahead of the elections, Sata was moved from health and appointed as a minister without portfolio, a job that allowed him to focus on his role as national secretary of the party while keeping a foot in government. This allowed him to become known as 'Chiluba's chief-fixer'. Kalumba, meanwhile, took over as Cabinet minister responsible for health. Sata, though certainly not free from controversy himself during his time in health, claimed that after him it became a 'free for all' in the health sector. Regardless of Sata's self-aggrandising opinions, it is true that by the end of Kalumba's time in health and thereafter, the health reforms had run into a debilitating hurdle and that political distractions became more than a mere annoyance but seriously disturbed cooperation between donors and the ministry.

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65 Kaka Wesu being the familiar nick-name given to Kalumba locally.

66 ML0706/04 and ML0812/01. Also in the media, during the race for Chiluba's succession, he was quoted as saying, "I am a technocrat and not a politician and I do not hope to spend my entire life in politics". *Post*, 'Chiluba Picks Katele As His Successor', 12 December 2000.

67 This is not surprising, as the competition over Chiluba's succession and Kalumba's later role as MMD national secretary, while Sata was the primary opposition leader, would have furthered rivalry or even enmity between these individuals.

68 ML0804/03.

A mid-term review of health reforms

Before turning to the imminent stagnation of the health reforms at the end of Kalumba's tenure at the Ministry of Health, let us take the time to assess the accomplishments of the health reforms up to that point in time. Equally, we will see where the reforms fell short of expectations. In September 1996 a multi-disciplinary team of seven international and three Zambian experts under the leadership of a retired director-general of the World Health Organization, Professor Mahler, conducted an independent external review of the health sector. According to the report itself, the ministry had requested this in 1995.[69] Needless to say, there must have equally been a strong demand for such a review on the donor side. The report was balanced and pointed our several critical issues in the reform process. Nevertheless, as is the case with such evaluations, the team took an aggregated and abstracted perspective, not zooming in on political dynamics and certainly not on personalities. The report's tone was mainly diplomatic, as stakeholders from the side of donor agencies as well as the ministry would have the opportunity to comment before the final draft.

The Mahler report described the Zambian health reforms as 'something remarkable in Africa'. This was attributed to the spirit that permeated the reforms and had led to 'many good things (being) accomplished'. In some in the health sector this had lit a spark 'which enabled them to express their latent skills and begin the fulfilment of their hopes for the nation'. These people were seen to be 'grappling with problems, determined to solve them'. The team, however, had also seen confusion and misunderstanding, with some in the health sector sitting on the fence and others possibly involved in the reforms 'for what they can gain'. The preface to the report suggested in hindsight that after a period in which the momentum was strong in order to 'take advantage of the favourable conditions for as long as they persist', the reforms were momentarily 'blown off course when political obstacles were thrown in its path'.[70] Though not naming names, the report stated that after 1993 the reforms had slowed under 'a new Minister who was much less committed'. It referred to Sata's blocking and weakening of the health services act, indicating that it was only 'thanks to heavy prodding from the donors' that the hurdle had finally been taken. After Sata was removed in May 1996, 'the pace of reforms picked up rapidly'.[71] The ministry, however, was on the whole seen to be taking an incremental approach to reform, seizing on some opportunities though avoiding conflict by inaction in other areas. This instrumentalism itself, the report felt, led to new problems, as achievements had created an uncertain patchwork of intended and unintended consequences with lack of clarity on details of the further reform process, despite consensus on the general vision. While the review team welcomed the reformers' attitude to take a learning, experimental approach and to embrace error,[72] one wonders whether the reforms had not been caught up in the 'disjointed incrementalism of the past', which Kalumba in the foreword of the strategic health plan had intended to avoid.[73]

The Mahler report went on to list a number of achievements, noting that some achievements were still on the drawing board, while others were just being imple-

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69 Mahler *et al.*, *Independent*, Introduction.
70 *Ibid.* Preface.
71 *Ibid*. 9.
72 *Ibid.* 10.
73 Annex I.

mented. The primary achievement of the reforms was the decentralisation of health service management to the district level and further down towards the neighbourhood level, closer to the family. The report credits the ministry for seizing the opportunity to make grants available to the districts when additional donor funding became available. Another achievement, though controversial until its reversal a decade later, was the institution of user fees. Cooperation with donors was described as unusual and successful because of the innovativeness of 'basket funding' and the 'rare degree of donor cooperation in support of the nationally led reform strategy'. Though the report remarked on the tentative nature of some achievements and described the ministry as sometimes proceeding very rapidly and sometimes very slowly, it concluded: 'Because the reforms have taken place during a period of turbulence both within and without the Ministry (economically, politically, structurally, and personally) it is sometimes astonishing that as much change has taken place'.[74]

Of course, the review team still found many areas wanting. For instance, while it acknowledged that extensive preparatory work had been put into defining essential care packages, this approach had serious shortcomings in its implementation. While lists of essential services appeared to exist, calculation of the operating cost of these packages per person did not include the costs of the system that was required to support service delivery. The actually available resources for universally providing these packages of care were thus not enough. In addition, the designers of the package failed to seize other advantages of this package-approach, such as using it as the basis for developing guidelines and protocols – in short, standardisation and norm-setting. The team concluded from observations in the field that very little of the package was actually operational. They spoke of 'business as usual' in the clinics they visited. They generally found no treatment schedules in place, no standardised equipment lists, and little attention to the improvement of clinical care.[75] The team appreciated that much focus had gone on management issues, but less attention had been paid to the quality of care.[76] This argument that too much attention was given to systems and too little to service delivery would later be central to the rhetoric of those opposed to the health reforms.

Zambia's drug policies were another area of concern, an area seen by patients as an indicator of 'health reforms at work'. Many essential elements of this policy area were in need of attention, such as drug selection, procurement, and distribution mechanisms as well as guidelines on rational drug use. This contributed to 'poor and erratic availability of drugs'.[77] This in effect influenced popular acceptance of user fees, as people were loath to pay for services when drugs were unavailable. The main reason the report cited for the lack of progress in this area was that opposition to reform in this area was strongly entrenched. The reformers were thus seen to be strategically avoiding direct conflict as they thought they might not win on this issue.[78] The report was positive, however, about the ministry's initiatives to address such issues, pointing out the drawing up of an essential drug list and plans for the privatisation of Medical Stores. It warned, however, that failing to address these issues risked compromising the imple-

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74 Mahler *et al*., *Independent*, 8.

75 Sukwa, T. & J. Chabot, 'Summary report of the public health group on Zambian reform and the health system', 10-1. In: Mahler *et al*., *Independent*.

76 Mahler *et al*., *Independent*, 12.

77 Distribution of drugs to rural health centres was less erratic, however (Sukwa and Chabot indicate that this was stable from March to September 1996). This was due to the system of rural health kits that provided drugs to these centres. Sukwa & Chabot, 'Summary', 8.

78 Mahler *et al*., *Independent*, 10.

mentation of the essential package.[79] Despite its convincing diagnosis of these drug problems, the report did not foresee the difficulties to which the drug distribution issue would later lead.

A further issue that was equally important to the public perception of the reforms was the contentious issue of user fees. For some, health reforms were nearly synonymous with user fees, as can be seen in the numerous studies on this issue.[80] The controversy in this issue was that it threatened to deny access to health services for those in need. The political leadership of the ministry had seen the sensitivity of this issue. Kawimbe, for example, proposed and piloted a scheme that allowed rural people to pay their fees upfront in-kind with maize that could be sold to the food reserve agency. Following Kawimbe's departure from health, this scheme was never fully implemented.[81] Sata was very much in favour of a monetary pre-paying scheme. One former official claimed this was because of the money this would generate.[82] In addition, he could micro-manage the implementation and management of prepayment schemes and user-fee collection, publicly contradicting and warning his staff. Media, for instance, reported that he ordered UTH to revise the terms of its pre-payment scheme as it covered only certain costs and not others, arguing that this favoured the rich.[83] In another instance, the *Times* reported that boards had decided to raise fees from 750 to 1,000 Kwacha.[84] Several weeks later it reported that following Sata's intervention, it had been lowered to 800.[85] In yet another case, Sata publicly warned staff they would be punished if they were found to charge children.[86] It is clear that Sata was aware of the political ramifications of these policies. Donors such as the World Bank felt that the ill-designed pre-paying scheme and ad hoc adjustments were contrary to the letter and the spirit of the reforms. The fear was that the ministry would have to raise subsidies to hospitals.[87] The Mahler report concluded that user-fee policies had been controversial and inconsistent, and there was ambiguity about the principle aim. Was this policy aimed at generating revenues or at fostering popular involvement in health care? The implementation of exemptions was considered 'to leave much to be desired' owing to lack of administrative capacity and an effective information system. Finally, user fees were, together with drug shortages and broader socio-economic factors, linked to a trend of decreasing use of health services by patients.[88]

Notwithstanding the achievements of the decentralisation process, in this area also the review team had serious issues to address. It was found that while district directors of health were active in districts, this was much less the case for district health boards. Many district health management teams were found to lack planning capacity and were hard pressed to maintain financial accountability, let alone supervise health facilities. The relations between management teams and boards, meanwhile, were sometimes difficult, in part because district health directors would have to cede newly won authority to the boards that were being established. Moreover, the review reported 'acute

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79 *Ibid.* 12-13.
80 Refer to the studies cited in Chapter 1.
81 Lake *et al*., *Analyzing*, 73.
82 *Ibid*; ML0706/03.
83 *Times of Zambia*, 'Sata tears up UTH scheme', 9 January 1995.
84 *Times of Zambia*, 'Health scheme fees upped', 13 January 1995.
85 *Times of Zambia*, 'Medical fees cut', 2 February 1995.
86 *Times of Zambia*, 'Sata to punish defiant officials', 20 May 1995.
87 Lake *et al*., *Analyzing*, 74.
88 Mahler *et al*., *Independent*, 14.

anxiety among some staff' over the planned transfer of the authority to 'hire and fire' to local health boards.[89]

The most serious point of criticism in this field, particularly if we look through the neo-patrimonial lens, was that in some places 'new elites' seemed to have been formed in district health management that were seen not to 'respect the rules of accountability and transparency'.[90] In the technical volume of this review, this allegation was described in more detail. It was explained that some health centres could not access funds because the district health management team told them that there was 'no money'. No further information would be given. The reviewers argued that this could affect motivation and the willingness to show initiative, as well as lead to distrust, rumours, or conflict. They recommended supervision and technical support.[91] A former Dutch technical advisor at the provincial level supported this picture when he reported on the faults of the reform process. He complained of badly selected district directors and deputies who had started to act autocratically. In fact, some district health boards had become small *politbureaus*. This advisor attested that in a number of districts he had encountered petty corruption, which could be seen as 'decentralised stealing'.[92] There is of course no data to allow us to draw general conclusions on how widespread such behaviour was. However, considering also our previous narrative on the alleged behaviour of certain political actors and the anecdotal illustrations provided, it does seem likely that such forming of new elites, who did not respect the rules of accountability and transparency, occurred – at least, if the people involved had the inclination, and loopholes in the systems allowed them to get away with it.

Going back to the assessment of the decentralisation process, the review team concluded that more was to be done in overseeing and supporting the process, not least by setting standards. This was a major set of tasks that the Central Board of Health, which was just about to be established, would take over from the HRIT. In addition to further developing instruments to monitor and support districts, more work was to be done. This included further establishing local management boards. Also, in 11 newly created districts, such as Kalumba's new constituency of Chienge, staff and structures needed to be put in place before they could start receiving grants in 1997. To ensure the success of the decentralisation process, the Central Board would require the necessary policies, standards, and staff. The review team considered the design for the new Central Board, which was then in its final stages before its establishment in 1997, as a major step forward in 'the drive to separate normative and policy related functions from the executive operational tasks'. The team voiced its support for the sweeping changes this 'purchaser-provider split' would entail. It was less supportive, however, of the changes that had been made to the institutional autonomy of the Central Board. This focussed particularly on the changes Sata had insisted upon. Tellingly, the team recommended that the members of the Central Board and its director-general be appointed by the president.

With respect to human resource management, the review team found that this was one of the most complex issues for the reforms to tackle, but that it had been hitherto left behind. This was because the focus had been put on structural, financial, and legal frameworks for the reforms. One ambition of the reforms was to staff health centres

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89 *Ibid.* 15.
90 *Ibid.* 13.
91 Sukwa & Chabot, 'Summary', 12-13.
92 ML0810/01.

with public health practitioners rather than the various traditional cadres. This came from the idea that cadres trained in line with Western-modelled training programmes may not be culturally competent for working in the Zambian context. However, the report concluded that this ambitious plan had not fully taken into account the implications in terms of costs, the effort required for developing a new curriculum, and the clashes this could imply with vested professional interests and established identities.[93]

An even more far-reaching initiative was also set to be launched. With the expected establishment of a Central Board apart from the civil service, other staff would also have to be transferred from the public service to employment by health boards. The reviewers reported that while the extent of boards' autonomy to set conditions of service was yet to be determined, it was clear that boards would receive the authority to appoint, transfer, promote, discipline, and terminate the contracts of their staff. Among the staff affected, the review team found 'total ignorance and a lot of anxiety' about what this de-linkage would entail and how it would affect staff. People were worried about what this would mean if they were 'unwanted' by a board, about what would happen to pensions, salaries, and other benefits. There was also uncertainty about the possibilities to seek redress if people were unfairly treated. Moreover, the team reported perceptions of lack of openness and transparency in the appointment of staff to the Central Board. These findings by the review team about the uncertainties and anxieties are crucial for our understanding of how the reforms would fare from here on. As we will see shortly, the de-linkage process – essential on the drawing board of the health reformers to give the boards the autonomy to adjust their staffing to their local needs and also to be able to set better conditions of service for staff – would run up against the perceptions, anxieties, and short-term interests of those who would be affected. This would lay the seeds for the near-fatal blow the Zambian health reforms would later sustain, as we shall see in the next chapter.

In response to a colleague about the initial draft of this review report, a Dutch embassy representative wrote that he had seen much of his own criticism of the reform process reflected in this report. Crucially, there was insufficient data about the impact of the reforms. The ministry was piqued by this criticism from the review team. They felt it was too early in the process to expect any impact. The Dutch representative partially agreed with this response, as districts had not received direct funding until January 1994. This, however, underlined the need to pursue the development of a health management information system to measure progress. The representative also reflected on some faults of the decentralisation process district management guidelines: Job descriptions were lacking, and the divisions of roles for local committees and hospital and district boards were unclear. He also reflected on the fact that early on in the process, as districts were trained in planning and budgeting, the Dutch model from Western Province for planning and quality assurance had been badly incorporated into the national approach. Finally, he commented that the financial and administrative management systems had been poorly developed.[94] The Dutch embassy representative drew a conclusion that was quite consistent with the review report: concerns remained about the quality of care at health centre level, and perhaps there was a little too much learning-

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93 Mahler *et al.*, *Independent*, 6-7.

94 Fax RNE Lusaka to RNE Harare on health reforms review, 16 January 1997; (EKN files, ISN 4966).

by-doing.[95] Nevertheless, in 1996 the Netherlands began to contribute to the district basket, following an audit of the financial and administrative management systems.[96]

Conclusions

This chapter saw the health reforms reach their zenith. We also saw most markedly during this episode how rational-legal and patrimonial logics not only compete, but also interact and can even reinforce each other. A rational-legal process of institutional reform directly offered opportunities for patrimonial interests to exert themselves. This exertion of patrimonial power did not undermine the rational-legal process but rather reinforced it because of the opportunities and resources the process generated. This argument is most clearly reflected in Michael Sata's positioning towards the process of drafting the Health Services Act. The process of setting up a National Health Council, and later its alternative Central Board of Health, appeared as if it would undermine the power vested in the office he held; therefore, he opposed it. However, he was not the dominant player in this arena. Instead, he faced the combined power of bilateral donors and the World Bank, technocrats in the sector, and one of his rivals, Katele Kalumba. As he could not block the process, he forced concessions. These concessions strengthened the institutionalised patronage power of the Minister of Health, he being the appointing authority for various boards. Moreover, this not only offered power to his office but also to his person, as he generated political loyalty by appointing district board members nationwide. At the same time, however, the minister also lost operational control over many of the resources in the health sector, both financial and human.

Katele Kalumba also instrumentalised the health reforms to build his political stature. He used the political capital he had gained with the political project of the health reforms, reforms which attracted donor resources and represented to the public that the MMD was making good on the promises it made when it came to power. In this way, he pulled off a remarkable feat of political patronage by creating a district in his home area and thus building a strong political support base, based on the personal loyalty of his constituents. Thus, the intellectual technocrat became a 'big man' politician, albeit one who performed by attracting resources for his people. Moreover, as Kalumba was so successful in playing to divergent constituencies – local, national, and international – he was apparently able to win the struggle for political dominance in the Ministry of Health by negotiating a transfer for his rival, Sata.

The role played by donors was also essential to this neo-patrimonial narrative. It is beyond doubt that the heterogeneous group of donors were a significant force in the arena in which the health reforms were negotiated. Their advisors played key roles in designing the various components of the reforms. Their influence, backed up by their financial clout, forced politicians like Sata to concede to reforms. At the same time, as we saw in this episode, they cannot be seen as the dominant actors. We saw how Katele Kalumba, as a broker of discourse, displayed a remarkable performative capacity in convincing donors to open their purse strings. Moreover, by directly targeting donor interests using their discursive logic, this even contributed to renegotiating the conditions under which this support was given. Significantly, this did not remain merely a rhetorical exercise; rather, this demonstrates how discourse is able to influence practice,

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95 Fax RNE Lusaka to RNE Harare on health reforms review, 16 January 1997; (EKN files, ISN 4966).

96 Fax RNE Lusaka to Danish Embassy, Lusaka on conditionalities for health support, 9 February 1998; (EKN files, ISN 4966).

not only between donors and the recipient government, but also within the sector. It would thus be an abuse of empirical reality to argue that either local political (perhaps even patrimonial) interests or the interests of 'foreign powers' were dominant in shaping the institutional reality in the Zambian health sector.

This episode supports a key argument central to this dissertation on the essential role played by rational-legal institutions and logic in neo-patrimonial settings. The object of struggle and negotiation in this episode was the design of institutional arrangements and the formal division of power. Zambian political actors like Sata and Kalumba (and, as can be inferred, also others in Cabinet) followed the process of redesigning the legal framework governing the sector with interest. The renegotiation of these rules, as argued above, created opportunities for patronage, clientalism, and electoral success. This is thus not merely an issue of subverting formal rational-legal order. This order is thus significant and more than a façade. In other words, this points towards instrumentalisation of order and towards the argument that rational-legal and patrimonial interests can converge and be concurrently served.

This is not to deny, however, that in practice formal rules and rational-legal logic are not ignored or violated. Numerous credible accusations have been reported in this chapter and elsewhere against specific political actors. It is accepted that an instrumentalisation of the discourse of corruption can partly explain such allegations, that is, that political actors may use allegations of corruption to discredit a rival. At the same time, the fact that numerous suspicions appeared grave enough to prosecute but that such prosecution was not pursued because it was not politically opportune, suggests that the rule of law was frequently violated in order to protect influential politicians such as Michael Sata.

This chapter ends by reflecting interim conclusions on the health reforms. By this time, while instrumentalised, the reforms could not be considered 'partial reform' but rather 'health reforms at work'. The decentralistion of power to the district level, combined with the channelling of grants to that level, managed to significantly alter the power structure of the health sector. This thus amounted to a partial reversal of the trend of centralisation of power which is often associated with neo-patrimonialism. The review of the reforms justified some of the enthusiasm that characterised these flagship reforms. At the same time, many shortcomings were highlighted, including the instrumentalisation of the process illustrated by the concessions forced by Sata. It is also evident that Kawimbe's jesting defence of the reforms, "let us decentralise stealing", was indeed partially realised. The review concluded that local elites had been created and doubts existed about accountability. Most significantly, however, the independent review of the health reforms pointed towards two of the reforms' shortcomings which contributed to making these reforms reflective of Van de Walle's syndrome of partial reform. One was the discursive argument – which opponents would later use – that too much effort went into systems, too little into service delivery. The other concerned a point of interest and power. There was anxiety among health workers about the consequences of these health reforms for the security of their livelihoods. This threat to the collective interests of a horizontally linked group would, as we will see in the next chapter, lead to a terminal, but long-term process of derailing the health reforms.