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Professional skills development in a resource-poor setting: the case of pharmacy in Malawi

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1. Introduction:the skills discourse

With increasing commercialisation of education, knowledge is commodifiedinto a capital readily used for 'knowledge economy'. In what is therefore called the 'human capital' approach to education, education institutions are turned into factories that generate human capital for the labour market. Educational toolkits that smoothen the manufacturing process thus dominates our education system today, for instance the 'banking' style of teaching/learning (Freire, 2005). As if offloading goods from teachers to learners, knowledge is quantified into discrete training blocks. With this, there emerged the concept of 'skills' as a powerful toolkit for producing these training blocks. Learning thus can be measured by the number of training blocks delivered or the number of skills acquired. First applied in vocational education/ training (VET) for measuring technical knowhow, the definition of skills soon expanded to include interpersonal and transferable skills such as communication and teamwork; and even to personal traits such as emotional intelligence. The notion of skills has since permeated to all other levels of education: from basic education to post-compulsory and tertiary education. Such extensive uptake of the skill toolkit is conceivable in a global neoliberal environment as it provides an attractive solution to producing the human capital most ideal for employment. With this toolkit, almost all desirable employee traits, even personalities, are 'trainable'. 'Skills development' therefore becomes so important that it is almost treated as an end, rather than as a means (Baker and Brown, 2007). Oftentimes, universities are conceptualised as mere skills suppliers for the industry hence the subsequent coalition between university, industry and government, often referred to as the 'triple helix' (Leydesdorff, 1996). The neoliberal agenda of the educational industry is executed in a matter-of-factly manner so much so that even elite higher education has begun to use the language of employability and employability skills, first introduced into second chance vocational provision (Brown et al., 2011).

This discursive and policy shift towards an ever more powerful concentration of education on human capital, employability and the knowledge economy, however, has been subjected to a series of major critiques. The limitation of the knowledge economy account has been shown by authors such as Brown et al. (2011), who arguethat the claims regarding the benefits to individuals of investmentin their human capital amount to "broken promises". A large number of authors have critiqued the limitations of the broadened account of skills (e.g. (Payne, 2000), (Unwin, 2004)); of competencies (e.g. (Hager, 2004), (Hyland, 1997)) and of employability (McGrath et al., 2010). In recent years, IJED has seen a number ofpapers that question the simplistic relationships of the orthodox position. Palmer argues that the orthodoxy is flawed due to a lack of enabling environment for skills application and a severe lack of educational/training programme 'buy-in' by the beneficiaries (Palmer, 2007). He also notes that relying on education as a 'black box' for generating human capital encounters the problem of sustainability (Palmer, 2009). Cheng stresses the importance of building relationships and trust within communities and seeing VET as a broad-based contributor to decent livelihoods rather than merely a credential provider for employability (Cheng, 2010). Wallenborn notes that commitment from teachers, students and local community is needed to perceive VET as genuinely beneficial to local needs–a shift from the usual opinion about VET being short-term, top-down, donor supported programmes (Wallenborn, 2009).

In this special issue, we can see how the critique has been consolidated into the beginnings of a new scholarly paradigm for skills–with a refined research focus on re-defining and reconceptualising skills. The orthodoxy about tailoring skills to job market continues to be challenged. It is argued to be a paradox in itself because of the rapid

change in skills requirement in today's job market. We may risk training for yesterday's skills that will no longer be needed for tomorrow's work. 'Market-driven' VET policies therefore need reformulation, particularly in countries with fast changing economic profiles (Allais, 2012). At the individual level, receiving skills training cannot be reduced to merely an investment for securing a job. Powell's paper in this special issue reports on interviews with VET beneficiaries that suggest an emancipatory function of VET: one that provides 'freedom to choose'. With this freedom learners are empowered to seek out a livelihood–a concept different from that of seeking employment. It is a 'capability' that sustains; not just an 'ability' to be used for earning a living (Powell, this issue). Most broadly, across this special issue we are seeking to redefine 'development' in order to break through its economic restriction. Indeed, it is time we rethink why economic development should be prioritised if it is not to improve human wellbeing and encourage human-centred growth. To redefine development in a broader context, we could borrow lenses from other disciplinary areas, such as those of the philosophical and religious disciplines, which already have well established debates regarding such approaches (McGrath, this issue).

Thus, there appears to be a strong account emerging from IJED and a broader critical literature on education and development that questions the dominant utilitarian approach to VET; and presents an alternative, critical view of the functions and roles of VET. However, there is a very different storyline from that which remains dominant in writing about the professional education of health workers in developing countries. There seems to be less doubt, and indeed more enthusiasm, in embracing and developing new skills toolkit. In a developing context, where resources are scarce, the state is invariably put under enormous financial pressure to train for 'just enough' skills for local use–as 'over' production of skills leads to brain drain (Carrington and Detragiache, 1998); whilst 'under' supply of skills is seen to result in a 'second class health system' (Packer et al., 2009). As a result the skills toolkit becomes essential in governments' ambition to train the 'right' skills or health worker cadres in the most cost effective ways. The mantra is to train the 'right' cadres of health workers with the 'right' skills in order to deliver the 'right' services to the 'right' population at the 'right' time and the 'right' place (Birch, 2002). In the research arena, there has thus been launched a search for the 'holy grail' of the 'right' model for health planning–where we see the mushrooming of a myriad of strategic plans/tools for improving accuracy in predicting 'human resources for health' (HRH) needs (Hirschhorn et al., 2006; Van Damme et al., 2007; Nyoni et al., 2006); identifying skills/competencies gaps to deliver health services (Waako et al., 2009); and exploring the feasibility of numerous incentives to encourage in-country retention (Wuliji et al., 2009; Mathauer and Imhoff, 2006; Witter et al., 2011). The dominance of the human capital approach is therefore apparent through conceptualisation of HRH as a capital for health–as an asset to be built, improved and safeguarded. The 'best' asset should be one that is the most closely matched with the local health needs.

This axiomatic supply-and-demand relationship creates a rather scientific discourse within global health policy making, where most attention is put on matching skill supply to health needs. Whilst other papers in this issue (especially McGrath) talk critically of a VET toolkit and locate it within a wider context of aid dependence and 'global' governance, such critiques seem not to have penetrated the health arena. This may simply be due to the far older tradition of critiquing skills policies, which are far older than HRH. Policy and research interest shift towards HRH was triggered by the threatening of global security because of the spread of communicable diseases especially HIV/AIDS (Zacher and Keefe, 2008). The Global Health Worker Alliance (GHWA) was established only in the 2006, followed by the Kampala Declaration in 2008, which recognised a critical health worker shortage as a major barrier to achieving health related Millennium Development Goals (MDGs) (Møgedal and Sheikh, 2009; GHWA, 2008). HRH literature that has sprung up since then has therefore been immersed in the MDG discourse, which emphasises quantitative targets and scientific solutions. What this paper will offer, therefore, is not a comparative study between health professional education and vocational education. Rather, it seeks to engage both HRH and VET audiences regarding the transferability of the critique of the

human capital approach to education across different educational settings. Is the HRH discourse indeed a more 'scientific' one that is immune to critiques raised in the VET discourse? Can a human capital approach be applied unproblematically in health professional education? By studying a HRH strategy (called 'task shifting', see section 3) applied in a resource-poor setting, this paper provides a self reflective account of how the limitations of the human capital approach was encountered.[1] In fact, the initial aim of my study was to determine how many pharmacy students are needed according to local health needs; and what are the most cost effective ways to train them. As a health professional being trained and currently working in the HRH tradition, I was by no means questioning the scientific approach to building HRH. It was not until upon reflection of research data during fieldwork that I started to challenge the assumed linear relationship between skills set owned by HRH and their performance. To explain the barriers that deny this linear relationship, I adopted lenses beyond the HRH discourse including literature about post-coloniality and aid-dependence. This paper therefore illustrates my cross-disciplinary research 'journey' that ultimately questions the dominant paradigm about the utilitarian approach in management of HRH.

2. Research aim and methodology

Although the issues are of far wider salience, this paper is grounded in my own research contexts: a professional focus on pharmacy; and a geographic focus on Malawi. It emerges from my ongoing doctoral research initiated by the International Pharmaceutical Federation (or FIP) Global Pharmacy Education Taskforce. The Taskforce was born out of the HRH tradition; in fact it is an international coalition between leaders and educators in pharmacy established in response to GHWA's call for boosting HRH in resource-poor settings. Deeply embedded in the discourses and practices of HRH research, this research started off by asking what functions pharmacists should perform to fulfil local health needs. In accordance to the principles of 'needs-based education' (Anderson et al., 2009), this research seeks to match skills with needs. To achieve this, skill mix methods such as 'task shifting' are examined (see section 3). Malawi therefore appeared to provide an ideal case study for this issue because it has traditionally been dependent on task shifting in the pharmacy sector.

This study however has evolved into one that has stepped outside the HRH paradigm. This is because the research data has showed a lack of applicability of the skills-needs formula in reality. Instead of providing a definite answer to skill mix, this research has turned out to ask what the right question is to start with. The expansion of thinking outside of one's paradigm is made possible by two measures: first, my exposure to critical literatures on VET, aid and Africa through my supervisory team, which encouraged me to seek to take a far more ethnographic approach to my data collection and analysis than is typical in the HRH tradition. Secondly, ethnography was used to allow me, an ethnic Chinese Malaysian who had never lived in Africa, to better grasp meanings through enhanced cultural sensitivity. I worked on overcoming my disciplinary and cultural deficiencies by repeatedly challenging my old assumptions and reformulating my research questions based on new understandings. Ethnographic fieldnotes and interview data from pharmacists, pharmacy technicians and policymakers have been interpreted and reinterpreted both through my own process of critical reflection on rereading my profession, research and broader self through engagement in a radically new context, and my encounter with literatures of aid dependence and post-coloniality.

In order to explore this within the confines of a journal article, a case study approach is employed where only one HRH strategy (i.e. 'task shifting') will be discussed. I will explain why and how this strategy has become a self-evident proposition in light of the global development in pharmacy/health discourse (in section 3); before presenting evidence, in

[1] In what follows, the first person singular is used to reflect the grounding of this paper in the first author's doctoral work and process, although these were profoundly mediated by the involvement of the second and third authors as doctoral supervisors.

section 4, that pinpoints why task shifting does not work under certain circumstances, hence challenging the generalisability of this current proposition. Section 5 further explains how a false assumption (about professional superiority) inhibits the effective implementation of task shifting in Malawi. To trace the origin of this false assumption, a second-layer analysis will then be presented in section 6 which will touch on postcoloniality and global health governance. I will eventually argue about, as well as against, the 'hidden' assumption underpinning HRH paradigm that involves exploitation of 'skills' in a decontextualised manner. Interweaving with the storyline there also is embedded an attempt at reconceptualising professional skills/ competency development in a postcolonial and aid-dependent context. The right question to ask, I would argue, is not about what skills are important; but about who owns the process of defining policies.

3. The skills discourse in pharmacy education

Industrialisation has displaced pharmacists from their traditional role of drug compounding. Instead of making drugs, pharmacists dispense medications which are produced by the pharmaceutical industry. However the task of dispensing is perceived to be a nonprofessional one because medications are handed out with simple administration instructions (e.g. take 2 tablets 3 times a day) in most cases, particularly in understaffed pharmacies loaded with long queues of patients waiting for their medications. Although a technician cadre is trained to take over manual (and menial) tasks such as dispensing, the major function expected from pharmacists in health remains unchanged–i.e. to hand out medications to patients as correctly and as quickly as possible. This has pressured pharmacists to prioritise filling up prescriptions at the expense of developing their professionalism. Pharmacy's professional status is therefore being questioned and in some cases it has been labelled as a 'quasi' or 'incomplete' profession (Dingwall and Wilson, 1995). Responding to such threats of de-professionalisation, pharmacists have proposed their new professional identity as providers of 'pharmaceutical care' and 'clinical pharmacy' (Higby, 1997; Kremers and Sonnedecker, 1976). This new professional role requires an educational reform that incorporates care-based components on top of its science-based foundation (which was suited for the older compounding role). It is an ongoing process still in many pharmacy schools around the world. In practice, role transformation has been a struggle in many countries, including the industrialised ones, hence resulting in pharmacists reverting to a dispensing role in many cases. Many pharmacists therefore felt their skills were under-utilised (Humphrys and O'Brien, 1986).

Facing huge barriers to role transformation, many pharmacists are trapped in tasks more or less similar with the technicians. This results in blurring of the professional-technician boundary, hence threatening pharmacists' professional status. To defend their professional status, pharmacists have to explicitly demonstrate their superiority, in terms of professional knowledge and ethics, to that of the technician cadre. One of the strategies, therefore, is to segregate professional attributes from that of the nonprofessional ones–where the use of 'competencies' and 'skills' come in convenient. Indeed, the use of a competency-based approach to specify professional roles spans different professional disciplines, including medicine, nursing, dentistry, psychology, etc (Cowling et al., 1999; Fey and Miltner, 2000; Hand, 2006; France et al., 2008). In one of the most recent medical school studies, which is the largest in scale to date, competency-driven reform was deemed necessary to cope with health education/system challenges in the new century (Frenk et al., 2010). However, the use of competency is contextualised in different ways in different settings. In industrialised setting, where professionalism needs to be vigorously defended, competency provides a toolkit to justify the superiority of professional knowledge. The pharmacy profession strives to acquire higher competencies, often through continuing/postgraduate education, in order to maintain professional status (Freidson, 2001; Parsons, 1939). On the contrary, competency is turned into a toolkit to curtail demand for professional skills in the HRH discourse, where professional HRH is scarce. By rationally matching skills to local needs, most professional pharmaceutical skills are deemed excessive for basic needs such as drug distribution. It is therefore justifiable, using a competency-based toolkit, to hand over certain pharmaceutical services from

pharmacists to the technician cadre in settings experiencing a critical shortage of the professional cadre. In FIP's global recommendations for good pharmacy practice in developing countries, people's access to pharmaceutical care should be achieved in a 'step-wise' manner (see Box 1) i.e. first have technicians, then have pharmacists (FIP, 1997)– which actually threatens the expansion of the professional cadre.

Box 1. Access to pharmaceutical personnel in developing countries
STEP 1 Access to a community health care worker with appropriate pharmaceutical training
STEP 2 Access to a person trained to a higher level than a community health care worker
STEP 3 Access to a qualified pharmacy technician with appropriate training
STEP 4 Access to a qualified pharmacy technician working under the direct supervision of a pharmacist
STEP 5 Direct access to a pharmacist

Within the HRH discourse, the increasing popularity of the competency-based toolkit has given rise to several competency-based strategies, inter alia, 'task shifting'. 'Task shifting' is introduced as a cost-effective HRH strategy because a lower cadre can be employed as long as it has the skills required to fulfil requirement of certain 'tasks'. Being a new jargon in HRH discourse, the practice of task shifting itself is however nothing new to many resource-poor countries especially those in the sub-Saharan Africa. In the past decades, many of these countries have traditionally been employing the nonprofessional cadre due to shortage of the professional cadre. Many tasks of providing healthcare needs have therefore been traditionally 'shifted' to the nonprofessional cadre. Task shifting began to gain heightened attention only when HRH shortage was recognised as the bottleneck to anti-retroviral drug distributive system. By adopting the competency-based toolkit, the development of a lower cadre (that of the pharmacy technician) is well justified because there is no need for 'professional' skills in a distributive function. In fact, the lack of training (and retention) capacity for the professional cadre has made task shifting the soundest solution. There was research evidence about nonprofessional health providers being associated with a higher in-country (and rural) retention rate, cheaper training cost and lower costs for employment (Lehmann et al., 2009; Dovlo, 2004). Furthermore, studies that compared clinical skills between professional and nonprofessional clinicians demonstrated a similar success rate in surgeries carried out by clinical officers, who are technician equivalents to surgeons (Hounton et al., 2009; Chilopora et al., 2007).

Such a positive outlook has ushered in a new era in WHO policies coined as the 'renaissance of primary health care', in which adopting task shifting is translated into a new form of public health initiative. High hopes are placed in this strategy to provide a solution to increase access to healthcare, particularly ARV treatment and prevention. To guide country implementation of task shifting, the WHO-Commissioned Study on Task Shifting recommends 'countries should adopt a systematic approach to harmonized, standardized and competency based training that is needs-driven and accredited so that all health workers are equipped with the appropriate competencies to undertake the tasks they are to perform' (WHO, 2008). In a practical sense, the competency-based toolkit is used to benchmark every stage of HRH management: planning, training and employment. It is the discursive language used throughout the health professional discourse and has surely becoming the prescription for successful HRH management–one that resonates strongly with the search for the 'right' skills, in the 'VET toolkit', in the vocational discourse. Unlike the latter, there has been very little criticism of this new toolkit in the health professional arena (cf. Lugg and McGrath, this issue). The creation of competency frameworks, one after another, seems to be unquestionable even in academic enquiries. Against this backdrop, the following section will question the un-questionable by using evidence from fieldwork in Malawi.

4. Case study: task shifting in pharmacy in Malawi

4.1. Introduction: successful middle-cadre HRH scale-up through a six-year emergency plan

Task shifting is not a concept alien to Malawi's health setting. The public health service has been delivered by nonprofessional cadres such as the medical assistants, clinical officers, pharmacy technicians and enrolled nurses (Muula, 2009). It was not uncommon to find nonprofessional cadres staffing key managerial positions. This is due to the critically low number of health professionals in the country, particularly in the public sector. There was less than 1 physician and 6 nurses/midwives (in 2004) serving 100,000 population (World Health Organisation, 2010).[2] A basic headcount carried out by the Ministry of Health and Population (or MoHP) in 2007 showed vacancy rates of 28% and 91% for pharmacy staff in MoHP and the Christian Health Association of Malawi (CHAM) respectively.[3] At the time of fieldwork, there were only 7 pharmacists working in public service; and only 2 (out of 7) serving health facilities. It was therefore not possible to place even just one pharmacist per hospital. In 2010, there were 4 Central Hospitals, 24 District Hospitals and 328 Health Centres in the country.[4] For decades, pharmacies in District Hospitals have been managed by pharmacy technicians. Pharmacists, if there were any available, were placed in Central Hospitals and other key managerial positions at Central Medical Store, the Pharmacy Board and the Ministry of Health headquarters. Because of their limited number, there have been no pharmaceutical personnel available at the health centre level. At facilities with no pharmaceutical personnel, services were handled by nurses and/or medical assistants.

In 2004, the Government of Malawi announced its five-year health plan, which identified a critical shortage of HRH as one of the major barriers to health service delivery. Recognising the urgency of tackling the HRH crisis, Malawi launched a 'Six-Year Emergency Human Resource Plan' from 2004 to 2010, with support from a sector-wide programme and other development partners. Under this plan, pre-service training at the technician and community level was prioritised. Pre-service training of the professional cadre was of secondary importance–the Faculty of Pharmacy, for example, would be established only if funds were available (Government of Malawi, 2004). In fact, the fund for establishing the Pharmacy course two years later (in 2006) was not from this plan but from other donor sources.

In six years, the total number of health workers increased by 53%, from 5,453 in 2004 to 8,369 in 2009. The number of pharmacy technicians increased by 84%, from 120 in 2004 to 221 in 2009 (O'Neil et al., 2010). These impressive results made Malawi exemplary for its successful HRH scale-up amongst its resource-poor counterparts, particularly in sub-Saharan Africa. In the most recent GHWA conference in Bangkok, Malawi's Minister of Health was invited as one of the keynote speakers; and several officials from the Ministry were invited to share their success stories. At the international platform, it seems undoubtedly true that Malawi has achieved a success in its HRH development.

4.2. The other side of the story: the near-collapse of the pharmaceutical service

Despite showing a significant improvement in the total number of pharmacy technicians, ethnographic enquiry depicted a rather gloomy picture where pharmacies in public health facilities were constantly running out of drug stock, even essential items like dextrose, amoxicillin and aspirin. Pilfering of drugs and other medical/pharmaceutical items was

[2] In comparison with the physician density (against 100,000 population) of 8 in South Africa (2004 figure) and 23 in the United Kingdom (1997); nursing and midwifery density of 41 in South Africa (2004) and 128 in the United Kingdom (1997). There is no WHO-recommended standardised HRH density because of between-country difference in disease burden and HRH capacity.

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[4] And also 121 other types of public health facilities. Figures adopted from GoM's official website (accessed 18/05/2011) http://www.malawi.gov.mw/index.php?option=com_content&view=article&id=57&Itemid=136.

commonplace. Commenting on the severe leakage of public drugs for private resale, one of the former Pharmacy Board[5] inspectors said:

> It's not a secret you know. It's quite a lot of pilferage. Not only Medical Store but maybe at all levels of supply. When I was in Pharmacy Board, because we were doing inspection we were going around everywhere. And some of the drugs we found were government drugs. With the vendors. And also private clinics. We found government drugs with these people. I'm sure if you read the newspaper. This is true. It's not false allegations. I have been there I have seen it.

When pilfering became a 'culture', the pharmaceutical service soon degenerated into a calamitous state. Drug supplies to public health facilities were haphazard–stock availability was constantly variable and unpredictable, thereby threatening patient safety and even warning of a collapse of the healthcare system. It was not uncommon to find medication shortage hitting the news headlines in the country[6]–an 'acute' crisis that had turned 'chronic'. In fact, this 'chronic emergency' was not limited to drug items:

> To make matters worse, drugs are not the only items being stolen–medical equipment, linen, blankets, plates, etc are also being daily stolen from our health institutions, and they are being stolen by patients, guardians and staff members.
> Statement by the Honourable Aleke K. Banda, Ministry of Health and Population, presented to Parliament, 20th June 2000. Lilongwe.

Although the number of pharmacy technicians almost doubled, they had not reached the critical mass to provide pharmaceutical service to a country of 15 million population (of which most are dependent on the public health service) and nearly 500 public health facilities. Undeniably, the critically low number of pharmaceutical personnel was one of the key factors causing a near-collapse state in public pharmaceutical service. However, the problems were caused by not only understaffing, but also by a severe lack of public accountability. There was a lack of a regulatory system to govern public servants. Some were said to be restored to their old positions even after they were found guilty of having committed pilfering. Indeed, reports or complaints about the lack of public accountability in many aid-dependent states are not at all new (Bräutigam and Knack, 2004). In what is known as the 'know-do' gap that deeply frustrates many development partners, it is hoped that these recalcitrant public officers would one day wake up to do what they know they are supposed to do. There have been divided opinions about what solutions there are to eventually uproot such 'culture' that almost characterises the African public service: does the problem come from 'bad' governance, lack of skills for human resource management, or simply a cultural difference (Fiszbein et al., 2011; Mathauer and Imhoff, 2006; Blunt and Jones, 1997)? Interestingly, or rather paradoxically, these debates seem not to find their way into the HRH discourse. 'Public accountability' seems an issue for political or management science, which is not really relevant to the field of enquiry in HRH. The HRH paradigm is therefore a 'technical' one that involves 'fixing' health-related problems–just like health professionals 'treating' diseases. My study has attempted to look at HRH issues from health/technical and non-health/technical perspectives; and sought to relate both sides to each other. The following sections will explain why one of the HRH 'treatment tools' (i.e. task shifting) has not achieved the expected results in Malawi, and how it is associated with other non health issues such as the country's socio-political culture.

4.3. Why doesn't task shifting work?

[5]The Pharmacy Board is the regulatory body whose responsibilities include policing illegal drug markets.

[6]For example, one of the most recent headlines ''Donors tell Malawi 'fight corruption' to solve drug shortage'', dated 29th September, available online from http://www.nyasatimes.com/malawi/2011/09/29/donors-tell-malawi- %E2%80%98fight-corruption%E2%80%99-to-solve-drug-shortage/ (accessed 29/09/ 2011)

4.3.1. Why task shifting is supposed to work

On the 'skills' level, there was little difference in job functions between the professional and technician cadres. Because of the instability in drug distributive system, the primary role for any pharmaceutical personnel (whether a pharmacist or a pharmacy technician) is distributive. There was practically no space for utilising other non-distributive and more clinically oriented skills. To give a sense of how overwhelmingly demanding the distributive role was, it is worth quoting a statement from one of the chief pharmacists at length:

> If you see the staff who are working today you'll find that they're grossly overworked. As an estimate of the amount of patients we see, we see on average between 1500 and 1800 outpatients a day. On top of that, we have 1250 beds inside the hospital. So, on outpatient department, at 1500 patients, our windows are open for 8 hours per day. And there're three windows. So 1500 divided by 3, it's about 500 patients per window. On average. So we have to see one person standing at the window [who] have to see 500 patients in one day. Not 500 drugs issued, 500 patients with polypharmacy [i.e. use of multiple drugs in one prescription]. . . It gives us with each patient what. 50 seconds? With no breaks. 50 seconds. From start to finish. From 7.30 in the morning to 5.30 at night. That's what we have to work under. For outpatients alone. Inpatients we have 1250 beds for which we need to supply all the syringes, cotton, gauze, medications, all of the injectable medications that... like chloride, dextrose, that's what we have to deal with, on a daily basis. Plus we have our discharges to do. We have a clinic we can at least.. I have my job as the HOD, which takes me away from the department from time to time. Which means there are six people, to serve.

From here we can see how distributive function takes pharmacists away from performing other pharmaceutical roles. Therefore it was widely perceived that the current role a pharmacist played was not much different from that performed by a technician. One lecturer from the training institution for pharmacy technicians described pharmacists' role as similar to the technicians' one ''plus management skills''. The professional-technician separation was thought to be an artificial one–one that was just an ''ambition'' rather than a need:

> It's just a national ambition to have pharmacists. But I don't think it makes any difference. If anything, what is needed, is just to train the technicians in management skills. That's all. But they will do the same job. But urm. . . of course any country would want to have all the necessary cadres.

Interviews with different categories of stakeholders in pharmacy (including doctors, nurses, policymakers, etc) showed their expectation that pharmacists would become no more than managers in drug supply chain in the foreseeable future. Even the mission statement in the first newly established pharmacy programme in the country wants its graduates to perform no more than distributive roles[7]:

> This programme is aimed at equipping the Malawi health sector with pharmacists who have necessary knowledge, skills, attitudes and values in order to help health institutions with everyday procurement and storage procedures of drugs, medicines and other health facilities. This, in turn, will help institutions avoid wastage and reduce costs of medicines on both short and long term bases.

Judging from such 'low' level of skills (or competencies) required at work, as compared to much higher level of skills acquired in Pharmacy School, one would definitely wonder why should a pharmacist be needed (currently) in Malawi–whilst such tasks can be easily

[7]Distributive functions in pharmacy sector include drug (as well as non drug in some cases) procurement, storage, supply to health facilities (e.g. wards, outpatient clinics) and direct dispensing to patients.

shifted to a technician. If a competency-based toolkit was to be used, according to WHO's recommendation (as discussed above), there is no doubt that pharmacy technicians are adequately competent to perform such tasks. Indeed, they have been playing the managerial roles for decades–so what are the barriers to implementing task shifting in the Pharmacy sector at present?

Barrier I: incompatibility with current pro-democracy political culture.
Malawi gained political independence from Britain in 1964. In the following thirty years, Malawi was under the despotic rule of Dr. Hastings Kamuzu Banda. His dictatorial grip on the country was evidenced by expulsion, detention and even mysterious disappearance of political competitors (Lwanda, 1993). Under the Banda government's tight surveillance, every Malawian was fearful of falling victim to false accusations; therefore people were carefully observing their actions in public. It was described as a politically oppressive period, in which the public observed self vigilance out of fear. Ironically, this was perceived as an effective disciplinary power imposed on public service in Malawi. A veteran pharmacist described Banda's autocratic rule with a 'good old time' nostalgia: a period when 'nobody steals' and people were 'accountable for their actions'. The Banda government was ended with a referendum voting for multiparty election in 1994, whereby his political party (Malawi Congress Party) was defeated by a pro-democracy political opponent, the United Democratic Front (UDF). Malawi's second President, Mr BakiliMuluzi, revered the ideologies of 'freedom' and 'democracy'. However uncontrolled personal freedom soon turned into selfish individualism–a period which was described as the 'Malawi's lost decade' (Muula and Chanika, 2005). In public service, it formed a culture of malaise, apathy and even fraud and whitecollar crime amongst civil servants. In public sector pharmacy, it resulted in an almost dysfunctional state of pharmaceutical service delivery (see previous section). What happened during such political culture was a shift from 'personal responsibility', which was emphasised during Banda's regime, to 'hierarchical responsibility' (Thompson, 1980). It was commonly perceived that people occupying the higher level of the hierarchy should assume all responsibilities; leaving subordinates almost responsibility-free. In the pharmacy service, pharmacy technicians perceived they should shoulder fewer responsibilities because of their lower position in the hierarchy, even when there was no pharmacist available. When one talked about the pharmacy service in Malawi, a common perception found was the representation of the entire sector by only 'three big men': the Head of Pharmaceutical Service at Ministry of Health headquarters, the Registrar at the Pharmacy, Medicine and Poisons Board, and the Controller at the Central Medical Store. Pharmacy technicians, who had been managers in pharmacy service since independence, became unwilling to assume hierarchical responsibility:

> There's no ownership on the side of pharmacy technicians. They would say 'OK any hospital pharmacy should be manned by a pharmacist. I'm just a pharmacy technician, there's no pharmacist, whether I mess up anything, I don't mind because the one who is responsible is the pharmacist, who is at the Ministry of Health.
> a former public service pharmacy technician

Barrier II: inflexible public sector human resource policies.
The legacies of British colonisation, as well as Banda's regime, left Malawi with a bureaucratic system similar to the British one. Amongst these pro-British public policies, there was one that insisted upon a distinct division between professionals and technicians (Lwanda, 2008). In the civil service, the salary scale was structured to draw a sizeable income differential between pharmacists and pharmacy technicians. This created an excuse for technicians not to assume responsibilities that should be borne by the pharmacists, who were much better paid. Technicians expressed frustration about the rigid occupational hierarchy whereby 'a technician will always remain as a technician', unless he/she was upgraded through further education/training. Since chances for further education were limited in Malawi, many would not stand a chance to be upgraded to the professional level.

Meanwhile, it was inconceivable that pharmacy technicians would be granted a pay rise because of the rigid salary structure in civil service:

> It won't happen. Because government is so rigid. They can't (laugh). Because in civil service if you're technical officer, whether you're in the Ministry of Health, you're in the Ministry of Agriculture, you're in Ministry of what, all your salaries are the same. So they can't just raise salary for one grade, for one type of people. If you're employed as technician, no matter what job you do as a technician, your salary will be the same. (. . .) If you want, you have to do it for the whole civil service. Because raising salary for pharmacy technicians means all those people at the same level (i.e. technicians across all government sectors) have to get the same salary.
> a retired government servant

Low pay, as well as lack of opportunities for career development, has severely de-motivated pharmacy technicians in the public service. Inevitably, this resulted in low job performance, and even crime. The 'culture' of pilfering public resources was normalised as a way of 'compensation' from government to its mistreated servants.

Barrier III: perceived importance of professional power.
Medical services in Malawi have conventionally been run by the clinical officers (i.e. a substitute cadre for surgeons) and medical assistants (i.e. a substitute cadre for general practitioners) for many years, even before independence (Muula, 2009). However, this has been changing since the establishment of the first medical school in Malawi in 1991 (Zijlstra and Broadhead, 2007). As the years go by, there have been an increasing number of medical doctors serving key managerial positions in the public service, for example in the District Health Officer positions. Clinical officers and medical assistants, apart from those incumbent ones, have been slowly phased out in management positions. However, such a trend of 'professionalisation' has not happened in the pharmacy sector because of the extremely small number of pharmacists in the country. As a result, pharmacy technicians found themselves with a much lesser political voice compared with their medical counterparts. They felt they were being sidelined (by the medical doctors) in key managerial decision makings about resource allocation for the pharmacy service. Therefore a professional cadre in pharmacy, one that has equivalent professional power with the medical profession, had to be created in order to fight for professional needs:

> I'm not belittling the effort the pharmacy technicians are making, but when I look at the whole issue of urm. commanding respect and people should really be listening to you and abcd, they're looked at as inferior... if you come to the District Hospitals what is called the DHMT, District Health Management Team... they don't actually include them (the pharmacy technicians) in the DHMT... If I have a pharmacist at the district, they would definitely be in there.
> a senior Ministry of Health official

Professional power was also considered to be a solution to rampant drug pilferage. It was perceived to be effective for governing pharmacy technicians, who were blamed as the main culprits for drug pilferage. Pharmacists, as the ones occupying higher hierarchical positions, should hold power to discipline their subordinates. During fieldwork, an uneasy atmosphere amongst the pharmacy interns was observed–because they were expected to impose disciplinary actions to even the senior ranked pharmacy technicians soon after finishing their internship and gaining the pharmacist positions. Without a viable regulatory framework in place in the civil service, pharmacists' supervisory power was hoped to become a way to deter the 'crime-prone' technicians.

Barrier IV: perceived limitation of professional ethics to only pharmacists.

Ethical codes of conduct were perceived to apply by default, and only, to the professional cadre. The technician cadre, therefore, could bypass ethics because they were not 'professional'. This was generally perceived to result in an excuse for drug pilfering. Pharmacists, on the other hand, should self-police their actions because they are bound by professional ethics:

> Because you know pharmacists have got ethics. They observe the code of conduct, unlike the pharmacy technicians. That's why there's a lot of pilferage... Because they're like on the lower side so they don't care. But when you're a pharmacist, afraid of being removed from the register, that's one thing.
> a drug inspector

> I think it [i.e. the problem of drug pilferage] will improve [by having more pharmacists]. Because people [i.e. pharmacists] are honest. I think pharmacy is a course which also teaches people ethics... Most people say they trust their pharmacists. Yea. Yea. So one would believe that if somebody is trained as pharmacist (he or she) should have ethics. Not to indulge in illegal things.
> a retired public service pharmacist

Some informants thought the widely-perceived lack of ethics amongst pharmacy technicians was due to failure to internalise this trait into the students during technician training–that the school did not 'teach' them ethics. However, pharmacy technicians have been trained in the same college, by using similar curricula, throughout Malawian independence. The present day scornful statement about pharmacy technicians–"do you go to school to learn how to steal?" was not a common perception in the past. It therefore was not convincing that pilfering culture was caused by 'bad' training. Also, it is uncertain at the moment whether or not future pharmacists would be more ethical than pharmacy technicians because public service pharmacists were subjected to similar temptations (e.g. much lower pay than private sector pharmacists) and opportunities to pilfer.

Instead of a training issue, most were more confident to say problems such as drug pilferage in Malawi were caused mainly by lack of governance and public accountability. Lacking the more conventional, patriarchal way to regulate public servants' behaviour, the public service turned to ethics to enforce public accountability. Conceptualised as the third wing to public accountability, after market forces and political regulation (Emanuel and Emanuel, 1996), professional ethics is relied on as the last resort to salvage 'bad behaviour'.

5. Unpacking perceptual barriers to effective task shifting: how a new perception changes an old practice

Research data presented (in section 4) shows how perceptual barriers influence the practice of task shifting. Having worked in replacement of the pharmacists for decades, why would the pharmacy technicians be suspected of being incapable or unwilling of task shifting? To explain the perceived inferiority of the nonprofessional cadre, a deeper analysis was undertaken. The existing literature offers varied explanations and solutions to this problem: HRH research literature would suggest it was most possibly caused by a lack of supervision by the professional cadre (Dovlo, 2004); whilst public administration literature would suggest simply a lack of regulatory system in place for ensuring accountability (Bovens, 2005). Undeniably both are crucial issues facing all (i.e. not only pharmacy) public service sectors in Malawi. However they have not fully explained the perceptual barriers, which emerged after task shifting had been practised for many years in Malawi. Such a change in perception, which is a strong theme of the data, is a result of change in context–which is not factored into the competency-based formula of task shifting. What appears to have happened is that adding a new layer to the top of the occupational hierarchy has resulted in responsibilities being shifted upward rather than downward. New perceptions emerged regarding 'who should be responsible'–a perception

change that was not always based on competencies. Parallel to the new definitions given to 'democracy' and 'professionals', pharmacy technicians were freed from personal responsibilities. Therefore in what follows, task shifting is able to shift the professional cadre's 'tasks', but not 'responsibility', to the nonprofessional cadre. It seeks a change in job descriptions whilst leaving occupational hierarchy unchanged. Hence the need for supervision remains. As a result, pharmacy technicians took over the tasks, for which they had skills to perform, but not the sense of responsibility.

What was unusual about this perception change was the overly positive image given to the professional cadre: as being high social status, powerful and ethical. Such unquestionable faith placed in professionals is certainly perplexing, particularly when existing evidence suggests a lack of professional traits. There were a couple of self confessed statements that revealed pharmacists' lack of motivation for change. One of them said:

> This problem we realised in the early 1990s was that we would not sustain the operation of Central Medical Store. 20 years down the line nothing changed.
> a retired senior pharmacist

However, such a lack of professional commitment was usually blamed on the public service 'culture' that was resistant to change. Therefore ''it's not really me'' who did not want to change, but ''it's the system, the way things are''. It was also not uncommon to find 'blame games' between professional groups. In the case of drug pilferage, the blame game was played between the Pharmacy Board (blamed to be failing their mandate as drug inspector) and the Medical Council (blamed for allowing government prescribers to open private clinics therefore encouraging pilfering of public drugs for private resale).

If these contradictory evidences were not sufficient to question the unquestionable faith in professionals, perhaps one would start to become more sceptical when learning how government officials (of whom many were well educated professionals) could easily travel to South Africa for medical treatment, thereby bypassing the Malawi public health service. In fact, such display of 'blind faith' in professionals was actually not restricted to Malawi. In Ghana, for example, it was perceived as an 'uncritical acceptance of the necessity of this manpower' (Bennell, 1982) albeit lack of concrete evidence of needs for a professional cadre. In Zambia, pharmacists are aiming to attain doctoral degrees because that was perceived to be the only pathway to gain equivalent status as medical doctors (Wuliji, 2010). In other words, the perceived superiority attached to the notion of 'professionals' has inhibited the otherwise effective implementation of task shifting. The next question to ponder, as explored in the following section, is where does this new perception (about the superiority owned by the professionals) come from.

6. Tracing the origin of the new perception: postcoloniality and global health governance

When examining these new meanings given to professionalism, it can be observed that these meanings are indeed not 'new' from the perspective of the sociological literature about professionalism. Indeed, the Malawian definition of professionalism mirrors perfectly the Anglo-American model practised mainly in industrialised settings: in which professional means superior in knowledge, ethical conduct and social status. The difference lies in the process of earning professional status. In the developed country settings this has been developed through a long process of acting professionally and demonstrating that status is earned: by 'professionalisation'. However, this process has not taken place in the Malawian setting. Indeed, why should the professionals be trusted even before they are proven trustworthy? To understand how professionalism was earned without professionalisation, new research questions were formulated during fieldwork to enquire about this important gap. Themes that emerged from research data include postcoloniality and global health governance.

Theme I: Postcoloniality

> The British give us pharmacists. We borrow from what the UK does. Yea. That's what we do.
> a senior Ministry of Health official

British influence could be traced back to colonial times. Western medical provision was brought into Nyasaland by mainly the missionaries. Although it shaped the early form of the government health service, it was arguably meant to service mainly the European missionaries and settlers (Baker, 1976). Healthcare of the indigenous population was left more or less to the hands of traditional healers. A duality in healthcare provision was deliberately pursued: 'mankhwalaachizungu' (European medicine) for the white settlers; and 'mankhwalaachikuda' (African medicine) for the indigenous (Lwanda, 2005). During periods immediately post-independence, British influence had not ceased but was perpetuated by the Banda governance, which had imposed an Anglophone metropolitan governance structure for thirty years (Lwanda, 2008). The process of indigenisation (or 'Malawianisation') of public service did not erode British influence, but merely a continual production of pro-British bureaucratic elites. This is because most public administrators received their education from abroad (and many from the United Kingdom) and continued to strengthen Western ideologies, which were already deeply implanted in the public administrative structure (Nkomo, 1986). Indeed, the impact left by colonialism is widely available in postcolonial literature (Lange, 2004; Joireman, 2001; Gandhi, 1998)

In this case, the dominated mind had 'inherited' the meanings attached to professionals without resistance. Instead of 'earning' a professional status (Turner, 1985; Klegon, 1978), it is 'borrowed' or 'copied' in a post-colonial setting like Malawi. Professional power, ethics and superiority (as discussed in barriers I-IV) come de facto with the professional titles–by emulating the British occupational hierarchy.

Theme II: Global health governance

Globalisation has flattened the world by the spread (and acceptance) of dominant ideologies. In health, this process is accelerated by emergence of global health governance following the HIV/AIDS outbreak–a phenomenon that is 'united by contagion' (Zacher and Keefe, 2008). The desire to have pharmacists of ''international standard'', as expressed by local stakeholders, is a typical challenge faced by the latecomers–one has to 'catch up' with the pioneers whilst redefining one's destiny. However in most cases, catching-up is prioritised over redefinition because of international pressure, particularly when there are international development targets to meet (King and Rose, 2005).

The world of aid realises very well the flaws of one-way, North-South knowledge/policy transfer. To counter imposition of northern ideologies, aid policies and guidelines stress very much a demand-driven, beneficiary-centred approach. Several conferences were held and declarations signed to vow respecting country ownership, for instance the 2005 Paris Declaration on Aid Effectiveness, the Accra Agenda for Action of 2008, the Bogota Statement towards Effective and Inclusive Development Partnerships and, most recently, the Busan Outcome Declaration of 2011. The commitment to 'partnership' however is questionable should donors remain sceptical toward country accountability. The tendency to micromanage recipient countries would not be removed by signing up to declarations.[8] This new aid modality therefore risks becoming yet another 'toolkit' that may, under certain circumstances, clash with local interests (Colclough et al., 2010).

Not dissimilar with concerns that are raised in the educational discourse, 'respecting country ownership' in the health discourse has also become rather instrumental when one examines the local realities. In the HRH discourse, it involves a painstaking effort to gather opinions from all 'stakeholders' in the country (donor agencies included)–each representing an interest or having a 'stake' in the matter discussed–sometimes through roundtable

[8]Not applicable to donor countries (e.g. China) which maintain a 'noninterference policy', i.e. abstaining from interfering with aid recipient countries' internal affairs.

discussions to achieve consensus on what is best for all in the country. In fact, 'stakeholder consultancy' was the very first concept I adopted in this project. However, it led to the issues of true representation–I found myself speaking to only the burgeoning middle class in the country, who might or might not represent interest of all. Because of the critically low human resource in public service, it was not unusual to find one person in-charge of (or dictating) decisions for an entire service area. The very official who confessed to ''borrowing from the UK'' (see Theme I), for instance, described how a country decision might be made ''alone'':

> At the moment, as it is, I can see me looking at it maybe alone and say this is the role we should do and abcd so long as I give it to the Permanent Secretary downstairs and say endorse this, this is the role of abcd, xyz.

When we revisit the university-industry-state model, as discussed in the first section, we find severe lack of true local ownership: the 'state' is dominated by postcoloniality and global health governance; the industry is limited to the thin layer of wealthier members of the society; whereas the university was highly dependent on British-styled curricula. There was hardly any space for trials and errors because of massive demand for reporting to multiple donor groups:

> The pool (funding[9]) itself has got bigger. We've got DfID in the pool, the Norwegians in the pool, we've got the Germans in the pool. . . UNICEF in the pool. . . WHO in the pool. . . UNFPA in the pool. The trouble is all of them put all the resources in the pool. The UN family tend to put as much as it can but it has got other donors who want to see accountability to their own money so you find there are a number of projects, currently a hundred and something projects, unfortunately, in the Ministry of Health. So they have gone up rather than down.
> a Ministry of Health official

Government officials, who work amidst such tension, have little room for innovation and even less for developing indigenous ideologies. Most often than not, the only stakeholder groups that were free to explore and express their true opinions were donor/ consultancy agencies.

7. The imposition of western ideologies on task shifting: why one size does not fit all

In section 6, we saw how external influences such as colonial legacies and aid dependence invariably impose some western ideas on local perceptions. Because of perceived superiority of the western ideas, the introduction of an alternative model becomes difficult. Task shifting is resisted because of its mismatch with the borrowed idea about professionalism. The right question to start with, therefore, is not about finding the answers to a western formulated question; but to find out the hidden western ideologies in a seemingly scientific HRH research question. In this section, we will pull out these hidden ideologies by contextualising task shifting in a post-colonial and aid-dependent setting.

The working principles underpinning task shifting assume a gapless relationship between knowing and doing. In fact, many other HRH strategic plans assume a linear progress in HRH planning, training and employment; with attrition resulting from HRH physically leaving the positions (e.g. because of emigration, retirement or death). However this

[9] In 'pooled funding', funds from different donor groups are pulled together to enable recipient country drawing funds from 'a big basket' instead of from individual donors. This is one of the SWAp (or Sector Wide Approach) strategies to improve aid efficiency by reducing fragmentation and bureaucracies. However, it is questionable to what extent SWAp has been successful. See Samoff, 2004. From funding projects to supporting sectors? Observation on the aid relationship in Burkina Faso. International Journal of Educational Development, 24, 397-427.

linearity is arguably derived from an Anglo-American workforce model, which is built on a steady-state health system. It is not transferrable to a less mature system because of the higher possibility of under- (or non-) utilisation of skills/competencies. In almost anarchic work environment, under-utilisation of skills happens in the form of workers' absenteeism, intentional poor work productivity and petty thefts of public resources. Workforce planning in such a setting therefore cannot equate skills acquisition with skills application. Less than desired job performance may not be due to skills deficiency but more likely from lack of work commitment. What needs to be addressed, therefore, may not be the lack of skills but ways to curb under-utilisation of skills. In this case, where professionalism was used as an excuse to evade responsibility, the false definition of professionalism needs to be recognised and removed.

Another Anglo-American concept adopted by task shifting is the 'triple helix. Using this concept, universities are supposed to be responsive to the market demand in order to train up the right skills. The state is expected to play the central role in coordinating the relationship between university and market. However this model does not work well in Malawi because there was no true relationship between university, market and the state. Instead, reporting to external (donor) stakeholders is prioritised over communication with internal stakeholders. The 'supply-anddemand' relationship between education and market is broken; and the mediator role of the state is suppressed. In fact, the most important stakeholder of this triple helix, i.e. service users or the general public, is completely left out of the scene. As a result, the assumption about skills-needs match is faulted because real needs are often silenced by demands by more powerful voices. In this case, perhaps what needs to be investigated is not about what the local needs are, but how to enable the supply-and-demand relationship between skills and needs.

8. Conclusion

By revisiting critiques and new concepts raised in VET, it is indeed puzzling why the human capital paradigm remains unwavering in health professional education. Whilst 'employability' is contested as the sole buzzword in VET, 'performance' and 'competence' are gaining popularity in professional education. The application of many different lenses to VET, for instance AmartyaSen's idea of justice or faith-based interpretations of human development, moulds the VET debates into an increasingly human-oriented one. As the 'VET toolkit' is increasingly being 'humanised' by these debates, one wonders whether the 'health professional toolkit' should also be subjected to similar enquiries. Is the health profession more 'scientific' and hence less susceptible to the critique posed to VET? This paper has attempted answering this question and suggested the answer to be a 'no'. Research evidence presented in this paper demonstrates how people's perception could (unintentionally) hamper the effective use of an otherwise scientifically credible toolkit (e.g. a competency-based approach). Not unlike challenges faced by the use of VET toolkit, one has to contextualise the use of the health professional toolkit according to the local dynamics.

We discovered how colonial legacies and global health governance are amongst the external influences inhibiting the direct application of one such tool called 'task shifting'. It is however not a commonplace in HRH, which is usually scientific and practice/action-based, to engage alternative lenses when formulating health strategies. Issues such as postcoloniality and aid-dependence seem to be theoretical problems situated in disciplinary areas completely distant from the HRH ones. Despite their pervasiveness and huge impact on the everyday life of every person in resource-poor countries, such issues generally remain merely 'concerns'; but not a targetable problem to take action upon. This paper therefore would like to highlight the importance of, and also the current literature gap in, inter-disciplinary enquiries in HRH. In our quest for solution of any health issues in a postcolonial and aid dependent context, there is a need to draw in cross-disciplinary knowledge such as how postcolonialism affects strategic plan implementation. The conventional way to solve health problems in isolation from its wider context will not be sustainable in the long run.

By questioning what assumptions are in place behind the competency-based toolkit, this paper has also uncovered the (perhaps unintentional) application of a resource-rich model (an Anglo-American one) on a resource-poor setting. 'Triple helix' and 'professionalism', for example, are concepts based upon an industrialised setting where free market styled supply-and-demand principles may be viable (Neal and Morgan, 2000). They become problematic in a postcolonial and aid-dependent context, where agency is highly restricted. The lack of institutional autonomy in many sub-Saharan African (SSA) countries, for instance, restricts universities from responding directly to country needs (Teferra and Altbach, 2004; Brock-Utne, 1996; Kerr and Mapanje, 2002). Despite the known problematic relationship between SSA universities and industry, this issue has not been incorporated into the thinking for HRH training. It is therefore the intention of this paper to fill in this literature gap; and to highlight the importance of reconceptualising the relationship between education, the profession, the industry and the state in Malawi, and in other countries with similar contexts. It is still unknown to what extent we should redefine (the Anglo-American) models that are previously thought to be transferrable across different settings; and indeed it is difficult to uncover 'assumptions' that are self camouflaged.

Nevertheless, this is not to accuse the HRH paradigm of being completely oblivious to development issues. Indeed, the overarching principle applied in HRH research is 'needs-based', or in other words, finding out what the local people want (Anderson and Futter, 2009). However, this study suggests that this principle can be reduced to mere securing consensus from powerful stakeholders, who cannot be assumed to speak for ''the people'', whatever that slippery term means. It is not uncommon in a 'policy borrowing' environment that 'new', 'local' ideas are actually a reproduction of external positions from fellow policy makers (Lugg and McGrath, this issue). Using a 'stakeholder consultancy' approach, this research therefore encountered the problem of true representation, especially in cases of deep poverty and thin democracy. It is beyond the scope of this paper (or this project) to explore ways to create true representation. However, it does provide caveats to using 'stakeholder engagement' as a sole method to look for what the local needs truly are.

Sharing similar concern with the development discourse, this study suggests that HRH discourse too should be a human-centred one. However, there is still a journey to be made. In setting out, I would argue that the 'right' question to start with in a HRH skills development project, in a postcolonial and aid-dependent setting, is not what the right skills are–but how to engage people to define what is right for themselves. Perhaps, today's journey to (HRH) development is not too dissimilar with what had been set out by Kung Fu-Tzu more than two thousand years ago:

''Do not impose on others what you yourself do not desire''

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