CAPACITY BUILDING IN PHARMACY EDUCATION IN RESOURCE-POOR SETTINGS: AN ETHNOGRAPHIC CASE STUDY OF MALAWI

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Abstract

In many low-income countries, the disease burden is high but health workers are scarce. To increase the number of health workers, one of the most urgent tasks is to produce more health workers. Grounded in the disciplinary focus of pharmacy, this research looks for alternative, innovative strategies to build the capacity of an education institution in a resource-poor setting. Malawi was chosen as a case study country because of its newly established pharmacy degree programme. A broadly ethnographic approach is employed in order to enhance cultural sensitivity and to understand capacity problems from an insider perspective. The fieldwork took place in 2010 and explored a wide range of pharmaceutical activities in the country. An interpretivist epistemology has also facilitated this research to cross beyond its science-based roots in the 'human resource for health' (HRH) research paradigm into other disciplinary areas, notably education and African Studies.

The first objective of this study was to explore the roles of pharmacists in Malawi. It was agreed by all stakeholders that pharmacists should become managers of medicines, particularly at the district hospitals. Pharmacists were expected to solve the chronic problems of rampant drug pilferage and shortages in essential drugs. Although pharmacy technicians had traditionally assumed the managerial roles at district hospitals, they were deemed unfit for these roles at present day. Some were even accused of stealing drugs. This phenomenon was caused by multiple contextual factors, including a new perception about professionalism. Because of their professional titles, pharmacists were perceived to be superior to the pharmacy technicians in terms of knowledge, power and ethics. This perception was not supported by concrete evidence of pharmacists' more superior behaviour. A deeper investigation revealed this perception was most probably shaped by colonial legacies and Western views. Home grown definition of professionalism was suppressed because it was not an agenda deemed important by the community of global health governance. The primary agenda by the global health governance to scale up service delivery, but ignoring the

growth of domestic agendas for professionalism, may need reconsidering in post-Millennium Development Goal era.

The second objective of the study was to explore capacity problems in pharmacy education in Malawi. Capacity problems faced by the education institution were found to be similar to problems reported in the wider literature of African higher education, which include underfunding, understaffing, lack of university autonomy from the state, small student intake and hence high unit costs. There were also serious problems concerning leadership and accountability. Rather than simply filling up these capacity gaps, this study argues that it is more important to see how the problems are closely linked with local contexts. Several cultural contexts, for instance regionalism and traditional practice of witchcraft, were found to be strong divisive factors threatening cohesiveness in an institution. The euphoria for personal freedom, after a 30-year dictatorship, still had its impact on governance and accountability. Colonial legacies and donor policies, which were often interventionist, left little space to inspire creativity and leadership. To link contexts to capacity building, this research argues for the importance of using an interdisciplinary approach. In fact, the journey of how this study evolved from single to an interdisciplinary was recorded in this thesis.

The third objective of the study was to explore stakeholders' opinions and interests toward supporting capacity building in pharmacy education. Although the study did identify several groups of domestic stakeholders who were able to mobilise resources for the benefits of the education institution, a more serious capacity problem was the absence of initiative from the education institution to engage these stakeholders. However, institution was more eager to engage with foreign stakeholders. Closely linked to the culture of aid dependency, foreign aid was found to have the greatest influence on institutional capacity building. Hence, the question about whether aid is good or bad, as well as how to make aid work, becomes one of the emphases of this research. This study argues that aid does not need to be big, but to be genuinely helpful.

Publications

Lim Z., Anderson C. and McGrath S. 2012. Professional skills development in a resource-poor setting: the case of pharmacy in Malawi. *International Journal of Educational Development,* **32**, p. 654-64.

Lim Z. and Anderson C. 2011. Expanding teaching capacity in pharmacy education: how to engage practicing pharmacists in teaching? *International Journal of Pharmacy Practice*, **19** (Suppl. 2), p.9.

Lim Z., Anderson C. and McGrath S. 2011. Drug Pilferage: is this just about ethics? Exploring a sensitive issue using an ethnographic approach. *International Journal of Pharmacy Practice*, **19** (Suppl. 1), p.43.

Conferences and Symposia

2012

FIP Centennial Congress (Amsterdam, the Netherlands)
Podium presentation: "Task-shifting in Malawi: why context matters" (at the the FIP Symposium for Pharmacy Technicians and Pharmacy Support Workforce)
Podium presentation: "Developing pharmacy education in resource-poor setting: the problem with the 'workforce' language"

2011

11th UKFIET International Conference on Education and Development (Oxford, UK)
Podium presentation: "Specialised skills development in resource-poor settings: the case of pharmacy in Malawi"

Royal Pharmaceutical Society Conference (London, UK)
Podium presentation: "Expanding teaching capacity in pharmacy education: how to engage practicing pharmacists in teaching?"

The University of Nottingham's 'Integrated Global Society' and 'Science, Technology and Society' Research Priority Groups Launch (Nottingham, UK)
Poster presentation: "Redefining aid dependency: perspectives of stakeholders from a recipient country"

Summer Institute in Qualitative Research: Putting Theory to Work (Manchester, UK)
Podium presentation (delegate-led sessions): "Transcending disciplinary boundaries: how does qualitative research help?"

Health Services Research and Pharmacy Practice Conference (Norwich, UK)
Workshop presentation: "PhD Students Engaged in Cross-Disciplinary and/or Cross-National Research Projects". Abstract published in *International Journal of Pharmacy Practice*, **19** (Suppl. 1), p.2.
Poster Presentation: "Drug Pilferage: is this just about ethics? Exploring a sensitive issue using an ethnographic approach"

Second Global Forum on Human Resources for Health (Bangkok, Thailand)
Podium presentation (co-speaking at a side meeting): "Global Pharmacy Education Taskforce by the International Pharmaceutical Federation (FIP)"

2010

East Midlands Postgraduate Conference (Nottingham, UK)
Poster presentation: "Institutional Capacity Building in Pharmacy Education: is there an African model?"

70th Annual FIP Congress (Lisbon, Portugal)
Podium presentation (co-speaking): "How to Develop Academic Capacity to Ensure Seamless Education"
Podium presentation (co-speaking): "5th Global Pharmacy Education Taskforce Consultation"
Workshop presentation (co-speaking): "Learning to Teach Workshop"
Poster presentation: "Blended Learning in Pharmacy Education – A Global Survey"

29th AGM of the Pharmaceutical Society of Zambia (Livingstone, Zambia)

2009

The 69th International Congress of FIP (Istanbul, Turkey)
Podium presentation (co-speaking): "4th Global Pharmacy Education Taskforce Consultation"

The Regional African Forum, Country Case Study Workshop 2009, (Nairobi, Kenya)

Monash University Pharmacy Education Symposium 2009 (Prato, Italy)

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List of Abbreviations and Acronyms

CoM	College of Medicine
COMREC	College of Medicine Research and Ethics Committee
CMS	Central Medical Store
DfID	Department for International Department
DHMT	District Health Management Team
DoP	Department of Pharmacy
EFA	Education for all
EHP	Essential Health Packages
FIP	International Pharmaceutical Federation
GHWA	Global Health Workforce Alliance
GoM	Government of Malawi
HOD	Head of Department
HRH	Human resource for health
MATHUA	Malawi Traditional Healers Umbrella Association
MCHS	Malawi College of Health Sciences
MCM	Medical Council of Malawi
MDG	Millennium Development Goal
MHEN	Malawi Health Equity Network
MK	Malawian Kwacha
MLW	Malawi-Liverpool Wellcome Trust
MoE	Ministry of Education
MoH	Ministry of Health
NAC	National AIDS Commission
NGO	Non Governmental Organisation
PET	Pharmacy Education Taskforce
PHASOM	Pharmacy Society of Malawi
PMPB	Pharmacy, Medicines and Poisons Board
RMS	Regional Medical Store
RSA	Republic of South Africa
SSA	Sub Saharan Africa
TEVET	Technical, entrepreneurial and vocational education and training
T/CAM	Traditional/ complementary alternative medicine
QECH	Queen Elizabeth Central Hospital
UNIMA	University of Malawi
WHO	World Health Organisation

Glossary

Cadre

Oxford dictionary defines cadre as “a small group of people specially trained for a particular purpose or profession”. In HRH terms, cadre is often used to refer to a category of the health workforce. For instance, there are health worker cadres of doctors, pharmacists and nurses. Within the pharmacy cadre, there are the professional cadre (i.e., the pharmacists) and the nonprofessional cadre (i.e., the pharmacy technicians). Nonprofessional cadre is used interchangeably with “mid-level” cadre, “substitute” cadre and “replacement” cadre.

Department of Pharmacy (DoP)

The pharmacy degree course in Malawi is offered by one of the departments situated in the College of Medicine (CoM) as there is no stand-alone pharmacy school. Therefore, the education institution for pharmacy is called the ‘Department of Pharmacy’ (DoP) and not the School of Pharmacy. To avoid confusion with the pharmacy department in the Ministry of Health (MoH), the latter is called the ‘Pharmaceutical Service Section’.

Global North (or North)

“The terms ‘global north’ and ‘global south’ are an attempt to correct the use of other economically based terms, such as First World and Third World and developed world and developing world, as well as core and peripheral. Global north and global south are terms that provide a more open definition of global difference, one based in social relations and cultural differences and political and economic disparity. In mapping the global north and global south, it is possible to discern a broad trend line that divides the world, roughly, between a wealthier north and a poorer south. This is approximate to the famous Brandt Line, which was proposed by former German Chancellor William Brandt, to distinguish global difference. There are immediate exceptions to this line and to a global north/global south distinction, including the fact that Australia, New Zealand, and sometimes South Africa are considered part of the global north.”

Definitions taken from (Del Casino Jr, 2009)

Human Resource for Health (HRH)

It is a term used interchangeably with ‘health workers’ and ‘health workforce’.

Institutional capacity building

Since DoP is a department and not an institution, the term 'institutional' capacity building may also be confusing. However, this term is used throughout this thesis to refer to capacity building for the DoP because of the way departmental/institutional finance system works.

Internal vs. external stakeholders

Internal stakeholder is situated in the internal environment of an institution/organisation; whereas an external stakeholder situated in the external environment. However, a stakeholder can be both internal and external stakeholder, depending on the context involved. For instance, The UNIMA administration office is an internal stakeholder to the CoM when a government subvention is distributed to the university. The office becomes an external stakeholder when it comes to the decision how the subvention should be allocated to individual colleges and departments.

To the Venerable Sangharakshita,

who shows me the way.

"Purity is power."

CHAPTER 1

Introduction

Figure 1-1. Aspirin available from street vendors.

Location: Mount Mulanje, Malawi. Date taken: 12/06/2010.

"Aspirin."

This was often the answer when I asked "have you taken any medications for this problem?" regardless of the types of medical problems encountered. I was not practising as a health worker but nonetheless received many enquiries from friends and the local community during my site visit to Malawi in 2010. In one of the cases, a patient suffering from an allergic condition had taken aspirin for the past year without improvement. On top of that, he started to experience gastrointestinal discomfort[1]. When the site visit was conducted, there were seven pharmacists serving in public sector pharmacy, and only two of them served in hospitals. Malawi has a population of about 15 million people, which is about one quarter of Britain's population. In Britain, there might be over 100 pharmacists serving in one hospital. Because of the shortage of health workers, as well as poor access to health facilities, patients in Malawi often have to resort to alternative sources of medicines, such as from the street vendors who often only sell aspirin and paracetamol (see Figure 1-1).

[1] Aspirin is not indicated for allergic reactions, hence there was not improvement in the patient's condition. One of the commonest side effects of aspirin is gastric discomfort and ulcer.

This research is located in the wider efforts of scaling up health workforce in resource-poor countries, especially countries in sub-Saharan Africa (SSA), to look for alternative strategies to improve the education capacity of their health education institutions. It is an interdisciplinary research that seeks answers to this international effort, through a case study with geographic focus in Malawi and a disciplinary focus in pharmacy.

To start with, this chapter will introduce the research by situating the research (in section 1.1), explaining research questions and its aim and objectives (in section 1.2), introducing two key terms that will be used throughout the thesis (in section 1.3) and describing very briefly what each chapter contains (in section 1.4).

1.1 Situating the research

I do not come from Malawi (not even from Africa) and I am not commissioned by any development agency to research about Malawi. In this section, I will explain why I started this research and how I had done so. I will discuss this in three parts: the megatrends set by the MDGs (Millennium Development Goals), the establishment of the GHWA (Global Health Workforce Alliance) as well as its relation to HRH (Human Resources for Health) and the establishment of the PET (Pharmacy Education Taskforce). Through these discussions, I also hope to explain the research paradigm which this study started from.

1.1.1 The Millennium Development Goals (MDGs)

First introduced in 2000, the MDGs are eight development targets, which aim to improve the social and economic conditions in the world's poorest countries (see Box 1-1). MDGs engender a powerful development agenda, by revealing situations in the most impoverished parts of the world. Sub-Saharan Africa (SSA) becomes the target for development with its lowest score in almost all development indicators. In terms of health-related indicators, the region has the

highest child mortality (see Figure 1-2), highest maternal mortality (see Figure 1-3) and highest HIV incidence rate (see Figure 1-4) in the world. These comparisons have raised global awareness about global inequality, particularly about the extreme poverty and the high disease burden in the SSA region. To 'rescue' Africa, numerous funds are channelled into development projects taking place in the SSA. Health, as one of the crucial areas in achieving MDGs, is given a priority. Research in health in SSA has grown rapidly, even amongst research areas previously not engaging the SSA. This is probably due to the non-specificity of the MDGs, which allow a context-free access to researching health problems in SSA. These researches are largely concerned about the severe shortages in capacity for improving health: i.e. shortages in drugs [e.g., (Waako *et al.*, 2009)], health facilities [e.g., (Mundy *et al.*, 2003)] and health workers [e.g., (Haq and Hafeez, 2009)]. Research investigates possible ways to improve these shortages. For example, in cases of health worker shortages, researchers ask questions such as why health workers migrate in large number out of the SSA? What affects health workers' job satisfaction? Is it feasible to employ health workers with lower qualifications? This project, therefore, came from the MDG research paradigm, with the aim of improving health worker shortages in a low-income country.

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
6. Combat HIV/AIDS, malaria and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Box 1-1. Eight Millennium Development Goals.

There are numerical targets for each goal, see (MDG Monitor, 2012).

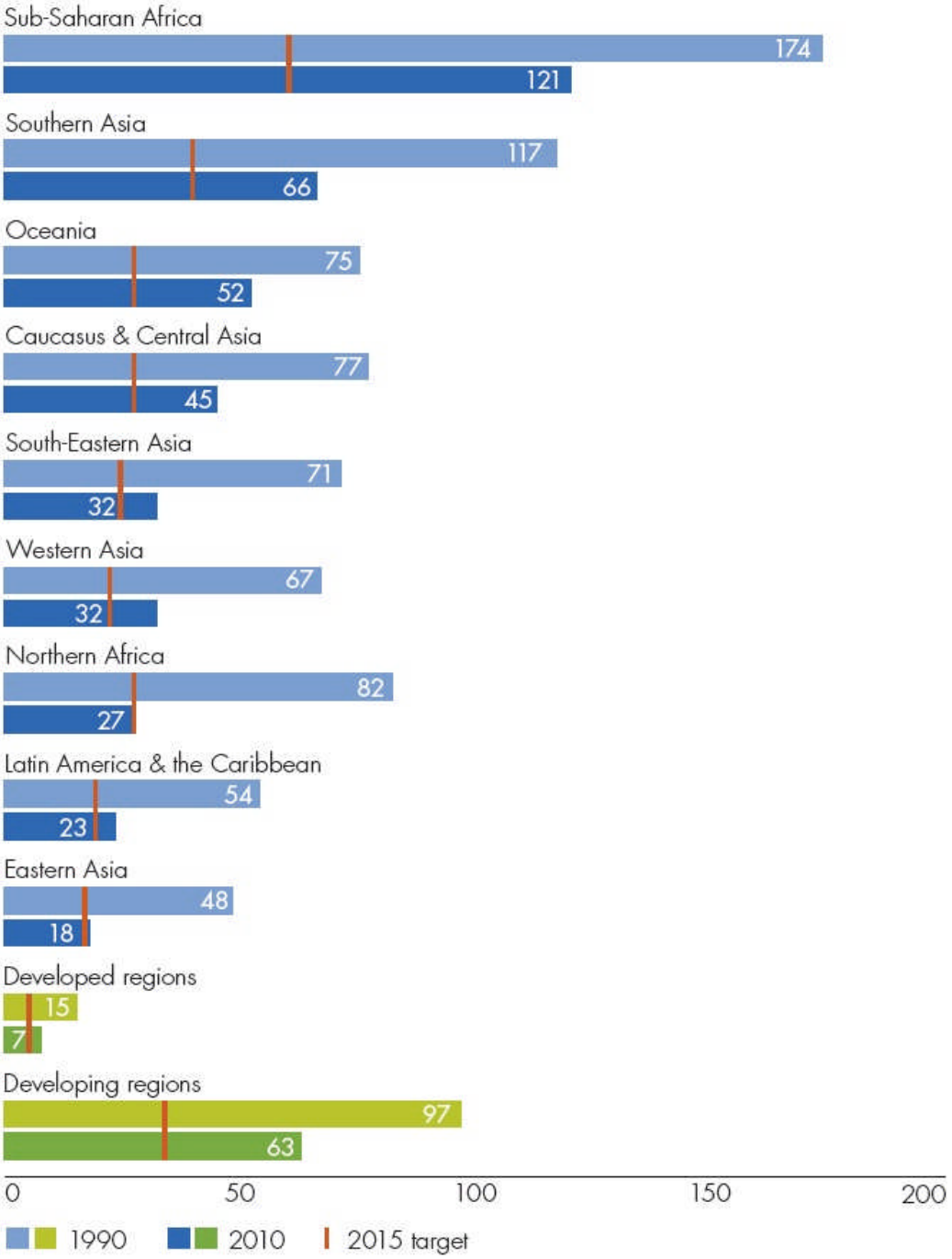

Figure 1-2. World progress towards MDG no. 4 (reducing child mortality).

As measured by under-five mortality rate, in years 1990 and 2010. Unit: Deaths per 1,000 live births. Figure taken from (United Nations, 2012a), MDG Report 2012. Reproduced with permission from the United Nations.

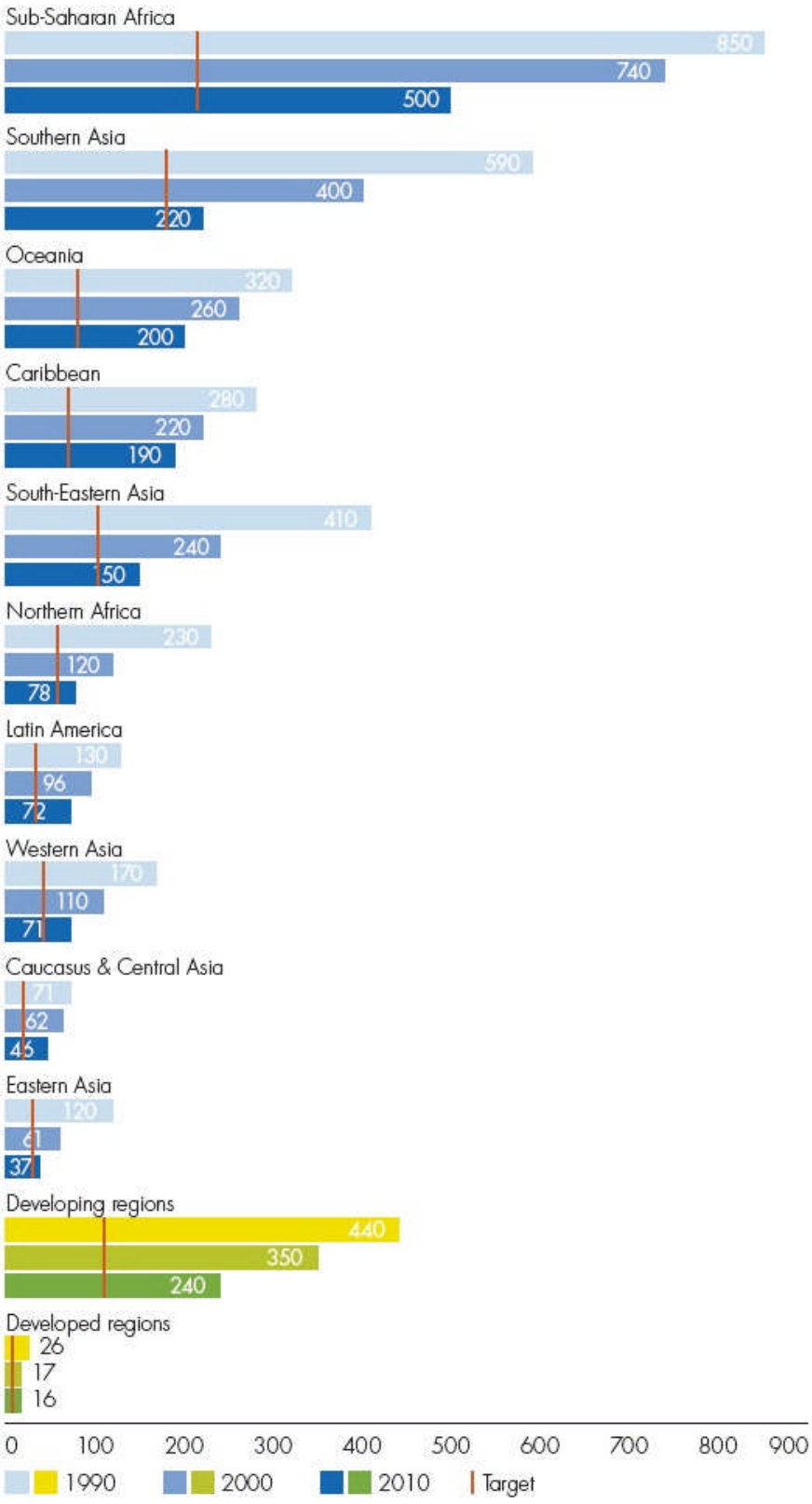

Figure 1-3. World progress towards MDG no. 5 (improving maternal health).

As measured by maternal mortality ratio (maternal deaths per 100,000 live births, amongst women aged 15-49), in years 1990, 2000 and 2010. Figure taken from (United Nations, 2012b). Reproduced with permission from the United Nations.

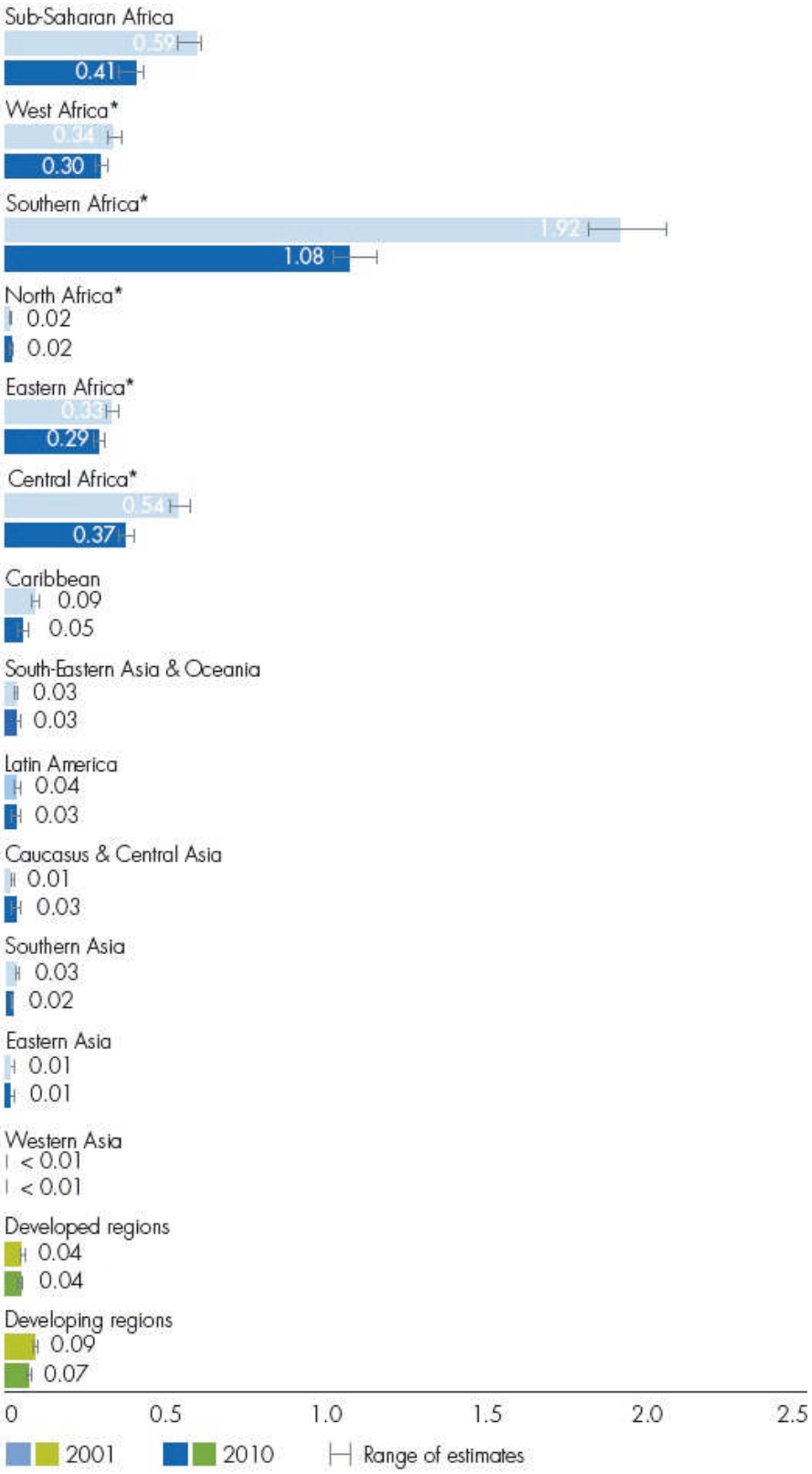

Figure 1-4. World progress towards MDG no. 6 (combating HIV/AIDS).

As measured by HIV incidence rates (estimated number of new HIV infections per year per 100 people aged 15-49), in years 2001 and 2010. Figure taken from (United Nations, 2012c). Reproduced with permission from the United Nations.

1.1.2 The Human Resource for Health (HRH) and the Global Health Workforce Alliance (GHWA)

Health workers, or human resource for health (HRH), is defined as "all people engaged in actions whose primary intent is to enhance health" (World Health Organisation, 2006c). There is an unequal distribution of HRH worldwide (see Figure 1-5). Whilst none of the European countries were experiencing HRH shortages, it was a problem in 36 out of 46 African countries. These HRH statistics left out pharmacists but a similar situation was shared by the pharmacy sector, as seen from another measurement in Figure 1-6. This unequal distribution can range from having 188.8 pharmacists per 100,000 population in Malta to 0.4 pharmacists per 100,000 population in Chad (Chan and Wuliji, 2006). In recent years, HRH crisis is increasingly highlighted as one of the main causes for failing to achieve the health-related MDGs (UN, 2008; World Health Organisation, 2008b; Wyss, 2004).

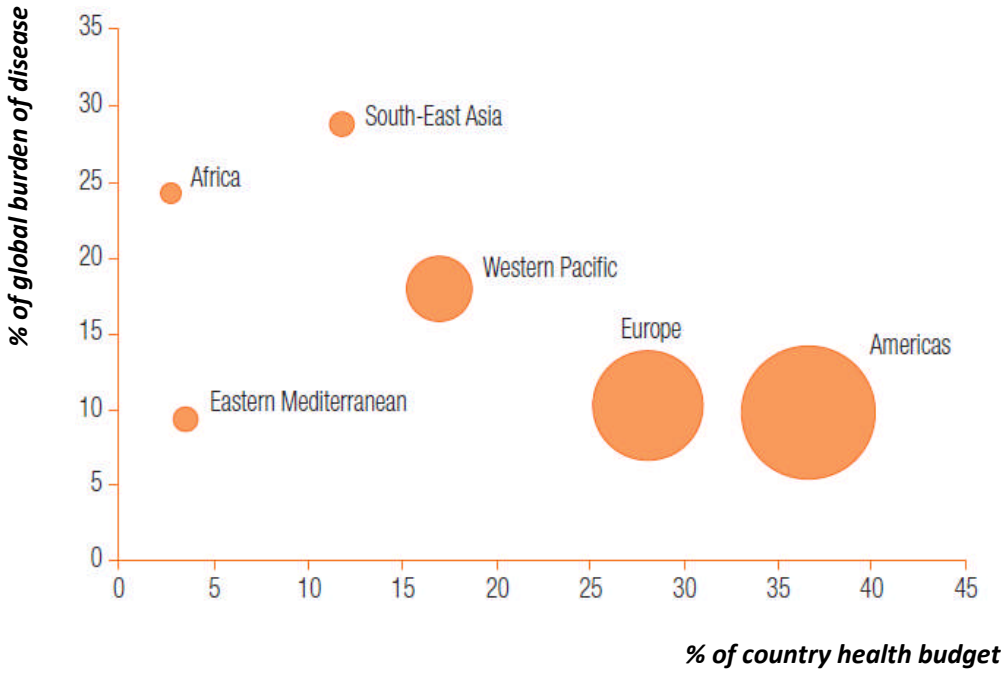

Figure 1-5. Global distribution of HRH by WHO region.

Figure taken from (World Health Organisation, 2006b). Reproduced with permission from the World Health Organisation (permission ID: 104774).

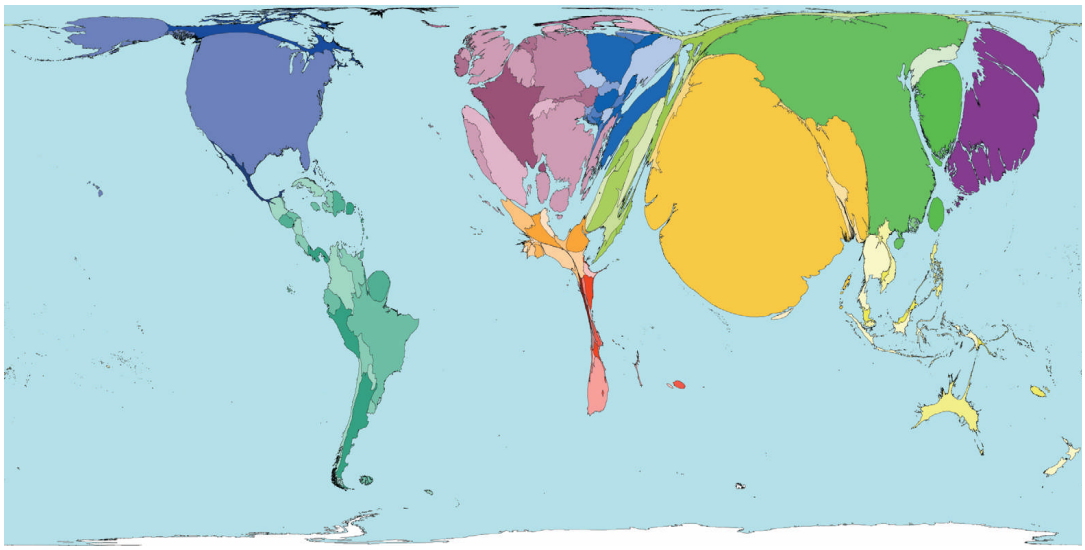

Figure 1-6. Global distribution of pharmacists

The size of a country is proportionate to the number of pharmacists in the country. Note that SSA is the continent with the most disproportionate number of pharmacists to its population. Figure taken from (the WorldMapper Team, 2011). Reproduced with permission from © Copyright SASI Group (University of Sheffield) and Mark Newman (University of Michigan).

The establishment of the 'Global Health Workforce Alliance' (GHWA) in 2006 is a WHO[2] commitment to look into HRH-related crisis. Its mission is "to advocate and catalyse global and country actions to resolve the HRH crisis, to support the achievement of the health-related MDGs and health for all". It seeks to secure political commitment in resolving the HRH crisis. In the Kampala Declaration of 2008, heads of state and governments pledged to "determine the appropriate health workforce skill mix and to institute coordinated policies, including through public private partnerships, for an immediate, massive scale-up of community and mid-level health workers, while also addressing the need for more highly trained and specialised staff" (Global Health Workforce Alliance, 2008a). The establishment of GHWA is a cornerstone that raises global awareness about the importance of HRH scale-up in countries experiencing poor health. Its strategic plan to reduce HRH crisis, as shown in Figure 1-7, involves the application of a 'stakeholder' approach, which is also used by this research (see section 1.3.2).

[2] The WHO does not fund nor manage GHWA's operations, but is a founding member and remains a partner of the Alliance.

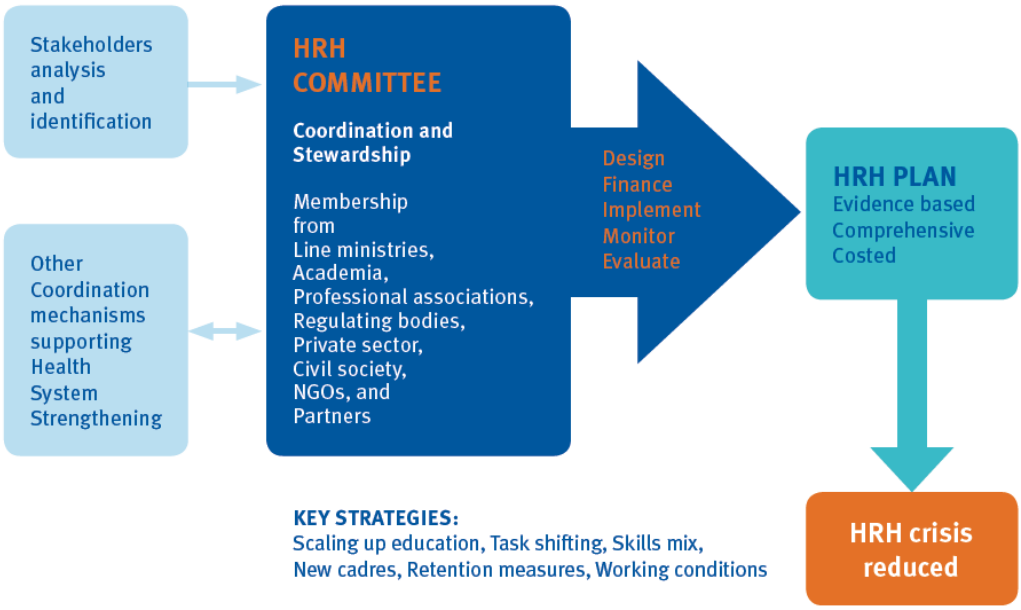

Figure 1-7. A conceptual framework from the GHWA about strategies to reduce HRH crisis through HRH stakeholder engagement.

Figure taken from (Global Health Workforce Alliance, 2012a).

1.1.3 The Pharmacy Education Taskforce (PET)

When increasing attention is paid to the HRH crises, shortages in HRH training are also treated as an urgent problem. In the pharmacy sector, this led to the establishment of the 'Pharmacy Education Taskforce', or PET in abbreviation. Established in November 2007, PET received endorsement from the International Pharmaceutical Federation (FIP), World Health Organisation (WHO) and United Nations Educational, Scientific and Cultural Organisation (UNESCO). It aims to provide evidence-based support for education and training of pharmacists around the world, with particular interest in SSA countries (Anderson *et al.*, 2009). The taskforce is drawn up in three domains: institutional capacity building, competency and quality assurance[3]. This research falls under the capacity domain, which is headed by my PhD supervisor Prof Claire Anderson. To explore the conceptual issues about capacity building, it was thought that a case study

[3] There are also other areas like vision and leadership.

approach was appropriate. Malawi was chosen as the case-study country[4] because of three reasons: first, it had a newly established pharmacy school[5] which had yet to produce its first graduates. The country was keen to know more about this new development. Second, Malawi is traditionally dependent on pharmacy technicians (rather than pharmacists) hence it would make an interesting case to study issues about 'task-shifting', which is at the moment a core issue in HRH planning (see Chapter 3). Third, administrative inconvenience from most other countries did not leave me with many choices. With the support of the former head of school Prof Michael Berry, I was given a green light to proceed with this research.

1.2 Research questions, aim and objectives

In section 1.1, it is explained how the megatrends and establishments have enabled a new focus in pharmacy education research. Amidst these global political commitments to resolve HRH crisis, pharmacy education research is challenged with a new set of questions concerning capacity building in resource-poor settings. In Malawi, the country has only one pharmacy school, generating an output of about 20 graduates yearly. As the country is severely restricted in resources, this research seeks to provide innovative solutions: is there a quicker alternative to increase the school's capacity so that more than 20 pharmacy graduates can be produced per year? Are there any local resources untapped into, which can be mobilised for capacity building of the education institution? Alternatively, might the solution lay somewhere outside of Malawi? How much can foreign aid help? Should students receive their education outside of the country instead? Or should more foreign lecturers come into Malawi? All these

[4] Out of seven case study countries signed up to the taskforce: Ethiopia, Ghana, Kenya, Malawi, Tanzania, Uganda and Zambia.

[5] It is actually called the *Department* of Pharmacy, as it comes under the medical school. However, to avoid confusion the phrase pharmacy school is used here. The correct term will be used later in subsequent chapters.

questions might most probably have been asked already, but is there a new way of seeing a solution? Are there any issues that are discipline specific: problems that are faced by only pharmacy but not other disciplines?

Perhaps the problem is not about the number of pharmacists. The solution might come from increasing the number of other health cadres (e.g., pharmacy technicians), who are cheaper, easier to train and equally competent in the job. Then, the purpose of having pharmacists needs to be redefined. However, then again the problem might not necessarily come from the number of health workers. With large number of health workers migrating out of Malawi, increased recruitment might not cope with the larger loss from attrition. With this, the solution could be turned to mitigating attrition. Therefore, this research seeks to establish a broader understanding of capacity in pharmacy education, by not limiting it only to specific areas or issues.

The overall research aim is to establish a conceptual understanding of capacity building in pharmacy education in resource-poor settings. The specific objectives are:

i. To explore the current and desired roles for pharmacists in Malawi.
ii. To explore the capacity problems within higher education sector in Malawi, as well as within the education institution for pharmacy.
iii. To explore the agendas, attitudes and opinions of important stakeholders who could influence institutional capacity building.

1.3 Key terms

Although this research was first situated in the MDG research paradigm, it has eventually reached out to non-health disciplinary areas. This research journey of discipline-crossing is signposted by two key theories: 'needs-based education' and 'stakeholder engagement'. In this section, these theories are introduced by situating them in the health science research paradigm. It will be explained why they are regarded as axiomatic by this paradigm. They will be reviewed again in

the literature review sections (in 3.1 and 5.1), by including perspectives from other disciplines. The purpose of introducing these theories twice is to allow comparison between how they are viewed from a single-discipline (as in this section) and from a multiple-disciplinary perspective. In the latter, there will be less certainty and more critique. Then, the data chapters (4, 6 and 7) will report the data emerged from using these two theories[6]. Based on the data, the decision about how these theories can be used (or not used) in Malawian pharmacy education will be reached in the concluding sections in Chapters 4 and 6, and discussed in length in Chapter 8.

1.3.1 "Needs-based education"

Contemporary medical or health education literature speaks the language of *x*-based education. This variable *x* is contentious. So far, the 'x's that have gained most recognition is 'competence' (or 'competency'), 'outcome', 'problem' and 'team' (see section 5.1.3). Although 'needs-based' education has not received as much research attention as the others in the literature, it is the overarching working principle for PET. It comes from a deliberate effort to make African (pharmacy) education for Africans, where 'one size does not fit all' is made a motto in the work of the taskforce. This stems from the concern about the lack of the practical value of using a Western (e.g., British or American) education model in African settings. There are concerns about students learning skills not applicable to solving the local health problems. For instance, students might learn too much about degenerative diseases (which mostly affected older population[7]) and too little about tropical diseases. Therefore, the 'needs-based' concept was created to align education with local health needs. This concept

[6] Data collection was not restricted to these two theories; however they were the major ones used, modified and critiqued.

[7] Malawians, for example, have life expectancy much shorter than people living in richer countries. Nearly half of the population (47%) is aged below 15 and only 5% aged over 60 years old (World Health Organisation, 2009).

suggests translating health services needed by the local population into 'competencies', which should be achieved by health workers delivering these services. Based on these needs-based competencies, education should be provided to the health workers (see Figure 1-8).

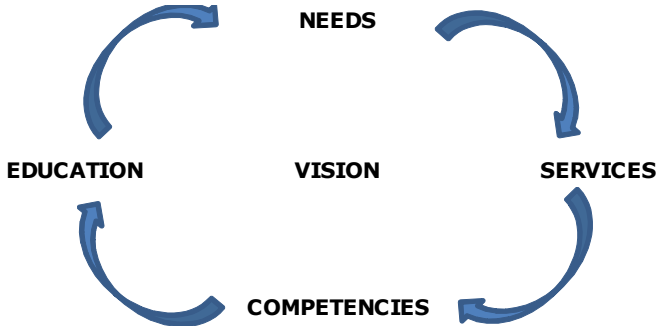

Figure 1-8. A conceptual framework for needs-based pharmacy education.

Figure adapted from (Anderson *et al.*, 2009).

1.3.2 "Stakeholder engagement"

'Stakeholders' becomes a useful concept for the 'needs-based' notion, where local stakeholders become the agents to decide what is needed locally. The classic definition of 'stakeholder' is given by Freeman as "any group or individual who can affect or is affected by the achievement of the organisation's objectives". There are two categories of stakeholders: the "internal stakeholders", who are situated in the internal environment of the organisation; and "external stakeholders", who are situated externally. The reason to differentiate them is because organisations do not operate in a black-box process, thus it is important to acknowledge the influence of internal stakeholders (Freeman, 1984). In the case of pharmacy education, stakeholder groups consist of the education institution, the job market, professional registration board, patient groups, etc. By engaging stakeholders, it is hoped that agendas from different interest groups can be taken care of. This is to ensure even stakeholder groups with little political power (e.g., the patients) should have a say in decisions affecting their stake. In fact, stakeholder theory is used for discussing the concept of 'fairness'; in which the conferring of a stakeholder status denotes the responsibility of the organisation's towards the stakeholder's welfare.

However, most of the debates about this concept is contained in the literature of business ethics (Phillips, 1997). It is not an area studied by this research because the organisation studied by this research, i.e. the education institution for pharmacy, is not a business organisation. Instead, the discussions focus on how this theory is applied in the health sector. The purpose of mentioning business ethics is to clarify where stakeholder theory comes from; and where the debates about how valid it is take place[8]. When this theory is transported into health literature, the issue about ethics ceases to be the main attraction. Instead, what attracts health projects or research to stakeholder theory is its power of representation. By inviting the leaders of each stakeholder groups to the table of decision making, it gives a sense of fair representation of all interest groups. Stakeholder-ship is used as a method to achieve representation, for example through consulting stakeholders' opinions [e.g., (El-Jardali *et al.*, 2010), (Kapiriri and Norheim, 2004)]; and building consensus amongst stakeholders [e.g., (Spero, McQuide and Matte, 2011)]. Multi-sectoral participation is often implied in health strategic plans when stakeholders' names appear in the reports. For instance, the participation of civil society stakeholders in Malawi's health sector wide approach (Government of Malawi, 2004) and education sector plan (Government of Malawi, 2008). Engaging private-sector stakeholders in government projects is encouraged by global health initiatives[9], who are the major funder to government budgets, in the hope to empowering the non-governmental organisations (NGOs) and fostering public-private partnership (Biesma *et al.*, 2009). World health organisation, in its 2006 report that makes scaling-up HRH a central theme, proposed a 'global stakeholder alliance' that has to be started from alliance of in-country stakeholders (see Figure 1-9).

[8] For a quick overview of what the debates about stakeholder theory in business ethics are, see (Phillips, Freeman and Wicks, 2003).

[9] For instance, the World Bank, the Global Fund to fight AIDS, TB and Malaria, PEPFAR (The President's Emergency Plan for AIDS Relief), etc.

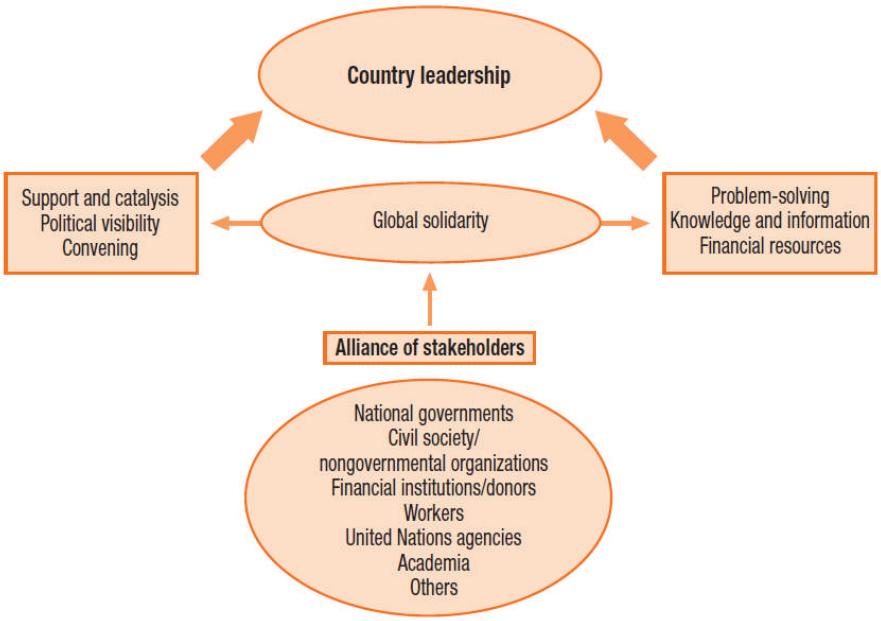

Figure 1-9. Global stakeholder alliance to reduce HRH crisis.

Figure taken from (World Health Organisation, 2006b). Reproduced with permission from the World Health Organisation (permission ID: 104774).

Situated in the HRH research paradigm, this research also adopts the stakeholder notion. There are two objectives to using the stakeholder approach: first, to find out the purpose of pharmacy education through stakeholders' opinions; second, to look for capacity building strategies through stakeholders' expressed support for pharmacy education. In the later chapters, this approach will be debated again. In this section, it suffices to say the stakeholder approach lays the foundation for the thesis, as illustrated by Figure 1-10. This figure also explains how the thesis is divided thematically into two parts: purpose and capacity.

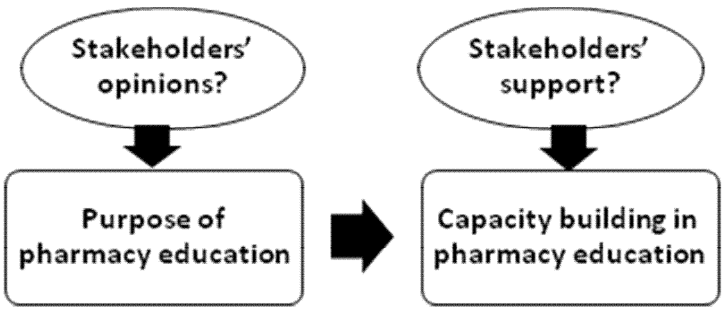

Figure 1-10. The application of the stakeholder notion in this research.

1.4 Thesis structure

This thesis is structured thematically, based on the objectives of the thesis: 'purpose' (of pharmacy education) as the first theme; and 'capacity' (for pharmacy education) as the second. Each theme consists of two to three chapters: one literature chapter plus one or two data chapters. So, Chapters 3 and 4 focus on the theme 'purpose'; whereas Chapters 5, 6 and 7 are about 'capacity'. This thematic grouping requires the methodology chapter to be placed ahead of other chapters. Also, the background information about Malawi has to be split thematically into two sections. Literature about Malawi's health system and pharmacy sector is written in section 3.2; whereas literature about Malawi's higher education sector and University of Malawi is written in section 5.2. Finally, the concluding chapter (i.e., Chapter 8) brings both themes together.

It must be noted that the literature chapters seek to cover the breadth, rather than the depth, of the literature. In the literature review about capacity building, for instance, it seeks to bring in perspectives from four disciplinary areas, rather than dwelling in-depth with just one perspective. The data chapters put together data collected from fieldwork (e.g., interview quotes), data published in public domains (e.g., country reports) and also literature (that may or may not be raised in the literature chapters) to form arguments. In a way, this thesis is a cross-disciplinary one not only in its content, but also in its writing style. In the following paragraphs, I shall describe in more details what each chapter is about.

Chapter 2 explains the research methodologies. It is an account of how this research evolved methodologically and why the decision to employ an ethnographic approach was actually a product of fieldwork analysis. It also discusses in detail what methods were used to collect and analyse data; and how research rigour is reached.

Chapter 3 is the literature chapter for the theme of 'purpose'. The purpose for having pharmacists in the health system is examined by looking at what roles pharmacists (should) play; and this is discussed from five different perspectives:

the structural functionalist perspective, the notion of 'competence', the notion of 'skills', the notion of 'needs' and the sociology of professional boundary. The purpose of providing multiple perspectives is to contextualise the issue of roles; and subsequently the notion of 'needs', which is often discussed in a context-free manner otherwise. In the second section of the chapter, the health system and pharmacy sector in Malawi is described.

Chapter 4 is the data chapter for the theme 'purpose'. It reports the roles of pharmacists from the needs-based perspective. It also examines whether 'task-shifting' (i.e., replacing pharmacists with pharmacy technicians) is feasible in present-day public pharmacy sector. Based on the data, this chapter comments on why 'needs-based' notion may not be adequate to decide what roles pharmacists should play in the country.

Chapter 5 is the literature chapter for the theme of 'capacity'. It seeks to pull together discipline-specific definitions of capacity from four areas: African higher education, pharmacy, health workforce and development. Like Chapter 3, the purpose of doing so is to demonstrate that this issue can be examined from a number of theoretical lenses. However, each theoretical lens offers only partial explanation to the empirical data, which becomes evident in Chapters 6 and 7. In the second part of the chapter, the higher education system in Malawi is described; and capacity problems faced by the University of Malawi are reported.

Chapter 6 is the first data chapter in response to issues raised in Chapter 5. It starts off by engaging the notion of stakeholder, through analysing the strengths, weaknesses, opportunities and threats (SWOTs) of six categories of stakeholders. The reason for doing SWOT analysis is to identify stakeholders who have the best potential to mobilise resources for institutional capacity building. At the same time, these analyses also point out the problems of doing 'stakeholder engagement' in a postcolonial, aid-dependent setting, because of the lack of readiness in the institution to engage its stakeholders. Capacity building in pharmacy education, as argued by this chapter, is not necessarily discipline-

specific, but involves issues that are commonly found in literature about African higher education and development.

Chapter 7 is the second data chapter, which writes about foreign aid in Malawi. It is also a continuation of the development-related themes from Chapter 6. It starts off by describing six different types of foreign aid and how each one impacted on the domestic structure. A large part of this chapter is devoted to explain the causes and habit of aid dependency, from the perspectives of both the aid givers and receivers. Based on the empirical data, it explores the issues of aid modality (e.g., money vs. knowledge), mentorship, ownership, partnership, etc. Through these discussions, it is argued that not all forms of foreign aid are helpful to domestic capacity building; hence there should be screening for only helpful aid to come through.

Chapter 8 is the concluding chapter. This brings together all themes and issues raised in the previous chapters. By doing so, this chapter generates fresh insights into the issues of 'purpose' and 'capacity'. It seeks to break down disciplinary restrictions to the interpretation of these two issues and argues for an inter-disciplinary approach in future HRH research. At the final sections of the chapter, collective limitations and implications of the research will be summarised.

CHAPTER 2

Research methodologies and methods

As explained in Chapter 1, the research methodology chapter comes before the literature review because of the need to situate this research in a cross-disciplinary area, before discipline-specific literature can be presented. In this chapter, I will talk about both the 'hardware' (in terms of concepts, theories and techniques) and 'software' (in terms of cross-disciplinary tension, emotions and self identity) applicable to this research. By the end of the chapter, the reader should be able to gain a sense of understanding not only about the problems as presented in the research question but, more importantly, the context within which research questions are situated. There are four major parts in this chapter: philosophical and theoretical frameworks for the research (section 2.1), rationales for using an ethnographic approach (section 2.2), methodological tools (section 2.3) and processes of data collection and analysis (section 2.4).

2.1 Philosophy and theoretical frameworks

2.1.1 Philosophical framework

In this section, I will examine the notion of 'truth' and explain the version of truth this research works on. This has to start from the first task given to this research: i.e., to find out the 'African' reality. This task is based on a realist assumption about an independent truth that was unknown to the outsiders. Putting aside the debate about whether or not this ontological assumption is 'true', this assumption provokes high level of interest in investigating the contextual differences between an African and an orthodox setting. This is important because examining contexts is not always a priority in a predominantly context-free health science tradition. Although qualitative research work cannot always resolve the problem of what truth (e.g., realist vs. relativist) it represents, it does frequently bring the external world closer to reality not of commercial value to the world's mainstream media.

'Realism', which assumes a single truth or a social world exists independently from its observer or researcher, is more or less out of qualitative research fashion particularly amidst postmodernist thoughts. Using this approach, Malawi

would have an independently constructed reality ready to be accessed only if I was unbiased, diligent (in extracting details of the objective truth) and completely nonjudgmental. Theoretically, this constructivist approach might most accurately answer the research question (i.e., what is 'different' about Malawi?). However, practically there is an epistemological difficulty. How could I, a person who had never stepped foot in Africa prior to this research, access this independent truth (Hammersley, 1992b)? This led to the use of an ethnographic approach (see section 2.2), which typically involves a long period of intensive interaction with the local reality so that the researcher could eventually (in ideal cases) think and act like an insider, hence resolving the epistemological difficulty in realism. Yet, this cannot be achieved in perfection in the real world, because researchers are human beings too whose thoughts and feelings cannot be programmed into becoming the insiders' merely through fieldwork. However, this does not mean that I cannot use ethnography, but what is required is research honesty in disclosing the approach and subjectivities applied in accessing the reality (see section 2.2).

Therefore, I refuse to label this research as either 'realist' or a 'relativist' (i.e., claiming multiple realities). Instead, I would claim a closer representation of the reality of some (e.g., the aid workers) but less of the others. This is because I was frequently related to, by the indigenous society, as an aid worker, thus it gave me a bigger chance to react, reflect and ultimately represent the aid workers' reality. This gives me a stronger analytical power to interpret what goes wrong, or right, in the aid industry in Malawi (see Chapter 7). However, this does not mean I cannot do the same for the indigenous others: I can, but to a lesser extent. This deficiency was improved by "triangulation" (i.e., comparing data from different sources), which is a research rigour check not different from any other research.

2.1.2 Theoretical framework

In research, whichever theoretical lens one uses, one will find relevant data. The advantage of qualitative research, therefore, is the flexibility in modifying and/or changing the theoretical lenses in accordance to data. This data-driven approach can avoid limiting data to only those fitting one specific theoretical lens. In this research, this flexibility helps to compare, contrast and combine theories from different disciplines. To best explain the evolution of the theoretical framework used by this research, I will divide theories into two categories: ideational and materialist. Ideational theorists believe social reality can only be changed by changing opinions and perceptions; whereas materialist theorists believe it should be changed by appropriating systems and policies (Fetterman, 2010). In the earliest stage of the research, a materialistic perspective was selected to inform its theoretical basis. 'Stakeholder theory' was adopted because it was believed that stakeholder support could be secured as long as suitable strategies are applied to manage stakeholder relationship. Not long after stepping into the field, this was thought to be insufficient to explain the reality (see section 2.2.1). Subsequent data analysis suggested the importance of an ideational perspective, such as postcolonial mentality. In Chapter 7 for example, I will explain why and how psychological conditioning plays an important part in deciding the nature of foreign aid in Malawi. However, this does not mean only ideational theories revealed truth but, rather, that the evolution of the research encouraged me to pursue this thread rather than developing further in the materialist direction. Indeed, there is only so much a thesis can do thus I have chosen to put forward a voice that is not commonly found in the health science tradition. Subsequently, stakeholder theory was modified into a structure to guide sampling (see section 2.4.1), and not as a tool to distribute fair voices to all interest groups.

2.2 Debating ethnography

This research is methodologically challenging because of the epistemological differences between disciplines. Although a constructivist approach had been decided upon from the beginning of the research, how it eventually manifested

(in both field methods and data analysis) is very much dependent on how much I have evolved as an inter-disciplinary researcher. Starting off with an applied research question (e.g., is strategy *x* feasible to overcome resource constraints when setting up a new pharmacy school?) within the health science epistemology, realist interviews were deemed sufficient to provide answers. However, field data immediately revealed the importance of blending in basic research questions (e.g., where does cultural interpretation *y* come from?), which may need a non-health science epistemology. It was at this point that ethnographic techniques were employed in order to grasp the local reality that was dense with cultural interpretation. Indeed, the merging between ethnographic authoring and a positivist structure has produced an inter-disciplinary flavour throughout this thesis. Unlike most ethnographic writing that does 'thick description' (Geertz, 1973), this thesis does more explaining than describing (see section 2.2.1). The ultimate result was a response to finding a balance between conveying cultural meanings and offering practical solutions to technical questions. Therefore there might not be as many references to 'me' appearing in the following chapters as in a full ethnographic work. Most work of self reflexivity will be done in this section through issues like subjectivities (section 2.2.2), emotions (section 2.2.3) and ethics (section 2.2.4). At the very end of the concluding chapter, there will also be a short paragraph summarising personal development.

2.2.1 Why ethnography?

Ethnography literally means writing ('*graphe*') of the ethnic others ('*ethne*'). Having an anthropological origin, ethnography started out as studying the exotic others. The founding father of modern ethnography, Bronislaw Malinowski, for instance, studied the social structure of a people of Melanesian in Trobriand Islands, Melanesia, in the early twentieth century (Malinowski, 1979). Later in the 1920s, the Chicago School of Ethnography pioneered studying urbanites with ethnography. Led by two most prominent figures, Robert Park and Ernest

Burgess, Chicago research studied the subaltern[10] living in the 'natural areas' of the city (Deegan, 2001). In these studies, researchers spent a long period of time living in the studied community in order to gain 'emic' (or insiders') perspectives. This is done in a systematic way by looking for the patterns of behaviours and/or thoughts underlying the organisation of a community. To gather evidence for constructing these social patterns, ethnographers immerse themselves, as both participants and observers, in the day-to-day life of the researched community. They must refrain, as much as possible, from imposing their judgement and perception when constructing an understanding about the local culture. In short, the mission is to faithfully reproduce the local reality to the outsiders. The closer the representation is, the more successful this mission is. Therefore, ethnography provides a scientific approach to understanding a culture, rather than depending on the frequently opinionated reports and diaries written based on personal experience that is non scientific (e.g., by travellers, missionaries or colonial officials). An ethnographer is not merely a storyteller or a journalist but also a scientist, who must exercise research rigour in ensuring the validity and reliability of his/her research.

It is upon realising the need for understanding the Malawian context in an ideational, on top of the materialist, way (see section 2.1.2) that I embarked on an ethnographic journey. The first instance where I became aware about the importance of understanding the emic perspective was when I sensed that dense contextualisation was needed beyond labelling the situation as merely 'resource-poor', 'aid-dependent', etc. Indeed, these labels diminished automatically (from my thinking) when an ethnographic approach was adopted in the field. For example, I stopped thinking whether policy *x* could save resources, but (like the locals) began pondering about who likes or dislikes the policy. By immersing myself in the thoughts and actions of the Malawians, I was able to relate better to the people, rather than just to structures and problems.

[10] A term used in postcolonial theory (made popular by Spivak in 'can the subaltern speak?'), which means members of a society who reside out of the hegemonic power structure.

Although I cannot claim using grounded theory in this research (as I had not entered the field theory-free), the phenomenological-based approach applied in ethnography allowed me to do 'grounded theorising', which opened up discipline-free enquiries. For example, I would not have thought of reading the biography of Dr Hastings Banda (which often lies in the political science section) if I had not allowed data to highlight the intense fear people had toward losing personal freedom under his regime[11] (see section 4.3.1). Although a discipline- and theory-free approach was applied when looking at the data, subsequent theory building could be discipline specific. What was attempted was to look at the social world with a holistic (or 'multicultural') perspective, before narrowing it down to the key areas of concern. For instance, low student-teacher ratio has always been blamed for high unit costs in universities in sub-Saharan Africa. It could well be reported this way by simply noting the low number of students in the school. However, an ethnographic enquiry allowed contextualising beyond simply a residential-or-non-residential debate. Poor housing and public transport system, often not mentioned in World Bank's reports about African universities, were actually the bottleneck to having non residential programmes (see section 5.2.1).

There are, however, two technical issues that make my fieldwork look less like a typical ethnography. First, it has a shorter duration (i.e., three months) than most ethnography work, which typically takes six months or longer. This is due to the nature of the research questions, which could be satisfied by being aware of how and why cultural meaning should be brought into answering a technical question but not deeper than that. At the same time, funding and resources available did not allow fieldwork longer than three months. In fact, it was already an extension from an earlier plan of just a two-week (or maximum one month) 'visit'. The second feature that makes it unlike typical ethnography fieldwork was its multi-sitedness. Instead of staying in just one location, I covered five major

[11] It was this fear that eventually created a twisted definition of 'democracy', which claims personal freedom without accountability.

sites in Malawi: Blanytre, Lilongwe, Mzuzu, Livingstonia and Zomba[12]. Although the main reason for doing so was to access stakeholders who were located in different locations throughout the country, a more epistemologically important impact from multi-sitedness was to crystallise my understanding about Malawi from different angles or perspectives, which were not segmented into discipline or geographic specific issues (e.g., about pharmacy only, or about urban areas only). When moving from one location to the other, I purposely chose to stay with families of different ethnic backgrounds[13] in order to allow triangulation of (particularly racist) opinions voiced by certain members of the society. For instance, I listened to the comments about the 'laziness' of African Malawian workers, during meetings with Indian Malawian employers. These comments were later contrasted with African Malawians' perception about social exclusion, where Indian Malawians were thought to belong to the richer circle of the society and showed no interest in integrating themselves to the indigenous community. In other words, moving between different sites and interacting with different ethnic groups provided me a chance to grasp, however superficially, the cultural construction of the society. This allowed me to identify the generic patterns of actions, opinions and behaviours most potentially exhibited when

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[12] To very crudely describe what these five towns represent (in linking with their stake in pharmacy education): Blanytre is where the new pharmacy school is; Lilongwe is the capital, where government machineries including decision making in public pharmacy service takes place; Mzuzu is the major town in the northern region, where missionary hospitals/universities were first established; Livingstonia is not far from Mzuzu and was the primary site for the first missionary settlement led by Dr David Livingstone; whereas Zomba has the university central office, located next to the Chancellor College. Another reason for visiting Mzuzu/Livingstonia was to explore the alleged 'regionalism' frequently hinted between conversations, during my stay in the southern region.

[13] I had lived with families of the following ethnic/nationality backgrounds: African Malawian, Indian Malawian, expatriate (white/black Americans), refugee from a neighbouring African country (granted citizenship) and Asian (who worked on donor projects). Despite a short period of time spent with each family, I remained in contact with most of them (through Facebook for example) since then, which also allows a loose but 'network-able' connection with the daily reality in Malawi.

encountering a new issue. For instance, the identification of 'regionalism' as one of the primary 'cultural'[14] reactions to a new policy allowed me to understand why the current 'southern' government would prefer a quota system to apply to university enrolment policy (see section 5.2.1). In this way, I was moving back and forth between macro-theories (e.g., regionalism) and micro-foundations (e.g., objections to the quota system) whilst collecting data. To more effectively enact these macro-micro links, I eventually did more 'explaining' (about these links) in the thesis, rather than doing in-depth 'describing' of the micro-level data. In fact, 'multi-sited ethnography' was first coined only in 1995 by George Marcus. In an increasingly inter-connected world (through globalisation or other forces and processes), cultural formation and production is arguably transcending time, space and causality. To insist on localism might paradoxically forsake the actual site of cultural production in the contemporary social world, which may lie across multiple sites (Marcus, 1995).

In summary, this research might not look like a 'full' ethnographic work but it needs very much the ethnographic 'sense' to make sense of the social work I study. In the next three subsections, I will talk about three issues dear to ethnographers: subjectivities, emotions and ethics.

2.2.2 Research subjectivities

I will talk about research subjectivities in two parts: first, how my past experience, identity and personal faith has influenced the research processes; second, how the research participants' perceived my identity. It is important to reflect on the second point because this could determine what the research participants were

[14] The term 'culture' or 'cultural' will be used throughout the thesis despite being highly problematic (i.e., on 'otherness'). In this particular case, regionalism could most probably be contextual (rather than 'cultural') because of legacies left behind by early-day missionaries' preference of the high lands in the north (compared with low lands in other regions which exposed them to higher chance of contracting malaria).

going to say to me and/or how my presence might affect their expressed opinions or behaviours.

To very quickly introduce my several identities that could impact on this research: I am a Malaysian, an ethnic Chinese, female, a pharmacist and a Buddhist. Being an Asian, particularly one who had never been to the African continent, gave me almost a clean slate of mind before entering fieldwork. This does not mean I had no knowledge of what Malawi was but the more important thing was that I was agenda-free. All emotions and opinions evoked during or after fieldwork can be safely claimed to have come from the field, rather than other origins (such as 'colonial guilt'). My ethical judgement (which will be discussed in more details in section 2.2.4) is derived largely from the Buddhist precepts (of non violence) and Confucian teachings (of not inflicting harm which you yourself do not desire). The very strong sense of injustice felt (see section 2.2.3) could be the result of such ethical judgements. An advantage I had from my background as a Buddhist was how the Buddhist principle of 'mindfulness'[15] could conveniently apply to the working of an ethnographer, almost intuitively. Another advantage I had was from my Malaysian identity, which allowed me to quickly understand similar Commonwealth structures in the Malawian setting.

There are a few possible identities regarding how I was perceived by the research participants: a potential donor (see section 2.2.4), a pharmacist advocate, a Chinese[16] and a research student. I was mindful of all of these identities during fieldwork and had always tried to persuade research participants to see me as no more than a research student. Apart from what I explained in the consent information sheet (see Appendix II), my dress code presented me as a novice but enthusiastic student. Indeed, many said all they

[15] Which encourages 'staying with primary contact' (vs. forming perception based on past experience), thereby greatly increase receptivity toward a new culture/surrounding.

[16] I was certain of this because I was greeted by (friendly) labels such as 'China' (or 'ni hao') or 'Japan' (or 'konichiwa') at least 3-5 times every day during fieldwork.

would like to do was to 'help' my project. To avoid extracting opinions favouring pharmacy, I tried to convince the informants about my non judgemental stance by probing them with more 'why' questions. As with my ethnic Chinese appearance, I received no obvious association with the local Chinese community as most of them did not interact with the local population (because of the language barrier).

2.2.3 Emotions, opinions and 'taking side'

Ethnography demands honesty. Therefore, I shall disclose my personal opinions and judgements before presenting further data. It is necessary because the 'I' (or 'me') is where data is (selectively) entered, processed and produced; hence which voice(s) eventually come(s) out from this thesis is a decision made by not just the academic exercise, but unavoidably, what I felt to be righteous personally.

Keeping secrets was particularly excruciating. There were at least four occasions where the informants spent hours revealing 'secrets' (e.g., corruption and unjust treatments imposed on them) and their frustration to me. These inevitably stirred up a lot of emotions. However, I had tried to keep a clear mind by triangulating their statements with the accused parties'. Of course I was not always successful in eliminating my negative opinions. Consequently, I found myself starting to take sides and this made me question the possibility of researchers retaining a neutral stance throughout the research. As a human being I think this is not at all possible thus what I can do is to make my judgement explicit, as can be seen throughout the thesis.

There were numerous occasions where I was questioned regarding my ability to help; and my intention to exploit if I actually was not able to help. Such confrontation came either directly (through angry questions such as 'so, what can YOU do?') or indirectly (through disclosure of personal plight, as mentioned above). For a long period of time, I was overwhelmed by a feeling of helplessness,

deep sadness and untoward anger. I have been mindful about how this emotion could impact on the research and had actually removed part of the data which I thought I had become prejudiced in the interviews. What remains to be resolved is perhaps a lifelong homework, however what can be done during the research process is being mindful of the potential influence of emotions on data analysis.

In other words, it is undeniable that this research journey has been an emotional one but this does not mean research rigour would be compromised. By talking to myself, I was aware of how my personal self is influencing my professional self; and by talking to the readers about myself, I allow judgement to be reached independently by the readers.

2.2.4 Ethical concerns and personal safety issues

In the research proposal approved by the COMREC (College of Medicine Research and Ethics Committee), it was mentioned that this research was 'explorative' in nature, hence it was highly unpredictable how the research would evolve. Although I had the leeway to change research methods whenever necessary, I had a particular ethical concern about not mentioning 'participant observation' in the proposal. During fieldwork, it actually happened too quickly before I realised what I was doing was participant observation when I was scribbling down what I had seen and felt. It was too late to reapply for ethics clearance and, therefore, I decided to exercise ethical judgement on a practical basis (i.e., on a case per case basis and by consulting my supervisory team), rather than depending on a yes or a no from an authority. My observation notes recorded only things that could be accessible by any 'tourists' in Malawi (since I was entering the country with a tourist visa) therefore there was no intrusion into private space in any sense. To protect anonymity, figures in photographs

taken were pixelated and no names were disclosed[17]. Because of the 'multi-sited' nature of the fieldwork (see section 2.2.1), I had only description, but not 'thick' description, of a particular place or community anyway. Also, the patterns I observed (e.g., regionalism, tall poppy syndrome, postcoloniality) were confirmed by discussion with friends and/or informants. Interestingly, almost all patterns were widely acknowledged and they were, by no means, of any sort of taboo in Malawian society.

Perhaps what was trickier was managing expectation from some of the informants. Because of general association of a *mzungu*[18] with potential financial assistance, I was aware of how consent could be easily gained from financially desperate informants. There were two ethically challenging episodes where I realised the only intention to accept my interview was the hope for gaining a sponsorship from me. I faced the choice of declaring my lack of funding up front and potentially lost the informants; or pretending to not be aware of his/her intention, proceed with the interview and only politely turn down the request at the end of the interview. What I chose to do in the end was no different from any other consent procedures I had gone through with other informants, which declared myself as no more than a doctoral research student. Although this did not necessarily eliminate informants' hope for gaining financial assistance, I supposed I myself could not eliminate entirely this possibility (that I would actually become a benefactor one day). To simplify ethical judgement, I eventually adopted a strategy where the decision (to interview or not) was based on not crossing the line where I felt I had manipulated informants' vulnerability. On leaving the field, I was confident about not giving false hope to anybody. Also, until the point of writing (i.e., nearly two years after fieldwork), there was no

[17] Position titles (e.g., the Head of Pharmaceutical Services) were not removed in this thesis. This is done upon consent from the interviewees (see information sheet in the consent form in Appendix II).

[18] A local language that means a 'white person'; the meaning was later expanded to include all non blacks.

research participant demanding withdrawal from the interview and/or seeking financial support from me (I had given every research participant my name card).

On reflection, I was less concerned about reducing harm for myself than for others. In the field, I had experienced extortion, coercion and harassment; though these were limited to only a small fraction of my interactions with the mostly friendly and helpful population. Because there was just nobody who could 'look after' me in the field, decisions concerning personal safety had to depend on quick judgement, sometimes almost an intuition. There was one unforgettable occasion where I had no choice but to stay overnight in a room with two male travellers (one of whom a self declared porn star and another one a brothel visitor!); and on another I was squeezed into a tiny pick-up, together with another 15 hitchhikers, which would have all of us killed if we were not to stop, after severe vomiting from one of the passengers, to find one of the tyres had already punctured. Reflecting back, I certainly will not repeat these acts. However, going through 'native' moments like these gave me a deep sense of life insecurity, experienced daily by people in Malawi. It was a great, but dangerous, lesson. It was impossible to make a health-and-safety decision like how I would do one in Nottingham, because part of me had already 'gone native', i.e. I had felt I should not live differently from all other people around me (so it did not look at all 'dangerous' to me at that moment).

2.3 Research methods

Ethnography is a methodology that uses different methods and tools to achieve its aim. In this section, I will talk about how these methods and tools were employed in the data collection process.

2.3.1 In-depth interviews (individual and group)

As explained in the previous sections about the change in philosophical and theoretical frameworks, the nature of interviewing in the study evolved from a

realist to a discursive model. Instead of treating the interview data as a representation of the local reality, it was used to examine, construct and reproduce (later in writings) a discourse. Very frequently, opposing world views were voiced by informants representing different interests. In these cases, opposing views would be checked by alternative data resources, for example documentary materials, observation and/or interviews with a neutral party.

All interviews were conducted in English. An interview guide was developed prior to fieldwork (see Appendix III). There are two types of interviews in the study: in-depth individual interviews and focus group discussions (FGDs). FGDs were conducted only with the students. Looking back, the questions asked in this guide might not reflect the data presented throughout this thesis. This is because of the evolving nature of this research, as I repeatedly talk about in this chapter. Even the list of informants evolved and branched out into non-health or non-education stakeholders such as the media (see section 2.4.1). What eventually was asked in interviews was based on quick analysis, in the field, from the previous interviews (as well as other ethnographic data). Unavoidably this could not be always a systematic process because of the intensity of fieldwork. Therefore, this process was aided with a constant communication with my supervisory team, including my local supervisor who is a Malawian pharmacist having over 20 years of field experience in the sector[19].

Because of the evolving nature of the research, the number of interviews conducted increased from the pre-planned 30 to 120 (with the number of

[19] My local supervisor, Mr Richman James Mwale, has work experience in various sectors in pharmacy in the country, including community and hospital pharmacy, the professional regulatory body, the ministry, the central medical store, the manufacturing industry and in academia. During fieldwork, I reported my findings to him whenever I gathered enough data for a discussion. Also, he provided me information regarding who I should interview and how I should access these interviewees. The supervision process stopped as soon as I completed my fieldwork. In short, Mr Mwale played an important role in shaping this research though he did not overlook the entire process of the research.

interviewees reaching 145, see Appendix I), by the end of the fieldwork. This posed a huge challenge to transcribing and analysis. All interview recordings were listened to but not all of them were transcribed verbatim. Transcriptions are used in two ways in this thesis: first, in full quotes as evidence to claims made in the thesis; and second, in just one word or one sentence to give a flavour of how the opinions were expressed by the interviewees. In the quotes, words that were emphasised by the interviewee are written in italics; whereas words that were spoken in raised voice are written in capital letters. Meanwhile, some interview recordings are not transcribed because the interviews were conducted as a way to triangulate observation data. Also, many interviews were long, often reaching two or more hours. The reason for having these long interviews was because of the people's enthusiasm in story-telling. To get the 'meat' of the story, I had to wait patiently for the story to ultimately reveal (after enough ice-breaking conversation was done) and that often meant staying long hours for just one interview. As a result, I had to turn into a highly intuitive, superbly organised[20] ethnographer to squeeze in as many as 3-4 long interviews in one single day. Despite the labour, I can confidently claim not even one interview was done for the sake of doing it but because I needed to find out certain things from the interview.

2.3.2 Participation observation

Participant observation provides two pathways to understanding the culture: as both an insider (in participant role) and outsider (in observer role). As explained in section 2.1.1, I was often treated as an aid worker in Malawi, even when I

[20] One important strategy used was establishing rapport before meeting informants face-to-face. By average I emailed each informant twice and made at least one call before the interview. When this failed to get an appointment, I would just show up at informants' workplace to ask for an appointment. In most cases I was given an appointment within a few days (I encountered none of the so-called 'African time' in these cases. Was I being lucky? Perhaps, but I guess African time might most probably be a generalisation!). Negotiating access became much easier and friendlier when I turned up in person than doing it through emails/calls.

declared I was merely a research student. This gave me some insider feel as part of the (aid worker) community in the country. My daily interactions with different contacts (of various backgrounds, as mentioned in section 2.2.1) gave me glimpses into people's feelings and opinions about living in Malawi. Ethical and practical constraints (see section 2.2.4) disallowed me to conduct in-depth, micro-level observation of a small circle of the society at a single site. Instead, my observation had more of a macro nature where I was observant of people's expressed emotions, reactions and concerns. For instance, I made notes of how people displayed guarded behaviour (e.g., by saying 'please do not tell others that I have *xyz*', despite having *xyz* was entirely legal) of their private lives due to fear of inviting jealousy; or how people disapproved of eating scrambled eggs except for breakfast[21] (!). These could be mundane, day-to-day interactions that are actually discursive forming. By capturing these moments, I slowly gained understanding about how people think and act, for instance why many were worried about not living up to the 'British standard'.

There were four types of notes taken: observational (like examples mentioned above), methodological, theoretical and emotional (Gobo, 2008). In methodological notes, I reflected on the way I collected research data (e.g., whether I had put words in the mouth of the informants because of my personal judgement), whether a different method was needed, and who or what else should be included in the data pool. In theoretical notes, I jotted down some theories I used to explain observational data (e.g., colonial legacies to explain the scrambled egg incident). In emotional notes, I reflected on what I personally felt about what I had witnessed and how that could affect data collection and/or analysis processes (e.g., see 2.2.3). All these notes were written up daily in my field notes and stored in a password protected word document in my computer. Although the notes were not literally separated into four different categories, this categorisation provided a mental checklist for what should go into the field

[21] Scrambled eggs are traditionally eaten at breakfast in England. However they can be eaten at other times hence it is not an unbreakable rule to have them outside of breakfast hours.

notes. Because they were stored digitally, relevant data can be retrieved easily by using the 'find' function in word document, hence saving the work to rearrange the notes should it be handwritten.

2.3.3 Documentary materials

Documentary materials are helpful to differentiate facts from opinions. For example, the arguments between the medical council and pharmacy board regarding doctors having dispensing licenses (see section 4.1.1) needed clarification from documents containing the Medical Act and the PMPB Act. Most of the documents were available from official websites. However, it was helpful to acquire these from the officials-in-charge, just in case online materials were not updated (in the case of PMPB Act for example, the document online was outdated). Also, it was more convincing to let the officials point out which documents were actually in use, amidst a sea of different information available online.

There were also some documents that could not be retrieved from the public domain, for instance the salary scale of university lecturers. These documents were usually of a confidential nature; hence I was not always successful in collecting them. For instance, I was refused the document showing how funding was allocated to the College of Medicine. However, in some instances, I was told (verbally) what was in the documents, despite having no access to them. In these cases, I have reported this verbal information rather than presenting the figural evidence. For the list of documents I tried accessing, please refer to Appendix IV.

2.4 The fieldwork

The process to negotiate access to the field site took nine months[22]. The ethics clearance from COMREC finally came on 12th May 2010 and I flew to Malawi two days later. The fieldwork lasted exactly three months and I left Malawi on 13th August 2010.

2.4.1 Sampling

The decision about whom to interview was dependent on how the research had evolved and how new themes and/or theories had unfolded. In the following paragraphs, I will explain why sampling is both 'systematic, non probabalistic' and 'theoretical'.

In the very early phase of the fieldwork, sampling was informed by 'stakeholder consultation' approach (see section 1.3.2). The circle of informants was composed of people considered important stakeholders for pharmacy education in Malawi. The intention was to include all voices in order to represent the interests of all. This was to maximise the generalisability of this research, since the opinions, interests and agendas of every party have been consulted. Although this assumption (about equal representation) was later faulted (see section 5.1.1), the sampling strategy was nonetheless a systematic one, with deliberate effort made to meet (in person) the representative(s) of every stakeholder group. That was why the fieldwork had to be multi-sited: because these representatives were located in different places in the country[23]. Therefore,

[22] A lack of understanding about Malawian work culture certainly played a part in this long wait for a 'yes': I had spent a lot of time waiting for replies through emails until I finally realised phone calls were more effective (and no less official than emails) in contacting people and getting work done.

[23] The issue of 'regionalism' made me particularly wary of regional difference hence had always tested out the same theme throughout different regions. For instance, community pharmacies in three major cities (Blanytre, Lilongwe and Mzuzu) were visited to make sure the discourse was not too dissimilar with each other across different regions.

my sampling strategy can be named 'systematic, non probabalistic'. At the same time, I also collected data from people beyond the initial stakeholder list, because of the development of ideational theories (see section 2.1.2). For instance, I interviewed nongovernmental organisations working in civic education when data analysis told me there was thin democracy in Malawi. This method makes it a 'theoretical' sample (Mays and Pope, 1995).

In other words, sampling strategies again show how this research has attempted to address two different epistemological paradigms: generalisability or representativeness (on the health science end) and empirical-based theory development (on the comparative and international education end). This resulted in a huge expansion to the size of the sample, but it did not necessarily mean I had to stay in the field for longer than planned. The decision about when to stop recruitment depended on two considerations: resources and reasonable doubt (Hammersley, 1992a). Of course it is convenient to declare an abrupt end to data collection when (the very limited) funding (for a PhD fieldwork) has run out. To avoid this, I had learned (very quickly) tricks to save money[24] and thus it was possible to complete all tasks within a small budget. The second consideration about 'reasonable doubt' is about scrutinising research rigour based on 'common sense': has the data collected so far been able to provide a reasonably satisfactory answer to research questions? How many more resources (in terms of money, time, effort) are needed for collecting further data? Will it be too costly? Will the quality of the research be improved if I pursue further threads or if I use the limited time to read, analyse and write?

I finally exited from the site after I felt I had sufficient data to tell a reasonably holistic story, before I was overwhelmed by too much data, and with about MK500 (£2) left in my purse.

[24] For examples, reaching out for friendly help rather than buying services; even if a service is to be bought, going for a non-*mzungu* price; shopping at local markets instead of supermarkets, etc.

2.4.2 Data analysis

What is both enriching and problematic in qualitative data analysis is the use of the human mind (instead of, say, computer software) in doing this process. Although analytical software such as Nvivo provides technical aid to organising data, the ultimate challenge still lies in how to improve the mind's analytical power. In this section, I shall talk about how the mind works (however reductive this could be), as well as techniques supplementing this mental process, to organise and interpret data in this research.

Because the brain does not stop working in the manner that a computer can be switched off, the analysis process invariably takes place from the very first bit of data entry. As mentioned in the sampling strategy in the previous section, analysis worked toward developing theories (hence 'theoretical sampling'). In the field, data analysis was done less systematically: partly registered in the brain, and partly recorded in the theoretical notes. What is worth noting in this process is the painstaking effort paid to 'bracketing' out my past experience. This is a technique advocated by phenomenological-based approach, where 'phenomenological reduction' requires researchers to separate their personal (i.e., subjective) experience and opinions in order not to contaminate what truly comes from the field. However, this technique is suited more for reproducing reality (i.e., through 'thick description') but less for explaining it. More often than not, thick description might leave the readers still with the question 'so what?' because it provides no more than plain copying of the studied phenomenon (Glendinning, 2007). Therefore, the use of this technique was restricted to in-the-field analysis, when transferring what was observed to field notes.

After fieldwork, data analysis was refined by first doing transcribing[25] and 'coding'. Coding means assigning an interpreted meaning to a datum. For example, 'lack of recording for drug stock statuses' was coded as 'lack of monitoring measures'. However, the problem with coding is that every datum

[25] Like mentioned in section 2.3.1, not all interview data was transcribed verbatim.

could be read from many different perspectives, which could then bring in many different theoretical implications. Using the same example, the code developed (above) was based on a governance perspective (where accountability is essential). The same code could also be coded as 'apathy in civil service' if the organisational culture lens is to be used (for it was a norm not to record stock statuses). Alternatively, the code could be 'lack of competence in drug management' if the human resources lens is to be used (for it indicates the lack of skills to manage drug stock). That means a theoretical framework would eventually have to be imposed before a datum can be coded. Here, I came to a typical difficulty encountered by most qualitative researchers: the sequence of data and theory. Does data precede theory, as conventionally argued by grounded theorists? Or do theories invariably precede data, as it is unrealistic to assume ethnographers to enter the field completely theory-free? Although an ethnographic approach favours the former, under its principle of 'analytical induction', what I eventually did was a combination of both. What happened was a series of trial and error with different theoretical lenses, driven by data but also inspired by different theories held by different disciplines, to eventually arrive at a few theories that best explained the data. Because existing theories are good enough to explain the data, there is no 'new' theory emerging from this research. Eventually what is novel about this research is not the excitement of new theory discovery but the creation of a renewed way to interpret the already well-established old theories.

This trial-and-error process was invariably 'messy', involving not only the sorting out of theories but also the sorting out of self, the 'me' who was rooted in one disciplinary paradigm. To impose some sort of 'discipline' amidst such a 'mess',

the coding strategy of grounded theory approach[26] was borrowed, to meticulously scrutinise *every* sentence said, *every* observation made; and thoroughly search through the data set to look for deviant cases. Through such a systematic approach, it was ensured that theorising was truly data driven rather than influenced by what was 'trendy'. This does not mean that this research is insulated from the dominant thinking in the established scholarly circle. After all, what needs to be communicated has to be presented in a language understandable by the circle. Therefore, the end product has always to be equilibrated between data, self and the language.

One unique problem faced by a cross-disciplinary researcher is the difficulty in creating uniform 'axial codes' for all 'open codes'[27]. Because of the epistemological differences, I had to put on different analytical hats when shifting between disciplines. As a result, as the readers will soon find out in subsequent chapters, axial codes were developed in different ways. Here, I shall talk about two major techniques used for developing them: first, a 'mini case studies' approach with each case representing a discursive forming event (or a 'story'). The rationale for doing so was due to the unique nature of the Malawian data, where they are more likely to be narrative in nature (see section 2.3.1 about how informants like to 'tell stories'). The advantage of doing so was to reproduce the discourse in a more accurate way (vs. when the data was separated by individual codes). From each mini case study, meanings were

[26] Grounded theory was first developed by Barney Glaser and Anselm Strauss in the mid-1960s. However, the methodology to use grounded theory was split into two approaches in later years: the 'Glaserian approach' (more for theory generation) and 'Straussian approach' (more for theory verification). Although the overall analytical approach in this research looks more Glaserian than Straussian, certain techniques (e.g., axial coding) in the Straussian approach are useful for guarding against missing out of important codes. For more detailed comparison between these two approaches, see (Grbich, 2007) and (Charmaz, 2008).

[27] Using NVivo analytical software, an 'axial code' is the 'tree code' while an 'open code' is the 'free code'. Nvivo was used in the initial phase of data analysis to assist sorting data into different themes. However, it stops being useful later because, in my opinion, it cannot really do more than sorting.

assigned to people's displayed opinion, behaviour and attitude, akin to symbolic interactionism underpinning grounded theory[28]. Subsequently, theories were inducted from compilation of these meanings and symbols. The second technique applied was 'SWOT analysis', where open codes were organised into axial headings of 'strengths, weaknesses, opportunities and threats'. The purpose of using SWOT analysis was to respond to the interest of the CoM, who wanted to learn the opinions and agendas of other stakeholders; and as a modification to the 'stakeholder analysis' method (see section 5.1.1 for further explanation). Also, it is user-friendly thus enables easy understanding regardless of disciplinary background. With either of these techniques used, the initial development of these axial codes formed the first-layer analysis. A deeper (second, or sometimes third) analysis was then performed to explain first-layer analysis. Most of the deeper analyses will be presented in Chapter 8.

In other words, there is no single methodological label that can fully explain how data was analysed in this research. Rather, several techniques were combined to enhance analytical power, each serving a unique purpose: phenomenological reduction (when interpreting data in the field), grounded theorising aided by cross-disciplinary reading, symbolic interactionist analysis from discursive forming events, SWOT analysis and multi-layered analysis. In fact, whatever labels applied for these processes, what took place the majority of times was,

[28] 'Symbolic interactionism' is a theoretical term developed by the Chicago School of Sociology to provide an epistemology for studying micro-level interactions. The locus for this approach is the 'symbols' adopted by social agents in their interactions with each other. This is based on the assumption that one's action is based on his/her interpretation of how another person should react. Therefore, it is based on such exchanges of symbols that the social reality is constructed. Symbolic interactionism is also the philosophical underpinning of grounded theory, where every datum is dissected to look for its meanings. Indeed, grounded theory had first emerged from the famous ethnography work 'Awareness of Dying' by Strauss and Glaser. The later loosening of the relationship between ethnography and grounded theory is due to the development of grounded theory into a standalone qualitative methodology. Please see (Timmermans and Tavory, 2007) and (Rock, 2001) for more details.

like Fetterman (2010) wrote, simply 'clear thinking' and 'large doses of common sense'.

2.4.3 Rigour of the research

As explained in section 2.2.1, ethnography exercises scientific rigour (vs. non scientific methods such as diaries written by travellers) in the processes of data collection and analysis. In this section, I will look at how questions of 'validity' and 'reliability' are tackled in ethnography and how I came to mobilise them in this study. These two terms were first used in quantitative research, as a means to demonstrate scientific rigour. Later in qualitative research, many qualitative equivalent terms were invented to demonstrate qualitative research was no less meticulous than the quantitative research. For instance, 'trustworthiness' as an equivalent to validity (Golafshani, 2003); and 'multiple coding' as an equivalent to 'inter-rater reliability' (Barbour, 2001), etc. Bryman suggested discussing qualitative research rigour using four criteria: authenticity, credibility, representativeness and meaning (Bryman, 2008). Lincoln and Guba (1985) proposed 'trustworthiness', which should be examined via four criteria: 'credibility', 'transferability', 'dependability' and 'confirmability' (Lincoln and Guba, 1985). Although this section will not delve into each criterion in-depth, a display of these terms is hoped to give a sense of the criteria generally applied to checking the quality of qualitative research. The lack of repeatability[29] in qualitative research makes it important for the researcher to demonstrate that he/she has thought about what could go wrong in data collection process (e.g., mistaking an atypical case as a typical one), what could possibly lead to false interpretation (e.g., claiming theory *x* when it is untrue in reality) and what techniques (e.g., triangulation) should be applied to minimise errors.

In scientific terms, 'validity' means how accurately the research data and analysis represent or measure what is truly going on in reality. This concept emerged

[29] Or what is called 'test-retest reliability' in quantitative terms.

from the assumption of an independent truth, which is the ontological stance of natural science research. However, it does not mean validity cannot be discussed in ethnographic research, though it frequently assumes multiple truths (see section 2.1.1). It could be about how valid it is the ethnographer can claim *one*, out of the many, versions of truth to be. The first question would be how truthful the ethnographer is in telling the story and how accurate his/her interpretation of the reality is. This is usually translated into the questions of 'trustworthiness' or 'credibility'. To demonstrate these qualities, I had made my potential biases explicit by reflecting on subjectivities (in section 2.2.2); as well as diligently presenting evidence before making any claims (pending judgment from the readers!). Of course, this does not eliminate the need for external validation. What is problematic, then, is that the instruments for checking validity are also the (third party) human minds, which are again highly variable. There is simply no one who can claim a nearer access to 'truth' (whatever version that is). Even respondent validation (i.e., verifying findings with research participants) might not necessarily be reliable because, first, they might be too much of an insider to verify a social world so closely lived in; and, secondly, they might have personal agendas to present their version of reality. However, this does not mean all imperfect means should be faulted. With caveats, they can be employed reasonably well, to claim reasonably close representation of the (selected) truth. In this research, a few research participants (whom I assume having no strong personal agenda to withhold truths) have been kept in communication to verify findings. Also, different methods were applied to triangulate findings (see section 2.3). Having no scholarly background in African development, I tested out the findings at conferences targeted at this area (e.g., UKFIET[30] Conference). Feedback from experienced scholars and workers in this area served as a means to judge how valid these findings could be.

[30] Abbreviation for 'UK Forum for International Education and Training', which is concerned about the link between education and development. See www.ukfiet.org for more details.

In quantitative research, validity and reliability are maximised by closing in the gap between sample and population. Therefore, techniques like random sampling and calculating effective sample size are used to claim representativeness. Using the same rationale, qualitative research is often criticised for lacking representative rigour. Like any other qualitative research, I was particularly concerned about missing out an important discourse[31], simply because I could not access all sites and all people. However, because of the unique 'smallness' of Malawi pharmacy sector, this research has managed to come very close to including every perspective possible. Because most decision making power is concentrated in the hands of very few individuals, they are both 'agencies' and (almost) 'structures' of the local reality[32]. By systematic sampling of these power-holding individuals, it gives almost a full picture of the discourses at play in the studied social world. In other words, this research cannot claim absolute generalisability (of that based on quantitative representativeness) but what is called a 'subtle' one[33].

[31] For example, see how the ethnographer in (Magolda, 2000) felt he had missed reading the students' life by having no access to the 'secret' life (e.g., smoking marijuana).

[32] This is an ontological debate commonly found in qualitative research: whether the social world is constructed by micro-level individual acts (i.e., 'agency') or deterministically by macro-level structural trends (i.e., 'structure')? The former is advocated by liberalist thinkers like JS Mill, who believed individuals have freedom to choose their actions and the sum of many of these actions will form the mega-structure. However, this view is contrasted by thinkers like Karl Marx, who thought 'personal freedom' is merely an illusion amidst powerful structures. For instance, an individual's decision to work/study abroad must vary hugely between last century and today, simply because globalisation has made international travel possible and a norm in some societies. This ontological assumption is important to determine a research's epistemology/methodology: if agency-driven social reality is assumed true, the social world should be understood by understanding individuals' acts/behaviours/attitudes and ideas/thoughts/perceptions. On the contrary, it should be from understanding the mega-trends (e.g., globalisation), mode of production, systems, policies. For more discussion, see (Hollis, 1994).

[33] See 'subtle realism' as discussed in (Hammersley, 1992a): p. 69-72.

2.5 Conclusion

There are a few streams I need to cross in this research: disciplinary, contextual, cultural and geographical. What then becomes inevitable is the tension brought by demands from all these different corners. In this chapter, I have explained in detail how this research evolved in its philosophy (by transcending the realist-relativist division), theoretical framework (from materialist to the addition of ideational theories), methods (from realist interviews to ethnography) and disciplinary position (from health science to multiple disciplines). By doing this, it is hoped some understanding can be brought about why this research has to be situated in an unconventional position. Despite not looking 'right' in every direction taken, the way this research is conducted might be argued as creative, adventurous and ambitious to break down disciplinary and methodological territories.

CHAPTER 3

Pharmacist's roles: a literature review and an introduction to Malawi health system

This chapter serves to provide a background understanding of pharmacy as a discipline, as well as pharmacy as a public sector service in Malawi. In section 3.1, literatures that explore pharmacists' roles will be reviewed. In section 3.2, a brief introduction of Malawi's health sector will be made, in particular the public pharmacy sector. Most empirical data in response to issues raised in this chapter will be presented, and discussed, in Chapter 4; and some in Chapter 8.

3.1 What are the pharmacist's roles? A literature review

In this section, literature regarding different perspectives of pharmacist's roles will be reviewed. Literature is derived from research papers published from both developed (particularly the US and the UK) and developing (particularly African) settings.

3.1.1 The structural functionalist perspective

Literature of the structural functionalist perspective views pharmacists as *de facto* medicines experts thus concerns primarily with answering the question 'what': what roles should be played by the pharmacists in accordance with contemporary challenges and changes in medicines development or management? It is particularly keen on discussing pharmacists' 'extended' (i.e., non distributive) health practitioner roles. Because of a wide range of settings (e.g., community, hospital, manufacturing) pharmacists could work in, there are many possible roles and functions yet to be fully embraced. 'New' (or simply new to the field of research and not necessarily new to practice) roles are subjected to cost-effectiveness query to justify offering a new (or not) healthcare provision contract to the profession. This kind of research happens more frequently in secondary care pharmacy, where pharmacists do not fully own professional autonomy over clinical decision [e.g. in antimicrobial dosing (Tonna *et al.*, 2008)]. To single out the contribution from just one profession, amidst care provided by a multi-disciplinary team, is difficult and often has to depend on process indicators, for example reduction in medication errors and adherence to practice

guidelines. Therefore process indicators are widely accepted as the primary outcomes in research measuring pharmacists' contribution [e.g., the PINCER trial which examined cost-effectiveness of pharmacist-led IT intervention for reducing medication errors, see (Avery *et al.*, 2012)]. Evidence in this area is so far optimistic about inviting greater roles from the pharmacists (Schumock *et al.*, 2003), despite issues about inter-professional territorial encroachment (see section 3.1.5).

In the primary care setting, most pharmacy services to the public are provided through a community or retail pharmacy setting. Working fairly independently from other professions, community pharmacists can assume a leading role in clinical services like medicine use reviews (MURs) (Bryant *et al.*, 2009; Latif, Pollock and Boardman, 2011), supplementary prescribing (Stewart *et al.*, 2011; Gilbert, 1998a; Cooper *et al.*, 2008) and pharmacist-led clinics [e.g., chronic pain clinic (Briggs *et al.*, 2008)] or point of care testing services [e.g., lipid and anticoagulant monitoring services (Evans and Officer, 2011)]. However, it has been difficult for pharmacists to justify charging for these services[34] because of the traditional image community pharmacies have as medicines 'shops' (Hughes and McCann, 2003). Indeed, pharmacists spend a major proportion of their working hours on dispensing[35]. This is understandable in view of how dispensing has been becoming the most important source of income over the past century (see Figure 3-1). After decades fighting to expand its role into non-distributive (or non dispensing) areas, the profession faces scepticism regarding its competency, as well as intention, to do so. Only very recently, MUR service was labelled as a

[34] Charges may be paid by patients (out of the pocket), health insurance schemes or government health funding.

[35] According to a total of 12,306 observations carried out at community pharmacies in London, pharmacist spent 25.48%, (SD 10.97) of their time on assembling and labelling of products and prescription; 11.87% (SD 6.91) on monitoring and appropriateness; 11.24% (SD 7.10) on rest, waiting and breaks; 6.64% (SD 4.40) on counselling non prescription medicines; 4.24% (SD 2.12) on counselling prescription medicines; 5% on providing clinical services; and 8.2% (SD 4.26) on endorsing prescriptions and health related clerical work (Davies, Taylor and Barber, 2012)

'wasteful subsidy' by the UK Taxpayers' Alliance in a paper released on 20th April 2012 (Tax Payers Alliance, 2012). This was soon refuted by the Pharmacy spokesperson from the Department of Health, who said the research conducted was "insubstantial, out of date and utterly misleading" (pjonline, 2012). Indeed, how to marry a professional service with a business is a century-old question for community pharmacists. To investigate the possibility to do so, different types of studies have been carried out. However, 'randomised controlled trials' (RCTs) are regarded, within the circles of health sciences, as the most reliable in providing evidence to this question. One example of such RCTs is the 'MEDMAN Study', which investigated the cost-effectiveness in having community pharmacy to lead medicines management for patients with coronary heart disease (The Community Pharmacy Medicines Management Project Evaluation Team, 2007). Another one is the on-going evaluation of the 'new medicine service' commissioned by the Department of Health for England (NHS Employers, 2012).

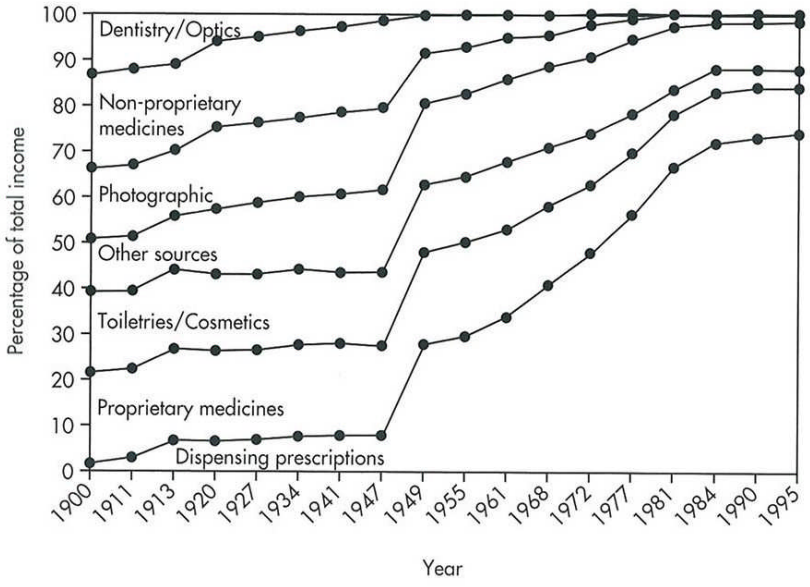

Figure 3-1. Sources of income of community pharmacists in Britain, from 1900 to 1995.

Figure is taken from (Anderson, 2005).

Whilst pharmacists' clinical roles are often challenged about their 'usefulness', so much so it requires large scale RCTs, their roles in public health seem to gain more approval. Community pharmacies are deemed suitable sites for carrying

out public health measures like vaccination (Steyer *et al.*, 2004; Sokos, 2005), prevention and treatment of culturally sensitive health issues like sexually transmitted diseases (Leiva *et al.*, 2001; Chalker *et al.*, 2000; Viberg *et al.*, 2007), contraception or family planning (Wells *et al.*, 1998), needle exchange and methadone treatment for drug addicts (Roberts *et al.*, 1998), pharmaco-vigilance or drug safety monitoring (van Grootheest and de Jong-van den Berg, 2005), etc. In poorer countries, where government health facilities are underfunded to provide all services and/or understaffed to provide health education to the public, community pharmacies can play a gap-filling role (Smith, 2009).

Meanwhile, pharmacists' role in the manufacturing industry is subjected to lesser enquiries. Although legislation in most countries requires licensed pharmacists to become plant managers and/or in-charge of overall production and procurement, it is a common practice to hire non-pharmacist scientists (e.g., chemists) at manufacturing plants. Even so, the industry did express its concern about the lesser content of pharmaceutical science taught in new pharmacy degree programmes, because this knowledge is pertinent to the development of pharmaceutical industry (Broedel-Zaugg, Kisor and Sullivan, 2003). However, this issue has not received as much attention as issues concerning pharmacists in the clinical setting, probably because most pharmacists work in the latter setting. According to a global pharmacy workforce survey conducted in 2009, 58% of pharmacists worldwide worked in retail community setting, 12% in hospital setting, 12% in the industry, 4% in research and 4% in regulation; though variation exists between regions and between countries (Wuliji, 2009).

3.1.2 The notion of competence (or competency)

Pharmacists' roles can be highly variable across different settings and geographical locations. Whilst pharmacists in the UK earn a major income from filling prescriptions, their counterparts in Malaysia do not even own dispensing

rights[36]. The distinction between pharmacists and pharmacy technicians too can vary between countries, depending on resources and education structures. Although clinical roles are desired for the purpose of professionalisation (see 3.1.5 for meaning of professionalisation), and may appear as a favourable trend if one reads only literature written in English, it does not necessarily happen in all countries. Pharmacists in China, for example, do no more than dispensing and selling medications because of the way 'professions'[37] are governed. Countries have different laws governing the activities of medicines management, for instance community pharmacies must be operated in the presence of licensed pharmacists in most but not all countries (e.g., a pharmacy diploma holder can run a pharmacy in India; and in Mexico no pharmacy qualification is needed). Although there is no intention to harmonise pharmacists' roles, there seems to be emerging interest in harmonising pharmacists' 'competence' and/or 'competencies'[38]. In fact, the need for harmonisation arises particularly in recent years, following on three forces: first, a higher public demand for professional accountability (i.e., professionals have to continuously prove themselves competent in their jobs). Second, the creation of shared communication platforms for pharmacists worldwide through organisations like the FIP (International Pharmaceutical Federation) and the CPA (Commonwealth Pharmaceutical Association), which often act as the catalyst to harmonisation. Third, increasing workforce mobility particularly in recent decades where international migration is encouraged by cheaper transportation and growing income gap between rich and poor nations.

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[36] Prescribing and dispensing are not separated in Malaysia. Therefore, doctors can dispense medications from their private practices.

[37] 'Profession' is written in inverted commas because in China, the concept of 'profession' has yet to be fully developed. The division of labour is state prescribed, instead of driven by the professions like what happened in a more democratic setting.

[38] These two terms are used interchangeably but if a variation is to be imposed, 'competence' refers to the ability to perform certain tasks whereas 'competency' refers to the doer's attitudes or attributes to do so. In other words, 'competence' is task-oriented and 'competency' is person-orientated.

The subsequent adoption of the 'competence' notion in pharmacy has so far been welcomed with much enthusiasm within the profession. It provides convenient solutions to education, training and employment, where their outcomes and criteria become targetable and measurable. With this, it ushered in a plethora of research papers about *what* competence should be fitted into the professional arena [e.g. (Nimmo and Holland, 1999)]. Indeed, similar optimism is shared by other health professions, for instance in medicine (Good, 1998; Holmboe and Hawkins, 1998; Rodgers *et al.*, 2000; Maudsley and Strivens, 2000) and nursing (Cowan *et al.*, 2008; Cowin *et al.*, 2008)]. Competence-based guidelines are drawn up to guide undergraduate training[39], residencies, employment[40], on-the-job training[41] and continual professional education[42]. This sparks enthusiasm to harmonise competence frameworks at a regional [e.g, in Southern and Eastern African countries (WHO Department of Essential Drugs and Medicines Policy, 2002)] or even a global [e.g., (Bruno, 2011)] scale.

Despite a strong faith displayed by the practice sector, the notion of competence has actually been viewed with much scepticism in the field of educational studies. It is argued to have reduced education and learning into a string of acquirable attributes constituting of knowledge, skill and attitude. This 'KSA model' is accused of dissociating learners from the work or study context (Sandberg and Pinnington, 2009), by making learning a tick-box exercise. Despite its popularity, this model has been questioned for its ability to actually dispense employability (McGrath *et al.*, 2010), economic performance and social cohesion (Lloyd and Payne, 2003). Within the confine of this thesis the critique of competence cannot

[39] For example, ACCP (American College of Clinical Pharmacy) commissioned research to identify core competencies for PharmD programmes, see (Jungnickel *et al.*, 2009); or a specific teaching module like geriatric therapy, see (Odegard *et al.*, 2007).

[40] For example, ACCP White Paper on clinical pharmacists competencies, see (Burke *et al.*, 2008).

[41] For example, as a tool to help community pharmacists provide pharmaceutical care to elderly ambulatory patients in Alberta, see (Kassam *et al.*, 1999).

[42] For example, the competency-based general level framework used as an educational tool for Croatian community pharmacists, see (Meštrović *et al.*, 2012).

be elaborated at length[43], but it suffices to say similar concerns have surfaced in medicine, in which there is fear of 'signing off' students with a 'criterion-referenced' teaching/learning method. Similar concerns are raised in nursing education, where attributes like empathy and care might risk devaluation to more measurable, task-oriented competence (Chapman, 1999; McAllister, 1998). However, such critique has yet to be found in pharmacy education literature.

3.1.3 The notion of skills and cadres

Whilst the notion of competence seems to spring from profession-related literature, it does share similar concerns with the notion of 'skills', which is found more commonly in vocation-related literature. However, it will be unwise to draw a professional-nonprofessional distinction between these two notions, because both actually share the same working principle: i.e., the KSA model (as explained in 3.1.2). The skills notion was created to provide measurable, trainable blocks of knowledge for vocational education, in order to increase students' employability. However, later employability started to include non-technical 'skills' such as teamwork, leadership, etc. As a result, the notion of skills has been expanded to include interpersonal and transferable skills; and in some cases even personalities and emotional intelligence (Payne, 2000). This definitional expansion makes almost all things, even personal traits, possible to acquire through training, or in the context of this research, 'capacity building'.

The reason for bringing in the skills notion, in the discussion about pharmacists' roles, is because of the increasing tendency to treat health professionals as 'human capital' for health, a phenomenon similar to how students of vocational education are often treated as human capital for a country's economic development. 'Human capital' is an economically convenient planning tool for linking education with practice needs. In the health sector, the country may train only the minimum skills required for health service, when resources are limited.

[43] For further reading about the limits of competence, please see (Barnett, 1994).

By labelling each cadre with skills it owns, division of labour is prescribed by matching skills owned with skills required in certain health services. In this case, tasks that are traditionally performed by a higher cadre can be 'shifted' to a lower one[44], should the latter demonstrates sufficient skills to do so. In many countries with critical shortages in the professional cadres, 'task-shifting' is thought to offer a timely solution. In fact, the is an obsession in skills optimisation, where the 'right' cadres should be trained with the 'right' skills to deliver the 'right' services to the 'right' population at the 'right' time and 'right' place (Birch, 2002). This leads to practical strategies called 'skill mix' and 'cadre mix', which allows flexibility in employing a mixed cadre for services requiring different levels of skills. In many SSA countries, task-shifting and skill or cadre mix is highly popular, and in fact has been traditionally practised in some countries. Compared with the professional cadres, the mid-level cadres are thought to bring three advantages: first, higher cost-effectiveness due to lower costs for training and employment. Shorter training duration also allows a faster scale-up in human resource. Second, better workforce sustainability is ensured because of higher in-country (and rural) retention rate. Third, public access to healthcare provision becomes more equitable because of their larger number (Dovlo, 2004; Lehmann *et al.*, 2009). To encourage countries short of HRH to adopt task-shifting, the WHO has commissioned a study which then come up with 22 recommendations. One of those recommendations said "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" (World Health Organisation, 2008a), reflecting very well the current trend to capitalise on competency or skills to provide the currency for 'needs-based' (see section 3.1.3) services.

[44] Interchangeable terms used for non-professional cadres are: 'middle cadres', 'mid-level cadres' and 'substitute cadres'.

This pool of literature is focused on maximising the 'skills-needs' match. The role of a health worker cadre, then, is investigated by matching its skills to health service needs. Therefore, research is often interested in finding out whether a mid-level cadre is equally skilled as the professional cadre. For example, studies showed a similar success rate in surgeries carried out by clinical officers, who are technician equivalents to surgeons (Chilopora *et al.*, 2007; Hounton *et al.*, 2009). Although task-shifting receives the highest attention in resource-poor settings, it has also started to be adopted in health planning in more advanced countries, where health costs are escalating. For instance, the creation of the (non-nurse) 'Health Care Assistants'[45] cadre in nursing in Britain (Francis and Humphreys, 1999). However, there are caveats to treating the mid-level cadres as the magic pills for cost savings. Despite evidence of their advantage to the professional cadres, it is not to assume they could be employed to do more but be paid less (McAuliffe *et al.*, 2009). It could result in a de-motivated workforce, which might affect performance and eventually lead to attrition (Bradley and McAuliffe, 2009). However, this critique seems to be overshadowed by the enthusiasm, in both academic literature and in policy papers.

3.1.4 The rise of the 'needs-based' notion

It must be mentioned here that the trend to scale up the mid-level cadre comes from not only the task-shifting formula, but also from a longstanding belief in the values of primary care. In 1978, the signing of the Declaration of Alma Ata signified a landmark shift from secondary and tertiary care to primary healthcare and public health. Followed by a string of WHO country guidelines which

[45] It is argued that this cadre has a role not dissimilar to the 'Enrolled Nurse' cadre, which was phased out in late 1980s to make 'Registered Nurse' cadre the only mid-level cadre available in the nursing profession. Today, new worries emerged on whether these Health Care Assistants have actually threatened to replace the 'care' role supposedly carried out by nurses.

endorsed the importance of primary healthcare and public health[46], there was a massive uptake of workers from the lower health cadres into public health services, particularly in resource-poor countries. At the same time, the emergence of the concept of 'essential medicines' attracted widespread concern regarding the lack of accessibility to even simple life-saving medicines. Equating this to the abuse of human rights, provision of basic healthcare services (including essential medicines) to all is increasingly being seen as serving a social justice function. This is further propelled by growing evidence (e.g., the MDG reports, see section 1.1.1) showing huge health and income gaps between countries, or between rural and urban areas within countries. The need to correct this inequality is enhanced with not only a sense for justice, but also the fear of global security since the beginning of the 1980s, when HIV/AIDS was first discovered. The global players' anxiety in curbing the spread of this deadly disease has resulted in decades of interference (or even dominance) in domestic governance of many aid-dependent countries, which often have the highest disease burden. Donors' favoured option for a 'step-wise', centrally planned HRH development model has greatly influence HRH policies in these aid-dependent countries. According to this model, the creation of HRH must be started from the lowest cadre (though a small number of the higher cadre workers will still be trained for supervision and management purposes), before expansion of the higher cadres is made (see Box 3-1 for an example). In most cases, donors are most interested to fund the scale-up of the 'basic' cadres[47]. Amongst these basic cadres, the community care workers are most favoured due to their close proximity to the majority rural population. The unexpected outcomes, which are not often reported, are the changing nature of community care workers' 'basic' work nature. Today, CCWs have many roles, including health education, surveillance, preventive care (e.g., vaccination) to minor diseases detection,

[46] For example, "the World Health Report 2008 – Primary Health Care (Now More than Ever)", numerous reports/guidelines on social determinants of health stressing the importance of public health measures, see (WHO, 2008).

[47] Reasons of this preference are the same with reasons for 'task-shifting', as discussed in section 3.1.3.

referral or even treatment. In a way, they actually play the roles of health counsellors, nurses, pharmacists and doctors to the local communities.

Step	*All people should have:*
1	Access to community health care worker with appropriate pharmaceutical training
2	Access to a person trained to a higher level than a community health care worker
3	Access to a qualified pharmacy technician with appropriate training
4	Access to a qualified pharmacy technician working under the direct supervision of a pharmacist
5	Direct access to a pharmacist

Box 3-1. Stepwise implementation of access to pharmacy personnel.

Adapted from (International Pharmaceutical Federation, 1997).

Nevertheless, this is not to dispute the logic of the prioritising the basic needs, but to provide a more comprehensive understanding of the underlying motivation for advocating the 'needs-based' roles for health workers in resource-poor countries. It is important to realise how the notion of 'needs-based' is conceptually situated in the health science paradigm, which has its evidence base rooted in systematic identification of needs (see section 1.3.1). What is central to the enquiry within this paradigm is the accuracy of identifying the 'right' health needs. Therefore much emphasis is placed on increasing the validity and representativeness of the methods used to assess health needs. To achieve this, a collective of research methods are used for the purpose of 'triangulation' [e.g. four methods used in (Murray and Graham, 1995)]. However, qualitative methods are mostly used to confirm quantitative findings (e.g., by providing interview quotes to give a real-life flavour to survey results) rather than to provide critique and exploration. What I am attempting to point out here is how the 'needs-based' notion has come from a science paradigm, which operates value- and politics-free. It is not to say a scientific approach is wrong, but it certainly results in limitation in conceptualising 'needs-based' in the value- and politics-laden reality. It is no doubt that disease burden is high and healthcare capacity is low in many resource-poor countries hence justifying a scientific solution by identifying the most essential needs. However, in reality the

agendas at play are often more complicated than simply saving lives by identifying the right needs.

3.1.5 The territorial debates

A sociological approach to studying pharmacists' role often deals with the issues of inter-professional territory. The change in pharmacists' roles, therefore, is dependent on whether the professional territory has expanded or constricted. Professional roles are created, maintained or extended by processes called 'professionalisation'; they can also be replaced, diminished or restricted by the opposite force called 'de-professionalisation'. The study of professionalism first adopted a 'taxonomic approach', which propose a checklist of traits upon which occupations can be segregated into professional and non-professional (Klegon, 1978). Amongst the main criteria for an occupation to become professional are: specialist and exclusive knowledge (to be acquired through), lengthy training, altruistic service for public good, self-regulating autonomy[48] and monopoly over practice[49] (Parsons, 1939). Based on these criteria the most traditional professions are law, the clergy and medicine.

However, these checklists were soon proven to be too ambiguous and inadequate to explain professionalism and the process of professionalisation. Rather than assuming some occupations to be inherently professional (whilst others not), sociologists started to ask why and how certain occupations gain social recognition for their professional statuses. So far, three forms of professionalisation are identified from the literature. The first one is elites-driven professionalisation. This happened in societies with elitist government like England, a system that escapes revolution despite all other forces of modernisation. Professions are legitimised by a royal charter (hence the titles of

[48] Professional bodies are entrusted by their clientele to curtail membership (e.g., through licensure), enact their own codes of ethical conducts and education/training processes.

[49] It means what the profession wants to do with its practice is not controlled by other groups.

'Royal', e.g. the Royal Pharmaceutical Society); and enjoy a high level of autonomy in dictating qualifications, licensure and codes of ethics. This model maintains the legacy of the 'trait theory' (as advocated by Parsons), where its exclusivity is justified by the ideals of professionalism (Siegrist, 1994). However, this model describes how professions in England, typically medicine and law, were created. Certainly, nowadays the professions cannot operate in vacuum of state intervention, not unlike those experienced by the 'American model' (see below), though still relatively more elitist.

Second, professionalisation in response to what is needed by the society an occupation serves. It happened mostly in post-revolutionary societies like in America, where things are built up in a liberal-democratic process. Wilensky explained this process in a five step-wise approach: (1) turning a service into a full-time commitment, following higher demand for the service; (2) establishing education or training institutions to master skills and knowledge required for provision of this full-time service; (3) establishing professional bodies, as a 'soul-searching' endeavour to define professionalism; (4) seeking legal protection for occupational boundaries; and (5) consolidating all these processes into an officially recognised codes of ethical conducts, which also function as a seal of professionalism for the occupation (Wilensky, 1964). In this process, the members of the professions have to continually justify why their professional service is needed for public good; and why this service is distinct from services provided by other groups. In other words, they have to constantly innovate to gain public confidence, thereby retaining the legitimacy of the profession (Campbell, 1983; Turner, 1985). Termed as 'social collective mobility', professionalisation collectively move the members of the professions up the social ladder (Larson, 1979). Indeed, the history of professionalisation of several health professions tells stories of hard earned public trust (James and Willis, 2001; Bondi, 2004) – some even did it with false claims e.g. in dentistry (Richards, 1968). Professionalisation, in this case, is a constant effort to re-appraise and re-define professional roles amidst threats of de-professionalisation.

So far, the first and second forms of professionalisation follow a bottom-up approach. The third form of professionalisation uses a top-down approach, which is (awkwardly[50]) called the 'professionalisation from above'. In this case, professions are created by the state apparatus, in countries like Germany (Neal and Morgan, 2000). However, these three forms of professionalisation do not necessarily happen in isolation from each other. With professional services becoming a major part of the civil service, the idea of having professions evolve independently from the state seem remotely applicable in present day. Whilst the bureaucratisation of professional services can be seen as a threat of de-professionalisation (Southon and Braithwaite, 1998), it can also be seen as a merger between professionalism and public administration to increase 'bureaucratic responsiveness', by injecting civil service a sense of professional responsibility (Kearney and Sinha, 1988).

To apply these concepts in the language of pharmacists' roles, the question then becomes the negotiation of roles between the interests and agendas of the public, the pharmacy profession, other health professions or occupations and the state. The first threat to the professional territory came from industrialisation, where medicines compounding (traditionally done by pharmacists) was replaced by mass produced medicines. With its exclusive body of knowledge (in compounding) made redundant, pharmacist's professional status has been questioned. It has been labelled as an 'incomplete' (Dingwall and Wilson, 1995), 'marginal' (McCormack, 1956), 'limited' or 'quasi' profession. For decades, pharmacists have been striving for (re)-professionalisation by breaking through this conventional distributive role, which was tied to medicines compounding. One of the major professionalisation strategies is the initiation of clinical pharmacy or pharmaceutical care, which takes the form of consultation rather than mere dispensing of drugs (Holloway, Jewson and Mason, 1986). However, such effort has often been retaliated by other health professions, particularly

[50] It is awkward (to label as 'professionalisation') because 'profession' or 'professionalisation' is not a viable concept in certain settings outside of the Anglo-American context.

from the medical profession. Termed as 'medical hegemony', the medical profession is often accused by non-medical professions (like nursing and pharmacy) to exercise power control over the latter. For decades, pharmacists and doctors seem not able to break loose from the prescribing/dispensing rights disputes, with each accusing the other profession encroaching on respective professional boundaries (Gail Eaton, 1979; Mesler, 1991). Although in very few cases pharmacists did win a legal contract to do more than dispensing and counselling[51], in most cases pharmacists are seen to be subordinate to doctors. Pharmacists' professional autonomy is highly restricted by their medical counterparts, either politically, economically or clinically.

Apart from technology and clinicians, the profession's territory is increasingly being challenged by new actors in health services. With attractive profit margins, the drug supply chain has lured many non-health partners into the scene. There is increasing number of internet pharmacies, alongside wider use of online purchasing, which makes visiting pharmacy premises less necessary. The easier accessibility to information on the internet also means customers are better informed, though not necessarily by the evidence-based information. Facing fiercer business competition and self-researched customers, pharmacists have to re-define roles areas to justify both professional and business agendas. It has been a longstanding debate regarding whether a pharmacist should have a professional or a business role orientation (McCormack, 1956; Chappell and Barnes, 1984; Resnik, Ranelli and Resnik, 2000). Some would seek shelter in small-scale businesses (hence excused from being overtly business oriented); however the chance to run independent pharmacies has gradually been eroded by the expansion of large chain pharmacies.

[51] For example, pharmacists can practise prescribing in rural, under-served areas in South Africa (Gilbert, 1998b); also, pharmacists who have gone through special training can practise supplementary prescribing in the UK.

At the same time, continued advancement in technologies provided automation to relieve pharmacists from menial tasks. Automatic medication dispensing devices were found to be not only labour saving, but also better (than human dispensing) in preventing medication errors (Schwarz and Brodowy, 1995; Franklin *et al.*, 2008). However, these advantages may be mitigated by other new problems. In one of the most recent publications, electronic prescription service (EPS)[52] was found to both enhance and inhibit professionalisation at the same time. Whilst being freed from manual tasks (e.g., of typing prescriptions), pharmacists are challenged with uncertainties created by these virtual transactions (e.g., from missing electronic prescriptions). The increased visibility of professional tasks also encouraged the growth of internet pharmacy, as well as wholesalers or distribution-based businesses, which further threatens the survival of small independent pharmacies (Petrakaki, Barber and Waring, 2012). In another case, the creation of clinical decision-support tools may also change the way health professionals work. Studies found favourable outcomes when using these tools in certain cases (e.g., drug dosing) but not in all (e.g., not good in diagnosing) clinical tasks. The impact of using this application on patient outcomes is so far unclear (Garg Ax and et al., 2005), hence posing an ethical challenge to relying on computer software to make clinical decisions (Miller and Goodman, 1998). The alienation of health practitioners from patient contact challenges the notion of professionalism, should the 'care' aspect of health be reduced by computation. In fact, apart from computation, there have been concerns about further alienation created by mounting paper work (Mason, 1999). Clinical guidelines, care plans, and many quality control measures are greatly influencing the way health professionals work nowadays. In other words, technology is most probably a two-edged sword requiring the profession to constantly re-define its roles.

Whilst new technologies are changing the pharmacists' roles, their roles in the use of traditional and/or complementary alternative medicines (T/CAM) remain

[52] Officially implemented by the NHS (UK) from Feb 2005.

unclear. The use of T/CAM is high not only in settings with a rural majority, but also increasingly higher in urbanised settings. For instance, nearly 30% of the population in the US (Ni, Simile and Hardy, 2002) and 70% in Australia (Xue *et al.*, 2007) use at least one form of CAM. Drug-herb and drug-T/CAM interactions are commonly suspected but under-researched. This leaves pharmacists in an ambiguous position regarding their scope of professional responsibilities. Another inhibitive factor to pharmacists assuming greater roles in T/CAM may come from traditional health practitioners, who resist interference from orthodox medicine practitioners.

3.2 Pharmaceutical service in Malawi

In this section, I will seek to provide concise information about Malawi's public health sector, with more detailed description given to the pharmacy service. The purpose is to give an idea about how the organisational and administrative structure looks like; as well as what the main agendas are.

3.2.1 Healthcare provision in Malawi

There are three types of health care providers in Malawi: the Ministry of Health (MoH), Christian Health Association of Malawi (CHAM)[53] and private for-profit providers (see Table 3-1). Government taxation revenue funds MoH hospitals and staff salaries working in CHAM hospitals. Other expenses in CHAM hospitals were supported by charging user fees, and from church or overseas donations (Banda and Simukonda, 1994). The faith-based health provider has a long history of serving in rural areas unreachable by government facilities, which explains its role as an important player in Malawi's health sector. As late as the mid-1980s, all private hospital beds were provided by CHAM and none from the private for-profit hospitals (Hanson and Berman, 1998). Today, private for-profit health facilities are used by only the richest of the population who could afford private

[53] The umbrella body that oversees all faith-based health facilities in the country.

health insurance[54]. Although low fees are charged at CHAM facilities, some services under the Essential Health Care Packages (EHP, see last paragraph of this subsection) are provided free at the point of delivery, under Service Level Agreements with the MoH (UNAIDS, 2008).

Provision sector	***Service provider***	***Payment***	***Percentage of population using the service[55]***
Public	The Ministry of Health (MoH)	Free of charge	60%
Private not-for-profit	Christian Health Association of Malawi (CHAM)	Small fee[56]	30%
Private for-profit	Private providers	Private health insurance	10%

Table 3-1. Healthcare provision in Malawi.

There are five levels of healthcare facilities in Malawi (see Figure 3-2), with the higher levels serving as referral facilities for the next lower levels. Apart from providing health services, the central hospitals also serve as teaching hospitals for universities and colleges. District health offices hold important policy making and execution power because of the decentralisation policy. Health centres provide basic health services to the local population and are managed by medical officers and clinical assistants. At community level, outreach activities are provided by mobile health posts and health surveillance assistants.

However, the supervision structure has a different hierarchy than that of facility hierarchy (see Figure 3-3). Whilst MoH Headquarters and the Zonal Offices overlook all services, the District Health Management Teams (DHMTs) assume

[54] The largest and most popular private health insurance company, up to the time of writing, is MASM or the Medical Aid Society of Malawi.

[55] There is no current figure regarding patient choice of facilities however these results from a 1991 survey probably still hold true (Forshaw, 1991).

[56] For example, medical consultation fees charged by Ekwendeni Mission Hospital: MK1000 (about £4) for adults, MK100 (40p) for children and MK50 (20p) for under-5s.

the supervisory role of all frontline services[57]. However, the Zonal Offices' role is still ambiguous because they are a replacement to the older system of 'Regional Office'[58], and are still developing their role in supervising the DHMTs. Therefore, in practice the DHMTs have more power than the hierarchical structure suggests. It is important to understand this difference when it comes to interpret the data (in Chapter 4), where there was a competition (between pharmacists and doctors) to assume a leading role in DHMT but not at the Zonal Offices or MoH Headquarters.

However, to what extent the DHMT has its power devolved from the central government is unclear. Although the 'Decentralisation Policy'[59] was introduced by the newly elected government in 1994[60], in response to their pledge to exercise the 'principles of participatory democracy', in reality the process of decentralisation was a long and difficult one. The central government was criticised of not having real intention to share power, notwithstanding their inherit lack of resources (Meinhardt, Patel and Konrad-Adenauer-Stiftung, 2003). According to the Malawi Health Equity Network, a NGO watchdog reviewing the

[57] Apart from central hospitals, which are directly supervised by the MoH.

[58] According to a trainer for drug supply chain in Malawi, it was upon donors' request that the three Regional Offices were scrapped and replaced with five Zonal Offices. Therefore, the zonal division has yet to be fully understood by the Malawi system, which operates according to regions.

[59] Under the Local Government Act 1999, District Assemblies are assigned with functions to "provide, maintain, equip and manage either alone or jointly with another Assembly or body, clinics including maternity clinics, health centres, and dispensaries"; and to "employ such medical professional and ancillary staff as may be required".

[60] Malawi had its first multi-party election in 1994, after 30 years of autocratic rule by Dr. Kamuzu Hastings Banda. Dr. Banda was defeated in the election and the new government was greeted with high hope as promising to restore personal freedom, which was highly restricted during Banda's rule. The Decentralisation Policy was developed as one of the pro-democracy policies. However, one must also be aware of how 'democracy' is part of the good governance agenda expounded by the donors. In fact, the 1994 election was held following pressure from donors to do so.

MoH, more than half of the health budget was held by Headquarters, leaving the service facilities severely under-funded (see Figure 3-4).

Figure 3-2. Hierarchy of public health facility referral system in Malawi[61].

HSA: Health Surveillance Assistant.

[61] In the past, there was a layer called 'Special Hospitals', which provide specialised care for certain diseases such as leprosy, tuberculosis and mental diseases. However, leprosy and tuberculosis treatment had already been incorporated into tertiary care at Central Hospitals. There are only two psychiatric hospitals at present that can be categorised as Special Hospitals.

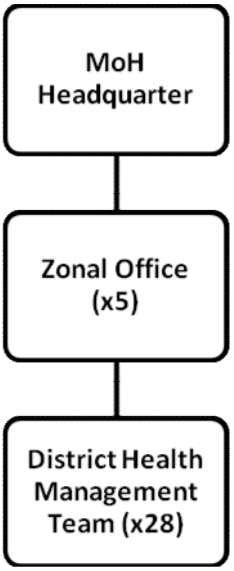


Figure 3-3. Supervisory structure in public health facilities in Malawi

(in brackets number of offices or work teams).

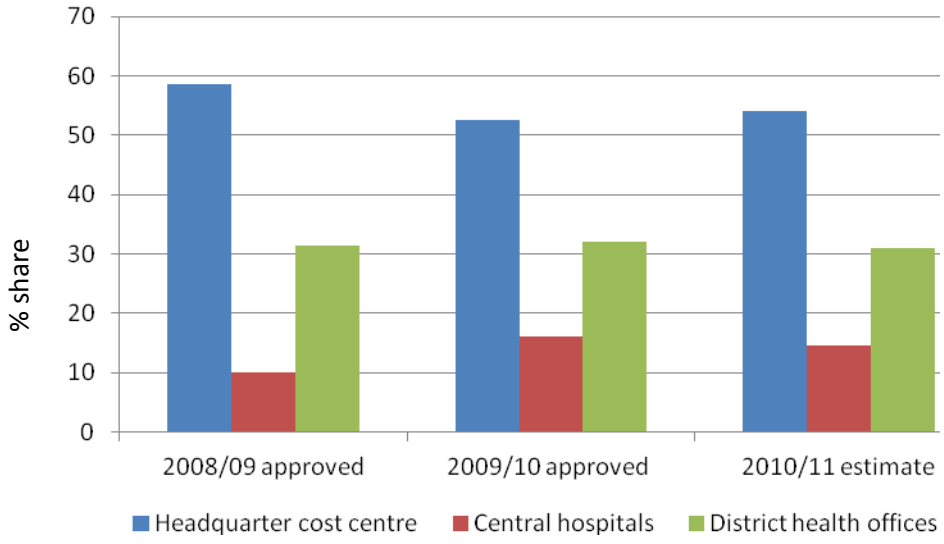


Figure 3-4. Health budget distribution across MoH headquarter, central hospitals and district health offices.

Figure adapted from (Malawi Health Equity Network, 2010).

There were altogether 477 health facilities (see Table 3-2). Four central hospitals are distributed over three regions: one in the northern region (Mzuzu); one in the central region (Lilongwe); and two in southern region (Blantyre and Zomba). Although there are 28 districts in Malawi, there are only 24 District Hospitals. Four districts have no district hospitals: Blantyre, Lilongwe, Likoma and Neno

(see Malawi map in Appendix V). The lack of primary health facilities in highly populated cities like Blantyre and Lilongwe resulted in patients seeking primary healthcare at the central hospitals (which should function only as tertiary facilities). Also, some patients from other districts preferred to visit central hospitals directly because of poor access and/or services provided by the lower level facilities. Such bypassing of referral system often resulted in patient overcrowding and overstretched resources at the central hospitals (Banda and Simukonda, 1994).

	Central Hospital	District Hospital	Health Centre	Dispen-sary	Mater-nity	Rural Hospital	Mental Hospital
Northern Region	1	5	68	9	1	11	1
Central Region	1	8	125	19	4	16	0
Southern Region	2	11	135	40	11	8	1
National Total	4	24	328	68	16	35	2

Table 3-2. Public health facilities distributed over three regions in Malawi.

Adapted from (Government of Malawi, 2011).

Because of scarce resources, the MoH initiated the Essential Health Packages (EHPs) in 2002 to prioritise delivery of eleven selective health services (see Box 3-2), which were thought to generate the best 'value for money'. This forms part of the Malawi 'Poverty Reduction Strategy' (PRS)[62], hence targeting diseases that most affect the poor. As the WHO technical group argued, EHPs are expected to achieve "improved efficiency; equity; political empowerment, accountability, and altogether more effective care". EHPs formed the basis for service delivery in the National Health Plan (which is called 'The Programme of Work') 2004-2010. The idea was to provide only the most *basic* services, at a cost of USD17.53 per capita and delivered free-of-charge (Government of Malawi, 2004). This was achieved,

[62] It must be noted that PRS is a policy replacing the structural adjustment policies (SAP). Although PRS is argued, by the World Bank, to invite country ownership, it is said to have largely maintained the legacies of SPA.

partly, by employing the most 'cost-effective' cadres for service delivery, through 'task-shifting' (see Chapter 4). As much as it looked logical and practical, follow-up investigations revealed the delivery of EHPs could not be shielded from structural problems (e.g., shortages in HRH and essential drugs) in the wider health system (Mueller *et al.*, 2011).

Essential health package components:

- Control and management of vaccine preventable diseases.
- Malaria prevention and treatment.
- Reproductive health services (including family planning, safe motherhood and PMTCT).
- Prevention and treatment of tuberculosis and related complications.
- Prevention and treatment of Schistosomiasis and environment management.
- Prevention and treatment of acute respiratory infections and related complications.
- Prevention and treatment of acute diarrhoeal diseases and related complications (including cholera).
- Prevention and treatment of sexually transmitted diseases, HIV/AIDS and related complications (ARVT and VCT).
- Prevention and management of malnutrition, nutrition deficiencies and related complications.
- Prevention and treatment of eye, ear and skin infections and related complications.
- Prevention and treatment of common injuries and related complications.

EHP support services:

- Essential laboratory services.
- Drug procurement, distribution and management.
- Information, education and communication.
- Pre- and in-service training.
- Planning, budgeting and management systems.
- Monitoring and evaluation.

Box 3-2. Essential health packages offered by the MoH, Malawi.

3.2.2 Human Resource for Health (HRH) in Malawi

The management of human resource for health (HRH) is governed by three Acts, which creates some confusion in some overlapping areas of responsibility. Under the Public Service Act 1994, the Department of Human Resource Management and Development (DHRM&D) was in charge of the overall performance of the public service, with oversight of conditions of service, codes and ethics, precedents and norms. Under the Health Service Act 2002, the Health Service Commission (HSC) is in charge of the HRH recruitment, including setting and reviewing terms and conditions of HRH employment (e.g., salaries, conditions of employment, and qualifications of employment). Under the Local Government Act 1998, the District Assemblies are empowered to make decisions regarding salaries, supplementary allowances and conditions of service for its employees within the Assemblies. The District Assemblies have come up with their own health establishment, which differs from that prepared by the MoH. Although the process of decentralisation had taken a long time to implement (see section 3.2.1), local government had taken over the budgeting process, funding and implementation of the health budget from financial year 2004/2005. The funding is provided by the Ministry of Finance through the Treasury (German Technical Cooperation Agency, 2007).

Traditionally, the public sector health service in Malawi was staffed by mid-level cadre workers (Muula, 2009). For medical services, medical assistants and clinical officers had been in charge of medical and surgical departments. In pharmacy service, pharmacy technicians had been in charge of the service as there were very few pharmacists in the country. Pharmacists, if there were any available, were placed in central hospitals and other key managerial positions at the Central Medical Store (CMS), the Pharmacy, Medicines and Poisons Board (PMPB) and the MoH headquarters. Because of their limited number, there have been no pharmaceutical personnel available at and below the health centre level. At facilities with no pharmaceutical personnel, services were handled by nurses and/or medical assistants. Pharmacists working at district level (or below) were

mostly volunteers from abroad. Table 3-3 shows different cadres of health workers who were available at the different levels of health facilities.

Level	*Staffing (medical & pharmacy)*
Central Hospital	Specialists, GPs, COs, may have MAs in some instances; Pharmacists, PTs
Regional Hospitals	Phased out
District Hospital	GPs, COs, MAs; PTs
Community/ Rural Hospital	COs, MAs; PTs to some extent
Health Centre	MAs; HSAs*

Table 3-3. Availability of different health worker cadres at different levels of health facilities.
GP: General Practitioner, CO: Clinical Officer, MA: Medical Assistant, PT: Pharmacy Technician, HAS: Health Surveillance Assistant. *HSAs reports to the health centres but they spend most time in the villages.

In terms of vacancies, there were many unfilled positions. In 2004 there was less than 1 physician and 6 nurses or midwives serving 100,000 population[63] (World Health Organisation, 2010). The number of pharmaceutical staff is not recorded in the WHO statistics but reported to be 73 in total (2009/10 figure) by the Pharmacy Board, which means there was less than 1 pharmacist per 100,000 population. Out of these 73 pharmacists, only seven served in the public sector. A basic headcount carried out by the MoH in 2007 showed vacancy rates of 28% and 91% for pharmacy personnel at MoH and CHAM facilities respectively. In 2004, the Government of Malawi announced its five-year health sector plan, which identified a critical shortage of HRH as one of the major barriers to health service delivery. Following this, a 'Six-Year Emergency Human Resource Plan' was launched during the period of 2004 to 2010. With support from a sector-wide programme and other development partners, there was a political commitment

[63] 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.

to scale up pre-service training of the middle and community level health cadres. Pre-service training of the professional cadre was of secondary importance, which would only be done when additional funds were available (Government of Malawi, 2004). After six years, this plan was hailed as a success: 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 second GHWA conference (2011), 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 level, Malawi has received much praise for success in its HRH development.

3.2.3 The pharmacy sector: authorities, legislations and education/training

In the public sector, there are three major players in pharmaceutical services: the MoH, the PMPB and the CMS. The MoH is in charge of national planning (in cooperation with donors in most cases) and is the executive for health service provision. The PMPB is an independent regulatory body, which is equivalent to the General Pharmaceutical Council in the UK. Its responsibilities include inspection and registration of medicines and drug selling premises (e.g., manufacturing sites, wholesale stores, community outlets); registration of pharmacists and pharmacy technicians; as well as vetting the pharmacy degree curriculum and accrediting training institutions. It should be noted that PMPB is not a professional body. The professional body for pharmacists and pharmacy technicians is called the 'Pharmaceutical Society of Malawi' (PHASOM). The CMS is the drug (and medical devices) procurement agency for all MoH and CHAM facilities. The purpose of having CMS, instead of a more decentralised system, is to allow pooled procurement in order to reduce purchasing costs.

In theory, these three bodies should work closely with but independent from each other, to avoid conflict of interest. However, in practice this was not always

the case. Under the PMPB Act 1988, all pharmacy premises must be inspected and licensed by the PMPB; and all drugs used in the country must be registered with the PMPB. However, in practice different attitudes were applied to inspection of MoH's pharmacy premises and drugs. It was said that the inspection of the government drugs was lax, resulting in the use of even unregistered drugs in the public sector. On the contrary, the private-sector pharmacy premises and drugs were said to be subjected to stricter inspection. In another instance, CMS was supposed to buy drugs on behalf of the MoH; and the latter should pay CMS directly. However, in practice this did not happen and CMS had to continue supplying drugs to MoH even though the latter had owed CMS a huge sum of money. These problems will be discussed in more details in Chapter 4. However, in this section it should be made clear that the legislation requires the MoH, the PMPB and the CMS to work independent from each other.

Regarding the education and training institutions for pharmaceutical HRH, currently there is only one for pharmacy technicians and one for pharmacists. The Malawian College of Health Sciences (MCHS) started training for pharmacy technicians in 1977. This training gave a qualification of 'Certificate of Pharmacy', which was upgraded to diploma level in 1984. The average output from MCHS is estimated to be 13 per year (German Technical Cooperation Agency, 2007). The duration of study is three years. After three years, graduates are deployed at central hospitals, where they work under close supervision. Legislation does not require pre-registration experiential training for pharmacy technicians. However, this one-year's work in central hospitals is regarded as experiential training for them. After one year, they are re-deployed to district hospitals.

The pharmacy degree was started at the Department of Pharmacy (DoP), under the College of Medicine in early 2006, with a target output of 20 per year. Although only eight graduated in late 2009 from the first cohort, it was hoped that the number would increase in the near future. The duration of study is four years. Upon graduation, pharmacy graduates have to undertake one year of experiential training before they can register as pharmacists with the PMPB. This

one-year experiential training can be shortened to six months if the pharmacists have already gone through experiential training elsewhere outside of the country, for instance those who receive their education abroad.

3.3 Conclusion

The first part of this chapter presents the five different theoretical lenses one can put on when investigating the roles of pharmacists. These different perspectives serve to inform, and not to direct, the research. The final decision about whether these theories can be applied to explain the reality in Malawi is entirely data driven, which will be seen in the next chapter. The second part of this chapter provides a basic understanding about the health system in Malawi. It explains how the players in pharmacy sector are supposed to work, which will be helpful in understanding data presented in the following chapter.

CHAPTER 4

Pharmacy in Malawi: what are the 'needs-based' functions of pharmacists?

As mentioned in Chapter 1, the first objective of this research is to find out what the purpose of pharmacy education in Malawi is; and how this purpose can be 'needs-based'. In this chapter, this question will be explored using the data. It starts by reporting the ethnographic data regarding problems faced by public sector pharmacy (in section 4.1). This is followed by investigating the current and desired roles for pharmacists (in section 4.2). In section 4.3, I will question why pharmacy technicians, who are traditionally managers in public sector pharmacy, failed to play this role in present-day Malawi. This leads to suggestion for a wider perspective when answering the question of the pharmacist's 'role', as discussed in section 4.4.

4.1 An ethnographic enquiry of problems in public sector pharmacy

Some of the problems (e.g., pilferage) faced by public sector pharmacy in Malawi were mentioned only in passing, or not at all, in mainstream literature including WHO country reports. Therefore, these problems might be known but not yet fully understood. In this section, I will report what was thought to be the most critical problems in the opinions of the domestic actors.

4.1.1 Major problem I: rampant drug pilferages

Drug pilferage, or stealing of public sector drugs (for the purpose of private use or resale), was rampant. It was a crime that was almost habitually committed – a crisis that had grown into a 'phenomenon'. It appeared even in a parliament speech, presented by the then Minister of Health Aleke K. Banda (Government of Malawi, 2000b):

> 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.

Pharmacy staff were not hesitant about discussing what was stolen and who stole them. It was admittedly a serious issue, which had persisted for a long period of time. This seemed to have been normalised and accepted as part of the public sector pharmacy service in Malawi. My worry about raising a 'sensitive' issue seemed unnecessary because informants did not intend to conceal such illegal activity from even the outsiders. In many cases it was mentioned by the informant before the question was even asked:

> In drug management, we have issues of pilferage, you name it. Accountability.
>
> Head of Pharmaceutical Service, MoH

Drugs were believed to have been stolen by health workers at different points of the drug distribution process and then sold to street vendors or to private clinics. Officers from the Pharmacy, Medicines and Poisons Board (PMPB) claimed detection of pilfered government drugs from local markets and private clinics.

> There's a problem now at the public sector. There's a lot of drug pilferage. Around 60% of the medicine goes down the drain. They're available in the market.
>
> Acting Chief Executive, the PMPB

> 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 PMPB, 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.
>
> Drug inspector IV

Indeed, pilferages happened not only with drugs but with other items. Non-pharmacy health workers experienced it with non-drug items:

> The first time I heard of it is from the people but I don't have close contact with drugs so I wouldn't know. I wouldn't know. I know everybody says it's very rife. And we notice it with other things. We notice it with, if we get new blood pressure machine given to the wards. Probably within two weeks it'll disappear.
>
> HOD, Medical Ward, Central Hospital I

It was not uncommon to find local newspapers reporting about pilferage (see Figure 4-1 for an example). During interviews, stakeholders sometimes quoted examples from the news to prove it was not at all a secret.

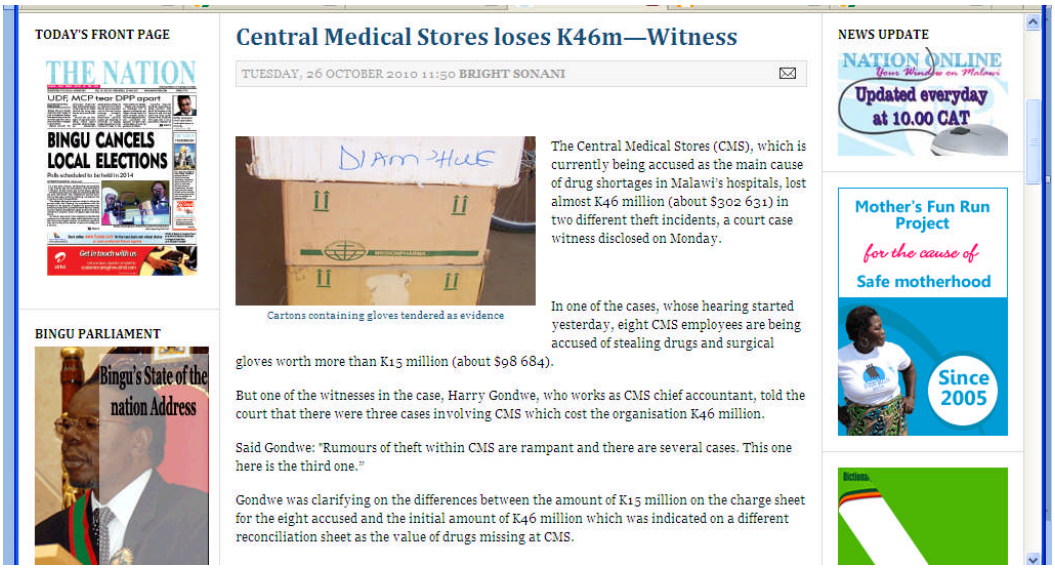


Figure 4-1. One of the news reports about drug theft committed by CMS staff (26/10/2010).

News article extracted from (The Nation, 2010).

During the few days I spent observing the pharmacy department, I overheard several discussions between pharmacy staff about ways to prevent theft. On one occasion one of the staff was reprimanded for not keeping the doorway locked. There was very limited access to the pharmacy department for fear of pilferage (see Figure 4-2).

Figure 4-2. Staff entrance to the Pharmacy Department at one of the central hospitals.
The notice on the door on the left reads ''please close the door promptly when you leave'.

Various reasons were cited for causing pilferage. One of them one was the lack of enforcement of the checks and balances mechanism, which often existed only on paper. For instance, at least one representative from the Drug Committee[64] should monitor the process of drug downloading from the trucks of medical store to the health facilities. In reality nobody did the checks when drugs were issued and/or received. Also, drug stock status was not updated accordingly, mostly because of understaffing. However, in some cases it was also said that the failure to update stock status was intentional (i.e., despite availability of staff) in order to make pilferage more convenient. When those who wanted intentional errors became a majority, a pilfering 'culture' might be formed and those refused to pilfer might be victimised. There was one staff member, who requested

[64] The Drug Committee was supposed to be established at every service delivery points at and below the District level, i.e. District Hospitals, Community/Rural Hospitals and Health Centres.

anonymity, claimed he/she had been displaced several times from his/her position because of his/her refusal to 'cooperate'.

Nonetheless, the failure to enforce surveillance was thought to have resulted from a chronic shortage of pharmacy staff. As was noted earlier, out of the 73 pharmacists in the country, only seven were serving in the public sector. Although most pharmacy technicians worked in the public sector, their small number was insufficient even for every facility to have at least one of them. At most district hospitals, there were usually one or at the most two pharmacy technicians. At facilities below district level (e.g., health centres), there were virtually no pharmacy staff thus they had to be dependent on nursing or medical staff, who already had many other responsibilities. Some facilities had to use hospital assistants or attendants, who had no technical training, to dispense medications.

> Hospital maids, who have just received secondary education and got employed at the hospitals, were trained to read prescriptions and dispense.
>
> Intern Pharmacist VI

The lack of staff made it difficult for task execution, let alone monitoring. It was not uncommon to hear cases where offenders were reinstated their old positions (or 'rotated' to similar position in other locations) simply because there was not enough staff. Taking a longer-than-usual 'personal leave' was a euphemism for employment suspension due to suspected wrongdoing.

> [In] most of our hospitals, you get only one pharmacy technician. So he has to take a break to come here [to the CMS], collect the medicine and go back. [So] nobody checks."
>
> Controller, CMS

The other reason for committing this opportunistic crime was poor salaries. Most health workers in the public sector were of the middle cadres and were poorly paid. For instance, a pharmacy technician's monthly salary was estimated to range from MK15,000 to 30,000 (equivalent to £60 to £120 per month). These paycheques are insufficient to cope with living expenses in Malawi. Even in rural areas, these could barely cover expenses for a family. Most people have to do at least two jobs to make ends meet. Selling government drugs, in this case, provided a convenient solution to 'supplement' low salaries.

> The answer is simple, they're handling the merchandise that sells fast. And your salary is down here, so the temptation to sell this is higher because you get more money. Yea? That's the explanation. One likes to think if they're paid a good enough salary, yea of course that doesn't eliminate thieves. Thieves are at all levels include people higher, whatever. But you're not putting somebody into deliberate temptations to steal. Because his income is low [but] he controls a multi-million enterprise here. And you're only giving him this much – I mean he's going to steal! It's common sense! It's survival! Yea. He has got to survive. So he will sell the merchandise.
>
> Assistant Registrar, Medical Council of Malawi

Despite this 'common sense' argument, there was a different opinion that the reason to commit such crime was the lack of ethics. According to informants, one should not commit such crimes regardless of the temptations (i.e., poverty) and opportunities (i.e., loose checks) to do so. Such acts were considered highly unethical; hence it was perceived that there was an 'attitudinal problem'. This opinion refused the proposal of raising the salary of the pharmacy technicians in order to curb pilferages.

> Yes they can say that they have little money, everywhere in the civil service the pay is always low. Everywhere in the civil service in the

> world. So I will not take that as a big issue but I will take that as an attitudinal problem.
>
> Principal HR Planning Officer, the MoH

> I think another thing is um... obviously a lot medicines are left in the hands of pharmacy assistants or technicians, instead of pharmacists, who have no ethics. And that is the problem. That is the biggest problem.
>
> Community Pharmacist VII

> 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.
>
> Acting Chief Executive, the PMPB

At the same time, an uninformed public, who are not aware of the dangers of inappropriate medicine use, has made curbing pilferage even harder. Health education campaigns, for instance 'Pharmacy Awareness Week', were run for a period of time but to little or no avail. Even if the public was aware of the hazard of buying drugs from the street, they might be forced to do so because of the lack of access to health facilities and/or essential drugs (due to drug shortages at the facilities).

Although offenders would be taken to court, PMPB expressed difficulties in winning the prosecution because offenders could afford to hire good lawyers to win the cases. Also, even if prosecution was successful, the penalty fine of up to only MK50,000 (£200) was too light to deter repeated offence. It was proposed by the PMPB that the fine should be increased to MK10 million (£40,000). However, it was unsure when the proposed amendment could be passed by Parliament. Therefore, many convicted offenders were not afraid to continue

committing this crime. Also, the fear of being caught was reduced by the fact that PMPB simply did not have enough staff to carry out inspection. To make matters worse, this crime was joined by public servants who were allowed to open private practices. This was argued to be the main reason for pilferage, because private practices could easily sell off pilfered drugs:

> Medical Council allows the opening of private clinics and those doctors or clinicians who work in the public sector can open private clinics. So if they don't have medicines in their clinics they can easily get them from the hospitals.
>
> Acting Chief Executive, the PMPB

The Assistant Registrar of MCM however refuted such a claim because private practices had only 'small corners' of pharmacy to sell drugs, unlike large pharmacy chains where more profits were made. Also, it was actually PMPB's fault to grant dispensing license to these private practices[65]. PMPB responded by saying dispensing was by default allowed in a private practice, a provision which was contained in the Medical Act. On reviewing the Medical Act, it says medical practitioners are allowed to administer emergency drugs, hence permitting storage of these drugs at private practices (see Box 4-1). There is no mention of whether medical practitioners need to own dispensing license for the purpose of dispensing medications. On reviewing the PMPB Act, it says there is no need for a medical practitioner to apply for a dispensing license "for administration, sale or supply to his/her particular patient" (see Box 4-2). In short, there was a blame game going on between MCM and PMPB regarding this issue, which eventually led to no solutions.

[65] This was done in the past when there were insufficient pharmacies around to dispense medications. However, private practices continued to dispense medications today even in areas with sufficient number of pharmacies. This created conflict between community pharmacies and private practices.

MMC Regulations: Minimum Requirements for a Private Practice

Part 1 – For a Private Practice Providing Out-Patient Service Only

A. Medical Practitioners

Clause 3: STOCKING OF DRUGS

Subject to the relevant provisions of the Pharmacy, Medicines and Poisons Act, 1988, the practitioner should attempt to keep in his premises a stock of those essential drugs which he considers should be administered to his patients in his premises and especially if his practice is not in a location where there may be dispensing pharmacy. The range of drugs that he should have is wide, but he ought to have at least the following-

injections of analgesics (for example, pethedine, morphine, etc); and

antibiotics, antihistamines, brochodilators, antienetics, antispasmodics, local anesthetics and cortisteroids.

Box 4-1. Regulation about stocking of drugs at private practice providing outpatient service only.

Extract taken from (Medical Council of Malawi, 2012).

The PMPB Act 1988

Part IV – Medicinal Products

Clause 35: Classes of license

(4) No person other than a person lawfully carrying on a retail pharmacy business shall sell or supply any medicinal product by way of dispensing except in accordance with a licence granted for that purpose (hereinafter referred to as a "dispensing licence").

Clause 36: Exemptions

The provisions of section 35 shall not apply to-

(a) anything done by a medical practitioner or dentist which-

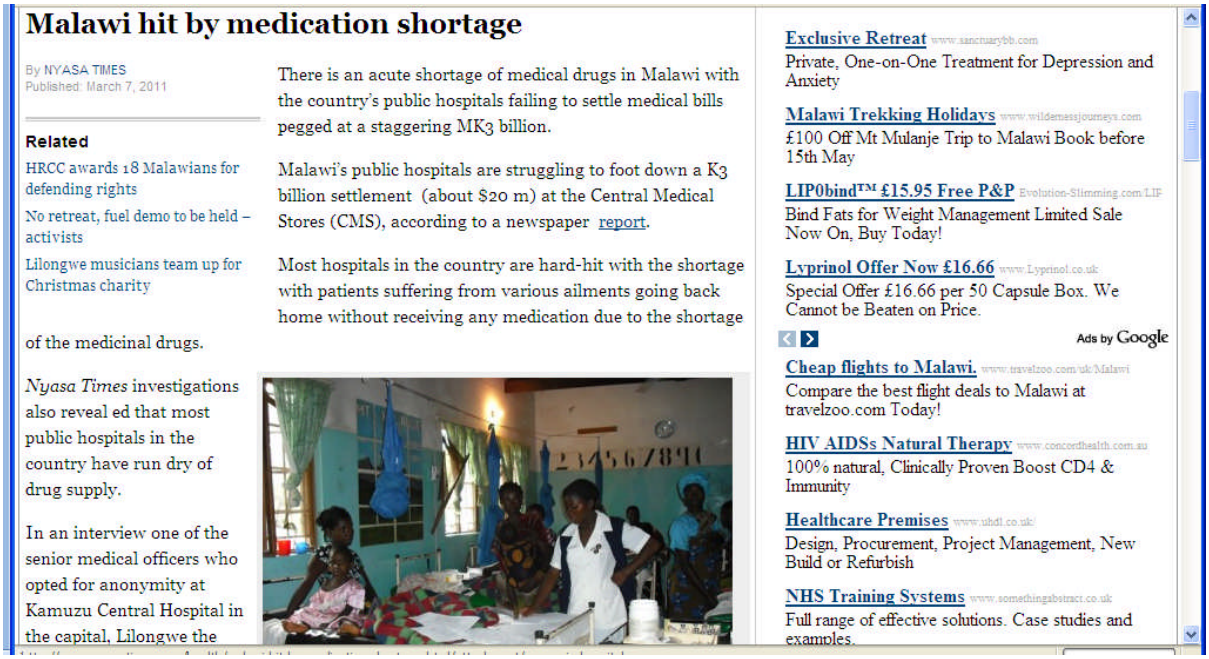
relates to a medicinal product specially prepared, or specially imported by him/her or to his/her order, for administration, sale or supply to his/her particular patient; or

relates to a medicinal product specially prepared by a medical practitioner or dentist at the request of another medical practitioner or dentist for administration, sale, or supply to a particular patient of that other medical practitioner or dentist.

Box 4-2. Extract from PBPB Act 1988 about 'dispensing license'.

4.1.2 Major problem II: frequent drug 'stock-outs'

'Stock-out' is a commonly used phrase in the pharmacy sector in Malawi. It means a certain drug is 'out of stock' or running out of availability. This was often quoted, by pharmacy as well as medical or nursing staff, as the most critical problem facing the public pharmacy sector. Like the pilferage problem, it was not uncommon to find news about stock-out hitting national headlines (see Figure 4-3). During a visit to one of the Regional Medical Stores, I was told that even essential lifesaving items such as aspirin and dextrose were out of stock.



Malawi hit by medication shortage

By NYASA TIMES
Published: March 7, 2011

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There is an acute shortage of medical drugs in Malawi with the country's public hospitals failing to settle medical bills pegged at a staggering MK3 billion.

Malawi's public hospitals are struggling to foot down a K3 billion settlement (about $20 m) at the Central Medical Stores (CMS), according to a newspaper report.

Most hospitals in the country are hard-hit with the shortage with patients suffering from various ailments going back home without receiving any medication due to the shortage of the medicinal drugs.

Nyasa Times investigations also reveal ed that most public hospitals in the country have run dry of drug supply.

In an interview one of the senior medical officers who opted for anonymity at Kamuzu Central Hospital in the capital, Lilongwe the

Figure 4-3. Shortage of medicines made the headlines in Nyasa Times on 07/03/2010.

News article extracted from (Nyasa Times, 2010).

The multifactorial nature of this problem again invited different arguments regarding how it should be solved. According to the CMS, cash flow in the CMS was controlled not just by its own management but also by the foreign exchange rate, the wholesalers, the manufacturers and the debtors. The limited cash flow was contributed by several reasons, *inter alia*, the huge debt owed by the District Health Offices, which amounted to as high as MK2.5 billion (equivalent to £10 million). It was made worse by the fluctuating foreign exchange rate of the kwacha, which often caused a shortage in (US) dollars to buy imported drugs. At the same time, CMS experienced difficulty in deciding purchase volume because

of the lack of consumption data from the MoH facilities, which is needed for charting usage. In addition, this decision was made even more complicated when the (often local) manufacturers could not fulfil the purchasing orders on time. One of the examples he gave was "we give Manufacturer III an order of aspirin some two years ago. Up to now they have not completed." This affected the accuracy in deciding how much stock CMS could supply the health facilities, because it was unsure to what extent the manufacturer could complete the order. However, CMS could not abandon slow manufacturers and go for other choices, because there were only two (out of four) local manufacturing sites which were GMP[66] compliant. Those who were not GMP-compliant were disqualified from becoming suppliers to CMS. As a result, the CMS would prefer to buy drugs from wholesalers, who could deliver on time and in addition, offer cheaper drugs. This was also the reason why the government would welcome procurement through agencies like the UNICEF, which holds sufficient dollars for bulk procurement (hence cutting down costs to buy drugs).

Because of the many difficulties posed by limited cash flow, it was thought that the solution should come from enhancing CMS's cash flow. One of the most widely agreeable ways to do so was to turn CMS into a trust, which allows it to operate independently from government machineries (though in theory, it should, see section 3.2.3). Without the pressure from the government, CMS could demand payment from the facilities and could refuse to supply if the payment was not made. In fact, this suggestion had been raised more than 20 years ago. However, there had yet been any action taken. One of the former Controllers of the CMS said "this problem we realised [in] early 1990s that we would not sustain the operation of medical store. Twenty years down the line nothing changed."

[66] Good Manufacturing Practice, which is a legislative quality assurance practice to ensure the quality of pharmaceutical products.

It needs no further explanation about the impact of frequent unavailability of essential drugs to patients. This chronic shortage of medicines made treatment plans almost impossible, as commented by one of the Head of Departments (in internal medicine, at Central Hospital I) in the quote below. Also, it affected the practice and training in prescribing. Many clinicians and prescribers were trained to prescribe only a limited range of drugs, making teaching pharmacotherapy a difficult task, even when new drugs became available (see the last paragraph in section 4.2.2).

> So for example, one week we may get one ACE inhibitor [i.e., a type of anti-hypertensive] and then next week, we have a different ACE inhibitor. And the week after that, we may have the *third* ACE inhibitor. I think it makes it *very* difficult, particularly for chronic disease management because drugs like ACE inhibitors are available mainly for chronic diseases. And having our patients to understand their medications and adhere, because each week what they get is different colour, and they have to take it so many times a day, often it's captopril and it's TDS [i.e., three times a day]. And the following week it's enalapril it's once a day. So, it makes chronic disease management very difficult.

4.1.3 Major problem III: under-developed local manufacturing industry

Almost all drugs were imported because of the low local manufacturing capacity. There were only four manufacturing sites in Malawi: Kentam (in the Northern Region), SADM (in the Central Region), Malawi Pharmacies and Pharmanova (both in the Southern Region). On visiting these sites, I found many manufacturing machines were left idle. According to the managers, production had to be stopped because of low demand. Most of the time, they manufactured only general sales items because of the lack of capacity to expand the production line to more sophisticated items. All four of them expressed their frustration at the lack of support from the government for the local manufacturing industry.

Capital for reinvestment (to expand manufacturing capacity) would have been rapidly generated should the local manufacturers be granted with the government contract to supply drugs to public sector pharmacy. However, CMS said the reason for not doing so was manufacturers' repeated failure to supply drugs on time (see section 4.1.2). This chicken-and-egg situation eventually resulted in mutual loss, where manufacturers faced stale demand for their products whereas the government had to buy expensive imported drugs.

4.2 The perceived 'needs-based' roles of pharmacists in Malawi

Although it is not difficult to see where the 'needs' are in public sector pharmacy in Malawi (based on findings reported in section 4.1), prioritisation of these urgent needs might be less straightforward, involving a political solution as well as a practical one. In this section, I will report opinions from stakeholders from different categories regarding current and future job functions of pharmacists.

4.2.1 Current roles of pharmacists in Malawi: the managers

By August 2010 there were only seven pharmacists serving in the public sector: one at MoH headquarters, two at PMPB, two at CMS and two at central hospitals. Because of such extremely small numbers, all pharmacists were holding managerial positions. In fact, the (public sector) pharmacists' circle was so small that the same positions were 'rotated' among the same few individuals. A common saying was that once you talked to the 'three big men' (i.e., those heading the MoH pharmacy headquarter, CMS and the PMPB), you have talked to the whole sector.

Part of the reasons for a very small number of pharmacists in the public sector was the attraction of private sector, which still had a lot of vacancies and was more rewarding financially. Therefore, most registered pharmacists worked in the private sector. This included work settings in retail, wholesaling, manufacturing and consultancy industries. 42 (or 57.5%) were foreign

pharmacists (see Table 4-1). Most of the foreign pharmacists came from India or Zimbabwe. Through interviews, I was told most Indian pharmacists were hired by Malawian-Indian owned businesses; whilst most Zimbabwean pharmacists intended to work for a limited period of time before they could go home, when Zimbabwe regained political stability. Privately owned pharmacies were concentrated in urban areas and some of them were owned by the largest private health insurance company in Malawi, i.e. the MASM (Medical Aid Society of Malawi). Apart from MASM pharmacies, there were no other chain pharmacies. Most community pharmacies were owned by Malawian pharmacists who had received pharmacy education from outside of Malawi. Community pharmacists said they played a role that was partly business-making and partly healthcare providing. However visits to several community pharmacies revealed a lack of the 'healthcare providing' function because pharmacists were not in the pharmacies most of the time. Pharmacy technicians, or shop assistants in most cases, were placed in charge to advise patients. This was possible because most advice given was product based rather than healthcare focused. Pharmacists would be contacted (via phones) when necessary[67]. In other words, community pharmacies in Malawi shared the public image of community pharmacies elsewhere in the world, i.e. as medicine 'shops'.

[67] These observations came from my visits to five independent community pharmacists in Blantyre (i.e., the main city in southern region in Malawi) and two pharmacies in Lilongwe and one in Mzuzu.

Nationality	*Registered**	*Non Registered***	*Total (%)*
Malawian	23	8	31 (42.5)
Indian	16	6	22 (30.1)
Zimbabwean	11	1	12 (16.4)
British	3	0	3 (4.1)
Tanzanian	1	1	2 (2.7)
Nigerian	0	1	1 (1.4)
Taiwanese	1	0	1 (1.4)
Unknown nationality	1	0	1 (1.4)
Total	56	17	73 (100)

Table 4-1. Nationalities and number of registered and non registered pharmacists in Malawi in year 2009/10

*Either practising and/or paid registration fee in 2009/10. ** Either non practising and/or not paid registration fee in 2009/10. Source: PMPB Malawi.

In manufacturing plants, pharmacists were the plant managers, either being hired (3 cases) or self-employed (1 case). Pharmacists were in charge of quality assurance for the manufacturing line; and in two cases, managing finances of the company. Therefore, pharmacists in Malawi had built themselves an image of being the managers – both in the public (by managing health system) and the private sectors (by managing businesses).

4.2.2 Desired roles for pharmacists: first a manager, second a health educator

Although almost all pharmacists were currently managers, it was thought that they had not done enough. This was due partly to their small number but mostly to the crisis in public sector pharmacy (as described in sections 4.1.1 and 4.1.2). The two most important responsibilities expected from the pharmacists were: maintaining consistent supply of drugs and preventing drug pilferage. Most stakeholders expected pharmacists to play no more than managerial roles in the near future. Frustrated by current state of pharmaceutical service, stakeholders expected pharmacists to first solve these two major problems before considering

playing any other roles. When asked about which areas needed managers the most, the answer was government hospitals, particularly the district hospitals.

> Priority areas for pharmacists, as it were for the time, are the services in the district hospitals. Reasons being each and every district should have at least a pharmacist to guide the pharmaceutical services in the district. Of course I think you have heard about the decentralisation process in Malawi, whereby each and every district gets its own kind of funding and it helps manage its own resources. So as the programme to train pharmacists started in Malawi, first priority would be, as they graduate, they finish the internship, we have to actually post them to the district hospitals. Because currently there is no district hospital in Malawi that has got pharmacists. All of them have got pharmacy technicians or pharmacy assistants. And worse still, some of them have only a nurse or a medical assistant actually giving pharmaceutical services. So that actually is our major concern.
>
> Head of Pharmaceutical Services, MoH

Only one medical doctor (who had 16 years of work and management experience at Central Hospital I) had a different opinion about stock problems. In his view, the reason for constant stock-out was the lack of understanding and appreciation of the clinical importance of maintaining good stock status. Therefore, the solution involved more than adding the number of pharmacists but to have pharmacists (as well as pharmacy students) engaged in clinical meetings:

> Somebody from pharmacy could be coming to some of the handovers of the medicine and paediatric department in particular, where drugs are main tools. You know just sit there in the morning, from 8 till 9[am] and hear the kinds of problems there are. Then you get ideas about, about the drugs being used, the drugs we don't have. So that if problems cropping up about that availability and

> distribution of drugs, as well as the function on the pharmacology of drugs, drug interactions, drug potential toxicity... So by coming now and then to these meetings, we happen to have every morning of every week from 8 till 9, there's a meeting in medicine and in paediatric, and in surgery and in obs and gynae, these are the furnace of the hospital practice. There are where we discuss problems of the last 24 hours. People present cases. We discuss the problems of those cases they've presented. That's a very good point at which pharmacy people could come and just understand the role of... you know where the context, why we need drugs at all and what happens if we give them or don't give them. What we suffer from when we don't have them. Um, yea, come in and perhaps get involved. That would be, I think, inspiring to pharmacy students. They need to talk about it perhaps with the Head of Department. Try not to be a little enclave that could be anywhere.
>
> Medical doctor III

However, getting pharmacists to be involved in clinical discussions was easier said than done in view of the enormous workload just from dispensing. To give a sense of how overwhelmingly demanding pharmacy workload was, it is worth quoting at length a statement from the Head of Department (HOD) of the Pharmacy Department, at Central Hospital I:

> 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 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 Head of Department, which takes me away from the department from time to time. Which means there are six people, to serve.
>
> The HOD, Department of Pharmacy, Central Hospital I

Through visits to several outpatient pharmacies[68] (see Figure 4-4), I observed a simplified dispensing procedure due to shortage of dispensing staff: patient handed over to dispensing staff his/her 'health passport' (see Figure 4-5); dispensing staff screened the prescribed items; if there was no perceived illegible or wrong prescription pre-packed medications would be given to patients with simple administration instructions. For stock-out items, patients were advised to buy them from a private pharmacy. Patient's name, date and other details were not written on the package because of time constraints. There were no prescription slips[69] and any other forms of recording of the amount of drugs dispensed (hence the difficult to check stock balance). Duration taken for dispensing was, by average, no longer than one minute per patient. In short, the main purpose of dispensing was merely to supply the prescribed items. The workload was so high that the only measurement of performance was the speed of dispensing:

[68] At 2 central hospitals, 1 district hospital and 2 health centres.

[69] The use of prescription slips was started at Mzuzu Hospital in August 2010.

Figure 4-4. Outpatient pharmacy at one of the district hospitals in Malawi.

Only two (out of four) dispensing windows were open.

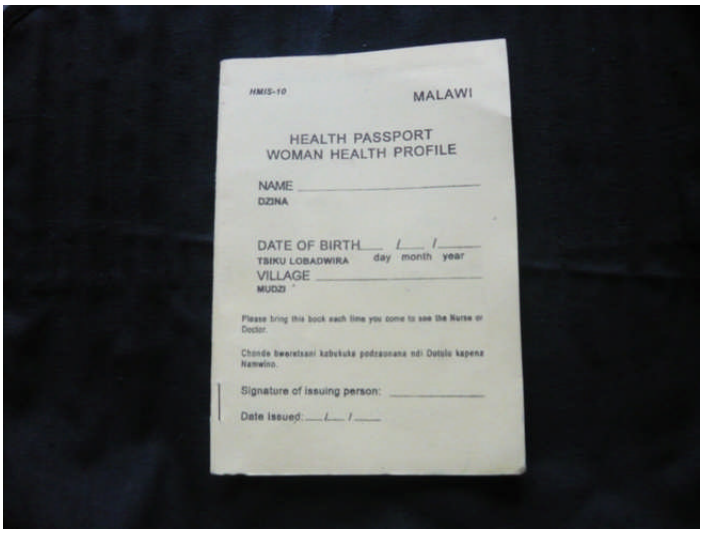

Figure 4-5. Example of a health passport.

Patients' medical and medication histories were recorded in health passport. There was no prescription slips used. The logic was patients carried with them records that enabled communication between health workers without having to establish complicated record keeping system.

From here we can see how the distributive function takes pharmacists away from performing other pharmaceutical roles, even 'routine' (as perceived by Western standard) functions such as patient counselling. In fact, patient education was the second most desired function of the pharmacists. Pharmacists were urged to dedicate more time for educating patients in medicines use, particularly complicated medications such as insulin and inhalers.

> Well the thing that I would like them to do but they don't, because they don't have time, is education work. You know they literally just dish out the drugs and they don't have time to counsel the patients in any way. And that's particularly if the drug requires certain things, like Salbutamol inhaler where the technique is important. I mean I would hope that the pharmacy would have some role in teaching the patients how to use the inhalers but that doesn't happen.
>
> Head of Medical Department, Central Hospital I

Although bound up with huge distribution workload, pharmacists actually gained most job satisfaction from clinical tasks such as scanning for medication errors, advising prescribing and counselling patients. In fact, there were a lot of prescribing errors that could be easily resolved by pharmacists, if only they were available. For instance:

> Well I give you an example of glibenclamide. Looking at the prescriptions at Central Hospital IV, you'll find four or five tablets of glibenclamide. The maximum is three. They just tell you that glibenclamide is no longer effective in this patient. You need to switch to another drug, let say metformin. But this clinician was trained on glibenclamide, only. And he was trained like 20 years ago. There's no one to explain this is the trend and this is what you need to do now. So we need someone who is an expert.
>
> Pharmacy Intern V

4.3 Traditional vs. present-day task-shifting: why pharmacy technicians can no longer be managers?

Data in the previous section shows the needs-based role of pharmacists is reduced to the distributive function due to critically low pharmaceutical HRH. It then raised another question: why can't pharmacy technicians do the same job? In fact, traditionally pharmacy technicians were managers of district hospitals and some of the central hospitals. There were a total of 160 pharmacy technicians (2009/10 figure, see Table 4-2) in Malawi. It was believed that most of them worked in the public sector. As explained in section 3.2.2, the PMPB had often failed to enforce registration on public servants. Because of the low number of pharmacy technicians in the country, the PMPB could not afford to bar non registered pharmacy technicians from practising. With only 24 district hospitals in the country, it means pharmacy technician can be a cadre that could easily fill up positions at the district hospitals. Assuming pharmacy technicians could take care of the distribution tasks; pharmacists could be relieved for clinical roles. Although this assumption might most probably sound outrageous in a more advanced setting, it could be possible under the principles of 'task-shifting' (see section 3.1.3), which is supposed to be a creative solution to the shortage of the professional cadre. If the clinical officers continue to perform surgery (replacing surgeons), why can't the pharmacy technicians continue to manage district hospitals (replacing pharmacists)? What is the difference between the past and present-day practice in task-shifting?

Nationality	*Registered**	*Non Registered***	*Total*
Malawian	61	98	159
Zambian	1	0	1
Total	62	98	160

Table 4-2. Nationalities and number of registered and non registered pharmacy technicians in Malawi in year 2009/10.

*Either practising and/or paid registration fee in 2009/10. ** Either non practising and/or not paid registration fee in 2009/10. Source document was obtained from the PMPB, Malawi.

On the skills level, pharmacy technicians were thought to have been adequately trained to perform this function. Indeed 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 um... of course any country would want to have all the necessary cadres.

As explained in section 3.1.3, the implementation of task-shifting is decided by whether the substitute cadre has sufficient skills and competence to perform the tasks. However, I will argue that task-shifting could be decided by perceptual and political issues, rather than by skills *per se*, or by how much the substitute cadres are paid. In the following subsections, evidence will be presented to support this argument.

4.3.1 Barrier I: the ill definition of "democracy"

To explain this barrier one has to understand Malawi's political climate. For a period of thirty years after independence (1964-94), Malawi's first President (Dr Kamuzu Banda) imposed a despotic rule of the country. His dictatorship was evidenced by expulsion, detention and even mysterious disappearance of political competitors (Lwanda, 1993). During this period of time, Malawians were said to have become "submissive" due to fear of falling prey to false accusations. It was a politically oppressive period, in which the public observed self vigilance to a great extent. Ironically, this was also said to be a 'disciplined' period of time, because very few dared to abuse public resources. A veteran pharmacist even described Banda's autocratic rule with nostalgia, because back then "nobody steals" and people were "accountable for their actions".

Banda was defeated in a (donor pressured) multiparty election in 1994. The euphoria of ending thirty years of political suppression ushered in a new, "democratic" era. However, such 'democracy' was ill-defined as 'doing whatever one pleases'. Uncontrolled personal freedom soon turned into selfish actions and even crime. In the public sector pharmacy, it had formed pilfering culture which nearly paralysed the sector (see section 4.1). Instead of becoming a progressive nation, the second government was said to have created 'Malawi's lost decade' (Muula and Chanika, 2005).

This ill definition of 'democracy' had removed the need to observe personal conduct. What happened, then, was a shift from 'personal responsibility' (which was emphasised during Banda's regime) to 'hierarchical responsibility' (Thompson, 1980). A new excuse for avoiding personal responsibility was created: because somebody *else* should be responsible, not *me*. In the pharmacy sector, pharmacy technicians perceived they could not bear higher responsibility because of their lower position in the hierarchy, even when there was no pharmacist available. Pharmacy technicians, who had been traditionally the managers in pharmacy service, 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.
> Intern Pharmacist III

4.3.2 Barrier II: the de-motivating human resource policies

In the civil service, the salary scale was structured to draw a sizeable income differential between professionals and technicians. Pharmacy technicians, junior and senior alike, belong to 'J' scale (see Appendix VI) which is a completely different salary scale than that of the 'I' scale (i.e. the pharmacist scale). Status differential by salary scale not only created resistance toward assuming responsibility amongst pharmacy technicians, it also created sense of inferiority when communicating with clinical officers (whose salary scale is 'I'). Also, "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. At the same time, it was thought to be impossible that pharmacy technicians would be granted a pay rise because of the way salary scale was structured 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

In other words, pharmacy technicians were de-motivated by low salary and the lack of opportunities for career development. This resulted in low job performance, and even crime. Perhaps, pilfering was normalised as a way to compensate what the technicians could not get from the system.

4.3.3 Barrier III: the perceived importance of professional power

Medical services in Malawi have traditionally been staffed by clinical officers (i.e., a substitute cadre for surgeons) and medical assistants (i.e., a substitute cadre for general practitioners), even before independence (Muula, 2009). However, this has been gradually changing since the establishment of the first medical school in Malawi in 1991 (Zijlstra and Broadhead, 2007). With a larger number of medical doctors available in the country, they started to take over 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 gradually phased out of management positions. Meanwhile, the pharmacy sector had not kept pace with this trend of professionalisation in managerial positions, because of the extremely small number of pharmacists in the country. As a result, pharmacy technicians found their political power threatened by the medical doctors. They felt they were being marginalised in key managerial decision making about resource allocation for the pharmacy service. To guard professional interest, only pharmacists, who has equivalent professional power with the medical doctors, can fight for the pharmacy sector:

> I'm not belittling the effort the pharmacy technicians are making, but when I look at the whole issue of um... commanding respect and people should really be listening to you and abcd, they're looked at

> as inferior. If you come to the DHMT, District Health Management Team, they don't actually include them [i.e., the pharmacy technicians] in the DHMT. If I have a pharmacist at the district, they would definitely be in there[70].
>
> Head of Pharmaceutical Service, MoH

> There is a big difference [between pharmacists and pharmacy technicians]. And that's why the only work which can be properly done by pharmacy technicians is mainly the dispensing because they are not well [versed] in most of their knowledge. Even the pharmacology, usually there's a limit in what they learn. Everything they have their limit. So they cannot easily advise other things. In most cases also there's also an inferior complex, whereby if a pharmacy technician may be has seen a problem. Although a clinician might be junior to him [i.e., the pharmacy technician], he or she cannot meet that clinician to discuss that this is a problem. Because he [or she] feels inferior to the clinician. Whereas pharmacists can usually go to the doctor to say no, from my knowledge, from my training I think this is wrong. Because you can find the fellow there you can easily convince a clinician and discuss everything. And he will have respect for you than the pharmacy technician.
>
> Intern Pharmacist III (who had worked as a pharmacy technician)

It was also thought that professional power could be used to put an end to drug pilferage. Pharmacists, as the ones occupying higher hierarchical positions, should hold the power to discipline their subordinates. This opinion came from an observation in the field, where pharmacy interns expressed their uneasiness to have to impose disciplinary actions to even the senior ranked pharmacy

[70] As explained in section 3.2.1, parliament gives statutory power to District Assemblies to manage resources, under the Local Government Act 1999. Therefore, the DHMT has the most power in deciding ways to distribute resources.

technicians soon after registration. In a way, professional power was hoped to substitute dysfunctional regulatory framework.

4.3.4 Barrier IV: the perceived importance of professional ethics

Another reason for the difficulty in task-shifting might be due to the perceived importance of professional ethics. Professional ethics were perceived to apply by default, and only, to the professional cadre. Pharmacists should self-police their actions because they are bound by professional ethics. The technician cadre, on the other hand, could bypass ethics because they were not 'professional'. This was thought to have created excuses for drug pilfering[71]:

> 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. 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 sector pharmacist

> We need more mature people, managers, maybe when pharmacists start coming to the hospitals, things might change. We think so. Things might change because the way we value, the fact that these medicines are for the sick in the hospitals, ethics maybe will teach us that these commodities are made for these patients lying at ward 2A or something and that we must have that feeling that these medicines were bought for the sick.
>
> Controller, CMS

[71] More quotes regarding the lack of ethics amongst pharmacy technicians are available in section 4.1.1 (as one of the explanations for rampant drug pilferage).

> I take the whole issue of accountability as one that pharmacists should actually deal with better than anybody else.
>
> Head of Pharmaceutical Service, MoH

Some informants thought the cause for unethical conduct (i.e., pilfering) amongst pharmacy technicians was due to the failure of MCHS (i.e., the training institution) to teach ethics. However, pharmacy technicians have been trained in the same college, and using similar curricula, even before pilfering became rampant. Therefore, it was not convincing that this crime was caused by 'bad' training. In fact, it was puzzling why there was so much certainty about pharmacists having stronger sense of ethics than the technicians. Indeed, it is uncertain at the moment whether or not future pharmacists would be more ethical than pharmacy technicians: they would be exposed to similar temptations (e.g. much lower pay than private sector pharmacists) and opportunities to pilfer, anyway. Perhaps, a better interpretation of how ethics was used was not about who was more ethical; but how it was perceived to be useful. Like professional power (as discussed in section 4.3.3), professional ethics is hoped to substitute surveillance and public accountability. With the absence of political regulation and market forces (Emanuel and Emanuel, 1996), professional ethics is relied on as the last resort to salvage 'bad behaviour'.

4.4 Rethinking 'needs-based' roles: is this just about management competence?

Chapter 3 talks about different perspectives from which the question about pharmacist's roles can be addressed. Based on these perspectives, empirical data in this chapter can be divided into two sets: one that adopts the 'needs-based' perspective and the other the 'territorial' perspective. The first set of data, as written in section 4.2, says that pharmacists were managers; expected to be managers and aspired to be good managers. Digging deeper into the rationales beyond these 'needs-based' roles, the second set of data (as written in section 4.3) reveals that 'needs' cannot be measured scientifically by skills or

competence *per se*, but are always contextual. In here, the 'territorial' perspective can be applied, such as through the data about professional power. It also opens up many other issues beyond the mere issue of 'roles'. Does an expert in medicines actually make an expert in medicines management? And how much does 'medicines management' in Malawi overlap with the area of public service management? The complexity of the current problems in the sector makes these issues larger than simply 'managing' drugs. When there is rampant pilferage amidst an apathetic public service culture, the situation might call for governance and/or leadership instead of simply 'management', as we commonly understand the Western concept. In this case, the pharmacists are actually called, though implicitly, to play these roles (i.e., governing, policing and leading). Therefore, should the problem be studied as a 'governance' (Dieleman and Hilhorst, 2011) or 'public administration' issue rather than a pharmacy one? Is there a tendency to read this as a 'competence' problem in pharmacy (i.e., the lack of managerial competence in pharmacists), amidst the dominance of this notion?

Interestingly, when the similar questions are asked in the OECD context, they are conceptualised in a different way. There is less certainty about whether health professionals should also be health system managers; hence it is a question to what extent a clinician should also be trained as a manager (vs. the 'yes' or 'no' question in Malawi). For instance, a continuum of clinical management roles is created, ranging from the high end of strategic management (e.g., having clinically trained managers) to the low end of operational management (e.g., having specialists to supervise clinical staff). Whilst Malawi seems to have decided pharmacists must also be managers, the OECD countries have answers that change with time and circumstances (Mathiasen, 1999). A comparative study between Denmark and England, for instance, revealed Denmark's health system management adopts higher clinical involvement than England. To prepare clinicians for management roles, both the under- and post-graduate studies in Denmark has a higher emphasis on clinical leadership than England (Kirkpatrick *et al.*, 2009). Although a direct comparison cannot be made, it can be

hypothetically said that pharmacists in Malawi have higher management duties than pharmacists in England but (unlike Denmark) they are educated using a fairly similar curriculum to that of England. However, this is merely one example to demonstrate how the same question is interpreted with more critique in the OECD setting. Perhaps there can be more understanding about this issue if it is approached with more enquiries, and fewer certainties, in Malawi.

The very certainty about 'pharmacists must first be managers' is perhaps a direct deduction from what can easily be labelled as 'mismanagement' in public sector pharmacy. What can be disguised, amidst such crisis, is the importance of clinical knowledge to become good managers. However, the overwhelming workload resulting from management has overruled any chance for pharmacists' continual clinical training. This research cannot offer a solution to the challenge of to what extent pharmacists should allocate time for non-managerial professional development, but it suffices to say this should serve as a starting point for further thinking about management competence. At the same time, this also brings us to the question whether pharmacy technicians can be managers. If clinical knowledge is important for managing drugs, surely pharmacy technicians cannot be as good managers as the pharmacists. However, in the case of acute shortages of pharmacists, can pharmacy technicians be a temporary replacement? This has in fact been the case for Malawi for a few decades, with fairly satisfactory outcomes (e.g., there were periods of time where there was no pilferage). So, the problem here may not be caused merely by the lack of clinical competence. In section 4.3, there are four perceptual and political barriers discussed as evidences for the failure to implement task-shifting in present-day public pharmacy sector. The new language that has emerged, upon introduction of the professional cadre, is 'professionalism'. There is an uncritical acceptance of the superiority of the professional cadre, to the extent the professional ethics and power should come by default (see section 8.1), which can be detrimental to creative HRH strategies such as 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. With the presence

of pharmacists in the system, regardless of their number, it may be taken for granted that they are the new bosses who should be responsible. Parallel to the new definitions given to 'democracy' and 'professionalism', pharmacy technicians were freed from personal responsibilities. Therefore in what follows, task shifting is able to shift tasks, but not necessarily the sense of responsibility. It changes only the job descriptions whilst leaving occupational hierarchy unchanged; therefore 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.

Also, this limited definition of professionalism might inhibit funding support for the education institution to produce more than 20 graduates per year. With only 24 district hospitals and 4 central hospitals in Malawi, a 'needs-based' calculation reveals that no more than 60 pharmacists are needed. It means the education institution can easily produce this number of pharmacists within very few years. Therefore, capacity building for the education institution is directly affected by their current function and vision of this profession. Without true professionalisation, it is difficult for the education institution to justify expanding its capacity. Issues regarding professionalisation will be explored further in Chapter 6.

4.5 Conclusion: the problem of the 'needs-based' approach

In this chapter, I have presented evidence to support argument against deciding pharmacists' roles based on tasks they need to perform. Apart from skills, there are socio-political and cultural factors which could possibly affect performance of a cadre. Notions such as 'competence' and 'needs-based' are context-free; and may actually restrain researchers from asking contextual questions. It is not to refute the importance of assessing competence and needs (e.g., for quality assurance purposes) but to highlight the importance of contextualisation. This research started off by looking for an 'African' answer to solve 'African' problems. However, I found there is no 'African' problem but the same problems faced by

the rest of the world, merely clad in an African context. I find it unfair to apply two languages to the same problem in different settings. In fact, stock-out problems also happen in the developed settings like the UK, where the debates involve many other parties apart from the pharmacists. Although stock shortage in an advanced country is not a life-or-death issue, like what happened in Malawi, this issue is allowed a more robust discussion in a developed country. In a way, I find the development language is used to justify a positivist solution for African (or in this case, Malawian) problems. Further discussion can be found in Chapter 8, where I will argue how these prescriptive development agendas may hinder other 'non basic' agendas, like professionalism.

CHAPTER 5

Institutional capacity building for pharmacy education in Malawi: definitions, debates and data

Having debated the issue of 'purpose' for pharmacy education in chapters 3 and 4, the following three chapters look at issues regarding 'capacity building'. To start with, this chapter serves as a literature chapter to inform empirical data presented in Chapters 6 and 7. Like section 3.1, literature review in section 5.1 gives a flavour of how different theoretical lenses can be applied to studying 'capacity'. However, literature review of section 5.1 is harder than that of section 3.1 because it has to make links between different research paradigms. There will be a deliberate effort in marrying literatures as diverse as African higher education, academic pharmacy and development. Owing to the huge differences in disciplinary epistemologies, literatures from different disciplinary areas have different approaches to 'criticality', 'evidentiality' and 'voice'[72]. This means, for the same topics of concern, different disciplines will ask different questions; have different ideas about what constitute evidence; and have different opinions about researchers' impartiality or identity (Gimenez, 2012). For instance, literature of academic pharmacy may talk about 'capacity' in terms of teaching/learning methods, or recruitment of university lecturers; whereas literature of development cooperation may ask about the problems of capacity ownership and sustainability. Therefore, not all issues discussed in the literature review sector would be relevant to the data presented in following chapters. However, it is important to understand the epistemologies of different disciplines, as it is one of the objectives of this thesis to communicate cross-disciplinarily. After the literature review section, in section 5.2, the higher education system in Malawi and capacity problems faced by the university is discussed.

5.1 Defining 'capacity building': a literature review

'Capacity' is a generic term, which can be interpreted with different meanings by different disciplines. In this section, a literature review on 'capacity building' is started from its generic definition (in 5.1.1); before being read from four

[72] These three terms in inverted commas are the generic attributes of academic writing.

research disciplines: African higher education (5.1.2), pharmacy (5.1.3), health workforce (5.1.4) and development (5.1.5). Apart from describing how each discipline defines capacity, this section has an equally important job in explaining the differences in research epistemology between disciplines. Every discipline has its own way of asking questions, forming evidence and writing. It also has its discipline-specific 'blind spots', which are areas that cannot be reached by using certain epistemology. As a result, a cross-disciplinary approach is required, as evidenced from the diverse issues emerged from the empirical data (as presented in Chapters 6 and 7). By the end of this section, it is hoped that capacity can be understood in a cross-disciplinary way.

5.1.1 'Capacity' as a generic term: the UNDP prototypes

'Capacity' is a term commonly used in literature written by development agencies. Search terms such as 'capacity building', 'capacity development' and 'capacity strengthening' are mostly found on websites of the development agencies such as the United Nations Development Programmes (UNDP), World Health Organisation (WHO), Organisation for Economic Cooperation and Development (OECD), World Bank (WB) and African Capacity Building Foundation (ACBF). Websites of major bilateral donor agencies (such as CIDA, DfID, GTZ, NORAD, AusAID) also write about capacity building, though these writings are similar to the prototype developed by UNDP. Therefore, the definition by UNDP shall be used as a start:

> The process through which individuals, organisations and societies obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time (United Nations Development Programmes, 2008c).

So, capacity is often implied as a set of abilities or competencies that must be acquired in order to achieve certain goals. In the context of a health sector, capacity is defined by the World Health Organisation as:

> Capacity of a health professional, a team, an organisation or a health system is an ability to perform the defined functions effectively, efficiently and sustainably and so that the functions contribute to the mission, policies and strategic objectives of the team, organisation and the health system (Milen, 2001).

To avoid having everything and anything as capacity, perhaps a more practical way to conceptualise it is by differentiating 'effective capacity' from other forms of capacity. Capacity can only be effective when it is identifiable and can be acted on (Ubels, Acquaye-Baddoo and Fowler, 2010). With this in mind, capacity can be 'hardware' like human resource capacity or 'software' like organisational culture. Even a country's socio-politics, such as class system and political stability, can be included as one of the dimensions of capacity. Grindle and Hilderbrand conceptualised capacity into four layers: individual (or human resource), organisation, institution and action environment (Grindle and Hilderbrand, 1995). Similarly, UNDP developed a conceptual tool to identify capacity in a three-tiered format (see Figure 5-1), which can be helpful in conceptualising the relationship between different levels of capacity. For instance, training of individual skills (i.e., a micro-level capacity) is dependent on organisational policies (i.e., a meso-level capacity), which are subjected to control by country legislation (i.e., a macro-level capacity).

Figure 5-1. Three levels of capacity as detailed in 'UNDP's capacity development practice note'. Figure adapted from (United Nations Development Programmes, 2008b). Reproduced with permission from the UNDP Capacity Development Group.

Based on this model, capacity building is about the acquisition of the capacity necessary for achieving certain desirable outcomes. The process of acquisition is also elaborated by a generic model, where the gaps in capacity are identified, filled and monitored (see Figure 5-2). This model becomes a prototype for capacity building work done by many development agencies. The WHO, for instance, uses this model for conducting HRH situational analysis (see Figure 5-3). What is dominant in this model is the emphasis in giving the decision making power to the 'stakeholders'. The notion of stakeholder is explained, in the context of HRH research, in section 1.3.2. In this section, I shall bring in the development context, which proposes the link between 'stakeholder engagement' and 'country ownership' (see section 5.1.5). Engaging stakeholders is crucial because domestic players should be playing a leading role, hence encouraging ownership. By involving stakeholders in the key steps of capacity building, it is hoped to make capacity building a truly country-owned process. Stakeholder opinions' and consensus are seen to be essential ingredients for the success of a project or policy. Therefore, there has been relentless effort in

persuading a diverse range of stakeholders to participate in the process of capacity building (as described in Chapter 1). One of the tools used for achieving this effort is called 'stakeholder analysis'. It requires the measurement of stakeholders' level of influence and support for the institution. Based on this analysis, a matrix of level of influence and support is drawn. Then, different modes of engagement are proposed. For example, stakeholders with high influence and high support should be nurtured into becoming 'key players'; whereas stakeholders with high influence but low support should be persuaded to increase its level of support (Futter, 2009; Gardner and Rachlin, 1986; Varvasovszky and Brugha, 2000).

Although stakeholder analysis tool has its value in finding ways to engage stakeholders, what might become problematic is the failure to differentiate between participation, empowerment, consensus and ownership. In UNDP's special issues about technician cooperation, it warns:

> It is easier to invoke participation than to empower, and easier to empower than to build consensus. However, empowerment without consensus can lead to chaos. And if consensus, along with participation and empowerment is to result in stakeholder responsibility for the process, it must be genuine. A forced or artificial consensus often results in stakeholders' abdicating responsibility, but retaining the right to interfere and criticise while refusing to contribute to the process or the outcome. *Ownership*, therefore, is the acceptance of *responsibility* through the process of stakeholder *participation, empowerment* and *consensus*.
>
> Taken from (Singh, 2002)

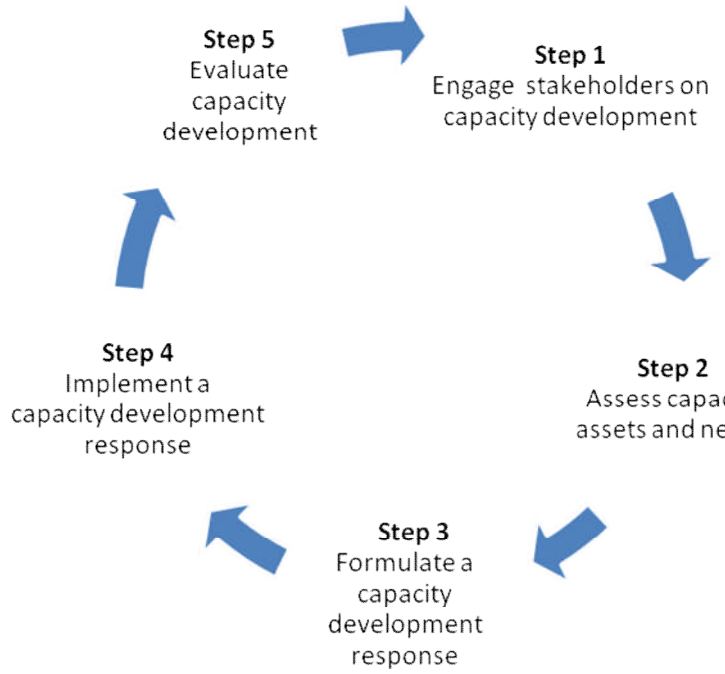

Figure 5-2. The five steps of the capacity development process.

Figure adapted from (United Nations Development Programmes, 2008a).

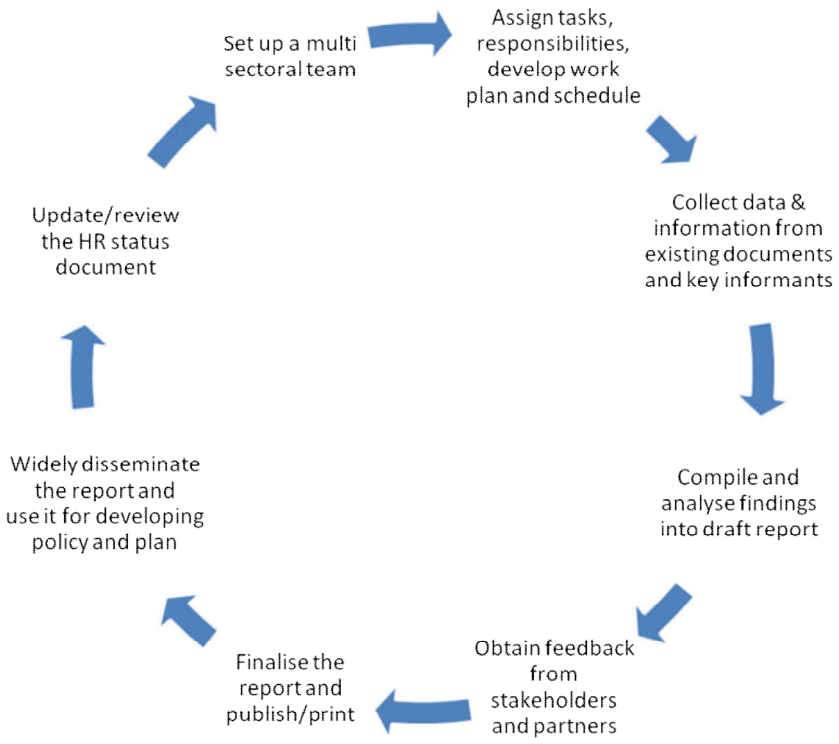

Figure 5-3. Process for undertaking HRH situational analysis.

Figure adapted from (Nyoni *et al.*, 2006).

To what extent capacity building is reliant on stakeholder ownership is still subjected to much debate. There might be other notions such as 'knowledge' and 'capabilities' which can be instilled into capacity building. Therefore, the UNDP capacity building prototypes shown here might be a convenient but incomplete guidance. Indeed, capacity might not always be visible and measurable. Some scholars argued that capacity building should be a process of 'transformation', and not simply an enhancement of existing capacities (Fukuda-Parr, Lopes and Malik, 2002).

Eventually, the stakeholder approach was applied, in this research, in a different way from a traditional approach in the HRH tradition. Instead of treating 'stakeholder consultation' as the pathway to knowing local needs, stakeholders' opinions were treated as merely the opinions of power-holding individuals, which might not necessarily representing the true needs of the interest groups the stakeholders represent. Instead of doing 'stakeholder analysis' in a conventional way, SWOT analysis is performed in order to allow more critical interpretation of their expressed support. The stakeholder approach was also used as a way to guide systematic sampling of the interviewees (see section 2.4.1).

5.1.2 'Capacity building' in sub-Saharan African universities

SSA universities have been facing multiple capacity problems since independence: severe underfunding, under-staffing, poor teaching/learning facilities and quality, student activism, lack of academic freedom, graduate unemployment and brain drain, just to name a few. In this section, the debates regarding capacity building in SSA universities will be presented in three themes: relevance, costs and brain drain.

The relevance debates

Capacity issues in post-independence African universities have to start from its competing interest with basic education. It was argued that returns on higher

education was lower than basic education hence the latter should be prioritised (Psacharopoulos, 1981). University education was thought to benefit individuals more than the public good. Therefore using public expenditure to support university students' tuition, accommodation, meals and book allowance was said to be a 'luxury' when many people were still living under poverty line. The World Conference on 'Education for All' (EFA) in Jomtien (in 1990) has endorsed this argument; and has since resulted in SSA universities losing significant funding. The subsequent withdrawal of foreign aid, together with fiscal austerity measured imposed by structural adjustment policies[73], severely depleted the already fragile capacity of SSA universities. Student riots and academic brain drain, following university fiscal austerity measures, almost paralysed the institutions, causing (temporary) closure in some (Atteh, 1996).

The link between higher education and (economic) development was not re-established until the late-1990s, when World Bank began to acknowledge the importance of higher education in creating 'human capital' for global 'knowledge economy'[74] (World Bank, 2000; Bloom, Canning and Chan, 2006). In the subsequent decade, another World Bank document urged higher education in

[73] 'Structural adjustment policies/programmes' (SAPs) are imposed on fiscal policies in low-income countries, which receive loans from the International Monetary Fund (IMF) and the World Bank (WB). Conditionalities attached to loan-giving are characterised by privatisation, liberation and deregulation; in order to create 'free market' to reduce the countries' fiscal imbalances. However, SPAs are found to cause more harm than good, see (Riddell, 1992).

[74] The utilitarian approach to education is problematic not only in SSA but also in the other parts of the world. The debates about relevance of higher education, including whether it merely serves the economic purpose, command a field of study itself. Please see (Teichler, 2000) for new perspectives on the role of higher education; or (Brown, Lauder and Ashton, 2011) for the 'broken promises' of higher education in securing middle-class lifestyle, even in industrialised setting.

SSA countries to 'accelerate' in order to 'catch up' with the rest of the world (see Figure 5-4) (World Bank, 2009)[75].

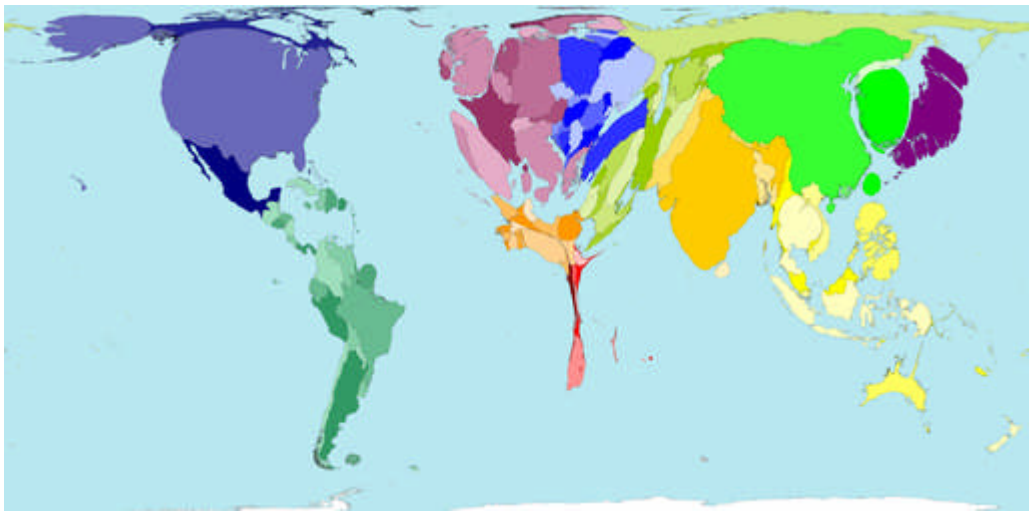

Figure 5-4. World atlas of tertiary enrolment.

The size of a country is proportionate to the amount of tertiary enrolment in the country. Note that SSA is the continent with the most disproportionate tertiary enrolment to its population. Figure taken from (the WorldMapper Team, 2011). Reproduced with permission from © Copyright SASI Group (University of Sheffield) and Mark Newman (University of Michigan).

The return of attention to SSA higher education came at a time when there was a rapid increase in demand for higher education, due to an increased number of people completing basic education post-EFA. The problem with EFA is that it has allowed more people to access basic education but has not considered what would happen after basic education. Many school leavers cannot find jobs, hence turning to tertiary education in the hope to enhance employability. Therefore, universities found themselves under pressure to deliver education for employability. Although evidence suggests that education does not guarantee employment (Berg and Gorelick, 1970), the 'education for jobs' notion still

[75] The WB plays a central role in deciding SSA countries' domestic policies. In the higher education section, please see (Samoff and Carrol, 2004), (Brock-Utne, 2003) and (Salmi and Bassett, 2010) for WB's influence and policies on higher education in SSA countries. The third literature is written by WB and argued for its influence on bilateral donors to relocate funding from basic to higher education sector.

dictates the functions of most universities, even the most prestigious ones in the world. Enrolment to the universities, therefore, is equated with a ticket for a better job and a better life. In this way, universities are expected to dispense social justice, by enrolling students from different socioeconomic backgrounds. However it remained clear that there was considerable inequality between institutions at secondary and tertiary level. This reinforced older concerns that higher education, especially in elite institutions, was not supportive of social justice. Thus, universities have come to be expected to combine educative, economic and social justice functions (Baker and Brown, 2007).

Cost debates

SSA governments have been accused of spending disproportionately for higher education, compared with spending for basic education, as evidenced from its high annual per student costs (or 'unit costs'[76]) compared with other regions in the world. University provision of student welfare, such as food and accommodation, was thought to be a major contributing factor to high unit costs (see section 5.2.1 for similar comment in the case of the CoM). Universities were criticised to have failed to 'distinguish welfare and educational responsibilities' (Banya and Elu, 2001) and actually further disadvantaged the poor, because majority university places were occupied by wealthier members of the society (Castro-Leal *et al.*, 1999).

In fact, fiscal pressure is a problem faced by universities worldwide, both in the north and the south. As a result, 'market-like' behaviours are often adopted in response (Ntshoe, 2004; Renault, 2006; Johnstone, Arora and Experton, 1998). In the north, these market-like behaviours are labelled as 'faculty entrepreneurship' or 'academic capitalism'; whereas literature written for the south frequently used the term 'cost-sharing'. No longer sustainable as an ivory tower, universities engage in financial diversification activities, for instance franchising, charging full or higher tuition fees, having 'dual track' (or 'parallel' or

[76] Measured by countries' per capita GDP.

'module 2') programmes[77], replacing student scholarships or grants with loans[78], outsourcing of non pedagogic services like catering and accommodation, etc. In cases where public universities can no longer accommodate escalating demand for higher education (following population boom and higher completion rate in basic education post-EFA), private provision is argued to provide a relief (Banya, 2001). However, these for-profit institutions are mainly interested in fast-turnover and market-friendly course like business and management studies, leaving the old problems unresolved. Proliferation of private tertiary institutions also resulted in a 'moonlighting' culture amongst public sector lecturers, particularly during salary cut-backs. In short, SSA universities are facing financial decisions not unlike other parts of the world, though in an entirely different context, with continual tension between costs and access/equity or between states and markets.

Brain drain debates

Teaching capacity in SSA universities is greatly depleted by the 'brain drain', defined as the mass emigration of SSA academics, professionals and skilled workers to other parts of the world. This phenomenon is heavily researched, revealing an almost one-directional flow of highly skilled workers from the poorest to the richest nations (Carrington and Detragiache, 1998; Hagopian *et al.*, 2004; Clemens and Pettersson, 2008). The most common causes cited to induce brain drain are the 'push-pull' factors, whereby African brains are pushed out by

[77] Parallel students are enrolled for evening and/or weekend classes. It is thought that higher tuition fees collected from this group of students can be used to cover costs for students who are enrolled through conventional route. As a result, parallel programmes are usually regarded as an alternative entrance for students with less performance but higher ability to pay. See (Oketch, 2003) and (Wangenge-Ouma, 2008) for problems associated with parallel programmes, e.g. over-worked academics, crowded classrooms, poor quality full fee-paying students, etc.

[78] Two main technical problems about using student loans to recover public investment in higher education: first, high rate of failure in loan recollection. Second, unnecessary loaning to wealthy students, when 'means-tested' or 'needs-based' allocation mechanism is not in place. See (Johnstone, 2004) for a more in-depth analysis of the political economy of cost-sharing.

unfavourable conditions in their home countries (e.g., low pay, low job satisfaction, lack of academic freedom, lack of chances for professional development) and pulled in by favourable conditions in receiving countries (i.e., the reverse of the examples given above). In addition, newest evidence has inserted new forces in explaining brain drain, for instance globalisation (Altbach, 2004) and differences in career outlook between different generations.

Strategies to reverse brain drain mainly target the improvement of remuneration packages and other incentives for academics. It is also thought that postgraduate training should take place within the SSA region in order to improve in-country (or at least regional) retention of these future academics (Zijlstra and Broadhead, 2007). This is because scholarships for postgraduate training abroad often result in reluctance to return upon graduation. However, universities are also advised to look at their HR policies, to see whether they are 'investing in individuals' to attract (and not simply contract-bound) retention. Otherwise, brain drain may occur when individuals feel disintegrated from the domestic teaching environment (after returning from doctoral studies) and vague about opportunities for professional development. Supportive measures, such as mentorship and creation of postdoctoral research positions, may encourage retention (The British Academy and The Association of Commonwealth Universities, 2009).

In situations where retention strategies failed, alternative solutions may seek to replace conventional classroom education with distance learning, apprenticeship, community-based learning, etc. However, amongst these strategies, only distance education was claimed as a successful substitute to classroom teaching in certain areas of study such as public health [e.g. (Mokwena *et al.*, 2007)], continuing professional education [e.g. (Bagayoko, Muller and Geissbuhler, 2006)] or inter-university tele-conferencing [e.g. (Le Beux and Fieschi, 2007)]. Other methods can supplement, but not substitute, conventional classroom teaching, for instance 'experiential education', where practice site resources are tapped into for educational purposes. In other words, the literature suggests no short-

cut to building up teaching capacity in the universities albeit possibilities of supplementing teaching with alternative methods.

5.1.3 'Capacity' in pharmacy education

'Pharmacy education' is a relatively new area of research; pioneered by pharmacy educators who are concerned about how new changes in practice could impact on education. Since most pharmacy educators are traditionally working from the science paradigm, their way of conducting research is also strongly flavoured by 'science'. Research in pharmacy education is concerned about the 'best' way to teach pharmacy students. Studies are conducted to find out what the most effective educational tools are, with the intention to match education to practice needs. In the American Journal of Pharmacy Education (AJPE), which is the leading journal in pharmacy education, a large section is devoted to researching 'Instructional Design and Assessment'. Most pharmacy education research adopts a science-based approach to evidentiality, where the best evidence should come from the RCTs[79]. Scientific toolkit such as the notion of 'competence' (see section 3.1.2) is frequently applied to measure the effectiveness of the educational tools. Things that can be measured in the language of competence include technical skills (e.g., clinical, research skills), interpersonal skills such as cultural sensitivity [e.g. (Onyoni and Ives, 2007), (Echeverri, Brookover and Kennedy, 2010)], professional behaviour [e.g., (Spies *et al.*, 2010), (Poirier and Gupchup, 2010)] and leadership [e.g. ("Buzz" Kerr *et al.*, 2009), (Sorensen, Traynor and Janke, 2009)], and even personality traits such as empathy [e.g., (Manolakis *et al.*, 2011)]. Through the use of the language of competence, educational tools are given new names such as 'abilities-based' curriculum, 'performance-based' outcome, outcome-based learning, etc. This is

[79] Examples of educational tools being tested in trials include problem/case-based learning [e.g., (Romero, Eriksen and Haworth, 2010), (Novak *et al.*, 2006)], virtual learning [e.g., virtual patients in (Benedict, 2010) and (Curtin *et al.*, 2011)], inter-professional learning, experiential education, etc.

not to equate 'abilities', 'performance', 'outcomes' and the other terms with 'competence'. The intention of making a generalised statement is to give an idea of how this science-based approach may actually amplify the tendency to 'measure'. Although there are quite a number of new terms introduced in this paragraph, the argument does not intend to dwell in-depth with each one of them. Also, much attention is paid to whether new (clinical and social) subjects should be introduced into the curriculum, and how they should be 'integrated' with the old (i.e., science-based) ones [e.g., (Kolluru, Roesch and Akhtar de la Fuente, 2012), (Black *et al.*, 2012)][80]. To solve the tension between learning depth and learning breadth, there is also research about how to divide learning into three phases: pre-service, in-service (called 'continual professional development' or CPD) and postgraduate[81].

Next, I will turn to the literature that talks about teaching staff recruitment and retention, which is a capacity issue more closely related to this research. Compared to the literature about educational tools, which mostly involves original research, this pool of literature appears more frequently in the form of commentary, reports or working papers. There have been suggestions to innovate recruitment and retention based on demographic changes in the workforce. Feminisation of the workforce, for instance, should call for recruiting from women and ethnic minorities and the award of non-tenure track positions, as more women prefer to work part-time (Patry and Eiland, 2007; Rogers and Finks, 2009). Innovation also moves towards the trend of increasing recruitment from 'teacher practitioners' or 'preceptors', who are pharmacy practitioners conducting experiential training on a part-time basis. Literature is concerned about what kind of training and/or orientation programmes the recruitment

[80] To very simplistically generalise, integration was thought to be best achieved by reshuffling curriculum, for instance by sandwiching experiential training between didactic ones, as well as with a multi-disciplinary approach.

[81] For instance, one of the debates involve whether the university or the professional body should be responsible for CPD. In some places, this responsibility has been shifted from the professional body to the university, e.g. the University of Alberta (Schindel *et al.*, 2012).

institution should offer teacher practitioners, who may not have any teaching experience. For instance, there were modules designed specifically for new practitioner educators (Cerulli and Briceland, 2004); and 'rural preceptor-ship' programme implemented in Australia (Marriott *et al.*, 2005). According to this pool of evidence, teacher practitioners have become an increasingly important teaching workforce in pharmacy education, in conjunction with higher emphasis on experiential education. However, such innovations seem yet to be embraced by African universities, which still insist very much on research orientation of teaching staff, for instance University Zimbabwe's most recent mission statement for 'every lecturer to have a PhD by 2015' (University World News, 2012a).

Another capacity issue that has attracted commentaries (but not yet original research) is the 'import' of the American 'Doctor of Pharmacy' (or Pharm.D.) programme into Africa, or developing nations in general. This was frowned upon by some commentators who argued that this American pharmacy curriculum does not produce skills and competencies for local health needs. This is because Pharm.D. places most emphasis on clinical training and less on drug distribution and drug development. Whilst the US has a mature drug distribution system which allows the development of clinical pharmacy in practice, most other countries do not. To transfer the American model into an immature system, therefore, is deemed not needs-based (Anderson and Futter, 2009). Counter-arguments said that the production of pharmacy graduates was not meant for local employment but for 'export' purposes; and this country decision, which is not 'needs-based', should be respected [e.g. Pharm.D. in Pakistan (Aslam and Ahmed, 2011)]. It was also argued that what Pakistan wants to do was to 'move together with the world' in her pharmacy education (Ahmed and Hassali, 2008). This highlights the pressure faced by developing countries in coping with the 'international standards', regardless of whether these standards fit with domestic needs. Elsewhere in Zambia, the rationale for starting the Pharm.D. programme is also not 'needs-based'. It comes from the intention to fight for an equal pay with the medical doctors, hence needing a 'doctor' title (Wuliji, 2010).

As these capacity issues appearing mostly in commentaries, but not in original research, one could suspect that capacity may actually be situated in the blind spots of the research paradigm. A scientific design to studying pharmacy education may have limited research questions to positivist ones; hence leaving the critiques to commentaries. In most cases, 'pharmacy education' is being studied as pharmacy subjects + matching educational tools. Therefore, pharmacy education has yet to become a fully cross-disciplinary research area. It is a 'subset' to 'pharmacy' research, sharing its epistemology with the latter. Although this research has labelled itself a 'pharmacy education' research, there is a need to engage other research paradigm(s) and/or discipline(s), in order to ask questions situating in the blind spots.

5.1.4 'Capacity' in health worker education

Section 5.1.3 explains how the pharmacy education literature is a subset of 'pharmacy' research. Likewise, in this section, I shall explain how health worker education literature could be a subset of 'health workforce' literature. It is still a relatively new area of study; even the only journal dedicated to studying HRH issues, "Human Resource for Health", has said very little about education. This journal concerns mostly with issues like skills mix (see section 3.1.3), strategies for HRH retention[82] and tools for HRH planning[83]. Situated within the MDG paradigm, there are plenty of prescriptions when it comes to how the health worker education should operate (see Box 5-1). Of importance is the use of skills toolkit to transfer local health needs into education/training priorities. In pharmacy, the education *should* be concerned about fulfilling MDG-related pharmaceutical needs, *inter alia*, distribution of anti-retroviral medications. This

[82] For instance, measurement of job satisfaction [e.g., (Peters *et al.*, 2010; Mathauer and Imhoff, 2006; Dieleman *et al.*, 2003)]; measurement of intention to stay on for a rural posting [e.g., (Lori *et al.*, 2012)], etc.

[83] For instance, measurement of staffing ratios (Cartmill *et al.*, 2012).

is not to dispute the priorities set by the MDGs[84] but to point out the way how 'needs' are actually established globally (and not locally). Because of pharmacists' prescribed position as an 'allied health cadre' (notwithstanding its 'incomplete' professional status even in the West, see Chapter 3) for drug distribution, pharmacy education is objectified to become a tool to achieving the MDGs.

By comparing literature in sections 5.1.3 and 5.1.4, research in African pharmacy education encounters two agendas: one profession-oriented and the other development-oriented. It carries a different connotation when pharmacists are identified as 'health workers' than when they are identified as 'professionals'. Whilst literature in section 5.1.3 suggests pharmacists should be educated to achieve certain competence (or competencies), literature in this section suggests they should be educated to deliver MDG-driven services. Therefore, this research seeks to speak about this grey area about pharmacists' identity and how the education sector is constructed: should this research be situated within the literature of the profession (as in section 5.1.3) and/or the MDGs (as in this section); or within the literature about African universities (as in section 5.1.2), if this issue is not discipline-specific? In an African Medical School Study that involved 168 medical schools, capacity issues identified (e.g., understaffing, lack of physical infrastructure and lack of quality assurance measures) are indeed not discipline-specific, even when the research team was led by medical doctors. Strategies suggested for capacity building, for instance privatisation and international partnership, are not dissimilar with those already mentioned in the background literature (as in section 5.1.2) (Fitzhugh *et al.*, 2011). Therefore, it was suspected that similar findings might be shared by this research. Like medicine, pharmacy might be able to attract health-related funding for institutional capacity building. However, unlike medicine, its ability to attract funding may be limited by its quasi professional status. In the next section, I shall

[84] See (Hayman, 2007) for debates about why target-driven development goals can be problematic.

look at the literature in development, which explains where these development-based 'prescriptions' come from.

Principles

- Address country health needs and embed education and training in the health system;
- Increase equity and efficiencies of scale through innovation in curriculum design and delivery; and
- Enhance quality through leadership and collaboration.

Strategies

- Reduce attrition among students and teachers, and improve accessibility.
- Integrate pre-service and in-service education and training.
- Develop common educational platforms for different types of health worker.
- Move learning to the community, using modular education and action learning.
- Increase use of information and communication technologies.
- Improve education through quality assurance programmes.
- Build institutional capacity by:
- Expanding teaching capacity;
- Fostering twinning and partnerships;
- Maximizing impact through regional approaches; and
- Harnessing public–private partnerships.

Box 5-1. Principles and strategies for scaling up health workforce education in countries with critical shortage of HRH.

Taken from (Global Health Workforce Alliance, 2008b).

5.1.5 'Capacity building' via development assistance and cooperation

Most of the SSA states are aid dependent, and so are the countries' higher education sectors. The success of capacity building in SSA universities, therefore, is invariably dependent on the effectiveness of aid, or more politely 'development assistance (later cooperation)'.

Most African states gained independence in the 1960s. As part of the de-colonisation process, the exit of colonial governments was accompanied by a gradual withdrawal of colonial administrators in order to allow time for their positions to be taken over by the domestic governments. Termed as 'indigenisation', the building up of local capacity was measured by foreigner: indigenous ratio. The lower the ratio, the higher domestic capacity is built. Capacity building programmes in this period were focused on North-South knowledge transfer, achieved by awarding scholarships to study abroad (usually at institutions in former colonial countries), setting-up of teaching institutions staffed by expatriate teachers, and direct consultancy service offered by experts from the North (UK Department for International Development, 2002). This existed as part of a wider 'modernisation' era whereby under-development was thought to be rectified by emulating strategies once adopted by 'developed' nations for economic growth. This brought in debates about how transferable the model of Western industrialisation, which was admittedly unsustainable and reductive, into African settings. The limited success of such strategies and a growing concern in the North that capacity building was failing because of Southern deficiencies led, from the 1980s to early 1990s, to a series of capacity building effort on correcting governance. Expertise (mainly) from the North was called upon to provide consultancy on how best to restructure an organisation, policy and practice (Moss, 2007). However, the northern enthusiasm in correcting southern governance was often accompanied by geopolitical agenda where African states were bribed into certain ideologies by aid packages. This was evident by the sharp fall in the amount of aid channelled to Africa in the immediate post-Cold War period. Although geopolitical aid was revived post-9/11[85], African states lost their 'privileged' aid positions to states perceived to be more threatening to global security like Iraq and Afghanistan (Novelli, 2010). Anyway, the dominance of Northern ideologies (on Southern country policies)

[85] 9/11, or September 11th, refers to a series of four coordinated suicide attacks carried out an Islamic militant group al-Qaeda, upon the United States on 11/09/2001.

was continued by the increased (and still increasing) influence of international development agencies, led by the World Bank. In tandem with the neoliberal development model in the 1980s, it was believed that national economic growth should be spurred by market liberation, deregulation and privatisation (Pieterse, 2001). Termed as 'structural adjustment', this IMF-prescribed capacity strengthening policy has resulted in massive civil servant (university staff inclusive) retrenchment, which has yet to be recovered from even today. Although there has been much criticism about the failure of international development agencies to aid failing states or economies, they remain the core funders for capacity building in African states so the debate has turned to how to do make development cooperation work better.

Although modernisation has become a past fashion, its legacy continues. Aid projects were often accused to be donor-driven thus robbing the domestic players of their autonomy. This became conceptualised as an 'ownership' problem, which was seen as an inevitable side effect from the inherent power and resource asymmetries in a donor-recipient relationship (King, 2009b). 'Partnership' or 'collaboration' then comes naturally as a solution, as evidenced from its increasing uptake by declarations to make aid effective. Across the Paris (2005), Accra (2008), Bogotá (2010) and Busan (2011) Declarations, there have been continual attempts to enact an equal relationship between donors and aid recipients. However, these seemingly apolitical and rational guidelines may well remain ideological, in view of how the present relationship has already been distorted by 'enclavisation' (i.e. nurturing only an enclave of pro-donor bureaucrats) and 'extraversion' (i.e. prioritising the service to the donors). The paradox of doing capacity building, which is often itself capacity draining, was increasingly subjected to the critique of 'capacity for whom and for what' (Mkandawire, 2002) during the 2000s. Whilst the most radical positions called for a complete withdrawal of aid from SSA, most have called for modifying aid mechanism. For instance, Ellerman (2006) proposed 'autonomy-respecting assistance', using 'indirect' approaches akin to teaching people to fish rather than directly dishing out the fish. Panday (2002) suggested donor harmonisation

and 'specialisation', where only the most specialised one is chosen to represent all donors, in order to ease the over-crowding scene of the aid industry. However, these suggestions to revert donors to a supplementary role is in reality very challenging, as evidenced from the recurrent challenges of the sector wide approach (SWAp) over more than a decade since its inception. Donor countries have frequently refused to trust pooled funding due to home countries' pressure for direct accountability of taxpayers' money (Samoff, 2004). The controversial line between 'helping' and 'herding' makes a 'non-interference' aid modality look attractive, where aid is handed out without interfering in internal state affairs. Despite its controversial motives[86] in establishing development cooperation with African countries, Chinese aid was observed to have a more equal relationship with its partners. Unlike traditional Western donors, non-aid elements such as the presence of local Chinese businesses, who live interdependently with the local communities, have arguably made China government less a donor but more of a partner (King, 2010).

In other words, capacity building through development assistance or cooperation has been complicated by multiple actors and different modalities. The capacity spent for cooperation perhaps is almost as much as, if not more, than capacity spent for development.

5.2 Higher education in Malawi and University of Malawi: establishment, capacity and policies

A short introduction to the higher education sector in Malawi

Malawi education system runs on the 6-6-4 format: six years of (compulsory) primary school, six years of secondary school and four years of post-secondary school education. All levels of education have both public and private providers; however only primary school education is free for all under the EFA policy from

[86] The most prominent ones are mineral extraction and human migration.

1994 onwards. Only 0.5% (2008 figure) of the population obtained post-secondary education, compared with the world average of 26% and SSA average of 6%. This ratio is many times lower than the gross enrolment ratio of 16% in upper secondary school. Limited spaces in tertiary education created high outbound mobility. 31% of Malawian tertiary students received their education abroad[87] (UNESCO-UIS, 2009).

Post-secondary education is divided into three categories: university education, vocational training and teacher training. There are three types of higher education institutions providing post-secondary education (see Table 5-1). Out of these, there are two public and four private universities. The University of Malawi (UNIMA) is the first public university in Malawi, which was founded under the UNIMA (Provisional Council) Act in October 1964[88]. The second public university, Mzuzu University (MZUNI) was opened in 1999 following high demand for public higher education. All private universities were set up in the 2000s[89]. Public universities enrolled 8,081 students in 2008. Although this number is small (for a population of 15 million), it is a large improvement from the small intake of 180 in 1964 (Government of Malawi, 2009). Private universities, though larger in number, enrolled only 1,001 students in total (2008 figure) because of the limited range of courses offered[90] (World Bank, 2010a).

[87] The five top destinations for studying abroad are (with number of students in brackets, 2009 figure): South Africa (656), United Kingdom (581), U.S.A. (328), Australia (85) and Norway (36).

[88] The provisional act was replaced by the UNIMA Act in 1974, and again amended in 1998.

[89] Livingstonia University in Rumphi (2003), Shareworld University with campuses in Blantyre, Lilongwe and Mzuzu (2006), Catholic University of Malawi in Blantyre (2006) and Adventist University of Malawi in Ntcheu (2007).

[90] Courses are offered only in the fields of education, humanities, commerce, development studies and information technology. None of the private universities offered science, engineering, health or other professional courses. Source: p. 151, (World Bank, 2010a).

Type of HE institution	*Number of institutions*	*Estimated % of HE students enrolled in this type of institution*
Publicly funded universities	2	50%
Publicly-funded polytechnics or specialised colleges	7	10%
Privately-funded, accredited universities or colleges	4	40%
Total	13	100%

Table 5-1. Higher education (HE) institutions in Malawi.

Taken from (Butcher *et al.*, 2008).

A large proportion of government expenditure is allocated to education. It constituted nearly a quarter of the total expenditure in 1999 and consumed 5.8% of the country's gross domestic product (UNICEF, 2008). There were an estimated 7,700 (2007/08 figure) students in public higher education institutions in Malawi. However, this small number of students consumed a comparatively large share of public expenditure, amounting to 2,147% of GDP per capita[91] (2007 figure). Funding one university student is equivalent to funding 259 primary school students (see Table 5-2). The problems and solutions to high unit costs for university education will be discussed in section 5.2.1.

[91] It means the cost of one student in a public university is equivalent to 21.5 times the average Malawian annual production.

	Total number of students	Public recurrent expenditure (MK million)	Public recurrent unit cost (MK)	As % of GDP per capita	As a multiple of primary education	SADC average (% of GDP per capita)	SSA average (% of GDP per capita
Primary	3,264,594	9,857	3,019	8.3	1	12	11
Secondary	161,575	4,894	30,292	83	10	34	30
TEVET (non residential)	4,807	247	51,408	141	17	-	-
TEVET (residential)	1,810	247	136,529	376	45	-	-
Teacher training	6,029	669	110,905	305	37	-	-
Higher education	7,700	6,010	780,479	2,147	259	-	314

Table 5-2. Public recurrent unit costs by level of schooling in Malawi (2007 figure).

Taken from (World Bank, 2010b). TEVET: technical, entrepreneurial and vocational education and training.

Brief history and administrative structure of UNIMA, CoM and DoP

During its early years, the UNIMA opened as Chancellor College at Chichiri, Soche Hill College and Mpemba Institute of Public Administration and Law, the Blantyre Polytechnic, and Bunda College of Agriculture. In 1974 the faculties at Chichiri, Mpemba and Soche were moved to Zomba, along with the university administration. In later years, Kamuzu College of Nursing (KCN) was opened in Lilongwe in September 1979; and the College of Medicine (CoM) in Blantyre in 1991 (Kerr and Mapanje, 2002). Today, UNIMA consists of five constituent colleges (see Figure 5-5). These five colleges are located in three cities: Bunda College and KCN in Lilongwe; Chancellor College in Zomba; and CoM and Polytechnic in Blantyre. Apart from teaching colleges, the UNIMA has five research centres[92].

[92] Centre for Social Research, Centre for Language Studies, Centre for Educational Research and Training, Agricultural Policy Research Unit and Gender Studies Unit. Source: UNIMA Calendar 2007-09.

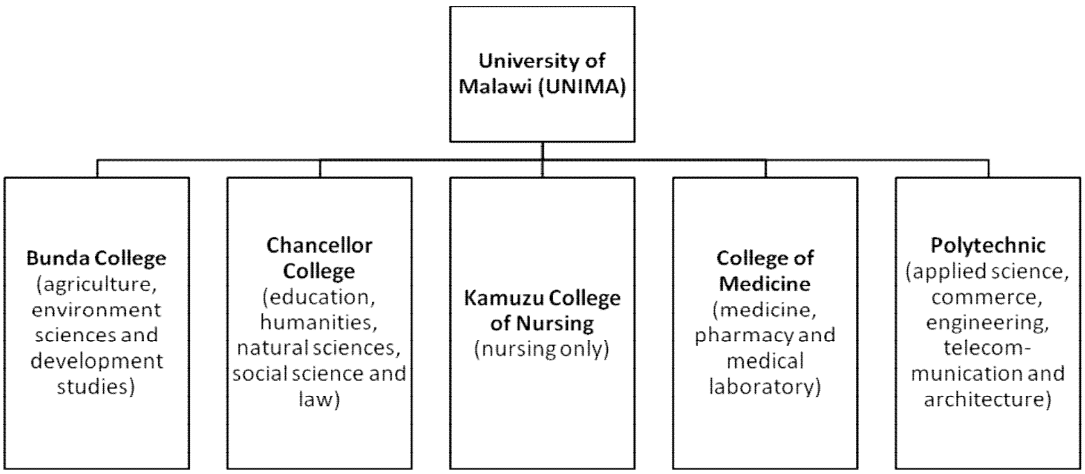

Figure 5-5. Five constituent colleges under UNIMA (and courses offered in brackets).

Prior to having its own medical school, Malawians were sent by the government for medical training overseas (especially in the UK) and also neighbouring African countries (especially Zambia and Zimbabwe). The problem resulting from this was a high number of non-returners amongst these Malawian doctors trained abroad. The foundation of the first medical school, the Collge of Medicine (CoM), was hoped to avoid this problem by educating Malawian doctors in-country (Broadhead and Muula, 2002). The CoM was established in 1991, with financial contributions from the Netherlands, Germany and the UK. In 2004, with financial support from its European donors (i.e., Netherlands, Norway and Sweden) it started to offer postgraduate degrees[93] (Zijlstra and Broadhead, 2007).

The Department of Pharmacy (DoP) was established in 2006, with financial support from the Global Fund (see sections 6.1 and 7.1.1). The curriculum is intended to fit the country's health needs, or in other words 'needs-based', thus was decided upon consultation with important stakeholders such as the PMPB, the CMS and PHASOM. There was yet any inter-university partnership between the DoP with any pharmacy schools abroad. However, individual experts from abroad have been involved with the development of the department. They were involved in the process of designing the curriculum, together with the domestic

[93] Students could register for Master of Medicine in several disciplines, including Medicine, Paediatrics, Surgery, Obstetrics and Gynaecology, Anaesthesia and Ophthalmology.

stakeholders (Lockwood, 2005); and two of them were heading the department during its foundation years. The curriculum outline for the Bachelor of Pharmacy programme looks similar to a traditional undergraduate pharmacy programme, particularly the British model (see Table 5-3), in terms of the subjects and sequence of how these subjects are taught. It was hoped to prepare future pharmacists to undertake two major roles: drug supply chain management and health education. Although not directly visible from the curriculum, it was mentioned in the earliest documents that knowledge in traditional medicine was crucial, because of its high usage amongst the rural majority. Therefore, pharmacy education was hoped to also teach the future pharmacists about the concurrent use of traditional medicines and modern medicines.

Year of Study	*Curriculum outline*
1	An introduction to pharmacy Basic medical sciences – anatomy, physiology, biochemistry Community health – an introduction
2	Pharmaceutics I Pharmaceutical chemistry I Pharmacology I Pharmacognosy Microbiology Community health – principles of epidemiology & statistics
3	Pharmaceutics II Pharmaceutical chemistry II Pharmacology II Pharmacy practice I Pharmacy law Drug management I
4	Pharmaceutics III Clinical pharmacy Pharmacy practice II Drug management II Medicinal chemistry Toxicology Research in practice

Table 5-3. Curricular outline of the Bachelor of Pharmacy programme, DoP, CoM.

In the following subsections, capacity problems faced by the higher education sector in Malawi are discussed. There is a specific focus on DoP (or CoM or UNIMA) wherever data is available.

5.2.1 Capacity problem I: small intake and high unit costs

The World Bank's working paper on the Malawian education system attributed the high unit costs of higher education student to several factors: first, small student-teacher ratio (of 11, vs. SADC average of 17 and SSA average of 20). Malawi had one of the lowest university enrolment rate (average of 51 per 100,000 inhabitants; with male students double that of female, i.e., 70 vs. 33) in the SSA region. Most of the qualified students cannot enter university education[94] because of limited university places, which was caused by limited accommodation. Because of the unavailability of other accommodation options, universities had to bear the costs of providing hostels, food and other living allowances. Spending for student provisions and allowances (see Table 5-4) far exceeded the tuition fee (of MK25,000) paid by residential students. In the opinion of the Director of Higher Education, the post-independence link of university places and accommodation was unsustainable:

> The trouble with our university acts is that they link selection to the number of beds available. If the beds are one thousand, we can only take one thousand students. But we want to move away from there. We want the universities to outsource these services so the universities are not involved in offering bed space to students, giving them food, you know, companies should do that. So that now we can take in more students. But there must be available accommodation for these people to rent. Like Malawi Housing Cooperation has now built an apartment in Zomba for students to rent. And that's what we want! So if you have money, go and build one. Our students would rent! That's the way we want to move forward. We've outsourced catering, so that people expert in food industry should provide food

[94] For 2011/12 academic year, 7791 candidates wrote the University Entrance Examination and 6615 (85%) passed. However, only 2379 (36%) were accepted based on the quota system. UNIMA claimed this was an increase from a 25% acceptance rate in past years (University of Malawi, 2011).

> for the students. So that when the food is bad, they don't go to the Principal of the College. So let the Principal concentrate on the core business: teaching and learning, research, outreach and consultancy. That's what the university should be concentrating on! But right now they're spending more of their effort chasing food, strikes from these labourers, carpenters... all those should be outsourced!

To increase enrolment figure, MZUNI and three (out of five) colleges[95] of UNIMA had increased its intake of non-residential (or 'parallel') students[96]. As a result, total university enrolment almost doubled from 4,659 (in 2003) to 9,081 (in 2008), with most growth coming from increased intake of non-residential students. However, the CoM still maintained a policy of enrolling only residential students because of the need for practice-based learning. Students needed to travel frequently between the teaching hospital and the campus, both for study purposes and on-call duties (see quote below). Interviews with the administration office of the CoM showed non-residential programme as not immediately feasible, though it was said that this policy could be considered for academic years with no on-call duties. Whilst the college was building more bed spaces with funding from the Norwegian government, the fundamental problems associated with residential programmes remained unsolved: i.e., high private rental and transport costs. Capacity building in higher education perhaps has to go hand-in-hand with capacity building in supporting areas, e.g., expanding private housing and improving the public transport system. Otherwise, the universities have to continue paying for students' accommodation.

> Our medical students go on call. And therefore it may not be feasible to have non-residential students. Considering that the transport

[95] The CoM and Kamuzu College of Nursing did not enrol non-residential students.

[96] Unlike residential students, non-residential students did not get free accommodation within university campuses. They also paid full tuition fees (MK300,000, vs. MK25,000 paid by residential students), their own food and other living expenses, because they were not eligible to apply for university loans.

> infrastructure in Blantyre is not good, a student cannot live ten kilometres away and be on-call and leave at 10pm, because by 10pm there's no transportation within Blantyre.
>
> Dean of Undergraduate Study

The second factor quoted in the World Bank's report was the high salary received by the university lecturers. Malawi paid its university lecturers 65.8 units of GDP per capita, which was 2.7 times higher than the average in seven countries with GDP per capital lower than USD500 (in 2007)[97]. Emoluments and benefits constituted 60% of the unit costs (see Table 5-4). Even so, salary remained an important factor for staff attrition because Malawian salaries were still far lower than those in wealthier countries (see section 6.4 for comparison of lecturer salaries between different countries).

	Actual cost per student (in MK)	***Percentage***
Emoluments and benefits	404,965	60
Student provisions/ allowances	47,594	7.1
Teaching materials/ equipment	6,519	1
Books and periodicals	1,374	0.2
Common services (represents general administration)	96,899	14.4

Table 5-4. Unit cost and percentage (2006/07 statistics) by expenditure category at UNIMA.

Taken from (World Bank, 2010c).

The third factor causing high unit costs was the lack of cost-sharing (from students) and the dysfunctional cost recovery mechanism in the higher education sector in Malawi. Because of merit-based enrolment, the universities enrolled a large proportion of their students from private secondary schools. Students attending these expensive secondary schools mostly come from well-to-do families, who could actually afford to pay for their children's university

[97] The other six countries are DRC, Guinea, Mali, Madagascar, Ethiopia and Burundi.

education. According to World Bank statistics, 90% of the university students were from the wealthiest 20% of the country. At the same time, student loans were only eligible for residential students but not for non-residential (including mature entry students, who were denied residential status), non-degree tertiary programmes (e.g. TEVET) or private university students. In other words, funding was concentrated on just a small number of public university residential students, who could most probably afford to pay the full tuition fee anyway. On top of this, the lack of an enforcement system resulted in slow and inefficient loan recovery. It was said (by a local online daily newspaper) that UNIMA students owed MK850 million. Regarding this issue, the University Finance Office said the solution was to let a domestic private bank to take charge of loan recovery. The rationale was that this bank was used by many Malawians thus it should be more effective in tracing indebted students.

Recognising cost-sharing as an essential step forward, the government planned to reduce its contribution to the unit costs. Student fees were planned to be increased from 0% (1997) to 47% in 2012 (Government of Malawi, 2000a). In the academic year 2011/12, the university declared a fee hike for residential students from MK25,000 to MK80,000 (equivalent to a 220% increase). However, this decision was later revoked by the (late) President, who was also the Chancellor of UNIMA, following protests from students, political leaders and civil society organisations. As a result, cost-sharing was difficult to implement because it was politically unfavourable.

The next strategy attempted was the 'quota' system (or 'equitable access to education policy', as called by the government), which was applied for the first time for the 2010/11 academic year intake (Nyasa Times, 2011b). Under this system, each one of the 28 districts would be offered 10 university places[98]. After the first 280 places were filled up, the remaining places were open for merit-based competition. This policy also soon became political. It was criticised as a

[98] On a non residential basis, selected students then would have to compete for residential places.

discriminatory against the northerners, who currently outperformed their southern counterparts academically. Because of the identity of the late President as a southerner, the northerners felt the decision was made based on favouritism[99]. However, this decision was opposed not only by the northerners but also by the universities. There were worries about the quota system absorbing students who could not perform in the university. In the CoM, the one-year pre-medical course is supposed to eliminate the inequality caused by different qualities in secondary education. There was concern that this could not be done if the inequality was too large[100]. Students from poor quality secondary schools were said to be weak in science subjects because of the unavailability of laboratory equipment in the schools. Eventually, the quota policy went through despite public and university resistance. However, this decision was reversed by the new President in July 2012, barely two years into implementation[101].

To fundamentally solve the tension between costs, equity and quality of university education, the government vowed to build five new universities in ten years[102]. At the time of fieldwork, the government had managed to source funding for only one university (which would be based in Thyolo). Therefore, it is unknown how practical or how quickly this promise could be materialised. From these instances, it is evident that educational policies are greatly influenced by domestic politics. In a way, these highly volatile political decisions had forced the

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[99] Words like 'extinction' was used to describe political discrimination imposed by the late President Bingu wa Mutharika towards northerners (Nyasa Times, 2011a).

[100] Pre-medical programme was created to prepare students before entering first years, with special focus on areas under-studied at secondary level e.g. science, English and computer skills. Because of the lack of A-level programmes in the country, most students were enrolled based on MSCE (O-level equivalent) results. To compensate their lack of science knowledge, students who wished to enter CoM programmes needed to do the first two years of study in a science programme at Chancellor College.

[101] Joyce Banda took over Presidency from Bingu wa Mutharika, following the sudden death of the latter in April 2012. For the news of Banda scrapping the university quota system, see (University World News, 2012b).

[102] A statement made by the President, Dr Bingu wa Mutharika, on the occasion of the state opening of the 2010/22 budget meeting of the Malawi Parliament (Government of Malawi, 2010).

individual institutions to look for their own ways for financial survival. In Chapters 6 and 7, CoM's survival strategies through cost cutting (e.g. sharing resources using servicing departments) and income generation (e.g. research and consultancy) will be discussed.

5.2.2 Capacity problem II: teaching staff shortages

Despite being one of the highest paid employees in the country, the teaching staff still complained of low salaries. Many staff were particularly concerned about the loss of housing benefit (from 2006 onwards), since the cost of private housing was very high. As a result, an academic career was not financially attractive.

> People do not want to come. Salary is too low. Even if they come, they don't stay. We had very good technicians. They only stayed six months, nine months, they found another job and they left. Salary is too low. They can come for interview but if they are told the salary, they don't come.
>
> Lecturer VIII

> But their packages, their salaries are *very low*. Even myself, I was receiving 1400 [in MK, equivalent to about £5.60] all the way from here [i.e. Lilongwe[103]] to Blantyre to teach. Just imagine.
>
> A part-time lecturer

At the same time, recruitment and retention was made even harder by fierce competition from private sector and/or international recruitment.

[103] The distance between Lilongwe and Blantyre is approximately 310km and the cost of petrol was about MK250 (or £1) per litre when this interview was taking place. Therefore, the pay was not enough to cover petrol costs.

> We trained someone in biochemistry. We trained them in Manchester at PhD level. They came, worked for us for a year, and left and went back to Manchester. And when we asked them to pay back they simply said no.
>
> We produced 700 nurses a year. We lose 300 nurses a year. The net gain is only 400. How could they expect to fill 16,000 required nurses with this kind of training?
>
> Dean of Undergraduate Study

Staff establishment in many departments at CoM was thin (see Appendix VII). At the DoP, only nine positions were approved and five filled at the time of fieldwork. As mentioned above, the pharmacy curriculum used by the DoP has similar contents with a British undergraduate pharmacy degree programme. That means the same amount of teaching applies even though with a smaller number of teaching staff. Meanwhile, the criteria for academic staff employment were also modelled after the British template (see Table 5-5). For instance, a PhD in Pharmacy was a requirement for recruiting academic staff at or above the level of senior lectureship. There seemed to be an expectation to educate pharmacy students using similar capacity, in terms of curriculum and lecturer qualifications, as that of Britain. However, domestic capacity might fall short of this expectation. Indeed, Britain has been more flexible in employing academics especially in shortage or developing areas like pharmacy practice without PhDs.

Position	*Main responsibilities*	*Qualifications/ experience required*
Professor	Head Department and academic teaching	PhD Pharmacy plus 7 years teaching and research experience
Associate Professor	Teaching and research	PhD Pharmacy plus 5 years teaching experience
Senior Lecturer	Teaching and research	PhD Pharmacy plus 3 years teaching experience
Lecturer	Teaching and research	Masters degree or PhD
Assistant Lecturer	Teaching and research	Bachelor of Pharmacy Honors degree
Chief Technician	Heading laboratory section and conducting lab sessions	HND Laboratory Technology plus 5 years experience
Senior Technician	Conducting lab sessions	Diploma in Laboratory Technology plus 3 years experience
Laboratory Technician	Conducting lab sessions	Diploma in Laboratory Technology
Laboratory Assistant	Lab sessions	Certificate in Laboratory Technology

Table 5-5. Academic qualification required for academic staff recruitment at the DoP, CoM.

Source: teaching manual, Bachelor of Pharmacy programme**.**

Because of the low number of teaching staff, some areas lacked expertise and lecturers could not simply 'cover' areas they were not familiar with. Consequently, some lessons were missed and sometimes the entire module was not delivered. This problem was brought up by the pharmacy students. Three focus groups were conducted with students ranging from year 1 to year 4 (see Table 5-6). This complaint was repeatedly raised in all focus groups; hence it is believed that this issue should be concerning pharmacy students from all years (see Table 5-7). According to students, the lack of laboratory work forced them to do rote learning, by just memorising facts without actual understanding. In some cases, rote learning was also caused by poor teaching quality, for instance using PowerPoint presentation slides that are downloaded from the internet. Also, teaching also was rarely conducted outside of mass lectures. There were very few assignments given; and almost no continual assessments (such as quizzes) carried out. Therefore, shortages of lecturers lead to not only a shortfall in quantity that can be taught, but also in the quality of the education.

Date of focus group	*Number of students*
02/06/2010	7 (5 first-year; 2 second-year)
09/06/2010	3 (1 second-year; 2 fourth-year)
10/06/2010	4 (all third-year)
Total	14 (5 first-year; 3 second-year; 4 third-year; and 2 fourth-year)

Table 5-6. Focus group interview dates and number of students interviewed.

Year of Study	*Number of student (male/female)*
1	16 (5/11)
2	19 (3/16)
3	20 (7/13)
4	16 (5/11)
Total	71 (20/51)

Table 5-7. Number of students studying pharmacy course (Year 1-4) at the CoM, UNIMA, during academic year 2009/10.

Source: Registrar Office, the CoM.

5.3 Conclusion

Capacity problems faced by the UNIMA are similar to those discussed in the literature of African higher education. These university-wide problems affected the individual schools and departments directly, resulting in staffing and funding restrictions. At the same time, capacity problems faced by the DoP are not discipline-specific. This means there might not be a need to investigate capacity issues according to disciplines. Instead, lessons learned from faculty retention in general (and in the context of SSA) may be applicable to the DoP. Facing burning problems like unavailability of lecturers for the entire module, in the next chapter I shall explore if there is any innovative solution to expand the teaching capacity in the shortest period possible. It will be enquired if stakeholders' resources can be mobilised to assist institutional capacity building; and whether pharmacy can receive 'special' attention in terms of funding, because of it being a health discipline.

CHAPTER 6

Stakeholder engagement for capacity building in pharmacy education: engage who and how to?

In this chapter, capacity building is investigated in two ways: first, capacity building in terms of improving the 'hardware' of the education institution (e.g., lecturer recruitment); second, capacity building in terms of expanding the purpose for having pharmacist profession in the country, or in sociological terms 'professionalisation' (see Chapter 4 for the relationship between professionalisation and capacity building). Empirical data will be presented on how six categories of stakeholders contributed to institutional capacity building in these two ways. They are the government of Malawi (6.1), the pharmacy profession (6.2), the training institution for pharmacy technicians (6.3), the UNIMA administration office (6.4), the College of Medicine (6.5) and the Department of Pharmacy itself (6.6). This will be done using 'SWOT' (strength, weakness, opportunity and threat) analyses, in order to identify stakeholders with the most favourable SWOTs to support pharmacy education. Meanwhile, embedded throughout the chapter, there is an incompatibility between the underlying principles of 'stakeholder-ship' and the local reality. In the final sections of the chapter, the notion of 'stakeholder engagement' will be challenged regarding its applicability in a postcolonial, aid-dependent setting.

6.1 The Government of Malawi

In Malawi, the government is the sole provider of pharmacy education in the country. Private universities do not offer health professional courses such as pharmacy and medicine (see section 5.2). It was upon state decision and funding[104] that the Department of Pharmacy (DoP) was established in 2006. State funding, as used in this section, refers to money that is channelled through governmental mechanism, regardless of how the fund is raised.

[104] To what extent the decision was originated from the state (or bound by donor effect) will be debated in Chapter 7.

Strength Held accountable for providing funding.	***Weaknesses*** Chronic under-funding; Donor dependence; Ambiguous role between the MoE and the MoH.
Opportunity Increasing recognition of the contribution of pharmaceutical HRH.	***Threat*** Lack of intention to professionalise pharmacy.

Table 6-1. SWOT analysis of the government of Malawi.

The government of Malawi (henceforth GoM) is the biggest funder to UNIMA, funding 95% of its expenditure; whereas the international donors fund 95% of research activities (Butcher *et al.*, 2008). Although there was an increasing trend in cost-sharing, government subvention remained as the major funding for the CoM (see Table 6-2).

Year	***Government Subvention***	***Fees***	***Others***[105]
2004/05	93.5%	4.0%	2.5%
2005/06	87.5%	3.4%	9.1%
2006/07	69.9%	27.4%[106]	2.7%
2007/08	49.6%	29.2%	21.2%

Table 6-2. Sources of income for the CoM, UNIMA.

Taken from (World Bank, 2010d).

Through UNIMA and CoM finance administration (see Figure 5.2), DoP received its funding. Government funding however was unstable because of its poorly resourced and aid dependent nature. Chronic under-funding was a widespread phenomenon in the public sector. As a result, it was normalised to become a chronic crisis that had to be adapted by the receiving ends. The UoM Finance Officer said:

[105] Usually comes from research and consultancy work.

[106] The sharp increase in tuition fees was contributed by NAC scholarships, which paid full-scale tuition fees, at approx USD8,000 per student (instead of MK25,000 normally paid by the students).

> Of course we don't get all the money we would like to get. We submit our budget and usually they give us only part of what we indicate. That happens almost every year.
>
> University Finance Officer

Another cause for unstable funding comes from a longstanding ambiguity regarding the responsibility to source funding for the pharmacy degree course, as well as pre-service education/training for all other health cadres. It had been unclear whether the responsibility should lie with the Ministry of Education (MoE) or the Ministry of Health (MoH). Although it was eventually agreed that all pre-service HRH training be moved to the MoE (whilst in-service training to the MoH), the MoH still had to monitor the MoE's budget for pre-service training. This was because the MoH had a higher stake than the MoE should the HRH training be interrupted. To guard its future HRH, the MoH needed to 'mobilise resources' to supplement MoE's budget for training HRH. In fact 'resource mobilisation' was a commonplace, and also regarded as an important fundraising mechanism, within government. The nature of resource mobilisation was expressed by the following excerpt, which is summed up well with the saying "everybody (is) doing something for (HRH) education":

> If MoH can go and say like to, say Clinton Foundation, and say I want to train so many people, can you give us some funding or resources. This will at least pay for their fees. This is one way of MoH mobilising resources for that training institution, for that course… When that prerogative should [actually] rest with the MoE. Ok. That has been going on for some years… where we come, it has been like mishmash. Everybody doing something for education.
>
> Head of Pharmaceutical Service, MoH

Without such funding supplements, MoH's share might risk being 'forgotten' when the MoE budget was shared between many other national priorities. If the MoH did not 'remind' the MoE of its HRH training needs, by providing some

supplements, it was perceived as a potential risk to have the needs overlooked. Supplementing training budget in the MoE in return for having the training needs prioritised was perceived as a 'partnership' that was crucial for training success.

> Partnership is just a must. So we have that kind of understanding that MoH is not overlooked when the cake is being shared at the MoE.
>
> Head of Pharmaceutical Service, MoH

The lack of clarity on who should bear the full responsibility made the pre-service HRH training an orphan issue. Although the MoE acknowledged that it should be taking full responsibility for university education, it did not always have the capacity to do so. Until the time data was collected, there was only one person in-charge of all higher education issues in the country:

> Currently there's only *one* ministry handling everything: primary, secondary, university. You know in other countries they have split them you know… into higher education and basic education. Then you know you can split those functions. But currently there's one ministry. So *all* those problems should go to one person only. You get crazy! Oh no… you get stressed out and you just can't work […] Ideally there should be four people in this Directorate [i.e., Director, Deputy Director, Chief Education Officer and Principal Education Officer]. But in the government machinery the recruitment of people takes a while so I don't know when I'm getting the other people.
>
> Director of Higher Education, MoE

Without a government unit specifically assigned for pre-service HRH training, institutional capacity building for HRH training institutions became rather opportunistic. The 'Six-Year Emergency Human Resource Programme' (see section 3.2.2) was of 'ad-hoc' basis and primarily driven by donor initiative. The establishment of the pharmacy degree course too was born out of an international security threat presented by the spread of HIV/AIDS. Funding was

pumped into the National AIDS Commission (NAC) by the Global Fund. Describing its establishment as a 'hurried' process, the former HOD of the DoP said:

> They were promised funding by the National AIDS Commission. And that has happened. […] As a result of that they were able to start the programme in January 2006 but they did so in a very great hurry. And the reason for they being in such a hurry was the um... curriculum though it was written was not at that stage approved by Senate. So, they founded the department in a great hurry because otherwise they would have *lost* the money at the end of 2006.

Nevertheless the opportunity for 'opportunistic' growth did look bright. Pharmacy, as well as other supportive services, seemed to gain increasing political recognition. New principles and concepts embraced by the WHO or other international agencies clearly penetrated MoH's staffing strategy:

> Our priorities were doctors and nurses because they overlooked the others. But now we are saying yes [that we should also recognise the pharmacists]. Yes the doctor does the diagnosis and prescription but if you send to somebody who doesn't know the drugs it's a problem. So now we're saying let's all move together: so doctors, pharmacists, nurses, labs... let's move them all at the same time. But it's expensive.
>
> Principal HR Planning Officer, MoH

The intention to train pharmaceutical HRH however was limited to their drug distribution function (see Chapter 4). Lacking the vision to expand pharmacists' roles, the purpose of having pharmacy education unfortunately was reduced to producing enough 'managers' to fill up all key managerial positions within the MoH. A head count of these positions had revealed that no more than 50 pharmacists were needed in the country (see section 4.2). GoM's budget allocation for pharmacy education therefore was small – with a target output of

20 per year from the CoM. Apparently, it was not within GoM's vision to professionalise public sector pharmacy when this target output is compared with those of the medical and nursing programmes. The state's intention to maintain pharmacists to their ancillary status was actually made explicit in the following statement regarding the purpose of having a pharmacist degree programme:

The Aim of Pharmacy Programme

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.

Box 6-1. The aim of pharmacy programme.

Source: teaching manual, BPharm programme, Department of Pharmacy, CoM, UNIMA.

Within the MoH, pharmacy was categorised as one of the 'technical support services'. Unlike medical and nursing professions where they had their own Directorates (of Clinical and Nursing Services), pharmacy was merely a department under technical support. A similar situation was found in the higher education sector – whilst medical and nursing students had stand-alone training institutions (CoM and Kamuzu College of Nursing), pharmacy students were housed inside one department under the College of Medicine.

In summary the government provided a major, albeit instable, source of funding. Such instability augmented the tendency to seek for a quicker resolve from the donors. The (international) political climate that favoured expansion of the pharmacist cadre, because of currently inefficient distribution of anti-retrovirals, provided an opportunity. And the DoP had benefited from it by receiving direct funding from the NAC. However such an opportunity could also be a threat to professionalisation of the pharmacy sector. By restricting pharmacists' roles to just pharmaceutical managers, target output at the DoP was therefore limited to 20 per year. The state therefore becomes a supportive stakeholder by granting the commencement of the pharmacy course; but becomes an inhibitive one

should there be intention to develop the course as a fully professional and clinical one.

6.2 The Profession (PHASOM and the PMPB)

The roles played by the profession in departmental capacity building are explored in two ways in this section: first, a direct role through recruitment of practising pharmacists into teaching positions (both full-time and part-time); second, an indirect role through the process of professionalisation. As explained at the beginning of the chapter, professionalisation is needed for strengthening the purpose of having the pharmacy profession in this country, before it can be justified that more resources should be distributed for developing pharmacy education. The profession, therefore, plays an important, though indirect, role in capacity building in pharmacy education.

Strength Availability of widely experienced practising pharmacists.	***Weaknesses*** Small number; Weak PHASOM and PMPB; Severe lack of professional solidarity.
Opportunity Increasing number of pharmacists.	***Threats*** Attrition due to migration to private sector; Competition from other health professions; Peer jealousy.

Table 6-3. SWOT analysis of the pharmacy profession.

According to the local opinions, the pharmacy profession was threatened by a lack of political power. Professional solidarity was urgently called for to form a professional pressure group, which is then useful for professionalisation.

> No voice. No power. That's *exactly* the situation [of pharmacy profession] in Malawi. […] until PHASOM takes *serious* responsibility as a civil society body who represents the profession, the pharmacists will get nowhere.
>
> An expatriate who had worked closely with the profession

> I mean it [i.e., the professional body] is considered a pressure group for the profession. Because they should be spearheading problems first in the profession and take it to the authorities. Because it only works if we speak as one voice. You know. There has to be somebody. I mean there are a lot of problems here. We have dispensing doctors here, which means it has to be sorted out.
>
> Community Pharmacist VII

The profession was represented by the Pharmaceutical Society of Malawi (PHASOM). Unlike the professional bodies of their medical and nursing counterparts, PHASOM has no regulatory power[107]. Professional registration and power to carry out drug inspection lies with the Pharmacy, Medicine and Poisons Board (PMPB). Lacking governing power, PHASOM did not attract members hence it could hardly claim true representation of the profession. Describing the lack of professional solidarity amongst PHASOM members, two widely experienced pharmacists commented:

> PHASOM has been very much in the background. They're not known. They're not as powerful as our colleagues in the nursing or medical. They have been quiet. PHASOM members... I tend to look at them... Everybody is busy with their own businesses. They don't care what is happening elsewhere.
>
> One of the council members of PHASOM

> But even if you're a member of PHASOM, unless the executive members of PHASOM is doing something, what can you do? On the other hand, when the committee wants to do something and they ask members for money, they say what do I get out of PHASOM?

[107] This is not to propose that professional bodies should also own regulatory power, but to point out the situation where the pharmacists had become politically weaker than doctors and nurses, because the latter own regulatory power.

> Why should I pay? You see what I mean? It's an egg and chicken situation.
>
> Community Pharmacist VI

Because of its inactivity, PHASOM was described by its members as 'useless' or 'weak'. Interview data about PHASOM involved largely negative comments:

> We have the Principle Secretary of Health put as the Chairman of the board. Nobody raised any hem. Why? This is undermining the pharmacy profession. We need a Chairman, according to the law, who is a pharmacist. So that the Chairman articulates the minds of all pharmacists in Malawi. That is the idea behind this law. But you put somebody, who is an administrator, as your Chairman and nobody complains. Huh... I look at that and said well the Society cannot help anybody. The PHASOM is a dead body.
>
> One of the council members of PHASOM

> There is a pharmacy association in Malawi (i.e., the PHASOM) but they hasn't been really active to conduct continual education stuff.
>
> Community Pharmacist II

As mentioned in the first quote above, PMPB had a role that was perceived to be larger than merely a regulatory body. In most cases, pharmacists would turn to the PMPB (instead of the PHASOM) when it came to professional issues. For instance, community pharmacists were dissatisfied with PMPB for not solving the dispensing doctor issue. Expectation was placed on the PMPB to reclaim what was thought belonging to the pharmacists (i.e., the dispensing rights) from the doctors.

> I think the PMPB is overworked. I think they're overloaded and they don't have the potential to do stuff. For example everyday there's a law being broken in pharmacy. Down the road from me, like less than

> 100 metres, there is a doctor, according to the PMPB or according to the Malawian Act for Pharmacy it states distinctly that if there is a pharmacy within 5km of a doctor's surgery, that doctor is not allowed to have a dispensing license. So I think a lot of people are, personally I think a lot of people are getting annoyed with the PMPB because at the end of the day they're not able to withhold the law. If it states the doctor shouldn't dispense, then the doctor shouldn't dispense! There is a pharmacy, then what's the point of us if the doctor is going to dispense everything?
>
> Community Pharmacist IV

Such replacement, however, was not legally justified because the Board, as a regulatory body, could not exert political pressure for professional interest. This resulted in the profession not having any political representative, which was perceived essential for guarding professional boundaries. When asked about the reason why the PHASOM and the PMPB failed to act upon professional interest, the cause was blamed on the critically low number of pharmacists in the country. In the PMPB for instance, there were only two full-time pharmacist administrators cum drug inspectors. Because of this small number, pharmacists in Malawi lacked political power that was deemed crucial for development of the profession.

The idea to equate a larger member number with a stronger political voice probably was derived from what happened to the medical and nursing professions in Malawi. As shown in Table 6-4, nurses and midwives made up the majority portion of health workers in Malawi whereas pharmacy staff was almost missing from the health service composition in 2006. Indeed, pharmacists felt threatened by competition posed by these two health professions. Similar view was expressed by a representative figure from the Medical Council of Malawi in an interview.

It's a game of number. Nurses can influence *a lot* because they're a bigger group. So every time they say, it's a bigger loud voice. Then everybody cannot object to what they say cause they know they're powerful voice. It's the number. So I'm saying, at the district level, something can start changing if I have a voice at the DHMT. But I'm saying at the national level we can change so much if there're so many of us. Come on, just imagine, a country maybe having 15 pharmacists. And a country if we say having 500 pharmacists, when will we make a bigger difference? When we have 500.

Head of Pharmaceutical Service, MoH

The profession is not well recognised here in Malawi. Because like in the MoH they actually recognise the doctors. They recognise the doctors but not the pharmacists because we're in minority. They give more benefits to doctors than to pharmacists.

Acting Chief Executive, the PMPB

So for me really it's time for soul searching for pharmacists. How do you project yourselves as a profession? How do you make yourselves heard? How do you enforce your beliefs, your philosophy? Alright? The moment you don't do that, then you're a subsidiary of somebody else. And this is where doctors push you around. Because they know you guys don't have a soul. Yea. You can be told what to do and how to do it. Even if you're a profession in your own right. That's not right! That's not right. But you *allow* yourself to be messed around because you're not like put in place some mechanisms… some forms of… um.. assertiveness.

Assistant Registrar, the Medical Council of Malawi

Cadre	*Percentage of cadre in Malawi*	*Percentage of cadre in African region*
Physicians	3.2	9.7
Nurses and midwives	87.4	50.7
Dentists and technicians	*Data not available*	1.5
Pharmacists and technicians	*Data not available*	2.8
Environmental and public health	0.3	1.5
Laboratory technicians	0.6	2.6
Other health workers	8.5	7.5
Community health	*Data not available*	11.2
Management and support	*Data not available*	12.5

Table 6-4. Distribution of health workforce by cadre – a comparison between Malawi and the African region.

Table adapted from a WHO document entitled 'Country Health System Fact Sheet 2006: Malawi' (World Health Organisation, 2006a).

Because of the strong belief about the change that could be brought on by a bigger number, high hope was placed on the DoP to produce enough pharmacists in the country for strengthening professional power. There seemed to be optimism about Malawi for achieving sufficient number of pharmacists eventually in future years. Although the output from DoP was low (at 20 per year) and attrition to private sector was high, achieving the critical mass was seen as a slow but sure process. One of the main topics of discussion was about what could be done "when we have enough pharmacists".

> [In order to bring changes to the profession,] in the first place I think the number should increase. That's what we're doing now as we're producing a lot of pharmacists from the CoM. So with the number increased, then we would have a bigger voice.
>
> Acting Chief Executive, the PMPB

How this could happen, judging from the current lack of capacity in the DoP, was however not an immediate concern because most pharmacists did not perceive themselves having a stake in pharmacy education. Indeed, pharmacists were occupied with many problems in their businesses and careers. That left little space for work that did not affect them directly. On enquiring what they could do

for building pharmacy education in Malawi, answers generally involved offering training to pharmacy students through on-site placement. Because of the small salary, most private sector pharmacists were unwilling to take up full-time teaching positions. However, some were inhibited by the idea of teaching (and doing research) rather than by the money issues. The association of an academic life with purely scholarly activities (such as teaching and research) resulted in resistance in some pharmacists toward having an academic career. The promotion criteria (as described in section 6.4), which emphasises research publications, might discourage pharmacists who were keener on clinical practice from joining the university. For those who offered help to part-time teaching, it was said that the very small compensation they received was disappointing. Some felt that unequal treatment between Malawian and expatriate teaching staff was unfair, whereby the latter received a higher remuneration package.

> I joined the department just to help I am not interested. I'm sorry to say that [chuckle]. Basically I'm not an academic I'm not. […] I think it is [a demanding job]. To be honest I would rather [see] people who are really interested in teaching, doing research [to be in my position]. That's all about it [i.e., academic work]. Me, I can't do that. I can't do that.
>
> Pharmacist with over 20 years of practice in various sectors

> But their packages, their salaries are *very low*. Even myself, I was receiving MK1400 [equivalent to £5.60] all the way from here [Lilongwe[108]] to Blantyre to teach. Just imagine.
>
> A part-time lecturer

The idea to recruit pharmacy lecturers from the existing pool of practising pharmacists was inhibited by current HR recruitment and promotion policies.

[108] The distance between Lilongwe and Blantyre is approximately 310km and the cost of petrol was about MK250 (or £1) per litre when this interview was taking place.

Despite these inhibiting factors (as mentioned above), it must be noted that almost all pharmacists interviewed were very keen on continuing professional education (CPD). Because of a lack of facilities to do CPD locally, many saw teaching as a good way to improving one's knowledge. Quite a few had also expressed an interest in pursuing further education, which would then be useful for an academic career. However, this potential had not been fully harnessed by the DoP or the CoM.

> I think also for my own personal development to keep abreast with what is happening. I was also looking into the same… to say I can teach one course maybe at the weekend, whenever I'm free. […] But I was looking at it maybe something that I can just do and maybe get a small fee just to cover probably my cost but not to get anything really out of it. To say making money out of it. May be I look at it some allowance to cover the travelling. But then it's really not an issue because it really is within our community service.
>
> Community Pharmacist II

> I have [thought of becoming an academic] and I wanted to teach at the CoM. Prof *X*, who used to be the old [i.e., former] teacher there, he had spoken to me and had seen my CV. He said ok ok… […] But it just doesn't materialise after Prof *X* left. […] I promised you that there're certain subjects that I'm so passionate about that I would *love* to teach. But… I don't know. Sometimes I just think that it's just a waste of time, to be honest. It's something I would love to do but sometimes I think because of all the bureaucracy, and all the politics… why bother? Why bother?! You give up! And I've never been a person who gives up. I ALWAYS go for it. In South Africa that would help me. Here, it doesn't make a difference! You can go for it as much as you want but nothing will happen! It just makes no difference. So, what's the point?
>
> Community Pharmacist IV

Although the difficulty in recruiting lecturers was said to be a major concern, it was also revealed that gaining a teaching position at the DoP was not always easy. The following excerpt comes from a conversation with a friend of a first-class pharmacy degree holder, newly graduated from the DoP and wanted to join the department as an Assistant Lecturer:

> It was very strange and I'm surprised to say why they are so reluctant to employ Talent[109]! Because he has always wanted to be a lecturer! He was always saying I want to be a lecturer I want to be a lecturer. And he was working hard and he had a first-class degree. So eventually the college was not ready to employ him and he had to squeeze himself into the college. To find himself going there, started teaching. So eventually it was *him* trying to fight to join the college because he *wanted* to be. […] He actually started pushing for that before he left the college. Please, if possible let me join the department. So at one point, he was told to stop teaching and the students were like where are the lecturers? The students almost went on protesting because he was told not to continue teaching. He started as part-time teaching and he was told to stop because he was not employed then. And the students protested because there was no lecturer. It was very frustrating. If it were me I probably had given up.
>
> A friend of Talent

What seemed to be evident here was a lack of absorption capacity at the institution, even though it was severely understaffed. The same difficulty was also said to be experienced by the newly graduated pharmacists, whose entry to the (also severely understaffed) public service was inhibited by red tape. A few months were wasted on disagreement about internship payment and finding accommodation.

---

[109] A fictitious name.

> What happened was that we went to *site x* in March this year, for one month. At the end of the month, we were lodging in um… sort of hotel. Because of the cost we had to go back home because we needed to find a house, because the hotel is expensive. So it had taken us almost one and a half months. That's why we… We started [work], we went out [of work], and we came back [to work].
>
> Intern Pharmacists I and V

When further probed the complicated nature of the situation, it was revealed that there were other issues apart from red tape. When higher level of trust was gained further into fieldwork, informants started to spill information about their biggest fear. An anonymised source of information revealed resistance from certain power-holding individuals to appoint intern pharmacists, who had completed internship, to pharmacist positions out of fear of younger pharmacists vying for their incumbent power-holding positions. By June 2011 (i.e., three months upon completion of internship) none of the intern pharmacists had been promoted. On the contrary, pharmacy technicians were promoted to higher grades. This resulted in intern pharmacists working at an even lower grade than the pharmacy technicians. Also, none of the newly trained pharmacists assumed the managerial vacancies as per expected from the initial plans (and purposes) to train pharmacists. Frustration amongst intern pharmacists finally led to decision to leave government service.

Probably due to critical shortage in human resource, in Malawi it was common to find one individual dominating a fairly large area of the sector. These individuals, called the 'big men' in this thesis, had highly concentrated decision-making power. In Chapter 8, the reason why 'big man syndrome' occurred will be further explored. In this section, what needs to be highlighted is the huge impact of this syndrome in creating fear and frustration amongst new pharmacists. Further interviews with younger generation pharmacists revealed how their aspiration had gone unsupported:

> In the PMPB the government chooses who should sit in the Board, right? And I don't think any young blood is put into that Board. It's always people who are of seniority. Do you know what I mean? So when you have fresh blood that is coming to the country, who has gone out, who is a Malawian, for example I have gone out; I have studied; I have fresh ideas; I did stuff with the South African Pharmaceutical Federation. I did stuff with everyone. We have the experience to help. Or we have the experience to enforce the laws. But we're not put onto the Board. And everything that happens with the Board is so delayed and it shouldn't be that way. For example when I was in South Africa, as soon as you leave your fourth year you receive a piece of paper in South Africa to say *yes* now you have to register for your internship. Once you finish your internship, *yes* here's your registration or your certificate. It's *not* as complicated as people make it out to be here, like everything is so *delayed* over here.
>
> Community Pharmacist IV

In summary, the pharmacists hoped for an agency-driven professionalisation, which could only be achieved when sufficient number of pharmacists was created by the DoP. However, the members of the profession might not always have the spare resources to mobilise for the DoP. At the same time, there seemed to be a potential teaching pool (currently residing within the practice sector) still untapped into because of barriers of different kinds: bureaucratic, perceptual and cultural. The profession, in conclusion, may need to interact more closely with the education institution for mutual benefits.

6.3 Pharmacy technician training institution (i.e., the MCHS)

As discussed in Chapter 4, similar job functions were held by pharmacists and pharmacy technicians. Interview and focus group discussions with students, who studied the pharmacy technician course prior to the pharmacy course, confirmed that some elements in the curriculum were repetition. Many felt this was a

waste of time and resources for pharmacy technicians to re-learn what they had been skilled at. There was, therefore, a proposal about merging the CoM and the MCHS (Malawi College of Health Sciences, which trains pharmacy technicians and other middle health cadres) so that resources could be shared and time spent on training pharmacists would be cut down. In fact, it had already been an issue being looked into by the GoM at the moment fieldwork was conducted.

Strength Overlapping curriculum hence possibilities to share resources.	***Weakness*** Bad reputation amongst pharmacy technicians (accused for being 'thieves').
Opportunities Pharmacy technicians eager for upgrade; On-going talk about merging MCHS and CoM.	***Threat*** Pharmacy technicians' pilfering culture may not be eliminated by re-education.

Table 6-5. SWOT analysis of the training institution for pharmacy technicians.

Unlike in the more advanced settings, where 'vocational' education usually recruits students whose grade do not allow entrance to university, in Malawi university enrolment limit was usually caused by limited spaces in the university rather than students not achieving the required grades, as explained below:

> The entrance qualification to Clinical Officer training is that you get credits in English and Mathematics and in any two science subjects. So these are credits and it has the same entry criteria to the UNIMA. The issue is about number. The university can only take x number of students. Yea. And now, it's the quota system. You can only pick so many from this region... you see. So it's because there are just so many places in the university. So these students find themselves in the paramedical colleges. It's not because they are daft. No, they are not. Because they have proved that when you take them, upgrade them, they do well. So it's taking a much longer route to becoming a doctor than they otherwise would have been if the place, there were adequate spaces in the university.
>
> Assistant Registrar, Medical Council of Malawi

As a result, MCHS lost some students who were qualified for CoM entrance. These students might have already studied for some time at the MCHS before quitting. Such wastage was deemed unnecessary because these places could have been offered to other students.

> Of course the intake is 20 [per year] but sometimes due to other factors, you may have 18, 17, because if some people cannot perform may be end of year then they would be expelled. Like the third year batch, there are 18. And the second year, there are 14. Some people left for upper education. They left mid way for CoM. Yea. Because they had better grades in their MSE. So when they're here for a year they [are] also called to sit for the entrance exams at the COM, of which they were successful. […] So they simply sneak out and they go for the entrance exams. That is what that has happened. That is why we cannot deny them.
>
> Lecturer II, MCHS

During a focus group interview with a group of second year pharmacy technician students, strong determination was expressed about upgrading oneself to a pharmacist position should any opportunity arise. Personal interviews with practising pharmacy technicians too revealed similar intentions.

It therefore seemed rational to have a multiple entrance and/or multiple exit pharmacy programmes, judging from potential savings on resources and eagerness shown by pharmacy technicians. The only caveat raised was concerning the ethical conduct of pharmacy technicians seeking entrance into the pharmacy profession. Because of pharmacy technicians' involvement in the pilfering culture (see Chapter 4), it was feared that such demeanour would be spilled over into the pharmacy profession should the technicians be allowed to be upgraded. It was highly doubtful that pharmacy technicians, once they entered public service, could ever have their conduct be rectified simply by a

pharmacy course[110]. If this doubt was real, the resources saved (from merging the two courses) could easily be outweighed by resources wasted from pilferage in the future.

In short, we again face the question about the need for professionalisation (see Chapter 4). Although MCHS looks an ideal stakeholder for partnering in terms of continuity in skills development, it could in turn be incompatible when the purpose of having a professional course was more complicated than merely a need for higher skills.

6.4 The UNIMA administration

As explained in section 5.2, DoP is one of the departments situated in the CoM; whereas CoM one of the constituent colleges under the UNIMA. Policies and practice concerning DoP must, therefore, adhere to the college's and university's rules and regulations. In this section, we will explore the role UNIMA played as an external stakeholder to the CoM. By using the term 'UNIMA', it means the central administration office of University of Malawi. Data will focus on the funding aspects because this was considered the major part to institutional capacity building for CoM. CoM in this case is regarded an internal stakeholder of DoP.

Strength Statutory power to monitor college-level corruption.	***Weaknesses*** Itself lack of capacity; Rigid and unattractive HR policies.
Opportunity Seeing health as a priority agenda.	***Threat*** Negative views about CoM's autonomy.

Table 6-6. SWOT analysis of the UNIMA central administration.

[110] This anxiety came from the impending absorption into the public sector the first cohort of pharmacy graduates, where seven (out of eight) of them were former pharmacy technicians. Before this, there was no case of pharmacist who had worked as a pharmacy technician. It must be noted that this anxiety was purely speculative, caused by the stereotype imposed on pharmacy technicians.

University-wide policies were seen as having both advantages and disadvantages. The biggest perceived weakness, judging from its stake in CoM, was its lack of flexibility in human resource (HR) retention policies. Because of the need to enforce equality, salary scales for a position remained the same across all disciplines. In what was quoted as 'in order to increase one college, you have to increase *five* colleges' salary policy, the UNIMA was reluctant to suggest salary increments for fear of inducing a huge budgetary demand. However, in reality, some disciplines (e.g., the medical field) were more prone to losing people to the competing sectors (in private sector and/or other countries) should the salary not comparable to the competitors. Indeed, much had been written (in the literature) about this huge income gap being one of the greatest causes for brain drain from sub-Saharan African countries. By having rough comparison between salary scale in UNIMA (2010) and five other commonwealth countries (2006), it was not difficult to understand why CoM loses its staff easily to other countries (compare both following tables). Also, earning a small salary is not compensated for by urban living costs that are not cheaper than many other places in the world, for instance, Nottingham city in the UK.

	Australia	Canada	New Zealand	South Africa	United Kingdom	Overall average
Top of scale	71,823	70,078	48,210	54,497	51,273	59,176
Bottom of scale	60,568	47,996	39,755	34,522	42,569	45,082
Midpoint	66,196	59,037	43,983	44,510	46,921	52,129

Table 6-7. Lecturer (or Assistant Professor in Canada; Lecturer A in the UK; Lecturer B in Australia) annual salary scale comparison between five commonwealth countries.

Salary data is converted using Big Max Index therefore in USD currency. Taken from (Kubler and Lennon, 2007).

Position	*Annual income (top of scale)*	*Annual income (bottom of scale)*
Professor	39,615	32,080
Associate Professor	28,466	26,510
Senior Lecturer	26,045	24,281
Lecturer (PhD entry)	22,432	20,128
Lecturer (Masters entry)	19,778	18,168
Assistant Lecturer	16,444	13,010

Table 6-8. Annual salary scale (in USD) for academic staff at the CoM, UNIMA.

Document given by the CoM Registrar.

Facing critical shortages of teaching staff, in-country practising pharmacists were seen as a potential human resource for recruitment. However, this might not be feasible because of the academic-based recruitment policy, which required certain academic achievement and experience (see section 5.2). It was therefore not possible to appoint a practising pharmacist, with a Masters degree, to a position higher than a lecturer's because of their lack of academic qualification. Appointment to a lecturer level (or lower) however was not an attractive offer to practising pharmacists, who could easily earn more than the salary offered by the CoM. The following transcript was hoped to explain this issue further from the perspective of one of the former HODs of DoP:

> Now here we have problems, again, to become a lecturer you *must* have at least a Masters degree. In other words you need higher degree qualifications *but*, you imagine you're in a resource limited country, *very* few pharmacists. You know a pharmacist who has 25 years experience of pharmacy practice. He's recognized in the country as an excellent teacher because he's taught perhaps at the College of Health Sciences. He's taken many public debates. He's been involved in conferences all over the world. He's a *very* important man. And I am thinking of one particular person and... this person is WIDELY experienced. But he *hasn't* got a master. You *cannot* appoint him as a lecturer. Ridiculous! […] We recognise his

> skills, his experience, but no, they [i.e., the recruitment office] just will not contemplate that. So there were numbers of people whom I could see in Malawi, who could have come into the university sector but I couldn't employ them because they haven't got a master at that level. But if you ask them to come in as an assistant lecturership level, it's WAY below their present salary!

What was said by the HOD was then confirmed by the CoM Registrar (in-charge of the recruitment office), who acknowledged the difficulty in getting Masters-qualified lecturers:

> We have people with Bachelor degree but for them to teach on a pharmacy programme, they must have a higher qualification like a Masters. Um… and most people who have the level of qualification they do private practice. They're running their own personal pharmacies. So there is more pay than what the university can offer them. So each time you advertise you would know the results... so we've been struggling.

Apart from unattractive recruitment salary, the university's publication-based promotion criteria were perceived to be a 'frustration' to many at the CoM. The College Registrar said:

> A person with a Master degree, he/she can go up to the level of Professor as long as you're able to publish. […] The minimum qualification of a person to teach is a Masters, so if you have a Masters and you've published three papers, you move to senior lecturers. If you've published five after that you move to Associate Professor. […] Normally we don't have such cases [of promoting academic staff based on clinical service]. But the set-up in the department decides that we encourage people to do research, even when they're not um... certainly in most departments, in their

> academic set-up, you have some kind of involvement in research. Because they know it's necessary for their progression. So they would be doing research related to what they're doing because research is not restricted to um... one area. They can do research even in their area of practice.

Publication pressure is a norm in the academic world everywhere else in the world. However such pressure was regarded as an unfair competition at the CoM, where clinical research was prioritised. Although on paper it was said that research grants would be awarded to all types of research, there was a general perception that clinical research was favoured. There were more chances to do clinical research, particularly those offered by donor-sponsored research sites such as the Malawi-Liverpool Wellcome Trust (MLW), Johns Hopkins project and UNC (University of North Carolina) project. At one of the basic science departments, the HOD talked about the need for basic scientists to be 'flexible', i.e. to get involved in clinical research. This opinion was however not commonly shared amongst basic science lecturers (see quote below). In this particular case, this lecturer was frustrated by the lack of basic lab equipment to conduct basic science research; and was eager to leave the department when a job offer from South Africa finally came through.

> As it is now, no grant for basic science research. It's really hard to get a grant for a study that is basic science nature. So we really have to be forced to join the clinical science type of research. The thing is we do not have experience in that area. So one has to sit down for a long time to try to figure out where you can really fit. So it's quite hard to really say ok no grant for basic sciences, so I'll just go for the clinical study. Because even the kind of research study that happens in basic sciences and clinical study are different. Even the methodological approach is so different. […] I know you really have to come up with a good proposal, which will fit in what they're doing there. So first of all I'm not interested. I know most of the things they do there. Um... it

> has not generated interest in me for me to actually say ok I think I know what so and so is doing; I would like, I would really like to join the research group. It has not generated that kind of interest in me.
>
> Lecturer IV

One lecturer, who was regarded (by students and lecturers alike) as very good in teaching and very kind to students, felt an academic career was "not for me" because he/she was "not an academic person". He/she perceived his/her position as temporary and should leave immediately when the DoP had more teaching staff.

> I think it is [a demanding job]. To be honest I would rather [see] people who are really interested in teaching, doing research [to be in my position]. That's all about it [i.e., academic work]. Me I can't do that. I can't do that. […] when it comes to research, I'm not into that. I'm not.
>
> Lecturer VIII[111]

There seemed to be little flexibility in the HR policies, even when recruitment and retention was difficult. Another complaint heard from a currently employed lecturer was about imposition of age limit to career development. According to the College Registrar, scholarship for further study would not be offered to staff older than 45 years old. The reason might be because of a relatively short life expectancy in Malawi (i.e., only 44 years for men and 51 years for women). However, attrition happened even amongst the younger generation, due to reasons such as HIV/AIDS. It was therefore perceived unjust to deny an equal chance for an older but healthy academic member. As a result, this lecturer expressed loss of motivation to continue teaching.

[111] The informant was both a lecturer and a pharmacist therefore this quote was used twice in different contexts.

> I did once *seek* to go and do my PhD. But the Dean said I'm too old. [Laugh] So I stopped seeking further development. […] IT'S NOT FAIR! I mean does it mean at 50 years you stop teaching? […] If I was given a chance, I want to do my PhD. I would definitely continue to teach. But if somebody tells you no you're too old, we don't need you, why should I go on a contract?! [So] I'm just waiting to retire [and] sell my shop, go farming, produce maize or something [laugh].
>
> Lecturer VII

Apart from teaching staff, inflexible HR policies also affected technical support staff (e.g., lab technicians). There was a failure to retain these staff once they upgrade their Diploma qualification to a Degree. There was no promotion, or any sort of financial incentive, given to a technician who earned a qualification higher than a Diploma. This is because the highest salary scale they could achieve, as a technician, was H (see Table 6-9). Those who aspired to go further than a Diploma level would not be supported by the university because no distinction was made between a Diploma and a Degree. Due to this reason, the DoP lost a technician who wanted to go for further education. Since his resignation, there was a long period of time the DoP could not find a suitable candidate to fill the vacancy. The quote below was derived from the interview with this technician.

> It was an issue of remuneration. Beside that I was getting at the CoM, I can say generally in [other colleges too in] the UNIMA – if you're a technician. Besides having a degree, you're paid as somebody having a Diploma or a Certificate, MSC[112] Certificate. They don't recognise technician as a professional career. So we were really… because I worked for the UNIMA for five years. The whole five years was so frustrated for me. […] And the other frustration thing is if you're a technician, you cannot go for further studies in the UNIMA. They said

[112] MSC or MSCE – an abbreviation for Malawi School Certificate (of Education), which is equivalent to O-Level or secondary school education.

> you would be over qualified [for the current position]. So it was frustrating in career wise and salary wise.
>
> A former Chief Technician at the DoP

Position	*Salary scale*	*Qualification for direct entry*
Chief Laboratory Technician	H	Relevant University degree or University Diploma or its equivalent plus 5 years experience
Senior Laboratory Technician	G	Relevant University Diploma or its equivalent plus 3 years experience
Laboratory technician	F	Relevant University Diploma or its equivalent
Senior Laboratory Assistant	E	Malawi School Certificate of Education with Laboratory Technology Certificate or its equivalent plus 3 years experience
Laboratory Assistant	D	Malawi School Certificate of Education with Laboratory Technology Certificate

Table 6-9. Recruitment and promotion policy for laboratory technicians at the CoM.

Extracted a document entitled 'UNIMA Qualifications for Direct Entry and Promotion Ceilings' (University of Malawi, 2010).

It was said that this unfilled vacancy had caused many problems and affected the quality of teaching. Technician's work was taken over by lecturers; in some cases even the cleaners when simpler tasks (e.g., washing of test tubes) were involved. When lecturers' workload was too high and laboratory exercise was not possible to carry out, computer simulation was used instead or in some instances the lab work would be completely abandoned.

Such university-level HR policies were deemed ineffective in retaining lecturers at the CoM. Anxious to do things differently to safeguard staff retention, the CoM requested from UNIMA a different remuneration package for its lecturers. UNIMA consented to this proposal by giving CoM lecturers a higher salary, which was 20% higher than lecturers from other constituent college. UNIMA considered this a 'special treatment' and felt CoM should be contented with it.

> I don't think anybody is complaining about money there. If they have told you that, don't believe them.
>
> University Finance Officer

However this opinion was not shared by the CoM. According to the Dean of Undergraduate Programme, the college was still suffering from brain drain because the salary was still considered small comparatively, even with the 20% increment.

> We don't get anybody because our salaries are not competitive. We trained someone in South Africa, a renophysician. He came here for 18 months. And he has gone to Canada. He left in October last year to go to Canada. Because our salary is not competitive enough.

To improve staff retention, CoM sought alternative funding on its own. In many cases, it involves arrangement with donors. The most important revenues came from collaborative research activities and salary support for teaching staff (see Chapter 7). The success to source funding gave each CoM lecturer a monthly USD1000 top-up, in addition to the 20% pay rise from the UNIMA, in their salaries. What CoM had done was considered unconventional, judging from how other colleges were still dependent on the government subvention (see Table 6-10).

> We get only 55% budget from the university. And the, much of the remaining budget comes from activities like research. Um... to contribute to the running of the college. Um... we normally don't get budget for capital development from treasury. We have to find our own ways of... finding our own donors and things like that.
>
> Dean of Undergraduate Programme, CoM

> So from outside people think 'oh people from the CoM are getting a lot of money'. Because we go out and try to talk to donors. We

> realise that the government salaries, because this is a government institution, they are not enough.
>
> Dean of Student, CoM

	2004/05	2005/06	2006/07	2007/08
Bunda College	89.8	83.3	81.3	88.3
Chancellor College	85.4	90.0	88.6	86.1
Kamuzu College of Nursing	82.0	84.3	80.6	86.8
Polytechnic	75.9	89.1	83.6	80.4
The CoM	93.5	87.5	69.9	49.6

Table 6-10. Percentages of college income from government subvention.

Note that the percentage for the CoM had reduced from 93.5% to 49.6% over the years; whereas no apparent change is observed with percentage for other colleges. Taken from (World Bank, 2010d).

This sponsorship, however, was not well received by the UNIMA because it was (said to be) "introduced without proper consultation". In UNIMA's opinion, the way CoM engaged with the donors without first informing the UNIMA was an act of bypassing higher authorities. It was termed an activity that was "not integrated" or "separate" from the university administration; or even a "secret" because of a lack of transparency. UNIMA questioned the sustainability of this scheme; that the CoM would be financially crippled should the donors withdraw their funding. Therefore, the scheme must be subjected to UNIMA's regulation to ensure funding security.

> So we want to find a way of regulating it. And then the government... at least they should know that this is happening. In the event that we're not able to raise funds from donors, government has to come in. Otherwise the college… [will run out of funding]. So... we haven't been happy that this was kept as a secret by the college. We're not happy. [University] Council has not been happy.
>
> University Finance Officer

This argument however was not supported by the CoM. Instead, CoM said it had already got its own long term plan for donor fund withdrawal:

> We realise that we cannot depend on donors to sustain this retention, with this 1000USD, which is [from] the retention scheme. So this money that we collected goes into a pool. That pool is theoretically should be later on a sustainable way of having the retention scheme in where the basic top-up is 1000USD.
>
> Dean of Student, CoM

This clash of opinions was thought to be resolved only through good communication. However, both blamed the other party for being reluctant to initiate a communication.

> But they don't want to understand. If only they came and we sat down together, and discussed this thing openly and we gave them the book, properly they would understand. But they don't want to come. They don't want to come.
>
> Dean of Undergraduate Programme, CoM

> It has not been done transparently. The whole system. The whole scheme. That is why I'm saying, we've been talking about this. I wouldn't be surprised if others who are left out because um... it has not been properly done. Um... it has been kept like a secret [laugh].
>
> University Finance Officer

What was meant by 'others who are left out' in the quote above refers to some lecturers who were not paid the donor-sponsored USD1000 salary top-up. The news about this top-up was not circulated widely and some were not aware of such benefit. According to an anonymised source of information, this USD1000 scheme was not made transparent to all lecturers and only those who were 'favoured' or aware of it would receive the top-up. It appeared that the

information was withheld by certain power-holding individuals. Further data about this incident will be presented in Chapter 7 (particularly in section 7.1.3).

In summary, UNIMA's HR policies lacked flexibility for attracting an alternative pool of teaching staff. By adhering to conventional rules such as publication-based recruitment/promotion and age limit to career development, the university might risk losing valuable teaching staff. The candidates deemed eligible for recruitment or promotion were easily lured by the more lucrative private sector and/or institutions abroad. This is not to argue that the university should recruit or promote 'second-class' academics; but to highlight what the barriers to innovative HR recruitment/retention are. The UNIMA was targeting a group of academics who are highly sought after in the rest of the world: i.e., Masters and PhD holders who are able to attract research funding. Unfortunately, remuneration packages offered by the UNIMA were comparatively less attractive. There was insufficient support given to less desirable candidates, e.g. non researcher practitioners, older teaching staff, basic science lecturers, etc. When retention failed and alternative solutions were initiated by the CoM, tension was created between the UNIMA and the CoM. To UNIMA officials, CoM was perceived as part of the university system therefore their activities should be integrated with and monitored by the higher authorities at the university level. The lack of communication might have contributed to a less effective relationship than it otherwise could have. Instead of being a governing body supporting its subordinating units, UNIMA was perceived to be more a trouble (and less a support) in fundraising issues.

6.5 The College of Medicine (CoM)

In many instances, DoP existed in the shadow of the CoM. Because DoP's position as merely a department in a medical school, pharmacy students were said to have graduated from the CoM (but not the DoP). When we discussed about external stakeholders in previous sections, CoM was referred as an

internal stakeholder. However in this section we will look at CoM's role as an external stakeholder.

Strengths An institution already well recognised; Shared resources e.g. servicing departments.	***Weaknesses*** Short of capacity themselves; Limitation on DoP's staff establishment; Self audit as sole QA measure.
Opportunity Share the vision to expand the DoP into a School of Pharmacy.	***Threat*** Loss of professional self autonomy.

Table 6-11. SWOT analysis of the CoM.

The major benefit derived from situating the pharmacy course within an already well established medical school was the opportunity to share resources already available. The teaching of non pharmaceutical subjects was undertaken by what was called the 'servicing departments' within the CoM. This removed the need for finding resources for teaching basic sciences subjects including anatomy, biochemistry, physiology, community health, microbiology and research in practice. What the DoP needed to do was to decide the scope of teaching, as well as the teaching timetables, with lecturers from the servicing departments.

What was restricting, by placing DoP beyond CoM discretion, was staffing restriction. Because of the identification of DoP as a department (and not a school), staff establishment in the department was limited to nine (see Table 5-5). When fieldwork was conducted, only five vacancies were filled including the Head of Department (who was often taken away for his/her administrative duties) and a voluntary lecturer. Every lecturer would therefore have to bear the teaching workload equivalent to, by British standard, an entire teaching department.

Filling nine vacancies was seen as a challenge because of a shortage in suitable candidates and also because of recruitment bureaucracy. There was limited freedom in recruiting the department's own lecturers because recruitment process was bound to college-level administration. The recruitment office

opened the application for new academic staff only once a year, i.e. before the beginning of an academic year in June/July. If the department missed the application, as it did in the case of recruiting a lab technician, it had to wait for another year before vacancies were open for application.

> It was hoped that staff establishment could be expanded should the DoP become a standalone school or college. Indeed, this was a vision not only for pharmacy but also other allied health degree courses like physiotherapy (see quote below). However, this vision could not materialise in the near future because of severe resource restriction.
>
> We want the course of rehabilitation to be physiotherapy, occupational therapy and speech therapy. And they will be[come] a school on their own. Pharmacy would be a school on its own. Dentistry would be a school on its own when we have it. We're now in the process [of] creating a curriculum for dentistry. So to be a school on its own. We also want to have a school of public health, where management will be part of it. But all of these things require money and manpower. Right now, we don't have enough people to create this into their own schools. But we would want to do so.
>
> Dean of Undergraduate Programme, CoM

If the DoP wanted to recruit more than nine lecturers, the procedure must be started with creating new positions in the existing staff establishment. The approval for creating a new position must come from consensus amongst academics at the college level (see quote [1] below). It must be satisfied that this new teaching requirement could not be fulfilled by any teaching staff from other departments in the same college. Once college-level decision was made, a proposal (to create a new position) would be submitted to the university council. The decision from the council, then, would be passed down to the department through the college. Therefore, adding new positions to the existing nine is not as straightforward process. Instead, it involves relentless effort from the department to justify why this needs to be done and to keep pushing the

departmental agenda to the forefront. The head of department, therefore, played an important role in spearheading this initiative (see quote [2] below).

> [1] What is required is that they just have to justify their needs. Because you know in the first place, you [have to] know what programme or which disciplines are relevant to the training of pharmacists. Now, then they demonstrate to us that they don't have [these] in their current establishment. [Otherwise] there is no way they would have people who can come to [teach] these areas. [So] They need actually new posts for people to apply for them to be able to deliver whatever they're expected to deliver. Once they, you know, come off from the department level, they go to faculty [or college], which is composed of fellow academics. They [i.e., the college academics] will be able to understand these requirements. They'll be able to assess whether the areas that they [i.e., the department] need are not existing in other departments. Now, if they are satisfied, then they'll tell us that they want new positions.
>
> [2] The department would carry out what we call 'needs analysis', identify shortfall in the system in our country. And then they assist in bringing manpower into those areas.
>
> Deputy University Registrar

Despite this red tape, what could possibly make it easier was the priority given to request for new staff establishment from health related disciplines, because of the recognition that the country was facing health crisis:

> But I can assure you that the health sector in Malawi is where we have got a lot of challenges. And it's not… actually I don't think the department in the CoM would come, with their requirement for additional positions, and the Academic Planning Committee would

> say no. Because everybody knows this is the area that requires to be strengthened.
>
> Deputy University Registrar

On the issue of quality assurance (QA), the Dean of Undergraduate Study mentioned six measures to monitor the quality of teaching done at the departmental level: 1) department-level curriculum review; 2) external examination, who should be invited by the department itself; 3) academic staff training; 4) student appraisal of teaching quality; 5) college-level meeting (twice per semester) to discuss progress and problems faced by individual departments; and 6) university-wide quality assurance and quality control. Until the time of fieldwork, there was no regular external audit. There was a high level of self directedness expected from the departments. There was a policy document created to provide guidance on doing self-audit. In the 'follow-up' section, it said:

> The University expects that: 1) Departments will take responsibility for initiating any follow up actions required; 2) Departments will make a formal report on progress to the College, on then to Senate, within one year of the Senate accepting self-audit reports from the Colleges.
>
> Extract taken from a document entitled 'UNIMA Procedures & Guidelines for Self-Audit of Colleges as Part of Development of QA Unit'

Because of severe understaffing experienced at every level in the college, hardly any additional workforce could be summoned to monitor the QA processes. The Dean had to assume every department would have to independently assure its teaching quality. When there was a problem, the department needed to take the initiative to solve it, and to ask for help when necessary. Although the college had the authority to monitor the performance of its departments, in reality such surveillance function was lost because of resource constraint. Another factor contributing to lack of surveillance was said to come from the reluctance to impose discipline. Because of a small number of academic members, heading

positions (such as HODs and Deans) were usually rotated amongst very few people. To avoid future 'revenge', it was said that most in the managerial positions would prefer not to offend (i.e., reprimand) their fellow colleagues. It formed a culture (see quote below) of pushing such responsibility to a higher authority. At the same time, students were unwilling to bring their complaints to the higher authority for fear of repercussions. The department therefore was left with no pressure groups, either from the top (i.e., the college and university-level inspection) or the bottom (i.e., the students), who could scrutinise teaching and learning activities.

> It could be part of our culture maybe. Because we don't want to be seen… you know we always expect that somebody above us is the one who is responsible. Not us. When we know that we're the ones who are responsible… like the HOD would say ok we have a problem with a particular staff member. You know he would think that it's not his responsibility to discipline that staff member. It's maybe the Dean. Right? The Dean might know that the HOD is not really performing but few Deans would take that as their responsibility. They would think that maybe it's the Principal, who should be responsible. You get my point? So we lack, you know, the spirit of taking responsibility over our own areas of jurisdiction. We've got few Heads and few Deans in the system who are bold enough, you know, to actually take responsibility over their staff members.
>
> Deputy University Registrar
> (who had also worked as a College Registrar)

In short, the CoM provided a supportive environment for starting the pharmacy programme. By having servicing departments in place, the DoP saved its limited resources for teaching basic sciences. However the teaching of pharmaceutical subjects became a tough mission when staffing establishment was restricted by DoP's status as just a department (and not a school). Expansion in staff establishment was made difficult by resource constraint and high level of

bureaucracy. At the same time, performance at the departmental level lacked monitoring from a higher and/or external body. This might result in a lack of self discipline (see section 5.2.2 for problems such as missing lectures) and/or self motivation (see next section) amongst the departmental staff members.

6.6 The Department of Pharmacy (DoP)

As the only pharmacy course in the country, the DoP was the only route available for gaining pharmacy degree. The advantage of this was that there was no competition from other education institutions vying for funding for pharmacy education. For instance, the establishment of the DoP was a result of a funding received directly from the National AIDS Commission (NAC). Also, ten pharmacy students were chosen for the award of NAC-sponsored scholarships every year.

Strength	***Weakness*** Rigid administrative structure: power concentration on one individual
Opportunity Easier to attract pharmacy-related funding.	***Threats*** Severely underfunded and understaffed; Centralised administrative structure; Deeply frustrated academic members.

Table 6-12. SWOT analysis of the DoP.

Still a very young department, DoP certainly could not be perfect. There were many hints, brought up in the previous sections, regarding its slips of duties (e.g., missing lectures). It was well understood that this problem was caused by underfunding and understaffing, which should improve as time goes by. However, there might be another significant challenged faced by the department that could possibly hamper departmental performance: i.e. the highly centralised administration (or the 'big man syndrome', as mentioned in section 6.2). There was a high level of administrative duties being placed on the HOD position, even minor issues like signing forms for buses to take students to their attachment sites. There were many occasions where delays (or even cancellations) were caused by department-level red tape that required a signature from the HOD, who was not always available at the department. For instance, lecturers could

not prepare lab work because the laboratory key was held by the HOD; or employment of a visiting lecturer was abandoned in its process because the HOD had not signed the paper (even after the Vice Chancellor had). Frustration was expressed by many. However, most would prefer confidentiality and only one person allowed me to record their conversation:

> It's very hard to receive proper information. And, easy things turned out to be very complicated. So we need very simple things, very cheap things, to get some laboratory equipments running; and the responsible person is not moving to support at least... to get things moving. I was told that I am not responsible or not allowed to do such things because I am at the lower level of the hierarchy. This is what I was told so I have ability to achieve anything in this direction I am just left with whatever I can find. […] I have to wait for signature from an important person [for purchasing lab equipments]. And if this signature is not there, I can't do anything. […] I don't feel supported at anyway *at all*. For me, it even seems to be the other way round if I have new ideas. I feel somehow hindered, somehow blocked by the person who should somehow support me, at least, somehow.
>
> One of the lecturers

Although this could well be an isolated case of mismanagement, it also revealed the weakness of the current administrative structure. The concentration of decision making power on just one or very few individuals resulted in delays or even cancellation of work needed to be done. As discussed in the previous section, the DoP was expected to be self-directed and self-motivated. In cases where the HOD was not sufficiently motivated, it was difficult for the members of staff to challenge the HOD because of power differential. In fact, there might be very little motivation to do so because the members of staff were occupied with their personal lives. To make ends meet, most teaching staff would have to be engaged in at least one additional private remunerative job. Termed as

'moonlighting', it was not uncommon to find this consuming working hours of the teaching staff. However, moonlighting activities were preferred not to be exposed, for fear of inviting jealousy and/or disciplinary action. As a result, there was loose relationship between colleagues in the department. In most days, lecturers worked behind a closed door and had little space for workplace interaction. In one of the interviews, a lecturer referred to another lecturer as the person 'next door' rather than saying his/her name. Consequently, there was a lack of collective action from the members of staff to challenge the status quo. The department's performance, therefore, was very much dependent on the HOD's self directedness and self motivation. If the HOD personally lacked these qualities, it was difficult for the department to make progress, or even to run its daily operations.

In summary, departmental recruitment was expected (by both internal and external stakeholders) to be initiated by the department itself; or more accurately by the HOD. It needs strong departmental determination to push through college-level recruitment red tape. Problems emerged when the HOD was under-motivated and/or under-resourced to perform this task. The over reliance on the HOD on administrative decisions (inclusive of minor ones like signing off student transport forms) created unnecessary department-level red tape which eventually resulted in under-utilisation of resources already available (e.g., the holding of laboratory key by the HOD). At the same time, uncompetitive college remuneration made moonlighting a common phenomenon amongst teaching staff. This left little room and time for department staff to be concerned with departmental issues, let alone challenging decisions made by their superior.

6.7 Stakeholder analysis: who can help?

In this chapter, an inventory of stakeholders' interests in and potentially mobilisable resources for supporting departmental capacity building has been created. The purpose of doing so is to strategise stakeholder engagement in

order to minimise effort needed for departmental capacity building. It is hoped that by identifying supportive stakeholders, collaboration could be liaised for boosting departmental recruitment. They include stakeholders who could provide alternative human resource for teaching (e.g., practising pharmacists), alternative sites for training (e.g., manufacturing and community pharmacies) and alternative resources for shortening training period (e.g., merging MCHS with CoM). It was hoped that these untapped resources could be mobilised, by actively engaging these stakeholders. Interview data revealed that these resourceful stakeholders were willing to support the DoP, though in ways not compromising their personal agendas. For instance, students were welcomed to visit the private practice for training purposes though with no supervisors ready on site. To match agendas from both parties, it needs initiative from the DoP (or CoM or UNIMA) to create an environment conducive for previously unengaged stakeholders to offer their help. For instance, the HR policies need re-adjustment for more flexible recruitment.

Meanwhile, there was a lack of motivation, and in some cases a lack of intention, to professionalise public sector pharmacy in the country. Private sector pharmacy is left out of discussions in this thesis because pharmacy education is seen as a public endeavour. It is perceived as one of the government apparatuses to improve health status of its people; and not an institution to fend for profession's needs. Since pharmacists were required to serve only distributive and managerial functions, 'professionalisation from above' (or professionalisation by the state, see section 3.1.5) seemed an unlikely development. This leaves the profession to act as the sole agency for professionalisation. What the data then revealed was an intention, within the profession, but a lack of collective action to do so. The lack of agency for professionalisation may eventually leave the profession unprofessional; and eventually make institutional capacity building unjustified.

Apart from data about ways to building further capacity, the data also revealed how currently available capacity was utilised. The relationships between the DoP

and its internal stakeholders are explored. The presumably vertical relationship between these stakeholders (GoM → UNIMA → CoM → DoP) was interrupted by severe understaffing and underfunding at every level. The lack of capacity to monitor (or audit) the subordinating unit resulted in the lack of accountability. It could be left unchecked in the cases of duty negligence. What was expected, or had to be expected, amidst a resource-constraint setting was self discipline and self motivation in individuals occupying power-holding positions. Unfortunately, this was not always the case. This resulted in the attrition of currently available capacity, which threatens the survival of the already fragile system.

From these analyses, stakeholders in general appeared to be neither overtly supportive nor aggressively oppressive toward departmental capacity building. Attitudes seemed to be neutral, and at times passive. There were many untapped resources, which might open up promising results, but it all depends on whether the DoP had the capacity (and motivation) to venture into these resources. For instance, expansion in the staff establishment was difficult but not impossible. In other words, stakeholder support needs to be secured through motivation and leadership. The HOD of the DoP had to be self motivated to get what the department needed. Likewise, the PHASOM had to find its leadership, as well as unity amongst its members, for the purpose of professionalisation. What remains the biggest obstacle, then, was actually the lack of agency (in terms of motivation and intention) to engage stakeholders. This means it could be flawed to impose the notion of stakeholder in a setting with little agency. Here, it challenges the assumption that stakeholder approach can be applicable to all contexts, as the notion needs to work on the basis that all stakeholders are free to act on their agendas. In fact, the purpose of collecting stakeholder data in the first place was to provide the DoP with information that it could act upon to build its capacity. However, it was not long after entering the field that I realised it might end up being merely an assumption. The Department might already had sufficient information awaiting action, hence might need no further 'advice'. I could have easily declared my research aim accomplished by listing down all the suggestions for the Department, for instance simplifying recruitment process and

giving more credits to non-research academic staff. However, this friendly advice might not be useful to solving the actual problems. Instead, I would challenge the norm of gathering stakeholders (in a workshop, etc) for problem-solving. As discussed in section 5.1.1, true engagement must come from the ownership of the responsibility and not merely physical participation. In this case, ownership might be antagonised by external intervention (which will be elaborated in detail in the next chapter), as well as local 'culture' such as the big man syndrome. Culture is written in inverted commas because these issues are usually treated as something that cannot be solved immediately, hence peripheral to the serious work of capacity building. However, evidence presented in this chapter suggests that these issues are not peripheral, and indeed central to the capacity problems[113]. Interruption from both external and internal sources, therefore, seriously jeopardise the agency and freedom to own the institutional agenda.

6.8 Conclusion: does stakeholder engagement really work?

Starting off with much enthusiasm about finding creative solutions for the Department, I unexpectedly stumbled upon a rather 'cold' reaction from local stakeholders in return. Conventionalities such as publication-based promotion, as well as self-antagonising culture such as big man syndrome, indicate a strong resistance towards innovation or alternative solutions. The research took a reflexive turn upon encountering such data. Indeed, the adoption of the 'stakeholder engagement' concept was based upon an ontological assumption that agency inherently exists within the host institution. To use this theory, one has to assume that the institution researched would *want* to participate in stakeholder engagement; so what this research would offer was an analysis of *how* the institution could do it. However, this does not mean that all the findings presented in this chapter are not useful. They provide valuable information for scanning both the internal and external environments of the DoP. From this it is understood that whilst some problems faced could be country-specific (e.g., the

[113] Further exploration of the links between culture and capacity can be found in Chapter 8.

big man syndrome), most problems are not. The education institution in Malawi too shared similar problems faced by the rest of the world, e.g. the reluctance of practitioners to have an academic career for fear of publication pressure. The findings also indicate that securing stakeholder support for pharmacy education could be a discipline-specific issue, because of the unresolved 'quasi' professional status of the profession. In summary, there is no generic answer and there is a need to contextualise capacity problems. A simple HRH question could be embedded with layers of country and/or discipline-specific issues. In Chapter 8, I will discuss how the use of an inter-disciplinary approach can fulfil this need.

6.9 Epilogue

A change in leadership took place at the Department of Pharmacy approximately 2 years after the completion of my PhD fieldwork. As conveyed by some informal sources (later confirmed by one of the members of the DoP), this new development brought a positive change to the departmental work culture. This means the DoP's SWOT analysis might also have changed due to friendlier work environment and higher staff morale.

CHAPTER 7

Engaging foreign aid for capacity building in pharmacy education in Malawi

In this chapter, I will explore the nature and impact of foreign aid on institutional capacity building in pharmacy education in Malawi. Because of the intensity and complexity of aid issues, as well as the sheer amount of data gathered, foreign aid as one of the groups of stakeholders must occupy one whole chapter by themselves (unlike other stakeholders who are allocated only one section in the previous chapter). In Malawi, donor funding constituted as much as 20% of its gross domestic production (GDP), 40-50% of government spending, and as much as 80% of the development budget (World Bank, 2006). Despite receiving aid for nearly half a century, Malawi remains as one of the poorest countries in the world. Such a case is not unique to Malawi but is consistent with a number of other sub-Saharan African countries (Doucouliagos and Paldam, 2009). Contemporary debates about aid therefore question the legitimacy and efficacy of aid and potential harm caused by giving aid. In this chapter, I will seek to engage with these debates through studying local realities at the Department of Pharmacy (DoP), the College of Medicine (CoM) and the University of Malawi (UNIMA). In section 7.1, there will be description of six types of foreign aid engaged by the DoP, the CoM and the UNIMA. This will be followed by discussions regarding whether foreign aid is useful for institutional capacity building; by analysing attitudes of both the donors (in section 7.2) and the domestic players (in section 7.3). In the final section (7.4), I will argue for an alternative way to engage foreign aid, which could possibly be more effective than the current model.

7.1 The different types and actors in foreign aid

In this section, six major types of foreign aid will be presented using a case study format. There were probably many other forms of aid with which the department, college and university was engaged with. A limited access to 'all' data disallowed me to study all of them; however it allowed me to focus on cases which provoked the most attention and controversy locally. Each case study will report on how the relationship was started, as well as its impact on local capacity,

both positive and negative. Table 7-1 summarises these six cases, which will be discussed throughout this chapter.

Development partners	*Contribution to departmental capacity building*
The Global Fund	Funding to establish the DoP in 2006
The Wellcome Trust (WT)	Research collaboration since 1999 through 'Malawi-Liverpool Wellcome Trust' (MLW) Programme
Norwegian[114]/ Swedish governments	Various capacity building projects at CoM (a particular focus on staff retention scheme, which involves salary top-up of USD1000)
Organisations sending volunteer lecturers (e.g., CIM, VSO, AAU)	Volunteer lecturers
American aid	Supplementing public sector pharmacy (in supply chain management & clinical pharmacy)
Individual philanthropists	Various (e.g., sponsoring Masters scholarships for pharmacy graduates)

Table 7-1. Summary of development partners who contributed to departmental capacity building.

CIM: Centre for International Migration and Development; VSO: Volunteer Service Overseas; AAU: Association of African Universities.

7.1.1 The Global Fund

In section 6.1, I mentioned 'government funding' and 'government initiatives' to set up the Department of Pharmacy (DoP). This has to be rephrased, when it comes to the aid language in this chapter, because it was, to a larger extent, donor funding and donor initiatives. The very establishment of the DoP originated from funding given by the National AIDS Commission (NAC), which is

[114] Note that NORAD (Norwegian Agency for Development Cooperation) is a technical agency that does not have funding power. The Norwegian Government is the correct term when referring to the funding body of Norwegian aid.

in turn funded by the Global Fund for Tuberculosis, Malaria and AIDS (or the Global Fund in short).

> They were promised funding by the National AIDS Commission. And that has happened. They get funding in two ways. One is directly for students, so ten students per year are given scholarships. And the other way is the university given money directly which is then divided into two portions: one is used for general infrastructure – building up the college and the other part is given specifically to fund the foundation of the pharmacy department and its equipment and staff and so on. As a result of that they were able to start the programme in January 2006.
>
> One of the former HODs of the DoP

7.1.2 The MLW Clinical Research Programme: research (for) capacity building[115]

Regarding itself as a 'global charitable foundation dedicated to achieving extraordinary improvements in health by supporting the brightest minds', Wellcome Trust (WT) is a major funder for medical research in Malawi. It founded the Malawi-Liverpool Wellcome Trust (MLW) programme, which supports research capacity building in the country by partnering with the Liverpool School of Tropical Medicine. Locally, MLW works closely with the College of Medicine (CoM) and the university teaching hospital i.e. the Queen Elizabeth Central Hospital (QECH). The tripartite coalition between these three institutions was an idea conceptualised by the founder of the MLW, Prof

[115] There are several research affiliates that are closely linked to the College of Medicine, for instance the Malawi-Liverpool Wellcome Trust (MLW), Johns Hopkins University (JHU) and University of North Carolina (UNC). Because of MLWT's longest history of association with the CoM, it is selected as the primary discussion within the confine of a thesis.

Malcolm Molyneux, who thought research should not be separated from teaching and practice:

> I think research improves teaching. Teaching improves research. Clinical practice informs both of them. And clinical practice was improved by both research and teaching. So I see a kind of mutually virtuous circle. So clinical work, the care of patients, the teaching of medical disciplines, and research into current local problems, all happen together and inform each other. I think they're mutually enhancing. And any one of them on their own becomes sterile. But, together they are stimulating. And I think the idea was that the problems in Malawi *need* to be grabbed locally, on-site. That's why I moved here, to study the problems where they are, not from a distance.
>
> Prof Malcolm Molyneux

The partnership with the Liverpool School of Tropical Medicine came from Prof Molyneux's early engagement with the school. The research laboratories were officially opened on the 22nd January 1999, with a specific interest in malaria research (Winstanley, 1999). In subsequent years, partnership with external bodies was enabled by a network established by faculty members outside of Malawi, as was noted by the Dean of Postgraduate Study and Research at the CoM:

> So, most of us would have been trained out in the UK and maintain that kind of collaboration. So most of the PhD level's faculty [members] we have at present would have active collaboration in the UK.

Apart from research capacity building, the presence of MLW was perceived to give, either directly or indirectly, benefits such as providing research incomes for academic staff at the CoM (see quote [1]); improving teaching facility through

sharing (or donation of used) laboratory equipments (see quote [2]); and improving the skills and knowledge in using the equipments (see quote [3]).

> [1] We think that if people are into research, not only can they end up getting extra income, which is the [financial reward for the] effort they put into the research, but [also] everybody who is an academic they want to progress academically so this research also will make them retaining here.
>
> Dean of Student

> [2] Research can be used to bring in more equipment. That's what often happens. You know you're short of some equipment, a research project requires such equipment, and can be a very good way of getting the equipment. You then do the research (you ask questions, you answer them), and meanwhile you've got the equipment to use for other purposes as well. Other research, QC [i.e., quality control], and often for clinical service needs.
>
> Prof Malcolm Molyneux

> [3] It's the capacity to use it. And *that*'s where, again, research projects are valuable. They can make somebody, force somebody into using some equipments and *learning* capacity, limitations to do it. Troubleshooting. Becoming competent. Whereas there're ,in some places, I think *redundant* items of equipment that is just not being made use of. Because nobody knows how to use them. You'll find those in the different rooms of the college. Things that were installed from 1994 or something. That have never been used because nobody knew how to use them. Um... so that, we need to march with both legs of course – expertise and equipment. Hand in hand. Leg in leg.
>
> Prof Malcolm Molyneux

Because of the lack of postdoctoral programmes in Malawi, lecturers who had just finished their doctoral studies might lack chances to learn about grant writing and supervising research students. Research affiliation therefore brought in opportunities for mentorship particularly in areas where local expertise was yet to be available.

> We have the Wellcome Trust, state-of-the-art WT laboratory, where you get a lot of researchers coming from Europe, from America. We have the Johns Hopkins. They're more into HIV. We've Michigan State. They're doing their own work in malaria. So you have established researchers from outside. The thing is some of them will spend two years here. So you can link up a junior basic scientist with somebody there. So that he learn how to conduct research, how to write proposals, how to write papers, so that with time they can also write their own grant applications.
>
> One of the HODs at the CoM

Over the years, research positions at these research institutions was said to have been going through the 'indigenisation' process, which means the lowering of expatriate: local staff ratio. The Principal Investigator position at the Johns Hopkins research unit, for instance, was occupied by a Malawian clinical researcher. This growing indigenisation was also reported by a publication from the Principal of CoM regarding the increasing replacement of expatriate staff by Malawian staff [see (Zijlstra and Broadhead, 2007)]. In the DoP, the first and second HOD were foreigners. The third HOD was a Malawian and it is to be hoped that this position would continued to be filled by Malawians. Therefore, there was a unanimous opinion about the gradual take-over of the positions by the Malawian staff. However, the expatriate staff, though smaller in number, still exerted high level of influence on domestic capacity. This question will be probed further in section 7.2.1, where the concept of mentorship is explored.

Because of the link between clinical research and clinical practice, research funds indirectly contributed to the improvement of clinical facilities. Since it was relatively easier to obtain research funding, the presence of research institutions might actually offer a quicker way to improving clinical service.

> [1] I would say that research can contribute importantly, in a *huge* way, to improving clinical services. In indirect ways, to use the most blatant clear-cut example, right here, because of the Wellcome Trust's support for research here over the last 13 years, they have decided to give the hospital a new Accident and Emergency Department. So Wellcome Trust has given the hospital a large grant of hard currency to build what you can see being built right now, now it's half way up.
>
> [2] The people doing the research have been mostly, largely clinical scientists. And they've devoted a significant proportion of their time and effort to doing clinical service. So individuals who are here to study, usually to study clinical disease, have spent a lot of their time doing clinical service – partly because that brings them into contact with the things they're trying to study. But in so doing they're *greatly* contributing to the staffing of the wards. Looking after the sick. They would not be there if there wasn't a research project, but in doing the research they contribute to service and teaching.
>
> Prof Malcolm Molyneux

However the downside of having well resourced clinical research projects was a higher possibility to exploit the local patient population, who were powerless to resist allowances and/or better clinical services provided by research teams. Also, these projects created conflict between health workers working for the research projects (and received higher pay) and those who did not (hence not receiving extra income):

> Sometimes there are different salary scales between research nurses and service nurses. And that can cause resentment, especially since the workload *looks* a lot smaller in the research side than the service side. This is a very unpleasant problem and a difficult one.
>
> Prof Malcolm Molyneux

Amongst the academic staff, those doing clinical research were getting extra research income and publications; and this might arouse jealousy from non-clinical researchers (as discussed in section 6.3). However, it was said that it was important 'not to throw the baby out with the bath water'. The college administration thought continual engagement with the MLW was necessary for the long-term financial survival of the college. As the Norwegian funding would be withdrawn by the year 2012, the college needed a long-term strategy to replace the USD1000 supplementation. It was hoped that revenues generated by staff's research and consultancy activities could be pooled to set up a fund, which could then be used to continue giving out supplementary salaries after 2012. So, research incomes earned did not go entirely to the individuals. Instead, certain percentage was taken from incomes generated by individuals' research activities and/or consultancy work:

> The College charges (known as a 'levy') of 20% of the basic consultancy income (i.e. excluding college direct charges for facilities) is payable when a staff member undertakes work by private contract for a third. The levy must be paid to the College cashiers and will be credited to the College income code. The levy payments should be made either on completion of each consultancy, or twice annually for each six months period ending on 30th June and 31st December. Receipts for the levy payments will be issued by the Cashier to the individuals for their personal tax returns.
>
> Page 2, Policy for Private Remunerative Work and Consultancy, CoM, UNIMA (Draft)

At the same time, several measures were taken to minimise the undesirable impacts brought by clinical research projects. Research councils such as the COMREC (College of Medicine Research and Ethics Committee) and the NHSRC (National Health Sciences Research Committee) were set up to scrutinise research proposals; and to reject proposals that do not benefit the country. Research Support Centre (RSC) was set up (within the CoM compound) to train research grant writing skills so that it could benefit all researchers, regardless of their fields of research. However, the presence of the Research Support Centre was received with little enthusiasm. It was said that one's chances to do good research was determined by how closely one was associated with the MLW. The MLW was perceived as the goose that laid the golden eggs; so what remained to be done is to find the route to retrieving those golden eggs. Because no successful cases of large-scale funding were seen to have been generated through consultation with the RSC or through any other non donor-assisted routes, it became attractive for CoM members to want to be part of the MLW. A member of staff from the CoM said he had not thought about approaching the RSC, despite his desperate hope to get a research grant, simply because he had not seen any successful cases. This person also regarded the training courses offered by the RSC as clinically oriented (e.g. statistics for analysing epidemiological data) and, therefore, unhelpful to basic scientists[116].

> One of my colleagues approached the Research Support Centre Director. And they discussed his proposal. And the Director of Research Centre contacted him later to provide possible sources of funding. That was it. He was not able to get any funding from the suggested funding and um… I have not heard him say he went to see the Director of Research (Support Centre) again.
>
> One of the basic science lecturers cum researchers at CoM

[116] However, the RSC and the research councils were relatively new establishments compared to the MLW. So, it might take some time before they could become more helpful to the researchers.

7.1.3 Norwegian aid

The main concern that brought me to the Norwegian aid agency was the controversy surrounding its 'Staff Retention Scheme', which gave every teaching staff a salary top-up of USD1000 per month. The dispute was caused by the way this top-up was distributed, which was said to be done without following the university-wide procedures (see section 6.4). Some of the staff members, who did not receive the top-up, felt they were being discriminated against. This scheme provoked so much controversy that it became the only discussion topic concerning Norwegian aid. Therefore, during the interview with the First Secretary of Health at the Royal Norwegian Embassy, I was surprised to find out about many other capacity building projects sponsored by the Norwegian Government. Apart from the salary top-up scheme, the governments of Norway and Sweden have been supporting the construction of new infrastructures (e.g., libraries, laboratories, lecture rooms, student hostels) and the creation of new courses (e.g., medical laboratory technology, physiology, pharmacy). These capacity building projects were funded by four consecutive 3-year renewable aid contracts starting August 2000[117]. Interestingly, these projects were said to be funded by Prof Broadhead's (i.e., the Principal of the CoM) 'friends'; whilst the staff retention scheme was referred to as 'Norwegian aid'.

Perhaps, the salary top-up scheme received a much higher visibility than other projects because of its direct impact on individuals' income. It should be noted that an additional USD1000 per month was a relatively large sum of income for staff members at the CoM. Therefore it could create anger and despair if one was denied such an attractive package. It was commented that the execution of this scheme lacked transparency; hence it was even suspected of potential favouritism and corruption. This accusation, however, was dismissed by the

[117] Phase 1: August 2000-December 2003; Phase 2: December 2003-December 2006; Phase 3: January 2007-December 2009; Phase 4: December 2009-December 2012. There is no need to elaborate at length what these Nordic governments have contributed as information can be found online at (Norad, 2009).

college administration, who claimed their accounts were audited every year. Also, this scheme created a sense of insecurity amongst staff members. It was thought that many would eventually quit their jobs once the supplementation was withdrawn. Therefore, whoever did not quit would have to bear huge workload left behind by those quitting. Although leaders of the institution already had their back-up plans to ensure continual supplementation (as mentioned above), it seemed the staff members had not yet to be reassured. As a result, many had prepared themselves an exit strategy so that they would not end up with low pay and high workload.

Another reason for the low visibility of Norwegian aid projects might be caused by the lack of publicity. Unlike their British and American counterparts, the Nordic aid seemed not to promote their national identity as strongly. Such an impression was confirmed further when I met the First Secretary of Health at the Royal Norwegian Embassy in person in Lilongwe. What struck me most, during the meeting, was her *learning* attitude. In fact, 'learning' was a word she repeatedly used throughout our discussion (e.g., "I finally understand it's about HARNESSING"). Although I did not fully grasp the lessons she had learned over the years about the purpose of this aid project, it was evident about her openness to embrace new concepts and culture. She perceived the aid project as a process rather than an end. Therefore, she would encourage the CoM to take their time in learning their capacity needs and how the limited money given by the Norwegian government could fit into those needs. Indeed, the interview eventually turned out to be a discussion between two foreigners about Malawi culture (rather than a one-way provision of information, like the interviews at DfID and USAID headquarters[118]), which was a learning process in itself.

[118] Interviews at both institutions were not reported in this thesis because of their lack of relevance to institutional capacity building. However these interviews and subsequent reflections were important for me, as a novice researcher with zero experience dealing with aid agencies, for 'compare and contrast' purposes.

It was difficult to decide whether her attitude was representative of the overall Norwegian aid discourse in Malawi. The nature of this small scale research does not warrant data collection of more than one interview. It could be argued that such attitude was simply a result of an individual's personality. However, it could also be argued that it was one of the micro-level representations of the macro-level practices and discourses of Norwegian aid [cf. the Swedish aid discourse in (King and McGrath, 2004)]. In addition, the attitude of one key decision-maker in the donor agency could possibly have a great effect on the whole country, because Malawi is a small country. Therefore, in a way, this interview provided a cross sectional testimony, however anecdotal it might seem, of an attitude to aid that is otherwise not revealed by merely studying agency's aid policies.

7.1.4 Volunteer teaching staff

In this section, the discussion will be focused on three organisations which were sending the DoP volunteer teaching staff. The first one was the VSO (Voluntary Service Overseas) UK, which was the major recruitment agency for volunteer workers in Malawi. VSO UK is largely funded by the UK Department for International Development (DfID)[119]. VSO volunteers in Malawi are recruited from five international locations: UK, Canada, Kenya, the Netherlands and the Philippines. The selection process was said to be a rigorous one, accepting only those with qualifications approved by the country's pertinent authority (e.g., the Medical Council of Malawi). Volunteers were provided accommodation and subsistence allowances (of MK8,000 per month) during their service period.

[119] DfID is a UK government department responsible for overseas development. Although it is the largest UK donor agency in Malawi, discussion is focused on VSO because of VSO's direct involvement with departmental capacity building. DfID subscribes mainly to the poverty reduction agenda and is involved in many areas of development in Malawi (e.g. health, education, water and sanitation, etc).

The second organisation was the 'Centre for International Migration and Development' (CIM), which was funded by Germany[120]. Unlike VSO volunteers, CIM volunteers were paid the same wage they could otherwise earn in Germany during their service period. This strategy could probably increase the likelihood of people volunteering in Malawi as money was less of a concern.

The third organisation was the Association of African Universities (AAU). Under its 'Academic Staff Exchange' Programme, the AAU sponsored inter-university collaboration where member universities exchange teaching expertise between themselves. It was through this programme that the DoP received its visiting lecturers, on a yearly basis, to assist teaching in areas that departmental staff was deficient in. The advantage of this scheme, compared with the others, was the flexibility allowed for the exchange staff to leave their employment for a duration longer than what was normally allowed for annual leaves (e.g., a month).

Volunteer staff was supposed to temporarily fill the gap before a sufficient number of local staff could be employed. However, it was also hoped that their contribution could sustain for a period longer than the duration they volunteered. This was difficult to achieve because the gap-filling function would usually take up most of their time and resources. To achieve these two functions (i.e., gap-filling and long-term capacity building) concurrently, one of the most commonly used strategies was building up a 'pack' during the service period. This pack

[120] CIM is an abbreviation for 'Centrum für internationale Migration und Entwicklung' in German. There are a number of German aid agencies operating in Malawi. Apart from CIM, other major aid agencies include GTZ (Gesellschaft für Technische Zusammenarbeit – Agency for Technical Cooperation) and DED (Deutscher Entwicklungs-dienst – German Development Service). These two agencies were then merged, together with InWEnt (Internationale Weiterbildung und Entwicklung - Capacity Building International), in 2011 to form GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit – the German Agency for International Cooperation). However, only CIM is discussed in this thesis because of its direct support for departmental capacity by sending volunteer lecturers.

should contain a collection of teaching materials, in the form of notes and presentation slides, which was ready to be delivered by any other new lecturers[121].

Another important contribution by volunteer staff, as commented by one of the HODs at the CoM, was their demonstration of how teaching could be done creatively. Coming from different parts of the world, they brought in different ideas to allow improvising from a limited range of available teaching resources:

> I think where voluntary staff from overseas had great strength. They could bring in the ideas from Europe, or America, or Australia, wherever, of practical work, that is simple and doesn't require a lot of equipment. That gives data to analyse. Which is relevant to pharmacy. And that was the great strength of how the volunteer, to the VSO service.
>
> One of the HODs at the CoM

> You don't really have to have high tech equipment to do chemistry practical. And you can do very simple things... with a few chemicals, and very basic glassware. And that's what I did. And I found plenty of research in the internet and then just when you're teaching, you come across ideas you can show you can give an example to the students on how to work in the lab. I mean that we have quite a lot of glassware in the lab and we could obtain the chemicals. Sometimes we didn't have them but we could ask another uni [or] another college for example.
>
> Volunteer lecturer II

[121] The success of this strategy, however, depends on whether this pack would eventually be put to use. In one case, a pack developed by a volunteer staff was left unused because the new staff was unaware of it.

Volunteer staff said that they faced great challenge in adapting to the local setting. Most often than not, these foreign workers spent a lot of time and energy in understanding internal politics and overcoming cultural differences. Some of them were frustrated by red tape and/or the internal politics, wishing instead their skills and knowledge could be maximised during their relatively short period of stay in Malawi. Although pre-departure briefing had informed volunteers about potential cultural and circumstantial differences, it was still up to the receiving organisations to help the volunteers to adjust. Two volunteer lecturers raised their concern about not receiving enough information about what to teach. This could seriously deter both work output and motivation. In some cases, there was a sheer lack of preparedness in facing stressful situations:

> For some people, just the experience of poverty and of this abysmal injustice, as such, is *tiresome*. It's something that is stressful, and tires you out, wears you down. That could be a problem with some expats. But sometimes, sometimes we have people who are expats who come to the ward, look, cry, and leave. Never to be seen again. That happens quite often.
>
> One of the expatriate specialists

7.1.5 American aid or USAID

American aid, or USAID, was not directly involved with departmental capacity building. However it had been an active player in the public sector pharmacy in Malawi. Hence this thread was actively pursued during fieldwork, in order to enhance understanding about aid discourse within the pharmacy sector in Malawi. At the time of fieldwork, two primary agencies working in pharmacy sector in Malawi were 'Supply Inc'[122], which was involved in strengthening supply chain management; and 'Clinical Inc'[122], which was involved in strengthening

[122] A pseudonym.

clinical pharmacy delivery. These agencies are called the 'implementers', which means they bid for projects funded by the American aid, or the USAID.

Three senior personnel at Supply Inc were interviewed. A large part of the interview data consists of information about the do's and don'ts of managing the supply chain in Malawi. With the agency's 10-years plus field experience in Malawi, Supply Inc claimed they understood the Malawian system very well. Compared with the Norwegian way of learning, the American aid workers were keener on looking for the 'right' way of doing things. For example, one of the aid workers described how the agency actively shaped the health system in Malawi using their knowledge:

> We change the role of people. Because the pharmacy technicians at the District [level] were used to keep commodities. And then we said that no more keeping commodities. So we needed to give them a new role. The new role was like they're going to be doing supportive supervisions. They do on-the-job training. We came and train them [to do on-the-job training]. But then, we found that there was a different problem. The different problem was um... to do the supportive supervision, you need money to travel to the post. You need the per diem to sleep wherever you're going. So it was a big issue again. So what do you do? So we brought the supply chain manager [i.e., a computer software] to the District. So it's a supervision tool that doesn't need you to leave [your workplace] but you can see and you can plan where to go.
>
> One of the USAID senior advisors
>
> (as 'USAID Senior Advisor' in later quotes)

The American way of delivering knowledge-based aid was to give training on areas identified as the 'right' way of doing things. Such knowledge was packaged in a deliverable format to enable a convenient transfer from trainers to trainees. During one of the on-the-job training courses, one of the instructors disclosed

(through an informal chat) that only two weeks of training was required for him/her to become an instructor. The mission was to disseminate the knowledge and it was done via two types of training module: first, a two-week module (which was done every two years[123]) to train supply chain managers on managerial skills such as establishing a stock reporting system. The second one was a three-day module that trains supply chain health workers on skills such as how to fill up a stock card. It was then up to the aid recipients to make use of the knowledge gained from the training courses. From this perspective, the reason why there was a lack of improvement in the system was probably due to the lack of application of this knowledge, that the recipients "not really helping to make it happen".

> Because the system is as good as its user. You can have a beautiful system but if people don't use it, it doesn't work. And that is not our role. We have no role in motivating people. We have no role in making sure that they do it. That's the ministry's role. So, there is a gap in terms... there is a huge gap in terms of capacity. I think we've given the people who are on the ground the skills. Because I think we have trained everybody. The issue of motivation, it's key. It's really, really key.
>
> Country Director, Supply Inc

> It's sad that they don't notice our effort. And sometimes they are not really helping to make it happen. Like for this programme I wanted to see programme people were also being involved. I have nothing against we have all these level people that came. And we have all these intern pharmacists that could bring a new way of seeing things, which is good also. Well whoever they sent there is good but we

[123] First implemented in 2006; then 2008 and 2010.

> don't have any programme people to continue bringing the change in programmes that we've started[124].
>
> USAID Senior Advisor

On the other hand, this prescriptive style of aid was well received by the client country, because these aid could provide sound advice and "strengthen the system":

> They [i.e., the Supply Inc] are useful. They give us um... they do assist us. Like for example, very lately they've done an assessment of our distribution systems. Rerouting... you do six routes to distribute in a district. But I think if you can do abcd, we can easily reduce these six routes into something like 3 routes. In the process it saves you well. It saves delivery time, you know, such things. Yea they've come to assist us in logistics, in supervision, all several ways. Yea. Yea. Clinical Inc is the same thing. They do go around hospitals... they strengthen system. Yea. So we're partners. Yea.
>
> Controller, CMS

The downside of delivering aid this way was the creation of aid dependence. The CMS was said (by almost all informants) not to have improved for the past 20 years because 'emergency' help was always available from the agencies. This might make improving domestic system less urgent. In one case, where there was an amount of debt that CMS could not afford to pay back, the solution was to seek negotiation to write off the debt:

> My experience was sometimes it was such that um... there was so much debt there, we have to ask donors to rescue us. Just to pay

[124] It was said that this particular training failed to attract the 'programme people' (i.e., managers or key decision makers in the system) because of the lack of per diem payment. Under the USAID policy, programmes run in Lilongwe are not entitled to receiving per diem.

> bills. And I know that the EC, the European Union, came in and helped us to clear the bills. But they're only choosing companies which are from their own countries. So [for example] if it is a UK company that I owe the EC paid on my behalf.
>
> One of the former Controllers at the CMS

The Country Director of Supply Inc considered it as an improvement regarding the big increase in the number of drug items being managed by the agency. This number had increased from 6, when Supply Inc started their project in Malawi, to 1500 at the time of fieldwork. The following quote is given at length in order to allow readers to gain a sense of how performance was measured within the USAID modality[125]:

> Supply Inc has been here [for a long time]. We keep on having our projects renewed. We started what we called Project *X*, which was basically looking at family planning products. Ok? That ended. Succeeded. And then the Ministry requested for a new project which now looks at reproductive health products. So, contraceptives and other reproductive health supply, which are basically drugs for managing STIs, sexually transmitted diseases. So the next project broadened, from six products to 18, I think, 20 products. And at that time it was still vertical. A 100% vertical procurement, warehousing. In fact, I think procurement at that time was being done by DfID. And then Supply Inc was supporting the warehousing, the distribution and the information management. That ended in [year] 2002. [In] 2002 we got what we called Project *Y*. So the name changed from Project *X* to Project *Y*. So under Project *Y*, the request came from the Ministry to expand this system which is only managing 20 products to integrate other essential drugs. Ok? So under Project *Y*, we worked with the Ministry for this new integrated system to manage not only

[125] It is not important to understand the technical issues outlined in the quote.

> reproductive products but also essential drugs. Then Project *Y* ended. So it moves from managing 20 products to 1500 drugs. And it's at that time that we set up the integrated system – you go to each and every district there's a computer. There's a software that manages the data. Um... we set up the paper based system on how to report, how should the supply be done. We reduced the levels from 4 levels to 2 levels. We have all the products now being managed under one system. As supposed when it was vertical, CMS came in, the Ministry came in and took over the system. So ours is to help them manage the system. So we helped them to design what should the paper based system look like. How should the re-supply system looks like. How should you order, how should you procure, what do you quantify, we helped them. We helped them with quantification. Every year we helped them set up a National Quantification Team. Quantification and review every six months. So we did do that. So that ended in 2006. Ok in 2007 came Project *Z*, which is now the current one. And that's why I came in. I came in in Oct 2007 to help Project *Z*. Now, in Project *Z* what they wanted was now to strengthen the *other* system. The HIV/AIDS system, the ACT system with the new malarial drugs, the lab system. And the TB system. Like they also get integrated into this essential drug system. So we managed to do everything except TB, which is to do in Year 5.
>
> Country Director, Supply Inc

Commenting on whether Supply Inc had actually dominated the domestic system, the Country Director said they merely "responded to what the government wanted":

> Because we respond to what the government wants. We don't impose on them. We don't.

One of the most unexpected observations, when visiting sites of these aid agencies, was the high ratio of Malawian staff (compared with non Malawians). This observation was triangulated by a common perception about how aid agencies eventually turned into a competitor to the domestic system. With higher salaries and better career prospects, it was not difficult for aid agencies to be favoured over domestic positions. Also, it was said that the training courses provided by the agencies (which was meant to improve the domestic system) eventually served as a form of training for those wishing to join the agencies. After acquiring employable skills through these training courses, government servants were tempted to come off their poorly paid positions. The following quote shows the personal dilemma experienced by one of the USAID workers, who had 27 years of experience in aid projects, regarding this issue:

> I know part of my job is that how can I make people be like me [i.e., as capable as I am] everywhere I go. But what I noticed is that whenever I make people become like me, those people when I go back I found them now they're just my friends. They've been taken by someone else. They're no longer in the Ministry. They are very grateful that I gave them a nice treat that made them get a job. So can you say that we're not doing that [i.e., building domestic capacity]? I believe that we're doing that! But people are taking them. And then someone from USAID, who was seated by me, who is a friend from Belgium, he told me in French that you yourself, you deliver, you take them, you hire them – which is sometimes true! Because... arrgh! Sometimes you know I train all these people, when they are hiring in country, sometimes my colleagues ask me we have this person who requested to be hired. This person be trained by you in the country. Sometimes I would know. That person received the training. The person has put in a CV. Received this. So they'll ask me. And I'll say yes and I'll give them my opinion how good the person is because I'm training them. So I know each one of them so in the future people would ask me, and?! You recommend them. But it's

> not us, it's other NGO that have been taking them! So it's a fact and you cannot say no to these people that don't leave us, we train you, NO! Everyone of us is looking for a better life! So that is what is happening. You train more and more. Even me there's another organisation that is courting me to go there because they're receiving money for food and security in ten countries. So they feel if they have me I can coordinate those things.

The competition for human resource came not from the pharmacy sector but also other supply chain related industries, e.g. Coca Cola.

> The supply chain is a BIG, BIG component in *everything* that is happening. It's a BIG thing. Not only for health. But even for food. For EVERYTHING. Supply chain, if you have it, you get it. Even one of our own workers working with us, Coca Cola just stole the person. So that means it's all the same! All these young people we're training today, when there's a new NGO coming, even the old NGOs when they're looking for new people, they target the same people. When you said you have our certificate in supply chain, it's recognised! It's a course they're taking now. So you show everybody that I've taken this course people would believe that you'll be able to deliver and they would hire you.
>
> USAID Senior Advisor

Commenting on this issue about in-country attrition to NGOs, the Head of Pharmaceutical Service was of the opinion that the country did not lose its human resource as long as it stayed physically within the country (see quote below). Informal chats with younger pharmaceutical personnel revealed their hope to have more aid agencies in the country because things were "too slow" or "too frustrating" for any ambitious young people to work in the public sector. The aid agencies therefore provided an alternative route to expanding their skills and vision.

> We have to look at it from both angles. They've come in our setting. They're coming for our own very cause. When you win some, you lose some. They've come to help us, they need resources. They're pulling resources from within the country. I think it's a good one. Because I would rather lose that somebody to an NGO within the country than they leave for abroad. Better that within the country. But at the end of the day, that NGO is helping the country. You're dealing more with NGOs being present than an NGO not being there. What I'm really trying to say is it's not a win-win situation. It's a win-lose situation. But for the country, so long as somebody stays within, the country, the net effect on the country is zero.

In short it seemed the aid format exercised by the USAID, though perceived to be detrimental to domestic capacity building, was accepted by the client country. It was said that such a status quo was most likely to be maintained because all involved parties were personally benefiting from it.

> I mean for a central medical store with this record, for decades, it's a clear proof that those in power benefit from this.
>
> Medical doctor IV

7.1.6 Individual philanthropists

The number of individual philanthropists was not officially recorded; nor was their nature of donation and involvement documented like those from aid agencies. Even so, this category of donors was most frequently discussed because of the personal relationships between donors and recipients. In the DoP alone, the first two HODs came for their appointment through personal networks rather than contracts from an aid agency. One of them, having established close ties with the students, personally sponsored several field trips abroad for some of the pharmacy students. The students were grateful for the opportunity and the HOD was revered as a Good Samaritan at the DoP. In 2010, he personally

sourced five scholarships for Masters Degrees abroad and offered them to five pharmacy graduates who were serving their internship. Unfortunately, what seemed to be a great gift sparked suspicion in the Ministry of Health. This personal arrangement was said to be problematic because of its lack of alignment with government policy (i.e., "people have got to serve first before they can leave the service for further training"). The Head of Pharmaceutical Service (at the MoH) quoted five reasons for objecting to the interns receiving the scholarships:

> Problem number one is, they applied for those scholarships without actually telling MoH of their wishes. That's definitely a problem in itself. Secondly, they've got an internship programme to manage. They have not even finished it. Let alone somebody gives you an application for a Masters degree to go somewhere. [This is] Problem number two. Problem number three, in the application, I don't know how far they committed the government. But they committed the government without the concern of the government. Now, the reply that comes that says they [i.e., the sponsor] will actually take care of them [i.e., the scholarship recipients] but they have to actually find their own tuition plus transport expenses. That takes government prepare and find a budget for. We do not budget for those items. Fourthly, we don't expect that because policy of government is [that] somebody from college has got to serve first before they can actually be going to another training programme. That exists in our [i.e., MoH's] setting as well. They have not even fulfilled it. All I'm saying is that they have just being introduced to the payroll then you say this time I want to go for another training. What are we training them for? They have not proved that they can do what we want them to do. Then later on they say they are still going for another training. When are they going to prove that indeed we're actually banging on the right people? Fifth, they're assuming that they're the only people who exist, who can actually be developed. For any system, they

> should not. There are people, when they come to the system, they should know that there are other people there. And it works as a cascade effect. People coming in, those who are there, if they need to be developed, they should be developed first before the people who have just come.

All five prospective scholarship recipients were interviewed. Apart from their excitement, they also displayed a high level of anxiety. For those who were breadwinners, there was a worry about the cessation of household income should they decide to take up this opportunity. Some thought they might actually have less chance of returning to the service after they gained a higher academic qualification. This was because getting a better qualification in areas such as pharmacy administration might be perceived as wanting to take over the administrative positions, which were powerful positions that their superiors would like to stay on with. Despite all these worries and financial difficulties, all five scholarships were accepted eventually due to the greater fear of losing such rare opportunities for further study. However two students changed their mind and returned to Malawi after some time, without completing their two-year Masters study.

7.2 The archetype of donors: why some helps are unhelpful

The six case studies in section 7.1 illustrate the different ways for the institution to receive foreign aid. Further analyses, in the following three sections, will discuss ways to make aid works. In this section, analyses are done from the perspective of the aid givers. In section 7.3, they will focus on perspective of the aid recipients or clients or doers (these three terms will be used interchangeably, depending on context). A suggested solution for donor engagement, argued upon analyses from both sections, will be presented in section 7.4.

7.2.1 Breaking through the orthodoxy of knowledge transfer: differentiating 'mentors' from 'trainers'

If you want to build a ship, don't herd people together to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.

Antione de Saint-Exupery

Although north-south knowledge transfer has been increasingly rejected by the latest practices in aid, it remains a much easier and more convenient solution. One of the most frequently heard complaints amongst the expatriate community, which was picked up from both formal interviews and casual chats, was the very slow responses from their domestic partners. 'African time' was a common expression used in either a compliment (i.e., enjoying a relaxed pace of life) or a complaint (i.e., things are too slow to cope). At times, it could be very frustrating for northern workers who were used to a (much) faster pace in life and work:

> I continually pleaded also to the staff to try and invent practical exercises. Now I hope it doesn't sound derogative. It's not meant to be. But I have discovered that Malawians are *not* very innovative. That's my view. They are very happy to institute things where they are given instructions or directions or syllabus but they *can't* innovate, particularly on the practical side. They don't seem to *want* to innovate. This is partly the national culture… it's partly perhaps the reticence on their part because they are *young* staff and it's [also] partly because, I think, they have no technical assistance to try things through once and get the ideas.
>
> One of the HODs at the CoM

When things became too slow to wait, it was tempting for the aid workers to jump in and rescue. Indeed, the act of emergency rescuing pleases all parties by

solving problems on the client side, satisfying aid funders and giving a sense of satisfaction to the aid workers on the ground.

> Ideally we should not be doing it. It should be the Ministry doing it. And giving us the details. The ministry [should be] getting all the data and collecting it, and share it with the stakeholders, including Supply Inc, who is a stakeholder. But since that gap [i.e., lack of motivation], USAID has requested us to help them doing that.
>
> Country Director, Supply Inc

As a result, donor projects often end up as a replacement to a dysfunctional domestic organisation. Supply Inc, in this case, became both a hero and a villain to their domestic partners. Because of the great effort required to resist jumping prematurely into the driver's seat, there emerged a school of thought that labelled aid as harmful. Popularised in recent years by books such as 'Dead Aid' (Moyo, 2009), which has a radical proposal for immediate termination of all forms of aid in order to avoid further harm to the already fragile domestic system. In Malawi, this school of thought seemed to receive much higher acceptance amongst expatriate community compared with the locals.

Indeed, it might seem logical to assume aid should fall at one end of the polarity: to interfere or not to interfere; because it is difficult for a trainer not to also become a 'replacement manager'. However, the case studies suggest yet another archetype of aid that transcends such duality: mentorship. Whilst trainers 'herd people together to collect wood' and 'assign them tasks and work', mentors inspires people to 'long for the endless immensity of the sea'; as the quotation above from Saint-Exupery puts it.

Characteristics of the mentors

Leadership and mentorship provided by some of the eminent figures, such as Prof Malcolm Molyneux and Prof Robin Broadhead, was evident in spearheading

capacity building for the CoM since its very early years. In fact it was awkward to label these figures as 'donors' because of they had already been integrated and seen as part of the local community, following many years of stay in Malawi. The difference between a trainer and a mentor was shown in the interview data, when they were asked to comment about their achievement so far in building domestic capacity. Whilst the former spoke about the agency's past "success" (see quote [1]), the latter talked about their vision for the institution (see quotes [2] and [3]):

> [1] Supply Inc has been here for the last 13 years, what have they done? But I have told you, we have started with 18 products, now we have thousands of products plus, if that is not a success I don't know what success is. Within a period of 18 months, we moved from 16 products, the system now can manage 2000 plus products. It can manage. It is not managing very well. But the system is there. People want to use it, it's available. Each and every district has a computer, bought by us. People [are] trained on this software to help manage the data. If today the DHO [District Health Officer] wants to know how much aspirin is used in that district for the last one year, they just go to the computer. And the information is up there. But do they use it? That's another question. So, it really depends. The system is as good as the people who use it.
>
> Country Director, Supply Inc (i.e., the 'trainer' turned 'replacement manager')

> [2] They have undoubtedly improved [in grant writing skills]. But not across the board. And all improvements could be improved upon further, there's no doubt that this is a very difficult area. Many trainees have developed great skill in writing grant applications, and have gotten their own grants. They need to mentor others, spread the fire.
>
> Prof Malcolm Molyneux (i.e., the 'mentor')

> What the CoM needs to do was to capitalise on its unique strengths such as traditional medicine. Its future is dependent on building up of academic leadership, instead of administrative leadership. Therefore, we need expatriate teachers for their mentorship and not merely technical assistance.
>
> Extracted from notes of an unrecorded interview with Prof Broadhead

Another widely regarded mentor in the field of clinical pharmacy was Ms Judy Wang, a Taiwanese pharmacist who had practised for seven years in Mzuzu Hospital. She was the first to practice clinical pharmacy in the hospital, through services such as pharmacist advice slip[126]. Although this service was simple, it had set an example to pharmacy technicians working at Mzuzu Hospital during her service period. Those who had been mentored by Judy thought they learned how to innovate, thus had a "good learning experience", rather than merely extracted knowledge from her.

At the moment, finding mentors was an informal process. However, it was suggested that this might be made a formal arrangement, by pairing up a senior staff member from the MLW research site and a junior staff member from the CoM. Through mentorship, it was hoped that the junior staff could absorb international experience without having to go abroad; and to use this experience to innovate from the local setting.

> Most of us were trained outside. You come in [to local research setting], you have a doctorate but that's not enough for you, because like if you go to South Africa, you go to Europe, the set up is already there. It's easy for you to write up applications, to get a grant; while

[126] A note from pharmacists is inserted between medical notes to inform doctors of issues needing attention e.g. availability of drug stock, drug dosage, etc. It facilities inter-professional communication because doctors and pharmacists cannot always meet face-to-face.

> here it's a different environment altogether. So the thinking is if you pair up a junior scientist, who has just come back, with a senior researcher, they would learn how to operate in the environment, how to write a proper grant which would be suitable for Malawi. So you're almost mentoring. […] I'll give an example. Me, I come back from my training in PhD, I came here, there was nobody to mentor me. So it means me I had to stand on my own feet, with a background of having nothing in the lab. How do I start when you have also to prepare for teaching and all that? So in the end you end up being just a teacher and a researcher. Yes. So whilst if you link up with um... I was lucky because I have connection with the WT laboratory, so when I came back I went there and said I'm back, I'm here, is there anything that I can [do]. [It's] not really my field but [I was] just trying to get here. So, I was able to go there. But there're others who don't have anybody there. They come back, they would just stay in their office. You see. So that's why we need to do deliberate effort to having this mentoring process so that when they come back, they know that they can look for somebody whom they can partner with.
>
> One of the HODs, CoM

The distinction between trainers and mentors however may become blurred should the mentoring process be formalised. However, how likely this is to happen in the future is beyond the scope of investigation of this research. What needs to be highlighted, based on currently available evidence, is the effective learning brought by mentors, who are often visionary figures themselves. They could be few in number but might be highly influential.

7.2.2 Do mentors build sustainable capacity for the CoM?

Although mentorship was not (yet) a form of 'aid' given by any specific agency, the most interest was shown by the MLW programme, which intended to formalise it into the CoM training system. Analysis in this subsection, therefore,

examines whether mentorship at the MLW programme actually produce positive and sustainable effect on domestic capacity. The first, direct answer to this question was 'yes', because mentorship could create a pool of local talent, who are competitive at international level:

> Well we certainly hope that creation of people with competence, such as the people I mentioned, will contribute to local capability. If Wellcome Trust were to pull itself out, those individuals [would] remain capable of applying for money. They're not going to be more privileged than their American or their British counterparts. Such people, anywhere in the world, need to raise money for their future support. These people, we hope, will have a CV and a track record and a publication record that will make them capable of raising such money. Sustainability is really based on people. And their capacity to go on. I don't doubt that one day the Wellcome Trust will cease to provide core support for MLW. My hope is that by then there'll be enough fire burning on the ground for the original logs to be pulled out and the fire keeps burning.
>
> Prof Malcolm Molyneux

Apart from individual academic capacity, mentorship seemed to be also able to create leadership. The Principal Investigator of the Johns Hopkins project, for instance, was once mentored by the MLW programme. I had a personal encounter with one of the protégés of the research programmes at MLW, who displayed not only expertise in his area of research but also a visionary attitude:

> What I'm looking forward to is the establishment of a Pharmacology unit within this department [of Pharmacy]. So that we can develop a research agenda, that is primarily pharmacology in orientation. And we're moving towards that. We've received a lot of equipment that will allow the building up of a team of pharmaco-kineticists, that has been my focus in the past four years. Population pharmacokinetic

> modelling. Yea. So, we've linked up with the University of Cape Town and University of Liverpool and they're providing resources. We're sending our new recruits there. The hope is that finally we'll have a robust team of pharmacokinetic modellers. And we can run therapeutic drug monitoring unit within the department. So that really is my vision.
>
> One of the lecturers-cum-researchers at the DoP

Although the actual number of local leaders created by MLW was unknown, and what effect it might have on institutional capacity was not conclusive; what was demonstrated was the possibility of MLW mentorship to produce local leaders. However, the 'side effects' of producing local leaders was also observed. The local champions were not always liked by their colleagues. Their better-than-peers performance could potentially jeopardise inter-collegial relationship, which was an important asset for building institutional capacity. In some cases, these MLW mentees were resented by their colleagues because of the perceived privilege and extra research income they enjoyed.

> The Wellcome Trust, some of them funded by.. like *him* next door. Who's paying I don't know but he's spending most of, some of his time at the Wellcome Trust. But he's a member of this department but he spends quite a bit of time there so they pay him. I don't know. No idea.
>
> One of the lecturers, not sponsored by MLW

As suggested in section 6.4, non-clinical researchers felt they were left out (as a reminder, see quote below) and perceived a glass ceiling to their career development in the college. Failing to join the 'elites' for the 'best' research resources (available at MLW or other research affiliate sites), bitterness was bred amongst non-(clinical) researchers and lecturers. In other words, the sheer presence of MLW created an impression of a professional hierarchy amongst the members of staff at CoM, with MLW mentees occupying the top rungs of the

ladder. As a result, there was an environment of hostile competitiveness. Because staff members were focused on winning the race, there was less thought of working *with* (rather than *against*) each other.

> [M]ost of the research is being driven from the outside. It's not locally driven. And most of the people that are bringing the research they're normally bringing clinical research.
>
> One of MLW mentees

The resultant weak relationship between colleagues also encouraged the culture of prioritising private work over faculty roles, since nobody should meddle with other people's businesses. Although it would be unfair to attribute all internal disciplinary problems to external partners like MLW, it must be noted that the latter played an important role in shaping the perception regarding private work in a loosely supervised environment. It justified, as well as normalised, a work culture that lacked accountability to its service users, i.e. the students. It was not uncommon to find staff members running errands, for example at banks or the post office, during office hours.

Both the lack of staff cohesion and discipline resulted in a very tough environment for management. The local leaders often spent a lot of energy fighting against the system and many ended up overworked, frustrated and in some cases, de-motivated.

> Sometimes I leave this place, go home and I don't know whether I'll also leave or not. I mean… if effort that people put into whatever they're doing doesn't pay off, what do you want? You would rather be in a place where your effort will be appreciated.
>
> One of the key figures at CoM

Nevertheless this is not to claim the failure of mentorship in building domestic capacity. It is inconclusive, based on the limited evidence available for a PhD

project, as to whether things could be improved in the long run should more local leaders enter the domestic system. Rather, what needs to be highlighted is the potential risk (of weakening domestic work culture) underneath the rosy picture of MLW success.

7.2.3 What about just giving money?

With much evidence pointing to the drawbacks of knowledge-based aid, it could be timely to revisit a conventional aid modality: monetary aid. Out of six case studies, three offered monetary aid (the Global Fund, Norwegian aid and individual philanthropists). Incidentally each represented a different level of interaction: multilateral, bilateral and personal. Amongst these three levels, it seemed only the multilateral aid given by the Global Fund was causing the least dispute. Although the Norwegian partner adopted a non-interference stance, whereby internal arrangement about how the money was spent was not interfered (see section 7.1.3 for details), it nonetheless caused turmoil at the receiving end. It seemed internal conflict was unavoidable regardless of who decided how money should be distributed (either externally in MLW's case, or internally in the Norwegian case) as long as preferential treatment was perceived to have been given to certain groups or individuals. With this, I suspect there was a local culture called 'tall poppy syndrome', which means resenting merits given to any achieving individuals or groups.

It was therefore not surprising, should this reading of the local culture be accurate, to find the personal aid from an individual philanthropist causing so much controversy at the MoH headquarters. To award five individual scholarships to junior pharmacy staff, who had not even completed their internship, was interpreted as a preferential treatment. It also explains the worry amongst these five scholarship recipients about being resented (i.e., by becoming the 'tall poppy') and, hence, not being able to return to public service upon completion of their Masters study.

In short, either form of foreign aid, knowledge- or money-based, is associated with some form of internal dispute because of the nature of aid itself: i.e. selectivity. Preferential treatment, either perceived or actual, feeds into tall poppy syndrome thus creating a vicious cycle of resentment.

7.2.4 The superiority of donors: how architecture speaks for 'trustworthiness'

Many of the internal problems discussed in the previous subsections, from jealousy caused by well-intentioned mentorship to mistrust caused by the Norwegian salary top-up scheme, are probably caused by an impression of the superior role of the external players to the internal ones. Donors were frequently given more favourable comments, for instance their salaries were more consistent than salaries given by the government. Undoubtedly, they did have a better track record in some areas like paying salaries. However, from my ethnographic enquiry, I found such a superior image might be constructed from more than merely a better track record. Visits to a number of different agency and governmental offices gave me, a novice with no preconceptions, a much more superior first impression of the former. I will elaborate briefly this impression from two points: the architecture of the office buildings and the workplace atmosphere.

First of all, it was simply nicer to work in the donor offices. The size of offices could range from one section of a two-floor building (e.g., the British Council) to a fenced, huge bungalow (e.g., the USAID and the DfID headquarters). Regardless of its size, they always appeared neat and well equipped (for example, you don't have to carry your own toilet paper around). Before you get to the person you need to see, you probably will need to go through many steps of referral – an ordeal that probably confers a high status to that person. At the USAID headquarters, I was searched twice, scanned through an electronic scanner door, handed in my identification document (which reduced my particular identity to that of a general 'visitor') and escorted at all times in the building. Contrary to how I was allowed to roam freely in the ministrial buildings, I felt like a criminal;

sinful at even taking a glimpse around the building. The office of the person I was about to meet (who was a senior advisor of one of the many projects run by USAID) was much more impressive than the office of the Director of Higher Education or the Head of Pharmaceutical Service. Although I was treated politely, I felt small and intimidated.

The workplace atmosphere at donor buildings was sombre, as if everybody was busy doing something very important. There were people moving around at all times. This was not the case in governmental buildings, where you probably see jackets hanging around but not the people. People were always away for a course, to go to banks or in a meeting. On many occasions, I saw people gathered around for chatting, akin to what people generally joked about 'African time'. I felt completely relaxed because of the friendly environment. However I doubted how much could be achieved when people were not 'serious' enough. In almost all interviews with the government officials, I was allowed as much time as I wished (sometimes up to 2 hours); whereas in the donor officers, I was probably given no more than half an hour (apart from the interview at the Royal Norwegian Embassy).

In short, it certainly feels donors are reliable: they are organised, disciplined and probably very important. The sheer scale of manpower hired at the USAID headquarters (which felt larger than one whole ministry) easily convinced one of its ability to do a very good and efficient job. Because of its grandiosity, donors became an unquestionable saviour from the sufferings in Malawi.

 vs. 

Figure 7-1. The entrance of USAID headquarter. Figure 7-2. The entrance of one of the Ministry buildings (at Capital Hill, Lilongwe).

Source: picture on the left was taken on 13/07/2010 whilst picture on the right was extracted from the official website of the Ministry of Local Government.

7.2.5 Conclusion:

In conclusion, we see the potential brought by mentor-styled donors to indigenous leadership capacity building. Whilst this could potentially generate long term capacity building, the problem that emerged might seriously jeopardise such potential. Because of the perception that only certain privileged individuals were given preferential treatment, this well-intentioned aid turned out to be a strong dividing factor amongst local workers. It was indeed perplexing to observe a cold, individualistic culture at workplace which was a stark contrast to the warm, communal environment in evidence on stepping out to the social space. Although the association between the lack of relational capacity and systemic capacity building cannot be confidently established by this research, it is worthwhile to point out its potential hazard: when there are only very few who are taught to long for the endless immensity of the sea, those left behind may feel abandoned hence removing the motivation to build a ship.

Whilst it is convenient to blame the tall poppy syndrome for its undermining of cohesiveness between colleagues, one must be mindful of how local context could also be actively shaped by the external players. The local researchers, when they looked around for opportunities (or extra incomes), found the good ones being distributed by only one or two donors (e.g., MLW research projects, Norwegian salary top-up). Unlike a resource-rich environment, where one could

easily knock on the second door should one be turned down at the first, opportunities are scarce in Malawi. Fiercer competition in Malawi provoked stronger resentment toward other people's success, hence reinforced the tall poppy syndrome.

What seemed to be a common problem, therefore, was the disruption or weakening of the domestic system when relationships with the donors were prioritised over internal relationships. In the case of the MLW-CoM partnership, the supposed interdependent relationship between stakeholders of the university-college-department structure was lost when accountability was shifted elsewhere to external players. This happened because extra effort was rewarded by the MLW (e.g., with a research position) whilst insufficient effort was not penalised in the domestic teaching positions (because of a lack of HR to supervise teaching). As a result, the MLW-CoM relationship was strengthened; whereas the university-college-department-student relationship was weakened. In the case of USAID, many functions of the domestic drug supply chain system were replaced by the trainers-turned 'replacement managers'. The supply function of the CMS was not stimulated because the demand (from the health facilities) was conveniently shifted to the USAID-sponsored organisations. In fact, this situation was not isolated to the CoM. It was not uncommon to find comments about how donors were bypassing local authorities, such as the PMPB in cases of drug registration:

> I think what annoyed me about the NGOs in Malawi is a lot of them don't respect the law. I know that the laws in Malawi are not enforced as much as they should be but um... if you don't abide by them it's not really fair. So, for example they would have drugs coming in from Belgium, which is fine, but then the wholesale I mean the warehouse wouldn't be registered or approved by the Board of Pharmacy. Secondly they'll put someone in-charge of pharmacy who is not a pharmacist […] because they're cheaper or for other reasons.
>
> Community Pharmacist IV

Even in cases where domestic functions were not taken over by the foreigners, such as the Norwegian aid and overseas scholarship awards, a seemingly harmless award of aid could easily cause internal chaos. The local reaction seemed to be strongly conditioned by habitual dependency, which might be reinforced by both the donors (as discussed in 7.2.4); as well as the recipients (see next section). Any external help, even a very small amount, could trigger furious competition, for instance the dispute around obeying seniority when five scholarships were offered for Masters study. The sheer presence of donors, even with different levels of interference in internal affairs, stirred up turbulence across the whole organisation or even sector. The domestic capacity was too fragile to withstand even the slightest, innocent external intervention. By taking away five pharmacy graduates, for instance, there was a great deal of disruption to the pharmaceutical system which consisted only of less than ten qualified staff in the public service.

7.3 The stories from the aid recipients: why they can't help being helpless

The client country is usually contextualised as a passive receiver of aid and, therefore, it is argued that the nature of donor-client relationship is largely shaped by the donors (Easterly, 2006). This is only true to a certain extent, as, my ethnographic data suggests. In this section, I shall explain how this passive behaviour can actually be actively formed, and reinforced in Malawian's everyday life.

7.3.1 The culture of aid dependency

As discussed in Chapter 6, most domestic stakeholders lacked motivation and/or resources to support capacity building in pharmacy education. Feeling a lack of financial support from even the university finance office, it was thought that the college needed to source funding by itself from alternative resources. It must be

also noted that there was a lack of faculty entrepreneurship because of the unavailability of local funding agencies. There were no local research institutes and virtually no pharmaceutical industry. The four local pharmaceutical companies were producing only General Sales Items and were not involved in research and development activities. Funding from philanthropists was variable and students' tuition fees were almost negligible, and entirely insufficient in financing faculty expenses. Under these circumstances, foreign aid came in as a quicker solution to fulfilling institutional capacity needs, as described in section 7.1. It became the only help when there was no help available locally.

During its foundation years, the medical programme had built its capacity through links established with foreign universities. In the first 7 years, (three-year) pre-clinical medical training was taking place outside of Malawi due to the lack of teaching facilities. Students were sent to the UK (St Andrews and University College London), Australia (Flinders and Adelaide Universities) and South Africa (University of Cape Town). The less expensive clinical training in the following two years was undertaken at the Queen Elizabeth Central Hospital (QECH), i.e. a teaching hospital adjacent to the CoM. When teaching annexes and laboratories were built after 7 years, pre-clinical teaching was eventually shifted back to the CoM. Because of these successful outcomes brought by these external links, it was assumed that the pharmacy programme should also do the same. The leaders of the pharmacy programme were expected to initiate such links:

> We're just beginning, we are just starting, so we could have problems in terms of capacity. But I think it is something that can be overcome. Look, the CoM when it was also starting, it didn't start with local expertise. It had to rely upon expatriate staff to build capacity for the country. So one would expect that even with pharmacy, you know, in the initial stage of its operation they would rely upon expatriates until they build enough capacity within the country. […] So you would expect also in pharmacy department, the leadership within the

> department or the leadership within the programme to follow the same path.
>
> Deputy University Registrar

Therefore, it was therefore rational, as well as natural, to consider the donors as the first port of call when it came to fundraising:

> I think because of the way it's structured, the college, the university and all that... The best way is to get extra funding somewhere. Because the college does get [enough] funding. Maybe use that funding [from somewhere else]. You know. Part of that funding that actually pay the technicians.
>
> Acting HOD, the DoP

Receiving aid has become a norm in daily governmental operations. The general attitude to aid was to welcome all forms of aid. For instance, the CoM administration expressed its wish to absorb volunteer teachers of any field, and regardless of the duration they could teach, even as short as only two weeks. This policy is questioned by some scholars because this may deplete the already low level of administrative capacity; at the same time leaving behind no significant impact on local teaching capacity (King, 2009b). Even so, the CoM expressed no refusal of any foreign aid in the face of human resource crisis.

> We are just hoping that the from this discussion, whoever is going to read your work, would probably come back to help because we accept any kind of help – six-month teaching, one-month teaching, any kind of broad teaching, we accept any kind of support. We have so many people volunteering to come, just for a month or two, just to teach on some areas. That is very, very important for us because it broadens the scope of learning for the students. They learn what is happening somewhere else.
>
> Registrar, the CoM

A similar 'beggars cannot be choosers' attitude was conveyed by the Head of Pharmaceutical Service in MoH. He felt the ministry should not expect "too much" from development partners because there were "too many" problems that "could not be solved at one go". Therefore, even in cases where aid had proven to be less helpful than expected, it was believed that the outcome was already the best result one could ask for.

> Of course we say beggars cannot be choosers. But sometimes we behave that way. Project comes in, we actually expect that it would answer all our problems. It has all these many resources to answer your problems. But you'll find that these projects are also limited in resources. So you would not cover everything in one go.

The faith in donors was all pervasive, permeating every aspect of life in Malawi. As a fair skinned person, I was constantly regarded as a potential donor simply because of my 'mzungu' identity. Mzungu is a local term that refers to Europeans but later inclusive of any non-black persons. During fieldtrips, I was frequently stopped on the streets (even in my worst jeans and dirt covered rucksack) by people asking for jobs (in case I run a company) and/or money. I was told many stories of how one's life can be changed by a *mzungu* sponsoring education for the local young people. In some interviews, the consent to accepting an interview actually came from the hope to gain some sort of donation from me. For instance, there was one researcher who asked for my help to donate laboratory equipment and a pharmacy technician who asked for a sponsorship for studying the pharmacy degree (see section 2.2.4 regarding research ethics).

The purpose of giving all these real-life examples, despite our knowledge about severe aid dependency of the country, is to give a sense of how asking for foreign aid has turned into a culture, a norm that one is easily influenced by and significantly engaged with. It does not exist only in aid projects and contracts; it is the mentality in everyday life in Malawi. Everywhere I went, in Malawi, I constantly felt obliged to give something, whether or not there was begging. It

becomes a habit that is hard to be undone, not only by the locals but also the mzungus. In the following subsections, I will explain how new languages in aid (e.g., ownership and partnership) fail to reform the old ways of development cooperation, because of the culture of aid dependency.

7.3.2 The problem of ownership: when action is not initiated by doers

The language of aid effectiveness speaks about country ownership and putting clients in the driver's seat. The purpose of doing so is to ensure sustainability and to allow eventual withdrawal of donor intervention. I have discussed, in section 7.2, how 'replacement managers' could easily wreck the sense of ownership. Even the mentors have problems building local ownership, even though they could create local leadership. I also visited the notion of 'non interference', where aid was given without intervening in internal affairs. However, non interference aid was not necessarily causing less internal dispute due to tall poppy syndrome, and perhaps other factors beyond the investigation of this research. In short, there seemed to have a great difficulty in absorbing aid. Before I explore further what was causing this difficulty, I shall elaborate on one additional example in the next paragraph.

Four years after establishment, and following departure of the two expatriate founding Heads, the DoP was described as being at 'near collapse' in its state of staffing. Although this was a problem commonly faced by new departments, the problem seemed to go beyond the mere shortage of available teaching staff. As mentioned in section 6.2, the absorption mechanism in the department was so problematic that it even resisted its best graduate taking up an Assistant Lecturer[127] position. A rare opportunity to get a visiting lecturer was wasted because of departmental bureaucracy. Teaching packs and creative ideas developed by volunteer lecturers, as a means for sustainability, were left in the dust. Also, the vacancies for lab technicians were left unfilled for more than a

[127] It is a training position for teaching staff without a postgraduate degree.

year simply because of missed application deadlines (see section 6.5). A severe lack of concern about the staffing crisis indicates a serious lack of sense of purpose of this department. By revisiting the aim of the programme, it is not difficult to understand why the lack of ownership occurred: the programme was designed by the government, or more accurately, by the donors who wanted to contain the spread of HIV/AIDS[128]. The first pot of money given by Global Fund-sponsored NAC had therefore created the department in its name but not in the spirit. In other words, the department was not *owned* locally because the process of creating it was not participated. As a result, it might be harder to create motivation to improve it.

There was only one case study that reported effective absorption of external aid: Norwegian aid. Putting aside the dispute about salary top-up, there was clear evidence of aid money being absorbed into building teaching blocks and student facilities around the college campus (see pictures below). As mentioned in section 7.1.3, the donor claimed that all plans and ideas came from the CoM. This tallied with statements from the CoM leadership about how they 'go out and talk to the donors'. Strong domestic leadership from the CoM, albeit under a College Principal of the British nationality, enabled internally motivated actions.

[128] For further reading about how HIV/AIDS started a trend of 'global governance', please see (Zacher and Keefe, 2008).

Figure 7-3. The infrastructure built from Norwegian aid.

Construction of well facilitated[129] student hostels, seen in the picture on the left; and sports facilities, picture on the right (the building in the background is a sports centre).

7.3.3 The language of partnership: an illusion when there is nothing to exchange?

The intriguing partnership rhetoric, as commonly mentioned in aid effectiveness declarations (see section 5.1.5), was investigated with much curiosity during fieldwork. One of the interview questions, as well as a topic in informal chats, was what was so unique about Malawi (or the CoM in particular) that could eventually induce true partnership. People were generally attracted to life in Malawi because of its unspoilt nature and the friendly society at large. The only feature that seemed to draw commercial interest for partnership, unfortunately, was a large pool of patients ready to participate in clinical trials, as well as a research ethics procedure that was less rigorous than say, the NHS in Britain. Some people read this as exploitation of the local patients, whereas some saw it as a currency for partnership.

The language of partnership was created to counteract the power differential between donors and recipients. However, it normally ends up as a decorative term to repackage an old relationship. The way CMS and Supply Inc labelled each

[129] Hostels were spacious and comfortable, with a maximum of 2 students per room, which was a luxury compared to my university years in Malaysia where I had 3 or 4 people in one room the same size. Cafeteria was providing food free-of-charge. For recreational activities, there was a recreation centre and a student bar.

other as 'partners' was a typical example. True partnership seemed to be a very difficult mission at present when the recipient has very little to offer the donor in return.

It has been suggested that 'indigenous knowledge' might be used for initiating true partnership. However, this suggestion might exist merely rhetorically. A glance of the examples as to what indigenous knowledge is, given by the World Bank's policy paper 'Indigenous Knowledge for Development' (see Box 7-1), explains why it does not interest most knowledge consumers in the West.

Examples of indigenous knowledge:

- Midwives and herbal medicine.
- Treatment of cattle ticks by the Fulani using Tephrosia plants.
- Soil and land classifications in Nigeria.
- Water catching stone bunds in Burkina Faso.
- Construction of buildings with natural "air conditioning" in the Sudan.
- Kpelle artisans' steel making technology in Liberia.
- Agroforestry systems emulating the natural climax vegetation on the Kilimanjaro.
- Settlement for land disputes between farmers and nomads in Togo.
- Communal use and individual allocation of land by the Washambaa in Tanzania.
- Local healers' role in post-conflict resolution in Mozambique.
- Transfer of knowledge through elders, rituals, initiation, and story tellers in West Africa.
- Systems to control power and distribute wealth among the Maasai in East Africa

Box 7-1. Examples of indigenous knowledge.

Taken from (World Bank, 1998).

The only indigenous knowledge in Malawi thought to have the potential for inducing research and commercial interest is knowledge in traditional herbal

medicine. Interviews with the key informants[130] in traditional Malawian herbal medicines revealed massive barriers in bringing this type of knowledge for modern use. It was a body of knowledge that was completely incompatible with a modern epistemological knowledge base. It was not easy even for local researchers to initiate association with the herbalist, making extra difficult to be understood. According to the President of Malawi Traditional Healers Umbrella Association (MATHUA), the reason behind the resistance to giving out information about traditional cures was the worry of being exploited: "some white men come here collecting plants and gives nothing back". During the interview, as a modern medicine practitioner I felt utterly baffled by his unwavering belief in a concoction cure for HIV/AIDS. At the same time, the practice of witchcraft, as part of the traditional medicine, perhaps frightens non-indigenous researchers (like myself). Although I cannot judge how effective indigenous knowledge can be, as a modern knowledge user, I can confidently claim a massive epistemological differential between traditional and modern medicine. This certainly undermines motivation for (Western[131]) partnership in indigenous knowledge development.

Although not an asset for partnership in the near future, traditional medicine remains an area worth capitalising on. Ethnographic experience described in the previous paragraph is meant to provide a sense of why external players would prefer to stay away from it. Domestic stakeholders, however, was more enthusiastic about it. The MoH, for example, was drafting a policy paper to incorporate traditional medicine into the mainstream healthcare provision. Perhaps one day, when Malawi's true potential is uncovered, either through traditional medicine or other forms of indigenous knowledge, the vision to make

[130] A researcher of traditional herbal medicine, the President of MATHUA (Malawi Traditional Healers Umbrella Association) and a person heading the policy unit for traditional medicine at MoH headquarter.

[131] The President of MATHUA had expressed high hope for a coalition between the Association and Traditional Chinese Medicine practitioners from China. However, it was beyond the scope of this project to examine non-Western partnership.

the MLW and the CoM a hub of international academic excellence, as described by Prof Malcolm Molyneux, could be materialised:

> In the North, we have mentors from elsewhere in the North all the time. In Britain, we have people from America, from Japan. The Americans welcome bright spots from Britain to go over there. I mean, it's not the kind of top-down thing. It's a joint effort. Very often in Britain proposals would come from two different universities *within* Britain. It's *stronger* than the proposal coming from one. Because there are different skills. And funders like to see areas of expertise informing each other. And here, I would say we've got a lot of people, many of them Malawians, who are at the level of being mentors themselves. But they also should work with others, both their juniors and their seniors, inside and outside of Malawi. The idea that Malawi should run itself without *any* external collaborations, seems to me quite superfluous. I mean in Britain we don't presume any such thing. We rely on linkages with America, Europe, Far East, so it's a matter of linkages and partnership that are mutually strengthening.

7.3.4 Empowering the powerless

One of the structural problems observed, through illustrations of several case studies, is the presence of power-holding gatekeepers, who were too recalcitrant for change and in some cases, might prioritise self interest over public good. As a result, the intended effect of aid could be stuck at this gate-keeping layer and eventually diminishes. For instance, the HOD of the DoP who passively blocked out lots of the potential external help offered. Bypassing this layer of 'big people' would certainly be labelled as an act of disrespecting local autonomy. This brings the research to ponder upon an alternative way to counteract this problem: the bottom-up way. In the case of the DoP/ CoM, I looked at the issues about

student rights[132]. It was found that students were afraid to challenge the authorities, because of fear of being victimised. They were small in number and many of them, unlike students in the West who are 'customers' of universities, were sponsored in their studies, mainly by NAC and the MoH. Making complaints or demands certainly was not in the culture amongst students in CoM campus. Outside of the CoM, the bottom-up approach to demand accountability was equally, if not more, difficult. Malawians often regarded themselves as "very peaceful", "reserved" and "not aggressive". In the eyes of some African expatriates, Malawians were different from other Africans because of these characteristics. On its positive side, Malawians were said to be polite, indeed sometimes "too polite", and tolerant. On the negative side, Malawians were commented to be lacking the courage to challenge authority and the motivation to do something different. This fear of challenging authority was probably instilled by the Banda government (see section 4.3.1) and might become a barrier to public accountability. During a visit to one of the health facilities, I encountered an unusual obedience to authority:

> There were too many people in too small a waiting room. I knew I should leave as soon as possible because my heart had already started to cry. But the pharmacist in me pushed me toward the dispensing counter, where there was too much to do with too few hands [see Figure 7-4]. Even without saying anything I was called to come forward to help in dispensing (perhaps they thought I was one of the aid workers?). Speaking no Chichewa or Tumbuku, the only communication tool I had was the pictures of a sun and a moon on the labels. Patients however showed very little interest in listening to any instructions because most would like to leave the crowd as soon as possible. Perhaps the only concern was whether one was lucky

[132] This was investigated by having discussions/interviews with three groups of stakeholders: first, the students (in focus groups, see Table 5-6); second, the Dean of Undergraduate Study; and third, the representatives from the Student Union.

enough to get some drugs because almost a third of the items prescribed were not in stock. In these cases patients were told to buy the medicines themselves. I was surprised no patients objected. All they did was to nod at whatever I said. Reading the scribbled prescriptions was difficult only for the first few minutes because many prescriptions were almost identical. There were not more than 5 to 10 types of drugs for dispensing [see Figure 7-5]. I had dispensed no other than paracetomol, amoxicillin, co-trimoxazole, aspirin and indomethacin. The only prescription for chlorphenamine found none in stock. I did not know what the diagnoses were but I doubt whether all the patients waiting outside the door had almost the same illnesses. Perhaps they did. Otherwise all the effort to deliver these 'basic' services would just end up a wasted effort, or even creating new problems such as NSAID[133]-induced gastrointestinal problems. I understand that in resource poor setting, patients can only get the very minimum. But I am not sure whether this has any meaning in it at all, when all that matters was to clear the queue so that everybody could happily go home. What makes it the most painful was to see how quiet and disciplined the patients were. They did what they 'should' as patients: queuing up for registration, queuing up for prescriptions, queuing up for drugs, and then leaving quietly. No fuss. No qualms.

[133] Aspirin and indomethacin are widely prescribed, or self medicated because of its easy availability from the clinics, or even from the streets.

Figure 7-4. Outpatient pharmacy dispensing counter.

Location: one of the health centres in Malawi. Date taken: 09/08/2010.

Figure 7-5. Choices of drugs available at outpatient pharmacy dispensing counter.

Location: one of the health centres in Malawi. Date taken: 09/08/2010. Some of the bottles might contain the same medication but in different dosing, for example paracetamol had four: 2 tablets TDS, 1 tablet TDS, half tablet TDS and quarter tablet TDS; co-trimoxazole had two: 1 tablet daily and 2 tablets daily; aspirin had two: 1 tablet daily and half tablet daily; amoxicillin had two: 2 tablets TDS and 1 tablet TDS. TDS: three times daily.

I found very little was done, or could be done, to empower to the powerless. There were very few NGOs working in the area of community empowerment in Malawi. It was not an area that donors were interested in, not even the USAID

who claimed to advance democratic practices in Malawi (which was the agency's mission statement printed on a huge golden plate at its front entrance). There was only one NGO building, namely the Human Rights Resource Centre (see Figure 7-6), that could be conveniently accessed by the public in central Lilongwe because of its location next to a busy minibus depot. The MHEN (Malawi Health Equity Network), which functions as a nongovernmental watchdog to the MoH, was operating from an office on the upper floor (see Figure 7-7). Compared to the donor offices, I quickly gained access to this office even without having to make an appointment. However, it was not long before I lost interest and left. There was only one person working in the office, who paid no attention to my roaming around. I was told the spokesperson was not around and was given one of the annual reports of MHEN (which then proves to be a valuable source of information to understand problems within the Malawian health system later on). On the lower floor, there was an office for the 'National Initiative for Civic Education' (NICE). A brief chat with one of the officers revealed a massive frustration regarding political suppression of this initiative. Although I could not investigate how true the statement was, it was claimed that activities carried out by the office to educate people about their rights (including electoral rights) were severely sabotaged by politicians, who wanted to continue winning the votes without proving their worth. Although NICE was funded by the European Commission, I did not see any European aid workers around. Next to the NICE office, there was a library for community use. The walls of the room were painted with messages for purpose of civic education, including the message about 'the six pillars of democracy'[134]. The room was crowded with people reading and chatting among themselves (see Figure 7-8). According to the person in-charge of the library, most people used the space to search for job vacancies (see the 'vacancy corner' in Figure 7-9). Compared to the high usage of the vacancy corners, books and magazines in the library were less frequently used. The purpose of giving a detailed description about the activities (or inactivity) in

[134] They are: 1. Respect for the rule of law; 2. Citizen participation; 3. Regular, free and fair elections; 4. Tolerance; 5. Transparency and accountability; 6. Respect for human rights.

this building is to convey nonverbal messages about people's lack of resources and power to demand for their 'rights' (however problematic the notion of right is). Indeed, how can a hungry man be free to question about his rights?

Figure 7-6. The building of Malawi Human Rights Resource Centre.

Location: Area 3, Central Lilongwe. Date taken: 29/07/2010.

Figure 7-7. The entrance to the Malawi Health Equity Network headquarter office.

Location: upper floor, Malawi Human Rights Resource Centre, Area 3, Central Lilongwe. Date taken: 29/07/2010.

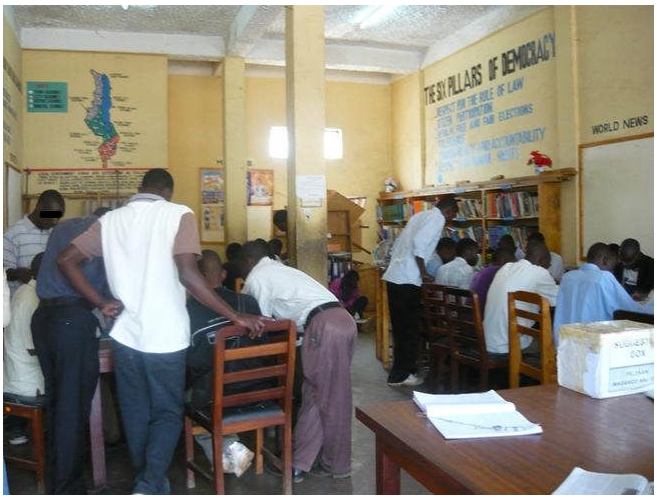

Figure 7-8. The inside view of the library in the building of Malawi Human Rights Resource Centre.

Date taken: 29/07/2010.

Figure 7-9. Vacancy corner inside the library in the building of Malawi Human Rights Resource Centre.

The purpose of reporting these experiences is to paint a picture of daily experience in Malawi which is not of press value in any foreign media. The public

in the West are often fed sensational news about hunger, poverty and diseases in Africa, but in the field I found what frustrates people the most is not the threat of death (from hunger, poverty and diseases) but the depletion of self-worth caused by unemployment. People did not talk about human rights. The fear about contracting HIV/AIDS was reduced to a casual statement: "edzi ili mu uufa". This saying in Chichewa means "it is in the nsima[135]", which means HIV/AIDS is so widespread that you cannot avoid it. Therefore, there is no need to worry about contracting HIV/AIDS[136]. People most frequently talked about jobs, and a great deal about marriage (with special sympathy for an unmarried woman in her late 20s like me). They begged for jobs from me, from the very central areas of Lilongwe to the rural villages in Liwonde. Young people who were educated up to secondary school level wanted a job other than farming. I personally met a mother who begged for a job for her son, who was a college graduate. Living in a village, this young man did nothing but spend time in his room waiting for a job opportunity that might never come.

Putting this situation into academic writing, it may be reduced to just one simple sentence: disempowerment because of a high illiteracy and widespread unemployment. The reason to extensively elaborate this sentence, in this section, is to give a deeper understanding about people's emotions. By observing the attitude towards powerlessness, I learned that this might not necessarily be labelled as 'social injustice' like I did. By experiencing the emotions provoked by witnessing powerlessness, I also learned about the reasons why aid workers (who are often outsiders like myself) are often too eager to 'save' the helpless, too angry toward the 'useless' civil service and too sad about achieving nothing at all in the end. Empowering the powerless is a long and hard journey in a setting like this; however there might be alternative ways to give voices to the powerless:

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[135] The staple food in Malawi that is made from corn flour.

[136] This might be one of the reasons to explain the spread of HIV/AIDS, as well as the failure in getting people to use condoms.

If we think [about] what goes wrong in maternal healthcare in this country: why do women die in this HUGE number? In the 21st century. Why? And I think our analysis is that basically there are three reasons for that: one is that these women are poor; the other one is that these women are voiceless, or powerless, it's the same thing. And the third is because they are women! And these three things, I believe *strongly*, are the *real* reasons why these things never get better. And what can we as health workers do about this? We can't do anything about poverty, we do not want to do anything about our patients being female, apart from you can't do anything about it. Women are great, there's no reason to change, to *want* to change that. But we can do something about voiceless-ness or powerlessness. And I think the mistake NGOs make, or people from outside make, is that they think ok these women have no voice, so *we* are their voice. Sounds good but it's bad because I DON'T KNOW what you want to say. I only know what I want to say so I can use my voice only for me. I can imagine may be what you might need. Yes... like if you are my child, my baby or something I will do what I think is in your best interest. But we're in the 21st century and I think paternalism is a bit old fashioned. What we should do and what might really facilitate change is to create spaces, to create opportunities, possibilities, for our patients to find their voice. And to say something. And then react to what they say. And that is exactly what we try with our new hospital, where the architecture is welcoming. The patients have a feeling that wow this is a space that clearly shows that I am worth *something*, as opposed to the old concentration camp-like building, where the building already told you that you are worth less than nothing. And you just *shut up*. And people did shut up. Women never say anything. They were literally voiceless. Not only in the sense of not having power, they didn't use their voices, they said nothing. Even in labour ward the room was fairly quiet. And now we have single delivery room for each and

> every woman, which means that she has her *own* space, which will be entered by us, the health workers. There's a different power relationship. If I come into your room, rather than you into my room, then there is space for you to have your partner, your mother, somebody with you, you're not alone anymore as you used to be before. So you have your own advocate there. You have much more the chance to say something. And if you can't, you can tell your husband, say this say that, ask this ask that, yeah… so these are attempts from our side to create this space for the women to find their voice. And I believe in the long run, that's the only option. If all the patients, not just mothers in our case, but all patients would find a voice, would be able to just clearly say, this is what we need, this is what we want – that would be a factor that would probably lead to change. Or if all the pupils in the school would say, no we need good school books, we need good school rooms, et cetera, *that* would change things.
>
> Dr Tarek Meguid, Head of O&G at KCH and Bwaila Hospital, service period 2004-2010

7.3.5 Conclusion

In this section, four deficiencies in the home institution are discussed: lack of confidence (or perhaps habit) to be aid independent, lack of sense of purpose for ownership, lack of capacity for partnership and lack of empowerment at the service user end. In other words, it is a society so lacking in capacity that it needs genuine help, not businessmen in the name of aid; or exchanged favoured in the name of partnership. In the next section, I will argue for the definition of 'real' aid.

7.4 The 'real' aid: why small is beautiful

In this section, I would like to suggest a local solution for a new way to engage donors at the CoM. In section 7.2, I explain how the value of mentorship (in individual cases) was soon outweighed by the sheer presence of a dominating organisation. In section 7.3, I describe why aid dependency a commonplace because of multiple donor interventions (notwithstanding local culture like tall poppy syndrome), ranging from aid projects to impressions created by massive agency buildings. I would like to argue, therefore, the 'industrial' scale of aid has defeated its very initial purpose to aid. The suggested solution is not to eliminate donors, but to reduce its scale to say, only taking in the mentors.

If one Prof Molyneux could set the MLW up and running; one Prof Broadhead could build a new medical school from scratch; one Prof Berry could lay the foundation work for the DoP in three years; and one Dr Meguid could build a new maternity block in six years; we actually may not need an army of aid workers. Personal encounters (and friendship in the latter two cases) revealed one similar theme for internal motivation: altruism. Indeed, interviews with many other aid workers received similar statements:

> The first aim is to teach the students well. And get them a little step forward to become pharmacists. And if there's, yeah, if I can't do that, I think I would leave.
>
> Volunteer lecturer III

> My motivation is not salary or what they are going to give. My motivation is I want the best training for upcoming pharmacists that they don't become a problem to the profession as a body. And anywhere in Africa, anywhere in the world, no trained graduate pharmacists would be less qualified, or less competent, compared with other pharmacists. It's a worldwide profession. And the curriculum is similar all over the world. If pharmacists trained in

> Malawi not as competent as the ones trained maybe in Zimbabwe, it's not proper.
>
> Volunteer lecturer I

> It's my pleasure to teach them. It was *so* interesting and so motivated. The other thing that I enjoyed, I would say the working environment. It was frustrating sometimes because you have to cope with a different culture and with a very different pacing of life. It's like things have slowed down quite a lot in Africa. But you get used to it. And I enjoyed it. People are so lovely and that it was actually nice. And you *feel* it, you feel how important it is what you are doing it because you're living in the country and you realise how much is lacking there. The lack of facilities in Africa. The lack of doctors. The lack of financial. So you are seeing it. You realise how important (it) is what you are doing.
>
> Volunteer lecturer II

The aid industry is crowded with too many pseudo-aiders who want to exploit something for personal gain: money, research publications, a shiny line in one's CV or simply a holiday. To filter out pseudo-aiders, one has to simply minimise these rewards and replace them with facilitation for genuine aiders. Although volunteer bodies like VSO and CIM did a good job in recruiting volunteers, many of the outstanding aid workers did not come through an agency. According to the (now former) Principal of CoM, many experienced mentors would prefer a hassle-free, straightforward contract because all they wanted to do was to help. It was also observed that most genuine aiders had prior experience working either in the Malawian public service or somewhere else in the African continent (e.g., Prof Berry had worked in Nigeria for four years and Tarek had worked in Namibia for ten years). Many came through personal network of friends (e.g., see quote below) and many would desire indirect help like reduced air fare. Perhaps positive publicity like promoting the annual musical festival at Lake

Malawi (and less about the figures of HIV/AIDS) could reduce fear to travel to the country.

> In 2007, a friend of mine came here as a visiting lecturer in physiology. And I think pharmacy programme in the UNIMA was in early stage then. Probably he interacted with the department and found out that they really needed help. And he got in touch with me and told me that please, this department would need you. They would need your help because they were just starting and I know you are good. And I think they would need your help. And that's how it was started.
>
> Volunteer lecturer I

In short, needs may be individualised (because some preferred to go through group training, especially the younger workers) however all these do not need a grandiose strategic plan to create success stories. Perhaps things started to fall apart when we try to formalise the informal. A simple definition of aid, from Oxford English Dictionary, says 'help, typically of a practical nature'. It is not dissimilar to jumping into the water for a drowning person. You do not ask the drowning person to sign a contract before you jump into the water. Aid should not be an industry, it should be a vocation.

7.5 Conclusion: the importance of understanding context, culture and conditionings

It is not by coincidence that the length of this chapter is almost double of those of most other chapters. Donors are not just 'one of' the many stakeholders but a major one in Malawi. Deciding which method to engage donors decides not only the donor-recipient relationship but also relationships with other internal stakeholders. Although my suggestion (in section 7.4) to downscale aid industry may end up a romantic idea considering its current scale, and the trend to

upscale (instead of downscale), it can nonetheless provide a space for reflection for donors wishing to engage with the CoM. It is indeed perplexing to see how aid dependency is called to be ended whilst we encourage the aid industry to get larger (by pouring in more money), and the domestic ones to remain small (otherwise they lose entitlement to aid). This is, at the same time, does not mean all the responsibilities (of ending aid dependency) should fall on the donor community, though they should bear a larger part of it. The domestic stakeholders actually have many opportunities to get into the driver's seat, should they make a choice to do so. Self antagonising culture, such as tall poppy syndrome, is something highlighted by, but not caused by, the competition introduced by the aid agencies. The local community will still have to look inward to learn about, and grow out of, themselves. Aid agencies need to be sensitive toward local culture and context. In this case, making 'preferential treatment' transparent was an important step to avoid internal dispute. In helping the recipient to stop being aid dependent, this chapter wishes to highlight how reactions are often habitually conditioned by a longstanding culture. New aid modalities such as country ownership and partnership cannot be embraced without a process of 'de-conditioning'. It is a process that has yet to be highlighted in any aid literature, though the concept of 'learning' starts emerging. Whilst there is a strong advocacy for 'teaching how to fish' (rather than giving out the fish) as a more helpful means to 'helping people help themselves' (Ellerman, 2006), there is yet a more comprehensive understanding of the aid dependent mindset. Whilst we could easily apprehend how difficult it could be to persuade a heavy smoker to stop smoking, we do not usually pour in similar sympathy when it comes to the issue of aid dependence. There is perhaps a lot more gained from intellectual knowhow (in ways to avoid a dependency relationship), but less on the much muddier issues of habitual dependence. Whilst this research may not bring up any issues that are previously unknown, it does hope to bring to the forefront the often overlooked, but strong effects, of conditioned behaviours.

CHAPTER 8

Deconstructing the development agendas: the need for an interdisciplinary approach

> 'It is all very good for you white men to follow the Word of God,' Sekhome more than once said. 'God made you with straight hearts like this,'—holding out his finger straight; 'but it is a very different thing with us black people. God made us with a crooked heart like this,'—holding out his bent finger. 'Now suppose a black man tells a story, he goes round and round so,'—drawing a number of circles on the ground; 'but when you (white people) open your mouth your tale proceeds like a straight line, so' –drawing a vigorous stroke through all the circles he had previously made.
>
> Cited in (Bennett, 1997)

This conversation between Sekgoma Kgari ('The King' and 'The Rainmaker') and the Christain missionary, John Mackenzie, conveys the epistemological difference between Western and African way of constructing knowledge and reality. So far, this thesis has attempted to tell stories representing the straight line and the circles in parallel. In this chapter, I shall attempt to make the straight line and the circles meet. To do this, a second-layer analysis is performed to examine the links between the development agendas and the local realities. These links will be explained in two sections: the first link between HRH language and professionalism (in section 8.1) and the second link between capacity building and culture (in section 8.2). It is then found that a crucial way to make these links is through an interdisciplinary approach (see section 8.3). Finally, the chapter will conclude by recapitulating important themes of this thesis in the last section. Before then, it has to be acknowledged that some of the data presented in this chapter has already been published in (Lim, Anderson and McGrath, 2012).

8.1 HRH and professionalism: two conflicting agendas?

By the end of the investigation about 'purpose', there seems to emerge more questions than answers: what are pharmacists for then, if they are not to be 'just' managers? What can professionalism offer, amidst so many structural problems? Does Malawi need pharmacists at all, anyway? In this section, these

questions will be explored. I will first look at how professionalism was defined in Malawi, before arriving at my argument about the lack of *true* professionalism in the pharmacy sector in the country. I will also explain why the current HRH paradigm, which emphasises service delivery, has silenced the enquiry about true professionalism.

To begin with, I will summarise findings from Chapter 4. Pharmacists have two primary roles: first, a policing role amidst a work culture of rampant pilfering; second, a power balancing role when their medical and nursing counterparts had been professionalised. On examining why pharmacists are given these roles, themes surrounding 'professionalism' emerged. Pharmacists were perceived to be superior (to the nonprofessional cadre) in knowledge, power and ethical conduct. Such a perception, however, contradicts evidence from the field that actually suggests a lack of professional traits. As discussed in section 3.1.5, the trait theory suggests professionals being superior in knowledge, power and ethics. In the case of pharmacy in Malawi, evidence suggests that it was difficult to see that the pharmacists were more superior in their professional knowledge to the pharmacy technicians, when their roles were restricted mainly to distribution. In terms of professional power, they were more superior. However, in terms of professional ethics, there was little evidence to suggest they were more ethical. Although this research could not measure who was more ethical, it was found that the pharmacists might not be more motivated than the pharmacy technicians in improving the sector. For instance, very little had been done to resolve the debt crisis at CMS in a period as long as more than two decades:

> 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

Certainly, such a statement may cause one to doubt, if not actually deny, the assumption of professional commitment from individual pharmacists. After all,

the painfully slow pace of change in the public sector can easily be blamed on the culture of public service, which is resistant to change. Therefore, ''it's not really me'' who did not want to change, but ''it's the system, the way things are''[137]. It was also not uncommon to find 'blame games' or scapegoating 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). However, the lack of change (or improvement) was said to be caused also by a lack of personal stake to do so. Since South Africa is not too far to travel to for personal healthcare treatment, it was perceived those in powerful positions (and rich enough to afford treatment in the RSA) did not have to improve the domestic healthcare system. Therefore, so far there has been a lack of concrete evidence suggesting professionals would actually *want to* use professional knowledge, power and code of ethics to bring changes and improvement. However, this is not to naively assume professionals in Malawi *must* be altruistic, but to point out the problem of having unrealistic assumption that professionals would have altruistic conduct, which should be capitalised on for maintaining accountability in public service. Here, this has to be challenged: is there a blind faith in professionalism?

What happens here contradicts sociological theories about the professions in two aspects: the process of professionalisation and the role of education in professionalisation. Theories propose that a profession can be created from public demand (for professional service), elite self interest and/or state planning (see section 3.1.5). Public sector[138] pharmacists in Malawi have not earned their

[137] These are statements quoted from one of the high-profile MoH officials.

[138] Discussion excludes private sector pharmacists for two reasons: first, the core argument of this thesis surrounds the needs and capacity building issues for *public* sector pharmacists; second, there was a substantial attitudinal difference between public and private sector pharmacists, in which the latter showed higher professional commitment that was most probably due to the direct involvement of private profit.

professional status through any of these three approaches; and the reasons for not being able to do so may be twofold: first, the number was simply too small for bottom-up professionalisation. At the time of fieldwork, there were only seven pharmacists serving in the public sector, leaving them little workforce to prove their merit. Second, the state was not interested in professionalising the sector (i.e., by assigning the profession to only 'technical support' functions). Also, it is also difficult for top-down professionalisation to happen in Malawi, because of its aid dependent status. Although the first pharmacy degree course was initiated in the name of the state, it actually was masterminded by the donors (see section 7.1.1). Meanwhile, the way professional education is developed in Malawi is also different from the models (both British and American) suggested in the literature. In the orthodox model, professional education functions as a gateway to curtail entrance to the profession; hence is seen as an important component of the profession. In most cases, the education sector is controlled by the profession, even in cases of professionalisation from above. On the contrary, in Malawi pharmacy education is subjected to little control by the profession. In fact, the profession itself seemed to be reluctant to claim a stake in education, because of the perception that pharmacy education served only the public sector (see Chapter 6). Since most pharmacists were working in the private sector, the link between pharmacy education and their professional interests became less obvious. Also, the aims of pharmacy education clearly serve the agendas of HRH development more than professionalism. In a way, the language of HRH seemed to have created a public-private divide in the profession, which makes pharmacy education useful only for the public sector.

These differences suggest that professionalisation in the Malawian setting is more likely to have originated from sources not mentioned in currently available literature about professionalism. Based on the evidence, I would argue that it is borrowed from or was informed by, the HRH language (will be discussed later in this section), colonial legacies (see section 8.2) and/or other sources. It is beyond the limits of a PhD thesis to ascertain its true origin. However based on evidence

available to me from this research, I would like to discuss how the HRH language has prescribed functions to the pharmacist profession; and, more worryingly, inhibited the growth of true professionalism. Before I do so, I would like to first explain why this alternative form of professionalism, termed as 'pseudo' professionalism in this chapter, can be detrimental not only to the profession, but also to long-term HRH development.

What happens in pseudo professionalism is the addition of a professional layer to the occupational hierarchy without full ownership of the process to do so. By imposing a need for professionals, less possibility is allowed for innovations that bypass professionals. As discussed in section 4.3, task-shifting becomes difficult when non-professionals are regarded as unsuitable for higher responsibilities. This perception emerged when professionals are thought to be the ones to do so. Because of the perceived superiority of the professional cadre, responsibilities were shifted upward in accordance with 'hierarchical responsibility' (Thompson, 1980). At the same time, parallel to the new definitions given to 'democracy' (see section 4.3.1), pharmacy technicians were freed from personal responsibilities. As a result, pharmacy technicians may have taken over the tasks, for which they had skills to perform, but not the sense of responsibility.

In the education sector, a multiple exit pharmacy course (which is more cost-effective than running two separate courses) is ideologically incompatible with the presence of an artificial divide between pharmacists and pharmacy technicians. When a pharmacy course is regarded as far superior to that of a technician's, building a professional course on top of a technician's may risk undermining the former. As a result, qualified pharmacy technicians have to re-learn even things they are already good at (e.g., dispensing) in their upgrading

process to become pharmacists. The training done during one-year pre-registration internship was therefore criticised as 'a waste of time'[139]:

> If you look at the students doing pharmacy internship now, they were pharmacy technicians before. And that internship to me, I mean who am I to say that, but I mean they have been doing that job, some of them for 10 or 15 years! So what sort of internship you're providing?
>
> Assistant Registrar, the Medical Council of Malawi

Having suggested the drawbacks of pseudo professionalism, now I will return my discussion about the origin of professionalism in the Malawian pharmacy sector. To support my argument about its origin in the HRH language, I will first summarise the imprints left by the global health initiatives on Malawian pharmacy education (details of this summary are presented in Chapters 6 and 7). Donors are the 'amorphous stakeholders' (Crosby, 1991) to the Department of Pharmacy, vague but powerful. They are influential in the DoP's inception (i.e., founded by the Global Fund), its operations (i.e., training pharmacists to manage drug supply chain), as well as its interaction with both internal and external stakeholders (e.g., stronger bonds with donors than domestic partners). Putting these themes together, it can be safely claimed that donors' agendas directly influence the country's agenda. Even in cases where there was desire to pursue home-grown agendas, the donors' demands on the country most probably had kept the country fairly busy:

> The pool [funding[140]] itself has got bigger. We've got DfID in the pool, the Norwegians in the pool, we've got the Germans in the pool…

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[139] The reasons for having separating pharmacy education from the pharmacy technician one can be multiple. It can be due to bureaucracy, political decisions, etc. In fact, plans were already taking place to merge the MCHS (where the technician training course is) with the CoM. What I wish to convey here is how pseudo professionalism could potentially form a conceptual barrier to the merge.

[140] 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

> 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.
>
> Health SWAp Planning Officer

Because of this direct influence from donor's agenda, I shall refer to the donors' agenda for having health professionals (in resource-poor settings). In GHWA[141] authored country guidelines 'scaling up, saving lives', the purpose for having a professional cadre is twofold: supervision of the lower cadres and career development ladder for the mid-level cadres. At the same time, this cadre should be curtailed because of their higher tendency to emigrate (Global Health Workforce Alliance, 2008b). This means the number of the professionals should be kept to the minimum, just enough to carry out the supervisory function and to entice retention of the middle-level cadre (because there is a step higher in the career ladder for the middle-level cadre to climb). Four years after the publication of 'scaling up, saving lives', an annual report of GHWA was published in July 2012. In this most recent publication, not a single word is mentioned about the role of professional HRH. Mid-level health cadres and community health workers continue to receive most attention, with 'evidence-based HRH solutions' concentrating on how best to utilise these cadres to scale up health services (Global Health Workforce Alliance, 2012b). The political attention paid to health service scale-up is indeed overwhelming, as evidenced from not only

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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).

[141] Global Health Workforce Alliance, a WHO-hosted HRH development agency (see section 1.1.2 for further explanation).

GHWA but also work from its partners like 'Capacity Plus'[142] (funded by USAID). In short, almost all resources, thoughts and debates in the HRH and GHWA platforms are directed to one single agenda: service delivery. This agenda was echoed in Malawi's country strategic plans and reports [e.g. in (Government of Malawi, 2004)], where much emphasis is put in scaling up service delivery, leaving little thought to what the professionals should actually do apart from supervising service. By making delivery-oriented strategies such as 'essential health packages' (see section 3.2.1) central to the agenda, HRH may be reduced to manual workers dishing out pre-package services.

In fact, it is questioned whether simply intensifying service delivery can actually improve health equity (Mathanga and Bowie, 2007). Research has shown that health disparity continued to widen even during the period when EHP was implemented (Zere *et al.*, 2007). Whilst Malawi is hailed as a success in HRH scale-up (see section 3.2.2), has it made a significant impact on people's health? Can the HRH actually *serve* well when they merely deliver services? Undoubtedly, it is not 'wrong' to prioritise service delivery when so much needs to be done. However, what does need rethinking is how indigenous health professions are appropriated by the delivery agenda. Linking this to the previous argument about pseudo professionalism: has the delivery agenda robbed the professionals of their agency? Has the growth of true professionalism become an orphaned issue when delivery is the golden child? As much as I would like to say 'yes' to these two questions, I shall leave these questions open for further research and debates, because evidence from this research is only able to ask questions but not to provide definite answers. What is baffling, however, is the complete lack of critique about the language of HRH (or MDGs) in the research field of African health professional education, despite widespread criticism about the MDGs[143]. MDGs are thought to have made donors, development agencies and donors lose

[142] A glance at its website will give a sense of similar discourse with that in HRH/MDG/GHWA languages (USAID, 2012).

[143] HRH is a product of the MDGs, see Chapter 1 and section 5.1.4.

sight of the purpose in policies and projects (Sumner and Tiwari, 2011). The development goals have been manipulated by parties of vested interest to become narrowly defined targets (Vandemoortele, 2009). For instance, 'combating malaria' can be reduced to the 'number of mosquito nets distributed'. Development agencies which successfully bid for donor money to distribute mosquito nets may easily report a job well done, regardless of whether the distributed mosquito nets can actually combat malaria, or end up being used as fishing nets[144]. Here, I would like to raise similar enquiry to the way professional education is appropriated by the MDG discourse: is the relationship between health professionals (or other HRH) and health being over-simplified? Has professionalism been used as a 'fishing net', hence the beginning of 'pseudo professionalism'?

If the answer is yes, then what is true professionalism? What is the purpose of doing African professional education? It is understandable that these questions have not been asked within the HRH/MDG framework, because professionalism is not a central concern. However, why have these questions been asked elsewhere in non-HRH literature? Has the HRH/MDG agenda been so powerful that it actually silences non-delivery related agenda? In the West, these questions are loudly and heatedly debated. For example, there is a constant battle between the 'training' versus the 'educating' camps in health professional education. Professional education is certainly *not* a straight line of health needs → educational outcomes → training → service. Professional training is more than accumulating exclusive scientific knowledge. It involves tacit changes that can hardly be grasped by a curriculum, a statement or description of professional traits. It is a transformative process of 'becoming' professionals (Alba, 2009). Some argue this happens through a socialisation process (Richardson, 1999), but this debate has not been resolved. The relationship between professional education and becoming professionals is certainly not linked *only* to what health needs there are in the country.

[144] This is a real-life example that happened in Malawi!

Now, this research has generated more questions than answers. Indeed, the problem faced by an aid-dependent country like Malawi is not about the lack of answers to these questions, but about the lack of opportunity to raise these questions. Undoubtedly, the delivery-oriented HRH model has the benefit of generating a quick expansion in resources for health professional education. Therefore, these questions are not meant to refute the priority set by the HRH agenda, but to request for a broadened account of professionalism in Malawi. In the search for post-2015 development agenda, perhaps this request can be considered by the new development framework.

8.2 Capacity building and culture: two incompatible languages?

By the end of the investigation about 'capacity', this research has opened up a plethora of issues seemingly unrelated to capacity. To name a few: aid dependence, big man syndrome, tall poppy syndrome – are these related to capacity building? As much as this research brings in 'contexts' and 'cultural aspects' from an emic perspective, has it contributed to the 'serious' work of capacity building? How can we, both internal and external stakeholders, use this knowledge to build institutional capacity? These questions will be explored in this section and an argument about the close relationship between culture and capacity should be established by the end of this section.

Interestingly, many of these capacity themes become 'cultural' only when they are read through a HRH capacity building lens[145]. In what follows, I will demonstrate how these capacity themes can be sidelined as cultural issues, according to the HRH capacity building model. At the same time, I will also

[145] As explained in Chapter 5, what 'capacity' is has yet to reach full consensus. The 'HRH capacity building lens' mentioned in this section will be based on the UNDP model (see section 5.1.1).

present similar themes through a postcolonial lens[146]. The purpose of making these comparisons is to demonstrate why the contemporary HRH capacity paradigm may reject context; and how it may dismiss the true problems as 'cultural'.

Throughout the thesis, a lack of ownership is a constant theme; from ownership of purpose to ownership of capacity building. It frequently gives a nihilistic impression; and very commonly brings a sense of 'hopelessness' to any mission to build indigenous capacity.

> They would just go through the motion. There's no development. No vision. No direction. No purpose. No drive. All these things that you expect of leadership.
>
> An expatriate, having worked in Malawi and also other parts of Africa

Using the HRH capacity lens, many 'capacity gaps' are spotted: lack of vision, lack of sense of purpose, lack of motivation, lack of leadership. Therefore, the logical next step is to fill these gaps; hence it is about building up vision, purpose, motivation and leadership. For instance, ownership is 'given' by engaging domestic players in policy making (e.g., see strategic plans endorsed by domestic governments); African-styled leadership is built by adjusting cross-cultural difference in management style (Jackson, 2004); and management skills are mastered through training workshops. Certainly, these strategies must have their respective benefits and shortfalls. What this research does is to pinpoint how

[146] To very briefly explain postcolonialism, it is a postmodern study on the legacies left by colonialism (and later, imperialism). It is used to centralise the peripheral, 'subaltern' [see Spivak's 'Can the subaltern speak?'] voice. It was first applied to studying 'post-colonial' societies in literally term, because of the colonial masters/colonies or First World/Third World power differential. However, geographic focus becomes less important later and it has been used to study marginalised groups, including those residing in developed countries (Gandhi, 1998). This term will be self explained in the following comparisons between a Western (i.e., one adopted by HRH capacity model) lens and a postcolonial lens.

these strategies may be missing the point of ownership, should deficiencies become the only target for building capacity. Using a postcolonial lens, voices like the following come through:

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

> The future belongs to someone else, other than us. It's like the future belongs to God. And it's too far away. I am more concerned with what is happening now. May be someone else will come in to be part of my future, not necessarily that I will be responsible for my future. May be God. Or my uncle, my parents… you know this dependency that we have. You know in Malawi we're generally very dependent. Some people are very dependent on God. Unfortunately there are very few who only rely on God alone. But there are also people who rely on charms, issues of witchcraft and the like. So the dependency on something else. So when it comes to the issues of the future, may be someone will help me. Even if I do something, I don't change anything. That kind of fatalistic believing, resigning, sort of… why bother. There is so much poverty. There is really nothing I can do. If there is any help, I have to get it from somewhere else. So the long term planning misses out because of the mindset.
>
> A social researcher

Certainly, the capacity lens is able to detect what is 'wrong' or what is lacking quickly. However, the postcolonial lens can provide a deeper insight into the indigenous world view. The 'borrowing' practice, as mentioned in the first quote above, was observed to be a norm in Malawi, not just in workplace, but also in daily lives. English lifestyle (e.g., table manners, choice of food at different times of the day, how to drink tea) was frequently taken as the 'right' way of doing things, particularly amongst the emerging middle class in the country. To what

extent colonial legacies still affect indigenous thinking is beyond the investigation of this research. However, even this limited evidence carries strong messages about the continuing influence from the colonial past. Therefore, it may well be premature to assume Malawian society to have fully gained sovereignty in respect of culture and governance, even 48 years after independence. This can be a point missed by the capacity lens, where the working principles are based on 'rational' (i.e., un-dominated) mind. It may well be wishful thinking to think that Malawian society acts as rational, or 'scientific', as a Western society. Traditional belief, such as witchcraft, is still deep-rooted in modern day Malawi, even amongst the most educated:

> In Malawi it is almost a normal thing. People believe in witchcraft, a lot. It doesn't matter [whether you are educated or not]. Sometimes educated people are the ones who believe in it more to protect their positions, possessions. [...] There are a good number of people, even the politicians, are known to be witches [or wizards]. Once, a politician was arrested for conversing at the graveyard. And this is a well educated person, you know, once a Minister of Education. Well educated. Such a senior, high-profile person!
>
> A social researcher

Issues like witchcraft are a complete misfit to the HRH capacity framework. This is not to suggest that a HRH capacity project should carry out detailed investigation of the phenomenon of witchcraft, but simply to shed light on how the capacity project can easily overlook context. So, why does context matter [cf. how context matters in education in small states in (Crossley, 2010)]? Why does understanding the impact of witchcraft matter? How does it relate to capacity building? The following quote may give readers a sense of how big a role this traditional practice plays in people's lives:

> In Malawi, if someone has a high position, especially let say a position that you earn through your profession or personal achievement,

> people will tell you um you better be protected. If you're the boss there, people can bewitch you. Because people are aiming for that, they want that position. If you're the most famous person or somehow, you have to be... you know (i.e., beware of witchcraft). Unless your fame comes from your interaction with, let say I can be famous by having many children. Because people will not bewitch you. Because they (i.e., the children) are part of me.
>
> A social researcher

There is a fear about achieving personal success because of the possibility of being 'bewitched'. Returning to the capacity problems related to ownership, there may be a link between this cultural belief and the reluctance to assume responsibility or a leadership position. 'Tall poppy syndrome', a term used in this thesis to describe fear of outperforming the others, may also be an expression of this cultural belief. However, witchcraft is just one of many cultural beliefs. There are many others[147] which were not inquired into or examined by this research. What I wish to do here is to explore the link between culture and capacity, and to convey the potentially great impact brought by culture, using just one example. 'Tall poppy syndrome' can be a result of many other forces and factors, which will demand further research (see section 8.3). Having said so, it could also well be a Western interpretation, based on a Western capacity building model that requires high achievers and leaders. What is undesirable here is to see how tall poppy syndrome is often diagnosed as 'lack of motivation' (when no one assumes agency) or 'lack of leadership' (when no one dares to come forward to assume leadership) by the capacity diagnostics. This is not to say these diagnoses are wrong. What becomes problematic is how these diagnoses will induce swift, symptomatic 'treatment', which may overlook the need for a long-term cure.

[147] For instance, 'Prophet Billy Chisupe' became an overnight celebrity in Malawi in 1995 because of his claim of finding the cure to AIDS, brought to him through spirits. Many people, including ministers, queued up to get his concoction (Schoffeleers, 1999).

Indeed, it may be time to rethink whether 'capacity building' is itself a form of symptomatic relief. Is it created to reject context in the first place, anyway? Certainly context cannot be changed overnight, so does capacity building actually intend to build an island of excellence out of a structurally problematic ocean? If we cannot change the ocean, what is wrong with building islands of excellence? The evidence from this research suggests that neither is possible: building individual islands only or fixing the ocean only. Perhaps, what can be inferred from here is the need to do both, concurrently. Let's look at the next example: 'big man syndrome', which is a term used in this thesis to refer to concentration, or rotation, of power amongst very few individuals. Using a de-contextualised (i.e., capacity) lens, this situation is often interpreted as a critical shortage of human resource. Hence the solution should be quickly producing more who can assume the managerial positions. However, on inserting the contextual frame, the problem becomes much more complicated. It could be about the fear of offending the powerful contacts. In Malawi, association with powerful figures in the society is seen as one's 'wealth' (see quote below). Therefore, a harmonious relationship is desirable. The problem, then, is not because of shortages in human resource. In fact, there may be many young, well qualified Malawians, who are stopped at the gate of power because of the fear to challenge a powerful position, or the desire to safeguard harmony, or the fear to be bewitched, or many other reasons. A young Malawian working in an NGO once told me that "you can't do anything in the government", because of these reasons. The influx of many development agencies, then, provided these young Malawians opportunities to apply their skills without meddling in government politics. Now, returning to the argument about whether to build capacity in or out of context, in this case it becomes rather evident that both a quick fix (i.e., simply generating more qualified people) cannot solve the problem, but it is not a wrong fix. What needs to be mindful of here is the irrationality of the 'rational' HRH planning formula: planning → training → employment. It simply does *not* work in one straight line.

> It's who you're associating, you know. If you can associate with the chief, the politicians, that's ok, even if you don't have money. But if you can associate with such people, people will aspire to be associated with, you know, I mean simple things like being associated with the British. That is important. Of course, at the back of all these things there are issues of security, like economic security, because most Malawians don't put money in the bank. Because really they don't have money to put in the bank. So the wealth is not in the bank. They don't have money in the bank. They invest in friendships, in relationships, if they have livestock may be in land, food, and all that. Unlike in the West, where basically you can have a card. If you don't have money, you have problems. But here... [Regarding the issue of extended family] most of the security comes from those you're connected to by blood. I visited some place last week when I was up north. From nowhere my dad said "ah I think we have to arrange, you have to meet so and so". And I was saying "Dad, for ALL these years you've *never* bothered me with visiting that guy." And he was saying "ah no, this guy is a very close relative". I said "if you have never told me how closely related we are to this guy all these years, I don't think he really matters anymore to me". He said "oh no, that is a wrong thinking! You don't have to think that way!". Why he was saying that is because now he is growing older and he wants me to make sure that I take care of all those people. But these people, to me they don't exist. He has not taken care of them. He knows they are just relatives but because he is *proud* of me, so actually he wants to show off. That is the reality! ... I am his wealth, yes, his prize, which you can't put in the bank.
>
> A social researcher

Likewise, the problem of 'moonlighting' frequently receives the symptomatic fix by merely increasing one's salary. The argument is that employees do not have to hold more than one job to make ends meet, if one salary is enough. However,

a postcolonial reading of the data shows the problem extends beyond the money or renumerative issue. As noted in my field observation, there was very little sense of belonging to the employer institution (see section 6.6). People seemed to identify with their own families, clans or tribes, and regions more than their employer institution. As a result, personal (or family, tribal or regional) agendas very frequently override institutional agendas. Job position is merely one, and perhaps a small part, of one's many identities. One can hardly find a 'workaholic' in Malawi, for people do not identify themselves with their work as much as in the Western culture. Also, the norm of fending for children from extended families gives additional financial burden to breadwinners in Malawi, which then affect how they assume their agency in the workplace. If the social and cultural context is to be taken into consideration, the solution may not be about increasing salary or improving accountability (or leadership, management, etc) but it is perhaps about improving social welfare in the country (to relieve breadwinners from social responsibilities).

In fact, accusing Malawians of not following the scientific procedures outlined by the capacity framework may simply be unfair. The problem of not doing what is 'right' is not unique to Malawi, or Africa. If capacity building is said to be restricted by 'culture' in Malawi, it is restricted by medical hegemony, wealthy capitalists and other powerful players in the West. Take capacity building in needs-based health professional education (though 'capacity building' and 'needs-based' are not terms used in the Western context), for instance. For decades, research evidence (e.g., health statistics from WHO website) and political coercion (e.g., Alma-Ata Declaration) has been used to motivate shifting focus from speciality care to primary care and public health. 'Reforms' and 'transformations' [e.g., (Lueddeke, 2012)] are called for to make health care truly 'needs-based'. But change does not come easily. Doctors are said to cling on to their professional power, hence making the creation of, or task-shifting to, mid-level cadres difficult. With the most lucrative rewards concentrated at the top rungs of the professional ladder, it is difficult to control the commercialisation of health professional education. At the same time, global competition has forced

national institutions to create more market-friendly courses. State interference in academic institutions is contested, frequently dubbed as 'interfering academic freedom' (Vang, 1994). This is made even harder when policy decision has to depend on political popularity, as in say, winning wealthy voters who can sponsor election campaigns. In other words, there can be many issues, factors and barriers to building a truly 'needs-based' health professional education in the developed setting. However, these are not studied within the narrowly defined capacity framework. It would be absurd to label, say, medical hegemony as a 'culture', and so it is rejected as a capacity problem. Instead of labelling the social phenomena in Malawi as 'culture', perhaps they are simply *contextual* differences. Whilst the West is struggling with powerful doctors, drug companies and the super-rich, Malawi is struggling with powerful donors, local elites and witch doctors. If it is reductive to ask "what are the local health needs that need translating into a needs-based curriculum?" in Britain, it is equally reductive to do so in Malawi.

Although this research has not found all the answers to linking capacity and culture, it has certainly illustrated the importance of making such links. The problem with the existing capacity framework is its tendency to de-contextualise problems by attributing contextual difference to 'cultural' (hence not capacity) problems. What then follows could be a series of pseudo corrective actions that may not solve the actual problems. To transcend the culture-capacity duality, an interdisciplinary approach is needed, where social science and anthropology studies are crucial in bringing understanding and solutions to capacity problems (see next section). Otherwise, 'capacity building', however well intentioned it may be, can risk turning into an imperialist vision, casting its gaze on the African others.

8.3 Making links and finding solutions: the need for a interdisciplinary approach

In the last two sections, I have attempted to deconstruct what is believed to be unproblematic in the HRH discourse: first, the delivery orientation in the HRH language that has sidelined the growth of indigenous professionalism; and second, the deficiency-based capacity building model that has de-contextualised capacity problems. I have also explained that why these HRH agendas are not 'wrong', but simply too narrow for real 'development'. Development is quoted in inverted commas because it is itself a problematic notion. What development actually is and how development should be pursued is still a question requiring different answers at different times and in different contexts. Whilst there are still many unknowns or uncertainties in development studies, HRH's approach appears to be rather positivist and in many cases, prescriptive. In fact, it is not even clear whether dividing the world into 'developed' and 'developing' actually helps the latter to develop (de Rivero, 2010). Considering this, perhaps it is less certain about how 'basic' functions must be prioritised over 'higher' functions; that delivery must be prioritised over the growth of professionalism. Perhaps some insights can be gained from other sectors, such as the debate regarding prioritising basic education over higher education (see section 5.1.2). Although the link between higher education and development has yet to be fully conceptualised[148], twenty two years of EFA (Education for All) experience has conveyed a need for a broadened account between education and development. It is now commonly acknowledged that simply getting more people to school does not promise poverty reduction or economic development (Cremin and Nakabugo, 2012). Worse still, this supposedly pro-poor policy may not eventually turn out to benefit the poor (Lewin and Sabates, 2012). Similarly, vocational education research also cautioned a simplistic equation between skills and work,

[148] The World Bank conceptualises a vague link between higher education and economic development, established by higher tax revenues collected from higher individual earnings when individuals become more educated; also by higher skills from these better educated individuals to utilise new technologies to generate economic outcome, see (Bloom, Canning and Chan, 2006).

and even more problematically, between work and development (McGrath, 2012; Allais, 2012). What seems to be logical, straightforward, or axiomatic may not always turn out to be so (King, 2009a).

Although these critiques cannot be transplanted directly into health sciences, certainly they cannot be isolated to only one disciplinary area. New (or relatively new) agendas in education, such as social justice and capabilities (Tikly and Barrett, 2011; Unterhalter, 2005; Barrett, 2011), may be valuable to the research area in African professional (or HRH) education. In fact, there has been some work around pro-poor professionalism (Walker *et al.*, 2009). Even if the new agendas cannot be transferrable, perhaps the methodologies can be borrowed, or considered. Most HRH studies have used a medical science methodology (i.e., diagnosis → treatment → evaluation) to study social science questions. To move beyond this biomedical approach, studies will have to consider stepping out of their own disciplinary area. Evidence from this study has suggested bringing in the social science approach, with particular focus on the postcolonial perspective (see section 8.2). In fact, there is some ongoing work surrounding postcolonial African professionalism [e.g.,(Sawadogo, 2011)], though not always receiving attention in mainstream literature[149]. Also, this research highlights the importance of understanding local culture; but cautions against surrendering cultural issues to only anthropological concerns. It has attempted to argue for treating African problems as *contextually* different, and not as 'African otherness'. This is in congruence with calls from 'comparative and international education' (CIE) research, which suggest comparison grounded in contextual difference, and the avoidance of 'uncritical international transfer' (Crossley and Watson, 2009). In fact, the concern about policy borrowing is also shared by the Pharmacy Education Taskforce (PET), alongside its working principles of 'one-size-does-not-fit-all' and 'collaboration, not colonisation'. Perhaps much insight can be taken from the history of how CIE has evolved, where in its earliest day's education policies in developing countries were cherry picked from models used

[149] Sawadogo's book (quoted above), for example, is not indexed by the British Library.

in more developed countries. In one of the conversations I had in my work with PET, I was asked "otherwise, how else can we do it?". Clearly, the answer is not simple but there may be some insightful caution from Sir Michael Sadler (1900), regarding using a positivist orientation in doing CIE:

> We cannot wander at pleasure among the educational systems of the world, like a child strolling through a garden, and pick off a flower from one bush and some leaves from another, and then expect that if we stick what we have gathered into the soil at home, we shall have a living plant…
>
> Cited in (Crossley, 1999)

This research has suggested some ways, but not all the ways, to nurture a Malawian (or African) plant. However, more importantly it makes it clear that the plant must be home grown; and grown by gardeners who *want* to grow it. What then is required is an interdisciplinary approach, in order to allow the process of returning ownership to the domestic players. In addition, it can be worthwhile to make links with ongoing work in related areas, as not everything needs to be built from scratch. For instance, evidence from this research has shown that most of the capacity problems are not discipline-specific after all. Therefore, research and/or development projects in this area can be linked to existing work about capacity building in African universities, for instance the 'Nairobi Report' commissioned by the British Academy (The British Academy and The Association of Commonwealth Universities, 2009).

To conclude, interdisciplinary links discussed in this section are merely suggestions based on evidence from this research. Most probably there are many more ways to make the links, which are beyond the reach of this research. Even within these suggested links, it is simply beyond the limits of one PhD thesis to say anything more in-depth. Therefore, the questions about what other disciplinary areas to be engaged and how exactly these engagement should be made are subjected to further thinking and research. The main message here is

about the importance of transcending one's disciplinary area, or research paradigm, in order to find solutions and also to ask the right questions.

8.4 Conclusion

8.4.1 Summary of the thesis

This thesis is an academic diary of a journey; a journey that links not only the straight line and the circles, but also two or more disciplinary areas, research paradigms, cultures, and selves. To cross so many streams at one time, this research has to be experimental in its methodologies, analyses and even agendas. It is a 'high risk' PhD, with the price of making many wrong turns but the gains of bringing in new perspectives to old issues. These 'wrong turns' are not hidden in the final write-up of the thesis, and how they happened is given an honest account. The purpose of doing so is twofold: first, to create a learning curve that is repeatable by other health science (particularly HRH) researchers or managers; second, to also explain to non-HRH partners about the HRH discourse, its agendas and paradigm. In other words, I want to let people at the opposite banks of the stream see each other [cf. work in "bridging cultures and traditions" in (Crossley, 2008)].

Amongst the wrong turns, 'stakeholder consultation' had proven immediately to be an inept approach in the field, because of its unrealistic assumption about stakeholder representation in a scarcely democratic context. However, it still commanded some space in the thesis because this is a methodology widely used in the HRH tradition. It must be emphasised again here that it is merely artificial to extract stakeholder consensus to secure country ownership. This is because the spokespersons of a stakeholder group do not necessarily represent an interest group in most cases, and in fact many of the spokespersons have already been heavily interviewed by donor projects, and are consequently well trained in providing diplomatic answers. The second, slightly less serious, wrong turn was the adoption of the 'needs-based' notion. It was proven to be futile to chase after the answers to fill in the blanks of a formula (identify health needs →

translated into training needs → fulfilling health needs), which is itself deficient. This formula is completely context-free, hence leaving behind many contextual difficulties unresolved. However, the working principle of needs-based education is not wrong, but it needs to be contextualised. This is where an interdisciplinary approach needs to come in. By tackling the development issues of country ownership, needs-based notion can be repaired when its construction is participated by the countries.

Perhaps what was even more challenging was to identify things that were unsaid or not directly mentioned by the data. I have to wade through political correctness to claim that professionalism, or more accurately true professionalism, has yet to exist in public sector pharmacy in Malawi. This is not to say pharmacists in Malawi are less competent or less altruistic than their colleagues from other parts of the world. Rather, it is to point out the blind faith placed in the profession, regardless of whether true professionalism exists. Termed as 'pseudo professionalism' in this thesis, there was an uncritical assumption that pharmacists must be more superior to pharmacy technicians in their ethics, power and knowledge. Because of pseudo professionalism, innovations such as 'task-shifting' become conceptually and politically impossible. Asking why true professionalisation has not taken place in Malawi, this research brought forward three main reasons: an extremely small number of pharmacists in the public sector, private-sector pharmacists not sharing similar professional interests and, more crucially, the intensive interference of HRH agendas in country agendas. Because of the great emphasis placed in scaling up health services, through programmes like essential health packages, most resources and thinking were being steered away from 'non priority' areas, such as the growth of indigenous professionalism. This research does not doubt the importance of prioritising health service delivery, but it cautions against the silencing power of this powerful agenda. By citing lessons learned from the 'basic education or higher education' dilemma experienced in the education-for-all policy, this research suggests perhaps it is not worthwhile to neglect the growth of the

higher function, especially when it is even unsure the basic one will actually fulfil its development mandate.

This research seeks to not only discuss theories but also *communicate*, by bringing forward voices that are frequently silenced. It is hoped to bring to the forefront the frustration and aspiration of the Malawian people. With widespread poverty and extremely scarce public resources, people could hardly afford any long term planning. Whenever a rare opportunity arises, such as the coming in of a foreign aid, it often results in fierce competition. This can breed jealousy and hatred, which then may harm the working relationship between colleagues. To avoid jealousy-induced harm, such as being bewitched, people may shun personal achievement. Termed as 'tall poppy syndrome' in this thesis, this fear of achievement may slow down not only personal growth but also institutional, and even national, development. Foreign aid that comes into the country without understanding this culture may risk diminishing even further existing capacity. This culture cannot be sidelined as a cultural issue per se, but a contextual one that should shape foreign aid policies in the country. Donors should be sensitive to this kind of domestic conflict, which may not necessarily be brought to the attention of the donors. Any personal award must be dispensed with extreme caution and transparency in order to avoid harming domestic working relationships.

It must also be mindful that 'personal' agenda may not necessarily serve only one individual. In most cases, it is related to agendas of one's family, tribe or region. Because of the lack of publicly funded social security, people have to create and rely on their social network. Living together with members from an extended family is a norm in Malawi and actually most parts of Africa. Compared to the Western culture, Africans are much more communal. Unfortunately, this sense of community has yet to be extended into the workplace, perhaps due to competition for limited resources. An institution or organisation, therefore, frequently exists in names only, but not in spirit, because of individuals scrambling for personal gains. 'Regionalism', a term commonly used in Malawi to

indicate favouritism towards one's region, is one expression of the lack of sense of belonging to the working institution. Looking through a context-free capacity building lens, this phenomenon can be easily read as a lack of teamwork or motivation. Indeed, there can be many labels of deficiencies regarding the work culture in public service: lack of accountability, lack of vision, lack of leadership, lack of management or governance, etc. Without digging deeper to understand the root causes of all these lacks, one can be easily overwhelmed by these 'hopeless' situations. What then follows can be a series of corrective actions that may be merely symptomatic. To save donors from having a nihilistic outlook on African 'lacks', this research recommends donors to consider problems from the perspective of the receiving end. Frequently, culture cannot be accommodated into a single-discipline research framework. To transcend the duality between culture and capacity, additional disciplinary lenses, *inter alia*, social science and possibly anthropology must be used.

Ethnographic evidence from this research also suggests that aid dependency is something more complicated than simply an intellectual understanding of it. It is far too easy to induce the desire to give on one hand; and far too habitual to accept it on the other. This makes ending aid dependency an extremely difficult task. One important factor that continues to promote the mindset of aid dependency is the reinforcement of the impression that donors are always more superior than the indigenous people. This is conveyed not just by the colonial past and the media, but also by everyday interaction between donors and the locals. Working in comparatively extravagant offices and only permitting limited access to their premises, donors are displaying their superiority even without uttering a word. Of course this research cannot suggest stripping all these privileges enjoyed by donor agencies, but it will certainly recommend building a more local friendly image. In any case, the perceived hierarchical gap between donors and recipients cannot be removed overnight. This perception is further enforced by Malawian's 'dominated minds'; dominated by the colonial past, global governance and even cultural beliefs. It cannot be assumed that Malawians have the same level of freedom as people in the West. In some cases,

domination can even happen 'by consensus' (Roberts, 2010), where it simply feels comfortably appropriate to be imposed upon by some sort of 'feel good' policies, like the MDGs. Therefore, it is pointless to pretend an equal relationship between donors and recipients. Instead of squeezing 'partnership' out of the current power differential, it may be more realistic to return to the notion of altruism in aid. Aid does not need to be big, but only to be sincere.

In conclusion, this research proposes three changes: first, a change in the way donors and recipients *relate* to each other. The donors need to be context sensitive and stay alert to the easy trap of aid dependency. This level of understanding and can only achieved through personal interactions, and not remote-controlled projects. At the same time, the indigenous players must also be aware of how traditional beliefs and social pressure may greatly influence their identities, even in the workplace. To cultivate teamwork and create agency for an institution, perhaps sensitive issues such as regionalism need to be openly addressed. Second, a change is needed in the uncritical embracing of 'commonsense' truths, such as the statement that improved health service delivery certainly leads to improved health. Of course this is not easy because these truths speak the language of justice, righteousness and efficient solutions. To deconstruct these seemingly unproblematic messages, an interdisciplinary approach will be needed. It is, therefore, hoped that social science research in Malawi can be given equal, if not more, attention than the health related research. Third, a change is required in the tendency to 'othering' with respect to African problems. African problems need researching and thinking in a way that is no different from problems faced by other parts of the world. African professionalism, for example, needs to be studied in its own context, and not as African culture + mainstream professionalism.

Last but not least, if all these changes cannot happen, well, at least this research has changed me. Because of the reflective space allowed for a PhD, I have had the chance to learn beyond merely intellectual understanding. The personal growth unreported in thesis writing is perhaps the best long-term gain I can have

from this academic training. My education comes from multiple, including non academic, sources. But more importantly, what triggers the process of education is the heart-changing field experience in the 'warm heart of Africa' (i.e., Malawi). Education, from this experience, cannot simply be a left brain-only process. Instead, it is a product of intellectual understanding, personal growth and friendship.

8.4.2 Research limitations

As reflexivity is inherent to the methodologies in ethnography, research limitations are reflected throughout the thesis. Also, in section 2.4.3, the issues of validity and reliability are discussed. To summarise and pull together the collective limitations of the study, this section will talk about the 'blind spots' and 'blank spots' of the research (Wagner, 1993).

Certain questions or problems reside in the 'blind spots' of this research, because they cannot be addressed by the methodologies, theories and identities of the research. By using a qualitative approach, the explanatory power of this research is limited to a cross-sectional contextualisation of pharmacy education at the time the research was conducted. It is unable to establish trends and draw strategic plans for capacity building. Instead, it serves as a conceptual toolkit for quantitative work in this area in the future. This conceptual toolkit was built by using perspectives from different disciplines. The purpose of doing so was to minimise blind spots, which cannot be addressed if research problems are only viewed from a single perspective. However, as an outsider to the Malawian culture and society, I might still have left many blind spots unanswered.

The blank spots of the research are answers that cannot be provided by the research, though the right questions have been asked. One of the major blank spots of this research is created by the nature of a PhD research, i.e., the lack of power and resources to demand data. This is because certain data could only be accessed by higher level research. For instance, sensitive data like budgets and missing drug stocks. Another blank spot was caused by time and resource

constraints. The fieldtrip lasted only three months; hence there certainly were sites and people I failed to meet. The research cannot claim representativeness in opinions by all stakeholders (e.g., all pharmacists), because only a purposive sample of the stakeholders were interviewed. In some cases, only the representatives of the stakeholder groups (e.g., the Director of Higher Education) were interviewed. As a result, this research covers the opinions voiced by power-holding stakeholders (or individuals) but not necessarily opinions at the rank-and-file level.

Lastly, the intention of this research to bridge different epistemologies (as mentioned in the last section) produces both strengths and limitations. Whilst it could possibly act as glue to a diverse range of issues, otherwise not related to each other, it cannot carry out in-depth debates about certain issues. For instance, the discussion about professionalism was limited to certain aspects of professionalisation but not the entire literature about the sociology of profession. In fact, this research inherits the ontological problem of ethnography regarding the tension between enacting a realist representation and finding practical solutions. Therefore, the limitation to trying to do both at the same time is the lack of depth in either of these objectives.

8.4.3 Research implications

As mentioned in the last section, this research was caught between two objectives: explaining (by describing the reality) and finding solutions. Explaining is a distinct feature of ethnographic work; hence it is explicit throughout the thesis. On the contrary, giving solutions is done more implicitly, almost requiring the readers to decide what can be inferred from the explaining. This is because solutions can be easily reduced to actions if their meanings or purposes (as derived from explaining) are not preserved. In this final section of the thesis, these subtle links between explaining and problem solving will be strengthened. Experiences, lessons and reflections learned from this research will be translated into implications and recommendations for practice and policy. To ease accessibility of these implications for stakeholders from different levels,

implications are written in bullet points and targeting specific communities or institutions.

Implications for practice and policy in foreign aid:

- Development partners need to be mindful of how scarce resources can result in fierce competition or jealousy, as denoted by 'tall poppy syndrome' in this research. To avoid dispute about preferential treatments given to only certain individuals, it is suggested that aid awarded on individual basis must be followed by clear explanations.
- It has to be acknowledged that true partnership cannot yet develop under current circumstances. The reality of aid dependency needs to be addressed and overcome. Therefore, it is suggested development agencies to draw up practice and policies to encourage genuine local ownership.
- There is one form of foreign aid that was identified as helpful to building capacity of the education institution: informal mentorship. Local institutions and development agencies could work hand-in-hand to encourage recruitment of this specific group of academic aid workers. As argued by this research, their number does not need to be big; hence special arrangements to simplify the process of recruitment might be necessary. Also, this research warned against the potential pitfalls of making mentorship a formal process (i.e., creating impressions of preferential treatment, as discussed above). Therefore, institutions wanting to build domestic capacity through mentorship have to apply careful thoughts into the mechanism in which mentorship is carried out.

Implications for policy makers in public sector pharmacy in Malawi:

- This research reported several longstanding, structural problems which had not been highlighted in country health sector plan or donors' reports. These include drug pilferage, cash flow problems at CMS and manufacturers' plight in not getting government contracts. It is evident that poor access to essential medicines cannot be resolved without

addressing these structural problems. It is suggested that quotes from different stakeholders in this research, which express their opinions and intentions, to be used to initiate dialogue between stakeholders.

- This research cautioned against the application of a direct relationship between training and employment, as brought in by the HRH discourse. This discourse has directed pharmacy education, and possibly all other health professional education in resource-poor settings, toward a single agenda i.e. health service delivery in the public sector. This makes investment in pharmacy education a short-sighted endeavour. Also, not all pharmacy graduates would be retained in the public sector. It was highly possible that most would leave the public sector as there was still a high rate of vacancy in the private sector. Therefore, there is a need to reconsider whether it is sufficient to produce only 20 pharmacy graduates per year.
- Whilst the problem of HRH shortage cannot be resolved immediately, this research pointed out that intentional attrition from existing HRH could result in serious problems. Governance and accountability are two major issues facing public administration in Malawi. In the pharmacy sector, the perception of 'democracy' (i.e., freedom from personal responsibility) has to be re-examined. To eliminate the fear of getting revenge (e.g., getting bewitched), it is suggested that policies for policing behaviour to be designed in accordance to this cultural context.
- Another important cause to the lack of accountability was the general public's lack of power to demand accountability. Certainly, there is no simple answer to the question of empowerment, particularly in a population with a poor, rural majority. However, this research cited an example where empowerment could be done indirectly (i.e., the case of giving pregnant women a space larger than that of the doctors, hence reducing the power differential between patients and doctors, see section 7.3.4). There might be other ways to empower the patients, and it first requires motivation from the powerful ones to do so. The motivation can come from agendas such as equity, human rights and social justice.

Implications for practice and policy in public sector universities in Malawi:

- The concurrent identity of the President of the country as also the Chancellor of the UNIMA had seen several cases of political interference in the long-term planning of the university. Therefore, leadership in the country might need to consider ways to segregate politics and academic affairs.
- This research identified several untapped pools of potential teaching staff, who might not possess a Masters or a PhD and/or the interest in doing research. These individuals comprised mainly of pharmacists who had many years of work experience in different sectors in pharmacy. To tap into these resources, the university might consider alternative recruitment criteria (e.g., field experience) rather than adhere strictly to conventional criteria. Alternatively, the university might absorb young pharmacy graduates into the faculty by sponsoring them for postgraduate education.
- In a similar way to the health sector, the higher education sector in Malawi was also facing problems of accountability. Again, this was partly caused by the lack of human resource to carry out the supervisory function (hence leaving individual departments to self audit). However, this research also highlighted the negative impact of surrendering most decision-making power to just a few individuals. There was a tendency to polarise the issues of accountability and academic freedom (that one cannot co-exist with another). This could easily create a leadership crisis if the responsible person abandons his or her duties. Therefore, there is a need to re-establish effective communication between the university and the college, as well as between the college and individual departments.

Implications for Pharmacy Education Taskforce (PET):

- This research reported a problem in country ownership due to the tendency to imitate what happens in Britain. The concept of needs-based education, therefore, is a timely advocacy tool for pushing the ownership agenda forward. However, as shown by this research this concept still

lacks methodologies. This research suggests using contextual analytical tools such as postcoloniality and aid dependency to study needs-based education in resource-poor settings like Malawi. However, new methodologies may be required according to changes in both global and local contexts. The questions and answers for needs-based education, therefore, have to be constantly redefined.

- Malawi may be a silent partner in PET, due to its lack of local leadership to engage with the international community. Therefore, PET may need to find alternative ways to effectively engage with Malawi. However, it may also indicate that Malawi is not yet a partner to PET because it is not an equal to other participating countries. Perhaps, Malawi may be more in need of one directional aid and less of global partnership.
- Findings from this research showed that capacity issues can be heavily contextualised. For instance, the creation of local leadership cannot be detached from the local context of 'tall poppy syndrome'. To enhance sensitivity to local context, PET's research work may take onboard researchers from other disciplinary backgrounds, in particular comparative education, sociology and development studies.

Implications for future research and post-2015 development framework:

This research presented evidence for 'pseudo-professionalism' and suggests that true professionalism has yet to be developed in Malawi. What professionals are meant to do in Malawi may be strongly hinted by the deep poverty and thin democracy as experienced by the majority of the population in their daily lives. Whilst the equity and social justice agendas are speaking loud for the post-2015 (i.e., post-MDG) development framework, African professionalism may play a vital role in aiding these agendas. In the health sector, these agendas would mean pushing boundaries beyond simply service delivery.

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APPENDICES

Appendix I. Categories and number of stakeholders interviewed.

Stakeholder category or stakeholder position	*Number of informants*	*Number of interviews*
Lecturers at the CoM	9	9
Volunteer/part-time lecturers at the CoM	6	6
HODs at the CoM	6	6
Dean of Undergraduate Programme	1	1
Dean of Postgraduate Programe	1	1
Dean of Student	1	1
Deputy Director, Research Support Centre	1	1
Registrar, the CoM	1	1
Assistant Registrar, the CoM	1	1
Finance Office, the CoM	1	1
UNIMA Finance Officer	1	1
Deputy University Registrar	1	1
Chair, Steering Committee, Higher Education Quality Management Initiative for Southern Africa	1	1
Pharmacy students, the CoM	15	4*
Representatives from the Student Union	3	1*
Former employee of the CoM	1	1
Intern pharmacists	8	8
Community pharmacists	7	7
Hospital pharmacists (Chief Pharmacists)	2	2
Manufacturing pharmacists/ managers	4	4
Wholesale pharmacists	2	2
Head of Pharmaceutical Service, MoH	1	1
Health SWAp Planning Officer, MoH	1	1
Secretariat, CHAM	1	1
Acting Chief Executive, the PMPB	1	1
Drug inspectors	4	4
Controller, CMS	1	1
Supply Chain Management Pharmacist, CMS	1	1
Principal HR Planning Officer	1	1
Assistant Director, Human Resource Management Division (Development Section)	1	1
PHASOM council members	3	3
Medical doctors (including three HODs)	6	6
Assistant Registrar, Medical Council of Malawi	1	1
Nurses	3	3
HOD, Medical & Surgical Nursing Department, Kamuzu College of Nursing	1	1
Registrar, Nurses and Midwives Council of Malawi	1	1

Health workers at missionary hospitals	4	4
President, MATHUO	1	1
Chairperson, ANAMED[150] Malawi	1	1
Pharmacy technicians	2	2
Pharmacy technician lecturers, MCHS	2	2
Pharmacy technician students (2nd year)	11	1*
Researchers (in social science or traditional medicines)	3	3
Director of Higher Education, MoE	1	1
National AIDS Comission	1	1
Supply Inc	1	1
Clinical Inc	1	1
USAID project advisors	2	1
MLW programme	1	1
VSO headquarter	1	1
WHO headquarter	1	1
African Development Bank	1	1
Global Fund	1	1
Royal Norwegian Embassy	1	1
USAID headquarter	1	1
DfID headquarter	1	1
NGOs	2	2
Missionary universities	1	1
The media	3	3
Total	**145**	**120**

*Focus group interviews. Note: a small number of informants represent more than one stakeholder category.

[150] Abbreviation for "Action for Natural Medicine". ANAMED is an international Christian movement, started in former Zaire (now the Democratic Republic of Congo), to promote the use of locally available resources for treating illnesses. Today, ANAMED has 35 groups in 15 countries.

Appendix II. Research participant information sheet and consent form

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http://www.medcol.mw/

Project Title: WHO UNESCO FIP Pharmacy Education Taskforce

Institutional Capacity Development for Needs-Based Pharmacy Education in Sub-Saharan Africa

15/04/2010 (Version 2.0)

Information about the Research

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. This information sheet tells you the purpose of this study and what will happen to you if you take part. Please ask us if there is anything that is not clear or if you would like more information and take time to decide whether or not you wish to take part.

What is the purpose of the study?

Pharmacy graduates should ideally be trained to serve the local community. Mismatch between educational objectives and local community needs might cause ineffective use of the pharmacist workforce. In some countries, pharmacists' roles and the purpose of pharmacy education are still unclear. Opinions from stakeholders involved in pharmacy education therefore provide useful insights into what the educational needs are. This research aims to explore stakeholders' opinions and perceptions toward pharmacy education and how pharmacy educational institutions might meet the educational needs.

Why have I been asked to participate in the study?
You are identified as one of the stakeholders for pharmacy education in Malawi. We are interested to listen to your opinions about pharmacy education.

Do I have to take part?
It is up to you to decide. You do not have to take part in this study. We will describe the study and go through this information sheet, which we will then give it to you. If you agree to take part, we will ask you to sign a consent form to show you have agreed to take part (you will be given a copy to keep). You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
If you agree to take part in this study, you will be contacted by the researcher at a later date to arrange an interview or a focus group discussion. Focus group is a discussion group of 4 –12 people and discussion is facilitated by the researcher. If you decide that you would like to speak about pharmacy education, you will have the opportunity to choose the venue and time that you want the interview to take place. We will ask you to comment on current situation of undergraduate pharmacy education and what changes/improvement do you wish to see. Your opinion will be sought regarding the purpose of pharmacy education particularly about the roles and responsibilities of pharmacists in this country. You will also be invited to talk about what your institution might gain from pharmacy education (e.g. competent pharmacist workforce, more effective supply of medicines). However you are free to talk about any other issues that you think are important for pharmacy education. You will not have to answer any questions about issues you do not want to discuss.
If you are unable to make your interview appointment for whatever reason, do not worry. Please let us know and we will arrange a more suitable time. Interviews will last approximately 1 to 1.5 hours. If you decide that you do not want a face-to-face interview, you may choose to have a telephone interview instead. If you choose this option you will be contacted by us to arrange a convenient time for the interview to take place. If you decide not to have face-to-face interview/focus group discussion or phone interview, you may also choose to give your opinions through emails/written documents.
With your permission we would like to audio record the interview and also with your permission we may use direct quotes from the interview material in any publication of the results. You will not be identified unless you hold a unique position. All identifiable information will be removed apart from your position.

Can I change my mind once I have signed the consent form?
If you have agreed to take part in the study, and for whatever reason you are unable to or change your mind and want to withdraw, that is absolutely fine. If you initially decided not to take part, and would now like to be involved that is OK too. All you need to do is contact us and let us know.

Will I be paid for taking part in the study?
No, you will not receive any money for taking part in this study.

What are the possible benefits of taking part?
It is unlikely that the study will benefit you directly, but the information we collect may help improve pharmacy education in Malawi/sub-Saharan Africa in the future.

What are the risks of taking part in this study?
This study involves you talking to us about your needs, interests and support for pharmacy education. We believe that the risks of taking part in this project are minimal.

What happens if something goes wrong?
If you have any concerns or complaints concerning any aspects of this study please speak to the researcher who will do her best to answer your question (contact Zoe Lim on +265 (0)1871911 or +44(0)1158232275 (UK) or email paxzl1@nottingham.ac.uk)
If you would prefer to share your complaint with someone else or remain unhappy about a decision you may contact the supervisors of this project: Mr Richman James Mwale on +265 (0)1989722/1830520 or email livingstone@globemw.net OR Prof Claire Anderson on +44(0)1159515389 or email claire.anderson@nottingham.ac.uk OR Prof Simon McGrath on +44(0)1159514508 or email simon.mcgrath@nottingham.ac.uk.
If you remain unhappy you may complain formally to the College of Medicine Research and Ethics Committee (COMREC).

Will the information provided be kept confidential?
All information which is collected about you during the course of this research will remain confidential. All identifying information about you (apart from your position, if you are an official holding a special position) will be removed from reports and publications resulting from this study. Readers may recognise you as a result of your position but names will not be quoted in the study.

Will the information be handled and stored safely?
The overall responsibility for handling any information you provide during the course of this study lies with Zoe Lim. The information you provide us with will be held on secure password protected computers and/ or in a locked and secure drawer/filing cabinet.

Who will have access to the data collected during the study?
Only the researcher team involved will have access to the collected data. The data collected will be stored at the University of Nottingham for 7 years following completion of the study.

What will happen to the results of the study?
Research findings will be analysed and disseminated as PhD thesis and report for WHO UNESCO FIP Pharmacy Education Taskforce. We will send you a short communication of the findings of the study. We will also present results at conferences and write journal articles so that other people can learn from our study.

Who is organising and funding this research?
This research is being organised by the University of Nottingham for completion of an educational qualification (PhD) for Zoe Lim. This study is conducted under the supervision of Prof Claire Anderson, Prof Simon McGrath and Mr Richman James Mwale. It is supported jointly by the WHO-UNESCO-FIP Pharmacy Education Taskforce and the Department of Pharmacy, College of Medicine, University of Malawi.

Who has reviewed this study?
This study has been reviewed and given favourable opinion by governmental body in Malawi, namely the College of Medicine Research and Ethics Committee (COMREC).

Who should I contact for further information?
If you need further information about this study please feel free to contact us on the details provided below:

Name of researcher:	Zoe Lim (Tel +265 (0)1 871 911 or +44 (0)115 823 2275 email paxzl1@nottingham.ac.uk)
Names of supervisors:	Mr Richman James Mwale (Tel: +265 (0)1 989 722/1 830 520 or email livingstone@globemw.net) Prof Claire Anderson (Tel: +44 (0)11 595 15389 or email claire.anderson@nottingham.ac.uk) Prof Simon McGrath (Tel +44 (0)11 595 14508 or email simon.mcgrath@nottingham.ac.uk)
Name of project advisor:	Dr Louisa Alfazema (Tel: +265 (0)1 871 911 Ext. 242 or email lalfazema@medcol.mw Prof Ian Bates (Tel: +44 (0)20 775 35866 or email ian.bates@pharmacy.ac.uk

Thank you for reading this consent explanation sheet.

Please don't hesitate to ask me any question if you need to.

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Department of Pharmacy
College of Medicine
University of Malawi
P.O. Box 360, Blantyre 3
Malawi
Tel +265 (0)1871911
Fax +265 (0)1862644 or 01875313
http://www.medcol.mw/

Protocol number:
Participant identification number for this study:

STUDY PARTICIPANT CONSENT FORM

Project Title: WHO UNESCO FIP Pharmacy Education Taskforce Institutional Capacity Development for Needs-Based Pharmacy Education in Sub-Saharan Africa

15/04/2010 (Version 2.0)

Name of the researcher: Zoe Lim

Please initial box

1 I confirm that I have read and understand the information sheet dated 15/04/2010 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my welfare or legal rights being affected. ☐

3 I understand that relevant data collected during the study may be looked at by individuals from regulatory authorities (i.e. for University auditing ☐

purposes) where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

4 I give my consent for any notes taken during the interview/focus group discussion to be used in reports and publications. ☐

5 I agree to take part in the above study. ☐

……	…….	…….
Name of study participant	Date	Signature
……	…….	…….
Name of person taking consent (if different from researcher)	Date	Signature
……	…….	…….
Researcher	Date	Signature

When completed, one copy to be given to study participant and one for researcher.

Appendix III. Interview guides

Interview Guide (for academicians in the College of Medicine)

- Relevance of curricular topics to practice (discussion of topics depend on which topics the academician is involving in e.g. for lecturer in pharmaceutical chemistry, topics about pharmaceutical chemistry will be discussed in depth)
- What pharmaceutical service needs teaching of certain topics? E.g. service of patient education needs the curricular topics in the area of social pharmacy.
- Teachers with what qualifications should be recruited to teach the above mentioned curricular topics?
- How do we train or where should we source such qualified teachers?
- Retention issues: what makes you stay/leave this institution? What could be improved? How do we attract more academics?

Interview Guide (for employers of pharmacists including MoH/CHAM hospitals, retail pharmacies, pharmaceutical industry, Central Medical Store, and Pharmacy, Medicine and Poisons Board)

- Explore pharmaceutical problems currently faced by the institution/stakeholder group
- Who or which healthcare cadre is in-charge in the above mentioned problem?
- Should or should not pharmacist play a role? Why yes/no? Can other healthcare cadres do a better job than pharmacists? Or vice versa?
- What skills/knowledge/attitude that you look for in a pharmacist if he/she is to be entrusted with the above mentioned role?
- If you have pharmacists currently in-charge of such task, are they competent enough? What is lacking and what is to improve?
- If you don't think sufficient number of pharmacists is available in the near future to manage such roles, do you still foresee such roles are shifted back to pharmacists once they have sufficient number?
- Capacity issues: would you provide opportunities for student placement? Or relieving your staff to teach in the SoP?

Interview Guide (for other healthcare professionals or cadres, i.e. doctors, nurses, pharmacy technicians)

- What pharmaceutical services you would like to see to be provided by pharmacists?
- Why pharmacists are suitable to provide such services? Why not other healthcare cadres? Why can't pharmacy technicians do that?
- Any services provided by pharmacists now that you think they should not provide? Why?
- Inter-professional practice: rhetoric or reality?
- What skills/knowledge/attitude that you look for in a pharmacist if he/she is to be entrusted with providing the above mentioned services?
- Capacity issues: would you like to be involved in teaching pharmacy students?

Interview Guide (for professional bodies, i.e. Pharmaceutical Society of Malawi or PHASOM, Medical Council of Malawi, Nurses and Midwives Council of Malawi, the Herbalist Association)

- Explore issues about professional boundaries: dispensing doctors, prescribing

pharmacists, pharmacists selling herbs (?), other overlap in roles?
- How pharmacist could best contribute to health services? What do you want pharmacists to be?
- If pharmacists were to expand their roles into clinical services, do you think it's a good idea? Why yes/no?
- For PHASOM only: what stops the pharmacy profession from achieving what the pharmacists want? What do most pharmacists want?

Interview Guide (for Ministry of Health and Population)
- Name and prioritise pharmaceutical problems in the country.
- Staffing model for each pharmaceutical service: task assignment and skill mix?
- Comment about current number and distribution of pharmacists – what is to be improved? Which areas need more (or less) pharmacists?
- Comment about future development of pharmacy workforce – how much increase in anticipation? Would the job market absorb the increase in number?

Interview Guide (for Pharmacy, Medicine and Poisons Board)
- Internship issues: funding, length, training module (relief for pharmacy interns who wish to teach in the SoP?)
- Counterfeit medicine issues: statistics, enforcement, pharmacists' roles
- Local generic production issues: how much we could save by producing local generics? Do pharmacists play a role?

Interview Guide (for Ministry of Education, Science and Technology)
- The purpose of higher education? Is it planned according to the workforce need in the country? According to budgets? (compliance to donor policies?)
- Who should provide higher education – public vs private institutions? Send students abroad? How to increase access and to improve quality?
- Quality assurance body for higher education? Who accredits the SoP?
- Setting of standards according to what (e.g. international standards?)?
- Capacity issues: how to train the trainers? What about post-graduate programmes?

Interview Guide (for National AIDS Commission or NAC, which is the funder for pharmacy education in Malawi)
- Describe your role in pharmacy education.
- What is the main purpose of having pharmacy education? To train human resources for delivering ARV therapy?
- How long the funding will last? And after that who funds?
- Any policies from NAC that must be followed by the SoP?

Interview Guide (for development partners/NGOs/donor groups)
- Describe your role in improving health and/or educational status in Malawi.
- What is successful and what is not from your past experience in Malawi? Why?
- In what way do you think Malawi is different/similar to other countries in the world?
- Is there 'donor policy' imposed by your institution? What is its use and whether it is followed?

Focus Group Guide (for Pharmacy Students)

Introduction (5minutes)

- introduce myself: a facilitator to the meeting, not controlling the discussion; emphasise the importance of everybody taking part in the discussion; encourage difference in views; no 'dumb' answers
- rules: one person talks at one time; loud enough so that recorder could capture what you say; take phone calls out of the room; encourage to take the refreshment; wear name tags at all times
- run through what we're going to discuss: estimated length of time; topic outline; confidentiality of the discussion
- let everybody introduces him/herself (using name tags): first name, hometown, which year in pharmacy

'Write-down' exercise (2 minutes)

- write in not more than 3-5 words what you think about pharmacy education you're receiving now

Warm-up Discussion (30 minutes)

- comparison of the comment you've just written down with your prior assumption before coming to the SoP
- why did you choose pharmacy course: career prospects, pharmacist's roles

Curriculum (45 minutes)

- Which curricular topics you find it difficult?
- Which curricular topics you find relevant/not relevant to your future career?

Capacity issues (45 minutes)

- Funding (loans/scholarships); family expectations
- Teaching staff sufficient? Where do you get help for study – peers/senior students/using library?

Conclusion (15minutes)

- What advice/suggestion could you give to future students/SoP/UNIMA?
- Any final concluding remarks?

Focus Group Guide (for Lecturers)

Introduction (5minutes)

- introduce myself: a facilitator to the meeting, not controlling the discussion; emphasise the importance of everybody taking part in the discussion; encourage difference in views; no 'dumb' answers
- rules: one person talks at one time; loud enough so that recorder could capture what you say; take phone calls out of the room; encourage to take the refreshment; wear name tags at all times
- run through what we're going to discuss: estimated length of time; topic outline; confidentiality of the discussion
- let everybody introduces him/herself (using name tags): first name, hometown, which year in pharmacy

'Write-down' exercise (2 minutes)

- write in not more than 3-5 words what you think about pharmacy education in Malawi

Warm-up Discussion (30 minutes)

- explain what you've just written by linking it to your teaching experience

Curriculum (45 minutes)

- Which curricular topics do you think are relevant/irrelevant to practice?
- Which curricular topics you find it difficult to deliver? Why?
- Any curricular topics that we should just leave them to CPD (continuing professional development) and/or post-graduate courses?

Capacity issues (45 minutes)

- Why made you accept your current position? What makes you stay/leave? Teaching load, salary, working environment..
- Any strategy to improve staff level?
- How do you improvise when staff level remains low?

Conclusion (15minutes)

- What advice/suggestion could you give to future lecturers/SoP/UNIMA?
- Any final concluding remarks?

Focus Group Guide (for Pharmacists)

Introduction (5minutes)

- introduce myself: a facilitator to the meeting, not controlling the discussion; emphasise the importance of everybody taking part in the discussion; encourage difference in views; no 'dumb' answers
- rules: one person talks at one time; loud enough so that recorder could capture what you say; take phone calls out of the room; encourage to take the refreshment; wear name tags at all times
- run through what we're going to discuss: estimated length of time; topic outline; confidentiality of the discussion
- let everybody introduces him/herself (using name tags): first name, hometown, which year in pharmacy

'Write-down' exercise (2 minutes)

- write in not more than 3-5 words what you think about pharmacy profession in Malawi

Warm-up Discussion (30 minutes)

- comment on what you've just written by linking it to your work experience

Pharmacists' Roles (45 minutes)

- What roles are we playing now? what pharmaceutical services do we give?
- What needs changing? How?

Curriculum and capacity (60 minutes)

- Relevance of what you learned in school to your current practice?
- Would you like to teach? Why yes/no?

Conclusion (15minutes)

- What advice/suggestion could you give to future pharmacist/SoP/UNIMA?
- Any final concluding remarks?

Focus Group Guide (for Doctors and Nurses)

Introduction (5minutes)

- introduce myself: a facilitator to the meeting, not controlling the discussion; emphasise the importance of everybody taking part in the discussion; encourage difference in views; no 'dumb' answers
- rules: one person talks at one time; loud enough so that recorder could capture what you say; take phone calls out of the room; encourage to take the refreshment; wear name tags at all times
- run through what we're going to discuss: estimated length of time; topic outline; confidentiality of the discussion
- let everybody introduces him/herself (using name tags): first name, hometown, which year in pharmacy

'Write-down' exercise (2 minutes)

- write in not more than 3-5 words what you think about health services in Malawi

Warm-up Discussion (30 minutes)

- comment on what you've just written by linking it to your work experience

Pharmacists' Roles (30 minutes)

- In what way pharmacists could contribute to improve health?
- What are the tasks that should be done by pharmacists by currently not done?
- What are the tasks that are not supposed to be done by pharmacists?
- How should different professions work together?

Capacity (30 minutes)

- Would you like to supervise/teach pharmacy students?
- Is inter-professional learning possible?

Conclusion (15minutes)

- What advice/suggestion could you give to pharmacists/SoP/UNIMA?
- Any final concluding remarks?

Appendix IV. Documentary materials

Types of documents	Source
National health sector plan	Public domain
Number and distribution of HRH (particularly the pharmacy sector)	Only the number of pharmacists is available.
Number and distribution of health facilities	Public domain
List of development partners in health	Ministry of Health
Health SWAp reports	Ministry of Health
Six Year Emergency Human Resource Programme	Ministry of Health
Essential Health Package Programme	Public domain (limited information)
The Medical Act	Public domain
The PMPB Act	The PMPB
UNIMA Act	Public domain
Malawi decentralisation policy	Public domain
Statistics of pilfered drugs	Not available
Statistics of out-of-stock drugs	Not available
PHASOM members (number and membership fees)	Not accessible
National education sector plan	Ministry of Education
Quality assurance programme, UNIMA	University QA team
Staff establishment of the CoM	Registrar Office, the CoM
CoM recruitment and promotion policies	Registrar Office, the CoM
CoM private work policy	Registrar Office, the CoM
Research funds and sponsors	COMREC
Salary scale for academic staff at the CoM	Registrar Office, the CoM
CoM tuition fee schedule	Registrar Office, the CoM
Number of students at the DoP	Registrar Office, the CoM
Entry requirements to the CoM	Public domain
Budget for the CoM	Not accessible
The history of the CoM	Library, the CoM
Partnership project with foreign sponsors	Not accessible[151]
Departmental long- or medium-term plans	Not available
Teaching manual of the BPharm programme	The DoP
Annual reports of the DoP	The DoP
External examiner reports	The DoP
Examples of lecture slides	Pharmacy students
Foreign recruitment policy of the RSA	Public domain
Living costs in the cities (e.g. utility bills)	Friends living in Lilongwe

[151] The only development partner who gave access to reports (not available on public domain) was the Norwegian Government.

Appendix V. Malawi map

Figure taken from (International Food Policy Research Institute, 2012).

Appendix VI. Staffing norms to meet HR requirements of the POW (medium term)

Positions	*Salary Grade*	*Community Level*	*HC Rural** [152]	*HC Urban*	*Rural/ Community Hosp*	*District Hospital*
Chief Medical Officer	F					1
Principal Medical Officer	F					1
Senior Medical Officer	H					1
Chief Dental therapist	I					1
Dental Therapist	K					2
Pharmacist	I					1
Senior Pharmacy Technician	J					1
Pharmacy Technician	J			1	1	
Senior Night Superintendent Nursing Sister	J					4
Senior Nursing Sister	J					18
Senior Nursing Officer	I					13
Nursing Officer	I		1	6	6	30
Chief Enrolled Nurse	I			3	10	15
Principal Enrolled Nurse	J			4	12	32
Senior Enrolled Nurse (Psych)	K			2	6	10
Senior Enrolled Nurse	K			12	24	50
Senior Nursing Sister	J					21
Nursing Sister	K					6
Senior Enrolled Nurse/ Midwife	L					20
Enrolled Nurse/Midwife	M		2	15	25	54
Senior Nursing Officer	H			2	2	4
Senior Public Health Nurse	H			10	4	4
Public Health Nurse	I			4	8	8
Senior Community Health Nurse	J			14	24	15
Community Health Nurse	K		1	1	2	5
Clinical Superintendent	H					1
Chief Clinical Officer	I					1
Principal Clinical Officer	I			1	1	1
Senior Clinical Officer	J			1	1	1
Clinical Officer	K		1	1	2	2
Chief Orthopaedic Clinical Officer	I					1

[152] A Health Centre serves about 12,000-20,000 people (service population). The service population of a rural HC, is estimated at 15,000 while the urban one is estimated at 20,000 people. The trend will continue for the entire planned period.

Positions	Salary Grade	Com-munity Level	HC Rural* [152]	HC Urban	Rural/ Com-munity Hosp	District Hos-pital
Chief Anaesthetic Clinical. Officer	I					1
Chief Ophthalmic Clinical Officer	I					1
Senior Orthopaedic Clinical Officer	J					2
Senior Anaesthetic Clinical Officer	J					2
Anaesthetic Clinical Officer	K					2
Ophthalmic Clinical Officer	K					1
Senior Assistant Dermatology Officer	J					1
Assistant Dermatology Officer	K					1
Physiotherapist	I					1
Senior Physiotherapy Technician	J					2
Physiotherapy Technician	K					1
Senior Laboratory Technician	J				1	1
Laboratory Technician	K			1	1	4
Senior Lab Assistant			1		1	1
Laboratory Assistant	M		1	2	2	2
Principal Med Lab Technologist					1	1
Senior Med Laboratory Technologist	I				1	1
Med Laboratory Technologist	I					1
Chief Radiographer	I				1	1
Senior Radiographer	J				1	1
Radiographer	K				2	4
Senior Assistant Radiographer						1
Assistant Radiographer					2	2
Environmental Health Officer	I					1
Senior Assistant Env. Health Off	J					7
Assistant Environ Health Officer	K		1	1	2	10
Senior Health Education Off	H					1
Health Education Officer	I					1
Senior Assistant Health Education Officer	J					1
Senior Nutritionist	H					1
Nutritionist	I					1
Senior Reproductive Health Off	H					1
Reproductive Health Off	I					3
Senior Assistant Rep Health Off	J					4
Senior Asst Disease Control Off (TB& Cancer)	J					1
Senior Assit Disease Control Off (ARI and Malaria)	J					1

Positions	*Salary Grade*	*Com-munity Level*	*HC Rural** [152]	*HC Urban*	*Rural/ Com-munity Hosp*	*District Hos-pital*
Senior Asst Disease Control Off (Repro, Skin and Oncocerciasis)	J					1
Senior Asst Disease Control Off (AIDS and Trypanosomiasis)	J					1
Assistant Reproductive Health Officer	K					5
Health Surveillance Assistant*[153]	O	1				
Mechanical Engineering Techn	K					1
Medical Assistant	M		2		2	
Principal Hospital Administrator	G					1
Assistant HR Management Officer	K				1	1
Senior Clerical Officer	L				1	2
Clerical Officer	M					2
Copy Typist	M				1	2
Stores Supervisor	K					1
Stores Clerk	M				1	1
Assistant Statistician	K		1	1	1	1
Mortuary Assistant	M					2
Senior Head Security Guards	N					2
Head Security Guard	O					3
Security Guard	P		3	3	6	15
Senior PBX Operator	O					5
Senior Head Messenger	O					2
Messenger	P		1	1	1	1
Dark-room Attendant	O					1
Accountant	I					1
Assistant Accountant	K					2
Senior Accounts Assistant	L					2
Accounts Assistant	M				1	3
Drivers	O				3	10
Cooks	O					12
Artisans	O					6
Support Staff	O				2	3
Totals		**1**	**15**	**86**	**163**	**481**

Source: HRH Strategic Plan 2008, MoH Document.

[153] One Health Surveillance Assistant is required per 1,000 people during the plan period (which is a combination of 2-3 villages). One village is estimated at 300-500 people.

Appendix VII. Staff Establishment at the College of Medicine, UNIMA

Department	*Approv-ed number*	*Number in post (fixed)*	*Number in post (con-tract)*	*Number in training*	*Vacancy*	*Volun-teer staff*
Anatomy	6	2	1	3	1	
Biochemistry	7	3	1	3	-	1
Physiology	6	4	-	-	2	-
Haematology	5	2	-	2	1	1
Histopathology	5	2	-	2	1	
Microbiology	7	4	2	-	1	1
Anaesthesia	4	-	2	1	1	
Medicine	14	2	7	2	3	
Obs & Gynae	12	2	1	4	5	
Paediatrics	12	2	6	3	1	1
Surgery	12	3	5	4	1	
Mental Health	3	2	1	-	-	
Public Health	8	8	-	2	(2)	
Health Social science	3	1	1	-	1	
Pharmacy	9	3	2	1	3	
Medical Laboratory	7	3	-	1	4	
Physiotherapy	7	-	1	-	6	
Premedical	5	-	4	-	1	
Radiology	2	-	-	1	1	
Total	134	43	34	30	28(2)	1

Source: Registrar Office, the College of Medicine.