# Phillip Passmore: not your ordinary pharmacist

*By Robin Davies*

During times of disaster, people naturally want to help. Unfortunately, they sometimes choose to do so in ways that do more harm and create more chaos: like emptying their medicine cabinets of expired goods and shipping them off overseas. Pharmacist **Phillip Passmore** has helped swamped local health systems deal with dodgy or unneeded drugs in post-tsunami Aceh and much, much more during his fascinating career.

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Major emergencies in developing countries tend to beget major flows of donated medical supplies from international sources. A depressingly large proportion of these donated goods is useless, provided in blatant contravention of the World Health Organisation's (WHO) Guidelines for Medicine Donations. Worse than useless, in fact, because the need to sort, store or safely destroy donated products creates additional burdens on stressed local health authorities, as well as creating considerable financial costs.

In the aftermath of the Boxing Day earthquake and tsunami in 2004, the government of Indonesia, overcoming its initial hesitation, opened the province of Aceh to international assistance. No medical supplies were requested yet, according to a 2005 survey by *Pharmaciens sans Frontières*, some 4,000 tonnes of them arrived from 39 foreign governments, 48 international organisations and 53 organisations in other parts of Indonesia.

Among the drugs received, some 60% were not on Indonesia's national list of essential drugs, 70% were labelled in foreign languages and 25% were past or

close to their expiry dates, or undated. Around 600 tonnes of drugs were estimated to be in just the latter, unequivocally useless category, with an estimated disposal cost of €2.4 million.

Some of the drugs received might have been appropriate enough in themselves but were provided far in excess of requirements, including oral rehydration salts and tetracycline. In some cases, the quantities provided would have been sufficient to supply the province for between four and eight years. Storage facilities in Aceh had been inadequate before the tsunami and were mostly wrecked afterward. Around half of the province's health workforce had perished. In these circumstances, managing the influx of well-intended medical supplies was a nightmare.

# Keep your drugs

Phillip in Aceh, January 2005.

Enter Phillip Passmore, a practising pharmacist from Perth, Western Australia, with a long pedigree in acute and protracted emergencies. He had previously, at the request of the Australian government, helped the provincial health department in Bali to deal with the inflow of donated medical supplies after the 2002 bombings in Kuta. He worked effectively in that role, and his name quickly came to mind when aid officials at the Australian embassy in Jakarta drew up a list of potentially emergency response personnel in the days following the

tsunami.

Phillip arrived in Banda Aceh on one of the earliest Australian Defence Force relief flights, in January 2005, and spent much of the next six months there. As he came in to land at the airfield in Banda Aceh, he saw familiar mounds of cast-aside drugs along its perimeter.

> *'People in Australia were asked—even by radio announcers—to empty their medicine cabinets and send the contents. Other countries sent heaps of donated goods as well, especially countries where a form of taxation relief is granted when medicines and medical supplies are donated for humanitarian programs. Officials in Indonesia were reluctant to say no to anybody or anything that was being offered. So, tons and tons of medicines and equipment arrived.'*

Once the medicines had arrived, they could hardly be thrown away indiscriminately. Phillip's immediate task was more complex—to help the provincial government determine which products might be put to good use, make an inventory of them, arrange for them to be sorted and warehoused (often in high-rent, 'quick build' facilities erected by enterprising locals) and put in place the infrastructure, protocols and safeguards necessary for them to be distributed to and used in particular locations. Disposing of unsuitable products — most of which were some time later incinerated in a brick factory furnace — was among the least of his problems.

At times, Phillip had to act forcefully to head off further unwanted donations.

> *'I sometimes had to get quite angry with people and say, "No, we do not want your 700 tonnes of medical supplies because we've got no place to store them." I had to convince people that there was no shortage of medicine in Indonesia. What we needed could be obtained from Medan, Jakarta and other places.*
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> *'But still a lot of stuff came from professional groups around the world. Many companies supply medicines and medical supplies because they've either overproduced relative to their own needs or they've got products that they don't need any more, and can get a tax benefit by having them shipped overseas. The stuff that came from people who were trying to be really helpful, in Australia and other places—that actually came in smaller quantities.'*

A further, critical task was to obtain essential medicines that did not feature in the avalanche of donated supplies — including special-purpose antibiotics and doses of tetanus immunoglobulin. The former were for people whose bacterial infections proved resistant to more mainstream antibiotics. The latter, rarely needed in developed countries thanks to compulsory immunisation with tetanus toxoid, were for people who might have been exposed to tetanus bacteria. Large numbers of people had suffered deep lacerations during the earthquake and tsunami or else during the subsequent rescue and clearance effort.

> *'Aceh after the tsunami was a great breeding ground for tetanus. I think we had over a 100 cases. In Indonesia, the product that's normally used is horse immunoglobulin. But this wasn't working, and in some cases was causing quite adverse outcomes.*
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> *'The medical people on the ground said, "Well, we've really got to get some human immunoglobulin." This is taken from people who have a high immunity and antibodies against tetanus. CSL, in Australia, produces this and holds stocks of it for use in Australia. I think in actual fact we almost cleaned Australia out of it.'*

Phillip recalls fondly the vision and enthusiasm of his local counterparts in Aceh, but the manner in which he related to them was clearly also a big factor in getting things done. He was, after all, dealing with people who were traumatised, having lost, almost universally, close family members. They were overstretched by the task of restoring essential services. On top of that, they were beleaguered by aggressively helpful international health workers.

Phillip had, in effect, to wear two hats—as tirelessly supportive colleague to his Acehnese counterparts, and as tour guide to a series of foreign doctors and health workers wanting to know where they might set up shop, how they might obtain supplies, and so on.

> *'There were lots and lots of new groups coming in, many of them not at all well-established, and all wanting to do something, somewhere. In many ways, they were just a nuisance. I don't want to be harsh with my words. It's not for me to judge people's motives. But it was hardly what you'd call organized—not really thinking of the local people.*

*‘And that’s the thing that struck me: how important it is to respect the local people. Even though things might not be quite the way we are used to, how important it is to work with people to help them, first of all, re-establish. And then, if there are things that we could do better, we should always look for those as well.’*

Phillip with Hmong refugees in Ban Vinai camp, Thailand.

# From Perth to Ban Vinai

Phillip and his wife established a community pharmacy in Perth in 1973. The business flourished, and by the end of the decade Phillip was looking for a new challenge. He found it in December 1979, when World Vision Australia issued an urgent call for a pharmacist to go to Thailand and help manage medical supplies for the huge outflow of refugees from Cambodia and Laos after the Vietnamese invasion of Cambodia. Phillip responded, and within 10 days was on the ground.

He worked primarily in the Ban Vinai refugee camp in the Loei province of north-

east Thailand. The camp's population of mainly Hmong people from Laos had grown very rapidly from about 13,000 to 42,000 people in a very short period of time. Phillip decided to live in the camp rather than travel almost two hours back and forth each day to the accommodation that other expatriates were using.

Over the course of an initial three-month assignment, he learned many things that have stayed with him up to the present time. He began to understand the politics of emergency responses and the importance of building productive relationships across organisations. He developed his practical skills, learning how to manage supply chains in remote areas and, as the only trained pharmacist in the vicinity, how to use unskilled workers to perform many of the key tasks of a health workforce.

> *'We broke down tasks into small areas on which an individual could be trained. I had these often young people, whose education had been interrupted in Laos. Some of them were educated to probably year 9 or 10 level. But all of them were keen to do something. So, if you can imagine, I made an assembly line—from receiving the prescriptions to counselling people as they went out the door.'*

> *'And in between all of that was pre-packaging medicine. Because of the huge numbers of people who came into the clinics each morning, you just didn't have time to be packing medicine. Many of the people were illiterate, so we used labels sourced from central Australia that were being used in health care programs for indigenous people, and we used "morning", "noon" and "night" stickers.'*

Phillip instructing volunteer Hmong refugee pharmacy assistants in Thailand.

Phillip created in Ban Vinai a comprehensive pharmaceutical service. His team was not only dispensing drugs but also doing initial injections of antibiotics and even sending workers out to households in order to make sure people were using their medicines correctly. Phillip was influencing doctors to prescribe standard products and dosages for each diagnosis in line with standard WHO treatment protocols, and calibrating the flow of medical supplies accordingly. He was exceedingly proud of the team that he had put together, though it needed constant renewal as people left in the hope of making their way to France or the United States.

His experience in Ban Vinai taught Phillip about the importance of establishing simple and robust systems to support effective teamwork. It also taught him something about himself—that, despite flying by the seat of his pants throughout much of this first international assignment—he had the management and people skills to work effectively in fluid, complex, post-emergency situations.

Interestingly, he says he learned something else too, namely that after a few months, perhaps six at most, emergency response specialists really need to make way for people of a different type. However, his own case, as we shall see, seems

to constitute a counter-example to this thesis. He’s a person of both types.

World Vision Australia asked Phillip to continue his work with them in Thailand and, after selling half of the family’s pharmacy business to another trusted couple, he was able to do this with his wife and children until 1984. Thus began an unusually mixed, yet coherent career as community pharmacist, husband and father of three children, international public health consultant, and—following the typically efficient completion of masters and doctoral degrees based on his international work—university lecturer.

Phillip with refugees in South Sudan.

Phillip at the Drug Information Centre at Hanoi University of Pharmacy.

Philip with international visitors.

Phillip teaching in Vietnam.

Phillip with colleagues in Danang, Vietnam.

# Relief, development, whatever

Anybody watching Phillip work in Aceh and elsewhere—and he works continuously—would have been struck by two things.

First, it was evident how close he was to local health workers and administrators, and how attuned to their day-to-day problems. He behaved and was received as one of them, rather than as what he was, a highly-trained international consultant.

Second, it was striking how far he took a long-term view in everything he did. He didn't merely try to solve immediate problems; he thought about how his actions at a given point in time might help to set the stage for later assistance from other sources.

Phillip was giving practical effect in Aceh to Bill Clinton's now-hackneyed mantra as Special Envoy for Tsunami Recovery, 'Build Back Better'. That is, he was always looking for opportunities to create systems and practices superior to those that existed before the tsunami. When asked now to look back over his experiences and nominate the context in which his development assistance work has been most effective, he quickly nominates Aceh rather than any of the numerous places in which he has run traditional development assistance projects.

*'In Aceh we were able to re-establish pharmaceutical services. That's a great*

*outcome, achieved in a short period of time. When you get people who have a focus, when people are stimulated to cooperate, you can achieve a lot.*

*'So I feel that development can occur where there is a good partnership between donor and recipient—where the recipients say, "These are our problems. These are our difficulties. Can you help?", rather than the donors saying, "Well, we've got a bunch of money". Then you can achieve a great deal.*

*'In other places, there's just not that enthusiasm. I'm not sure whether I would want to work in areas where there wasn't that commonality of purpose and that enthusiasm to see change.'*

Phillip spent much time working in traditional development assistance mode in the Indonesian province of Nusa Tenggara Timur (NTT, or West Timor). NTT is at the other end of the archipelago from Aceh and, as one of Indonesia's poorest and eastern-most provinces, has long been a focus, at least in principle, of Australia's development assistance efforts. There, from mid-2006 to early 2009, Phillip was contracted to deliver a pharmaceutical services strengthening project under the auspices of Australia's ill-fated ANTARA regional development program.

Paradoxically—though in a neat inversion of his view about his work in Aceh—he considers this in retrospect to have been more of a relief intervention than a development assistance one.

*'We went to NTT to try to deal with some of the issues that were identified in Aceh—we had some advice there were similar problems out in NTT. But I soon realised that we were working more in a relief and rehabilitation-type mode in NTT.'*

The national government had recently passed legislation to decentralize many health functions from the centre right down to district level, bypassing provincial administrations. The districts chosen to receive support under Phillip's project embraced it enthusiastically because, all of a sudden, they had been thrust into a situation where they were entirely responsible for the planning and delivery of pharmaceutical services within their boundaries.

But the difficulties Phillip and his team encountered were not merely the universal, technical ones. They often arose, rather, from differences of opinion

between people at the national, provincial and district levels—about roles, needs and priorities, and therefore about what should be procured and distributed and who should be responsible for these functions. And there were some persistent bad practices. Drugs were being purchased beyond need, suggesting the presence of unhealthy incentives.

Phillip worked hard to address some of these issues. The provincial administration, however, proved unwilling to give up its procurement, storage and distribution functions, even though there was insufficient storage capacity and no budget for distribution. Phillip tried a different tack, seeking to persuade the provincial administration to think of itself in an emergency response capacity, not delivering routine pharmaceutical services but holding buffer stocks of antibiotics, intravenous fluids and the like, for use in case of natural or man-made disasters.

This met with some success. Stocks held by the province were designated as buffer stocks. But there was still no money for distribution. Districts would have to come and get the emergency stocks if they needed them! Phillip's project was ultimately closed prematurely, before more progress could be made. In any case, more progress would likely have required much more than project itself could ever have provided—namely high-level political engagement.

In the circumstances, then, Phillip's project in NTT had to be content with small advances throughout its relatively short lifetime, aimed mainly at preserving the quality of medicines. And those advances often required actions of the sort normally undertaken only in emergency contexts, such as the direct provision of minor infrastructure like shelving, vaccine fridges, fans, roof insulation and generators.

> *'One of the things in NTT was to get a good refrigerator so that you could actually store the valuable vaccine products that needed to be kept between 4 and 8 degrees, and to have a generator backup system that kicked in if the power went off, as it did regularly, so as to make sure that these products were kept viable.*
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> *'Of course you can get criticized for assisting with infrastructure. People say, "Why would you do that?" I say you have to have a balance between the things that you spend money on, and not be too pedantic about whether it's relief or*

*development. Leadership requires sometimes that you come in and say, "We've got to do this."'*

# Robinson Crusoe

Phillip has almost always had the peculiar experience of being alone in crowded spaces. In Aceh, he was part an international emergency response which was unprecedented in scale. Yet, as it seemed at the time, he was the only international adviser on the ground able to provide advice on the management of donated medical supplies and the restoration of pharmaceutical services. You can now find references to a small EU-funded project, said to have been established in February 2005, to help the provincial government manage donated drugs. At the time, though, you would have searched in vain for anybody else doing what Phillip was doing.

Likewise, eastern Indonesia is, or was in the past, said to be the focus of many donors' development assistance efforts, because it is among the poorest regions of the country. But, in his work with provincial and district health administrations, Phillip found precious little trace of all this past activity, and almost no present activity other than his own.

*'When I was in NTT, I could not believe that donor agencies had been working there for something like 20 years. It was very difficult to see what was the outcome of that. The pharmaceutical service problems that we had were so much part of deficiencies in overall health sector management. It was just not there.'*

A large part of the problem, in Phillip's view, was that effective health programs simply could not be implemented in the absence of an overall health sector management plan. In one sense, of course, developing countries are knee-deep in such plans, often produced by international consultants to meet the requirements of international funding agencies. But the real need, Phillip insists, is for something far more practical, based on a genuine understanding of needs and capacities all the way down to the lowest levels of government and the front lines of service delivery. The most fundamental requirements, he believes, are good

data and analysis, allied with long-term, flexible engagement between donor agencies and lower levels of government.

Fair enough. But, sadly, these are surprisingly big asks when you consider that donor agencies tend to prefer a different kind of flexibility—the flexibility to back out of programs at will, and to reallocate resources to the priorities of the moment. In addition, donor agencies typically prefer to be untroubled by detail. This, in fact, is why the NTT regional development program of which Phillip's project formed one part was ultimately abandoned. It required too lengthy a commitment, and too much fiddly interaction with local authorities and organisations.

Phillip is in many ways the very model of a good international development consultant. He sees the whole canvas but directs his expertise to areas where it is matched by local commitment. He works much more as a peer than as a foreign expert. He does not fuss about distinctions between development and relief, or between in-line work and capacity building; doing, rather, whatever needs to be done.

If only he weren't Robinson Crusoe.

*Listen to Robin Davies' two-part interview with Phillip Passmore below, or download as podcasts here and here. You can also download the transcripts: Part 1 and Part 2.*

## Interview Part 1

http://devpolicy.org/aidprofiles/wp-content/uploads/2016/11/Phillip-Passmore-Interview-Pt-1.mp3

## Interview Part 2

http://devpolicy.org/aidprofiles/wp-content/uploads/2016/11/Phillip-Passmore-Interview-Pt-2.mp3