

ROBIN: This is the Development Policy Centre podcast, and I'm Robin Davies. In this episode, I'm speaking with Dr. Phillip Passmore. Phillip is somebody I know personally from my experience working in Indonesia. He is most easily described as an emergency pharmacist, and perhaps you never thought there was such a thing, but that actually doesn't fully describe what he does and you'll hear much more about that in this discussion.

It's split into two parts. It was more than an hour. So the first part focuses mainly on Phillip's work in the aftermath of natural disasters, and man-made ones too. And the second part talks more about his work in development programs, long-term development programs, and gives him an opportunity to reflect on his experience in working with donors and in partnership with developing country governments at all levels.

Phillip's based in Perth. He is still active, though perhaps spending less time overseas than previously. He received a WA Lifetime Achievement award from the Pharmaceutical Society of Australia in March 2015, for his service not only overseas but within Australia. In addition to the enormous amount of work he does overseas, he ran a community pharmacy with partners for 35 years. He teaches at Curtin University in West Australia, and does a range of other things.

So we'll commence the interview here and pause just before we move into a discussion of his work in West Timor, which we'll pick up in the next episode.

Phillip, you've been called upon more than once, especially in Bali after the 2002 bombings, and in Aceh after the tsunami in 2004 to help governments deal with the avalanches of donated medical supplies that always follow major disasters. What does that actually involve?

PHILLIP: Each case I think is a little different. But the one that's sort of—that we both have had some recent experience with—is the situation in Aceh, and I'll cover that more than the other settings, the bombings, Jogjakarta and other places I've been.

Just a little bit of a background. The sending of donated medicines and medical supplies is not a new phenomenon. It's been going on for a long time. And because of this, WHO has developed good guidelines regarding the responsible provision of donated medicines and equipment, but nobody seems to want to follow them. In my experience, when an emergency situation arises, whether humans have caused it, like a bomb, or a natural event like the earthquake/tsunami, people are often encouraged to do what they can, to be generous.

And that was the case in Bali and the Aceh tragedy. People in some parts of Australia, they were asked by—even by radio announcers—to empty their medicine cabinets and send medicines. Of course, other countries also sent heaps of donated goods as well, especially from countries where there's a form of taxation relief that's granted when medicines and medical supplies are donated for these humanitarian programs.

So in these situations, you're going to get lots and lots of medicines. In addition, a complicating factor in Aceh was that 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.

A great deal of the products ended up being warehoused and then eventually incinerated in a brick factory furnace. So all these essential inputs to manage donated medicines professionally incur high costs, and often the returns are very low and cause a lot of distraction from re-establishing much needed healthcare services in general, including the pharmaceutical services.

And of course our function in Aceh was really trying to rehabilitate something that was smashed with the tsunami, and we needed to focus on that more than on managing donated medicines that hadn't been called for.

It takes a lot of time and human resources to arrange, as you can imagine, the security of the products, port entry clearance, their use in particular localities, getting approvals from health officials, transporting, warehousing, sorting, developing, inventory development, whether they are useful or unsuitable products, making decisions about the quality of the products, and then responsible distribution of the products, if it gets that far, to the hospitals and health centers, and trying to make some determination if there's human resources at these places who can actually manage these medicines that, you've got to understand, are not in the local language. They're often in English. And there's many places, of course, who have people working there, doctors and nurses and others, who can't speak the languages. And at the end of all of that, you have to think of the safe disposal of these tons of inappropriate products.

And the big complicating factor in Aceh was that many warehouses were destroyed. So we really had incredible problems trying to solve this issue. Enterprising locals, you might remember, were quick to notice the value of warehousing, not just for medicines but for the huge consignment of other items needed to respond appropriately to the tragedy.

And quick-build warehouses started to pop up. Of course, high demand and short supply, tended to create higher prices than normal or reasonable costs. That added costs, high costs,

to any value that the donated medicines might have gained. So securing these hazardous products created huge problems. So that's part of the deal we had. They were unsolicited and I believe that unsolicited medical supplies shouldn't be sent.

ROBIN: Well that answers the question that I was about to put to you because, certainly in the Aceh case, there was a lot of material that was either unneeded or unusable because it was expired and so forth. So I guess that raises the question, "Are there tradeoffs here? On balance is it still useful, or is the arrival of this stuff essentially a huge distraction?" So it's your view, I take it, that this is essentially a distraction.

PHILLIP: It is a distraction. But of course I'm not saying that donating medicines is not valuable. Donating medicines is extremely valuable if it's done properly. Like, for instance, you shouldn't send unsolicited medical supplies. If you remember the case we had in Aceh, where there were needs for particular and specific products.

The tetanus immunoglobulin sent from Australia and the special antibiotics that were sent from Australia, especially after the Jogjakarta earthquake, were cases where donated medicines were extremely valuable and lifesaving. But first of all, it was worked out at the local level and working with local officials that these products were needed if these people's lives were to be saved.

And then we all worked very hard together to get things working so that the immunoglobulin and the antibiotics arrived on time, in a timely fashion, and that there were people on the ground who could use them properly. And lives were saved.

ROBIN: Could you perhaps tell the story in a little more detail about those medicines? So these were things that were not in the initial avalanche in the case of those two disasters. The need was identified and then you played a role in procuring those medicines. So maybe if you could just talk a bit more about that situation.

PHILLIP: Yeah, well the situation was that as you can imagine in Aceh, there were a lot of casualties like this, and they weren't as many survivors as you would expect. But the survivors that were in the hospitals, they had wounds from flying roof panels and glass, so they had a lot of deep wounds.

And so, a great breeding ground for tetanus. And of course this is where the whole question of immunization comes in. Now whether these people had some immunization and some immune response to tetanus, who can tell. But the issue was that I think we had 100-something cases, over a 100 cases of tetanus.

In Indonesia, the product that's used is horse immunoglobulin. So this wasn't working. And not only wasn't working, in some people it causes some adverse results, adverse outcomes. So the local officials and the Australian medical people who were on the ground said, "Well, we've really got to get some human immunoglobulin."

This is immunoglobulin that's taken from people who have a high immunity and have antibodies against tetanus. And CSL, in Australia, produces this, and there's stocks held for when it's got to be used for the cases where Australians get tetanus, for some reason or another.

So I remember being in—I had just arrived, and we were in Jakarta, and heard that this was a possibility that we needed to get this stock. And then we flew to Aceh, and this was confirmed it was needed, and then there was just—we worked tirelessly to make contact with Canberra and the Department of Foreign Affairs, or AusAid, there.

They got to work and they worked with CSL and other groups so that these products were made available. And I think in actual fact we almost cleaned Australia out of the immunoglobulin. I suppose it just needed people on the ground who actually were able to be convinced that, "Yes, we'll do this."

We had other situations where I had to handle, actually getting quite forceful, quite angry with people to say, "No, we do not want your 700 tons of donated medical supplies because we've got no place to store them." And what I had to convince people of, and the irony of it was there a lot of damage, of course, with the tsunami, and we lost considerable amounts of medicine with the warehouses being just washed away and the medicines being washed away.

You might remember the incredible damage that was there and seeing all these medical supplies just ruined. But the actual fact, there was no shortage of medicine in Indonesia. There was no shortage of medicine. All we needed was to have, again, a fast response and get truckloads of stuff from Medan, and get stuff shipped up from Jakarta and other places.

So within Indonesia there wasn't a shortage of medicine, and this is where I get a little bit confused that people either have short memories or there is some economic/financial benefit for people who donate these medicines. I mean the stuff that came from Australia and other places, from just general people, and people who were trying to be really helpful, they were in small quantities.

But a lot of stuff came from professional groups around the world that collect donated medicines and medical supplies. And many companies supply medicines and medical

supplies because they've either oversupplied their needs, they've overproduced their needs, or they've got—they're refurbishing a hospital so they've got lots of beds that they don't need anymore.

And you can get a tax benefit by having them shipped overseas. So there's a lot of incentives why people send these medicines. Not purely egalitarian and humanitarian, and all those reasons. So I think it's a real mixed bag. You've got some people who just send their leftover antibiotics.

I've even seen that in Bali. We saw that a lot, certainly coming out of people's medicine cabinets. But again, in Bali there was no shortage of medicine either, because all the foreign patients were shipped out very quickly, and the local people, they weren't—there was no shortage of medicine in Bali.

But again, lots and lots of problems. And in Bali, there were people who were coming up from Australia carrying even vials of morphine. They thought there's bomb blasts. There's a need for donated medicines. Some of them were nurses who worked in doctor surgeries and others, who came up with narcotic injections.

And then because I was there on the ground with AusAID there, they would come and say, "Oh, I've got these. What should I do with them?" I thought, "Well, can you imagine dealing with local authorities and telling them that you're carrying morphine around?" So there's some silly nonsense that goes on with trying to be helpful, but hardly wise. So we need to always remind people that please ask first, and don't just send donated medicines.

ROBIN: What I find really interesting, thinking back to the time with the Aceh response, the sort of role that you played, the role that you describe, it is obviously so essential. And yet, it's not as if there were 10, or even 5, Phillip Passmores running around in Aceh. There was just the one.

And yet this was a huge international response, and within this response there seemed to be very little thought given to the issues that you've described and the need for the sort of role that you played. I find that surprising and fascinating. It makes me wonder, in the case of other disasters, let's think of say the Haiti earthquake in which Australia played no role. But was there a Phillip Passmore? I wonder. It's a fascinating situation.

PHILLIP: Well you see it surprises me too. I was actually, in many ways, I played a role of being the encourager and supporter of the local survivors who had been working in the pharmaceutical sector there. They, quite frankly, they had just gone through this tsunami and this terrible burden that they were carrying.

Many of them had lost family members. And here they are being called back by their government to get back to work, to get on with the job. Well, can you imagine? They had to deal with screaming, ranting and raving foreigners who come and say, “Well, where is this medicine? I’m seeing patients down at the foreshore there”—the foreshore was 5 kilometers in almost.

But “And I need this and I need that,” and all that. They were saying “What do we do with these people?” We had one doctor from Australia who had just flown up and just started practising. I thought, “Well, I can’t really work this out in my brain,” but to be courteous I had to say, “Well, please talk to this person. Please go and see this person. If they can’t help you, then come back to me and I’ll see if I can help you with something.”

But I’ve got two hats, if you know what I mean. I’m being the sort of the guide, the tour guide, as you know, for a lot of these people, and helping them to know where to go and seek things. But at the same time, work with the colleagues to—with the local colleagues to say, “Well, we’ve got to start thinking of what we’ve got to put in place.”

We had to clear out—identify warehouses that were still intact, dry them out, clean them up. Then we had to—because not only did we have tons of these donated medicines, but we also had stock that was coming in from the Indonesians, the natural response to replenishing the stock from Indonesia.

And where to put this stuff, getting new shelving put in, and just really getting them to think step by step about re-establishing the pharmaceutical services there. And at the same time, there was just this chaotic response from the foreign donors, or the foreign groups, who would come there. I think—I can’t remember.

There was over 100, I think. And they weren’t well-established NGOs. There was lots and lots of new groups that were coming in, all wanting to do something there. And 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 for doing things, but it was hardly what you’d call organized and really thinking of the local people.

And that’s the thing that struck me is how important it is to respect the local people. And even though things mightn’t have been quite the way that we might be used to, how important it is to work with people to help them, first of all to re-establish. And then if there were things that we could do better, well we’re always looking for that. And sometimes it was successful, sometimes it was not quite so successful.

But one of the—this is why I feel so strongly about donated medicines, that they aren't cost-effective. They really aren't cost-effective unless they are—unsolicited, I'm talking about unsolicited donated medicines, just not cost-effective. Because it's so much extra work. And knowing, with the understanding that every nation has their own national drug authorities.

They have their own rules, regulations, legislation, legal system, that determines which medicines can be used and which medicines can't be used, what labeling they need to have and all these things. Of course in terrible tragedies like happened in Bali, Jogjakarta and other places, there are waivers.

And governments issue these waivers and say, "This type of thing can happen," like the tetanus immunoglobulin wasn't registered in Indonesia at all. We got proper documentation, proper authorization to use those products when they came, and the same with the antibiotics. But people often, in their enthusiasm to help, they just run roughshod over all the local laws and things like that.

And I often remind people, can you imagine if there was a disaster in Perth, or Sydney, or anywhere else in Australia? Can you imagine how the local authorities would consider somebody coming in from another country and just setting up shop and saying, "Well this, I'm helping people and this is what I'm doing. Why aren't you helping me?" All this business. This would go down like a lead balloon, as we know.

ROBIN: I want to go back a bit in time and just talk about how you got into this business. So you've given us a good sense of at least one of the things you do overseas. But I guess to most people, they think of the pharmacist in his or her dispensary in the suburbs. You did in fact run a community pharmacy in Perth for nearly 35 years until a few years ago.

PHILLIP: That's right.

ROBIN: How did you get involved in international work?

PHILLIP: Heather, my wife, and I bought a small pharmacy in a rented property in December 1973. And we moved that business to our own newly developed medical center in 1976, a long time ago. That business flourished, I'm happy to say. And by 1979 I was looking for some new challenge.

And although I didn't initially recognize it, the challenge came in December 1979 after I responded to an urgent call for a pharmacist to go to Thailand, and that was to assist with managing the medical supplies for that—for World Vision, for that—to respond to that huge influx of people from Cambodia, or Kampuchea as it was called then, and Laos.

Remember this was, for the people who might be hearing this, this was the end of the—this was the mop-up time after Vietnam invaded Cambodia. And the Hmong—particularly the Hmong people from Laos who had been the CIA supporters, or supported by CIA to work on the Ho-Chi-Min Trail, they were fleeing to Thailand.

And so I had this business. It was nearly Christmas, and my eldest child was just about to start school in the February of 1980. And within about 10 days of hearing this call, there's a long story to that, but in 10 days I was in Thailand at this—trying to help out. And I had volunteered for three months because after three months, they—World Vision had found another pharmacist who was available longer term.

So I was in Ban Vinai mainly, because of the short time I was there, because remember, there was camps, huge numbers of people on the Cambodian border, the Thai/Cambodian border. But there was a rapidly growing population up in Ban Vinai refugee camp, and that's in Loi Province in Northeast Thailand.

I think the population grew very rapidly from about 13,000 to 42,000 in an extremely short time. So I was in this camp, and—which rapidly grew in population, and I—well I suppose what I did, I learned many things by the seat of my pants. That's the way I've described it. I just got to it. I decided that I wanted to live in the camp rather than travel almost two hours back and forth each day to the accommodation that other people had.

And so I learned a lot of things that sort of stayed with me up until this time. I mean some of the things I learned, the basic importance of managing medical supplies, haven't changed. So things like program management in emergency response situations, supply chain management in remote areas, health chain management, staff training and delegation of duties, all that, to do this in a short time.

And also to understand the politics, I suppose, of emergency responses. And again, I was the only pharmacist. And because I was the only pharmacist, I had to mobilize and train refugee helpers to perform many of the tasks. We broke down tasks into small areas on which an individual was trained.

And so in the end if you can imagine, we had doctors there, some of them were refugee doctors, and others were foreign doctors. And we had a pharmaceutical service running in these remote and quite basic circumstances. But I had these often young people. They were young people whose education had been interrupted in Laos, and some of them were sort of equivalent to probably year 9, year 10.

But all of them were keen to do something. So if you can imagine, I broke down all of—made like what do they call it? Assembly line, like an assembly line. So from receiving the prescriptions to counseling people as they went out the door. And in between all of that was prepackaging medicine.

I got doctors to prescribe as much as possible standard products and standard dosages for a particular diagnosis. Almost like, if you can think of, this is what WHO really promotes, is standard treatment protocols. And then the supplies to match those standard treatment protocols.

So we, because of the huge numbers of people who came into the clinics each morning, you just didn't have time to be packing medicine. So we had prepacked medicine. And because many of the people were illiterate, we used labels that we got from Central Australia for illiterate indigenous people, and we used the morning, noon and night stickers.

And we did initial injections of antibiotics in the pharmacy. That was a pharmacy task. And all in all, we had a very comprehensive pharmaceutical service, and that's to say even to the point of having people outside. So when people left, there was a real—often a grilling of the families as to how they were going to use this medicine and did they understand how to use the medicine.

So I was very chuffed and very proud of the team that we had in the pharmacy. But I have to say that in a short time I lost most of the staff because they hopped on buses and either went to France or to the United States. So we had to start all that over again. So anyway, you can imagine that I learned lots of things, and not only that, I had to deal with UNHCR, who was supplying the medicines.

So I had to keep good relationships, and to seek lots of support on what to put into inventory lists, and received truckloads of stuff which had to be properly warehoused. I was—I had to oversee the building of a warehouse as well. So this is all in a short time, and it kept me very busy, as you can imagine.

And—but from that, I supposed I learned many things, but the encouraging thing for me was to learn that the skills I had as a pharmacist and as a manager were vital to a team approach in the provision of emergency and preventive health care to vulnerable people.

And I learned that emergency responses should only be in place for the shortest possible time before rehabilitation and restorative programs need to be implemented. Often I've seen, over the years of my work, where emergency situations carry on for too long. You've got to change.

If you haven't sort of settled things down in three to four months, or maybe six months at the absolute outside, I think you've got a real problem on your hands. And at the end of that time, people often need changing. You can't—often you can't have the same people doing the work in the emergency phase and then think they can then switch over to be rehabilitation workers or even development workers.

That's something I learned very quickly. And in a way, I was instrumental in trying to get people to move on. In the end, I did move on and had recommended that—to World Vision, that they either stay there and change their whole approach or—because the same procedures for emergencies is different to long-term rehabilitation and long-term development.

And people get bored. If they are emergency-type people, they get bored in doing development. From there, I was asked to come back. I'm jumping ahead of myself a bit here, but I went for three months, but World Vision asked me to come back after that three-month period.

And I got quite excited about that, because I thought that was a challenge that I would like to do. If you ask how do I juggle the business as well as that, well that's what my wife asked as well. I was excited about going back and she said, "What has happened to you? Have you got cerebral malaria or something?"

She sensibly reasoned that we had three young children, a successful and rapidly growing business. Surely the challenge is enough. How could we manage and maintain the quality of the pharmacy while we were away? Anyway, at that time, the answer came to us by selling half our successful business to a trusted pharmacist husband and wife team.

The lady, Maree, the wife, had done her internship with us and managed the pharmacy extremely well whilst I was away for that initial three-month period. And I'm happy to say that this couple are still our dear friends, and they and others purchased our share of the pharmacy and the business in June 2007, which was where I finished being very much involved in the community pharmacy area.

So here we have two things happening at once. I've got a community pharmacy. I'm very much involved in the management of that, in the operation of that, including hands-on dispensing skills and a lot of management stuff as well. And at the same time, I'm able to use those skills in overseas work and in development-type situations, emergency situations. So they complemented each other, and I was very happy about that.

ROBIN: So you've talked about that transition from emergency response to development assistance. Yeah, absolutely, it requires different people, different approaches. But again, you're unusual in that you are both people. So you've done a lot of emergency response, but sometimes you've stayed well into what is really more a development assistance phase.

And in other places, I'm thinking for example, of Eastern Indonesia, Nusa Tenggara Timur, you've played a purely development assistance roles, also in Papua New Guinea. So I'm interested in I guess that aspect of your work. I remember that in Aceh you seemed to be very consciously approaching your emergency response work in development mode, thinking quite far ahead.

PHILLIP: That's right. Yes, that's another point. I mean the—anything that you do in an emergency response, you should be thinking longer term. I mean you don't implement things, you must think of the overall program and what are your aims for overall. So that does necessarily make you think past the initial phase.

But of course, as I've said before, many people can't think that way, and they can only think right in this emergency phase. So often it requires a change of staff. But I'm thankful that I'm able to—was able to have that role. And let me just go back a little bit too, after I came back and I worked, I worked in Thailand up until 1984.

And knowing the sort of the scene for overseas development work, that you needed pieces of paper. So I went and formalized the—what I'd learned in Thailand in emergency response, and in rehabilitation and development. I went and formalized that into a Master's degree in the UK at the Centre for Development Studies in Swansea, Wales, and Cardiff.

And so that was helpful. So that really formally set up the fact that I had a business. I could—and I had formal development-type qualifications, that I could have two jobs. Essentially that's what's been my life. I've had essentially two income generating jobs, having the pharmacy and in development work.

So I am extremely thankful, and I know very few people have had the opportunity that I've had. Because you see I've been able to remain independent. I haven't had to rely on another group being my employer. And this has enabled me to be quite flexible. I make conscious decisions because I had an income stream from the pharmacy.

I was then able to do doctoral research, because the scene was changing in the consulting world, especially developing countries weren't interested in bringing consultants who didn't have a doctoral degree because all of them were taught they need a doctorate. So I went and did the doctoral research, which I enjoyed very much.

But—and I learned things too that helped me more in technical matters with pharmaceutical planning and management. So these are the—and in the end I had three components to my pharmaceutical work, which was the academic, the public health consulting and the pharmacy, the community pharmacy dispensing and management work.

And I had that up until—essentially I retired, and now what's just remaining is the public health work that I don't need to have a license to do, if you know what I mean. Because when I sold the pharmacy, I gave up my license to dispense. So that's how I've been able to manage it.

And moving over to NTT was an interesting exercise. Purely development, and it was development at a very vulnerable time, which again, made me learn lessons that to do development well it's got to be an ideal climate for you to be able to achieve what you want to achieve.

In many ways, going to NTT was almost like a rehabilitation or a change time, because at that same time, the national government had recently decided to decentralize many functions, as you would know, the functions decentralized to the districts. And this essentially left the pharmaceutical sector at the provincial level disenfranchised and they weren't very happy, and there was a lot of clamoring to retrieve influence, and to carve out a niche to have influence in the districts.

But in NTT, it was also over the districts. So these created some interesting circumstances. The provincial health director at that time had very definite ideas, that anything the project must go through the province. And that curtailed some of our really chosen activities in the districts.

And the enormity of the change, thinking in change procedures that were needed, especially that decentralization and implementation mode required a much longer period than the usual donor-funded periods. And that's another lesson learned, is that—we can talk about these things later, but doing development is a bit like bringing up children.

It takes—and working with people. It takes lifetimes sometimes to do these things. And there are some—of course we all talk about when you have to have exit strategies and there's a whole lot of jargon about that. But at the end of the day, I think we have to make some very tough decisions about where we're going to support and where we're going to have perseverance and where we're going to go in for the long term.

That's just to me my personal experience. If we go in for short periods, then let's call it what it is. It's relief and rehabilitation. It's not development. And I'm very much for thinking positively about relief and rehabilitation, because it saves lives and it can change things for the benefit of vulnerable people.

So I think we've, all of a sudden, maybe even in the 80s and 90s, it became a dirty word to talk about relief and rehabilitation. But I'm not a believer in that. There's some very good examples of where—and you mentioned about me doing relief and rehabilitation with a development perspective, and I think that's extremely important.

And I think it can be done and it should be done more so that you truly can work and move over to a development mode when the climate is right and when you've got people around you who really want to change, who respect the changes that you're proposing, they themselves feel comfortable with the changes and more importantly, they have the authority to make the changes or to oversee the changes and they themselves don't feel threatened.

And so to do—to make these incredible changes that are needed, you need to have a very, very stable type environment. And again, in many of the projects, this is not—it's not easily found. It's not always there. So in NTT, we had to curtail our thinking, but we did achieve some very good outcomes. But of course I'm a bit of a—I'm enthusiastic and I like to see more change more quickly. But again, I have to keep on reminding myself it takes a long time to get these outcomes.

ROBIN: We'll break the discussion there. And in the second part of this podcast, we'll come back to a discussion of Phillip's work with the provincial government of Nusa Tenggara Timur in Eastern Indonesia. Meanwhile, you can read my written profile of Phillip Passmore if you go to the Devpolicy website, devpolicy.org, and search on "Aid Profiles", "Phillip Passmore". Thanks for listening.

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