ROBIN: This is the Development Policy Centre podcast, and I'm Robin Davies. This is part 2 of a two-part discussion that I had with Dr. Phillip Passmore. Phillip's a pharmacist who works in the Asia-Pacific, sometimes further afield, in emergency situations and also in development programs.

In the first part of our discussion, we talked about Phillip's work in Indonesia, particularly in the aftermath of the Bali bombings in 2002 and the tsunami in 2004. In the second part of our discussion, we talk mainly about his work in development programs, beginning with his work in support of the provincial health department in Nusa Tenggara Timur, in Eastern Indonesia.

We've talked in general terms about the difference between working in emergency response mode and in development mode, and we've talked about the fact that the two things often really do merge in practice. But I'm interested in the work that you did with the provincial government in NTT, in Eastern Indonesia. Could you perhaps say a bit about I guess the nature of the problems that you were dealing with and what sort of tactics you used to tackle them?

PHILLIP: We went to NTT to try to implement some of the issues that were identified in Aceh, and we wondered if there were similar—well we actually had some advice there were similar problems out in NTT. So when we got there, first of all we were incorporated as a sub-project of another larger project, and there was a delay in establishing the larger project's strategic plan.

So it really did make it difficult for us to work out what—how we would fit into that larger program. But we eventually became a sub-project of it. But because of delays and the absence of an overall strategic plan, some of the issues that we felt needed to be addressed were probably overambitious as the delay—the initial time that we had was short anyway, and that made things more difficult.

So it really made us focus that we were more in a rehabilitation-type mode rather than a development mode out in NTT. And that has cemented my views before, as I might have mentioned, that I think there are—there is this dovetailing, where you might have to introduce some relief type initiatives into a rehabilitation that can then maybe be developed into some more longer term development outcomes.

But the things we were working on is first of all, we looked at some policy issues, some legislation that governs the role of the management of pharmaceutical products in the province. And I mentioned before that the national government had just decentralized, had

passed legislation to decentralize many of the functions in the health center, right through to district level.

And this left the province really high and dry. They were left sort of disenfranchised, the province, in regards to their role, which before was a national to province to district type distribution and management, and there were different roles for each. Essentially the same roles, but it was a hierarchy of responsibilities and authority.

Well, the districts that were chosen in this project, they embraced the project enthusiastically because they needed a great deal of help because all of a sudden they were thrust into a situation where they had to do all the planning, organizing, leading and controlling of pharmaceutical services for their district.

So we had to—we helped them there to look at what all those issues entailed, and we tried to start with really good development principles such as what was the disease burden and what then would—what were the products that would be needed and in what quantities? So we had to look at population issues.

We had to look at what was the data that was available regarding disease. And to have some buffer stock as to what, depending on how long it took to replenish stocks. So the whole procurement and distribution, and storage systems, needed to be looked at, and the districts embraced these issues quite enthusiastically.

But the difficulties often were differences of opinion between people at the national level and provincial level and district level, as you can imagine. Because—as to what drugs and other healthcare products needed to be procured. There were some bad practices, I mean to say it frankly, where drugs that were not needed in the quantities that were seen to being bought, and so I can only assume there was some incentives to buy products that weren't needed.

But we tried to address some of those issues. And the biggest other issue was quantification. How do you quantify? How do you get people to quantify the amount of stocks needed related to replenishment time frames? And then of course how to store the products once they arrived.

So these are universal issues. I mean these are not specific to any particular country. You need to do—have ideas of how to manage these very important products, whether you're in this particular province or in the—at the national level. And at the same time, whilst we were in NTT, we had difficulties with redefining the work, what would be the role of the province?

And the province were not willing to give up a lot of their procurement and storage and distribution functions, although there were great problems in those areas because they had insufficient storage space. They had no budget for distribution. And some of the products, a lot of the products that they were procuring, were really not needed.

So we tried to encourage them to think of themselves as an emergency response level of responding to—in the pharmaceutical services sense, so that they would have, if you can imagine, extra antibiotic levels, extra intravenous fluid, stocks. And those items that were always in high demand and need to respond quickly to any human or natural disaster.

And we had some success in that, and we enabled storage stocks to be clearly identified as buffer stocks. But again, there was no budget for distribution, so these emergency stocks, if they were called upon, they had to rely on the districts being able to come and pick them up. And so—but at least we identified these particular issues.

The other problem that we had is many of the vertical programs, which often came with international donor funding, that seemed to be retained by the province. And there were difficulties associated with that. There seemed to be some stockpiles, and as I mentioned before, there was no budget to distribute a lot of these products.

So the districts were—they had to rely on the province distributing those products. And that needed to be addressed. And at the end of the project time, we had made some inroads into that, but it took—it was going to take some time, and we would probably need to get higher government involvement, higher political involvement to change some of the ideas of people who wanted to hold onto the power and authority that comes with managing pharmaceuticals.

Human resources was another area where—we wanted to develop human resources, and especially looking at what roles were—written job descriptions and aspects of how those job descriptions would be monitored, and how other people would be supervising. One of the biggest issues that we've come across, not only in NTT but in other development areas, is the whole area of supervision of human resources is lacking. And that causes lots of quality problems.

ROBIN: I wanted to ask about that. So you pointed to a couple of areas of similarity with the situation in Aceh, even though in Aceh we're dealing with the aftermath of a major natural disaster and there was nothing of that kind happening in NTT, even right down to the supply of unneeded medicines based on sort of shonky incentives. So that's interesting.

But there's two big areas of difference between the two contexts. You've talked about one, which is the power of the provincial government, and in principle that was greater in Aceh, even though the government had been decimated or worse. But the other was in fact, I guess that decimation. So in Aceh, you were moving into a situation where a large number of the staff of the provincial health service, were literally missing. Whereas in NTT, the people were there, but with variable capacity, variable quality. So—

PHILLIP: Very entrenched in their ways.

ROBIN: Yes. So in Aceh, you could step in and roll up your sleeves and build trust and gain influence by doing some of the work. But in NTT, how did you get in there and develop that sort of trust?

PHILLIP: Essentially by getting in and sitting down and listening to them and trying to identify what problems individuals had. The people who were supposed to run the program, what were their major issues? So building trust is absolutely important, and I have to say when the project finished, a great compliment that I felt was reflected, what I really, really tried hard to do along, was that I would listen and try to find a solution to their problem, not come in and—I could identify problems very easily, as most people could.

You could go in and identify. But I didn't want to just come in and say, "Well, if you do this, you do this, you do this. You might get somewhere." But I wanted to hear how they identified their problems, and then we tried to address those problems as much as possible. So it really pointed to the fact that you can't do development, don't even think of doing development until you have a very clear trust and understanding of the needs of each other, if you know what I mean, the partner and the donor, and the recipient.

And so I am very much a believer that—we often use the word partnership rather loosely, but that is a key thing, a key requirement if you want to have any success in these longer-term change of behavior requirements. And I just feel that this is where often to go in and identify a very clear relief issue, then you can identify so well, often, how people work and what they think.

But we didn't have that. We certainly had that in Aceh. We didn't have it in NTT. But I still wanted to sit down and listen. I felt it was absolutely necessary to sit down and listen. Now many projects start by going in and doing a what they call baseline surveys, as you know, but they're super expensive.

And in the end, you may or may not, it's not clear, that you'll get a clear outline of where projects need to focus. But by sitting down and listening to people and saying—doing your

job—first of all, identifying, get them to say what their job was, and then say, "Well, what's your problems? Do you have issues that prevent you achieving your goals?"

Then they would tell you and you say, "Well can anything be done?" And that's the way we tried to start. So we looked at whether the planning, as I say the planning, the amounts of medicines available, then what responsibility or what function did they have in procurement?

Often they had little function in procurement. So you get what you are sent from the national level. And then of course, what about how do you receive them? Is there good communication about when these products will arrive? And have you got sufficient storage? Have you cleared out older stock?

Have you got room for new storage, new products coming in? And so forth. Many issues. An inventory management program. And we tried them—we helped them with that. We helped them with developing simple Excel files, with stock control aspects of it. And that helped in the—at the province level anyway.

And we tried also to implement that at the district levels, but that had other problems, which we don't need to get into now. But certainly listening and responding to their needs. And at the end of the project, the people were most appreciative that we would discuss and often we could come up with a solution to some of the major problems that they were having.

ROBIN: So I'm interested in I guess how 'helping' looks. In development agencies like the former AusAID, a sharp distinction, an unrealistically sharp distinction, is made between capacity building and in-line assistance. So when you talk about working, to some extent, in relief and rehabilitation mode, that puts me in mind of in-line assistance. So what was the balance there? How much did you actually have to simply do somebody's job versus advising them?

PHILLIP: Well, that is, again, a development of trust. I mean that question that you've asked is a—we could take a whole interview answering those issues. As a consultant in NTT, it's very difficult to achieve a lot. Whereas in Aceh, we could achieve a lot more because in many ways people coming directly to me and I was able to make decisions about certain things because there were—but all the time, working alongside my colleagues.

But I was able to support them by saying, "Well, you should do this," or "It's possibly best if you do this." And I was respected there as a person who was looking after their interests. Whereas in NTT, of course, I was just one of the consultants who assist in helping them. So it's a lot of advice and sometimes that advice is not taken because what clearly needs to be

done may not be suitable because there are many ingrained, entrenched procedures or scenarios that won't allow that change to occur very quickly.

For instance, one of the things we did have success in was the warehouses. One of the major warehouses in NTT was absolutely chock-a-block with products that were well and truly out of date. And so valuable warehousing space. You can hear the similarities, can't you, with getting donated goods.

But anyway, there were—the warehouses were full of these out-of-date products. But I and others were able to convince the management that it was good to dispose of these products in an ecofriendly way and make room for new stock. So one of the issues is that the procedures for destroying old stock was just not known.

I mean nobody knew what the government required. So people would come from the national level to do audits of medicine, and often I think they counted and recounted, and often over a great period of time, counted a lot of this product that was just out of date and had been out of date for a long time.

So that was a great advantage of responding to a problem at the local level, that they had no room to store new medicines when all this stock is there. And we were able to give shelving. We were able to give generator support, those infrastructure things that you just can't store medicines without a proper infrastructure.

And so that was also helpful. Of course you can get criticized for assisting with infrastructure because people say, "Why would you do that?" If you're interested in having a system that works, this is why I say you have to have this balance between things that you have to spend money on and not be too pedantic about whether you're saying this is relief or this is development.

For instance, in other situations I was working with—I was actually in Northeast Thailand where you have to spend money to work on the sewage system from houses. Now there are many people who said, "Oh, well that ought to be done by this government or this group, or this group, or this group."

In the end, people were getting cross and there was so much argument going on. And leadership requires sometimes you come in and say, "We've got to do this." One of the things in NTT was to get a good refrigerator so you can actually store some of the valuable vaccine products that need to be kept between 4 and 8 degrees, and to have a generator backup system where it kicks in if the power goes off, as it did regularly, and to make sure

that these products were kept and could be monitored to be kept between the manufacturer's required temperatures to keep these products viable.

ROBIN: Yeah, and I guess being able to solve what are really small problems like that which can't be dealt with within your counterpart system is also part of the process of building trust and credibility.

PHILLIP: Absolutely, building trust.

ROBIN: So just the last question on your work there in NTT, I mean I guess I have the same feeling that I did in relation to your work in Aceh, which is—where was everybody else, both at the time and over the preceding years? I mean as you worked in the provincial health department, did you see many traces of what were presumably the many other donor programs that had been supported in the health sector there?

PHILLIP: This is an extremely important question. I'm—to answer your question, when I was in NTT, what I looked at, I could not believe that donor agencies had been working there for the last something like, nearly 20 years I believe. Very difficult to see what was the outcome of that. Because I saw the pharmaceutical problems, the pharmaceutical service problems that we had were so much part of deficiencies in the overall health sector management plan, or lack of, it was just not there.

And there—well, there was some sort of plan, but what I'm saying is there wasn't an incorporated health sector management plan. And many of the deficiencies definitely, in the management quality of the pharmaceutical/medical supply sector, mirrored the deficiencies in the overall health sector.

And I couldn't work out how health programs could be implemented, like maternal and child health, and women's ministries and education programs, related to the health sector, how they could be worked out unless you had an overall management plan.

And for instance, the difficulty you have is that if you go in and there's a technical person, like you want to solve cold chain management, if you want to solve how to do quantification of requirements based on a disease burden, you can't do those things if there is no overall sector management plan because you can't do it just for one little group.

And I'm a believer that some essential programs that I feel would have helped a great deal of development in any particular province or district is that first of all, donors fund those irreducible minimum standards. I mean you need to have a—for instance, good data management.

You have to get good statistics. I don't know how many baseline surveys have been done in a lot of these districts or provinces, where it seems that it would have been great to have organized with the particular health authorities and say, "Let's all work together to build a good health services plan and also have good data management so that any group that could come in could buy that data and it would be obligatory that their data dovetailed into that."

And as their particular inputs progressed. And there are other examples of where you'd have like provincial-based data management or district-based management that would dovetail together so that you could go in, any group could go in and immediately know what the situation's like and then say, "Well, at least we know where we can respond, in a shorter period of time."

Well, that made—going into a province and trying to address some of the pharmaceutical issues was always going to be just difficult in the absence of these—this sector management plan. And unfortunately, in NTT, there wasn't a lot of evidence that there was plans, a lot of plans in place.

ROBIN: I want to move onto a broader question, which you have already touched on. You've worked in a lot of different countries, Papua New Guinea, I think all of the countries of the Mekong Basin, Indonesia, a little bit in China and even Southern Sudan right at the beginning. So in all of these contexts, have you tended to come across similar problems?

Yousaid there are certainly some universal issues that you always find yourself dealing with. Or do you really have to—I guess it's really more around the responses. Do you have to tailor your responses to circumstances or have you developed sort of a template over the years, a set of tactics that tends to work?

PHILLIP: Well, one of the issues with the pharmaceutical sector, we have universal products, you know what I mean? Ampicillin, amoxicillin, flucloxacillin. They are the same whether you're in Timbuktu or in Timor. And all these products need to—they have a, as I say, irreducible minimum standards of how they need to be stored, managed, distributed, used.

So whether or not you're from a very, very, very poor environment, you do need to keep your vaccines between 4 and 8 degrees centigrade. And you can't tolerate, as I've heard, often that people say, "We're very poor. We don't have this. So don't blame us for having our vaccines at 16 degrees, 20 degrees," as I've seen quite often.

The issue is there. I'm not being critical of these communities, because they struggle, struggle, struggle. But what I've been trying to promote all around these countries that

you've mentioned is that first of all, to recognize as professional pharmacists and health sector workers, we have to say, "This product needs this management."

It's like if you're diagnosing some illness, as our medical colleagues have to do, they can't—there are minimum standards, and so they have to follow those minimum standards as is managing the products to treat these diseases need minimum standards. And these minimum standards have been developed over many years.

So even though we're in—wherever we are, we know that these products need this management. So you don't have—so the problem is often not technical. That's the issue I'm saying. It's not technical. Everybody knows that the vaccine needs to be refrigerated. Now the issue that the electricity is only on for six hours a day, and that happens to be between 6 pm and midnight, the fact that there's no kerosene to use the wonderful UNICEF-supplied vaccine refrigerators.

So it would be better if we only have short supplies of electricity to use the kerosene to run them. But you see they don't run them because it takes a lot of work to trim the wicks and to manage—for them to run. And then there's not enough kerosene. There's no budget for kerosene, or the kerosene's been stolen to cook food at home.

There are many, many issues of integrity and many issues of human resources that need to be managed. So everywhere I've gone, these human factors are the same. And I mean this is not saying that in Australia or anywhere else we've got it all together, by no means, but these are issues that are often overlooked in development projects.

The simplistic thing is to say, "Oh, they need more training. There's a lack of knowledge." Things that people think they can put a budget line on. But I feel that there needs to be much more sophistication and partnership between donors and recipients to say, "We recognize these issues and we have proper strategies to address them."

And the issues in fact are not just technical. For instance, pharmacists like myself, I go in there and I recognize that the refrigerators are not being kept, and so the vaccines are not kept well. So at the end of the time, by the time the vaccines are to be used in an immunization program, it's very difficult for anybody to sign off and say, "Well, we can guarantee that the vaccines are of top quality and we know that, given everything else being equal, an immune response will develop from these vaccines."

Which should be the case. So you need to have a much broader understanding of issues of integrity and issues of why, if there is only electricity for six hours a day, if you can't correct

that, therefore we have to have another strategy. And if there's people at that level, the professionals have to call for help.

This is where you need good journalists around the place too who can actually help you make some issues and say, "How can we keep vaccines at a good—at the proper requirement if we don't communicate it?" See what I mean? So it becomes very much more complicated than we are often told that development is. More training, more this or that. But in fact, it's not anywhere near that simple.

ROBIN: So in a lot of the countries where you've worked, obviously from what you say, the problems that you've faced have come from outside the health sector. Some are to do with the structure of government, intra-governmental fiscal relations, whatever that might be. Some are to do with poverty, leading to the theft of kerosene for the vaccine fridges.

Some are to do with corruption and so forth. So looking across all these countries where you've worked, I don't want you to nominate your worst country, but I'd be interested in what was your best experience, where you think your assistance was able to be used most effectively because the broader environment was conducive?

PHILLIP: Well without doubt, I mean in Aceh we were able to reestablish pharmaceutical services. So that's a great outcome. In a short period of time, the things were—drugs were being procured, they were being stored and they were being distributed to the health centers and to the hospitals.

And I think that's a good factor. One of the other issues, like in Bali after the bomb, it's very clear when you get people who have a focus, we can achieve a lot of things in a short period of time when people are stimulated to cooperate. So I feel that development can occur, and it's where there is a good partnership, as I say, between donor and recipient, where the recipients are up-front and they say, "These are our problems. These are our difficulties. Can you help?"

Rather than donors coming in and saying, "Well, we've got a bunch of money, a bucket of money. What can we do to do things?" So there's got to be a genuine partnership with how do you improve the lives of people? And that's certainly where, like in Aceh for say, and in other places I've been to, where there is a genuine understanding of our role as professionals in the health sector to improve the lot of the people.

Then you can achieve a great deal. It doesn't mean to say it's all beer and skittles. It's not. But where you've got that partnership and that commonality, and just enthusiasm to see less deaths of neonates and less deaths of women in childbirth, and where you want to see

no—and be able to be confident that the products that are being used are of high quality, and that the vaccines that are used, I can sign off on them, that I can guarantee that the supply chain, from the manufacturing, has been intact.

And they're just great things to be able to do. And whereas now in other places, you can't do that because there's just not that enthusiasm by people involved in these programs. So to get back to the point, I'm not sure whether I would want to do work in areas where there wasn't that commonality and that enthusiasm to see change.

And I know more now than I did in my earlier years, that in areas where I could recognize that development wouldn't …, if there was a real need, I'd still do relief-type programs if there was a lot of need. I'd do relief, but have shorter-term goals and just hope that by doing some relief and rehabilitation you then may be able to work into a more comprehensive and longer term change of practice and generally make things better.

But again, all the time, if I go into areas, I'm looking how can I, in the short term or in the longer term, really change the way, or just change factors for people who need our help but also change the ideas of people who are working in the system?

ROBIN: You've also worked with a lot of international development agencies, obviously the former AusAID, which has since been integrated into DFAT, and you've worked with WHO, the World Bank, World Vision and UNICEF, lots of others. Now I'm conscious that you may well continue to work with some of these agencies, but I'm interested, I guess particularly in the question of health systems strengthening, which is really what you're all about.

All of these agencies talk about the fundamental importance of strengthening health systems and not just dropping specified products into those systems. Even the big vertical funds now have a strong focus on this. But what's your actual experience? Looking across a number of contexts in which you've worked, are these organizations actually moving in that direction, and how could they do that better?

PHILLIP: Well, I—without doubt, the increased funding that's come from the Global Fund and Gavi has obviously brought a great deal more assurance in financing for health programs, especially as they're focused on HIV/AIDS, malaria, TB control and childhood communicable diseases. And I think that's wonderful, so I'm not at all critical of that approach.

My only problem is these are often, they're big international programs that don't have a great deal of understanding of what it's like in district A, district B, which probably are in remote areas where—or part of this province where there is, as we've mentioned before,

there are problems with the whole management system rather than just in the health system.

And so my take on this is that health system strengthening is an essential part of any program, and certainly in the programs I've worked with, health systems' weaknesses across the whole sector have contributed to problems for a long time. And we have programs coming to, for instance, reduce neonatal deaths, or improve the lot of women in childbirth, or TB.

But the programs, just by looking at the macro—at the national level, working with national governments, unless there's some pressure by the Global Fund, or Gavi, or similar groups like that, Clinton Foundation, if there's not a focus in saying "We want to look at your program of how you're going to ensure that the assistance we give in either getting vaccines into your country or drug products, pharmaceutical products, to treat these diseases, or to prevent these diseases. Can you tell me how it's going to look like right down to the operational level where people/patients actually receive these medicines?"

Because that's the only point. People often forget that the only way you treat malaria is where a doctor or another diagnostic person is taking a blood sample and checking it. And then there's drugs available to do it. I mean we often forget that. And I've sat in many high-level meetings, and it just strikes me that most of the people there have actually never seen a person suffering from malaria or TB, or whatever.

And so I suppose I've had the good fortune of being right down at this operational level and knowing what it's like when there's no medicines there. But at the same time, knowing that in a warehouse maybe 20 or 30 kilometers away, it's up to the rafters in medicines. So I feel that we've got to be honest and say, "Unless our—these medicines and these products are available across the board in all these areas, we're not doing the best we can." We have to do better than that.

ROBIN: I guess another one of these development agency terms, or pieces of jargon, is "sector program", this slightly mythical idea that all of the donors to a particular sector, under the leadership of a government, all play their parts in beautiful coordination.

Now have you seen anything beginning to resemble that in your area of work, where perhaps you've got substantial financial inputs from the Global Fund and you may have a few bilateral donors doing some of the more fiddly work, or supporting some of the more fiddly work? Such as your own work right down at the district level. Has that worked well anywhere in your experience?

PHILLIP: I haven't been the recipient of Global Fund money in my work. I have worked with people, as a consultant, who themselves, their areas have Global Fund money. But it's a little difficult for me to say but often the indicators used, possibly necessarily by these large, large macro groups, they don't reflect what the situation is right on the ground.

And so I suppose I use the rather maybe—I was going to say derogatory, but it's not derogatory—but they're tick the box indicators. "Do you have this in place?" "Yes." "Do you have that…" for instance, "Do you have standard treatment guidelines? Do you have essential drug lists? Do you have a national pharmaceutical policy, drug policy?" "Yes."

But there's not any question, "Are they working and are they working in parallel or are they integrated?" So I mean I've worked in countries where you can have fairly comprehensive standard treatment guidelines but then you find out that the essential drug lists are developed independently.

And so people/practitioners on the ground really can't comply with the standard treatment guidelines because the drugs aren't available or there are—on the other side of it is that the essential drug list has got a lot more drugs that the practitioner might feel is better than what's on the standard treatment guidelines.

But if you look at the indicator, "Did you have standard treatment guidelines?" "Yes." "Did you have essential drug lists?" "Yes." It would give the wrong impression. And this is what I've found so often. But to see the way I'm talking is actually not popular. If I got into a discussion with a group of professionals, they would say I'm a cynic, but I'm not a cynic at all.

I just know that unless it's—this is why I keep going back to the thing I said about supervision. Unless there's really genuine supervision, a supervision model, where practitioners who often in very poor conditions, remote areas, unless you're really sure about these areas, there could be 50,000, or 60,000, or 100,000 or more people who are missing out on your brand-new program to improve these things. You see what I mean?

So every life matters, as I say. I think we've got to give more credibility, more focus to being sure that if we have these funds, which are wonderful, are they doing all that they can, all that can be done? And like malaria, every malaria death, you have to see as a failure. Because we can treat malaria, we can solve the malaria problem.

But there's still lots of malaria deaths. That's all I'm saying. I mean if a child dies of tetanus or another preventable disease, how shocking is that? Because it's a failure in the system.

But we don't use the word failure. That's another thing I find is that you can't say it as it is. And political correctness is rife.

Like WHO does some wonderful work. I'm absolutely, really endorse what they do with their development of standards and the overall work that they do. But because it's an international grouping, they can't say it as it is. Because that's not acceptable to be able to—you can only advise and support and encourage particular member governments.

You can't. Things that not just have, for instance at the moment, this antimicrobial resistance program, or the emergency response to artemisinin resistance. These are issues that affect the whole globe. And because of our global village, if you've got bad practices in one country, in no time at all it has adverse effects in the other.

So we have to recognize that the bad management of pharmaceuticals, which end up with antimicrobial resistance, or if you've got—supposedly got a good immunization program in a country, yet at the same time you know that the vaccines, nobody will sign off on the vaccine and say, "I can guarantee that this vaccine's been kept—manufactured to start with, and then kept in a manner which has preserved its efficacy."

And if you have a communicable disease outbreak somewhere else, it soon has adverse effects in another country as well. So I feel that we've got to get more serious in being able to say, "Here's some big problems." And we see that in the Greater Mekong region where you have real problems in Myanmar and in Cambodia, in Laos, and not so many problems in Vietnam and in Thailand, and in China.

So here we've got these Mekong countries that border the river, and big variations in their ability to cope with problems. And I feel that we've got to just say that—and therefore we work very hard to help those groups to help each other. And it's a start, and then we—other donor groups can get in there and help them to sort out problems which really affect the whole region and the globe.

Because if we have artemisinin resistance that's developing in those countries, or antimicrobial resistance generally, developing in those countries, then for goodness sake, the whole globe has got a real, real problem. So why aren't we working? Why aren't we seeing a lot more cooperation occurring in between numbers of donors to solve these problems? And that's where I feel that we're letting the side down a bit.

ROBIN: So the impression I get from hearing you talk about your experience in a number of places is that while these international development agencies can be effective at the national level,

especially at the policy level, in terms of standards and a range of other things, the problem is really when you're dealing with a level of government that's closest to the ground.

PHILLIP: That's correct.

ROBIN: And in those situations, it does sound like you've often found yourself to be Robinson Crusoe.

PHILLIP: That's right.

ROBIN: So I guess this leads me to the next and more general question. You've had a lot to do with aid practice over several decades, and I suspect you've had experiences, both good and bad. I just thought it would be good to give you a chance to reflect on how aid agencies could work more effectively in general to achieve greater impacts.

PHILLIP: Well I did touch, I think, on some of the issues that have come across. Good question, difficult to answer sort of thing. But I think the way that funds are developed, development funding is automatically political because it's government's decision as to how much we give and where we give.

So given that, that's natural and normal, but we have to make sure that the political goals, I think, and the technical goals of health development programs are not mutually exclusive. So that's one area where I've seen that is important. I mean in some areas it might be politically astute to do some intervention.

But technically, it's either difficult or there just may be a lack of human resources on the ground who can actually do it, then you have to work out what's more important. Is the political goal going to win the day or are some technical goals able to be developed?

And I've been in areas where the—where a particular human resources, or lack of, or particular people who are in authority or power, they are such stumbling blocks to development occurring. So possibly a good decision would be to say—to promote some people to "inactive posts", as is the term used in a country in Asia, which I love.

Some people need to be promoted to inactive posts, and then you would see a lot of development could occur with a change of human resources. But so I think you've got to really work out what are the major hindrances to development? What has caused a problem in the first place?

Why is there high infant mortality? Why is there serious problem with maternal mortality? It's actually interesting. You get a mix of different reasons. But if you really want to make a difference, you've got to know exactly what's—what is the problem in the first place. And sometimes it's not technical. A lot of times maybe it's not technical. It's not as if people don't know what needs to be done. And it could be political or just a lack of integrity of workers. So then if you can address what the real issues are, a lot more can be done.

ROBIN: You talked earlier about the way projects tend to be run by development agencies in discussing your experience in NTT. You talked about having to work within really quite a short-term timeframe, being unable to do anything until a strategic planning document was completed, and so forth. Given your experience working within projects of that kind, how would you like to see donors change the way they approach particularly support for district-level administrations?

PHILLIP: Well, going back a little bit, the—I feel that the donors ought to be really more professional in deciding where is their theater of influence or interest. And be active in creating—it goes back to strengthening the health sector, but if you're a donor and you are interested in a particular area, why not establish some partnership group where, for instance, professional data collectors, think tanks, so that you could go to these groups and say, "What's the situation?"

So a lot of programs, I think, are started where there isn't enough intelligence. There's not enough knowledge as to what's going on. So if you don't establish a long-term think tank about development, say for instance, Australia and Papua New Guinea or Australia and Indonesia, which would be—you would hope that there are organizations which are feeding information to development agencies and to donors within these countries.

"This is the situation – why we've got higher than normal, than would be expected cases of TB, in one group, in one province or another." You can actually find out all this data. You'd say "Well is it a technical problem? Is it just a lack of—overall lack of resources?

Is it human resources related? Is it practices of the people? Is it a cultural issue? You actually have that knowledge. And I find it very typical sometimes to find any of this type of data and understanding that's within the development agencies themselves. And so I suppose I would be wanting to see more intelligence, more knowledge.

Now if you can't have that, then you respond in a relief mode. For instance, if it's really people are suffering. In the interest, as I said before, of enhancing people's lives, I would be going in looking at a short-term/medium-term relief type program. You can establish medical clinics, or you can work alongside local people to enhance their work.

In the pharmaceutical sector, that can involve all the steps of a pharmaceutical service. You go in there and you learn by doing. You learn by being there. And you get to learn a whole lot of stuff. So you're developing this body of knowledge and you then get to understand that these are certainly areas where unless people change their minds, these workers change their minds or the recipients of medical care.

If they don't change their minds, then it's an uphill battle. I just go in and I see tons and tons and tons of resources used in what they call training. Now I have a particular problem with this because so much of this training that's done is in the absence of any policy. So you find out, well, what is the goal of this training, so-called training?

Nothing. Nothing's expected. Nothing's expected of the people to change their lifestyle or their mode of operation. And so I actually like to call it what it is. If it's just information sharing, and of course often there's a need to give people options of how you can respond to particular problems.

That's information sharing, and you can do that. But if you're talking about training, and if you look through—I've looked through many project proposals, and a big chunk of money always is related to training. But they're training on this and training on that and training on that.

But you find there's no policy. The government, the local government or the—whether it be national, province, district, they have no policy about that. So what is the use of that? Because if the governor hasn't signed off on a law or a decree to say that, "We will introduce this stuff," and then training people in response to the policy, you're not going to get anywhere.

That's what I find. And so that's one area where I'd like to see how to work more effectively is at least being honest and saying, "Information sharing is one thing, but if you're talking about training, it's got to be a policy and a requirement for people to change practices." That's pretty simple to me.

ROBIN: So yeah, it seems there are some really strongly competing incentives here. So development agencies like to retain a lot of flexibility around the allocation of resources, so they don't want to tie them up for too long. They also like to be untroubled by detail. And what you're suggesting I guess pushes the other way, that agencies should be investing in some quite fiddly work to really understand the problems they're dealing with.

They should be patient and willing to invest for longer periods of time or else, if they're going to be short-term, they should really more explicitly operate in quasi-relief mode. So it's—yeah, it's—

PHILLIP: Say what it is. Back in the 80s, there was this switch immediately. Most people were quite happy and satisfied to talk about their work being relief. But that became a dirty word and a no-no. So in no time at all, everybody that was doing relief's now doing development. But in actual fact, so much of what's now called development, at best is relief, and it may not be good relief because it hasn't been planned as relief.

Relief is not relief done where there are entry and exit strategies and where you can actually measure that we've saved this many lives by doing it. And at the same time, using that time to gain some intelligence and knowledge as to whether or not you could say, "We can now work with this group or that group and put into practice a longer-term operation."

ROBIN: Yeah, that's very interesting, and it complements something that people are saying all the time now that in a lot of relief situations what is really happening, what is really needed, and what's really happening is development programming around some of the long-term refugee camps in Africa and the Middle East.

PHILLIP: That's right. Refugee camps—relief, I'm talking even six months. For instance, in the refugee camps, if things hadn't stabilized within six months, you could be accused of not doing your job. But if as it's become a stable-type population, and then very quickly in those situations, because it's a new environment, you can actually start working on development quite quickly.

I mean we developed human resources up in Ban Vinai refugee camp to do a lot of work. There was a lot of gardening going on, a lot of vegetable production, food production. Certainly water and sanitation programs were in place that would be suitable for any village to have. So I think there's just got to be clarity as to what the outcomes are in a period of time.

ROBIN: That's where we ended the discussion. You can read more about Phillip in my written profile if you go to the DevPolicy website, devpolicy.org and look for "Aid Profiles" and "Phillip Passmore". Thanks for listening.

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