WHEC UPDATE

Briefings of worldwide activity of Women's Health and Education Center (WHEC)

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Before & After Issue

Our annual Before & After issue, perhaps more than any other issue through the year, reaffirms our belief in possibilities. We focus on – Drug Donations – in this edition of *WHEC Update* and in ***WomensHealthSection.com***. Drug donations are pharmaceutical agents given to countries or health facilities at no cost by nongovernmental organizations (NGOs), other countries, private corporations or groups of donors. The donations may be made for different purposes, such as providing assistance during emergency situations, supply specific medicines over the long term or recycling drugs (e.g. donating leftover drugs just before they expire if a clinic purchased more than it actually needed). Drug donations can do more harm than good for the recipient countries in many instances. We must ensure that drug donations are driven by strengthening the structures and systems for the recipient countries. This will improve adherence to the drug donation guidelines. Disaster-related donations are less likely to comply with the guidelines, particularly in terms of meeting the recipient's needs, quality assurance and shelf-life, packaging and labeling, and information management. The immediate effect of excessive, unorganized donations is to overwhelm the aid workers of the recipient country and can make it difficult for them to inventory, store and handle the drugs. Donations that exceed local needs require large amounts of storage space, with a resulting risk of improper storage and of occupying space that could be used for shelter. After the disasters, many excess drugs received by the recipient countries are either destroyed or kept in health facilities for later use, but the costs invariably are not covered by the donors. One of the examples of improper storage and its tragic consequences is – following the Sri Lankan tsunami in 2005, extra storage space in Colombo was rented and the Ministry of Health had to bear all costs for the transport, storage and handling of the donated medicines. There is evidence suggesting that in Sri Lankan improper storage of an anesthetic agent left over from a donation in 2005 led to contamination with *Aspergillus fumigates* and to the death of three pregnant women who contracted nosocomial meningitis after receiving spinal anesthesia for cesarean sections. The cost to the recipient countries of destroying leftover drugs after the tsunami amounted to US $ 26,039 in Sri Lanka (2007) and US $ 3,420,000 in Aceh, Indonesia (2005). Furthermore, many times donated drugs discourage local drug production and development.

Acts of charity, though always worthwhile, can be complicated. World Health Organization's (WHO's) drug donation guidelines were developed to help countries manage drug donations. However, recipient countries should formulate their own national drug donation guidelines to avoid receiving unnecessary medicines. Countries in need of drug donations should provide a list of medicines as recommended in their guidelines, along with a list of any financial or human resources needed to store, transport or dispense the medicines. Recipient countries could also publicly request cash rather than drug donations. Guideline implementation could perhaps be improved by providing recipient countries with a mechanism for declining donations. Countries that accept donations should require that any unused or unusable portion of the donation be removed from their territory and properly disposed of by the donor. To better plan for receiving actual donations, countries could perform "virtual" donation exercises as part of their disaster preparedness activities. Good coordination among donors is a feature common to most successful donations. To avoid being burdened with unnecessary or unusable medicines, donation recipients could demand that donors work together or through coordinating NGOs. Donors consistently ignore the WHO's drug donation guidelines indicating that the donor should bear the costs of sorting, storing, distributing and destroying products donated in excess. By having to cover these costs, donors would become more aware of the problems faced by the recipient countries and strive for better coordination. Using locally-produced medicines should be

the priority; advising the media not to issue requests for medicines, and discouraging donations from individuals to avoid receiving expired, unsorted, open or partially used products is recommended. Strengthening the structures and systems required for the coordination and monitoring of drug donations, which should be driven by recipient need rather than by charitable intentions, will improve adherence to drug donation guidelines.

Compliance with Drug Donation Guidelines
Rita Luthra, MD

Your Questions, Our Reply

Can drug donations do more harm than good for the recipient countries? Are there any drug donation guidelines?

Drug Donation Guidelines: Drug donations are intended to provide the medicines needed to alleviate suffering, yet drug donations often generate problems. For example, the donated drugs may not meet the needs of the recipient and donor countries / agencies and may fail to comply with local procedures for approving, labeling, storing or inventorying medicines. The donated drugs are often also labeled in a language foreign to the recipient population, they may fail to meet the quality standards established by the recipient country or may even have expired. It can be a financial burden on the recipient country. If the donated drugs have a high declared value, import taxes and overhead costs may be high; if the quantity of the donation is larger than required to meet the recipient's needs, the recipient may have to bear the cost of properly disposing of the excess. To avoid being burdened with unnecessary or unusable medicines, donation recipients could demand that donors work together or through coordinating with non-governmental organizations (NGOs). Good coordination among donors is a feature common to most successful donations. Countries that accept donations should require that any unused or unusable portion of the donation be removed from their territory and properly disposed of by the donor. The most frequently reported problem linked to disaster-related drug donations is a failure to meet the needs of the country. The other most frequently reported problem with disaster-related drug donations is improper labeling and insufficient information to identify and use of the drugs.

In 1996, the World Health Organization (WHO), in collaboration with major international agencies active in humanitarian relief, issued guidelines aimed at reducing the problems that are often linked with drug donations. Because the guidelines were developed from the standpoint of providing aid to countries who are in need of drugs, the donations are guided by four core principles: They must be: (1) of maximum benefit to the recipient; (2) given with respect for the recipient's wishes and authority; (3) free from any double standards in product quality; and (4) provided through effective communication between donor and recipient. The 12 articles of the guidelines on drug donations are based on these four principles. The guidelines are applicable to both emergency and long-term donations. WHO guidelines require a shelf-life of at least one year or, in exceptional cases, of at least one-third of the drug's total shelf-life at the time of donation. For details: WHO *Guidelines for drug donations* (see below).

We suggest; coordination among different donation programs is important. Long-term programs target overlapping areas, mostly in Africa. On the surface drug donations are appealing because they satisfy the human drive to help those in need. Donors are generally well intentioned and genuinely believe in the importance and value of their donations. However, they need to realize that donations are not always in the best interests of the recipient countries. While the needs of the donor may be met, the needs of the recipients often go unsatisfied.

About NGO Association with the UN

UN Partner on Millennium Development Goals (MDGs)
A Gateway to the UN System's Work on MDGs

United Nations Fund for International Partnership – UNFIP
Addressing Global Challenges

The United Nations Office for Partnerships serves as a gateway for partnership opportunities with the United Nations family. It promotes new collaborations and alliances in furtherance of the Millennium Development Goals (MDGs) and provides support to new initiatives of the Secretary-General. UNOP provides Partnership Advisory Services and Outreach to a variety of entities, as well as managing the United Nations Fund for International Partnerships (UNFIP), established by the Secretary-General in March 1998 to serve as the interface in the partnership between the UN system and the UN Foundation, and the United Nations Democracy Fund (UNDEF), established by the Secretary-General in July 2005 to support democratization throughout the world.

Established by the Secretary-General in March 1998, the United Nations Fund for International Partnerships (UNFIP) serves as the interface in the partnership between the UN system and the UN Foundation - the public charity responsible for administering Ted Turner's $1 billion contribution in support of UN causes. In 1997 Ted Turner announced a $1 billion pledge to support UN causes and set up the UN Foundation to administer the gift. In turn, the Secretary-General established UNFIP as the central interface with the UN Foundation. In making his historic contribution, Mr. Turner paved the way for other foundations to engage with the UN and in the process spurred a multiplier effect that has enabled the Office for Partnerships and the UN to attract and foster additional partnerships. Through UNFIP, funds mobilized by the UN Foundation are channeled to the UN system, for implementation of projects focused on Children's Health, Women and Population, Environment, and Peace, Security and Human Rights. To date over US $1 billion has been programmed for 450 projects implemented by 39 United Nations entities in 123 countries.

Objectives and Structure:

In accordance with the relevant sections of the agreement between the United Nations and the United Nations Foundation, Inc., as well as the earlier concept paper concerning the gift of Mr. Turner, the Secretary-General established an advisory board to assist him in his review of proposals received by UNFIP for funding by the Foundation.
Unless otherwise decided by the Secretary-General, the UNFIP Advisory Board is responsible for the following functions:

1. To provide broad policy guidance to the Secretary-General and monitoring of the operations and activities of UNFIP;

2. To advise the Secretary-General in the review of project proposals, particularly with regard to the appropriateness of the projects to be proposed by the United Nations to the Foundation for funding and support, as well as the capacity and capability of the United Nations system to deliver the outputs and results proposed in such project proposals. In this regard, the Advisory Board shall:
    - Assist the Secretary-General in such review in the light of criteria established by the United Nations and the Foundation for approval of such project proposals, such as urgency, effectiveness, innovation, forward-looking orientation and availability of funding from other sources.
    - Consider unity of focus and technical compliance with United Nations aims and objectives;
    - Assist UNFIP in ensuring that project proposals to be funded and supported by the Foundation are in conformity with the goals, policies, aims and objectives of

the United Nations, in particular with the goals and objectives of the Agenda for Development and recent United Nations global conferences, and that they take full account of programming mechanisms, such as national development plans and priorities, country strategy notes and United Nations Development Assistance Frameworks;

- Ensure that project proposals to be funded and supported by the Foundation are in conformity with the orientation of the Secretary-General's reform program;

3. To contribute to identifying projects and activities that are suitable to be funded and supported by the Foundation, based on new developments and factors that may arise from time to time. The Secretary-General, having received the advice of the Advisory Board, decides on projects and activities to be proposed to the Foundation for funding and support. e management oversight and administrative services to the Fund's operations

Collaboration with World Health Organization (WHO)

WHO Guidelines for Drug Donations

These Guidelines for drug donations have been developed by the World Health Organization (WHO) in cooperation with the major international agencies active in humanitarian relief. The first version was issued in May 1996 and represented the consensus of WHO, Churches' Action for Health of the World Council of Churches, the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières, the Office of the United Nations High Commissioner for Refugees, OXFAM and the United Nations Children's Fund. In 1999 the number of co-sponsors expanded to include Caritas Internationalis, the International Pharmaceutical Federation, Pharmaciens Sans Frontières, UNAIDS, the United Nations Development Program, the United Nations Population Fund and the World Bank. The Guidelines aim to improve the quality of drug donations, not to hinder them. They are not an international regulation, but are intended to serve as a basis for national or institutional guidelines, to be reviewed, adapted and implemented by governments and organizations dealing with drug donations.

The original Guidelines were based on several rounds of consultation and comments by over 100 humanitarian organizations and individual experts. In 1996 WHO was requested by the World Health Assembly, in resolution WHA49.14, to review the experiences with the guidelines after one year. In autumn 1997 WHO's Action Programme on Essential Drugs therefore initiated a global review of first-year experiences. The results of the review are presented in the forthcoming document First-year experiences with the interagency guidelines for drug donations. The evaluation formed the basis for the changes in the text. In general, experiences with the Guidelines were very positive. But there were complaints that the authorities in some recipient countries strictly adhered to the Guidelines, without regard for the exceptions specifically included, and as a result useful donations were lost. For example, problems were reported with Guideline 6: "donated drugs should have a remaining shelf-life of 12 months upon arrival in the recipient country". However, the problems arose from misunderstanding of or failure to refer to the stated exceptions to that guideline, rather than from the text of Guideline 6 itself. In this revised edition Guideline 6 has been modified. It now allows for direct donations of drugs with a remaining shelf-life of less than one year to specific health facilities, provided assurance can be given that the drugs can be used prior to expiration.

There are many different scenarios for drug donations. They may take place in acute emergencies or as part of development aid in non-emergency situations. They may be corporate donations (direct or through private voluntary organizations); aid by governments, or donations aimed directly at single health facilities. And although there are legitimate differences between these scenarios, there are many basic rules for an appropriate donation that apply to all. The

Guidelines aim to describe this common core of “Good Donation Practice”. This document starts with a discussion on the need for guidelines, followed by a presentation of the four core principles for drug donations. The guidelines for drug donations are presented in Chapter IV. When necessary for specific situations, possible exceptions to the general guidelines are indicated. Chapter V gives some suggestions on other ways that donors may help, and Chapter VI contains practical advice on how to implement a policy on drug donations.
Details: http://whqlibdoc.who.int/hq/1999/WHO_EDM_PAR_99.4.pdf

Bulletin of the World Health Organization; Complete list of contents for Volume 89, Number 7, July 2011,

Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Poverty and Time

We examine the measurement of individual poverty in an intertemporal context. Our aim is to capture the importance of persistence in a state of poverty and we characterize a corresponding individual intertemporal poverty measure. Our first axiom requires that intertemporal poverty is identical to static poverty in the degenerate single-period case. The remaining two properties express decomposability requirements within poverty spells and across spells in order to reflect the persistence issue. In addition, we axiomatize an aggregation procedure to obtain an intertemporal poverty measure for societies and we illustrate our new index with an application to EU countries.

Time is an important aspect of individual lives. Experiences are accumulated over lifetimes and the assessment of the impact a poverty spell has on a person's situation may very well differ according to what happened to the individual in previous periods. The index of intertemporal poverty that we propose aims at including experiences in addition to the incidence of poverty and inequality among those who are poor when measuring poverty. The results of our simple application to EU countries show that a very different picture can emerge when we value individual experiences. Clearly, we do not claim that our index is the only plausible measure of intertemporal poverty, just as no one would, we believe, declare the Gini coefficient to be the only possible choice as a tool to measure income inequality, to the exclusion of all other measures. However, we view our proposal as an attractive option and we think the properties used in its characterization have some strong intuitive appeal.

We restrict attention to the intertemporal aggregation of per-period overall poverty in this paper. Clearly, our approach can be modified easily in order to obtain measures of chronic poverty based on the idea underlying our new index. For instance, any particular definition of chronic poverty can be accommodated by adding a duration criterion and declaring an individual to be chronically poor if there is at least one poverty spell of at least that duration and then perform the aggregation over individuals by calculating the arithmetic mean of the poverty values only of all those satisfying this criterion. Further work could be done by performing statistical inference with the index we propose and by considering the possibility that poverty spells are censored when estimating intertemporal poverty.

Publisher: UNU-WIDER; Authors: Walter Bossert, Satya R. Chakravarty and Conchita d'Ambrosio; Sponsor: UNU-WIDER gratefully acknowledges the financial contributions to the project by the Finnish Ministry for Foreign Affairs, and the financial contributions to the research program by the governments of Denmark (Royal Ministry of Foreign Affairs), Finland (Finnish

Ministry for Foreign Affairs), Sweden (Swedish International Development Cooperation Agency—Sida) and the United Kingdom (Department for International Development—DFID).

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page http://www.womenshealthsection.com/content/cme/)

Constitution Of The World Health Organization

(Continued)

CHAPTER XVII – AMENDMENTS

Article 73
Texts of proposed amendments to this Constitution shall be communicated by the Director-General to Members at least six months in advance of their consideration by the Health Assembly. Amendments shall come into force for all Members when adopted by a two-thirds vote of the Health Assembly and accepted by two-thirds of the Members in accordance with their respective constitutional processes.

CHAPTER XVIII – INTERPRETATION

Article 74
The Chinese, English, French, Russian and Spanish texts of this Constitution shall be regarded as equally authentic.

Article 75
Any question or dispute concerning the interpretation or application of this Constitution which is not settled by negotiation or by the Health Assembly shall be referred to the International Court of Justice in conformity with the Statute of the Court, unless the parties concerned agree on another mode of settlement.

Article 76
Upon authorization by the General Assembly of the United Nations or upon authorization in accordance with any agreement between the Organization and the United Nations, the Organization may request the International Court of Justice for an advisory opinion on any legal question arising within the competence of the Organization.

Article 77
The Director-General may appear before the Court on behalf of the Organization in connexion with any proceedings arising out of any such request for an advisory opinion. He shall make arrangements for the presentation of the case before the Court, including arrangements for the argument of different views on the question.

To be continued……

Top Two-Articles Accessed in June 2011

1. Medical Liability: Current Status and Patient Safety;
   http://www.womenshealthsection.com/content/heal/heal018.php3
   WHEC Publications. The Women's Health and Education Center (WHEC) with its partners in health, has developed this curriculum which will enable and encourage medical schools and healthcare providers to include patient safety in their courses. This four part series on Medical Liability is funded by WHEC Initiative for Global Health. If you wish to contribute please contact us.

2. Medical Liability: Risk Management;
   http://www.womenshealthsection.com/content/heal/heal019.php3
   WHEC Publications. The Women's Health and Education Center (WHEC) with its partners in health, has developed this curriculum which will enable and encourage medical schools and healthcare providers to include patient safety in their courses. This four part series on Medical Liability is funded by WHEC Initiative for Global Health. If you wish to contribute please contact us.

From Editor's Desk

Selection of Essential Medicines

Essential medicines are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness. The 16th is the current Model List of Essential Medicines, prepared by the WHO Expert Committee in March 2009 and revised after the Emergency Session of the Expert Committee on the Selection and Use of Essential Medicines in March 2010.

WHO Essential Medicine List: The Model List is a guide for the development of national and institutional essential medicine lists. It was not designed as a global standard. However, for the past 30 years the Model List has led to a global acceptance of the concept of essential medicines as a powerful means to promote health equity. Most countries have national lists and some have provincial or state lists as well. National lists of essential medicines usually relate closely to national guidelines for clinical health care practice which are used for the training and supervision of health workers. The 17th WHO Expert Committee met in March 2009 to produce the following lists: 16th WHO Model List of Essential Medicines and 2nd WHO Model List of Medicines for Children. These two lists have then been updated in March 2010 after the Report of the Supplementary Meeting of the Expert Committee on the Selection and Use of Essential Medicines which took place on 15 January 2010.

WHO Model Formulary: Since its first publication in 2002, the WHO Model Formulary has become an indispensable source of independent information on essential medicines for pharmaceutical policy-makers and prescribers worldwide. The Formulary is the authoritative guide on how to make effective use of the medicines on the WHO Model List of Essential Medicines, and the 2008 edition follows the structure and sections used in the List. For each medicine the Model Formulary provides information on use, dosage, adverse effects, contraindications and warnings, supplemented by guidance on selecting the right medicine for a range of conditions. The aim is to improve patient safety, and limit unnecessary medical spending.
Essential Medicines Lists

Words *of* Wisdom

He that is down, needs fear no fall
        He that is low, no pride;
He that is humble ever shall
        Have God to be his guide
I am content with what I have,
        Be it little or much
And, Lord, contentment shall I crave
        Because Thou savest such
Fullness to such a burden is
        That go on pilgrimage
Here little and here after bliss;
        Is best from age to age

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities