Drug donations must be strictly regulated

Georgia has tight guidelines

EDITOR,—The economic and social structure of Georgia has deteriorated since independence in April 1991. The government continues to struggle with the change to a market economy and is under pressure because of falling living standards.¹ The official health care system is deteriorating and becoming increasingly dependent on humanitarian aid, including pharmaceutical donations. Despite the existence of clear guidelines, such as those of the Christian Medical Commission² and World Health Organisation,³ large quantities of expired or inappropriate drugs are found among the donations from various donors, including humanitarian organisations, pharmaceutical industries, and governments.

In 1994 one humanitarian aid organisation received, without prior notice, 20 tonnes of silver sulphadiazine ointment, which had expired one year before. The quantity was so large that it took months to incinerate. During a recent visit to one of the government's warehouses Médecins Sans Frontières recorded 12 tonnes of unnecessary or expired drugs. About 9 tonnes had expired before arrival or was due to expire within three months of arrival.

In July last year the donation of a big shipment of short acting insulin that arrived three days before the expiry date prompted the Ministry of Health to formulate an agreement concerning donations of pharmaceutical supplies. By signing this agreement organisations working in Georgia commit themselves to a version of the WHO's guidelines on donations of drugs, which have been adapted to the Georgian requirements. These ensure that medicines that are brought into the Republic of Georgia are on Georgia's essential drug list; are from a reliable producer (the WHO's certificate must be enclosed); arrive in Georgia at least one year before their expiry date; are labelled with their generic (international non-proprietary, or INN) names; are labelled in the Georgian or Russian language; have not already been issued and returned to a pharmacy; are in unimpaired packages (no loose tablets or blisters); and are given with guarantees of continuity.

Donors should know that the donation of inappropriate or expired drugs causes more harm than good. It is encouraging that some governments, as in Georgia, develop policies on donations

of pharmaceutical supplies. These initiatives should be supported.

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- 1 United Nations Department of Humanitarian Affairs. *Situation report 2, Armenia, Azerbaijan, Georgia. 1 August-30 September 1994*. Geneva: UN, 1994.
- 2 Christian Medical Commission. *Guidelines for donors and recipients of pharmaceutical donations*. Geneva: World Council of Churches, 1990.
- 3 The use of essential drugs—model list of essential drugs. *WHO Tech Rep Ser* 1992;825:13.

Assortment of drugs causes more problems than it solves

EDITOR,—It is estimated that between 5% and 40% of the drugs that are sold in pharmacies in western Europe are not used.¹ Although the legal framework in the European Union prohibits the collection and export of drugs that have been issued to patients and returned to pharmacies, practice shows that there are many loopholes in the legislation and control.

Several non-government organisations have carried out public campaigns to promote the collection of unused drugs for humanitarian purposes, with slogans such as "giving an unused drug will save the life of a child in the Third World." Thousands of people are involved in drug donations through non-government organisations. Unselected drugs continue to be sent to Africa, Asia, and eastern Europe. Long experience with these donations has shown that the distribution of unused drugs that have been collected is inappropriate.

Inappropriate drug donations have led to many problems. In 1994 the World Health Organisation's office in Zagreb issued a press statement urging potential donors to "think before you send."² A large part of the donations was unusable or even dangerous. Last November a Dutch team from Médecins Sans Frontières stationed in Djibouti was confronted with an epidemic of cholera after flooding in the region. The team received a donation from a French non-government organisation which contained more than 100 kinds of unsorted and partly expired drugs collected in France. The mixture contained antidiarrhoeal drugs such as loperamide and kaolin. Twelve co-trimoxazole tablets were the only drugs in the box that could be considered to be of potential use in the epidemic. No oral rehydration solution or intravenous fluids were included.

Last year a Dutch non-government organisation proposed to study the possibility of collecting and distributing unused drugs for humanitarian purposes. After questions in parliament the Dutch minister of health and the minister for development cooperation clearly stated that the collection of unused drugs is not acceptable according to the WHO's guidelines, to which the Dutch government subscribes. Whether the Dutch position will be a trigger for stricter enforcement remains to be seen.

The public also needs to receive this message. In the past, several Dutch humanitarian non-government organisations have collected unused drugs. Although their policies changed long ago, they still get regular requests from the public to

accept or give unused drugs that have been collected.

The situation in Europe is far from perfect, and it would be worth while if other governments followed the Dutch policy. Professional organisations should take a similar position. Humanitarian non-government organisations should adopt a written drug policy based on the provision and rational use of essential drugs obtained from a reliable source.

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- 1 Pour une Information Médicale Ethique et le Développement. *Les médicaments non utilisés en Europe: recueil, destruction et réutilisation à des fins humanitaires*. Paris: PIMED, 1994.
- 2 World Health Organisation. *Think before you send*. Zagreb: WHO Regional Office for Europe, 1994. (Press release.)

Hospital acquired infections could still be prevented

EDITOR,—P J Sanderson correctly states that many local hospital acquired infections arise because of interventions such as urinary catheterisation or tracheal intubation and infers that infection rates reflect the number of patients subjected to these procedures. Sanderson concludes that these infections are inevitable and not so amenable to conventional infection control. We have a wider view of the role of infection control in reducing hospital acquired infection.

Firstly, infection control is not simply a matter of preventing cross infection. Promoting good practice, such as encouraging the removal of urinary catheters, falls within the remit of the infection control team. This has an impact on the "irreducible minimum" rate of hospital acquired infection. As an example, Haley *et al* showed that rates of pneumonia and urinary tract infection fell in hospitals with good infection control programmes but rose in those with ineffective programmes.²

Secondly, while it is true that infections may arise from the patient's bacterial flora, the organisms responsible are often more resistant or virulent ones acquired by the patient through cross infection in the hospital. Recent outbreaks of respiratory infection due to *Staphylococcus aureus* resistant to methicillin have highlighted this problem.³ Infection control measures such as antibiotic policies, handwashing, and isolation can prevent the emergence and spread of these organisms.

Thirdly, though the concept of an irreducible minimum level of infection is readily understood, it is hard to define or quantify.

To assume that observed rates of hospital acquired infection are close to this minimum risks complacency and lowering of standards. In a recent policy document, the Department of Health estimated that "currently 30% of hospital acquired infection could be prevented."⁴ Clearly, the irreducible minimum is some way off for most hospitals.

Advice to authors

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