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Field Study: Haiti

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Introduction

Background on Haiti

Haiti, with a population of 7 million, is located between the Caribbean Sea and the North Atlantic Ocean. It is the poorest country in the hemisphere (75 percent of the population lives in poverty), with a per capita income in 1995 of US\$190. The literacy rate is approximately 20 percent.

Since the country's independence in 1804, the political situation has been chronically unstable, dominated by nondemocratic governments. The first free elections in 1990, which brought to power Father Jean Bertrand Aristide, were overturned by a military coup in September 1991. The international community, after three years of sanctions against the country, intervened militarily in July 1994 to restore the elected democratic government. The elections for the presidency in December 1995 brought René Garcia Preval to power.

Haiti's new democracy is facing many challenges. It has to implement economic reforms in order to obtain badly needed foreign aid and improve its ability to attract foreign capital. Haiti currently depends heavily on foreign aid; according to the report issued by PAHO/WHO on the 1996 health situation in Haiti, 75 percent of the government's total health expenditures in 1995 (\$70.6 M) were funded by international aid.¹

Another challenge for this government is to improve regulation of the manufacture, quality control, and distribution of drugs. This need became critical in the summer of 1996 when the country experienced an epidemic of acute renal failure among children under age five. After

months of investigation with the help of international agencies and the FDA, two syrups manufactured in Haiti were identified as the cause. Contaminated with diethylene glycol, they provoked the deaths of at least 85 children.² In response to this incident, the Ministry of Public Health and Population created a task force to report on the poisoning, to make proposals to improve the control of drugs in the country, and to prepare a national pharmaceutical policy.

According to a PAHO/WHO report, there are 663 health institutions in Haiti: 49 hospitals, 61 centers with beds, 139 centers without beds, and 405 dispensaries. The public sector represents only one-third of the institutions, and the nonprofit private or mixed (under contract to the government, with some staff on government pay) comprise approximately two-thirds of the country's health resources. The latter serve an estimated 50 percent of the population. There are few private clinics, most of which are located in the capital. With regard to the main health problems, the PAHO/WHO report provides the following information:

- The major causes of morbidity are infectious, transmissible, and parasitic diseases.
- The primary reasons for medical visits are infectious respiratory diseases and diarrhea.
- Malnutrition and diarrhea are the principal factors in infant mortality (ages one to 59 months). At the age of five, 41 percent of the children are growth-impaired.
- Of the urban population aged 18 and older, 13 to 15 percent suffer from high blood pressure.

For additional basic health statistics on Haiti, see the report from PAHO/WHO.

Limitations of the field study

This study was designed to provide preliminary findings in order to better understand the uses and impacts of private drug donations in Haiti and potential impacts of implementing the WHO *Guidelines*. It was carried out in a week and is based on a limited number of interviews and limited access to recorded information on donated drugs from the health facilities and the in-country NGOs interviewed. Because of these limitations and those noted below, this study is not intended to give a full and comprehensive picture of these issues, a fact that should be considered in

any use and interpretation of the findings, especially regarding the robustness of the conclusions:

- The geographic area covered in the interviews was concentrated around the capital city of Port-au-Prince; six of the nine health facilities interviewed are located in Port-au-Prince or, at most, 120 km from the capital.
- The study focuses primarily on donations involving private US sources; the health facilities (except for the public hospital) and the in-country NGOs selected receive 75 percent to 100 percent of their donated drugs from private US donors.
- The informal sector, as well as the public primary healthcare centers without physicians, are not covered in this study.
- The respondents' lack of awareness about the WHO *Guidelines*, and the limited amount of time available during the interview to study them, influenced the respondents' reactions.

Profile of the Interviewees

From May 26, 1997, to May 30, 1997, 15 face-to-face interviews (one to two hours long) were conducted in Haiti: nine at health facilities (one public and eight private or mixed nonprofit institutions); one at the Ministry of Public Health and Population (MSPP); one at the warehouse of PROMESS; three at in-country PVOs; and one at an NGO. The institutions selected are either major players in the Haitian health sector (MSPP, PROMESS, the public hospital, and the association of NGOs) or they receive 75 to 100 percent of their private drug donations from the United States (the eight private or mixed nonprofit health facilities and two of the in-country NGOs). The names of the facilities and persons interviewed are all anonymous in this report.

The health facilities

Six health facilities were located in the Port-au-Prince area or, at most, 120 km from the capital, and the interviews were done onsite. Three health facilities were located in other parts of the country, and the interviews were done offsite in Port-au-Prince. All the private (four) or mixed (four) nonprofit health facilities interviewed are affiliated (some formally, some informally) with a religious institution in the United States. Table 7.1 provides data on the nine health facilities interviewed in this study.

T A B L E 7 . 1

Profile of the Health Facilities Interviewed

Facility No. and Type	Data per Year	1996 Total Budget (\$US)	% Drug/ Total Budget	% Purchased/ Donated Drugs	% US Donations/ Sources of donations	Services Provided
No. 1 Private	124 beds 5,436 admissions 94,004 outpatient visits 3,426 surgeries 200,000 covered population	NA	NA	80 20	75 percent/ from abroad, from international agencies	Internal medicine, pediatric, OBGYN, maternity, surgery
No. 2 Private	120 beds 3,600 admissions	214,286	25	70 30	90 percent/ from abroad, from international agencies	Internal medicine, pediatric, OBGYN, maternity, surgery polyclinic
No. 3 Private	10 beds	164,286	NA	85 15	90 percent/ from abroad, from international agencies, from in-country health facilities	Primary care/ prenatal care
No. 4 Private	80 beds 1,440 admissions 420 surgeries 100,000 covered population	105,810	NA	75 25	100 percent/ from abroad, from international agencies	Internal medicine, pediatric, OBGYN, maternity, surgery, ophthalmology
No. 5 Mixed	80 beds 161,000 covered population	120,000	NA	85 15	100 percent/ from abroad (only individual carriers), from international agencies	Internal medicine, pediatric, OBGYN, maternity, surgery
No. 6 Mixed	120 beds 2,607 admissions 90,000 out patients visits 900 surgeries	500,000	25 percent	75 25	80 percent/ from abroad (only individual carriers), from international agencies	Internal medicine, pediatric, OBGYN, maternity, surgery, ophthalmology

T A B L E 7 . 1
Profile of the Health Facilities Interviewed (continued)

Facility No. and Type	Data per Year	1996 Total Budget (\$US)	% Drug/ Total Budget	% Purchased/ % Donated Drugs	% US Donations/ Sources of donations	Services Provided
No. 7 Mixed	70 beds 2,607 admissions 21,000 outpatients visits	NA	NA	99 1	100 percent/ from abroad, from international agencies	Internal medicine, pediatric, OBGYN, maternity, surgery
No. 8 Mixed	72 beds 20,250 admissions 78,000 outpatients visits	NA	10 percent	90 10	80 percent/ from abroad, from international agencies	Tuberculosis and other respiratory diseases
No. 9 Public	557 beds 8,918 admissions	NA	NA	95 5	NA/ from abroad, from international agencies, from in-country health facilities	All services except psychiatry

NA= not available

Approximately two-thirds of the health facilities offer primary, secondary, and tertiary care. One is specialized in respiratory diseases, and one offers mainly primary care services. All of the facilities also have some kind of community health/family planning programs.

At the private or mixed nonprofit health facilities, the director of the hospital (Facilities No. 2, 3, 4, 5, 6, 7, 8) and/or the person in charge of procurement (Facilities No. 1 and 3) were interviewed. At the public hospital, the pharmacist was interviewed. For Facility No. 2, the US president of the private voluntary organization (PVO) that supports it also took part in the discussion. When possible, the pharmacy/drug warehouse of the health facility was visited (four of the six onsite visits).

The health facilities studied purchase between 60 and 80 percent of their drugs at the Programme des Medicaments Essentiels, or PROMESS. Some also buy drugs from local companies, and from the Dominican Republic, Europe, or the United States. The source of the remaining drug volume is private donations. The percentage of drugs donated from private sources ranges from 1 to 30 percent, with an average of 5 percent. The US donations for the private and mixed facilities represent 75 to 100 percent of their donations.

The countries from which drug donations originated are not well defined for the public hospital. At the time of the visit, however, the pharmacist reported that 40 percent of the pharmacy's donated drugs were obtained from France or its overseas departments (Martinique and Guadeloupe).

The in-country NGOs

The three in-country NGOs³ interviewed are located in Port-au-Prince (NGOs No. 1, No. 2 and No. 3). Their mission is to help the weakest, poorest, and most vulnerable populations. Two are religious organizations with representatives in other countries and activities beyond those related to health. The third is a local nonreligious organization specialized in health. The directors of these organizations were interviewed. For NGO No. 2, two people involved in the health program also participated in the discussion. Table 7.2 provides data on these three in-country NGOs.

The association of NGOs

This association represents most of the NGOs in the Haitian health sector (approximately 100 organizations). Its technical director was interviewed. The involvement of this organization in drug donations is very limited, and no detailed information was collected on this issue. The

TABLE 7.2

Profile of the In-Country NGOs

NGO	Activities	Donations
No. 1	<p>Manages privately owned or governmental health facilities: two health centers with beds (10), one hospital (37 beds), and four dispensaries.</p> <p>Participates in vaccination, anti-diarrhea, and nutrition programs.</p> <p>Covered population: 329,300.</p>	<p>Donated drugs represent 10 percent of total volume of drugs.</p> <p>100 percent from one American donor.</p>
No. 2	<p>Helps 39 religious health facilities in two parts of the country.</p> <p>Participates in programs such as health-nutrition, child survival, and food for progress.</p> <p>Activities in health, nutrition, education, social work.</p>	<p>Very limited volume of donated drugs.</p> <p>100 percent from one American donor.</p>
No. 3	<p>International religious charitable organization with 250 religious medical centers in Haiti.</p> <p>Activities in health and agriculture.</p> <p>Humanitarian aid for development.</p>	<p>Each medical center may have its own sources of donated drugs.</p> <p>The information on drug donations is not centralized.</p>

interview focused on the profile of the health facilities in Haiti. This association plays the role of a coordinator and provides technical help for its members. This organization is presently building a comprehensive data base on all health facilities in Haiti.

PROMESS

The Programme des Medicaments Essentiels (Program of Essential Drugs) was set up in 1992 by PAHO with humanitarian funds. It is a permanent distribution facility for essential drugs and medical supplies. PAHO/WHO assumes the legal, technical, and administrative responsibility for PROMESS, with a management committee bringing together the main figures in the Haitian health sector (including governmental and nongovernmental representation) as well as UNICEF and major foreign donors (Canada, the United States, and the European Union). The director was interviewed over the phone, and the consultant who assists him was interviewed face-to-face.

PROMESS offers more than 300 products, including drugs, medical supplies, syringes, x-ray equipment, and small surgical instruments. The facility is seeking to become Haiti's sole medical supplier, offering institutions a range of goods for all their requirements. The prices set by PROMESS correspond to cost plus 10 percent to cover operational expenses. The standard list of drugs utilized by PROMESS is based on the WHO Model List of Essential Drugs (WHO-ML), the 1995 Haiti EDL, and some adaptations to address the specific needs of the country.

The institutions eligible to buy at PROMESS (public, nonprofit mixed and nonprofit private) are initially provided a free stock of drugs. PROMESS then stipulates that the revenue from sale of these drugs should be used to buy new stocks from PROMESS. All subsequent drugs from PROMESS must be purchased at cost plus 10 percent. This system is called a cost-recovery system. Those drugs that have been donated to PROMESS are excluded from the cost-recovery system. Currently, 504 institutions are supplied by PROMESS.

The Ministry of Public Health and Population

The minister and a consultant who participates in the task force on Haiti's new health policy were interviewed at the Ministry of Health (MSPP: *Ministere de la Sante Publique et de la Population*). Information on drug regulations, in general, and on drug donations, in particular, was collected.

Description of the Current Donation Process

Regulations for drug donations: role of MSPP

Although Haiti's new democratic government is now looking at different issues regarding drug policies, including drug donations, MSPP has little control over drug donations. MSPP defines itself as being in a "transition" phase. Currently, there is no organization or entity in Haiti controlling the quality of manufactured, purchased, or donated drugs in the country.

A new bill regarding drugs and pharmacies has been prepared and was voted on in the fall of 1997 by the parliament. The legislation included a requirement for authorization from MSPP for all drug donations, and donations will have to follow the WHO *Guidelines*, which may be adapted later to reflect the realities of the country.

According to the minister of health, MSPP supports the Essential Drugs Program of PROMESS, and the listing of drugs prepared by PROMESS has become the defacto essential drugs list for Haiti. MSPP sees the current drug donations as uncontrolled and of questionable

quality and appropriateness for the needs of the population. It also feels that drug donations interfere with the Essential Drugs Program in two ways: The donated drugs are usually not from the PROMESS list, and they do not follow the practice of cost-recovery. Indeed, donated drugs are often given free to the patients. The opposition to drug donations may also reflect the desire of this ministry to regain control over the activity of the religious private nonprofit health organizations in Haiti, viewed as “a state within the state” (quote from NGO No. 3).

Interviewees reported that since the summer of 1996 (when the incident of diethylene glycol contamination became public), the control of drug donations has become more strictly enforced through Customs, using a tax-free policy for humanitarian aid (generally referred to as “the franchise”). Before the summer of 1996, this tax exemption was guaranteed for public and private/mixed nonprofit health institutions on any goods they received. Two interviewees even mentioned a booklet of pre-issued exemptions. Since the summer of 1996, the process of obtaining the franchise has been made more difficult, with stricter control of the expiration dates of the drug donations (expired products are confiscated) and an increased bureaucracy. Previously, MSPP issued an agreement for exemption after looking at information on the shipment. But now, after reviewing the shipment and requiring more comprehensive information such as expiration dates of the drugs, MSPP passes the file on to the Ministry of Finance. This ministry releases the authorization after verifying that the institution has paid all taxes related to its activities. For some institutions, the franchise means no tax at all (mostly for nonprofit mixed institutions), while others have to pay a variable percentage of the value of the shipment (mostly for nonprofit private institutions). The value of the shipment is evaluated by its weight or by the monetary value estimated by the donors.

Sources of drug donations, actors involved, and logistics of the shipments

Health facilities

There are three main sources of donated drugs for health facilities: (1) drugs that come from abroad through individuals/churches/PVOs; (2) drugs from in-country health facilities; and (3) drugs for health programs from international organizations.

Donated drugs from abroad through individuals, churches, and PVOs. Private drug donations can be received by health facilities by container ship, by air, or by individual carriers (missionaries or health workers). All the

private nonprofit health facilities interviewed for the study have an office or representative in the United States that has some kind of involvement with drug donations. This involvement ranges from providing the list of needed drugs to potential drug donors or those who are planning to go and work at the hospital, organizing the transport of donated drugs that are sent by air, and informing the facility when a container has left the United States for Haiti.

Interviewees indicated that the request for needed drugs is typically made by the nonprofit health facility, more specifically, by the director of the hospital after consultation with the medical director. A list of “always needed drugs,” which is updated every six to twelve months (depending on the facility), is generally sent to the US office. In addition to this list of needed drugs, more urgent requests can be made through the US office. To make drug donation requests, six out of the eight nonprofit health facilities also use the list sent by some US-based PVOs. This list describes the drugs they have available for donation.

According to the hospital’s pharmacist, the public hospital interviewed receives drug donations through the hospital’s central administration. The hospital does not always know the sources of the donations, but sources that were mentioned included the French Antilles and health facilities in Haiti. (The hospital has an exchange program with these French overseas territories.) It also reported receiving drugs from one PVO abroad. This hospital has not set up a formal process for drug donations like the nonprofit institutions. Instead, it utilizes a list of “always needed drugs,” contacts abroad, offices abroad, and other avenues. The drug donations are received and coordinated by the central administration of the hospital.

Donated drugs sent by boat. The nonprofit private and mixed health facilities interviewed usually receive shipments of donated drugs by boat two to four times a year. Donated drugs are usually sent directly from donors to a consolidator warehouse in the US. There the donated drugs are collected, packaged in a 20- or 40-foot ocean freight container, and shipped when the container is full. A container may include drugs, as well as other components such as food, medical equipment, and electrical appliances. A container may also be shared by more than one hospital in Haiti. The drugs that are sent by boat come from various sources such as US-based PVOs, churches, hospitals, and individuals.

The facilities reported that donated drugs sent by US-based PVOs are usually (but not always) requested by the facility based upon a list of

available drugs sent by the US-based PVOs. The request is usually made by the director of the health facility, with the help of the medical director. Occasionally the facilities may receive a fax or call from a US-based PVO about drugs that are available for immediate shipment, or about a container of various drugs that is already sealed and ready to leave. The facility managers noted that generally this kind of container must be accepted with its full contents in order to be received. In this case, the health facility usually does not receive any detailed information on the donated drugs.

Usually four to six months elapse from the time the drugs are made available by the donor or requested by the health facility to the time they arrive at the hospital. This long period of time is required to fill the container, ship it, and clear it at Customs in Haiti with the franchise.

Based upon the interviews, there does not seem to be a systematic procedure by which health facilities learn about a shipment that is due to arrive or that is already in the harbor. Prompt notification depends on how well organized the health facility is on this issue. They can learn about a shipment from their US office, from the consolidators, from their office in Port-au-Prince (if they have one), or finally from Haitian Customs. Sometimes a shipment arrives and the facility has not been notified of its arrival.

To clear a container through Customs and organize its transport from the harbor to the hospital, the person in charge of procurement, typically the administrator or the director, has to go to the docks in person. To save the trip and the time required to clear the shipment, some health facilities hire a broker to do the job.

Donated drugs brought by individual carriers. Health facilities No. 5 and No. 6 also receive donated drugs carried by individuals such as missionaries, health workers, visitors, or others who are coming to work for a certain period of time at their health facilities. In addition there are also some individuals who visit Haiti and, at the same time, want to help hospitals. They donate drugs during their onsite visits.

The health professionals who come to Haiti to work at the health facility reportedly collect the drugs from different sources, such as pharmaceutical companies (some companies have a special program to donate drugs for health workers who go to work in developing countries) or their own personal stocks of drug samples. They are requested to bring drugs from the list of "always needed drugs" or drugs that they use in their specialty. They bring the drugs to Haiti in their luggage. This kind of shipment

may be as frequent as once a week. The trips of health workers coming to work at the health facility are organized by the US office of the health facility. However, interviewees noted that the visits of these individuals who carry donations to a health facilities are often not known in advance.

Donated drugs sent by plane. Donated drugs sent by plane come from various sources, including individuals, PVOs, and churches. These donations are usually received and coordinated by the US office or representative of the facility. An airline, called Missionary Flight, specializes in the transport of supplies for health facilities in Haiti. In most cases these drugs are in response to an urgent request or could not be sent by boat because of their expiration dates or because the container has already left for Haiti.

These donated drugs are picked up by a representative of the hospital at the airport. The facilities indicated that clearing the boxes through Customs seems faster at the airport than at the harbor, and the entire process appears easier logistically if donations are shipped by air. The whole process takes from two to four weeks, from request or arrival at the US office until the drugs reach the hospital

Donated drugs from in-country health facilities. Health facilities No. 3 and No. 9 also reported receiving drug donations from other health facilities within Haiti. Health facilities that receive drug donations from abroad in quantities too large to use before their shelf life expires or not useful for their needs sometimes give them to other facilities.

Donated drugs from health programs of international organizations. Drugs that are part of international health assistance for Haiti (for example, USAID, UNFPA, UNICEF) are donated, without any fee, to public and private nonprofit health facilities through PROMESS.

PROMESS

The only drugs that are accepted as donations by PROMESS are those donated by international institutions such as UNICEF, UNFPA, or USAID for national health programs. Some are bought directly by PROMESS with the financial aid of these organizations, and others are bought by these international agencies and given directly to PROMESS. These drugs, which are given to health facilities free of charge, cover three areas: (1) child health and reproductive health (that is, contraceptives, vaccines, vitamin A), (2) maternity/child products (iron, folic acid), and (3) tuberculosis drugs. These drugs, which represent about 66 percent of the total volume of drugs at the PROMESS warehouse, are stored at the ware-

house in Port-au-Prince and distributed to public and private/mixed nonprofit health facilities.

The drugs donated by PROMESS to health facilities follow the same quality standards as the purchased drugs (international standard of quality, at least one year on expiration dates, and so forth). This type of international agency donation in Haiti is not discussed further in this report, inasmuch as the research is focused primarily on drug donations by private donors (with particular attention to US donors).

In-country NGOs

Among the three in-country NGOs interviewed, two are closely involved with drug donations. NGO No. 3 is not directly involved in the drug donation process of its 250 health centers around the country. Each center may have its own network of donors from abroad. Unfortunately, we were not able to interview any of these health centers.

The two other NGOs (No. 1 and No. 2) each obtain their donated drugs from only one US-based PVO. (US-based PVOs provide drugs for free not only to Haiti but also to other developing countries.) For both of these in-country NGOs, the drug donations are sent by boat. The shipments generally contained not only drugs but also medical supplies, infant formula, and cleaning supplies. NGO No. 1 receives drug donations approximately three times a year, while NGO No. 2 receives only one shipment every one or two years, usually in small quantities.

Both institutions send a list of "always needed drugs" to their US-based PVOs. For every shipment available, NGO No. 1 receives from its US counterpart a list of available drugs and can choose among the various items listed. This list describes the generic names, the dosages, the brand names, the numbers of units, the expiration dates, and the donor companies. After each order, a fax is sent from the US-based PVO to NGO No. 1 with the list of drugs to be donated. NGO No. 1 has to approve the list, and it also must certify to the US-based PVO that the drugs requested are approved for use in Haiti and could be fully utilized within the given expiration dates. NGO No. 1 also commits to sending a report to the US-based PVO detailing the distribution of all donated drugs. In return, the US-based PVO ensures that the drugs meet the international standard of Good Manufacturing Practice. Prior to each shipment, the US-based PVO sends a detailed packing list to NGO No. 1 that specifies the contents of each shipment. NGO No. 1 then distributes the donated drugs according to the needs of the 39 health facilities it manages. The needs are assessed by the medical director of the organization.

For NGO No. 2, the US-based PVO requests a description of the health facilities that will benefit from the drugs (number of patients, pathologies found in the area, and so forth), as well as a description of the activities of the in-country NGO. For its 1997 donations, the US-based PVO also asked for some success stories of previous drug donations, accompanied by pictures. The drugs donated are packaged for each facility directly by the donor, and are identified with the name of the facility and the contents of the package. Each drug is described with the NDC number, the quantity, the brand name, the generic name, the expiration date, and the price in dollar value. In addition to this kind of shipment, NGO No. 2 reported periodically receiving a phone call or a fax from the US-based PVO about drugs that are available for immediate donation.

Characteristics of the donated drugs

General characteristics

For drug donations, the private or mixed nonprofit health facilities are looking for two types of drugs (the public hospital interviewed did not express a need for private donations). First, they want drugs that meet their basic needs and that can be bought at PROMESS (as part of the essential drugs program) or elsewhere. According to the eight health facilities interviewed, these drugs fall into the following categories: anti-infective drugs (injectable antibiotics, oral, and topical), analgesics, anti-inflammatory drugs, cough suppressants and/or decongestant drugs, and vitamins. Two-thirds of the hospitals interviewed that offer secondary and tertiary services also mentioned cardiac drugs, gastrointestinal drugs (antacids and histamine antagonists), anesthetics, and antiasthma drugs. Facility No. 8, which specializes in children, also requests anti-parasitic drugs. Second, they want drugs that cannot be found in the country and/or are newer, more sophisticated and, therefore, more expensive than those on the PROMESS list. The interviewees cited as examples second- or third-generation cephalosporins, gastrointestinal drugs such as omeprazol, cardiac drugs such as angiotensin-converting enzyme inhibitors, and strong pain medications like morphine (Facility No. 3).

Only Facility No. 1 provided data on donated drugs currently in stock, and these data are discussed below. Except for Facility No. 1, the tracking of drug stocks is currently done manually. (However, more than half the health facilities interviewed are expecting a computerized system in the near future.) Donated drugs are not always recorded, or recorded separately, from purchased drugs.

Depending on the health facility, the drugs that are donated were stored (1) with the purchased drugs, (2) in a different place than purchased drugs, or (3) with the purchased drugs if they are of the same composition (generic name) and in a different place if they are not. The method of storage is independent of whether or not the drugs are dispensed to patients free or for a reduced fee.

The pharmacies were visited at four of the six onsite health facilities. The visits revealed a large variety of drugs with US brand names. Table 7.3 describes the donated drugs that were observed. This list is not exhaustive and does not indicate the quantities of each drug received.

Status of the donated drugs with regard to the PROMESS list

The interviewees have some knowledge of the PROMESS list. At some point in the interview, however, they all mentioned at least one product as not being on the PROMESS list when, in fact, it is. Therefore, the information given by the interviewees on the percentage of donated drugs they receive that are on the PROMESS list is not necessary reliable and is not reported. In order to have some sense of the status of donated drugs regarding the PROMESS list, we analyzed the lists of “always needed drugs” given by health facilities No. 1 and No. 8, as well as a list of all the donations received by Facility No. 1 from January 1996 through July 1996, and from January 1997 to May 1997, using our classification (see Chapter 2 in this report). This system classifies drugs that are on the PROMESS list as “PROMESS EDL drugs.” The donated drugs that are not on the PROMESS listing fall into one of the three following categories: “*therapeutic alternatives*,” “*WHO-ML drugs*,” and “*non-list drugs*.”⁴

T A B L E 7 . 3

Donated Drugs Observed at Pharmacies of Four Health Facilities

Facility	Type of Drugs
No. 1	Steroid inhalers, analgesics, antibiotics (cephalosporins), histamine antagonists and antacids, cough syrups.
No. 4	Mucolytics, diuretics, analgesics, third-generation cephalosporins, antihemorrhoidal suppositories, antibiotics for the eye, cough syrups, antiasthma drugs.
No. 7	Anesthetics, analgesics, antacids, antibiotics (penicillin).
No. 9	Analgesics in different dosages, decongestants, antidepressants, antiasthma drugs, antibiotics.

On the “always needed drugs” and donated drugs lists, the categories are anesthetics, analgesics, anti-infective drugs, cardiac drugs, gastrointestinal drugs, and antiasthma medications. Thirty-three percent of the “always needed drugs” (Facilities No. 1 and No. 8) and 44 percent of the donated drugs of Facility No. 1 are on the PROMESS list. Approximately 25 percent of the drugs on both lists are therapeutic alternatives, 16 percent belong to the WHO-ML, and between 23 and 16 percent are non-list drugs. On both lists, the anti-infective category shows the largest percentage of non-list drugs (25 percent of “the always needed drug” list from Facilities No. 1 and No. 8, and 33 percent of the donated drugs list from Facility No. 1).

The twenty-seven “always needed drugs” of Health Facilities No. 1 and No. 8

Table 7.4 presents an analysis of the 27 drugs that appear on the “always needed drugs” listing of Facilities No. 1 and No. 8. An analysis shows that 33 percent of the drugs on the lists are on the PROMESS list, 29 percent are therapeutic alternatives, 19 percent are WHO-ML drugs and 19 percent are non-list drugs. More specifically, 60 percent of all cardiac drugs are WHO-ML drugs, one is a non-list drug, and one belongs to the PROMESS list. The gastrointestinal medications are not on the PROMESS list, but all three are therapeutic alternatives for a PROMESS drug (cimetidine). Of the 12 anti-infective drugs, 50 percent are on the PROMESS list, 25 percent are therapeutic alternatives, 17 percent are WHO-ML drugs, and one is a non-list drug.

The seventy-nine donated drugs of Facility No. 1

Table 7.5 presents an analysis of the 79 donated drugs received at Facility No. 1. (The list excludes donated drugs received from PROMESS.) The analysis shows that 44 percent of the donated drugs are on the PROMESS list, 20 percent are therapeutic alternatives, 18 percent are WHO-ML drugs, and 16 percent are non-list drugs. More specifically, of the 27 anti-infective drugs, 41 percent are on the PROMESS list, 22 percent are therapeutic alternatives, 7 percent are WHO-ML drugs, and 30 percent are non-list drugs. Of the eight cardiac drugs, 38 percent are on the PROMESS list and 62 percent are WHO-ML drugs. Of the 7 antiasthma medications, 43 percent are on the PROMESS list, 43 percent are therapeutic alternatives, and one is a non-list drug. Of the 7 gastrointestinal drugs, 29 percent are on the PROMESS list, 43 percent are therapeutic alternatives, and 29 percent are non-list. Of the 5 dermatologic prepara-

TABLE 7.4

List of Always Needed Drugs from Facility No. 1 and Facility No. 8

	On PROMESS List (5/21/97)	Not on PROMESS List (5/21/97)		
	PROMESS EDL Drug	Therapeutic Alternative	WHO-ML Drug	Non-List Drug
<i>Anesthetics</i>				propofol tetracaine
<i>Analgesics</i>	acetaminophen	morphine		
<i>Anti-infectives</i>	ciprofloxacin cephalexine griseofulvin doxycycline metronidazole acyclovir	ampicillin/ sulbactam amoxicillin/ clavulanic acid clarithromycin	ceftriaxone sulfamethoxazole	cefaclor
<i>Cardiac drugs</i>	nifedipine		enalapril captopril lisinopril	benazepril/ hydrochlorothiazide
<i>Hormones</i>				danazol
<i>Gastrointestinal medications</i>		nizatidine famotidine ranitidine		
<i>Antiasthma medications</i>	beclomethasone	albuterol		

tions, 60 percent are therapeutic alternatives, one is a WHO-ML drug, and one is a non-list drug.

Requested drugs from NGO No. 2

The 1996 list of “requested drugs” for in-country NGO No. 2 included both specific and nonspecific drugs (for example, “other antibiotics” and “other antacids”). Among the specific drugs, except for cough and decongestant syrups, all seven are on the PROMESS list:

1. Anti-infective: ampicillin
2. Analgesic: acetaminophen
3. Anti-parasitic: albendazole
4. Antacid: cimetidine

TABLE 7.5

Drugs Donated to Facility No. 1

	On PROMESS List (5/21/97)	Not on PROMESS List (5/21/97)		
	PROMESS EDL Drug	Therapeutic Alternative	WHO-ML Drug	Non-List Drug
<i>Anesthetics</i>	lidocaine		bupivacaine	tetracaine
<i>Analgesics</i>	aspirin ibuprofen acetaminophen			
<i>Antiallergics/ shock medications</i>	epinephrine chlorpheniramine hydrocortisone acetate	prednisone		
<i>Antiepileptic medications</i>	carbamazepine			
<i>Anti-infectives</i>	acyclovir ciprofloxacin cephalexin amoxicillin chloramphenicol doxycycline rifampicin streptomycin ethambutol isoniazid pyrazinamide	clarithromycin ofloxacin tobramycin amoxicillin/ clavulanic acid ampicillin/ sulbactam azithromycin	ceftriaxone penicillin VK	cefuroxime cefazolin cefixime tetracycline cefprozil cefaclor cefuroxime thiabendazole
<i>Cardiac drugs</i>	methyl dopa nifedipine hydralazine		enalapril lisinopril benazepril ramipril quinapril	
<i>Dermatologic preparations</i>		terbinafine mometasone clotrimazole	hydrocortisone/ pramoxine	erythromycin
<i>Desinfectants</i>	hydrogen peroxide			isopropyl alcohol
<i>Gastrointestinal medications</i>	cimetidine "antacid"	nizatidine famotidine ranitidine		omeprazole sucralfate

TABLE 7.5

Drugs Donated to Facility No. 1 (continued)

	On PROMESS List (5/21/97)		Not on PROMESS List (5/21/97)	
	PROMESS EDL Drug	Therapeutic Alternative	WHO-ML Drug	Non-List Drug
<i>Hormones</i>	medroxyprogesterone inj norplant ethinylestradiol/ norgestrel		medroxyprogesterone po	
<i>Psychotropics</i>	promethazine			
<i>Antiasthma medication</i>	beclomethasone aminophyllin salbutamol	pirbuterol flunisolide albuterol		salmeterol
<i>Electrolytes</i>	ORS			
<i>IV fluids</i>	sodium chloride Ringer's lactate dextrose			
<i>Various medications</i>			propylthiouracil methotrexate atropine sulfate	

5. Anti-fungal: nystatin

6. Anti-hypertensive: methyldopa

7. Anti-anemic: ferrous sulfate

The shipment that this NGO received in 1996, following this request, contained most of the requested drugs, but there was no methyldopa. And instead of albendazole, thiabendazole, a non-list drug (deleted from the 1995 WHO-ML due to its potential side-effects), was shipped. It is interesting to note that on its list, this NGO had emphasized the promotion of albendazole by PROMESS and stipulated that it did not want thiabendazole or piperazine. The shipment also had some oral rehydration salts, which were not requested or needed. In the nonspecific categories, the antibiotic combination sulfamethoxazole/trimethoprim was sent (on the PROMESS list). In volume, cough syrups and analgesics represented three-quarters of the drugs donated.

The shelf life of the donated drugs***Health facilities***

Table 7.6 describes the status of donated drugs with respect to their expiration dates when they arrived at the facilities. The percentages given by the respondents in interviews are approximations. Only Facility No. 1 had a systematic written record of drug donation expiration dates and performed a continuous follow-up of expiration dates. Drugs that have expired at their arrival at the harbor or at the airport are usually confiscated by Customs.

Overall, the percentage of expired drugs on arrival at the health facilities varies from one facility to another, and it is difficult to see a general trend. Table 7.6 shows that seven of the nine health facilities had at least 40 percent of donated drugs with less than three months dating on arrival (including substantial portions of expired drugs). On the other hand, seven facilities had 50 percent or more of donations with at least nine months dating on arrival. An estimated 50 percent of donated drugs received by health facilities No. 3 and No. 9 were expired on arrival. This may be due to the tendency for these two facilities to receive part of their donated drugs from other facilities in Haiti and to have fewer connections abroad.

In-country NGOs

Before every shipment, NGO No. 1 receives a list of the requested drugs with their expiration dates. It therefore reported not receiving any ex-

TABLE 7.6

Shelf Life on Arrival of Donated Drugs (Estimated Dating Percentage*)

Health Care Facility	Estimated Dating %*			
	Expired at Arrival	Less than 3 Months	9 Months	12 Months and More
No. 1 Private	20	20	30	30
No. 2 Private			10	90
No. 3 Private	50		50	
No. 4 Private	30	20	40	10
No. 5 Mixed	None	10	80	10
No. 6 Mixed	25	50		25
No. 7 Mixed	30	20	50	
No. 8 Mixed	20	20	40	20
No. 9 Public	50	10	30	

* Percentage of all drugs donated to this facility over the last 12 months.

pired drugs (unless due to problems at Customs). The interviewee mentioned that 45 percent of its donations have six to nine months dating remaining and 55 percent have nine months or more. Sometimes it also receives drugs with a remaining shelf life of two years.

NGO No. 2 stated that it generally receives drugs with at least a year of shelf life left. An analysis of the donated drugs from its 1996 list showed that 80 percent of donated drugs had between a year and two years shelf life remaining. Two types of drugs had less: 66 percent of the acetaminophen shipped had six to nine months, and the oral rehydration salts had nine months. The thiabendazole had three years of shelf life.

Other characteristics of the drug donations

Donated drugs are reportedly received in their original packaging, with labeling in English, French, or Spanish. The public hospital is the only facility that reported receiving donated drugs in another language (Chinese).

Health facilities reported that the packaging and specific drug information varies, depending on the quantity of each product, on the method of shipping, and on the source of the drug. A product may be packaged separately (with its NDC code, dosage, generic name, and manufacturer) or mixed with other drugs, with very little specific information provided. The generic name of a drug is typically included on its individual package, together with the brand name and the dosage. Before being given to patients, however, donated drugs are usually repackaged. The exact amount of drug needed is usually given to the patients in a plastic bag (Facility No. 7 uses PROMESS plastic bags). The medical staff gives instructions on how to take the drugs, using either drawings or Creole.

Costs of drug donations for the recipients

Health facilities

The analysis identified three kinds of costs related to drug donations: financial, time, and transaction.

Financial costs. For the health facilities interviewed, there were two kinds of donations: drugs that are provided free (from various sources) and drugs that are donated with a cost called a “handling fee” (from certain US-based PVOs). The interviewees called this latter type of donation a “semi-donation.” Three of the eight health facilities noted that with the creation of PROMESS, their requests for “semi-donations” have decreased tremendously, as the latter have been replaced with drugs purchased from

PROMESS. As one interviewee at Facility No. 2 put it, “*Before, 60 percent of my volume was donated mostly through a PVO with a handling fee, and 40 percent was bought. With PROMESS the percentages are reversed.*”

In addition to the PVO handling fee for the drugs, health facilities can incur other financial costs: shipping the drugs by boat or air to Haiti (for example, by air US\$1/pound); transport from the place of arrival to the facility; and, for some facilities that are outside the capital and do not have an office downtown, a broker to clear the shipment through Customs. When the drug donations are hand-carried by individual carriers, none of these costs is incurred. All of Facility No. 2’s shipping costs, and some of those for Facility No. 1, were reportedly paid by the donors. In all other cases, the recipients indicated that they bore the costs.

Despite the franchise, three of the four private nonprofit health facilities mentioned a tax at the docks that must be paid in order to receive the shipment. The tax is reported to be based on various calculations: 4 percent of the value of the donations, 4 percent of the volume, or a variable fee. This tax is cited only by the private nonprofit health institutions for drug donations sent by boat.

Time costs. This cost seems to be particularly heavy for shipments by boat. It represents the time spent by the facility to:

- Select from or answer donation offers.
- Go to clear the donations at Customs, or brief a broker or the downtown agency to do it.
- Fill out the forms for the franchise and follow-up on the process.
- Sort the drug donations once they have arrived at the facility (or, for Facility No. 3, to sort them at their US office before they are shipped to Haiti).

Transaction costs for shipments sent by boat. This cost is linked to the difficult process involved in getting the tax exemption. Some facilities reported preferring to pay a variable amount (actually a bribe, which may or may not be returned) to a Customs official in order to have their shipments cleared before receiving the exemption. This fee is reported to vary from one facility to another (from US\$100 to US\$1,000). According to Facility No. 2, during a short period in the summer of 1996 this fee was increased to US\$7,000. More detailed information on this process could not be collected. The process was not checked with MSPP, but this

transaction cost was mentioned by all the nonprofit health facilities. Some facilities (No. 1, 3, and 4) refuse to follow this practice because of moral objections, viewing the fee as a bribe.

The in-country NGOs

For in-country NGOs No. 1 and No. 2, donated drugs are free. Until recently, all drug shipments for NGO No. 1 were underwritten by a local bank in Haiti. Now it can receive the franchise, but it also mentioned paying \$4,000 to clear a 40-foot container before obtaining the franchise. It also reported using a broker at the docks, with a cost of less than \$500 per container.

For NGO No. 2, shipping is paid by the US-based PVO, and no other costs are involved in the donations.

Perceptions of the Current Drug Donation Process by the Recipients

Regulations on drug donations

Neither the private/mixed nonprofit health facilities nor the in-country NGOs report any complaints about the government's lack of involvement in drug donations. This attitude can be explained, first, by the distrust of government that is rooted in the times of dictatorial and military rule. The still-young democracy has not yet gained the people's confidence. The increasingly difficult process of receiving a tax exemption for humanitarian aid and the practice of clearing shipments in exchange for a variable amount both contribute to this continuing distrust of government. Second, the nonprofit health facilities feel independent of the government and are used to running their organizations with a great deal of autonomy. The government has little involvement in their affairs and is perceived as providing little help. And third, the religiously affiliated health facilities view their effort to obtain free drugs as "a good action" for a country in a difficult economic and political situation where drugs are in short supply. They do not perceive the need for control from someone other than themselves.

The public hospital, however, which has a closer relationship with the government, expressed an attitude of positive support for government regulation, similar to the attitude expressed at MSPP. Officials there asked for more intervention by the government to control the quality of drug donations.

Benefits and drawbacks of the current drug donation process

In this section, discussion of the health facilities and the in-country NGOs is combined. Most of the information came from the facilities, and the NGOs generally raised the same issues. With the exception of the public hospital, the interviewees believed that the benefits of drug donations exceed their drawbacks. Table 7.7 presents a summary of the perceived benefits and drawbacks of drug donations, as reported by the interviewees.

Perceived benefits

The eight nonprofit health facilities and the two in-country NGOs identified three main benefits of the current drug donations: (1) They receive free drugs; (2) they receive drugs that are not on the PROMESS list; and (3) they can obtain drugs that are out of stock at PROMESS.

Free drugs

The donated drugs allow the health facilities to fulfill their mission of helping the poor by giving them free drugs. For the religiously affiliated organizations, such donations also have a religious dimension.⁵ The health facilities also mentioned strong social equity considerations in the donation of drugs. When they provide free drugs, health workers feel that they are changing unfair practices that allow only the rich to be treated with expensive and state-of-the-art drugs.⁶

A number of the facilities interviewed also noted a positive financial impact of donated drugs. The donations enable them to provide higher-quality drugs without causing excessive financial hardships by reducing the size of their drug budgets.⁷

NGO No. 2 emphasized that donated drugs allow the organization to make trade-offs in an already tight budget: *"In 1994 we received a two-year donated supply of abendazole. Therefore, for 1996, we requested this drug again, and we used the money we saved on this drug to buy other products."*

Drugs not on the PROMESS EDL

According to the interviewees, many of the donated drugs that are not on the PROMESS list are those that have a greater efficacy or that give greater comfort to the patient (for example, one pill a day instead of three). Most of the interviewees mentioned second- or third-generation cephalosporins. This type of drug is usually expensive in Haiti, and could not be bought by most of the health facilities.⁸

TABLE 7.7

Perceptions of the Overall Donation Process and of the Donated Drugs

Benefits	Drawbacks
<p><i>Free drugs:</i></p> <ul style="list-style-type: none"> • Fulfill the mission of the facility. • Provide expensive drugs for the poor. • Reduce drug budget. <p><i>Non-PROMESS drugs:</i></p> <ul style="list-style-type: none"> • Provide greater efficacy/comfort. • Provide expensive drugs. • Fulfill scientific curiosity. • Provide drugs not available in Haiti. <p><i>Drugs out of stock or unavailable from PROMESS</i></p>	<p><i>Lack of control over:</i></p> <ul style="list-style-type: none"> • Volume • Type of drugs • Time of shipments <p><i>Expired drugs:</i></p> <ul style="list-style-type: none"> • Problem of disposal • Potential black market <p><i>Costs:</i></p> <ul style="list-style-type: none"> • Time • Financial • Transaction <p><i>Bureaucratic process</i></p>

Some health facilities viewed the donated drugs not on the PROMESS list as essential for the patients,⁹ while other facilities viewed drugs not on the PROMESS list as “nice to have” for patients and doctors, but not essential.¹⁰ According to the interviewees, the supply of drugs at PROMESS is imperfect, and some drugs may be unavailable for months. These facilities see the drug donations as a necessary means of supplementing their inventories.¹¹

Perceived drawbacks

The interviewees reported four main problems with the current drug donation process: (1) They cannot plan to ensure a predictable drug supply; (2) they often receive expired or close-to-expired drugs; (3) donations can entail significant costs; and (4) the process of receiving and clearing donation shipments is slow and bureaucratic. (The public hospital did not mention this last factor.)

Uncertainty regarding donations

Although recipients would like to be able to rely on a predictable supply of donated drugs, their lack of control over the type and quantity of drugs shipped and the timing of their arrival prevents adequate planning for their distribution and use. While specific requests are often submitted to

donors, receipt of the requested item is uncertain, because some donors “give what they have” and some US-based PVOs have a “first come, first served” policy. These varying PVO policies were reportedly viewed as one of the main problems in receiving donations from these organizations.¹²

Expired or close-to-expired donated drugs

The expiration dating of the donated drugs is a universal complaint,¹³ but Facilities No. 1, No. 2 and No. 4 have noticed an improvement over the years. Numerous reminders to their donors of the problems of expired or close-to-expired drugs seem to have helped. Shipments of expired or close-to-expired donations raise different issues for the facilities. By law, expired drugs must be burned. Carrying this policy out effectively requires appropriate equipment to enable burning the drugs at a high enough temperature. Furthermore, open burning raises the danger of environmental pollution in the immediate surroundings. Most health organizations do not have adequate means of disposal by incineration. Facility No. 1 also mentioned that in a country where drugs are desperately needed, it is a shame and almost unethical to burn them. In addition there is the problem of a black market in expired drugs confiscated at Customs.

The interviewees from Facilities No. 3 and No. 6 noted that they sometimes utilize expired drugs (such as antacid and ointments), but everyone agreed that generally the pharmacist, the medical staff, and the patients refuse them.

Costs associated with donations

Among the costs associated with the donation program are money, time, and transaction costs. For some health facilities, the transaction cost is viewed as an insult to their integrity, since they are forced to bribe Customs officials to release their shipments before receiving the tax exemption. For the recipients, the time and transaction costs are more significant than the financial cost, because it is those costs that cause recipients to be reluctant to request additional donations.¹⁴

A bureaucratic process

According to the interviewees, the time spent clearing donations from the docks as well as receiving the tax exemption (from two to three months) makes the drug donation process longer and more difficult. In addition to the time and transaction costs associated with the Haitian bureaucracy, there is the aggravation caused by this process. Some facilities reported containers being held so long at Customs that when they were released, the drugs were out-of-date.¹⁵

Benefits and drawbacks by source of drugs

Table 7.8 describes a rating of sources of donated drugs based on four parameters:

1. Characteristics of the drugs (quality of the drugs with respect to the needs of the facility and the expiration date).
2. Communication between the donor and the recipients (the drugs have been requested, the recipient knows in advance the type of drugs and when they are due, and the recipient knows the source of the drugs).
3. The cost of the drugs (financial, time, and transaction).
4. The logistics (ease and timeliness of receiving the shipments).

The rating on a scale of poor to good is based on an analysis of the interviews with the health facilities and the in-country NGOs. Individual carriers were generally viewed as the preferred source on the basis of the listed criteria. The rating scale is based upon this preference.

TABLE 7.8

Evaluation of Drug Donations

Source	Parameters Evaluated			
	Characteristics of the Drugs	Communi- cation	Costs	Logistics
<i>Individual carriers</i> (from pharmaceutical company, individuals)	good	good	good (low)	good
<i>(US-based) PVO</i> with a request list*	average	average	average	average
<i>(US-based) PVO</i> without a request list*	poor	poor	poor (high)	poor
<i>Church</i> (from closing hospitals/ individuals)	poor	average	poor (high)	poor
<i>Health facility US office</i>	average	good	average	good
<i>In-Country facilities</i>	bad	bad	good (low)	good

* Drug donations sent according to a request from the recipients through a list of available drugs provided by the US-based PVO.

From this table, general conclusions regarding drug donations can be drawn. For the interviewees, the individual carriers represent the best source, and the US-based PVOs without a request list and some donations collected by churches are the most problematic. By comparing their characteristics, one can identify patterns of “good and bad” donations as perceived by the interviewees.

Although not every facility receives hand-carried donations, the interviewees felt that individual carriers bring “the best donations” because they have a close relationship with the US office and with the facility where they are going to work. They also know the drug needs from the list of “always needed drugs” or from their personal discussions with the facility. Usually, they have time to prepare for the trip and to collect the drugs, which allows careful choice of the type as well as the quality of drugs. They bring the drugs on the plane personally. This method of shipment makes for minimal financial costs and smooth logistics. Finally, the carriers are directly involved in the whole process, since they are going to work in Haiti and may actually prescribe the drugs. According to the respondents, the only drawback of this kind of donations is the small volume of drugs that can be brought.

For the interviewees, the donors that collect “bad donations” may know the drug needs of the facility through their “always needed drugs” lists or from previous requests, but they seem to be less involved in the process and do not appear to heed recipients’ requests. The respondents have the impression that these donors think that to send something is better than to send nothing, regardless of the recipients’ needs. The interviewees believed that these donors are collecting drugs from different places and that they often do not have the time to sort them and to check their quality. Regarding donations from US-based PVOs without a request list, the interviewees mentioned US-based PVOs that have a container ready to go and “just want to send it somewhere.” The US-based PVOs that send drugs according to a request list rate “average,” as indicated in Table 7.8. The list of available drugs prepared by the US-based PVOs and used by the recipients for their request may have information on the source of the drugs, the generic name, the dosage, and the expiration dates. Communications between donor and recipient may include feedback to the donor before shipment to verify the accuracy of the request and, after shipment, to verify the use of the drugs. According to the interviewees, those US-based PVOs that follow a “first come, first served” policy, do not always send the most-needed drugs or the needed quantity. Overall, the interviewees felt that the US-based PVOs’ involvement is

often limited and that they do not seem concerned with the difficult logistics and the costs to the recipients involved in shipping by boat.

The drugs sent by plane through the US office of the health facility are in smaller packages than those sent by boat. The US office may verify the shelf life of the drugs and the need for them. There is a higher cost in sending them by plane, and there may also be costs at Customs, but the logistics are faster and easier than if the donations are sent by boat.

Drugs donated by the health facilities within Haiti rate poorly by the criteria of drug quality and communication. Products that the donor-facility cannot use, most of these drugs are close to expiration or are for use in specialized hospitals.

The WHO *Guidelines for Drug Donations*

Knowledge of and reactions to the WHO *Guidelines*

One-third of the health facilities and in-country NGOs involved in drug donations knew about the WHO *Guidelines* because they had received a copy of them from the government, and the rest did not know of their existence. Only two nonprofit health facilities sent this information to their US office and to their donors.

During the interview, the WHO *Guidelines* were presented to the interviewees for comments. Their overall reaction was positive (Table 7.9). They respect WHO, and they understand that it is the responsibility of a country to develop standards for receiving drug donations. However, some interviewees voiced concern that the guidelines may be applied without any consideration of local conditions and needs, observing that Haiti has limited means to adapt them.

Analysis of interviewee reactions reveals that they all endorse the four core principles: maximum benefit to the recipient, respect for wishes and authority of the recipient, no double standards in quality, and effective communication between donor and recipient. With these core principles, they perceive a change in their status from “beggars” to “equal partners.”

Reactions to specific WHO Guidelines

The reactions of interviewees to specific sections of the WHO *Guidelines* are presented in Table 7.10 and below. The respondents had no comments regarding presentation, strength, and formulation.

Guideline No. 1: All drug donations should be based on expressed need. . . . Drugs should not be sent without prior consent by the recipient. *Reaction:*

TABLE 7.9

Knowledge of and Reactions to the *Guidelines*

No. Interview: Health Facilities/ In-country NGOs	Knowledge of Existence of the <i>Guidelines</i>	Received a Copy of the <i>Guidelines</i>	Overall Reactions to the <i>Guidelines</i>
No. 1	yes	yes	positive
No. 2	no	no	positive
No. 3	no	no	positive
No. 4	no	no	positive
No. 5	no	no	positive
No. 6	yes	yes	positive
No. 7	no	no	positive
No. 8	no	no	positive
No. 9	yes	yes	positive
No. 10	yes	yes	positive
No. 11	no	no	positive

TABLE 7.10

Perception of *Guidelines* by Health Facility Interviewees**Guidelines perceived as advantageous:**

1. Expressed need/prior consent.
4. Reliable sources.
7. Labeling in appropriate language, with INN.
- 5a. No returned drugs.
10. Advance notice.

Guidelines perceived as disadvantageous or difficult*:

2. On EDL, approved for use in country.
3. Formulation as in Haiti.
4. WHO Certification Scheme.
- 5b. No physician samples.
6. Shelf life > 12 months.
8. Larger quantity units/hospital packs.
9. Packing list, weight, mixed mailing.
11. Declared at generic value.
12. No transportation charges, unless first discussed.

* These guidelines were considered too difficult to implement, could lead to reduced shipments, or should be decided by the recipient.

The interviewees agreed that drug donations should be based on expressed needs. Therefore, they opposed the notion that the donated drugs should be exclusively on the PROMESS EDL.

Guideline No. 4: All donated drugs should be obtained from a reliable source and comply with quality standards in both donor and recipient country. The WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce should be used. *Reaction:* The respondents interviewed agreed that the donations should be obtained from a reliable source, but they would not limit the certification scheme to WHO certification. The possibility of donor-country certification was mentioned.

Guideline No. 5: No drugs should be donated that...were given to health professionals as free samples. *Reaction:* The health facility managers and pharmacists find free samples in unbroken packaging useful and safe, and they would not want them prohibited.

Guideline No. 6: After arrival in the recipient country, all donated drugs should have a remaining shelf life of at least one year. *Reaction:* This guideline on shelf life, which is currently a problem in Haiti, is appreciated. However, the one-year or more of shelf life at arrival recommended by WHO for all drugs is considered too long. Instead, they proposed a six-month shelf life, or even less for urgent donations brought by plane or for drugs they use quickly.

Guideline No. 7: All drugs should be labeled in a language that is easily understood by health professionals in the recipient country; the label on each container should contain at least the International Nonproprietary Name (INN, or generic name), batch number, dosage form, strength, name of manufacturer, quantity in the container, storage conditions, and expiry date. *Reaction:* Those interviewed agreed that the labeling should be in an easily understood language. This is not currently a problem: Their donated drugs are labeled in English, French, or Spanish.

Guideline No. 9: All drug donations should be packed in accordance with international shipping regulations and be accompanied by a detailed packing list that specifies the contents of each numbered carton by INN, dosage form, quantity, batch number, expiry date, volume, weight, and any special storage conditions. The weight per carton should not exceed 50 kilograms. Drugs should not be mixed with other supplies in the same carton. *Reaction:* In shipments by boat, the health facilities and NGOs

receive containers of donated drugs mixed with other goods. This practice allows the recipients to save money by filling a container. A more detailed packing list was viewed as desirable but not crucial. The same holds true for larger-quantity packages.

Guideline No. 10: Recipients should be informed of all drug donations that are being considered, prepared, or actually underway. *Reaction:* Prior notice of donated drugs being considered, prepared, or underway was perceived as being very important, but currently it is not always provided. The interviewees related this guideline to the two core principles: respect for the wishes and authority of the recipient and effective communication between donor and recipient.

Guideline No. 11: In the recipient country, the declared value of a drug donation should be based upon the wholesale price of its generic equivalent. *Reaction:* The respondents viewed this guideline as not helpful because these rules are complicated and not relevant to the current regulations or practice of the country. They stated that no attempt should be made to apply them.

Guideline No. 12: Costs of international and local transport, warehousing, port clearance, and appropriate storage and handling should be paid by the donor agency unless specifically agreed otherwise with the recipient in advance. *Reaction:* This guideline raised a concern. The interviewees stated that such a practice would be helpful, but feared that it would reduce the number of donations. In addition, they noted that this guideline takes into account only the financial cost of donations and does not consider the time and transaction costs.

Potential impacts of the WHO *Guidelines*

The potential impacts of the WHO *Guidelines* in Haiti depend on the answers to the following two questions: (1) Are the *Guidelines* going to be adapted to Haiti's reality? (2) Who is going to control drug donations?

Worst-case scenario

The WHO guidelines are not adapted to the current reality in Haiti and control is exercised directly by the government through Customs. As a result, the interviewees foresaw a number of unfavorable outcomes:

- A reduction in the quantity of drugs not on the PROMESS list and of drug donations in general.

- The process would become more complicated and their drug needs would not be met. (They cite their experience with the franchise process in substantiating their concerns.)
- Interpretation of WHO *Guidelines* would be subject to Customs, and exceptions might be ignored, resulting in biased and unfair distribution.
- Distribution might depend not on drug quality or recipient need but on the type of health facility preferred by a given bureaucrat, “under the table” money given by recipients, idiosyncratic decisions by individual Customs officials, or recipient/bureaucrat personal relationships.

Best-case scenario

The interviewees’ comments are incorporated in Haiti’s drug donation guidelines, and the process is controlled by an independent organization that has the confidence of the recipients. This institution ideally would work in collaboration with MSPP. To illustrate the type of organization they are looking for, some interviewees cited PROMESS. In this scenario, everything would improve. The *Guidelines’* objective of providing high-quality drugs that meet the needs of the recipients would then be fulfilled (according to the interviewees).

If the guidelines are not adapted to Haiti, but the drug donations are controlled by an independent, reliable organization, they still foresaw a positive outcome, because they believed there are enough exceptions to each guideline to allow them to negotiate with a trustworthy institution.

Aspects of donation policies that require improvement

Interviewees recommended changes in three aspects of donation policies that are not dealt with in the WHO *Guidelines*. First, they want to improve access to information on companies that donate drugs. The level of knowledge about donor companies (that is, PVOs and programs of pharmaceutical companies) varies among facilities. The extent is related to how long the health facility or in-country NGO has been in existence and the number of contacts it has in the United States or with other health facilities. The recipients often learn about a PVO only when they receive a brochure or a list of available drugs. A more organized international process to spread this information could be put in place.

Second, they recommend changing the PVOs’ policy of “first come, first served.” There was general agreement that this policy contributes to the recipients’ perceptions that they cannot rely on drug donations. They request specific drugs and quantities, but they do not always receive what

they request. Follow-up of requests and communication with the recipient when a requested drug or its quantity is not available could resolve this problem.

And third, they want international guidelines for import tax exemption on drug donations. Those interviewed felt that international guidelines for the provision of import tax exemption could ease the process of obtaining the franchise in Haiti. The transaction and time costs of drug donations would then be reduced.

Conclusions and Recommendations

This chapter has presented an analysis of 15 face-to-face interviews conducted in Haiti with nine health facilities, three in-country NGOs, the Ministry of Public Health and Population, and one association of NGOs. However, the conclusions are based mainly on the information collected from eight of the nonprofit health facilities and two of the in-country NGOs. These organizations are those most involved in drug donations, specifically from the United States. Health facilities and in-country NGOs have two sources of drug donations: international agencies that donate through the government warehouse run by PAHO/WHO (PROMESS), and private donors, mostly in the United States. In light of the objectives of this study, the conclusions focus on the latter type of donations.

Strengths and weaknesses of the current drug donation process

The main strength of the current drug donation process is that it supplies useful drugs. It provides, first of all, free drugs, which allow recipients to both fulfill their mission to help the poor and reduce their drug budgets. Second, it provides drugs not on the PROMESS list that physicians perceive to be more efficacious or to give more comfort to their patients. These are often expensive drugs that the respondents could not otherwise afford—drugs that sometimes save lives. And last, it provides drugs on the PROMESS list that are out of stock at the warehouse.

Nevertheless, the current drug donation process has weaknesses. First, the recipients cannot rely on drug donations to meet their needs. Despite the availability to donors of a list of “always needed drugs” and a request placed by the recipients for many US-based PVOs’ drug donations, the recipients do not always receive what they need. They may not obtain the right type of drug or the right quantity. There are two reasons for this problem: lack of communication between donors and recipients, and the

“first come, first served” policy of some US-based PVOs. Donors appear to not fully understand the importance of the needs list made by the facility. They may believe that they “do good” by sending “what they have.” The donor PVOs offer their drugs to many institutions in many countries. By the time a request arrives from a facility, they may be out of stock, yet the recipient may not become aware of it until he or she receives the shipment. Most often, facilities do not have control over when they receive their drugs.

Second, seven health facilities included in this study estimated that at least 20 percent of donated drugs arrive at the health facilities after expiration. The expiration dates of the drugs may not be carefully monitored up front, or the time required to get them to the facility may not have been known by the donors. Two health facilities and two in-country NGOs did not report this problem.

Third, although government involvement in the donation process is limited, it slows the entire process and creates additional problems for the facilities. Drug donations are supposed to receive a tax exemption (the franchise), but for boat shipments, the process of obtaining the exemption is very lengthy and bureaucratic (taking up to three months). In addition, the scope of the exemption is not clearly defined; therefore, some respondents still pay a fee, while others do not. Given these difficulties, some facilities do not request the exemption and prefer to pay a “bribe” at Customs to receive their shipments. The delay problem was so acute that sometimes the drugs expired before the exemption was granted. For the recipient, this difficult process means a loss of both money and time.

However, given the many donor sources (US-based PVOs both with and without explicit request lists from recipients, churches, individuals, and in-country facilities) and variable methods of shipment (individual carrier, ocean freight, and air freight), the outcomes of the donation process vary significantly. It is worth noting that donations brought by individual carriers who come into Haiti to work at a health facility are perceived as avoiding the weaknesses noted above. They meet the four core principles of the WHO *Guidelines*, and the donor is committed to the whole donation process.

Reactions to the WHO *Guidelines* and potential impacts

At the time of the interviews, the WHO *Guidelines* were known to only one-third of the respondents. All the interviewees supported the four core principles of the guidelines, and they believed that these principles would

help build a more equal relationship between donors and recipients. They concurred with the guidelines regarding prior consent, notice of drug donations, and easy-to-understand labeling. Control of expiration dating was also appreciated, but one year or more for all drugs was viewed as too restrictive. They noted, however, that the guidelines should require a guarantee of the quality of the drugs (certification, expiration dates, and so forth), but leave the specific choice of drugs to the recipient. The respondents were not opposed to having the costs of drug donations borne by the donors, but they voiced concern that it could reduce the number of donations.

The recipients considered some guidelines to be inappropriate to their needs or ill-suited to the situation in Haiti. If they are not modified, these four guidelines listed below were considered potentially more harmful than beneficial to the process:

1. Donated drugs should be on the Essential Drug List of the country.
2. Drugs should not be mixed with other products.
3. Health professionals' free samples should not be donated.
4. The declared value of the donations should be based upon the wholesale price of the generic equivalent in Haiti or on the world market.

The interviewees added that the overall potential impact of the *Guidelines* depends on where control of the donation program is vested. They distrust governmental control through Customs; they fear it may use the "undesirable" guidelines to reduce the flow of drugs. Government control was perceived as potentially leading to arbitrary distribution and unpredictable interpretation of the guidelines. The respondents preferred to see control in the hands of an independent and trustworthy organization that could work with MSPP. In their views, it would guarantee a more flexible and honest approach to the WHO *Guidelines* for the greater benefit of all.

Recommendations for improving the drug donation process in Haiti

This analysis recommends three areas for improvement. First, the US-based PVOs' "first come, first served policy" should be changed. It contributes to the recipients' perception that they cannot rely on the predictability of drug donations. Careful monitoring of requests by the PVOs

and immediate communication to the recipients when a requested drug is not available or is in short supply could help resolve this problem.

Second, donors need to give careful consideration to the lists of “requested drugs” or “always needed drugs” when deciding on the drugs to be shipped. It may be helpful for recipients to emphasize the values of specific drugs for specific purposes.

Finally, promulgation of an international regulation on tax exemption for drug donations could ease the process of obtaining a tax exemption in Haiti. It could reduce the “undefined” financial costs to the recipients, the lengthy and wasteful Customs clearance process, and the risk of receiving out-of-date drugs.

Endnotes

- 1 PAHO/WHO: *Analyse de la situation sanitaire Haiti, 1996* (Report on health situation in Haiti, 1996). (Port-au-Prince, Haiti, June 1996).
- 2 K. L. O'Brien, J. D. Selanikio, C. Hechdivert, et al., “Epidemic of pediatric deaths from acute renal failure caused by diethylene glycol poisoning,” *JAMA* (1998), 279:1175–1180.
- 3 The in-country organizations are referred to as NGOs in the study in order to make a clear distinction between donor agencies and agencies providing direct services in Haiti.
- 4 Those drugs classified as PROMESS EDL drugs and WHO-ML drugs can be inferred as comprising “essential drugs.” The WHO-ML also allows for the usage of therapeutic alternatives.
- 5 *“We are Christians and we are here to help the people that need us. We give the donated drugs for free to people that otherwise could not buy them. And, we are doing our job. 30 to 40 percent of the patients can't pay. We give them the donated drugs for free.”* (Facility No. 5)
- 6 *“Thanks to the donated drugs, not only the rich can get the best and most expensive drugs.”* (Facility No. 6)
- 7 *“For the facility it is actual income, because it is a cost that we don't have to pay.”* (Facility No. 4) *“3rd-generation antibiotics are expensive in Haiti. Even if we get a few bottles, it saves us money.”* (Facility No. 8) *“Without the donated drugs, we would go bankrupt. It allows us to save \$1,000 or \$2,000 a month.”* (Facility No. 5)
- 8 *“3rd generation antibiotics cost \$5/tab. We cannot afford it.”* (Facility No. 3) *“We got 25 vials of ceftriaxone sodium, and we felt rich.”* (Facility No. 4) *“We received a year's supply of corticoid inhaler for asthma. Each inhaler costs \$6.”* (Facility No. 1)
- 9 *For meningitis, the only treatment to save the patient is a 3rd generation antibiotic.* (Facility No. 8) *“For a difficult septicemia, the only solution is a 2nd or 3rd generation antibiotic.”* (Facility No. 5) *“For the kind of diabetes we have in Haiti we need fructose 5 percent, and only dextrose is available at PROMESS.”* (Facility No. 4)
- 10 *“Proton Pump Inhibitors with antibiotics cure 95 percent of the ulcers with helicobacter pylori. One can also use cimetidine which is at PROMESS, but it will cure only 85 percent of this type of ulcer.”* (Facility No. 6)
- 11 *“PROMESS has not had antacid drugs since January. Fortunately, we received some donations.”* (Facility No. 1) *“They were out of trimethoprim-sulfamethoxazole for two weeks, but we had some donations.”* (Facility No. 1)

- 12 *"I am not ordering from this US PVO anymore. In April, they sent me a list, I ordered antibiotics, antacids which I really needed. Since they also had on their list baby powder, diapers and cough medicine, I also checked them. But, because they have this first come, first served policy, I only got diapers, cough medicine and baby powder."* (Facility No. 4) *"I need IM ampicillin and what I get is IV."* (Facility No. 1) *"You never know when you are going to get them, especially the donations sent by boat."* (Facility No. 6)
- 13 *"I got 500 boxes of acetaminophen (12 bottles each box), and their shelf life was a month."* (Facility No. 1) *"We got donated drugs from France which had expired four years ago."* (Facility No. 9) *"We got antibiotics in May that expired in June."* (Facility No. 4)
- 14 *"Drugs donations demand too much time to organize them and to get them through Customs."* (Facility No. 5) *"It is too much of a headache. I went to Customs at the docks. I did not know where to go, to whom to talk. I spent too much time."* (Facility No. 3)
- 15 *"In the summer of 1996, the government increased its regulation. It took nine months to get the container out. All the drugs were expired by then and we had to leave them at Customs. I don't know what they did with it."* (Facility No. 2)

Bibliography

- MSPP, Politique Pharmaceutique Nationale (Haiti, March, 1997).
- MSPP, Rapport de la commission sur l'intoxication au diéthylène glycol (Haiti, January 1997).
- MSPP, Les médicaments et la pharmacie en Haiti Projet de loi. Haiti.
- PAHO/WHO, Analyse de la situation sanitaire Haiti 1996 (Report on the health situation in Haiti 1996). (Port-au-Prince Haiti, June 1996).
- World Health Organization, et al., *Guidelines for Drug Donations*. (Geneva: World Health Organization, May 1996). WHO/DAP/96.2.