The study findings of our 2022 Research on Availability and Affordability of sexual and reproductive health commodities clearly indicate an overall challenge in the availability of commodities in Zambia, as only 36.4% of the commodities were available in the facilities. As MedRAP, we believe that an in-depth review of the components of MOH essential medicines supply chain strategy is critically urgent in order to nip out and address inherent push factors that have led to a myriad of problems in the availability of essential medicines in health facilities.

1.1 Inadequate Domestic Financing of the Health Sector

The main challenge regarding financing and procurement of essential medicines is the inadequate domestic financing by GRZ through the Ministry of Health. There has been a progressive reduction in the health budget from 9.3% in 2019, 8.8% in 2020, 8.1% in 2021, and 8.0% in 2022. However, the health budget rose to 10.4% in 2023 and a further increase to 11.8% in 2024. This is still far away from the Abuja declaration set target of allocating at least 15% of the annual budget to the health sector. Hence, there is an urgent need to increase Domestic Financing to the Health Sector by allocating at least 15% of the annual budget to improve the availability of commodities.
1.2 Storage and Distribution

The Zambia Medicines and Medical Supplies Agency (ZAMMSA) is responsible for procurement, storage and distribution up to the last mile. Provincial Health Offices (PHOs) have also been involved in the storage and distribution (collect from ZAMMSA store to PHO pharmacy stores and distribute to districts and health facilities).

The involvement of PHOs was not initially part of the design of the supply chain system, as only ZAMMSA was mandated to distribute up to the last mile. Although some essential medicines such as family planning products have been consistently available at ZAMMSA and district level, there are challenges in the distribution up to the last mile. The key challenges facing commodity security include:

- Districts are not empowered to distribute to the last mile resulting in stock outs at facility level, especially in the rural areas;
- Stock-outs at Service Delivery Points (SDPs)- Commodities are available at the central level but not available at the facilities point due to challenges with transport and logistics to the last mile;
- Coordination at sub-national level is weak;
- Low quality of data from downstream affecting forecasting and quantification, and utilization;
- Weaknesses with commodity security at the last mile e.g. some districts receive excess while others receive less and;
- Challenges with ZAMMSA in moving stocks to the last mile and in some cases does not stick to the schedule.
- At times delays in delivery of commodities by ZAMMSA.

1.3 Supply Chain Management Information System

The MoH operates a centralized National Drug Budget Fund and Health Management Information System (HMIS) that was designed as an integrated aggregation of information from all sub-systems. These include: District Health Information System, Provincial Health Information System (PHIS), SmartCare, Human Resources for Health Information System (HRHIS), Electronic...
Logistics Management Information System (eLMIS), Financial Management Information System (FMIS), HIV/AIDS, Malaria, TB

Information Sub-System (under the National HIV/Aids Council, NAC) and others. In practice these sub-systems are still quite fragmented or stand-alone, and are at different levels of operational functionality. For example, the District Health Information System captures aggregated quarterly data and information on epidemiology, human resources available, health services delivered (including outreach and public health services), medicines and medical supplies, and finance across all First Level Hospitals (FLH) and other primary care facilities in the district. However, quality and completeness of information are compromised. Further, information on medicine inventory management and control is managed through the eLMIS, which is not integrated in or aligned with HMIS.

Medicine information systems are challenged by multiple ordering mechanisms, parallel programme reporting, human resources (HR) constraints, lack of clear policy decisions on the development of an electronic information system, lack of real time information at all levels in the system, and reporting of consumption vs issue data.

1.4 Quality Assurance

Zambia Medicines Regulatory Authority (ZAMRA) ensures the quality, safety and efficacy of contraceptive commodities by regulating their importation, storage, distribution and use. They also carry out pharmacovigilance and post marketing activities after the products have been registered. However, ZAMRA needs further statutory protection so that it is not amenable to undue political interference as was seen in the case of a Pharmacy registration saga leading to delivery, distribution and dispensing of poor quality medicines to the citizens of Zambia.

1.5 Procurement of goods and services at exorbitant prices

The government has been procuring goods and services at exorbitant prices above the market value. Challenges in procurement of medicines and medical supplies by MOH and procurement in Government Spending Agencies in general led to some cooperating partners to stop funding procurement through the MoH.

1.6 National (Pharma) Policies and Governance

There are concerns that current national policies, legislations and regulations that regard access to medicines and their implementation are not or not fully adhering to the internationally accepted standards and guidelines. This situation creates a risk as it increases the likelihood for political interference that may affect its operations negatively. For instance, Zambia is one of the few countries that has no formal National Medicines Policy (NMP) and NMP Implementation Plan. Although there is a subsection of Essential Medicines and Medical Supplies in the National Health Policy (NHP), this may not be seen as the replacement for the NMP. Pharmacy services in the NHP is restricted to putting in place a mechanism to ensure adequate coordination of roles being played by the many partners in the pharmaceutical services.
2.0 RECOMMENDATIONS/REMEDIAL MECHANISMS

2.1 Strengthen ZAMMSA Procurement Unit Capacity

We are happy to note that the New Dawn government has made a significant step by transferring the procurement function for medicines and medical supplies to the Zambia Medicines and Medical Supplies Agency (ZAMMSA) in accordance with the ZAMMSA Act No. 9 of 2019. This provides the legal basis for ZAMMSA to lead the selection and quantification process of all essential medicines including SRH commodities, which in turn could strengthen the supply chain. This will help deliver quality health services to the citizens of Zambia through improved procurement efficiency and pooled national procurement of generics for both the public and private sectors through a process of commercialization of ZAMMSA services. The commercialization process will be achieved through creation of adequate and sustainable financing by establishment of a seed fund to ZAMMSA. This will ultimately lead to increased availability of essential medicines and enhanced commodity security at both central and facility level.

CPs are therefore encouraged to invest in human capacity development and a seed fund so that the procurement unit can carry out the procurement function professionally.
2.2 CPs budgets for Medicines and other Health Products

2.3 GRZ Budgets for Medicines and Other Health Products

The budget for procurement of medicines and medical supplies is still sitting in the MOH. For ZAMMSA to start procurement, there is need for the Ministry of Finance to start allocating and sending funds for procurement of medicines and medical supplies directly to ZAMMSA.

Supply security in the public sector is at risk as long as the budget of medicines procurement is disconnected from ZAMMSA, which is to be regarded as non-adherence to the WHO’s *Operational Principles of Good Pharmaceutical Procurement*. This has proven to affect availability of medicines in health facilities.

2.4 Increase Financing of Essential Medicines and Medical Supplies through National Health Insurance Authority (NHIMA)

The GRZ launched its first-ever National Health Insurance Management Authority (NHIMA) in 2018 as a key step towards Universal Health Coverage, with the objective of providing universal access to quality health care services. Members of the National Health Insurance (NHI) Scheme receive covered medical services for free at all public and private accredited health facilities in the program. The NHIMA scheme allows all citizens above 18 to be registered as members of the Scheme and will pay prescribed contributions under the NHI.

The NHIMA scheme has provided an excellent opportunity for the private sector to complement the efforts of government in providing quality health services to the citizens of Zambia without having to pay out-of-pocket. NHIMA members are assured of quality medicines in which the private sector could fill the gap in access to medicines left by the partly failing public sector in large parts of the country, while NHI pays for the services on behalf of all its members. According to the Act, NHIMA will provide reimbursement to public and private healthcare providers for services offered to its clients. This mechanism will promote private health providers to set up quality health services even in rural areas as sustainability of the business can be assured mainly through the NHIMA scheme. By the same token, public health facilities will also be able to recoup their drug expenditure funds and other services through the NHIMA reimbursement system. These funds can then be used to purchase more medicines and other medical supplies from ZAMMSA. In turn, ZAMMSA can also use these funds to procure more medicines, creating a sustainable cycle.

This mechanism will automatically transfer the responsibility of purchasing and maintaining commodity stock level to the facility, and hence will lead to the following advantages:
i) Elimination of multiple ordering systems and enhancing accountability;
ii) Creation of a pull system, rational use of medicines, elimination of over- and understocking, and reduced expiration of medicines;
iii) Enhanced maintenance of medicine inventories;
iv) Adequate stocks of essential medicines at hospitals and health facilities.

MedRAP strongly advocates that responsibility of NHIMA is returned to MoH because its mandate lies by and large with the health sector based on social security mechanisms. Therefore, it is not per se a social security entity and hence the Ministry of Labour and Social Security (MLSS) cannot adequately provide appropriate policy oversight for a health entity. By the same token, placing it under MLSS puts NHIMA at a distance from direct policy oversight from MoH, and complicates the supervisory role and programmatic integration with MoH.

2.5 Decentralisation of the National Drug Budget/ Commercialization of ZAMMSA

There is need for a policy change enabling decentralisation of the national drug budget to be allocated to each health institution/ district. Health facilities may be able to make their own budgets and purchase medicines and medical supplies from ZAMMSA on a cash basis. The institutions will then recoup their money through NHIMA in a sustainable way. Advantages of this will be many-fold i.e.:

1. It will improve the low availability of essential medicines in both the public and private sectors;
2. ZAMMSA will leverage economies of scale to negotiate lower procurement prices directly from manufacturers resulting in lower final prices to patients, and;
3. It will ensure self-sustainability of ZAMMSA in that profits from the commercialization programme may be used to secure increased and sustained availability of essential medicines in public institutions and reduce the financing strain on the government. It is also envisaged that the ZAMMSA will develop a time-bound robust strategic plan to create internal capacities to house and manage the national procurement of all essential medicines and commodities, including SRHC. This must also include a business plan of supply and sale of commodities to both the public and private sector.

2.6 Monitoring and Evaluation Mechanisms

With the increase in public sector expenditure, a decentralized drug budget and increased procurement by ZAMMSA and at facility/ district level, there is a dire need for proper monitoring and evaluation of all procurement activities to be conducted by the central level (MoH). This will provide an opportunity for early detection of problems and follow-ups in order to keep the system viable and responsive. Creation of strong district and facility community health committees comprising of local health managers/ providers, local community/ religious leader and grassroots CSO, CBO etc will lead to greater accountability and transparency in government decentralized procurement as it involves huge sums of public funds.
3.0 Conclusion

Ministry of Health operates a centralized National drug budget fund and Health Management Information System (HMIS) that was designed as an integrated aggregation of information from all sub-systems. We as MedRAP recommend that MoH should take clear leadership to develop a single programme to which all levels, donors and other funding agencies must adapt and adhere to.

There is need for MoH to formulate a formal National Medicines Policy (NMP) and NMP Implementation Plan. These plans must clearly align themselves with decentralization policy of the New Dawn government and WHO’s Operational Principles of Good Pharmaceutical Procurement Practice. In the meantime, government needs to revise the essential medicines supply chain strategy taking into account the recommendations made by parliament and other stakeholders.

It is clearly evident that the last mile distribution system of the centralized distribution system, through which ZAMMSA is obligated to deliver essential medicines up to facilities based on a “push” system, whereby ZAMMSA determines the needs and send drugs and commodities to the facilities via district delivery points has failed and is no longer tenable. What we propose instead is for ZAMMSA to expand the number of hubs which will hold reflective stocks of the central warehouse. This will enable easier access for facilities to order and purchase medicines and medical supplies from the nearby local ZAMMSA hubs thus, transitioning to a “pull” system. This will facilitate and help anchor the decentralized procurement of medicines to facility/ district level. This will lower the accountability threshold down to the facility/ district level which will be obligated to keep and maintain proper records.

In conclusion, it is in our considered view that a well-defined decentralized drug budget system, a commercialized ZAMMSA and a fully rolled out NHIMA reimbursement programme must constitute the initial key components of a new and sustainable medicines supply chain strategy that will ensure achievement of Universal Health Coverage (UHC) through the Vision 2030, which envisions a prosperous country where all Zambians have access to quality health services, including medicines.
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