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RHCS country case study:
Zambia
Final version

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Abbreviations

ANC	Antenatal Coverage
ARVs	Antiretroviral Therapy
BHCP	Basic Health Care Package
CBOH	Central Board of Health
CDD	Communicable Disease Control
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
DANIDA	Danish International Development Agency
DCI	Development Cooperation of Ireland
DFID	Department for International Development (UK)
DHMT	District Health Management Team
DILSAT	District Integrated Logistics Management Self Assessment Tool
DSBL	Drug Supply Budget Line
EPI	Expanded Programme of Immunisation
FP	Family Planning
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
GTZ	German Technical Cooperation Agency
HIV	Human Immuno Virus
HMIS	Health Management Information System
HSSP	Health System Support Program
IPPF	International Planned Parenthood Federation
ITCP	Inter-agency Technical Committee on Population
IUD	Intra Uterine Device
JICA	Japan International Cooperation Agency
LMS	Logistics Management Information System
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MSL	Medical Stores Limited
MTR	Mid Term Review
MVA	Manual Vacuum Aspiration
NGO	Non Governmental Organisation
NHSP	National Health Strategic Plan
PPAZ	Planned Parenthood Association of Zambia
PMTCT	Preventing Mother-to-Child Transmission
PRS	Poverty Reduction Strategy
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHU	Reproductive Health Unit
RNE	Royal Netherlands Embassy
SIDA	Swedish International Development Agency
SFH	Society for Family Health
STI	Sexually Transmitted Infections
SWAP	Sector Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant

TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VEN	Vital / Essential / Necessary
WHO	World Health Organisation
ZDHS	Zambia Demographic and Health Survey
ZEML	Zambia Essential Medicines List

EXECUTIVE SUMMARY

Zambia RH commodity security is evidently poor with a series of problems in ensuring safe supply from forecasting, procurement, financing distribution and the capacity of health professionals to administer drugs or deliver appropriate services. As a result although demand for contraception is quite high, the CPR is low and the total fertility rate one of the highest in sub-saharan Africa.

Widespread capacity problems undermine the scope for achievement. These challenges apply not only to RH; other services are also affected by critical shortages in human resources, and problems in procurement and logistics management. However the ***policy environment*** fails to gives priority to RH. National level policies do not give a prominence to RH, and several of the sector level policies and plans that directly relate to improving RH status and which could impact on commodity security, have not yet been finalised and implemented. Within MoH it is not clear who is charged with addressing commodity security issues suggesting an overall lack of accountability.

This in part reflects very limited capacity in the RH Unit; it is difficult to see, how with present staffing the RHU can either finalise those strategies, or support their implementation. This is likely to be exacerbated by the reintegration of MoH and CBoH which may reduce capacity at the centre because of changes in staff terms and conditions leading to resignations, demotivation etc. These capacity problems come at a time when the growing human resources problem in Zambia continues to undermine efforts for improvement.

Zambia has had a long history of difficulties with the drug and commodity distribution system and despite significant changes and achievements in some management and financing systems most notably the basket financing arrangement and the development of the CBOH, this area has remained problematic. A lack of faith in government systems and GRZ willingness and capacity to address problems has undermined commitment to a joint approach to forecasting, procurement and distribution. As a result these are fragmented and inefficient with parallel arrangements failing to ensure contraceptive or drug security.

With regard to funding for contraceptives the sector has been reliant on three donors, DFID, USAID and UNFPA to provide parallel financing and procurement. The first of these two are refocusing their support and although the introduction of a Drug Supply Budget Line will make better use of government controlled funds, including the budget support available from DFID, there needs to a conscious effort to ensure that RH supplies do not fall short in the interim as the fund is set up.

Although this picture is rather gloomy there are lessons to be learned from past experience in Zambia where contraceptives and RH drugs have been more secure, and ***there are developments underway which could improve the current situation.***

Two key TA inputs from DFID and USAID have made an important contribution to ensuring commodity security, demonstrating the importance of staffing and coordination in managing the technical complexities of forecasting, ordering and

procuring. The gap in staffing in MoH left by the end of the DFID project is shortly to be filled by UNFPA funded logistics coordinator who will be an essential support to the RHU. A further boost to the capacity and effectiveness of the RHU could come if proposals to raise it to the level of sub-directorate are implemented.

The presence of this logistics coordinator is expected to contribute towards the work of the proposed RHCS committee. This is expected to be an important focal point for donors, government and other stakeholders such as NGOs to address funding for commodities though considerable work will still need to be done on putting this multi-agency coordination into practice.

Within the wider MoH important reforms are proposed which should also have a beneficial impact on commodity security. A Drug Supply Budget Line (effectively a basket fund for drugs) is under development and after several years of discussion may now become a reality as donor confidence in government systems increases. Changes in national procurement planning will also be implemented in tandem with this, which will rationalise forecasting and procurement and have a beneficial effect on distribution. Huge system inefficiencies and some procurement irregularities should be reduced so that the entire system works in a much more streamlined fashion.

In terms of the ***impact of the wider reform environment*** the sector wide approach within which the Zambia health sector operates has provided a forum for raising concerns on procurement and the performance of Medical Stores Limited (MSL). However It has been less successful as a forum for promoting RH concerns and within the RH sub-sector parallel financing and procurement arrangements and a preponderance of projects means that in many ways the RH Unit is operating in a more old-fashioned project based environment. DFID moving upstream to budget support will be an interesting change in relationship between that donor and GRZ.

With regard to the ***impact of international support*** on the way that commodity security is addressed, at the moment the country level interface with global procurement and financing is more or less non-existent with limited interaction between donor procurement and national systems for example. There are examples of procurement inefficiencies and mistakes due to poor communication and coordination between the various systems. The government is clearly conscious of the problems created by this fragmentation and is still labouring under parallel systems which occupy its capacity whilst preferring that donors use more flexible funding modalities and place more reliance on using existing government systems. That said the RHU clearly values the support of all the donors with good working relationships and coherent programming within the limits of parallel systems. At the end of the day however higher level Government ownership of the problem of RH commodity security seems to be low and may be undermined by donor approaches to providing parallel support. The global funds also divert funding and capacity away from more integrated programmes.

Further opportunities exist for continuing to improve commodity security, which GRZ is beginning to explore. The PRS includes a section on addressing RH issues and could provide a spur to provide for needs that are not adequately addressed; in 2005 funding has been allocated to MoH and programmed support of achieving better maternal mortality. The RH unit has started to look more holistically at the contribution of the non-government sector, especially the contribution made by

social marketing and NGO distribution. This is perhaps the start of thinking about a total market approach. And whilst the global funds are proving to be a mixed blessing in some respects as they are substituting funds and diverting NGO activities away from RH, the Prevention of Mother-to-Child Transmission programme (PMTCT) has become an important opportunity to improve RH commodity security and services.

1. COUNTRY CONTEXT

1.1. RHC demand and supply profile.

1.1.1 Use of contraceptives

Knowledge of contraception among women in Zambia is high and there is considerable desire among women to control either the timing or number of births. According to the last Zambia Demographic and Health Survey (ZDHS) in 2001-02, 71% of currently married women would like to either wait for another birth or not have any more. Despite this, the contraceptive prevalence rate is low. There has been some progress recorded since the 1996 ZDHS from 26% use of modern methods among married women to 34% in 2001 but this is still insufficient to impact on one of the highest TFRs in sub-saharan Africa (5.9 in 2001-02 ZDHS). Low contraceptive use is associated with unmet need (27%), poor education (about half of women who have at least some secondary education are using contraceptives compared to 31% with only a primary education), and rural residency (45% of urban women use contraception in contrast to 28% of their rural counterparts). Similarly there is a correlation with poverty: amongst the provinces, Lusaka and Copperbelt (the wealthier provinces) have the largest percentage of women using contraceptives (47% and 45% respectively) whilst the poorer Western province has the lowest with 21%.

Male attitudes to family sizes generally predominate over those of women, with men often preferring larger families. Other social factors impacting on low CPR include poor education among women, social respect for large families and a belief among some that fewer children in a family will make a man turn to other women.

The most popular method of modern contraception is the pill, followed by injectables. The use of both of these has increased between the 1996 and 2001 surveys. Male participation in family planning is low as seen by condom use which saw only a very marginal increase over the same period. This in part reflects a lack of male oriented RH services. Condom use overall by sexually active men, whether for family planning or HIV/STI prevention, stood at 19.4% (ZDHS 2001-02) but for women was only 10.3%

Although government services for family planning, antenatal and postnatal care and delivery are free according to the health policy, collateral costs of accessing RH services are high for the poor. In addition to transport and opportunity costs etc, all patients are charged a nominal fee to register with a health facility which sets a barrier to access.

According to the ZDHS 2001-2002, women accessed FP mostly through the public sector: pills 67%, injectables 83%, female sterilization 40%, and condoms 39%.

Private hospitals and private surgeries also have a share in providing FP methods especially for female sterilization (36%) and condoms (35% obtained from shops)

1.1.2 Other reproductive health issues

In addition to low usage of contraceptives, another main concern is the high level of maternal mortality and morbidity. In fact the maternal mortality rate has been increasing: in 1996 it was recorded at 649/100, 000 live births but has risen to 729/100,000 in 2001-2002. This is despite a high rate of antenatal coverage of 93% percent with 72% of those women attending antenatal clinic 4 times. A very significant contributory factor to high mortality is the poor access to emergency obstetric care, as indicated by a very low rate of caesarean sections (only 2.1%). It is estimated that approximately 50% of maternal mortality is directly attributed to postpartum haemorrhage, sepsis, obstructed labour, abortion and eclampsia. Indirect causes of maternal mortality include malaria, anaemia and HIV/AIDS related conditions. Although 47% of all deliveries are recorded as supervised this includes oversight by TBAs whose impact is questionable. Other contributory factors are the poor quality of ANC despite high attendance rates and the lack of postnatal care; 77% of women who deliver at home do not get any postnatal care and those delivering in hospital are routinely discharged within 24 hours without any follow up.

The 2001-02 DHS showed an HIV prevalence rate of 16% among those tested with higher rates among women (18% for women versus 13% for men). Prevalence is twice as high in urban areas as in rural areas. Health seeking behaviour to address sexual health problems is poor. For example although 90% of women and men know one or more symptoms of STIs only about 30% seek treatment.

1.2. National policy and strategy structures

1.2.1 Linking RH and poverty

The Zambian **Poverty Reduction Strategy Paper** covers the period 2002 – 2005 (including a one year extension). It makes no reference to a link between poverty and population growth, or poverty and reproductive health. Reproductive health is included in the basic package of health services and as such is targeted for improved performance and investment but it is not singled out for special attention unlike malaria, EPI and CDD and other disease prevention measures, with the exception of PMTCT under the HIV programme. The MMR is one of the health indicators of increased life expectancy. However although a target of 500/100,000 live births is identified from a 1996 baseline of 649/100,000 no date is given for the achievement of that target. An indirect impact on reproductive health and commodity security could be assumed from the references to improved drug supply and better provision of kits to community level health workers, but it is not clear whether contraceptives are included in this. It is likely that they are not, given that only condoms are included in kits at the moment. Under the HIV programme there is reference to enhanced condom promotion and establishing a regular distribution mechanism for them.

Restructuring of procurement is identified as a way of improving the purchase of drugs which could impact on safe delivery and maternal mortality, as well as on contraceptive procurement if this was more integrated into government procurement systems.

At the time of writing a second PRSP/national development plan was under preparation. Although there are meant to be close links between this and the sector plan which is also being developed, there has been concern expressed that the current drafts do not translate into each other, and that the development processes of the two have been unrelated.

1.2.2 National policies and reproductive health

The 2004 MTR of NHSP was critical of the speed of policy development which it suggested had adversely affected implementation on the ground. Some policies, including the national RH policy, remain in draft form after some considerable time

Zambia has a ***National Population Policy*** which was revised in January 2005 (though not yet passed), produced by the Ministry of Finance and National Planning. This does identify a link between population growth and poverty, stating that the growth rate has affected the Government's development efforts. It also has as one of its guiding principles, that "All couples and individuals have the basic right to decide freely and responsibly on the timing, number and spacing of their children and to have the information and means to do so"[1]. However there is no reference to the need to improve access to contraception as a way of addressing population growth. The low CPR is not mentioned in relation to high fertility rates, indeed it is not mentioned at all in the policy, as a cause of population growth or a problem that needs to be addressed. It is therefore not surprising that commodity security, either for contraceptives or drugs, is not discussed.

There is a draft ***National Reproductive Health Policy*** which has yet to be finalised since a revision commenced in 2003. The current draft of the policy presumably has some way to go before it is complete. Whilst it acknowledges that safe delivery is compromised by a failed drug supply system, in the narrative it does not recognise problems of supply of contraceptives specifically although this has been a problem within the last year; it is not clear whether these are included in the drug supply problems mentioned at community service level. It does however acknowledge that women are deterred from accessing government services by the limited range of methods that are available there. Under specific measures to increase access to quality family planning services there is the need to "Ensure sustainable procurement, storage and distribution systems for family planning commodities throughout the country"[2]; but this is not carried through into the Implementation, Monitoring and Evaluation Matrix, so the importance of backing up services with supplies may be lost through failure to monitor for outcomes of the policy.

At sector level the **National Health Strategic Plan 2001 – 2005** states that that RH is major component of the Zambia health package because of the need to address the 'ever increasing burden' of maternal morbidity and mortality[3]. It acknowledges the high unmet need for family planning and inadequate contraceptive mix. The issue of drugs and supplies for the sector as a whole, along with problems of procurement and distribution, are given attention as key issues in improving service delivery and strategies are proposed for solving problems. Although contraceptive

[1] National Population Policy p5
[2] National Reproductive Health Policy p29
[3] National Health Strategic Plan p24

and supplies for safe delivery are not referred to specifically, one can assume that they are intended to be covered by these strategies as they are within the health package. Strategies proposed in 2001 included

- Establishment of a procurement unit in the Central Board of Health (CBoH) with comprehensive procurement procedures.
- Better performance monitoring of Medical Stores Limited
- Operationalising a Drug and Supply Fund (DSF), in order to secure and sustain sufficient funds from both GRZ and donors for the procurement of drugs and supplies.
- Scaling up resources for drugs to $1.8per capita from $1.3
- Reviewing the Essential Drug List, Zambia National Formulary and the National Drug Policy.

1.2.3 The National Reproductive Health Strategy and commodities

At subsector level The **Integrated RH Plan of Action for 2003 – 2005** which was written in 2002 aims to accelerate implementation of the MoH policy to provide integrated health services and to ensure technical capacity building for IRH in non-health sectors such as the Ministry of Education. Within this it plans to mobilise additional funding for drugs and contraceptives, and costs expected requirements for 2002 – 2007.

There is also a **Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Zambia**. Still in draft, and developed through a regional WHO process, this has been prepared by MoH/CBOH with support from WHO, UNICEF, Health System Support Program (HSSP) and UNFPA. It aims to provide a framework for building strategic partnerships for increased investment in maternal and newborn health at institutional and programme levels. The framework acknowledges the importance of essential supplies to save lives but does not offer any specific strategies to address the problems of commodity security in Zambia. However CYPs, and CPR are included as indicators.

Neither of these plans really translate into concrete action any proposals that will improve the supply of appropriate contraceptives and drugs to where they are needed.

1.2.4 Monitoring RH and RHCS

RH is monitored through the Health Management Information System (HMIS). Information on selected indicators including maternal deaths, CPR, use of condoms and new family planning acceptors are gathered at facility level and aggregated to district then provincial then national level. The system has its problems. Computerised systems for data aggregation and analysis cover approximately 85% of district facilities but far fewer hospitals, which compromises the accuracy of reporting. Coverage of private practitioners is also more or less non-existent which implies that there are failures to report both maternal deaths and family planning uptake accurately. Other issues include untrained staff gathering the data, incorrect interpretation of HMIS definitions, and a consistency level between primary records and health units reports of about 70%. However districts do seem to use the information for decision making at that level, although this is less evident at provincial or national level

Annual reviews of the sector as a whole are held each year with a review of aggregated performance data. In 2004, there was a mid term review of the national health strategic plan. Within these, RH is monitored alongside other basic package components but it has not been highlighted out for special attention, likewise for maternal mortality. This perhaps reflects the fact that NHSP did not prioritise its strategies so that RH sits as one of a number of interventions – important but not targeted for special review.

Although RH commodity security for both contraceptive and drugs are also not singled out for particular focus, considerable attention has been given in sector reviews and the mid term review to the problem of ensuring adequate quantities and delivery of all drugs and supplies. The introduction of DILSAT (District Integrated Logistics Management Self Assessment Tool) has highlighted the poor status of all aspects of the supply chain. Covering financing, stores management, quantification and re-supply, distribution and rational drug use, it is meant to assist district, hospital and health centre staff assess their performance in logistics management and medical supplies. Use of the tool has shown there to be problems in all these areas and that an adequate Logistics Management Information System (LMS) is essential. One has been introduced but it is in limited use and needs further development and support; MoH is currently preparing for roll out of LMS to all health facilities and considering how to address the key issue of training and retaining suitably qualified staff.

1.2.5 Translating the national agenda into district priorities

At district level the RH programme is just one of several in the basic package that have to be implemented to reach targets developed as part of the planning process so beyond this there is no special priority to be given to RH. The planning process is meant to be based on 'an analysis of the local health situation, locally defined priorities and affordable objectives which have been agreed with all key stakeholders'.[4] This gives some room to address locally defined health priorities based on epidemiological data, as agreed with the district health boards. In practise however, districts need support to focus on areas which will have the greatest health impact. As a result RH may or may not be seen as a priority area. This may be skewed either positively or negatively by donor funded activities taking place in districts which may promote a focus on RH or not depending on the projects.

Even where RH is seen as a priority inevitably the capacity of the districts to provide a full service is constrained. District health management teams have a lot of power and scope but performance depends very much on the capability of the director, and there is a lot of variation. Also, although the leading principle behind the Basic Health Care Package (BHCP) is that 'if health services are to be provided to all, then not all services can be provided' [5] the reality is that the current definition of the BHCP is still too wide so that there is a mismatch between funding and interventions planned (but then not implemented). Critical constraints for the delivery of RH, as for many other programmes, include staff shortages especially in rural areas aggravated by the severe HIV epidemic (one third of rural health facilities have no trained health worked), high staff turnover which affects the training and support needed to achieve and maintain service quality, poor communications and transport links to facilitate

[4] Mid Term Review Report February 2004, Of National Health Strategic Plan p14
[5] ibid p38

referrals, the lack of effective supervision from the top down and a shortage of funds to provide essential drugs. This is in addition to a failed procurement and supplies system for contraceptives. The Zambia SWAp has been commended for its improvements in policies, plans and structural developments to support better implementation, but this has not been sufficient to counteract failing services.

In addition to low capacity common to all programmes, skills for managing safe deliveries and giving family planning services are recognised by MoH personnel and donors to be undeveloped, which means that the whole range of services cannot always be provided. Staff are unfamiliar with correct administration of some drugs that should be relatively straightforward to use, and others need specialists to administer them who are in short supply – this in part accounts for the low usage of magnesium sulphate. It has been estimated[6] that of the safe delivery marker drugs identified for this study, only lignocaine is really used. Similarly staff are unfamiliar with necessary family planning techniques such as IUD insertion (it is estimated that there are currently a number of IUD stocks in the country at health facilities which are about to expire as a result of non-use by staff due to poor skills). A constant programme of training is needed to address these shortfalls; for example a program to train staff in IUD insertion is now being supported by cooperating partners. The current development of training materials will also be essential to upgrading skills.

1.2.6 Working groups on reproductive health commodities

At the time of writing there is no specific working group on RH commodity security although an RHSC Committee is planned as soon as the proposed UNFPA funded logistics manager joins the RH Unit and has the time to convene it. The purpose of the group will be to bring together high level representatives of government, donors, social marketing and other non-governmental organisations such as Planned Parenthood Association of Zambia (PPAZ), the private sector including pharmacies, and other stakeholders to mobilise support and resources around better commodity security. It will link to the Family planning task group, which is chaired by UNFPA, and the RH sub-committee but will be appointed by the minister and so will not report through them. RHD will act as the secretariat. This group, or a similar one seems to have been in existence before but as yet there has been no sustained action to ensure its continued activity.

The RH Sub-Committee reports to Inter-agency Technical Committee on Population (ITCP), Ministry of Finance and Planning. The main responsibility of the Sub-Committee is to coordinate and provide technical oversight to improve reproductive health services in Zambia by developing policy, and developing reviewing and supporting development plans for RH. It aims to ensure RH priorities are included in national plans, to facilitate regular review of the national reproductive health action plan, support provinces in their planning and identification of priorities, and facilitate research. Membership is large and it meets once a year, so the task groups are meant to carry out more 'hands on' work. At the moment the Family Planning Task Group is the one most concerned with contraceptive security as part of its remit to support a refocus on family planning and improve services. The group meets in a rather ad hoc fashion 4 – 5 times a year and although it has looked at issues that affect commodity security such as recommending changes to generics and advocating for training, its main focus is on advocating for wider method

[6] various respondents in interview

availability/choice and better forecasting rather than actually taking practical steps to make these happen.

1.3 National policy making, strategy development and co-ordination process

1.3.1 The SWAp context

Zambia's sector wide approach was one of the first in Africa. Since the mid 90s 'cooperating partners' have agreed to support the government through a common sector strategy delivering a basic package of health services through more flexible funding arrangements. After a difficult period in the late 1990s, the process is coming back on track and nearing the end of the implementation of the current NHSP. A new Plan is under development to cover the period 2006 - 2011. The current NHSP aims to provide Zambians with cost effective quality health care based on the principles of improving efficiency, equity and effectiveness through leadership, accountability, partnership and affordability.

Although the NHSP is meant to provide a focus for GRZ and donor support, the lack of an elaborated and finalised annual programme of work arising from it has meant that the plan has not been the vehicle for effective change that had been hoped for. The SWAp working arrangement put into practice through various coordinating committees and sub-committees has however acted as a forum for discussion of key issues even though follow up by government has not always been adequate. The MTR suggested that many see this as part of a general culture of lack of accountability, mainly from government.[7].

Over the life of the SWAp there has been a considerable focus on improving planning capacity and systems at both central and district level; there is evidence that this has had an effect at both national and local levels, supported by the channelling of flexible money through the basket funding arrangements. This increase in capacity was one of the motivations behind creating the Central Board of Health and provincial functions, separating this implementation role from the policy making MoH and enabling donors to bypass some intransigent problems within MoH. This strategy has had mixed results to the extent that at the time of writing the two were being amalgamated: MoH lacked the ability to carry out its supervisory functions and parallel systems had evolved (e.g. in procurement), which along with better terms and conditions for staff in CBoH led to conflict and confusion. At the time of writing the details for the reunification had not yet been announced. It is known however that it will have an impact on salary levels for those staff previously with the CBOH who had been attracted to the posts because of the greater earning potential. Those higher salaries may be guaranteed to the end of their current medium term contracts (i.e. 2 – 3 years at most) but after that they will probably revert to the less favourable civil service terms and conditions. Not surprisingly morale is affected and some key staff have left which will diminish capacity at the centre.

Despite the emphasis on improving systems there has not been the impact on service quality and overall health status that has been hoped for. The increase in maternal mortality since 1996 is an indication that services are sliding downwards in quality and effectiveness, undermined by the constraints described in section 1.2.5. particularly HIV. In the course of interviews for this case study various people from

[7] Mid Term Review Report February 2004 Of National Health Strategic Plan p18

both the GRZ and donor organisations suggested that this deterioration may be in part because the emphasis on systems improvement (in particular on management and financing issues) has rather overshadowed more technical discussions on improving the quality of service delivery, and that a new emphasis is needed.

1.3.2 Funding RH within the SWAp

The key funding arrangement for the SWAp is in the form of a series of 'baskets'. Initially when the SWAp started a district basket funding arrangement was created in which only district health management teams and level one hospitals were covered, and not all cost items were included. During 2003 another basket was created for level 2 and 3 hospitals expanding to include all hospitals by the end of 2003 and now basket funding for training institutions. At the same time parallel funding arrangements have continued, largely directed to projects at district level, used by those partners who are either unable or unwilling to use the pooled funding systems. However the feeling among some in government is that this allows some of those funding agencies to keep away from mainstream policy issues, and maintain their own approaches and priorities without really buying into the government agenda shared with those basket funding donors. This is borne out by the fact that district level projects are not necessarily integrated into district work plans or budgets.

RH is particularly supported by parallel funded projects. CIDA, UNFPA, UNICEF, GTZ, DCI and WHO are all currently supporting various district level projects to a tune of approximately US$13.4 million since 2000 or at least US$2.0 million per year (including some projects which have finished, funded by DANIDA and USAID)[8].

The MTR of early 2004 estimated that the resource envelope for the period covered by NHSP (01 – 05) was likely to have expanded by 2005 although within this GRZ contributions have not grown as expected so the difference has been covered by the donors. However the review suggests that the flow of funds from central to districts has improved over the period so that even if the real value of funds has not necessarily increased, disbursements as well as nominal allocations have generally improved. The review also suggests that there have been efficiency gains in terms of implementing activities which could imply better resource flow to RH over the period as part of the basic health care package implemented at district level. However to offset this, there is a concern that the budget for ARVs could potentially consume a considerable proportion of the total MoH budget. Given that the overall MoH budget has not grown there could be a substitution effect between ARVs and other GRZ funded interventions such as health centre drug kits.

In August 2005, DFID and UNFPA funded a study to identify resource flows to RH in Zambia[9] to determine whether changes in priorities at district and national level were needed to address RH needs and to identify planning mechanisms to be developed or strengthened to address RH funding problems. The study estimated that RH as a whole (including commodities, and a share of HR, overheads, and transport) received a high level of investment at 0.8% of GDP or 40% of the total 2% GDP spend in the public health care system over the last four years. The study did not state whether these levels of expenditure had risen or fallen over time, nor how RH fared in comparison to other elements of the basic health packages. However the

[8] Resource Flows to Reproductive Health in Zambia p42
[9] ibid

study did observe that of all the funds available at district level, decreasing amounts were being channelled through the basket funding arrangement in favour of parallel funding for specific vertical interventions such as TB. This has reduced the available flexible money for the districts to direct to priority interventions such as RH; this in addition to the problem of substitution described above. Again the study did not estimate likely funding available to RH in the future.

A further development which could have an important bearing on RHCS is the development of the Drug supply budget line which is discussed in section 1.4.2

1.4 Funding, procurement and distribution

1.4.1 Overview

There are a number of different arrangements for funding, procuring and packaging the distribution of RH commodities within the government system. Drugs for safe delivery are largely included in the drug kits (see Box 1). They are funded and procured by various donors according to who is supporting procurement at any one time. Some items such as magnesium sulphate are only available as bulk items which are supplementary to the kits. Some government funds are also spent on drugs.

Box 1: Drug distribution: Pushing and Pulling

Drug kits were initiated in 1987 by SIDA to counteract the persistent problems of frequent shortages of drugs and supplies that were experienced in most health facilities. Before the kits were introduced hospitals were meant to order drugs and distribute them to health centres in their referral network. In practise clinics often did not get adequate supplies, for a variety of reasons to do with the capacity to order and distribute, and the availability of items. Although it was acknowledged that needs would vary across the country and facilities the kit system was assumed to offer greater security than relying on health centres and hospitals to order correctly. There are now 2 drug kits, one for health centres to meet the basic needs of 1000 new clients per month, and the other for hospitals. These are 'pushed' to the districts and hospitals. The content is periodically revised to take account of changes in need and drug availability. A number of different donors have funded the provision of the kits, specifically RNE, JICA, and UNICEF over the last 3 years.

In addition to the kits individual 'bulk' drugs may be ordered to supplement what is in the kits. These are obtained through a 'pulling' system whereby districts are meant to order what they need from MSL. The kits are meant to provide the basic necessities for clinics and hospitals but the availability of the bulk items gives them the flexibility to meet the particular needs of their patient workload.

Contraceptives are available to order only as 'bulk' items with the exception of male condoms which are also included in limited quantities in the kits.

All contraceptives with the exception of some condoms are funded and procured by bilateral or multilateral donors. Contraceptives are ordered as 'bulk' items supplementary to the drug kits, with the exception of a limited number of condoms

which are included in the health centre drug kits, and are also available for additional ordering as bulk items

All contraceptives and drugs are delivered straight to Medial Stores Ltd which undertakes national distribution of drugs, supplies and equipment with the exception of vaccines.

In addition to this system a number of other arrangements have proliferated to address the procurement, funding and supply of particular items, where the national system is thought to be failing. For example MVA kits are bought by whichever donor can offer support at the time; they are held in the University teaching hospital stores, and are requested by units writing to the coordinator who keeps a tally on who has been trained and should therefore receive them. A revolving fund to endure continuity of supply is under discussion possible to be managed by the University Teaching Hospital (UTH). The intention is to retain this arrangement until MSL and the procurement and forecasting systems can show that they can cope with it.

1.4.2 Funding of commodities

At the moment the funding of all commodities for RH, whether they are contraceptives or drugs is under various parallel financing arrangements. This is because the district basket is essentially limited to provision of recurrent costs to districts. It has been difficult to get sufficient consensus between donors and MoH to allow use of pooled funds for crucial cost items such as drugs and supplies because of wider issues over procurement and distribution arrangements which have undermined donor faith in government systems. Similarly a drugs account opened by GRZ in 2000 never really got off the ground.

DFID, USAID and UNFPA have been the three donors supporting the supply of contraceptives. DFID have provided funding for micogynon and microlute, implants and male condoms. USAID have funded depo-provera, norplant and condoms for social marketing, and UNFPA have financed combined oral contraceptives, implants (Jardell), and male and female condoms.

This however will be changing as donor funding arrangements alter and it is not clear what new provision there is going to be for sustained financing of necessary items; nor is it entirely clear what the long terms needs will be due to the problems with forecasting which are discussed in 1.4.3. USAID support for condoms is moving away from supplying the social marketing organisation the Society for Family Health (SFH) to managing PEPFAR funded activities. DFID is moving to budget support which should offer greater sustainability and predictability of funding to the health sector as a whole, but there is as yet no strategy by government for increasing their contributions for commodity procurement to address potential shortfalls, other than the changes implied by the move to the Drug Supply Budget Line as discussed below. The potential gap left will be too great for UNFPA to fill on its presently available funds and replacement by another parallel arrangement would only be a short term measure with all the high transaction costs, lack of ownership etc that these systems create.

With regard to RH drugs, some of the bilateral donors supporting RH projects fund and procure the necessary supplies for their activities. For example UNICEF

procures midwifery kits, obstetric surgical kits, iron folate and other supplies to support emergency obstetric care services in all districts for 2002-2006. Other donors support is channelled to the procurement of the drug kits and other bulk drugs (see box 1).

Parts of this system are likely to change however with the proposed introduction of the Drug Supply Budget Line (DSBL), which would have an immediate impact on the availability of RH drugs, and which in the longer term could affect contraceptives as well. At the moment District and Hospital Boards budget for the drugs they predict they will need and those drugs are meant to be supplied in line with these budgets. (They also are allowed to use a proportion of their budgets to procure drugs from the local market - 4% for clinics, 20% for hospitals - in case of emergency stock outs etc.) In practise this does not work particularly well because of the disconnect between procurement, forecasting and budgeting and the resultant stock availability, and facilities' needs (see section 1.4.3). The DSBL would be a joint drug budget line in MoH/CBOH using government accounting procedures and staff to administer it, but with agreed procedures and voluntary oversight by a DSBL committee. Each district's budget allocations for drugs would appear as virtual credit lines against which they could draw. The DSBL would be introduced alongside improvements to the procurement and stock management systems in order to streamline the entire process.

Ideally GRZ would like the two drug kits (see box 1) plus bulk items for districts and level I – III hospitals to be included in the first year with an expansion to include other vertical programmes. Drugs would be procured by a combination of one-off emergency purchases to fill the pipeline and cover immediate urgent needs, followed by 2 year framework contracts which would allow for a steady flow of drugs coming in through phased orders with only intermittent large scale procurement to set up the frameworks. Ultimately all funding and procurement would be handled in this way, but as an interim step vertically funded commodities, such as contraceptives, will be included as in-kind contributions to the budget line; i.e. they would come on budget but still be funded separately; this does however depend on sustained parallel funding which is not the case (see above). The main aim will be to get one harmonised budget line which reflects all contributions, and which will then support more rational procurement. The RH Unit has come forward to request that RH commodities be included as one of the first programmes to be covered.

GRZ is very committed to this idea and is inviting all donors to join it, transferring their financial support to this mechanism. The reaction has been mixed due to different agency's stance on pooled funding and their confidence in the system's security and governance issues.

It is encouraging that UNFPA supports the introduction of the DSBL and understands the rationale. At the moment their financial support for contraceptives is all funded in parallel but if their internal procedures allowed, the country office would be prepared to contribute to the Drug Supply Budget Line. The office already contributes to the basket fund and regards it as an important lever in UNFPA influencing the national agenda, raising the agency's profile. Although this support is not earmarked, UNFPA is confident that in integrated service delivery, RH is being enhanced by their contribution.

1.4.3 Procurement and Forecasting

Both forecasting and procurement are problematic leaving contraceptives and RH drugs susceptible to stock outs and expiry at both national and local level. The presence of a DFID funded project had helped to address problems in the system in terms of both processes and funding, as described in section 2.1 but since that project finished a year ago the DFID TCO has no longer been present to actively engage in logistics coordination. MoH did not fill the role itself and there does not seem to have been much momentum to recruit the UNFPA funded RH logistical coordinator. As a result difficulties have arisen again and security is under greater threat.

With regard to forecasting for both drugs and contraceptives MOH/CBoH has decentralised the forecasting role to the districts and provinces who feed into the main system at the central level. Every year all districts participate in the planning phase for the following year predicting their likely needs. However districts and hospitals when forecasting have relied on a mixture of issues from MSL and consumption rates which do not yield accurate forecasts, based as they are on a weak system of quantification and affected by periodic stock outs. The introduction of HMIS had led to the abolishment of the existing supply management information system so that the current system is now meant to supply data that can be used for both forecasting and ordering. In practise it is inadequate and various other systems have been introduced to supplement this. In most cases the data from MSL is not accurate as the issues do not necessarily equate with consumption – poor stock management at both MSL and facility level leads to expiries and drug wastage. Similarly basing forecasting on consumption limits calculations to what was actually available rather than what would have been used if there had been no shortages in MSL. The ordering forms which are used to obtain bulk items and contraceptives from MSL can be used to calculate true possible consumption but in practise this does not seem to happen. A further complication is the extent to which the drug kits actually meet the needs of the local population. Whilst these are meant to be supplemented by orders of bulk items different rates of consumption of items in the kits makes it difficult to judge true usage.

Plans from districts and hospitals are then submitted to the CBoH which aggregates estimates. For contraceptives, the RH unit is expected to be responsible for aggregating the national requirements despite their limited capacity, i.e. one person. They receive considerable support from UNFPA for forecasting to supplement information generated through the national process and are about to have a contraceptive logistics coordinator funded by UNFPA within the Unit. Responsibility for procurement on the government side for contraceptives is not clear so mistakes have been made; for example a recent tender for an implant was insufficiently specified in the procurement process with the result that a new product with a different formula won the tender and national retraining was necessary to support its introduction.

Similarly responsibility for procurement of drugs is also unclear and systems vary according to which agency is funding the procurement. A review of current tenders as part of the 2005-07 procurement plan revealed more than 5 different approaches using different procedures. Theoretically there is meant to be a distinction between what MoH coordinates and what is done by CBOH, and similarly what each procures with government money. In practise this is not followed and each has been reluctant

to hand over control to the other with the result that responsibilities and functions are muddled and delays often occur. The reunification of MoH and CBoH should resolve this but at the time of writing it was not clear what form the unified procurement unit would take. As a result of the problems with forecasting, procurement has become an academic exercise which is not based on the true needs of districts. A procurement technical working group set in 2002 has helped to rationalise and clarify procurement arrangements and the participation of the donors and other stakeholders has increased confidence in the government system. However there is still some considerable way to go and mistakes still happen brought about government not being in the driving seat of the process so that that donors can essentially procure without any reference to government; streamlined procurement is therefore dependent on good communication between partners which does not always happen. Global fund procurement of condoms was regarded as no longer necessary once 47 million pieces suddenly arrived in country (funded by DFID and procured by UNFPA) without RHU being aware of the process even being underway. The consignment now sits in MSL who are faced with the problem of distributing this enormous one off import before any of it expires, and with districts having received no advice from the MoH/CBoH pharmacy team on the units in which to order them. Some irregularities within the government procurement process have also been identified which have suggested that there may be advantages to some in having a poorly managed system.

In response to the ad hoc nature of much of the procurement that was happening and its impact on drug security, including commodities for reproductive health, and also to support the introduction of the DSBL, a process of procurement planning has been introduced with a draft medium term procurement plan for 2005-07 produced and another one underway. The intention is to produce one single list of items for procurement on the essential drugs list, regardless of who funds them, which will be better integrated into the supply chain and with the storage and distribution functions at MSL. Many of the problems of procurement and forecasting lie with the fact that MSL is not sufficiently integrated into either process. For example it lacks information on what is to arrive in stores leading to problems of distribution and storage and it cannot predict future stock levels as it is not always aware of what the various programmes order, or what the clients use.

Once the procurement list has been drawn up it will form the basis for a framework contract which will allow for flexible and responsive ordering of stocks at the right level with only occasional retendering being necessary. This will be underpinned by an overhaul of the procurement procedures and supported by technical assistance. This could have a major beneficial impact on the security of RH drugs, both those included in the kits and additional to them, and also on contraceptives even if funding remains outside the DSBL and procurement is still done by other agencies. However if the proposed improvements in procurement are realised then the rationale for undertaking procurement outside the government system will become more an issue of donor regulations and tied aid restrictions (and possibly economies of scale with some products), rather than lack of government capacity to procure using more flexible funds.

The procurement list for the 2005-06 draft was problematic to draw up partly due to the very poor response rate by the various units of CBoH to their likely needs. The RH Unit was one of those that failed to respond. The exercise also revealed problems with the Zambian Essential Medicines List and how it correlated with the

practise of drug ordering and utilisation. For example the Vital / Essential / Necessary (VEN) classification is not correctly applied, many of the essential medicines are not features in the standard treatment guidelines and several Zambia Essential Medicines List (ZEML) listings have more than one dosage form under the same code.

1.4.4 Distribution

Distribution of commodities is effected through a contract with MSL which provides storage and distribution of drugs and medical supplies (with the exception of vaccines). MSL works out a distribution schedule, and provides stock status of what is available at MSL. Kit requisitions are raised by CBoH on a monthly basis and then MSL distributes every month to all districts or hospitals according to a tight delivery schedule. Other bulk items excluding contraceptives supplies are requested according to need. Districts then distribute items to the health centres.

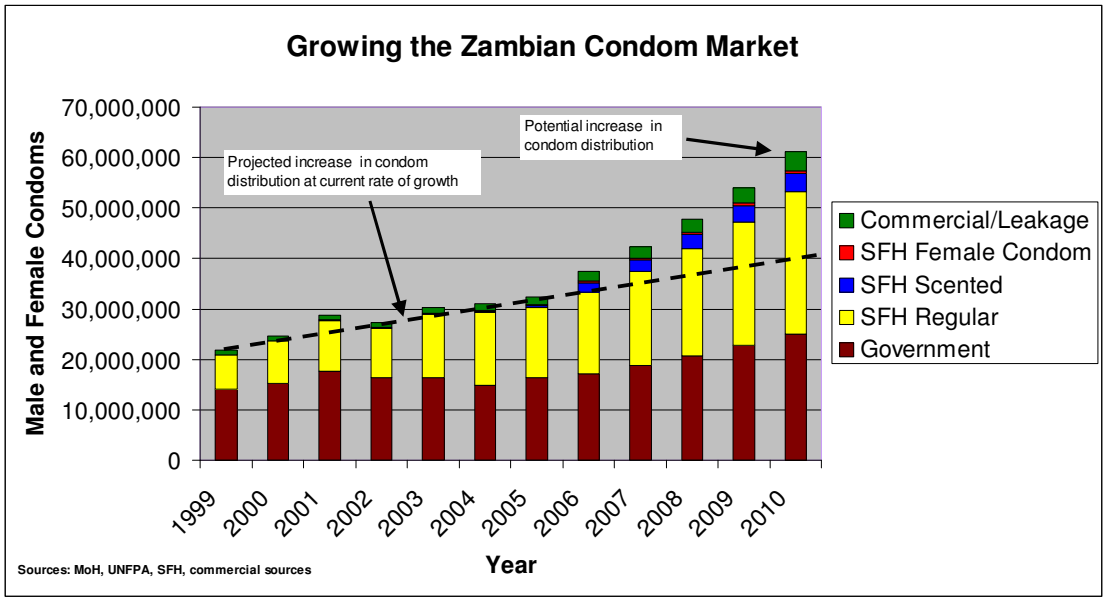
Contraceptives are treated differently in that they are meant to be ordered directly from MSL by the Districts. However in practice some contraceptive orders are also sent to CBoH instead of MSL and then have to be forwarded to MSL. The system is also held up by the requirement on MSL to aggregate those contraceptive orders that it receives and send them to CBoH for approval. Contraceptives are ordered through a different requisition form to drugs which aims to capture additional information that can be used in forecasting. The rationale behind the system is that CBoH, in the absence of information from MSL needs to keep on top of distribution of contraceptives. However this system, which varies from the main drug ordering procedure and is not applied consistency, creates confusion and delays.

Underpinning many of the problems with the whole forecasting – procurement – distribution system, lies the long history of difficulties at MSL. The management of MSL had been contracted out in 1998 to a dubious firm through a process that raised governance issues among the donors. The failure to address the many concerns raised led to a crisis of confidence among donors and prompted serious consideration of setting up an alternative parallel distribution system through the one already run by the Churches Health Association of Zambia. However since then the retendering process for MSL management, and the new conditions under which the contract operates, have improved confidence amongst the donor community. Crown Agents now have the contract and are faced with the difficult task of counteracting years of underinvestment, poor storage conditions, underpaid staff and weak systems. However the timing has been good for the change over, as MSL will need to be very involved in the systems improvements which could be brought about by better procurement planning and the DSBL.

1.5 Role of non-state providers

Non-state providers make a major contribution to the provision of contraceptives in Zambia. Approximately 47% of male condoms are provided through social marketing, by the Society for Family Health (see graph). Some government condoms are channelled through NGOs such as PPAZ, Care and CHAZ (Churches Health Association of Zambia). For example in 2001 PPAZ distributed 1 million condoms of which 50% were provided by IPPF in London and 50% through MOH.. The contribution of the for-profit private sector is smaller and as can be seen from the

chart below the differentiation between the commercial sector and public sector systems leakage is not known.



Social marketing of contraceptives is supported by USAID. SFH has regional offices in all 9 Provinces which are responsible for ensuring that products are available at district level both through the private and government sectors. SFH has come to the rescue of the public health facilities when they experience stock outs by providing supplies such as condoms, and also collaborates with District Health Management Teams (DHMT) on an ongoing basis in reaching places the public sector finds difficult to access in particular remote rural areas. SFH forecasting is based mostly on consumption rates calculated from the previous supply period and taking into account demand that could be created as a result of marketing strategies. Because of special recognition by the government, SFH enjoys tax exemption for all commodities that are brought into the country for their distribution. All are subject to the standard registration procedures.

There are a number of private pharmacies and clinics around the country that are providing RH commodities, and it is estimated that a substantial proportion of the population seek help form these institutions. Currently Zambia does not have a system of collecting the information on usage that would give a national overview[10]. However, the performance of the private sector in Zambia has created a greater demand for condoms and contraceptives.

The Planned Parenthood Association of Zambia is one of the diminishing numbers of NGOs still working on sexual and reproductive health, many of the others having reoriented their programmes to ARVs in response to new funding opportunities from the US. In other words the 'crowding out' seen within the international finance and advocacy space areas is also demonstrated by the reorientation of domestic service providers. PPAZ however continue to provide family planning services through its

[10] Actual numbers are not known partly because of the multiplicity of facilities that offer some form of RH services such as private hospitals and clinics, missions programmes and defence institutions

own clinics. For its contraceptives supplies it in part on imports from IPPF, but largely on accessing government supplies which means that they are also subject to commodity insecurity. These contraceptives are obtained by writing to CBoH and then collecting them from MSL. There is however no centrally collected data on distribution done by PPAZ which has prompted CBoH to encourage the NGO to order their supplies from districts so that they can be captured in the existing forecasting arrangement. PPAZ is reluctant to do this, doubting the capacity of districts to manage this process. Indeed PPAZ often has requests from government clinics for supplies when they have stock outs. Similarly the Churches Association of Zambia, CHAZ also relies on government for its oral contraceptives and faces problems of irregular supply because of stock outs at NMS.

NGOs and social marketing play an important role in mobilising demand for contraception but some organisations find their contribution to both distribution and demand programmes to be limited by a lack of engagement by GRZ. There is greater potential for using NGOs in hard to reach and underserved areas, but indeed there had been government grants in support of outreach programmes. These stopped several years ago and communications with all but the biggest players have been limited.

1.6 National drugs policy, legal and regulatory issues, and entry procedures

The National Drug Policy was formulated in 1999 and focuses on addressing issues of drug legislation and regulation, drug quality assurance, drug financing, procurement, storage and distribution, local production of pharmaceuticals, rational drug use, drug selection, human resource development, research and development, traditional medicines and international co-operation. Although implementation is multisectoral, MoH plays a leading role.

In practice however drug regulation has been very weak. The Pharmaceuticals and Poisons Board had a secretariat which was meant to be enforcing regulation but in practise this was not functioning. The National Pharmaceutical Act 1941 revised in 2004 was designed to address some of these problems and establish a Pharmaceutical Regulatory Authority but the secretariat and board are not yet operational. Once it is up and running however the new Act should enable the Authority to have more 'teeth'. For example unlike in the past there will no longer just be an emphasis on the licensing process but on what has been licensed so it will have the authority to withdraw products that are not meeting standards.

There are meant to be controls on what comes into the country, implemented through the Zambia revenue authority but these are not particularly effective, although they have been sufficient to derail donor imports where there has been a lack of coordination to ensure due process is followed. All drugs should theoretically be registered in country unless they are being used for a pilot project but a recent consignment of 750,000 USAID funded depo provera doses ran into difficulties because whilst the lack of registration for the pilot phase had not been a problem this large volume could not be distributed without official approval. As a result the half completed training was halted and the manufacturer is being urged to complete the procedures as quickly as possible.

Drugs are brought into the country tax free, although when the packing is done within Zambia that is taxed.. Any wholesaler who deals in pharmaceuticals needs to have a

licence to bring in any pharmaceuticals into the country and those drugs are meant to be subject to quality control procedures to check whether the consignment meets the standards. Zambia currently does not have a laboratory for quality control but uses services of the Food and Drug laboratory where appropriate and those tests that are done can usually only be carried out in part so full quality control is not undertaken. Although there have not been any studies on the numbers of bad quality drugs in the Zambian market, the number is thought to be high and likely to include commodities and drugs for reproductive health. Drug stores and pharmacies have opened in most communities, offering useful local access to drugs. While they are meant to be registered by the Pharmaceutical Regulatory Authority some outlets still operate without licenses.

2. KEY ISSUES

2.1. Strengthening procurement, financing and supply systems

Various strategies to address procurement, financing and supply issues have been used or are planned to improve commodity security:

The DFID FP and HIV logistics management project had made an important contribution to ensuring commodity security. During the last 5 years of its implementation it prevented any stock outs of commodities taking place. The project supported the presence of TA in the CBOH Pharmacy Unit and aimed to ensure contraceptive availability and uptake and to improve access of women, the poor in particular. The logistics management component built the capacity to providers to order appropriately, whilst there were also efforts to increase method mix and improve access through NGOs and other institutions. Although the project was meant to focus on contraceptives, it was based in the CBOH pharmacy unit to promote integration of the whole logistics system and was afforded a degree of flexibility to take this broader view, which was important for investing in the system as a whole. The TA based in the pharmacy unit had scope and influence in strategic planning and enjoyed a good relationship with other CBoH staff, but very importantly was able to focus on the practical problems of forecasting, mobilising funding and coordinating procurement. It was probably also assisted in the fact that the project was supported by an influential and vocal donor who was able to use the knowledge gained from the project to promote support for addressing wider systems issues. It is clear however that there were tensions between the project and the RH Unit which questions the extent to which the agenda of better security was really shared and how much there was the perception that the security of contraceptives depended in part on the strength of the system as a whole.

Support from the HSSP has also been important for sustained efforts in improving commodity security. Started in 2004 and funded by USAID the project has a wide remit to support many of the functions of CBOH, including logistics. In its earlier incarnation of the Zambia Integrated Health programme, it was responsible, in partnership with a number of other collaborating partners for supporting the introduction of DILSAT, the District Integrated Logistics Management Self Assessment Tool. The project has also supported the implementation of the National Drug Policy agenda, and with financial support from DFID has worked with CBOH to implement the Logistics Management Information System including the development of a manual and training for key staff from all districts and hospitals. The project has

clearly played an important part in supplementing the limited capacity of CBOH and the provinces to development and implement new systems and concepts and has helped to keep a focus on the problems of logistics supply. However HSSP will shortly no longer have this as its remit because DELIVER, also funded by USAID, has been tasked with the issue by the donor. Unfortunately their remit is to focus on ARV distribution so it is not clear where the continued support for the rest of the system will come from. Without the support of either USAID or DFID projects, there will be no continued technical input which may undermine effective advocacy by these donors unless they are still able to exert influence through their ongoing policy dialogue with MoH.

The new logistics supply coordinator to be based in the RH Unit also has the potential to improve commodity security. It is unfortunate that it has taken over a year for this person to be put in post and at the time of writing a start date had still not yet been confirmed, though he or she was meant to arrive 'soon'. The need for this person and the recruitment process simply seemed to be an issue to which no one in government was paying sufficient attention in order to line up a replacement in time. Commodity security has suffered in this time, an indication that this post is much needed. It is to be hoped that this person is able to work effectively on the specific remit of contraceptives whilst contributing to the systems development as a whole. Much can clearly be done from within RHU to improve commodity security, but it is important that this links with wider systems development and separate processes are not overly developed to counteract those systems failures. The presence and capacity of the person will be particularly important once the DELIVER project takes over the logistic remit from HSSP and there is no longer backing from that project. DELIVER is expected to only focus on ARV logistics, but HSSP is expected to step down, leaving a potential void in focus and technical capacity which will need to be filled by the new logistics coordinator, with strong support from UNFPA.

The RHCS committee will be an important focal point for donors, government and other stakeholders such as NGOs to address funding for commodities. It is not so clear that the committee will address some of the very practical problems of coordination and communication that seem to beset the forecasting, procurement and distribution process and where the absence of one coherent system leads to mistakes and problems. It will be important that the government provides leadership and pro-active follow up to the meetings. Whilst the problems are of funding in the longer term, more immediate issues need to be solved to make sensible funding decisions such as obtaining more reliable forecasting information. However the view has also been expressed that this group is not necessary and that there should be more focus on getting the procurement working group functioning effectively, thereby making this group redundant.

The DSBL and National procurement planning should improve integrated systems that will start to remove the need for the fragmented interim arrangements. It will be important however that the RH Unit, like all other programme units, understands this potential and is engaged with the development process. The DSBL and procurement planning are an indication that government and donors are working together more effectively after the crisis of confidence brought on by management and governance issues in MSL. Greater transparency and a rational integration of the MoH and CBoH procurement functions will be a key test of the extent to which GRZ really wishes to address fundamental problems in the

system. It is not surprising that the current weaknesses allow for procurement irregularities. It will be particularly important that better integration of MSL into the procurement and forecasting process takes place even if this stops short of MSL undertaking the procurement itself which would be a rational step (and follow the pattern in many countries) , but unpopular with MoH.

The RH Unit may be upgraded to a sub-directorate. There seems to be a consensus that this would benefit the status and the impact of the work of the RH team at the centre. However the details have not yet been worked out, nor is it clear how the CBOH staff will work with the two people already covering RH in MoH once the merger of the two organisations has been finalised. It will also be necessary to address the capacity problems of the team and make a realistic match of resources to expectations in order to maximise the possible benefits of the integration and upgrade. This is further discussed below.

Despite these initiatives, there are still issues remaining in attaining better commodity security. In particular these relate to the wider environment in which the security issue must be addressed, which fails to gives priority to RH and where capacity problems undermine the scope for achievement.

National and sector level policies do not give a prominence to RH. This is surprising considering the high proportion of resources that are used by RH programmes (see section 1.3.2). Even maternal mortality does not feature particularly strongly despite its importance under the MDGs. It is therefore difficult to see national level commitment to addressing RH as a priority issue. Those policies that do address RH more directly have been slow to be developed and approved which suggests a lack of commitment to the issue; and translation of these policies into plans is weak so that it is difficult to identify actions which carry out policy statements. For example the Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Zambia acknowledges the importance of essential supplies to save lives but does not offer any specific strategies to address the problems of commodity security in an effective and practical manner.

It is difficult to pinpoint the reasons behind low government commitment to RH. This may in part reflect wide social issues such as the status of women, and sensitivities in dealing with some aspects of RH provision. It is probably also bound up in the way that donors and MoH have conducted their business over the last few years, various aspects of which are discussed in this report. Allowing donors to evolve a myriad of parallel systems, even though this has been done with good intentions also enabled government to take a back seat, has made RH a donor problem and generated frustration on both sides at a seeming disengagement from core issues be they building government capacity (from the government point of view) or taking the lead in RH (according to the donors). A willingness of some agencies to provide lots of support also in one sense makes life easier for their government counterparts in the RH Unit as it means that they don't have to engage with central MoH planning processes that negotiate funding levels thus removing themselves from debate on programme priorities and enabling RH to fall off the government's main agenda. A transition to budget support or sector level pooled funding, some of which will need be directed to commodities, will therefore necessitate encouraging MoH to take the lead in RH and ensuring commodity security. If GRZ is able to take on this role it could lead to a more sustainable, institutionalised and ultimately effective long term strategy for tackling poor RH.

Capacity in the RH Unit in what was CBoH is so limited it is very difficult to see how the RH programme can be adequately supported from the centre. The RH specialist has two project staff working with her on PMTCT and a logistics supply coordinator is expected to start shortly, funded by UNFPA. There is also a UNFPA RH adviser. The agenda for RH is however so ambitious, that aspirations outstrip capacity and the team are completely overloaded. Obviously donor support is vital to the RH programme but one has to question the reality of the workplans with such limited government capacity at the centre and whether there can really be government ownership of a programme that it cannot deliver. The situation will be better once the logistics coordinator starts and there can be attention given to commodity security but other areas of the programme will still be unsupported which will undermine improvements in the contraceptive supply. One of the problems is that the approach to planning, implementation and monitoring is not sufficiently geared towards achieving and measuring results so responsibilities are poorly defined.

It is not clear where responsibility lies in CBoH/MoH for addressing security issues, of contraceptives in particular. Roles and functions for forecasting and procuring are not clear and there does not seem to be any one person charged with addressing these problems. The presence of the logistics coordinator will certainly help but only if this person can operate at the right level, and he or she will not replace higher level accountability in CBoH/MoH.

The human resources problem in Zamia continues to undermine efforts for improvement in RH as in other programmes. Staff turnover and shortages meant that those systems that are in place are either not supported by adequate numbers of people to operate them, or where there are the staff the turnover means that there has to be a constant process of retraining, as well as supervision. Although training has taken place on the DILSAT system for example this has tended to be a one-off and therefore not enough to counteract the churn. HR capacity problems are felt at all levels and in all programmes, so neither the districts, provinces nor the centre are able to provide the supervision of processes and people below them. Donor support has been focussed on long term input to recurrent costs but funding for HR has lagged behind.

A lack of faith in government systems and GRZ willingness and capacity to address problems has undermined commitment to a joint approach to forecasting, procurement and distribution. As a result many other arrangements have proliferated. These came about for good reasons at the time. It makes sense to have the distribution of MVA kits carefully monitored so that they are only given to those that have training, but this fragmentation, whilst it achieve short term aims, undermines the whole principle of the sector wide approach. Donors and other supporting organisations like NGOs cannot be expected to use government systems where they are failing and it would further compromise RH commodity security if they did so, but there needs to be a consensus on what an adequate system would look like and when there may be further integration of these initiatives. At the moment this discussion seems a long way off, with the result that these initiatives are being more elaborate and fragmentation is probably increasing rather than reducing. Crucially these separate arrangement enable government to take a back seat in the whole issue of commodity security.

There is no strategy for replacing the donors who are refocusing their support from parallel funding of contraceptives to either budget support or other areas. MoH either needs to replace them with new parallel donors or make more active plans to utilise other sources of funding such as pooled contributions to the DSBL. The RH unit was one of the first to come forward and express interest in having contraceptives listed on the DSBL and there is the potential for pooled contributions to the DSBL to enable greater security of supply. However movement towards this needs to be accelerated to ensure continuity and there needs to be the recognition that government controlled funds will need to address shortfalls in future. There also needs to be wider dialogue as yet about achieving longer term security. The RHCS Committee will be addressing these issues but it has not been convened yet after months of discussion.

2.2. The impact of the wider reform environment

The sector wide environment has provided a forum for raising concerns on procurement and MSL performance. It has been less successful as a forum for promoting RH concerns, which may be a result of a preoccupation by most parties on systems development. The impact of joint planning and policy making has been limited by the lack of really concrete plans. Within RH however it is not clear that sector working is really in evidence. With a large project workload with which to engage, and powerful donors concerned to achieve particular outputs in these areas, and parallel funding, much if it by agencies that maintain their own monitoring systems, in many ways the RH Unit is operating in a more old-fashioned project based environment. This is despite the stated preference of GRZ for basket funding. Trying to move the responsibility for contraceptive commodity security out of the remit of a few donors and into that of government and other donors as a whole will be challenging particularly in the face of other competing demands.

DFID moving upstream to budget support will be an interesting change in relationship between that donor and GRZ. DFID support has been essential to maintaining both a technical focus on commodity security and ensuring an adequate supply of contraceptives. They have been able to move quickly and flexibility to respond to potential stock outs and their intimate knowledge of the supply system gained from the technical assistance provided has no doubt been of benefit to all parties. Provision of budget support to the Ministry of Finance does potentially allow for greater leverage over the allocation of resources to the sector and to the proportions spent at district and central level, and there would still be the scope to advocate for more government funding for RH commodities. This leverage could also be important to influence political will within GRZ to address the thorny problems of procurement harmonisation, and help to focus on the HR crisis which is undermining so much of the progress in the health sector. However the devil will remain in the detail of the whole forecasting, procurement and logistics system and it will be important that if DFID and USAID are no longer engaged with it at this level, then some other donor is providing the technical leadership needed to address these problems. UNFPA is an obvious agency to step in here, particularly with the presence of the logistics supply coordinator in RHU.

2.3. The impact of international support

At the moment the country level interface with global procurement and financing is more or less non-existent. Moreover donors have not always contributed positively to systems development. Zambia provides an interesting example of UNFPA acting as an agent on behalf of other donors. DFID funded commodities have been procured by UNFPA and this offers a model for how UNFPA might act as an agent for government. Having said that however, UNFPA (and DFID) have been criticised for the fact that they have not communicated sufficiently about the procurement that was being done with the result that 47 million condoms arriving unexpectedly in MSL have created problems with storage and distribution. This is in part an indication that government has not been in the driving seat for this transaction but had left it to the donors to manage the details. It will be important in future that any donors providing contraceptives and other commodities try to facilitate government leadership or at the very least better communication. A lack of information to MSL means that they cannot check consignments properly against orders or suppliers which leaves the way open for abuse of the procurement system. Donors need to set an example of good practise so that they are in a stronger position to advocate for better government performance.

The government is clearly conscious of the problems created by this fragmentation but is in a period of transition from parallel to more integrated forms of funding. The perception held by some in GRZ is that the multilaterals are particularly guilty of maintaining their separate systems with regard to procurement despite criticism in the procurement working group; the result are parallel systems which drain government capacity. Commodities and other items purchased for projects are separate from those for the national RH programme with the result that it is difficult to get an overview of all needs and plan accordingly. There is also the sense within GRZ that systems have developed well at district level and below and there should be wider donor commitment to investing in them by engaging more with government systems. At the same time however some donors are moving away from parallel funding in RH towards budget support, and so no longer provide the specific support for procurement and technical assistance. That budget support could ensure greater predictability of funding, contribute to more flexible working arrangements such as the DSBL and thus reduce transaction costs. Most importantly it could afford GRZ the opportunity to take a stronger lead in all aspects of procurement and distribution and institutionalise the RH agenda as being firmly owned by government. It will be important that all donors urge the Ministry of Health to take this opportunity.

That said however the RHU clearly values the support of all the donors. Commitments are made readily and at the right time and donors stand by those promises. GRZ has little money for RH covering only basic staff and office costs, so all technical inputs are reliant upon the donors. These inputs seem to be programmed fairly coherently with the donors fitting in well with the national programme. However questions still need to be asked about the realism of attempting such a broad range of activities.

Government ownership of the problem of RH commodity security seems to be low and may be undermined by donor approaches to providing support. Low ownership is suggested by the poor policy formulation, limited capacity in RHU, and delayed progress in addressing problems in MSL; even with the new contract in

place MoH is still slow to respond to strategies presented for improvement. The donor response to this situation has been to take on responsibility for ensuring continuity of contraceptive supplies, and to provide TA which has been essential for pushing through improvements in the forecasting and supplies system. These responses have been understandable in the current environment and have been necessary as short term solutions. However the existence of the DSBL does offer the hope of a funding arrangement which could enable government to exercise more ownership – but GRZ will need to allocate funding to this. DFID has been a major source of support and will no longer be providing contraceptives. USAID will be focussing more on PEPFAR. Therefore there is potentially a significant gap which will need to be filled by alternative funding. UNFPA could continue to offer some support but there needs to be a common strategy development to identify alternative funding and to encourage government to play a greater role in this.

The presence of the global programmes are a mixed blessing for RH. The government has been canny in using the PMTCT initiatives supported by the GF as a way of improving some aspects of RH, and the presence of the two GF financed staff in the RHU are a useful asset, even though their focus is very much on the PMTCT programme. However on a broader scale it is clear that substitution of funding is taking place which is disadvantageous for the sector as a whole, including RH. Hard budget ceilings for the health sector mean that additional funds for global programmes squeeze out other funding, probably from GRZ, so that single issue programmes get attention, time, staffing and funding over wider more integrated services like RH. And resources which had been targeted for RH, like DELIVER are now being redirected to the single issue of ART. Trying to get additionality into the sector and counteract these distortionary and diversionary programmes is therefore problematic, requiring upstream influencing; it is one of DFID's goals over the coming period. Moreover NGOS are reorienting their programmes to match GF priorities, thus moving away from other areas. The impact on RH is not yet clear but seems likely to be negative.

2.4. New opportunities for improving commodity security

The PRS includes a section on addressing RH issues and could provide a spur to provide for needs that are not adequately addressed. A positive indication that there is meaning and power in the PRS is the one billion kwacha being allocated in 2005 from MoF for PRS implementation which is being used by MoH for the construction of maternity wings in identified areas of need, and for training of key staff in RH service delivery. This suggest an improved focus on addressing maternal mortality.

The RH unit has started to look more holistically at the contribution of the non-government sector, especially the contribution made by social marketing and NGO distribution. Some organisations including SFH have been asked for information on the volumes of contraceptives that they issue. This is perhaps the start of thinking about a total market approach because the RHU is clearly aware of the impact one sector has upon the other and that there should be better coordination between the two so that both can play to their strengths in their respective markets. To develop this further however would require additional support and much better information on forecasting and unmet need for the country as a whole.

The PMTCT programme is an important opportunity to improve RH commodity security and services. It addresses most major RH interventions and family planning is a major thrust, and the programme advocates for dual protection. There are opportunities within this programme to mobilise support for better commodity security.

The example of the revolving fund managed by CHAZ for its drug and supplies offers an interesting example of how to generate greater resources. The fund originally supported by DANIDA with $120,000 has grown in 7 years or so to about $300,000. Although the mark-up on the drugs distributed has been low, the increase in demand and the fact that CHAZ can meet this demand has meant that the cumulative effect of reinvestment has been significant.

Annex 1 List of people met

NAME	DESIGNATION	ORGANIZATION/INSTITUTION
Ms Jane Miller	Health Adviser	DFID
Dr. Mirriam Chipimo	RH Specialist	CBoH/MOH
Dr. Sarai Malumo	RH Focal person	UNFPA
Ms. Mika Mwambazi	Commodity Logistics Officer	CBoH/MOH
Ms. Patricia Kamanga	RH/Gender National Officer	WHO
Mr. Nicholas Chikwenya	Donor Coordinator	Ministry of Health
Mr. Kandeke	Chief Pharmacist	Churches Association of Zambia
Dr. Bob Hollister	Deputy Chief of Party	Health System Support Program (HSSP)
Ms. Violet Kabwe	Drug Logistics Management Specialist	Health System Support Program (HSSP)
Ms. Rabecca Kalwani	Family Planning Officer	Health System Support Program(HSSP)
Mr. Oliver Hazemba	Regional Technical Advisor	Management Sciences for Health
Dr. Girma Alemayehu	RH Advisor	UNFPA/CBoH
Ms. Caroline Yeta	Pharmacy Specialist	CBoH
Ms. Mara Joy Brain	PSI/SFH Fellow	Society for Family health
Ms. Matilda Zyambo	Procurement Specialist	Zambia Medical Injection Safety-MISP
Mr. Festus Lubinga	Program officer	JICA
Mr. Taro Kikuchi	Assistant Resident Representative	JICA
Dr. Velepi Mtonga	Director Diagnostics and Clinical Care	CBoH/MOH
Mr. Mangisha Pelekelo	Pharmacist –in-Charge of Product Registration	Pharmaceutical Regulation Authority
Ms. Lishimpi Loyce	Procurement National officer	WHO
Dr. Christopher Mazimba	Chief of Party	Zambia Medical Injection Safety-MISP
Ms. Christine Mutungwa	RH Focal person	UNICEF
Mr. Rob Varhage	Procurement Advisor	MOH
Dr. Fwasa Singogo	Executive Director	PPAZ
Mr. Wilfred Mwamba	Senior program Officer	DFID
Ms. Maria Skarphed	Assistant Health officer	DFID
Ms. Esther Hamayuwa	Program officer	DFID

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