

Theft & Corruption of Public Health Medicines

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Is USAID Embarking on a Solution? Or Greater Cost?

An aspect of long concern regarding public health supply chain management, is theft and corruption. Have major donors had enough and, in hopes of stemming the huge losses, are they looking for a way to shift responsibility?

An August 2022 write up in Devex addresses the issue of drug shortages faced in the southeastern African country of Malawi. While critical medicines and medications are in stockout due to the supply disruptions from the coronavirus, the final paragraph of the article summed up the years long struggle with theft and corruption. Alluding to both, the article concluded, “Theft of medicines has also cost the country and donors billions of dollars annually, with the government losing an estimated 30% of drugs and medical supplies it purchases to theft. About 35% of these stolen commodities end up in private health facilities.”

Logenix, through our pharma deliveries and operations in over 140 developing countries, are very familiar with just how widespread the threat of theft is to the distribution of medicines and supplies across the developing world. Our global operations are tasked with undertaking various levels of prevention – with varying levels of increased costs.

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The less conspicuous preventive measures implemented worldwide include the use of only hard sided/closed trucks to deliver shipments, foregoing the less expensive and more readily available open sided trucks. Implemented in tandem with closed trucks we often contract unaffiliated escorts to ride with the driver. Experience has proven a lone driver may be pressured, threatened or enticed to abscond with his load. Also very inconspicuous, but highly effective, we often use our own tamper proof seals on containers and trucks. Overt deterrent measures are required for many countries. Medicine operations in South Africa require armed escorts for all deliveries from the port of Durban to local warehouses and to Zambia, Zimbabwe, Mozambique, Botswana, Eswatini and Lesotho.

The same is true in Nigeria for all transfers of medicines between Lagos and Abuja. Theft being so endemic in Nigeria, even the distribution of malaria insecticide nets requires armed escort. In Haiti, where civil unrest has reached a level of outright anarchy, we have been forced to enact extensive armed measures to guard medicines from the roving gangs and territorial warlords now ruling the country.

The Devex article subtly points out the other area where billions are lost, and that would be through corruption. That over a third of stolen medicines wind up in private health facilities is not a random outcome, but speaks to a sophisticated level of systemic corruption.

Is Malawi the rule or the exception as regards corruption? The outcry regarding the Covid funding corruption uncovered in Kenya, resulting in the dismissal of the CEO and top officials of the Kenya Medical Supplies Authority (KEMSA) is suggestive the level corruption surrounding medicines and medical funding is not an isolated case. Depending upon how calculations are tabulated, over \$70 million was misused or misappropriated. Cameroon, South Africa, Nigeria, Ghana & Zimbabwe also reportedly had millions lost to misuse such as procurement and contracting irregularities.

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In just under a year and a half rebuilding the Sierra Leone medical distribution we had to implement measures to prevent siphoning of medicines at hospitals and medical stores, and we experienced warehouse theft committed by the donors hired security force. With head shaking logic, the security force thought themselves above suspicion. Most unexpected though were systemic attempts by the United Nations local staff to confuse inventory counts during monthly restocking operations. Once reconciliations showed substantive medicine discrepancies, it took months of diligent hard copy inventory matching to prove the medicines were indeed manifested, but not delivered. Unsurprisingly, the miscounts were found to be on the medicines with the greatest black-market value. In the end, there was little doubt about the organized efforts to obscure the systemic theft of medicines during restocking.

So, if the level of loss in Malawi due to theft and corruption is as endemic across the developing world as it would seem from the above, perhaps this is the driving force behind the unprecedented Vendor Managed Supply (VMS) efforts currently being explored by USAID to completely reshape the future of the delivery and distribution of public health medicines? If it is, it gives rise to many questions.

At the overview level are sweeping questions of philosophy surrounding the future of public health in Africa.

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Given the duty exempt/donated nature encompassing the entire public health field, can a commercial approach in this arena of limited and shrinking funding end the massive losses? What happens to the ‘fiduciary’ role USAID’s procurement contractors have played in the past? Can a commercial pharma supplier be expected to act in the interest of the donor? How will the massive infrastructure surrounding Good Distribution Practices (GDP) requirements and inherent liability for pharma suppliers be financed?

Most importantly, these questions all drive at the same point – what the groundbreaking change to VMS would mean to the future costs and availability of public health across the developing world. Will pharma suppliers be forced to price so many contingencies surrounding theft and corruption, not to mention the formidable infrastructure buildout and exponential increase in liability to be borne, so as to increase total costs well beyond current levels? Will there be lowered availability of life sustaining medicines?

There are many more important questions, but we think the answers to just these are daunting. 