Future of Global Health Procurement

Final summary presentation

April 2018

Prepared by the Clinton Health Access Initiative (CHAI)
• Project Framework

• Highlights of current procurement landscape
We have developed a standardized framework to organize global and country level findings.

### Inputs and characteristics that determine the outcomes of procurement

**Funding**
- Amount of available funding
- Predictability and timeliness of fund disbursement
- Sustainability of funding

**Policy & Regulations**
- International and/or local policies, regulations, and guidelines on procurement of commodities, e.g., currency considerations, shelf life, quality standards, timeframe, volume commitments

**Strategy & Processes**
- Processes, procedures/methodologies, and relevant stakeholders including: demand estimation, budgeting, tendering, bid evaluation, contracting, and performance monitoring
- Designs of tender and contracts (e.g., criteria), and the underlying rationale

**Supporting infrastructure & resources**
- Availability of appropriate supporting resources, e.g., personnel, IT infrastructure, tools, etc.

### Outputs from system

- Cost / price
- Responsiveness & Reliability
- Quality
- Long-term market sustainability / innovation
<table>
<thead>
<tr>
<th>Agenda</th>
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- Project Framework

<table>
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<tr>
<th>Highlights of current procurement landscape</th>
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<tbody>
<tr>
<td><img src="#" alt="Key observations from global procurers" /></td>
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<td><img src="#" alt="Key observations from visited countries" /></td>
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USAID/ PSM – Key observations

<table>
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<tr>
<th>Highlights</th>
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<tr>
<td><strong>Funding</strong></td>
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<tr>
<td>• <em>Annual funding/appropriations cycle</em> drives procurement cycle</td>
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<td>• Funding expected to be <em>fairly stable</em> across years – except reproductive health</td>
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<td><strong>Policy &amp; Regulations</strong></td>
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<td>• <em>Annual budget commitments</em> impede multi-year volume commitments</td>
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<td>• <em>Different quality policies</em> for various therapeutic areas (e.g. FDA approval required for ARVs but not FP products)</td>
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<td>• <em>Shelf life requirements</em> defined as percentages affected procurers’ flexibility &amp; efficiency</td>
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<td><strong>Strategy &amp; Processes</strong></td>
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<tr>
<td>• Emphasizes <em>market-specific strategies</em>, i.e., set up of product-specific commodity group councils to develop targeted plans</td>
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<td>• <em>Shared-risk arrangements; framework contracts; use of forward looking operational plans</em> (e.g., malaria) to provide high level estimates for suppliers</td>
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<td>• <em>Exploring optimization of SKUs to allow for consolidation</em> of orders</td>
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<tr>
<td>• Emphasis on supply security – e.g. target ~3 suppliers per product in awards</td>
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<td>• <em>Data quality and forecast accuracy issues</em> create challenges</td>
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<td>• Starting to <em>explore local procurement</em></td>
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<td><strong>Supporting infrastructure &amp; resources</strong></td>
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<td>• Developing / refining <em>supporting systems</em> in collaboration with IBM with a view to enhancing <em>On Time In Full (OTIF)</em> performance</td>
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<td>• <em>Standardization of information and data</em></td>
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<td>• Attempting to <em>strengthen visibility into supply chain</em>, i.e., PPMR for HIV/AIDS as a pilot</td>
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Sources: Interviews with GHSC-PSM/ IBM; GHSC-PSM/ HIV/AIDS; USAID/ Supply Chain for Health for HIV/AIDS
# GFATM – Key observations

## Funding

- **Ability to underwrite multi-year contracts** and provide incentives such as volume guarantees allows greater leverage & flexibility when working with suppliers

## Policy & Regulations

- **Extend framework agreements** to partner agencies (e.g., UNFPA, UNDP, UNITAID) and governments with national funding (e.g., Cameroon, Georgia)

## Strategy & Processes

- **Deliberate strategy** to develop market context tailored procurement approaches across therapeutic areas
- **Holistic, multi-faceted approach to** supplier engagement: *Multi-year agreements*; *total cost approach* (e.g., responsiveness) as reflected in reduced commercial weighting in tenders; **direct engagement with both API and FPP suppliers** for supply security and ensuring responsible procurement; active **risk management** (e.g., reserved volume for new entrants; geographical balance; collaboration with other global buyers)
- **Rigorous analytical approach to negotiations based on**: demand forecasts/ tender timing/ benchmark pricing for suppliers; reference price and lead time estimates for countries; PQR
- **In-country supply chain strengthening and capability building** is a key focus

## Supporting infrastructure & resources

- **Wambo.org as a platform** to reduce market complexity, decrease administrative burden for PPM PRs (e.g., automated ordering), and facilitate efficient reporting

Sources: Interviews with GFATM (Direct Procurement; Global Sourcing; Analytics & Data Management, Health Procurement and Supply Management)}
UNFPA – Key observations

Funding

- **Lack of visibility** into long-term funding
- **Funding received in annual tranches** (which are sometimes topped up within the year) which limits flexibility with procurement; newly created **bridge financing mechanism** could help

Policy & Regulations

- Orders will only be placed with “cash in the bank”; this extends to third party procurement mechanism where countries have to pay upfront

Strategy & Processes

- Use of **multi-year contracts** but with no committed volumes; ensure supply security by diversifying FPP and API sources
- **Collaboration** with other partners:
  - Conducts **procurement of condoms for Global Fund** (pilot in 2017) and help generate savings through its greater scale and assure quality
  - Standardization of data collection with USAID and other UN Agencies
- Leverage its scale to encourage manufacturers to adopt **green manufacturing** practices, e.g., ISO 14000
- Categorization of countries to **facilitate preparation for future transition**, e.g., For “category c” countries, 75% of funding is targeted for technical support with 25% for commodity procurement vs. 75% for commodity for other countries

Supporting infrastructure & resources

- **Third party procurement** services to countries for a 5% administrative fee
- **Manual systems**: implementing partners reporting back to UNFPA country offices currently use **excel spreadsheets**; Warehouse manager has to report manually on different excel sheets

Sources: Interviews with UNFPA (CSB & PSB)
PAHO – Key observations

Funding

- Majority of funds used to procure comes from governments directly, very limited donor funding; use of the fund has grown significantly as countries transition out of donor funds (3X from 2011 to 2016)

Policy & Regulations

- Orders will only be placed with “cash in the bank”; hence capital account is very beneficial to countries

Strategy & Processes

- Use of multi-year contracts, but with no committed volumes, for key products deemed as important for public health or requested by many countries
- Lack of demand visibility makes it difficult for some negotiations, however suppliers still provide more favorable terms than to countries because PAHO is a reliable payer
- Strategic fund is positioned as a tool to improve access for countries as opposed to procurement-focused; no obligation from countries to procure
- Countries vary in engagement with the fund; some use the fund to benchmark prices to local suppliers or for budgetary purposes, others use to procure products they have limited access to

Supporting infrastructure & resources

- Capital account provides interest free loans (60 days from purchase order) for countries to place orders through Strategic Fund; funded through 3%+1.5% admin fee on all purchase orders

Sources: Interviews with PAHO (Procurement Strategic Fund; Revolving Fund)
• Project Framework

• **Highlights of current procurement landscape**
  – Key observations from global procurers
  – Key observations from visited countries
### Uganda – Country overview

**Population:** 41 Million (2016)

**GNI per capita, PPP:** Current international $: 1,790

**Life expectancy:** 60

**Total fertility rate:** 5.7

**Health expenditure (2014):**
- 7.2% of GDP
- 25% public

### Disease burden:

- Neonatal mortality rate: 21.4 per 1,000 live births
- Maternal mortality ratio: 343 per 100,000 live births
- Malaria incidence: 218 cases/1,000 people at risk
- Tuberculosis incidence: 201/100,000 people
- HIV prevalence: 6.5% of population ages 15-49

### Major donors:

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<th>CDC</th>
<th>PEPFAR</th>
<th>USAID</th>
<th>PMI</th>
<th>GFATM</th>
<th>UNFPA</th>
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### Annual budget (rough estimate)

- N/A
- $32M ARVs (2016)
- $40M non-ARVs and reagents (2016)
- $3M on RH (2014-16 avg)
- $15M
- $40-60M\(^1\) (2014-17 avg)
- $3M on RH (2014-16 avg)

### Procurers

- MAUL
- GHSC-PSM
- GHSC-PSM
- Abt Associates (IRS)
- PPM
- UNFPA

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1 Estimated based on 40% of grant disbursement

Sources: World Bank, PEPFAR, PMI, RHI, expert interviews
Uganda – Overview of current procurement mechanism and key stakeholders (non-exhaustive)

**Funders**
- Gov’t of Uganda
- GFATM
- UNFPA
- USAID
- CDC
- GF-PPM
- NMS
- UNFPA
- JMS

**Procurement Agent**
- National Medical Store (NMS)
- Uganda Cancer Institute
- GF-PPM
- UNFPA
- PSM
- MAUL
- JMS

**Central warehouses**
- NMS
- UHMG
- Joint Medical Store (JMS)

**Commodities**
- ARVs
- TB
- ACTs
- EM
- RH/FP
- Cancer drugs
- ARVs
- Labs
- ACTs
- Bednets
- RH/FP
- ARVs
- EM
- ARVs
- EM

Sources: Interviews with government officials, donors, and implementing partners (NMS, QPPU, UNFPA, USAID, PSM)
Funding

- **Domestic funding gaps and uncertainty** often cited as the primary constraint for optimal local procurement
- **Funding/payment delays** by government procurers make it hard to **hold suppliers accountable** for performance issues
- Challenges in **coordinating** between various donor/funding agencies

Policy & Regulations

- A number of policies have affected cost and quality of domestic procurement:
  - **Buy Uganda Build Uganda** (BUBU)
  - Tendering in **local currency**
  - Tender criteria focus primarily on **lowest unit cost**
  - Suppliers need to commit to **multi-year prices** (no volume commitments)
  - **Shelf life requirements** defined in percentage terms affected procurers’ flexibility and efficiency

Strategy & Processes

- **Fragmented supply chains** (including multiple warehouses for different therapeutic areas/sectors) create complexities and challenges for optimal coordination and securing product availability across POCs

Supporting infrastructure & resources

- **Data limitations** (quality and visibility beyond central levels) affect ability to develop accurate quantification and supply plans
- **Multiple manual processes and proliferation of software programs**
- **Staff capacity and capability** limitations throughout supply chain

Sources: Interviews with government officials, donors, and implementing partners (NMS, QPPU, UNFPA, USAID, PSM)
Kenya – Country overview

**Population:** 48 Million (2016)

**GNI per capita, PPP:** Current international $: 3,130

**Life expectancy:** 63

**Total fertility rate:** 4.3

Health expenditure (2014):
- 5.7% of GDP
- 61% public

**Disease burden:**
- Neonatal mortality rate: 22.6 per 1,000 live births
- Maternal mortality ratio: 510 per 100,000 live births
- Malaria incidence: 166 cases/ 1,000 people at risk
- Tuberculosis incidence: 348/ 100,000 people
- HIV prevalence: 5.4% of population ages 15-49

**Major donors:**

- **PEPFAR**
  - $62.4M ARVs (2016)
  - $31M non-ARVs and reagents (2016)
  - $12M HIV Test kits (2016)

- **USAID**
  - $2.6M on RH (2014-16 avg)

- **PMI**
  - $13M (FY 2018 MOP)

- **GFATM**
  - ~$120M\(^3\) (2014-17 avg)

- **UNFPA**
  - $3.8M on RH (2014-16 avg)

**Annual budget (rough estimate)**

**Procurers**

- Donor procurements primarily go through KEMSA
- Following devolution - counties can order through KEMSA, MEDS or procure directly with their own funds

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Sources: World Bank, PEPFAR, PMI, RHI, expert interviews

1 Estimated based on 40% of grant disbursement
Discussion

- Following a vote in 2010, responsibility for procurement was decentralized to 47 counties.
- Counties have the ability to choose how to procure; effectively creating a market.
- Both donors and GOK have invested in creating a strong procurement function – KEMSA.
- Yadav 2014 attributes the success of this to the following factors:
  - Recruiting leadership talent
  - Creating an appropriate legal framework
  - Robust and effective governance structure
  - Greater transparency
  - Building a change coalition
  - Robust quality assurance
  - Adequate staffing
- USAID announced an expansion of its collaboration with KEMSA in June 2016 – it will procure US $650 million through KEMSA under a multi-year agreement.
Funding

- Funding uncertainty (both government and donors) cited as the biggest constraint for optimal procurement
- Inability to roll-over government funding between periods
- Lack of coordination amongst donors and GOK in funding cycles

Policy & Regulations

- 2010 devolution put much of the power to purchase at the county level
- Counties can choose how to procure (KEMSA, MEDs, direct tendering)
- Shelf life requirements defined as percentages affect procurers’ flexibility & efficiency

Strategy & Processes

- Fragmented demand (at county level) coupled with lack of accurate data systems at lower levels (varies by disease category) complicate quantification and tendering

Notes

- Donor procurements and procurement of certain GOK-funded commodities (e.g. oncology drugs) all flow through KEMSA
- KEMSA charges a 10% fee for its procurement, warehousing and distribution services
- Donors and GOK invested heavily in upskilling KEMSA and the current institution is seen as reliable and successful
- USAID agreed to a multi-year award to KEMSA in June 2016
- KEMSA has had to suspend deliveries to counties due to non-payment, these counties then often procure through other channels (e.g. MEDs)

Sources: Interviews with USAID HIV Division and other Kenya procurement experts; literature review
India – Procurement for national disease programs is done at the central level (not exhaustive)

National Disease programs (e.g., HIV, TB, MNCH, Vaccines)

- **Funders**
  - Donors (e.g., World Bank, GFATM)
  - Central Government
  - State Governments

- **Coordinating Programs**
  - Disease programs, e.g., NACO – National AIDS Control Organization

- **Procurement Agent**
  - Rail India Technical and Economic Services (RITES) Ltd
  - Central Medical Services Society (CMSS)

**Sources:** Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh); lit search

- Set up as an autonomous, non-governmental body in 2012 with a grant from government
- Aims to self-sustain through 3% fee
- Procurers for national disease programs
India – Various models exist at the state level, with Tamil Nadu being recognized as a role model with its centralized set-up (not exhaustive)

Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh) ; lit search
Tamil Nadu – Impact by TNMSC

Overview

- 72M population
- Tamil Nadu Medical Service Corporation (TNMSC) established in 1994, covering 90% of budget
- Central Medical Services Society (CMSS) modeled after TNMSC
- Advised other states, e.g., Rajasthan, Andhra Pradesh, Assam

Pre-TNMSC

- Fragmented; open tender by each hospital
- Supply by dealers
- Due to fragmented purchases often in small volumes, quality checks are difficult and less frequent
- Generally higher prices
- More variability in prices between hospitals
- Fragmented
- Higher risk of delayed/non-payments for suppliers

Post-TNMSC

- Single source; Open tender by TNMSC
- Direct supply by manufacturers
- More rigorous quality checks
- Lower prices
- Standardized prices
- Single source
- More compliance to payment terms

Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCl, Prabal Singh); lit search
India – Key observations

Funding

- Central government funds and procures for national disease programs (e.g., HIV, TB) and national organizations (e.g., armed forces)
- State government procures for others with funding from central and state levels

Policy & Regulations

- Governments have indicated disagreements with regulatory authorities on approving new products, e.g., HIV Peds (LPV/r pellets), TB (FDC for rifampicin/isoniazid)
- To ensure product quality, Kerala has instituted a BGx policy

Strategy & Processes

- Degree of procurement centralization differs by state: however more centralized ones such as Tamil Nadu and Kerala appear to have benefited from:
  - Tighter control over quality and supplier performance, e.g., own quality assessment and penalty clauses for supplier under-performance; PHCs in Maharashtra face supplier unresponsiveness and failing to meet delivery schedule
  - Management of product ranges (~260 essential drugs vs. over 1800 in Maharashtra)
  - Better prices through increased scale and greater efficiency, e.g., Tamil Nadu pays INR 500 per CT scan vs. 1700 in some other states
- Tamil Nadu merged all health programs except AIDS; with Tamil Nadu Medical Service Corporation (TNMSC) managing ~90% of procurement budget; TNMSC is known as a role model and provides consultancy projects for others (e.g., Andhra Pradesh)
- States have different bidding and evaluation processes, creating complexity and costs for suppliers
- To tackle uncertainties in demand estimation, Kerala state has a two-PO system where the first is 75% of the estimated order and the second will be set later with more data
- State reflect preference for in-state suppliers and public-sector undertakings (PSUs), e.g., In Kerala 15% premium for state PSU and 10% premium for small/ micro companies

Supporting infrastructure & resources

- Lack of trained staff on supply chain management (e.g., inventory management, data reporting)
- Tamil Nadu enjoys greater visibility of supply chain due to computerization

Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh) ; lit search
Nigeria – Country overview

- **Population:** 186 Million (2016)
- **GNI per capita, PPP:** Current international $: 2,450
- **Life expectancy:** 53
- **Total fertility rate:** 5.6
- **Health expenditure (2014):**
  - 3.7% of GDP
  - 25% public

**Disease burden:**
- Neonatal mortality rate: 34.1 per 1,000 live births
- Maternal mortality ratio: 814 per 100,000 live births
- Malaria incidence: 381 cases/1,000 people at risk
- Tuberculosis incidence: 219/100,000 people
- HIV prevalence: 2.9% of population ages 15-49

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**Major donors:**

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<th>Donor</th>
<th>Annual budget (rough estimate)</th>
<th>Procurers</th>
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<tr>
<td><strong>USAID</strong></td>
<td>• $6M on RH (2014-16 avg)</td>
<td>• GHSC-PSM</td>
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<td><strong>PMI</strong></td>
<td>• $49M (2016-18 avg)</td>
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<td><strong>PEPFAR</strong></td>
<td>• $66M ARVs (2015-16)</td>
<td>• GFATM</td>
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<td>• $17M Rapid Test Kits (2015-16)</td>
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<td>• $15M Reagents (2015-16)</td>
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<tr>
<td><strong>GFATM</strong></td>
<td>• $87M¹ (2014-17 avg)</td>
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<td><strong>UNFPA</strong></td>
<td>• $10M on RH (2014-16 avg)</td>
<td>• UNFPA</td>
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¹ Global estimate of 40% of grant disbursement
Sources: World Bank, PEPFAR, PMI, RHI, GFATM
### Nigeria (Federal) – Key observations

#### Highlights

**Funding**
- **Funding releases, gaps, and uncertainty** pose significant constraints to procurement e.g. payment delays result in suppliers increasing bid prices to MOH tenders.
- **States are largely autonomous in funding and procurement decisions** so advocacy for health commodity funding needs to be done at both the federal and state levels.
- Public-sector commodity needs are met through donor funds, direct procurement from the private sector, and state mechanisms like Drug Revolving Funds (DRF).
- **Lack of foreign currency reserves at central bank** affect pricing of quality assured products.

**Policy & Regulations**
- **Customs clearance is a major barrier**; some partners/donors e.g. UNFPA take over.
- NAFDAC regulates quality, but **states have own methods of evaluating suppliers**.
- **National EML list is a guidance, states can customize** to their needs (remove/add).
- National tenders in **local currency** presents some challenge as some raw materials are sourced internationally (incentivizes buying from lower quality/cost supplier).

**Strategy & Processes**
- **Quantification is coordinated** at federal level with donors/government by program.
- **Some states distribute donor-funded commodities through CMS**, other states donors have parallel supply chains which are currently being integrated through the Nigeria Supply Chain Integration Project (NSCIP).
- **Local procurement preference is given (not more than 15 percent of contract price)** but supplier capacity is a constraint.

**Supporting infrastructure & resources**
- **Procurement process** is generally **manual and done on paper**, cannot be easily monitored to benchmark performance.
- **NSCIP developing Navision tool to support streamlining of processes** and provide end to end visibility of stock levels.

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Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)
## Funding

- **Most states have sustainable drug supply systems with a Drug Revolving Fund (DRF) that use markups** to fund operations and procurement of Essential Medicines and some RH commodities, anti-malarials; DRFs vary in functionality.
- **Funding still a key constraint despite DRFs**; limited funding from federal government (mostly towards tertiary facilities) and state governments.
- States are turning to World Bank loans to continue funding where donors have pulled out e.g. Lagos for Malaria.

## Policy & Regulations

- DRF in Lagos state is used to fund government free health commodities schemes for certain individuals who qualify; vary state by state.

## Strategy & Processes

- States funded by the same donor e.g. DFID will keep in contact and exchange excess/in-need commodities with each other.
- States are developing capacity to do tendering and framework contracts; capabilities vary by state.
- States likely vary in ability to negotiate prices and favorable terms with suppliers based on supply and volume.
- **Local procurement focus**, but supplier capacity is a constraint.

## Supporting infrastructure & resources

- Data collection, quantification, monitoring, logistics is currently supported by donors and partners and is seen as a major risk in discussions of donor transition.
- Various manual tools at PHC level with duplication.

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**Highlights**

- **Most states have sustainable drug supply systems with a Drug Revolving Fund (DRF) that use markups** to fund operations and procurement of Essential Medicines and some RH commodities, anti-malarials; DRFs vary in functionality.
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**Sources:** Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)
Nigeria – Drug Revolving Fund Scheme, Kano State Example

**Seed stock ~300M Naira from DFID in 2005**

**Free commodities from donors/gov’t**

**DMCSA (State Procuring Agent)**

**Zonal Stores or State CMS**

**7.5% Markup Breakdown**
- Operational costs (~4%)
- Expiry
- Inflation
- Deferral and Exemption

**Kano State DRF Stats**
- Estimated value of commodities 1.3B Naira annually
- Working Capital of 400M Naira
- 700 out of 1200 HF part of DRF; 30 to be added this year

**Benefits to HF / End User**
- Renovation of facilities
- Seed stock
- Quality assurance of commodities
- Autonomy to facilities
- Price control to end user

**Non-Exhaustive**

*Health Facilities (HF) outside of State DRF and Tertiary Hospitals can purchase from State CMS but mainly purchase from manufacturers directly or the open market*
Nigeria (Kano State) – Overview of current procurement mechanism and key stakeholders

**Essential Medicines**

- State DRF → DMCSA
- Facility DRF → Tertiary Facility
- SMOH
- Facility DRF → Tertiary Facility
- UNFPA/USAID/FMOH → UNFPA, PSM
- UNFPA, USAID, DFID, FMOH (20%) → UNFPA, PSM
- SMOH (20%) → DMCSA
- FMOH+WB, GF (80%) → NMEP, GF
- SMOH
- FMOH (5%) → NACA
- GF, PEPFAR (95%) → GF, PSM
- NTBLC
- GDF, PEPFAR → GDF (IDA)

**Warehousing**

- State CMS + Zonal Stores; *Pull from facilities
- 3 PL; push
- Zonal Store through a PPP *Pull from facilities
- SACAC *Push

**Private Sector** (mostly EM, some RH, FP, Malaria)

- Donors (GF)
- Health Facility DRF or Individual OOP
- Donors (GF)
- Health Facility
- Private Warehouses (Suppliers, SFH, 3PL) 25

Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCL Kano State, MoH Lagos)
# Nigeria (Lagos State) – Overview of current procurement mechanism and key stakeholders

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<th>Procurers</th>
<th>Warehousing</th>
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<td>Tertiary Hospital</td>
<td>Federal and State CMS</td>
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<td>Facility DRF</td>
<td>Tertiary Hospital</td>
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<td>UNFPA, USAID, DFID, FMOH (20%)</td>
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<td>Health Facility</td>
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<th>Malaria</th>
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**Private Sector** (mostly EM, some RH, FP, Malaria)

- Health Facility DRF or Individual OOP
- Health Facility
- Private Warehouses (Suppliers, SFH, 3PL)

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Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)
South Africa – Country overview

- **Population:** 56 Million (2016)
- **GNI per capita, PPP:** 5,480 (2016)
- **Life expectancy:** 62 years (2015)
- **Total fertility rate:** 2.5
- **Health expenditure (2014):**
  - 4.2% of GDP (public)
  - 48% public

**Disease burden:**
- Neonatal mortality rate: 12 per 1000 live births
- Maternal mortality ratio: 138 per 100,000 live births
- Malaria incidence: 3.1 cases / 1,000 people at risk
- Tuberculosis incidence: 781 cases / 100,000 people at risk
- HIV prevalence: 18.9% of population ages 15-49

**Major donors:**
- **GFATM**

**Annual budget (rough estimate):**
- $33M\(^1\) (2014-17 avg)

**Procurers:**
- SA government

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1 Global Estimates based on 40% of grant disbursement
Sources: World Bank, GFATM
South Africa – Key Observations

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<th>Funding</th>
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<td>• Donors provide small % of funding (10% for ARVs) but SA does procurement; majority of donor funding is for systems strengthening and there has not been transition discussion</td>
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<td>• Provinces hold budget and procurement power and may buy outside of national contracts (~5-20%); reports of funds designated to medicines being repurposed inefficiently</td>
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<td>• Payment delays from gov’t crowd out smaller suppliers; also difficult to enforce penalties</td>
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<td>• Volatility of the Rand impacts local manufacturing as the majority of API is imported</td>
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<th>Policy &amp; Regulations</th>
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<td>• All products have to be registered with the MCC, which has lengthy processes</td>
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<td>• Tendering practices give preference to manufacturers who formulate specified products in SA, but local formulators have trouble competing on price, a major factor in tender awards; as a result, a lot of FPP is imported even though there is ability to formulate in SA</td>
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<tr>
<td>• The Broad Based Black Economic Empowerment (B-BBEE) policy accounts for 10% or 20% of the bid, precluding some international and local suppliers from competing</td>
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<th>Strategy &amp; Processes</th>
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<td>• SA procurement has sophisticated tendering practices e.g. requiring transparency from manufacturers on pricing; contracting is done nationally</td>
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<td>• Irrational ordering due to budget and tender cycles adds complexity for demand planning</td>
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<td>• Lack of communication between programmatic and procurement functions leads to misalignment in rollout of program</td>
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<td>• Need for increased collaboration between government and suppliers to improve development of local manufacturing industry</td>
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<th>Supporting infrastructure &amp; resources</th>
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<td>• Inconsistent data and lack of visibility into full procurement spend from provinces and facilities stock levels makes demand planning difficult; a Visibility Analytics Network (VAN), a donor-funded initiative is working to improve data visibility</td>
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Sources: Interviews with experts, government officials, donors, and implementing partners (Contract Management Unit, Sector Wide Procurement, GHSC-PSM, GHSC-TA)