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# EVALUATION OF COUNTRY-LEVEL CONSTRAINTS IN ACCESSING FINANCING FOR THE PROCUREMENT OF NATIONALLY FUNDED MNCH COMMODITIES

**August 2015**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Financing for Development Corp. (F4D) with support from Crown Agents Ltd. and John Snow, Inc.

# ACKNOWLEDGMENTS

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## Final Report, Findings and Analysis for Parts I and II

August 2015

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# ACRONYMS

ANCS	Antenatal corticosteroids
CA	Crown Agents
CAFTA-DR	Dominican Republic-Central America Free Trade Agreement
CAL	Central de apoyo logistico
CIPS	Chartered Institute of Procurement and Supply
CMS	Central Medical Stores
DRC	Democratic Republic of Congo
EWEC	Every Woman Every Child
F4D	Financing for Development Corp.
FMHACA	Food, Medicine and Health Care Administration and Authority (Ethiopia)
FPGC	Fund for Protection against Catastrophic Health Expenditures
GAVI	Global Alliance for Vaccines and Immunisation
HFG	Health Finance and Governance
HMO	Health management organization
IMR	Infant mortality rate
IPAs	International Procurement Agencies
JSI	John Snow, Inc.
LAC	Latin America and Caribbean
LGS	General Health Law
MCDMCH	Ministry of Community Development Mother & Child Health (Zambia)
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal mortality ratio
MNCH	Maternal, neonatal and child health
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Non-governmental organization
NPHCDA	National Primary Health Care Development Agency (Nigeria)
PAHO	Pan American Health Organization
PFA	Pharmaceuticals Fund and Supply Agency (Ethiopia)
PHI	Popular Health Insurance
PLMU	Pharmaceutical Logistics Management Unit
PROMESS	Program for Essential Medicines and Supply
RAMNI	Accelerated Reduction of Maternal and Child Mortality
RMNCH	Reproductive, maternal, neonatal and child health
SGSSS	General System of Social Security in Health
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SOH	Secretariat of Health
SPSS	System of Social Protection in Health
SUN	Scaling Up Nutrition
SWAp	Sector Wide Approach
TOR	Terms of reference
UNCoLSC	UN Commission on Life Saving Commodities for Women and Children
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization



# EXECUTIVE SUMMARY

## EVALUATION PURPOSE AND QUESTIONS

As the 2015 deadline to the Millennium Development Goals (MDGs) fast approaches, evidence suggests there is an urgent need to accelerate progress on improving the health of women and children, as outlined in USAID’s Vision for Ending Preventable Maternal Mortality, the UN-Secretary General’s Global Strategy for Women and Children’s Health, the Every Woman, Every Child (EWEC) initiative, and the Global Financing Facility. Given that national governments typically fund the procurement of maternal, newborn and child health (MNCH) commodities from their own national budgets, there is a risk that there will not be enough funding available at the right time, resulting in procurement inefficiencies such as insufficient purchase volumes or quality issues. The findings of this analysis suggest that a working capital facility may be a useful tool in improving timely access to funding and helping national governments improve MNCH outcomes.

With support from USAID and the RMNCH Trust Fund, F4D—in partnership with Crown Agents and JSI as third-party validators—has undertaken a study to evaluate these assumptions, measure the scope of the challenges, and determine whether a working capital facility might be an appropriate solution for these challenges.

**UNCoLSC  
Commodities**

1. Oxytocin
2. Misoprostol
3. Magnesium Sulfate
4. Injectable Antibiotics
5. Antenatal Corticosteroids
6. Female Condoms
7. Contraceptive Implants
8. Emergency Contraception
9. Chlorhexidine
10. Resuscitation Devices
11. Amoxicillin
12. Oral Rehydration Salts
13. Zinc

## EVALUATION QUESTIONS, DESIGN, METHODS AND LIMITATIONS

The study focuses on the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC) list of 13 underutilized life-saving commodities, with a particular emphasis on the 10 MNCH commodities. It includes data and information for USAID’s 24 priority *Ending Preventable Child and Maternal Deaths* countries:

<i>East Africa</i>	<i>West/South Africa</i>	<i>Asia/Middle East/LAC</i>
Democratic Republic of Congo	Ghana	Bangladesh
Ethiopia	Liberia	India
Kenya	Mali	Indonesia
Rwanda	Nigeria	Nepal
South Sudan	Senegal	Afghanistan
Tanzania	Madagascar	Pakistan
Uganda	Malawi	Yemen
Zambia	Mozambique	Haiti

Where possible, the analysis focuses on the following two subsets of countries:

Tier 1 countries: DRC, Ethiopia, Zambia, Mozambique and Tanzania

Tier 2 countries: Malawi, Ghana, Nigeria, Rwanda, Uganda and Liberia

However, it is important to note that, as this exercise was part of a larger analysis to include 31 countries in total, some figures included are representative of a larger country set.<sup>1</sup>

F4D and its partners have produced a framework for analysis of the 31 country case studies and developed tools to help compile the necessary data and elicit findings for the research questions. These tools include: (1) a questionnaire to cover the wider aspects of procurement finance management and health systems strengthening as well as the specific areas included in the study; (2) a list of questions for face-to-face and phone/Skype interviews for follow-on discussions; (3) a priority list of contacts for each country covered in the study; (4) a template for data collating and analysis; and (5) a literature and desk review of available information to substantiate and supplement the findings from the questionnaires and interviews.

This study is based on reviews of existing literature, feedback from questionnaires, telephone consultations, and face-to-face interviews with a wide range of stakeholders, including officials from Ministries of Health, Ministries of Finance, and Central Medical Stores and other health and procurement professionals. The data principally reflect respondents' best knowledge and perceptions of procurement, financing and health programming operations in their respective countries.

Information in the form of survey responses or interview participation was received from 60 individual respondents from the following 23 countries: Democratic Republic of the Congo, Ethiopia, Mozambique, Tanzania, Zambia, Liberia, Nigeria, Uganda, Kenya, Madagascar, Mali, Senegal, South Sudan, Afghanistan, Bangladesh, Haiti, India, Colombia, the Dominican Republic, Guatemala, Honduras, Mexico and Paraguay. Responses were not received from the following countries: Ghana, Rwanda, Malawi, Indonesia, Nepal, Pakistan, Yemen and the Philippines.

## **FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

### **Findings & Conclusions**

F4D received information from 23 of the 31 countries that were covered in the study (see section IV below), representing 74 percent of the entire sample size. Based principally on the perceptions and opinions of experts in Ministries of Health and Finance surveyed, a number of themes emerged from the study:

- Virtually all countries primarily use national budgets to fund MNCH procurements, and RH commodities are comparatively more often financed by donor funds;
- A significant number of respondents say that procurement and national budgetary funding cycles do not match;
- Late funding and procurement inefficiencies are cited as a cause of stockouts of MNCH commodities;
- As a result, commodities procured with funds from national budgets are more likely to be last-minute procurements that results in extra costs;
- A majority of respondents said that price and weakness in their procurement and regulatory systems are the causes of procurements of non-quality-assured supplies.

In addition, most respondents indicated that they are interested in engaging more with International Procurement Agencies (IPAs), and a considerable number do not think their fees are a barrier.

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<sup>1</sup> Afghanistan, Bangladesh, Colombia, Democratic Republic of Congo, Dominican Republic, Ethiopia, Ghana, Guatemala, Haiti, Honduras, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mexico, Mozambique, Nepal, Nigeria, Pakistan, Paraguay, Philippines, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, Zambia

However, they do not typically engage with IPAs, because delayed funding causes an inability to meet IPA requirements to pay in advance.

Finally, many respondents believed that a working capital facility that enables national governments to pre-finance procurement using IPAs could help improve the overall efficiency of procurement.

**Question 1: Is there a problem? Is access to financing a problem in procurement of the commodities? Does lack of access to financing lead to higher costs and/or lower quality?**

- **Nationally funded procurements are more difficult.** Most respondents said that those commodities procured through national funds (primarily MNCH commodities) were more difficult (i.e., they are not able to procure what they need when they need it) to procure than those funded by international donors (primarily RH commodities).
- **Nationally funded procurements have more stockouts.** They also said that commodities procured using national funds were more likely to incur stockouts and/or last minute procurement that resulted in extra costs than those procured with funds from international donors.
- **Limited access to funding in national procurements leads to different outcomes.** Respondents also confirmed that access to finance is a central problem in commodity procurement, and it is clear that the source of funding (i.e., national vs. donor) does lead to different outcomes in terms of predictable procurement and consumer-level access, with donor-funded procurements generally being more accessible and predictable.

**Question 2: What causes the problem?**

- **Adequacy of funding vs. timing of funding.** The first challenge in answering this question is getting beyond whether there is adequate funding overall for procurement of the commodities (all respondents identified inadequate funding as the primary issue in procuring commodities), and focusing on whether mismatches in the timing of funding leads to insufficient volumes being procured and/or to quality issues with the commodities procured.
- **Mismatches between budget and procurement.** Forty-five of the 60 respondents (75 percent) did note that there were often mismatches in budget and procurement cycles, leading to frequent stockouts and/or emergency procurement that resulted in extra costs in certain commodity categories—the second most common reason for difficulties after insufficient levels of funding overall. Of those that experienced emergency procurement, 67 percent stated it was becoming more frequent with the increased pressure on domestic resources.
- **Late government disbursement.** Fifty of the 60 respondents (83 percent) said that late government disbursements contribute to the inability to procure on time, and 18 of the 60 respondents (30 percent) said that late government disbursement often or always contributed to an inability to procure.
- **Inefficiency of procurement.** The third most common reason cited for an inability to procure on time was inefficiency in the procurement process itself (e.g., bureaucratic hurdles resulting in delayed response times, protracted production or shipping times, stockouts at the supplier level, etc.), with all 60 of the respondents citing such inefficiencies as sometimes contributing to the problem, and 36 respondents (60 percent) saying that it often or always contributed to the problem. These inefficiencies can lead to quality problems as well if government procurement or regulatory authorities do not have policies and procedures in place to ensure quality.

- **Weak procurement and supply management.** However, there are other reasons for stockouts. For example, national procurement and supply systems are sometimes weak and result in poor storage conditions, such as overstocking in central medical stores and stockouts in remote areas. Inefficient national procurement, distribution and supply chain systems may lead to the development of parallel mechanisms to procure drugs and devices, thereby further reducing efficiency. Another challenge is the lack of coordinated implementation and information exchange between the private and public sectors, across countries, and between local, national and global levels.
- **Poor regulatory and procurement capacity.** Many countries use bidding processes in which the lowest bidder is awarded the supply contract if it has the requisite qualifications and fulfills the specifications in the tender. Respondents claim that in instances where the government does not procure quality commodities, 40 percent of the time the reason is poor regulatory and procurement capacity. Even if the right quality specifications were included in tenders, national capacity to enforce pharmacovigilance may be insufficient.

### Question 3: How big of a problem is it?

- **There is significant unmet demand for MNCH commodities.** In conjunction with the third-party market analyses via JSI and Crown Agents, F4D has been working with additional stakeholders to gain an understanding of the potential demand for MNCH commodity procurement at the national level. In total, CHAI estimates that there is an annual procurement need of approximately US \$514 million in UNCoLSC commodities across available countries, with an estimated US \$128 million in annual procurement demand. Of this, nearly US \$70 million is demand for MNCH commodities and over US \$500 million is need for MNCH commodities. The variance between these two estimates, approximately US \$400 million, represents an unmet need for end users of these life-saving MNCH commodities.
- **Funding is very often not available at the right time.** Respondents from 21 of the 23 countries (91 percent) surveyed confirmed they have a problem with access to funding *at the right time*. While the data in the bullet above point to the fact that many countries simply do not have *enough funding overall* to procure the commodities that they need, the point here is that even when countries do have funding, the timing of the availability of that funding also has an impact on their ability to procure what they need.

### Question 4: Would a working capital facility be an appropriate solution?

- **Improve mismatched funding cycles.** According to the results of the study, mismatches in budget cycles do affect country procurements, indicating that financing to bridge those mismatches could solve this particular problem.
- **Improve access to IPAs.** All 60 of the individual respondents cited inefficient national procurement practices as contributing to emergency procurements to avoid stockouts, and a significant number of the respondents attributed procurement of non-quality-assured commodities to price constraints (28 of the 60, or 47 percent) and to poor regulatory and procurement systems (24 of the 60, or 40 percent). Engagement with IPAs could help countries to alleviate emergency procurements, stockouts and quality issues, as IPAs only engage with quality-assured suppliers and have enough purchasing power to ensure access to timely, efficient procurement of quality goods.

Importantly, 13 of the 23 countries (57 percent) surveyed responded that they are interested in engaging more with IPAs, and 10 of the 23 countries (44 percent) say that the IPA fees would not be a barrier to using their services. However, 13 of the countries (57 percent) said that they

usually would not be able to engage with IPAs as a direct result of the fact that the delays in funding resulting from their own budgetary cycle mismatches do not allow them to pay IPAs in advance, as they require. Therefore, access to a working capital facility, used to facilitate procurements through IPAs, could be an appropriate solution to the problems outlined above.

Finally, in determining whether a working capital facility would be a useful solution to some of the procurement problems outlined, the lack of access to funding as a result of budget mismatches must be weighed against a general lack of funding. An overall lack of funding for RH, MNCH and the health sector in general is a common message that surfaced during the course of the study across all geographic regions. In many countries, the level of funding directed towards public health—and specifically toward health commodities—is simply not sufficient to support the needs of the population. Even when good quality national commodity forecasts are developed, they may need to be downwardly adjusted to accommodate budget ceilings. Constraints in government budgets and conflicting priorities in public spending, along with delayed payments/release of funds, are cross-cutting issues in a large number of the countries studied and across all of the regions. Therefore, while applicability would certainly vary by country, such a facility could be of value for a considerable number of countries where budget mismatches or lack of access to quality commodities are central issues, and where governments have policies and procedures in place that would allow them to take advantage of such a facility.

### **Emerging Questions Recommended for Further Study**

- 1. Do emergency procurements become necessary due to inadequate funding, poorly timed funding or some combination of the two?** The overwhelming reason given for emergency procurements (that are necessary to avoid stockouts, but that result in extra costs) was an “insufficient level of funding for procurement of required products, in the right quantity and quality.” More work needs to be done to determine whether the answer to this question actually relates to the timing of funding availability, or whether respondents simply felt that not enough funding overall was available for procurement of commodities.
- 2. Are the small number of quality claims indicative of a lack of quality assurance programming or a lack of quality issues?** Fifty-two of the 60 respondents (87 percent) stated that they had not filed any quality claims against MNCH commodity suppliers within the last year, suggesting that this is not a major issue in the majority of the focus countries. However, this may not necessarily indicate the lack of a quality problem, but rather a lack of quality assurance programs and pharmacovigilance sufficient to identify a quality problem. Further work in this area should examine quality testing rates and examined purity levels among respondent countries throughout their continuum of care.
- 3. What is a “competitive price”?** By individual commodity, 18-38 percent of respondents stated that they were unable to receive competitive pricing by procuring directly through their domestic procurement entities. However, there is a general lack of pricing transparency across countries, commodities and suppliers, and it is unclear whether respondents’ *perception* of a competitive price actually represents a truly competitive price. Further work in this area would examine prices received for each of the 10 commodities across the focus countries from multiple supplier tenders, and determine a benchmark price that is deemed competitive in each market. Then, a more objective view of competitive price receipt can be examined by comparing price received vs. benchmark competitive price.
- 4. What (if any) national policies are in place that would prevent efficient and timely procurement of health commodities?** Finally, when asked if there were national policies in place that prevented efficient and timely procurement of health commodities, many respondents reported that there were not. However, there is the potential for bias when answering this

question, depending upon the position of the respondent, given that most are senior officers in the Ministries of Health and Finance, and thus, responsible for setting policy. Therefore, it may be the case that there are policies in place that do prevent funding from being available for MNCH commodity procurement; however, the respondents may not be aware of them, or they may not be aware of any resulting negative effects on procurement.

# I. INTRODUCTION

## EVALUATION PURPOSE

As the 2015 deadline to the Millennium Development Goals (MDGs) fast approaches, evidence suggests that there is an urgent need to accelerate progress on improving the health of women and children, as outlined in USAID’s Maternal Health Vision for Action, the UN-Secretary General’s Global Strategy for Women and Children’s Health, the Every Woman, Every Child (EWEC) initiative, and the Global Financing Facility. Given that national governments typically fund maternal, neonatal and child health (MNCH) commodities from their own national budgets, there is a risk that there will not be enough funding available at the right time, resulting in procurement inefficiencies such as insufficient volumes purchased or quality issues. Evidence to date suggests that a working capital facility can help improve timely access to funding and help national governments improve outcomes related to MNCH commodities.

In particular, to fulfill the MDG goals, the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC) has identified and endorsed an initial list of 13 underutilized life-saving commodities that, if more widely accessed and appropriately used, could save the lives of more than six million women and children. Unlike other global health commodities such as antiretroviral drugs (ARVs), vaccines and contraceptives, international donors typically do not procure MNCH commodities. Instead, funding and procurement of these commodities is left to national governments and the in-country private sector.

Countries that finance procurements from national budgets may face constraints in accessing the capital they need in time to appropriately plan for procurements and may either have to buy on credit or delay procurement until full funding becomes available. Further, most procurement agents and suppliers require payment upfront, and are not willing to extend credit. The 2012 UN Commissioners’ Report on UNCoLSC identified financial barriers as a key obstacle in the MNCH commodity-related market, affecting the supply chain, overall access to health care, and performance.

In addition, evidence suggests that even when national funding is available when necessary to start procurement processes, the prices that countries are charged vary widely, with only some countries being able to negotiate competitive prices for themselves. Perhaps more critically, what remains unknown is the quality of the commodities being procured. In some cases, governments are procuring MNCH commodities via reputable procurement agents, and the quality, to some extent, can be assured. However, for a number of countries negotiating directly with suppliers and manufacturers or procuring via smaller, less well-regulated procurement agents, it is possible that the lower prices may come at the expense of quality—even when quality specifications have been included in the tenders.

With the goal of driving more efficient procurement of MNCH commodities, the objective of this study is to identify if access to funding at the right time is a challenge and find solutions that will help national governments avoid delays in procurements and ensure that funds are available when needed. Leveraging the insights and experiences from experts in the Ministries of Health and Finance in target countries, the assignment was specifically to:

### UNCoLSC Commodities

1. Oxytocin
2. Misoprostol
3. Magnesium Sulfate
4. Injectable Antibiotics
5. Antenatal Corticosteroids
6. Female Condoms
7. Contraceptive Implants
8. Emergency Contraception
9. Chlorhexidine
10. Resuscitation Devices
11. Amoxicillin
12. Oral Rehydration Salts
13. Zinc

- Conduct a technical analysis that attempts to answer the question of whether or not access to timely funding is a challenge when countries procure MNCH commodities;
- Develop analytical tools and techniques to undertake the technical study;
- Validate whether availability/access to funds for the procurement of MNCH commodities is the specific challenge, and assess the impact of the linkages between finance and:
  - Procurement systems
  - Quality of commodities
  - Supply chain capabilities
  - Pricing of commodities
- Analyze results of the outcomes from the study; and
- Find solutions that will help national governments avoid delays in procurements and ensure that funds are available when needed.

The analysis and findings of this study are based on reviews of existing literature, feedback from questionnaires, telephone consultations and face-to-face interviews with a wide range of stakeholders, including officials from Ministries of Health, Ministries of Finance, Central Medical Stores and other health and procurement professionals. The data principally reflect respondents' best knowledge and perceptions of procurement, financing and health programming operations in their respective countries.

The study includes data and information on USAID's priority 24 *Ending Preventable Child and Maternal Deaths* (EPCMD) countries:

**Table 1: Countries included in the market analysis**

<b>East Africa</b>	<b>West/South Africa</b>	<b>Asia/Middle East/LAC</b>
<b>Democratic Republic of Congo</b>	<b>Ghana</b>	<b>Bangladesh</b>
<b>Ethiopia</b>	<b>Liberia</b>	<b>India</b>
<b>Kenya</b>	<b>Mali</b>	<b>Indonesia</b>
<b>Rwanda</b>	<b>Nigeria</b>	<b>Nepal</b>
<b>South Sudan</b>	<b>Senegal</b>	<b>Afghanistan</b>
<b>Tanzania</b>	<b>Madagascar</b>	<b>Pakistan</b>
<b>Uganda</b>	<b>Malawi</b>	<b>Yemen</b>
<b>Zambia</b>	<b>Mozambique</b>	<b>Haiti</b>

In all instances possible, the analysis focuses on a subset of the 24 priority countries:

Tier 1 countries: DRC, Ethiopia, Zambia, Mozambique and Tanzania

Tier 2 countries: Malawi, Ghana, Nigeria, Rwanda, Uganda and Liberia

It is important to note that, as this exercise was part of a larger analysis to include 31 countries in total of which 23 countries participated, figures included in Section IV are representative of a larger country set.<sup>2</sup>

The report is structured as follows:

**Section II** describes the methodology used in the study.

**Section III** presents the findings from the study that most directly address the major questions/assumptions posed in the SOW. The data presented in the tables and figures in this section are from the full set of 60 participating respondents across 23 countries (see Note 3), however the conclusions and results are focused on the smaller subset of Tier 1 and 2 countries listed above and MNCH commodities only.

**Section IV** presents additional findings from a broader analysis including the results of the in-country visits, and data on all 13 UNCoLSC commodities. The data presented in the tables and figures in this section are from the more limited set of African and Asian countries.<sup>3</sup> Every country discussed in this section is one of USAID's priority EPCMD countries.

## EVALUATION QUESTIONS

The findings presented below attempt to answer the following questions:

*Question 1: Is there a problem? Is access to financing a problem in procurement of the commodities? Does lack of access to financing lead to higher costs and/or lower quality?*

*Question 2: What causes the problem?*

*Question 3: How big of a problem is it?*

*Question 4: Would a working capital facility be an appropriate solution?*

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<sup>2</sup> Afghanistan, Bangladesh, Colombia, Democratic Republic of Congo, the Dominican Republic, Ethiopia, Guatemala, Haiti, Honduras, India, Kenya, Liberia, Madagascar, Mali, Mexico, Mozambique, Nigeria, Paraguay, Senegal, South Sudan, Tanzania, Uganda, Zambia.

<sup>3</sup> Afghanistan, Bangladesh, Democratic Republic of the Congo, Ethiopia, India, Kenya, Liberia, Madagascar, Mali, Mozambique, Nigeria, Senegal, South Sudan, Tanzania, Uganda, Zambia.



## II. EVALUATION METHODS & LIMITATIONS

This study is based on reviews of existing literature, feedback from questionnaires, telephone consultations, and face-to-face interviews with a wide range of stakeholders, including officials from Ministries of Health, Ministries of Finance, and Central Medical Stores and other health and procurement professionals.

### RESEARCH ACTIVITIES

The research team carried out a number of activities including the collection, collation and analysis of secondary data. The team distributed and followed up on the survey results with respondents from all of the countries included in the study. Individual questionnaire responses and country case studies are included in Annex I. The questionnaires were typically completed by key informants prior to in-country work and/or interviews. The in-country work, interviews and desk reviews were used to substantiate and clarify the questionnaire responses. No single country-specific source was viewed as incontrovertible, and the use of all research methods was critical. The report reflects the views of individuals, including their individual biases and perspectives, as well as data collected from other resources.

### Questionnaire and research tools

F4D and its partners produced a framework for analysis of the country case studies and developed tools to help compile the necessary data and elicit findings for the research questions. These tools include: (1) a questionnaire distributed to individuals who were deemed best placed to provide good quality information from Ministries of Health and Finance, and Central Medical stores in each country, which covers the wider aspects of procurement finance management and health systems strengthening as well as the specific areas included in the study (Annex III); (2) a list of questions for face-to-face and phone/Skype interviews for follow-on discussions; (3) a priority list of potential questionnaire participants and/or interviewees for each country in the study (see Acknowledgements and References); (4) an Excel template to be used for collating and analysis of questionnaire responses; and (5) an extensive review of existing research and literature to substantiate the findings from the questionnaires and meetings.

In all instances, selection of individuals was purposive, as there are select individuals with access to correct and accurate data regarding purchase volumes, funding flows, budgetary policies and health sector performance. Selected participants were contacted by email with a request to voluntarily participate in a multiple choice, ranking, and short-answer questionnaire for the purposes of this report. Those who replied with an interest in participating were provided with the questionnaire and invited to return their responses by email. Participants had the option to remain anonymous, or to voluntarily provide identifying contact information for potential follow-up interviews via phone or Skype as indicated above.

The questionnaire data were analyzed in Excel with minimal manipulation, including the generation of absolute values, averages and proportions, to result in the included charts and tables. More information on the questionnaire respondents and interviewees can be found in Annex IV, and the background references and literature can be found in Annex V.

### Desk review

Reviews of available information provided background on health systems and known issues surrounding the uptake and procurement of MNCH commodities. The desk studies focused on those countries where comprehensive data were available for analysis. In a few instances, where data for countries

proved difficult to access for confidentiality reasons, especially relating to MNCH statistics, the team endeavored to use its network to gather pertinent information from knowledgeable individuals in country, and used verifiable data available in the public domain for analysis.

### In-country work/visits

Information gathered from the desk review was supplemented by visits and conversations with in-country stakeholders. Countries selected for field visits were those where the procurement of MNCH commodities is often undertaken by national governments, where MDG indicators are low, and that are identified as donor priority countries.

In addition to the targeted visits, the team made full use of its presence on the ground, as well as its network of contacts within governments, to ensure that it was able to maximize face-to-face interactions for data collection.

### SAMPLE SIZE AND COMPOSITION

The study collates the qualitative and quantitative feedback from individuals in 23 countries, including 30 individual respondents from eight of USAID's 11 Tier 1 and Tier 2 priority countries<sup>4</sup> and respondents from 17 of USAID's priority EPCMD countries.<sup>5</sup> Literature from the majority of the countries in the study was available, with the exception of Yemen, Nepal and the Philippines, where limited literature exists in the public domain. In addition, it was difficult collecting responses to the questionnaire from individuals in some USAID Tier 1 and Tier 2 priority countries, including Ghana, Malawi and Rwanda.

Of the 79 individuals contacted to respond to the questionnaire, 60 responded, including 30 from USAID priority countries.

**Table 2: Sample size and composition**

Country	Who was contacted for questionnaire/interviewed	No.	Who responded/ interviewed	No.
<b>Nigeria</b>	<i>Subtotal</i>	6	<i>Subtotal</i>	<b>6</b>
	Federal Medical Stores	1	Logistics Manager	1
	National Primary Health Care Development Agency	1	Technical Assistant to CEO	1
	Ministry of Health	1	Supply Chain Officer (RMNCH)	1
	Zamfara State Medical Stores	1	Director of Pharmacy	1
	Kaduna State MNCH unit	1	Director of Pharmacy	1
	Jigawa State MNCH unit	1	Director of pharmacy	1
<b>Tanzania</b>	<i>Subtotal</i>	8	<i>Subtotal</i>	<b>7</b>
	MSD	1	Director General	1
	MOHFSW	5	Representatives	<b>4</b>
	SCMS	2	Country Director	<b>2</b>
<b>Ethiopia</b>	<i>Subtotal</i>	5	<i>Subtotal</i>	<b>5</b>
	MOH	1	Head of Logistics	1
	MOH MNCH unit	2	MNCH Experts	<b>2</b>

<sup>4</sup> Democratic Republic of Congo, Ethiopia, Liberia, Mozambique, Nigeria, Tanzania, Uganda, Zambia

<sup>5</sup> Afghanistan, Bangladesh, Democratic Republic of Congo, Ethiopia, Haiti, India, Kenya, Liberia, Madagascar, Mali, Mozambique, Nigeria, Senegal, South Sudan, Tanzania, Uganda, Zambia

Country	Who was contacted for questionnaire/interviewed	No.	Who responded/ interviewed	No.
	PFSA	1	Head of Procurement	1
	FMHACA	1	Representative	1
<b>Kenya</b>	<i>Subtotal</i>	5	<i>Subtotal</i>	6
	KEMSA	2	Representatives	3
	Pharmacy and Poison Board	1	The Registrar	2
	National Treasury	1	Asst. Director Supply Chain	1
	MOH	1	Director of Medical Services	0
<b>Uganda</b>	<i>Subtotal</i>	7	<i>Subtotal</i>	6
	National Medical Stores	2	Head of Client Services; Procurement Department	2
	Ministry of Health	2	RMNCH Commodity Security Advisor	1
	Ministry of Finance, Planning & Economic Development	2	Permanent Secretary; Director Budget	2
	Makerere University, School of Public Health	1	Researcher, MNCH Specialist	1
<b>DRC</b>	<i>Subtotal</i>	3	<i>Subtotal</i>	3
	FEDECAME/BCAF	1	Head of Procurement	1
	Director of Pharmaceuticals and Medicines and Direction of Health Family and Specific Groups	1	Directors	1
	Health Reproductive Program	1	Pharmacist in charge	1
<b>Zambia</b>	<i>Subtotal</i>	2	<i>Subtotal</i>	1
	Medical Stores Limited	1	Project Manager	0
	Ministry of Community Development Mother and Child Health (MCDMCH)	1	MNCH	1
<b>Afghanistan</b>	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	Ministry of Public Health, Directorate of Monitoring and Evaluation	1	Acting Director	1
<b>Senegal</b>	<i>Subtotal</i>	3	<i>Subtotal</i>	1
	Pharmacie Nationale d'Approvisionnement (PNA)	1	Logistician Pharmacist – Project Manager	1
	Direction Sante de la Reproduction	1	Director	0
	Ministère de l'Economie, des Finances et du Plan – Health Program	1	Person in charge of the health programs (directed us to PNA)	0
<b>Mozambique</b>	<i>Subtotal</i>	2	<i>Subtotal</i>	1
	Ministry of Health	1	Deputy Director	1

Country	Who was contacted for questionnaire/interviewed	No.	Who responded/ interviewed	No.
	Ministry of Health UGEA	1	Head of Department	0
South Sudan	<i>Subtotal</i>	2	<i>Subtotal</i>	2
	Ministry of Health	2	Senior Quality Assurance, Director General, Reproductive Health	2
Madagascar	<i>Subtotal</i>	2	<i>Subtotal</i>	1
	SALAMA – Central Medical Stores	1	Director	1
	Reproductive Health Direction	1	Director	0
Liberia	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	Ministry of Health	1	Supply Chain Management Unit	1
Bangladesh	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	Maternal, Neonatal, Child and Adolescent Health, DGHS	1	Deputy Program Manager - MNH	1
India	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	India Immunization Technical Support Unit	1		1
Rwanda	<i>Subtotal</i>	2	<i>Subtotal</i>	0
	USAID	2	Commodities Advisor and Health System Strengthening	0
Ghana	<i>Subtotal</i>	3	<i>Subtotal</i>	0
	Ministry of Health	1	Director Procurement	0
	Ghana Health Service	1	Director Supplies	0
	Ministry of Finance	1	Director Budget	0
Malawi	<i>Subtotal</i>	2	<i>Subtotal</i>	0
	Ministry of Health	1	Permanent Secretary	0
	Public Health Institute of Malawi	1	Team Leader PHIM	0
Pakistan	<i>Subtotal</i>	0	<i>Subtotal</i>	0
		0		0
Mali	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	Reproductive Health Director	1	Director	1
Indonesia	<i>Subtotal</i>	1	<i>Subtotal</i>	0
	Ministry of Health	1	Permanent Secretary	0
Nepal	<i>Subtotal</i>	0	<i>Subtotal</i>	0
		0		0
Philippines	<i>Subtotal</i>	3	<i>Subtotal</i>	0
	Department of Health	3	Various	0
	<i>Subtotal</i>	4	<i>Subtotal</i>	3

Country	Who was contacted for questionnaire/interviewed	No.	Who responded/ interviewed	No.
<b>LAC Regional (across countries)</b>	Pan American Health Organization (PAHO)	2	Strategic Regional Fund Advisor, Director of Drugs and Technology in Health	2
	Council of Ministers of Health of Central America (COMISCA)	2	Executive Secretary	1
<b>Colombia</b>	<i>Subtotal</i>	2	<i>Subtotal</i>	2
	Ministerio de Salud y Proteccion Social (health ministry)	2	Health Consultant, Direccion de Medicamentos (department for drugs and technologies in health)	2
<b>Dominican Republic</b>	<i>Subtotal</i>	2	<i>Subtotal</i>	2
	Ministerio de Salud Publica	1	National Drug Management Unit	1
	PROMESE-CAL (program for essential medicines and central logistics support)	1	Manager of Planning and Development	1
<b>Guatemala</b>	<i>Subtotal</i>	2	<i>Subtotal</i>	2
	Ministerio de Salud Publica y Asistencia Social	1	Programa Nacional de Salud Reproductiva (national RH program)	1
	USAID DELIVER PROJECT	1	Resident Advisor	1
<b>Haiti</b>	<i>Subtotal</i>	4	<i>Subtotal</i>	3
	Ministere de la Sante Publique et de la Population	1		0
	Health Finance and Governance Project (HFG)	2	Haiti Country Manager, Health Financing Advisor	2
	University Research Co. (URC)	1	Senior Health Systems Strengthening Advisor	1
<b>Honduras</b>	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	Ministry of Health – Drug Logistics Unit	1	Area Coordinator for Medicines and Supplies	1
<b>Mexico</b>	<i>Subtotal</i>	2	<i>Subtotal</i>	1
	Ministry of Health	1		0
	Instituto de Salud del Estado de Chiapas (health ministry for Chiapas)	1	Manager of the Coordinating Unit for the Salud Mesoamerica initiative in Chiapas	1
<b>Paraguay</b>	<i>Subtotal</i>	1	<i>Subtotal</i>	1
	Ministerio de Salud Publica y Bienestar Social (health ministry)	1	Dirección General de Gestión de Insumos Estratégicos (general directorate of strategic procurement management) - Unidad Presupuestaria (Budgeting unit)	1
<b>TOTAL</b>	<b>PLANNED</b>	<b>79</b>	<b>ACTUAL</b>	<b>60</b>

**Table 3: Percentage of responses by region**

<b>Coverage</b>	<b>Planned response</b>	<b>Actual response</b>	<b>Percent of response</b>
<b>East Africa</b>	8	7	88%
<b>West/South Africa</b>	8	6	75%
<b>Asia/Middle East</b>	8	3	38%
<b>LAC</b>	7	7	100%
<b>Total</b>	<b>31</b>	<b>23</b>	<b>74%</b>

### III. FINDINGS

This section presents key findings from the 60 individual questionnaire responses received from 23 of the 31 countries, with a focus on eight of the Tier 1 and Tier 2 countries that USAID identified as priorities.<sup>6</sup> The findings presented below attempt to answer the following questions:

*Question 1: Is there a problem? Is access to financing a problem in procurement of the commodities? Does lack of access to financing lead to higher costs and/or lower quality?*

*Question 2: What causes the problem?*

*Question 3: How big of a problem is it?*

*Question 4: Would a working capital facility be an appropriate solution?*

Overall, the responses show that access to financing, including lack of funding from national government budgets, bureaucratic procurement processes and late disbursement of funds from the government, is a problem in the procurement of MNCH commodities.

While the tables and figures included here represent the larger set of 23 responding countries, it should be noted that when comparing USAID’s focus countries and commodities to the larger set, a few key differences emerged:

- More MNCH commodities are procured using national funds than RH commodities.
- USAID’s focus countries had more issues with supply than did non-USAID countries.
- USAID’s focus countries had more issues relating to the price of commodities than did non-USAID countries.

#### QUESTION 1: IS THERE A PROBLEM?

This section highlights the overarching problems identified relating to the funding, supply and quality of MNCH commodities in the countries studied. We focus here specifically on the questions related to stockouts of MNCH commodities, the ability of countries to purchase MNCH commodities at competitive prices, and quality assurance.

##### Stockouts

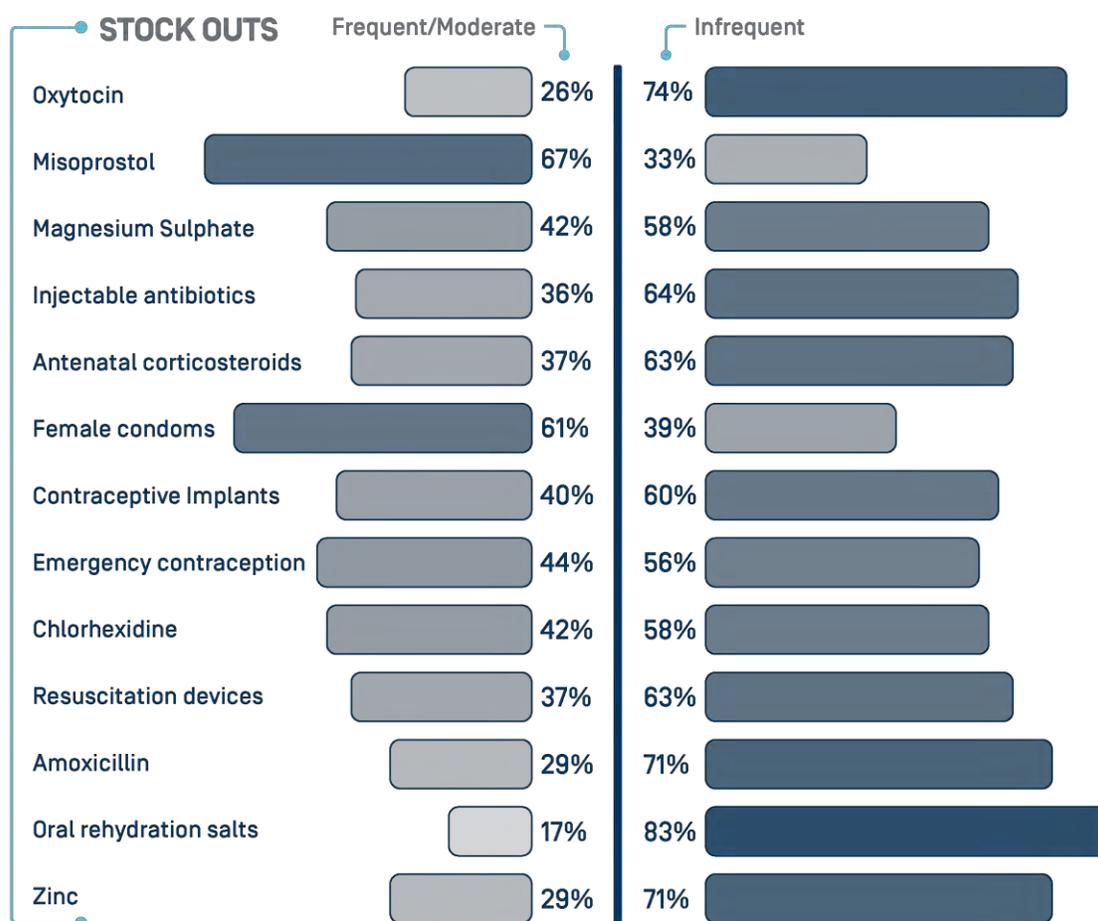
Figure 1 below presents the responses to the questionnaire on the perceived frequency of stockouts. Respondents were asked to rank the frequency with which stockouts are faced for each commodity on a scale of 1–7 (1=always, 7=never). The chart below maps the percentage of responses between 1 and 4, indicating that stockouts are “always” or “sometimes” an issue (labelled “frequent/moderate” in the figure below), and responses between 5 and 7, indicating stockouts are “infrequently” an issue.

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<sup>6</sup> Democratic Republic of Congo, Ethiopia, Liberia, Mozambique, Nigeria, Tanzania, Uganda, Zambia

**Figure 1: Frequency of commodity stockouts according to survey respondents**

**Percent of survey respondents that believed a particular commodity experienced “frequent/moderate” vs. “infrequent” level of stockouts**



The data in Figure 1 show that respondents indicated that misoprostol was most likely to experience a stockout, with 67 percent of respondents reporting it as a “frequent/moderate” issue. Frequent stockouts of this commodity may be related to non-procurement as a result of its use for multiple indications. For example, misoprostol is used not only for labor induction and to stem post-partum bleeding, but can also be used to induce abortion, which is illegal in many countries. As a result, some countries may not procure misoprostol at all.

Magnesium sulfate and chlorhexidine were also ranked as commodities for which there were frequent stockouts across the regions, each with 40 percent or more respondents ranking them between 1 and 4.

Stockouts of oral rehydration salts appear to be less common in comparison to the other nine MNCH commodities, with only 17 percent ranking it between 1 and 4, and the remaining 83 percent ranking between 5 and 7, suggesting stockouts occur rarely or not at all. That could be because oral rehydration salts are an inexpensive and locally manufactured commodity, and are therefore much easier to acquire. However, overall stockouts and lack of supply of the 13 RMNCH commodities appears to be an issue in the countries studied, with over 26 percent of respondents ranking 12 of them between 1 and 4.

Regionally, East and West Africa appear to face the greatest problems with MNCH commodity stockouts, in comparison to the Asian countries.

Among respondents from East Africa, 75 percent ranked misoprostol between 1 and 4, suggesting regular stockouts, while 67 percent ranked magnesium sulfate between 1 and 4. Resuscitation devices and antenatal corticosteroids also stand out as commodities for which lack of supply/stockout is a major problem, each with 63 percent of respondents in the region ranking them between 1 and 4.

Similarly for West/South Africa, many of the commodities were ranked highly in terms of stockout frequency. Chlorhexidine and misoprostol stand out in particular in the West/South Africa region with 75 percent and 60 percent of respondents, respectively, ranking them between 1 and 4.

The frequency of stockouts for some commodities varies greatly between regions. For example, 75 percent of respondents in West/South Africa claimed that they face the issue of stockouts frequently for chlorhexidine, compared to 50 percent of East African respondents. Similarly, 56 percent of respondents in East Africa claimed that they face the issue of stockouts frequently for amoxicillin, compared to 33 percent of West/South African respondents.

### Funding Issues Leading to Stockouts

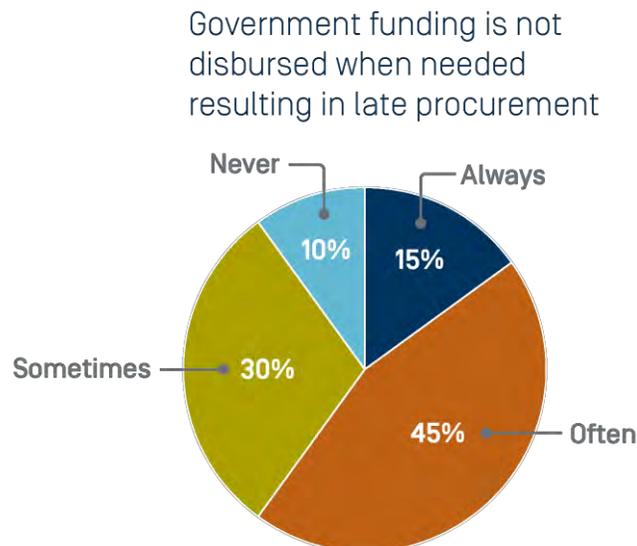
Respondents to the questionnaire were asked to provide the most common reasons for stockouts and lack of supply of the 13 UNCoLSC commodities, and they were given a list of potential reasons that were to be ranked as: “always,” “often,” “sometimes,” or “never” the cause of stockouts, along with the option to provide alternatives that were not listed.

According to the surveys, the two reasons that were most frequently selected as either “always” or “often” the cause of stockouts were:

- “Government funding is not disbursed when needed resulting in late procurement;” and
- “Insufficient level of funding for the procurement of required products, in the right quantity and quality.”

**Figure 2: Timing of government disbursements for commodity procurement according to survey respondents**

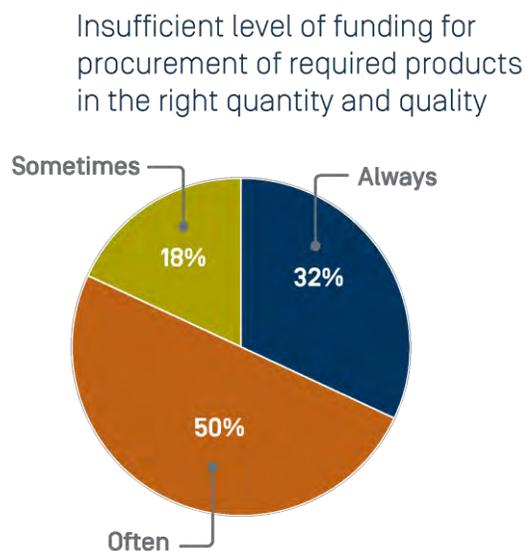
**Percent of survey respondents that agreed with the following phrase:**



Funding not being available at the right time for the procurement of the MNCH commodities appears to be a significant factor for the countries surveyed, with 60 percent claiming that this is always or often the reason for MNCH commodity stockouts. Only 10 percent suggested that this was never the cause. This reason for stockouts was commonly cited across all geographic regions.

**Figure 3: Sufficiency of funding for MNCH commodity procurement according to survey respondents**

**Percent of survey respondents that agreed with the following phrase:**



An overall lack of funding for RH, MNCH and the health sector in general is a common message that surfaced during the course of the study across all geographic regions. In many countries, the level of funding directed toward public health and specifically toward health commodities is simply not sufficient to support the needs of the population. Thus, even when good quality national commodity forecasts are developed, they may need to be downwardly adjusted to accommodate budget ceilings. Similarly, many respondents suggested that governments do not prioritize MNCH adequately. Constraints in government budgets and conflicting priorities in terms of public spending, along with delayed payments/release of funds, are cross-cutting issues in a large number of the countries studied and across all of the regions.

Respondents who highlighted the mismatch between funding and procurement cycles as the primary cause of stockouts also suggested that the proposed working capital facility could allow for improved forecasting and supply management for MNCH. However, in countries where the total level of funding directed toward public health and health commodities is the primary issue, access to a working capital facility would not necessarily address the problem, and in fact could pose creditworthiness issues, since governments might not actually have sufficient funds to repay loans taken from such a facility.

The two other major reasons for stockouts provided by many respondents were overly bureaucratic procurement processes resulting in late procurement, and poor quantification and forecasting of MNCH commodities. High levels of bureaucracy can often result in delays in receiving funds and in cash flow issues. This problem was reported across the geographic regions, and at various levels within health care systems.

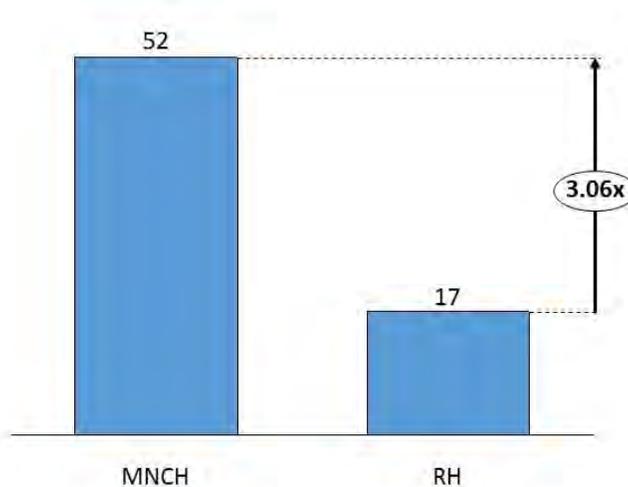
Less common causes of commodity stockouts cited included:

- “Regulatory issues (e.g., products not being registered in country)”
- “Incapacity/inability to find suppliers and/or manufacturers which offer good quality products at the right price”
- “Supply chain issues (warehousing, distribution, etc.)”

### Emergency Procurements at Extra Costs to Avoid or End Stockouts

As previously discussed, RH commodities tend to be funded by donors, whereas MNCH commodities tend to be primarily funded using national resources. When asked which of the 13 RMNCH commodities had experienced emergency procurements resulting in extra costs over the last 12 months, respondents indicated that MNCH commodities were more likely to experience this than RH commodities (see Figure 4).

**Figure 4: Percent of respondents who cited incidents of emergency procurements within the last 12 months, resulting in extra costs**

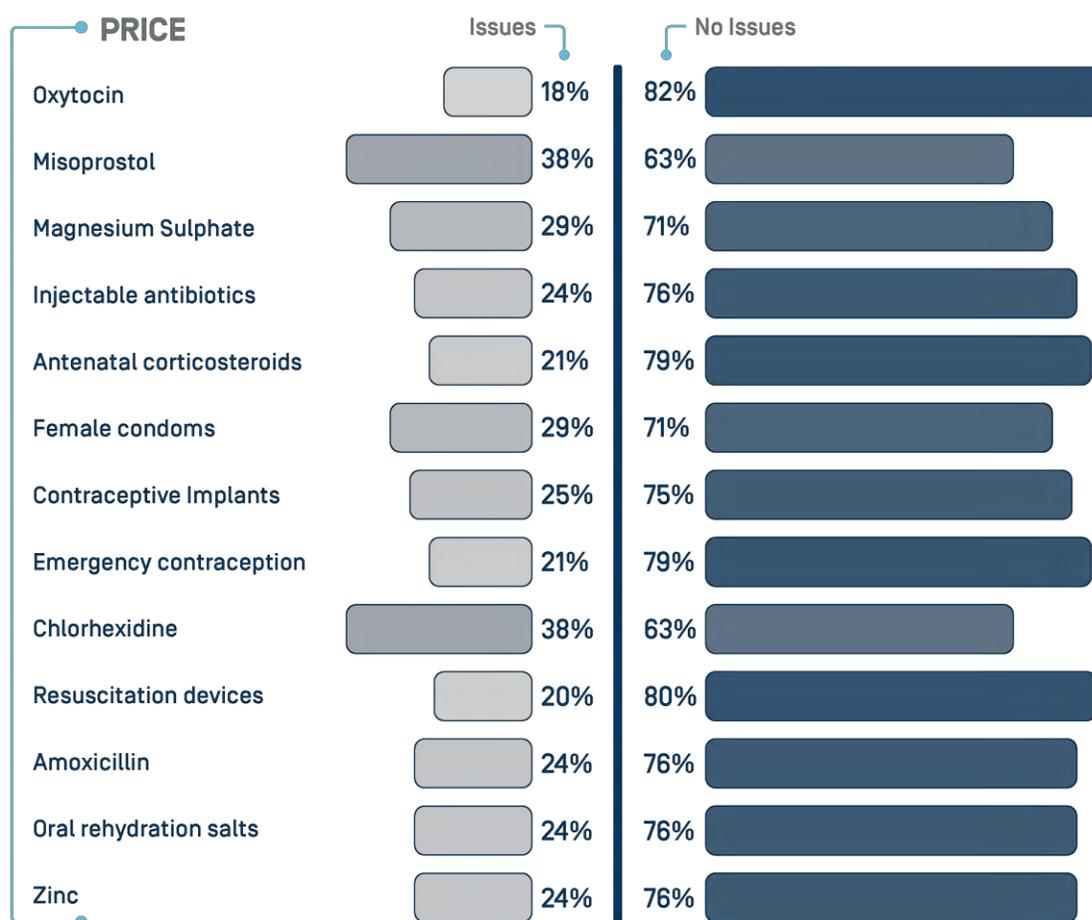


### Governments Procuring at Uncompetitive Prices

Figure 5 presents the responses to the questionnaire regarding the frequency with which governments are unable to procure at competitive prices for each of the 13 commodities. Respondents were asked to rank the frequency with which this issue is faced for each commodity on a scale of 1– (1=always, 7=never). The chart below shows the percentage of responses between 1 and 4, capturing those for whom this is “always” or “sometimes” an issue (“Issues”), as well as responses between 5 and 7, capturing those for whom procurement at uncompetitive prices is “rarely” or “never” an issue (“No Issues”).

**Figure 5: Commodity pricing issues according to survey respondents**

**Percent of survey respondents who believed they experienced issues with being able to procure MNCH commodities at competitive prices**



At first glance, it appears that the issue of governments being unable to procure RMNCH commodities at competitive prices is a much smaller issue than those of lack of overall supply and stockouts, with a much higher percentage of respondents claiming that uncompetitive pricing is not really an issue that they face. However, it is not clear whether governments actually have adequate information in order to make this determination. While some work has been done internationally to bring transparency to pricing of health commodities, such as CHAI’s work on ARVs, it is not clear that governments have access to such information for the commodities covered in this study, especially if they are procuring directly from suppliers rather than through international procurement agents. Prices paid by the public sector of various countries for the RMNCH commodities have been included in the report, where such information was made available through interviews and completed questionnaires.

The general trend is that misoprostol and chlorhexidine are the two commodities that governments believe they are regularly procuring at uncompetitive prices.

Another question posed in the survey was whether the lack of access to international procurement agencies was a major barrier to the procurement of quality assured MNCH commodities at competitive prices. Thirty-six percent of respondents claimed that the main reason they could not access procurement through IPAs is because the ability to pay or engage with them in advance is hampered by delays in availability of funding. A significant number of countries are interested in engaging more with

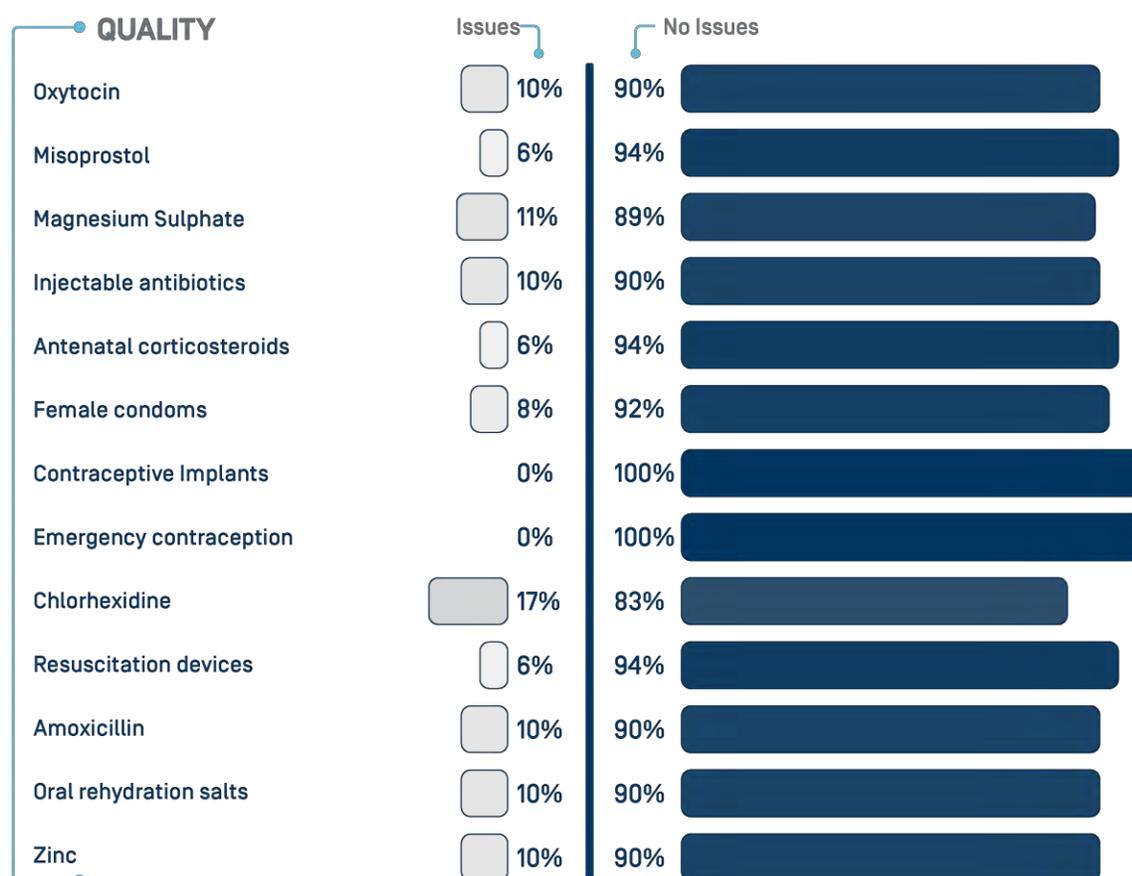
IPAs (55 percent of surveyed respondents), and do not think that their fees are a barrier (45 percent of surveyed respondents).

### Procurement of Poor Quality MNCH Commodities

Figure 6 presents the responses to the questionnaire regarding the frequency with which governments reported that they do not procure quality-assured MNCH commodities and control RH commodities. Respondents were asked to rank the frequency with which this issue is faced for each commodity on a scale of 1–7 (1=always, 7=never). The chart below shows the percentage of responses between 1 and 4, capturing those for whom this is “always” or “sometimes” an issue (“Issues”), as well as responses between 5 and 7, capturing those for whom the government being unable to procure quality assured commodities is “rarely” or “never” an issue (“No Issues”).

The data show that the procurement of poor-quality RH commodities is not an issue faced by the countries studied, while a small number of respondents indicated there are some quality issues with MNCH commodities. However, since most respondents work within or close to government agencies, it is possible that most did not wish to imply that the commodities being procured by government were not quality assured and potentially unsafe for the public’s use. A more thorough investigation would be required to gain a better understanding of whether or not a lack of awareness and/or appropriate pharmacovigilance is an issue that contributes to the mismatch between a perception of quality and actual quality issues.

**Figure 6: Commodity quality issues according to survey respondents**  
**Percent of survey respondents that believed they experienced quality issues with a particular commodity**



In a study released in September 2014 by the National Bureau of Economics, “Poor Quality of Drugs and Global Trade,” considerable evidence was presented that some health commodity suppliers sent low-quality goods to sub-Saharan African consignments (presumably knowingly) at a higher rate than more developed regions, principally because capacity for quality assurance is considered to be lower. Despite this evidence, 87 percent of respondents to the survey stated that they did not believe their country had filed any quality claims against MNCH commodity suppliers within the last year.

Given the results of the NBER study, and the fact that the most common reason given for the procurement of poor quality commodities was that “regulatory systems in place are weak, leading to non-quality-assured commodities being procured,” there may be a response bias. While it is possible to infer from respondent surveys that quality is not an issue, the more likely scenario is that in-country pharmacovigilance is low and, therefore, the purchasing party is unaware of quality issues and, as a result, no claims are filed.

Despite the small number of respondents claiming quality to be a major issue in their country, chlorhexidine does stand out as the MNCH commodity for which this is more of an issue than others, with 17 percent ranking it between 1 and 4, suggesting that there could potentially be a common trend among some of the countries. For example, a discussion with the Ministry of Health in Uganda revealed that there is little, if any, information on chlorhexidine available to the population, with a number of unsafe alternatives being used instead. This again relates to a lack of education and knowledge of MNCH commodities leading to unsafe, potentially harmful alternatives.

## **QUESTION 2: WHAT CAUSES THE PROBLEM?**

The questionnaire responses received suggest that the major reasons for the problems associated with the procurement of MNCH commodities include: incompatible funding and MNCH procurement cycles, delayed funding leading to inability to access international procurement agencies (which most often require payment in advance) or to conduct efficient procurements, and insufficient levels of funding being provided for the procurement of required products in the right quantity and quality.

These factors are often interrelated and can lead to chronic shortages and stockouts of many of the 10 MNCH commodities. For example, if the disbursement of funds from the Ministry of Finance does not coincide with the optimal timing for procurement of MNCH commodities, funding gaps emerge, potentially resulting in last minute/emergency procurement and additional incurred costs.

Based on the responses received from the countries included in the study, 43 percent of respondents from Africa and Asia claimed that MNCH procurement cycles do not match the government funding cycles, with the same percentage claiming that this often leads to last minute/emergency procurement and extra costs.

## **QUESTION 3: HOW BIG IS THE PROBLEM?**

In evaluating the breadth and depth of national MNCH procurement inefficiency and the potential impact that an intervention in this space could achieve, there are two major approaches to consider: the dollar value of procurements annually and the size of population potentially affected.

MNCH procurement data are historically weak because of direct purchasing trends and a lack of centralized reporting, and, as a result, metrics on potential market size in dollar value are rough. However, even conservative estimates indicate that MNCH purchasing represents a sizeable volume. In total, CHAI estimates that there is an annual procurement need of approximately US \$514 million for the UNCoLSC commodities across available country-level data, with an estimated US \$128 million in annual procurement demand. Of this, nearly US \$70 million is demand for MNCH commodities and over US \$500 million is need for MNCH commodities.

In considering the size of population potentially affected, it is reasonable to consider the geographic footprint of the national governments that are experiencing negative effects of MNCH procurement inefficiencies. According to respondent data from the study questionnaire, 19 of 23 countries indicated that late access to funding, rather than a lack of funding alone, was an issue they faced. These 19 countries serve a cumulative population of 1.96 billion individual patients and, in markets that are generally stocked with public goods, these challenges represent a significant burden on access to timely, affordable, high-quality MNCH goods.

When asked if there is currently any unmet need for MNCH commodity procurement, 67 percent of participants in the study agreed that there is unmet need for the procurement of MNCH commodities, while only 13 percent disagreed that this was the case in their country.

#### **QUESTION 4: IS A WORKING CAPITAL FACILITY AN APPROPRIATE SOLUTION?**

In determining whether a working capital facility would be a useful solution to some of the procurement problems outlined, the lack of access to funding as a result of budget and procurement cycle mismatches must be weighed against a general lack of funding. An overall lack of funding for RH, MNCH and the health sector in general is a common message that surfaced during the course of this study across all geographic regions. In many countries, the level of funding directed toward public health, and specifically toward health commodities, is simply not sufficient to support the needs of the population. Thus, even when good quality national commodity forecasts are developed, they may need to be downwardly adjusted to accommodate budget ceilings. Constraints in government budgets and conflicting priorities in terms of public spending, along with delayed payments/release of funds, are cross-cutting issues in a large number of the countries studied and across all of the regions. Therefore, such a facility could be of value for a considerable number of countries where budget mismatches are a central issue or where lack of access to quality commodities is a central issue, and where governments have policies and procedures in place that would allow them to take advantage of such a facility. Applicability would certainly vary by country. For example, in the few African countries where MNCH procurement is largely decentralized, a revolving fund would operate differently than in countries where procurement is centralized at the national level.

In addition, responses to the questionnaire appear to indicate that respondents agree that a working capital facility could be an appropriate mechanism to overcome the issues of inefficient timing in the release of funds for the 10 MNCH commodities in their respective countries. When directly asked this question, 22 respondents<sup>7</sup> said “Yes,” while one respondent answered “No,” and the balance did not answer the question.

The potential viability for a temporary financing mechanism such as a working capital facility to support MNCH procurement appears to be quite strong in most countries across all regions examined. Differences do exist in terms of how the revolving fund would operate most effectively in all of the countries.

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<sup>7</sup> Of the subset of 33 respondents that had *fully completed* the questionnaire.

**Key**

Was there a challenge with access to capital at the right time	No issues	Moderate issues	Frequent issues	Critical issue	Unknown
Was there appetite for a Revolving Fund solution	None	Weak	Moderate	Strong	Unknown

**Table 4: Country Mapping<sup>8</sup>**

Country	Challenges					Appetite for revolving fund	Additional comments
	Quality	Supply	Price	Timing of fund release	Lack of overall funding		
<b>Afghanistan</b>							In principle, the procurement cycle matches the government funding cycle. However, sometimes funding is delayed, causing the cycles to be mismatched.
<b>Bangladesh</b>							The procurement cycle matches the government funding cycle. Local health managers are capable of meeting emergency situations. High out-of-pocket expenditures by consumers for RMNCH.
<b>Colombia</b>							Cash flow is a key concern for the IPSEs (health care providers) who conduct their own decentralized procurement (within the national health insurance scheme). Low quantity of EmONC kits purchased centrally.
<b>Dominican Republic</b>							Relatively strong essential medicines management organization (PROMESE/CAL). FP products are procured by the ministry (not by PROMESE/CAL) and may be an opportunity for revolving fund support.
<b>DRC</b>							Limited government involvement with procurement of commodities. Primarily done via FEDECAME, a parastatal organization with financial problems. There are supply chain issues at all levels of the supply chain. Procurement of many of the products by donors (and donations), but the vision of the international community is to get the government more involved by increasing capacity for domestic funding/procurement.

<sup>8</sup> While a questionnaire response was received from Mali, there was not enough information included in the response to be included in this table.

Key

Was there a challenge with access to capital at the right time	No issues	Moderate issues	Frequent issues	Critical issue	Unknown
Was there appetite for a Revolving Fund solution	None	Weak	Moderate	Strong	Unknown

Country	Challenges					Appetite for revolving fund	Additional comments
	Quality	Supply	Price	Timing of fund release	Lack of overall funding		
<b>Ethiopia</b>							Delayed release of funds from the MDG Pooled Fund results in inefficient procurement of RMNCH commodities.
<b>Guatemala</b>							Limited overall funding for health and health products. Insufficient funding for the execution units (which conduct their own decentralized procurement). Misalignment of funding and procurement cycles for central-level and lower-level procurements.
<b>Haiti</b>							Public sector procurement and supply chain management is primarily conducted by donors and implementing partners. The national essential medicines management unit is managed by PAHO/WHO.
<b>Honduras</b>							Limited overall funding for health and health products. Misalignment of funding and procurement cycles.
<b>India</b>							Links with budget planning are weak, and plans are not required to match the budgetary allocation available before expenses are committed.
<b>Kenya</b>							The issues do not appear to be applicable in Kenya.
<b>Liberia</b>							The government is not actively involved in the procurement of RMNCH commodities.
<b>Madagascar</b>							Links with budget planning are weak, and plans are not required to match the budgetary allocation available before expenses are committed.
<b>Mexico</b>							State-level procurement and supply chain challenges in the state of Chiapas are serious, but access to capital is not their primary driver. FP products are procured centrally in Mexico DF and shipped to states; there is

Key

Was there a challenge with access to capital at the right time	No issues	Moderate issues	Frequent issues	Critical issue	Unknown
Was there appetite for a Revolving Fund solution	None	Weak	Moderate	Strong	Unknown

Country	Challenges					Appetite for revolving fund	Additional comments
	Quality	Supply	Price	Timing of fund release	Lack of overall funding		
							potential for state-level procurement of these FP products, which could be supported by a revolving fund.
<b>Mozambique</b>							Procurement cycle is long, making it difficult to match with budgeting process.
<b>Nigeria</b>							Late release of funds and non-roll-over of budget to following year is a problem.
<b>Paraguay</b>							There is limited funding available for RMNCH products overall. Frequent delays in receiving funds leads to delays in placing orders and product shortages.
<b>Senegal</b>							The Pharmacie Nationale d'Appro (PNA) pre-funds procurements, with cost recovery after products are distributed to health centers.
<b>South Sudan</b>							There are no links between procurement plans and the budget formulation process. There is some evidence of corruption in the system.
<b>Tanzania</b>							Most funding for MNCH commodities is dependent on development partners basket funding. Political issues have often delayed the disbursement of funds, causing repetitive emergency procurement.
<b>Uganda</b>							There is limited budget support to the health sector (including RMNCH). The timing of funds release is not the primary issue.
<b>Zambia</b>							There is a general lack of central government funds for MNCH. The release of funds for MNCH commodity procurement is often late, leading to stockouts.

## IV. ADDITIONAL FINDINGS FROM ASIA AND AFRICA

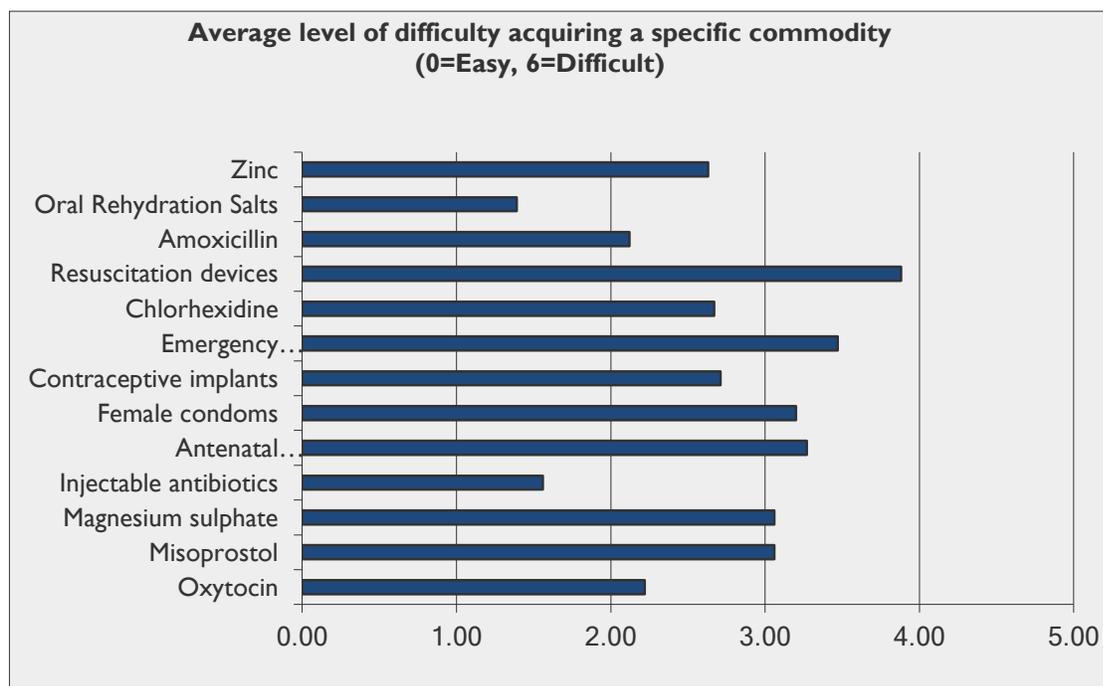
This section presents additional data gathered from the questionnaire responses received from countries in Africa and Asia, analyzing both the general trends shown across all countries, as well as specific comments and issues raised in individual country circumstances. The tables, figures and analysis included here reflect the responses from 16 of the 24 African and Asian countries<sup>9</sup> included in the larger country set, and include all 13 UNCoLSC commodities. All 16 countries discussed in this section are a part of USAID’s 24 EPCMD priority countries.

### QUESTION 1: IS THERE A PROBLEM?

#### Difficulty in Acquiring RMNCH Commodities

Respondents were asked to rate how easy it is for them to procure the 13 priority RMNCH commodities. The results, presented below in Figure 7, indicated that the following commodities were perceived as the most difficult to acquire across all of the countries covered: neonatal resuscitation devices, antenatal corticosteroids, female condoms and emergency contraceptives. The commodities that are easiest to acquire, based on the aggregated responses, are oral rehydration salts and injectable antibiotics, neither of which were given the lowest ranking of “very difficult to acquire” by any of the respondents.

**Figure 7: Level of difficulty acquiring commodities according to survey respondents**

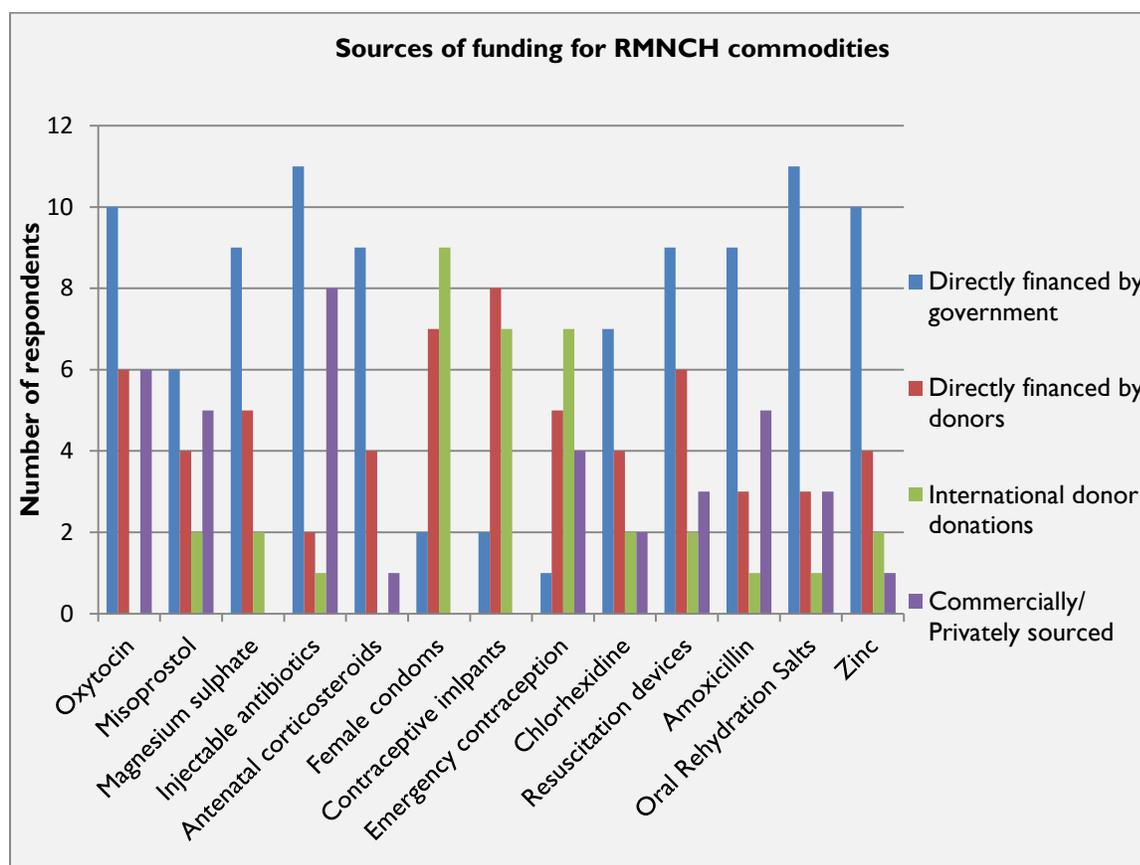


<sup>9</sup> Afghanistan, Bangladesh, Democratic Republic of the Congo, Ethiopia, India, Kenya, Liberia, Madagascar, Mali, Mozambique, Nigeria, Senegal, South Sudan, Tanzania, Uganda, Zambia

## Dependence on Government Financing for RMNCH Procurement

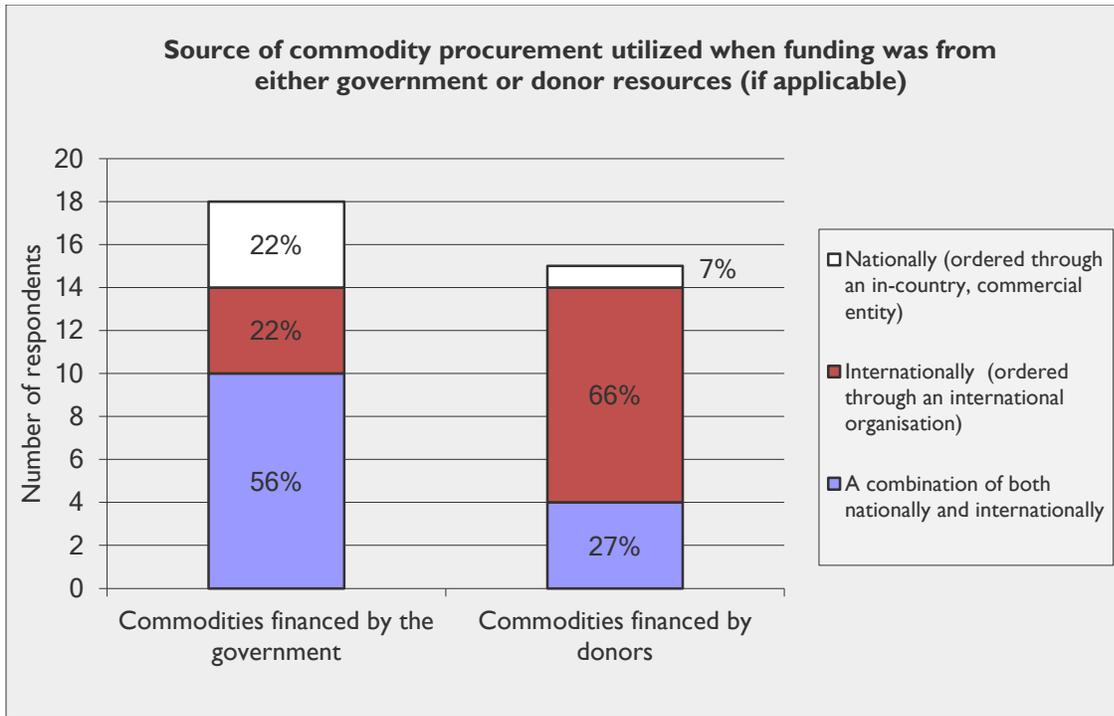
There is generally more reliance on international aid and donor funding for procurement of health commodities in Africa compared to Latin America; however, evidence presented in Figure 8 below suggests that the majority of the funding for 10 of the 13 RMNCH commodities comes directly from governments and not donors. The procurement of female condoms, contraceptive implants and emergency contraception appears to be heavily reliant on donor funding, with very few governments directly financing those procurements themselves.

**Figure 8: RMNCH commodity funding sources according to survey respondents**



For commodities financed primarily by donors, 66 percent of respondents said they were principally procured internationally, and just 7 percent said through a local commercial organization. See Figure 9 below.

**Figure 9: Source of RMNCH commodities according to survey respondents**

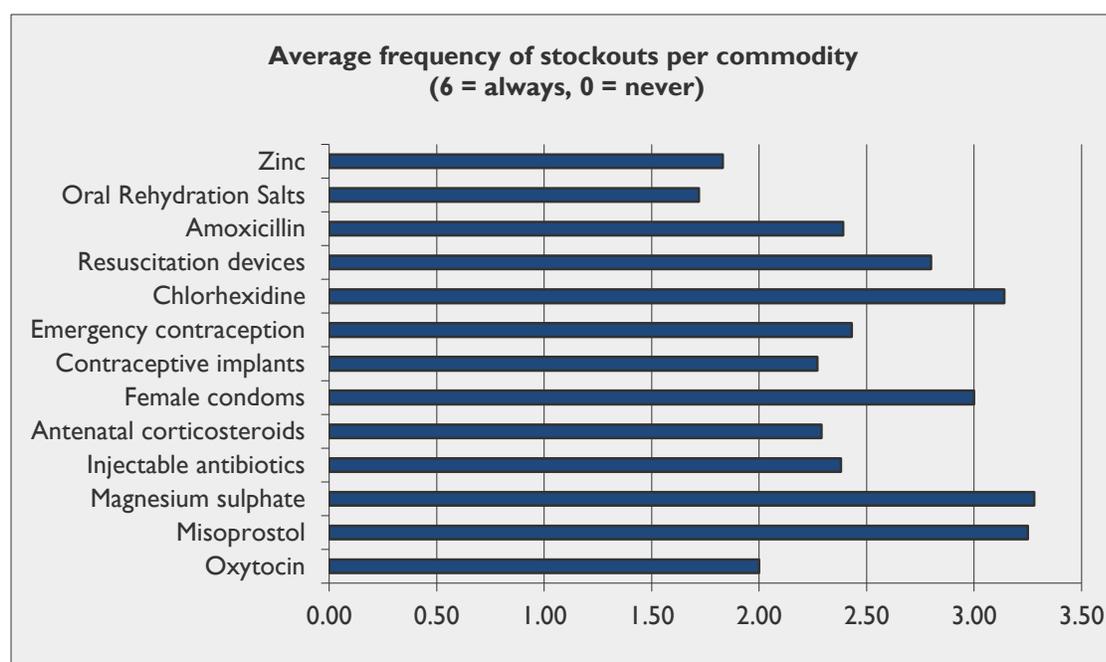


It is evident from the responses to the questionnaire that national governments tend to use national/local commercial enterprises more for the procurement of RMNCH commodities, while donors rely more on international organizations. Such support for local, domestic organizations may help to reduce reliance on international suppliers, can improve efficiency in terms of time and cost, and can accelerate access to commodities. This in turn can reduce the number of issues, such as stockouts, that are faced in these countries. However, 39 percent of respondents stated that they do not use procurement agents who have third-party verification, for example by the WHO Prequalification of Medicines Programme. As a result, local procurement options may help accelerate access to commodities but, importantly, quality may still be an issue.

### **National, Regional/District Stockouts of RMNCH Commodities**

Respondents were asked to rank how often they encountered national, regional or district stockouts of the 13 RMNCH commodities. The results were aggregated and weighted (0 = never, 6 = always) to indicate which of the commodities respondents believed were frequently out of stock. The results are presented in Figure 10 below.

**Figure 10: Frequency commodity stockouts according to survey respondents**



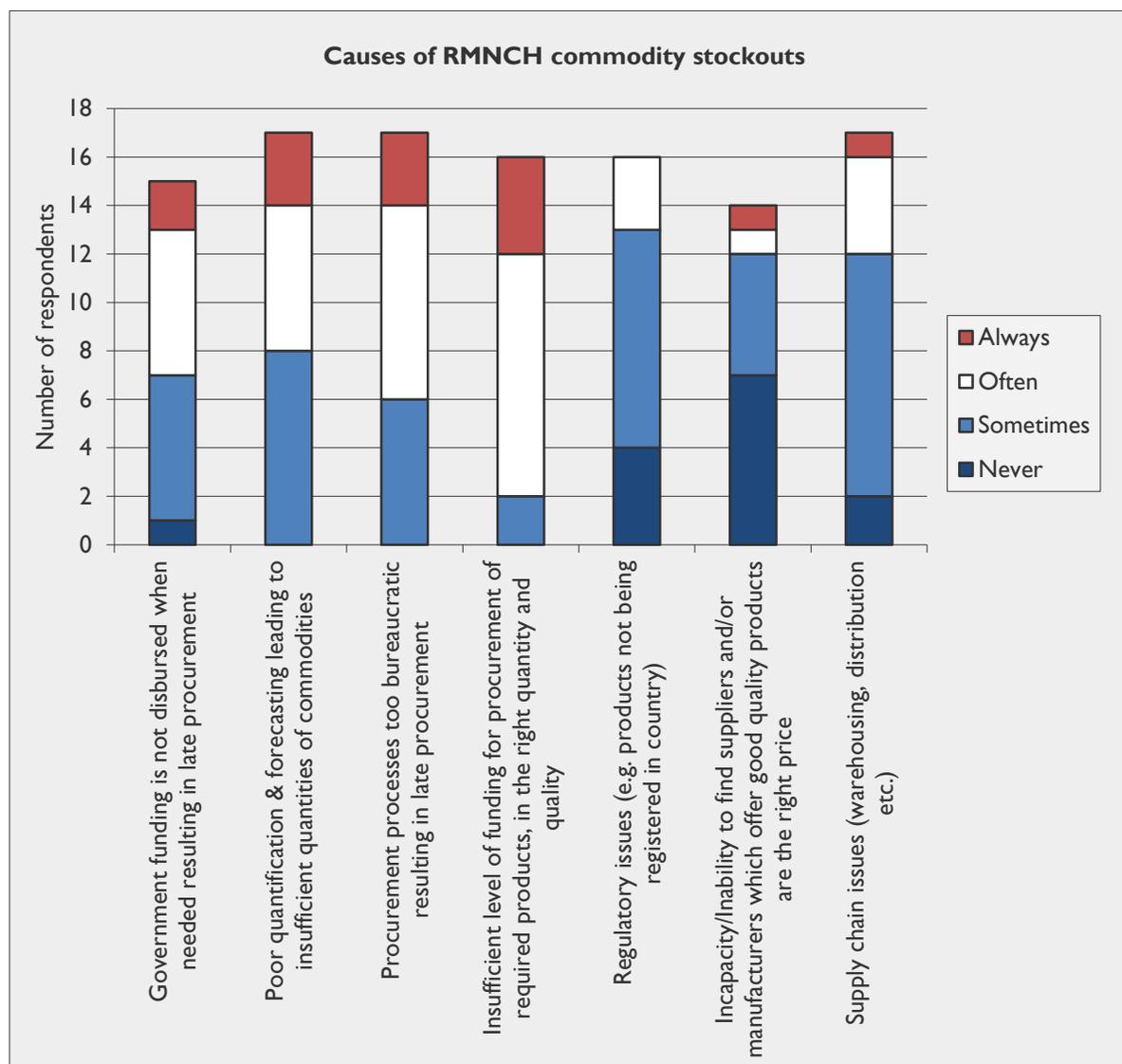
Based on the data above, four commodities stand out as those that respondents believe are most likely to experience stockouts, with an average rating of 3 or above: chlorhexidine, neonatal resuscitation devices, magnesium sulfate and misoprostol. The results are further broken down in the table below, showing the percentage of respondents that ranked the commodities between 4 and 6 (frequent), 3 (moderate), and 0–2 (infrequent) in terms of stockout frequency. This gives a clearer indication of the commodities for which the issue of stockouts and inconsistent supply are most common.

**Table 5: Frequency of stockouts per commodity**

Commodity	Frequency of stockouts according to survey respondents		
	Frequent	Moderate	Infrequent
Oxytocin	18%	12%	71%
Misoprostol	44%	19%	38%
Magnesium sulfate	44%	6%	50%
Injectable antibiotics	25%	19%	56%
Antenatal corticosteroids	21%	21%	57%
Female condoms	40%	13%	47%
Contraceptive implants	27%	13%	60%
Emergency contraception	36%	7%	57%
Chlorhexidine	43%	7%	50%
Resuscitation devices	33%	7%	60%
Amoxicillin	28%	11%	61%
Oral rehydration salts	22%	0%	78%
Zinc	22%	6%	72%

Respondents were asked to provide the most common causes of the stockouts and the frequency with which they applied to RMNCH commodities in their country. The breakdown of the responses can be seen below in Figure 11.

**Figure 11: Causes of stockouts according to survey respondents**



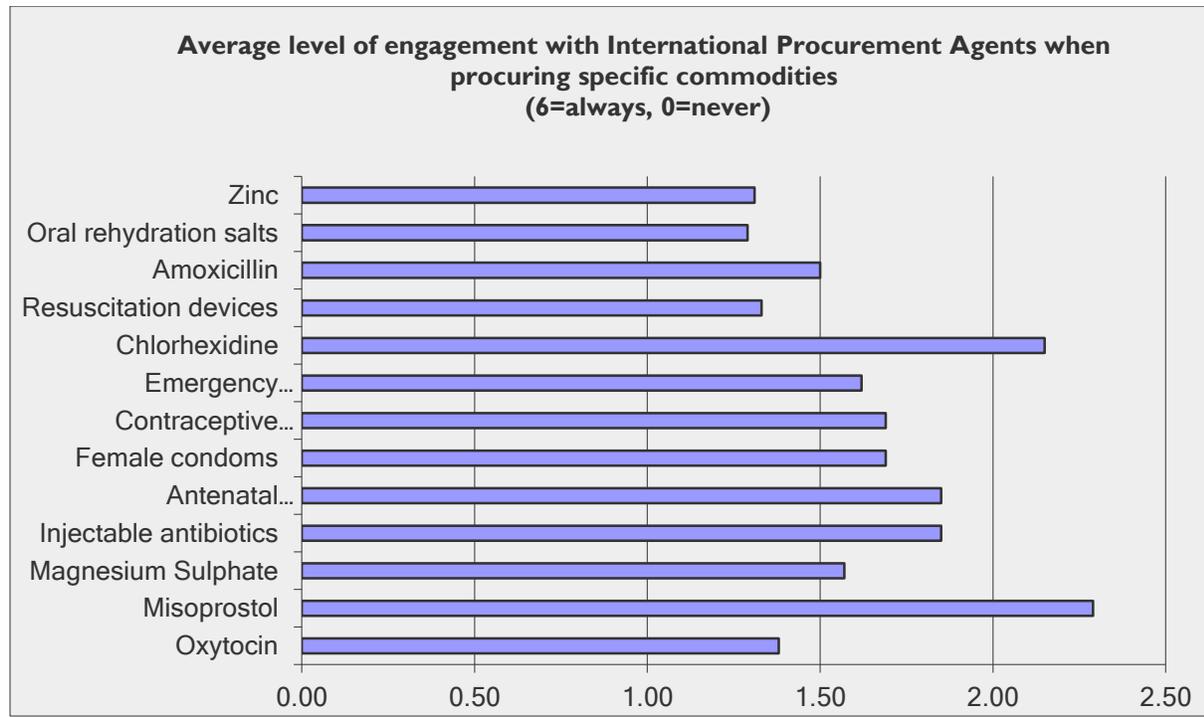
The overwhelming reason given for stockouts in each country was an “insufficient level of funding for procurement of required products, in the right quantity and quality,” with 88 percent of respondents claiming that this was either “always” or “often” the reason, and the remaining 12 percent stating this was “sometimes” the reason. The two other major reasons provided by many respondents were overly bureaucratic procurement processes resulting in late procurement, and poor quantification and forecasting of RMNCH commodities.

### **Government ability to engage with International Procurement Agencies**

Respondents were asked to rank the frequency with which the government is unable to engage with International Procurement Agencies (IPAs), from which they could potentially gain access to more competitive prices and quality-assured RMNCH commodities. The results were aggregated and

weighted (0=never, 6=always) to indicate for which of the commodities respondents typically faced this issue.

**Figure 12: Frequency of engagement with IPAs according to survey respondents**



The data presented in Figure 12 show that respondents did not see a lack of access to IPAs as a major issue, since every commodity averaged a low score, and 11 of the 13 commodities scored below 2 (where 6=always an issue, and 0=never an issue). There are some notable exceptions. For example, the Ministry of Health in South Sudan claimed that lack of access to IPAs was always an issue, with 9 of the 13 commodities given the highest possible ranking, for the following reasons: “insufficient funding to pay procurement agent fees,” “procurement agents unwilling to work with us due to frequent payment delays,” and “delayed funding to engage/pay IPAs in advance.”

Individual responses suggest that misoprostol is often difficult to access through IPAs, with a respondent from the Ethiopian Pharmaceuticals Logistics Management Unit saying that this is “always” the case, while a Ugandan respondent indicated that for resuscitation devices there is “always” an issue gaining access to IPAs. Government access to IPAs does not appear to be a major issue in Nigeria, with both respondents suggesting that this is “rarely” an issue.

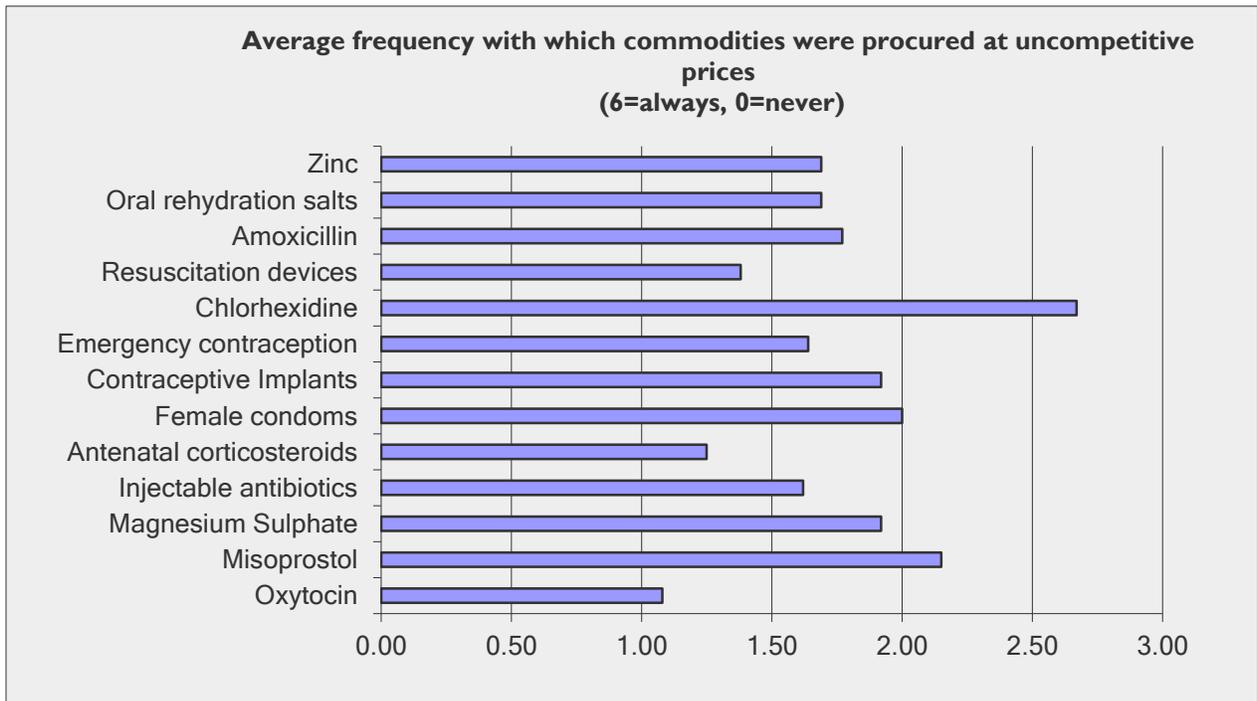
Respondents from South Sudan, Mozambique, Nigeria and Uganda claimed that delayed funding to engage/pay IPAs in advance was either “always” or “often” the reason why they had difficulty accessing IPAs.

### **Government does not procure at competitive prices**

Respondents were asked to rank how often the national government is unable to procure the 13 RMNCH commodities at competitive prices. The results were aggregated and weighted (0=never, 6=always) to indicate the commodities for which respondents typically faced this issue.

Overall, aggregated responses suggest that the inability to procure at competitive prices is not a major issue, with many respondents suggesting that this is rarely an issue for the 13 RMNCH commodities.

**Figure 13: Frequency of commodity procurement at uncompetitive prices according to survey respondents**



Most commodities scored an average of below 2 (where 6=always an issue, and 0=never an issue), suggesting that competitive pricing is not a major concern. However, chlorhexidine stands out as the commodity for which pricing might be an issue, with an average rating that exceeds the 12 other commodities.

Results are broken down further in the table below, showing the percentage of respondents that ranked how often they must procure commodities at uncompetitive prices—between 4 and 6 (frequent), 3 (moderate), and 0 to 2 (infrequent)—giving a clearer indication for which commodities they believe this is an issue. As with Figure 13, the results in Table 6 show that 42 percent of respondents ranked chlorhexidine between 4 and 6, making it the commodity for which uncompetitive pricing is the largest issue.

**Table 6: Respondents' perception of uncompetitive prices**

Commodity	Percent of survey respondents that believed they frequently received uncompetitive pricing for a particular commodity		
	Frequent (4-6)	Moderate (3)	Infrequent (0-2)
Oxytocin	8%	15%	77%
Misoprostol	23%	15%	62%
Magnesium Sulfate	23%	15%	62%
Injectable antibiotics	23%	8%	69%
Antenatal corticosteroids	17%	8%	75%
Female condoms	27%	9%	64%
Contraceptive implants	33%	0%	67%
Emergency contraception	27%	0%	73%
Chlorhexidine	42%	8%	50%
Resuscitation devices	23%	0%	77%
Amoxicillin	23%	8%	69%
Oral rehydration salts	23%	8%	69%
Zinc	15%	15%	69%

A respondent from the Zambian Ministry of Health highlighted that the inability to procure at competitive prices was particularly an issue for the procurement of misoprostol, since Zambia has very few registered suppliers for this commodity, limiting access to competitive prices.

Similarly, 83 percent of all respondents claimed that when pricing is an issue, it is due to an under-developed local market for that particular commodity.

It is worth noting that it is unclear whether or not respondents had enough information to determine whether the prices that they were being charged were actually competitive, and whether any benchmarks that they might have used to make this assessment are accurate.

Therefore, additional conversations regarding this issue were carried out during phone interviews and in-country meetings in several of the priority countries in order to gain better insight into the price issue. Despite the responses to the questionnaire, during the follow-up interviews and meetings many respondents indicated that improvements could be made in this area through the use of a mechanism that would allow for greater access to IPAs and more reliable and consistent forecasting for RMNCH commodities. For example, a respondent from the Ethiopian Pharmaceuticals Logistics Management Unit was very enthusiastic that a working capital facility would be beneficial in Ethiopia, citing previous experience with Pledge Guarantee for Health as quite positive, and which led the improvement in price for the contraceptive implant, IMPLANON, from approximately \$18 per unit to \$8.50 per unit.

Similarly, in Uganda a representative from the Ministry of Health stated that a working capital facility would be a suitable mechanism on which to build a sustainable supply of contraceptives by establishing and maintaining long-term relationships with international procurement agencies, with which the government could place large orders and gain access to more competitive prices.

### **Government does not procure quality assured commodities**

Respondents were asked to rank how often the government was not able to procure quality-assured RMNCH commodities. The results were aggregated and weighted (0=never, 6=always) to indicate for

which of the commodities respondents typically faced this issue. The percentage of the responses given in the 4–6 bracket (frequent), 3 (moderate) and 0–2 (infrequent) are presented below.

**Table 7: Frequency of procurement of poor-quality commodities according to survey respondents**

Commodity	Percent of survey respondents that believed their government procured poor-quality commodities		
	Frequent (4-6)	Moderate (3)	Infrequent (0-2)
Oxytocin	14%	0%	86%
Misoprostol	8%	0%	92%
Magnesium Sulfate	15%	0%	85%
Injectable antibiotics	14%	0%	86%
Antenatal corticosteroids	7%	0%	93%
Female condoms	10%	0%	90%
Contraceptive implants	0%	0%	100%
Emergency contraception	0%	0%	100%
Chlorhexidine	15%	8%	77%
Resuscitation devices	8%	0%	92%
Amoxicillin	14%	0%	86%
Oral rehydration salts	14%	0%	86%
Zinc	14%	0%	86%

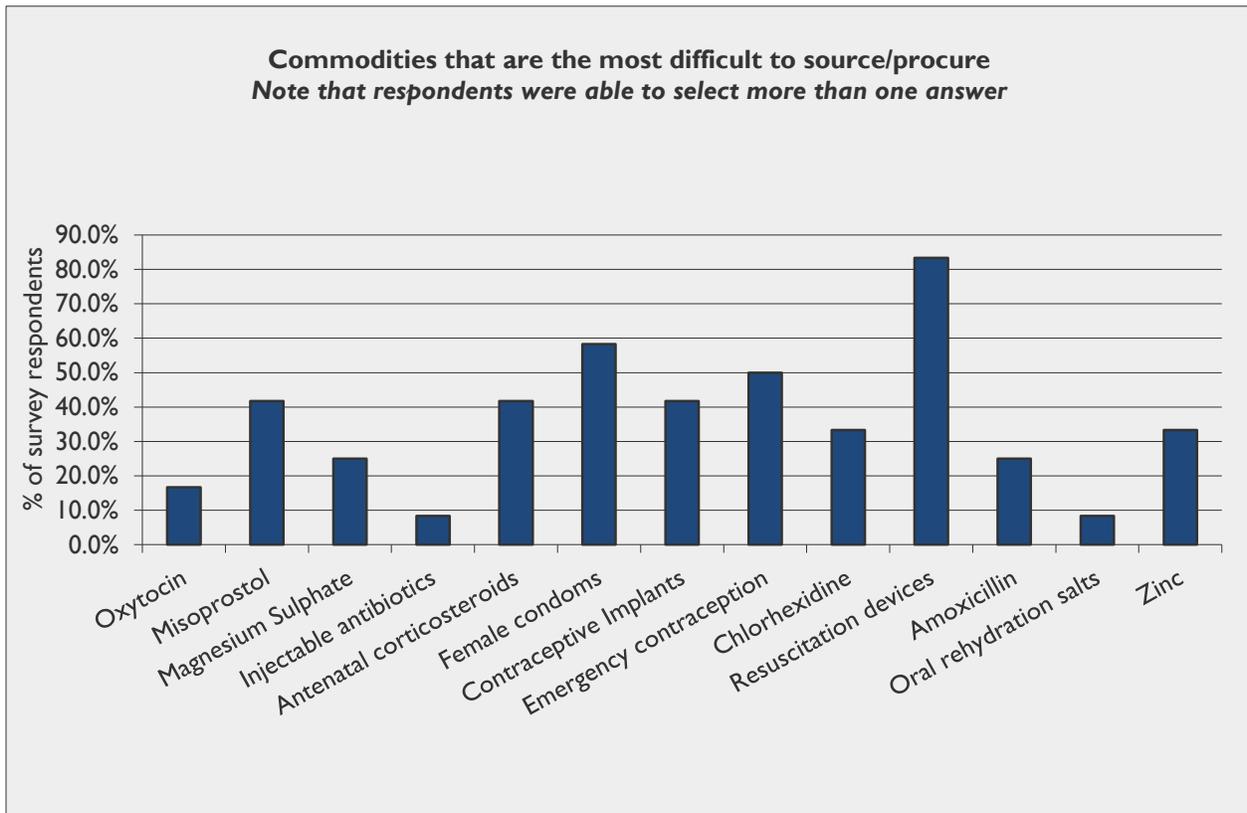
Few respondents claimed that procurement of non-quality-assured RMNCH commodities was an issue in their country. However, South Sudan, Bangladesh and Afghanistan did say there were issues. Overall, 87 percent of respondents stated that they had not filed any quality claims against RMNCH commodity suppliers within the last year. For those countries identifying quality as an issue, the most common reason given was that “regulatory systems in place are weak leading to non-quality assured commodities being procured.”

However, since most respondents are working within or closely with government departments, it is feasible that many did not wish to imply that the RMNCH commodities being procured by government were not quality assured and potentially unsafe. Therefore, attempts were made during interviews to dig deeper into this issue, and that information is covered in the relevant country sections of the report.

### **Commodities most difficult to source/procure**

When questioned about which of the 13 RMNCH commodities directly financed by government or donors were most difficult to procure/source, 83 percent of respondents identified resuscitation devices, and 58 percent identified female condoms.

**Figure 14: Survey respondents' perceptions of which commodities are the most difficult to source/procure**



### Alternative funding mechanisms

Respondents were asked to detail any alternative funding mechanisms that had been/are being employed in their country, particularly any pooled funding mechanisms, for the procurement of RMNCH commodities. Seventy-eight percent responded that there had been a pooled funding mechanism adopted, with 67 percent either agreeing or strongly agreeing that those mechanisms had been successful for their country.

However, it appears that previous donor attempts to provide pooled funding for RMNCH commodities have not been comprehensive, with many of the 13 priority commodities excluded from those mechanisms. For example, both respondents from Nigeria confirmed that only reproductive health commodities such as condoms and emergency contraceptives are procured through pooled funds.

In addition, a respondent from Zambia's MCDMCH stated that "basket funding/pool funding ended in 2006 and currently the RMNCH commodity budget is supported directly with donor funds as a specific component to budget support." This refers to the Sector Wide Approach (SWAp) that is being employed in Zambia, among other countries, to create working partnerships between governments and development agencies to improve health systems. There is little evidence available to detail the success of this approach for the funding of RMNCH commodity procurement. However, results for a SWAp underway in Jigawa, Nigeria, show that despite an increase in donor support in the health sector, the funding remains fragmented and is not properly integrated into the state budgeting process.

Despite the overall indication that pooled funding has contributed to ensure timely and competitive procurement of high-quality RMNCH commodities, lack of clarity and fragmentation of implementation appear to be a problem faced by many countries in the study.

Results from the surveys also found that a lack of access/availability of funding when needed is not only an issue in the procurement of RMNCH commodities, but also extends to the procurement of other health commodities in general, with 94 percent of respondents claiming that non-RMNCH commodities also suffer from a lack of access to funds.

In short, the questionnaire responses received suggest that there is a problem accessing the required funds for the procurement of the 13 RMNCH commodities, and that the two main issues identified are stockouts and an inability to engage with international procurement agencies to ensure quality. The primary causes of these two issues are insufficient funding for RMNCH commodities and delayed funding to engage/pay IPAs in advance. This is also likely to lead to additional costs, and the possibility that many of the countries studied are missing out on opportunities to reduce costs through improved funding cycles and engagement with IPAs. Similarly, despite most respondents claiming that there is no problem with the quality of RMNCH commodities, independent studies by NBER and others suggests that quality is an issue. The ability to engage IPAs could potentially lead to better pricing by pooling procurement, and would ensure quality in the short term.

## **QUESTION 2: WHAT CAUSES THE PROBLEM?**

In addition to identifying the problems faced by the study's focus countries in procuring quality commodities, the questionnaire also attempts to identify the types of financial barriers that cause countries to have limited availability/access to capital when needed to ensure efficient and timely procurement of RMNCH commodities.

One of the major challenges/barriers identified by respondents is that of incompatible funding and procurement cycles. If the disbursement of funds from the Ministry of Health to the procurement body does not coincide with procurement, funding gaps emerge resulting in more costly last-minute, emergency procurements. Indeed, 43 percent of respondents from Africa and Asia indicated that RMNCH commodity procurement cycles do not match government funding cycles, and the same percentage claimed that this often leads to last-minute/emergency procurement and extra costs.

A respondent from Nigeria's National Primary Health Care Development Agency wrote that the major issue faced within Nigeria is "late funds release" and the fact that budget does not "roll-over to the following year." This situation could cause gaps in funding and uncertainty for procurement of essential medicines.

A respondent from within Zambia's MCDMCH stated, "Procurement for essential medicines, which includes RMNCH drugs, is initiated when funds are made available by the Ministry of Finance." This indicates that procurement is not necessarily initiated according to current need, which could cause inefficiency in stock levels and unmet need in the procurement of RMNCH commodities.

A respondent from the Ethiopian Pharmaceutical Logistics Management Unit suggested that funds were disbursed from the Ministry of Finance to the Ministry of Health annually (at the beginning of the fiscal year) and that procurement planning coincides with this "based on budget allocation for the year procurement process will be started."

A Senegalese respondent, however, suggested that this was not an issue in Senegal and gave the following reason: "Contrary to other countries, Pharmacie Nationale d'Appro (PNA) pre-funds, and cost recovery happens after products being made available to health centers in parallel to the budget government transfer to PNA account."

Additionally, 67 percent of all respondents said that late release of funds is an issue. A respondent from the Mozambique National Medical Stores claimed that procurement for government-financed RMNCH commodities takes place annually, and with “the procurement cycle so long, it is almost impossible to match with the annual budgeting process.”

The respondent from within Zambia’s MCDMCH added that “inadequate central government funds and lack of priority for certain components of drugs like RMNCH commodities” were key factors that cause delayed availability/access to funds for the efficient procurement of RMNCH commodities in the Zambian context.

The questionnaire also asked whether or not there were any national government policies in place that prevent funding from being available to procure RMNCH commodities. Eighty-four percent of respondents “strongly disagreed” or “disagreed” that this was the case.

The questionnaire responses received suggest that the major reasons for the problems associated with the procurement RMNCH commodities include: incompatible funding and RMNCH procurement cycles, delayed funding leading to an inability to access international procurement agencies, and insufficient levels of funding required to procure the right quantity and quality of commodities.

### **QUESTION 3: HOW BIG A PROBLEM IS IT?**

The limited sample size of the study makes it difficult to gain a completely clear picture of the scale of the cross-cutting issues, however, there are some inferences that can be made. For example, issues with supply and stockouts were attributed by a majority of respondents to an “insufficient level of funding for procurement of required products, in the right quantity and quality.” Meanwhile lack of access to IPAs, and the potential price and quality benefits that they bring, are largely attributed by respondents to “insufficient funding to pay procurement agent fees,” “procurement agents unwilling to work with us due to frequent payment delays,” and “delayed funding to engage/pay IPAs in advance.”

It is evident that the issues of an overall lack of funding due to constraints in government budget and conflicting priorities in terms of public spending, along with delayed payments/release of funds, are cross-cutting issues in a large number of the countries studied.

While the data collected in the study point to the fact that many countries simply *do not have enough funding overall* to procure the commodities that they need, countries have expressed the view that even when they have funding, the timing of the availability of that funding has an impact on their ability to procure what they need. See Section Three for additional information on measuring the size of the problem.

### **QUESTION 4: WOULD A WORKING CAPITAL FACILITY BE AN APPROPRIATE SOLUTION?**

Based on the questionnaire responses and follow-on discussions, it appears that a working capital facility could be a feasible way to address some of the challenges outlined above.

A working capital facility could be used to close funding gaps that occur, particularly when a country’s procurement cycle does not coincide with its funding cycle. Forty-three percent of respondents indicated that procurement cycles do not match government funding cycles, and that the mismatch often leads to last minute/emergency procurement and extra costs.

However, a working capital facility is not the only solution needed. It is important to note that a lack of funding budgeted for procurement is still the main challenge that countries face, and a working capital facility will not address that issue. Sixty-seven percent of respondents noted that there is currently unmet need for MNCH commodity procurement, indicating a lack of overall funding levels (i.e., a lack of

available funding leads to the inability to procure the right amount of commodities at the right time). Specific examples of feedback included the following:

- A response from the Ethiopian Ministry of Health's Pharmaceuticals Logistics Management Unit (PLMU) claimed, "Unmet need for family planning is from 20-25 percent and for other MNCH commodities too, there are gaps at health facilities. Although the country's law dictates that most of the MNCH services to be rendered free of charge, the application is not uniform."
- A representative of Nigeria's National Primary Health Care Development Agency (NPHCDA) stated that "inadequate funding" was the reason for unmet need in Nigeria.
- A representative of the National Medical Stores of Uganda claimed that there is "a general deficiency of budget support to the health sector that includes the budget support to MNCH commodities."
- A representative of Zambia's MCDMCH stated that insufficient funding leads to "frequent stockouts in life saving maternal health medicines and inadequate trained health providers." (Although, in a follow-up interview with the same respondent from Zambia, he was very explicit that frequent stockouts were the result of issues in the timing of the release of funds for the procurement of these commodities, confirming that a working capital facility would be very beneficial in addressing this and would thus reduce the frequency with which stockouts occur.)

In conclusion, the results of the study point to unmet RMNCH commodity needs in the countries surveyed. Some of this unmet need occurs as a result of funding for the procurement of the commodities not being available in the right amount and at the right time to meet procurement needs. A working capital facility, which would allow governments to bridge funding gaps that occur when procurement and budget cycles do not align, could be a useful tool in facilitating those procurements and could help governments to avoid stockouts of critical RMNCH commodities.



# ANNEX I: COUNTRY PROFILES AND KEY FINDINGS

## LITERATURE REVIEW AND FINDINGS FROM IN-COUNTRY VISITS

This section explores the background and context of each country, focusing on the challenges faced in health systems, national health policies on poverty reduction, and available government funding for the health sector, with particular focus on mother and child health. Additionally, details of existing literature findings are provided, focusing on challenges with lack of availability of commodities, lack of access to capital when needed, and the potential for inefficiencies in nationally funded procurement of RMNCH commodities. It also presents the findings from the in-country visits to Uganda, Ethiopia, Kenya, Tanzania and the DRC.

## EAST AFRICA REGION

### Ethiopia

#### *Background*

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

Ethiopia is the tenth largest country in Africa and has a total surface area of 1.1 million square kilometers. Administratively, the country is composed of nine Regional States and two City Administrations. These are subdivided into 817 administrative woredas (districts), which are further divided into around 16,253 kebeles, the smallest administrative units in the governance structure. The size of the country and its location has accorded it with diverse topography, geography, climatic zones and resources.

According to the projections of the 2007 population and housing census, the total population of the country for the year 2013 is estimated to be 85.9 million. It is one of the least urbanized countries in the world with 83.6 percent of the population living in the rural areas and only 16.4 percent residing in urban areas. Females comprise 49.5 percent of the total population, of whom 24 percent are in the reproductive age bracket (15-49 years). The population is predominantly young, with 44.9 percent under the age of 15 years and 14.6 percent under 5 years, and it is reported to grow by 2.6 percent every year. The average size of a household is 4.7. The fertility trend in recent years shows that there has been a marked decline in the total fertility rate from the 1990 level of 6.4 births to 4.8 births per woman.

#### *Health System*

The country has a three-tier health care delivery system. The first tier woreda (district) health system consists of a primary hospital (with population coverage 1 per 100,000 people), health centers (25,000 population), and their satellite health posts (5,000 population). The second tier is made up of a general hospital with population coverage of 1-1.5 million people. The third tier is a specialized hospital that covers a population of 3.5-5 million. A primary hospital and each health center with five satellite health posts form a Primary Health Care Unit (PHCU). The Ethiopian health care system is augmented by the rapid growth of the private-for-profit and NGO sectors playing significant roles in expanding health service coverage and utilization.

The devolution of power to regional governments has resulted in the shifting of decision making for public service deliveries from the center to the regions and down to the district level.

Regions and districts have regional health bureaus (RHBs) and district health offices, respectively, for the management of public health services at each level. The FMOH and the RHBs focus more on policy matters and technical support, while woreda health offices have basic roles of managing and coordinating the operation of the district health system under their jurisdiction.

Medical supplies and logistics are managed by the Pharmaceutical Fund and Supply Agency (PFSA) in Ethiopia. PFSA was founded in 2007 to handle forecasting, procurement, storage, distribution and rational use of drugs in all public health facilities. It has about 17 branch warehouses, which are distributed throughout the country in such a manner that they can distribute all health commodities directly to health facilities. The agency is responsible to build the capacity of health facilities in all aspects of supply chain management.

In 2007, a new LMIS was designed, and according to this system, the PFSA is expected to deliver health commodities directly to health facilities and collect LMIS reports from the health facilities.

### ***Maternal, Newborn and Child Health***

Although considerable progress has been made to improve the health status of the population in the last few years, Ethiopia's population still faces high morbidity and mortality. The major health problems of the country remain largely preventable communicable diseases and nutritional disorders, although the country is increasingly facing the double burden of diseases due to chronic health problems such as cardiovascular diseases, diabetic mellitus and cancers. Vital health status indicators show a life expectancy of 54 years (53.4 years for males and 55.4 for females), an infant mortality rate (IMR) of 59/1,000 and under-5 mortality rate of 88/1,000. The neonatal mortality rate is estimated to be 37 per 1,000 live births, while the maternal mortality ratio (MMR) stands at 676 per 100,000 live births. According to the global estimates for "trends in Maternal Mortality", the MMR for Ethiopia has come down from 950/100,000 live births in 1990 to 350/100,000 live births in 2010, which shows an average annual decline of 4.9 percent.

The causes and determinants of maternal and newborn mortality are generally interrelated. An estimated 3 million births occur each year in Ethiopia, and about 15 percent of pregnant women in Ethiopia are estimated to develop life-threatening obstetric complications. Direct obstetric complications account for 85 percent of maternal deaths as well as many acute and chronic illnesses. The distribution of maternal deaths due to all causes in health facilities showed that the most important causes of death include: obstructed labor (13 percent), ruptured uterus (12 percent) severe pre-eclampsia/eclampsia (11 percent), severe complications of abortion (6 percent), postpartum hemorrhage/retained placenta (7 percent), postpartum sepsis (5 percent), ante-partum hemorrhage (5 percent) and direct complications from other causes (9 percent). Indirect causes such as HIV/AIDS (4 percent), anemia (4 percent), malaria (9 percent), and complications from other causes (9 percent) contribute to about 21 percent of the maternal deaths.

Similarly, some 120,000 newborns die of preventable causes annually, making Ethiopia one of the 10 countries with the highest number of neonatal deaths per year globally. Currently, newborn deaths contribute to more than half of infant deaths and over 40 percent of the 260,000 under-5 children dying each year.

The unacceptably high neonatal mortality rate in the country is attributable to various factors: low coverage of maternal and child health care services, high levels of unskilled home delivery, little postnatal care follow-up, and lack of recognition of maternal and newborn danger signs. The major direct causes of newborn deaths are infection (36 percent), intrapartum-related complication (birth asphyxia) (25 percent) and prematurity (17 percent). The major contributors of under-5 mortality are pneumonia, diarrhea and malaria, with malnutrition as underlining cause. These are either preventable or treatable.

The Ethiopian Government has prioritized six of the 13 RMNCH commodities which include: female condoms, emergency contraceptives, oral and injectable antibiotics, chlorhexidine and resuscitation equipment. There is a funding gap for emergency contraceptive pills. The Ethiopian Federal Ministry of Health (FMOH) has formulated and implemented a number of policies and strategies that afforded an effective framework for improving health in the country, including MNCH. This includes the establishment of the MDG Pooled Fund and the priority given to RMNCH, therein creating a profound opportunity for mobilizing the much-required financial resources to procure RMNCH commodities and reduce IMR and MMR. The government of Ethiopia has attempted to resolve such issues through the launch of the roadmap for accelerating reduction of maternal and newborn mortality and morbidity in Ethiopia for the years 2012-2015.

As the health system has rapidly expanded and become more decentralized in Ethiopia, it has become a significant challenge to keep health care workers informed with up-to-date information on drug formularies and treatment guidelines. The FMOH has, in cooperation with the World Health Organization, created several authoritative documents to guide commodities procurement, availability and in-country use. In addition, the Ethiopian medicines regulatory agency, FMHACA (previously DACA), has attempted to address the unmet need for information by also developing drug information materials, leaflets and bulletins/brochures.

There are no local manufacturers currently producing magnesium sulfate, misoprostol, or oxytocin in Ethiopia; all three are purchased from different sources overseas though very little information is available on which countries and specific manufacturers Ethiopia sources from. Medical supplies and logistics are managed by the Pharmaceutical Fund and Supply Agency (PFSA) in Ethiopia. PFSA was founded in 2007 to handle forecasting, procurement, storage, distribution and rational use of drugs in all public health facilities. It has about 17 branch warehouses, which are distributed throughout the country in such a manner that they can distribute all health commodities directly to health facilities. The agency is responsible to build the capacity of health facilities in all aspects of supply chain management. In 2007, a new LMIS was designed, and according to this system, the PFSA is expected to deliver health commodities directly to health facilities and collect LMIS reports from the health facilities.

In Ethiopia, challenges faced are demonstrated in the total estimated cost for the provision of RMNCH services in 2013/2014 was \$224,132,614, with a total funding gap of around \$22m. The financial gap for RMNCH services in 2013/14 are illustrated in the table below.

**Table 8: Example of limited access to capital to procure MNCH commodities**

Service area	Financial Need (\$)	Financial Commitment (\$)	Financial Gap (\$)
Reproductive health (FP and CAC)	41,956,289	37,734,508	4,221,781
Maternal health	62,955,481	56,150,000	6,805,481
Newborn health	30,066,979	23,689,246	6,377,733
Child health	101,153,865	96,694,407	4,459,458

Source: Ethiopian Ministry of Health

Note that while funds may have been available in the MDG Pooled Fund to fill the financial gaps outlined above, the MCH Program may not have mandated procurement of these commodities.

Even if the total existing RMNCH funding gap for the year 2013/2014 is about \$21,864,453, the FMOH and the national RMNCH technical working groups had to prioritize. And accordingly, the group proposed to consider the financial support from the UN Commission on Life-Saving Commodities for covering costs of commodity gaps for rolling out CBNC (amoxicillin DT, injectable antibiotics,

chlorhexidine, antenatal corticosteroid and resuscitation equipment), regular routine follow-up and clinical mentoring of health centers and health posts implementing CBNC, in-service training of HEW's on IMPLANON contraceptive insertion, female condoms, emergency contraceptives and demand creation activities for female condom and emergency contraception. This amounts about \$3,560,342.

A large portion of this grant would be used to fill the gap for commodity purchases. The FMOH has planned to list all of these commodities on the list of those essential drugs and items to be procured annually by the government.

### ***Field Visit/In-country Interviews***

Upon receipt of robust feedback from head of the procurement logistics management unit (PLMU) at the Ministry of Health, and with subsequent a subsequent telephone interview, a field visit to Ethiopia was organized to test the premise that lack of availability/access to funding when needed contribute to inefficient procurement of RMNCH commodities.

Ethiopia operates centralized procurement and warehousing of all essential medicines through the PFSA, which is responsible for the procurement and distribution of these commodities. The PLMU, on the other hand, does the quantification and forecasting based on information from health facilities. The main challenges identified are inaccurate information and delay in the release of funds for procurement leading to stockouts of essential medicines.

The RMNCH & Nutrition department is responsible for managing program plans. The department provides guidance for the implementation of the RMNCH program in Ethiopia. This department is responsible for service delivery.

Interviews with the two RMNCH experts at the RMNCH & Nutrition department focused on the challenges experienced in the course of discharging their duties limiting access to RMNCH commodities. From their perspectives, access to RMNCH commodities has improved over the years. The main issue identified was relating to service quality at the health facilities—coverage and equity of delivery.

Delay in the release of funding from donor grants was highlighted as a major issue in the grant application with the RMNCH Trust Fund. A grant was approved for the RMNCH program in 2014, and funds were released in March of 2015. This means that the target will not be met until 2016. There are also challenges with cold chain equipment. To identify the gaps and gain consensus with all stakeholders, one of the senior RMNCH experts interviewed advised that a focused group meeting be organized with RMNCH, PLMU Procurement Logistics Management Unit, PFSA Pharmaceuticals Fund and Supply Agency and FMHACA to brainstorm on solutions to the overall quality issues limiting access to RMNCH commodities.

### ***Impact of Regulatory Process on MNCH Commodities in Ethiopia***

The interview with the head of pharmacy at the Food Medicine Health Administration and Control Authority (FMHACA) focused on how the quality of RMNCH commodities supplied to public facilities is managed to ensure the integrity of commodities at the health facilities. The majority of the commodities supplied through the public health system come from India and China. All commodities supplied to public health facilities are subject to rigorous regulatory checks. The FMHACA conducts a thorough GMP before products are registered. For pharmacovigilance, the FMHACA conducts random sampling at health facilities and the central medical stores, but there are no guarantees that falsified medicines do not filter into the supply chain.

### ***Findings***

With reference to the questions originally posed in the SOW, we can draw the following conclusions for Ethiopia:

### Is there a problem?

The findings from the available literature, telephone interviews, questionnaire feedback and in-country visit indicates that in Ethiopia there is a problem with availability/access to capital when needed, contributing to inefficient nationally funded procurements of RMNCH commodities. Even though Ethiopia has some of the highest availability rates for these commodities, these inefficiencies led the survey respondents to express the overall opinion that RMNCH commodities are often out of stock at PFSA at health facilities.

### What causes the problem?

Study findings point to the timing of the release of funding allocated for the procurement of RMNCH commodities as a cause of the lack of availability of funding overall. The survey respondents said that the unmet needs are due largely to funding gaps, and it was their perception that those gaps have increased in the last several years.

### Would a working capital facility be an appropriate solution?

Based on the questionnaire feedback and in-country consultations, there is appetite for a working capital facility as a solution to bridge the funding gaps.

## **Tanzania**

### **Background**

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

Tanzania has been able to achieve remarkable success in reducing under-5 and infant mortality rates. According to Demographic and Health Surveys (DHS), under-5 mortality has declined from 147 per 1,000 live births in 1999 to 81 per 1,000 live births in 2010. Over the same period, the infant mortality rate declined from 99 per 1,000 live births in 1999 to 51 per 1,000 live births in 2010. Neonatal mortality rates reduced from 40 per 1,000 live births in 1999 to 26 per 1,000 live births in 2010.

Progress in improving maternal health and reducing maternal mortality was slow between 1996 and 2004/5. However, the 2010 DHS does show that the MMR is beginning to decline. The MMR in 2004/5 was estimated to be 578 per 100,000 live births and has declined to 454 per 100,000 live births in 2010.

Most maternal deaths occur during childbirth and in the immediate postpartum period.

### **Current Issues**

In many respects, Tanzania has a model logistics management information system. There is a single integrated system that extends down from the Procurement Agency and National Medical Stores Department through to the district level. Stock reporting and requisition forms are being completed at the facility level to provide real-time information on stock levels. A paper-based system is currently transitioning to an electronic system. The country has managed to avoid parallel/vertical distribution systems that are common elsewhere and that potentially undermine national capacity in the long term.

However, this system is relatively new, and stockouts at the zonal and peripheral levels take place frequently. A recent estimate based on the Integrated Logistics Management System (ILMS) reports (where facilities report on stock levels by rapid SMS) stockout with an LSC are experienced by around 1/3 of facilities each month. Stockout levels at the zonal and regional levels are slightly lower but still of concern.

The MSD faces a number of procurement, storage and distribution challenges that are important to draw attention to:

- **Budget:** Disbursements from the government to purchase medicines generally fall short of forecasted estimates—sometimes by as much as 30-40 percent. In addition, payment is often delayed, leading to inevitable stock shortages. A ‘basket fund’ mechanism for partner resources that was created to support procurement is tightly regulated around priority commodities and cannot be used flexibly to manage shortfalls.
- **Tendering process:** A 6-9 month tender process for medicines is impractical to meet evolving demands from programs that deliver life-saving commodities. An amendment to this process has been submitted by MSD and is currently under review. This should be prioritized.
- **Storage and distribution:** MSD currently does storage and distribution to zonal storage units only. There are clearly some challenges as zonal MSD outlets are clearly experiencing higher levels of stockouts than central levels.

Transport from zones to facilities is generally not overseen by MSD, but rather by the District Medical Officer (DMO). As highlighted above, it is this stock-shortage gap that is the most severe—with 30-40 percent of facilities experiencing a stockout of an essential tracer commodity in the past quarter. The MSD has piloted coordinating distribution on behalf of the DMO in one region (Tanga).

In addition, it is important to note that most zones and facilities are supplied on a quarterly basis—which is relatively infrequent. Some vertical programs such as HIV, TB and Malaria, where distribution takes place monthly, experience less frequent stock shortages. Addressing this issue would require substantial additional investments in transport.

### **Structure of Financing**

The budget of the health sector is directed to the Ministry of Health and Social Welfare (MOHSW) and its directorates. There are three sources of public sector funding for health care in Tanzania:

1. **Government of Tanzania (GOT) health sector annual budget allocation:** In 2010/2011, the government contributed 35 percent of the national health sector allocation. This allocation was approximately 9 percent of GDP but still below the Abuja declaration target of 15 percent.
2. **Health Sector Basket funding:** Development partners contribute funding to the national development budget. In 2010/11, this contributed to 60 percent of the national health sector allocation from the MOF.
3. **Cost-sharing funds contributed by users:** Funds collected from public service users in the form of user fees. In 2010/11, this accounted for less than 5 percent of national public health care expenditures.

There are considerable gaps in funding between estimated requirements and actual funds committed by the GOT and donor partners. Funding is skewed towards AIDS and malaria. In 2012/13 less than 50 percent of the funds required for essential medicines and family planning was released for procurement.

Funds from the government are divided into two: those that go to the MOHSW and those that go to LGAs through the Prime Minister’s Office—Regional Administration and Local Government. Funds that go to the MOHSW are then allocated to all referral and regional hospitals. The funds are also allocated to district hospitals and to all other public health facilities at district level by depositing their money at the MSD. This means each health facility at district level has an account at MSD to facilitate the purchase essential drugs, with each having an estimated fixed amount as follows:

Dispensaries Tshs. 390,000/month

Health Centers Tshs. 810,000/month

Hospitals Tshs. 1,500,000/month

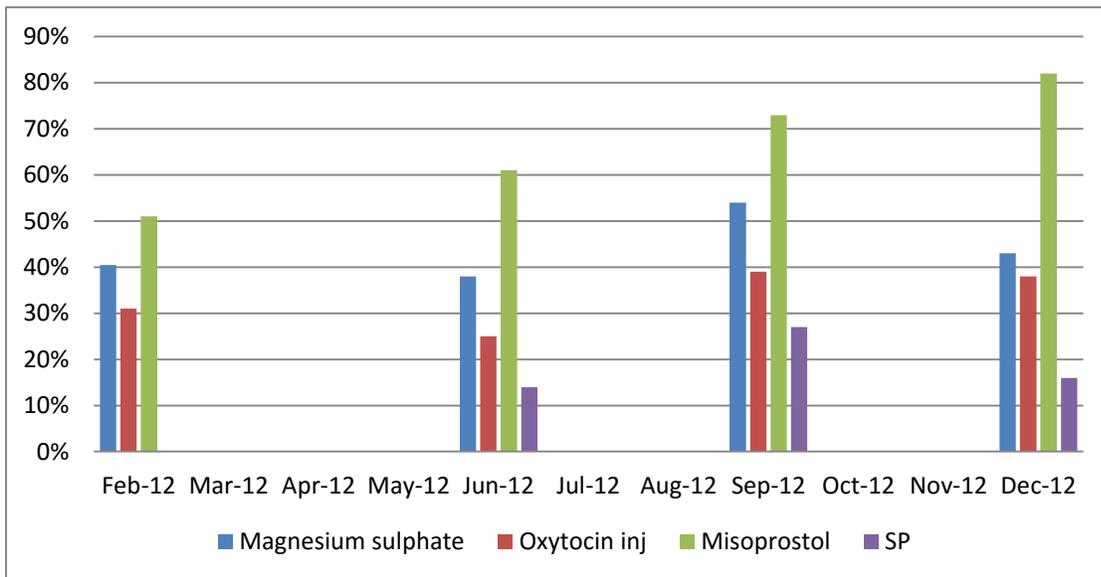
Funds that go through the PMO-RALG are meant for LGAs and are for enabling LGAs supplement their needs for drugs, most likely because the above funds will never be enough. General criteria used in allocating budget to districts include; poverty, distance, IMR and population. For each year, there is a ceiling for each LGA, which is fixed by the Ministry of Finance and Economic Affairs.

**Field Visit/In-country Interviews**

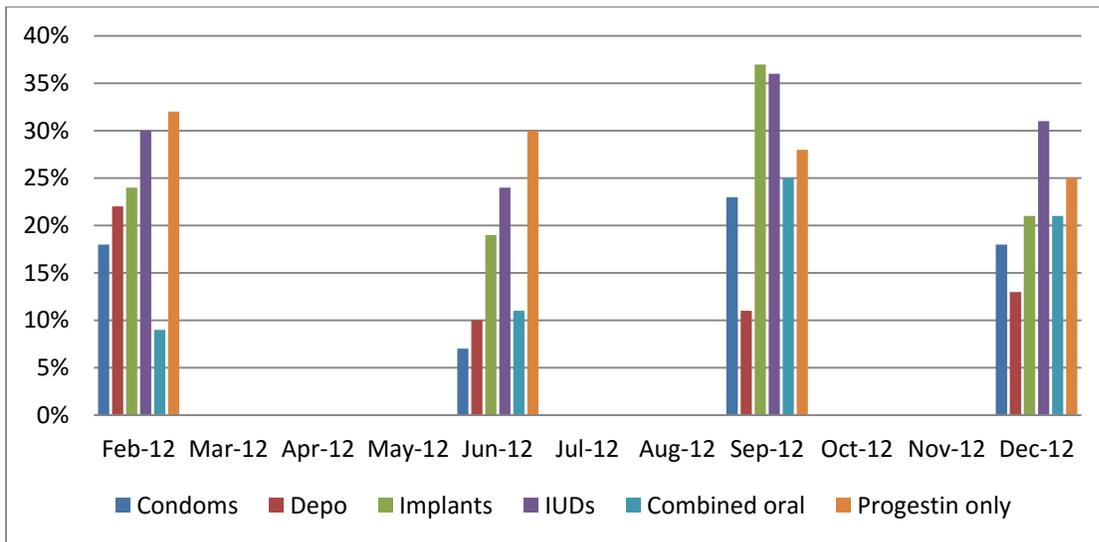
*Availability of MNCH Commodities in Health Facilities*

Information from the in-country visit indicated that key essential medicines, including RMNCH commodities, are often out of stock at MSD and health facilities, particularly amoxicillin suspension and co-trimoxazole suspension.

**Figure 15: Percentage of facilities facing MCH commodity stockouts in Tanzania as supplied by Tanzanian Medical Stores**



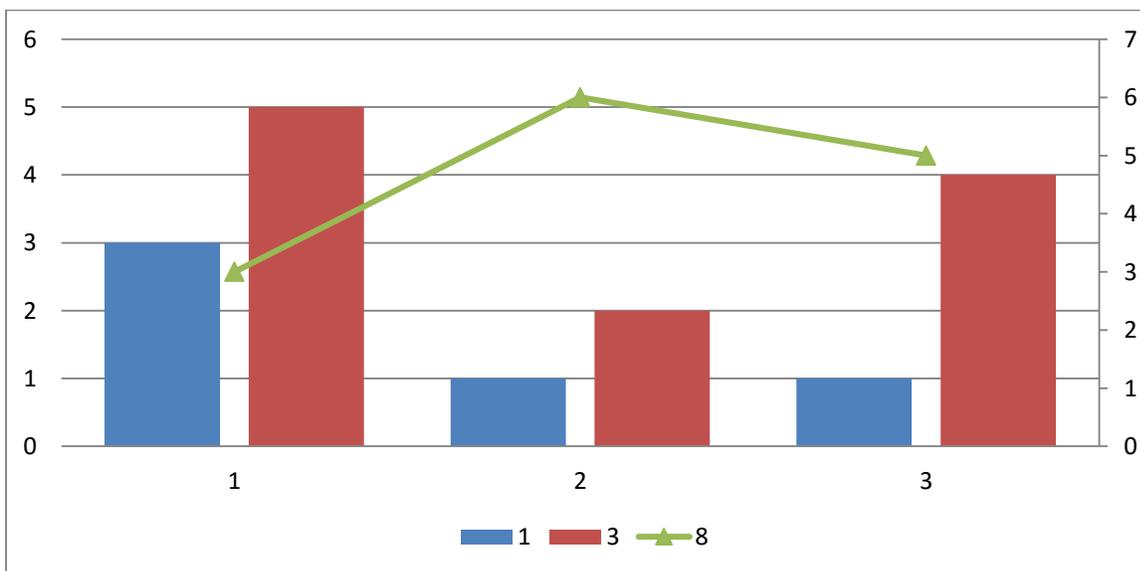
**Figure 16: Percentage of facilities stocked out of FP commodities in Tanzania as supplied by Tanzanian Medical Stores**



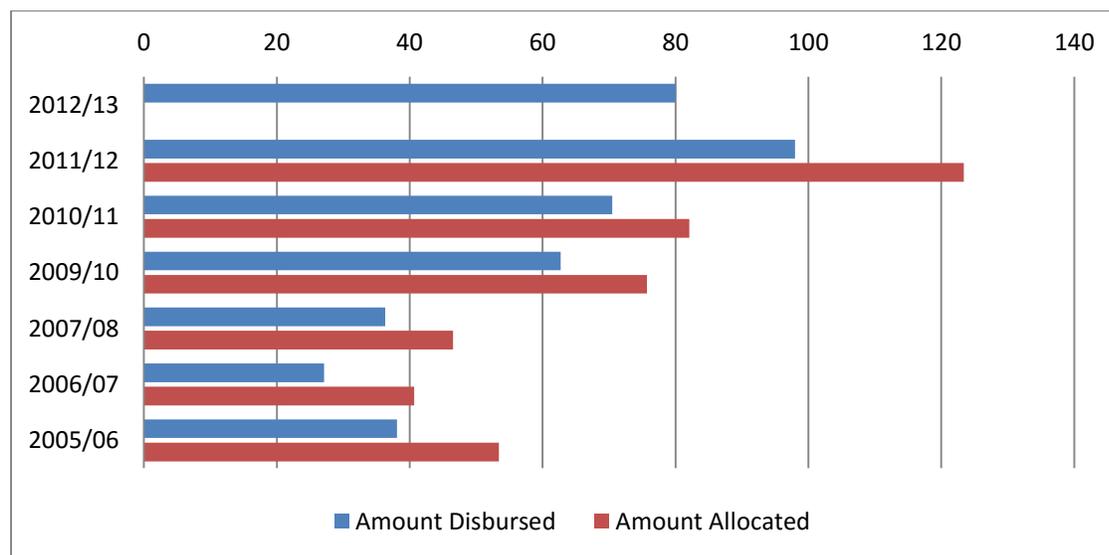
#### Public Finance Management

There are routine inconsistencies between the funds allocated to MSD in the MOHSW budget and the actual funds disbursed to MSD from the MOF. The figures available indicate on average only about 75 percent of the annual funding allocation is actually released, which implies that MSD has to operate on a deficit budget each year. The information available from the assessment commissioned by the World Bank in 2008 and by the auditor general in 2011 estimated that funds can take between 32 to 132 days to move from the national treasury to a health facility account at MSD. This long bureaucratic process has a significant trickle-down effect on the internal processes that need to be set up at MSD in order to execute procurement, warehousing and distribution functions adequately.

**Figure 17: Estimated funding gap for selected health commodities for 2012/13 in Tanzania as supplied by Tanzanian Medical Stores**



**Figure 18: Comparison of funds disbursed with amount allocated to MSD as supplied by Tanzanian Medical Stores**



#### Challenges with Availability of MNCH Commodities

According to one senior MOH official on RMNCH some of the major challenges facing RMNCH commodities in Tanzania have been highlighted in the list below:

- Decreasing allocations of funds through the MTEF/BASKET/GOT
- Late, partial, irregular release of funds
- Delays in the procurement process (PPRA/WHO guidelines)
- Nationwide stockouts for some products (funding/procurement issues)
- Localized stockouts for others (stock management/re-ordering issues)
- MSD Zones not keeping Max-Min stock
- Poor MSD HQ filling of MSD zonal orders
- Poor HFs facilities quantification and ordering, late submission
- Lack of MSD handling charges from donated products
- Poor data on RCH supply chain
- Lack of national supply chain indicators
- Uncoordinated donations and non-adherence to donation guidelines (politically oriented)
- Confusion at MSD on how to handle (distribute) donated products while having the same as saleable stock
- Inadequate human resources for supply chain

#### Quality of RMNCH Commodities

Tanzania Food and Drug Authority (TFDA) is the authority responsible for quality in Tanzania. The TFDA inspects medicines coming through private and public drug outlets. These include medicines ordered by hospitals, wholesalers, Accredited Drug Dispensing Outlets (ADDO) (*maduka ya dawa muhimu*) and private drug shops (*maduka ya dawa baridi*). In the process of procuring commodities, TFDA requires them to obtain import permit before reproductive health commodities are ordered. It was reported that the import permit from TFDA usually takes 24 hours. The drugs procured are those that have full registrations with TFDA. The registration process involves evaluating products for quality, safety and effectiveness, and all suppliers must have a Good Manufacturing Practice (GMP) certificate. All

the interviews and face-to-face discussions with officials at the MOH and MSD seem to suggest that their quality system is quite stringent and that they have not encountered issues with falsified or counterfeit medicines from suppliers of MNCH commodities.

## **Findings**

With reference to the questions originally posed in the SOW, we can draw the following conclusions for Tanzania:

### Is there a problem?

There is a problem in Tanzania with availability/access to capital when needed, which contributes to inefficient nationally funded procurements of MNCH commodities. Results show that due to inadequate funding, there are unmet needs for the procurement of MNCH commodities. MNCH commodities are often out of stock at MSD and health facilities. Amoxicillin suspension and co-trimoxazole suspension are the products most often out of stock.

### What causes the problem?

Based upon the review of existing literature, face-to-face interviews and field visits, it is clear that routine inconsistent lack of funding from government resulting in inefficient procurement of RMNCH commodities. The major causes of availability of funding are compounded by delay by the MOHFW in releasing budgets allocated for the procurement of RMNCH commodities to MSD. Also the financing gaps between what is budgeted and actual expenditure is significant. From 2010 to date, the government owes outstanding payments of \$52M to MSD.

### Would a working capital facility an appropriate solution?

Feedback to the questionnaire and interviews conducted in country suggests very strong interest for a working capital facility. The other challenge with the public finance system in Tanzania is that while the working capital facility could provide the acceleration fund to bridge the funding gaps, the level of funding from GOT need to be addressed to make funding available for all the unmet RMNCH needs in Tanzania.

## **Uganda**

### **Background**

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

While Uganda has made some progress towards the attainment of Millennium Development Goals 4 and 5, the rate of reduction is slow, compared to the set MDG target of 54 per 1,000 live births and 131 per 100,000 by the year 2015, respectively. The under-5 mortality rate has been reduced from 137/1,000 live births in 2006 to 90 in 2011, and the IMR has been reduced from 90/1,000 to 54/1,000 live births in the same period (UDHS 2006 and 2011). Similarly the MMR has been reduced from 505 to 435 deaths per 100,000 live births. Yet more than 200,000 children under 5 years die every year mainly due to preventable conditions, especially malaria, pneumonia, diarrhea, vaccine-preventable diseases (e.g. measles), HIV/AIDS and neonatal conditions. The leading direct causes of maternal deaths are hemorrhage (26 percent), sepsis (22 percent), obstructed labor (13 percent), unsafe abortion (8 percent) and hypertensive disorders in pregnancy (6 percent).

The major challenge in Uganda is high fertility, with a total fertility rate of 6.6 (UDHS 2011). This drives other related issues, including pre-term delivery, post-partum hemorrhage, sepsis, pre-eclampsia and eclampsia. There is poor coverage of family planning services, especially in the hard-to-reach areas. Unmet need is 41 percent, mostly as a result of inadequate access of young people to contraceptives and inadequate use of long acting and permanent methods. Another major problem concerns newborn

deaths, which have maintained the high, sustained levels of the IMR, making it impossible for Uganda to achieve the MDG 4 target of reducing by two-thirds the mortality rate among children under 5 by 2015. According to the Uganda newborn situation analysis of 2008, 39 percent and 25 percent of deaths among infants and children under 5, respectively, are under 28 days of life. The majority of these deaths result from preventable causes like infections, birth asphyxia or injuries and complications of prematurity. A related problem is early, unplanned and unwanted pregnancy, with evidence of high incidence of unsafe abortions and related complications.

The Uganda Road Map for Acceleration of Reduction of Maternal and Neonatal Morbidity and Mortality, the Reproductive Health Commodity Security Strategy and the National Child Survival Strategy were formulated in 2007, 2008 and 2009, respectively. With regard to newborn health, a detailed framework was developed to operationalize the newborn health component of the Child Survival Strategy. In an attempt to bring services closer to the people, the community treatment of malaria, pneumonia and diarrhea through use of village health teams was adopted in 2010. The effective implementation of these strategies is expected to contribute significantly towards achievement of MDGs 4 and 5 by 2015.

The Uganda National Drug Policy is operationalized through the Pharmaceutical Sector Strategic Plan and aims at ensuring the availability and accessibility of adequate quantities of affordable, efficacious, safe and good quality essential medicines to all. The public sector national medicines procurement is mainly through National Medical Stores (NMS), a parastatal organization, while the Joint Medical Stores (JMS) is the major private-not-for-profit (PNFP) sector supplier for medicines and health supplies. The National Drug Authority (NDA) is responsible for regulating the pharmaceutical market, licensing premises, drug information, pharmacovigilance, quality assurance, import permissions and disposal of expired medicines, but it has a limited capacity with insufficient outreach. Global initiatives provide the bulk of reproductive health commodities. The Government of Uganda distributes lifesaving commodities free of charge through the public health system. The public health system includes National Referral Hospitals, Regional Referral Hospitals, General Hospitals, Health Centres IV, III, and II, and community-based distributors.

### ***Challenges in the Ugandan Health System***

- Medicine credit line budgets have stagnated, while PHC grants for commodities have only increased slightly, with low utilization of approximately 55 percent.
- Delays in procurement, poor quantification by and late orders from facilities and poor record keeping are among the management issues that contribute to shortage and wastage of these commodities in the public sector.
- Frequent stockouts of essential and life-saving medicines and commodities have been a critical factor hampering RMNCH services. Families do not want to risk spending their scarce resources travelling to seek care when it is common knowledge that health facilities have no drugs.
- While some commodities are overstocked, others are in limited supply, such as oral rehydration salts, zinc tablets and female condoms.
- Medicine availability in the sector has improved over the years, however, with the percentage of facilities without stockouts of any of the six indicator medicines reported as 21 percent in 2009/10, 43 percent in 2010/11, and 69.8 percent in 2011/12.
- Expenditures on health compared to the total government budget has not changed much over the years, and stands at 7 percent making it difficult to prioritize needed commodities, with out of pocket expenditure accounting for 42 percent of total health expenditure.
- Ninety percent of all medicines are imported, and close to 95 percent of these are generic products. The challenge of counterfeit products on the market is also becoming an increasing problem.

- A key health system bottleneck is in supply chain management, especially “last mile deliveries.”
- Support is being provided to build institutional capacity of NDA and tools for promoting rational use of medicines like the Essential Medicines List and the Uganda clinical guidelines have been updated and are available in more than 90 percent of facilities.

#### *Female Condom*

Female condoms are not widely known among potential clients and the market is still small. Uganda introduced female condoms in the public sector in 2006, but the majority expired in stock. A pilot re-introduction of female condoms commenced in 2009 with 200,000 female condoms in specific communities with a focus on most-at-risk populations. Information on female condom use/needs is also not included in Government Health Information Systems; neither is it on the NMS catalogue, order form, or in the national forecast and quantification process.

#### *Contraceptive Implants*

A large proportion of service providers are not trained in insertion and removal. Paramedical workers are not allowed by law to insert and remove implants. There is also minimal capacity to test the quality of implants and register additional suppliers for Uganda. There is inadequate post testing capacity at the National Drug Authority, including inability to carryout post market surveys to determine quality of implants.

#### *Emergency Contraceptive Pill*

Emergency contraception is not well integrated into family planning programs. Adolescents and youth in schools and rural areas have limited access and knowledge on where to find it and how to use it. Pharmacists and drug-sellers are not trained in advocacy and provision. There is poor availability and access at public health facilities, and it is expensive to purchase from the private sector.

#### *Misoprostol*

Misoprostol is registered for use in prevention and management of PPH in health facilities in Uganda and not at the community level, yet only 51 percent of women in Uganda deliver in health facilities. Mechanisms of facilitating access to misoprostol in home births or births in the community are not in place. It is usually not encouraged by the system because of being used for medical abortion (off-label, self-administered) and there is low demand due to poor provider prescribing habits and the limited knowledge and skills. Also there is poor needs estimation and quantification, forecasting and delivery mechanisms lead to stockouts.

#### *Magnesium Sulfate*

The main issue with magnesium sulfate is insufficient use by health workers. The Ministry of Health developed protocols and guidelines on its use in these contexts, but these have not been widely disseminated.

#### *Antenatal Corticosteroids*

Less than half of hospitals have antenatal corticosteroids (ACS) available. ACS is almost absent at lower levels, where pre-referral treatment could be of most benefit considering Uganda's contextual care-seeking challenges, especially among pregnant women.

#### *Injectable Antibiotics*

There is insufficient use of injectable antibiotics and lack of appropriate products and formulations for neonates at health facility levels, where first contact of a neonate with sepsis is most likely.

### *Resuscitation Devices*

Although quality affordable devices that are meeting international standards are available, the specifications and standardization of such devices are rarely regulated at the national level, and product selection guidance is not universally available to national-level procurement leads. Further, the devices themselves are infrequently available and used at every location where deliveries occur. As a medical device, this commodity faces additional supply challenges, including irregular procurement and sterilization, compared to the other 12 focus commodities of the Commission. Quality issues include inappropriate specifications of devices (in size, quantity and quality) leading to wrong procurement and distribution to centers where deliveries take place.

### *Oral Rehydration Salts and Zinc*

Procurement and distribution at the public health facility level is not based on actual demand: a significant proportion of public health facilities in Uganda do not stock adequate supplies of zinc and ORS. This is largely due to Uganda's supply system, where volumes of medicines are "pushed" to health centers based on assumed demand. This results in chronic under-stocking of zinc and ORS. In the 45 districts covered by SURE, ORS was only available in 86 percent of HC2 and 89 percent of HC3 during the last quarter of 2012. For facilities that have been out of stock at least one day, the average stockout over the last 3 months lasted 15 days at HC2 and 18 days at HC3.

### *Amoxicillin*

There is a general lack of active coordination between partners, with a significant number of stakeholders having an interest in the pneumonia diagnosis and treatment: public, private for-profit, and private not-for-profit organizations. There is a risk of overlap, inefficiencies and loss of opportunity if these efforts are not well harmonized and coordinated. The scale-up of amoxicillin supply in the public sector could become, if price remains unchanged, an unsustainable burden for the government.

### **Findings**

With reference to the questions originally posed in the SOW, we can draw the following conclusions for Uganda:

#### *Is there a problem?*

The major issue faced in Uganda based upon the review of existing literature and discussions with relevant individuals in-country is that the overall MNCH procurement system is underfunded as a result of conflicting government priorities, particularly with the ring-fencing of funds for commodities to tackle AIDS, TB and malaria. Timing of fund release can sometimes be an issue, with procurement and budget cycles sometimes mismatching, although it is not the most pressing concern. The challenge of counterfeit products on the market is also becoming an increasing problem, with 95 percent of imported medicines being generic products.

#### *What causes the problem?*

Along with the issues mentioned above, individual responses to the questionnaire and interview questions cited the following as major causes: the quantification for MNCH products that is currently taking place is not necessarily robust, often likely to lead to inefficient stock levels and potential emergency procurement procedures. Furthermore inconsistencies occur in the procurement of these goods, as the NMS and MOH have their own suppliers; meanwhile USAID, the Global Fund and the World Bank each use their own suppliers and procurement methods.

#### *Would a working capital facility be an appropriate solution?*

Based on individual responses to the questionnaire and interview questions, a working capital facility could provide greater predictability, price, and overall supply levels should it be implemented in Uganda. However the appetite of the Ministry of Finance for such a mechanism is difficult to gauge at this stage.

Interviewees from the MoH and the National Medical Stores agreed that a working capital facility would be beneficial to Uganda.

## **Kenya**

### **Background**

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

Maternal mortality levels in Kenya remain unacceptably high at 488 per 100,000 live births. The UN estimated in 2005 that one in every 39 Kenyan women dies in childbirth. While major progress has been made in reducing infant and child mortality rates, one in every 19 babies born in Kenya this year will die before its first birthday. Sixty percent of these deaths will occur in the neonatal period. While poverty and high rates of HIV, TB, malaria and other infectious diseases provide underlying substantial challenges, the appalling mortality statistics implicate dysfunctional health systems as the principal obstacle for addressing these challenges and preventing premature mortality.

The Government of Kenya's March 2009 National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya and the Child Survival and Development Strategy 2008-153 identified several barriers for program improvement, including: lack of recognition of danger signs in pregnancy; poor accessibility and low utilization of skilled attendance during pregnancy, childbirth and postpartum period; limited access to essential and emergency obstetric care due to limited health provider competencies and inadequate staffing, equipment and supplies; socio-cultural barriers leading to delays in seeking care; and limited national commitment of resources for maternal and newborn health.

The Government's three-pillar Vision 2030 and the Second Medium Term Plan (2014-2018) aim to deliver, among others, accelerated and inclusive economic growth, higher living standards, better education and health care, through which Kenya aims to attain the MDGs. The Kenya Health Policy (2014-2030) defines the country's long-term intent in health. The overall objective of this policy will be to attain universal coverage with critical services that positively contribute to the realization of the overall policy goal. The target of the policy is to attain a level and distribution of health at a level commensurate with that of a middle-income country, with specific impact targets of attaining a 16 percent improvement in life expectancy; a 50 percent reduction in annual mortality from all causes; and a 25 percent reduction in time spent in ill health.

The Right to Health for every Kenyan is affirmed through a recent comprehensive Bill of Rights. Governance structures fundamentally changed from a previously centralized structure to a two-tier system comprising the National Government and 47 devolved County Governments. The counties are the units of service delivery and resource allocation. These orientations require restructuring of health governance and health care delivery systems to align with the Constitution. A health bill is under development to consolidate, harmonize and update all health related legislation, and to align it with the Constitution.

### **Health Policy**

Nationally, Kenya has a sufficient and strong legal and policy framework that governs RMNCH; the country has a number of good policies that support RMNCH and provide strategic direction and, in some cases, identifies targets which can be achieved within a medium-term implementation framework. These include: the Constitution of Kenya (which was revised and ratified in 2010), Vision 2030 (a national long-term development agenda which includes a component on health), the Poverty Reduction

Strategy, the Kenya Health Policy (2012-2030), and the National Health Sector Strategic Plan. However, many of these policies do not identify mechanisms of accountability.

### **Field Visit/In-country Interviews**

Kenya operates an integrated supply chain for the delivery of medicines from Nairobi through several hubs located at strategic districts for the efficient delivery of service. KEMSA operates a demand-driven supply chain responsible for forecasting, procurement, warehousing and distribution. According to the findings in Kenya, there is no separate budget line for the procurement of RMNCH commodities, suggesting there could be unmet gaps that the government may not be aware of. The in-country visit to Kenya focused on three aspects of the challenges with availability/access to RMNCH commodities. The access to funding when needed for the procurement of these commodities, access to quality suppliers at competitive prices of RMNCH commodities, and lastly, have they encountered any issue with quality of the RMNCH commodities procured.

The interviews with Kenya medical stores (KEMSA) officials addressed some of the concerns with the quality of RMNCH commodities supplied by Indian or Chinese companies, pricing of the commodities and timing of release of funding from GOK budgets. The QA system in Kenya is robust with pharmacovigilance in place to monitor adverse reaction at health facility level. Patients are empowered to report any changes noticed in the packaging of medicines received this is indicative of the efforts the government have put in place to curb influx of counterfeit/falsified into the supply chain. Respondents said that they have access to quality at competitive pricing. The challenge is with the recent devolution of power from the central government to the districts. Health districts have to pay for the procurement of commodities to KEMSA before goods are supplied resulting in stockouts at the facility level because of inadequate funding and prioritization at the local levels. KEMSA is owed a large amount of funds from the district health facilities where they have supplied medicines. Timing of the release of funds for GOK funding of commodities in general is a concern, especially for family planning commodities.

For donor-funded programs KEMSA has a working capital facility to bridge the grant-release gaps. One senior reproductive health official interviewed revealed that while they are meeting their targets on maternal and child health, the current devolution of power to district governments may lead to prioritization of other areas, which could limit continued success. Of the 13 RMNCH commodities prioritized by the UNCoLSC, misoprostol is not a stock line at KEMSA.

It was difficult to ascertain from discussions whether there was an element of bias regarding questions of quality and funding. However, the devolution of power from the central to district governments means that each district will fund the procurement of their health requirements by paying KEMSA in advance for services. It could not be determined at the time of the visit if there are any funding gaps for the procurement of RMNCH commodities, as the officials met could not comment firmly.

### **Findings**

With reference to the questions originally posed in the SOW, we can draw the following conclusions for Kenya:

#### *Is there a problem?*

Contrary to the literature review, the face-to-face interviews conducted with officials from KEMSA and PPB suggest that Kenya is a hallmark for other African countries to emulate regarding access to funding of their health systems, the quality of commodities in circulation and access to quality suppliers at competitive prices, but there are still unmet needs for the procurement of RMNCH commodities at the facility levels.

#### *What causes the problem?*

The results from the study suggest that government emphasis on RMNCH has proven to be yielding results, but these results need to be maintained to prevent a relapse. The concern is with devolution of power, and how this might impact health delivery in the coming years.

#### *Is a working capital facility an appropriate solution?*

Respondents from KEMSA seem to suggest there is not a mismatch in funding release and procurement of MNCH and other commodities. However, evidence suggests otherwise that there are unmet needs for essential commodities in Kenya, due largely to recent devolution of powers to the districts, resulting in lack of finance from the local districts to meet their obligatory to procure commodities from KEMSA. Further investigation is required to ascertain the need for a working capital facility.

## **Rwanda**

### **Background**

Rwanda is a small landlocked country in East-Central Africa, and is the most densely populated country in Africa, with a population of over 11 million in a land area of only 28,338 square km. The country has achieved impressive development progress since the 1994 genocide and civil war. It is now consolidating gains in social development and accelerating growth while ensuring that they are broadly shared to mitigate risks to eroding the country's hard-won political and social stability.

### **Rwanda Health System**

In the pre-genocide era before 1994, Rwanda's health care was supported by the Bamako Initiative, which was sponsored by UNICEF and WHO and adopted by African ministers of health in 1987. Progress was started towards decentralizing the health management system, first to the province level and then to the district level. Unfortunately, this was disrupted by the 1994 genocide, which crippled the health care system alongside the economy.

In the post-genocide period, Rwanda has had an uphill climb in the recovery of its health system as well as its economy. In 1998, a new government launched a consultative process to create a national development plan based on inclusive social cohesion and health equity, involving substantial investments in public health and health care delivery. Community-based health insurance and performance-based financing systems began in three of the country's districts and expanded nationwide in 2004. In 2010, the Ministry of Health instituted a three-tiered premium system based on Rwanda's socioeconomic assessment system, *ubudehe*. There was simultaneous decentralization and integration of health services, increasing domestic funding alongside external resources. By 2010, 58 percent of foreign assistance was channeled through Rwandan national systems, compared with an average of 20 percent in post-conflict settings.

Recognizing that improving health requires a partnership between the government and local communities, the Ministry of Health has put in place mechanisms that directly involve and empower local communities in health promotion. Community Health Workers have proven to be a way of providing effective and efficient basic health care services at a community level in a resource-constrained country with financial, infrastructural and geographical barriers to accessing health care. The significant improvements in child and maternal health witnesses over the last five to ten years are undoubtedly due, at least in part, to the service provided by Community Health Workers.

### **MDG Targets**

Rwanda is one of the countries that is on track in fulfilling the MDGs 4 and 5. In 2013, Rwanda was ranked number one out of 48 African countries that have registered significant progress towards achieving the MDGs, according to the continental data report released by the campaign and advocacy organization ONE. The under-5 mortality rate is at 52 deaths per 1,000 live births, reaching the target set for 2015. There has been an overall decline in the under-5 mortality rate since 1994, with consistent

reductions seen from 1998. Prior to this date there was an increase in under-5 mortality from 152 deaths per 1,000 live births in 1990 to 288 deaths per 1,000 live births in 1994, coincident with the Rwandan genocide. However, infant mortality in Rwanda remains high at 62.51 deaths per 1,000 live births. There has been a significant decrease in the MMR from 1,400 deaths per 100,000 live births in 1990 to 320 deaths per 100,000 live births in 2013, with Rwanda making good progress towards achieving the MDG target. The main reason for the improvement is an increasing number of women giving birth in a health care facility attended by a qualified health care professional, and the introduction of a maternal death audit. However, to achieve the target it will be necessary to significantly further increase the number of women giving birth in a health care facility from 52 percent to nearer the WHO target of 90 percent, as well as encouraging more pregnant women to attend for an early antenatal visit and make the four recommended visits. Part of the goal also stipulates that 100 percent of births must be attended by a skilled health professional. In the period 2007-2012 this figure stood at 69 percent. Consequently, progress needs to be made if Rwanda is to achieve this target.

### **Findings**

With reference to the questions originally posed in the SOW, we can draw the following conclusions for Rwanda:

#### ***Is there a problem?***

Available literature suggests that there has been significant decline in maternal and child deaths, suggesting that the efforts of the country towards improving the health outcomes for mother neonatal and child health are on track.

## **Zambia**

### **Background**

In the last decade, Zambia has made notable progress in improving selected health outcomes. Incidence and death rates from HIV/AIDS and malaria have dropped for all age groups. However, progress is insufficient to achieve health and nutrition MDGs by 2015. There has been a very remarkable decrease in under-5 mortality, from 192 to 89 deaths per 1,000 live births between 1990 and 2012. However, it is still high compared to the average for lower middle-income countries (61 deaths per 1,000 live births), and insufficient to achieve the MDG 4 target of 64. The MMR also fell from 470 to 440 deaths per 100,000 live births between 1990 and 2010, but this 7 percent reduction is insufficient to achieve the MDG 5 target.

Zambia has one of the highest total fertility rates (TFR) in the world (5.9 births in 2010), contributing to both under-5 and maternal mortality, and to increased malnutrition. Although stunting in children under 5 has decreased from 53 percent in 2002 to 45 percent in 2007, it remains high compared to regional averages (35 percent) and is far from the MDG 1c target of 23 percent. An estimated one-third of under-5 mortality and almost a quarter of maternal mortality are associated with malnutrition, which affects immune status, physical and cognitive development, learning performance and productivity in adult life.

### **Health Coverage**

Zambia's coverage and utilization of high impact MNCH and nutrition interventions present a number of challenges, particularly high urban-rural disparities. Rural areas are worse off for many indicators. For example, TFR is 7.0 per woman in rural and 4.6 in urban areas; and deliveries assisted by a skilled birth attendant are 31.3 percent in rural and 83.0 percent in urban areas. The only exception where rural areas are performing better than urban areas is in the Insecticide Treated Nets (ITN) indicators—children who slept under an ITN is 60.1 percent in rural areas and 50.9 percent in urban areas. Although measles immunization coverage is 83 percent (versus 75 percent regionally), full immunization coverage for children aged 12-23 months has been stagnant during the past decade at around 70 percent. While

overall ITN coverage has increased substantially in recent years, 43 percent of children under 5 still do not sleep under an ITN. 60 percent of children under 5 with suspected malaria do not receive antimalarial drugs, and only 36 percent receive deworming tablets. While 60 of women receive four antenatal care (ANC) visits (better than the regional average of 43 percent), the quality of ANC is doubtful. HIV prevalence is at 14.3 percent among adults aged 15-49 years, and higher in women (16.1 percent) than men (12.3 percent). Contraceptive prevalence rate (CPR) is low (32.7 percent), contributing to poor reproductive health outcomes, such as high fertility, high teen pregnancy and low birth spacing.

Low coverage and utilization of MNCH and nutrition services are attributed to demand as well as supply side constraints. On the demand side, communities often lack information on preventive practices, including early detection of health and nutrition complications. In addition, long distances to health facilities and lack of transportation often limit access to services and delay in seeking care. On the supply side, despite the increase in the number of health facilities, including primary care, service utilization remains low due to bottlenecks such as:

- stockouts of essential health and nutrition supplies and consumables due largely to supply chain issues;
- insufficient and inequitable distribution of skilled health workers to carry out facility-based and outreach activities, especially in the management of childhood illnesses and severe malnutrition, midwifery and obstetric complications; and
- compromised efficiency of health workers due to tardiness, low morale and absenteeism. The for-profit private sector owns about 14 percent of the total number of health facilities, reflecting Zambia's limited experience with public-private partnerships in the health sector.

### **Financing Provision for the Health Sector**

Fiscal constraints and allocative inefficiencies in health financing exacerbate the challenges in the health sector. According to the 2010 National Health Accounts (NHA), Zambia's total health expenditure per capita was US\$59 (50 percent from government, 39 percent from donor funding, and 7 percent from out-of-pocket payments). An analysis of changes over time in Zambia and other Africa comparators in health outcomes (e.g., under-5 mortality, maternal mortality and life expectancy), and system capacity (e.g., beds, physicians) shows poor health returns despite relatively high health sector expenditures.

Health services are delivered through the MOH and MCDMCH, and are organized into three levels: (i) the PHC level (preventive, curative and rehabilitative health services based on a basic health care package at health posts, health centers and district/first-level referral hospitals); (ii) the secondary level that consists of more than twenty general/second-level referral hospitals providing curative care in internal medicine, pediatrics, obstetrics and gynecology, and general surgery; and (iii) the tertiary level that consists of six central hospitals (including the University Teaching Hospital) providing specialized and sub-specialized care.

### **Findings**

With reference to the questions originally posed by Financing for Development, we can draw the following conclusions from Zambia:

#### ***Is there a problem?***

Based upon a review of existing literature and responses to the questionnaire, the major issues in Zambia appear to be issues with stockouts of essential commodities, including the 13 RMNCH commodities, and with misoprostol and magnesium sulfate always encountering stockout situations at national, regional and district facilities. There is no specific budget line for financing the 13 RMNCH commodities, suggesting that there is unmet need due to lack of funding.

### What causes the problem?

The results from the study suggest that there are government inefficiencies and lack of commitment for health sector funding. The major cause of the problem with stockouts is often late procurement caused by bureaucratic procurement process and insufficient levels of funding from national government. Most of the challenges identified are with accessing necessary funding for misoprostol, zinc, and resuscitation devices. The linkages between procurement planning and budget formulation is weak, resulting in delays in the release of funds. These delays have occurred frequently, and have led to at least one emergency shipment of misoprostol and antenatal corticosteroids last year.

### Is a working capital facility an appropriate solution?

The questionnaire response from the Medical Store Limited suggest that there is appetite for a working capital facility mechanism in order to ensure price and quality for MNCH commodities by improved access to IPAs.

## **South Sudan**

### **Background**

South Sudan became the world's newest nation in July 2011, formally ending an independence struggle with Sudan that had led to Africa's longest civil war. The Comprehensive Peace Agreement ended the war in 2005 and laid out a path to political transition, but the nation of South Sudan that emerged in 2011 bore the scars of decades of conflict, neglect and poverty. The cost of 40 years of war cannot be calculated purely in terms of lives lost and homes destroyed. With poor infrastructure and a population with limited human capital, the government is faced with some huge challenges and sees a need to move away from oil-based revenue, a fact brought into sharp relief by the recent cessation in oil production.

### **Health System**

There are numerous challenges facing South Sudan in attaining the Millennium Development Goals (MDGs) by the end of 2015 including: weak institutional capacity of national institutions; weak coordination among sectors; political uncertainty and insecurity in large parts of the country; poor basic infrastructure; lack of a development and antipoverty strategy; weak civil society organizations; and limited resources for development. The country endured years of armed conflict, which only ended in 2005, five years after the adoption of the Millennium Declaration. The start of work towards these goals was therefore delayed and started from a very low baseline. National capacities and institutions need to be strengthened to manage initiatives oriented to achieving the MDGs.

South Sudan is acknowledged to have some of the worst health indicators in the world. With 2,054 maternal deaths per 100,000 live births, the country has the highest maternal mortality rate in the world. Due in part to the high fertility rate at 5.0, each mother has a one in seven chance of dying during her lifetime from pregnancy-related causes. Currently, there is only one qualified midwife per 30,000 people, and progress is still short of the 5.5 percent annual decline required to meet the MDG target. In fact, in UNDP's assessment, under the 2010 budget plans, MDG 5 will never be achieved. The under-5 mortality rate is at 99 per 1,000 live births in 2013 and has had a constant decline. However, this is still short of the MDG 4 target of 72 per 1,000 live births, and one in eight children dies before its fifth birthday.

South Sudan has a health system structured with three tiers; Primary Health Care Units (PHCU), Primary Health Care Centers (PHCC) and Hospitals (which exist as state, county, police or military). Primary health services in South Sudan are currently provided by a large number of NGOs, funded by donors. This has ensured a basic level of health care, but now the government's ambition is to build a sustainable government-led health system. The Health Pooled Fund, funded by the UK Department for International Development (DFID), is helping the country towards this goal by aligning primary health care activities with the national health strategy, building the government's capacity to manage the health

service and boosting community engagement and ownership so that services become responsive to local needs.

South Sudan faces a severe shortage of all categories of trained human resources for health (HRH) professionals, including physicians and midwives. Due to these severe shortages in HRH, the country relies on inadequately trained or low-skilled health workers. Further contributing to these challenges are a lack of a federal HRH retention policy, high staff turnover in all government-managed health facilities, lack of financial resources for training output and poor HRH management. In the face of these difficulties, achievements have been made by the Ministry of Health, including creation of a Health Sector Development Plan (2011-2015) that emphasizes HRH as a determinant of all three of the Plan's objectives, a Strategic Plan for Human Resources for Health (2007-2017), a draft national HRH policy (2011-2015) and a Basic Packages for Health plan.

### **Findings**

With reference to the questions originally posed by Financing for Development, we can draw the following conclusions for South Sudan:

#### *Is there a problem?*

The findings from the literature reviewed and questionnaire responses point to occasional stockouts and frequent emergency shipments of MNCH commodities caused by delay in the disbursement of funding needed for procurements from national governments.

#### *What causes the problem?*

Based on the findings from the questionnaire, the approximate national government budget percentage allocated to the procurement of MNCH commodities is less than 3 percent. This suggests a lack of government commitment to improving access to MNCH commodities, resulting in emergency shipments on a regular basis. Also procurement cycles are often mismatched to disbursements from the national government.

#### *Would a working capital facility be an appropriate solution?*

Respondents from the Ministry of Health in South Sudan believe a working capital facility could help improve the procurement process for MNCH commodities.

## **Democratic Republic of Congo**

### **Country Profile**

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

The Democratic Republic of Congo (DRC) spreads across 2,345,409 km with an estimated population of 77.8 million of people in 2012.

The DRC has some of the worst health indicators in sub-Saharan Africa. With one-fifth of children born not reaching their first birthday, the DRC has the second highest level of child mortality. It also has the fourth highest level of maternal deaths, accounting for almost one in ten of all maternal deaths in Africa.

Access to health is an integral part of the government's strategy and is part of the third backbone of the 2006 "Document de la Stratégie de croissance et de réduction de la pauvreté" (Strategy Document of growth and poverty reduction). In the same year, the "Stratégie de renforcement du système de santé" (Health system strengthening strategy) was implemented by the Ministry of Health and is currently operationalized through the "Plan National de Développement Sanitaire 2011-2015" (National Health Development Plan). Despite this commitment, the government budget allocated to the health sector is low at 4.86 percent in 2015, which is far below the 15 percent of the Alma Ata Declaration.

The Democratic Republic of Congo has one of the highest neonatal, under-5 and maternal mortality rates of the world. To put things into perspective, in the DRC there are 10 neonatal deaths per hour, 21 deaths of children under age 1 per hour, 185 deaths of children under age 5 per hour, and three maternal deaths per hour. In order to reach the targets of 66/1,000 for children and 335/100,000 for mothers, as estimated in the Ministry of Health's presentation entitled "*Evolution de l'état de santé de la population congolaise*" (*Health Status of the Congolese Population*) during the 2010 Annual Review of the Ministry of Health, there are still significant efforts to be made. As such, the government of the Republic of Congo has demonstrated its commitment by undertaking a number of initiatives. In July 2013, responding to the call of the UNCoLSC, the Ministry of Health has elaborated the "*Plan National pour l'élimination des goulots d'étranglement pour l'accès aux 13 médicaments qui sauvent la vie des femmes et des enfants*" (*National Plan for the elimination of access bottlenecks to the 13 medicines that save the lives of women and children*).

### **Health Systems**

Access to health services is extremely limited. It is estimated that less than a quarter of citizens have access to health care across the country. Some of this lack of access is related to the cost barriers, since user fees are widespread.

The DRC remains affected by conflict and fragility, which continues to impact the health system. This is a complex environment to work in with many challenges. Better access to basic health services and strengthened empowerment and accountability can have a positive impact on both recovery from conflict recovery and preventing further conflict.

The DRC currently has a health care system that is divided into three structural levels. The first consists of the Ministry of Health (MOH), the second of 11 regional health departments and 48 health districts, and the third level is divided into 515 health zones containing 6,000 health centers. The DRC's health system relies on voluntary health workers for treatment of patients and other various activities such as advertisement. However, most of the health workers are very poorly paid and are often unable to provide neither qualitative nor quantitative service. Inefficient government dealings and lack of investment from the government means the current health care system of DRC is ineffectual.

In 2002, the Government of the Republic of Congo created the "*Système National d'Approvisionnement en Médicaments*," or SNAME (*National System of Medicine Supply*). The SNAME is based on the centralization of the procurement through FEDECAME and on the decentralization of the distribution through Regional Distribution Centers. Sixteen Regional Distribution Centers are currently operational, while the aim under the devolution process is to extend the number to 26 to cover the 26 provinces. FEDECAME has two procurement agencies also called FEDECAME procurement coordination offices, the West Agency called BCAF FEDECAME and the East Agency called ASRAMES. The *Programme National d'Approvisionnement en Médicaments essentiels* (PNAM, *National Program of Essential Medicine Supply*) has been set up in 2002 to coordinate, oversee and evaluate the implementation of the SNAME.

The SNAME faces a number of challenges, including:

- The government's spending for essential medicines other than for funding partners' priority products (HIV, TB and malaria) is insufficient, which weakens the SNAME and its ability to make medicines available from the central level down to the patient. The medicine supply chain mapping completed in January 2010 pointed the existence of a medical supply chain of the Ministry of Health separate from the SNAME, which took up a large part of the government's budget allocated to the supply of medicines.
- The existence of parallel supply chains: although this situation has improved, the supply chain mapping highlighted the number of parallel supply chains with a total of 19 procurement agencies,

and 99 distribution systems which mobilized 52 different partners. Eighty-five percent of donors used their own procurement agency.

- A large share of external aid dedicated to medicines does not fall under SNAME procurement processes. This constitutes an important shortfall for FEDECAME. The National Health Development Plan 2011-2015 highlighted that the budget dedicated to medicine supply under Global Found Round 8 is 20 times higher than FEDECAME turnover.

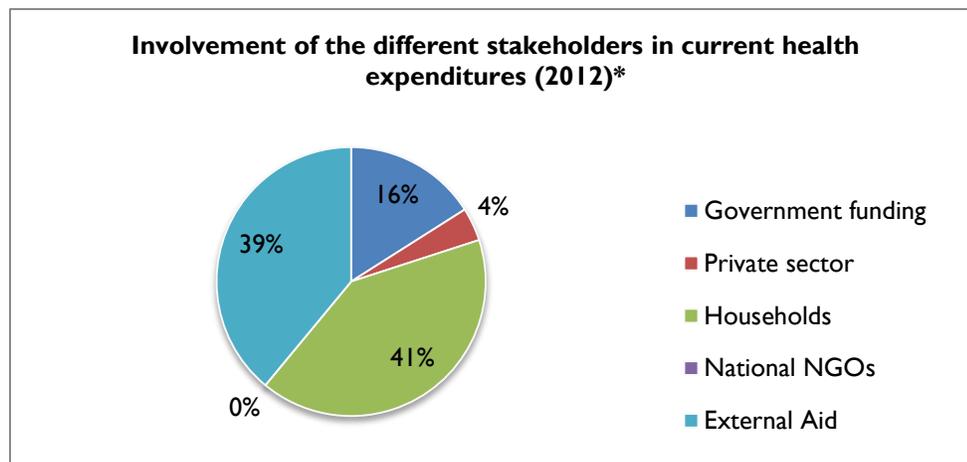
### Health Financing

Government financing of health care is extremely limited, and as a result the Ministry of Health takes very limited responsibility for the provision of salaries and other resources required for public service provision. Per person per annum, the government contributes \$2, donors \$4 and households \$6. User fees are the norm and act as a barrier to care. There is a strong link between subsidizing the care of vulnerable groups and delivering improved health outcomes.

The literature showed some issues related to the budget cycle with a lack of collaboration between the Ministry of Finance and the Ministry of Health. The Ministry of Health is not involved in setting the budgetary envelope or in elaborating the budget and treasury plan.

Results from the 2012 health accounts showed low involvement of the government in financing the health sector. Day to day health expenditures are financed by three main contributors: the government, external aid and households. However, government health spending in comparison to the other sources remains low, with a contribution of 16 percent in 2012.

**Figure 19: Involvement of different stakeholders in current health expenditure in DRC as supplied by DRC Ministry of Health**



A costing study of essential medicines (*Costing des besoins nationaux en médicaments et consommables médicaux dans le cadre de la mise en œuvre du PNDS 2011–2015*) done in November 2012 revealed that the financing gap for essential medicines and medical consumables, taking into account available funding from government and donors only, is above 90 percent. The report advocates for an increase of the government budget allocated to medicines and medical consumables for health zones. If there are no increases, the population—71 percent of which still live under the poverty threshold—will still carry the financing burden for these goods.

## **Maternal, Child and Neonatal Health**

The DRC has one of the highest neonatal, child under 5 and mother mortality rates of the world. As such, the government of the Democratic Republic of Congo has demonstrated its commitment by undertaking a number of initiatives.

With the objective of “Contributing to the Congolese population health’s improvement, in the context of the fight against poverty,” the National Health Development Plan’s targets 1 and 2 are:

- Contribute to reducing maternal deaths per 100,000 live births from 549 to 300 by 2015.
- Contribute to reducing the infant-juvenile mortality from 92 to 40 deaths per 1,000 live births by 2015.

In July 2013, the Ministry of Health has elaborated the “*Plan National pour l’éliminations des goulots d’étranglement pour l’accès aux 13 médicaments qui sauvent la vie des femmes et des enfants*” (National Plan for the elimination of access bottlenecks to the 13 medicines that save the lives of women and children).

The plan highlighted three main types of bottlenecks related to the 13 commodities:

- Bottleneck 1: Insufficient supply of quality health products
- Bottleneck 2: Incapacity to regulate efficiently the quality of these products
- Bottleneck 3: Lack of access and lack of awareness of how, why and when to use these products

A country visit was undertaken in DRC from the 18<sup>th</sup> to the 24<sup>th</sup> of April to gather more information and to find out about the interest of the Ministry of Health in a working capital facility. Two questionnaires, filled out before the in-country visit, suggested that there was a need for such a mechanism.

## **Accessibility of Health Facilities**

Problems regarding accessibility are a factor that keeps the people of the DRC from utilizing health facilities. Lack of means of transportation, long distances from households to the nearest hospital, and an insufficient number of hospitals in relation to the population are all factors that worsen accessibility. The World Health Organization reported that there were only eight hospital beds and one physician per 10,000 people in DRC and that only 37 percent of population has access to health facilities.

## **Health Awareness**

Lack of awareness about health and health care services is a significant reason why people do not choose to use health care. People often don’t know about the effectiveness of health care and so do not often feel the need to seek it out, even when they are gravely ill. Research done by the NGO Doctors showed that nearly 50 percent of people in the DRC did not even try to find a hospital when they were sick. These kinds of barriers are called demand barriers; barriers that influence decisions of individuals and households from accessing health care.

The SNAME is in charge of deploying the National Pharmaceutical Policy. SNAME is based on the centralization of purchasing through two procurement agencies: BCAF in Kinshasa and ASRAMES in Goma. Medicines are distributed through 15 Regional Distribution Centers.

However, about 85 percent of donors use their own procurement agencies (17 in total) for procurement/import of medicines and other products. Only two use the SNAME procurement agencies.

There are two HSC public systems: the SNAME system and a sub-system of the MOH, which is rather informal.

Despite its efforts, the DRC still has one of the highest maternal, infant and child mortality rates of the world and is far from meeting the MDGs 4 and 5. Worldwide, five countries account for half of all child deaths in the world, and the DRC is one of them. Its annual population growth rate is one of the highest in the world, and many women who report that they would like to plan and space births have no access to modern contraceptive methods.

### **Field Visit/In-country Interviews**

The field visit to DRC provided better perspectives about the main challenges faced by the country with regard to RMNCH commodities. The DRC has benefitted from funding from the RMNCH Trust Fund and also from some donors' funding specifically for the 13 commodities (WHO and UNICEF). Meetings with the Pharmaceutical and Medicines Direction and the Family and Specific Group Health Direction, which are primarily responsible for the implementation of the MNCH plan, pointed to the following activities, which have been financed:

- Capacity strengthening of the Pharmacy and Medicine Direction
- Decision to support local production of zinc, SRO and chlorhexidine
- Upcoming feasibility study for the implementation of the Quality Control National Laboratory
- Quantification and procurement plan for the 13 commodities
- Commitment of the partners including US\$ 12 million from UNICEF (for the procurement of goods) and US\$ 3 million from WHO for strengthening the capacity of the piloting bodies.
- Introduction of chlorhexidine solution 7.1 percent to the National Essential Medicines List (NEML)
- Adoption of norms, directives and user guide documents for oxytocin, misoprostol and chlorhexidine digluconate 7.1 percent
- Update of norms and directives for female condoms, magnesium sulfate and amoxicillin, dispersible 250mg

The in country visit also reinforced the evidence of issues in health financing, including:

- **Low budget commitment of the government:** Data collected at the National Program of the National Health Accounts showed a low share of the government's global budget allocated to the Ministry of Health over the 5 past year's ranges from 3.5 percent at the lowest to 7.8 percent with 4.9 percent in 2015.
- **Insufficient budget execution** with discrepancies between budget allocation and money effectively being disbursed. In 2012 and 2013 the execution rate of the government budget allocated to the Ministry of Health was 27.4 percent and 68.8 percent respectively.
- **Low collaboration between the Ministry of Health and the Ministry of Finance with regard to the budget cycle:** Health priorities are not often taken into account when disbursement is made. On a quarterly basis, a commission (made up of the Finance and Budget Ministries notably) undertakes a budget arbitration to decide where, and in what sectors to disburse funds. Interviewees mentioned that the Ministry of Health is not part of this arbitration, which often results in other priorities being financed at the expense of the health sector.
- **Delay in the budget cycle process:** While the government budget is voted on every year in October by Parliament, there is sometimes a delay in this process.

- **Low government subsidies to the SNAME:** Since its creation, FEDECAME has never had access to the government's essential medicine budget line. In 2013 however, the government launched the *Programme d'Équipement des Structures Sanitaire* (Health Structures Equipment Program-PESS) which aims for its first phase at rehabilitating, equipping and supplying in basic medicines health structures in 11 provinces. To date, FEDECAME has benefited from US\$ 3,650,000 for medicines. This money has ultimately benefitted health structures in the form of medicines and as credit lines installed at the CDRs.

Apart from the low commitment of the government in health financing, another critical health financing issue in DRC relates to the ailing cost recovery system for medicines. A number of health structures (although not all, given the high number of health facilities in DRC) have benefitted from credit lines either from the government with the PESS project or from donors. Health structures are supposed to fuel these credit lines with the margin made on medicines sold. In reality, health structures often use the money from the margin they made for buying products from the private sector. Health structures' pharmacists met during hospital visits argued that, on the one hand, products are not always available in the SNAME (FEDECAME network), and on the other hand, products sold through the SNAME are more expensive than products sold with the private sector, which is why they usually prefer to use other parallel channels. This situation, coupled with the number of drugs being donated by donors directly to health facilities, creates a "false competition" with the SNAME and undermines the cost recovery system. Regional Distribution Centers find difficulty in selling their products to their clients and as such to recover costs. With low subsidies, CDRs are left with very low cash flows, which prevents them from buying products on time from the two procurement agencies. In turn, the two procurement agencies have difficulties to recover costs and their lack of cash flow prevents them from procuring goods on time. The procurement manager of BCAF reported that the procurement agency sometimes had to wait for 6 months to be able to effectively place an order, which impacts the availability of products at all levels of the supply chain.

**The ailing medicine cost recovery system associated with the lack of subsidies from the government to the national procurement agencies makes effective procurement very difficult for FEDECAME.** During the country visit, some time was spent with people from FEDECAME and BCAF to truly understand their functioning and needs. BCAF, the western procurement agency, has to supply 12 Regional Distribution Centers throughout the western zone of the territory. Each center has a credit line for essential medicines at FEDECAME with a certain sum of money that they use to buy products from the procurement agencies, which they have to pay back with money collected through the cost recovery system to be able to buy again and again. Since 2009, FEDECAME has implemented suppliers' payments as 50 percent in advance and 50 percent 45 days after delivery. While this situation worked previously with EU subsidies, FEDECAME now finds it difficult to pre-fund orders and as such to place an order. As a result FEDECAME has to wait for CDR to pre-fund their goods in repaying their credit lines. However, as stated before, CDRs also face difficulty in recovering costs, as the working capital facility has a number of weaknesses. Likewise, CDRs have to pay FEDECAME 50 percent in advance and 50 percent after delivery. This critical situation results in FEDECAME having real difficulties in procuring goods on time. As an example, having placed an order in August 2014, they were only able to do advance payment in February 2015, which delayed the procurement of goods to FEDECAME and its procurement agencies, and resulted in delays in medicines being made available to patients.

Figures from FEDECAME/BCAF speak for themselves: In October 2014, money being made available at BCAF from all its CDR (essential medicines capital) amounted to US\$ 628K while funding suppliers' gap for BCAF to get medicines amounted to US\$ 1.2M. The total sum of money expected by BCAF from all its CDRs for January 2015 is US\$ 1.7M but the CDRs are known by BCAF to have difficulties in

receiving the funds. With such funding gaps, it is really difficult for FEDECAME to make effective procurement.

**With regard to the procurement of the 13 commodities specifically:**

The 13 products as identified by the Republic of Congo are:

1. Oxytocin 10UI
2. Misoprostol 200 µg
3. Magnesium sulfate 500mg/10ml
4. Amoxicillin 1g inj
5. Ceftriaxone 1g inj
6. Dexamethasone 4mg inj
7. Chlorhexidine solution 7.1 percent
8. Amoxicillin dispersible 250mg
9. Oral rehydration salts (low osmolarity)
10. Zinc 20mg divisible
11. Latex female condoms and lubricant
12. Levonorgestrel (Levonorgestrel 2x75mg (Implants) - Levonorgestrel 150mg (Implants) - Levonorgestrel 6x25mg (Implants))
13. Levonorgestrel 750mg

The national quantification, made for the first time last year, indicates that the projected budget to cover the 13 commodities needs equals to US\$ 4.7M and US\$ 6.3M for 2015 and 2016 respectively, which gives a total amount of US\$ 11M for two years.

Within the National System of Essential Medicines Supply (SNAME), FEDECAME buys the following products routinely:

- Oxytocin 10UI
- Amoxicillin 1g inj
- Ceftriaxone 1g inj
- Dexamethasone 4mg inj
- Oral rehydration salts (low osmolarity)

Female condoms have been bought in the event of the PESS project. FEDECAME plans introduce to its pre-qualification process the five other products below:

- Misoprostol 200 µg
- Magnesium sulfate 500mg/10ml
- Chlorhexidine solution 7.1 percent
- Amoxicillin dispersible 250mg
- Zinc 20mg divisible

In procuring a larger number of commodities, FEDECAME will have even more difficulty in procuring goods if no external financial support is received.

FEDECAME has access to international suppliers but does not use procurement agents. While the names of the suppliers from which FEDECAME get these RMNCH commodities is not known, suppliers'

names providing essential medicines in general and that FEDECAME/BCAF needs to pay have been provided and are listed below.

**Table 9: Supplier list**

<b>BCAF suppliers list (might not be exhaustive)</b>
MPHARMA
MISSION PH
IDA
TETRA MEDICAL
B. BRAUN
MACLEODS
MULTI G BVBA
MEDICAL EXPORT GROUP
IPCA
PHARMAKINA SARL
LIFE PHARMA FZE
SVIZERA
ADHE-ELS
SANDOZ
STEROPS OVERSEAS
VIKMED VENEFICIS
BON SANTE LABORATORIES
ESSOR EQUIPMENTS SPRL
STANDARD DIAGNOSTIC
AFRICA MEDICAL SUPPLIER

With regard to the quality and prices of products from the SNAME, while both the literature and interview findings highlighted that prices from the private sector were lower than within the public sector, it was also stressed that lower prices also mean lower quality. It is also reckoned that private sector firms don't respect the tax system, which explains why they get cheaper products. According to the 2013 Pharmaceutical profile of the DRC (for Global Fund purposes), 3 percent of the orders placed by BCAF within the last 12 months had product quality issues. However, respondents from both the questionnaires and face-to-face interviews mentioned that the quality of products bought through the SNAME was acceptable.

It is worth also noting that donors participate in the procurement of these 13 commodities (notably UNICEF, UNFPA, USAID and DFID). UNICEF is particularly committed to RMNCH commodities, as demonstrated by the implementation of family kits as part of the *Cadre d'Accelération de la réduction de la mortalité de la mère et de l'enfant en République Démocratique du Congo* (acceleration framework for maternal and child mortality reduction in the DRC). These kits include some of the 13 commodities. While the elaboration guidelines of this framework stipulate that these kits will be distributed using the public sector supply chain (SNAME), it is not quite clear who will be responsible for procuring the kits, although it is mentioned that "FEDECAME will oversee the regular supply of CDRs."

## **Findings**

### Is there a problem?

There does appear to be a problem in DRC with availability/access to capital when needed, which contributes to inefficient procurement of RMNCH commodities. The findings also point to an insufficient supply of quality RMNCH commodities. RMNCH commodities are often out of stock at MSD and health facilities.

### What causes the problem?

The study results point to a lack of commitment from the DRC government towards MNCH commodities, resulting in low budget allocations, insufficient budget execution, and lack of coordination between the MOH and MOF leading to delays in the release of budget allocated for procurement of MNCH commodities. There are unmet needs for MNCH as a result of funding gaps.

*Is a working capital facility an appropriate solution?*

Responses to the questionnaire and interviews conducted in-country suggests that while a working capital facility will be very useful for helping FEDECAME to procure its products, the operator of the facility should liaise closely with UNICEF in order to set up such mechanism.

## **WEST/SOUTH AFRICA REGION**

### **Ghana**

#### **Background**

Ghana's national health system has two principal components. The Ministry of Health is responsible for policy formulation as well as program monitoring and evaluation. The Ghana Health Service (GHS) is responsible for health service delivery. In addition, Ghana's National Health Insurance Scheme (NHIS), which is administered by the National Health Insurance Authority (NHIA), covers 95 percent of all health-care costs for an estimated 40 percent of the population.

#### **Health System**

In Ghana's decentralized health system, authority rests with the Regional and District Health Services, and care is provided at the community, sub-district and district levels. The Community-based Health Planning and Services (CHPS) program places community health nurses in health compounds, where they treat malaria, acute respiratory infections and diarrheal diseases, and provide childhood immunizations and family planning services. Pregnant women, children under the age of 18, the elderly and the indigent are granted membership in the NHIS free of charge. Immunizations and services at CHPS compounds are covered directly by the GHS and are not included among NHIS benefits.

While Ghana has made considerable strides toward meeting MDGs 4 and 5 in the more populous and prosperous southern regions of the country, health indicators in the northern provinces, which have historically been underdeveloped, reflect significant challenges.

In Ghana, most health care is provided by the government and largely administered by the Ministry of Health and Ghana Health Services. The health care system has five levels of providers: health posts—first-level primary care for rural areas, health centers and clinics, district hospitals, regional hospitals and tertiary hospitals. The government, financial credits, Internally Generated Fund (IGF) and donor-pooled health funds finance these programs. Some hospitals and clinics are run by the Christian Health Association of Ghana. Ghana has about 200 hospitals; some for-profit clinics exist, but they provide less than 2 percent of health care services. Health care varies through the country, with urban centers having the most facilities while rural areas are often deprived. Patients in these areas either rely on traditional medicine or travel great distances for health care.

In order to promote universal coverage and equity in health care delivery services, the Government of Ghana adopted the National Health Insurance Scheme (NHIS) in 2003, which was fully implemented in 2005. The ultimate goal of the NHIS is the provision of universal health insurance coverage for all Ghanaians, irrespective of their socio-economic background. The NHIS is based on District Mutual Health Insurance Schemes (DMHIS), which operates in all 170 districts of the country. This covers both formal and informal sectors of the economy. As of June 2009, about 67 percent of the population had subscribed to the NHIS, which is financed by a National Health Insurance levy of 2.5 percent on certain goods and services, 2.5 percent monthly payroll deduction being part of the contribution to the Social

Security and National Insurance Trust (SSNIT) for formal sector workers, government budgetary allocation and donor funding. The formal sector workers pay a registration fee for an identity card for access health care services. Contributions from members of the informal sector are also made to the NHIS with the minimum and maximum premium being GH 7.20 and 47.70 respectively. However, the core poor, pregnant women, pensioners, people above 70 and below 18 years are exempted from premium payment.

The benefit package of the NHIS consists of basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and caesarean delivery), eye, dental and emergency care. About 95 percent of the diseases in Ghana are covered under the NHIS. However, some services classified to be unnecessary or very expensive are on the exclusion list. Among these are; cosmetic surgery, drugs not listed on the NHIS drugs list (including antiretroviral drugs), assisted reproduction, organ transplantation and private inpatient accommodation.

Bottleneck issues under policy and governance, as highlighted in the Ghana Newborn Care Strategy 2014-2018, are summarized below.

- Inadequate focus on newborn health at national, regional and district levels.
- Newborn health has not been prioritized in the past in maternal and child health services.
- Focal person at the national level is currently on a temporary post funded by an NGO.
- Only two regions have a regional newborn health focal person.
- Registration of births and deaths is mandatory but is implemented poorly.
- Under-resourced Department of Births and Deaths Registry.
- Inadequate collaboration with other stakeholders such as GHS.
- Inadequate public education.
- Hindering social-cultural factors influencing registration of newborn births and deaths.
- Newborn care, including the three major causes of mortality, is inadequately addressed.
- Capacity exists at the District Health Management Team but is inadequate.
- Poor accountability for newborn health at all levels.
- Inadequate visibility of newborn care issues.
- Absence of key newborn indicators on Sector Wide Indicators and Health Information Management System, including DHIMS2, GHS integrated indicators.

### **Health Financing**

Bottleneck issues concerning health financing include the following:

- Limited funding to health sector.
- Inadequate and irregular financial resource flow, resulting in donor dependency.
- Delayed reimbursement by the NHIS.
- Presence of additional payments for maternal and newborn care due to:
  - Stockout of essential commodities leading to the family buying them.
  - Tests ordered by physician not covered by NHIS.
  - Presence of ‘unofficial’ fees.
- Though the NHIS is supposed to cover all services for pregnant women and children under 18 years, including newborns, a number of essential newborn services are not covered, mainly because essential drugs for newborn care are not on the National Essential Drug List.

- 2nd postnatal care visit is not covered by NHIS.

### **Health Information Management System**

The bottlenecks include the following:

- Essential newborn indicators not covered by DHIMS2.
- Poor timeliness and completeness of data capture.
- Not all private facilities are included.
- Data collection tools used by some private facilities are not in synchrony with DHIMS2 format.

### **Medical Products and Technologies**

Challenges/bottlenecks in this area include the following:

- Although coordination mechanisms and the National Procurement Framework (ACT 663 2003) exist at national, regional and district levels, there is inadequate demand from care providers and inappropriate purchase of essential newborn commodities according to the opinion of participants in the bottleneck analysis workshop on newborn health.
- Inadequate supply of essential newborn equipment, medicines and other commodities.

### **Community Beliefs, Practices, Ownership and Partnership**

Some of the challenges related to these areas are noted below:

- Inappropriate community beliefs, attitudes and practices negatively affect uptake of newborn and other services.
- Significant delays in care seeking for ill newborns occur in Ghana.
- Barriers to prompt allopathic care seeking include sequential care-seeking practices, with often-exclusive use of traditional medicine as first-line treatment for 7 days; previous negative experiences with health service facilities; financial constraints and remoteness from health facilities.
- Despite widespread recognition of danger signs and reported intentions to treat ill infants through the formal health care system, traditional approaches to perinatal illness remain common.
- Health care decisions regarding infant care are often influenced by community members other than the infant's mother, and confidence in health care providers is issue-specific.

There is a widespread understanding in rural northern Ghana of the need for clean delivery to reduce the risk of infection to both mothers and their babies during and shortly after delivery. Despite this understanding, many activities to do with cord care involve unclean materials and practices.

### **Findings**

With reference to the questions originally posed by Financing for Development, we can draw the following conclusions for Ghana:

#### *Is there a problem?*

A number of issues exist in Ghana that prevent effective procurement of MNCH commodities, including limited overall funding to the health sector, inadequate and irregular financial resource flow resulting in donor dependency, and delayed reimbursement by the National Health Insurance Scheme (NHIS).

#### *What causes the problem?*

Based upon the review of existing literature we can conclude that the major causes of the issues identified are a lack of priority for MNCH commodities, inappropriate community and cultural attitudes towards some forms of MNCH care, inadequate procurement and supply chain systems in place.

## **Nigeria**

### **Background**

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

Nigeria has three tiers of government: the federal government (the supreme administrative unit of the country), state governments (the administrative unit in charge of each state), and local governments that have jurisdiction over specific areas within a state. Health care provision in Nigeria is a concurrent responsibility of these three tiers. The federal, state, and local governments have broad responsibilities for tertiary, secondary and primary health care, respectively. The concurrent nature of these obligations sometimes leads to overlaps and/or gaps in service provision.

The federal government, through the FMOH, provides policy guidance and technical assistance to the 36 states and the Capital Territory (Abuja), and coordinates state efforts toward achievement of the goals set in the national health policy. The FMOH monitors and evaluates the implementation of the national health policy, and has direct operational responsibility for training medical doctors; operating teaching, psychiatric and orthopedic hospitals; monitoring and controlling contagious and communicable diseases; and ensuring adequate availability of vaccines and essential drugs. Formal linkage between the FMOH and the SMOHs is through the National Council of Health, which the Federal Minister of Health chairs; it comprises all state commissioners of health. This council meets once a quarter to discuss national health concerns.

Despite a considerable investment in the health sector over the years, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system, which is characterized by inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, negative attitude of health care providers, weak referral systems, poor coverage of high-impact cost-effective interventions, unavailability of essential drugs and other health commodities, lack of integration, and poor supportive supervision.

Consequently, the health care system cannot provide basic, cost-effective services for preventing and managing common health problems, especially at the Local Government Area (LGA) and ward levels. The Essential Drugs Program, including the first national essential drug list in the country, was developed in 1988, after the 1987 Bamako Initiative, which sought to strengthen primary health care (PHC) by ensuring sustainable quality drug supply systems. In Nigeria, this was reinvigorated in all LGAs in 1998, under the Petroleum Trust Fund. These initiatives are now ineffective because the commitment to establish systemic procurement systems for health commodities was weak. This resulted in a loss of confidence and decreased use of public sector health facilities because of the drug stockouts.

One consequence of a lack of trust in public health facilities is the proliferation of patent medicine vendors and drug hawkers who compound the problem of irrational drug use. The market is filled with substandard and fake drugs. In recent years, however, confidence has been growing for the drug regulatory framework, which is operated by the National Agency for Food and Drug Administration and Control (NAFDAC). A significant, concerted effort is required to address the weak and fragmented logistics and supply chain system for drugs and health commodities in the country.

### **Population Growth**

According to projections from the 2006 Population and Housing Census, Nigeria will have a population of 175,074,668 by the end of 2013 with 36,765,680 being women of reproductive age (15-49 years) and 8,573,402 expected pregnant women per year. The total fertility rate (TFR) is 5.7 children per woman; the contraceptive prevalence rate for modern methods of contraceptives is 10 percent and unmet need for family planning is 20 percent (NDHS 2008).

With an estimated 545 maternal deaths for every 100,000 live births in 2008, according to some estimates, Nigeria contributes about 10 percent of global burden of maternal deaths with about 33,000 Nigerian women dying from pregnancy-related causes. The obstetric causes of maternal mortality in Nigeria are well documented, and these are largely preventable. They include hemorrhage (23 percent), obstructed labor (11 percent), septicemia/puerperal infection (11 percent), anemia in pregnancy (11 percent), complicated/unsafe abortion (11 percent), malaria in pregnancy (11 percent), others (11 percent) and eclampsia (5 percent).

According to the 2008 NDHS, total deliveries by skilled birth attendants is 39 percent, and the institutional delivery rate is 35 percent, with 20 percent occurring in public facilities and 15 percent in private facilities. There are also contextual factors that significantly contribute to maternal mortality, including lack of health facilities that provide emergency obstetrics care services, limited proximity to care and transportation, and insufficient support from the male partners.

Studies have shown disparities within and between states and regions in Nigeria. In the southern region of the Nigeria, which is predominately urban and more densely populated, a majority of women receive antenatal care, deliver in health facilities and are attended to by a skilled birth attendant. In contrast, the northern region of the country, where a majority of families are from, the lowest national wealth quintile do not receive antenatal care and deliver at home with a traditional birth attendant. There are still problems in promoting awareness for contraception as many women lack the knowledge about how to avoid unwanted pregnancies, which can lead to unsafe abortions. For example, according to the Gender in Nigeria Report 2012, 94 percent of 15-24 year olds in Kebbi State have no knowledge of contraceptives.

Existing national plans, guidelines, policies and standards include: the National Strategic Health Development Plan (NSHDP), the costed Reproductive Health Commodity Security (RHCS) Strategic Plan 2011–2015 including a 5-year forecast, and the Reproductive Health Policy.

### **Funding Gaps**

When looking at the Nigerian context, evidence from existing literature demonstrates clear issues of funding gaps, which in turn can result in stockouts and also poor quality of commodities. 'Nigeria's Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children' builds on the analyses and 10 recommendations of the UN Commission, applying its recommendations to each of the prioritized life-saving commodities identified by RMNCH stakeholders in the country.<sup>10</sup>

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<sup>10</sup> Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children, Federal Democratic Public of Nigeria, (June 2013).

**Figure 20: Nigeria's current commitments and estimated gap: child health commodities<sup>11</sup>**

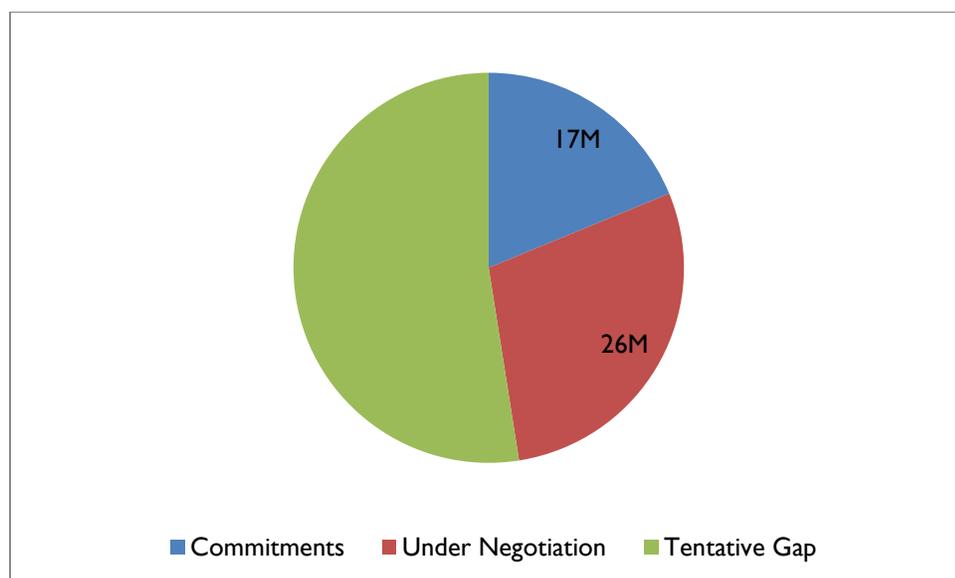


Figure 20 demonstrates the funding need for Child Health Commodities, 2012–2015 in Nigeria. To date, over US\$ 17 million has been committed in support of the National Essential Medicines Scale-Up Plan, and an additional US\$26 million is under negotiation with three additional donors. However, gaps in implementation for high-burden states still exist. While several development partners have committed to adding targeted zinc/ORS activities into existing programs in the northwest, few of these high-burden states have plans to roll out the comprehensive package of scale-up interventions called for in the National Essential Medicines Scale-Up Plan.

Specific issues faced in Nigeria, as highlighted within the Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children, Nigeria (2013):

### ***Budgeting and Financing***

On the whole, efforts to improve access to maternal health services rely heavily on donor contributions. However, these investments are fragmented, and essential commodities do not appear to be priorities in either broader commodities-related efforts or maternal health-specific programming.

Most funds for essential commodities are applied to vertical, disease specific programs. As of 2010, there were at least 12 different donors involved in procuring supplies such as vaccines, contraceptives, HIV/AIDS treatments in Nigeria. Additionally, funding from donors to advance maternal health efforts are often components of broader health systems strengthening efforts rather than specifically targeted for interventions such as commodities.

Maternal health funds also are utilized for specific projects managed by NGOs, but there is no comprehensive information on how much money is allocated to NGOs or how much of it goes to purchase maternal health commodities through these organizations. This arrangement creates a gap in knowledge—and likely a gap in investment—around maternal health commodities.

### ***State and Local Budgets***

It seems clear that state level financing for commodities—whether included as explicit budget lines or folded into other areas—varies enormously in amount, and, without a national procurement plan or

<sup>11</sup> Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children, Federal Democratic Public of Nigeria, (June 2013).

other strong guidance, even the highest-spending states likely fall short of what is needed. As one in-country informant noted, some state governors have been willing to purchase medicines, but this is still “unreliable, episodic, and frequently makes little sense,” with little effort to determine what medicines are needed and in what quantity.

### *Out-of-Pocket Spending*

As a result of low levels of public financing, most of the cost of maternal health commodities, as well as health services in general, is covered by out-of-pocket spending, posing a major barrier to access. There is some evidence suggesting that such practices are very common in maternal health services in particular.

### **Procurement, Distribution & Storage**

Procurement and management of health supplies commodities is almost exclusively funded through international donor initiatives related to specific diseases and health areas. As a result, supply chains are managed more or less independently and access to a particular commodity appears to be determined by very specific investments by very specific donors, rather than as part of an integrated or coordinated approach that spans health issues or institutions. The government appears to be aware of the problems that accompany this arrangement, as the NSHDP acknowledges that supply chains managed by the government are weak. It states, “Poor commitment to the establishment of systemic procurement systems for health commodities resulting in loss of confidence and decreased utilization of public sector health facilities due to medicine stockouts.” Yet there is little evidence regarding what efforts are being made to remedy this situation across commodities, and there appear to be no plans by donors or government agencies to improve logistics and procurement processes for maternal health commodities specifically.

Nigeria’s National Drug Policy, which was last updated in 2005, lays out a number of good practices for the procurement of essential medicines. However, it appears that this policy has little impact on actual practice. For example, legally, the Federal Medical Store (FMS) has primary responsibility for managing procurement of all commodities included on the EML. However, there is little evidence that either donors or the federal government follow this policy. Instead, the FMS does not handle essential medicines, and, rather than taking part in managing procurement processes, acts only as a storage “depot” for donors’ supplies. Perhaps more importantly, there appears to be *no* national procurement plan, so not only do various donors procure supplies based on their own timeframes, but various government bodies do too, and there is little to suggest that these groups communicate regarding storage needs or distribution schedules for a given storage facility at a given time.

Based on what can be inferred from information on other items on the EML that are not managed by donors, procurement practices for essential maternal health commodities are decentralized. The State Medical Stores act as the most central sites in the supply chain. It appears that most facilities are expected to place orders for supplies as they are required, rather than according to a set schedule. Stockouts at the State Medical Stores appear to be common, and distribution is frequently delayed, a fact which compromises the as-needed system of ordering supplies. There is also some doubt as to whether even these stores even function as integral parts of supply chains. Informants seemed to agree that state governments are rarely involved in procurement, and there is evidence to suggest that facilities are most often left to fend for themselves, even though many lack copies of critical guidance, such as the EML and rarely use stock cards or other record-keeping systems to monitor supplies.

There is little specific information on supply shortages or stockouts, and it does not appear that this information is monitored closely: the NSHDP notes that there are not even baseline data on status of stockouts across essential commodities in general, and it appears that the government assumes that the vast majority of facilities lack sufficient supplies. In fact, the NSHDP names achieving stockouts at 80 percent of facilities as a first target for efforts to reduce stockouts. However, questionnaire responses

during this study have indicated frequent stockouts occur for many of the 13 essential MNCH commodities, particularly oxytocin, misoprostol, magnesium sulfate, chlorhexidine, amoxicillin and ORS.

## **Findings**

With reference to the questions originally posed by Financing for Development, we can draw the following conclusions for Nigeria:

### *Is there a problem?*

Questionnaire responses during this study have indicated frequent stockouts occur for many of the 13 essential MNCH commodities, particularly oxytocin, misoprostol, magnesium sulfate, chlorhexidine, amoxicillin and ORS due to inadequate funding. As a result of low levels of public financing, most of the cost of maternal health commodities, as well as health services in general, is covered by out-of-pocket spending, posing a major barrier to access.

### *What causes the problem?*

The major reasons provided for the frequency of MNCH commodity stockouts are insufficient levels of funding for the procurement of the required products in the right quantity and quality, and one respondent from the National Primary Health Care Development Agency claimed, “The main issue is late release of funds and non-roll-over of budget to the following year.” Questionnaire respondents also highlighted the point that the funding cycle often mismatches procurement cycles leading to last-minute/emergency procurement and extra costs.

### *Would a working capital facility be an appropriate solution?*

Based upon discussions with in-country individuals and questionnaire responses, it appears there is an appetite for a working capital facility mechanism in Nigeria.

## **Liberia**

### **Background**

Liberia is Africa's oldest republic, but became known in the 1990s for its long-running, ruinous civil war and its role in a rebellion in neighboring Sierra Leone. Liberia's 14-year civil war ended in 2003 after destroying approximately 95 percent of the country's health care facilities. People were left with poor living conditions, little access to education and jobs, and facing multiple diseases. In 2008, Liberia had only one doctor and 27 nurses per 100,000 people.

### **Health**

Liberia has heavily relied on the international community for health infrastructure and aid. International relief organizations assisted the government to rebuild health facilities and provide essential health care for its citizens. The World Health Organization (WHO) donated equipment and helped provide and assist in vaccinating the population to prevent the spreading of many communicable diseases. The Global Alliance for Vaccines and Immunization (GAVI) funded US\$ 160 million to improve the health care system and increase the quality of immunization services in Liberia. Médecins Sans Frontières (MSF) helped Liberia by operating free hospitals immediately after the civil war and treated more than 20,000 women and children per year.

In response to the post-war health challenges, the Ministry of Health and Social Welfare, with assistance from donors and international NGOs, embarked on rebuilding the health system. The Ministry's first aim was to expand the provision of primary health care, particularly in rural areas that were underserved even before the war. The 2007 National Health Plan outlined a basic package of health services: essential health services that would be provided without charge at clinics and hospitals throughout the country, ranging from HIV testing to emergency obstetric care. The preventive and curative interventions in the basic package of health services target the disease burden in the country, particularly infectious disease and the high maternal and child morbidity and mortality. The Ministry partnered with a large group of

international and national NGOs to deliver a basic package of health services. Basic packages of health services implemented with support from international and national NGOs have been used to jump-start the rebuilding of the health system in other post-conflict countries such as Afghanistan and Sierra Leone, where they have been credited with increasing the utilization of health services and reducing mortality and morbidity. In 2009, government expenditure on health care per capita was US\$ 22, accounting for 10.6 percent of total GDP.

Liberia has made astounding progress as it has achieved reductions in under-5 mortality of at least two thirds since 1990. The country has made history in becoming the first sub-Saharan country to achieve MDG 4, despite only recently emerging from 14 years of civil war that devastated the country's infrastructure on all fronts. The MMR was 640 deaths per 100,000 live births in 2013, which is a significant reduction from 990 in 2007-2012 and almost halved since 1990.

However, this is still behind the target of 300 by 2015. Poor infrastructure and urban-rural and education disparities are key factors which limit interventions to reducing maternal deaths. A Rapid Maternal Needs Assessment conducted for the draft Operational Plan to Reduce Maternal and Neonatal Mortality reveals that maternal mortality is affected by inadequate facilities, equipment and drug supplies; health workers' inability to perform essential procedures; lack of adequate transport system; and lack of alignment between traditional practices and standard of care. The fertility rate is currently 4.9, indicating a substantial reduction since 1986 from 6.2 in 1999-2000 and 6.6 in 1986.

Achieving universal access to reproductive health provides the enabling environment for long-term successes in childbearing, development and adulthood. Addressing factors that impede universal access to reproductive health is paramount. Access increases quality of life and reduces economic dependency related to and reinforcement of the demographic (poverty) gap where low standards of living lead to high fertility rates leading to lower standards of living. Policies should include a range of reproductive health methods and culturally sensitive outreach and awareness on the importance and application of family planning, prenatal and antenatal care.

Malaria, which is endemic in Liberia, is a major cause of morbidity and an important contributor to under-5 mortality. In 2006, one-third of the population had at least one episode of the disease and an estimated 6,000 children died from its complications. Mental health problems related to war trauma and exacerbated by dislocation are also a pressing concern. A 2008 survey found that 40 percent of the population had self-reported symptoms indicative of major depression and 44 percent probably had post-traumatic stress disorder.

## **Findings**

With reference to the questions originally posed in the SOW, we can draw the following conclusions for Liberia:

### *Is there a problem?*

Based upon the review of existing literature and a completed questionnaire from the Ministry of Health, the major issue faced in Liberia is that of supply and the frequency of stockouts. However, the government is not actively involved in the procurement of MNCH commodities; this is completely done by donors.

### *Would a working capital facility be an appropriate solution?*

With no government involvement in the procurement of MNCH commodities in Liberia, it is difficult to gauge whether such a mechanism would be of any great use. However, a respondent from the Ministry of Health expressed an opinion that it would be an appropriate solution in order to sustainably improve the largely inadequate in-country supply chain systems.

## Mozambique

### Background

*Note that there may be some discrepancies between responses collected in the initial surveys and the conclusions reached, because additional information gathered during face-to-face interviews sometimes clarified those initial responses and led to different answers than originally given.*

Mozambique has undergone substantial developmental growth and change since achieving independence from Portugal in 1975, despite the disturbance caused by civil war, economic mismanagement and famine. A peace deal in 1992 ended 16 years of civil war, and the country has made much progress in economic development and political stability. Mozambique has emerged as one of the world's fastest growing economies, with foreign investors showing interest in the country's untapped oil and gas reserves. However, despite Mozambique's economic growth at an annual rate of 8 percent and rapid economic expansion over the past twenty years, Mozambique is still one of the poorest countries in the world. The geographical distribution of poverty remains largely unchanged, with more than 50 percent of Mozambicans living on less than one US dollar per day.

### Health

After its independence in 1975, the Mozambique government has made a commitment for health care reform and improvement in all health and human service sectors. The government established a primary health care system that was cited by the World Health Organization (WHO) as a model for other developing countries. However, the civil war led to a great setback in the primary health system in Mozambique.

### Health Sector Plan

A new Health Sector Strategic Plan 2014-2019 was approved following a comprehensive review of the previous Strategic Plan. The Sector Strategic Plan comprises of seven strategic objectives and is based on principles of primary health care, equity and better quality of services: Increase access and utilization of health services; improve quality of service provision; reduce geographic inequities and between different population groups in accessing and utilizing health services; improve efficiency of service provision and resource utilization; strengthen partnerships for health; increase transparency and accountability on management of public goods; and strengthen the health system.

### Health System

The health system is composed of the public, private for-profit and private non-profit sectors, with the public sector being the main health provider, although its network covers only about 60 percent of the population. Mozambique needs more investment in its health system structures and functions. Stronger support for the primary health care approach is essential for the success and sustainability of disease-specific programs. This should be followed by improvements in quality of care in every aspect of service delivery and at every level. Scaling up the health workforce and expansion of the health facility network will need to precede increased coverage and access to services.

The determinants of health related to nutrition and food security, access to safe water and sanitation, gender inequality, illiteracy and poverty reduction require recognition by decision makers and planners of the holistic nature of health issues and the importance of cross-sectoral cooperation. The human right to health envisages a more active involvement of local communities and requires reorientation in the approach of health professionals towards care seekers. Health promotion should be stepped up to inform and encourage communities to adopt healthy lifestyles.

The political and social landscape of Mozambique is changing for the better, but still the legacy of war and conflict is painfully evident as the nation strives to reach the MDGs. To achieve the targets for the reduction of child mortality, which form MDG 4, Mozambique's plan is to reduce under-5 deaths per

1,000 live births to 78, and increase measles immunization to 100 percent by 2015. The under-5 mortality rate in Mozambique has declined steadily since 1990. However, it has not yet reached the country's target; under-5 mortality stood at 90 deaths per 1,000 live births, and measles immunization at 82 percent. The most prominent cause of death for children below the age of 5 years was malaria, which accounted for 19 percent of deaths. Other contributory causes to under-5 mortality were pneumonia, prematurity and diarrhea. Mozambique's MMR is one of the highest at 480 deaths per 100,000 live births. Significant progress has been made, with an average annual decrease in the MMR of 3.1 percent, from almost 1,000 per 100,000 live births in 1990. However, the overall rate of decrease will need to improve dramatically if Mozambique is to achieve its target of 228 cases per 100,000 live births. Part of the goal also stipulates that 100 percent of births must be attended by a skilled health professional. In the period 2007-2012 this figure stood at 55 percent, so progress towards this target is currently off track.

## **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for Mozambique:

### *Is there a problem?*

Based on the review of existing literature and a questionnaire response from the Ministry of Health, the major issues identified are the occasional stockouts of each of the 13 essential RMNCH commodities, as well as a lack of access to IPAs.

### *What causes the problem?*

Based upon the review of existing literature and discussions with individuals based in country, it appears that the major causes of the issues identified are insufficient levels of overall funding for the procurement of required RMNCH commodities, overly bureaucratic procurement procedures, and the inability to pay IPAs in advance.

### *Would a working capital facility be an appropriate solution?*

Based upon discussions with individuals based in-country and questionnaire responses, it appears there is an interest in a working capital facility in Mozambique.

## **Malawi**

### **Country Background**

The Malawi Growth and Development Strategy II (2011-2016) is the overarching medium-term strategy designed to attain Malawi's long-term aspirations as presented in the Vision 20:20. The MGDS II is built around six broad thematic areas: Sustainable Economic Growth; Social Development; Social Support and Disaster Risk Management; Infrastructure and Improved Governance; and Cross Cutting Issues. The National Health Bill is under review to replace the Public Health Act of 1948, while the National Health Policy is still in draft form.

The Health Sector Strategic Plan (HSSP) 2011-2016 is aligned with the MDGs and guides the implementation of health interventions. The HSSP emphasizes increasing coverage of high-quality Essential Health Package (EHP) services and strengthening performance of the health systems to improve equity, efficiency and quality of EHP services in Malawi. The health care delivery system mainly consists of government facilities (63 percent), Christian Health Association of Malawi (26 percent) and some private for-profit providers.

Malawi is developing a health financing strategy to help in improving the funding available for health and move towards universal health coverage. As part of resource tracking, the government has been conducting National Health Accounts (NHA) assessments since 1998. WHO provides support for the NHA. In order to strengthen timely reporting and use of data at all levels, the country introduced a

web-based District Health Information System (DHIS2) in 2011. This is expected to strengthen monitoring of the disease burden in the country.

Some of the notable challenges in the health care delivery system pertain to inadequate human resources coupled with skewed distribution favoring the urban areas. Despite the 50 percent increase in the health workforce that was achieved through the implementation of the 6-year Emergency Human Resources Plan (2005-2010), challenges still remain in sustaining the gains, and there continue to be inadequate financing, infrastructure and equipment.

Maternal mortality in Malawi is among the highest in Africa, at 807 women per 100,000 live births, with 25 percent of these due to post-partum hemorrhage. Obstetric complications contribute significantly to maternal deaths. Where women in Malawi are giving birth at home, TBAs have no resources to stop excessive bleeding in the case of complications, and women are often brought to a medical facility when it is too late to be given medical help. Other indirect causes include delays in seeking care, poor referral system, and lack of appropriate drugs, equipment and staff capacity. Despite significant progress towards achieving MDG 4 neonatal mortality still remains high.

The risk to children is also great. According to the WHO, of all the reasons for death in children under 5 in Malawi, 7 percent is due to birth asphyxia, and 5 percent is due to neonatal sepsis. Only 3 percent of births are by C-section in Malawi: 4.4 percent in urban areas, and just 2.9 percent in rural areas.

Malawi has made remarkable progress to reduce UMR from 189/1,000 live births in 2000 to 112 in 2010; however newborn mortality has remained stagnant at 31/1,000 due to lack of progress to prevention of premature births (Malawi at 18 percent has the highest rate in the world) and virtual lack of treatment of neonatal sepsis at primary health care level.

Malawi is off track on reduction of its maternal mortality ratio (DHS 2010 estimate is 675/100,000 live births against the 2015 target of 155/100 000 live births). This is due to poor access to basic emergency obstetric and neonatal care (BEMONC), with the 2010 EMONC survey revealing that only 2 percent of BEMONC facilities are functioning as per MOH standards of quality care and 43 percent of women accessing postnatal care (DHS 2010).

Frequent stockouts of essential and life-saving medicines and commodities have been a critical factor hampering RMNCH service delivery since 2010, and as almost 51 percent of households live below the poverty line (2012 Malawi MDG Report by MoEPD), families don't want to risk spending their scarce resources travelling to seek care when it is common knowledge that health facilities have no drugs.

The critical shortages of essential medicines and commodities have multiple root causes, which are severely impacting access to and quality of RMNCH service delivery in all districts of Malawi. Notable reasons include:

- Poor evidence-based quantification, procurement planning and management of RMNCH products impeding adequate gap analysis and resource mobilization, specifically due to weak LMIS;
- Multiple uncoordinated supply chains for health commodities, which overload operational level teams and undermine timely action to maintain uninterrupted supply of essential and lifesaving RMNCH commodities;
- Inadequate funding for essential and life-saving RMNCH medicines and medical commodities compounded by limited ring-fencing mechanisms of the drug budgets for RMNCH at central and district levels;

- Lack of updated EML and treatment guidelines that incorporate the full essential and lifesaving RMNCH commodities coupled with poor adherence to existing guidelines;
- Limited capacity for quality assurance and poor pharmacovigilance program.

### **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for Malawi:

#### Is there a problem?

Stockouts of essential MNCH commodities, coupled with limited capacity for quality assurance are the major issues faced in Malawi.

#### What causes the problem?

Based upon the review of existing literature, severe levels of stockouts can be attributed to various causes, such as inadequate overall funding for RMNCH, delays in funding for RMNCH commodities, weak and uncoordinated supply chains and poor quantification and procurement planning.

## **Mali**

### **Background**

Between March 2012 and September 2014, Mali has undergone exceptional socio-political turmoil following a coup that impacted the health sector. According to the National Action Plan of Family Planning of Mali 2014-2018, the country has high rates of maternal mortality (368 per 100,000 live births), neonatal mortality (35 percent) and infantile and infant-juvenile mortality (58 percent and 98 percent respectively). The Government of Mali has committed to improve the situation for mothers, newborns and children under 5 through a number of initiatives. Like other African countries, Mali has elaborated a *feuille de route pour l'accélération de la réduction de la mortalité maternelle et néonatale* (national roadmap to accelerate reduction of neonatal and maternal mortality) in order to achieve the MDGs related to mothers and newborns. In addition, the objective of reducing maternal, neonatal, infantile and infant-juvenile morbidity and mortality is the first strategic objective of the new socio-health development program for the period 2014-2018.

### **Health System Challenges**

The new socio-health development program for the period 2014-2018 highlights a number of health supply chain challenges, including the pricing of medicines in public health structures, which jeopardizes financial access to health care. In addition, the reference document underlines the supply/re-supply difficulties of the Central Medical Stores (CMS). Delays in the payments of its invoices by the government undermine value for money for essential medicines procurement. Called *Pharmacie Populaire du Mali* (PPM), the CMS is responsible for buying essential medicines for the country. The government payment procedure for PPM's medicine purchases starts after medicine delivery. With a low operating cash flow, PPM has difficulty following its procurement plan, which leads to stockouts at the different levels of the supply chain. The implementation of the free medicine policy is also a challenge for PPM, which faces even more financial constraints. The socio-health development program for the period 2014-2018 also highlights the inexistence of a concerted plan to track the quality of medicines throughout the territory.

### **Health Financing**

The reference document underlines how health spending is split between actors: households contribute to 60 percent of health expenditures, decentralized communities 6 percent, donors 13 percent and the government 17 percent. The purchase of medicines represents more than  $\frac{3}{4}$  of households' direct spending related to health and most of the purchase is made outside health facilities in the event of auto-

medication or prescriptions from pharmacies which are out of stocks (*Banque Mondiale, La Problématique de la Santé et de la Pauvreté au Mali Volume 1, 2011*).

## **Madagascar**

### **Background**

In 2010, the population of Madagascar was estimated to 20 million inhabitants with a 2.8 percent annual rate of growth. The poverty rate was 76.5 percent, with the poverty situation exacerbated in rural areas.

Economic and political turmoil in the country in 2009 resulted in a decrease in the government budget allocated to the health sector.

In 2011 the government adopted the Global Strategy on Women's and Children's Health of the UN Secretary-General and developed an operational plan for 2012-2015. At this time, while the country has made progress on child and neonatal health, the MMR has remained problematic. In December 2014, the government and its partners signed the “*Feuille de route pour l'accélération de la réduction de la mortalité maternelle et néonatale*” for the period 2015-2019 (roadmap for the acceleration of maternal and neonatal mortality reduction) following the initial roadmap for the period 2005-2015. The objective of this updated reference document is to reduce the maternal mortality rate from 478 to 369 per 100,000 live births and the neonatal mortality rate from 26 to 21 per 1,000 live births.

### **Health System Challenges**

Desk research on the health supply chain in Madagascar suggests that SALAME, the Central Medical Stores of the country (a parastatal not-for-profit organization) has financial difficulties. SALAME is responsible for purchasing essential medicines and other strategic products and to supply all the health structures of the country. As in other African countries, SALAME's financial viability relies on the overall cost recovery system of the public health supply chain. With little external support, SALAME revenues come mainly from the sale of medicines. In November 2013, UNICEF reported that with its low operating capital, SALAME had difficulties in procuring products, could not purchase the necessary quantities of medicines to avoid stockouts, and did not have access to quality pharmaceutical firms because of its bad credit history.

### **Health Financing**

In order to improve maternal, neonatal and children health, the government of Madagascar has undertaken a number of initiatives in the past several years. Between 2009 and 2011, the Ministry of Health has increased the budget for the maternal and child survival program from 3 percent to 13.3 percent. In 2012, the general government expenditure on health as percentage of total government expenditure was 13 percent (2014 report of “*Fulfilling the Health Agenda for Women and Children*”).

### **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for Madagascar:

#### *Is there a problem?*

Based upon the review of existing literature and a completed questionnaire from the Ministry of Health, the major issues faced in Madagascar are poor quantification and forecasting, and long bureaucratic procurement processes, resulting in frequent stockouts.

#### *What causes the problem?*

The information in the available literature and on the questionnaire responses suggests that the availability of funding from government budgets is limited for the procurement of RMNCH commodities, with no linkages between procurement planning and budget formulation.

### Would a working capital facility be an appropriate solution?

Feedback from the respondent to the questionnaire suggests that a working capital facility that bridges the funding gap would improve the quality, cost and timing of the procurement of RMNCH commodities in Madagascar.

## **Senegal**

### **Background**

According to the last DHS with multiple indicators (2010-2011), Senegal has made progress towards maternal, neonatal and child health during the 2005-2010 period. Infant-juvenile mortality went from 121 percent to 72 percent and neonatal death from 35 percent to 29 percent. However during the same period maternal mortality decreased slowly, from 401/100,000 live births in 2005 to 392/100,000 in 2010. Significant progress still needs to be made to achieve the target of 200/100,000 live births for 2015.

The commitment of the government toward maternal, child and neonatal health is high, as demonstrated by a number of national health strategic documents that target these specific groups of the population. The first objective of the Plan National de Développement Sanitaire 2009-2018 (The health national development plan—the reference document of the health sector) is to “reduce the burden of maternal and infant-juvenile morbidity and mortality,” and the first of the eleven strategies is to “accelerate the fight against maternal, neonatal and infant-juvenile mortality.” Other reference documents include the multi-sector roadmap to accelerate maternal and neonatal morbidity and mortality reduction, the national strategy for child survival and the strategic plan for securing reproductive health products. There is also the presidential initiative called the Bajenu Gox program, the main objective of which is to increase the use of health services by children aged 0-5 and women during pregnancy, childbirth and post-partum.

### **Health System Challenges**

Senegal has committed to the United Commission on Life Saving Commodities for Women and Children and has drafted an action plan: *Sécurisation des produits indispensables à la santé de la mère et à la survie de l'enfant* (securing products paramount to maternal health and child survival). The most frequent barriers within the health system highlighted by this plan are fees linked to health services' use, the availability and cost of medicines and quality of care. Senegal has added three products to the list, with a total of 16 products important for maternal, child and neonatal health. Among health supply chain bottlenecks, the plan has identified quantification, distribution and price, and financial access as the main issues in Senegal. While during the first year of the plan (2013), procurement was made by international donors, the *Pharmacie Nationale d'Approvisionnement* (PNA—the CMS) was supposed to take over from year two. The funding for medicines in Senegal is based on a cost recovery system whereby the selling of products allows in turn the buying of products. PNA currently pre-finances orders (before costs are fully recovered by its clients), which means that a working capital facility would likely facilitate payments to suppliers.

### **Health Financing**

The Senegalese government's commitment to health is reflected in its budget allocations. As an example, until 2006, the Senegalese government has been the main funding source of the health sector in the implementation of its National Health Development Plan, with 51 percent of its funding. According to Fulfilling the Health Agenda for Women and Children-The 2014 Report, general government expenditure on health as a percentage of total government expenditure was 10 percent in 2012, which is still below the 15 percent of the Alma Ata Declaration but encouraging. There is also a budget line allocated to RMNCH commodities.

## **ASIA/MIDDLE EAST REGION**

### **Afghanistan**

#### **Background**

Afghanistan is a mountainous, landlocked country in South-Central Asia that has suffered from chronic instability and conflict during its modern history. Its economy and infrastructure are in ruins, and many of its people are refugees. Currently, different parts of the country are at different stages of insecurity—some parts are post-conflict, others are still in-conflict, and others experience periodic conflict. More than half of the country's 30 million people live in abject poverty, and the average life expectancy is estimated to be around 60 years for both sexes, according to the WHO.

#### **Health**

Afghanistan's health sector needs to recover from decades of neglect, under-funding, institutional vacuum and fragmentation. At the end of the conflict, what was left of the health system was characterized by: inadequate infrastructures with dilapidated facilities unevenly distributed across the country; impaired access to health services due to difficult communications and poor security; chronic shortage of skilled health providers (especially female providers); poor information systems; and weak implementation of the newly approved national health policy. This situation resulted in inefficient coverage and health services delivery, and NGOs working to some extent independently from national structures.

Afghanistan's health status is one of the worst in the world. Almost half of all deaths of women in the reproductive age bracket (15-49 years) in the country result from complications during pregnancy and childbirth. Nine out of ten births take place at home without the assistance of an educated health care worker. Furthermore, the country has the ninth highest total fertility rate in the world, at 5.14 children born per woman, according to the 2012 World Bank data. The fertility rate has declined from its original 6.2 base value in 2003; however the rate of 4.7 targeted for 2015 is not likely to be achievable. Harmful cultural practices such as early marriage—more than half of women get married before the age of 18—along with taboos against male physicians attending to women have exacerbated the country's maternal and infant mortality rates. Because of poor sanitation and insufficient potable water supply, infectious and parasitic diseases such as malaria and diarrhea are very common.

#### **Improvement in Health Services**

Strong political will and acknowledgment of maternal health as a health and development priority has led to improvements in both the quantity and quality of maternal health services. Over the last decade, the Ministry of Public Health, in a strong partnership with the international community, has made major progress in improving the health of Afghan mothers and children. National programs to improve the quality of, and increase access to, basic health services and essential hospital services, along with programs to increase the number of trained female providers including midwives, and improved community-based health care, contributed to these significant achievements. The implementation of the Basic Package of Health Service (BPHS) by the Ministry of Public Health is a new drive by the government in an effort to provide health care that would have the most cost-effective impact on common health problems. As the BPHS focuses on maternal and child health, the shortage of female health workers is a major problem. Around 40 percent of facilities are without female staff; hence to fill this gap, an intensive training of midwives has started. The country currently has more than 3,000 midwives, with an additional 300 to 400 being trained each year.

#### **Family Planning**

The 2010 Afghanistan Mortality Survey, the first population-based survey of its kind in Afghanistan, found that women's use of modern methods of family planning has doubled from 10 to 20 percent since 2003.

The maternal mortality ratio decreased from an estimated 1,600 deaths per 100,000 live births to 327 per 100,000 live births from its base year 2003. The MDG 5 target—MMR reduced to 320—is likely already achieved or will certainly be achieved by the end of 2015. The target for proportion of births attended by skilled birth attendants is likely already achieved, since over 40 percent of births are attended by skilled birth attendants relative to the 6 percent that was recorded for base year 2003. Under-5 mortality declined from a previous estimate of 172 to 97 deaths per 1,000 live births, and infant mortality decreased from an estimated 115 to 77 deaths per 1,000 live births. The Ministry of Public Health plans to cut the infant mortality rate to 400 for every 100,000 live births before 2020.

According to a 2012 report by Save the Children, improved health care and the rise of females attending school have made Afghanistan climb up from its position as the worst place on earth to be a mother. “More mothers are surviving and fewer children are dying and this is something we need to be celebrating,” said Rachel Maranto, Advocacy and Mobilization Senior Manager at Save the Children in Kabul. However, despite the known risks of childbearing and the increase in supply of services, maternal health care service is still limited, and the quality of services can be low as a result of service delivery capacity, particularly among the most difficult to access rural areas. Sima Ayubi, a maternity doctor in Kabul who advocates hospital births explains: “Now pregnant women have more information about health. This mortality rate is still a problem. There's just a decrease. The problem is not completely eliminated or under control.”

### **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for Afghanistan:

#### *Is there a problem?*

Based upon a review of existing literature and responses to the questionnaire, the major issues in Afghanistan appear to be issues with lack of access of the government to IPAs and to quality-assured RMNCH commodities at competitive prices.

#### *What causes the problem?*

Based upon the review of existing literature and responses to the questionnaire, the following reasons have been given for the issues faced: occasional delays in the release of funds for RMNCH commodity procurement, limiting access to IPAs, underdeveloped local market, and overly bureaucratic procurement processes. According to information provided in the questionnaire, more emphasis is put on gaining a better price than assuring the quality of the products procured.

#### *Would a working capital facility be an appropriate solution?*

The questionnaire response from the Ministry of Health suggested that there would be an appetite for a working capital facility mechanism in order to ensure price and quality for RMNCH commodities by improved access to IPAs.

## **Bangladesh**

### **Background**

Bangladesh is one of the world's most densely populated countries, and the world's eighth-most populous country, with over 160 million people. Poverty is deep and widespread, but the country is undergoing considerable social and economic changes and has reduced population growth and has improved health and education in recent years. Some economists see it as one of the “Next Eleven” tier of developing countries with potential for significant foreign-investment-led growth. Bangladesh's population is relatively young, with only 4 percent being over 65 years of age or older. However, this is expected to change, with the proportion of over 65 years of age or older rising to 6.6 percent by 2025.

## Health

Bangladesh has made substantial progress since the 1970s in expanding the coverage of health care services to its population. The country has already met several targets of the MDGs, including under-5 mortality rate reduction, and has made remarkable progress in the areas of poverty reduction and lowering the infant mortality rate and maternal mortality ratio.

According to Bangladesh Maternal Mortality Survey (BMMS), maternal mortality declined from 322 in 2001 to 194 in 2010, a 40 percent decline in nine years. The average rate of decline from the base year has been about 3.3 percent per year, compared with the average annual rate of reduction of 3.0 percent required for achieving the MDG 5 in 2015. The BMMS 2001 and 2010 show that overall mortality among women in the reproductive ages has consistently declined during these nine years. One in eight women receives delivery care from medically trained providers and fewer than half of all pregnant women in Bangladesh seek antenatal care. Inequity in maternity care would be significantly reduced by ensuring the accessibility of health services.

A very successful family planning program and the remarkable progress in expanding child immunization coverage have helped reduce child mortality in Bangladesh. Different NGOs and private clinic/hospitals, especially in urban areas, played a vital role for the higher decline in urban areas than in rural areas. However, challenges still remain, as there are higher neonatal mortality rates, higher child malnutrition, and differences regarding mortality by sex, division and residence in Bangladesh. Most mothers give birth outside of health care facilities, and many sick children do not receive appropriate medical care. For many health conditions, treatment by qualified providers, based in adequately equipped health care facilities using effective treatments, is critical to improving health outcomes and reducing mortality. Further improvements in MNCH, as well as overall health outcomes, require that Bangladesh increase access to services, which implies both additional financial investments and greater efficiency in the delivery and management of health care services.

MNCH care is obtained in Bangladesh from three major types of providers: (i) the government, principally Ministry of Health and Family Welfare (MoHFW), health care facilities; (ii) private practitioners and institutions, including nongovernment organization providers and traditional birth attendants; and (iii) pharmacies and medicines retailers, which sell medicines to households. The government almost exclusively finances the first category of providers, and household out-of-pocket spending almost entirely the last two categories, since third-party and insurance financing in Bangladesh is minimal. In addressing the need for greater financing and provision of services, a critical aspect of the situation in Bangladesh is the extensive role of private financing and provision of services. Private financing, mostly household out-of-pocket spending, accounts for 67 percent of national health expenditures and household out-of-pocket spend also accounts for the largest share of financing of MNCH services. Most of this private spending finances the provision of care by private providers, with the bulk of spending going to private pharmacies and medicines retailers, and the rest going to a diverse range of medical providers, including traditional birth attendants, unqualified medical practitioners, physicians' clinics and private hospitals.

Assessing and measuring the respective roles of private and public financing of MNCH care is a critical step in identifying and understanding the impact of out-of-pocket MNCH spending on households as well as the potential need for and role of public financing. Although Bangladesh has relatively good statistics on the public-private mix in financing and the public-private mix in provision of key MNCH services, from the Bangladesh national health accounts and the Bangladesh DHS, detailed information on how MNCH care is financed is not available.

Bangladesh's achievement in child mortality is optimistic, especially in infant and under-5 mortality, but immunization is yet to achieve universal coverage, as it is needed to achieve MDG 4. To improve the health of children further, some issues, such as lower use of maternal health care services, hazardous

environmental effects on childhood illness, low use of health care for children, and strategies lacking area-wide focus on child mortality need to be considered. Newborns should be given the highest priority so that neonatal deaths contribute more to the reduction of under-5 mortality in this country. Management of financial support from inside and outside the country should also be ensured so that services provided to the neediest population, especially the rural poor, become smooth. With the right types of interventions, the achievement of MDG 4 and 5 may not be very difficult to achieve.

### ***Regulatory Issues in Bangladesh***

Bangladesh has well-developed policies to regulate production, distribution, sale and use of all drugs as well as to ensure that they are of good quality, efficacious and safe. All drugs, medicines and other mechanical substances in final dosage forms (those manufactured, imported, distributed, marketed, or consumed in the country) must be registered with the regulatory authority—the Directorate General of Drug Administration. The Directorate General of Drug Administration’s capacity seems to be logistically limited and lacks skilled manpower, while other regulatory factors including pharmaceutical companies’ individual operating procedures, quality control and quality assurance programs complicate regulatory issues.

### ***Registration and Commodity Availability***

In an analysis conducted by the Population Council, policymakers and program managers were found not to be aware of the UN Commission report or its recommendations. Stakeholders were generally aware from international and UN organizations and involved in actual implementation of the Commission’s recommendations. With the exception of the female condom, each of the 13 life-saving commodities is registered and available in Bangladesh. Not all of maternal and neonatal commodities are registered in the dosage forms recommended by the World Health Organization for their specified indications, nor do service delivery guidelines provide indications for their use.

Other findings were that availability and shortages of the commodities need to be addressed. Oxytocin and misoprostol were not available in two out of three district hospitals visited but were available in all Mother and Child Welfare Centers. Similarly, misoprostol was not available in any Union Health and Family Welfare Centers or Community Clinics visited. Although oxytocin is available and used for induction of labor and preventing postpartum hemorrhage in most district and sub-district facilities (although not in community facilities), consistent lack of cold chain storage necessary for the drug’s integrity remains a significant challenge. Many government facilities and most private drug stores lack functioning refrigerators. Often oxytocin is stored on an open shelf, rendering it ineffective.

The female condom is not registered in Bangladesh, as policymakers and program managers consider it unsuitable for the local context.

### ***Logistics and Supply Ordering***

The findings from the study conducted by the Population Council found that centralized and decentralized procurement processes for commodities and logistics each exist within MoHFW. MoHFW follows the World Bank procedure for procuring drugs and commodities, through an open bidding process, whereby the lowest bidder is awarded the supply contract if it has the requisite qualifications and fulfills the specifications in the tender. Procurement is by two separate MoHFW systems.

### ***Manufacturing and Distribution***

Several domestic pharmaceutical manufacturers produce most of the 13 life-saving commodities; resuscitation devices, contraceptive implants and female condoms are the only products not manufactured locally. Contraceptive implants (IMPLANON) are imported from Organon, MSD, and Netherland, and are distributed by Janata Traders.

Resuscitation devices were donated by USAID through the Helping Babies Breathe program. Many companies do not manufacture hormonal preparations such as contraceptive pills or injectables—only one pharmaceutical company manufactures injectable contraceptives—but at least four companies produce ECPs. No pharmaceutical company produces chlorhexidine and antenatal corticosteroids in appropriate dose forms, although they have preparations in different dose forms for other indications. Only four local companies manufacture and market oxytocin, as its need for cold chain production and storage requires more specialized resources and skills.

The prices of local products are regulated by DGDA. Without DGDA approval, no pharmaceutical company can set a price for their drugs or commodities. Companies adhere to drug policy rules and regulations when setting their prices, which results in no excessive pricing differences for drugs produced by various domestic companies; drugs manufactured by foreign companies do not adhere to those pricing guidelines.

Pharmaceutical companies generally teach storage practices to drug distributors but not to drug stores themselves, which has resulted in deficient knowledge of correct product storage. Although there is no visible public-private partnership in pharmaceutical production, DGDA has expressed an interest in such efforts.

### **Financing**

It is government policy to supply all drugs and commodities (including FP commodities) free of cost to those securing services either at facilities or through doorstep delivery. In reality, service and drugs from facilities are not free of cost, with clients encountering considerable out-of-pocket expenses. They frequently must purchase drugs from private drug stores due to supply shortages or pay informal service fees.

Clients are charged for services within the private sector. NGOs charge subsidized rates. All interviewed respondents, workshop participants and public facility service providers mentioned that end users are not willing to pay for drugs and commodities, and the ultra-poor cannot pay for anything. Drug sellers, however, are of the opinion that, in terms of health expenditures and out-of-pocket expenses, the costs of MNH drugs and commodities on the open market are within most end users' reach. The respondents also mentioned that there must be a safety net provided for the ultra-poor. All respondents also felt that products should be included in conditional cash transfer coupons, vouchers, or other similar schemes, particularly the ongoing public sector maternal health voucher schemes.

### **Challenges Identified**

- Shortages of all essential drugs and commodities in public health facilities;
- Widespread inappropriate storage of oxytocin (and subsequent use of an ineffective drug during crucial medical events);
- Unavailability of antenatal corticosteroids in correct dosage forms (6 mg injection) for pre-term respiratory distress syndrome; unavailability of chlorhexidine in the correct concentration (7.1 percent) for newborn cord care; provider use of inappropriate concentration; and lack of related service delivery guidelines;
- Unavailability of magnesium sulfate in appropriate dose forms; manufacture of a single loading dose for severe pre-eclampsia and eclampsia is needed, but pharmaceutical companies lack interest;
- Lack of advocacy with pharmaceutical companies for manufacturing less profitable but essential drugs in appropriate dosage forms;
- Lack of awareness of emergency contraceptive pills due to lack of educational efforts;
- Lack of knowledge and low use of zinc sulfate for neonatal diarrhea;

- Absence of a Directorate General of Family Planning forum for advocating for mothers and ensuring access to and use of essential maternal health drugs and commodities.

## **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for Bangladesh:

### Is there a problem?

Based upon a review of existing literature and responses to the questionnaire, the major issues in Bangladesh appear to be access to quality RMNCH commodities, including the lack of public awareness and government commitment to improve the health outcomes of mother and child.

### What causes the problem?

Based upon the review of existing literature and responses to the questionnaire, access to IPAs would help address the quality issue.

### Would a working capital facility be an appropriate solution?

The questionnaire response from the Ministry of Health suggested that there is not a need for a working capital facility, as the government is capable of meeting the needs of their RMNCH requirements.

## **India**

### **Background**

India still spends only about 4.2 percent of its national GDP on health care goods and services. Additionally, there are wide gaps between the rural and urban populations in its health care system, which worsens the problem. Seventy percent of the population lives in rural areas and has no or limited access to hospitals and clinics. Consequently, the rural population mostly relies on alternative medicine and government programs in rural health clinics. One such government program is the National Urban Health Mission, which pays individuals for health care premiums, in partnership with various local private partners, which have proven ineffective to date.

In contrast, the urban centers have numerous private hospitals and clinics, which provide quality health care. These centers have better doctors, access to preventive medicine, and quality clinics, which are a result of better profitability for investors compared to the not-so-profitable rural areas.

### **Health Landscape**

Besides the rural-urban divide, another key driver of India's health care landscape is high out-of-pocket expenditure (roughly 70 percent of costs). According to the World Bank and National Commission's report on Macroeconomics, only 5 percent of Indians are covered by health insurance policies.

The Indian government plays an important role in running several safety net health insurance programs for the high-risk population and actively regulates the private insurance markets. Currently there are a handful of such programs, including the Community Health Insurance program for the population below the poverty line (similar to Medicaid in the United States) and Life Insurance Company (LIC) policy for senior citizens (similar to Medicare in the United States). All these plans are monitored and controlled by the government-run General Insurance Corporation, which is designed for people to pay cash up front and then get reimbursed by filing a claim.

India faces a growing need to fix its basic health concerns in the areas of HIV, malaria, tuberculosis and diarrhea. Additionally, children under 5 are often born underweight, and roughly 7 percent of them die before their fifth birthday.

For primary health care, the Indian government spends only about 30 percent of the country's total health care budget.

According to the Indian Brand Equity Foundation (IBEF), India is the third-largest exporter of pharmaceutical products in terms of volume. Around 80 percent of the market is composed of generic low-cost drugs, which seem to be the major driver of this industry.

India accounts for 19 percent of maternal deaths around the world. Seventy percent of these can be prevented. The main causes of death are heavy bleeding (hemorrhage) and eclampsia (high blood pressure).

A large number of global maternal and neonatal deaths occur in India. According to the recent State of World's Mothers report released in May 2013 by Save the Children, India ranked 142 out of 176 countries. The index for this ranking was developed on the basis of five indicators—maternal health, children's well-being, and educational, economic and political status of women in the country.

There has been some progress. The maternal death rate has fallen from about 390 to 212 deaths per 100,000 live births in about 10 years, a 67 percent decrease. However, for every woman dying in childbirth there are about 20 women who suffer long-lasting and debilitating illnesses, which are highly neglected. The states of Assam, Rajasthan, and Uttar Pradesh/Uttarakhand still have a high maternal death rate above 300 per 100,000 live births.

The northeastern state of Assam, with the highest maternal deaths in the country, has managed to lower its number of maternal deaths in the last few years. However, it continues to be the highest in the country. Assam is grappling with challenges such as difficult terrain and inaccessibility to health services, since a percentage of the population live on islands along the river Brahmaputra, which can be aggressive and harsh in the rainy season. Earlier there were no health services available in these areas. For the last eight years, a Public Private Partnership between the Government of Assam and civil society has been running boat clinics to reach the remote, under served, unreached areas and saving lives.

Social determinants such as early age of marriage, early and repeated childbearing, where 47 percent of girls marry before the age of 18, are also contributing factors. Early marriage traditions have serious repercussions, as girls are more likely to become pregnant at younger and riskier ages. Thirty-six percent of Indian women are malnourished and about 55 percent are anemic. Bodies are ill prepared to handle childbirth with poor nutrition, stunting with negative outcomes for maternal health.

### **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for India:

#### *Is there a problem?*

India faces many problems with the supply and quality of RMNCH commodities and with such a small budget for health care, a large proportion of the population is required to purchase products out-of-pocket.

#### *What causes the problem?*

The major causes of the issues identified are a lack of overall funding to the health sector, including RMNCH, and disparities in access to health care between rural and urban populations. Furthermore, for primary health care, the Indian government spends only about 30 percent of the country's total health care budget.

#### *Would a working capital facility be an appropriate solution?*

Based upon questionnaire responses, it appears there is an appetite for a working capital facility in India.

## Indonesia

### Background

Indonesia consists of 13,000 islands spread over 1.9 million square kilometers and is the second most populous country in Asia with approximately 240 million people. Its population is characterized by its wide demographic, economic, political, social and cultural diversity, with 56 percent of the population living in rural areas. Each of the country's 34 provinces has its own legislative council headed by a governor (Badan Pusat Statistik, 2012).

### Health System

The Indonesian National Health Development Program is based on a primary health care concept where the community health center is the basic health care facility, supported by hospitals and other community-based health care facilities. The Ministry of Health has overall responsibility for Indonesia's health care policy and operates health care programs, including staffing, education and training and health services.

### Cultural Influence

Cultural factors must also be considered when examining the RMNCH situation in Indonesia, with many maternal and newborn care practices strongly influenced by diverse local belief systems. Central among these beliefs is the role of fate or God's will in the outcomes of pregnancy and delivery.

### Health Expenditure

Indonesia's total health expenditure is relatively low compared with that of other East and Southeast Asian countries. Indonesia spent 3 percent of its gross domestic product (GDP) on health in 2010; by contrast, the regional (East Asia and Pacific) average was 7 percent, and the global average was 10 percent (World Bank, 2012). In 2010 Indonesia spent US\$18 billion on health care, almost all (99 percent) of which came from domestic funding sources (WHO, 2012). From 1995 to 2010, both government and household out-of-pocket spending on health increased.

In 2010 Indonesia's Ministry of Health had a budget of Rp 23.8 trillion (US\$2.6 billion or about \$12 per capita). Of those funds, 71 percent was allocated to patient services, comprising social health insurance, 30.4 percent; medical services, 29.4 percent; public health services, 6.7 percent; and pharmacy and medical supplies, 4.4 percent (Ministry of Finance, 2011). It is likely that both the patient services and non-patient services categories of the MoH budget contribute to MNH services in an accounting sense, including both direct and indirect costs. For example, the MoH budget allocated to patient services, totaling US\$1.8 billion, includes MNH expenditures such as the cost of deliveries and prenatal and postnatal care. The national budget does not provide a detailed function or service-level breakdown to allow a full accounting. Nor has a specific MNH "subaccounts" analysis been undertaken to provide such a breakdown. As of September 2012, Indonesia did not have a reproductive, maternal, newborn and child health (RMNCH) subaccount to track MNH-related expenditures, which would allow full measurement of MoH expenditures related to MNH.

Districts are responsible for implementing government-provided health care. However, the complex flow of resources through the intergovernmental financial system and the varying capacities of district governments to generate health revenue on their own and through external revenue sources reportedly result in inequitable, inefficient and fragmented financing across districts (Rokx et al., 2009). Legally, the authority of the central and provincial governments to regulate and even monitor district-level expenditures is quite limited. As a result, districts may allocate funds earmarked for MNH to other purposes and vice versa.

Most intergovernmental funds are passed from the central government to the district as a lump sum budget transfer and not for payment of specific health services. Because the decentralization policies do

not require specific financial reporting, the districts do not report to the central government how resources have been used from the various funding streams. As a result, the central government records only aggregated funding stream transfers without any detailed information on expenditures at the district level.

The current Indonesian programs directed at reducing maternal and neonatal mortality have proven insufficient to meet the MDG targets, according to the commonly accepted data sources. Many of the actions needed must be implemented locally, in or near where people live.

### **Health Delivery**

A lack of coordination among the many organizations involved in the delivery of health care services affect the delivery of all health services at a local level, including the strategies required to address MNCH issues—this applies to the various levels of the health system itself and to institutions outside the health system.

It is also often the case that there is untimely access to funds; with delays in the channeling of funds from the central level to health institutions, and delayed reimbursement by Jamkesmas (national Indonesian social health insurance scheme that enables disadvantaged people to access health services) inhibits planning. This constraint involves many departments, such as the Ministry of Finance, Parliament, sub-national Parliament, and sub-national Government.

### **Findings**

With reference to the questions originally posed by the SOW, we can draw the following conclusions for Indonesia:

#### ***Is there a problem?***

The vast number of islands and isolated areas make health service delivery in Indonesia challenging, with many facing short supply of essential RMNCH commodities, and an overall lack of government funding for RMNCH procurement.

#### ***What causes the problem?***

It is often the case that there is untimely access to funds; with delays in the channeling of funds from the central level to health institutions, and delayed reimbursement by Jamkesmas (national Indonesian social health insurance scheme that enables disadvantaged people to access health services) inhibits planning.

## **Pakistan**

### **Background**

Pakistan is a lower-middle-income country, but it is also a fragile state that is in the early phases of state building. It is the sixth most populous country, with more than 195 million people, and it faces significant economic, governance and security challenges to achieve durable development outcomes. The persistence of conflict in the border areas and security challenges throughout the country is a reality that affects all aspects of life in Pakistan and impedes development. A range of governance and business environment indicators suggest that deep improvements in governance are needed to unleash Pakistan's growth potential. The increasing proportion of Pakistan's working-age population provides the country with a potential demographic dividend but also with the critical challenge to provide adequate services and increase employment.

### **Health**

Pakistan's low literacy and high fertility rates coupled with a poor economy translates into high morbidity and mortality. Women and children are the most vulnerable segments in terms of health. Progress on MDG 4 is off-track as Pakistan stands among the worst performers in child and infant mortality. The number of deaths of children under 1 year of age per 1,000 live births is 69 against the

target of 40. The child mortality rate has only marginally decreased, from 117 per 1,000 live births in 1990-1991 to 94 per 1,000 in 2006-2007. Currently, under-5 mortality is 86 deaths per 1,000 live births. At this mortality level, one in every 11 Pakistani children dies before their fifth birthday resulting in over 1,100 deaths per day. The incidence of child mortality in Pakistan is indicative of not only the medical and health care facilities available for the mother and child but also the sanitation situation in the country.

Closely linked to MDG 4 is MDG 5 for which Pakistan has a considerable distance to go to meet the MDG 5 target by 2015, especially in reducing the maternal mortality ratio. In 1990 the MMR was 533 per 100,000 live births, which needs to be reduced by three-quarters to the level of 134 per 100,000 by 2015. The recent statistics by the Pakistan Demographic and Health Survey (PDHS) show that MMR ranges between 250 in urban areas and 750 in rural areas of the country. These statistics are among the worst in the world. A lifetime risk of death due to pregnancy-related causes for a Pakistani woman is 1 in 80 compared to 1 in 61 in developing countries as a whole and 1 in 4,085 in industrialized countries. High maternal mortality in Pakistan is indicative of neglect of women's health; however, in the absence of accurate maternal health data, the magnitude of problem in rural areas of the country is difficult to gauge. However, more pregnant women are receiving antenatal care, post-natal visits and improved delivery services from skilled providers. Almost three-quarters of the women surveyed for the 2012-13 PDHS received antenatal care from a skilled provider (doctor, nurse, midwife or lady health visitor) compared to 61 percent in the 2006-07 PDHS. Nearly half of the births occurred in health facilities, an increase from one-third in 2006-07.

Pakistan's health care system is a three-tiered health care delivery system: primary, secondary and tertiary care. Starting at the grassroots level, health houses provide community health care services through female health workers and are connected to basic health units with an upward referral pathway to rural health centers, *tehsil* hospitals and district hospitals. There are also well-equipped tertiary level teaching hospitals. However, this extensive health care infrastructure has not been translated into optimal health care delivery, due to a number of issues related to the health system. These include the poor motivation of the health workforce due to lack of good career structures and work environments, misdistribution of resources between urban and rural areas, and the lack of national human resources for health policy. Pakistan spends only 0.5 percent of its gross domestic product (GDP) on health, which is very low. This leads to an inability of the government to provide the required medicine and laboratory support to health care delivery resulting in an out-of-pocket expenditure on health of around 80 percent.

### **Findings**

The literature reviews show that there are still significant unmet needs for RMNCH commodities in Pakistan. Further investigation will be required to test the assumption that there is a problem with access to RMNCH commodities that the cause of the problem is a lack of access to funding needed for the procurement of RMNCH commodities and that provision of a working capital facility will improve access.

## **Yemen**

### **Background**

Yemen is a low-middle-income country where more than half of the population lives in rural areas and lacks access to the most basic health care. At US\$40 per capita, Yemen's annual total health expenditure (THE) is among the lowest worldwide. It has a four-tiered health care system characterized by high geographic and financial access barriers, mainly for the poor.

Out-of-pocket payments constitute 55 percent of THE, and cost-sharing exemption schemes are not well organized. Resource-allocation practices are inequitable, because about 30 percent of THE gets spent on treatment abroad for a small number of patients, mainly from better-off families.

Against the background of a lack of social health protection, a series of small-scale and often informal solidarity schemes have developed, and a number of public and private companies have set up health benefit schemes for their employees. Employment-based schemes usually provide reasonable health care at an average annual cost of YR44 000 (US\$200) per employee. In contrast, civil servants contribute to a mandatory health insurance scheme without receiving any additional health benefits in return.

Yemeni women face a 1 in 39 lifetime risk of maternal death. UNICEF estimates that 470 women per 100,000 live births die from obstetric complications. An estimated 82 percent of these deaths occur during delivery. Yemen's high maternal mortality rate is primarily due to a lack of skilled health care personnel for antenatal, delivery and postnatal care. In order to reduce the rate of maternal mortality and improve the overall health status of women, the government should focus on recruiting and training midwives, especially in rural and underserved areas.

In Yemen, pregnancy and childbirth are "life-threatening events." Maternal deaths account for 42 percent of all female deaths among women of reproductive age (15-49 years). It is the leading cause of death among women in that age group. Most maternal deaths occur between the third trimester and the first week after the end of pregnancy. Approximately 80 percent of maternal deaths are from direct causes, such as hemorrhaging (39 percent), obstructed labor (23 percent), infection (19 percent) and eclampsia (19 percent). Indirect causes account for the other 20 percent. Indirect causes are diseases that complicate, or are complicated by pregnancy, such as malaria, anemia, HIV/AIDS and cardiovascular disease. In addition, for every woman who dies due to childbirth complications, 20 more will suffer injuries, infections and disabilities.

### **Findings**

Although, there are limited literature study on RMNCH coverage in Yemen available research indicates significant number of unmet needs with large percentage of mothers and child at risks of death due to lack of access to RMNCH commodities when needed. Further investigation is required to test the assumption that lack of funding from national governments causes the problem of access to RMNCH commodities leading to deaths in mothers and children.

## **LATIN AMERICA AND CARIBBEAN REGION**

The UNCoLSC has facilitated and funded efforts, including research, in its initial eight Pathfinder countries related to the 13 RMNCH commodities. The list of Pathfinder countries, however, does not include any countries from the LAC region, so there were no reports/documents released through these UNCoLSC efforts in Pathfinder countries that related to LAC countries. For the literature review, therefore, JSI identified and reviewed other documents, and the level of relevant information discovered differed by country.

Significant variations are apparent between various areas such as public health infrastructure, financing mechanisms for the public health sector, and the level of engagement of the private sector. It is within this context that JSI worked to conduct interviews and collect and analyze information to address the primary questions of whether a lack of availability/access to capital contributes to inefficient nationally funded procurements of RMNCH commodities (e.g., from the Commission's initial list of 13 overlooked commodities), and, if so, to explore the root causes and the potential for a working capital facility to alleviate any existing issues related to the access to capital for procurement of such commodities.

With the exception of Haiti, no LAC countries are included in USAID’s list of priority countries for RMNCH. From a family planning perspective, the countries are considered to have “graduated.” Despite this, international partners do have presences in many of these countries. Refer to Table 10, as follows.

**Table 10: MNCH programmatic presence in LAC countries**

Countries in Which MNCH Programs Are Being Implemented (out of the 7 LAC priority countries only)	Organization
Haiti	CIDA, GAVI Alliance, Micronutrient Initiative (MI), Plan, Save the Children, UNFPA, USAID, WFP
Honduras	CIDA, GAVI Alliance, PAHO, Plan, UNFPA, USAID, WFP
Guatemala	Micronutrient Initiative (MI), PAHO, Plan, Save the Children, UNFPA, USAID, USAID, WFP
Colombia	PAHO, UNFPA, WFP
Dominican Republic	PAHO, Save the Children, UNFPA, USAID
Paraguay	PAHO, UNFPA

(The Canadian Red Cross Society with the International Federation of Red Cross and Red Crescent Societies, *MNCH in the Americas: a Report on the Commitments to Women’s and Children’s Health*, 2013.)

In recognition that pooling financial resources and specialized procurement expertise are required to meet the public health needs of countries in the LAC region, joint procurement mechanisms for the health sector, through PAHO and COMISCA, have been established regionally. Consideration of these mechanisms and the context within which they operate may be valuable when assessing how a new working capital facility would also operate in this environment. Following are brief descriptions of these mechanisms.

## Existing Procurement Mechanisms in the LAC Region

### *PAHO Strategic Fund*

#### *Procurement Mechanisms*

PAHO has two working capital facility mechanisms. One is the Working Capital Facility for Vaccine Procurement, and the other is the Strategic Fund. These are administrative cyclical procurement tools that are coupled with technical cooperation in supplies management and use. Financially, they are capitalization accounts that grow as procurement increases. The funds are limited in scope to defined product lists that address specific public health priorities, and for which economies of scale are achievable in procurement. The mechanisms provide countries with a source of funds for ordering supplies and avoiding supply disruptions, consolidated requirements that provide economies of scale and thereby quality supplies at lower prices, and single prices for each unit size for a one-year period for all member states. The Revolving Fund for Vaccine Procurement was founded in 1979, primarily for vaccines and syringes. This fund will not be described in detail in this report because it does not relate directly to the 13 UNCoLSC commodities.

#### *Strategic Fund*

The PAHO Strategic Fund is a procurement mechanism that was created in 2000 with a particular focus on HIV/AIDS, TB and malaria, although it is not limited to these health conditions. This fund is known as

the Regional Revolving Fund for Strategic Public Health Supplies. Its objectives are to promote the planning, continued supply and rational use of affordable public health commodities. The Fund currently serves about 24 countries and spent approximately 41 million US dollars in 2013 in procurement. The capitalization account, as of 2013 year-end, contained approximately six million US dollars to meet emergencies. Significant price reductions are enabled through the Fund for ARVs, anti-TB and anti-malarial commodities.

Member states review their procurement needs for essential public health supplies, and PAHO, through the Strategic Fund, offers technical support and assistance in building capacity for procurement planning and supply management. Thereafter, the member states may procure through the Strategic Fund. Commodities procured are strategic public health supplies and included on the Strategic Fund's Product List. This List encompasses a broad range of product categories, including anti-bacterial (amoxicillin), oral hormonal contraceptive, injectable contraceptive, anti-allergic (dexamethasone), oxytocics (oxytocin, misoprostol) and anticonvulsant (magnesium sulfate) products. It is derived from the WHO Model List of Essential Medicines. Strategic Fund suppliers are prequalified by PAHO/WHO and are selected based on product quality and pricing, as well as on historical procurement performance. The Strategic Fund negotiates with international suppliers to obtain competitively low product prices.

The Fund is capitalized through the allocation of a portion of the 3 percent procurement service charge to the Fund's capital account. Countries pay an additional 1.25 percent administrative charge. As countries purchase through the Fund, the Fund's purchasing power increases, resulting in lower product prices for member countries. To place an order, the member state transfers funds to PAHO and requests PAHO to purchase the needed commodities. PAHO reviews country requirements, performs the tender, and provides price estimates to countries. Commodities are then shipped from suppliers to the member state. The participating member states and/or the Principal Recipients (PR) deposit funds with PAHO in order to procure commodities through the Fund. After payment is received, PAHO deposits the funds in a separate Member State Account from which supplier invoices are paid. Any balances are retained in this account for future procurement by the member state, or refunded as appropriate.

For some exceptions, as a procurement mechanism, the Strategic Fund allows participating members to utilize a common fund for payment of authorized purchases of essential public health commodities. Members reimburse the common fund for the cost of each purchase within a specified period of time.

The PAHO Strategic Fund's Product List includes medicines for treatment of a variety of health conditions. The following UNCoLSC RMNCH commodities are on PAHO's Strategic Fund Product List: amoxicillin, dexamethasone, magnesium sulfate, misoprostol and oxytocin.

## **COMISCA**

The Council of Ministers of Health of Central America (COMISCA) is the political arm of the System for Central American Integration (SICA) and is made up of the Ministers/Secretaries of Health of the following eight member countries: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and the Dominican Republic. COMISCA's mandate and reason for existence is straightforward and critical: improve public health in a part of the world beset by health challenges, strained budgets, and technical limitations, by joining forces and combining resources. The idea is that by locking arms together, sharing data and logistics, and agreeing on a public health blueprint, people in each member country will benefit.

One of COMISCA's functions is to acquire medicines that are relatively more expensive and difficult for member countries to access. This is performed through the "joint negotiation of prices and buying drugs" (*negociacion conjunta regional*) within Central America and the Dominican Republic. The joint negotiation is a mechanism that uses economies of scale to facilitate access to quality medicines that are

safe, effective, and affordable for the region. The medicines procured are in the following categories: anesthetic, anticonvulsant, diabetes, cardiovascular, oncologic, contraceptive (oral contraceptives and Depo-Provera), anti-retroviral and miscellaneous. The UNCoLSC commodities do not appear in the 2014 edition of this list.

## Haiti

### Country Context

Haiti is divided geographically into 10 departments, 41 arrondissements (similar to districts), 135 communes (similar to parishes), and 565 communal sections. The two official languages are French and Creole. The country has experienced negative economic growth over the last two decades, and unemployment rates are high, particularly in the Port-au-Prince metropolitan area. Migration from the country is very significant, and Haiti is the world's most remittance-dependent country, measured by its share of household income and GDP.

### Health Policy and Systems

Haiti's health ministry is known as the Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population* [MSPP]). The ministry's Pharmaceutical Services Division is *Direction de la Pharmacie, du Médicament et de la Médecine Traditionnelle* (DPM/MT).

The Haitian health care system is organized in three levels of care. At the lowest level, about 700 primary health care facilities across the country provide care and are supported by community hospitals. Ten departmental hospitals represent the second level of care, and, at the highest level, four university hospitals supply tertiary care. Approximately half of Haiti's health care facilities are concentrated in the Port-au-Prince metropolitan area. Traditional medicine is the first course of treatment sought by about 80 percent of Haitians, due perhaps to low cost and accessibility.

### Health Policy

Haiti does not have a current national policy on pharmaceutical products. The last National Medicine Policy is from 1997, and it was never adopted by the Parliament. Pharmaceutical activities were minimally regulated by legislation from 1948 and 1955. A law on pharmacy and medicines was presented to Parliament in 2003 and passed by the Chamber of Representatives; however, as of 2012, the Senate had not adopted this legislation.

Haiti also has no comprehensive national standard treatment guidelines. Treatment standards are available, however, for public health programs such as HIV/AIDS, malaria, reproductive health, TB, integrated management of childhood illnesses, and sexually transmitted infections. Irrational prescription of medicines is common because of lack of training and standards.

As of 2012, no national public health sector policy was in place to guarantee that medicines will be supplied free of charge at public health care facilities. Although some public facilities dispense medicines without charge, many sell the medicines to patients and their families.

The country's National Essential Medicines List (EML) was reportedly last updated in 2011 but has not been officially adopted or widely disseminated.

### Product Registration and Quality Assurance

The role and capacity of the DPM/MT as a regulatory body need to be strengthened. This could positively impact the enforcement of product registration, quality assurance, and management of donations in the future. Product registration is governed by a law that dates back to 1948 that requires all products to be registered, but it has never been enforced. The product registration process is lengthy, has a significant backlog, and is complicated. Quality assurance protocols and mechanisms are severely lacking in Haiti. As of 2012, the country lacked a national quality control laboratory, and it also

was not using the services of reputable laboratories in nearby countries on a regular basis. Additionally, Haiti lacks a pharmacovigilance or post marketing surveillance system and a public sector pharmaceutical management information system. Each international partner uses their own systems, with no information-sharing mechanism in place.

### **Commodity Donations**

Official guidelines have not been established for donors of medicines or for the public, private, or NGO sectors on accepting and handling donated medicines. Particularly after recent natural disasters, Haiti received some very large commodity donations; some of these donated commodities expired rapidly, or were already expired when received, and were also not on the country's EML. Waste management is another concern related to donated commodities in Haiti. When commodities are not used, for whatever reason, they require disposal. Most Haitian health care facilities lack incinerators and policies for disposal.

### **Importation Challenges**

Regulations are in place for the licensing of manufacturers, distributors, and others; however, the regulatory system is outdated and weak, and many importers do not adhere to regulations for various reasons. One issue is that of lengthy delays for importers to obtain import authorizations. The association of pharmaceutical product importers, *Association Nationale des Importateurs et Distributeurs des Produits Pharmaceutiques*, includes less than half of the country's importers.

### **Pharmacies**

Most retail pharmacies are not registered and also are not owned or operated by licensed prescribers or pharmacists. Approximately 120-200 licensed, private retail medicine outlets exist, primarily in the Port-au-Prince area; only about 31 are registered in other areas of the country. Marketing and promotion of pharmaceuticals is not regulated. Private pharmacies supply themselves, sometimes from the country's informal and unregulated market. As of 2012, Haiti lacked a national Pharmacy Council. The three local production laboratories are Caribbean Canadian Chemical (4C), Farmatrix, and Pharva.

### **Study on Availability of Essential Medicines in Haiti**

A study conducted in 2011<sup>12</sup> on the availability of essential medicines in Haiti revealed very low availability of the lowest priced generic medicines in all market sectors and even lower availability of branded medicines. Highest priced generics were located primarily in the private sector, and the vast majority of outlets in the other sectors carried only one generic product per medicine. Comparisons with other countries in the region suggest that the availability of lowest priced generic medicines in Haiti is similar to that of the other countries. However, since these medicines are very frequently priced higher in Haiti than in those other countries, the affordability and access of those medicines is worse. Because of the country's weak pharmaceutical regulatory system, there is also no assurance of the quality of medicines available.

### **Health Outcomes**

Haiti has the highest under-5 mortality rate, neonatal mortality rate, and maternal mortality ratio in the Americas (UNICEF, 2012). The under-5 mortality rate has decreased from 144 in 1990 to 76 in 2012. Primary causes of death in children under 5 years of age are infections, malnutrition, injuries, HIV/AIDS, TB and malaria. The adjusted maternal mortality ratio in 2010 was 350 (UNICEF, 2012), and the number of facility births in Haiti has increased significantly during the last decade.

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<sup>12</sup> Chahal, Harinder Singh, Nazaire St. Fort, and Lisa Bero. "Availability, Prices and Affordability of Essential Medicines in Haiti." *Journal of Global Health* 3.2 (2013): 020405. PMC. Web. 20 Jan. 2015.

## **Health Budgeting and Financing**

As of 2014, the government's health budget was developed on an annual basis. Planning for the health sector beyond a one-year time horizon is limited. This short planning timeframe creates challenges for the planning of activities and interventions, for the necessary financing in the short term, and to estimate financing needs over the longer term.

Although the country has an approved National Health Policy, known as *Politique Nationale de Santé*, and is developing a National Health Plan, Haiti lacks a national health financing strategy that describes where resources will originate and how they will be deployed to achieve the desired health objectives. The USAID-supported Health Finance and Governance (HFG) Project is working with the Planning and Evaluation Unit of the MSPP to develop a national health financing strategy that will include an operational plan. The focus will be on the mobilization of resources, pooling of risks and financial protection, and purchasing and provider payment.

## **Health Spending**

Although total health spending in Haiti is high, it is driven almost entirely by external donor financing (over 60 percent of total spending) and private household spending (about 28 percent of total spending). The government only contributes to approximately 7 percent of total health spending, or 6 percent of its total budget. This is low in comparison to other countries with similar levels of GDP per capita. An insufficient budget is allocated to the MSPP on a regular basis. The government manages a combination of government resources and donor funding that is awarded to the MSPP. The government only has programmatic control over about 10 percent of health spending. Additionally, only 1 percent of current health spending is through private insurance.

There is a great diversity and number of independent actors in Haiti's health sector, and their approaches and agendas are often not aligned. The health ministry's control over foreign aid is not consistent, and donor assistance is often fragmented. The MSPP is not necessarily in a position to refuse or demand the realignment of projects offered by technical and financial partners due to financial reasons and because their own contribution to total health spending is so low. The MSPP is also not always informed of foreign aid funneled through NGOs. Public health care systems, as well as the rest of the country, were devastated by the earthquake in January 2010 and then by the cholera outbreak in October 2010.

Curative care represents about 40 percent of total health care spending in Haiti, with 75 percent of this spent on inpatient care. Moreover, medicines purchased by households at private pharmacies represent 17 percent of total health care spending. This high level of consumer spending for medicines from private sources may be exacerbated by the unavailability of medicines in health care facilities.

## **IDB and Haiti**

Following the 2010 earthquake, the IDB cancelled all of Haiti's outstanding debt and converted undisbursed loan balances into grants. Since that time, the IDB has approved US\$ 735.5 million in new grants and has disbursed US\$ 501.9 million into Haiti. The IDB currently has a Haiti country strategy in effect from December 2011 to December 2015. This strategy has the following six priority areas: education, private sector development, energy, water and sanitation, agriculture and transportation.

## **Financing and Procurement of Commodities – Including RMNCH Commodities**

### **PROMESS**

The Program for Essential Medicines and Supply (*Programme de Medicaments Essentiels [PROMESS]*), is the central agency for the provision of essential medicines and supplies in Haiti. PROMESS has been operating under PAHO/WHO technical and managerial leadership since 1992; it is the primary storage and distribution center for essential medicines in Haiti, coordinating the efforts and contributions of

international partners. Haiti is a member state of the PAHO Strategic Fund; and PROMESS is managed by PAHO/WHO, not by the MSPP. PROMESS is not integrated into the national public health system. Commodity sourcing is also reportedly donor-financed, not through ministry funds.

Commodity selection, quantification and procurement are all functions under the control of PAHO/WHO. PROMESS's actual procurement process is performed in Washington, DC. No procurement for PROMESS is done in country. PROMESS submits purchase orders with available funds through PAHO/WHO as needed. Medicines are procured based on availability of funds and to remedy stockouts or shortages. Products procured by PROMESS are sold to health care facilities and depots (warehouses) under a cost-recovery plan. PROMESS services peripheral depots, NGOs, other partner-sponsored organizations, and institutions such as the State University Hospital.

#### *Procurement of Program Commodities*

HIV/AIDS commodities have been procured by Supply Chain Management System (SCMS). Reproductive health commodities have been procured by UNFPA and the USAID | DELIVER PROJECT, using donor funds. The USAID | DELIVER PROJECT has procured family planning commodities, including Jadelle implants. The primary recipient for these commodities is the USAID-funded Leadership, Management and Sustainability Project (LMS Haiti). Family planning commodities have also been procured by the USAID | DELIVER PROJECT for Population Services International (PSI).

#### *Leadership, Management, and Sustainability Haiti Project*

LMS Haiti stores commodities in a central warehouse located in Port au Prince and manages commodity distribution to about 300 facilities offering FP services that are supported by the U.S. Government. In the 2012-2013 timeframe, approximately 6,293 Jadelle implants were distributed at 279 U.S. Government sites. LMS also works to strengthen the capacity of staff at all U.S. Government-supported sites and at the ministry level to ensure that all aspects of supply chain management are in compliance with U.S. Government regulations and established practices. Within the health ministry's structure, about 600 facilities provide FP services.

#### *UNFPA-Funded Commodities*

Facilities that are not supported by the U.S. Government receive UNFPA-funded FP commodities. These commodities flow from the central PROMESS warehouse through regional warehouses (*Centre Departementaux d'approvisionnement en Intrants [CDAI]*), departmental offices (*Bureau Communal de Santé [BCS]*), and/or hospitals. There are ten regional departments in Haiti, and health care facility staff can go to the regional warehouses for resupply of commodities, where and when available.

Donor funds are reportedly not channeled through the MSPP for these procurements; instead, donor funding flows through parallel donor-supported procurement and supply chain processes. This is done for various reasons, such as to prevent corruption and mismanagement of funds. From interviews conducted, it is understood that any government-to-government transfer of funds from donors to the Haitian public sector would be subject to a significant level of scrutiny and risk assessment.

#### *CDAI*

The regional warehouses (CDAI) link the central medicine store with health institutions. They are supplied by PROMESS and serve many health care institutions across the country. Hospital pharmacies, health centers, and dispensaries may be resupplied via CDAIs. Health care facilities may additionally procure directly from private sources of supply and through noncompetitive processes. Peripheral depots exist and may be supplied from the CDAIs. Operational challenges for the various levels of the supply chain include: weak transportation, lack of communication between different levels of the health system, and lack of formally established operational procedures for the CDAIs and peripheral depots.

## **Findings**

Yes, there is a problem. As described previously, there are many problems associated with access to RMNCH commodities in Haiti, and the MSPP does lack capital for procurement. The reason for the lack of access to capital is primarily the very low level of public sector funding allocated annually to health and health commodities. Essential commodities, including RMNCH commodities, are primarily procured on a donor-financed basis and are managed via parallel supply systems.

A working capital facility would likely not be an appropriate solution in this setting. The reasons for this include: the vast majority of imported commodity supply is either financed by donors and managed via parallel supply systems or procured by actors in the private sector; insufficient management and oversight capacity in the public sector; level of risk assessment and mitigation that may be required prior to providing funds directly to the MSPP; and weak national pharmaceutical regulatory system.

# ANNEX II. SCOPE OF WORK

**ATTACHMENT A**  
**STATEMENT OF WORK**  
**Global Health Program Cycle Improvement Project**  
**GH Pro**  
**Contract No. AID-OAA-C-14-00067**  
1/9/2015

## I. TITLE

**Activity: GH/CII: MNCH Country Procurement Analysis**

**II. PERFORMANCE PERIOD Starting o/a January 15, 2015 and continuing thru o/a June 30, 2015**

**III. FUNDING SOURCE CII**

## IV. PURPOSE

The purpose of this activity is to identify the country-level financial bottlenecks to procuring maternal, neonatal and child health commodities, and potential solutions to address them. The results and conclusions of this project will be used by USAID and its partners to determine if there is a need for a revolving fund to help support country procurement.

## IV. OBJECTIVES

Underpinning the problem statement are a number of high-level assumptions that need to be tested and validated in the priority Maternal and Child Health (MCH) countries:

- 1. Is there a problem:** Does a lack of availability or access to capital when needed contribute to inefficient nationally funded procurements of MNCH commodities, resulting in:
  - a) Governments not procuring at competitive prices
  - b) Governments not procuring quality-assured commodities
  - c) Stockouts of priority MNCH commodities
  - d) Governments not being able to take advantage of bulk purchasing and price reductions
  - e) Governments not being able to sufficiently engage with international procurement agencies that can potentially guarantee competitive prices and quality-assured commodities
  
- 2. What causes the problem:** What type of financial barriers cause countries to have limited availability or access to capital when needed to ensure efficient and timely procurements of MNCH commodities:
  - a) National government policies prevent capital from being available when needed
  - b) Funding cycles do not match procurement cycles, resulting in last minute/emergency procurement and extra costs
  - c) The amount of funding is insufficient to procure forecasted need
  - d) There are barriers to accessing international procurement agencies
  
- 3. How big of a problem is it:** Do a significant number of countries suffer from the limited availability of, or access to capital when needed to procure MNCH commodities:
  - a) Financial barriers frequently affect nationally funded procurement

- b) MCH priority countries in particular experience this limitation
  - c) A significant volume of nationally funded MNCH procurements experience this limitation
  - d) Future trends suggest continued limitations
- 4. Is a revolving fund an appropriate solution:** A revolving fund that provides access to working capital and can facilitate procurement via international procurement agencies (IPAs) can yield greater value for money for nationally funded procurement of MNCH commodities:
- a) A revolving fund can provide countries access to capital to match procurement cycle needs
  - b) A revolving fund can enable countries to procure MNCH commodities through IPAs, thus assuring better pricing, assurances of quality and timing of delivery
- 5. Can a pilot revolving fund be developed to determine appropriate initial support and scale-up:** After a revolving fund is determined to be an appropriate solution, developing a pilot revolving fund, structured to address the key issues (identified in 1-4 above), and can ensure nationally funded procurement of MNCH has increased availability/access to capital to engage with IPAs

## V. BACKGROUND

International donors frequently procure global health commodities such as ARVs, vaccines and contraceptives, but typically do not procure maternal, neonatal and child health (MNCH) commodities. Instead, funding and procurement of MNCH commodities, which includes the 13 priority commodities identified by the UN Commission on Life Saving Commodities for Women and Children (UNCoLSC),<sup>13</sup> is left to national governments and the in-country private sector.

Importantly, many of the countries that finance procurements from national budgets often cannot access the capital they need in time to appropriately plan for procurements. As a result, countries either have to buy on credit or delay procurement until full funding becomes available. Further, most procurement agents and suppliers are not willing to extend credit; as a result, delays are common, leading to decreased access to essential health supplies, stock outs, and ultimately resulting in negative health outcomes. The 2012 UN Commissioners' Report on UNCoLSC identified financial barriers as a key obstacle in the MNCH commodity related market, affecting the supply chain, overall access to health care and performance.

In addition, evidence suggests that even when national funding is available, the prices countries are charged vary widely, with only some countries being able to negotiate competitive prices. Perhaps more critically, what remains unknown is the quality of the commodities being procured. In some cases, governments are procuring MNCH commodities via reputable procurement agents and the quality, to some extent, can be assured. But for a number of countries negotiating directly with suppliers and manufacturers, or procuring via smaller, less well-regulated procurement agents, the lower prices often come at the expense of quality, even when quality specifications have been included in the tenders.

The overarching objectives of this assignment are to assess the challenges to MNCH procurement and assess solutions that will help national governments avoid delays in procurements and ensure funds are available when needed. Specifically, USAID is considering supporting the creation of a revolving fund that will provide governments with access to working capital and international procurement agencies (IPAs) to secure better prices, quality and timing of delivery of MNCH commodities.

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<sup>13</sup> The 13 priority commodities are oxytocin, misoprostol, magnesium sulfate, injectable antibiotics, antenatal corticosteroids, chlorhexidine, resuscitation devices, amoxicillin, oral rehydration salts, zinc, female condoms, contraceptive implants and emergency contraception.

## VI. METHODOLOGY

### Target Countries

The countries selected for the analysis are a subset of the 24 priority MCH countries (listed below).

<i>East Africa</i>	<i>West/South Africa</i>	<i>Asia/Middle East/LAC</i>
Democratic Republic of Congo	Ghana	Bangladesh
Ethiopia	Liberia	India
Kenya	Mali	Indonesia
Rwanda	Nigeria	Nepal
South Sudan	Senegal	Afghanistan
Tanzania	Madagascar	Pakistan
Uganda	Malawi	Yemen
Zambia	Mozambique	Haiti

For the purpose of this analysis, the countries listed in the Asia/Middle East/LAC column will be excluded. The countries listed as Tier 1 (below) will be the primary focus of this exercise, however any relevant information found for countries in the Tier 2 category should be included in the final deliverables as well.

Tier 1 countries: DRC, Ethiopia, Zambia, Mozambique and Tanzania

Tier 2 countries: Malawi, Ghana, Nigeria, Rwanda, Uganda and Liberia

### Commodities

Ten of the 13 MNCH priority commodities as defined by the UNCoLSC will be prioritized (oxytocin, misoprostol, magnesium sulfate, injectable antibiotics, antenatal corticosteroids, chlorhexidine, resuscitation devices, amoxicillin, oral rehydration salts and zinc). However, the analysis does not need be exclusive to these commodities.

The focus will be put on ensuring access to quality commodities, which are sourced from suppliers that have third-party verification in the following form: (a) Prequalified by the WHO Prequalification of Medicines Programme; or (b) Received a risk category 1 or 2 by a WHO Expert Review Panel (ERP); or (c) approved by a Stringent Regulatory Authority (SRA); or (d) the recipient has independent documentation that demonstrates the safety, quality and efficacy of the commodity.

### Data collection, methodology and analysis

The aim of the analysis will be to determine the rationale, applicability and value proposition of the solution, and then focus on supporting the development of a pilot. The data collection and analysis for this assignment is thus divided into three parts:

- I. Is there a significant problem with availability and/or access to capital that drives inefficient nationally funded procurement of MNCH, and what are the main causes [*based on addressing assumptions 1, 2, 3*]
- II. Is a revolving fund an appropriate solution for increasing availability and/or access to capital, and for helping countries access IPAs for greater efficiency in MNCH commodity procurement [*based on addressing assumption 4*]
- III. If appropriate, how best to support development of the solution/revolving fund [*based on addressing assumption 5*]

Part I-Data collection and analysis on whether the selected countries face financial barriers that results in inefficient national procurement of MNCH commodities, and if the increased availability or access to capital is a valid solution [*addressing assumptions 1, 2, 3*]

- Develop a research plan and determine the data/information and sources needed to test the key assumptions in each country

- Conduct an appropriate scan of existing research and analysis to provide an initial perspective on key assumptions
- Present initial findings to a working group of advisors
- Augment existing analysis with new analysis where necessary to complete validation of key assumptions
- Relevant information includes, but is not limited to:
  - Procurement bottlenecks caused by financing for nationally funded procurements
  - Sources of financing for the government office responsible for budget decisions and for the office with fiduciary responsibility
  - Ability of the MOH (or other appropriate agency) to access funds when needed for nationally funded procurements of MNCH supplies
  - Potential causes of delayed availability and/or access to funds (e.g., policy, timing mismatch)
  - Prevalence of potential causes in priority countries (e.g., how many have policy problems or timing mismatches) and if they are expected to continue into the future
  - Methods of national tendering (payment policies, policies related to sourcing (domestic versus international), quality of commodities, use of forecasting, etc.)
  - Suppliers, manufacturers and procurement agencies used
  - Volumes purchased and total price paid, per country and commodity
  - Number of emergency shipments of MNCH commodities in last 12-18 months due to financial bottlenecks

Part II-Assess a revolving fund as a way to provide greater availability/access to capital in nationally funded procurement of MNCH commodities (addressing inefficiencies identified in Part I)

- Conduct appropriate scan of existing research, analysis and lessons learned on innovative financing available to nationally funded procurement (especially revolving funds)
- Identify possible models for increasing access to IPAs for nationally funded procurement of MNCH commodities
- Develop a recommended structure for a revolving fund (specifically to address nationally funded procurement), including both a global or regional solution options
- Identify appropriate stakeholders (in consultation with USAID)
- Present initial findings to working group of advisors
- Refine approach based on incorporated stakeholder objectives

Part III – Supporting the development of a pilot

- Based on the data collected and the analyses conducted in Parts I and II, determine how to support the development of a pilot revolving fund as an appropriate solution to address the financial bottlenecks observed.

The consultant team will consider a range of possible data sources, methods and approaches for collecting and analyzing the data. Data sources, methodologies and specific analytical methods will be discussed with, and approved by, USAID. It is anticipated that the data collection process will require a mix of desk-based research as well as fieldwork, including key informant interviews at the relevant Ministries/Agencies.

A maximum of 2 trips (with 2 consultants) to 3-5 of the Tier 1 countries is expected. The length of stay in each country will be 3-5 days, depending upon the number of countries visited.

USAID and the consultant team will confer regularly (weekly or bi-monthly depending on need) to review the data, the analysis and the recommendations at all stages of the project including for the final report.

**Note:** This assessment assumes that the 10 MNCH priority commodities (oxytocin, misoprostol, magnesium sulfate, injectable antibiotics, antenatal corticosteroids, chlorhexidine, resuscitation devices, amoxicillin, oral rehydration salts and zinc) to be included in this study are registered in each target country as needed, are incorporated in the MNCH standard treatment guidelines, and that the drugs on this list are on the essential drug lists (EDL). If this assumption is not correct, we request that USAID inform the team, as these factors may affect the procurement policies and practices in a given country.

The methods described below assume that the focus of this investigation will on DRC, Ethiopia, Zambia, Mozambique and Tanzania, as Tier 1 priority countries. However, some information will also be gathered for Malawi, Ghana, Nigeria, Rwanda, Uganda and Liberia, as Tier 2 countries.

To conduct this analysis of procurement of MNCH commodities, the team must gather sufficient information to address the questions within this SOW. These methods, at this time, only address Part I, regarding problems of availability and/or access to capital needed for efficient national procurement of MNCH commodities; and Part II, use of a revolving fund as an appropriate solution. Once these data are collected and analyzed, then the team will design the methods needed for Part III, determining a pilot for a revolving fund.

## **Assessment Methods**

### Identify and Obtain Information Sources

For each country identify sources of information and data on the procurement of the 10 MNCH priority commodities to be included in this study. The documents and/or data will be needed on the following; however, the team may request additional documents and/or data. If this information and data are readily available for other essential medicines they should be collected as well.

- Procurement policies
- Funding sources
- Funding processes/cycles
- Supplier
- Quality control of commodities
  - Third-party verification
- Forecasting need
- Procurement records
- Procurement processes
  - Timing/cycles
  - Responsible or lead agency
  - Step-by-step process
  - Authorization processes
  - Access to capital
  - Procurement tracking
- Bulk purchasing & price reductions
- Stock tracking
  - Inventory
  - Stockouts
- Costs of commodities through IPAs and other common quality suppliers

- Reports, research and other materials on use of revolving funding for commodity procurements and other health care financing
- Reports, research and other material on use of IPAs for national procurement

### Desk Review

The team will carefully review all documents and data. This review will serve as a preliminary analysis. Additional information will be added to each country as more data are obtained through other data collection methods.

Desk review data will be analyzed per each country, resulting in a user-friendly document. The review will begin with an overview of the funding and procurement processes, as gleaned from the documents and data. This information will then be further broken out for each country by evaluation question:

1. Is there are problem?
2. What causes the problem?
3. How big of a problem is it?
4. Is a revolving fund an appropriate solution?

Additionally, the team will gather evidence on:

1. Strategies that were employed to address problems.
  - a. Successes
  - b. Failures or met with limited success
2. Strengths of the funding and procurement process
3. Other contributing factors and influences in the funding and procurement processes
4. Planned efforts to address problems

### Key Informant Interviews (KII)

To obtain additional needed information and/or to confirm information provided in the documents that were reviewed, the team will conduct virtual interviews with key informants. These interviews will be conducted by phone or Skype. Identifying information on each key informant will be collected using a structured data collection instrument. The remainder of the interview will be unstructured, but will be based on a question guide developed by the team. Each interview will have a customized question guide with the purpose of the specific interview and a list of information to be sought. The team, in consultation with USAID, will determine what key informants need to be interviewed. The list of key informants may include:

- Government officials involved in the procurement process
- USAID implementing partner procurement specialists (e.g., from DELIVER and SCMS)
- USAID staff involved in the procurement processes
- IPA representatives
- Quality MNCH commodity supplier representatives
- Other key informants identified through document review

### Secondary Data Analysis (as needed)

The team may elect to conduct secondary data analyses of country stock, procurement and/or finance data related to health commodity procurement. When the team is granted access to these data, they may seek to review these data for specific commodities, timing of stockouts, timing of financing compared to timing of procurement, levels of financing compared with procurement orders, procurement orders compared to receipt of orders, etc. Secondary data analyses are left to the discretion of the team based on need for further analyses to answer the SOW questions, and in consultation with USAID.

## **VII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT**

A project team of 3-5 should be sufficient to carry out the activities outlined in this SOW. There will also be a project team lead whose responsibilities are outlined below. The project is expected to last no more than 6 months, with a final deliverable due on, or before, June 30<sup>th</sup>, 2015.

The team should be comprised of experts in maternal and child health, procurement and distribution, supply chain management and health/innovative financing. Additionally, team members should also have experience working with international procurement agents such as UNICEF, IDA and Crown Agents, and country governments and donors.

No statistical or econometric modeling is expected however analyses around market sizing for MNCH commodities at the country level and globally will be necessary. Similarly, for Parts II and III some basic financial modeling will be necessary to develop the “value proposition” (i.e. costs versus benefits) of a revolving fund to support country procurements.

### **LOE and Draft Schedule**

There are four overarching tasks to be completed for Parts I and II. These are:

1. Test and validate assumptions listed above
2. Refine assumptions based on information and data collected
3. Share draft analysis with key thought leaders and partner for feedback
4. Aggregate the analysis and feedback for submission

Preliminary results from this phase of work will be shared with and presented to USAID by April 1<sup>st</sup>, 2015.

## **VIII. LOGISTICS**

USAID/DC will work with the relevant country missions to help facilitate in-country introductions and interviews with key-stakeholders. If the mission is unable to assist, GH Pro may be required to take on some of this support, in conjunction with USAID/DC.

## **IX. DELIVERABLES AND PRODUCTS**

### **Deliverables**

There will be two larger deliverables: (1) a written report and (2) a summary slide deck to be completed by June 30, 2015. In addition, there will be several intermediary deliverables and briefings to USAID to present the results and conclusions.

A draft report with preliminary data and results for Parts I and II is due by April 1, 2015. The draft report will be copy edited only and not formatted according to acceptable USAID report guidelines. This report is to be used for Internal USAID Distribution Only and will not be a public report.

The final report should detail whether or not the key assumptions have been validated and in which countries, provide a comprehensive explanation as to whether or not a revolving fund is an appropriate solution, and if so, provide concrete next steps for developing a pilot. All relevant supporting data and analyses should be included as well.

All raw data (both qualitative and quantitative) collected and referenced should be stored in an organized and usable format, and provided to USAID at the end of the assignment.

<b>Deliverable:</b>	<b>Due Date:</b>
Final Work Plan, PMP, timeline and protocols submitted and approved by GH Pro	On or about January 20, 2015
Interim update meeting with USAID and GH Pro on progress of work. Submission of report outline.	February 15, 2015
Submission and USAID approval of interim report, preliminary data and results for Parts I and II, and summary slide deck	April 1, 2015
Draft design for Revolving Fund structure submitted to and approved by USAID	April 1, 2015
Revised structure of Revolving Fund Approach submitted to and approved by USAID	May 1, 2015
Final report, all raw data (both qualitative and quantitative), supporting analyses, and slide deck submitted to and approved by USAID. Briefing to USAID to present the final results and conclusions.	June 30, 2015
Development Plan of a pilot revolving fund submitted to and approved by USAID.	June 30, 2015

## **XI. RELATIONSHIPS AND RESPONSIBILITIES (USAID and Consultants)**

### **USAID**

The main point of contact for USAID will be Priya Sharma. Her primary responsibilities will include the following:

- Overall management and oversight of the project, including troubleshooting
- Technical guidance and input as necessary, including into the final deliverables
- Support with the identification of and introduction to relevant key informants and stakeholders
- Coordination and communication with other parts of the MCH team and/or the Global Health Bureau

### **Consultants**

There will be a project team lead whose main responsibilities will include day to day oversight and management of the larger project team, regular communication and updates with the USAID POC, ensuring that activities are on track and deliverables are on schedule.

## **XII. MISSION AND/OR WASHINGTON CONTACT PEOPLE/PERSON**

Name:	Priya Sharma
Title:	Policy and Innovative Financing Advisor
USAID Office/Mission	Center for Accelerating Innovation and Impact/GH
Email:	psharma@usaid.gov
Phone:	202-712-0285

Note: The RMNCH Strategy and Coordination Team is providing additional funding to support and complement this SOW.

## **XIII. COST ESTIMATE**

To be provided by GH Pro.

## **XIV. REFERENCES (PROJECT DOCUMENTS)**

To be provided by GH/CII.

## ANNEX III. EVALUATION METHODS AND LIMITATIONS

The study focuses on the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC) list of 13 underutilized life-saving commodities, with a particular emphasis on the 10 MNCH commodities. It includes data and information for USAID’s 24 priority *Ending Preventable Child and Maternal Deaths* countries:

<b>East Africa</b>	<b>West/South Africa</b>	<b>Asia/Middle East/LAC</b>
Democratic Republic of Congo	Ghana	Bangladesh
Ethiopia	Liberia	India
Kenya	Mali	Indonesia
Rwanda	Nigeria	Nepal
South Sudan	Senegal	Afghanistan
Tanzania	Madagascar	Pakistan
Uganda	Malawi	Yemen
Zambia	Mozambique	Haiti

In all instances possible, the analysis focuses on the following two subsets of countries:

Tier 1 countries: DRC, Ethiopia, Zambia, Mozambique and Tanzania

Tier 2 countries: Malawi, Ghana, Nigeria, Rwanda, Uganda and Liberia

However, it is important to note that, as this exercise was part of a larger analysis to include 31 countries in total, some figures included are representative of a larger country set.<sup>14</sup>

F4D and its partners have produced a framework for analysis of the 31 country case studies and developed tools to help compile the necessary data and elicit findings for the research questions. These tools include: (1) a questionnaire to cover the wider aspects of procurement finance management and health systems strengthening as well as the specific areas included in the study; (2) a list of questions for face-to-face and phone/Skype interviews for follow-on discussions; (3) a priority list of contacts for each country covered in the study; (4) a template for data collating and analysis; and (5) a literature and desk review of available information to substantiate and supplement the findings from the questionnaires and interviews.

This study is based on reviews of existing literature, feedback from questionnaires, telephone consultations and face-to-face interviews with a wide range of stakeholders including officials from Ministries of Health, Ministries of Finance, Central Medical Stores and other health and procurement professionals. The data principally reflect respondents’ best knowledge and perceptions of procurement, financing, and health programming operations in their respective countries.

During the study, information in the form of survey responses or interview participation was received from 60 individual respondents from the following 23 countries: Democratic Republic of the Congo, Ethiopia, Mozambique, Tanzania, Zambia, Liberia, Nigeria, Uganda, Kenya, Madagascar, Mali, Senegal, South Sudan, Afghanistan, Bangladesh, Haiti, India, Colombia, the Dominican Republic, Guatemala, Honduras, Mexico and Paraguay. Responses were not received from the following countries: Ghana, Rwanda, Malawi, Indonesia, Nepal, Pakistan, Yemen and the Philippines.

<sup>14</sup> Afghanistan, Bangladesh, Colombia, Democratic Republic of Congo, Dominican Republic, Ethiopia, Ghana, Guatemala, Haiti, Honduras, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mexico, Mozambique, Nepal, Nigeria, Pakistan, Paraguay, Philippines, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, Zambia



# ANNEX IV. PERSONS INTERVIEWED

## PERSONS INTERVIEWED

**Anthony Ddamba** – Uganda National Medical Stores

**Bernard Konga** – Director Department of Policy and Planning, Ministry of Health and Social Welfare, Tanzania

**Clément MUKANYA** – UNICEF- National Consultant, Democratic Republic of Congo

**Cosmas Mwaifawani** – Ag. Director General, Medical Stores Department, Tanzania

**Daniel Ngeleka MUTOLO** – Director of the Direction of Pharmaceutical and Medicines, Ministry of Public Health, Democratic Republic of Congo

**Deo Kimera** – Country Director, SCMS & USAID/ Deliver Projects, Tanzania

**Dieudonne MPUNGA MUKENDI** – Public Health Expert, Direction des Etudes et de la Planification (DEP) (*Studies and planning Direction*) Ministry of Public Health, Democratic Republic of Congo

**Dr. Lisanu Tadesse and Dr. Azmach Hadush** – RMNCH unit, Ministry of Health Child and Health Experts, Ethiopia

**Dr. Peter Waiswa** – Makerere University, Uganda

**Dr. Jonah Mwangi** – Program Manager RH Commodities, Ministry of Health Reproductive & Maternal Health Services Unit, Kenya

**Dr. Kipkerich Koskey** – The Registrar, Pharmacy Poison Board (PPB), Kenya

**Dr. Margaret Mhando** – Director for curative services, Ministry of Health and Social Welfare, Tanzania

**Dr. Shamim Kuppuswamy** – Customer Service Manager, Kenya Medical Supplies Authority (KEMSA), Kenya

**Engineer Ashenafi** – Head of Procurement, Pharmaceuticals Fund and Supply Agency (PFSA), Ethiopia

**Franck Biayi** – Procurement and Stock Manager, Cellule d'appui et de gestion financiere (*Financial support and management cell*), Ministry of Public Health, Democratic Republic of Congo

**Gerard ELOKO EYA MATANGELO** – Director of Programme National des Comptes Nationaux de la Sante (*National Program of National Health Accounts*), Ministry of Public Health, Democratic Republic of Congo

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## ANNEX V. SOURCES OF INFORMATION

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# ANNEX VI. DATA COLLECTION INSTRUMENTS

## Questionnaire:

An investigation into bottlenecks in the procurement of maternal, neonatal and child health (MNCH) commodities

### Background

Unlike other global health commodities, international donors typically do not procure maternal, neonatal and child health (MNCH) commodities. This is left to national governments and their in-country private sectors. The 2012 UN Commissioners' Report on the UN Commission of Life-Saving Commodities (UNCoLSC) identified financial barriers as a key obstacle affecting the supply chain and overall access to health care and performance within the MNCH commodity market.

The aim of this study is to therefore investigate the issues and challenges associated with the procurement of MNCH commodities in 31 countries. Based on the results of our research, your responses to this questionnaire, and also face to face and phone/skype interviews Financing for Development Corp., Crown Agents, and JSI will work together to test and validate whether a working capital facility would be an appropriate financial instrument to address the specific challenges in the procurement of MNCH commodities.

### Guidelines

For the purposes of this questionnaire, we are looking specifically at the 13 overlooked life-saving commodities<sup>15</sup> that the UNCoLSC identified. If more widely accessed and properly used, they could save the lives of more than six million women and children.

- This questionnaire comprises 3 sections with questions, being predominantly multiple choice questions and a few descriptive questions.
- We would be very grateful for your valuable feedback and anticipate that this questionnaire should take about 30 minutes of your time.
- We would request you to please complete this questionnaire by–Date–.
- Financing for Development has appointed Crown Agents and JSI to undertake this technical study. Should you have any clarification questions, please contact XXXX.
- We have provided you with an online version of the questionnaire, as well as an attached document. Please feel free to answer via the platform that is preferable to you.

### List of Abbreviations

EWEC	Every Women and Every Child
IPA	International Procurement Agency
MDGs	Millennium Development Goals
MNCH	Maternal, neonatal and child health
PRSP	Poverty reduction strategic plan

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<sup>15</sup>The list of 13 overlooked life-saving commodities for women and children under the UN Commission on Life-Saving Commodities for Women and Children: Oxytocin, Misoprostol, Magnesium Sulphate, Injectable antibiotics, Antenatal corticosteroids, Female condoms, Contraceptive Implants, Emergency contraception, Chlorhexidine, Resuscitation devices, Amoxicillin, Oral rehydration salts and Zinc.

## List of definitions:

Bridge fund	A type of gap financing arrangement wherein recipients are empowered to use donor committed funding in advance of disbursement, resulting in increased buying power, greater value, accelerated procurement and delivery
Innovative financing	Non-traditional mechanisms to raise additional funds for development aid through "innovative" projects such as micro-contributions, taxes, public-private partnerships and market-based financial transactions
Pooled fund	A funding mechanism in which multiple investors contribute assets (mainly financial) and hold them as a group to achieve a specific purpose. E.g. a donor pooled fund, including contributions from multiple donors

## General Information

We would be grateful if you could provide us with your contact details should we need further clarifications.

Name of your Ministry/ Department/Direction:	Click here to enter text.
Name of Respondent: (Optional)	Click here to enter text.
Position:	Click here to enter text.
Email Address:	Click here to enter text.
Telephone number:	Click here to enter text.

## Questionnaire

Section I:

As you might know, the UNCoLSC has come up with a set of recommendations including:

- By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations
- By 2013 pooled procurement and/or aggregated demand have increased the availability of quality, MNCH commodities at an optimal price and volume

In view of these, this section will look at issues related to the availability and access to capital, to procure nationally-funded MNCH commodities. It will also look at whether MNCH commodities can be procured in a timely manner, at a good price and of good quality.

There are a combination of questions that will cover both the financing and procurement of MNCH commodities and we would be very grateful if you could answer these questions.

There are a combination of questions that will cover both the financing and procurement of MNCH commodities and we would be very grateful if you could answer these questions.

- I. In the table below, please indicate the most common form of funding for the listed MNCH commodities by ranking on a scale from 1 to 4 (1 = most common form of funding, and 4 = least common form of funding)

MNCH Commodities	Acquired directly by the government	Directly financed by donors <sup>16</sup>	International donor donations	Commercially/ privately sourced
e.g. Product x	1 (most common)	2	3	4 (least common)
1) Oxytocin				
2) Misoprostol				
3) Magnesium Sulfate				
4) Injectable antibiotics				
5) Antenatal corticosteroids				
6) Female condoms				
7) Contraceptive Implants				
8) Emergency contraception				
9) Chlorhexidine				
10) Resuscitation devices				
11) Amoxicillin				
12) Oral rehydration salts				
13) Zinc				

2. In the table below, please rank how easily listed MNCH commodities can be acquired. (1=very easy to get, large quantities/supply of quality goods, 7 =very hard to get, low quantities/supply of quality goods)

MNCH Commodities	1	2	3	4	5	6	7
1) Oxytocin	<input type="checkbox"/>						
2) Misoprostol	<input type="checkbox"/>						
3) Magnesium Sulfate	<input type="checkbox"/>						
4) Injectable antibiotics	<input type="checkbox"/>						
5) Antenatal corticosteroids	<input type="checkbox"/>						
6) Female condoms	<input type="checkbox"/>						
7) Contraceptive Implants	<input type="checkbox"/>						
8) Emergency contraception	<input type="checkbox"/>						
9) Chlorhexidine	<input type="checkbox"/>						
10) Resuscitation devices	<input type="checkbox"/>						

<sup>16</sup> Directly financed by donors, but still procured by governments.

11) Amoxicillin	<input type="checkbox"/>						
12) Oral rehydration salts	<input type="checkbox"/>						
13) Zinc	<input type="checkbox"/>						

3. Please indicate how MNCH commodities financed directly by government and those financed by donors (if applicable) are generally procured:

	Nationally (ordered through an in-country, commercial entity)	Internationally (ordered through an international organization)	A combination of both nationally and internationally
Commodities financed by the government	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commodities financed by donors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Does/ has your country used a funding mechanism, such as a pooled fund, to support the procurement of the 13 mentioned MNCH commodities?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If T please provide further detail. E.g. sources of funding.

Click here to enter text.

5. If you have selected "Yes", to what extent do you agree that such a mechanism has contributed to ensure a timely and competitive procurement of good quality MNCH commodities?

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Neither agree or disagree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

Please explain your answer:

Click here to enter text.

6. Which of the following methods do you regularly use for procuring MNCH commodities? (You may select multiple choices)

Framework agreement with suppliers	<input type="checkbox"/>
International tender	<input type="checkbox"/>
Direct contract (e.g. contract award, purchase orders)	<input type="checkbox"/>
Pooled procurement	<input type="checkbox"/>
Use of an international procurement agent	<input type="checkbox"/>
Use of local agent/wholesaler	<input type="checkbox"/>
Others –please indicate	Click here to enter text.

7. If you procure commodities internationally, do you use procurement agents who have third party verification, for example by the WHO Prequalification of Medicines Program?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If yes, please provide further which procurement agents typically used

Click here to enter text.

8. Are there any existing loan agreements in place (for the 13 commodities) that would prevent you from entering into another procurement loan agreement or contract? (E.g.: a World Bank loan procurement contract).

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If yes, please provide further information

Click here to enter text.

9. This question focuses on challenges generally faced in the procurement of MNCH commodities.
- a) Stockouts: Rank on a scale from 1-7 how often you encounter national, regional or district stockouts of MNCH commodities in the last year (1 = always, 7 = never)

MNCH Commodities	1	2	3	4	5	6	7
Oxytocin	<input type="checkbox"/>						
Misoprostol	<input type="checkbox"/>						
Magnesium Sulfate	<input type="checkbox"/>						
Injectable antibiotics	<input type="checkbox"/>						
Antenatal corticosteroids	<input type="checkbox"/>						
Female condoms	<input type="checkbox"/>						
Contraceptive Implants	<input type="checkbox"/>						
Emergency contraception	<input type="checkbox"/>						
Chlorhexidine	<input type="checkbox"/>						
Resuscitation devices	<input type="checkbox"/>						
Amoxicillin	<input type="checkbox"/>						
Oral rehydration salts	<input type="checkbox"/>						
Zinc	<input type="checkbox"/>						

When you have faced this issue, please indicate how often you believe the following statements to be the cause of the problem

	Always	Often	Sometimes	Never
Government funding is not disbursed when needed resulting in late procurement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor quantification & forecasting leading to insufficient quantities of commodities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procurement processes too bureaucratic resulting in late procurement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient level of funding for procurement of required products, in the right quantity and quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulatory issues (e.g. products not being registered in country)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incapacity/Inability to find suppliers and/or manufacturers which offer good quality products are the right price	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supply chain issues (warehousing, distribution etc.,)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others? Please indicate	Click here to enter text.			

- b) Access to International Procurement Agencies: Rank on a scale from 1-7 how often the government is not able to engage with International Procurement Agencies (IPAs) that can potentially guarantee competitive prices and quality assured commodities. (1 = always, 7 = never)

MNCH Commodities	1	2	3	4	5	6	7
Oxytocin	<input type="checkbox"/>						
Misoprostol	<input type="checkbox"/>						
Magnesium Sulfate	<input type="checkbox"/>						
Injectable antibiotics	<input type="checkbox"/>						
Antenatal corticosteroids	<input type="checkbox"/>						
Female condoms	<input type="checkbox"/>						
Contraceptive Implants	<input type="checkbox"/>						
Emergency contraception	<input type="checkbox"/>						
Chlorhexidine	<input type="checkbox"/>						
Resuscitation devices	<input type="checkbox"/>						
Amoxicillin	<input type="checkbox"/>						
Oral rehydration salts	<input type="checkbox"/>						
Zinc	<input type="checkbox"/>						

When you have faced this issue, please indicate how often you believe the following statements to be the cause of the problem

	Always	Often	Sometimes	Never
Insufficient quantity of products ordered to warrant use of a procurement agent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient funding to pay procurement agent fees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procurement agents unwilling to work with us due to frequent payment delays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We are not interested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delayed funding to engage/pay in advance IPAs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy barrier to advance payment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others? Please indicate opposite	<a href="#">Click here to enter text.</a>			

- c) Competitive prices: Rank on a scale from 1-7 how often the government does not procure at competitive prices. (1 = always, 7 = never)

MNCH Commodities	1	2	3	4	5	6	7
Oxytocin	<input type="checkbox"/>						
Misoprostol	<input type="checkbox"/>						
Magnesium Sulfate	<input type="checkbox"/>						
Injectable antibiotics	<input type="checkbox"/>						
Antenatal corticosteroids	<input type="checkbox"/>						
Female condoms	<input type="checkbox"/>						

Contraceptive Implants	<input type="checkbox"/>						
Emergency contraception	<input type="checkbox"/>						
Chlorhexidine	<input type="checkbox"/>						
Resuscitation devices	<input type="checkbox"/>						
Amoxicillin	<input type="checkbox"/>						
Oral rehydration salts	<input type="checkbox"/>						
Zinc	<input type="checkbox"/>						

When you have faced this issue, please indicate how often you believe the following statements to be the cause of the problem

	Always	Often	Sometimes	Never
We don't have access to International Procurement Agencies (IPAs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We often procure at the last minute, which results in suppliers and manufacturers adding a mark-up on products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We are not able to negotiate good prices with our suppliers because they know we tend to be late in our payment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The local market is not developed enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We are not buying high quantities of MNCH products so few suppliers are interested in responding to our request and when they are, they add mark-ups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Too few suppliers are authorized to import their products in country resulting in low competition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others? Please indicate opposite	Click here to enter text.			

d) Quality assured commodities: Rank on a scale from 1-7 how often the government does not procure quality assured commodities. (1 = always, 7 = never)

MNCH Commodities	1	2	3	4	5	6	7
Oxytocin	<input type="checkbox"/>						
Misoprostol	<input type="checkbox"/>						
Magnesium Sulfate	<input type="checkbox"/>						
Injectable antibiotics	<input type="checkbox"/>						
Antenatal corticosteroids	<input type="checkbox"/>						
Female condoms	<input type="checkbox"/>						
Contraceptive Implants	<input type="checkbox"/>						
Emergency contraception	<input type="checkbox"/>						

Chlorhexidine	<input type="checkbox"/>						
Resuscitation devices	<input type="checkbox"/>						
Amoxicillin	<input type="checkbox"/>						
Oral rehydration salts	<input type="checkbox"/>						
Zinc	<input type="checkbox"/>						

When you have faced this issue, please indicate how often you believe the following statements to be the cause of the problem

	Always	Often	Sometimes	Never
Insufficient funding prevents us from procuring quality assured commodities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We don't have a WHO supplier pre-qualification process in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The main criteria when we evaluate the offers from suppliers and manufacturers, is price. Quality comes after.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulatory systems in place are weak leading to non-quality assured commodities being procured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others? Please indicate	<a href="#">Click here to enter text.</a>			

Have you filed any quality claims against MNCH commodity suppliers in the past year?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

e) Emergency procedures: Rank on a scale from 1-7 how often the government has to procure through emergency procedures with extra financial and logistics costs. (1 = always, 7 = never)

MNCH Commodities	1	2	3	4	5	6	7
Oxytocin	<input type="checkbox"/>						
Misoprostol	<input type="checkbox"/>						
Magnesium Sulfate	<input type="checkbox"/>						
Injectable antibiotics	<input type="checkbox"/>						
Antenatal corticosteroids	<input type="checkbox"/>						
Female condoms	<input type="checkbox"/>						
Contraceptive Implants	<input type="checkbox"/>						
Emergency contraception	<input type="checkbox"/>						
Chlorhexidine	<input type="checkbox"/>						
Resuscitation devices	<input type="checkbox"/>						

Amoxicillin	<input type="checkbox"/>						
Oral rehydration salts	<input type="checkbox"/>						
Zinc	<input type="checkbox"/>						

10. Of the commodities directly financed by the government or by donors, which of the following do you face most challenges (as illustrated above) in accessing the necessary funding?

Oxytocin <input type="checkbox"/>	Misoprostol <input type="checkbox"/>	Magnesium Sulfate <input type="checkbox"/>	Injectable antibiotics <input type="checkbox"/>
Antenatal corticosteroids <input type="checkbox"/>	Female condoms <input type="checkbox"/>	Contraceptive Implants <input type="checkbox"/>	Emergency contraception <input type="checkbox"/>
Chlorhexidine <input type="checkbox"/>	Resuscitation devices <input type="checkbox"/>	Amoxicillin <input type="checkbox"/>	Oral rehydration salts <input type="checkbox"/>
Zinc <input type="checkbox"/>			

11. Of the commodities directly financed by government or by donors, which of the following do you have most difficulty in sourcing/procuring?

Oxytocin <input type="checkbox"/>	Misoprostol <input type="checkbox"/>	Magnesium Sulfate <input type="checkbox"/>	Injectable antibiotics <input type="checkbox"/>
Antenatal corticosteroids <input type="checkbox"/>	Female condoms <input type="checkbox"/>	Contraceptive Implants <input type="checkbox"/>	Emergency contraception <input type="checkbox"/>
Chlorhexidine <input type="checkbox"/>	Resuscitation devices <input type="checkbox"/>	Amoxicillin <input type="checkbox"/>	Oral rehydration salts <input type="checkbox"/>
Zinc <input type="checkbox"/>			

## Section 2:

This section will focus on the financial barriers that you may face that result in inefficient procurement of MNCH commodities. This will allow us to get a better understanding of why capital is often unavailable or difficult to access when needed during the procurement cycle.

- I. If known, what is the approximate national budget percentage allocated to the health sector (excluding donor support)?

0 to 3 percent	<input type="checkbox"/>
3 to 6 percent	<input type="checkbox"/>
6 to 9 percent	<input type="checkbox"/>
9 to 12 percent	<input type="checkbox"/>
12 to 15 percent	<input type="checkbox"/>
Over 15 percent	<input type="checkbox"/>
If you know the exact figure, please indicate	
Don't know	<input type="checkbox"/>

2. If known, what is the approximate national health government budget percentage allocated to the procurement of priority MNCH commodities?

0 to 3 percent	<input type="checkbox"/>
3 to 6 percent	<input type="checkbox"/>
6 to 9 percent	<input type="checkbox"/>
9 to 12 percent	<input type="checkbox"/>
12 to 15 percent	<input type="checkbox"/>
Over 15 percent	<input type="checkbox"/>
If you know the exact figure, please indicate	
Don't know	<input type="checkbox"/>

3. Does a poverty reduction strategic plan (PRSP) exist that specifically addresses MNCH commodity access?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If you answered “yes”, could you please provide indicators, outcomes and funding commitments indicated in the strategy:

Click here to enter text.

4. Is there a budget line within the government budget specifically dedicated to the procurement of MNCH commodities?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

5. To what extent do you agree that there is unmet need for the procurement of MNCH commodities?

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Neither agree or disagree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

If you do believe that there is currently an unmet need towards the procurement of MNCH commodities, please provide further detail:

Click here to enter text.

6. Is the department in charge of the procurement of these commodities involved with budget planning of the Ministry of Health?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

7. What finance and budget policies are in place to channel government funds for procuring MNCH commodities?

There is a specific budget line	<input type="checkbox"/>
An annual budget negotiation process takes place	<input type="checkbox"/>
There is a specific law	<input type="checkbox"/>
Others, please indicate	

8. How frequently are funds disbursed from the Ministry of Finance to the Ministry of Health?

Monthly	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>
Semi-annually	<input type="checkbox"/>
Annually	<input type="checkbox"/>
Other, please indicate	

9. How often does procurement for government-financed MNCH take place?

Quarterly	<input type="checkbox"/>
Annually	<input type="checkbox"/>
Other, please indicate	

10. How does procurement timing coincide with government funding cycles in the country?

The procurement cycle matches the government funding cycle	<input type="checkbox"/>
The procurement cycle doesn't match the government funding cycle	<input type="checkbox"/>
I don't know	<input type="checkbox"/>

Please provide further details of how the compatibility of procurement and funding cycles has an effect on you:

Click here to enter text.

11. Is there a co-ordination mechanism in place between the Ministry of Finance and the Budgeting and Programming units of the Ministry of Health to guarantee the timely access of funds for the purchase of MNCH products?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

12. To what extent do you agree that the co-ordination between the Ministry of Finance and the Ministry of Health ensures timely access of funds for MNCH products?

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Neither agree or disagree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

13. Which of the following statements best describes current situation in your country? You can select multiple choices if applicable.

There is no linkage between procurement plan and the budget formulation process	<input type="checkbox"/>
Links with budget planning are weak and plans are not required to match the budgetary allocation available before expenses are committed	<input type="checkbox"/>
MNCH procurement planning and data on costing are part of the budget formulation and multiyear planning	<input type="checkbox"/>
Budget law and financial procedures support the timely procurement, contract execution and payment	<input type="checkbox"/>
Funds are voted or committed before procurement starts	<input type="checkbox"/>
There is regular procurement planning exercise instituted by law or regulation in support of the budget planning and formulation process	<input type="checkbox"/>

14. Are forecasts of MNCH commodities prepared on a schedule consistent with budgeting and procurement cycle?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If you answered "No", what common issues do you face?

Click here to enter text.

15. Do any policies provide guidance or requirements for developing procurement plans? If so, describe the policy and practice.

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

Click here to enter text.

16. If there is a MNCH procurement plan in place, does it contain budget information?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

17. To what extent do you agree with the following statements?

- a. There are national government policies that prevent funding from being available to procure MNCH commodities

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Neither agree or disagree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

If you have selected either "Strongly agree" or "agree", do you believe that this is an increasing trend?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

Could you please provide more detail below (which policies specifically and how do they prevent capital from being available?)

Click here to enter text.

- b. The funding cycle often mismatches procurement cycles leading to last minute/emergency procurement and extra costs?

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Neither agree or disagree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

If you have selected either "Strongly agree" or "agree", do you believe that this is an increasing trend?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

18. Do you think that there are other elements/factors that cause delayed availability/access to funds? If so please provide details

Click here to enter text.

Section 3:

So far, we have looked at whether the lack of availability/access to capital when needed, is a challenge for the timely and cost-effective procurement of high quality MNCH commodities. We have tried to identify the potential causes of this lack of availability/access to capital. In this section, we want to assess the extent to which financial barriers are a key obstacle to procure MNCH commodities.

1. On a scale from 1 to 7, how frequently do financial barriers affect nationally funded procurement? (1 = always and 7 = never)

1	2	3	4	5	6	7
<input type="checkbox"/>						

2. If possible, please provide us with the number of emergency shipments of MNCH commodities in last 12 months

MNCH Commodities	
Oxytocin	
Misoprostol	
Magnesium Sulfate	
Injectable antibiotics	
Antenatal corticosteroids	
Female condoms	
Contraceptive Implants	
Emergency contraception	
Chlorhexidine	
Resuscitation devices	
Amoxicillin	
Oral rehydration salts	
Zinc	

3. Apart from MNCH commodities, would you say that the procurement of other health commodities suffer from a lack of access/availability of funding when needed

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

4. Could you please provide us with the approximate total value (detailing both price and quantity) including your main supplier of the 13 MNCH commodities within the last year?

MNCH Commodities	Price	Quantity	Main Supplier
Oxytocin			
Misoprostol			
Magnesium Sulfate			
Injectable antibiotics			
Antenatal corticosteroids			
Female condoms			
Contraceptive Implants			
Emergency contraception			
Chlorhexidine			
Resuscitation devices			
Amoxicillin			
Oral rehydration salts			
Zinc			

5. If applicable, describe the measures the government may have taken to improve the access and availability of funding when needed to procure MNCH commodities efficiently?

Click here to enter text.

6. Do you believe that a revolving fund that provides bridge financing to government borrowers would improve the quality, cost and timing of MNCH commodity procurement?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

This is the end of the questionnaire. Thank you for your participation in this study. This will be used to test and validate whether a revolving fund would be an appropriate financial instrument to address the specific challenges in the procurement of MNCH commodities.

7. Do you believe that a revolving fund that provides bridge financing to government borrowers would improve the quality, cost and timing of MNCH commodity procurement?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

This is the end of the questionnaire. Thank you for your participation in this study. This will be used to test and validate whether a revolving fund would be an appropriate financial instrument to address the specific challenges in the procurement of MNCH commodities.



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