

# The West Africa Reproductive Health Commodity Security Study

*Summary of Findings from Phase One*

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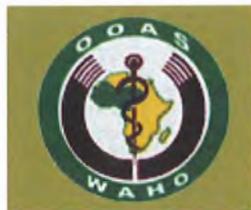




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## **DELIVER**

DELIVER, a five-year worldwide technical assistance support contract, is funded by the Commodities Security and Logistics Division (CSL) of the Office of Population and Reproductive Health (PRN) of the Bureau for Global Health (GH) of the U.S. Agency for International Development (USAID).

Implemented by John Snow, Inc. (JSI), (contract no. HRN-C-00-00-00010-00), and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], Social Sectors Development Strategies, Inc., and Synaxis, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical support to USAID's central contraceptive procurement and management, and analysis of USAID's central commodity management information system (NEWVERN).

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# Contents

<b>Acronyms</b> .....	iii
<b>Acknowledgements</b> .....	v
<b>Executive Summary</b> .....	vii
<b>1. Background</b> .....	1
1.1 West Africa RHCS Study .....	2
<b>2. Summary Findings on Pooled Procurement</b> .....	3
2.1 Options and Models for Pooled Procurement .....	3
2.2 Potential Benefits for West Africa RHCS .....	6
2.3 Key Factors for Success and Implications for West Africa .....	8
<b>3. Summary Findings on Private Sector Expansion</b> .....	15
3.1 Current Market Share .....	15
3.2 Expansion Potential for Commercial Sector .....	15
3.3 Role of Social Marketing.....	16
3.4 Local Manufacturing .....	16
<b>4. Phase One Conclusions and Recommendations</b> .....	19
4.1 Pooled Procurement and Finance .....	19
4.2 Private Sector.....	20
<b>5. Next Steps</b> .....	21
<b>Appendices</b>	
Appendix 1 Description of Select Pooled Procurement Mechanisms.....	23
Appendix 2 RH Commodity Price Variance.....	31
Appendix 3 The Impact of Nigeria .....	33
<b>References</b> .....	35
<b>Figures</b>	
Figure 1.1 ECOWAS Past and Projected Donor Financing and Costs for Contraceptives (excluding condoms) 1996–2010 .....	1
Figure 2.1.1 Comparative Cost, Benefits and Complexity for Different Pooled Procurement Options .....	3
Figure 2.2.1 IRP and Pooled Price Cost Comparison for Select Reproductive Health Commodities .....	6
Figure 2.2.2 Comparison of Costs Between Contraceptive Prices Currently Paid in Ghana and Pooled Prices, Based on Projected Demand, 2003–2010.....	7
Figure 2.2.3 Comparison of Costs Between Contraceptive Prices Currently Paid in Burkina Faso and Pooled Prices Based on Projected Demand, 2003–2010 .....	7
Figure 2.2.4 Comparison of Costs Between ORS Prices Currently Paid in Burkina Faso and Pooled Prices Based on Projected Demand, 2003–2010 .....	8
Figure 2.3.1 Stock Status of Public Service Delivery Points .....	11

**Tables**

Table 2.1.1	Summary Description of Pooled Procurement Options .....	4
Table 2.1.2	Summary of Examples of Real-life “Contracting” Pooled Procurement Mechanisms.....	5
Table 2.3.1	Critical Requirements for Pooled Procurement Options.....	9
Table 2.3.2	Comparison of the Source of Funding for Contraceptives and Other Health Commodities in Burkina Faso and Ghana .....	10
Table 3.1	Percentage of Market Shares for Contraceptive Methods in West Africa.....	17

# Acronyms

ACAME	Association of West African Central Medical Stores
AIDS	acquired immunodeficiency syndrome
API	active pharmaceutical ingredient
ARV	antiretroviral
BCC	behavior change communication
CIF	Cost Insurance Freight
CIP	Carriage and Insurance Paid To
DHS	Demographic and Health Survey
ECDS	Eastern Caribbean Drug System
ECOWAS	Economic Community of West African States
EDL	essential drug list
EPI	Expanded Program on Immunization
EU	European Union
FP	family planning
GAVI	Global Alliance for Vaccines and Immunizations
GCC	Gulf Cooperation Council
GDF	Global Drug Facility
HIV	human immunodeficiency virus
IDA	International Dispensary Association
IEC	information, education, and communication
IMR	infant mortality rate
IRP	International Reference Price
IUD	intrauterine device
JSI	John Snow, Inc.
MDG	Millennium Development Goal
MEASURE	Monitoring and Evaluation to Assess and Use Results
MMR	maternal mortality rate
MNE	multinational entity
NGO	nongovernmental organization
OB	obstetrics
OC	oral contraceptive
OI	opportunistic infections
ORS	oral rehydration solution
OTC	over-the-counter
PAHO-RFV	Pan American Health Organization Revolving Fund for Vaccines
PRB	Population Reference Bureau
PSI	Population Services International
RH	reproductive health
RHCS	Reproductive Health Commodity Security
STG	standard treatment guidelines
STI	sexually transmitted infections
SWAp	sector wide approach

UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization

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# Executive Summary

In 2002, the maternal mortality rate (MMR) in West Africa stood at 1,100 per 100,000 births, nearly three times the worldwide average (PRB 2002). An estimated 100,000 women are dying in childbirth each year across West Africa, the result of poor reproductive health (RH) care, lack of available contraceptives, and inadequate birth spacing. After recognizing this pressing health priority, the West Africa Health Organization (WAHO) developed a strategy to reduce maternal and perinatal mortality in the West African region. This approach includes strengthening reproductive health commodity security (RHCS) to ensure that couples can choose, obtain, and use reproductive health products whenever they need them. A key element of this strategy is to improve the availability and reduce the cost of essential RH commodities through some type of pooled procurement mechanism. The Economic Community of West African States (ECOWAS) Health Ministers at the July 2003 Fourth Ordinary Meeting of WAHO asked John Snow, Inc. (JSI)/DELIVER to study the different options for securing commodities in the sub-region, including pooled finance and procurement, and to examine the scope for private sector expansion.

JSI/DELIVER has completed the first phase of a desk-based study of pooled procurement options, which was supported by fieldwork in two ECOWAS countries: Burkina Faso and Ghana. This report presents those findings. Stakeholders will have an opportunity to review and give feedback before deciding whether further work is warranted.

Evidence suggests that ECOWAS member countries could realize gains from pooled procurement with significant unit price savings for contraceptives. These savings could come from a combination of lower prices from increased purchase volume and from better-informed purchasing by individual countries. Other benefits could include improved commodity quality and harmonization of standards, increased opportunities for private investors, improved supply chain management, and reduced wastage and loss.

Five options for pooled procurement were identified, in ascending order of complexity, cost, benefit, and risk (Onyango 2003):

1. informed buying
2. coordinated informed buying
3. group contracting
4. central contracting
5. pooled financing and procurement.

Informed buying, when countries share information on prices and suppliers but conduct separate procurements, would reduce administrative cost and risk factors, and allow greater country-level independence in decision making, but would generate few benefits. Pooled financing and procurement would be more costly to establish and manage, involve greater potential risk, and give countries less independence in their procurement decision making, but it would provide the greatest potential savings. The options between these two mechanisms would involve increasingly greater costs, benefits, and risks.

International experience suggests that pooled procurement works best when participating countries—

- share a common language
- deal with similar health conditions
- use harmonized drug registration procedures
- have access to convertible currency
- possess adequate in-country supply chain management systems

- maintain a tradition of regional cooperation
- make a commitment to finance and sole source their drug needs
- operate in an environment without trade barriers and with supportive policies and regulatory conditions.

While some of these preconditions do exist in ECOWAS, several are not yet in place. Each country has separate drug registration procedures, different essential drug lists and lists of registered products, different standard treatment guidelines, and very different capacities for commodity forecasting and management. Furthermore, ECOWAS has a mixed record with regional financial and economic integration. Some elements, like the external tariff, have been successful, but others, such as free intraregional trade and member financial contributions, have had less success.

Our recommendation is to adopt a phased approach, which would initially involve a lower cost and lower risk, by establishing a RHCS information exchange that could facilitate informed buying. A web-based exchange of information would keep start-up and operating costs down while creating a framework for the evolution of the exchange into more coordinated, informed buying as members realize the real benefits. The next stage, group contracting, could then be considered for a subset of commodities, such as contraceptives where product standardization and registration across the region could be more easily achieved. Other products could be added as drug registration and essential drugs lists are harmonized. The advantage of this evolutionary approach would be that members would still have some flexibility until real savings could be demonstrated. An important prerequisite would be to provide technical assistance to strengthen commodity forecasting and in-country supply chains.

Regardless of which, if any, pooled procurement mechanism is selected, ECOWAS and WAHO will need to decide on the physical and institutional location of that procurement mechanism. Options include WAHO, the Association of West African Central Medical Stores (ACAME), another ECOWAS financial institution, or the establishment of a new organization, possibly through a contract to a private provider. Clearly, the size and complexity of that institution will vary, depending on the type of mechanism selected.

While the 248 million people living within ECOWAS represent a very significant market potential, the scope for creating opportunities for private manufacturers is limited by low consumer purchasing power, weak demand, and infrastructure and cost constraints. The public sector should concentrate on further development of regional social marketing models supported by increased behavior change and communication (BCC) campaigns to promote contraceptives and other RH commodity use. Implementation of planned ECOWAS trade reforms, harmonization of drug registration, and establishment of an ECOWAS drug registration standard would improve the opportunities for local manufacturers to realize market opportunities.

Next steps for the work would include—

- Have discussions with WAHO-pooled procurement technical advisors to review the identified options, analyze the costs and benefits, and determine their feasibility given the institutional and financial constraints.
- Obtain feedback on the present report, and then prepare and present the report to the next meeting of the Ministers of Health.
- Begin discussions with funding partners to inform them of findings and ascertain interest in supporting a regional pooled procurement.
- Identify additional research areas, including country assessments, needed to determine national-level interest in pooled procurement.
- Hold discussions with partners to identify potential funding commitments for regional RHCS efforts.

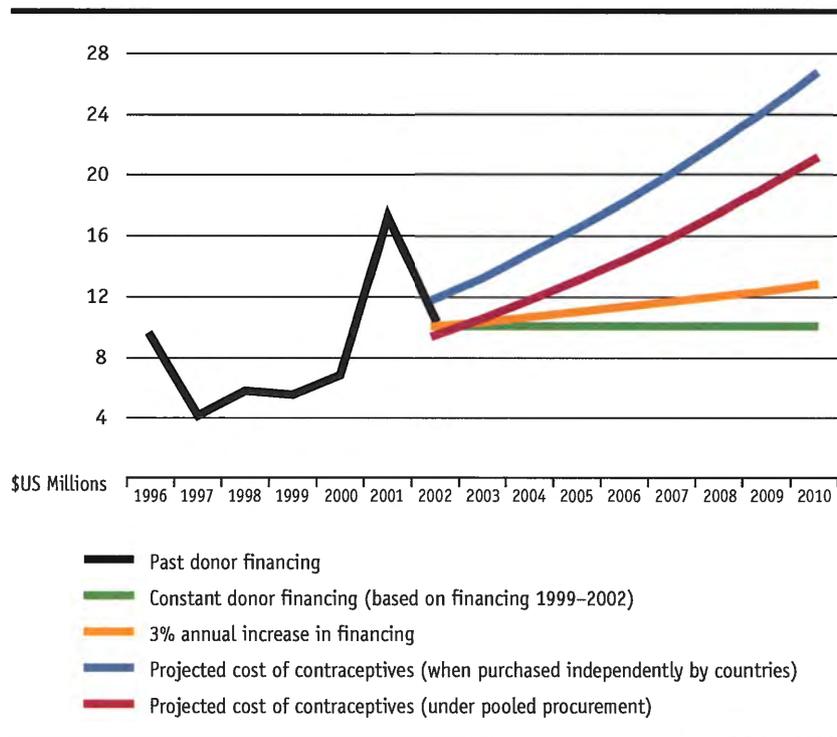
# 1. Background

West Africa continues to face enormous development challenges. Maternal and infant mortality rates are still unacceptably high. In 2002, MMR in the West Africa sub-region stood at 1,100 per 100,000 births compared to a worldwide average of 400<sup>1</sup> (PRB 2002). The toll in lives and the economic consequences are staggering. Economic losses due to these high MMRs have been estimated at U.S.\$22 million (WAHO 2003). Significant portions of the ECOWAS population live on less than U.S.\$1 a day, and they do not have access to safe drinking water. Deaths due to preventable diseases remain a public health and a development challenge. And, HIV/AIDS prevalence rates, while not as high as those seen in the hardest hit countries of Eastern and Southern Africa, are nevertheless a serious cause for concern.

A number of factors contribute to the high maternal and infant mortality, including limited access to and use of RH services, and the resultant decline in health status. Total fertility rates remain high in the sub-region at 5.8 births per woman (PRB 2003), although desired fertility is considerably lower. This is reflected in the low regional contraceptive prevalence rates—less than 10 percent for all ECOWAS countries except Ghana at 19 percent (GDHS 2003) and Cape Verde at 46 percent. High unmet demand for family planning ranges from 18 percent in Niger to 40 percent in Togo. Although current overall use of family planning and RH services in the sub-region is low, the number of users will increase dramatically given the high population growth and the large numbers of couples entering their reproductive years. Even as demand grows, funding for reproductive health has been erratic and declining during the last five years, with projected funding levels below projected needs (see figure 1.1).

To address this reproductive health crisis, WAHO, at the request of the ECOWAS Ministers of Health, developed a strategy for reducing maternal and perinatal mortality in the West African sub-region. The strategy addresses a number of critical approaches to improve maternal health, and it enables WAHO's member states to meet the Millennium Development Goal (MDG) of reducing maternal mortality by 75 percent by 2015 (United Nations 2000). One such approach is to build the capacity of regional leaders and managers to improve RHCS, ensuring that couples can chose, obtain, and use RH products whenever they want them.

**Figure 1.1**  
**ECOWAS Past and Projected Donor Financing and Costs for Contraceptives (excluding condoms) 1996–2010**



1. This figure excludes Australia, Japan, and New Zealand.

WAHO also developed a concept paper on improving RHCS in the West African sub-region with the support of its development partners, including USAID, the World Bank, and UNFPA. Using the paper as a guide, WAHO asked DELIVER to prepare a paper and presentation for the Fourth Annual Meeting of the Assembly of the ECOWAS Health Ministers that outlined the current RHCS situation in the sub-region and various options to improve it. The Health Ministers agreed that DELIVER should study the different options for securing commodities in the sub-region, including pooled finance and procurement, and private sector expansion.

## 1.1 West Africa RHCS Study

With the Ministers' mandate, DELIVER with WAHO and its development partners, designed a study in three sequential phases:

1. conduct an expanded desk review and two country case studies
2. conduct in-depth country assessments
3. develop a regional RHCS strategy and implementation plan.

The study's goal is to assess specific RHCS options and inform the development of a regional RHCS strategy and implementation plan.

The objective of this report is to summarize the Phase one findings, including an overview and synthesis of previous experience with pooled procurement, identification of the potential benefits to West Africa of pooled procurement of RH products, and analysis of the potential for private sector expansion in the sub-region.

The report examines the—

1. impact pooled procurement would have on improving the supply of RH commodities in the sub-region (lower cost, improved quality, increased supply)
2. possible options for pooled procurement mechanisms for RH commodities
3. policy and market barriers to pooled procurement
4. opportunities to expand the private sector's role in the manufacturing and supply of RH commodities and possible barriers to expansion.

Phase one of the study began in February 2004. The data sources include the most recent Demographic and Health Surveys (DHS) for the ECOWAS countries, other secondary sources, literature reviews, key informant discussions, a questionnaire completed by RH advisors from 11 ECOWAS countries, and country assessments in Burkina Faso and Ghana.

## 2. Summary Findings on Pooled Procurement

Phase one of the study explored current and past experience with pooled procurement and finance to explore the potential contribution it might have for RHCS in West Africa. Pooled procurement of RH commodities can potentially lower the unit costs through volume-driven low prices and efficiencies achieved in the procurement process. Some additional benefits include ensuring the quality of commodities procured and improving the reliability of the supply. Many pooled procurement mechanisms include a pooled finance component that can increase financial resources for commodity supply through both donor and country contributions.

### 2.1 Options and Models for Pooled Procurement

Pooled procurement can take many forms, ranging from informed buying, primarily an information sharing mechanism; to central contracting, which centralizes tendering, contracting, and purchasing. The administrative burden increases as you move along the continuum, as do the potential benefits.

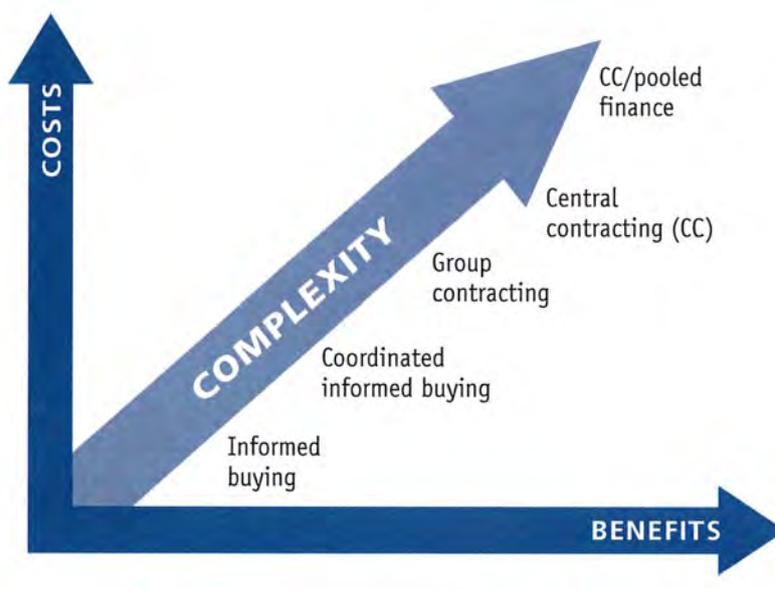
Table 2.1.1 describes the range of pooled procurement options.

There has been significant regional and global experience with pooled procurement of medicines and vaccines. Each system reviewed under this study was unique, reflecting the differences in their operating environment and objectives. The initial capitalization of the mechanism, the cost of administering it, and cost savings achieved vary significantly. Table 2.1.2 summarizes selected pooled procurement and finance mechanisms. Appendix 1 provides more detail on three mechanisms that seem to be the most relevant to the subregion, including ACAME, the Stop TB Global Drug Facility (GDF), and the Eastern Caribbean Drug Service (ECDS).

#### 2.1.2 Indicative Costs and Benefits of Different Models

Each pooled procurement model comes with different levels of cost, benefit, and complexity (see figure 2.1). Compared with the other options, informed buying provides the least costly and complex options but fewer potential benefits. Central contracting with pooled finance, at the other end of the spectrum of options, creates more complexity and cost but could also provide the greatest benefit.

**Figure 2.1.1**  
**Comparative Cost, Benefits and Complexity for Different Pooled Procurement Options**



**Table 2.1.1: Summary Description of Pooled Procurement Options**

Option	Description	Comments
Informed Buying	<ul style="list-style-type: none"> <li>Member countries share information about prices and suppliers.</li> <li>Countries conduct procurement individually.</li> </ul>	<ul style="list-style-type: none"> <li>Low administrative costs.</li> <li>Limited central procurement and financial management capacity required.</li> <li>Can take advantage of advances in information technology.</li> <li>Resources include online catalogues (UNICEF, International Dispensary Association (IDA)).</li> <li>May not achieve significant volume cost savings.</li> </ul>
Coordinated Informed Buying	<ul style="list-style-type: none"> <li>Member countries undertake joint market research, share supplier performance information, and monitor prices.</li> <li>Countries conduct procurement individually.</li> </ul>	<ul style="list-style-type: none"> <li>Similar advantages and disadvantages to informed buying but requires greater coordination and central capacity to manage shared information.</li> <li>Can assist in quality assurance and reliability of supply by sharing information about suppliers.</li> </ul>
Group Contracting (e.g., ACAME)	<ul style="list-style-type: none"> <li>Member countries jointly negotiate prices and select suppliers.</li> <li>Member countries agree to purchase from selected suppliers.</li> <li>Countries conduct purchasing individually.</li> </ul>	<ul style="list-style-type: none"> <li>Requires central capacity to negotiate prices, and commitment from countries to use selected suppliers.</li> <li>Can achieve volume cost savings through negotiation.</li> <li>Pre-qualification of suppliers may improve quality and reliability of supply.</li> <li>Allows countries to retain autonomy for purchasing.</li> <li>Does not require transfer of funds to a central procurement organization.</li> <li>Requires contractual commitment from participants.</li> <li>Requires some degree of harmonization of essential medicines lists and in drug registration procedures.</li> </ul>
Central Contracting (e.g., ECDS)	<ul style="list-style-type: none"> <li>Member countries jointly conduct tenders and awards contracts through an organization acting on their behalf.</li> <li>Central buying unit manages the purchase on behalf of countries.</li> </ul>	<ul style="list-style-type: none"> <li>Greatest potential for volume cost savings.</li> <li>Most leverage with suppliers to ensure reliability and quality of supply.</li> <li>Can achieve efficiency savings in administrative costs through central procurement.</li> <li>Requires significant capacity in tendering, contracting, purchasing, and financial management by organization responsible for procurement.</li> <li>Requires commitment from countries, including prompt payment and sole source purchasing from central mechanism.</li> <li>Requires harmonized essential drugs lists and drug registration procedures.</li> </ul>
Pooled Finance/ Central Contracting (e.g., PAHO vaccines, GDF, GAVI)	<ul style="list-style-type: none"> <li>Same as central contracting but initial capitalization by donor or regional organizations.</li> </ul>	<ul style="list-style-type: none"> <li>Similar advantages and disadvantages as for central contracting.</li> <li>May ease administrative burden on donors (manage one grant rather than multiple grants to individual countries).</li> <li>Needs strong regional ownership by participating countries.</li> <li>Dependent on donor funding priorities.</li> <li>Long-term viability requires increasing country level financial contributions through regional contributions.</li> </ul>

Source: Adapted from Onyango 2003.

**Table 2.1.2: Summary of Examples of Real-life “Contracting” Pooled Procurement Mechanisms**

	<b>ECDS— Eastern Caribbean</b>	<b>PAHO Vaccines RDF—Latin America</b>	<b>ACAME— West Africa</b>	<b>GAVI—Global</b>	<b>GDF (TB)— Global</b>
Category	Central contracting	Central contracting	Group contracting	Pooled funding— Central contracting	Pooled funding— Central contracting
Number of commodities	59 in 1st cycle; 420 more recently	11	5 (under pilot test)	(Under-used) vaccines	1st line TB drugs <sup>2</sup>
Number of countries or members	9 countries	24 countries initially, 35 in 2002	3 countries participated in pilot test; 12 attend meetings	<ul style="list-style-type: none"> <li>• 13 countries supported 1st year</li> <li>• 60 in 2002</li> </ul>	<ul style="list-style-type: none"> <li>• Stop TB Partnership</li> <li>• 46 organizations funded (2004)</li> </ul>
Cost saving	Up to 52% over unit cost (15–88% per country tender)	Up to 80% of price of vaccine	7%–27% over unit price (pilot test only)	NA	30% for treatment course
Financing of procurements	<ul style="list-style-type: none"> <li>• Initial cash contribution of 1/3 of each country's pharmaceutical budget</li> <li>• Eastern Caribbean Central Bank pays suppliers directly and is reimbursed by countries upon delivery of products</li> </ul>	<ul style="list-style-type: none"> <li>• \$1 million initial capitalization, plus donations since</li> <li>• Countries reimburse PAHO RDF once they receive commodities</li> <li>• 3% service charge collection in excess of \$100,000 is capitalized to procurement fund</li> </ul>	<ul style="list-style-type: none"> <li>• Each country has contract with supplier (under pilot)</li> </ul>	<ul style="list-style-type: none"> <li>• Donations, fund raising, with majority from Bill &amp; Melinda Gates Foundation</li> <li>• \$1.1 billion by 2002</li> </ul>	<ul style="list-style-type: none"> <li>• \$10 million initial funding from Canadian IDA</li> <li>• Funding raising from Stop TB partnership</li> </ul>
Financing of mechanism	15% admin fee	3% service charge, donations	<ul style="list-style-type: none"> <li>• Membership fees from members, currently 500,000 CFA (about \$900)</li> <li>• \$4,000 initial grant from WHO</li> <li>• Minimal, partial support from UEOMOA for defraying meeting costs meeting</li> <li>• Tendering fee of 100,000 CFA (pilot)</li> </ul>	<ul style="list-style-type: none"> <li>• Fund raising, donations</li> <li>• Longer term financing options being considered (e.g., put options, securitization, IDA loan buy-down)</li> </ul>	<ul style="list-style-type: none"> <li>• Funding raising from Stop TB partnership</li> <li>• WHO provides office and support</li> <li>• UNDP IAPSO for procurement</li> <li>• Phase-out plan being discussed</li> </ul>
Other factors	<ul style="list-style-type: none"> <li>• Common currency, language, and regional integration tradition, common demand pattern</li> </ul>	<ul style="list-style-type: none"> <li>• Initial capitalization fund, timely fund reimbursement, small product list</li> </ul>	<ul style="list-style-type: none"> <li>• Convertible currencies, regional tradition of integration, secretariat with databank, grouping by geography and language</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term funding commitment, public and private sector collaboration</li> </ul>	<ul style="list-style-type: none"> <li>• WHO defined essential medicines, limited range of products, strong leadership, donor funding commitment, tied to programmatic goals</li> </ul>

2. Considering the addition of diagnostics materials and second-line TB drugs.

## 2.2 Potential Benefits for West Africa RHCS

### 2.2.1 Cost Savings

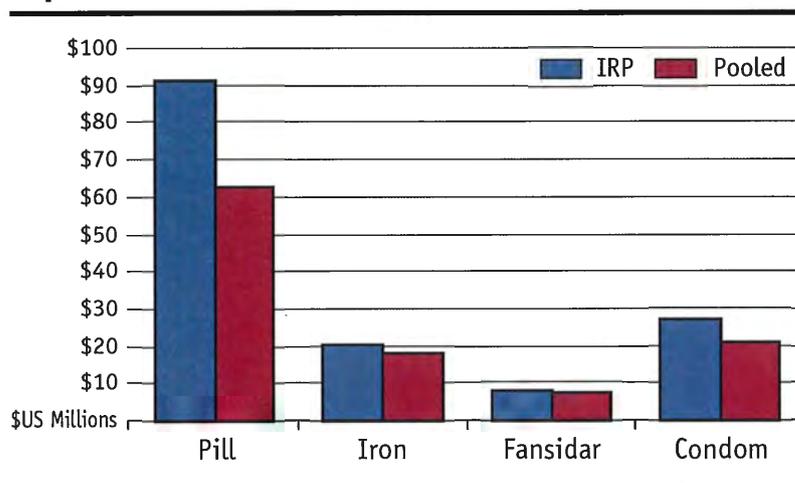
To estimate the potential cost savings from pooled procurement, the study determined the lowest international reference price (IRP) for 22 tracer commodities, including contraceptives, sexually transmitted infection (STI) and HIV/AIDS drugs, antenatal products, and obstetric/neonatal commodities (IDA 2004; MSH 2003; UNFPA 2004).<sup>3</sup> This list was agreed to in consultation with WAHO and other stakeholders as indicative of key RH commodities used in the sub-region. The unit prices were then compared to commodity unit prices quoted by selected procurement agents for pooled volumes based on the aggregate estimated demand for the 22 commodities in the sub-region (IDA 2004; UNFPA 2004).<sup>4</sup> See appendix 2 for detailed results of this analysis.

When the IRPs were compared to the theoretical pooled volume price, it was determined that a 14 percent unweighted average savings is possible when compared to the lowest IRPs. While this is only an estimate provided by procurement agents, and the averages provided are unweighted,<sup>5</sup> it indicates that bulk procurements can affect unit prices. The unit price reductions at 28 percent were most significant for contraceptives. Within that category, there was a 60 percent unit price reduction for the combined oral pill. Potential savings can be even greater for some countries because many countries in the sub-region are currently paying more than IRPs for some commodities. Based on forecasted commodity requirements, the 14 percent price variation between IRPs and pooled prices could result in a potential \$53 million savings for the sub-region between 2002 and 2010.

Figure 2.2.1 compares the IRP and pooled prices for several RH commodities. Total aggregate cost (2002–2010) for select RH tracer commodities are shown. In addition to condoms and pills, potential cost savings exists for Fansidar<sup>®</sup> and iron tablets if the sub-region can obtain the pooled procurement price through sole source purchasing.

The study also collected country-level data on prices paid for the tracer commodities in Burkina Faso and Ghana, and compared them with both the IRP and pooled prices. The findings were mixed. Ghana, and Burkina Faso to a lesser extent, were able to procure many of the tracer commodities at a lower price than the IRP and even the quoted pooled prices. Some possible reasons for the lower prices obtained by the

**Figure 2.2.1**  
**IRP and Pooled Price Cost Comparison for Select Reproductive Health Commodities, 2002–2010**



3. RH tracer commodities: Contraceptives: condoms, injectables, IUDs, implants, and OCPs; STI/HIV/AIDS: nevirapine tablets and syrup, benzathine penicillin, co-trimoxazole, doxycycline, and metronidazole; Antenatal: tetanus toxoid vaccine, iron, folic acid, and Fansidar; OB/neonatal: oxytocin and ergometrine; Other: gloves and ORS.

4. Hypothetical pooled procurement prices were obtained from the International Dispensary Association (IDA) and UNFPA. These prices are estimates and are based on a variety of factors listed in the text.

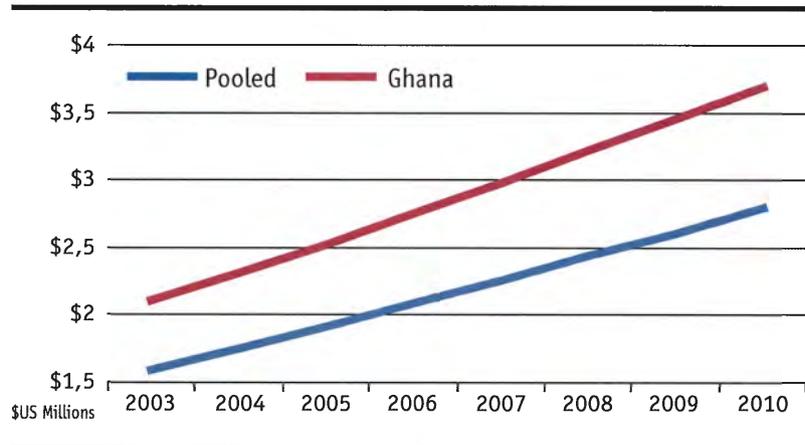
5. Actual savings could be more or less depending on the volume procured for individual commodities. If lower quantities were procured for items with larger price differences, the savings would be less.

countries include purchase from local manufacturers (no freight charges), long relationships with suppliers, and potentially higher volumes as the same medicine can be used for a range of illnesses, not just those related to RH. It should also be pointed out that the quoted pooled prices were informational and not subject to negotiation; in all likelihood, in a real pooled procurement situation, even better prices could be obtained. In contrast to some of the other commodities, each country could potentially obtain a cost saving in contraceptive prices from pooled procurement. Burkina Faso paid 18 percent and Ghana 32 percent above quoted pooled prices for contraceptives.<sup>6</sup> Figures 2.2.2 and 2.2.3 illustrate the potential contraceptive savings for each country. Burkina Faso could also achieve cost savings for oxytocin (29 percent), Fansidar (28 percent), doxycycline (20 percent), and oral rehydration solution (ORS) (41 percent) (see figure 2.2.4).

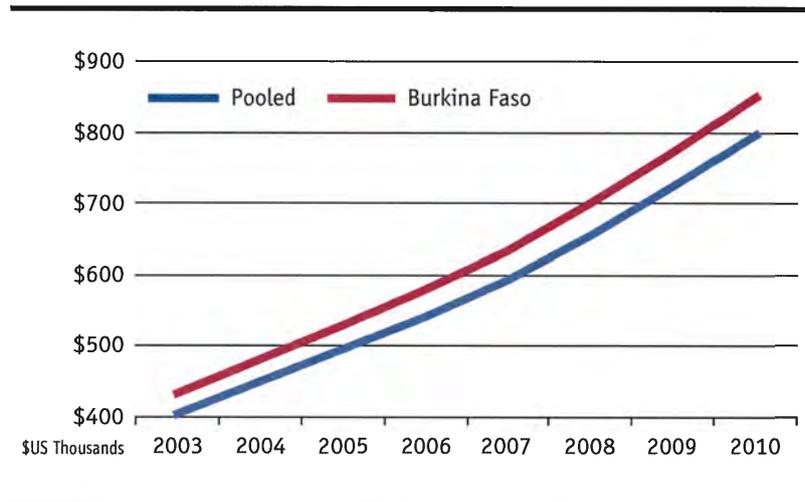
### 2.2.2 Other Benefits

In addition to the potential cost savings, countries in the region might benefit from improved quality of the products procured through the pre-qualification of suppliers, although those interviewed in Burkina Faso and Ghana felt their current procurement process already ensured high quality. The other area where pooled procurement might provide some benefit is with the reliability of the supply, particularly for contraceptives. A number of countries in West Africa have experienced problems in their contraceptive supply, including long periods between order and delivery, limited coordination among current contraceptive funders, and poor communication between the supplier and the country. These problems led to product sitting in port collecting demurrage charges, gaps in the supply, and an oversupply of one product (e.g., condoms) arriving at the same time. A central procurement body, especially one where donors pool their funding for commodities, could

**Figure 2.2.2**  
**Comparison of Costs Between Contraceptive Prices Currently Paid in Ghana and Pooled Prices, Based on Projected Demand, 2003–2010**



**Figure 2.2.3**  
**Comparison of Costs Between Contraceptive Prices Currently Paid in Burkina Faso and Pooled Prices, Based on Projected Demand, 2003–2010**



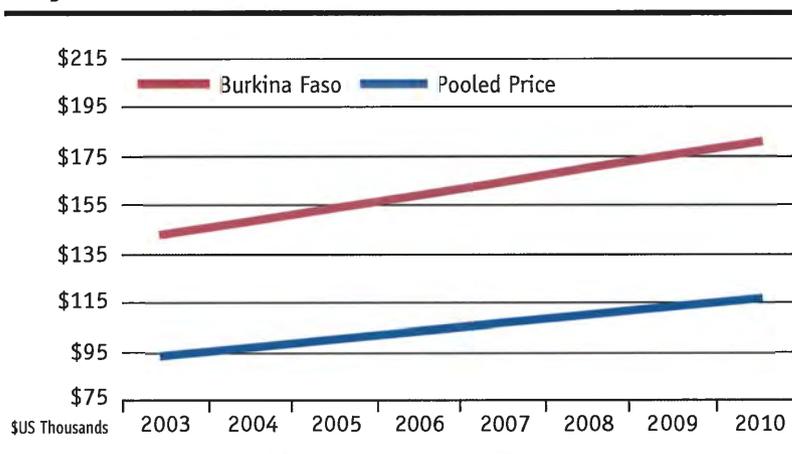
6. Based on lowest country procurement prices.

facilitate communication and manage the procurement process to limit such issues in the future.

### 2.3. Key Factors for Success and Implications for West Africa

A review of the global and regional experience in pooled procurement showed that some requirements (Burnett 2003) are similar for the various pooled procurement options (see table 2.3.1). The study analyzed the implications of these requirements for pooled procurement in the sub-region based on data collected through the two country assessments and discussions with key informants.

**Figure 2.2.4**  
**Comparison of Costs Between ORS Prices Currently Paid in Burkina Faso and Pooled Prices Based on Projected Demand, 2003–2010**



#### 2.3.1 Supportive Policies and Legal Mechanisms

All participating countries must have policies and regulations that facilitate their participation in pooled procurement, such as allowing the outsourcing of price negotiation and selection of suppliers. For example, regulations prohibiting international tenders or third-party procurement would limit that country’s ability to participate in a pooled mechanism. Findings from Burkina Faso and Ghana indicate that presently there is no policy or regulatory constraint that might prohibit their participation in a regional pooled procurement mechanism.

The study also conducted a regional policy analysis to better understand the RH policy environment (POLICY 2004). A supportive policy environment is critical to RHCS and any pooled procurement mechanism that focuses on RH commodities. The assessment found that RH commodities are not explicitly addressed in RH or pharmaceutical policies, which leads to inconsistent and ineffective RH commodity management. Narrowing this gap would strengthen RHCS within the sub-region and facilitate the pooled procurement of RH commodities.

#### 2.3.2 Reliable Forecasting, Procurement, and Distribution Systems

Pooled procurement needs timely and accurate forecasts to ensure that a sufficient volume of each product is procured. Inaccurate forecasting could lead to emergency orders, resulting in high prices. It could also impact the credibility of the procurement mechanism with suppliers, again resulting in higher prices. An analysis of DELIVER logistics assessments in the sub-region indicates that national-level forecasting for RH commodities is generally weak. Forecasting capacity for contraceptives often differed from other RH commodities because the contraceptive supply chain was commonly managed separately from other pharmaceuticals. Respondents to a DELIVER questionnaire from eight ECOWAS countries said that an insufficient number of trained staff were available to adequately forecast RH commodity needs.<sup>7</sup> The country assessments undertaken in Burkina Faso and Ghana also supported these conclusions.

7. JSI/DELIVER distributed a questionnaire to national RH supply chain managers and obtained feedback from 8 countries.

**Table 2.3.1: Critical Requirements for Pooled Procurement Options**

	<b>Informed Buying</b>	<b>Coordinated Informed Buying</b>	<b>Group Contracting</b>	<b>Pooled Finance/ Central Contracting</b>
<b>2.3.1 Supportive Policies and Legal Mechanisms</b> <ul style="list-style-type: none"> <li>• Legal/policy mechanism for information sharing</li> <li>• Independent representative secretariat for the procurement</li> <li>• Clear understanding of the costs, benefits, and obligations for each country and possible need for a transfer mechanism<sup>8</sup></li> <li>• Good governance and accountability for funds flow</li> <li>• Supportive policies and a legal mechanism for jointly negotiating (outsourcing negotiation) of prices and selection of suppliers</li> </ul>	✓	✓	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓
<b>2.3.2 Reliable forecasting, procurement and distribution systems</b> <ul style="list-style-type: none"> <li>• In-country capacity to computerize/standardize supplier and price information</li> <li>• Reliable supply chain management including forecasts of national commodity needs and national distribution systems</li> <li>• Similarity and transparency of procurement policies and procedures</li> <li>• Ensure supply chain does not lengthen with central contracting</li> </ul>	✓	✓	✓ ✓	✓ ✓ ✓
<b>2.3.3 Reliable financial support</b> <ul style="list-style-type: none"> <li>• Financial commitment by participating countries and funding partners</li> <li>• Evidence of reliable payment of suppliers by countries</li> </ul>			✓	✓ ✓
<b>2.3.4 Commitment to sole source</b> <ul style="list-style-type: none"> <li>• Political will including willingness to sole source</li> </ul>				✓
<b>2.3.5 Common language and currency</b> <ul style="list-style-type: none"> <li>• Common language</li> <li>• Convertible currencies among participating countries</li> </ul>			✓ ✓	✓ ✓
<b>2.3.6 Harmonizing drug registration, essential drug list, suppliers, and standard treatment guidelines</b> <ul style="list-style-type: none"> <li>• Establish a unique regional drug registration standard policy and procedure</li> <li>• Existence of similar essential drug lists (EDLs) and STGs</li> <li>• Adequate in-country QA capacity</li> </ul>			✓ ✓ ✓	✓ ✓ ✓

Source: Adapted from Onyango 2003.

8. Typically the costs and benefits of regional integration mechanisms are not distributed evenly across all participating countries, necessitating some countervailing compensation mechanism.

Additionally, the data used for forecasting varied considerably between ECOWAS countries, with some countries using logistics data and others using demographic data. Reliable data (preferably consumption data from service delivery points) provides the most accurate basis for forecasting future commodity needs. Because half the ECOWAS countries do not have a routine data collection system for logistics, they have a limited ability to accurately forecast RH commodity needs.

Distribution is also critical to commodity security. Weak distribution systems lead to waste, loss, and stockouts at the facility level. Although all ECOWAS countries have a system in place to manage the distribution of RH commodities, the systems are often poorly managed. More than half the ECOWAS countries reported having insufficient numbers of skilled staff to manage the distribution of commodities. Frequently, products are not distributed based on a schedule that would ensure the rational use of vehicles and drivers. These limitations in distribution lead to stockouts at service delivery points (see figure 2.3.1). Care should also be taken to ensure that any pooled procurement mechanism adopted does not lengthen product pipelines.

Because of the importance of reliable forecasts and distribution systems, a number of procurement models include technical support to supply chain management (e.g., GDF and ECDS). Given the limitations of the country-level forecasting and distribution systems in West Africa, it would be important for any regional procurement mechanism to include this support.

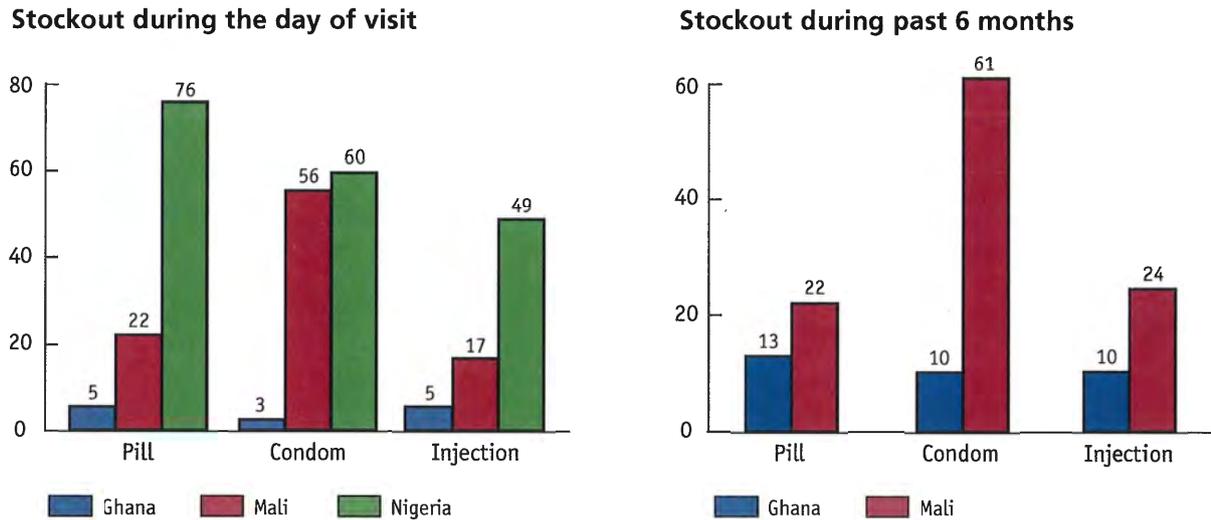
### 2.3.3 Reliable Financial Support

Pooled procurement requires adequate, reliable funding for both the commodity purchase and to cover the administrative costs of the procurement mechanism. Funding for RH commodities in West Africa currently comes from a variety of sources, including government budgets, SWAp or basket funding, and donor funds. Private households also provide financial support for commodities by paying user fees. In the public sector, these funds go to the government to support future commodity procurements. Contraceptives, vaccines, and HIV/AIDS medications are primarily supported through donor financing while sexually transmitted infection/opportunistic infection (STI/OI) medications and antenatal/obstetric/neonatal care products are primarily funded through government expenditure. See table 2.3.2 for information on the sources of commodity funding in Burkina Faso and Ghana.

**Table 2.3.2: Comparison of the Source of Funding for Contraceptives and Other Health Commodities in Burkina Faso and Ghana**

<b>Burkina Faso</b>	<b>Contraceptives 1997–2004</b>	<b>EPI Vaccines/Consumables 2004</b>
Government	12%	NA
USAID	15%	NA
UNFPA	23%	NA
World Bank	50%	NA
<b>Ghana</b>	<b>Contraceptives 2004</b>	<b>EPI Vaccines/Consumables 2004</b>
Government	5%	8%
Basket funded	23%	25%
Donor	72%	67%

**Figure 2.3.1**  
**Stock Status of Public Service Delivery Points**



Almost all the international group and central contracting mechanisms reviewed had some initial capitalization of the procurement mechanism, either through country contributions or donor support. Given that many of the RH commodities in West Africa are currently funded by donor agencies, it is expected that donors will provide a significant portion of the initial commodity funding for any RH commodity procurement.

The GDF, Pan American Health Organization (PAHO) Revolving Drug Fund for Vaccines, and WAHO's plans for pooled procurement of HIV/AIDS commodities are examples of this type of donor-supported financing. Each currently requires some level of country or regional contribution. While, initially, the GDF did not require matching country funds, it is considering that option.

Most West African countries are currently covering part of their RH commodity costs through their own funds. In a potential pooled procurement mechanism, they will need to continue to commit funding to cover a percentage of these costs and to provide financing for some administrative costs.<sup>9</sup> Based on past pooled procurement experience, countries in the sub-region can expect to gradually take on greater financial responsibility as donors phase out support. Key government officials in both Burkina Faso and Ghana expressed interest in further exploring pooled procurement options to determine whether they can realize the benefits described above.

Prompt payment, either to the central procurement agency/financial institution or directly to the supplier is also critical to the success of pooled procurement. Suppliers use several criteria to determine the prices they charge: volume is one factor and prompt payment is another. Respondents in Burkina Faso expressed some reservations that a regional procurement mechanism could lose credibility if one member defaults in payment or is slow in paying to a central mechanism. This risk may be limited if there is significant donor financing.

9. Administrative costs would only be applicable for the Central Contracting and Pooled Finance models.

### **2.3.4 Commitment to Sole Source**

Countries must demonstrate a willingness to sole source a portion (e.g., ECDS) or all (e.g., Saudi Arabia in Gulf Cooperation Council [GCC]) of their pharmaceutical needs to the pooled procurement mechanism. This guarantees a demand and a financial base for fully leveraging the volume advantage inherent to pooled procurement. In West Africa, an evaluation of the pilot procurement under ACAME found that countries had not committed to purchasing a large percentage of their pharmaceutical needs through ACAME; therefore, there was not sufficient volume to maximize price reductions (WHO 1999). Procurement agents active in the sub-region thought that because of the differences between countries in the sub-region, forming the required political will to sole source to a central procurement mechanism may be limited. Additionally, an analysis of RH policies in the sub-region found that while policies exist and high-level officials have voiced their support of RH, there has not been a significant and sustained effort to provide the resources needed to implement RH programs to meet demand and to satisfy unmet needs. This could be an indication of insufficient commitment to sole source or to finance the procurement of contraceptives.

The other issue related to commitment and the potential of pooled procurement in the sub-region is whether or not Nigeria is willing to participate. For the tracer RH commodities included in the study, Nigeria accounted for approximately 50 percent of the demand. For example, without Nigeria's participation, demand for folic acid is reduced from 36 billion to 20 billion units in the sub-region (as an aggregate) for 2002–2010. The demand for condoms decreases from 1 billion to 500 million (see appendix 3). Given this, the sub-region is not likely to be able to achieve the same level of price reduction presented above unless Nigeria participates. It is unclear what prices could be obtained without Nigeria's participation. Procurement agents quoted RH commodity prices based on a volume estimate that included Nigeria. An additional scenario without Nigeria will need to be conducted to determine what savings could be realized.

### **2.3.5 Common Language and Convertible Currency**

A number of evaluations of pooled procurement found that a common language was an important condition for success. Interviews with several private procurement agents operating in the sub-region mentioned the need to package the commodities in several languages as a possible constraint to pooled procurement. While absence of a common language makes coordination difficult, the team found it to be less critical than the related issues of a common currency (or convertible currency) and the general differences in the procurement approaches and structures found in West African Francophone and Anglophone countries. Respondents in both the Burkina Faso and Ghana assessments agreed that differences in the drug management systems in the region were a potential limitation to pooled procurement. This was echoed in the interviews with private procurement agents. Country respondents also cited custom restrictions as inhibiting the free movement of goods within the sub-region and a lack of a common currency as potential barriers to effective pooled procurement. However, all felt that the planned reforms under ECOWAS, in terms of both trade and a common currency, would greatly facilitate pooled procurement in the sub-region.

### **2.3.6 Harmonizing Drug Registration, Essential Drug Lists, and Standard Treatment Guidelines**

To achieve the volume savings under pooled procurement, all participating countries must agree on the products being procured, and these products must be registered for use in each country. All the tracer commodities are included in Burkina Faso and Ghana's essential drug lists, and all are registered for use in both countries. However, registration is specific to a particular manufacturer and the manufacturer is not always the same for both countries. Respondents in both country assessments mentioned that the lack of coordinated product selection, harmonization of product lists, and regional standards in product

labeling within the sub-region were a constraint to effective pooled procurement. However, both countries expressed a commitment to work toward greater sub-regional cooperation, including harmonizing drug policies and standards with other countries. Respondents in Burkina Faso cited that discussions among member states currently underway have the ultimate goal of adopting common drug registration requirements, essential drug lists, and treatment guidelines within the sub-region. Ideally, this should allow drug registration in any member state to be accepted in other member states. If the countries agreed, this would greatly facilitate pooled procurement in the West Africa. An important part of harmonizing drug registration would be to improve the drug quality assurance standards and systems to ensure product quality and mutual confidence among countries involved in any pooled mechanism.



# 3. Summary Findings on Private Sector Expansion

In addition to investigating pooled procurement, the study also reviewed the status of the private sector in the supply of RH commodities in West Africa.

## 3.1 Current Market Share

The current private sector market share in supplying RH commodities varies from country to country and it is usually quite large. The true commercial sector share, however, defined as unsubsidized products distributed through for-profit facilities and providers, is very small, no more than a few percentage points in all countries. Subsidized social marketing products distributed through a mixture of true private sector retailers and providers and NGOs account for most of the private sector market share. Table 3.1 shows market share information for various contraceptive methods in West Africa. This information is categorized by source of method, and does not indicate whether the product is subsidized (social marketing) or not (commercial).

In most West African countries, the majority of condoms are distributed through social marketing programs. Injectable contraceptives and IUDs are predominantly distributed through the public sector, because there are few private medical practitioners. For oral pills, there is a significant private sector share, which varies from country to country. In Ghana, the private sector share for condoms is 83 percent, for injectables it is 12 percent, for IUDs it is 8 percent, and for pills it is 60 percent. In Burkina Faso, the private sector share for condoms is 88 percent, injectables is 6 percent, IUDs is 5 percent, and pills is 11 percent.

## 3.2 Expansion Potential for Commercial Sector

Several factors constrain the ability of the commercial sector to participate in contraceptive markets in the sub-region including—

- limited income levels
- low demand
- shortages of private medical practitioners (both pharmacists and providers)
- trade barriers
- lack of controls on counterfeit drugs
- regulatory issues, such as restrictions on advertising and on dispensing and prescribing,
- non-harmonization of drug registration in the different countries of the region
- availability of free or subsidized products through the public sector at very low prices.

Given the low prevalence levels in West Africa, high unmet need, and relatively low-income levels, the priority should be to increase use through improved service delivery and promotion. However, increased prevalence and increased private sector share are not mutually exclusive; the private sector can also play a role in increasing use.

Greater integration of ECOWAS by harmonizing drug registration, implementing policies on free trade within the zone, and providing better transportation links would allow the creation of a West African

market with a population of 280 million that would be more attractive to commercial entities. Intra-regional free trade would greatly facilitate the movement of RH commodities between ECOWAS members. It would also strongly encourage local manufacturers to participate in tendering for pooled procurements. Although ECOWAS members are supposed to have free trade for industrial goods, Benin is the only country to waive tariffs on ECOWAS imports. Other ECOWAS measures, including harmonized motor vehicle insurance and the removal of transit taxes and other restrictions, will facilitate trade but, so far, they have not been universally applied. The availability of cheaper generic products from Asia may potentially offer increased commercial product availability and accessibility in the region.

### 3.3 Role of Social Marketing

Income levels in West Africa probably preclude the development of a significant commercial market for contraceptives over the short term (Gwatkin et al. 2000). Meanwhile, social marketing has an important role to play in tapping into the current large unmet need for family planning and in creating a market that will, in the future, attract commercial partners. Social marketing can play this role, not only by making affordable products available, but also through promotion, provider training for improved service delivery, and development of in-country supply chains. Governments can do more to support social marketing programs through market segmentation approaches, including targeting public sector services toward lower income groups and pricing policies. Social marketing organizations can become more efficient by adopting regional approaches to product selection, branding, advertising campaigns, and packaging.

### 3.4 Local Manufacturing

Local manufacturing includes the manufacture of active pharmaceutical ingredients (APIs), the manufacture of finished dosage forms (e.g., tablets, capsules, and liquids), and the repackaging of finished dosage forms. The term local manufacturing can also be defined in terms of ownership, from wholly locally owned organizations to subsidiaries of foreign multinational enterprises (MNEs).

Current manufacturing capacity in West Africa is limited, and consists of the manufacture of finished dosage forms of essential drugs and over-the-counter (OTC) preparations and repackaging of drugs. The main products are tablets, capsules, and some liquid preparations of antibiotics, antimalarials, anthelmintics, and analgesics. There is little to no API manufacture and no manufacture of contraceptives, though some other reproductive health commodities are made. Manufacturing is concentrated in Nigeria and Ghana, with limited information available on production in Cote d'Ivoire and Senegal. Burkina Faso, apart from some repackaging, has no manufacturing capacity. Ownership in Nigeria and Ghana consists of some locally owned manufacturers (either privately or publicly held), and subsidiaries of MNEs. Manufacturers in Nigeria and Ghana also have significant export markets to other ECOWAS countries.

Constraints to local manufacturing include no economies of scale, lack of trained personnel and technology, inadequate infrastructure, and the necessity to import most raw materials. Local manufacturing must compete with branded products from Europe and the U.S. and, increasingly, with cheap generic drugs from Asia. The competitive advantages of local manufacturers because of their location within ECOWAS and proximity to their customer base are often not realized because intra-regional trade barriers still exist within ECOWAS, alongside non-harmonized drug registration processes and non-transparent or overly complicated procurement procedures.

The role of governments in increasing opportunities for local manufacturers lies in developing and implementing policies that make it easier for local manufacturers to operate. Regional and international experience has shown that governments should not invest directly in manufacturing plants. Direct subsidies or tariffs on imports will lead to higher prices for consumers and poorer public health.

Creation of some form of pooled local manufacturing for West Africa is unrealistic and unadvisable. Local manufacturers must compete on price and quality with imported drugs. Local capacity can be fostered by creating an enabling environment through developing infrastructure; ensuring the educational system produces adequate human resources; harmonizing drug registration; and ensuring drug procurements are open, transparent, and accessible for local manufacturers. In this way, local manufacturers can exploit their competitive advantages in carving out a market for themselves.

**Table 3.1: Percentage of Market Shares for Contraceptive Methods in West Africa**

Country/ Survey Year	Oral Pill			Injectable			Condom			IUD		
	Public	Private medical	Other private	Public	Private medical	Other private	Public	Private medical	Other private	Public	Private medical	Other private
Benin 1996	35.3	28.7	30.2	77.8	19.8	2.4	8.2	28.4	55.2	89.6	10.4	0
Burkina Faso 1998/99	85.3	8	2.9	94.5	5.5	0	7.3	12.6	75.8	89.4	5.3	0
Cote d'Ivoire 1998/1999	45.4	42.7	11.9	75.3	24.7	0	1	34.5	54.1	67.6	32.4	0
Ghana 1998	33.3	60.1	1.2	88	10.9	1.1	15.9	68.1	13.4	91.7	8.3	0
Guinea 1998	49.6	23.9	22.6	82.4	12	5.7	12.6	27.1	38.9	66.7	33.3	0
Liberia 1986	21.3	60.2	17.9	40.8	50.1	9.1	31.5	1.7	26.7	49.8	50.2	0
Mali 2001	38.9	45.6	12.8	75.5	19.9	4	6.9	43.8	37	75.1	22.4	0
Mauritania 2000/01	77.4	19.8	0.3	83.5	4.4	0	32.6	48.5	0	61.9	31.2	0
Niger 1998	79.8	12.3	8	96.5	2.8	0.8	36.3	17.4	46.3	90.2	9.8	0
Nigeria 1999	29.1	53.1	8.3	68.6	27	1.9	12.9	62.7	14.3	74.4	19.5	0.8
Senegal 1997	73.6	17.8	7.9	92.1	4.6	3.3	22.9	57.2	13	66.8	17.2	14.9
Togo 1998	37.6	15.4	42.3	91.6	7.4	0.5	14.9	18	66.3	82.9	17.1	0

Source: DHS.



# 4. Phase One Conclusions and Recommendations

## 4.1 Pooled Procurement and Finance

Based on the findings from phase one of the study, some but not all the preconditions for pooled procurement exist in ECOWAS. This is especially true for the more complex models including group contracting, central contracting and central contracting with pooled finance. However, the analysis indicates that pooled procurement of some RH commodities, specifically contraceptives, has the potential to provide significant costs savings to the sub-region.

Although we recommend further investigation of the identified options, the findings from phase one suggest the following:

- The sub-region should adopt a phased approach beginning with an option such as coordinated informed buying that has fewer requirements and is less of an administrative burden than group or central contracting. As the ECOWAS reforms are implemented, resulting in greater harmonization of key macroeconomic policies, procurement procedures, common or easily convertible currency, and fewer trade barriers, the sub-region could move toward group or central contracting. Alternatively, the sub-region could strengthen the already established procurement mechanism under ACAME, expanding its product list to include key RH commodities. If it is successful and as greater harmonization occurs in the sub-region, it could be expanded to the English- and Portuguese-speaking countries.
- As the sub-region moves to a more complicated procurement option, such as group contracting, it should begin with a few products and expand after the systems and procedures are established. From the analysis, the greatest savings could be achieved from the pooled procurement of contraceptives. Given this, the mechanism should initially focus on contraceptives and eventually expand to other RH products where volume savings could be achieved.
- As the sub-region develops its capacity, a model similar to the Global TB Drug Facility may be strategically desirable, as West Africa will probably, for the mid-term, rely on external finance for RH commodity support. The GDF, with donor support, initially granted TB drugs directly to qualified countries and is increasingly serving as a procurement agent for others, which helps guarantee the lowest price. It plans to gradually shift its support from grants to pooled procurement as countries increasingly invest in TB commodities. Such a model provides a mechanism for efficient procurement (in the case of West Africa securing the lowest possible prices for contraceptives and other RH products), as well as for continued fund raising/strategic partnerships. WAHO is considering a similar model for the pooled procurement of HIV/AIDS commodities, including antiretrovirals (ARVs), and this may be an opportunity to link pooled procurement of RH commodities with this mechanism.
- To realize the benefits of pooled procurement, investments should be made in strengthening country level forecasting and distribution systems. Given the current limitations of the country level supply chain management in West Africa, it is critical to build logistics capacity in the sub-region. Other regions—the Eastern Caribbean—and global initiatives (GDF) have provided such assistance to support their pooled procurement activities, and found that it contributed significantly to their success.

## 4.2 Private Sector

Phase one findings also suggest that the current potential for unsubsidized commercial sector expansion in providing contraceptives is limited. This finding is based principally on the current low contraceptive prevalence rates in the sub-region and the limited purchasing power of private households. Instead, sub-regional RHCS efforts should continue to focus their support on the social marketing sector, and to help the public sector better target low-income groups and rural populations. Social marketing organizations should work with donors and governments to develop regional brands, thus achieving economies in packaging and advertising. In addition, the public sector can begin to facilitate future commercial sector expansion by—

- Reducing barriers to private provision of RH commodities including easing restrictions on the ability of pharmacists to dispense hormonal contraceptives without a physician's prescription; removing laws that ban the advertising of branded contraceptives; standardizing drug registration in West Africa; and, limiting tariffs and taxes on RH commodities.
- Increasing demand for RH services and products. With its mandate to promote the health of its citizens, the public sector is best positioned to undertake large-scale behavior change and communication activities. After the population understands the benefits of RH services, it will be easier to reorient them toward private sector products.
- Creating better targeting subsidies. The private sector has limited growth opportunities when the public sector provides free services and products to all. Given the low purchasing power and contraceptive prevalence in the sub-region, promoting utilization through subsidized services and products remains important. However, the public sector should focus its subsidies on the poor and rural populations, while the social marketing sector should focus on middle-income groups, allowing the commercial sector to serve those who can afford to pay the full cost.
- Strengthen governmental regulatory capacity. The public sector has an important role in overseeing quality standards in the private sector. If this is done effectively, regulation can ensure public safety while promoting a level market for open competition.

## 5. Next Steps

To complete the study on options for improving RHCS in West Africa, DELIVER proposes the following key activities:

- Participate in WAHO's planned pooled procurement technical advisors group meeting to review the options and models for pooled procurement presented in this paper. Through discussions with the regional technical experts, drawn from all member state central medical stores and procurement units, determine the feasibility of each pooled procurement option for West Africa. Also, discuss the possibility of using one pooled procurement mechanism for all RH commodities or have separate approaches, for example, for HIV/AIDS commodities and contraceptives.
- Based on feedback to the current report from technical partners and other stakeholders, present recommended options for future work to the next ECOWAS health ministers meeting.
- Begin discussions with funding partners to inform them of the phase one findings, and gauge their interest in supporting regional RHCS efforts.
- Conduct additional research of technical options, including country assessments, to supplement the data collected during phase one.
- Support WAHO in developing a West African strategy and implementation plan for RHCS, based on phase two findings and input from regional procurement experts.



## Appendix 1

# Description of Select Pooled Procurement Mechanisms

### **African Association of Central Medical Stores for Generic Essential Drugs (ACAME)**

Description	<ul style="list-style-type: none"><li>• Impetus was devaluation of the franc, leading to sharp fall in purchase and utilization of generic essential drugs.</li><li>• Objectives were to (1) Promote establishment of central stores for essential drugs in African countries which do not have them, (2) to set up a data bank on suppliers, prices, etc., and promote the exchange of information among central medical stores for generic essential drugs, (3) to progressively organize joint bulk purchasing, and (4) to protect the morale and material interests of members (i.e., central medical stores).</li><li>• Initial group of countries included Chad, Mali, Niger, Senegal, and Burkina Faso. Other West African countries have participated in ACAME meetings, including Benin, Togo, Côte d'Ivoire, Guinea (who participated in the first procurement pilot test), Guinea Bissau, and Cameroon. Countries outside the region have also attended these meetings, including Rwanda (active participant), Burundi, Central African Republic (Congo), Chad, Comoros, and Madagascar.</li><li>• ACAME was established in 1996, with the First General Assembly held June 1997.</li><li>• First joint bulk purchasing test in 1998 (coordinated by the <i>Pharmacy Populaire du Mali</i>); experience summarized below.</li><li>• Results from pilot tender assessment found prices that were 7% to 27% lower than the lowest prices each country had obtained over the 3 years for any of the (five) drugs involved in the joint bulk purchasing test.</li><li>• Since the pilot, ACAME has not been involved in any bulk purchasing event. It is still active and recently signed a cooperative agreement with UEMOA in 2002 to operate as UEMOA's procurement structure. The agreement is binding with the 8-member countries of UEMOA.</li><li>• Currently based in Ouagadougou, with a rotating presidents and 2 part-time staff.</li></ul>
Organizational Structure	<ul style="list-style-type: none"><li>• ACAME has a rotating chair, currently held by Burkina Faso under the <i>Centrale d'Achat Médicaments Essentiel Générique</i> (CAMEG), and for 2004/2005 it will be Guinea. The current chairman is the Director of CAMEG.</li><li>• There is also a permanent secretariat, which is also assured by CAMEG in Burkina Faso with one staff member based at CAMEG. Unlike the presidency, the secretariat does not rotate and has been based in Burkina Faso for some time. The hope is that; with the aid of donors like WHO, WAHO, and UMEAO; a permanent office with a full-time dedicated staff member can be established.</li></ul>
Forecasting	<ul style="list-style-type: none"><li>• Presumably performed by individuals countries.</li></ul>
Procurement	<ul style="list-style-type: none"><li>• A shortlist of 25 suppliers were authorized to bid in the initial test (they were identified based on a longer list of suppliers compiled by central medical stores identifying their choice for 10 suppliers)</li><li>• Each central medical store then provided information on 10 drugs in high demand and 5 drugs were selected (high demand products: cotrimozale 400+800 mg, bezylpenicillin 1mu injection, ampicillin 1g injection, chloroquine 100 mg base tablets, amoxycillin 500 mg tablets. Information on the specifications and quantity purchased were consolidated</li><li>• Drug purchases were pooled to obtain a single cost insurance freight (CIF) price with goods delivered to 3 purchasers (3 countries involved in the test were Guinea, Mali, Niger), and each purchaser would sign a contract with the selected supplier.</li><li>• Supplier is paid 30% on delivery and 70% after quality control.</li><li>• The Niamey Regional Quality Control laboratory selected to do quality control; however, for cost and communication, the <i>Laboratoire National de la Sante du Mali</i> carried out the tests.</li></ul>

## **African Association of Central Medical Stores for Generic Essential Drugs (ACAME) (cont'd)**

	<ul style="list-style-type: none"> <li>• Tender assessment commission made up of procurement managers of the central medical stores was set up to receive tender documents (set at 100,000 francs: this fee was used to cover the cost of preparing tender documents and the committee's expenses (accommodation, food and per diem).</li> <li>• Note was made in the article that none of the eligible local suppliers submitted offers during the (test) tender process and it was unclear why.</li> </ul>
Financing	<ul style="list-style-type: none"> <li>• Under the pilot, part of the committee's costs were defrayed using the revenue from the tender document</li> <li>• Apart from \$4,000 grant provided to ACAME by WHO in 1996, ACAME receives little external funding; UEOMOA contributed minimal, partial support for defraying costs of recent meeting.</li> <li>• Membership fees collected from members, currently 500,000 CF (about \$900).</li> <li>• Not clear how individual country procurements were financed.</li> </ul>
Distribution	<ul style="list-style-type: none"> <li>• Only pilot completed; delivered direct to country.</li> </ul>
Threats to Success	<ul style="list-style-type: none"> <li>* Political instability in countries.</li> <li>• Lack of transparency in carrying out analyses and inviting tenders.</li> <li>• Need for firm commitment of managers of central medical stores with support of Ministries of Health of member countries (which may change).</li> <li>• Need for preparation and signing of an agreement that defines application rules during the entire tender period to cover all matters concerning drug marketing. This was particularly important where regulations in countries differed.</li> <li>• Transparency in the implementation of framework agreement in order to assure suppliers.</li> <li>• Also, other threats cited during the pilot test refer to Guinea's difficulty with the mode of payment (its currency differs from the CFA franc), and non-compliance with coverage of insurance expenses by suppliers.</li> <li>• Political differences between the countries in the region.</li> <li>• Absence of a secretariat and funding. Without a secretariat to carry out duties and a budget to fund operations, such an initiative will not work. ACAME is mainly a "voluntary" organization with limited capacity.</li> <li>• Differences in constitution of CMS. PPM in Mali has independence in financing decisions, whereas several CMS must obtain government approval of any tenders.</li> <li>• Differences in drug registration (although not such a big problem for essential drugs, for contraceptives it may be).</li> <li>• The Niger CMS had political problems and was dissolved and reconstituted by the government.</li> <li>• Mali did achieve cost savings during pilot because the purchase price was negotiated on a larger order than they normally place. But, supplier was unwilling to guarantee that price for Mali in following years in the absence of such a pooled order.</li> <li>• A fixed price for all countries, landed in the respective capitals contributed to reluctance from some countries (especially coastal) to participate in the past. They felt they could obtain prices as good as if they were acting on their own.</li> </ul>
Best when ...	<p>(Stated based on lessons from Maghreb and Gulf States)</p> <ul style="list-style-type: none"> <li>• Political agreement of MOHs.</li> <li>• Establishment of (permanent) secretariat with data bank and mandate to disseminate information to all member states.</li> <li>• Signing of framework agreement governing joint bulk purchasing process and procedures.</li> <li>• Pooling by limited number of countries, preferably according to geography or linguistic grouping.</li> <li>• Setting up of standing committee on tendering.</li> </ul>

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**African Association of Central Medical Stores for Generic Essential Drugs (ACAME)  
(cont'd)**

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| Lessons for<br>WA Initiative | <ul style="list-style-type: none"><li>* Committee was going to look into assessing whether the profit obtained by each medical store from the joint bulk purchasing justified the costs incurred by organizing the purchase.</li><li>• Success seen as depending on (1) firm commitment of managers of central medical stores backed by MOH, (2) preparation and signing of agreement defining applicable rules during the entire tender period, and (3) transparency in the implementation of the framework agreement in order to reassure suppliers.</li></ul> |
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## Global TB Drug Facility

Description	<ul style="list-style-type: none"> <li>• Initiative of the Stop TB Partnership; has been operating since January of 2001.</li> <li>• Approach to securing access to high-quality TB drugs, including: mobilization of funds, procurement of high-quality TB drugs through competitive bidding process, and reviewing requests for drugs from countries linked with monitoring expansion in the use of DOTS.</li> <li>• Goals are to (1) ensure uninterrupted access to quality TB drug, (2) catalyze rapid DOTS expansion to achieve TB goal targets, (3) stimulate political and popular support for public funding of TB drug supplies, and (4) secure sustainable global TB control and elimination. Fulfills this mission by (a) providing grants to countries that qualify for support, (b) procuring drugs through bulk purchasing, and (c) mobilizing Stop TB partners for technical assistance to National TB Programmes.</li> <li>• Governments and NGOs with well-defined plan to expand DOTS can apply for GDF support. In first round, countries with GNP per capita of less than \$1,000 and estimated TB cases of at least 100 per 100,000 population were eligible to apply. Five countries were approved support: Kenya, Myanmar, Republic of Moldova, Somalia, and Tajikistan. Seven more countries approved in round 2, including Togo, Liberia, Republic of Congo, Sudan, Pakistan, Democratic Republic of Korea, and Yemen. Six rounds completed as of 2004 and 46 governments and NGOs approved. Eleven countries awarded emergency grants of anti-TB drugs</li> <li>• Access for high burden countries to quality drugs for DOTS implementation has been increased: half million patients reached in first year, and 1.9 million in 26 months. Goal is to treat 11.6 million people by 2005, 45 million by 2010.</li> <li>• Approach of GDF has facilitated the creation of a flexible supply system to meet differing program needs, and standardization of products, and collaboration with partners.</li> <li>• Estimated that drug prices were reduced by 30% to less than \$ 10 for 6–8 month course of treatment (In 2001, estimated that financial savings in reduced drug prices would translate into nearly \$150 million over 5 years.)</li> <li>• In the future, GDF considering the inclusion of second-line drugs and diagnostic materials for TB.</li> </ul>
Organizational Structure	<ul style="list-style-type: none"> <li>• Managed by Stop TB Partnership Secretariat, located in WHO headquarters in Geneva. WHO provides the legal identity for GDF, facilitates access to WHO country and regional offices, coordinates with DOTS Expansion working group, and ensures administrative support.</li> <li>• The Stop TB partnership provides funding and technical assistance. Secretariat provides administrative support (alignment in decision making and execution of grants), manages procurement, and mobilizes partners for technical assistance.</li> <li>• Technical assistance delivered through contractual (fee-based) and collaborative (non-fee-based) partners. Quality of services is frequently evaluated by partner.</li> <li>• Technical Review Committee (TRC) responsible for reviewing applications. Committee consists of independent TB control experts, drug management, and TB program management. Will recommend level of support to countries and will propose agencies to monitor GDF-related country activities.</li> <li>• Coordinating Board provides oversight in reviewing annual workplans and TRC recommendations in relation to grants. Responsible for resource mobilization.</li> </ul>
Forecasting	<ul style="list-style-type: none"> <li>• GDF species and quantifies drugs.</li> <li>• WHO-approved catalogue of TB drugs and formulations is relatively limited, in large part to promote standardization of treatment regimens and products.</li> </ul>
Procurement	<ul style="list-style-type: none"> <li>• Arranged through UNDP Inter-Agency Procurement Services Office (IAPSO), which includes among its clients many NGOs, international finance institutions, and UN agencies. IAPSO uses state-of-the-art technology to track the movement of TB drugs from purchase to delivery.</li> <li>• Pre-shipment QA and testing of products is outsourced through competitive tender and done externally by Societe Generale de Surveillance (Netherlands and Belgium). IAPSO coordinates services.</li> <li>• Drugs are tendered through Limited International Competitive Bidding of pre-qualified suppliers. Pre-qualification is based on document review, good manufacturing practices inspection, and quality control. Suppliers included on the white list are available on the GDF website.</li> <li>• GDF grants are typically for 3 years and include 100% buffer of drugs to prevent stockouts.</li> </ul>

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**Global TB Drug Facility (cont'd)**


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Financing	<ul style="list-style-type: none"> <li>• Initial \$ 10 million funding for the GDF was provided by the Canadian International Development Agency.</li> <li>• Relies heavily for financial as well as technical and logistics support on Stop TB Partners, such as Dutch Government, USAID, World Bank, International Union Against Tuberculosis and Lung Disease, Royal Netherlands Tuberculosis Association, MSH, Rockefeller Foundation, and UNDP Inter-Agency Procurement Services Office (IAPSO).</li> <li>• GDF estimated that \$ 250 million would be needed between 2001 to 2005 to catalyze national DOTS expansion efforts. However, estimated that 2004 would see funding gap of \$25 million, increasing to \$30 million in 2005.</li> </ul>
Distribution	<ul style="list-style-type: none"> <li>• Drugs purchased for direct shipment to recipient country.</li> <li>• IAPSO is responsible for managing delivery plan of TB drugs, ensuring that shipping information is available through Web Buy system. IAPSO is also responsible for payment to suppliers, freight forwarders, insurance company, and inspection agency.</li> <li>• Countries can track orders online.</li> </ul>
Threats to Success	<ul style="list-style-type: none"> <li>• Reliance on grant funding mechanism to catalyze TB DOTS expansion programs may lead to over-dependence on external funding; means there is still a need for developing sustainable strategies for supporting TB programs. GDF tries to deal with this issue by ensuring that grants are additional to funding that is already ear-marked by countries for TB drugs or programs. It also makes continued funding conditional on local funding not being reduced, or can be reallocated for pediatric drugs or single drugs (for side effects), which are not provided by the GDF. GDF also provides direct procurement services (established in 2002) and white list of quality drugs and suppliers; these are intended to strengthen the drug procurement and QA systems in countries. Countries encouraged to use direct procurement as cost-sharing exercise. Direct procurement, while restricted to the WHO-approved treatment regimens for DOTS and includes a requirement that drugs be provided for free to patients, affords procurers to obtain competitive prices, benefit from quality control, access web-based tracking systems, choice of loose or blister packed tablets with user-friendly packaging, and access value-added on-going technical support and annual monitoring missions.</li> </ul>
Best when ...	<ul style="list-style-type: none"> <li>• Drug supply can be tied to efforts to expand programmatic goals (in this case, the DOTS program).</li> <li>• Successful case studies include countries where political and public commitment was expressed to dealing with health threat.</li> <li>• Spirit of collaboration, "dynamism, innovation, "can-do" (...), and technically competent leadership"<sup>10</sup> exists in Secretariat and overall implementing team. This creates a supporting operating environment of partnership mobilizing technical support, donor support, and strategic guidance to GDF.</li> <li>• Range of products in bulk purchasing is relatively limited (and product packaging [blisters and patient packs] used to simplify drug management) and, again, tied to specific public health programs, particularly where rational use is critical (unlike the case for contraceptives, for instance, where choice is more important for adherence to methods for instance) and where there is a significant economic case for providing drugs for free.</li> <li>• Pooled procurement tied to a focused mandate that addresses drug supply.</li> <li>• Single operating entity combining grants, procurement, and technical assistance can be implemented (unlinked system would not have the same effect).</li> <li>• Virtual organization can be set up (including competitive bidding of QQA, freight forwarding services, and outsourcing of technical services on contractual or collaborative basis). Creates a lean organization.</li> <li>• Diverse funding base, particularly the use of direct procurement mechanism offered by GDF to countries and NGOs who access their own resources through donors/lending agencies, or donations.</li> </ul>

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10. McKinsey & Co. 2003.

## Eastern Caribbean Drug Service

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Description	<ul style="list-style-type: none"> <li>• Pooled procurement of class A and B essential drugs for 9 Ministries of Health.</li> <li>• Established in 1986 with 6 ministries, under RPM (funded by USAID); 3 additional MOHs joined in 1995.</li> <li>• Financially self-sufficient by 1989, based on 15% administrative fee charged to participating governments. Operated surplus by 1994, and surplus was invested by the Eastern Caribbean Central Bank (ECCB).</li> <li>• 52% unit cost reduction during first procurement cycle, 18% in second with competitive bidding (for 59 class A products). Average country saving in first tender ranged from 16% to 88%.</li> <li>• Does not purchase for private sector, which often needs branded products, symptomatic treatment, and more expensive packaging (also potential administrative cost of supplying multiple small pharmacies).</li> </ul>
Organizational Structure	<ul style="list-style-type: none"> <li>• Structure: Policy Board includes MOHs (assisted by Permanent Secretaries), the OECS (Organization of Eastern Caribbean States) Director General, the ECCB Governor and the ECDS Managing Director. Two sub-committees (The Technical Advisory Committee and Tenders Sub-committee) report to Policy Board. Supplies Officers of each MOH constitute the Tenders Sub-Committee. Policy Board and sub-committees meet at least annually and the chair rotates.</li> </ul>
Forecasting	<ul style="list-style-type: none"> <li>• Each country does its own forecasting and typically may begin more than 9 months before the contracts are awarded.</li> <li>• This is an area of chronic problem for ECDS ; e.g., in 1994, a routine review showed that ECDS purchased 75% of the regional estimates, while actual purchases for individual line items ranged from 25% to 150% of original forecasts.</li> <li>• Factors include inadequate stock control at country level, sudden changes in prescribing patterns, marketing of new products by suppliers, partial shipments from previous tender cycles, extended lead time, and formulary changes.</li> <li>• Multiple negative consequences are understocking or overstocking, reducing supplier confidence in submitting tender offers because amounts may vary under actual contract.</li> <li>• Also meant that ECDS had difficulty guaranteeing supplies with multiple countries participating, opportunity to maximize cost saving are not fully leveraged.</li> </ul>
Procurement	<ul style="list-style-type: none"> <li>• 85% of public sector purchases are procured through ECDS.</li> <li>• Tenders Subcommittee selects drug items to be included in the Regional Formulary and Therapeutics Manual. In the first year, no manual existed. Not all items on the formulary are tendered though items listed for pooled procurement represent class A or B items (large volumes with large demand in each country). Items like anti-cancer drugs (low use, erratic demand), and biological products or vaccines (that can be obtained at low-cost through PAHO EPI) are excluded from the list.</li> <li>• Pooled procurement required that choices be standardized for items on the tender list, including specific drug products, pack sizes, dosage forms, and strength. Generic bidding and therapeutic alternative bidding. Process for standardizing these elements took varying amounts of time and effort.</li> <li>• Restricted tenders (through screening and pre-qualifying of suppliers) used to ensure lowest price can be obtained while assuring quality.</li> <li>• Tenders usually made for CIF air and CIF sea prices, particularly because transportation is a major component of purchase costs (i.e., for small shipments to nine islands).</li> <li>• ECDS does not operate bulk procurements (e.g., a large quantity is purchased at one time): annual requirements of MOHs are pooled and bid solicitation put out on behalf of the countries for a year-long contract; individual countries can order more frequently (typically moving toward 2 to 3 orders per country per year).</li> </ul>

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## Eastern Caribbean Drug Service (cont'd)

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	<ul style="list-style-type: none"> <li>• Sole Source Commitment was critical policy commitment: participating MOHs commit to purchase products tender by ECDS exclusively through the ECDS à this guaranteed contracted suppliers most of the public sector demand and prevents non-contracted suppliers from undercutting the 15% admin fee.</li> <li>• Adjudication process: strict written guidelines and administrative procedures were developed for processing tender documents, ensuring that entire process was transparent and guaranteeing a fair deal for suppliers. Six weeks were allowed for data entry of data from tenders. Price is the major criterion (others include supplier performance, quality standards, and product characteristics).</li> <li>• Contracts were drafted based on review of contracts from 10 other agencies, and within the parameters of what the ECDS was able to monitor, control, and reinforce.</li> <li>• Random testing conducted through the Caribbean Regional Drug Testing Laboratory of new suppliers, products that countries have complained about, 13 priority drugs with potential bioavailability, and quality-sensitive manufacturing processes.</li> </ul>
Financing	<ul style="list-style-type: none"> <li>• Original ECDS members committed to contributing about 1/3 of their annual pharmaceutical budgets to individual country drug accounts held by ECCB to ensure payment to suppliers for their orders, a cash contribution in advance of project implementation [is this correct?].</li> <li>• After ECDS places order with suppliers, ECCB pays the suppliers directly, and credits the ECDS account a 15% administrative fee. After countries receive supplies, they reimburse ECCB drug accounts directly.</li> <li>• Bids are solicited in U.S. dollars (and EC pegged to dollar at relatively fixed rate), facilitating price comparisons.</li> </ul>
Distribution	<ul style="list-style-type: none"> <li>• ECDS tenders, awards contracts, places orders directly to suppliers and monitors these activities, but suppliers ship directly to the countries.</li> <li>• Orders are mostly done via air (little difference in cost with sea delivery and air is more predictable and presents faster port clearance), except for larger or less isolated countries (e.g., for large-volume IV fluids).</li> </ul>
Threats to success	<ul style="list-style-type: none"> <li>• Diversity of member states (language, history, etc.) was a potential threat but this was being overcome by efforts of OECS .</li> <li>• Member countries defaulting (being allowed to default) on reimbursements to their accounts with ECCB.</li> <li>• Instability of local (regional) currency.</li> <li>• Weak forecasting performance means full potential of pooled procurement may not be leveraged.</li> </ul>

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## Appendix 2

# RH Commodity Price Variance

Commodities	Dosage	RH Commodity Prices				IRP Variance			Pooled Variance	
		IRP	Pooled price	Ghana	Burkina Faso	Pooled price	Ghana	Burkina Faso	Ghana	Burkina Faso
<b>Contraceptives</b>										
Condom	condom	0.026	0.020	0.041	0.030	-31%	36%	13%	51%	33%
Injectable	inj.	0.893	0.850	0.803	0.790	-5%	-11%	-13%	-6%	-8%
IUD	IUD	0.404	0.310	1.800	1.000	-30%	78%	60%	83%	69%
Implant	Rod	26.565	23.000	26.180	23.883	-16%	-1%	-11%	12%	4%
Pill	Tablet	0.347	0.217	0.270	0.204	-60%	-28%	-70%	20%	-6%
<b>Subtotal average</b>						<b>-28%</b>	<b>15%</b>	<b>-4%</b>	<b>32%</b>	<b>18%</b>
<b>STI/HIV/OI</b>										
Nevirapine tabs	Tablet	0.145	0.143	0.193		-2%	25%		26%	
Nevirapine syrup	Syrup	2.232	2.232			0%				
Benzath. Pen.2.4 MIU	Vial	0.236	0.203		0.139	-16%		-69%		-45%
Cotrimoxazole 480 mg	Tablet	0.009	0.008	0.007	0.007	-9%	-25%	-24%	-15%	-14%
Doxycycline 100 mg	Tablet	0.008	0.008		0.010	-8%		14%		20%
Metronidazole	inj.	0.775	0.688	0.180	0.440	-13%	-330%	-76%	-282%	-56%
Metronidazole tab 250 mg	Tablet	0.004	0.004	0.002	0.004	-9%	-79%	6%	-64%	14%
<b>Subtotal average</b>						<b>-8%</b>	<b>-103%</b>	<b>-30%</b>	<b>-84%</b>	<b>-16%</b>
<b>Antenatal</b>										
Tetanus Vaccine.5 ml	inj.	1.020	0.952	0.600		-7%	-70%		-59%	
Iron (tabs) 65 mg	Tablet	0.002	0.002	0.002	0.002	-10%	14%	3%	22%	12%
Folic acid 5 mg	Tablet	0.003	0.003	0.001	0.002	-9%	-407%	-86%	-364%	-71%
Fansidar (tabs) 500/25 mg	Tablet	0.020	0.019	0.048	0.026	-7%	59%	24%	61%	28%
<b>Subtotal average</b>						<b>-8%</b>	<b>-101%</b>	<b>-20%</b>	<b>-85%</b>	<b>-10%</b>
<b>Obstetrics/neonatal</b>										
Oxytocin 10 IU	ampoule	0.095	0.093	0.065	0.130	-2%	-46%	27%	-43%	29%
Ergometrine injection	inj.	0.158	0.140	0.117	0.161	-13%	-35%	2%	-20%	13%
Ergometrine (tabs) 3 .2 mg	Tablet	0.013	0.009			-44%				
<b>Subtotal average</b>						<b>-20%</b>	<b>-41%</b>	<b>14%</b>	<b>-31%</b>	<b>21%</b>
<b>Other</b>										
Gloves (examination)	Piece	0.025	0.025	0.020	0.025	-1%	-27%	-3%	-26%	-2%
Gloves (surgical)	Pair	0.160	0.153	0.110	0.145	-5%	-46%	-11%	-39%	-6%
ORS 1000 ml	Sachet	0.060	0.059	0.027	0.100	-1%	-126%	40%	-123%	41%
<b>Subtotal average</b>						<b>-2%</b>	<b>-66%</b>	<b>9%</b>	<b>-63%</b>	<b>11%</b>
<b>Total average</b>						<b>-14%</b>	<b>-57%</b>	<b>-10%</b>	<b>-43%</b>	<b>3%</b>

Notes: Source for volume pricing: IDA, 2004. Exchange rate 1 euro = 1.22 USD. Source for contraceptive volume pricing: UNFPA. All prices CIF/CIP. Volume unit prices based on 2004 aggregated quantities. Source for Ghana prices: MoH/Procurement Unit. Source for Burkina Faso prices: CAMEG (Central Medical Store in Burkina Faso). Price in single units.



## Appendix 3

# The Impact of Nigeria

### ECOWAS Region RH Tracer Commodity Demand 2002-2010 Inclusive and Exclusive of Nigeria

RH Tracer Commodities	With Nigeria	W/O Nigeria
Contraceptives		
Condom (male)	1,037,982,987	528,641,343
Implant	693,568	213,733
Injectable	61,538,541	31,232,715
IUD	4,076,020	877,132
Pill	290,713,142	163,377,726
STI/HIV/OI		
Nevirapine (tabs)	2,666,372	1,173,644
Nevirapine Syrup	849,571	351,995
Benzathine Penicillin	3,897,576	1,851,152
Co-trimoxazole	88,562,903	50,596,336
Doxycycline	228,002,497	131,583,574
Metronidazole (tabs)	92,420,689	51,468,585
Antenatal		
Tetanus Vaccine	12,443,741	6,483,558
Iron (tabs)	12,221,441,955	6,681,485,126
Folic Acid (tabs)	36,664,325,865	20,044,455,377
Fansidar (tabs)	407,381,398	222,716,171
Obstetrical/Neonatal		
Oxytocin	45,836,857	22,733,967
Ergometrine (tabs)	48,879,059	15,711,390
Other		
Gloves (examination)	77,903,805	42,441,032
Gloves (surgical)	32,685,369	14,353,349
ORS	455,486,733	184,857,641



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