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Study of the Contraceptive Supply Logistics in the PRISM Project Zone in Guinea

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SUMMARY

The purpose of the mission was to study the logistics of supplying contraceptive products in the PRISM project zone, which covers 3 health regions in Guinea. It was conducted in Guinea from March 19 to 29, 2006, the period during which many contributors affected by this issue could be met. The discussions concerned the possible alternatives for continuing the supply of contraceptives after the end of the project, which is scheduled in September 2006.

Currently, the contraceptive coverage financed by USAID is in the regions of Faranah, Kankan and N'Zérékoré where PRISM has been involved since it started in 1998 with a subsequent concentration of activities in the first two regions since 2004. This zone involves a population of approximately 3.5 million inhabitants, or 40% of the country's population.

During the project period, PRISM was very involved the contraceptive supply logistics operations in order to fill gaps in the existing national systems. The question posed today relative to transferring these activities is critical insofar as the pharmaceutical supply remains very problematic in the country and maintaining the achievements of the project after the interventions stop is linked to the continuation of the activities and the availability of contraceptive products.

Analysis

Analysis of the current context shows the elements favorable to an evolution of the supply issue. Given the harmful consequences resulting from the malfunction of the national pharmaceutical supply, there is a true awareness and mobilization of the responsible parties and partners. "Assuring the availability of the essential pharmaceutical products accessible to the majority of the population" is declared a major aspect of the National Pharmaceutical Policy. An integrated logistics process based on the centralization of the supply activities at the Guinea Central Pharmacy (GCP) has been defined. It concerns all health products, including those from the vertical programs and advocates a progressive transfer of the supply operations for which various parties involved in health are responsible. In addition, a National Plan to Secure Reproductive Health Products (French acronym SPSR) was established. One of the orientations of this plan is to reinforce the coordination of the different interventions in the supply of contraceptive products and their integration into a comprehensive system of RH products. Despite the continuing political blocks, this mobilization is favorable to clarifying the situation and establishing lasting supply solutions. It is important for it to be accompanied by the collective support of the partners involved.

The transfer of the contraceptive supply activities, currently ensured with the support of PRISM, to national players was planned based on the existing organizations and systems and taking into account the recommendations of the integrated logistics process. All the supply activities plainly speaking come back in practice to the GCP whose mission it is and which has logistical means and storage spaces in both Conakry and in the regions. The alternatives explored are not satisfactory, either because they would again create a parallel system relying on a new player (an NGO for example), or because they would rely on a system involving eventual integration in the GCP (EVP/ED unit).

The financial analysis made it possible to determine the volume of activity and assess the cost of the logistics of supplying the project zone. During the project period, USAID subsidized 83%[1] of the price of the contraceptives. The contraceptive sale system makes it possible to recover less than 17% of the actual price of the products. Therefore, it is wishful

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[1] Proportion varying with the currency conversion rate.

thinking to expect complete self-funding of the supply including the purchase cost of the products. Consequently, it is desirable for USAID to continue its commitment by guaranteeing the funding of contraceptives in the future years, while waiting for the government or another partner to be able to ensure the supply.

The estimate of the distribution costs borne by the GCP, which would be responsible for the reception, transit, transport and management operations in its regional warehouses is approximately 28% of the sales made with contraceptives (or the products assessed at their transfer price). The rest is a net profit for GCP, or a maximum amount of 60 million GNF (in year 1) to 79 million (in year 3), which represents between 72% and 75% of the amount of the sales.

The estimate of the supply costs of the health centers and community agents involves the purchase costs of the products and shipment to the regional warehouses, the re-supply location. On the peripheral level, the products are resold; related to the receipts, the purchases represent 50%, the re-supply costs represent 4 to 8% and the rest, or 42 to 46%, represent the profits made. The shipment cost is significant. It is possible to lower it by adopting more favorable logistics solutions, for example by grouping HC orders.

For the entire supply system and with initial financing of the products by USAID – estimated over 3 years from 225,000 USD to 270,000 USD – the costs break down as follows : offering for sale made at 17% of their actual value or a total amount of 168 million GNF, of this amount 22% covers the operating expenses of the entire supply system (or approximately 36 million GNF) and 78% represents a profit for the facilities divided into 36% for the GCP regional warehouses (60 million) and 42% for the peripheral resellers and HC's (or 70 million).

Proposals and Recommendations

The proposed system is based on the GCP national structure with which the health facilities will be supplied based on their needs. This material flow is increased by a financial flow, which makes it possible to produce revenue largely covering the operating costs of the system and making rewarding profits possible. In parallel, a flow of information must make it possible to track the consumption and needs and assess the availability of the products. In this scheme, there will no longer be outside parties involved. The operators and officials will face their responsibilities fully. After having been accompanied for a certain number of years and having received support from the project, the regional health officials must ensure that awareness is maintained. The challenge is big; the Regional Health Offices are ready to take it on in order to show their abilities. The same is true for the GCP, which has an opportunity to demonstrate its credibility and efficiency by taking over this system, which is straightforward (5 references, reduced volume, subsidized products). Finally, for the MSP [Ministry of Public Health], this is the time to show that it is possible to integrate the supply systems.

In order to establish this mechanism, in accord with the MSP, it is recommended to establish agreements between USAID and the GCP on the one hand and the RHA's on the other. The terms of these agreements will specify the commitments expected of the various parties: financial commitment of USAID, mobilization of means and responsibility for the supply operations by the GCP, control and supervision by the RHA's of the contraceptive re-supply and usage operations. In return, profits will be collected by the GCP and by the peripheral sites (a portion of which may be returned to the RHA's to fund supervision activities).

It is also recommended to make provisions for appropriate – and graduated - technical support to facilitate the transition after the withdrawal of the project. With this purpose, a national consultant will be hired to strengthen the transfer of know-how after the project and accompany the different proceedings, on both the central, regional and peripheral levels, in the performance and monitoring of the contraceptive supply activities.

Finally, it is recommended that the PRISM project prepare starting now the conditions for the transition of the supply system: information and cooperation, training and awareness, preparation of the agreements and signatures, hire TA, transfer inventory.

With regard to the funding to be provided in the future years: it basically concerns the purchase cost of the products (in contraceptives first, then in currency), as well as the cost of the appropriate technical assistance endowed with the means to go in the field during the first two years. The rest of the means necessary are included in the operating costs of the re-supply system and therefore covered by the sales margins. The financial commitment of USAID is estimated at a budget of 250,000 USD (at 270,000 USD in year 3).

Conclusion

Several positive elements emerge from the current context. The impact of the project has led to a growing demand for contraceptives expressed by the HC's and awareness of the officials of the importance of a reliable distribution network for these products.

The proposals are line with the project's strategy to disengage and transfer to the national players. The responsible parties met with from the GCP and one of the RHA's showed a real will to be involved in order to take over and monitor the supply of these products. The proposed system is also completely consistent with the orientations of the MSP, both with regard to the integration and standardization of supply logistics and the wish to make reproductive health products secure.

Nevertheless, a major risk remains, which is out of the reach of the project and which may threaten the proper development of the system: if the financial situation of the HC's continues to deteriorate, with the continuing shortage of medications, the entire operation of the HC's will be disrupted and the contraceptive supply will not be able to be maintained in such a situation. This "catastrophic" scenario places the health system in peril on the periphery. It is up to the MSP and partners to mobilize their efforts to stabilize the situation as soon as possible and reestablish a lasting operational pharmaceutical supply.

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1 INTRODUCTION

The mission took place during the last year of PRISM activity and its purpose was to study the contraceptive supply methods of the project's intervention zone with a view to ensure the continuing availability of these products at the end of the project.

With a duration of 10 days, the mission was conducted in Conakry from March 19 to 29, 2006. The mission was carried out by C. Damour, pharmacist, as a team with Dr. Sekou Condé, a physician currently working for PRISM in Kankan and Youssouf Doumbouya, a pharmacist who was employed for a long time by PRISM as a medication management adviser.

In the scope of this work, different parties involved in this issue were able to be met, specifically (i) the managers of the Guinea Central Pharmacy (GCP), (ii) managers from the Ministry of Public Health (MSP), the National Pharmacy and Laboratory Administration (DNPL), the Reproductive Health Division (RHD), the Kankan Regional Health Director (RHA), and (iii) partners : FNUAP, AGBEF.

In accordance with the reference terms, the team investigated various alternatives for continuing contraceptive supply logistics taking into account the current context, the existing competencies and potential and the risks able to limit the feasibility of the solutions. The financial elements available were also analyzed in order to evaluate the capacity for self-funding and the permanence of the proposed system.

The study conducted resulted in the proposal of a realistic supply system, as well as recommendations and accompanying measures to establish and monitor this system.

2 THE CONTRACEPTIVE SUPPLY SITUATION AND ISSUE IN THE PRISM INTERVENTION AREA

The PRISM project began activities in 1998 in 3 health regions in Guinea (Faranah, Kankan and N'zérékoré), which represents a total population of nearly 3.5 million inhabitants or approximately 40% of the country's population[2]. This intervention zone was later reduced (in 2004) in order to concentrate on supporting activities in 109 health centers in the Faranah and Kankan regions. The contraceptive supply continued nevertheless in the 3 initial regions.

The supply of contraceptives to the health facilities, essential to beginning the family planning activities (FP) supported by PRISM, was planned from the start. In parallel, the responsible parties on different levels of the system were all trained in the management of medications and contraceptives during the course of the project.

At the beginning of the project, initial gifts of contraceptives were placed in the user sites, with the distribution and re-supply carried out at no charge. It was only beginning in 2001 that the MSP agreed to implement a paying system for these products.

The initial attempts made by PRISM to rely on the national networks were not fulfilled: the approaches used with the essential drugs unit of the EVP/PC/ED to transport products in its regional warehouses and with the GCP to take responsibility for purchases still have no results due to the lack of commitment of these facilities and a chronic lack of means. The project therefore took the place of these facilities to ensure on the central level the operations of quanitification, transit and delivery of the products to the regions, while USAID continued to ensure the purchases of the contraceptives that it was financing.

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[2] See Appendix No. 2: List of the HC's by prefecture and region - PRISM intervention zone

On the regional level, the supply system is no longer proving very functional. While provided free of charge, contraceptives were not always integrated in the orders of the health centers or provided by the regional warehouse. These malfunctions led to a shortage situation in the health centers and stagnation of the inventory in the warehouses. There again a replacement solution was adopted by the project, which ensured with its own logistical means the direct supply of contraceptives to the health centers.

Over the years, the development of the FP activities has nevertheless made it possible to increase and consolidate demand, leading health centers henceforth to systematically integrate contraceptives in their pharmaceutical supplies. Expanding the recovery of the costs applicable to contraceptives beginning in 2001 should make it possible to ensure the re-supply, in the same way as essential drugs. Half of the revenue from the contraceptives sales, which was previously collected in full by the HC's, came back to the EVP/PC/ED unit. However, this provision had no noticeable impact on improving the supply service rendered by the unit.

Afterwards, the deficiencies of the national supply system for drugs for health centers (through the EVP/PC/ED unit) worsened, leading to a worrisome shortage of medication in the regional warehouses. In 2004, PRISM notes the constant progression of the indicators measuring stock outages in the health centers since 2002 with more marked deterioration in 2004. The project emphasizes the very negative impact of this situation on the operation of the health centers. In fact, no longer able to appropriately supply drugs, health centers experience decreases in revenue and a source of their working capital, which is directly reflected on the contraceptive supply, which was seriously curbed by it.

Despite mobilization of the officials and partners on this critical subject, there were no radical solutions making it possible to reestablish this situation. The persistent stock outages of drugs in the regional warehouses finally discouraged the health centers from coming for supplies, abandoning at the same time the buyback of contraceptives. Therefore, it is a situation of contraceptive shortages in the health centers of the zone, which was widespread in 2005. Facing this alarming assessment on the local level, and in order to prevent paralysis of the community-based services (CBS) distribution system recently implemented and dependent on the health centers, the project reacted by organizing a new distribution of products. The sites were again given a free inventory for approximately 9 months of consumption.

If thanks to this timely operation, baptized "orange," the availability of contraceptives was able in this way to be reestablished in the health centers, it is not certain that replacing this inventory can be assured permanently if the drug problems persist as well and if the financial situation of the centers remains as precarious.

It is therefore, in a very sensitive context that the question is posed for continuing the contraceptive supply in the regions concerned after the withdrawal of PRISM, which successfully guaranteed the availability of the contraceptives during the 7 years of its intervention at the price of a very high level of involvement.

3 CONTEXT

3.1 National Situation

The recent analysis of the pharmaceutical sector conducted in 2006 during the update of the National Pharmaceutical Policy (NPP) emphasizes the principal problems of the sector. It underlines the generally low availability of the drugs in the public health facilities and denounces the inability of the current supply systems to appropriately meet the pharmaceutical needs. This shortage situation is even more disconcerting as it contributes to promoting the development of an illegal market, [which is] particularly large in the country.

The NPP, in the process of reformulation and approval, has reaffirmed among its principal strategic orientations "better assurance of the availability of the essential pharmaceutical products accessible to the majority of the population."

The public health sector is principally supplied by the Guinea Central Pharmacy. This national structure, reorganized and endowed with bylaws in 1992 granting it management autonomy (EPIC), is responsible for supplying the country's hospitals and health centers. To do so, it has a decentralized system with five regional warehouses. Its activity, however, is essentially impeded by financial constraints and a lack of access to currency, which limit international purchases. Despite technical support funded by the EU and an improvement in the capacities of the structure, the GCP only has the limited confidence of partners and does not receive the full support of its appropriate minister.

A second public structure manages the distribution of drugs to the public sector. It is the "essential drugs of the EVP/PC/ED" unit, which was created as a temporary measure in 1988 in the framework of launching the Bamako initiative (cost recovery). Placed under the responsibility of the coordination of the EVP, it also has a network of regional warehouses and supplies health centers. It distributes products often funded by donors and applies a fixed rate of subsidized prices (established in 1997 and revised in 2002). Therefore, its prices differ from those of the GCP, which does not receive subsidies. Despite a decision in 2002 to integrate the unit in the GCP – but not carried out – this double system continues, leading to wasted resources and means. This double purchasing and distribution system also does not meet the drug needs of the structures. Diverging interests are clearly the source of a political block maintaining this nebulous situation.

These systems encounter multiple difficulties: insufficient funds, poor management of the available resources, difficulty accessing cash accentuated by a significant fluctuation and continuing depreciation of the currency, administrative delays in the purchase process, failure to manage needs, etc. Prices are high compared with the buying power of a large part of the population, which impedes accessibility to medications. The cost recovery, throughout all structures, is partial and does not maintain the replacement of medications, which must be periodically re-injected in the structures.

In this context, and in order to meet their specific needs, the various existing vertical programs have all be led to use other purchasing methods and parallel distribution networks (vaccines with the EVP, ARV by the PNPCSP, ATB by the PNLT, anti-leprosy treatments by the PNLL, etc.), a solution PRISM has also adopted in its intervention zone for contraceptives. If turning to other systems proves inevitable in these cases, these multiple supply systems are criticized for the negative consequences they entail. In the first place, this creates a waste of resources, most often with stock outages or inventory overages, and finally that raises the question of the permanence of these multiple systems.

3.2 Integrated Logistics Manual

Given this inextricable situation, the MSP recently commissioned a study to define an implementation process for the integrated logistics of health products whose objective is to secure the availability of medications and medical devices at all health facilities. This process first rests on optimizing and centralizing all logistics functions, i.e. purchasing, inventory management, distribution, at the Guinea Central Pharmacy (according to the application of the text[3] of 2002). In this perspective, a master agreement must be signed by the government and the GCP to make it the preferred tool for supplying public, parastatal and community health facilities.

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[3] Order No. 2855 of June 25, 2002 – Article 2 : "The Guinea Central Pharmacy is responsible for supplying all public and parastatal health facilities in the country with generic essential drugs, medical supplies and analyzed reagents."

A specific tool was established[4] in this sense in the form of an "integrated logistics manual," which details and standardizes the purchasing and distribution activities through the GCP of which it is the principal mission.

This document conveys the wish of some technical managers and partners to implement an adapted response in order to resolve the supply issue, which is currently a major risk for the various health programs. In this outline, all health products are involved, including those of the vertical programs (ED, vaccines, contraceptives, medical devices). Therefore, the integration also applies to the reproductive health contributors for a progressive transfer of the supply missions that they support.

It is really desirable for the various donors and partners to be involved in order to collectively support this initiative, in order to enable it to become a reality as soon as the current political blocks can be bypassed.

3.3 National Plan to Secure Reproductive Health Products (SPSR)

A global strategic plan[5] intended to ensure the accessibility and availability of RH products was defined by the MSP with a view to make RH programs permanent. This plan is line with the National Health Development Plan (PNDS Strategic Theme No. 1).

The different partners involved in this intervention area – including USAID with PRISM, UNFPA, etc. – participated in establishing it in 2004 and made commitments to support and implement it.

One aspect of this plan is to reinforce the coordination of the various interventions in the supply of contraceptives and their integration into an integrated RH product management system.

Some scheduled activities were already carried out, but the groups planned have not all been formed. The plan must be updated and submitted to the partners in order to pool financing and available support.

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4 National Integrated Logistics Manual for public health products, including contraceptives – Oct 2005 . DNPL with the technical support of the UNFPA

[5] National Plan to Secure Reproductive Health Products – DNPL/UNFPA – December 2004

4 ANALYSIS OF THE CONTRACEPTIVE SUPPY SYSTEM

4.1 Transfer of the Contraceptive Supply Activities

The supply activities currently ensured in large part thanks to the support of the project have been identified. Their transfer to national players was planned relying on the existing organizations and systems and taking into account the recommendations of the integrated logistics process.

The table below continues: the description of the tasks, the proposed players and their assets, the possible risks or obstacles, as well as the foreseeable alternatives.

The project currently ensures (i) quantification and planning of the needs, which are sent to USAID, which ensures their funding and purchase, (ii) then hires the services of a forwarding agent, (iii) uses a GCP storage space, (iv) then mobilizes the shipping means to transfer the products to the regions where they are distributed by the regional warehouses of the EVP/ED unit. All these supply activities in fact come back to the GCP whose mission it is and which has logistical means and storage areas in both Conakry and the regions. Recommendations are developed to guarantee these tasks are performed under the best conditions by the GCP.

The alternatives are less than satisfactory: (i) entrusting these activities to the EVP/ED unit system is not a lasting solution insofar as this structure is planned to “disappear” more or less over the short term by being integrated in the GCP. In addition, this system is not sufficiently efficient, (ii) entrusting these activities to another player, such as an NGO for example, once again poses the problem of replacing and creating a new parallel system.

In the regions, contraceptives like all drugs, must be purchased by the health centers from regional warehouses. On several occasions, the project organized contraceptive distribution campaigns at the health centers and used an NGO to gather and process data. Henceforth, local officials, which are the RHA’s and PHA’s, are responsible for ensuring that contraceptives are actually available, the health centers are appropriately supplied and FP activities are continued on the periphery. To do this, they will ensure, as they were trained to do during the project, the monitoring/supervision and processing of the contraceptive consumption data. Recommendations will be made to consolidate these activities and facilitate the supply operations of the health centers.

Similarly, there are few alternatives on this level. Turning to an NGO contributes to maintaining the same type of external intervention as the project and does not have the operators and officials fully face their responsibilities.

TABLE No. 1: Description and transfer of the contraceptive supply and monitoring activities

Activities	Description	Proposed Player	Arguments Strengths	Threats Risks	Alternatives
1 Estimation of Needs	- Quantification of needs - Use of regional consumption data and commercial statistics - Planning of needs	GCP	- Displayed experience - Prerogative of one supply structure.	- Lack of field data - No specific monitoring at GCP	DNPL NGO (AGBF or other) EVP/ED Unit
2- Purchases	- Vendors/price choice - Entering into contract - Import terms	GCP	- Experience - Prerogatives of the GCP	- Lack of currency - Ignorance of the contraceptives market (vendors) - Procedures accepted by USAID ?	USAID (cash purchases abroad) EVP/ED Unit
3- Transit and Receipt	- Merchandise collection and customs clearance - Receiptxxx ask matt acceptance - Storage on the central level	GCP	- Experience and prerogatives of the GCP - Central storage area available (already used by PRISM)	- Lack of funds to finance transit costs	NGO EVP/ED Unit
4- Shipment to Regions	- Distribution of the inventory in the 3 regions - Shipment	GCP	- Experience - Prerogatives of the GCP - Fleet of vehicles available	- Lack of funds to finance shipment costs - Trucks broken down	NGO EVP/ED Unit
5- Management and Distribution – Regional Level	- Managment of the stock - Sales to clients - Financial management	GCP Warehouse	- Prerogatives of the warehouse - Management/distribution knowhow	- No recourse to the GCP (GCP and EVP/SSPxxx/ED warehouse rivalry) - Inventory and financial management data not available (lack of transparency)	RHA NGO EVP/ED Unit

Activities	**Description**	**Proposed Player**	**Arguments** **Strengths**	**Threats** **Risks**	**Alternatives**
6-Regional Monitoring	-Compilation and analysis of the consumption data from the prefectures - Estimate of the regional needs	RHA (Pharmacist inspector)	- Prerogatives of the pharmacist inspector - Monitoring conducted for hospitals and vaccines - Participation in the supervision (Project achievement)	- Lack of motivation - Absence of specific monitoring	NGO
7-Prefecture-level Monitoring	- Gathering and compilation of the data from the health centers - Supervision (availability, quality, use) - Facilitation of the supply terms (group orders, put in mutual networks, etc.)	PHA	- Compilation of the monthly reports of the HC's with RAMCES - Supervision conducted (Project achievement)	- Lack of motivation - Absence of specific monitoring	NGO
8- Management in the Health Centers	-Management of inventory and buyback - Financial management - Supply of the HP's and CA's - Gathering of data (PS-CA) and transmission to PHA	HC	- Managers trained - Demand for services and contraceptives (Project achievement)	- Fragile financial situation (HC decapitalization) - ED stock outage in the regional warehouses	NGO

4.2 Financial Analysis

The quantified elements available were used to determine the volume of activity and assess the cost of the supply logistics.

4.2.1 Amount of the Contraceptive Needs in the Project Zone (3 Regions)

The quantities valued correspond to (i) the quantities of contraceptives effectively distributed in the project zone for the year 2005, (ii) the quantities scheduled for the year 2006 and (iii) the projected needs for the year 2007. The purchase prices are those paid in 2005/2006 by USAID (CIF price = FOB + cost and freight), they were used without an increase to value the quantities of the 3 years. Details on this costing appear in the appendix[6]. The amounts are converted into Guinea Francs (GNF) at the constant conversion rate (March 2006 rate).

Table No. 2: Comparison of the amounts of the contraceptive needs at purchase (in USD) and at sale (in GNF)

	(a) Value of the needs in acquisition cost CIF - USD	(b) Value of the needs in acquisition cost CIF-in FG	(c) Value of the needs at the sale price in GNF	Ratio (c)/(b)
2005	224,930	1,012,186,010	168,063,300	17%
2006	237,250	1,067,623,200	184,110,000	17%
2007	271,687	1,222,591,104	212,630,000	17%

Column (a) corresponds to the amounts financed by USAID to purchase contraceptives. Column (b) corresponds to the equivalent of these purchases converted into GNF and Column (c) corresponds to the value of these products at the public sale prices in GNF according to the national rate in effect. The result is that the products are sold at only 17% of their actual acquisition cost, and therefore USAID subsidizes 83% of the price of the contraceptives. (This portion will increase according to the current evolution of the currency conversion rate.)

Under these conditions, it is wishful to think that the contraceptive sale system is capable of financing the purchases, as the portion available (17%) is insufficient to be a significant counterpart. A noticeable increase in the sale prices of contraceptives cannot be imagined at this time given the very low buying power of the populations. Therefore, provisions must be made to maintain specific funding for these products. Since the government cannot guarantee taking over this funding, it would be desirable for USAID to continue its commitment by maintaining this funding in the future years.

[6] See Appendix No. 3: Costing the contraceptive needs of the project zone 2005-2007

4.2.2 Estimate of the supply costs of the GCP (central and regional level)

These costs cover the activities of (i) transit and receipt of the merchandise, (ii) storage on the central level, (iii) transport to the 3 regional warehouses and (iv) storage and commercial management in these warehouses. They are linked in part to the volume to be handled. These costs were estimated based on the quantities distributed or estimated over 3 years (2005, 2006 and 2007), the volume and tonnage of which were calculated[7]. The volume to be handled goes from 28m^3 to 37m^3; according to the evolution of the quantities, a size of 30 to 35m^3 will be used.

Considering these volumes, the transit costs used are estimated at 5 million GNF, based on the costs actually paid by the project these last 2 years. those [sic.] provided by the GCP, based on 2 annual deliveries of 20-foot containers, are lower however.

The transmission cost of the products in the regions was calculated based on the unit costs provided by the GCP for the transport by truck, at the rate of 2 transfers per year[8]. Two options were calculated, the size used is 10 million GNF, considering that the cost of the transport is assigned in whole to the contraceptives (which will not be the reality).

An amount of 5% is allocated to the management cost including the cost of stock-keeping, computer processing, staff, loss, etc. for the management of contraceptives (5 references), or 8.4 million (= high scenario).

The accumulation of these costs represents the operating costs of the GCP attributable to the distribution of contraceptives. For year 1, they would be a total of 23.4 million GNF. For the other years, these costs are assigned a 10% increase then 15% in proportion to the increase in the total amount of the products to be distributed[9].

The potential sales of the GCP is based on the quantities of products assessed at the transfer price, which according to the official tariff, corresponds to half of the final sale price. In year 1: the amount of the products assessed at the sale price at 168 million, would represent for the GCP a transfer amount of 84 million.

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[7] See Appendix No. 4: Assessing the weight and volumes of the contraceptives per year – estimate of the transit costs

[8] See Appendix No. 5: Estimate of the transport costs to the project regions

[9] See Appendix No. 6: Estimate of the costs of contraceptive distribution by the GCP

Table No. 3: ESTIMATE OF THE DISTRIBUTION COSTS OF THE CONTRACEPTIVES BY THE GCP

	2005	2006	2007
(a) Product value in public sale price	**168,063,300**	**184,110,000**	**212,630,000**
(b) Product value in transfer price	**84,031,650**	**92,055,000**	**106,315,000**
(c)Transit costs	5,000,000	5,500,000	5,750,000
(d) Transport costs in the regional warehouses	10,000,000	11,000,000	11,500,000
(e) Costs of storage, distribution (5%)	8,403,165	9,243,482	9,663,640
(f=c+d+e) total op. cost GCP	**23,403,165**	**25,743,482**	**26,913,640**
ratio (f)/(b)	28%	28%	25%
(b) Receipts (Sales)	84,031,650	92,055,000	106,315,000
(g=b-f) Profit	**60,628,485**	**66,311,519**	**79,401,360**
(g/b)	72%	72%	75%

Related to the sales, the operating cost represents a share of 28%. This margin is very wide; in general it should be, in a cost streamlining context, under 20%. The profit made by the GCP (sales – operating costs) would be a maximum of 60.6 million GNF or over 70% of the sales. This is the amount if all products are actually sold, yet it is probable that a portion of these products will remain in the safety stock or it is possible that the quantities are slightly overestimated. However, after these estimates, the GCP only has to sell a minimum of 30% of the quantities to recover the total operating costs. Beyond that, the GCP receives a net profit insofar as it does not pay for the products upon purchase.

The result of these estimates is that this contraceptive distribution activity generates revenue at the rate of 60 million for the GCP. Twenty-eight percent of the portion of the sales completely covers the operating costs. The rest, or 72%, represents a profit for the GCP.

4.2.3 Estimate of the health center supply costs (peripheral level)

The estimate of the costs of the supply logistics for which the HC's are responsible is detailed in the appendix[10].

Unlike the GCP, the HC's must buy contraceptives in the regional warehouses at the transfer price. They redistribute a portion of them to the periphery (health post, community agents) and the contraceptives are then resold to the public at double their purchase price (according to the rate in effect).

The HC's go to the regional warehouse, generally two times per year, for their re-supply of essential drugs (of which contraceptives). Transport is therefore a significant cost category. An estimate was made based on the distance the HC travels to the regional warehouse with

[10] See Appendix No. 7: Estimate of the logistics costs of the HC's.

the moped, which was provided to it, assuming a single roundtrip journey was attributable to contraceptives (the other must be recorded on the receipts of the medications). This calculation made for the 109 HC's monitored by PRISM was extrapolated to assess the costs for all HC's in the 3 regions. It comes to an estimated amount of 10.3 million GNF, or 12% of the acquisition cost of the products. This amount is accurate if the HC's are supplied individually. If they share the transportation costs by grouping to several [sic.], this cost may easily be divided by 2 or 3 (see Options 2 and 3 in the table below).

Three percent of the acquisition cost of the products is added to cover the management and redistribution costs paid by the HC's (or 2.5 million). In total, the operating costs appropriate to the supply logistics go up to nearly 13 million (or 15% of the acquisition cost of the products) and may be lowered to 7.6 million or 6 million if the transportation costs are reduced.

This data appears in the table below: the profits (shared by the resellers HC+HP+CA), i.e. the receipts minus the acquisition and logistics costs, are over 70 million GNF and vary in proportion to the reduction of the transportation charges.

Related to the receipts: the acquisition costs are 50%, the operating costs for the re-supply are between 4% and 8% and the profit is 42-46% of the receipts.

Table No. 4: ESTIMATE OF THE HC RESUPPLY COSTS

Cost Category	Option 1	Option 2	Option 3
(a) Acquisition cost	**84,031,650**	**84,031,650**	**84,031,650**
(b) logistics cost (12%)	10,300,000	5,150,000	3,433,333
(c) management cost (3%)	2,520,950	2,520,950	2,520,950
(d=b+c) S Total operating costs	***12,820,950***	***7,670,950***	***5,954,283***
(e) Receipts	**168,063,300**	**168,063,300**	**168,063,300**
(f=e-(d+a)) Profit	**71,210,701**	**76,360,701**	**78,077,367**
portion of the purchases over the receipts (a/e)	50%	50%	50%
portion of the oper. over the receipts (d/e)	**8%**	**5%**	**4%**
portion of the profit over the receipts (f/e)	**42%**	**45%**	**46%**

The maximum profits apply if all the products purchased are resold, with the structures normally already endowed with safety stock. However, the HC's only have to resell a minimum of 10% of the products purchased to recover their re-supply charges and a show a profit.

The difference shown between the 3 options shows the benefit of minimizing transportation costs by developing initiatives to group the re-supply operations of the HC's, which will have a direct impact on increasing the revenue received.

4.2.4 Summary of the Supply Costs

The costs of the entire supply chain appear in the table below and provide an idea of the costs entailed and the profits generated on each level[11]. The evolution over the years will depend on the quantities actually distributed (realization of the needs), and the evolution of the tariffs. The profits calculated are the maximum, considering that the quantities corresponding to the needs are the actual sales.

[11] See Appendix No. 8: Summary of the contraceptive supply costs of the PRISM zone.

Table No. 5: SUMMARY OF THE CONTRACEPTIVE SUPPLY SYSTEM COSTS

	Year 1	Year 2	Year 3
Q Annual/valued public price	**168,063,300**	**184,110,000**	**212,630,000**
GCP Costs			
GCP purchase	-	-	-
Transit	5,000,000	5,500,000	5,750,000
Transportation	10,000,000	11,000,000	11,500,000
Storage/management/loss	8,403,165	9,243,482	9,663,640
op. cost subtotal	*23,403,165*	*25,743,482*	*26,913,640*
Receipts	84,031,650	92,055,000	106,315,000
GCP Profit	**60,628,485**	**66,311,519**	**79,401,360**
HC Costs			
HC purchase	84,031,650	92,055,000	106,315,000
Transport (Option 1)	10,300,000	11,330,000	11,845,000
Management/distribution	2,520,950	2,773,044	2,899,092
op. cost subtotal	*12,820,950*	*14,103,044*	*14,744,092*
Receipts	168,063,300	184,110,000	212,630,000
Periphery Profit	**71,210,701**	**77,951,956**	**91,570,908**

In the following table, all costs are summarized. An amount of nearly 225,000 USD is currently granted by USAID in the form of contraceptives, which are placed on the market in the project zone, at an amount equal to 17% of their actual value (at the current conversion rate), or a total amount of 168 million GNF.

For this amount, 22% (high scenario) covers the operating expenses of the supply system (or nearly 36 million GNF), and 78% represents a profit for the structures divided into 36% for the GCP regional warehouses (60 million) and 42% for the peripheral resellers and HC's (or 70 million).

Table No. 6: Summary of the contraceptive supply costs of the PRISM zone

	Year 1	**Year 2**	**Year 3**
CIF value $ (USAID)	224,930	237,250	271,687
CIF value GNF	1 012,186,010	1,067,623,200	1,222,591,104
PP [sic.] Value GNF **(100%)**	**168,063,300**	**184,110,000**	**212,630,000**
GCP Op. Cost **(14%)**	23,528,862	25,743,482	26,913,640
HC Op. Cost **(8%)**	*12,820,950*	14,103,044	14,744,092
GCP Profit **(36%)**	**60,628,485**	**66,311,519**	**79,401,360**
HC Profit **(42%)**	**71,210,701**	**77,951,956**	**91,570,908**

5 PROPOSALS

5.1 Supply Diagram

According to the analysis, the supply system, which appears the most logical, is illustrated in the diagram below. The diagram shows a flow of material going from the GCP supply structure to the Health Centers and the periphery, doubled by a financial flow corresponding to the sale of the products, and in parallel, a flow of information making possible to monitor the consumption and group the data to better estimate the needs.

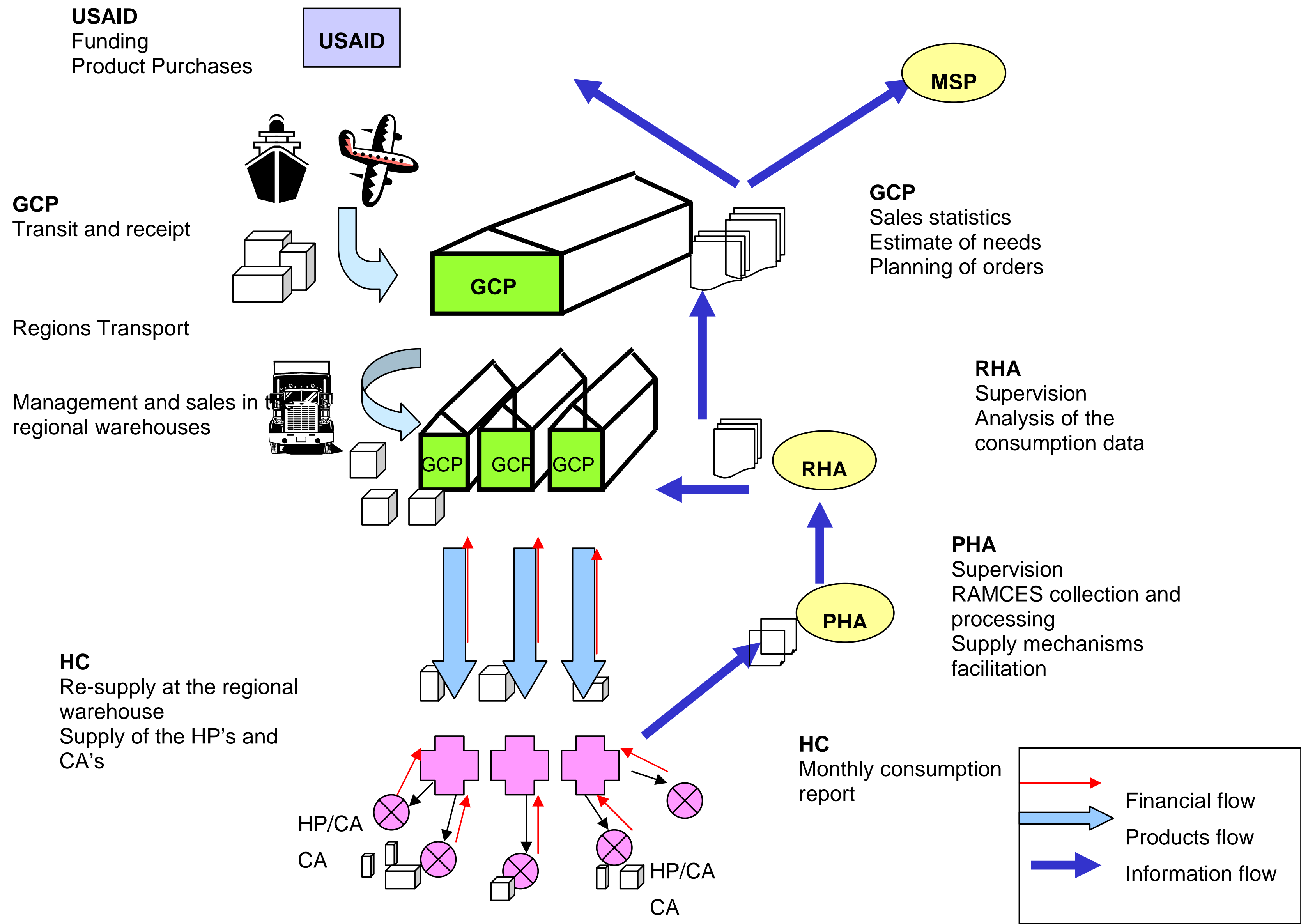
This system remains supplied by USAID, which funds the contraceptives, while waiting for either another partner or the government to take it over. USAID will continue to provide the products [until] the time when the GCP is able to ensure the purchases (2 years). Then it will provide the currency necessary to purchase the products. The GCP will be responsible for maintaining a sufficient supply in its regional warehouses (with no stock outages). The HC's will be re-supplied on demand, i.e. based on the needs expressed by the periphery (HP+HC+CA).

Compared with the current situation, there will no longer be outside parties involved. The alternative of turning to a local NGO, which would maintain a parallel vertical solution is not advised because it contradicts the logic of the withdrawal of the project. Therefore, the system completely relies on the GCP and excludes the option of turning to the temporary EVP/PC/ED unit insofar as it must be integrated in the end into a single system. Therefore, the GCP has the opportunity to demonstrate its credibility and efficiency by taking responsibility for this system, which is straightforward (5 references, reduced volume).

The information system is important. It is managed by the local health officials and makes it possible to know the status of both the supply and the development of the FP activities. It is in fact the responsibility of the local health officials to ensure that the HC's continue the activities integrated during the course of the project.

SUPPLY OF CONTRACEPTIVES

DIAGRAM OF THE FLOW OF PRODUCTS, FINANCING, AND INFORMATION



5.2 Recommendations

Provisions must be made to better establish the recommended system with regard to the risks, which were identified.

5.2.1 Agreement with the GCP

An agreement, or partnership agreement, will be made with the GCP and will define the terms and services expected.

- GCP will be responsible for supplying the contraceptives in the regions concerned,
- GCP will identify a responsible party, which will be a "focal point" responsible for specifically monitoring the contraceptive supply operations,
- GCP will take the measures to ensure in the end the contraceptive purchases (exploration of the market, knowledge of the vendors, specification of the products),
- GCP will be responsible for estimating the contraceptive needs for the 3 regions concerned and the planning of the supplies (to be transmitted to USAID for the purchases the first 2 years),
- GCP will mobilize its own operations means to ensure the operations for which it is responsible (transit, storage, transportation, etc.),
- GCP must guarantee transparent management (computerized, in principle) in its regional warehouses,
- GCP will provide a six-month report on the distribution of the contraceptives (status of the receipts, inventory, sales and receipts).

In return, USAID will provide the contraceptives to the GCP free of charge. The GCP will show a profit on the product through the resale of the contraceptives at the national rate.

5.2.2 Agreement with the RHA

An agreement will also be made with the RHA, as the health official representing the beneficiary structures.

- The RHA will mobilize a key person for this issue (inspector pharmacist assigned to the RHA);
- The information will be processed (by computer) on the health region level, providing information on the availability and consumption of the contraceptives in relation to the development of the FP activities;
- The RHA will ensure that the PHA's process the data from the monthly reports of the HC's and transmit it to them (via RAMCES);
- The RHA will encourage the PHA's to favor supply strategies, which enable the HC's to renew their products according to their needs at a lower cost;
- The RHA and the PHA's will continue the supervisions, which will include a FP/contraceptive availability component;
- A six-month report will be prepared reporting on the supervision activities and the general status of contraceptives in the region.

In return:

- The dependent health centers of the RHA will have access to the contraceptives subsidized by USAID and sold by the GCP.
- The RHA may receive a portion of the profits made on the sales by the GCP (for example 10%), which will enable it to contribute to the costs of supervisions (average cost of a supervision assessed at 3 million).

5.2.3 Technical Support

Appropriate technical assistance will be provided to ensure a transition after the withdrawal of the project. It will be planned for two years, in a graduated manner, i.e. 8 months then 5 months [sic.]

It is advised that a national consultant be used, a more subtle arrangement, rather than calling on an NGO.

This consultant will have good knowledge of the PRISM project, the contraceptive supply issue, as well as the field, in particular the project intervention regions.

His role will be to consolidate the transfer of know-how after the withdrawal of the project and to accompany the different officials on the central, regional and peripheral levels in the performance and monitoring of the contraceptive supply activities.

He will specifically assist:

- The manager, focal point at the GCP, with knowledge of the products, quantifying the needs and planning the supplies, as well as processing the management data provided by the regional warehouses.
- The inspector pharmacist of the RHA in processing information on the availability and consumption of contraceptives (in relation to the FP activities) and the supervision.
- The PHA in using the consumption data, processing with RAMCES, supervision and support in the organization of the HC supply systems.
- Through regular reports, he will provide information on the proper operation of the system, possible obstacles and weaknesses encountered.

The following table summarizes the recommendations issued for each phase of the supply. It remains, however, a major risk, which may threaten the proper development of the system: in fact if the HC situation continues to deteriorate, with an increasingly precarious financial situation and a deficient supply of medications, the entire operation of the HC will be disrupted. In this case, the sale and replacement of the contraceptives will not continue in the appropriate manner. This situation must be resolved on the central level, and the MSP along with the partners must mobilize their efforts to stabilize the situation as soon as possible and reestablish an operational pharmaceutical supply.

TABLE No. 7: RECOMMENDATIONS

Activities	Proposed Player	Threats Risks	Recommendations	Means/input	Source of Funding
1 Estimation of Needs	GCP	- Lack of field data - No specific monitoring at GCP	1- Designate a focal point at the GCP responsible for data analysis (planning and quantification) and monitoring. 2- Technical Assistance: appropriate support in the analysis and monitoring	Appropriate TA	USAID
2- Purchases	GCP	- Lack of currency - Ignorance of the contraceptives market (vendors) - Procedures accepted by USAID ?	1- Continue direct purchases by USAID in Years 1 and 2. 2-Develop knowledge of the market (products and vendors) by GCP. 3- Provide currency for direct purchases by GCP in Year 3.	Funding and purchase of contraceptives Currency (yr. 3)	USAID USAID
3- Transit and Receipt	GCP	- Lack of funds to finance transit costs	1- Integration into the GCP activities. 2- Agreement with the GCP: commitment to make available the means and funding necessary.	Transit costs	GCP receipts (op. costs)
4- Shipment to Regions	GCP	- Lack of funds to finance shipment costs - Trucks broken down	1- Integration into the GCP activities. 2- Agreement with the GCP: commitment to make available the means and funding necessary.	Delivery costs	GCP receipts (op. costs)
5- Management and Distribution – Regional Level	GCP Warehouse	- No recourse to the GCP (GCP and EVP/PC/ED warehouse rivalry) - Inventory and financial management data not available (lack of transparency)	1-Support GCP warehouses through the local officials (EVP/PC/ED and GCP integration). 2- Develop computerized management capacity in the 3 GCP warehouses. 3- Agreement with the GCP: commitment to provide activity and financial information.	Equipment and training	USAID/PRISM

Activities	Proposed Player	Threats Risks	Recommendations	Means/input	Source of Funding
6-Regional Monitoring	DRS (Pharm. inspect.)	- Lack of motivation - Absence of specific monitoring	1- Computerized processing of the data (training of the pharmacist inspector – computer equipment) 2- Appropriate technical assistance (analysis of the data and assessment of the system on the regional level). 3- RHA agreement: commitment to ensure monitoring and supervisions.	Computer equipment Appropriate TA Supervision costs	USAID :PRISM USAID Portion of the GCP profits
7-Prefecture-level Monitoring	DPS	- Lack of motivation - Absence of specific monitoring	1- Adaptation of RAMCES to compile data from the HC reports (consumption data). 2- Development of initiatives to facilitate the supply systems (and reduce costs). 3- Continue supervisions/monitoring 4- Appropriate technical assistance: prefecture-level evaluation system and support in organizing supply terms.	Supervision costs Appropriate TA	Portion of the profits USAID
8- Management in the Health Centers	CS	- Fragile financial situation (HC decapitalization) - ED stock outage in the regional warehouses	1-Transmission of the data on the consumption and availability of contraceptives (HC, CA, HP) 2- Financial management (sale-buyback, use of receipts)	Re-supply costs	HC receipts

5.3 Means/Input

The necessary means will be included in large part in the operating costs of the re-supply system and therefore covered by the sales margins.

USAID has the principal financial commitment, and it should maintain its initial involvement by ensuring the funding of contraceptives.

The costs relative to the PRISM project will be suspended as soon as the project ends. Only appropriate technical assistance will be funded on a graduated basis during the 2 years following the withdrawal of the project. The cost of this technical assistance was assessed based on 8 men per month the first year and 5 men per month the second year, including the fees, rental of a vehicle and travel expenses in the three regions (3*5000km).

With regard to the equipment necessary, it is the computer equipment necessary for the pharmacy inspector position in the RHA's as well as that necessary to managing the GCP warehouses. It is cited for the record because it is (i) part of the equipment left by PRISM upon its departure, or (ii) may be paid for through the profits made (GCP warehouses). Therefore, there will be no need to plan specific funding.

Table No. 8: COSTS AFTER WITHDRAWAL OF PRISM

Cost Category	Year 1	Year 2	Year 3
Computer equipment	p.m. (PRISM)	-	-
Appropriate technical assistance	8 men per month 25,000 USD	5 men per month 20,000 USD	-
Contraceptive products	225,000 USD	240,000 USD	
Currency			270,000 USD
Total	**250,000 USD**	**260,000 USD**	**270,000 USD**

In total, the USAID commitment will remain lower with a maximum budget of 300,000 USD and will basically concern the funding of the contraceptives necessary to maintain the achievements of the project.

5.4 Transition Phase

The PRISM project is about 6 months away from its final withdrawal. Therefore, a transition phase must begin now to prepare the conditions for continuing and preserving the achievements in the zone where the project operated all these years. This step is crucial. It must lead to mobilizing the responsible officials to ensure the continuation of the activities developed during the course of the project. In this perspective, it is essential to put in place an operational supply system for a regular supply of contraceptives.

Therefore, the project must quickly begin the following actions:

- **Begin cooperation with the MSP** on the proposals made for the supply terms and system in the future.
- **Discuss with the GCP** and establish the terms of the agreement to be signed: services expected and GCP duties, USAID commitment and circumstances of possible withdrawal, etc.
- **Discuss with the RHA's** and establish the terms of the agreement to be signed: mutual commitments and responsibilities.
- **Inform RHA, PHA, HC:** (i) of the new supply system (GCP warehouse), (ii) of the importance of the information system.
- **Adjust the RAMCES system:** make the minor adjustments necessary to ensure the use of the consumption data.
- **Make aware and train the RHA pharmacist** in data processing.
- **Identify and recruit the appropriate technical assistance.**
- **Sign the agreements** with GCP and RHA.
- **Transfer the current inventory** to the GCP warehouses.

6 CONCLUSION

During the project, PRISM had to take charge of nearly all of the supply activities in order to ensure sufficient availability of contraceptives, essential to the development of the FP activities in the three regions covered. Today, on the eve of the project withdrawal, the sensitive question is posed regarding the transfer of these supply activities.

Several positive elements emerge from the current context. The impact of the project led to a growing demand for contraceptives expressed by the HC's and an awareness of the officials of the importance of a reliable distribution network for these products. The responsible parties met with from the GCP and one of the RHA's showed a real will to be involved in order to take charge and monitor the supply of these products. On the other hand, the financial analysis demonstrated the need to continue the contribution of a substantial subsidy of the products, which for the time remains the responsibility of the international partners.

For the GCP, it is an opportunity to demonstrate its know-how and reliability. The GCP has already made contractual commitments with other partners (for example, PSI) and declared that it is ready to do the same with USAID for the distribution of contraceptives in the 3 regions.

The proposed system is also completely consistent with the orientations followed by the MSP, both with regard to the integration and standardization of supply logistics and the will to ensure reproductive health products.

The proposals are in line with the project's strategy to withdraw and transfer to the national players. Their commitment to make the system work so that the project's achievements endure will have the consequence of USAID's commitment to continue to fund contraceptives.

LIST OF ABBREVIATIONS

AGBEF Guinean Family Welfare Association

ARV Anti-retroviral [drugs]

ATB Anti-tuberculosis [drugs]

HC Health Centers

DNPL Direction Nationale de la Pharmacie et des Laboratoires [National Pharmacy and Laboratory Administration]

PHA Prefecture Health Administration

RHA Regional Health Administration

DSR Division Santé de la Reproduction [Reproductive Health Administration]

EPIC Etablissement Public à caractère Industriel et Commercial [Industrial and Commercial Public Undertaking]

EVP Expanded Vaccination Program

PRISM Pour Renforcer les Interventions en Santé Reproductive [To Reinforce Interventions in Reproductive Health and STD/AIDS]

STD Sexually Transmitted Disease

MSH Management Science for Health

MSP Ministère de la Santé Publique [Ministry of Public Health]

GCP Guinea Central Pharmacy

FP Family Planning

PNLL Programme National de Lutte contre la Lèpre [National Leprosy Prevention Program]

PNLT Programme National de Lutte contre la Tuberculose [National Tuberculosis Prevention Program]

PNDS Plan National de Développement Sanitaire [National Health Development Plan]

NPP National Pharmaceutical Policy

RAMCES RApport Mensuel des CEntres de Santé [Health Center Monthly Report]

CBS Community-based Services

SPSR Plan national de Sécurisation des Produits de Santé de la Reproduction [National Plan to Secure Reproductive Health Products]

RH Reproductive Health

LIST OF APPENDICES

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Appendix No. 7: Estimation des coûts de logistique des CS

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APPENDIX NO. 1

MISSION SCHEDULE - March 19–28, 2006

Sunday, March 19
Arrive in Conakry

Monday, March 20
- Briefing with Tanou Diallo, Director of the PRISM Project

Desk research

Tuesday, March 21
- Teamwork with Y. Doumbouya and Dr. Sékou Condé
- GCP: meet with and interview Dr. Housseiny Bah, GCP Managing Director
- EVP Unit: interview not accepted
- Guinean Family Welfare Association AGBEF: Executive Director Robert Sara Tambalou

Wednesday, March 22
Teamwork
- Discussion Dr. Alpha Oumar Barry – Regional Health Director from Kankan
- Dr. Hawa Condé - UNFPA

Thursday, March 23
- MSP: interview with Dr. Aboubacar Sidiki Diakite – General Inspection
- MSP: schedule a meeting with Dr. Harirata Bah – DNLP Director
- Visit to GCP sites – Dr. Abdouramane Diallo

PRISM Teamwork

Friday, March 24
- Meeting at the MSP: DNPL Dr. Harirata Bah, Dr. Nagnouma Sanoh, Dr. Karifa Dounoh, GCP: Dr. Bah, Dr. Abdoulaye Tangaly Diallo, PRISM Dr. Conde Sekou, Dr. Youssouf Doumbouya, Ms. C. Damour
- GCP: accounting, purchasing/Dr. Sankhon M'Bembalaye

PRISM Teamwork

Saturday, March 25
PRISM Teamwork

Sunday, March 26

Monday, March 27
- Collect data at the GCP

PRISM Teamwork

Tuesday, March 28
- Interview with Dr. Sidaty Keita Director of the MSP Reproductive Health Division

PRISM Teamwork
Debriefing Mr. Tanou Diallo
End of the mission