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BANGLADESH: CONTRACEPTIVE PROCUREMENT IN TRANSITION

HOW CONTEXT CAN AFFECT OUTCOMES



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HOW CONTEXT CAN AFFECT OUTCOMES

USAID | DELIVER PROJECT, Task Order 1

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Abstract

This paper considers the types of work on contraceptive procurement being undertaken world-wide, and examines the experiences of Bangladesh, considering factors that may have promoted or impeded progress. It also places the results in context, comparing experiences of two other countries — Peru and Malawi. Finally, the paper suggests a framework for identifying and assessing variables that may affect procurement outcomes.

Cover photo: Field workers receiving contraceptives from an upazila store keeper in Bangladesh, 2002.

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ACRONYMS

CIDA	Canadian International Development Agency
CMS	Central Medical Stores
CMSD	Central Medical Stores Depot (Bangladesh)
CPC	Cabinet Purchase Committee (Bangladesh)
CPR	contraceptive prevalence rate
DCA	development credit agreement
DDA	Department of Drug Administration (Bangladesh)
DGFP	Directorate General of Family Planning (Bangladesh)
DFID	Department for International Development (UK)
DHO	District Health Office
FPHP	Fourth Population and Health Program
FPLM	Family Planning Logistics Management Project
GNI	gross national income
HPSP	Health and Population Sector Program
HSR	health sector reform
ICB	international competitive bidding
ICRC	International Committee of the Red Cross
IDA	International Development Association
IDA	International Dispensary Association
IUD	intrauterine device
KFW	<i>Kreditanstalt für Wiederaufbau</i> (German funding agency for international development)
LMIS	logistics management information system
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare (Bangladesh)
NGO	non-governmental organization
MSF	<i>Médecins Sans Frontières</i> (Doctors Without Borders)
PAAG	<i>Programa de Administración de Acuerdos de Gestión</i> (Peru)
PATH	Program for Appropriate Technology in Health
PMCC	Procurement Monitoring and Coordination Cell

PPA	private procurement agent
PPR	Public Procurement Reform Project (Bangladesh)
RNE	Royal Netherlands Embassy
SMC	Social Marketing Company (Bangladesh)
SWAp	sector wide approach
TEC	Tender Evaluation Committee
TFR	total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

Since the late 1990s, contraceptive security has evolved as an area of reproductive health that concerns itself with the diverse activities required to ensure that countries can provide, through the public and private sectors, contraceptives to anyone who wants and needs them. Initiatives to provide contraceptive security have included policy formation, total market approaches, diversification of funding, supply chain improvements and upgrading procurement practices. This paper focuses on the latter and carries out the following tasks:

- Consider the types of work on contraceptive procurement being undertaken world-wide.
- Examine the experiences of one country — Bangladesh — in depth and consider the factors that may have promoted or impeded progress.
- Place results from Bangladesh in context by more briefly considering comparable experience in two other countries — Peru and Malawi.
- Put forth a framework for identifying and assessing variables that promote or constrain good outcomes.

There is a general phenomenon of “transitions in contraceptive procurement responsibilities” that requires more and more countries to take a direct role in managing procurements. One stimulus has been the phasing out or reduction of donors’ commodity grants. Another incentive has been the emergence of International Development Association (IDA) credits and global fund monies as sources of funding for contraceptives and other health supplies. Still another encouragement for countries to take on the responsibility is the use of the sector wide approach (SWAp), in which bilateral and multilateral funds are pooled and used for a variety of purposes, including contraceptive purchases. Finally, and not to be overlooked, is the use of government budget funds, which is already prominent in some countries, and globally is expected to grow over time. Although motivated by different causes, what they have in common, however, are explicit requirements that procurements managed by country governments be competitive, transparent and executed according to international standards.

In Bangladesh, for years, donors supplied almost all the contraceptives used in the country. In 1998, however, the World Bank’s Health and Population Sector Program (HPSP), set up as a SWAp, provided funding for procurement of goods and services through IDA credits. In an attempt to avoid or accommodate potential problems during this transition process, a “funding reserve” was provided by HPSP’s predecessor. Despite these considerations, however, as time went on, stock quantities still fell below the six-month safety level built into the distribution system.

Whatever was intended, the measures taken to ensure the continuity of contraceptive supply through the transition to SWAp funding failed. The Directorate General of Family Planning (DGFP) and the Central Medical Stores Depot (CMSD) had no prior training in the highly technical discipline of international competitive bidding (ICB) and no thought had been given to human resources and equipment requirements.

Obstacles during this transition included insufficient knowledge and experience in preparing bidding documents, and in evaluating bids and selecting winners. Also, there were insufficient human resources for the massive amount of procurement tasks associated with the transition. There was no unit within the Ministry of Health and Family Welfare (MOHFW) designated or empowered to manage, monitor and support the procurement activities. Finally, a disaggregated procurement process at MOHFW, with work passing through many steps, held a potential for delay at each stop. Outside of MOHFW, the World Bank had bidding requirements that contradicted the drug regulatory authorities' mandates to protect the local pharmaceutical industry.

The MOHFW requested USAID technical assistance to help develop a Procurement Monitoring and Coordination Cell (PMCC). USAID provided funding for three procurement experts to work inside the Ministry and deal with urgent problems. Local experts helped MOHFW with day-to-day work and problem solving, while two short-term expatriate consultants from the DELIVER partner Program for Appropriate Technology in Health (PATH) worked to plan the interventions for training MOHFW staff in ICB. Additionally, DELIVER's Dhaka office played major technical and logistical support roles.

To provide capacity building, the team developed a set of four interventions:

- Day-to-day support to DGFP and CMSD
- Bangladesh-specific manuals and reference manuals
- Training sessions for procurement staff
- Attention to the broader procurement environment

The most often reported results of the return on the investment summarized above were large savings on condom and oral contraceptive procurement obtained in 2002 and 2003. During this period, DGFP staff independently conducted a successful international procurement for these products, resulting in approximately \$19.6 million in savings.

But despite these achievements, there was very little international procurement in 2004 and 2005. By June 2006 the national stock of condoms, orals, injectables and IUDs had again descended below the critical six-month level. Key informants repeatedly cited delays in obtaining approvals from officials and committees involved in the procurement process as being the principal reason. Delays occurred when documents were in MOHFW hands as well as when they were in the World Bank's hands.

The "bad news" continues to the present as procurement delays have placed tremendous pressure on the contraceptive logistics system and have led to widespread stockouts or near-stockouts of certain contraceptives at public sector and NGO facilities in 2007.

To place Bangladesh's experience in perspective, this paper also examines Peru's and Malawi's experiences in procurement transition, albeit in less detail. Despite their diverse settings and big differences in the details, there are some similarities across these country examples. In all three cases, donor preferences played a strong role. These took the form of withdrawal of commodity grants in Peru and Bangladesh and implementation of SWAp funding arrangements in Malawi and Bangladesh. Also, in all three cases the Ministries of Health delegated procurement responsibilities to their internal procurement offices (that is, they decided to carry out the transition through existing administrative machinery). In two cases, Peru and Bangladesh, UNFPA continued to play a key role as a procurement agent, although the reasons are different in the two cases. In the Peruvian case,

this was an explicit decision, whereas in Bangladesh it was politically charged and hesitantly arrived at as a last resort.

Where ICB conforming procurement was required — in Malawi and Bangladesh — it represented a major new burden for Minister of Health (MOH) procurement staff. Peru, the only country replacing donor grants with government funds, also seems to be the only one to have completed the transition with its own staff making informed contraceptive procurement decisions.

In the case of Bangladesh, we can identify with reasonable confidence a number of “contextual factors” that, between 1998 and 2006, confounded efforts to implement an efficient, public sector-based and SWAp-funded procurement operation. First, there were several indications that the government was either not committed to change or saw little benefit in applying the principles of ICB. Also, despite the fact that there are major public health consequences of disruptions in contraceptive supplies, including unwanted pregnancies and a number of related maternal and child health problems, ensuring product availability did not seem to have had much priority at indeterminate higher levels of the Ministry. The abrupt arrival of ICB at DGFP also put procurement staff and decision makers in a very awkward position due to a discrepancy in World Bank and Bangladesh policies. It is difficult to discern whether an obstacle to ICB was embedded in national policy. It is clear that a number of prevailing policy practices had small effects, whereas others posed major problems. For example, significant delays in granting approvals occurred after procurement packages had left the hands of procurement staff and were in the hands of evaluation committees, the Minister, or the Cabinet Purchase Committee. Finally, two basic human resource constraints were a major factor: staff inexperience in planning and executing ICB, and high rates of staff turnover at both decision-making and implementation levels.

Recognizing this paper’s limitations in sampling and methodologies, further research is needed to understand the process of transitioning away from donated contraceptives to a more sustainable process, particularly because SWAps linked to ICB are now widespread features of the global contraceptive security landscape. The next steps to evaluate its impact on contraceptive security could be:

1. Determine the global coverage of the public “SWAp/ICB” strategy.
2. Gather details for as many countries as possible at the level for Peru and Malawi.
3. Using information gathered for step 2, select a sample of countries for in-depth review, that is, a historical review of events at the same level of detail as for Bangladesh.
4. Refine and finalize the “contextual factors” list presented above for Bangladesh.
5. Synthesize the results and disseminate them to all relevant stakeholders by helping to improve ongoing assessment, planning and implementation activities. One practical application would consist of reviewing the most used assessment tools and revising them to take into account the results of this work.

INTRODUCTION

BACKGROUND

USAID supported the DELIVER Project from October 2000 through March 2007. Prominent among the project's several components was "resource mobilization for contraceptive security." Since the late 1990s, contraceptive security has evolved as an activity area of reproductive health that concerns itself with the diverse activities required to ensure that countries can provide, through the public and private sectors, contraceptives to anyone who wants and needs them.

Many date the broad recognition of contraceptive security as a priority to the conference held in Istanbul in 2001 under the banner "Meeting the Reproductive Health Challenge: Securing Contraceptives and Condoms for HIV/AIDS Prevention." Projections prepared for the conference estimated that by 2015 there would be \$140 million to \$210 million annual shortfalls in funding of contraceptives for developing countries. At this early point, much of the thinking about resource mobilization focused on the role of donors, and conference documents called for an immediate increase of \$24 million in global donor funding, immediately followed by subsequent annual increases of 5.3 percent to close the gap.

The DELIVER Project Final Report released in 2007 noted that data analyzed for the period 2002 through 2005 suggested that the hoped-for increases in global donor funding had not materialized. The same report also noted, however, that despite this disappointment the outlook for contraceptive security appeared to be improving, and attributed this trend to a range of practical initiatives at country and regional levels. The initiatives have included policy formation, total market approaches, diversification of funding, supply chain improvements and upgrading procurement practices.

PURPOSE

All of these initiatives have enjoyed and continue to enjoy considerable attention. Upgrading procurement practices is of particular interest because it is on the critical path to financial sustainability and is closely linked to funding diversification and supply chain improvement. The purpose of this paper is to work at an exploratory level of inquiry and carry out four tasks:

- Consider the types of work on contraceptive procurement being undertaken world-wide.
- Examine the experiences of one country — Bangladesh — in depth and consider the factors that may have promoted or impeded progress.
- Place results from Bangladesh in context by more briefly considering comparable experience in two other countries — Peru and Malawi.
- Put forth a framework for identifying and assessing variables that promote or constrain good outcomes.

METHODS

Bangladesh was selected for in-depth review for a number of reasons, including the size of USAID's investment in procurement-related activities, the abundance of documentation and, very importantly, the availability of key participants in the technical assistance effort for in-depth discussions. Peru and Malawi were selected for more cursory review because recent documentation is available on their efforts at procurement reform.

The methods for evaluating the information gathered have been entirely qualitative and consist of describing key events and making selective comparisons and contrasts. Due to the convenience sampling, the unevenness of the detail across countries and the susceptibility of qualitative methods to bias, the general applicability of the findings is very limited. However, the findings do give useful indications of the types of country responses to transitions in contraceptive procurement and to some of the factors that can support or impede good outcomes. These insights, in turn, may be used to develop a framework for more systematic review and synthesis of country experiences.

COUNTRY EXPERIENCES

OPTIONS FOR MANAGING PROCUREMENTS

In its final months, the DELIVER Project produced a review entitled “Procurement Strategies for Health Commodities: An Examination of Options and Mechanisms within the Commodity Security Context” (Rao et al 2006). Taking into account procurement of public health supplies in general, not just contraceptives, this paper provides some useful background for this review:

- There is a general phenomenon of “transitions in contraceptive procurement responsibilities” that requires more and more countries to take a direct role in managing procurements. One stimulus has been the phasing out or reduction of donors’ commodity grants. USAID, for example, has in Latin America ended grants to five countries and has put an additional nine on notice that it will end the grants at some point. Another stimulus has been the emergence of IDA credits and global fund monies as sources of funding for contraceptives and other health supplies. Still another is use of SWAps, in which bilateral and multilateral funds are pooled and used for a variety of purposes, including contraceptive purchases. All of these sources are increasingly important in the funding diversification strategies that seek to overcome the negative impacts of diminishing commodity grants. Finally, and not to be overlooked, is use of government budget funds, which is already prominent in some countries, and globally is expected to grow over time.
- As these new funding sources come into play, governments and ministries of health are using a number of mechanisms for managing the procurements. They include:
 - Public procurement carried out at the traditional center of public sector logistics — the Central Medical Stores (CMS)
 - Public procurement through non-MOH central procurement offices
 - Public procurement through centrally managed parastatal agencies that are (or are supposed to be) managed on business models
 - Decentralized public procurement through which provinces, districts or health facilities may use their own budgets to purchase from designated suppliers
 - International agencies that offer procurement services, including UNICEF, WHO, UNFPA, MSF and ICRC
 - Specialized procurement firms, including public service organizations (IDA, Mission Pharma, and Imres) and commercial groups (Crown Agents and Charles Kendall)

In some cases, some of these elements are combined. In Malawi, for example, the CMS manages public tenders, whereas district health offices use their own budgets to buy from the CMS, which becomes their primary supplier. In Peru, the Programa de Administración de Acuerdos de Gestión (PAAG) manages both public tenders and procurements through UNFPA.

- IDA, global funds and SWAps are all very different types of funding mechanisms that are intended to fill different needs across the health sector. What they have in common, however, are explicit requirements that procurements managed by country governments be competitive, transparent and executed according to international standards. Most often, this means international competitive bidding (ICB) as described in “Guidelines: Procurement under IBRD Loans and IDA Credits” (World Bank 2004).

CLOSER LOOK AT BANGLADESH

At this point we pass to an in-depth examination of developments in one country. We will see that Bangladesh opted for Ministry of Health-based procurement, but did sometimes turn to UNFPA. We will also see that the need to conform to ICB posed major challenges.

CONTEXT

CONTRACEPTIVE USE

Bangladesh is well known for its receptivity to family planning and the success of its programs. From 1975 through 2000, the CPR for modern methods increased from 5 percent to more than 43 percent. Total contraceptive use, including traditional methods, increased during the same period from 8 percent to 54 percent. This represents an increase in users of modern methods from 800,000 to 14,000,000 (Hudgins 2002). A widely used projection made in 2001 estimated that, world-wide, the number of contraceptive users would rise by 28 percent by 2015.¹ Projections made by the DELIVER Project suggest that the global trend could result in as many as 11 million new users in Bangladesh within this time frame (Hudgins 2002). An obvious consequence will be an enormous and increasing demand for contraceptives.

CONTRACEPTIVE MARKET

For purposes of distribution, two key players dominate the family planning market in Bangladesh. They are the public sector, meaning MOHFW, and the Social Marketing Company (SMC); the commercial sector share is relatively small. This is not surprising in a low-income country with a per capita gross national income (GNI) of \$380 and 36 percent of the population below the poverty line (Chawla et al. 2003).

MOHFW supplies 64 percent of current modern contraceptives, providing for 85 percent of Bangladeshi women using injectables, and 90 percent of the women using long-term methods, such as intrauterine devices (IUDs) and sterilization. The government oral brand also has more than 63 percent of the market share. The SMC, a not-for-profit social marketing organization that sells its brands at prices lower than the bulk product costs because of its reliance on donated products, also has a big share of the market. SMC sells orals, condoms, and injectables, mostly through private sector outlets. SMC has captured 71 percent of the market for condoms and 29 percent for orals. The commercial sector plays a small role, with its market share not exceeding 5 percent of the IUD, injectable, and sterilization markets. Commercial sector condom sales account for only 3.5 percent of condoms sold (Chawla et al. 2003).

¹ Projections made for the Interim Working Group on Reproductive Health Commodity Security. 2001. Istanbul. John Snow, Inc., Population Action International, Program for Appropriate Technology in Health and the Wallace Global Fund.

It is important to understand, however, that for purposes of procurement SMC receives condoms from MOHFW. What this means, in turn, is that almost all condom users in Bangladesh nearly always rely on product originally provided by MOHFW. Thus, MOHFW's capacity to manage procurements is critical to the country's contraceptive security.

FUNDING TRANSITION

For many years, donors supplied almost all the contraceptives used in the country. Important contributors have included CIDA, DFID, KFW, RNE, UNFPA and USAID. However, this began to change radically in 1998. In that year a World Bank-led five-year initiative called the Health and Population Sector Program (HPSP) began operations. HPSP replaced the Fourth Population and Health Program (FPHP), which had had 26 donors and 120 projects. Under FPHP, implementers executed procurements through individual projects relying on the procurement arms of various UN agencies such as UNDP, UNFPA and UNICEF. However, HPSP was set up as a SWAp; funding for procurement of goods and services came from IDA credits. Out of a total program value of \$3.4 billion, about \$1.5 billion was reserved for procurement. Contraceptives accounted for about 27 percent of the overall budget for procurement. Very roughly, this would be about \$81 million per year for the life of the program. Some sense of the scale of the shift from donor grants to IDA funding can be gathered from data compiled for 2000 and 2001. In 2000, funds expended on contraceptives totaled \$29.2 million, with \$6.9 million (24 percent) coming from IDA credits. In 2001, total funds expended were \$64 million, with \$26.5 million (41 percent) coming from IDA. We have not encountered comparable data for subsequent years, but the consensus of informants is that the trend toward IDA credit financing has continued.

IMPACT IN THE WORK PLACE

Whether the funding shift described above represents any real progress toward a financially sustainable health care system is unclear. To some it looks a lot like switching from one form of spending other people's money to another form of spending other people's money. What is clear, however, is that the real consequences in the work place were not anticipated.

The development credit agreement (DCA) for HPSP specified that all purchases of goods and services be purchased using World Bank ICB policies and procedures. These are designed to follow international public procurement standards through the use of the following practices:

- Ensuring economy and efficiency without regard to political or other non-economic influences or considerations, while assuring quality
- Equal opportunity to compete for contracts
- Encouraging domestic contracting and manufacturing²
- Ensuring transparency in the procurement process

Under the agreement, and depending on the threshold for prior review, World Bank staff must approve key steps in the process before it may proceed. They do this by providing "no objection" determinations. To play the fiduciary role expected of the World Bank staff of ensuring the

² Domestic companies are allowed a margin of up to a 15% upward price adjustment to enhance their ability to compete with international suppliers.

principles of public procurement are adhered to, World Bank staff are expected to be very strict in their insistence that the procedures be followed exactly in Bangladesh and elsewhere.

The government procurement regulations in force at the time did not conform to the processes and procedures called for by the World Bank regulations. Within MOHFW, the Directorate General of Family Planning and Central Medical Stores Depot were responsible for procurement. Within these units, however, staff had no experience with ICB. HPSP planners expected to overcome these deficits using two measures. The DCA stipulated that during the first year UN agencies could be used, and thereafter MOHFW would engage a mutually acceptable private procurement agent (PPA). A third precaution was also taken. At the urging of the development partners and over MOHFW's initial objections, \$19.1 million from HPSP's predecessor, FPHP, was allocated to UNFPA to purchase contraceptives. Between February 1998 and June 1999, these monies provided 85 million condoms, 21 million orals, 12 million injectables and 47,000 implants. This, combined with pre-existing stocks, was to create a reserve of 12–18 months (Hossain 2007).

MOHFW and the World Bank were unable to reach an agreement on the PPA. In August 2000, more than two years after HPSP startup, the World Bank rejected the Ministry's candidate and MOHFW abandoned the PPA plan, although it had been part of the DCA. (Subsequently, in 2002 MOHFW would also decide not to implement another key part of the DCA and halted work to integrate the Health and Family Planning supply chains, after considerable time and money had been invested in this reform.)

To this point, UN agencies' procurement option had not been exercised. Thus, for the first two years of HPSP there were no contraceptive procurements. This, of course, undermined the strategy described above of creating the FPHP-funded "transition reserve." By December 1999, stocks were falling below the six-month safety level built into the distribution system. It was only at this point, to ward off system collapse, that the first HPSP-funded contraceptives were purchased. The World Bank assented to an MOHFW request to use UNFPA³ rather than an IDA-sanctioned procurement to make an emergency procurement. This plan was accepted and \$27.3 million in HPSP credit funds were allocated to UNFPA. CIDA and KFW also came forward at this time with commodity grants (Hossain 2007).

Whatever was intended, the measures taken to ensure the continuity of contraceptive supply through the transition to SWAp funding failed. Accordingly, procurement staff in place at the Directorate General of Family Planning and the Central Medical Stores Depot became responsible for the HPSP procurements. They had no prior training in the highly technical discipline of ICB and no thought had been given to human resources and equipment requirements. In the real world, there was no possibility that they could do what was suddenly expected of them. Supply chain staff at central, district, upazila and health facility levels were also negatively affected when planned procurements did not take place. Their stocks, originally abundant with the transition reserve, dwindled. This disrupted the min/max inventory control system and necessitated emergency shipments to lower levels to compensate for unforeseen stockouts. The emergency shipments gave the government a 12- to 18-month lead time to get the capacity and processes in place for doing an ICB procurement (Hossain 2007).

³ According to the World Bank guidelines, use of UN agencies for procurement of specialized goods and services is considered most appropriate for small quantities of off-the-shelf goods (primarily in health and education), and in the procurement of specialized products where the number of suppliers is limited, such as vaccines and drugs.

INTERVENTIONS

By the beginning of 2000, MOHFW and the development partners were beginning to take stock of the unsatisfactory procurement situation. Between March and July, both the World Bank and USAID brought in senior consultants to identify the problems that accounted for the disappointing results and recommend solutions.

OBSTACLES TO EFFICIENT PROCUREMENT

The experts' findings coincided closely. Together they comprise many pages of technical details on a variety of topics and cannot be summarized in a few lines. The delays in procurement were attributed to the following factors:

- Inadequate planning information for many product categories (contraceptives being an exception)
- Insufficient knowledge and experience in preparing bidding documents
- Insufficient knowledge and experience in evaluating bids and selecting winners
- Insufficient manpower for the magnitude of the procurement tasks associated with HPSP
- No unit within MOHFW designated or empowered to manage, monitor and support the overall HPSP procurement activity
- Disaggregated procurement process at MOHFW, with work passing through many steps and committees, with potential for delay at each stop
- Difficulty satisfying the World Bank procurement requirements and receiving approvals (Woodle 2000)

There were also some important problems outside the MOHFW system:

- National procurement regulations, which MOHFW staff normally followed, were limited in their requirements for documentation and transparency
- The World Bank required that bidding be open to manufacturers of products not yet registered in-country, which contradicted the drug regulatory authority's (Department of Drug Administration or DDA) legitimate mandate to protect the local pharmaceutical industry (Dickens n.d.)⁴

TECHNICAL ASSISTANCE AND COUNTERPARTS

Subsequent to the World Bank's consultant visit in March 2000, MOHFW decided to establish a Procurement Monitoring and Coordination Cell (PMCC) and requested technical assistance from

⁴ Mr. Dickens further notes that in the interest of encouraging widest possible competition, World Bank procurement policy does not require suppliers to register their products prior to submitting bids. If a supplier is selected whose product is not registered, it must register its product prior to a contract being awarded. Problems did occur when international suppliers attempted to register a product for which there is an interested local manufacturer. Because DDA has a mandate to protect local manufacturers, it did create obstacles that delayed registration of international products. This situation is not unique to Bangladesh. Both developing and industrialized countries have strong industry associations that lobby to protect their interests.

USAID to help make the unit operational. USAID responded by agreeing to provide expertise through the Family Planning Logistics Management Project (FPLM), DELIVER's predecessor. In fact, the primary reason for USAID's July visit had been to plan this program of assistance.

Whatever would eventually come of the planned assistance, MOHFW and its PMCC were in urgent need of help.⁵ USAID provided this by funding the placement of three local procurement experts to work inside the Ministry and confront the burgeoning list of urgent problems to be solved. By the time DELIVER inherited the activity in October 2000, it had taken form around three core inputs: The local experts helped MOHFW with day-to-day work and problem solving, while two short-term expatriate consultants from DELIVER partner PATH worked to plan the interventions for training MOHFW staff. One of the local experts was assigned to DGFP and another to CMSD. The third worked primarily at DGFP but assisted at CMSD. At about this time, KFW also funded an international procurement specialist who was placed at CMSD. In addition, DELIVER's Dhaka office played major technical and logistics support roles. In time, all of these actors would work together with counterparts to implement a package of specific interventions. Who would be the counterparts?

When the Government of Bangladesh decided to abandon the loan agreement's plan for a PPA, MOHFW confirmed that DGFP would procure contraceptives and equipment for family planning and reproductive health activities, and CMSD would be responsible for broader health-related material as well as services. An important feature of MOHFW's request for technical assistance was its insistence that help was required in all areas, not just family planning products. It was expected that the Line Directors for the various HPSP sectors would determine their needs and communicate them to the procurement Desk Officers in DGFP and CMSD. Thus, at the outset, the counterparts for the procurement assistance team consisted of both the Line Directors and the procurement Desk Officers. Events would soon show that other parties in other places would also require attention.

To this point, this paper has described the context in which a need for assistance arose, the types of technical assistance provided, and the principal counterparts. These parties worked together for three years, from September 2000 through August 2003. Against this background, we now consider the details of this collaboration and its results.

BUILDING PROCUREMENT CAPACITY

DELIVER's Dhaka office hired the three local consultants to work inside the MOHFW, while international consultants were provided for short-term assignments by DELIVER partner PATH. Based on the original plan put forth by the USAID consultant, this team developed a set of interventions, consisting of the following elements:

- Day-to-day support to DGFP and CMSD
- Bangladesh-specific manuals and reference manuals
- Training sessions for procurement staff
- Attention to the broader procurement environment

Information on each element is given below.

⁵ After a first mention, PMCC, as a discrete unit, seems to drop from sight. The documents consulted continue commentary on developments in DGFP and CMSD, but there is no mention of any significant role for PMCC.

DAY-TO-DAY SUPPORT

DELIVER's work with upgrading procurement capacity began in an atmosphere of crisis two years into the HPSP program. Relations between MOHFW and the World Bank were tense as a result of difficulties in obtaining "no objection" determinations and the failure to agree on a PPA.

Contraceptive stocks had reached dangerously low levels and the pressure on MOHFW decision makers, Line Directors and procurement Desk Officers was mounting. The DELIVER Dhaka office had for years supported contraceptive procurement by assisting MOHFW to maintain the contraceptive logistics management information system (LMIS) and assisting with quantification of different donors' contributions. The continuity of this support through the HPSP procurement crises had been critical to the success of the UNFPA emergency procurement option.

The UNFPA emergency procurement was an exceptional case and did not change the fact that adherence to World Bank procurement regulations would be the rule in accordance with the agreement between all the major donors and the government in moving the assistance from a project approach to SWAp. This left DGFP and CMSD staff with an enormous amount of paperwork they did not understand. An initial USAID report gives some insight into what greeted the procurement Desk Officers:

- It was difficult to get information on product requirements from the Line Directors so that overall needs could be packaged for procurement action.
- International bidders (those who can supply the best quality and prices) need requested goods to be described in widely accepted, standard ways so they can understand what is being requested and determine their offering prices. Neither the Line Officers nor the Desk Officers had ever been exposed to this vocabulary.
- The World Bank has published Standard Guidelines for several categories of goods and services. They are not interchangeable. A new set of Standard Bidding Documents for the Health Sector had been published in May 2000, but they were not initially available in Bangladesh.
- There was no common agreement within MOHFW on how to interpret some of the World Bank's common phrases; for example, the phrase "substantially responsive" was troublesome to bid evaluators (Woodle 2000).

The role of the local consultants was to work side-by-side with their counterparts and use their skills to make the work at least manageable while the means to transfer these skills were being developed. About a year after they began their work, the situation at DGFP appeared to be coming under control. But at CMSD, which had the greatest number of packages to prepare, still more help would be required. The following excerpt from one of the PATH team's reports summarizes the situation in September 2001:

"A review of the HPSP I procurement packages status indicates that the packages for the DFP are being processed as scheduled by local consultants Mr. Mahbubur Rahman and Mr. Muhammad Ali. There are no apparent bottlenecks in processing the DFP packages (though Government of Bangladesh committee approval of contracts has delayed some packages.) Mr. Muhammad Ali is also processing selective service packages in a timely manner. Mr. Abul Hayat's efforts to process CMSD procurement packages has been hindered by delays in receiving accurate specifications from Line Directors. In discussion with the KFW procurement management specialist it was determined that the provision of four additional local

consultants to be funded by KFW would help alleviate this bottleneck.” (Dickens and Woodle 2001)

It is difficult to imagine that assistance, which had focused only on transfer of skills, would have been of much practical use to address the MOHFW’s immediate procurement backlog. As a result of underestimations at the planning stage, the placement of the hands-on procurement specialists within MOHFW was the only way to dig out. The magnitude of need is suggested by the decision to double the number of local consultants based in MOHFW.

MANUALS AND REFERENCE MATERIALS

The DELIVER team held its first training activity in September 2000. At this meeting it became apparent that there was urgent need for high-quality, Bangladesh-specific training materials. This led the team to develop the cornerstone of future training activities — a 360-page manual on procurement of goods, designed especially for the Desk Officers — that provided step-by-step instructions for preparing bidding documents, evaluating bids, awarding contracts and monitoring supplier performance. The manual contained sample product specifications for contraceptives, essential drugs and medical supplies, and quality assurance guidelines for each product. Subsequently, the team also produced a manual for procurement of services.

TRAINING FOR PROCUREMENT STAFF

The manuals were written in the six months or so following the first training session, and were tested in April 2001 at a training session for Desk Officers organized especially for this purpose. The next step was to finalize these documents and develop practical exercises. Based on this foundation, DELIVER organized three additional training sessions designed to help Desk Officers comply with World Bank procurement regulations:

- September 2001, preparing bid documents
- January 2002, evaluating bids and preparing documentation to submit to decision-making committees
- October 2002, “refresher” training in which critical functions and areas with recurring problems were reviewed

These training sessions were all held at a training center outside Dhaka, lasted four days each, and made extensive use of practical exercises. Notably, they also covered procurement of equipment and services, not just contraceptives. The local consultants played vital roles at all of the training sessions through teaching some of the sessions and assisting participants with understanding the English terms and documents. From 2001 through 2006 DELIVER assisted with 23 training courses, in which 650 participants from MOHFW participated, including both health and family planning staff.

ATTENTION TO THE BROADER PROCUREMENT ENVIRONMENT

The July 2000 assessment had identified a number of obstacles to efficient management of ICB. The skills deficits of MOHFW figured most prominently and, accordingly, the initial responses were the ones discussed above — the day-to-day support from the local procurement consultants and training. As these activities made progress, attention was turned to other obstacles in the broader environment. These included:

- MOHFW’s organizational environment, particularly the role that Line Directors play in initiating the process and the roles that senior officials play in overseeing procurement, and the role evaluation committees play in evaluating bids and selecting suppliers
- The policy environment, which includes national laws and regulations and donor policies
- The external environment, consisting primarily of suppliers, manufacturers and other private sector groups involved in procurement

We describe below the ways in which all three of these elements received attention.

Organizational environment. The newly appointed Line Directors, who supervise the Desk Officers, were not fully aware of their responsibilities in the procurement process. Program end users would often delay submitting their requirements to the Line Directors, which would create additional delays in processing the procurement actions. As with the procurement staff and Line Directors, evaluation committee members did not understand the World Bank requirements for a fair and transparent supplier selection process. Committee members would often revert to a traditional way of doing business, which allowed for selecting winning bids by evoking “executive privilege” instead of looking at a supplier’s ability to meet the evaluation criteria.

To address these problems, the DELIVER PATH team members wrote the “Procurement Primer of Health and Family Planning in Bangladesh.” Whereas the manuals are detailed guides for procurement professionals, the primer is more in the nature of an orientation aimed at those who play roles — in some cases, very important roles — but are not involved full-time. The primer was used in special add-on sessions at the Desk Officer training courses, to which both Line Officers and senior staff were invited for purposes of orientation on World Bank procurement regulations. The team also developed a dramatized video presentation for use in these sessions.

Policy environment. MOHFW procurement staff were working in a very awkward situation in which they could be fully complying with Government of Bangladesh procurement regulations and still be very far from meeting World Bank criteria. To address this problem, the World Bank funded a separate activity, the Public Procurement Reform Project (PPR). This project completely rewrote the country’s regulations and brought them in line with accepted international practice. In 2004 DELIVER helped to integrate the new provisions into the World Bank procurement guidelines. The PPR became law in 2006 and DELIVER integrated its provisions into the procurement manuals and training materials.

As noted on page 8, some international manufacturers experienced delays in obtaining product registration with the Department of Drug Administration. The attention directed at this problem has been somewhat limited but, under a separate agreement with the World Bank, in November 2004 PATH carried out an assessment of the drug regulatory environment. The primary recommendation was to provide technical assistance that could help bring about an accommodation between international standards on competitive procurement practices and national regulations. This problem has not yet been fully resolved.

External environment. Many local suppliers and local agents of international firms had a limited understanding of World Bank bid requirements and procedures. To address this problem, the team wrote the “Bangladesh Bidder’s Guide.” This publication was designed to help suppliers understand the documents and procedures they will encounter when they compete for MOHFW contracts that are either wholly or partly funded by World Bank credits. In August 2003, MOHFW, with

DELIVER's support, held an orientation for local suppliers to introduce the Bidders' Guide and answer questions. The rationale behind this activity was that by helping suppliers in this way, fewer bids will be rejected, competition will be increased and lower prices will result.

This concludes the description of DELIVER-sponsored interventions to strengthen procurement capacities. To summarize: The key inputs were day-to-day assistance in preparing procurements from local consultants; training for MOHFW procurement staff; and communications with other key audiences inside and outside the Ministry. Built into these activities was preparation and dissemination of a number of manuals and orientation documents.

RESULTS AND FOLLOW-THROUGH

FIRST, THE GOOD NEWS...

The most reported results of the return on the investment summarized above were large savings on condom and oral contraceptive procurement obtained in 2002 and 2003. During this period, DGFP staff independently conducted a successful international procurement for 446 million condoms, in conformance with World Bank regulations. UNFPA offered a unit price of \$0.026 plus a 5 percent service fee on the total quantity purchased. DGFP's final price was \$0.022. In this case, DGFP's independent work achieved a savings of more than \$2.6 million.

DGFP also achieved significant savings in oral contraceptives procurement, obtaining per-cycle prices of \$0.07 and \$0.11 compared to the CIDA and KFW per-cycle price of \$0.23 for orals that had been procured during 2000. This case resulted in a total savings of approximately \$17 million (DELIVER 2007).

One informant, in retrospect, estimated the lead times for these DGFP procurements to have been about 12 months, significantly less than the 15 to 18 months he cites as the norm.

Over time, the potential cost savings achieved through effective competitive procurement of contraceptive products can be significant. In the case of Bangladesh, using the lower prices obtained through the DGFP procurements has resulted in projected \$20 million in savings. According to Sarley et al. (John Snow, Inc./DELIVER 2006), "Forecasts of Bangladesh's funding needs for 2010 were reduced downwards from \$60 million estimated in 2000 prices to \$40 million for the same volume of commodities."

In light of these and similar developments, in April 2004 a DELIVER report made the following recommendations:

- "MOHFW does not wish to engage a procurement agent or an "external agent for change." In light of recent progress and notable success, both wings of MOHFW should handle their own procurement. In addition the structure and leadership of MOHFW procurement can and should be built up internally. Operations level procurement personnel in the MOHFW should continue to be supported by local consultants; additional computer equipment and better access to internet should also be provided. Ongoing training should be provided at all levels.
- All procurement by the Family Planning wing should remain centralized; international procurement and high value procurement by the Health wing should also remain centralized.
- International procurement (funded through an IDA Development Credit Agreement) should continue to use IDA procurement guidelines and documents; local procurement uses the new Government of Bangladesh Public Procurement Regulations and related documents." (Woodle 2004)

Without intending irony, the report also suggested that, at the conclusion of HPSP, the next DCA should allow of unlimited procurement through UN agencies. This would give all concerned a reliable procurement option in case of emergencies or delays.

... AND NOW THE BAD NEWS

Despite the progress seen in 2002 and 2003, the MOHFW carried out very little international procurement in 2004 and 2005. By June 2006, the national stock of condoms, orals, injectables and IUDs had again descended below the critical six-month level. This situation was unfortunately reminiscent of that in 2000 with product stockouts. Was there no institutional memory? Had all the staff previously trained been moved on, leaving the documentation languishing on dusty shelves?

More than a year before, in August 2005, specific steps had been taken to avoid this situation. At the UNFPA-sponsored Reproductive Health Policy Dialogue, it was decided to make an emergency procurement of 60 million condoms, 30 million orals, and 8 million injectables. The plan was to use IDA funds and have UNFPA procure half of these amounts and DGFP the other. The plan called for the DGFP procurements to be completed within 8 months, but it took more than 14 months.

The sources are not very specific about what accounted for these delays, but written reports as well as key informants repeatedly cite delays in obtaining approvals from officials and committees involved in the procurement process. An April 2005 report noted:

“[International Competitive Bidding] takes 18-24 months in the GOB context. Eighteen months is not unreasonable, given requirements for procurement plans, budget approvals and other aspects of government process. A 24 month cycle suggests room for improvement. Technical assistance has concentrated on training staff members who are responsible for procurement from inception to point of bid opening and preliminary examination. This TA has resulted in better documents and faster processing. However, [procurement] personnel have no control over procurement processing time once a package goes to the evaluation committee and upwards for approvals. One earlier calculation suggests as much as 45 percent of delay risk occurs after responsibility passes out of the hands of procurement personnel.”(Woodle 2005)

The report concludes the discussion with the following observation:

“The key message is to direct attention to the correct level of the system. In general [procurement staff] have no control over the Minister or Cabinet [Purchase] Committee’s action or lack thereof.” (Woodle 2005)

Although this observation is important, it is not the case that delays were only caused in higher levels of the Ministry and Government committees. In March 2007, a World Bank report presented an analysis of the emergency procurement for injectables initiated in September 2005. It identified a number of specific points of delay:

- The emergency procurement was decided upon in August 2005 at a meeting chaired by the Minister. It took another 58 days for DGFP and MOHFW to specify the items and quantities to purchase.
- Once the Tender Evaluation Committee (TEC) made their recommendation and it was sent to the World Bank for a “no objection” determination, it took 80 days for the World Bank to make all of its requests for clarifications.

- After all of the World Bank’s queries had reached the TEC, it took MOHFW another 72 days to respond. After that it took an additional 28 days to resolve the final problems and issue the “no objection” determination (Ali 2007).

In this case, some of the big delays occurred when documents were in MOHFW hands and others occurred when they were in the World Bank’s hands. The 80-day delay for the World Bank to evaluate the documents and request its clarifications occurred after DGFP procurement staff were trained and supposedly producing better bid evaluation documents. This is only one case, and without more information there is no knowing where the “fault” lies. However, we do know from the data presented that, in a case where contraceptive stocks descended below the safety level — after DGFP’s procurement capacity had been “strengthened” and after MOHFW decided to make an emergency procurement, within the then existing procurement environment — it took 14 months for the Ministry to issue a notification of acceptance to the winning bidder. It would still be some months before approval of the Government of Bangladesh was secured, the winning supplier notified, and the injectables reached MOHFW.

Another source describes the role of the Cabinet Purchase Committee (CPB) to which the April 2005 report alluded above. Government procurement procedures require that any procurement above \$357,000 be approved by the CPB, a national-level body composed of designated ministers. Even at the Minister’s level, MOHFW does not have the clout to expedite decisions. It can take as long as a year to receive a CPB approval (Hossain 2007).

Another very important obstacle that has probably been under-reported in the documentary sources, but stressed by informants, is staff turnover — whether of procurement staff who have been trained, or higher-level staff who have been sensitized to the requirements of ICB. More research is in order on this point, but we have not yet seen any analysis that gets at how long trained staff remained in place post-training. However, the fact that in such a narrow arena of action as central-level procurement, more than 100 staff members were trained or oriented each year suggests that turnover was a major problem. In one of the few specific examples we have for this issue, one of the informants stated that between 2000 and 2006 there were 16 Logistics Directors in DGFP and six or seven Joint Secretaries in charge of procurement (Hossain 2007). Another has expressed the opinion that the problem has accelerated under the interim government that came to power in 2006 and extends far beyond MOHFW to the entire civil service.

The “bad news” continues to the present. Procurement delays led to widespread stockouts of injectable contraceptives at public sector and NGO facilities in 2007, causing users to switch to other methods or to Blue Star providers (who are supplied with injectables by the Social Marketing Company). Condom stockouts were only narrowly averted (or minimized) in early 2008 by a costly emergency shipment of 6 million condoms funded by USAID. Admittedly, the condom crisis was brought on by a contractual dispute with a supplier. Nonetheless, delays in the original procurement left the Government of Bangladesh little room to sort out the dispute, and there seemed to be little pressure to find an immediate fix in order to ensure continued product availability. Finally, as of July 2008, the Government of Bangladesh had not initiated a procurement of implants. This despite stocks reaching a level (about four months before stockouts could occur) that is far less than is necessary for a procurement, even under the best of circumstances.

TWO OTHER COUNTRY EXPERIENCES

The Bangladesh case is one in which a ministry of health has tried to capacitate its internal procurement staff to work efficiently with ICB. Here we attempt to put these efforts in a comparative light by considering two other countries that have attempted similar reforms. Developments in Peru and Malawi are summarized below.

PERU

Government and donor investments in family planning during the 1990s produced rapid increases in overall contraceptive use and equally rapid reductions in the total fertility rate. In 2004 the CPR was estimated at 71 percent and total fertility rate (TFR) at 2.4. Although relative market shares have fluctuated, in that same year the public sector accounted for about 60 percent of the national supply and the commercial sector about 26 percent.

For many years, contraceptive procurements enjoyed strong external support. USAID began making commodity grants to the private sector in 1985 and to the Ministry of Health (MOH) in 1995. Since 1999, in the face of declining USAID commodity grants, the MOH has been using public funds to purchase contraceptives. By 2005, 100 percent of contraceptives distributed in the public sector were financed by the government, and included a mix of purchases through local competitive bidding and UNFPA. Within the MOH, the unit responsible for managing the contraceptive procurements is Programa de Administración de Acuerdos de Gestión (PAAG).

National procurement laws provide that public tendering is required for purchases in excess of \$136,000. The laws do not allow for international tenders and assume that the public tenders will be executed in the domestic marketplace. The laws do allow, however, for international purchase through agreements with external organizations for which special approvals must be sought. Among the accepted grounds for such approvals is significant price advantage. The MOH's contraceptive purchases through UNFPA are based on such an agreement. Under the terms of the agreement, MOH transfers funds to UNFPA, which, acting as procurement agent for the government, uses them to buy low-priced contraceptives on the international market.

Peru has also been exploring options for purchasing low-priced, good-quality contraceptives in the local market. In 2004, MOH, with UNFPA support, conducted a market study to identify the best available prices for four contraceptive products. Condoms were not procured that year because of sufficient stocks from previous years. In the case of IUDs, the UNFPA price was far lower than prices available in the local market. The local and UNFPA prices for medroxyprogesterone were identical. MOH opted to buy from UNFPA in both cases. However, the price of the oral contraceptive ethinylestradiol was significantly lower in the local market, even after including the cost of shipping to regional level facilities, a service not offered by UNFPA. In this case, MOH chose to procure locally, gaining significant savings. The supplier of the local contraceptive was ESKE, the local representative of the Indian company FamyCare.

The DELIVER documentation does raise one concern. There is no dedicated budget line for contraceptives. Rather, contraceptive funding is taken from the Ministry of Finance's general allocation to the MOH. Through 2004, MOH decision makers had been willing to fund all of its contraceptive requirements, which, as noted, amounted to about 60 percent of the national market share at that time. On the basis of this brief summary, one might reasonably conclude that Peru is making a successful transition from commodity grants to country-managed procurement. Within the framework of national laws, it appears able to execute procurements in both the international and domestic markets. (Dayaratna et al. 2006)

MALAWI

This southern African country's family planning program has produced good results. From 1992 until 2004, the CPR rose from 7 percent to 28 percent. The dramatic increase in CPR is primarily attributable to the increased use of injectable contraceptives, which account for 66 percent of users. The second most popular method is tubal ligation, accounting for 6 percent. With the private sector providing very little of the national supply, future progress (including reduction of the unmet need of 27 percent) is heavily dependent on public sector procurement and distribution.

In the past, the Ministry of Health has received significant commodity grants. External support is continuing, but changes in donor financing methods have created a need for the MOH to manage procurements for most of its contraceptives. In 2004, Malawi began using a SWAp financing mechanism for the health sector. Before that, through the support of two major donors, DFID and USAID, the country was assured enough contraceptive security to meet the clients' contraceptive needs. DFID provided the injectable contraceptives and USAID provided the oral contraceptives, IUDs, implants and condoms. USAID continues to provide its contraceptives through commodity grants, but DFID now provides its support through the SWAp. This requires the government of Malawi to use SWAp funds for the procurement of the injectables. It also obliges the government to provide a share of the contraceptives it purchases to NGOs.

As in other countries, the SWAp has come to Malawi as part of a Health Sector Reform (HSR) program. Also included under the HSR umbrella is a decentralization program through which the 27 district health offices (DHOs) have been granted the right to execute their own budgets. In the case of drugs, including contraceptives, the overall system works as follows: The Central Medical Store carries out the procurements and maintains central stocks. The districts, in turn, buy their drugs from the CMS according to their own perceived needs. Under the decentralized system it is expected that the Treasury will disburse funds to the districts monthly, and reports indicate that this plan has worked well so far.

The CMS is not part of the MOH budget but is funded directly from the Treasury. Essentially, CMS borrows money from the Treasury, sells the drugs to the districts, and then pays back the funds to the Treasury. This arrangement ensures that CMS has the capital to make large procurements on behalf of all the districts and have them in stock in advance of the district's orders. Districts only have to pay for drugs purchased by CMS; with the exception of a handling fee, donated products are free to the districts.

The system described above only began operating in 2007. In that year, the government tendered for injectables, expecting delivery in December of the same year. It is too soon to tell how well the system will work in all of its aspects, including:

- Treasury monies to CMS for large procurements

- Treasury disbursements to districts for purchases from CMS
- Execution of purchases within lead times that will avoid stockouts
- Redistribution of purchased supplies to the districts

Although CMS purchased injectable contraceptives in 2006, the fiscal year 2007–2008 is the first in which the districts are expected to purchase their supplies from CMS.

One problem did come up early on, when the length of the procurement process exceeded the months of stock on hand and it was necessary to procure an emergency stock through USAID. As the process goes forward, a number of concerns are being raised. They are typical of problems encountered in other countries and are by no means unique to Malawi. They include the following:

- CMS staff do not yet have all of the skills required for forecasting and quantifying needs for specific procurement actions. The USAID | DELIVER PROJECT is providing assistance with this problem.
- The terms of the SWAp require CMS to conform to World Bank ICB regulations for procurements of \$100,000 or more. These regulations, although important and necessary, are notoriously difficult for first-time bidders to satisfy. This accounts for the longer than expected lead time for the 2007 procurement.
- A U.S.-based management consulting firm, Glocoms, had been contracted to provide technical assistance for strengthening CMS's core activities of procurement, storage and distribution. Glocoms was to assist with transforming CMS into a trust-based, autonomous procurement agency. It is reported that the work on the core activities has been hampered by vacancy of key CMS staff positions.
- Although there is at the central and district levels a reserved budget line for essential drugs, there is not a separate one for contraceptives. If district-level decision makers decide to not purchase sufficient contraceptives in light of perfectly legitimate competing demands, it is possible that CPR will drop and unmet need will rise. In other words, the procurement reforms could result in weakening rather than securing the contraceptive supply.
- Before the SWAp, NGOs received their DFID-funded injectables directly. Now they are expected to buy them from CMS. Individual organizations have expressed concern that this may impede their access.

None of this is to say that MOH-based procurements or the SWAp are not good ideas. Rather, it goes to show the range of issues to be confronted and resolved in order to get a good result. We might say that Peru, at least for now, has achieved a successful transition in contraceptive procurement, whereas Malawi is at the beginning of the process (USAID | Health Policy Initiative and USAID | DELIVER PROJECT n.d.).

SYNTHESIS

Despite their diverse settings and big differences in the details, there are some similarities across these country examples. In all three cases, donor preferences played a strong role. These took the form of withdrawal of commodity grants in Peru and Bangladesh, and implementation of SWAp funding arrangements in Malawi and Bangladesh. Also, in all three cases the Ministries of Health delegated procurement responsibilities to their internal procurement offices (that is, they decided to carry out the transition through existing administrative machinery). In two cases, Peru and Bangladesh, UNFPA continued to play a key role as a procurement agent, although the reasons are different in each case. In the Peruvian case this was an explicit decision, whereas in Bangladesh it was politically charged and hesitantly arrived at as a last resort.

Where ICB-conforming procurement was required, in Malawi and Bangladesh, it represented a major new burden for MOH procurement staff. Peru, the only one of the three replacing donor grants with government funds, also seems to be the only one to have completed the transition with its own staff making informed contraceptive procurement decisions. Our information is limited, however, and says little about problems encountered in that process and nothing about developments since 2004. The practical problems of transition emerge most clearly in the cases of Malawi and Bangladesh with their ICB inheritances. The information we have makes it clear that they still have a long way to go before anyone can claim that contraceptive security has benefited from the changes.

The sense of ongoing struggle in Malawi and Bangladesh is unmistakable, raising both concern and curiosity. Mindful that our sample is much too small for making grand generalizations, we still can't help but note that SWAps linked to ICB are now widespread features of the global contraceptive security landscape. With this in mind, we have to be concerned about the real results produced so far in those countries. In both cases it is as if the battle for installing ICB was won, at least in the short term, but that, overall, the war to ensure contraceptive product availability continues. In both cases, procurement lead times were lengthy — so much so that it was necessary for donors to step in with emergency procurements to avoid stockouts. This raises the question of whether lower prices through ICB really resulted in any savings when the costs of long lead times, emergency procurements, and downstream health problems associated with non-availability of contraceptives are factored in.

CONTEXT AND OUTCOMES

In Bangladesh the program of assistance that began in September 2000 was based on assessments by consultants from two different organizations, whose findings largely coincided.⁶ It was broad-based and continued over a number of years. In 2002 and 2003 it seemed to have produced good results. The documents are unclear about 2004, but by April 2005 signs of trouble were first formally noted — a capacity to procure according to ICB had been created at DGFP but, once documents were sent to higher levels at both higher MOHFW and Cabinet Procurement Committee levels, significant delays were taking place. Subsequent analysis would also identify delays at the World Bank (Ali 2007).

The fact that these and other problems occurred after DGFP had been strengthened and had conducted successful procurements in accordance with ICB suggests that the problem was not simply one of failure of procurement capacity building. It appears, rather, that there were multiple issues involved and that many of them arose outside the procurement machinery in the broader context of the Ministry of Health and the Government of Bangladesh.

In the Bangladesh country case, we can identify with reasonable confidence a number of “contextual factors” that, between 1998 and 2006, confounded efforts to implement an efficient public sector-based and SWAp-funded procurement operation. These are summarized in regular font below. For Peru and Malawi we know much less, but what we can say at this point is summarized in italic font.

- **Political commitment to change.** There were several indications that the government was either not committed to change or saw little benefit in applying the principles of ICB. These include the abandonment of the commitment to PPA, although it was part of the loan agreement, and of the integration of health and family planning supply chains, also part of the loan agreement.⁷

In retrospect, it appears as if the government’s willingness to sign a loan agreement containing stipulations calling for procurement reform did not mean that it fully embraced the idea when it came to implementation. If the Government of Bangladesh was in fact not supportive of procurement reform when the DCA was signed, World Bank planners failed to detect this sentiment. This raises the question of whether risk analysis of politically sensitive issues was sufficiently rigorous, if it was carried out at all.

The Peruvian Ministry of Health’s willingness to fund contraceptive procurements amounting to about 60 percent of the national supply certainly suggests political commitment. In general, Peru, using its own funds, is managing procurements in accordance with existing national laws and procedures, and it seems that very little change has been required in their situation. Another indicator of support has been the government’s willingness to actually use the machinery it has in place to gain access to international suppliers through UNFPA.

For Malawi, we know that the SWAp mechanism was accepted by the Ministry of Health along with the donor’s stipulation that the procurements be country-managed according to ICB. It is too soon to know how well these

⁶ This consisted of day-to-day support to DGFP and CMSD; Bangladesh-specific manuals and reference manuals; training sessions for procurement staff; and attention to the broader procurement environment.

⁷ There were also suggestions that the GOB wanted to have national manufacturing enterprises short-listed for ICB, even though they had little or no track record in contraceptive manufacturing.

changes, as well as others adopted under the HSR program, will work in practice over the life of the program and beyond. An indirect but also very inclusive positive indicator is that the HSR linking the MOH's central procurement with decentralized district procurements has worked well "so far."

- **Priority of product availability.** The public health consequences of disruptions in contraceptive supplies include unwanted pregnancies and a number of related maternal and child health problems. They also include loss of consumer confidence in the family planning program. Yet, at indeterminate higher levels of the MOHFW, ensuring product availability does not seem to have had much priority. In 1998, at the end of FPHP, the development partners anticipated the difficult procurement transition that lay ahead and advocated creating a special reserve using FPHP funds and a UNFPA procurement. MOHFW initially opposed this, although they eventually consented. Despite this measure, by the end of 1999 stocks were dangerously low and it was necessary for UNFPA to make an emergency procurement with HPSP funds and for CIDA and KFW to make commodity grants. Although the situation improved for a brief time, in 2005 and 2006 stocks again approached critical levels and it took MOHFW 14 months to execute an emergency procurement. Procurement-related supply disruptions have continued to the time of this report.

The sources consulted do not tell us why MOHFW was reluctant to create a safety stock at the transition between FPHP and HPSP, or why — two years into HPSP — no procurements had been executed, or why it took 14 months to execute an emergency procurement in 2005 and 2006. We can say, however, that threats to product availability did not stimulate expedient use of resources for avoiding stockouts.

For Peru and Malawi, we do not yet have direct information linking decision makers to events that might illustrate strong or weak commitment to product availability at clinic facilities. In Peru at the central level, we note that there has not been a reserved budget line established for contraceptives, although contraceptive funding, at least through 2004, appears to have been adequate. For Malawi, we know that product procurement decision making is also taking place at both national and central levels and that here, too, there are no reserved line items for contraceptives. Concern has been expressed that district-level decision makers, with their constrained budgets, might place low priority on contraceptives and this could lead to stockouts.

- **Policy environment.** The abrupt arrival of ICB at DGFP put procurement staff and decision makers in a very awkward position. As noted, they could be fully complying with Bangladeshi law and still not satisfy the World Bank's criteria for supplier selection. In fact, the problem had been recognized and received attention when the World Bank supported the Public Procurement Reform Project. However, the results of this strategically important intervention did not become law until 2006, eight years after the start of the HPSP program.

One concrete example of a negative effect for ICB lay in the fact that the national laws were not designed to promote procurement efficiency with the international marketplace in mind. The drug regulatory authority, the Department of Drug Administration, has a mandate to promote national self-sufficiency of the essential drug supply, in part by protecting local manufacturers. World Bank policy does not require suppliers to register their products unless they are selected as bid winners. Some problems with delayed registration did occur when international suppliers attempted to register a product for which there was an interested local manufacturer.

The limited material we read for Peru described a country whose procurement laws and regulations may or may not promote competition and transparency in domestic markets, but which regard international procurement as an exceptional situation to be handled by special agreements with international organizations. In Malawi, ICB has not been the norm in the past and, with difficulty, MOH procurement staff are now implementing it as required

by a SWAp agreement. We do not have the same background information that we have for Bangladesh and Peru, and it is too early to know from actual practice what value the government places on international procurement.

- **Local procurement practices.** We have not undertaken the extensive policy and legal review that would enable us to state in every case whether an obstacle to ICB was embedded in national policy. It is clear, however, that a number of prevailing practices had negative effects. Some of them were not major and were corrected through training and work with local procurement experts. Falling into this category was the simple lack of familiarity with the need to take certain steps required for ICB. For example, Line Officers did not have previous experience with quantifying their needs, or the procurement staff did not have experience in preparing product specifications at an international standard.

Other practices, however, posed major problems. The best example would be the very significant delays in granting approvals that occurred after procurement packages had left the hands of procurement staff and were in the hands of evaluation committees, the Minister, or the Cabinet Purchase Committee. It is noted that the World Bank was a member of the overall local procurement team, and lengthy delays in granting “no objection” certificates have also occurred there.

None of the documents or informants consulted explained the causes of delays that occurred above the level of the DGFP procurement staff. One often-heard reaction is that local decision makers preferred selecting winning bidders through “executive privilege” rather than through use of transparent evaluation criteria. This does not, however, take into account the possible influence of long-standing national policy to protect national manufacturers.

Our information on this point for Peru and Malawi is very limited. The limited information provided for the preceding point on policy environment is relevant here, but we cannot say more.

- **Human resources.** There have been and still are two basic human resource constraints that are somewhat interrelated. One is the inexperience of MOHFW staff in planning and executing ICB; the other is the high rates of staff turnover at both decision-making and implementation levels. The sources leave the impression that the least of all problems was the training of DGFP procurement staff members. The successful procurements of 2002 and 2003 demonstrated that a transfer of capacity had taken place through a thoughtfully designed program of local experts, manuals, trainings and orientations. The observation that much of the delay in executing procurements occurred at higher levels seems to largely exonerate DGFP line staff, the local experts and the trainers. It appears, however, that staff turnover was a much bigger problem and raises questions about the long-term viability of ICB in the national environment. The least that may be said is that if an acceptable level of performance is achieved again, the staff turnover problem greatly increases the recurrent cost of maintaining it.

For Peru, staff capacity for ICB is not a major issue because it is handled by means of engaging international organizations to carry it out. For Malawi, staff have found ICB to be difficult to manage and we know that delays in execution have led to emergency shipments from donors. Technical assistance is available for one important skills deficit, forecasting. Bangladesh’s experience suggests that much more will be required, but it has also been shown in Bangladesh that transfer of skills and expertise used for procurement can be successful.

NEXT STEPS

In considering next steps, it will be useful to return to the purposes of this paper:

- Consider the types of work on contraceptive procurement being undertaken in different countries.
- Examine the experiences of one country — Bangladesh — in depth and consider the factors associated with progress or the lack of it.
- Place results from Bangladesh in context by more briefly considering comparable experience two other countries — Peru and Malawi.
- Put forth a framework for identifying and assessing variables that promote or constrain good outcomes.

We feel that all four of these purposes have been accomplished. Although this paper's limitations in sampling and methods are obvious, we feel that the work does justify a hypothesis for further testing: Investments in procurement technical assistance and training notwithstanding, contextual factors can and do pose significant obstacles to implementation of public contraceptive procurement using SWAp funding.

The test would necessarily require the gathering and organizing of more data from a range of countries and contexts. This information could be used to clarify what contextual factors tend to intervene, what problems they cause and what solutions are being attempted.

Such a test is especially timely since, as stated previously, “SWAps linked to ICB are now widespread features of the global contraceptive security landscape.” With this in mind, the following next steps are suggested:

1. Determine the global coverage of the public “SWAp/ICB” strategy.
2. Gather details for as many countries as possible at the level for Peru and Malawi.
3. Using information gathered for step 2, select a sample of countries for in-depth review, that is, a historical review of events at the same level of detail as for Bangladesh
4. Refine and finalize the “contextual factors” list presented above for Bangladesh.
5. Synthesize the results and disseminate them to all relevant stakeholders by helping to improve ongoing assessment, planning and implementation activities. One practical application would consist of reviewing the most used assessment tools and revising them to take into account the results of this work.

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