



# Analysis of the Operational Policy Barriers to Financing and Procuring Contraceptives in Malawi



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Cover photo: Villagers laugh as they watch a group of actors perform a play about the benefits of family planning near Blantrye, Malawi. The festivities are part of a larger effort of the Adventist Health Service in Malawi to promote community-based family planning. © 2007 Virginia Lamprecht, Courtesy of Photoshare.

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



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## Executive Summary

Contraceptive security exists when every person can choose, obtain, and use high-quality contraceptives whenever they need them. Two of the most important factors in achieving contraceptive security are adequate financing and efficient contraceptive procurement mechanisms.

The USAID | Health Policy Initiative and USAID | DELIVER Project are working together to develop a methodology for identifying operational policy barriers in the financing and procurement of family planning (FP) products. The projects chose to conduct a study in Malawi to pilot this methodology.

Malawi's FP program has been highly successful, with a fourfold increase in the modern method contraceptive prevalence rate (CPR) from 1992 (7.4%) to 2004 (28.1%). This dramatic increase is primarily attributable to the use of injectable contraceptives, which accounts for 64 percent of modern contraceptive use. However, the Demographic and Health Surveys in 2000 and 2004 show that the growth in CPR has been leveling off, while unmet need for family planning continues to be high at 27 percent (2004) among married women—indicating that factors other than demand are involved.

Malawi's next Demographic and Health Survey is scheduled for 2009; the findings of the study indicate that Malawi's CPR will have at the least stagnated and more likely declined—despite the government's strong commitment to family planning and reproductive health. These findings largely reflect the lack of human capacity and funding to efficiently operate the overall health system; although funding for health has increased, it is still not at the level needed to fully finance drugs and supplies. Implementation of the country's Sector-Wide Approach (SWAp) and decentralization have made it more difficult to mobilize champions and leaders to fund family planning as there are so many competing demands. The SWAp bundles all health funding together, forcing countries to make particular health conditions a priority over others—often placing curative health products such as antibiotics above preventive products such as FP commodities. Another factor is the lack of private sector involvement in the supply of drugs, particularly contraceptives—thereby hindering the efficiency and effectiveness of the health system.

In late 2004, Malawi began using the SWAp finance mechanism for its health sector. An unintended consequence of a SWAp is drug stockouts. These stockouts can occur as a result of lengthy, structured procurement procedures and process reviews required under the SWAp agreement; and government personnel's unfamiliarity with the new procedures. For example, in 2006, the procurement process for injectable contraceptives lasted longer than the months of supply available, leading to an emergency donation of 960,000 units of Depo-Provera from USAID. The government of Malawi since tendered for injectables in 2007; at the time of the study, the first stocks were scheduled to arrive in Malawi in December 2007.

Malawi is currently decentralizing its governance, with funding now being allocated to 27 districts. Malawi's central government earmarks funding to ensure that the districts allocate resources to health; however, the districts determine how to divide those resources. While the government purchased injectable contraceptives in 2005, 2007–2008 is the first fiscal year that districts will need to purchase injectable contraceptives directly from the Central Medical Stores (CMS). The primary concern is that—faced with stockouts of other essential drugs and commodities—district health officers might decide not to purchase injectable contraceptives.

The Christian Hospital Association of Malawi (CHAM) and Banja la Mtsogolo (BLM) make significant contributions to Malawi's healthcare system and the provision of FP services. However, the study found that representatives of CHAM and BLM are uncertain of how to access drugs and contraceptives from the government for their facilities. BLM faces an additional burden of being unable to access contraceptives

until it complies with U.S. government FP policies that flow down through the government of Malawi; the United Kingdom’s Department for International Development has phased out its provision of injectable contraceptives and support of BLM, and the organization now has few alternatives to obtaining contraceptives through the public sector.

The above factors, combined, may have serious implications for contraceptive use in Malawi if not addressed. This report includes recommendations for addressing some of the identified challenges related to procurement and financing (see Table 1).

**Table 1. Recommendations for Addressing Financing and Procurement Challenges**

<b>Financing</b>		
	<b>Challenge</b>	<b>Recommendation</b>
1.	The supply of contraceptives, particularly injectable contraceptives, is vulnerable because of the bundling of funding under the SWAp without specific protections for contraceptives and because of decentralization, among other factors.	<ul style="list-style-type: none"> <li>• During the modification of the SWAp/Program of Work indicators, include an FP method as a proxy for the FP program—specifically, a stockout indicator for injectable contraceptives (the most popular and vulnerable method).</li> </ul>
2.	Stakeholders lack the information needed to understand and monitor trends in contraceptive funding, gauge levels of commitment, identify potential funding gaps, and advocate for government funding to be committed to contraceptive procurement.	<ul style="list-style-type: none"> <li>• FP stakeholders such as the Reproductive Health Unit should collect, monitor, and analyze FP commodity quantities and value by source of supply.</li> <li>• The Reproductive Health Unit could adopt and expand the information available through the RHInterchange.</li> </ul>
<b>Procurement</b>		
	<b>Challenge</b>	<b>Recommendation</b>
3.	Human and resource capacity are inadequate and data is limited for drug quantification for procurement.	<ul style="list-style-type: none"> <li>• Continue to work with the USAID   DELIVER Project to strengthen the quantification and forecasting process.</li> </ul>
4.	The long annual length of the tender and procurement cycle leads to stockouts.	<ul style="list-style-type: none"> <li>• Use a two-year framework contract for drug procurement, with the option for a third year.</li> </ul>
5.	Inclusion of all or most drugs in one tender may slow delivery of drugs if there are issues with the tender or procurement.	<ul style="list-style-type: none"> <li>• Issue tenders with smaller number of items based on product/drug classification.</li> </ul>
6.	The procurement capacity-building effort for CMS has not been completed and has been significantly hampered by turnover and delays in hiring key staff.	<ul style="list-style-type: none"> <li>• Prior to CMS’ transition to a trust, the ministry should               <ul style="list-style-type: none"> <li>○ Establish operational performance indicators;</li> <li>○ Ensure human resource gaps in procurement are filled and procurement capacity is strengthened;</li> <li>○ Build a buffer stock to account for challenges that might arise in transition to trust;</li> <li>○ Strengthen financial management systems; and</li> <li>○ Introduce quality parameters and a client-driven approach.</li> </ul> </li> </ul>

7.	The representation of CMS on the Internal Procurement Committee that evaluates tenders and makes contract award decisions can create a conflict of interest.	<ul style="list-style-type: none"> <li>To avoid a conflict of interest, remove CMS as a voting member of the Internal Procurement Committee.</li> </ul>
8.	The division of procurement responsibilities between the Ministry of Health procurement unit and Central Medical Stores is unclear.	<ul style="list-style-type: none"> <li>CMS should develop guidelines that clearly delineate procurement responsibilities.</li> </ul>
9.	The Technical Working Group that oversees CMS' activities provides little technical guidance because of an infrequent meeting schedule.	<ul style="list-style-type: none"> <li>This Technical Working Group should hold regularly scheduled meetings to provide oversight and guidance to CMS.</li> </ul>
<b>District-Level</b>		
	<b>Challenge</b>	<b>Recommendation</b>
10.	For the first time, districts will need to purchase injectable contraceptives from CMS using the ringfenced drug budget.	<ul style="list-style-type: none"> <li>Track the impact of new costs for injectable contraceptives for the districts to see if the introduction of fees for this commodity will negatively impact the district's decision to order these products using their budgets.</li> </ul>

## Abbreviations

AIDS	acquired immune deficiency syndrome
BLM	Banja la Mtsogolo
CHAM	Christian Hospital Association of Malawi
CMS	Central Medical Stores
CPR	contraceptive prevalence rate
DFID	Department for International Development (United Kingdom)
DHO	District Health Officer
EHP	Essential Health Package
FP	family planning
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HTSS	(Department of) Health and Technical Support Services
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
MOF	Ministry of Finance
MOH	Ministry of Health
NDQCL	National Drug Quality Control Laboratory
NHA	National Health Accounts
NORAD	Agency for Development Cooperation
SWAp	Sector-Wide Approach
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

## Introduction

Contraceptive security exists when every person can choose, obtain, and use high-quality contraceptives whenever they need them. Two of the most important factors in achieving contraceptive security are adequate financing and efficient contraceptive procurement mechanisms.

The USAID | Health Policy Initiative, Task Order 1 and USAID | DELIVER Project received funding from the Contraceptive Security Global Leadership Priority of USAID's Global Health Bureau/Office of Population and Reproductive Health to develop an approach for countries to identify the critical operational policy barriers to efficient procurement and financing of health commodities, especially contraceptives. The goal is to help national governments, donors, and other key stakeholders improve the policy environment for contraceptive security.

*Operational policies* are defined as the formal or informal rules, regulations, codes, guidelines, plans, budgets, procedures, and administrative norms that governments use to translate national laws and policies into programs and services. *Operational policy barriers* are the operational policies or norms that pose obstacles or challenges to commodity security. These may be unintended consequences of policy implementation or the result of policies and procedures that are not sufficient enough to safeguard contraceptive supply.

## Methodology

The Health Policy Initiative and DELIVER are working together to develop a methodology to identify operational policy barriers in the financing and procurement of family planning (FP) products. The projects conducted a study in Malawi to pilot this methodology.

The study included two phases: (1) gaining an understanding the policy and stakeholder landscape and (2) validating the current policy landscape for contraceptive security and identifying critical operational policy barriers. First, the study team engaged a local Malawian consultant to review the country's policy documents and gain a basic understanding of the Malawi context for contraceptive security (see Annex A: Study Team Members). As part of this effort, the consultant prepared an inventory to apprise the study team of all policies, regulations, and guidelines that pertain to financing and procuring health commodities, particularly contraceptives (see Annex B: Documents Reviewed).

Next, the study team used the results of the policy review to prepare for a two-week visit to Malawi beginning in late November 2007. The team interviewed approximately 28 stakeholders at both the national and district levels regarding operational policy barriers to the financing and procurement of contraceptives (see Annex C: Stakeholders Interviewed). This report summarizes the barriers identified and the team's recommendations for addressing them.

## Malawi Context

Malawi's FP program has been highly successful, with a fourfold increase in the modern method contraceptive prevalence rate (CPR) from 1992 (7.4%) to 2004 (28.1%). This dramatic increase is primarily attributable to the use of injectable contraceptives, accounting for 64 percent of the modern CPR. The second most used method is tubal ligation, accounting for 21 percent of the modern CPR. However, the Demographic and Health Surveys in 2000 and 2004 show that the growth in CPR has been leveling off, while unmet need for family planning continues to be high at 27 percent (2004) among married women—indicating that factors other than demand are involved. Malawi's next scheduled Demographic and Health Survey is scheduled for 2009; the findings of this study indicate that Malawi's

CPR will have at the least stagnated and more likely declined—despite the government’s strong commitment to family planning and reproductive health.

Malawi has national procurement policies and regulations, drug policies, a reproductive health strategy, a contraceptive security strategy, and an Essential Health Package that includes FP services and contraceptives. The Sector-Wide Approach (SWAp) has increased funding for the health sector and improved cash flow from the Treasury to health programs. However, during the site visits, the study team consistently heard about the lack of human capacity and funding to efficiently operate the overall health system. Although funding for health has increased, it is still not at the level needed to fully finance drugs and supplies. Implementation of the country’s SWAp and decentralization have made it more difficult to mobilize champions and leaders to fund family planning as there are so many competing demands. The SWAp bundles all health funding together, forcing countries to make particular health conditions a priority over others—often placing curative health products such as antibiotics above preventive products such as FP commodities. Another issue is the lack of private sector involvement in the supply of drugs, particularly contraceptives—thereby hindering the efficiency and effectiveness of the health system.

In late 2004, Malawi began using the SWAp finance mechanism for its health sector. Previous to the SWAp arrangement, the United Kingdom’s Department for International Development (DFID) provided injectable contraceptives and supported the nongovernmental organization (NGO) Banja la Mtsogolo (BLM). USAID provided oral contraceptives, intrauterine devices (IUDs), implants, and condoms. While USAID continues to provide contraceptives, DFID now provides financial support for health through the SWAp, requiring the government of Malawi to use SWAp funds for the procurement of injectables and to support BLM. In addition, the Christian Hospital Association of Malawi (CHAM) is expected to access drugs through the public sector.

An unintended consequence of a SWAp is drug stockouts. These stockouts can occur as a result of lengthy, structured procurement procedures and process reviews required under the SWAp agreement; and government personnel’s unfamiliarity with the new procedures. For example, in 2006, the procurement process for injectable contraceptives lasted longer than the months of supply available, leading to an emergency donation of 960,000 units of Depo-Provera from USAID. The government of Malawi since tendered for injectables in 2007; at the time of this study, the first stocks were scheduled to arrive in Malawi in December 2007. The delays associated with the procurement have resulted in extremely low stocks of injectable contraceptives. Some parts of the country are already reporting stockouts. This situation highlights a larger issue related to financing and cash flow; the government uses current year funds to procure current year drugs, resulting in an inability to establish buffer stock. In other words, the government has no means to create a supply pipeline.

Malawi is decentralizing its governance, with funding now being allocated to 27 districts. The government earmarks funding to ensure that districts allocate resources to health, but the districts determine how to spend those resources. This report describes the potential consequences of decentralizing health funding to the district level, including the impact of district-level budget control on contraceptive procurement.

The CHAM and BLM make significant contributions to Malawi’s healthcare system and the provision of FP services. As key providers of services under Malawi’s Essential Health Package, both organizations are directed to access drugs through the public system. Though public sector staff feel there is clear guidance as to how this works, representatives of CHAM and BLM did not indicate that they understood the process. Government policies state that these organizations should access drugs through the respective district hospitals in which they have facilities or programs. However, of the two districts the study team visited, health staff members in one district were not aware of this policy. BLM faces an additional burden of being unable to access contraceptives until it complies with U.S. government FP policies that

flow down through the government of Malawi; as mentioned earlier, DFID originally provided injectable contraceptives and support for BLM—the organization now has few alternatives to obtaining contraceptives through the public sector.

### **Study Limitations**

While the study team interviewed approximately 28 stakeholders in Malawi, the site visits lasted only two weeks, which could be considered a limitation. Because of time constraints, the team was only able to visit two districts. The team discussed their district-level findings with several stakeholders at the central level and confirmed that these findings were generally applicable to the other 25 districts. While the team reviewed most of the primary policy documents that pertain to contraceptive financing and procurement, the team did not have access to as many operational policies, such as those governing procedures, guidelines, and regulations.

## Financing of Contraceptives

Adequate and consistent financing for contraceptives and supplies is critical in achieving contraceptive security. In Malawi, funding for contraceptives is particularly vulnerable within the current SWAp finance structure. This situation is further exacerbated by the ongoing devolution of resource allocation decisionmaking to the district level. This section of the report examines the overall funding environment for health, the commitment to and availability of funding for contraceptives, and the operational policies affecting contraceptive procurement.

### Overall Funding for Health

The overall funding environment for health is an important macro-level consideration, as it will directly affect the availability of FP commodities. The government estimates that the current Program of Work (POW) (2004–2010) for the health sector will cost approximately \$763 million to implement over the six years.<sup>1</sup> The centerpiece of the SWAp is the Essential Health Package (EHP), which includes FP services and commodities. The government estimates that the EHP costs \$17 per person to deliver. Currently, the government spends only \$12. According to the National Health Accounts (NHA), of this \$12, the government provides \$7 while households contribute out-of-pocket the remaining \$5.

Within the health budget structure, the government has recognized the importance of sustaining a supply of essential drugs. The POW includes drugs and medical supplies as one of its six pillars, and the government and partners have ringfenced the drug budget at the central and district levels to ensure that the Central Medical Stores (CMS) receives funds directly from the Treasury to procure drugs; a portion of district health budgets are used for the procurement of essential drugs.

Partners and funders of the health sector SWAp include the government of Malawi; DFID; the Norwegian Agency for Development Cooperation (NORAD); the World Bank; the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); KfW; and the United Nations Population Fund (UNFPA). In addition, the United Nations Children's Fund (UNICEF) and GTZ are discrete donors who are signatories to the SWAp Memorandum of Understanding. USAID is considered a non-signatory discrete donor.

As part of this study, the team examined the budget and funding allocation processes as well as cash flow to determine whether any of these factors affect services and the delivery of drugs, particularly contraceptives. The budgeting and financing for health services is two-pronged. A budget is prepared for the Ministry of Health (MOH) at the national level, which includes the central hospitals. The health budget at the district level is part of the overall district budget. The allocation for health is determined at the national level, based on a set of criteria specified in the SWAp. Once the budgets are finalized, the health funding for the district level is earmarked to ensure that districts spend the funds on health services.

Malawi's federal fiscal year is July 1–June 30. The budget process starts in February with the issue of a circular from the Ministry of Finance (MOF) to the MOH and the districts. At the same time, the government and the SWAp donors meet to determine the contribution of all SWAp partners. The budgets come back to the MOF, where they are compiled and submitted to Parliament. Once approved, the cost centers are notified of their final budget and asked to submit monthly cash flow projections. The Treasury then provides the funds on a monthly basis. In our discussions, the study team was informed that this system is working well and has significantly improved the availability of resources throughout the health system.

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<sup>1</sup> Carlson, C., M. Bolvin, A. Chirwa, S. Chirwa, F. Chitalu, G. Hoare, M. Huelsmann, W. Ilunga, K. Maleta, A. Marsden, T. Martineau, C. Minett, A. Mlambala, F. von Massow, H. Njie, and I.Theo Olsen. *Malawi Health SWAp Mid-Term Review: Summary Report (Draft)*, November 2007 revision.

All district health services are supervised and coordinated by the District Health Officer (DHO). Each district is a cost center, with the DHO making the financial decisions. As is the case at the national level, the district budget includes a ringfence for drugs. The districts determine their drug needs and submit orders to CMS. If the drugs are out of stock, the district can then procure on the open market, according to public procurement rules.

CMS is not funded through the MOH's budget but rather directly through the Treasury. Essentially, it borrows money from the Treasury, supplies drugs to the districts, and then pays back the funds to Treasury. This process is followed to ensure that CMS can procure drugs before the districts place orders. Districts only purchase drugs that CMS purchases; donated products are free to the districts, with the exception of a small handling fee.

Though the nominal expenditures on drugs increased from approximately \$13.2 million (2004/2005) to \$16.2 million (2006/2007), the MOH reported that funding for the health sector, particularly essential drugs, is insufficient. Consequently, the inadequate drug supply creates competition among the many needs within the EHP. The concern regarding family planning is that the DHO will place a much higher priority on curative treatment than on prevention. Although this concern is primarily limited to the injectable because USAID donates many of the other contraceptives, the injectable is by far the most popular method and the potential negative impact on the CPR and cost-effectiveness is tremendous. As the government procures more contraceptive methods using basket funds, districts will face challenges in financing these methods as well.

Even if the DHO allocates funds for contraceptives, the financing system will limit the amount that can be procured. The annual budget generally increases 5 percent from the previous year; however, annual inflation is currently about 7 percent, so the amount of supplies that can be procured is actually decreasing. Therefore, injectable use (and ultimately use of other methods) will likely decrease simply because of insufficient supply.

The government has fallen short in meeting its intermediary targets for health spending. For example, within the government's overall budget, the 2005/2006 target percentage for health was 11.5 percent; but the government only allocated 10.7 percent. Furthermore, within the health budget, the amount allocated for drugs was less than requested. However, most stakeholders reported that once the budget amount is committed, the Treasury disburses the full amount—an accomplishment many countries have yet to attain. Moreover, according to the SWAp Mid-Term Review, the "Ministry of Finance is disbursing funds from the health accounts on a regular basis, which has helped the managers in different cost centers gain confidence that funds in their approved budget will actually come to them."<sup>2</sup> The disbursement of funds is typically evenly distributed on a monthly basis to the cost centers throughout the year based on their respective budget commitments. While this process has the benefit of being routine and therefore predictable, some stakeholders reported that the monthly disbursement schedule can limit their ability to make larger procurements.

### **Funding for Contraceptives**

At the policy level, there is strong commitment for family planning. The Joint POW for the Health Sector supports the priorities identified within the EHP and, as such, includes family planning.<sup>3</sup> The MOH also has a National Reproductive Health Strategy.

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<sup>2</sup> Ibid, p. 40.

<sup>3</sup> Ibid.

While family planning is a priority within the SWAp, so are numerous other programs (related to vaccines, malaria, tuberculosis, HIV/AIDS, etc.). As a result, family planning must compete with other programs for limited resources. Some indicators hold the stakeholders accountable to FP improvements, such as the CPR, but this information is only collected every five years. The SWAp Program of Work does include routine indicators, but these are not focused on family planning. For example, there is an indicator to measure stockout rates. While a proxy is included for most of the priority programs, no proxy exists to measure the stockouts of FP commodities. The result is that family planning might be overlooked while stakeholders make critical planning and funding decisions and commit limited resources to improve this indicator for other program commodities.

Additionally, while there is a mechanism to ringfence the budget for drugs, there is no mechanism to further safeguard FP products in particular—again putting support and funding for FP commodities at particular risk in the inevitable event of a funding shortfall. One strategy adopted in other countries to secure funding for family planning is the establishment of a specific line item for FP commodities. However, stakeholders within the MOH and other development partners believe that this strategy is against the philosophy of the SWAp structure and might serve as a precedent for other programs (sexually-transmitted infections, immunization, etc.) to seek similar line items. Instead, stakeholders noted that the increasing advocacy role of program staff can help ensure that some of the limited funds available in the respective budgets are dedicated to FP products. However, the Reproductive Health Unit (RHU) has limited capacity (e.g., time and staff) to develop evidence-based advocacy needed to lobby for increased and sustainable contraceptive security.

Tracking the funding trends for FP commodities could provide valuable information for effective advocacy and monitoring. To date, there does not seem to be a complete picture of who is contributing FP products—either through donations or government support. This information is potentially available through Pipeline,<sup>4</sup> a tool that the RHU and the Department of Health and Technical Support Services (HTSS) can use to track contraceptive shipment information according to source, quantity, and value by year. However, the RHU does not appear to be regularly updating, analyzing, or sharing Pipeline data (the last update was July 2007); and information contained in the program might be unreliable because of capacity issues. Stakeholders also have access to information through the RHInterchange—a web-based information system that provides standardized data on contraceptive shipment quantity and value from participating donor agencies [USAID, UNFPA, and the International Planned Parenthood Federation (IPPF)]. Again, however, stakeholders do not seem to be aware of or using this tool as a resource for supply and funding information. Although the government budget system does not provide a mechanism to track FP products specifically, this data is critical to understanding trends in funding commitments and need.

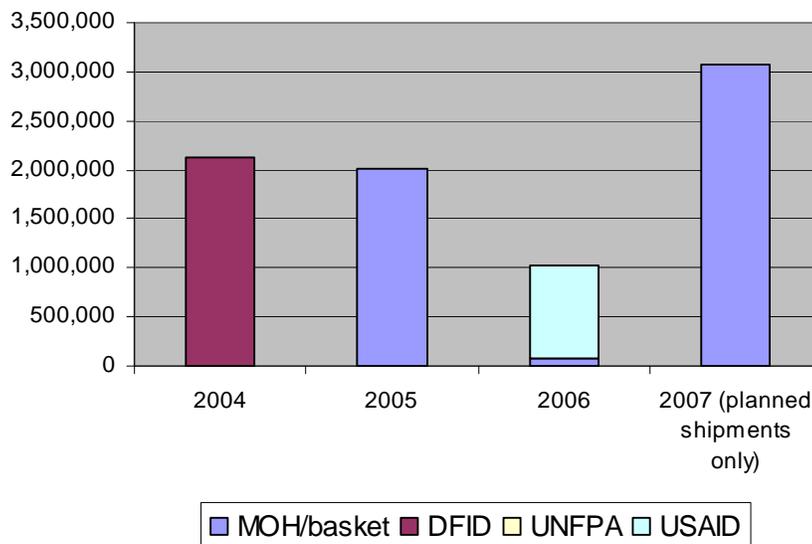
The data available through Pipeline does highlight some funding challenges the MOH has encountered related to specific methods—especially challenges surrounding the transition of donor support to the SWAp. Historically, DFID had directly donated injectables, the most popular method in Malawi, to the public sector. However, when DFID entered the SWAp in 2005, it stopped procuring and donating injectables to the public sector, and no guarantee was given that those funds historically dedicated to injectables would be used for this method within the SWAp. Prior to entering the SWAp in 2005, DFID was the sole provider of injectables (see Figure 1). In 2005, it appears that almost 100 percent of the quantity of injectables previously procured by DFID was procured by the MOH/basket, implying a seamless transition for injectables. However, in 2006, for various reasons, there were insufficient government commitments to injectables, leaving a large gap that donors (USAID) had to fill. While it

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<sup>4</sup> The Pipeline Monitoring and Procurement Planning (Pipeline) system is a software tool that helps program managers gather critical forecasting information, ensure that products arrive on time, maintain consistent stock levels at the program or national level, and prevent stockouts.

appears that this gap was remedied in 2007 (although the 2007–2008 supply of injectables has not yet arrived in country), the issue highlights the uncertainty surrounding these commodities.

**Figure 1: Injectable Contraceptive Supply According to Source, 2004–2007**



Source: Pipeline data (January 2004–December 2007); data updated July 2007)

The example of injectables highlights the MOH’s effectiveness in leveraging donor support outside of the SWAp in emergency situations. In 2006, the ministry turned to USAID to help fill the gap for injectables. As a discrete donor, USAID has been a major source of contraceptives for the public sector, funding and procuring LoFemenal, Ovrette, and Norplant (and Jadelle), IUDs, and condoms. USAID has also stepped in when basket funds have been insufficient. As a result of this collaboration and support from donors, many stakeholders reported that FP commodities are in a somewhat better position than other commodity programs. However, while the MOH has shown success in lobbying partners such as UNFPA and USAID to fill the gaps and “top up” basket funds, this strategy places the ministry in a vulnerable position, as it is at the mercy of donor priorities, which vary from year to year.

DFID’s transition to the SWAp has resulted in an immediate and short-term challenge for BLM’s access to contraceptives. Prior to entering the SWAp, DFID directly supplied FP commodities to BLM. When DFID entered the SWAp arrangement, BLM then expected to access its supply through the MOH. However, while all agree that this was to be the case, reality has proven challenging, as BLM’s access to commodities has been negatively affected by donor policy, particularly the required compliance with U.S. FP policies that flow down through the Malawi government. Until the situation is resolved, BLM is not able to access MOH-funded products from CMS. Additional operational policy barriers that BLM will face when accessing FP products from CMS are discussed in greater detail in the procurement section.

### Financing Recommendations

As described in the findings, many of the issues that affect contraceptive funding relate to overall health financing. The government of Malawi has just completed a mid-term review of SWAp implementation. This review highlighted many of the issues described above and outlined some specific, system-wide financing recommendations for the government to consider. While many issues are beyond the scope of FP stakeholders to address, they are important to understand as they have a direct impact on FP commodity financing and should thus be taken into consideration.

For the purposes of this assessment, the following recommendations relate specifically to addressing operational barriers to the financing of contraceptives:

- When modifying the SWAp/Program of Work indicators, include an FP method as a proxy for the family planning program. It is suggested that the commodity be injectables as this is the most popular method in the country, and it is also the one that might be most vulnerable as the government begins using basket funds to procure the needed amount.
- Monitor funding trends for contraceptives. FP stakeholders such as the Reproductive Health Unit should collect, monitor, and analyze FP commodity quantities and value by source of supply. This information will help stakeholders understand the trends in funding, gauge the levels of commitment, identify potential funding gaps, and advocate for government funding to be committed to contraceptive procurement.
  - FP stakeholders, such as the RHU, should routinely update and share Pipeline data with other key stakeholders (CMS, HTSS, etc.) and designate this activity as a routine reporting requirement for their coordination meetings.
  - In addition and for the long term, the RHU could adopt and expand the information available through the RHInterchange. Currently, the RHInterchange provides timely information on the value and quantity of donated contraceptives from UNFPA, USAID, and the IPPF (see Table 2). Stakeholders could, with RHInterchange management support, add the procurement information for contraceptives funded through the basket to create a more complete picture and better understanding of the total funding and contraceptives available.

**Table 2: USAID Donated Contraceptives (January 1–December 31, 2007)**

<b>Method</b>	<b>Quantity</b>	<b>Value (US\$)</b>
Condoms—males (pieces)	31,629,000	\$1,469,181
IUDs (pieces)	9,800	\$17,538
Implants (pieces)	4,350	\$109,545
Orals—combined (cycles)	1,126,800	\$279,328
Orals—Progestin only (cycles)	196,800	\$62,168

## Procurement of Contraceptives

The Public Procurement Act, established in 2003, identifies the important principles—transparency, accountability, and competition—for the procurement of goods, works, and services in Malawi. The act outlines key procurement procedures, such as requesting quotations and tendering; establishes the Office of Director of Public Procurement as a monitoring and oversight body, and promotes the development of a professional procurement workforce.

CMS, established under the government of Malawi Finance and Audit Act of 1968 as a commercially oriented treasury fund, is the government agency responsible for the procurement, storage, and distribution of medical supplies to the public sector. By charter, CMS is responsible for procuring public sector reproductive health supplies and contraceptives. CMS' procurement of contraceptives is limited as donors currently supply the majority of methods available. However, in 2007, CMS procured condoms using financing from the Global Fund and released a tender and awarded a contract for injectable contraceptives to be delivered beginning in 2008.

The Malawi POW for the Essential Health Package identifies six “Pillars,” broad operational areas of focus that require additional resources to strengthen local capacity (see Annex D: Program of Work Pillars). These pillars provide a common framework by which to periodically assess the overall progress in achieving the POW.

One pillar, “Pharmaceuticals and Medical Supplies,” focuses on the forecasting, planning, procurement, supply, and distribution of essential medicines and other health supplies—thus reflecting the importance of an effective and efficient procurement and supply system in improving access to these supplies. This section of the report reviews the procurement process, principally as conducted by CMS, to identify challenges, problems, and barriers that affect the successful provision of health commodities, particularly contraceptives, and the fulfillment of program needs.

### Procurement Challenges

In preparing for the assessment, the team first conducted a desk review of several key documents, including the mid-term reviews of the Malawi Health SWAp. These reports identified several challenges facing the public sector procurement of essential medicines and supplies—the most persistent being the stockouts of essential medicines. The report on the Joint Mid-Year Review of the Health Sector, 2005–2006, noted: “The shortage of drugs in health facilities was highlighted as the top concern and is acting as a “brake” on the performance of the sector. The mid-year review report indicated that key basic drugs are out-of-stock over 50 percent of the time.”<sup>5</sup>

The Malawi Health SWAp Mid-Term Review, 2006–2007, noted: “Pillar 2 ‘Pharmaceuticals’ was the only key element in the Program of Work for which health service staff suggested that the ‘SWAp hadn’t started yet.’ Unlike improvements in other pillars, there has been little progress in ensuring that a stable and reliable medicine supply is available through the public health service in Malawi.”<sup>6</sup>

The team met in-country with several government agencies (e.g., CMS, the RHU, and the MOF) and international stakeholders to identify barriers, bottlenecks, and challenges to procuring essential medicines and contraceptives (see Annex C: Stakeholders Interviewed). The findings below are

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<sup>5</sup> Government of the Republic of Malawi. *Report for the Joint Mid-Year Review of the Health Sector, 2005–2006*, p. 2.

<sup>6</sup> Government of the Republic of Malawi *Draft Health SWAp Mid-Term Review*, released September 2007, revised November 2007, p. 12.

categorized as follows: quantification and forecasting, procurement processes, product quality, CMS capacity, procurement roles, and monitoring.

### **Quantification and forecasting**

The ability to accurately quantify and forecast health commodity requirements is a critical component in establishing an effective procurement and supply system that can reliably fulfill program needs. The capacity of Malawi's public sector to quantify consumption and forecast demand is limited at this time and is a significant cause of the regular stockouts of essential medicines and some contraceptives.

The health facility is to forecast its need based on stock on-hand and consumption data, and the resulting requirements are to be forwarded to the district level for aggregation and then forwarded to the regional medical stores. Unfortunately, there is no consistent, systematic measure of consumption at the health facility or district hospital levels. Problems include inaccurate stock card records; incomplete donation records; inaccurate consumption data due to stockouts; and inaccurate data on the consumption of organizations such as CHAM, which draw supplies from the district.

As a result of these problems, it is common practice to determine forecasts by simply increasing consumption levels from the previous year by a fixed percentage. In the health facility visited in Dowa District, the local facility staff confirmed that they forecast next year's consumption by increasing the current year consumption by a small percentage. Given the questionable accuracy of consumption data on which the forecast is based, as discussed above, this practice creates a high probability for product stockouts and subsequent emergency procurements.

However, some progress is being made in improving quantification practices in Malawi. The USAID | DELIVER Project has introduced Supply Chain Manager software for tracking contraceptives and essential drugs, and as district personnel learn its application, the potential exists to establish a more robust product quantification process nationwide.

### **Procurement processes**

The Public Procurement Act of 2003 comprises the legal framework governing public sector procurement in Malawi and the Desk Instructions for Public Procurement of 2005 detail the implementation of the procurement process. CMS follows the government procurement process for all government-funded goods.

For SWAp-funded goods, the SWAp Memorandum of Understanding Article 4 allows CMS to use the government procurement process for contracts valued up to US\$100,000. For procurements valued more than this amount, CMS must initiate an international competitive bidding process in accordance with the World Bank procurement requirements, as identified in the Guide for Procurement under IBRD Loans and IDA Credits of May 2004. In exercising its fiduciary oversight responsibility, the World Bank reviews the procurement process at several key stages. If the procurement is in compliance with the requirements, the World Bank issues a "no objection" declaration, authorizing the procurement to proceed to the next stage of the process. If the procurement does not comply with the requirements, the procuring entity must adjust the current process to become compliant.

World Bank procurement requirements, although sound and complete, are also exhaustive; and procurement personnel implementing these requirements for the first time can face a considerable learning curve, which can initially lead to an extended procurement process. The process can take from 9–12 months (or longer) from the time of quantification to the delivery of goods to the regional medical stores. This situation occurred at CMS when procurement personnel conducted their first tender in accordance with the World Bank's requirements; however, it is anticipated that future SWAp-funded tender processes implemented by CMS will be more efficient and timely.

In reviewing CMS' recent tender process, it was noted that a single tender was issued for a large number of products with diverse requirements. Combining a large number of products into one tender can save some time by reducing the number of tenders that need to be processed; however, this practice is often more complex to manage and requires additional time. Also, if a bidder protests a contract award under the tender, there could be a delay in releasing the other contracts under the tender; CMS noted that this situation had recently occurred—the local bidder took the Office of the Director of Public Procurement to court, creating a four-month delay and holding up the entire tender from further release. To prevent this problem in the future, CMS should consider issuing tenders with fewer items, grouped according to common product and/or drug classifications.

Prior to the most recent tender, CMS had been issuing one-year contracts to suppliers. Under the recent tender, CMS had planned to issue a two-year contract; however, limited funding prohibited this change in timeframe. The SWAp Mid-Term Review report of 2007 recommends that a two-year, framework contract be awarded, with an option for an additional year (see Annex E: Framework Contract). A multi-year framework contract will mean a reduction (by several months) in the lead time for product delivery in years two and three, as the time required to conduct subsequent tenders in those years has been eliminated.

Within CMS, for bids valued under MK10,000,000, the Internal Procurement Committee evaluates and awards the contracts. For bid values above this amount, the Medical Buying Board evaluates and awards the contracts. A CMS representative sits on both evaluation committees; this representation can be perceived as a potential conflict-of-interest as the agency that conducted the tender process (CMS) is in a position to influence which supplier is awarded the contract. Consideration should be given to removing the CMS representatives as members of the Internal Procurement Committee and Medical Buying Board. Alternatively, the representatives could be considered technical resources for the committee or non-voting members.

### **Product quality**

The Pharmacy, Medicines and Poisons Act of 1988 established the Pharmacy, Medicines and Poisons Board. Its primary responsibilities are to license suppliers of medicines, register and test pharmaceutical products, train pharmacy personnel, and regulate the pharmaceutical profession in Malawi. The National Drug Quality Control Laboratory (NDCQL) supports the registration of healthcare products and conducts the quality control tests for medicines and contraceptives intended for the public health sector.

The team met with an NDQCL representative who explained the testing requirements for registering new products. For CMS medicines, the laboratory conducts quality control testing on about 60–70 percent of the medicines, with the other 30–40 percent subject to physical inspection. Donated medicines and products, such as emergency contraception and the female condom, are not required to be registered at this time; however, the new drug donation guidelines have been drafted and are currently being reviewed and approved. The representative also clarified that the Pharmacy, Medicines and Poisons Act is being amended to add requirements for the registration of medical devices (condoms and IUDs).

In discussing condom testing requirements, the representative mentioned that all batches of new condoms could be subject to testing and that the Global Fund was providing financing to procure testing equipment for male and female condoms and latex gloves. The team shared that given the testing USAID-donated condoms undergo, there is no value-added in retesting these lots in-country. The team also mentioned that condom testing equipment has created problems in other countries—typically when either the operator fails to use the equipment properly or the equipment goes out of calibration, leading to inaccurate test reports. The problems occur more often in countries where the operator does not need to conduct tests frequently enough to build or maintain the necessary skill level.

## **CMS capacity**

To fully comply with the World Bank's procurement requirements, skilled staff must be trained on the principles of good procurement practices and procedures. Recognizing the need to strengthen the capacity of CMS to meet the overall procurement needs under the SWAp, in April 2006, the government of Malawi contracted Glocoms, Inc., a U.S.-based management consulting firm, to assist CMS' with improving the implementation of its procurement, distribution, and management core activities and to develop a strategic plan to transition CMS to a trust.

Thus far, the capacity-building effort at CMS has been significantly hampered by delays in hiring counterpart staff to work with the Glocoms management staff and by turnovers of both counterpart and Glocoms staff. Plans are underway to secure seven counterparts to conduct and manage CMS procurement. Until the staff capacity, clear operating procedures, and sound management systems are in place, the procurement of essential medicines and contraceptives will continue to be at risk. The need for additional emergency procurements through donors seems likely. Glocoms has developed a CMS Reforms Proposal Plan to address the capacity needs.

Glocoms is also managing the transition of CMS to a semi-autonomous public trust, governed by the Trustee law of Malawi. Consultants from DFID had recommended to the MOH that CMS become a trust. Glocoms is currently developing a transition plan. One anticipated key feature of the trust will be the ability to hire and maintain competent staff.

Hiring delays and staff turnover have caused concern that the human resources at CMS are insufficient to build capacity and make the necessary system improvements. Before the transition to a trust occurs, sound CMS operational systems from procurement to product distribution and warehouse management should be in place. Performance indicators should be established to monitor progress in these areas. Also, given the ability of CMS to generate revenue from the fee it charges for procurement (approximately 7 percent, with an additional 5 percent fee for handling costs), it is important that transparent financial management systems to track this revenue be in place prior to the transition.

In any transition process, there are bound to be unexpected problems and delays. In the case of CMS, these delays will most likely affect the procurement process and subsequent delivery of goods. Therefore, both CMS and SWAp partners should consider establishing a buffer stock of critical medicines and contraceptives.

## **Monitoring**

Stakeholders reported that the SWAp's Technical Working Group in charge of monitoring CMS activities has not been meeting regularly, resulting in limited oversight and guidance as CMS strives to implement its improvement plan.

## **Procurement roles**

According to the SWAp Mid-Term Review report and interview data, there is an apparent overlap in procurement responsibilities between the MOH headquarters' procurement unit and CMS. Both the MOH and CMS procure health sector goods and both have procured drugs and equipment at some point in time. The overlap in roles gives rise to ad hoc decisionmaking about who should procure what goods, which can lead to inefficiency and waste. The MOH should develop guidelines that clearly identify which institution is responsible for general goods, medical equipment, and health sector goods. The guidelines would not only increase efficiency but also help to determine funding requirements for each institution.

## Procurement Recommendations

- Continue to work with the USAID | DELIVER Project to strengthen the quantification and forecasting process.
- Issue two-year, framework contracts, with an option for a third year.
  - Prior to transitioning CMS to a trust:
    - Establish operational performance indicators
    - Strengthen financial management systems
    - Fill the human resource gaps in procurement and strengthen procurement capacity
    - Build a buffer stock to account for delays that could arise during the transition
    - Introduce quality parameters/a client-driven approach
  - Issue tenders with a smaller number of items based on product/drug classification
- Remove the CMS representatives as voting members of the Internal Procurement Committee, and Medical Buying Board given the potential conflict-of-interest this membership creates.
- Develop guidelines that clearly delineate procurement responsibilities between the CMS and MOH headquarters' procurement unit.
- Hold regularly scheduled meetings of the Technical Working Group that provides SWAp oversight to CMS activities.

## **Financing and Procurement of Contraceptives at the District Level**

In 1998, Malawi began to decentralize government functions to empower the country's 27 districts and alleviate pressures on the central government to coordinate and deliver services at the community level. With approximately 85 percent of Malawi's population residing in rural areas, government structures at the district level can be more efficient in targeting remote populations and tailoring government services to specific needs of the local population.

The chief executive for the health sector in each district is the DHO, typically a medical professional who is located in the district hospital. The officer coordinates with the Local Financing Committee to manage the budget for all district health services. The DHO also coordinates the procurement of all drugs and health commodities for the district, including contraceptives, from CMS. A district's budget for health services and supplies and the procurement of those supplies covers the needs of not only the district hospital but also the health facilities within the district.

According to the stakeholder interviews, Malawi's districts play a large role in delivering health services to the end health consumer. The study team visited district hospitals to discuss the barriers to financing and procuring contraceptives. Note that because of time and logistical constraints, the team was only able to visit two districts: Mchinji and Dowa, approximately 110 and 60 kilometers from the capital, respectively. These findings should be interpreted within that context. The team's objectives in visiting Mchinji and Dowa were the following:

- Assess the financing structures and timing
- Evaluate the procurement capacity
- Identify the operational policy barriers

### **Health Sector Successes at the District Level**

As a result of decentralization, the Malawi Treasury directly passes funds through the Local Financing Committee to sector-specific entities at the district level. Giving district government structures this budgetary control is a major shift in policy and practice. The study team therefore expected to identify challenges regarding management of the funds, as this function is relatively new at the district level. In fact, although DHOs in both Mchinji and Dowa noted that overall resources for health services are inadequate to meet the demand for services, they reported no significant issues with funding and financing. The annual financing, promised by the MOH once Parliament has approved the budgets, arrives predictably each month.

The DHO in Dowa specifically noted that districts are better off now under a decentralized environment than they were under a centralized environment. Districts now have more autonomy and are better able to customize services according to the needs and circumstances of the local population. Health facilities and local organizations in other sectors can also provide community-level input into planning and budget allocations. The consensus among the two districts was that the more localized the budget control, the more effective government can be in delivering essential public services.

### **Challenges to Financing and Procurement of Contraceptives at the District Level**

Despite general improvements in district-level financing under decentralization, it was clear from the district visits that financing and procurement of commodities—and particularly contraceptives—remain a challenge. As mentioned previously, the DHO controls the financing for all health services in the district. Financing specifically for drugs is ringfenced and must be spent solely on drugs for the district. Financing

for contraceptives, however, is not as explicitly protected. As overall funding levels for drugs and other health services are not adequate to meet the needs of the local population, decisions regarding funding allocations and which commodities to purchase rest entirely with the DHO—and there are no policies that guide DHOs’ decisionmaking for drug procurement. While data from Pipeline indicates that the government of Malawi purchased injectable contraceptives in 2005, 2007–2008 is the first fiscal year that districts will need to directly purchase injectable contraceptives from CMS. The primary concern is that—faced with stockouts of other essential drugs and commodities—DHOs might decide not to purchase injectable (or other) contraceptives.

### **Tradeoffs**

The possibility that districts might have to trade purchasing contraceptives with purchasing essential curative drugs such as magnesium sulfate has significant implications for the health sector. Although contraceptives are part of the Essential Health Package promised to all Malawians, district-level government structures might not be able to procure these supplies because of weaknesses in commodity procurement in general. Both the general financial shortfall for required drug resources and capacity issues related to procurement at CMS mean that DHOs are faced with making a sometimes monthly decision between preventive versus curative commodities. The DHOs in Mchinji and Dowa reported having no guidance or policy at the district level to help make these decisions. Procurement tradeoffs are major barriers to contraceptive security at the district level.

### **Uniformity of financing**

Financing for contraceptives is not uniform. Some contraceptives are still donated and as such are not included in SWAp funding for other drugs and health services. For example, USAID donates oral contraceptives. As both USAID and UNFPA made emergency procurements of condoms for Malawi in 2007, it is unclear whether districts will be required to purchase condoms. Malawi’s high HIV prevalence rate means that several other donors and vertical programs might provide condoms free to the districts. Districts procure these commodities from CMS but, as described earlier in this report, the MOH and CMS might not charge districts for donated contraceptives, except for a 5 percent handling fee.

Prior to Malawi’s current fiscal year (2007–2008), all contraceptives were donated and districts had ordered contraceptives from CMS for a 5 percent handling fee; in other words, procuring contraceptives at the district level did not significantly affect district health budgets. As of January 2008, when the first shipment is expected to reach CMS, injectable contraceptives will be the first method not donated and therefore purchased by DHOs from CMS using district-level funds.

### **Quantification**

The successful procurement and purchase of injectable contraceptives at the district level might not be a huge concern except for two mitigating factors: (1) injectable contraceptives are the most popular method of contraception in Malawi with a sizeable unmet need; and (2) procurement by CMS relies on the accurate quantification of contraceptive requirements at the health facility level. Anecdotally, the study team learned that health facilities—for lack of better data regarding actual consumption and demand—typically projected requirements for drugs and contraceptives by increasing the previous year’s consumption levels by a few percentage points. De facto, this method of quantification means that inflation or even a slight increase in demand for contraceptives will cause a shortfall in supplies.

It will soon be clear—when districts are required to order injectable contraceptives for the district hospital and health facilities—whether DHOs will actually order from CMS and pay for contraceptives out of an already tight budget.

### **Alternative procurement in the private sector**

If CMS is out-of-stock of a particular drug or contraceptive, it can grant permission to a district to purchase that commodity from a local commercial source. In theory, districts faced with procuring commodities from another source other than CMS must follow the appropriate procurement laws and regulations. Typically, procurements at the district level will amount to less than US\$100,000, which allows districts to follow national procurement procedures rather than World Bank procurement procedures. The government procedures stipulate that procurement entities (DHOs, in the case of contraceptives) must obtain three quotes for the commodity to be purchased. The challenges facing districts in successfully procuring out-of-stock commodities are numerous:

- Human capacity in the health sector at the district level is already challenged by limited resources and competing health issues such as maternal mortality and HIV.
- Private sector sources for drugs and contraceptives are minimal.
- Even existing private sector sources do not have a consistent supply of commodities because of the unpredictable nature of local demand.

Neither district that the study team visited had a pharmacy or drug shop. The study team in Mchinji visited a private clinic and found that it only sold oral contraceptives. The oral contraceptives that it did have were apparently prescribed primarily for hormone regulation and not explicitly for family planning. The team that visited Dowa discovered that the nearest pharmacy for any drug was in Lilongwe. The pharmacist that the team interviewed did not have injectable contraceptives on hand but said that he would order them if there was demand. Without a predictable market and demand for contraceptives, however, it is unreasonable to expect the private sector to stock products that—in principle—are provided free in the public sector. Public sector provision of free contraceptives has completely crowded out the private sector.

Even if a local commercial supply of contraceptives was accessible to a district, stockouts at CMS for contraceptives can simultaneously affect multiple districts and result in them searching for contraceptives in the private sector at the same time. Even if there were more pharmacies in Malawi, it would be difficult for the private sector to respond to the erratic demand not met by the public sector and have on-hand supplies for those that could afford them.

### **Managing changes in the finance environment**

Finally, districts face a huge challenge in managing and interpreting continual change in the health financing environment. This study revealed that when CMS experiences stockouts, the situation typically triggers an emergency procurement—e.g., by UNFPA for condoms in early 2007. If a product is procured through an emergency process, and a donor donates those products, CMS must provide the product at no cost to the district except for a 5 percent handling fee. For these products, a DHO would order a quantity from CMS and simply pay the 5 percent handling fee from the district's budget. However, if CMS procures that particular product several months later (as in the example of condoms, which CMS also procures using Global Fund funds from the SWAp), that product is no longer available for only a 5 percent handling fee and districts must cover the costs of the product plus a 12 percent handling fee.

The study team learned from CMS and others that specific codes exist for donated drugs and commodities versus non-donated drugs. Presumably districts understand from these codes the donation status and cost implications of each product. Nevertheless, even with this information, districts might have a difficult time controlling and managing their budgets if they cannot predict when a required commodity will be donated and when it will have to be purchased, using the already stretched district budget.

## **District-Level Recommendations**

- Track the effects of new costs for FP commodities so the districts can see if the costs will negatively affect their decisions to order these products using their budgets. A specific analysis could focus on the order rate for injectables over the past three months (when the method was free to districts) and for February–April 2008 (when districts will have to use their own budgets to buy injectables). Considerations should include the availability of injectables, as this factor could affect the order rate.

## **Annex A: Study Team Members**

### **USAID | Health Policy Initiative, Task Order I**

- Joan Robertson
- Margot Fahnestock
- Alex Mkandawire Consultant

### **USAID | DELIVER Project and subcontractor, PATH**

- Jayne Waweru, DELIVER
- Leslie Patykewich, DELIVER
- Todd Dickens, PATH

## **Annex B. Documents Reviewed**

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World Bank Health, Nutrition, and Population Group/Poverty Thematic Group. May 2000. *Socio-Economic Differences in Health, Nutrition, and Population in Malawi*.

## Annex C. Stakeholders Interviewed

Organization	Contact
Deputy Minister, Education, Science and Technology	Richard Musoya
BLM	George Macheke, Director of Operations
CHAM	Desiree Mhango, Acting Director
Clinton Foundation	Veronica Chipeta
DFID	Matt Gordon, Social Sector Governance Advisor
Malawi Revenue Authority	Mr. Msalanyama
Management Sciences for Health	Mexon Nyirongo Deliwe Malema
MOF	Mr. Manda Mr. Kantayeni
MOH/CMS	Ivy Zingano, Director Charles Abondo, Senior Manager (Glocoms, Inc.)
MOH/Finance Unit	Gerald Adamson Kachepa, Director Saidi Kaluwa, Senior Financial Management Specialist (LATH) Nick Hall
MOH/HTSS	Mr. Francis Chafulumira
MOH/Planning Unit	Edward Katayika, Deputy Director
MOH/Procurement Unit	Mexon Kasembara, MOH Procurement Officer Victor Tembo, Senior Procurement Specialist (LATH)
MOH/RHU	Dr. Chisale Mhango, Director Fannie Kachale, Deputy Director Family Planning Coordinator Condom Program Coordinator MNH Director
MOH/SWAp Secretariat	Dr. Ann Phoya, Director
National Drug Quality Control Lab Pharmacy Medicines & Poisons Board	Steven Chapima, Senior Drug Analyst
NORAD	Abel Kawonga
O&M Associates	Alex Mkandawire, Executive Director
Office of Director of Public Procurement	Mr. Mhango, Deputy Director Mr. Arnold Chirwa

Organization	Contact
Pharmacy Medicines and Poisons Board	Aaron Sosola, Deputy Registrar and Head of Technical Services
Population Services International	Jones Katangwe, Deputy Director Jephta Mtema, Director of Finance Alfred Zulu, Administration/Human Resources Fred Mwasangari, Logistics
UNFPA	Dorothy Lazaro, National Programme Officer
UNICEF	Caesar Mudondo, Procurement Officer
USAID	Lilly Banda-Maliro, Reproductive Health Specialist
USAID   DELIVER Project	Jayne Waweru, Resident Advisor
World Bank	Simon Chirwa, Program Officer Alfred Chirwa, HPN Officer
District: Dowa	<i>District Hospital</i> Ms. Kamfose, Acting DHO <i>Chankhunga Health Center,</i> Medical Assistant and Nurse
District: Mchinji	Dr. Fosko, District Health Officer

## **Annex D. Malawi Sector-Wide Approach Program: Components of the Essential Health Package and the Program of Work Pillars**

<b>Components of the Essential Health Package</b>	<b>Pillars</b>
Vaccine Preventable Diseases	Human Resources Development
Acute Respiratory Tract Infections	Pharmaceuticals and Medical Supplies
Diarrhea, including Cholera	Essential/Basic Health Equipment
Adverse Maternal and Newborn Outcomes, including Family Planning	Infrastructure Development
Malaria	Routine Operations at Service Delivery Level
Tuberculosis	Central Operations, including Policy and Systems Development
HIV/AIDS/STI	
Schistosomiasis	
Malnutrition, including Micronutrients	
Eye, Ear, and Skin Infections	
Common Injuries, Accidents, and Trauma	

## **Annex E. Benefits of a Framework Contract**

A framework contract establishes the terms and conditions under which subsequent contracts will be placed. There are different variations of framework contracts. In many framework contracts, there is no defined commitment for the purchaser, while the supplier commits to supply goods under the defined terms and conditions of the contract.

Some benefits of a framework contract include the following:

- Reduced administration—only one bidding exercise needs to be conducted.
- Competitive pricing—the initial bidding process generates price competition.
- Assurance of product quality—the quality assurance requirements for the product are included in the contract.
- Delivery of goods—the supplier will generally hold goods for the agreed range, which means delivery times are usually reduced and the requirement of the purchaser to hold excess stock is eliminated.
- Supplier stock control—the supplier is better able to plan stock levels, thereby reducing costs, which can often translate to lower prices to the purchaser.
- Improved relationship—a long-term relationship is established between the purchaser and supplier, which can improve the supplier's willingness to be flexible and cooperative in addressing a purchaser's needs.

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