

# USAID MEDICINES, TECHNOLOGIES, AND PHARMACEUTICAL SERVICES (MTaPS) PROGRAM

*Improved Access. Improved Services. Better Health Outcomes.*

## A GUIDE TO BEST PRACTICES IN SUBNATIONAL PROCUREMENT OF MNCH COMMODITIES IN THE PUBLIC SECTOR



PHOTO CREDIT: SAMY RAKOTONJAINA



**USAID**  
FROM THE AMERICAN PEOPLE





## I. INTRODUCTION

Providing quality maternal, newborn, and child health (MNCH) services requires a range of essential medicines and supplies at the point of care, including such lifesaving medicines as oxytocin, misoprostol, and amoxicillin. Making quality MNCH products available and affordable is typically the responsibility of national government procurement and supply agencies based on national laws and regulations rather than of donors and donor procurement mechanisms. However, in many countries, these public supply systems' poor performance produces frequent stock outs at health facilities, who then turn to local private suppliers to fill the gap. In Nigeria, for example, an investigation found that public sector health facilities frequently purchased reproductive health and MNCH commodities from the private sector due to the public sector's unreliable procurement and supply system and the private sector's better prices and delivery services.<sup>1</sup>

In response to political reform or problems with centrally controlled health product supply, including poor availability and unresponsive service, many low- and middle-income countries have decentralized the procurement of health commodities to a province, county, district, or even facility level, termed subnational procurement. Besides poor central-level performance and decentralization as a policy, another context for subnational procurement is the use of performance-based financing (PBF), where lower levels receive financial incentives for achievements, including availability of tracer essential medicines, and which can then be used to purchase locally to reduce stock outs if needed.

---

<sup>1</sup> Lyudmila Nepomnyashchiy and Prashant Yadav. 2022. Decentralized Purchasing of Essential Medicines and Its Impact on Availability, Prices, and Quality: A Review of Current Evidence. CGD Working Paper 605. Washington, DC: Center for Global Development. <https://www.cgdev.org/publication/decentralized-purchasing-essential-medicines-and-its-impact-availability-prices-and>.

## Decentralized procurement linked to PBF

In some countries, efforts to decentralize procurement responsibilities have been bolstered with PBF programs. In these programs, decision-making is shifted to lower levels of the health system and paired with incentives to improve service quality including the availability of essential medicines and supplies—especially those unsupported by donor-based vertical programs. In their 2014 PBF Toolkit,<sup>2</sup> the World Bank described the potential of PBF schemes to support subnational procurement and argued that facilities' high percentage of medicine-associated costs meant that understanding their drug procurement and supply options was essential in designing successful PBF schemes. With budgets integrated across all funding sources; the requisite skills and systems in place; and a way to provide easy access to well-regulated, qualified suppliers and competitive prices, health facilities can use PBF systems to facilitate decentralized drug procurement.

Evidence of PBF's impact has been mixed,<sup>3</sup> perhaps because of its design or country context, however some studies have found that PBF incentives have increased health commodity stock.<sup>4</sup> For example, a PBF program piloted in Tanzania in 2011 that provided financial incentives for meeting service targets significantly increased the availability of 37 essential reproductive and MNCH medicines.<sup>5</sup> Similarly, in 2019, health workers in Cameroon<sup>6</sup> perceived improvement in medicine availability due to a PBF scheme that based 20% of the evaluation on MNCH medicines. Pharmacy autonomy, accountable pharmacy staff, and strong local regulation to ensure quality<sup>7</sup> were highlighted as key components of the perceived success; equally important was allowing facilities to buy from the private sector for the first time. In areas without these features, progress stalled and inequities between facilities worsened. Of particular concern was the perception that the regional authorities responsible for supplier accreditation and product quality did not have the expertise or technical resources to carry out these responsibilities; in addition, smaller facilities generating insufficient PBF funds were unable to access the better pricing that larger facilities achieved by buying bigger quantities, so they faced cost increases, dwindling funds, and worsening stock outs.

Through case studies and other examples, this guide outlines best practices and approaches for subnational procurement entities to purchase quality-assured, low-cost MNCH medicines and supplies and to respond to the following challenges.

<sup>2</sup> György Béla Fritsche, Robert Soeters, Bruno Meessen, with Cedric Ndizeye, Caryn Bredenkamp, and Godelieve van Heteren. 2014. Performance Based Financing Toolkit. Washington, DC: World Bank.

<sup>3</sup> For example, findings from studies in Afghanistan and Burundi did not find evidence any impact. See: Engineer CY, Dale E, Agarwal A, Agarwal A, Alonge O, Edward A, Gupta S, Schuh HB, Burnham G, Peters DH. Effectiveness of a pay-for-performance intervention to improve maternal and child health services in Afghanistan: a cluster-randomized trial. *Int J Epidemiol*. 2016 Apr;45(2):451-9. doi: 10.1093/ije/dyv362; Bonfrer I, Soeters R, Van de Poel E, Basenya O, Longin G, van de Looij F, van Doorslaer E. Introduction of performance-based financing in Burundi was associated with improvements in care and quality. *Health Aff (Millwood)*. 2014 Dec;33(12):2179-87. doi: 10.1377/hlthaff.2014.0081; and Rudasingwa M, Soeters R, Bossuyt M. The effect of performance-based financial incentives on improving health care provision in Burundi: a controlled cohort study. *Glob J Health Sci*. 2014 Oct 29;7(3):15-29. doi: 10.5539/gjhs.v7n3p15.

<sup>4</sup> Brenner S, Wilhelm D, Lohmann J, Kambala C, Chinkhumba J, Muula AS, De Allegri M. Implementation research to improve quality of maternal and newborn health care, Malawi. *Bull World Health Organ*. 2017 Jul 1;95(7):491-502. doi: 10.2471/BLT.16.178202.

<sup>5</sup> Mayumana et al. 2017: <https://pubmed.ncbi.nlm.nih.gov/28257886>, cited by: Lyudmila Nepomnyashchiy and Prashant Yadav. 2022. "Decentralized Purchasing of Essential Medicines and Its Impact on Availability, Prices, and Quality: A Review of Current Evidence." CGD Working Paper 605. Washington, DC: Center for Global Development. <https://www.cgdev.org/publication/decentralized-purchasing-essential-medicines-and-its-impact-availability-prices-and>

<sup>6</sup> Sieleunou I, Turcotte-Tremblay AM, De Allegri M, Taptué Fotsó JC, Azinyui Yumo H, Magne Tamga D, Ridde V. How does performance-based financing affect the availability of essential medicines in Cameroon? A qualitative study. *Health Policy Plan*. 2019 Dec 1;34(Supplement\_3):iii4-iii19. doi: 10.1093/heapol/czz084.

<sup>7</sup> An unintended consequence, however, was some health staff developing a parallel drug management system that reported only on PBF medicines that would improve their performance indicators for personal gains (Sieleunou I, et al, *Health Policy Plan*. 2019).

## 2. PROBLEMS WITH DECENTRALIZED HEALTH COMMODITY PROCUREMENT

Decentralizing procurement to a subnational level can bring greater flexibility to decision-making and allow local governments to respond better to their people's needs; however, if the procurement process does not integrate good procurement principles, including alignment with the World Health Organization's (WHO) model quality assurance system<sup>8</sup> that covers product and supplier prequalification, purchasing, storage, and distribution, it can lead to poor prices, services, and product quality.<sup>9,10</sup> These outcomes often result from local procurement services operating without appropriate standard operating procedures or guidelines, adequate understanding and management of conflicts of interest, or government or public oversight. Additionally, often lacking are administrative and professional capacity and resources that local authorities need to prequalify suppliers and to monitor, inspect, test, and report on product and service quality. For example, decentralized procurement's disaggregated order volumes tend to shift market power to suppliers and put public health buyers at a disadvantage, which can lead to higher prices that deplete restricted health budgets. Furthermore, buying from smaller, local suppliers with limited financial, inventory, and management capacity can compromise product and service quality. The risk of corruption is also higher due to a lack of transparency in contracting suppliers at the local level, especially because procedures, standards, and oversight are more limited. Procurement reform, however, should consider that once these powers are decentralized, local governments are extremely reluctant to lose them. Such reform must therefore find a way to counterbalance the shift in market power without surrendering local government autonomy.

An important review<sup>11</sup> of health facility-led procurement concluded that although rigorous evidence was sparse, decentralizing purchasing to facilities improved the availability of quality-assured medicines aligned with standard treatment guidelines and stimulated the expansion of distribution to rural areas. Nonetheless, these positive outcomes depended critically on health facility staff with the skills and systems to manage inventory and purchasing, a competitive pharmaceutical wholesaler-distributor market, and governments that could effectively oversee and manage supplier performance and procurement responsibilities. A recent review<sup>12</sup> of pooled procurement programs identified similar dependencies, with technical and financial capacity as well as compatible laws and regulation being crucial preconditions for success.



<sup>8</sup> WHO. 2014. A model quality assurance system for procurement agencies. Geneva: World Health Organization.

<https://www.who.int/publications/m/item/who-model-quality-assurance-system-for-procurement-agencies---trs-986---annex-3>.

<sup>9</sup> In addition, the WHO model refers to general requirements for procurement agencies, including physical resources, financial systems, and documented policies and standards such as a quality manual and standard operating procedures.

<sup>10</sup> While outside the scope of this paper, it should be noted that the quality of MNCH medicines depends critically on adherence to established standards for storage and distribution, especially those that require cold chain handling such as oxytocin.

<sup>11</sup> Nepomnyashchiy and Yadav, 2022.

<sup>12</sup> Parmaksiz K, Pisani E, Bal R, Kok MO. A systematic review of pooled procurement of medicines and vaccines: identifying elements of success. *Global Health*. 2022 Jun 11;18(1):59. doi: 10.1186/s12992-022-00847-z.

## Example of subnational procurement problems in Nepal

Without adherence to good procurement practices, a range of problems can occur related to price, quality, and service. A 2022 study of subnational procurement of MNCH medicines in Nepal, for example, found widespread use of direct purchasing and weak procurement methods that resulted in a wide range of prices, with lower levels of the health system generally paying substantially higher prices.<sup>13</sup>

For example, price range per unit:

- Oxytocin inj/10IU amp: NPR 9–43 (USD 0.07-0.33)
- Misoprostol tabs 200mg: NPR 3.75–47.5 (USD 0.03-0.36)
- Magnesium sulfate 500mg/ml (50%) inj/10ml amp: NPR 15–58 (USD 0.11-0.44)

Duplication and poor coordination between different government levels further contributed to an inefficient use of resources because some medicines were purchased by multiple procurement units while some medicines were not purchased at all.

Product and service quality were compromised because suppliers were not being prequalified or monitored. Local governments had only a superficial understanding of quality issues and no access to laboratory testing, which produced additional risks. Additionally, procurement teams did not prioritize the importance of documents that suppliers submitted, such as not verifying registration certificates with the regulatory authority.

Furthermore, the procurement process lacked transparency because local governments did not follow standardized procedures or guidelines. Where guidelines and procedures existed, they were not designed to procure pharmaceuticals. Neither the federal government nor civil society monitored subnational procurement and audit reports were not published. Finally, the existing code of conduct regarding conflicts of interest was not strictly applied, which created opportunities for collusion and other corrupt practices.

---

<sup>13</sup> MTaPS. Subnational Procurement Practices of Maternal, Newborn, and Child Health Medicines in Nepal. July 2022. Arlington, VA: Management Sciences for Health.

### 3. GOOD PROCUREMENT PRACTICE AND SUPPORTING SYSTEMS

Good procurement practice drives desired outcomes in any setting; however, applying it in a decentralized system should not sacrifice the advantages of decentralization or compromise local government autonomy.<sup>14</sup> The following are core objectives of good procurement practice that should be an integral part of both central and subnational procurement.

**Value for money and optimized use of available resources.** Central to maximizing resource use and achieving value for money is determining demand for generic products across as many health facilities as possible. This requires a system for capturing and reporting demand and aggregating it at the highest level possible—ideally, the national level—thereby centralizing contracting and price setting without disrupting local budget and purchasing management. Strong financial management is required at all levels to better track budgets and prioritize procurements.

A 2019 study by the Center for Global Development<sup>15</sup> found that aggregating demand and awarding contracts to larger suppliers could lead to savings as large as 50% to 75% compared to decentralized procurement. This ensued from the enforcement of a generics policy as well as price discounts and enhanced bargaining power arising from larger quantities. In the Philippines, for instance, the study found that the cost per standard unit for nine common medicines was USD 0.11 in the centralized public channel, but USD 0.46 in the decentralized channels. These advantages were achievable without over-centralizing budget control or management or undermining the autonomy of local purchasing decisions based on local priorities. Moreover, the study found that savings could be realized without centralizing the procurement of every product because centralizing the procurement of a subgroup of products pressured all prices downward.

Of course, adequate funding for subnational procurement is needed to ensure the viability of aggregated demand contracts (framework agreements or prime vendor). Funding can come through several mechanisms including central funding (e.g., through credit lines to districts/facilities); out-of-pocket contributions from patients (drug revolving funds, user fees, co-payments); or PBF.

**Transparent, impartial, and accountable processes followed with integrity.** The procurement process must generate fair and open competition by establishing explicit criteria to evaluate bids and award contracts that provide reliably available, quality-assured products at a good price. The government must also effectively monitor local procurement to maintain transparency including requiring that lower levels of the health system report to higher levels. Easily accessible information in a decentralized system allows price comparisons among different facilities, which can help identify price manipulation but also lead to more negotiating power with suppliers.<sup>16</sup> In addition, engaging civil society to oversee pharmaceutical procurement and budgeting can complement formal government oversight and increase accountability. For example, in Honduras, a coalition of civil society organizations discovered corruption in public sector pharmaceutical procurement, including

---

<sup>14</sup> See, for example: WHO. Operational Principles for Good Pharmaceutical Procurement, WHO/EDM/PAR/99.5 <https://apps.who.int/iris/handle/10665/66251?show=full> and WHO 2014. A model quality assurance system for procurement agencies. Geneva: World Health Organization. <https://www.who.int/publications/m/item/who-model-quality-assurance-system-for-procurement-agencies---trs-986---annex-3>.

<sup>15</sup> Pierre Dubois, Yassine Lefouili, and Stéphane Straub. Pooled Procurement of Drugs in Low and Middle Income Countries. CGD Working Paper 508., 2019 <https://www.cgdev.org/publication/pooled-procurement-drugs-low-and-middle-income-countries>.

<sup>16</sup> Kohler JC, Dimancesco D. The risk of corruption in public pharmaceutical procurement: how anti-corruption, transparency and accountability measures may reduce this risk. *Glob Health Action*. 2020;13(sup1):1694745.

57% of 405 essential medicines being purchased from one supplier without competition and at prices 41% higher than international averages.<sup>17</sup>

**Use of formal, written procedures.** Clear, written, standardized procedures and guidelines for subnational procurement can help personnel who lack technical expertise but also provide a standard for conducting control reviews or audits.<sup>18</sup> Attaining cost and service quality benefits entails clearly defined roles and responsibilities at every government level involved in the procurement system. While each country will define this differently depending on national circumstances, table I illustrates a potential division of procurement responsibilities between central and local governments.



Table I. Illustrative division of procurement responsibilities between central and local governments

Responsibility	Central level	Local level
Aggregate demand	X	
Issue and manage tenders through to contracting	X	
Negotiation, contracting, price setting	X	
Quantification, purchasing, supplier payment, receive stock		X
Budget management	X (set budget ceilings)	X (allocation and spending decisions)

**Systems supporting the achievement of good procurement practice and assurance of product and service quality.** Good procurement practice is not carried out in isolation—to be successful, pharmaceutical procurement needs to be underpinned by supportive systems that quantify demand based on need; monitor and report on competition and supplier performance (catalog, price, availability, and delivery); and assure product quality. A list of complementary procedures follows:

- Rigorously prequalify suppliers to ensure standards of performance, quality, and price
- Base the list of products that can be procured subnationally on the essential medicines list and standard treatment guidelines
- Require that only products with a valid market authorization be procured
- Establish a systematic method to monitor and report on supplier performance at all government levels and through appropriate public forums
- Include penalties for poor performance in contracts and rigorously enforce them
- Ensure quantification, forecasting, and supply planning are robust with standardized guidelines for using quality data at all levels that conduct quantification

<sup>17</sup> Transparency International. 2017. Making the Case for Open Contracting in Healthcare Procurement. [http://ti-health.org/wp-content/uploads/2017/01/Making\\_The\\_Case\\_for\\_Open\\_Contracting\\_TI\\_PHP\\_Web.pdf](http://ti-health.org/wp-content/uploads/2017/01/Making_The_Case_for_Open_Contracting_TI_PHP_Web.pdf).

<sup>18</sup> Vian T. Review of corruption in the health sector: theory, methods and interventions. Health Policy Plan. 2008 Mar;23(2):83-94.



## 4. SUGGESTED APPROACHES TO SUBNATIONAL PROCUREMENT

Good pharmaceutical procurement practice as described above should always be applied, and designers of a decentralized system can consider one or more of the following three mechanisms to operationalize elements of good pharmaceutical practice:

- Central framework agreements for vital and essential pharmaceuticals and supplies that are frequently procured
- Prime vendor programs as an alternative approach in the absence of framework agreements for assuring product and service quality and transparency at acceptable prices
- e-procurement systems to provide transparency and adherence to standard operating procedures

### Framework agreements

In countries with a competitive market, achieving the kind of cost savings described in the Center for Global Development 2019 study<sup>19</sup> above is especially feasible for widely used, high-volume, easily specified items purchased repeatedly. In this case, central framework agreements, especially for priority pharmaceuticals and medical supplies such as for MNCH, can be a powerful tool to assure product and service quality and get significant price benefits. The World Bank has noted that many countries have used framework agreements successfully, particularly in North America and Europe.<sup>20</sup> However, while interest is growing outside of these areas, only a handful of low- or middle-income countries use framework agreements, which opens the door to scaling up their use.

Framework agreements aggregate demand across multiple health facilities, often into national contracts, but could also be regional depending on the county context, to leverage the buying power of larger volumes. Such agreements are typically longer-term—frequently up to three years—which gives suppliers the security they need to offer best pricing and service. While contracting and price-setting are done centrally, local purchasing bodies continue to make buying decisions by drawing down from these framework agreements while managing budgets, thereby retaining a decentralized system’s advantages. Separating supplier selection, contracting, and price-setting from purchasing and budget management is requisite to successfully decentralizing procurement.

Assuring product quality in framework agreements calls for a process that carefully prequalifies suppliers and clearly defines product specifications and selection criteria, such as market authorization from the national regulatory body. Procurement procedures must be clear and standardized, and equally important is supplier performance that is closely monitored, publicly reported, and penalized when poor.

Well-functioning framework agreements offer a range of pluses, including:

- Improved efficiency through a single, aggregated, procurement process rather than multiple procurements spread across the country
- Enhanced visibility and competition by knowing which suppliers fulfilled orders, for whom, and at what price
- Assured product quality by buying only from prequalified suppliers

---

<sup>19</sup> Pierre Dubois, Yassine Lefouili, and Stéphane Straub. Pooled Procurement of Drugs in Low and Middle Income Countries. CGD Working Paper 508., 2019 <https://www.cgdev.org/publication/pooled-procurement-drugs-low-and-middle-income-countries>.

<sup>20</sup> World Bank. Guidebook for Setting-up and Operating Framework Agreements, 2021. Washington DC: World Bank.

- Easier performance monitoring of fewer, larger contracts
- Better value due to the economies of scale and ongoing competition

While framework agreements have many advantages, achieving them consistently requires public procurement legislation that permits their use in addition to maintaining competition and providing an open, robust way to allow new suppliers to enter the market. Without this, the system can become resistant to change and even vulnerable to collusion and corruption. A management unit staffed by qualified and experienced procurement experts who can effectively manage the agreements is fundamental. Legislation and associated regulations must also provide methods and sufficient resources for enforcing the use of the framework agreements and their conditions and ensuring that local buying decisions remain transparent.

The World Bank and Organisation for Economic Co-operation and Development have established useful guidelines<sup>21</sup> for establishing framework agreements.

### Examples of framework agreements: South Africa, New Zealand, and Liberia

**South Africa's** National Department of Health is responsible for the national tendering mechanism that aggregates the nine provinces' demand for strategic commodities (e.g., HIV, oncology, TB) into a central tender. Contracts with indicative volumes but no minimum commitments typically last for two to three years with multiple awards per product and a delivery requirement—even to the point of care. Provinces hold budgets and purchase most of their strategic commodities through 13 to 14 national contracts that account for 90% of total spending. However, provinces do sometimes procure independently with some overlap with central government purchases.

The power and attractiveness of this centralized approach for the government is that the risk of expiries, thefts, and damages are shifted to the vendor, who is also penalized for non-performance. Furthermore, the supplier holds the stock needed to respond to contractual demands, meaning that the government has no direct warehousing responsibilities or costs. The government encourages competition by offering a price preference to new market entrants and local manufacturers.

This approach's benefit is illustrated by the fact that the National Department of Health paid less for antiretrovirals than what many multilaterals paid for annual procurements (table 2).

*Table 2. Antiretroviral price comparisons by purchaser<sup>22</sup>*

Product* (mg)	Pack size (tabs)	Purchaser and pack price (USD)		
		Global Fund: March 2021	Global Health Supply Chain- Procurement and Supply Management: September 2021	South Africa weighted average: 2019-2022
ABC/3TC (600/300)	30	8.78	8.90	7.60
AZT/3TC (300/150)	60	5.55	6.05	4.85
LPV/r (200/50)	120	18.65	18.65	11.69
TDF/3TC/DTG (300/300/50)	30	5.55	— <sup>23</sup>	4.82

\*ABC—abacavir; 3TC—lamivudine; AZT—zidovudine; LPV/r—lopinavir and ritonavir; TDF—tenofovir disoproxil fumarate; DTG—dolutegravir

<sup>21</sup> World Bank, 2021. [Guidebook for Setting-up and Operating Framework Agreements](#) and OECD 2014, [Manual for Framework Agreements](#).

<sup>22</sup> Clinton Health Access Initiative. 2021 HIV Market Report: The state of HIV treatment, testing, and prevention in low- and middle-income countries. <https://www.clintonhealthaccess.org/report/2021-hiv-market-report-the-state-of-the-hiv-market-in-low-and-middle-income-countries/>

<sup>23</sup> Price missing in reference source

In **New Zealand**, Pharmac is the government agency that contracts for the public health service's medicine supply.<sup>24</sup> Importantly, Pharmac does not buy anything but reviews and approves products to be included in its annual tenders and negotiates contracts with suppliers. Hospitals and community pharmacies then use their individual budgets to buy against these central contracts. Pharmac started in 1993 with a contract for one product, paracetamol. By 2020-2021 its schedule had 1,500 products with a budget of USD 1.08B.

Each year, Pharmac issues an annual tender for a third of the products that must be registered by the regulatory authority. For common generics, winning companies are given a sole-source agreement for three years, although if having only one supplier is risky, some medicines will have more. For medical devices, volumes are split between multiple suppliers—for example, 60%, 20%, 20%.

As in South Africa, Pharmac's strict contract conditions have incentives to maintain supply and supplier requirements to avoid or mitigate stock outs. For example, if a contracted supplier cannot meet its obligations, it must source an alternative at the same price or cover any price difference.

Although New Zealand is a small market without any pharmaceutical manufacturing, international distributors find it desirable because the winners' contracts cover about 95% of the whole public market for three years. The national regulatory authority requires winning contractors to have local agents who must manage any supply chain problem through their international home office (e.g., India, Australia, Canada). Moreover, having secure, sole-source contracts means that the suppliers do not need a sales force, which reduces overhead costs. The appeal of Pharmac's business to suppliers maintains competition in every tender with Pharmac, consistently saving USD 30M to USD 50M a year.

**Liberia** established pharmaceutical framework contracts that allowed three counties with a PBF in place to procure specific MNCH essential medicines from selected private wholesalers.<sup>25</sup> These contracts supplement the central medical store (CMS) when they are unable to supply. The framework contracts fix prices, which include delivery to the county depot within 10 days of receiving the purchase order. All medicines must be registered by the Liberia Medicines and Health Products Regulatory Authority, who conducts post-market surveillance to further help guarantee product quality. A third-party national verification agency monitors framework agreement adherence on a quarterly basis to confirm that the counties place accurate quarterly orders to the CMS, order from the approved pharmaceutical wholesaler only if the CMS has insufficient supplies, and procure only from the preapproved wholesaler at the negotiated fixed prices using the approved list. Under PBF, and using this framework agreement for local procurement, the number of facilities in the three counties with stock outs of tracer medicines decreased from 100% in 2019 to 20% in the third quarter of 2020.

## Prime vendor programs

Another approach to improving procurement outcomes in a decentralized system is a prime vendor program where a government contract (central or local) establishes a private sector pharmaceutical wholesaler/distributor as the primary supplier of medicines and medical supplies for public health facilities. Essentially a “one-stop shop,” the prime vendor can either supplement a traditional government supply system (e.g., CMS) to alleviate stock-out problems or serve

The process for selecting a prime vendor is transparent and follows the following broad steps:

- Pre-tender vendor meeting
- Prequalification of vendor
- Tender
- Evaluation
- Due diligence
- Contract negotiation, award, signing
- Performance management

<sup>24</sup> Presentation to MTaPS Philippines: The role of PHARMAC in New Zealand: Chloe Dimock, Procurement Team Leader; Sarah Fitt, Chief Executive; July 6, 2021.

<sup>25</sup> MTaPS. Ensuring the Quality of Subnationally Procured MNCH Medical Products; Findings from Liberia, Nigeria, and Tanzania March 2021. Arlington, VA: Management Sciences for health.

as the principal supplier with prices and service levels set through a national or local government-negotiated contract. A prime vendor's success, however, depends on it stocking the required medicines, meeting the demands of the subnational procurers, and receiving timely payments from the government. If payments are tardy, the prime vendor will stop supplying, and facilities will revert to buying outside the system and experience previous problems related to quality, service, and price. Competition must also be built into the process for selecting a prime vendor, with the pool of competitors regularly refreshed, and contracts periodically recompeted.

### Example of a prime vendor system: Tanzania<sup>26</sup>

In Tanzania's public-private partnership, Jazia, health facilities procure priority medicines directly from a prime vendor through a regional contract, which complements regular government supply from the central level. The district usually receives orders from primary health facilities, verifies them, and forwards them to the Jazia prime vendor. Facilities pay their bills through their individual facility accounts using government funds available for buying medicines from the Medical Stores Department (MSD) and complementary funds from user fees, a community health fund, and national health insurance. Each regional Jazia prime vendor delivers to the district hospital, and facilities are not limited by order size or frequency beyond the availability of funds. Beginning in 2014 in one region, Jazia had been rolled out nationwide by 2019.

Figure 1 provides a schematic overview of the Jazia prime vendor model and the role of facilities.<sup>27</sup>

Before Jazia was in use, regional procurement was allowed if the MSD could not supply, but health facilities purchased from unqualified companies, which threatened quality assurance and increased costs. However, with order fulfillment at less than 60%,<sup>28</sup> MSD's poor performance forced regional governments to purchase locally or experience stock outs. From 2014 to 2018, Jazia had improved the average availability of a tracer list in the pilot region from 69% to 94%, while availability in health facilities increased by an average of 35%.

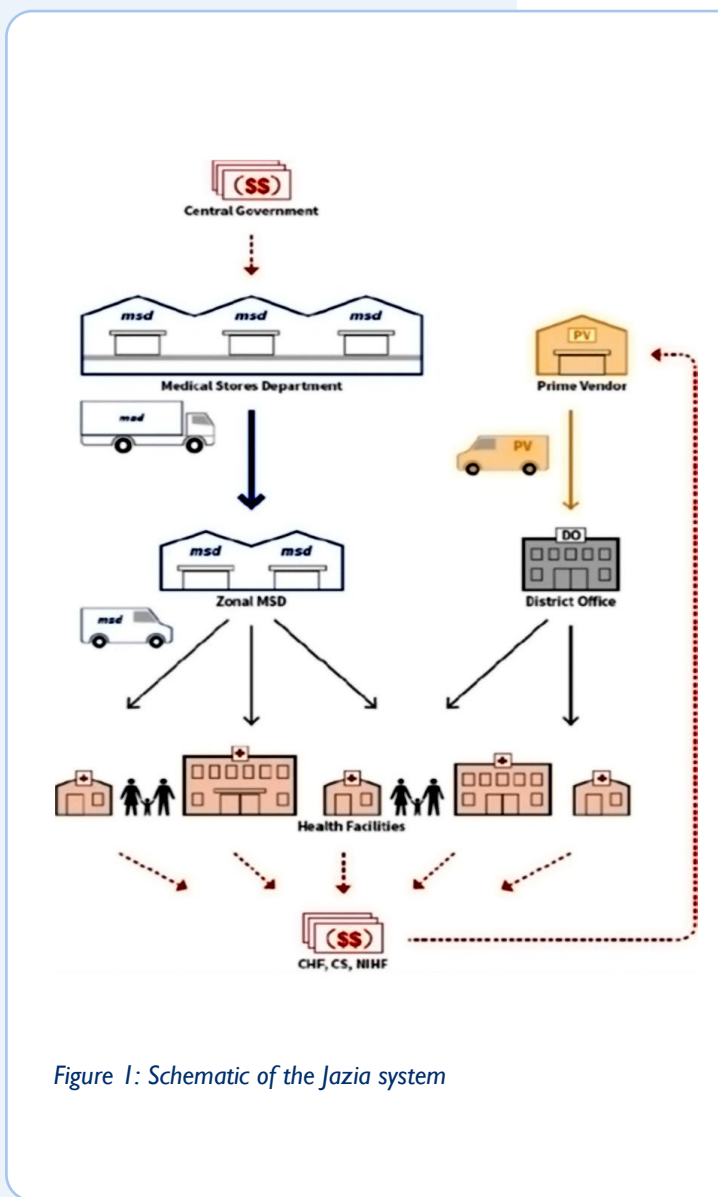


Figure 1: Schematic of the Jazia system

<sup>26</sup> Wiedenmayer K, Mbwasi R, Mfuko W, Mpuya E, Charles J, Chilunda F, Mbepera D, Kapologwe N. Jazia prime vendor system- a public-private partnership to improve medicine availability in Tanzania: from pilot to scale. J Pharm Policy Pract. 2019 Feb 25;12:4. doi: 10.1186/s40545-019-0163-4.

<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

The good procurement practices and transparency that underlie Jazia's effectiveness rely on qualifying the supplier before contracting and purchasing from them. To assure quality, all products must be registered with the Tanzania Medicines and Medical Devices Authority and be on the country's essential medicines list and in MSD's product catalogue. Suppliers find the contracts attractive because only one is awarded per region with prices negotiated for three years. The system also created strong political will and ownership at all levels of government, which has been another factor in its success.<sup>29</sup>

## e-procurement

e-procurement systems provide subnational governments easy access to framework agreements and prices as well as facilitate transparency and standardization. They are increasingly common in the Asia-Pacific region; in 2011, the Asian Development Bank found that 16 of 27 countries surveyed were planning or implementing e-procurement systems.<sup>30</sup> e-procurement systems provide cost savings; adherence to set procedures and legal requirements; improved coordination and visibility into individual buyers' behavior and across the system as a whole; accountability; and responsiveness. Also, more transparency appeals to superior suppliers, which in turn improves service and product quality. e-procurement systems also increase efficiency, not least by eliminating the need for moving large amounts of paper between different levels of government.

However, e-procurement is a large, complex undertaking entailing comprehensive change management; therefore, implementation requires significant budget and political support, which can often be promoted through public pressure for greater government transparency and efficiency, especially if legislative changes are required to put in place new procurement schemes. Though complicated, establishing e-procurement can be a step toward evolving a government's role from managing day-to-day procurement operations (sourcing products, placing orders, paying invoices, tracking deliveries, etc.) to overseeing the appropriate use of procurement contracts, such as framework agreements, at the subnational level. e-procurement also facilitates monitoring and responding to supplier performance against contractual expectations.

### Example of an e-procurement system: Indonesia

Following a problematic experience with e-procurement in the 2000s, Indonesia rolled out an improved e-procurement system in 2012 consisting of two modules, e-tendering and the health sectoral "e-katalog," which by 2016 contained 13,000 drugs and health commodities. By 2019, the government was purchasing USD 2.7B worth of goods through the e-katalog system. Buyers can order online through central framework contracts with prices updated annually. The e-tendering module is used when an item in the e-katalog is unavailable from contracted suppliers or is not in the e-katalog or when a defined cost threshold is exceeded. Purchasing using subnational budgets in Indonesia remains decentralized and works largely through a centrally managed, integrated system where the national framework contracts assure quality and competitive prices.

<sup>29</sup> Kuwawenaruwa A, Tediosi F, Metta E, Obrist B, Wiedenmayer K, Msamba VS, Wyss K. *Int J Health Policy Manag.* 2021 Oct 1;10(10):625-637. doi: 10.34172/ijhpm.2020.90.

<sup>30</sup> Asian Development Bank. 2013. *E-government procurement handbook.* Mandaluyong City, Philippines: Asian Development Bank.

## 5. CONCLUSION

Subnational procurement can improve the availability of essential medicines including those used in MNCH programs; however, if not implemented thoughtfully and with an eye toward institutionalizing good procurement practice, the method may compromise product quality, affordability, and ultimately availability. Local procurement staff frequently lack the training and experience to carry out complex procurement functions that can be exacerbated when procedures are not standardized or documented or when the licensing or registration status of suppliers or their products cannot be verified. The appropriate use of technology can significantly help address some of these issues. As a result, subnational procurement systems need measures to guarantee product quality and affordability and a transparent fair process, although those measures are multifaceted and require the investment of significant time, financial resources, and political capital, in addition to stakeholder engagement and collaboration.



# USAID MEDICINES, TECHNOLOGIES, AND PHARMACEUTICAL SERVICES (MTaPS) PROGRAM

*Improved Access. Improved Services. Better Health Outcomes.*

## Contact Us

[mtaps@msh.org](mailto:mtaps@msh.org)

[www.mtapsprogram.org](http://www.mtapsprogram.org)



**USAID**  
FROM THE AMERICAN PEOPLE

This document is made possible by the generous support of the American people through the US Agency for International Development (USAID) contract no. 7200AA18C00074. The contents are the responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.