Future of Global Health Procurement

Final summary presentation

April 2018

Prepared by the Clinton Health Access Initiative (CHAI)

Agenda

- **Project Framework**
- Highlights of current procurement landscape

We have developed a standardized framework to organize global and country level findings

Inputs and characteristics that determine the outcomes of procurement

Outputs from system

Funding

- Amount of available funding
- Predictability and timeliness of fund disbursement
- Sustainability of funding

Policy & Regulations

- International and/or local policies, regulations, and guidelines on procurement of commodities, e.g., currency considerations, shelf life, quality standards, timeframe, volume commitments

Strategy & Processes

- Processes, procedures/ methodologies, and relevant stakeholders including: demand estimation, budgeting, tendering, bid evaluation, contracting, and performance monitoring
- Designs of tender and contracts (e.g., criteria), and the underlying rationale

Supporting infrastructure & resources

- Availability of appropriate supporting resources, e.g., personnel, IT infrastructure, tools, etc.

Cost / price

Responsiveness & Reliability

Quality

Long-term market sustainability / innovation

Agenda

- Project Framework
- **Highlights of current procurement landscape**
  - **Key observations from global procurers**
  - Key observations from visited countries

USAID/ PSM – Key observations

NON-EXHAUSTIVE

	Highlights
Funding	• **Annual funding/ appropriations cycle** drives procurement cycle • Funding expected to be **fairly stable** across years – except reproductive health
Policy & Regulations	• **Annual budget commitments** impede multi-year volume commitments • **Different quality policies** for various therapeutic areas (e.g. FDA approval required for ARVs but not FP products) • **Shelf life requirements** defined as percentages affected procurers' flexibility & efficiency
Strategy & Processes	• Emphasizes **market-specific strategies**, i.e., set up of product-specific commodity group councils to develop targeted plans • **Shared-risk arrangements; framework contracts; use of forward looking operational plans (e.g., malaria)** to provide high level estimates for suppliers • **Exploring optimization of SKUs to allow for consolidation** of orders • Emphasis on supply security – e.g. target ~3 suppliers per product in awards • **Data quality and forecast accuracy issues** create challenges • Starting to **explore local procurement**
Supporting infrastructure & resources	• Developing / refining **supporting systems** in collaboration with **IBM** with a view to enhancing **On Time In Full (OTIF) performance** • **Standardization of information and data** • Attempting to **strengthen visibility into supply chain**, i.e., PPMR for HIV/AIDs as a pilot

Sources: Interviews with GHSC-PSM/ IBM; GHSC-PSM/ HIV/AIDS; USAID/ Supply Chain for Health for HIV/AIDS

GFATM – Key observations

Highlights

NON-EXHAUSTIVE

Funding	• **Ability to underwrite multi-year contracts** and provide incentives such as volume guarantees allows greater leverage & flexibility when working with suppliers
Policy & Regulations	• Extend **framework agreements** to partner agencies (e.g., UNFPA, UNDP, UNITAID) and governments with national funding (e.g., Cameroon, Georgia)
Strategy & Processes	• **Deliberate strategy** to develop market context tailored procurement approaches across therapeutic areas • **Holistic, multi-facetted approach to** supplier engagement: **Multi-year agreements**; **total cost approach** (e.g., responsiveness) as reflected in reduced commercial weighting in tenders; **direct engagement with both API and FPP suppliers** for supply security and ensuring responsible procurement; active **risk management** (e.g., reserved volume for new entrants; geographical balance; collaboration with other global buyers) • **Rigorous analytical approach to negotiations based on**: demand forecasts/ tender timing/ benchmark pricing for suppliers; reference price and lead time estimates for countries; PQR • **In-country supply chain strengthening and capability building** is a key focus
Supporting infrastructure & resources	• Wambo.org as a **platform** to reduce market complexity, decrease administrative burden for PPM PRs (e.g., automated ordering), and facilitate efficient reporting

Sources: Interviews with GFATM (Direct Procurement; Global Sourcing; Analytics & Data Management, Health Procurement and Supply Management)

UNFPA – Key observations

NON-EXHAUSTIVE

	Highlights
Funding	• **Lack of visibility** into long-term funding • **Funding received in annual tranches** (which are sometimes topped up within the year) which **limits flexibility** with procurement; newly created **bridge financing mechanism** could help
Policy & Regulations	• Orders will only be placed with **"cash in the bank";** this extends to third party procurement mechanism where countries have to pay upfront
Strategy & Processes	• Use of **multi-year contracts** but with no committed volumes; ensure supply security by diversifying FPP and API sources • **Collaboration** with other partners: – Conducts **procurement of condoms for Global Fund** (pilot in 2017) and help generate savings through its greater scale and assure quality – Standardization of data collection with USAID and other UN Agencies • Leverage its scale to encourage manufacturers to adopt **green manufacturing** practices, e.g., ISO 14000 • Categorization of countries to **facilitate preparation for future transition**, e.g., For "category c" countries, 75% of funding is targeted for technical support with 25% for commodity procurement vs. 75% for commodity for other countries
Supporting infrastructure & resources	• **Third party procurement** services to countries for a 5% administrative fee • **Manual systems:** implementing partners reporting back to UNFPA country offices currently use **excel spreadsheets**; Warehouse manager has to report manually on different excel sheets

Sources: Interviews with UNFPA (CSB & PSB)

PAHO – Key observations

NON-EXHAUSTIVE

	Highlights
Funding	• **Majority of funds used to procure comes from governments** directly, very limited donor funding; use of the fund has grown significantly as countries transition out of donor funds (3X from 2011 to 2016)
Policy & Regulations	• Orders will only be placed with **"cash in the bank";** hence capital account is very beneficial to countries
Strategy & Processes	• Use of **multi-year contracts,** but with no committed volumes, for key products deemed as important for public health or requested by many countries • Lack of demand visibility makes it difficult for some negotiations, however **suppliers still provide more favorable terms** than to countries because PAHO is a reliable payer • Strategic fund is positioned as a **tool to improve access** for countries as opposed to procurement-focused; **no obligation from countries to procure** • Countries **vary in engagement with the fund**; some use the fund to benchmark prices to local suppliers or for budgetary purposes, others use to procure products they have limited access to
Supporting infrastructure & resources	• **Capital account provides interest free loans (60 days from purchase order)** for countries to place orders through Strategic Fund; funded through 3%+1.5% admin fee on all purchase orders

Sources: Interviews with PAHO (Procurement Strategic Fund; Revolving Fund)

Agenda

- Project Framework
- **Highlights of current procurement landscape**
  - Key observations from global procurers
  - **Key observations from visited countries**

Uganda – Country overview

NON-EXHAUSTIVE

- **Population:** 41 Million (2016)
- **GNI per capita, PPP:** Current international $: 1,790
- **Life expectancy:** 60
- **Total fertility rate:** 5.7
- **Health expenditure (2014)**:
  - 7.2 % of GDP
  - 25% public

Disease burden:

- Neonatal mortality rate: 21.4 per 1,000 live births
- Maternal mortality ratio: 343 per 100,000 live births
- Malaria incidence: 218 cases/ 1,000 people at risk
- Tuberculosis incidence: 201/ 100,000 people
- HIV prevalence: 6.5% of population ages 15-49

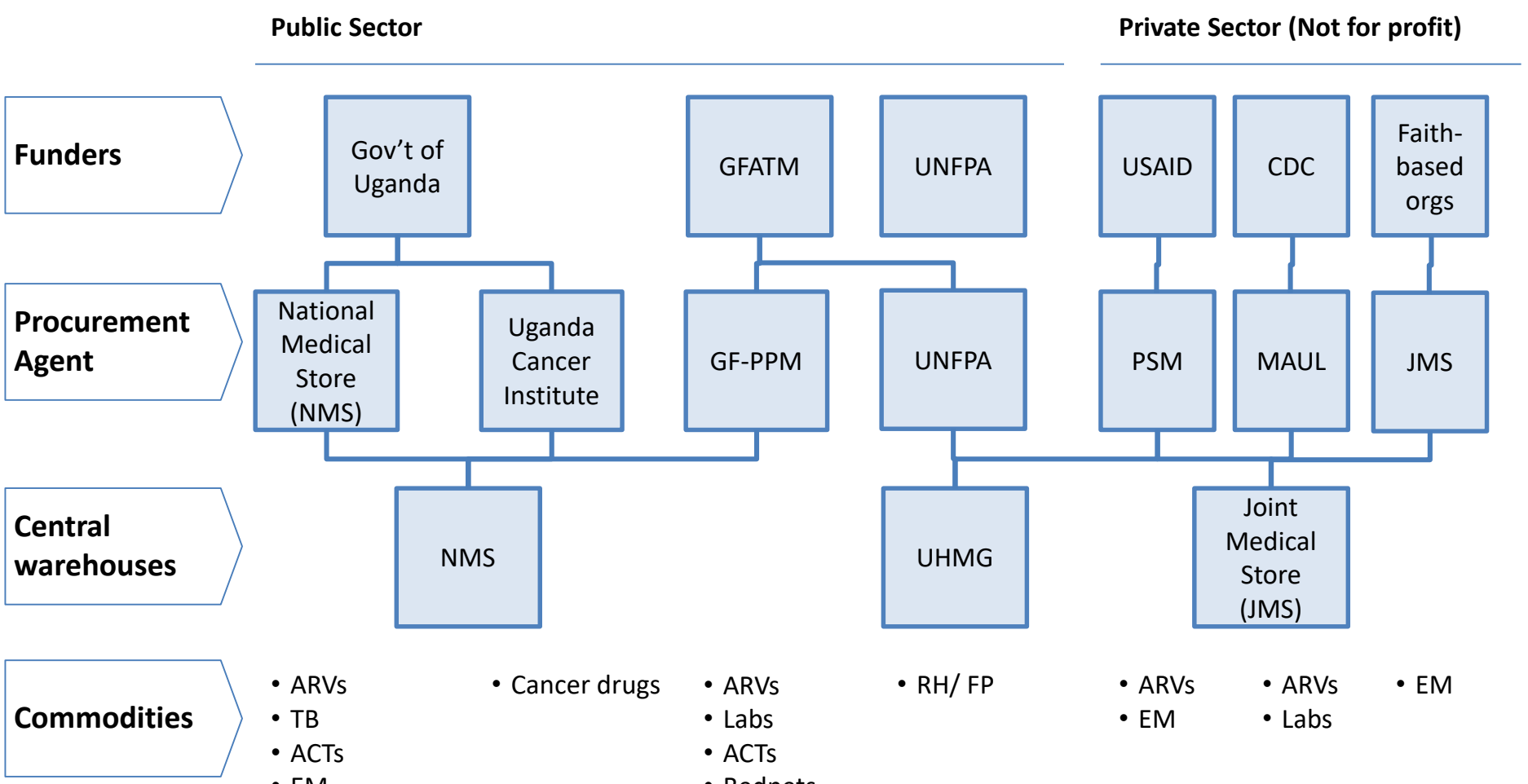
Major donors:	Annual budget (rough estimate)	Procurers
CDC	• N/A	• MAUL
PEPFAR	• $32M ARVs (2016) • $40M non-ARVs and reagents (2016)	• GHSC-PSM
USAID	• $3M on RH (2014-16 avg)	
PMI	• $15M	• GHSC-PSM • Abt Associates (IRS)
GFATM	• $40-60M[1] (2014-17 avg)	• PPM
UNFPA	• $3M on RH (2014-16 avg)	• UNFPA

1 Estimated based on 40% of grant disbursement

Sources: World Bank, PEPFAR, PMI, RHI, expert interviews

Uganda – Overview of current procurement mechanism and key stakeholders (non-exhaustive)

NON-EXHAUSTIVE



Sources: Interviews with government officials, donors, and implementing partners (NMS, QPPU, UNFPA, USAID, PSM)

Uganda – Key observations

NON-EXHAUSTIVE

Highlights

Funding

- **Domestic funding gaps and uncertainty** often cited as the primary constraint for optimal local procurement
- **Funding/ payment delays** by government procurers make it hard to **hold suppliers accountable** for performance issues
- Challenges in **coordinating** between various donor / funding agencies

Policy & Regulations

- A number of policies have affected cost and quality of domestic procurement:
  - **Buy Uganda Build Uganda** (BUBU)
  - Tendering in **local currency**
  - Tender criteria focus primarily on **lowest unit cost**
  - Suppliers need to commit to **multi-year prices** (no volume commitments)
  - **Shelf life requirements** defined in percentage terms affected procurers' flexibility and efficiency

Strategy & Processes

- **Fragmented supply chains** (including multiple warehouses for different therapeutic areas / sectors) create complexities and challenges for optimal coordination and securing product availability across POCs

Supporting infrastructure & resources

- **Data limitations (quality and visibility beyond central levels)** affect ability to develop accurate quantification and supply plans
- **Multiple manual processes and proliferation of software programs**
- **Staff capacity and capability** limitations throughout supply chain

Sources: Interviews with government officials, donors, and implementing partners (NMS, QPPU, UNFPA, USAID, PSM)

Kenya – Country overview

NON-EXHAUSTIVE

- **Population:** 48 Million (2016)
- **GNI per capita, PPP:** Current international $: 3,130
- **Life expectancy:** 63
- **Total fertility rate:** 4.3
- Health expenditure (2014):
  - 5.7 % of GDP
  - 61% public

Disease burden:

- Neonatal mortality rate: 22.6 per 1,000 live births
- Maternal mortality ratio: 510 per 100,000 live births
- Malaria incidence: 166 cases/ 1,000 people at risk
- Tuberculosis incidence: 348/ 100,000 people
- HIV prevalence: 5.4% of population ages 15-49

Major donors:	Annual budget (rough estimate)
PEPFAR	• $62.4M ARVs (2016) • $31M non-ARVs and reagents (2016) • $12M HIV Test kits (2016)
USAID	• $2.6M on RH (2014-16 avg)
PMI	• $13M (FY 2018 MOP)
GFATM	• ~$120M[1] (2014-17 avg)
UNFPA	• $3.8M on RH (2014-16 avg)

Procurers

- Donor procurements primarily go through KEMSA
- Following devolution - counties can order through KEMSA, MEDS or procure directly with their own funds

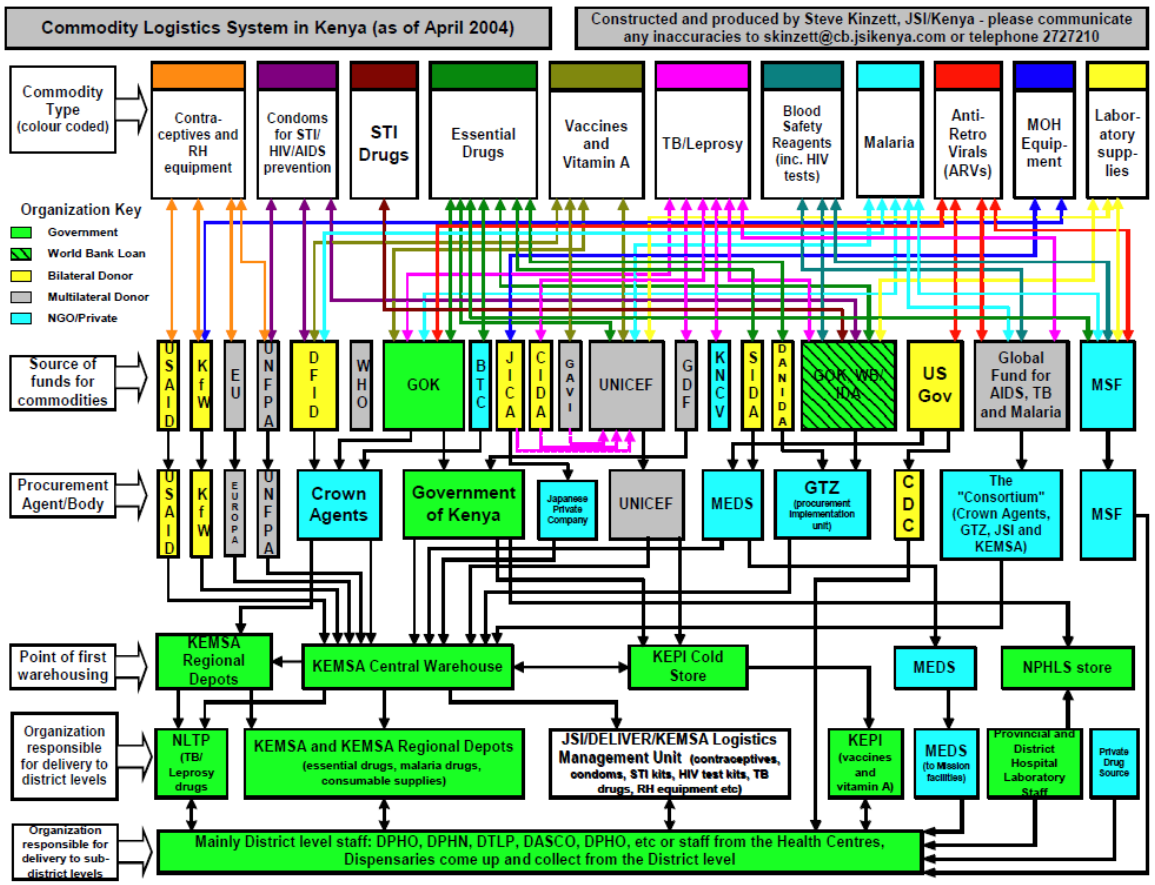
1 Estimated based on 40% of grant disbursement

Sources: World Bank, PEPFAR, PMI, RHI, expert interviews

Kenya – Overview of procurement mechanism and key stakeholders

NON-EXHAUSTIVE

Kenya supply chain overview - 2004[1]



Discussion

- Following a vote in **2010**, responsibility for procurement was **decentralized** to 47 counties
- Counties have the ability to **chose how to procure**; effectively creating a **market**
- Both donors and GOK have **invested in creating a strong procurement** function – KEMSA.
- Yadav 2014[2] attributes the success of this to the following factors:
  - Recruiting leadership talent
  - Creating an Appropriate Legal Framework
  - Robust and Effective Governance Structure
  - Greater Transparency
  - Building a Change Coalition
  - Robust Quality Assurance
  - Adequate Staffing
- USAID announced an expansion of its collaboration with KEMSA in June 2016 – it will procure **US $650 million through KEMSA under a multi-year agreement**

1 – Source: KEMSA Study, Pamela Steele and Silvia Rossi Tafuri

2 - Yadav, Prashant. 2014. 'Kenya Medical Supplies Authority (KEMSA): a case study of the ongoing transition from an ungainly bureaucracy to a competitive and customer focused medical logistics organization'. Study conducted by the World Bank.

Sources: Expert interviews, literature review

Kenya – Key observations

NON-EXHAUSTIVE

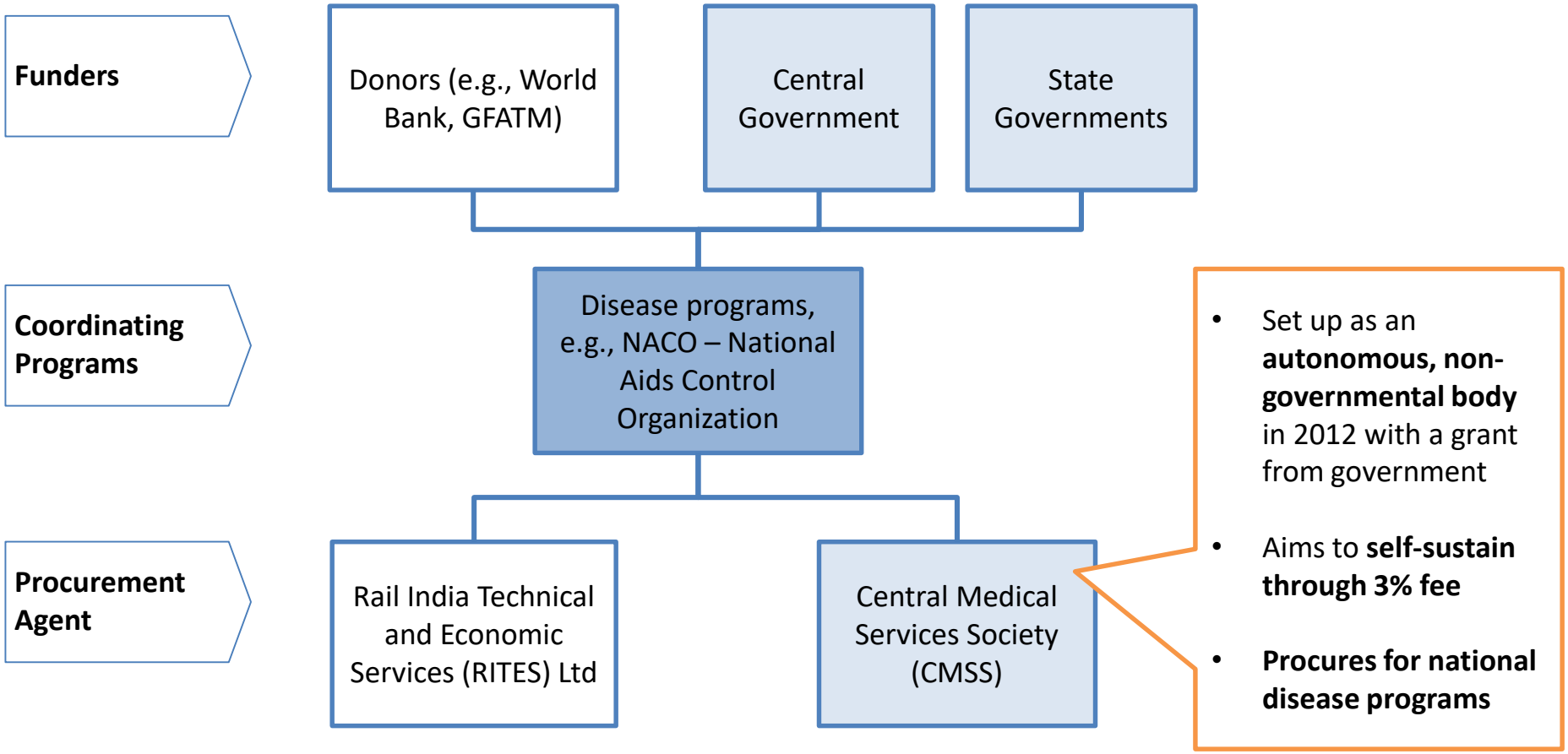
	Highlights
Funding	• **Funding uncertainty** (both government and donors) cited as the biggest constraint for optimal procurement • Inability to **roll-over** government funding between periods • Lack of coordination amongst donors and GOK in funding cycles
Policy & Regulations	• 2010 **devolution** put much of the power to purchase at the county level • Counties can **chose** how to procure (KEMSA, MEDs, direct tendering) • **Shelf life requirements** defined as percentages affect procurers' flexibility & efficiency
Strategy & Processes	• **Fragmented** demand (at county level) coupled with lack of accurate data systems at lower levels (varies by disease category) complicate quantification and tendering
Notes	• Donor procurements and procurement of certain GOK-funded commodities (e.g. oncology drugs) all flow through **KEMSA** • KEMSA charges a **10% fee** for its procurement, warehousing and distribution services • Donors and GOK **invested heavily in upskilling KEMSA** and the current institution is seen as reliable and successful • USAID agreed to a **multi-year** award to KEMSA in June 2016 • KEMSA has had to **suspend deliveries** to counties due to non-payment, these counties then often procure through other channels (e.g. MEDs)

Sources: Interviews with USAID HIV Division and other Kenya procurement experts; literature review

India – Procurement for national disease programs is done at the central level (not exhaustive)

NON-EXHAUSTIVE

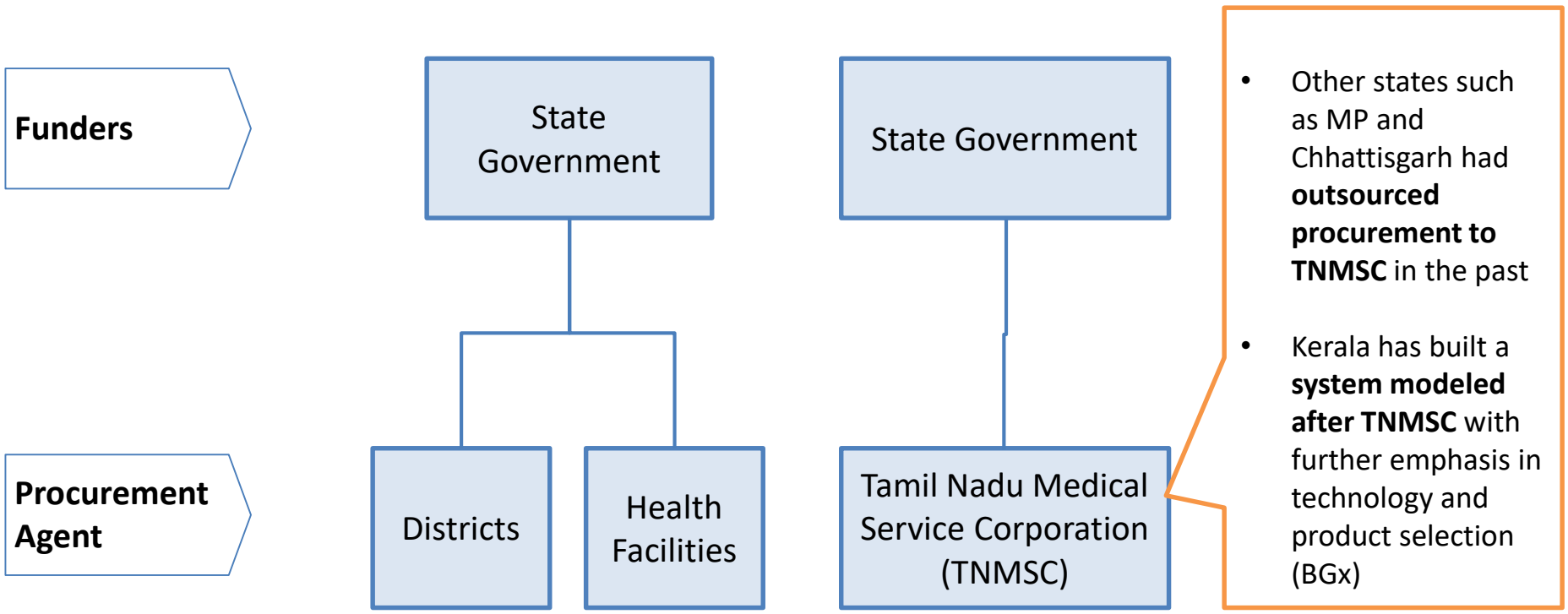
National Disease programs (e.g., HIV, TB, MNCH, Vaccines)



Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh) ; lit search

India – Various models exist at the state level, with Tamil Nadu being recognized as a role model with its centralized set-up (not exhaustive)

NON-EXHAUSTIVE



Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh) ; lit search

Tamil Nadu – Impact by TNMSC

NON-EXHAUSTIVE

Overview

- 72M population
- **Tamil Nadu Medical Service Corporation (TNMSC)** established in 1994, covering 90% of budget
- Central Medical Services Society (CMSS) modeled after TNMSC
- **Advised other states**, e.g., Rajasthan, Andhra Pradesh, Assam

	Pre-TNMSC	Post-TNMSC
Product purchase	• Fragmented; open tender by each hospital	• Singe source; Open tender by TNMSC
Supply	• Supply by dealers	• Direct supply by manufacturers
Quality	• Due to fragmented purchases often in small volumes, quality checks are difficult and less frequent	• More rigorous quality checks
Prices	• Generally higher prices • More variability in prices between hospitals	• Lower prices • Standardized prices
Payment	• Fragmented • Higher risk of delayed/non-payments for suppliers	• Singe source • More compliance to payment terms

Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh) ; lit search

India – Key observations

NON-EXHAUSTIVE

	Highlights
Funding	• Central government funds and procures for national disease programs (e.g., HIV, TB) and national organizations (e.g., armed forces) • State government procures for others with funding from central and state levels
Policy & Regulations	• Governments have indicated disagreements with regulatory authorities on approving new products, e.g., HIV Peds (LPV/r pellets), TB (FDC for rifampicin/isoniazid) • To ensure product quality, Kerala has instituted a BGx policy
Strategy & Processes	• Degree of **procurement centralization differs by state**: however **more centralized ones such as Tamil Nadu and Kerala** appear to have benefited from: – Tighter control over **quality and supplier performance**, e.g., own quality assessment and penalty clauses for supplier under-performance; PHCs in Maharashtra face supplier unresponsiveness and failing to meet delivery schedule – Management of **product ranges** (~260 essential drugs vs. over 1800 in Maharashtra) – Better prices through increased scale and greater efficiency, e.g., Tamil Nadu pays INR 500 per CT scan vs. 1700 in some other states • Tamil Nadu merged all health programs except AIDS; with Tamil Nadu Medical Service Corporation (TNMSC) managing ~90% of procurement budget**; TNMSC is known as a role model** and provides consultancy projects for others (e.g., Andhra Pradesh) • States have different bidding and evaluation processes, creating complexity and costs for suppliers • To tackle **uncertainties in demand estimation**, Kerala state has a **two-PO system** where the first is 75% of the estimated order and the second will be set later with more data • State reflect **preference for in-state suppliers and public-sector undertakings** (PSUs), e.g., In Kerala 15% premium for state PSU and 10% premium for small/ micro companies
Supporting infrastructure & resources	• Lack of trained staff on supply chain management (e.g., inventory management, data reporting) • Tamil Nadu enjoys greater visibility of supply chain due to computerization

Sources: Interviews with experts and government officials (CMSS, TNMSC, MPPHSCL, Prabal Singh) ; lit search

Nigeria – Country overview

NON-EXHAUSTIVE

- **Population:** 186 Million (2016)
- **GNI per capita, PPP:** Current international $: 2,450
- **Life expectancy:** 53
- **Total fertility rate:** 5.6
- Health expenditure (2014):
  - 3.7 % of GDP
  - 25% public

Disease burden:

- Neonatal mortality rate: 34.1 per 1,000 live births
- Maternal mortality ratio: 814 per 100,000 live births
- Malaria incidence: 381 cases/ 1,000 people at risk
- Tuberculosis incidence: 219/ 100,000 people
- HIV prevalence: 2.9% of population ages 15-49

Major donors:	Annual budget (rough estimate)	Procurers
USAID	• $6M on RH (2014-16 avg)	• GHSC-PSM
PMI	• $49M (2016-18 avg)	
PEPFAR	• $66M ARVs (2015-16) • $17M Rapid Test Kits (2015-16) • $15M Reagents (2015-16)	
GFATM	• $87M[1] (2014-17 avg)	• GFATM
UNFPA	• $10M on RH (2014-16 avg)	• UNFPA

1 Global estimate of 40% of grant disbursement

Sources: World Bank, PEPFAR, PMI, RHI, GFATM

Nigeria (Federal) – Key observations

Highlights

NON-EXHAUSTIVE

Funding

- **Funding releases, gaps, and uncertainty** pose significant constraints to procurement e.g. payment delays results in suppliers increasing bid prices to MOH tenders
- **States are largely autonomous in funding and procurement decisions** so advocacy for heath commodity funding needs to be done at both the federal and state levels
- Public-sector commodity needs are met through donor funds, direct procurement from the private sector, and state mechanisms like Drug Revolving Funds (DRF).
- **Lack of foreign currency reserves at central bank** affect pricing of quality assured products

Policy & Regulations

- **Customs clearance is a major barrier**; some partners/donors e.g. UNFPA take over
- NAFDAC regulates quality, but **states have own methods of evaluating suppliers**
- **National EML list is a guidance, states can customize** to their needs (remove/add)
- National tenders in **local currency** presents some challenge as some raw materials are sourced internationally (incentivizes buying from lower quality/cost supplier)

Strategy & Processes

- **Quantification is coordinated** at federal level with donors/government **by program**
- **Some states distribute donor-funded commodities through CMS**, other states donors have parallel supply chains which are currently being integrated through the Nigeria Supply Chain Integration Project (NSCIP)
- **Local procurement preference is given (not more than 15 percent of contract price)** but supplier capacity is a constraint

Supporting infrastructure & resources

- **Procurement process** is generally **manual and done on paper**, cannot be easily monitored to benchmark performance
- NSCIP developing **Navision tool to support streamlining of processes** and provide end to end visibility of stock levels

Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)

Nigeria (States) – Key observations

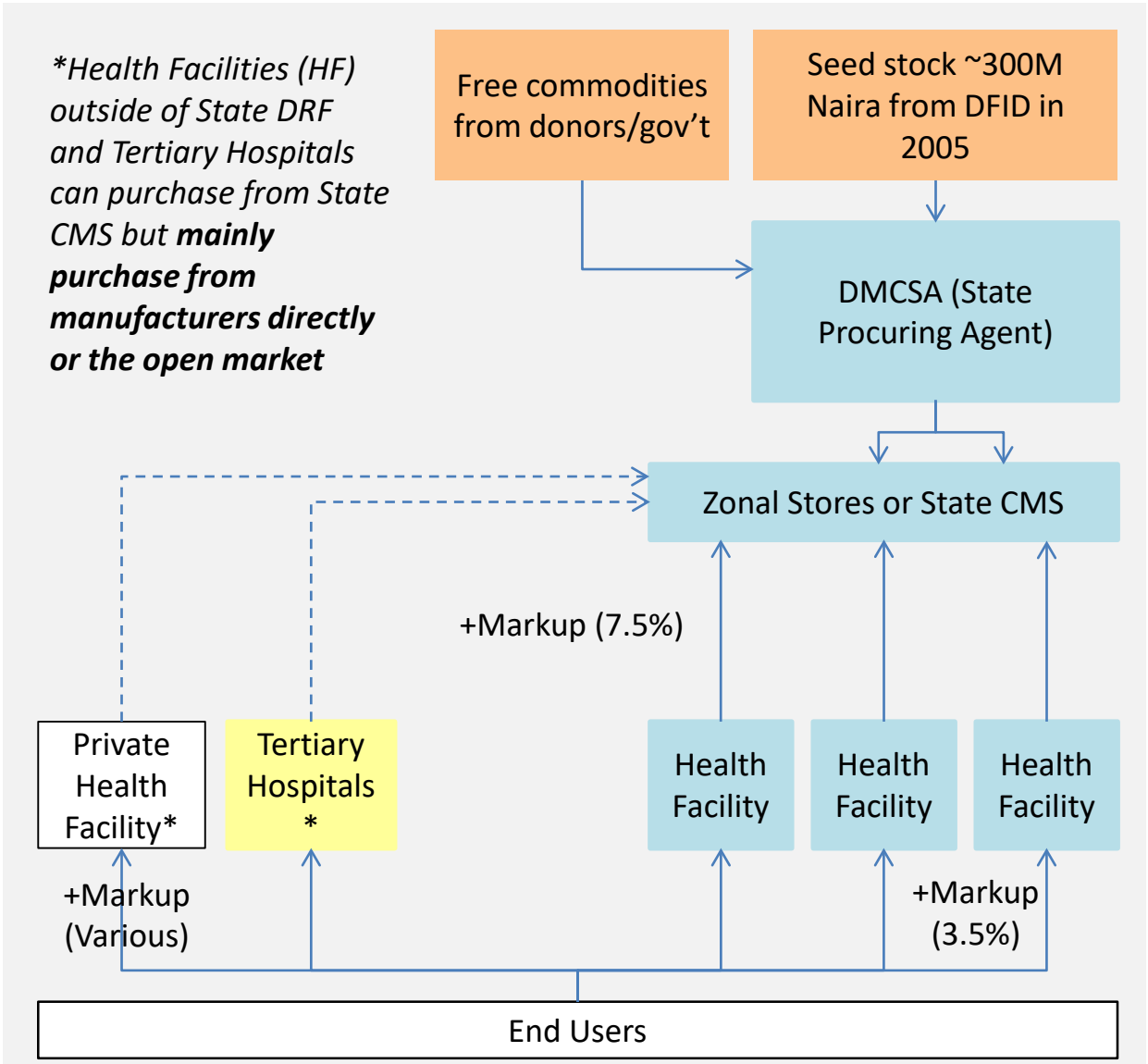
NON-EXHAUSTIVE

	Highlights
Funding	• Most states have **sustainable drug supply systems with a Drug Revolving Fund (DRF) that use markups** to fund operations and procurement of Essential Medicines and some RH commodities, anti-malarials; DRFs vary in functionality • **Funding still a key constraint despite DRFs**; limited funding from federal government (mostly towards tertiary facilities) and state governments • States are turning to World Bank loans to continue funding where donors have pulled out e.g. Lagos for Malaria
Policy & Regulations	• DRF in Lagos state is used to fund government free health commodities schemes for certain individuals who qualify; vary state by state
Strategy & Processes	• States funded by the same donor e.g. DFID will keep in contact and **exchange excess/in-need commodities** with each other • States are **developing capacity to do tendering and framework contracts**; capabilities vary by state • States likely **vary in ability to negotiate prices and favorable terms** with suppliers based on supply and volume • **Local procurement focus**, but supplier capacity is a constraint
Supporting infrastructure & resources	• Data collection, quantification, monitoring, logistics is currently supported by donors and partners and is seen as a major risk in discussions of donor transition • **Various manual tools at PHC level with duplication**

Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)

Nigeria – Drug Revolving Fund Scheme, Kano State Example

State | Federal | Donor



NON-EXHAUSTIVE

DRF History

- DRF can be funded by gov't
- In Kano State, DRF existed on a small scale, with only secondary facilities & 20M Naira in working capital prior to DFID

Kano State DRF Stats

- Estimated value of commodities 1.3B Naira annually
- Working Capital of 400M Naira
- 700 out of 1200 HF part of DRF; 30 to be added this year

7.5% Markup Breakdown

- Operational costs (~4%)
- Expiry
- Inflation
- Deferral and Exemption

Benefits to HF / End User

- Renovation of facilities
- Seed stock
- Quality assurance of commodities
- Autonomy to facilities
- Price control to end user

Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)

Nigeria **(Kano State)** – Overview of current procurement mechanism and key stakeholders

State | Federal | Donor

NON-EXHAUSTIVE

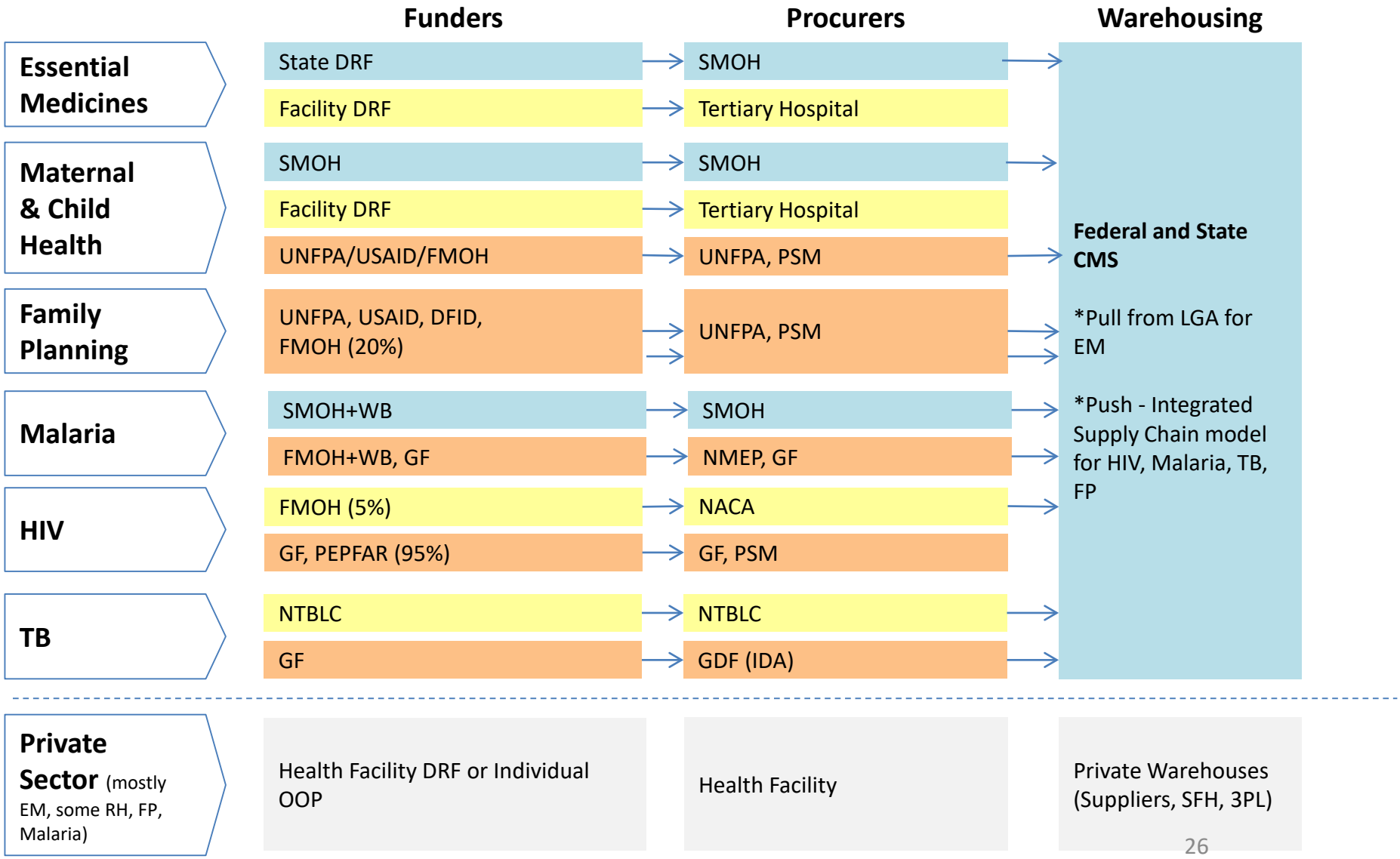
	Funders	Procurers	Warehousing
Essential Medicines	State DRF	DMCSA	**State CMS + Zonal Stores;** *Pull from facilities
	Facility DRF	Tertiary Facility	
Maternal & Child Health	SMOH	DMCSA	
	Facility DRF	Tertiary Facility	
	UNFPA/USAID/FMOH	UNFPA, PSM	
Family Planning	UNFPA, USAID, DFID, FMOH (20%)	UNFPA, PSM	
Malaria	SMOH (20%)	DMCSA	
	FMOH+WB, GF (80%)	NMEP, GF	3 PL; push
HIV	SMOH	SACA, DMCSA	Zonal Store through a PPP *Pull from facilities
	FMOH (5%)	NACA	
	GF, PEPFAR (95%)	GF, PSM	
TB	NTBLC	NTBLC	SACA *Push
	GDF, PEPFAR	GDF (IDA)	
Private Sector (mostly EM, some RH, FP, Malaria)	Donors (GF)	Donors (GF)	Private Warehouses (Suppliers, SFH, 3PL)
	Health Facility DRF or Individual OOP	Health Facility	

Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)

Nigeria **(Lagos State)** – Overview of current procurement mechanism and key stakeholders

State | Federal | Donor

NON-EXHAUSTIVE



Sources: Interviews with government officials, donors, and implementing partners (UNFPA, NASCP, NMEP, NSCIP, NPSCMP, DMCSA Kano State, LMCU Kano State, MoH Lagos)

South Africa – Country overview

- **Population:** 56 Million (2016)
- **GNI per capita, PPP:** 5,480 (2016)
- **Life expectancy:** 62 years (2015)
- **Total fertility rate:** 2.5
- Health expenditure (2014):
  - 4.2% of GDP (public)
  - 48% public

Disease burden:

- Neonatal mortality rate: 12 per 1000 live births
- Maternal mortality ratio: 138 per 100,000 live births
- Malaria incidence: 3.1 cases / 1,000 people at risk
- Tuberculosis incidence: 781 cases / 100,000 people at risk
- HIV prevalence: 18.9% of population ages 15-49

Major donors:	Annual budget (rough estimate)	Procurers
GFATM	• $33M[1] (2014-17 avg)	• SA government

Remainder of commodity procurement is domestically funded

1 Global Estimates based on 40% of grant disbursement
Sources: World Bank, GFATM

South Africa – Key Observations

	Highlights
Funding	• Donors provide small % of funding (10% for ARVs) but SA does procurement; majority of donor funding is for systems strengthening and there has not been transition discussion • Provinces hold budget and procurement power and may buy outside of national contracts (~5-20%); reports of funds designated to medicines being repurposed inefficiently • Payment delays from gov't crowd out smaller suppliers; also difficult to enforce penalties • Volatility of the Rand impacts local manufacturing as the majority of API is imported
Policy & Regulations	• All products have to be registered with the MCC, which has lengthy processes • Tendering practices give preference to manufacturers who formulate specified products in SA, but local formulators have trouble competing on price, a major factor in tender awards; as a result, a lot of FPP is imported even though there is ability to formulate in SA • The Broad Based Black Economic Empowerment (B-BBEE) policy accounts for 10% or 20% of the bid, precluding some international and local suppliers from competing
Strategy & Processes	• SA procurement has sophisticated tendering practices e.g. requiring transparency from manufacturers on pricing; contracting is done nationally • Irrational ordering due to budget and tender cycles adds complexity for demand planning • Lack of communication between programmatic and procurement functions leads to misalignment in rollout of program • Need for increased collaboration between government and suppliers to improve development of local manufacturing industry
Supporting infrastructure & resources	• Inconsistent data and lack of visibility into full procurement spend from provinces and facilities stock levels makes demand planning difficult; a Visibility Analytics Network (VAN), a donor-funded initiative is working to improve data visibility

Sources: Interviews with experts, government officials, donors, and implementing partners (Contract Management Unit, Sector Wide Procurement, GHSC-PSM, GHSC-TA)