



USAID
FROM THE AMERICAN PEOPLE

OPTIONS FOR CONTRACEPTIVE PROCUREMENT

LESSONS LEARNED FROM LATIN AMERICA AND THE CARIBBEAN



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DELIVER

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Abstract

In upcoming years, countries in the Latin America and Caribbean Region will see a gradual decline in donations and technical assistance toward ensuring contraceptive security (CS), which is when people are able to choose, obtain, and use high-quality contraceptives whenever they need them. In light of this trend, governments throughout the region are faced with ensuring the provision of family planning services, including a continuous supply of contraceptives. Several countries, including Bolivia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru, have begun to explore ways to finance and efficiently procure contraceptives for their target populations. This report analyzes the legal and regulatory framework in each of the nine focus countries that may affect future procurement of contraceptive commodities, as well as the current policy environments of five USAID "graduated" countries that are now procuring contraceptives without foreign assistance (namely, Brazil, Chile, Colombia, Costa Rica, and Mexico). Additionally, this report presents country-specific pricing data for contraceptives, providing a comparative analysis of how different procurement policies affect price as well as the large variation in price found among international suppliers. Next, the report illustrates lessons learned from all 14 countries to help improve procurement processes, streamline regulations, and prepare for the eventual phaseout of donations and technical assistance. Careful consideration of these lessons, especially experiences from the five graduated countries, can help governments prepare to efficiently procure their own contraceptives in the long run. Finally, taking into account analyses presented in this report and the various levels of efficiency and procurement capacity of each of the nine focus countries, the final section presents a series of recommendations and outlines different options that each country may implement to improve access to contraceptives and realize potentially significant cost-savings.

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ACRONYMS

ADOPLAFAM	<i>Asociación Dominicana de Planificación Familiar, Inc.</i> (Dominican Republic family planning association, a nonprofit organization)
ANVISA	National Health Surveillance Agency (Brazil)
APROFA	<i>Asociación Chilena De Protección De La Familia</i> (Chilean family planning association, a nonprofit organization)
ARV	antiretroviral
BEMFAM	<i>Bem-Estar Familiar no Brasil</i> (Brazilian family planning association, a nonprofit organization)
CAFTA	Central American Free Trade Agreement
CBD	community based distribution
CCSS	<i>Caja Costarricense de Seguro Social</i> (Costa Rican Social Security Institute)
CEDPA	Center for Development and Population Activities
CENABAST	<i>Central de Abastecimiento</i> (Chilean national procurement agency for the National Health Service)
CGRL	<i>Coordenação Geral de Recursos Logísticos</i> (Brazilian General Coordination of Logistics Resources)
CIF	Cost Insurance Freight
CIPS	<i>Centro de Insumos Para la Salud</i> (Nicaraguan MOH Central Warehouse)
COFEPRIS	<i>Comisión Federal para la Protección contra Riesgos Sanitarios</i> (Mexican Federal Commission for Protection against Sanitary Risk)
CONECTA	USAID-funded project to improve programs for reproductive health, child survival and against HIV/AIDS in the Dominican Republic. Executed by Family Health International, with collaboration from Abt Associates and ALEPH
CPR	contraceptive prevalence rate
CS	contraceptive security
DAIA	<i>Disponibilidad Asegurada de Insumos Anticonceptivos</i> (Contraceptive Security)
DMPA	depot medroxyprogesterone acetate (generic name for Depo-Provera)
EDL	essential drug list
EMP	Empresa Médica Previsional (Nicaraguan Provisional Medical Supplier)
EXO	USAID Executive Office
FDA	Food and Drug Administration
FIM	<i>Farmacia Institucional Municipal</i> (Bolivian Institutional Municipal Pharmacy)
FOB	free on board
FP	family planning
GMP	good manufacturing practice
HAI	Heath Action International
IAPSO	Inter-Agency Procurement Services Office
IBRD	International Bank for Reconstruction and Development (World Bank)
ICB	International Competitive Bidding
ICPD	International Conference on Population and Development

IDA	International Dispensary Association
IDB	Inter-American Development Bank
IESS	<i>Instituto Ecuatoriano de Seguro Social</i> (Ecuadorian Social Security Institute)
IGSS	<i>Instituto Guatemalteco de Seguro Social</i> (Guatemalan Social Security Institute)
IMSS	<i>Instituto Mexicano del Seguro Social</i> (Mexican Social Security Institute)
INSS	<i>Instituto Nicaragüense del Seguro Social</i> (Nicaraguan Social Security Institute)
IPPF	International Planned Parenthood Federation
IPS	<i>Instituto de Previsión Social</i> (Paraguay Social Security Institute)
IRP	International Reference Price
ISP	<i>Instituto de Salud Pública</i> (Chilean Institute of Public Health)
IUD	intrauterine device
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean
MERCOSUR	<i>Mercado Común del Sur</i> (Southern Common Market)
MEXFAM	<i>Fundación Mexicana para la Planeación Familiar</i> (Mexican family planning nonprofit organization)
MINSA	<i>Ministerio de Salud</i> (Peru Ministry of Health)
MOH	Ministry of Health
MOP	Ministry of Planning
MOU	Memorandum of Understanding
MSPAS	<i>Ministerio de Salud Pública y Asistencia Social</i> (El Salvador Ministry of Public Health and Social Assistance)
MSPBS	<i>Ministerio de Salud Pública y Bienestar Social</i> (Paraguayan Ministry of Health and Social Well-Being)
MUDE	<i>Mujeres en Desarrollo Dominicana</i> (Dominican Republic nonprofit organization)
NAFTA	North American Free Trade Agreement
NGO	nongovernmental organization
OTS	Order Tracking System
PAFIE	Program of Assistance with Pharmaceutical and Strategic Supplies (Brazil)
PAHO	Pan-American Health Organization
PATH	Program for Appropriate Technology in Health
PROFAMILIA	<i>Asociación Pro-Bienestar de la Familia Colombiana</i> (Colombian family planning association, a nonprofit organization)
PROFAMILIA	<i>Asociación Dominicana Pro-Bienestar de la Familia</i> (A Dominican family planning association, a nonprofit organization)
PROMESE	<i>Programa de Medicamentos Esenciales</i> (Dominican Republic Program of Essential Medicines)
PSI	Population Services International
RH	reproductive health
RHC	reproductive health commodity
RHI	Reproductive Health Interchange
RTI	Research Triangle Institute

SABS	<i>Sistema de Administración de Bienes y Servicios</i> (Bolivian Goods and Services Administration System)
SAFCO	<i>Sistema integrado de administración financiera y control gubernamental</i> (Bolivian integrated system for finance administration and government control)
SDPs	service delivery point(s)
SESPAS	<i>Secretaría de Estado de Salud Pública</i> (Dominican Republic Ministry of Health)
SIBASI	<i>Sistema Básico de Salud Integral</i> (El Salvador Regional level of the MOH—Basic System for Integrated Health)
SICA	<i>Sistema de Integración Centroamericana</i> (Central American Integration System)
SISMED	<i>Sistema de Suministro de Medicamentos</i> (Peruvian Medical Supply Purchasing System)
SLI	Standard of Living Index
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SSA	<i>Secretaría de Salud</i> (Mexican Secretary of Health)
SUMI	<i>Seguro Universal Materno Infantil</i> (Bolivian Universal Maternal-Infant Insurance)
SUS	Unified Health System (Brazil)
SWAp	sector wide approach
TB	tuberculosis
TLC	<i>Tratado de Libre Comercio</i> (Free Trade Agreement)
UFV	<i>Unidad de Fomento de Vivienda</i> (Bolivian unit of account linked to inflation)
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VAT	value-added tax
WHO	World Health Organization

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The report is based on information about procurement regulations and laws, as well as on actual contraceptive prices, collected from June 2005 through March 2006 in nine countries: Bolivia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru. This regional procurement practices and options report is available in English and Spanish, as are the individual country reports. All of the documents, including the full country assessment reports, are listed in the references for this document and may be obtained directly from DELIVER and the USAID | Health Policy Initiative. Summaries of the country assessment reports can be found on the DELIVER and Health Policy Initiative websites (www.deliver.jsi.com and www.healthpolicyinitiative.com).

1. The POLICY Project ended June 30, 2006. Work on this activity continued under Task Order 1 of the USAID | Health Policy Initiative, implemented by Constella Futures.

EXECUTIVE SUMMARY

INTRODUCTION

Rapidly scaling up procurement capacity in Latin America and the Caribbean

Contraceptive security is said to exist when people are able to choose, obtain, and use high-quality contraceptives whenever they need them.

As donors begin to phase out donations to countries in Latin America and the Caribbean (LAC), governments are taking increasing responsibility for contraceptive procurement. This report summarizes experiences and valuable lessons learned while facing new procurement challenges in 14 countries in the LAC region, including nine United States Agency for International Development (USAID) presence countries (Bolivia, the Dominican Republic, Ecuador,² El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru) and five countries that no longer receive technical assistance or donations for contraceptive procurement (Brazil, Chile, Colombia, Costa Rica, and Mexico).

In addition to this regional summary, DELIVER and POLICY have developed nine reports detailing conditions in countries where USAID continues to have a presence or receive technical assistance, five reports from USAID-graduated countries, and two annexes summarizing procurement regulations and practices in LAC.

Governments in LAC have the common goal of achieving sustainable contraceptive security (CS) for their citizens. While rapidly scaling up their procurement capacity, these countries have faced a multitude of challenges in obtaining quality contraceptives in the most efficient and cost-effective manner possible. The wide array of experiences, challenges, and solutions implemented in each country provide important lessons for the region on how to strengthen CS through improvements of the procurement process.

The ultimate purpose of this report is to identify options for strengthening and ensuring sustainable CS by improving legal and regulatory environments and providing options for the efficient procurement of high-quality contraceptives in countries throughout the region.

LEGAL AND REGULATORY ANALYSIS

Restrictive procurement laws but creative solutions

2. Ecuador is included in the list of USAID-presence countries, because, although it has been graduated from health programs, it continues to have other USAID-funded activities. Through this project and others, Ecuador has recently received some technical assistance from USAID for health programs.

Wide variety of prices both within and between countries and subregions

All of the countries studied have made both legal and financial commitments to ensure that their citizens have access to family planning services when they need them. Some countries have gone further than others by earmarking funds (such as in Guatemala, El Salvador, Paraguay and Peru), providing legal protection for ensuring a budget line for contraceptives (such as in Ecuador), and including contraceptives on essential drug lists (EDLs).³ Some of these countries have developed their procurement capacity by designing and implementing public sector-funded strategies for purchasing contraceptives (Peru, Honduras, the Dominican Republic, El Salvador, Ecuador, and Guatemala), while others are just beginning to devise procurement strategies and continue to receive donations on behalf of their citizens (Nicaragua, Bolivia, and Paraguay).

The legal and regulatory environments in these countries are often complex and restrictive when procurement involves the use of public funds: some favor contracts to benefit local producers (most of the USAID-presence countries) or impose taxes that make imported goods expensive (Peru and El Salvador); others allow slightly more flexibility for procurement agents to explore prices in local and international markets.

In an effort to streamline procurement processes and gain access to lower-priced commodities, most countries have adopted a centralized system in which a single agency is responsible for acquiring or negotiating a bulk price for contraceptives to be distributed throughout the country. Other countries, like Bolivia and Ecuador, have decentralized health management and procurement, respectively.

Similarly, to obtain quality commodities at a good price, despite restrictive legal frameworks, many countries have exceptions that, in some cases, allow the public sector to purchase contraceptives from international organizations, such as the United Nations Population Fund (UNFPA). This option preserves principles of efficiency and transparency throughout the procurement process while giving countries access to economies of scale, lower prices, and quality commodities.

PRICING ANALYSIS

Experience in prices obtained through public procurement has been mixed. Countries such as Chile, Costa Rica, and Peru have obtained prices at or even below international reference prices (IRPs), in some cases lower than prices paid by donors, by buying generic rather than brand items. Other countries have done less well. In Brazil, the more restrictive and closed domestic market combined with governance concerns, including issues related to transparency, has contributed to high prices. In Ecuador, decentralization has contributed to lower purchase volumes and higher prices paid to local suppliers.

By using international organizations as procurement agents and accessing international markets, countries have managed to obtain quality generic contraceptives at internationally competitive prices. For instance, several countries have achieved dramatic savings by procuring through UNFPA (Peru, the Dominican Republic, and El Salvador). In El Salvador, for example, these savings were estimated at approximately U.S.\$3 million per year in 2004 and 2005. Nevertheless, there are also costs associated with using this mechanism, including the cost of distribution because UNFPA delivers at the central level; the need to pay upfront; and the cost of delays when procurements are not planned well in advance.

Those countries that are the most informed throughout the buying process have been able to obtain the most competitive prices (Chile, Costa Rica, Peru, and El Salvador). For instance, following extensive market research

3. All nine USAID-presence countries include contraceptives on their EDLs except Paraguay and, for some products, Ecuador.

and price comparisons, Peru procures some contraceptive methods from UNFPA, while procuring others from private suppliers such as Pfizer (for injectables delivered to the district level) and ESKE/FamyCare (for oral contraceptives).⁴ Similarly, in 2005, El Salvador procured condoms from a local supplier because there was not a significant price difference from UNFPA and, at the time, the Ministry of Health (MOH) did not have the funds to procure all methods at once. Costa Rica has established a similar practice of relying on multiple sources for contraceptives.

In addition, some countries have realized significant savings on the purchase of high-quality products by allowing a centralized agency to negotiate procurements on behalf of health facilities throughout the country. By centralizing these purchases or negotiating prices for a larger volume of products, countries are able to obtain bulk rates.

There are considerable variations in prices paid for the same contraceptive method by the public and nongovernmental organization (NGO) sectors in each country. This disparity suggests the need for greater coordination and exchange of information. Furthermore, there are published recommended retail and wholesaler prices for a wide range of pharmaceuticals, including contraceptives in several South American countries.⁵ This helps to ensure that prices in the private sector do not vary considerably among different regions of a country or different neighborhoods within a municipality. Published prices were not obtained in Central America, and greater variation was observed in prices for individual methods both between and within countries.

An analysis of contraceptive prices in the private sector shows large variations across the region and even within each subregion. These variations are partly explained by differential pricing as international suppliers adjust their supply prices according to the different socioeconomic situation in each country. They are partly due to the restrictive nature of the procurement regulations, with prices (commercial margins) tending to be higher in the Central American countries that have the most restrictive procurement regulations and the least competitive commercial sectors. The larger more economically developed Andean countries appear to have lower retail prices for hormonal methods. These price variations across countries demonstrate the need for more information sharing among countries about prices being paid for contraceptives.

In sum, contraceptive are being procured at a wide variety of prices in the public and private sectors. There is significant scope for countries to streamline the procurement process, build the capacity necessary, and tap into international sources to obtain lower prices.

LESSONS LEARNED

Wealth of diverse experience in contraceptive financing, procurement, and distribution

The 14 Latin American countries reviewed for this study have their own unique set of economic, health, and development conditions; regulations; and institutions. They are characterized by diverse and valuable experiences in contraceptive financing, procurement, and distribution. Enough similarities exist among the countries to suggest that lessons can be learned from the region. Further, USAID-graduated countries provide important perspectives on strengthening contraceptive procurement mechanisms without donor assistance, through both their successes and shortcomings.

4. In the Pfizer case, Peru was willing to pay a premium over what it could have obtained from UNFPA to get the product distributed to the district level. The ESKE/FamyCare costs were lower than UNFPA. Recently, however, UNFPA has negotiated a Most Favored Customer arrangement whereby FamyCare agrees that if it offers the same goods under the same market conditions to another party, it will make that pricing available to UNFPA. Situations such as the Peru example may still occur under differing market conditions.
5. Price data were obtained from reference manuals, where available, and through personal interviews between DELIVER staff/consultants and official representatives for the different sectors in each country. See the references for a list of price manuals (FarmaPrecios).

Experience from various countries in the region suggests that they must consider the following lessons to institute an effective procurement system:

- **Strengthen procurement management capacity to ensure efficiency.** Better management requires improvements throughout the procurement cycle. It begins with identifying and quantifying product requirements, including a budget review and approval process; a tender process that is either international or national, depending on the circumstances; a tender evaluation process and a post-tender contract management process; and a quality assurance process to ensure that only products meeting the requirements are accepted for delivery.
- **Increase procurement transparency through good governance, management oversight, and public accountability.** A number of strategies have been adopted, including using independent procurement agents (Peru, El Salvador, the Dominican Republic, and Honduras); establishing autonomous agencies to manage the procurement process (Chile and Costa Rica); separating procurement responsibility from quality control (Chile and Costa Rica); relying on external entities to audit the procurement process (Chile); and establishing clear and open information flows (Chile, Costa Rica, and Guatemala).
- **Implement regulations that allow unrestricted access to supplies from different sources, and institute centralized procurement, which will result in high value for money.** Adopted strategies include comparing prices (El Salvador and Peru, although their processes are neither comprehensive nor systematic); informed buying (Peru and Costa Rica); negotiating with manufacturers (Peru); ensuring that budgets are funded at optimal time intervals to reduce cost; ensuring that the procurement process is independent of political considerations (Chile); and removing regulatory barriers so countries have access to competitive prices.

Strategies also include engaging in pooled procurement. The closest example of a regional pooled procurement model is the Eastern Caribbean Drug Service, under which the MOHs from nine separate islands pool their procurement of class A and B essential drugs. This service has achieved financial sustainability through an administrative fee, and has allowed member countries to gain significant savings. None of the countries in the analysis currently engage in regional pooled procurement, but Central America and the Southern Common Market—*Mercado Común del Sur* (MERCOSUR)—countries have taken important steps toward facilitating this model in the future.

- **Strengthen technical quality assurance capacity and access to testing laboratories to ensure safe and efficacious methods.** Quality control for contraceptives and medicines needs to be regulated throughout the procurement process: manufacturers should be prequalified; tenders should be correctly specified; drug registration should support public safety but should not create a barrier to supply (e.g., through regional drug registries); countries should conduct pre- and postshipment inspection and quality testing, either through their own laboratories or through regional or international laboratories; and procurement contracts should hold manufacturers liable for failed shipments and for disposing of failed lots of contraceptives.

In addition, challenges that have arisen in graduated countries following donor phaseout relate to the preparation of adequate financial and procurement phaseout plans: (1) Mexico decentralized the procurement responsibilities for contraceptives to the state level after USAID's departure, causing frequent stockouts, because most states were unprepared and unfamiliar with how to forecast, plan, and budget for their contraceptive needs; (2) nonprofits can be vulnerable to donor phaseout when they do not fully comprehend or believe USAID's, or other donors', intentions to end support (e.g., the *Asociación Chilena De Protección De La Familia* [APROFA] in Chile), or when they are prematurely forced to implement user fees to become sustainable (e.g., the *Fundación Mexicana para la Planeación Familiar* [MEXFAM] in Mexico and APROFA in Chile). Nevertheless, some NGOs, such as *Bem-Estar Familiar no Brasil* [BEMFAM] in Brazil and *Asociación Pro bienestar de la Familia Colombiana* (PROFAMILIA) in Colombia, were able to implement effective strategies for marketing, innovation, and fundraising and have thrived following donor phaseout.

PROCUREMENT OPTIONS

Range of options exist for countries at any stage of development—efficient procurement requires sustained effort, informed decisions, and active public participation to ensure accountability.

Ideally, public procurement should be efficient, transparent, and provide value for money while safeguarding quality and public safety. Based on the pricing and regulatory analyses, several key options have been identified to improve effectiveness, transparency, and efficiency of contraceptive procurement strategies in the region. These options have been grouped according to short-term, medium-term, and long-term phases, as countries in various stages of development toward sustained CS have differing priorities and face differing challenges.

SHORT-TERM OPTIONS:

- Develop long-term financial and procurement plans for eventual phaseout of USAID-donated contraceptives.
- Develop the ability to accurately forecast national contraceptive needs, prepare and carry out procurement plans, place orders in a timely manner, and efficiently distribute commodities to all levels.
- Consider working with UNFPA as a procurement agent while domestic procurement capacity is being developed and regulatory barriers are being addressed, and take steps to formalize this relationship (i.e., implement a memorandum of understanding).
- Include expanded method mix in Essential Drug Lists (EDLs) and harmonize drug list for all public sector providers.

MEDIUM-TERM OPTIONS:

- Develop procurement capacity, including the ability to access competitive prices, forecast, order, and distribute at all public sector levels.
- Monitor UNFPA performance and continue to refine and formalize this relationship.
- Establish a protected budget line item or find creative ways of ensuring sustained funding for contraceptive commodities.
- Begin to explore the option of informed buying by promoting the use of price comparison tools to identify and select the best purchase options.
- Identify and implement a mechanism through which different countries can share their reference prices.
- Enter into negotiations with new sources of supply, including UNFPA or other lower price providers such as NGOs and good manufacturing practice (GMP) generic manufacturers.⁶
- When conducting decentralized procurement, ensure that price negotiations are consolidated at the central level to capitalize on the benefits of national economies of scale.

6. GMPs are developed at both the company and industry levels. They may include a variety of practices that ensure quality, including quality assurance for raw materials; record keeping of substances throughout the manufacturing process; standards for cleanliness and safety; qualifications of manufacturing personnel; in-house testing; production and process controls; and warehousing and distribution.

- Examine the scope for addressing restrictive regulatory environments.
- Make a case for exempting contraceptives purchased by the public sector from value-added tax (VAT) and duties.

LONG-TERM OPTIONS:

- Strengthen procurement capacity to enable staff to conduct informed buying, contract management, tendering, and competitive bidding.
- Eliminate regulatory barriers that impede access to low-priced, quality reproductive health commodities (e.g., unnecessary tariffs, limits on access to a range of suppliers, bureaucratic delays throughout the procurement process, VAT on contraceptives).
- Strengthen quality control mechanisms and develop capacity to guarantee effective and independent testing of contraceptives.
- If a government does not have the capacity to guarantee effective, independent testing of contraceptives, conduct limited biddings, inviting only manufacturers that are prequalified by UNFPA, the World Health Organization (WHO), and the United Nations Children's Fund (UNICEF).
- Devise strategies for ensuring transparency throughout the procurement process, including making price and source information publicly available.
- Develop a regional information system that regularly provides up-to-date price and provider information to be used throughout the procurement decision-making process.
- Take steps to facilitate pooled procurement at the regional or subregional level.
- When procuring at a decentralized level, ensure that qualified procurement staff are available at levels that have the capacity and funding necessary to effectively forecast their own needs; procure in a timely manner; access low-priced, quality commodities from reliable providers; and efficiently distribute sufficient quantities to all levels.

Details on the strategies being adopted by different countries in the region are elaborated throughout the text and in the more detailed country reports.

INTRODUCTION

OBJECTIVE AND APPROACH

For more than three decades, countries in Latin America and the Caribbean (LAC) have relied on donations from international agencies such as the United States Agency for International Development (USAID) to meet the contraceptive needs of their populations. These donations are now being phased out: Peru and Ecuador are no longer receiving contraceptives from USAID, and Guatemala, El Salvador, and the Dominican Republic will stop receiving them in the very near future. Financing and procuring contraceptives will soon become the responsibility of all national governments in the region.

USAID uses direct contracts to purchase the contraceptives that it donates to countries. Because funding for donated contraceptives does not come from the recipient country’s treasury, procurement by USAID and other international donors is not restricted by national laws. As governments take over the responsibility of procuring contraceptives, however, each country will need to consider its own national laws and norms that regulate the procurement of goods and services with public sector funds.

The objective of this study is to assess the impact of different procurement regulations on the price of contraceptives in the LAC region and to identify viable strategies for countries to adopt in ensuring sustainable access to lower priced, quality contraceptives in sufficient quantities. This analysis has involved the collection of quantitative and qualitative information on procurement and other relevant regulations and on the prices of contraceptives by method and source at the central level and at selected regional sites. Fieldwork was conducted by a joint DELIVER-POLICY team in nine USAID-presence countries: Bolivia, the Dominican Republic, Ecuador,⁷ El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru.

In addition, DELIVER and POLICY conducted an analysis of procurement procedures and policies in Brazil, Chile, Colombia, Costa Rica, and Mexico, where USAID Population Assistance has been phased out. The experiences of these countries can serve as important lessons for the nine countries that are preparing for the phaseout of population support from USAID.

The legal and regulatory portion of this analysis examines country-level laws, regulations, and policies that affect the purchase of medicines, including contraceptive commodities, with the objective of assessing the feasibility of using different procurement mechanisms available in the region. Special attention was paid to national procurement laws that regulate the purchase of goods and services with public sector funds. The analysis focused not only on the written law, but also on actual procurement practices within the legal and regulatory framework.

The pricing analysis involved the collection of price information for a wide range of contraceptive methods at various levels of the distribution system and from different sources in each country. This facilitated comparisons of unit prices available across sectors within a country and across countries at a given point in time. These price

Contraceptive security (CS) is said to exist when people are able to choose, obtain, and use high-quality contraceptives whenever they need them. Improving the efficiency and effectiveness of procurement is central to strengthened CS in the LAC region.

7. Ecuador is included in the list of USAID-presence countries, because, although it is considered a graduated country in terms of health and family planning, Ecuador has recently continued to receive some technical assistance in health from USAID.

comparisons and accompanying analyses can help policymakers understand the factors that contribute to different contraceptive prices, as well as identify opportunities to save scarce resources by changing contraceptive procurement sources and mechanisms.

This study highlights similarities and differences in the legal and regulatory framework and contraceptive prices across countries. It is intended to provide governments, social security institutes, and nongovernmental organizations (NGOs) with the information necessary to identify procurement mechanisms that are legally viable and result in the timely availability of low-priced, high-quality contraceptives. It can also help policymakers determine how changes in the legal and regulatory environment, pricing policies, and procurement mechanisms can result in better contraceptive prices, thereby improving access, availability, affordability, and equity in the contraceptive market. More detailed country reports have been produced for the nine USAID-presence countries, along with reports for the five USAID-graduated countries.⁸

METHODOLOGY

Following is a summary of the methodology used in this two-part study:

1. **Legal and Regulatory Analysis**—data collection in each country consisted of three phases:

- Review of country-level CS assessments and market segmentation analyses conducted by POLICY and DELIVER.
- Review and analysis of laws and norms related to family planning (FP) and reproductive health (RH), particularly those that affect the procurement of medicines and contraceptives.
- In-depth interviews with key informants with experience in procuring medicines and contraceptives in the public sector, including the Ministry of Health (MOH) and Social Security Institute, international agencies such as USAID and United Nations Population Fund (UNFPA), and NGOs.

2. **Pricing Study**—data on import prices, namely, Cost Insurance Freight (CIF);⁹ costs incurred in clearing customs; and transportation to central warehouses were collected from government procurement units, UNFPA, NGOs (including social marketing organizations, private importers, and distributors), and service delivery points (SDPs). In countries with more difficult geographic access, cost of transport/distribution to SDPs was factored into the analysis. Retail prices, including pharmacy and distributor margins, were also collected.

The pricing study adopted a methodology developed by the World Health Organization (WHO) and Health Action International (HAI).¹⁰ The methodology was used to record contraceptive prices at client, wholesale (or regional), and central levels in the public sector; describe how “price components” (e.g., taxes, distribution/transportation costs) affect prices; and reveal price variations between products, including brand-name and generics.

For price comparisons to be meaningful, they need to compare the same product, in the same quantity, at the same point in the supply chain, at a given point in time, and, if possible, in similar geographic locations. For the purpose of this analysis, we are comparing unit prices at similar points in the supply chain, across countries, and across sectors within the same country. Price differences reflect the influence of, among other things, national and local procurement policies and laws and their application; differences in taxes and tariffs; national and local transportation and supply chain costs; and pricing policies of international suppliers and local distributors.

Table 1 summarizes common terms used to describe prices at different points in the supply chain:

8. All of the citations for these documents are listed in the References section for this document and may be obtained directly from the JSI/DELIVER and Constella Futures/USAID | Health Policy Initiative projects (www.deliverjsi.com, www.healthpolicyinitiative.com).

9. See table 1 for definitions of common terms used to describe prices at different points in the supply chain.

10. The World Health Organization (WHO), Health Action International (HAI). *Medicines Prices: A New Approach to Measurement*. Geneva, Switzerland: WHO/HAI; 2003.

TABLE I. PRICING TERMINOLOGY

Price/Cost	Definition	Observation
Ex factory	The price of a commodity as it leaves the factory gate, including all manufacturing costs and manufacturer's profit.	Not used in this study except for local Brazilian manufacturers.
FOB	Free on board—the cost of the commodity loaded onto the ship or aircraft at the port of origin in the manufacturer's country before being shipped.	Most suppliers quote CIF rather than FOB prices.
CIF	Cost insurance freight—the cost of the commodity, including the cost of insurance and transport to the port of destination or entry.	Obtained for public and NGO supply chains but not always for private supply chains because of commercial sensitivity.
Customs tariffs	Tariffs usually applied by customs on the declared CIF value of the commodity given on the bill of lading, the official invoice document accompanying the shipment. The tariff rate applied can vary from country to country and between products within a country. Other taxes can also be levied on imports as de facto tariffs.	Tariffs are levied on contraceptives in Bolivia, Brazil, El Salvador, the Dominican Republic, Paraguay, and Peru, although several countries exempt donations and sometimes purchases by the public sector.
Other port clearance charges	These charges include port handling and warehousing charges, agent's fees, and other costs in getting the commodities through customs and the port.	We provide information on comparative port clearance costs.
Ex port price	Usually accumulated costs incurred in getting the commodities out of the port of entry.	CIF plus customs tariffs plus port clearance costs.
Warehousing costs	Both public and private supply chains typically order in bulk, consolidating the commodities in a central warehouse before picking out individual items for an order; packing them, and shipping them to the next stage in the supply chain. For social marketing companies, a key cost incurred is the cost of repackaging bulk commodities into retail packing with social marketing messages.	For social marketing, these costs represent an important component. We typically add other social marketing overhead costs here as well. For the public sector, these costs may not be explicit, while for the private sector, they coincide with distribution margins (see below).
Import agent fees	The role of private manufacturers' agents is to facilitate the movement of goods through the port and into the public or private sector supply chain. Agent costs include the actual cost of importation, clearance, warehousing, and transporting to the next level, as well as agency fees and profits. These last two cost elements tend to be larger where there are local regulations requiring the use of agents and where competition is limited.	CIF plus customs tariffs plus port clearance costs plus warehouse costs plus agent's costs plus fees and profit. This fee can also include local transport costs if delivered directly to districts or service delivery points.
In-country transport costs	From the central store to regional or district stores and on to local pharmacies and NGO and public clinics.	Comparative information on transportation costs are available for several countries from the private and NGO sectors but not the public sector.

TABLE I. PRICING TERMINOLOGY (CONTINUED)

Price/Cost	Definition	Observation
<i>Distributor's margins</i>	In larger countries, an intermediate private wholesaler or distributor may be responsible for moving commodities from central to regional locations for onward sale to pharmacies. In the public sector, this function may be fulfilled by regional or departmental medical stores, sometimes with explicit distribution charges being levied. In some supply chains, the central warehousing costs may be part of the distributor's margin.	While several countries have some form of price control, their application is uneven with some variation in distributor and retail margins observed. The more levels within a supply chain, the greater the cumulative effect of these margins on the final price. In-country public sector supply chain costs frequently were not available because few if any public systems assign explicit costs to their supply chains, and a costing exercise was beyond the present scope of work. Where necessary, NGO costs were used as a proxy.
<i>Retail margins</i>	In the private sector, these are the margins pharmacies will charge. In the NGO and public sectors, there may be some cost recovered by the NGO or public clinic.	
<i>Sales price</i>	The final price actually paid by the client for the commodity reflecting all of the above costs.	Small nonrepresentative samples of pharmacies were made to get some perspective on price variation within each country.
<i>UFV</i>	<i>Unidad de Fomento de Vivienda (UFV)</i> is an accounting unit that the Central Bank of Bolivia changes daily to adjust the national currency (Boliviano) for inflation. It facilitates the financing of households and all official actions, including contracts, that require the Boliviano to maintain its value with respect to changes in the rate of inflation. Payments and charges are made in Bolivianos according to the daily UFV.	This unit is used only in Bolivia.

REPORT ORGANIZATION

This report synthesizes the findings on procurement regulations and contraceptive pricing from work in 14 LAC countries. We first present a summary of the regulatory environment, followed by an analysis of the contraceptive procurement options being adopted across the region. Next, we look at prices for contraceptives in each country and the reasons for variations within and between countries. We then synthesize regional lessons learned from procurement before presenting regionwide and country-specific recommendations in the short, medium and longer term.

LEGAL AND REGULATORY FRAMEWORK

A SUPPORTIVE NATIONAL POLICY ENVIRONMENT

The countries under study have well-established policy frameworks that support the rights of their citizens to plan their families. Constitutions, population policies, RH plans, and health laws include mandates and written commitments that directly or indirectly support FP. All the countries in this report have demonstrated their commitment to supporting FP through concrete actions as well as by providing FP services to the poorest and most vulnerable segments of their population. Additionally, all have adhered to or ratified various international declarations and treaties—including the Millennium Declaration, the Convention on Elimination of Discrimination against Women, and the 1994 International Conference on Population and Development (ICPD) Programme of Action—that clearly establish citizens’ rights to health, particularly maternal-child health, and ensure access to RH services.

These countries consider access to modern methods of contraception an important strategy to improve the general health of their populations, and more specifically, to reduce maternal, perinatal, and infant mortality. The health benefits of FP provide a strong argument in support of governments allocating the funding necessary to procure and distribute contraceptives to all those who need and want them.

PUBLIC SECTOR FUNDING FOR CONTRACEPTIVES

In the face of donor phaseout, some governments, including those of El Salvador, Guatemala, the Dominican Republic, and Peru, have created line items in their national budgets to allocate funding for contraceptive procurement. In 1999 in Peru, an MOH decision to guarantee the financing, purchase, and availability of medicines and inputs necessary to implement their vertical programs (now called “health strategies”) has led to annual budgetary allocations for the purchase of contraceptives. In Paraguay, the government has passed legislation to earmark funds for contraceptives in its national budget. In the meantime, for the first time ever the MOH of Paraguay set aside U.S.\$260,000 for the purchase of contraceptives through UNFPA in 2006. In the Dominican Republic, no formally established mechanisms exist for assigning money for the purchase of contraceptives and the availability of public sector resources is left to the discretion of government officials. In Guatemala, under an agreement with UNFPA, the government set aside public sector funds annually during 2002–06 to create a fund for the purchase and distribution of contraceptives, which will begin in 2007. During this five-year period, UNFPA used funds from Holland and Canada to purchase and donate contraceptives to the MOH. In addition, future funds will come from a tax levied on the purchase of alcoholic beverages, 15 percent of which was set aside by Congress to fund the Reproductive Health Program. In Ecuador, funding for contraceptives for all women of reproductive age is protected and guaranteed under the Law of Free Maternity and Infant Care (*Ley de Maternidad Gratuita y Atención a la Infancia*).

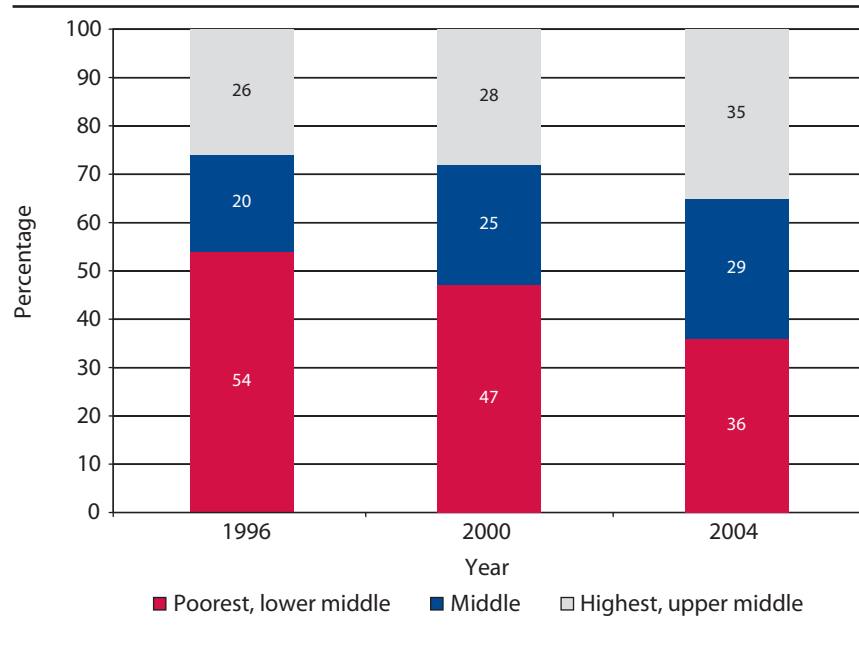
Country	Public sector funding for contraceptives
Bolivia	No
Ecuador	Yes
El Salvador	Yes
Dominican Republic	Yes, at discretion of government officials
Guatemala	Yes, as of 2007
Honduras	Yes
Nicaragua	No
Paraguay	Yes, as of 2006
Peru	Yes
Brazil	Yes, but not earmarked
Chile	Yes
Colombia	No
Costa Rica	Yes, but not earmarked
Mexico	Yes

Despite the fact that some countries in Latin America have budget line items, government commitments, and/or recent practices for allocating money for contraceptive procurement, with the exception of Ecuador, they do not give FP a protected status that would guarantee availability of funding every year. Absent this protected status, funding for contraceptives depends on the discretion of policymakers, the fiscal climate, and the perseverance of skilled family planning advocates.

In Peru, El Salvador, and Guatemala,¹¹ the Social Security Institutes include FP within their basic package of services. Nevertheless, a significant proportion of social security beneficiaries rely on other sources—for example, the private sector and MOHs—for contraceptives. In Nicaragua, although the National Social Security Institute (INSS) includes contraceptives in the basic package, the Provisional Medical Suppliers (EMPs, *Empresas Medicas Previsionales*) do not generally stock supplies and therefore do not generally offer FP to affiliates or their beneficiaries. Although the INSS covers 11 percent of the population, 43 percent of INSS’s eligible beneficiaries obtain their FP methods from the MOH at no charge.¹² In El Salvador in 2002, for example, only 51 percent of women (ages 15–44) covered by social security went to social security facilities for their contraceptives, while more than 25 percent obtained contraceptives from the Ministry of Public Health and Social Assistance (MSPAS, Ministerio de Salud Pública y Asistencia Social).¹³ In addition, the Social Security Institutes in Paraguay and the Dominican Republic do not provide contraceptives to their beneficiaries on a regular basis, and their supplies depend largely on MOH donations. To achieve CS, governments need to ensure that sufficient public sector resources are available. Using public resources has the potential to improve equity if those resources are used to provide basic services to the neediest populations. Achieving these equity goals requires that emphasis be placed on improving the segmentation of contraceptive markets, MOHs targeting their resources to serve the poor, Social Security Institutes being responsible for their beneficiaries’ FP needs, and those with the ability to pay for services obtaining contraceptives from NGOs or the private commercial sector.

Often, limited public sector resources are unfairly consumed by individuals who have a greater ability to pay. For instance, a comparison of Peruvian MOH clients by standard of living index (SLI) quintile between 1996 and 2004 indicates that women with a greater ability to pay have benefited disproportionately from free MOH contraceptives. The proportion of MOH FP clientele from the two lowest quintiles declined by 7 percent between 1996 and 2000 (see figure 1), while use by women from the upper middle and wealthiest quintiles (the nonpoor) increased by 2 percent. Between 2000 and 2004, these trends

Figure 1. Family Planning Client Profiles in Peru’s Ministry of Health, 1996–2004



11. In Guatemala, FP was reinstated within the basic package of services provided by the IGSS in September 2005. Between 2003 and 2005, the FP services provided by the IGSS were restricted to postpartum women for a period of 30 days.

12. Comité de la Disponibilidad Asegurada de Insumos Anticonceptivos de Nicaragua (DAIA), John Snow, Inc./DELIVER. Abramson, Wendy B., Sharon Soper, Leslie Patykewich, Ali Karim, David Sarley. 2005. Estudio de la Segmentación del Mercado de Nicaragua. Arlington, Virginia: John Snow, Inc./DELIVER para la Agencia de los Estados Unidos para el Desarrollo Internacional.

13. POLICY Project. Segmentación de mercado de la planificación familiar en El Salvador, June 2005.

continued, with the poorest and lower middle quintiles representing only 36 percent of MOH clientele, and the upper middle and wealthiest quintiles increasing to represent 35 percent of the MOH clientele.

To maintain a healthy and growing private sector that can alleviate demands on the limited resources of the public sector, free or subsidized commodities should be targeted to low-income and hard-to-reach populations. The various sectors must coordinate their activities to ensure that all individuals are covered while maintaining an environment in which NGOs and the commercial sector can flourish. Through achievement of better prices and savings from more streamlined procurement, NGOs and the private sector can begin to help cover contraceptive needs in a cost-efficient manner. This will ensure that individuals with a greater ability to pay begin to look to other providers for their commodities, enabling the public sector to focus on the poorest quintiles.

LAWS THAT GOVERN THE PROCUREMENT OF MEDICINES AND CONTRACEPTIVES

All of the countries under study have laws that regulate the purchase of goods and services with public sector funds. The laws apply to all government agencies and institutions, including Social Security Institutes, and to most transactions in which public sector funds are used. The following sections describe these laws, particularly as they pertain to the procurement of medicines, medical supplies, and contraceptives. Ideally, public procurement should be efficient, transparent, and provide value for money while safeguarding quality and public safety. We examine the laws in place against these criteria for good procurement.

PROCUREMENT MODALITIES: FROM PUBLIC TENDER TO DIRECT PURCHASE

National procurement laws clearly establish the modalities to be used for procuring goods with public sector resources. The emphasis in much of Latin America is to protect the public interest by defining procedures that try to reduce potential for corruption. At the same time, an underlying preference promotes local distributors and, in some cases, local manufacturers. Procedures include public tenders (open to all providers), restricted tenders (in which smaller numbers of providers are invited to participate), and direct contracts with a specific provider. The most common procurement mechanism that governments use to purchase medicines is the public tender, which is a long, multistep process that is often limited to local suppliers. In certain circumstances, however, governments can circumvent the public tender process; these instances are discussed in the next section. Direct purchase through a specific provider generally can be used only if there is a patent in effect, if a tender has yielded no viable options, or in the case of a public health emergency (e.g., stockout of supplies).

EXCEPTIONS TO PUBLIC TENDER

There are several general exceptions to the use of public tenders for the purchase of goods with public sector funds. In all the countries—except the Dominican Republic—government purchases made within the context of international or multilateral agreements, contracts, or treaties, and with funding from loans or external sources (donations or otherwise), do not fall under the jurisdiction of public sector procurement laws. Most of the countries also allow for exceptions in emergency situations. In addition, in Paraguay, El Salvador, Nicaragua, Honduras, and Bolivia, transactions between public entities fall outside the purview of this law, thus facilitating pooled (joint) procurement of medicines and contraceptives by the MOH at the central level or for health facilities at the decentralized level.

Exceptions to public tender—

- Purchases in the context of international/multilateral agreements and contracts (all countries but the Dominican Republic)
- Purchases made with funding from loans or external sources (International Development Bank, World Bank)
- Emergency situations (all countries)
- Transactions between public entities (Paraguay, Nicaragua, Honduras, El Salvador, Bolivia)
- Clear price advantage (Nicaragua, Paraguay).

In Paraguay, the government can circumvent public tenders for “technical reasons.” In Nicaragua, purchases related to “public interest” can also avoid public tenders. In the short term, these exceptions have potentially practical implications for contraceptive procurement in both countries because they permit direct purchases to obtain better commodity prices. In the long run, these exceptions could provide justification for revising the law and formalizing the option to circumvent public tenders when better priced, quality commodities can be obtained.

In Guatemala, public sector health establishments procure medicines through a prequalification mechanism, which does not require public tender. Under this mechanism, health establishments that belong to the Ministries of Health and Defense and the Guatemalan Social Security Institute (IGSS, *Instituto Guatemalteco de Seguro Social*) can directly purchase medicines and medical and surgical supplies from a short list of prequalified providers at preset unit prices based on guaranteed future bulk procurement. The providers are selected annually by the Contracts and Procurement Office in the Ministry of Finance through a competitive bidding process, in which international and national providers are eligible to participate, on the basis of product quality, ability to meet technical specifications and quantity requirements, and price. Technically, contraceptives could be purchased through this mechanism; however, at present, the MOH plans to continue to purchase contraceptives through UNFPA.

Regardless of the mechanism or exception used, all medical products being offered must be registered in all countries, which is a necessary although often time-consuming process, to ensure that the product is effective, safe, and of good quality. It is important to note that the registration process, while a necessary step, can often be used to favor special interests or give unfair preference to select providers. An important element of effective procurement includes a transparent, efficient, and accountable registration process.

INTERNATIONAL TENDERS AND PROCUREMENT: A LEGALLY VIABLE OPTION?

There is a clear bias toward procuring goods and services from local suppliers in all of the countries. Procurement laws in Peru, Nicaragua, and the Dominican Republic do not mention international tender as an option within the provisions of the law. In the other six countries (El Salvador, Paraguay, Guatemala, Ecuador, Bolivia, and Honduras), international tenders and procurement are legal under special circumstances and conditions. In El Salvador, the government can issue an international tender if “the nature and specialty of the goods” justifies it. Even under these circumstances, however, the law treats an international supplier’s medical products like those of local suppliers, requiring them to be registered within the country, which can cost up to U.S.\$700 and take three to six months. In Paraguay, the law permits international tenders if market studies indicate the absence of local suppliers for a specific product or if international suppliers can offer prices that are **at least 10 percent less** than their local suppliers. The law also establishes a preference for local products by requiring that international suppliers have at least five years of local representation in the country. Similar to Paraguay, Guatemala’s law allows international tender in the absence of local production of the product or on the basis of prices that are **at least 15 percent less** than local prices, after customs fees, tariffs, and insurance costs have been factored in. In Ecuador, there are no apparent restrictions to international procurement. With decentralization, however, each area purchases its medicines locally, and there has been no attempt to explore bulk procurement through local or international tender. In Bolivia, the law permits international tender for purchases that exceed 15 million UFV (which are converted into Bolivianos). However, products with a greater composition of local inputs (labor, raw materials) receive greater price advantages, thereby giving them a competitive edge over international products in a tender process. In Honduras, the original law contained a mechanism that favored national bidders except in the cases of bilateral or multilateral agreements or when a project was supported with external funds. Before the Central American Free Trade Agreement (CAFTA), to

While national procurement laws clearly favor purchase from local suppliers, most countries allow international purchases through UN agencies (UNFPA and UNDP) that serve as procurement agents. UNDP does not negotiate prices, rather it manages the bidding and the general process on behalf of the government. In contrast, UNFPA has procurement contracts with worldwide contraceptive manufacturers.

participate in public tenders, foreign firms were required to act through a local agent (at least 51 percent Honduran owned); this requirement was eliminated when CAFTA went into effect.

Although the legal framework in most of the countries under study does not explicitly prohibit international procurement, the requirements and conditions that international suppliers are expected to follow are restrictive and, at times, prohibitive. Furthermore, regardless of the legality of international tenders, none of the nine USAID-presence countries have public sector experience in directly purchasing medicines or contraceptives on the international market. In Bolivia and Ecuador there are NGOs with experience purchasing contraceptives on the international market.

CONTRACEPTIVES AND THE ESSENTIAL DRUG LIST

The essential drug lists (EDLs) of the MOHs in Peru, El Salvador, Nicaragua, the Dominican Republic, Guatemala, and Bolivia include all hormonal contraceptives. In Peru and the Dominican Republic, the EDLs also include condoms and intrauterine devices (IUDs). In the majority of these countries, the EDLs are restrictive; if the drug/medicine (or contraceptive) is not included on the list, it may not be purchased with government funds. As a result, the inclusion of all contraceptives is vital to ensuring that governments procure them. In Ecuador, the EDL is restrictive in nature and includes only oral contraceptives and IUDs. However, in the case of other contraceptives, the MOH can purchase products that are not on the EDL because the Law of Free Maternity and Infant Care guarantees their availability at SDPs and has a different and wider EDL that includes all contraceptive methods. Ecuador's Social Security Institute (IESS, *Instituto Ecuatoriano de Seguro Social*), does not have similar flexibility and can only purchase those contraceptives named on the national EDL. In Paraguay, neither the EDL for the MOH nor the Social Security Institute (IPS, *Instituto de Previsión Social*) includes contraceptives. Because the Ministry's EDL is not restrictive, this exclusion has not been a barrier to purchasing contraceptives. However, IPS cannot purchase medicines that are not included in its EDL and they can only provide contraceptives to its beneficiaries if they are donated by the MOH.

The inclusion of contraceptives on a country's EDL is an important step to achieving CS, particularly if the list is restrictive. However, a drug's inclusion on the EDL does not in itself guarantee its availability in sufficient quantities in health establishments.

PROCUREMENT PRACTICES AND MECHANISMS

The timely and uninterrupted availability of high-quality contraceptives in the public sector is essential to achieving CS, particularly among those in the lowest socioeconomic quintiles. As donors phase out contraceptive donations in Latin America, governments must prepare to assume responsibility for procuring contraceptives. Price and quality of products are important factors in this process. In addition, the actual capacity of the public sector to procure and deliver contraceptives must be considered when decisions are made about how to improve procurement practices. That said, this document will not address whether in-land transportation and distribution is better handled by a private company already operating within the country or better handled by the MOH. The intent of this analysis was not to gather data on private distribution options, especially because this type of decision will depend on a number of factors, including country infrastructure, government capacity, legal framework, and cost.

PROCURING IN BULK: GOOD FOR EFFICIENCY

A country's ability to obtain the best possible price for a specific product, including medicines and contraceptives, depends in large part on the volume being purchased. El Salvador, Honduras, Guatemala, Peru, and Nicaragua have systems in place for national centralized purchase or centralized price negotiations of medicines for the entire public sector health system, thereby realizing significant economies of scale and associated savings. In Peru, for example, a centralized (pooled) purchase of medicines for vertical health programs in 2003 yielded savings of approximately U.S.\$9.2 million.

In 2003, El Salvador initiated a new process for bulk procurement of medicine for its 27 individual health establishments (SIBASI, *Sistema Básico de Salud Integral*). Before the new system, each SIBASI purchased medicines and supplies using its own budget. Under that system, there were 27 tenders, 27 contracts with vendors, and 27 payments, and no economies of scale. In 2003, MSPAS introduced two new mechanisms for procuring medicines:

- **MSPAS would negotiate prices with suppliers based on the total volume of medicines required by the 27 SIBASI establishments. Each SIBASI would then purchase its own commodities at the negotiated price (one tender, 27 contracts, 27 payments).**
- **MSPAS would use financial resources provided by each SIBASI to undertake one pooled purchase of the total volume of medicines required within the public sector health system (one tender, one contract, one payment).**

Both mechanisms provide opportunities to obtain low prices based on bulk procurement. While these opportunities were successfully used to procure some low-priced generic medicines, bulk procurement of contraceptives tended to include higher priced generic-brand products from local suppliers. Consequently, MSPAS is currently using the option of procuring contraceptives through UNFPA.

Guatemala's prequalification mechanism, described in the previous section, constitutes yet another mechanism through which public sector facilities (Ministries of Health, Defense, and IGSS) purchase medicines at prenegotiated low prices that are based on bulk procurement. Box 1 describes another efficient system of pooled national procurement through the Chilean autonomous purchasing agency (CENABAST, *Central de Abastecimiento*). A similar example is the Nicaraguan Center for Health Supplies (CIPS, *Centro de Insumos Para la Salud*); however, CIPS procures only medicine (not contraceptives) at this point.

The Dominican Republic's Program of Essential Medicines (*Programa de Medicamentos Esenciales*, PROMESE) purchases medicines and supplies for all MOH (*Secretaría de Estado de Salud Pública*, SESPAS) establishments, thereby achieving savings of between 56 and 1,017 percent for individual medicines.¹⁴ However, the Dominican Social Security Institute and the armed forces, which also belong to the public sector, purchase their medicines separately, thereby missing out on an opportunity for even further savings that could be achieved by purchasing through PROMESE. Furthermore, SESPAS directly procures medicines and drugs for special programs, including tuberculosis (TB), vaccines, antiretrovirals (ARVs), and contraceptives.

Procurement of medicines in Bolivia and Ecuador occurs at a decentralized level. For example, in Bolivia, 314 municipalities individually purchase the medicines necessary to provide services under the Universal Mother and Child Health Insurance Law. In Ecuador, purchases take place at the level of the 167 health areas. Because each purchase is small in quantity and noncompetitive in nature, municipalities and health areas both pay very high prices to local suppliers.

PUBLIC SECTOR CONTRACEPTIVE PROCUREMENT MECHANISMS

The MOHs in Guatemala, El Salvador, Peru, the Dominican Republic, Paraguay, Honduras, and Ecuador have used public sector funds to purchase and distribute contraceptives in recent years. In Paraguay, the MOH has supplemented UNFPA and USAID donations by purchasing small quantities of contraceptives each year since 2003 from local suppliers (except in 2005). In Ecuador, contraceptives are purchased by individual health areas from local suppliers.

In general, decentralized procurement without international competitive tendering tends to be the most expensive procurement mechanism, in terms of the average unit purchase price. The smaller scale of these orders, the restriction

14. Sarley, David, Wendy Abramson, Varuni Dayaratna, Jay Gribble, Carlos Lamadrid, Cristian Morales, Nadia Olson, Nora Quesada, and Verónica Siman Betancourt. 2006. *Contraceptive Procurement Policies, Practices, and Options in the Dominican Republic*. Arlington, VA: DELIVER, and POLICY II, for the U.S. Agency for International Development.

on international competition and the consequent oligopolistic position of regional suppliers, and the diseconomies of scale associated with smaller fragmented domestic markets all contribute to higher unit prices.

As a result, countries such as El Salvador, Peru, and the Dominican Republic have taken a different approach. They signed special agreements or memoranda of understanding (MOUs) with UNFPA establishing the agency as a procurement agent, thus enabling them to purchase quality contraceptives at very low prices supplied by reliable sources. This arrangement permits these countries to obtain contraceptives at the competitive prices offered in the international market without having to directly issue an international tender or procure directly from international suppliers, both of which have legal restrictions.

However, one of the more difficult requirements of the UNFPA agreement is that MOHs must transfer the entire payment for the contraceptives being purchased to UNFPA before the actual procurement. Following the transfer, UNFPA proceeds with the procurement. The political will and fiscal ability to commit the necessary sums of money upfront for contraceptives is absent in some countries, making this requirement a potential barrier to bulk procurement through UNFPA. Additionally, UNFPA charges countries a 5 percent administrative fee. Even with these fees, as the price analysis shows later in the report, UNFPA prices are often lower than other available prices.

BOX I. IMPROVING EFFICIENCY AND TRANSPARENCY THROUGH POOLED PROCUREMENT OF CONTRACEPTIVES BY A SEMI-AUTONOMOUS ENTITY

CENABAST is Chile's semiautonomous public agency that manages contraceptive procurement for the Ministry of Health, with decision making and planning done at the decentralized level, but coordinated by the central level. CENABAST purchases contraceptives and essential drugs from local representatives of international companies and local producers and, occasionally, directly on the international market. Given the transparency and high levels of competition in the Chilean economy, local prices are close to international prices. Therefore, international procurement is infrequent. CENABAST procures and distributes contraceptives to 26 regional health authorities, which in turn distribute the commodities to public sector SDPs. In Chile's decentralized health system, district health offices have the latitude to purchase from whichever source offers the best service or price. The fact that all the districts continue to use CENABAST is a testimony to the quality of its service.

CENABAST's procurement process is straightforward, efficient, and transparent. CENABAST receives consolidated information on contraceptive requirements for the entire public sector health system. This information originates at health facilities. Using this information and accompanying technical specifications about necessary commodities, CENABAST calls for bids that may be open to foreign firms, but in most cases are directed only to local suppliers who are preapproved and registered by the Public Health Institute (ISP). These preapproval and registration processes serve as mechanisms of quality control.

CENABAST's procurement management cycle includes nine major steps: (1) once a year the first line facilities submit their commodity needs for the following year to the health district; (2) the health district submits the demands to cover the needs of the health facilities under its jurisdiction; (3) the Women's Program of the Macro-Networks Department, with the Women's Health Department, consolidates the demand; (4) the Women's Program of the Macro-Networks Department with direction from the Women's Health Department sends a memo to CENABAST with all the needed technical specifications to procure the commodities: quantity, reference prices (based on past bids), and estimated delays; (5) CENABAST, with the consolidated demand, calls for bids, which may be open to foreign firms, but in most cases, are only addressed to local firms; (6) ISP—the Public Health Institute—and authorized bidders are invited to participate; (7) ISP ensures that the products are of good quality; (8) CENABAST pays the provider and takes responsibility for distribution to the health services; and (9) health services distributes to the first line facilities under its jurisdiction.

Centralized pooled procurement through CENABAST from registered providers ensures that health facilities receive low-priced high-quality contraceptives. CENABAST's autonomy and external auditing procedures also ensure transparency. Stakeholders in Chile expressed general satisfaction with the prevailing procurement process for medicines and contraceptives. The only weakness identified pertained to delays in consolidating demand and purchasing, which seem to be related to the availability of funding. However, funding for the FP policy was included in the national budget this year. Hence, lack of funds should no longer be a bottleneck to procuring contraceptives in a timely and efficient manner.

Contraceptives that are purchased with public sector funding through UNFPA must adhere to regulations established by national procurement laws. They are subject to import taxes, value-added taxes (VATs), and other taxes, except when a national law or decree explicitly exempts such taxation for certain imported goods. In El Salvador, for example, contraceptives purchased through UNFPA with public sector funds are exempt from import taxes if they are introduced into the country using a Presidential Decree (*Franquicia Presidencial*), although the VAT still applies. Furthermore, UNFPA contraceptives must be registered within El Salvador through the national-level medical and pharmaceutical product registry. Under current agreements with UNFPA, national governments are responsible for paying transport and insurance costs; receiving, inspecting (the quality), unloading, storing, and distributing the product; and completing all customs requirements, product registration, and other bureaucratic procedures.

Although the option has not been used in Latin America, another mechanism under which UNFPA can act as procurement agent is through pooled donor funds associated with Sector Wide Approaches (SWAs). The success of these mechanisms elsewhere has depended on either the MOH's ability to strengthen its own procurement capacity (Bangladesh) or appoint procurement agents (Ghana) to realize gains from lower international contraceptive prices. Where national procurement regulations are less restrictive and the MOH has the capacity, such as in Peru, it can engage in informed buying and obtain prices similar to those obtained by UNFPA.

Finally, procuring through IPPF has been discussed several times in the past as a potential procurement option for the LAC region. Although IPPF seems to offer competitive prices, similar to those offered by UNFPA, the procurement mechanism poses some barriers for institutions. Generally, this mechanism requires that institutions establish a procurement agreement with the local IPPF affiliate, which in turn would contact IPPF and place the order. Since IPPF is a private NGO, however, compared to UNFPA or the Pan-American Health Organization (PAHO), which are both part of the United Nations (UN) system, it is required to meet taxation requisites and therefore may not in fact be competitive for the public sector.

Table 2 summarizes the advantages and disadvantages of different procurement options in order of increasing unit CIF prices. UNFPA, with its bulk purchasing at international prices, is likely to generate the lowest CIF prices, while fragmented (unconsolidated) purchasing in decentralized health care systems is likely to incur the highest unit cost.

TABLE 2. ADVANTAGES AND DISADVANTAGES OF DIFFERENT PUBLIC SECTOR OPTIONS FOR OBTAINING CONTRACEPTIVES

Procurement Mechanism	Key Features and Countries (public sector) currently using the option	Advantages	Disadvantages
1. UNFPA	UNFPA acts as a procurement agent for MOH. Countries: Peru, El Salvador; Honduras, and the Dominican Republic; Nicaragua, Guatemala, and Paraguay do not yet have agreements	–Because of global bulk purchasing, MOHs can obtain generic high-quality contraceptives from reliable suppliers at very low international prices while overcoming national procurement restrictions on ICB.	–UNFPA charges a 5% procurement fee, with payment required upfront. –Only delivers to the central level, passing the responsibility for customs clearance and delivery to the MOH, thereby adding further costs. –Because of great distances, delays make it all the more challenging for countries to accurately forecast their needs and meet those needs.
2. IPPF	Local NGOs that are affiliates of IPPF procure through regional IPPF offices. Countries: None	–Using local IPPF affiliates helps the organizations to generate additional income, as a result of procurement activity. –IPPF offers very competitive prices, sometimes lower than UNFPA, and high-quality products. It also guarantees continuity of brands, as they offer the same products that USAID and UNFPA have donated to the region for years. –Products can be brought in country in several scheduled shipments, throughout the year, giving governments the ability to gather funds throughout the year.	–Not clear if the public sector is willing to contract to NGOs or if NGOs have the cash flow to sell to the MOH. Purchases may be subject to VAT. –Unlike exceptions made for UNFPA, MOH cannot necessarily establish procurement agreements with NGOs or IPPF affiliates, because normally, by law, they have to go through tenders, just like any other local supplier, if they want to get a contract awarded. –NGOs do not have a financial “cushion,” in case a government or institution fails to cover the total cost of the quantities procured at a certain point in time.
3. USAID and other bilateral donors^a	Donors obtain contraceptive methods from their own suppliers and sometimes through UNFPA, and provide them to the MOH. Countries: Nicaragua, Guatemala, Paraguay, and Bolivia	–Commodities are free, reducing the burden on the MOH budget. MOH does not need to take procurement actions and decisions. No taxes are paid.	–Most donors are phasing out donations, therefore this is not a sustainable option over the medium to long term. –Historically higher cost suppliers have been used although this is changing with untied aid. –Needs careful coordination between donors to avoid duplication. –MOH has less control of commodities. –Donations do not keep pace with growing demand.
4. UNDP	UNDP acts as a procurement agent in Honduras for contraceptive purchases made through the IBRD loan. Countries: Honduras	–Allows international bidding and avoids restrictions associated with national procurement regulations. –UNDP/IAPSO and UNFPA have now set up a system in which UNDP clients may access condoms through the IAPSO Web Buy e-procurement system. This may be extended to other RHCs.	–UNDP is not a specialized FP procurement agent and appears to have procured at prices higher than UNFPA, probably because of the lack of bulk purchasing. –UNDP does not always select prequalified suppliers.

TABLE 2. ADVANTAGES AND DISADVANTAGES OF DIFFERENT PUBLIC SECTOR OPTIONS FOR OBTAINING CONTRACEPTIVES (CONTINUED)

Procurement Mechanism	Key Features and Countries (public sector) currently using the option	Advantages	Disadvantages
5. International competitive bidding by the MOH, including SWAp	None of the nine countries studied have undertaken international bids; Peru has diversified its supply sources to include a generic Indian manufacturer with a local representative. In other regions, donors pool resources and make them available to the MOH for ICB as part of sectorwide programs.	–The MOH has greater autonomy around procurement decisions subject to the application of IBRD procurement rules. This can lead to economies of scale and lower prices.	–International bidding may contravene national procurement laws. –Familiarity with IBRD/IDB procurement regulations may be beyond the capacity of the MOH unless they have prior experience with international bidding. –Requires strong local procurement capacity (including the ability to efficiently carry out quality assurance measures).
6. National procurement	Most LAC countries have specific regulations governing national procurement that limit the scope for international tender and require purchasing only from local agents. Countries: Peru, Paraguay, Nicaragua, and Brazil	–Local suppliers, including local manufacturers and agents, know local conditions better, can arrange for local delivery, and can foster local commerce. –Where there is local production capacity, delivery lead times can be shorter and orders can be placed in smaller volumes	–Can contribute to cartelization of supply, reduced competition, and higher prices because international suppliers need to operate through local intermediaries, and commodities may be subject to VAT. –Local manufacturers may be more expensive than international competitors; this is less likely an issue in open economies like Chile and Costa Rica but a bigger issue in protected economies like Brazil. –Local suppliers, if not prequalified by WHO, do not necessarily provide the same level of quality that internationally certified suppliers are able to guarantee.
7. Local Procurement	In decentralized health systems, contraceptives and essential medicines are sometimes procured at a local level. Countries: Bolivia and Ecuador	–Decision making stays at the lowest level (closest to the client), delivery is efficient, and prices include the cost of local delivery.	–Procurement volumes are small and local suppliers are used, usually resulting in much higher unit prices being paid, including possibly VAT.

Source: Interviews with key players.

Note: IAPSO = Inter-Agency Procurement Services Office; IBRD = International Bank for Reconstruction and Development; ICB = international competitive bidding; IDB = Inter-American Development Bank; RHC = Reproductive Health Commodities.

a. USAID and other bilateral donors do not and cannot function as procurement agents for the public sector as do UNFPA, UNDP, and IPPF.

For further detailed study, a description of the main contraceptive procurement options being used in each country is included at the end of the report in annex 1. For all 14 countries studied, annex 2 presents information on drug supply systems, contraceptive financing, and procurement. Annex 3 summarizes the regulations governing the purchase of supplies with public funds.

CONCLUSIONS: LEGAL AND REGULATORY ENVIRONMENT

All of the nine presence countries have well-established policy frameworks, including health laws that support the rights of their citizens to plan their families. As international donations of contraceptives are phased out, most of the countries examined have begun the process of earmarking public funds for their future procurement. Several countries, including El Salvador, Guatemala, and Peru, have allocated public sector funding for the purchase of contraceptives. Ecuador has gone further by providing legal protection for these funds to ensure the availability of contraceptives for the people who need them. Presently, only Nicaragua and Bolivia do not provide public sector funding for contraceptives.

Despite policy commitments by all of the countries to provide FP services to their citizens, a comparison of legal and regulatory frameworks illustrates a range of legal options related to the procurement of health commodities. These options range from slightly more open environments in which a country can search for a lower price in local or international markets to more restrictive environments in which a country must favor a local distributor or manufacturer.

There are an array of laws in all the countries to regulate the purchase of goods and services with public sector funds. Most countries have explicit procurement regulations that limit the scope of purchasing from international suppliers. Countries have used exceptions to these laws to try to access lower international prices. They have taken steps to be more efficient, to be transparent, and to provide value for money while safeguarding quality and public safety throughout the procurement process. For instance, while some national procurement laws limit options to local suppliers, most countries allow international purchases through UN agencies, such as UNFPA or UNDP. A notable advantage of using UNFPA as a procurement agent is that it gives a government access to the competitive prices offered in the international market without the legal restrictions involved in obtaining products directly from an international supplier, while ensuring quality and transparency throughout the process.

A regional comparison of public sector procurement practices revealed that the MOHs in four of the nine countries examined (Peru, the Dominican Republic, El Salvador, and Guatemala) use UNFPA as a procurement agent to secure contraceptives on the international market, while three more countries (Paraguay, Nicaragua, and Honduras) have plans in place to contract UNFPA for a similar function in the future. Table 3 summarizes current procurement practices in the 14 countries studied.

TABLE 3. REGIONAL COMPARISON OF PUBLIC SECTOR CONTRACEPTIVE PROCUREMENT PRACTICES

Country	MOH Procurement Agent	Centralized Pooled Procurement	Public Sector Funding for Contraceptives
Peru	UNFPA	Yes	Yes (since 1999)
Bolivia	None	No	No
Paraguay	UNFPA planned	Yes	Yes (since 2002)
Ecuador	Local	No	Yes (protected)
Dominican Republic	UNFPA	Yes	Yes
Nicaragua	UNFPA planned	Yes	No
Honduras	UNDP, switching to UNFPA	Yes	Yes, through IDB loan
El Salvador	UNFPA	Yes	Yes (since 2003)
Guatemala	UNFPA	Yes	Yes (from 2007)
Brazil	Local	No	Yes (at least since 2000)
Chile	Local and International	Yes	Yes (at least since 1995)
Colombia	Local and International	No	Yes (at least since 1995)
Costa Rica	Local and International	Yes	Yes (at least since 1993)
Mexico	UNFPA and Local	Optional	Yes (at least since 1996)

Source: Interviews with key players.

The following pricing analysis will provide evidence that agreements with agencies such as UNFPA offer countries access to significant savings compared with other local purchase options. Similarly, to take advantage of the benefits of economies of scale, most of the countries in the study use a centralized procurement strategy in securing contraceptives, whether they are on the local or international market. The two notable exceptions to this type of procurement strategy are Ecuador, which procures at a decentralized level, and Bolivia, which still receives all of its contraceptives as donations. Consequently, Bolivia has not developed detailed plans on how it will go about procuring contraceptives with public funds given its decentralized health management system.

CONTRACEPTIVE PRICES

In analyzing contraceptive prices, it is important to ensure that comparisons are made for the same product, at the same point in the supply chain, in the same period of time. Making price comparisons between and across countries is difficult. For example, prices will vary depending on a host of factors that are not part of this study per se, such as volumes, financial commitment and timing, market conditions, the supplier's view of the particular client, and so on. Furthermore, although this study did not collect detailed information about suppliers, a clear distinction must be made between prequalified sources with batch traceability and less desirable sources. In addition, higher prices in the private sector for various countries in the LAC region seem mostly to be caused by differences in import duties and variances in related administrative paperwork.

In this section, we first look at CIF prices for publicly and NGO-procured oral and injectable contraceptives and IUDs. The cost structures for these methods, which include cost of the product, duties and tariffs, transportation, and administrative costs, are then examined. Contraceptives that have been donated are distinguished from those actually procured, and subregional average prices are calculated for South and Central America.¹⁵

Donor prices are quoted for reference purposes. The volumes that USAID and UNFPA typically buy allow manufacturers to quote lower prices to these agencies than they would typically quote to individual countries. Also, as mentioned above, this study did not gather information about volumes and the extent to which volume has affected price. As countries diversify their sources of supply, however, several have identified prices that are comparable to UNFPA prices and much lower than prices quoted by domestic agents and suppliers.

COMPARING CIF PRICES

CIF prices reflect the international cost of the commodity landed at a country's port of entry; they do not include local tariffs and duties or domestic supply chain costs. For domestically produced commodities, the equivalent point in the supply chain is the ex works (or ex factory) price (see table 1 for pricing terminology). Variations in the CIF price for a commodity in different countries reflect the procurement efficiency of the individual country, the price differences at which pharmaceutical companies make products available in different markets, the distance between the point of origin and port of entry, and the chosen shipping method. Assuming that the products being compared are identical, the more efficient the procurement, the lower the CIF price that will have been negotiated. Procurement efficiency can reflect the scale of the procurement, the competitiveness of the process, and how well informed the procurement agents were in making their selection. The following analysis addresses prices paid for generic oral contraceptives and injectable contraceptives by the public and nonprofit/NGO sectors throughout the region.

CIF PRICES FOR ORAL CONTRACEPTIVES

Table 4 presents the range of prices for generic oral contraceptives for the public and nonprofit/NGO sectors in 10 countries. Most prices fell within a range of U.S.\$0.29 to U.S.\$0.33 per cycle. Two exceptions were an NGO in the Dominican Republic and a local public procurement in Ecuador, which paid U.S.\$0.93 and U.S.\$2.22, respectively. The higher price in Ecuador reflects the high cost of local procurement. The lowest procurement price paid was by the Chilean public sector (U.S.\$0.14 per cycle), followed by an Ecuadorian NGO (U.S.\$0.17). The

15. Price data were obtained from reference manuals, where available, and through personal interviews between DELIVER staff/consultants and official representatives for the different sectors in each country.

price data indicate that the average cost for generic oral contraceptives was approximately 50 percent higher in Central America and the Caribbean than in South America. Table 4 reveals several key points on CIF prices for generic oral contraceptives:

- The low prices in Chile and for the Ecuador NGO reflect access to international prices. In the Chilean case, the open economy allowed for greater competition. In the Ecuadorian case, the NGO carried out an international tender.
- The large variations across countries in CIF prices paid reflect not only procurement efficiencies, but also different prices that pharmaceutical companies charge countries based on economic conditions and the supplier's own pricing policies. An additional reason for higher average prices in Central America could be that the legal and regulatory environment is more stringent, and thus, the market is less competitive.

- Across the region, there is little variation between prices in the public and nonprofit sectors, except in the Dominican Republic, where the public sector paid U.S.\$0.31 per cycle in contrast to U.S.\$0.93 per cycle paid by a local NGO. The discrepancies observed between sectors in this case suggest that if provider organizations pooled procurement, there could be substantial savings.
- Although several countries rely on UNFPA to procure commodities, UNFPA prices are not always the lowest. In Peru, the public sector procured through UNFPA and ESKE/FamyCare (an Indian manufacturer). Prices paid to UNFPA were approximately 25 percent higher than the price paid to ESKE/FamyCare for oral cycles.¹⁶

CIF PRICES FOR THREE-MONTH INJECTABLE CONTRACEPTIVES

Table 5 presents comparisons in CIF prices for injectable contraceptives. Overall, the best price (U.S.\$0.78 per injection) was obtained in Guatemala (public) and Nicaragua (public), which may reflect more recent procurement data. Peru's public sector obtained injectables for U.S.\$0.85 per injection. In all three cases, UNFPA served as the procurement agent, and the prices obtained were lower than the price of the donated commodity, as was

TABLE 4. CIF PRICES FOR GENERIC ORAL CONTRACEPTIVES

Country	Sector	Price (U.S.\$)
Bolivia	Nonprofit *	0.29
	Public *	0.21
Chile	Nonprofit	0.33
	Public	0.14
Ecuador	Public	2.22
Paraguay	Public *	0.30
	Nonprofit	0.30
Peru	Public ESKE/FamyCare	0.24
	Public UNFPA	0.31
Average (South America)		0.25**
Dominican Republic	Nonprofit	0.93
	Public	0.31
El Salvador	Nonprofit	0.32
	Public	0.31
Guatemala	Nonprofit *	0.31
	Public *	0.33
Honduras	Nonprofit	0.31
	Public	0.39
Nicaragua	Nonprofit	0.31
	Public *	0.34
Average (Central America/Caribbean)		0.39

* Donations.

** South America average excludes U.S.\$2.22 outlying value from Ecuadorian public sector.

16. UNFPA has negotiated a Most Favored Customer arrangement whereby FamyCare agrees that, if it offers the same goods under the same market conditions to another party, it will make that pricing available to UNFPA. Situations such as the Peru example may still occur under differing market conditions. There is at least one new prequalified generic supplier of Depo-Provera (generic: DMPA, depot medroxyprogesterone acetate) that offers a competitive price compared with Pfizer and Organon.

the case with Guatemala’s nonprofit sector (and partial donations to the public sector), with a cost of U.S.\$1.18. (The injections donated to the public sector in Guatemala were then supplied to NGOs.) Both Brazil and Chile paid procurement prices that were higher than those obtained by UNFPA. Table 5 highlights the following:

- In contrast to oral contraceptives, the average CIF prices for injectable contraceptives are lower in Central America and the Caribbean than in South America. This shift is due to the fact that the subregional average price in South America is inflated by the higher price paid in Brazil, which has a more restrictive environment, and in the Paraguay nonprofit sector, which is

required to pay taxes on imported commodities. If Brazil and Paraguay (nonprofit) are excluded, the average South American price is U.S.\$1.04, which is still higher than in Central America.

- UNFPA serving as procurement agent appears to be a desirable option because its prices were the lowest in the region.
- Cost difference across different organizations in Bolivia and the Dominican Republic was extremely large—approximately 70 percent in the Dominican Republic. This variation in prices paid by different organizations in the same country highlights the need for closer coordination and information exchange between NGOs and the public sector. However, the scope for pooling in-country procurement between different partners may be limited, partly because of the nature of the organizations, but mainly because of the markets they cover. If NGOs and MOHs were to pool procurement, the NGOs would not benefit from brand differentiation. They would have the same chronic problem that others have had in the region, as NGOs try to develop their own niche, but are unable to because the MOH has the same products and distributes them for free.

TABLE 5. CIF PRICES FOR INJECTABLE CONTRACEPTIVES

Country	Sector	Price (U.S.\$)
Bolivia	Nonprofit *	1.19
	Public *	0.90
Brazil	Public	1.56
Chile	Nonprofit	1.19
	Public	1.15
Paraguay	Nonprofit	1.42
	Public *	1.11
Peru	Public	0.85
Average (South America)		1.17
Dominican Republic	Nonprofit	1.38
	Public	1.08
El Salvador	Public *	0.89
Guatemala	Nonprofit *	1.18
	Public	0.78
Nicaragua	Public *	0.78
Average (Central America/Caribbean)		1.02

* Donations.

CIF PRICES FOR IUDS

Table 6 compares prices for public and NGO procurement of Copper T-380A IUDs. CENABAST in Chile procured IUDs for the lowest price (U.S.\$0.31), which was close to prices obtained by international donors for the public sector in Bolivia (U.S.\$0.35). Public sectors in Brazil and Ecuador paid the highest prices. In Brazil, the price of U.S.\$3.20 was paid to a domestic producer that did not face any international competition. In Ecuador, the price of U.S.\$2.89 was a result of low-volume procurement at the decentralized level. Table 6 highlights the following:

- Average CIF price in South America and Central America/Caribbean are similar.
- There are large differences among countries in the public sector, such as between Nicaragua (U.S.\$1.63 per unit—USAID donation) and the Dominican Republic (average of U.S.\$0.33 per unit—UNFPA, Government of

TABLE 6. CIF PRICES FOR COPPER T-380A IUDS

Country	Sector	Price (U.S.\$)
Bolivia	Nonprofit *	1.95
	Public *	0.35
Brazil	Public	3.20
Chile	Nonprofit	0.81
	Public	0.31
Ecuador	Public	2.89
Paraguay	Nonprofit	0.56
	Public *	0.42
Peru	Public	0.54
Average (South America)		1.23
Dominican Republic	Nonprofit	0.75
	Public	0.33
Guatemala	Nonprofit	1.57
	Public *	1.49
Nicaragua	Public *	1.63
Average (Central America/Caribbean)		1.15

* Donations: Bolivia and Paraguay public sectors (from UNFPA). Guatemala and Nicaragua public sectors and Bolivia nonprofit sector (from USAID).

the Dominican Republic purchase). These differences reflect procurement efficiencies, such as UNFPA procuring for the Dominican Republic; in contrast to Nicaragua, which has not begun to procure its own contraceptives.

- Even within a given country, large price differences are observed across sectors. In Bolivia, for example, commodities donated by UNFPA and Japan International Cooperation Agency (JICA) to the public sector had a unit costs of U.S.\$0.35. On the other hand, commodities donated by USAID to the nonprofit sector were much more expensive (U.S.\$1.95 per IUD). Differences in Chile are not as extreme, but CIF prices for IUDs are more than twice as high for the nonprofit sector as for the public sector (U.S.\$0.81 versus U.S.\$0.31 per unit).

- As with injectables, coordination and information sharing between NGO and public sector partners can help identify where different organizations are paying different prices for the same contraceptive methods. While national governments may not have access to the same prices given to donors, donor prices do represent a benchmark that governments should take into account.

In summary, countries procuring through UNFPA (such as El Salvador, Peru, and the Dominican Republic) generally obtain commodities at a lower price than those countries that procure on their own locally (such as Ecuador and Brazil). However, UNFPA does not always ensure the lowest prices for all products, as seen by Peru's procurement of oral contraceptives through ESKE/FamyCare. CIF prices of donated commodities vary depending on the donor; UNFPA donations are often lower priced, but donated commodities are not necessarily the lowest priced commodities on the market.

COMPARING PRIVATE SECTOR PRICES

Analysis of private sector retail prices is particularly instructive for countries with decentralized procurement, because they approximate the prices that local municipalities may be forced to pay unless concrete steps are taken to coordinate public purchases. Prices charged by the private sector implicitly include price of the imported (or manufactured) commodity; taxes, tariffs, and duties; and administration, transportation, and distribution costs. However, this information disaggregated is not readily available from pharmacies and individual retail outlets. The components of price are discussed in the next section of this report.

The larger economies of South America should be able to get a more competitive price for commodities because of larger volumes, greater economies of scale with distribution systems, and better developed transport systems. However, because these countries are larger, distances between cities are greater. These factors all influence private sector prices.

RETAIL PRICES FOR ORAL CONTRACEPTIVES

Table 7 presents the average prices for five different brands of oral contraceptives: Microgynon, Nordette, Duofem, Micropil, and Anovulatorio. The wide variation in prices per cycle reflects some differences in commercial pricing for brands. The regionwide average price of U.S.\$4.24 per cycle in the private sector is substantially more than the average CIF price of U.S.\$0.32 per cycle, including subsidized products (in the case of Bolivia). This difference reflects the potential gap between national procurement in bulk and local, small-scale purchasing, as well as higher transportation costs that the private sector pays (discussed in the next section). The highest average-priced product in the region was Microgynon in Guatemala, with an average price of U.S.\$9.92 per cycle. Highlights from table 7 include the following:

- Average prices in South America tend to be lower for Microgynon, but the prices showed great variation within any given country, reflecting different cost structures for products, transportation, distribution, and profit margins. In Colombia, even though the average price is U.S.\$3.80 per cycle, the range varies more than in any other country, which shows that no price control allows for wider price fluctuations and, possibly, more accessible prices.
- Within a country, average prices for different brands also varied greatly. Duofem in Bolivia, with an average price of U.S.\$0.74 per cycle, costs consumers a fraction of the average price of Microgynon (U.S.\$3.24 per cycle). It is important to note that Duofem in Bolivia is a donated product, and its price in pharmacies is subsidized. In the Dominican Republic, Brazil, and Chile, similar price differentials were also observed.
- Although average prices were higher in Central America than South America, in part because of the legally restrictive procurement environment, there was great variation in average price within the subregion. In Guatemala, the average price for Microgynon was U.S.\$9.92 per cycle; in neighboring Honduras and El Salvador, average prices were lower (U.S.\$5.69 and U.S.\$6.47, respectively, per cycle). This may reflect differential pricing by the pharmaceutical companies; it may also reflect different prices charged in different neighborhoods in each country.
- Unlike in South America, where retail prices are published, retail prices in Central America were obtained only from a small number of pharmacies. A larger survey of pharmacy prices may be required to gain a more thorough understanding of price variations in each Central American country.

TABLE 7. RETAIL PRICES FOR ORAL CONTRACEPTIVES

Product	Country	Price (U.S.\$)	
		Average	Range
Microgynon	Paraguay	2.72	2.64–2.89
	Ecuador	3.22	n.a.
	Dominican Republic	3.22	3.11–3.23
	Bolivia	3.24	3.12–3.37
	Colombia	3.80	2.95–6.61
	Peru	4.29	n.a.
	Nicaragua	5.00	n.a.
	Honduras	5.69	n.a.
	El Salvador	6.47	n.a.
	Guatemala	9.92	n.a.
Nordette	Brazil	1.80	n.a.
	Colombia	3.39	n.a.
	Ecuador	3.93	n.a.
	Dominican Republic	5.98	5.80–6.07
Duofem	Bolivia	0.74	0.62–0.81
	Dominican Republic	2.14	1.67–2.83
Micropil r-28	Brazil	7.60	n.a.
Micropil	Brazil	6.14	n.a.
Anovulatorio	Chile	1.69	1.68–1.90

TABLE 8. RETAIL PRICES FOR INJECTABLE CONTRACEPTIVES

Product	Country	Price (U.S.\$)	
		Average	Range
Depo-Provera	Bolivia	1.46	1.12 - 1.50
	Colombia	2.68	n.a.
	Nicaragua	3.37	n.a.
	Honduras	6.82	6.63–11.09
	Peru	9.82	n.a.
	Ecuador	11.44	n.a.
	El Salvador	13.84	n.a.
	Dominican Republic	17.21	16.00–18.53
	Guatemala	23.57	n.a.
Mesigyna	Bolivia	5.62	5.11–6.32
	Brazil	6.20	0.00–8.15
	Chile	9.74	8.43–9.90
	Ecuador	5.30	n.a.
	Paraguay	3.97	n.a.
	Peru	5.99	n.a.
	Dominican Republic	10.00	9.97–10.07
	El Salvador	7.03	5.16–7.85
	Guatemala	9.93	n.a.
	Honduras	5.89	n.a.
	Nicaragua	4.64	3.15–11.00
	Colombia	6.55	6.12 – 6.87

RETAIL PRICES FOR INJECTABLE CONTRACEPTIVES

Table 8 presents data on average retail prices for two injectable contraceptives: Depo-Provera (three months) and Mesigyna (one month). Overall, the average price for injectables in the region was U.S.\$8.00, but average prices were higher in Central America and the Caribbean (U.S.\$10.00) than in South America (U.S.\$6.80). Within each country, the low and high prices reflect retail prices in different locations, as pharmacists in wealthier neighborhoods often charge higher prices than those in poorer neighborhoods. Highlights from table 8 include the following:

- Price comparisons are available for both products in seven countries; in Bolivia, Colombia, and Nicaragua, average prices for Depo-Provera were lower; in Ecuador, Peru, Guatemala, Honduras, and the

Dominican Republic, average prices for Mesigyna were lower. However, in Bolivia, Depo-Provera is donated by USAID and commercialized by local distributors through pharmacies.

- The average price of Depo-Provera in Guatemala (U.S.\$23.57), which also had the highest retail price for oral contraceptives, is at least twice as high as in other Central American countries. The reasons for these wide variations are not clear. As with oral contraceptives, factors could include differences in supplier pricing policies, the lack of published price information in Central America, and the fact that only a few pharmacies were visited. Future analysis of a larger number of pharmacies would be beneficial.
- Although CIF prices for the private sector are not available, when comparing public and NGO CIF prices to private sector retail prices, it immediately becomes clear that the private sector is earning a significant profit margin on contraceptives. For instance, the median CIF price for Depo-Provera is U.S.\$1.13 versus the median retail price U.S.\$6.82.

Note: Retail prices for IUDs were excluded because there was not enough information on product comparability.

COMPARING COST STRUCTURES

Better knowledge about the cost structure for contraceptives is crucial for a good understanding of the observed price differences for commodities across countries and sectors. Information about how the components affect price can help countries make more informed procurement decisions. This section examines the different price components for oral contraceptives, injectable contraceptives, and IUDs: CIF (or ex factory) price; taxes, tariffs, and duties; costs associated with transportation, distribution, and retail margins; and costs associated with administration and

TABLE 9. COSTS ASSOCIATED WITH TRANSPORTATION, DUTIES AND TARIFFS, AND VAT

Country	Duty/Tariff (percent)		VAT		Transport (percent)
	Public	Nonprofit	Public	Nonprofit	
Bolivia	<15	<15	No	Yes	n.a.
Chile	5–10	n.a.	Yes	Yes	3.5
Colombia	0–10	0–10	No	No	3.0
Ecuador	n.a.	n.a.	No	Yes	<1.0
Paraguay	<5	n.a.	No	Yes	n.a.
Peru	5–10	<5	Yes	Yes	2.7*
Dominican Republic	<15	<15	No	Yes	n.a.
El Salvador	<5	5–10	Yes	Yes	n.a.
Guatemala	n.a.	n.a.	No	Yes	3.6*–2.4**
Honduras	n.a.	n.a.	No	Yes	6.5**
Nicaragua	n.a.	n.a.	No	Yes	5.4**

* Public sector ** Nonprofit sector

Source: Interviews with key players

social marketing. Although it was not possible to collect information on each of the price components for all products in each country, it is still possible to compare some key elements of the supply chain cost structure in both the public and social marketing sectors for selected FP methods.

The public sector tends to provide commodities free-of-charge, but it still incurs costs for the commodity, duties and taxes, and distribution and transportation. Public sector data include detailed information on these four cost components, including delivery at the central level and sometimes the district level.¹⁷ The social marketing (nonprofit) sector was the most

detailed source of information on the cost structure of commodities. For social marketing organizations, the cost of repackaging and marketing represents an important cost component. Although this information is presented in Figures 2, 3, and 4, the objective of doing so is *not* to compare the relative costs for different social marketing organizations, because they operate under different levels of sustainability and cost recovery.

Other costs—transportation, duties and tariffs, and VAT—are handled differently in each country, as shown in table 9. Donated contraceptives usually enter a country duty free. However, as countries procure their own contraceptives, tariffs on imported commodities could form an increasing proportion of total contraceptive costs.

Some countries impose VAT as high as 19 percent on contraceptives, while others exclude them. Only Peru, El Salvador, and Chile charge VAT for all contraceptive methods, regardless of the purchasing agent. Bolivia, Ecuador, Paraguay, Guatemala, Honduras, Nicaragua, and the Dominican Republic impose VAT only on private (profit and nonprofit) organizations, unless the commodities are donations.

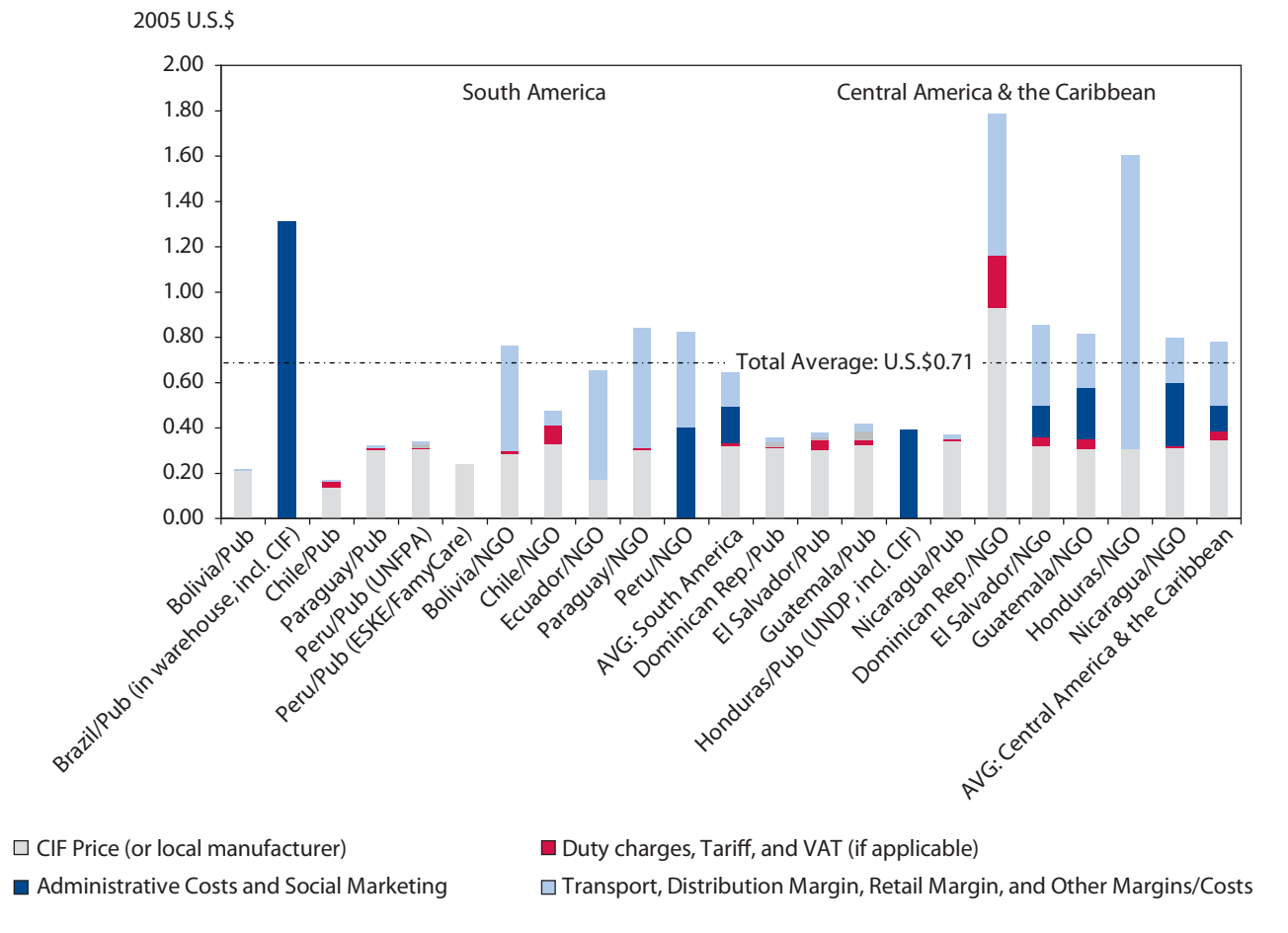
Transport costs were more difficult to obtain because they frequently are subsumed in administrative and overhead costs. Central American countries, with the exception of Guatemala, tend to have higher transportation costs (around 6 percent) than in South America, where countries like Chile and Peru show an average of less than 4 percent, perhaps because transportation systems and highways are better developed in some of the more developed countries of South America.

COST STRUCTURE FOR ORAL CONTRACEPTIVES

Figure 2 presents cost structures for oral contraceptives in the public and social marketing (nonprofit) sectors. The figure shows that average costs in Central America and the Caribbean are higher than those in South American countries: U.S.\$0.78 compared with U.S.\$0.64. Chile’s public sector reports the lowest total cost, followed by public sectors in Peru, Honduras, and Guatemala, while Ecuador’s public sector reports the highest total cost, U.S.\$2.22, reflecting the decentralized purchases made by the health areas. This price is not shown in figure

17. Price information from private pharmacies and distributors was available, but the underlying costs components were considered commercially sensitive and, thus, not made available.

Figure 2. Cost Structure for Oral Contraceptives in the Public and Social Marketing Sectors (2005 U.S.\$)

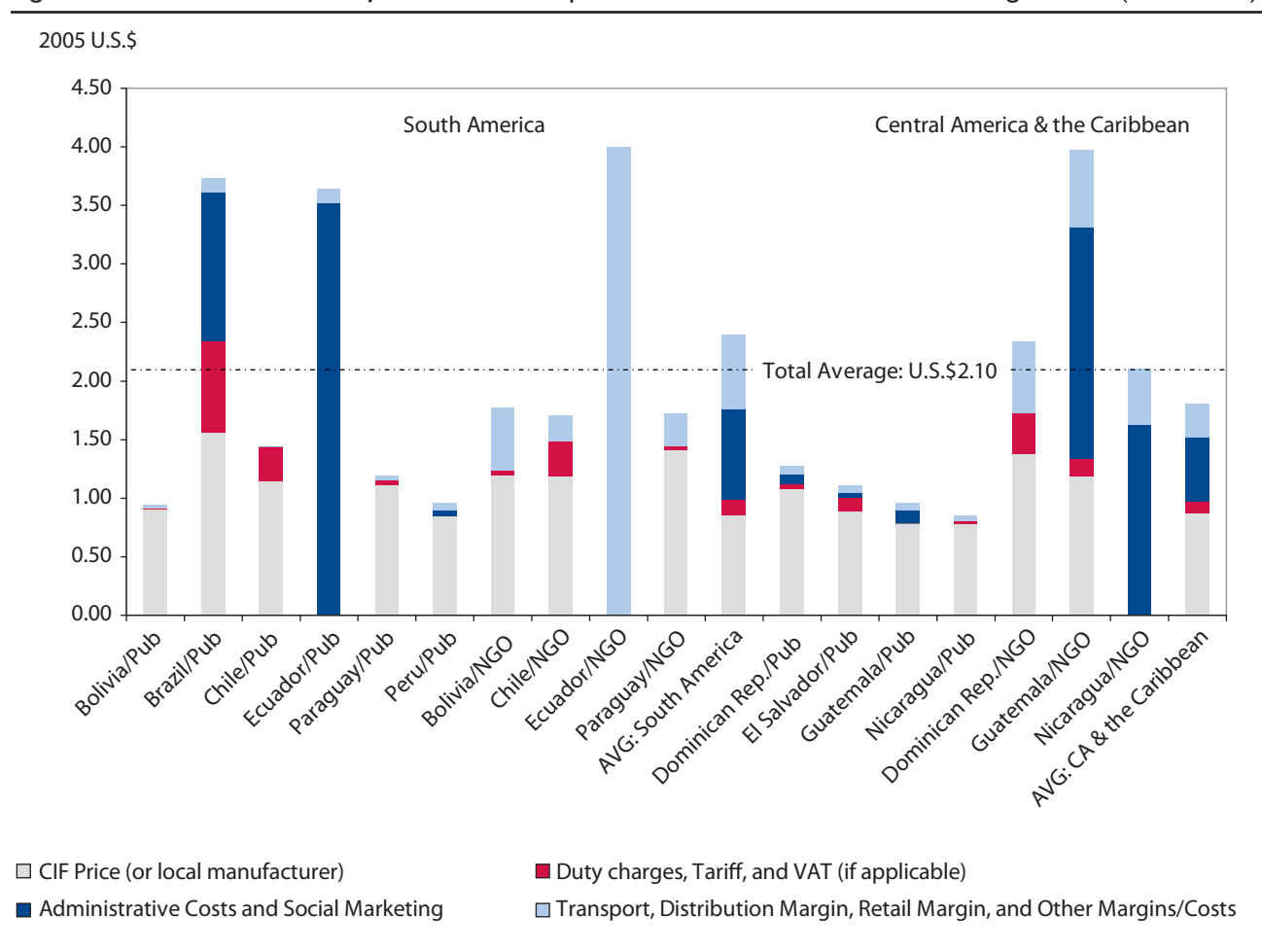


2 because it would distort the graph, making the other cost structures more difficult to read. The Dominican Republic's nonprofit sector (U.S.\$1.57 per cycle) and Brazil's public sector (U.S.\$1.31 per cycle) also have very high costs. Nonprofit costs in Central America tended to be higher than nonprofit costs in South America.

Highlights from figure 2 include the following:

- Public sector costs tend to be lower than those in the social marketing (nonprofit) sectors. For the public sector, almost all of the cost of oral contraceptives was due to the CIF (or local manufacturer) price. In the public system in South America, transport and warehousing costs are estimated to be relatively low, less than 3 percent, whereas in Central America they are estimated to be higher, around 6 percent.
- For social marketing programs in Paraguay, Peru, Ecuador, Honduras, and Guatemala, the CIF represented less than half of the total cost of making the commodity accessible to the public. Transportation and distribution represented a significant part of the total cost.
- While duties and VAT represented a relatively small portion of the total cost in most countries, in the Dominican Republic, they represented approximately 18 percent of the total cost of commodities provided by social marketing programs.

Figure 3. Cost Structure for Injectable Contraceptives in the Public and Social Marketing Sectors (2005 U.S.\$)



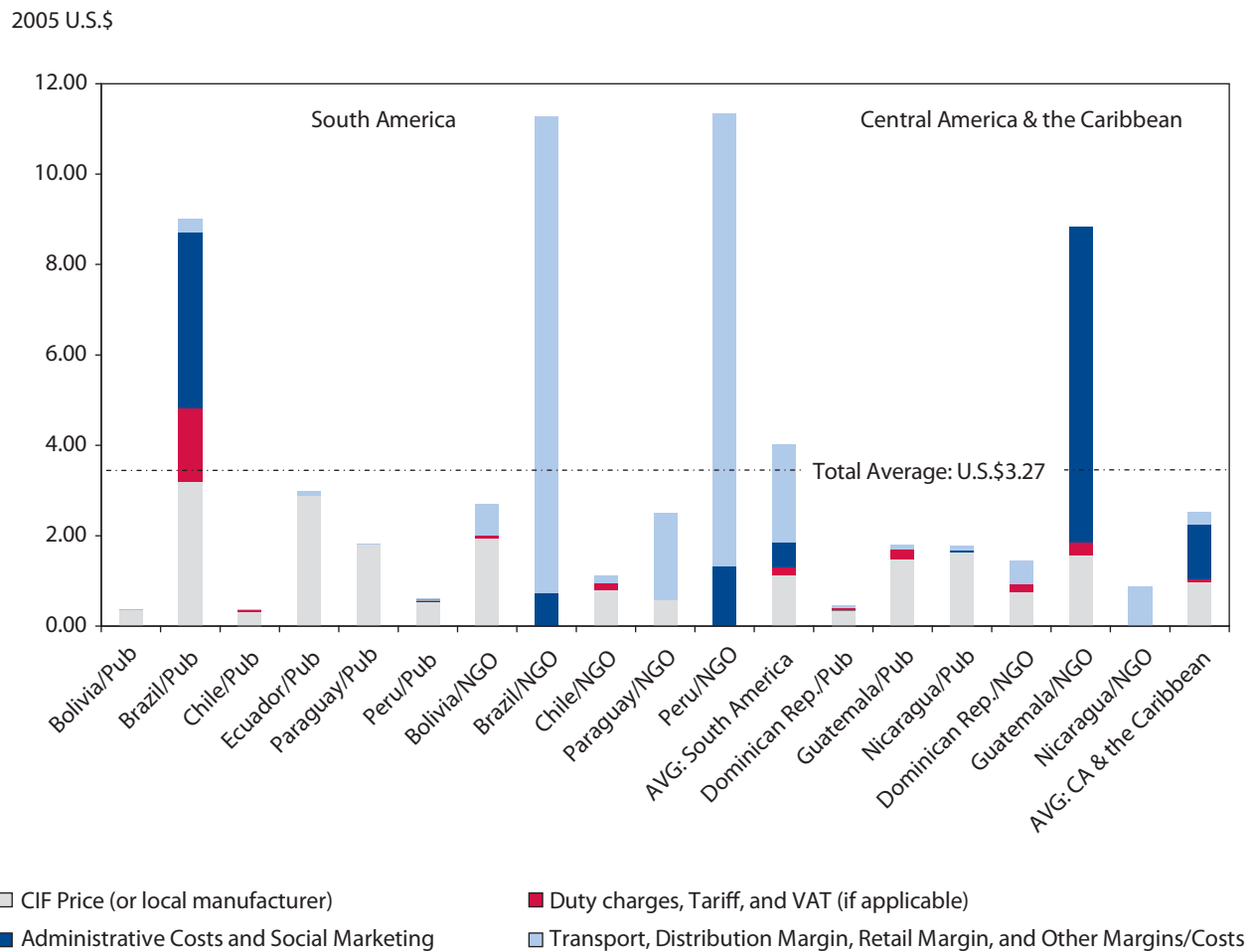
COST STRUCTURE FOR INJECTABLE CONTRACEPTIVES

Figure 3 shows the cost structure for injectables in the public and social marketing sectors. At U.S.\$1.90, the average total cost in South America is higher than in Central America and the Caribbean. The highest average total cost for injectables is in the nonprofit sector in Ecuador, with a cost of U.S.\$4.00 per injection because of decentralized procurement. Nicaragua’s public sector had the lowest average total cost of U.S.\$0.85.

Highlights from figure 3 are as follows:

- Overall, total costs for injectables were higher in the nonprofit sector than in the public sector, because most products are donated in the public sector, whereas the NGO sector has to buy them and pay all related taxes and duties. Duties, tariffs, and VAT represented an important element of total costs in the public sectors of Brazil and Chile—approximately 33 percent and 21 percent, respectively.
- Comparing total average costs of oral and injectable contraceptives within the same country and sector suggests that, in some cases, one injectable has a lower total cost than three cycles of oral contraceptives. For example, in the nonprofit sector of the Dominican Republic, total costs for one injection are approximately U.S.\$2.35 compared with U.S.\$5.37 for three cycles of oral contraceptives. Similarly, in the public sector of Peru, one injection has a total cost of approximately U.S.\$0.96 compared with U.S.\$1.02 for three cycles of oral contraceptives.

Figure 4. Cost Structure for IUDs in the Public and Social Marketing Sectors (2005 U.S.\$)



COST STRUCTURE FOR IUDS

Figure 4 provides information on the cost structure for Copper T-380A IUDs in the region. The small number of observations in figure 4 limits the conclusions that can be drawn. Overall, the average price of U.S.\$3.24 masks the considerable variation between the average total cost for Central America and the Caribbean (U.S.\$2.54 USD) and South America (U.S.\$3.89). The lowest costs are observed in the public sectors of Bolivia, Chile, Paraguay, Peru, and the Dominican Republic, followed by the nonprofit sector of Nicaragua. Estimated transport and distribution costs for most of the nonprofit organizations outweigh CIF costs, at times representing more than 10 times the cost of the imported (or locally manufactured) commodity.

PRICING CONCLUSIONS

Comparisons of CIF prices between countries and with median international reference price (IRPs) provide an indication of a country's procurement efficiency. Assuming similar transport costs, the landed price of contraceptives would reflect whether a country has achieved economies of scale and identified lower cost suppliers for their contraceptives. While the analysis of the CIF prices paid by donors does not necessarily indicate prices that countries could achieve, they do represent relevant reference points. These prices can be considered when looking at prices available from commercial sources to determine whether there is scope for cost savings that result from using a procurement agent such as UNFPA.

Comparisons of contraceptive prices obtained by donors, national governments, NGOs, and the private sector show considerable variation both across and within the countries studied. Donor prices represent a low base that most countries will not be able to obtain for name-brand products because national governments are unlikely to match the purchased volumes achieved by donors, except when they choose UNFPA as the procurement agent. Simultaneously, suppliers will face more transactions costs in dealing with individual national governments and thus charge higher prices. Switching to Good Manufacturing Practice (GMP)-certified generic producers does offer the opportunity to obtain lower prices, although this places greater demands on national capacity to ensure product quality.

Countries have experienced mixed results in the prices obtained through public procurement. Countries such as Chile, Costa Rica, and Peru have obtained prices at or even below international reference prices, in some cases lower than prices paid by donors, by buying generic rather than brand-name items. Other countries have done less well. In Brazil, the more restrictive and more closed domestic market combined with governance concerns have contributed to higher prices. In Ecuador, decentralization has contributed to lower purchase volumes and higher prices paid to local suppliers.

El Salvador, the Dominican Republic, Guatemala, and now Paraguay and Honduras have tried to overcome restrictive procurement regulations and high local prices by using UNFPA as the purchasing agent. Although UNFPA usually does provide products at the lowest prices, Peru's experience in purchasing generic oral pills from FamyCare is an example of one country obtaining lower prices. Considerable variations in prices paid for the same contraceptive method by the public and NGO sectors within each country suggest the need for greater coordination and exchange of information.

Transport and distribution costs represent, at most, 6 percent of the commodity costs in Central America and 3 percent in South America. Suppliers should be able to quote prices for products delivered to at least the district store level to minimize the need for public sector distribution.

Retail prices for contraceptives are typically higher in Central American than in South America, reflecting a combination of factors, including less open and smaller economies, less price competition among domestic distributors, and higher transport and distribution costs. Brazil is an exception to this in South America because of its less open and more protected domestic economy.

Recommended retail and wholesaler prices for a wide range of pharmaceuticals, including contraceptives, are published in several South American countries. This helps ensure that prices in the private sector do not vary considerably across different regions or different neighborhoods within a municipality. Published prices were not obtained in Central America, and greater price variations were observed for individual contraceptive methods both between and within countries.

LESSONS LEARNED

Governments need to ensure that their procurement capacity can indeed purchase the right contraceptive products at the right time, in the right place, for the right price, in the right quantity, and of the right quality. These six procurement “rights” are key to the procurement challenges countries are increasingly addressing.

The 14 Latin American countries reviewed for this study have a wealth of diverse experience in contraceptive financing, procurement, and distribution. While each country has its own set of economic, health, and development conditions, regulations, and institutions, there are a number of common factors that suggest lessons can be learned from examples of best practice in the region. Because many USAID-presence countries are facing similar issues to those faced by countries USAID has phased out, it is important to learn from others’ successes and mistakes. We present examples of both success stories and problems experienced with financing, procurement, and distribution. We also present some other lessons learned from the experience of countries that were phased out of donor support.

The public purchase of contraceptives should adhere to the procurement principles noted in table 10.

As table 10 shows, these procurement principles require several regulatory, institutional, management, and technical capacity preconditions. It will not be possible to attain these ideal procurement conditions unless regulations allow access to products from different sources, procurement staff are accountable to following clear guidelines, and staff can make informed purchasing decisions based on price and quality comparisons while ensuring product safety. In many countries, the conditions are not yet in place to allow these procurement principles to be applied. Nevertheless,

- The Six “Rights”
1. Right *product*
 2. At the right *time*
 3. In the right *place*
 4. For the right *price*
 5. In the right *quantity* and
 6. Of the right *quality*.

TABLE 10. PROCUREMENT PRINCIPLES

Principle	Rationale	Preconditions
Procurement management efficiency	The process should be as smooth and efficient as possible and managed carefully from initial product specification through product delivery and use. This requires pre- and postshipment procurement management to ensure supplier quality standards and shipment issues are addressed.	Requires a procurement management capacity.
Transparency	The procurement process should be transparent, clearly following defined guidelines and criteria for selection that encourage decision making to be rational so that procurement decisions can be clearly understood by outside scrutiny.	Supposes good governance, management oversight, and public accountability.
Provides value for money	Use of public funds demands that spending demonstrate value for money and the best possible deal be obtained subject to quality and safety considerations. This requires a review of a choice of products from different national and international sources and comparisons of price, product shipment conditions, and an evaluation of product quality. Bulk purchase is a key way to ensure value for money to obtain economies of scale in delivery and lower unit prices.	Requires regulations that allow unrestricted access to supplies from different sources and centralized procurement.
Provide effective safe and efficacious methods	Effective quality control is of paramount importance to safeguard public safety and ensure that effective and efficacious methods are procured.	Requires technical quality assurance capacity and access to testing laboratories.

several countries have adapted to their regulatory, governance, and management constraints to try to improve their procurement process.

STRENGTHENING PROCUREMENT PLANNING AND MANAGEMENT

Improved procurement planning and management are essential if countries are to ensure that public funds are used wisely in purchasing contraceptives. Better management requires improvements across the procurement cycle. This begins with identification and quantification of product requirements, and includes a budget review and approval process, a tender process that is either international or national depending on the product, a tender evaluation process and a post-tender contract management process, and a quality assurance process to ensure that only products meeting requirements are accepted for delivery. Key elements or steps of the procurement cycle include the following:

- procurement planning, including product selection, quantification, and budgeting
- preparation of bidding documents
- management of bidding process from advertisement to bid opening
- bid evaluation
- contract award
- preparation and signing of contract
- contract management during implementation, including dispute resolution methods
- general handling of procurement cycle (duration, participants, reviews, etc.).

In the process of procuring commodities, the following elements of the procurement cycle are captured to explain a flow of activities based on policy, legislation, and adequate guidelines:

- specialized knowledge and expertise of pharmaceuticals and contraceptives
- sustainable financing sources
- knowledge of and compliance with lender, donor, and government procurement procedures
- careful product selection and specifications
- accurate forecasting
- specific quality testing protocols and procedures
- precise preparation of tender documents
- addressing brand preferences
- transparent negotiations and contract management
- receipt and inspection of products.

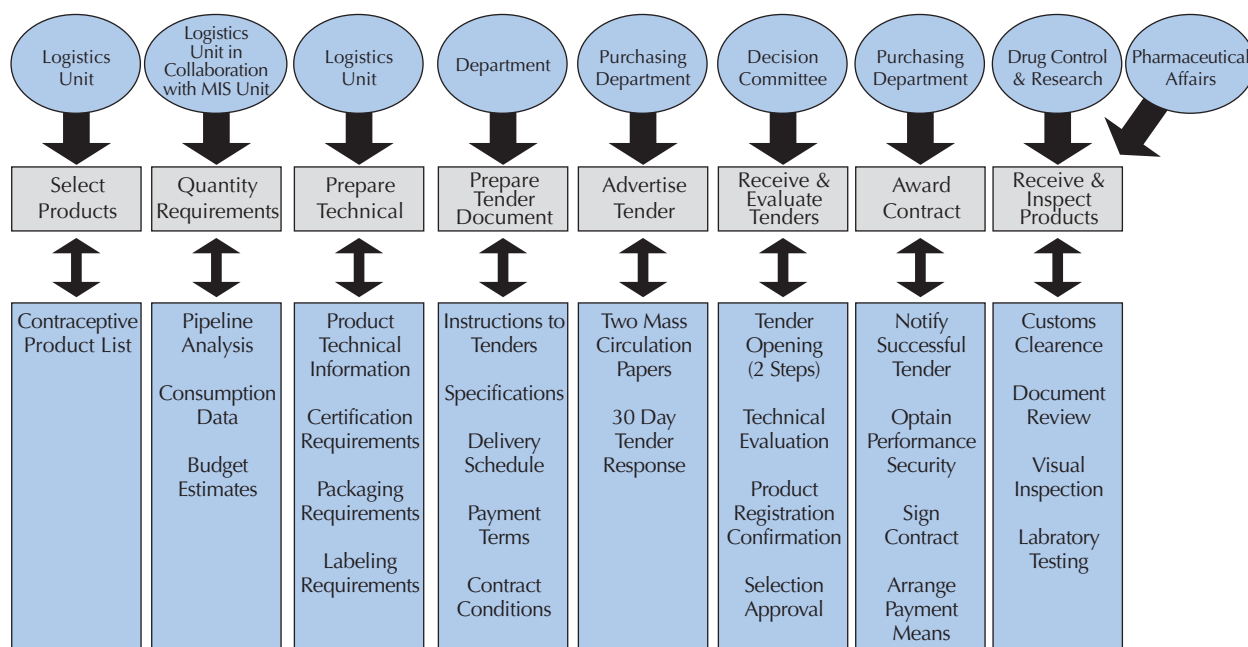
Figure 5 illustrates the chronological flow of procurement-related steps. Failure to address accurate forecasting, for example, could result in the production of erroneous tender documents, leading to supply imbalances. Similarly, financing sources should be identified and secured before beginning the procurement process. Furthermore, the number of agencies involved dictates a high level of coordination among the regulatory bodies, logistics functions, financing agencies, and others involved in the process.

PROCUREMENT KEY STEPS

Experience suggests that attaining the six procurement rights requires careful planning and management. These six rights require the following:

- Funding should be earmarked and disbursed in a timely manner to ensure that economies of scale can be achieved with public procurement.
- International competitive bidding (ICB)¹⁸ can provide access to the best prices, but this requires MOH staff with specialized training in procurement best practices.
- Use of procurement agents should be considered, particularly while MOH staff are being trained in procedures such as ICB and World Bank procedures.¹⁹
- UNFPA can act as a procurement agent to allow access to international prices, particularly where regulations are a constraint. UNFPA performance should be monitored and managed, as with any procurement agent, to ensure that lower priced contraceptives are actually being delivered on time. The use of procurement agents also improves transparency and ensures quality.
- The regulatory environment should permit international tenders to encourage price competition.
- Procurement agencies should review international reference prices, where possible, exchanging information with neighboring countries to allow better informed buying.

Figure 5. Illustrative Procurement Steps



Source: Procurement Strategies for Health Commodities, DELIVER/USAID.

18. International competitive bidding is a procurement process designed to provide the recipient with a wide range of choices in selecting the best tender/ bid offer from competing suppliers/contractors, and to give to all prospective tenderers/bidders from eligible source countries adequate, fair, and equal opportunity to bid on goods and works that are being procured. For more information please refer to *Procurement Strategies for Health Commodities: An Examination of Options and Mechanisms within the Commodity Security Context*. (Rao et al.).

19. World Bank procurement procedures are designed to support good governance and value for money in public spending. They encourage international competitive bidding (ICB) for large purchases and involve a series of approval steps and crosschecks to ensure these steps are being followed.

- Negotiations with manufacturers should look at the benefits of generic purchase while ensuring proper quality and drug safety standards.
- Manufacturers may be able to quote prices for in-country delivery to districts or regional stores.
- Procurement decisions should be transparent and independent of political interference.
- Use of the Internet to publicize procurement opportunities and to document procurement decisions can help improve governance by putting procurement decisions under public scrutiny.
- Use of regional and international quality standards and laboratories can offset the cost of contraceptive quality control.

MEASURES TO IMPROVE TRANSPARENCY

Ensuring good governance and transparency in implementing regulations, norms, and processes related to procurement is a persistent problem in both developed and developing countries. Therefore, establishing policies and clear procedures to improve transparency and accountability in the procurement process, quality control, and information flow is a critical step toward ensuring that procurement decisions can withstand outside scrutiny. These measures also raise public confidence in public sector management of the health system. A number of strategies have been adopted within the region to improve transparency and safeguard good governance in the procurement process. They include the following:

Using independent procurement agents (Peru, El Salvador, the Dominican Republic, and Honduras). Independent procurement agents such as UNFPA and UNDP help improve transparency in the contraceptive procurement process. For example, because of concerns about corruption in the use of loan funds, the World Bank and the IDB require governments to use procurement agents to manage commodity procurement processes. In Honduras, UNDP acts as a procurement agent for the IDB loan. Countries in other regions have used commercial agents—Crown Agents, SGS, International Dispensary Association (IDA), Charles Kendall—to procure drugs and contraceptives as procurement agents for sectorwide health loans.

Establishing autonomous agencies to manage the procurement process. As described in box 1, CENABAST, an autonomous agency in Chile, is in charge of procurement for the government. In Costa Rica, an autonomous agency, the Costa Rican Social Security Fund (CCSS, *Caja Costarricense de Seguro Social*), procures all essential drugs for the public sector, leaving little room for political pressure, while enabling the CCSS to gain stronger leveraging power with commercial suppliers, despite Costa Rica's relatively small market. Although first steps have been taken to remove political

BOX 2. A LESSON FROM COSTA RICA—ENSURING TRANSPARENCY IN QUALITY CONTROL

In Costa Rica, because of public concern about impending changes resulting from CAFTA and increased public vigilance generated by government corruption scandals, a healthy public debate has emerged around procurement. Citizens are concerned about the efficiency and integrity of the procurement process for medicines and quality health commodities. As a result, new laws, decrees, and policies designed to streamline the procurement process, increase transparency, and improve quality of products within the CCSS are being widely discussed at all levels of government.

As a result of public debate and pressure, the Costa Rican government established a national commission to ensure the quality of health commodities. In an attempt to separate procurement responsibility from quality control, and in the interest of increasing transparency, in January 2004, the commission transferred quality control for health commodities from CCSS, the procuring agency, to the MOH. This transfer came into effect during the last quarter of 2005. In addition, in recent months, the national commission has required that generic commodities be tested for therapeutic equivalence. It is expected that more changes and reforms will take place as CAFTA is ratified and citizens continue to demand more transparency, increased availability, and higher product quality from the public sector.

influence throughout the decision-making process in Costa Rica, recent corruption scandals illustrate that further steps must be taken to ensure better governance, increased availability, and deepened transparency throughout the procurement process. See box 2 for recent steps being taken to further governance and ensure transparency in Costa Rica.

Separating procurement responsibility from quality control. In Chile, quality control is outsourced to an international firm that is responsible for accrediting and prequalifying local suppliers from whom CENABAST is authorized to solicit procurement bids. In Costa Rica, the MOH is responsible for ensuring the quality of health commodities that are procured by the CCSS (also see box 2).

Relying on external entities to audit the procurement process. In Chile, bids, demand consolidation, and provider classification are audited by a private firm, thereby increasing transparency and reducing opportunities for corruption.

Establishing clear and open information flows. Chile, Guatemala, and Costa Rica have started to use the Internet to promote e-commerce-driven procurement. This strategy increases competition by providing information to more suppliers and helps to make the process more transparent and open. In Chile, CENABAST uses the Web site www.Chilecompra.cl to solicit bids for public sector goods and services. All documents and information related to the bidding process, as well as results, are publicly available on this Web site. The CCSS in Costa Rica is exploring ways to improve efficiency and transparency in the procurement process by automating tenders, increasing the use of the Internet as a procurement vehicle, and even conducting its own online procurements. Currently, public information is made available via the CCSS Web site (<http://www.ccss.sa.cr/>), and eventually, the CCSS will provide price and procurement data online to ensure accountability and reduce the amount of staff time spent responding to audits. In Guatemala, the Web site www.guatemcompras.gt has been set up to announce bids and share information widely.

VALUE-FOR-MONEY STRATEGIES

A number of value-for-money strategies have already been adopted in the region. The underlying premise is that procurement management capacity exists for informed buying choices to be made.

PRICE COMPARISONS

Prices should be one of the most important factors for countries to consider in selecting contraceptive suppliers. Securing the best possible price for good-quality contraceptives is vital for achieving CS in the absence of donor funding. Nonetheless, the USAID-presence countries studied do not have a tool or system in place that allows them to compare prices of different local, international (including local agents of international companies), and NGO suppliers. Developing and systematizing such a tool is an important first step in identifying a procurement option or options that will ensure the efficient use of government resources for contraceptive purchases. While some countries do engage in price comparisons to justify their choice of supplier (El Salvador, Peru), these comparisons are neither comprehensive nor systematic. A systematic, comprehensive price comparison tool, which includes both brand-name and generic contraceptives, would help keep decision makers informed about the various supply options available in both the national and international markets. It would also help improve transparency and price competitiveness in the contraceptive market.

INFORMED BUYING IN PERU

As mentioned previously, in 2004, the Peru Ministry of Health (MINSA, *Ministerio de Salud*) (with UNFPA) conducted a market study to identify the best available prices for the four contraceptive commodities that the FP program procures. In the case of injectables and IUDs, MINSA opted to procure from UNFPA because its prices were the lowest available. However, the price of the oral contraceptive (etinil estradiol) was significantly lower in the local market, even after including cost of distribution to local delivery points, a service not offered by UNFPA.

Hence, in 2004, MINSA chose to procure etinil estradiol locally, thereby achieving significant savings. The supplier was ESKE, the local representative of the Indian company FamyCare. The entry of companies like ESKE into local markets has great potential to increase competition among local suppliers, thereby yielding better prices for contraceptives.

This experience underscores the importance of establishing, updating, and maintaining a systematic, comprehensive price comparison tool to inform decision makers about the various supply options available in national and international markets.

INFORMED BUYING IN COSTA RICA

The CCSS has procured contraceptive products at competitive pricing levels during the last five years from both international and local manufacturers. The cost information provided by the CCSS suggests that it has established several cost-effective alternatives by alternating between local and international manufacturers. The fact that it is able to procure locally manufactured as well as international competitively priced products means that Costa Rica has important alternatives that are not available to many countries.

Furthermore, the CCSS is developing and evaluating new strategies to improve procurement efficiencies and ensure more competitive prices. Staff from the CCSS mentioned the limitation of supplying a small market in order to negotiate prices with suppliers. They have considered the possibility of merging with larger countries to conduct what they describe as “parallel” purchases, whereby they would purchase some medications directly from these larger countries to access the same economies of scale. This strategy has not yet been fully evaluated, and the details are under development by CCSS staff. Some informants expressed that CAFTA may facilitate the establishment of a regional procurement system and thus help the region obtain better prices as a result of demands for higher volume. In addition, the Central American region is evaluating the feasibility of having a customs union, which would standardize and regionalize the requirements for registration of all medicines and medical supplies and consequently streamline the procurement process.

NEGOTIATING WITH MANUFACTURERS

Peru also negotiated a contract with the local Pfizer distribution office for Depo-Provera. MINSA was willing to pay 20 percent over the UNFPA price to have Depo-Provera delivered to the district level rather than the central level. It thus used the UNFPA price as a reference price in negotiating better delivery terms from the local Pfizer office than UNFPA could offer. The Pfizer office was able to make a small profit on the deal. Otherwise, it would have been bypassed by UNFPA, which would have procured from Pfizer’s international headquarters. There may be other situations in which manufacturers would be willing to be more competitive on price. Several manufacturer’s agents approached MINSA after UNFPA had been awarded the procurement contract to say they could have offered better prices, which is exactly the sort of competitive response required for the next tender.

The public and private sectors in some countries have diversified their sources of contraceptive purchases to include new, more competitive suppliers, such as producers from Brazil and India. The experience of ESKE in Peru is such a case. Similarly, distributors such as the International Dispensary Association (IDA/Holland), which already supply ARVs in the region, could emerge as future low-priced providers of contraceptives in national, subregional, or regional markets. IDA’s list of products includes contraceptives. The entry of new suppliers into the contraceptive market has the potential to increase competition, break the monopolies of big pharmaceutical companies, and reduce prices significantly.

Finally, free trade agreements in the Americas, such as CAFTA and the Free Trade Agreement could create barriers of entry for new players wishing to participate in the market for medicines and contraceptives. Some of these commercial agreements require that signatory governments adhere to common pharmaceutical regulations and standards for their purchases. These regulations and standards are likely to favor larger, well-established pharma-

ceutical companies over newer, smaller ones. Countries in Central America and the Dominican Republic recently signed free trade agreements with the United States that allow U.S. companies to compete as suppliers for government purchases over a specified monetary value. This new development, coupled with new pharmaceutical standards with which only large companies can comply, could well reduce competition in the contraceptive market.

POOLED PROCUREMENT MODELS

None of the countries studied has any experience in the pooled procurement of contraceptives at the regional level. Many consider procurement through UNFPA akin to a globally pooled procurement system that takes advantage of economies of scale.

Central America has taken an important step toward facilitating the pooled procurement of medicines and medical inputs subregionally. These countries have harmonized their medical registries (*registros sanitarios*) by establishing common pharmaceutical norms that establish the technical criteria required for authorization by the registry. Under this system, a medical/drug registry in one country can be officially recognized by any or all of the other countries in the subregion. This obviates the need for any given drug to be registered multiple times in different countries, thereby speeding up drug registration processes and paving the way for pooled procurement. However, this common drug registry is not regularly updated and has yet to be incorporated into national legislation.

The Central American countries have established common standards for GMPs in the pharmaceutical industry and harmonized inspection procedures for the industry. This is also true of the MERCOSUR (*Mercado Común del Sur*) member countries (Brazil, Argentine, Uruguay, Paraguay, and Venezuela).

The negotiation of low ARV prices by 10 Andean countries points to a relevant subregional experience in which a group of countries successfully negotiated with pharmaceutical companies and establish regulated prices at which they could purchase ARVs. A similar price negotiation process has also been utilized by MOHs in El Salvador, Peru, and Nicaragua, for example, to purchase medicines for the entire health system, albeit from local suppliers. Regional or subregional price negotiations that take advantage of economies of scale could be an interesting option to explore for contraceptive purchases in Latin America.

The Strategic Fund for the purchase of medicines and other goods, established by the Pan-American Health Organization (PAHO) in 2000, is a fund countries can draw from, and it is made up of voluntary contributions from participating countries. One of its objectives is to facilitate the “supply of pharmaceutical products to national health programs related to nutrition, child and adolescent health, and reproductive health of women,” while achieving savings through economies of scale and receiving high-quality products in a timely and efficient manner.

This fund represents another mechanism through which countries can purchase drugs and contraceptives. However, its solvency depends on the timely and adequate contributions of the member countries. It would be advisable, therefore, for PAHO to work in close coordination with UNFPA for the purchase of contraceptives, given UNFPA’s established agreements with contraceptive manufacturers.

Finally, a nearby example of a pooled procurement mechanism is the Eastern Caribbean Drug Service. Under this model, the MOHs from nine separate islands pool their procurement of class A and B essential drugs. Established in 1986 with six ministries, under the USAID-funded Rational Pharmaceutical Management program, three additional MOHs joined in 1995. The service became financially self-sufficient in 1989, based on a 15 percent administrative fee charged to participating governments. By 1994, it was operating with a surplus that it invested through the Eastern Caribbean Central Bank. During its first procurement cycle, the service realized a 52 percent unit cost reduction, followed by an additional 18 percent in its second cycle with competitive bidding (for 59 class A products). The average country savings for the first tender ranged from 16 percent to 88 percent. The service does not purchase for the private sector, which often needs branded products, symptomatic treatment, and more expensive packaging (also potential administrative costs to supply multiple small pharmacies).

TABLE II. LEVELS OF QUALITY CONTROL

Manufacturers should be prequalified	Manufacturers participating in tenders should ideally be prequalified to ensure that they apply GMP are internationally recognized with U.S. Food and Drug Administration and/or European Union drug approvals and recognized by WHO. For example, under Guatemala's open contract mechanism, the Ministry of Finance solicits bids from a short list of prequalified providers who are selected by the government on the basis of price, quality, and ability to provide sufficient volume. In Chile, CENABAST solicits bids only from local suppliers that have been preapproved by ISP. The accreditation of these providers is outsourced to an international firm in the interest of transparency.
Tenders should be correctly specified	Contraceptive commodity tenders should have clear technical specifications that can be verified by the tender evaluation committee.
Drug registration	All countries require that new drugs be registered. Registration should strike the right balance between supporting public safety without creating a barrier to supply. To facilitate this process, Central American countries are implementing a regional harmonization of drug registration. Under this system, a drug registered in one country can be officially recognized by any or all other countries in the subregion, as they now do it in some of the South American countries (e.g., Ecuador and Colombia).
Pre- and postshipment inspection and quality testing	Protocols for testing the quality of contraceptives should specify the basis and frequency for quality testing. Use of international and regional laboratories should be considered where in-country facilities are underdeveloped. In Chile, where capacity exists, the ISP screens samples of all products that are imported.
Addressing manufacturer liability for failed shipments	Supplier contracts should specify that manufacturers assume responsibility for disposing of failed lots of contraceptives.

Note: CENABAST = Chilean national procurement agency for the National Health Service; GMP = good manufacturing practice; ISP = Chilean National Institute of Public Health; WHO = World Health Organization.

This service encountered some difficulties, including the diversity of its member states (language, history, etc.), which was being overcome by efforts from the Organization of Eastern Caribbean States. In addition, member countries were defaulting, or being allowed to do so, on reimbursements to their accounts with the Eastern Caribbean Central Bank; the local (regional) currency was not stable; and weak forecasting performance diminished the full potential of pooled procurement.²⁰

ENSURING BUDGETS ARE FUNDED

Procurement using public funds is frequently affected by two problems that undermine efficient planning and result in higher costs to the public sector. Even where budget lines are allocated, cash flow and treasury management constraints can undermine the ability of the Ministry of Finance to make all the necessary procurement funds available at one time. If budgets are made available on a quarterly basis, the MOH may be forced to make four smaller purchases of commodities rather than one bulk purchase. Furthermore, payment delays can occur depending on how purchases are actually paid for, with invoices for approved purchase orders being sent to the treasury for payment. These delays and risks of nonpayment will reduce the possibility of negotiating lower prices from suppliers or entering into agreements with UNFPA.

20. Abdallah, Hany. 2005. *West Africa Reproductive Health Commodity Security. Review of Pooled Procurement*. Arlington, Va.: John Snow, Inc./DELIVER, for the U.S. Agency for International Development.

ESTABLISHING QUALITY CONTROL PROCEDURES

Effective quality control is of paramount importance to safeguard public safety and ensure that effective methods are procured. Quality control for contraceptives and medicines needs to be regulated at several points throughout the procurement process, as presented in table 11.

The capacity for quality control of medicines, including contraceptives, differs widely across countries in the region. In some countries, quality control mechanisms are quite rudimentary. These countries lack the infrastructure, equipment, and qualified personnel to carry out quality control functions systematically. In these countries, MOHs often rely exclusively on the quality certification that a supplier presents with its bid. Designing strong quality control standards and procedures, assigning an autonomous entity the role of oversight, training personnel in quality control procedures, and allocating funds for purchase of equipment and infrastructure are all necessary steps in improving a country's quality control procedures.

OTHER LESSONS FOR PHASEOUT

PREPARING A FINANCIAL AND PROCUREMENT PLAN

Countries need a clear plan of how they will fund and procure their contraceptives once USAID and other donors withdraw. Following are examples of procurement strategies that other countries within the LAC region implemented following donor phaseout of contraceptives.

PROCUREMENT MECHANISMS AND PRACTICES IN MEXICO

The withdrawal of USAID support for contraceptive commodities in Mexico was characterized by an overall supportive environment for RH and FP. In general, contraceptive prevalence had reached a mature level, the government's support for FP and RH had been institutionalized, and the program had the technical and financial capacity to meet the FP needs of the Mexican population.

In 1996, when USAID contraceptive donations ended, the government's family planning budget stood at U.S.\$13 million. These critical factors set the stage for a smooth transition from USAID support. However, the fact that procurement responsibilities for contraceptives were decentralized to the state level almost immediately after USAID's phaseout caused a major rupture in the provision and

BOX 3. NGO SUSTAINABILITY AND THE CASE OF APROFA IN CHILE

In mid-1992, USAID officially announced its intention to withdraw from Chile, given the level of socioeconomic development attained by the country and the level of maturity of the institutions that benefited from donations. The phaseout strategy was deployed over three years, from 1992 to 1995. At that time, USAID offered a matching grant to help APROFA. The grant aimed to help APROFA reorganize and develop new business lines to ensure long-term economic viability and to assist the organization in defining its new role after phaseout.

Because APROFA did not truly expect USAID to phase out, the organization did not accept the grant and did very little to formally plan for phaseout. The perception of APROFA today is that, at the time, there was a problem of credibility concerning the announcement of USAID's withdrawal. Until then, there had been a history of nearly 30 years of collaboration. During that period, USAID subsidized most APROFA activities, including planning, procurement, distribution, and promotion of FP methods. Thus, APROFA did not anticipate the dramatic level of reduction in assistance, even though phaseout plans had been announced.

As a result of a lack of planning and preparation, APROFA experienced a dramatic reduction in its portfolio of services. In fact, of the 40 associated clinics that APROFA managed at some point, today only 5 are in operation. Today, APROFA is self-critical for not having taken better advantage of the resources available to it during the transition period. The organization feels that a formal phaseout strategy, deeply involving the public and social market sectors, would have mitigated the dramatic negative impact on the organization.

supply of contraceptives. Most states were unprepared and unfamiliar with the processes for projecting, planning, and budgeting for their contraceptive needs. The result was frequent stockouts. This represents a major lesson for other countries that are facing USAID phaseout and addressing CS in a decentralized setting. These countries must make sure they gradually develop capacity at lower levels to ensure that facilities are able to forecast, plan for procurement, order, and distribute contraceptives in an efficient manner before devolving full responsibility to them.²¹

NGO SUSTAINABILITY PLANS

In the LAC region, USAID technical assistance has worked toward ensuring CS and efficient use of available resources by promoting a multisectoral approach. Throughout the phaseout period in the five graduated countries studied, USAID encouraged partnerships between public and private sector providers and emphasized the complementary role that the private sector can play in reaching all segments of the population. In addition, USAID worked with NGOs to develop sustainability plans after phaseout as well as to form partnerships or collaborate with public and commercial sectors.

It is helpful to examine what happened to these NGO service providers once USAID funding ended. Although some NGOs were able to sustain themselves through a variety of methods, such as instituting or increasing user fees, developing successful social marketing programs, offering additional services to family planning, obtaining funding from new sources, and collaborating with other sectors to contract out services, some organizations were more effective in dealing with phaseout than others.

For instance, while USAID provided funding support to develop a strategic response to phaseout, NGOs did not always take the prospect seriously, in some cases mistakenly assuming that USAID funding for their FP activities would continue. Box 3 provides an important example of how the IPPF affiliate in Chile (APROFA, *Asociación Chilena De Protección De La Familia*), previously one of the leading FP service providers, lost its share of the market to the public sector by not clearly understanding the impact of USAID's intention to phase out support to Chile.

Furthermore, although NGOs in the five graduated countries were committed to reaching the most vulnerable segments of the population, they were often forced to make trade-offs between serving the poor and becoming sustainable. Most of the NGOs in the five graduated countries experienced a decline in low-income clients after fees were initiated and targeted activities were cut from work plans. For instance, in Mexico, the *Fundación Mexicana para la Planeación Familiar* (MEXFAM) clinics planned to cover their own costs by cross-subsidizing their community programs. However, they were only able to generate enough funds to cover one-third of their social programs and, consequently, were forced to scale back their programs. APROFA, in Chile, also saw a shift in clientele and was no longer able to reach the poorest segments of the population by providing free services and contraceptives.

Despite challenges of becoming sustainable, some NGOs developed successful phaseout strategies. For example, unlike other NGOs in Brazil, *Bem-Estar Familiar no Brasil* (BEMFAM) is still actively involved in the sale of contraceptives and providing services to an ever-increasing number of clients (see box 4). BEMFAM characterizes its role as complementary to government activities. It often works through cooperative agreements established with the public sector that allow the NGO to directly influence municipal management by bringing attention to two important issues: (1) the diversification and expansion of method mix as a true demonstration of respect for women's and men's choices in FP; and (2) discussion about important issues related to women's and men's health (e.g., gender, poverty, and youth). In the last 12 years, BEMFAM served more than 4 million clients and patients through municipal cooperative agreements. BEMFAM also operates six RH clinics that are designed to model

21. For a more in-depth discussion of issues related to decentralization, please refer to *Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean: With Lessons Learned from Asia and Africa* (Beith, et al.) and *Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean: Considerations for Informed Decision-Making When Decentralizing and Integrating Health Logistics System Functions* (Sánchez et al.).

ways that women's and men's health care needs should and could be satisfied in Brazil.

Unlike many NGOs in the LAC region, the *Asociación Pro-Bienestar de la Familia Colombiana* (PROFAMILIA) in Colombia has been a leader in FP since the 1960s. In 1990, the organization provided at least 65 percent of all FP services in the country and managed to maintain a leading role during and throughout phaseout. PROFAMILIA manages clinics throughout the entire country and effectively

reaches the rural and urban poor through the use community-based distribution strategies and partnerships with the public (Social Security) and commercial sector. PROFAMILIA's success has been attributed to strong leadership; effective strategies for marketing, innovation, and fundraising; a focus on the client; and the provision of high-quality services.

The organization's service delivery strategies were essential to ensuring sustainability. Since its inception, the organization instituted a fee-for-service approach that operated on a sliding scale. In this manner, the organization began working toward sustainability from the outset and applied cross-subsidies to maintain the lowest prices for the poorest of the poor.

At the same time, the organization focused on providing high-quality services and an appropriate method mix to close the gap between public and commercial services. In other words, PROFAMILIA focused on the needs and preferences of the client by providing a broad mix of contraceptive methods and excellent care. By focusing on the client, the organization stood out in comparison to the public sector, which was unable to provide the same broad range of products and the same level of care. Furthermore, during the 1970s, PROFAMILIA implemented a self-sustaining social marketing program by purchasing contraceptives wholesale and selling them to local distributors and commercial outlets at a reduced price. The organization used the profits from this program to help fund its Community Based Distribution and other programs, including sterilization.

During the 1980s, the CBD and social marketing programs faced major challenges as revenue declined because of higher priced contraceptives, MOH-established prices for drugs, and government prohibitions on the NGO sale of donated products. In response, the organization developed various strategies for reducing costs, generating additional funds, and operating more efficiently. PROFAMILIA combined the social marketing and CBD programs to lower overhead costs. In addition, the organization diversified the types of services it provided as well as looked for new partners. PROFAMILIA broadened its services to include a range of RH services it had not previously provided. The NGO charged a higher margin on these services but maintained a lower price than other private facilities. The revenue generated from these services was used to subsidize FP services for the poor and the CBD and other programs. In addition, PROFAMILIA obtained contracts with public and private entities to provide services on their behalf, such as the Social Security institution. Through the use of innovative business strategies and good planning, PROFAMILIA withstood some of the same pressures that other NGOs in the LAC region experienced during phaseout and successfully managed to sustain itself while maintaining its commitment to serve the poor.

The various case studies presented above illustrate key lessons for NGOs to draw upon when developing plans for eventual phaseout. To prepare for a smooth transition, NGOs should consider the following important lessons:

BOX 4. LESSONS LEARNED IN BRAZIL FROM BEMFAM

Several factors contributed to BEMFAM's success in sustaining FP services after USAID phaseout. First, since the very beginning, and during its 40 years of existence, BEMFAM received but never depended on USAID funding. USAID funds traditionally represented only a small percentage of BEMFAM's budget. Thus, the impact of USAID's withdrawal on the organization and its operations was not severe. Furthermore, BEMFAM has been largely implementing its activities through direct cooperative agreements with state and municipal health secretariats, which has set its operations apart from the other NGOs in Brazil (a majority of which depend on international financial support or on sporadic and irregular MOH funding and projects). Finally, BEMFAM's experience, size, and connections with the government give it credibility and strengthen its image of being a strong candidate for public funding and MOH contracts.

- Recognize that phaseout is real, and prepare for it with business plans that identify service diversification options and identify NGO strengths and weaknesses.
- Develop strategic partnerships with public sector (such as Social Security) to supplement local public services.
- Follow Colombia's PROFAMILIA example and develop a business plan that helps them to be part of the health reform, so that clients can pay according to their classification in the socio-economic scale.

PROCUREMENT OPTIONS

Before elaborating country-specific regional procurement options, it is important to reiterate some core relationships between CS and procurement:

- Efficient and effective procurement is a cornerstone of CS in the LAC region.
- Effective procurement requires an emphasis on striking a balance between obtaining value for money, ensuring product quality, and ensuring transparency and efficiency in procurement.
- Ideally, wherever possible, national capacity and the regulatory environment should be developed to enable the public sector to make informed buying decisions from different international and national sources.
- Where capacity or regulatory constraints do not permit a wide range of procurement options, mechanisms, such as using UNFPA as a procurement agent, should be considered in the short to medium term.

Ideally, public procurement should be efficient, transparent, and provide value for money while safeguarding quality and public safety. Based on the pricing and regulatory analyses, several key options have been identified to improve the effectiveness, transparency, and efficiency of contraceptive procurement strategies in the region. These options have been grouped according to short-term, medium-term, and long-term phases as countries in various stages of development toward sustained CS have differing priorities and face a range of challenges.

Each LAC country studied faces a unique set of circumstances and conditions. Table 12 summarizes regulatory and capacity constraints as well as suggested procurement options (drawn from lesson learned in all 14 countries) for each of the nine USAID-presence countries. Recommendations are clustered depending on whether countries are already engaging in or are considering informed buying, which is purchasing based on market studies where comparisons of alternative pricing options are identified to guide the bidding process.²²

We next elaborate on each of the recommendations and indicate those that could be considered for the short-, medium-, and long-term solutions.

SHORT-TERM OPTIONS

Countries that have not begun to procure contraceptives for themselves should take some first steps to ensure a smooth transition once donors phase out support. Most likely, countries that are just beginning to prepare for phaseout will require technical assistance in planning and preparing for procurement on their own. Below are a series of first steps that can be taken to begin to build the foundation for efficient and sustainable procurement into the future.

Develop financial and procurement plans for eventual phaseout of contraceptives from USAID and others donors. Financial and procurement planning should be in place in countries preparing for phaseout from USAID and other donors in order to identify who will take over responsibility for procurement, what measures need to be in place for these institutions to take over, and which interim mechanisms, such as UNFPA or other procurement agents, can be considered as a solution until national capacity is in place. The plans should include commodity and

22. It is necessary to distinguish between informed buying and coordinated informed buying. Informed buying is when countries share information about prices and suppliers before individually conducting procurement. Alternatively, coordinated informed buying refers to the practice by which member countries undertake joint market research, share supplier performance information, and monitor prices, followed by individual procurement.

TABLE 12. SUMMARY OF CONSTRAINTS AND PROCUREMENT OPTIONS

	Procurement Capacity	Regulatory Environment	Procurement Options
Countries Engaged in Informed Buying			
Peru	MOH is already undertaking informed buying with market studies and using different sources for different contraceptive methods, including local private suppliers and UNFPA.	There are restrictive procurement regulations, but these are being overcome with the use of special exceptions.	<ul style="list-style-type: none"> • Further develop procurement capacity at all levels and collaborate with the private sector when possible and efficient • Continue to use price comparisons (including added costs), collect pricing information over time, and share information with other countries in the region
Dominican Republic	Price comparisons have led to a switch from local procurement to using UNFPA as an agent.	There are restrictive procurement regulations, but these are being overcome by using UNFPA.	<ul style="list-style-type: none"> • Implement regulatory reform when possible • Monitor performance of UNFPA and other local and international suppliers
El Salvador	Price comparisons have led to a switch from local procurement to using UNFPA as an agent.	There are restrictive procurement regulations, but these are being overcome with the use of special exceptions.	<ul style="list-style-type: none"> • Implement quality assurance measures, especially when procuring from suppliers that have not been prequalified by WHO. • Publish prices obtained to further deepen transparency • Explore opportunities for pooling procurement • Advocate for public monitoring of the procurement process
Countries Using Procurement Agents			
Guatemala	Procurement being undertaken by UNFPA	There are less-restrictive local procurement regulations.	<ul style="list-style-type: none"> • Develop procurement capacity, including the ability to access competitive prices, forecast, order, and distribute at all public sector levels • Collect pricing information to ensure that the UNFPA price is the best available • Monitor UNFPA performance and continue to refine and formalize this relationship • Examine scope for regulatory reform
Honduras	Procurement was undertaken by UNDP in the past; new government officials will assess the effectiveness of this mechanism.	There are restrictive local procurement regulations.	<ul style="list-style-type: none"> • Develop procurement capacity, including ability to access competitive prices, forecast, order, and distribute at all public sector levels • Analyze other procurement options, such as UNFPA, and take steps to formalize this relationship if it proves more efficient than the UNDP option • Collect pricing information to ensure UNFPA or UNDP prices are the best available • Monitor UNDP performance • Examine scope for regulatory reform

TABLE 12. SUMMARY OF CONSTRAINTS AND PROCUREMENT OPTIONS (CONTINUED)

	Procurement Capacity	Regulatory Environment	Procurement Options
Countries Considering Their Options			
Ecuador	Procurement at the local level at high prices	Decentralized procurement at the health area Less-restrictive local procurement regulations	<ul style="list-style-type: none"> Examine mechanisms for pooling procurement for health areas and/or municipalities to take advantage of economies of scale
Bolivia	No procurement yet of contraceptives as products are still donated	Decentralized procurement at the municipality	<ul style="list-style-type: none"> Develop procurement capacity, including the ability to forecast and efficiently manage ordering and distribution systems Consider UNFPA as a short- to mid-term solution and take steps to formalize this relationship (i.e., MOU)
Paraguay	Little FP procurement	Less-restrictive regulations	<ul style="list-style-type: none"> Develop procurement capacity, including ability to forecast and efficiently manage ordering and distribution systems Consider UNFPA as a short- to mid-term solution and take steps to formalize this relationship (i.e., MOU)
Nicaragua	No FP procurement	There are restrictive local procurement regulations	

financial projections using SPECTRUM²³ and PipeLine²⁴. Support from donors will likely still be required, as in Guatemala, to establish initial funding and reinforce the commitment from governments to fund budget lines. Bolivia, with its lower contraceptive prevalence rate (CPR) and higher poverty levels, will also require continued donor support.

Develop the ability within each institution to accurately forecast national contraceptive needs and financial requirements, prepare and carry out procurement plans, place orders in a timely manner, and efficiently distribute commodities to all levels. If contraceptives are to be available to those who need them, the ability to prepare for, plan, procure, and efficiently distribute contraceptives is essential at all levels of the public sector. Technical assistance from donors will likely be required to assist countries with the proper management of an efficient supply chain, including efficient procurement processes.

Consider the option of working with UNFPA as a procurement agent while domestic procurement capacity is being developed and regulatory barriers are addressed. Using UNFPA as a procurement agent will entail setting up an MOU with UNFPA, coming to an understanding about gradual decreases in donations and gradual increases in country funding for the purchase of contraceptives, preparing budgets and financial forecasts that slowly set aside funding for the eventual purchase of all contraceptives, and beginning to understand how economies of scale obtained from UNFPA can benefit a country. Throughout this stage, a country may need technical assistance from UNFPA and other donors to plan for a gradual decrease in donations, to assist the forecasting and financial budgeting process, and to identify procedures for establishing an agreement with UNFPA. Strengthening procurement capacity requires specialized regional training so that those responsible for procurement are familiar with contraceptives specifications, can correctly define bid requirements, are equipped to evaluate bid quality, and can monitor and evaluate bid performance.

Implement measures to include an expanded method mix in the EDL and harmonize this list with other public institutions' basic drug lists. MOH EDLs in Peru, El Salvador, Nicaragua, the Dominican Republic,

23. SPECTRUM is a software suite of policy models that are used to project the need for reproductive health services and the consequences of not addressing reproductive health needs (available at <http://www.constellafutures.com>).

24. PipeLine is a monitoring and procurement planning 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 stock-outs (available at <http://www.deliverjsi.com>).

Guatemala, Ecuador, and Bolivia are restrictive²⁵—if the drug/medicine (or contraceptive in this case) is not on the list, it may not be purchased with government funds—so, the inclusion of all contraceptive methods is vital to ensuring their availability at MOH establishments. The EDLs in all these countries, except Ecuador²⁶ include a wide range of contraceptive methods. However, they often do not include condoms, which are nonhormonal and do not qualify as drugs, and IUDs, which are considered medical devices. Including condoms and IUDs in an expanded EDL would allow the MOH to purchase these methods and ensure their availability at public sector health facilities after contraceptive donations end. Harmonizing the MOH EDL with the basic drug lists of Social Security Institutes in these countries would also enable them to purchase and provide a wide range of contraceptives to their beneficiaries, many of whom now rely on the MOH or private sector for their FP needs²⁷

MEDIUM-TERM OPTIONS

Countries looking at options in the medium term need to establish the ability to procure, forecast, and finance contraceptives without external technical assistance; begin to remove regulatory barriers; and develop the ability to obtain better prices than UNFPA, if they are available locally or internationally. If countries can begin to remove restrictive procurement regulations and develop greater domestic procurement capacity, then they may benefit from establishing a Web-based coordinated informed buying arrangement. Information similar to that collected for this analysis could be collected and shared on a routine basis to help inform procurement decisions.

Establish a fully funded, protected budget line item for contraceptive commodities. Although many countries in the LAC region have allocated funds for procuring contraceptives, most government commitments and recent practices for allocating money for contraceptive procurement do not give FP a legally protected status that would guarantee full disbursement of required funding each year. In these countries, cash flow and treasury management constraints typically can undermine the ability of the Ministry of Finance to make all the necessary procurement funds available at one time. Vaccines in many of these countries, however, do have a protected status and, because of this, the Ministry of Finance is legally obligated to transfer the entire amount of resources budgeted for the purchase of vaccines in any given year. These funds are then transferred to the PAHO revolving fund through which these countries purchase vaccines. Ensuring CS in an environment of limited public sector resources may well require that RH and FP be elevated to a similar level of importance, particularly given their links to reducing maternal, neonatal, and infant mortality (see box 5). This would enable governments to make bulk purchases through UNFPA and other suppliers, as well as participate in regional or subregional pooled procurement schemes (similar to the vaccine fund) in the future.

Promote the use of price comparison tools to identify best prices. Prices are one of the most important factors that countries need to consider in selecting suppliers of contraceptives.²⁸ Securing the best possible price for good-quality contraceptives is vital for achieving CS in the absence of donor funding. Countries in this study do not have a comprehensive tool or system in place to allow them to compare prices offered by different local and international suppliers of medicines and contraceptives in the region. Developing, systematizing, and updating such a tool (e.g., a reference price list) is an important first step in identifying the best procurement option or combination of options that will ensure efficient use of scarce government resources for contraceptive purchases. Management Sciences for Health (MSH) publishes an annual price indicator guide²⁹ providing ex works and CIF prices

25. In Paraguay, the EDL does not include contraceptives. However, this has not been a barrier to purchasing contraceptives because the Ministry's EDL is not restrictive.

26. In Ecuador, the EDL is restrictive in nature and includes only oral contraceptives and IUDs. However, the MOH can purchase contraceptive commodities that are not on the EDL because the Law of Free Maternity and Infant Care guarantees their availability at SDPs and includes all methods in its own EDL.

27. Until recently, the Social Security Institute in Paraguay (IPS) could not purchase contraceptives because they were not included on its basic drug list. At present, IPS only provides contraceptives to its beneficiaries if they are donated by the MOH, but it is expected that institutional purchases will begin later in 2006.

28. Other important factors to consider include quality, availability of product in sufficient quantities, and timeliness.

on medicines and consumables charged by key suppliers to public sector programs. The price guide provides low, high, and median prices that can be compared with those obtained in LAC countries. This guide can serve as a powerful advocacy tool to liberalize procurement if wide disparities are found, or at least help institutions consider the need to open their bids to international suppliers, so that direct information on prices can be obtained from both local and international suppliers.

Explore and enter into negotiations with new sources of supply, including UNFPA or other lower price providers (NGOs and GMP generic manufacturers). As mentioned throughout this analysis, some countries have diversified their sources of contraceptive purchases to include new, more competitive suppliers, such as producers from Brazil and India, or to negotiate directly with larger manufacturers. The experience of ESKE in Peru represents such a case. If lower prices are available from other sources, countries can consider new sources of supply while continuing to procure from UNFPA as long as UN prices remain competitive. Nevertheless, if countries intend to procure from multiple suppliers, they should continue to monitor and formalize their relationships with suppliers and build the capacity to correct inefficiencies throughout the procurement process. Clearly, monitoring more than one supplier requires added administrative oversight, increased procurement capacity, and a more liberal regulatory environment. Furthermore, countries must continue to refine their ability to select contraceptives and clearly determine specifications, define bid requirements, evaluate bid quality, and monitor and evaluate bid performance. In addition, as countries begin to procure from new sources, they must implement quality assurance measures to guarantee that these commodities are as efficacious and safe as those provided directly through the UN system.

Examine the scope for addressing restrictive regulatory environments, including unnecessary tariffs, limits on access to a range of suppliers, bureaucratic delays throughout the procurement process, and VAT on contraceptives. Identify laws and regulations that impact price as well as breadth of quality suppliers and begin to determine whether there is any scope to reform or eliminate these restrictions. For instance, countries can consider making the case for exempting contraceptives purchased by the public sector from VAT and duties. As table 8 shows, public sector purchases of contraceptives are exempt from VAT in six out of the nine countries studied. These

BOX 5. PAHO REVOLVING FUND FOR VACCINES—CAN IT WORK FOR CONTRACEPTIVES?

In the past, several meetings and discussions have been held with PAHO officials regarding contraceptive procurement. In most of these discussions, PAHO has expressed an interest in facilitating the procurement process on behalf of governments in the region through a mechanism similar to the revolving funds used to procure vaccines. Three conditions facilitate the implementation of the vaccine mechanism:

1. The immunization program is one of the high-priority programs in each of the countries, and governments consider vaccines as “strategic products.” Therefore, governments are obligated to allocate funds to procure them.
2. On an annual basis, governments have to deposit funds into the revolving fund for vaccines, and PAHO has the flexibility to procure supplies on behalf of governments, even if not all governments have allocated all the needed funds for their particular program, since it usually has a “financial cushion,” just like USAID through its global procurement agreements.
3. Vaccines are highly visible, politically speaking, and governments will not risk their political status. This makes the immunization program financially viable, since funds are earmarked and ensure availability.

This mechanism has not been implemented for contraceptives because FP programs do not fulfill the set of criteria described above. As long as FP is not considered a high priority, contraceptives will not be considered “strategic products,” and funds will not be earmarked for contraceptive procurement. There is limited possibility to procure contraceptives using the revolving fund mechanism unless FP were to receive more concentrated attention and an elevated status as a priority program.

29. *International Drug Price Indicator Guide* is available at <http://www.msh.org/resources/publications/index.cfm>

BOX 6. BENEFITS OF REMOVING VAT FROM CONDOMS IN BRAZIL, AND FROM ALL METHODS IN COLOMBIA

In Brazil, the petition to exempt condoms from the value-added sales taxes was accepted by the government. Its ratification came in 1997, when the condom tax exemption was granted by all states of the Brazilian federation. This action significantly lowered the price of the product, despite the fact that it did not lower any import taxes or prices of raw materials. In Colombia, since the beginning of health reform (1993), all contraceptive methods were exempted from VAT, and condoms were exempted from VAT and tax/duties. This exemption has contributed to an increase in competition in the contraceptive market, which has resulted in more variety in methods and lower prices. Such prices have benefited consumers by providing them with better choices in both quality and price. The final outcome has been a wider choice for users. In Brazil, both supply and demand of condoms in the market increased, with 425 million condoms sold per year in pharmacies and drugstores (70 percent), supermarkets (25 percent), and other small outlets (5 percent).

exemptions apply only to the public sector, not to NGOs. These taxes increase the financial burden on governments, particularly because all governments provide contraceptives free-of-charge to consumers and, hence, there is no option to pass on the tax burden to consumers. MOHs should consider following the lead of Colombia, where all contraceptives are exempt from VAT, and condoms are both exempt from both VAT and import duty because they form part of the basic basket (*canasta básica*) (see box 6). Seeking duty exemption would require making a case to the Ministry of Finance for exempting from tariffs and taxes either (1) all drugs and medicines on the EDL or (2)

those drugs and medicines that do not enter the commercial route. There are precedents for such tax exemptions. Vaccine purchases in most countries are exempted from taxes because immunization is considered a health priority and vaccines have a protected status. In El Salvador, contraceptives purchased with public sector funds through UNFPA are exempted from import taxes if they are introduced into the country using a Presidential Decree (*Francia Presidencial*).

When conducting decentralized procurement, at a minimum, it is important to ensure that price negotiations are consolidated at the central level to capitalize on the benefits of economies of scale. A country's ability to negotiate the best possible price for a specific product, including medicines and contraceptives, depends in large part on the volume being purchased. Higher volumes vastly improve the purchaser's power of negotiation, thereby yielding lower prices and significant savings. Recognizing this reality, some countries in the region have systems in place for centralized purchase or centralized price negotiations of medicines for the entire public sector health system. In other countries, however, the purchase of drugs and medicines is fragmented, with purchases taking place at the individual health region and municipality, health establishment, or program level. Fragmented purchases are small in quantity, noncompetitive in nature, and very costly, with none of the attendant advantages of bulk procurement, which leads to a significant waste of scarce resources. Countries that do not have systems in place for consolidated or centralized procurement and price negotiation would be well-served by studying the consolidated procurement mechanisms in use in such countries as Mexico, Chile, Costa Rica, Guatemala (open contract mechanism), Peru, Honduras, and El Salvador, and using those and other models to design their own centralized procurement or price negotiation mechanisms.

LONG-TERM OPTIONS

As countries strengthen their procurement capacity, improve regulatory environments, and implement tools to facilitate efficient procurement (i.e., price selection), they can transition from utilizing UNFPA as a procurement agent and for the source of their supply to using local or open international competitive procurement and informed buying. On the other hand, if countries are unable to remove regulatory barriers or to develop the capacity to select qualified and cost-efficient suppliers on their own, they should consider procuring through UNFPA

on a permanent basis or only through manufacturers that have been prequalified by UNFPA and its partner agencies, notably WHO and the United Nations Children’s Fund (UNICEF).

Strengthen procurement capacity to enable staff to conduct informed buying, contract management, tendering, and competitive bidding at all levels of the public sector. Continue to build the capacity for local staff to manage the procurement process on their own, including monitoring the performance of selected providers and adjusting the bidding process accordingly. Continue to train staff at all levels in the basic principles and practice of an effective public sector health commodity procurement system:

- selecting the most cost-effective and safest essential medicines
- forecasting and quantifying needed purchase volumes
- ensuring adequate financing for the purchase of essential medicine
- identifying qualified suppliers
- managing the tendering, bidding, award, and contracting processes
- maintaining transparency and accountability in all transactions
- ensuring good-quality, safe commodities
- monitoring the performance of the range of processes involved in procurement management.

When procuring at a decentralized level, ensure that qualified procurement staff are available at these levels who have the capacity and funding levels necessary to effectively forecast their own needs; procure in a timely manner; access low-priced, quality commodities from reliable providers; and efficiently distribute sufficient quantities to all levels.

Develop a regional information system that regularly provides up-to-date price and provider information to be used throughout the procurement decision-making process. Share prices obtained at the local level with neighboring countries in order to better monitor supplier performance over time and ensure that the best prices are available in local and international markets. While some countries —El Salvador, Peru, Honduras, and the Dominican Republic—do engage in price comparisons to justify their choice of supplier, these comparisons are neither comprehensive (i.e., they do not include all possible supplier options) nor systematic (comparison is not a routine part of the procurement process). A price comparison tool that includes brand-name and generic products and is regularly updated to include potential new suppliers would help keep decision makers informed about the various supply options available in both the national and international markets. It would also help improve transparency and price competitiveness. However, this can be achieved only when countries really engage in direct negotiations with the suppliers of similar products in both the local and international markets. Exchanging price comparison tools among countries will inform governments about price discrepancies, giving them the option of using that information to negotiate with suppliers. It will also provide information about new sources that a country may not have used in the past but would like to use in the future. For example, Peru’s price list, which would include ESKE/FamyCare as a low-priced provider of etinil estradiol, may prompt another country to initiate discussions with FamyCare.

Eliminate regulatory barriers that impede access to low-priced, quality RH commodities (unnecessary tariffs, limits on access to a range of suppliers, bureaucratic delays throughout the procurement process, VAT on contraceptives, etc.). As mentioned above, the legal and regulatory environments in the LAC countries are often complex and restrictive when procurement involves the use of public funds: some favor contracts to benefit local producers (most of the USAID-presence countries); others impose taxes that make imported goods expensive (Peru and El Salvador); and others allow slightly more flexibility for procurement agents to explore

prices in both local and international markets. Use of public funds demands that spending demonstrate value for money and that the best possible deal be obtained, subject to quality and safety considerations. This requires a review of a choice of products from different national and international sources and comparisons of price, product shipment conditions, and product quality. Bulk purchase is a key way to ensure value for money to obtain economies of scale in delivery and lower unit prices. Where there is scope, governments should consider eliminating regulatory barriers that impede access to low-priced quality commodities in both domestic and international markets. Political leadership is a necessary instrument to establish a legal and regulatory framework that supports commodities, including affordable prices, tariff exemptions for essential medicines, adequate financing, and transparent procurement mechanisms.

BOX 7. SOME EXAMPLES OF SUBREGIONAL HARMONIZATION

- Central American countries have harmonized their registro sanitario by establishing common pharmaceutical norms and technical criteria. Under this system, a drug registry in one country can be officially recognized by any or all other countries in the subregion, obviating the need for a drug to be registered multiple times in different countries.
- Both MERCOSUR and Central American countries have established common standards for GMPs in the pharmaceutical industry and harmonized inspection procedures.
- The negotiation of low ARV prices by 10 Andean countries is an example of how a group of countries successfully negotiated with pharmaceutical companies to obtain regulated prices for ARVs (economies of scale).
- The Eastern Caribbean Drug Service pools the procurement of class A and B essential drugs for the Ministries of Health of nine separate islands. Through this mechanism, countries have been able to realize substantial savings and the service has made itself sustainable through a 15 percent administrative fee charged to participating governments.

Take steps to facilitate pooled procurement at the regional or subregional level. Although none of the countries studied have experience in regional procurement of contraceptives, many consider procurement through UNFPA akin to a globally pooled procurement system that takes advantage of large economies of scale. Moreover, experiences under MERCOSUR, Pacto Andino, the Central American Integration System (SICA, *Sistema de Integración Centroamericana*), and other subregional integration initiatives provide important opportunities and examples for countries exploring regional procurement options (see box 7).

The PAHO Strategic Fund for the purchase of medicines and other goods represents another possible mechanism through which countries can purchase contraceptives. The fund is composed of voluntary contributions from participating countries, and seeks to facilitate the “supply of (high-quality) pharmaceutical products to national health programs related to... adolescent health, and reproductive health of women” while achieving savings through economies of scale. However, its solvency depends on the member countries and their timely and adequate contributions. Furthermore, it would be prudent for PAHO to use UNFPA’s experience and agreements with contraceptive manufacturers for the purchase of contraceptives.

In Costa Rica, the CCSS—which faces the difficult task of having to negotiate low prices for a small market—is currently developing and evaluating new strategies to improve procurement efficiencies and ensure more competitive prices. It has considered the possibility of merging with larger countries to conduct “parallel” purchases, whereby it would purchase some medications directly from these larger countries to access the same economies of scale. Although this strategy has yet to be fully evaluated and implemented, it could benefit smaller countries in the region.

Strengthening and expanding successful efforts at harmonization and pooled procurement, as well as testing and implementing new ones, could help countries take advantage of economies of scale and expedite drug registration processes.

Strengthen quality control mechanisms through the harmonization of national EDLs, the use of manufacturers prequalified by internationally recognized organizations, and/or the use of regional testing laboratories for the random testing of manufacturing lots to ensure improved quality control. Where domestic procurement capacity is unable to meet these standards, use of independent procurement agents should be considered. If a government does not have the capacity to guarantee effective independent testing of contraceptives, it should conduct limited biddings, inviting only manufacturers that are prequalified by UNFPA, WHO, and UNICEF.

Implement transparency measures to ensure good governance throughout the procurement process. As recent experiences in Costa Rica and Brazil have shown, ensuring transparency and good governance around contraceptive and pharmaceutical procurement is a challenge. Strategies to address transparency and governance need to consider several elements simultaneously:

- Ensuring the clear definition and application of procurement procedures, ideally following internationally accepted norms, such as those applied by the World Bank.
- Improving information flows. Publishing procurement information on the Internet, as in Chile and Guatemala, and ensuring that procurement decisions can stand up to public scrutiny are important elements. Publishing prices paid and comparing these published prices across the region would also help.
- Defining independence in procurement decision making without political interference, as with CENABAST in Chile, can help improve transparency as long as accountability is clearly defined and public oversight maintained.

LONG-TERM SUSTAINABLE PROCUREMENT

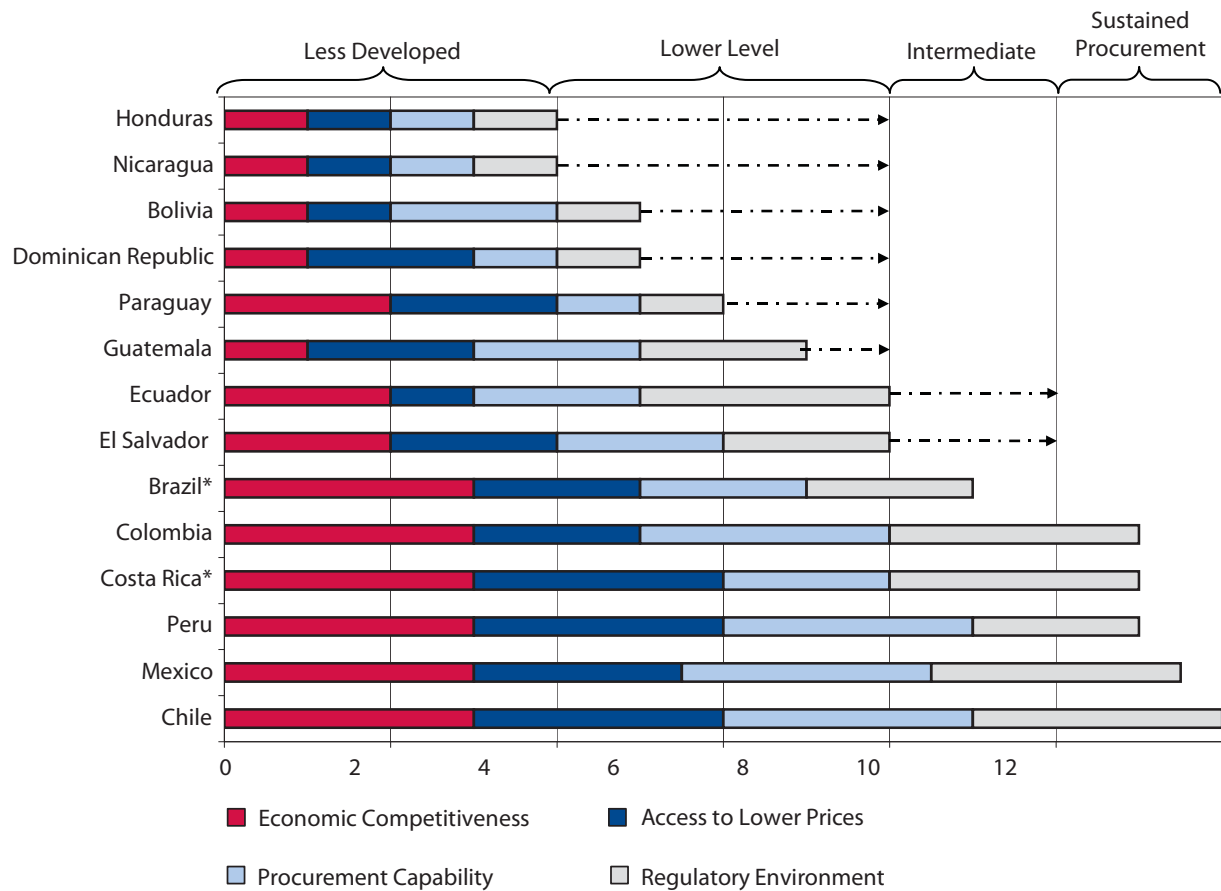
LAC governments aim to institute efficient and effective long-term procurement strategies to enable their citizens to choose, obtain, and use quality contraceptives whenever they need them. These countries' ability to achieve sustainable contraceptive procurement depends on four primary factors:

- competitiveness within the regional economy (i.e., purchasing power, infrastructure, economies of scale)
- ability of the government to access domestic or international sources and prices for contraceptive procurement
- capability of the government to take transparent procurement action
- a regulatory environment supportive of FP (the regulatory environment is cross-cutting and affects the three factors listed above).

To date, Chile, Colombia, and Mexico have been able to meet three of these four criteria nearly completely and have therefore been able to achieve long-term financial sustainability for contraceptive procurement. Unfortunately, neither Colombia nor Mexico has managed to secure low prices for contraceptives, so they scored lower on the competitive price criteria. Similarly, although Costa Rica has developed much of the capacity to ensure efficient procurement and obtain competitive prices, recent problems with stockouts and corruption related to essential medicines suggest the CCSS has not fully realized its potential for sustained procurement. Other countries face challenges in one or more of the factors, requiring action on the part of the government to address obstacles to achieving sustainable procurement.

Figure 6 presents a comparison of the 14 countries in the report using a qualitative analysis of each one's position in achieving sustained procurement of contraceptives. Scores were determined on a scale of 1 to 3 for each factor (with 1 being weakest and 3 being strongest) and rely on the analysis presented in the report. Countries with a total score of 10–12 are already achieving procurement goals and, although they may have barriers that they must still address, they are moving toward achieving sustainable procurement. Countries where USAID will be phasing out donations that have “intermediate” scores of 8–10, “lower level” scores of 4–8, or “less developed” scores of

Figure 6. Levels of Sustainability of Procurement in LAC Region



*Public awareness of issues related to governance and corruption have led to increased expectations for transparency, which in the long run may help countries like Brazil and Costa Rica address recent governance challenges. The restrictive regulatory environment in the nine presence countries helps offset the possibility of corruption caused by poverty and a lack of transparency and solid governance and democratic participation. Until these challenges can be addressed, it may behoove countries to maintain a more restrictive regulatory environment in the short term.

0–4 can take concrete steps in the short and medium term toward ensuring sustained procurement (depicted by the dashed arrows). Based on relative economic strengths, civil service, and regulatory environments, among other factors, some of these countries will be able to advance farther toward achieving sustained procurement than others (represented by the length of the dashed arrows).

For example, a country such as Bolivia, with a score of 4, could move up the scale to a score of 6–8 by (a) strengthening procurement in the short term with an MOU to use UNFPA for contraceptive procurement (so the value for the “Procurement Capability” factor would increase from 1 to 2); and (b) allowing Bolivian municipalities to procure contraceptives or building procurement capacity at the central level (so the value for “Access to Lower Prices” would increase from 1–2). The goal, therefore, could be to strengthen Bolivia to an “intermediate” level in terms of CS.

CONCLUSIONS

The analysis in this report has been based on detailed studies in 14 countries (nine USAID-presence countries and five countries where USAID no longer provides FP support). A more detailed report has been prepared for each country, and readers are referred to these for more specifics on many of the examples quoted in this report.³⁰

Ideally, public procurement should be efficient, transparent, and provide value for money while safeguarding quality and public safety. These are demanding management principles, yet many countries in Latin America have attained them. Both Chile and Costa Rica have managed public procurement without recent outside assistance, addressing internal problems when they have occurred and going a long way toward ensuring efficiency, transparency, and value for money. It is noteworthy that both countries attained these high standards while also supporting local manufacturing and distribution interests. Other countries, such as Brazil, where more restrictive trade policies have meant higher prices for consumers, have been less successful in dealing with transparency, quality, and efficiency issues. Brazil has had at least four changes in direction in the decentralization and then recentralization of public procurement of contraceptives since 1997. These changes were forced by a lack of proper preparation for health reforms, inadequate local procurement capacity, and weak governance and oversight at the local and federal levels.³¹

Procurement capacities are less well developed in the nine USAID-presence countries that have not yet been phased out of USAID FP assistance.³² However, in the face of donor phaseout, they too are experimenting with various cost-saving procurement options. An increasing number are using UNFPA as a procurement agent for contraceptives, thereby overcoming legal restrictions on international competitive bidding to access lower cost generic methods. The savings that countries achieve by procuring through UNFPA versus local suppliers are often dramatic. It is important to note, however, that while there are clear price advantages to procuring through UNFPA, there also are costs. Payment needs to be made up front; delivery is made only to the central warehouse, whereas national suppliers may deliver to regions, and clinics, depending on the conditions in the procurement contract; shipping information is not always shared on a timely basis; and, if procurements are not planned well in advance, delays in delivery can cause stockouts.

UNFPA has begun to address these constraints with the introduction of an Internet-based Order Tracking System (OTS), currently being rolled out. This application, which feeds information to the Reproductive Health Interchange (RHI),³³ allows their Country Offices and, potentially, client governments to view the progress and status of their procurement directly. OTS should enable UNFPA to manage the delivery pipeline system in an efficient and effective manner and enable clients to monitor their shipments more closely. Despite drawbacks, the Dominican Republic, El Salvador, and Guatemala have opted to procure contraceptives primarily through UNFPA because of the significant price advantage, and the satisfactory results in procurement timeliness. A slightly different approach

30. Please see the Reference section for complete citations. Sources included under the heading Country-Specific Documents deal with contraceptive procurement in the nine USAID-presence countries (Bolivia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru) and the five USAID-graduated countries (Brazil, Chile, Colombia, Costa Rica, and Mexico).

31. DELIVER. 2006. *Contraceptive Procurement Policies, Practices, and Lessons Learned in Brazil*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

32. Ecuador is included in the list of USAID-presence countries because, although it is considered a graduated country in terms of health programs, it continues to have USAID programs in other sectors. Ecuador has recently continued to receive some technical assistance from USAID, primarily in the form of a Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) assessment and in other areas.

33. The Reproductive Health Interchange is a Web-based tool for tracking the procurement of supplies and related financial flows.

has been taken by Peru, which uses UNFPA as one of several procurement sources for contraceptives. Following extensive market research and price comparisons, Peru procures some methods from UNFPA and procures others from private suppliers such as Pfizer (for injectables to the district level) and ESKE/FamyCare (for oral contraceptives).³⁴ El Salvador procures condoms from a local supplier, and Costa Rica has established a similar practice of relying on multiple sources for contraceptives.

Based on the experiences of its regional counterpart, Paraguay, and Nicaragua are planning to appoint UNFPA as their procurement agent. The situation in Ecuador and Bolivia is more complicated because of decentralized procurement decision making at the municipal and health area level. This has the potential to fragment the procurement of contraceptives from local suppliers, as well as result in higher prices.

In a number of cases, international and regional NGOs have obtained CIF prices for contraceptives even lower than those paid by UNFPA. NGOs may not, however, be registered as procurement agents under existing procurement regulations. Even if they were, NGOs may not have the cash flow to finance purchases for the public sector, where delays in payment are not uncommon.

Another possible alternative to using UNFPA as a procurement agent would be for countries to engage directly in ICB. However, there are two main obstacles to this approach. First, in most USAID-presence countries in Latin America, ICB is not permitted. Purchases must be made from locally registered companies and agents. Second, even where ICB is permitted, there is a lack of MOH procurement capacity and experience in prequalifying and conducting ICB, which is a substantial barrier that has taken countries in other regions several years to overcome.

In many countries with restrictive national procurement policies, the only viable alternative to UNFPA is procurement through local agents of private sector suppliers. These purchases occur at very high prices that are driven by restrictive local procurement regulations, lack of international competition, and small (nonpooled) purchase volumes.

Analysis of contraceptive prices shows large variations across the region and even within each subregion. These variations are partly explained by differential pricing as international suppliers adjust their supply prices according to the different socioeconomic situation in each country. They are partly due to the restrictive nature of the procurement regulations, with prices (commercial margins) tending to be higher in Central American countries that have the most restrictive procurement regulations and the least competitive commercial sectors. The larger, more economically developed Latin American countries appear to have lower retail prices for hormonal methods. These price variations across countries demonstrate the need for more information sharing among countries about prices being paid for contraceptives and further analysis of the cost composition in each country.

Funding for contraceptive purchases in most of the countries studied comes from public sector budgets. While only Ecuador and Paraguay have earmarked funding for contraceptives, the majority of governments are setting aside money for contraceptive purchases in the face of donor phaseout. While these financial commitments are a significant achievement on the road to CS, funding for contraceptives depends largely on political will, the fiscal climate, and the perseverance of skilled advocates.

34. In the Pfizer case, Peru was willing to pay a premium over what it could have obtained from UNFPA to get the product distributed to the regional level, while the ESKE/FamyCare costs were lower than those of UNFPA.

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ANNEX I. SUMMARY PROCUREMENT PRACTICES BY COUNTRY

BOLIVIA

The public sector in Bolivia continues to receive donated contraceptives from the United Nations Population Fund (UNFPA) and Japan International Cooperation Agency (JICA) to support its Sexual and Reproductive Health Program, whereas the United States Agency for International Development (USAID) continues to donate contraceptives to PROSALUD, the major nongovernmental organization (NGO) in the country. To date, the Ministry of Health (MOH) has not directly purchased contraceptives using public sector funds. However, the municipal governments and health facilities fund the purchase of some contraceptives through the Institutional Municipal Pharmacies (FIMs, *Farmacias Institucionales Municipales*) for sale to users who can afford to pay. Municipal governments can either transfer the funds to the health facilities or they can purchase the contraceptives on the local market, but they are purchased in such small amounts that the prices tend to be high.

The Universal Maternal-Infant Insurance (SUMI, *Seguro Universal Materno Infantil*) includes family planning (FP) for all women as one of its benefits. While the principal source of contraceptives for the SUMI is supposed to be municipal governments' funds, contraceptive donations for the centralized FP program go to the SUMI beneficiaries. However, municipalities are often compelled to use SUMI funds to purchase additional contraceptives from the local market to cover frequent shortfalls. These local purchases take place through commercial pharmacies; however, because these purchases are generally not pooled between municipalities or health areas, prices are very high.

DOMINICAN REPUBLIC

During the first years of implementation of the CONECTA project, which started in 2002, USAID donated some contraceptives to hospitals and service delivery points (SDPs) to make contraceptives available and test interventions aimed at improving access to FP methods. In 2002, the Ministry of Health (SESPAS, *Secretaría de Estado de Salud Pública*) purchased small amounts of contraceptives from local suppliers. In 2003, SESPAS signed an agreement with UNFPA, establishing the UN agency as a procurement agent. In 2005, SESPAS procured contraceptives (Rigevidon and Microval, condoms, intrauterine devices [IUDs], and Depo-Provera) through UNFPA at prices that were one-sixteenth the price offered by local suppliers, and has managed to generate sufficient funds to procure close to 85 percent of total government contraceptive needs. UNFPA still donates contraceptives to some provinces in four of the nine health regions and in four health areas in the capital of Santo Domingo, and provides logistics technical assistance and training to those regions.

USAID has been the major donor of contraceptive supplies to the NGO sector. With the phaseout of contraceptive donations, USAID continued to provide contraceptives and technical assistance to *Asociación Dominicana Pro-Bienestar de la Familia* (PROFAMILIA) and *Mujeres en Desarrollo Dominicana* (MUDE) until 2000 and to *Asociación Dominicana de Planificación Familiar* (ADOPLAFAM) until 2004. Through USAID/Executive Office USAID continues to donate condoms to the HIV/AIDS social marketing program managed by Population Services International (PSI).

The Dominican Republic is currently undergoing a health reform process that is expected to be finalized in 2011. At present, several important issues regarding the health system are under debate. Hence, there is little clarity on the contraceptive procurement mechanisms that will be available to the government under the reformed health system in 2011.

ECUADOR

Ecuador's MOH stopped receiving contraceptive donations from UNFPA in 2003. Public sector procurement is decentralized with each of the 167 heads of the health areas (*areas de salud*) purchasing locally. Any local producers willing to participate in the tender must be previously registered in a pool of authorized providers. The tendering process is competitive. Although the public sector has no restriction on buying through international competitive tendering, this alternative is not used due to the decentralized health system, whereby each health district buys directly from local producers. Therefore, as in Bolivia, there is no bulk procurement and thus, no economies of scale are achieved. And, similar to Colombia, the MOH central office does not play a role in prenegotiating prices with local suppliers, and simply prequalifies suppliers based on the goods and services they can offer.

As part of the 1994 Law on Free Maternity and Attention to Children, the government of Ecuador has earmarked U.S.\$15 million a year for the family planning/reproductive health (FP/RH) program, including the procurement of contraceptives. The funds come from lottery, liquor taxes, and other sustainable sources. This law guarantees enough funds to procure all contraceptives needed in the country, even when purchased at high prices.

EL SALVADOR

Between 2002 and 2004, in anticipation of USAID phaseout, the government of El Salvador purchased contraceptives locally. In 2004, the Ministry of Foreign Affairs approved a memorandum of understanding (MOU) between UNFPA and the Ministry of Public Health and Social Assistance (MSPAS, *Ministerio de Salud Pública y Asistencia Social*), which establishes the UN agency as a procurement agent for the government, thereby making way for purchases of medicines and contraceptives through UNFPA. The Ministry of Finance approved the purchase of contraceptives through this mechanism on the basis of price comparisons that favored UNFPA. In 2004, the government began purchasing contraceptives through UNFPA. The resulting savings, both because of bulk procurement and low prices obtained by UNFPA, have been staggering. According to MSPAS officials' 2003 estimates, these savings were close to U.S.\$3 million per year in 2004 and 2005.

In the case of condoms, purchases are still being carried out by each of the 27 basic health systems (SIBASI, *Sistema Básico de Salud Integral*), because prices are very low compared with those of UNFPA, even using this decentralized mechanism. El Salvador procured condoms from a local supplier because there was not much of a price difference with UNFPA.

GUATEMALA

USAID ended all contraceptive donations, except IUDs, to Guatemala in 2001. In March 2002, the Ministry of Health (MSPAS) signed an agreement with UNFPA under which the UN agency—using funds from Holland and Canada—would donate 100 percent of the MSPAS contraceptive needs. In turn, the MSPAS would deposit an amount equivalent to a specified percentage of the total donation for each year (5 percent in 2002, 20 percent in 2003, 30 percent in 2004, 40 percent in 2005, and 45 percent in

BOX A-1. ENSURING SUSTAINABILITY OF CS—INNOVATIVE EXAMPLES FROM GUATEMALA AND ECUADOR

The long-term objectives of LAC governments in regard to ensuring CS for their citizens are to find sustainable methods of procuring high-quality contraceptives in the absence of external donations. Guatemala and Ecuador have taken innovative steps toward achieving this goal.

In 2004, the government of Guatemala enacted the Law on Taxation of Alcoholic Beverages, which secured financial resources for the provision of reproductive health and contraceptives by earmarking a minimum of 15 percent of alcoholic beverage revenue to finance the MOH National Reproductive Health Program. As a result, in 2006 the MOH budget includes a line item for the Reproductive Health Program for the first time in the country's history.

Similarly, as part of the 1994 Law on Free Maternity and Attention to Children, the Government of Ecuador has earmarked \$15 million a year for the FP/RH program, including the procurement of contraceptives. The funds come from lottery, liquor taxes, and other sustainable sources.

2006) in a joint bank account. This money has gone toward a fund to be used to purchase contraceptives as well as to improve the logistics functions of the public health system. It is expected that by 2008 the government of Guatemala will have enough funds to cover 100 percent of its contraceptive needs, and by 2008 the government of Guatemala will need to allocate enough funds in its budget to cover its needs for 2009. See box A-1 for details about how these funds have been obtained and will be guaranteed in the future.

HONDURAS

In Honduras, within the context of its larger role in the health sector, UNDP acted as a procurement agent for contraceptives until the new government took office early in 2006. Honduras used UNDP for contraceptive procurement because, under its World Bank loan for procurement, it was easier to incorporate contraceptives into the health loan package. Procuring through UNDP is an atypical option, but in this case, it facilitated the process, given problems with procurement capacity in Honduras. The MOH also receives donations from UNFPA and USAID. Using UN agencies as its procurement agent has enabled the Honduran government to overcome the restrictions associated with national procurement regulations and obtain lower prices for contraceptives. However, with the ending of the agreement between UNDP and the government of Honduras, the MOH will have to explore other mechanisms to continue procuring contraceptives at low prices.

NICARAGUA

To date, Nicaragua has not purchased contraceptives, relying instead on donations from USAID and UNFPA. As donations are reduced, however, Nicaragua is considering appointing UNFPA as a procurement agent using tax funds.

PARAGUAY

USAID and UNFPA continue to donate contraceptives to the Ministry of Health and Social Well-Being (MSP y BS, *Ministerio de Salud Pública y Bienestar Social*). The ministry's investment in contraceptives to date has been very small. In 2004, MSP y BS purchased just U.S.\$21,500 worth of contraceptives. The amount allotted for 2005 was significantly higher (U.S.\$130,000); however, these funds were not fully expended. The decision to procure through UNFPA was made in 2005, but an agreement for a one-time purchase through UNFPA was not actually signed until November 21, 2005. For 2006, the MOH has assigned U.S.\$260,000 for contraceptive procurement that would cover 80 percent of the needs for this year, utilizing UNFPA as the procurement agency. The MOH estimates that if it used those funds in the local market, it would cover only 53 percent of actual need. As mentioned, in Paraguay, public sector purchases can be exempted from the public tender process for "technical reasons," one of which is price advantage. If Paraguay signs a procurement agreement with UNFPA, the purchase of contraceptives without a public tender could be justified on the basis of the comparatively low prices that UNFPA can obtain on the international market. To do this, however, the government will need to commit between U.S.\$350,000 and U.S.\$450,000 up front to UNFPA between 2007 and 2011.

PERU

In 1999, in the face of gradually declining USAID contraceptive donations, the Ministry of Health in Peru (MINSA, *Ministerio de Salud*) started using public sector funds to purchase contraceptives through UNFPA. Since 2005, 100 percent of the contraceptives distributed by the public health systems have been financed by the government.

The agreement between UNFPA and MINSA was initially signed in 1999 and renewed with new provisions in 2004. Agreements in which the government of Peru gives an international entity responsibility for administering its funds must be approved by Supreme Resolution and signed by the minister of the relevant sector (the health sector, in this case) on the basis of a report prepared by the Budget Office that demonstrates the benefits of the

proposed agreement and the availability of funds for its execution. Under the terms of this agreement, MINSA transfers funds to UNFPA, which, acting as a procurement agent for the government, uses the funds to buy low-priced contraceptives on the international market. On the basis of this agreement, public sector contraceptive purchases are exonerated from the public tender requirements of the national procurement law.

Between 1999 and 2004, no taxes were paid on MINSA's contraceptive purchases. However, starting in 2005, under the terms of the new MINSA-UNFPA agreement, contraceptive purchases will be subject to taxation. This will have implications for the price advantage that UNFPA now offers.

Peru has also been exploring different options for procuring low-priced contraceptives on the local market. In 2004, MINSA (with UNFPA) conducted a market study to identify the best available prices for the four contraceptive commodities. Condoms were not procured that year because of sufficient stocks from previous years. In the case of IUDs, the UNFPA price was far lower than prices available on the local market. The local and UNFPA prices for the injectable medroxyprogesterone acetate (Depo-Provera, Farlutal, and Provera), were identical. MINSA opted to buy both these products from UNFPA. However, the price of the oral contraceptive, etinil estradiol/levonorgestrel,³⁵ was significantly lower on the local market, even after including the cost of distribution to regional levels, a service not offered by UNFPA. Hence, in 2004, MINSA chose to procure etinil estradiol/levonorgestrel locally, thereby achieving significant savings. The supplier of the oral contraceptive was ESKE, the local representative of the Indian company FamyCare. The entry of companies like ESKE into local markets has great potential to increase competition among local suppliers, thereby yielding better prices for contraceptives.

MINSA also has a contract with Pfizer to supply Depo-Provera at prices 20 percent higher than UNFPA obtains. Unlike with UNFPA, this price would include delivery to local SDPs using Pfizer's existing commercial transport network in country. This approach could be considered with other local suppliers.³⁶

CHILE³⁷

Chile has been phased out as a recipient of donated contraceptives, with the last contribution from USAID dating back to 1995. Since then, the public sector has assumed responsibility for the procurement, distribution, and provision of FP methods for the population. Contraceptive methods are provided by commercial international

BOX A-2. EXPLORING NEW PROCUREMENT OPTIONS IN PERU

Two other innovative procurement options that are being explored in Peru are the Price Reference Agreement (Convenio Marco de Precios) and the Reverse Auction (Subasta Inversa). Both options were recently included in Peru's procurement law, but have yet to be implemented.

Price Reference Agreement. This is an agreement between government and providers in which prices for specific products are predetermined on the basis of quantity. Government agencies can then opt to purchase those products for the prenegotiated price.

Reverse Auction. The government announces technical specifications and quantity requirements for the product being sought. Suppliers respond with competing bids. Public sector organizations can then opt to buy the good (contraceptives in this case) from the supplier that offers the best price, with the assurance that all suppliers are prequalified by the government. This is similar to procurement mechanisms for health commodities in Guatemala (open contract), Costa Rica, and Chile.

35. Brand names include Alesse, Aviane, Enpresse, Lessina-28, Leven, Levlite, Levora, Nordette, Portia, Seasonale, Tri-Leven, Triphasil, and Trivora-28.

36. In the Pfizer case, Peru was willing to pay a premium over what it could have obtained from UNFPA to get the product distributed to the district level, while the ESKE/FamyCare costs were lower than UNFPA. Recently, however, UNFPA has negotiated a Most Favored Customer arrangement whereby FamyCare agrees that, if it offers

37. Morales, Cristian. 2006. *Contraceptive Procurement Policies, Practices, and Lessons Learned in Chile*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

suppliers from Europe, the United States, India, Brazil, and Thailand (e.g., Schering, Wyeth, Pfizer, Organon, and FamyCare) and local producers (e.g., Silecia, Laboratorio Chile, Andrómaco, and Recalcine).

The Chilean national procurement agency for the National Health Service (CENABAST, *Central de Abastecimiento*), founded in 1970 as a parastatal organization, is the public purchasing agency. It may buy contraceptives from local representatives of international companies, from local producers, and, occasionally, directly from the international market. This last option is not common, mainly because of the difficulties related to personalized labeling and other requirements of the MOH that seem to outweigh the potential savings. Moreover, prices obtained by the public sector in Chile are relatively competitive in the Latin American context, mainly because of the large market that a single institution represents for local suppliers.

Based on instructions from the Ministry of Health (MINSAL, *Ministerio de Salud*) FP program, CENABAST distributes methods to the 26 regional health authorities from which point they are distributed to health regions. Health regions then provide contraceptive methods at no charge to affiliated public sector clinics to finally reach low-income and general populations. Beneficiaries of the program mainly include women of childbearing age as well as sexually active men registered within the public sector network of first-line health facilities.

BRAZIL

The government of Brazil has made serious efforts to take on responsibilities for FP and the provision of contraceptives after USAID phased out its donations in 2000.³⁸ A combination of corruption scandals and restructuring of the health sector have led to a national procurement strategy that has oscillated between centralization and decentralization multiple times between 1997 and 2005. A resulting challenge from these policies has been that international suppliers have been able to charge higher prices when municipalities have been responsible for the procurement of their own contraceptives. Not all municipalities, however, have the infrastructure and capacity to take on the responsibilities of providing and managing health care and contraceptive procurement, thus obligating the federal government to provide logistic and technical assistance. Other factors that contribute to the high price of contraceptives in Brazil are high tariff and importation duty rates and a restrictive regulatory environment.

The Program of Assistance with Pharmaceutical and Strategic Supplies (PAFIE) coordinates the procurement and distribution of strategic health commodities and those on the EDLs. The EDL category is further divided into centralized and decentralized purchases. Although the federal government now centralizes all contraceptive procurements, some municipalities purchase additional contraceptive methods on their own.

The MOH contraceptive procurement plans, once developed at the federal or at times municipal levels of the ministry, are passed on to the Ministry of Planning (MOP). Once reviewed by the MOP, the plans return to the MOH, which follows both internal rules and the regulations of ANVISA (National Health Surveillance Agency) and SUS (Unified Health System) in implementing them. The MOH sends the completed procurement plans to the General Coordination of Logistics Resources (CGRL), which manages the procurement process and contracts with national and international contraceptives suppliers. This program coordinates the logistics of distribution, warehousing management, and, in the case of imported products, importation and customs clearance processes.

Following forecasting of contraceptives (including condoms) and demand estimation, the CGRL uses the resulting procurement plans to issue a public invitation for registration of product prices to potential suppliers. There are some prequalification procedures to participate in the bidding process. The price registration process gives the government a chance to reserve the funds needed for procurement and, once the funds are allocated for this

38. DELIVER. 2006. *Contraceptive Procurement Policies, Practices, and Lessons Learned in Brazil*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

purpose, public tender may be announced through four modalities³⁹: competition among any interested parties; acceptance of prices from officially registered firms; invitation by the administrative authorities; and public auctions of goods (electronic or live auctions).

All procurements (tenders, invitations, and auctions—both live and electronic) must be published in the Official Publication of the Federal Government (*Diario Oficial*) and in state-level equivalents of the federal publication. Information pertaining to every step of the process, from the announcement of price registration, to the details of the bidding documents, to the results and provisions of the competition must be made available to the public.

COSTA RICA⁴⁰

The Costa Rican government, through the Social Security Fund (CCSS, *Caja Costarricense del Seguro Social*), received its final contraceptive commodity support from international donors more than 12 years ago and, according to the 1999 RH survey, has been able to maintain a high contraceptive prevalence rate of around 80 percent .

The CCSS, which is the only public sector organization that procures medicines and provides health services on behalf of the Costa Rican government, procures contraceptive supplies that are manufactured internationally and imported into Costa Rica (through a local importer/distributor) as well as locally manufactured oral contraceptives purchased at competitive prices within the region. The fact that the CCSS procures the majority of its medicines centrally gives it significantly more negotiating power, as well as more control over the quality of products. Procurement orders are generated automatically by the central warehouse system (based on supply levels and projected consumption), leaving little room in the process for political pressure and stalling tactics that could be used to inhibit the procurement of contraceptive commodities.

The CCSS ensures availability of contraceptives, but it has recently experienced problems with corruption throughout the procurement process for other medicines and lab supplies and has had difficulties ensuring the availability of essential medicines at SDPs throughout the country. The CCSS procures all of its contraceptive supplies centrally through its system of pre-enrolled bidders—the current sources of supply in Costa Rica for contraceptives are all commercial.

Contraceptives are considered part of the EDL in Costa Rica, but there is a relatively limited choice of methods. The EDL includes only two formulations of oral contraceptives, Medroxyprogesterona (a three-month 150 mg injectable), normal and extra-strong condoms, and the Copper-T IUD. The CCSS procured oral contraceptives through a local manufacturer for the most recent tenders. Several distributors have registered and imported generic injectable products from Thailand in order to respond to tenders from the CCSS. This importer (Medirep) has been the primary supplier of injectables to the CCSS over the last several years.

COLOMBIA

Since 1995, when contraceptive donations ended in Colombia, the Ministry of Social Protection (MSP) and PROFAMILIA (an IPPF affiliate) have been responsible for obtaining, distributing, and providing all contraceptive methods.⁴¹

The general social security system in Colombia has two different regimes: contributive and subsidized. The first is composed of people who have formal jobs, are independent or are retired, and receives funds from employers

39. World Trade Organization (WTO). 2005. "Measures Affecting Production and Trade: Arrangements Affecting Market Structure and Competition: Government Procurement". Available at http://www.wto.org/english/tratop_e/gproc_e/brazil.pdf (accessed on October 5, 2005).

40. Cisek, Cindi and Nadia Olson. 2006. *Contraceptive Procurement Policies, Practices, and Lessons Learned in Costa Rica*. Arlington, Va.: DELIVER, and Washington, DC: USAID | Health Policy Initiative, for the U.S. Agency for International Development.

41. Agudelo, Juan and Nora Quesada. 2006. *Contraceptive Procurement Policies, Practices, and Lessons Learned in Colombia*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

and employees to ensure funding for health services; the second covers the poor population. Methods approved by the public sector (orals and IUDs) are to be used in the subsidized as well as the contributive sector, and these supplies, by law, are included in the *Plan Obligatorio de Salud* of both regimens. All contraceptives are free for the subsidized sector, whereas the contributive sector pays between U.S.\$0.66 and U.S.\$6.83 for either a cycle of pill or an IUD, based on the socioeconomic classification of the employee. Therefore, for those who belong to the higher economic strata, it is often more economical to buy contraceptives from commercial pharmacies.

Procurement of goods and services, including contraceptives, is done directly by departments, municipal governments, and hospitals. The only role that the Ministry of Social Protection (the former MOH) plays in the process is to prequalify suppliers based on their contracting history, capacity to deliver the goods and services needed, distribution capacity, and working capital. Once suppliers are prequalified and selected by the MSP, the central office informs the departments, municipal governments, and hospitals which suppliers they may use for their purchases of goods and services, including contraceptives. However, prices are not prenegotiated throughout this prequalification process and, consequently, different facilities end up paying different prices for the same product. The current procurement system does not allow the public sector to benefit from economies of scale through bulk purchases. For procurement, distribution, and commercialization to take place, contraceptives must be registered.

The budget for procuring contraceptives is not protected under the MSP; therefore it must be justified and defended annually. The amount that can be used to procure contraceptives depends on the resources available, and there is no minimum amount guaranteed for contraceptive purchases.

PROFAMILIA's procurement system is straightforward. The central office, through its own funding, procures contraceptives from local and international suppliers, depending on the availability of the product in the local market. For instance, it imports injectables (monthly and three-month), IUDs, condoms, and emergency contraceptive pills. Locally, it purchases oral cycles, and most of its contraceptives are branded with the PROFAMILIA logo. PROFAMILIA has 34 clinics throughout the country and manages the procurement and distribution of all supplies from its central warehouse. It resupplies its clinics from this centralized facility, which ensures the best price possible because of bulk purchases. In addition, PROFAMILIA centralizes all administrative functions, delegating some of them. By doing so, Profamilia has reduced administrative costs, and at the same time ensures the standardized implementation of institutional policies and quality.

MEXICO

USAID provided support to Mexico's FP program beginning in the late 1970s.⁴² The withdrawal of USAID support for contraceptive commodities in 1996 was characterized by an overall supportive environment for RH and FP. In general, contraceptive prevalence had reached a mature level, the government's support for FP and RH had been institutionalized, and the program has the technical and financial capacity to meet the FP needs of the Mexican population. However, Mexico's two major public health institutions—the *Instituto Mexicano del Seguro Social* (IMSS) and the *Secretaría de Salud* (SSA)—adopted different approaches for meeting their contraceptive needs.

As a result of decentralization, many SSA facilities began experiencing contraceptive stockouts in the early 2000s. To address this gap, in 2002, the SSA at the central level established a “coordinated” procurement mechanism for contraceptives through UNFPA. These commodities are sourced through the international market using UNFPA's procurement support. The SSA has made three consecutive annual procurements through UNFPA, achieving significant cost savings for the states. In 2002 alone, the estimated savings (compared with what the states would

42. Cisek, Cindi. 2006. *Contraceptive Procurement Policies, Practices, and Lessons Learned in Mexico*. Washington, DC: USAID | Health Policy Initiative, for the U.S. Agency for International Development.

43. Rivera, Gabriela. April 2005. Powerpoint Presentation: Technical Assistance for Acquisition and Control of RH Commodities. UNFPA.

have paid for similar amounts of contraceptives on the commercial market) was approximately U.S.\$3.9 million.⁴³ However, despite the highly competitive prices available through this procurement mechanism, fewer than half of Mexico's 32 states have participated in the coordinated procurement. Reasons for low levels of participation include (1) delays in delivery; (2) stringent quality control measures for imported products; (3) requirement of full payment in advance—many states do not receive their budgetary allocations in full (and they do not know in what increments they will receive their funds) and some states have laws prohibiting government entities from purchasing supplies using advance payment; and (4) UNFPA's reluctance to issue fiscal receipts that are required by most federal and state entities.

IMSS has faced a unique set of challenges. IMSS had been procuring contraceptives from commercial suppliers since the early 1990s, and was never totally dependent on contraceptive donations from international donors. Until recently, these procurements were centralized. Although IMSS personnel were included in the early discussions by the SSA to identify other contraceptive procurement options through UNFPA, ultimately they declined to participate. IMSS stated that it was fearful of the length of the procurement process (and the possible stockouts that it could create) and that it was unsure of the real cost savings, because distribution costs were not included in the UNFPA prices. As a result, IMSS continued to procure its contraceptives through commercial suppliers at significantly higher prices. Today, however, IMSS is under increasing pressure to improve the transparency of its procurement processes—and under criticism that it purchases too many of its medications from multinational pharmaceutical companies.

The Mexican government is increasingly moving toward the purchase of interchangeable generic medications. As of January 2006, 321 medicines were listed on the government's official list, and there is a recommended modification to include various contraceptive products as well. The addition of contraceptive products to the list of interchangeable generic medicines will present a major change for public sector institutions and likely significantly reduce procurement costs.

ANNEX 2. SUMMARY OF DRUG SUPPLY SYSTEMS, CONTRACEPTIVE FINANCING, AND PROCUREMENT

DRUG SUPPLY SYSTEMS, CONTRACEPTIVE FINANCING, AND PROCUREMENT.

Country	Is there a single drug procurement system?	Contraceptives procurement	Health registry	Tariffs and taxes on purchases from the UNFPA
Bolivia	No. The public sector in Bolivia continues to receive donated contraceptives, while municipal governments and health facilities fund the purchase of some contraceptives for sale to users who can afford to pay.	The public sector does not purchase contraceptives. It receives them as donations from the UNFPA. Municipalities make local purchases for the Universal Maternal and Child Health Insurance (SUMI).	There is a need for a health registry.	Donations of contraceptives are tax exempt by agreements with international organizations.
Brazil	No. Procurement is the responsibility of each individual government body, including state enterprises.	The government purchases contraceptives through an open bidding process. Even though the federal government now centralizes all contraceptive procurements, some municipalities do purchase additional contraceptive methods on their own.	All health products and medicine require registration at ANVISA, the National Health Surveillance Agency.	Does not apply.
Chile	Yes. CENABAST is used by all the regions to purchase drugs, including contraceptives. However, if they choose to do so, regions can procure individually.	Contraceptives are procured through CENABAST at reasonable prices (close to UNFPA's prices). CENABAST procures contraceptives from local representatives of international companies local producers and, occasionally, directly from the international market.	Does not apply.	Does not apply.
Colombia	No. Departments, municipal governments, and hospitals make purchases directly.	Departments, municipal governments, and hospital purchase directly from prequalified suppliers, without going through a tendering process. They just compare prices from different suppliers when they need the supplies.	Need to be registered in order to procure, distribute and commercialize contraceptives.	Does not apply, although all medicine and contraceptives are exempt from sales tax and have minimal import duties.
Costa Rica	Yes. The CCSS procures all medicine on behalf of the Costa Rican government, because CCSS is the provider of all health services in the country.	CCSS procures contraceptives from local and international suppliers, through open bids.	Yes. All medications must be registered at the MOH.	Does not apply, although all medicine is exempt from sales tax and import duties.

DRUG SUPPLY SYSTEMS, CONTRACEPTIVE FINANCING, AND PROCUREMENT. (CONTINUED)

Country	Is there a single drug procurement system?	Contraceptives procurement	Health registry	Tariffs and taxes on purchases from the UNFPA
Dominican Republic	No. There is not a single system. Procurement is divided up between the Council for Public Health and Social Assistance (SESPAS) and the presidency's secretariat.	In 2004, the Council for Public Health and Social Assistance (SESPAS) began purchasing contraceptives from the UNFPA. In the past, procurement was done in the local market.	There is a need for a health registry.	There is no information available.
Ecuador	No. The MOH purchases contraceptives in a decentralized manner for prequalified establishments at the beginning of the year. Purchases are at the national level.	The MOH purchases contraceptives in a decentralized manner. Each of the 167 health areas handles its own procurement. The Ecuadorian Social Security Institute (IESS) only purchases oral contraceptives, because other contraceptives are not included in the Essential Drugs List. Procurement takes place at the local level.	There is a need for a health registry for all products, whether purchased or donated.	Purchases made through international organizations do not pay any kind of taxes, as long as the product already exists in the national market.
El Salvador	No. There is not a single system. There have been joint purchases, during which the SIBASIs (Basic Integrated Health Systems) have acted together.	In 2004 and 2005, the government purchased contraceptives from UNFPA. Another purchase is under way for 2006. In the past, purchases were made in the local market. The MOH continues to receive donations from USAID as well.	There is a need for a health registry.	The introduction into the country of contraceptives purchased with tax money may be duty free by a "presidential tax exemption."
Guatemala	Yes. There is a single system by "Open Contract." Procurement is consolidated for the Ministries of Health and Defense, and the Guatemalan Social Security Institute (IGSS).	Purchases are made with funds from the UNFPA, Holland and Canada, using UNFPA as the administrative entity. The Government of Guatemala will increasingly assume full responsibility for contraceptive procurement. Guatemala's matching funds—by donation—go into a revolving fund, to be used starting in 2008. The entire MOH's needs are consolidated. The IGSS will follow the same procurement procedure.	There is a need for a health registry. All contraceptives used in the country have been registered.	These purchases do not pay taxes because they are brought into the country by the UNFPA, and international organizations are tax exempt. The IGSS is tax exempt under Article 100 of the Constitution.
Honduras	Yes. Until 2005, UNDP procured all goods and services on behalf of the Government of Honduras, which included all ministries, and other governmental agencies.	Until 2005, the government purchased contraceptives using UNDP international procurement mechanism. They also continue to receive donations from USAID, based on a detailed phaseout plan.	All products need to be registered in country to be donated or purchased.	Does not apply.

DRUG SUPPLY SYSTEMS, CONTRACEPTIVE FINANCING, AND PROCUREMENT. (CONTINUED)

Country	Is there a single drug procurement system?	Contraceptives procurement	Health registry	Tariffs and taxes on purchases from the UNFPA
Mexico	No. MOH centrally procures contraceptives through UNFPA, although states may or may not choose to use this mechanism, thus procuring directly from local suppliers. IMSS procures independently of the MOH, with its local "delegations" procuring individually from local commercial suppliers.	The MOH procures contraceptives through the international market using UNFPA's procurement support. However, this process is not mandatory, and most states procure through local suppliers, bids, and direct purchases.	COFEPRIS is responsible for registration and quality control of all medications.	
Nicaragua	No. Procurement is "centralized."	The public sector does not purchase contraceptives. It gets them through donations.	There is a need for a health registry.	No prior experience on this issue.
Paraguay	No. There is not a single drug procurement system.	The Ministry of Health and Social Welfare has purchased contraceptives in small amounts in the local market (5 percent of the total). It has not signed a purchase agreement with the UNFPA.	All contraceptives purchased must be registered.	Purchased and donated supplies that do not enter the commercial market are tax exempt.
Peru	Yes. There is a Drug Supply Procurement System (SISMED), which makes the country's purchases.	For several years now, the MOH has been purchasing contraceptives from the UNFPA with public funds. It has also purchased contraceptives from a local provider because of lower prices.	There is a need for a health registry. An "admittance permit" is issued for supplies purchased from the UNFPA that are not registered.	State purchases pay taxes, without exception. This includes contraceptives purchased through the UNFPA.

Source: Interviews with key players.

Note: ANVISA = National Health Surveillance Agency; CENABAST = Chilean national procurement agency for the National Health Service; CCSS = Costa Rican Social Security Institute; COFEPRIS = Mexican Federal Commission for the Protection against Sanitary Risk; IECS = Ecuadorian Social Security Institute; IGSS = Guatemalan Social Security Institute; IMSS = Mexican Social Security Institute; MOH = Ministry of Health; SESPAS = Dominican Republic Ministry of Health; SIBASI = El Salvador Basic System for Integrated Health; SISMED = Peruvian Medical Supply Purchasing System; SUMI = Bolivian Universal Maternal-Infant Insurance; UNFPA = United Nations Population Fund; USAID = U.S. Agency for International Development.

ANNEX 3. SUMMARY OF REGULATIONS

REGULATIONS GOVERNING THE PURCHASE OF SUPPLIES WITH PUBLIC FUNDS

Country	Is there a regulation governing public procurement?	General exceptions	Is international bidding allowed?	Are there exceptions to public bidding? ^a	Is there an Essential Drugs List (EDL)? ^b
Bolivia	Yes. Act 1178 SAFCO (fiscal management and control system) and Supreme Decree 2732 SABS (system for controlling the procurement of goods and services).	Purchases in the context of international agreements. National, departmental, and municipal emergency situations, or to reduce risk and mitigate disasters. Contracts by public agencies, when there are no legally established commercial companies.	Yes, when the contract amounts are higher than 15.000.000 UFV.	Established under general exceptions.	Yes, and it includes contraceptives.
Brazil	Article 37 of the Federal Constitution indicates that public works and purchases of goods and services should be contracted through a public process of bidding/tenders. The relevant regulations are established under the Law No. 8,666 of June 21, 1993, which applies to government procurement at the federal, state, and municipal levels as well as to public agencies.	The bidding procedure can only be waived in narrowly defined cases and with detailed justifications.	For foreign firms to be able to participate in bids, they must be officially registered in Brazil.	In an emergency situation, the bidding process can be bypassed and the product acquired through Emergency Situation Acquisitions.	Yes, and it includes contraceptives.
Chile			Yes, although is not frequently used, mainly because of the difficulties related to personalized labeling and other requirements of the MOH that seem to outweigh the savings that may be attained by procuring from the international market.		

REGULATIONS GOVERNING THE PURCHASE OF SUPPLIES WITH PUBLIC FUNDS (CONTINUED)

Country	Is there a regulation governing public procurement?	General exceptions	Is international bidding allowed?	Are there exceptions to public bidding?^a	Is there an Essential Drugs List (EDL)?^b
Colombia	The Procurement and Contracts Law 80 of 1993 allows the public sector to buy directly from suppliers, without a bidding process. The only restriction they have is that they have to buy from prequalified suppliers, previously approved by the MOH central.	No.	Foreign companies can participate in bids only if they have local representatives in Colombia. Public sector institutions cannot import directly from international companies.	No.	Yes, and contraceptives are included.
Costa Rica	Law 6914 outlines a streamlined process specifically for the procurement of medicine, which allows the CCSS to function with a list of pre-enrolled suppliers for virtually all of the 541 types of medicine that are part of the basic drug list.		There is no direct law that inhibits international suppliers from participating in tender requests from the CCSS. However, there is a law/decreed that favors national suppliers. The law states that if proposals are similar in price, the national supplier (manufacturer) should be selected. A 10 percent penalty is added onto international prices.	Under the law 6914, health facilities are permitted to purchase medicine directly from the provider in the case of an emergency or impending stockout.	Yes. Contraceptives are considered part of the EDL, but there is a relatively limited choice of methods. The EDL includes only two formulations of oral contraceptives, a three-month injectable, normal and extra strong condoms, and the Copper-T IUD.
Dominican Republic	Yes. Act 295 on Government Procurement (Aprovisionamiento del Gobierno). Includes the Social Security Institute.	Procurement "for emergencies," "public safety," and "to prevent great State losses."	It is not addressed under the law.	Included under general exceptions.	Yes. The list is restrictive. It includes contraceptives.
Ecuador	Yes. Public Contracts Act (Ley de Contratación Pública) and internal regulations.	In the event of natural disasters and emergencies, and pursuant to international agreements.	The bidding process addresses requests for bids from national and foreign firms.	Contemplated in Article 6 of the applicable law.	Yes. Some contraceptives are included: IUDs, progestogen, and estrogen.
El Salvador	Yes. The Procurement and Contracts Law (Ley de adquisiciones y contrataciones). Includes the Salvadoran Social Security Institute.	Purchases and financing in the context of international agreements/multilateral organizations. Contracts between government agencies.	Yes. For supplies of a "special or specific nature." Requests for bids are made in specialized international printed media. There is no prior experience with international drug purchases.	Yes. The law allows direct contracts in emergencies, among other reasons.	Yes. The list is restrictive. It includes contraceptives.

REGULATIONS GOVERNING THE PURCHASE OF SUPPLIES WITH PUBLIC FUNDS (CONTINUED)

Country	Is there a regulation governing public procurement?	General exceptions	Is international bidding allowed?	Are there exceptions to public bidding?^a	Is there an Essential Drugs List (EDL)?^b
Guatemala	<p>Yes. Legislative Decree 57-92.</p> <p>State Procurement and Contracts Act (Ley de compras y contrataciones del Estado).</p> <p>The State Contracts Act's Regulations (Reglamento de la ley de contrataciones del Estado).</p> <p>Government Agreement 1056-92 and amendments.</p>	<p>As provided in international treaties and agreements.</p> <p>Donations to the state, its agencies, institutions, and municipalities by individuals, organizations, associations, and foreign states and governments—as provided by agreements between the parties.</p>	<p>Yes. When the products are not sold in the country, or not sold in sufficient amounts; and when the import price, including customs duties, taxes, insurance, and other related expenses, is 15 percent below national market prices. (When the price is at least 15 percent cheaper).</p>	<p>If an “open contract” is used, it is not necessary to follow bidding procedures.</p> <p>For purchases through international organizations.</p>	<p>Yes, contraceptives are included in the Ministry of Public Health List.</p> <p>The Guatemalan Social Security Institute list also includes contraceptives.</p>
Honduras	<p>Legislative Decree 74-2001 of 06/01/01 implements the State Procurement and Contracts Law. The law allows the Government of Honduras to do local and international tenders, celebrate agreements with international agencies for the procurement of goods and services, and allows.</p>	<p>All contraceptives are tax exempt, except condoms, which are not considered medicine. They are subject to 12 percent VAT.</p>	<p>Under the agreement with UNDP, UNDP posts the requests for bids both locally and internationally, allowing both local and international companies to bid. In practice, however, if a manufacturer has a local representative in country, the local representative responds to the bid, as per instructions from the manufacturer.</p>	<p>No.</p>	<p>Yes, and contraceptives are included. Last update was in 2002.</p>
Mexico	<p>The primary laws which affect procurement include the Organic Law of Federal Administration (29 December 1976) and the Law of Procurements, Rentals, and Services for the Public Sector (4 March 2000). The Presidential Act published in the Official Newspaper on November 6, 1996, establishes that the IMSS may only procure products and supplies that are part of the Basic List and Catalog of Health Sector Supplies that is established by the General Health Council.</p>		<p>No.</p>	<p>No.</p>	<p>Yes, and it includes contraceptives.</p>

REGULATIONS GOVERNING THE PURCHASE OF SUPPLIES WITH PUBLIC FUNDS (CONTINUED)

Country	Is there a regulation governing public procurement?	General exceptions	Is international bidding allowed?	Are there exceptions to public bidding? ^a	Is there an Essential Drugs List (EDL)? ^b
Nicaragua	Yes. Act 323. Includes the Nicaraguan Social Security. ^c	Purchases and financing in the context of international agreements/multilateral organizations. Procurement "for emergencies, public safety, or public interest."	It is not addressed under the law.	This is addressed under general exceptions.	Yes, and it includes contraceptives.
Paraguay	Yes. Act No.2.051/2003. Includes the Social Insurance Institute (Instituto de Previsión Social).	Purchases made in the context of international agreements/multilateral organizations. Contracts between government agencies.	Yes. Under certain conditions, if market studies reveal no adequate local sources or if prices are better. Preference is given to local companies. There is no prior experience with international drug purchases.	Yes. Various reasons, including "technical reasons" (e.g., the price of supplies).	Yes. But only as a reference, and it does not include contraceptive drugs and supplies.
Peru	Yes. Acts 26850 and 28267. Government Contracts and Procurement Act (Ley de Contrataciones y Adquisiciones del Estado). Includes the Social Security Institute.	Emergency situations, imminent stock depletion, or sole supplier. Irreplaceable supplies. Contracts between government agencies. International contracts governed by treaty, or financed by allies or through loans.	It is not addressed under the law.	The same general exceptions.	Yes. The list is restrictive. It includes contraceptives.

Source: Interviews with key players.

Notes: CCSS = Costa Rican Social Security Institute; EDL = essential drugs list; IUD = intrauterine device; SABS = Sistema de Administración de Bienes y Servicios (Bolivian Goods and Services Administration System); SAFCO = Sistema integrado de administración financiera y control gubernamental (Bolivian integrated system for finance administration and government control); MOH = Ministry of Health; UFV = inflation linked unit of account; UNDP = United Nations Development Program; VAT = value-added tax.

- Generally, contraceptives are purchased in amounts that are subject to public bidding.
- The EDLs generally indicate which drugs can be purchased with public funds.
- However, the Nicaraguan Social Security Institute does not purchase drugs. It is only a financial agency for health benefits.

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