West Africa Reproductive Health Commodity Security

Study Phase 1
Task Report: 9

Ghana Reproductive Health Commodity Security Country Assessment
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# Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>African Development Bank</td>
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<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>AWARE-RH</td>
<td>Action for West Africa Region Reproductive Health and Child Survival Project</td>
</tr>
<tr>
<td>CAP</td>
<td>Country Assistance Plan (DFID)</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>CPR</td>
<td>contraceptive prevalence rate</td>
</tr>
<tr>
<td>CS</td>
<td>contraceptive security</td>
</tr>
<tr>
<td>CSEP</td>
<td>Commodity Security Evaluation Plan</td>
</tr>
<tr>
<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<tr>
<td>DFID</td>
<td>British Department for International Development</td>
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<td>DHS</td>
<td>District Health Management</td>
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<tr>
<td>ECOWAS</td>
<td>Economic Community of West Africa States</td>
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<tr>
<td>EF</td>
<td>earmarked funds</td>
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<tr>
<td>FPLM</td>
<td>Family Planning Logistics Management</td>
</tr>
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<td>GDHS</td>
<td>Ghana Demographic Health Survey</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>GNI</td>
<td>gross national income</td>
</tr>
<tr>
<td>GOG</td>
<td>Government of Ghana</td>
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<tr>
<td>GPRS</td>
<td>Ghana Poverty Reduction Strategy</td>
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<td>GSMF</td>
<td>Ghana Social Marketing Foundation</td>
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<tr>
<td>HF</td>
<td>health funds</td>
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<tr>
<td>ICC/CS</td>
<td>Inter-Agency Coordinating Committee for Contraceptive Security</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IGF</td>
<td>internally generated funds</td>
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<tr>
<td>IPA</td>
<td>International Procurement Agency</td>
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<td>IPS</td>
<td>International Policy Services</td>
</tr>
<tr>
<td>IMR</td>
<td>infant mortality rate</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow, Inc.</td>
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<tr>
<td>MDA</td>
<td>Ministries, Departments and Agencies (Government)</td>
</tr>
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<td>MDDBS</td>
<td>Multi Donor Direct Budget Support</td>
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<tr>
<td>MMR</td>
<td>maternal mortality rate</td>
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<td>MOF</td>
<td>Ministry of Finance</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OI</td>
<td>opportunistic infection</td>
</tr>
<tr>
<td>PPME</td>
<td>Policy, Program, Monitoring and Evaluation Unit</td>
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</table>
PRB  Population Reference Bureau
PU   Procurement Unit
RCHU Reproductive and Child Health Unit
RH   reproductive health
RHS  Regional Health Administrations
RHCS reproductive health commodity security
SEAM Strategies for Enhancing Access to Medicines
SES  socioeconomic status
STI  sexually transmitted infection
SWAp sector wide approach
TA   technical assistance
TEOMS Tender Evaluation and Order Monitoring System
TFR  total fertility rate
THS  teaching hospitals
TRIPS Trade Related Aspects of Intellectual Property Rights
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
USAID U.S. Agency for International Development
WAHO West African Health Organization
WARP West African Regional Program
WHO  World Health Organization
WTO  World Trade Organization
Acknowledgements

John Snow, Inc./DELIVER would like to acknowledge the significant contributions that made this assessment possible. U.S. Agency for International Development (USAID)/West African Regional Program (WARP), USAID/Washington, United Nations Population Fund (UNFPA)/New York, and the World Bank provided financial and technical support for the overall West African Reproductive Health Commodity Security study and for this assessment, in particular.

The Ghana country assessment benefited from significant inputs from these partners. Action for West Africa Region Reproductive Health and Child Survival Project (AWARE/RH) provided two staff members to serve on the assessment team. UNFPA/Ghana also provided a dedicated team member and logistical support, including transport for field trips and data collection. These team members participated in all stages of the assessment in Ghana, from a review of the data collection instruments to taking lead responsibility for gathering data for specific sections of the assessment instrument assigned by the team leader. The knowledge and experience of these local team members was an invaluable resource in achieving the objectives of the assessment. UNFPA provided further assistance by their guidance and by making information available to the team.

The team would also like to acknowledge the Ministry of Health, which was extremely forthcoming with information required for the assessment.

Finally, the assessment team would like to thank the Honorable Minister of Health for taking time from his busy schedule to meet with the team members.
Background

West Africa Reproductive Health Commodity Security Study

Donor support for reproductive health (RH) commodities in the West Africa sub-region has significantly declined or remained flat during the past few years. This situation is particularly alarming as maternal mortality, infant mortality, and fertility rates remain high, and pose a significant obstacle to achieving RH commodity security (RHCS). In seeking a regional solution to these challenges, the West African Health Organization (WAHO) and its health partners, the USAID, World Bank, UNFPA, and African Development Bank (ADB) met in 2002 to discuss approaches to strengthen RHCS in West Africa. These discussions lead to a concept paper, co-authored by the partners, that outlines both the status and possible strategies to improve key RHCS indicators among Economic Community of West African States (ECOWAS).

In 2003, WAHO asked the John Snow, Inc./DELIVER project to examine the RHCS situation in the sub-region and present strategic options to strengthen RHCS. Based on the presentation made in July 2003 in Banjul to the ECOWAS Health Ministers, DELIVER was asked to conduct a desk-based study and two country assessments that would recommend a potential strategy based on two specific options:

1. Pooled procurement of RH commodities, including an analysis of commodity financing mechanisms and logistics management capacity.
2. The expansion of the private sector’s participation in securing the supply of key RH commodities, including exploring local manufacturing opportunities.

Ghana and Burkina Faso Country Assessments

A central focus of the initial two-country assessments is to determine the feasibility of a regional pooled procurement system for RH commodities by comparing the potential savings that can be gained by regional bulk purchasing of commodities, while also addressing the many financial and political barriers that would likely arise. Included in this initial phase were two RHCS country assessments conducted in Ghana and Burkina Faso. The objectives of the country assessments were to—

- Verify the data collected through the desk review.
- Collect information to supplement the desk review (including experience with pooled procurement, pricing, product availability, service delivery, and capacity of local manufacturing).

The initial country assessments conducted in Ghana and Burkina Faso confirmed and denied a number of conclusions from the 2003 presentation. The country assessments also helped clarify the commitment and capacity of the two ECOWAS member governments in moving forward with the options presented above.

Country Profile—Ghana

The challenges facing the West Africa sub-region as it attempts to meet its development objectives remain substantial. Political instability, poverty, inflation, and other factors have, in part, contributed to

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1 The right of every woman and man to choose, obtain, and use reproductive health commodities whenever he or she needs them.
2 The Economic Community of West Africa States is a West Africa regional economic and trade bloc comprising 15 nations. WAHO is the regional health unit of ECOWAS.
poor health outcomes in the region. Gross national income (GNI) per capita in the region is U.S.$1,060, compared to U.S.$1,710 for sub-Saharan Africa (Population Reference Bureau [PRB] 2003). Literacy rates for women (15–49) are below 50 percent and infant and maternal mortality rates (MMR) are significantly higher than the rest of the continent.

In contrast, the political, economic, and health outlook for Ghana is bright compared to its neighbors in the sub-region and in sub-Saharan Africa. Ghana is the third largest member of ECOWAS (pop. 20,471,000) and is a major trading partner with its neighbors and within the sub-region. In February 2003, Parliament approved the Ghana Poverty Reduction Strategy (GPRS), which acts as a conduit for continued development assistance and, perhaps more important, outlines a medium-term strategy for promoting growth and reducing poverty. Relative to sub-Saharan Africa and the West Africa sub-region, Ghana’s political stability and economic base make it a likely candidate to achieve some, if not all, of the Millennium Development Goals outlined in the GPRS (World Bank 2004).

Ghana’s per capita GNI was U.S.$2,170 in 2001. Using World Bank classifications, this figure is low. It is double the average for West Africa and puts its only behind Gambia and Cape Verde among ECOWAS countries. In 2000, its public sector expenditure on health as a percentage of gross domestic product (GDP) was 8 percent, the highest among ECOWAS countries. Public sector expenditure on health as a percentage of the total is 59.6 percent, with private sector health expenditures accounting for the remaining 40.4 percent (WHO 2001).

In 2003, the preliminary report of the Ghana Demographic and Health Survey (DHS) was released, providing recent statistics for a number of RHCS indicators. Of note, the total fertility rate (TFR) has continued to decrease from 6.4 in 1988 to 4.4 in 2003 (see figure 1). Compared with other countries in sub-Saharan Africa, fertility is lower only in Gabon, Zimbabwe, and South Africa (where data is available). From 1998 to 2003, the rate of fertility decline has shown indications of leveling off, with the decline approximately 0.2 during this period.

In a contrast to the slowing in the decline of fertility, use of modern methods of contraception among married women has increased significantly from 13 percent in 1998 to nearly 19 percent in 2003 (see figure 2). Use of all methods is 25 percent (GDHS 2003). The latest figures confirm a trend that has been seen since 1998, when the use of modern methods stood at 5 percent. While prevalence has slowed somewhat over the past five years, the use of modern methods has nearly doubled since 1993 (GDHS 2003).

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3 Gross national income in purchasing power parity (PPP).
While Ghana is a leader in the sub-region in contraceptive prevalence, unmet need for contraception remains significant. In 1998, the latest figures available, unmet need was 23 percent. This is a sharp drop from 1993, when unmet need was nearly 37 percent, and also indicates that total demand for contraception (contraceptive prevalence rate \([\text{CPR}]\) plus unmet need) remains high, relative to the sub-region.

RH commodity security is also a necessary component for the delivery of maternal and other RH services. Antenatal care from a health professional showed a slight increase from 1998 to 2003; 89 percent and 92 percent, respectively. Medically assisted deliveries rose from 40 percent in 1988 to 47 percent in 2003. Tetanus toxoid injections rose by 4 percent from 1998 levels to 85 percent in 2003. Overall, the Ghana Demographic Health Survey (GDHS) figures indicate a steady increase in these indicators.

Other factors linked to good RH outcomes are maternal and infant mortality. Ghana’s MMR was 590 in 2001. This rate was lower only in Cape Verde (190), and is much lower than the average rate for West Africa, which stands at 1,100 (PRB 2002). The infant mortality rate (IMR) in Ghana has also seen a steady decline since 1998. IMR has declined from 77.2 in 1988 to 56.7 (per 1,000 live births) in 1998 (the latest figures available) (GDHS 1998).

The growing prevalence of the HIV infection rate in West Africa is increasing the importance of a secure supply of RH commodities. In 2003, Ghana’s HIV rate was 3.6 percent (DFID, Country Assistance Plan (CAP) April 2003). This figure represents a slight increase during the past five years, although it remains below the infection rate in many neighboring countries, such as Côte d’Ivoire and Burkina Faso. Among sub-populations, the HIV prevalence rate for females aged 18–24 is 3.9 percent, compared to males in the same age group at 1.8 percent\(^4\). (PRBa 2003)

**Reproductive Health Commodity Demand**

The group of West Africa study partners developed a comprehensive list of RH tracer commodities that are a representative sample of widely used RH commodities in the region. These commodities include contraceptives, non-drug consumables, and pharmaceuticals to provide antenatal, obstetric, and neonatal care. The tracer list also includes commodities for the prevention and treatment of sexually transmitted infections (STIs). While projections can vary significantly, table 1, based on readily available and recent demographic information, illustrates the increasing demand for RH commodities in Ghana.

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\(^4\) Upper Bound populations only.
Table 1. Demand for Reproductive Health Commodities in Ghana

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<tr>
<td><strong>Contraceptives</strong></td>
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<td></td>
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<tr>
<td>Condom (male)</td>
<td>18,421,200</td>
<td>20,067,194</td>
<td>21,903,944</td>
<td>23,685,910</td>
<td>25,667,248</td>
<td>27,446,056</td>
<td>29,421,740</td>
</tr>
<tr>
<td>Condom (female)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant</td>
<td>2,505</td>
<td>2,744</td>
<td>2,914</td>
<td>3,170</td>
<td>3,302</td>
<td>3,556</td>
<td>3,812</td>
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<tr>
<td>Injectable</td>
<td>705,009</td>
<td>768,003</td>
<td>838,299</td>
<td>906,497</td>
<td>982,328</td>
<td>1,050,404</td>
<td>1,126,017</td>
</tr>
<tr>
<td>IUD</td>
<td>17,533</td>
<td>19,206</td>
<td>20,397</td>
<td>22,190</td>
<td>23,112</td>
<td>24,894</td>
<td>26,682</td>
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<tr>
<td>Pill</td>
<td>3,326,050</td>
<td>3,623,243</td>
<td>3,954,879</td>
<td>4,276,622</td>
<td>4,634,364</td>
<td>4,955,537</td>
<td>5,312,258</td>
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<td><strong>STI/HIV/OI</strong></td>
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<td></td>
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<tr>
<td>Nevirapine (tablets)</td>
<td>9,080</td>
<td>12,222</td>
<td>15,360</td>
<td>18,540</td>
<td>21,662</td>
<td>24,864</td>
<td>27,968</td>
</tr>
<tr>
<td>Nevirapine syrup</td>
<td>2,389</td>
<td>3,216</td>
<td>4,042</td>
<td>4,879</td>
<td>5,701</td>
<td>6,543</td>
<td>7,360</td>
</tr>
<tr>
<td>Benzathine penicillin</td>
<td>8,432</td>
<td>8,946</td>
<td>9,476</td>
<td>10,023</td>
<td>10,588</td>
<td>11,169</td>
<td>11,767</td>
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<tr>
<td>Cotrimoxazole</td>
<td>782,217</td>
<td>829,817</td>
<td>878,982</td>
<td>929,750</td>
<td>982,164</td>
<td>1,036,034</td>
<td>1,091,499</td>
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<tr>
<td>Doxycycline</td>
<td>17,100</td>
<td>18,141</td>
<td>19,216</td>
<td>20,326</td>
<td>21,471</td>
<td>22,649</td>
<td>23,862</td>
</tr>
<tr>
<td>Metronidazole (tablets)</td>
<td>855,899</td>
<td>907,312</td>
<td>960,318</td>
<td>1,014,937</td>
<td>1,071,197</td>
<td>1,128,851</td>
<td>1,188,039</td>
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<td><strong>Antenatal</strong></td>
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<td>Tetanus vaccine</td>
<td>97,026</td>
<td>98,704</td>
<td>100,001</td>
<td>101,350</td>
<td>102,270</td>
<td>103,481</td>
<td>104,239</td>
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<tr>
<td>Iron (tablets)</td>
<td>121,713,909</td>
<td>124,050,940</td>
<td>125,911,447</td>
<td>127,841,192</td>
<td>129,230,980</td>
<td>130,990,786</td>
<td>132,177,271</td>
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<tr>
<td>Folic acid (tablets)</td>
<td>365,141,726</td>
<td>372,152,819</td>
<td>377,734,342</td>
<td>383,523,576</td>
<td>387,692,941</td>
<td>392,972,358</td>
<td>396,531,814</td>
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<td>Fansidar (tablets)</td>
<td>80,449</td>
<td>81,994</td>
<td>83,223</td>
<td>84,499</td>
<td>85,418</td>
<td>86,581</td>
<td>87,365</td>
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<td><strong>Obstetrical/Neonatal</strong></td>
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<tr>
<td>Oxytocin</td>
<td>37,572</td>
<td>38,257</td>
<td>38,794</td>
<td>39,351</td>
<td>39,743</td>
<td>40,248</td>
<td>40,576</td>
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<tr>
<td>Ergometrine (tablets)</td>
<td>496,862</td>
<td>503,779</td>
<td>508,723</td>
<td>513,917</td>
<td>516,922</td>
<td>521,392</td>
<td>523,569</td>
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<td><strong>Other</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves (examination)</td>
<td>737,212</td>
<td>753,909</td>
<td>768,081</td>
<td>782,763</td>
<td>794,573</td>
<td>808,552</td>
<td>819,471</td>
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<tr>
<td>Gloves (surgical)</td>
<td>267,727</td>
<td>273,348</td>
<td>277,499</td>
<td>282,383</td>
<td>285,291</td>
<td>289,805</td>
<td>293,162</td>
</tr>
</tbody>
</table>

1 Female condom projections not available.
Study Methodology

As presented in the background section, this country assessment constitutes the phase two implementation of the West Africa regional study on RH commodity security. The data collected during the earlier phases of the study needed to be validated with country-level data.

This stage of the study involved a country assessment team that implemented data collection based on the data collection instrument (see appendix 1). The country team had six members, drawn from partner organizations: DELIVER, UNFPA, and AWARE-RH, as well as the Ministry of Health (MOH), Ghana. Different data collection methods were used to collect the data based on the type of data needed.

Assessment Team Meetings
Team meetings were devoted to reviewing the questions in the data collection tools and identifying the potential information and data sources to create a matrix of data requirements and sources. Team members were then assigned lead responsibility, either working alone or together, to collect data required for specific sections of the assessment tool. Information was gathered from documents and reports as well as individual interviews with key informants from various organizations.

Key Informant Interviews
Key informants were identified by the team and also in interactions with the organizations from which data or information was required. The questionnaire was then used by the team to elicit responses. Where necessary, further information was given to respondents to ensure that they understood the questions and could determine the type of information required. More than 30 key informants were interviewed during the assessment.

Panel Discussions
In some cases, the team used panel discussions to elicit responses to the questionnaires. In these instances, more than one individual from the relevant organization was needed to provide the relevant information. To save time and to ensure that the information provided was instantly validated by more than one source, a panel of the key informants was formed to discuss the issues, within the framework provided by the data collection tool. The panel discussions encouraged informants to talk about the issues, which provided information for the assessment team.

Document Review
The review of documents was another information gathering tool. A number of reports and policy documents were reviewed in many areas. In some cases, key informants were unable to meet with the assessment team. In such instances, if a pertinent document was available, the team reviewed the document.

Spreadsheets have also been used to collect the needed data. They were discussed with the key informants, and they were allowed to collate the data to complete the sheets.
Field Trips

To obtain key data on product availability and financial information from the periphery, the team made field visits to selected public and private sector facilities in three regions in the country, as well as in the capital. Two field trip teams were made from Volta Region, Eastern Region, and Western Region. In each region, the team collected data on commodity availability and prices from the public sector at the regional medical stores, service delivery points (SDPs); and from the private sector at pharmacies and licensed chemical shops. Selection of the regions for this phase of the assessment was both purposive and opportunistic. Knowledge about the diversity in the coverage of the regions informed the selection. The Volta and Western regions were selected based on their distal locations relative to the capital, as well as their relatively lower socioeconomic status (SES). The distance from the capital was perceived as a factor that was likely to affect both product availability and prices. The Eastern region, which is close to the capital, has slightly higher SES indicators; it provided a median measure against which other regional measures could be compared.
Assessment Findings

Logistics Capacity

A 1999 Family Planning Logistics Management (FPLM) project assessment, and more recent DELIVER project assessments, indicate that Ghana has a relatively well-functioning contraceptive logistics system that has been successful in making a wide range of contraceptive methods available through the MOH distribution system, even in the most inaccessible and rural areas. Products from the private for-profit sector, the not-for profit sector, as well as the social marketing sector are widely available in the country and are responsible for a fair market share of services.

Logistics system capacity in Ghana reflects a number of years of sustained effort at improving health commodity availability in both the public and social marketing sectors. DELIVER will continue to provide technical assistance (TA) to the MOH and the Ghana Social Marketing Foundation (GSMF). This section presents a summary of the current situation and key strengths and weaknesses of the contraceptive logistics management systems of the two organizations.

Ministry of Health

Logistics data is collected through order forms and is reported to the national level, which permits the use of logistics data in forecasting contraceptive requirements. While the supply of contraceptive products has been deemed adequate to meet past demand, future shortfalls are predicted if additional funds are not committed to the procurement of contraceptive supplies (John Snow, Inc./DELIVER 2003).

Despite the strengths and accomplishments noted, several areas of weakness were identified. Storage conditions were deemed inadequate, and there was general agreement that, under the current conditions, clients could not be guaranteed a consistent supply of quality contraceptives. Stock level guidelines were applied irregularly, including adherence to maximum stock levels and calculations of average monthly consumption. Increases in the volume of commodities, due to program successes, were overburdening central level commodity managers. The result has been stock imbalances throughout the system and an inability to maximize the use of scarce resources. With respect to the information system, too much data are collected on too many forms, leading to duplication of effort and late submission of reports. This situation led, in some cases, to stockouts at the regional level. Finally, while staff had been trained in basic storekeeping skills for contraceptives, such training has not been extended to the management and storage of other health commodities, particularly drugs. The staff does not have the capacity to prepare forecasts for contraceptive requirements.

To comprehensively address the systemic weaknesses, the MOH decided to fully integrate the family planning and health commodities, and to do so within the context of a fully reengineered commodity management system. The objective was to create a single streamlined and integrated supply chain that would achieve customer service and MOH objectives.

Ghana Social Marketing Foundation

The GSMF is a private voluntary organization that uses social marketing and behavior change techniques to motivate and empower individuals and families to achieve an improved quality of life. GSMF areas of intervention include HIV/AIDS, fertility management, adolescent reproductive health, and malaria.

Since its launch in 1985, GSMF has become a significant player in providing contraceptives in Ghana. With sales having quadrupled since 1986, GSMF is now the largest provider of private sector contraceptives in Ghana. In December 1995, GSMF became an independent foundation. GSMF uses a
network of three distributors and more than a dozen nongovernmental organizations (NGOs) to distribute supplies.

Several constraints will have an impact on the continued success of GSMF. A serious impediment to further growth in sales is the adverse price differential between GSMF and MOH products. MOH products are sold at much lower prices and the result is a flow of clients from the private sector to the MOH delivery system. There is a concurrent flow of public sector supplies to the private sector, as it is cheaper for private sector suppliers to obtain supplies from the MOH rather than through GSMF. This situation has recently been partially relieved by an increase in MOH prices and the introduction of Champion condoms as a low-cost competitor to MOH products.

Another issue for GSMF is its lack of staff adequately trained in logistics management and contraceptive forecasting. However, one staff member recently attended the DELIVER logistics management course. Finally, GSMF’s ability to expand its program is constrained by a lack of sufficient staff and funding to continue to support the NGO program with its own funds. They have had difficulty in finding private sector partners (e.g., workplaces) willing to share responsibility in supporting condom distribution.

### Service Delivery and Demand

Reproductive health services are prevalent in all care delivery settings in Ghana. A recent survey of service availability found that modern temporary contraception methods are available in 89 percent of all facilities. The service is offered by all types of facilities and available in almost all facilities (95 percent) five or more days a week. Permanent methods are available in 76 percent of hospitals (GSS 2003). Sixty-nine percent of all facilities offer at least four modern methods of contraception. Private religious facilities offer the smallest types of methods. Combined oral contraceptives, progesterone-only injections, and male condoms are the methods most commonly reported as being offered, and they were available in approximately 80 percent of the facilities offering these methods.

The recent population census has provided a new, more realistic population baseline with which a number of the health indicators of performance can be measured. Based on the new population figures, some indicators have changed and an appropriate way to interpret some of the indicators has been to adjust these in the light of new population figures. The annual review of the health sector gives some of these indicators reported below.  

Family planning acceptors were also affected by new population proportions. The pre-census proportions were 20 percent of the population while the new figures have been given as 24 percent of the population. Using both scenarios, the percentage of family planning acceptors at the national level increased from 21.0 percent to 22.6 percent (see figure 3). There was an identical rise using the new 20 percent proportions.

---

The regional figures show varying performance by region over the years. While percentage acceptors have remained persistently low in the Western, Ashanti, and Northern and Upper East regions, the dramatic increases observed in Greater Accra appear to be slowing, with the Eastern Region showing the greatest increase in 2003 (see figure 4).

Figure 3. Trend in Family Planning Acceptor Rate (1998–2003)

Figure 4. Percentage Acceptors by Region (2001–2003)
Reproductive Health Care

Antenatal care (ANC) coverage continued to register a slight downward fluctuation during the year (see figure 5). This occurred in both scenarios, with the 4 percent remaining well under the 100 percent mark, while the new proportions push the performance well above the 100 percent mark.

The regional performance also continued to show a fairly uniform performance across the country (see figure 6). However, the difference in the population figures appears to affect the regions differently.
Post-natal care, on the other hand, registered a continued upward trend in the year, increasing from 53.7 percent to 55.8 percent (see figure 7).

**Figure 7. Trend in Postnatal Care Coverage (2000–2003)**

The regional performance shows the Upper West Region as the highest performing region; with the Central, Eastern, and Ashanti regions as having consistent high performance in postnatal care coverage (see figure 8).

**Figure 8. Postnatal Coverage by Region (2003)**
**Supervised Deliveries**

Supervised deliveries showed a downward fluctuation during the year after a one-year upward trend (see figure 9).

**Figure 9. Trend in Percentage of Supervised Deliveries (2000–2003)**

![Graph showing the trend in percentage of supervised deliveries from 2000 to 2003. The graph indicates a downward fluctuation after an initial upward trend.](image)

The regional performance shows Upper West and Central regions with the highest coverage, and Northern and Upper East regions among the lowest performing (see figure 10).

**Figure 10. Percentage of Supervised Deliveries by Region (2003)**

![Bar chart showing the percentage of supervised deliveries by region in 2003. The chart highlights the regions with the highest and lowest coverage.](image)
A tracer list of drugs is used to monitor the availability of essential drugs. The 2003 review data shows the availability is between 88.9 percent and 98 percent, which is an improvement over the previous year. An earlier survey specifically focused on STI treatment found that STI treatment is integrated with family planning services in most of the health care delivery services in the country. Medicines most commonly available for treating STIs were metronidazole (in 75 percent of facilities) and either benzathine penicillin or procaine penicillin (68 percent).

At the time of this assessment, a select list of drugs showed very high availability rates. Stockouts of the tracer drugs at facilities visited on the day of assessment ranged from 8.3 percent to 16 percent. Reported stockout of any of the products tracked during the past six months was 34 percent.

**Financing of Reproductive Health Products**

The systems in Ghana for financing reproductive health commodities are multiple, dynamic, and changing.

In the mid 1980s, Ghana implemented far-reaching policies aimed at improving the availability of health commodities through the introduction of user fees and devolving the management of drug supply budgets to the SDP level (GNPD 1998). While these changes related mainly to the mainstream supply of essential drugs, it was eventually extended to cover non-drug supplies, and also paved the way for introducing cost recovery policies for a broader range of commodities.

With the user fee system came the introduction of revolving drug funds managed at each facility, at all levels of the supply chain. The net result of this system has been the removal of the annual recurrent budgetary allocation at the central level for the procurement and supply of these commodities. Even though there has often been the need to inject more capital into the funding of health commodities, this does not take away from the government’s apparent success with shifting most of the health commodity costs to consumers. It is believed that the cost recovery for essential drugs has improved the general availability of drugs in the health facilities. It is also believed that this has made it easier to implement some level of cost recovery for products previously distributed for free, such as contraceptives.

At the central level, funding arrangements for health commodities can be classified into three main categories:

1. **Contraceptive products.** Funding for these products has been traditionally exclusively from donor sources. The main donors are USAID, British Department for International Development (DFID), and UNFPA. Commodity requirements have been determined through joint forecasting and procurement planning activities by both the public and social marketing sectors. Funding is then secured for these products through in-kind donations of products, with each donor associated with the supply of specific products.

   During the past few years, changes in donor capacity to meet all requirements have resulted in new strategies to meet demand. Among these has been the identification of new donors for particular products. DFID has, for instance, become the main supplier of most of the condom requirements, taking over from USAID because of a number of factors, including, but not limited to, DFID’s ability to obtain condoms at more competitive prices and the dwindling or stagnating funding levels from USAID.

   Another strategy that has been used to meet the demand for contraceptive products has been the use of basket funds at the MOH to procure contraceptive products (UNFPA 2002). Approximately U.S.$3 million was spent this way in 2001.

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2. **Non-contraceptive reproductive health products.** In the past, funding for most essential drugs has been covered by multiple funding streams but captured within the MOH resource pool. Under the funding arrangements to support the sector wide approach (SWAp), the MOH develops medium-term health strategies that cover a period of five years at a time. Currently, in the third year of implementing the current medium health strategy, the Ministry identifies its priority intervention programs and develops and costs its work plan to meet these objectives. Resources are then mobilized from national and donor sources to meet its requirements. The main types of funding identified in its common basket are—

- **Government of Ghana:** These are composed of central government budgetary allocations and releases charged to the consolidated fund.

- **Internally generated fund:** Made up of funds generated through user charges and related fees collected by the health sector. This category of funds should be mentioned because it tends to be the source of funding for most of health commodity purchases. These funds are held and managed by each facility at all levels of the health care system, including the Central Medical Stores.

- **Health fund:** Refers to the donor pooled funds that support the MOH work plan.

3. **Donor earmarked funds:** This category represents the portion of donor funds for the health sector that are earmarked for specific types of expenditures by the donor. This category is of interest because the STI and family planning programs are one of the programs that receive earmarked support. Earmarked funds have been used to procure STI drugs.

Ghana has developed and is implementing a national poverty reduction strategy. *The Ghana Poverty Reduction Strategy, an Agenda for Growth and Prosperity*, identifies a number of key interventions. Under the strategies for human development and provision of basic services, recognition is given to the significant gaps that exist in access and utilization of basic services by the poor, particularly concerning health, HIV/AIDS control, population management, and others. (GOG n.d.)

The health sector, challenged by the ideals of the GPRS, has taken steps to incorporate these in its own medium-term strategy and work plans. Due to significant progress made on the SWAp to health care, the GPRS will highlight three priority interventions that need to be planned for in the (next) 2002–2007 Programme of Work of the Ministry of Health, including—

- bridging equity gaps in access to quality health services
- ensuring sustainable financing arrangements that protect the poor

The selected indicators for monitoring the GPRS include key reproductive health indicators, thereby demonstrating policy-level commitment to RH programs.

The adequacy of resource mobilization for the procurement and supply of reproductive health commodities remains unclear. A careful analysis of the resource needs and commitments obtained are unclear, depending on the source of information. MOH officials indicate that adequate funding for the current medium-term health strategy for 2002–2006 has been secured, based on the assumption that funding levels and arrangements with all its partners will remain in place and will continue until the end of the current work program. However, this is not so. The traditional donors of contraceptive requirements have not guaranteed funding until the end of the work plan as assumed by the health sector. The potential shortfall in funding is estimated to reach U.S.$4.5 million by 2006 if no action is taken (GMOH 2003).

Of more significant concern are the impending changes in the funding arrangements with the MOH development partners. Important changes to current arrangements are anticipated at the end of the current
medium-term strategy in 2006. Until now, and over the course of implementing two five-year medium-term strategies, the health sector, under the SWAp arrangements, have secured funding to implement programs that have been either jointly developed or agreed upon with its donor partners. The strategies and work plans have been approved and budgeted with the partners; any funding gaps that were identified have been met with a basket funding mechanism, with resources from the donor partners supplementing government allocations to health. These arrangements have allowed the health sector to mobilize adequate funds to support its program of work. These arrangements have also allowed the health sector to plan its cash flow requirements, ensuring that donor inflows and government releases are coordinated. This has allowed effective management of the liquidity requirements of the Ministry, and enabled it to overcome the periodic cash flow problems that other sectors that rely solely on releases from the government have faced. The health sector also has the flexibility to reprioritize its spending to cope with exigencies.

Donor partners and the government are seriously discussing and planning to change the funding process. The new mechanism, called Multi Donor Direct Budget Support (MDDBS) will shift all donor support for health into direct budget support through the Ministry of Finance (MOF). Funds from donor sources will no longer move directly to the health sector but will flow through the MOF. Under the new mechanism, funding gaps are expected to be identified in a way similar to the current system under the SWAp arrangements, except that any shortfall will be met through direct budget support to the central government, to be held and managed by the MOF.

Within the health sector, there are some concerns about the practical implementation of this mechanism. Ghana will be the first country to introduce this type of system. Health sector officials envision that there could be national reprioritization of funds, to the detriment of the health programs.

The funding arrangements during the past decade under the SWAp have enabled the health sector to develop skills in mobilizing funds from donor sources, as shown by the larger percentage of donor inflows that go to the sector. At the same time, it is possible that Ministries, Departments, and Agencies (MDAs) not supported to the same extent by donors may also have developed mechanisms to ensure that allocations to their sectors are released on time. The health sector officials suspect that this situation may be a disadvantage when they compete for funds from government sources.

Table 2 and figure 11 illustrate some of these considerations. They show the number of steps that headquarters (HQ), teaching hospitals (THS), Regional Health Administrations (RHS), and District Health Management (DHS) must take to access funds from the main sources of funds. The main funding sources are internally generated funds (IGF), earmarked funds (EF), health funds (HF), and Government of Ghana sources for 2002 and 2003.8

Table 2. Steps to Access Funds

<table>
<thead>
<tr>
<th>Steps in Accessing Funds</th>
<th>IGF</th>
<th>EF</th>
<th>HF</th>
<th>GOG-3</th>
<th>GOG-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HQ</td>
<td>N/A</td>
<td>8</td>
<td>11</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>THS</td>
<td>3</td>
<td>9</td>
<td>12</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>RHS</td>
<td>3</td>
<td>10</td>
<td>13</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>DHS</td>
<td>3</td>
<td>13</td>
<td>14</td>
<td>23</td>
<td>23</td>
</tr>
</tbody>
</table>

8 Financial management appraisal presentation HSR 2003 MOH/Partners.
While the immediate impact of these financing issues may not be crucial to financing most reproductive health products, it is necessary to examine the potential effect of these changes on the availability of reproductive health products in the medium- to long-term.

Policies and Regulations

Reproductive health programs are managed under the dual auspices of the National Population Council and the MOH. The National Population Council is responsible for setting the broad policies and national agenda for population issues, while the MOH is responsible for all health related interventions. The country has a national population policy (NPC 1994). This policy addresses all the key issues, including the importance of commodities. Under section 5.2 Fertility Regulation and Family Planning, it states, “Family Planning Programmes shall make available a variety of methods of fertility regulation to ensure free and conscious choice by all. The activities of family planning clinics and commercial distribution outlets shall be intensified at national, regional and district levels.” (5.2.4)

The National Population Policy document recognizes the need for careful planning and states, “Efforts shall be made to improve planning, funding and management of agencies devoted to family planning.” The policy also indicates that efforts will be made to plan with budgets to consolidate existing service capacities, coordinate manpower planning and training, mobilize additional domestic and external resources, and improve cost effectiveness and the monitoring and evaluation of family planning services.

The link between the national policy and reproductive health service delivery is made through the National Reproductive Health Policy of the Ministry of Health. First published in 1996 and updated in 2003, the policy provides the guidance and framework for reproductive health services in the country.

The reproductive health policy of the MOH states that “all individuals are eligible for family planning services” (GOG MOH 1998). Spousal consent is not required for married couples. Fees for services, including commodity prices, are determined centrally by the MOH for the public sector, while the GSMF gives recommended retail prices to commercial private sector outlets that distribute their products.

A National Adolescent Reproductive Health Policy is in place that gives adolescents the right to information. The policy states that messages should be unambiguous and should respect the socio-cultural sensitivities of various sectors of the population. (NPC 2000)
The published National Reproductive Health Standards addresses issues relating to service provider capacities by specifying what cadre of service personnel can perform specific services. It also prescribes the training requirements by type of service provider. These standards, in addition to logistics standards in specifying minimum levels of supply required, are necessary to ensure quality of services.9

**Coordination Mechanisms**

Efforts to coordinate RHCS in Ghana are extensive. The number of different programs, funding sources, and project cycles involved in RH commodities and services are comprehensive, and do not fit programmatically under one coordinating umbrella. Instead, donors, Government of Ghana (GOG) partners (from the MOF and MOH), and technical partners coordinate activities to improve RHCS.

First, at the broad, macro-level health policy level, health partners meet monthly to review progress and discuss issues related to the SWAp. Health partners who attend these meetings include the MOH, USAID, DFID, Japan International Cooperation Agency (JICA), Canadian International Development Agency (CIDA), Danish International Development Agency (DANIDA), United Nations Children’s Fund (UNICEF), UNFPA, and the World Health Organization (WHO), and other partners. These partners also meet annually at the GOG-sponsored health summit where decisions are taken that inform the SWAp and the MOH’s Five-Year Programme of Work and its annual health sector plans.

Second, the primary coordinating body for ensuring contraceptive security (CS) is the Inter-Agency Coordinating Committee for Contraceptive Security (ICC/CS). The ICC/CS was formed following a CS workshop in May 2002. Its members include key units in the MOH involved in the delivery of RH commodities and services, including the Reproductive and Child Health Unit (RCHU) Procurement Unit; Office of Procurement and Supplies; MOF; and the Policy, Program, Monitoring and Evaluation Unit (PPME). Donors who supply funds for RH commodities, including the World Bank, USAID, DFID, UNFPA, and others, are also members, as well as technical partners and NGOs. The family coordinator, within the RCHU, leads the ICC/CS. The group acts as the focal point for coordinating the on-going RH and family planning programs in Ghana, and has recently developed the first national strategy to address RHCS in Ghana. In addition, annual projections and related financing commitments for contraceptives are presented at the ICC/CS meetings.

The ICC/CS can be effective in responding to changes in the external environment. For example, when the ICC/CS was initially formed in 2002, it was able to respond to the short-term funding gap by submitting a request for funding to UNFPA. This request was successful, and a stockout was averted. More recently, the group formed a core technical committee to develop a national CS strategy that addresses the medium- and long-term RHCS facing the country, including the financing gap for contraceptives, quality of commodities and services, and the need to increase procurement capacity. This plan was adopted at a MOH sponsored conference, and plans are in place to transfer the oversight of implementation to the MOH units. The ICC/CS has become an effective agent principally because it is lead by senior members of the MOH and Ghana Health Service (the implementation arm of the MOH). Its advocacy role has resulted in government commitment to fund contraceptive procurement from its tax revenue and World Bank credits.

By creating the ICC/CS and by making the initial MOH policy decision to strengthen RHCS by developing a national CS strategy shows a high level of policy commitment to RHCS. Senior leadership within the Ministry is now engaged in the operational success of CS for Ghana. They have provided policy support and technical direction to the ICC/CS, and have shown a willingness to own a strategy that may lead to significant strengthening of RHCS.

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9 National RH Services Standards and Protocols.
Regional Trade

Ghana occupies a unique position in regional trade issues. Its central location and well-developed port infrastructure and vibrant market economy places it at the center of regional trade issues. The secretariat of the regional economic monetary union is located in Accra.

Within the sub-region, Ghana’s pharmaceutical market, second only to that of Nigeria, has a number of key pharmaceutical wholesalers and manufacturers. In Ghana, the local drug manufacturing industry accounts for about 20 percent of the market share. (Center for Pharmaceutical Management 2003) Of the 30 pharmaceutical manufacturing facilities in Ghana, most are pharmaceutical wholesalers who have integrated backwards into production. High interest rates, taxes, and higher mark-ups for local manufacturers lead to higher prices, which limited their competitiveness. To help local industry, the government restricts the importation of 17 basic pharmaceutical products, including paracetamol and chloroquine.

Raw materials for local production come mainly from India and China. Installed capacity in most of the manufacturing plants is extremely underutilized. Because of lower manufacturing overheads, an opportunity exists for greater exchange and exploitation of opportunities for voluntary licensing. A few manufacturers, such as KAMA and Ernest Chemists, currently manufacture some products under voluntary licensing from patent holders (DFID 2003).

Ghana is a signatory to the World Trade Organization (WTO) conventions. The country’s patent law, the PNDC Law 305A of 1992, protects the rights of patent holders to their invention. It has been reported that amendments are underway, which would make the law compliant with the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement, and would also enable the country to take advantage of TRIPS agreement reliefs, pursuant to the DoHA (Qatar) Declaration.

Under the ECOWAS protocol, the right to free movement of goods and people has not taken full effect in the pharmaceutical trade. In Ghana, regulatory control of the trade requires that products be registered prior to market distribution, as it is in all other countries in the sub-region. Currently, drug regulatory issues are not harmonized in the sub-region. At the time of this assessment, the number of countries where products from Ghanaian manufacturers have marketing rights was unknown, but if there are any, the number is probably very low. Only a few Nigerian manufacturers had registered their products with the Food and Drugs Board in Ghana. Intra-regional trade in pharmaceuticals in the formal sector is very low. Anecdotally, it was reported that the pharmaceutical trade across country borders is quite pervasive. However, the volume of this trade is not documented; further analysis is needed to determine the impact this will have on regional harmonization of trade.

Private Sector and Social Marketing

In general, pharmaceutical trade in Ghana is one of the major areas of trade activity in the country. Local manufacturing accounts for approximately 20 percent of the total pharmaceutical market; reports are that it is expanding, with about 20 percent of all imports coming through unofficial or smuggled channels.

See table 3 for the estimated sales by the major wholesalers in the country in 2000.
Table 3. Estimated Sales by the Major Wholesalers in Country for 2000

<table>
<thead>
<tr>
<th>Wholesaler</th>
<th>Estimated Sales (U.S.$ million)</th>
<th>Market Share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ernest</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Kama</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Unichem</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Gokals</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Osons (of Kumasi)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Kina Pharma</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Western (of Kumasi)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Geo Pharmacy</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Baseline</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other*</td>
<td>74</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Market</strong></td>
<td><strong>117</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Interviews, market research, FDB, CEPS.

*All other individual wholesalers have less than 1 percent of the market share.

The role of the true private for-profit sector in reproductive health is very limited, including family contraceptive products.

The GSMF is responsible for all the social marketing of contraceptives in the country. With considerable donor support, the GSMF supplies social marketing contraceptive products through established pharmacies and licensed chemical shops. It does not have its own outlets for direct distribution to consumers.

Contraceptive commodities for the country have been jointly forecast by all the partners through technical support from DELIVER and sourced from multiple sources, depending on the product. The range of products available from the three contraceptive programs in the country are summarized in table 4.

Table 4. Products Available from the Three Contraceptive Programs In Ghana

<table>
<thead>
<tr>
<th>Method</th>
<th>MOH</th>
<th>PPAG</th>
<th>GSMF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>Be Safe (male) Female condom</td>
<td>Be Safe (male) Female condom</td>
<td>Champion Panther ProtectPlus Bazooka (all male)</td>
</tr>
<tr>
<td>Pill</td>
<td>Lo-Femenal Ovrette Microgynon Micronor Postinor¹⁰</td>
<td>Lo-Femenal Microgynon Postinor</td>
<td>Secure</td>
</tr>
<tr>
<td>Injectable</td>
<td>Depo-Provera® Norgynon</td>
<td>Depo-Provera® Norgynon</td>
<td>FAMPLAN</td>
</tr>
<tr>
<td>Implant</td>
<td>NORPLANT</td>
<td>NORPLANT</td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>Copper T 280a</td>
<td>Copper T 280a</td>
<td></td>
</tr>
<tr>
<td>Spermicide</td>
<td>Neo-Sampoon</td>
<td>Neo-Sampoon</td>
<td>Kamal¹¹</td>
</tr>
</tbody>
</table>

¹⁰ Postinor is currently on order for the MOH.
¹¹ Phasing out in 2004.
A successful family planning program is characterized by a growing interest in contraceptive use. This is demonstrated by an increase in the number of contraceptive users and requires an increased supply of commodities. The population of potential users is growing. The Ghana 2000 Population and Housing Census shows an increasing number of young people; many will enter the reproductive age group and require reproductive health services and products.

Internationally, in the early 1990s, donor support for contraceptives increased, peaking in 1993 at 15 percent of the total population assistance. As global population assistance levels rose briefly following the International Conference on Population and Development (ICPD), donor support for contraceptives also increased, doubling from U.S.$83 million to U.S.$172 million between 1992 and 1996. However, by 1999 the total available financing from donors dropped to U.S.$131 million and has continued to decline. The global decline in contraceptive commodities indicates an inconsistent and unpredictable trend in commodity financing by donors at a time when commodity requirements are increasing dramatically. This has been further amplified by the demand for barrier methods to prevent reproductive tract infections, including HIV/AIDS and other STIs.

Ghana currently faces an ever-widening financing gap for purchasing contraceptive commodities. In 2002, the funding gap was U.S.$400,000. In 2004, the funding gap was reduced to zero, due in part to the use of health funds, MOH tax revenue, and donor commitments. However, in 2005 and 2006 this gap is expected to increase to U.S.$2.5 million and U.S.$5.3 million, respectively. (These figures are based on prevailing pledged or committed funds by development partners and the government at the time of this writing.)

The Government of Ghana acknowledges that CS is not strictly a donor problem. Following the initial Sogakope national workshop on CS in 2002, an agreement was reached on the strategic vision of CS in Ghana that is in line with the five strategic pillars of the Health Sector’s Programme of Work: Access, Quality, Efficiency, Financing, and Partnerships.12

The GSMF recently introduced some pure commercial brands of condoms but, at this time, the market share is negligible.

The GSMF envisages that the supply sources for its commodities will continue to be in collaboration with the public sector. The idea of pooled procurement is very welcomed by the organization as a strategy that will continue to enable it to access commodities at a lower price and to maintain or even increase its market share. The GSMF does not do its own procurements. Donors provide the commodities using their procurement arrangements, and, currently, they decide the procurement mechanisms used to obtain their commodities.

**Pooled Procurement**

The MOH/Ghana Health service has limited experience in pooled procurement, if any at all. Procurement was one key area of management within the health sector that received sustained and deliberate intervention in the mid- to late-1990s, when Ghana was in the phase of intense health sector reform innovations. One key intervention in procurement was an 18-month TA support from the consortium, which is made up of International Procurement Agency (IPA) and International Policy Services (IPS). During this TA support, a full-time expatriate procurement consultant was placed in the MOH with the specific mandate to reform and strengthen their procurement systems.

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12 As mentioned, during the strategic planning process Access was combined with Quality and Monitoring and Evaluation was added as the fifth strategic pillar.
One major objective for these interventions was to establish a procurement system that was consistent with national laws and policies and also acceptable to the multiple funding streams that were going to the health sector as part of the SWAp arrangements.

As part of this effort, a procurement unit was set up at the MOH headquarters level, and produced a procurement procedures manual for use at all levels of the MOH. Staff were trained to implement the new system. As part of the reform process, the MOH, with its development partners, instituted annual post-procurement audits. An independent external procurement auditor was appointed to review and comment on the procurement practices and actions of the Ministry. Generally, the procurement systems established in the Ministry have been accepted by all the major donor partners, including the World Bank and USAID. This has enabled the health sector to access funds from multiple sources to support its procurement activities.

In a recent review of factors affecting access to medicines in Ghana, the reviewers found that the public sector has a functional procurement system. By establishing a procurement unit in the health sector, improvements were made in procurement procedures. (DFID 2003) The recent procurement audit documents that a number of areas of the procurement system need strengthening. The auditors said that they did not find evidence of corrupt practices in the activities reviewed, but the procedures did contain a number of irregularities, informal practices, and poor documentation, which prevented control at all stages of the procurement cycle (Bening Annang and Partners 2002). Despite these weaknesses in some areas of procurement, the audit report also shows that the central level procurement unit received the World Bank No Objections for its contracts, which confirms that they generally conformed to the requirements of the procurement procedures manual. This opinion was based on the review of 19 of 28 procurement contracts, the equivalent of $3,198,396 of a total of $3,958,523 contracts placed.

The Procurement Unit (PU) of the MOH has been cited as a model for both in-country and other sector ministries, and, beyond Ghana, as having achieved significant improvements. It is widely documented that the PU secures very competitive prices for its procurements when compared to international median prices.

An assessment team was able to collect unit price information for 18 of the 22 RH commodities on the tracer list from the Ghana MOH procurement unit and country donors.13 Procurement records for nevirapine syrup, benzathine penicillin, doxycycline, and ergometrine tablets were not found. For the records that were found, the most recent procurements were used to obtain unit price information. Several records from 2003 were used, as well as some from the first quarter of 2004. Based on the information available, Ghana is able to obtain a 57 percent total unweighted average lower price when compared to the lowest international reference price. The procurement unit obtained a 330 percent and 407 percent lower price for metronidazole tablets and folic acid tablets, respectively. As categories, the unit prices Ghana is able to achieve over IRPs exceeds 100 percent for drugs used to treat STIs, HIV, opportunistic infection (OIs), and antenatal RH commodities.

It is likely that the Ghana MOH is able to obtain such significant price reductions because it procures many of its RH commodities (and essential medicines) from local manufacturers. Procurement records indicate that folic acid was purchased through a local manufacturer—M&G Pharmaceuticals. Similarly, ergometrine injections were purchased through another local supplier, Mission Pharmaceuticals, which resulted in a 35 percent lower price.

A second comparison was made using the pooled volume price quoted by suppliers and the actual prices obtained in Ghana. Surprisingly, while the pooled volume price was, as expected, lower than the IRPs, the total unweighted average for the list of RH tracer commodities was still 43 percent lower than the volume

13 The Ghana MOH does not procure contraceptives. Price information for condoms, injectables, IUD, pill, and implant were obtained from UNFPA, DFID and USAID.
price quoted by suppliers. The price difference for folic acid and metronidazole remained significant, and a comparison between each category of RH commodities (except contraceptives) indicated a lower country price between 31 and 84 percent. This simple price comparison indicates that it would be difficult to justify the participation of Ghana (based on price alone) in a sole source pooled procurement system for four out of the five RH commodity categories.

On December 31, 2003, a new Public Procurement Law, Act 663, came into force. This new law, which should reform and streamline all procurements in the public sector, is not expected to greatly modify what the MOH already does, because it is believed that the earlier reforms in the health sector were a large part of the new law. However, it remains to be seen how this law and other administrative changes will affect procurement in the health sector.

The health sector has no direct experience in a pooled procurement mechanism. Most officials, however, wanted to pursue the mechanism if it lowered prices currently obtained through the Ministry’s procurement mechanism. Almost all interviewees said the best benefit was cost reduction. Before the alternative is considered, the quality of products and dependability of the procurement mechanisms were non-negotiable benefits and, therefore, must at least equal the current systems.

A great deal of skepticism remains about the viability of the pooled procurement mechanism for many respondents coupled with the lack of harmonization of product lists. Quality issues across the sub-region to this level of skepticism was high. The other factor contributing to this general feeling had to do with the Anglophone-Francophone divide in the sub-region; as they relate to drug management, the systems in the two areas are quite different.

At the political level, our interview with the Minister of Health and other officials at the health sector demonstrated a strong commitment and the desire to move along sub-regional cooperation to the benefit of health care across the member nations. Ghana’s commitment to sub-regional cooperation is further demonstrated by the creation of a Ministry of Regional Cooperation and the appointment of a cabinet-level Minister.

The current procurement and financial administration rules and policies systems will enable the Ministry to take advantage of any procurement system that is transparent and has demonstrated that it will achieve value for money.

At the country level, to achieve bulk and reduce per unit costs, two procurement initiatives are designed as a pooled procurement system line. These relate to one managed by Management Sciences for Health’s (MSH) Strategies for Enhancing Access to Medicines (SEAM) initiative, working for the Mission hospitals sector. Under this initiative, a pooled procurement mechanism by the SEAM project and the Mission sector in Ghana achieved savings of up to 20 percent for 20 of the most widely prescribed essential medicines (MSH n.d.). Under a similar system, GSMF is implementing a franchise system for licensed chemical stores in two regions to improve the drug supply situation in the communities served by these chemical sellers. A pooled procurement mechanism is being implemented as a cost reduction strategy to improve the viability and performance of these businesses (GSMF EL n.d.).

The national ability to forecast drug requirements at the central level is weak, which is evident because supplemental shopping is done at the national level each year to augment needs at the Central Medical Stores. Local purchases occur both at the health facility level and the national level. The frequent local purchases have been a concern in recent procurement audits; they undermine the gains made through competitive international purchases. The PU reports that these frequent purchases result from a lack of proper quantification of needs (MSH 2003).

The MOH PU manages its procurements using custom-made software, “Tender Evaluation and Order Monitoring System (TEOMS),” a Microsoft Access®-based database management software with a front end in SQL® server. Tender information can be managed and retrieved quickly.
Conclusions

Pooled Procurement

Willingness and commitment to pooled procurement
This assessment found significant support for any process that will lead to lower prices. Ghana’s commitment to regional initiatives implies a real support for a regional pooled procurement. Some respondents stated that there will be economic gains for Ghana beyond the savings made in commodity prices, because Ghana was better positioned to create jobs and other roles using that mechanism.

Ability to participate in pooled procurement
Current policies and procedures in procurement and financial management and fiscal policies would not impede pooled procurement. The annual work planning process, including procurement planning in the MOH and social marketing sector, would support pooled procurement; because requirements are set when the beginning planning period begins; these would go directly into a pooled procurement initiative.

Suggested model of pooled procurement
Currently, no regional cooperation for procurement and preliminary enquiry indicates that logistics management organizations with a sub-regional reach are operating in the country. It is unlikely that an organization capable of storage and distribution functions across the sub-region exists; therefore, any regional pooled procurement will require the supplier to deliver directly to the recipient countries.

Issues that would need to be addressed before participating in regional mechanism
Product selection and registration are not coordinated at the sub-regional level. For any pooled procurement to be effective, a quality harmonization scheme across the region must be established. Regional standards in product labeling may need to be harmonized to support a procurement initiative.

Potential institutions that have the capacity to manage the procurement mechanism
A number of procurement organizations in Ghana, including Crown Agents and Charles Kendall, can manage the procurement mechanism. At the time of this assessment, the MOH was in the process of contracting a procurement agent to manage its large and complex procurements. It is possible that some organizations may be able to play a role in a regional procurement initiative.

Financing of Reproductive Health Commodities

Short- to medium-term funding issues
Funding mechanisms for health commodities, in general, and for reproductive health commodities, in particular, seem adequate for the short- to medium-term. The revolving funds managed at the various levels of the health system seem to be self-sustaining; they have enabled facilities to maintain drug availability at a high and improving level. At the central level, resource mobilization to fund the current medium-term health strategy, which ends in 2006, is said to be adequate.
Long-term funding issues
It is unclear how new financing arrangements being discussed by the GOH and its donor partners will affect funding for RH health products. Currently, earmarked funding is used for most donor funding for contraceptive procurements. There very likely that if funds are moved into the MDDBS currently under discussion, prioritizing of contraceptive procurement may be considered after other competing interests.

Alternative funding mixes
Ghana is actively planning to establish a national health insurance scheme. As benefit packages are described, it would be an ideal time to ensure that RH services are covered. At the national program level, it is unknown how insurance will support the commodity procurement. It is essential to recognize its potential impact on service availability and uptake at the SDP, and to inform national plans accordingly.

Private Sector Expansion

Potential for private sector to expand
Currently, the private sector has a small role in reproductive health services. However, the private sector provides a significant level of health care delivery to more and more clients; it is possible to greatly expand the private sector role in RH services. The success of social marketing, measured by the availability of social marketing products in the country, indicates the important role social marketing can play as the private sector role expands.

Potential for local manufacturing of RH commodities
Pharmaceutical manufacturing in Ghana is increasing. New manufacturing plants have been established and existing ones expanded. During the past five years, manufacturers—Ernest, SanBao, and Kinapharma—have started operations or significantly expanded existing operations. Large manufacturers (Phyto-Riker), have discussed collaborations to begin manufacturing antiretroviral drugs in Ghana. Establishing Export Free Zones, coupled with tax and other export-oriented concessions, have probably stimulated these investments. The potential for expansion is great. However, in-country, complex products—hormonals and other biologicals—are not being manufactured; and, until now, most pharmaceutical manufacturing has been limited to very basic essential drugs.

Other Issues That May Impact RHCS

Logistics capacity
As said earlier, the logistics system of the public sector is undergoing reengineering to improve the efficiency of delivering products to support all service delivery. It is seen that by creating an integrated logistics system, the other interventions aimed at RH commodity security will be more successful.

Service delivery and demand constraints
National policies in reproductive health and the recent formulation of a National RHCS strategy are key successful RHCS. The strengths and weaknesses of the system are documented and strategies are developed to ensure that Ghana will achieve RHCS.

Policy constraints
This assessment could not identify policy constraints to RHCS or to support implementing a pooled procurement mechanism.
References


Ghana Social Marketing Foundation (GSMF) EL. Personal communication.


