

Medicine Procurement Framework for Public Hospitals under the Ministry of Health in Ghana: A Case of the Western Region

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Abstract

Medicine availability is one of the six fundamental building blocks of any well-functioning health system. In Ghana, the Ministry of Health (MOH) introduced the Medicines Procurement Framework Agreement (MPFA) policy in 2017 as part of strategies to ensure an all-time availability of essential medicines to improve the quality of healthcare delivery. The purpose of this research study is to explore the views and opinions of health professionals on the content, context, process, actors, and sustainability of the Medicines Procurement Framework Agreement of the Ministry of Health, Ghana in the Western Region of Ghana and to identify strategies that will help the key stakeholders to better understand the implementation problems and to address them to ensure the sustainability of the policy. This study utilized the traditional case-study approach to explore the key stakeholders' opinions, views, and experiences on implementing and sustaining the Medicines Procurement Framework Agreement. The main population of the study was healthcare professionals in the public sector. The study sample consisted of twenty-five healthcare professionals from six government health facilities in the Western Region of Ghana. A qualitative methodology including non-probability sampling (Purposive and convenient), in-depth interviews, and documentary review was the main method of data collection. Data were coded and entered into Nvivo 7 statistical software for content and thematic analysis. Descriptive statistics were employed to analyze demographic data and narrative analysis was used to describe respondents' views, perceptions, and opinions with direct quotations to support the analysis. Technical considerations such as improving equity, efficiency, and, quality of healthcare delivery and minimization of administrative bottlenecks associated with institutional base procurements provided the contexts for the introduction of the MPFA; yet most healthcare professionals are not fully aware of the content

and context of the policy. The study recommends strong stakeholder involvement to ensure ownership, interest, and motivation in the policy.

Keywords

Call-Offs, Essential Medicines, Ghana, Ghana Health Service, Medicines Procurement Framework Agreement, Ministry of Health, Public Policy Sustainability, Procurement, Quality Healthcare Delivery

1. Introduction

Medicines are vital elements of healthcare, and access to medicines is a fundamental human right and forms one of the basic building blocks of all functioning health systems (Hogerzeil, 1986, 2006; United Nations, 2015; WHO, 2018). Availability of essential medicine is key to ensuring quality healthcare delivery. In Ghana, available records show that essential medicines availability in almost all public health facilities falls below the WHO recommended threshold of 80% (Osei-Assibey & Akweongo, 2017; GHS, 2019, 2020). It is also evident that health facilities are struggling to meet their medicines requirements for the treatment of patients (GHS, 2020). Anvuur, Kumaraswamy, and Male (2006) reported that health facilities in developing countries are unable to ensure value-for-money procurement due to inadequate capacity resulting in equity, efficiency, and quality issues. Ghana's healthcare system had been battling with the inadequacy of essential medicine, affecting the quality of healthcare delivery (Osei-Assibey & Akweongo, 2017). Verhage, van de Gronden, Awanyo, & Boateng (2002) reported that the decentralized procurement method applied by the MOH and its agencies resulted in a myriad of problems including a lack of value for money. The World Bank in its report noted that procurement of medicines had been with the MOH sector since its inception with huge budgetary allocations with at least 18% percent of Ghana's Gross Domestic Product, GDP and close to about 80 percent of tax revenue is spent on procurement and its related activities annually (World Bank, 2018). Osei-Assibey & Akweongo (2017); Anvuur, Kumaraswamy, & Male (2006) variously noted that Ghana as a country is faced with enormous difficulties in terms of procurement management mainly occasioned by lack of general capacity which had accounted for poor value for money transactions in both government and donor financed projects. The authors further cited insufficient procurement planning, wasteful expenditures, lack of capacity to pay suppliers, funding inadequacies, general low supplier delivery problems, and lack of qualified procurement staff making the execution of many policy reforms in health a very difficult endeavor. To address the issue of perennial medicine stock-outs within public health facilities, the Ministry of Health (MOH) Ghana officially introduced the concept of framework agreement or contract for the procurement of medicines in 2017 which initially covered 54 medi-

cines and later expanded to 65 medicines (Korto, 2019). The general terms and conditions of the policy are that it governs the relationship between the Procurement Coordinator which is the MOH, Procuring Entities (the GHS and its RMSs), and Eligible Suppliers in respect of the provision of the Essential Medicines and Related Services specified under it. This is to ensure that essential medicines are made available to health facilities to promote quality healthcare delivery. The purpose of this research study is to explore the views and opinions of health professionals on the content, context, process, actors, and sustainability of the Medicines Procurement Framework Agreement of the Ministry of Health-Ghana in the Western Region of Ghana. The results of the study will help the Ministry of Health, Ghana Health Service, and Healthcare Practitioners and managers to better understand the implementation problems of the policy and how to address them to ensure the sustainability of the policy.

2. Background

United Nations (2015) indicated that the availability of medicines is crucial in the attainment of goals four, five, and, six of the Millennium Development Goals (MDGs) and goal three of the Sustainable Development Goals (SDGs). Ritchie et al. (2018) and UNDP (2007) also respectively noted that medicines are fundamental to quality healthcare delivery and that achieving the MDGs and SDGs and Universal Health Coverage (UHC) would need strong structures that ensure ready availability of drugs that would assist to provide integrated services and improve the quality lives of people. In its report outlining a draft road map for access to medicines, vaccines, and other health products and expressing concern about the proliferation of sub-standard medicines and their effects on quality healthcare delivery, WHO (2018) stated that strong regulatory frameworks, assessment of the quality, safety, and efficacy or performance of health products through prequalification market surveillance and assessment of quality, safety, and performance are the surest ways to achieve and maintain medicines and other health-related supplies for effective healthcare delivery. The main Health Sector goal of Ghana is to attain Universal Health Coverage through the availability of essential medicines for the improvement of curative, preventive, promotive, and rehabilitative health of the population as evidenced in the Ghana Health Services strategic plan (GHS, 2016-2021). As a sector, several interventions and activities have been initiated and are being implemented to ensure the regular availability of drugs. Among them is the review of the Public Procurement Act, the development of a sector-specific procurement manual, improvement in planning and budgeting, renovation of various Regional Medical Stores (RMSs), training of Supply Chain Practitioners (SCPs), and the introduction of the Medicines Procurement Framework Agreement (MPFA) (GHS, 2019).

However, Studies by Osei-Assibey & Akweongo (2017) and Anvuur, Kumaraswamy, and Male (2006) show that less developed countries including Ghana faced enormous difficulties with their decentralized procurement systems due to

a lack of general capacity accounting for poor value for money transactions in both government and donor financed projects. It cited issues such as insufficient procurement planning, wasteful expenditures, lack of capacity to pay suppliers, funding inadequacies, general low supplier delivery problems, and lack of qualified procurement staff in the execution of health policy reforms difficult and maintained that problems of the procurement system of the health sector should be comprehensively addressed. A study by [Osei-Assibey & Akweongo \(2017\)](#) concluded that GHS accounted for only 17% - 18% availability of essential medicines as against the WHO standard of 80% and the Ghana Health Service also indicates that only 64% of total medicines requirement was available at RMSs ([GHS, 2020](#)). To address these technical gaps, the government of Ghana through the MOH/GHS introduced the *Medicines Procurement Framework Agreement* in 2017 aimed at ensuring the constant availability of essential medicines in all public health facilities across the country for quality healthcare delivery. Medicine Procurement Framework Agreement or Contract otherwise known as a “Blanket Purchase Agreement” is a long-term agreement that provides terms and conditions specifically price and quantities under which smaller repeat purchasing orders may be issued for a defined period ([MOH, 2021](#)). Ahead of the rollout of the MPFA, [Kanyoma & Khomba \(2013\)](#) opined that, though framework agreements have some great benefits, there are thorny issues such as non-supplier adherence to the framework contracts resulting from shipment schedules and other financial difficulties as challenges for its successful implementation. [Arney, Yadav, Miller and Wilkerson \(2014\)](#) and [Ameyaw et al. \(2012\)](#) also confirmed that inadequate stakeholder engagement in any policy is a key factor responsible for the lack of understanding of the policy and its eventual successful implementation. Against these backdrops, the study sets out to explore the views and opinions of key stakeholders on the Medicines Procurement Framework Agreement of the Ministry of Health-Ghana in the Western Region of Ghana and to bring lessons learned to the attention of policymakers.

2.1. History of Public Procurement in Ghana

Public procurement had been with Ghana since independence. Initially, the Ghana Supply Commission (GSC) and the Ghana National Procurement Agency (GNPA) were the only state institutions that acted on behalf of the government to procure public goods and services ([Verhage, van de Gronden, Awanyo, & Boateng, 2002](#)). This system was challenged with patchwork legal frameworks, a weak civil service system, and a lack of access to information to assist donors and development partners to support its implementation ([World Bank Report, 2004](#)). Between 1981, 1994, and 1996, the World Trade Organization (WTO) sponsored a series of good governance in procurement initiatives which culminated in the “Agreement on Government Procurement” aimed at streamlining public procurement in Ghana ([World Bank Report, 2004](#)). Ghana as part of the reformation process embarked on the Public Financial Management Reform

Programme (PUFMARP) which was an integral component of Public Procurement System Reforms (PPSR) which eventually resulted in the enactment of the Public Procurement Act (Act 663) in 2003 which was later amended in 2016 as Act 914 to regulate all public procurement activities for all government agencies (Sarfo, 2011). The Ministry of Health (MOH), Ghana published its first institutional procurement manual in 2004, a document that provides guidelines and regulates public procurement for all agencies under the Ministry (MOH, 2004). Both the Public Procurement Act and the Procurement guidelines of the MOH set out eight (8) processes or steps to be followed before, during, and after any procurement activity. The procurement processes of the public health sector in Ghana, therefore, include planning, sourcing, contracting, contract management, storing, distribution, disposal, and evaluation (Public Procurement Act, 914; MOH, 2004). Between 2004 and 2016, the MOH and its agencies practiced decentralized procurement which allowed individual institutions to take charge of their own procurement needs including that of medicines (Anvuur, Kumaraswamy, & Male, 2006).

2.2. Problem Statement

The Medicines Procurement Framework Contract Agreement was initiated by MOH Ghana in 2017 as part of its overall health supply chain management review. The objectives of the policy are, to improve medicines availability, ensure uniformity in product pricing, and reduce administrative costs in the acquisition process involving bulk buying to enjoy economies of scale (MoFEP, 2019). Notwithstanding the objectives of the policy, there is a perceived low level of awareness among some health professionals of the content, context, and processes of the policy. The views and opinions of health professionals about the formulation, implementation, and sustainability of the policy and its effect on quality, access, and efficiency in service delivery have also not been explored and documented since its implementation. Studies conducted on Procurement Framework Agreements in Ghana, have not mainly focused on the health sector as they were limited to the education and information technology sectors. This accounted for a paucity of views and opinions of healthcare providers on the sustainability of the policy. There is also inadequate stakeholder engagement on the policy is a key factor responsible for the lack of understanding of the policy by some health professionals. A study conducted by Osei-Assibey & Akweongo (2017) concluded that GHS accounted for only 17% - 18% availability of essential medicines as against the WHO standard of 80%. The *GHS Holistic Assessment Report (2020)* also indicates that only 64% of medicines requirement was available at RMSs and this was supported by the Stores, Supply, and Drugs Management Division (SSDM). There are general stockouts of essential medicines in most facilities due to non-supplier responses meanwhile the initial terms of the MPFA forbid institutions from procuring medicines outside the framework.

3. Literature Review

According to Arney et al. (2014) “Framework agreements are long-term memorandum of understanding that provide the terms and conditions under which smaller repeat purchasing orders known as call-offs may be issued for a defined period and in the Ghanaian context, the Medicine Procurement Framework Agreement or Contract is also called “Blanket Purchase Agreement” an arrangement that specifies the general terms and conditions (price and quantities) under which the MOH a lead party will order smaller repeated purchasing orders from suppliers over period of one year though renewable but not guaranteed (MOH, 2017).

Before this agreement came into force, Public Procurement in Ghana had gone through series of transformations since independence transgressing from state dominance through to private participation, decentralization and finally with the promulgation of the Public Procurement Act (Act 663 as amended 914) (Verhage et al., 2002; Nathan, 2012; PPA, 2006; MOH, 2004). Public procurement in Ghana’s health sector suffered from a number of challenges including lack of general capacity, poor value for money, insufficient procurement planning, wasteful expenditures, lack of funds to pay suppliers, and low supplier delivery which resulted in almost non-availability of essential medicines to deliver healthcare in many state healthcare facilities (Osei-Assibey & Akweongo, 2017).

A number of studies conducted locally had concluded that medicines availability prior to and even after the enforcement of the agreement is way below the WHO standard resulting from implementation challenges such as poor response to call offs by framework contract suppliers, non-payment or delay in payment to framework contract suppliers from health facilities, and general lack of understanding of the policy goals and objectives by health professionals as key actors (Ameyaw et al., 2012; Miller et al., 2014; Osei-Assibey & Akweongo, 2017; GHS Holistic Assessment Report, 2020). To address the gap and ensure all time availability of medicines for healthcare delivery the medicine procurement framework agreement was instituted with a centralized power by the Ministry of Health to be the lead (sole negotiator and purchaser) in the contract execution which is similar to that of South Africa where all procurement for essential medicines was done by a national tendering unit on behalf of the provinces but in cases of supplier failures the provinces were allowed to do “buyouts” with approval from provincial authorities contrary to what pertains in the Ghanaian version (Médecins Sans Frontières, 2013; Zuma, 2017; Zuma & Modiba, 2020) and also in the USA where Arney et al. (2014) reported that although the framework for the procurement of medicines is usually characterized by centralized negotiation and contract management, the agreement allows for decentralized procurement authority with the key elements being federal (regional) pricing arrangements, direct negotiation of flexible contracts with manufacturers and a direct purchase and distribution approach facilitated by prime vendor programs.

Arney et al. (2014) further noted that the USA framework, also allows for all indefinite-delivery contracts to be directly shipped to facilities (users) with suppliers permitted to determine the realistic minimum and maximum quantities for each delivery order which makes their system more decentralized and acceptable by all stakeholders. Indeed, the South African and the USA medicine frameworks are hybrids of centralized negotiation (where framework contracts are first negotiated between the federal government agencies and multiple manufacturers under the framework agreements) and decentralized ordering (where facilities engage in direct ordering through decentralized procuring entities from private distributors/wholesalers operating under these service contracts. Studies show that the South African Framework for medicine procurement is too cumbersome and is not working perfectly due to long contract process, non-payment of suppliers, poor supplier performance, and lengthy buy-out process and non-inclusivity of stakeholders resulting in unnecessary stock-outs (Arney et al., 2014; Modisakeng et al., 2020). Similar sentiments were expressed with regards to the Ghanaian context (Osei-Assibey & Akweongo, 2017; Anvuur, Kumaraswamy, & Male, 2006) which might have alarmed the Ministry of Health (MOH) as part of its overall health supply chain management review introduced the Medicine Procurement Framework which objectives are to improve medicines availability, ensure uniformity in product pricing, reduce administrative cost in acquisition process involving bulk buying to enjoy economies of scale (MOH, 2017). That notwithstanding, there is low level of awareness among some health professionals of the content, context and the processes of the policy. Also, the views and opinions of health professionals with regards to the formulation, implementation and sustainability of the policy and its effect on the access, quality, and efficiency in service delivery have not been explored and documented. Only few studies on Procurement Framework Agreements in Ghana, have focused on the health sector and their scope was limited to either one category of professionals or one facility and there seem to be paucity of views and opinions of health care providers on the policy implementation and its sustainability.

Theoretical and Conceptual Frameworks for the Study

The study was theoretically based on Walt and Gilson's Policy Triangle (1994) which explain policy from four dimensions/elements namely the content, context, process, and actors and had been used by other scholars as the basis of policy studies (Walt & Gilson, 1994; Buse, 2008; Rajkotia & Frick, 2012; Addai et al., 2006; Colombini et al., 2011) as illustrated in **Figure 1** below. The policy triangle explains that to every policy, there is a content (what the policy is all about), the context (conditions necessitating the policy), the process (the implementation structure of the policy), and the actors (the stakeholders of the policy). In many developing country contexts, the Walt and Gilson's policy triangle had been used

as a relevant tool for exploring other health related policies such the study of setting priorities for reproductive health at the district level in the context of health sector reforms in Ghana by [Addai, Addico, Ajayi Askew, Appiah and Nyarko \(2006\)](#) and on vaccinations in Malaysia by [Colombini, Ali, Watts and Mayhew \(2011\)](#).

The conceptual framework demonstrates the assumed relationship between four fundamental variables; One Independent Variable the Procurement Framework Agreement (IV), and three Dependent Variables; the operations at Regional Medical Store (DV¹), Availability of Essential Medicines at health facilities (DV²), and Patients Health and Quality Care Delivery (DV³). The conceptual framework assumed that the availability of essential medicines at various health-care facilities for providing quality healthcare delivery are dependent on the

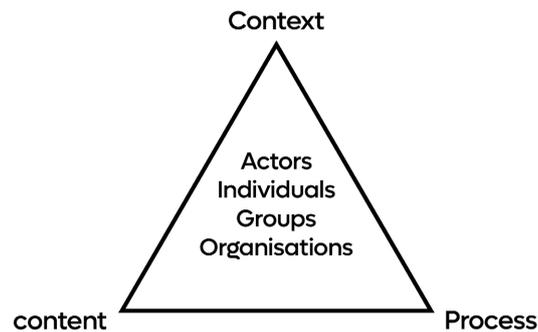


Figure 1. Walt and Gilson (1994).

Conceptual Framework

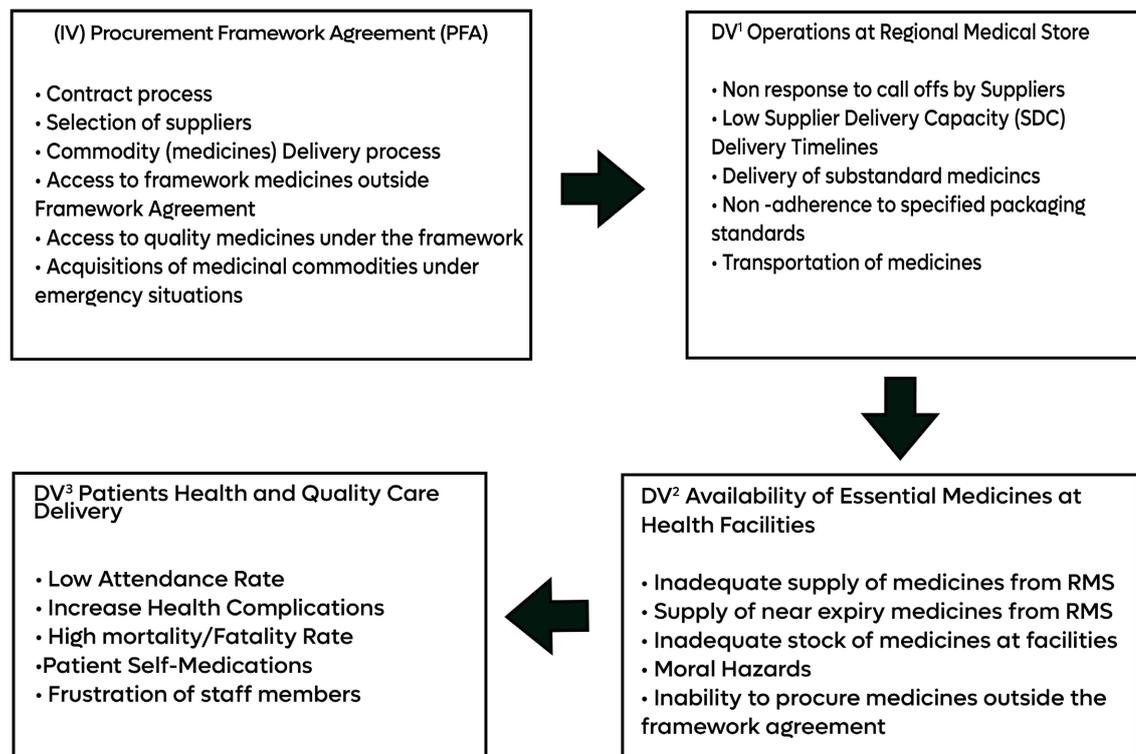


Figure 2. Conceptual framework. Author's Construct (2022).

operations of the Regional medical Store which in turn depends on the process (implementation) of the Medicines Procurement Framework Agreement as illustrated in **Figure 2**.

4. The Study Setting

The study was conducted in the Western Region of Ghana. Geographically, the Western Region is located in the southern part of Ghana and lies between latitude 5.5573°N and longitude 2.3024°W. The region shares borders with La Cote D'Ivoire on the West, the Central Region on the East, parts of Ashanti, Bono, Western North, and Ahafo Regions in the North, and the Gulf of Guinea in the South. The region accounts for about 10 percent of the total land surface of Ghana and had a population of 2,376,021 with a projected population of 3,093,201 as of 2019 (GSS, 2013). The Western Region was chosen for the study based on several factors. The region has a well-established Supply Chain Management system including the availability of human resources such as Doctors, Pharmacists, Supply Officers, Procurement Managers, Administrators, and Accountants with adequate experience in procurement and supply chain management. Again, several capacity-building programs have been organized for procurement and supply chain staff on the Procurement Act of Ghana and the MOH procurement manual. The region also has well-established Regional Medical Stores with adequate storage space, stock facilities, and the use of technology such as the Ghana Integrated Supply Management (GhiLMIS) and the Last Mile Distribution (LMD) systems for their supply chain management. The Western Region also has 895 health facilities made up of 50 Hospitals, 80 Health Centers, 126 Clinics, 601 functional CHPS compounds, and 38 Maternity Homes (WRHD, 2021). The western region was chosen because of the remoteness of its facilities from the RMS and the fact that the region is challenged in terms of poor road networks and most of the facilities do not have haulage trucks for transporting medicines from the RMS. The fact that the number of health facilities-hospitals, health centers, and CHIPS compounds providing a range of health services placed a high demand for health commodities also justifies the selection. The fact also that the Western Region GHS Holistic Assessment Report indicated that the RMS could only serve 54% of all medicine demands from facilities within the region also justifies the selection of the region for the study (WRHD, 2020).

5. Methodology

This study was conducted in the Western Region of Ghana. A case-study approach was utilized. The study population included Health Professionals with procurement and drug usage responsibilities and a sample of 25 respondents were drawn from 6 facilities across the region. Data Collection tools and techniques used for the study were In-depth interviews and Documentary review. The data collection instruments were tested/piloted for reliability and validity in the Bono Region where seven respondents were involved. Data for the study was

collected between January and June 2022. The Discrete unit of analysis include District Directors, Doctors, Physician Assistants, Nurses, Accountants, Health Service Administrators, Regional Medical Stores staff, District and facility Supply Chain managers/officers, Procurement Managers and Pharmacists as shown in **Table 1** and the distribution of Health staff per facility involved in the study as shown in **Table 2**. Data was collected on Demographic profile of respondents, the Content, context, and processes of the medicine procurement framework agreement, views, opinions and perceptions of healthcare professionals on the implementation of the policy and its sustainability. Qualitative content analysis was used for data analysis and field data was methodically organized and coded into themes using Nvivo 7 statistical software for content and thematic analysis. Demographic data were quantitatively presented and other results, descriptively presented. Descriptive statistics (percentages) were employed to analyze demographic data and narrative analysis was used to describe the views, perceptions, and opinions of respondents with direct quotations to support the analysis. Ethical

Table 1. Health Staff selected for the study.

Category of Staff	Number
Doctors	3
Nurses managers	2
Physician Assistants	2
Accountants	3
Administrators	3
Supply Chain managers	4
Procurement manager/officers	4
Pharmacists	4
TOTAL	25

Source: Field Work (2022).

Table 2. Distribution of health staff per facility.

Health Facility	Number	Number of staff
Regional Medical Stores	1	4
Regional Hospital	1	4
District Health Directorate	1	4
District Hospital	1	5
Health Centre	1	3
CHPS Compound	1	3
TOTAL	7	25

Source: Field Work (2022).

clearance was obtained from the GHS Ethical Review Committee for the conduct of the study (GHS-ERC/21/57C). Permission was granted by participating facilities and informed consent obtained from respondents who voluntarily participated in the study.

6. Results

The data collected in this study is presented and analyzed using the Descriptive statistics (percentages) to analyze demographic data and narrative analysis for other data.

6.1. Demographic Profile of Respondents

Out of the twenty five (25) health professionals interviewed, five (5) were aged between 30 and 39 years, thirteen were between 40 - 49 years and seven (7) were between 50 - 59 years. Eighteen (18) of the respondents were males and 7 were females. There were 3 doctors, 2 nurses, 2 physician assistants and 2 accountants. The rests were 3 health services administrators, 4 supply chain managers, 4 procurement officers and 4 pharmacists. 15 out of the 25 of respondents had more than 10 years working experience with 5 or more of the years in procurement related functions and 10 respondents had between 6 and 10 years working experience. Seventeen (17) of the respondents had university degrees, four (4) had Higher National Diploma (HND) Purchasing and Supply and another four (4) also have Advanced Diplomas in Nursing. Ten (10) of the respondents are management level staff, nine (9) are senior level staff and six of them junior level staff. All the 25 respondents are registered professionals and belong to various regulatory and professional associations such as Association of Health Services Administrators (Ghana) (AHSAG), the Ghana Medical and Dental Council (GMDC), the Pharmacy Council, the Nurses and Midwives Council (NMC), the Ghana Medical Association (GMA), the Health Sector Supply Chain Professionals Association (Ghana) (HESSCPAG) and the Health Accounting Staff Association (HASAG) as depicted in **Table 3**.

6.2. Stakeholders Take on the Policy

6.2.1. Policy Content

Out of the three categories identified from the 25 respondents, 15 respondents constituting 60% were not aware of the policy, six respondents, accounting for 24% were aware of the policy but had no idea about its content and 4 respondents making up 16% were both aware of and have knowledge of the content of the policy as indicated in **Table 4**. However, while some were aware of the policy, they were unable to state the goals, objectives and the elements of the policy. Some also indicated they had not sighted the policy document because they were unable to say anything factual about it. More interesting is that, even those who were directly involved in the implementation at the regional level were not able to effectively relate to content of the policy. This confirms the position of Ameyaw

et al. (2012) on the introduction and implementation of framework agreement in the educational sector where they found out that most stakeholders in the sector

Table 3. Demographic profile of respondents.

Index	Category	Number	Percentages
Gender	Male	18	72
	Female	7	28
Total		25	100
Age	30 - 39	5	20
	40 - 49	13	52
	50 - 59	7	28
Total		25	100
Working Experience	6 - 10 years	10	40
	More than 10 Years	15	60
Total		25	100
Licensing/Registration status	Yes	25	100
	No	0	0
Total		25	100
Educational Background	First Degree/Masters/PhD	17	68
	Higher National Diploma	4	16
	Advanced Diploma (Nursing)	4	16
Total		25	100
Level of Responsibility	Lower Level management	6	24
	Middle Level Management	9	36
	Senior Level Management	10	40
Total		25	100
Professional Category	Accountant	3	12
	Health Services Administrator	3	12
	Procurement Staff	4	16
	Supply Chain Staff	4	16
	Doctor	3	12
	Nurse Managers	2	8
	Pharmacist	4	16
	Physician Assistant	2	8
Total		25	100

Source: Field Data (2022).

Table 4. Respondents awareness of the medicines procurement framework agreement.

Indicators	Number	Percentage
Not aware of the policy	15	60
Aware of the policy but had no idea about its content	6	24
Aware of and have knowledge of the content of the policy	4	16
Total	25	100

Source: Field Data (2022).

were unaware of the framework because they were not fully engaged and involved. It is clear that some health professionals at the regional, district and sub-district levels are not fully aware of the policy and supported by a respondent: *“No am not aware of any policy. Usually such things when they are done at the National and Regional levels, they always organize training on them for us but... I mean this one nothing like that was done”*

6.2.2. Policy Context

The results of the study indicate that a number of factors necessitated the roll-out and the implementation of the Medicines Procurement Framework Agreement. Notable among them are minimization of administrative bottlenecks, improving equity, efficiency and quality of care. Others included technical issues such as to reduce corruption in procurement, address the problems of lack of funds at the lower levels to engage in large volumes of procurement to enjoy economies of scale, low staff capacity and lack of qualified procurement staffs especially at the regional and district levels. These contextual factors are supported by literature (Grindle, 2017) in their studies into policy analysis where they enumerated factors such as sector reforms, technical and administrative bottlenecks, economic factors, traditional and socio-cultural factors and environmental factors and demographic changes as key determinants of policies. It is also evident that technical and administrative bottlenecks necessitated the roll out of the policy and this was underscored by a respondent as *“I think the first consideration was purely to address some technical issues and that informed the policy; I mean it was to improve equity, efficiency and quality of healthcare delivery.”*

6.2.3. Policy Process

The results of the study confirmed that the initiation and formulation of the Medicines Procurement Framework Agreement was done at the highest level and the regional, district and sub-district levels are expected to ensure the implementation of the policy. This was in agreement with Anderson (2011) and this was supported by a respondent: *“Sincerely I don’t know how the medicine procurement policy was formulated. I was not involved. I don’t think I remember any stakeholder engagement to roll out the policy in the health sector.”*

6.2.4. Policy Implementation

Although policy actors generically play very essential roles in any policy implementation, the results of the study indicate that health professionals at the Regional and District levels were not involved in the negotiation, award and management of the framework contracts and are unable to perform their roles effectively in the implementation of the policy. This is against the position of [Sutcliffe & Court \(2005\)](#) where he maintained that policy actors at the implementation level should be allowed to provide technical skills, expert knowledge and practical experience and also develop monitoring mechanisms that will reveal discrepancies between the policy's expected and actual results as means of policy evaluation. This was echoed by respondents *"I was not involved in the formulation of the policy.....even as a group, I don't remember our group AHSAG was even involved in any of the process"*, and in a rather long statement, another respondent noted:- *"We were not adequately engaged in the policy process such as its initiation and formulation making us not to play our roles effectively. This has denied inputs from the lower levels into the policy process. Also, there are no implementation guidelines and role definitions for regional, district and sub-district level actors except that they send their medicine requirements in the case of regional level to the national level and the districts and sub-districts to the RMS and all these can affect sustainability. In fact, actors at the regional, district and sub-district levels are not allowed to take part in the selection of suppliers and award of contracts under the MPFA thereby rendering us unable to monitor and supervise supplier performance a situation that can affect the implementation of the policy"*.

The study also revealed that implementation is associated with non-availability of medicines as expressed by a participant: *"If you asked me, I'll say that the policy is not making drugs available at the RMS, how much more would the District get it not to talk of the facilities. The policy just needs a review to relax its rigid clauses. Districts and regions should deal with their suppliers. National cannot understand local needs better than the locals themselves. Simplicita"* which contradicts the position of [MoFEP \(2019\)](#) and [MOH \(2021\)](#) when they maintained that the Medicine Procurement Framework Agreement will ensure all time availability of essential medicines to all health facilities across the country.

6.2.5. Sustainability of the Policy

The results of the study also indicate that low level of involvement of key stakeholders in the policy process is a potential to affect its ownership, proprietorship, acceptability, legitimacy, and eventual sustainability. The study further revealed that lack of or inadequate financial resources to enable facilities pay for medicine supplies to ensure constant supplier response to call offs is another factor that will strongly militate against the policies sustainability. These facts support what [Bennett et al. \(2004\)](#), [Shigayeva et al. \(2010\)](#), [Bates et al. \(2011\)](#), and [Anderson \(2011\)](#), concluded about policy sustainability and also a direct opposite of the USA and the South African version of the Medicine Procurement Frame-

works. These positions were supported by respondents as indicated. *“They need to fully involve us. I think the whole thing was too centralized and rushed”*. *“The authorities should allow us at the district level to engage the suppliers. The current arrangement is not helping because we even don’t know the suppliers we are dealing with”*. In adequate provision of financial resources to enable facilities pay for medicine supplies and *“The policy is not bad, but we cannot sustain it with the current level of erratic NHIS claims payment”*.

7. Discussions, Conclusion, and Recommendations

The contents of the Medicines Procurement Framework Agreement in terms of its objectives, scope of medicines and relevance are good initiatives to ensure efficiency, equity and quality of healthcare delivery. The context of the policy seeks to address technical and administrative problems such as lack of capacity of procurement professionals at the regional and district levels and also to minimize fraud, malpractices and corruption within the public sector health procurement of medicines. The existence of such limitations affects value for money and these were to be reduced with the introduction of the policy. Although the process of formulating the Medicines Procurement Framework Agreement remains a high level strategic responsibility, it would have been appropriate if the process had been widened to include regional and district levels to afford health professionals at those levels the opportunity to learn and also make some input into the policy since they are the direct implementers and beneficiaries of the policy. The roles of healthcare professionals in the implementation of the policy at the regional and district levels were however limited since they are only to request, receive and manage the usage of medicines under the framework. Health professional’s roles should have been expanded to include selection of suppliers, evaluation of tenders, contract awards and management. The limited engagement of health professionals at the regional and district levels in terms of their views, perceptions and opinions can affect the sustainability of the policy. The implementation of the Medicines Procurement Framework Agreement for now has not achieved its full objectives of ensuring all time availability of essential medicines to impact the equity, efficiency and quality of services. This stems from some implementation challenges such as delayed and sometimes non-response of framework contract suppliers to call-off making facilities intermittently run out of stocks. There is also the likelihood that, exchange rate fluctuations and some importation constraints are also contributing to supplier’s inability to meet demands. These problems can be reduced by government supporting the local pharmaceutical industries to acquire easy and cheaper credits and also give them some tax incentives to enable them produce in large quantities to meet the ever increasing demands of the public health sector.

On the basis of the findings and the conclusions, the study recommended that there is the need for a broader and an all-inclusive stakeholder engagement to ensure all implementation challenges of the policy are addressed including fi-

nancial resource availability. There should also be the formation of Technical Working Groups or Committees across all regions and districts to oversee implementation of the policy. There is also the need for continuous capacity building for health professionals to ensure their full understanding of the policy. As a long term measure, there should be a full stakeholder participation and involvement for a possible review of the policy implementation guidelines to promote its acceptability.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Appendix: Interview Guide

Background Characteristics

1. **Sex** (a) Male [] (b) Female []
2. **Age Group** (a) [30 - 39] (b) [40 - 49] (c) [50 - 59]
3. **Educational level** (a) Diploma [] (b) HND []
(c) First Degree [] (d) Master Degree []
(e) PhD []
4. **Experience/No of Years served**
(a) 6 - 10 years [] (b) More than 10 years []
5. **Department.** (a) Account [] (b) Stores []
(c) Procurement [] (d) Administration []
Other please specify.....
6. **Professional category**
(a) Accountant/Finance Officer [] (b) Administrator []
(c) Head of Stores /Procurement [] (d) Pharmacist []
(e) Procurement manager/officer []
7. **Grade, please specify**

8. Facility Type

- (a) Regional Health Directorate [] (b) Regional Medical Stores []
- (c) Regional Hospital [] (d) District Health Directorate []
- (e) District Hospital [] (f) Health Centre []
- (g) CHIPS Compound []

ASSESSMENT OF THE OF MEDICINES PROCUREMENT FRAMEWORK OF THE MINISTRY OF HEALTH IN THE WESTERN REGION

As you will recall, the Ministry of Health in 2017 adopted the Medicines Procurement Framework Agreement as a policy for procuring medicines for public health facilities. I crave your indulgence to engage you in a discussion on few issues about the policy.

Segment A: Planning, Design and Development of MPFA:

1. Have you ever been involved in any policy formulation process? (If yes in what capacity were you involved? Please describe in detail how you were involved?)
2. Were you involved in the formulation of the MPFA?
3. If yes what role did you play? Please describe in detail the role you played?
Probe
4. If no why you were not involved in the processes leading to the formulation of the MPFA?
5. Do you have any recommendations on the process adopted for the formulation of the policy?

6. What will you suggest to be the process for any future policy formulation in health sector which should be adopted? Why that process? Is your suggestion borne out of your involvement or non-involvement in the MPFA policy formulation process? Probe for explanations

SEGMENT B: Implementation of the MPFA

The MPFA was introduced in 2017 and had since been in operation. I want us now to look at the MPFA Policy Implementation.

1. I would be glad if you can describe the implementation process of the policy in your facility
2. Who are involved in the implementing of the policy?
3. What specific responsibilities do they have and why?
4. What is your opinion about the implementation of policy in general?
5. In your estimation, has the MPFA policy accomplished its desired goals and objectives? If yes why and if no why?
6. If the policy has achieved its objectives can you please tell me what should be done to consolidate the gains made?
7. If the policy has not achieved its purpose, kindly suggest ways of improving the policy

Segment C: Sustaining the MPFA

The main aim of the MOH is to sustain the MPFA. Please let us have some discussion in that regard.

1. Kindly share your view on what you think healthcare professionals in general can do to ensure the sustainability of the policy?
2. Kindly share your views on what you think the MOH can do to ensure the sustainability of the policy?
3. Kindly share your view on what you think the GHS can do to ensure the sustainability of the policy?

Segment D: Problems and Challenges of the MPFA

Like any other policy, the implementation of the MPFA may be facing some problems/challenges. I want you to share your opinion or views on the problems/challenges facing the MPFA in the context of healthcare delivery

1. Can you tell me what in your opinion are the main problems or challenges facing MPFA?
2. Kindly suggest measures to address the problems or challenges.

Thank you.