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Research Article

Procurement Processes at Gwanda Provincial Hospital, Matebeleland South Province, Zimbabwe, 2012; a Descriptive Cross Sectional Study

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Abstract

Introduction: Gwanda Provincial Hospital received one million eight hundred dollars from treasury in 2011 through Targeted Approach. By year end, the hospital experienced stock-outs of essential goods, medicines and surgicals. A routine audit carried out in 2012 exposed procurement irregularities. We conducted this study to evaluate adherence to procurement and accountability by public health officials in the institution.

Methods: We conducted a descriptive cross sectional study at Gwanda Hospital. We used interviewer administered questionnaires, key informant interviews and desk review of records for data collection.

Results: Fifty seven primary respondents were interviewed and we reviewed 47 procurement documents. The majority were nurses (29.8%), 53% were females. The median age in service was 10.5 years (Q1=4; Q3=17). Fifty-eight percent had low knowledge on procurement processes. Legislation and policy documents on procurement were not easily accessible. Key procurement committees were non functional while inter-departmental communication was poor. Procured goods were reported to be of poor quality.

Conclusion: The hospital did not getting value for money during Target Approach. Administrative controls on procurement processes were not followed. There was no proper procurement planning. Procurement trends were not being utilized to inform decision making. As a result of this study, staff trainings on procurement were conducted while standard operating procedures on procurement were developed. This study is the first published document on understanding procurement processes in Zimbabwe public health delivery at a tertiary referral institution. The study will add to existing knowledge on improving accountability of public health managers in resource poor settings.

Keywords: Procurement processes; Gwanda Hospital; Targeted Approach; Tenders

Abbreviations

CBU: Centralized Buying Unit; CC: Commissioning Committee; CI; Confidence Internal; DMO: District Medical Officer; GTB: Government Tender Board; GPH: Gwanda Provincial Hospital; HAS: Health Services Administrator; HoD: Head of Department; MoHCC: Ministry of Health and Child Care; MTC: Medicines and Therapeutic Committee; PBA: Purchase out of Best Advantage; PFMS: Public Finance Management System; PMD: Provincial Medical Director; PTC: Procurement and Tender Committee; RC: Receiving Committee; SWOT: Strength, Weaknesses, Opportunities, Threats

Introduction

Public procurement is the process of acquiring goods and services to meet the needs of the end user in the right quantities, right conditions, delivered to the right place, for the right cost and the right goods using public funds [1,2,3]. The aims of public procurement are to get the best value for money; efficient and effective use of resources; transparency; provision of resource accountability and utilization; ensuring monitoring and evaluation [2,4-6].

Where procurement is done according to sound policies, there is potential benefit to the economy and these help in wealth distribution [6,7]. In the health sector, ensuring availability of effective medicines for priority health problems remains a challenge while there is widespread concern over efficiency of public procurement in Africa [8,9]. Procurement is done through tenders; formal, special formal tenders, approved list tenders and Purchase out to Best Advantage (PBA) [2,5,10,11].

This enables companies to bid, enhancing competitive advantage and thus the goods procured will be cheaper, but satisfying value for money [12]. When proper procurement procedures are followed, the processes are auditable, verifiable and transparent [7].

Procurement in Zimbabwe is guided by legislative policies, acts of parliament and supporting documents. These include the Zimbabwe Procurement Act; Public Finance Management Act; Secretary for Health Guidelines for Procurement; Treasury

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Instructions; Accounting Officers' Instructions on Procurement and Ministerial circulars [2,10,13]. In the Ministry of Health and Child Care (MoHCC), procurement is done in designated cost centers by procurement committees. These are the: Procurement Tender Committee (P.T.C), Centralized Buying Unit (C.B.U), Commissioning Committee (C.C), Receiving Committee (R.C) and the Medicines and Therapeutic Committee (M.T.C) [2,5,10]. At the Provincial Health Services the Medical Superintendent and the Provincial Medical Director (P.M.D) are Sub-accounting officers at these cost centers [2].

In the year 2011, the Government of Zimbabwe, aiming at revitalizing health delivery system that had nearly collapsed during the height of economic meltdown, embarked on a Targeted Approach Program. The health institutions were funded from Treasury to renovate dilapidated health infrastructure, purchase medical equipment and to procure medical and surgical consumables. Gwanda Provincial Hospital (G.P.H) was allocated a sum of US$ 1.8 million under Targeted Approach Program. This was in addition to a yearly Treasury approved budget allocation of US$ 443 260.00, disbursed through Public Finance Management System (P.F.M.S) and gross institutional user fees collections amounting to US$ 242 404. 00. Commodities inclusive of medicines, surgical consumables and hospital plant equipment were procured through the tender procurement processes.

Routine internal audits carried out in January 2012 by the Office of the Auditor General revealed irregularities in the tendering processes during Targeted Approach Program at the hospital with allegations that the Government of Zimbabwe was prejudiced about three hundred thousand dollars. Complaints were raised by user departments within the institution that procured goods did not meet stipulated specifications and were sub-standard. The end users reported that they had minimal input in the procurement process. By year end, 2011 the hospital had run out of vital and essential medicines in the pharmacy department. There reportedly were food shortages for hospitalized patients.

We therefore carried out this study to identify the possible reasons for poor adherence to procurement procedures at Gwanda Provincial Hospital? There are no studies that have been published that evaluate the procurement processes in public health delivery system in Zimbabwe. This study will add knowledge and appreciation of procurement processes in public health delivery sector, in a tertiary health centre in a rural resource poor setting in Zimbabwe.

Materials and Methods

We conducted a descriptive cross sectional study at G.P.H. An Ishikawa (cause and effect) diagram (Figure 1) was used as the framework for identifying factors that influence the procurement processes. It depicts how factors such as human, material and financial resources, policies and procedures and environmental factors may contribute to poor performance of procurement system in a tertiary health centre.

We used all health workers employed at Gwanda hospital, N= 225 officers as the sampling frame. Using StatCal version of Epi Info, assuming 50% of the participants complained of poor quality of procured goods, with worst expected result of 60%. At 95% Confidence

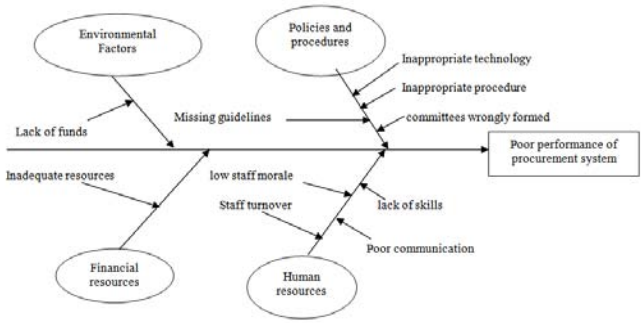

Figure 1: Fishbone analysis; possible root causes of poor performance of the procurement processes at Gwand Provincial Hospital, Zimbabwe, 2012.

Interval (CI) and assuming refusal rate of 10%, 74 health workers were enrolled into the study. All health workers who were directly involved in procurement in C.B.U, P.T.C, heads of departments and other members of staff who were in the receiving committee found on duty during the study period were interviewed. Assuming reported delay in sourcing for quotations was 50%, with the worst expected result of 70% procurement forms were wrongly processed, at 99% CI, a minimum of 41 procurement documents were reviewed.

A semi-structured interviewer administered questionnaire was used to collect data. A desk review of procurement documents (tradesman's requisition, tender documents, payment vouchers) and Central Buying Unit & Procurement Tender Committee minutes from January to December 2011 was done. A comparison of prices within the institution, retail shops, local private pharmacy and National Pharmaceutical Stores was done. A checklist was used to assess the availability of key commodities, policies and procedure documents. Quantitative data was analyzed using Epi Info™ version 3.5.1. To generate frequencies, means and proportions. Analysis of qualitative data was done manually.

Written permission to carry out the study was sought and granted from the Medical Research Council of Zimbabwe; Ministry of Health and Child Care, Health Studies office, the Provincial Medical Director Matabeleland South and the Hospital Executive Gwanda Provincial Hospital. Written consent was sought from study participants; the choice of unwillingness to participate in the study was respected.

Results

We interviewed 57 primary respondents where 53% were females.

Table 1: Designation/ departments of primary respondents, procurement processes at Gwanda Provincial Hospital in 2012.

Department / Designation	n=57	%
Accounts	3	5.26
Doctors/Administration	9	15.79
Nursing	17	29.82
Nurse aide/ primary care counsellor	6	10.53
General hand/driver/cook	12	21.05
Physiotherapy	6	10.53
Environmental health/radiology/laboratory	4	7.02
Median years in post	**5 (Q_1=3.5 ; Q_3=10)**	
Median years in service	**10.5 (Q_1=4 ; Q_3=17)**	

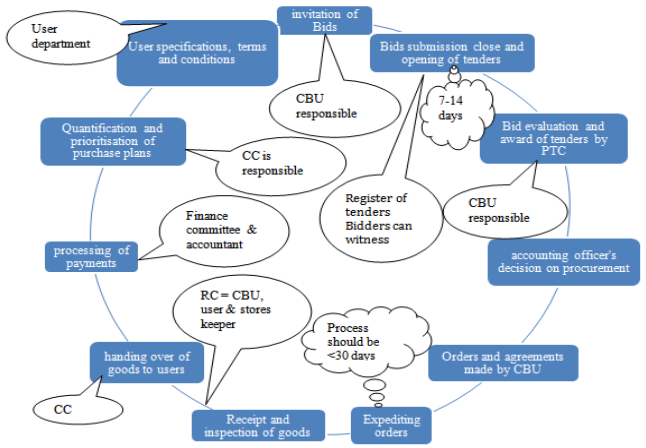

Figure 2: The Procurement cycle, Ministry of Health and Child Care, Zimbabwe, 2012.
*Adapted from; Accounting Officer's Instructions on Procurement, November 1995 [5]

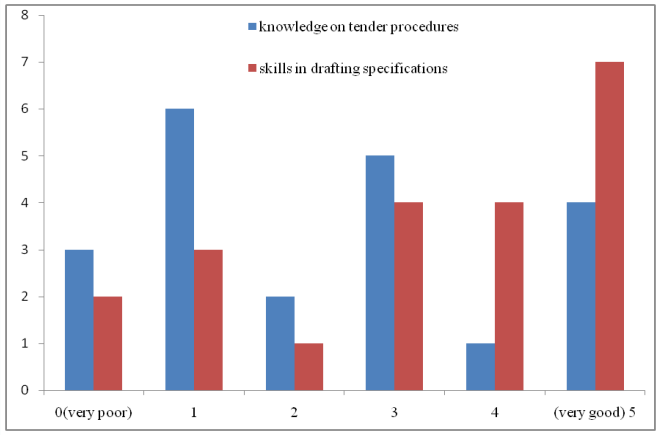

Figure 3: Perceptions of health managers in knowledge on tender procedures and skills competence in drafting specifications of goods, Gwanda hospital, 2012.

Nurses were the majority accounting for 29.8% of all the respondents. Their median age in service was 10.5 years.

[Q_1=4 years; Q_3=17 years] while their median years in post was 5 years.

[Q_1=3.5 years; Q_3=10 years] (Table 1). We interviewed 21 health managers that were directly involved in procurement committees and departmental heads. Forty seven procurement documents were reviewed. These included; sets of completed and uncompleted procurement documents (25), executive meeting minutes (12), Audit reports (2), and Heads of Department (HoD) meetings (8).

Procurement cycle steps (Figure 2) commonly known included; ordering of goods by user department (68%), invitation of bids (53%), ordering of goods by the C.B.U (46%) and awarding of tenders by the P.T.C. (44%). Commissioning of goods (25%), processing of payments (33%) and receipt of goods by the receiving committee (35%) were not popularly known steps in the procurement cycle.

Sixty three percent of participants knew that prioritization is done at the hospital. Twenty six percent of respondents said the Medical Superintendent was the accounting officer while 23% thought it was the administrator and 46% did not know. Fifty one percent reported that the role of the accounting officer was for processing payment while 25% correctly stated that the accounting officer was responsible for the final procurement decision. The C.B.U (58%) and P.T.C (52%) were reported to have the most important with roles in procurement.

Sixty eight percent of primary respondents strongly agreed and 25% agreed that procurement was an important activity in the institution. The roles of user departments were stated as; drawing specifications (72%), identifying needs (37%) and feedback on quality of goods (25%). Among health managers, 3/21 correctly stated the tender limit for informal tenders and 8/21 knew authority for formal tender was given by the Government Tender Board (G.T.B). Challenges with suppliers were reported by 13/21 respondents.

Among the health managers, reported knowledge on the policy document used for procurement was low. None mentioned the Secretary of Health Guidelines; only 3/21 mentioned the Accounting officers' manual and 3/21 stated the Public Finance Management Act. Fifty seven percent of the managers reported that they used guidelines always. There was a copy of the Procurement Act in the Human Resources Office and circulars on procurement were seen. However all other pieces of legislation were not availed the hospital officials. Priority lists were reported as being drafted by the hospital executive by 11/21 managers, 6/21 by departments, 2/21 by the accounts department and the rest said either the administrator or by first come first serve.

Knowledge on procurement procedures was poor though respondents felt more confident of their skills in drafting specifications (Figure 3). Fifty eight percent of primary respondents had low knowledge, 23% had good knowledge and 19% had high knowledge. The stores keeper had a certificate in Purchasing and Supply while the rest of the health managers who had knowledge in procurement got it through workshops. 5/21 had received on-job training and 2/21 had attended a one week workshop. 12/21 had not received any form of training on procurement.

Stationery for procurement was adequate as some, for example the comparative schedules were in electronic version. Communication with suppliers was easy as there were functional telephones, internet access, photocopiers and transport was readily available.

The hospital had a "purchase order" document for adjudication purposes during awarding of tenders. Tracking of who adjudicated in C.B.U, P.T.C and who was awarded the tender was easy on the document. It had allowance for C.B.U recommendations to the P.T.C. There was no specific portion where reasons for awarding tenders were documented. Thus the approval chain of events was difficult to follow. However, it lacked a final procurement authority by the Sub-Accounting Officer.

There were three main stores departments which received goods; the hospital pharmacy, catering/kitchen and the general stores. During target approach however, the hospital equipment department became a "stores" department as they received hospital equipment. The goods received register was in place at stores, pharmacy and at the kitchen while there was another in the hospital equipment

Table 2: Comparison of prices of some goods bought at hospital pharmacy, local shop and at NatPharm, Gwanda hospital 2012.

Commodity	Hospital pharmacy		Nat Pharma		Local shop/ Pharmacy	
	Quantity	Price($)	Quantity	Price($)	Quantity	Price($)
Amoxyl syrup	100mls	3	100mls	1.25	100mls	3
Diclofenac sodium 25mg	1 ampoule	2	B/100	160	1 ampoule	2
Crepe bandage	100mm roll	2	-	O/S	100mm roll	2
X-Ray film 18x43	finger	10	-	-	100 (KDB wholesalers)	92
Toner cartridge	-	-	-	-	05A x1	65
Chicken	-	-	-	-	per bird	7
Cabbage	-	-	-	-	per head	0.5

department. There were no registers for all the bids received when tender boxes were opened.

Committees that were present at G.P.H included the; P.T.C, C.B.U and M.T.C. The P.T.C was chaired by the Health Services Administrator (H.S.A); other members included the Matron, Equipment Technician, School co-coordinator, Pharmacist and Accountant. The C.B.U was chaired by the Human Resources Officer, had fixed departmental representatives from theatre, hospital equipment department, pharmacy and stores. The M.T.C was setup on paper but it was not active. The Finance Committee and R.C were not constituted. There was no hospital purchase plans found for the year 2011, although departments had their individual priority procurement needs and plans. There were no hospital procurement trends analysis charts.

The C.B.U had no designated office for conducting procurement business and they filed their minutes on open shelves in the human resources department. The P.T.C met in the H.S.A's office and minutes were stored secured in box files. Procurement documents tradesmen's requisitions and payment vouchers were filed systematically and securely in the accountants' office under lock and key in a steel cabinet.

The procurement process was mainly driven by the Hospital Executive. The user departments request for consumables to their departmental heads. When the executive met, they then discussed what needed to be procured. The C.B.U would then advertise for tenders or source for quotations. During target approach, a list of procurement items was developed by the institution and then tenders were advertised for the C.B.U did comparative schedules and signed at the back pages of the quotations. They recommended the best bidder to the P.T.C who signed the quotations on the front pages and awarded tenders; during this process the C.B.U. chair assumed the role of P.T.C secretary.

Authority for raising a requisition was sought by the C.B.U Chairperson and was approved by the H.S.A The C.B.U chairperson and secretary contacted the winning bidding company to expedite the order and deliver. On delivery, the goods were received by the stores keeper or the hospital equipment technician (for hospital equipment). Stores and equipment departments were responsible for distribution of goods received to relevant departments. The Accountant processed and passed vouchers in consultation with the H.S.A.

During target approach, there was direct communication between some P.T.C members, Head Office and Ministry of Finance officials. Some tenders above competitive tender limits were adjudicated at Gwanda Provincial Hospital without the authority of the G.T.B Tender documents were sent directly to Head Office for payment without final procurement authority from the Sub-accounting officer.

Forty percent of primary respondents had never been consulted on what needed to be procured and 39% did not know their departmental representative in the C.B.U Sixty three percent of health workers thought tender procedures were not adhered to, while 46% thought there may be companies influencing tender procedures in the hospital. Only 4% strongly disagreed and 10% disagreed that there was corruption involved in tendering processes. The majority (47%) were not sure while the rest were convinced that there was corruption involved during tendering processes.

The main challenges faced by the health managers in procurement included poor quality of goods (9/21), delayed delivery (7/21), non delivery (5/21) and threats (5/21). There were no complaints registers.

The institution experienced stock outs reported by 96% of respondents and patients had to buy medical and surgical consumables for use in the hospital. It took more than 30 days for ordered goods to be delivered to hospital (9/21). There were some of documents seen in the accounts office of goods that had been supplied in February 2011 that has not been paid for, a year later. They were for surgicals, medicines and food items. Regarding the quality of goods used by health workers at work compared to their homes; 61% reported poorer quality, 35% said it were similar quality while only 4% thought the goods they use in the hospital were of better quality than those in their homes.

The prices at the hospital were competitive to those in the private market (Table 2).

The hospital returned several goods that were of wrong specifications purchased during targeted approach program. Some supplied equipment such as wheel chairs were substandard and all ten supplied had broken down a year later including the switchboard exchange PABX machine.

Discussion

Public accountability is the government's obligation to demonstrate effectiveness towards pubic satisfaction. Lack of accountability creates suspicions for corruption which is misuse of entrusted power for private gain [14,15]. The rising cost of procurement of healthcare deliverables is a concern to the health managers and the respective governments funding for healthcare

[12]. Health officials are exposed to bribes and undue political influences to sway tender processes in some way to benefit the elite and themselves [16]. When procurement is not done according to sound principles, corruption, wasteful expenditure, higher prizes and failure to deliver are manifest leading to loss of faith in government procurement processes [6].

General public procurement principles were being adhered to in the hospital though some operational activities were wrongly being done. There is need for high levels of attention on procurement by management to be knowledgeable even if there are no guidelines [16]. However it has been noted that in Sub-Saharan Africa, the capacity to develop knowledge and participate in knowledge society is declining [17]. The role of C.B.U after sourcing for quotations is to prepare a comparative schedule and submit to the PTC. The C.B.U should not be recommending to the P.T.C. what needs to be procured as it risks the independence of the two committees compromising transparency and accountability, of which corruption may be a factor [18]. Transparency is actively disclosing information on how decisions are made as well as measures of performance [9,19]. Reporting transparently to the public and legislature improves the institution's image on accountability [9,15]. This improves public deliberation, reinforces accountability and informed citizen choices and politicians alike [16,18].

Lack of knowledge on procurement among government department may be due to lack of trainings and high staff turnover. As we noted that regulatory policies and legislation were not easily accessible at G.P.H. Furthermore, national guidelines should be adapted while crafting local guidelines as this becomes the basis of procurement planning. Thus, there is need to use minimum resources available to prioritize expenditure, identifying goals of the organization and finding effective mechanisms of achieving them [6,16,18]. This improves efficiency, cost-effectiveness and enhances maximizing health gain at a given budget [9]. Transparency is a public good that bears an immediate cost for the government and the bidders [19]. Guidelines will ensure proper committees are properly set up and are following standard procurement principles. In the process, proper documentation should also be compiled to for transparency, monitoring and evaluation of the procurement processes [16,18]. Managing procurement processes need a systematic approach that can register and track activities [15].

SWOT analysis of the Procurement procedures at Gwanda Provincial Hospital

Strengths: There were procurement procedures clearly laid down in the Ministry of Health and Child Care guided by procurement policies and regulations for use as a guide for reference. Trainings can be done to the staff involved on-job or as workshops. Discussion of audit reports had been taking place during exit interviews with auditors and necessary changes had been implemented by the executive.

Weaknesses: The hospital had no annual purchase plans. This led to poor debt control and management. There were no institutional guidelines on purchasing and procurement. Poor knowledge on procurement among health officials and wrong composition or non existence of key committees was noted. There was poor interdepartmental communication and no feedback mechanisms as there was no complaints registers to address end user views on issues of quality of goods, delivery turnaround and challenges with suppliers.

Opportunities: There were training opportunities for on-job induction of the health workers involved in procurement. Procuring policy documents and making them available for reference is feasible. Local procurement standard operating procedures can be drafted, adopted and popularised in the hospital in simplified manner for ease of access, reference and utilisation.

Threats: Lack of financial support for trainings as it was difficult to virament funds from other line items to fund procurement trainings, lack of self enthusiasm to learn and high staff turnover were constant threats to improved procurement in the hospital.

The strengths of the study were that the hospital employees were keen to participate in a study which the focus they were not well versed with. Some took the opportunity to seek clarification on issues that related to procurement processes. Thus some knowledge gaps were addressed with some willing study participants and it became an information sharing platform. The study had limitations. One of the researchers was the Medical Superintendent of the hospital. During data collection, there were ongoing investigations by the Police, Anti-Corruption Commission and some hospital executive members had been suspended and attending court sessions for alleged fraud. Thus some hospital employees were suspicious that the Head of institution was on a witch hunting exercise. This may have directly or indirectly influenced the quality of their responses to some questions they felt were sensitive, especially on questions that were probing for corruption suspicions and activities.

Conclusion

Gwanda Provincial hospital and in turn the Ministry of Health and Child Care, did not get value for money during the Targeted Approach Program. This was as a result of administrative controls on procurement processes and regulations that were not being adhered to. The institution lacked proper procurement planning, monitoring and evaluation. Thus procurement trends were not being utilized as a tool to inform procurement decision making and resource allocation. As a result of this study, legislative documents and policies were made accessible to the institution. This formed a basis of having readily available referencing guidelines and standard operating procedures on procurement. On-job trainings were conducted and the institution was on course to develop standard guidelines and operating procedures on procurement. This study is the first published document on understanding procurement processes in Zimbabwe public health delivery at a tertiary referral institution. Thus, the study will add to existing knowledge in improving accountability of public health managers in resource poor settings.

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