The Politics and Pathology of Drug Service Administration in Third World Countries: Lessons of Two Drug Distribution Experiments in Nigeria*

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Abstract
This paper emphasizes the importance of a good drug distribution system to the realization of the objectives of the health and drug policies of any country. This, it notes, is very true of many Third World countries, Nigeria inclusive, where healthcare delivery and the attainment of health targets have been significantly hampered by poor healthcare policy making and implementation practices. Among other factors, effective drug service administration has been affected in such countries by lack of political commitment to strong pharmaceutical regulation to ensure the quality of products and regulate prices. Some fall outs of this include the existence of poor drug distribution systems or practices in such countries; circulation of drugs of doubtful or outright negative therapeutic effects; the pricing of drugs above the reach of the average citizen; and increasing cases of drug tragedies and fatalities. The paper notes that although the problem of poor drug distribution can be addressed through policy, legislation and affirmative action, some governments are not paying sufficient attention while others gloss over the key issues. In Nigeria, this has led to the emergence of two new experiments, located in Benue and Ekiti states, in spearheading the reform of the drug distribution system in the country. In view of the strategic importance of the drug component to efficient healthcare delivery, this paper examines the lessons of the two efforts for the restructuring of ineffective drug distribution systems in parts of the Third World. For this purpose, the paper compares the two experiments in terms of funding, operation and outcomes, particularly on the question of ensuring physical and economic access to quality drugs by the citizenry. The paper concludes by outlining the lessons of the two experiments for evolving appropriate drug distribution systems as a key step towards ensuring effective and affordable drug treatment for citizens of many Third World countries where such cannot be taken for granted.
Keywords: Healthcare, Medical care, National Drug Policy, Drug Distribution system

Introduction

The dawn of the Twentieth Century had gradually put an end to the acceptance of a night-watchman state that had little or no responsibility for the lives of its citizens beyond the provision of physical security. Thus, most modern democratic governments recognize their responsibility to facilitate access by their citizenry to the good life, of which healthcare is paramount. After all, health is wealth, as the adage goes. Quite often, therefore, provisions for good healthcare delivery are often enshrined in modern constitutions. For instance, Section 14 (subsection 2b) of the 1999 Constitution of Nigeria states that "the security and welfare of the people shall be the primary purpose of government". In specific terms, Section 17 (subsection 3c) provides that the government of Nigeria should ensure that "there are adequate medical and health facilities for all persons" (Federal Republic of Nigeria, 1999). It was with the desire to provide a safe, qualitative and efficient healthcare delivery system to its citizenry that the Nigerian government adopted both a National Health Policy and a National Drug Policy over the years. This is in consonance with both the Fundamental Objectives and Directive Principles of State Policy as enshrined in the 1999 Constitution of Nigeria, and the 1978 Alma Ata, USSR Declaration of the World Health Organization (W.H.O.) that made health-for-all by the year 2000 a concern of governments that were signatories to it, of which Nigeria was one.

Drug treatment constitutes an indispensable aspect of healthcare and adds credibility to a healthcare delivery system. Indeed, most people equate good health care delivery with availability and accessibility to good quality, safe and efficacious drugs. Drugs are desired because they can be used for diagnosis of ailments, treatment or prevention of diseases or abnormal conditions in man or animals, prolonging the lives of patients with incurable or terminal diseases; and as a component of medications (Akinola, 2007). Drugs can also be used to restore, correct, or modify organic functions in man and animals; and they can be used to disinfect or control vermin, insects or pests, apart from being used as contraception (Ejiofor, 2006:12). According to Lambo (2005:

i), "no matter how vibrant a health policy (may be), without availability of good quality and affordable medicines, that policy will be sterile". However, such values and health benefits can be derived from the industry and its products only when such products are available, affordable, of the right quality and used rationally.

It can be safely said that, with the exception of spiritual invocations, many people trust in the efficacy of medical consultations once drug treatment is involved. It is partly for these reasons that the Nigerian government adopted a National Drug Formulary and Essential Drugs List in 1986 and a National Drug Policy in 1990 (FGN, 1986, 2005). Although Hippocrates admonished humanity two millennia ago to make food their medicine and get medicine from their food, citizens of poor developing countries of the world, Nigeria inclusive, can hardly maintain good health by taking good food alone. This is due to the negative effects of the poor economic situation. Indeed, Africans are among those suffering from serious malnutrition and hunger, as they have low calorie intakes and low levels of animal and vegetable protein in the most popular diets (Espenshade, 1990: 20-24; 20-27). The World Health Organization (W.H.O.) estimates that in any given year, the nutritional status of most Africans is between 45 and 75 per cent of basic recommended levels (Ikubolajeh, 1995:58), a situation that makes drug availability and affordability crucial factors for maintaining health. Also, most people in the Third World rely on drug use to treat communicable diseases which are very common as a result of poor sanitation.

Unfortunately, since independence in 1960, just as successive Nigerian governments have found it increasingly difficult to provide quality healthcare delivery to the majority of the citizenry; they have not been able to grapple effectively with several issues of importance to virile drug treatment for its citizens, such as effective regulation to maintain high quality, boosting local pharmaceutical production to reduce dependence on imports and create jobs, appropriate drug pricing, and distribution, the focus of this paper, among others. For instance, it has been revealed concerning healthcare delivery in Nigeria, that after five decades of political independence:

- Nigeria ranks 187th out of 191 countries in the world in terms of healthcare performance;
- The Nigerian government expends only $5 per capita ($34 in the 1st World) on healthcare;
- Over 70% of health expenditure is borne out-of-pocket by healthcare seekers in Nigeria;
- Nigerians have a low purchasing power (which has adverse effects on their ability to seek proper healthcare services);
- There is low community participation in healthcare provision in Nigeria;
- There are low consultations between Federal, States and Local Governments on health;
- There is weak public/private partnership on health in Nigeria;
- (Until the National Health Insurance Scheme (NHIS) was launched recently), there was no coordinated broad-based healthcare financing strategy in Nigeria. Even the NHIS currently covers only a small proportion of the population; and that
- There is a low life expectancy of 48.8 years in Nigeria (76 years in the 1st World) (Akande, 2007: 3-5).

These facts are not surprising, since the Nigerian healthcare system has its roots in colonialism, and the Nigerian state has been successfully appended to, and operate at the periphery of the international capitalist system. The entire healthcare delivery system, drug distribution inclusive, therefore operates within and serves the interests of international capital and its local comprador elements. As Alubo (1985:319-335) has demonstrated, in Nigeria as in other parts of the world, Western medicine was used as an instrument of domination. Apart from transforming the territory from 'the white man's grave' into a habitable environment for colonial expansion, Western (colonial) medicine was curative, urban-based and emphasized medical rather than health care, values which were incorporated into the 'healthcare policies' of the newly emergent nation. Also, it depends on multinational drugs and equipment, thus reinforcing existing structures of dependency, domination and exploitation. It is a known fact that the bulk of the world's drug needs are manufactured and supplied from few, mainly industrialized, capitalist countries. Rather than treat disease as a political issue (by identifying its causes as mainly unemployment, malnutrition, poverty, unhealthy environment, etc) and seeking solutions within that milieu, Nigeria's health policies are designed to treat symptoms rather than their causes.

As Nigeria's Fourth National Development Plan (FGN, 1981) indicates, Nigeria's health care policies have mostly emphasized the curative rather than the preventive orientation, revolving around the superficial and neglecting the concrete issues (Alubo, 1983, 1985). Nigeria's health policies have been designed to:

- increase the practitioner-patient ratio by training more personnel;
- build more hospitals, clinics and dispensaries while also expanding existing ones. In the Fourth Republic, it has gone as far as building a health outpost in each electoral ward or constituency even when there are insufficient personnel and equipment to run them; and
- procurement and distribution of drugs, medical supplies and other consumables for medical and other emergency needs (FGN, 1981, Alubo, 1983).

In this way, Nigeria's health policies (drug distribution inclusive) only entrench existing patterns of appropriation, accumulation and invariably, the dominant capitalist hegemony. And it is legitimated with glee by the top echelons of the bureaucracy who are already in partnership with the political and business classes as beneficiaries of the existing order. The effectiveness and efficiency of the drug distribution system constitutes one of the major determinants of the efficacy of the overall healthcare delivery system of any country. The questions of effectiveness and efficiency of the drug distribution system relates to whether essential drugs reach the citizens of a country on a regular basis, in good quality and at affordable prices. Incidentally, these are major but often neglected aspects of healthcare delivery in many developing capitalist countries, Nigeria inclusive, as they ignore the concrete problems of providing good healthcare delivery systems to their populations. Part of these problems is the task of establishing and maintaining effective drug distribution systems.

The Nigerian Pharmaceutical Industry and the Drug Distribution System

The pharmaceutical industry has some unique characteristics which makes it a major target for government attention and regulation. One of these is that it operates on an international dimension such that its products cross international boundaries as a matter of necessity and with relative ease. Another is that its products have both positive and negative values and as such, must be monitored and regulated in order to maximize its benefits while minimizing its potential dangers. As Cohen, Mrazek and Hawkins (2007:32) argue, government regulation of the pharmaceutical sector is justified because the pharmaceutical market is imperfect, and because of the need to protect human life and public health by making only safe and efficacious drugs available in the market. However, the purposes of regulation are sometimes compromised partly because there are gaps in public policy implementation which the regulated may exploit to gain unfair advantage. Marshall (2001) infers that bureaucracy is one of the factors that creates such gaps. Also, the products of the pharmaceutical industry are desired by many for their positive benefits, and this makes the industry a prime target for fraudsters.

As Angell (2006:68) demonstrates, profits accruing to pharmaceutical industries are so huge that it attracts a lot of prospective investors, both genuine and fake, a situation that renders it very susceptible to fraud and corruption, especially through the distribution network as products are transported across international boundaries and distributed in many countries in order to reach the final consumer. Drug distribution is one aspect of administrative processes that adds to the cost of pharmaceuticals. If not properly regulated, distribution can lead to other negative effects in this sector of the economy. Unfortunately, although the pharmaceutical industry runs smoothly in several countries, in many others it does not. WHO estimates that only about 20% of the countries in the world have good drug procurement and distribution practices, while majority of the remaining 80% with poor access and poor drug distribution practices are in the developing world (WHO, 1988:54,116).

For many of such countries, Nigeria inclusive, the problem of access to essential medicines is not only a function of affordability but also physical availability (distributive). In such cases, the problems of physical and economic access to drugs reinforce each other. Nigeria has one of the most uncoordinated drug distribution systems in the world and the drug distribution system is arguably the 'Achille's Heel' of the pharmaceutical industry in Nigeria (Olaoye, 2010). It became so bad at a time in the past that fake, adulterated, substandard, expired and re-labeled drugs flooded the Nigerian market. Made in Nigeria pharmaceuticals were rejected even in the neighbouring countries of West Africa (Atueyi, 2004: 27). Expectedly, this was accompanied by deaths and incapacitation (Mabadeje, 1997; Adeluyi-Adelusi, 2004:13; Uwaga, 2004:15).

By the year 2002, the report of a study published in *Lancet*, an international journal indicated that 48 per cent of drugs in circulation in Nigeria were considered unfit for human consumption. By the year 2004, the report of another study put the percentage of fake drugs in the Nigerian market at about 60 per cent (Peel, 2003; Fajemirokun, 2004: 37, 38). Nigeria's image suffered terribly for this. This proliferation of chaotic and illegal drug distribution channels across the length and breadth of Nigeria was the result of a weak and ineffective drug regulatory structure (Akunyili, 2004:10). Other effects included rising cases of treatment failures (Atueyi, 2004: 28), the divestment or closure of multinational pharmaceutical industries such as Boehringer, ICI, Sandoz, Merck, Aventis Pharma, Boots, etc and scaring away of new prospective investors from the pharmaceutical sector of Nigeria's economy (Akunyili, 2004:10; Atueyi, 2004:27-28; Fajemirokun, 2004:37).

In the midst of these, government hospitals continued to lack essential drugs (*Sunday Times*, 1988: 10-12) while many citizens continued to patronize private hospitals, clinics and, for the abject poor, private pharmacies where they got fake and adulterated drugs in many cases (Igun, 1987: 689—695, cited in W.H.O., 1988:113). Also, sale of medicines in unauthorized places by uncertified persons continued to soar, further endangering the health of Nigerians (Alubo, 1994). Up till now, these markets continue to provide support and backup services to drug fakers by helping to distribute their fake products. In Nigeria today, drugs are still sold in open markets, car parks, unlicensed chemists and shops, on buses, ferries and almost in any gathering of people. Some of the most popular illegal drug markets in the country are located at the Onitsha Bridgehead

Market in the eastern part of Nigeria, parts of the central business districts in Kano and Idumota in Lagos, among others. Most of the products sold in such and similar places are exposed to adverse weather conditions that can affect their quality, apart from the fact that they are mostly adulterated or substandard.

As the institution officially empowered to control and regulate the manufacture, importation, exportation, distribution, advertisement, sale and use of food, drugs, cosmetics, chemicals detergents, medical devices and all drinks including…pure (packaged) water through the Food and Drug Administration and Control Decree No. 15 of 1993 [as amended by the NAFDAC (Amendment) Decree No. 19 of March 23, 1999] (Akunyili, 2004:10), the National Agency for Food and Drug Administration and Control (NAFDAC) has been making efforts to sanitize the drug distribution system in the country through various strategies. However, political opposition from several stakeholders prevented such efforts from yielding positive results, as the failure of the Zonal Drug Distribution Centres (ZDDC) that was proposed by NAFDAC in 2001 demonstrates.

That effort at restructuring the drug distribution system failed mainly due to opposition by the Pharmacists Council of Nigeria (PCN) acting through the instrumentality of the National Assembly. Years after the failure of NAFDAC's ZDDC, a unique model for drug distribution in Nigeria came to the fore, represented by the Central Medical Stores-Unified Drug Revolving Scheme (CMS-UDRF) in Ekiti State, and the Essential Pharmaceuticals Limited (EPL) in Benue State. This paper aims to study these experiments in drug distribution with a view to assessing their strengths in dealing with the hydra-headed problems of drug distribution in Nigeria.

Models of Drug Supply and Distribution

There are various models of drug supply and distribution. Cohen, Mrazek and Hawkins (2007) have identified about five models for drug distribution. According to them, these include the autonomous or semi-autonomous supply agency; the direct delivery model; the prime-vendor model; the fully private drug purchase, supply and distribution model; and finally, the Central Medical Store (CMS) system.

The autonomous or semi-autonomous supply agency model allows an agency to divide purchasing volume into bits. Though flexible, this model has the tendency to increase drug prices. The direct delivery model is a situation in which a government procurement office tenders for drug and other pharmaceutical inputs directly from manufacturers who supplies them to health facilities where they are used. Here, government does not bear the cost of storage and transport, as these are taken up by suppliers. This model will reduce drug price and improve affordability. If properly monitored, it can also reduce the incidence of fake drugs in health facilities. In the prime-vendor model, government procurement office calls for tenders for two types of contracts. One tender comes from the drug manufacturer and the other from a prime vendor, specifically for drug supply to public stores and health institutions. In this arrangement, it is the duty of the prime vendor to ensure adequate and regular supply of drugs and other pharmaceutical supplies to the various health institutions.

There is also the fully private drug purchase, supply and distribution model. Private investors establish and run this model with the sole aim of profit maximization. This model is difficult to monitor or regulate as the sources of supply are not certain or fixed; hence the quality of products cannot be guaranteed. The private drug distribution model thrives in many Third World countries where the public sector is either not active in drug distribution or it is not involved at all, although the latter scenario is uncommon. Here, drug syndicates and cabals wield much influence on the system and the incidence of fake drugs may be high.

Finally, there is the Central Medical Store (CMS) system. In this case drugs are financed, procured and distributed by government and its agencies. Sometimes, however, the finance comes from other stakeholders such as international agencies and bodies. Examples include the World Bank (I.B.R.D.) and PATHS-DFID's sponsorship of the Drug Revolving Fund in parts of the developing world, such as Nigeria. This model has the capacity to take advantage of bulk purchase in order to lower prices. However, it is not a very flexible arrangement and participating hospitals and healthcare delivery institutions have to fit into it.

It must be noted, however, that the above models are, in many cases, normative. In reality, drug supply systems are usually a mixture of aspects of two or more of the models, depending on the particular need of the country in question. However, the model that will work for a particular system depends on several factors, including among other things, whether the system is entirely public or private and, in the case of hybrid systems, the extent of public or private ownership and participation involved.

In many Third World countries where funds are scarce and social service delivery is low, the governments only get marginally involved in drug distribution. Very often, government involvement is at the regulatory level, which may not even be very effective, a situation that can easily compromise quality and increase prices. Also in such countries, a sizeable proportion of payment for drugs is made out-of-pocket by patients and their relatives, and this constitutes an economic limitation to drug treatment for many citizens. Where governments announce free health services, there may be political conditions or limitations to the enjoyment of such services, such as possession of the membership card of the political party in power. These and

similar scenarios in Third World countries demonstrate the need for drug distribution systems that can expand socio-economic and political access to drug treatment in such countries.

The Central Medical Stores-Unified Drug Revolving Fund (CMS-UDRF) and Essential Pharma Limited (EPL) schemes

The drug distribution model that prevails in a country is a product of several factors, which includes the country's needs and the ideological orientation of the government in power. Although the public supply model has historically existed side-by-side with the private model in Nigeria, the private supply model has tended to overshadow the public supply and distribution model because of the rentier nature of the Nigerian state and the accumulative inclinations of her leadership. This explains why the private drug supply and distribution system has grown faster in coverage and popularity than the public supply and distribution system in Nigeria. Expectedly, this development has occurred side-by-side with a rise in sharp practices in the sector while government either looked the other way or condoned it by making non-deterrent policies that fail to discourage exploitation and punish offenders.

The reasons for this development are not far-fetched. The first has to do with government policy in the past, of issuing drug retail sales licences to friends, family members and business associates quite indiscriminately in the 1960s and the 1980s, often without regard to training, competence and experience (Adeoti, 2004:136; Fajemirokun, 2004). Another reason is that a sizeable proportion of the citizenry lacks regular access to qualified doctors. In many of such cases, the patent medicine vendor is the 'local doctor' who prescribes and dispenses drugs (Igun, 1987). In other situations, untrained and unskilled itinerant medicine vendors move about in rural communities and in cities, hawking medicines in the streets, in the buses, in motor parks and in other public places, exposing the medicines to harsh weather and in disregard of the relevant rules (Alubo, 1994). Another reason is the lack of regular, prompt and satisfactory access to treatment in public hospitals for various reasons. This problem has been documented by Igun (1987: 689-695) in a study of health-seeking behaviour among Nigerians in Maiduguri, northern Nigeria.

The political economy of drug treatment is equally important here since private drug supply, distribution and retail outlets offer drugs sometimes at rates cheaper than public hospitals and dispensaries (PATHS, 2007:23). However, the reality is that the quality of many of the drugs in the private distribution system might have been compromised, thus offering low quality, expired and repackaged drugs at prices the poor majority can afford. With a large and growing number of drugs in the private sector in Nigeria (fifteen thousand as at 1988) (W.H.O. 1988: 59), the system has been much abused, leading to a characterization of Nigeria as one of the countries with the highest incidences of fake, substantial and adulterated drugs in Africa.

As a panacea to this problem, NAFDAC attempted to establish a new drug distribution system in Nigeria called the Zonal Drug Distribution Centres (ZDDC) to ensure a sanitized drug distribution system in the country. The idea was to blend the lessons of the Swedish model of drug distribution called *The Apoteket AB,* with some African systems, especially the Cameroonian system and apply it in Nigeria, based on the realities of the Nigerian situation and experience (NAFDAC:2001).

However, in spite of the readiness of the National Assembly to allocate a sum of eight hundred million Naira (N800 million) to the project (Oyeyemi, 2004:32), the agency had problems convincing some relevant stakeholders in the pharmaceutical profession and trade in Nigeria, particularly the Pharmacist Council of Nigeria (PCN), the Pharmaceutical Society of Nigeria (PSN) and the medicine dealers in the various open drug markets. Thus, the idea died a natural death and hope was lost while the problems posed by an uncontrolled drug distribution system remained until the establishment of the CMS-UDRF and the EPL by the governments of Ekiti and Benue state (Personal interviews with Pharmaceutical Council of Nigeria (PCN) and Pharmaceutical Society of Nigeria executives between March and June, 2008).

Goals and Objectives of CMS-UDRF and EPL Mega Depots

The CMS-UDRF Mega Store and the Benue EPL are attempts to integrate the public drug supply and distribution system into the dominant private sector drug distribution system in an effort to have quality and affordable drugs in both private and public sectors of the health systems of both states (Thomas, 2008:12; PATHS, 2007:1). The CMS-UDRF is aimed at rolling out and extending the existing public sector International Bank for Reconstruction and Development (IBRD) (that is, World Bank)-sponsored Unified Drug Revolving Fund (UDRF) to the private sector consisting of private hospitals, clinics, pharmacies, propriety and patent medicine vendors in Ekiti state, and also to meet the Millennium Development Goal (MDG) of guaranteeing access to quality and affordable drugs by members of the public (CMS-UDRF PPP, 2008:26).

The Benue EPL is also a public-private Partnership (PPP) initiative aimed at providing a bulk one-stop-shop for pharmaceutical and medical sundries and to become a "leading supplier of quality and affordable medicines and other supplies in the state of Benue, supplying public and private markets in a sustainable

manner" (PATHS, 2007:1). It was a technical/funding collaborative effort between the Partnership for Transforming Health Systems (PATHS) and the British Department for International Development (DFID) to ensure quality drug supply to the masses. Therefore, both the CMS-UDRF and EPL projects were sponsored by foreign donor agencies with the aim of bridging the gap between the public and private sectors in drug distribution, extending the advantage of assured sources of genuine pharmaceutical products to members of the public as well as patients within government healthcare facilities.

Comparative Assessment of CMS-UDRF and EPL Schemes

Both programmes were designed to achieve stability in the delivery of pharmaceuticals in the states, each being the first in a series of programmes planned by the state governments in their Primary Health Initiative (PHI) policies, aimed at providing an essential health system and services package in each state. The programmes were aimed at complimenting the modest achievements of the National Drug Policy (NDP) in Nigeria and to establish effective drug procurement and distribution systems, which are part of the cardinal objectives of the NDP (Federal Government of Nigeria, 2005: i).

The objectives of both projects are therefore in line with those of the National Drug Policy (NDP) because they project potentials for meeting some of its cardinal objectives. These features included creation of a facility one-stop-shop for drugs and medical supplies, which constitute the major attraction of the open drug markets that offer products of doubtful quality. In addition, the CMS-UDRF Mega-Depot and the EPL also have the advantage of offering standard drugs of high quality under ideal storage conditions that open drug markets cannot provide.

Although each of the programmes claim to have a strong community representation in its facility management committee such that it could ensure access to drug treatment for the very poor and vulnerable groups, the composition of the management board of the CMS-UDRF appears to be more representative of community interests, although this is at a high cost in terms of professional requirements for representation on the board. To enlist high community mobilization for, and participation in the programme, the CMS-UDRF Management (Technical) Committee is headed by the Chairman of the State Traditional Council, supported by three community representatives, one from each of the three senatorial zones in the state. To assist the General Manager in ensuring that professional ethics and practices are observed, a list of offences with appropriate sanctions have been drawn and agreed upon by the management and community representatives.

On the other hand, the EPL Board is more representative of business groups, albeit within the community. This is not surprising, given the fact that the private investment group (Multi Sig Ltd.) contributed 58.7% while Benue Health Care Foundation which represents government controls 41.3% of the N500 million authorized share capital(PATHS, 2007:4-5).

The state government is the main financier of CMS-UDRF, with resource rollover from the IBRD-sponsored Drug Revolving Fund (DRF) scheme. Membership of the CMS-UDRF Management (Technical) Committee, its main administrative organ, is drawn from relevant stakeholders. They consist of representatives of the community, the primary beneficiary of the programme; state and local government representatives; representatives of tertiary institutions and federal government agencies in the state; representatives of the private sector and development partners' representatives, who are on the committee as observers. This is in addition to those specified in the Memorandum of Understanding (MOU) of CMS-UDRF (CMS-UDRF Training Manual, 2008:1-2). However, the private sector was involved through the supply of pharmaceutical products on the basis of a time-targeted credit facility. The performance of each private sector partner in terms of repayment determines its eligibility for further credit facilities on a roll-over-basis.

The CMS-UDRF and EPL are meant to address issues related to inadequacies in drug availability, supply and distribution, which are contained in the introduction to the National Drug Policy (NDP). These include an ineffective system of drug administration and control; inadequate funding of drug supply and drug control activities; inadequate facilities for storage, transportation and distribution of drugs; poor drug selection and procurement practices; the involvement of unqualified persons in procurement, distribution and sale of drugs; poor performance of drug suppliers to public health care institutions; and a lack of political will to provide safe, efficacious and good quality drugs to meet the health needs of Nigerians (Federal Government of Nigeria,2005:1).

The CMS-UDRF and EPL projects are therefore, symbolic of efforts to combine the strengths and resources of the public and private sectors of the economy for the advancement of the welfare of Nigerians in the provision of quality and affordable drugs for the citizenry. Also, they can be interpreted as attempts to resuscitate, rejuvenate and accomplish the stillborn desire of NAFDAC and the government of Nigeria to have an effectively-controlled drug distribution system in the country which the ZDDC failed to achieve in 2001. Thus, while launching the CMS-UDRF programme, Professor Akunyili stated:

This is indeed a great step in the right direction and gives me renewed confidence that
our proposed Drug Mart still remains the best solution to the lingering drug
distribution crisis in Nigeria. I therefore implore other states to emulate ... this noble
and laudable venture.

(CMS-UDRF Training Manual, 2008:1-2).

Philosophy, Organization and Management of the CMS-UDRF and EPL Mega Depots

The operational procedures of both CMS-UDRF and EPL Mega Depots are geared towards achieving effective drug procurement and a well-ordered drug distribution system in both States. The operational procedures can be divided into a minimum of five sub-heads namely drug selection and sourcing, drug pricing, distribution, accounting and banking processes, and supervision and monitoring. Drug selection and sourcing is done on the basis of the Essential Drugs List (EDL), which is a list of drugs that is drawn up on the basis of knowledge of prevalent common ailments in the nation.

For the purpose of selecting drugs for the CMS-UDRF Mega Depot, a new State Essential Drugs List (as approved by the state Ministry of Health) was launched along with the Mega Depot at inception. In order to make drugs affordable for the citizenry, and in obedience to the demands of the people expressed through the purchase orders by wholesale, retail pharmacists and accredited medicine vendors, the management of the CMS-UDRF places higher orders for generic drugs that are often sold as over the counter (OTC) drugs (Interview with the CMS-UDRF General Manager, September 2008). However, the management makes preferred branded drugs available for each group of generic drugs. Drugs are sourced through local and internationally recognized pharmaceutical companies through recognized pharmaceutical suppliers and for take-off, stocks were available for up to six months (CMS-UDRF, 2008:31).

Pricing is an important consideration in drug distribution because affordability is a major consideration in access to medicines. The CMS-UDRF and EPL programmes aim to deliver quality and safe drugs to members of the public at affordable prices. Drug pricing in government-operated drug distribution outlets should aim primarily at ensuring that the objective of making drugs affordable is not defeated by the opportunistic behaviours of middlemen. It may also aim at achieving price stability and uniformity. While the EPL puts a 33% markup (profits) on its drugs, the CMS-UDRF puts a maximum of 20% mark-up on its drugs, depending on the type of outlet, as follows: CMS-UDRF 5% (i.e. cost price + 5% mark-up); wholesale pharmacists 10%; retail pharmacists 10-20%; and private hospitals/clinics 15-20%.

Performance Assessment and Lessons of CMS-UDRF/EPL Schemes for Third World Countries

The CMS-UDRF and EPL projects are efforts to address some problems of a drug distribution system that has failed to deliver quality drugs to Nigerians, in good condition and at affordable prices since independence in 1960. These include drug financing; provision of one-stop-shops for pharmaceuticals where quality can be assured, meeting of the standard requirements for good drug storage, etc. Altogether, the projects supposedly enjoy the political will to address the problems of a poor drug distribution system. However, because of the crucial importance of the substructure (i.e material conditions) in shaping the superstructure in every society, the composition of the management boards as well as the *modus operandi* of the two PPP outfits differ in terms of their ability to address concretely the issue of drug pricing.

While each of the projects has created a positive public image, enjoys appreciable level of acceptance, has achieved appreciable coverage and offers good quality pharmaceuticals from assured sources, the CMS-UDRF is modest in its pricing policy that has affected pricing positively while the EPL pricing policy fails to affect prices positively. And this has to do with the structure of funding and ownership. While the CMS-UDRF places premium on the purchase and distribution of quality but cheaper generic drugs that citizens can afford, it also makes branded drugs available on demand. This has not been consciously and fully integrated into the operations of EPL, although it provides an explanation for its high mark-ups.

Also, both projects need to increase their product range, embrace more robust governance that is accountable and work consciously to bring down their operating costs so that they can survive in the long run. This will require each of them to prepare an integrated strategic plan (or road map), strengthen internal delivery capacity, manage their finances better and develop pro-poor strategies to influence prices further. The lesson is that government cannot afford to allow private sector interests alone to drive drug distribution, not even in collaboration with donor agencies, as the case is with the EPL.

On the other hand, there is the need to balance the desires for community ownership and participation with that of sound management. The case, as it is with the CMS-UDRF in which patronage devoid of professional qualification and experience determine who is put in charge of sensitive outfits like the drug distribution is risky. For instance, the Chairman of the Council of Traditional Rulers in Ekiti is the board

chairman of the CMS-UDRF! Putting non-professionals on the board of drug distribution outfits may prove as dangerous as the open drug distribution system that public-private initiatives are designed to replace.

In order to ensure lasting success of the CMS-UDRF and the EPL, there is the need for greater political commitment by government and this should translate to better funding, ensure that only quality products are distributed, bring down prices to create economic access for the poor and other vulnerable groups, increase accountability and ensure feedback from clients. Also, there should be wider media publicity. Finally, while the Benue EPL has been officially registered with the Corporate Affairs Commission, the CMS-UDRF is not yet registered. There is the urgent need to do this in order to protect it from the effects of political uncertainty such as regime change.

Conclusion

This paper has compared the operations of two public-private partnership (PPP) initiatives in drug distribution (the Central Medical Stores–Unified Drug Revolving Fund (CMS-UDRF) scheme in Ekiti State, and Essential Pharma Limited in Benue State) that were designed to meet some of the challenges posed by the inability of the Nigerian state to assure quality healthcare delivery to the citizenry, specifically in the area of drug treatment, five decades after political independence. The National Drug Policy (NDP) was adopted to address the tasks of providing quality, safe and effective drugs to citizens at affordable prices, as part of the obligations of government to provide good healthcare delivery for the citizenry. However, our findings indicate that the capitalist, rentier nature of the Nigerian state that prevented sufficient political commitment by successive governments to provide good healthcare services also affected the operation of the two drug distribution experiments that were expected to provide examples in ensuring a sanitized drug distribution system in Nigeria.

Given the rentier nature of politics and the bureaucracy in many Third World states and the general attraction of the pharmaceutical sector to investors, the study shows that strong political will is crucial to the institutionalization of effective drug distribution systems in the public sectors of such countries. In addition, our comparative assessment of the drug distribution experiments suggest that, given the profit motive of the private sector, and the fact that health is a security issue which government cannot leave entirely to the whims and caprices of the private sector for the reasons of equity and security, governments of Third World countries should not abdicate their responsibility for funding and management of drug distribution exclusively to the private sector.

As the experiments indicate, Third World governments can partner with the private sector to establish effective drug distribution systems, in which case governments would set acceptable standards of quality, streamline price regulation and establish monitoring activities while the private sector would provide substantial funding, innovation, management and expertise. In establishing such partnerships, however, care should be taken to avoid political patronage devoid of merit in making appointments into the management cadre of such outfits or systems. Although the rent-seeking nature of many Third World governments may pose obstacles to the attainment of that level of objectivity and fairness in the establishment and running of drug distribution systems, governments of this group of countries should learn to demonstrate sufficient resolve to evolve sanitized drug distribution systems that can meet national healthcare goals and citizens' need of quality and affordable medicines.

Due to the emergence of Public-Private Partnership (PPP) in essential service delivery in several developing countries in areas like healthcare and pharmaceuticals, infrastructure, housing, aviation, etc., the new private sector should add to its basic goal of doing business to make profit, an understanding of the public service ethic of service delivery, and a readiness to collaborate effectively with government to achieve that. This is necessary as a means of making the private sector more strategically relevant to the lives of the generality of the citizenry in countries of operation. It can also be a means of perpetuating public-private partnership in the existential horizons of the citizenry and a means of furthering the private sector's basic profit-orientation on the long run in ways that meet popular needs and expectations.

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