COMPLEMENTING PUBLIC-SECTOR MEDICINE SUPPLY THROUGH A PUBLIC-PRIVATE PARTNERSHIP IN TANZANIA:
JAZIA—A PRIME VENDOR SYSTEM FOR DODOMA REGION PUBLIC HEALTH FACILITIES

BACKGROUND

The Health Promotion and System Strengthening (HPSS) project is part of a development cooperation between Tanzania and Switzerland. It supports the Dodoma Region in the areas of health insurance, community health promotion, pharmaceutical management, and management of maintenance and repair services. The project is funded by the Swiss Agency for Development and Cooperation and implemented by the Swiss Tropical and Public Health Institute.

Access to health care is determined by the availability of medicines and medical supplies. Patients equate quality of care with the availability of medicines. Clinicians depend on effective, safe, and good quality medicines to provide adequate health care. If medicines are out of stock, patients suffer and lose confidence in health services. Stock-outs discourage patients from enrolling in the Community Health Fund (CHF) and other insurance schemes.

The Medical Stores Department (MSD) is the backbone of the public medicine supply in Tanzania. It faces challenges in filling orders for health facilities. In the last few years, this supply gap has been growing and now includes more than 40% of orders.

Centrally, the Ministry of Health (MoHCDGEC) allocates defined sums for medical supplies for each health facility directly to the MSD. At the health facility level, complementary funds from the CHF, national health insurance, and cost sharing are generated and managed by the Health Facility Governing Committee. Therefore, health facilities have two main sources of funding for their supplies: direct funding deposited at the MSD by the Ministry and supplementary funds collected by the health facility. Of those supplementary funds, 67% are dedicated to the purchase of medicines by health facilities when the MSD is out of stock.

In the Dodoma Region, a 2010 situation analysis and a 2011 comprehensive baseline survey revealed an availability of essential medicines of 53% with a corresponding stock-out rate of 47% based on 24 tracer medicines. The order fulfillment rate by the MSD was 58.6%.

The supply gap of more than 40% stemming from the stock-out situation and the low order fulfillment rate for supplies by the MSD needs to be complemented by medicines from other sources. Health facilities normally fill this gap with purchases by quotation from multiple private sources both within and outside of the Dodoma Region and use complementary funds (e.g., insurance schemes, user fees, basket funds), incurring in the process high opportunity costs such as travel and fuel, per diems, and high medicine prices. This makes the whole task of filling this gap cost inefficient. The procedure is uneconomic, bureaucratic, intransparent, and lengthy and supplies are of questionable quality.

Alternative strategies were needed to fill the supply gap and complement the public-sector supply system. To resolve this situation, the Dodoma Regional Administration and Local Government embarked on a novel process to establish a Prime Vendor System (PVS) and to engage, on a public-private partnership (PPP) basis, one private-sector pharmaceutical vendor as the primary supplier for supplementary medicines needed by public health facilities in the region.

In principle, a PVS was established in the Dodoma Region to serve as a “one stop shop” intended to alleviate opportunity costs previously incurred by health facilities when they had to search for alternative sources for supplies they could not obtain from the MSD. At the health facility level, complementary funds were once used to make purchases from multiple private sources. However, this supplementary source was now to be used for purchases only from one appointed Prime Vendor (PV).

IMPLEMENTATION

A concept note was widely circulated and discussed. Districts and the region endorsed the PV concept involving the private sector. Procedures to procure complementary supplies from a single vendor in a pooled regional approach were developed. A supplier was selected based on good procurement practice. Prices from the contracted PV are fixed and comparable to MSD prices. The system was registered as Jazia PVS.

Districts now pool their demand for supplementary medicines at the regional level, allowing them to benefit from lower prices (economy of scale). This allows health facilities to manage their own funds following standard operating procedures (SOPs) and enhancing fiscal decentralization. Funds are used for pooled purchase from the PV based on a PPP framework contract.

The general steps and expected outputs presented in table 1 were required for successful implementation:

Table 1. General Steps for Implementation

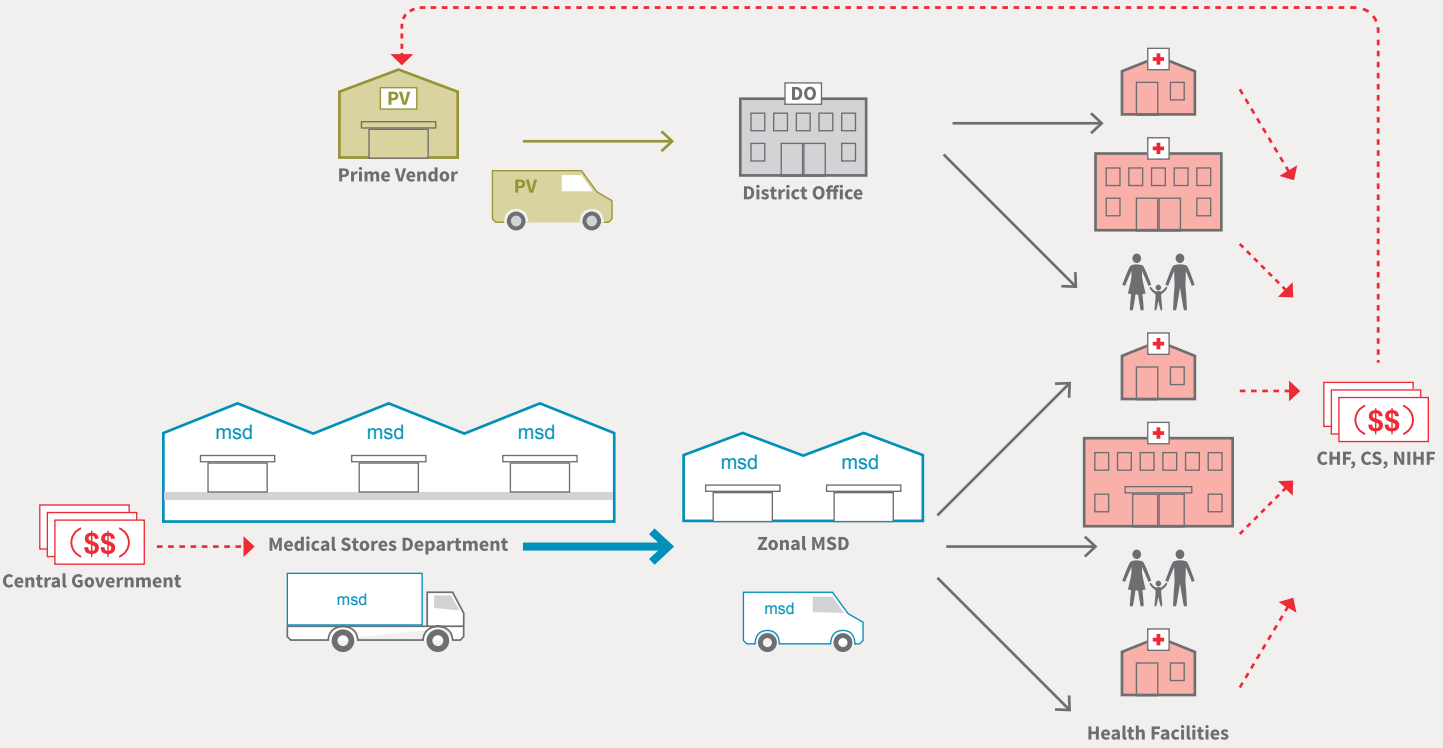
STEP	OBJECTIVE	EXPECTED OUTPUT
1	Baseline data	Quantification of medicine needs is available Current private procurement practices are analyzed Financial management of complementary funds, flow, amount, and procedures is assessed
2	Advocacy and buy-in	Consent and buy-in is reached by all stakeholders
3	Administrative structures	A PV technical committee, PV board, and temporary tender evaluation committee are appointed with terms of reference A Jazia PVS office is identified, equipped, and staffed A Jazia PVS coordinator is appointed and trained
4	Jazia PVS documents	All documents driving the Jazia PVS are reviewed and approved
5	Vendor forum	Interested private suppliers are informed about possible PPPs and given prequalification documents
6	Prequalification	A selected number of potential suppliers have been prequalified
7	Tender	A final supplier (PV) is selected and approved
8	PPP contracting	A PPP contract is negotiated between RAS and private supplier
9	SOP and M&E documents	SOPs and a M&E framework are available and approved
10	PVS training	Regional and district stakeholders and health care workers at the facility level are competent in SOPs for Jazia PVS activities
11	Launch	The Jazia PVS is officially launched by signing contract between RAS and private supplier and operations start
12	Follow-up	Enablers and obstacles of Jazia PVS are assessed and the regional team is supported

The region operates a Jazia PVS office staffed by a PV coordinator, a dedicated pharmacist, and support staff. The system is closely managed and supported by mandated administrative structures, such as a Technical Committee and a Board appointed by regional authorities.

While the MSD will remain the backbone for medicine supply, this unique PVS has the objective to ensure that health facilities have the medicines and medical supplies to meet the needs of the people. This PPP supplements the regular government supply with additional supplies from a single vendor in a pooled regional approach. PV supplies are of assured efficacy, safety, and quality in accordance with MoHCDGEC and Tanzania Food and Drug Authority (TFDA) standards.

Figure 1 illustrates the fully functional Jazia PVS and the synergy created by the collaboration between the MSD and the PV system in improving medicine availability from the perspective of public health facilities in the Dodoma Region.

Figure 1. Concept of the fully functioning Jazia Prime Vendor System



Operations of the Jazia PVS are managed and driven by SOPs. A comprehensive but user-friendly handbook with SOPs for health facilities and districts was developed that covers six key operational areas.

These SOPs now guide the process and purchase of medicines from the PV when these are out of stock, short supplied, or not stocked by the MSD. All purchases from the PV are consolidated at the district level and forwarded to the PV.

An M&E handbook provides a framework for evaluating the performance of both the system and the PV. System performance is monitored quarterly using supply chain indicators such as medicine availability, utilization, district HQ delivery time to health facilities, promptness of payment to PV by district, and stock sufficiency. The performance of the PV is monitored using overall physical product quality, service level/order fulfillment rate, shelf life remaining at time of delivery, delivery lead time, delivery point, general quality of communication, and overall satisfaction with PV services.

All stakeholders involved in the Jazia PVS were trained in the use of the SOPs. Monitoring is conducted by the PV coordination office.

Table 2. Standard Operating Procedures

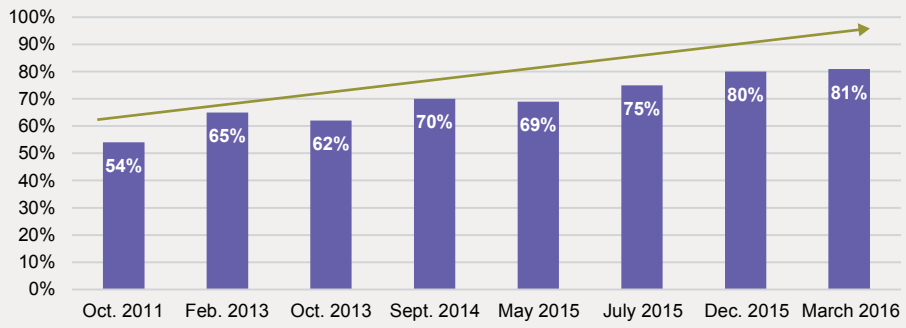
SOP	PRIME VENDOR OPERATIONAL AREA
1	Determination of quarterly order quantities to be purchased from PV by health facility
2	Health facility orders consolidation at district HQ and forwarding to PV
3	Receiving and inspection of consignments from PV at district HQ
4	Inspection of supplies from PV at health facility
5	Funds transfer and payment to PV by health facility
6	Lines of communication within PVS

RESULTS

Tracer medicine availability in the region increased from 54% in 2011 to more than 80% in 2016. All districts place orders with the PV. PV utilization in 2016 reached 50% as compared to the value of orders from the MSD. District and health facility satisfaction with PV performance as a complementary supplier is good. The performance score reached 94% in 2016. The PV adhered to and generally significantly undercut the contractual delivery time of 22 days. Prices of medicines by the PV are negotiated and contractually fixed. Average prices of PV supplies equaled listed MSD prices.

Twenty-four tracer items are used to monitor medicine availability at health facilities. Due to the innovative Jazia PVS and accompanying measures, such as auditing and coaching, mean medicine availability in the region increased by more than 40% between 2011 and 2016.

Figure 2. Medicine availability (2011–2016)



LESSONS

Challenges

The development of advocacy, tools, tendering, and establishing a regional PV system is time intensive because it follows good procurement practice. Payment to the PV was initially delayed by districts due to weak financial management and to resistance to a transparent new supply system. Mitigating measures were the simplification of financial transfers, continued persuasion of all actors regarding the successful intervention, pressure and sanctions by local authorities, and visibility of good performance in the region. Another challenge was initial compliance with the SOPs. This has improved after repeated training followed by internal coaching and supervision.

Enablers/Drivers

Enabling factors included strong political will and support by the regional secretariat and Regional Health Management Team (RHMT); leadership by committed district medical officers; ownership of Jazia PVS by the region and stakeholders; an engaged project implementation team; and constructive collaboration with the MSD, TFDA, and other stakeholders. Additional drivers were an official circular to underpin and instruct purchases by health facilities limited to the two approved suppliers (MSD and PV), incorporation of PV operations into the RHMT's routine operations, and recognition of good performance. Participation and engagement of all actors created ownership and pride in the functional system. A systemic approach to supply chain management that included a bundle of accompanying activities in pharmaceutical management and accountability was crucial. These enabling factors are further enhanced by regular meetings of all stakeholders, integration of pharmaceutical staff in decision making, and operational research. Dissemination of results and regular policy dialogue contributed to acceptance and ownership.

CONCLUSION

The Jazia PVS in the Dodoma Region is anchored in the regional health administration structures and in the decentralization policy of the country. Its objective is to ensure that health facilities have medicines and medical supplies available to meet the needs of the people by supplementing the regular government supplies. When quality of care is improved, the population will be motivated to join insurance schemes, which in

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turn generate funds to ensure the supply of medicines and maintain the quality of care. It is a new option that empowers public health facilities to purchase supplementary medicines and supplies with their own sources through a shortened and simplified procedure, thereby improving medicine availability without compromising quality or price.

In addition to the Jazia PVS, a bundle of systemic supply chain interventions, including capacity building, coaching, and auditing, is needed to improve accountability, medicine availability, and access to therapy for patients.

Following the successful implementation in the Dodoma Region, the Jazia PVS was expanded to two additional regions (Morogoro and Shinyanga) in 2016. Based on the convincing results from the pilot regions, the existing national policy framework, and requests from regions, the President's Office Regional Administration and Local Government (PORALG) and the MoHCDGEC have decided to scale-up Jazia PVS countrywide. To take into account the complexities of an urban context (e.g., population, mobility, level of care, public financial management, private sector, insurance schemes, coverage), additional technical assistance and an urban adaptation study will accompany and guide the implementation in the Dar es Salaam region.

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