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Federal Department of Foreign Affairs FDFA
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JAZIA
Prime Vendor System Dodoma Region, Tanzania

Summary and description of the Prime Vendor System

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Abbreviations

CCHP	Council Comprehensive Health Plan
CFAO	Chief Finance and Administration Officer
CHF	Community Health Fund
CHMT	Council Health Management Team
COOF	Cooperation Office (of SDC)
DCC	District Coordination Committee
DSM	Dar es Salaam
DED	District Executive Director
DHIS2	District Health Information System 2
DMO	District Medical Officer
HC	Health Centre
HFGC	Health Facility Governing Committee
HF	Health facility
HSSP IV	Health Sector Strategic Plan IV
ILS	Integrated Logistics System
IT	Information Technology
LGA	Local Government Authority
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
M&E	Monitoring and Evaluation
MSD	Medical Stores Department
NEML	National Essential Medicines List
NGO	Non-governmental Organization
NHIF	National Health Insurance Fund
NHP	National Health Policy
NMP	National Medicine Policy
PO- RALG	President's Office - Regional Administration and Local Government
PPP	Public Private Partnerships
PSS	Pharmaceutical Services Section (of the MoHCDGEC)
PVS	Prime Vendor System
R&R	Report and Request Forms
RAB	Regional Advisory Board
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Teams

RMO	Regional Medical Officer
SCIH	Swiss Centre for International Health, at the Swiss TPH
SDC	Swiss Agency for Development and Cooperation
SDC COOF	SDC Coordination Office
SHIB	Social Health Insurance Benefit (under the National Social Security Fund)
SOP	Standard Operational Procedure
SWAP	Sector-wide Approach
Swiss TPH	Swiss Tropical and Public Health Institute
STG	Standard Treatment Guidelines
TA	Technical Advisor
WHO	World Health Organisation

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1. Executive Summary

Communities equate quality of health care with the availability of medicines and supplies. Clinicians depend on medicines to provide adequate quality health care. Medicines availability in most public health facilities in Tanzania is problematic. One cause of medicines shortage is unavailability at Medical Stores Department (MSD), the sole supplier for public health facilities. Districts may purchase from private suppliers in case of stock-out at MSD upon its approval. However, this procedure is lacking consistency and transparency, is bureaucratic and uneconomic; and it prolongs lead-time for delivery of supplies.

Alternative strategies are needed to fill the supply gap and to complement the public sector supply system. While MSD will remain the backbone for medicines supply, Dodoma Region together with the Swiss Government funded Health Promotion and System Strengthening (HPSS) project established a Prime Vendor (PV) system as a public private partnership (PPP). The primary objective is to improve availability of health commodities in public health facilities.

Districts and the region endorsed a 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. The PV system is financed with complementary funds at health facility level such as CHF, NHIF, cost sharing/user fees and health basket funds. The region operates a PV office represented by a PV coordinator and dedicated pharmacy staff.

The Dodoma PV system was launched in 2014; ever since the availability of medicines has increased. Prices are fixed and comparable to MSD. It is closely monitored within an M&E framework. The PV system is integrated into the Dodoma Regional Administration and operates on behalf of the district and municipal councils of Dodoma Region. It is supervised by the Regional Administrative Secretary (RAS). While in a period of 18-months, medicines availability at health facilities increased by about 15%, the PV system together with other HPSS project interventions implemented has seen a significant 40% increase in medicines availability in the region between 2011 and 2015.

The PV system serves as a safety net to the region in case of stock rupture at MSD. It allows health facilities to manage their own funds following standard operating procedures (SOP) hence enhancing fiscal decentralization. Funds are used for pooled purchase from the PV, based on a PPP contract framework. PV supplies are of assured efficacy, safety and quality in accordance with MoHCDGEC and TFDA standards. The PV system of Dodoma has significantly improved medicines availability which is greatly appreciated by health workers and patients. The PV system is sustainable as it is not a parallel system. It is built on existing government policies and operates within the regional government structure.

In 2016 the successful PVS was expanded to Morogoro and Shinyanga regions by HPSS. To differentiate the systemic approach of this PPP from generic prime vendor schemes, the Dodoma model was branded and registered as Jazia PVS.

Following the launch in Morogoro, Swiss Agency for Development and Cooperation (SDC) was approached with the request to support the roll-out of the Jazia PVS in the 5 districts of Dar es Salaam region and 22 additional regions in Tanzania.

The implementation of Jazia PVS in any other region will be grounded in the RALG, guided by HPSS, using the toolkit (templates, SOPs etc) and expertise at the Health System Strengthening Resource Centre (HSS-RC) of PORALG, supported by expertise from Dodoma stakeholders as multipliers, senior national consultants and backstopping by Swiss TPH.

A step-by-step approach is proposed including expected outputs and with clear allocation of roles and technical respectively financial responsibilities.

The general steps and expected outputs presented in Table 1 will be required for successful implementation:

Table 1. General steps and expected outputs required for successful implementation

Step No	Objective	Expected output
1	**Baseline data**	Quantification of medicines needs is available Current private procurement practices are analysed 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 is appointed with TORs A Jazia PVS office is identified, equipped and staffed A Jazia PVS coordinator is appointed and instructed
4	**Vendor Forum**	Interested private suppliers are informed about possible PPP and have prequalification documents
5	**Prequalification**	A selected number of potential suppliers have been prequalified
6	**Tender**	A final supplier (Prime Vendor) is selected and approved
7	**PPP contracting**	PPP contract is signed between RAS and private supplier
8	**SOP and M&E documents**	SOPs and a M&E framework is available and approved
9	**PVS training**	Regional and district stakeholders and HCW at facility level are competent in SOP of Jazia PVS activities
10	**Launch**	The Jazia PVS is officially launched to start operations

Indicative activities based on expected outputs above are outlined in annex 6. An indicative detailed budget has been developed based on the proposed activities and can be provided on request. This budget is project based and deducted from the Dodoma model. In the context of scaling up a pilot such as the Jazia PVS from Dodoma to Dar es Salaam, however, internal staff of DSM region will be assumed to take over activities and the replication will be conducted as a systemic reform activity within their capacities, supported financially only for additional work required such as baseline studies, facilitation and guidance.

Reference: www.jaziaprimevendor.or.tz

2. Background and context

The Health Promotion and System Strengthening (HPSS) or Tuimarishe Afya Project is part of the development cooperation between Tanzania and Switzerland. The HPSS project was launched in 2011 and supports 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 (SDC) and implemented by the Swiss Tropical and Public Health Institute (Swiss TPH). The components of health insurance and medicines management were rolled out to two more regions, Morogoro and Shinyanga, in 2015.

The overall goal is to improve the health status and well-being of the Tanzanians with a focus on those most at risk (women, children, elderly etc.) and support the health system to become more responsive to health needs and demands of the different population groups. The project applies a comprehensive approach to health system strengthening: it looks both at the supply side (availability of medicines, availability of functioning equipment, financing) and the demand side (health promotion priorities from a community perspective, and social protection of the population).

The implementation of the Swiss Government funded HPSS project is embedded in a political, economic, social, and environmental context which has been analysed by the project management in order to optimize the project's contributions. One of the important recent political context factors are the national elections that took place in 2015. The timing and intensity of implementation activities may be influenced by election related events and activities. Another context factor is the development of the Health Sector Strategic Plan IV (HSSP IV) 2015 – 2020. All elements of the HPSS project will be aligned to the policies as expressed in the HSSP IV.

2.1 Essential Medicines and Health Products

Availability of key medicines in public health facilities in Tanzania remains low, with no clear trend of improvement. A number of factors (internal and external) affect overall management of commodities in the sector. Internal factors include inadequate funding, poor planning and coordination, inadequate tracking mechanisms and tools, as well as inadequate pharmaceutical human resources at the facility level resulting in poor inventory management. External factors include lack of coordination of externally funded vertical programmes' medicines and health products and donated supplies, and pilferage. This negatively affects quality of care and performance of service provision in general.

MSD, a semiautonomous government entity with 9 zonal stores, is responsible for procuring, storage and distribution of all (over 5000) public health commodities in Tanzania.

The Integrated Logistics System (ILS) was designed in 2004, and integrated several of the previous vertical distribution systems in country. More than 150 products are managed as part of the ILS, including but not limited to: malaria products, family planning products, some laboratory supplies, and a range of essential medicines and medical supplies. In the ILS, essential logistics data are collected at the facility level and reported up to the district. A combined Report and Request Form (R&R) is completed by facilities on a quarterly basis which are reviewed at district level where facility reports for the entire district are combined and forwarded to the appropriate MSD zonal store for order fulfillment.[1]

[1] Tanzania: Strategic Review of the National Supply Chain for Health Commodities, USAID deliver Project, 2013

Funding of medical supplies is not improving in real per capita terms and disbursement issues continue to affect the efficient use of limited funds. Budgetary shortfalls are exacerbated by disbursement practices (e.g. less than approved budget is disbursed by Treasury to the MOHCDGEC; irregular disbursements late in the financial year; long lead times for disbursed funds to be credited to health facility accounts at MSD). In addition, failure to budget for distribution costs for externally financed products has eroded MSD working capital. MSD's limited cash flow negatively affects the stock levels and order fulfilment rate for medicines and other products. Local manufacturing to increase availability of medicines in the country is still low at about 30% of the requirements. Rational use of medicines is a major challenge despite some positive developments that include the development of Medicines and Therapeutics Committee (MTC) guidelines, training on MTCs at public sector hospitals and the update and wider distribution of Standard Treatment Guidelines and National Essential Medicines List.

On the positive side, the regulatory framework through the Tanzania Food and Drug Authority (TFDA) has improved over the years. TFDA was able to increase the annual number of medicine samples to be tested (from 340 to 675 between 2010 and 2012), as well as the number of samples actually processed (from 52% to 96% between 2010 and 2012) in its WHO pre-qualified quality control laboratory. However, there are still medicines and health products of questionable quality in the market.

Communities equate the quality of health care with the availability of medicines and other essential supplies.[2] Understandably, they perceive health services to be poor when such essential health commodities are not available and they have to buy them from private medicines outlets.[3,4] On the other hand, clinicians, among other inputs, primarily depend on medicines availability to provide adequate health care.

In Dodoma region, a situation analysis conducted in 2010[5] and a comprehensive baseline survey in 2012 have revealed an availability of essential medicines of 53% with a corresponding stock-out rate of 47% based on 24 tracer medicines; and the order fulfillment rate offered by Medical Stores Department (MSD) was 58.6%.[6]

2.2 Problem statement in Dodoma Region

The supply gap of more than 40% stemming from the out-of-stock situation and low order fulfillment rates for supplies by MSD needs to be complemented by medicines from other sources.

In the last four years, this gap has been growing significantly; while the gap was 40% in 2011; currently it is at 50% (Figure 1).[7]

[2] Nabbuye-Sekandi, J., Makumbi, F.E., Kasangaki, A., Kizza, I.B., Tugumisirize, J., Nshimye, E., Mbabali, S., Peters, D.H., 2011. Patient satisfaction with services in outpatient clinics at Mulago hospital, Uganda. Int J Qual Health Care 23, 516–523.
[3] Hanson, K., McPake, B., Nakamba, P., Archard, L., 2005. Preferences for hospital quality in Zambia: results from a discrete choice experiment. Health Econ 14, 687–701.
[4] Mugisha, F., Bocar, K., Dong, H., Chepng'eno, G., 2004. The two faces of enhancing utilization of health-care services: determinants of patient initiation and retention in rural Burkina Faso. Bulletin of the World Health Organization 82, 572–579.
[5] Karin Wiedenmayer. 2011. Report – Situation Analysis – HPSS Dodoma, Tanzania. HPSS Project Dodoma, Tanzania
[6] Karin Wiedenmayer. 2012. Report Health Facilities baseline survey – Medicines Management. HPSS Project Dodoma, Tanzania
[7] Empirical data from the field – July 2016

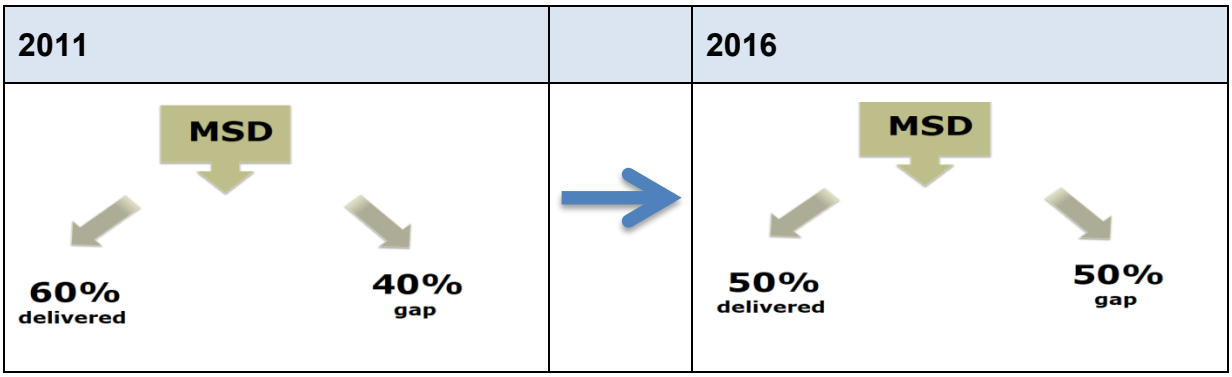

Figure 1. MSD supply gap (2011 vs 2016)

Normally, health facilities in the region, like other facilities in the country, fill this gap with purchases using complementary funds (CHF, NIHF, user fees and basket funds) from multiple private sources (Figure 2), within and outside Dodoma region; incurring in the process high opportunity costs (travel and fuel, per diems, high prices of medicines they purchase) making the whole task of filling this gap cost inefficient.[8]

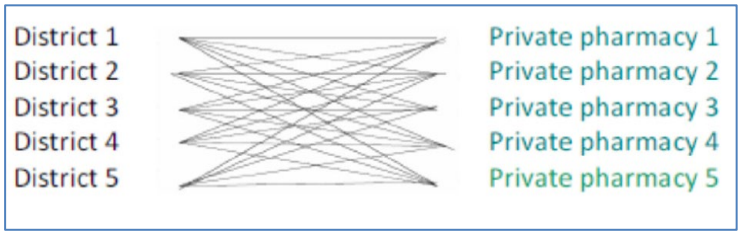

Figure 2. Erratic supply from multiple private pharmacies

To resolve this situation the Dodoma Regional Administration and Local Government (RALG) decided to embark on a long process to establish and engage, on a Public-Private Partnership (PPP) basis, a private sector pharmaceutical supplier, as the primary supplier to provide the supplementary medicines needed by public health facilities in the region. A concept note was circulated and discussed. [9] In principle, as illustrated in Figure 3 below, the Prime Vendor System established in Dodoma region serves as a "one stop shop" intended to alleviate opportunity costs previously incurred by health facilities when they have to search for alternative sources of supplies they could not obtain from MSD.

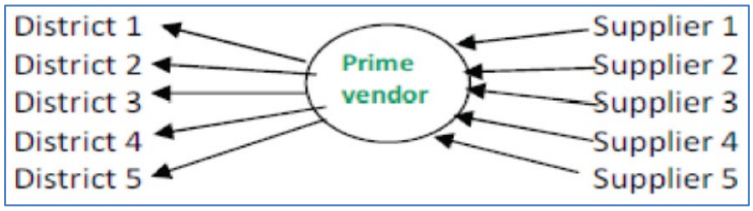

Figure 3. Organized and reliable supply from one private sector source

[8] Karin Wiedenmayer. 2012. Report on Private Supplier Assessment. HPSS Project Dodoma, Tanzania

[9] Karin Wiedenmayer. 2012. Medicines gap supply- Concept note. HPSS Project Dodoma, Tanzania

2.3 Development of the Prime Vendor System in Dodoma Region

Below we summarize the development of the Prime Vendor Supply System for the supply of supplementary medicines to public health facilities in Dodoma region. It provides a short description of the process and practical steps followed to establish the system, its outcome, the tools developed and used to establish the system. Figure 4 below describes the steps and milestones achieved in the development of the system.

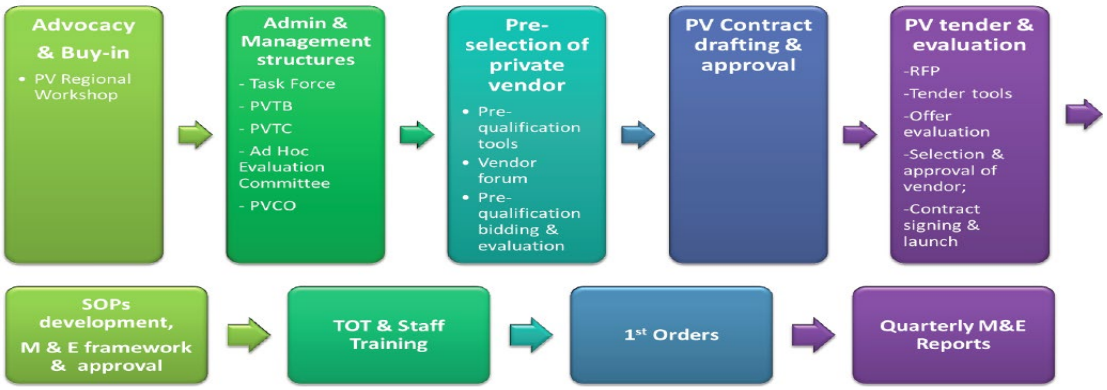

Figure 4. Steps and milestones in the development of the prime vendor system

To realize development of the system the following essential steps were important:

1. Stakeholders' mobilization – advocacy and buy-in to the Prime Vendor idea and setting up the necessary administrative and operational structures;
2. Technical and financial support, including staff capacity building – throughout the entire process;
3. Outlining the process, development of tools for the transparent selection of the Prime Vendor and operating procedures – and their approval before use; and
4. Launch and operations – contract signing, training and utilization of the system, monitoring and evaluation (Prime Vendor and System performance).

2.4 Key operational features of the Prime Vendor System

The concept of the fully functional PV system is illustrated below (Figure 5).

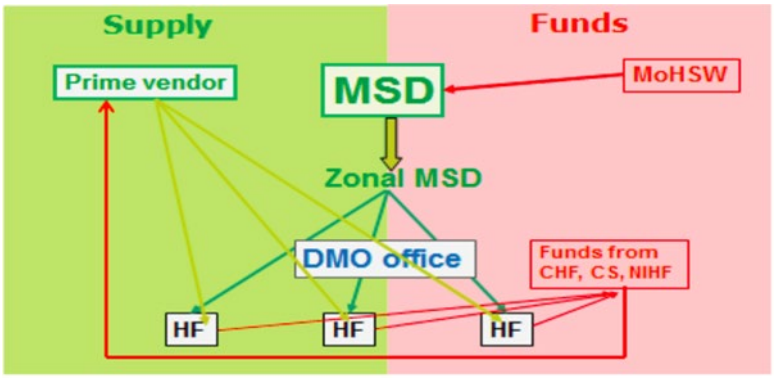

Figure 5. Concept of the fully functioning Prime Vendor system

Health facilities (HF) have two main sources of funding for their supplies: direct funding deposited at MSD by the Ministry of Finance (MoF) through the MoHCDGEC; and supplementary funds collected by and/or residing at Health Facilities level. These include:

CHF, Cost Sharing/User fee, NHIF and donor/health basket funds. The later were formerly used to purchase from multiple private sources. However, now this supplementary source is used for purchases only from the appointed Prime Vendor. Figure 6 below illustrates the synergy created by the collaboration between MSD and the Prime Vendor system in improving medicines availability from the public health facilities' perspective in Dodoma region.

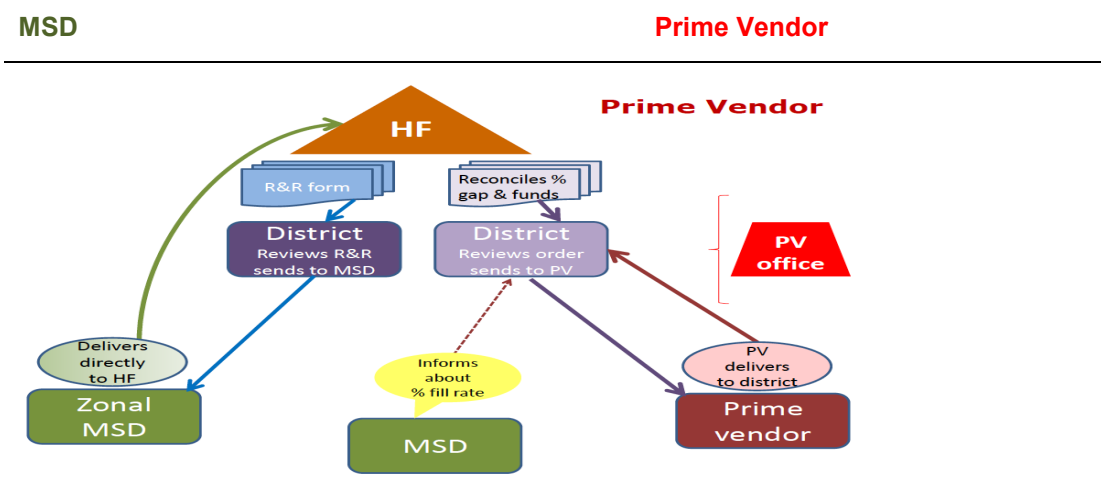

Figure 6. Bridging the medicines supply gap at HF– synergy between MSD and PV

A set of six (6) standard operating procedures are available to guide the process and the purchase of medicines from the Prime Vendor when these are either out of stock, short supplied or not stocked by MSD. All purchases from the Prime Vendor are consolidated at the district level and forwarded to the Prime Vendor.

Operations of the PV system are managed and driven by Standard Operating Procedures (SOPs, see Table 2). A comprehensive but user-friendly handbook with SOPs for health facilities and districts was developed, covering the following 6 key PV system operational areas:

Table 2. Standard Operational Procedures

SOP #	Prime Vendor Operational Area
1	Determination of quarterly order quantities to be purchased from PV – by HF
2	HFs 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 HF
5	Funds transfer & payment to PV- by HF
6	Lines of communication within PV system

All stakeholders involved in the PV system were trained in the content and use of these SOPs. For instance, SOP# 1, 4, 5 and 6 relate to activities at health facility level whereas SOP# 2 and 3 concern district headquarters. The monitoring itself is conducted by the PV coordination office.

2.5 Results from Dodoma Region

An M&E handbook provides the framework for evaluating the performance of both the system and the Prime Vendor. Overall, the performance of the PV system as monitored in 2016 is rated as good.

Tracer medicines availability in the region is on the increase from 54% in 2011 to over 80% in 2016. All districts place orders with the Prime vendor. The PV utilization in 2016 reached 50% as compared to the value of orders from MSD. Satisfaction of districts and health facilities with the PV performance as a complementary supplier is good. The performance score reached 94% in 2016. For instance the PV adhered 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. Below we describe some key results in more detail.

2.5.1 Availability of tracer medicines

Twenty-four tracer items (Annex 2) are used to monitor medicines availability at health facilities. Due to the innovative PV system and accompanying measures such as auditing and coaching, mean medicine availability in the region increased by over 40% between 2011 and 2016.

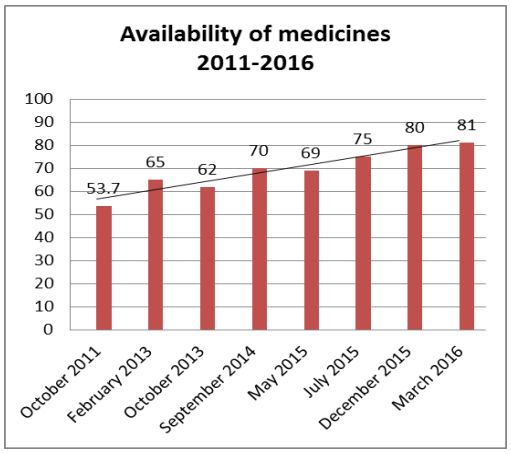

Figure 7. Medicines availability in % (2011 - 2016)

2.5.2 System performance

A composite of five (5) operational indicators are used to monitor the performance of the PV system on a quarterly basis (Annex 3). As of June 2016, purchases by health facilities over the period of 21-month of PV system operations were estimated at TShs 2.4 billion from MSD and TShs 2.7 billion from the Prime Vendor, which translates to about TShs 1.35 billion annual purchases from the Prime Vendor. Table 3 summarizes relative purchases from PV and MSD during the period of 21-month after operations of the PV system began. Overall, purchases from the PV (at 53%) were slightly more than purchased from MSD (at 47%).

Table 3. Relative purchases by Councils (MSD vs PV) in the last 21 months

Reference Period	PV	MSD
Period 1 (6mo)	36%	64%
Period 2 (3mo)	47%	53%

Period 3 (6mo)	48%	52%
Period 4 (3mo)	52%	48%
Period 5 (3mo)	67%	33%
All periods (21 mo)	**53%**	**47%**

2.5.3 Prime Vendor performance

The Prime Vendor's (as a supplier) overall performance, measured by a composite of 7 indicators (Annex 4) has been rated "Good" in 2016 based on the scale displayed in Table 4.

Table 4. Performance of Prime Vendor

Rating	Score range
Excellent	95% -100%
Good	**80% - 94%**
Satisfactory	65%- 79%
Poor	<65%.

2.6 Implementation: lessons learned

2.6.1 Challenges

One challenge initially concerned delays by districts in processing payment to the Prime Vendor. This was due to complications in financial management and to resistance to a transparent new supply system. Generally interventions aiming at increased transparency tend to cause resistance by interested parties. Mitigating measures were simplification of financial transfers, continued persuasion of all actors regarding the successful intervention, pressure by local authorities and visibility of performance in the region. Another challenge was the implementation of SOPs. This has improved after repeated training followed by internal coaching and supervision. The M&E capacity of the coordination office had to be built up. Further common factors that slow implementation of new procedures are the diversity of districts, their leaders and frequent rotation of health staff and authorities which has to be taken into account by offering orientation and continuing training. The development of tools, advocacy, tendering and establishing a regional PV system is time-intensive following good procurement practice (GPP).

2.6.2 Enablers / Drivers

Enabling factors included among others: Strong political will (politicians), strong regional support by Regional secretariat and RHMT; leadership by committed DMOs; ownership of project by the region and stakeholders; a good and engaged project implementation team; constructive collaboration with MSD, TFDA and other stakeholders; a regional circular to underpin and instruct purchases by HFs limited to the two approved suppliers (MSD and PV); incorporation of PV operations into the Regional Health Management Team's routine

operations; and recognition of good performance. Clearly participation and engagement of all actors created ownership and pride in the functional system. Finally a systemic approach to supply chain management including 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 as well as invitation to participate at conferences for dissemination of results. In conclusion, a combination of interventions is required to address the supply gap by MSD. This includes, in addition to the new PV model system, activities within existing resources to build capacity and accountability.

2.7 Conclusion

The PV system in Dodoma Region is anchored in the regional health administration structures and in the decentralisation policy of the country. Its objective is to ensure that health facilities have medicines and medical supplies available to meet the need of the people, by supplementing the regular government supplies with additional supplies. When quality of care is improved the population will be motivated to join the community health fund (CHF) and renew their membership, which in turn generates funds to ensure supply of medicines and maintaining of quality of care. The decentralized PV mechanism therefore works in synergy with a functioning CHF, which both are an integral part of the districts' ability to fill the gaps left by the central government procurement system. It is a new option, which empowers public health facilities to purchase supplementary medicines and supplies with their own sources through a shortened and simplified procedure thus improving medicine availability without compromising quality or price.

Key features of the Dodoma Region supplementary PV system are enumerated in Annex 5.

Finally, it is important to note that the PV system in itself is not a panacea. A combination of concurrent supply chain interventions including for instance capacity building, coaching, financial and medicine auditing is needed to improve medicines availability and access to therapy for patients.

2.8 From supplier to supply system – JAZIA PVS

Seeing results of the PV system in Dodoma region, other regions and donors showed interest in replicating the model as a complement to MSD which is still struggling to fulfill its mandate nationwide. However, it also became clear that stakeholders did not fully understand the PV concept which is more than selecting a single supplier. As part of health system strengthening, the PV model has to be viewed as a system that is embedded and interlinks with financing flows and insurance schemes, the logistic information system, accountability and other efforts. Its success is grounded in a systemic and regionally owned approach. To differentiate a generic Prime Vendor supplier from the Dodoma model of a Prime Vendor system, the regional administration branded and registered the system at national level as JAZIA Prime Vendor System (Jazia PVS).

3. From pilot to expansion – Roll-out in additional regions

Following the successful implementation in Dodoma region, the system has been expanded to two more regions (Morogoro and Shinyanga) in December 2016, supported by SDC. The Jazia PVS is now operating in three regions.

Further regions have inquired about support for implementing the PV system. The PORALG and MOHCDGEC have requested the HPSS project to elaborate a concept note for discussion of possible national roll-out of the PV system (available on request).

4. Annexes

Annex 1: Development steps of the Prime Vendor System in Dodoma Region

1.0 Advocacy and buy-in to the idea

1.1 Advocacy to relevant stakeholders

The process of establishing a Prime Vendor (PV) System in Dodoma involved a number of critical steps. Amongst which included, conducting advocacy campaigns and meetings to obtain buy-in from district and regional leadership and other stakeholders on the idea of a single supplier to serve the region for their supplementary medicines needs. At these advocacy campaign meetings, options for the system were clarified. One such meeting was held on 22 March, 2013 at Dodoma hotel. At this meeting, options for implementing the system were agreed upon; paving the way to start active planning and implementation of the concept. Following this meeting and under the strong leadership of the Regional Administration Secretary (RAS), organs and structures to oversee the establishment of the system were initiated and eventually put in place (see Section 2.0 below).

1.2 Technical, financial support and staff capacity building

Technical and financial support, including staff capacity building has and continues to be provided through Health Promotion System Strengthening (HPSS) project, pharmaceutical component, funded by the Swiss Agency for Development and Cooperation (SDC) and implemented by the Swiss Tropical and Public Health Institute (TPH). Through this support, two senior pharmacists with over 30 years of experience in the pharmaceutical sector in the country and abroad, have and continue to provide technical support and staff capacity building to set up the now fully functioning Prime Vendor system for Dodoma region. Support is currently being provided in two more regions (Morogoro and Shinyanga) that have launched the system recently.

Training and hands-on capacity building of the project four key technical and administrative structures (see Section 2.0 below) has been going on throughout the process of establishing the PV system in the region and continues in Morogoro and Shinyanga regions.

It is worth noting that to impart ownership and build capacity to key staff of the project in this area; for example, the PV Coordinator presented at the 2nd Prime Vendor Technical Committee (PVTC) meeting and 1st Regional Prime Vendor Tender Board (RPVTB) an overview of the PV system. These opportunities, along with active participation in PVTC meeting (review of the key documents and discussion that were collectively made) seem to have imparted ownership and confidence in on his role as a Coordinator. Similar empowering process is going on in Morogoro and Shinyanga.

Likewise, the Chair of the PVTC, through this process has become more knowledgeable about the PV system. He, and other member of the PVTC and the Regional Prime

Vendor Tender Board (RPVTB) are now capable of talking confidently about the system and what is required to make it functional.

Engagement of the PVTC members in the preparation of project documents for the system, the pre-qualification (PQ) bid process and its evaluation imparted more knowledge and ownership of the program to the relevant RALG officials in the region. Similar efforts have been replicated in Morogoro and Shinyanga region.

2.0 Establishment of the essential administrative structures

2.1 Taskforce

In March, 2013 a task force was appointed to guide and provide direction for the development of the system. It comprised of representative from:

- Regional Referral Hospital
- District Hospitals
- Procurement Units
- Regional Health Management Team (RHMT)
- HPSS Project

This task force, among other responsibilities, guided the establishment of the essential administrative and management structures of the system as briefly described below.

2.2 Regional Prime Vendor Technical Committee (RPVTC)

A Regional Prime Vendor Technical Committee (RPVTC or TC in short) has been established and is functional. The TC advises the Board on all technical and administrative matters related to the transparent selection of the single supplier Prime Vendor to serve the region and in all other matters related to the performance of the system and the Prime Vendor as a supplier. Terms of references of the TC are available and were approved by the Regional PV Tender Board. The TC held its first and inaugural meeting on 18 February 2014. Since then it has met several times to deliberate on various technical issues pertaining to the establishment and performance of the Prime Vendor pilot system. The TC is managing the process for renewing the services of a Prime Vendor through national competitive bidding process every two years.

2.3 Regional Prime Vendor Tender Board (RPVTB)

A Regional Prime Vendor Tender Board (RPVTB, hereinafter referred to as the Board or TB in short) to oversee, among other functions, the transparent selection of the Prime Vendor (PV) has been established and functional. The Board terms of references (ToRs) are available on request. The Board held its first meeting on 24 and 25 March, 2014 when it reviewed and approved the Board ToRs and the three fundamental tools for soliciting transparently a suitable, reliable and capable Prime Vendor. The Board is chaired by the Dodoma Assistant Regional Administrative Secretary (ARAS)/Regional Medical Officer (RMO). Since then, the Board has met several times and has adjudicated and approved twice the selection of a suitable vendor to serve the region. The second phase Prime Vendor was inaugurated in October, 2016.

2.4 Regional Prime Vendor Coordination Office

A Regional Prime Vendor Coordination Office has been established and it is functional. The office acts as an intermediary unit for the system with the following responsibilities:

- System and product quality assurance, in close collaboration with TFDA
  - Supportive Supervision
  - Training: Rational Use of Medicines, Ordering & Reporting
  - Monitoring of PV Performance (system and supplier performance).
  - Overseeing implementation of the system SOPs such as:

1. Quantification and Ordering at Health Facility Level
2. Order consolidation – at District Level
3. Receiving & Inspection – at district level
4. Receiving & Inspection – at Health Facility level
5. Prime Vendor Payment
6. Lines of Communication

A handbook for these SOPs is available.

2.5 Ad hoc Regional Bids Evaluation Committee (EC)

Ad hoc Regional Prime Vendor Evaluation Committees established as and when needed to undertake evaluations of vendor selection proposals. Four such Committees served to evaluate the 1st (in 2014) and 2nd (in 2016) round of prequalification of suppliers and the 1st (in 2014) and 2nd (in 2016) round (Request for Proposal) bidding documents submitted by vendors.

3.0 Process and tools used for the selection of a suitable and capable vendor

3.1 Vendor Forum

Prior to advertising the prequalification tender document, a high profile vendor forum is normally held. Its opening graced by the Regional Administrative Secretary. Table below summarize vendor forums so far held.

Region	**Vendor Forum**			
	1st Time		**2nd Time**	
	Advertised	**Held**	**Advertised (Jointly)**	**Held (Jointly)**
Dodoma	30 March 14	4 Apr-14	30 July-16	3 Aug-16
Shinyanga (first time)	n/a	n/a	n/a	3 Aug-16
Morogoro (first time)	n/a	n/a	n/a	3 Aug-16

The first vendor forum for Dodoma region was held on 4 April, 2014 (09:00 – 13:00H) at Dodoma Hotel. The forum served to inform pharmaceutical wholesaler vendors of the system being developed as well as to provide them with the opportunity to learn about it, ask questions and eventually to solicit their interest to participate in the prequalification process that followed soon thereafter the forum. About 10 vendors attended the forum. A second (joint) vendor forum was held on 3 August 2016, at the same venue in preparation for the vendor selection process for Dodoma, Morogoro and Shinyanga regions. Eight interested vendors attended the joint forum.

3.2 Vendor Prequalification – 1st round bidding process

A prequalification questionnaire (PQQ) was developed and approved by the Board. This questionnaire seeks to establish vendors' legal standing and business capacity in the following areas:

- Number of years a vendor has been in business
- Vendor general standing
- Vendor financial standing
- Stocking and inventory levels
- Vendor's customer profile
- Vendor's distribution capacity and geographical reach
- Staff establishment
- Vendor capacity and extent of use of electronic Management Information Systems, Communication and Information Technology – medicines and related supplies management
- Quality assurance practices
- Product availability

A copy of this PQQ is available (on request). Table below summarize the PQ bidding advertising and closing dates in the three regions.

Region	**PQ bidding**			
	1st Time		**2nd Time**	
	Advertised	**Closing**	**Advertised**	**Closing**
Dodoma	21-Apr-14	14-May-14 (15:00H)	03 July-16	11 August-16
Shinyanga	09-Aug-16	30-Aug-16	Due in 2019	Due in 2019
Morogoro	15-Aug-16	05-Sep-16	Due in 2019	Due in 2019

- In Dodoma advertisement of the **first PQ bid process** was done for the first time on 21 April, 2014 and for the second time on 05 August 2016 for three consecutive days in the local print media (Mwananchi, Guardian and Daily News). On the first time it closed on 14 May 2014, 15:00Hrs. Seventeen (17) interested vendors purchased the PQ document and thirteen (13) of them returned their duly completed documents on or before the indicated deadline and there were not late bids. The **second PQ bidding process** in Dodoma was advertised on 03 July, 2016 in the same print media and for the same duration. It closed on 11 August, 2016. Eight (8) interested vendors purchased the PQ document and six (6) of them returned their duly completed documents on or before the indicated deadline.

- In Shinyanga PQ bidding was advertised on 09 August 2016 and it closed on 30 August 2016. Fourteen (14) interested vendors purchased the PQ document and seven (7) returned their duly completed documents on or before the indicated deadline.
- In Morogoro it was advertised on 15 August 2016 and it closed on 05 September 2016. Fifteen (15) interested vendors purchased the PQ document and eight (8) returned their duly completed documents on or before the indicated deadline.

The vendor PQ advertisement requested interested vendors to purchase the PQQ document (for TShs 100,000/=) at the RPVCO located at the respective Regional Referral Hospital compound, in Dodoma, Shinyanga and Morogoro.

PQ bid evaluation

Section I the tool, guided members of Evaluation Committee to review vendors' responses on the basis of ***"yes/no"***. Among other critical requirements the tool enabled the EC (Preliminary Evaluation Section I) to assess:

- Vendor general legal standing
- Receipt of the document in/on time
- Proof of purchase of the PQQ document by a vendor
- State of document sealing at the time of opening
- Commitment signatures, names and title of responsible manager/director and that of superintendent pharmacist over stamped with official company stamp or seal;
- Availability of a certified original copy of power of attorney
- The way the document was filled (typed or hand written in indelible ink)
- Corrected errors, if any, initialed by a vendor
- All pages of the document initialed by the vendor
- Etc.

This section comprises of a total 83 score points, which were equally available to be earned by all evaluated vendors. Details of the specific elements contested by all the vendors can be reviewed in Section II of the tool (available on request).

Section II of the tool seeks to document vendor capacity to undertake the role of a Prime Vendor, if selected. Detailed aspects of vendor responses evaluated can be reviewed in the tool. Examples of capacity assessed, included:-

- Number of years a vendor has been in business
- Vendor financial standing
- Stocking and inventory levels
- Vendor's customer profile
- Vendor's distribution capacity and geographical reach
- Staff establishment
- Vendor capacity and extent of use of electronic Management Information Systems, Communication and Information Technology – medicines and related supplies management
- Quality assurance practices
- Product range

This section comprised of a total 115 score points, which were equally available to be earned by all evaluated vendors. Details of the specific elements contested by all the vendors can be reviewed in Section II of the tool (available on request).

PQ bid evaluation - scores interpretations

- S.I of the PQQ (tender document) provides conditions of tendering, including legal requirements that a vendor must comply. A vendor earning 100% (83/83 points) in this section would be considered to be fully compliant to the tender conditions. Therefore, on a scale of 0% (0/83) - 100% (83/83), score earned by a vendor in this section, indicates the extent to which a vendor complied with the specified tender requirements.

- S.II of the PQQ (tender documents) provides a measure of the relative capacity or the extent of a vendor capacity, in terms of the areas specified in this section (see previous page above). A score of 100% (11/115 points) by a vendor in this section would mean a vendor has the full desired capacity to become a Prime Vendor for the region. Accordingly, on a scale of 0% (0/115) - 100% (115/115), scores earned by a vendor in this section, indicates the vendor's relative capacity to assume the role of a Prime Vendor if selected.

- A vendor relative compliance with the specified tender conditions, including legal requirements (Section I) and a vendor preliminary and comparative capacity to undertake the Prime Vendor role, if successful, are normally summarized for the review and acceptance by the TC and approved by the PV Board. Table below summarize the PQ bid evaluation dates and the outcome in the three regions. Details Evaluation reports are available (on request).

Region	**PQ bids Evaluation**		**Outcome**	
	1st Time	**2nd Time**	**1st Time**	**2nd Time**
Dodoma	5 days (14 – 18 July 2014)	4 days (11 -14 Aug 2016)	6/13 vendors were prequalified to proceed with the 2nd RFP bidding process	3/6 vendors were prequalified to proceed with 2nd RFP bidding process
Shinyanga	4 days (30 Aug – 2 Sept 2016)	Due in 2019	4/7 vendors were prequalified to proceed with the RFP bidding process	Due in 2019
Morogoro	4 days (15-18 Sept 2016)	Due in 2019	4/8 vendors were prequalified to proceed with the 2nd RFP bidding process	Due in 2019

- An important feature to note in the evaluation of the submitted PQ bids was that prior to undertaking the evaluation process members of the Evaluation Committee, and all individuals (consultant, lawyer and PV Coordinators participating in the evaluation) had to declare whether they have any real or perceived conflict of interests related to

any of the vendors being evaluated. Accordingly they all signed a conflict of interest declaration form.

- A tool (Prequalification Evaluation Scheme (PQ-ES), an Excel worksheet, accepted by the RPVTC and approved by the RPVTB was used to evaluate the submitted bids. The evaluation tool and PQ Evaluation reports from the three regions are available (on request).

Notification to unsuccessful & successful vendor

Following the approval of PQQ Evaluation report by the Board, and cognizant of the fact that at this stage a contract was not being awarded to any of the prequalified/short listed vendors, a 4-day notification embargo notwithstanding, notifications were sent to both the unsuccessful vendors and the successful/short listed vendors, concurrently.

PV draft contract

A draft Prime Vendor contract, to inform on essential elements of the RFP, was prepared and accepted by the TC and approved the Boards in the three regions. A copy of the final Contract is available (on request). Key aspects and clauses of the draft contract were featured in the RFP in order to obtain initial agreement with the shortlisted vendors through the RFP bidding process (described below).

3.2 Request for proposal – 2nd round bidding process

A Request for Proposal (RFP) consisting of two parts (Section I: Technical proposal and Section II: Pricing proposal and its Evaluation Scheme) were developed, accepted by the TC and approved the PV Board in the three region. To the extent possible, the contents of the RFP were a mirror image of the draft Contract, which for example, in:

- RFP Section I - sought vendors' commitment to fixed price contract including, among other things, obtaining their guarantee on matters related to the quality of medicines, medical and laboratory supplies to be supplied, product packing and labeling, stock availability, delivery lead times and delivery documents, modalities for payment, price adjustments during the contract period and

- RFP Section II – sought price quotations for more than 500 medicines, medical and laboratory supplies items against quantities estimated to be needed on annual basis by health facilities in the three regions to supplement purchases of those short supplied or out stock or not stocked by MSD.

Accordingly, the RFP sought to establish vendors' agreement to the Prime Vendor draft Contract by responding to "yes/no" and/or "agree/disagree" questions.

RFP were sent to short-listed vendors including the closing date for the bids.

In the case of Dodoma (on going for the other two regions, at the time of writing this report) notifications and the RFP documents were sent to the 6 short-listed vendors on 14 June, 2014 with a closing date on 9 July, 2014 (2014 bidding process). Please note that: the closing date for submission of the duly completed RFP by the successful vendors was initially communicated to vendors to be on 2 July (short of the legally acceptable duration of the minimum of 21 days). To avoid violation of the applicable public procurement laws and regulations this was extended to 9 July and the 6 short listed vendors were accordingly informed of the extended deadline. All the six vendors,

to which the RFP questionnaires were sent, submitted their proposal on time at the closing date on the 9 July, 2014 when the proposal were immediately opened at a brief ceremony chaired by the Board Chairperson and witnessed by some officials of the Regional Administration & Local Government Authority. Two vendor representatives attended the opening ceremony.

For the most recent RFP process (2016, 2nd bidding process) notifications and the RFP documents were sent to short listed vendor on 22 September 2016, with closing date on 14 September 2016.

RFP bid evaluation

Prior to undertaking the evaluation, members of the EC are trained on how to evaluate and score bidders responses. Training is based on *Request for Proposal Evaluation Scheme*, an Excel worksheet, a tool accepted the Regional PV Technical Committee and approved by the Regional PV Tender Board. The tool allows a systematic review of the information provided by vendors. Details on the organization and conduct of the RFP evaluation can be found in the approved RFP Evaluation Final Report (available on request). Bids were evaluated and the outcome of the evaluation accepted by the TC and approved by the Board.

Like in the PQ bid evaluation, members of the Evaluation Committee and all individuals (consultant, lawyer and PV Coordinators participating in the evaluation) signed the conflict of interest declaration form.

3.3 Post qualification/physical inspection visits to potential vendors

In the case of Dodoma (to be repeated in the other two regions) a 3rd round – physical visit to 3 vendors was made to allow the final decision on the selection of the Prime Vendor. In addition to verification of some of the information the provided in the PQ and RFP process, the 3 vendors were assessed in the following areas:

- Vendor readiness to take up the role of PV – general level of enthusiasm to become a PV for the program in Dodoma and understanding of the supplementary (to MSD) nature of the pilot and Contract demands
- Office environment as a proxy for comfort to inspire productivity and proficiency at work place (as opposed to unsystematic, chaotic, disorderly office environment)
- Number of warehouses and their condition
- Computer hardware (in terms of numbers vs staff) available
- Capacity to produce tailored usage/sales reports as would be needed
- Transportation/delivery capacity
- Vendor greatest strengths that makes the vendor to consider themselves as the best vendors among others, in terms of: Infrastructure, financial situation, staffing, flexibility in delivery services, a wider customer base, international links, etc.

3.4 Adjudication - most responsive vendor to the process

Overall scores earned by a vendor throughout the processes (prequalification, RFP Sections I&II, and Inspection/Interviews) determined the most responsive vendor to the process of securing a reliable and capable vendor to serve the region as its Prime Vendor for the supply of supplementary medicines, medical and laboratory supplies often short supplied or out of stock or not stocked by MSD.

Cognizant of critical factors and the in-depth analysis provided is the final report the Regional Prime Vendor Evaluation Committee, in close collaboration with the Regional Prime Vendor Technical Committee; it was recommended that the role of Prime Vendor for Dodoma region be assigned to Bahari Pharmacy Limited of P.O. Box 40591, Dar-es-salaam, Tanzania. Table bellow illustrates the final outcome of the prequalification visits in the case of Dodoma.

Region	**Post qualification/physical verification visit**		**Outcome**	
	1st Time (Date)	**2nd Time (Date)**	**1st Time (Date)**	**2nd Time (Date)**
Dodoma	The vendor was found to have fulfilled all criteria which were required by RFP	PVTB found it unnecessary to visit the vendor as difference of marks between the winner and the runner-up is >60% and the winner is the same vendor whose first contract is ending.	One vendor (Bahari Pharmacy appointed as the PV for a period of 24 months	One vendor (Bahari Pharmacy appointed as the PV for 3-year contract

3.5 Notification to the successful & unsuccessful vendors

Public Procurement Act (2011, Section 75) and Regulations (2013, Section 231) requirements that prior to awarding a contract, all bidders (successful and unsuccessful) must be informed in writing the tenderer intention to award a contract to the successful bidder. Any aggrieved vendor has 14 days to raise complaints to the tenderer on any aspects of the tendering process. At the expiration of this period if there had been no complaints raised by any bidder, the tenderer may proceed to award a contract to the successful bidder.

In the case of Dodoma, successful and unsuccessful vendor were accordingly informed on 11 August, 2014 and until the expiration date of this embargo, which was on 27 August 2014, no vendor raised any formal complaint about the bidding process and its adjudication by the Board.

3.6 Contract negotiations and signing

In Dodoma given that there were no complaints raised by any of the unsuccessful vendors, formal contract negotiations with the successful vendor (Bahari Pharmacy Limited) was conducted during September 2014 and the contract was signed by the two parties on 11 September 2014 at the launch ceremony held at New Dodoma Hotel, Dodoma.

3.7 PV Launch (Official contract signing)

Prime Vendor launch signifying the official start of the Prime Vendor operations in

Dodoma region was held on 11 September 2014 at a colorful ceremony held at New Dodoma Hotel.

Deputy Minister of Health, in place of the Minister, graced the opening ceremony, which was attended by, among other dignitaries:

- Honorable, Ambassador of Switzerland
- Regional Commissioner, Dodoma Region
- Regional Administrative Secretary, Dodoma Region
- Regional Medical Officer, Dodoma Region
- Various groups and stakeholders from:
    - Prominent elders of Dodoma region
    - Ministry of Health Officials
    - Medical Stores Department
    - Tanzania Food & Drug Authority
    - Pharmacy Council
    - Representatives from Morogoro and Shinyanga Regional Administration and Local Government Authorities

The ceremony received high media coverage (print media and local and national TVs) captured live speeches delivered at the ceremony. Intermittently, a Dodoma traditional dance group entertained invited guests. A press release describing the Prime Vendor system launch in Dodoma was published in several print and electronic media.

Also factsheet-summarizing facts about the Prime Vendor (objectives, stakeholders and the approach) has been developed and shared with invited guests at the launch of the Prime Vendor.

Similarly, Prime Vendor launches signifying the official start of the Prime Vendor system operations in Morogoro and Shinyanga regions were held in December 2016 framed by colorful ceremonies and received high media coverage.

4.0 Standard Operating Procedures (SOPs)

Operations of the system is managed and driven by standard operating procedures (SOPs). There are 6 such standard operating procedures, developed by the TC in close collaboration with some members of the TB and other stakeholders outside these structures. The procedures cover the following six operational areas of the Prime Vendor system:

SOP #	Prime Vendor Operational Area	Accountable officer
1	Determination of Quarterly Order Quantities to be purchased from the Prime Vendor – at Health Facility Level	HF staff responsible for placing orders
2	HFs Orders consolidation at District Headquarters and forwarding of Consolidated Order(s) to PV	District Pharmacist or delegated official

3	Receiving and Inspection of consignments from PV - at District Headquarters	District Pharmacist & MTC acting as the district Inspection & Receiving Committee
4	Inspection of supplies received from PV - by Health Facility level	HF officer responsible for collection of HF supplies from the district headquarters and HF MTC acting as the Inspection & Receiving Committee
5	Funds Transfer & Payment to Prime Vendor	At HF level, HF i/c and at the district level DED or delegated officials e.g. DMOs; and at hospital level MO i/c.
6	Lines of Communication with Prime Vendor	Regional Prime Vendor Coordination Office official in close collaboration with TFDA Dodoma/Central Zonal Office

SOP handbook and M&E handbook describing the procedures in detail are available (on request).

5.0 After launch advocacy and information of stakeholders

After the launch, to ensure that district leadership including the more influential district counselors were on board and to support operations of the Prime Vendor, a 1-day advocacy seminar was held on 18 September 2014. At this seminar, the regional leadership presented the different aspects of the Prime Vendor system operations and solicited support from districts to ensure the success of the Prime Vendor pilot.

To get a better understanding of the system, councilors asked several questions and provided practical advice to implementers. One such advice was the need for a formal general circular, signed by regional leadership (e.g. RC or RAS) to inform procurement entities in the region about the new purchase method for medicines and related supplies that cannot be obtained from MSD.

On 19 November 2014 such circular, signed by RAS, was circulated to all district procurement entities.

6.0 Mobilization of the system for operations startup

After the launch, a mobilization period of one month was set aside for the Prime Vendor to prepare to receive orders from the districts; and districts staff to be trained, among other procedures, how to place orders with the Prime Vendor. This included introduction of the new financial management guidelines at health facility and district level. The capacity building to HFGCs of Dodoma region took into consideration the applicability of the new HFs Financial Management Guidelines and medicine supply management.

7.0 Monitoring & Evaluation

Please see Annex 3 and 4

8.0 Staff training

Staff training on operation of the system based on the available SOPs was conducted based on the following schedule:

- **A 3-day technical ToT workshop:** was conducted on 30 September – 2 October 2014 fort technical staff (RMO, RPs, DMOs, DPs and other relevant technical staff, e.g. potential staff of the PV Coordination Office). Trained staff formed a core team of trainers that trained health facility staff on the 4 essential non-technical SOPs (#s 1, 4, 5 and 10).

- **Health Facility Staff Training:** Trained technical staff (mostly District Pharmacists) managed the training for their respective health facility staff, basically on the four SOPs (#s 1, 4, 5 and 10). Training materials were based on the package of training referred above; translated to Swahili, including a 1-pager version of these four.
- Training sessions were held from 29 October – 13 November 2014. Immediately after training, HFs were expected to prepare and place their first orders with the Prime Vendor.
- By the end these training (and beyond – up to 31 December 2014 and the new year January 2015) Bahi District, Kondoa District and the Regional Referral Hospital placed their first orders (in October) with the Prime Vendor and received the ordered medicines within 3 weeks. As of June 2015, all districts have ordered from the Prime Vendor.

9.0 Coordination office and staff

A PV coordination office has been acquired inside the compound of the Regional Referral Hospital. It has been furnished to provide a suitable working environment for the RPV Coordinator and at least 2 staff to undertake the following duties:

- 1 senior staff/Pharmacist - as deputy/counterpart to RPV Coordinator
- 1 staff - to follow-up Prime Vendor performance; MSD stock position data and assisting HF to prepare their orders with the Prime Vendor; including follow-up, computation and documentation of system performance indicators.

Annex 2: Tool used to monitor tracer medicines availability at HFs

Date_____ **Name of data collector:** _____ _	**Name of HF in charge**_____ _ **Tel of HF in-charge**_____ _	**Facility** _____ **Type of facility**_____ **District**_____ _

1. Availability of medicines (A= dispensary, B= Health Centre, C= Hospital)
Which of the following medicines is available today?

Name	Available		QOH	AMC	MOS	Number of OS days
	Yes	No				
1. Artemether/Lumefantrine (ALU) tabs	1☐	0☐				
2. Artesunate inj or Quinine inj	1☐	0☐				
3. Amoxicillin 250mg caps or Cotrimoxazole tabs	1☐	0☐				
4. Amoxicillin syrup or Cotrimoxazole suspension	1☐	0☐				
5. Benzyl Penicillin 5MU injection	1☐	0☐				
6. Antiallergic e.g. Chlorpheniramine tabs	1☐	0☐				
7. Mebendazole or Albendazole tabs	1☐	0☐				
8. Griseofulvin oral or Clotrimoxazole cream	1☐	0☐				
9. Metronidazole tabs	1☐	0☐				
10. ORS sachet and Zinc	1☐	0☐				
11. Paracetamol 500mg tabs	1☐	0☐				
12. Contraceptive e.g. Medroxyprogesterone acetate (depo) injection	1☐	0☐				
13. Oxytocin	1☐	0☐				
14. Ferrous salt and folic acid	1☐	0☐				
15. Condoms	1☐	0☐				
16. Vaccine e.g. DTP vaccine	1☐	0☐				
17. Bendrofluazide tabs	1☐	0☐				
18. Sulfadoxine - Pyrimethamine (SP) tabs	1☐	0☐				
19. Ophthalmologic drops or cream	1☐	0☐				
20. Dextrose 5% or DNS or Ringer solution	1☐	0☐				
21. Surgical gloves	1☐	0☐				
22. mRDT	1☐	0☐				
23. Syringe and needle disposable	1☐	0☐				
24. Diazepam injection	1☐	0☐				
Total number of yes and no answers						

Result:

Availability in % = Total number of yes answers divided by 24 x100

Availability in % = _____

Annex 3: Five operational areas monitored to gauge performance of the PVS

An M&E handbook provides the framework for evaluating the performance of both the system and the Prime Vendor (Annex 4). System performance is being monitored on quarterly basis using 8 indicators covering 5 areas of the supply chain**:**

#	Areas of Measure & Indicator
1	Medicines availability
2	Utilization
	Proportion of districts and facilities that purchased from the PV
	Number of orders and value placed
	Proportion of complementary funds used by facilities
	Proportion of orders (by value) placed with the PV compared to all orders (MSD + PV)
3	District HQ delivery time to HFs
4	Promptness of payment to PV by district
5	Stock sufficiency

Annex 4: Performance measures for the Prime Vendor (as a supplier)

The performance of the Prime Vendor, on a scaled of 0 – 100%, is being monitored on quarterly basis using the following indicators and standard scores:

#	Performance Measure	Max Score
1	Overall physical product quality	20%
2	Service level/Order fulfilment rate	25%
3	Shelf-life remaining at time of delivery	10%
4	Delivery lead time	15%
5	Delivery point	5%
6	General quality of communication	5%
7	Overall satisfaction with PV services	20%
Total Score		**100%**

Annex 5: Key features of the Dodoma Region Prime Vendor supply system

- The PV concept is a pilot system as described under the bilateral governmental agreement between the GoT and the Swiss government, signed by MoHCDGEC and PO-RALG
- The PV system was conceptualized and designed in a fully transparent and participatory approach involving regional, district and health facility stakeholders from the beginning in meetings and hearings.
- The new system serves, as a safety net to the region should there be either a major stock rupture at MSD and/or an unexpected spike in demand due to natural or other disasters.
- The new system does not replace MSD but serves as a supplementary source for medicines and supplies out of stock or short supplied or not stocked by MSD.
- The system does not utilize conventional source of funding e.g. funds deposited by the government at MSD for health facilities; but utilizes supplementary sources of funds such as user/cost sharing fees, CHF, NHIF and basket funds.
- Public health facilities in the region have gained new options for improving drug availability without compromising quality or price.
- Districts pool their demand for supplementary medicines at the regional level, which allows benefitting from uniform prices in all districts.
- The PV system allows health facilities through Health Facility Governing Committees (HFGCs) to manage their own funds following stringent SOPs hence enhancing fiscal decentralization. This is in line with the government policy of empowering health facilities to be able to respond to community needs.
- The supply system is available to all districts in the region, with option of expanding coverage to other regions in in the country. In December 2016 the PV system has already been launched in two more regions (Morogoro and Shinyanga).
- The system supplies essential medicines and supplies of assured quality, safety and efficacy in accordance with the MoHCDGEC National Essential Medicines List and national oversight by the TFDA.
- The Prime Vendor maintains sufficient stock level to meet supply shortfalls experienced from MSD.
- The system initially delivers to district headquarters; with option in the future to deliver directly to health facilities.
- The region operates a PV office represented by a PV coordinator, a dedicated pharmacist and support staff to coordinate and monitor the performance of the system and to provide support to district as needed.
- The system has been closely managed and supported by mandated administrative structures such as a technical committee and a tender board appointed by the regional authorities.
- The new system appears to motivate MSD to improve services.

The PVS is sustainable as it is not a parallel system. It is built basing on existing government policies and guidelines and operates within the regional government structure.