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Schweizerisches Tropen- und Public Health-Institut
Institut Tropical et de Santé Publique Suisse

Associated Institute of the University of Basel

Swiss Centre for International Health

Health Promotion
and System Strengthening Project (HPSS)

CONCEPT BRIEF

NATIONAL COMPLEMENTARY SUPPLY SYSTEM FOR HEALTH COMMODITIES IN PUBLIC HEALTH FACILITIES

For

Swiss Agency for Development and Cooperation
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Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
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Abbreviations

BF	Basket Funds
CHF	Community Health Fund
DMO	District Medical Officer
DP	District Pharmacist
GoT	Government of Tanzania
HCW	Health care worker
HF	Health Facility
HFGC	Health Facility Governing Committee
HPSS	Health Promotion and Systems Strengthening (Project)
ILS	Integrated Logistical Supply
M&E	Monitoring and Evaluation
MSD	Medical Stores Department
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NHIF	National Health Insurance Fund
PO-RALG	President's Office – Regional Administration and Local Government
PPP	Public Private Partnership
PV	Prime Vendor
PVTB	Prime Vendor Board
PVTC	Prime Vendor Technical Committee
PVCO	Prime Vendor Coordination Office
RAB	Regional Advisory Board
RAS	Regional Administration Secretary
RFP	Request for Proposal
SCIH	Swiss Centre for International Health, at the Swiss TPH
SDC	Swiss Agency for Development and Cooperation
SOP	Standard Operating Procedures
Swiss TPH	Swiss Tropical and Public Health Institute
TFDA	Tanzania Food and Drug Authority
UF	User Fees

1 Introduction

Communities equate the quality of health care with the availability of medicines.[1] Understandably they perceive health services to be poor when medicines are not available and they have to purchase them from private medicines outlets.[2,3] On the other hand, clinicians, among other inputs, primarily depend on medicines availability to provide adequate health care. Good quality of care also encourages the population to enroll in community health funds (CHF). Medicines availability in most of public health facilities in the country is problematic. Most patients receiving medical consultation at these facilities are forced to purchase their medication from private pharmacy shops at high prices. The main cause of medicines shortage at these facilities, among other reasons, is their unavailability at Medical Stores Department (MSD), the sole supplier for public health facilities.

Overall problems with stock availability at MSD have been evident in recent years and projections of significantly increased demand, at least for the next several years has put further pressure on MSD's financial, physical and managerial capacity. Except for donor funded health products (for vertical programmes), MSD capacity to import core products as needed by health facilities in the country is declining. Consequently, MSD is increasingly dependent on local suppliers (MSD "prime vendors") to fill existing gaps. As a result of this MSD is progressively becoming a middleman; selling more expensive what is being purchased locally. Given population growth and the ensuing increase in Tanzania's healthcare requirements, it would be unfair to expect that any single vendor could meet 100% of a country's demand for drugs and supplies without incurring some degree of stock outs for various vital and essential supplies.

However, to MSD and MOHCDGEC credit, steps are being taken to resolve medicines and medical supply availability issues by various approaches. This includes for instance an independent study carried out to better understand MSD's debt and liquidity situation. The study will provide recommendations to support re-structuring and/or recapitalization, if needed, for improving the long-term sustainability of MSD.
At the same time the PO-RALG has requested the Swiss Tropical and Public Health Institute (Swiss TPH) implementing the Dodoma HPSS project and its Prime Vendor (PV) system, funded by the Swiss Agency for Development and Cooperation (SDC) to assist the Government of Tanzania, under the mandate of the current bi-lateral agreement between the two countries, to support the development of a solid and efficient backup system with private sector vendor(s). This system should apply lessons learnt and best practice from the on-going PV program in Dodoma, to fill existing health commodities availability gaps resulting from MSD's inability to fully meet the current demand.

[1] Nabbuye-Sekandi, J. et al.2011. Patient satisfaction with services in outpatient clinics at Mulago hospital, Uganda. Int J Qual Health Care 23, 516–523.

[2] 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.

[3] 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.

This concept note seeks to initiate a dialogue and the process for assisting the MOHCDGEC, and in particular MSD in developing and implementing a backup supplementary supply system for health commodities that augments MSD operations, specifically catering for public health to cost-effectively fill any supply gaps essential to ensure success of MOHCDGEC objectives.
Four approaches for developing a national backup or prime vendor system to support MSD can be described, of which option #1 is currently practiced by MSD and option #3 is implemented in Dodoma region.

Table 1: Options for MSD back-up system

	Option	Comments
1.	**Multiple vendors**, contracted by MSD with each supplying limited number of (1-5) items directly to MSD	Unlikely to resolve stock out problems due to coordination issues. Prices not competitive. Attracts conflict of interest and transparency issues. Supplies to be stored and logistically administrated by MSD.
2.	**A single national PV**, contracted by MSD/MOHCDGEC	Difficult to find one vendor with such national capacity. Difficult financial management of various fund flows, i.e. MSD funds and complementary funds (CHF, NHIF, UF, BF). Supplies to be stored and logistically administrated by MSD
3.	**A singe regional PV**, with MSD as one of the signatories	Provides an option for step-by-step (region by region) allowing for lessons to inform efficient and cost-effective scale-up. Not dependent on public warehousing and logistics. Ownership and clear financial flow of complementary funds. Slow implementation. Small business volume affecting pricing.
4.	**A zonal PV**, with one PV per zone, jointly selected by regions comprising the zone with MSD as one of the signatories	Offering PV competition among zones and larger business volumes hence lower prices. Possible zonal coordination with shorter leadtime, shared warehousing and transport. Rapid scale up. Separation of fund flow. Complex to implement due to the massiveness of a zone (comprising many regions) with varying interests and differences.

Any backup supplier(s) or PV model will need to be embedded in the broader and systemic context recognizing the importance of additional activities at the level of HFs and district level such as capacity building of health care workers (HCW), close monitoring and evaluation and measures to strengthen accountability to avoid leakage. Supply chains as providers of medical supplies also depend on recipients at district and health facility level being competent, responsive, responsible and accountable. Therefore any backup system to MSD needs to also consider a bundle of measures at district level to arrive at a best possible performance in terms of making medicines available and accessible.

Implementation of this complementary backup supplier programme will require extensive cooperation from both the public and private sectors. A thorough evaluation by government officials to determine feasibility of this program for the whole nation is required in order to help resolve the issue of medicines availability in the country. Maintenance of government commitment to MSD will be a prerequisite to avoid negative incentives to reduce funding.

2 The Prime Vendor Model in Dodoma Region

The Dodoma PV concept is a pilot system developed under the bilateral governmental agreement between the GoT and the Swiss government, signed by MOHCDGEC and PO-RALG. Consequently, the PV system for Dodoma region is anchored and integrated into and under the overall governance structures of Dodoma Regional Administration and Local Government (RALG) headed and guided by the Regional Administration Secretary (RAS), and fully integrating the participating district and municipal councils.

Operationally, it is managed through administrative structures, appointed by the regional authorities; namely: (a) A Prime Vendor Board (PVB) comprised of eleven members drawn from the region's seven districts,[4] is a decision making board for overseeing the general affairs of the PV system in the region. It advises and is answerable to the RAS in all matters related to the operations of the PV program in the region; (b) A Prime Vendor Technical Committee (PVTC) that reviews, on quarterly basis, activities of the PV performance as a system and those by the supplier; it accordingly lists issues and challenges for the attention and guidance of the PV Board; (c) Ad hoc bid evaluation committees reporting to and directly answerable to the PVTC; (d) A Prime Vendor Coordination Office (PVCO), which coordinates monitoring and evaluation activities of the program on quarterly basis. It reports to the PVTC.

The primary objective for establishing the PV system is to improve availability and equitable access to health commodities in public health facilities in Dodoma region. The 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. It allows health facilities through health facility governing committees (HFGC) to manage their own complementary funds (User fees, CHF funds, NHIF funds, Basket Funds, etc.) following stringent standard operating procedures (SOP) hence enhancing fiscal decentralization, in line with the government policy of empowering health facilities to be able to respond to community needs. These funds are used for direct purchase from the PV. The system supplies essential medicines and supplies of assured efficacy, safety and quality in accordance with MOHCDGEC National Essential Medicines List and national oversight by TFDA.

The PV system is implemented under the auspices of the Health Promotion and Health System Strengthening (HPSS) project, which, among other components, is comprised of a medicines supply management strengthening constituent, incorporating the development and implementation of a PV (supplementary supply) system pilot aimed at improving medicines availability at public health facilities in the region. HPSS is funded by the Swiss Agency for Development and Cooperation (SDC) and implemented by the Swiss Centre for International Health (SCIH) of the Swiss Tropical and Public Health Institute (Swiss TPH). A high level Regional Advisory Board (RAB) oversees implementation of the HPSS project in the region. The Dodoma PV system was officially launched in September 2014 and has since been operational. It is closely monitored within an M&E framework and a SOP manual that was

[4] Members of the PV Board are drawn from an array of official designations which include: a medical officer in-charge of Dodoma referral hospital (chair), a district medical officer, 5 district tender board chairs, a regional and district pharmacist, a regional procurement officer, and a regional financial controller.

implemented through training of Health Facility Governing Committees (HFGC), health facilities, district and regional health actors. A more comprehensive description of the PV model Dodoma is available upon request. The figures below illustrate the process flow, and the management and oversight set-up in Dodoma region.

Figure 1: Steps in MSD and PV process flow numbered chronologically

		MSD		
		1. MSD Stock out Report		
		🡻		
HEALTH FACILITY	🡺🡸	**DMO/DP**	🡺🡸	**PRIME VENDOR**
3. Quantification of PV needs	🡸	**2.** MSD Stock out Report		
4. Order & Payment	🡺	**5.** Order consolidation & conveyance	🡺	**6.** Order receipt, picking, packing & labeling
		8. Order receipt & inspection 1	🡸	**7.** Order delivery
		9. Inspection report 1		
		🡻		
11. Order receipt & inspection 2	🡸	**10.** Delivery to/Collection by HF		
12. Inspection report 2	🡺	**13.** Payment to PV	🡺🡸	**14.** Payment acknowledgement

Figure 2: Management, Oversight & Controls

PRIME VENDOR		**RALG**		
🡹🡻				
PV COORDINATION UNIT	🡺🡸	**TECH COMMITTEE**	🡺🡸	**PV BOARD**
System & Vendor M&E				
1. Indicators data collection: system & vendor performance reports & related matters	🡺	**2.** Review & Submission to PV Board	🡸🡺	**3.** Report acceptance & guidance on issues
5. Support supervision & feedback to districts & HFs	🡸	**4.** Feedback		

3 Features of a national backup supply system for health commodities to public health facilities

The preferred option for a national backup supply system with a zonal/regional scenario (# 4 on page 3) will augment MSD and not replace it, will provide nationwide coverage, convenience and competitive product pricing and supply of TFDA quality assured medicines. Vendor selection will be transparent with the full participation of Local Government Authorities (LGAs). Purchases from PV will be funded through complementary funds e.g. User fees, CHF funds, NHIF funds, Basket Funds with fiscal decentralization under the direct control of Health Facilities Governing Committees (HFGC).

1. **Augmenting MSD:** The new system will entail the selection and approval of capable vendors that will supplement the services of MSD. Any new, approved private sector suppliers are not a replacement for MSD. Instead, they will strengthen the efforts of MSD to ensure that public sector requirements are satisfied. This is important given the national strategic position and role of MSD. The new backup system will provide a safety net to the government should there be either stock rupture at the MSD and/or an unexpected spike in demand.

2. **Nationwide coverage:** The backup supply system will be available to all regions of the country. The approved alternative vendor(s), provided with estimated annual requirements for health facilities, will be responsible for assuring sufficient inventory of health commodities to meet possible MSD shortfalls. When a facility is faced with an out of stock situation (and items are unavailable at MSD), supplies could be ordered directly from the alternative vendor who will make arrangements to have the required items delivered either to the health facility or to a location convenient to the HF, based on contractual agreement. An optimal scenario needs to consider cost-effective warehousing capacity as well as transport logistics.

3. **Complementarity:** Both the public health system MSD and the private vendor will benefit from the introduction of complementarity between the two systems, hence a public-private partnership (PPP). The new system will provide an opportunity to improve cost-efficiency to both players in the system. Public health facilities will gain new options for improving drug availability without compromising quality or price. It should be expected that secondary to complementarity pressure, MSD would be motivated toward improving its services to public and faith-based health facilities.

4. **Essential medicines selection and price control:** The government will continue to have control on medicine selection, prices (as negotiated with the selected private sector backup suppliers), and assure equitable access to essential medicines. Health commodities on the National Essential Medicines List will be supplied in line with MOHCDGEC policy.

5. **Convenience, product pricing:** Since the selected private sector vendor will be required to deliver competitively priced products, a new dimension of convenience will be afforded to public health facilities. Private suppliers might offer new types of services, including direct delivery and electronic ordering. Product prices will be competitive with those from MSD. An important aspect of the new system will be to have approved vendor price lists distributed to all public health facilities in the region. Districts will pool their demand for supplementary medicines at the zonal level. This will allow them to benefit from economies of scale. Prices, depending on contract terms, will remain fixed at least for one year and in subsequent years reviewed semi-annually. Serious thoughts need to be given to inform how various private sector vendors could provide similar prices throughout the country.

6. **Medicines Quality:** Only Tanzania Food and Drug Authority (TFDA) registered health commodities will be supplied by the selected vendors. Suppliers could be required to participate in drug quality assurance activities and report results to TFDA.

7. **Vendor Selection:** Selection and final approval of vendors will be made in line with procedures described in the Procurement Act and Government regulations. Methods used in the selection of vendors will be reviewed to enable the adaptation of a robust and transparent vendor selection process.
   - A prequalification process will inform the selection process (on vendor capacity: financial, stocking, warehousing, geographical distribution and reach, business associates, legality of and years in business, etc.)
   - A Request for Proposal (RFP) for short-listed vendors will consist of a technical component (seeking vendor agreement to key elements of the contract) and a financial component (items pricing)

8. **Contract:** Contracts signed with the approved vendors will specify essential articles and paragraphs, similar to the PV contract signed between Dodoma RALG and their current PV (copy of contract available on request). Signatories to the contract(s) will include all relevant parties (regional PO-RALG high-level official e.g. RAS or RC, MSD, and the appointed vendor). To ensure vendor margins are attainable, prices will be those agreed upon by parties to the Contract(s) but at acceptable market prices plus other overhead cost such as transportation, depending on the location of the vendor.

9. **Purchasing at PV:** Purchases to PV by districts will be triggered by what is not available and/or expected to be short-supplied. MSD as a party to the PV agreement(s) will be required to issue a statement indicating unavailability of products before health facilities make their routine orders. This will enable HFs to make their advance orders to a PV to receive health commodities from MSD and PV(s) at the same time (to achieve 100% availability at all times). Another strategy could be that zonal MSD communicates stock outs directly to the zonal resp. regional PV, thus shortening communication times to districts/HFs and ensuing lead time for delivery.

10. **Public sector funding, funds flow and controls:** Supplementary health facility funds (user fees, CHF funds, NHIF funds, Basket Funds, etc.) under the control of HFGC, will be used for direct purchases from the PV. Separation of financial flows (MOHCDGEC allocation to MSD vs complementary funds) needs to be managed carefully to avoid a backlash on fiscal decentralization. Adherence to adopted local government reform and associated financial accountability and procurement standards will help ensure that public funds are used appropriately. The PV system will allow health facilities through HFGC to manage their own funds following stringent SOPs hence enhancing fiscal decentralization. This is in line with the government policy of empowering health facility to be able to respond to community needs.

11. **Monitoring and Supervision:** The MOHCDGEC with MSD and perhaps with other ministries (e.g. PO-RALG - TAMISEMI), will be responsible for contract management with the private sector supplier(s). A vendor performance, monitoring and rating system adopted from Dodoma region is recommended for monitoring and supervision of vendor performance in respect to terms and conditions of contracts. PO-RALGs, in close collaboration with MSD zonal offices, through a zonal Prime Vendor Coordination Office (PVCO), as part of contract management, will monitor vendor performance related to adherence to agreed prices, product quality, shelf life, delivery performance, customer

satisfaction etc. On the overall the PVCO will ensure that approved private suppliers adhere to contract terms and are paid on timely basis for every service rendered to public health facilities. District and their respective health facilities will adhere to developed system operations procedures.

4 Institutional set-up: roles & responsibilities

Table 2 below summarizes roles and functions of institutions involved in the overall implementation and management of a national PV system at zonal/regional level.

Table 2: Institutional set-up

	#	Institution	Roles & Functions
Central level Public sector	1.0	**MOHCDGEC**	Overall Policy Guidance & Oversight
	1.1	**TFDA**	National safety of Health products (QA/QC)
	1.2	**MSD HDQ**	Primary supplier of TFDA approved health commodities to public & FOB health facilities
			Supply policy monitoring and operational guidance
			Prequalification of suppliers eligible for PV tenders at regional level (shortlisting)
			Signatory to PV Contract
	1.3	**MSD (HDQ/Zones)**	Monthly Stock Out data
			Support of PV through zonal warehouse space
			PV Contract management, M&E and regular reporting
Zonal/regional level Public sector	2.0	**PO-RALG HDQ**	Overall Policy Guidance & Oversight
	2.1	**Regional PO-RALG RAS Office**	Overall Policy implementation & Oversight
			Signatory to PV Contract
	2.2	**PV zonal/regional Board**	Oversight PV advisory Policy & Operations
			Oversight for transparent process for selection of PV
			Appointment & approval of the PV
	2.3	**PV TC**	Technical Review & Advisory Committee
			Selection & quantification of health products to be procured from PV
	2.4	**Ad hoc bid evaluation committee**	Independent evaluation of PV selection bids
	2.5	**PV Coordination Unit**	PV Contract management, M&E and regular reporting
			Training, coaching & support supervision
District level Public sector	2.6	**DMO & District Pharmacist**	Order coordination, consolidation & submission to vendo
			Order delivery/collection to HFs
			Payment to Vendor
			Receipt & Inspection (mid-way)
	2.7	**Health facilities**	Use of MSD Stock out information
			Quantification of needs from PV
			Order & payment to districts
			Receipt & Inspection (end user)
Private sector	3.0	**Prime Vendor**	Complementary supply of TFDA approved health commodities
			Signatory to PV Contract

5 Implementation

Establishment of the Dodoma PV program (from conception of the idea to launching the program) took about 3 years. Therefore, the development of an alternative supplier/prime vendor program for the entire country would require extensive planning and preparation on the part of Government and private sector participants (advocacy and sensitization, among others). For an expedited process, it is therefore projected that the planning and preparation phase may last twelve months (for each region, possibly covering several regions at the same time, preferably regions constituting a MSD zone).

The following implementation plan is proposed, indicating step-by-step processes and milestones to be achieved up to the launch of the system by individual region/zone.

Figure 3: Implementation plan