

**Use of a 3rd Party Logistics Provider (3PL) for
Direct Delivery of Medical Commodities:
Learnings from a Pilot Implementation in Tete
Province, Mozambique**

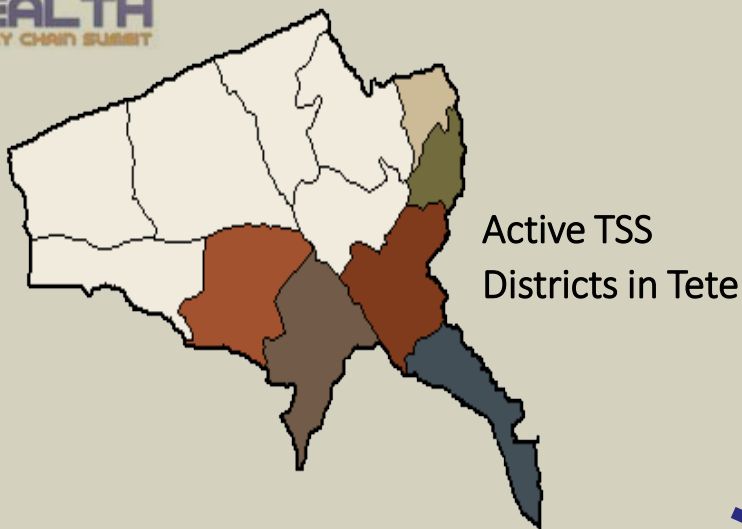


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Tanzania, November 2016



Life at the last Mile: Tete Province

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Statistics:

- 70% DTP-Hib-HepB immunization rates
- Only 53% of children fully immunized (7 % HIV prevalence rate)
- **1 doctor** per about 30,000 people
- Infant and juvenile mortality: 129 / 1,000 (IDS 2011)

Population: 2.6 million people

Poverty index: 42%

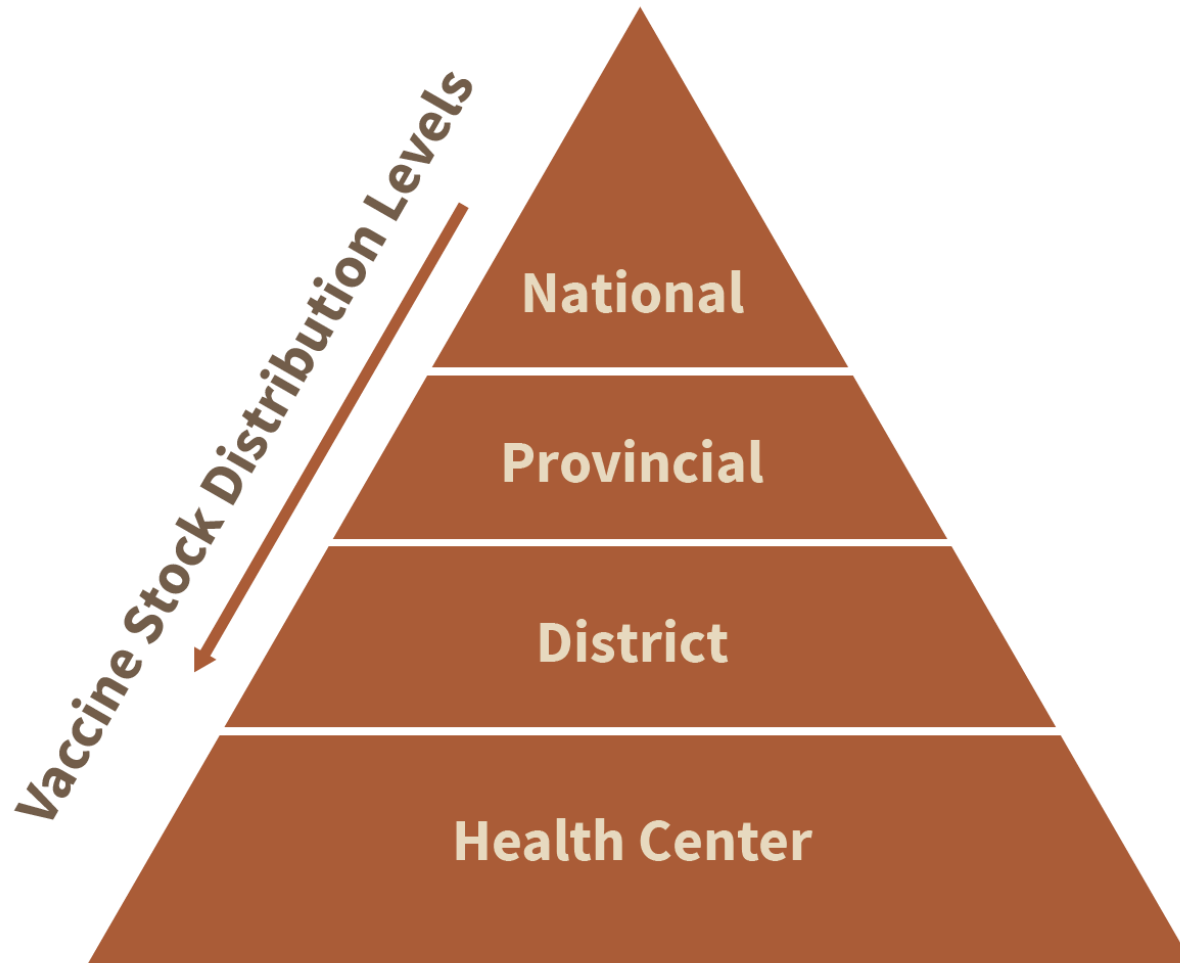
Illiteracy:

Male - 39.7%; Female -69.1%





What did the original distribution model look like?





What does the new distribution model look like? A TSS Snapshot

DIRECT DISTRIBUTION

The goods are monthly distributed directly from the DPM (Provincial Medicines Depo) to the health units without excluding DDM (District Medicines Depo).

NO BOUNDARIES

The distribution routes do not stay within administrative boundaries of the districts, but organized based on the most efficient routes between certain points.

TRANSPORT

The carrier only distributes what they are hired to carry - ambulances (traditionally used for distribution) carry only patients.

- A well maintained fleet reduces the risk of unavailability of the vehicles to some of the necessary ones and increases the time of operation of the same ones.

JUST IN TIME

Goods are delivered from the province to the HC on a minimum number of days and in the right quantity enough to cover the month. Distribution follow a pre-defined calendar.

LOW COST

Lower overall cost and lower unit cost - higher capacity, meeting the real needs of the population.

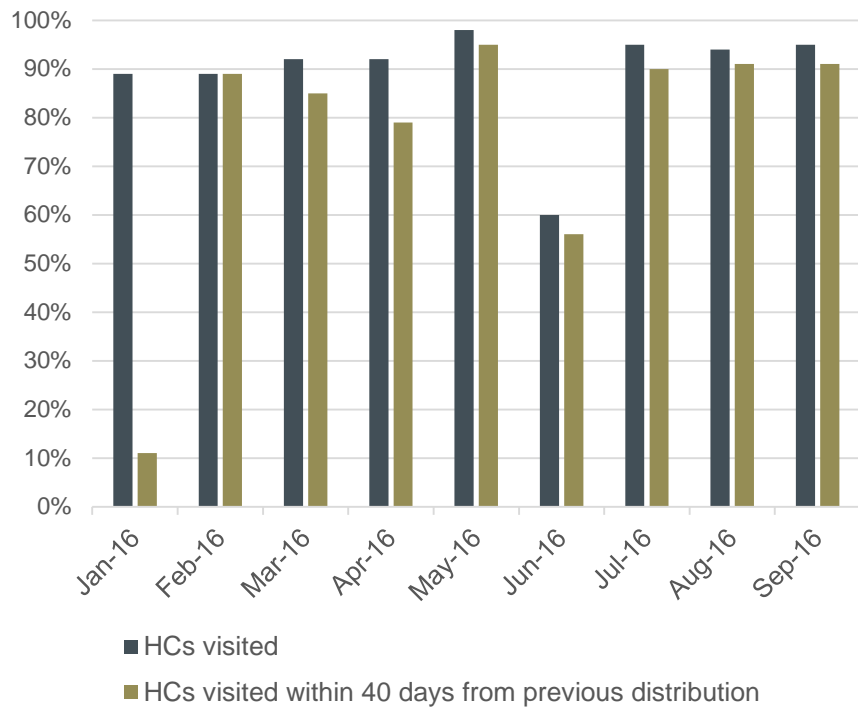
- Carriers are encouraged to allocate maximum capacity per journey in order to reduce unit costs = high efficiency. Compensation is linked to performance. Incentives lead to high performance.



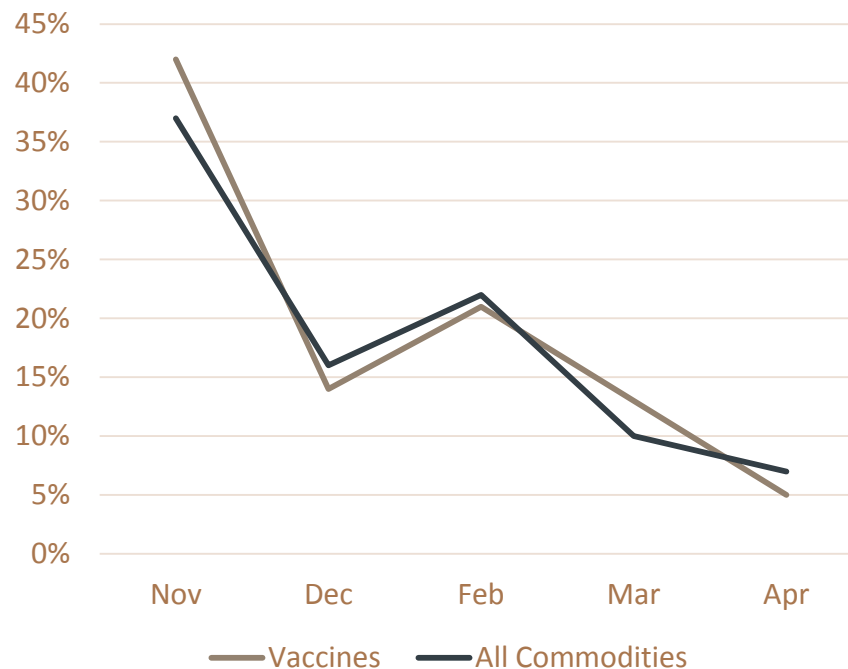
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What are the results in the first year?

2016: Comparison of Visit Rates and Delivery Intervals between Distributions



Stockout Rate (Health Centers that had a Stockout at Time of Visit)





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How did we get those results in the first year?

COLLABORATION AND INTEGRATION



DPS

- Secondary responsibility in project management
- Handling of medicines (delivery / receipt)



VillageReach

- Primary responsibility in project management
- Produce operational reports and general supervision



3PL

- Ensure loading, stowage / unloading and correct transportation of medicines in the car
- Logistics data collection at the health facilities



MSF

- Oversight of ARV Data collection & analysis
- Financial support to 3 PL system

More predictable, reliable and constant
Data are recorded correctly and electronically and in the instant
Reduced charge in health units

Instant and increased transparency on inventories of drug stock and cold chain



Successes

INTEGRATION

- VillageReach and MSF-Tete participate in the pilot with Technical and Financial support.
- 4 entities (DPS, VR, MSF and 3PL) are all involved in reducing the stock breakages in vaccines, ARVs, registration books and Kits, by assuring transportation from Provincial Depot to the Health Units
- Interest nationally for the system and its impact.
- Increase collaboration with other provinces and organizations for the success and improvement of the system.

COLLABORATION

- The private sector is quicker / more efficient in distribution in 7 to 10 days in the three districts, Mutarara-Doa, Changara¹-Marara and Moatize on average 3 days per District.
- Operations (distribution and data collection) with minimal involvement of health technicians in logistics.
- Monthly collection of stock information and data related to logistics;
- Successfully expanded to 3 more districts
- Inclusion of Health Facilities KITS in the distribution

Challenges



- ❖ Improve the quality of data collection by the transport company's logisticians by **adapting the tool DATAWINERS** to capture non-vaccines commodities use and stock data electronically;
- ❖ Ensure transportation and distribution at all times of year by **ensuring cash flow**;
- ❖ Improve the **maintenance plan** to increase availability of the cold chain in the Province;
- ❖ **Integrate more drugs**, in the medium term and long term integrate all commodities;



- ❖ Improve the **timely submission of MMIAS** (ARV requisitions) by introducing electronic version ;
- ❖ **Continuous training** to face the ongoing replacement of health technicians;
- ❖ Continuous supervision at the health facilities to **improve quality of data** and stock management;
- ❖ Adapt requisition and information systems SOPs with the system in place, to enable the direct delivery of various other medicines;
- ❖ Increase the **managerial responsibilities of the Provincial Directorate**,



Stakeholders' Reactions / Support



Presentations about the system
> increased stakeholders interest

Increased Recognition at all
levels of the country

Field visits by National
and Intl decision makers

Peer Learning Visits
made by other
provinces & countries



Goals 2016/ Expectations 2017

- ❖ Improve the quality of data collected, providing ongoing training to US technicians.
- ❖ Continue expanding geographically by piloting in other provinces.
- ❖ Pilot the PELV system – intermediary ware houses
- ❖ Discussion over the system nationally – gradually pass off the financial responsibility to DPS





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THANK YOU!

