

Establishment of a Prime Vendor system to complement public sector supply as a public-private partnership in Tanzania



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Establishment of a Prime Vendor system to complement public sector supply as a public-private partnership in Tanzania

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What is a Prime Vendor?

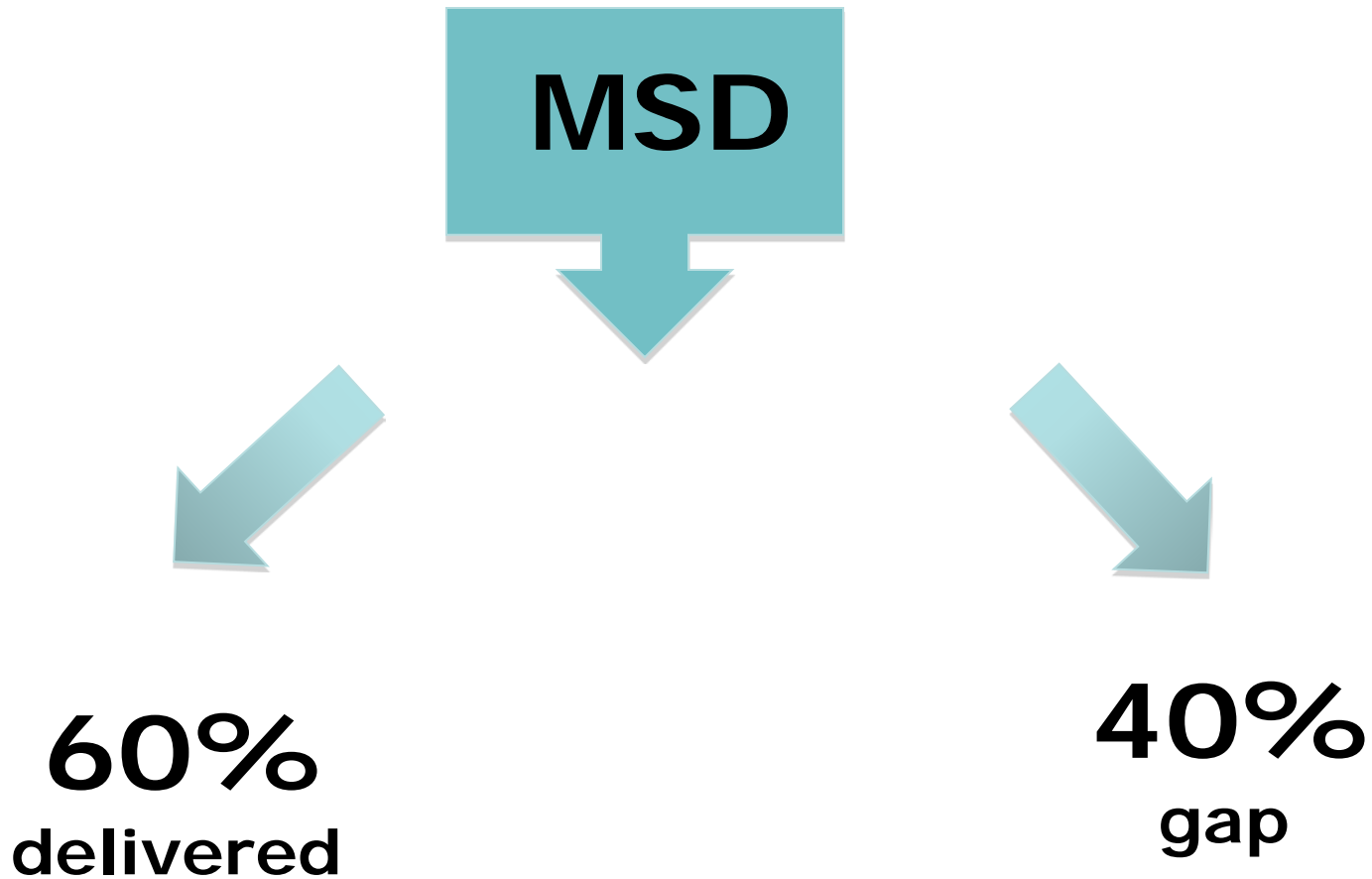
- = Primary supplier (or vendor)
- = Sole supplier (or vendor)
- = One supplier (or vendor)



As opposed to multiple suppliers (vendors) – where public health facilities usually purchase their requirements when these are out of stock or insufficiently supplied by Medical Stores Department (MSD)



Level of medicines supply to facilities 2011

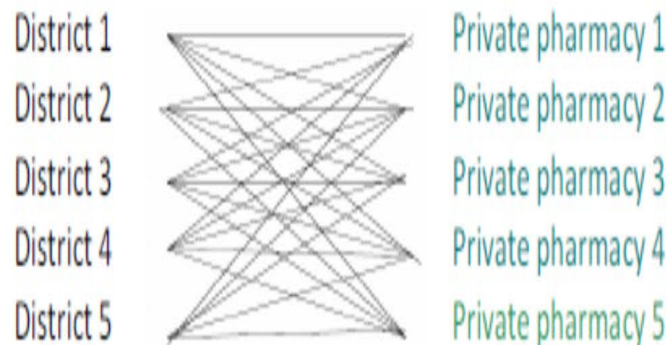


Complementary supplies in 2011

Complementary purchases from the private sector were

- from multiple sources
- intransparent
- uneconomic (high product prices, per diems, travel costs)
- without assurance of quality of what was being purchased

Figure 1: Supply from private pharmacies





Prime Vendor System: Rationale

To address

- the 40 % supply gap from MSD and
- the bureaucratic, lengthy and intransparent procedure for complementary purchases
- Efficiency-economies of scale
- **A Prime Vendor system was established**
- Complementary funds available from CHF, NHIF, CS
- In case of o/s, districts purchase from one private supplier → regional approach with regional pooling of orders allowing economies of scale
- Public private partnerships (PPP) promoted by GoT

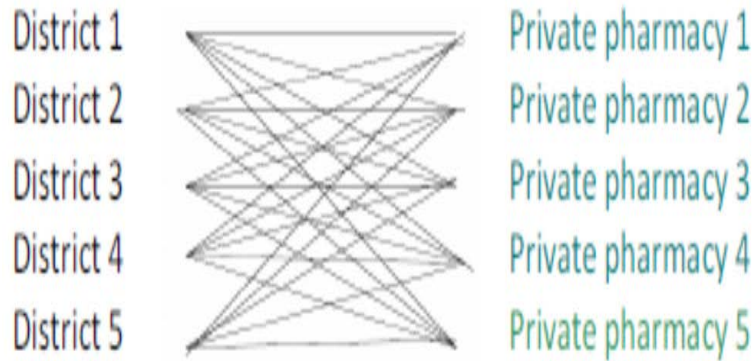
Overcoming the situation

Filling the gap with a **Prime Vendor system**

- Purchase of supplementary medicines from one private supplier= Prime Vendor with complementary funds

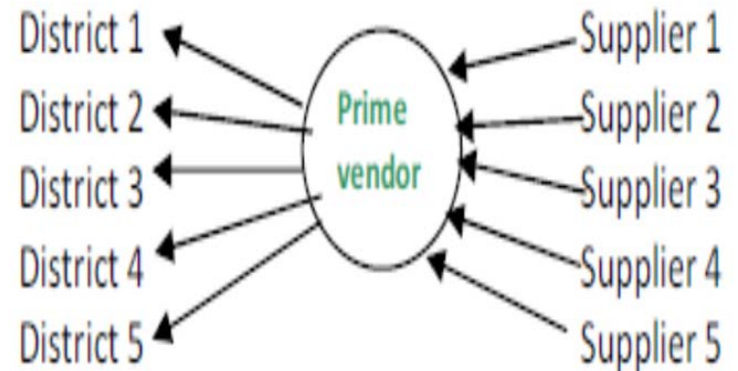
Before PV

Figure 1: Supply from private pharmacies



After PV

Figure 2: Supply through prime vendor





Objectives of the PV system

- To improve medicines availability and equitable access to health commodities in health facilities (HF)
- To bridge the gap of what is missed from MSD
- Pooling of orders and economies of scale
- Complementing MSD supply **NOT** replacing MSD supply
- To support CHF enrollment and other health insurance schemes
- To make procurement of medicines and supplies by councils more systematic and transparent
- To promote public private partnership (PPP)



Funding for the PV system

Complementary funds:

1. Cost Sharing (CS) /User fees
 2. Community Health Fund (CHF)
 3. National Health Insurance Funds (NHIF)
 4. Council Health Basket funds
- Does not utilize conventional funds for health facilities normally allocated to HFs and directly deposited to MSD
 - Fiscal decentralization to HF own funds



Features of the PV System

Features

- Complementary funds used from CHF, NHIF, UF
- Public financial management (PFM) guidelines
- Public private partnership (PPP)
- Supply channel complementary to MSD and in collaboration with MSD
- Regional approach with regional pooling of orders
- Simplified procedures for complementary purchases
- Strong ownership by regional authorities: RMO, RAS

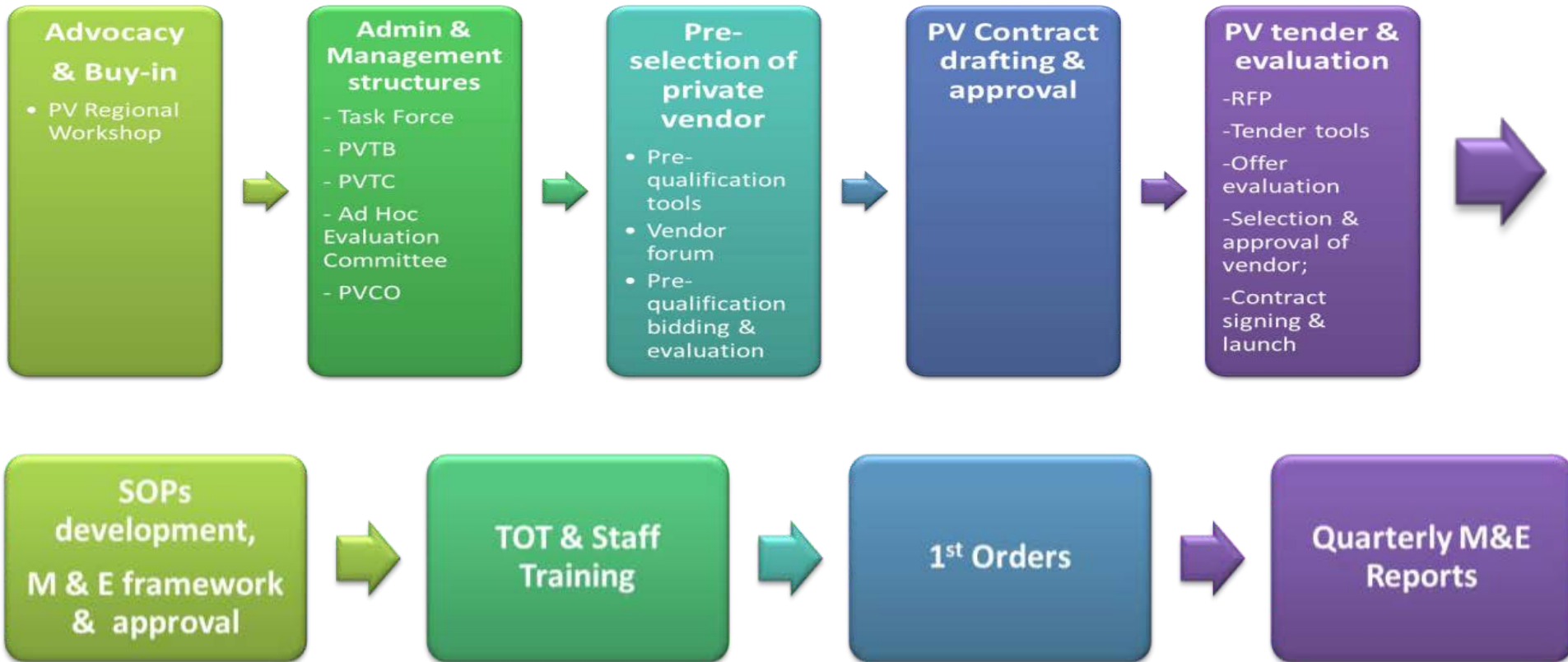


Prime Vendor: Steps and process

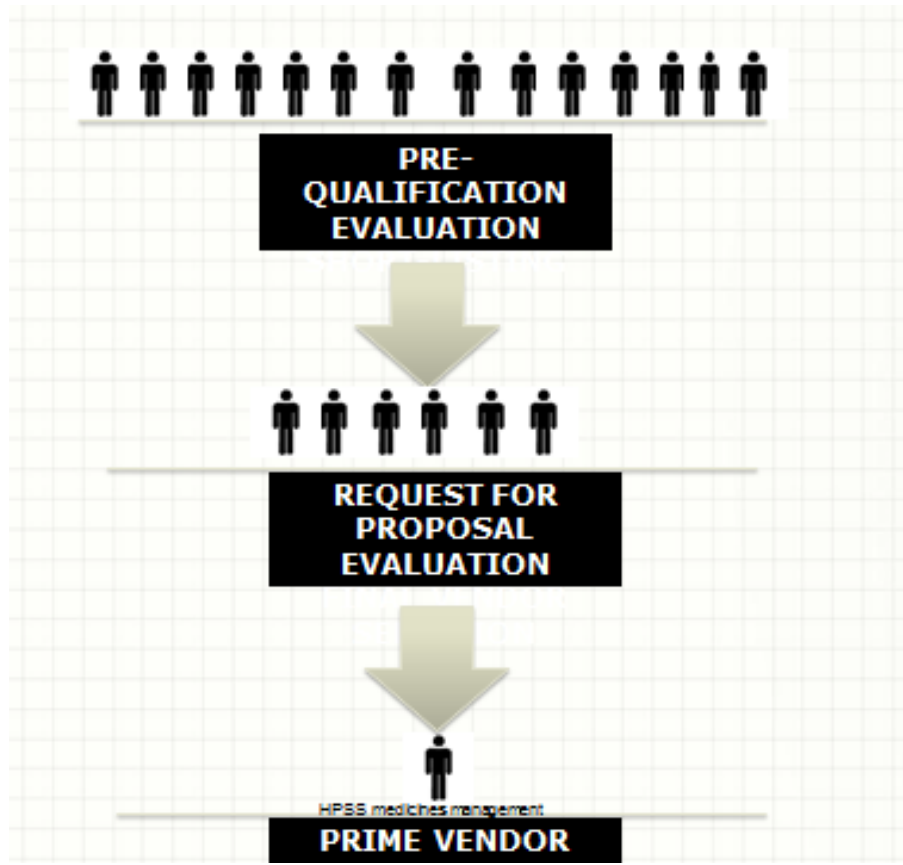
- **Concept** for PV system endorsed by districts and region
- **Advocacy** with regional workshops
- **Technical Committee:** PQ questionnaire, RFP, Vendor Guide, Evaluation Criteria
- **PV Forum** for potential vendors to introduce PV concept
- **PQ** Evaluation Committee evaluates questionnaires & recommends short-listed/prequalified vendors
- **RFP** to successful short-listed/prequalified vendors
- **Evaluation Committee assesses** submitted **offers** & recommends most competitive bidder
- Regional PV **Board:** approval
- Development of **contract** for selected PV
- Adjudication of **recommended Prime Vendor**



Establishment of the system – chronological steps



Prime Vendor selection





Prime Vendor system

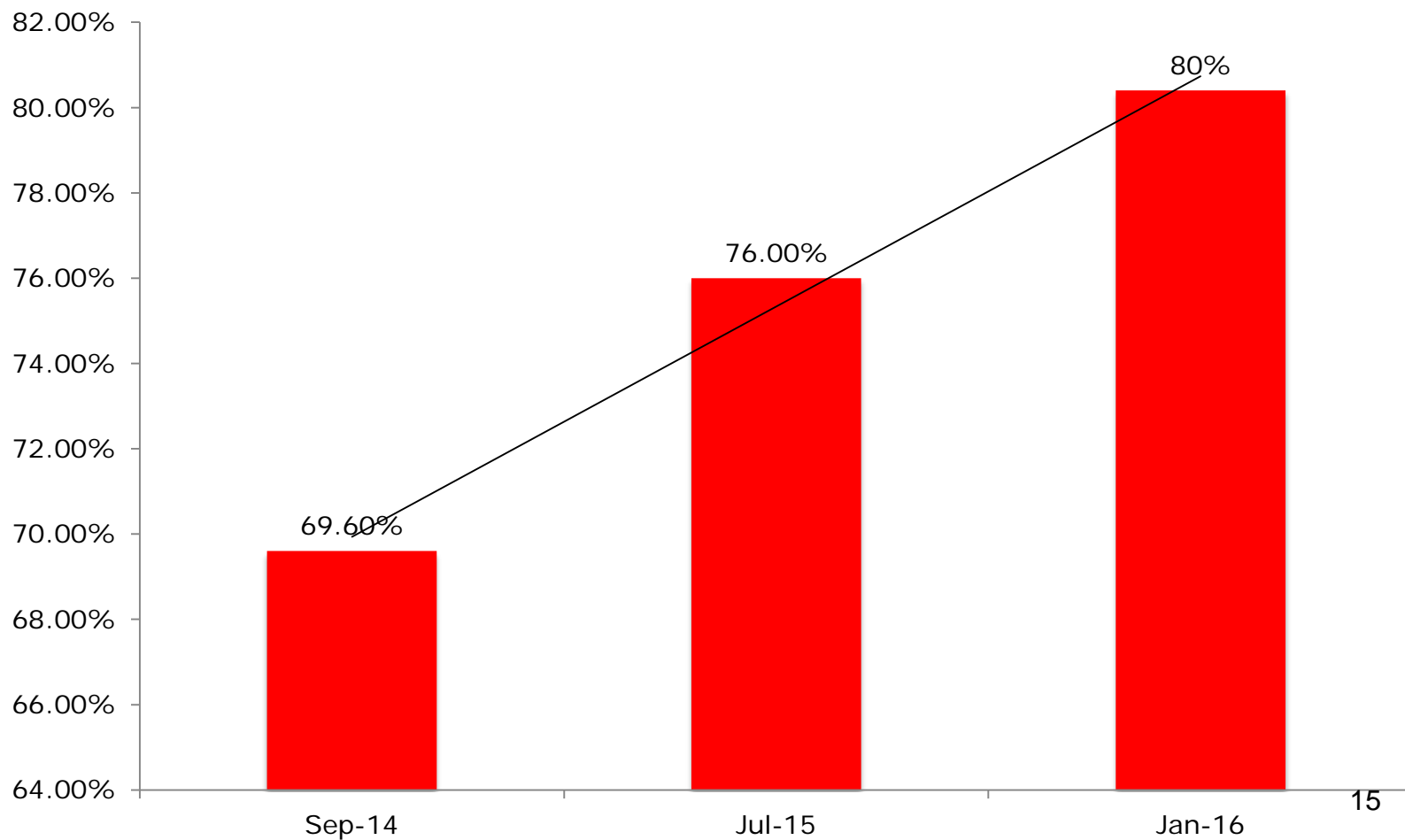
- **PV coordination office:** Regional coordinator and dedicated staff for monitoring and oversight
- **SOP manual** and training of all actors
- **M&E framework** with indicators for monitoring
- **Contract** between regional authorities of Dodoma and selected vendor
- **Funding:** with complementary funds (CHF, NHIF, user fees and basket funds).
- **Technical committee** and a **Board** appointed by regional authorities: administrative structures
- **Audits** to strengthen accountability



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Implementation results Dodoma

1. Medicines availability



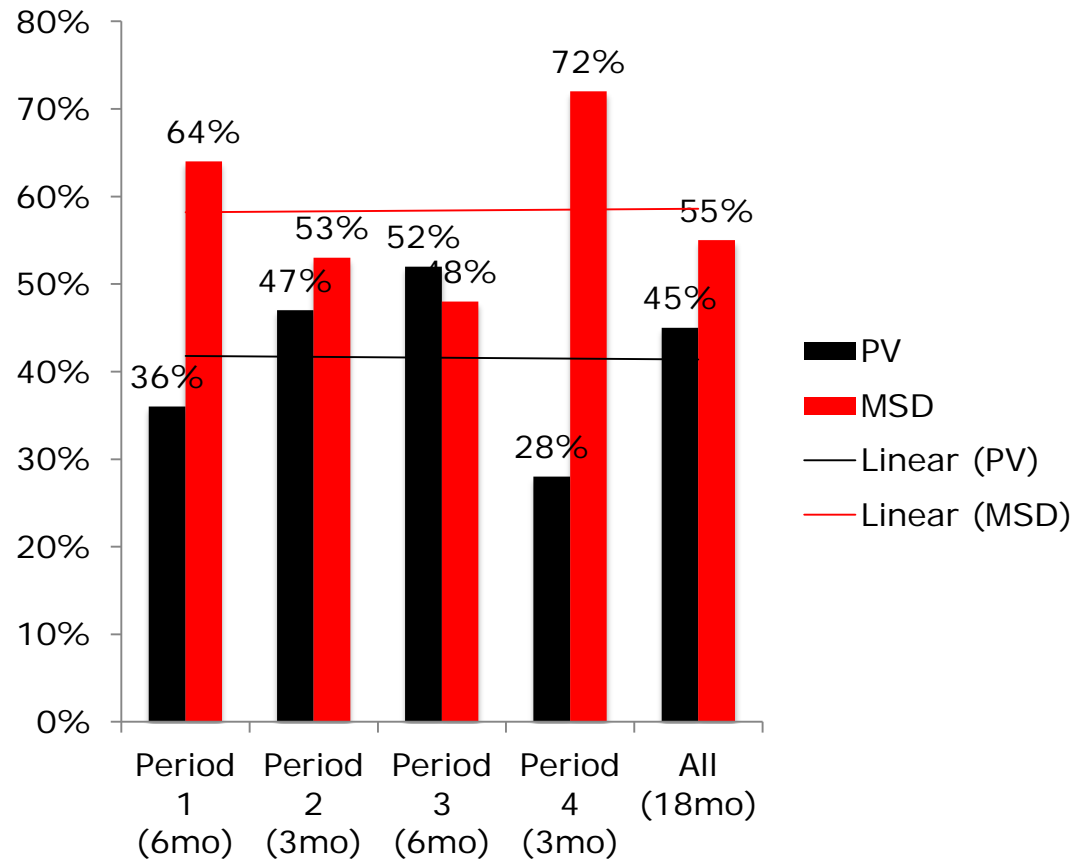


Implementation results Dodoma

3. Purchases: PV vis-à-vis MSD

Relative purchases by councils from MSD versus from PV in the first 18 months

TSh 2.4b (MSD) vs **TSh 2.0b (PV)**



Prime Vendor system performance

- Scheme of 7 performance rating criteria (indicators)
- Overall rated “good” on a scale of:

1. Excellent = 95% - 100%

2. Good = 80% - 94%

3. Satisfactory = 65%- 79%

4. Poor = <65%





Prime Vendor system: Summary

- PV concept is a pilot system under the bilateral governmental agreement between the GoT and the Swiss government, signed by MoHCDEGEC and PO-RALG
- The new system serves as a safety net to the region in case of major stock rupture at MSD and/or an unexpected spike in demand
- PV system does not replace MSD but serves as a supplementary source for medicines and supplies out of stock or short supplied by MSD
- Districts pool their demand for supplementary medicines at the regional level allowing and benefiting from competitive prices (economies of scale) – throughout the year



Prime Vendor System: Summary

- 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 fees, CHF, NHIF and basket funds
- Public financial management (PFM) guidelines implemented
- Health facility governing committees (HFGC) are empowered to manage their own funds following stringent SOPs hence enhancing fiscal decentralization
- PV system supplies essential medicines and supplies of assured quality, safety and efficacy in accordance to MoHCDGEC National Essential Medicines List and national oversight by the TFDA



Prime Vendor System: Summary

- Close management and support by mandated administrative structures (TC and Board) appointed by regional authorities
- Strong ownership by region: RMO, RAS
- The PV system is available to all districts in the region, now expanding to 2 other regions in the country
- PV maintains sufficient stock 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

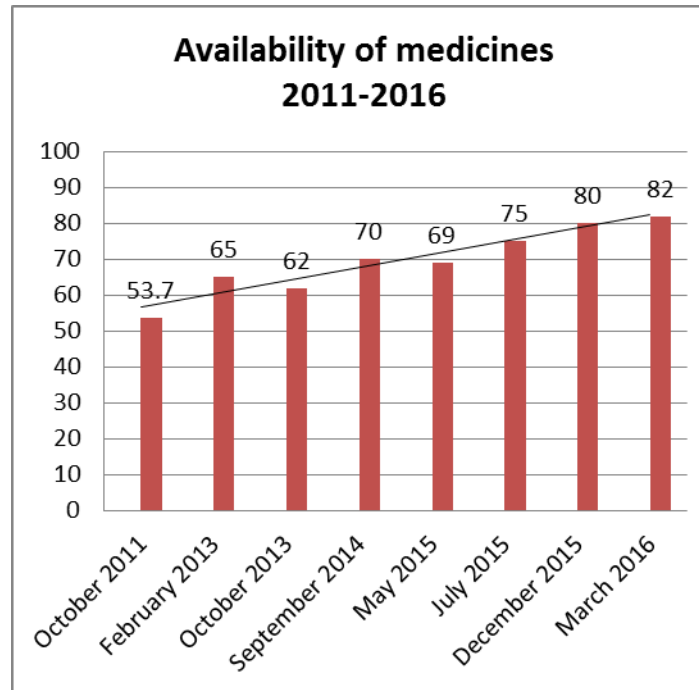


Conclusion

- PV system in Dodoma Region is anchored in regional health structure and decentralisation policy of the country
- New option for public health facilities to improve medicine availability without compromising quality or price
- With improved quality of care, population joins CHF and renews membership, in turn generating funds to ensure medicines supply
- Health facilities are empowered to purchase supplementary medicines and supplies with own sources through a shortened and simplified procedure
- **The PV system ensures that health facilities have medicines and medical supplies to meet the need of the people, by supplementing the regular government supplies with additional supplies.**

Conclusion

- Due to innovative PV system and accompanying measures, mean medicine availability increased by 40%



However, it is important to note that the PV system is not a panacea (cure all)! A combination of interventions is needed to improve medicines availability



Implementation: lessons learnt

Challenges

- Diversity of districts, leaders and size of project
- Frequent rotation of health staff and authorities
- Interventions that increase transparency tend to cause bypassing
- Resistance by interested parties
- System, structure and procedures in place: human factor will determine extent of success
- Absorption capacity of already overburdened health staff for new systems is low and has to be respected
- Regional PV system is time-intensive following good procurement practice (GPP)

Implementation: lessons learnt

Drivers

- Strong regional support by RMO and RAS
- Leadership by committed DMOs
- Ownership of project by region and stakeholders
- Good and engaged project implementation team
- Participation and engagement of actors creates ownership
- Recognition of good performance
- Systemic approach crucial





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Acknowledgments

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