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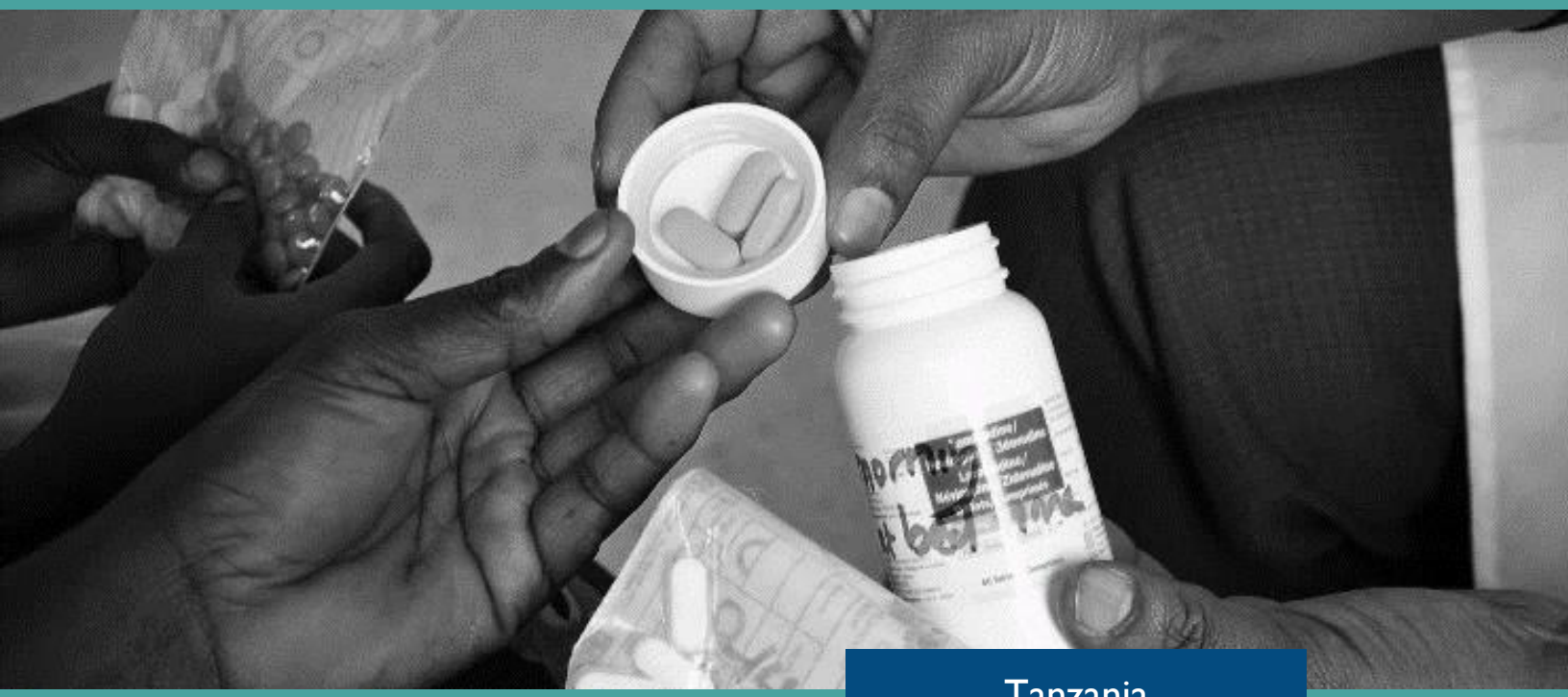

Tanzania

Frontier Health Markets (FHM) Engage

PRIME VENDOR SYSTEM REPORT

Ensuring the Inclusion of Key Products

November 1, 2022

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Acronyms

ARV	Antiretroviral
BRELA	Business Registration and Licensing Agency
BRN	Big Results Now
CCM	Chama Cha Mapinduzi
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
DED	District Executive Director
DHFF	Direct Health Facility Financing
DHS	Director of Health Services
DMO	District Medical Officer
DT	Dispersible Tablet
EML	Essential Medicines List
FHM	Frontier Health Markets Engage
FP	Family Planning
HF	Health Facility
HFGC	Health Facility Governing Committee
HPSS	Health Promotion and Systems Strengthening
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
ISU	Country Health Information Systems and Data Use
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MSD	Medical Stores Department
MTC	Medicines and Therapeutics Committee
NEML	National Essential Medicine List
NHIF	National Health Insurance Fund
PMU	Procurement Management Unit
PO-RALG	President's Office- Regional Administration and Local Government Authority
PPP	Public Private Partnership
PPRA	Public Procurement Regulatory Authority
PrEP	Pre-Exposure Prophylaxis
PS3+	Public Sector Systems Strengthening Plus
PV	Prime Vendor
PVS	Prime Vendor System
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team

SOP	Standard Operating Procedure
SoR	Schedule of Requirements
SRA	Stringent Regulatory Authority
STG	Standard Treatment Guideline
TANEPS	Tanzanian National e-Procurement System
TB	Tender Board
TMDA	Tanzanian Medicines and Medical Devices Authority
WHO	World Health Organization
WHO-PQ	WHO- Prequalification

Prime Vendor System

Background on the Activity and FHM Engage

Frontier Health Markets (FHM) Engage is a global cooperative agreement providing technical assistance supporting strategic engagement of the private sector to advance health outcomes, in areas such as family planning, and maternal and child health, alongside other priority areas. Building on over 30 years of USAID investment, FHM Engage focuses on strengthening local health markets by addressing the root causes of market underperformance in the core market functions[1] to create changes that catalyze supply and demand and support sustainable change. In line with this approach, FHM Engage seeks achievement towards two main results:

- Result 1: Improved market environment for greater private sector participation in the delivery of health products and services.
- Result 2: Improved equal access to and uptake of high-quality consumer driven health products, services, and information.

This brief relates to Activity 4.2 – Targets of Opportunity for Improving Access to Family Planning and Maternal, Newborn, and Child Health from the Tanzania workplan. Every year, more than five million children die prior to their fifth birthday[2] and three hundred thousand mothers die due to pregnancy or childbirth-related causes.[3] Life-saving maternal, newborn, and child health (MNCH) products could prevent more than half of these deaths, but access to these products remains low in sub-Saharan Africa where the majority of under-five and maternal mortality occurs. In Tanzania, under-five mortality remains a major health issue with a rate of 48.9 deaths per 1,000 live births, and the country continues to have one of the highest maternal mortality rates in the world, with 556 deaths per 100,000 live births.[4] The drivers of limited access to critical MNCH products are not fully understood, though may be partly explained by deficiencies in planning and procurement, unreliable or inadequate financing, and the fact that many of these products have not benefited from the types of coordinated market shaping that have helped to reduce costs, ensure high quality, and improve the availability of other essential health commodities, such as vaccines, HIV/AIDS, and malaria medicines.

The work that follows entailed consultation with the President's Office- Regional Administration and Local Government Authority (PO-RALG) on the status of the Prime Vendor System (PVS), a well-established public private partnership (PPP) in Tanzania that aims to improve the availability of high-quality, affordable essential medicines in public health facilities through private supply. This activity highlights the private sector's role in delivering critical health commodities to serve population needs, and points to areas where implementation of the PVS can be improved in order to fully realize the intended outcomes and health impact.

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[1] Core market functions include: 1) Rules and Regulations; 2) Stewardship; 3) Financing; 4) Market intelligence

[2] WHO. Fact Sheet. Children: Improving survival and well-being. 8 September 2020. Accessed from: https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality

[3] WHO. Fact Sheet. Maternal Mortality. 19 September 2019. Accessed from: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

[4] UNICEF. Maternal and Child Health: Today, Tanzanian children stand a better chance of surviving past their fifth birthday than ever before. Accessed from: https://www.unicef.org/tanzania/what-we-do/health

Rationale

The aim of the PVS is to support the public sector in its provision of high, quality, affordable medicines to public health facilities across the country. Since the PVS was piloted in 2014, it has been scaled across the mainland of Tanzania (26 regions) with oversight managed by the President's Office- Regional Administration and Local Government Authority. While there have been notable successes in improving the availability of key commodities through the PVS, challenges persist in monitoring the regional government's adherence to established guidelines.[5] Misalignments between policy and practice persist (medicines supplied by prime vendors do not always align with National Standard Treatment Guidelines) and pricing variations across the prime vendors and other suppliers in the market (for the same product[6]) point to efficiencies that can be gained. The brief that follows summarizes the current prime vendor system, draws insights into the regional government's adherence to established guidelines (through examining alignments and misalignments between some key products supplied by the Prime Vendors and the National Standard Treatment Guidelines), and highlights pricing variations across key products and suppliers (e.g., prime vendor vs. Medical Stores Department vs. other wholesalers in the market). Finally, it highlights a few potential areas that may require support by FHM Engage or other partners including: a formal review and rationalization of the list of medicines provided by the prime vendors against Tanzania's Standard Treatment Guidelines; and the creation of a reference price list to assist the regions in price negotiations as they enter into contracts with the prime vendors.

Introduction

Access to high quality, affordable, and acceptable medicines is essential to improving population health outcomes and requires a reliable supply; however, the supply of these commodities through the public sector in Tanzania has been historically unreliable. The Medical Stores Department (MSD), an autonomous unit under the Ministry of Health, is responsible for the procurement, storage, and distribution of approved medicines and supplies required by public health facilities (and private health facilities with service level agreements in place with the government) but its order fulfillment rates are often below 50 percent.[7] Reasons for stock-outs of key commodities are due to numerous factors including: delays in distribution of allocated funds, insufficient working capital, purchasing inefficiencies, inaccurate data leading to poor forecasting at the facility and national level, etc.[8] As a result, there is a need for a complementary system to address the supply gap and to provide quality, affordable medicines to the health facilities when MSD is unable to meet their needs.

In 2014-2016, the Prime Vendor System (PVS) model was piloted in Dodoma, Morogoro, and Shinyanga regions establishing procedures and mechanisms that allowed public health facilities within the region to procure quality health commodities from a qualified private sector vendor in a more transparent way. While the PVS has evolved over the years and has since been scaled-up across the country, the main tenets of the system remain the same. The system is a public private partnership (PPP) utilizing a regional contract approach for pooling orders across health facilities within a region. It's meant to be complementary to the public supply system and not in competition and is additionally anchored in

[5] Some of the key informants highlighted PVs are not always able to meet the lead times stipulated in the contract and supply in multiple batches instead of one consignmnet
[6] The same product in terms of active ingredients, strength and pack size.
[7] The CAG Report of 2020/21 revealed that the Medical Stores Department (MSD) order fulfillment rate was only 34%
[8] Githendu P, Morrison L, Silaa R, *et al*. Transformation of the Tanzania medical stores department through global fund support: an impact assessment study *BMJ Open* 2020;**10:**e040276. doi: 10.1136/bmjopen-2020-040276

regional structures which lends itself to sustainability. The successes of the PVS have resulted in its enshrinement in key national policies including: the Chama Cha Mapinduzi (CCM) Manifesto, Health Sector Strategic Plan (HSSP) IV, Public-Private-Partnership (PPP) Policy, Big Results Now (BRN) Report, and the National Pharmaceutical Action Plan. However, ongoing monitoring of the system is still required to ensure that the PVS is achieving optimal outcomes and that policy and practice are aligned.

Objectives

The objectives of this brief are to:

1. Summarize the current Prime Vendor System model
2. Draw insights into whether the Prime Vendor Schedule of Requirements for medicines in three regions are aligned with the National Standard Treatment Guideline (STG) and the National Essential Medicines List (NEML) looking specifically at the presence/absence of key HIV, Family Planning (FP), and Maternal, Newborn, and Child Health (MNCH) commodities[9]
3. Highlight the key decision-makers and opportunities for amending the prime vendor Schedule of Requirements (SoR)

Methodology

FHM Engage employed the following methodology for the analysis presented in this brief:

1. Desk review of documents related to the Prime Vendor System
2. Key informant interviews with stakeholders involved in the Prime Vendor System [see Annex 1. Key Informants]

Overview of the Current Prime Vendor System

Prime Vendor Selection

Prime vendors (PVs) are prequalified health commodity suppliers (wholesalers and distributors) that have been contracted by regional authorities to supply items to public health facilities when the National Medical Stores Department (MSD) faces a stock-out. PVs submit bids to publicly advertised tenders and are selected through a process led by the regions enumerated below. The tenders are generally split into four separate lots or groupings.[10] A PV can win a maximum of two lots; therefore, each region will have a minimum of two and a maximum of four prime vendors.

FIGURE 1. KEY STEPS IN THE PV SELECTION PROCESS

Vendor Forum

One of the first steps in the prime vendor selection process is the vendor forum, which historically has been conducted prior to the pre-qualification of suppliers. In the past, the PVS vendor forum was

[9] HIV: HIV self-test kits; FP: oral contraceptives, emergency contraception, injectables; MNCH: UN Commission of life saving commodities list and other medicines prioritized in key National MNCH policies (e.g., One Plan II)
[10] Lot 1: Medicines; Lot 2: Diagnostics; Lot 3: Orthopedics & Dental Supplies; Lot 4: Other medical supplies and consumables

organized at the national level by the President's Office- Regional Administration and Local Government Authority (PO-RALG); however, currently, the vendor forums are organized by the regions. During the forum, each region will convene registered and licensed private medicine and medical supplies distributors to share information about the PVS and how to participate in the tendering process.

Value Proposition for Vendors to Participate in PVS

- → Good opportunity for some Small and Medium Enterprises (SME) to become involved in government supply chain and improve their visibility in the market
- → Transparent, fair process
- → Pooled orders with organized transport to the district level reduces the supplier's transaction costs associated with many separate orders

Prequalification of suppliers

The prequalification of suppliers and tendering processes have been devolved to the regions. During the prequalification process, a region's tender board invites eligible suppliers to submit details about their company for a pre-qualification assessment [see Annex 2. Prime Vendor Pre-Qualification Requirements]. Only the short-listed, pre-qualified suppliers are eligible to bid on the prime vendor tenders.

Tendering

All tender related documents are submitted through the Government of Tanzania's National e-Procurement system (TANEPS). TANEPS is an electronic system that was created to facilitate public procurement processes in Tanzania in a more transparent way. Similar to the prequalification process, the tender process is led by the region's tender board with the Prime Vendor System Technical Committee providing inputs on the product specifications for the Schedule of Requirements.

The Schedule of Requirements is a list provided to the PV by the Prime Vendor Technical committee that describes the pharmaceutical products and supplies (e.g., medicine name, dosage form, strength, any applicable quality standards, etc.) required by public health facilities and should align with the Tanzania Standard Treatment Guidelines (STGs) and National Essential Medicines List (NEML). Epidemiological profiles, disease burden, and other factors may lead to some variations in these lists across the regions, as each region will make determinations on which priority products to include (with inputs from the districts and health facilities).

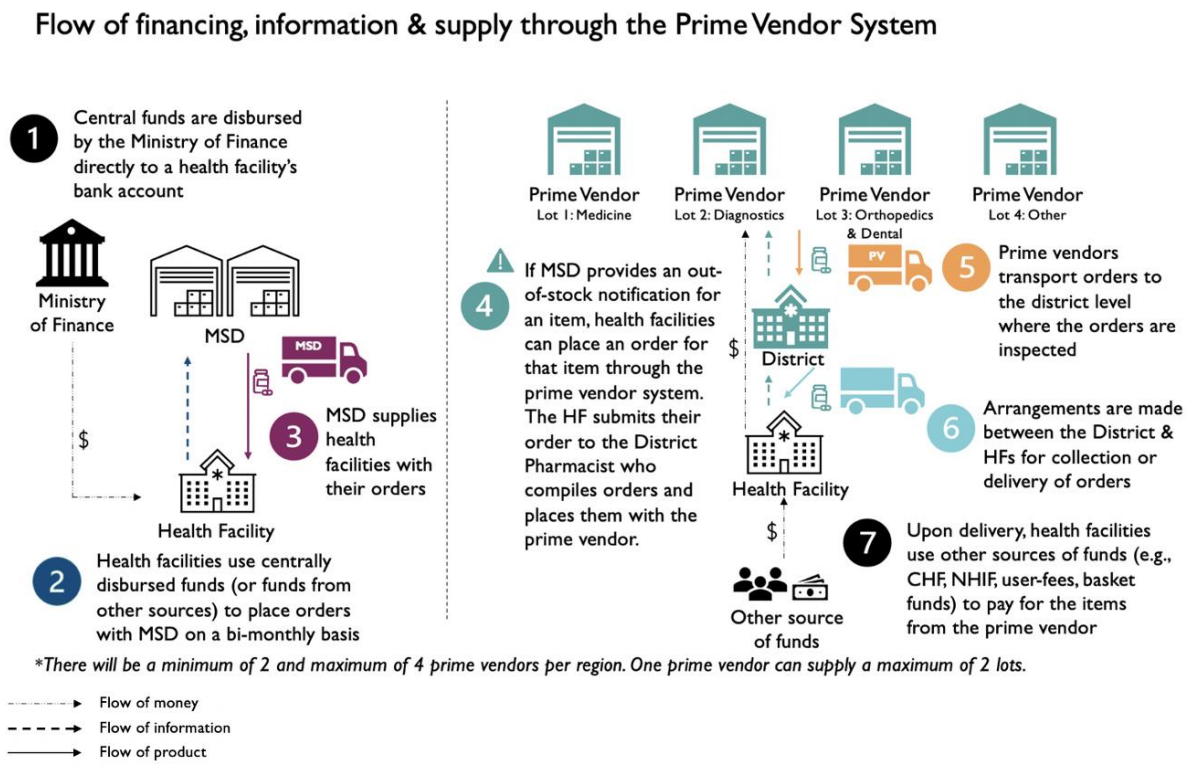
Negotiation, Contracting & Contract Review

Once the prime vendor(s) has been selected, the regional authorities will enter into negotiations to determine the pricing schedule for a framework contract. The contract is valid for three years with fixed pricing but is reviewed on an annual basis at which time amendments can be made if necessary [see Annex 3. Standard Operating Procedure (SOP) for Contract Review]. In the current prime vendor contracting process, the signatories to the contract include: the prime vendor, the Regional Administrative Secretary (RAS) as the "supervisor," and the District Executive Directors (DED) as the "implementers" which empowers and mandates both the districts and region to report and address issues related to the implementation of the Prime Vendor System.

The PVS in Action: Flow of Funds, Information (Orders), and Product

Prior to the implementation of the Prime Vendor System, the districts, on behalf of health facilities, were purchasing health commodities from private suppliers in a non-transparent and uneconomical way with implications on product pricing, quality, etc. The objective of the prime vendor system was to establish structures that encouraged more transparency, and accountability and would achieve efficiencies through pooling of orders. The flow of financing, information (orders placed), and product (supply) in the current PVS model are summarized in the figure below.

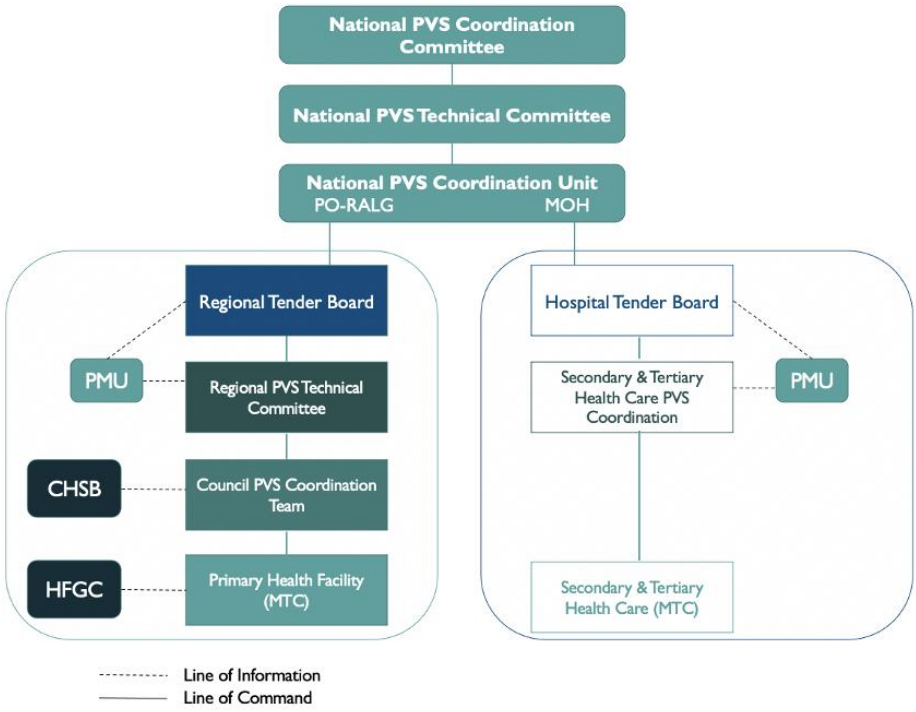
FIGURE 2. FLOW OF FINANCING, INFORMATION (ORDERS) AND PRODUCT THROUGH THE PRIME VENDOR SYSTEM



PVS Management Structure

The Prime Vendor System is embedded into existing structures within the public health system. The operational structures that support and oversee the day-to-day operation of the PVS are detailed in the figure below.

FIGURE 3. PVS OPERATIONAL MANAGEMENT STRUCTURE[11]



A description of these key management structures and their functions are below. Further details on the key membership of these committees are outlined in Annex 4.

National PVS Coordination Committee

Role	→ The role of the National PVS Coordination Committee is to: 1) guide and oversee the smooth implementation of the PVS, 2) approve innovations or changes required to optimize the operationalization of the PVS, 3) mobilize resources for monitoring PVS activities and other activities/functions as required to enhance the implementation of the PVS.
Meeting Cadence	→ Bi-annual basis (or quarterly if necessitated)

National PVS Technical Committee

Role	→ The role of the National PVS technical committee is to provide technical support and backstopping to the regions and councils in the implementation of the PVS. The Committee collects experiences related to the implementation of the PVS and proposes standardized approaches to improve system operations which are submitted and approved by the PVS Coordination Committee (or other high level authorities as needed).
Meeting cadence	→ Quarterly basis

[11] PO-RALG. PVS Implementation Manual. October 2021.

National PVS Coordination Unit

Role	→ The National PVS coordination unit is responsible for supervising, monitoring, and evaluating the performance of the prime vendors and overall PVS in terms of organization and management. The unit additionally receives, aggregates, and analyses quarterly PVS implementation reports from the regions and are responsible for their submission to the National PVS Technical Committee.
Meeting cadence	→ Quarterly basis

Tender Board

Role (as it relates to PVS)	→ The primary function of the tender board (TB) is to oversee the transparent selection of a prime vendor and the overall control and management of the PVS. → The Regional Tender Board oversees the tendering process for primary health care facilities in the region while the Hospital Tender Board oversees the tendering process for secondary and tertiary facilities.
Meeting Cadence	→ Quarterly basis

Regional PVS Technical Committee

Role	→ The primary function of the Regional PVS Technical Committee is to advise the Tender Board (TB) on all technical matters related to the transparent selection of prime vendor and performance of the system at the regional level. It is responsible for preparing technical inputs for PVS tender documents (e.g., schedule of requirements, supplier prequalification criteria, pricing schedule, etc.). Additionally, this Committee supports the Regional Administrative Secretary to review the Prime Vendor contracts on an annual basis. → Related to PVS implementation, the Committee is responsible for: 1) identifying gaps/issues related to the implementation of the PVS within the region; 2) ensuring adherence to the PVS standard operating procedures; and 3) compiling monthly reports on the implementation of the PVS from the districts and submits them to the National PVS coordinator.
Meeting cadence	→ Quarterly basis

Council PVS Coordination Team

Role	→ The role of the Council PVS Coordination Team is to coordinate all PVS activities within the Council including (but not limited to): managing communications with the PV (e.g., on issues related to orders and payment to the vendor); managing/tracking/reporting the contractual performance of the selected PV; identifying gaps/issues related to the implementation of the PVS; preparing and submitting monthly reports on PVS implementation to the Council Health Management Team (CHMT) and Council Health Services Board (CHSB).
Meeting cadence	→ Monthly

Health Facility Governing Committee (HFGC) & Medicines and Therapeutic Committee (MTC)

Role (as it relates to PVS)	→ The role of the HFGC and MTC is to review the orders, and based on the availability of funds, approve the procurement of health commodities from the Prime Vendor.

Review of the PV Schedule of Requirements Across 3 Regions

FHM Engage and the National Prime Vendor Coordinator[12] participated in the review and analysis of the Schedule of Requirements (SoR) across three regions—Dar es Salaam, Mtwara, and Tabora.

The team's analysis entailed the following:

1. Examining the presence and absence of key HIV/AIDS, FP, and MNCH commodities on the SoR [see Table 1 below for the list of commodities];
2. Assessing whether key products on the SoR align with the National Standard Treatment Guidelines and Essential Medicines List; and
3. Comparing PV prices for these key products to MSD's sellable price list[13] and three medicine wholesalers'[14] price lists.

The findings of this analysis are summarized below.

Findings and Discussion

HIV/AIDS and Family Planning Commodities

Vertical program items[15] (e.g., HIV/AIDS, family planning, Tuberculosis/Leprosy, neglected tropical diseases, malaria, etc.) are generally not found on the Schedule of Requirements (SoR). Across the three SoRs examined, there were no PVs supplying key HIV/AIDS or FP products.

The exclusion of HIV and FP commodities may be due to the following reasons:

- → HIV commodities (e.g., antiretrovirals (ARVs), HIV self-testing kits, oral pre-exposure prophylaxis (PrEP)) have not been commercialized in the country and are therefore not readily available in the private market.
- → The SoR is generated by the priorities and needs of health facilities within a region. As a result, regions may not prioritize family planning products because they do not anticipate the need or because they predict there are more critical (life-saving) products likely to face stock-outs that need to be prioritized with the limited resources available.

Maternal Newborn and Child Health Commodities (MNCH)

PRESENCE OF KEY MNCH MEDICINES ON PRIME VENDOR SCHEDULE OF REQUIREMENTS

[12] The National Prime Vendor Coordinator has since transitioned into a new position as the National Health and Pharmaceutical Policy Coordinator.
[13] The MSD prices were obtained from their 2022/2023 catalogue
[14] All three wholesalers were located in Dar es Salaam
[15] Vertical items receive donor or Central Government financial support and are distributed to public health facilities for free

A number of MNCH commodities (e.g., Amoxicillin DT, Misoprostol, Oxytocin, etc.) are considered vertical program items, yet they are present on all three PV SoR. The reasons why these products are exceptions to the "vertical program" rule is not completely clear, though key informants explained that the rationale may be as follows:

- Some of the products were "sellable" items[16] at MSD in the past (i.e., had non-vertical item status) or are currently transitioning to become a sellable item (e.g., Amoxicillin DT and ORS/Zinc co-pack).
- Most of the MNCH medicines on the SoR have a "life-saving" nature to them or are among the "most essential" medicines that require them to be stocked to meet the healthcare needs of the population.

ABSENCE OF KEY MNCH MEDICINES ON PRIME VENDOR SCHEDULE OF REQUIREMENTS

Although some key MNCH medicines are included on the PV SoR, other key products have been excluded (e.g., dexamethasone injection). Additional inquiry is required to understand why this essential medicine, and potentially others, have been excluded and to answer some of the following questions: 1) Were substitutes included and prioritized?; 2. Was the product's exclusion an oversight/ unintentional?; 3) Has the product historically been available in the public sector?, etc.

ALIGNMENT OF KEY MNCH MEDICINES WITH TANZANIA'S STANDARD TREATMENT GUIDELINES

In 2021, Tanzania's National Standard Treatment Guidelines and Essential Medicines list was updated. Notably, a child-friendly amoxicillin formulation—amoxicillin syrup—was removed in favor of amoxicillin dispersible tablet (DT), yet the syrup still appears on some of the PV SoR. This is counter to national guidance which states that the Prime Vendor Schedule of Requirements must be aligned with National Standard Treatment Guidelines. Further analysis is required to identify other misalignments between the PV SoR and National STGs to ensure that the PVS is delivering its intended benefits.

Pricing Across MSD, 3 PVs and 3 Medicine Wholesalers

There are a number of pricing variations that are inexplicable and require further inquiry and analysis.

- Although in general, MSD provides the lowest selling prices for these key products, there were some instances where the PV provided a lower price (See Table 1: ceftriaxone injection, magnesium sulphate, ORS/Zinc co-pack).
- There are wide variations in pricing for the same product, dosage and pack size and instances where the PV price is more than double MSD's sellable price (see Figures 3 and 4 for more details).
- Further inquiry into these products mentioned above is required to verify the parity in pack size and formulation sold by MSD, the PVs, and wholesalers, as well as to understand if these price differences are related to quality (stringent regulatory approved (SRA) or World Health Organization pre-qualified (WHO-PQ) medicines vs. non -SRA/WHO-PQ) or branded vs. generic medicines, etc.

[16] Sellable items are purchased by health facilities from the Medical Stores Department using centrally disbursed funds through the direct health facility financing mechanism

TABLE 1. KEY HIV, FP, MNCH PRODUCTS ON THE PV SCHEDULE OF REQUIREMENTS

Key Products	# of PVs with Product on the Schedule of Requirements (n=3)	Unit of Measure	Price Range Across 3 Prime Vendors (TZS)	MSD 2022/2023 Catalogue Price (TZS)	Price Range Across 3 Wholesalers in Dar es Salaam (TZS)
HIV/AIDS					
HIV Self-Testing Kits	0	n/a	n/a	n/a	n/a
PrEP	0	n/a	n/a	n/a	n/a
Family Planning					
Oral contraceptives	0	n/a	n/a	n/a	Not collected
Emergency contraceptives	0	n/a	n/a	n/a	Not collected
Maternal, Newborn, Child Health					
Amoxicillin 250mg DT	3	100 tablets	7,500-8,000	5,595.86	4,650-5,500
Amoxicillin Syrup	2	1 bottle		n/a	
Ampicillin injection	3	50 vials	65,000-82,500	17,784.35	44,000-60,000
Ceftriaxone 1g injection	3	1 vial	945-3,800	1,000	825-1,000
Ceftriaxone 500g injection	1	1 vial	950-1,350	1,191	n/a
Ceftriaxone 250g injection	2	1 vial	878-1,350	878	650-850
Dexamethasone injection	2	1 vial	1,200-1,620	556.65	1,100-1,200
Ferrous Sulfate + Folic Acid	3	100 tablets	4,455-5,000	2,501.91	2,700-3,300
Gentamicin 40mg/ml injection	3	10 vials	3,375-5,000	2,667.58	2,160-3000
Hydralazine injection	2	5 vials	35,000-93,425	16,672.39	95,000
Magnesium sulphate injection	3	1 vial	5,000-46,224	6,927.20	5,000
Methyldopa tablets	3	100 tablets	19,000-20,250	16,699.50	11,600-13000
Metronidazole injection	3	10 vials	8,000-9,000	556.65	560-6,000
Misoprostol	3	100 tablets	10,000-120,534	n/a	47,000-81,000
Oxytocin 10iu injection	3	10 vials	12,000-20,250	6,185	3,000-9,000
Zinc/ORS co-pack	3	1 kit	200-300	903	160-520

FIGURE 4. MIN AND MAX PRICES ACROSS MSD, 3 PVS, AND 3 MEDICINE WHOLESALERS IN DAR ES SALAAM

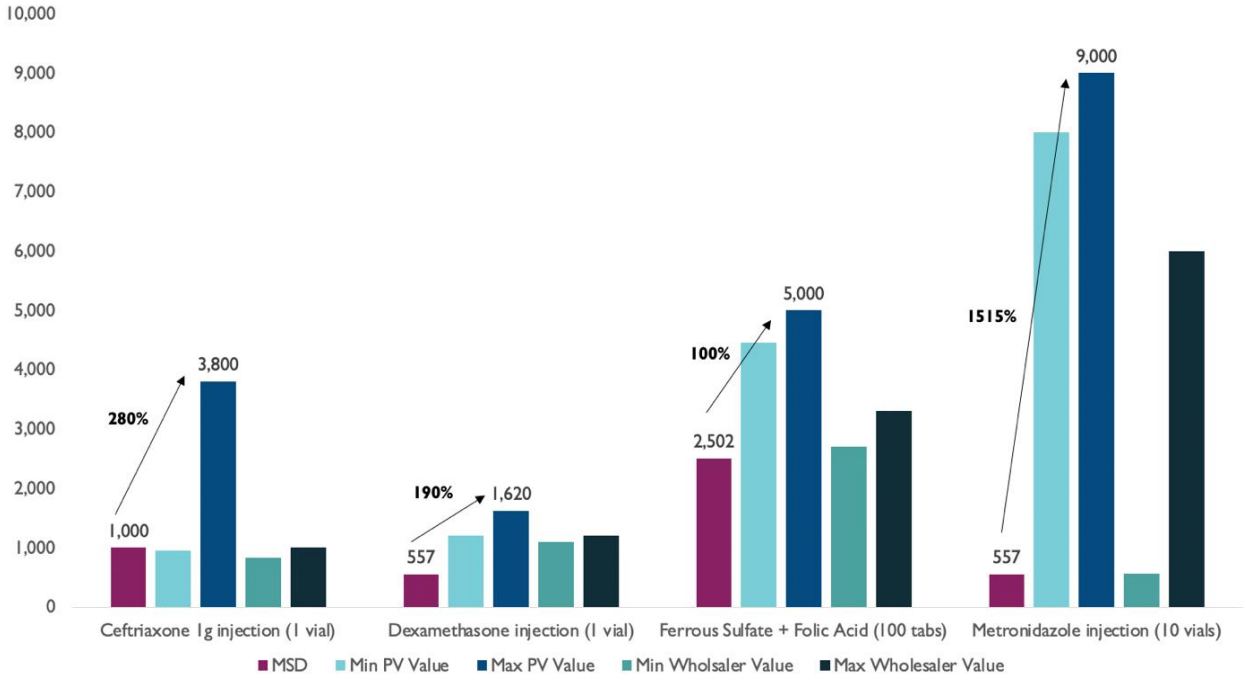
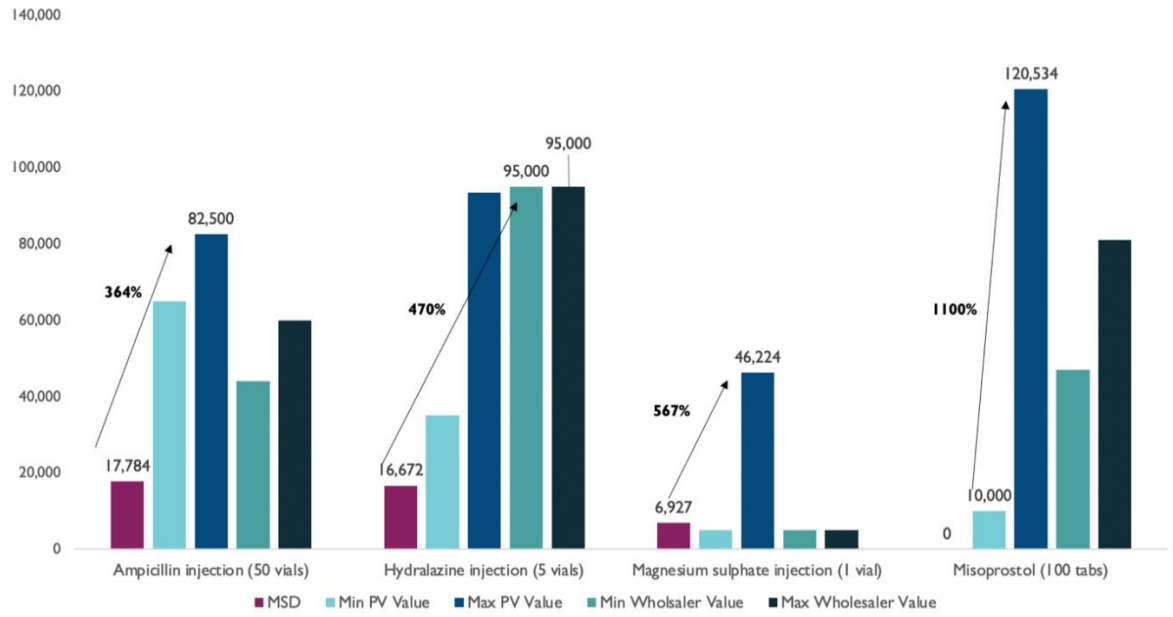


FIGURE 5: (CONT) MIN AND MAX PRICES ACROSS MSD, 3 PVS, AND 3 MEDICINE WHOLESALERS IN DAR ES SALAAM



Considerations for Adding/Removing Commodities to the PV Schedule of Requirements

Evidence generation and advocacy at various levels of the government may help to ensure the adoption of key products on the Prime Vendor Schedule of Requirements.

For the purpose of adoption, these efforts need to demonstrate that the product:

- Aligns with the National Standard Treatment Guidelines (STG) and Essential Medicines List (EML)
- Is required by health facilities within the region in order to meet the needs of the catchment population

For the purpose of removal, efforts should demonstrate that the product:

- Does not align with the National STGs or EML or will have a deleterious effect on population health or other negative consequences.

The table below summarizes some of the key opportunities where advocacy efforts can be targeted for the addition and removal of key products from the prime vendor schedule of requirements.

TABLE 2: KEY OPPORTUNITIES TO ADVOCATE FOR THE INCLUSION/EXCLUSION OF KEY PRODUCTS

PV Contract Status	Activity	Influencers/Decision-Makers	Timeline
Not yet in place	Advocacy efforts can be directed at the National and Regional PVS Technical Committees to ensure the inclusion/exclusion of the key product(s) is communicated during the vendor forum or up until the point of contract negotiation.	Chief Pharmacist (Ministry of Health) National PVS Coordinator (PO-RALG) Regional PVS Coordinator Regional Medical Officer Regional Administrative Secretary District Executive Directors	Prior to vendor forum (every 3 years or so) Or Prior to contract signing (every 3 years or so)
In place	Evidence generated about the need for the inclusion/exclusion of the key product(s) on the SoR should be presented during one of the quarterly meetings held by the National Technical Committee. The National Technical Committee can then bring forward recommendation to the regions' tender board so that an addendum can be made during the annual contract review.	Chief Pharmacist (Ministry of Health) National PVS Coordinator (PO-RALG) Regional Administrative Secretary Regional PV Coordinator District Executive Directors	In advance of the regions' annual contract reviews

Conclusion

Achieving the intended benefits of the Prime Vendor System—ensuring access to high quality, affordable medicines and health commodities—is reliant on the regions' ability to effectively implement the model and for the National PVS Technical Committee to provide strong oversight and support. The misalignments between the PV Schedule of Requirements and the National Standard Treatment Guidelines highlighted in this brief, as well as the wide pricing variations across the few products

examined, warrants further scrutiny to determine the full scope of these incongruencies and pricing inefficiencies across all health products supplied by the prime vendors.

Potential Areas for FHM (or other Partner) Intervention

This work surfaced a few potential areas for intervention by FHM (or other partners) to explore, including:

1. Supporting the National PVS Technical Committee to initiate a formal review to rationalize the regions' schedules of requirements and align them with the National Standard Treatment Guidelines. This activity would entail: 1) collaborating with the Regional PVS Technical Committees to systematically examine the PV Schedule of Requirements and compare these lists against the latest STGs; 2) Surfacing the misalignments and deliberating if these products (the products not in alignment with the STGs) are justified in their inclusion (or not); 3) Examining the highest volume and value medicines supplied through the PV to inform MSD's procurement planning and rationalizing of their supply catalogue.
2. Exploring how the prime vendor model can be applied/extended to other networks of private health facilities, pharmacies, or ADDOs.
3. Finally, the development of a reference price list[17] as a tool to support the regions as they enter pricing negotiations with prime vendors or during the annual contract review to limit wide, unjustifiable pricing variations.

All of these activities, if implemented in an intentional and sustained manner, will help to drive the intended outcomes of the Prime Vendor System and the overall intended results of FHM Engage - to improve private sector participation in delivering high quality health products and services to populations in need.

[17] While a reference price list aims to improve affordability, it can also have unintended consequences (e.g., price convergence, decreasing price transparency, etc.)

Annex 1. Key Informant Interviews

Name	Organization	Designation
[Redacted]	PO-RALG	[Redacted]
[Redacted]	PO-RALG	[Redacted]
[Redacted]	Medical Stores Department	[Redacted]
[Redacted]	Health Promotion and Systems Strengthening (HPSS)	[Redacted]
[Redacted]	Public Sector Systems Strengthening Plus (PS3+)	[Redacted]

Annex 2. PV Prequalification Requirements List

PRIME VENDOR PRE-QUALIFICATION REQUIREMENTS
→ Signed anti-bribery policy
→ Evidence of Professional related registration of premises and licenses issued by TMDA and Pharmacy Council
→ Business Permit as wholesaler/importer
→ Premises registration
→ Trading/Business licenses issued by relevant authorities
→ Business Registration and Licensing Agency (BRELA) certificate
→ Taxpayer Identification Number
→ Tax Clearance Certificate
→ Evidence of possession of Electronic Fiscal Device vendor machine
→ Average stock value in the last 3 financial years
→ Customer Profile including annual sales
→ Distribution capacity in Tanzania
→ Geographic reach of applicate services (number of customers in each region)
→ Details on Transportation/Vehicle ownership
→ Personnel details
→ Financial Status
→ Litigation History
→ Conflict of interest history
→ Supplier details
→ Management Information System- how orders are received, frequency of placing orders with suppliers

Annex 3. SOP for Contract Review

Objective

To enable both parties to propose, discuss, and agree on contract price increase or decrease of some specified items in order to maintain best value for money of health commodities in the event of any change which may be caused by any of the following: substantial market price changes of health commodities, increase in inflation rate, changes in pack sizes of health commodities, and changes on statutory charges affecting the cost of health commodities;

Accountable officials

- Procuring Entity (Accounting officer)
- Prime Vendor

S/N	Description procedures
1	Procurement Management Unit (PMU) should obtain price change requests in writing from the affected party (Public Procurement Regulation section 61)
2	PMU in collaboration with user department should review the request of price changes
3	PMU should submit the recommendations to accounting officer for request of meeting between two parties.
4	PMU organize and conduct the meeting between two parties to reach agreement.
5	PMU should submit the reached agreement to Regional Tender Board for approval
6	PMU prepare addendum for changes approved by Regional Tender Board.
7	PMU submit the addendum to legal department for vetting
8	PMU submit vetted addendum to Prime Vendor for consent
9	PMU submit vetted addendum to Accounting Officer for signing

Annex 4. PVS Management Structure

National PVS Coordination Committee

Key Membership *other members co-opted as necessary	→ Deputy Permanent Secretary – Health – Chair → Director of Health Services (DHS) – Secretary → Assistant Director for Health Services → Director of Regional Administration – Member → Director of Local Government – Member → Director of Procurement Management – Member → Director of Investigation and Fund Tracking – Member → Director of Legal Services – Member

National PVS Technical Committee

Key Membership *other members co-opted as necessary	→ Head of Health Commodities and Diagnostic Services – Chair → Coordinator of Diagnostic services – Member → PVS Coordinator – Secretary → Dental Services Coordinator → Procurement Officer – Member → Principal Legal officer – Member → Internal Auditor – Member → A representative from financial tracking – Member

National PVS Coordination Unit

Key Membership *other members co-opted as necessary	→ PVS Coordinator – PO-RALG → Coordinator of Laboratory Services – PO-RALG → Procurement Officer – PO-RALG → Head of Radiology and Imaging – Ministry of Health

Regional PVS Technical Committee

Key Membership *other members co-opted as necessary	→ Regional Medical Officer – Chair → Regional Pharmacist who will serve as PV Regional Coordinator and Secretary → Regional Laboratory Technologist → District Medical Officer (DMO) (from one of the Councils) – Member → Procurement Officer (from one of the Councils) – Member → Regional Dental Dfficer – Member → Councils' PVS Coordinator (from all the Councils) – Member

	→ Lab Scientist (from one of the Councils) – Member → Biomedical Engineer – Member → Legal Officer (from one of the Councils) → Any other member as shall be recommended and approved by the accounting officer

Council PVS Coordination Team

Key Membership *other members co-opted as necessary	→ Council Prime Vendor Coordinator – Council Pharmacist → Council Laboratory Technologist → Council Head of the Procurement Management Unit (PMU) → Council Nursing Officer → Council Dental Officer → Biomedical Technician/Engineer

Tender Board

Key Membership *other members co-opted as necessary	→ Regional Medical Officer → Regional Pharmacist → Regional Laboratory Technologist → Any other person invited by the Board

About FHM Engage

Frontier Health Markets (FHM) Engage is a five-year cooperative agreement (7200AA21CA00027) funded by the United States Agency for International Development. We work to improve the market environment for greater private sector participation in the delivery of health products and services and to improve equal access to and uptake of high-quality consumer driven health products, services, and information. Chemonics International implements FHM Engage in collaboration with Core Partners: Results for Development (co-technical lead), Pathfinder and Zenysis. FHM Engage Network Implementation Partners include ACCESS Health India, Africa Christian Health Association Platform, Africa Healthcare Federation, Amref Health Africa, Ariadne Labs, CERRHUD, Insight Health Advisors, Makerere University School of Public Health, Metrics for Management, Solina Group, Strategic Purchasing Africa Resource Center, Scope Impact, Stage Six, Strathmore University, Total Family Health Organization, and Ubora Institute.

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