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GLOBAL HEALTH SUPPLY CHAIN – TECHNICAL ASSISTANCE - TANZANIA

ANNUAL REPORT 2017





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WHILE TREMENDOUS PROGRESS HAS BEEN MADE IN ACHIEVING HEALTH OUTCOMES, CHALLENGES REMAIN

Overall*:

- In 2015, Tanzania's population was 48,366,270 (2.7% annual growth rate); of that 70% are living in rural areas*
- Some key health indicators are still quite low, despite the income status of country. For example, life expectancy at birth is 63 (women) and 60 (men)* and under 5 mortality rate/1,000 live births is 67**
- While Tanzania has made progress in reducing under-five mortality; maternal, newborn, and child health can still be improved (Births in health facilities: 63%**), indicating that access to health facilities is still a challenge)



Family Planning (FP)

- Total fertility rate: 5.2
- 32% of married women and 46% of unmarried women age 15-49 use a modern FP method.
- 61% of FP methods obtained through public sector



Malaria

- Thirty-five percent of pregnant women took 2+ doses of intermittent preventative therapy in pregnancy (IPTp), 8% took 3+ doses.
- Among children under five with fever in the two weeks before the survey who received an antimalarial, 85% received any artemisinin-based combination therapy.
- 14% of children age 6-59 months tested positive for malaria by rapid diagnostic test (RDT); 1% in Zanzibar



Tuberculosis (TB)

- Incidence: 164,000; 306 per 100,000
- Estimated % of TB cases with multi-drug resistant/rifampicin resistant (MDR/RR)-TB:
 - 1.3% (new cases)
 - 4.7% (previously treated cases)



Human immunodeficiency virus (HIV)

- HIV prevalence: 15-29 years*: 5.3%
- 67% of those with HIV are receiving ART
- 65% of HIV infected pregnant women receiving ARVs to reduce the risk of preventing mother to child transmission (PMTCT)

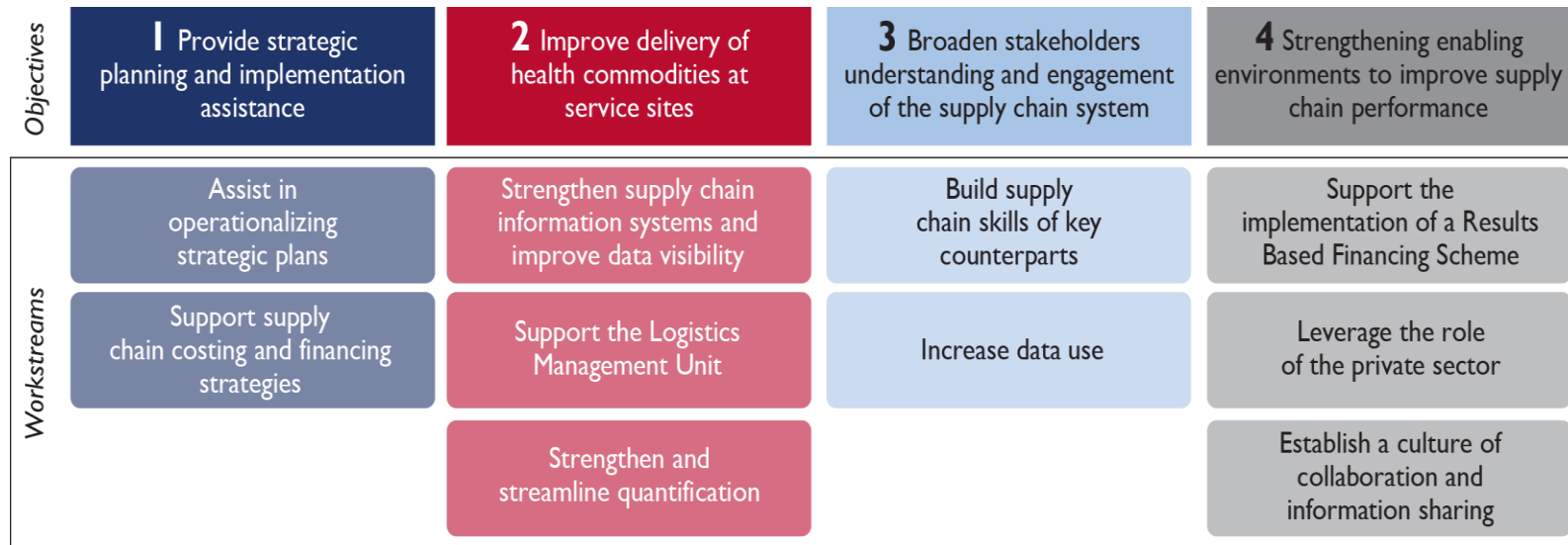
The ultimate goal of the Global Health Supply Chain – Technical Assistance – Tanzania (GHSC-TA-TZ) project is to support the development of an agile, flexible and sustainable health supply chain in Tanzania, and contribute to improving the health status of Tanzanians; this is closely linked to the Tanzania Country Development Cooperation Strategy and President's Emergency Plan for AIDS Relief (PEPFAR) and is designed to advance the objectives of the country strategy.

*taken from Health Sector Strategic Plan 2015-2020 (2015 baseline)

**Tanzania DHS/MIS 2015/16

GOAL OF THE GLOBAL HEALTH SUPPLY CHAIN-TECHNICAL ASSISTANCE-TANZANIA PROJECT:

Support the development of agile, robust and sustainable health supply chains that will contribute towards improving medicines availability and the health status of Tanzanians.



2018-013 CD USAID AR_001

Timeframe – June 2016 – June 2021*
(3 year base and 2 year option years)

Geographic focus – mainland + Zanzibar
Around 7,000 public sector health facilities

Key stakeholders (in addition to USAID): Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC)– specifically the Pharmaceutical Services Unit (PSU), vertical programs – including National AIDS Control Program (NACP), National Malaria Control Program (NMCP), Reproductive and Child Health Services (RCHS) Program, and National Tuberculosis and Leprosy Program (NTLP), Medical Stores Department (MSD) - central and 10 zones, President’s Office of Regional Administration and Local Governments (PO-RALG) (comprised of 184 councils, 168 districts, and 26 regions) and other partners.

SUMMARY OF ACCOMPLISHMENTS

Assist in Operationalizing Strategic Plans	Strengthen Supply Chain Information Systems and Improve Data Visibility	Support the Logistics Management Unit	Strengthen and Streamline Quantification	Establish a culture of collaboration and information sharing
<ul style="list-style-type: none"> • Provided leadership in planning, designing, and carrying out the holistic supply chain review (HSCR) • Facilitated development of the Costed Implementation Plan (CIP) • Recommended reprioritization of activities and supported resource mobilization/advocacy efforts for Zanzibar National Supply Chain Action Plan 	<ul style="list-style-type: none"> • Clarified and facilitated consensus on electronic Logistics Management Information Systems (eLMIS) roles and responsibilities • Trained and sensitized PO-RALG staff on eLMIS use and capabilities • Increased number of new users by 100% • Increased pool of staff for help desk support and software development 	<ul style="list-style-type: none"> • Resolved quality issues on 5,542 Report & Requisition (R&R) forms • Nurtured culture of accountability by sharing performance data • Avoided more 4.28B Tshs in product expiry via redistribution 	<ul style="list-style-type: none"> • Set the schedule for and conducted quarterly supply planning studies; Provided TA to manage pipelines • Coached and built the capacity of program staff, advocated for country ownership, and governance structures 	<ul style="list-style-type: none"> • Facilitated dialogue between MSD, PO-RALG, and MOHCDGEC on supply chain issues. • Encouraged sharing and use of information through coordination groups to promote learning and performance improvement
Build Supply Chain Skills of Key Counterparts	Increase Data Use	Support the implementation of a Results Based Financing Scheme	Leverage the Role of the Private Sector	
<ul style="list-style-type: none"> • Advocated for integration of SC into key strategy documents • Advised on supply chain implications of new product introductions • Supported use of data for decision making and facilitated information sharing 	<ul style="list-style-type: none"> • Established three IMPACT teams in Zanzibar, focused on supporting the MOH in using data to drive improvements to supply chain performance • Advocated for adoption of IMPACT team approach in other regions in mainland 	<ul style="list-style-type: none"> • Collaborated with MSD and MOHCDGEC to revise the indicators and refine the initial RBF design • Supported the participants in developing clear standard operating procedures (SOPs) for more objective verification activities 	<ul style="list-style-type: none"> • Performed an assessment and identified opportunities for increased private sector engagement in strengthening public supply chains 	

— WORK STREAM ACCOMPLISHMENTS

ASSIST IN OPERATIONALIZING STRATEGIC PLANS

Overview

The project works to align stakeholders on national supply chain objectives, to harmonize strategic documents with supply chain goals, and to hold stakeholders accountable for their contributions towards strategic plans.

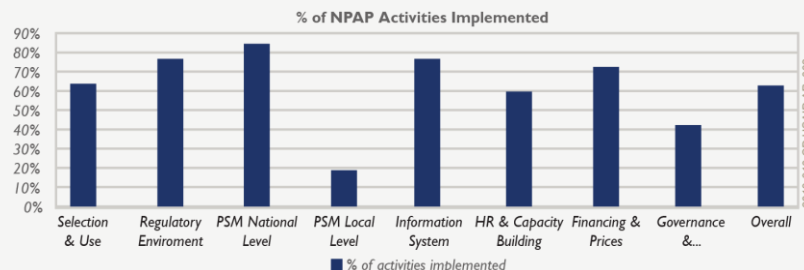
Activities and impact

- The project analyzed the progress of the implementation of the National Pharmaceutical Action Plan (NPAP) 2015-2020, and identified gaps in execution and opportunities to improve funding levels and stakeholder buy-in.
- GHSC-TA TZ aligned stakeholders on the need to participate in the HSCR, and provided technical leadership in planning, designing, and carrying out the HSCR, which resulted in >80 recommendations to gain efficiencies in the public health supply chain and to improve performance while reducing cost. The team facilitated the development of recommendations through a process of extensive consultation and field data collection and analysis, and prioritization and alignment on seven strategic, high-impact recommendations to be put in place within 18 months.
- Following the HSCR, the project supported the development of the Costed Implementation Plan (CIP), based on the HSCR recommendations. The CIP presents a roadmap for applying the seven strategic recommendations, and defines activities and sub-activities required to carry out each recommendation, as well as timelines, costs, roles and responsibilities. The CIP presents an opportunity for Tanzania to effectively carry out coordinated responses to supply chain challenges. Findings from the CIP will be integrated into the update of the NPAP.
- GHSC-TA-TZ facilitated an analysis and update of the Government of Zanzibar's National Supply Chain Costed Action Plan (2017-2020) and supported prioritization of activities, resource mobilization and advocacy efforts (including providing inputs to the Global Fund grant application)
- The project successfully advocated for mainstreaming supply chain interventions to the National Health Sector Reform Directorate for incorporation into national health policies
- GHSC-TA-TZ reviewed and provided input to MSD's medium-term 2017-2020 strategic plan, which outlines the areas of investment for MSD to shift to a self-sustaining business through revenue enhancement and improved cost efficiency

Looking forward

During Years 2 and beyond, the GHSC-TA-TZ project team will continue to advocate for policy changes and resources that support successful implementation of supply chain priority interventions, including those identified in the HSCR.

Related KPIs



While the NPAP suffered from poor stakeholder buy-in and funding, GHSC was successful in securing commitment to carry out supply chain interventions via the HSCR.



Successful implementation requires greater awareness and advocacy for NPAP recommendations to secure policy changes and stakeholder buy-in.

STRENGTHEN SUPPLY CHAIN INFORMATION SYSTEMS AND IMPROVE DATA VISIBILITY

Overview GHSC-TA-TZ supports the implementation of the electronic logistics management information system (eLMIS), to improve data visibility, the quality of data collected through automated data validation, and use of information. Support for eLMIS is done in the context of broader support to the Health Information System (HIS) architecture, and the project facilitates integration with Epicor9, DHIS2, and Government of Tanzania Hospital Management Information System (GoTHOMIS), and the Health Information Mediator (an interoperability layer). Technical Assistance (TA) includes providing eLMIS help desk support, building capacity of GoT staff to provide user support, and in developing dashboards, visualizations, and analytics. The project also supports ILSGateway, an SMS-based system used by facilities, that acts as an early warning for stock-outs of tracer commodities.

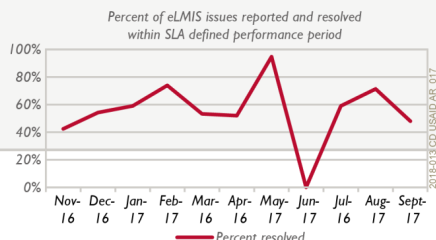
Activities and impact

- The project clarified, facilitated consensus and drafted guidance on roles and responsibilities related to ownership, maintenance, and use of eLMIS for GoT and other stakeholders.
- To engage PO-RALG in advocating for data use for decision making, the project trained and sensitized staff on eLMIS use and capabilities. The project also trained several supply IPs in eLMIS
- The number of new eLMIS users increased by 100% during the project’s first year. In 2016-2017, 1,624 new users were registered, compared to 743 new users the prior year.
- With a view towards sustainability, the project increased the pool of staff who can perform help desk support and software development. The project conducted a “Boot Camp” – to introduce the eLMIS code base and cultivate related skills within the MOHCDGEC and the University of Dar es Salaam (UDSM) team so that they can begin supporting software development directly. UDSM has begun to develop dashboard and visualizations. Further, the project trained LMU staff to increase the pool of basic help desk support, which has helped to resolve reported issues while working to improve our service level agreement (SLA) targets.
- The LMU builds the capacity of facility staff to enter data directly into the eLMIS, for facilities where this is possible. Currently, 16% of facilities enter data directly into the eLMIS. When facilities enter data directly into the eLMIS, this reduces the time required for order processing (no additional data entry and improves data quality by eliminating data entry errors).

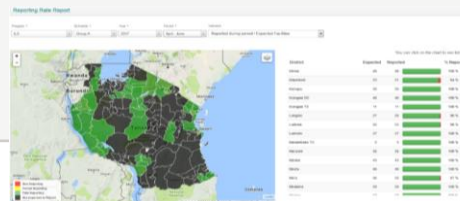
Looking forward

Year 2 and 3 activities will focus on transitioning responsibility related to hosting, change and release management, and maintenance and support of the eLMIS to the GoT, through consultation with the national eHealth Steering Committee. GHSC-TA-TZ will continue to build local capacity to support Tier 3 support.

Related KPIs



GHSC-TA-TZ has identified common issues, and are taking corrective actions to facilitate improved response times



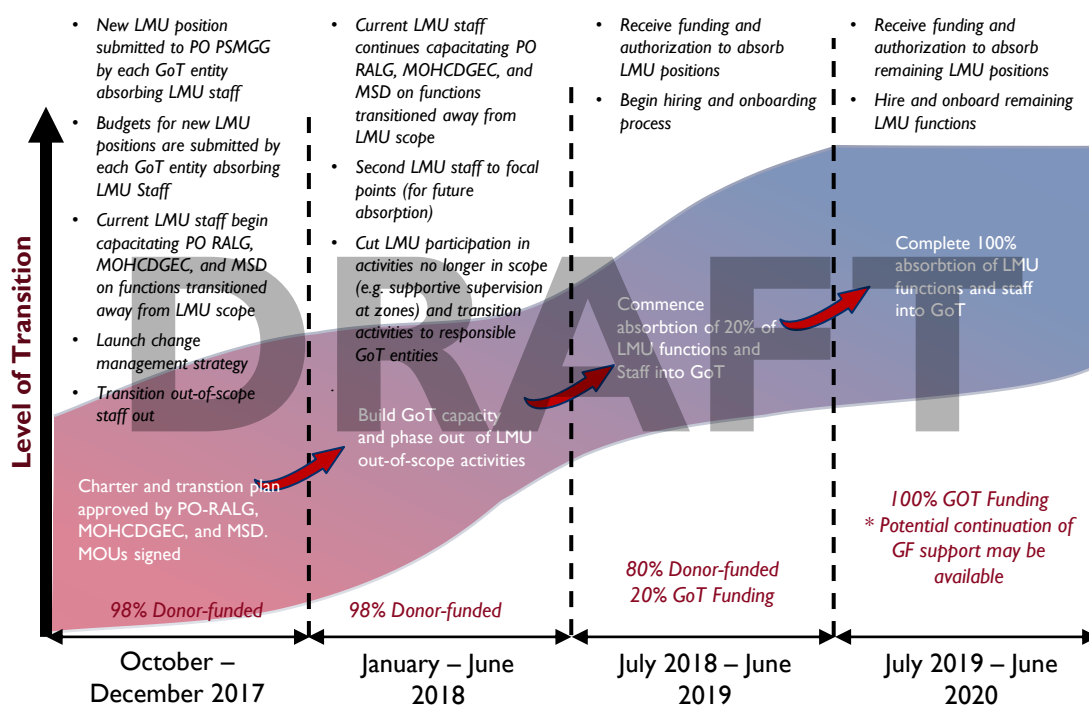
GHSC-TA-TZ has been successful in maintaining reporting rates, post transition from legacy projects.

SUPPORT THE LOGISTICS MANAGEMENT UNIT

Overview The LMU is a structure that was established by the GoT, USAID and the Global Fund to coordinate supply chain activities of different programs under one unit. GHSC-TA-TZ, in addition to providing technical assistance to the central level LMU, supported the operations of the LMU at the zonal level. Staff are based at the MSD zonal warehouses, where they provide a critical link between MSD and health facilities. The project also supports operations and staff at the LMU-Zanzibar.

Activities (outlined on p 11-13) GHSC-TA-TZ has supported the LMU operations in three primary areas:
 1. Improving data visibility and quality, and use
 2. Conducting supportive supervision
 3. Alleviating stock imbalances

Looking forward In Year 2 and beyond, the project will facilitate transition of operational support of the LMU from the USG to the GoT. The project will support the LMU in elevating skills related to data analytics and decision making, while responsibility for reviewing facility level data and performing supportive supervision will transition to Regional/Council Health Management Teams (R/CHMTs) per the draft LMU transition plan (pending approval).



Transitioning the LMU to GoT structures
 The LMU Charter stipulates that its ownership rests with the MOHCDGEC. Currently, the operations and staff of the LMU are supported by USAID (~91%), GoT (~2%) and the Global Fund (~6%). For sustainability, the LMU needs to transition completely to GoT. USAID funding for the June 2018.

GHSC-TA has worked collaboratively with GoT to prepare for this transition. A draft roadmap to transition has been developed, but requires stakeholder buy-in. As part of this transition, there are a number of external risks that need to be managed that are outside of the control of the project team. To the extent possible, GHSC-TA-TAZ will apply mitigation strategies to manage those risks, but requires support from USAID and the GoT.

At the end of this FY, the project engaged two consultants to design a future-state LMU, with a refined scope focused on data management, and to develop a transition plan for reaching that future state.

SUPPORT THE LOGISTICS MANAGEMENT UNIT - IMPROVING DATA VISIBILITY & QUALITY

Overview

In the Integrated Logistics System (ILS), essential health commodities logistics data are collected at the facility level and reported up to the district through a Report and Requisition form (R&R). One of the key roles of LMU is to complete thorough analyses of R&Rs at MSD and determine if there are any quality issues. If required, R&Rs are rejected, feedback is provided, and LMU staff follow up with health facilities and districts to confirm corrections are made and R&Rs are resubmitted.

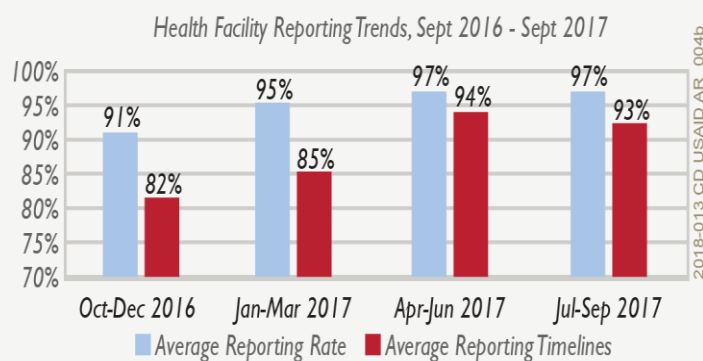
Activities and impact

- During the past year, LMU staff reviewed a total of 33,512 R&Rs from health facilities (out of expected 26,175) and helped to resolve quality issues on 5,542. Submission of accurate R&Rs contributes to reduced working capital tied up inventory and product expiry.
- Submission of R&Rs has significantly improved since deployment of the LMU and the eLMIS; over the last year, the LMU team, through extensive follow up, facilitated an average reporting rate of 95% and reporting timeliness of 88.5%.
- GHSC-TA-TZ monitored and shared data on the performance of zones in fulfilling facility orders with MSD leadership, to drive accountability and performance improvement at the zonal level

Looking forward

For the remainder of the base period, GHSC-TA-TZ will promote shared accountability with PO-RALG, MSD and PSU in terms of holding facilities accountable for data quality. The team will also continue to build capacity of the LMU and other stakeholders to visualize and analyse available data. Further, we will clarify and simplify processes related to data collection.

Related KPIs



Positive trend in average reporting rates quarter-on-quarter

R&Rs statistics	Oct-Dec 2016	Jan-Mar 2017	Apr-June 2017	July-Sept 2017	TOTAL Oct 2016 -Sept 2017
Number of R&Rs expected to be submitted	6,510	6,539	6,539	6,587	26,175
Total number of R&Rs reviewed & approved	8,015	8,972	7,723	8,802	33,512
Total number of Regular R&Rs reviewed and approved	5,920	6,192	5,458	6,367	23,937
Total number of Emergency orders reviewed and approved	2,095	2,780	2,265	2,640	9,780
Total number of orders rejected due to data quality issues	1,174	1,536	1,370	1,462	5,542

Despite support provided to health facilities, a significant number of errors still exist. As such, the LMU continues to improve the accuracy of the health facilities in ordering

SUPPORT THE LOGISTICS MANAGEMENT UNIT - CONDUCTING SUPPORTIVE SUPERVISION AND ALLEVIATING STOCK IMBALANCES

Overview

The LMU coaches R/CHMTs and health facilities staff on responding to findings related to quality of logistics data found in logistics through on-the-job training and joint facility supervision visits. Further, the LMU advocates for R/CHMTs to secure resources to build the capacity of their own health care workers (HCWs) to improve commodities management and quality of logistics data. Finally, LMU staff provide targeted, data-driven supportive supervision to HCWs in public and some private facilities. Over the past year, LMU staff provided technical assistance to health facilities and R/CHMTs, leveraging resources across other partners and GoT partners, and supported the GoT to build capacity to take over and own initiatives (such as supportive supervision) when the project ends. Facility supportive supervision visits are conducted with members from R/CHMTs. The LMU also works to identify and take action on stock imbalance to avoid overstocks and stakeouts.

Activities and impact

LMU by the numbers from January – September 2017

- Built the supply chain capacity of 104 Councils (56% of total councils).
- Provided on-the-job training to 3,307 HCWs on logistics data management and commodity management at 1,883 health facilities.
- Trained 923 HCWs on eLMIS and 563 HCWs on ILS Gateway
- 20 Health Management Teams from RHMT (1) CHMT (18) and Hospital Facilities (1) solicited their own resources to build skills and knowledge to HCWs on the use of eLMIS and ILSGateway and trained more than 300 HCWs on ordering and managing data quality. By increasing the number of staff capable of performing these functions, the LMU can focus on supply chain performance improvement.

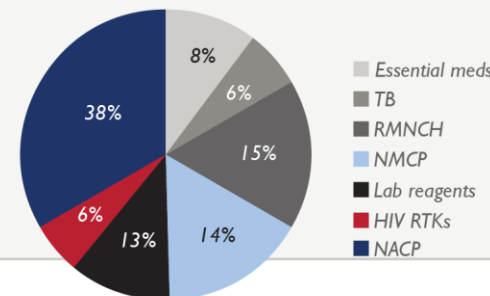
Looking forward

Per the draft LMU transition plan, the supportive supervision function will be transitioned to R/CHMTs. As such, the role of the LMU will be to build up the capacity of the R/CHMTs to perform this function.

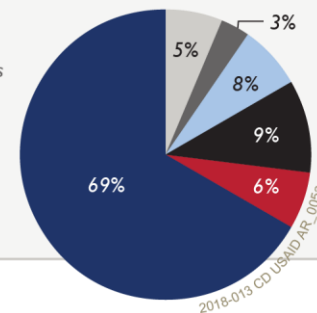
Impact Highlights

*During supportive supervision trips, the LMU team identifies potential system break downs that either may cause stock-outs or overstocks (potential expiries) at health facilities and/or MSD zones, and alleviates these stock imbalances. **In Year 1 of the GHSC-TA-TZ project, the LMU initiated and facilitated inter-health facility and inter-zonal redistribution of health commodities, saving more than 582 million Tshs and 3.7 billion Tshs respectively.***

Inter-Health Facilities Redistribution



Inter-Zonal Transfers



SUPPORT THE LOGISTICS MANAGEMENT UNIT

Spotlight on Zanzibar

Zanzibar's MOH has successfully integrated the role of the LMU into the functions of Chief Pharmacist Office (CPO). The majority of staff performing LMU functions were already embedded the CPO. LMU-ZnZ has carried out its functions in accordance to the Zanzibar Supply Chain Strategic Plan of 2014-2017, which is used to develop their annual workplans. For 2016/17, 71% of activities were carried out as scheduled.

- Over the past year, there was a notable improvement in visibility of logistics data for decision making. The eLMIS data are used by the LMU to select health facilities to be visited (based on the quality of data submitted, whether reports were submitted on time), and to measure key performance indicators. LMU-ZnZ performed supportive supervision, data validation, and on the job training to 177 health facilities in both Unguja and Pemba. This is almost 100% of health facilities in Zanzibar
- Leveraging available resources and support from different stakeholders, LMU facilitated classroom trainings on supply chain management to 147 health facility workers. The Zanzibar-MOH continued to work very closely with CPO to support LMU initiatives. For this year, they issued Certificates of Appreciation by the PS to 7 HCWs who have showed outstanding performance in health commodities logistics, and allowed their health facilities to graduate in supply chain activities.
- The LMU-ZnZ spearheads the Zanzibar Logistics Technical working Group (ZLTWG) each quarter. This important forum is used to share accomplishments, supply chain performance indicators, challenges and recommendations.
- Currently, LMU-ZnZ owns the quantification process with minor technical support from the project.

STRENGTHEN AND STREAMLINE QUANTIFICATION

Overview Quantification exercises bring together stakeholders to analyze available data-and develop forecasts and supply plans for key commodities. The GHSC-TA-TZ project provides technical assistance and builds capacity in quantification to the MOHCDGEC Tanzania mainland and the MOH in Zanzibar. Capacity building activities include providing assistance using software tools such as Quantimed for forecasting and PipeLine for supply planning.

Activities and impact

- GHSC-TA-TZ worked closely with MOHCDGEC programs to set the schedule for and conduct quarterly supply planning reviews and updates. The team also provided TA to manage the pipeline. Updated commodity supply plans were shared with various stakeholders including GoT, MSD, Global Fund, USAID, and GHSC-PSM, to inform procurement decisions. The project assisted programs in mobilizing required funding by providing technical justifications for the required shipments.
- GHSC-TA-TZ used quantification workshops to coach and build the capacity of program staff, advocate for country ownership, and strengthen governance structures for forecasting and supply planning activities. Support included overall coordination of quantification workshops and commodity security meetings, data collection and analysis, facilitating assumptions building, presenting results, and compiling technical reports. Further, the project collaborated with NACP and Clinton Health Access Initiative to train 28 MOHCDGEC staff on using PipeLine software.
- The team assessed forecasting accuracy, and provided mentoring and training to vertical programs to improve their capabilities to conduct such analyses.
- The project produces routine reports such as the Procurement Planning and Monitoring Report (PPMR), and the PPMR malaria (PPMRm), which provide visibility into consumption, stock levels, and upcoming shipments.
- In the past year, GHSC-TA-TZ absorbed some of the GHSC-PSM project activities, by placing orders, clarifying questions on orders placed, and facilitating procurement-related discussions on USG-funded procurements across vertical programs, USAID | Tanzania, GHSC-PSM, and MSD.

Looking forward GHSC-TA-TZ looks to institutionalize the quantification function (approach, process and management structures) within the GoT, by providing coaching to stakeholders to assume more technical responsibility through better governance. Additionally, the team will focus on improving the quality of data that informs quantification exercises.

Related KPIs

Forecast accuracy (July 2016 to June 2017)

- ACTs: 82%
- Malaria RDTs: 98.5%
- ARVs: 75%
- HIV rapid test kits: 82%
- RMNCH: 68% (Jan – June 2017 only)

Year 1 target was 70%, which was achieved for the entire list of commodities except RMNCH

Funding requirements for commodity procurement		
Product category	Jan-Dec 2018 funding requirements	Funding gap
ARVs	\$ 113,599,108.00	-
HIV-Lab	\$51,715,027.00	No Funding gap
Malaria	\$25,860,392.78	No Funding gap
RMNCH*	\$29,444,451.00	\$10,702,834.00

GHSC supported resource mobilization efforts related to health commodity needs

BUILD SUPPLY CHAIN SKILLS OF KEY COUNTERPARTS

Overview Capacity building is integrated throughout most of the project activities, and is intended to enhance the supply chain knowledge and skills of our key stakeholders within GoT. For example, GHSC-TA-TZ has supported building the skills of the R/CHMTs through the LMU workstream, PSU and MSD through the RBF workstream, and staff within vertical programs through the quantification workstream. We have also seconded staff to the NACP, MSD, and NTLP, to provide continuity to the technical assistance provided by the legacy projects, and to build the supply chain skills within the programs.

Activities and impact

NACP

- Advised on the restructuring of NACP to **elevate the importance of supply chain management, improve decision making, and shape the objectives of the HIV Pharmaceutical and Laboratory Services Unit**
- Successfully advocated for integration of supply chain as its own chapter within the Health Sector HIV Strategic Plan IV (HSHSP IV), thereby **raising awareness to support resource mobilization efforts**; Updated the PMTCT strategic plan, and the National Guidelines for Management of HIV/AIDS to include supply chain management considerations
- Supported development of the Global Fund concept note, Procurement and Supply Chain Management (PSM) module.

NTLP

- **Contributed to improved product availability associated with new product introductions**, by sensitizing NTLP and stakeholders on supply chain considerations and readiness of new formulations, combinations, and commodities, including those related to MDR-TB
- **Mentored NTLP on how to coach staff** in Regions and Districts with poor data reporting rates and data quality in the in TB and leprosy medicines logistics system.
- **Improved diagnostics capabilities and appropriate use of TB and leprosy medications** through the integration of laboratory reagents and supplies into the TB and leprosy logistics system.

MSD

- Provided TA in leading warehousing and distribution practices (e.g. inventory, storage) to **improve supply chain efficiency**
- **Supported the use of data in decision making** by preparing MSD monthly performance indicators such as fill rates and order turnaround time.
- **Facilitated information sharing** between MSD-Vertical Programmes and LMU.
- Provided specialized technical product knowledge for commodities requiring special handling (e.g. cold-chain, short shelf-life)
- Supported stock keeping unit rationalization
- Advised on product rationing for received commodities with small quantities e.g. ABC/3TC paediatric formulations to improve availability for high risk populations

Looking forward

GHSC-TA-TZ will transition responsibilities of seconded staff to the programs. Additionally, the project will focus on identifying innovative training approaches to build the capability of counterparts within supported programs.

INCREASE DATA USE

Overview

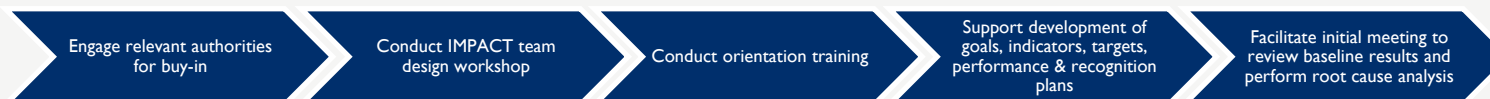
As the visibility of data has consistently improved, GHSC-TA-TZ is focused on increasing the use of supply chain data by stakeholders. One strategy is in the implementation of the IMPACT Team Network, which is a people-centered, data-driven approach to improve the performance of the supply chain by focusing on quality, efficiency and customer service. IMPACT teams routinely meet to analyze key performance indicators (such as stockouts), conduct root cause analysis, and develop action plans to address root causes. These action plans are then followed up at the next IMPACT team meeting.

Activities and impact

- **Three separate IMPACT teams have been established in Zanzibar** – Unguja, Pemba, and national
- GHSC-TA-TZ met with Zanzibar MOH to secure buy-in, conducted a design workshop, and developed an implementation and performance plan.

National Level IMPACT team performance plan

Goal: By the end of 2018, health facilities produce quality and reliable data through capacity building to confirm availability and accessibility of vital tracer medicines and supplies to all facilities in Zanzibar						
Indicator	Source of Data	Baseline	Target	Level of recognition	Criteria	How to recognize
Number of rejected R&R forms from health facilities	eLMIS	ZILS: July-Sept 17 = 45 rejected R&Rs per quarter ARVs = 3 rejected R&Rs	ZILS: 10 rejected R&Rs ARVs: 1 rejected R&R	District Pharmacist	Two consecutive quarters without any rejected R&R from facilities in the district	Certificate of appreciation from MOH presented during the ZLTWG meeting by PS-MOH
% of health facilities with stock outs of tracer commodities	eLMIS	April – June 2017: RHCS: 7%; EM: 16% ARV: 0%; RTKs: 16% Malaria: 3%	RCHS: 0%; EM: 10%; ARV: 0%; RTKs: 10%; Malaria: 0%	DHMT (DMO)	Two executive quarters where there are no facility stockouts of tracer commodities in the district	
% of logistics data accuracy	Data validation report	April – June 2017 38% accuracy	50% accuracy	Facility	Facility with 95% of logistics data accuracy for all tracer commodities in a data validation survey	



Looking forward

The GHSC-TA-TZ secured buy-in and began building capacity of teams using a standardized approach
In Tanzania mainland, the project plans to introduce the concept of IMPACT teams to PO-RALG leadership, and subsequently carry them out at regional and/or council levels, depending on the final design. The IMPACT teams approach has been adopted and included in the Zanzibar Supply Chain Action Plan, and GHSC-TA will continue to support the meetings and coach the Zanzibar team in performing root cause analyses and monitoring action plans to support achievement of targets.

SUPPORT THE IMPLEMENTATION OF A RESULTS BASED FINANCING SCHEME

Overview

The MOHCDGEC and PO-RALG have been applying Results-based Financing (RBF) approaches to improve the quality and utilization of health services in primary care facilities. RBF links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered. GHSC-TA-TZ has been supporting the implementation of RBF at MSD Central Strategic Business Units (SBUs) and zonal SBUs.

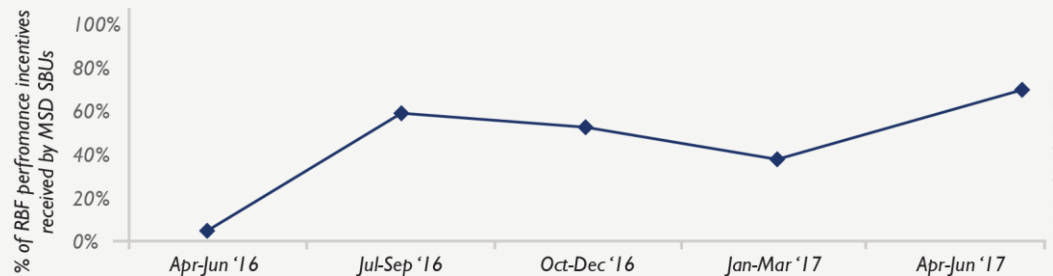
Activities and impact

- GHSC-TA-TZ supported the roll out of the supply chain component of the RBF scheme.
- The supply chain RBF component was initiated months after the take off of the health facility RBF scheme. To address a lack of ownership and commitment from the MOHCDGEC and the National RBF team to the supply chain RBF component, the project strategically collaborated with MSD and MOHCDGEC to revise the indicators and refine the initial RBF design.
- The project also participated in the quarterly MSD RBF verification exercise. It is through this participation that the project noted unclear and ambiguous interpretations of the verification guidelines and other implementation challenges. In response, GHSC-TA-TZ successfully brought together 26 MSD staff and MSD RBF verifiers to a consultative workshop. During this workshop, the project supported the participants in developing clear standard operating procedures (SOPs) for more objective verification activities. Through the workshop, further strategies for implementation were identified in order to support an efficient roll out of the scheme. The project has successfully provided its technical assistance, resulting in significant improvement in RBF incentives received by MSD SBUs.

Looking forward

GHSC-TA-TZ will provide TA in carrying out the revised SOPs for RBF verification. The project will also look into streamlining RBF activities and reduce cost, improve invoicing and financial documentation (for facilities and MSD). The program will also use historical eLMIS data to compare the availability of medicines in the RBF facilities vs. non-RBF facilities.

Related KPIs



MSD performance has fluctuated, in part due to a lack of understanding of scoring. GHSC-TA-TZ helped to provide clarity in terms of how indicators are measured

LEVERAGE THE ROLE OF THE PRIVATE SECTOR

Overview In year 1, GHSC-TA-TZ performed an assessment to identify opportunities for increased private sector engagement in strengthening public supply chains with the objective of improving availability of health commodities. During the assessment, the team also identified current challenges with private sector engagement in the public health supply chain.

Activities and impact Key recommendations from the assessment included:

- Increase the pool of suppliers considered in the Prime Vendor Model by conducting pre-bidding conference to promote awareness and understanding of the bidding process
- Formalize process of engagement for private transporters for direct distribution of commodities
- Engage small-scale transporters (motorcycles) for distribution of select commodities from zone to the facility
- Make visible to facilities the available stock at MSD prior to their orders, so they do not order commodities not in stock, and can sooner source from the private sector
- Increase wholesaler awareness and understanding of required documents needed for product registration

Looking forward GHSC-TA-TZ will support the improvement of last mile distribution by identifying potential private transporters to support MSD to distribute health commodities to health facilities. Additionally, the program will work with MSD and PO-RALG to improve the process of notifying health facilities when MSD is out of stock of product. Finally, GHSC-TA-TZ will continue to advocate to wholesalers to participate in Prime Vendor bidding.

Snapshot

- Private wholesalers purchase supplies from importers and local manufacturers
- Private sector stakeholders distribute to public and private health facilities, FBOs, retail pharmacies and Accredited Drug Dispensing Outlets (ADDOs)
- **Seven pharmaceutical manufacturers in Tanzania provide ~20% of MSD procurement**
- MSD sources from manufacturers and wholesalers

Findings from private sector assessment were shared with USAID, MSD, private sector organizations, and others.

Private Sector Pharmaceutical Suppliers	#
ADDOs	11,834
Retail pharmacies	917
Private health facilities with onsite pharmacies	659
Retail & Wholesale pharmacies	284
Private-not-for-profit health facilities with onsite pharmacies	155
Wholesaler pharmacies	126
Importers	50
ADDO Restricted wholesaler	17
Local Manufacturers	7

A range of private sector organizations contribute to the pharmaceutical value chain

ESTABLISH A CULTURE OF COLLABORATION AND INFORMATION SHARING

Overview

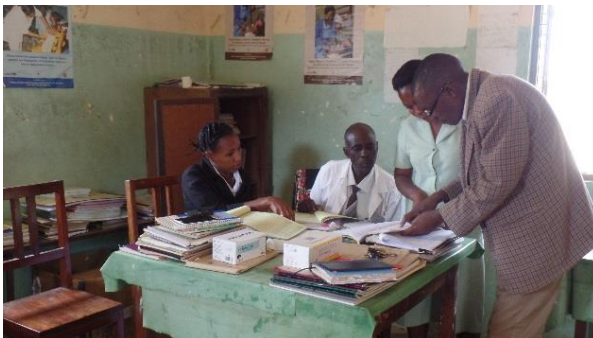
Collaboration with in-country stakeholders is central to the project's approach to supply chain strengthening, decision-making, and management. Coordination groups (such as commodity security meetings and technical working groups) provide a mechanism to share supply chain data, align objectives, and facilitate the effective management of commodity-related resources across stakeholders. The project provides quantitative and qualitative data on supply chain performance to these groups to promote information sharing and the use of data for decision making.

Activities and impact

- The project participates in routine Commodity Security working groups, which are integrated into each of the programs, as well as regular meetings with other supply chain partners such as Boresha Afya, the MOHCDGEC's Health Commodities and Health Technologies Working Group, and the vertical programs meeting at MSD.
- The project also facilitates dialogue between MSD, PO-RALG, and MOHCDGEC on supply chain issues.
- The project contributes to these collaborative forum by sharing data on: KPIs, stock status, planned shipments, quantification results, resource mobilization, upcoming supply chain activities, technical capacity building needs, supply chain challenges and solutions for common supply bottlenecks.

Looking forward

GHSC-TA-TZ will continue to identify opportunities to engage stakeholders in sharing information through technical and policy briefs, and conducting the annual supply chain forum that will include different supply chain stakeholders – including the private sector, GoT, IPs, DPs, professional bodies and others. Further, GHSC-TA-TZ will formalize and continue to cultivate supply chain collaboration between MSD, PO-RALG and MOHCDGEC.



IMPLEMENTATION CHALLENGES, RISKS, AND MITIGATION MEASURES

IMPLEMENTATION CHALLENGES, RISKS, AND MITIGATION MEASURES

Risks and Challenges	Mitigation
<p>There is a critical paradigm shift from the previous projects – rather than focusing on operational implementation, GHSC-TA-TZ acts in an advisory capacity, with a focus on strengthening governance and building capacity in supply chain.</p>	<p>Project staff continue to grow into this refined role, engaging stakeholders from this new perspective with support from GHSC-TA-TZ leadership.</p>
<p>A major activity conducted by the project in its first year was the HSCR, which was not included in the original workplan and proved to be more demanding on the project than initially envisioned. As a result, work plan implementation rhythm was disrupted, and some workplan activities became redundant.</p>	<p>The project identified activities that could be consolidated or removed while still working towards achieving the broader objectives. Plans were made to address the delayed activities, and the recommendations from the HSCR were incorporated into the Program’s Year 2 workplan.</p>
<p>PO-RALG is playing an increasingly important and visible role in public sector supply chain management and oversight. The MOHCDGEC which has historically been the primary beneficiary of technical assistance, remains a key stakeholder for GHSC-TA-TZ</p>	<p>The project intends to strengthen its relationship with PO-RALG, and increase its focus on aligning supply chain priorities across MOHCDGEC and PO-RALG in the coming year.</p>
<p>Another component of this shifting political landscape which has been a challenge for the project is to encourage sustained engagement by PSU. With several competing priorities and some vacant positions, cultivating supply chain leadership within PSU has been challenging.</p>	<p>To address this, the project has intentionally engaged the PS and the Chief Medical Officer in crucial supply chain activities and decision making. Additionally, the project intends to revitalize the Supply Chain Steering Committee, led by high-level officials within the MOHCDGEC, PO-RALG, and MSD. This collaborative focus will be important to sustain while some GoT staff are in Dodoma, and others in Dar es Salaam, though will eventually move to Dodoma.</p>

IMPLEMENTATION CHALLENGES, RISKS, AND MITIGATION MEASURES

Risk	Mitigation
<p>USAID funding for the LMU is scheduled to phase out in June 2018. The project has developed a draft timeline to transition and recently engaged consultants to develop an LMU future-state design and implementation plan. There are several risks with transitioning support to the LMU, including the ability and political will to transition support to GoT within planned timelines. The draft transition plan has not yet been approved, due to low attendance and cancellations of the Steering Committee.</p>	<p>As part of this transition, there are a number of external risks that need to be managed that are outside of the control of the project team. To the extent possible, GHSC-TA-TZ will carry out mitigation strategies to manage those risks, but requires support from USAID and the GoT (MOHCDGEC, PO-RALG, Ministry of Finance, MSD, The President’s Office, Public Service Management and Good Governance (PO-PSMGG)).</p>
<p>In its first year, it was anticipated that GHSC-TA- TZ would play an advisory rather than an operational role in quantification; however, to-date, GHSC-TA-TZ has continued to assume much of this role.</p>	<p>With PSM hiring a resource to facilitate ordering, we are able to free up time for one of our resources to focus on developing and applying strategies for building ownership of and transferring skills to the GoT. The leadership of GHSC-TA-TZ will support the new resource in shifting focus from carrying out activities to coaching and mentoring.</p>
<p>Data quality, particularly from the facilities, has improved; however, challenges remain, as demonstrated by the number of R&Rs that are rejected, and discrepancies between true stockouts and reported stockouts.</p>	<p>Moving forward, the project will focus on improving the quality of data through appropriately automating processes, revising the supportive supervision checklist, and developing an e-learning platform for eLMIS.</p>



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ANNUAL REPORT PMP & ROOT CAUSE ANALYSIS

2017

PROJECT MONITORING PLAN

DIRECT INDICATORS							
OBJECTIVE	MEASURE	TARGET	REPORTING FREQUENCY	Q1 OCT-DEC 2016	Q2 JAN-MARCH 2017	Q3 APR-JUNE 2017	Q4 JULY-SEPT 2017
I. Provide Strategic Planning and Implementation Assistance	I.1.2 Percent of activities carried out in accordance with NPAP Costed Implementation Plan	100% by 2019	Semi Annual		55%		63%
	I.1.3 Percentage adherence to LMU transition plan	100%	Annual (starting year 2)				N/A (transition plan waiting for approval from LMU Steering Committee)
CONTEXTUAL INDICATORS							
OBJECTIVE	MEASURE	TARGET	REPORTING FREQUENCY	Q1 OCT-DEC 2016	Q2 JAN-MARCH 2017	Q3 APR-JUNE 2017	Q4 JULY-SEPT 2017
I. Provide Strategic Planning and Implementation Assistance	I.1.4 Percentage of MoHCDGEC budget secured for health commodities (reported as the % of total needs budgeted to be procured by the MoHCDGEC)	Positive trend in GOT funding for health commodities	Annual				ARVs 0% RTKs 0% RH 0.02% Malaria 7% EM 36%
	I.1.5 Percent of shipments delivered on time and complete within an agreed upon window (Central to Zonal level only)	80%	Quarterly	ARVs 47%, RTKs 43% FP 55% Malaria 32%	ARVs 59% RTKs 79% FP 76% Malaria 38%	ARVs 43% RTKs 25% FP 62% Malaria 55%	ARVs 88% RTKs 62% FP 94% Malaria 69%
	I.1.6 Stock Out Rate	< 5%	Quarterly	ARVs 8% RTKs 15% FP 28% Malaria 30% EM 47%	ARVs 15% RTKs 10% FP 21% Malaria 47% EM 37%	ARVs 13% RTKs 10% FP 23% Malaria 16% EM 34%	ARVs 11% RTKs 11% FP 20% Malaria 15% EM 27%

PROJECT MONITORING PLAN

DIRECT INDICATORS							
OBJECTIVE	MEASURE	TARGET	REPORTING FREQUENCY	Q1 OCT-DEC 2016	Q2 JAN - MARCH 2017	Q3 APR-JUNE 2017	Q4 JULY-SEPT 2017
2. Improve Delivery of Health commodities in Service sites	2.1.1 Percent of eLMIS issues reported and resolved within SLA defined performance period	80%	Quarterly	35%	52%	56%	43%
	2.1.2 Percent of facilities sending timely and complete LMIS reports to the central level	80%	Quarterly	91%	95%	97%	94%
	2.1.3 Level of country counterpart ownership in quantification and supply planning	75%	Annual				81.8%
	2.1.4 Percent forecast accuracy (by commodity group)	70%	Annual				ARVs 75.5% RTKs 82% RH 68.3% Malaria 82.2% mRDT 98.5%
	2.1.5 Data use for routine supply chain decision making	Metric will be refined	Semi annual				55%*
	2.1.6 The percentage of data quality assessments with a passing score	80%	Quarterly	64%	48%	49%	48%

CONTEXTUAL INDICATORS							
OBJECTIVE	MEASURE	TARGET	REPORTING FREQUENCY	Q1 OCT-DEC 2016	Q2 JAN - MARCH 2017	Q3 APR-JUNE 2017	Q4 JULY-SEPT 2017
2. Improve Delivery of Health commodities in Service sites	2.1.7 Inventory turns (at MSD central)	2 <i>(to be confirmed with MSD)</i>	Quarterly	ARVs 1.0, FP 0.15, Malaria 1.3	ARVs -, FP 0.05, Malaria 0.7	ARVs -, FP 0, Malaria 0.5	ARVs 0.15, FP 0.26, Malaria 0.33
	2.1.8 Cycle time (average)	14 days	Quarterly	16 days	15 days	17 days	8 days
	2.1.9 Number of Artemisinin based combination therapy (ACT) treatments purchased in any fiscal year with USG funds that were distributed in this fiscal year	No target provided by PMI	Annual				1,796,520
	2.2.1 Percent of LMU operational costs paid for by the GOT	20% by June 2019; 100% by June 2020	Annual				2%

PROJECT MONITORING PLAN

DIRECT INDICATORS							
OBJECTIVE	MEASURE	TARGET	FREQUENCY OF REPORTING	Q1 OCT-DEC 2016	Q2 JAN -MARCH 2017	Q3 APR-JUNE 2017	Q4 JULY-SEPT 2017
3. Broaden Stakeholders' understanding and engagement of the supply chain system	3.1.2 Percent of RBF training participants who scored 80% proficiency on evidence based decision making assessment related to RBF	80%	Semi Annual		38%		14%

CONTEXTUAL INDICATORS							
OBJECTIVE	MEASURE	TARGET	FREQUENCY OF REPORTING	Q1 OCT-DEC 2016	Q2 JAN - MARCH 2017	Q3 APR-JUNE 2017	Q4 JULY-SEPT 2017
3. Broaden Stakeholders' understanding and engagement of the supply chain system	3.1.1 Percent of RBF performance incentives received by MSD SBUs over a specified period	75%	Quarterly	Central SBU 21%, Central VP 27%, Transport SBU 40%, Mwanza 64%	Central SBU 21%, Central VP 15%, Transport SBU 85%, Mwanza 28%	Central SBU 12%, Central VP 44%, Transport SBU 33%, Mwanza 90%, Dar 22%	N/A (will be available in November)
	3.1.3 Overall health facility satisfaction rating for supply chain activities	>80% for good or above	Quarterly				Very Good 10% Good 70%, Neutral 19%, Poor 1%, Very Poor 0%
	3.1.4 Number of local organizations identified and trained in promoting change management in health commodity supply chain	10	Quarterly	0	9	8	17
4 Strengthen Enabling Environments to improve supply chain performance	4.1.1 Number of identified private sector stakeholders working with MSD/CMS (focus on transporters)	Metric will be refined	Annual				2
	4.1.2 Percent improvement in results of the Comprehensive Self-Assessment Checklist over time (Year 1, Year 3 and Year 5)	Metric will be refined	Year 2, 3				

EMMP

INDICATOR	RESULT	NOTES
Number of project material including sound environment health and safety (EHS) practices	N/A	None of the project material produced during the year required integration of EHS practices
Number of training activities with an environment impact management section.	N/A	No training activities included (or should have included) an environment impact management section
Number of TA materials produced by the project that include references to HCWM guidelines.	1	The supervision checklist was updated to include questions around HCWM

PEPFAR STOCKED ACCORDING TO PLAN

PRODUCT CATEGORY	PERCENT OF FACILITIES BETWEEN MINIMUM AND MAXIMUM STOCK LEVELS
ARVs	20%
RTKs	18%
OI medicines	22%
Male condoms	17%

— ROOT CAUSE ANALYSIS FOR PMP INDICATORS

1.1.2 PERCENT OF ACTIVITIES CARRIED OUT IN ACCORDANCE WITH THE NATIONAL PHARMACEUTICAL ACTION PLAN (NPAP) COSTED IMPLEMENTATION PLAN (CIP)

Performance trends

There are 234 total activities in the NPAP costed implementation plan, of which 147 (63%) have been carried out (or are at some stage of implementation). These are broken down by strategic area below. Note: GHSC supports GoT in carrying out only those activities directly related to supply chain

Strategic area	No. Activities planned	No. activities carried out	% of activities with implementation underway
Selection & Use	22	14	64%
Regulatory environment	30	23	77%
PSM National level	45	38	84%
PSM Local level	32	6	19%
Information system	25	19	76%
HR and Capacity building	27	16	59%
Financing and Prices	29	21	72%
Governance & accountability	24	10	42%
Overall	234	147	63%

Root cause analysis

84% of PSM National level activities were sufficiently funded and resourced to facilitate implementation. GHSC-TA-TZ worked with GoT to align the NPAP with other strategic plan documents, including the MSD Medium term Plan III, HSSP IV and BRN. Strategic areas where implementation was higher, including regulatory environment (77%) and information system (76%), also had higher levels of support for implementation. Independent regulatory authorities (such as Pharmacy council and TFDA) have reliable funding, committed resources and incorporated these interventions into their respective strategic plans. Similarly, the MOHCDGEC was committed to coordinate partners to support Management Information Systems. The areas where fewer activities were carried out were at PSM local (19%) and governance and accountability (42%). Contributing factors include poor advocacy and interpretation of the NPAP document at local level, and misalignment of activities in the NPAP with local level plans. Consequently, this affected the buy in from the C/RCHM. Also, some local investments could not be captured because partners were carrying out activities directly to facilities and no mechanism was in place to capture their work. Finally, the HSCR addressed gaps in the supply chain, and proposed new activities, making some existing NPAP activities redundant.

Corrective actions

To promote successful, on time NPAP implementation, the following actions will be undertaken in collaboration with PSU.

- Raise awareness of resources required to fund activities in the CIP
- Conduct advocacy to key stakeholders to promote multi-stakeholder alignment
- Develop dashboard to facilitate monitoring of activities; disseminate to encourage accountability

I.1.4 PERCENT OF MOHCDGEC BUDGET SECURED FOR HEALTH COMMODITIES

Performance trends

Vertical Programs: Vertical program commodities costs are almost entirely covered by development partners. The MoHCDGEC budgeted to cover about 0.02% (Tshs 10,000,000) of the national reproductive health needs and 7% (Tshs ~4 billion) of the national need for malaria commodities

Essential medicines: EM quantification was not supported by GHSC in Year 1, but will be of greater focus throughout the remainder of the base period. As such, the project does not have current data about the total need for EM. For context, about 36% of the 251 million Tshs MoHCDGEC budget for health commodities for the financial year 2016/17 was deposited in health facility accounts located at MSD. The remaining MOHCDGEC budget for health commodities also covers MSD debt recovery, clearing and forwarding, and vertical program commodities.

Root cause analysis

In 2015/2016, the budget for health commodities was 29 million Tshs, which skyrocketed to 251 million shillings for 2016/2017. About half of these funds however, were committed to cover part of the accumulated MSD debt and clearing and forwarding of medical supplies and services.

According to the Strategic Review of the Medical Stores Department of Tanzania 2015, the disparity between the annual allocated budget and actual disbursement amounts grew from 4% in FY2012/13 to 51% in 2015/16. For 2016/17, there is a complete reversal, where 103% of the budgeted amount was actually disbursed.

Budget allocations from the MoHCDGEC for vertical program commodities are low. Additionally, these allocations are not disbursed completely. Although the budgeted needs for malaria were to cover 7% of the total need, no funding was disbursed. Although the MoHCDGEC budgeted Tshs 10,000,000 for RH needs, only Tshs 6,000,000 were disbursed. The allocation funds for vertical program health commodities were not fully disbursed due to competing interests in meeting the disbursements for the essential health commodities. the latter has been one of GoT priorities due to consistent stock out over years

Corrective actions

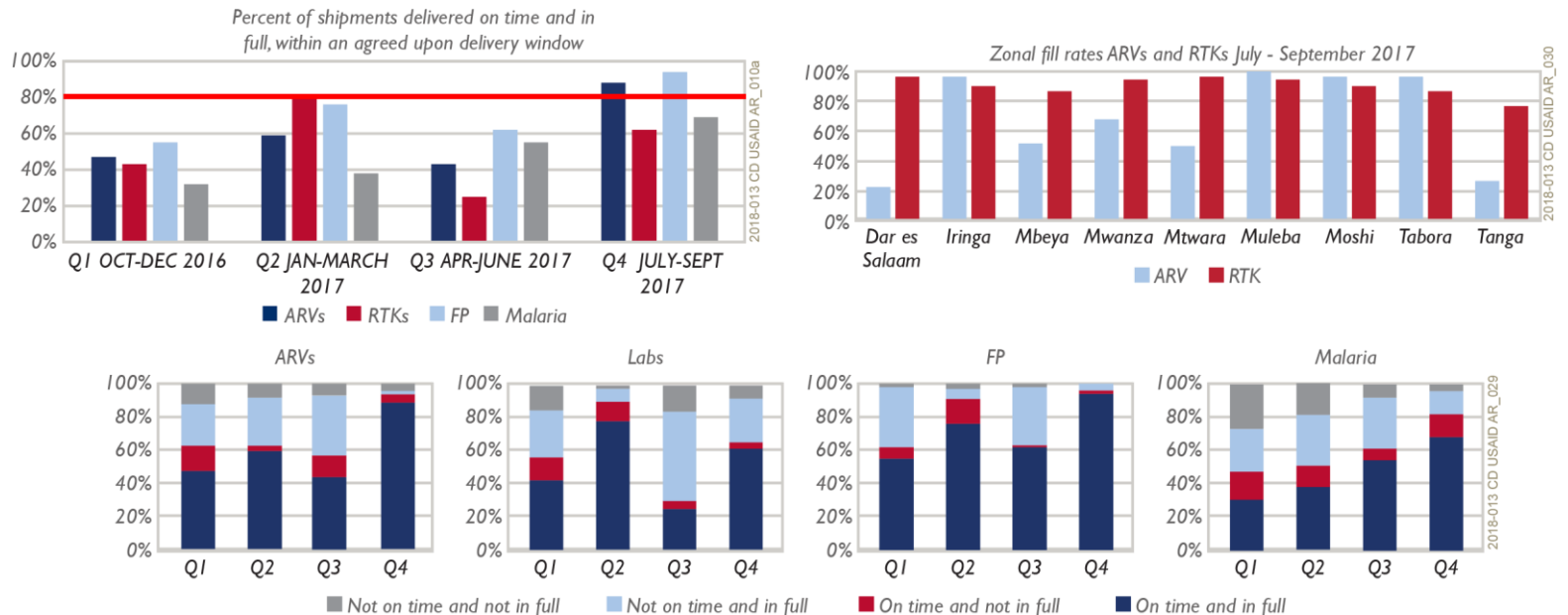
The GHSC-TA-TZ project plans to conduct a total health commodities financial needs assessment in Year 2. This information could inform the different players of health commodity procurement, particularly MSD, on how much of the total need is being covered by each funding source.

In addition, GHSC-TA-TZ will work closely with PS3 to explore how revenues collected by health facilities and councils (through Direct Health Facility Financing and other complementary funds) can help reduce facility dependence on in kind central funds disbursed through MOHCDGEC, and procure directly from MSD. For MSD on the other side, this information will first make it visible what their market share is and to inform them on what to procure based on the consumption levels of the HF they serve

I.1.5 PERCENT OF SHIPMENTS DELIVERED ON TIME AND COMPLETE, WITHIN AN AGREED UPON DELIVERY WINDOW

Performance trends

The percent of shipments delivered on time and complete, within an agreed upon delivery window, improved significantly during the fourth quarter. The graph below shows fulfillment from MSD central to MSD zones for the past year, and zonal fill rates for ARVs and RTKs for the past quarter.



Root cause analysis

Quarter 4 on time and complete rates were significantly improved from previous quarters. Low order fill rates are primarily due to insufficient stock levels at MSD central due to a variety of reasons, including lack of quality data to inform quantifications, lack of financial resources for procurement, or lack of coordination across supplying sources.

Corrective actions

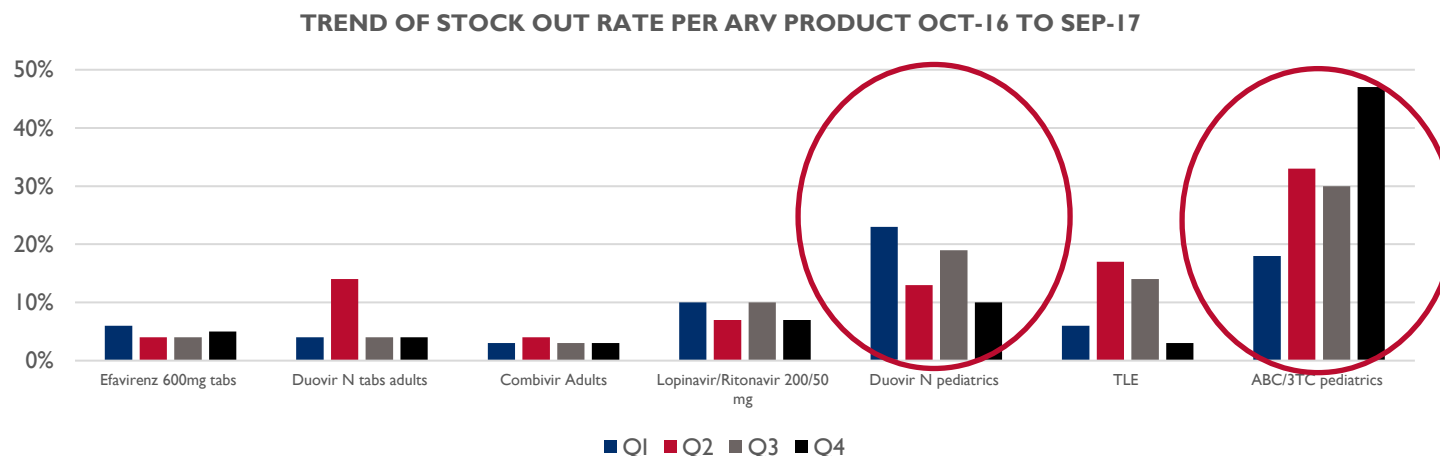
GHSC will work with vertical programs to strengthen on time delivery of shipments to MSD as per supply plan and to communicate any expected delays to enable proper planning and avoid stock outs at health facilities.

Through data analysis and reporting, GHSC-TZ-TA will advise MSD leadership to hold MSD zonal managers, Vertical program focal person and logistics staff accountable when it comes to poor performance.

I.1.6 STOCK OUT RATE:ARVS

Performance trends

Over the past year, stock out rates have been less than 15% on average



Root cause analysis

In the first quarter, Duovir N pediatrics contributed significantly to the ARVs stock out rate. The Duovir N stock had a short shelf life, expiring in December 2016; therefore, zonal orders were not fulfilled.

The supply of ABC/3TC 60/30mg pediatric formulation has been erratic from quarter two to quarter four; The available consignment at MSD had a short shelf life, which expired between January and July 2017; it was assumed that these quantities would have been consumed before expiry; however, uptake was lower than anticipated and product expired. Additionally, the product was stocked out at MSD zonal levels and health facilities in August 2017.

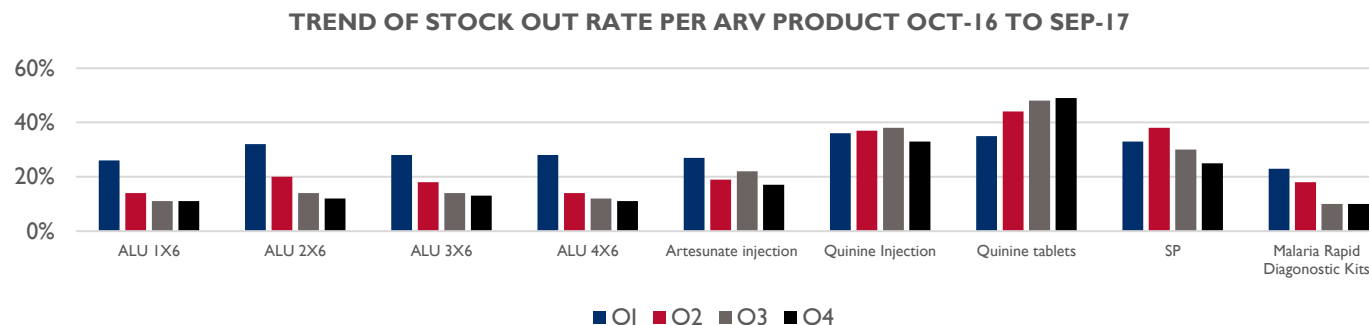
Corrective actions

- GHSC-TA-TZ will closely monitor the stock status of all ARVS, to alert to potential stockouts, and work with NACP and stakeholders to ensure supplier adherence to shipment schedules, and to adjust schedules when necessary
- The LMU will continue to facilitate redistribution of stock to help combat expiries and stockouts.
- During facility supportive supervision visits, LMU staff compare reported stockout rates as shown in the eLMIS with facility records (paper R&R, dispensing registers and stores ledgers) to investigate whether the stockout is true or not

I.1.6 STOCK OUT RATE: MALARIA

Performance trends

Stock out rates for malaria peaked at 47% in March, but reduced to 15% for the latest quarter.



Root cause analysis

In the first quarter, the stock out rate for malaria commodities was partly attributed to low fill rates to MSD zones by Central, caused by stock outs of ALU presentations and defective batches of mRDT that were quarantined while awaiting quality checks. Beyond this, the availability of sulphadoxine pyrimethamine (SP) at MSD has been low as the GoT has not procured the quantities of SP that they committed to. At the end of July, there was 0.3 MOS at MSD central. In September, this number had increased to 2.9 MOS, but was still far below the minimum inventory levels. 30% of facilities were stocked out of SP in September. One contributing factor is the delays in arrival of 10 MOS of SP funded by the President's Malaria Initiative (PMI) that was expected to arrive in May 2017, which is now scheduled for January 2018.

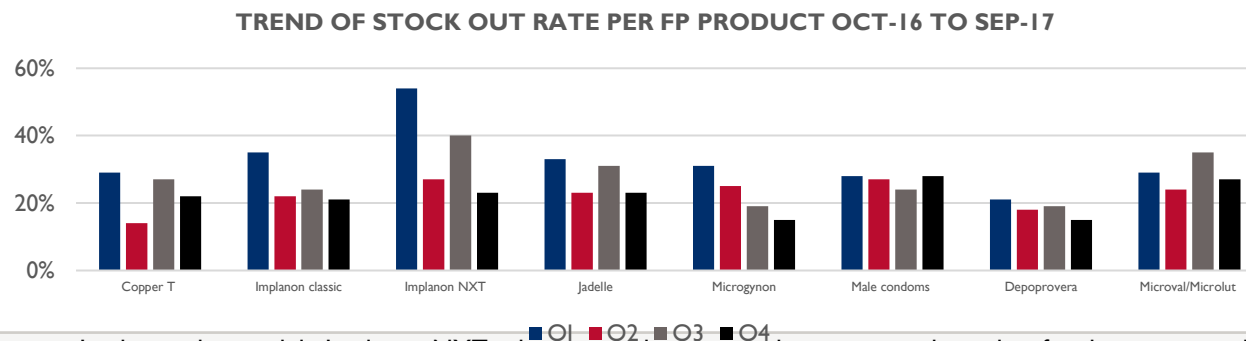
Corrective actions

- GHSC-TA-TZ will work with NMCP to plan for SP procurements as far in advance as possible, and continue advocating with the GoT to procure SP, as per their commitment. HF to continue procuring SP using other sources of the funds from other vendors other than MSD to alleviate the shortages
- The project will follow up with NMCP on their monitoring of rational use of quinine.
- LMU assisted in rationing of available non-defective mRDTs to be distributed to HFs.
- During facility supportive supervision visits, LMU staff compare reported stockout rates as shown in the eLMIS with facility records (paper R&R, dispensing registers and stores ledgers) to investigate whether the stockout is true or not

I.I.6 STOCK OUT RATE: REPRODUCTIVE HEALTH

Performance trends

Stock out rates for FP commodities have fluctuated between 20% and 28%.



Root cause analysis

RCCHS is phasing out Implanon classic while Implanon NXT is being introduced to replace it, so stockout data for these two products must be interpreted in the context of transition.

Male latex condoms have not been at full supply. The July-August zonal orders were not supplied with condoms due to shortages at the Program level.

There was a decrease in preference by clients to use Copper-T and Jadelle methods in favor of Implanon NXT; a long term method and easy to use leading to service providers preferring to order NXT. This preference has increased pressure on Implanon NXT.

With Microgynon, there were stock availability issues at central MSD which was addressed towards quarter four by the program resulting into decreased stock out rate.

At MSD, there are different part numbers for Depo Provera. Many health facilities ordered Depo Provera via the part number that was stocked out at MSD, and so were not supplied.

In some cases, district pharmacists made changes to facility orders when they recognized that some of the items were ordered incorrectly and may not be used at the facility.

Corrective actions

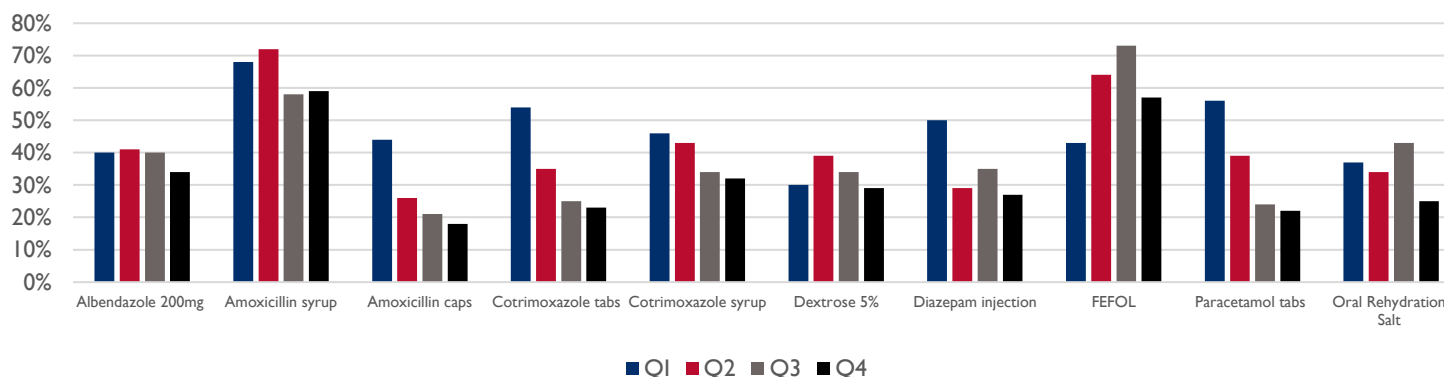
- GHSC-TA-TZ will continue to work with RCCHS on alerting to national stock imbalances, highlighting upcoming shipments required, and identifying financial resources required through quarterly supply planning updates and commodity security meetings. Also, advocate for the use of data for timely corrective measures at program level.
- LMU communicated with health facilities on the correct part numbers to use from MSD, and the project will explore options for MSD to provide feedback to health facilities on medicines available with their correct part numbers.
- During facility supportive supervision visits, LMU staff compare reported stockout rates as shown in the eLMIS with facility records (paper R&R, dispensing registers and stores ledgers) to investigate whether the stockout is true or not

I.1.6 STOCK OUT RATE: ESSENTIAL MEDICINES

Performance trends

For essential medicines, stock-out rates have declined from 47% to 27%

TREND OF STOCK OUT RATE PER ESSENTIAL MEDICINE OCT-16 TO SEP-17



Root cause analysis

FEFOL has been a challenge since the beginning of the year, with stock outs at MSD zonal levels and facility levels due to huge quantities of commodities expiring in December 2016. FEFOL shifted from being donor funded item to an MSD saleable item. Quantities procured by MSD were insufficient to supply facilities completely. No zonal orders for July-August were filled.

High stockouts rates of amoxicillin syrup are primarily due to the fact that RCHS is replacing amoxicillin oral suspension with amoxicillin dispersible tablets.

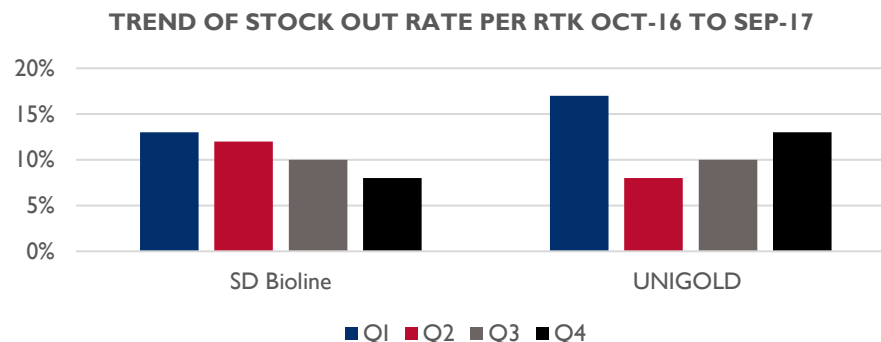
Corrective actions

- GHSC-TA-TZ through LMU has been advocating for procurement of FEFOL by facilities using complimentary funds. Also the project will support the RBF initiative of advocating for the procurement of FEFOL using RBF funds. Finally the project will work through the LMU and the warehouse and distribution advisor to timely process zonal and facilities orders.
- During facility supportive supervision visits, LMU staff compare reported stockout rates as shown in the eLMIS with facility records (paper R&R, dispensing registers and stores ledgers) to investigate whether the stockout is true or not

I.1.6 STOCK OUT RATE: RTKS

Performance trends

Stock out rates averaged 12% over the last year.



Root cause analysis

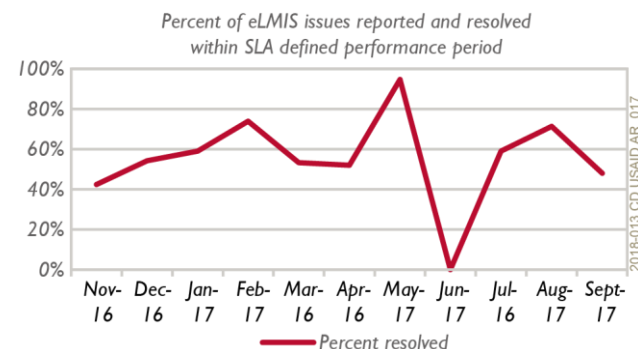
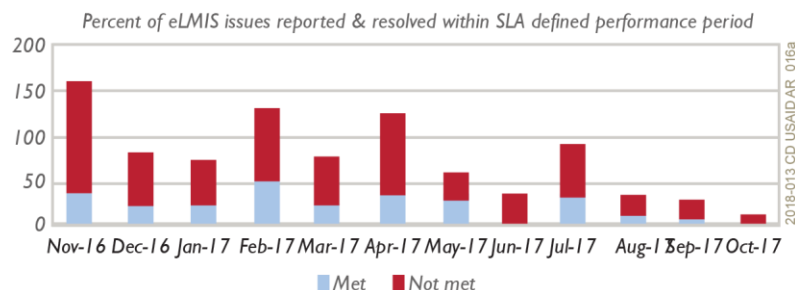
During the first half of the year, there were stock outs of Unigold at MSD central, which led to low fill rates at zones. Additionally, uncoordinated testing campaigns organized by partners in Iringa, Katavi and Kigoma regions led to unanticipated high consumption of test kits, which contributed to stock outs. In the second half of the year, some stock outs of Unigold were still experienced at some facilities (including in the Moshi zone in July 2017 and in the Mwanza zone in August 2017). The testing guidelines specify that SD Bioline is the screening test while Unigold is the confirmatory test. There is anecdotal evidence that facilities may prefer to use Unigold for screening as well; if a facility is using Unigold as the screening test, this will result in unanticipated consumption.

Corrective actions

- The LMU will advocate to R/CHMTs for HCWs to adhere to the testing guidelines.
- At the national level, the GHSC-TA-TZ team will encourage the quantification team consider HCW preferences when determining the overall quantities required. GHSC-TA-TZ will also use the PEPFAR ART and PMTCT partners forum to provide feedback to other IPs on the importance of better planning before community testing campaigns as well as on the implications that these campaigns may have on stock availability.
- During facility supportive supervision visits, LMU staff compare reported stockout rates as shown in the eLMIS with facility records (paper R&R, dispensing registers and stores ledgers) to investigate whether the stockout is true or not

2.1.1 PERCENT OF ELMIS ISSUES REPORTED AND RESOLVED WITHIN SLA DEFINED PERFORMANCE PERIOD.

Performance trends



Root cause analysis

Most tickets reported are from when users experience difficulties to login to the live system, most often during or just after eLMIS trainings.

Further, the process for creating/editing a product in the eLMIS is cumbersome in the current workflow, as the process requires back-to-back verification with MSD and program focal people to make sure the right product and correct details are entered.

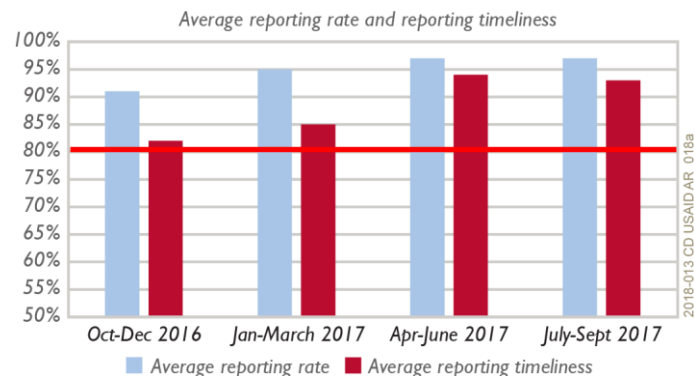
Corrective actions

- Future training plans need to allocate enough time for user registration and provide support to login for the first time. eLMIS staff supporting training should gather user information prior to training, to facilitate a supportive training environment.
- The project will support efforts to develop a standard registry for health commodities, while increasing the efficiency in coordinating the process for product registration/editing.
- The project has hired a software developer based in the Dar es Salaam office, which will allow for faster response time to some tickets.

2.1.2. PERCENT OF FACILITIES SENDING TIMELY AND COMPLETE LMIS REPORTS TO THE CENTRAL LEVEL

Performance trends

The timeliness of reporting increased from 82% to 94% over the year. Reporting rate was consistently above 90%



Root cause analysis

- R&Rs can be rejected due to quality issues; therefore, resubmission is past timeline
- Workload in some councils due to number of health facilities that are required to submit R&Rs
- Due to poor infrastructure and internet connectivity in some councils
- Registration of new HFs during reporting period also affects performance
- Weak accountability with some health facilities and councils

Corrective actions

- The LMU team will continue to proactively follow up with late reporters, and will liaise with the CHMTs and health facilities directly.
- Creation of new HFs to be in line with submission of the first order

2.1.3 LEVEL OF COUNTRY COUNTERPART OWNERSHIP IN QUANTIFICATION AND SUPPLY PLANNING*

Performance trends The level of ownership by country counterparts in quantification and supply chain in Year 1 was 81.8% compared to the target of 75%.
 *This indicator is calculated by looking at the various activities that comprise quantification exercises and supply plan updates and determining the level of leadership (wholly counterpart led, shared counterpart led, shared project led and wholly project led)

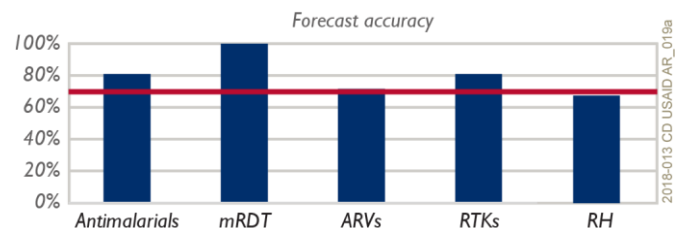
Phase	Activities	Participation scores
Quantification exercise	1)Initiation of and management of processes	WC
	2) Data collection for forecasting and supply planning	SC
	3)Data validation and analysis	SC
	4) Generation of long term forecasts (24 months)	SS
	5) Preparation of a 12 – 18 month supply plan	SS
	6)Document inputs, assumptions and outputs	WC
	7)Coordination of sourcing for planned shipments	SC
Supply Plan Updates	1)Data collection for supply plan updates	SC
	2)Data validation and analysis	SC
	3)Update supply plan mechanism	SC
	4) Generation and sharing (with procurement mechanism) of updated and extended supply plan.	SC

Root cause analysis In Year 1, Vertical Programs (including the National AIDS Control Program) and PSU took a leading role in the quantification process with the support from GHSC-TA-TZ and other partners and stakeholders in HIV/AIDS supply chain management

Corrective actions In Year 2, the project will further foster ownership in quantification and supply planning, including defining as-is and to-be roles for the quantification process, identifying action owners, and developing a timeline for transitioning ownership of the activities currently wholly project led.

2.1.4 FORECAST ACCURACY

Performance trends



Root cause analysis

- Antimalarials: Forecast error in part can be attributed to low uptake of artesunate injection. Also, the actual consumption reported for artesunate injection may not be correct which may be due to multiple pack sizes used on the R&R and the possibility that some HCWs may have made errors in their reporting.
- ARVs: The forecast accuracy for the default first ARV regimen(TLE) for adults is 92%, but only 57% on the second line adult ARV Lopinavir/ritonavir. One contributor to this lower accuracy was the introduction of a new second line ARV for adults (Atazanavir/ritonavir 300mg/100mg tabs) – more patients were switched to this medicine than assumed.
- RTKs: The forecast accuracy for Uni-Gold was less that for SD Bioline. In the 2016 quantification, the HIV prevalence rate from general population (5.3%) was used to calculated Uni-Gold needs, which resulted in an underestimation for some facilities. Further, there were unplanned HIV testing campaigns which made the consumption higher than anticipated.
- RH: Between Jan-Mar 2017, there was a shortage of Microval; hence actual consumption was reduced.

Corrective actions

- Antimalarial: The project will facilitate the standardization of pack sizes of Artesunate injection in the R&Rs, and will work closely with NMCP to monitor Artesunate injection uptake. Will work closely with NMCP to suggest areas to advocate for increased Artesunate injection uptake.
- ARVs: The project to support NACP to develop plans when introducing new product in order to avoid product expiry and wastage. Currently (Nov-2017) collaborating with NACP to plan for future regimen switches. Participation in supply chain sub-committee meeting to discuss solutions to adopting regimen change.
- GHSC collaborate with vertical programs in different forums to advocate for funding mobilization from partners, and drive alignment of programmatic activities with those of supply chain. This is done through quarterly supply plan review, biannual quantification review and participation in quarterly commodity security meetings. Example: GHSC participated in the funding gap meeting to push for Government to budget for gaps in FP commodities (NB: FP funding Gap was \$10m for FP commodities)

2.1.5 DATA USE FOR ROUTINE SUPPLY CHAIN DECISION MAKING

Performance trends	<p>This is the first time reporting on this indicator, so there are no trends to compare of the score of 55%.</p> <p>In Year 1, this measure was is calculated from data collected during the Data Quality Assessment which was funded by WHO and supported by GHSC-TA-TZ. For data quality, the assessment measured the knowledge and ability of the R/CHMT members particularly DPs and DLTs to pull and analyse the information available in the eLMIS reports. The interviewees were given a score of 1 (lowest) to 5 (highest).</p>
Root cause analysis	<p>The knowledge and use of eLMIS is variable across R/CHMTs. The main reason mentioned by most DPs and DLTs on poor use of the eLMIS reports is that they were not aware that these reports existed and that they mainly use the eLMIS to enter R&Rs to order commodities from MSD.</p>
Corrective actions	<p>The LMU team in their routine supportive supervision visits will raise awareness of DPs and DLTs on various reports available in the eLMIS. More importantly they will demonstrate to DPs and DLTs how data from the eLMIS can guide them to conduct supportive supervisions and redistribution of commodities. Further, establishment of IMPACT teams at the regional level will encourage the analysis of data to assess supply chain performance and take appropriate action to alleviate various challenges.</p>

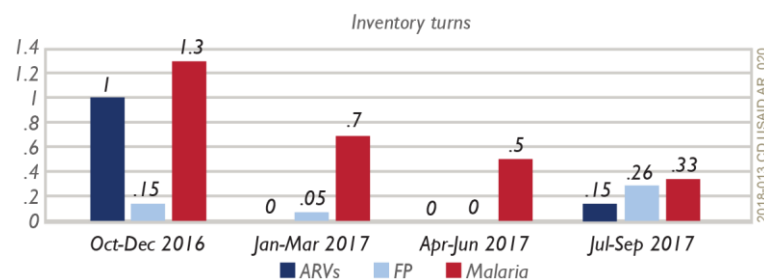
2.1.6 PERCENT OF DATA QUALITY ASSESSMENTS THAT RECEIVE A PASSING SCORE

Performance trends	Out of the 31 districts visited by the project (566 health facilities) in the July-September 2017 quarter, 48% of facilities had their stores ledger ending balance match with the eLMIS ending balance
Root cause analysis	Poor data quality is attributed to the following: <ul style="list-style-type: none">• Non-adherence to ILS SOPs by health care workers. This is evident when conducting physical counts where commodities are supposed to be counted at both the main store and dispensing area but counting is done only at the main store• Most health facilities do not update their stores ledgers• Entry errors occur at the district level when transferring data from the paper based R&R to the eLMIS
Corrective actions	<ul style="list-style-type: none">• GHSC-TA-TZ will encourage R/CHMTs and LMU to provide on-the-job training to health care workers on how to properly fill in the stores ledgers and R&Rs.• The project will identify and carry out interventions to decrease the risk of data entry errors from paper based R&Rs to eLMIS – such as targeting communications to facilities entering data directly into the eLMIS, identifying district pharmacists with the most errors so that they can receive targeted support in collaboration with R/CHMTs, and/or working with R/CHMTs to determine if other cadres of staff are available to assist with data entry.• LMU will notify PO-RALG of facilities and councils that are consistently poor in eLMIS data quality for follow-up and appropriate actions.

2.1.7 INVENTORY TURNS

Performance trends

With regards to inventory turns, zero signifies that MSD is not holding any inventory and that commodities are being distributed to zones immediately upon receipt. As such, the inventory turn figure is misleading. Over the year, the average inventory turns ranged from from zero to 1.3 times, for different commodity categories.



Root cause analysis

Inventory turns on average are very low. One factor in this is the maximum months of stock that MSD is supposed to hold, and the quarterly distribution design.

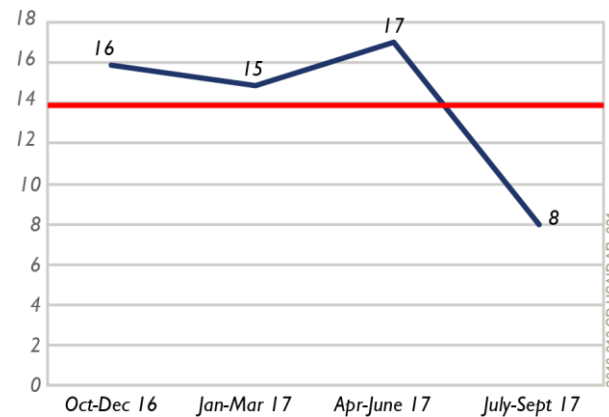
Corrective actions

The project will facilitate the new procedures of monthly reporting and bi-monthly distribution.

2.1.8. CYCLE TIME (MSD CENTRAL TO ZONE)

Performance trends

This metric reflects the average cycle time from when an order is placed by the zone to when it is fulfilled by MSD. There is a significant improvement in average cycle time for the July-September quarter, as compared to the previous quarters. In the previous quarters, the cycle time was 16, 15 and 17 days respectively, where as in the July-September the cycle time was 8 days.



Root cause analysis

The cycle time for the entire program commodities has improved due to collaborative efforts between MSD central team and LMU staff both at central and zonal levels to improve the timeliness of order placement, processing and shipping as per distribution calendar

Corrective actions

The LMU team will continue to encourage stakeholders through feedback meetings to take action in response to deviations from the reporting calendar.

2.2.1 PERCENT OF LMU OPERATIONAL COSTS PAID FOR BY THE GOVERNMENT OF TANZANIA (GOT)

Performance trends

The total operational cost for the LMU was estimated at TZS 4.75 billion for the financial year 2016/17. The Government of Tanzania through MoHCDGEC and MSD contributed 2% (~TZS 84.2 million).

	GOT	GF	USAID
Personnel	49.8	337.8	2,149.3
Supplies	-	-	40.9
Vehicle ops	-	79.7	489.9
Building ops	34.4	-	23.1
Meetings	-	-	286.7
Supervision	-	328.7	914.4
Others	-	-	13.2
Total	84.2 (2%)	746.2 (15%)	3,917.5 (83%)

Root cause analysis

According to the LMU Charter, LMU staff should have begun transitioning in the second year of its operation. However, as the GoT has been unable to absorb these positions, USAID has continued to provide ~83% of the funding for LMU operations

Corrective actions

USAID will be phasing out funding for the LMU starting June 2018. The project is currently developing a transition plan, which includes this phasing out of USAID funding and transition to GoT. This draft transition plan has been developed, but has not yet been signed off on by the Steering Committee (including membership from USAID and GoT).

3.1.1 PERCENT OF RBF PERFORMANCE INCENTIVES RECEIVED BY MSD STRATEGIC BUSINESS UNITS (SBUS) OVER A SPECIFIED PERIOD

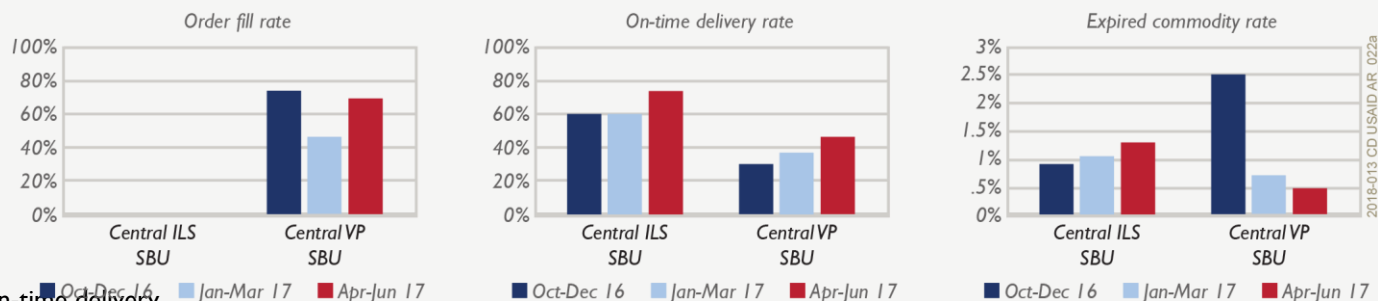
Performance trends Performance trends for RBF applying MSD SBUs have been fluctuating. The lowest scores have been recorded for the Jan-Mar 2017 quarter for most SBUs, with the exception of the Transport SBU. The Mwanza zone SBU has showed a more than twofold increase in performance incentives received as compared to the last two quarters.

Root cause analysis Over the course of one year of MSD RBF implementation, verification guidelines have been interpreted differently by different verifiers, presenting a challenge to replicability and also raising questions as to the validity of the performance scores.

Central MSD SBUs

Order fill rate

The central ILS SBU has performed the worst with regards to percentage of RBF incentives received due to its inability to confirm the most important indicator – order fill rate – which is worth TZS 64 million. This is because zones are requested to order based on what is available instead of the actual zonal needs. This approach has been justified on the basis of frequent lack of availability of commodities and hence need for central MSD to ration. The central VP SBU performed poorly on this indicator as well, especially for the Jan-Mar 2017 quarter, due to changes in commodities monitored for the indicator from tracer commodities (Oct-Dec 2016) to all commodities (Jan-Mar 2017).



On-time delivery

The central VP SBU has not performed well on the on-time delivery rate indicator due non-availability of a delivery schedule and space constraints at the receiving zones forcing orders to be delivered in parts

Expired commodity rate

The expired commodity rate has been increasing for central ILS SBU and decreasing for central VP SBU over the three quarters. These results are unexpected, given the influence that the central ILS SBU has on commodity procurement as compared to central VP SBU. Other possible reasons are: the intended behavior change in practicing first in - first out has not been practiced sufficiently enough to yield results or the influence of sales in a given quarter on expired commodity rate affected the performance of this indicator due to the long-term unavailability of stock for sale in this warehouse

3.1.1. PERCENT OF RBF PERFORMANCE INCENTIVES RECEIVED BY MSD STRATEGIC BUSINESS UNITS (SBUS) OVER A SPECIFIED PERIOD

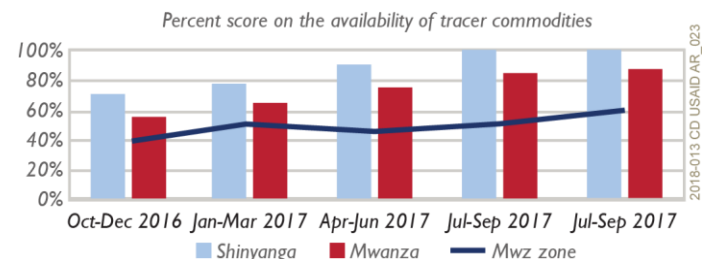
Root cause analysis

Zonal MSD SBUs

As indicated by the percentage of incentives received, Mwanza zone SBU has performed remarkably well, particularly in the Apr-Jun 2017 proven quarter. These results were contributed by reaching/surpassing the targets for inventory accuracy (80%), expired commodity rate (1%) and order lead time (38 days). Such results have implications on decisions of whether these indicators still need to be incentivized or some new indicators are called for.

Dar zone SBU started off on higher scores indicators, except expired commodity rate, compared to Mwanza zone SBU scores from one year ago. Continued good performance will rely on constant tailored supportive supervision from the MoHCDGEC, which has been missing throughout this year of implementation.

	Order fill rate	Order lead time	Expired commodity rate	Inventory accuracy
Mwanza Apr-Jun'16	42%	59 days	3.2%	60%
Dar Apr-Jun '17	43%	36 days	7.1%	80%



MSD zones using RBF are those serving regions currently under the scheme. Between 74% and 59% of PHC quantity and quality indicators depends on the availability of health commodities. Data from health facilities in Shinyanga and Mwanza indicate significant improvement in the availability of tracer commodities. However, this improvement is not in-line with performance trends in the order fill rate indicator observed for the Mwanza zone SBU. This implies that the PHC seek other means of acquiring health commodities in order to compliment what is unavailable from MSD.

Corrective actions

The National RBF Team at the MoHCDGEC has a nearly full-time supply chain RBF coordinator within the team.

GHSC-TA-TZ has supported a two-day MSD verification consultative workshop to develop clear verification SOPs to reduce subjectivity and confirm the order fill rate for central SBU is verifiable.

- The approved MoHCDGEC RBF budget has allocated funds for quarterly supportive supervision of RBF using MSD SBUs; this will facilitate continuous performance analysis to the RBF scheme
- GHSC-TA-TZ will provide TA to MoHCDGEC to develop quality indicators for both central and zonal MSD SBUs targeting the following:
 - Updated business plans in order to incentivize SBU into developing and follow up on strategies for improvement
 - Supervision roles from central to zonal MSD level
 - Timely performance reporting
 - In financial year 2016/17, the GoT has budgeted and disbursed substantial amount of funds to MSD for drug procurement. It is therefore envisioned that with health commodities readily available, most of these indicators especially order fill rate and on-time delivery will improve

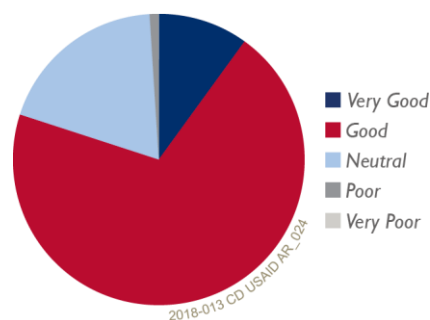
3.1.2 PERCENT OF TRAINING PARTICIPANTS WHO SCORED 80% PROFICIENCY ON EVIDENCE BASED DECISION MAKING ASSESSMENT RELATED TO RBF

Performance trends	For two periods of October 2016 to March 2017 and April to September 2017, a total of 21 MSD staff and 38 RBF verifiers were trained. For October 2016 – March 2017, 38% of the participants scored 80% and above in the RBF post-training test. For April to September 2017, 14% scored 80% and above.
Root cause analysis	<p>The following factors may have contributed to the low performance in the post test</p> <ul style="list-style-type: none">• The MSD RBF training was taught in English. The participant manuals were also in English. This could have contributed to low understanding of the topics taught due to the language barrier.• Availability of a few facilitators (2) that are time constrained - juggling teaching and managing the logistics of the trainings - which may have limited their ability to engage and explain the training content clearly.• Even though the RBF verifiers training was taught in Swahili, performance was worse compared to MSD RBF training. Issues contributing to this could be:<ul style="list-style-type: none">• The content to be covered in RBF trainings was large. The training days are limited to 5 due to budget constraints. This limitation in time constrained deep discussion on some of the practical and valid issues• Inability of trainers to use context specific examples to aid understanding.
Corrective actions	In GHSC-TA-TZ's year 2 workplan , the RBF/commodity financing portfolio in collaboration with LMU teams at the zones will build capacity to MSD staff on self-assessment with regards to MSD RBF indicators and use of data to strategize on improving performance. The project will also collaborate with PS3 will provide technical assistance in translating and re-phrasing participants' manual in order to better aid understanding of the RBF concept.

3.1.3. OVERALL HEALTH FACILITY SATISFACTION RATING FOR SUPPLY CHAIN SERVICES

Performance trends

During this reporting period, a survey was conducted to determine the health facility satisfaction rate regarding MSD supply chain services. A total of five MSD zones and one sales point were involved in this survey. These were Moshi, Mwanza zone, Tabora, Mbeya and Dodoma zones and Tanga sales point. A total of 117 health facilities responded to the survey.



Root cause analysis

Health facilities were asked to rate supply chain services offered by MSD zones including: timely delivery, order fulfillment, communication with customers, quality of commodities, range of commodities, prompt service provision and customer care provided by MSD drivers. Most of the health facilities were either moderately content or very content with the supply chain services offered by MSD zones.

There are a few factors which could be influencing the results: MSD is the only source of supply for some facilities, and there is no competition hence customers may have no other basis for comparison. Also, the survey was conducted by LMU staff who are often regarded as MSD staff. Facilities may be reporting what they want MSD to hear.

Corrective actions

GHSC-TA-TZ will support MSD to institutionalize this survey and conduct it more routinely. For the customers that gave a neutral or poor ranking, the survey should include suggestions for specific areas of improvement, and MSD should follow up directly with those customers. In addition, GHSC-TA-TZ will advocate for MSD having external data collectors to carry out the survey.

GHSC-TA-TZ will support MSD central and zones in conducting SWOT analysis and assess itself on regular basis on these parameters and work on recommendations from its customers so as to address the concerns of their and remain at a competitive advantage.

3.1.4 NUMBER OF LOCAL ORGANIZATIONS IDENTIFIED AND TRAINED IN PROMOTING CHANGE MANAGEMENT IN THE HEALTH COMMODITY SUPPLY CHAIN

<p>Performance trends</p>	<p>There were 16 local organizations trained in promoting change management in Tanzania mainland, including:</p> <ul style="list-style-type: none"> • Management Development for Health (MDH). • Walter Reed Program (WRP) • Elizabeth Glaser Pediatric Aids Foundation (EGPAF) • Ariel Glaser Pediatric Aids Healthcare Initiative (AGPAHI) • PharmaAccess • PO-RALG – Directorate of Health and Nutrition Services • Regional Health Management Teams in Manyara • Council Health Management Teams in Kilindi, Korogwe, Muheza, Simanjiro, Misungwi and Bumbuli. <p>Most of the organizations such as MDH, EGPAF, AGPAHI, WRP, PharmAccess, PO-RALG and Councils health management teams were engaged, trained and coached on and around eLMIS. This included how to provide eLMIS OJT to health facilities, facilitating the eLMIS trainings, eLMIS data quality and data use.</p> <p>Regional health management teams were mostly engaged in stakeholders meetings which discussed commodities management, use of data in the eLMIS and ILSGateway, and data quality issues, among other items. From those meetings it was agreed that districts supportive supervision visits should be driven to a large extent by reports from the eLMIS, further more they should mentor health facility staff on how to properly fill the LMIS tools which will improve overall data quality.</p>
<p>Root cause analysis</p>	<p>N/A</p>
<p>Corrective actions</p>	<p>The project to continue providing supply chain technical assistance and coaching different stakeholders and orienting them on supply chain matters to improve overall supply chain performance by 31st March, 2018</p>

4.1.1 NUMBER OF IDENTIFIED PRIVATE SECTOR STAKEHOLDERS WORKING WITH MSD/CMS

Performance trends

From October 2016 to September 2017, only MSD central and MSD Dar-es-salaam zone partnered with private sector third party logistics (TPL) companies. Note: While MSD partners with a number of private sector organization, this metric only focuses on partnerships with transporters.

MSD Central partnered with Usangi Logistic (T) Ltd to support distribution of commodities to zones, and Dar-es-salaam zone partnered with Shakha Transport company Ltd to facilitate distribution to health facilities. With regards to Zanzibar, distribution of health commodities is exclusively done by the Central Medical Stores (CMS) hence the private sector has not been engaged to support distribution.

Root cause analysis

MSD has faced challenges with timely delivery of commodities to the last mile due to fleet challenges. This challenge is reflected in RBF indicators of lead time and on-time delivery. The number of third party logistics companies that MSD uses is still low and the fact that only MSD central and Dar zone have contracts with the third party logistic companies shows that distribution which is a final activity of confirming availability of commodities to the users has not been given enough attention.

Corrective actions

Using available information and data (and the landscape analysis report for the private sector engagement in public health supply chain); GHSC-TA-TZ will continue to work with MSD to determine when it is appropriate to outsource, and how to improve partnerships.



ANNEX



USAID
FROM THE AMERICAN PEOPLE

ACRONYM LIST

ACT	Artemisinin-based combination therapy
ART	Antiretroviral therapy
ARV	Antiretroviral
CHMT	Council Health Management Team
CIP	Costed Implementation Plan
DHMT	District Health Management Team
DP	Development partner
eLMIS	electronic Logistics Management Information System
EM	Essential medicines
FP	Family Planning
GHSC-TA-TZ	Global Health Supply Chain – Technical Assistance - Tanzania
HCW	Health care worker
HIM	Health Information Mediator
HSCR	Holistic Supply Chain Review
HIV	Human Immunodeficiency Virus
ILS	Integrated Logistics System
KPI	Key performance indicator
LMU	Logistics Management Unit

ACRONYM LIST

MOH	Ministry of Health (Zanzibar)
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MDR-TB	Multi-drug resistant TB
MSD	Medical Stores Department
NACP	National AIDS Control Program
NMCP	National Malaria Control Program
NPAP	National Pharmaceutical Action Plan
NTP	National Tuberculosis and Leprosy Program
PHC	Primary health care
PMTCT	Prevention of mother to child transmission (of HIV)
PO-PSMGG	President's Office, Public Service Management and Good Governance
PO-RALG	President's Office of Regional Administration and Local Governments
PS	Permanent Secretary
PSM	Procurement and supply management
PSU	Pharmaceutical Services Unit

ACRONYM LIST

R&R	Report and Requisition (Form)
RBF	Results Based Financing
RCHS	Reproductive and Child Health Services
RDT	Rapid diagnostic test
RHMT	Regional Health Management Team
RMNCH	Reproductive, Maternal, Newborn, and Child Health
RTK	Rapid test kit
SBU	Strategic business unit
SLA	Service level agreement
SOP	Standard operating procedures
TA	Technical assistance
TB	Tuberculosis
UDSM	University of Dar es Salaam
ZILS	Zanzibar Integrated Logistics System
ZnZ	Zanzibar