UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

PHARMACEUTICAL SECTOR ACTION PLAN 2020
2014 – 2020
TANZANIA MAINLAND

DRAFT – March 2014

Foreword

Acknowledgements

Acronyms

ACT	Artemisin Combination Therapy
ADDO	Accredited Drug Dispensing Outlet
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral ~~(medicines)~~
CHF	Community Health Fund
CHMT	Council Health Management Team
CIP	Costed Implementation Plan
CPD	Continuing Professional Development
CSO	Civil Society Organisation
DANIDA	
DFID	United Kingdom Department for International Development
DHIS	District Health Information System
DHRD	Directorate Human Resources Development
D~~iagn~~ SS	Diagnostic Services Section (MOHSW)
DPP	Directorate Policy and Planning
eLMIS	electronic Logistics Management Information System
ERP	Enterprise Resource Planning (system)
GF	Global Fund for HIV/AIDS, Tuberculosis, and Malaria
GMP	Good Manufacturing Practices
GOT	Government of Tanzania
HBF	Health Basket Fund
HMIS	Health Management Information System
HPSS	Health Promotion and Systems Strengthening project (Dodoma Region)
HSSP III /IV	Health Sector Strategic Plan III /IV
ILS	Integrated Logistics System
IP	Implementation Plan
LMU	Logistics Management Unit
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MEMS	Mission for Essential Medical Supplies ~~(Company)~~
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (Primary Health Services Development Plan)
MOHSW	Ministry of Health and Social Welfare,
MOF	Ministry of Finance
MSD	Medical Stores Department

MTC	Medicines Therapeutics Committee
NACP	National Aids Control Programme
NEMLIT	National Essential Medicines List for Tanzania
NHIF	National Health Insurance Fund
NMCP	National Malaria Control Programme
NMP	National Medicines Policy
NMP IS	National Medicines Policy Implementation Strategy
NMTC	National Medicines and Therapeutics Committee
NTLP	National Tuberculosis and Leprosy Programme
PC	Pharmacy Council
PEPFAR	President's Emergency Plan for AIDS Relief
PIF-TWG	Pharmaceutical, Infrastructure and Food Safety Technical Working Group
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
PMTCT	Prevention of ~~ng~~ Mother to Child Transmission
POPC	President's Office Planning Commission
POPSM	President's Office Public Service Management
PSAP	Pharmaceutical Sector Action Plan
PSS	Pharmaceutical Services Section
PPRM	Public Procurement Regulatory Authority
RHMT	Regional Health Management Team
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SMS	Short Messaging System
SOP	Standard Operating Procedure
SP	Strategic Plan
SSFFC	Substandard, Spurious, Falsely labelled, Falsified and Counterfeit (products)
STGs	Standard Treatment Guidelines
SWAp	Sector Wide Approach
TB	Tuberculosis
TFDA	Tanzania Food and Drugs Authority
TRIPS	Trade Related Aspects of Intellectual Property Rights
UN	United Nations
URT	United Republic of Tanzania
USAID	U.S. Agency for International Development
WB	World Bank
WHO	World Health Organisation
ZHRC	Zonal Health Resource Centre

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Summary

1 Introduction

1.1 Sector Context

The pharmaceutical sector and pharmacy profession in Tanzania are governed by sector policies and legislation. Areas of focus of the regulatory framework include safety, efficacy and quality of medical products; public sector procurement -remember for MSD ; and oversight of the pharmacy profession –Pharmacy council. The National Medicines Policy of 1991 is currently being revised, and a related 10-year implementation has been drafted. The revision process took into account many of the significant changes that have occurred in the 20+ years in the socio-economic, demographic, administrative, and health sector environments. These changes include the emergence of new diseases (e.g. HIV/AIDS), the establishment of global funding mechanisms (e.g. the Global Fund), increased health systems strengthening efforts, the decentralisation of health services, a focus on the health-related Millennium Development Goals, and more recently, Universal Health Coverage and other health financing reforms. The revised Policy further considers specific achievements within the pharmaceutical sector, such as the establishment of the Tanzania Food and Drugs Authority (TFDA) and the Pharmacy Council, as well as a shift in the public sector pharmaceutical supply chain from a kit-based push system to a demand driven system.

The draft National Medicines Policy is further guided by the Government of Tanzania's health-related development goals as defined in the National Development Vision 2025 and the National Strategy for Growth and Reduction of Poverty, and specific pharmaceutical sector priorities as identified in the National Health Policy of 2007.

In the context of Decentralisation by Devolution, the Ministry of Health and Social Welfare (MOHSW) is mandated to formulate health and social welfare related policies, provide guidelines, and monitor and evaluate their implementation in order to ensure that the population has access to quality health and social welfare services. Local Government Authorities (LGAs) are responsible for health service delivery within their Councils in line with the strategic guidance provided by the MOHSW. The Prime Minister's Office - Regional Administration and Local Government (PMO- RALG) is responsible for Decentralisation by Devolution and provides the interface between LGAs and line ministries.

Within the MOHSW, the Pharmaceutical Services Section (PSS) under the Division of Health Quality Assurance is mandated to oversee the implementation of the National Medicines Policy. Examples of specific responsibilities are formulation of technical guidelines for pharmaceutical services (e.g. standard treatment guidelines (STGs) and the national formulary), coordination of quantification of and budgeting for the pharmaceuticals needed for the public sector, resource allocation to health facility accounts held at Medical Stores Department (MSD,) and facilitation of the incorporation of relevant concepts related to medicines use and supply in health training curricula. Through the regional administrative and local government structures (Regional and Council Health Management Teams) PSS supports and helps to build the capacity of the Councils to implement national policies and guidelines.

1.2 Rationale for the Pharmaceutical Sector Action Plan (PSAP) 2020

The current Health Sector Strategic Plan III (HSSP III) is the crosscutting strategic plan for the health sector of Tanzania for the period July 2009 – June 2015. It incorporates existing policies, strategic plans and work plans that are available for a number of MOHSW programmes, departments and agencies, focusing on the priorities for the current period. HSSP III (and subsequent sector strategic plans) also provides overall guidance on priority setting for the Councils and hospitals for development of their strategic and annual work plans.

HSSP III is organised around eleven (11) strategic areas and three (3) 'other important issues', one of which is tilted 'medicines and supplies'. Four specific strategies are included under this topic:

i. To ensure accessibility at all levels of safe, efficacious pharmaceuticals, medical supplies and equipment

ii. Strengthen control of quality, safety and efficacy of pharmaceuticals, medical supplies, medical equipment

iii. Ensure gender sensitive, equitable availability and rational use of quality pharmaceuticals, medical supplies and equipment in health facilities, and

iv. Enhance harmonisation and coordination and information management of procurement, stocking and distribution of medicines and supplies for specific health programmes.

Preparations for the development of HSSP IV (July 2015 - June 2020) have just started, and HSSP IV is expected to be ready for presentation to the Joint Annual Health Sector Review in October 2014. There are expectations that HSSP IV will include medical products and health technologies as one of its main strategic areas - as recommended in the 2013 HSSP III Mid Term Review.

As noted above, a National Medicines Policy Implementation Strategy for 2014-2024 has been developed to guide the implementation of the National Medicines Policy. The 10-year strategy identifies objectives, strategies, main activities, indicators, and responsible units/agencies, and includes estimates for financial requirements for each of the 17 strategic areas included in the policy. However, funding sources have yet to be identified, and implementation priorities will need to be agreed among the stakeholders and matched with available budgets and commitments from the government and development partners.

In parallel, various parties suggested that there was a need for a specific health commodity supply chain strategic plan. The MOHSW, through the PSS, thus resolved that a prioritised action plan for the pharmaceutical sector was the appropriate course of action. They proposed that the Action Plan should be linked to HSSP III and IV, that it incorporate health commodity supply chain improvements, and that it consider prioritised strategies and actions from the draft NMP Implementation Strategy. It was agreed that the PSAP would cover the six year period 2014-2020, i.e. the last year of HSSP III and the full 5 years of HSSP IV.

The PSAP 2020 will be implemented through 3-Year Rolling Costed Implementation Plans (CIPs) which are to be updated periodically. The Costed Implementation Plans will facilitate aligned and harmonised sub-sector support by development partners who will be able to contribute to overall plan implementation by supporting those areas that are in line with their specific interests.

1.3 PSAP 2020 Development Process

In January 2014, a Task Team, comprised of staff members from MOSHW PSS, the MOHSW Health Quality Assurance advisor, the WHO National Programme Officer for pharmaceuticals, staff members from USAID │DELIVER country office, and three international consultants started preparatory work for the development of the action plan. This included identification of relevant stakeholders, a mapping of stakeholder interests and ongoing activities, identification of main issues and challenges through document review, and interviews with the Minister of Health, the Deputy Minister of Health, Chief Medical Officer, MOHSW Directors, senior MOHSW managers, and the Deputy Permanent Secretary for Health at PMO-RALG.

The Task Team was supported by a Stakeholder Technical Team which included representatives from MOHSW Policy and Planning Directorate, TFDA, Pharmacy Council, Medical Stores Department (MSD), Zonal Training Centres, Muhimbili University of Health and Allied Sciences, Regional Pharmacists, and District Pharmacist ~~Council pharmacy personnel~~, PMO-RALG representatives, Ministry of Finance and the Health Promotion & System Strengthening Project in Dodoma. The

Stakeholder Technical Team's role was to ensure that all relevant issues were identified in the preparatory phase.

An Inception Report was presented to the Pharmaceutical, Infrastructure and Food Safety Technical Working Group (PIF-TWG) and other stakeholders, where the overall approach and methodology were approved.

In the final 2 weeks of February 2014, two workshops were held to: (i) identify the main issues and challenges to be addressed, agree on desired results and objectives, and formulate strategic interventions, and (ii) develop the 3-Year Costed Implementation Plan for the prioritised interventions, including end-of period milestones, key activities, time-frame, responsible and supporting entities, and key assumptions and risks[1]. Workshop participants comprised members of the Task Team, the Stakeholder Technical Team and other stakeholders, including additional representatives from PMO -RALG, the MOHSW vertical programmes, the National Health Insurance Fund, UN agencies, development partners, the private sector and civil society.

1.4 Key Issues from the Situational Analysis

The Task Team summarised the results of document review, stakeholder mapping, and interviews in matrices for internal use. Some of the findings are highlighted below.

There are a number of recent comprehensive pharmaceutical sector reviews such as the *Strategic Supply Chain Review* (2013), the *MSD Audit Report* (2011), and the *HSSP III Mid Term Review* (including the specific report on the pharmaceutical sector / 2013) which include recommendations for addressing the identified challenges. There are additional in-depth reviews and assessments, e.g. *In-depth Assessment of Medicines Supply System in Tanzania* (2008) or the *Drug Tracking Study* (2007). However, because quite a number of significant changes have been introduced or completed recently, some of the older studies are out-of-date.

According to these reviews, the main problem in the public sector remains inadequate access to essential medicines - measured as availability (or stock-outs) of key medicines at health facilities. Contributing factors identified include limited budgets, de-capitalisation of MSD, performance and capacity issues at different levels (MSD, PSS, councils, health facilities), inadequate coordination amongst stakeholders within and outside MOSHW, and challenges related to governance and accountability. There are also overall concerns regarding sustainability, as funding for procurement and operational activities is highly dependent on contributions from development partners. For the private sector, quality and access problems are noted. The combination of regular medicine stock-outs at public health facilities along with access problems in the private sector raises equity concerns, as the poor are affected the most by these factors.

Other specific challenges are included in Section 4 for each of the eight (8) components of the PSAP 2020.

Recommendations provided in these reviews focus on most of the supply chain management functions; however, there is less recent evidence or focus on quality of pharmaceutical services, including rational use of medicines, and its impact on the availability of medicines and health outcomes.

There are several recent documents developed by the MOHSW which address specific medicine management issues and include specific strategies and activities; for example, the 2010 *Report of the Meeting to Discuss Planning of Pharmaceutical Interventions at the Regional and District Levels,* and the 2009 *Communication Strategy for Promoting Rational Use of Medicines in the Community*). There are also private pharmaceutical sector strategies spearheaded by the MOHSW, e.g. the

[1] Detailed costing was done by a smaller group in early March, based on information on the inputs that were provided during the implementation planning process.

Strategy for Promotion of Domestic Pharmaceutical Production in Tanzania 2013-2023. Implementation of these strategies has not progressed well.

Important reform initiatives are planned to begin soon or are already ongoing. Examples most relevant for the PSAP 2020 include:

- Appointment of the Deputy Permanent Secretary for Health at PMO-RALG and establishment of quarterly inter-ministerial meetings between PMO-RALG and MOHSW.
- Establishment of the Logistics Management Unit under PSS. The Logistics Management Unit will make systems and additional human resources available to complement and build logistics management capacity and linkages from health facilities through Councils and MSD zonal stores up to MSD / MOHSW at national level. Existing parallel logistics systems should be harmonised.
- Implementation of the electronic Logistics Management Information System (eLMIS) to improve data accuracy, visibility and use from council to national MOSHW level. The eLMIS will also integrate existing parallel systems and interface with the District Health Information System and the MSD's Enterprise Resource Planning system.
- Publication of the MOHSW e-Health Strategy 2013-2015.
- Establishment of a Memorandum of Understanding between MSD and the MOHSW vertical programmes.
- An assessment of ways to address MSD's debt, working capital and financial sustainability challenges.
- The national quantification exercise published a first draft report. Findings will also provide inputs for a financing plan for medicines and health technologies that can be linked to the Health Financing Strategy (under development).
- Extension of Results-based Financing models where mobilised funds can be used together with other complementary funds for additional procurement of health commodities.
- Public private partnerships in the form of prime vendor models (MSD; PEPFAR implementing partners; Health Promotion & System Strengthening Project in Dodoma) and outsourcing of services (MSD transport).
- Establishment of the not-for-profit pharmaceutical wholesaler Mission for Essential Medical Supplies Company (MEMS).
- Facilitation of disposal of expired pharmaceuticals at health facilities (includes development of new guidelines).
- Distribution of updated Standard Treatment Guidelines (STGs) and National Essential Medicines List for Tanzania (NEMLIT).
- Development of a Toolkit for Medicines Management and Governance for Councils. This includes documentation of best practices from well-performing Councils in Tanzania.
- Development of pre- and in-service training modules for pharmaceutical supply chain management, expansion of capacity for intake of pharmacy students, development of Masters Programmes, and work toward a continuing professional development (CPD) programme for pharmacists.
- Establishment of pharmaco-vigilance centres at regional hospitals.

There is continuing interest in, and commitment from development partners to support systems strengthening in the pharmaceutical sector. Partners include the Global Fund, UN agencies, the U.S.

government through the United States Agency for Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR), the Ministry of Foreign Affairs of Denmark (through DANIDA), the Swiss Development Corporation, the UK Department for International Development (DFID), and the World Bank. The PSAP 2020 provides a unique opportunity to improve the efficiency of partner funding through better alignment and complementarity of external funding towards overall systems strengthening.

2 PSAP 2020 Guiding Principles and Strategic Framework

2.1 MOHSW and draft National Medicines Policy Guidance

The PSAP 2020 sets out to contribute to the achievement of the overall vision of the MOHSW "to have a healthy society, with improved social well-being that will contribute effectively to personal and national development".

Identification of strategic results, objectives and interventions has further been guided by the Vision and Mission of the draft National Medicines Policy and its 10-year implementation strategy:

Comment [M1]: These are still subject to review, because they are currently not in line with the guidelines for policies provided by cabinet.

> **Vision:** Safe, efficacious and quality essential medicines are available and affordable to those who need them.
>
> **Mission:** Facilitating the provision of pharmaceutical services by an adequate number of skilled and motivated personnel guided by appropriate policies, guidelines and standards at all levels of health service delivery.

The draft National Medicines Policy also defines eight (8) specific objectives – six of which are explicitly addressed in the PSAP 2020. The table below documents these specific objectives and the related expected outcomes in the National Medicines Policy 10-year implementation strategy.

National Medicines Policy Specific Objective	10- Year Implementation Strategy Expected Outcome
i. To ensure availability and accessibility of essential medicines at affordable cost to an individual and the community.	Availability in health facilities increased from 70% to 90%. Prices of medicines will be affordable to all Tanzanians.
ii. To ensure medicines circulating on the market are safe, efficacious and of acceptable quality.	Reduced number of counterfeit and sub-standard medicines circulating in the market.
iii. To promote rational use of medicines at all levels.	Rational use of medicines improved.
iv. To ensure availability of adequate and competent human resources for the pharmaceutical sector at all levels.	Ratio of skilled pharmaceutical personnel / population increased.
v. To ensure efficiency and effectiveness in managing pharmaceutical services.	Reduced number of expired medicines in health facilities.
vi. To promote and support local manufacturing of essential medicines.	Domestic production increased from 30 to 60%.

The development of the PSAP 2020 took into account cross-cutting issues included in HSSP III. Quality, equity, gender sensitivity, community ownership, coherence in health service planning and

implementation, and complementarity in governance were discussed and incorporated in relevant strategies.

Many of the identified priority interventions are aligned with those already included in the existing strategic plans of agencies and departments (e.g. the MSD Medium Term Strategic Plan II 2014-2020 or the TFDA Strategic Plan 2012/13 – 2016/17).

The overall emphasis of the PSAP 2020 is on providing the community with quality pharmaceutical services which includes sustained access to affordable quality assured essential pharmaceutical products.

2.2 Strategic Framework

The PSAP 2020 has eight (8) components that comprehensively incorporate the strategic areas of the National Medicines Policy. As for the National Medicines Policy, the plan's scope extends beyond medicines and medical supplies through its inclusion of other health technologies such as diagnostics, laboratory reagents and medical devices.

1. Medicines Selection and Use

   This components deals with systems for medicines and other health technologies selection applying the 'essential medicines' concept; interventions to ensure rational use by health workers and the community; medicines information; and related pre- and in-service training.

2. Financing and pricing (affordability)

   This component includes strategies for comprehensive financial planning for product procurement and health commodity supply chain operation; equitable and efficient use of locally generated complementary funds; financial sustainability of MSD; and private sector pricing.

3. Procurement and Supply Chain Management at National Level

   This component addresses the relationship between MOHSW and MSD to ensure adequate performance; cooperation with MSD for efficient and effective operations and quality assured products; establishment of the Logistics Management Unit; communication and information sharing between the main stakeholders and MSD clients; and harmonised quantification for national medicines and health technology requirements.

4. Procurement and Supply Chain Management at Local Government Authority Level

   This component is focussed at council level and deals with systems for product quality assurance; procurement of pharmaceutical products using complementary funds; transparency in terms of roles and responsibilities of the various health commodity supply chain actors; more efficient use of qualified human resources; and storage capacity and conditions at health facilities.

5. Information Systems

   This component addresses implementation of the eLMIS; data management roles and responsibilities; data visibility and use; harmonisation of existing systems; and the MSD Enterprise Resource Planning system.

6. Human Resources and Capacity Building

   This component includes strategies for increasing the number of skilled pharmaceutical human resources including with specific health commodity supply chain capacities at all levels; retaining qualified human resources in the public sector; ensuring performance and accountability of pharmaceutical staff; and establishing a career path for pharmaceutical staff.

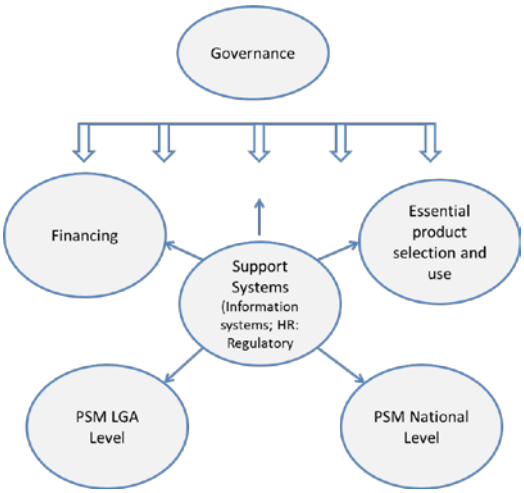
7. Regulatory Environment

   This component focusses on capacity building for market control and post-marketing surveillance; collaboration mechanisms between TFDA, Pharmacy Council, PSS, and PMO-RALG; and systems for reporting and feedback and quality and adverse drug reactions.

8. Governance and Accountability

   This component deals with improving existing oversight and coordination mechanisms (through PIF-TWG); creating transparency in terms of political and financial commitments for the health commodity supply chain; full operationalisation of existing governance and accountability systems at council and health facility level; two-way service/performance agreements between MSD and councils; and inclusion of results based financing ~~pharmaceutical management criteria in the Pay for Performance system~~.

Figure 1 – Strategic Framework

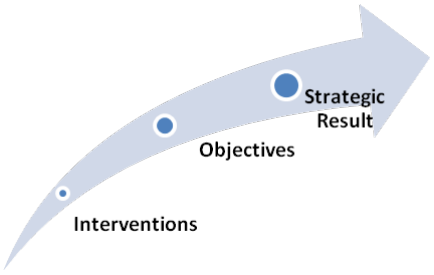


In terms of roles and responsibilities, the MOHSW / PSS will be responsible for overseeing the implementation and monitoring of PSAP 2020. The Pharmaceutical Services Section will also be responsible for directly implementing selected interventions. The PIF-TWG will be responsible for some of the priority interventions, especially related to the Financing Component, while PMO -RALG will be the main driver for interventions directly related to the LGA level, in particular those related to governance and accountability at the lower levels (please see Section 4 for a detailed description of the institutional implementation framework).

3 PSAP 2020 Components: Strategic Results, Objectives and Interventions

This section documents the specific issues and challenges that are to be addressed by the PSAP 2020, as well as the related strategic results (i.e. the change that should happen), objectives, and interventions for each of the 8 components:

Figure 2 – PSAP 2020 Results Chain (per Component)



3.1 Component 1 – Medicines Selection and Use

Selecting medicines for procurement and prescribing medicines should be informed by evidence based treatment guidelines that establish the most cost effective treatment options. The National Medicines and Therapeutics Committee (NMTC) has recently reviewed the Standard Treatment Guidelines and related National Essential Medicines List for Tanzania (NEMLIT). However, a baseline survey conducted by the Health Promotion and System Strengthening (HPSS) Project in Dodoma Region found that only 40% of public health facilities had the documents available (previous edition). The same survey established that less than 50% of health workers had received training in rational use of medicines. Facility Medicine and Therapeutics Committees (MTC) that are mandated to promote and monitor rational use of medicines were revitalised but are not operating as desired at most public and private hospitals.

At MSD some items on the NEMLIT are not routinely kept in stock, leading to special procurements and therefore long delays in availability, and there does not seem to be mechanisms in place to limit health facilities from only accessing approved products, i.e. on the NEMLIT for the specific level of care or included in the Standard Treatment Guidelines. This contributes to limited adherence to the NEMLIT and Standard Treatment Guidelines at many health facilities in the public and private sectors.

Health technologies used for diagnosis are not standardised and there is usually no provision for their maintenance. There is also inadequate communication to MSD regarding changes in diagnostic tools and related reagents.

Overall there has been little focus on the quality of pharmaceutical services in the public and private sectors, specifically in relation to rational use of medicines. In this context it is noteworthy that the Pharmacy Council has apportioned nearly 50% of its Strategic Plan budget to rational use activities. However, the Pharmacy Council still needs to build the organisation's capacity and ensure availability of resources to carry out the planned activities.

The PSAP 2020 will address the existing challenges by working towards the following strategic result:

Strategic Result:
Evidence based policies and guidelines for selection and rational use of medicines and health technologies in public and private sectors and the community are available, coordinated, implemented and monitored - by 2020, and mechanisms are in place for

providing unbiased information to the public and to health professionals.

Objective 1: Essential medicines are selected with due regard to disease prevalence, evidence on efficacy and safety, availability and comparative cost-effectiveness

This objective reiterates the principles of the essential medicines concept established by WHO that has guided selection of medicines in Tanzania since 1991.

Intervention 1: Develop and implement standard operating procedures (SOPs) for review of the Standard Treatment Guidelines and NEMLIT.

The NMTC was re-established and accomplished the fourth revision of the Standard Treatment Guidelines and NEMLT in 2013. Distribution of printed copies and electronic publishing on the PSS website are planned. Challenges remain with coordination of update of treatment guidelines for specific vertical programmes. The SOPs to be developed will provide a transparent and standardised approach for guideline revision across all programmes. The intervention will also address the use of Standard Treatment Guidelines and the NEMLIT by social or national health insurance and private health insurance.

Intervention 2: Strengthen Medicine and Therapeutics Committees at all levels

Guidelines for facility based MTCs were developed and training was conducted during 2012. However, MTCs do not meet as regularly as anticipated and tend to focus their agenda on medicines availability. Through this intervention activities will be implemented that facilitate functioning of MTCs at hospitals in public and private sectors, including performing their role for rational use of medicines promotion and monitoring.

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Objective 2: Processes for improvement of rational use of medicines and medical supplies are coordinated at all levels

This objective aims at a coordinated and coherent approach to address rational use of medicines involving all relevant stakeholders (e.g. MOHSW PSS, Pharmacy and Medical Councils, Pharmaceutical Society or Zonal Health Resource Centres).

Intervention 1: Apply evidence-based approaches to improve application of the Rational Use of Medicines concepts by prescribers, dispensers and the community

This is a broad intervention that includes developing tool such as a revised National Formulary and good describing (is it prescribing?) and dispensing practices manuals, and assessment and piloting of interventions that have shown to be effective in similar contexts. In order to assess impact of the activities a monitoring and evaluation system for Rational Use of Medicines in public and private sectors will be established.

Intervention 2: Mechanisms are developed for MTCs to support rational prescribing, dispensing and use of medicines

Intervention 3: Monitor medicines use in both public and private health facilities, in order to target interventions to context-specific needs

Comment [M2]: These interventions do not appear in the latest CIP document; they apparently were integrated in other interventions; I will delete them

Objective 3: Health professionals and the community have access to unbiased information on medicines.

Unbiased information on medicines (indications, comparative effectiveness, side-effects, dosage regimens etc.) is crucial for ensuring their rational use. Medicines and poisons information centres had been established at referral hospitals but are not functioning anymore. A draft Rational Use of Medicines Communication Strategy aimed at the community is available.

Intervention 1: Implement medicines information strategies for health workers and the community

This intervention will address medicines information to the community by finalising and implementing the Rational Use of Medicines Communication Strategy. Medicines and poisons information centres will be revitalised and expanded to regional hospital level. Innovative strategies to inform the community on medicines and their use will be developed.

Objective 4: Accurate and reliable diagnosis and clinical care is supported by standardised and functioning health technologies

There are recent developments in the area of diagnostic health technologies that require adaptation to incorporate those that are effective and affordable into national health systems. So far there is no single standardised approach in Tanzania to selection of health technologies to be used in the public sector. This complicates procurement and can lead to either unavailability of diagnostic equipment and related commodities. In addition, councils often do not budget for maintenance of diagnostic equipment and/or do not have the necessary technical capacity to perform maintenance.

Intervention 1: Develop and ensure the use of a list of standardized health technologies

The MOHSW with partners will perform a situational analysis on health technologies in use and a needs assessment / gap analysis. The findings will feed into the revision of existing standards and development of a standardised list of 'essential' health technologies per level of care.

Intervention 2: MOHSW to put in place mechanisms for continuous maintenance of health technologies (pilot and assess improvement over baseline in Dodoma region

Comment [M3]: This intervention has apparently been incorporated as an activity in Intervention 1 (in the CIP). Because maintenance does not really fit under intervention one I kept this here.

Infrastructure and equipment maintenance are one component of the HPSS project currently being implemented in Dodoma Region. Under the project a health technology maintenance system will be defined and implemented. Experiences and lessons learned from this project will inform the development of national recommendations / policy.

Objective 5: Essential medicines concept and Rational Use of Medicines are incorporated in pre-service and in-service health training institution curricula and training programs

While training on rational use of medicines is done on an 'ad-hoc' basis there is no coordinated and systematic approach to ensure that health workers are fully conversant with the concept, principles and importance of rational medicines use.

Intervention 1: Develop and ensure the use of curricula with essential medicine and Rational Use of Medicines concept for pre-service and in-service - in all health training institutions.

Under this intervention the relevant institutions will develop standardised training modules to be used by pre-service training institutions and for in-service training. Zonal Health Resource Centres will be supported to conduct specific trainings on rational use of medicine for all cadres of health workers.

3.2 Component 2 – Financing and Pricing

Health financing is fragmented and not visible for planning and prioritizing. The Government of Tanzania (GOT) annual contribution to essential medicines and health commodity requirements has not increased in tandem with population growth, inflation and other factors over the last six years. Central allocation to health facilities accounts from the health basket fund (HBF) will probably reduce in absolute figures for fiscal year 2014/15. For a number of years, the Global Fund and US Government have been the largest funders of medicines and medical supplies for HIV and malaria by a significant margin. Donors are also funding a relevant portion of Reproductive, Maternal, Newborn and Child Health (RMNCH) commodities which are government priorities. The collection and utilization of complementary funds (Community Health Fund and National Health Insurance Fund) is low. Also the funds generated by health facilities are not following the patients.

Health is not among the six top government priorities, hence there is no plan on how to transition from high dependence on external funding to other sources of funding for medicines and health commodities.

There is little consensus on how much funding is required to meet all medicine and medical supply needs in the country. For the upcoming financial year USD 0.62/capita are available for essential medicines from GOT/HBF combined. Given current estimates of requirements, however, it is clear that funding is insufficient. There are no multi-year projections for pharmaceutical supplies financing needs, and no coordinated financing plans.

The formula for allocation of medicines budgets to health facilities has been revised recently. However, the reality is that the information used is incomplete or not up to date. Allocations are not reflective of the actual load of care at health facilities. The allocation among products categories is skewed towards medicine (e.g. allocation for diagnostic has fallen from 25% -5% from 2006-2013). Local governments are entitled to adjust facility allocations within their ceiling, but this is rarely done. As a consequence, health facility allocations (both at MSD and through PMO-RALG) are not well matched to individual facility requirements. Stock outs at facility level can be partially attributed to insufficient funding at national level. Some facilities overdraw their credit limits at MSD, resulting in debts while others remain with surpluses at the end of the fiscal year.

Fund disbursements are consistently delayed – from Ministry of Finance (MOF) to MOHSW and from MOHSW to MSD, and to the end user, thus impacting the ability of facilities to settle payment to MSD (there is no clear evidence on how this affects the ability of MSD to perform). Studies suggest a delay of between 32 and 132 days.

An unsustainable level of debt owed to MSD by MOF/MOHSW has accumulated in the last 5 years, primarily from handling fees owed by programs and to a lesser extent from overdrawn health facility accounts. This has caused cash flow problems at MSD and delays local and international procurement processes and payments. The current level of debt is estimated at TSh 76.5billion. MSD was last recapitalized in 1994. Towards the end of 2013 an initial debt amount of 42 Billion was verified and accepted by the MOF. Plans for payment in instalments are being developed. Most likely no additional money will be made available through the MOHSW budget to pay MSD for logistics costs arising from vertical programme items in FY 2014/15. The MOHSW does not budget repayment of MSD debts and or funding of the other logistics of the vertical programmes.

The extended mandate for MSD to deliver commodities directly to health facilities will require increased capital investments and significant ongoing operational expenditures. Mechanisms and additional funds for recovering additional transport costs are not yet in place.

There is no regulation of prices for pharmaceuticals in the private sector. Medicines tend to be unaffordable specifically for the rural poor.

The PSAP 2020 aims to address these issues and challenges by achieving two strategic results:

Strategic Results:
a. Adequate funds for medicines and health commodities and related logistics are mobilised from sustainable sources, efficiently managed, and equitably distributed.

b. Mechanisms are in place to address affordability of medicines and health commodities in the public and private sectors.

Objective 1: Step-wise increase of government funding for health commodities including for RMNCH in line with health sector priorities

Intervention 1: Government (MOF, MOHSW, MSD, PMO-RALG) and stakeholders to develop mechanisms, specific plans and processes to ensure the adequacy of funds for the procurement of all essential commodities

Under this intervention the finalisation of the ongoing quantification study led by the National Institute for Medical Research will be supported to arrive at a reliable estimate for medicine requirements. Results will feed in a proposal for the step-wise increase of government funding. Support will also be sought through advocacy to the Social Services Parliamentary Committee and civil society.

Objective 2: Harmonized and aligned funding from all sources (government, partners, and donors) for provision of essential medicines and health commodities and for effective supply chain infrastructure and operations

Under this objective the current fragmentation and lack of transparency of health commodity financing and financing for supply chain activities and infrastructure will be addressed.

Intervention 1: Overseen by PIF TWG, PSS/DSS in collaboration with the budget section of MOHSW and other stakeholders to develop medium term financial plan for medicines, health technologies and operation of supply chain that will also to ensure data visibility for improved forecasts and coordination for implementation of the plan.

Amongst others the intervention will include a mapping of current contributions by all stakeholders and related gap analysis as an input to development of a medium term financial plan. Terms for alignment of health commodity financing with HSSP IV priorities in the SwAP mechanism will also be addressed.

Intervention 2: MOF and MOHSW to coordinate and harmonize commitments/allocations of funds from all sources to meet the HSSP priorities for health commodities, (including strengthening information technology, human resources, vehicles, warehousing and other systems).

This intervention will include determining the key coordination actions and how these will be incorporated in GOT budgeting and partners funding processes. Reporting procedures for tracking funding processes and flows will be implemented.

Objective 3: Health Financing Strategy provides a long term plan and framework that equitably and efficiently allocates resources for medicines and health commodities and operation of the supply chain

Intervention 1: Directly involving stakeholders in articulating financing mechanisms for medicines in relation to revenue collection and purchasing.

There will be a stronger involvement of PIF TWG in the ongoing development of the MOHSW financing strategy. PIF TWG will also take the lead to ensure that the data used in the allocation formula is accurate and up to date, and to assess whether this leads to an actual allocation that is more in line with actual needs and service volumes of selected councils.

Objective 4: Procedures to access complementary funds for medicines procurement that are generated by health facilities are transparent, clear and efficient.

Recent reviews established that locally generated complementary funds are not used efficiently for procurement of medicines that are not available from MSD. Reasons include health facilities not being aware of the required procedures to access these funds, overly complicated approval procedures and long procurement lead times.

Intervention 1: MOHSW and PMO-RALG to actively support / implement innovative plans to make transparent, standardize and increase access and utilization of complementary funds for medicines benefits (i.e. NHIF, reimbursements, CHF premiums, and cost sharing funds) from health facilities.

This intervention will include assessing the results of the prime vendor pilot implemented under the HPSS project in Dodoma region and ongoing initiatives in other regions, councils. SOPs for utilisation (and possibly pooling) of complementary funds will be developed. The intervention will also address how to improve access by members of insurance schemes to accredited private sector facilities for provision of medicines benefits under CHF and NHIF. Examples could be inclusion of certain Accredited Drug Dispensing Outlets (ADDOs) in the list of NHIF or CHF accredited facilities.

Objective 5: MOHSW fully meets operational costs and handling charges for medicines and health commodities through MSD

The MOHSW has allocated a limited budget to contribute to vertical programmes' logistics costs. However, these funds are not reflecting actual cost and are sourced from the already limited budget for essential medicines. There is need for a long term solution to avoid further de-capitalisation of MSD.

Intervention 1: MOHSW & MSD to set operational and service charges based on results of the independent analysis of MSD operations costs, to inform a forum (MOHSW, PMORALG and MOF with MSD and partners) that develops long-term solutions to handling fees, and the growing level of debt owed to MSD. In addition, a percentage over and above operational costs may be allowed at a level which allows growth of MSD working capital for the long term.

Objective 6: MSD to be recapitalized and plan for growth of working capital to meet growth in projected procurement and sales turnover. This will ensure financial sustainability of MSD.

Although part of the MOHSW debt to MSD has recently been verified and accepted there is no clear plan on when this debt will actually be paid. In addition, MSD is expected to expand its business in terms of services and products provided to its clients. Such an expansion is only possible if the overall capital of MSD is increased.

Intervention 1: MOHSW/MOF to define the schedule and make commitments to pay the cumulative debt owed to MSD as a national priority. MSD annual business plans include growth of working capital.

This intervention includes high level engagement between MOHSW and MOF concerning payment of verified debt. The intervention also draws on existing plans for increase of revenue included in the current MSD Medium Term Strategic Plan.

Objective 7: Mechanisms in place for affordability of medicines in both public and private sector as justified for public health or equity reasons

The most recent study on medicines affordability in Tanzania established that for paediatric generic medicines patients had to pay on average 1.5 times as much in the private than in the public sector. In terms of affordability less than 1 day of wage was needed to pay for most of the treatment courses investigated. The same study also established low availability of products in both sectors. (URT 2010: *Assessment of the prices and availability of medicines for children in Tanzania*). The Tanzania Medicine Price Monitor June/July 2007 – not focussing on paediatric medicines – established that for the treatment of Type 2 Diabetes and Malaria 2.4 and 4.6 days of wages respectively needed to paid in the private sector, indicating affordability problems.

In the context of the Affordable Medicines Facility for Malaria pilot programme private sector subsidy mechanisms and recommended retail prices for Artemisin Combination Products (ACT) were established. However, a survey conducted in 2013 by the CSO Twaweza established that 71% of private sector and 63% of public sector patients paid more than the recommended retail price.

Intervention 1: In consultation with stakeholders, MOHSW to develop options for medicines price regulations in both the public and private sector (e.g. maximum recommended price, subsidy for high-cost medicines).

Amongst others this intervention includes annual pricing surveys in public and private for-profit and not-for-profit sectors, consideration of maximum prices for selected health commodities and expansion of private sector subsidies, and engagement of NHIF to ensure sustained affordability of medicines benefits.

Objective 8: Streamlined procedures and reliable mechanisms for predictable and timely disbursements and allocation of approved funds from MOF to MOHSW/MSD facility accounts

This objective aims to address the long-standing issue of delayed and unpredictable release of funds from the MOF to MOHSW and their further transfer to health facility accounts held at MSD. These delays led in the past to facilities relying on buying on credit from MSD at the beginning of the financial year which in turn impacts MSD cash-flow situation.

Intervention 1: The MOHSW and MOF to expedite the procedure for predictable and timely disbursements of approved funds from MOF to MOHSW/MSD.

Intervention 2: MOHSW request POPSM to create a vote for MSD to facilitate direct transfer of funds from MOF.

Intervention 3: MOHSW-Directorate Policy and Planning evaluates the possibility of pooling funds (both GOT and health basket fund) directly into a holding account for MSD. The pooling of funds will support PSS to complete systematically and regularly the allocation process for facilities.

3.3 Component 3 – Procurement and Supply Chain Management at National Level

MSD is the public sector procurement and distribution agency set up as an autonomous department within the MOHSW. MSD procurement is funded through GOT and HBF contributions to health facility accounts, and is subject to provisions of the Public Procurement Act. MSD is supposed to be self-sustained. Operational costs for procurement, storage and distribution are included in the sales prices of health commodities. On behalf of the MOHSW MSD also (procures), stores and distributes health commodities that are provided to health facilities for free.

Several challenges for procurement and supply chain management at national level have been identified in recent reviews, including

- Stakeholders do not fully understand what is within MSD's control and what is not, so MSD is sometimes incorrectly blamed for problems related to commodity availability.
- Active participation/ information sharing about procurement plans among MOHSW, MSD, donors and other sources of supply is insufficient. For example, procurement of commodities by vertical programs/donors often leads to insufficiencies and duplication by including items in MSD catalogues and procurement plan. Leadership for the quantification and procurement planning process for the different product groups has not been clearly identified.
- There are no uniform charges for logistics services provided by MSD for the different programs, and GOT does not regularly pay its share of these costs.
- There are frequent delays in procurement of commodities at central level. For example, procurement by MSD can only be done when funds are available, as replenishment orders cannot be placed unless funds are on hand. When cash flow is not sufficient, MSD cannot procure all required commodities. Procurement agreements following Public Procurement Regulatory Authority (PPRA) guidelines take quite a long time to finalise, usually 6-8 months.
- Supply lead times are long, especially for non-framework international tenders (more than 40 weeks). Lead times are considerably shorter when local suppliers are used (5 to 10 weeks). Framework international tenders offer a middle ground (20-24 weeks).

- Zonal stores are not holding all the commodities that might be ordered by facilities, which may be one of the reasons for facility orders not being ready on time. In addition, the agreed standard of bi-weekly resupply from MSD central to MSD zones is not being adhered to on a regular basis.
- The physical storage capacity of MSD's network (central and zones) is insufficient for the needs of the future.
- Some facilities prefer direct deliveries from MSD, but it is unclear whether this initiative has actually improved product availability to date. The delays that have been noted at certain facilities in receiving commodities from MSD are reasons for giving preference to the previous distribution system through district stores.

Local suppliers are complaining that they are not competing on the same level with international suppliers. However, there are provisions for local suppliers for a 15% preference during tender adjudication. Local suppliers also reported that there were often delays in tender adjudication at MSD, and difficulties in tender management and communications.

The PSAP 2020 will address these issues and challenges by achieving the following strategic result:

> **Strategic Result:**
> Well-coordinated, responsive and reliable procurement and supply systems, incorporating private sector participation, are in place at national level, fulfilling demand for quality assured medicines and health commodities.

Objective 1: Improvements in oversight, coordination and information sharing for the management of health commodities and equipment, and for pharmaceutical services are made by the MOHSW and key stakeholders

Intervention 1: MOHSW and MSD to establish mechanisms for information sharing and performance monitoring of MSD against agreed indicators

Intervention 2: MOHSW to delegate oversight and accountability for the procurement and management of health commodities and supply chain to the PSS. PSS staff and advisors placed in the vertical programs are responsible to the Chief Pharmacist on technical matters.

Intervention 3: To fully operationalise the Logistics Management Unit (LMU) and secure funds for the next 6 years.

Intervention 4: MOHSW, PMO-RALG & MSD to develop and implement a customer relations programme which emphasizes improvements in terms of communications and feedback to facilities, Councils, Regions and central level clients and partners

Objective 2: Adequate procurement capacity (facilities, processes and information systems/tools, human and other resources) exists at each level where procurement is performed for the effective management of procurement and procurement planning activities, order (pipeline) monitoring, and reporting to key supply chain partners (funders, service providers, and programs)

Intervention 1: MOHSW supports MSD in building and maintaining capacity and systems for efficient procurement, procurement planning and contract and supplier management.

Objective 3: Health commodities procured for the public sector consistently meet recognized standards for quality as defined by the relevant regulatory authority, and quality standards are upheld at all levels in all procurement transactions

Intervention 1: MOHSW/PSS supports TFDA and MSD to perform their respective mandates for ensuring the quality of health products throughout the entire supply chain.

Objective 4: The annual health commodity quantification process is well coordinated, managed in a participatory manner and in accordance with agreed procedures - by PSS in collaboration with relevant stakeholders. Forecasts and supply plans are shared with all necessary stakeholders, including comprehensive documentation of process, methodology, and assumptions

Intervention 1: PSS/LMU plans and coordinates annual quantification exercises, supply planning process, and quarterly reviews of supply plans for all health commodities, and quantification reports are submitted to PIF TWG for review / information.

Objective 5: The distribution system is predictable, reliable, and responsive, with quantitative decisions made from user requirements (demand-based ordering and procurement). Distributors' internal systems are adequate to support operational and client (health facility) needs and to provide timely reports on the status of health commodities

Intervention 1: MOHSW ensures that the direct delivery system for the delivery of health commodities to the last mile is cost-effective and meets client needs (facilities and programs).

Objective 6: MSD's distribution network infrastructure meets minimum standards of good storage practices as defined by relevant authorities, internal inventory management systems and procedures are effective, and staffing is adequate to meet standards and expectations. Transport resources are adequate, well-maintained, and replaced in a timely manner

Intervention 1: MSD and other stakeholders ensure the availability of adequate and routinely maintained storage facilities and vehicles to accommodate increasing program needs (scale-up) over the medium to long term.

Objective 7: Leadership / responsibility for the procurement of all health commodities is clearly defined by the MOHSW, the Ministry's procurement office/unit monitors and coordinates all procurement agents and partners, and funds are used effectively by all procurement agents

Intervention 1: Comprehensive SOPs are developed/ regularly reviewed by MOHSW, MSD and other procuring entities (including PMORALG and LGAs) which enshrine the principles of competitive tendering, framework contracting, transparency, and value for money, while protecting the importance of quality as one of the important criteria for the selection of commodities. The SOPs should include guidelines on health product donations as well as responsibilities of the different tiers of government on which product to procure, how, and by whom.

Intervention 2: MOHSW & PMORALG set up a long term solution to resolve/avoid inefficient procurement processes for health products using complementary funds. This solution should emphasize the principle of value for money.

Intervention 3: MOHSW, MSD and MOF reduce total lead time as a result of process reviews and improvements in coordination. (Activity?)

Objective 8: The MOHSW should promote local pharmaceutical manufacturing industry to ensure they are able to compete favourably with international suppliers

Intervention 1: The MOHSW develops a plan of action which supports a favourable "playing field" for local manufacturers in comparison to international suppliers. This should include, without limitation, the waiver of customs levies and import taxes for all imported medicines, including active pharmaceutical Ingredients, packaging materials, finished pharmaceutical products (medicines, etc.), donations and supplies funded by development partners

Objective 9: Public safety is protected and organizational effectiveness is supported by waste and disposal processes and procedures; the administrative procedures for managing waste disposal are appropriate yet reasonably implemented. Environmentally safe waste disposal facilities and equipment are accessible by all facilities in both the public and private sectors

Comment [M4]: This is addressed under PSM local level

Comment [M5]: Agree that this is rather an activity – could be deleted.

Comment [M6]: This is addressed under governance and in a better way (I don't believe that it is the MOHSW role to promote tax waivers for industry). Suggest to delete this. This objective is also not included in the CIP.

Intervention 1: MOHSW, in collaboration with relevant stakeholders, to ensure implementation of an effective waste management program for public, faith-based and private sector organizations/entities.

Intervention 2: The waste management program to include expansion of access to incinerators and other alternative methods of waste disposal

3.4 Component 4 – Procurement and Supply Chain Management at Regional, Council, and Health Facility Level (PMO-RALG)

Staff at health facilities is in charge of managing health commodities including ordering of supplies at MSD and purchasing (through their council) supplies using complementary funding. Performance of these functions is constrained by inadequate human resources capacity (e.g. lack of staff trained in logistics or pharmacy) at health facilities and inefficient supervisory support in most councils. Health workers also complain about the burden of uncoordinated supervision by programmes and projects.

Recent reviews noted that health facilities tend to complain about late delivery of supplies from MSD, and that orders are usually not fully honoured in terms of type and quantity of items. In addition, item quality is sometimes unsatisfactory. This relates especially to medical supplies and smaller equipment (e.g. blood pressure machines). Procedures for returning defect items to MSD for refund are in place but not consistently used. In case of stock outs at MSD health facilities can use locally generated funds to procure from alternative suppliers. However, procedures for local procurement are lengthy and bureaucratic and do not ensure quality and value for money. There is also no information available at council level regarding appropriate price levels for medicines and related supplies procured in the private sector.

In general, poor communication between all levels (MOHSW, MSD, regions, councils, health facilities) is noted and pharmaceutical management roles and responsibilities are not clear to all stakeholders.

Inventory management systems for health commodities at health facilities stores are not (yet) automated and health workers struggle to correctly use the Integrated Logistics Management System (ILS). They are also overburdened by the existing parallel logistics information systems where information needs to be tabulated, in addition to the overall District Management Information System. These issues are further addressed under Component 5 (Information Systems).

In most councils storage space and storage conditions for medicines and other health commodities are inadequate. In many places there are also large quantities of expired commodities that have accumulated over several years. Current procedures for disposal of these commodities are felt to be cumbersome. Expired stock has the potential to re-enter the distribution system if not adequately controlled. It is noted that the PSS in collaboration with TFDA has recently developed new guidelines and started facilitating disposal of expired products at district level.

The above contributes to the fact that there are several loopholes for leakage or pilferage of health commodities.

In general there are constraints with overall governance of the pharmaceutical supply chain at regional and council level. The established governing bodies at council and health facility level are often not functioning properly. This will be further addressed under Component 8 (Governance).

The PSAP 2020 will address these challenges by achieving the following strategic result:

> **Strategic Result:**
> Quality assured and affordable essential medicines, program items and related supplies

are available in adequate quantities at health facilities and efficiently managed by skilled personnel.

Objective 1: Medicines, laboratory supplies and medical device procured centrally and locally supplied are of assured quality

Intervention 1: Institute a system for identifying, reporting and feedback on quality issues of medicines and related supplies medical devices and laboratory supplies in the public sector

Objective 2: Procurement procedures for local procurement are streamlined to shorten the lead time while ensuring value for money

Intervention 1: Identify and adopt alternative models for procurement at local level (e.g. pooled procurement and prequalified suppliers) and adopt best practices from other districts / regions

Objective 3: Roles for central, regional / zonal and lower levels of the supply chain are well defined and well understood by all players and stakeholders

Intervention 1: Review the current distribution roles and accountability and disseminate to all key plays in the supply chain.

Objective 4: The health commodity distribution system to public health facilities is predictable, reliable, and responsive, with quantity decisions made from utilization data and available budget/resource allocation (priority- and budget-based ordering and procurement)

Intervention 1: Establish service agreement between MSD zones and councils specifying the responsibilities of both parties (to include review of the current distribution timelines, communication and coordination between MSD and health facilities to ensure reliable and predictable deliveries)

Objective 5: Systems for supporting commodity management at facility level are in place

Intervention 1: MOHSW to complete and support implementation of councils' technical committee under the Council Health Management Team to oversee systems and procedures of commodity management and rational use of medicines and related laboratory supplies (technical committee to include pharmacy staff & vertical programme officers).

Objective 6: Management and governance of medicines and related medical supplies by LGAs and health facilities strengthened to obtain maximum benefit from disbursed funds

Intervention 1: MOHSW to finalize medicine management toolkit for quality and improved commodity management including supportive supervision.

Objective 7: Health facilities have storage facilities that ensure quality and safety of health commodities

Intervention 1: Establish financing mechanism for accessing multiple sources (e.g. including councils, communities, donors, others) for construction of standardized storage facilities at local level.

Intervention 2: Review the current facility storage requirements at all levels and implement changes to ensure adequate store rooms, racking/shelving, and warehouse equipment to properly manage the receipt, storage, and issuing/dispensing of health commodities, based on specific sector-wide standards.

Objective 8: Market intelligence available to guide local procurement of medicines, laboratory supplies and medical devices

Intervention 1: Establish national reference price system for medicines, related laboratory supplies and medical devices.

Objective 9: Waste and disposal issues are carefully addressed to protect public safety

Intervention 1: Develop and implement effective waste disposal procedures and mechanisms for medicines, laboratory supplies and devices

Objective 10: Staff at facilities assigned to manage health commodities (and stores) has appropriate skills and are dedicated to these tasks

Intervention 1: PMO-RALG through councils to increase human resource capacity levels and numbers to support health commodity management.

Intervention 2: Enhance the capacity of councils to identify, allocate and hire health care workers at council level.

3.5 Component 5 – Information Systems

The main logistics information system currently in use is the paper based Integrated Logistics System (ILS) managed at health facility level. Reviews established that reporting rates in the ILS are low and that the requirements of the ILS (1,580 data fields have to be completed quarterly) are very demanding on health facility staff, leading to errors and report avoidance. It also happens that forms are being copied from one reporting period to the next by some facilities or at council level. PSS facilitated training of health facility staff in ILS and ILS Gateway. It is not clear whether this had an impact on data quality. The paper based system also does not promote data visibility and usage because aggregate reports are not being prepared and specific analysis of information is not facilitated.

Reviews also suggest that the percentage of facilities with up-to-date stock cards is around 50%. This implies that accurate logistics information for the public sector is not maintained / available.

In addition to the paper based ILS there are electronic systems reporting on selected items (SMS for Life, ILS Gateway).

At a single facility there are several registers to capture the same data items (patient register, dispensing register, injection register, ART register, Dispensing Register for ARVs, TB Register, RCHS register, PMTCT Register, Laboratory Register etc.), and the same data from the same facility may be reported through multiple channels.

An important development initiated by the MOHSW supported by development partners is the electronic Logistics Management Information System (eLMIS) for electronic processing of information generated through the ILS. This system will initially be implemented at MSD zonal level and later expanded to district level. The eLMIS will interface with SMS for Life and ILS Gateway and plans are to provide an interface to the District Health Information System.

At MSD implementation of the Enterprise Resource Planning (ERP) system has been delayed which impacts reporting on key performance indicators. Pipeline, stock and issue reports from MSD have thus not been generated and shared with partners and relevant stakeholder. An additional burden on MSD are frequent ad hoc requests for specific reports by various stakeholders, including programmes and partners, which distract them from their core business activities

The PSAP 2020 will address these challenges by achieving the following strategic results:

Strategic Results:
a. Accurate information needed for the management and monitoring of the health commodity supply chain is available to ensure that adequate quantities of the right health commodities are available at the point of service to meet patient needs.

b. The information systems support increased data visibility, data quality, and access to information, improving health commodity related decision-making.

Objective 1: Computerization across the supply chain will utilize a standardized system which is flexible to adapt to future changes in the supply chain and be scaled up to include facilities in districts with appropriate infrastructure

Intervention 1: An electronic LMIS is being developed and rolled out by MOHSW to districts and primary health care facilities, where appropriate infrastructure exists, by Dec 2015.

Objective 2: Data management tasks (collection, verification, aggregation, analysing, interpretation, reporting, quality assurance, dissemination of SC data) and schedules should be clearly defined and followed for each level and function within the supply chain

Intervention 1: MOHSW to define data management tasks and reporting schedules by June 2014.

Objective 3: The information system(s) both paper and electronic based are used to ensure that relevant data for decision-making and performance monitoring are collected and reported per an established schedule, made available to the appropriate users, and utilized by all levels.

Intervention 1: MOHSW to develop and implement a change management strategy that aims to improve the use of data for decision-making for key supply chain decisions at various levels by June 2015.

Objective 4: eLMIS processes and data are clearly aligned with HMIS/DHIS

Intervention 1: ILS Gateway and ERP electronic systems are being interfaced with eLMIS by Sept 2014. The eLMIS is interfaced with the DHIS to enable, among other uses, the availability of tracer medicine reports by Dec. 2015.

Objective 5: At facility level, data collection and reporting are optimized, especially for health providers and the various reporting tools are harmonised.

Intervention 1: ILS tools to be revised to ensure that they are in line with eLMIS by September 2014.

Objective 6: Routine schedule for evaluating electronic and paper based logistics systems is established

Intervention 1: PSS to define key performance indicators and information requirements by September 2014 for monitoring information systems interventions and processes for their ongoing review.

Objective 7: Deliverables of ERP implementation at MSD, phases one and two, are available

Intervention 1: MSD to provide the following reports to MOHSW on monthly intervals beginning June 2014: i. Batch traceability reports; ii. Periodic cycle count reports with comparison of physical and system stocks; iii. Procurement pipeline reports; iv. National monthly stock status reports.

Objective 8: Facility and staff entrusted with data management are evaluated by respective authority

Intervention 1: MOHSW to conduct performance appraisal on quarterly basis and use results as the basis for recognition or corrective action for high and low performing staff and health facilities respectively.

Objective 9: The various electronic reporting systems are streamlined to achieve value for money

Intervention 1: Review existing electronic systems (SMS for Life, ILS gateway, Pharmacy module and eLMIS) with a view to maintain the most comprehensive and cost effective system - by June 2014.

Objective 10: Information systems have sufficient technical and financial resources to support and sustain smooth operation

Intervention 1: MOHSW, MSD, and PMO RALG to ensure that they have, collectively, the management information system capacity and resources to manage and sustain existing systems - by July 2015

3.6 Component 6 – Human Resources Capacity

Comment [J7]: IS component wanted to ensure that HR component adequately addresses need for sufficient and capable IT staff / data management tasks at all levels for LMIS, etc. Is it covered here?

The number of pharmaceutical personnel in the public sector has not increased over the past years contrary to what has been seen with other health professionals. While output of pharmacists from national universities has increased there is low capacity of GOT to absorb them in the public sector due to bureaucracy and financial constraints. Once employed retention is an ongoing challenge in the public sector. There is thus a shortage of pharmacists, pharmaceutical technicians and assistants.

There are no job descriptions or posts dedicated to supply chain management at council level. Current key supply chain positions are donor dependent, which raises issues of sustainability.

Pre-service supply chain management training suffers from a lack of standardized curriculum and qualified trainers, academics, instructors or tutors. Staff especially at the health centre level does not have sufficient capacity for management of supply chain responsibilities due to high turnover and a lack of ongoing training opportunities. Existing in service training for the management of medicines and related medical supplies is also not coordinated and harmonized.

Human resource management in public and private sectors is an ongoing challenge. For example, there is weak coordination of pharmacy personnel due to having multiple ministries / organizations / institutions involved (MOHSW, MSD, and PMO-RALG). Since most of the MOHSW policies are implemented by different ministries, departments and agencies the mechanism to hold MOHSW accountable for some of its responsibilities is unclear. At MSD, human resources functions are centralized, limiting the autonomy at the zonal MSD level for effective management of human resources.

At the council level there is a lack of recognition for pharmaceutical discipline and academic advancement – filling pharmaceutical positions is not always prioritised.

Existing continuous professional development activities do not meet the needs for professional development within the pharmacy profession.

The PSAP 2020 will address these challenges by achieving the following strategic results:

Strategic Results:
a. Greater numbers of qualified pharmaceutical professionals produced and actively employed in the public and private sectors to provide patient care and supply chain services at all levels.

b. Incentives, accountability, supervision, and MOHSW allocation mechanisms for health professionals are strengthened, and there is an increase in human resources within the pharmaceutical sector as a result of advocacy by the MOHSW and its partners.

Objective 1: GOT funding of, and resources committed to the pharmaceutical sector, are increased for the support of skilled and dedicated personnel (within the pharmaceutical sector generally and for pharmaceutical supply chain tasks specifically), and to gradually reduce donor dependency

Intervention 1: President's Office – Public Service Management (POPSM,) MOHSW (including MSD) and PMO-RALG to discuss and develop a medium term plan of action to address the human resources needed to effectively manage pharmaceutical supply chain tasks.

Objective 2: Competent human resources in appropriate quantities and with the right skill mix are available at all levels of the system to meet requirements and ensure effective patient care and management of medicines and related medical supplies

Intervention 1: The MOHSW-PSS to implement and amend recently developed Human Resources Strategy for the pharmaceutical sector that supports the improvement of patient care services and the management of health commodities

Intervention 2: The LMU to be fully established and maintained to serve as the central coordination unit for pharmaceutical supply chain functions within the public health sector and with MSD and PMO-RALG.

Objective 3: A career ladder for pharmacy professionals is developed within the cadre of pharmacy services

Intervention 1: The Pharmacy Council develops a career ladder program for pharmacy professionals within the cadre of pharmacy services and advocates for its approval with MOHSW and POPSM.

Objective 4: Pharmaceutical supply chain management / logistics courses are incorporated into selected pre-service education programs by the MOHSW/PSS, Pharmacy Council and involved educational institutions

Intervention 1: To develop and introduce pharmaceutical supply chain courses within pre-service education across various cadres of health professionals (dependent on decisions reached by MOHSW and PMO-RALG on supply chain roles at each level).

Objective 5: Working conditions, workers motivation, and the retention of health care workers (in the pharmaceutical sector) are improved through the use of incentive schemes

Intervention 1: To develop and adopt incentive pay-for-performance (and results based financing) programme performance indicators for pharmaceutical management in primary care facilities, councils and regions.

Objective 6: Performance and accountability of health care workers (in the pharmaceutical sector) is strengthened due to improvements in supervisory systems.

Intervention 1: To develop a performance driven supportive supervision programme especially for primary care health facilities.

It can be considered to devote a portion of the resources obtained through cost-sharing to funding this initiative.

Intervention 2: Supportive supervision is linked with performance reviews and subsequent rewards, either monetary or non-monetary in line with ongoing broader initiatives.

Objective 7: Dedicated pharmaceutical supply chain management positions are established at key levels to support the effective functioning of the health commodity supply chain

Intervention 1: MOHSW to propose and advocate for dedicated health commodity management positions at key levels within the health commodity supply chain to ensure sufficient capacity and accountability.

One proposal for this intervention is the introduction of an additional position – the District Health Commodity Manager - in line with the LMU structure.

Objective 8: In-service training for pharmaceutical services provision (including the management of health commodities) is institutionalized through innovative and sustainable systems, facilitating

continuing professional development for health workers in the pharmaceutical and laboratory sectors

Intervention 1: The MOHSW (Pharmacy Council) and partner institutions to develop an ongoing CPD programme to support the growth and development of health care workers. It is recommended that the CPD program is tied to professional registration.

Intervention 2: PSS (LMU) to plan and coordinate in-service capacity building efforts for council and facility staff in pharmaceutical supply chain management and other related skills.

3.7 Component 7 – Regulatory Environment

The TFDA regulates medicinal products (including diagnostics and medical devices) including their marketing, import and manufacturing, and wholesale business. The Pharmacy Council regulates the pharmacy profession and the pharmaceutical retail sector.

Despite considerable achievements over the previous years challenges remain in terms of capacity of the two institutions to effectively regulate the market. MSD, hospitals, and health centres all report 'ad hoc' quality problems with medicines and equipment and quality testing of samples from post marketing surveillance and the prime vendor quality assurance scheme show failures among locally manufactured products, raising question of their compliance with Good Manufacturing Practices (GMP). Substandard, spurious, falsely labelled, falsified, and counterfeit (SSFFC) products are also found to be available on the market. This situation is aggravated by the fact that the public is not educated on medicines safety and quality issues.

Overall there is low coverage of post marketing surveillance, testing and feedback. Mechanisms for pharmacovigilance are not used widely by practitioners and manufacturers, and control of product promotion and advertisement is still inadequate. The TFDA quality control laboratory does not yet have capacity for quality assurance of vaccines.

There are capacity constraints at council level to perform delegated functions on behalf of regulatory agencies leading to inadequate inspection and investigation systems. For example, ADDOs, wholesalers, public and private pharmacies are not supervised and inspected as required. There is also poor coordination between regulatory authorities and district councils. Duplication of roles at council level (supervisors also working as inspectors) raises issues of conflict of interest.

The Pharmacy Council suffers from capacity constraints (human resources, financial, systems) to discharge its expanded responsibilities, i.e. licensing & inspection of retail sector based on clear set of standards and guidelines.

The guidelines for donations are not adhered to and it is not clear who is responsible for enforcement. The existing guidelines also need to be updated and their scope extended to include other health technologies.

The PSAP 2020 will address these challenges by achieving the following strategic result:

Strategic Result:
Capacity of TFDA and Pharmacy Council for market control and control of pharmacy practice is enhanced through improved collaboration and contributions by stakeholders

Objective 1: TFDA and Pharmacy Council are resourced to effectively oversee medicine safety, efficacy and quality and pharmacy practice in the country

Intervention 1: Establish mechanisms for resource mobilization for Pharmacy Council and for TFDA.

Objective 2: Capacity is built at regional and council levels to execute delegated regulatory functions for medicines

Intervention 1: PMO-RALG at Regional and District levels to strengthen execution of medicines regulatory functions, especially post marketing surveillance, pharmacovigilance, and reporting of quality issues.

Objective 3: Systems are in place to address conflict of interest at all levels regarding inspection activities

Intervention 1: Development/revision of inspectors' guide & enforcement of code of ethics / conduct

Objective 4: Structured collaboration between TFDA, Pharmacy Council, PSS and PMO-RALG to ensure efficient use of available resources

Intervention 1: Establishment of collaboration mechanism (TFDA, Pharmacy Council, PSS, PMO-RALG) with PSS serving as the lead.

Objective 5: Systems for reporting to TFDA and feedback from TFDA on quality and safety problems with medicines and equipment are in place and used at all levels of the health system (MSD, hospitals, health centres, dispensaries & private sector)

Intervention 1: Strengthen existing mechanisms at TFDA for pharmacovigilance, including the process for provision of feedback to reporting person/ organization on adverse drug reactions and quality problems (e.g. bulletin, website, SMS feedback).

Intervention 2: Capacitate Hospital Medicines and Therapeutics Committees in public and private sector and health facility governing committees for adverse drug reaction reporting in their facility and by the community (private sector needs training).

Objective 6: Systems for combatting substandard, spurious, falsely labelled, falsified, counterfeit (SSFFC) pharmaceutical products are in place

Inervention1: Amendment of the TFDA Act

Objective 7: Donation guidelines & regulations are adhered to

Intervention 1: MOHSW (PSS, TFDA, MSD, vertical programmes) collaborate with development partners and non-state actors

Objective 8: There is increased capacity for post – marketing quality control (e.g. mini labs, sampling and testing in public and private sectors

Intervention 1: Establish processes and build additional capacity (human resources, funding) for post registration quality testing of batches of products entering the public and private sectors.

Objective 9: Domestic manufacturers comply with GMP

Intervention 1: Licensing of locally manufactured products based on risk of products (existing guideline)

This initiative is seen as an incentive for domestic manufacturers to move towards GMP compliance.

Objective 10: Capacity is built locally to assess and monitor quality and safety of vaccines and other health technologies

Intervention 1: Extend TFDA Quality Control Laboratory to include testing of vaccines, medical devices and diagnostics.

3.8 Component 8 – Governance and Accountability

While decentralisation by devolution should improve outcome of health service provision by bringing decision making closer to the implementation level, there are also challenges in terms of overall governance and accountability specifically for the health commodity supply chain where many levels and actors are involved, e.g.

- MSD is concentrated at the central and zonal levels; beyond that – regions, councils, and health facilities – fall administratively under the PMO-RALG. The roles and responsibilities of MOHSW and PMO-RALG are not clearly defined with regards to supply chain and information management.
- The Direct Delivery System from MSD to health facilities takes away the responsibility and accountability of PMO-RALG at regional or council levels.
- There are no formal linkages and/or communications between MSD and local government (communications, meetings, etc.).
- Councils do not have up to date information on the release of funds for health commodity procurement because transfers of government funds into health facility accounts at MSD are not yet regularly published on the MOHSW website or in the local print media.

At council level Council Health Management Teams (CHMT) have responsibilities for holding facility level staff accountable for stock management tasks, but this does not seem to happen. Regional Health Management Teams' (RHMT) and CHMT integrated supervision visits do not include logistics or supply chain performance elements.

In addition, Health Facility Governing Committees who have accountability responsibilities are not functioning as envisaged. This may be due to capacity constraints and lack of incentives. Civil Society Organizations (CSOs), such as Wajibika and Sikika, are increasingly publicizing challenges in the health system (such as product availability) – and they believe accountability is weak or lacking.

Current systems for local government level procurement are complicated and not clearly understood by the implementers. Health facilities do not know how much funds from complementary sources are available to them for procurement of additional medicines and how to utilize these funds.

At national level MOHSW PSS is supposed to oversee MSD performance, but the position of PSS in the MOHSW organogram, i.e. a unit under the Health Quality Assurance Department, may compromise its ability to fulfil this responsibility effectively. The same applies to PSS relation to vertical programmes, where in addition coordination and reporting responsibilities are not clearly defined / understood. There is also inadequate coordination with / involvement of PSS and the PIF TWG in donor projects that have a large component of commodity procurement and supply chain management support.

Promotion of domestic pharmaceutical manufacturing is a priority of the GOT. This involves many different sectors and stakeholders. A champion to lead the process has not yet been identified, and the MOHSW might not be best placed to perform this role.

The PSAP 2020 will address these challenges by achieving the following strategic results:

Strategic Results:
a. All stakeholders fulfil their agreed roles and responsibilities to ensure oversight coordination, and transparency in the public and private health commodity management, including local pharmaceutical production.

b. Results and performance based approach are applied to promote effective management and accountability for health commodity management.

Objective 1: Effective mechanisms in place for oversight and coordination of the different stakeholders in the pharmaceutical sector (e.g. MOHSW, PMO-RALG, agencies, development and implementation partners)

Intervention 1: Increase the participation of various stakeholders in coordination.

Intervention 2: PMO-RALG to strengthen the unit responsible for oversight of local government on health service delivery and management

Intervention 3: Technical Committee-SWAp to oversee the implementation of pharmaceutical management and governance milestones.

Intervention 4: MOHSW with POPSM position and profile the pharmaceutical services entity within MOHSW to ensure appropriate level of authority to supervise all health commodities and related supply chain issues and provide appropriate oversight to other institutions involved in health commodity management e.g. MSD, TFDA.

Objective 2: Political and financial commitments for an effective supply chain are fully met by MOF, MOHSW and PMO-RALG leadership

Intervention 1: Inter-ministerial forum of MOHSW, and PMO-RALG to involve MOF and President's Office Planning Commission (POPC) to resolve issues related pharmaceutical sector and supply chain.

Objective 3: Communities are empowered to participate in health facility governance

Intervention 1: PMO-RALG to strengthen Council Health Services Boards and Facility Health Governing Committees to perform agreed functions, including development of comprehensive reporting and performance incentive mechanisms.

Intervention 2: GOT to put information in the public domain regarding all resources provided to health facilities, in line with Open Government Initiative.

Objective 4: Civil Society Organizations involved in supporting local accountability and governance structures

Intervention 1: CSOs to increase use of independent research to advocate for improved accountability in public and private supply chain.

Objective 5: Service agreements between MSD and local governments hold both parties accountable for performance of the supply chain

Comment [M8]: Also addressed under Component 4

Intervention 1: PMO-RALG to institute a mechanism for monitoring performance of service agreement against performance benchmarks on ordering and direct delivery arrangements, order fulfilments, information and reporting requirements for both parties (including rewards and penalties to ensure accountability).

Objective 6: Effective systems and capacity in place to ensure accountability at all levels

Intervention 1: PMO-RALG to make to better use existing capacity at Councils by establishing a task team under the CHMT including pharmaceutical staff and vertical programme officers. The task team could be in charge of overseeing and supporting pharmaceutical management at health facilities.

Comment [M9]: Also addressed under Component 4

Intervention 2: MOHSW and PMO-RALG to showcase successes beyond their region, develop 'accreditation' criteria for guiding incentives for health facilities to improve pharmaceutical management and accountability.

Intervention 3: To develop and implement interventions that align supply chain responsibilities with capacity and sufficiency of staff, especially at service delivery point level. Consider redefining roles and responsibilities as required (relate to interventions under 'oversight' objectives, and re-design around ILS implementation).

Intervention 4: Councils to seek additional sources of funding to support effective supportive supervision.

Comment [M10]: Also addressed in Component 4 – use of cost sharing funds is suggested there.

Intervention 5: Map and explicitly describe mechanisms for how each actor is held accountable (and how they are measured), by whom, and what the consequences are for not fulfilling designated responsibilities.

Intervention 6: PMO-RALG to disseminate knowledge of procedures and best practice in local government procurement and financial management of medical commodities.

Objective 7: Enabling environment established for promoting domestic pharmaceutical production and strategies for capacity building in quality assurance (TFDA) that safeguard public safety available

Intervention 1: MOHSW to call for a forum of all stakeholders involved to determine the champion for taking the domestic manufacturing strategy forward and define the role of the other stakeholders.

Intervention 2: MOHSW participates in reviewing the Patent Act to ensure all Trade Related Aspects of Intellectual Property Rights (TRIPS) flexibilities are incorporated to safeguard public health.

Objective 8: Supply chain roles and responsibilities are clearly defined, communicated, and endorsed for each level and by each oversight organization/entity and change is effectively managed

Intervention 1: MOHSW to clearly define roles, responsibilities for LMU staff and those seconded by partners into MOHSW vertical programs, and prepare absorption plan for integration into MOHSW, PMO-RALG and MSD structure to ensure sustainability.

4 PSAP 2020 Implementation Framework

The 3-year rolling costed implementation plan (CIP) describes the interventions, key milestones and specific activities that are expected to be implemented in the pharmaceutical sector, in order to achieve the PSAP 2020 objectives and strategic results. The three-year CIP includes the specific tasks, timing and institutions with lead responsibility for monitoring progress throughout the year.

The purpose of the CIP is threefold:

- Firstly, the CIP is an execution framework for the PSAP 2020. In this regard, it can be presented to partners to get harmonised support in the form of both financial and technical assistance, for implementation of the various interventions.
- Secondly, it can form the basis of grant applications to major public health funding entities such as the Global Fund.
- Thirdly, the CIP can be used by PSS as a guide for their annual operational planning.

The 3-year rolling CIP will be revised and updated periodically.

4.1 Development of the Implementation Plan

The first 3-Year rolling CIP was developed for the period July 2014 to June 2017. The full implementation plan including detailed description of the costing approach and concepts is included as a separate stand-alone Annex. A three day workshop bringing together key stakeholders and potential implementation partners was convened in February 2014 to develop the CIP.

Prioritization of interventions

The objectives and interventions included in the PSAP 2020 underwent a group prioritization process to create consensus among workshop participants about which interventions were most important to focus on in the first three years of the PSAP. The interventions were prioritized according to the following criteria:

a) Financial, technical and other resources required for each intervention

b) Possible barriers to implementation (e.g. health system challenges, political sensitivities)

c) Expected impact on achieving the strategic results for each component.

For the purpose of implementation planning objectives were then ranked in order of priority to facilitate decision making by the workshop participants.

Designing activities for interventions

The workshop participants convened in groups based on the eight components of the PSAP 2020 to formulate activities for the interventions. The first task was to select which objectives and interventions the group would be designing activities for, also taking into account the result of the prioritization exercise described above. As a general guide, participants ensured that the activities were directly linked to the intervention and were in line with the objectives of that component.

The groups then discussed what the milestone for each intervention would be by the end of the 3-year CIP, i.e. the 'end of period milestone'. The milestone was the group's vision of what the intervention would accomplish by the end of the three year implementation period. After agreeing on the milestone, the groups then proposed institutions or individuals who would have primary responsibility for the implementation of the activities under each intervention. Where appropriate,

the groups also suggested other parties who could provide inputs or oversight for the activities as key stakeholders.

Participants also discussed how these activities could be designed given the context of Tanzania. For each activity, workshop participants added inputs that would be required for implementation and costing. Key assumptions and risks that could affect the implementation of these activities were also added. For instance, assumptions about the possible impact of any ongoing activities on the proposed interventions were clearly highlighted.

Roles and responsibilities of main stakeholders

The tables below show the key stakeholders and some of the interventions for which they will have primary responsibility.

Pharmaceutical Services Section (PSS)	
Component	**Interventions**
1. Medicines selection and use	Strengthen Medicines and Therapeutics Committees at all levels
	Apply evidence based approaches to improve application of the RUM concept by prescribers, dispensers and the community.
	Implement medicines information strategies for health workers and the community.
	Develop and ensure the use of a list of standardized health technologies
2. Financing and pricing	Government (MOF, MOHSW, MSD, PMO-RALG) and stakeholders to develop mechanisms, specific plans and processes to ensure the adequacy of funds for the procurement of all essential commodities.
	MOHSW and PMO-RALG to actively support / implement innovative plans to make transparent, standardize and increase access and utilization of Complementary funds for medicines benefits (i.e. NHIF, reimbursements, CHF premiums, and cost sharing funds) from health facilities
	In consultation with stakeholders, MOHSW to develop options for medicines price regulations in both the public and private sector. (e.g. maximum recommended price, subsidy for high-cost medicines)
3. Procurement & Supply Chain Management – National level	MOHSW and MSD establish mechanisms for information-sharing and performance monitoring of MSD against agreed indicators
	The Pharmaceutical Services Section (PSS) should fully operationalize LMU and secure funds for the next 6 years.
	MOHSW, PMO RALG & MSD to develop and implement a customer relations program which emphasizes improvements in terms of communications and feedback to facilities, Districts, Regions and central level clients and partners.
	PSS/LMU plans and coordinates annual quantification exercises, supply planning process, and quarterly reviews of supply plans for all health commodities, and quantification reports are submitted to PIFWG for review / information.
4. Procurement & Supply Chain Management – Local level (PMO RALG)	Institute a system for identifying, reporting, and feedback on quality issues of medicines and related supplies, medical devices and laboratory supplies.
	Review the current distribution roles and accountability and disseminate to all key players in the supply chain.
5. Information Systems	An electronic LMIS is being developed and rolled out by MOHSW to districts and primary health care facilities, where appropriate infrastructure exists, by Dec 2015.
	MOHSW to define data management tasks and reporting schedules by June 2014.

Pharmaceutical Services Section (PSS)	
Component	**Interventions**
	MOHSW to develop and implement a change management strategy that aims to improve the use of data for decision-making for key supply chain decisions at various levels by June 2015.
	PSS to define key performance indicators and information requirements by Sept. 2014 for monitoring LMIS interventions and processes for their ongoing review.
	The combined training program roll out for the revised ILS / ILS Gateway for Essential Medicines has been completed. Reporting tools to be revised to ensure that they are in line eLMIS by Sept. 2014.
6. Human resources	The MOHSW-PSS to implement and amend recently developed Human Resources Strategy for the pharmaceutical sector that supports the improvement of patient care services and the management of health commodities.
	The logistics management unit (LMU) is fully established and maintained to serve as the central coordination unit for pharmaceutical supply chain functions within the public health sector and with MSD and PMO RALG.
	Pharmaceutical supply chain courses within pre-service education are developed and introduced across various cadres of health professionals (dependent on decisions reached by MOHSW and PMO RALG on supply chain roles at each level).
	Incentive pay-for-performance (and results based financing) program performance indicators for pharmaceutical management are adopted in primary care facilities, councils, and/or regions.
	Supportive supervision is linked with performance reviews and subsequent rewards, either monetary or non-monetary (incentives) - in line with broader initiatives.
	A performance driven supportive supervision program is developed, especially for primary care health facilities. (Proposed to devote a portion of the resources obtained through cost-sharing needs to funding this process.)
7. Regulatory Environment	Establishment of collaboration mechanism (TFDA, PC, PSS, PMO-RALG), with PSS serving as the lead.
	Capacitate Hospital Medicines Therapeutics Committees (MTCs) in public and private sector and health facility governing committees for adverse drug reaction reporting in their facility and by the community (private sector needs training).

Pharmaceutical Infrastructure and Food safety Technical Working Group (PIFTWG)	
Component	**Interventions**
2. Financing and pricing	PSS/DSS in collaboration with the budget section of MOHSW and other stakeholders to develop medium term financial plan for medicines, health technologies and operation of supply chain. Also to ensure data visibility for improved forecasts and coordination for implementation of the plan.
	Stakeholders are directly involved in articulating financing mechanisms for medicines in relation to revenue collection and purchasing
8. Governance & Accountability	Increase the participation of various stakeholders in coordination

PMO-RALG

Component	Interventions
4. Procurement & Supply Chain Management – Local level (PMO RALG)	Identify and adopt alternative models for procurement at local level (e.g. pooled procurement and prequalified suppliers) and adopt best practices from other districts / regions.
	Review the current distribution roles and accountability and disseminate to all key players in the supply chain.
	Establish service agreement between MSD and PMO-RALG specifying the responsibilities of both parties (to include review the current distribution timelines, communication and coordination between MSD and health facilities to ensure reliable and predictable deliveries).
	PMO-RALG to implement medicine management toolkit for quality and coordinated supportive supervision.
	Establish financing mechanism for accessing multiple sources (e.g. including councils, communities, donors, others) for construction of standardized storage facilities at local level.
7. Regulatory Environment	PMO RALG at Regional and District levels strengthens execution of medicines regulatory functions, especially post marketing surveillance, pharmacovigilance, and reporting of quality issues.
	Capacitate Hospital Medicines Therapeutics Committees (MTCs) in public and private sector and health facility governing committees for adverse drug reaction reporting in their facility and by the community (private sector needs training).
8. Governance	PMO-RALG to strengthen Council Health Services Boards and Facility Health Governing Committees to perform agreed functions , including development of comprehensive reporting and performance incentive mechanisms
	PMO RALG institute a mechanism for monitoring performance of service agreement against performance benchmarks on ordering and direct delivery arrangements, order fulfilments, information and reporting requirements for both parties (including rewards and penalties to ensure accountability)
	PMO RALG disseminates knowledge of procedures and best practice in local government procurement and financial management of medical commodities.

Medical Stores Department (MSD)	
Component	**Interventions**
2. Financing and pricing	MOHSW & MSD to set operational and service charges based on results of the independent analysis of MSD operations costs, to inform a forum (MOHSW, PMORALG and MOF with MSD and partners) that develops long-term solutions to handling fees, and the growing level of debt owed to MSD. In addition, a percentage over and above operational costs may be allowed at a level which allows growth of MSD working capital for the long term.
	MOHSW/MOF to define the schedule and make commitments to pay the cumulative debt owed to MSD as a national priority. MSD annual business plans include growth of working capital.
3. Procurement & Supply Chain Management – National level	MOHSW and MSD establish mechanisms for information-sharing and performance monitoring of MSD against agreed indicators.
	MOHSW ensures that the direct delivery system for the delivery of health commodities to the last mile is cost-effective and meets client needs (facilities and programs).
	MSD and other stakeholders ensure the availability of adequate and routinely maintained storage facilities and vehicles to accommodate

Medical Stores Department (MSD)	
Component	**Interventions**
	increasing program needs (scale-up) over the medium to long term.
5. Information systems	MSD to provide the following reports to MOHSW on monthly intervals beginning June 2014 (i. Batch traceability reports; ii. Periodic Cycle count reports with comparison of physical and system stocks; iii. Procurement pipeline reports; iv. National Monthly Stock status).

4.2 Costing of the 3-Year Implementation Plan

For the costing part: specific costing methodology to be completed after in-country team has concluded the costing.

5 Monitoring and Evaluation

A key component of the PSAP 2020 is the monitoring and evaluation (M&E) process. The PSAP 2020 will cover a six year period from 2014 to 2020. The CIP for the PSAP 2020 was designed for an initial three year period from 2014 to 2017. This monitoring and evaluation plan will cover the same three year period of the CIP. The aim of monitoring and evaluating the PSAP 2020 is to determine how well it has been implemented (including, who, what, when, where, and how activities were accomplished). The process will include three phases:

a) Collection of baseline information regarding the status of the eight components of the pharmaceutical sector which are included in the PSAP 2020.
b) Ongoing monitoring of trends that may be impacting the progress, or lack of progress, towards goals. This will include identifying individual goals and objectives that are progressing well according to the plan, and those that are falling short, and suggesting any actions or adjustments that may be needed for the plan to succeed.
c) A final evaluation after the plan is concluded to determine overall success and impact.

The evaluation procedure will include:

- Who is responsible for reporting, gathering, and evaluating data
- What data needs to be collected and how data are collected
- A timeline for completion
- Quantitative and qualitative measurements

The ongoing monitoring effort will answer:

- Are the activities being implemented as planned? Why or why not? What is facilitating or impeding implementation?
- Did all activities fit within the plan objectives?
- Are there objectives, or interventions that are receiving less attention than others?
- What do the results indicate as to how to improve?
- Is there a need to change the plan?

5.1 The Monitoring and Evaluation subcommittee

All monitoring and evaluation activities will be managed by the PIF TWG. This multi-stakeholder group will be able to bring together different stakeholders who may be able to provide resources that will be necessary for M&E activities. If necessary, the PIF TWG may convene a smaller M&E subcommittee from among its members to focus solely on this effort. The M&E subcommittee will co-opt other members from time to time as necessary. The roles and responsibilities of the M&E subcommittee will be to:

- Develop a list of indicators to be used to monitor activities under each of the eight components of the PSAP
- Develop an annual operation plan for each year of the PSAP. This could be taken largely from each year of the costed implementation plan.
- Develop periodic reports against the annual operational plan to review progress towards meeting the strategic aims and objectives. These reports should be circulated to relevant stakeholders through the forum of the PIF TWG and be linked to HSSPIII (and later HSSPIV) reporting mechanisms.

In order to accomplish these tasks, the M&E subcommittee must ensure that whoever is carrying out activities stipulated in the PSAP is keeping appropriate records so that progress can be assessed. It will be the responsibility of the M&E subcommittee to request for activity reports from all partners implementing activities in the PSAP. When reviewing progress towards achieving the specific objectives of each activity, the M&E subcommittee should:

- Ensure that activities are kept within the parameters of the agreed objectives
- Ensure that activities are consistent with MOHSW vision, mission and goals
- Keep under review any internal and external changes which may require changes to the PSAP or affect the ability to achieve the objectives.

5.2 Baseline data

A good M&E plan should be based on comprehensive baseline data. Several assessments have already been done in the pharmaceutical sector in Tanzania. The reports from these assessments have been used to gather lists of existing challenges for each of the components of the PSAP. Some examples of these reports include:

- In-Depth Assessment Of The Medicines Supply System In Tanzania, 2008
- Mapping of the medicines procurement and supply management system in Tanzania, 2008
- Survey of the Medicine Prices in Tanzania, 2004
- Drug Tracking Study Report, August 2007
- Situational analysis of the domestic production of medicines in pediatric dosage forms in Tanzania, November 2010
- Assessment of the Pharmaceutical Human Resources in Tanzania and The Strategic Framework, 2009
- Tanzania: Strategic Review of the National Supply Chain for Health Commodities and MSD, 2013
- Tanzania – Innovation and Access to Health Technologies (Draft)
- Midterm review of the Health Sector Strategic Plan III, 2013
- MSD controller and auditor general report 2011

Since all these assessments were carried out before development of the PSAP, the reports will serve as baseline information for the M&E plan. A list of mapped challenges and suggested interventions is available in the inception report that was written for the development process of the PSAP (Annex 4 of Inception report). This information, together with the lists of ongoing challenges used for the development of the PSAP, should be used by the M&E subcommittee as baseline data. Most of the information in these reports is qualitative. Where necessary, the M&E subcommittee should consider obtaining up to date quantitative data for some of the indicators that will be developed.

5.3 Monitoring

To begin the monitoring process, the M&E subcommittee will compile a list of all primary responsible parties for the implementation plan and time frames for the completion of activities under each implementation partner. The M&E subcommittee will also develop specific indicators for each activity. The indicators will be used to monitor progress.

Each implementer will produce a quarterly implementation report of their activities in the PSAP and submit to the M&E subcommittee. The M&E subcommittee will compile this information into regular updates for the wider PIF TWG and other stakeholders.

5.4 Evaluation

Comment [M11]: Still I believe that quarterly review should just be under monitoring; this is not an evaluation.

The M&E subcommittee will carry out a review of implementing partner reports at the end of each quarter. The evaluation will cover:

- The implementation status of activities under the eight components of the PSAP
- Timeliness of the activities
- Resources available (financial, technical and others)
- Reasons for any delays and proposed alternatives

A sample reporting template for the quarterly review reports to be submitted by the M&E subcommittee to the PIFTWG is shown below.

Quarterly Review Report of the PSAP				
Component 3: Procurement and supply chain management at national level				
Activities	**Implementation status**	**Resources available**	**Timeliness**	**Comments (e.g. reasons for delay, suggested alternatives**
MOHSW and MSD establish mechanisms for information sharing and performance monitoring of MSD against agreed indicators.	e.g. initial meeting set up with MSD and MOHSW program managers	e.g. Technical expertise from PSS, MSD and programs	e.g. Behind schedule	e.g. Delayed by ongoing stock taking exercise at MSD. Corrective action: further meetings to be rescheduled

This quarterly review report will be presented to the wider forum of stakeholders in the PIF TWG. It will be the responsibility of the PIFTWG to reassign responsibilities and resources if necessary, following their review of the quarterly evaluation reports.

5.5 Midterm Review of the PSAP

Eighteen months into the first phase of the implementation of the PSAP, the M&E subcommittee will organize for and lead the midterm review. To accomplish this task, the M&E subcommittee will convene a joint review team that includes at least two independent evaluators, relevant stakeholders and key implementing partners. The joint review team will produce a technical report that will detail results achieved so far, as well as any necessary adjustments that need to be made to the implementation plan in order to achieve the objectives for each of the eight components of the PSAP.

Annex 1 – High Level Results Framework

Goal (Impact level)	**Indicator**
From Health Policy 2007??	
Purpose (overall objective)	**Indicator**
Providing the community with quality pharmaceutical services including sustained access to affordable quality assured essential pharmaceutical products	

Strategic result1 (Outcome level)	**Indicators**	**Assumptions / Risks**
OUTCOME 1: Evidence based policies and guidelines for selection and rational use of medicines and health technologies in public and private sectors and the community are available, coordinated, implemented and monitored by 2020 and mechanisms are in place for providing unbiased information to the public and professionals		
Objectives (intermediate results)	**Indicators**	**Assumptions / Risks**
1. Essential medicines are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness		
2. Processes for improvement of rational use of medicines and medical supplies are coordinated at all levels		
3. Health professionals and the community have access to unbiased medicines information		
4. Accurate diagnosis and clinical care is supported by standardised and functioning health technologies		
5. Essential medicines concept & RUM are incorporated in pre- services and in-services in health training institution curricula and training programs		
Strategic Result 2 (Outcome level)	**Indicators**	**Assumptions / Risks**

OUTCOME 2: a) Adequate funds for medicines and health commodities and related logistics mobilised from sustainable sources and are efficiently managed and equitably distributed b) Mechanisms in place addressing affordability of medicines and health commodities in public and private sector		
Objectives **(Intermediate results/output level)**		
1. Step-wise increase of government funding for medicines including RMNCH in line with health sector priorities		
2. Harmonized and aligned funding from all sources (government, partners, and donors) for provision of essential medicines and health commodities and for effective supply chain infrastructure and operations		
3. Health Financing Strategy provides a long term plan and framework that equitably and efficiently allocates resources for medicines and health commodities and operation of the supply chain		
4. Procedures to access complementary funds for medicines procurement that are generated by health facilities are transparent, clear and efficient		
5. MOHSW fully meets operational costs for handling charges for medicines and health commodities through MSD		
6. MSD recapitalized and plan available for growth of working capital to meet growth in projected procurement and sales turnover.		
7. Mechanisms in place for affordability of medicines in both public and private sector as justified for public health or equity reasons.		
8. Streamlined procedures and reliable mechanisms for predictable and timely disbursements and allocation of approved funds from MOF to MOHSW/MSD facility accounts		
Strategic Result 3 **(Outcome level)**	**Indicators**	**Assumptions / Risks**
OUTCOME 3: Well coordinated, responsive and reliable procurement and supply systems, incorporating private sector participation, are in place at national level, fulfilling demand for quality assured medicines and health commodities		
Objectives **(Intermediate results/output level)**		

1. Improvements in oversight, coordination and information-sharing for the management of health commodities and equipment and pharmaceutical services are made by the MOHSW and key stakeholders.		
2. Adequate procurement capacity (facilities, processes and information systems/tools, human and other resources) exists at each level where procurement is performed for the effective management of procurement and procurement planning activities, order (pipeline) monitoring, and reporting to key supply chain partners (funders, service providers, and programs)		
3. Health commodities procured for the public sector consistently meet recognized standards for quality as defined by the relevant regulatory authority, and quality standards are upheld at all levels in all procurement transactions		
4. The annual health commodity quantification process is well coordinated, managed in a participatory manner and in accordance with agreed procedures by PSS in collaboration with relevant stakeholders. Forecasts and supply plans are shared with all necessary stakeholders, including comprehensive documentation of process, methodology, and assumptions		
5. The distribution system is predictable, reliable, and responsive, with quantitative decisions made from user requirements (demand-based ordering and procurement). Distributors' internal systems are adequate to support operational and client (health facility) and to provide timely reports on the status of health commodities.		
6. MSD's infrastructure (within its distribution network) meets minimum standards of good storage practices as defined by relevant, their internal inventory management systems and procedures are effective, and staffing (numbers and skills) is adequate to meet mandates and expectations. Transport resources are adequate, well-maintained, and replaced in a timely manner.		
7. Financial resources at MSD are adequate to support its distribution mandates and services.		
8. Leadership / responsibility for the procurement of all health commodities is clearly defined by the MOHSW, the Ministry's procurement office/unit monitors and coordinates all procurement agents and partners, and funds are used effectively by all procurement agents		
9. Local pharmaceutical manufacturing industry is promoted to ensure they are able to compete favourably with international suppliers		
10. Public safety is protected and organizational effectiveness is supported by environment friendly waste and disposal processes and procedures accessible by public and private sector facilities		

Strategic Result 4 **(Outcome level)**	Indicators	Assumptions / Risks
OUTCOME 4: Quality assured and affordable essential medicines, program items and related supplies are available in adequate quantities at health facilities and efficiently managed by skilled personnel		
Objectives **(Intermediate results/output level)**		
1. Medicines, laboratory supplies and medical device procured centrally and locally supplied are of assured quality		
2. Procurement procedures for local procurement are streamlined to shorten the lead time while ensuring value for money		
3. Roles for central, regional / zonal and lower levels of the supply chain are well defined and well understood by all players and stakeholders		
4. The health commodity distribution system to public health facilities is predictable, reliable, and responsive, with quantity decisions made from utilization data and available budget/resource allocation (priority- and budget-based ordering and procurement)		
5. Systems for supporting commodity management at facility level are in place		
6. Management and governance of medicines and related medical supplies by LGAs and health facilities is strengthened to obtain maximum benefit from disbursed funds		
7. Health facilities have storage facilities that ensure quality and safety of health commodities		
8. Market intelligence available to guide local procurement of medicine, laboratory supplies and medical devices		
9. Waste and disposal issues are carefully addressed to protect public safety		
10. Staff at facilities assigned to manage health commodities (and stores) have appropriate skills and are dedicated to these tasks		
Strategic Result 5 **(Outcome level)**	**Indicators**	**Assumptions / Risks**
OUTCOME 5: a) Commodity information will be timely, accessible at all levels, and used regularly for decision making b) The information system supports increased data visibility, data quality, access to information, and data use for informed decision-making for commodity-related decisions.		
Objectives **(Intermediate results/output level)**		

1. Computerization across the supply chain utilizes a standardized system which is flexible to adapt to future changes in the supply chain and be scaled up to include facilities in districts with appropriate infrastructure		
2. Data management tasks and schedules are clearly defined and followed for each level and function within the supply chain		
3. The information system(s) both paper and electronic based are used to ensure that relevant data for decision-making and performance monitoring are collected and reported per an established schedule, made available to the appropriate users, and utilized by all levels as needed.		
4. eLMIS processes and data are clearly aligned with HMIS/DHIS		
5. At facility level, data collection and reporting is optimised for health providers including harmonisation of reporting tools		
6. Routine schedule for evaluating electronic and paper based logistics system established		
7. Deliverables of ERP phase one and two implementation at MSD are available		
8. The various electronic reporting systems are streamlined to achieve value for money		
9. Information systems have sufficient technical and financial resources to support and sustain smooth operation		
Strategic Result 6 **(Outcome level)**	**Indicators**	**Assumptions / Risks**
OUTCOME 6: a) Greater numbers of qualified pharmaceutical professionals produced and actively employed in the public and private sectors to provide patient care and supply chain services at all levels. b) Incentives, accountability, supervision, and MOHSW allocation mechanisms for health professionals are strengthened, and there is an increase in human resources within the pharmaceutical sector as a result of advocacy by the MOHSW and its partners.		
Objectives **(Intermediate results/output level)**		
1. GOT funding of, and resources committed to the pharmaceutical sector, are increased for the support of skilled and dedicated personnel and to gradually reduce donor dependency		
2. Competent human resources in appropriate quantities and with the right skill mix are available at all levels of the system to meet requirements and ensure effective patient care and management of medicines and related medical supplies		

3. A career ladder for pharmacy professionals is developed within the cadre of pharmacy services		
4. Pharmaceutical supply chain management / logistics courses are incorporated into selected pre-service education programs		
5. Working conditions, workers motivation, and the retention of health care workers (in the pharmaceutical sector) are improved through the use of incentive schemes		
6. Performance and accountability of health care workers (in the pharmaceutical sector) are strengthened due to improvements in supervisory systems		
7. Dedicated pharmaceutical supply chain management positions are established at key levels to support the effective functioning of the health commodity supply chain		
8. In-service training for the management of health commodities is institutionalized through innovative and sustainable systems, facilitating continuing professional development (CPD) for health workers in the pharmaceutical and laboratory sectors		
Strategic Result 7 **(Outcome level)**	**Indicators**	**Assumptions / Risks**
OUTCOME 7: Capacity of TFDA and Pharmacy Council for market control and control of pharmacy practice enhanced through improved collaboration and contributions by stakeholders		
Objectives **(Intermediate results/output level)**		
1. TFDA and PC are resourced to effectively oversee medicine safety, efficacy and quality and pharmacy practice in the country		
2. Capacity is built at regional and council levels to execute delegated regulatory functions for medicines		
3. Systems are in place to address conflict of interest at all levels regarding inspection activities		
4. Structured collaboration between TFDA, Pharmacy Council, PSS and PMO-RALG to ensure efficient use of available resources		
5. Systems for reporting to TFDA and feedback from TFDA on quality and safety problems with medicines and equipment are in place and used at all levels of the health system (MSD, hospitals, health centres, dispensaries & private sector)		
6. Systems for combatting substandard, spurious, falsely labelled, falsified, counterfeit (SSFFC) pharmaceutical products are in place		
7. Donation guidelines & regulations are adhered to		
8. There is increased capacity for post – marketing quality control (e.g. mini labs, sampling and testing in public and private sectors		

9. Domestic manufacturers comply with GMP		
10. Capacity is built locally to assess and monitor quality and safety of vaccines and other health technologies		
Strategic Result 8 **(Outcome level)**	**Indicators**	**Assumptions / Risks**
OUTCOME 8: A) All stakeholders fulfil their agreed roles and responsibilities to ensure oversight coordination, and transparency in the public and private health commodity management, including local pharmaceutical production B) Results and performance based approach are applied to promote effective management and accountability for health commodity management		
Objectives **(Intermediate results/output level)**		
1. Effective mechanisms in place for oversight and coordination of the different stakeholders in the pharmaceutical sector		
2. Political and financial commitments for an effective supply chain are fully met by MOF, MOHSW and PMO-RALG leadership		
3. Communities are empowered to participate in health facility governance		
4. Civil Society Organizations involved in supporting local accountability and governance structures		
5. Service Level agreements between MSD and Local governments hold both parties accountable for performance of the supply chain.		
6. Effective systems and capacity in place to ensure accountability at all levels		
7. Enabling environment established for promoting local pharmaceutical production and strategies for capacity building in quality assurance (TFDA) that safeguard public safety available		
8. Supply chain roles and responsibilities are clearly defined, communicated, and endorsed for each level and by each oversight organization/entity and change is effectively managed		

Annex 2 – Costed Implementation Plan

(as separate document???)

Annex 3 – Monitoring and Evaluation Plan

Annex 4 – Findings & Recommendations from Document Review

COMPONENT 1: SELECTION AND USE OF MEDICINES

				Addressed in						
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**	**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**	**NACP SP**	**MMAM**
1. MTC not operating as expected at most hospitals										
Strengthen MTCs		X		X	X			X		
MO in charge of hospital to ensure operation of MTC as per manual			X							
2. Little focus on quality of pharmaceutical services (e.g. RUM)									X	X
Focus on efficiency and quality improvements	X			X				X		
3. No recent evidence on medicines use										
Perform RUD surveys					X			X		
4. < 50% of HW received training in RUD (Dodoma baseline)										
5. only 40% of facilities had STGs & NEML available (Dodoma baseline)										
6. adherence to STGs and NEML limited										
Limit distribution to items authorised in NEML per level of care		X								

Comments:

Nearly 50% of the PC SP budget is allocated to support RUM activities
To include pharmacovigilance? (NACP, TFDA, NMCP)
NMCP SP: mentions NTC as responsible for approving any changes in treatment guidelines
NMCP SP: mentions pharmacovigilance with TFDA
NMCP SP: mentions problems with adequate treatment provision in private sector

COMPONENT 2: FINANCING & PRICING

				Addressed in	
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**	**HSSP III**	**NMP IS**
1. Inefficient disbursement of funds from MOHSW to MSD health facility accounts & high accumulated debt					
Create MOHSW holding account at MSD		X			
MOHSWS to create Task Force to address funding inefficiencies & accumulated debt	X	X			
Create special vote from national Treasury for MSD recapitalisation		X			
MOF & MOHSW to ensure regular and timely disbursement of funds to health facility accounts (e.g. inter ministerial forum)		X	X		
Government should make efforts to pay the debt to MSD		X	X		X
2. Inadequate use of locally generated complementary funds				X	X
Test & implement innovative plans		X			
enhance collection and use of funds accrued from complimentary financing options			X		X
3. Overall inadequate budget for medicines (incl. unsustainable financing for vertical programme items)					
Increase GOT resources proportionally to HBF contributions			X		
4. Inadequate resource allocation formula (design & implementation					
PSS to update data used to allocate resources			X		
Formula to incorporate disease burden			X		

Issues from other documents:

MSD SP: includes option to capture 'market' for use of NHIF & CHF resources
HSSP III: alternative financing sources (NHIF, health financing strategy etc.)
HSSP III: private sector prices high; affordability is a challenge
Innovation & Access report: recommends establishing price monitoring mechanism in collaboration with universities
What happened to Tanzania Price Monitor???
Relation with NHIF in terms of medicine benefits & related pricing

COMPONENT 3: PSCM AT NATIONAL LEVEL

				Addressed in				
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**	**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**
1. No reliable and harmonised mechanisms for quantification								
Institutionalised quantification		X				X		
MSD to provide HF with excel sheets for annual quantification			X					
PSS to provide technical support in quantification					X			
2. Procurement delays at central level (MSD)								
MSD to follow up on suppliers			X					
MSD to have stock levels of 9 months for priority items			X					
3. Uncoordinated procurement by vertical programmes / donors leads to inefficiencies								
Strengthen coordination of all players (including SOPs)	X	X		X		X		
MOU MSD / Vertical Programmes						X		

Issues from other documents:

NACP SP: 'strengthen LMU' for HIV/AIDS commodities at national level (which LMU is that?)

NACP SP: p 83 in collaboration with procurement unit facilitate procurement, …. (which procurement unit is meant here?)

NMCP SP: pp 51 includes strategy on logistic system (quantification through to delivery)

NMCP SP: pp 55 strategic approach on logistics (stakeholders mentioned include PSS, TFDA, MSD, PC; collaboration with stakeholders documented)

NTLP SP: p 19 procure & distribute products; do stock taking at MSD

NLTP SP: TLCU responsible for coordination of drugs procurement and distribution

NTLP SP: procurement does not mention PSS as stakeholder

COMPONENT 4: PSCM AND PMO-RALG / COUNCIL LEVEL

				Addressed in				
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**	**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**
1. ILS not performing optimally						X		
DMO & D pharmacist to follow up/ensure adequate ordering by health facilities			X					
RHMT & CHMT improve supervision	X	X	X					
Link supervision with performance review & rewards		X						
Assess options to simplify ILS	X	X			X			
Capacity buidling ILS			X					
2. Low order fulfilment rates (MSD)					X	X		
MSD to improve contract management		X	X					
MSD to ensure minimum stock levels			X					
Document impact of funding on procurement efficiency		X						
Conduct study on options for alternative private sector suppliers	X							
Consider partnership with private sector						X		
3. Inadquate storage at facilities (GSP & record keeping)					X			
Develop & implement GSP					X			
4. high quantities of expired products at health facilities								
Clear procedures for disposal of expired medicines		X	X		X			
5. local procurement inefficiencies (can take long, more expensive)				X				
Conduct study on options for alternative suppliers (see e.g. Dodoma prime vendor pilot)	X							
6. Distribution to HF not as scheduled					X	X		
Review distribution schedules & ensure value for money of network optimisation		X	X					

Findings, recommendations from other documents:

Expired medicines piling up NACP

lack of accurate data for quantification NACP SP

Integrate management of HIV/AIDS commodities in the general health system at regional and district level NACP SP

train HW on SC management for TB drugs & HIV test kits NTLP SP

stock taking at regional & peripheral units NTLP SP

stock outs at health facilities MMAM

inadequate equity in access to medicines MMAM

COMPONENT 5: INFORMATION SYSTEMS

					Addressed in				
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**		**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**
1. ILS data submission rate and quality of data inadequate					X	X	X		
ILS training			X						
improved supervision	X	X							
simplify ILS	X	X							
2. Multiple logistics information systems exist / are used side by side (incl. for TB & laboratory supplies)									
3. Nobody held accountable for appropriate functioning of ILS									

NMCP SP: use of SMS f L & ILS gateway to monitor availability; end use verification services; SPAs; batch tracking surveys

NMCP SP: on logistics IS p66 - also promotes integration with DHIS

COMPONENT 6: HUMAN RESOURCES CAPACITY

				Addressed in				
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**	**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**
1. Inadequate HR capacity (numbers & skills)				X				
Review role of district pharmacist & consider additional position of district commodity manger (logistics function)	X	X						
Consider PFP mechanisms (also to improve retention)		X						
Develop incentive package					X			
Ensure inclusion of supply chain issues in continuous professional education		X						
MSD to train health workers on ILS and quantification			X					
More pharmaceutical personnel to be trained				X				
Support training institutes					X			X

Issues from other documents

improve HR for SCM	NACP SP
improve HR capacity for SCM at district with PSS	NLTP SP
train HW in TB SCM	NLTP SP

COMPONENT 7: REGULATORY ENVIRONMENT

					Addressed in					
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**		**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**	**NACP**
1. Health facilities report quality problems										
Post registration testing of more batches of products in public sector supply chain		X			X			X		
2. Unregistered products available on the market										
Increase TFDA & PC capacity for market control	X				X			X	X	
3. Donations not complying with guidelines										
Update donation guidelines						X				
4. Substandard & counterfeit products on the market										
Strenthen inspection capacity all levels					X	X		X		
5. Low reporting rates for ADRs										
Advocate/strengthen pharmacovigilance					X	X		X		X

Issues from other documents:

NMCP SP: QA system in collaboration with TFDA, PC and others; QA of products with TFDA

NLTP SP: collaborate with TFDA to monitor quality

TFDA, PSS, & NTD: developed specific GL for medicines for NTDs

COMPONENT 8: GOVERNANCE

				Addressed in					
Findings & Recommendations	**MTR Pharma Report**	**Strategic SC Review**	**MSD Audit Report**	**HSSP III**	**NMP IS**	**MSD SP**	**TFDA SP**	**PC SP**	
1. Supply chain accountability & responsibilities are not clear or not effectively implemented									e.g. nobody held accountable if ILS forms not processed as per manual
Regular meetings between MOHSW, PMO-RALG, MSD & define accountability mechanisms		X							
Collaborate with CSOs & NGOs and capacitate Health Facility Governing Committees	X	X							
MoU/Service Delivery agreement MSD/MOHSW	X					X			
MSD to be directly accountable/responsible (rearrange responsibilities PSS/MSD)						X			
Include clear unambiguous lines of accountability in the PSAP		X							
2. Responsibly / coordination PSS / Vertical Programmes not clearly defined									not from reviews but a known issue
3. Coordination of donor projects / activities with MOHSW/PSS not adequate									not from reviews but a known issue
Mechanism to coordinate donations					X				
4. Local manufacturing capacity low		X		X	X				
Facilitate provision of financial incentives					X				
Upgrade quality					X		X		
5. Patent Act not in line with TRIPS agreement					X				
review patent act (see assessment of innovation and access to medicines)									

Issues from other documents:

NACP SP emphasises linkages & alignment but PSS is not mentioned as one of the priority partners, neither participation in PIF TWG

NMCP SP strong on linkages with PSS and other relevant agencies

NTLP SP includes medical research in new treatments and test

Local manufacturing under TFDA as per Strategy for promotion of domestic pharm production (2013-2023); MOHSW to develop annual plan (who in MOHSW?)

Annex 5 – Ongoing Activities & Gaps from Stakeholder Mapping

The following pages show the results of the stakeholder mapping by component. Mapping was done by the PSAP 2020 Task Team and Stakeholder Technical Team.

Please note:

- O indicates ongoing activities
- P indicates planned activities
- X indicates potential interest of the stakeholder
- Highlight indicates the champion for this activity as perceived by the TT and STT
- Highlight indicates an existing gap identified by the TT and STT
- For Acronyms please refer to the List of Acronyms provided at the beginning of the document

COMPONENT 1: Medicines Selection & Use

	Stakeholders																
Ongoing (O) or planned (P) initiatives	**PSS**	**NMTC**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**VDI**	**PC**	**TFDA**	**HFs**	**Universities / research institutes**	**WHO**	**MSD**	**DANIDA**	**JSI**	**MSH**	**PSI**
Functional National Medicine and Therapeutic Committee		O						O	O	O			O		O		
Revitalized Medicines and Therapeutic Committee	O							O	O	O							
Available Medicines and Therapeutic Committee guidelines		O						O	O	O							
Reviewed Standard Treatment Guidelines and Essential Medicines List version 2013		O						O	O	O							
Distribution of printed STG/NEMLIT (prority for PHC facilities)	P							P	P	P			P				
Printing more copies of STG/NEMLIT	P													X			
Electronic publishing of STG/NEMLIT	P													X			
MSD to print more copies and CDs and sell to those who will need the document	P							P	P	P			P				
Implementation of STG/NEMLIT (sensitisation; behaviour change prescribers?) including private sector; how to produce, where to sell (through PC / also zonal offices)	?		O	O	O	O				?		?			?		
Mentoring medicines and therapeutic committee	P							P	P	P							
Assessment on Rational Use of Medicines	P							P	P	P				X			
Guidance on selection of medicines in place		O						O	O	O							
National Formulary (2005)								?	?			?					

	Stakeholders																
Ongoing (O) or planned (P) initiatives	**PSS**	**NMTC**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**VDI**	**PC**	**TFDA**	**HFs**	**Universities / research institutes**	**WHO**	**MSD**	**DANIDA**	**JSI**	**MSH**	**PSI**
Availability of hospital formulary (in some hospitals)	O							O	O	O							
Finalization of RUM communication strategy (not yet funded)	P							P		P							
Evidence based review of programme specific guidelines within NMTC framework	O	O	O	O	O	O	O				O	O					
Medicines & Poisons Information Centre (e.g. at zonal hospital level?)	?							?	?			?					
Link of accreditation to prescribing habits	?																
Medication errors (MTCs, RUM? STGs? information centres?) - prescribing / dispensing standards & management - monitoring; public AND private sector	?	?						?	?	X	?	?					
Prevention of resistance of anti-microbials	?	?						?			O						
Involvement of ADDOs in RUM (patient information)								O	O						O	O	O

COMPONENT 2: Financing & Pricing

	Stakeholders																					
Ongoing (O) or planned (P) initiatives	**Pharm Services (PSS)**	**Diagn. SSs**	**MOHSW**	**MSD**	**NIMR**	**NHIF/ CHF**	**MOF**	**PMO RALG**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**JSI**	**HBF partners**	**Global Fund**	**GAVI**	**WHO**	**WB**	**DPs**	**HPSS**	**UNICEF/ UNFPA**
Financing plan for medicines and health technologies (5-year framework), supported by quantification model developed with NIMR, and linked to new HFS (strategy 4, general revenues).	O	X	O	O	O	X	X	X	X	X	X	X	X	O	X	X	X	O	X	X		X
Mobilisation of RBF and complementary funds (NHIF, CHF, cost-sharing) for purchase of medicines and health commodities, linked to new HFS (strategy 6 - innovations in resource mobilisation).	P		P			O	X	O							O				O		O	
Financial sustainability plan for externally financed VP commodities, improved mechanisms for financial flows and supply (Coordination unit, MSD-VPP, AMFm model of privare sector participation - 9 FLB).	X	X	X				X	X	?	O	?	O	O	?	?	?	O					
MOHSW Programmes budgeting for MSD handling fees in MTEF			P									O	?		O	O	?					

	Stakeholders																					
Ongoing (O) or planned (P) initiatives	**Pharm Services (PSS)**	**Diagn. SSs**	**MOHSW**	**MSD**	**NIMR**	**NHIF/ CHF**	**MOF**	**PMO RALG**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**JSI**	**HBF partners**	**Global Fund**	**GAVI**	**WHO**	**WB**	**DPs**	**HPSS**	**UNICEF/ UNFPA**
Financing direct delivery (by local government)								X														
Mechanism for flow of funds from MOF to MSD facility accounts (also discussion to have medicines budget disbursed in one tranche for the whole year?)	X	X	O	X			O	X							X							
Resource allocation formula updated for hospitals, FY allocation plan and monitoring system for utilisation of funds through MSD sales/complementary suppliers)	O	X	O												O				P			
MSD debt, working capital and financial sustainability	P		O	O			O	X							X							
MSD handing fees and charging mechanism for provision of VP commodities	P		P	O					X	X	X	X	X									
MSD pricing scheme for sale of stock products, and mechanism for subsidised / co-financed medicines and health commodities	O			O						O												

	Stakeholders																					
Ongoing (O) or planned (P) initiatives	**Pharm Services (PSS)**	**Diagn. SSs**	**MOHSW**	**MSD**	**NIMR**	**NHIF/ CHF**	**MOF**	**PMO RALG**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**JSI**	**HBF partners**	**Global Fund**	**GAVI**	**WHO**	**WB**	**DPs**	**HPSS**	**UNICEF/ UNFPA**
Support and innovation in insurance schemes related to provider payment systems including pharmaceutical benefits			O																		O	
Pricing surveys in public, NGO, and private facilities	O		X	X		X		X										O				
NHIF Accreditation of pharmacies/ADDOs and reimbursement scheme for pharmaceuticals	X	X	X			O		O														
Private Sector co-payment mechanism (e.g. ACTs) , possible expansion to MRDTs		X								O						O						CHAI
Maximum price setting ?																						

SOURCES:

1. Health Financing Strategy - Options Paper
2. NIMR QMMS
3. MSD Pricing scheme approved by Board
4. HPPS Dodoma project docs
5. RMNCH costed implementation plan for comodities
6. GF approved grants
7. AMFm country evaluation

COMPONENT 3: PSCM National Level

	Stakeholders																		
Ongoing (O) or planned (P) initiatives	**PSS**	**ICT MOHSW**	**MSD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**Diagnostic Services**	**NIMR**	**WHO**	**JSI**	**Accenture**	**MEMS Company**	**GF**	**PEPFAR**	**PMI**	**Action Medeor**	**USAID**
Implementing a Logistics Management Unit (LMU)MOHSW to sustain the supply chain activities	O		O	O	O	O	O	P	O			O			O				
Direct Delivery System of health commodiities to Health facilities	O		O									O							
eLMIS development and roll out across the country	O	O	O	O	O	O	O	O	O		O	O							
SMS for life	O	O			O	P									O				
Mobile reporting system for tracer essential medicines(ILS Gateway)	O	O	O	O	O		O	O	O			O							
National Quantification exercise	O		O	O	O	O	O	O	O	O	O	O							
Network optimization, including options for cross dock facilities, mobile warehouse, and route optimization.			O									O	O						
Strategies for procurement and quantification (including VPP, GDF) - issue of coordination with MSD			X	P	P	P									O	O	O		
Not for profit alternative providers (incl. Supply chain trategic plan for FBO Hospitals)														P				O	

	Stakeholders																		
Ongoing (O) or planned (P) initiatives	**PSS**	**ICT MOHSW**	**MSD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**Diagnostic Services**	**NIMR**	**WHO**	**JSI**	**Accenture**	**MEMS Company**	**GF**	**PEPFAR**	**PMI**	**Action Medeor**	**USAID**
Establishment of Public Private Distribution partnerships (distribution)			O		P (Bed Nets)														
Prime vendor model MSD (pilot at 3 zones)			O									O							
Transfer Zones to strategic business units																			
Prime vendor model for 37 products procured with programme funds (PEPFAR implementing partners)												O				O			O

COMPONENT 4: PSCM at PMO-RALG, Council Level

	Stakeholders																			
Ongoing (O) or planned (P) initiatives	**PSS**	**MSD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**Diagnostic Services**	**Council**	**HF**	**TFDA**	**MOF**	**JSI**	**Accenture**	**HPSS**	**PMO-RALG**	**PC**	**WHO**	**Danida**	**GF**
Prime Vendor system	O								O	O					O	O				
Direct Delivery System	O	O							O	O			O	O						
e-LMIS	O	O	O	O	O	O	O	O	O	O			O					O		
SMS for life	O	O		O			O	O	O	O										O
ILS Gateway	O	O				O		O	O	O			O							
Strengthen capabilities of councils in managing medicines at health facilities (including tool kit)	O								O	O			O						O	
Strengthen Logistics system for the management of TB and Leprosy Commodities	O				O								O							
Strengthen logistics system for the management of Laboratory supplies	O							O					O							
Harmonize implemented logistics systems	O	O	O	O	O	O	O	O	O	O			O							
Continue reviewing & improvement to existing ILS in context of eLMIS implementation	O								O	O			O							

	Stakeholders																			
Ongoing (O) or planned (P) initiatives	**PSS**	**MSD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**Diagnostic Services**	**Council**	**HF**	**TFDA**	**MOF**	**JSI**	**Accenture**	**HPSS**	**PMO-RALG**	**PC**	**WHO**	**Danida**	**GF**
Continue capacity building in the use of ILS as required as input for e-LMIS	O								O	O			O							
Strengthen HR for Supply chain Management			P (Hire commodity manager for program commodities)																	
Disposal of expired medicines at HF	O								O	O	O	O	O							
Address additional workloads arising from vertical programmes																				
Good storage practices	O								O	O						O	O			
Technical Committee reporting to CHMP (SC, local procurement, e-lmis etc)																				
Payment mechanisms HF - MSD (no automatic deduction)																				

COMPONENT 5: Information Systems

	Stakeholders													
Ongoing (O) or planned (P) initiatives	**PSS**	**ICT MOHSW**	**HMIS**	**MSD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**IVD**	**Diagnostic Services**	**PMO Ralg**	**TFDA**	**JSI DELIVER/ SCMS**	**Global Fund**
e-LMIS Development and roll out	O	O		O	O	O	O	O					O	
ILS Gateway for Essential Medicines	O	O			P	O		O					P	
Mobile reporting system for Malaria Commodities -SMS for Life	O	O				O								O
Strengthen capabilities of councils in Medicine data Management at health facilities through eLMIS	O	O									O		O	
Enable an electronic logistics and supplies system to ensure adequate quality and quantities of health commodities are always available at the point of service to meet patient demand	O	O		O										
Interfacing existing electronic system with eLMIS	O	O		O									O	
Interfacing DHIS with eLMIS	P	P											P	
Improving data availability & visibility	O	O	O	O	O	O	O	O	O	O	O		O	
Enabling availability of Tracer Medicine reports through HMIS	O	O	O											O
MSD ERP systems	O	O		O									O	O
MOHSW e-health strategy														

COMPONENT 6: Human Resources Capacity

	Stakeholders																	
Ongoing (O) or planned (P) initiatives	**PSS**	**MOHSW HRD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**VDI**	**PC**	**TFDA**	**Muhimbili (SoPh)**	**Other training institutes**	**ITECH**	**NACTE**	**TCU**	**JSI**	**Zonal training centre**	**POPSM**	**PMO Ralg**
Development of generic curriculum for B Pharm								**P**		**P**	P	**P**	**P**	**P**				
Development of pre-service training curriculum for supply chain		O								O			O	O	O			
Development of in-service training curricula supply chain								O		O					O	O		
MSc pharmaceutical programmes										O								
Development of 1-year dispenser course	O							O	O	O	O				O			
Development of CPD programme (registration of training providers)								O										
Make a case for adjustment of salary scale for public sector pharmacy personnel	X	?						X									?	
Sensitise stakeholders, promote & facilitate establishing pharmacy training school								O										
Provision of minimum standards for pharmacy schools								o										

	Stakeholders																	
Ongoing (O) or planned (P) initiatives	**PSS**	**MOHSW HRD**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**VDI**	**PC**	**TFDA**	**Muhimbili (SoPh)**	**Other training institutes**	**ITECH**	**NACTE**	**TCU**	**JSI**	**Zonal training centre**	**POPSM**	**PMO Ralg**
Assessing Retention Mechanism of Pharm HR (including incentives)	O	O	O	O	O	O	O	O										
Assessing Motivational system of HR	O	O	O	O	O	O	O	O	O	O	O				O	O		
Assessing adequate availability and distribution of Pharmaceutical HR	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O		
Creating Job description for the different pharmaceutical cadres	X							X	O	O	O	O	O	O	O	O		
Incorporate basic SC principles into Council Executive Directors training curriculum (or short courses for different LG cadres)	X																	X
Expand intake of pharmacy students (e.g. new MUHAS)										O	O							
Plan for filling vacancies in public sector is there																		
Develop module based pharmacy training								P										
Establishment of miniature of pharmaceutical manufacturing industry for training pharmacy students											O							
No system for mentoring and professional coaching (move to HR)	X																	

COMPONENT 7: Regulatory Environment

	Stakeholders							
Ongoing (O) or planned (P) initiatives	**PSS**	**MOHSW**	**VDI**	**Diagnostic Services**	**PC**	**TFDA**	**JSI**	**GF**
Inspection of manufacturing facilities as well as to promote local manufacturers to be GMP compliant	O					O		
Expanding of registration not only to medicines but also to health technologies				O		O		
Post marketing surveillance of diagnostics and medical devices				O		O		
Pharmacovigilance of medicines, vaccines and health technologies	O		O			O	O	O
Development of PV Guidelines for specific categories of medicines (with specific vertical programs involved)	X	X				X		
Revision of the TFDC Act to take allow TFDA to regulate medicines, food, cosmetics, diagnostics, blood and products as well as medical devices	O	O		O		O		
Quality assurance/analysis of medicines and other products from one sto border posts to zones to TFDA Laboratory						O		
Combatting counterfeit medicines and providing education to the public to identify counterfeit						O		
Inspection of Health facility and training institutions					O			
Training of inspectors from Ward to district to Regional levels					O			
Development of regulations for the pharmaceutical cadre					O			
Development of guidelines for intern supervisors					O			
Sensitization of stakeholders on mandate and responsibilities					O			

COMONENT 8: Governance

	Stakeholders																
Ongoing (O) or planned (P) initiatives	**PSS**	**MOHSW**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**VDI**	**Diagn. Services**	**PC**	**TFDA**	**PMO-RALG**	**RHMT CHMT**	**Health facilities**	**other Ministries (Industry, EAC, Finance, etc)**	**MSD**	**Danida**	**JSI**
National initiatives to promote local pharmaceutical production	O									O				O			
Supportive Supervision	O								O			O					
Only half of Government Health Facilities Committees are functional											X			x			
NMP and Its NMPIP are in approval process	O	O															
MTC meetings not held and focusing more in procurement than RUM and ADRS monitoring																	
Tool kit for medicines management and governance at LGAs	O	O									O	O	O			O	O
Develop Clients Service Charter									P								
Conduct Zonal meeting to sensitize ADR reporting from health facilities and drug outlets	P								P	P							
Conduct community awareness programmes on ADR	P								P	P							
Quarterly inter-ministerial meetings (PMO RALG - MOHSW)		O									O						
PIF TWG established	O	O	O	O	O	O			O	O	O						

	Stakeholders																
Ongoing (O) or planned (P) initiatives	**PSS**	**MOHSW**	**NACP**	**NMCP**	**NTLP**	**RCHS**	**VDI**	**Diagn. Services**	**PC**	**TFDA**	**PMO-RALG**	**RHMT CHMT**	**Health facilities**	**other Ministries (Industry, EAC, Finance, etc)**	**MSD**	**Danida**	**JSI**
Social accountability monitoring of medicines availability (Sikita)																	
professional ethics TOT (code of conduct)									O								
publishing HF allocations on website	P	P															
MOU MSD VP	O	O	O	O	O	O	O	O							O		
position of office of CP not appropriate to get information as needed																	