RESULTS FOR DEVELOPMENT

Opportunities to align supply chain, market shaping and health financing functions and policies

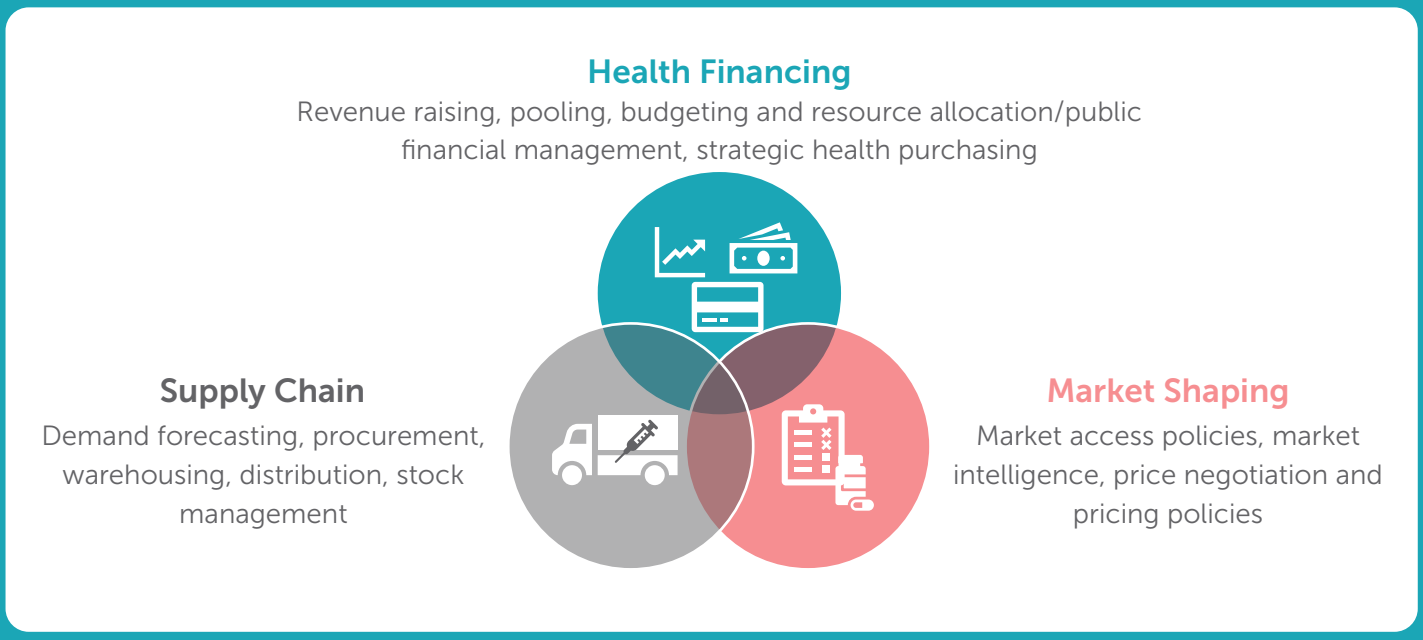
TANZANIA

Access to essential medicines and other health products is fundamental to achieving Universal Health Coverage (UHC) and improving population health[1]. To successfully ensure that people receive the medicines and health products they need, Governments must take a complex set of actions that span health financing, supply chain and market shaping policy. They must:

- Set priorities about which services and products they will fund
- Forecast the amount of products to buy based on population health needs
- Use market shaping tools to promote adequate supply of quality products at the best prices
- Ensure that enough resources are allocated in budgets
- Ensure that funds flow effectively through the various health financing arrangements to cover the costs of medicines and products
- Ensure that the procurement and distribution of commodities functions well and the products reach the end users
- Ensure the flow of funds, pricing and payment to providers align with the flow of products through supply chains

This brief examines how Tanzania's health financing, supply chain, and market shaping functions align and intersect — and where they fall short in reinforcing each other and working together — to inform strategies, policies, and learning aimed at ensuring more reliable, better-financed access to essential medicines and health products.

Strengthening alignment between health financing, supply chain, and market shaping functions and policies is vital to ensure that the flow of financing aligns with the flow of products for reliable and affordable access to quality primary health care (PHC).



GOVERNANCE

Tanzania's health supply chain is organized around the Medical Stores Department (MSD) as the national pooled procurer and distributor, with the Prime Vendor System (PVS) providing a complementary regional level pooled-procurement option when MSD stock is unavailable. The MSD Medium-Term Strategic Plan III (2021–2026)[1] and Tanzania Health Sector Strategic Plan V (2021–2026)[2] emphasize governance, inventory control, service levels, and digital visibility (electronic Logistics Management Information System, eLMIS). These frameworks reference financial sustainability within MSD operations but do not set out a cross-Government, supply-chain financing architecture that explicitly links to essential medicines and health products access.

Tanzania uses the Standard Treatment Guidelines & National Essential Medicines List (STG/NEMLIT, 2021)[3] to guide product selection, while MSD tenders, published catalogues, and PVS competition influence prices through pooled demand and supplier performance. A single

nationwide medicines pricing policy with uniform reference prices is not being implemented; pricing signals therefore flow mainly through procurement mechanisms and purchaser schedules. Ongoing e-LMIS expansion, continued MSD/PVS coordination, and the active use of STG/NEMLIT provide a clear platform to strengthen financing linkages and price transparency—positioning the system to further improve availability, value for money, and equitable access. Coordination with the National Health Insurance Fund (NHIF), Community Health Fund (CHF) and other essential medicines financing mechanisms can also enhance strategic purchasing, proving value for money and improved access[4].

SOURCES OF FINANCING FOR ESSENTIAL MEDICINES

Tanzania's commodity financing landscape relies on a mix of Government allocations, donor-backed direct facility financing, insurance payments, and out-of-pocket payments (OOP). Health facilities maintain a Drug Revolving Fund (DRF) in which essential medicines funding is maintained.

Methods

Results for Development (R4D) with support from the Gates Foundation, conducted a multi-country rapid analysis in Ghana, Ethiopia, Nigeria and Tanzania to examine existing linkages between supply chain, health financing, and market shaping functions and policies. An opportunistic qualitative analysis was conducted guided by a set of analytical questions focused on the following themes: forecasting and budget formulation, budget execution, pricing, funds flow and provider payments, and data systems. Data was gathered through document reviews and key informant interviews with technical staff from the Ministry of Health (MOH), President's Office Regional Administration and Local Government (PoRALG), Tanzania's public pooled procurement entity, health financing agencies, regulatory authorities, regional, district and community health management teams, and health care facilities.

ESSENTIAL MEDICINES FINANCING SOURCES

Government Allocations	▪ Funds allocated by the MOH are sent directly to MSD for pooled procurement. intended 100% for essential medicines. ▪ Earmark: intended 100% for essential medicines. ▪ Constraints: disbursement delays; budget ceilings not linked to quantified need; insufficient DRF capital due to unpaid facility debts to MSD.
Health Basket Fund (HBF via direct health facility financing)	▪ Donor-supported basket channeled through direct health facility financing to facilities. ▪ Earmark: 35% allocated to essential medicines (via facility DRFs). ▪ Constraints: delayed releases and reporting requirements slow execution.
National Health Insurance Fund (NHIF)	▪ Purchaser payments to facilities for delivering the services and medicines covered in the benefits package. ▪ Earmark: 50% of insurance payments are allocated to essential medicines (via facility DRFs). ▪ Constraints: frequent delays in claims submission and provider payment.
Community Health Fund (CHF)	▪ Sub-national insurance for the informal sector. ▪ Earmark: 50% allocated to essential medicines (via facility DRFs). ▪ Constraints: similar to NHIF – claims and provider payment delays are common.
Out-of-Pocket	▪ Revenue collected by facilities from patients. ▪ Earmark: policy target of 50% allocated to essential medicines (via facility DRFs) but difficult to enforce. ▪ Constraints: can create financial hardship and access barriers; practice varies by facilities; weak accountability.
Donor Funding	▪ Program commodities for HIV, tuberculosis (TB), malaria, vaccines, family planning, maternal and child health, nutrition often supplied in kind or via parallel arrangements. ▪ Constraints: flows may not align with domestic budget cycles, creating parallel systems.

While these diverse funding streams offer potential resilience, their predictability and timeliness vary significantly, leading to fragmentation, delayed procurement, and budget execution challenges. Furthermore, the visibility across each of the systems to gain a comprehensive picture of essential medicines funding and gaps is absent. Each revenue source is siloed and comes with its own set of rules and processes that health facilities have to juggle. Understanding the strengths and constraints of each source is essential for improving supply chain performance and financial sustainability, while consolidation or coordination across funding sources could improve efficiency.

FORECASTING AND BUDGETING

Forecasting

In Tanzania, forecasting for essential medicines begins at the health facility level. Facilities use historical consumption data, service population, and disease burden to project needs, validating estimates with dispensing registers and data from the eLMIS, which now incorporates AI-driven features.

Forecasts are submitted upward through the Council Health Management Teams (CHMTs) and Regional Health Management Teams (RHMTs), then consolidated by PoRALG and the MOH's Pharmaceutical Services Unit (PSU). Secondary and tertiary hospitals conduct a similar process using their electronic Medical Records (EMR) systems.

The final national forecast is reviewed by the National Quantification Team (NQT) before submission to the Ministry of Finance (MOF). This process is intended to generate an annual national forecast that informs procurement by MSD.

Budgeting

Budgeting also follows a bottom – up approach, with facilities estimating revenues from their own-source funding streams – Health Basket Fund, NHIF, CHF, and out-of-pocket payments – taking account of earmarking requirements.

These facility-level revenue estimates are submitted upwards via CHMTs and RHMTs and aggregated into national funding requests. The MOH then submits a consolidated health budget to MOF, including requests for essential medicines financing.

Misalignments Between Forecasting and Budgeting

Despite detailed bottom – up forecasting and budgeting, there is a persistent disconnect between forecasts and actual budget allocations. MOH requests to MOF are constrained by macro – fiscal ceilings, and final budget allocations are often based on historical spending patterns rather than forecasted demand. As a result, the resources approved for essential medicines rarely match estimated need.

While the MOH in theory attempts to fill gaps by combining facility own-source revenues with national allocations, in practice funds are released without consistently applying forecasting data. For reproductive, maternal, newborn, child, and adolescent health (RMNCAH) commodities, MOH often

divides the budget between RMNCAH and other commodities based on discretionary judgment rather than forecasted requirements.

Parallel processes further complicate alignment with donor-financed program commodities (HIV, TB, malaria, vaccines, nutrition, maternal and child health, family planning) forecasted and budgeted for separately at the national level. These vertical systems tend to achieve better alignment between need, budget, and procurement than domestically financed essential medicines, but the process remains siloed and not integrated into the broader national system for essential medicines.

BUDGET EXECUTION

In Tanzania, delays in the release of funds for commodity purchases stem from multiple sources. Central Government transfers to MSD are often slow due to rigid budgeting and public financial management (PFM) processes. Disbursements from the HBF and insurance provider payments (NHIF, CHF) are frequently delayed due to administrative bottlenecks, incomplete reporting, or limited digitization of claims systems. Additionally, there is no integrated platform that tracks disbursement timelines across funding sources, making it difficult for facilities and MSD to plan procurements effectively. These delays undermine the predictability of financing, disrupt procurement schedules, and force health facilities to rely on emergency purchases from the open (private) market, often at higher prices.

Source	Key Constraints
Government Budget	Delays in disbursement; insufficient capital in the DRF because of debts from health facilities that have not been paid to MSD.
HBF	Delayed releases.
NHIF	Delays are common in the filing and processing of claims and transfer of payments to facilities.
CHF	Delays are common in the filing and processing of claims and transfer of payments to facilities.

Table 1: Sources of essential medicine financing in Tanzania and budget execution delays

In Tanzania, delays in budget releases and procurement cycles translate into frequent stockouts at facilities, forcing emergency purchases from private suppliers at higher prices. These timing misalignments strain DRFs, which slip into deficits as costs outpace inflows, and the resulting price pressures make essential commodities less affordable for patients – ultimately increasing out-of-pocket spending and undermining consistent access to care.

POOLED PROCUREMENT: DRUG MANAGEMENT AGENCIES

MSD is the sole public procurement agency at the national level responsible for pooled procurement, warehousing, and distribution of health commodities. In addition to MSD, PoRALG works with a set of local prime vendors, through the PVS, at the regional level to procure and supply essential medicines. Facilities are permitted to procure from the regional prime vendors when MSD is stocked out and can also procure from the open (private) market if prime vendors are stocked out. While this system was put into place to ensure continuity of services, this fragmented procurement approach often results in higher costs and limited price control in the public sector[5].

Key Functions of MSD

- Supply planning of the national demand and executes procurement.
- Maintains and updates the price list annually (e-catalogue) based on market research, as well as framework agreement prices with suppliers.
- Storage and distribution of essential medicines primarily using a pull system through e-LMIS.
- Manages MOH allocated commodity financing accounts for facilities; allows drawdown until account balances are depleted.

Challenges

- Limited visibility into total available financing: MSD has access only to budget allocations received through the MOH and lacks visibility into other key financing sources such as the HBF, NHIF, CHF, and user fees. This fragmentation constrains MSD's ability to develop demand-based procurement plans that reflect the full resource envelope across financing streams.
- Fragmented planning and budgeting processes: Coordination between MSD, MOH, PoRALG, and health insurance schemes remains limited, leading to misaligned quantification, delayed disbursements, and inconsistent supply plans. Facilities often rely on their own funds or insurance reimbursements to bridge gaps, weakening centralized procurement.
- Inadequate market intelligence: While MSD updates its annual price catalogue through market research, the process lacks independent, routine cost analysis and does not fully account for inflation, currency fluctuations, or regional price variations. This reduces responsiveness to changing market conditions and limits opportunities for strategic market shaping.
- Misalignment with insurance tariffs: Price discrepancies between MSD's catalogue and NHIF reimbursement tariffs create friction in procurement and cost recovery. Both

institutions maintain separate methodologies without a shared national pricing framework, resulting in inefficiencies and missed opportunities to influence market prices.

- Procurement inefficiencies and higher costs: When MSD experiences stockouts, facilities procure through PoRALG-designated prime vendors or the open market. While this system ensures continuity of care, it introduces price variability and limits national price control. Fragmented procurement channels and delayed budget releases also erode MSD's capital base, increasing reliance on emergency purchases at higher unit costs.

Tanzania's health commodity supply system is evolving, with growing efforts to align financing and supply institutions[6]. Further strengthening coordination among MSD, NHIF, CHF, and PoRALG would enhance budget predictability, improve procurement efficiency, and create greater opportunities for market shaping and more sustainable access to essential medicines.

PRICING

Price Setting

Essential medicines pricing in Tanzania is decentralized, with no single national pricing authority or registry to coordinate methodologies across institutions. MSD sets benchmark prices through its annual e-catalogue, applying a 20.4% markup for locally procured medicines and 26.4% for imported products to cover logistics and administrative costs. Prices are updated through market research but are not routinely validated by independent cost analysis and often lag behind inflation, exchange-rate movements, and regional price variation.

NHIF maintains a separate essential medicines tari list, developed using market surveys and applying a 20 – 30% markup for administrative costs. However, NHIF and MSD use different pricing methodologies, resulting in discrepancies between procurement and provider payments rates.

At the subnational level, PoRALG contracts regional prime vendors who negotiate prices independently, with limited alignment to MSD or NHIF benchmarks. Prices can vary significantly across regions, reflecting supplier competition, transport costs, and negotiation capacity. When MSD and Prime vendors are both out of stock, facilities purchase from the open (private) market, where prices are unregulated and quality oversight is limited.

Essential medicines pricing in Tanzania is decentralized, with no single national pricing authority or registry to coordinate methodologies across institutions.

Drivers of Price Variation

Several structural and operational factors continue to drive variation in essential medicine prices across Tanzania's public and private procurement channels, as summarized in Table 2 below.

Challenge	Description
Fragmented pricing governance	Multiple actors—MSD, NHIF, prime vendors, and private suppliers—set prices independently with no unified oversight or national price registry, leading to inconsistent benchmarks and limited transparency.
Market volatility (inflation/foreign exchange)	Price catalogues are not routinely adjusted for inflation, foreign-exchange movements, or input cost increases, making reference prices outdated.
Procurement timing and cash-flow constraints	Delayed or partial budget releases and high facility debt levels constrain MSD's liquidity, forcing small-batch or emergency procurement at higher unit prices.
Tariff and reimbursement misalignment	Discrepancies between MSD's price catalogue and NHIF reimbursement tariffs create challenges for cost recovery and budgeting consistency.
Geographic disparities	Prime vendor prices differ widely by region due to transport costs, supplier access, and purchasing power, with remote areas often paying higher rates.
Emergency procurement and limited price intelligence	When MSD and prime vendors are stocked out, facilities resort to the open (private) market at higher prices, often without standardized price verification or quality assurance mechanisms.

Table 2: Drivers of price variation

Tanzania has laid a foundation for stronger pricing governance through MSD's national e-catalogue and NHIF's published tariff lists. However, the absence of a national price registry and unified methodology continues to limit transparency and market-shaping leverage. Establishing a coordinated pricing framework that aligns MSD, NHIF, and PoRALG would enhance cost predictability, rationalize markups, and improve value for money in public sector medicine procurement.

The example below illustrates price variation for oxytocin across different procurement sources in Tanzania, highlighting inconsistencies between MSD catalogue prices, NHIF reimbursement tariffs, and market-based purchases.

Tanzania Oxytocin Price Variation Example (July 2025) Prices paid by health facilities can vary depending on whether they buy from MSD, a regional Prime vendor, or directly from the open (private) market — often not aligning with provider payment (NHIF)			
MSD	NHIF Tariff	Prime Vendor	Private Supplier to Facility in Public Sector
$0.46	$0.58	Min - $0.42 Max - $0.69	Min - $0.69 Max - $0.96

Table 3: Tanzania Oxytocin Price Variation (July 2025)

Bright spot

Building Blocks for Pricing Transparency: Tanzania has laid a strong foundation for improved pharmaceutical price governance through the introduction of MSD's national e-catalogue and NHIF's published tariff lists. Together, these tools have begun to standardize pricing information across the public sector, providing health facilities, planners, and policymakers with greater visibility into medicine costs. The e-catalogue allows facilities to plan and budget based on current MSD prices, while NHIF's tariffs establish reference points for provider payment. With further alignment and regular updates, these systems could evolve into a national pricing registry—enhancing transparency, promoting fair competition, and supporting data-driven procurement decisions across the health sector.

FUNDS FLOW AND PROVIDER PAYMENT

Health facilities in Tanzania receive funds for essential medicines from multiple sources, each governed by its own payment rules and modalities. Depending on the funding stream, payments for medicines may be made separately (e.g., direct MOH allocation to MSD; NHIF payments and user fees) or bundled within broader service payments (e.g., HBF and CHF capitation payment). Fragmented budgeting and disbursement processes across these streams complicate cross-source planning, weaken visibility of the total essential medicines envelope, and limit strategic purchasing.

Funding Source	Payment Mechanism	Are payments for medicines bundled into service payments?	Notes
MOH	Allocation to MSD	No	Funds are allocated prospectively for medicines (100%); budgets are often inadequate, and releases delayed or incomplete.
Health Basket Fund (HBF)	Direct Facility Financing	Yes	35% of allocations earmarked for essential medicines and health products; delayed disbursements are common, affecting timely procurement.
National Health Insurance Fund (NHIF)	Fee-for-Service	No	50% of reimbursements earmarked for medicines and health products; tariffs not always aligned with MSD prices; claim filing and payment delays frequently reported.
Community Health Fund (CHF/iCHF)	Capitation	Yes	50% of allocations intended for medicines and health products; delayed reimbursements and limited claim management capacity at facility level.
OOP	Fee-for-Service	No	Variable by facility; typically 50% earmarked for medicines; regressive structure and inconsistent revenue generation across facilities.

Table 4: Provider payment mechanisms for essential medicines in Tanzania

DATA SYSTEMS

Multiple Data Systems for Financing, Supply Chain and Service Delivery

For health systems to effectively manage a robust portfolio of essential medicines and health products, managers need visibility across financing, supply chain, and service delivery functions. In Tanzania, multiple platforms exist to capture these data streams. Below are a few of the key systems currently in use:

- Epicor Integrated Financial Management Information System (IFMIS): Epicor IFMIS is used by the Government of Tanzania to automate and manage its financial processes.
- MUSE: Digital payment and accounting system designed to manage and track all Government expenditure transactions.
- Facility Financial Accounting and Reporting System (FFARS): Used for financial management in public health facilities including tracking revenues and expenditures.
- Electronic Logistics Management Information System (eLMIS): Electronic logistics management information system that tracks the procurement, distribution, and stock status of health commodities across all levels of the supply chain.
- MSD Epicor 10: Logistics and inventory management system.
- Electronic Medical Records (EMRs): National EMR used to digitally capture, store, and manage patient information at health facilities to improve service delivery, data quality, and continuity of care.
- District Health Information System (DHIS2): National health management information system used by the Ministry of Health and health facilities to collect, analyze, and utilize health data for planning, monitoring, and improving health services.

Gaps

- Fragmented and siloed systems: Key platforms—Epicor IFMIS, MUSE, FFARS, eLMIS, MSD Epicor 10, EMRs, and DHIS2—operate independently with minimal interoperability, limiting visibility across financing, supply chain, and service delivery functions.
- Incomplete integration efforts: While integration of EMRs (service delivery), eLMIS (facility-level logistics), and MSD Epicor 10 (central procurement) is underway, these systems are not yet interoperable, preventing end-to-end tracking of commodities and funds.
- Limited linkage between financial and logistics data: Financial management systems (MUSE, Facility Accounting System) are not connected to eLMIS or Epicor, creating a disconnect between budget execution and commodity availability.

- Inconsistent data quality and reporting: Data timeliness and completeness vary across facilities, especially in rural areas where connectivity challenges hinder routine reporting into eLMIS and DHIS2.
- Weak visibility into last-mile performance: Existing systems capture procurement and distribution well but provide limited insight into facility-level stock status, stockouts, and patient-level medicine access.
- Lack of unified analytics and feedback loops: Absence of an integrated dashboard or cross-platform analytics prevents decision-makers from routinely monitoring core indicators such as budget execution vs. stock levels, procurement lead times, and stockout duration.

Strengthening Tanzania's data ecosystem will require moving beyond system-specific upgrades toward mapping and harmonization across financing, supply chain, and service delivery platforms. Establishing a unified, consensus-driven dashboard that connects financing, supply chain, and service delivery data could enable real-time visibility of commodity flows and financial performance. This integration—supported by consistent reporting standards and investment in data quality—would allow managers to proactively identify and close gaps between planned budgets, procurement, and actual essential medicine availability. Without such reforms, Tanzania risks continued inefficiencies and missed opportunities to optimize public resources and ensure consistent access to essential medicines.

RECOMMENDATIONS

Establish an integrated essential medicines and health products financing framework: Consolidate Government budget, NHIF, CHF, donor, and user fee resources under a unified essential medicines and health products planning and budgeting process, with aligned provider payment rules and digital tracking across all sources.

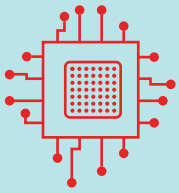
Institutionalize forecast-to-budget linkages: Ensure that quantified needs drive MOH budget proposals and MOF allocations, including clear identification of commodity budget gaps for further consideration by the Government and stakeholders.

Fully integrate donor-supported program commodities forecasting and budgeting processes into Government systems: With shifts in the global health financing landscape, donor support for program commodities (HIV, TB, malaria, family planning, vaccines, maternal and child health, and nutrition) is likely to vary. This creates an opportunity to harmonize donor-funded support with national forecasting and budgeting for essential medicines and health products, ensuring full integration into country systems.

Advocate for timely budget and provider payment disbursements: Use evidence on stockouts, price volatility, and service delivery gaps to raise awareness of the financial and health costs of delayed insurance reimbursements and MOF/MOH budget releases. Develop tools to systematically monitor disbursement timelines and associated opportunity costs.

Harmonize public procurement costs with provider payment rates: Ensure NHIF and CHF payment rates reflect actual health facility procurement costs, especially from MSD, to avoid provider losses and maintain supply chain sustainability.

Establish a national price governance mechanism: Create a coordinated essential medicines and health products pricing and market intelligence platform to manage a national price registry, conduct regular cost and market analysis, and publish benchmark pricing and markup guidelines. This would reduce price variability and support more equitable, cost-effective procurement practices. A market shaping strategy implemented through demand aggregation, supply planning, transparent pricing, and coordination with key financing and procurement actors can unlock system-wide savings and improve access.



Integrate data systems: Link siloed information systems to enable end-to-end visibility of financing, supply chain and service delivery data. A unified dashboard should enable real-time monitoring of commodity needs, financing flows, stock levels, and service delivery gaps — improving transparency, accountability, and timely decision-making.

Leverage peer learning platforms: While each recommendation will require country-specific dialogue and stakeholder engagement, there is also a unique opportunity for countries such as Tanzania to share experiences, assess effective practices, and co-create solutions through forums like the Joint Learning Network, fostering evidence-based learning and best practice development.

Theme	Key Finding	Recommendation	Intended Outcome
Essential Medicines Financing Framework.	Fragmented financing across Government, NHIF, CHF, donors, and user fees.	Establish an integrated financing framework consolidating all funding streams under one planning and budgeting process with aligned provider payment rules.	Improve efficiency, reduce duplication, and enable unified, transparent procurement and financing.
Forecast-to-Budget Linkages.	Quantified needs not systematically linked to MOH budget submissions or MoF allocations.	Institutionalize structured forecast-to-budget reviews and explicitly identify commodity funding gaps.	Ensure budget allocations reflect actual needs, highlight shortfalls, and strengthen advocacy with MoF and stakeholders.
Donor Integration.	Program commodities (HIV, TB, malaria, family planning, vaccines, maternal and child health, nutrition) managed in parallel donor-driven processes.	Fully integrate donor-supported forecasting and budgeting into Government systems.	Harmonize donor and domestic financing, improve sustainability, and align with national priorities.
Budget Execution.	Delayed treasury and insurance disbursements disrupt procurement and service delivery.	Use evidence on stockouts and costs of delays to advocate for timely disbursements; track and publish disbursement timelines.	Enhance predictability, accountability, and timeliness of financing flows.
Insurance Reimbursements & Provider Payments.	NHIF and CHF reimbursements not aligned with MSD or private supplier costs.	Harmonize reimbursement rates with actual procurement prices.	Reduce facility financial losses, sustain DRFs, and incentivize use of MSD.
Pricing & Market Governance.	Significant price.	Establish a national price governance mechanism with a benchmark price registry and market intelligence platform.	Reduce price variability, improve value for money, and enable market-shaping strategies.
Peer Learning Platforms.	Limited structured opportunities for cross-country exchange.	Leverage forums like the Joint Learning Network for shared learning and co-created solutions.	Foster evidence-based reform, accelerate adoption of best practices.

Table 5: Recommendations summary

ENDNOTES

1 Tanzania Ministry of Health. Medical Stores Department Medium Term Strategic Plan (MTSP III) (2021-2026)

2 Tanzania Health Sector Strategic Plan July 2021 – June 2026 (HSSP V). Ministry of Health, Community Development, Gender, Elderly and Children.

3 Tanzania STANDARD TREATMENT GUIDELINES AND NATIONAL ESSENTIAL MEDICINES LIST FOR TANZANIA MAINLAND. Ministry of Health, Community Development, Gender, Elderly and Children.

4 USAID Global Health Supply Chain Program (GHSC-TA). Creating a *Demand-Driven Supply Chain: Aligning Stakeholders and Priorities*. Technical Issue Brief, October 2018.

5 USAID Global Health Supply Chain Program (GHSC-TA). Creating a Demand-Driven Supply Chain: *Aligning Stakeholders and Priorities*. Technical Issue Brief, October 2018. Arlington, VA: Chemonics International Inc.

6 USAID Global Health Supply Chain Program (GHSC-TA). Creating a Demand-Driven Supply Chain: Aligning Stakeholders and Priorities. Technical Issue Brief, October 2018. Arlington, VA: Chemonics International Inc.

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