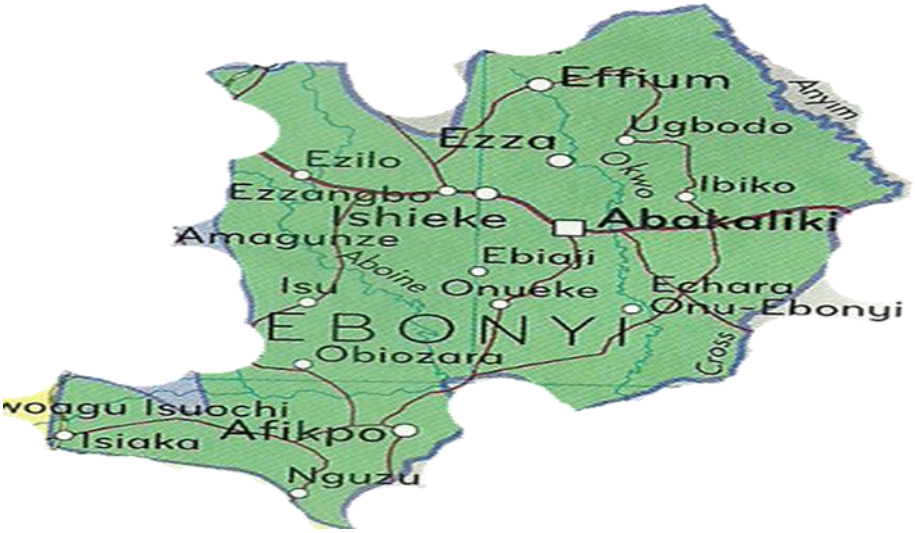
EBONYI STATE GOVERNMENT

STATE MINISTRY OF HEALTH



STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY

STRATEGY DESIGN

FOR THE

PRIMARY HEALTH CARE – DRUG REVOLVING FUND(PHC-DRF) SCHEME

(Version 1.0)

SEPTEMBER 2018

Foreword

Following the emergence of this present government under the able leadership of the His Excellency Chief Engr. David Nweze Umahi, FNSE, FNATE, the Executive Governor of Ebonyi State, great priority has been placed on the improvement of primary health care service delivery across the State.

A key component of an efficient primary health care system is the availability of life-saving essential commodities that enhance the quality of reproductive, maternal, newborn child and adolescent health services.

Therefore, reports of the uncoordinated drug distribution system at the State's primary health care level has triggered the establishment of a Primary Health Care Drug Revolving Fund (PHC-DRF) scheme. The scheme aims at strengthening the adoption of the principles of Primary Health Care Under One Roof (PHCUOR) and improving the quality of life of our women and children whose health needs are greatly met at the primary health care level.

The State Ministry of Health (SMOH) and the State Primary Health Care Development Agency (SPHCDA) in collaboration and with the support of the USAID funded Maternal and Child Survival Programme (MCSP) undertook a rapid and significant commodity financing system strategy design process to ensure the institutionalization of a context- driven efficient drug management system. These collaborative efforts have culminated into the development of the "Ebonyi State PHC-DRF Strategy Design (Version 1.0)" which was adopted and validated in September 2018.

The purpose of the strategy is to enhance the governance, financial and supply management of the scheme which shall lay the foundation for its sustainability and solvency. The process also ensured the emergence of a PHC-DRF Directorate at the SPHCDA to oversee the daily implementation of the scheme, supervise the performance of the DRF operators and further monitor compliance to the recommendations outlined in the strategy.

Furthermore, the establishment of the PHC-DRF Scheme has set the tone for the State's readiness for the utilization of the anticipated Basic Health Care Provision Fund (BHCPF) in strengthening quality PHC delivery through improved essential medicines availability at its primary health care level.

Dr. Daniel Umezuruike, FWACS, FICS
Honourable Commissioner for Health
Ebonyi State, Nigeria

Acknowledgments

The establishment of the a PHC-Drug Revolving Fund Scheme in Ebonyi State is an evidence of the priority placed by the government in improving the quality of reproductive, maternal, newborn and child health service delivery in the State. This intervention is line with the World Health Organization's recommendation that responsive health care systems are synonymous with sustained availability of essential medicines particularly at the primary health care level.

Furthermore, with the recent global and national shift for efficient and equitable primary health care systems, the establishment of the scheme has come at the right time in the advancement of the Ebonyi State Primary Health Care Development Agency (ESPHCDA) in fulfilling its mandate of strengthening PHC management across the 13 LGAs of the State.

The development of the Ebonyi State PHC-Drug Revolving Fund – Strategy Design (Version 1.0) was a structured, coordinated multi-sectoral process which took into cognizance the inputs of State and Local Government Health Authority officials and representatives of partner organizations within the State.

First to be acknowledged is His Excellency Chief Engr. David Nweze Umahi, FNSE, FNATE the Executive Governor of Ebonyi State who graciously gave the approval for the Scheme to commence.

The Honourable Commissioner for Health Dr. Daniel Uwazuruike, FWACS, FICS for his dogged oversight in ensuring the establishment and immediate take-off the scheme.

We also appreciate the support of the Directors of Pharmaceutical Services namely; Pharm Victor Chukwu, FPSN – Director, Pharmaceutical Services, SMoH; Pharm Nwuzor Augustine, PHD – Director, Pharmaceutical Services - Central Medical Stores, SMOH; the Director of Pharmaceutical Services - Hospitals Management Agency - Pharm (Dr) Ikechukwu Uchendu and of course the Director of Pharmaceutical Services, SPHCDA, Pharm (Dr.) Moses Okoro, FPC PHARM on whom the activities of the PHC-DRF scheme is resting upon.

In a special way we appreciate the technical and financial support of the USAID funded Maternal and Child Survival Programme (MCSP) towards the system design process, capacity building of the DRF operators on financial and logistics management and donation of relevant logistics management information system (LMIS) tools. Of worthy mention is the Health Systems Strengthening/Equity Consultant for MCSP - Pharm Uche Ebenezer, who led the overall high-quality collaborative, participatory and structured system design process towards the establishment of the Ebonyi PHC-DRF Scheme.

May God bless you all.

Dr. James Okata Nwali
Executive Secretary, ESPHCDA
Ebonyi State,Nigeria

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Abbreviations and Acronyms

AS	Administrative Secretary
BHCPF	Basic Health Care Provision Fund
BI	Bamako Initiative
CRF	Consolidated Revenue Fund
CHEW	Community Health Extension Worker
CMS	Central Medical Store
DHIS	District Health information System
DFID	Department for International Development
DRF	Drug Revolving Fund
DT	Dispersible Tablet
DPS	Director Pharmaceutical Services
EML	Essential Medicines List
EDP	Essential Drug Programme
ES	Executive Secretary
FMS	Financial Management Systems
FMoH	Federal Ministry of Health
GF	Global Fund
HCH	Honourable Commissioner for Health
HF	Health Facility
HMIS	Health Management Information System
ICC	Inventory Control Card

KPIs	Key Performance Indicators
LGAs	Local Government Areas
LGHA	Local Government Health Authority
LMCU	Logistics Management and Coordinating Unit
LLMCU	Local Government Logistics Management and Coordinating Unit
LMIS	Logistics Management Information System
MAPS	Malaria Action Program for States
MCSP	Maternal and Child Survival Program
M&E	Monitoring & Evaluation
MNCH	Maternal, Newborn and Child Health
MSV	Monitoring and Supervision Visit
NHA	National Health Act
OOP	Out-of-Pocket
PATH	Partnership for Transforming Health System
PHC(s)	Primary Health Care (Centres)
PHCUOR	Primary Health Care Under One Roof
PSM	Procurement and Supply Management
SDSS	Sustainable Drug Supply System
SMOH	State Ministry of Health
SOML PforR	Saving One Million Lives-Performance for Results
SPHCDA	State Primary Health Care Development Agency
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

Summary

The purpose of this document is to describe the design of a primary health care drug revolving fund (PHC-DRF) strategy for Ebonyi State. In the design of this strategy, the peculiarities of the Ebonyi health system has been broadly considered with focus on its management, challenges, opportunities and resilience. The underpinning objective factor in the design of this PHC-DRF strategy is the uncoordinated drug management system at the PHC level. This situation has given rise to poor access and inadequate availability of life saving commodities required for improved reproductive, maternal, newborn child and adolescent health services.

Operators of the health system at the facility, local government and state levels were duly consulted through structured processes during the development process. Their inputs were noted and reflected in the contents therein.

The strategy design has been broadly divided into three (3) major sections-the financial management features, the drug supply features and the governance features. Each component section outlines specific roles and responsibilities of all actors, including cross-cutting elements of accountability, transparency, decentralization, community participation and sustainability under the principles for bringing Primary Health Care Under One Roof (PHCUOR).

The financial management features outline actions related to transparency in account holding, account authorizations, frequency of lodgment, financial instruments and application of financial modelling tools. The drug supply features outline actions related to procurement, storage and distribution while the governance features outlines actions on policy implementation and institutionalization of administrative management structures such as related to personnel and supervision.

The design also lays emphasis on performance management as a bedrock for ensuring the solvency and sustainability of the PHC–DRF scheme. Key performance indicators (KPIs) have been outlined along each feature intended to provide measurable evidence of compliance to the components of the strategy design.

With the adoption of the design of Ebonyi PHC-DRF Scheme, strong political will is sacrosanct in institutionalizing accountability, equity of access and responsiveness to the needs of the people which are required for its smooth implementation. Furthermore, the political will to enforce civil service rules against operators at the PHC and LGHA levels who may want to undermine the overall efforts of entrenching a coordinated drug management system through the PHC-DRF scheme shall be a great asset in the implementation of proposed guideline contained therein.

As the implementation of the design goes underway, operational issues that require further clarification can be referred to the Essential Drugs and Logistics Unit of the State Primary Health Care Agency. This however calls on the unit to ensure conscious documentation of these clarifications which shall serve as the foundation for the periodic review of the strategy design (Version 1.0).

1.0 Background

Nigeria's poor maternal and child health (MCH) indices has prompted several interventions to address barriers to quality maternal and child health services particularly at the PHC level. Beyond the challenges of gender inequality, low male involvement in maternal and child health, low literacy and poor income of women of child bearing age, the unavailability of essential life-saving medicines at the PHC level is of topmost concern.

Findings from the National Health Facility Survey (FMoH, 2017)[1] showed that the availability of essential drugs in PHCs across the nation was 32.3% and in the south-east zone, 37.4%. The adoption of commodity financing options such as Drug Revolving Fund Schemes is one way of ensuring equitable access to essential life-saving medicines particularly for under-5 children. The flagship USAID funded Maternal and Child Survival Programme (MCSP) in Nigeria, as part of fulfilling its project objectives has supported the Government of Ebonyi State to adopt a sustainable drug financing strategy for essential medicines.

2.0 Primary Health Care and Universal Health Coverage

Primary health care is recognized as the fulcrum of service delivery in any health system. Primary health centres offer basic medical care for individuals and communities before referring them to more advanced, hospital-based care. However, fragmentation of PHC management weakens the delivery of primary health care to the populace. This is particularly evident in Nigeria with the ranking of her health system as 187th position out of 191 other countries' health system (Tandon, Murray, Pettigrew, Kumar, van Weel)[2].

Attempts since the declaration of Alma-Ata in 1978 to strengthen the PHC system has evolved over time, with health system actors calling on governments to make bold steps and take concrete actions in the defragmented management of primary health care. In line with this, there has been a global acceptance that the attainment of Universal Health Coverage, through harmonized coordination platforms, is hinged on effectiveness and efficiency of primary health care delivery (Stigler, Macinko, Pettigrew, Kumar & van Weel, 2016[3] Okpani & Abimbola,2015[4]; Bloom,2017[5]).

2.1 Financing Primary Health Care

The WHO ranking report and other published reviews have listed poor financing of primary health care as the major bane in the inability of this level of health care to attain the objectives of providing

[1] Federal Ministry of Health SOML PforR. National Health Facility Survey 2016. Abuja, Nigeria. Federal Ministry of Health,2017

[2] Tandon A, Murray C, Lauer J, Evans B. Measuring overall health system performance for 191 countries. Geneva, Switzerland. World Health Organization, 2000 (GPE Discussion Paper Series No.30)

[3] Stigler FL, Macinko J, Pettigrew LM, Kumar R.van Weel C. No universal health coverage without primary health care. The Lancet 2016; 387. https://doi.org/10.1016/S0140-6736(16)30315-4

[4] Okpani AI, Abimbola S. Operationalizing universal health coverage through social health insurance. Niger. Med J 2015; 56(5):305-310

[5] Bloom G. Universal health coverage: Lessons from Japan. Intl J Health Policy Manag 2017; 6(4):229-231

accessible, equitable and affordable people-centered service (Uzochukwu, Ughasoro, Etiaba, Okwuosa, Envuladu & Onwujekwe,2015[6]; Shaw, Wang, Kress & Hovig 2015[7]).

An attempt to correct this anomaly is enshrined in the 2014 National Health Act which advocates for improvements in primary health care financing through the Basic Health Care Provision Fund (BHCPF). The fund is been established to reduce the degree of out-of-pocket (OOP) expenditures for healthcare by Nigerian households which has been argued to catastrophic(Onwujekwe et al, 2015[8]; Onoka, Onwujekwe, Hanson & Uzochukwu, 2011[9]; Ukwaja, Alobu, Abimbola & Hopewell 2013[10]).

The BHCPF shall be financed from the federal government annual grant of not less than 1% of its consolidated revenue fund (CRF), grants from international donors and other sources of funds. The BHCPF payment gateways specific to primary health include 50% of the fund for the provision of basic minimum package of health services to all citizens; 25% of the fund for the provision of essential drugs for primary healthcare; 15% of the funds for the provision and maintenance of facilities, equipment and transport for primary healthcare and 10% of the fund for the development of human resources for eligible PHC facilities (FMOH, NHIS, NPHCDA, 2016)[11].

Four (4) years after the bill assent, the World Bank and Bill & Melinda Gates Foundation through the Global Financing Facility provision of $2million shall support the smooth implementation of BHPF in three-take off states of Niger, Abia and Osun States, with a committee set up by the Federal Ministry of Health to facilitate the process.

2.2 Essential Drugs for Primary Health Care through Drug Revolving Fund Schemes

The concept of essential drugs for primary health care in Nigeria dates to 1987 with the establishment of the Essential Drug Programme (EDP) which came as a result of the collaboration between the Federal Ministry of Health and the World Health Organization (Haque, 2017)[12]. Subsequently, Nigeria adopted the Bamako Initiative (BI) in 1988 to enhance access and availability of essential drugs for primary health care within the framework of a drug revolving fund scheme (Uzochukwu, Onwujekwe

[6] Uzochukwu BS, Ughasoro MD, Etiaba E, Okwuosa C, Envuladu E, Onwujekwe OE. Health care financing in Nigeria: Implications for achieving universal health coverage. Niger J Clin Pract 2015; 18:(4)437-44

[7] Shaw RP, Wang H, Kress D, Hovig D. Donor and domestic financing of primary health care in low income countries. Health Systems & Reform 2015 1:(1) 72-88 DOI: 10.1080/23288604.2014.996413

[8] Ibid

[9] Onoka CA, Onwujekwe OE, Hanson K, Uzochukwu BSC. Examining catastrophic health expenditures at variable thresholds using household consumption expenditure diaries. Trop Med Int Health. 2011;16(10):1334-41

[10] Ukwaja KN, Alobu I, Abimbola J. Hopewell PC. Household catastrophic payments for Tuberculosis Care in Nigeria: Incidence, determinants and policy implications for universal health coverage. Infectious Diseases of Poverty 2013; 2:21

[11] Federal Ministry of Health (FMOH), National Health Insurance Scheme (NHIS) and the National Primary Care Development Agency (NPHCDA) Basic Health Care Provision Fund Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund. Abuja, Nigeria: Federal Ministry of Health (FMOH), National Health Insurance Scheme (NHIS) and the National Primary Care Development Agency (NPHCDA) 2016

[12] Hague M. Essential Medicine Utilization and Situation in Selected Ten Developing Countries: A Compendious Audit J. Int Soc Prev Community Dent 2017; 7(4) :147-160

& Akpala 2002[13]; Haque, 2017[14]). The initiative relied on the principles of a stable supply chain system which is the fulcrum of drug revolving fund schemes.

Drug revolving schemes have been described as a cost-recovery system whereby revenue generated from the sale of drugs to patients is used to purchase new drugs to ensure availability of commodities, promote equity in access and maintain an efficient drug distribution system. (Ogbonna & Nwako, 2016)[15]. The Federal Ministry of Health launched the National Drug Policy (FMOH, 2015)[16] where the drug revolving fund was described as "a strategy for ensuring uninterrupted supply of essential drugs within the health care delivery."

To ensure lifesaving commodities were available for maternal and child services in primary health facilities, Nigeria developed her first Essential Medicines List (EML) in 1989 in accordance with decree 49 of 1989 (FMOH 2010[17]; Hague,2017[18]). The list was further compiled to guide the procurement of essential commodities under the Bamako Initiative Drug Revolving Fund Scheme, towards saving cost for the patient and the health system (Uzochukwu, Onwujekwe, Okwuosa & Ibe, 2014)[19]. The 6th edition of the Nigeria EML was published in 2016 with special attention on medicines for women and children. The EML aims at improving the quality of maternal and child care services vis a vis the nation's current poor maternal and health indices of newborn mortality rate of 37 deaths per 1000 births and under-five mortality rate of 120 deaths per 1000 births (UNICEF, 2016/201711)[20].

On whether the Bamako Initiative achieved one of its key objectives of improving availability of essential medicines at primary health care centres, a retrospective review by Uzochukwu et al (2002) [21]and Abegunde & Asuzu (2002)[22] were of the opinion that essential drugs were more available in BI health centres than in non-BI health centres. However, Sambo, Lewis & Sabitu (2008)[23] argued that the initiative had not met this objective based on the absence of essential drugs at the facilities reviewed in their study.

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[13] Uzochukwu BS, Onwujekwe OE, Akapala CO. Effect of the Bamako-Initiative drug revolving fund on availability and rational use of essential drugs in primary health care facilities in south-east Nigeria. Health Policy Plan. 2002;17(4):378-83

[14] Hague M. Essential Medicine Utilization and Situation in Selected Ten Developing Countries: A Compendious Audit J. Int Soc Prev Community Dent 2017; 7(4) :147-160

[15] Ogbonna B, Nwako C. Essential Drugs Revolving Fund Scheme in Nigeria; from the Edge of a Precipice towards Sustainability. Journal of Advances in Medical and Pharmaceutical Sciences 2016; 8(2):1-8

[16] Federal Ministry of Health (FMOH). National Drug Policy. FMOH, Abuja: FMOH2015

[17] Federal Ministry of Health (FMOH). Essential Medicines List (5th Revision) FMOH, Abuja: FMOH 2010

[18] Hague M. Essential Medicine Utilization and Situation in Selected Ten Developing Countries: A Compendious Audit J. Int Soc Prev Community Dent 2017; 7(4) :147-160

[19] Uzochukwu BSC, Onwujekwe OE, Okwuosa C, Ibe OP. Patent medicine dealers and irrational use of medicines in children: the economic cost and implications for reducing childhood mortality in Southeast Nigeria. PLoS ONE 2014; 9(3)

[20] National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). Multiple Indicator Cluster Survey 2016-17, Survey Findings Report. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund 2017

[21] Ibid

[22] Abegunde KA, Asuzu MC. Facility user's preference between the free and the Bamako Initiative (Drug Revolving Fund-Based) health services in Iwajowa Local Government, Oyo State. Journal of Community Medicine and Primary Health Care 2013; 26(2) 1-6

[23] Sambo MN, Lewis I, Sabitu K. Essential drugs in primary health centres of north central Nigeria; where is Bamako initiative? Nig J. of Clinical Practice 2008;11(1)9-13

Towards efforts to enhance wider availability of essential drugs across the nation, the Government of Nigeria introduced the Petroleum Trust Fund (PTF) for financing DRF schemes at the three (3) tier health levels in 1997. The initiative which was abolished in 1999 failed to strengthen the drug supply situation due to challenges related to absence of technical oversight, weak financial management systems, overbearing political interference, inappropriate selection and quantification procedures that led to overstocking, wastage and expiries particularly in primary healthcare facilities (Ogbonna & Nwako,2016)[24].

2.3 Commodity Financing through Drug Revolving Fund in Ebonyi State

Historically, Nigeria has instituted various DRF systems that were unsuccessful due to several challenges including poor management and capacity of health staff to oversee the DRF, inadequate financial resources, political interference, and lack of transparency and accountability. Evidence based on the Nigerian context suggests that components of a successful DRF scheme include: establishment of facility-based DRF systems; strengthening financial management systems; creation of a safety net for the poor; establishment of guaranteed drug source (PATHS Technical Brief).

In Ebonyi State, the Ministry of Health established a DRF scheme for the secondary-level of health care facilities with an initial capitalization of NGN1,156,700.00 in addition to the NGN713, 141.00 worth of other drugs inherited from assets- sharing between Enugu and Ebonyi States. To date, these funds have been managed and recycled to maintain a continuous flow of essential drugs in the thirteen (13) General Hospitals- one (1) per LGA across the State. The performance of the DRF-Hospitals is monitored quarterly to track the system's efficiency and effectiveness in sustaining essential drug supply management at the secondary level of the healthcare system.

However, in 2013 a rapid appraisal of the State's sustainable drug supply system (SDSS) was carried through funds provided by the USAID/Malaria Action Program for States (MAPS) and in collaboration with the State Ministry of Health. Findings showed a high degree of unofficial drug supply systems at the PHC level, inadequate funding and imbalance in the mix of appropriate human resources were the challenges faced by Ebonyi State in SDSS.

Therefore, it became imperative to address these challenges towards improvements in essential drug provision for quality of maternal, newborn and child health (MNCH) services across primary health centres in the state.

To this end, the Government of Ebonyi State in 2018, approved the provision of NGN100, 000 worth of seed stock per PHC facility for 171 PHC facilities through the Saving One Million Lives (SOML) Performance for Results Programme for the initial capitalization of the state-wide flagship Primary Health Care- Drug Revolving (PHC-DRF) scheme. The selection of the 171 PHC facilities are in line with the modalities of the NPHCDA's "PHC Under one Roof" roadmap to universal health coverage. Furthermore, the establishment of the PHC-DRF scheme is a health system strengthening (HSS) approach to the solving the irregularities in the management of drug supply management at the PHC level.

The scheme shall be domiciled within the State Primary Health Development Agency (SPHCDA) with real time interface with the Pharmaceutical Services Unit of the State Ministry of Health. It is

[24] Ibid

expected that the SMOH/SPHCDA authorities shall respond to the needs of the scheme in relation to deployment of competent human resources and other physical infrastructure requirements for its smooth operation.

The list of seed stock medicines and consumables procured were drawn from the 2nd edition of the Ebonyi State Essential Medicines List (SMoH 2015). See Annex 1 for the list of PHC-DRF seed stock. It is also expected that the SMoH would revise this EML in line with the 6th Edition of the Nigeria Essential Medicines list as the scheme progresses.

The commodity financing strategy for PHC facilities in Ebonyi State will introduce a new approach to drug financing for primary health care level in Ebonyi State. The strategy aims to create a path to sustainable financing for drugs in PHCs, which in turn will:

- Increase access to essential commodities for primary health care
- Improve quality and increase utilization of health care services
- Involve communities in decision making and accountability for health system performance
- Create an evidence base for future health financing reforms

The design is based on findings from the implementation of previous DRF schemes across the country, policy recommendations and the findings from the 2013 rapid appraisal of the Drug Supply Systems in Ebonyi State. For example, the PHC-DRF design has considered supervision as an element that will drive sustainability and also serve as a performance management mechanism. Furthermore, the potential for improved responsiveness of the Ebonyi health system to the needs of the people in terms of regular availability, affordability and accessibility to the commodities were also of note in the development of this design.

Inputs into the design commenced with the sensitization of officers-in-charge (OIC) of health facilities, LGHA pharmacy technicians and administrative secretaries supported by the Ebonyi State of Ministry of Health in April 2018. This was followed structured technical high level meetings (HLM) supported by USAID/MCSP for senior SMOH/SPHCDA officials, administrative secretaries, LGHA pharmacy technicians and selected OICs. The objectives of the HLM were to sensitize these State and LGA stakeholders on the purpose of the scheme, their roles and responsibilities in the scheme and to obtain inputs and buy-in from the State and LGA stakeholders on the draft strategy for the Ebonyi PHC-DRF scheme. The HLM was also used as a platform to adopt the sustainable commodity financing strategy for essential medicines in Ebonyi State. (See Annex 6 for list of stakeholders).

The strategy design of the Ebonyi PHC-DRF scheme consists of three (3) major categories: (1) governance features, (2) drug supply features, and (3) financial features. The outlines below highlight sub-components of these categories and options for the Ebonyi State PHC-DRF approach.

3.1 Financial Features

The financial features describe the investment, accounting, and cash flow elements of the PHC-DRF strategy. It provides guide on pricing of commodities, revenue remittance and financial management at all levels of operation. It further takes into cognizance the importance of robust, decentralized and transparent financial management systems model for setting a sustainable PHC-DRF system in Ebonyi State.

	Issues	Guideline
3.1.1	**Price List and Commodity Markup**	**Pricing and Markups** • To determine the price list for medicines, a range of standardized mark –up price between a minimum of 5% and a maximum of 30% shall be maintained for each procurement cycle. In applying these percentages, the type of commodity, the unit cost of the commodity and the prevailing market prices at the point in time shall be considered. • For each procurement cycle, the markup on the procured PHC-DRF commodities shall be centrally determined by the members of the PHC-DRF implementation and the PHC-DRF procurement bid committee at the SPHCDA. • The standardized price list following determination of appropriate markup by the members of the PHC-DRF implementation and the PHC-DRF procurement bid committee at the SPHCDA shall be approved by the Director Pharmaceutical Services at the SPHCDA before circulation to primary health care centres participating in the scheme. • Changes in prices of up 20% from of any commodity following a new round of procurement shall also be co-approved by the Director Pharmaceutical Services at the SPHCDA and the Executive Secretary. • The standardized price list shall be distributed to all participating facilities through the pharmacy technician responsible for the PHC-DRF with each local government health authority.

		• Each pharmacy technician with oversight from the administrative secretary shall supervise compliance to the pricelist by officers-in-charge (OICs). • The PHC-DRF implementation team with oversight from the Executive Secretary shall supervise compliance to the pricelist by each Local Government Health Authority. **Elements for Cost Recovery** • The elements of the pricing policy are hinged on 100% cost recovery and provisions for sustainable resupply and availability of essential medicines at the PHC level. • The surplus shall be used to undertake recurrent costs related to implementing the PHC-DRF such as supervision to participating PHCs, transportation to the CMS, storage and financial management. This recurrent cost shall be carried out at the SPHCDA level, the Local Government Health Authority level and at the PHC level as applicable.
3.1.2	**Subsidies**	• Drug subsidies shall not be included in the initial rollout of the PHC-DRF scheme. • Subsidies for specific commodities may be considered during the revision of the Ebonyi PHC-DRF strategy design Version 1.0.
3.1.3	**Exemptions**	• Due to the relatively low capitalization of the PHC-DRF scheme, exemptions were not included in the rollout of the PHC-DRF scheme. • However, based on the evidence-based literature exemptions for specific patient groups can improve the equity of health care delivery purchasing exemptions for pregnant women, children under 5, elderly, and the poorest and most vulnerable patients shall be considered in future. This will arise when government has made provisions for separate funding channels that shall bear the exemption costs. • In the future, the following population groups could be considered for exemptions: **Under 5:**

		- Under 5 children who are double orphans or only have the mother alive. - Under 5 who is physically challenged. - Under 5 who is living with HIV. **Women of reproductive age:** - Indigent women who are living with HIV - Indigent women who are physically challenged.
3.1.4	**Accounts and Accounting**	**PHC-DRF Account Holding** The PHC-DRF accounts shall operate at three levels: • At the SPHCDA level • At the LGHA level • At the PHC Level It is the responsibility of the DPS, SPHCDA with oversight from the ES, SPHCDA to open these levels of accounts as the scheme progresses. The central SPHCDA PHC-DRF account is currently operational. However, it is the vision of the scheme to have each of the 13 Local Government Health Authorities and the participating PHCs to own and operate PHC-DRF accounts for transparency and increased availability to essential medicines. **A. Signatories to the PHC-DRF Accounts** • Signatories at the SPHCDA PHC-DRF Account shall be the 1. Signatory A: The Executive Secretary, SPHCDA 2. Signatory B: The Director Pharmaceutical Services or the SPHCDA PHC-DRF Pharmacist (as recommended by the National Drug Policy (2005) Law 6.3(iv) 3. Signatory C: The SPHCDA Accountant Account Mandate: Signatory A; Signatory B and Signatory C to sign at the same time.

		• Signatories for the LGHA PHC-DRF Account shall be the 1. Signatory A: The Administrative Secretary of the LGHA 2. Signatory B: The designated PHC-DRF Pharmacy Technician of the LGHA 3. Signatory C: The SPHCDA Accountant Account Mandate: Signatory A; Signatory B and Signatory C to sign at the same time. • Signatories for the Health Facility PHC-DRF Account shall be the 1. Signatory A: The Administrative Secretary of the LGHA 2. Signatory B: The Officer-In-Charge of Health Facility 3. Signatory C: The designated PHC-DRF Pharmacy Technician of the LGHA Account Mandate: Signatory A; Signatory B Signatory C to sign at the same time. **Authorization of payments or invoicing for orders** • At the Health Facility Level: Purchase orders to the SPHCDA Drug Store from the participating PHCs shall be co-signed by the officer-in-charge and the designated pharmacy technician of the LGA Level. Copies of purchase orders is to be made available at the health facility for sighting during supervision and internal audit process. • At the SPHCDA Level Purchase orders to pre-qualified suppliers shall be co-signed by the Director Pharm Services, SPHCDA and the SPHCDA Accountant. Copies of purchase orders will be available at the SPHCDA PHC-DRF unit for auditing processes.

3.1.5	**Revenue Remittance and Financial Management**	**Revenue Remittance** • The revenue from the PHC-DRF scheme shall be deposited into the SPHCDA PHC-DRF account on monthly basis by the officer-in-charge of the primary health care facility. It can also be deposited weekly depending on the consumption rate of the commodities. • Each PHC operating the PHC-DRF scheme shall be funded quarterly through the SPHCDA PHC-DRF account with 7.5% of the markup of its value of stock purchases to make provisions for transportation to the central medical store for resupplies. Appropriately authorized SHCDA PHC-DRF account cheques shall be issued to the beneficiary PHCs pending when the PHC–DRF accounts at the health facilities become operational. However, 7.5% can be scaled up or down according to the performance of the scheme. This value shall be determined by the DRF Procurement Bid Committee and the PHC-DRF implementation team and approved by the Executive Secretary of SPHCDA. • Each LGHA PHC-DRF Account shall be funded quarterly through the Agency DRF Account with 2.5% of the markup based on the consolidated revenue deposits of the participating facilities under each LGA. The funds shall be used for supportive supervisory visits and other legitimate oversight functions by the Administrative Secretary and the Pharmacy Technician(s). Similarly, 2.5% can be scaled up or down according to the performance of the scheme. This value shall be determined by the DRF Procurement Bid Committee and the PHC-DRF implementation team and approved by the Executive Secretary of SPHCDA. • The SPHCDA shall make quarterly provisions up to 10% from the overall markup sale of PHC-DRF commodities to undertake legitimate expenditures such as mentoring and supervisory visits (4%), report development and documentation (2%), wastage and expiries (1%), drug store maintenance (2%) and bank charges (1%). The remaining 10% of

		the 30% markup shall be ploughed back into the DRF capital for increased availability of essential medicines. • The PHC-DRF markup funds shall not be used to undertake expenditures pertaining to the personal needs of the PHC-DRF operators such as loans, food aid, gambling.

3.2 Drug Supply Features

The drug supply features provide information on the selection of commodities under the PHC-DRF scheme, procurement, supplies, storage and distribution

	Issue	Guideline
3.2.1	**Selection of Commodities**	**The Essential Medicines List/PHC-DRF Drug List** • The seed stock commodities covered under the PHC-DRF scheme were derived from the Ebonyi State 2015 Essential Medicines List, the current edition of the State's Essential Medicines List. • The State EDL is based on the 5th edition of the National Essential Drugs List. The State EDL will be reviewed in future in line with the 6th edition of the National Essential Drug List, 2016. • The selection of the maiden PHC-DRF list of seed stock commodities were carried by the Pharmaceutical Services Department of SMOH on behalf of SPHCDA. In making the selections, drugs and consumables that aid the treatment of most health problems at the primary health care level were put into consideration. • In the event of where additional type of commodities are further required to be covered in the scheme, the SPHCDA through the PHC-DRF implementation team incorporate the new medicines after a careful review in subsequent procurements.
3.2.2	**Procurement**	**A. Responsibility** • The SPHCDA shall be responsible for procurement of the PHC-DRF drugs and other consumables as captured in the State 2015 EDL. This implies that only one (1) level of procurement shall exist and it shall be at SPHCDA. **B. Competitive Pre-Qualification** • It is recommended that the SPHCDA through the SPHCDA Procurement Committee shall pre-qualify suppliers on an annual basis. This shall eliminate procurement bottlenecks which may hinder the

		overall objective of increased availability of life saving commodities at the PHC level. • The SPHCDA Procurement Bid Committee carries out the prequalification of suppliers based on the conditions as enumerated on the legal and national conditioners to be met known as Condition A and the competitive price comparison known as Condition B that ensures quality at good price. • The Drug Bid Procurement Committee is made up of: i. The Executive Secretary, ESPHCDA ii. The Director, Planning Research & Statistics, SPHCDA iii. The Director of Accounts or the Most Senior Accountant of the Agency iv. The Director of Pharmaceutical Services of the Agency, who is the Secretary of the Drug Bid Procurement Committee. The DPS is equally saddled with convening the meeting. **Placement of Orders** • Orders shall be received periodically at the SPHCDA Drug Store/CMS with a 2-week minimum and shall be treated within the SHCDA defined procurement cycles. It is only the SHCDA store that makes procurement for the LGHA/PHCs. Therefore, no parallel DRF shall exist for any of the 171 PHCs participating in the scheme. • Procurement shall be in line with the aggregate needs of participating facilities. Primary health care facilities shall in return make requisitions based on their needs from commodities from the PHC-DRF list. **Timing** • The SHCDA shall adopt a 3-month procurement cycle for the Ebonyi PHC-DRF Scheme. This shall eliminate stock-outs which encourage sourcing of commodities from parallel supplies among operators of the scheme.

		Quantification • The DRF implementation team shall quantify the number and type of commodities for procurement based on pooled requisitions from the PHCs participating in the scheme. The team shall also as much as possible rely on logistics data showing the consumption pattern and stock levels of commodities.
3.2.3	**Storage and Distribution**	**Storage** • The SPHCDA shall always ensure the availability of drugs at the stores for the smooth operation and sustenance of the scheme. • Storage of the PHC-DRF commodities shall be at the PHC-DRF Drug Store. However, until the PHC-DRF drug store is ready for use, commodities shall be stored at the CMS. • PHC-DRF commodities can also be held temporarily at the LGHA level – either in a primary health care facility with good storage capacity or at the LGHA store prior to distribution to participating PHCs. • Minimum requirements for storage at the PHC level include a single wooden shelf, a wooden table for placement of commodities and or wooden pallets. Commodities or cartons of drugs are not to be placed directly on the floor.
3.2.4	**Stock Levels**	**Minimum Stock Level** • Minimum stock/re-stock levels at the PHC level shall be two (2)-month of stock based on past and anticipated patterns of consumption. At any point in time, 2 months of stock of each specific commodity is expected to be available at the facility. This will decrease the frequency of stock out of essential medicines and also aid in monitoring expiries.

3.3 Governance Features

The governance feature describes the institutions, management and procedures required to operate the PHC DRF scheme in the primary health care centres in Ebonyi State. The governance features align with the Implementation Guidelines for PHCUOR, March 2018 edition. The roles and responsibilities of the Local Government Health Authority and the SPHCDA as key players in coordinating the scheme have been clearly highlighted. Community involvement and continued education on the benefits of patronizing primary health centres is also a vehicle for sustainability and is encouraged. There are various dimensions at which quality of process, supervision and performance assessment is established for effective and successful running of PHC- DRF in the state. These dimensions are highlighted in this subsection.

	Issue	Guidelines
3.3.1	**PHC-DRF Management Team**	**Structure** • **At the SPHCDA Level** There shall be a PHC-DRF Management Team at the SPHCDA comprising of: 1. Executive Secretary (ES) of SPHCDA or delegated representative. The ES shall serve as the chairman. 2. Director Essential Drugs and Logistics – The most senior PHC-DRF pharmacist shall serve as the convener 3. Director –Finance or the most senior SPHCDA Accountant 4. Director Planning Research & M & E or delegated representative 5. Director Community Health and Family Services or delegated representative 6. Programme Officer – Essential Drugs **At the LGHA Level** • There shall be an LGA-level Management Team comprising of: 1. Director PHC/Administrative Secretary 2. Programme Officer- Essential Drugs/Most Senior Pharmacy Technician 3. Programme Officer – Reproductive Health, Maternal Newborn and Child Health 4. SPHCDA Accountant or delegated representative

		At the Primary Healthcare Level • There shall be a Facility Level Management Team comprising of : 1. Officer in-charge (OIC) of the facility. The OIC shall serve as the convener 2. 1 CHEW/JCHEW in the facility – who shall serve as the secretary. 3. Chairman or delegated representative of the Ward Development Committee – shall serve as the chairman. **At the Community Level** The Ward Development Committee shall be engaged through other community level platform from time to time to mobilize support for the scheme. The PHC-DRF Implementation Team shall work closely with the Chief Health Educator in the SMoH towards engaging communities for increased utilization of PHC services **Frequency and Purpose of Meetings** • The State-level PHC-DRF Management Team shall meet on quarterly basis to deliberate on the activities of the scheme: procurement, requisitions, resupplies, distribution, monitoring, supervision, logistics management, financial operations and performance management. - Emergency meetings can also be convened based on emerging issues. • The LGA-level PHC-DRF Management Team shall meet on bi-monthly basis to deliberate on the activities of the scheme: requisitions, resupplies, distribution, monitoring, supervision, financial operations and performance management. - Emergency meetings can also be convened based on emerging issues. • The facility-level PHC-DRF Management Team shall meet on quarterly basis to deliberate on the activities of the scheme mainly on community

		awareness and participation. Other related discussions shall focus on requisitions, resupplies, financial operations and performance management. - Emergency meetings can also be convened based on emerging issues.
3.3.2	**Supportive Supervision**	**Structure** • **At the SPHCDA Level** There shall be a PHC-DRF Supervisory Team at the SPHCDA comprising of : 1. Executive Secretary (ES) of SPHB or delegated representative. The ES shall serve as the chairman. 2. Director Essential Drugs and Logistics – The most senior PHC-DRF pharmacist shall serve as the convener 3. Director –Finance or the most senior SPHCDA Accountant 4. Director Planning Research & M & E or delegated representative 5. Director Community Health and Family Services or delegated representative 6. The Chief Health Educator 7. Programme Officer –Essential Drugs **At the LGHA Level** • There shall be an LGA-level Supervisory Team comprising of : 1. Director PHC/Administrative Secretary 2. Programme Officer- Essential Drugs/Most Senior Pharmacy Technician 3. Programme Officer – Reproductive Health, Maternal Newborn and Child Health 4. SPHCDA Accountant or delegated representative 5. Programme Officer- Health Promotion/Social Mobilization Officer At any point in time, a minimum 3 members of the supervision team shall be available for supervision.

3.3.2	**Stewardship & Accountability**	• On needs basis there shall be redeployment and or recruitment of relevant manpower (pharmacists, pharmacy technicians, monitoring & evaluation officers, accounts officers) at the SPHCDA • to enhance the management of the PHC-DRF scheme. • Strict adherence to the use of PHC-DRF Funds for procurement and resupply of drugs to the PHC-DRF facilities to ensure sustained availability of essential medicines at the PHC level.
3.3.4	**Quality Assessment of the PHC–DRF Scheme**	This will be assessed by considering the following: • Source(s) of drugs • Storage conditions of drugs at the State and LGA/Facility Levels • Observation of procurement process • Observation of financial management process • Observation of drug supply and distribution process

PERFORMANCE MONITORING

Monitoring the performance of the PHC-DRF scheme provides the framework to determine its survival and sustainability. It shall entail the tracking of the major components of the scheme which are the financial management system, the logistics management system and the governance system. Monitoring the performance of the scheme shall be the collective responsibility of the operators at the central and primary health care levels. The performance monitoring reports from the PHC and central implementation levels shall be utilized by the policy makers to make informed decisions that are essential for the scheme to continue revolving drugs and stay financially solvent. Following contributions from the operators of the scheme, the following set of key performance indicators and its accompanying elements are hereby shown below.

Table 1.0 Key Performance Indicators for the Governance System

Indicator	What Data	Level of Operation	Where From (Source)	Frequency	Who Collects	Reported to Whom
Performance Status of the of the PHC-DRF Scheme	• LMIS Reports • Financial Reports • Programme Reports	Central Level	Programmatic report of activities the PHC-DRF Scheme	-Monthly (by the 15th of each month following the reporting period) -Quarterly (by the 15th of the beginning of the next quarter following the reporting period)	M & E Officer, SPHCDA	PHC-DRF Management Team
Frequency of Management Meetings	Meeting Reports	Central Level	Minutes of Meetings	Quarterly	Director, Pharm Services, SPHCDA	PHC-DRF Management Team

Table 2.0 Key Performance Indicators for the Financial Management System

Indicator	What Data	Level of Operation	Where From (Source)	Frequency	Who Collects	Reported to Whom
Proportion of sales revenue	Monthly sales	PHC Level	PHC - DRF Drug Sales Ledger/Cash Receipts	Monthly	OIC/Pharmacy Technician/ PHC-DRF Accountant, SPHCDA	Admin Sec, Director Pharm Services, SPHCDA
Proportion of cash payments for commodities	Cash receipts for payments of commodities	Central Level	Central PHC- DRF Cash Receipts	Bi-Monthly	OIC/Pharmacy Technician/CMS Store Keeper/PHC-DRF Accountant, SPHCDA	Director Pharm Services, SPHCDA
Proportion of cash payments for legitimate expenditures	Cash receipts from vendors	PHC Level	Expenditure Ledgers	Quarterly	OIC	Pharmacy Technician
	Cash receipts from vendors	LGHA Level	Expenditure Ledgers	Quarterly	Pharmacy Technician	PHC-DRF Accountant, SPHCDA
	Cash receipts from vendors	Central Level	Expenditure Ledgers	Quarterly	PHC-DRF Accountant, SPHCDA	Director Pharm Services, SPHCDA
Percentage of cash losses	Value of damaged and expired drugs	PHC Level	ICC Price List	Monthly	OIC/Storekeeper/Pharmacy Technician	PHC-DRF Accountant, SPHCDA
Proportion of PHCs depositing monthly cash revenues	Revenue Deposits	PHC Level	Bank Tellers	Monthly; on or before 5th of each month following the reporting period	Pharmacy Technician	• Admin Secs • PHC-DRF Accountant, SPHCDA • Director Pharm Services, SPHCDA

Indicator	What Data	**Level of Operation**	• **Where From (Source)**	• **Frequency**	**Who Collects**	**Reported to Whom**
Timeliness of monthly bank reconciliations and subsequent production of monthly financial reports	Financial Reports	Central Level	• Bank Tellers • Sales Revenue Reports • Legitimate expenditure Reports • Value of damaged and expired drugs	• Monthly (by the 10th of each month following the reporting period) • Quarterly by the 10th of the beginning of the next quarter following the reporting period	PHC-DRF Accountant, SPHCDA and M & E Officer, SPHCDA	Director Pharm Services, SPHCDA
Frequency and timeliness of performance of statutory obligations to the LGHA PHC-DRF Account	Quarterly Financial Reports	Central Level	Monthly Financial Reports	Quarterly by the 15th of the beginning of the next quarter following the reporting period	Director Pharm Services, SPHCDA	• PHC-DRF Management Team • HCH
Frequency and performance of performance of statutory obligations to the PHC-DRF facilities.	Quarterly Financial Reports	Central Level	Monthly Financial Reports	Quarterly by the 15th of the beginning of the next quarter following the reporting period	Director Pharm Services, SPHCDA	• PHC-DRF Management Team • HCH

Indicator	What Data	Level of Operation	Where From (Source)	Frequency	Who Collects	Reported to Whom
Quantity Received	Quantity of commodities at PHCs received from the CMS Quantity of commodities at the CMS received from suppliers	PHCs/CMS	RIRV/ICC	Bi-monthly at PHCs Quarterly at the CMS	OICs/Pharmacy Technician/ /CMS Storekeeper	• Admin Sec • Director, Pharm Services-SPHCDA
Quantity Issued	• Quantity of commodities issued to PHCs from the CMS • Quantity issued to patients at PHCs	CMS/PHCs	RIRV/ICC	Daily at PHCs, Bi-monthly at CMS	OICs/Pharmacy Technician/ /CMS Storekeeper	• Admin Sec • Director, Pharm Services-SPHCDA
Quantity of Losses	Quantity of health commodities removed from the distribution system (losses, expiry and damages)	CMS/PHCs	ICC	Anytime	OIC/Pharmacy Technician/CMS Storekeeper	• Admin Sec • Director, Pharm Services-SPHCDA
Quantity of Adjustments	Receipt or issue of supplies to/from one PHC to another at the same level or a	PHCs	ICC/RIRV	Anytime	OIC/Pharmacy Technician/CMS Storekeeper	• Admin Sec • Director, Pharm Services-SPHCDA

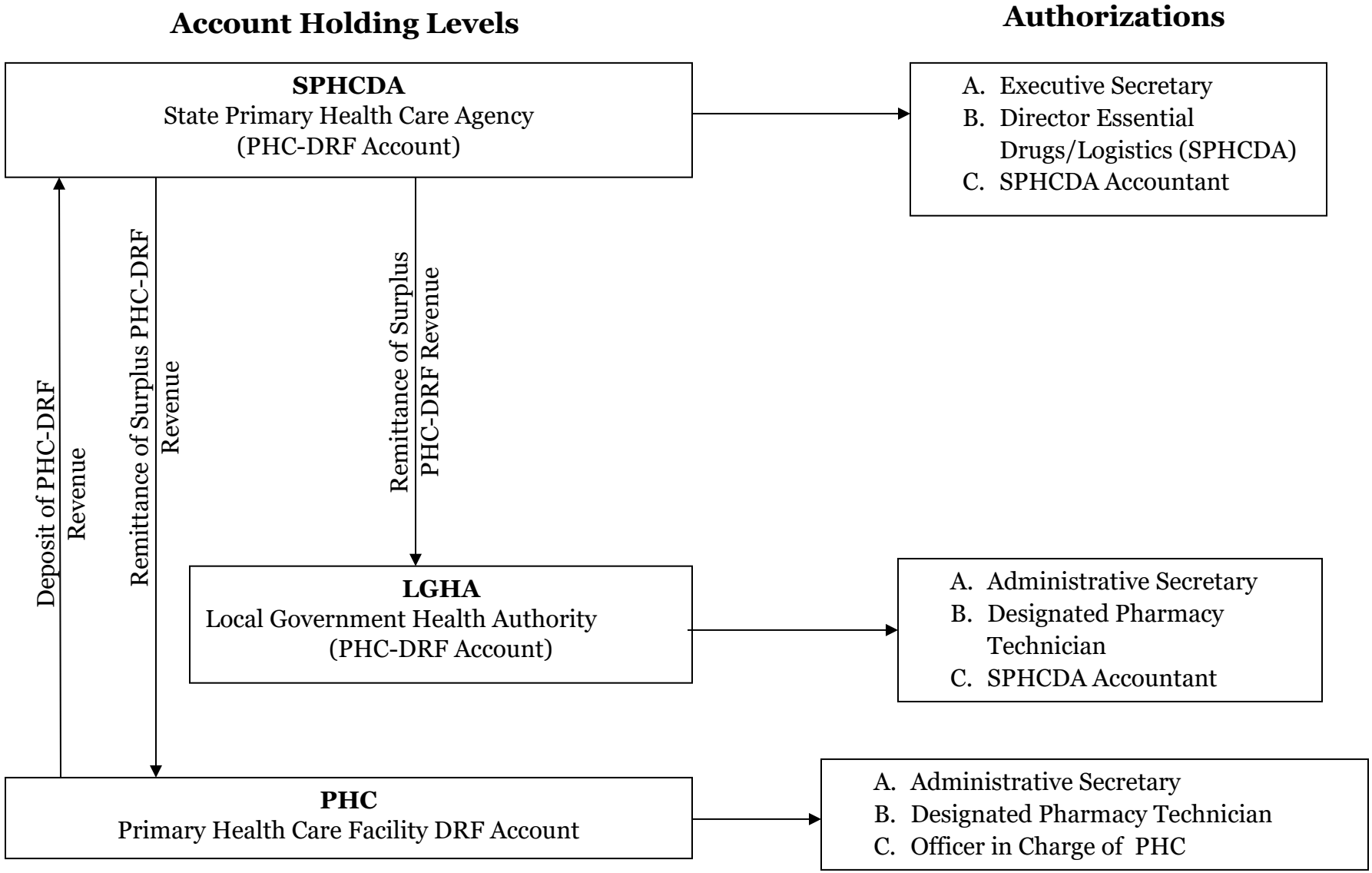
	correction for an error in counting					
Stock on Hand (SOH)	Available and useable stock	CMS/PHCs	ICC	Monthly/quarterly	OIC/Pharmacy Technician/CMS Storekeeper	• Admin Sec • Director, Pharm Services-SPHCDA
Balance of Stock	Difference between received, issued & losses	CMS/PHCs	ICC	Anytime	OIC/Pharmacy Technician/CMS Storekeeper	• Admin Sec • Director, Pharm Services-SPHCDA

Annexes

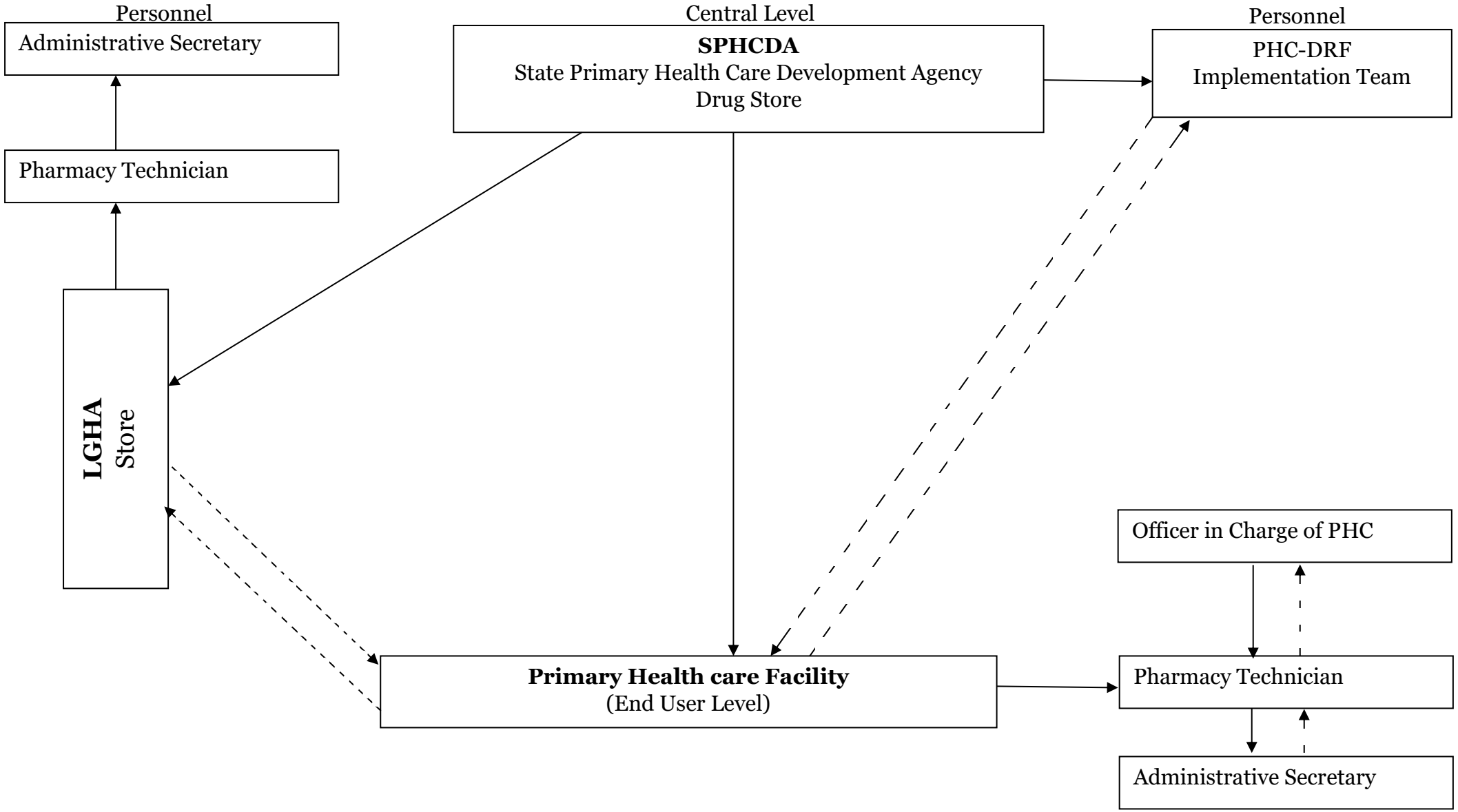
Annex 1: List of Seed Stock Commodities – Ebonyi PHC-DRF Scheme

LIST OF SEED STOCK COMMODITIES			
S/N	**DESCRIBTION**	**UNIT PACK**	**QTY**
1	Tab Paracetamol	1000	2
2	Tab Vit. C	1000	2
3	Tab Vit. C BCo	1000	2
4	Tab Folic Acid	1000	2
5	Tab Multivite	100	2
6	Tab Ferrous	1000	2
7	Tab Calcium Lactate	1000	2
8	Cap Ampiclox (500mg)	100	3
9	Cap Amoxicillin (500mg)	100	3
10	Amoxicillin DT 125mg	10	10
11	Tab Co-trimoxazole	1000	1
12	Tab Metronidazole	1000	1
13	Tab Chlorpheniramine	1000	1
14	Tab Salbutamol	1000	1
15	Tab Zinc Sulphate	100	1
16	ORS	3	20
17	Inj Hydrocortisone	Vials	180
18	Inj Genta (80mg/2ml)	100	1
19	Inj C-Pen	Vials	50
20	IVF Dextrose (5%) water ½ litre	20	1
21	IVF Dextrose (5%) Saline	20	1
22	IVF Normal Saline	20	1
23	Syringes (5ml)	100	1
24	Syringes (2ml)	100	1
25	Needles (21g)	100	1
26	Needles (23g)	100	1
27	Inj Water	50	1
28	Drip Set	PCS	50
29	Syr. Paracetamol	60ml	40
30	Syr. Metronidazole	60ml	10
31	Syr. Multivite	100ml	10
32	Syr. Vit C.	100ml	10
33	Syr. Cough Adult	100ml	10
34	Syr. Cough Children	100ml	10
35	Susp. Mag. Trisilicate	200ml	10
36	Susp. Ampiclox	100ml	10
37	Susp. Cotrimoxazole	60ml	10
38	Dispensing Envelopes	100	10

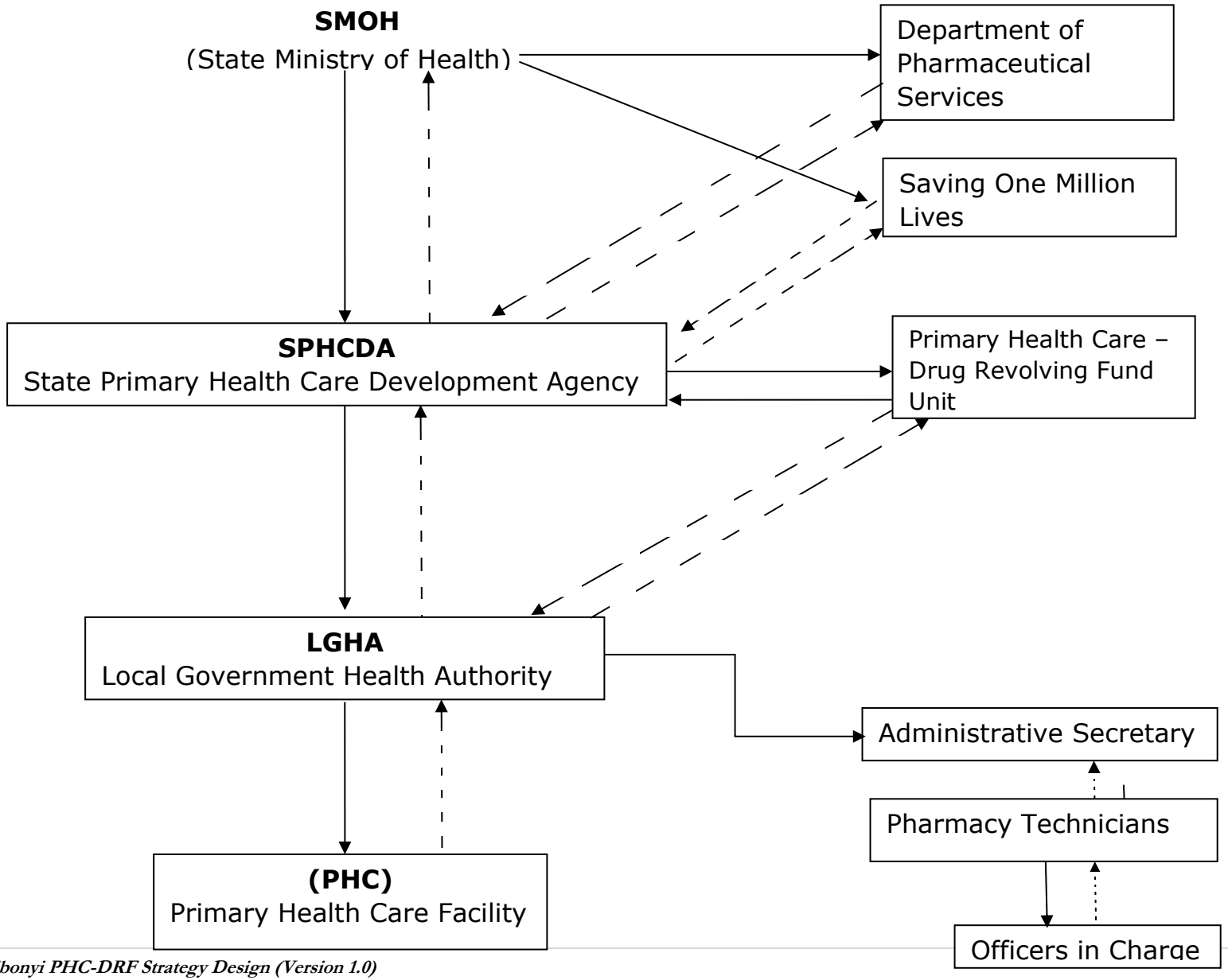
Annex 2: Lines and Flow of PHC-DRF Financial Management



Annex 3: Lines and Flow of Supply Chain Management



Annex 4: Lines and Flow of Administrative Authority



Legend for Annexes 3 and 4

depicts reverse flow of information

depicts direct flow of information

Annex 5: Frequently Asked Questions (FAQ) from LGA Level DRF Operators during the Series of Formal & Informal Engagements that led to the Adoption of the Strategy

Q1. What informed the type of drugs in the current PHC-DRF List?
A1: Ebonyi State has an Essential Medicines List (2015). All the drugs in the current PHC-DRF List are from the State EML.

Q2. Are there opportunities to increase the number and type of drugs on the DRF List?
A2. Yes, in future, with guidance from the Essential Drug List and corresponding consumption/requisition pattern from the facilities, more items will be added on the PHC-DRF List.

Q3. Should every item on the DRF List be captured on one inventory control card?
A3: Yes, for the purposes of accountability and updated stock levels, every item should be captured on one inventory control card. The PHC-DRF unit shall facilitate the supply of additional copies of ICC to the DRF primary health care facilities with the support of MCSP.

Q4: What prices should we sell the drugs to the patients at the PHC level?
A4: The prices indicated on the price list provided only by the LGA pharmacy technicians are the prices that should be sold to the patients.

Q5: Can we pay cash from sales of drugs to the LGA pharmacy technicians?
A5: All cash payments should be lodged at the bank using the SPHCDA account number provided by the pharmacy technicians. Cash should not be paid to any individual.

Q6: The original copy of the teller should be submitted to the LGA pharmacy technician?
A6: Yes, the original copy of the teller should be submitted to the LGA pharmacy technician, however, you should keep a duplicate of the teller for audit purposes.

Q7: Can we re-distribute the DRF drugs supplied to us?
A7: No, for the purposes of accountability, OICs cannot redistribute the DRF commodities supplied to PHCs. If the need for re-distribution arises, it would be the responsibility of the pharmacy technician in collaboration with the Admin Secretary and due reference to the Director Pharm Services, SPHCDA.

Q8: How will the community people know we now have some DRF commodities in our PHC?
A8: Utilize every opportunity during outreaches, formal and informal discussions with community people and their gatekeepers, health facility activities such as antenatal care sessions to inform the community people about the commencement of the PHC-DRF scheme.

Q9: Can we have Amoxicillin DT supplied in 250 mg to reduce the number of dosages given to a child?
A9: Yes, Amoxicillin 250mg DT will be supplied in future.

Q10: Will there be an opportunity to increase the number of participating health facilities beyond the 171PHCs
A10: Yes, there are opportunities for scale-up beyond 171PHCs in the future as the scheme grows and becomes resilient.

Annex 6: Roles of key PHC-DRF Operators

Table 1		
LEVEL	**PERSON**	**RESPONSIBILITIES**
PHC	OIC	• Makes requisitions • Submits requisitions • Stores commodities • Takes inventory • Keep financial data • Submits tellers to pharm tech • Remits fund to PHC-DRF account
LGHA	AS	• Conducts Supervision • Confirms lodgments to Central - DRF account • Receives report of inventory of commodities
	Pharmacy Technician	• Collates requisition from OICs • Submits requisition to SPHCDA CMS • Collects and distribute drugs • Distribute LMIS tools to PHCs • Collect tellers from OICs and submit same to SPHCDA • Conducts monitoring and supervision • Oversees inventory of commodities
SPHCDA	Executive Secretary	• Co-approves purchases • Co-authorizes payments to suppliers • Leads the decision-making process over management of the PHC-DRF scheme
	Director of Essential Medicines (DEM)/DPS	• Provides/distributes drugs • Ensures quality of drugs • Provides pricing guide • Conducts mentoring and supportive visits • Provides LMIS tools • Ensures development and submission of logistics reports as they may be required
	Accountant	• Confirms lodgments • Provide bank statements • Write cheques/withdrawals • Make payments as authorized • Generate financial reports
	Pharm Tech	• Assist DEM/DPS to distribute drugs to PHCs • Conduct monitoring and supervision
	M&E Officer	• Collects data • Collates data • Validates data • Utilizes the financial modelling tool to generate forecast and other relevant data • Analyzes data and submits for decision-making