Developing and supporting implementation of state-specific Drug Revolving Funds (DRF)

Master Playbook | [February 9, 2022]

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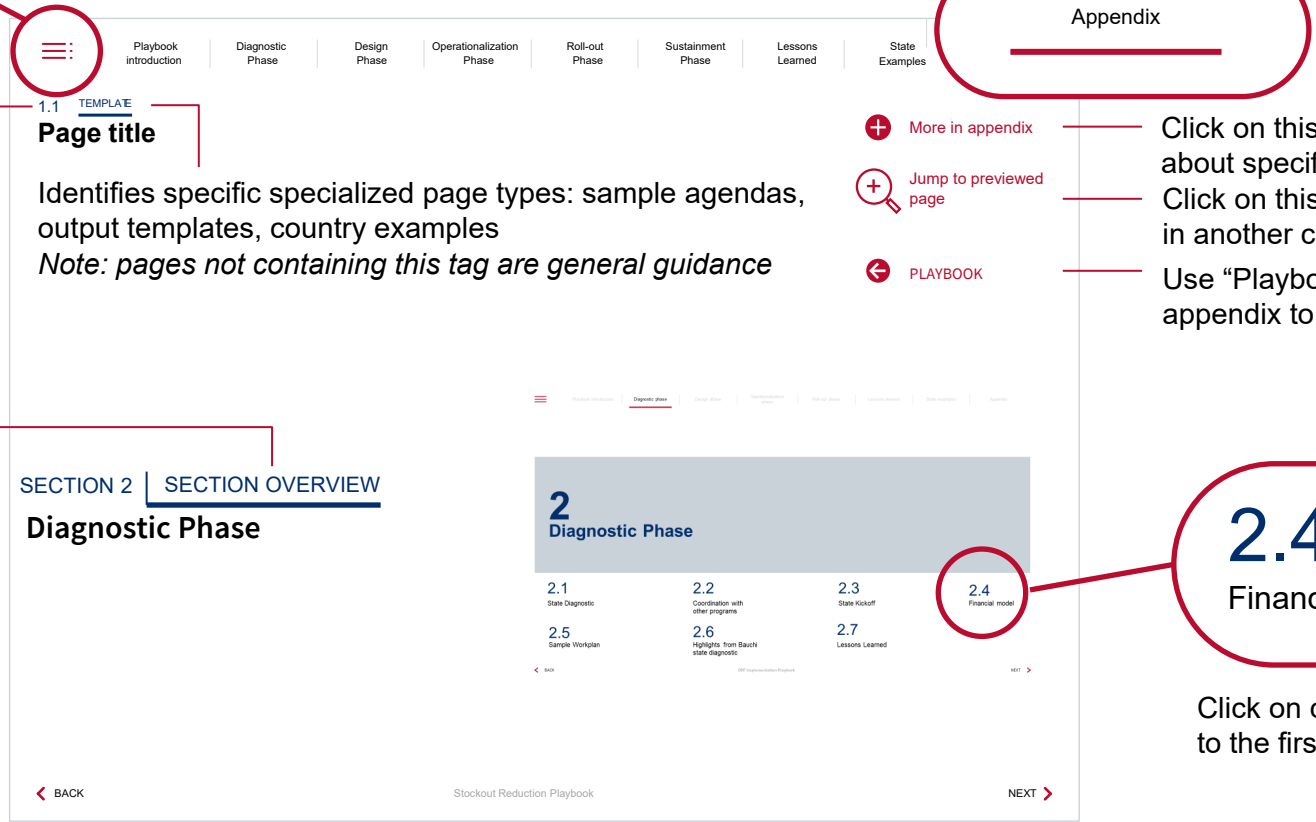
Playbook navigation guide

Use this button to go back to the playbook's table of contents

Use the navigation bar located on the top to quickly jump to the start of the chapter



Indicates which chapter and subchapter you are on- overall the playbook contains 8 chapters each containing 2-6 subchapters

Identifies specific specialized page types: sample agendas, output templates, country examples
Note: pages not containing this tag are general guidance

Click on this button to find more information about specific topics in the appendix

Click on this icon to skip to previewed page in another chapter

Use "Playbook" to jump back from the appendix to the main section

Use "section overview" to have a quick view of the content

2.4 Financial model

Click on chapter sub-section to jump to the first page of that sub-section

Foreword

In 2017, USAID commissioned a Human Centered Design (HCD) study to understand what interventions could improve maternal, neonatal and child health (MNCH) services availability and uptake in 3 states – Bauchi, Kebbi and Sokoto states. The MNCH supply chain systems in these states were fragmented and underperforming. This had resulted in commodity stock-outs at service delivery points and low uptake of MNCH services by mothers and children. On average, availability of 7 tracer MNCH commodities at PHCs ranged from 34% in Sokoto and Bauchi, to 48% in Kebbi.

The HCD work uncovered significant challenges around governance, sufficiency and distribution of commodities across the target states.

Governance and coordination challenges: These included a lack of clear governance for managing, financing and coordinating supply chain and program activities, fragmented data collection systems. Donors were also known to run ad-hoc parallel programs without coordinating with states, causing poor visibility and hindering sustainability

Sufficiency challenges: Poor forecasting resulted in commodity availability and demand mismatch. Inaccurate quantification of commodity requirements resulted in expiries and stock outs at facilities, while limited financial autonomy and the budgetary constraints of state agencies made it difficult to meet needs in a timely and consistent manner

Distribution challenges: Challenges identified included inadequate cold chain infrastructure and storage, insufficient funding for transportation of commodities, lack of skilled power and inadequate funding for LMCU activities, cumbersome manual order taking processes

The HCD approach was used to identify pain points along the MNCH system and collaboratively develop user-centric solutions. **To overcome the MNCH commodity availability problem, a key recommendation made by the stakeholders was the need to implement a sustainable state-wide Drug Revolving Fund (DRF).**

USAID piloted state-specific DRF implementation in three states – Bauchi, Kebbi and Sokoto. **This playbook is intended to support USAID country teams and their implementing partners in designing, implementing and monitoring DRFs in more states across Nigeria.** It contains a number of resources organized around a consistent approach to supporting DRF implementation, including process and technical guidance, tools and templates and examples of what was done in Bauchi, Kebbi and Sokoto.

It is important to remember that this **playbook is not a rule book**; country teams are expected and empowered to leverage their expertise and creativity in developing their DRF implementation initiatives and to tailor and adapt playbook resources as needed.

This playbook will be updated based on continued input and feedback from you and your teams. If you have suggestions or ideas to improve future versions of this playbook, please reach out to the USAID MNCH team.

Thank you for your continued efforts and commitment to supporting the improvement of MNCH programs.

Sponsor

Title

Signature

Glossary

Acronym	Full Meaning
CMS	Central Medical Store
D&E	Deferral and Exemptions
DMA	Drugs Management Agency
DPS	Director Pharmaceutical Services
DRF	Drug Revolving Fund
GH	General Hospital
GHSC-PSM	Global Health Supply Chain Program - Procurement and Supply Management project
HCD	Human Centred Design
HF	Health Facility
HMB	Hospital Management Board
IP	Implementing partner
LGA	Local Government Area
LGHA	Local Government Health Authority
LMCU	Logistics Management Coordination Unit
MNCH	Maternal, Newborn and Child Health
NSHIP	Nigeria State Health Investment Project
PBF	Performance Based Result Financing
PCN	Pharmacists Council of Nigeria
PHC	Primary Health Care/center
PHF	Primary Health Facility
SHC	Secondary Health Center
SHF	Secondary Health Facility
SMOH	State Ministry of Health
SOP	Standard Operating Procedures
SPHCDA	State Primary Health Care Development Agency
TA	Technical Assistance
THF/THC	Tertiary Health Facility/Center
WDC	Ward Development Committee

Table of contents

1 INTRODUCTION

1.1
Overview of drug revolving funds

1.2
Introduction of playbook components

1.1

Overview of drug revolving funds

What is a DRF?

DRF is a scheme that involves the use of initial funds (seed stock) to procure drugs for use in a given health system on a user fee basis for sustainability

It involves the use of funds to procure an initial stock of essential medicines to be sold to end users at an affordable price

The users pay just enough to cover their treatment. The money collected from users is in turn used to buy DRF commodities and the process continues.

Goals of the DRF

To ensure availability of quality health commodities at facilities in a sustainable manner

To ensure accessibility and affordability of health commodities.

To curtail dependence on external funding

To encourage patients' (community members) patronage and participation in the system by involving community leaders in overseeing the system

To reduce the annual budgetary burden on State & LGAs on drugs and medical consumables

1.1

Overview of drug revolving funds

Drug Revolving Fund (DRF) flow

Donor supplies initial seed stock…and the cycle continues!

1.1

Overview of drug revolving funds

A strengthened DRF will improve critical health outcomes, significantly impacting the lives and wellbeing of mothers and children

From…

"During my first pregnancy, I had to go to the next village which is 30 minutes away because my local PHC had not received drugs from the government in 2 years…"

"My daughter's cough got worse, and she went with pneumonia because there was no antibiotics at our local PHC when we first visited…"

…To

"For my next pregnancy, all the drugs I needed were available at the PHC close to my house, and it made a big difference…"

"I was able to get everything I needed for my baby when she was ill, at a fair price…"

1.1

State-specific DRF implementation

USAID has identified five stages to DRF implementation

1 Diagnose

Understand ongoing DRF activities and essential medicine supply chain strengths and challenges

Activities include:

- 1.1 State diagnostic
- 1.2 Coordination with other programs
- 1.3 State kick-off
- 1.4 Financial modelling

2 Design

Design or strengthen state-specific plans for effective, sustainable DRF governance and operations

Activities include:

- 2.1 Design workshop
- 2.2 SOP review workshop
- 2.3 Readiness assessment
- 2.4 USAID mission visit

3 Operationalize

Develop or strengthen required structures and systems for a functional DRF

Activities include:

- 3.1 Seed stock quantification
- 3.2 Capability building
- 3.3 Readiness verification
- 3.4 Seed stock procurement and release

4 Roll out

Strengthen/roll out DRF operations across facilities

Activities include:

- 4.1 Capacity building
- 4.2 Seed stock distribution
- 4.3 Monitoring and evaluation
- 4.4 Continuous system strengthening

5 Sustain

Provide light-touch support to ensure DRF sustainability

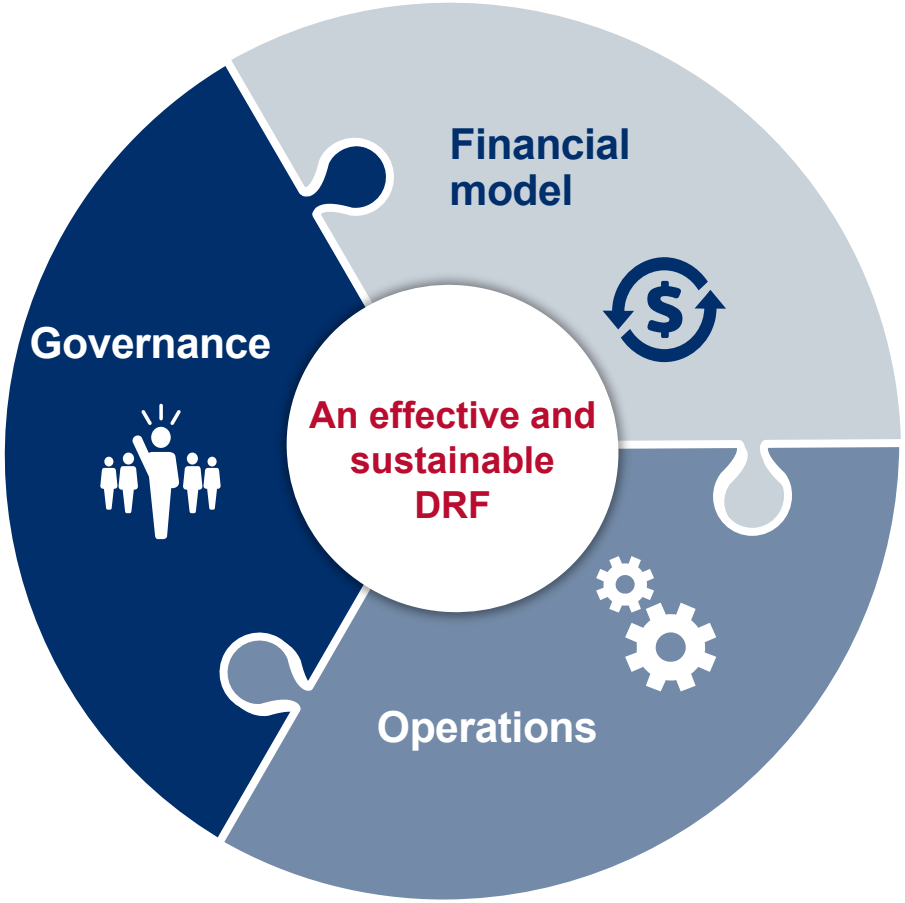
Activities include:

- 5.1 DRF governance strengthening
- 5.2 DRF operations strengthening

1.1

State-specific DRF implementation

The proposed systematic approach to state-specific DRF implementation is centered on governance, operations and a sustainable financial model



At each implementation stage, activities can be assessed, organized and evaluated against the three elements of operations, governance and financial model

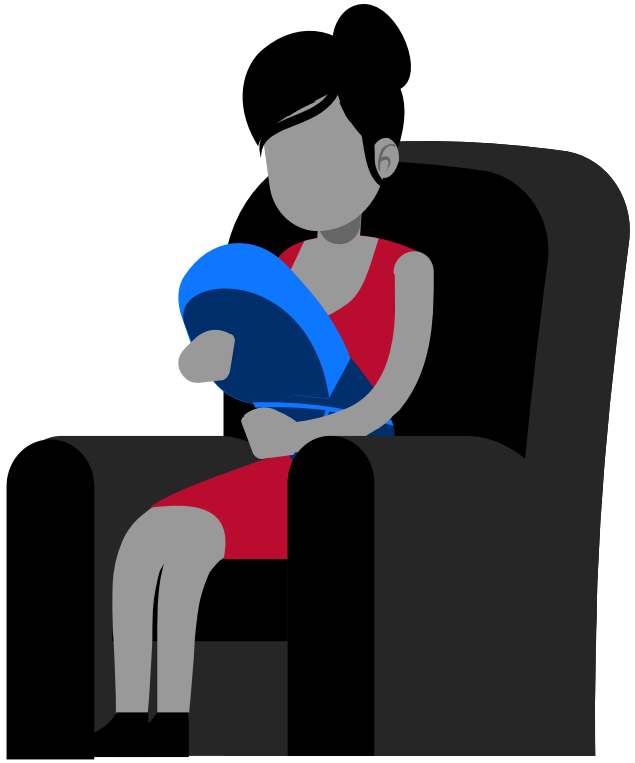
1.2

Introduction to playbook components

USAID has developed a playbook to support USAID Implementing Partners (IPs) with setting up state-specific DRF schemes

Playbook objective

Serve as an end-to-end technical guide and resource for USAID country teams and their IPs to develop a sustainable DRF scheme that supports MNCH supply chain system-strengthening efforts



Primary audience

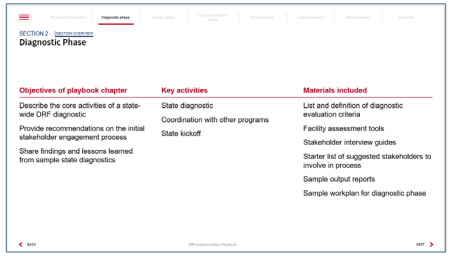
USAID implementing partner leadership and staff

1.2

Introduction to playbook components

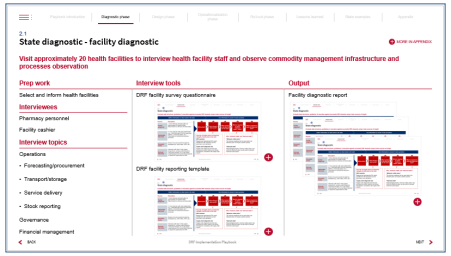
This playbook contains different types of pages with different intended uses

Section overviews



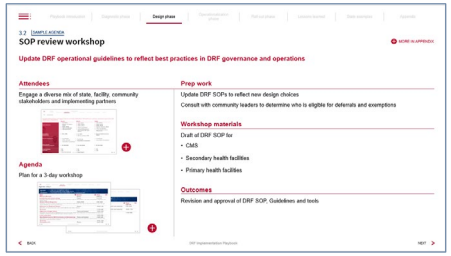
Section overview pages appear at the beginning of each playbook section and describe key objectives and activities for the section

General guidance



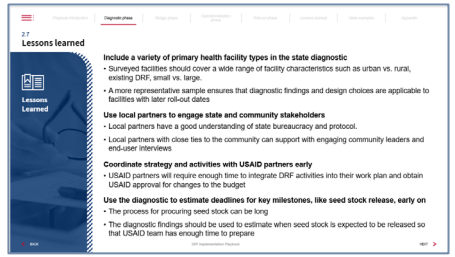
The broadest and most common category, these pages include all general guidance (including frameworks, recommended approaches, technical resources, etc.) across all stages of state DRF implementation

Agendas and checklists



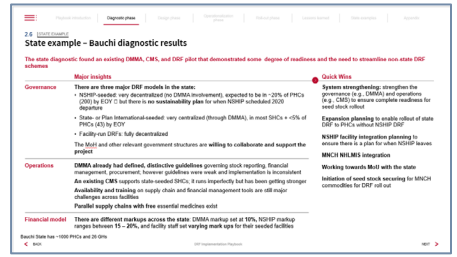
These specialized pages are sample outlines of meeting agendas to be used in stakeholder engagement activities throughout the DRF implementation; they are meant to be tailored to specific state contexts

Lessons learned



These pages include lessons learned from DRF implementation in other states, specifically the states in which USAID first piloted this approach.

State examples



These pages are a state-specific example of filled-in outputs that serve as a reference to help countries as they complete similar activities

2 Diagnostic Phase

SECTION 2 | SECTION OVERVIEW

Diagnostic Phase

Objectives of playbook chapter

Describe the core activities of a state-wide DRF diagnostic

Provide recommendations on the initial stakeholder engagement process

Share findings and lessons learned from sample state diagnostics

Key activities

State diagnostic

Coordination with other programs

State kickoff

Materials included

List and definition of diagnostic evaluation criteria

Facility assessment tools

Stakeholder interview guides

Starter list of suggested stakeholders to involve in the process

Sample output reports

Sample workplan for diagnostic phase

2.1

State diagnostic

Evaluate state structures, guidelines, & execution against successful DRF elements using 4 main sources of insight

Gather information on what exists in the state → ***Use information to answer 5 main questions***

Sources	Description
Facility diagnostic	~2 hour interview and observation at approximately 20 health facilities. Report based on interview and observation
Stakeholder interviews	1-2 hour interview with select stakeholders, e.g., Central Medical Store (CMS) staff, Drugs Management Agency (DMA) staff, State Primary Health Care Development Agency (SPHCDA) leadership, partners, community leaders, etc. Observation of central-level structures / processes
Document review	Review of documents the state has developed (e.g., text of laws, SOPs, etc.)
End-user interviews	Interviews with "Users" (including mothers/families, community members, etc.) of the system to get a deeper understanding of the human factors that limit or expand the opportunities for DRF

1. **What exists?**
2. **How strong is what exists?**
3. **What system is the best fit for the state**
4. **What is required to reach "minimum viable" status?**
5. **What is required to reach the ideal end state?**

Sources of insight used to evaluate the strength of what exists in the state

DRF expertise

Nigerian and international DRF expert with experience across governance and operations

Supply chain diagnostic tool

Supply chain diagnostic tools that rate processes as weak, medium, and strong, developed in consultation with supply chain experts

Why "minimum viable" and "ideal end state"?

"Minimum viable status"

The minimum readiness bar for seed stock to be released (does not require a perfect system)

"Ideal end state"

Acknowledging that the "minimum viable state" may not be the ideal end state, we also want to evaluate what that would require

2.1

State diagnostic - facility diagnostic

MORE IN APPENDIX

Visit approximately 20 health facilities to interview health facility staff and observe commodity Phase infrastructure and processes

Preparatory work

Select and inform health facilities

Interviewees

Pharmacy personnel

Facility cashier

Interview topics

Operations

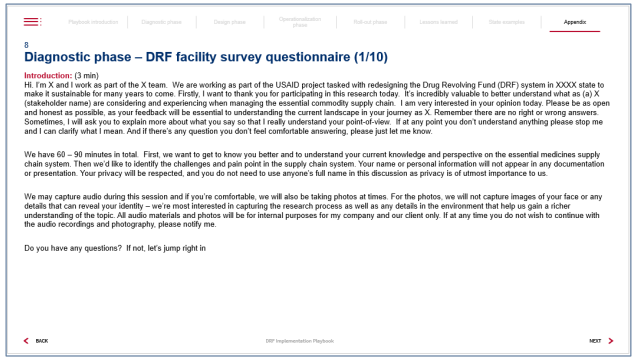
- Forecasting/procurement
- Transport/storage
- Service delivery
- Stock reporting

Governance

Financial Management

Interview tools

DRF facility survey questionnaire



8

Diagnostic phase – DRF facility survey questionnaire (1/10)

Introduction: (3 min)

Hi. I'm X and I work as part of the X team. We are working as part of the USAID project tasked with redesigning the Drug Revolving Fund (DRF) system in XXXX state to make it sustainable for many years to come. Firstly, I want to thank you for participating in this research today. It's incredibly valuable to better understand what as (a) X (stakeholder name) are considering and experiencing when managing the essential commodity supply chain. I am very interested in your opinion today. Please be as open and honest as possible, as your feedback will be essential to understanding the current landscape in your journey as X. Remember there are no right or wrong answers. Sometimes, I will ask you to explain more about what you say so that I really understand your point-of-view. If at any point you don't understand anything please stop me and I can clarify what I mean. And if there's any question you don't feel comfortable answering, please just let me know.

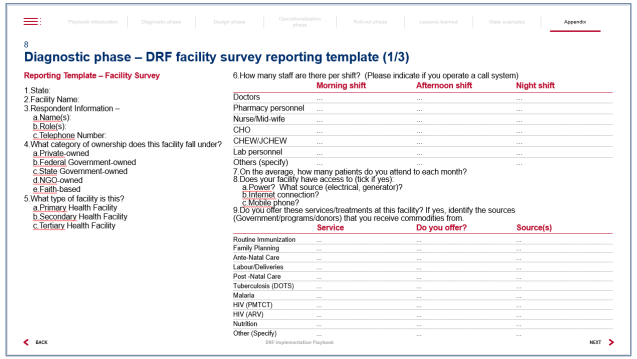
We have 60 – 90 minutes in total. First, we want to get to know you better and to understand your current knowledge and perspective on the essential medicines supply chain system. Then we'd like to identify the challenges and pain point in the supply chain system. Your name or personal information will not appear in any documentation or presentation. Your privacy will be respected, and you do not need to use anyone's full name in this discussion as privacy is of utmost importance to us.

We may capture audio during this session and if you're comfortable, we will also be taking photos at times. For the photos, we will not capture images of your face or any details that can reveal your identity – we're most interested in capturing the research process as well as any details in the environment that help us gain a richer understanding of the topic. All audio materials and photos will be for internal purposes for my company and our client only. If at any time you do not wish to continue with the audio recordings and photography, please notify me.

Do you have any questions? If not, let's jump right in

BACK DRF Implementation Playbook NEXT

DRF facility reporting template



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Diagnostic phase – DRF facility survey reporting template (1/3)

Reporting Template – Facility Survey

1.State:
2.Facility Name:
3.Respondent Information –
a.Name(s):
b.Role(s):
c.Telephone Number:
4.What category of ownership does this facility fall under?
a.Private-owned
b.Federal Government-owned
c.State Government-owned
d.NGO-owned
e.Faith-based
5.What type of facility is this?
a.Primary Health Facility
b.Secondary Health Facility
c.Tertiary Health Facility

6.How many staff are there per shift? (Please indicate if you operate a call system)

	Morning shift	Afternoon shift	Night shift
Doctors	...	...	...
Pharmacy personnel	...	...	...
Nurse/Mid-wife	...	...	...
CHO	...	...	...
CHEW/JCHEW	...	...	...
Lab personnel	...	...	...
Others (specify)	...	...	...

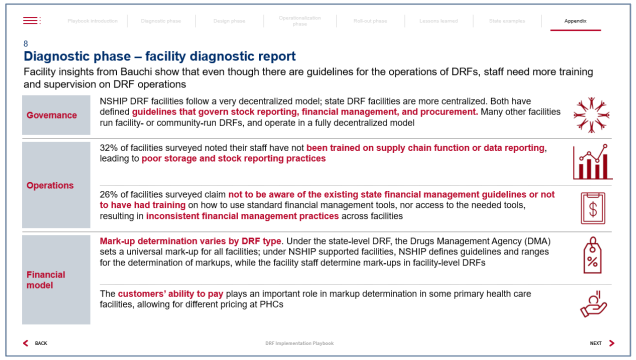
7.On the average, how many patients do you attend to each month?
8.Does your facility have access to (tick if yes)
a.Power? What source (electrical, generator)?
b.Internet connection?
c.Mobile phone?
9.Do you offer these services/treatments at this facility? If yes, identify the sources (Government/programs/donors) that you receive commodities from

Service	Do you offer?	Source(s)
Routine Immunization	...	...
Family Planning	...	...
Ante-Natal Care	...	...
Labour/Deliveries	...	...
Post -Natal Care	...	...
Tuberculosis (DOTS)	...	...
Malaria	...	...
HIV (PMTCT)	...	...
HIV (ARV)	...	...
Nutrition	...	...
Other (Specify)	...	...

BACK DRF Implementation Playbook NEXT

Output

Facility diagnostic report



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Diagnostic phase – facility diagnostic report

Facility insights from Bauchi show that even though there are guidelines for the operations of DRFs, staff need more training and supervision on DRF operations

Governance	NSHIP DRF facilities follow a very decentralized model; state DRF facilities are more centralized. Both have defined **guidelines that govern stock reporting, financial management, and procurement.** Many other facilities run facility- or community-run DRFs, and operate in a fully decentralized model
Operations	32% of facilities surveyed noted their staff have not **been trained on supply chain function or data reporting,** leading to **poor storage and stock reporting practices**
	26% of facilities surveyed claim **not to be aware of the existing state financial management guidelines or not to have had training** on how to use standard financial management tools, nor access to the needed tools, resulting in **inconsistent financial management practices** across facilities
Financial model	**Mark-up determination varies by DRF type.** Under the state-level DRF, the Drugs Management Agency (DMA) sets a universal mark-up for all facilities; under NSHIP supported facilities, NSHIP defines guidelines and ranges for the determination of markups, while the facility staff determine mark-ups in facility-level DRFs
	The **customers' ability to pay** plays an important role in markup determination in some primary health care facilities, allowing for different pricing at PHCs

BACK DRF Implementation Playbook NEXT

2.1 NOT EXHAUSTIVE

State diagnostic – stakeholder interviews

MORE IN APPENDIX

Interview both governmental and non-governmental stakeholders at the state, LGA and community levels to assess the governance of the state DRF.

Governance

State	LGA	Community	Others	Interview materials
Governor	LGA Chairpersons	Ward Development Committees	Facility heads	Stakeholder interview guide on DRF governance
Commissioners for Health, Finance, Local Government Affairs and Justice	Primary Health Care Coordinators	Facility Health Committees	Integrated Health Program/Breakthrough Action	Stakeholder interview reporting template for DRF governance
Permanent Secretary, Health	Essential drug officers	Village Health Committees	Other donors/IP	
Director, Pharmaceutical Services	Local Government Authority health program officers	District and Village heads	Civil Society Organizations	
Director, Public Health	Cold Chain Officer	Other traditional rulers	Community-based organizations	
Director, Planning, Research & Statistics	Zonal Cold Chain Officer	Clerics	Faith-based organizations	
Managers of Health programs in Ministry of Health		Ward Technical Officers	Community influencers	
		Ward Focal Persons	Patent and proprietary medicine vendors (PPMVs)	

2.1 NOT EXHAUSTIVE

State diagnostic – stakeholder interviews

MORE IN APPENDIX

Interview both governmental and non-governmental stakeholders at the state, LGA and community levels to assess each of the three main components of DRF operations – supply chain, financial management and data management.

Governance

State

Quantification & Forecasting

Logistics Management Coordination Unit (LMCU)

Directors of Pharmaceutical Services, Public Health and Planning, Research and Statistics

Facility heads

Donors and IPs

Procurement

Drug Management Agency

Director of Pharmacy

Pharmacy Suppliers

Procurement pricing committee

Warehousing & Distribution

Director of Pharmaceutical Services

Central Medical Store Pharmacist – in charge

State/LGA store managers

LMCU Coordinator

Suppliers & third-party logistics suppliers

Financial mgmt.

CMS Management committee

Director of Pharmaceutical Services

CMS Pharmacist

Facility heads

Facility Pharmacists

Facility cashiers

Facility Health Committees

Ward Development Committees

Data mgmt.

State-level

Directors of Pharmaceutical Services, Public Health, Planning Research & Statistics

LMCU data officers

Health Management Information System officer

CMS Pharmacist

Health program managers

Facility-level

Facility heads

Medical records officers

Other health workers

Interview materials

Stakeholder interview guide on DRF operations

Stakeholder interview reporting template for DRF operations

2.1 NOT EXHAUSTIVE

State diagnostic – document review

Review existing legal documents, standard operating procedures and guidelines to evaluate the existence and strength of guidelines for DRF governance and operations in the state

Legal documents	**The DMMA law:** This is the law passed by state assemblies to establish an agency solely responsible for procuring medical commodities and for governing the DRF scheme
SOPs / guidelines	**The state minimum service package (MSP):** The guidelines for the standard minimum of service at a facility level to inform the minimum number of staff required at a facility **DRF operational guidelines for the CMS:** The guidelines for the implementation of the DRF at the state level **DRF operational guidelines for LGA:** The guidelines for the implementation of the DRF at the LGA level **DRF operational guidelines for the SHC:** The guidelines for the details on the DRF end to end supply chain process at the secondary facility level, including financial management, data management and performance management. **DRF operational guidelines for the PHC:** The guidelines for the details on the DRF end to end supply chain process at the primary facility level, including financial management, data management and performance management.
Other documents	**Memoranda of Understanding:** Any agreements between the state and partners on procuring medical commodities and governing the DRF scheme

2.1

State diagnostic – evaluation report

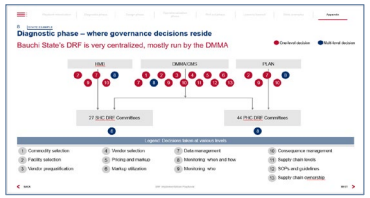
MORE IN APPENDIX

Share and reflect on diagnostic findings with stakeholders including state leaders, traditional leaders, and partners

Evaluate DRF governance in the state

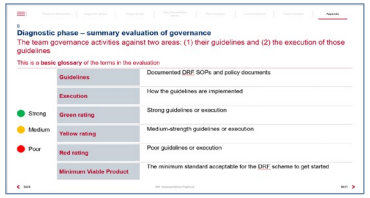
A Define major governance activities

B Explain where governance activities reside today



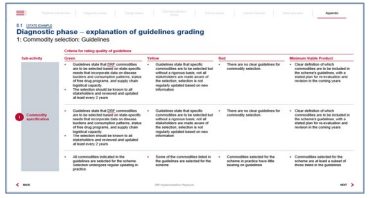
C Summarize evaluation of governance

- Laws
- Governing bodies
- Governance guidelines



D Deep dive into each governance guideline

- Current state: existence, quality, execution
- Path to "minimum viable product"

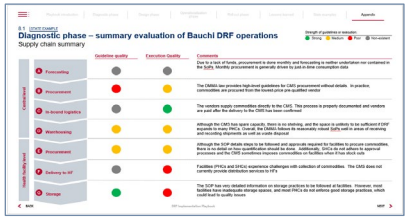


Evaluate DRF operations in the state

For each component of operations (supply chain management, financial management, data management and performance management, and human resources):

A Provide an overview of each component

- Are there guidelines and what is their quality?
- How strong is execution of those guidelines?



B Deep dive on each process:

- Path to "minimum viable product" (MVP)
  - Definition of the "minimum viable product"
  - What will it take for state to achieve MVP?
  - How hard will it be to achieve MVP?

2.2 NOT EXHAUSTIVE

Coordination with other programs

Identify and meet with critical stakeholders prior to initiate introduction to agree on how to collaborate

	Government	Implementing partners
Examples	Logistics Management Coordination Unit (LMCU) Nigeria Supply Chain Integration Project (NSCIP)	Integrated Health Project Breakthrough Action PLAN
Points to discuss	Leadership support for DRF Roles that the government, USAID and other partners will play Expansion and sustainability plans for existing DRF schemes Frequency of touchpoints at central and state level	Leadership support for DRF Specific ways in which the partner can support the DRF scheme during the diagnostics phase Suggested ways in which the partner can support DRF implementation from the diagnostic phase through the sustainability phase Frequency of touchpoints at central and state levels The importance of partners scheduling their own meetings with state and central level officials
When to first engage	At the very beginning of the diagnostic phase	After engaging state stakeholders During stakeholder interviews

2.3

Kick-off

MORE IN APPENDIX

Officially launch DRF activities in the state and gain stakeholder support

Preparatory work

Meet with critical stakeholders

Agenda

Explain context of DRF

Outline workplan for setting up state DRF

Discuss support needed from different stakeholders

Outcomes

Minimum viable success:

- Alignment on data inputs for country baseline, plan in place for follow-ups to set baseline and calculate targets

Ideal outcome:

- Public support for DRF implementation plan from all critical stakeholders

Attendees

Approximately 50 attendees including

State stakeholders

- Commissioner for Health
- Permanent Secretary MoH
- Director Pharmaceutical Services
- Director of Planning, Research and Statistics
- Director, Public Health
- General Manager, Drugs Management Agency (DMA)
- LMCU Coordinator

Community leaders

- Ward Development Committee (WDC) Chairman

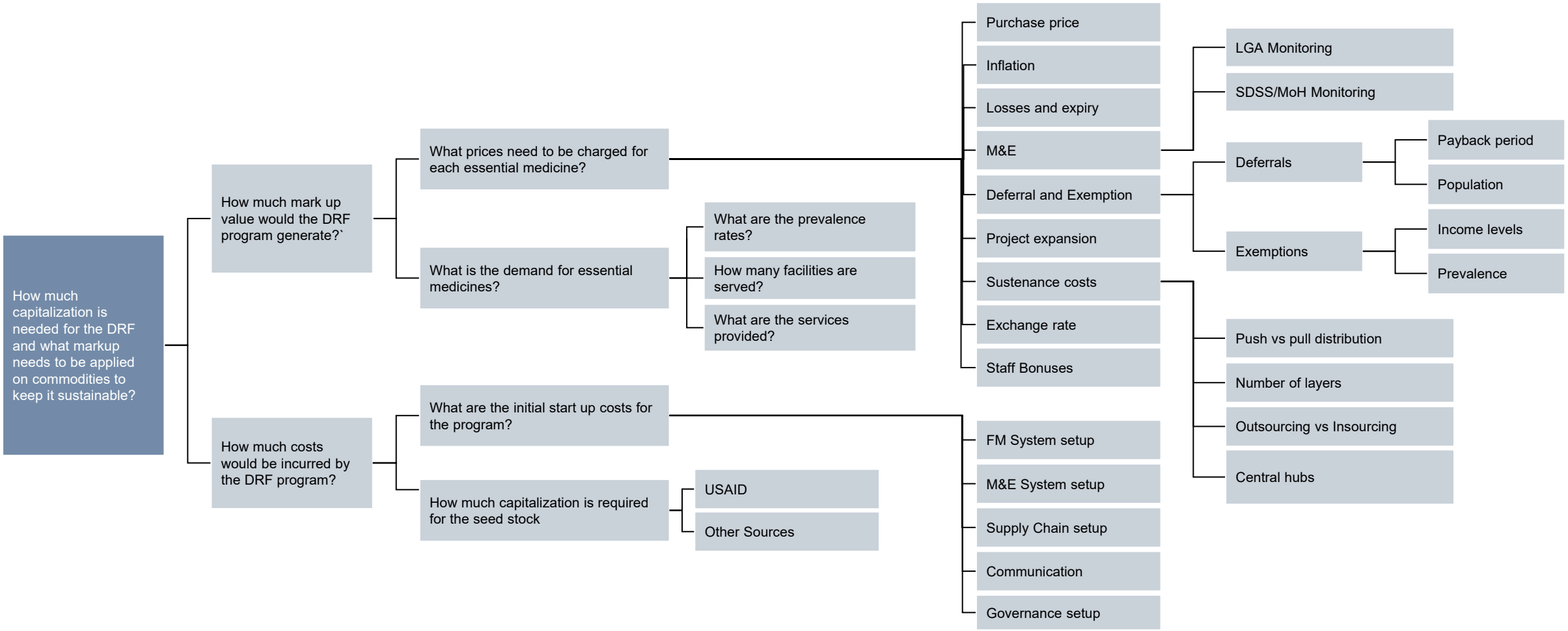
Partners

- Nigeria State Health Investment Project
- PLAN
- Saving One Million Lives
- Integrated Health Project
- Breakthrough Action
- Management Sciences for Health
- United Nation’s Children Fund

2.4

Financial Model – issue tree

Develop a financial model to determine what costs will be incurred by the DRF program and how much mark up value the DRF program should generate



2.4

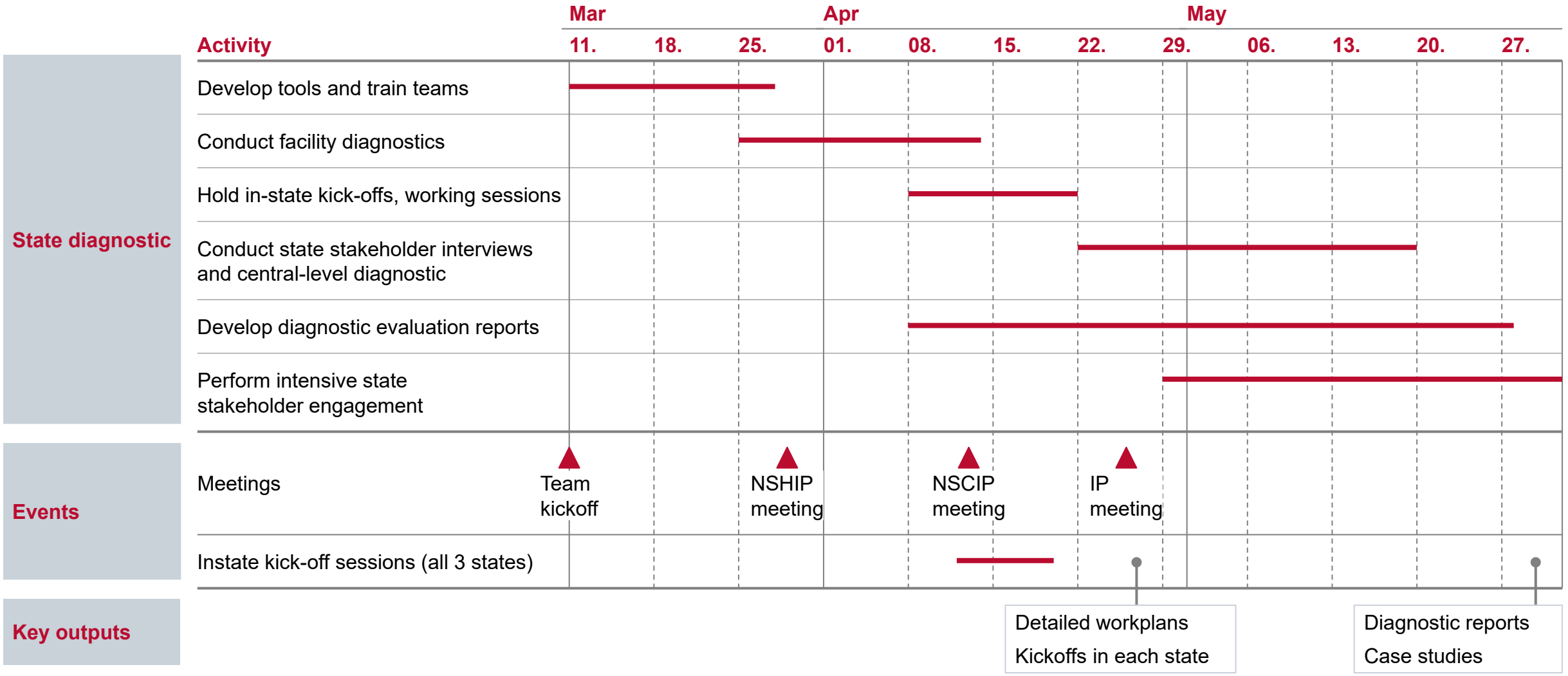
Financial Model - mark-up and pricing

The mark-up estimation will be mainly bottom up with the exception of losses and expiry (L&E) and staff bonus estimations

Mark-up element	Bottom up approach	Data	Recommended approach
Losses and Expiry	Forecast losses and expiry based on historical consumption data	Historical consumption data at CMS and HF level	Top down
Deferrals and Exemptions	Deferrals – estimate payback period and deferring population Exemptions – define exempt population and estimate demand	Detailed state demographic data with income level splits Prevalence data for each demographic group	Bottom up
Monitoring and Evaluation	Define structure and frequency of M&E with associated costs, e.g., transport, meals, lodging, bonuses, printing	Current market rates - transport, meals, lodging, bonuses, printing	Bottom up
Program Expansion	Model steady state DRF and define phasing for expansion of both programs and HFs	Steady state financial model	Bottom up
Sustanance Costs	Define supply structure • Push vs pull distribution • Number of layers, e.g., CMS to LGA to HS • Outsource vs insourcing transport • Number of central hubs	Transport costs – vehicles, diesel/petrol, distances between facilities, maintenance, drivers Facility costs – consumables, additional staff	Bottom up
Inflation	Forecast inflation based on historical records, e.g., historical medicine prices from Management Sciences for Health	Historical prices, e.g., commodities, transport	Bottom up
Exchange Rates	Forecast exchange rate fluctuations based on historical records	Historical NGN to USD exchange rates	Bottom up
Staff Bonuses	Define incentive structure, e.g., amount necessary to encourage behavioral change for staff	Comparison of states incentive structures	Top down

2.5 ILLUSTRATIVE

Sample workplan for diagnostic phase



2.6 STATE EXAMPLE

State example – Bauchi diagnostic activities

State diagnostic	Interviewed 22 state stakeholders on DRF governance and operations Visited 1 tertiary health facility, 6 secondary facilities and 11 primary health facilities of various types (urban vs. rural, existing DRF, small vs. large, etc.) across the state Reviewed the DMMA law, DMMA DRF policy in the DMMA law, facility and DMMA DRF operational guidelines, and the Bauchi Minimum Service Package (MSP) guidelines
Coordination with other programs	Met with staff from Nigeria State Health Investment Project (NSHIP) and Plan International to learn about DRF schemes supported by these partners Met with BA to discuss specific ways a partner could support DRF implementation • Sought BÁ's support in engaging community stakeholders (traditional leaders, ward health development committees, patients and families) to capture the community's view of a DRF scheme and appropriate deferral and exemption policies. • Asked BA to help develop behavior change and communication plans to help patients understand the value of purchasing quality products and to help with understanding and developing the optimal structures and systems for deferrals and exemptions Met with IHP to discuss specific ways IHP could support DRF implementation • Asked IHP to support with engaging facility staff in DRF design • Asked IHP to collaborate on developing a change management plan to prepare facility staff to operationalize DRF, and designing an accountability mechanism to optimize staff performance
Kick-off	Held kickoff with >50 attendees including key state, community and partner stakeholders • State stakeholders: Commissioner for Health, Permanent Secretary MoH, DPS, DPRS, Director Public Health, DMA General Manager, LMCU Coordinator • Community leaders: WDC Chairman • Partners: NSHIP, PLAN, SOML, e-Health The state government participants clearly committed to supporting the scheme All participants engaged actively and asked relevant questions regarding the scope of the project and support to be provided

2.6 STATE EXAMPLE

State example – Bauchi diagnostic results

The state diagnostic found an existing DMMA, CMS, and DRF pilot that demonstrated some degree of readiness and the need to streamline non-state DRF schemes

	Major insights
Governance	**There were three major DRF models in the state:** • NSHIP-seeded: very decentralized (no DMMA involvement), expected to be in ~20% of PHCs (200) by end-of-year (EOY), but there was **no sustainability plan** for when NSHIP scheduled 2020 departure • State- or Plan International-seeded: very centralized (through DMMA), in most SHCs + <5% of PHCs (43) by EOY • Facility-run DRFs: fully decentralized The MoH and other relevant government structures were **willing to collaborate and support the project**
Operations	**DMMA already had defined, distinctive guidelines** governing stock reporting, financial management, procurement; however, guidelines were weak and implementation is inconsistent **An existing CMS** supported state-seeded SHC; it runs imperfectly but had been getting stronger **Availability and training** on supply chain and financial management tools were still major challenges across facilities **Parallel supply chains with free** essential medicines existed
Financial model	**There were different markups across the state**: DMMA markup set at **10%,** NSHIP markup ranged between **15 – 20%,** and facility staff set **varying mark ups** for their seeded facilities

Quick Wins identified after diagnostic

System strengthening to strengthen the governance (e.g., DMMA) and operations (e.g., CMS) to ensure complete readiness for seed stock rollout

Expansion planning to enable rollout of state DRF to PHCs without NSHIP DRF

NSHIP facility integration planning to ensure presence of a plan for when NSHIP leaves

MNCH NHLMIS integration

Working towards MoU with the state

Initiation of seed stock securing for MNCH commodities for DRF roll out

Bauchi State has ~1000 PHCs and 26 GHs

2.7

Lessons learned

Include a variety of primary health facility types in the state diagnostic

- Surveyed facilities should cover a wide range of facility characteristics such as urban vs. rural, existing DRF, small vs. large.
- A more representative sample ensures that diagnostic findings and design choices are applicable to facilities with later roll-out dates

Use local partners to engage state and community stakeholders

- Local partners have a good understanding of state bureaucracy and protocol.
- Local partners with close ties to the community can support with engaging community leaders and end-user interviews

Coordinate strategy and activities with USAID partners early

- USAID partners will require enough time to integrate DRF activities into their work plan and obtain USAID approval for changes to the budget

Use the diagnostic to estimate deadlines for key milestones, like seed stock release

- The process for procuring seed stock can be long
- The diagnostic findings should be used to estimate when seed stock is expected to be released so that USAID team has enough time to prepare

3 Design Phase

3.1
Diagnostic and design choices workshop

3.2
SOP review workshops

3.3
Readiness assessment and facility selection

3.4
Mission Visit

3.5
Sample Workplan

3.6
Highlights from Bauchi state diagnostic

3.7
Lessons Learned

SECTION 3 SECTION OVERVIEW

Design Phase

Objectives of playbook chapter

Describe how to use diagnostics results to design a state-wide DRF scheme

Provide recommendations on how to engage stakeholders in the design process

Share findings and lessons learned from the design phase of example states

Key activities

Diagnostic and design choices workshop

SOP review workshops

Mission Visit

Materials included

Workshop agenda

List and explanation of DRF design principles

Sample table of contents for best-in-class DRF operational guidelines

Sample workplan for design phase

3.1 SAMPLE AGENDA

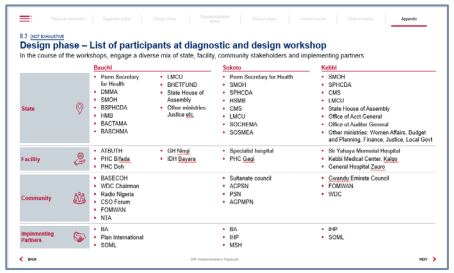
Diagnostic and design choices workshop

MORE IN APPENDIX

Use the diagnostic findings to map the design choices and risk mitigation strategies for the reformed DRF system

Attendees

Engage a diverse mix of state, facility, community stakeholders and implementing partners

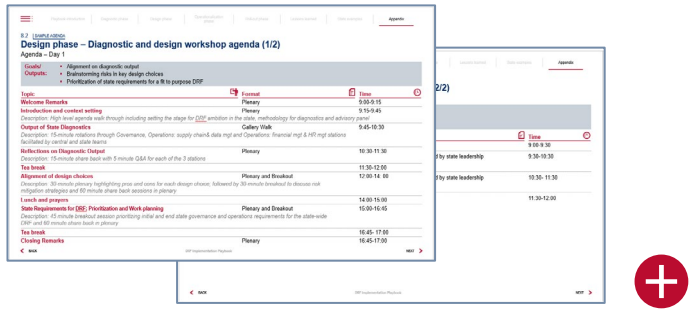

Design phase – List of participants at diagnostic and design workshop

In the course of the workshop, engage a diverse mix of state, facility, community stakeholders and implementing partners

	Beachi	Sokoto	Kebbi
State	• Perm Secretary for Health • DMMA • SMOH • BSPHCDA • HMB • BACTAMA • BASCHMA • LMCU • BHETTUND • State House of Assembly • Other ministries: Justice etc.	• Perm Secretary for Health • SMOH • SPHCDA • HSMB • CMS • LMCU • SOCHMA • SOSMEA	• SMOH • SPHCDA • CMS • LMCU • State House of Assembly • Office of Acct General • Office of Auditor General • Other ministries: Women Affairs, Budget and Planning, Finance, Justice, Local Govt
Facility	• ATBUTH • PHC Bifada • PHC Dixh • GH Ningi • IDH Bayara	• Specialist hospital • PHC Gagi	• Sir Yahaya Memorial Hospital • Kebbi Medical Center, Kalgo • General Hospital Zauro
Community	• BASECOH • WDC Chairman • Radio Nigeria • CSO Forum • FOMWAN • NTA	• Sultanate council • ACPSN • PSN • AGPMPN	• Cowandy Emirate Council • FOMWAN • WDC
Implementing Partners	• BA • Plan International • SOML	• BA • IHP • MSH	• IHP • SOML

Agenda

Plan for a 2-day workshop


Design phase – Diagnostic and design workshop agenda (1/2)

Agenda – Day 1

Goals/ Outputs:
- Alignment on diagnostic output
- Brainstorming risks in key design choices
- Prioritization of state requirements for a fit to purpose DRF

Topic	Format	Time
Welcome Remarks	Plenary	9:00-9:15
Introduction and context setting Description: High level agenda walk through including setting the stage for DRF ambition in the state, methodology for diagnostics and advisory panel	Plenary	9:15-9:45
Output of State Diagnostics Description: 15-minute rotations through Governance, Operations: supply chain& data mgt and Operations: financial mgt & HR mgt stations facilitated by central and state teams	Gallery Walk	9:45-10:30
Reflections on Diagnostic Output Description: 15-minute share back with 5 minute Q&A for each of the 3 stations	Plenary	10:30-11:30
Tea break		11:30-12:00
Alignment of design choices Description: 30-minute plenary highlighting pros and cons for each design choice, followed by 30 minute breakout to discuss risk mitigation strategies and 60 minute share back sessions in plenary	Plenary and Breakout	12:00-14: 00
Lunch and prayers		14:00-15:00
State Requirements for DRF: Prioritization and Work planning Description: 45 minute breakout session prioritizing initial and end state governance and operations requirements for the state-wide DRF and 60 minute share back in plenary	Plenary and Breakout	15:00-16:45
Tea break		16:45- 17:00
Closing Remarks	Plenary	16:45-17:00

Prep work

Align with state stakeholders on recommended design choices

Minimum viable requirements

Draft of monitoring and evaluation (M&E) plan

Workshop materials

Diagnostic results printed on posters for gallery walk

Worksheets for developing risk mitigation strategies

Draft M&E plan

Outcomes

Alignment on design choices and strategies to mitigate risks associated with selected choices

Development of an implementation plan by state stakeholders

Selection of Phase 1 facilities

Updated M&E plan

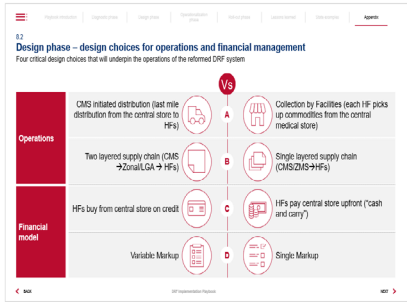
3.1

Diagnostic and design choices workshop

MORE IN APPENDIX

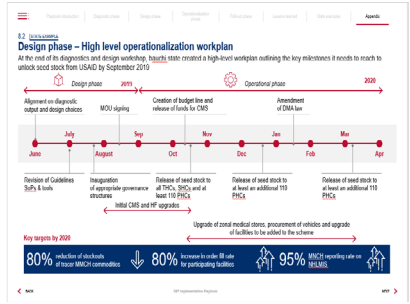
To achieve the desired outcome of the workshop, participants should focus on 4 major activities

A Decide on four critical design choices underpinning the operations of the reformed DRF system

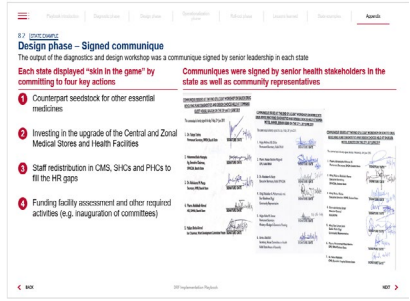


B Develop mitigation strategies for risks identified for selected design choices

C Align on high level workplan



D Sign a communiqué on agreed requirements



3.2 SAMPLE AGENDA

SOP review workshop

MORE IN APPENDIX

Update DRF operational guidelines to reflect best practices in DRF governance and operations

Attendees

Engage a diverse mix of state, facility, community stakeholders and implementing partners

Agenda

Plan for a 3-day workshop

Prep work

Update DRF SOPs to reflect new design choices

Consult with community leaders to determine who is eligible for deferrals and exemptions

Workshop materials

Draft of DRF SOP for

- CMS
- Secondary health facilities
- Primary health facilities

Outcomes

Revision and approval of DRF SOP, guidelines and tools

3.2

SOP review workshop

MORE IN APPENDIX

To achieve the desired outcome of the workshop, participants should answer 4 main questions

1 What?

- Review current guidelines in SOP and incorporate best practices +

2 How?

- Steps to be followed in executing guidelines

3 When?

- Timelines and frequency of activities of executing guidelines

4 Who?

- Stakeholders responsible for executing the operations of the guidelines

MORE IN APPENDIX
JUMP TO PREVIEWED PAGE

3.3

Readiness assessment

Identify gaps in infrastructure that would delay readiness of the state healthcare system to implement the DRF system and calculate the cost required for the equipment and/or staff needed to fill the identified gaps

Baseline assessment: Infrastructural gap analysis → Costing → Phasing out upgrades

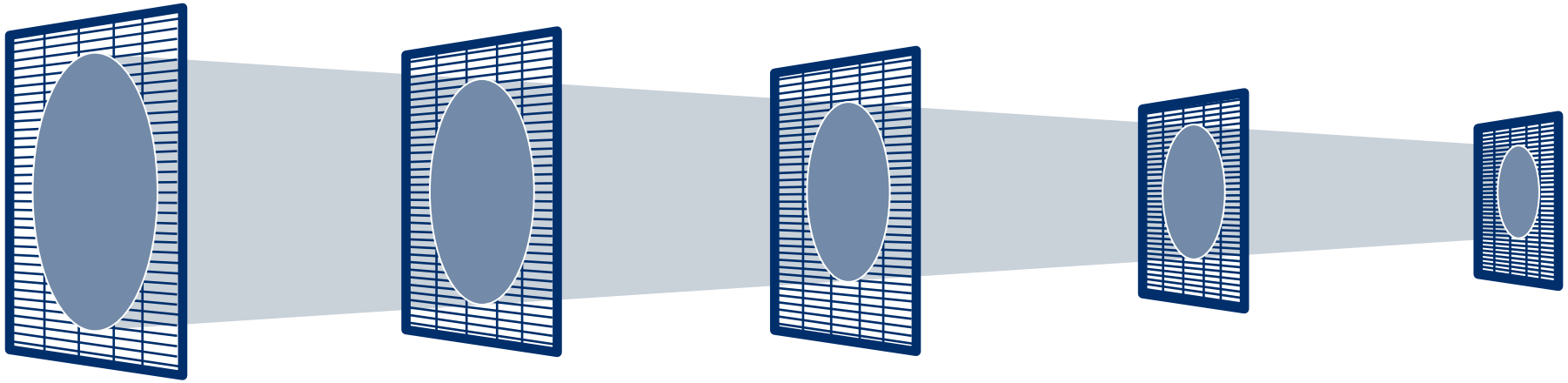
Site	Evaluation Criteria	Assessment tools	Assessors	Output
Central / Zonal Medical Stores (CMS/ZMS) CMS ZMS in districts covered by project	Cooling Operational tools Power Human resources	Checklist of essential CMS/ZMS items	Selected by DMMA	Costing for • Initial-state upgrades • End-state upgrades
Healthcare Facilities 1 PHC per ward in LGAs covered by project SHCs and THCs	Storage infrastructure Security Human resources Data management	PHC DRF readiness assessment tool	Selected by State Primary Healthcare Development Agency (SPHCDA)	List of facilities requiring • Minor updates • Major upgrades

3.3

Facility selection

Using the results of the readiness assessment, the stakeholders applied a 5- step funnel selection criteria to identify pilot facilities for DRF

All PHC facilities
+ All SHCS
+ All THCS



Final list of PHC facilities
+ All SHCS
+ All THCS

1. General Rule of thumb selection (1PHC per ward)
   a) Is the facility functional?
2. Is USAID (GHSC PSM, IHP, BA) present in those facilities?
3. Does the facility have at least 1 CHEW, and book keeping personnel as aligned in the signed communique from design workshop?
4. Does the facility have adequate storage capacity – at least 4 months worth of storage capacity?
5. Does the facility have proper security - can the facility store be locked?

Other selection criteria for consideration: **The facilities selected must report on NHLMIS/DHIS**

Commitment of community members through a signed written agreement

MORE IN APPENDIX
JUMP TO PREVIEWED PAGE

3.4

Mission Visit

Confirm the state's readiness to implement the newly designed DRF and formalize stakeholder's commitment to the operationalization and roll-out plans

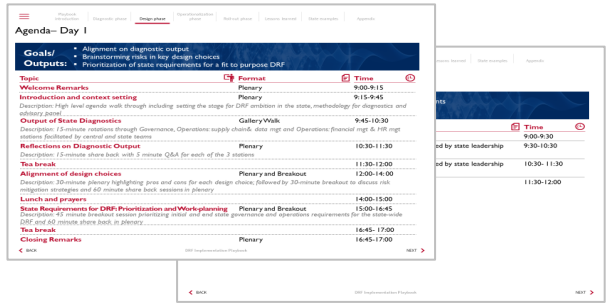
Participants

USAID team will need to meet with key persons including

- Governor
- High Commissioner for Health
- Community rulers

Agenda

Plan for a 2-day trip


Agenda– Day 1

Goals/ Outputs:
- Alignment on diagnostic output
- Brainstorming risks in key design choices
- Prioritization of state requirements for a fit to purpose DRF

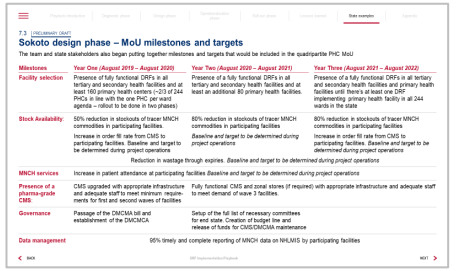
Topic	Format	Time
Welcome Remarks	Plenary	9:00-9:15
Introduction and context setting	Plenary	9:15-9:45
Output of State Diagnostics	Gallery Walk	9:45-10:30
Reflections on Diagnostic Output	Plenary	10:30-11:30
Tea break		11:30-12:00
Alignment of design choices	Plenary and Breakout	12:00-14:00
Lunch and prayers		14:00-15:00
State Requirements for DRF: Prioritization and Work-planning	Plenary and Breakout	15:00-16:45
Tea break		16:45- 17:00
Closing Remarks	Plenary	16:45-17:00

Pre-visit

Draft commitments to include in quadripartite PHS MoU

Set up committee to review commitments

Complete state readiness assessment


Sokoto design phase – MoU milestones and targets

The team and state stakeholders also began putting together milestones and targets that would be included in the quadripartite PHC MoU

Milestones	Year One (August 2019 – August 2020)	Year Two (August 2020 – August 2021)	Year Three (August 2021 – August 2022)
Facility selection	Presence of fully functional DRFs in all tertiary and secondary health facilities and at least 150 primary health centers (~2/3 of 244 PHCs in line with the one PHC per ward agenda – rollout to be done in two phases)	Presence of a fully functional DRFs in all tertiary and secondary health facilities and at least an additional 80 primary health facilities.	Presence of a fully functional DRFs in all tertiary and secondary health facilities and primary health facilities until there's at least one DRF implementing primary health facility in all 244 wards in the state
Stock Availability:	50% reduction in stockouts of tracer MNCH commodities in participating facilities Increase in order fill rate from CMS to participating facilities. Baseline and target to be determined during project operations	80% reduction in stockouts of tracer MNCH commodities in participating facilities *Baseline and target to be determined during project operations*	80% reduction in stockouts of tracer MNCH commodities in participating facilities Increase in order fill rate from CMS to participating facilities. *Baseline and target to be determined during project operations*
	Reduction in wastage through expiries. *Baseline and target to be determined during project operations*		
MNCH services	Increase in patient attendance at participating facilities *Baseline and target to be determined during project operations*		
Presence of a pharma-grade CMS:	CMS upgraded with appropriate infrastructure and adequate staff to meet minimum require-ments for first and second waves of facilities	Fully functional CMS and zonal stores (if required) with appropriate infrastructure and adequate staff to meet demand of wave 3 facilities.	
Governance	Passage of the DMCMA bill and establishment of the DMCMCA	Setup of the full list of necessary committees for end state. Creation of budget line and release of funds for CMS/DMCMA maintenance	
Data management	95% timely and complete reporting of MNCH data on NHLMIS by participating facilities		

Visit materials

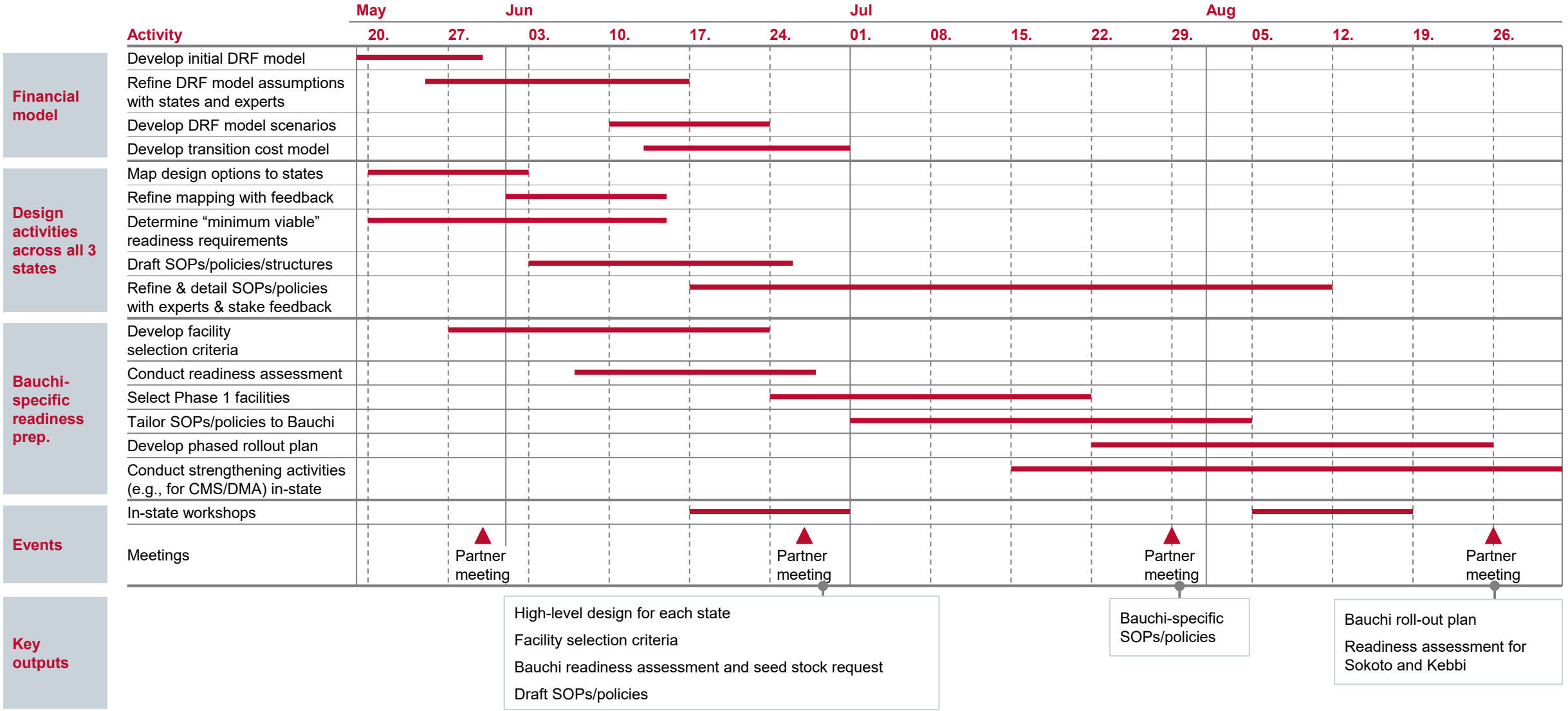
Final commitments to include in quadripartite PHS MoU

Outcomes

Renewed commitment from USAID and state government to support the DRF scheme

3.5 ILLUSTRATIVE

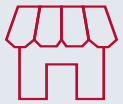
Sample workplan for design phase



3.6 STATE EXAMPLE

State example – Bauchi design choices

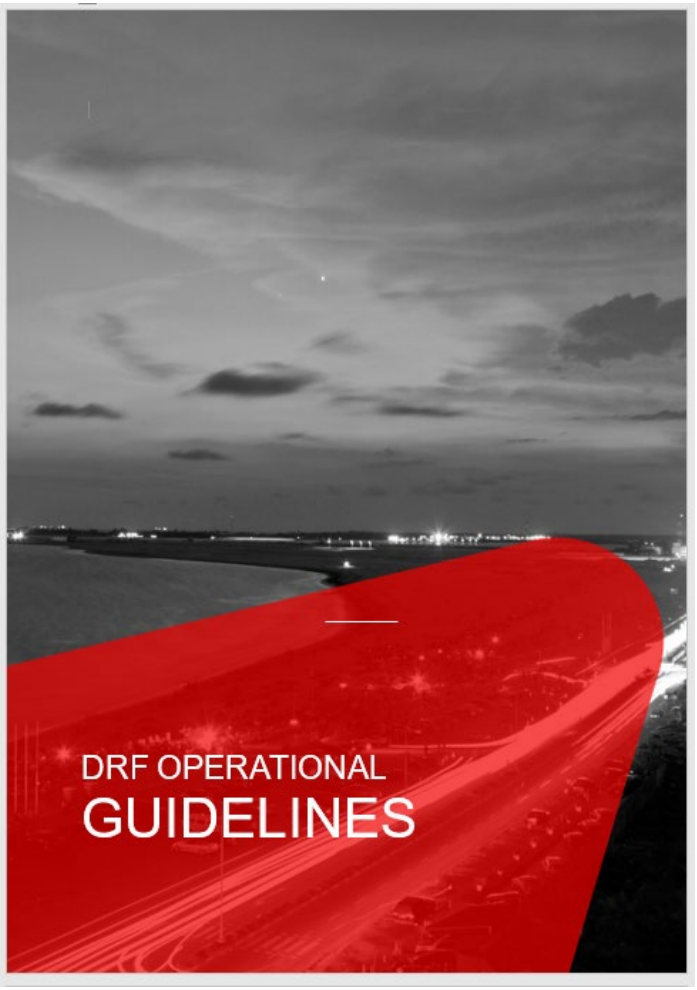
By the end of its diagnostics and design workshop, Bauchi had aligned on 4 design choices and identified possible risks and mitigation strategies for each design choice

Design choice	Risks	Mitigation strategies
Collection by Facilities (each HF picks up commodities from the central store 	Increase in transportation costs Decrease in staff productivity	Minimum of bimonthly facility procurement to reduce the time facility staff spend out of station Pooled purchasing by HFs to reduce the cost of transportation per facility Leverage the National Union of Road Transport Workers (NURTW) for transportation to reduce operational costs for HFs with proper orientation on standards for drug distribution
Single Markup 	Higher transport cost for facilities in hard-to-reach areas	CMS assumes the costs of distribution and operates a km-based reimbursement system for HFs HFs supplementing distribution costs with HF service accounts Bulk purchasing and application for tax holidays to ensure prices remain more competitive than open market and conducive for the end-user
Single layer supply chain (CMS ☐ HFs) 	Difficulty accessing the CMS and vice versa	Support CMS operations by instituting zonal stores and leveraging ZMS to strengthen data management processes In the interim, options discussed include: • Leveraging SHCs as a distribution hub for surrounding PHCs • In the interim, selecting facilities close to the CMS for pilot
HFs pay central store upfront ("cash and carry") 	Delayed reimbursement by health insurance agency	All states aligned on cash and carry as a payment model. However, when insurance is launched: • Agreement between SPHCDA and health insurance agency specifying reimbursement schedule with oversight from State DRF committee • Credit agreement between CMS and HFs • Strong financial management policies to prevent illicit practices

3.6 STATE EXAMPLE

State example – Bauchi revised SOPs

By the end of the SOP workshop, Bauchi had developed robust guidelines that would govern DRF operations in the CMS and health facility



The guidelines covered DRF operations at the DMMA/CMS, tertiary/secondary health facilities and primary health facilities

CMS (excerpt from table of contents)

Tertiary/secondary health facility (excerpt from table of contents)

Primary health facility (excerpt from table of contents)

3.6 STATE EXAMPLE

State example – Bauchi Mission

By the USAID mission visit, Bauchi State had already shown some commitment to strengthening the DRF in the state, however there was still a need to indicate further "skin in the game" in readiness for seed stock

	Achievements	Support needed
Stakeholders	**DMMA, HMB, SPHCDA** all very engaged and supportive of DRF Bauchi State Governor approved the **setting up of a review committee** in preparation for USAID DRF MoU	**Advocacy for HCoH support** needed for the ratification of the **updated DRF SOP and inauguration of DRF committees**
Facility assessment and upgrade	**Completed assessment** of 114 facilities in 9 LGAs **Commenced staff redistribution in SHCs** to meet requirements in the communique	Funding needed for assessment **of additional facilities in remaining 11 LGAs** Funding needed for **upgrade of facilities** to meet requirements in communique Advocacy for **PHC staff redistribution** to meet requirements in communique
CMS assessment and upgrade	Completed **assessment of CMS and shared position** paper with office of the governor DMMA commenced **minor upgrades of the CMS**	Funding needed for **major CMS upgrades** to meet requirements in communique

3.6 STATE EXAMPLE

Lessons learned

Include a variety of primary health facility types in the Phase 1 facilities

- Phase 1 facilities should cover a wide range of facility characteristics such as urban vs. rural, existing vs no prior DRF, small vs. large
- A more representative sample of Phase 1 facilities will help highlight possible challenges to roll-out in subsequent phases of facilities

Promote state ownership of the design choices and revised SOPs

- A small group of state agents should be involved in the initial selection of design choices and initial revision of SOPs presented to participants at the design and SOP revision workshops
- State ownership of the design choices and revised SOP will be vital to getting the state to sign off on commitments included in the communique at the end of the design workshop

Include community members at the diagnostics and design workshop to validate findings

- Community members should be present at the diagnostic and design workshop to share their experience with the healthcare system
- Shared experiences will help workshop attendees validate the diagnostic findings

Be strategic about the state agents involved in drafting and getting buy-in for commitments to include in the memorandum of understanding.

- The memorandum of understanding is a political document
- The team should staff the review committee with state agents who can push forward the conversation

4 Operationalization Phase

SECTION 4 SECTION OVERVIEW

Operationalization Phase

Objectives of playbook chapter

Describe core activities that each state needs to implement during the operationalization phase

Share findings and lessons learned from the operationalization phase of example states

Key activities

Quantification exercise

Capability building

Readiness verification

Materials included

Guidance on how to complete the quantification exercise

Training curriculum and job aids

Readiness checklist for CMS and health facilities

Operationalization Phase

During the operationalization phase, each state will engage in 4 major interactions, in addition to day-to-day activities to reach state-specific goals

Each state is planned to have four major interactions during this phase

A. Quantification exercise

Week long activity in each state inviting health system stakeholders to quantify the amount of commodities needed

B. Capacity Building

A comprehensive capacity building rollout covering State Governance Committees, Central Medical Stores and Health Facilities. Modules include Supply Chain and Financial Management

C. Readiness verification (CMS & Facility upgrades)

1-2 day visit in each state to include meetings with Governor, Honorable Commissioner for Health, and traditional rulers; personal inspection of readiness (e.g., CMS)

D. Seed stock release

Seed stock to be released to Central Medical Stores

Targets to be achieved by end of operationalize phase

Governance

Operationalization of DRF Committees

- Constitution of State DRF committees and sub-committees
- Inauguration of committees
- Orientation of committees as part of capacity building rollout
- Monitoring functionality of committees

DMA Law development/amendment

Operations

Execution of facility upgrades

Execution of CMS upgrades

Quantification of seed stock commodities

Capability building & rollout including tools

Staff reassignments across facilities

Seed stock released to CMS

4.1

Quantification exercise

The quantification exercise marks the beginning of the procurement process

Process	Responsible
1 Quantification	Central Medical Stores
2 Tendering	Procurement Sub Committee
3 Vendor Selection	Procurement Sub Committee
4 Purchase verification	Procurement Sub Committee
5 Vendor Management	Procurement Sub Committee

Quantification process

1. Preparation

- Assemble forecasting team
- Collect consumption data

2. Forecast

- Organise, analyse and adjust collected data
- Build forecasting assumptions
- Calculate forecasted assumptions

3. Supply Planning

- Build supply planning assumptions that define how and when the commodities would be supplied to the facilities
- Estimate the total quantity of commodities required
- Develop supply plan
- Compare costs to available funds

4.1

Quantification exercise

Calculate the amount of commodities needed to cover a specified period by the CMS and participating facilities

Data required

State Population data

List of Facilities and types

List of services provided at the facilities

Service catchment area by Facility

Service catchment area by LGA

Demographic Data

Disease Prevalence data

State MSP

Consumption data

NHMIS data

Forecasting assumptions (not exhaustive)

Calculations should ensure that the CMS and participating facilities can maintain the following stock levels for DRF commodities

Stock levels	Central Medical Stores	Secondary Health Facilities	Primary Healthcare centers
Maximum	8 months	4 months	4 months
Minimum	4 months	2 months	2 months
Emergency order	1 month	0.5 months	0.5 months

4.2

Capacity building

MORE IN APPENDIX

DRF capacity building efforts consist of three different training interactions, 2 of which occur during the operationalization phase

Training	Expected # of participants	Proposed duration	Knowledge transfer approach	Objective
1 Orientation of state DRF committee & sub committees and Local Government Health Authority (LGHA) DRF committee	50-70	2 days	Direct	Prepare the state DRF committee to perform its oversight function and orient the sub committees on their specific mandates & terms of reference.
2 Training of DMMA/ CMS staff	30-40	1 week	Direct	Equip DRF operators in the DMMA/CMS with the right stock management and financial management knowledge to run DRF effectively
3 Training of HF stakeholders (staff and facility DRF committee)[1]	6 - 10 per facility	4 weeks	Train the trainer	Equip DRF operators in health facilities with the right stock management and financial management knowledge to run DRF effectively

[1] This training takes place during the roll-out phase

4.2

Capability building

The training interactions use 16 modules to cover 4 DRF competence areas

	Modules	Committee orientation	CMS staff	HF staff
Governance	1 DRF overview and management structure (including committees)	✓	✓	✓
	2 Commodity selection (MNCH and non-MNCH commodities)	✓		
	3 Pricing & markup	✓	✓	✓
	4 Monitoring & evaluation	✓	✓	✓
	5 Consequence management	✓	✓	✓
	6 Contract management		✓	
Supply chain	7 Procurement (including bid process and vendor prequalification)	✓	✓	
	8 Good warehouse practices	✓	✓	
	9 Inventory management	✓		✓
Data Management	10 Reporting		✓	✓
	11 Stock management tools		✓	✓
	12 Financial management tools		✓	✓
Financial Management	13 Accounting process & procedures		✓	✓
	14 Financial reporting		✓	✓
	15 Financial planning & budgeting		✓	✓
	16 Deferrals and Exemption		✓	✓

4.3

Readiness verification

MORE IN APPENDIX

Each state must demonstrate readiness by accomplishing a set of predefined criteria

Readiness Criteria	Description	Measurement metric/Evidence required
Operationalization of DRF Committees	Selection, Notification and Orientation of the State DRF committee and its subcommittees, LGA DRF committees and facility DRF committees	Evidence of committee inauguration and minutes of inaugural meeting
Presence of management structure (DMA/DRF committee)	Presence of a management team (DMA and/or DRF Committee) to provide oversight function	Verified list of committee members with a memo from SMoH taking responsibility for DRF operations
Presence of robust operational guidelines	Availability of up to date operational guidelines to inform DRF operations in the CMS and heath facilities	Evidence of approved and validated SOP
Alignment on state and USAID commitments	Commitments from the state and USAID to implement the DRF in the facilities	Commitments included in signed communique and quadripartite Primary Health Care MoU
Upgrade of health facilities	Assessment, selection and commencement of necessary storage and security upgrades	Verification of upgrades in a sample size (25-30%) of facilities
Upgrade of CMS	Assessment and commencement of the CMS upgrade to meet minimum acceptable standards	Verification of upgrades in CMS
Opening of DRF accounts	Availability of at least 2 DRF accounts in all Phase 1 facilities as outlined in SOP	Verification of accounts (bank cheque) in a sample size (25-30%) of facilities
Staff redistribution	Deployment of relevant staff to meet requirements needed at CMS and health facilities	Evidence of staff redistribution plus verification through interviews/observation of sample
Capability building	Intensive stock and financial management training for all CMS and facility staff	Attendance sheets for all training sessions

4.4

Seed stock release

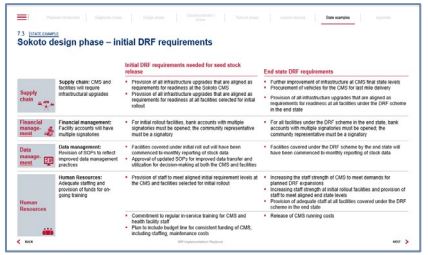
Jump to previewed page

To ensure timely release of seed stock to the CMS, the DRF procurement sub-committee should launch the procurement process for non-MNCH commodities as the state works towards meeting DRF readiness.

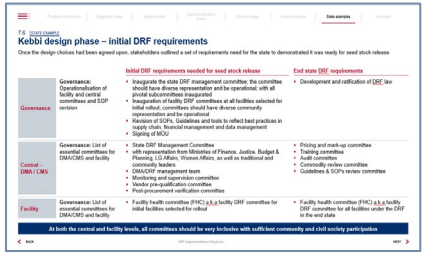
A State prepares for readiness verification

- Specific requirements for each of the 9 readiness criteria will vary from state to state
- Minimum viable product (MVP) across DRF governance and operations were determined at the end of the design phase

Sokoto - Initial DRF requirements needed for seed stock release



Kebbi - Initial DRF requirements needed for seed stock release

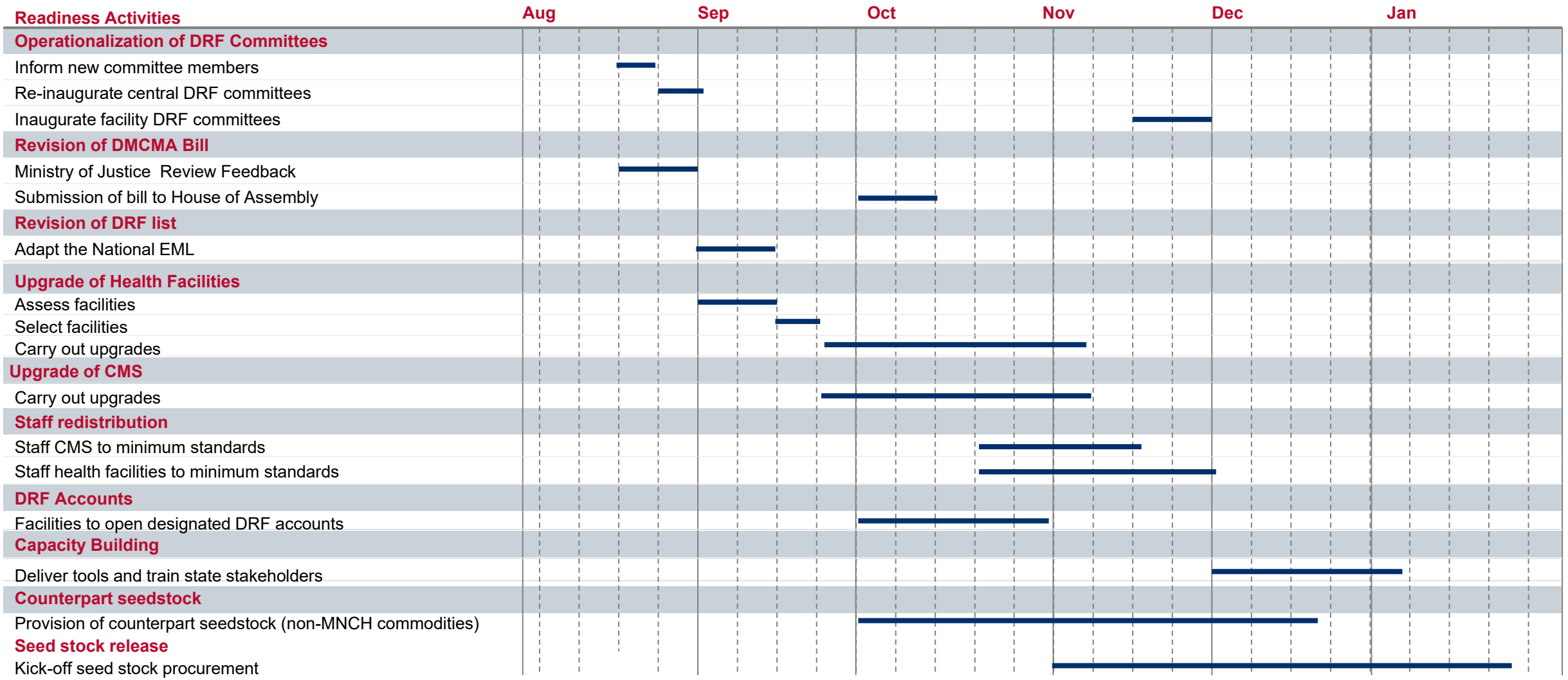


B DRF procurement sub-committee kicks off the procurement process after quantification exercise and approval from USAID

Process	Responsible
Tendering	Procurement Sub Committee
Vendor selection	Procurement Sub Committee
Purchase verification	Procurement Sub Committee
Vendor management	Procurement Sub Committee

4.5 ILLUSTRATIVE

Sample Workplan – readiness activities

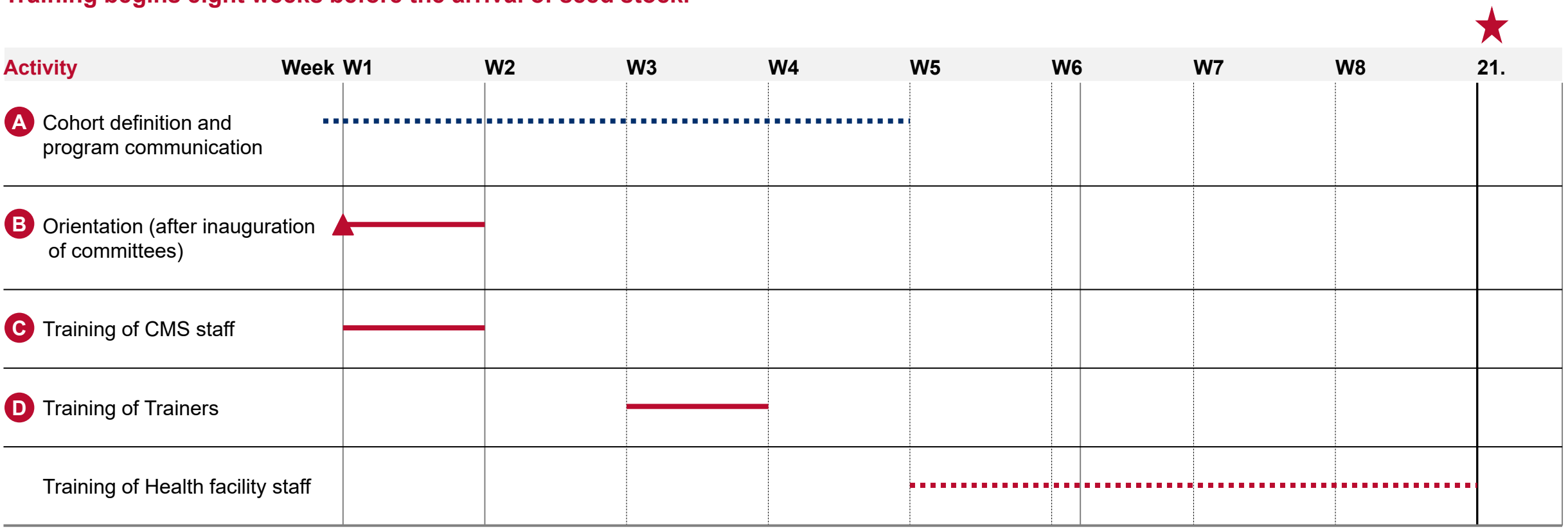


4.5 ILLUSTRATIVE

Sample Workplan – Capacity building

Inauguration ★ Seed Stock — Direct training - - - Step down training

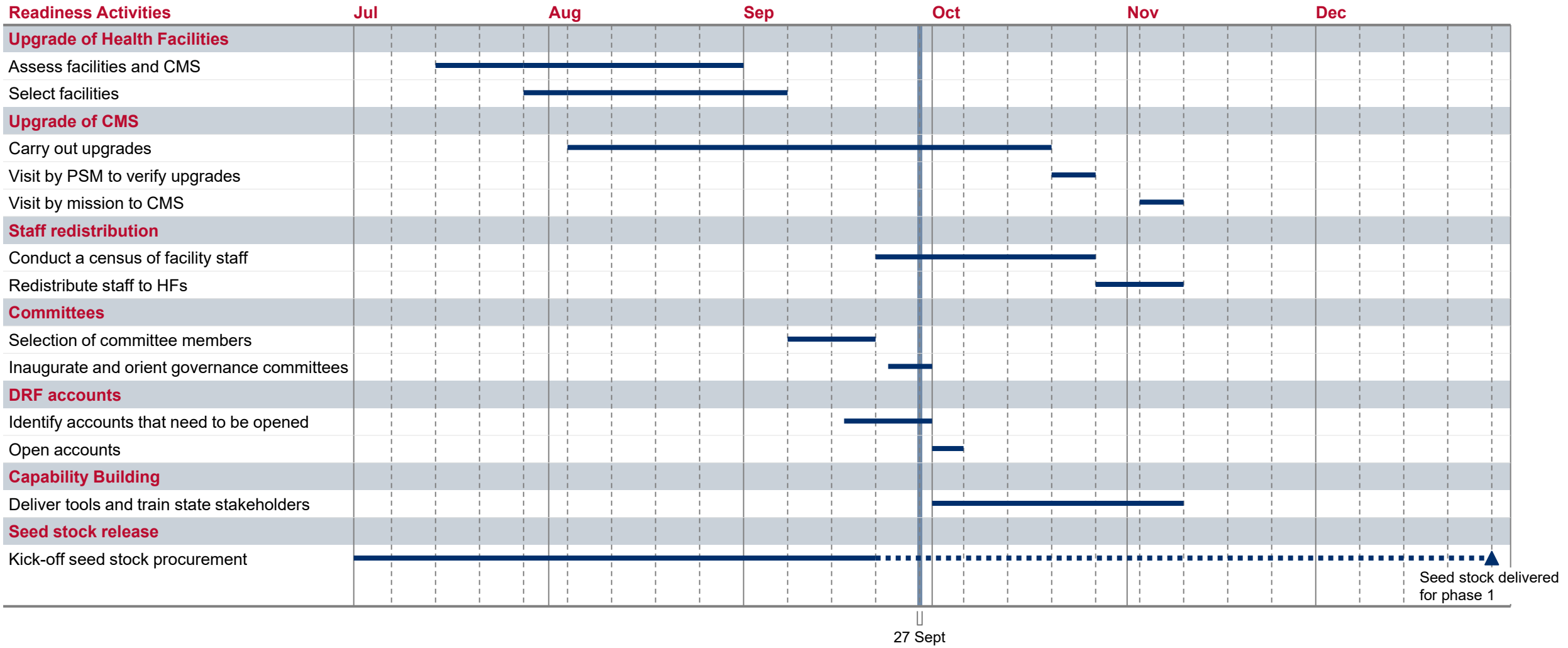
Training begins eight weeks before the arrival of seed stock.



4.6 ILLUSTRATIVE

State example – Bauchi readiness activities

These are highlights from how the state of Bauchi completed its operationalization phase



4.7

Lessons learned

Funding delays might slow down CMS and facility upgrades needed to reach DRF readiness

- Political and financial procedures might delay the release of funds needed for CMS and facility upgrades
- Involving the right state agents can help push forward the conversation

Engage legislators involved in passing revised DMMA law early on

- Legislators might not have been involved in the design phase
- The team should schedule enough time to explain the project and the proposed bill to legislators

Regularly update USAID Mission on state readiness for seed stock release

- The state lead USAID IP should regularly update the central team on the expected timeline for the state to achieve DRF readiness
- Any expected delays in seed stock release should be communicated to the state government in order to maintain trust in the collaboration

5 Roll-out Phase

5.1 Continued capacity building

5.2 Seed stock distribution

5.3 Monitoring and evaluation

5.4 Continuous system strengthening

SECTION 5 SECTION OVERVIEW

Roll-out Phase

Objectives of playbook chapter	Key activities	Materials included
Describe the process for the release of seed stock to facilities	Capacity building	Training curriculum and job aids
Describe ongoing activities that need to be carried out to support DRF sustainability	Seed stock release	CMS monitoring checklists
Share findings and lessons learned from the roll-out phase of example states	Monitoring and evaluation	Facility monitoring checklists
	Continuous system strengthening	

5.1

Capacity building - training health facility staff

MORE IN APPENDIX

Begin training health facility staff on DRF operations six weeks prior to the arrival of seed stock

Knowledge transfer approach

Train the trainer
A "DRF State expert" cohort will be trained as super users to champion adoption of best practice processes within their area of expertise

- 5-day training (training for 4 days and inauguration on 5th day)
- 2 – 4 facilities per cluster (depending on geography and number of staff in facility)

Expected number of participants

6 - 10 people per facility

Governance	Supply chain	Data management	Financial management
Modules			
DRF overview and management structure (including committees) Pricing & markup Monitoring & evaluation Consequence management	Inventory management	Reporting Stock management tools Financial management tools	Accounting process & procedures Financial reporting Financial planning & budgeting Deferrals and Exemption
Participating HF staff			
Pharmacist-in-charge Program Management Officer/ Chief Medical Director - in charge	Pharmacist in-charge Pharmacy Technicians	Storekeeper Service unit heads	DRF Accountant Cashier

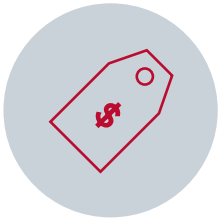
5.2

Seed stock distribution

The CMS completes four main activities before distributing seed stock to health facilities[1]

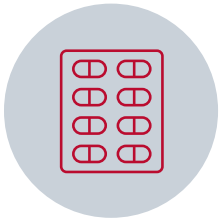
Set up for distribution

CMS and HFs put in place the infrastructure needed for last mile distribution from the CMS to HFs (trucks, drivers) or for HFs to pick up commodities from the CMS



Conduct market survey and set prices

Conduct market survey, set commodity prices, produce and distribute new price lists



Evaluate baseline stock at health facilities

Evaluate baseline stock at health facilities and adjust distribution plan

Complete HF training and distribution of tools

Complete training of HF staff and distribute tools and job aid required for stock management, financial management and data management

1. The four activities can be carried out concurrently

5.3

Monitoring and evaluation

There are two types of DRF M&E activities: Monitoring and Supervision and Performance Reviews

	Monitoring & Supervision	Performance Reviews
Objectives	Monitor and guide activities of CMS and facility staff with respect to the DRF Coach CMS and facility staff on best practices	Track financial and stock performance of CMS and facilities Provide feedback on performance of CMS and facility DRF operations
Frequency	Monthly for the first 3 months Bi-monthly for the next 9 months Quarterly subsequently	Monthly for facility DRF Committee internal reviews Tri-annually for State DRF Committee
Who is responsible?	DMMA management team Facility DRF Committee State DRF monitoring, evaluation and accountability subcommittee Local Government Health Authority DRF Committee	State DRF Committee

5.3

Monitoring and evaluation – CMS evaluation

MORE IN APPENDIX

The CMS will be evaluated at 2 levels on 3 key aspects: supply chain operations, financial management and stock management and reporting using a checklist

Level 1: Monthly DMMA management team

The DMMA Management team will supervise all units/departments within the DMMA to assess their performance. It is the responsibility of the store pharmacist and store officer to supervise all subordinates at the store.

Level 2: Quarterly State DRF monitoring, evaluation and accountability subcommittee

State DRF monitoring, evaluation and accountability sub-committee will be responsible for the 2nd level (external) monitoring and supervisory visit at the CMS and ZMS. The team will monitor and review all activities of the CMS/ZMS and DMMA

Supply Chain Operations

- The adherence to the DRF guidelines
- The availability of human resources at the CMS/ZMS
- The availability of tools used for recording the DRF process
- The procurement cycle process
- The process and method of receiving commodities
- The storage – adequate capacity, cleanliness and orderly arrangement of the commodities

Financial Management

- The adherence to the DRF Financial management guidelines
- The availability of tools used for documenting the financial aspect of the DRF
- The availability of bank account and its signatories
- The reconciliation of the DRF account and the stock at hand

Stock Management and Reporting

- The adherence to the DRF guidelines
- The availability of tools used for recording the DRF stock
- The stock level reports
- The report of drug expiries
- The storage – an adequate record of the commodities.
- Outbound registers

5.3

Monitoring and evaluation – health facility evaluation

Monitoring and evaluation of health facilities will occur at two levels: internally by the facility DRF committee and externally by the State/LGHA DRF Committee

Levels	Frequency	SHC	PHC
Level 1: Monthly facility (internal) review	Monthly	The **facility DRF committee** will conduct the periodic self-evaluation by supervising all units involved with the DRF in the facility to ensure adherence to guidelines. It is the responsibility of the **Facility in Charge** to supervise all subordinates at the health facility including Pharmacy unit to ensure compliance with protocols	
Level 2: State/ LGHA DRF Committee	First 3 months: Monthly Next 9 months: Bi-Monthly Subsequently: Quarterly	The **monitoring, evaluation and accountability sub-committee** in collaboration with Hospital Management Board will be responsible for the 2nd level (external) monitoring and supervisory visit at the secondary facility	**LGHA -DRF committee** will be responsible for the 2nd level (external) monitoring and supervisory visit at the primary facility

5.3

Monitoring and evaluation – health facility evaluation

MORE IN APPENDIX

Each facility will be evaluated on 3 key aspects: supply chain operations, financial management and stock management and reporting using a checklist

Supply Chain Operations

The adherence to the DRF guidelines

The availability of human resources (Pharmacist/Pharmacy Technician) at the facility

The availability of tools used for recording the DRF process

The procurement cycle and records of the facility

The process and method of receiving commodities

The storage – adequate capacity, condition, cleanliness and orderly arrangement of the commodities etc.

Financial Management

The adherence to the DRF Financial Management guidelines

The availability of tools used for recording finances of the DRF process

The availability of bank account and its signatories

The regulations of the Deferral and Exemptions (D&E) account

The reconciliation of the DRF account and the stock at hand

Stock Management and Reporting

The adherence to the DRF stock management guidelines

The availability of tools used for recording the DRF stock

The stock level reports

The report on expiries and damages

The storage – adequate records of the commodities.

Dispensing registers and delivery notes (RIRV-requisition issue and receive voucher)

5.3

Monitoring and evaluation – performance reviews

MORE IN APPENDIX

Objective	All facilities and the CMS/ZMS will conduct regular reviews of the DRF at each level. The objectives of these reviews are to track the progress of the DRF and to use information from reviews to improve the DRF
Who is responsible?	The **DMMA management team and the state DRF committee** will be responsible for the tri-annual review of the CMS/ZMS and facilities. The facility DRF committee will also be responsible for the 1st level (internal) review to assess themselves. This should happen monthly.
Types of performance reviews	**Stock review:** Review of stock management practices at facilities and the CMS by tracking certain indicators **Financial data review:** Review of financial performance and reporting at facilities and CMS

Stock review indicators	Financial review indicators
Reporting rate	Fund valuation form
DRF LMIS Monthly Report completion	Profit and loss
Appropriate stock levels	Transaction account
Tracer commodity stock levels	Profit and loss, cashflow and balance sheets
Total expiries	
DRF commodity storage conditions e.g. temperature	
Adherence to First Expired First Out (FEFO) principle	
Disparity between inventory and physical count	

5.3

Monitoring and evaluation – rewards and sanctions

MORE IN APPENDIX

The DRF operations should include a system for rewarding best performing staff and facilities annually and sanctioning offences

Rewards for Facilities and CMS/ZMS	Facilities should be rewarded based on high performances as displayed during assessments of the following: • The supply chain operations at the facility • The financial management operations at the facility • The stock management operations at the facility The State DRF Monitoring, Evaluation and Accountability Sub-committee or the LGHA DRF Committee should recommend the best performing facilities to State DRF Committee for rewards
Individual Rewards	Individuals involved in the DRF operation should be rewarded based on high performance in carrying out their duties as it relates to the DRF The DMMA should reward the best performing staff at CMS/ZMS The facility OIC recommends the best performing staff for the reward to the facility DRF Committee for action The specifications of the rewards will be determined by the State DRF Monitoring, Evaluation and Accountability Sub-committee.
Sanctionable offences	Examples of sanctionable offences include: • Inflation of prices of procurement • Irregular or wrong payments • Shortages or Losses of stock by the storekeeper • Shortage or Loss of cash by Cashier. Possible sanctions include: • Impose appropriate surcharge as determined by SPHCDA /HMB • Recovery of the amount involved and removal of the officer who certified the job. • Surcharge the affected officer and transfer to another schedule. • Shortage or Loss of cash by Cashier.

5.4

Continuous system strengthening

All stakeholders should continue to carry out system strengthening activities to scale up DRF to all health facilities

Universal system strengthening activities include facility upgrades, capacity building, staff redistribution

Facility upgrades

- Continue facility upgrades in Phase 1 facilities to attain DRF end-state requirements
- Start facility upgrades in facilities still preparing for roll-out

Capacity building

- Roll-out health facility training in next phase of DRF health facilities
- Support the governance structures with ad hoc capacity building

Staff redistribution

- Recruit and assign staff to facilities still preparing for roll-out

Other system strengthening activities vary by state but may include infrastructure development and legislation efforts

Infrastructure development

- Work with SMoH programs to address specific challenges in infrastructure such as cold chain storage for oxytocin

DMMA Law

- Continue to push revised DMMA law through State House of Assembly

6
Sustainment phase

6.1
Governance and operations activities

6.2
Ongoing stakeholder engagement

SECTION 6 SECTION OVERVIEW

Sustainment phase

Objectives of playbook chapter

Suggest activities that might be part of the sustainment phase

Key activities

DRF governance strengthening

DRF operations strengthening

Ongoing stakeholder engagement

6.1 NOT EXHAUSTIVE

DRF governance and operations sustainment activities

Activities carried out during this phase will enable the state reach the end-state requirements defined at the end of the design phase.

Governance

DMA Law
Continue to push for passage of DMA bill into law

Strengthening governance committees
Fully constitute all other DRF governing committees and provide governance committees with ongoing training and support

Monitoring and evaluation
Ongoing monitoring, evaluation and supervision that drives performance Phase and continuous improvement in the system

Operations

Infrastructure development
Further improvement of infrastructure at CMS and facilities to aligned end-state levels

Staff distribution
Increase staff strength across CMS and health facilities to meet future demands of the DRF

Capacity building
Provide regular in-service training for CMS and health facility staff

Data management
Promote regular use and analysis of stock and consumption data being collected from health facilities

6.1 NOT EXHAUSTIVE

Ongoing stakeholder engagement

The DMA/CMS should continue to engage all relevant stakeholders during this phase

Other state programs
Work with other state programs, like NSHIP, to ensure integration between the DRF scheme and these programs

Community
Monitor community acceptance of the DRF and encourage community leader participation in the DRF governance

Donors and implementing partners
Coordinate with donor and implementing partners to integrate parallel distribution systems and obtain technical assistance for governance and operations strengthening activities

7
Lessons learned

7.1
Lessons learned

7.1

Lessons learned

Throughout implementation, three groups of stakeholders are essential to successful DRF implementation and should be engaged early and regularly

State

- State ownership is needed to drive the entire process
- The state should be actively involved in each stage of DRF implementation
- The USAID team should develop a clear understanding of who the different state stakeholders are and what their role will be for DRF implementation

Community

- The community determines the extent to which the DRF scheme will be accepted and used
- Input from end-users should be part of the state diagnostic exercise and should be sought when designing the DRF scheme
- Community leaders should understand how the DRF scheme can benefit the community and what their role can be to make it a success

State partners

- State partners should engage the right state and community stakeholders
- USAID implementing partners should be given enough information and time to integrate DRF activities into their workplan and budget
- Partners with parallel supply chains for free drugs, like UNICEF and Plan International, will need to be consulted to understand how the parallel systems work and what the donor plans for transition to DRF over time

8 State Example

SECTION 8 SECTION OVERVIEW

State examples

SOKOTO STATE

8.1

Summary of Sokoto DRF implementation

A **Prior to the start of the project, there were four types of operational drug supply schemes in Sokoto.** In the absence of an at-scale, centralized DRF in Sokoto state, most facilities operated informal schemes following their own rules; some practices/challenges are shared

B **However, the state had begun to plan an at-scale centralized DRF and was already taking steps to strengthen its DRF governance structure.** A DRF steering committee and management committee for essential medicines had been established. Work had commenced towards the passage of laws required for the Sokoto State Drugs and Medical Supplies Management Agency (DMSMA) and the state was developing draft DRF Standard Operating procedures (SOPs) for the proposed DRF scheme. There was therefore an opportunity to support the state to accelerate DMSMA set-up and drive the right processes / systems.

C **The project engaged state and community stakeholders early on.** During the stake kick off, the project outlined four major areas in which it would need the state's commitment, and state leadership expressed a willingness to collaborate on the project, including contributing to seed stock. The project also held a separate workshop for community leaders during which the team laid out the pivotal role community leaders could play in DRF design, advocacy, and governance.

D **The state diagnostic revealed that Sokoto was making progress with strengthening its DRF governance structure, but further improvements could be made.** Sokoto had established 2 of 5 recommended standard minimum governance committees. The state was also developing guidelines for most governance activities, but execution was yet to begin. There were operational challenges across the supply chain including substandard quantification practices, delivery mechanisms, storage and data management. Additionally, markups varied across the state.

E **Based on these findings, the state decided on 4 key design choices, and identified risks and accompanying mitigation strategies for each choice.** For each of the components of DRF management (governance, supply chain management, financial management, data management and human resources), they identified initial DRF requirements needed for seed stock release and end-state DRF requirements. These were included in the communique and eventually in the MoU that was signed. The team helped Sokoto state to produce DRF operational guidelines for the DMSMA and heath facilities.

F **In preparation for the USAID mission visit, the project team and state drafted an MoU outlining project milestones and targets as well as the expected state and USAID commitments**. The state put together a high level workplan to demonstrate how it would achieve DRF readiness in the first phase of facilities to implement the DRF scheme.

8.1

History of DRF implementation in Sokoto

In the absence of an at-scale, centralized DRF in Sokoto state, most facilities operated informal schemes following their own rules; some practices/challenges are shared

Governance	With the exception of the few secondary facilities under the HMB DRF, virtually all facilities in Sokoto that had DRFs followed a very **decentralized model** with each facility making all decisions
	Ward Development Committees (WDC) had good structures that could be leveraged for **routine monitoring** of DRF operations at proximate facilities
Operations	With the exception of a few facilities, **stock and financial reporting were inconsistent** because of a **lack of training** and **lack of access** to **standard tools**
	Across the supply chain, facilities faced a range of challenges, from **poor quantification** to **lack of vehicles** for picking up commodities to **lack of adequate storage capacity**
Financial model	Only secondary facilities under the HSMB DRF had **externally-determined** mark-ups (set by the HSMB). Mark-ups in all facility-level DRFs were determined by the **facility staff** who were generally the **contributors** of the seed capital.
	Across all facilities with DRFs, a set **mark-up component** was paid to facility staff as **motivation;** a plurality of facilities had a **component** earmarked for **recapitalization**.

8.1

History of DRF implementation in Sokoto

Facilities either had one of four types of operational drug supply schemes or no DRF scheme

HMB	DRF at 6 SHCs for which the seed funding was provided by the state government and the administration was under the HMB. This system had faced several financial management challenges that had led to its failure
Community	Drug supply scheme for which seed funding was sourced through contributions from the community (often the Ward Development Committee) and given to selected facilities. In most cases, the WDC supervised the facility implementing such a scheme
Facility	Drug supply scheme for which seed funding was sourced through contributions from several facility staff who are the owners of the scheme. The owners may view their contribution as an investment (i.e., they share in profits) or a grant
Personal	Drug supply scheme for which seed funding was sourced by just one member of the facility, usually the OIC or the pharmacy personnel. These often operate as a “one-man,” for profit businesses
No-DRF	Facilities that do not have any form of DRFs operating

8.1

History of DRF implementation in Sokoto

There were, however, several ongoing activities geared towards the operation of a state-wide DRF in Sokoto state

Looking back…

In the past, there had been a number of interventions in the DRF space in Sokoto State

- **1988** – National Essential Drug Program DRF set-up following the Bamako initiative in 1987
- **1990** – An essential medicines DRF valued at N30 million was set up in old Sokoto State
- **2007** – National review of DRF projects conducted across states including Sokoto
- **2018 Q1** – USAID commissioned the Human-centered Design project which sought to understand key solutions to the MNCH supply chain in Sokoto; DRFs was identified as a major pillar for increased MNCH commodity availability and uptake
- **2018 Q2** – All facilities in Sokoto state were covered in the USAID MNCH lifesaving commodity quantification exercise
- **'18 Q4 – '19 Q1** – Development and roll out of MNCH data and commodity management system

…looking ahead

By the start of the project, the state government had taken steps towards strengthening a state-wide DRF in Sokoto

- Developed plans to establish a DMA by 2020
- Established DRF steering committee and management committee for essential medicines
- Conducted assessment of facility readiness for DRF piloting and selected 14 facilities across the state
- Started work towards the passage of laws required for the Sokoto DMSMA
- Developed a draft DRF Standard Operating procedures (SOPs) for proposed DRF scheme
- Started GIS mapping of facilities across the state

8.2

Sokoto diagnostics phase - overview

To come up with a comprehensive and accurate view of the drug supply chain governance and operations, the team engaged state stakeholders, community members and partners early on

State diagnostic	Interviewed 23 state stakeholders on DRF governance and operations Visited 1 tertiary health facility, 6 secondary facilities and 11 primary health facilities of various types (urban vs. rural, existing DRF, small vs. large, etc.) across the state Reviewed the DRF operational guidelines for the details on the DRF end to end supply chain process, financial, data and performance management at the state and facility level
Coordination with other programs	Met with staff from NSHIP and Plan International to learn about DRF schemes supported by these partners Met with Breakthrough Action Nigeria (BA-N) to discuss specific ways a partner could support DRF implementation • Sought BÁ-N's support in engaging community stakeholders (traditional leaders, ward health development committees, patients and families) to capture the community's view of a DRF scheme and appropriate deferral and exemption policies. • Asked BA-N to help develop behavior change and communication plans to help patients understand the value of purchasing quality products and to help with understanding and developing the optimal structures and systems for deferrals and exemptions Met with USAID Integrated Health Program (IHP) to discuss specific ways to support DRF implementation • Asked IHP to support with engaging facility staff in DRF design • Asked IHP to collaborate on developing a change management plan to prepare facility staff to operationalize DRF, and designing an accountability mechanism to optimize staff performance
Kick-off	Held kickoff meeting with >50 attendees including key state, community and partner stakeholders • State stakeholders : Commissioner for Health, Permanent Secretary MoH, DPS, DPRS, Director Public Health, DMA General Manager, LMCU Coordinator • Community leaders: WDC Chairman • Partners: NSHIP, PLAN,SOML, e-Health The state government participants clearly committed to supporting the scheme All participants engaged actively and asked relevant questions regarding the scope of the project and support to be provided

8.2 STATE EXAMPLE

Sokoto diagnostics phase – Kick-off event

PLAYBOOK

During its kickoff event, the team laid out four major areas in which the project would need the state's commitment

Director Pharmaceutical Services was to approve conversations with relevant stakeholders at all levels (state and LGA government departments and agencies, communities, private sector, health workers, etc.) so team could work with all to jointly identify solutions	Department of Health Planning, Research and Statistics was to grant continued access to all relevant data and sources of insight to be used in the system design and financial modelling	Honorable Commissioner for Health was to own and drive governance systems and processes needed to guarantee a sustainable DRF whose operation is autonomous	Leadership of the state (Governor, House, and all relevant ministries) were to own and drive the establishment and staffing of a DMSMA and any organizations needed to run DRF sustainably

It is important to clarify that the provision of seed-stock to Sokoto State was contingent upon the above commitments, as well as clear evidence of state readiness

8.2 STATE EXAMPLE

Sokoto diagnostics phase – community leader engagement

The team held a special workshop for community leaders during which it outlined the role that leaders could play in DRF design, advocacy, and governance

DRF design

Participate in workshops where the experience and knowledge of **community factors** are brought to bear in decision making

Ensure voice of the community is heard and ensure the **pain points** of patients accessing medicines are considered and incorporated in the DRF design

DRF advocacy

State leadership level: advocate to relevant state officials such as HCH, DPS, LMCU coordinator, DMA to hold community leaders accountable through **state DRF committees**

Local leadership level: advocate to LGA officials and facility staff to sustain momentum in driving DRF operations through **facility DRF committees**

Patient level: sensitize patients on the importance of accessing **quality assured commodities** at the facilities

DRF governance

Be members of new DRF governance structures to provide oversight functions and **monitor DRF performance** at the state and facility level

Use existing governance structures (e.g., WDCs) to provide **oversight functions** and monitor DRF performance

8.2 STATE EXAMPLE

Sokoto diagnostics phase – facility diagnostic

HMB DRF | Facility DRF | Community DRF | Personal DRF | No DRF

Local partners visited 19 health facilities of various types (tertiary, secondary, primary, urban, rural, existing DRF, no DRF, small and large) across the state

				Was this program covered under DRF?[2]		
Facility Type	Facility name	Staff size[1]	DRF type	Ante-Natal Care	Labor/ Deliveries	Post -Natal Care
Tertiary	Specialist Hospital, Sokoto	21	Facility DRF	✓	✓	✓
Secondary	General Hospital, Gwadabawa	20	Facility DRF	✓		✓
	General Hospital, Illela	19	HMB DRF	✓		✓
	WCWC Kanwuri	75	No DRF			
	General Hospital, Tangaza	11	Facility DRF	✓	✓	✓
	General Hospital, Tambuwal	24	Facility DRF	✓		✓
	General Hospital, Shagari	11	Facility DRF	✓	✓	✓
	Maryam Abacha Hospital	11	Personal DRF	✓	✓	✓
Primary	Jabo PHC	10	Facility DRF	✓	✓	✓
	PHC Sanyinna	8	No DRF			
	Dandin Mahe PHC	8	Facility DRF	✓	✓	✓
	Kajiji PHC	5	No DRF			
	Araba PHC	7	Personal DRF	✓	✓	✓
	PHC Asara	5	Facility DRF	✓	✓	✓
	Gigane Health Post	8	Facility DRF	✓		
	PHC Ambarura	8	Community DRF	✓	✓	✓
	Gidan Dare PHC	11	Facility DRF	✓	✓	✓
	Kofar Kade PHC	12	Facility DRF	✓		
	PHC Mongonho	1	Personal DRF	✓	✓	✓
	PHC Gidan Madi	1	No DRF			

Routine immunization and HIV (PMTCT) commodities were offered for free in all relevant facilities. Family Planning, nutrition, and tuberculosis commodities were not included in the DRF as they were mostly supplied for free by donors and the state

1 Morning shift only 2 Facilities that did not cover selected programs under DRF either did not offer the service at all or had received commodities provided by state/donor

8.2 STATE EXAMPLE

Sokoto diagnostics phase – findings

Findings from the diagnostic phase highlighted that Sokoto was already planning for an at-scale centralized DRF and that state leadership was excited to participate in this project, including contributing to seed stock

	Major insights
Governance	**State government had taken steps towards formal DRF** • **A DRF committee** (with SPHCDA, HMB, THC, Committee representatives) already existed • **Had developed centrally-run DRF in 10 SHCs**, led by the HMB (many PHCs still had informal/decentralized facility-based DRFs) • **There was statewide multi stakeholder support for a DMSMA** in 2020 • The state government had committed to **providing additional seed stock** to support the project
Operations	**There were operational challenges across the supply chain** • ~90% of facilities surveyed had substandard **quantification** practices • Poor **delivery mechanisms** & inadequate **storage** capacity across most facilities surveyed • ~95% of facilities surveyed had inconsistent **stock and financial reporting** (lack of training or access to tools) • Parallel supply chains with free essential medicines existed
Financial model	**There were different markups across the state**: HMB DRF facilities had externally-determined mark-ups (set by HMB); facility-based DRF markups were set by each facility's staff In 100% of DRFs irrespective of type; a component of the mark-up was paid to facility staff as **motivation** and **profits are shared** by contributors of seed stock

Quick Wins following the diagnostic

Accelerating the **establishment of** DMSMA**, CMS** and other proper systems and structures

Working towards an **MoU** with the state government to serve as a terms of reference

Developing **facility readiness plan** (e.g., building required facility-level systems and structures)

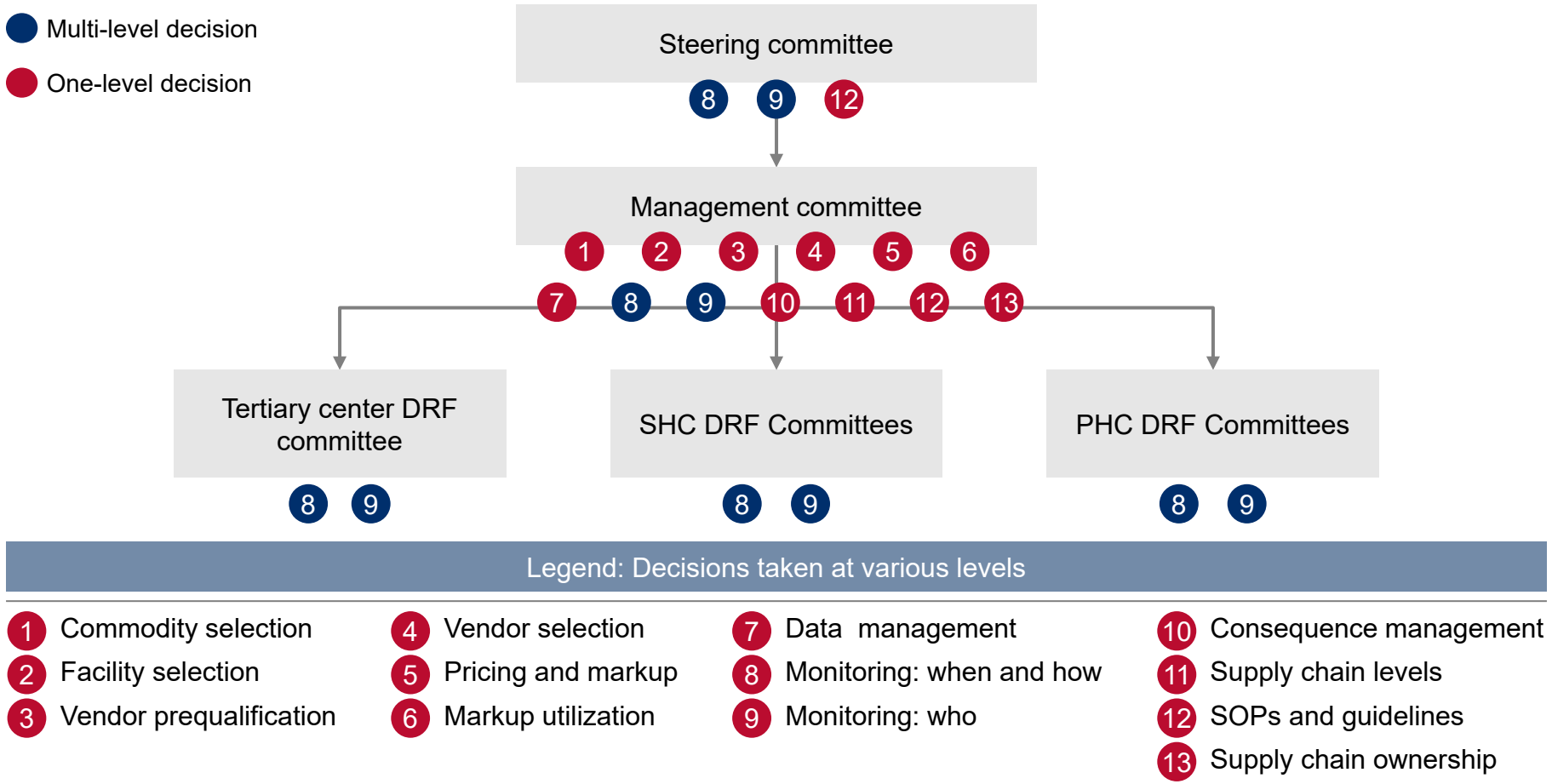
Commencing staff training on improved **data management and utilization practices**

Sokoto State has 741 PHCs, ~20 SHCs

8.2 STATE EXAMPLE

Sokoto diagnostics phase – findings on DRF governance

Two committees were set up to oversee the state's DRF, with most governance decisions taken by the management committee



To oversee the scheme and handle governance decisions, two committees were set up: **(1.) The Steering Committee**, **comprised of 8 senior leaders** from the SMoH, HMB, SPHCDA, Sultanate Council, etc. **(2.) The Management Committee, composed of 10 operational staff** from the SMoH, CMS, HMB and SPHCDA.

The number of people in these committees and the number of agencies represented appeared adequate, however these committees were yet to be functional

The state would need to establish 3 additional priority subcommittees (**Monitoring and Supervision Sub-committee, Vendor Pre-Qualification, Post-procurement verification)** to meet criteria for initial requirements

8.2 STATE EXAMPLE

Sokoto diagnostics phase – findings on DRF governance

While the committees were being inaugurated, there were few guidelines for the decisions these committees had to make

Strength of guidelines or execution

● Strong ● Medium ● Poor ● Non-existent

	Activity	Existence of a body to take the decision	Staffing of the body	Inclusiveness of the body	Policies and guidelines	Execution of guidelines	Comments
Coverage	1 Commodity selection	●	●	●	●	●	▪ **Current guidelines stated that the essential medicines list will be used,** but this had not been implemented
	2 Facility selection	●	●	●	●	●	▪ **Guidelines for facility selection only followed a rule-of-thumb approach** of all SHCs and 1 PHC per ward
Vendor Governance	3 Vendor prequalification	●	●	●	●	●	▪ **Guidelines stated a 'restricted competitive tender'** with at least 6 invited suppliers. For emergency procurement, three prequalified vendors were to be contacted. ▪ **Method of prequalification was not stated**
	4 Vendor selection	●	●	●	●	●	
Pricing	5 Pricing and markup	●	●	●	●	●	▪ Guidelines state **'complete cost-recovery plus 30% mark-up'** for CMS. **This was untenable**, especially when facility mark-up (which is not specified) was added ▪ Nothing was stated for the utilization of mark-ups
	6 Markup utilization	●	●	●	●	●	
Monitoring & Accountability	7 Data systems	●	●	●	●	●	▪ **Data collection tools were clearly stated,** but no details on reporting mechanisms. Tools were also not available
	8 Monitoring: how?	●	●	●	●	●	▪ **There was a clear monitoring and evaluation cadence,** but there were no key performance indicators (KPIs) and roles were not allocated ▪ **There were also clearly spelt out sanctions, but not for rewards**
	9 Monitoring: who?	●	●	●	●	●	
	10 Consequence management	●	●	●	●	●	
Supply Chain Governance	11 Supply chain levels	●	●	●	●	●	▪ **Guidelines defined a 2-tier supply chain (CMS – facility)** ▪ **There were some guidelines for warehousing,** but nothing for distribution ▪ State had sole ownership of CMS
	12 SOPs and Guidelines	●	●	●	●	●	
	13 Supply chain ownership	●	●	●	●	●	

8.2 STATE EXAMPLE

Sokoto diagnostics phase – findings on DRF operations

1. Supply chain summary

Guidelines for some supply chain activities but needed to be improved

Strength of guidelines or execution

Strong Medium Poor Non-existent

		Guideline quality	Execution Quality	Comments
Central level	A Forecasting	Non-existent	Non-existent	▪ The CMS guidelines did not have any details on how the CMS should forecast. At the time, the CMS did not undertake any procurement for the state, so forecasting was not needed
	B Procurement	Poor	Poor	▪ Since the CMS did not procure, the CMS guidelines did not provide any detail into the prequalification and tender assessment processes. While the SMOH did ad-hoc procurement, the processes involved were very vague
	C In-bound logistics	Non-existent	Strong	▪ Existing guidelines did not give any information on in-bound logistics. The vendors supplied commodities directly to the CMS with limited visibility into vendor management
	D Warehousing	Poor	Medium	▪ Existing guidelines provided few details on warehousing subprocesses. The CMS had satisfactory processes for inventory reporting & waste management. While the CMS had adequate storage capacity for Phase 1, more space and shelving capacity would be needed in the future
Health facility level	E Procurement	Non-existent	Poor	▪ The existing guidelines provided few details on facility procurement. ▪ In the existing HMB DRF operating in only 6 SHCs, facilities procured directly from state prequalified vendors with limited oversight of the processes followed
	F Delivery to HF	Non-existent	Poor	▪ Existing guidelines proposed a “push” delivery system but were light on details on key topics such as routing, driver optimization, etc. The CMS also did not have dedicated vehicles/drivers and thus borrowed SMOH vehicles for the ad-hoc delivery of free commodities
	G Storage	Poor	Poor	▪ Existing guidelines had very little detail about key topics such as – delivery audits and stock reporting as well as waste management ▪ In addition to having inadequate storages spaces, most facilities did not enforce good storage and waste management practices

8.2

Sokoto diagnostics phase – findings on DRF operations

2. Financial management summary

Guidelines for some financial management activities but were inadequately executed and needed to be improved

Strength of guidelines or execution

Strong | Medium | Poor | Non-existent

		Guideline quality	Execution Quality	Comments
Central level	A Budgeting	Non-existent	Non-existent	▪ There were no guidelines to inform the budgeting process at the CMS ▪ The CMS did not develop a budget for its operations but relied on budgetary allocations of the Department of Pharmaceutical Services of the SMoH
	B Expense management	Poor	Non-existent	▪ There were poorly detailed guidelines that specified that withdrawals from the DRF account must be for drug replenishment ▪ The CMS did not engage in payments to commodity suppliers yet
	C Sales management	Poor	Non-existent	▪ Guidelines specified that a DRF officer should make daily lodgment of revenue to the DRF account ▪ The CMS did not sell commodities to health facilities yet, thus there was no existing practice of revenue management
	D Budget Review	Non-existent	Non-existent	▪ There were no guidelines to inform the budget review process at the CMS ▪ Budget reviews were dependent on processes initiated by the SMoH
Facility level	E Sales management	Medium	Poor	▪ There were poorly detailed guidelines that informed revenue management process such as banking & funds management. ▪ Facilities did not operate separate DRF bank accounts and did not conduct reconciliations. Few facilities generated receipts as stipulated in the guidelines
	F D&E management	Non-existent	Poor	▪ There were no guidelines on the management of deferrals and exemptions at the facilities. ▪ In practice, facility OICs determined who received exemptions and deferrals. There were no financial treatments employed when deferrals were given.
	G Expense management	Poor	Non-existent	▪ Guidelines stipulated that signatories to accounts should approve payments ▪ Most facilities arbitrarily managed expenses – they did not follow any particular order

8.2

Sokoto diagnostics phase – findings on DRF operations

3. Data management summary

Guidelines for data management needed to be created

Strength of guidelines or execution: Strong, Medium, Poor, Non-existent

	Guideline quality	Execution quality	Comments
A **Stock and consumption data**	Poor	Poor	▪ There were poorly detailed guidelines stipulating the stock management tools at the secondary and primary facilities ▪ Stock data reporting was done only for donor-supported programs (which were separate from DRF commodities) in the state and sent to the LMCU via the respective LGA program focal persons. Facilities did not prepare stock reports on DRF commodities
B **Logistics data** (e.g., on-time delivery rate)	Non-existent	Non-existent	▪ There were no guidelines on and reporting of logistics data
C **Financial data**	Non-existent	Poor	▪ There were no guidelines on financial data reporting ▪ The CMS did not produce financial reports. However, few facilities reported occasionally while most did not report, and health facilities did not produce financial management reports either because of the lack of tools and trainings or poor accountability mechanisms

8.2 STATE EXAMPLE

Sokoto diagnostics phase – findings on DRF operations

Human Resources CMS: current state

Strong Medium Poor Non-existent

The CMS procurement team was well staffed and trained but other teams lacked both personnel and training

	Ideal requirement	Observed situation	Trained (Y/N)	Rating
Procurement	▪ DMMA MD ▪ Pharmacist (x4) ▪ Pharmacy technician (x4) ▪ Others (x4)	▪ CMS Director ▪ Pharmacist (x3) ▪ Pharmacy technician (x4)	▪ Yes ▪ Yes ▪ Yes	
Inspection / monitoring / evaluation	▪ Director ▪ Deputy director ▪ Planning officers (x2) ▪ M &E officer (x2)	▪ None	▪ N/A	
Administrative	▪ Director ▪ Conference secretary ▪ Stock officers (x2) ▪ Clerk/clerical assistant (x5) ▪ Store assistant (x9) ▪ Security officer (x 7)	▪ HOD Admin ▪ Store officer ▪ Security personnel (x4)	▪ Yes ▪ No ▪ Yes	
Finance	▪ Chief Accountant ▪ Accountant officers (x2) ▪ Cashier (x3)	▪ None	▪ N/A	
Audit	▪ Chief internal auditor ▪ Audit Assistant (x2)	▪ None	▪ N/A	

8.3 STATE EXAMPLE

Sokoto design phase – proposed design choices

From the diagnostic findings, the team proposed a set of design choices that were presented to stakeholders during the design and diagnostics phase

Preferred

		Vs	
A	CMS initiated distribution (last mile distribution from the central store to HFs)		Collection by Facilities (each HF picks up commodities from the central store)
B	HFs buy from central store on credit		HFs pay central store upfront (“cash and carry”)
C	Two layered supply chain (CMS →Zonal/LGA → HFs)		Single layered supply chain (CMS→HFs)
D	Variable Markup		Single Markup

8.3 STATE EXAMPLE

Sokoto design phase – benefits and drawbacks of design choices (1/2)

The team outlined the benefits and drawbacks of each design choice

In Sokoto, the SOP for DRF operations stated “Cash and Carry” as the payment model of choice[1]

Cash and Carry	A payment system that requires health facilities to make upfront payment to the central medical before receiving commodity orders
Benefits	• Enables smooth cash flow between facilities and CMS • Provides facilities with the option to collect drugs directly from CMS • Access to timely availability of funds for DRF operations • Builds the capacity of health facility staff in financial management • Requires minimal monitoring from the CMS • Promotes ownership of HFs to improve quality service delivery
Drawbacks	• Delayed reimbursement from health insurance payments could lead to liquidity challenges • Uncontrolled access to engagement of unapproved vendors • Increased risk of diversion of funds

In Sokoto, the SOP for DRF operations suggested Single mark up as the pricing system of choice[2]

Single mark up	The use of a standard mark up on all commodities in the DRF system without considering the impact on high cost commodities or cost of distribution for hard-to-reach health facilities
Benefits	▪ Uniformity in the pricing of drugs across facilities ▪ Creates transparency and build patients’ trust in the DRF system ▪ Makes financial monitoring and evaluation easier centrally and at facility levels ▪ Simplifies the process of determining and reviewing prices for all classes of drugs
Drawbacks	▪ Reduces the demand for drugs with high-cost price because they become even more expensive at point of service ▪ Eliminates consideration for variable factors such as the distribution cost, patient’s purchasing power and market dynamics ▪ Encourages unfavorable practices in facilities that do not find the single pricing system favorable

1. An alternative design option is a credit system that allows facilities to purchase drugs from the CMS on credit, payment is made after drugs are sold
2. An alternative design option is different markups based on commodity price or location of facilities

8.3 STATE EXAMPLE

Sokoto design phase – benefits and drawbacks of design choices (2/2)

The team outlined the benefits and drawbacks of each design choice

In Sokoto, the SOP for DRF operations suggested a single-layered supply chain system design choice

Single- layered supply chain system	Drugs will be delivered from the CMS directly to the facilities.
Benefits	• Lower maintenance costs for the CMS compared to a multi-layered supply chain system • Allows for more efficient logistics data collection as there are fewer points of data entry (facilities and the CMS) • Allows LGAs to focus on monitoring DRF operations at facility level • If properly managed, a single layered system could have a more efficient distribution system than a multi-layered system
Drawbacks	• Increased cost of transport logistics for facilities • With only one central store, the state could face concentration of risks if there is a system failure or mishap at the CMS • Due to long travel time and distance, facilities could prefer to purchase directly from other suppliers

In Sokoto, the SOP stated "Collection by Health Facilities" as a distribution design choice[1]

Single mark up	The use of a standard mark up on all commodities in the DRF system without considering the impact on high cost commodities or cost of distribution for hard-to-reach health facilities
Benefits	▪ Unburdens a developing CMS from the responsibility of last mile distribution ▪ Gives facilities more agency
Drawbacks	▪ Less efficient and possibly more expensive as the gains from route optimization are lost ▪ Requires health facility staff to abandon their post for commodity collection which will affect service delivery ▪ Requires health facilities to have a mode of transportation

1. An alternative design option is last mile distribution by the CMS

8.3 STATE EXAMPLE

Sokoto design phase – final design choices

After deliberation, stakeholders accepted all but one of the originally recommended design choices, and laid out the risks and risk mitigation strategies for each step

Design choice	Risks	Mitigation strategies
CMS initiated distribution (last mile distribution from the central store to HFs)	▪ Lack of funds to procure vehicles for last mile delivery	▪ In the short term, leverage SMOH vehicles for distribution ▪ In the medium term, distribution will be outsourced to 3PLs ▪ In the long term, the state wants to procure vehicles
Single Markup	▪ Higher transport cost for facilities in hard-to-reach areas	▪ CMS assumes the costs of distribution and operates a km-based reimbursement system for HFs ▪ HFs supplementing distribution costs with HF service accounts ▪ Bulk purchasing and application for tax holidays to ensure prices remain more competitive than open market and conducive for the end-user
Single layer supply chain (CMS → HFs)	▪ Difficulty accessing the CMS and vice versa	▪ Support CMS operations by instituting zonal stores and leveraging warehouse information management systems (WMS) to strengthen data management processes ▪ In the interim, options discussed include: – Leveraging SHCs as a distribution hub for surrounding PHCs – In the interim, selecting facilities close to the CMS for pilot
HFs pay central store upfront ("cash and carry")	▪ Delayed reimbursement by health insurance agency	▪ All states aligned on cash and carry as a payment model. However, when insurance is launched: – Agreement between SPHCDA and health insurance agency specifying reimbursement schedule with oversight from State DRF committee – Credit agreement between CMS and HFs – Strong financial management policies to prevent illicit practices

8.3 STATE EXAMPLE

Sokoto design phase – initial DRF requirements

PLAYBOOK

Once the design choices had been agreed upon, stakeholders outlined a set of requirements for the state to demonstrate it was ready for seed stock release

	Initial DRF requirements needed for seed stock release	End state DRF requirements
Governance	▪ Inauguration of state DRF management committee; the committee should have diverse representation and be operational; with all pivotal subcommittees inaugurated ▪ Inauguration of facility DRF committees at all facilities selected for initial rollout; committees should have diverse community representation and be operational ▪ Revision of SOPs, Guidelines and tools to reflect best practices in supply chain, financial management and data management ▪ Revision of essential medicines list ▪ Signing of MOU	▪ Passage of the DMSMA bill into law ▪ Fully constitute all other DRF governing bodies/committees
Central – DMA / CMS	▪ State DRF Steering Committee – With representation from Ministries of Finance, Justice, Budget & Planning, LG Affairs, Women Affairs, as well as traditional and community leaders ▪ DRF management committee ▪ Monitoring and supervision committee ▪ Procurement sub-committee	▪ Pricing and mark-up committee ▪ Training committee ▪ Audit committee ▪ Commodity review committee ▪ Guidelines & SOPs review committee
Facility	▪ Facility health committee (FHC) or facility DRF committee for initial facilities selected for rollout	▪ Facility health committee (FHC)or facility DRF committee for all facilities under the DRF in the end state

At both the central and facility levels, all committees should be very inclusive with sufficient community and civil society participation

8.3 STATE EXAMPLE

Sokoto design phase – initial DRF requirements

PLAYBOOK

		Initial DRF requirements needed for seed stock release	End state DRF requirements
Supply chain	**Supply chain:** CMS and facilities will require infrastructural upgrades	▪ Provision of all infrastructure upgrades that are aligned as requirements for readiness at the Sokoto CMS ▪ Provision of all infrastructure upgrades that are aligned as requirements for readiness at all facilities selected for initial rollout	▪ Further improvement of infrastructure at CMS final state levels ▪ Procurement of vehicles for the CMS for last mile delivery ▪ Provision of all infrastructure upgrades that are aligned as requirements for readiness at all facilities under the DRF scheme in the end state
Financial management	**Financial management:** Facility accounts will have multiple signatories	▪ For initial rollout facilities, bank accounts with multiple signatories must be opened; the community representative must be a signatory	▪ For all facilities under the DRF scheme in the end state, bank accounts with multiple signatories must be opened; the community representative must be a signatory
Data management	**Data management:** Revision of SOPs to reflect improved data management practices	▪ Facilities covered under initial roll out will have commenced bi-monthly reporting of stock data ▪ Approval of updated SOPs for improved data transfer and utilization for decision-making at both the CMS and facilities	▪ Facilities covered under the DRF scheme by the end state will have commenced bi-monthly reporting of stock data
Human Resources	**Human Resources:** Adequate staffing and provision of funds for on-going training	▪ Provision of staff to meet aligned initial requirement levels at the CMS and facilities selected for initial rollout	▪ Increasing the staff strength of CMS to meet demands for planned DRF expansions ▪ Increasing staff strength at initial rollout facilities and provision of staff to meet aligned end state levels ▪ Provision of adequate staff at all facilities covered under the DRF scheme in the end state
		▪ Commitment to regular in-service training for CMS and health facility staff ▪ Plan to include budget line for consistent funding of CMS; including staffing, maintenance costs	▪ Release of CMS running costs

8.3 STATE EXAMPLE

Sokoto design phase – initial DRF requirements

PLAYBOOK

Upgrades at the CMS were to be done in 2 phases

		CMS initial requirement	CMS end state requirement
Cooling	Refrigerator	✓	
	Freezer		✓
Operational tools	Fork lifts		✓
	Shelves		
	Air conditioner		
	Hygrometer	✓	
	Trolleys	✓	
	Ladder	✓	
Power	Generating set		✓
	Solar power	✓	✓
Transport	Vans		✓

8.3 STATE EXAMPLE

Sokoto design phase – initial DRF requirements

PLAYBOOK

Health facility upgrades in Sokoto were in two phases with the preliminary phase focusing on the most critical aspects for health facilities

		Initial requirement		End state requirement	
		SHCs	PHCs	SHCs	PHCs
Cooling	Refrigerator			✓	
	Cooling Flasks				✓
Operational tools	Shelves	✓	✓		
	Air conditioner			✓	
	Hygrometer			✓	
	Thermometer				
Power	Generating set	✓			✓
	Solar power			✓	✓
Transport	Buses, Vehicles	✓			
Security	Burglary	✓	✓		

8.3 STATE EXAMPLE

Sokoto design phase – initial DRF requirements

PLAYBOOK

In the long term, the finance and admin departments of the CMS and facilities would need to be staffed with trained personnel

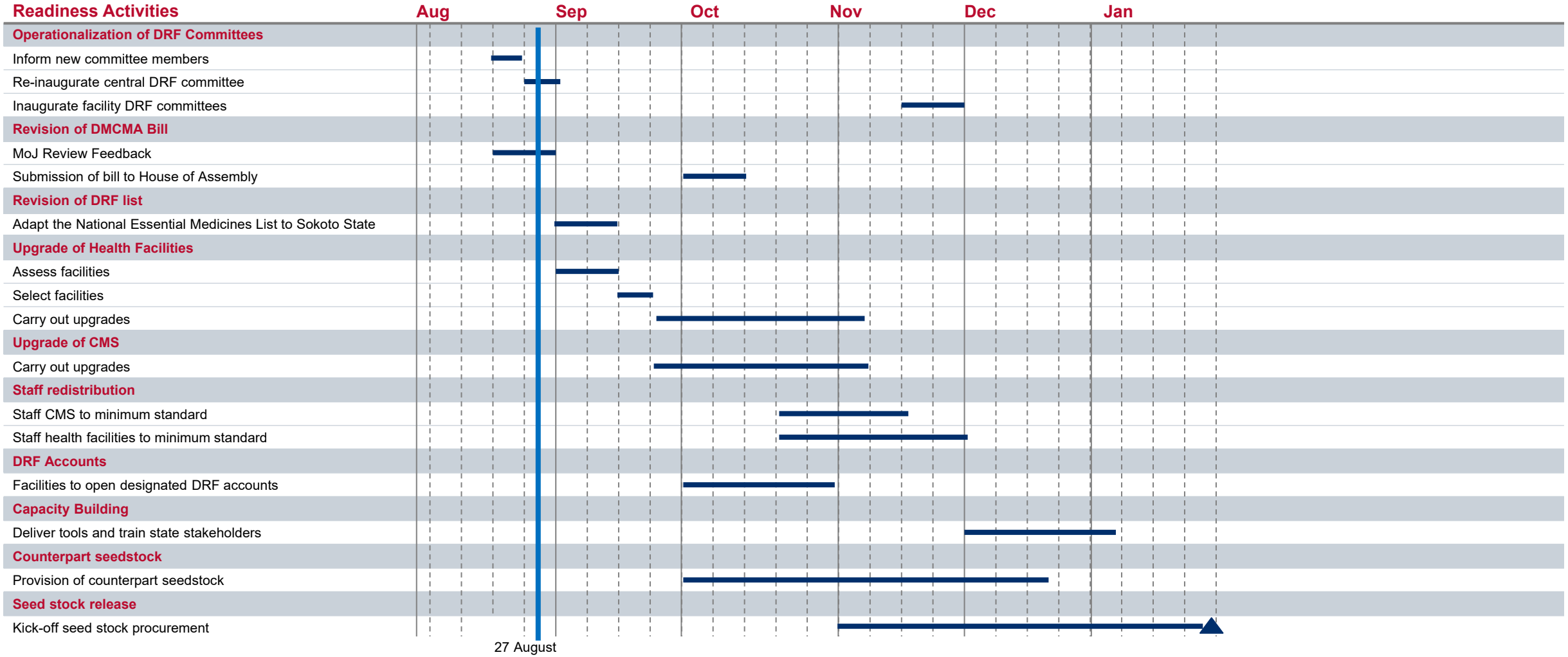
	Immediate hiring needs	End state hiring requirement
CMS	▪ Inspection department: Director and 2 M&E officers ▪ Admin department: Director of Administration and Finance, security staff and store assistants ▪ Finance department: Cashier and accountant ▪ Internal Audit – Chief Auditor	▪ Inspection Department: Deputy director ▪ Admin Department: Drivers and clerks ▪ Assistant auditor
Secondary health facility	▪ The following staff to be hired in **facilities selected for initial rollout –** – Cashiers	▪ The following staff to be hired in **facilities selected for initial rollout –** – Additional medical officer – Additional nurses/midwives – Additional accountant – Additional CHEW/JCHEW
Primary health facility	▪ The following staff to be hired in **facilities selected for initial rollout –** – 1 cashier	▪ The following staff to be hired in **facilities selected for initial rollout –** – 1 pharmacy technician ▪ The following staff to be hired in **facilities for all facilities covered by end state –** – 1 cashier – 1 pharmacy technician

Across board, staff will need to be trained on best practices in their respective roles

8.3 STATE EXAMPLE

Sokoto design phase – workplan

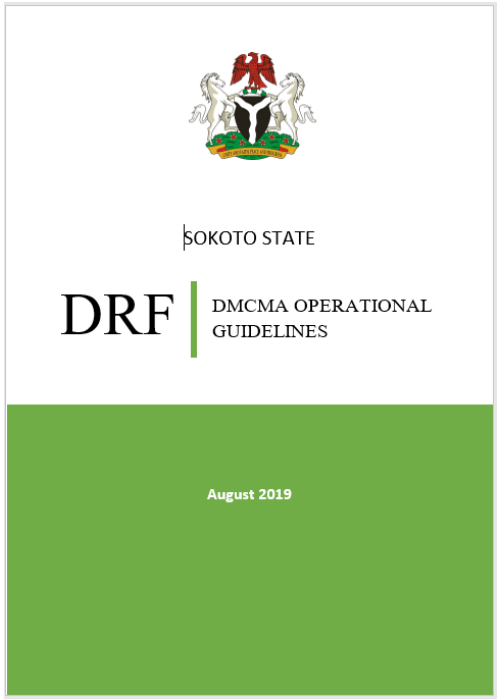
Stakeholders aligned on a work plan that would enable the state be ready for seed stock release in 6 months



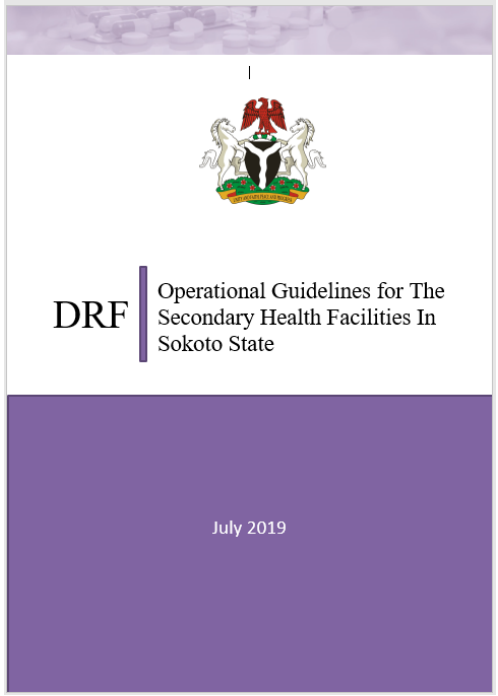
8.3

Sokoto design phase – SOP revision workshop

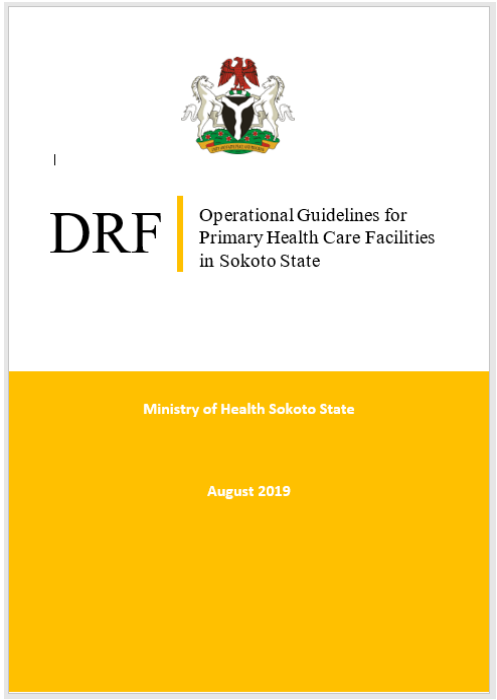
By the end of the design phase, the state had produced revised SOPs for the DMSMA, secondary health facilities and primary health facilities, and drafted a bill



Operational guidelines for the DMSMA in Sokoto state



Operational guidelines for the secondary health facilities in Sokoto state



Operational guidelines for the primary health facilities in Sokoto state

Institutionalizing the DRF

SMOH drafted a bill and sent to the Ministry of Justice. At the time it was sent, state stakeholders were confident that the bill would be ratified in a short period of time

8.3 DRAFT

Sokoto design phase – MoU milestones and targets

The team and state stakeholders also began putting together milestones and targets for strategic procurement and supply chain management and coordination that would be included in the quadripartite PHC MoU

End of year one

LMCU/CMS has an established organizational structure with defined structures

End of year two

Full end-to-end supply chain data visibility; data used for supply chain decision making

Review of essential health commodities and vaccines list in line with current needs in Sokoto State

.

Between year three and year four

Progressive reduction in stock-out rate at health facilities to less than 5 percent

Improved health facility reporting rate

Reduction in expiry of commodities (less than 1 percent)

SECTION 8 | SECTION OVERVIEW

State examples

KEBBI STATE

8.4

Summary of Kebbi DRF implementation

A **Prior to the start of the project, there were three types of operational drug supply schemes in Kebbi.**

B **However, the state had begun thinking about its state DRF scheme.** The state had formed guidelines for two DRF committees: a steering committee and a management committee, but they were yet to be implemented. Additionally, there were existing guidelines for DRF operation at each level of the state which the state had adopted from Jigawa state.

C **The state diagnostic revealed that Kebbi was making progress with strengthening its DRF governance structure, but further improvements could be made.** Kebbi had established 2 of 5 recommended standard minimum governance committees. The state was also developing guidelines for most governance activities, but execution was yet to begin.

D **Based on these findings, state decided on 4 key design choices, and identified risks and accompanying mitigation strategies for each choice.** For each of the components of DRF management (governance, supply chain management, financial management, data management and human resources), they identified initial DRF requirements needed for seed stock release and end-state DRF requirements. The team supported Kebbi state to develop operational guidelines for the Drug and Medical Consumables Management Agency (DMCMA), secondary and primary heath facilities.

8.4

History of DRF implementation in Kebbi

Prior to the start of the project, there was no formal DRF in Kebbi, but the state had begun initial plans for a state-wide DRF

There was no existing state-sponsored DRF in Kebbi; however, small scale and informal DRFs exist

- There were multiple types of informal schemes at facilities, including “personal” schemes (sourced by one member of the facility), “facility” schemes (sourced by multiple facility staff), and “community” schemes (sourced by community contributions)

The state had a CMS, but it only served as a basic store

- The CMS did not procure any commodities itself; rather, it acted as a basic storage space for some donor products and any free commodities procured by the state government on an ad-hoc basis
- The CMS did not have transportation infrastructure (vehicles or drivers); facilities were responsible for collecting any commodities from the CMS (even though the commodities had been donated by donors or the state government)

Kebbi has begun thinking about its state DRF scheme

- The state had formed guidelines for two DRF committees: a steering committee and a management committee, but they were yet to be implemented

8.4

History of DRF implementation in Kebbi

Facilities either had one of three types of informal drug supply schemes or no DRF scheme at all

Personal	Drug supply schemes for which seed funding was sourced by just one member of the facility, usually the OIC or the pharmacy personnel. These often operate as one-man for-profit businesses
Facility	Drug supply schemes for which seed funding was sourced by the facility, but not from a single individual. Two variants exist • Seed funding was sourced from several facility staff who are the owners of the DRF and see it as an investment or the seed capital as a grant • Seed funding was sourced from the cost of services at the facility
Community	Drug supply schemes for which seed funding was sourced through contributions from relevant community stakeholders (e.g., ward development committee) and given to selected facilities. In most cases, the WDC supervises the facilities implementing the DRF. The community also partakes in sharing the profits
No-DRF	Facilities that did not have any form of DRF operating

8.5

Kebbi diagnostics phase – facility diagnostic

Facility DRF | Community DRF | Single Person DRF | No DRF

Local partners visited 19 health facilities of various types (tertiary, secondary, primary, urban, rural, existing DRF, no DRF, small and large) across the state

Facility Type	Facility name	Staff size[1]	DRF type	Was this program covered under DRF?[2] Ante-Natal Care	Labor/ Deliveries	Post -Natal Care
Tertiary facility	Sir Yahaya Specialist Hospital, Birnin Kebbi	~100	Facility DRF	✓	✓	✓
Secondary Health Facility	Kebbi Medical center	TBD	Facility DRF			
	General Hospital, Aliero	25	Facility DRF	✓	✓	✓
	General Hospital, Augie	18	No DRF			
	General Hospital, Argungu	34	No DRF			
	General Hospital, Martha Bamaiyi	53	Facility DRF	✓	✓	✓
	General Hospital, Yauri	40	Facility DRF	✓	✓	✓
Primary Health Facility	Kalgo, MCHC	20	Community DRF	✓	✓	✓
	Unguwan Dikko, PHC	2	Single Person DRF			
	Birnin Tudu PHC	4	No DRF			
	Augie, PHC	12	Community DRF	✓	✓	✓
	Argungu MCHC	14	Facility DRF	✓	✓	✓
	Jada PHC	11	Facility DRF	✓		✓
	MDG Dabai	12	Facility DRF	✓	✓	✓
	Yelwa MCH	8	Facility DRF	✓	✓	✓
	Dangaladima 1 PHC	5	No DRF			
	Mallamawa PHC	5	Facility DRF	✓	✓	✓
	Town Disp. Yelwa	13	Single Person DRF	✓	✓	✓

Routine immunization was offered for free in all relevant facilities. FP, nutrition, and TB commodities were not included in the DRF as they were mostly supplied for free by donors and the state

1. Morning shift only 2 Facilities that do not cover selected programs under DRF either do not offer the service at all or have free commodities provided by state/donor

8.5

Kebbi diagnostics phase – facility diagnostic

The team reviewed Kebbi's existing guidelines for DRF operations at the CMS, LGA, secondary health facilities and primary health facilities

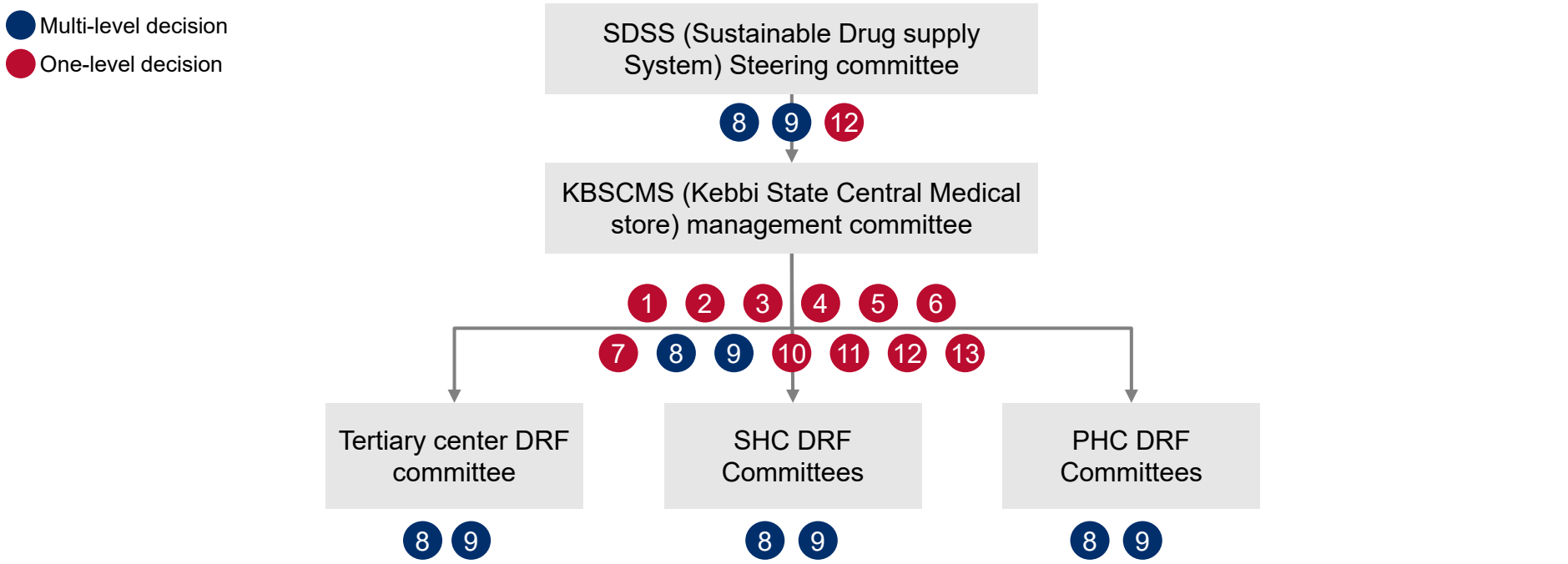
SOPs reviewed

- **DRF operational guidelines for the CMS:** The guidelines for the implementation of the DRF at the state level
- **DRF operational guidelines for LGA:** The guidelines for the implementation of the DRF at the LGA level
- **DRF operational guidelines for the SHC:** The guidelines for the details on the DRF end to end supply chain process, financial management and data management and performance management at the secondary facility level
- **DRF operational guidelines for the PHC:** The guidelines for the details on the DRF end to end supply chain process, financial ,data and performance managment at the primary facility level

8.5 STATE EXAMPLE

Kebbi diagnostics phase – findings on DRF governance

Three committees were planned to oversee the state's DRF, with most governance decisions to be taken by the management committee



Three committees were included on the guidelines

(1.) The SDSS Steering Committee, comprising of 10 senior leaders from the SMoH, HMB, SPHCDA, Donors, specialist hospital , etc.

(2.) The KBSCMS board, comprising of 7 senior leaders from the SMoH, HMB, SPHCDA,LGA chairman, Community, etc.

(3.) The KBSCMS management team comprised 4 operational staff from the General Manager, procurement manager, head of finance , and internal auditor, and head administration

8.5 STATE EXAMPLE

Kebbi diagnostics phase – findings on DRF governance

While the committees were being inaugurated, there were few guidelines for the decisions these committees had to make

Strength of guidelines or execution: Strong | Medium | Poor | Non-existent

	Activity	Existence of a body to take the decision	Staffing of the body	Inclusiveness of the body	Policies and guidelines	Execution of guidelines	Comments
Coverage	1 Commodity selection	Non-existent	Non-existent	Non-existent	Strong	Strong	• **Based on the guidelines, Kebbi had adopted the essential medicines list**
	2 Facility selection	Non-existent	Non-existent	Non-existent	Non-existent	Non-existent	• **Guidelines didn't specify facility selection**
Vendor governance	3 Vendor prequalification	Non-existent	Non-existent	Non-existent	Poor	Non-existent	• **The method of prequalification was not stated**
	4 Vendor selection	Non-existent	Non-existent	Non-existent	Medium	Non-existent	• **The guidelines stated that commodities were to be procured from prequalified vendors**
Pricing	5 Pricing and markup	Non-existent	Non-existent	Non-existent	Medium	Non-existent	• Guidelines stated **'complete cost-recovery plus 20% mark-up' in total** for both CMS and facilities (5% at the CMS/LGA and 15% at the facilities) • The guidelines stated the allocation of mark-ups for inflation, losses and expires, M & E and D&E. There was no eligibility criteria for D&E
	6 Markup utilization	Non-existent	Non-existent	Non-existent	Strong	Non-existent	
Monitoring & Accountability	7 Data systems	Medium	Medium	Medium	Medium	Non-existent	• **Data collection tools were clearly stated,** but there were no details on reporting mechanisms. Tools were also not available
	8 Monitoring : how?	Non-existent	Non-existent	Non-existent	Poor	Non-existent	• **The guidelines clearly stated the different levels of monitoring by different agencies,** but there was no cadence for monitoring and there were no KPIs or roles allocated • **There were clearly spelt out sanctions, but no rewards**
	9 Monitoring: who?	Non-existent	Non-existent	Non-existent	Medium	Non-existent	
	10 Consequence management	Non-existent	Non-existent	Non-existent	Medium	Non-existent	
Supply Chain governance	11 Supply chain levels	Non-existent	Non-existent	Non-existent	Medium	Poor	• **Guidelines defined a 3-tier supply chain (CMS –LGA – facility)** • **There were guidelines for supply chain operations,** but no clear details for distribution • State had sole ownership of CMS
	12 SOPs and Guidelines	Non-existent	Non-existent	Non-existent	Medium	Non-existent	
	13 Supply chain owner-ship	Non-existent	Non-existent	Non-existent	Strong	Strong	

8.5 STATE EXAMPLE

Kebbi diagnostics phase – findings on DRF operations

Strength of guidelines or execution: Strong | Medium | Poor | Non-existent

There was no state-wide DRF in Kebbi; hence no execution. However, the state adopted the SOPs from Jigawa, which were very comprehensive.

Supply chain summary

		Guideline quality	Execution Quality	Comments
Central level	A Forecasting	Strong	Non-existent	• The existing SOP detailed the steps along with their respective owners that would be followed in the creation of the CMS's annual procurement plan/forecast
	B Procurement	Strong	Non-existent	• The SOP clearly articulated the steps and the people that would be involved across all steps of commodity selection, quantification, and procurement approvals. There was information on steps involved bid evaluation and contract signing
	C In-bound logistics	Non-existent	Non-existent	• The SOP did not offer explicit information on the transportation of commodities to the CMS, but the processes suggested that vendors would be responsible for delivery
	D Warehousing	Strong	Non-existent	• The SOP detailed the steps along with their respective owners that needed to be followed for receipt of commodities, inspection, stock reporting, and management of expired/damaged drugs
Health facility level	E Procurement	Strong	Non-existent	• The SOP is very clear on the approved source of supply for different facility types (CMS for SHCs and LGA stores for PHCs and gives information on quantification and approvals required
	F Delivery to HF	Strong	Non-existent	• At all facilities, the SOP specified clear processes for last mile delivery (CMS delivers to SHCs while PHCs pick up), as well as inspection by relevant committees on delivery
	G Storage	Strong	Non-existent	• At all facilities, the SOP specified clear processes for storage (including requirements for the store and storage practices), stock reporting, and management of expired/damaged drugs

8.5 PRELIMINARY

Kebbi diagnostics phase – findings on DRF operations

There was no state-wide DRF in Kebbi; hence no execution. However, the state adopted the SOPs from Jigawa, which were very comprehensive.

Financial management summary

		Guideline quality	Execution Quality	Comments
Central level	A Budgeting			• The SOP stipulated at a high level that the CMS needed to develop a budget to be incorporated into the overall SMOH budget. There were no details about the relevant subprocesses
	B Expense management			• The SOP clearly specified processes involved with payments at the CMS along with signatories for different accounts and the approval limits for different levels (personnel & committees)
	C Sales management			• The SOP had clear processes, owners and tools to be used to manage revenues accrued when facilities procure commodities from the CMS
	D Budget Review			• There were no guidelines to inform the budget review process at the CMS
Facility level	E Sales management			• At facilities, the SOP specified manpower requirements and processed for managing payments from customers. It also detailed tools that need to be used for reporting and specified the internal audit systems to be applied
	F D&E management			• There were no guidelines on the management of deferrals and exemptions at the facilities.
	G Expense management			• The SOP provided details on the steps that would be followed for the approval of expenses, sign-off of payments and how the different tools should be filled out

8.5

Kebbi diagnostics phase – findings on DRF operations

There was no state-wide DRF in Kebbi; hence no execution. However, the state adopted the SOPs from Jigawa, which were very comprehensive.

Data management summary

Strength of guidelines or execution Strong Mediocre Poor Non-existent

	Guideline quality	Execution quality	Comments
A **Stock and consumption data**	Strong	Non-existent	▪ At both facilities and the CMS, the respective guidelines detailed how stock reporting should be done, how often it should be done and who is responsible. There was also guidance on how the tools should be used for decision-making
B **Logistics data** (e.g., on-time delivery rate)	Non-existent	Non-existent	▪ There were no guidelines on and reporting of logistics data
C **Financial data**	Strong	Non-existent	▪ The CMS and facility SOPs provided details on the tools that need to be used for financial data management as well as who is responsible for filling the tools and how they should be used for reconciliations & audits

8.5

Kebbi diagnostics phase – findings on DRF operations

The CMS teams were understaffed and undertrained

Human Resources DMMA/CMS: current state

Strength of guidelines or execution Strong Medium Poor Non-existent

	Ideal requirement	Observed situation	Trained (Y/N)	Rating
Procurement	▪ DMCMA MD ▪ Pharmacist (x4) ▪ Pharmacy technician (x4) ▪ Others (x4)	• Pharmacist (x1)	▪ No	
Inspection / monitoring / evaluation	▪ Director ▪ Deputy director ▪ Planning officers (x2) ▪ M &E officer (x2)	▪ None	▪ N/A	
Administrative	▪ Director ▪ Conference sec ▪ Stock officers (x2) ▪ Clerk/clerical assistant (x5) ▪ Store assistant (x9) ▪ Security officer (x 7)	▪ Stock officers (x3) ▪ Laborers (x11)	▪ No ▪ No	
Finance	▪ Chief Accountant ▪ Accountant officers (x2) ▪ Cashier (x3)	▪ None	▪ N/A	
Audit	▪ Chief internal auditor ▪ Audit Assistant (x2)	▪ None	▪ N/A	

8.6 STATE EXAMPLE

Kebbi design phase – proposed design choices

From the diagnostic findings, the team proposed a set of design choices that were presented to stakeholders during the design and diagnostics phase

Preferred

CMS initiated distribution (last mile distribution from the central store to HFs)	A	Vs	Collection by Facilities (each HF picks up commodities from the central store)
HFs buy from central store on credit	B	Vs	HFs pay central store upfront (“cash and carry”)
Two layered supply chain (CMS → HFs)	C	Vs	Three layered supply chain (CMS → Zonal/LGA store → HFs)
Variable Markup	D	Vs	Single Markup

8.6 STATE EXAMPLE

Kebbi design phase – benefits and drawbacks of design choices (1/2)

The team outlined the benefits and drawbacks of each design choice

In Kebbi, the SOP for DRF operations stated “Cash and Carry” as the payment model of choice[1]

Cash and Carry	A payment system that requires health facilities to make upfront payment to the central medical before receiving commodity orders
Benefits	• Enables smooth cash flow between facilities and CMS • Provides facilities with the option to collect drugs directly from CMS • Access to timely availability of funds for DRF operations • Builds the capacity of health facility staff in financial management • Requires minimal monitoring from the CMS advantages • Promotes ownership of HFs to improve quality service delivery
Drawbacks	• Delayed reimbursement from health insurance payments could lead to liquidity challenges • Uncontrolled access to engagement of unapproved vendors • Increased risk of diversion of funds

In Kebbi, the SOP for DRF operations states “Single mark up” as the pricing system of choice

Single mark up	The use of a standard mark up on all commodities in the DRF system without considering the impact on high cost commodities or cost of distribution for hard to reach health facilities
Benefits	▪ Uniformity in the pricing of drugs across facilities ▪ Creates transparency and build patients’ trust in the DRF system ▪ Makes financial monitoring and evaluation easier centrally and at facility levels ▪ Simplifies the process of determining and reviewing prices for all classes of drugs
Drawbacks	▪ Reduces the demand for drugs with high-cost price because they become even more expensive at point of service ▪ Eliminates consideration for variable factors such as the distribution cost, patient’s purchasing power and market dynamics ▪ Encourages unfavorable practices in facilities that do not find the single pricing system favorable

1. An alternative design option is a credit system that allows facilities to purchase drugs from the CMS on credit, payment is made after drugs are sold
2. An alternative design option is different markups based on commodity price or location of facilities

8.6 STATE EXAMPLE

Kebbi design phase – benefits and drawbacks of design choices (2/2)

The team outlined the benefits and drawbacks of each design choice

In Kebbi, the SOP for DRF operations states a "Three-layered supply chain system" design choice

Two- layered supply chain system — **Drugs will be delivered from the CMS through the zonal stores to the facilities.**

Benefits

- Increases warehouse capacity to meet demands as DRF scales to PHCs in the state
- Allows for more efficient distribution, especially for facilities further away from the center
- Reduces cost of transport logistics for facilities
- Allows LGAs to focus on monitoring DRF operations at facility level

Drawbacks

- Zonal stores currently don't exist and requires huge capital costs to build
- Multiple layers could reduce the efficiency of the distribution system
- Higher maintenance cost for the CMS and the zonal stores, which can impact mark - up
- Pick up system could increase the risk of facilities purchasing drugs directly from suppliers

In Kebbi, the SOP states "CMS Last Mile Delivery" as a distribution design choice

Last Mile Delivery — **In the interim, CMS will deliver drugs to the facilities directly, while the long term plan is for a last mile delivery distribution by the zonal stores**

Benefits

- More efficient and possibly cheaper due to gains from the implementation of route optimization
- Optimizes available time for patient interaction with health facility staff for service delivery
- Relieves health facilities from handling transportation of commodities

Drawbacks

- Saddles CMS with the responsibility of last mile delivery distribution
- Failure of the LMD distribution system could negatively impact a large number of facilities
- Eliminates the opportunity to address challenges with commodities ordered in real time

1. An alternative design option is collection by health facilities

8.6 STATE EXAMPLE

Kebbi design phase – final design choices

After deliberation, stakeholders accepted all but one of the originally recommended design choices, and laid out the risks and risk mitigation strategies for each step

Design choice	Risks	Mitigation strategies
Collection by Facilities (each HF picks up commodities from the central store)	▪ Increase in transportation costs ▪ Decrease in staff productivity	▪ Minimum of bimonthly facility procurement to reduce the time facility staff spend out of station ▪ Pooled purchasing by HFs to reduce the cost of transportation per facility ▪ Leverage NURTW for transportation to reduce operational costs for HFs with proper orientation on standards for drug distribution
Single Markup	▪ Higher transport cost for facilities in HTR area	▪ CMS assumes the costs of distribution and operates a km-based reimbursement system for HFs ▪ HFs supplementing distribution costs with HF service accounts ▪ Bulk purchasing and application for tax holidays to ensure prices remain more competitive than open market and conducive for the end-user
Single layer supply chain (CMS → HFs)	▪ Difficulty accessing the CMS and vice versa	▪ Support CMS operations by instituting zonal stores and leveraging WMS to strengthen data management processes ▪ In the interim, options discussed include: – Leveraging SHCs as a distribution hub for surrounding PHCs – In the interim, selecting facilities close to the CMS for pilot
HFs pay central store upfront ("cash and carry")	▪ Delayed reimbursement by health insurance agency ▪ Illicit practices	▪ All states aligned on cash and carry as a payment model. However, when insurance is launched: – Agreement between SPHCDA and health insurance agency specifying reimbursement schedule with oversight from State DRF committee – Credit agreement between CMS and HFs – Strong financial management policies to prevent illicit practices

8.6 STATE EXAMPLE

Kebbi design phase – initial DRF requirements

PLAYBOOK

Once the design choices had been agreed upon, stakeholders outlined a set of requirements for readiness to receive seed stock

		Initial DRF requirements needed for seed stock release	End state DRF requirements
Governance	**Governance:** Operationalization of facility and central committees and SOP revision	▪ Inaugurate the state DRF management committee; the committee should have diverse representation and be operational; with all pivotal subcommittees inaugurated ▪ Inauguration of facility DRF committees at all facilities selected for initial rollout; committees should have diverse community representation and be operational ▪ Revision of SOPs, Guidelines and tools to reflect best practices in supply chain, financial management and data management ▪ Signing of MOU	▪ Development and ratification of DRF law
Central – DMA / CMS	**Governance:** List of essential committees for DMCMA/CMS and facility	▪ State DRF management committee with representation from Ministries of Finance, Justice, Budget & Planning, LG Affairs, Women Affairs, as well as traditional and community leaders ▪ DMA management team ▪ Monitoring and supervision committee ▪ Vendor pre-qualification committee ▪ Post-procurement verification committee	▪ Pricing and mark-up committee ▪ Training committee ▪ Audit committee ▪ Commodity review committee ▪ Guidelines & SOPs review committee
Facility	**Governance:** List of essential committees for DMCMA/CMS and facility	▪ Facility health committee (FHC) a.k.a facility DRF committee for initial facilities selected for rollout	▪ Facility health committee (FHC) a.k.a facility DRF committee for all facilities under the DRF in the end state

At both the central and facility levels, all committees should be very inclusive with sufficient community and civil society participation

8.6 STATE EXAMPLE

Kebbi design phase – initial DRF requirements

PLAYBOOK

		Initial DRF requirements needed for seed stock release	End state DRF requirements
Supply chain	**Supply chain:** CMS and facilities will require infrastructural upgrades	▪ Provision of all infrastructure upgrades that are aligned as requirements for readiness at the Kebbi CMS ▪ Provision of all infrastructure upgrades that are aligned as requirements for readiness at all facilities selected for initial rollout	▪ Further improvement of infrastructure at CMS to aligned end state levels ▪ Procurement of vehicles for the CMS and zonal stores for last mile delivery ▪ Provision of all infrastructure upgrades including development of the zonal stores aligned as requirements for readiness at all facilities under the DRF scheme in the end state
Financial management	**Financial management:** Facility accounts will have multiple signatories	▪ For initial rollout facilities, bank accounts with multiple signatories must be opened; the community representative must be a signatory	▪ For all facilities under the DRF scheme in the end state, bank accounts with multiple signatories must be opened; the community representative must be a signatory
Data management	**Data management:** Revision of SOPs to reflect logistics data with evidence of good documentation and data management practices	▪ Facilities covered under initial roll out will have commenced bi-monthly reporting of stock data on to the NHLMIS platform ▪ Approval of updated SOPs for improved data transfer and utilization for decision-making at both the CMS and facilities	▪ Facilities covered under the DRF scheme by the end state will have commenced bi-monthly reporting of stock data on to the NHLMIS platform
Human Resources	**Human Resources:** Adequate staffing and provision of funds for on-going training	▪ Provision of staff to meet aligned initial requirement levels at the CMS and facilities selected for initial rollout	▪ Increasing the staff strength of CMS to meet demands for planned DRF expansions ▪ Increasing staff strength at initial rollout facilities and provision of staff to meet aligned end state levels ▪ Provision of adequate staff at all facilities covered under the DRF scheme in the end state
		▪ Commitment to regular in-service training for CMS and health facility staff ▪ Plan to include budget line for consistent funding of CMS; including staffing, maintenance costs	▪ Release of DMA/CMS running costs

8.6 STATE EXAMPLE

Kebbi design phase – initial DRF requirements

PLAYBOOK

Upgrades at the CMS were to be done in 2 phases

		Initial requirement	End state requirement	
		CMS	CMS	ZMS*
Cooling	Refrigerator			✓
	Freezer			✓
Operational tools	Fork lifts		✓	✓
	Shelves			✓
	Air conditioner			✓
	Hygrometer	✓		✓
	Trolleys	✓		✓
	Ladder	✓		✓
Power	Generating set	✓		✓
	Solar power		✓	✓
Transport	Vans		✓	✓

Assuming one zonal store per senatorial district

8.6 STATE EXAMPLE

Kebbi design phase – initial DRF requirements

PLAYBOOK

Health facility upgrades in Kebbi were in two phases with the preliminary phase focusing on the most critical aspects for health facilities

		Initial requirement		End state requirement	
		SHCs	PHCs	SHCs	PHCs
Cooling	Refrigerator	✓			✓
	Cooling Flasks		✓		
Operational tools	Shelves	✓	✓		
	Air conditioner	✓			✓
	Hygrometer			✓	
	Thermometer	✓	✓		
	Ladder			✓	
Power	Generating set	✓			✓
	Solar power		✓	✓	
Transport	Buses, Vehicles			✓	
Security	Burglary	✓	✓		

8.6 STATE EXAMPLE

Kebbi design phase – initial DRF requirements

PLAYBOOK

In the long term, the finance and admin departments of the CMS and facilities would need to be staffed with trained personnel

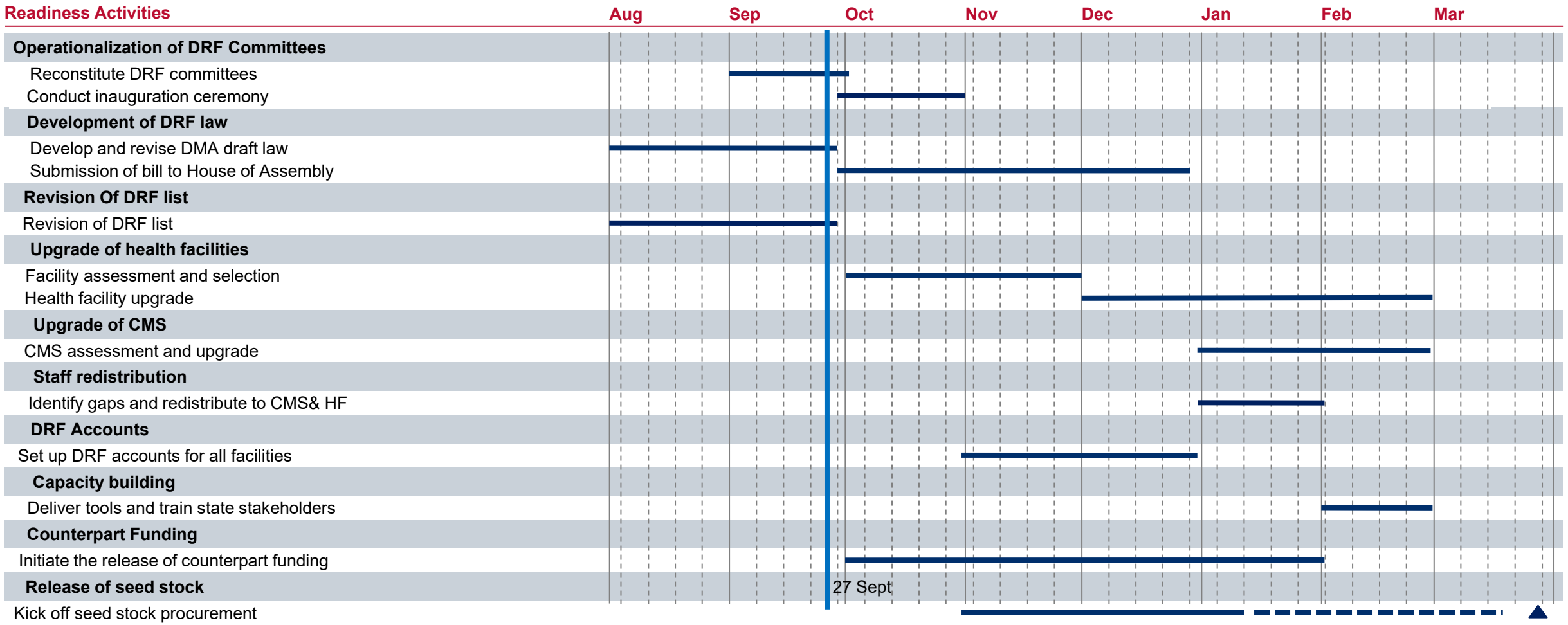
	Immediate hiring needs	End state hiring requirement
Central – DMA / CMS & ZMSs	▪ **CMS:** – Procurement department: Chief pharmacist and pharmacy technician – Inspection department: Director and M&E officer – Admin department: Director, clerks, security staff, store assistants and drivers – Finance department: Cashier and accountant – Audit department: Chief auditor and assistant auditor	▪ **CMS**: – Procurement Dept: Pharmacist and Pharmacy technician – Inspection Dept: Deputy director – Admin Dept: Drivers and clerks – Assistant auditor ▪ **ZMS**: – All roles obtainable at the CMS but based on capacity and operations
Secondary health facility	▪ The following staff to be hired in **facilities selected for initial rollout** – – Pharmacy personnel – Cashier – Accountant – Nurses	▪ The following staff to be hired in each **facility by end state** – – Additional medical officer – Additional nurses/midwives – Additional accountant – Additional CHEW/JCHEW
Primary health facility	▪ The following staff to be hired in **facilities selected for initial rollout** – – Cashier – JCHEW – Pharmacy technician	▪ The following staff to be hired in each **facility selected by end state** – – Additional pharmacy technician – Additional nurses – Additional CHEW/JCHEW – Additional cashier

Across board, staff will need to be trained on best practices in their respective roles

8.6 STATE EXAMPLE

Kebbi design phase – workplan

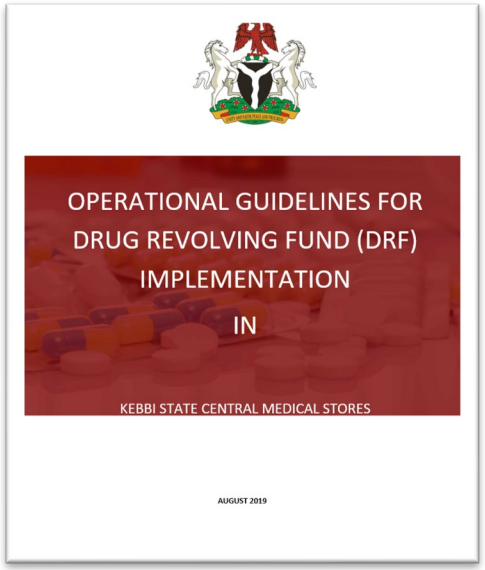
Stakeholders aligned on a work plan that would enable the state be ready for seed stock release in 8 months and demonstrated commitment to readiness activities in a signed communique

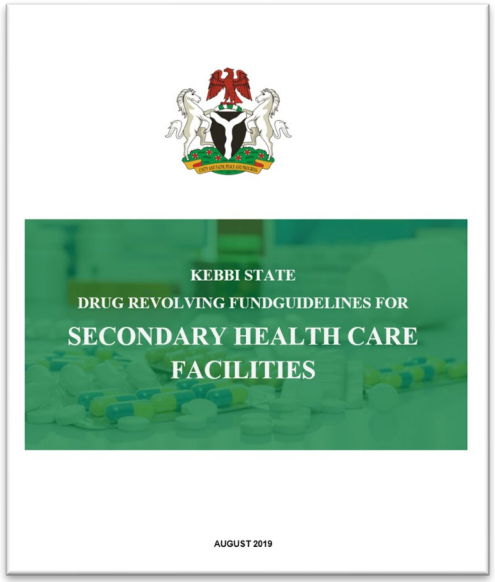


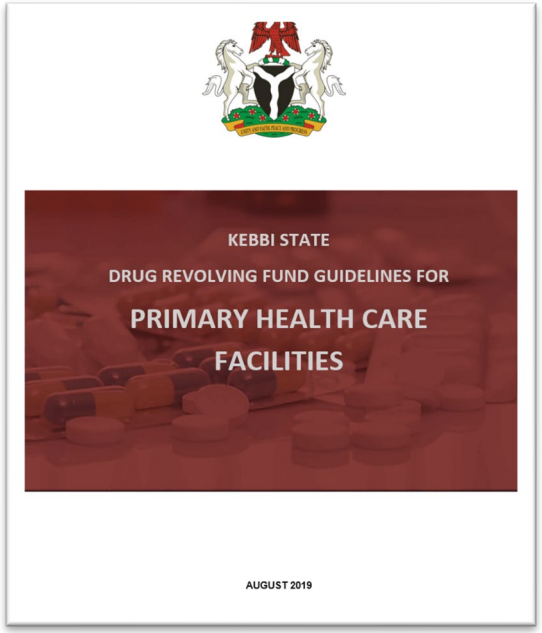
8.6 STATE EXAMPLE

Kebbi design phase – SOP revision workshop

During the SOP revision workshop, breakout groups worked on different parts of the SOP guidelines and produced SOPs for the CMS, secondary health facilities and primary health facilities







Participants who worked on SOP

CMS (Governance)	CMS (Operations)	Secondary Health facilitates	Primary Health Facilities
▪ DPS SMoH	▪ DPRS SMoH	▪ State MNCH Coordinator	▪ ES SPHCDA
▪ DDPS SMoH	▪ Director Finance, SMoH	▪ Director Medical Services, SMoH	▪ IHP
▪ KECHMA	▪ Central Medical Store Pharmacist		
▪ BA	▪ LMCU Coordinator		

9 Appendix

9.1

Diagnostic phase – DRF facility survey questionnaire (1/10)

PLAYBOOK

Introduction: (3 min)
Hi. I'm X and I work as part of the X team. We are working as part of the USAID project tasked with redesigning the Drug Revolving Fund (DRF) system in XXXX state to make it sustainable for many years to come. Firstly, I want to thank you for participating in this research today. It's incredibly valuable to better understand what as (a) X (stakeholder name) are considering and experiencing when managing the essential commodity supply chain. I am very interested in your opinion today. Please be as open and honest as possible, as your feedback will be essential to understanding the current landscape in your journey as X. Remember there are no right or wrong answers. Sometimes, I will ask you to explain more about what you say so that I really understand your point-of-view. If at any point you don't understand anything please stop me and I can clarify what I mean. And if there's any question you don't feel comfortable answering, please just let me know.

We have 60 – 90 minutes in total. First, we want to get to know you better and to understand your current knowledge and perspective on the essential medicines supply chain system. Then we'd like to identify the challenges and pain point in the supply chain system. Your name or personal information will not appear in any documentation or presentation. Your privacy will be respected, and you do not need to use anyone's full name in this discussion as privacy is of utmost importance to us.

We may capture audio during this session and if you're comfortable, we will also be taking photos at times. For the photos, we will not capture images of your face or any details that can reveal your identity – we're most interested in capturing the research process as well as any details in the environment that help us gain a richer understanding of the topic. All audio materials and photos will be for internal purposes for my company and our client only. If at any time you do not wish to continue with the audio recordings and photography, please notify me.

Do you have any questions? If not, let's jump right in

9.1

Diagnostic phase – DRF facility survey questionnaire (2/10)

PLAYBOOK

General information and Background

1.Facility Name –

2.Respondent Information –
- a.Name:
- b.Role:
- c.Telephone Number:

3.What category of ownership does this facility fall under?
- a.Private-owned
- b.Federal Government-owned
- c.State Government-owned
- d.NGO-owned
- e.Faith-based

4.What type of facility is this?
- a.Primary Health Facility
- b.Secondary Health Facility
- c.Tertiary Health Facility

5.How many staff are there per shift? (Please indicate if you operate a call system)

	Morning shift	Afternoon shift	Night shift
Doctors	...	...	...
Pharmacy personnel	...	...	...
Nurse/Mid-wife	...	...	...
CHO	...	...	...
CHEW/JCHEW	...	...	...
Lab personnel	...	...	...
Others (specify)	...	...	...

6.On the average, how many patients do you attend to each month?

7.Does your facility have access to (tick if yes):
- a.Power? What source (electrical, generator)?
- b.Internet connection?
- c.Mobile phone?

9.1

Diagnostic phase – DRF facility survey questionnaire (3/10)

PLAYBOOK

General information and Background

8.Do you offer these services/treatments at this facility? If yes, identify the sources (Government/programs/donors) that you receive commodities from.

Service	Do you offer?	Source(s)
Routine Immunization	...	...
Family Planning	...	...
Ante-Natal Care	...	...
Labour/Deliveries	...	...
Post -Natal Care	...	...
Tuberculosis (DOTS)	...	...
Malaria	...	...
HIV (PMTCT)	...	...
HIV (ARV)	...	...
Nutrition	...	...
Other (Specify)	...	...

DRF (Pharmacy personnel) Have you ever operated a Drug Revolving Fund (DRF) at this facility?
  a.Yes
  b.No
9.If yes, when was this DRF established?
10.If yes, is this DRF still operational?
  a.Yes
  b.No (if no – when did it stop being operational?)

11.What type of Drug Revolving Fund do/did you operate?
  a.State-based DRF
  b.Local government-based DRF
  c.Facility-run DRF
  d.Single person facility DRF
  e.Community DRF
  f.Other (please specify)

9.1

Diagnostic phase – DRF facility survey questionnaire (4/10)

PLAYBOOK

General information and Background

12.What programs are/were covered under the DRF?

Service	Tick if covered by DRF
Routine Immunization	...
Family Planning	...
Ante-Natal Care	...
Labour/Deliveries	...
Post -Natal Care	...
Tuberculosis (DOTS)	...
Malaria	...
HIV (PMTCT)	...
HIV (ARV)	...
Nutrition	...
Other (Specify)	...

Ask to see a list of commodity prices and take photos

15.What happens to the prices you charge when the price of the drugs goes up? (Describe)

16.Please walk through the entire DRF process:

a.Information/Data flows: How and what tools do you use to quantify/place orders for DRF commodities? (Describe)

b.Financial flows: how does cash flow within and after it leaves the facility to pay for the DRF commodities? Who keeps cash, who signs the cheques (Describe)

c.Commodities: how do DRF commodities flow to the facility? (Describe)

d.Monitoring: how is the DRF performance tracked? E.g. stock data, financial data (Describe)

13.Is there a DRF markup (i.e., markup on the price of drugs)?

a.If yes, what % markup is used?

i.Answer

b.How is the markup set? (who sets it)

i.Answer

c.What are the components of the markup (where does the markup go)?

i.Answer

d.Is the markup the same across facilities under the same DRF?

i.Answer

14.How are commodity prices determined?

a.Who sets the prices?

b.Are the prices the same across LGAs or the state? (Yes/No)

c.Please describe the process for setting prices (describe):

17.What are the biggest challenges you have/had with the DRF? What do you think are the biggest causes of those challenges? (Please describe Why is that the cause?

18.If the DRF is run by the facility, what are the most important aspects for success? Why?

Operations – Forecasting/Procurement (Pharmacy personnel)

19.How do you determine the quantity of commodities to be procured (i.e., how do you do quantification)? (Please describe)

a.Consumption data

b.Availability of funds

c.Other (specify)

9.1

Diagnostic phase – DRF facility survey questionnaire (5/10)

PLAYBOOK

General information and Background

20.Who is responsible for quantification (determining commodity resupply) at the facility?
a.OIC
b.Pharmacy personnel
c.Other (specify)
21.How often do you undertake quantification (determining commodity resupply)?
a.Every week
b.Every 2 weeks
c.Once a month
d.Once every 3 months
e.Once every 6 months
f.Ad-hoc
22.Who is responsible for actual purchase of the essential commodities for your facility? (Tick all that apply)
a.The Facility
b.State government
c.Federal Government
d.Donor
e.NGO
f.Community
g.Others (please specify)
23.If done by the facility or community, where is the purchase done?
a.PPMV
b.Wholesaler
c.Manufacturer
d.Other (specify)

Operations – Transport / Storage (Pharmacy personnel)

24.How do commodities arrive at the facility? (Tick all that apply)
a.Facility is responsible for picking up from a state warehouse
b.Facility is responsible for picking up from an LGA warehouse
c.Facility is responsible for collection from vendor
d.State funds delivery to the facility
e.Donor/NGO funds delivery to facility
f.Supplier is responsible for delivery to facility
g.Other (please specify)
25.What method of transport is used to deliver commodities to the facilities? (Indicate if different for cold and non-cold chain commodities)
a.Courier Motorcycle
b.Motorcycle
c.Van
d.Saloon car
e.Public transport (bus)
f.Other (specify)
26.What other challenges do you have with transport?
What causes those challenges? (Describe)
Why are those the causes?
27.How often are essential commodities resupplied? (indicate separately for cold chain and non-cold chain if applicable
a.Every week
b.Every 2 weeks
c.Once a month
d.Once every 3 months
e.Once every 6 months
f.Adhoc

9.1

Diagnostic phase – DRF facility survey questionnaire (6/10)

PLAYBOOK

Operations – Transport / Storage (Pharmacy personnel)

28.How often do deliveries or pickups happen as scheduled?
a.Always (100%)
b.Frequently (75%)
c.Occasionally (50%)
d.Rarely (25%)
e.Never (0%)
f.N/A – Deliveries are not scheduled
29.If the deliveries/pickups do not happen as scheduled, what are the reasons? Why are those the causes?
30.How often are the quantity of commodities supplied the same as what was ordered?
a.Always (100%)
b.Frequently (75%)
c.Occasionally (50%)
d.Rarely (25%)
e.Never (0%)
31.If the quantity received is not what was ordered, what are the primary reasons? Why are those the reasons?
32. (If applicable) What challenges do you experience with the storage of cold chain commodities at the facility?
a.Access to storage appliance (fridges)
b.Stable electricity supply
c.Lack of adequate space
d.Alternative power sources
e.Others (specify)
33.What challenges do you have with the storage of non-cold chain commodities at the facility?
a.Access to secure storage spaces
b.Security
c.Others (specify)
What causes those challenges?
34.What do you do with waste (e.g., used syringes, damaged or expired stock)?
35.How often are you stocked out of essential commodities (tick)?
a.Always stocked out of at least some products (100%)
b.Very often stocked out of at least some products (75%)
c.Often stocked out of at least some products (50%)
d.Occasionally stocked out of products (25%)
e.Rarely or never stocked out of any products (0%)
36.Are there particular products (or categories of products) that are more stocked out? (if yes, please list)
37. What are you fastest moving MNCH commodities? List top 5
a. ……
b. ……
c. ……
d. ……
e. ……

9.1

Diagnostic phase – DRF facility survey questionnaire (7/10)

PLAYBOOK

Service Delivery (Pharmacy personnel)

38.Which of these categories of clients do not pay for services/commodities at the facility?
- a.Children under the age of 5 Tick
- b.Pregnant women Tick
- c.Less-privileged Tick
- d.Others (Please specify) ……

39.Provide a list of the commodities that are currently offered for free
I…….
II…….
III…….
IV…….
V…….

40.If less-privileged people don't pay for services, who determines who is less-privileged?
- a.Community leader
- b.Health Facility Officer
- c.Hospital appointed committee
- d.LGA official
- e.WDC official
- f.Others (Please specify) ……

41.When there are stock-outs, how do patients get the medicines they need? (Tick one)
- a.Patients go to the nearest chemist (PPMV) or pharmacy
- b.Get a pharmacist to come and deliver to the patient at the facility
- c.Recommend that the patient comes back at a later date
- d.Patient pays money to the OIC who is responsible for procuring from PPMV or other sources?
- e.Other (specify)

Operations – Stock reporting (Pharmacy personnel)

43.Do you conduct any form of stock reporting?
- a.Yes
- b.No

44.If you do stock reporting, how often do you undertake stock reporting?
a.Every 1-2 weeks
- b.Monthly
- c.Quarterly
- d.Once in six months
- e.Annually
- f.Other (Please specify)

45.What records do you fill out for stock? (Tick all that apply)
- a.Deliveries
- b.Stock use / consumption
- c.Wastage
- d.Temperature of cold chain equipment
- e.Other (specify)

Request to view a sample of stock records / ledger and take some photos?

46.Which of these tools do you use for stock reporting?
- a.CRIRRF (Manual)
- b.CRIRRF (Electronic)
- c.National LMIS (NAVISION)
- d.BFSR (Bi-Monthly Facility Stock Report)
- e.Others (specify)

47.Who is responsible for collating and preparing your stock reports?
- a.State LMCU
- b.LGA LMCU
- c.Others (Please specify)

9.1

Diagnostic phase – DRF facility survey questionnaire (8/10)

PLAYBOOK

Operations – Stock reporting (Pharmacy personnel)

48.Who is responsible for collecting your stock reports?
- a.State LMCU
- b.LGA LMCU
- c.Others (Please specify)
- d.N/A – we do not give our stock report to anyone

49.What challenges do you have with stock reporting?
What causes those challenges? (Please describe)
Why are those the causes?
50.What do you use the stock reports for? (Please describe)

Operations - Financial management (Cashier)

51.Do you conduct any form of financial reporting (incl. receipting, cash books, bank teller management, regular internal audit, etc..)?
- a.Yes
- b.No

52.If you do financial reporting, how often is it reported?
- a.Every 1-2 weeks
- b.Monthly
- c.Quarterly
- d.Once in six months
- e.Annually
- f.Other (Please specify)

53.What tools do you use for financial reporting?
- a.Cash Register
- b.Sales Receipt / Invoice
- c.Bank Payment Register
- d.Stamps for receiving cash
- e.Others (specify)

Operations - Financial management (Cashier)

Who is responsible for preparing the financial reports at your facility?
- a.OIC
- b.Pharmacy Personnel
- c.Accountant
- d.Cashier
- e.Others (please specify)

55.Who do you submit your financial reports to?
- a.Facility Committee
- b.LGA
- c.SPHCDA
- d.DMA
- e.Others (please specify)

56.What challenges do you have with financial reporting?
What causes those challenges? (Please describe)
Why are those the causes
57.What do you use the financial reports for? (Please describe)
58.Are you aware of if the state has financial management operational guidelines?
- a.Yes
- b.No
- c.Not sure

59. Does this facility have a bank account? If yes, who are the signatories?
- a.……
- b.……
- c.……
- d.……
- e.……

9.1

Diagnostic phase – DRF facility survey questionnaire (9/10)

PLAYBOOK

Governance (Pharmacy personnel)

60. What monitoring and supportive supervision do you receive? (please tick)
    a. State
    b. LGA
    c. Federal government
    d. Partners
    e. Others (please specify)
61. How often do they visit? (Ask for evidence if possible)
    a. Every 1-2 weeks
    b. Monthly
    c. Quarterly
    d. Once in six months
    e. Annually
    f. Adhoc…
62. What is the impact of monitoring? (Is it effective? In what way is it effective?)
Why is it effective or not effective?

9.1

Diagnostic phase – DRF facility survey questionnaire (10/10)

PLAYBOOK

INSIGHT OVERVIEW – To be filled out by interviewers after the interview

Themes	Insight	Root-cause of Insight; Why is it that way?	What is the Implication of Insight
Key successes - Supply chain	1. … 2. … 3. … 4. … 5. …	1. … 2. … 3. … 4. … 5. …	1. … 2. … 3. … 4. … 5. …
Key successes – Financial management	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key areas of improvement - Supply chain	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key areas of improvement – Financial management	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …

9.1

Diagnostic phase – DRF facility survey reporting template (1/3)

PLAYBOOK

Reporting Template – Facility Survey

1.State:
2.Facility Name:
3.Respondent Information –
  a.Name(s):
  b.Role(s):
  c.Telephone Number:
4.What category of ownership does this facility fall under?
  a.Private-owned
  b.Federal Government-owned
  c.State Government-owned
  d.NGO-owned
  e.Faith-based
5.What type of facility is this?
  a.Primary Health Facility
  b.Secondary Health Facility
  c.Tertiary Health Facility

6.How many staff are there per shift? (Please indicate if you operate a call system)

	Morning shift	Afternoon shift	Night shift
Doctors	...	...	...
Pharmacy personnel	...	...	...
Nurse/Mid-wife	...	...	...
CHO	...	...	...
CHEW/JCHEW	...	...	...
Lab personnel	...	...	...
Others (specify)	...	...	...

7.On the average, how many patients do you attend to each month?
8.Does your facility have access to (tick if yes):
  a.Power? What source (electrical, generator)?
  b.Internet connection?
  c.Mobile phone?
9.Do you offer these services/treatments at this facility? If yes, identify the sources (Government/programs/donors) that you receive commodities from.

	Service	Do you offer?	Source(s)
Routine Immunization	...	...	...
Family Planning	...	...	...
Ante-Natal Care	...	...	...
Labour/Deliveries	...	...	...
Post -Natal Care	...	...	...
Tuberculosis (DOTS)	...	...	...
Malaria	...	...	...
HIV (PMTCT)	...	...	...
HIV (ARV)	...	...	...
Nutrition	...	...	...
Other (Specify)	...	...	...

9.1

Diagnostic phase – DRF facility survey reporting template (2/3)

PLAYBOOK

DRF

Have you ever operated a Drug Revolving Fund (DRF) at this facility?
- a.Yes
- b.No

10.If yes, when was this DRF established?

11.If yes, is tis DRF still operational?
- a.Yes
- b.No (if no – when did it stop being operational?)

12.What type of Drug Revolving Fund do/did you operate?
- a.State-based DRF
- b.Local government-based DRF
- c.Facility-run DRF
- d.Single person facility DRF
- e.Community DRF
- f.Other (please specify)

Service	Tick if covered by DRF
Routine Immunization	...
Family Planning	...
Ante-Natal Care	...
Labor/Deliveries	...
Post -Natal Care	...
Tuberculosis (DOTS)	...
Malaria	...
HIV (PMTCT)	...
HIV (ARV)	...
Nutrition	...
Other (Specify)	...

14.Is there a DRF markup (i.e., markup on the price of drugs)?
- a.If yes, what % markup is used?
  - i.Answer
- b.How is the markup set? (who sets it)
  - i.Answer
- c.What are the components of the markup (where does the markup go)?
  - i.Answer
- d.Is the markup the same across facilities under the same DRF?
  - i.Answer

9.1

Diagnostic phase – DRF facility survey reporting template (3/3)

PLAYBOOK

INSIGHT OVERVIEW – To be filled out by interviewers after the interview

Themes	Insight	Root-cause of Insight; Why is it that way?	What is the Implication of Insight
What is working well – Supply chain	1. … 2. … 3. … 4. … 5. …	1. … 2. … 3. … 4. … 5. …	1. … 2. … 3. … 4. … 5. …
What is working well – Financial management	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
What is NOT working well –Supply chain	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
What is NOT working well –Financial management	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …

9.1

Diagnostic phase – facility diagnostic report (1/9)

Facility insights from Bauchi show that even though there are guidelines for the operations of DRFs, staff need more training and supervision on DRF operations

Govemance	NSHIP DRF facilities follow a very decentralized model; state DRF facilities are more centralized. Both have defined **guidelines that govern stock reporting, financial management, and procurement.** Many other facilities run facility- or community-run DRFs, and operate in a fully decentralized model
Operations	32% of facilities surveyed noted their staff have not **been trained on supply chain function or data reporting**, leading to **poor storage and stock reporting practices**
	26% of facilities surveyed claim **not to be aware of the existing state financial management guidelines or not to have had training** on how to use standard financial management tools, nor access to the needed tools, resulting in **inconsistent financial management practices** across facilities
Financial model	**Mark-up determination varies by DRF type**. Under the state-level DRF, the Drugs Management Agency (DMA) sets a universal mark-up for all facilities; under NSHIP supported facilities, NSHIP defines guidelines and ranges for the determination of markups, while the facility staff determine mark-ups in facility-level DRFs
	The **customers' ability to pay** plays an important role in markup determination in some primary health care facilities, allowing for different pricing at PHCs

9.1

Diagnostic phase – facility diagnostic report (2/9)

PLAYBOOK

Forecasting: most of the facilities surveyed perform some form of forecasting, but PHCs use non-standard methods

Insights	Implications
Timely forecasting in many facilities: About half the facilities surveyed (across all facility types) conduct forecasting in a timely manner, helping decrease stockouts	▪ Need to explore avenues for leveraging forecasting skills available at a significant portion of facilities to scale up capacity across all facilities
Only SHCs do standard forecasting; PHCs use non-standard sources: ▪ Secondary health facilities do standard forecasting using consumption data ▪ Forecasting at most facilities (PHCs) is done based on M&E report (service data, not consumption data). While this process may just be good enough to prevent stock outs, it's not done in the right way ▪ Two orphan PHCs procure commodities without forecasting due to lack of funds (i.e., they procure every few days based on immediate needs when they happen to have cash)	▪ Need to improve PHC forecasting across the board
Poor staff capacity to conduct standardized forecasting in most PHCs: Almost all PHCs (including NSHIP) reported that staff do not have the requisite skills to perform forecasting and hence are unable to accurately forecast the amount of commodities required to meet the demand per time	▪ Need to explore how staff with forecasting skills be leveraged to provide training to facilities without skilled personnel
Data movement: very few facilities indicated any form upward reporting to the LGA and State Levels – most reporting is for done for use in the facility only	
General hospitals report stock data to the DMMA bi-monthly and also **report financial data to the HMB** monthly **PHCs are meant to report all data (stock and financial) to the SPHCDA monthly However, there is very limited submission of LMIS data, especially at the PHCs:** All tertiary and secondary facilities noted that they submit regular reports on the LMIS, but none of the PHCs did, indicating poor visibility of the system at the LGA and state levels. Facilities note that the LMIS tool is cumbersome because the staff have to write each commodity names on the form, every month, and that the LMCU does not provide much oversight	▪ Clear need to improve reporting and understand ways of making reporting more efficient

9.1

Diagnostic phase – facility diagnostic report (3/9)

PLAYBOOK

Procurement: procurement is mostly done in ways facilities deem as most efficient, except in cases where they are mandated to purchase from the CMS

Insights	Implications
CMS procurement causes issues for SHCs not close to the CMS. Secondary facilities under the state DRF program are mandated to procure only from the CMS, but some are far enough away that this is problematic	▪ Need to understand if the new zonal warehouses can solve the proximity issues or if pooled push distribution is a viable option
CMS has an inconsistent waiver policy enforcement on procurement of commodities not available at the CMS. Although CMS stock availability has improved over the past year, stockouts still occur. When this happens, some facilities are given a waiver to procure from other vendors, while others appear to be forced to procure drugs that are not required	▪ Need to understand root causes of CMS stockouts and identify mechanisms to improve, especially if an increasing number of facilities would be mandated to procure only from the CMS ▪ Need to verify if the other vendors are pre-approved by the DMMA and the quality of their commodities ▪ Need to understand why CMS waiver policy is inconsistent
CMS sometimes gives facilities commodities on credit	▪ Need to understand the CMS credit system and if it is a root cause of the CMS stockouts, or if it carries any benefit
Non-DMMA DRF facilities can procure from pre-approved vendors, however these vendors may have quality issues. These facilities can often achieve lower prices than the DMMA by buying lower-grade generics, which the CMS would not have procured, which can cause quality issues. Even for NSHIP facilities (where they are restricted to a pre-approved vendor list), facilities can still select products that do not fit current standards	▪ It may be challenging to change procurement behavior if PHCs currently can procure at lower prices than they could at CMS – need to heavily regulate and conduct behavior change ▪ Need to understand the quality control, particularly for NSHIP-selected vendors but also on drug sources for orphan facilities
Some facilities have already established procurement with particular vendors. 11% of the facilities surveyed (both NSHIP and orphan PHCs) have existing, trust-based relationships with particular vendors and already have transportation routes and stable landing costs	▪ It may be challenging to change procurement behavior: if a more central DRF is to be implemented, need to develop change management system that will secure buy-in from facilities with existing structures and coordination

9.1

Diagnostic phase – facility diagnostic report (4/9)

PLAYBOOK

In-bound logistics: over half of facilities reported that some element of transportation of commodities is a major challenge

Insights	Implications
Vehicle availability challenges: Almost all facilities (mostly PHCs) do not have vehicles or experience high fueling costs to transport commodities from distant vendors. Some SHCs have state-provided vehicles or use ambulances for CMS pickups; others use private cars. Many facilities even use public transportation, which can threaten products	▪ Need to explore if alternative distribution models can be implemented to prevent commodity supply from being reliant on the availability of vehicles at every facility (e.g., pooled distribution, push distribution) – but this may not be possible if every facility is procuring separately
Poor storage for cold chain transportation across facilities: Most facilities (across all types) do not have the appropriate vehicles and equipment for the transportation of cold chain commodities, hence compromising the quality of the drugs	▪ Need to explore transport options that can make the secure delivery of cold chain commodities to all facilities possible
One facility has seen success with pooled distribution: For distribution efficiency, an NSHIP facility worked with other new NSHIP facilities to transport their commodities together. The facility has a vehicle and cost is split evenly (all the facilities are located in a remote area)	▪ Should explore whether pooling distribution can be expanded across facilities (although unclear if this will make sense unless using a centralized procurement system)
Seed capital mobilization: NSHIP and the state government capitalized PHCs and SHCs respectively, but some SHCs are capitalized by both	
NSHIP provided seed capital for DRFs at133 PHCs, as part of the performance-based funding (PBF) project. The **state government, via the CMS, provided seed stock to 27 SHCs** NSHIP plans to provide seed capital to ~70 more PHCs as part of PBF expansion	▪ NSHIP's current operations and scale **pose a sustainability question**. Need to understand what happens if/when the NSHIP program terminates.
In addition to the 133 PHCs, **NSHIP (under the PBF) also provided additional seed funding to some general hospitals** with existing state-run / DMMA DRF schemes	▪ Need to understand whether these facilities have operational challenges with competing NHIP/DMMA schemes and think of solutions
In **orphan facilities, existing DRF schemes have seed funding from facility staff**, with community members contributing seed funding in some others. Profits are shared by the seed contributors in the privately funded ones while the community-funded also covers D&E	▪ **Facility staff sharing profits from privately-funded schemes may likely resist the set-up of a centrally-run scheme.** Our design needs to determine models that can effectively manage these facilities and their staff

9.1

Diagnostic phase – facility diagnostic report (5/9)

PLAYBOOK

Storage: efficient warehousing is limited by the lack of adequate storage spaces and poor knowledge of good storage practices across facilities

Insights	Implications
Poor storage practices across facilities: Almost all facilities surveyed (across all facility types) have sub-optimal warehousing practices, which could lead to quality issues	▪ Need to explore avenues to develop, disseminate, and train staff at all facilities on best practices for commodity storage
Inadequate storage spaces across facilities: Most facilities (across all facility types) reported that they needed cleaner and bigger storage areas. Although many NSHIP facilities have better storage facilities due to NSHIP-funded renovation, some others are limited to shelves and do not have the required space and equipment to meet storage requirements. Even some general hospitals do not have a well-equipped storage facility	▪ Need to explore avenues for the provision of funds to construct or expand storage spaces at PHCs, and if community investment be leveraged ▪ Need to understand why some NSHIP facilities have storage issues after funds were given for renovations at the facilities
Good inventory management techniques at GHs, but some donor product expiry: Most general hospitals surveyed indicated that they employ techniques such as FEFO and Min-Max systems to prevent expirees. However, donated products are more likely to be allowed to expire	▪ Need to explore avenues to leverage existing personnel with required skills to scale up training to facilities currently without skills ▪ Need to understand if paying for products (i.e., non-donated products) causes facilities to take better care of them, which would be an incentive to roll products under the DRF
Proper waste management at GHs: 11% of facilities (only general hospitals) noted that they properly document expirees and wastages for disposal by the DMMA because of the financial implication on the DRF. However, free donor commodities still expire regularly.	▪ Need to explore best way to develop and train staff at most facilities on best practices of expirees documentation and waste management

9.1

Diagnostic phase – facility diagnostic report (6/9)

PLAYBOOK

Pricing: PHCs with facility-based DRFs often struggle to balance price competitiveness and affordability with financial viability; prescribed price ranges are flouted regularly

Insights	Implications
Facility-based DRF PHCs have to lower prices to compete with PPMVs, creating profitability challenges: 11% of facilities (only PHCs with facility DRF) noted that PPMVs tend to offer more competitive prices than offered in the facilities. Thus, facilities often have to lower prices despite selling commodities of higher quality. 21% of facilities (only PHCs with facility DRF) are unable to set markups to cover their costs, threatening profitability	▪ PHCs will be very sensitive to pricing and mandated markups given stiff competition ▪ Likely need for customer behavior change (to generate WTP for higher quality products) ▪ Need to explore ways to lower all-in cost for PHCs ▪ Need to understand why this is only true for facility-based DRFs and not at NSHIP facilities
Customers' ability to pay affects pricing at both NSHIP facilities and orphan PHCs: ▪ All PHCs set prices based on a combination **the cost of the drugs, competitive landscape and the community willingness to pay** ▪ NSHIP facilities sometimes have to set their price below the agreed markup range for very expensive products, and counter by setting prices far above the agreed range for cheap products	▪ Need to explore how customer affordability and lowest-cost sourcing can be balanced in order to allow facilities provide quality commodities at affordable prices
In some PHCs, selling to customers on credit creates cash flow issues that lead to stockouts. When customers are paid only infrequently, facilities frequently sell on deferral. This leads to facilities running out of cash and being unable to restock	▪ Need to understand how large the required deferral policy would be and how this varies by geography ▪ Potentially a reason for procurement from the CMS on credit instead of cash and carry

9.1

Diagnostic phase – facility diagnostic report (7/9)

PLAYBOOK

Funds management: there is a mixed practice of fund management across the surveyed facilities – unlike larger facilities, PHCs do not have standardized processes

Insights	Implications
Good fund management in THCs, SHCs and NSHIP sites: All facilities except the orphan facilities surveyed indicated that they run separate accounts for the operations of the DRF and for the operations of the hospitals. They also have frequent meetings to monitor the growth and resolve issues on the performance of the DRF funds. NSHIP facilities have separate signatories for the DRF accounts	▪ Need to explore how best practices at THCs, SHCs, and NSHIP facilities can be rolled out to smaller facilities that do not have comparable manpower and structures
There are no separate accounts for the Deferrals and Exemptions in DRF facilities: Both DMMA and NSHIP facilities have no sperate D&E account. For DMMA facilities, 2% is added to the markup for D&E. Each facility keeps a register of commodities for D&E and remove it from profits	▪ Need to understand how frequently facilities exceed the 2% reserve ▪ Need to understand what happens when the D&E registered for the month exceeds the 2% assigned for D&E ▪ Potentially need to establish separate D&E bank accounts
Weak/undefined fund management in non-NSHIP PHCs: Most non-NSHIP PHCs do not run DRF accounts separately from the facility account and keep cash from sales in the facilities for up to one week. Although this is theoretically based on trust, it still creates an avenue for theft	▪ Need to explore how standard fund management guidelines as well as external monitoring systems can be developed and rolled out across PHCs to ensure best practices are being followed at all facilities
Poor cash flow in some PHCs: Some PHCs surveyed noted that they occasionally did not have enough funds to purchase the required drugs due to high deferral loans from sales. Sometimes, facilities are just unable to purchase enough commodities to meet demand	▪ Need to explore what D&E governance systems need to be rolled out across PHCs to minimize incidences deferrals

9.1

Diagnostic phase – facility diagnostic report (8/9)

PLAYBOOK

Financial data reporting: facilities with state-level or NSHIP-supported DRFs perform financial reporting, however more training is required

Insights	Implications
Knowledge of reporting requirements affects reporting rates: 63% of the facilities surveyed (mostly GHs and some NSHIP facilities) reported having good financial reporting practices due to an awareness of the financial management guidelines and training on the use of the appropriate financial reporting tools	▪ Need to explore how the state's strong platform in terms of both guidelines and training can be leveraged to get all facilities to adopt best practices in financial reporting
Capacity of staff is key to financial reporting: 26% of facilities (half of NSHIP facilities and most facility-based DRFs) surveyed noted that they do not report on financial data because staff have not been trained on the guidelines and the use of the tools	▪ Need to explore how training on best practices for financial reporting be rolled out to all facilities
Weak accountability links affect reporting: About a quarter of facilities (only facility-based DRFs) either do not perform financial reporting at all or report ad-hocly because they do not see a need to or are not required to	▪ Need to explore sensitization and monitoring systems needed to get all facilities to undertake financial reporting in a timely manner and at the right quality
Lack of reporting tools in many NSHIP facilities: About half of NSHIP facilities surveyed noted a lack of paper tools; NSHIP had not provided a way to access tools over time	▪ Need to understand methods for ensuring reliable access to reporting tools (as well as explore options for moving away from paper-based reporting)
Stock data reporting: although most facilities conduct some form of stock reporting, majority of the facilities report infrequently and with unstandardized forms	
Irregular stock reporting: 60% of the facilities (across all facility types) surveyed do not conduct frequent stock reporting or any form of stock reporting because they have either not been trained on the use of the necessary tools or do not see the need to.	▪ Need to understand if training is necessary to increase reporting ▪ Need to explore what sensitization and monitoring systems can be put in place to ensure that facilities are reporting regularly and at the required quality
Use of non-standardized reporting tools: About 30% of the facilities (mostly facility DRFs) reported on perform stock reporting with non-standardized tools, leading to unstructured and incomplete documentation. May NSHIP facilities also noted not receiving ongoing paper tools	▪ Need to explore what systems can be put in place to guarantee constant provision of all tools necessary for comprehensive stock reporting at all facilities
Parallel reporting systems: Stock reporting was seen as inefficient and time consuming in 10% of the facilities (1 general hospital) which have to report on separate tools developed by the DMMA and NSHIP.	▪ Need to explore how parallel reporting tools can be amalgamated and reports shared across stakeholders in order to reduce the paper work that facility staff have to do in terms of stock reporting?

9.1

Diagnostic phase – facility diagnostic report (9/9)

PLAYBOOK

Monitoring : NSHIP facilities are monitored at least once in a month while State DRF facilities are monitored quarterly

Insights	Implications
NSHIP conducts supervisory visits in addition to the standard state visits for all NSHIP facilities: All NSHIP-supported PHC facilities are visited at least once a month. The facilities are monitored by the NSHIP LGA supervisor, independent verifiers, and NSHIP coordinators. They monitor the financial record, stock records and other facilities PBF associated records	▪ Need to understand the NSHIP model better, especially what can be sustained after NSHIP project ends (i.e., what is NSHIP funding today?)
The DMMA conducts only quarterly visits to facilities : The DMMA is supposed to conduct a monthly supervisory visit to the DRF facilities, However they only conduct quarterly visits. The DMMA team drives the monitoring visit with help from the HMB. They also provide tools for reporting at the facility	▪ Need to verify if the quarterly monitoring is sufficient to track the DRF system, as well as understand why monitoring is not done monthly as directed by the DMMA; to explore whether the HMB can play a larger role
The state monitors the facility-based DRFs on services only: The state performs monthly or quarterly visits to all PHCs to investigate service delivery, but not on stock availability / quality or fund management	▪ Need to explore ways to leverage on the state service supervision team to monitor the DRF if it becomes centralized, which would require adding substantially to the content of the supervisory visits

9.1

Diagnostic phase – Stakeholder interview guide on DRF governance (1/2)

PLAYBOOK

Note to interviewer: This questionnaire is appropriate for a state with an existing DRF scheme e.g Bauchi. However, for states that do not currently operate a DRF, but have operated one in the past (e.g. Sokoto and Kebbi) the questions should be adapted to extract historical insights on the previous DRF scheme, as well as insights on DRF plans being proposed currently e.g. A question like 'What is the structure of the DMA?' can be changed to 'What was the structure of the former DRF?' or 'What is the structure being proposed for the new DRF?"

Interview details

Name (s) of interviewer:
Name (s) of interviewee:
Location:
Date:

Policies and regulations

1.What policies, regulations and guidelines are in place for running the DRF?
2.When and how were these enacted?
3.Who was/is responsible for making these policies and regulations?
4.What areas are covered by these policies and regulations?
5.Are there any policies or regulations that make it harder to operate the DRF successfully?
- How and why is this so?

Background

1. Does DRF exist in this state?
2. When was the DRF scheme formed?
3. Who provided the seed funding? Are there multiple seed funders/donors?
4. What does the DRF scheme cover? If multiple seed funders/donors, what does each cover in terms of the parameters below:
   - Number of facilities and the types (primary, secondary, tertiary)
   - Programs covered (e.g. Malaria, MNCH, Nutrition)
   - Portion of commodities covered within each program
5. What are the factors responsible for the DRF's good/poor performance over time?

Coordination, management and oversight

1.What is the structure of the DRF?
- Is there a CMS and a DMA?
- Who are the key figures involved in the management of the scheme?
- Are roles and responsibilities clearly spelled out, with clear reporting lines?
- What is the process of managing the scheme? (i.e. what does day-to-day management look like?)
- Who makes decisions on the business model? (e.g. commodities to be included, pricing, exemptions, profit sharing, etc.)
- What is the process of making these decisions?
- Are there financial constraints that delay decision-making? What are they and why do they delay decision-making?

9.1

Diagnostic phase – Stakeholder interview guide on DRF governance (2/2)

PLAYBOOK

Note to interviewer: This questionnaire is appropriate for a state with an existing DRF scheme e.g Bauchi. However, for states that do not currently operate a DRF, but have operated one in the past (e.g. Sokoto and Kebbi) the questions should be adapted to extract historical insights on the previous DRF scheme, as well as insights on DRF plans being proposed currently e.g. A question like 'What is the structure of the DMA?' can be changed to 'What was the structure of the former DRF?' or 'What is the structure being proposed for the new DRF?"

Monitoring and accountability structures

1. Are there any mechanisms in place for monitoring the performance of the scheme?
2. What are these mechanisms? (e.g. visits, audits, inspections)
   - Who is/are responsible for driving these mechanisms?
   - What is the regularity/frequency of these mechanisms?
3. Are there any specific tools developed for DRF monitoring and evaluation?
   - What are these tools, and who uses them?
   - Have they added any value to the monitoring of the scheme?
4. What checks and balance measures for accountability and fraud prevention are in place across the various levels of operation of the DRF? (e.g. CMS and facilities)
5. What other ways methods (formal/informal) of fraud/misuse prevention are there?
   - How successful are they?
6. What legislative (and other) measures are in place to protect the CMS/DMA from direct control of the Ministry of Health and other government organizations?
   - How successful have they been?

Coordination, management and oversight

2. Are there other stakeholders who are not directly involved but very important to decision-making on the DRF or its day-to-day running?
3. Are there any private sector players/development partners involved in the DRF?
   - What is their exact role?
4. Are there community leaders/members/groups involved in DRF coordination or decision-making?
   - What is their exact role?
   - If community reps are not involved, why is this?

Lessons learned

1. Overall, what are the most important things to get right in terms of governance?
   - Why do you think these are the most important?
2. What have you seen work very well that others need to learn from?
   - Why do you think it/they worked so well?
3. What would you have done differently?
   - Why would you want to do it differently?
4. What would you change if you could, and why?

9.1

Diagnostic phase – stakeholder interview reporting template for DRF governance

PLAYBOOK

Reporting tool for governance interviews from the states

Section	Key insights: Strengths	Why?	So What?
1. Historical background	…	...	...
2. Policies and regulations	The DRF is run by an autonomous DMA backed by law	There was 2-year advocacy to the Governor and the HoA by the SMoH which led to the law being passed	The DRF is already insulated from external interference
3.Coordination and oversight	...	...	...
4. Monitoring and accountability	...	...	...

Section	Key insights: Weaknesses	Why?	So What?
1. Historical background	Previous DRF started in 1990 collapsed in 1999	There were no monitoring or accountability systems in place	Monitoring and accountability needs to be a key consideration in setting up of DRF
2. Policies and regulations			
3.Coordination and oversight			
4. Monitoring and accountability			

9.1

Diagnostic phase – Stakeholder interview guide on DRF operations (1/3)

PLAYBOOK

Questionnaire for State Engagement – Operations

INSTRUCTIONS

For each section, find the person who is relevant for that process.
For each question asked, as much as possible, try to understand who the people involved are and what tools and controls are used.
Ask the major bullet point (e.g., “please walk us through the process involved with budget creation”) and probe for who, what tools, and what controls. If they do not mention the sub-bullets (e.g., approval of procurement budget), ask if they do that. But only mention the sub-process step if they fail to mention it themselves.
Note on how to use interview guide –
Use numbered questions as open-ended discussion starters to stimulate conversation. For each branch, ensure that respondent touches on all activities; 1st level bullet point. Also use 2nd level bullet points to probe further on each activity.
Feel free to use Why as a further probe on processes that:

- Seem unusual
- That are dismissed as not being important by respondent
- Seem not to be working well do you understand what causes it to fail?
- Seem to be working well and is critical to operational success do you understand why it works?

FINANCING

1. Can you please walk us through the process involved with the following financing activities?

- Budget creation:
  - Creating rough estimate of procurement budget
  - Prioritizing which commodities to procure
  - Approval of procurement budget
- Fund mobilization:
  - Negotiation with funders (donors and/or state government)
  - Collection of funds from donors/state government
- Expense management:
  - Review of funding requests (payment to suppliers and vendors)
  - Approval/release of funds

FINANCING

- Revenue management:
  - Invoicing to facilities
  - tracking/management of received funds
- Financial Reporting:
  - Reporting on financial indicators (including information flow and uses)
- Monitor/Adjust:
  - Evaluation of budgeting performance for the most recent cycle
  - Mid-year adjustment of annual budget
- Any other financing steps?

9.1

Diagnostic phase – Stakeholder interview guide on DRF operations (2/3)

PLAYBOOK

Questionnaire for State Engagement – Operations

FORECASTING

2. Can you please walk us through the process involved with the following forecasting activities?

- Forecast preparation:
  - Determination of scope of products to be forecasted
  - Collection of internal forecast/consumption data
  - Gathering of market intelligence
- Forecast creation:
  - Build and aligning forecast assumptions with all relevant stakeholders
- Forecast review:
  - Comparing forecast to actual consumption over the most recent cycle.
- Long term forecast accuracy monitoring:
  - Review of forecast vs. actual consumption/sales over several periods to track forecast accuracy
- Any other forecasting steps?

WAREHOUSING

- Receiving and storing commodities:
  - Preparation of commodity landing bay
  - Inspection of quality and quantity of deliveries at CMS
  - Receipt and issuance of proof of delivery documents
- Processing deliveries and storage:
- What is the state of the warehouse; is it pharma-grade across all dimensions?
  - Inventory stock taking
  - Recording received stock along with batch no and expiration information
  - Shelving in temporary storage area using FEFO (First Expire, First Out)
  - Transfer to designated long term storage shelves

PROCUREMENT

3. Can you please walk us through the process involved with the following procurement activities?

- Procurement preparation:
  - Consolidation of demand/orders from facilities
  - Calculation and ratification of order quantities
  - Creation of procurement budget
  - Definition of procurement strategy/award type and alignment on evaluation criteria of bids
- Tender submission:
  - Advertisement and soliciting of bids/tenders
  - Providing necessary support to bidders during tender preparation
- Tender evaluation
  - Technical and financial evaluation of bids
  - negotiation with preferred vendors
  - Finalizing terms and sign contracts
- Supply
  - Creation of Purchase order
  - Tracking/auditing of deliveries
  - Payment to suppliers
  - Contract management with vendors
- Any other procurement steps?

9.1

Diagnostic phase – Stakeholder interview guide on DRF operations (3/3)

PLAYBOOK

Questionnaire for State Engagement – Operations

WAREHOUSING

- Issuing / dispatch processing
  - Management of requisition documentation
  - Order processing – determination of actual stock allocation; which batch is going to be used to fulfil order
  - Picking and package of commodities into dispatch ready form and transport to outward loading bay
- Disposal and waste management:
  - Identification and documentation of products for disposal
  - Recording of stock taking out for disposal
  - Execution of safe disposal
- Any other warehousing steps?

TRANSPORT

6. Can you please walk us through the process involved with the following transport activities?

- Routing and securing trucks:
  - Identification of truck requirements
  - Procurement/hiring of trucks
  - Contract management with truck vendors or third-party logistics
  - Physical and documentary maintenance of trucks
  - Analysis of delivery locations and determination of optimal routing
- Loading of consignment:
  - Collection of consignments to loading bay
  - Loading onto trucks
  - Preparation of dispatch documents (proof of pick-up & delivery)

SUPPLY QUANTITY DETERMINATION

5. Can you please walk us through the process involved with the following supply quantity determination activities?

- Deciding what to supply facilities – push vs. pull
  - Frequency and causes of push system (CMS decides what to supply)
  - Frequency of pull system (facilities request)
- Strategic planning (if push system is prevalent):
  - Determination of supply quantities
- Strategic planning (if pull system is prevalent):
  - Consolidation of demand/orders from facilities
  - Calculation and ratification of order quantities
- Deciding volumes to be supplied (pull or push)
  - Frequency of full supply
  - Frequency of rationing
  - Causes of rationing

TRANSPORT

- Delivery and truck return to CMS:
  - Final assignment of vehicles/drivers & routing
  - Dropping commodities at the facility and proof of delivery
  - Evaluation of timeliness of truck return to CMS and fuel usage review
- Any other transport steps?

9.1

Diagnostic phase – stakeholder interview reporting template for DRF operations (1/2)

PLAYBOOK

Reporting Template – State Operations Survey

1.State:
2.Facility Name:
3.Respondent Information –

- a.Name(s):
- b.Role(s):
- c.Telephone Number:

4.Insight Overview

Themes	Insight	Root-cause of Insight; Why is it that way?	What is the Implication of Insight
Key successes - Finance	1. … 2. … 3. … 4. … 5. …	1. … 2. … 3. … 4. … 5. …	1. … 2. … 3. … 4. … 5. …
Key Development Area – Finance	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key successes – Forecasting	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key Development Area – Forecasting	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …

9.1

Diagnostic phase – stakeholder interview reporting template for DRF operations (2/2)

PLAYBOOK

Themes	Insight	Root-cause of Insight; Why is it that way?	What is the Implication of Insight
Key successes – Procurement	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key Development Area – Procurement	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key successes – Warehousing	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key Development Area – Warehousing	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key successes – ` Supply Quantity Determination	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
Key Development Area – Supply Quantity Determination	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …
successes – Transport	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …	1. … 2. … 3. … 4. …

9.1

Diagnostic phase – critical governance decisions

PLAYBOOK

There are 13 critical DRF activities for which governance bodies need to take decisions

	Activity	Definition
Coverage	**Commodity selection**	▪ Choosing **which commodities** to include in the DRF e.g., essential medicines or MNCH, including **expansion** considerations
	Facility selection	▪ Choosing **which facilities** to implement DRF in e.g., whether primary, secondary or tertiary facilities, and number of facilities, and **expansion** considerations
Vendor governance	**Vendor prequalification**	▪ Screening of potential suppliers, or vendors on the basis of experience, reputation, product quality, etc. in order to develop a **list of qualified bidders**
	Vendor selection	▪ Selecting the **right vendor for a given procurement** from a list of qualified bidders based on factors like commodity cost, quality, compliance
Pricing	**Pricing and markup**	▪ Deciding the **selling price** of commodities, including percentage markup allowed
	Markup utilization	▪ Deciding **how the percentage markup is to be used**, what percentage is ploughed back, and how the revenues are split across different supply chain layers
Monitoring & Accountability	**Data systems**	▪ Deciding which **data systems** should be used and how they should be used (e.g., frequency, tools, technology)
	Monitoring : how?	▪ Deciding **how the scheme should be monitored** for accountability (e.g., frequency, methods of reporting, audits)
	Monitoring: who?	▪ Deciding **who does the actual monitoring**; who owns accountability processes
	Consequence management	▪ Deciding on **rewards and punishment** for implementers of the scheme based on results of monitoring
Supply Chain governance	**Supply chain levels**	▪ Deciding **how many levels** the supply chain will operate through, e.g. State/LGA/HFs? Or State/HF?
	SOPs and Guidelines	▪ Determining, creating, and updating the **guidelines and SOPs** that will guide supply chain operations
	Supply chain ownership	▪ Deciding who **owns/operates** which sections of the supply chain e.g. warehouse managed by **private vendors** or the CMS? Distribution by **3PLs**? Etc.

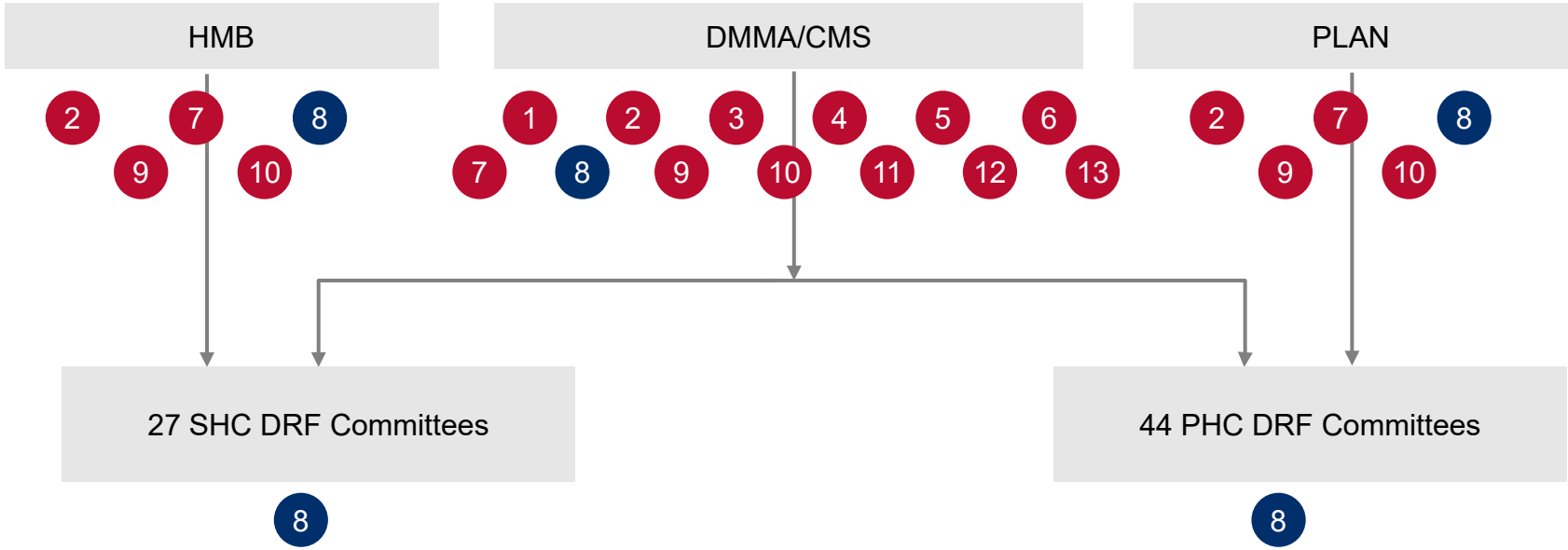
9.1 STATE EXAMPLE

Diagnostic phase – where governance decisions reside

PLAYBOOK

Bauchi State's DRF is very centralized, mostly run by the DMMA

One-level decision Multi-level decision



Legend: Decisions taken at various levels

1 Commodity selection
2 Facility selection
3 Vendor prequalification
4 Vendor selection
5 Pricing and markup
6 Markup utilization
7 Data management
8 Monitoring: when and how
9 Monitoring: who
10 Consequence management
11 Supply chain levels
12 SOPs and guidelines
13 Supply chain ownership

9.1

Diagnostic phase – summary evaluation of governance

PLAYBOOK

The team evaluates governance activities against two areas: (1) their guidelines and (2) the execution of those guidelines

This is a **basic glossary** of the terms in the evaluation

	Guidelines	Documented DRF SOPs and policy documents
	Execution	How the guidelines are implemented
Strong	**Green rating**	Strong guidelines or execution
Medium	**Yellow rating**	Medium-strength guidelines or execution
Poor	**Red rating**	Poor guidelines or execution
	Minimum Viable Product	The minimum standard acceptable for the DRF scheme to get started

9.1 STATE EXAMPLE

Diagnostic phase – summary evaluation of governance

Strength of guidelines or execution: Strong | Medium | Poor | Non-existent

PLAYBOOK Multi-level decision

Decision-making bodies: The DMMA leads decision-making in Bauchi, but it needs more technical experts and wider participation

	Decision	Existence of a body to take the decision	Staffing of the body	Inclusiveness of the body	Comments
Coverage	1 Commodity selection	Medium	Medium	Medium	**Commodity selection was done by DMMA along with HMB, MoH**
	2 Facility selection	Medium	Medium	Medium	**Facility selection for SHCs included HMB and for PHCs included SPHCDA**
Vendor governance	3 Vendor prequalification	Medium	Medium	Poor	**The DMMA staff handle all vendor-related decisions**, with no open tenders and no other stakeholders involved
	4 Vendor selection	Medium	Medium	Poor	
Pricing	5 Pricing and markup	Medium	Poor	Poor	**The DMMA decides the pricing and mark-up**, with no involvement from facilities, communities, or other stakeholders
	6 Markup utilization	Medium	Strong	Poor	
Monitoring & Accountability	7 Data systems	Medium	Strong	Poor	**The LMCU oversees data management**, involving LGAs and HFs. However, this is currently not linked to the DRF scheme
	8 Monitoring : how?	Medium	Medium	Medium	**The DMMA, which is understaffed** (6 technical staff compared to 26 in Jigawa) **is also responsible for monitoring the scheme,** with no participation from other organizations such as HMB, SPHCDA, or community groups
	9 Monitoring: who?	Medium	Medium	Medium	
	10 Consequence management	Medium	Medium	Poor	
Supply Chain governance	11 Supply chain levels	Medium	Medium	Poor	**The DMMA decided the supply chain levels to from CMS to Zonal store to facility.** They also developed supply chain SOPs and owned and operated the warehousing and distribution (without leveraging 3rd parties / private sector). DMMA decisions were taken without diverse participation
	12 SOPs and Guidelines	Medium	Medium	Poor	
	13 Supply chain ownership	Medium	Medium	Poor	

9.1 STATE EXAMPLE

Diagnostic phase – summary evaluation of governance

Strength of guidelines or execution: Strong | Medium | Poor | Non-existent

PLAYBOOK Multi-level decision

Policies and guidelines: Bauchi has guidelines in place for most governance activities, but lacks required level of implementation

	Decision	Policies and guidelines	Execution of guidelines	Comments
Coverage	1 Commodity selection	Medium	Medium	**DMMA adopted the national list of essential medicines** for the Bauchi DRF. Only a few of these commodities are currently available
	2 Facility selection	Medium	Medium	**Guidelines for facility selection only follow a rule-of-thumb approach** of all SHCs and 1 PHC per ward
Vendor governance	3 Vendor prequalification	Medium	Poor	**High-level procurement guidelines are contained in the DRF law,** with scant details on vendor prequalification and selection process. These are not followed in practice
	4 Vendor selection	Medium	Poor	
Pricing	5 Pricing and markup	Medium	Medium	**The DMMA has clear guidelines around pricing, mark-ups, and mark-up utilization, with a basic analysis done to set them.** The guidelines do not indicate any eligibility criteria for D & E. These set prices are being followed, but not posted in some facilities
	6 Markup utilization	Strong	Medium	
Monitoring & Accountability	7 Data systems	Strong	Medium	**Guidelines on data management are very detailed,** including data accountability and visibility. Data is however collected irregularly
	8 Monitoring : how?	Strong	Medium	**There are clear monitoring and evaluation guidelines, but they are not followed.** Monitoring is not regularly done
	9 Monitoring: who?	Strong	Poor	
	10 Consequence management	Poor	Poor	Clear guidelines for reward and punishment are not in place although guidelines allude to them; implementation is very ad-hoc
Supply Chain governance	11 Supply chain levels	Strong	Medium	**The DMMA has guidelines and SOPs governing supply chain operations at both the CMS and the facilities,** and also maintains ownership of the single CMS. However, not all levels of the supply chain mentioned on the SOP (i.e zonal store) are in existence. The SOPs are sometimes followed for some processes (e.g., warehousing), but not across the board
	12 SOPs and Guidelines	Strong	Medium	
	13 Supply chain ownership	Strong	Strong	

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

1: Commodity selection: Guidelines

PLAYBOOK

Sub-activity	Criteria for rating quality of guidelines			
	Green	**Yellow**	**Red**	**Minimum Viable Product**
	▪ Guidelines state that DRF commodities are to be selected based on state-specific needs that incorporate data on disease burdens and consumption patterns, status of free drug programs, and supply chain logistical capacity. ▪ The selection should be known to all stakeholders and reviewed and updated at least every 2 years	▪ Guidelines state that specific commodities are to be selected but without a rigorous basis; not all stakeholders are made aware of the selection; selection is not regularly updated based on new information	▪ There are no clear guidelines for commodity selection.	▪ Clear definition of which commodities are to be included in the scheme's guidelines, with a stated plan for re-evaluation and revision in the coming years
I **Commodity specification**	▪ Guidelines state that DRF commodities are to be selected based on state-specific needs that incorporate data on disease burdens and consumption patterns, status of free drug programs, and supply chain logistical capacity. ▪ The selection should be known to all stakeholders and reviewed and updated at least every 2 years	▪ Guidelines state that specific commodities are to be selected but without a rigorous basis; not all stakeholders are made aware of the selection; selection is not regularly updated based on new information	▪ There are no clear guidelines for commodity selection.	▪ Clear definition of which commodities are to be included in the scheme's guidelines, with a stated plan for re-evaluation and revision in the coming years
	▪ All commodities indicated in the guidelines are selected for the scheme. Selection undergoes regular updating in practice.	▪ Some of the commodities listed in the guidelines are selected for the scheme	▪ Commodities selected for the scheme in practice have little bearing on guidelines	▪ Commodities selected for the scheme are at least a subset of those listed in the guidelines

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

2: Commodity selection: Execution

Sub-activity	Criteria for rating quality of guidelines			
	Green	**Yellow**	**Red**	**Minimum Viable Product**
I **Initial facility identification**	▪ Facility selection criteria includes strength of infrastructure (e.g., storage capacity), human resources, and service delivery level, as well as community willingness to strengthen facilities and political ramifications	▪ Facility selection criteria only leverage basic demographic information (e.g., only focus on political ramifications or use rule-of-thumb approach such as 1 PHC per LGA)	▪ There is no facility selection criteria	▪ Guidelines include basic, most critical criteria (political ramification and basic HR considerations)
II **Final facility selection and stakeholder notification**	▪ There are guidelines to refine the list of identified facilities based on operational / financial limits (i.e., current scheme capacity); there are guidelines to clearly publicize list, including informing facilities, local partners, and community/customers, which may require behavior change initiatives	▪ There are guidelines to refine the list of identified facilities but it does not adequately take scheme capacity into account; notification does not adequately include relevant stakeholders (i.e., no behavior change included)	▪ There is no guideline to refine the list or publicize at the local level	▪ Guidelines indicate that final facility selection is done based on basic criteria and that immediate stakeholders (e.g., facilities themselves) are notified ▪ This basic criteria should include willingness of host community to support the scheme

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

2: Facility selection: Guidelines

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I Initial facility identification	▪ Facility selection criteria includes strength of infrastructure (e.g., storage capacity), human resources, and service delivery level, as well as community willingness to strengthen facilities and political ramifications	▪ Facility selection criteria only leverage basic demographic information (e.g., only focus on political ramifications or use rule-of-thumb approach such as 1 PHC per LGA)	▪ There is no facility selection criteria	▪ Guidelines include basic, most critical criteria (political ramification and basic HR considerations)
II Final facility selection and stakeholder notification	▪ There are guidelines to refine the list of identified facilities based on operational / financial limits (i.e., current scheme capacity); there are guidelines to clearly publicize list, including informing facilities, local partners, and community/customers, which may require behavior change initiatives	▪ There are guidelines to refine the list of identified facilities but it does not adequately take scheme capacity into account; notification does not adequately include relevant stakeholders (i.e., no behavior change included)	▪ There is no guideline to refine the list or publicize at the local level	▪ Guidelines indicate that final facility selection is done based on basic criteria and that immediate stakeholders (e.g., facilities themselves) are notified ▪ This basic criteria should include willingness of host community to support the scheme

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

2: Facility selection: Execution

	Criteria for rating quality of guidelines			
Sub-activity	**Green**	**Yellow**	**Red**	**Minimum Viable Product**
I **Initial facility identification**	▪ Facilities are identified according to comprehensive guidelines	▪ Facility identification does not closely follow guidelines, or are done based on basic rule-of-thumb guidelines	▪ Facility identification is done as if at random	▪ Facility selection follows some sort of guidelines
II **Final facility selection and stakeholder notification**	▪ There are guidelines to refine the list of identified facilities based on operational / financial limits (i.e., current scheme capacity); there are guidelines to clearly publicize list, including informing facilities, local partners, and community/customers, which may require behavior change initiatives	▪ There are guidelines to refine the list of identified facilities but it does not adequately take scheme capacity into account; notification does not adequately include relevant stakeholders (i.e., no behavior change included)	▪ There is no guideline to refine the list or publicize at the local level	▪ Final facility selection is done based on basic criteria; immediate stakeholders (e.g., facilities and the communities) are notified

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

3: Vendor prequalification: Guidelines

Sub-activity	Criteria for rating quality of guidelines			
	Green	**Yellow**	**Red**	**Minimum Viable Product**
I **Committee establishment**	▪ Committee establishment guidelines stipulate membership requirements that includes diverse representation (including representatives from DMA, MoH, MoF, HMB, SPHCDA, Due Process Bureau)	▪ Committee guidelines do not mandate full diversity of representation	▪ There is no guideline for committee establishment	▪ Guidelines provide for basic committee to be established even if it does not have full representation ▪ Organizations that must be represented as a minimum include the DMA, HMB, SPHCDA and SMoH
II **Vendor prequalification (PQ)**	▪ PQ guidelines include: transparency to suppliers (i.e., process to inform suppliers about PQ steps and criteria), solicitation process (annual ask for supplier information), and evaluation criteria (based on supplier pharmaceutical capacity and financial capacity - their track record for production and financial management)	▪ PQ guidelines exist but are unspecific or missing components, and are not made transparent to vendors	▪ There are no PQ guidelines	▪ Basic PQ criteria exist that evaluate supplier capacity and are listed in the guidelines; suppliers are informed of these criteria

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

3: Vendor prequalification: Execution

Sub-activity	Criteria for rating quality of guidelines			
	Green	**Yellow**	**Red**	**Minimum Viable Product**
I Committee establishment	▪ Committee has been established with all required representatives	▪ Committee has been established but without all required representatives	▪ No committee exists	▪ Basic committee is established even if it does not have full representation
II Vendor prequalification (PQ)	▪ PQ process happens according to guidelines, including rigorous and transparent evaluation of vendor pharmaceutical and financial capacity. PQ process happens annually	▪ PQ process happens sporadically and without adhering to rigorous guidelines	▪ PQ process does not happen or does not follow any guidelines	▪ A PQ process has been planned to take place according to the guidelines

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

4: Vendor selection: Guidelines

Sub-activity	Criteria for rating quality of guidelines			
	Green	**Yellow**	**Red**	**Minimum Viable Product**
I Selection team	▪ Guidelines stipulate that at least a team within the DMA/DRF committee should oversee the vendor selection process, including tendering, bid opening, evaluation and final vendor selection	▪ Committee guidelines do not mandate any team or committee to be in charge of vendor selection	▪ Guidelines do not exist for vendor selection	▪ Guidelines stipulate that a team within the DMA plus the DRF committee oversee vendor selection
II Vendor selection	▪ Guidelines clearly define criteria for selection of vendors from the prequalified list. Criteria focuses on best "all-in" price for a defined quality level out of prequalified vendors. "All-in" price includes commodity price, cost of other benefits (e.g., inbound transportation, payment terms (days payable), willingness to lock prices for at least 6 months). All members of selection commitee are required to be involed. Selection process is transparent to partners/stakeholders	▪ Guidelines focus only on commodity price and ignore other benefits, and demand that selection is done only from prequalified vendors. Not all committee members are required to be involved in selection	▪ Guidelines do not exist for vendor selection	▪ Vendor selection has basic guidelines that at least stipulate minimum quality standards against which prices are compared, driven by the DMA and DRF management committee

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

4: Vendor selection: Execution

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I Team	▪ DMA fully operational with a procurement/vendor selection unit/team	▪ Committee exists with restricted membership	▪ No committee exists	▪ DMA/DRF fully operational with a procurement/vendor selection unit/team
II Vendor selection	▪ Vendors are always selected transparently and according to robust guidelines, with all DMA vendor selection members involved	▪ Vendors are selected based on basic guidelines and without full committee involvement	▪ Vendors are not selected based on guidelines	▪ Vendor selection process has been planned according to a clear set of criteria

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

5: Pricing and mark-up: Guidelines

Sub-activity	Criteria for rating quality of guidelines: Green	Yellow	Red	Minimum Viable Product
I Committee establishment	▪ Guidelines stipulate that a team/committee from the governing board with a diverse representation (including representatives from DMA, MoH, MoF, HMB, SPHCDA) be in charge of price and mark-up determination	▪ Guidelines do not mandate full diversity of representation; committee is not required to be stand-alone (separate from other committees)	▪ There are no guidelines for a Pricing committee	▪ Guidelines stipulate the Governing Board or similar committee to be in charge of determining pricing
II Mark-up and pricing determination	▪ Guidelines for markup and pricing determination require financial analysis that includes assessment of commodity supplier pricing compared with basic operational and other costs and risks (e.g., D&E with clear selection criteria, wastage/expiries, inflation, etc.). ▪ Markup determination guidelines balance cost requirements with customer willingness and ability to pay, and require a plan to fill in cost requirements not covered by the markup. Mark-up and prices are also updated whenever guidelines are updated	▪ Markup guidelines require only basic analysis (e.g., comparison to existing markups from other commodity retailers). They are also not regularly updated	▪ There are no guidelines for mark-up and pricing determination	▪ Guidelines show a basic analysis used to determine mark-ups and prices ▪ Guidelines stipulate that mark-up and prices be updated whenever guidelines are updated ▪ Guidelines indicate eligibility for D & E
III Price publication	▪ Guidelines clearly stipulate that prices of all commodities be made public at all stores and facilities. They should also stipulate for these price lists to be updated whenever prices are updated	▪ Guidelines stipulate that prices be published in stores and facilities but do not stipulate price updates	▪ Guidelines do not stipulate publsihing prices of commodities	▪ Guidelines stipulate that prices are displayed at the state CMS and health facilities, and are updated whenever prices are updated

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

5: Pricing and mark-up: Execution

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I Committee establishment	▪ Pricing unit/committee within Governing Board established with all required representatives	▪ Another existing committee also sets proces e.g. DMA Board, Vendor selection committee	▪ No pricing committee exists	▪ Governing Board or equivalent established even if it does not have full representation OR an existing committee also undertakes pricing and mark-up
II Mark-up and pricing determination	▪ Prices and mark-up are set as determined in the guidelines, and are also updated as regularly as the guidelines are updated	▪ Prices and mark-up are set as determined in the guidelines only in some stores and facilities but not in others. OR they are set as determined but not updated regularly	▪ Prices and mark-up are not set as determined in the guidelines	▪ Basic financial analysis used to determine mark-ups and prices, which are set as determined across all stores and facilities
III Price publication	▪ Prices are displayed at all stores and health facilities as stipulated in the guidelines, and have been updated at least once a year as described in the guidelines	▪ Prices are displayed in some stores and health facilities, and have not been updated	▪ Prices are not displayed anywhere	▪ Prices are displayed at the state CMS and health facilities, and are updated whenever prices are updated

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

6: Mark-up utilization: Guidelines

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I Percentage allocation	▪ Guidelines describe allocation of mark-up between CMS, zonal/LGA stores and facilities, clearly stating differences for primary, secondary and tertiary facilities	▪ Guidelines describe allocation for CMS and facilities, but is not clear on differences between different types of facilities	▪ Guidelines do not describe allocation of mark-up	▪ Guidelines clearly allocate mark-ups between CMS and different facility types,

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

6: Mark-up utilization: Execution

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I Percentage allocation	▪ Mark-ups allocated as described in the guidelines between CMS, zonal/LGA stores and primary, secondary and tertiary facilities	▪ Mark-ups are allocated for CMS as described in the guidelines, but allocated similarly for all facility types irrespective of guideline provision	▪ Mark-ups are allocated randomly at the CMS and at the facilities irrespective of guidelines provision	▪ Mark-ups are clearly allocated between CMS and different facility types, and implemented as stipulated, with savings from some components (e.g. inflation) ploughed back into the Fund

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

7: Data systems: Guidelines

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I Data and tools definition	▪ Guidelines clearly define which data are to be collected for DRF scheme, and which tools (DRF-specific + generic LMIS) to be used for data collection at the CMS/zonal stores/LGA, as well as at the different health facilities	▪ Guidelines define tools to be used, but does not state what data is to be collected, or vice versa	▪ Guidelines do not describe which data is to be collected or which tools to be used	▪ Guidelines state which data to be collected and which tools to be used (DRF-specific + generic LMIS). These tools should be available in all the health facilities (both PHC and SHC) ▪ All staff are trained to use them and report with them
II Data accountability	▪ Guidelines clearly state which individuals/roles/group to collect relevant data	▪ Guidelines do not specifically state who should be responsible for particular data collection e.g. stating that PHCs should collect ABC data instead of PHC OIC	▪ Guidelines do not state who should collect data	▪ Guidelines state which individuals or roles to be responsible for data collection across all facility types, and these individuals are well-trained for the purpose
III Data reporting and visibility	▪ Guidelines clearly stipulate that DRF data be reported bi-monthly by PHCs and quarterly for SHCs and made available on platforms such as NHLMIS and DHIS2	▪ Guidelines state that DRF data, in paper form, be reported and regularly made accessible to state-level stakeholders	▪ Guidelines do not stipulate that data be reported to the state-level structures	▪ Guidelines stipulate bi-monthly reporting for PHCs and quarterly reporting for SHCs through paper or online platforms to both LMCU and DMA

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

7: Data systems: Execution

Sub-activity	Criteria for rating quality of guidelines: Green	Yellow	Red	Minimum Viable Product
I Data and tools definition	▪ Data tools are available at all stores and facilities, and all staff are well trained on use of these tools and use them to report all the time	▪ Tools are available in most stores and facilities, and most staff are trained on the use of these tools and use them to report frequently	▪ Tools are available only in a few facilities, and only few staff can use them and report infrequently	▪ Data tools are available in all the health facilities (both PHC and SHC), and all staff are trained to use them and report with them
II Data accountability	▪ Guidelines clearly state which individuals/roles/group to collect relevant data	▪ Guidelines do not specifically state who should be responsible for particular data collection e.g. stating that PHCs should collect ABC data instead of PHC OIC	▪ Guidelines do not state who should collect data	▪ Guidelines state which individuals or roles to be responsible for data collection across all facility types, and these individuals are well-trained for the purpose
III Data reporting and visibility	▪ DRF data is reported bi-monthly by PHCs and quarterly by SHCs in paper forms to the LMCU and DMA, as well as on NHLMIS and DHIS2 platforms	▪ DRF data is reported only in paper forms to the LMCU or DMA or both	▪ DRF data is not regularly reported whether through paper forms or on online platforms	▪ Bi-monthly reporting by PHCs and quarterly reporting by SHCs through paper or online platforms to both LMCU and DMA,
IV Data use for decision-making	▪ Quarterly meetings are held by the LMCU, DMA, SPHCDA, HMB and implementing partners to review data from stores and health facilities and subsequently take decisions to improve the scheme based on the data	▪ Monthly/bi-monthly meetings are held either by the DMA alone or occasionally with the LMCU, and decisions taken for the improvement of the DRF scheme	▪ No data review meetings are held and collected data is not used for any decision-making process	▪ Quarterly DRF data review meeting (e.g. through the QSSR) between the DMA and LMCU, with decisions taken to improve the scheme based on the reported data

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

8: Monitoring: How

		Criteria for rating quality of guidelines			
	Sub-activity	Green	Yellow	Red	Minimum Viable Product
Guidelines	I DRF KPIs and monitoring tools	▪ Guidelines clearly list a comprehensive range of KPIs (comprising governance, supply chain and financial management indices) and simple monitoring tools to be used to measure progress and impact at both the stores and the health facilities	▪ Guidelines list KPIs and tools that do not cover all the essential elements of the program (e.g. lists supply chain but not governance and finance indices) or list KPIs for facility assessments but not for stores	▪ Guidelines do not list KPIs or tools to be used in measuring the progress and impact of the DRF scheme	▪ Guidelines clearly list a comprehensive range of KPIs (comprising governance, supply chain and financial management indices) and simple monitoring tools to be used to measure progress and impact at both the stores and the health facilities
	II Monitoring cadence	▪ Guidelines clearly define how often monitoring visits to stores and facilities should take place (e.g. monthly for CMS and zonal stores, every other month for LGA stores and health facilities, etc	▪ Guidelines state that monitoring visits be carried out, but only stipulate cadence for either facilities only or stores only	▪ Guidelines are silent on monitoring cadence	▪ Cadence is clearly described in the guidelines for both stores and facilities e.g. monthly visits to all facilities in the first six months of the scheme, and quarterly thereafter
Execution	I DRF KPIs and monitoring tools	▪ The KPIs and monitoring tools are always used for measuring the progress and impact of the scheme as stipulated on the guidelines	▪ KPIs and tools are irregularly used to measure the progress and impact of the DRF	▪ KPIs and tools are not used for measuring the progress and impact of the project as stipulated on the guidelines	▪ Monitoring tool with KPIs to cover all aspects of the scheme, used on a monthly basis for monitoring visits
	II Monitoring cadence	▪ Monitoring visits are done for both stores and health facilities according to the cadence described in the guidelines	▪ Monitoring visits are sometimes conducted at stores and facilities according to the cadence guidelines	▪ No monitoring visits are conducted; whether to stores or health facilities	▪ Monitoring cadence is implemented in all the facilities

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

9: Monitoring: Who

	Sub-activity	Criteria for rating quality of guidelines: Green	Yellow	Red	Minimum Viable Product
Guidelines	I **Monitoring roles**	▪ Guidelines describe who should be involved in monitoring at which level; including which individuals and organizations should have representation on monitoring teams. ▪ Guidelines should specifically call out community participation in monitoring at the facility level	▪ Guidelines describe required monitoring requirements (e.g. monitoring team should visit PHCs quarterly) but does not clearly state the composition of these teams in terms of individuals and organizations, and community members	▪ Guidelines do not describe monitoring requirements or people to be involved	▪ Guidelines stipulate monitoring visits to the stores and facilities conducted with a diverse team composed of DMA, HMB, SPHCDA, LGA ▪ WDC/FHC should be involved at facility level
Execution	I **Monitoring roles**	▪ Monitoring is conducted by diverse monitoring teams as described in the guidelines, including community members	▪ Monitoring is conducted only by the DMA, with only a few of the organizations described in the guidelines being involved. The communty is not involved	▪ No monitoring is conducted	▪ Monitoring visits to the stores and facilities consistently conducted by a diverse team composed of DMA, HMB, SPHCDA and LGA ▪ WDC/FHC involved at the facility level

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

10: Consequence management: Guidelines

Criteria for rating quality of guidelines

Sub-activity	Green	Yellow	Red	Minimum Viable Product
I **Clear performance contracts, with defined rewards and punishments**	▪ Guidelines clearly state the development of performance contracts with both DMA and facilities. ▪ These contracts should outline well-defined rewards for keeping the contract and well-defined sanctions for breaking them ▪ They should also be reflected in the MoUs and DRF laws	▪ Guidelines state that rewards and sanctions should be implemented, but does not state what these should be	▪ Guidelines are silent on consequence management	▪ Guidelines stipulate performance contracts are developed, with clear and specific rewards and sanctions outlined for facilities ▪ These performance contracts are also be reflected in the MoUs and DRF laws

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

10: Consequence management: Execution

Sub-activity	Criteria for rating quality of guidelines			
	Green	Yellow	Red	Minimum Viable Product
I **Clear performance contracts, with defined rewards and punishments**	▪ Performance contracts exist for all staff, and specific rewards and sanctions are both stated in them and are also implemented at both the DMA/CMS and the health facilities.	▪ Rewards and sanctions are implemented in a random and inconsistent manner	▪ There are no rewards or sanctions implemented	▪ Performance contracts developed, with clear and specific rewards and sanctions outlined and also implemented

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

11: Supply chain governance: Guidelines

Sub-activity	Criteria for rating quality of guidelines: Green	Yellow	Red	Minimum Viable Product
I Definition of supply chain levels	▪ Guidelines clearly define how many levels the DRF supply chain should have e.g. CMS-zonal store-LGA store-facilities	▪ Guidelines state that there will be supply chain levels, but do not state these levels	▪ Guideline do not state how many levels the DRF supply chain should have	▪ Guidelines define how many levels the DRF supply chain will have, and at least a functional, effective and expanded CMS
II Definition and development of SOPs	▪ Detailed SOPs needed for efficient supply chain operations exist; with additional details on how they should be regularly updated and who should update them	▪ Some SOPs needed for efficient supply chain exist, but they are not detailed enough to cover end-to-end operations	▪ There are no supply chain SOPs	▪ Guidelines contain detailed end-to-end supply chain SOPs
III Definition of the supply chain ownership	▪ Guidelines describe who owns and operates the supply chain infrastructure and equipment e.g DMA or the private sector to own CMS/zonal stores, 3PLs to run outbound distribution, etc	▪ Guidelines mention who owns supply chain infrastructure without much detail	▪ Guidelines do not state who should own/operate the supply chain infrastructure and equipment	▪ DRF supply chain ownership is clearly defined in the guidelines

9.1 STATE EXAMPLE

Diagnostic phase – explanation of guidelines grading

PLAYBOOK

11: Supply chain governance: Execution

Sub-activity	Criteria for rating quality of guidelines: Green	Yellow	Red	Minimum Viable Product
I Definition of supply chain levels	▪ DRF supply chain comprises the levels stated in the guidelines	▪ Some of the levels stated in the guidelines exist, but not others e.g. CMS and zonal store existing, but no LGA store	▪ None of the levels stated in the guidelines exist	▪ A functional, effective and expanded CMS in operation
II Definition and development of SOPs	▪ Detailed SOPs are routinely followed as described for the end-to-end DRF supply chain	▪ Detailed SOPs are occasionally followed, or less detailed guidelines are routinely followed	▪ SOPs are not followed at all	▪ DRF SOPs are followed routinely
III Definition of the supply chain ownership	▪ DRF supply chain infrastructure and equipment are owned and operated as stated in the guidelines	▪ Some infrastructure and equipment are owned and operated as stated in the guidelines, while others are not	▪ DRF supply chain infrastructure is neither owned nor operated as stated in the guidelines	▪ DRF supply chain ownership executed as defined

9.1 STATE EXAMPLE

Diagnostic phase – summary evaluation of Bauchi DRF operations

Supply chain summary

Strength of guidelines or execution: PLAYBOOK

Strong | Medium | Poor | Non-existent

		Guideline quality	Execution Quality	Comments
Central level	A Forecasting	Non-existent	Non-existent	Due to a lack of funds, procurement is done monthly and forecasting is neither undertaken nor contained in the SoPs. Monthly procurement is generally driven by just-in-time consumption data
	B Procurement	Poor	Medium	The DMMA law provides high-level guidelines for CMS procurement without details. In practice, commodities are procured from the lowest-price pre-qualified vendor
	C In-bound logistics	Non-existent	Strong	The vendors supply commodities directly to the CMS. This process is properly documented and vendors are paid after the delivery to the CMS has been confirmed
	D Warehousing	Medium	Medium	Although the CMS has spare capacity, there is no shelving, and the space is unlikely to be sufficient if DRF expands to many PHCs. Overall, the DMMA follows its reasonably robust SoPs well in areas of receiving and recording shipments as well as waste disposal
Health facility level	E Procurement	Medium	Medium	Although the SOP details steps to be followed and approvals required for facilities to procure commodities, there is no detail on how quantification should be done. Additionally, SHCs do not adhere to approval processes and the CMS sometimes imposes commodities on facilities when it has stock outs
	F Delivery to HF	Non-existent	Poor	Facilities (PHCs and SHCs) experience challenges with collection of commodities. The CMS does not currently provide distribution services to HFs
	G Storage	Strong	Poor	The SOP has very detailed information on storage practices to be followed at facilities. However, most facilities have inadequate storage spaces, and most PHCs do not enforce good storage practices, which could lead to quality issues

9.1 STATE EXAMPLE

Diagnostic phase – summary evaluation of Bauchi DRF operations

Financial management summary

Strength of guidelines or execution: PLAYBOOK

Strong | Medium | Poor | Non-existent

		Guideline quality	Execution Quality	Comments
Central level	A Budgeting	Poor	Medium	Guidelines specify the department responsible for developing budgets for commodity procurement Budgeting is informed by a procurement plan for the year. However, the budgets are constrained to the fiscal provision that the state government advises on
	B Expense management	Strong	Strong	There are properly detailed guidelines guiding the management of expenses at the CMS, at least for commodity procurement According to CMS staff, the CMS uses sound processes for expense management, at least for commodity procurement
	C Sales management	Strong	Strong	There are properly detailed guidelines guiding the management of revenue at the CMS (except for processes for invoicing) According to CMs staff, the CMS follows the defined guidelines for revenue management at the CMS
	D Budget management	Non-existent	Medium	There are no guidelines to inform the budgeting process Still, budget reviews are done using the quarterly budget performance report sent to MOH, Budget and Planning, and Accountant General's office
Facility level	E Sales management	Strong	Medium	There are clear guidelines for facility-level revenue management Facilities with DRFs (THCs, SHCs) follow the stipulated guidelines. Orphan PHCs are yet to begin implementation. However, execution of the guidelines is not monitored for compliance
	F D&E management	Non-existent	Poor	There are no guidelines on the management of deferrals and exemptions at the facilities. In practice, facility OICs determine who receive exemptions and deferrals. There are no financial treatments employed when deferrals are given.
	G Expense management	Strong	Medium	There are guidelines only on the use of payment vouchers and cash books. There are no details on the supporting documents that should be reviewed before expenses are approved

9.1 STATE EXAMPLE

Diagnostic phase – summary evaluation of Bauchi DRF operations

Data management summary

Strength of guidelines or execution: PLAYBOOK

Strong | Medium | Poor | Non-existent

	Guideline quality	Execution quality	Comments
A **Stock and consumption data**			▪ There are guidelines that detail the different tools and the respective activities for which they are required for DRF data collection on the LMIS. Guidelines do not state specific officers the responsible persons ▪ Stock data reporting is not linked to the DRF- it is only linked to the program areas being supported by implementing partners. The LMCU receives stock reports for vaccines-RI (weekly), TB and leprosy quarterly
B **Logistics data** (e.g., on-time delivery rate)			• There are no specific guidelines on logistics data reporting for DRF commodities. The state follows the National LMCU guidelines, which currently does not cover DRF products (it is program specific, primarily where IPs support, such as malaria. HIV, FP.)
C **Financial data**			▪ There are guidelines that stipulate how often facilities and the CMS are required to report on financial data and what specific data points (reports) they should be reporting on ▪ However, execution of financial data reporting is limited to the program areas being supported by implementing partners, which excludes most DRF commodities. Where it is done, the financial data is gathered from the LMD (Last Mile Distribution) tool and exported to Navision

9.1 STATE EXAMPLE

Diagnostic phase – summary evaluation of Bauchi DRF operations

Human Resources DMMA/CMS: current state

Strength of guidelines or execution: PLAYBOOK
Strong | Medium | Poor | Non-existent

	Ideal requirement	Current situation	Trained (Y/N)	Rating
Procurement	▪ DMMA MD ▪ Pharmacist (x4) ▪ Pharmacy technician (x4) ▪ Others (x4)	▪ DMMA MD ▪ Pharmacist (x2) ▪ Pharmacy technician (x2)	▪ Yes ▪ Yes ▪ Yes	
Inspection / monitoring / evaluation	▪ Director ▪ Deputy director ▪ Planning officers (x2) ▪ M &E officer (x2)	▪ Planning officers (x2)	▪ Yes	
Administrative	▪ Director ▪ Conference sec ▪ Stock officers (x2) ▪ Clerk/clerical assistant (x5) ▪ Store assistant (x9) ▪ Security officer (x 7)	▪ Director ▪ Conference sec ▪ Stock officers (x2) ▪ Clerk/clerical assistant (x3) ▪ Store assistant (x11)	▪ Yes ▪ No ▪ Yes ▪ Yes ▪ Yes ▪ No	
Finance	▪ Chief Accountant ▪ Accountant officers (x2) ▪ Cashier (x3)	▪ Director of Finance (1) Cashier (x2)	▪ Yes ▪ Yes	
Audit	▪ Chief internal auditor ▪ Audit Assistant (x2)		▪ Yes	

9.1 STATE EXAMPLE

Diagnostic phase – Sokoto kick-off agenda

PLAYBOOK

Item	Facilitator	Time
1. Welcome and introductions 1. Opening prayer 2. Introductions 3. Opening remarks 4. Objectives for today's session 5. Welcome address	1. TBD 2. LMCU Coordinator 3. State leadership 4. Project team 5. Honorable Commissioner of Health	20 minutes
2. Introduction into the project 1. Cause for action 2. HCD recap; why USAID is supporting DRF strengthening in Sokoto 3. Project objectives	Project team	30 minutes
3. Project approach 1. Project scope and overall approach 2. How the project team will work with stakeholders in the state 3. Next steps	Project team	30 minutes
4. Question and answer session	Project team leadership	30 minutes
5. Closing remarks and commitment to working together	State leadership	5 minutes
6. Closing prayers	TBD	5 minutes
7. Refreshments and networking		

9.2 NOT EXHAUSTIVE

Design phase – List of participants at diagnostic and design workshop

PLAYBOOK

In the course of the workshops, engage a diverse mix of state, facility, community stakeholders and implementing partners

	Bauchi	Sokoto	Kebbi
State	▪ Perm Secretary for Health ▪ DMMA ▪ SMOH ▪ BSPHCDA ▪ HMB ▪ BACTAMA ▪ BASCHMA ▪ LMCU ▪ BHETFUND ▪ State House of Assembly ▪ Other ministries: Justice etc	▪ Perm Secretary for Health ▪ SMOH ▪ SPHCDA ▪ HSMB ▪ CMS ▪ LMCU ▪ SOCHEMA ▪ SOSMEA	▪ SMOH ▪ SPHCDA ▪ CMS ▪ LMCU ▪ State House of Assembly ▪ Office of Acct General ▪ Office of Auditor General ▪ Other ministries: Women Affairs, Budget and Planning, Finance, Justice, Local Govt
Facility	▪ ATBUTH ▪ PHC B/fada ▪ PHC Doh ▪ GH Ningi ▪ IDH Bayara	▪ Specialist hospital ▪ PHC Gagi	▪ Sir Yahaya Memorial Hospital ▪ Kebbi Medical Center, Kalgo ▪ General Hospital Zauro
Community	▪ BASECOH ▪ WDC Chairman ▪ Radio Nigeria ▪ CSO Forum ▪ FOMWAN ▪ NTA	▪ Sultanate council ▪ ACPSN ▪ PSN ▪ AGPMPN	▪ Gwandu Emirate Council ▪ FOMWAN ▪ WDC
Implementing Partners	▪ BA ▪ Plan International ▪ SOML	▪ BA ▪ IHP ▪ MSH	▪ IHP ▪ SOML

9.2 SAMPLE AGENDA

Design phase – Diagnostic and design workshop agenda (1/2)

PLAYBOOK

Agenda – Day 1

Goals/ Outputs:

- Alignment on diagnostic output
- Brainstorming risks in key design choices
- Prioritization of state requirements for a fit to purpose DRF

Topic	Format	Time
Welcome Remarks	Plenary	9:00-9:15
Introduction and context setting	Plenary	9:15-9:45
Description: High level agenda walk through including setting the stage for DRF ambition in the state, methodology for diagnostics and advisory panel		
Output of State Diagnostics	Gallery Walk	9:45-10:30
Description: 15-minute rotations through Governance, Operations: supply chain& data mgt and Operations: financial mgt & HR mgt stations facilitated by central and state teams		
Reflections on Diagnostic Output	Plenary	10:30-11:30
Description: 15-minute share back with 5 minute Q&A for each of the 3 stations		
Tea break		11:30-12:00
Alignment of design choices	Plenary and Breakout	12:00-14: 00
Description: 30-minute plenary highlighting pros and cons for each design choice; followed by 30-minute breakout to discuss risk mitigation strategies and 60 minute share back sessions in plenary		
Lunch and prayers		14:00-15:00
State Requirements for DRF: Prioritization and Work-planning	Plenary and Breakout	15:00-16:45
Description: 45 minute breakout session prioritizing initial and end state governance and operations requirements for the state-wide DRF and 60 minute share back in plenary		
Tea break		16:45- 17:00
Closing Remarks	Plenary	16:45-17:00

9.2 SAMPLE AGENDA

Design phase – Diagnostic and design workshop agenda (2/2)

PLAYBOOK

Agenda – Day 2

Goals/ Outputs:
- Sign off on communique of prioritized state requirements
- Syndicate implementation timeline

Topic	Format	Time
Welcome Remarks	Plenary	9:00-9:30
Alignment on Prioritized State Requirements *Description: A review of communique by senior health leadership.*	Plenary led by state leadership	9:30-10:30
Alignment on Implementation timeline *Description: Sharing high level timeline with key milestones and activities*	Plenary led by state leadership	10:30- 11:30
Closing remarks and Tea break	Plenary	11:30-12:00

9.2

Design phase – design choices for operations and financial management

PLAYBOOK

Four critical design choices that will underpin the operations of the reformed DRF system

		Vs	
Operations	CMS initiated distribution (last mile distribution from the central store to HFs)	A	Collection by Facilities (each HF picks up commodities from the central medical store)
	Two layered supply chain (CMS →Zonal/LGA → HFs)	B	Single layered supply chain (CMS/ZMS→HFs)
Financial model	HFs buy from central store on credit	C	HFs pay central store upfront (“cash and carry”)
	Variable Markup	D	Single Markup

9.2 STATE EXAMPLE

Design phase – design risks and mitigation strategies

PLAYBOOK

Through brainstorming sessions, stakeholders identified and addressed risks associated with each state's design choice

Bauchi Sokoto Kebbi

State	Design choice	Risks	Mitigation strategies
Bauchi, Kebbi	**Collection by Facilities (each HF picks up commodities from the central store)**	▪ Increase in transportation costs ▪ Decrease in staff productivity	▪ Minimum of bimonthly facility procurement to reduce the time facility staff spend out of station ▪ Pooled purchasing by HFs to reduce the cost of transportation per facility ▪ Leverage NURTW for transportation to reduce operational costs for HFs with proper orientation on standards for drug distribution
Sokoto	**CMS initiated distribution (last mile distribution from the central store to HFs)**	▪ Lack of funds to procure vehicles for last mile delivery	▪ In the short term, leverage SMOH vehicles for distribution ▪ In the medium term, distribution will be outsourced to 3PLs ▪ In the long term, the state wants to procure vehicles
Bauchi, Kebbi, Sokoto	**Single Markup**	▪ Higher transport cost for facilities in HTR area	▪ CMS assumes the costs of distribution and operates a km-based reimbursement system for HFs ▪ HFs supplementing distribution costs with HF service accounts ▪ Bulk purchasing and application for tax holidays to ensure prices remain more competitive than open market and conducive for the end-user
Bauchi, Kebbi, Sokoto	**Single layer supply chain (CMS → HFs)**	▪ Difficulty accessing the CMS and vice versa	▪ Support CMS operations by instituting zonal stores and leveraging WMS to strengthen data management processes ▪ In the interim, options discussed include: – Leveraging SHCs as a distribution hub for surrounding PHCs – In the interim, selecting facilities close to the CMS for pilot
Bauchi, Kebbi, Sokoto	**HFs pay central store upfront ("cash and carry")**	▪ Delayed reimbursement by health insurance agency ▪ Illicit practices	▪ All states aligned on cash and carry as a payment model. However, when insurance is launched: – Agreement between SPHCDA and health insurance agency specifying reimbursement schedule with oversight from State DRF committee – Credit agreement between CMS and HFs – Strong financial management policies to prevent illicit practices

9.2 PRELIMINARY

Design phase – governance design choices (1/2)

PLAYBOOK

States need to decide at which level the 13 different activities of DRF governance will be carried out. Interviews with an advisory panel led the project team that worked in Bauchi, Kebbi and Sokoto to put forward the following recommendations

Preferred

	Decision	Taken at the center	Taken at the facilities
Coverage	**Commodity selection**	**Pros:** Standardized commodity supply across all facilities **Cons:** Unable to customize based on local context	**Pros:** Allows facilities to customize commodity list based on local context **Cons:** Different commodities in different facilities might distort the scope of the scheme
	Facility selection	**Pros:** Central team has robust knowledge of facilities within the state and can utilize optimized distribution route **Cons**: N/A	**Pros:** N/A **Cons:** Selection bias irrespective of infrastructure and capacity to run DRF
Vendor governance	**Vendor prequalification**	**Pros**: Standardized vendor vetting process **Cons**: N/A	**Pros**: N/A **Cons:** Duplication of efforts; Increases potential for nepotism/fraud
	Vendor selection	**Pros:** Economies of Scale – CMS procurement can negotiate competitive wholesale prices directly from manufacturers; Quality control – Capacity available at CMS enables them to consistently quality-assure commodities being procured **Cons**: Lose local context; potential kickback from facility run DRFs	**Pros:** Builds facilities' procurement capacity **Cons:** Increase potential for fraud (e.g. tender manipulation)
Pricing	**Pricing and markup**	**Pros:** Standardized commodity pricing and markup creating trust and transparency; Easier to monitor **Cons:** Possibly higher prices, D&E, losses	**Pros:** Facilities setting prices helps them to factor in their local context and needs **Cons:** Different facilities offering different prices for same commodities may provide latitude for sharp practices
	Markup utilization	**Pros:** Sustainability of DRF system **Cons:** Lose local context	**Pros:** Increased motivation, buy-in and sense of ownership **Cons:** Potential for misappropriation of funds

9.2 PRELIMINARY

Design phase – governance design choices (2/2)

PLAYBOOK

States need to decide at which level the 13 different activities of DRF governance will be carried out. Interviews with an advisory panel led the project team that worked in Bauchi, Kebbi and Sokoto to put forward the following recommendation

Preferred

	Decision	Taken at the center	Taken at the facilities
Monitoring & Accountab-ility	Data systems	**Pros:** Standardized data systems processes across all facilities with data collection at facility level **Cons:** N/A	**Pros:** N/A **Cons:** Fragmented data systems
	Monitoring: how?	**Pros:** Standardized monitoring processes across all facilities **Cons:** N/A	**Pros:** Facilities build internal control systems in addition to centrally decided monitoring and accountability systems **Cons:** Fragmented monitoring processes
	Monitoring: who?	**Pros:** Capacity available at the center helps to effectively coordinate and monitor the scheme **Cons**: N/A	**Pros:** Involvement of Facility DRF committee creates sense of community ownership and accountability **Cons:** Extra layer of bureaucracy – facility staff having to follow 2 layers of accountability may be cumbersome
	Consequence management	**Pros**: Promotes proper enforcement mechanisms **Cons**: N/A	**Pros**: N/A **Cons:** Limits accountability and enforcement of rewards and punishment
Supply Chain governance	Supply chain levels	**Pros:** Creates a harmonized system with appropriate support structures across the SC system **Cons**: N/A	**Pros:** N/A **Cons:** Creates a fragmented system with confusion within the system
	SOPs and Guidelines	**Pros:** Standardized DRF SOPs and guidelines creates clarity on people, processes and tools **Cons:** Lack of ownership at HF level	**Pros:** HF involvement in setting SOPs and helps them to factor in their local context and needs **Cons:** N/A
	Supply chain Ownership	**Pros:** Ensures proper accountability mechanisms **Cons:** Inadequate capacity could lead to inefficiencies	**Pros:** Facilities leading more decision making gives them much more ownership in the scheme **Cons:** N/A

9.2 PRELIMINARY

Design phase – governance design choices, rationale and requirements (1/2)

PLAYBOOK

For each recommended decision, the team outlined the necessary requirements that need to be in place (1/2)

	Decision	Taken at the center	Taken at the facilities	Rationale and requirements
Coverage	Commodity selection	✓		**Selection of a unified commodity list with input from an inclusive committee allows a simpler procurement process** ▪ Presence of an appropriately staffed central team: CMS/DMA ▪ Clear alignment on commodity list and guidelines on updating list
	Facility selection	✓		**Selection of DRF facilities by an inclusive committee creates a systematic facility rollout plan as opposed to adhoc** ▪ Presence of an appropriately staffed central team: CMS/DMA ▪ Presence of an inclusive facility selection committee ▪ Robust and systematic facility selection criteria
Vendor governance	Vendor prequalification	✓		**Preapproval of vendors based by an inclusive vendor committee mitigates the risk of fraud** ▪ Presence of an inclusive vendor pre-qualification committee
	Vendor selection	✓		**Selection of vendors using standardized requirements using an open tender process prevents risk of fraud** ▪ Presence of an inclusive vendor selection committee ▪ Alignment on selection criteria (technical and financial)
Pricing	Pricing and markup	✓	✓	**A suggested range for facility markups from the central team allows facilities to customize prices based on local context** ▪ Presence of a pricing committee ▪ Systematic means of setting prices and markup ▪ Proper financial management systems and practices ▪ Price publication at facilities
	Markup utilization		✓	**Decision on markup utilization by facility creates a sense of ownership and accountability** ▪ Presence of a facility DRF committee to align on markup utilization

9.2 PRELIMINARY

Design phase – governance design choices, rationale and requirements (2/2)

PLAYBOOK

For each recommended decision, the team outlined the necessary requirements that need to be in place (2/2)

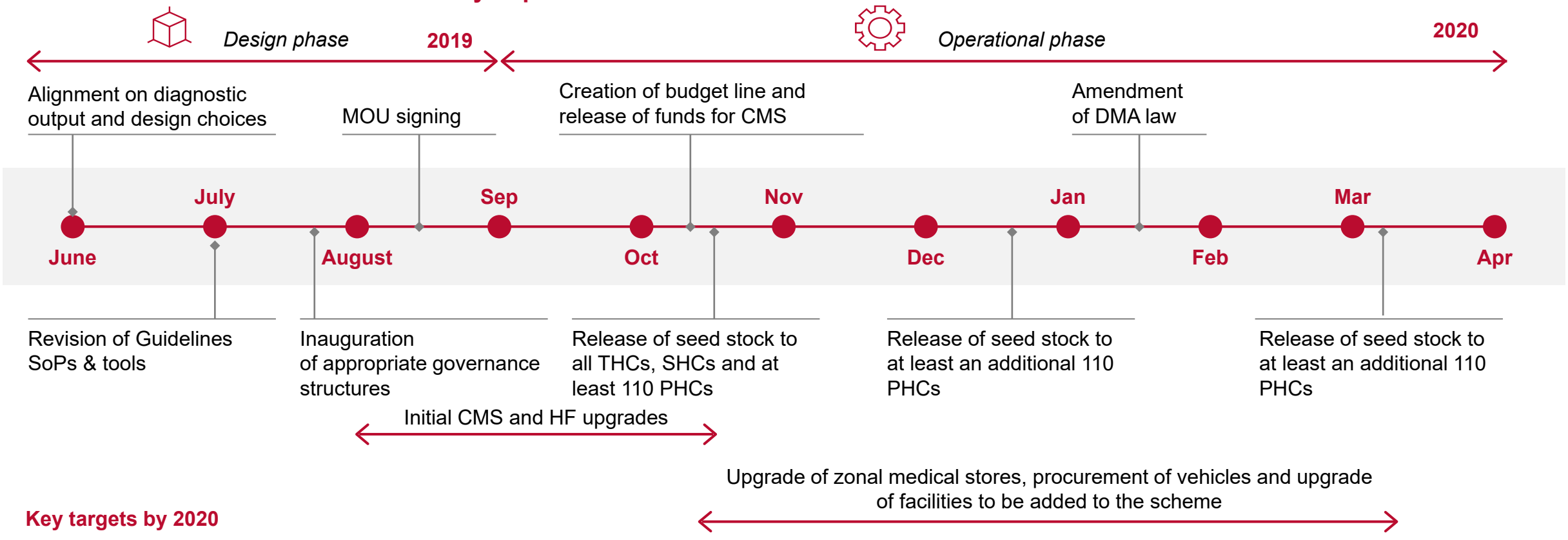
	Decision	Taken at the center	Taken at the facilities	Rationale and requirements
Monitoring & Accountability	Data systems	✓		**A centrally managed data system for stock, logistics and financial data avoids data duplication and creates a single source of truth** ▪ Availability of resources and capacity for data management
	Monitoring: how?	✓	✓	**Involvement of both central team and facility DRF committee in monitoring allows multi-level monitoring** ▪ Presence of inclusive facility DRF committee
	Monitoring: who?	✓		**Decision of monitoring responsibility** ▪ Presence of a facility DRF committee
	Consequence management	✓		**Central consequence management allows uniformity and clarity across all the HFs** ▪ Presence of enforcement mechanisms
Supply Chain governance	Supply chain levels	✓		
	SOPs and Guidelines	✓	✓	**Central decision making provides a uniform and integrated SC structure with the central team and HFs co-creating SOPs and guidelines leads to more ownership and follow-through** ▪ Presence of an inclusive DMA board and management team
	Supply chain Ownership	✓		

9.2 STATE EXAMPLE

Design phase – High level operationalization workplan

PLAYBOOK

At the end of its diagnostics and design workshop, Bauchi state created a high-level workplan outlining the key milestones it needs to reach to unlock seed stock from USAID by September 2019



Key targets by 2020

- **80%** reduction of stockouts of tracer MMCH commodities
- **80%** increase in order fill rate for participating facilities
- **95%** MNCH reporting rate on NHLMIS

9.2 STATE EXAMPLE

Design phase – Signed communique

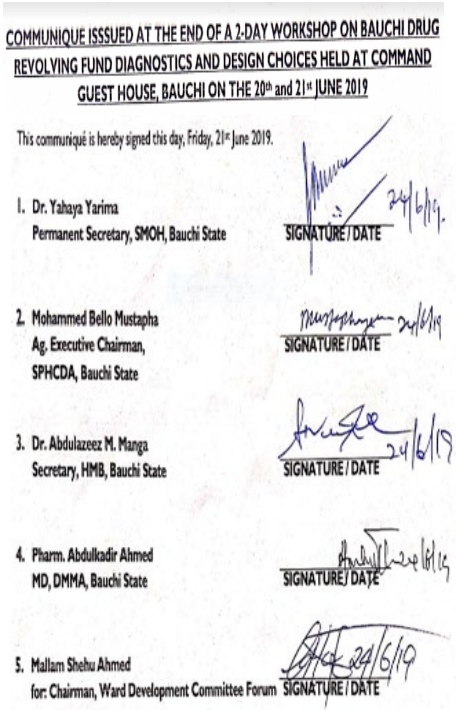
PLAYBOOK

The output of the diagnostics and design workshop was a communique signed by senior leadership in each state

Each state displayed "skin in the game" by committing to four key actions

1. Counterpart seedstock for other essential medicines
2. Investing in the upgrade of the Central and Zonal Medical Stores and Health Facilities
3. Staff redistribution in CMS, SHCs and PHCs to fill the HR gaps
4. Funding facility assessment and other required activities (e.g. inauguration of committees)

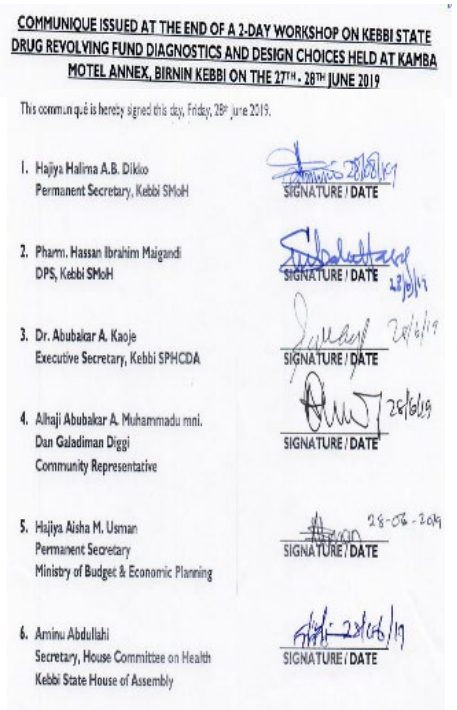
Communiques were signed by senior health stakeholders in the states as well as community representatives



COMMUNIQUE ISSSUED AT THE END OF A 2-DAY WORKSHOP ON BAUCHI DRUG REVOLVING FUND DIAGNOSTICS AND DESIGN CHOICES HELD AT COMMAND GUEST HOUSE, BAUCHI ON THE 20th and 21st JUNE 2019

This communiqué is hereby signed this day, Friday, 21st June 2019.

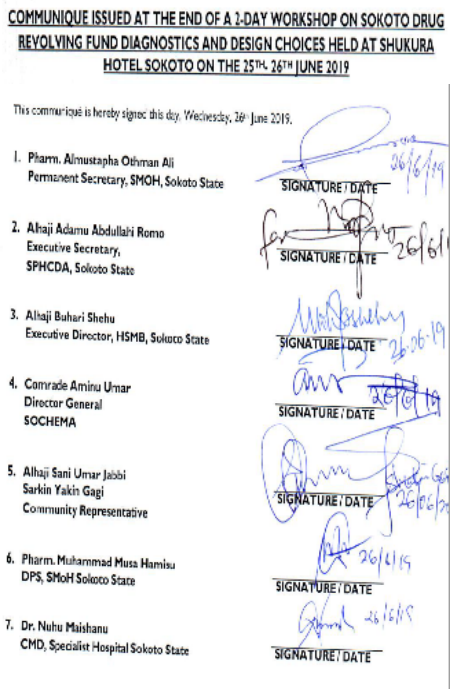
1. Dr. Yahaya Yarima, Permanent Secretary, SMOH, Bauchi State — SIGNATURE / DATE
2. Mohammed Bello Mustapha, Ag. Executive Chairman, SPHCDA, Bauchi State — SIGNATURE / DATE
3. Dr. Abdulazeez M. Manga, Secretary, HMB, Bauchi State — SIGNATURE / DATE
4. Pharm. Abdulkadir Ahmed, MD, DMMA, Bauchi State — SIGNATURE / DATE
5. Mallam Shehu Ahmed, for: Chairman, Ward Development Committee Forum — SIGNATURE / DATE



COMMUNIQUE ISSUED AT THE END OF A 2-DAY WORKSHOP ON KEBBI STATE DRUG REVOLVING FUND DIAGNOSTICS AND DESIGN CHOICES HELD AT KAMBA MOTEL ANNEX, BIRNIN KEBBI ON THE 27TH - 28TH JUNE 2019

This communiqué is hereby signed this day, Friday, 28th June 2019.

1. Hajiya Halima A.B. Dikko, Permanent Secretary, Kebbi SMoH — SIGNATURE / DATE
2. Pharm. Hassan Ibrahim Maigandi, DPS, Kebbi SMoH — SIGNATURE / DATE
3. Dr. Abubakar A. Kaoje, Executive Secretary, Kebbi SPHCDA — SIGNATURE / DATE
4. Alhaji Abubakar A. Muhammadu mni, Dan Galadiman Diggi, Community Representative — SIGNATURE / DATE
5. Hajiya Aisha M. Usman, Permanent Secretary, Ministry of Budget & Economic Planning — SIGNATURE / DATE
6. Aminu Abdullahi, Secretary, House Committee on Health, Kebbi State House of Assembly — SIGNATURE / DATE



COMMUNIQUE ISSUED AT THE END OF A 2-DAY WORKSHOP ON SOKOTO DRUG REVOLVING FUND DIAGNOSTICS AND DESIGN CHOICES HELD AT SHUKURA HOTEL SOKOTO ON THE 25TH- 26TH JUNE 2019

This communique is hereby signed this day, Wednesday, 26th June 2019.

1. Pharm. Almustapha Othman Ali, Permanent Secretary, SMOH, Sokoto State — SIGNATURE / DATE
2. Alhaji Adamu Abdullahi Romo, Executive Secretary, SPHCDA, Sokoto State — SIGNATURE / DATE
3. Alhaji Buhari Shehu, Executive Director, HSMB, Sokoto State — SIGNATURE / DATE
4. Comrade Aminu Umar, Director General, SOCHEMA — SIGNATURE / DATE
5. Alhaji Sani Umar Jabbi, Sarkin Yakin Gagi, Community Representative — SIGNATURE / DATE
6. Pharm. Muhammad Musa Hamisu, DPS, SMoH Sokoto State — SIGNATURE / DATE
7. Dr. Nuhu Maishanu, CMD, Specialist Hospital Sokoto State — SIGNATURE / DATE

9.2 NOT EXHAUSTIVE

Design phase – List of participants at SOP review workshop

PLAYBOOK

During the SOP workshops, we engaged a diverse mix of state stakeholders in the health sector, and were consistently supported by other USAID implementing partners

	Bauchi	Sokoto	Kebbi
State Ministry	▪ MD DMMA ▪ Director of Finance, DMMA ▪ DPRS, SMOH ▪ LMCU Coordinator ▪ CMS pharmacist	▪ DPS, SMOH ▪ DPRS, SMOH ▪ DDPS, SMOH ▪ LMCU Coordinator ▪ Central Medical store pharmacist/ DRF focal person	▪ DPS, SMOH ▪ DDPS, SMOH ▪ DPRS, SMOH ▪ Director Finance, SMOH ▪ LMCU Coordinator ▪ Central Medical Store Pharmacist
Secondary Healthcare	▪ DPS, HMB	▪ ED, HMB ▪ DRF Accountant, HMB	▪ Director Medical Service, SMOH
Primary Healthcare	▪ ES, SPHCDA ▪ DPRS, SPHCDA ▪ State MNCH Coordinator	▪ ES,SPHCDA ▪ State MNCH Coordinator	▪ ES SPHCDA ▪ State MNCH Coordinator
State Health Contributory Scheme	▪ DG BASHMA	▪ ED, SOCHEMA	▪ DG KECHMA
Implementing Partners	▪ BA ▪ IHP ▪ Plan International	▪ BA ▪ IHP ▪ Marie Stopes	▪ BA ▪ IHP

9.2 SAMPLE AGENDA

Design phase – SOP review workshop agenda (1/3)

PLAYBOOK

Daily goals for SOP Workshop

		CMS (Gov)	CMS (Ops)	SHCs (Gov and Ops)	PHCs (Gov and Ops)
Day 1	AM	▪ Decision making bodies	Procurement		
	PM	▪ Facility Selection, Commodity Selection and Pricing	Stock management		
Day 2	AM	▪ Monitoring: who, when, how	Financial management (including D&E)		
	PM		Data management (including tools)		
Day 3	AM	Validation: presentation of revised SOP in plenary			
	PM				

9.2 SAMPLE AGENDA

Design phase – SOP review workshop agenda (2/3)

PLAYBOOK

Agenda – Day 1

Goals/ Outputs: Development of robust operational guidelines and tools to guide DRF operations in the CMS, SHCs and PHCs

Topic	Format	Facilitator	Time
Introduction and welcome remarks	Plenary	GHSC- PSM	8:30-9:00
Working session 1	Breakout	All	9:00- 11:00
Tea break			11:00- 11:30
Working session 2	Breakout	All	11:30- 2:30
Lunch			2:30- 3:30
Working session 3	Breakout	All	3:30- 6:00
Wrap up and next steps	Plenary	GHSC-PSM	6:00- 6:15

At the end of Day 1, there will be homework for all participants

9.2 SAMPLE AGENDA

Design phase – SOP review workshop agenda (3/3)

PLAYBOOK

Agenda – Day 2

Goals/ Outputs: Development of robust operational guidelines and tools to guide DRF operations in the CMS, SHCs and PHCs

Topic	Format	Facilitator	Time
Arrival	Plenary	GHSC- PSM	8:30-9:00
CMS (Gov)	Breakout	MD DMMA/PSM	9:00- 11:00
Tea break			11:00- 11:30
CMS (Ops)	Breakout	All	11:30- 2:30
Lunch			2:30- 3:30
SHCs and PHCs (Gov & Ops)	Breakout	DPS HMB/PSM	3:30- 6:00
Wrap up and next steps	Plenary	GHSC-PSM	6:00- 6:15

At the end of Day 2, each group should have an end-to-end SOP guideline document

9.2 NOT EXHAUSTIVE

Design phase – Breakout groups to review SOPs during workshop

PLAYBOOK

	CMS (Governance)	CMS (Operations)	Secondary Health facilitates	Primary Health Facilities
Participants	▪ DPS SMoH ▪ ED SOCHEMA ▪ BA	▪ DPRS SMoH ▪ DDPS SMoH ▪ Central Medical Store Pharmacist / DRF Focal Person ▪ LMCU Coordinator	▪ ED, HMB ▪ State MNCH Coordinator ▪ DRF Accountant, HMB ▪ UNICEF	▪ ES SPHCDA ▪ IHP

9.2

Design phase – Standards for best-in-class DRF operational guidelines

PLAYBOOK

Each state aligned on key components that make up a best-in-class DRF operational guideline

SOP Components	Highlights across all states
Distinct facility selection criteria	▪ Facilities would be selected based on their performance against criteria that would ensure the safety and guarantee the quality of drugs dispensed, and ensure the right complement of staff to operate the DRF
Separation of procurement process	▪ The procurement of DRF items would be executed by three separate subcommittees, each tasked with a core procurement function, in order to de-risk the entire process from bias and to promote transparency within the system
Community inclusive management structure	▪ All states agreed on a management structure at the central and facility levels that involves a wide range of stakeholders from the State Ministries of Health, other MDAs, the community, key medical professional bodies, etc. This would ensure that all interests are considered in decisions made by the state
Robust financial management and markup utilization	▪ Guidelines on how to manage expenses and revenues were clearly defined with job aids on how to use the complementing tools. ▪ Markup does not include deferrals and exemptions to safeguard the DRF funds from being depleted by the D&E scheme
Clear deferrals and exemptions policies	▪ The source of funding for D&E activities will be from the monthly proceeds from the service account of health facilities. ▪ D&E selection tool was developed to assess the eligibility of patients for deferrals or exemptions
Rigorous monitoring and supervision practices	▪ A feedback tool and monitoring KPI checklist were developed for the DRF to effectively oversee and measure facility compliance ▪ SHFs and THFs will be monitored by both the DRF M&E committee & the Hospitals Management Board while the Local Government Health Authority (LGHA) DRF Committee will monitor PHCs due to the large number of PHCs in the states

9.2

Design phase – List of essential CMS items

PLAYBOOK

Initial infrastructural upgrades will focus on the most critical needs of the CMS

		Initial requirement	End state requirement	
		CMS	CMS	ZMS[1]
Cooling	Refrigerator			✓
	Freezer			✓
Operational tools	Forklift		✓	✓
	Shelves			✓
	Air conditioner			✓
	Hygrometer	✓		✓
	Trolleys	✓		✓
	Ladder	✓		✓
	Vans		✓	✓
Power	Generating set	✓		✓
	Solar power		✓	✓
Human Resources	Staff & training		✓	✓

1 Includes 2 zonal stores: Ningi and Azare

9.2

Design phase – List of essential facility items

PLAYBOOK

Health facility upgrades in Bauchi will happen in two phases with the preliminary phase focusing on the most critical aspects for health facilities

		Initial requirement		End state requirement	
		SHCs	PHCs	SHCs	PHCs
Cooling	Refrigerator	✓			✓
	Cooling Flasks		✓		
Operational tools	Shelves	✓	✓		
	Air conditioner	✓			✓
	Hygrometer			✓	
	Thermometer	✓	✓		
	Ladder			✓	
Power	Generating set	✓			✓
	Solar power		✓	✓	
Trans-port	Buses, Vehicles	✓			
Security	Burglary	✓	✓		

9.2 STATE EXAMPLE

Design phase – Criteria for minor facility upgrades

PLAYBOOK

In Bauchi, minimum criteria were set for facilities that require "minor" upgrades

Criteria that qualifies facilities for "minor upgrades"

Storage	▪ Presence of designated store ▪ At least 2 months of storage capacity or at least acceptable/adequate storage capacity ▪ Store condition: No window leakage or roof Leakage
Security	▪ Evidence of Lock and Key ▪ Presence of at least one security guard
Human resources	▪ At least 2 CHEWs/JCHEWs/CHOs that may serve the roles of accounting designate and pharmacy technician
Data management	▪ Evidence of NHLMIS/DHIS2 reporting

Key takeaways

- Based on the aligned criteria **79 facilities in Bauchi State** require minor upgrades
- These facilities will be shortlisted and the **upgrades required on each will be costed**
- Other facilities will undergo more comprehensive upgrades

9.2 STATE EXAMPLE

Design phase – Bauchi facilities requiring minor upgrades

PLAYBOOK

79 facilities (56% of assessed) require "minor" upgrades across storage infrastructure, security and human resources

Senatorial Districts	Local Governments	Number of facilities requiring upgrades
Bauchi North	Giade	8
	Shira	9
	Zaki	11
Bauchi Central	Dambam	5
	Ganjuwa	8
	Warji	11
Bauchi South	Alkaleri	10
	Tafawa Balewa	8
	Bogoro	9
	Total	**79**

"Minor" upgrades required

Storage infrastructure

- Shelves and/or pallets installed in stores
- Fire extinguishers
- Lighting, ventilation and pest treatment upgrades

Security

- Additional security personnel in facilities that have fewer than two burglar proof doors and windows

Human resources

- At least 2 additional CHEW/JCHEW/CHO in each facility that have less than 2

9.2 STATE EXAMPLE

Design phase – Bauchi facilities requiring major upgrades

PLAYBOOK

63 facilities require "major" upgrades – comprehensive upgrades across storage infrastructure, security and human resources

Senatorial Districts	Local Governments	Number of facilities requiring upgrades
Bauchi North	Giade	5
	Shira	8
	Zaki	7
Bauchi Central	Dambam	11
	Ganjuwa	8
	Warji	2
Bauchi South	Alkaleri	10
	Tafawa Balewa	8
	Bogoro	4
	Total	**63**

"Major" upgrades required

Storage infrastructure

- Construction of stores where stores are not present
- Upgrading stores to provide at least 2 months of storage capacity
- Fixing roof leakages

Security

- Provision of security personnel
- Ensuring facility can be locked using a lock and a key

Human resources

- Provision of at least 2 CHEWs/JCHEWs/CHOs at each facility

9.3

Operationalization phase – Orientation of DRF committees

PLAYBOOK

A 2-day DRF orientation session was held to formally introduce the strengthened DRF system to DRF committee members and ease the transition process

Description

- The orientation is designed to provide committee members (including members of the community) an overview of the revamped DRF system
  - Provides information on the roles, responsibilities and interactions between all the supply chain actors within the system
  - Introduces participants to the Standard operation guideline as the reference document for the processes, tools and code of conduct.

Purpose of Orientation

- Orientation eases the transition from status quo into the re-designed DRF system
- Gives committee members a sense of ownership, fosters buy in and alignment
- Positions the DRF program for success

Duration

- Orientation will be a **2-day event** held in a classroom setting with break out groups to deep dive into the terms of reference for each sub-committee

Participants

- Appointed and inaugurated members of the **State DRF committees and sub-committees**
  - M&E sub-committee
  - Procurement sub-committee
  - Pricing sub-committee
  - Project vetting sub-committee
  - Training sub-committee
  - Commodity review sub-committee
- Appointed and inaugurated members of the **LGHA DRF Committee**

9.3 SAMPLE AGENDA

Operationalization phase – Orientation of DRF committees

PLAYBOOK

State and LGA DRF Committee Orientation: Proposed Agenda (Day 1)

Activity	Duration	Responsible	Time
Welcome remarks and prayers	30 mins	…	09:00-09:30
Introductions	30 mins	…	09:30-10:00
Pretest	30 mins	…	10:00-10:30
Tea break 1	30 mins	…	10:30-11:00
Session 1: Overview of DRF in the state *Introduction to state DRF management structure, oversight committees, commodity and information flow, reporting, stock levels etc*	2 HRS	…	11:00-13:00
Lunch	1 HR	…	14:00-15:00
Session 2: Facility selection, commodity selection, pricing	1 HR	…	13:00-14:00
Energizer	30 mins	…	15:00-15:30
Session 3: Consequence managament	1 HR	…	15:30-16:30
Post test and reflections	30 mins	…	16:30-17:00
Tea break 2	30 mins	…	17:00-17:30

Goals/outputs: Increased knowledge in DRF governance

9.3 SAMPLE AGENDA

Operationalization phase – Orientation of DRF committees

PLAYBOOK

State and LGA DRF Committee Orientation: Proposed Agenda (Day 2)

	Activity	Duration	Responsible	Time
Plenary	Welcome remarks Reflections from Day 1	1 HR	…	09:00-10:00
	Tea break	30 mins	…	10:00-10:30
Sub-committee Breakout	Group 1: M&E, project vetting training sub-committees Group 2: Procurement, pricing and commodity review sub-committees Group 3: LGHA DRF committee	3 HRS	…	10:30-13:30
	Discussions on each group's mandate, roles and responsibilities and terms of reference (includes pre and post test)			
	Lunch	1 HR	…	13:30-14:30
Plenary	Q&A and next steps Closing remarks	1 HR	…	14:30-15:30

Goals/outputs: Increased knowledge in each subcommittees mandate

9.3 SAMPLE AGENDA

Operationalization phase – Training of CMS staff (1/6)

PLAYBOOK

Day 1 Agenda – Governance and procurement

Time	Activity	Format	Facilitator
08:30-08:45	Arrival	Plenary	GHSC-PSM
08:45-09:00	Welcome Address	Test	State leadership
09:00-9:30	Ice-breaker	Plenary	DRF Expert
9:30-10:00	Pre-test		
10:00-11:00	Overview of DRF system	Plenary	DRF Expert
11:00-11:30	Tea break		
11:30-12:30	Overview of DRF/DMA management structure	Plenary	DRF Expert
12:30-13:30	Procurement		
13:30-14:30	Lunch & prayers	Plenary	DRF Expert
14:30-15:00	Group activity	Break- out	DRF Expert
15:00-15:30	Post-test	Test	
15:30-16:00	Q&A and Closing Remarks	Plenary	

Goals/outputs: Increased knowledge in DRF governance and procurement topics

9.3 SAMPLE AGENDA

Operationalization phase – Training of CMS staff (2/6)

PLAYBOOK

Day 2 Agenda – Stock management breakout

Time	Activity	Format	Facilitator
08:30-09:00	Arrival and introduction	Plenary	GHSC-PSM
09:00-09:30	Pre test	Test	
09:30-11:00	Store and stock management	Plenary	DRF Expert
11:00-11:30	Tea break		
11.30-12:00	Energizer	Plenary	DRF Expert
12:00-13:30	Stock management tools 1	Plenary	DRF Expert
13:30-14:30	Lunch & prayers		
14:30-15:00	Post test	Test	DRF Expert

Outputs: Increased knowledge and skills in DRF stock management practices

9.3 SAMPLE AGENDA

Operationalization phase – Training of CMS staff (3/6)

PLAYBOOK

Day 2 Agenda – Financial management breakout

Time	Activity	Format	Facilitator
08:30-09:00	Arrival	Plenary	GHSC-PSM
09:00-09:30	Pre test	Test	
09:30-11:00	Accounting process & procedures	Plenary	DRF Expert
11:00-11:30	Tea break		
11:30-12:30	Financial planning & budgeting	Plenary	DRF Expert
12:30-13:30	Financial reporting	Plenary	DRF Expert
13:30-14:30	Lunch	Plenary	DRF Expert
14:30-15:00	Post test		
15:30-16:00	Exercise		

Outputs: Increased knowledge and skills in DRF financial management practices

9.3 SAMPLE AGENDA

Operationalization phase – Training of CMS staff (4/6)

PLAYBOOK

Day 3 Agenda – Financial management breakout

Time	Activity	Format	Facilitator
08:30-09:00	Arrival	Plenary	GHSC-PSM
09:00-09:30	Energizer	Test	
09:30-11:00	Financial reporting tools	Plenary	DRF Expert
11:00-11:30	Tea break		
11:30-12:30	Financial reporting tools	Plenary	DRF Expert
12:30-13:30	Exercises	Exercises	DRF Expert
13:30-14:30	Lunch	Plenary	DRF Expert
14:30-15:00	Post test	Test	

Outputs: Increased knowledge and skills in DRF financial management practices

9.3 SAMPLE AGENDA

Operationalization phase – Training of CMS staff (5/6)

PLAYBOOK

Day 3 Agenda – Stock management breakout

Time	Activity	Format	Facilitator
08:30-09:00	Arrival and introduction	Plenary	GHSC-PSM
09:00-10:30	Stock management tools 11	Exercises	DRF Expert
10:30-11:00	Energizer		
11:00-11:30	Tea break		DRF Expert
11:30-12:00	Pre test	Test	DRF Expert
12.00-12:30	Stock reporting tools 1	Plenary	DRF Expert
12:30-13:30	Stock reporting tools 11	Exercises	DRF Expert
13:30-14:30	Lunch & prayers		
14:30-15:00	Post-test	Test	DRF Expert

Outputs: Increased knowledge and skills in DRF stock management practices

9.3 SAMPLE AGENDA

Operationalization phase – Training of CMS staff (6/6)

PLAYBOOK

Day 4 Agenda – Monitoring, Supervision and Consequence management

Time	Activity	Format	Facilitator
08:30-09:05	Arrival & introduction	Plenary	GHSC-PSM
09:00-09:30	Pre-test	Test	GHSC-PSM
09:30- 10:00	Icebreaker	Plenary	GHSC-PSM
10:00-11:00	Monitoring and evaluation	Plenary	DRF Expert
11:00-11:30	Tea break		
11:30-12:30	Consequence management	Plenary	
12:30-13:00	Group activity	Break -out	DRF Expert
13:00-14:00	Lunch & prayers		
14:00-14:30	Case studies	Break -out	DRF Expert
14:30-15:00	Post test	Test	GHSC-PSM
15:00-16:00	Presentation of certificates of participation		GHSC-PSM

Output: Increased knowledge in monitoring, evaluation and consequence management practices

9.3

Operationalization phase – DRF committees

PLAYBOOK

Committees	Description
DRF management team	Manages day to day activities of the central medical store and the drug revolving fund (DRF)
State DRF Steering committee	Provides oversight of overall state DRF governance and operations
Monitoring and Supervision Sub-committee	Responsible for conducting monitoring and supervisory visits to DRF facilities
Vendor Pre-Qualification sub-committee	Responsible for screening pharmaceutical manufacturers based on SOP requirements, conducts site visits, in order to develop a list of pre-qualified suppliers
Post-procurement verification sub-committee	Conducts post-delivery inspection to ensure commodities delivered match order in quality and quantity
Pricing and mark-up sub-committee	Determine selling price of commodities as well as markup utilization for the CMS and health facilities
Training sub-committee	Responsible for identifying pre- and in-service training needs and ensuring regular training occurs for CMS and HF staff
Audit sub-committee	Conducts audits of CMS and health facilities to prevent leakages and minimize losses
Commodity review sub-committee	Chooses which commodities to include in the DRF and reviews the list, as specified in the operational guidelines
Guidelines & SOPs review sub-committee	Determines and updates the guidelines, SOPs and tools that will guide DRF operations

Standard minimum requirement

Best practice requirement

What needs to happen

- **Development of priority subcommittees to meet criteria for initial requirements**
- **Ensure all committees hold regular meetings with a clear cadence**
- **Build framework for facility input into facility-relevant decisions (e.g. commodity selection)**

9.3 STATE EXAMPLE

Operationalization phase – Bauchi staffing redistribution plan

PLAYBOOK

Human Resources: Adequate staffing is required at the CMS, PHCs and SHCs

	Initial Requirements	Timeline/Agency	End state Requirements	Timeline/Agency
Human Resources	**CMS & ZMS** The cadre will include the following per facility: 2 CMS, 1 ZMS Pharmacists 1 Inspection Officer (per CMS and ZMS) 3 M&E Officers (2 CMS and 1 ZMS) 3 Account Officers (2 CMS and 1 ZMS) 2 Admin Officers (1CMS and 1 ZMS) 6 Cashiers (4 CMS and 2 ZMS) 16 Security Officers (10 CMS and 6 ZMS) 15 Store Assistants (10 CMS and 5 ZMS) 2 Auditors (1CMS and 1 ZMS)	January 2020 DA, Director, Inspectorate Services, DPRS, , Accountant General, DPS, SMoH	**CMS & ZMS** The cadre will include the following per facility: 3 CMS, 2 ZMS Pharmacists, 4 Inspection Officer (2 CMS and 2 ZMS) 3 M&E Officers (2 CMS and 1 ZMS), 3 Account Officers (1 CMS and 2 ZMS) 3 Admin Officers (1CMS and 2 ZMS) 4 Cashiers (CMS and 2 ZMS) 16 Security Officers (10 CMS and 6 ZMS) 15 Store Assistants (10 CMS and 5 ZMS) 2 Auditors (1CMS and 1 ZMS)	October 2020 DA, DPRS, Accountant General DPS, SMoH
	SHCs The cadre will include the following per facility: 2 Pharmacist Personnel 1 Accountant 4 Cashiers 4 Nurses/Midwives	January 2020 DPS, SMoH	**SHC** The cadre will include the following per facility: 2 Pharmacist/Technician 8 Nurses/Midwives 2 Lab Personnel 4 Security	January 2020 DPS, SMoH DA
	PHCs The cadre will include the following per facility: 1 Pharmacy Technician 1 Accountant Designate 1 Cashier 1 CHEW	January 2020 SPHCDA	**PHCs** The cadre per primary health facility will include: CHO (1) CHEW (3) Pharmacy Technician (2) Cashier (1)	September 2020 SPHCDA

9.3 STATE EXAMPLE

Operationalization phase – Sokoto staffing redistribution plan

PLAYBOOK

Human Resources: Adequate staffing across the CMS and health facilities

	Initial Requirements	End state Requirements
Human Resources	**CMS** Pharmacists (3) Pharm. Technicians (6) Admin Officer (1) Store assistants (10) Security Officers (12) Accountant (1) Cashier (1) M&E Officers (1) Internal Auditor (1)	**CMS/DMCMA and ZMS** Additional staff to include: Pharmacists (1 per ZMS) Store assistants (10) Admin assistants (6) Drivers (2 per ZMS and 3 for CMS) Cashier (2 per ZMS) and Assistant auditor (1)
	SHCs Registered Pharmacist (1 per SHF and 5 at THF) Pharm Tech (4 per SHF and 10 at THF) Cashier (4 per SHF and 10 at THF) Medical Officers (at least 1 per SHF and 10 for THF)	**SHCs** Additional staff to include Medical officer (2 for SHF) Pharmacists (1 for SHF and 3 THF) Pharm. tech (2 for SHF and 6 for THF) Nurses (10 for SHF) Midwives (6 for SHF) Cashier (2 for SHF and 4 for THF), Accounting designates (1 for SHF)
	PHCs CHO/CHEW (1) Pharm Tech (1) Cashier (1)	**PHCs** Additional staff to include CHO (1) CHEW (4) Pharmacy Technician (3) Cashier (1)

9.4

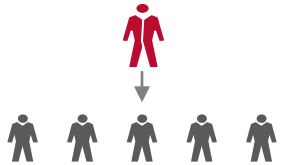
Roll-out phase – Health facility training model

PLAYBOOK (OPERATIONALIZATION)
PLAYBOOK (ROLL-OUT)

The "DRF State expert" cohort will be trained as super users to champion adoption of best practice processes within their area of expertise

DRF/USAID team facilitates | Central team Trainer | State trainer | Participant

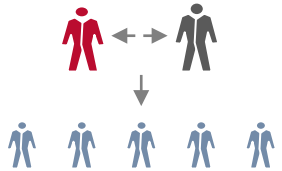
A Train-the-Trainer training model will be adopted with a focus on "feedback" and "coaching" to quickly scale up adoption…



Level 1 (TOT)

Attend classroom sessions as participants (a full-day session per topic)

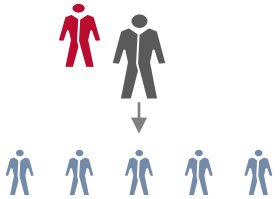
- Get acquainted with content and materials
- Learn best practice examples from faculty
- Understand training delivery basics



Level 2

Receive on-hand coaching and act as co-facilitator

- Facilitate part of a session and observe experienced faculty
- Receive intense feedback and coaching
- Will happen **at least twice** to ensure fidelity to the training process



Level 3

Act as facilitator to scale up DRF training roll-out

- Run training sessions completely; observed by experienced faculty
- Receive intense feedback and coaching
- Report on training roll-out to ensure adequate scale of handbook training has been achieved

…across key areas of the DRF Scheme

1. Governance
2. End-to-end supply chain
3. Data management
4. Financial management

9.4

Roll-out phase – Health facility trainees

PLAYBOOK (OPERATIONALIZATION)
PLAYBOOK (ROLL-OUT)

The train the trainer model will be delivered across 4 key competence areas for all 3 levels of the State's DRF scheme…

		Operations		
DRF Level	**Governance**	**Supply Chain**	**Data management**	**Financial management**
State Leadership (Committees)	▪ State DRF Committee	▪ Procurement Sub Committee	▪ M&E Sub Committee ▪ LMCU ▪ Directorate of Planning Monitoring and Evaluation, DMA	▪ M&E Sub Committee ▪ Directorate of Planning Monitoring and Evaluation, DMA ▪ Directorate of Finance and Account, DMA
Central Medical Stores	▪ CMS Pharmacist	▪ CMS pharmacist ▪ Store pharmacists ▪ Pharmacy technicians	▪ Store pharmacists ▪ Pharmacy technicians	▪ DRF Accountant ▪ Cashier
Health Facilities	▪ Pharmacist-in-charge ▪ PMO/ CMD in charge	▪ Pharmacist in-charge ▪ Pharmacy Technicians	▪ Store keeper ▪ Service unit heads	▪ DRF Accountant ▪ Cashier

9.4 SAMPLE AGENDA

Roll-out phase – Health facility training (1/3)

PLAYBOOK (OPERATIONALIZATION)
PLAYBOOK (ROLL-OUT)

Day 1 Agenda – Governance

Time	Activity	Format	Facilitator
09:00 – 09:30	Opening remarks & introduction	Plenary	GHSC-PSM
09:30 – 10:00	Pre test	Test	GHSC-PSM
10:00 – 11:00	Overview of DRF in the state & DRF management structure	Plenary	DRF Expert
11:00 – 11:30	Tea break		
11:30 – 12:30	Pricing & markup	Plenary	DRF Expert
12:30 – 13:30	Monitoring & evaluation	Plenary	DRF Expert
13:30 – 14:30	Lunch & prayers		
14:30 – 15:30	Consequence management	Plenary	DRF Expert
15:30 – 16:00	Post test	Plenary	DRF Expert

Goals/outputs: Full proficiency in DRF governance

9.4 SAMPLE AGENDA

Roll-out phase – Health facility training (2/3)

PLAYBOOK (OPERATIONALIZATION)
PLAYBOOK (ROLL-OUT)

Day 2 Agenda – Procurement & stock management

Time	Activity	Format	Facilitator
09:00 – 09:30	Arrival & introduction	Plenary	GHSC-PSM
09:30 – 10:00	Pre test	Test	GHSC-PSM
10:00 – 11:00	Procurement	Plenary	DRF Expert
11:00 – 11:30	Tea break		
11:30 – 12:00	Energizer	Plenary	DRF Expert
12:00 – 13:00	Stock & store management	Plenary	DRF Expert
13:00 – 14:00	Lunch & prayers		
14:00 – 15:30	Stock & store management tools	Exercises	DRF Expert
15:30 – 16:30	Post test	Test	GHSC-PSM
15:30 – 16:00	Final Closing	Plenary	

Goals/outputs: Full proficiency in use of store & stock management process and tools

9.4 SAMPLE AGENDA

Roll-out phase – Health facility training (3/3)

PLAYBOOK
PLAYBOOK

Day 3 Agenda – Financial management

Time	Activity	Format	Facilitator
09:00 – 09:30	Arrival	Plenary	GHSC-PSM
09:30 – 10:00	Pre-test		
10:00 – 11:00	Accounting process & procedures	Plenary	DRF Expert
11:00 – 11:30	Tea break		
11:30 – 12:30	Financial reporting	Plenary	DRF Expert
12:30 – 13:30	Financial reporting (tools)	Exercises	DRF Expert
13:30 – 14:30	Lunch & prayers		
14:30 – 15:30	Deferrals & exemptions	Plenary	DRF Expert
15:30 – 16:00	Deferrals & exemptions (tools)	Exercises	DRF Expert
16:00 – 16:30	Tea break & prayers		
16:30 – 17:30	Post test	Test	GHSC-PSM

Goals/outputs: Full proficiency in DRF financial management best practices including deferrals & exemptions

9.4

Roll-out phase – Health facility training documents

PLAYBOOK (OPERATIONALIZATION)
PLAYBOOK (ROLL-OUT)

The training interactions will be supported by 5 key documents

Document	Description
1 Training manual	Instruction booklet on the modules (to be presented and printed for participants for future reference)
2 User guide	Activity booklet that includes all activities that will take place during the training sessions- tests, exercises, group activities
3 Job aids	Detailed step-by-step guide for filling of the DRF tools (to be printed for participants for future reference)
4 SOP manual	Clear description of DRF operations in CMS and health facilities
5 Facilitators guide	Detailed guide for facilitators to ensure consistency in delivery of step down training

A playbook would also be developed to guide future implementation of these trainings in other settings

9.4

Roll-out phase – Health facility training job aids

PLAYBOOK (OPERATIONALIZATION)
PLAYBOOK (ROLL-OUT)

Training content will include job aids for the various D&E, stock and financial management tools at facility level

Management Tools for DRF

Stock Management

- Requisition Issue and Receipt Voucher (RIRV)
- DRF Stock card
- Tally Card
- DRF Internal Requisition Form
- Prescription form
- Bimonthly LMIS Report Form
- Inventory Control Card
- Stores Ledger
- Loss Register
- Store Issue Voucher Register
- Daily Pharmacy Consumption Register
- Pharmacy and Accounts Register
- Dangerous Drug Record Book
- Dangerous Drug Register
- Dangerous Drug Receipt Register and Administrative Record
- Emergency Cupboard Register
- Service Unit Utilization Register

Financial Management

- Fund Valuation Statement
- Cash Book
- Cash Receipt
- Daily Sales Register
- Payment Voucher
- Payment invoice
- Revenue Collector or Cashier's Register
- Service Point Account Register
- Daily DRF Accounts Summary Register
- Weekly DRF Reconciliation Register
- Service Points Weekly Reconciliation Register
- Stock Valuation Form

Deferrals and Exemption

- Deferral Bank Book
- D&E Ledger
- Statement of Income and Expenditure
- Monthly Service Units Credit Notes Register
- D&E Memorandum Register
- Deferral cash book
- Daily Pharmacy and D & E Account Register
- Exemption Memorandum Register
- Service Unit and D & E Account Register
- Statement of Monthly Variance
- D & E Credit Note
- D & E Exemption Note
- Exemption Eligibility Assessment Form (EEAF): Women
- Exemption Eligibility Assessment Form (EEAF): Men
- Exemption Eligibility Assessment Card
- Guarantor's Form
- Check List for D&E Facility Monitoring (At Full Implementation)

9.4

Roll-out phase – CMS monitoring and evaluation checklist

PLAYBOOK

M&E CMS checklist

Monitoring & Evaluation DRF supervisory checklist

BAUCH STATE DRUGS AND MEDICAL CONSUMABLES AGENCY (DMMA)
DRF SUPERVISORY CHECKLIST
CENTRAL MEDICAL STORE/ZONAL MEDICAL STORE

STORE NAME……

LGA……

DATE OF SUPERVISION……...

NAME AND DESIGNATION OF SUPERVISOR(S)……

DESIGNATION……

PHONE NUMBER ……

- Each Monitoring and Evaluation officer is to fill the checklist
- The checklist is split into components and scored

Components of M&E

There are 3 components of M&E:

1. Supply chain operations
2. Financial management
3. Stock management & reporting

Each component will be given a score by the relevant body conducting the monitoring and evaluation exercise

Component	Score
Monitoring for supply chain operations	100 points
Monitoring for financial management	60 points
Monitoring for stock management and reporting	60 points

9.4

Roll-out phase – CMS monitoring for supply chain operations (1/4)

PLAYBOOK

	Indicators [max 100 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 100 points]
Human resources	The Pharmacist/ storekeeper available	5	0		The person running the store must be a trained Pharmacist
	The store has the minimum number of staffs mentioned on the SOP	5	0		Use SOP to validate the number of staffs required to run a CMS/ZMS
	Total	**10**			
Commodity requirement estimation	Evidence of quantification	3	0		Show document for proof
	Staff maintains stock cards for Essential Drugs showing security stock levels = average monthly consumption	3	0		Show stock card and verify the frequency of use
	Supply in stock card corresponds with physical supply: a random sample of twenty (20) essential drugs	5	0		The theoretical stock on the stock cards of twenty (20) randomly selected drugs must be equal to the physical stock of these drugs found on the shelves.
	Total	**11**			
Procurement	Procurement cycle is done as stipulated in the guidelines	5	0		Refer to the procurement guideline
	Total	**5**			

9.4

Roll-out phase – CMS monitoring for supply chain operations (2/4)

PLAYBOOK

	Indicators [max 100 points]	YES	NO	SCORE	Descriptions [max 100 points]
Inbound	Clean and Functional clearing bay	2	0		
	Suppliers are provided with a clearance receipt/documents as stipulated in the guidelines	5	0		Check for a copy of the clearance receipts for last three suppliers or following the last monitoring
	Total	**7**			
Warehousing	Dry, clean place, well lit and ventilated and air-conditioned storage room, free from rodents	5	0		Ensure that the ACs are working properly All requirements are met - score full mark Not all requirements are met – Score zero (0)
	Store commodities according to their required temperatures e.g. using functional refrigerators	5	0		Ensure the refrigerator is working, a thermometer is available and temperature records are maintained. All requirements are met - score full mark Not all requirements are met – Score zero (0)
	Commodities are stored in well-labelled shelves and pallets	10	0		Check standard for all requirements: ▪ 10cm above the ground ▪ 30cm away from the wall ▪ Not more than 2.5m high

9.4

Roll-out phase – CMS monitoring for supply chain operations (3/4)

PLAYBOOK

	Indicators [max 100 points]	YES	NO	SCORE	Descriptions [max 100 points]
Warehousing	Commodities are stored in categories	10	0		It is recommended that commodities are stored according to their forms ▪ For example, the DRF items may be arranged as follows ▪ Tablets, Capsules, Surgical materials, Lab items and X-ray ▪ Syrups and Suspensions ▪ Parenteral products – Injections and Infusions
	Lockable store and burglary proof windows	5	0		All requirements are met - score full mark Not all requirements are met – Score zero (0)
	Serviced Fire extinguishers and buckets of sand	2	0		All requirements are met - score full mark Not all requirements are met – Score zero (0) Checked expiry date of fire extinguisher
	Proper inventory system. Drugs and medical consumables stored in first in(expired) - first out basis	10	0		
	Total	**47**			

9.4

Roll-out phase – CMS monitoring for supply chain operations (4/4)

PLAYBOOK

	Indicators [max 100 points]	YES	NO	SCORE	Descriptions [max 100 points]
Expired drugs	The supervisor verifies randomly ten (10) drugs and five (5) consumables	5	0		No expired drugs should be found on the shelves
	Expired, damaged and unreadable labelled drugs well separated from the stock and recorded appropriately	5	0		Observe that expired commodities are separated and labelled in red Verify records on the Loss and expiry register.
	Destruction protocol for expired, damaged and unreadable labelled available and applied	5	0		
	Total	**15**			
Outbound	The supervisor verifies that commodities are issued only through the requisition.	5	0		The supervisor verifies that commodities are issued through requisition form
	DRF manual/SOP available	5	0		
	Total	**10**			

9.4

Roll-out phase – CMS monitoring for financial management(1/3)

PLAYBOOK

Timing

The CMS/ZMS is expected to perform a monthly internal review of DRF scheme. The State DRF monitoring, evaluation and accountability sub-committee will monitor the CMS/ZMS **quarterly**

Indicators

The facilities will be monitored on their DRF operations as stated in the guidelines. Some of the indicators monitored will include:

- The adherence to the DRF financial management guidelines
- The availability of tools used for recording finances the DRF process
- The availability of bank account and its signatories
- The reconciliation of the DRF account and the stock at hand

Tool: Financial management monitoring checklist

A basic monitoring tool will be used to assess the financial management operations

9.4

Roll-out phase – CMS monitoring for financial management (2/3)

PLAYBOOK

	Indicators [max 100 points]	YES	NO	SCORE	Descriptions [max 100 points]
Human resources	Senior Accountant at the DMMA and at least 2 accountants for CMS/ZMS	10	0		
	Total	**10**			
Bank accounts	There is a state DRF bank account with the number of signatories specified on the SOP	5	0		Check for bank statement, cheques or any proof of account
	At least two signatories receive bank alert as stipulated in the guidelines	5	0		Check the phone and enquire if this regularly update with the change of staff
	Total	**10**			

9.4

Roll-out phase – CMS monitoring for financial management (3/3)

PLAYBOOK

	Indicators [max 60 points]	YES	NO	SCORE	Descriptions [max 60 points]
Record keeping and tools	Cash book for banks	5	0		Cash book must be used regularly A notebook is not acceptable
	Petty cash book	3	0		
	The CMS/ZMS has a transaction and reconciliation ledger	5	0		Same as above
	Funds valuation form	5	0		
	The CMS/ZMS has an official receipt	2	0		Same as above
	Monthly financial reconciliation done	5	0		Check the reconciliation ledger
	The price list is displayed at the CMS/ZMS	5	0		Check the entrance wall
	Total	**30**			
Record keeping and tools	Suppliers documents are verified before payment	10	0		Show proof of the document submitted and ensure it's in line with the DRF guidelines
	Total	**10**			

9.4

Roll-out phase – CMS Monitoring for Stock Management and Reporting (1/3)

PLAYBOOK

Timing

The CMS/ZMS is expected to perform a monthly internal review of DRF scheme. The monitoring committee will monitor the CMS/ZMS **quarterly**

Indicators

The facilities will be monitored on their DRF operations as stated in the guidelines. Some of the indicators monitored will include:

- The adherence to the DRF guidelines
- The availability of tools used for recording the DRF stock
- The stock level reports
- The report of drug expiries
- The storage – an adequate record of the commodities.
- Outbound registers

Tool: stock management and reporting monitoring checklist

A basic monitoring tool will be used to assess the CMS/ZMS on data and stock reporting

9.4

Roll-out phase – CMS Monitoring for Stock Management and Reporting (2/3)

PLAYBOOK

	Indicators [max 60 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 60 points]
Stock records	Commodities are recorded when received at the store	5	0		
	Incoming DRF items are arranged on the shelves, using the principle First Expire First Out (FEFO).	5	0		If no, do personnel understand the principle of FEFO? If not, explain the principle and provide ideas on how DRF commodities should be stored to facilitate FEFO distribution.
	Total	**10**			
Stock levels	Conduct regular stock counts/stock status	5	0		View stock card
	The store has adequate stock level as stated in the guidelines	5	0		not above the maximum quantity; not at or below the emergency order level. If you think there is a problem, advise the store personnel accordingly. Take the necessary actions to correct the situation.
	Reconcile stock at hand and funds available quarterly	5	0		
	Check the Months of Stock on Hand for each DRF commodity. Use the formula. Months of stock = Stock on hand/ Average monthly consumption	10	0		Check all tracer commodities.
	Total	**25**			

9.4

Roll-out phase – CMS Monitoring for Stock Management and Reporting (3/3)

PLAYBOOK

	Indicators [max 60 points]	YES	NO	SCORE	Descriptions [max 60 points]
Availability of Stock reporting tools	Inventory control card / stock card	5	0		Check if forms are available and are being utilized by the facility
	Damaged and expiry register	5	0		
	Stock valuation form	5	0		
	Total	**15**			
Checking of forms	Sent stock report to the State DRF committee	5	0		
	LMIS bi-monthly reporting form received from facilities	5	0		At least 95% of facilities have submitted
	DRF Requisition/Issue Receipt Voucher received from facilities	5	0		
	Total	**15**			

9.4

Roll-out phase – Facility monitoring and evaluation checklist

PLAYBOOK

M&E facility checklist

Monitoring & Evaluation DRF supervisory checklist

BAUCHI STATE DRUGS AND MEDICAL
CONSUMABLES MANAGEMENT AGENCY (DMMA)

DRF SUPERVISORY CHECKLIST

HF
NAME……

WARD……

LGA……

DATE OF SUPERVISION……..

NAME AND DESIGNATION OF
SUPERVISOR(S)……...

DESIGNATION ……...
PHONE NUMBER ……..

- Each Monitoring and Evaluation officer is to fill the checklist
- The checklist is split into components and scored

Components of M&E

There are 3 components of M&E:

1. Supply chain operations
2. Financial management
3. Stock management & reporting

Each component will be given a score by the relevant body conducting the monitoring and evaluation exercise

Component	Score
Monitoring for supply chain operations	100 points
Monitoring for financial management	60 points
Monitoring for stock management and reporting	60 points

9.4

Roll-out phase – Facility monitoring for supply chain operations (1/5)

PLAYBOOK

Timing

The CMS/ZMS is expected to perform a monthly internal review of the DRF scheme. The State DRF monitoring, evaluation and accountability sub-committee will monitor the CMS/ZMS **quarterly** or as needed

The Monitoring and supervision sub-committee may choose to conduct supervision on facilities whenever necessary.

Indicators

The CMS/ZMS will be monitored on their DRF operations as stated in the guidelines. Some of the indicators monitored will include:

- The adherence to the DRF guidelines
- The availability of human resources at the CMS/ZMS
- The availability of tools used for recording the DRF process
- The procurement cycle process
- The process and method of receiving commodities
- The storage – adequate capacity, cleanliness and orderly arrangement of the commodities

Tool: Operation monitoring checklist

A basic monitoring tool will be used to assess the CMS/ZMS on supply chain operations.

Note: Checklist – Form 2A supply chain Operations - ANNEX 1

9.4

Roll-out phase – Facility monitoring for supply chain operations (2/5)

PLAYBOOK

	Indicators [max 100 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 100 points]
Human resources	The Pharmacist/ Pharmacy Technician oversees the Pharmacy	2	0		The person running the pharmacy must be a trained Pharmacist for GHs and pharmacy technician for PHCs (give the half-mark to the facility with a CHEW/JCHEW in charge of the pharmacy)
	The Pharmacist/ Pharmacy Technician is available at the time of visit	3	0		The Pharmacist/ Pharmacy Technician is available at the time of the visit
	Facility DRF Committee available and functional	5	0		Use SOP to validate specific members of the committee recommended and request for minutes of the monthly meeting
	Total	**10**			
Commodity requirement estimation	Evidence of correct estimation of commodities requirement	4	0		Show requisition list to proof
	Staff maintains stock cards for essential Drugs showing stock levels = average monthly consumption	3	0		Show stock card and verify the frequency of use
	Balance in stock card corresponds with physical count: a random sample of ten (10) essential drug items	3	0		The theoretical stock on the stock cards of ten (10) randomly selected drugs must be equal to the physical stock of these drugs found on the shelves.
	Total	**10**			

9.4

Roll-out phase – Facility monitoring for supply chain operations (3/5)

PLAYBOOK

	Indicators [max 100 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 100 points]
Procurement	Last procurement list shows drugs (all) were procured from the CMS/ZMS only (If YES, score and skip question 8, if NO, score question 8 only)	15	0		Compare the invoices/receipts for the latest procurement (in the quarter under review) with the latest PCN list of approved distributors
	Prove of procurement waiver from the CMS/ZMS if commode-ties are not procured from the CMS/ZMS	15	0		
	All drugs and medical consumables are NAFDAC certified	5	0		
	Total	**35**			
Storage	Dry, clean place, well lit and ventilated storage room	6	0		All requirements are met - score full mark Not all requirements are met – Score zero (0)
	All drugs are stored on cupboards, pallet and labelled shelves	5	0		All requirements are met - score full mark Not all requirements are met – Score zero (0)
	The facility has storage for drugs based on temperature requirement e.g. a functional refrigerator	3	0		All requirements are met - score full mark Not all requirements are met – Score zero (0)

9.4

Roll-out phase – Facility monitoring for supply chain operations (4/5)

PLAYBOOK

	Indicators [max 100 points]	YES	NO	SCORE	Descriptions [max 100 points]
Storage	Lockable cupboards or store and burglary windows	5	0		All requirements are met - score full mark Not all requirements are met – Score zero (0)
	Fire extinguishers or buckets of sand	3	0		
	Proper inventory practices. Drugs and medical consumables stored in pharmacological classes, first expire, first-out (FEFO) basis	7	0		
	Total	**29**			
Expired drugs	The supervisor verifies randomly three drugs and 2 consumables	5	0		No expired drugs should be found on the shelves
	Expired drugs well separated and well labelled from the stock and properly recorded	5	0		Observe that expired commodities are separated and labelled in red Verify records on the Loss and expiry register.
	Destruction protocol for expired drugs available and applied	5	0		Expired commodities are transferred to the CMS, verify with the return and transfer (RT) form
	Total	**15**			

9.4

Roll-out phase – Facility monitoring for supply chain operations (5/5)

PLAYBOOK

	Indicators [max 100 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 100 points]
Pharmacy store delivery	The supervisor verifies that commodities are issued only through the internal requisition voucher.	5	0		Verify-in the requisition register of the dispensary and compare with the drug register of the main pharmacy or bin cards to ascertain that quantity received in dispensary equals quantity supplied from the main pharmacy. Identify one commonly used drug. From the daily dispensing register, count the total quantity of that drug dispensed in one day.
	Drugs to clients are uniquely dispensed through prescriptions. Prescriptions are stored and accessible	5	0		No notebook accepted Verify the prescription for this drug for that day and the quantity should be equal to the quantity in the daily dispensing register.
	DRF manual/SOP available at the facility	5	0		Check for SOP at the facility
	Total	**15**			

9.4

Roll-out phase – Facility monitoring for financial management (1/3)

PLAYBOOK

Timing

All facilities are expected to perform a monthly internal review of DRF scheme. The State DRF monitoring, evaluation and accountability subcommittee will monitor the facilities based on the stages of their DRF.

- **Monthly**: For the first 3 months of receiving seed stock at the facility by the LGHA DRF committee or the State DRF monitoring, evaluation and accountability subcommittee
- **Bi-Monthly**: For the next 9 months of running a DRF scheme at the facility by the LGHA DRF committee or the State DRF monitoring, evaluation and accountability subcommittee
- **Quarterly**: More than a year of running a DRF scheme at the facility by the LGHA DRF committee or the State DRF monitoring, evaluation and accountability subcommittee

The State DRF monitoring, evaluation and accountability subcommittee may choose to conduct supervision on facilities whenever necessary.

Indicators

The facilities will be monitored on their DRF operations as stated in the guidelines. Some of the indicators monitored will include:

- The adherence to the DRF financial management guidelines
- The availability of tools used for recording finances of the DRF process
- The availability of bank account and its signatories
- The regulations of the D&E account
- The reconciliation of the DRF account and the stock at hand

Tool: Financial management monitoring checklist

A basic monitoring tool will be used to assess the financial management operations

Note: Checklist – Form B Financial Management Operations - ANNEX 1

9.4

Roll-out phase – Facility monitoring for financial management (2/3)

PLAYBOOK

	Indicators [max 60 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 60 points]
Human resources	The facility (PHC and SHC) has an account designate for cash management	5	0		The facility assigns a staff preferably an accountant to record sales and manage the finances of the DRF
	An account designates for SHC and PHCs is available at the time of visit	5	0		
	Total	**10**			
Bank accounts	The facility has a DRF bank account with the number of signatories specified on the SOP	3	0		Check for bank statement, cheques or any proof of account
	At least two signatories receive bank alert	3	0		Check any signatory's phone and enquire if this regularly update with the change of signatories
	The facility has a D&E account	2	0		Same as above.
	D& E funds are paid into the D&E account	5	0		Same as above
	Total	**13**			

9.4

Roll-out phase – Facility monitoring for financial management (3/3)

PLAYBOOK

	Indicators [max 60 points]	YES	NO	SCORE	Descriptions [max 60 points]
Record keeping and tools	The facility has a cash book	5	0		Cash book must be used daily A notebook is not acceptable
	The facility has a cash book for D& E	5	0		Cash book must be used daily A notebook is not acceptable
	The facility has a transaction and reconciliation ledger for daily transactions	5	0		A reconciliation ledger is used A notebook is not acceptable
	Funds valuation form	5	0		Must be filled as stipulated in the SOPs
	The facility has an official cash receipt	2	0		Same as above A notebook/ plain paper is not acceptable
	Facility banks cash as stipulated in the guidelines	5	0		Pick a random day Review cash record (close of fund of the day), signed tellers and bank alert from any account signatories
	Monthly financial reconciliation done	5	0		Check the reconciliation ledger
	The price list is displayed at the facility and dispensary unit	5	0		Check the entrance wall and dispensary unit
	Total	**37**			

9.4

Roll-out phase – Facility Monitoring for Stock Management and Reporting (1/3)

PLAYBOOK

All facilities are expected to perform a monthly internal review of DRF scheme. The State DRF monitoring, evaluation and accountability subcommittee will monitor the facilities based on the stages of their DRF.

- **Monthly**: For the first 3 months of receiving seed stock at the facility by the LGHA DRF committee or the State DRF monitoring, evaluation and accountability subcommittee
- **Bi-Monthly**: For the next 9 months of running a DRF scheme at the facility by the LGHA DRF committee or the State DRF monitoring, evaluation and accountability subcommittee
- **Quarterly**: More than a year of running a DRF scheme at the facility by the LGHA DRF committee or the State DRF monitoring, evaluation and accountability subcommittee
- The State DRF monitoring, evaluation and accountability subcommittee may choose to conduct supervision on facilities whenever necessary.

Indicators

The facilities will be monitored on their DRF data and stock reporting as stated in the guidelines. Some of the indicators monitored will include:

- The adherence to the DRF stock management guidelines
- The availability of tools used for recording the DRF stock
- The stock level reports
- The report on expiries and damages
- The storage – adequate records of the commodities.
- Dispensing registers and delivery notes (RIRV- requisition issue and receive voucher)

Tool: Stock management and reporting monitoring checklist

A basic monitoring tool will be used to assess the facilities on data and stock reporting

Note: Checklist – Form C Data Reporting and Stock Management Operations - ANNEX 1

9.4

Roll-out phase – Facility Monitoring for Stock Management and Reporting (2/3)

PLAYBOOK

	Indicators [max 60 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 60 points]
Stock records	Commodities are recorded when received at the facility	5	0		
	Incoming DRF items are arranged on the shelves, using the principle First Expire, First Out (FEFO).	5	0		If no, do personnel understand the principle of FEFO? If not, explain the principle and provide ideas on how DRF commodities should be stored to facilitate FEFO distribution.
	Total	**10**			
Stock levels	Conduct regular stock counts/stock status	5	0		View real-time stock card update
	The facility has adequate stock level as stated on the guidelines	5	0		Not above the maximum quantity; not at or below the emergency order level If you think there is a problem, advise the facility personnel accordingly. Take the necessary actions to correct the situation.
	Reconciles stock at hand and funds available monthly	5	0		Use reconciliation ledger to verify
	Check the Months of Stock for each DRF commodity. Use the formula Months of stock = Stock on hand/ Average monthly consumption	10	0		Check tracer commodities. At least 10 random commodities should be checked.
	Total	**25**			

9.4

Roll-out phase – Facility Monitoring for Stock Management and Reporting (3/3)

PLAYBOOK

	Indicators [max 60 points]	**YES**	**NO**	**SCORE**	**Descriptions** [max 60 points]
Availability of Stock reporting tools	Inventory control card / stock card	4	0		Check if forms are available and are being utilized by the facility
	Damages and Expiry register	2	0		
	Stock valuation form	5	0		
	Prescription form	2	0		Prescription forms dispensed by the pharmacist
	Return and Transfer (RT) form	2	0		RT forms used for returning expired/ live drugs to CMS or transfer to another facility
	Total	**15**			
Checking of forms	LMIS monthly reporting form is filled and sent to the DMMA and LMCU	5	0		Check duplicate of forms at the facility If no, do personnel know how to fill in the different DRF LMIS data collection forms? If not, provide on-the-job training.
	DRF Combined Requisition/Issue Receipt Voucher	5	0		Check duplicate of forms at the facility
	Total	**10**			

9.4

Roll-out phase – Stock review indicators and key decisions to be made

PLAYBOOK

Indicators

- Reporting rate
- DRF LMIS Monthly Report completion
- Appropriate stock levels
- Tracer commodity stock levels
- Total expiries
- DRF commodity storage conditions e.g. temperature
- Adherence to FEFO principle
- Disparity between inventory and physical count

Key decisions to be made

- Quantification and forecasting of commodities
- Procurement cycle of the CMS/ZMS and the facility
- Distribution and delivery route of commodities
- Detecting and addressing stock out of fast-moving commodities at both levels
- Need for refresher or on-the-job training
- Identification of staff/facilities eligible for rewards or sanctions
- Others

9.4

Roll-out phase – Financial review indicators and key decisions to be made

PLAYBOOK

Indicators and forms

- Fund valuation form
- Profit and loss
- Transaction account
- Profit and loss, cashflow and balance sheets

Key decisions to be made

- Validation and necessary rectification of the financial operations of the DRF at all levels
- Profit and loss of the DRF scheme at all level
- Identification of funds available for other activities at the CMS or facility
- Identification of staff/facilities eligible for rewards or sanctions
- Others

Financial data reported will be reviewed by the **DMMA management team and the State DRF committee quarterly** at both the facility and state levels.

9.4

Roll-out phase – Offences and sanctions (1/2)

PLAYBOOK

S/N	Offences	Sanctions
1	**Inflation of prices of procurement**	Impose appropriate surcharge as determined by SPHCDA /HMB
2	**Irregular or wrong payments**	Recovery of the amount involved and removal of the officer who certified the job
3	**Shortages or Losses of Stores by the storekeeper**	Recovery of the amount involved and removal of the officer from the schedule
4	**Shortage or Loss of cash by Cashier**	Surcharge the affected officer and transfer to another schedule
5	**Items paid for but not collected**	Recovery of the amount involved and blacklists the supplier and transfer of officer to another schedule where collusion has been established
6	**Failure to collect DRF revenue**	Surcharge the affected officer and transfer him to another schedule
7	**Failure to account for DRF revenue**	Surcharge the affected officer and transfer him to another schedule

9.4

Roll-out phase – Offences and sanctions (2/2)

PLAYBOOK

S/N	Offences	Sanctions
8	Non-recovery of advances	All losses should be recovered from or surcharged against the defaulting officer if he is a civil servant. Where no losses are involved the defaulting civil servant would be warned.
9	Non-posting of ledger account	All losses should be recovered from or surcharged against the defaulting officer if he is a civil servant. Where no losses are involved the defaulting civil servant would be warned.
10	Cash in transit for too long (over 72 hours)	All losses should be recovered from or surcharged against the defaulting officer if he is a civil servant. Where no losses are involved the defaulting civil servant would be warned.
11	Failure to prepare Bank Reconciliation Statement	All losses should be recovered from or surcharged against the defaulting officer if he is a civil servant. Where no losses are involved the defaulting civil servant would be warned.
12	Non-rendering of monthly or other periodic returns	All losses should be recovered from or surcharged against the defaulting officer if he is a civil servant. Where no losses are involved the defaulting civil servant would be warned
13	Procurement outside CMS/ZMS without a waiver	The person should be queried and appropriate action taken
14	Allowing Drugs to expire due to negligence	The person should be queried and appropriate action taken