

Report 6

The Revolving DRUG FUND

Bringing the “Public” back into the Somaliland
Public Hospitals

HARGEISA GROUP HOSPITAL, SOMALILAND



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Foreword

Hospital services in Somalia

The health system in Somalia is very weak. The primary health care system offers a low range of services, frequently far from the household, of poor quality and at considerable cost to the user. The public health care (PHC) system would hardly function without external support from UN agencies (supplies) and NGOs (management and incentives) and even with support, health care typically reaches about 20% coverage of women and children, with low level preventive and curative services.

There are hospitals that continue to function and offer some degree of services with much lower levels of formal international assistance. Many hospitals are termed “public”, but there are a few private or not-for-profit hospitals (for example Manhal and the *Edna Adan* Maternity Hospital in Hargeisa and Burao, and SOS in Mogadishu). However, the difference between public and private hospitals is minimal; “public hospitals” receive either no government financial support (as in South Central zone (SCZ) or a very low percentage of overall operating costs from government budgets (typically < 5% in Puntland and Somaliland). “Public” hospitals also have to charge user fees and manage vicarious and unpredictable support from UN agencies, NGOs, donors, charities, diaspora remittances, business donations, etc. (as do private hospitals).

The main differences between private and public hospitals seem to be that:

- private hospitals are often organised around a requested specific service area (e.g. eye surgery, obstetrics) according to the specific skills of the founder;
- public hospitals have a broader range of infrastructure/equipment;
- the fees of public hospitals are often lower;
- public hospitals must execute directives from the

government, often with cost implications and no financial support; and

- in emergency periods public hospitals will often be used to treat large numbers of people for free, receiving donations from the international community.

It is a tribute to the hospital directors that they continue to survive and offer services.

However, in order to survive they have a highly private character and extremely low levels of public engagement and support. These “public” hospitals are forced to operate according to a financial logic in order to survive. They frequently operate at low levels of efficiency (typically 40 - 50% bed occupancy) and are only accessible to a low proportion of the urban population due to costs and distance. They exist and survive only in major towns with sufficient populations and an economy (as well as diaspora support networks) that enables them to be economically viable.

In some towns, hospitals function fairly well (Mogadishu, Bossaso, Merka, Kismayo, Galkayo, Hargeisa and Borama), while in other towns they survive at very low operating levels and depend on NGO support programmes to raise productivity and utility of services to the local population. In almost all cases there is no professional hospital management; hospitals are managed by strong, charismatic doctors upon whom the institutions depend to run clinical services as well as to keep the institutions afloat. Lack of a management function means there is considerable lack of transparency in the functioning and management of hospitals (making them hard to support from external sources) as well as considerable dependence on individuals of varying levels of competence. This also leads to problems when a director leaves. Humanitarian support programmes have tended to take over hospital management and financing for

intermittent periods (some also providing skilled clinicians to improve the range and quality of services), while subsidising care to the poor. However, these projects often undermine the capacities of hospitals to survive in between periods of NGO support. While this form of programming is probably inevitable in the SCZ for the future, in the bigger towns in the northern states at least, the fragile institutions that have been developed need to be protected as well as supported. Furthermore, these functioning institutions should be supported to increase the volume of service provision (increased efficiency) and increase accessibility to those unable to pay (equity). This will require a greater degree of **public** involvement in the hospitals.

Public drug supply

Public drug supply is one area in which the public sector frequently has a major operating advantage over the private system. Public procurement agencies can generally

- access good quality, cheap generic medicines, and do not need to rely on high-cost brands;
- bundle together drug orders - by ordering in bulk significantly lower costs for drugs can be accessed;
- concentrate on essential medicines (the public procurement agency can focus on the major drugs which account for more than 80% of the market and drive down drug management costs); and
- public drug procurement is generally imported tax-free.

Significantly lower costs are predicated on public reserves used to generate high volume orders and cover the risk of large drug orders, as well as public subsidies in terms of waiver of taxation. Lower medicine costs are in theory used to support operating costs of the public system and should also be transferred to the public, so subsidising access

to essential medicines. Hence, the benefits of public procurement depend on a degree of public financial support and financial risk-taking (large orders) as well as a high degree of public management capacity to ensure risks are reasonably taken (and large drug orders are not wasted).

In Somalia, drugs for the PHC system are procured and distributed via government and NGOs through UNICEF. Some extra drugs are supplied by other UN agencies such as WHO and the United Nations Population Fund (UNFPA) and NGOs in specific programme areas. Some public procurement of drugs for hospitals are supplied via WHO and the United Nations Population Fund (UNFPA), but only for a limited range of functions (specific diagnostics and service areas). NGO support programmes typically do purchase drug stocks for some hospitals. These drugs are sold and the recovered monies used in various ways to support hospital functioning (staff incentives, management costs, etc). Where hospitals receive no supplies they generally purchase medicines from the private market on an as-needed basis, hence many public hospitals have no prepaid medical stock and no real drug management practice. Again, in order to develop an effective public drug system in Somaliland there is a need for greater organisational involvement of the **public** sector in *“public” hospitals*.

The Hargeisa Group Hospital Revolving Drug Fund – the target of this work

Comic Relief provided funds through the Tropical Health and Education Trust (THET) for the development of a revolving drug fund in support of Hargeisa Group Hospital (HGH - the national-level “public” hospital for Somaliland). The objectives were to establish a permanent pre-paid drug stock in HGH to allow reduced

costs of service, improved stability of the HGH budget and management of services, as well as reduced costs of medicines made available to the public of Somaliland.

After three years the project was evaluated as a success in its own right, in terms of it having made low-cost essential generic drugs available to the public through the HGH, and having supported smoother hospital functioning and service. However, the evaluation indicated that profits realised from the revolving drug fund (RDF) were used to support exemptions of user fees as well as a range of other hospital overhead costs (including some salaries). The leaking of RDF funds to other areas of hospital overhead costs undermined the longer term viability of the RDF, ensuring the project would not continue beyond the end of 2009.

This study was commissioned by UNICEF Lot 3 Health Sector Development Programme in partnership with HGH and THET. The ToRs were co-developed with HGH (i.e. the hospital director and Regional Health Board), THET and UNICEF. The purpose of the work was to evaluate what actions would be needed to develop the RDF to a level where it would provide sustainable public support to the population, and enhance HGH services.

This would have implications for the development of the public drug procurement and supply system in Somaliland, and possibly Somalia in general.

The work is of great significance both for and beyond HGH, as it gives an insight into how external actors might provide better support to the fragile hospitals of Somaliland and possibly other zones of Somalia, improving their efficiency and equity of public service as well as encouraging an essential but progressive **re-publicising** of the “public” hospitals. This would involve increased essential public intervention in the public hospital service sector.

In general, the ToR focussed on the need to address:

- management of the drug stock and capital fund;
- means of protecting the capital fund from exemptions and other costs;
- means of promoting the public service aspects of cheap quality medicines; and
- possible recommendations to move forward and expand the programme to increase the drug supply market.

Austen Davis - UNICEF Health Sector Development Coordinator

Acknowledgements

The HGH Revolving Drug Fund was an initiative with financial support from Comic Relief and with some technical assistance from Tropical Health and Education Trust. The RDF was evaluated and proven to be successful if not sustainable. This report seeks to further the analysis of the RDF and make recommendations for the future.

To this end the author would like to thank in particular Dr. Yassin, Director of HGH, whose willingness and time were generously provided and whose commitment and leadership of the HGH are inspiring. Thanks are also due to many other staff at HGH who cooperated in this project.

The author must also thank the Ministry of Health and Labour Somaliland which eagerly facilitated the work; THET who supported and assisted the work with interviews and materials; and Dr Koleade from WHO.

Finally, the author would like to thank UNICEF for commissioning and supporting this work and the EC for financing this work. We hope it is an important contribution to the development of the Somaliland health system.

Finally, and with great regret, the author was unable to present his findings at the end of the consultancy to the hospital management, UNICEF, WHO and the MoHL. The debriefing meeting was interrupted by the tragic bombing events that occurred on Wednesday, October 29th 2008. The absence of a debriefing constitutes a lost opportunity to gather feedback on the findings and interpretations of those findings, as well as to impress on the various actors (especially the MoHL and the HGH board members) the seriousness of the situation and the relatively simple steps required to redress it.

Without the de-briefing, the consultant fears that the report will be lost or perceived as overly critical and with insufficient input from concerned parties. The consultant sincerely respects the efforts to date and the benefits of the RDF project that have already been realised, and does not want this report to be seen as anything other than a contribution to maximising the benefits of the RDF and enhancing the public service utility of the HGH hospital.

Bertrand Chenin - Consultant

Acronyms

HGH	Hargeisa Group Hospital
IDA	International Dispensary Association
IV	Intravenous Fluids
MoHL	Ministry of Health and Labour
NGOs	Non-Governmental Organisations
RDF or DRF	Revolving Drug Fund (Drug Revolving Fund)
RHB	Regional Health Board
SS	Somaliland Shilling
THET	Tropical Health and Education Trust
UNICEF	United Nations Children's Fund
USD	United States of America Dollar
WHO	World Health Organisation

1

Executive Summary

The Revolving Drug Fund of the Hargeisa Group Hospital is a valuable initiative that serves patients in great need of quality health care in general, and essential and generic drugs and quality medical supplies in particular. This initiative should be supported in perpetuity. The RDF deserves to be carefully managed and secured in an environment that does not have the usual requirements for reliability and sustainability.

This consultant believes the current investment by Comic Relief managed by THET has created a valuable activity, but the value of that investment could have been much higher if the project management had been more active in terms of technical assistance and business counselling than it has been. This has been a lost opportunity in developing a more realistic business approach and necessary management capacities that would have been valuable in terms of initiating the RDF on the right foot from the start, enhancing sustainability (objective three of the project) and attracting more attention to the RDF and the HGH, as well as providing education and training for the relevant staff.

Today, after almost three years of existence, the RDF has lost 35% of initial capital (constituted by three International Dispensary Association (IDA) indents and paid for by the THET project). Besides that, the hospital loses a gross amount of USD 10 000 a year. These losses are mainly financed through the RDF working capital (hence the 35% erosion of RDF capital) and

through a debt owed to hospital employees¹. These two factors, even if not completely linked at origin, become intimately linked for survival of the hospital. If not addressed immediately, these facts will erode the RDF capital, leading to financial collapse in a few years after which point the hospital will have no capital or RDF income to address operating losses and will have to change its operating modalities (leading to increased cost and reduced service to patients).

Causes of losses are multiple, but the main factors come from the necessary exemption mechanism (to exclude costs for those patients who cannot afford to pay) and the weakness of the RDF management. Immediate actions need to be taken to:

- reinforce management capacity;
- build a financial partnership between the HGH Board and the Ministry of Health and Labour (MoHL) (possibly with donor support); and
- develop a realistic business approach oriented mainly towards raising the income from the pharmacy (working capital) and realistic financing of hospital operating costs (through public budget support, not RDF income).

1. The non payment of public salaries is the "usual" financing means of public structures in need of income to finance operating costs. Salaries are paid a month in arrears. However, if this continues the salary payments and incentives will fall further and further in arrears each year and debt to employees will accumulate. Payment arrears cannot therefore be used as a regular financing option.

This report aims to provide suggestions on moving forward and stabilizing the situation through contractual approaches between HGH Board and a public / private partnership so that all necessary roles and responsibilities are delineated and fulfilled. This would meet requirements to build a sustainable and valuable tool and contribute to hospital sustainability and improved public service.

The report also emphasises the fact that hospital management should react immediately by putting in place the basic management information system developed during this consultancy, with support of the hospital director to allow management to understand and effectively manage the RDF.

This report focuses on two aspects: development of management functions in HGH (the public hospitals), and increased public engagement and financing of public hospitals. It is recognised that there is virtually no professional or dedicated management function in any of the hospitals to date. It is also recognised that the MoHL has limited financial and management capacity to increase their support to HGH and other hospitals, despite good intentions. Nevertheless, without increased management and public support the “public” hospitals will continue to function as before – at the vagaries of the capacities of their directors and the unpredictable financing flows through multiple channels. The argument developed in this report is that the Medical Directors of hospitals need managerial support, as do the volunteer regional health boards that manage the hospitals.

In order for the public hospitals to begin to function efficiently and effectively they require better management and better-organised public financing

to allow them to manage and staff their institutions appropriately. Technical assistance to the hospital(s) will be required to reorganise the hospital and to propose some judicious recruitment (new professional capacity) to enhance the overall capacity in management of the public hospitals.

Summary of recommendations:

- Provide technical support to HGH to enhance management in general and of the RDF in particular.
- Act rapidly to control risks – sell off drugs with imminent expiry dates, define a drug list, improve pricing policy and (if no one will underwrite their costs) cease all exemptions.
- Provide support to MoHL to enhance their involvement in management and allow them to underwrite risks and financial commitments of public hospitals.
- Extend the programme to other major regional hospitals, which will require working capital, facility renovation and TA.
- Enhance business and turnover of the “public” hospitals by buying services from hospitals for those unable to afford them – voucher schemes for obstetric complications, etc. Increased occupancy and equity will also lead to great income for hospitals and increase their ability to secure proper staffing functions and services.

2

Financial analysis

Disclaimer

Due to the lack of a reliable information system attached to the RDF and hospital functions in general, figures provided in this report are best estimates. All figures are gross figures which have been cross-checked as much as possible, but they are still not officially confirmed by an internal audit or random procedures of verification. The consultant believes the figures provide reasonable estimations or trends, but are not precise.

2.1 Working Capital

In order to define the potential for future development of the RDF initiative, it is necessary to review the state of affairs. The first action taken was to estimate the RDF working capital. To do so, the value of current stock (with valid expiry dates) must be known. A stock-taking procedure (part of the set of procedures left to the Director) has been designed and immediately implemented. As of October 18th 2008, the working capital was estimated as follows:

RDF SOMALILAND			
QUARTERLY ANALYSIS OF THE DRF WORKING CAPITAL			
Month of : October		Year : 2008	
Currency : USD		Responsible:	
Stock Value at Costed Price :			
Stock Taking Date : 18-oct-08		Value at Costed Price : 59 400	
Working Capital Value with Assets and Liabilities (short Term) :			
As at : 18-oct-08			
ASSETS in USD		LIABILITIES in USD	
Stock Value (Costed Price)	59 400		
Available Funds (Bank position)	62 640		
Cash :	1 601		
Creditors :		Debtors :	10 000
Advances made to suppliers :	53 264	Advances made by customers :	
Other Creditors (-1 year) :		Other Debtors (-1 year)	
Total Short Term Assets :	176 905	Total Short Term Liabilities :	10 000
Net Global Working Capital : =		166 905 USD	
Turn Over Analysis for the Period :			
From (Beginning date)	1-janv-08	Up to (End of period) :	30-sept-08
Turn Over for the Period :	57 452 USD	Number of month :	9
Average Monthly Turn Over :	6 313 USD		
Prospective for growth activity concerning the 3 following months :			
Forecasted Growth of Turn Over for the next 3 months :		Mark up on Costed Price :	
10%		50%	

2. This capital value includes a deduction of USD 10 000 owed to staff as back-pay, for incentives. Formally, the payment of incentives to hospital staff is not the responsibility of the RDF (in which case the capital stock would be USD 176 907). Incentives due to hospital staff are usually financed by the hospital services income. Nevertheless, income generated by the sales of drugs is a source of revenue for the hospital that is used to finance part of hospital running costs.

The table above shows a RDF working capital value of about USD 166 905.

The next stage is to estimate the current working capital level with total capital inputs to allow an estimation of capital losses:

	Euro	USD	SLSH
Conversion rates		(1.32)	(6200)
Losses in working Capital			
Stock	45000	59400	
Bank		62640	
Advance IDA from HGH Board		53264	
Cash		1601	9924600
Debtors		-10000	
Working Capital			
Received		237500	
Losses		70595	
Total Working Capital		166905	

The initial endowment was made through three IDA indents to a value of USD 237 500 (confirmed by THET and IDA). If the RDF had been properly managed and revolving, the short term assets should equal the initial endowment. However, the loss (about USD 70 000, or USD 60 000 without hospital salary debt) indicates problems with the design and management of the RDF.

This gross estimation indicates that a third of the initial capital has been lost. Furthermore, at the time of stocktaking significant quantities (capital) of drugs were discovered with an imminent expiry date, presenting further risk to the capital stock.

2.2 Net Margin Analysis

The margin is the amount of money or “profit” that comes on top of the sales and can be reinvested in:

- increasing working capital
- covering expenses
- modernising and upgrading hospital services
- reducing mark-up of drugs, so passing lower-priced medicines to the public

The net margin is calculated by estimating flows of goods. This is the only way to get accurate figures concerning the income potential of the RDF, which would be greatly affected by these losses.

For the first 28 months of the project there was a 70% mark-up of drug prices, and in the following 18 months there was a 50% mark up (currently still in practice).

RDF LOSSES	USD	SINCE 12/2005
IDA Stock	237,500 A	
Local Purchase	20,200 B	
Total in Stock	257,700 C = A + B	
Additional Costs	2,577 D	
Total Purchased	260,277 E = C + D	
Stock as at mid October	59,400 F	
Goods Distributed	200,877 G = E-F	
Turnover as at end September	202,069 H	
Net margin	1,192 I = H-G	0.59%
Working Capital Losses	70,595	
Margin	1,192	
Net Losses	70,595	35% of distribution 30% of distribution
Who finances the losses?		
Debtors:	10,000	
Working capital:	60,595	
Expired drugs		
Exemption mechanism		
Ex rate		

If RDF distributes 100 it loses 35

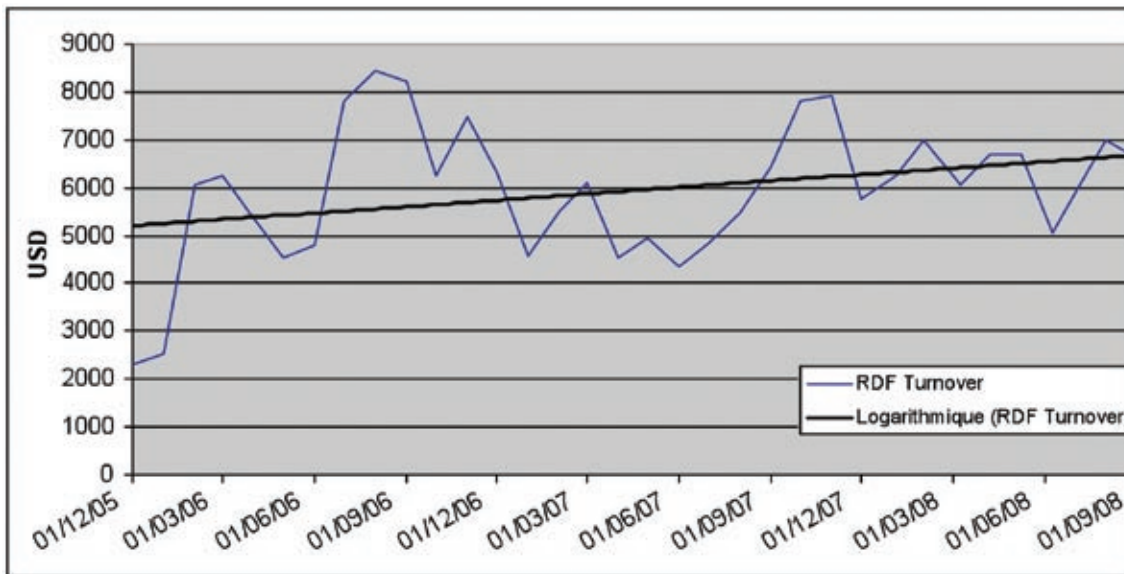
The net margin for the first 34 months of the RDF is <1%. However, if the losses unrelated to RDF functioning were funded by an external source or had not occurred, then the net margin would have come to 55%.

The margin or price mark-up of 50-70% is paid by patients, but due to a lack of general policy/financing (MoHL) and lack of management (hospital), the margin

is swallowed by the losses (exemption, expired, pricing policy not strong enough). The profit margin doesn't have to be seen as "profit" but should be seen as a valuable tool to be devoted to patients' welfare. In the case of the RDF, the low net margin due to losses constitutes a lost opportunity to impact on patient welfare and investment in improved hospital services.

2.3 Pharmacy turnover (RDF impact)

The following graph indicates RDF turn-over by month since the inception of the project.



The pharmacy turnover² shows a positive trend over the months, indicating that the hospital pharmacy is slowly but gradually building higher levels of public utilisation. The RDF is a success as it is a service that is demanded and wanted by patients. This provides a good rationale for investing in the RDF in order to further develop the service and serve more of the population.

2.4 Overview

Currently, the RDF is bleeding financial resources resulting in progressive erosion of the capital stock as well as a loss of net margin (margins swallowed up by losses). Hence the hospital is losing an excellent source of financing that could be used to promote better public service, and compromising the future of this drug sourcing instrument.

3. The turnover here is from 01/12/2005 to 30/09/2008, i.e. 34 months. Data for three months (July, August & September 2007) were unavailable, and turnovers for these months are based on assumptions.

What are the causes?

Without precise figures and therefore firm data on the causes of loss, working capital decreases because of:

- The **exemption mechanism** that distributes drugs, reagents and medical supplies to the emergency ward (free services, as decreed by the President), and exempted patients (perceived as being too poor to pay) for free.
- **Expired drugs (waste)** the level of drug expiry is quite high due to the lack of an information system so that management is unable to:
 - o properly calculate monthly consumptions and place indents accordingly, or
 - o recycle (sell) the nearly expired drugs to other markets, while NGOs and other health institutions are in great need of drugs.
- A **global pricing policy** that does not take into consideration international commercial terms and exchange rate fluctuations.

- **Insufficient budget** to support the basic operating costs of the hospital, so the RDF is used to cross-subsidize hospital operating costs.

In summary:

- The project has been useful in supporting continued public service from HGH to the population;
- There is increasing demand for RDF services to the people, therefore

- The project is successful and warrants continuation.

However, the project needs to be technically managed with greater roles played by management and the MoHL to allow the RDF to succeed. The timescale for effective intervention is immediate, to stop further erosion of the working capital and to enhance turn-over and profit margins.

3

Pharmaceutical overview

3.1 Pharmacy maintenance

From a pharmaceutical point of view, there is urgent need for rapid improvement in the management of drugs, particularly:

- The stock card system is not updated (random verifications among items in stock in both warehouse and pharmacy showed big differences between stock on cards and physical stock).
- Contents of fridges are not properly maintained and cold devices are not monitored on a daily basis. A temperature sheet must be attached to each fridge in order to follow the temperature management of contents.
- Expired pharmaceutical products should not exist in any of the storerooms. Expired products should be separated out to a special room and immediately costed. A monthly report (from management to the board), should be introduced to explain levels and causes of waste and to allow organised safe disposal.
- Following adequate explanations of waste management and costing, the MoHL will proceed to the destruction of expired drugs following MoHL procedures.
- The warehouse and pharmacy should be clean and tidy at all times. Improved lighting should be

installed in the warehouse so that stocktaking is easier.

- Stock management procedures were developed during this consultancy and should be implemented as standard regular practice, and strictly enforced by management.

3.2 List of drugs

The list of drugs and medical supplies maintained by the RDF must be shortened and rationalised (as reflected in the previous evaluation of the RDF by Dr Gamal). At the time of the consultancy, the fourth order was already in the pipeline and containers were ready for loading. This means that the next order should be prepared in six months, and the new list needs to be completed in advance of this fifth order.

Hospital management had already started reviewing the drug list in advance of this consultancy, with some assistance from WHO. This consultancy has also provided input to the process of drug list revision. A way forward has been proposed to the hospital director but no final consensus was reached on the list at time of writing.

4

Proposed ways forward

As shown previously in the graph on turnover, the RDF is necessary both to patients and hospital survival. Patients benefit from access to drugs and medical supplies of acceptable quality at subsidised/social price. The hospital benefits by using part of the net margin for operating costs and upgrading or modernisation of services. People come to HGH because of the availability of good, relatively cheap drugs as well as superior service quality, so the two benefits are mutually reinforcing. Both the social benefit to patients and the benefit to the hospital can be enhanced through better management.

4.1 Information is power

The very first steps towards improvement are the development of effective information management systems. The hospital in general and the pharmacy service in particular, need a basic information system³.

It is acknowledged that the hospital has insufficient dedicated management staff, capacity and/or systems, and the hospital is managed by the extraordinary efforts of the medical director and the dedication of the

volunteer regional health board. Nevertheless, there would be major benefits from improved management of the RDF and other hospital functions.

The consultant and the Director of HGH designed a basic information system in Excel along with procedures for users and the management team (see Annex 2 for this set of tools). If this set of procedures were to be regularly implemented, the pharmacy would be able to provide basic monthly, quarterly and yearly reports with a simple set of key indicators allowing discussion on financial health of the RDF. The generation of transparent information is crucial to improved management of the RDF and the development of an effective management partnership with MoHL and benefactors based on confidence and transparency. This management would show responsible management, effective RDF and demonstrable progress, as well as clear indications of endogenous threats managed and extent of exogenous threats needing assistance from the public sector or benefactors.

Above all, this set of procedures is dedicated to improving effective financial and pharmaceutical management. Management information is urgently required to boost the quality of internal management of the RDF (reducing waste, improving on drug costing, enhancing net margins, etc.). Procedures that have been developed need to be implemented by the director of HGH and the HGH board. Daily use of the information system

⁴ Several software programmes specially designed for dispensary information management exist that easily provide regular management information and promote reliable management of the pharmacy. In these conditions, it is not recommended to introduce new software (weak human resources, end of project, no technical assistance, lack of financing) but it should be envisaged in the case of increased further support to the RDF.

should generate a change in ways of thinking, of working and therefore of forecasting. It will also give the HGH board a greater opportunity to understand exactly what is going on in the RDF and to present this picture to donors and stakeholders for future partnerships.

In the current state of affairs, with the weakness of management structures (especially accounts) it may be necessary to envisage technical assistance to management for the support and development of the information system and management procedures as well as assistance to improving the capacity of management and Board members to use management information. Draft Terms of Reference for this TA are presented in Annex 3.

The RDF does need public support to cover costs of currency fluctuations, recover costs of acceptable levels of waste and to protect the RDF from alternative use of capital (exemptions). Hence there is a requirement for better and more substantial financial and managerial support of the HGH by the MoHL, with possible support from benefactors.

No effective partnership can be established (and therefore no consistent assistance provided) without a minimum amount of downstream information demonstrating effective performance and the legitimate extent of assistance required (as well as the implications of non-assistance). Eventual partners would require reliable information in order to justify financing and to understand the development of the RDF and the need for continuity of support. The issue of required increased commitment and support from MoHL in this PUBLIC:PRIVATE partnership is addressed later in the report.

Performance will enhance the feasibility and effectiveness (and therefore commitment) on both sides of an enhanced partnership:

- Performance of HGH Board and Hospital management will be enhanced by regularly using the IS – leading to improved management and performance of the pharmacy.
- Performance of the MoHL as a public partner providing timely support to the RDF and the hospital – allowing enhanced sustainability and public service (MoHL will need to provide a small additional source of income to subsidize the partnership and the hospital and protect the capital working stock of the RDF). Such a role is badly needed of the MoHL to begin to improve public services offered by the nation's key referral hospital and could serve expansion of the MoHL's role as a partner in promoting the public services of other hospitals in the future.

4.2 Exemption mechanism

The exemption mechanism is necessary – but it is a threat to the continued function of the RDF. The exemption mechanism is a public service and needs to be financed through other **PUBLIC** mechanisms. If alternative sources of financing are not found to support exemptions – and quickly – then either all exemptions will need to stop (reducing the public character and service of the HGH to the people) OR the working capital of the RDF will be rapidly eroded and there will not be any RDF in the near future.

- The working capital of the RDF needs to be reserved exclusively for the purchase of drugs and medical supplies to ensure that the capital revolves.
- The RDF is a public service (both in terms of drug supply to the population as well as an important component of HGH sustainability) – this should not be undermined by the need for exemptions.
- If the needs of another public service (exemptions) are paramount they must be met somehow - but not at the cost of undoing the RDF public service.

The exemption mechanism is government policy and is a pure public subsidy – and it is the responsibility of government to find a way to finance their public policies (presidential decree that all emergency ward cases should be free as well as exemption of some patients too poor to pay). However, the government needs to be confident that exemptions are provided on a rational and justified basis (otherwise financing requirements could increase unchecked). To do so, three main things must be quickly on line:

- HGH information system that precisely describes :

- Who is exempted (number of patients by age and group of disease).

A special procedure and tool has been built for this purpose. It records on a daily basis the flow of patients that receive drugs and medical supplies from the pharmacy. Both groups by age and diseases have been designed by the CCM and HIS teams in coordination with the Hospital Director.

- What is exempted and not exempted (wards, special services, departments and patients)

A special procedure and tool has been built for this purpose. It records on a daily basis the flow of drugs and medical supplies issued by the pharmacy. It will be used to record the consumption of pharmaceutical products and to cost out the losses (due to exemptions). Monthly reports are designed in order to monitor these flows.

- How much the exemption programme costs on a monthly basis at weighted cost price if possible or at cost price.

Losses and regular flows will be costed by an accountant so that a credible statement can be given of the cost of exemptions to the hospital budget – and these verified claims can then be reclaimed from the MoHL and/or any other financial partner.

- HGH pricing policy that allows the sale of pharmaceutical products with a sufficient margin to finance:

- A part of the operating costs of the hospital (mainly related to pharmacy department, warehouse improvement).
- A part of the exemption mechanism.
- Yet still ensure a discounted social price undercutting private pharmacy prices.

The Hospital Director will propose to the Board a new pricing policy which will first take into account the private market prices and will secondly monitor the global margin. To do so the Director will have to know quantities distributed by pharmaceutical product as these quantities are of great influence on the global margin. A special tool has been designed to implement the pricing policy.

- An annual hospital budget for running costs showing expenditures and income (projected trading account) for which both MoHL and HGH Board agree on. *A projected trading account which takes into account income (service, pharmacy and subsidies) and expenditures (cost of goods, operating cost and depreciation) must be introduced to the Board by the Director. This tool will show the total income with the global margin chosen so that expenditures will be identified and properly financed by margin and financing partnership (agreed subsidies or support).*

Any financing partner will require a set of indicators and basic information to allow an understanding of losses and their costs. A draft Memorandum of Understanding between the HGH Board and MoHL is based on hospital performance in providing this basic information (Annex 4).

4.3 Improving drug management

Drug management needs complete re-structuring. A set of procedures and tools has been designed to allow the pharmacy management to enhance their stock control and management. The tool set is about:

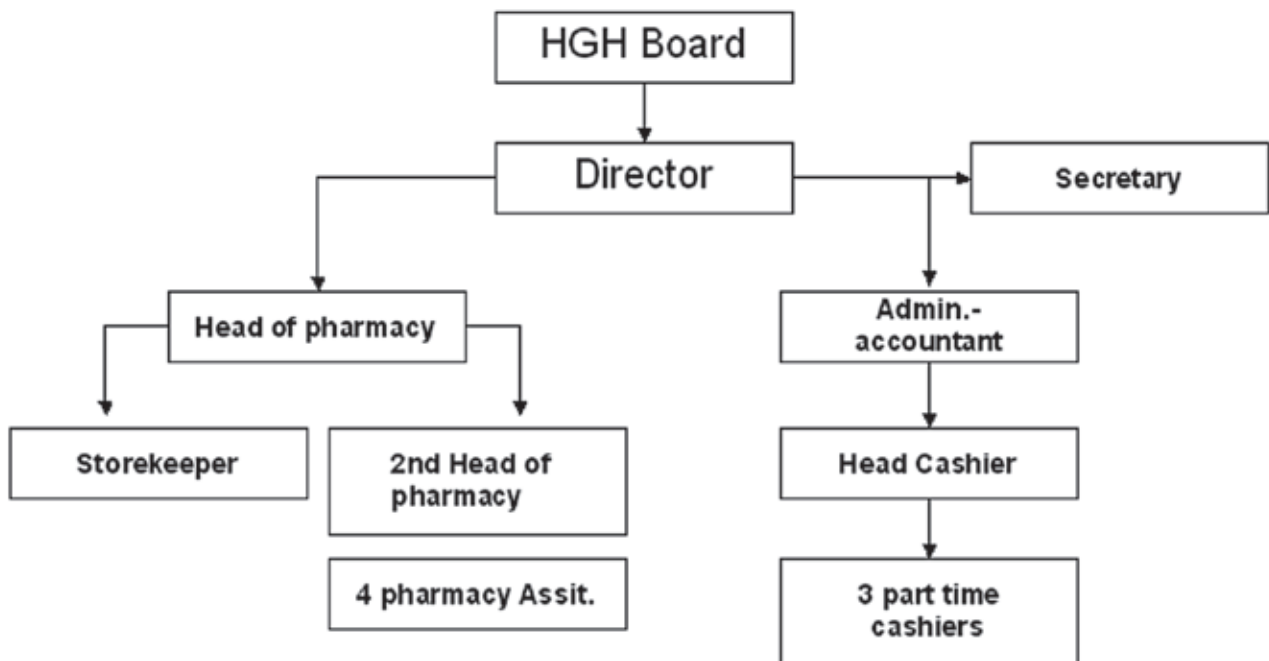
- Monthly and quarterly stocktaking :
A monthly stocktaking of the dispensary (pharmacy) is necessary in order to cross check results of the procedure aiming to record monthly flows and releases and monthly consumption. This cross checking will produce an indicator (number of products having the same quantity in both procedures) that will show the degree of commitment of

the pharmacy staff in doing proper recording and management.

A quarterly stocktaking is necessary in order to know the costed value of the stock. This value will be used to follow the working capital variation.

- Good storage practice
- Recording and reporting on drug consumption and pharmacy attendance
- Reporting on drug losses by type of loss:
Expired drugs must be cautiously monitored and costed. A special action from the Board will allow stabilizing the working capital by selling soon to be expired drugs at costed price to other actors (no margin but no loss).

Here is the current organisation chart of the HGH

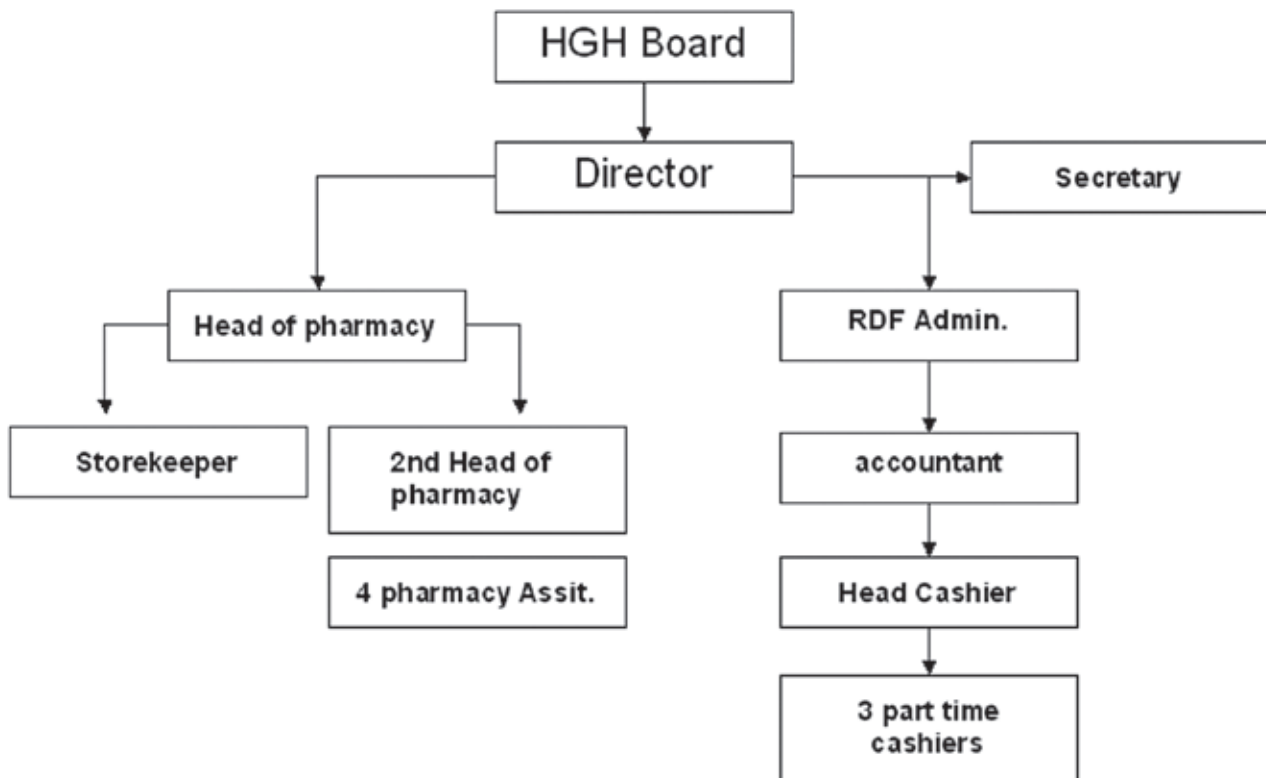


The lack of an RDF administrator in charge of the whole RDF monitoring and administration is a major reason for the weakness of the initiative. The proposition for a TA programme to support the organisation of the hospital would be in-part to establish such a function (along with procedures and tools). The TA should act to ensure RDF administration in the first stage and work towards recruitment and training of a competent administrator. The main functions of the RDF administrator should be to:

- secure the RDF
- report precisely accordingly to the Memorandum of Understanding (MoU)
- forecast and manage drug orders
- extend the initiative to other hospitals (although this step is part of the ToR of the TA (this expansion will depend on external commitment)

The RDF administrator should second the hospital Director in any businesses related to RDF (under the control and evaluation of the HGH Director).

Here is the intended organisation chart for a future RDF



4.4 Procurement policy

The evaluation of the RDF by Dr Gamal recommended issuance of tenders for bid as a means to increase competition and access to cheaper prices. This consultant reviewed the possibility of other suppliers based in Nairobi. However, the consultant recommends that the current procurement policy should not be changed. The RDF should continue to source all orders with IDA. The IDA is the sole supplier, which does not allow for competitive bidding; however, this consultant recommends continuing current practice (at least for now) for several reasons:

- Considering the volume of drugs that is purchased a year (about 45 000 EXW⁴) it could be quite dangerous to split indents across several suppliers, mainly for logistical reasons. A supplier always has a minimum economic level to accept orders, i.e. they will not accept an order below a certain amount and prices are calculated for orders only if indent is above this minimum economic amount. *The turnover of the RDF is insufficient to achieve real reductions in price through competitive bidding, as volumes are small.*
- If indents are smaller than today, they may be sent by bulk or collective shipment. As a result, losses will occur during transport and transfer. More complex and divided supply lines will slow down flows and generate many problems for both suppliers and client.
- The implementation of bids is an onerous technical task. Following international procurement rules is time- and resource intensive. The current RDF staff do not have the capacity to run such procedures.
- IDA has an online catalogue which is the same for everybody. IDA won't make further profits on

the RDF because the procurement policy does not include bids (i.e. IDA will not undercut their prices in a bidding procedure – one is already at minimum IDA prices).

On the other hand, what might be possible are enhanced relationships with the IDA, as the RDF pays IDA 100% in advance with a six-months lead time. The RDF could expect the following from the IDA:

- The IDA can use RDF monies to generate interest during the six months.
- RDF should request a discount from IDA, assuming that RDF money can be used to generate profits. If this is unacceptable by IDA then RDF should reduce the advance amount by 50% and release the final 50% upon receipt of the order (CIF Berbera).
- Another advantage in reducing the amount of advance to 50% is that working capital could finance twice as large a volume of drugs in stock, which would increase net margins if the volume of revolving the stock can be enhanced (and may lead to the possibilities of *greater public subsidies or lower costs of drugs to the end user*).

4.5 Financial management

A set of procedures and tools have been designed with the director and accountant. They give a basic view of the main elements constituting the financial monitoring system.

The HGH Board must be demanding in obtaining access to this information, as it will allow the board to see where finances go and how well managed they are. This will allow the board to take action to correct poor performance or exogenous shocks. Donors and financial partners will also be demanding financial management and transparency.

5 EXW : Ex Works : purchase price of goods sold at supplier's warehouse.

The current set of procedures and tools consists of:

- Monthly and quarterly stocktaking costed at cost price
Stocktaking used to be costed at selling price. This is not the way to do it. Every movement or stock-taking must be costed at weighted costed price (and if impossible, at least at costed price).
- Daily follow-up of the Weighted Costed Price
Tools and procedures are now well understood by the accountant but capacity still has to be measured.
- Monthly Sales costing at W. costed price
- Monthly losses costing at W. costed price
- Quarterly control of the DRF working capital
An important indicator that should be measured every quarter.
- Quarterly control of the Net Margin
The only way to monitor the real margin
- Projected and current trading account (with budget)
- Pricing policy & private market survey

4.6 Urgent actions to be taken

4.6.1 The HGH Board

- An agreement (see MoU in Annex 4) should be signed with the MoHL as soon as possible (at least for 2009). The MoU makes provision for:
- Providing public funds for reimbursement of exemption losses on quarterly basis reports
- Providing public funds based on projected trading account for reimbursement of hospital expenditures that are not covered by the forecasted income

Provided that the above is done:

- The board should reimburse debtors (about USD 10 000 owed to staff) either from the MoHL (preferably) or RDF working capital (the current working capital of USD 167 000 already considers this debt as paid), although the RDF is not responsible for the debt.
- The RDF warehouse needs substantial rehabilitation.

If the RDF wants to develop its activities, the warehouse will be the main asset allowing development. Today the warehouse is congested with unnecessary materials and low value or useless items. This confuses and complicates the absolute imperative to improve management of the valuable stock.

- The RDF staff need training and education
- There is an imperative to improve management of the RDF (and hospital). This consultancy has developed a reasonably coherent and simple set of tools. Nevertheless, starting to use these tools will require tremendous effort from management and the HGH Board. There may be insufficient capacity for implementation, but HGH management should however begin trying to implement the management system. If after three months the management system is not functional:
 - a) Technical support could be provided.
 - b) A two year project could be drafted for TA support in drug management.
 - c) If technical support appears essential, the Board should prepare a project for technical assistance to upgrade the hospital staff to manage the RDF.
 - d) Do whatever is expedient to slow down losses of expired drugs.
 - e) A quarterly note from the Board should be sent to all NGO's, health structures and international Institutions, to sell at weighted cost price all

excess drugs currently in stock that will soon expire (within three months).

4.6.2 The hospital management

- A clear budget (projected trading account) needs to be established for 2009, showing income and expenditure.
- The budget will depend on the pricing policy for the RDF (% mark-up).
- This budget is the agreed base (MoU) for partnership with the MoHL and for agreement on MoHL reimbursing certain over-expenditures.
- Implementation from immediate effect (November 2008) of procedures, tools and reports agreed by management and consultant.

4.6.3 The MoHL

Work with the HGH Board on a MoU to save the RDF, with long-term actions mainly oriented towards financing losses (exemptions and reasonable waste) and operating costs not covered by hospital income.

The MoHL should understand that the HGH belongs to the Ministry, even though the Board is in charge of management. Valuable tools in place should be largely financed (or subsidised) through public funding. A comprehensive collaboration between the MoHL and HGH Board should lead towards developing the HGH into a performing and long-lasting service provider with support from government, and commitment to serve the public good and provide welfare services.

5

The future of the RDF

5.1 Business capacity

Political commitment, public financial investment and management improvements are essential to both hospital development and RDF survival.

In order to attain healthy hospital development, the following conditions must be reached:

- Hospital expenditures are 100% financed by the RDF margin and MoHL subsidies.
- Exemption mechanism is 100% financed by MoHL.
- Improved drug stock management -> no expired drugs (or financial provision for stock depreciation in the annual hospital budget).

- Working capital stable.
- One order a year with a six-month lead time.

This model⁵ aims to show the maximum capacity of business development of the current RDF with a working capital of about USD 170 000, and considering the following:

- 100% advance payment for indent
- One indent a year covering 12 months order
- Six months lead time
- 20% additional costs
- 40% mark up on costed price
- Two-month security stock

		Lead time : 6 months			
		1 month Turnover :		11 500 Turn over	
		Value			
Mark up	40%	28.57%	3 286	8 214	Purchase Price Warehouse
Add. Costs	20%	16.67%	1 369	6 845	Purchase Price EXW
1 order covers (months) :		12	98 571		
Nb of months in bank :		12	98 571		
Nb of months in stock :					
lead time :		6	49 286		
Reserve :		2	16 429		
Need in Working Capital :			164 286		

In the current state of affairs, if the above conditions are respected the capacity of the RDF in is a monthly turnover of **US\$ 11 500**.

The RDF turnover currently about USD 6 500. In the event of stability and adequate finances, the RDF could almost double its current turnover with the same working capital (and could quadruple it with only 50% advance payment of orders).

The RDF is capitalised to allow it to turn over a far greater volume of drugs and serve more people and generate more income.

5.2 Business opportunities

In order to develop the RDF, the Board should find clients interested in purchasing drugs and medical supplies from HGH RDF. Contracts can be developed with potential clients until the upper limits of the monthly business capacity (USD 11 500) are reached. In order to protect the RDF from financial shortcomings (expired drugs, weakness of reimbursement system, etc.) this approach should be carefully monitored and contracts signed with reliable partners. The quarterly indicator given by the level of working capital is the actual limit of business capacity.

Should the Board find more business opportunities and wish to expand into these, this would require a bigger working capital. Recapitalisation would become necessary in order to procure sufficient stock to serve the aggregate demands. The THET project ongoing until mid-2009 could release available funds to strengthen working capital capacity. This should only be done if the board manages to demonstrate they have sufficient reliable contracts to exceed current limits.

5.3 Who could be identified as new customers?

Given that there is capacity to double or even quadruple RDF turnover (thereby reducing waste and enhancing profit margins) it is important to establish if there are public market opportunities that could be usefully expanded, thereby further enhancing the public utility of this project.

(a) From data provided by COOPI, Borama, Burao and Berbera hospitals have virtually no working capital for drugs and medical supplies (they have no RDF). Therefore, today they do not present a market opportunity. If these structures were to be provided with a reasonable working capital (dependent on turnover) they could potentially be useful clients of the HGH RDF. This would require a donor willing to pre-finance the establishment of mini-RDFs, as well as support the establishment of the HGH RDF management system currently in place.

The regional hospitals would need to:

- have significant turnover to create real demand;
- have significant management capacity to reliably forecast needs and provide reliable orders to the HGH RDF; and
- be reliable business partners, affording to pay for pre-orders, placed in reasonable time.

Otherwise, despite expanding the client base and population served by the RDF, poor business partners could undermine the long-term viability of the HGH RDF. The HGH RDF would carry financial risk by ordering and paying for drugs for the regional hospitals; if they cannot forecast accurately and pay for their orders, ordering on their behalf could collapse the RDF. Perhaps the MoHL would need to step in and cover liabilities in case of another public hospital defaulting.

(b) NGOs are potential customers (up to a reasonable RDF turnover capacity). However the RDF needs to forecast, so orders need to be predictable and regular. A contractual approach would be necessary with these institutions.

(c) UNICEF distributes kits to MCHs and HPs. This could be taken as a business development opportunity. But a serious threat has to be considered in this case:

- The order volume outstrips current working capital, so the RDF would need higher levels of capitalisation. If the RDF received a larger working capital⁶ in order to purchase stock needed for MCHs and HPs, UNICEF could then purchase from the RDF and pay an additional cost to RDF for services rendered. *However, this would require significant development of RDF capital and capacity; if UNICEF were to stop sourcing drugs to the public system or purchase drugs elsewhere, the RDF would collapse.*

- Alternatively, the MCHs and HPs could establish cost-recovery and buy drugs from the RDF (they are now free). Each facility would need capacity to forecast and pay for orders (each MCH and HP would need to have the capacity for consumption analysis, stock management, and indent management capacity. This is not the case today). *The RDF would aggregate all the risk for all the facilities. If facilities began to default, the RDF would collapse.*

(d) Other not-for-profit health structures (Edna Adan Maternity Hospital, etc) are potential sources. However, many private facilities only use branded drugs as a mark of quality (and as demanded by their patients) and may not be interested in generics. Furthermore, these institutions would also need to be reliable partners.

If an aggressive recruitment policy was implemented and new partners with management and financial capacity located and business exceeded USD 11 500 per month) an increase in capital is possible before mid-2009 with THET project funds.

⁶ UNICEF will need to inject one-year stock capacity in RDF working capital to create a revolving fund. This constitutes one year kit distribution cost as an investment in the RDF. UNICEF will then need to purchase yearly needs for MCHs and HPs.

6

A Central Medical Store?

For major external investment in the RDF, donors need to be convinced of the public benefit of the project. As the RDF is limited to HGH there might be a need to extend the concept in order to increase impact and coverage of public benefits.

This could be done through extending working capital and management capacity to all other public hospitals in Somaliland (as reviewed in Ch 6), increasing business for the RDF and increasing income to all public institutions as well as subsidising the public.

The RDF could also be converted into a national public private drug corporation, as foreseen in the proposals for establishment of a Somaliland Pharmaceutical Corporation (SPC).

A public-private Central Medical Store or SPC should only be seen as a realistic project under specific conditions described below. Sustainability of the SPC or CMS is the first objective. If this is not feasible, there is no point investing in start-up (a non-viable business model would collapse even if well run, once external financing was withdrawn and all institution-building costs would be lost). A business plan would need to be developed to establish a reasonable chance of financial autonomy (financial sustainability). This would require a detailed analysis of the potential market:

- **Customers**

The SPC would need a large number of serious and reliable partners with the capacity to manage and pre-order stocks and to pay for them on time. Today the only serious partners could be NGOs, of which there are few and none with multi-year partnership capacity.

- **Regulation**

A national pharmaceutical regulatory authority must be in place with coercive power to promote and favour quality drugs and slow down the deregulated private market, in order to protect the public and enhance differences between public and private drug supply. If regulation is not in place, quality public drugs will not be able to compete in price against low quality private imports and advantages to the public will be lost. Public advantage can only be realised on a level playing field where all drugs are quality controlled.

- **Scale of the public “market”**

The MoHL and government efforts should lead to a situation where all public and NFP institutions would be invited to purchase drugs and medical supplies from the SPC. A market survey should be undertaken so that the Somaliland public and NFP capacity becomes better-known, and working capital and turnover projections could be made to

estimate the scale of the required SPC. Typically, such an institution is only viable with a demand exceeding USD 8 million per year. This is not the case in Somaliland.

- **Financial need**

A public-private entity costs more than a public structure, as private competitive salaries have to be paid to attract quality staff. The sustainability objective is expensive. This means that the SPC turnover should be high enough in order to finance the whole business. The following projected trading account (see Annex 5) shows that:

- Without amortization, annual cost will be USD 168 000 (including compulsory endowment for stock depreciation and financial risks -devaluation).
- Mark-up should not be more than 20%. The CMS would constitute a new cost for hospitals and other client health structures (the CMS would need to take off a margin as well as the hospital RDF). In order to preserve patient accessibility, the CMS mark up has to be as low as possible.
- The required monthly stock to cover enough sales to reach sustainability should be 15 times the current monthly needs of the RDF. This means an activity multiplied by 15 (i.e. four times the current UNICEF expenditure on drugs for MCHs and HPs).

- This requires a comprehensive set of investments in tools for CMS management (administration, storage, drug management, distribution, etc).
- This will also require significant education and training of a new team in charge of international procurement, management, storage, distribution and marketing, and would be an expensive TA project.

To conclude

The development of a CMS/SPC would be a major cost involving facilities, wages, training, and TA. The conditions do not exist for CMS/SPC long-term viability (regulatory capacity over private sector, as well as demand and public decentralised capacity for drug management). All institutional development costs would be lost after funding ceased (the project would collapse, as it has done previously).

The CMS/SPC is definitely not a viable project at this stage. The two main factors are (i) the political environment is unstable, with low levels of commitment to health system development (the extended support to the current RDF and the political will to support it will be serious tests for both the HGH Board and MoHL); and (ii) the business environment (customer capacity) needs to be improved first so that they can respond to the "SPC appeal".

It is a better option to invest in the RDF and hospital management, resulting in increased MoHL engagement and extension of the programme across the public hospitals of Somaliland.

7

Recommendations

7.1 Current RDF

Local partners:

There is a need to increase managerial control over the RDF, to limit waste and build confidence and partnerships in support of the RDF.

- A Memorandum of Understanding (MoU) with the MoHL has to be signed as soon as possible in order to find a reliable and sustainable way of financing losses of the RDF. It will help hospital day to day operations and protect the RDF from collapse. Otherwise, the hospital must limit losses and stop exemptions.
- The management team needs to commit itself to providing better drug and financial management, using procedures and tools designed during the assignment. A viable MoU is dependent on improved management and Board performance.
- The Board could request technical assistance support with the objective of strengthening the RDF and introducing regional hospitals as potential RDF clients.

Donors:

- THET project could release the remaining monies to strengthen the RDF working capital on condition that:
 - An MoU is signed and properly implemented.

- Both hospital management and the Board show improvements in managerial capacity.
- Evaluation of MoU and managerial capacity improvements are made after six months (or before June 2009).
- Contracts are designed with potential RDF clients.
- As necessary, a TA project is designed before June 2009.
- The COOPI support project to Burao, Borama and Berbera hospitals could equip these three health structures with administrative equipment, and adapt warehouse facilities in order to prepare them to receive a similar system (working capital and management system). These structures could then receive support from the HGH technical assistance project to allow them to become potential clients for the HGH RDF. The same MoU between hospital boards and the MoHL should be signed in order to preserve the working capital. The MoHL may need to underwrite risks to the RDF.
- Donor support to the MoHL may be required to allow them to engage in such MoUs and underwrite costs.

7.2 Current RDF

Local partners:

- Parliament should ratify the relevant documentation related to the national pharmaceutical policy:
 - Somaliland Pharmacy Corporation
 - Pharmacy Regulatory Authority
 - Rules for the Registration of Drugs
 - Guidelines for the donations of drugs
 - Investment plan for implementation
- The MoHL should experiment managing their participation and financial risks through increased involvement in the RDF (through the proposed MoU). This may then be reproduced on a larger scale regarding the future SPC.
- The MoHL could organise a comprehensive plan for MCH and HP training, so that these entities can be meaningfully accepted as future clients of SPC.

Donors:

- Unless preparatory works (i.e. the above tasks) are undertaken for local partners, the SPC initiative will not be viable; this depends on an analysis of potential clients and their potential demands and capacities. The RDF initiative is an excellent case of establishing local capacity in terms of management and finances.

RDF solidification (in line with an increased role for the MoHL in management and under-writing risks), and possible expansion and maximisation of the business potential are important first steps in development of a public procurement capacity that can serve the nation over time, at reasonable cost.

7.3 Summary recommendations

- Provide technical support to HGH to enhance management in general, and the RDF in particular.
- Act rapidly to control risks – sell off drugs with imminent expiry dates, create a drug list and improve pricing policy. If no-one will underwrite costs of exemptions, cease all exemptions.
- Provide support to MoHL to enhance their involvement in management and allow them to underwrite risks and financial commitments of public hospitals.
- Extend the programme to other major regional hospitals, requiring working capital, facility renovation and TA.

In relation to this, it is important to begin transforming hospitals' business models to include investment in management and reform staffing practices. To this end, it is also important to increase turnover of the hospitals.

A related set of hospital interventions might look at:

- enhancing business and turnover of the "public" hospitals by buying services from hospitals for those unable to afford them;
- voucher schemes for obstetric complications, etc.; and
- increased occupancy and equity, which will also lead to greater income for hospitals and increase their ability to secure proper staffing functions and services.

Terms of reference

International Consultant

To review the Revolving Drug Fund of Hargeisa Group Hospital in Somaliland and devise a practical and costed plan of action to:

- assist the RDF to develop institutionally and
- expand operations to enhance the public good and
- ensure longer term viability and sustainability of the fund (at least to guarantee supply of quality medical materials to HGH).

1. Background and Context

An RDF has been running at Hargeisa Group Hospital (HGH) for over three years. It has proven popular among the local population (an estimated 2,000 people use the pharmacy every month) and is one of the few supplies of good quality, reliable drugs in the country. The RDF was set up with financial assistance from Comic Relief and placed its first drug order in May 2005. Comic Relief has funded the refurbishment of the main pharmacy dispensary and pharmacy stores, purchase of pharmacy computer equipment, training of pharmacy staff and seed funds to start the RDF (diminishing over the 5 year project period) along with professional, technical and financial assistance visits from pharmacists based in the UK via the KTSP (Kings College Hospital/Tropical Health Education Trust/Somaliland Partnership) Pharmacy Group, and support visits to the Regional Health Board (RHB) who manage HGH.

In 2006, the KTSP Pharmacy Group carried out an audit on the RDF which indicated much had been achieved but many steps needed to be taken in order to ensure its survival. A subsequent formal evaluation in 2007, as part of a mid term project review, established that the project had been a success in its own right (Gamal 2007). Nevertheless, the intermediate and long term future of the RDF is uncertain for a number of reasons. A series of recommendations were defined for action to improve the functioning of the RDF and ensure its long term viability.

The recommendations of the evaluation included (Gamal 2007):

- The RDF should continue to provide its services for the users of Hargeisa Group Hospital and to enjoy political support and maintain its independent status.
- The list of essential medicines needs to be rationalized and reduced to focus on core low cost medicines.
- Procurement procedures need to be reviewed to ensure lower cost supply of medicines and materials.
- Financial accounting (annual profit – loss statements) and management procedures need to be established, formalized and rigorously implemented.
- There is an urgent need for recruitment of some professional staff and upgrading of current staff.

- Drug costing policies need to be defined to maximize public benefit.
- Improved drug management and pharmacy supervision (including computerization of stock management).
- There should be explicit separation of the RDF from exemption mechanisms and management of access to care and drugs by those unable to pay.
- Potential expansion of the client base to include other facilities in the public sector and extending the benefits of public subsidy of quality medicines to other citizens of Somaliland should be explored.

- savings on prices and transport costs
- develop transportation procedures and policies
- develop staffing patterns and training recommendations
- develop criteria for eligibility for different public facilities to purchase (as well as rules and regulations to share costs in assisting new client base).
- develop stock storage and management procedures
- develop /improve basic financial management tools and procedures (e.g. profit/loss).

2. Purpose

To support the RHB and directorship of the Hargeisa Group Hospital to follow up on recommendations made in the 2007 evaluation of the RDF (Gamal).

Namely;

- 1) to develop existing internal rules and regulations to professionalize the management and standard operating procedures of the RDF
- 2) to explore the institutional arrangements – executive, governance and regulatory - to develop/establish such a public/private partnership for the public good.
- 3) to develop a practical costed business plan for the development of the RDF.

- 2) Explore the institutional arrangements – executive, governance and regulatory - to develop/establish such a public/private partnership for the public good.
 - suggest board composition and structures to govern and regulate the RDF for the public good.
 - suggest legislative framework to protect and regulate the RDF from interference and to enhance the contribution of the RDF to public good.
 - define the executive structure to ensure professional management of the RDF (bearing in mind costs of management and the threat to the RDF of high institutional costs).
- 3) Develop a practical business plan for the development of the RDF.
 - Practical and costed recommendations for the enhancement of the RDF – with a view to setting up a self sustaining institution over a 5 year term.

3. Specific Objectives

- 1) Develop existing internal rules and regulations to professionalize the management and standard operating procedures of the RDF
 - suggest drug rationalization procedures
 - develop drug pricing policies to protect the public good
 - develop drug ordering procedures to enhance

4. Key means of working to achieve these objectives

- Review short list of international literature for state of the art recommendations on different intervention.
- Review key documents relating to the RDF (proposal, 2006 review, 2007 evaluation etc.).
- Work with relevant partners (THET, HGH, RHB, MoHL etc.) in Hargeisa to develop proposals.
- Consult with international NGOs and regional hospital management to review potential for expanding utilization of the RDF.

5. Activities and Tasks

- Desk study - Review of international and regional literature and key documents
- Nairobi level work – interview main actors involved in current public drug supply to Somali health institutions.
- Field work in Somaliland – principally involving research into the current RDF and HGH management structures – but also including visiting 3 regional hospitals and MCHs, work with the MoHL, private sector and local agencies (UN, NGO).
- Assess/audit potential to include other public hospitals – and facilities.
- Assess requirements for premises
- Assess requirements for governance, management and accountability structures.
- Assess means to ensure and enhance public subsidies in the drug supply system.
- Draft a report and business plan for the future development of the RDF.

6. Management and Organization

6.1 Management

The consultant will report to the HSD coordinator of the EC Lot 3 project, H/N UNICEF USSC Nairobi. The consultant will work in close collaboration with:

- The manager of the THET RDF programme
- The medical director of Hargeisa Group Hospital.
- The Hargeisa Regional Health Board
- The Director of Planning MoHL
- The head of H/N UNICEF Hargeisa.

6.2 Organization

The consultant will be based in Nairobi for a short period with more considerable time spent in travel to Somaliland. The consultant will have desk space in UNICEF Hargeisa and UNICEF USSC Nairobi.

6.3 Timeframe

The overall time frame for the consultancy will be 5 weeks and will start as soon as possible.

7. Deliverables at End of Assignment

Deliverables

- Report on SOP and structure (executive, governance, regulatory)
- Practical costed business plan with step wise approach to enhancing the RDF (sustainability and role/relevance) over 5 year term.

8. Qualifications and Experience

Requirements for application:

- Higher degree (masters or PhD) in relevant field.
- Fluent written and spoken English
- At least 8 years professional work experience.
- At least 3 years international experience in drug procurement and supply management.

Additional factors to be considered strongly in the application:

- MPH
- Good working knowledge of international literature drug management.
- Flexible and patient – yet driving for results.
- Good analytic, communication and negotiation skills.
- Computer skills (word, excel etc.)

9. Remuneration

The consultancy will be set according to UNICEF standards applicable for international consultants.

The level is L3 level qualification. The contract will be processed in accordance with UNICEF standard procedures for special service agreements.

DSA and travel costs will be paid while in Somaliland. The full sum will be reimbursed at the end of the assignment upon satisfactory completion of deliverables.

10. Conditions of work

The consultant will be required to have their own laptop computer while on assignment. The consultant will be provided with desk space in the UNICEF offices when in Nairobi. And in UNICEF zonal offices in Somaliland.



Set of procedures and tools

The set of procedures consists of 16 procedures and 15 tools.
The 16 procedures are 68 pages long in total.
The 15 tools are in Excel format and are large, if stored in a report.

Anyone may access the set, obtainable from the consultant at:

bdlchenin1@orange.fr

RDF Procedures and Tools.zip

2 200 Kb

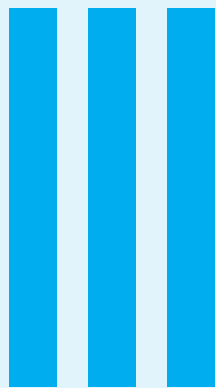
The set of procedures, the chart of procedure and tools and tools have been remitted to the HGH management team on CDs, and to Austen Davis at UNICEF (audavis@unicef.org).

The chart of procedures and tools follows, on pg36.

DRF PROCEDURES MAP TO BE IMPLEMENTED BY PHARMACY, FINANCE and DIRECTION DEPARTMENTS

October 2008

Frequency	Procedure Name	Description	Responsible Department
Daily	DRF PROCEDURE PH02.doc	Out stock Movements Recording	DRF PROCEDURE FH03.doc Weighted Costed Price Follow up DRF Weighted Costed Price Calculation.
	Record stock card (in / out)	DRF PROCEDURE PH05.doc Record of all losses Exp. Monthly Report	
	Monthly Report		
	000000_DRF Daily Stock Update.xls	PH05 Monthly Yearly Report losses.xls PH05 Losses recording Form.xls	
Monthly	DRF PROCEDURE PH01.doc	General standards Clean and tidy pharmacy	DRF PROCEDURE FH04.doc Record of all losses Exp. Monthly Report DRF PROCEDURE FH04.doc costing the losses Monthly Report DRF Average Costed Price Calculation.xls FH04 Monthly Yearly Report losses.xls
	DRF PROCEDURE PH04.doc	Record stock Card Warehouse	
	DRF PROCEDURE PH03.doc	Monthly consumption Cross-check PH02 results 000000_DRF Monthly Consumption Update.xls	
	DRF PROCEDURE IV02.doc	Monthly stocktaking DRF PROC IV01 IV02 Forms.xls	
Quarterly	DRF PROCEDURE IV01.doc	Quarterly stocktaking	Dr. Yassin (director) Abdoul Khader (Accountant) Dekha
	DRF PROC IV01 IV02 Forms.xls	DRF PROC IV01 IV02 Forms.xls	
	DRF PROCEDURE IV03.doc	Stocktaking update for further costing Quantities only 000000_DRF Stocktaking Costing.xls	
	DRF PROCEDURE FMS.doc	Pricing policy DRF Global Margin and Market Prices.xls	
Quarterly	DRF PROCEDURE F01.doc	Stocktaking Costing	DRF PROCEDURE F05.doc Budget Profit and loss calculation DRF Projected trading - working account.xls
	AAAA99_DRF Stocktaking Costing.xls	Projected Trading Account	
	Quarterly Report	DRF PROCEDURE F07 Net margin of the quarter Quarterly Report	
	DRF PROCEDURE F02.doc	Working capital update 000000_DRF Financial Quarterly Report.xls	



Terms of Reference for RDF Technical Assistance

Terms of Reference for Technical Assistance to the Revolving Drug Fund at Hargeisa Group Hospital

1. Background

The Hargeisa Group Hospital Revolving Drug Fund (RDF) is a cost-recovery mechanism which takes advantage of people's ability and willingness to pay for drugs in the absence of free publicly fund system. It was established by the Regional Health Board and Hargeisa Group Hospital (HGH), with the support of the Tropical Health and Education Trust (THET) and Kings College Hospital (which provide technical guidance).. The programme was funded by Comic Relief. The RDF addressed the core issues of drug supply systems (i.e. regular supply of quality medicines at low cost). Prior to the establishment of the RDF, the quality and supply of drugs was inadequate for the users of the HGH, and the cost at private alternatives was perceived to be prohibitive for most people. Previous reports by THET found that the project is succeeded in the regular provision of quality medicines with relatively lower cost in comparison to the market and other pharmacies in town.

2. Strengthening recommendations

In October 2008 a consultant specialised in drug management undertook an assignment in HGH which was aiming to review the whole RDF. Some recommendations made with regards to the implementation of a new way of working (mainly oriented towards a business like approach) lead to a support of management team, hospital Board and business opportunities environment.

Accordingly to these recommendations and because management team weaknesses are taken into consideration, the Board would like to call for a technical assistance support in business management oriented in both pharmaceutical and finance management.

3. Rationale

The RDF is a valuable tool that deserves careful management. This initiative is an opportunity to develop capacity of the current management team while assisting the hospital to be reorganised in terms of income and expenditure. The relationships with MoHL should be developed as a needed long term financial partnership. In order to raise hospital income and to maximize the working capital capacity, other clients have to be found for RDF. A global support to regional hospitals must be implemented so that they can become serious partners for the RDF.

4. Tasks

The technical assistance will have to main domains to take care of for a period of 2 years:

4.1 *Internal*

- Providing education and training to the management team in establishing a comprehensive management system based on the information system currently in place,

- Reorganize the human resources chart so that every employees knows its tasks and objectives,
- Establish a proper pricing policy for the RDF so that prices can compete with private sector prices while the global margin is attained,
- Establish a proper hospital budget that reflects the real needs of hospital,
- Develop financial partnership with MoHL,
- Develop business to cover the needs of the 4 other major hospitals in terms of drugs and medical supplies

4.2 External

- Berbera, Burao and Boroma hospitals need :
 - Working capital to constitute RDF
 - Management system (the same as HGH)
- In the conditions that the above is provided (monies for hospitals working capital and equipments to host the management system) the technical assistance will :
 - Provide education and training to the hospitals management team in order to reproduce the HGH management system
 - Reorganize the human resources chart so that every employees knows its tasks and objectives,
 - Establish a proper pricing policy for the hospitals RDF so that prices can compete with

private sector prices while the global margin is attained,

- Establish proper hospitals budgets that reflects the real needs of hospitals,
- Develop financial partnership with MoHL,

5. Financial needs

The 3 hospitals need a working capital (for a start) of USD 100 000 each.

As a necessary prerequisite, COOPI (or / and other implementing and financial partners) have prepared these 3 hospitals in administrative and logistic means so that they can be able to become active business partners of HGH RDF. As results, coverage in drugs and medical supplies extends to regional sites.

6. Technical assistance qualifications

A business development manager could handle this project. He or she doesn't need to be specialised in drug management.

A pharmacist could be called in spot support (1 month) to take care of the specific pharmaceutical issues (list of drugs for RDF, pharmacy and warehouse management, consumption adjustments, quality issue, procurement plan).

Draft Memorandum of Understanding

Memorandum of Understanding between the Government of Somaliland and the HGH BOARD

MEMORANDUM OF UNDERSTANDING

made and entered into by and between:

THE GOVERNMENT OF SOMALILAND

(hereinafter referred to as 'the Government' and represented herein by the Ministry of Health and Labour

and

THE HARGEISA GROUP HOSPITAL BOARD

(hereinafter referred to as 'The Hargeisa Group Hospital' and represented by its Board)

WHEREAS:

A. The Government intends to establish a financial partnership with the Hargeisa Group Hospital that procures, stores and sells to patient's drugs and medical supplies through its Drug Revolving Fund.

It is the intention that the principal services currently maintained by the Hargeisa Group Hospital Drug Revolving Fund be sustainable on a long term basis.

The main objectives of this partnership have been defined as follows:

- To create a new member of the Hargeisa Group Hospital Board directly named by the Ministry of Health and Labour whose main duty will be to

supervise and approve the monthly, quarterly and yearly financial and pharmaceutical reports presented by the Board.

- To finance on a monthly basis the Hargeisa Group Hospital declared losses due to the exemption policy only
- To finance on a quarterly basis all over expenditures identified on DRF annual budget that may not be financed by the quarterly net margin

The goal of the Hargeisa Group Hospital Board is to create an adequate, reliable and sustainable system for drug and other medical supplies procurement, supply and distribution through all hospital departments and patients.

- B.** It is agreed that Hargeisa Group Hospital Board must achieve certain performance objectives which are yet to be defined, and that the Drug Revolving Fund be managed as an independent business like entity.
- C.** The parties hereto wish to record Hargeisa Group Hospital Board undertaking and accountability to achieve the performance objectives, and the Government's policy of non-interference in the management of Hargeisa Group Hospital Drug Revolving Fund as an independent business like entity.

NOW THEREFORE IT IS AGREED AS FOLLOWS:

1. Government's Policy

The Government hereby records its intention that although it is not the major shareholder of the Board, it shall actively participate to the Drug Revolving Fund financing in order to preserve the public good; Nothing contained in this agreement shall in any manner whatsoever affect Government's rights as a member and shareholder of Hargeisa Group Hospital Board to exercise its rights in such capacity as contained in the Constitution of the Board, the common law or any other law;

OBLIGATIONS AND RIGHTS OF THE GOVERNMENT IN RELATION TO THE BOARD

The Ministry of Health and Labour shall assume the obligation to ensure the payment within 30 days of acceptable financial and pharmaceutical monthly reports presented by the Hargeisa Group Hospital Board to the Ministry or its institutions to reimburse the losses due to the exemption policy. The Ministry of Health and Labour shall be entitled to suspend payments on unsatisfactory reports from the Hargeisa Group Hospital Board.

The Ministry of Health and Labour will attend on a regular basis the monthly meeting of The Hargeisa Group Hospital Board the first Sunday of each month.

OBLIGATIONS AND RIGHTS OF THE HARGEISA GROUP HOSPITAL BOARD IN RELATION TO THE GOVERNMENT

2. Financial and pharmaceutical report

The Hargeisa Group Hospital Board will develop a set of procedures including;

- Financial procedures and tools allowing the Ministry of Health and Labour to appreciate :
 - the quarterly level of the Drug Revolving Fund working capital
 - the global drug and medical supplies pricing policy set up by the Hargeisa Group Hospital Board
 - the quarterly net margin generated by the Drug Revolving Fund
 - the precise amount of losses due to the sale of drugs and medical supplies free of charge in the framework of the exemption policy
- Pharmaceutical procedures and tools allowing the Ministry of Health and Labour to appreciate:
 - the monthly level of pharmacy (dispensary) attendance presented in two groups of patients :
 - exempted population
 - non exempted population
 - quarterly stocktaking of the Drug Revolving Fund
 - expired drug policy report
 - monthly consumption report for both groups of patients (exempted and non exempted)

Hargeisa Group Hospital Board undertakes to implement its set of procedures in terms of its stated objectives and to employ such resources and operational structures as are required to meet the performance levels as indicated in this memorandum;

The Hargeisa Group Hospital Board shall perform acceptable techniques of corporate governance to main-

tain its vital and strategic position as a competitive and viable business like entity;

Government and The Hargeisa Group Hospital Board acknowledge that the Drug Revolving Fund must be protected from decapitalisation and that its performance as such will be evaluated in terms of the principles of the Somaliland National Drug Policy; The Hargeisa Group Hospital Board shall ensure that drugs and medical supplies are available at prices which are fair and commensurate with the financial resources of the public health sector; The Hargeisa Group Hospital Board shall ensure that drugs and medical supplies are made available according to a pre-agreed monthly schedule to the Hospital patients;

3. Accountability

Hargeisa Group Hospital Board shall account for its compliance with the performance objectives to the Government at the meeting of the Hargeisa Group Hospital Board where the annual report is presented; The annual report of the Drug Revolving Fund shall be approved and certified by the Hargeisa Group Hospital Board;

4. Performance Indicators

It is agreed that the following initial performance indicators shall be used in the determination of whether Hargeisa Group Hospital Board has substantially achieved its performance targets:

- Compliance with the set of procedures;
- Monthly balance sheet on drug and medical supplies losses and reimbursements;
- Monthly amount of expired drugs and trend
- Monthly turn over for health services
- Monthly turn over for pharmacy services
- Monthly pharmacy attendance and trend
- Quarterly variation of Drug Revolving Fund working capital and trend;
- Quarterly net margin

5. Implementation

The Hargeisa Group Hospital Board hereby undertakes the obligations stated in this agreement and accepts responsibility to achieve the performance objectives; The Hargeisa Group Hospital Board shall adopt this agreement, the set of procedures and the performance objectives as part of approved policy of Hargeisa Group Hospital Board.

THUS DONE AND SIGNED AT HARGEISA ON THIS DAY, 20.....

For and on behalf of the Government of Somaliland

For and on behalf of Hargeisa Group Hospital
Board

Signed:
Name:
Title:
Date:

Signed:
Name:
Title:
Date:

AS WITNESSES

1. Signed:
Name:
Title:
Date:

1. Signed:
Name:
Title:
Date:

2. Signed:
Name:
Title:
Date:

2. Signed:
Name:
Title:
Date:

CMS or SPC projected trading account

PROJECTED TRADING - WORKING ACCOUNT FOR SOMALILAND CMS					
CMS	SOMALILAND	<i>Expected Average M. Turn Over Serv.</i>			0
Currency :	USD	<i>Expected Average Monthly Turn Over</i>			84 196
Ex Rate :	6200				2009
Red fields are modifiable, others are protected					YEAR 1
		From EXW to CIF :	19%	Value EXW :	700 732
1	DRUG PURCHASE VALUE				833 871
	Drug purchase value CIF Berbera	10	9	90.00%	783 871
	Drug purchase value CIP Hargeisa	10	1	10.00%	50 000
1.1	Custom duties and taxes on CIF Berbera				0
	1.11 Customs duties and taxes		% purchase	Rate	0
	<i>Drugs</i>		80%	0.0%	0
	<i>Medical supplies</i>		20%	0.0%	0
1.2	Additional costs up to warehouse CMS				8 089
	1.21 Transport on CIF Berbera			0.5%	3 919
	1.22 Transport on CIP Hargeisa			0.0%	0
	1.23 Other costs			0.5%	4 169
2	COSTED PRICE CMS				841 960
	Mark up on costed price (in %)				20.0%
3	EXPECTED YEARLY TURN OVER CMS				1 010 352
= >> EXPECTED MARGIN = (3) - (2) + (3.1) =					168 392
4	OTHER VARIABLE COSTS				12 629
4.1	Miscellaneous costs and consumables			Basis	4 210
	4.11 Financial costs		0.00%	Costed price	0
	4.12 Quality control cost		0.00%	Costed price	0
	4.13 Stock insurance		0%	Average stock (4 Mo)	0
	4.14 Consumables (packaging for sales, etc.)		0.50%	Costed price	4 210

4.2	Transport of sales to customers				8 420
4.21	Transport of sales from warehouse to clients		1.00%	Costed price	8 420
4.22	Transport insurance		0.00%	Costed price	0

5	FIXED RUNNING or OPERATING COSTS			Basis	78 646
5.0	Unexpected costs		1%	Total Fixed R.C.	779

5.1	Supply and services				2 168
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5.10	Water		12	81	968
5.11	Rent		12		0
5.12	Bank charges		12	100	1 200
5.13			12		0
5.14			12		0
5.15			12		0
5.16			12		0

5.2	Other costs and miscellaneous				72 000
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5 200	Office stationery & computer maintenance		12	500	6 000
5 201	Generator fuel & maintenance		12	4 000	48 000
5 202	Telephone communication - DHL - emails		12	500	6 000
5 203	Fuel & maintenance for 1 vehicle		12	400	4 800
5 204	Plant maintenance (warehouse, office, outside)		12	200	2 400
5 205	Quality assurance (lab controls, samples)		12	400	4 800
5 206			12		0
5 207			12		0
5 208			12		0
5 209			12		0
5 210			12		0
5 211			12		0
5 212			12		0
5 213			12		0
5 214			12		0
5 215			12		0
5 216			12		0

5.3	Fixed costs linked to administration and management				3 700
5.30	Board meetings & catering (DSA + travel)		12	100	1 200
5.31	Client's meetings		1	500	500
5.32	Financial audit		1	2 000	2 000
5.33					0
5.4	Others				0
5.40					0
5.41					0
5.42					0
5.43					0
5.44					0
= >>	Added Value (= EXPECTED MARGIN -4 -5)				77 116

6	SUBSIDY FOR RUNNING COSTS				0
6.1			12		0
7	HUMAN RESOURCES COSTS			Basis	51 000
7.1	Salaries			Salaries	51 000
7.2					0
7.3	Charges to be paid by employees			0.00%	0
7.2	Charges to be paid by DRF			0.00%	0
= >>	GROSS OPERATING SURPLUS (GOS = Added value + 6-7)				26 116

8	Depreciation	# Year	% Dep.	Appraisal	0
8.1	Plant	40	2.5%		0
8.2	Vehicles	5	20%		0
8.3	Equipment	8	12%		0
8.4	Computers	3	33%		0
9	Compulsory Endowment	# Month	%	Basis	25 259
9.1	For stock depreciation (average stock in month)	12	2.00%	Costed price	16 839
9.2	For financial risks (financial depreciation bad debts...)		1.00%	Costed price	8 420
= >>	NET OPERATING SURPLUS (NOP = GOS -8 -9)				857
10	Other Income	# Year	int. Rate	Amounts	0

	10.1	Exceptional income				0
	10.2	Interest on bank account	2		1000	0
11	Financial charges		# Year	int. Rate	Amounts	0
	11.1	Interest on loan	2			0
	11.2	Repayment on loan	6			0
= > > RÉSULTS BEFORE TAXES and EXCEPTIONAL CHARGES(= NOP + 10-11)						857
12	Endowment for exceptional charges linked to restructuring and social matters			Basis		0
	12.1	Social plan	0.0%	(10) Other income		0
	12.2	Outstanding discharge (arrears)	0.0%	(10) Other income		0
= > > RÉSULTS BEFORE TAXES						857
10	Corporate tax (company tax)					0
		Corporate tax			0.0%	0
= > > NET RESULT for the FINANCIAL YEAR						857
= > > Cash Flow (= Net Result + 8 + 9)						26 116

VI

Persons met

Persons met:

Austen Davis	Health Project Manager	UNICEF
Anna Maria Silingardi	Health Project Manager	COOPI
Dr. Annie Sparrow	Technical Advisor H&N	CRS
Edda Costarelli	Health Section	E.C. Delegation Nairobi
Gaël Mary	Coordinator	CHMP Kenya
Moses Njoroge	Director	Afriq Freight Services
Dr. Koleade	Essential Drug Coordinator	WHO Hargeisa
Dr. Yassin Arab Abdi	Director	HGH
Mohamed Hussein Abby	Chairman	HGH Board
Dr. Aden Yussuf Abkes	Vice Chairman	HGH Board
Sakin Jideh Hussein	Member	HGH Board
	Director of planning	MoHL Hargeisa
Dr. Hamed Hassan Gole	Director of Health Services	MoHL Hargeisa
Faduma	Head of Pharmacy	HGH
Mohamed Abdumäi	Vice Manager	MoHL CMS
Edna Adan Ismail	Director	Edna Adan MTH
Dr. Farhan	Director	Liban & Iman Medical Wholesaler

Persons contacted:

Karen Peachey	International Director	THET
Catherine Novi	Programme coordinator	THET

