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CONTRACEPTIVE SECURITY IN THE CENTRAL ASIAN REPUBLICS: KAZAKHSTAN, KYRGYZSTAN, AND TAJIKISTAN

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PSP-One

PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

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DELIVER

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Implemented by John Snow, Inc. (JSI), (contract no. HRN-C-00-00-00010-00) and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], and Social Sectors Development Strategies, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical management of USAID's central contraceptive management information system.

PSP-One

Private Sector Partnerships-One (PSP-One) is a worldwide project to increase private sector involvement in family planning, reproductive health, and other health products and services. Funded from 2004 to 2009 by the U.S. Agency for International Development (Contract No. GPO-I-00-04-00007-00), PSP-One is designed to encourage greater private sector delivery of high-quality and affordable health products and services in the developing world.

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Abstract

Lack of contraceptive commodities has plagued the CAR region for many years. USAID has determined contraceptive security is a barrier to achieving the Mission's health objectives, identifying a need for more information on this topic in Kazakhstan, Kyrgyzstan, and Tajikistan. The PSP-One and DELIVER Projects assessed the state of the family planning commodities as well as evaluated the private sector role in promoting contraceptive security. The report provides an overview of these two areas and offers specific recommendations for possible USAID interventions to improve the availability of affordable and quality family planning products in the three Central Asian countries.

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ACRONYMS

ADB	Additional Drug Benefit
ADP	Additional drug package
AKF	Aga Khan Foundation
BBP	Basic Benefits Package
CAR	Central Asian Republics
CHD	City Health Department
CME	Continuing medical education
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Security
CSL	Commodity Security and Logistics Division of USAID
CWP	Contraceptive Working Group
DHS	Demographic and Health Survey
EDL	Essential Drug List
EMA	European Marketing Authorization
FAP	Feldsher/midwife points
FDA	Federal Drug Administration
FEFO	First expiry first out
FGP	Family Group Practice
FGPA	Family Group Practice Association
FMC	Family Medicine Centers
FP	Family planning
GFATM	Global Fund for Aids, Tuberculosis, and Malaria
GMP	Good Manufacturing Practices
GOK	Government of Kyrgyzstan
GP	General Practitioners
GR	Gideon Richter
HIF	Health Insurance Fund
IEC	information, education, and communication
JSI	John Snow, Inc.
LAM	Lactational Amenorrhea Method
LIAT	Logistics Indicator Assessment Tool

LMIS	Logistics management information system
MCH	Maternal and child health
MDG	Millennium Development Goals
MHI	Mandatory Health Insurance
MHIF	Mandatory Health Insurance Fund
MMR	Maternal mortality rate
MOF	Ministry of Finance
MOH	Ministry of Health
NDC	National Drug Committee
NDF	National Drug Formulary
NDL	National Essential Drug List
OC	Oral contraceptive
ODBP	Outpatient Drug Benefits Plan
OHA	Oblast Health Administration
OOP	Out of pocket
PHC	Primary Health Care
POP	Progestin-only pill
PSF	Pharmaciens Sans Frontiers
PSP-<i>One</i>	Private Sector Partnerships- <i>One</i> Project
R&D	Research and Development
RDF	Revolving Drug Fund
RHC	Reproductive Health Center
RHCSSA	Reproductive Health Commodity Security Status Assessment
RHIC	Republican Health Information Center
ROK	Republic of Kyrgyzstan
RT	Republic of Tajikistan
SDM	Standard Days Method
SOW	Scope of Work
SPARHCS	Strategic Pathway for Reproductive Health Commodity Security
STG	Standard Treatment Guidelines
SWAp	Sector-wide approach
TB	Tuberculosis
TAR	Total Abortion Rate
UNFPA	United Nations Family Planning Agency

USAID	United States Agency for International Development
VAT	Value added tax
WCC	Women's Consultation Clinic
WHO	World Health Organization
WRA	Women of Reproductive Age

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INTRODUCTION

OBJECTIVES OF CONTRACEPTIVE SECURITY ASSESSMENT

The United States Agency for International Development/Central Asian Republics (USAID/CAR) is currently drafting its next mission strategy, and has identified contraceptive security (CS) as an impediment to achieving the mission's health objectives (Hare et al 2004). The mission has specifically identified a need for more information in the form of a CS assessment report for Kazakhstan, Kyrgyzstan, and Tajikistan. This assessment offers specific recommendations for possible MOH and USAID interventions to promote CS in Kazakhstan, Kyrgyzstan, and Tajikistan.

Contraceptive security is said to exist when every client is able to choose, obtain, and use the contraceptives of his or her choice.

A joint team from John Snow, Inc. (JSI) and Abt Associates, Inc. conducted the assessment under the DELIVER, PSP-*One*, and ZdravPlus projects, with funding from USAID's Commodity Security and Logistics (CSL) Division and from USAID/CAR. CSL funding enabled parallel assessment of the public and private sector supply chain by DELIVER and PSP-*One* staff, respectively. ZdravPlus provided policy and reform knowledge as well as overall administrative logistical and technical support to the assessment team.

ASSESSMENT APPROACH

The DELIVER/PSP-*One* team modified the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS) framework to carry out the CS assessment. USAID/Almaty charged the team to consider the following:

- Current and potential role of various private sector players in meeting CS objectives in Kazakhstan (primary emphasis) and Kyrgyzstan, and receiving updates of information, as needed, from the United Nations Family Planning Agency (UNFPA) Tajikistan report.
- Policy, regulatory, and capacity barriers to expanded private sector participation (Kazakhstan and Kyrgyzstan)
- Possible introduction of high-quality generic contraceptives to public and private sector (Kazakhstan and Kyrgyzstan)
- Ability of the population (Kyrgyzstan and Kazakhstan) to pay for family planning product based on qualitative assessment derived from interviews with 10 to 20 key informants.
- Public procurement capacity and issues at the central and oblast level (all countries)
- The drug and family planning commodity logistics system at the oblast level (all countries)
- Family planning service delivery issues and related policy issues and how these impact and are impacted by CS (all countries)

The team conducted the assessment in two stages. First, the team split into teams of three to cover Kazakhstan, Kyrgyzstan, and Tajikistan. In each country, the joint DELIVER/PSP-*One* team interviewed both public and private sector individuals and organizations and visited hospitals, clinics, and pharmacies. Second, the DELIVER team extended its assessment of the public sector supply chain by visiting several oblasts outside the capitals of Kazakhstan and Kyrgyzstan.

The team used a variety of methodologies and tools to interview the different individuals and organizations. PSP-*One* conducted spot visits of multiple pharmacies to identify prices and affordability, and to determine the reach of the private sector in rural areas. Moreover, they used elements of the PSP-*One* Legal and Regulatory Guide to interview public sector authorities to determine supportive and obstructive policies. DELIVER's Logistics Indicator Assessment Tool (LIAT) provided the basis for the clinic surveys.

OVERVIEW OF REPORT

Using the SPARHCS framework to structure the analysis, the assessment team divided the report into three sections based on each country. The report provides the following information:

- An overview of the **policy context** influencing CS. Included in the policy analysis is a description of the national and, to a limited degree, the local commitment and leadership to make CS a priority.
- A description of the **public sector supply chain** at both the national and regional levels and specifically the capacity to forecast, finance, procure, and deliver the contraceptives needed.
- A detailed description of the **private sector**, including information on the range of products and prices in the private sector as well as the private distribution network. This section also contains a discussion on the market potential to introduce generic contraceptives as a strategy to address CS.
- A brief description of **family planning services**, identifying provider and user perspectives on improving contraceptive availability. Each country report concludes with recommendations for USAID action to implement a strategy with stakeholders in both the public and private sectors.

**CONTRACEPTIVE SECURITY IN THE
CENTRAL ASIAN REPUBLICS:
KAZAKHSTAN**

EXECUTIVE SUMMARY

POLICY CONTEXT

The family planning situation and subsequent contraceptive availability in Kazakhstan has undergone substantial changes over the past 15 years. Some of the country's policies represent barriers while others present opportunities to ensuring widespread availability of affordable, quality family planning products.

Policies Affecting Public Supply of Family Planning Products

Increased gross domestic product (GDP) funding allocated to the Ministry of Health (MOH). Since 2003, the Republic of Kazakhstan (ROK) has been committed to increasing funding for health. Growth allocations to health have been higher than GDP's growth in 2003-2006. The increased funding presents an opportunity to ensure contraceptive security (CS), as there is more money in the system to purchase commodities.

Outpatient drug benefit plan (ODBP) limitations. Currently, the ODBP includes oral contraceptives (OCs), 3-month injectables (DMPA), and IUDs for *inpatient* care facilities (maternity hospitals and polyclinics) only, which limits the opportunity to obtain family planning or contraceptive methods to women who receive inpatient care for deliveries or gynecological-related needs.

Decentralized budgetary and procurement responsibilities to the oblast level. Decentralized budgeting represents a challenge to CS. Unless there is a national initiative requiring the oblasts to allocate funding for family planning commodities, particularly to ensure a steady supply of family planning methods for the vulnerable population, it will not happen.

Essential Drugs List (EDL). Although OCs are on the EDL, the EDL includes the most expensive formulations of OCs. Providers expressed dissatisfaction with the OCs available on the EDL, stating the EDL-approved OCs restricted their ability to procure and provide for a wider range of OCs to meet client demand.

Policies Affecting Private Sector Supply of Family Planning Products

The Kazakh pharmaceutical sector – both at the wholesale and retail levels – has undergone dramatic changes since the country's independence. Currently, almost 97 percent of all pharmacies are privately owned. Since privatization, the pharmaceutical sector has remained relatively free of government interference. As a result, drugs are sold in private outlets; prices are set without state restrictions; and there is widespread availability of all types of drugs.

Barriers appear to be:

- Affordability of modern drugs for vulnerable population groups

- Failure of the ROK to not recognize other internationally accredited regulatory authorities, such as the Federal Drug Administration (FDA) and European Marketing Authorization (EMA), therefore requiring registration and approval for all drugs; and
- The expectation that the ROK will introduce stricter regulations governing generics.

Other Factors Affecting Supply of Family Planning Products

Public sector leadership and commitment. The necessary leadership and commitment to family planning methods is lacking at the republican level. While maternal and child health (MCH) are official policy priorities, family planning is not seen by the ROK as a priority intervention and contraceptives have not been included in the ODBP for outpatient services. In addition, the public sector has limited understanding of the links between the availability of contraceptives, a reduction in the number of abortions, and a reduction in the maternal mortality rate (MMR) resulting from abortions and unwanted pregnancies. There appeared to be no concern at the prospect that oblasts were running out of contraceptives as the remaining stocks of humanitarian supplies were depleted. This situation compares starkly to the much more committed and innovative approaches that the oblasts and city administrations have taken regarding CS. In each of the four oblasts visited, the assessment team found that solutions were being identified to improve the quality of outpatient family planning services and to fund contraceptives, at least for socially vulnerable groups.

Provider and client bias. Recently, MOH providers have relied almost exclusively on the pharmaceutical industry to supply them with information on family planning products. As a result, providers have developed strong attitudes and preferences. Whereas MOH providers once preferred IUDs, they now recommend OCs, which has resulted in declined use of IUDs. Moreover, MOH providers prefer high-priced European and U.S. OC brands and are influencing their clients' perception and driving demand for certain methods.

PUBLIC SECTOR SUPPLY CHAIN

The assessment team visited MOH sites in Almaty, Astana, Karaganda, and Shimkent and found varying levels of contraceptive supplies. Almaty and Karaganda already experience stock outs and Shimshent has a supply able to meet only three rayon needs out of 16 plus Shimkent City. Astana City is the only site visited that has a sufficient supply of donated commodities to last through 2007, but there is concern about family planning commodities once the supply is depleted. Clearly, the contraceptive supply in the public sector is insufficient to meet demand and all of the oblasts are taking initiatives to address this problem. For example, both Almaty and Karanda Health Departments launched tenders to purchase different family planning commodities. In addition, individual health facilities in Karaganda have used their budget's discretionary funds to purchase family planning methods.

The oblast health administrations (OHAs) at all the sites visited have encountered obstacles in their efforts to ensure a consistent supply of family planning methods and are worried about how to provide these methods for socially vulnerable populations. The principle obstacle they face is the absence of family planning methods in the ODBP, limiting the OHAs' ability to purchase family planning commodities from its own budget. A second obstacle is the lack of

awareness at the republican level with no recognition of family planning as a means to improve MCH. Finally, some OHAs such as Karaganda would like to pool procurements for contraceptives but lack the budget and authority to do so.

The team observed no formal logistics management information system (LMIS) during visits to Women's Consultation Clinics (WCCs) at the four oblasts. All facilities maintain medical and patient records manually. These records show the family planning methods dispensed to users, and although these data are aggregated at the oblast and republican level, there is no analysis of consumption, no assessment of stock levels, and no setting of maximum or minimum stock levels. The Almaty City Health Department was the only administration that reported monitoring stock levels and moving stocks between facilities as needed.

Several facilities reported receiving supplies biannually and quarterly, with emergency orders placed if stocks ran out before resupply dates. In theory, facilities "pull" commodities from the oblast administration by reordering when they run out on the assumption that they will be supplied by their OHA within days. While UNFPA stocks exist, this is possible, but, with the exception of Astana City, these UNFPA supplies are running out. Facilities increasingly are experiencing stock outs, receiving fewer supplies than requested, and experiencing longer gaps between supply periods.

The team estimated the level of funds needed to supply vulnerable populations in Kazakhstan with publicly procured contraceptives. Assuming 2004 consumption data reflect demand for public sector contraceptives and using UNFPA prices, the cost of supplying all clients would be nearly \$1.75 million while the cost of supplying vulnerable groups would be \$524,000. Since oblasts are buying supplies from local wholesalers and retailers, they are paying local prices rather than the international prices available from UNFPA. The cost of using local, private sources to meet the needs of vulnerable populations would be just over \$2.5 million, five times the cost of using UNFPA.

KAZAKH PRIVATE SECTOR (PRODUCTS)

The commercial supply of contraceptives in Kazakhstan reflects the increasing popularity of hormonal contraceptives and includes a wider range of products today than it did in the late 1990s. Organizations representing the interests of manufacturers, importers, and pharmacists have been instrumental in protecting this industry from fiscal pressure, regulating the number of pharmacies, and pushing for legislation to control the quality and safety of the contraceptive drug supply. Kazakhstan's contraceptive supply is mostly delivered through private pharmacies. In the absence of price controls, the Kazakh contraceptive market is influenced mainly by demand, competition between suppliers, and consumers' ability and willingness to pay. Hormonal products are typically imported from European countries, while condoms and IUDs are imported from both Europe and Asia. Visits to the local bazaars revealed no evidence of smuggling of unregistered contraceptive products.

Product Supply

A wide range of contraceptive products, including condoms, spermicidal products, IUDs, and OCs, are found in Kazakhstan. There is an impressively wide variety of condom brands and

prices, suggesting widespread condom use across sociodemographic groups, as well as high market penetration by international manufacturers. With the exception of condom brands marketed by the French company Innotech and PSI, most condoms are imported and distributed through local distributors with little marketing or promotional support.

Hormonal contraceptives found in Almaty pharmacies reflect a preference for the latest formulations of OCs and IUDs, low sensitivity to price, and dissatisfaction with older, high-dose hormonal products. OC products sold in Kazakhstan include combined monophasic and multiphasic pills, and at least one brand of progestin-only pill (pop), although the latter is not widely available. Many OC brands originally developed by research and development (R&D) companies are now available in a generic version made by Gedeon Richter. High-dose formulations are no longer available on this market, and 3-month injectable contraceptives (*Depo-Provera*) are in low demand and sporadic supply. Pharmaceutical manufacturers facing long-time concerns about the safety of hormonal contraception in the former Soviet region have been intensively promoting newer formulations as safer and easier to tolerate. The responsibility to resist the current bias toward newer and expensive brands, however, may have to fall on the public sector and the medical community.

IUDs are still widely used and remain a preferred contraceptive method in Kazakhstan. At least five brands of IUDs were found in Almaty pharmacies. Their popularity, however, is diminishing in the commercial sector. Most IUDs found in Kazakhstan are made generically in Asia and imported by local distributors that do not invest much in marketing the method. One notable exception is the progestin-releasing IUD *Mirena*, which is actively promoted by Schering. Despite its high price, this product is a very good seller, according to pharmacists who carry it.

Although topical contraceptives did not register as a significant method in the last Demographic and Health Survey (DHS), these products appear to be popular in Kazakhstan, judging by their ubiquity in pharmacies. The most widely represented brand is *Pharmatex*, manufactured by Innotech, which includes ovules, spermicidal cream, tablets, tampons, and capsules.

Marketing and Distribution

Most of the pharmaceutical manufacturers marketing products in Kazakhstan are based in other countries. These companies typically partner with local importers and distributors that handle local customs and transportation, and implement promotional and incentive programs for different brands. Three manufacturers – Schering AG, Gedeon Richter, and Innotech – have representative offices in Kazakhstan, which gives them a substantial market advantage. A fourth company, Organon, appears to be gearing up for an expansion but will likely focus on building demand for its latest introduction, *Nuvaring*, a hormone-releasing vaginal ring. Because hormonal products cannot be advertised to consumers, OC manufacturers focus their efforts on providers, particularly “converted” doctors that serve their target group. Consequently, their investment in contraception awareness and knowledge only has an indirect impact on low-income or rural users.

The distribution of pharmaceutical products in Kazakhstan is fairly concentrated, with few intermediaries, moderately high industry markups, and high geographical access. About 70

percent of the drugs imported into the country are brought in by 10 major companies that focus on European or U.S.-made brands. These companies seek to build large product portfolios and aim for reputable brands that help build clout with pharmacies. Local distributors report that they have the capacity to reach rural areas, so long as there is demand for their products.

Although public sector procurement is an important business for local distributors, tenders for contraceptives do not represent a large share of this business. Commercial distributors are well positioned to serve the quantity, time, and delivery requirements of local health facilities, but they cannot match the low prices manufacturers extend to international procurement agencies.

Private Sector Role in Contraceptive Security

The private sector is already providing the bulk of the contraceptive supply in Kazakhstan, and will continue to do so in the absence of major market distortions. There is evidence that contraceptive manufacturers are investing in the Kazakh market, which offers growth potential and a relatively high consumer purchasing power. These companies are expected to continue to support provider education programs and cooperate closely with the MOH because of the success of this strategy.

Less positive from the standpoint of CS is the trend toward increasingly expensive products and methods, and the concentration of industry efforts on a small, educated target consumer group. Most private sector suppliers believe that the responsibility of educating the public and serving needy users should fall on the public sector.

Potential for Generic Supplies

The worldwide contraceptive market is one where competition is based on brand image and, to a lesser extent, price and formulation. This tends to favor companies with large brand portfolios, as well as those who can invest in marketing and provider detailing. Even generic manufacturers need to adopt a branded strategy to sell hormonal contraceptives. For example, Gedeon Richter, which produces generic bioequivalent copies of Schering and Organon brands, chooses to market its products as high-quality, low-cost brands, rather than unbranded generics.

Introducing unbranded, generic contraceptive products on the commercial market is a risky proposition. The country's relatively high purchasing power and low demand for contraceptives do not make a compelling case for the importation of cheaper generic products, which would likely be made in Asia. Such products would face significant market penetration barriers, including aggressive competition from established manufacturers, limited clout with local distributors, and a negative consumer and provider perception of non-European products. Pending bio-equivalency laws, which aim to regulate the quality of generic products, may also keep Asian-made products out of Kazakhstan because they would require costly clinical trials. Unbranded generics may therefore be better suited for the tender business than for the commercial pharmacy market, provided that a local distributor is willing to register and import those products.

CONCLUSIONS

CS has promise in Kazakhstan. The private sector has stepped into a gap created during the time period in which the public sector could not provide sufficient supplies of family planning methods. The assessment demonstrates that the private sector provides a wide range of methods and brands at consistent prices. Moreover, the private sector offers family planning methods throughout the country, even in peri-urban and limited rural areas.

CS becomes an issue, however, for vulnerable population groups in Kazakhstan. Everyone interviewed, including private sector individuals and organizations, acknowledged that private sector prices of family planning methods may be out of reach economically for poor and vulnerable groups. This problem is particularly acute in light of rising total abortion rates (TARs) and MMRs among vulnerable population.

The MOH is in a good position to address these concerns. For the first time since the fall of communism, the MOH has more public funds to direct toward its health priorities. Further, there is strong regional and local leadership committed to ensuring quality reproductive health/family planning services and products.

Kazakhstan is in a good position to ensure a reliable supply of a wide range of affordably priced contraceptives if the different actors involved play their respective roles. The private sector can contribute significantly toward ensuring CS in Kazakhstan, but the public sector still needs to guarantee contraceptive supply of subsidized products for those not able to pay for their family planning methods in the private sector.

RECOMMENDATIONS

The team proposed three general recommendations to improve CS in Kazakhstan, as summarized below in Tables 1-3.

TABLE 1: STRENGTHEN PUBLIC SECTOR COMMITMENT AND POLICIES

Action	USAID	UNFPA	MOH	Private Sector
Make FP one of MOH's top funding priorities	Through negotiations with MOH, encourage them to make FP a funding priority	Improve coordination with USAID on MOH policies		
MOH to include FP methods in ODBP	Support <i>ZdravPlus</i> to do analysis to make case for including FP in ODBP	Improve coordination with USAID on MOH policies	Reform ODBP to include FP methods	
Update MOH FP skills & knowledge; promote public health messages on the health benefits of FP	Provide resources and technical assistance to MOH to update skills and promote FP health messages	Coordinate with USAID TA and resources directed to FP	Update providers' knowledge of FP methods; improve provider counseling skills; implement broad-based info campaigns to generate FP demand	

TABLE 2: STRENGTHEN PUBLIC SECTOR LOGISTICS

Action	USAID	UNFPA	MOH/Oblast Health Managers	Private Sector
Strengthen commodity forecasting	Sponsor forecasting workshop	Sponsor forecast workshop	Determine vulnerable population; prepare financing and procurement plan	
Earmark funds for FP commodities	Support advocacy for FP funding	Support advocacy for FP funding	Permit oblasts to use budgetary allocation to purchase FP methods for vulnerable populations	
Improve procurement practices	Support procurement information dissemination; provide TA to review global experience in procurement and pricing	Act as procurement agent	Review different procurement mechanisms; hold seminar to share lessons learned; conduct market analysis to ID best procurement mechanism; pilot new mechanisms in south Kazakhstan	Respond to local tenders, including for framework contracts; provide import clearance and distribution for UNFPA procurement
Strengthen distribution and LMIS	Support roll out of south Kazakhstan LMIS; support training oblasts in use of LMIS	Support south Kazakhstan LMIS	Rationalize tiers in the supply chain; introduce and use simple LMIS	Provide tender for local distribution

TABLE 3: MAXIMIZE PRIVATE SECTOR PRESENCE IN FP MARKETPLACE

Action	USAID	UNFPA	MOH	Private Sector
Continue favorable policies supporting private sector	Support MOH efforts to rationalize and regulate pharmaceutical sector	Support MOH efforts to rationalize and regulate pharmaceutical sector	Do not need to make major changes in regulations or government policies	
Ensure continued presence of low-cost products in the private sector	Check to see if low-price pills (e.g., <i>Rigevidon</i>) and other products are available in pharmacies. If low-price products disappear, consider importing a generic to be distributed through private sector		Ensure that subsidized products do not compete with affordably priced products offered through commercial channels	
Ensure that MOH providers receive unbiased information about FP methods	See above (support MOH to offer provider training)		Supplement providers with independent, objective info on full range of methods and formulations available in pharmacies. Partner with pharmaceutical suppliers to conduct training and provide information	Partner with MOH to provide info not only own products but also safe, low-cost hormonal contraceptives, as well as IUDs, and injectables
Favor affordably priced formulations in public sector clinics			Implement policy and training to offer unbiased patient counseling that includes second-generation, low-dose OCs. Oblasts include second-generation, low-dose OCs in <i>all</i> contraceptive tenders.	Have private sector suppliers respond to tenders

KAZAKHSTAN FINDINGS

HEALTH POLICIES, REFORMS AND CONTRACEPTIVE SECURITY

This section presents an overview of current health sector reforms and policies that influence CS and private sector provision of family planning commodities in Kazakhstan. Annex A offers an overview of the evolution of policies and reforms as they relate to CS. As the text demonstrates, some of these policies represent barriers while others present opportunities to ensuring widespread availability of affordable, quality family planning products.

Policies Reforms Affecting Family Planning in the Public Sector

Increased GDP funds allocated to MOH

Since 2003, the ROK has been committed to increasing funding for health. As Table 4 indicates, growth allocations to health have been higher than GDP's growth in 2003-2006. Table 4 also presents annual public health expenditures by source.

TABLE 4: HEALTH EXPENDITURES, 2003-2006

		2003	2004	2005	2006 (FORECAST)
1	GDP, billion tenge	4612,0	5542,5	6780,0	8065,4
2	GDP annual growth	1,2	1,2	1,22	1,19
3	Health expenditures, total, billion tenge	92,9	134,1	190,2	228,9
4	Expenditures of the health sector (medical education included), billion tenge	90,8	131,2	187,1	224,5
4.1	Local budgets	71,7	101,9	129,9	141,7
4.2	Republican budget	2,1	2,9	3,1	4,4
5	Expenditures on health (other sectors), billion tenge	2,1	2,9	3,1	4,4
6	Total health expenditures, percentage of GDP	2,0	2,4	2,8	2,8
7	Health expenditures growth, percentage	1,27	1,44	1,42	1,20

Source: Republican Ministry of Health

MOH staff interviewed confirmed that oblasts have received increased funding levels over a 3-year period. Even remote polyclinics have benefited from the increased funding levels: staff at a remote clinic the team visited said their clinic was refurbished and they recently received new equipment and supplies not previously available. Also many of the pharmaceutical companies and distributors saw public procurement increase dramatically in the last year, although these public tenders were not for contraceptives.

The increased funding presents an opportunity for ensuring CS, as there is more money in the system to purchase commodities.

Limitations in the Outpatient drug policy

A second key policy reform, the ODBP has had a negative impact on the availability of contraceptives. Currently, the ODBP includes OCs, 3-month injectables (DMPA), and IUDs for *inpatient care facilities* (maternity hospitals and polyclinics) *only*, thereby limiting the opportunity to obtain these contraceptives to women who receive inpatient care for deliveries or gynecological-related needs. To ensure that high-risk women and vulnerable populations receive needed family planning commodities, maternity hospitals in Almaty City and other oblasts “share” methods with WCCs. Thus, the OCs are procured for gynecological problems, but, in practice, doctors prescribe them for family planning use.

Staff from the Vice Ministers of Health’s office indicated that preparation work on defining the 2008-2009 ODBP would begin the summer of 2006. There is, however, no consensus that the reforms will include family planning methods for *outpatient care* also. The UNFPA representative stated that reforming the plan would become part of their advocacy initiatives for 2006. The UNFPA advocacy initiative will focus on increasing visibility of the link between increasing TAR and MMR and the lack of access to family planning commodities, suggesting that reforming the ODBP to include family planning methods would be an effective strategy to help address these health problems.

Decentralization of budgetary and procurement responsibilities

As noted in the overview of policy changes in Annex A, the budgetary and procurement processes have been delegated to the oblast level. The ROK has established two systems to ensure equitable distribution of resources and funds between the 16 oblasts. First, the funds are pooled at the central level and then redistributed according to need to ensure an equitable allotment of funds between the poorer and more affluent oblasts. The second mechanism is prioritization of health areas in which the MOH authorizes the oblasts to spend their funds. The five health priorities are tuberculosis, cancer, diabetes, neonatal care, and diseases of children under the age of 5 years. In addition to these five priority areas, the oblasts do have some discretionary ability to allocate funds to other health priorities. Indeed, eight out of the 16 oblasts have already used some, albeit small amounts, of funds to purchase family planning methods.

Decentralized budgeting represents a challenge to CS. On one hand, there are more funds flowing into the MOH system, and the oblast level health authorities are allocating them to the designated priorities. On the other hand, despite the rising levels of TARs and MMR, maternal health priority lacks comprehensive action and, therefore, key women’s health services such as family planning programs are not a main concern. Unless there is a national initiative requiring the oblasts to allocate funding for family planning commodities, particularly to ensure a steady supply of family planning methods for the vulnerable population, it will not happen. Currently, oblasts with strong leadership that recognizes the link between the increased access of family planning methods to MMR are the ones who are purchasing these products while those

with the greatest unmet need do not buy them because they lack funds or have poor knowledge of the demand for them among reproductive age clients. Until family planning and maternal health become a national priority in action, the vulnerable populations will not be assured steady access to family planning methods.

Limitations in the Essential Drug List

In 1995, the ROK developed and published the first EDL based on the World Health Organization's (WHO's) EDL. This list is reviewed and updated annually. It contains 325 approved names used for common illnesses. OCs are included, mentioned by the generic composition, as are Depo Medroxyprogesterone Acetate (DMPA - *Depo-Provera*) and Levonorgestrel Emergency Contraceptive (Postinor). The UNFPA representative indicated that the most expensive formulations of OCs are on the EDL as a result of strong lobbying initiatives from pharmaceutical companies. Doctors in both the public and private sectors, however, report a preference for late-generation OCs and this may be more to do with personal preference than lobbying by private companies. In addition, providers interviewed expressed dissatisfaction with the OCs available on the EDL, stating the EDL-approved OCs restricted their ability to procure and provide for a wider range of OCs to meet client demand. IUDs, spermicides, and condoms are not included on the EDL. When asked about the absence of these methods, respondents indicated that IUDs and condoms are categorized as medical devices.

Policies And Reforms Affecting Private Sector Products

Revolution in the pharmaceutical industry

The Kazakh pharmaceutical sector — both at the wholesale and retail levels — has undergone dramatic changes since the country's independence. The newly independent government in Kazakhstan decided to privatize the monopolistic republican holding company "Pharmatsia." Within 5 years, almost 97 percent of all pharmacies were privately owned and run. As a consequence, drugs are freely sold in private outlets; prices are set without restrictions from the state; and there is widespread availability of all types of drugs. The only barrier appears to be affordability of modern drugs for the vulnerable population groups (Hafner et al., 2002).

Since privatization, the pharmaceutical sector has remained relatively free of government interference. As demonstrated elsewhere in this report, Kazakhstan offers a favorable marketplace for R&D companies to enter and sell their products, mainly because it is relatively easy to import products here. Indeed, many of the legal and regulatory barriers to family planning commodities identified in the 1997 Ravenholt assessment have been addressed: 1) difficulties in moving products through the custom system, 2) a 20 percent value added tax VAT on pharmaceutical and contraceptive products, and 3) an onerous regulatory system governing the importation process. Moreover, drug registration is relatively inexpensive; it costs \$5000 to apply for one dossier and \$1000 for additional files, and the process is not too onerous compared to that of other countries.

However, a few policies could potentially have a negative impact on the availability of family planning products. These include the fact that the ROK does not recognize other internationally accredited regulatory authorities, such as the FDA and EMA, therefore requiring registration and approval for all drugs; and the expectation that the ROK will introduce stricter regulations governing generics. These and other problems are discussed in the following section on private sector supply.

Evolving Framework of Checks and Balances

As part of the 2005 national plan, the MOH is putting into place the legal and regulatory framework to bring its pharmaceutical sector more in line with Western country customs and practices. Key features of the reforms are addressed in the following paragraphs.

Creating the regulatory bodies charged with the mandate of ensuring the availability of safe quality drugs: In March 2003, the MOH created the Pharmacy Committee – a republican-level agency with oblast-level representatives that have dual reporting responsibilities to the director of the Pharmacy Committee and to the oblast director of health. The Pharmacy Committee’s responsibilities are 1) control and monitor the quality of drugs in the marketplace; 2) review applications for new drugs (registration, renewals, import/export control); and 3) monitor prices of drugs listed on EDL. With the explosion of the pharmaceutical market in the last 10 years, the Pharmacy Committee is severely understaffed to meet the growing demand for registration of new products and to monitor and supervise the increasing number of distributors, hospital pharmacies, and retail pharmacies.

The second organization charged with ensuring the safety of available drugs is the National Center of Examination of Drugs and Medical Products. Originally, the National Centers had the same scope as the Pharmacy Committee, but under the reforms, it now focuses on conducting clinical trials and recommending the Pharmacy Committee approve or not approve a drug. Its work focuses on three stages: 1) initial assessment to check if the dossier is complete, 2) analytical assessment to verify the safety and efficacy of the drug, and 3) specialized testing. According to regulations, the National Centers have 6 months to review a product dossier but in practice it takes upwards of 6 months simply to conduct the initial assessment. With the addition of staff, it is hoped that the centers will be able to accelerate the review process.

In addition to reforming the regulations governing this sector (see below), the MOH has been investing in agency staff and capacity. More than 80 staff from both agencies have been sent to Western countries (e.g., United States, Denmark, Ukraine) to observe how their regulatory agencies function and to learn new management/clinical skills.

Strengthening regulatory practices governing quality of drugs in the market: As part of the overall effort to bring Kazakh practices in line with those of Western countries, the MOH will adopt future reforms – two of which can potentially impact CS. The Pharmacy Committee contemplates a major overhaul of the legal and regulatory framework of the roles and responsibilities of the two agencies governing the pharmaceutical sector occurring within the next 2 years (2008). One of the reforms will

have a positive impact on CS: ROK will eventually accept other internationally recognized regulatory bodies' product approvals. The recognition of FDA- and EMA-approved and registered drugs will further reduce barriers, such as time and cost, to the registration process of an R&D company's family planning products.

The second reform, however, will have a negative impact on importation of any generic family planning product. The MOH has developed a presidential decree reforming key areas of the pharmaceutical sector, in particular, generics. This new law will require that all generics register, undergo bio-equivalence testing, and allow inspection of the production site. Both chambers of Parliament have the draft reform and will review it soon. In preparation for this reform, the National Center has built a new lab to test bio-equivalency for generic drugs, and it claims the lab is ready to start testing generics. Implementation of this new law, however, is unclear. The National Centers has reported it will first focus on drugs listed on the EDL, such as insulin. Furthermore, it stated that the centers will review on a case-by-case basis any generic drug on the EDL that has received prior certification of bio-equivalency from an internationally recognized regulatory authority to determine if the product would be subject to Kazakh review. The National Center expects the new law to be in place within the next 6 months.

Strengthening practices governing distribution and sales. Since the deregulation of pharmacies, there has been a dramatic increase in the number and types of pharmacy outlets. Under Kazakh law, there are four categories of outlets: 1) pharmacy/wholesalers, 2) pharmacy drug store, 3) pharmacy point, and 4) pharmacy kiosk. The Pharmacy Committee acknowledges the sector has grown beyond its control and is now focusing its efforts in strengthening enforcement and compliance. Categories 1 through 3 have stricter facility and personnel requirements than does #4. Currently, the Pharmacy Committee is closing pharmacy kiosks located in hospital sites because the kiosks are not able to dispense drugs that require prescriptions and they offer a limited range of drugs.

Another future area of reform will involve restricting pharmaceutical companies' access to medical professionals. In the absence of MOH efforts to update and improve their health staff's knowledge of contraceptive technology, drug company detailers and sales representatives have become the primary source of new information on family planning methods. As a result, doctors and pharmacists almost always recommend the latest generations of OCs, which are more expensive than older formulations. This trend is further confirmed by the *ZdravPlus* Technical Report on Drug Prices in Kazakhstan (Hafner, 2002). This indicates that demand for Western products is fueled by two factors: medical bias and consumer demand. Both doctors and clients state that they prefer Western products because of their quality and they prefer newer, third generation OCs. To address the undue influence of the pharmaceutical companies, the Pharmacy Committee is drafting reforms that will address unregulated access, but it appears the MOH has no current plans to address the need for continuing education on family planning methods.

Creating a system of checks and balances. While the government is putting in more mechanisms to regulate the pharmaceutical sector, four vibrant and effective professional trade associations have emerged to ensure that government will not over-regulate the private sector. These organizations represent a wide range of private sector entities working in the pharmaceutical sector: R&D pharmaceutical firms, importers, pharmaceutical producers, and pharmacists. There is some evidence these organizations have become effective advocates for their constituents. First, they were successful in removing the 20 percent VAT on drugs, medical devices, and supplies. Second, they were able to push back on the ROK demand to completely eliminate all kiosks. In fact, they believe that the MOH now recognizes their position in policy formation and actively consults with them on all new legislation and reforms concerning the pharmaceutical sector. In general, they view their relationship with the MOH as collaborative. Indeed, many are in favor of the MOH's efforts to bring Kazakh industry practice more in line with Western standards governing the pharmaceutical sector, stating it is a good thing for the ROK to rationalize the markets. Their only concern is pace. They caution the GOK it will take more time than its 1-year deadline to meet WHO and GMP guidelines, as it took the Ukraine more than 5 years to do so.

PUBLIC SECTOR LEADERSHIP AND COMMITMENT

The necessary leadership and commitment is lacking at the republican level. While maternal and child health is one of the official policy priorities, family planning is not seen as a priority intervention and contraceptives have not been included in the ODBP for outpatient services. In meetings at the Republican MOH, officials reiterated that oblasts needed to focus on funding outpatient benefits for social priorities including diabetes, cancer, TB, and diseases of children under 5. There appeared to be no concern at the prospect that oblasts were running out of contraceptives as the remaining stocks of humanitarian supplies were depleted. There was also limited awareness of the links between contraceptive availability, reducing abortions, and the MMR resulting from abortions and unwanted pregnancies. When asked about the need to purchase family planning products, particularly for vulnerable population groups, MOH officials' response was "the private sector can do it."

The Pharmacy Department Director did not understand the need to focus on contraception nor its importance in averting maternal mortality and infertility from abortions. He was not aware that stocks of humanitarian contraceptives were running low and that oblasts were struggling to replace them. The MCH Department, while more receptive to family planning messages, seemed to lack the drive, commitment, or voice to champion for this cause within the MOH.

This situation compares starkly to the much more committed and innovative approaches taken at the oblasts and city administrations visited. Leadership for CS exists at the oblast level in each of the four oblasts visited. In Almaty City, Astana, Karaganda, and Shymkent a senior team led by the director of the oblast or city health department, the chief OB/GYN, family planning specialist, and the head of the pharmaceutical department all demonstrated a commitment to providing family planning services. In each location, solutions were being identified to improve the quality of outpatient

services and to fund contraceptives, at least for socially vulnerable groups. The following are examples from three of the areas visited.

The head of the Astana City Health Administration identified the importance of contraception in reducing the abortion rate and decreasing MMR and infertility. Astana still had sufficient stocks of humanitarian contraceptives to last it through 2007, when local funding would then be needed to resupply stocks.

In Karaganda, humanitarian contraceptives have run out and some polyclinics are already starting to purchase their own supplies. The OHA would like to undertake pooled procurement of contraceptives to supply its polyclinics but it feels it does not have the juridical right to do so for outpatients. The polyclinic purchases fall within the range of 2–5 percent of discretionary spending allowed for institutions.

In Almaty, the city administration has established a budget line for contraceptives, is funding pills, and will purchase IUDs soon. Contraceptives are distributed to polyclinics linked to hospitals and covered from within the inpatient drug budget — a practice not strictly permitted.

South Kazakhstan oblast administration organizes tenders for facilities pooling their requirements. From 2005 through the first half of 2006, facilities spent 4.9 million tenge on procurement of contraceptives that are not available from humanitarian stock. According to Oblast Perinatal Center, the funding of contraceptives from facilities' budgets is insufficient, and additional allocations are needed to meet requirements in various family planning methods.

PROVIDER AND CLIENT BIAS

Limited interviews with and observations of providers and clients revealed common attitudes and perceptions regarding family planning methods. The MOH has not invested recently in the continuing education of its providers to update their information and knowledge of contraceptive methods. Rather, MOH providers have relied on the pharmaceutical industry to supply them with information. The MOH has not intervened to regulate nor limit the pharmaceutical industry's access to its health professionals. As a result, providers have developed strong attitudes and preferences regarding family planning methods. The first perception is that low price equals poor quality. Clearly, MOH providers prefer prescribing European and U.S. brands, influencing their client's perception as well as demand for certain methods. Second, IUDs used to be the method of choice among providers. Now, MOH providers have moved past their previous bias against OCs and recommend clients use OCs, preferably those manufactured by Western companies.

Clients' tastes and preferences mirror those of their health care providers. As a result, many pharmacists interviewed stated that their clients always ask for certain brands, stating that higher price means better quality. The clients also indicate a preference for anything Western made. Notwithstanding the higher prices, clients are willing to pay top price for brands and late-generation products.

Compounding this problem is the fact that hormonal contraceptives sold commercially worldwide are always branded and never marketed as generic formulations. One reason for this is that contraceptive formulations tend to be difficult to decipher and understand, even for health providers. Another is that R&D companies have invested considerable resources in building product differentiation and brand image in this therapeutic class. In Kazakhstan, as in other countries, this is reflected in the absence of generically labeled contraceptives in pharmacies. There is, however, high demand for lower price branded copies of popular R&D brands (such as those made by Gideon Richter). Despite the widespread availability of different family planning methods in the private sector, many quality issues persist. High discontinuation rates of family planning methods reveal health care providers' limited counseling skills or lack of ability to manage side effects. In addition, the MOH has not allocated funds to continue information, education, and communication (IEC) activities similar to those in prior years, resulting in low demand among certain population groups. This situation is further exacerbated by the lack of methods available in the public health system, particularly for vulnerable population groups.

KAZAKH PUBLIC SECTOR SUPPLY CHAIN

The Public Sector in 2004

According to a recent World Bank UNFPA study (World Bank, UNFPA 2006), the total public expenditure for contraceptive protection for 1.5 million couples in 2004 was estimated at \$8.83 million (2006). Aggregating across different contraceptive methods yielded an average cost of \$5.37 per couple year of protection. The direct cost of commodities accounted for almost 50 percent of the total cost (except in the case of IUDs). Since UNFPA supplied all the commodities, almost 50 percent of the expenditures were subsidized by humanitarian aid from UNFPA in 2004.¹ The same study used MOH data to estimate a modern method contraceptive prevalence rate of 38.4 percent². This was very similar to that observed in the last Kazakh DHS, 1999 (38.6 percent).

Tables 5 and 6 give the total cost of contraceptive services in 2004 by number of couple years of protection (CYP). Table 5 has been calculated based on the costing estimates for one couple year of protection using different contraceptive methods. Since the cost of OCs can vary greatly by the brand used, in the calculation presented, the team member considered the cost of one cycle of *Rigevidon* FE (\$0.175) and Tri-Regol FE (\$0.19 per cycle) – the two brands procured and supplied by UNFPA in 2003. Similarly, for the IUD, the team member used the cost of Copper T 380A (\$0.414), manufactured by CONTECH Devices Pvt., LTD., and supplied by UNFPA. The cost of one condom supplied by UNFPA was \$0.02. A total of 100 condoms were assumed to provide one couple one year of protection. It was assumed that couples would require three consultations per year for OCs and IUDs (one for insertion and two for follow up), two

¹ Pp36 op cit UNFPA/World Bank

² There were 1,641,358 users of modern methods of contraceptives excluding the users of female sterilization. The total population of women in the 15-49 age group in MOH data was 4,273,762.

consultations per year for condom users, and four consultations for *Depo-Provera* users. With the ending of UNFPA humanitarian donations in 2004, commodity availability has declined in the public sector. UNFPA estimates unmet need in 2006 as high as 47 percent based on a survey of 15,000 respondents. The cost of obtaining these products would be greater, as UNFPA prices are several times lower than the prices available in the private sector in Kazakhstan.

TABLE 5: TOTAL PUBLIC SECTOR EXPENDITURE ON ORAL CONTRACEPTIVE AND CONDOM USERS IN 2004.

Region	Oral contraceptives			Condoms		
	Annual Cost (US \$)	Users (MOH 2004)	Total Cost	Annual Cost (US \$)	Users (MOH 2004)	Total Cost (US \$)
South Kazakhstan	4.96	49839	247201.4	3.84	37983	145854.7
East Kazakhstan	4.65	64166	298371.9	3.64	100165	364600.6
Astana	4.05	23066	93417.3	3.34	12265	40965.1
Almaty	5.46	39667	216581.8	4.05	11062	44801.1
West Kazakhstan	4.22	26622	112344.8	3.43	28468	97645.24
North Kazakhstan	4.16	81038	337118.1	3.40	89268	303511.2
National Average/Total	4.59	284398	1305035	3.57	279211	997378

TABLE 6: TOTAL PUBLIC SECTOR EXPENDITURE ON IUD AND DEPO-PROVERA USERS IN 2004

Region	IUD			Depo-Provera		
	Annual Cost (US \$)	Users (MOH 2004)	Total Cost (US \$)	Annual Cost (US \$)	Users (MOH 2004)	Total Cost (US \$)
South Kazakhstan	5.73	370882	2125154	7.61	15943	121326.2
East Kazakhstan	5.34	158269	845156.5	7.20	6078	43761.6
Astana	6.41	23266	149135.1	6.60	382	2521.2
Almaty	7.47	34191	255406.8	8.02	4086	32769.72
West Kazakhstan	6.41	131497	842895.8	6.79	1107	7516.53
North Kazakhstan	5.69	244508	1391251	6.72	2574	17297.28
National Average/Total	5.85	962613	5608998	7.43	30170	225193

Source: Fertility Regulation in Kazakhstan Attitudes towards Abortion and Contraceptive Use and Cost of Services, March 2006, World Bank, UNFPA

The number of contraceptive users in the public sector shown in Table 5 reflected the situation while stocks of humanitarian assistance still existed. During this period contraceptives were being given free of charge to all clients who sought them. As stocks of humanitarian assistance have declined, oblasts have been more selective in providing clients with free contraceptives, focusing on socially vulnerable women and those with medical conditions that would make pregnancy risky.

Current Situation

The situation in the public sector supply chain in each oblast is described below based on visits to Almaty City, Astana, Karaganda, and Shimkent.

Almaty City. The Almaty City OHA identified family planning and contraceptive commodities as a health priority. In 2006, the city allocated 10 million tenge to purchase contraceptives. The budget allocated was only 50 percent of the amount requested because of overall health budget constraints. Allocating its own funds to family planning reflected the recognition that the abortion rate was too high and was an avoidable source of maternal mortality. It also reflected the realization that up to 30 percent of the women of reproductive age attending WCCs could be classified as vulnerable and unable to pay for their contraceptives at commercial pharmacies. Since providing contraceptives, the OHA has observed that the number of abortions has decreased.

The OHA launched a procurement tender for OCs, which Gideon Richter was awarded. The company has provided two types of OCs, and the total number of boxes of OCs purchased (10,000), each with three cycles, reflected more budget availability than actual demand. A procurement of IUDs has been delayed because of a technical problem with earlier bids. It will be relaunched in the coming months.

Once the commodities were procured, they were delivered to a maternity hospital where they were stored in a small storage room on the ground floor of the hospital. Each of the 22 WCCs were immediately notified and they sent a staff member in a vehicle to collect the pills.

The Almaty City Reproductive Health Center (RHC) has a monitoring unit responsible for managing commodity stocks. The stocks were distributed to the WCC immediately because the RHC did not have the juridical right to hold commodity stocks and could be subject to audit from the tax police. Supervisors visit each facility once every 3 months to review user records, determine what products are dispensed to users, and ensure products are being dispensed appropriately to vulnerable women. Each WCC categorizes its population and identifies vulnerable women based on a combination of patient interviews, home visits, and staff observations. Vulnerable women include alcoholics, drug users, mothers of large families, students, women with frequent abortions, and the financially distraught.

The RHC tracks and analyzes usage and organizes for reallocation between facilities if one facility is running short. Although forms exist to track usage, there is no formal LMIS in use. Facilities do track dispensed-to-user data and keep a running stock balance, but there is no analysis at the facility level of consumption or stock levels, reorder quantity, maximum or minimum stock levels, or tracking of losses or adjustments. Facilities simply call when stocks are running low. In one facility visited, staff had not spotted a simple calculation error.

On the day of the visit in April, the maternity hospital store had fewer than seven cartons of OCs and yet each of the three facilities visited was expecting a resupply soon. The RHC confirmed that it has not always been able to meet the needs of its 22 WCCs;

for example, for 3 months at the end of 2005 there were no supplies. One of the WCCs reported rationing when stocks run low, dispensing only to priority cases. All WCCs stated they get resupplied two or three times each year.

Two maternity hospitals visited had no supplies of OCs, IUDs, or condoms to provide to women who come for abortions and could use contraceptives to prevent the need for future abortions. The Lactational Amenorrhea Method (LAM) is the contraceptive method doctors recommended to all post-partum women for at least the first 6 months of breastfeeding. Some IUDs are inserted, but typically clients bring their own IUD purchased at a local pharmacy. The doctors interviewed expressed reservations about IUD insertion as “they cause diseases and complications.” None of the facilities visited had condoms or *Depo-Provera*, and neither method has been available since humanitarian aid stopped in 2004. Administrators at one facility reported they sometimes experience “stock out” for one or two weeks before they are resupplied.

Astana. The Astana City Health Department (CHD) has sufficient inventory of donated UNFPA contraceptives to last city family planning facilities through to 2007. They are worried, however, about what will happen to the provision of free methods to the socially vulnerable once these supplies run out. The EDL includes four contraceptives methods that are not included on the ODBP, which limits the CHD’s scope for purchasing from its own funds. Those interviewed recognize the importance of family planning for MCH and are frustrated at the lack of awareness at the republican level. The Astana CHD asked the team to address this issue with the Republican MOH leadership and asked that a *prikaz* be issued to allow family planning for vulnerable groups to be included in the ODBP. They point to 15 percent infertility caused by induced abortions as a major problem. A third of maternal deaths are also caused by abortions.

The UNFPA donations included IUDs, Rigidon, spermicide, *Depo-Provera*, and condoms. These are distributed to three WCCs at the Perinatal hospital, #1 Maternity Hospital, and a Family Planning Center. Thus far, commodities have been provided free to all clients without distinguishing between vulnerable and poor clients and those able to pay. As the economy has developed, however, women are increasingly able to pay for contraceptives.

A visit to the WCC at the #1 Maternity Hospital identified that it serves 32,680 women of reproductive age in its catchment area. The WCC has a stock of IUDs, condoms, combined OCs, and *Depo-Provera*. This includes UNFPA-donated commodities and pills procured with its own funds for inpatients. The WCC has sufficient stocks for one more than 1 year but will run out in 2007. It would like to continue providing free contraceptives, but these are not included in the ODBP.

Once again no formal LMIS system was observed, although client records and dispensed-to-user data are hand recorded and reported to the oblast administration.

Karaganda Oblast. Karaganda OHA had a total budget of 14.972 billion tenge in 2005, up from 11.7 billion in 2000. The 2005 budget included 2.6 billion of targeted funds for the BBP drugs. Primary care and diagnostic services are funded on per capita basis of

140 tenge per month. The OHA budget is split, with 54 percent spent on secondary care and 46 percent on primary care, reflecting the increased importance placed on primary care services. The OHA last received humanitarian aid in contraceptives in 2003 and has since distributed all the contraceptives to the facilities.

The OHA has a Drug Analysis Center where staff monitor prescription patterns, prices, and availability of drugs in the oblast. The Center tries to promote more rational drug use and advises on drug policy and procurement.

The OHA would like to do pooled procurement for contraceptives but they neither have the budget nor the mandate to do so. The OHA did organize a tender in April 2006 where they took requests for contraceptives from different facilities. They organized and conducted the tender process, specifying the technical details and selecting the winning bid based on the consolidated orders. The minutes of the tender were published and then the various facilities contracted directly with the winning bidder. The tender included 6,500 IUDs and other contraceptive commodities, but other than that, individual facilities had the discretion to spend 2 percent to 5 percent of their budget. Facilities also have requested permission to use their excess funds to make individual purchases. One facility did this successfully, making a technical case to the oblast budget committee. Facilities can also shop locally without going through large-scale tendering for smaller purchases.

One polyclinic, run as a private entity, is contracted by the OHA to meet the general practitioner (GP) diagnostic and day surgery needs of a catchment area of 100,000 in central Karaganda. It provides the BBP free to clients and charges user fees for additional services provided over and above the BBP. It received humanitarian aid contraceptives from UNFPA in 2003 and 2005 and has sufficient IUDs for additional three years, as doctors only insert 200 IUDs per year. The polyclinic only has 40 boxes of *Depo-Provera* and a 6-months supply of OCs. The clinic provides contraceptives free to teenagers, socially vulnerable women, and women with health problems. It only serves 120 socially vulnerable women out of the 25,543 women of reproductive age located in that area. Although the polyclinic has procured a limited amount of contraceptives, those interviewed were not willing to disclose the amount. Once its humanitarian aid finishes, the clinic will not be able to serve as many women as it does currently.

A public sector polyclinic on the outskirts of the city has a smaller, poorer catchment area with a higher proportion of socially disadvantaged women. It serves a total population of 24,230, of which 7,519 are women of reproductive age, and 856 of which are classified as socially vulnerable, and an additional 2.5 percent are teenage girls. Condoms are the method of choice for these teenagers and for clients over 35, while OCs are the preferred method for women aged 20–35. The polyclinic estimates it achieves a contraceptive prevalence rate (CPR) of 59 percent, with 89 percent for the socially vulnerable. Although it had received humanitarian aid in the past and currently has 6-months' stock of *Rigevedon* and 2-months' stock of IUDs, it has run out of *Depo-Provera* and condoms. The clinic would like to have lower dose pills to give to teenagers and more choice in general to offer clients. Those interviewed expressed concern that they

have no budget and have to rely on the OHA to find contraceptive methods from other clinics.

The team visited a medical complex in the rural Abay rayon outside Karaganda. The complex is a combined facility located in Topar town, and includes a central rayon hospital and six primary health care (PHC) ambulatories located in rural areas of the district. The central rayon hospital has an inpatient and outpatient department. The latter consists of a family medicine unit and specialist care and diagnostic department. The combined facility serves 7,038 women of reproductive age (WRA). The CPR of WRA in Abay rayon is shown in Table 7.

TABLE 7: ABAY RAYON DATA ON CPR BY METHODS

# WRA	Total	IUDs	Hormone Total	Hormone Including		Spermicides	Barrier	
				Oral	Inject.		Total	Condoms
Covered in 2005 total	1479	486 (32.9%)	482 (32.6%)	443 (30%)	39 (2.6%)	70 (4.7%)	441 (29.8%)	441
Out of total: Post abortions	143	72 (50.3%)	62 (43.4%)	58 (40.6%)	4 (2.8%)	6 (4.2%)	3 (2.1%)	3
Post-delivery	180	160 (88.9%)	3 (1.7%)	3 (1.7%)	-	6 (3.3%)	11 (6.1%)	11
Total # under observations	5185	2720 (52.5%)	957 (18.5%)	950 (18.3%)	7 (0.1%)	39 (7.5%)	1469 (28.3)	1469

Obstetricians, gynecologists, and midwives, as well as PHC physicians in rural ambulatories, offer family planning counseling and various family planning methods to WRA. To ensure availability of contraceptives for all WRA in the district, the rural ambulatories procured hormonal contraceptives in 2005 adding them to remaining unexpired stock left from 2003 humanitarian aid from UNFPA. The oblast health department agreed to the procurement of these contraceptives and the facilities used public funds allocated for annual female physical exams (checkups) to procure them. The present stock is sufficient to cover more than one year of contraceptive requirements. The facility is determined to continue its effort in providing family planning methods for WRA in the future once availability of public funds permits it to do so free of charge. The facility's performance in family planning has been improving: in 2005, the ratio of the number of medical abortions to the number of deliveries was 60 to 100, while in 2004, it was 130 to 100. More than 40 percent of women who have given birth receive IUDs upon their discharge from the hospital. Providers report that their practical observations suggest that IUDs remain more suitable for the majority of women from rural areas as OCs require more discipline and full compliance with instructions for use. As Table 7 shows, 5,185 are currently accessing modern contraceptive methods at Rayon facilities. When compared with the Rayon population of 7,038 WRA then this gives a very high CPR for the Rayon of 73.7 percent (5185/7038).

South Kazakhstan Oblast. South Kazakhstan oblast has 15 percent of the country's population, the poorest social indicators, and the greatest proportion of underprivileged people. UNFPA has been working in south Kazakhstan as a pilot site and intends to continue providing support to undertake logistics improvements. The state of contraceptive management there has already been discussed in UNFPA's "Reproductive Health Commodity Security Status Assessment" (RHCSSA). As stated in the assessment, the goals of the UNFPA project are described as follows:

...pilot activities in south Kazakhstan will include setting up and providing training to run a Logistics Management Information System (LMIS) for contraceptives and eventually RH commodities, in order to support improved quality of reproductive health services and improved management capacity in reproductive health.

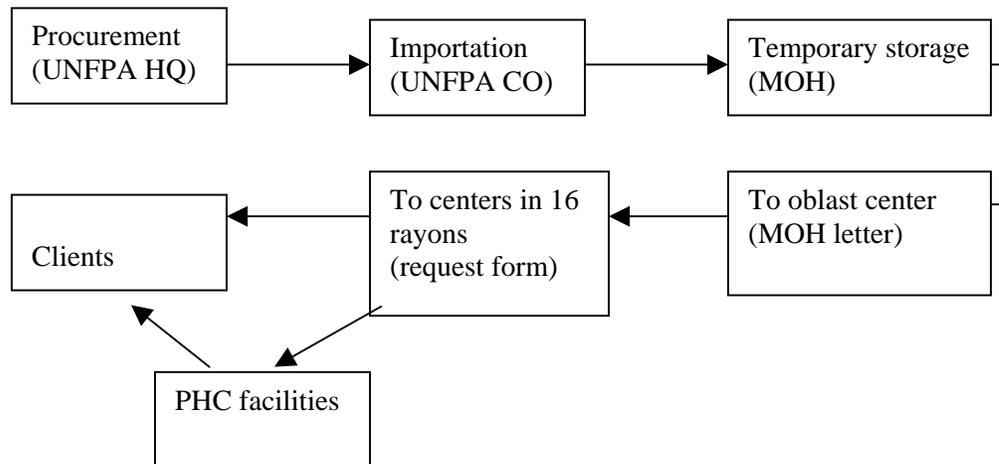
There is no formally established LMIS, but a manual supply and distribution system does exist. The RHCSSA provides a clear summary of the existing contraceptive distribution system, which, from oblast level down, has three tiers: oblast, rayon, and clinical facilities. The RHCSSA describes it as a "pull" system in which rayons request what they need from the oblast, although this description seems to be inaccurate. The rayon's request does trigger quarterly shipments from the oblast, but supplies are limited, and rationing decisions must be made at both the oblast and rayon levels. These limitations are evidenced by the fact that despite the south Kazakhstan OHA obtaining \$65,000 from the local consolidated oblast budget in 2005, which in itself was considered quite an achievement,³ these funds were sufficient to meet the needs of only three rayons out of 16 plus Shimkent City.

At lower levels, the rayon seems to decide what supplies and how much to issue, and staff at the clinical facilities are not always satisfied with the decisions. A staff member at one ambulatory put it succinctly, "I asked for IUDs for 4,000 women and I got 20; I did not ask for Depo, and I got a hundred boxes."

Recently, supplies have not been sufficient to set up a minimum/maximum inventory control system. Figure 1, which is based on the June 2005 assessment, depicts the current distribution system.

³ Dr Kathy Schroff pp14 op cit.

FIGURE 1: SUPPLY CHAIN FOR UNFPA-PROCURED SUPPLIES IN SOUTH KAZAKHSTAN IN 2003



Source: Dr. Kathy Schroff, Kazakhstan Reproductive Health Commodity Security Status Assessment, UNFPA, June 5, 2005.

During a brief visit to Shimkent from April 24-26, 2006, the team made the following observations. In addition to the UNFPA donation, some contraceptives for use in public sector clinical facilities are purchased from the oblast budget and, reportedly, rayon and even clinical facility budgets. In addition, some condoms are supplied by the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM). Reports are received regularly on the UNFPA and GFATM input, but these reporting systems are separate, and, therefore, their data are not aggregated. Nongovernmental organizations (NGOs) contracted by GFATM report on distribution of condoms to the Republican level, bypassing the oblast HIV/AIDS Center. Rayons and facilities are not required to, and consequently do not, report on the contraceptives they purchase. The end result is that no party in Shimkent has an accurate overview of all the contraceptives circulating in the public sector, and incomplete data are used to quantify requirements for oblast tenders.

The team traced the LMIS for UNFPA contraceptives from the oblast level down through rayon and on to clinical facilities. The reporting system is based on hand-drawn ledgers and reports, and, understandably, an oblast level staff from the Perinatal Clinic Health Information Unit reported difficulty in managing “all those little pieces of paper.” At every site, staff responsible for reporting lamented the need to create their own forms and the lack of computers. A more cost-effective approach would be to preprint LMIS forms and then have facility staff manually complete them. Moving to a computerized system would be justified once needed commodities are actually funded.

As an aside, this unit actually works for the OHD but is based in the clinic. The stock is located at the oblast health department’s warehouse and not the Shimkent Perinatal Clinic, although the clinic has a newly constructed warehouse facility. This could prove advantageous for achieving sustainability of an automated LMIS.

The team recommends serious consideration be given to the quantities of contraceptives that will be supplied as part of a package that includes LMIS and other activities. “Pull”

systems are usually desirable because they put order quantity determination in the hands of the people who are closest to the clients and know their preferences (e.g., IUDs as opposed to *Depo-Provera*). “Pull” systems require greater management capacity at the lower levels and, therefore, training and supervision than do “push” systems. Minimum/maximum inventory control systems are desirable because they greatly reduce stock outs and overstocking at clinical facilities when operated correctly. This becomes more important as donations end and more efficient use of existing financial resources is required.

Both of these refinements urge more, rather than less, commodity inputs. For example, when delivery intervals are quarterly, and minimum stock is set at 3 months and maximum at 6 months, it takes about 30 months of product to fill the pipeline, that is, two and a half times the annual consumption. This issue is examined in more detail below.

CURRENT LMIS

The team observed no formal LMIS during visits to WCCs in the four oblasts. In all facilities, staff meticulously maintain medical and patient records by hand. These show dispensed to user data and although these are aggregated at the oblast and Republican level there is no analysis of consumption, no assessment of stock levels and no setting of maximum or minimum stock levels. Almaty City Health Department was the only administration that stated they monitor stock levels and move stocks between facilities as needed.

Several facilities reported receiving supplies biannually and quarterly, with emergency orders placed if stocks ran out before these resupply dates. In theory, facilities “pull” commodities from the oblast administration by reordering when they run out on the assumption that they will be supplied by their OHA within days. Historically, while UNFPA stocks exist, this was possible in the oblasts visited. Several facilities in different oblasts reported a two-day turn around between order and supply, but, with the exception of Astana City, these UNFPA supplies are running out. Facilities increasingly are experiencing stock outs, receiving fewer supplies than requested, and experiencing longer gaps between supply periods. Products are therefore “pushed” down to facilities with several quoting receipt of fewer contraceptives than requested. Some oblasts have responded by using their own discretionary funds, but these are not meeting the needs of their socially vulnerable populations.

Recommendations for a Future Logistics System

Design of a future logistics system is dependent on contraceptives for vulnerable populations being included in the ODBP. This section discusses what would be required if the Republican MOH issues the necessary *prekaz* defining the vulnerable groups and products to be covered in the ODBP.

Forecasting. Individual oblasts and rayons would need to define their vulnerable populations based on existing clinical records. When consumption data are either absent or unreliable, forecasts should be based on data where reliable information and

population forecasts exist. Ideally, those oblasts with recent experience in dispensing contraceptives should examine the average monthly consumption by each method. This information is available from existing records and should highlight periods where there were stock outs or supply was interrupted. Forecasts should be monitored and compared with actual procurement across the country to help ensure target population needs are being met. This will require national- and oblast-level monitoring of forecast accuracy and actual consumption levels.

Finance. Using the UNFPA and World Bank estimates in Tables 8 and 9, the authors made some adjustments to estimate the financial need for supplying vulnerable populations in Kazakhstan with publicly procured contraceptives. For projection purposes, 2004 consumption data were used to reflect the demand for public sector contraceptives as 2004 reflects the last year of a nearly full supply. The team members assumed 30 percent of the population would need to be provided with subsidized contraceptives, while the remainder would be more able to pay private sector prices. This reflects the opinions of health officials in the oblasts visited and is used for indicative purposes. The actual size of vulnerable populations will vary considerably between regions. The cost of supplying 30 percent of the 2004 consumption figures is calculated using both adjusted UNFPA prices and selected private sector prices for equivalent products. UNFPA prices are those UNFPA has been able to negotiate with international manufacturers due to the large volumes they procure worldwide and to favorable prices these manufacturers are willing to offer for humanitarian assistance. These prices would only be available in Kazakhstan if UNFPA were contracted as a procurement agent. As UNFPA typically only quotes the cost of delivery to the port of entry, the authors added a 25 percent increase to cover port clearance, storage, and distribution to the oblasts by local pharmaceutical importers acting as distribution agents.

TABLE 8: PROJECTED FINANCING REQUIREMENT TO REACH 30 PERCENT OF THE POPULATION WITH PUBLIC CONTRACEPTIVES

Region	All Clients	Assuming 30 Percent	Cost of Commodities Using UNFPA Prices		Cost for 30 Percent Clients
	2004	Vulnerable clients	All clients	Vulnerable clients	Using local prices
South Kazakhstan	474,647	142,394	\$321,689	\$96,506	\$490,931
East Kazakhstan	328,678	98,603	\$478,483	\$143,545	\$658,757
Astana	58,979	17,694	\$105,485	\$31,645	\$161,248
Almaty	89,006	26,702	\$160,925	\$48,278	\$250,702
West Kazakhstan	187,694	56,308	\$172,105	\$51,631	\$258,273
North Kazakhstan	417,388	125,216	\$509,024	\$152,708	\$743,058
Total	1,556,392	466,918	\$1,747,710	\$524,313	\$2,562,971

As shown in Table 8, if contraceptives are procured at UNFPA prices, then the cost of supplying all clients would be nearly \$1.75 million while the cost of supplying vulnerable groups would be \$524,000. Currently, oblasts are buying from local wholesalers and retailers, and therefore are paying local prices rather than the

international prices available from UNFPA. The costs of meeting vulnerable populations from local private sources would be just over \$2.5 million, five times the cost of using UNFPA.

Centralized or Decentralized Procurement?

While centralized procurement typically can provide greater opportunities to procure contraceptives at lower prices, in the Kazakh context there are also a number of disadvantages given the decentralized management structure. The most important is the lack of national commitment, leadership, and capacity to manage family planning commodities. In addition, a national system would involve the greatest distance between central ordering and the client. This in turn would require a larger number of tiers in the distribution system and the longest supply chain as stocks would need to be managed at each tier and larger buffer stocks would be needed. Depending on reorder and supply intervals at each level, commodity stocks of between 24 to 30 months can be required (i.e., over twice the annual consumption rate as buffer stocks will be needed at the national, oblast, rayon and SDP levels).

Given the requirement to register drugs, importers, and import shipment, it is unclear whether generic manufacturers offering cheaper products would be interested in participating in international competitive bidding conducted at a central level in Kazakhstan. Current regulations do not allow UNFPA to procure contraceptives for the public sector because it is not licensed to do so. UNFPA would have to work with local importers and distributors to clear and distribute supplies. Table 9 presents the advantages and disadvantages of different procurement options.

The biggest advantage of decentralized, oblast-level decision making for procurements is that managers have a better understanding of their clients' needs and are more committed to family planning than leaders at the national level. Decentralized management is also consistent with the thrust of health sector reform in Kazakhstan. The main disadvantage of lower level procurement is the potential loss of price discounts due to smaller procurement volumes. This price disadvantage might be offset by existing drugs; wholesaler and import registration requirements will all act as barriers limiting the scope for international competitive bidding and lower prices.

While internal competition in the pharmaceutical distribution market has resulted in relatively low retail and wholesale margins, wide geographic coverage, and relatively consistent product pricing across the country, prices being offered in the market are as much as five times greater than the prices manufacturers are supplying to UNFPA.

Other countries in a similar situation to Kazakhstan, particularly those in South America, have started to use UNFPA as a procurement agent. These countries have been using their own funding to pay UNFPA to conduct their procurement so they can gain access to lower prices. UNFPA's procurement services require forward funding and incur a 5-6 percent administrative charge. Present procurement and import registration procedures do not allow UNFPA to act as a procurement agent in Kazakhstan. As noted above, the lack of a national distribution system and the lack of financial resources would make national procurement impractical. UNFPA could act for an oblast

administration, for example, for South Kazakhstan oblast, but this would still require a local agent to clear the products through customs and deliver the commodities to Shimkent.

TABLE 9: CENTRALIZED VERSUS DECENTRALIZED PROCUREMENT

Options	Advantages	Disadvantages
Centralized Republican Procurement	<ul style="list-style-type: none"> ▪ Larger bulk purchasing should allow a better chance of procurement at lower prices 	<ul style="list-style-type: none"> ▪ Lack of commitment at the republican level ▪ Lack of national management capacity to forecast, procure, and deliver ▪ Not clear the national budget would be earmarked ▪ Would require longest supply pipeline with most tiers in the supply chain and the largest buffer stocks ▪ International competitive bidding may still be limited by drug registration regulations ▪ Would reverse the trend for more decentralized health management
Centralized oblast procurement	<ul style="list-style-type: none"> ▪ Volumes may still be significant to allow some bulk purchase price discounts from competitive local wholesalers. ▪ Strong family planning commitment in eight out of 16 oblasts ▪ Scope for negotiating framework contracts for oblast facilities ▪ Management is closer to the client 	<ul style="list-style-type: none"> ▪ Volumes smaller than national procurement ▪ May still require a longer supply pipeline as two to three levels still needed in distribution system. ▪ Requires stronger logistics management skills at the oblast level ▪ Lack of commitment in some oblasts
Decentralized Rayon procurement	<ul style="list-style-type: none"> ▪ Management is much closer to the client and more likely to purchase what is really needed. ▪ Strong local leadership for family planning in some rayons/facilities ▪ Shortest pipeline as private sector supplies directly to the facility 	<ul style="list-style-type: none"> ▪ Much smaller procurement quantities and higher procurement prices ▪ Lack of family planning commitment in some facilities ▪ Requires better management skills at the facility level ▪ Requires greater management oversight to ensure good governance
Use of UNFPA as a Procurement agent	<ul style="list-style-type: none"> ▪ Could provide republican or oblast administrations with access to competitive internationally priced contraceptives 	<ul style="list-style-type: none"> ▪ Not allowed by existing procurement and importation regulations. ▪ Lack of national distribution structure and financial resources would make procurement for the republican level impractical ▪ Procurement for oblast administration would still require an agency to clear products at the port of entry. ▪ Requires advance payment

If oblasts can still obtain some volume discounts then the prices available may not vary substantially from those obtained at the national level. Oblast administrations will need to review the prices available from local wholesalers to see the extent that bulk order discounts could be obtained. Analysis of pharmacy prices and discussions with wholesalers suggest relatively limited geographic price variation for key contraceptives.

Table 10 provides some limited price comparisons based on observed prices in Kazakhstan and recently collected international prices. To allow comparisons between

local retail prices and international prices adjustments need to be made for local retail (10-15 percent) and wholesale margins (10-15 percent), transportation costs (10 percent) and port clearance costs (15 percent). These are deducted from local retail prices to provide imputed local prices at the border that can be compared with international prices.

TABLE 10: COMPARATIVE LOCAL AND INTERNATIONAL PRICES

	Retail Price	Cumulative Distribution Margins	Imputed Price	UNFPA	Ratio
Orals(Levonorgestrel 0.15 mg + ethinylestradiol 30 mcg)	\$1.34	65%	\$0.81	0.19	328%
Condoms	\$0.09	65%	\$0.05	0.02	171%
IUDs	\$4.25	65%	\$2.57	0.414	522%
Depo-Provera	\$0.53	65%	\$0.32	0.312	2%

Interestingly, these imputed price differences show that there is minimal landed price difference between *Depo-Provera* that is purchased locally and is available from UNFPA. The largest differences are for IUDs (more than 500 percent) and OCs (Levonorgestrel 0.15 mg + ethinylestradiol 30 mcg, 328 percent).

Another option already adopted in the Karaganda oblast administration is the negotiation of framework contracts with local suppliers that would fix prices, delivery points, and minimum and maximum order quantities and then allow facilities to procure within these contract parameters. Such contracts would make use of the extensive private sector pharmaceutical distribution network in Kazakhstan to deliver products to the oblast, rayon, and possibly even facility level. It combines the advantage of oblast-level procurement with facility-based decision-making.

The Republican MOH could still play an important role in a decentralized procurement setting by disseminating information on prices paid in different oblasts and promoting family planning objectives in those oblasts not spending on contraceptives.

Feasibility of A Two-Tiered Distribution System

In most oblasts a two-tiered distribution system would be feasible where either

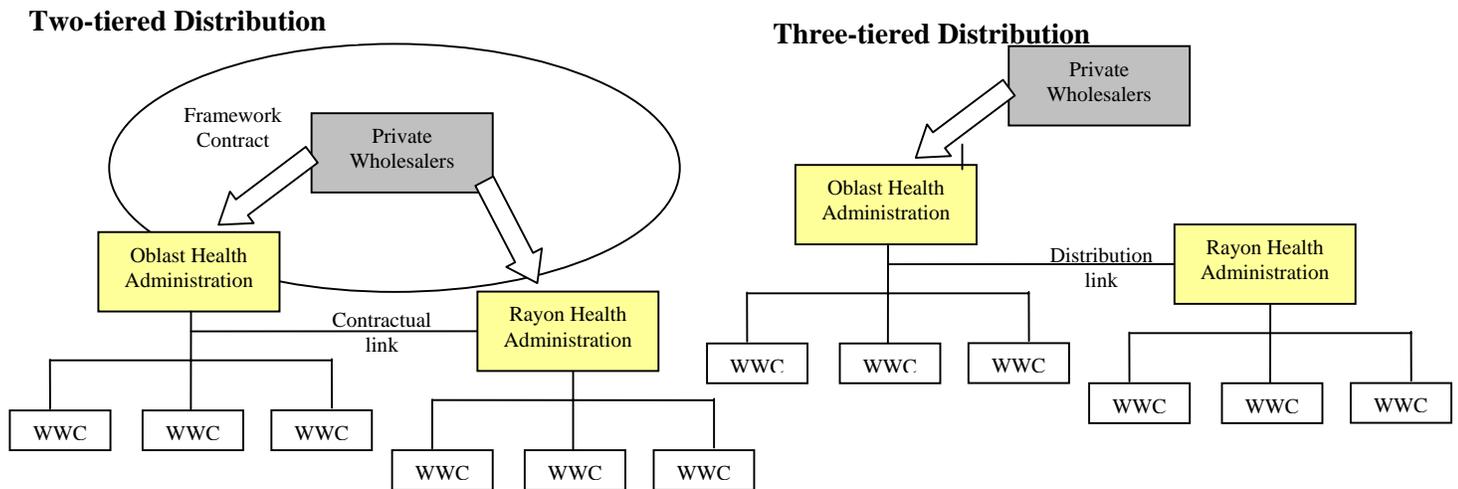
the oblast administration could procure and supply directly to the facility level, or

the oblast health administration could negotiate framework contracts with wholesalers supplying public facilities in their oblast. In this latter case, the rayon administrations/health facilities already managing their own budgets could also undertake local procurement, in turn supplying facilities within their jurisdiction.

A three-tiered distribution system would be necessary only where rayons located further from the oblast capital do not have local wholesalers to supply them and would

be forced to rely on supplies from the oblast health administration. Figure 2 illustrates the possible scenarios.

FIGURE 2: POSSIBLE PUBLIC CONTRACEPTIVE PROCUREMENT AND DISTRIBUTION STRUCTURES



KAZAKH PRIVATE SECTOR (PRODUCTS)

Key Characteristics

The commercial supply of contraceptives in Kazakhstan is similar to that of other former Soviet republics. It is directly influenced by reproductive health trends in the region, such as the gradual substitution of contraception for abortion as a birth control method and the increasing popularity of hormonal contraceptives. Two successive DHS (1995, 1999) documented an increase in the proportion of married women using modern methods; however, the method mix remained heavily concentrated on IUDs. The current supply of commercially sold contraceptive methods suggests that users are demanding and accessing a wider range of products today than they did in the late 1990s.

Pharmacies in urban areas reflect the following market characteristics:

- Availability of a wide range of contraceptive products, including condoms, spermicidal products, IUDs, and OCs. Injectable contraceptives, such as *Depo-Provera*, however, remain virtually absent from this market.
- A preference for the latest formulations of OCs and IUDs, reflecting intensive marketing by pharmaceutical companies, and dissatisfaction with older, high-dose hormonal products.
- A low sensitivity to price among pharmacy customers, judging by the demand for high-end OC brands and for Mirena, a progestin-releasing IUD retailing for 30,000 tenge.

The Pharmaceutical Industry

Organizations representing the interests of manufacturers, importers, and pharmacists have been instrumental in protecting this industry from fiscal pressure (notably by lobbying to exempt drugs from VAT), regulating the number of pharmacies, and pushing for legislation to control the quality and safety of drug supply. According to the Kazakh Association of Pharmacists, there are approximately 8,000 pharmacies in Kazakhstan, ensuring good physical access to contraceptive products, though there are reportedly wide regional variations, depending on urbanization and local demand. The retail pharmacy market has been largely privatized since 1996, and has remained relatively free of government interference. A study of the prices and availability of pharmaceuticals in Kazakhstan by the *ZdravPlus* Project (Hafner et al., 2002) described the following:

- A “highly developed” market, with “intense competition and many available products.” Drug prices were found to be generally higher in Kazakhstan, compared with international prices.
- Limited variations in the prices of specific brands in different pharmacies, but considerable variations between the prices of different brands of a particular product.
- A predominance of imported drugs (over 95 percent of the essential drug supply).
- No significant influx of unregistered drugs, in spite of allegations of illegal products smuggled from Russia and China.

The Contraceptive Product Supply

Kazakhstan’s contraceptive supply presents many of the same characteristics as the pharmaceutical market because it is mostly delivered through private pharmacies. Consistent with the *ZdravPlus* survey findings for essential drugs, pharmacies offer a wide choice of OC and condom brands at different prices, though variations in the prices of individual brands from one pharmacy to another tend to be minimal. In the absence of price controls, the Kazakh contraceptive market is influenced mainly by demand, competition between suppliers, and consumers’ ability and willingness to pay.

As is the case for other pharmaceuticals, imported contraceptive products dominate the market. Most OC brands are imported from European countries, while condoms and IUDs are imported from both Europe and Asia. Consistent with the 2002 survey, visits to the local bazaars revealed no evidence of smuggling of unregistered contraceptive products.

Products

Condoms. The condom market in Kazakhstan is highly diversified, as shown in Table 11. There is an impressively wide range of condom brands and prices, suggesting widespread condom use across sociodemographic groups, as well as high market penetration by international manufacturers.

Prices tend to reflect the manufacturer’s global reputation, brand image, and country of origin. European-made condoms and those made by well-known companies (such as Ansell, Durex, and Innotech) fetch the highest prices and are ubiquitous in pharmacies. Outside pharmacies, in retail outlets such as kiosks and convenience stores, cheaper brands of condoms made in India, China, and Russia are more common.

Condom brands are not directly marketed by manufacturers but merely imported and distributed through local commercial distributors. Exceptions are *Innotex*, marketed by a subsidiary of the French company Innotech, and *Favorite*, which PSI markets in both pharmacy and nontraditional outlets.

Hormonal Contraceptives. Hormonal contraceptive supply includes OCs and emergency contraceptive pills, injectable contraceptives, and the contraceptive patch. The only injectable product found on the market (in extremely sporadic supply) is *Depo-Provera*, which retails for about 1,200 tenge per vial. The *Eova* patch, manufactured by Janssen Cilag, is not widely distributed and not well known by pharmacists. Its price in Almaty pharmacies is 2,100 to 2,300 tenge for three patches, making it one of the most expensive products on the market. *NuvaRing*, Organon’s hormone-releasing vaginal ring, is pending introduction in Kazakhstan.

OCs are particularly well represented in Kazakhstan. Approximately 400,000 cycles of OCs were sold in the private sector in 2005 (IMS 2005). The OC supply in Kazakhstan is similar to the Russian market, as well as to other post-Soviet countries where pharmaceutical companies are hoping to create a market similar to Western Europe, with a focus on low-dose innovative hormonal formulations. “High-dose” pills containing 50 mcg or more of estrogen are not recommended for regular contraception and are no longer found on this or many other markets. These older formulations, which tended to produce undesirable side effects, were often the only option for women in Soviet countries. As a result, a general distrust for “older pills” has developed in the region, fueled by a tendency by pharmaceutical companies to promote the newest and most expensive formulations.

TABLE 11: CONDOM BRANDS IN KAZAKHSTAN (ALMATY AND ASTANA)

Brand	Country	Price per condom (tg)
Banana	India	8.3
Chica	N/A	43.3
Close Fit	N/A	43.3
Control	Spain	57
Context	Russia	50-60
Desire	India	10
Durex	UK	75-143
Horoscope	Chinese	28.3
Favorite	Germany	12
Innotex	France	50-65
Lifestyles	Belgium	98-110
Macho Man	India	18.3
Magnum	N/A	53.3
Masculan	Germany	53.3
Reflex	Russia	60-100
Sico	Germany	40-50
Sitabella	N/A	74.3
2 To Tango	India	20-35
Ultra 2	Germany	97.5
Vie Tex	N/A	43.3
Vizit	Germany	40-100

The following major types of OCs are currently available, mostly over the counter:

Monophasic combined pills, which provide a fixed combination of ethinylestradiol (an estrogen) in doses of 20-50 mcg and a progestin. The most commonly found OC formulation worldwide, in both the private and public sectors, is *ethinylestradiol 30mg/levonorgestrel 0.15mg*. It is marketed under more than 40 brand names and is recognized as safe and effective by the international medical community (International Planned Parenthood Federation, 2002). In Kazakhstan, two brands are based on this formulation: Schering's *Microgynon* and Gideon Richter's *Rigevidon*, which is the most widely distributed of the two and the lowest priced brand on the market (as low as 130 tg per cycle).

Monophasic pills containing newer progestins such as gestodene, desogestrel — known as “third generation” OCs — as well as even more recent formulations with the progestins drospirenone and dienogest, sometimes called “fourth generation,” are also easily accessible in Kazakhstan. These products tend to be much more expensive than older formulations. Despite their high prices and a slightly increased risk of thromboembolism associated with their use, these newer formulations are very popular in developed markets. For example, *Yasmin* (sold in Kazakhstan under the brand *Yarina*), which contains drospirenone, is now the world's best selling OC brand (Medical News Today 2005).

Multiphasic (Biphasic and triphasic) pills, which provide different doses of progestin and estrogen throughout the cycle. Such formulations provide low, overall hormone dosage and, according to manufacturers, provide a better match for the body's natural menstrual cycle than monophasic pills. These OC formulations are especially popular in developed markets (USA, Canada, Western Europe) and actively marketed by pharmaceutical companies.

Progestin-only pills (POP), which contain a low, uninterrupted daily dose of a progestin and no estrogen. The latter generally are recommended for women who are breastfeeding or who cannot take combined pills. There is only one brand of POP on the market, *Excluton*, which is marketed by Organon. Because this company appears to have limited coverage in Kazakhstan, it is unlikely that their POP brand is widely available. Other companies such as Schering and Gideon Richter do not see much potential demand for the formulation and are not planning to introduce new POP brands on the market. Increasing the availability of this method in pharmacies is therefore predicated on generating demand among providers and users.

Table 12 lists available OC brands in Kazakhstan, average retail prices (sampled from pharmacies in Almaty), and yearly sales. Brands based on the same formulation are grouped together. It is interesting to note that third-generation and multiphasic brands made by Schering or Organon often have a lower priced generic equivalent made by Gideon Richter.

TABLE 12: BRANDS OF ORAL CONTRACEPTIVES AVAILABLE IN PRIVATE PHARMACIES (ALMATY AND ASTANA)

Monophasic	Formulation	Manufacturer	Price per cycle (tg)	2005 sales (cycles) ⁴
Microgynon	Levonorgestrel 0.15 mg + ethinylestradiol 30mcg	Schering	530	2,700
Rigevidon	Levonorgestrel 0.15 mg + ethinylestradiol 30 mcg	Gideon Richter	180	77,700
Marvelon	Desogestrel 0.15 mg + ethinylestradiol 30 mcg	Organon	1,500	4,700
Regulon	Desogestrel 0.15 mg + ethinylestradiol 30 mcg	Gideon Richter	350	34,400
Mercilon	Desogestrel 0.15 mg + ethinylestradiol 20 mcg	Organon	1,900	N/A
Novinette	Desogestrel 0.15 mg + ethinylestradiol 20 mcg	Gideon Richter	570	36,800
Femoden	Gestodene 0.075 mg + ethinylestradiol 30 mcg	Schering	830	1,200
Logest	Gestodene 0.075 mg + ethinylestradiol 20 mcg	Schering	1,000	48,100
Lindynette 20	Gestodene 0.075 mg + ethinylestradiol 20 mcg	Gideon Richter	600	N/A
Jeanine	Dienogest 2 mg + ethinylestradiol 30 mcg	Schering	1,300	14,900
Yarina	Drospirenone 3 mg + ethinylestradiol 30 mcg	Schering	1,800	N/A
Diane 35	Cyproterone acetate 2 mg + ethinylestradiol 35 mcg	Schering	1,100	72,100
Multiphasic	Formulation	Manufacturer	Price per cycle (tg)	2005 sales (cycles) ⁵
Triquilar	Levonorgestrel 0.05/0.075/0.125mg + EE 30/40/30mcg	Schering	450	32,000
Tri-Regol	Levonorgestrel 0.05/0.075/0.125 mg + EE 30/40/30 mcg	Gideon Richter	180	46,900
Trisiston	Levonorgestrel 0.05/0.075/0.125 mg + EE 30/40/30 mcg	Jenapharm	330	N/A
Progestin-only				
Excluton	Lynestrenol 0.5 mg	Organon	1,700	N/A

Today's OC market appears quite different from what it was in 1999, when the last DHS report was published. Of the 19 brands available on the market then, 10 (mostly older, higher dose OCs) are no longer found in Almaty pharmacies. There appears to be nine new formulations on the market, two of which are found in a lower priced branded generic version made by Gideon Richter.

Although *Rigevidon*, the lowest priced OC on the market, still represents a high percentage of total sales, according to pharmacists and distributors, contraceptive users in Kazakhstan clearly show an increasing preference for high-priced, late-generation contraceptive products. The three best-selling OC brands are *Diane 35*, which doubles as an anti-acne treatment, and two products containing late-generation progestins: *Logest* and *Jeanine*. These brands sell for 1,100 tenge, 1,000 tenge, and 1,800 tenge per cycle, respectively. Reasons for their popularity may include the following:

- Pervasive concerns over the safety of “older” pills, and a belief among users and providers that OCs containing less hormones and new progestins are better tolerated.

⁴ Source: IMS 2005

⁵ Source: IMS 2005

- Strong provider-directed marketing by pharmaceutical companies. The following excerpt from an abstract submitted by Russian researchers at a recent conference of the European Society of Contraception, is a good example of strong provider support for the latest generation of OCs:
- Combined oral contraceptive Yarina (Yasmin) containing 0.03 mg ethynilestradiol and 3 mg new gestagen drospirenon is a novel stage in hormonal contraception. Yarina is a highly effective contraceptive. It is generally well tolerated, achieving good cycle control and having beneficial effects on acne and other skin-related conditions. There is evidence to suggest that Yarina has a beneficial effect in the treatment of premenstrual syndrome as well as having a positive effect on well-being and health-related quality of life. Overall, Yarina is a promising treatment option for women requiring contraception.
- High willingness to pay among current users. This does not necessarily translate into high ability or willingness to pay among the general Kazakh population. The perception that only expensive OC brands are safe (as reported by a private gynecologist in Almaty) may in fact be keeping potential users from using this method.

It is important to note that newer generations of OCs are not scientifically proven to be more effective or safer than monophasic OCs. There is also no good clinical evidence that any particular progestin in a combined pill regimen is superior to others (IPPF, 2002).

It is not surprising, however, that OC manufacturers facing long-time concerns about the safety of hormonal contraception in the former Soviet region would promote newer formulations as safer and easier to tolerate. The responsibility to “set the record straight” and resist the current bias toward newer and expensive brands, however, may have to fall on the public sector and the medical community, as there is nothing illegal about promoting one brand over another in a free market situation.

Intra-Uterine Devices (IUDs). IUDs are still widely used and remain a preferred contraception method in Kazakhstan. Their popularity, however, is not reflected in the commercial product supply, for the following reasons:

IUDs are much more provider dependent than resupply methods such as OCs and condoms. Although it was possible to buy several IUDs without a prescription, very few consumers ever buy any without a doctor’s recommendation, according to pharmacy employees. Because this method is mostly inserted in public clinics, where commodities have traditionally been available, there is still little incentive for anyone to purchase an IUD in a pharmacy, unless their public facility runs out of stock.

IUDs are not as actively marketed in the commercial sector as OCs. Basic IUDs can now be made cheaply in Asia and do not provide much room for product differentiation, unlike hormonal formulations. Most IUDs found in Kazakhstan are imported by local distributors and do not benefit from local marketing support by a manufacturer’s representative office. One notable exception is the progestin-releasing IUD *Mirena*,

which receives a lot of marketing support from Schering. Its high price (about 30,000 tg) does not appear to dampen its popularity and pharmacists carrying this product described it as a “very good seller.” Because it is not available in the public sector, patients must purchase the product on their own.

Although IUD supply appears to be sporadic, there are a variety of IUD brands on the market. What is available in Almaty appears to reflect provider preference for copper-bearing devices, which are proven to be safe and effective, with a low pregnancy rate (IPPF, 2004). These products include Organon’s *Multiload Cu 375* and the TCU 380A, typically imported in unbranded, generic form from India and China.

Other, much less known, brands found in Almaty pharmacies include the following:

T de Oro. This brand, which is described as containing gold and lasting about 4-5 years, is the most expensive on the market. It is manufactured by Eurogine, a dedicated IUD and diagnostic products manufacturer based in Spain.

Yunona Bio-T Ag. This ring-shaped IUD made by Simurg Medical Enterprise in Belarus retails for 3,500 tg. It is marketed as a long-lasting IUD (7-8 years) and recommended by the manufacturer for post-abortion insertion.

Table 13 identifies the various brands of IUDs available and their costs.

TABLE 13: BRANDS OF IUDS AVAILABLE IN PHARMACIES (ALMATY)

Brand	Manufacturer	Country	Price (tg)
Mirena	Schering	Germany	27,500-30,000
T de Oro-Gold T	Eurogine	Spain	52,000
Yunona Bio-T	Simurg Medical Enterprise	Belarus	3,500
Copper T 380A	ChinaZhejiang Daji Medical Instruments, Co., Ltd.	China	130-160
Copper T 380 A	FamyCare	India	570

Other Contraceptive Products

Although topical contraceptives did not register as a significant method in the last DHS, these products appear to be popular in Kazakhstan, judging by their wide availability in pharmacies. The most widely represented brand is *Pharmatex*, manufactured by Innotech, which includes ovules, spermicidal cream, tablets, tampons, and capsules. This company has about 80-85 percent market share. In addition to Pharmatex line, pharmacies offer a Russian brand of vaginal suppositories, *Kontraceptin T*, and two monoxynol-based spermicide brands: *Patentex* (German) and *Lady* (German/Kazakh joint venture) though they did not appear to be as widely available. Table 14 identifies these topical contraceptives and their costs.

TABLE 14: BRANDS OF TOPICAL CONTRACEPTIVES AVAILABLE IN PHARMACIES (ALMATY)

Brand	Manufacturer	Country	Price (tg)
Pharmatex vaginal capsules(6)	Innotech	France	620-850

<i>Pharmatex ovules (10)</i>	Innotech	France	800
<i>Pharmatex cream (18 applications)</i>	Innotech	France	800
<i>Pharmatex tampons (2)</i>	Innotech	France	800
<i>Kontraceptin T vaginal suppositories (10)</i>	Nigfarm	Russia	640

Marketing And Distribution

Manufacturers

Most pharmaceutical manufacturers marketing products in Kazakhstan are based in other countries. These companies typically partner with local importers/distributors with extensive networks of clients (mostly pharmacies) that have the ability to handle local customs, transport merchandise to various regions, and implement promotional and incentive programs for different brands. Condom manufacturers, which often seek a wider distribution base, may also partner with distributors specializing in fast-moving consumer goods (such as foodstuff and personal care products).

Some pharmaceutical companies (usually large, Western-based R&D companies) choose to have a representative office in Kazakhstan. This is often called a “scientific office” because its role is to disseminate the latest research available on the type of products sold by the company, as well as provide educational support to service providers. In practice, these offices focus essentially on marketing the company’s brands, although their contribution to contraceptive awareness and knowledge in Kazakhstan should not be underestimated.

Having a representative office in-country provides a substantial market advantage because a dedicated staff can be hired to lobby local public officials, organize lectures and conferences for the provider community, and visit prescribing doctors on a regular basis (this is called “detailing” in industry terminology). This type of structure is costly and only justifiable when a company enjoys a large market share and a wide portfolio of products, and believes that the market offers significant growth potential. The presence of a scientific office is an excellent indicator of a manufacturer’s interest in a particular market.

The following contraceptive manufacturers currently have a representative office in Almaty:

Schering AG: This worldwide market leader estimates its share of the Kazakh market at about 80 percent in dollar value, and 50 percent in volume. Schering’s representative believes that the overall OC market is growing at about 15-20 percent per year, with about 40 percent of the demand generated in Almaty. The company’s target market is of a relatively high socioeconomic status: recent consumer research determined that price sensitivity among Schering users is very low. Because hormonal products cannot be advertised to consumers, Schering focuses on service providers in the public and private sector. The representative office employs 10 medical representatives, supports a hotline, and funds many workshops and conferences on hormonal contraception. Schering admittedly focuses on “converted” doctors (who are sold to the benefits of modern methods) and those serving its target group. Consequently, this company’s investment

in contraception awareness and knowledge can only have a very indirect impact on low-income or rural women and their providers.

Gideon Richter: This Hungarian manufacturer has built a worldwide reputation as a producer of high-quality generic products. In Kazakhstan, Gideon Richter markets leukemia, diabetes, and renal deficiency treatments, as well as women's health products. The company offers an extensive range of contraceptive generic brands that reflects the pace of patent expirations in the industry. Although Gideon Richter often markets products as unbranded generics, it always promotes its contraceptives as individual brands, with no emphasis on the formulation, and no reference to the originator brand. As a generic manufacturer, this company draws a substantial amount of revenue from public tenders at the city and oblast levels. The manufacturer, however, does not get involved in the actual bidding process, which is the responsibility of its distributors. According to the Gideon Richter representative, public sector tenders for contraceptives are rare and do no account for a substantial proportion of OC sales.

Innotech: This French manufacturer of topical contraceptives (e.g., cream, ovules, tampons) targets a wide range of women, although its products are probably too expensive for low-income and rural users. The Innotech representative estimates the company's core consumer group to be composed of women aged 25-35, post-partum patients, and women nearing menopause. Emulating Schering and Gideon Richter, Innotech employs five national medical representatives (detailers), and supports continuing education for general practitioners, ob-gyns, and midwives. Topical contraceptives can be advertised to the public and Innotech invested in television ads about two years ago. Its current strategy, however, is to focus on prescribing providers and to promote its product line in medical publications. Innotech has participated in UN procurement in the past, which reportedly boosted the sales of its products in the private sector. Generally, however, the company feels that the development and government community is overly biased in favor of hormonal contraception.

Organon: This Dutch manufacturer has a limited range of products on the Kazakh market but appears to be gearing up for an expansion. The company does not yet have a full-fledge representative office but employs two detailers/sales representatives who support Organon's local distributors. In a telephone conversation, the company's Moscow-based regional manager ranked Kazakhstan as one of the most promising markets in the region. Organon, however, specializes in late-generation, high-end hormonal products and will likely focus on building demand for its latest introduction, *NuvaRing*, a hormone-releasing vaginal ring. Therefore, increased marketing efforts by this company will not have much impact on the availability or affordability of contraceptive products in Kazakhstan, though they will undoubtedly increase competitive pressure on Schering, the other high-end manufacturer.

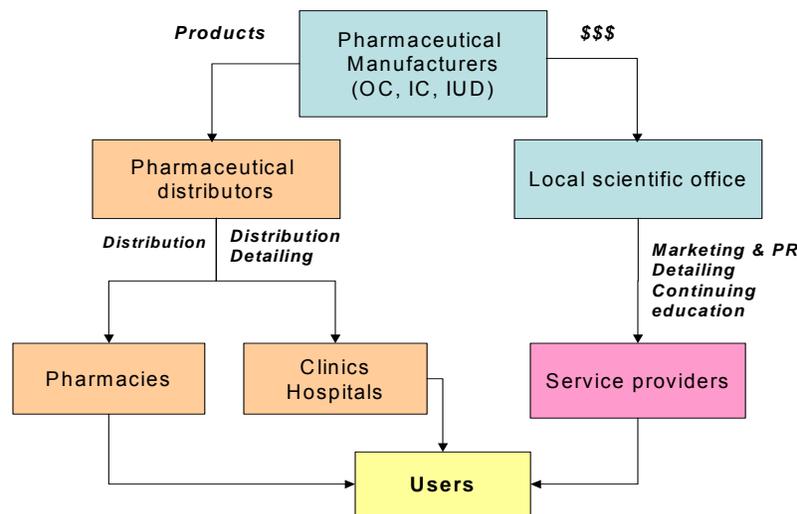
Distribution

The distribution of pharmaceutical products in Kazakhstan is fairly concentrated, with few intermediaries, moderately high industry markups (20-25 percent), and high geographical access. Pharmaceutical distributors are locally owned businesses that import, warehouse, and deliver products at the national or regional level. According to

one large Almaty-based company (Amity), there are about 600 licensed distributors in Kazakhstan but only 30 are reputed profitable. Ten major companies that focus on European or U.S.-made brands bring in about 70 percent of the drugs imported into the country. Exclusive distribution contracts with manufacturers are rare, and distributors, who may carry the same brands, compete on the basis of geographical coverage and prices. These companies seek to build large product portfolios by representing as many manufacturers as possible (some companies represent 200 or more) and aim for reputable brands in very high demand that help build clout with pharmacies.

Even when local distributors do not draw much of their revenue from rural areas, they certainly have the capacity to do so, so long as there is demand for their products. The largest companies have regional warehouses, vehicles, and sales representatives who can visit and place orders for small rural pharmacies, and some have established hotlines for rural pharmacists. If some products are not available at the rural level, it may have more to do with a lack of licensed pharmacists than with inefficiencies in the supply chain. It is even more likely to be due to low demand or inability to pay for commercial drugs. Figure 3 illustrates the current marketing and distribution cycle of pharmaceutical products in Kazakhstan.

FIGURE 3: MARKETING AND DISTRIBUTION OF PHARMACEUTICAL CONTRACEPTIVES IN THE COMMERCIAL SECTOR



Some distributors, including Medservice, Romat, and Amity, provide registration services to manufacturers that have no representation in Kazakhstan. In this case, the manufacturer is expected to make all necessary documentation available and pay for registration costs. In general, distributors have no complaints about the registration process, which takes anywhere between six months to a year. The length of this process is said to be highly dependent on a company’s ability to provide proper documentation, which is more likely to be the case when a manufacturer has a lot of experience in international product registration.

Contraceptive products do not represent a major source of revenue for distributors, although a few companies reach sales of up to \$1 million a year. The tender business is especially important for distributors (up to 60 percent of their business), and some have full departments specializing in public sector procurement. Distributors, however, can only lower prices by reducing their margin. They cannot match, for example, the very low prices companies such as Schering or Gideon Richter extend to international procurement agencies. The lower priced product goes on the distribution supply chain, regardless of the level of competition. Commercial distributors, however, may be better positioned to serve local health facilities' requirements concerning quantity, time, and delivery. As an example, one distributor was willing to bid on tenders as low as \$20,000.

Private Sector Role In Contraceptive Security

Positive Trends

The private sector is already providing the bulk of the contraceptive supply in Kazakhstan, and will continue to do so in the absence of major market distortions (such as price controls or massive product subsidization by the public sector). The private sector offers two significant advantages over a public distribution system: highly effective supply channels that reach far into the country's different regions and responsiveness to consumer demand through a wide range of products and prices. There is every sign that contraceptive manufacturers will continue to invest in the Kazakh market, which offers growth potential and a relatively high consumer purchasing power. These companies will also continue to support provider education programs and cooperate closely with the MOH because this strategy has worked very well for them.

Unmet Needs

Less positive from the standpoint of CS is the trend toward increasingly expensive products and methods, and the concentration of industry efforts on a small, educated target consumer group. Much needs to be done in the area of public education, yet the combination of advertising restrictions and low returns on investment make large-scale promotional programs unprofitable to manufacturers and distributors. Most private sector suppliers believe that the responsibility of educating the public and serving the neediest users should fall on the public sector.

Potential for New Players

New R&D Suppliers. The only major manufacturer whose brands remain conspicuously absent from Kazakhstan is Wyeth, the second largest contraceptive manufacturer in the world and a key supplier of governments and procurement agencies worldwide. It is unclear why Wyeth remains under-represented in former Soviet republics, though it is likely to be due to long-time investments in the region by Schering and the presence of Gideon Richter, a low-cost competitor marketing generic versions of Wyeth brands. It would probably take substantial increases in market size for this company to register its brands, appoint distributors, and open a representative office in Kazakhstan.

New Generic Suppliers. The 2002 *ZdravPlus* technical report on pharmaceuticals highlighted the need to educate consumers so they may “shop around” and purchase generic products (defined as lower cost copies of originator brands) whenever possible. In Kazakhstan, consumers looking for an analgesic product may ask for and find several generic paracetamol brands; physicians prescribing antibiotics commonly recommend generic Ampicillin or Amoxicillin, which are widely available in pharmacies. In the case of contraceptives, the only generic products on the market (mostly made by Gideon Richter) are branded as products that do not emphasize drug formulation. As in most countries, contraceptive users and prescribing physicians rarely request a generic formulation, such as *Levonorgestrol/Estradiol*, but refer instead to specific brand names.

The result is a market where competition is based on brand image and, to a lesser extent, price and formulation. This tends to favor companies with large brand portfolios, as well as those who have the ability to invest in marketing and provider detailing. Characteristically, Gideon Richter does not market its products generically (by emphasizing formulations and prices) but as unique brands (by positioning them as affordable, high-quality, European-made pharmaceutical products).

It can be argued that Gideon Richter’s brand marketing strategy drives up the cost of its products, and that lower priced products available on the world market could be introduced to Kazakhstan. The country’s relatively high purchasing power and low demand for contraceptives, however, do not make a compelling case for the importation of cheaper generic products, which would likely be made in Asia. In addition, such products would face the following significant market-penetration barriers:

Aggressive competition: The presence of two well-financed contraceptive manufacturers with considerable influence among prescribing physicians and pharmacists would present significant competition.

Limited clout with local distributors: Many generic contraceptive manufacturers, such as those located in Asia, produce a limited number of products, which is always a disadvantage with volume-driven distributors looking to increase their brand portfolio.

Negative perception of non-European products: Western-made products enjoy a clear advantage in the minds of consumers and providers. As stated in the *ZdravPlus* technical report of pharmaceutical prices, the introduction of generics may have to be supported by a two-pronged effort to verify product quality and promote their use (e.g., by requiring the use of generics when possible for all publicly funded medications).

Pending bioequivalency laws: These laws, which aim to regulate the quality of generic products and have been in the books since 2002, will eventually require generic manufacturers to conduct clinical studies that demonstrate the bioequivalency of their products with originator drugs. While desirable to ensure the quality and safety of the nation’s drug supply, these laws will effectively keep Asian-made contraceptives out of Kazakhstan. As a European-based company targeting developed markets, Gideon Richter has been conforming to U.S. and European bioequivalency requirements for years. In contrast, Asian contraceptive manufacturers typically focus on less regulated markets and are unlikely to invest in such studies.

Registration costs: Although current registration costs in Kazakhstan are modest by global standards (\$3,000 to \$5,000), they represent an additional disincentive for generic companies with lower profit margins that also face high market penetration costs.

CONCLUSIONS

CS has promise in Kazakhstan. The private sector has stepped into a gap created during the time period in which the public sector could not provide sufficient supplies of family planning methods. This assessment demonstrates that the private sector provides a wide range of methods and brands at consistent prices. Moreover, the private sector offers family planning methods throughout the country, even in peri-urban and limited rural areas. With increasing stock outs and dwindling supplies, the MOH and private sector pharmacies at the grassroots level have developed a working relationship where the MOH requests supplies of certain methods for its clients and the distributors and/or local pharmacies deliver them.

CS becomes an issue, however, for vulnerable population groups in Kazakhstan. Everyone interviewed, including the private sector individuals and organizations, acknowledged that private sector prices of different family planning methods may be out of reach economically for these poor and vulnerable groups. All the public sector groups interviewed underscored their concern about how to provide subsidized contraceptives to the vulnerable populations in light of increasing TARs and rising MMR. Yet, the MOH is in a good position to address these concerns. For the first time since the fall of communism, the MOH has more public funds to direct toward health priorities. Further, there is strong regional and local leadership committed to ensuring quality reproductive health and family planning services and products.

The private sector, therefore, can contribute significantly toward ensuring CS in Kazakhstan, but the public sector still needs to guarantee contraceptive supply of subsidized products for those not able to pay for their family planning methods through the private sector. The assessment team developed a series of recommendations to help the MOH assume its leadership role as the provider of health for the most vulnerable populations and strengthen its capacity to deliver the much-needed contraceptives to this group. In addition, recommendations are included for the public sector to ensure continued favorable conditions for private sector involvement in contraceptive supply and pricing.

RECOMMENDATIONS

The team proposed three general recommendations to improve CS in Kazakhstan.

- Strengthen public sector commitment to and policies on CS

- Strengthen public sector family planning commodity procurement and management at the oblast level in partnership with UNFPA and the private sector
- Maximize private sector presence and contribution

Under each of these recommendations, the team offers specific steps and actions that key groups – USAID, MOH, and private sector – can take to better ensure consistent and affordable supply of family planning products.

STRENGTHEN PUBLIC SECTOR COMMITMENT AND POLICIES

Recommendations for USAID

Stress how family planning is an important strategy to meet the MOH’s goal to improve maternal child health. Although MCH is a priority for the MOH, family planning is losing ground. Consistent support for family planning is lacking at the national level and there is little understanding of how increased access to family planning methods can help meet MCH goals. In addition, because MCH is not one of MOH’s five *funding* priorities, family planning programs and supplies do not receive sufficient funds to meet the need of vulnerable populations. Through dialogue and negotiations with the MOH, USAID can play a strategic role in helping the MOH recognize how family planning will help meet its MCH objectives.

Moreover, USAID can support the MCH Department to build the case for allocating more resources to family planning services and to purchase family planning methods for vulnerable populations. The MCH Department has proposed policy research on the following topics: 1) the definition of vulnerable population groups (who, where, how many); 2) users’ ability and willingness to pay for family planning methods; and 3) the size and magnitude of unmet need (who, where, and how many). USAID can assist the MCH Department by providing funds and technical assistance for the MOH to carry out this research and to disseminate it to the appropriate decision makers.

Encourage MOH to update MOH family planning skills and promote public health messages on the health benefits of family planning. Considerable work and progress have been made to strengthen the overall health system in Kazakhstan, but it may be time to return to some family planning basics. Under the Reproductive Health Services Expansion Program, USAID laid the groundwork for many of the successes experienced today: an increase in CPR, decrease in TAR, cultural shift in reliance on abortion as a family planning method, and greater acceptance of hormonal methods. Yet many of these successes are at risk if the MOH does not step in and reinvigorate its family planning activities. The MOH should be encouraged to update its providers’ knowledge of family planning methods, improve healthcare providers’ counseling skills to deal with side effects and discontinuation rates, and implement broad-based campaigns demonstrating the health benefits of family planning to generate demand. Through *ZdravPlus*, USAID can offer funds and technical assistance to MOH to carry out these activities.

Encourage MOH to include family planning methods in the ODBP. While the MOH works to define the 2008–2009 ODBP, effort is needed to present and champion the case for including family planning commodities and services, at least for the socially vulnerable, as part of the ODBP. The initial analysis based on earlier *ZdravPlus* and UNFPA World Bank work could be used to strengthen this case. If more analysis is needed, *ZdravPlus* could conduct additional research, which would be included as part of its recommendations for reform.

Coordinate with UNFPA on policy agenda supporting family planning. Through its advocacy initiatives, UNFPA is playing an active role in influencing and shaping the MOH's funding for family planning programs and ensuring that key policy changes occur (i.e., family planning is included in the ODBP). Both USAID and UNFPA's efforts with the MOH on funding for family planning methods would be strengthened if they joined forces and coordinated their messages and strategies to influence the MOH.

Recommendations for MOH

Support family planning programs and products as an integral part of strategy to improve maternal health and reduce abortions. Solid support exists among health managers and service providers at the oblast and rayon levels for stronger family planning programs as a means to improve maternal and child health and to reverse the trend of rising abortion rates among vulnerable population groups. Yet, these health providers do not have the tools to respond to the needs of their target population groups. The MOH should recognize the link between elevating family planning and MCH and achieving its maternal health goals, thereby making it one of the MOH's top priorities eligible for republic-level funding. Moreover, the MOH needs to emphasize that *all* oblasts should use a portion of their budgetary allocation to purchase sufficient supply of family planning products for vulnerable populations.

Permit oblasts to use budgetary allocation to purchase family planning methods for vulnerable populations. Although the private sector provides sufficient choices and supplies of family planning methods, the MOH does not have a sufficient supply to offer free or subsidized methods to those population groups unable to pay for them. The MOH still has an important role to play in offering free and/or subsidized family planning products to certain segments of its population groups. Therefore, the MOH should permit oblasts to use funds from their annual budgetary allocation to purchase these products. While national guidelines are needed on how to define vulnerable populations, local oblast health managers are best positioned to make the final decision defining their respective population groups.

Include family planning methods in the ODBP. MOH is currently defining the 2008–2009 ODBP. The MOH should extend coverage of family planning methods in the ODBP, not only for inpatient care but also for outpatient services. This will help address the shortage of family planning methods for vulnerable populations.

Refresh provider knowledge and counseling skills on family planning methods. MOH has achieved considerable success in improving MCH since the collapse of communism: an increase in CPR, decrease in TAR, cultural shift in reliance on abortion

as a family planning method, and greater acceptance of hormonal methods. Yet many of these successes are at risk if the MOH does not step in and reinvigorate its family planning activities. The MOH needs to update its providers' knowledge of family planning methods and offer an alternative source of information on contraception, improve healthcare providers' counseling skills to deal with side effects and high discontinuation rates, and implement broad-based campaigns demonstrating the health benefits of family planning to generate demand.

Raise awareness of the health benefits of family planning. High-risk women have little understanding of the health benefits of family planning. Moreover, many providers are also unaware of these benefits. The MOH needs to carry out public awareness campaigns targeted to provider and communities to generate demand for family planning services and products in general, with special focus among vulnerable population groups and those communities with high abortion rates.

STRENGTHEN PUBLIC SECTOR LOGISTICS

Decentralized health management in Kazakhstan has clear advantages as local managers better understand and respond to their clients' needs. To ensure local product availability and CS, oblast health managers need to strengthen their family planning commodity logistics function. Changes are required in how contraceptives are forecast, financed, procured, and delivered, and in the LMIS underpinning each of these logistics functions. These improvements should be implemented in partnership with the private sector and UNFPA and with support from USAID.

Recommendations for MOH

Strengthen commodity forecasts. Individual oblasts should have latitude to define their vulnerable populations and then make commodity forecasts based on 2004 consumption data – the last year of full supply in most oblasts. Training is required in forecasting techniques and using forecasting tools such as Pipeline. In oblasts where logistics data are inadequate or missing, population-based forecasts can be made using Spectrum software. USAID and UNFPA should sponsor a joint forecasting workshop to train oblast health managers in preparing Pipeline- and Spectrum-based commodity forecasts based upon different assumptions for the targeted vulnerable population. Oblast health managers should produce a financing and procurement plan defining funding needs and how and when commodities will be procured.

Improve procurement practices. There are a number of options oblasts can consider to improve the efficiency and effectiveness of their procurement practices. Working with local wholesalers will reduce the need for buffer stocks but it will increase local prices. A number of mechanisms can be considered to offset this. Framework contracts with local wholesalers should be considered so that rayons can purchase products at prearranged prices. Working with UNFPA as a procurement agent could increase access to lower international prices but would entail complications in clearing import shipments through customs.

Oblasts should review the implications of different purchasing options in terms of the prices they can obtain. Their experiences should be shared across Kazakhstan as different oblasts will have different experiences that will benefit others.

Oblast administrations should conduct market studies to determine the best procurement options available. Use of UNFPA to procure contraceptives should be considered on a pilot basis in south Kazakhstan and then rolled out once the necessary logistics distribution and LMIS are piloted. Given present import regulations, UNFPA will need to partner with local distributors who can be contracted by the oblast administration to handle customs clearance and distribution to the rayon level. Initial funding support may be required to facilitate the upfront payment for UNFPA procurement services as these require forward funding.

Recommendations for USAID

Improve procurement practices. USAID should support the exchange of information on procurement prices and practices including the local development of Internet-based exchange of information on family planning prices. The *ZdravPlus* project supported pharmaceutical pricing work in Karaganda and provides a model that could be expanded to other oblasts. USAID could also support documentation and dissemination of local procurement best practices including the Karaganda framework contract. Negotiating delivery by local distributors to the service delivery point should also be considered.

Strengthen distribution and LMIS. A two- or, at most, three-tier distribution system should be considered to minimize the length of the product pipeline. A simplified LMIS reporting system, including the elements indicated in the sample form in Annex C, should be introduced with explicit use of maximum and minimum stock levels. USAID and UNFPA should consider sponsoring training for oblast health managers in using an LMIS and in logistics management, including how to calculate monthly consumption and analyze stock levels to keep within maximum and minimum levels. The south Kazakhstan pilot should be rolled out with possible support from *ZdravPlus* or other USAID support. Oblast health managers should apply the LMIS and rationalize local distribution including using private sector for delivery to service delivery points.

MAXIMIZE PRIVATE SECTOR PRESENCE

Recommendations for USAID

Encourage the MOH to continue favorable policies. The current policy environment in Kazakhstan is highly conducive to private sector expansion in the pharmaceutical field. In the absence of price controls, manufacturers can earn satisfactory returns on the registration and marketing of new brands. Low taxes and import duties make it attractive for local distributors to expand their portfolios and build economies of scale. There is therefore *no need for major changes in regulations or government policies*. Because Kazakhstan is a sophisticated consumer market, the private sector can be relied upon to quickly bring to market innovative products developed by contraceptive manufacturers if the public sector does not over-regulate or interfere.

Monitor the availability of low-cost products in the private distribution. The current industry emphasis on high-price brands does not preclude commercial suppliers from offering low-price products, as evidenced by the widespread availability of *Rigevidon* in pharmacies. The continued availability of such a product is key to the country's CS and should be monitored. One factor that might lead to its removal from the market would be a sudden influx of low-price OCs in the public sector in areas where users have been obtaining their methods in pharmacies. In the event that low-cost OC or IUD brands should disappear from pharmacies, every effort should be made to identify new generic suppliers and encourage them to register and sell their products in Kazakhstan through a local distributor.

Invest resources in demand-side activities and limit supply-side interventions to low-income or underserved populations. The private sector cannot be reasonably expected to invest in developing informed demand among nonusers, particularly low income or rural groups. It also cannot be expected to promote products that are easily available in the public sector (such as copper-T IUDs) or face provider opposition (such as opposition to injectables). To be profitable, manufacturers and distributors must concentrate on expanding the sale of best-selling brands to their core consumer group, which appears to be the urban and educated population. What may encourage commercial suppliers to provide more affordable products or a wider choice of methods (by offering more brands of injectable contraceptives for example) is simply increased demand for such products. USAID can elect to invest available resources in increasing demand through consumer-directed campaigns, particularly in underserved areas. Private sector companies, which face legal limitations on advertising, may be willing to complement these efforts by increasing their provider-directed activities or expanding their rural distribution.

Recommendations for MOH

Maintain current legal and regulatory environment governing private sector provision of family planning products. The MOH is moving to bring the pharmaceutical sector in line with current practices of those in Europe and the United States. Although MOH should continue along this path, it also must monitor these reforms to determine any negative impacts such policies would have on private sector supply of family planning (other health products). Currently Kazakhstan has a vibrant private sector offering a wide range of family planning methods at different price ranges; over-regulation would only serve as a disincentive to the private sector.

Ensure that subsidized products do not compete with affordably priced products offered through commercial channels. The assessment team does not recommend MOH provide free products indiscriminately in urban areas. Subsidized contraceptives, however, may be necessary in rural, low-income areas, where commercial distributors can participate in oblast-level tenders. Although precise targeting of subsidy recipients is always difficult, most public sector clinics that receive subsidized contraceptives are able to identify vulnerable populations (such as low-income women or at-risk youths). Public sector doctors should also be trained to refer patients who can pay to commercial pharmacies, and describe the different methods and brands available at various prices.

Ensure that providers receive unbiased information about family planning methods.

Detailing and training efforts providers receive from pharmaceutical companies, which tend to favor high-priced OCs, should be supplemented with independent, objective contraceptive updates on the full range of methods and formulations available in pharmacies. This training can be conducted in partnership with pharmaceutical suppliers but should also provide information about safe, low-cost hormonal contraceptives, as well as IUDs and injectables, which the private sector rarely promotes.

Favor affordably priced formulations in public sector clinics. A continued shift by users to newer formulations of OCs could negatively affect the availability of affordably priced products through the private sector. Such a shift may, for example, lead to a complete discontinuation of *Rigevidon* and would be of concern since many users may not be able to afford more expensive brands. The medical community can help ensure continued demand for this product through unbiased patient counseling. Another effective way to ensure market demand is to include second-generation, low-dose OCs, which are considered to be the safest, most effective, and affordable worldwide, in all contraceptive tenders. Large tenders for the *Rigevidon* formula may also trigger interest from generic manufacturers in Asia that specialize in this formulation.

CONTRACEPTIVE SECURITY IN THE CENTRAL ASIAN REPUBLICS: KYRGYZSTAN

EXECUTIVE SUMMARY

POLICY CONTEXT

Although the economic situation in Kyrgyzstan has deteriorated steadily since the early 1990s, public expenditures for health have continued to grow since 2003. Further increasing public resources for health, however, presents a challenge to the government of Kyrgyzstan (GOK). In an effort to pool more resources for health and to address households' high informal health payments, the GOK introduced mandatory health insurance (MHI) and formal copayments, which vary by type of patient and service rendered.

It is significant that the draft of the reproductive health strategy examined contained no mention of contraceptive security (CS). The danger in this is that clients will become unaware of the availability of contraceptives since it is assumed that they get their products through the Additional Drug Package (ADP). In fact, clients hardly use the ADP to fund their contraceptive needs and the reasons for this should be examined. The availability of donated humanitarian products may be an explanation.

The GOK should demonstrate its commitment to CS by designing a comprehensive CS strategy, including a CS transition plan and CS sustainability plan. It is imperative that long-term contraceptive financing for CS sustainability be incorporated as part of the health insurance system combined with private market purchasing. Moreover, the United Nations Family Planning Agency (UNFPA) should take the lead in helping the Ministry of Health (MOH) identify funding options for a provider remuneration system. The Contraceptive Working Group (CWG) should meet regularly to review progress towards strategic reproductive health goals and to track the availability of financing for contraceptives.

A 2004 study found that contraceptive use remained low in both rural and urban areas, with approximately half of women of reproductive age using contraception. The study also found that more than half of respondents purchased condoms in pharmacy outlets.

Private sector suppliers in Kyrgyzstan currently serve a very small percentage of the population. This can be attributed to low demand and the availability of humanitarian aid commodity donations. The GOK could increase private sector participation in improving CS by including contraceptives in local drug procurement tenders and controlling leakage of donated commodities in the commercial sector. Educational and/or social marketing programs will also help stimulate overall demand for contraceptives.

Kyrgyzstan has a nascent accreditation process but currently there are few private institutions or doctors to accredit. Family Group Practices (FGPs) are structured to compete with each other for clients and revenue and, therefore, may be thought of as quasi-private. However, it appears that approval to establish commercial health enterprise on a broader scale will unlikely be forthcoming.

In contrast with Kazakhstan, where the contraceptive market is almost entirely private, Kyrgyzstan receives substantial quantities of donated products, notably through UNFPA, USAID, and the Global Fund. Products imported under humanitarian aid programs are exempt from certain regulations. In particular, they do not have to be registered with the MOH and do not need to be tested for safety or quality. Some donated products, particularly condoms, find their way into the commercial supply through the black market.

PUBLIC SERVICES AND DISTRIBUTION

Family planning counseling is well established in public primary health care (PHC) facilities in both urban and rural settings. Providers say that clients are well informed about their options. Family physicians with a background in gynecology take on the role of specialist in this area while other providers report feeling uncomfortable about providing family planning methods. Site visits conducted by the team suggest that provision of this service varies according to doctors' comfort level in providing family planning services. It is evident that continuing education and monitoring of family planning service provision is needed. This may account for the variation in the contraceptive prevalence rate (CPR) by regions. There are no specific performance targets and physicians seem unconcerned about the increasing CPR. When supplies are unavailable, providers ration products to clients or refer them to pharmacies. The Reproductive Health Center (RHC) in Issyk Kul, which provides family planning services, considers its staff to be more professional and regards PHC providers as competitors. Since the RHC distributes contraceptives to primary care providers, a conflict of interest exists, leading to some irrational decisions in the distribution of humanitarian aid. This has contributed to shortages of commodities at the PHC facilities.

The MOH distributes donated "humanitarian" contraceptives from a central warehouse through a four-tiered system operating on a "push principle." The majority of these contraceptives are dispensed at PHC facilities. The Republic Health Information Center operates a logistics management information system (LMIS) that provides information on the number of consumers (by method) receiving contraceptives at MOH facilities. Deliveries between tiers are quarterly. To minimize stockouts, tiers should have minimum stocks of 3 months and maximum stocks of 6 months. No maximum or minimum stock levels are set in the LMIS. The team visited a small sample of 14 service delivery sites with contraceptive stocks in Bishkek and Issyk Kul oblast to assess the general state of contraceptive management. Four sites were stocked at appropriate levels. The remainder had either excessive or insufficient stocks, which would be highlighted if maximum and minimum levels were formally set.

As a result of these visits, the team found public facilities had ample supplies of IUDs, injectables, and male condoms, but less availability of oral contraceptives. (Contraceptives are included in the National Essential Drug List (NDL) and ADP.) Using UNFPA prices, the annual cost of contraceptives is nearly \$210,000 including procurement and internal distribution costs. Given the four-tiered distribution system, however, to completely fill the pipeline with maximum levels of contraceptives at each level would require 30 months of consumption. The cost of optimizing contraceptive

distribution would therefore be closer to \$500,000 as a one off cost. The actual amount needed would be less because of products that are already available and in the system. Funding for contraceptive needs appears to be sufficient only through 2006. The CWG should address and monitor this through a finance and procurement plan.

PRODUCT SUPPLY

Condom brands found in Kyrgyzstan pharmacies are very similar to those sold in Kazakhstan. A much wider variety of condoms are available outside of pharmacies at prices as low as US\$0.04 per condom. As in Kazakhstan, condoms are distributed through distributors of pharmaceutical products and fast-moving consumer goods but nongovernmental organizations (NGOs) play a larger supplier role in this country. Many low-price brands are imported from China, India, and Thailand. A large number of condoms provided as part of humanitarian aid programs in and outside Kyrgyzstan also find their way into the so-called black market.

Oral contraceptives (OCs) represent the bulk of hormonal contraceptives sold in Kyrgyzstan. There appears to be very little demand for and supply of the 3-month injectable, *Depo-Provera*. New hormonal methods, such as the hormonal patch and vaginal ring, are not yet available in Kyrgyzstan.

Pharmacies in Bishkek offer a wide range of brands and prices, including both late-generation products and high dose OCs that are no longer found in many countries. Unlike the Kazakhstan market, prices offered in Bishkek pharmacies vary widely, which may be due to irregular supply and/or variations in consumers' ability to pay. Kyrgyzstan does not have as efficient a distribution system as Kazakhstan, as evidenced by the presence of a black market where drugs can be found that are not sold in registered pharmacies, or are too expensive for average users.

Marketing and Distribution

Only two manufacturers have a local representative office in Kyrgyzstan: Gedeon Richter and Innotech. Schering brands do not enjoy the same popularity in this market as they do in Kazakhstan. Gedeon Richter is the only contraceptive manufacturer whose brands have been included on the list of products covered under the Health Insurance Fund's (HIF's) Additional Benefits Package. Although this company draws the bulk of its revenue from products other than contraceptives, it has a strong commitment to women's health. Gedeon Richter and Innotech focus on promoting their products to providers through personal visits, workshops, and continuing education.

There are about 20 pharmaceutical distributors in Kyrgyzstan but a few large companies dominate the market. These companies have substantial marketing capacity, which is a competitive advantage because few manufacturers can justify having their own representative office in this small market. Distributors interviewed for this assessment do not draw a significant amount of revenue from contraceptives but seem to agree that the market is growing. They do not currently import IUDs because these products are distributed through humanitarian programs and are assumed to have limited sales potential.

As in Kazakhstan, city and oblast-level tenders are a large part of the distribution business but contraceptives are not usually included in these tenders. The HIF's Additional Benefits Package does not appear to have a significant impact on the private sector contraceptive business, and two of the four brands covered under this plan are being discontinued. Distributors seemed more favorable to increased funding for local tenders than centralized insurance or procurement schemes.

Private Sector Role in Contraceptive Security

Private sector manufacturers respond to existing demand for OCs and condoms. Only Gedeon Richter and Innotech have invested in long-term marketing, suggesting that the bulk of the private sector supply will center on OCs and topical contraceptives for some time. The current demand for injectables and IUDs does not support large imports of these products by private distributors.

Unlike the demand for condoms, which is spread among various socioeconomic groups, the demand for hormonal products is still nascent and tends to come from the most educated and wealthiest users. As a result, the current supply of OCs in Kyrgyzstan responds to this group's preferences and ability to pay. In the absence of population-based research, it is not possible to make a definite statement about OC affordability for a wide range of potential users in Kyrgyzstan.

There appears to be no quality concerns about the OC supply because most of these products have been approved for distribution in the United States, the European Union, and other countries with stringent regulations and testing requirements. The condom supply, in contrast, involves manufacturers in countries with less stringent regulatory environments, such as India and China. In particular, unregistered donated condoms and smuggled condoms sold on the black market may represent a health risk.

Potential for generic suppliers

In contrast with Kazakhstan, where demand for contraceptives appears to dictate cost, Kyrgyzstan may offer opportunities for low-cost generic manufacturers to sell their products. These manufacturers may be able to pursue both the tender and pharmaceutical business by appointing one or several local distributors in Kyrgyzstan.

Currently, the most significant disincentive for these companies is the very low demand for OCs in the private sector, together with the absence of any significant contraceptive tenders. Unless there is a significant increase in demand for these methods, new, low-cost suppliers will not emerge in either the public or private sector; therefore, Kyrgyzstan could greatly benefit from a social marketing program to increase the use of family planning methods. Such a program could be combined with a partnership with a low-cost generic supplier, since the latter would be unlikely to enter the market without a committed local partner. Two organizations that could potentially partner with generic manufacturers in Kyrgyzstan are PSI and the Alliance for Reproductive Health, an affiliate of the International Planned Parenthood Federation.

RECOMMENDATIONS

The GOK needs to fully fund the health budget as planned. Explicit reference to CS should appear in the reproductive health strategy and attention given to working out a phase-out plan as funding switches from donor to ADP funding. Donors can support this process by participating in the CWG and providing technical assistance to support GOK monitoring efforts. The GOK should evaluate the Additional Drug Benefit (ADB) reference pricing and rural populations' access to family planning methods. A forecast analysis is required and needs to take account of capitalization requirements. Improvements to the LMIS are also required to ensure product stocks remain between maximum and minimum levels.

Table 15: Summary of recommendations

Action	Government	Donor	Private Sector
Policy	<ul style="list-style-type: none"> ▪ Include CS in RH Strategy ▪ Fully fund and increase health expenditure ▪ Enhance RH representation in Manas Taalimi ▪ Improve ADB coverage 	<ul style="list-style-type: none"> ▪ Donors support and coordinate with Government 	<ul style="list-style-type: none"> ▪ Coordinate with public sector
Forecast	<ul style="list-style-type: none"> ▪ CWG develop more detailed forecasts ▪ Factor in full pipeline requirements 	<ul style="list-style-type: none"> ▪ Donors participate 	
Finance	<ul style="list-style-type: none"> ▪ Develop finance and procurement plan ▪ Define transition plan to ADB ▪ Ensure reference prices are defined 	<ul style="list-style-type: none"> ▪ Donors support transition plan ▪ Support analysis of ADB 	<ul style="list-style-type: none"> ▪ Households contribute co-payments ▪ Negotiate ADP reference prices
Procure	<ul style="list-style-type: none"> ▪ Use UNFPA for procurement of IUDs and Depo- Provera in the short term and then switch to private sources ▪ Procure public OCs form local distributors adopt framework contract ▪ QA on donated condoms 	<ul style="list-style-type: none"> ▪ GFATM procure condoms and agree to QA checks 	<ul style="list-style-type: none"> ▪ Pharmacies supply OCs and condoms as part of ADP ▪ Local distributors respond to tenders
Delivery	<ul style="list-style-type: none"> ▪ Introduce and monitor maximum and minimum stock levels at each level ▪ Monitor losses and adjustments and logistics system and address identified problems 		<ul style="list-style-type: none"> ▪ Pharmacies
Demand and Service	<ul style="list-style-type: none"> ▪ Conduct IEC and provider training 	<ul style="list-style-type: none"> ▪ Support IEC and provider training 	

KYRGYZSTAN FINDINGS

HEALTH FINANCING AND POLICY OVERVIEW

Since the early 1990s, the deteriorating economic situation has undermined the Kyrgyz health financing system. Several drastic reductions in public financing have occurred, with the latest being the severe underfunding in 2000-2003. This has challenged the system's ability to protect the population from the costs of illness. The Kyrgyz Republic has low public expenditures on health. Public resources for health declined from 3 percent of the gross domestic product (GDP) in 1996 to 1.8 percent in 2004 (World Bank Project Appraisal, 2005).

The introduction of MHI in 1997 and out-of-pocket (OOP) population copayments in 2001 was intended as a means of mobilizing and pooling more resources for health. During the period 2000-2003 payroll taxes for MHI and OOP payments indeed did contribute to an increase in resource mobilization for health care expenditures. Total spending as a share of GDP increased from 4.4 percent in 2000 to 5.3 percent in 2003 (see Table 16).

TABLE 16: PUBLIC-PRIVATE SHARES AND TOTAL EXPENDITURES

	2000	2001	2002	2003	Annual average growth rate
As share of GDP					
Budget	1.9%	1.7%	1.9%	1.8%	-0.9%
MHIF	0.2%	0.2%	0.2%	0.4%	23.0%
Private	2.3%	2.6%	3.0%	3.2%	11.8%
Total	4.4%	4.4%	5.1%	5.3%	7.0%
As share of total health expenditures					
Budget	42.2%	38.5%	36.8%	34.0%	-6.5%
MHIF	4.9%	4.0%	4.3%	6.8%	13.2%
Private	53.0%	57.5%	58.9%	59.3%	4.0%
Total	100.0%	100.0%	100.0%	100.0%	0.0%
Per capita health spending nominal (in som)					
Budget	247.5	255.7	283.1	300.6	7.2%
MHIF	28.5	26.9	33.4	60.0	36.8%
Private	310.8	382.0	453.2	524.4	22.9%
Total	586.8	664.6	769.7	885.0	16.9
Per capita health spending real 2000=100 (in som)					
Budget	247.5	243.2	263.6	286.3	5.2%
MHIF	28.5	25.6	31.1	57.1	33.5%
Private	310.8	363.4	421.9	499.4	20.2%
Total	586.8	632.2	716.6	842.8	14.5%

Adopted from Policy Research Paper № 31, WHO/DfID Health Policy Analysis Project, 2005, p.19.

In 1997, to overcome severe health budget shortages, the GOK introduced MHI to complement revenues from general taxes. A purchaser-provider split was introduced with contracts established between the Mandatory Health Insurance Fund (MHIF) and health care provider organizations. More importantly, a single-payer system administered by MHIF has been evolving in the Kyrgyz Republic since 2001. In 2006, previously pooled funds at the oblast level became possible at the republican level. In 2001-2004 in the context of high informal payments by households, the GOK introduced formal copayments, including the outpatient drug benefit (ADB). Currently, the population pays for services and commodities in three ways: copayments, full charges, and private transactions. Clients pay a copayment for outpatient specialist services, hospital admissions, and prescriptions from ADB. Copayments vary for patients of different social, insurance, and health status. They also vary for services with and without referrals and for admissions with and without surgeries. There are low or no fees for exempt groups and higher fees for the uninsured. The uninsured typically pay 30 percent to 50 percent more than the insured, while patients without referrals pay more than twice the amount of the insured. Once copayment for outpatient drugs becomes an option to finance contraceptives, it will be important to determine the present exemption system's shortcomings in protecting the poor. The Household Survey (2004) revealed that population exemption categories are not well targeted toward the poor. The exempt and non-exempt have the same mean OOP consumption of services and drugs.

Although public expenditures for health have been growing since 2003, further increasing public resources for health presents a key challenge for the GOK. Budget execution has a history of irregular and insufficient transfers from the Social Fund and republican budget. In 2003-2004 the Social Fund repaid KGS \$109.9 million of its debt to the MHIF, both in cash and via clearings (Meimanaliev A-S 2005). Transfers to the MHIF from the republican budget improved from 53.7 percent in 2001 to 86.2 percent in 2004, but this still represents an underpayment.

Trends in Contraceptive Use: A Blurry Picture.

Sample survey and service statistics together provide a mixed picture of trends in contraceptive use in Kyrgyzstan.

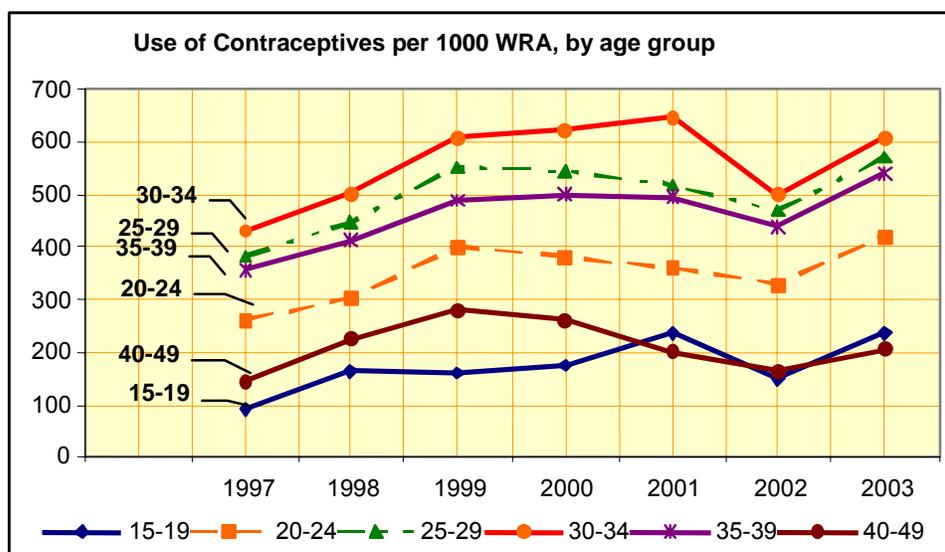
Table 17 below shows the preliminary results from the Multi-Indicator Cluster Survey (MICS) conducted in 2005. The overall drop in use of all methods among married women of reproductive age (MWRA) suggests a possible substantial falling off in the use of traditional methods that warrants further investigation. Modern method use has also dropped, although it is not clear at this time whether the difference is a statistically significant one.

TABLE 15: CONTRACEPTIVE PREVALENCE BY METHOD, MWRA, 1997 AND 2005

	1997 – DHS	2005 - MICS
Contraceptive Prevalence Rate, all methods	60	47.6
Contraceptive Prevalence Rate, modern methods	48.9	45.3
Female Sterilization		0.9
OCs		4.8
IUD		31.9
Injectable		1.2
Condom		5.9
LAM		0.7
Abstinence ⁶		0.5
Withdrawal ⁷		0.8

Yet, these results are contradicted by the findings of a 2004 study conducted by researchers from HIF and UNFPA on contraceptive use and forecasting using data available at the Republican Health Information Center (RHIC) of the MOH. They concluded that use of contraceptives was increasing among all (married and non-married) women of reproductive (WRA). Use increased among those ages 25-29, from 260.4/1000 in 1997 to 400.5/1000 in 2003, as shown in Figure 4.

FIGURE 4: USE OF CONTRACEPTIVES PER 1000 WRA, BY AGE GROUP



IUDs remained the most prevalent family planning method in 1997-2003. According to the 2005 MICS preliminary results, IUDs, which are used by almost one out of every three MWRA, continue to be the most widely used contraceptive method of any kind.

⁶ Counted as a modern method.

⁷ Counted as a modern method.

Condom increased over the 1997-2003 period and is estimated at close to 6 percent by the 2005 MICS. OCs use did not change significantly between 1997 and 2003; the MICS estimates that only about one percent of MWRA use this method.

At the time of this writing the final results of the MICS study were not available. We therefore reference here the results from the 2004 conducted by HIF. Some key findings from that study include:

- CPR among WRA reaches 499.2/1000 in urban and 464.9/1000 in rural areas, higher than documented by official statistics at 400.5/1000.
- CPR among MWRA is 606.5/1000, and it is higher in urban (710.9/1000) than in rural (453.0/1000) areas.
- As much as 96.6 percent of respondents believe contraceptives are accessible (affordable), and 57.8 percent believe that sufficient information about contraceptives is available.
- As much as 64.9 percent of respondents purchase condoms in pharmacy outlets, 20 percent received them from FGPs (97 percent received them free of charge and 3 percent paid providers 2 to 10 som).
- Among users of hormonal methods, 61.7 percent received them in FGPs, 27.7 percent purchased them in pharmacy outlets, and 10.6 percent, in the market. As much as 88.8 percent of respondents received OCs from FGPs free of charge, the rest paid from 15 to 50 som.
- Among female respondents using IUDs, 83.1 percent received them free of charge, and 16.9 percent paid from 15 to 200 som.
- Among women who use injectable methods, 74 percent responded they had obtained them free of charge, and 16 percent paid from five to 100 som.

Public Sector Family Planning Services

Based on visits to Issyk Kul facilities, the team determined that family planning counseling is well established in public PHC settings: urban and rural family medicine centers, FGPs, and rural feldsher stations routinely offering consulting and various contraception methods. According to providers, clients are better informed about family planning and more involved during counseling, and many have adopted modern contraception into their lifestyle. While rural women have become more active in using modern contraceptive methods, they tend to make decisions in relation to availability of humanitarian aid options.

While all family physicians can typically counsel outpatient clients, a “specialist” role is given to a family physician with a background in gynecology. This family doctor usually is the head of the family planning unit; he or she receives clients with health risks, assists clients that require manipulations (e.g., IUD inserts), and is responsible for family planning data collection in the clinic. PHC providers stated that family physicians vary

in their confidence of their family planning skills. PHC providers who are former gynecologists remain the most confident, while others seek their advice and direct involvement when necessary. Pediatricians often feel uncomfortable providing family planning methods. Apparently, because of staff shortages, family planning receives less attention in PHC facilities. The team visited a rural feldsher station that had a midwife who provides family planning services using supplies from humanitarian stock. While she is able to insert IUDs, such training was received from a relative (physician-gynecologist) outside the formal training process or system.

Rural providers at the visited sites expressed their concerns about the lack of information regarding the effectiveness and safety of contraceptives supplied by humanitarian sources. Referring to observations made by their clients, they consider the use of OCs and injectables (*Depo-Provera* in particular) to be risky. Without regular and easy access to sources of professional guidance and advice, rural providers feel less confident in providing family planning.

On-site findings about contraceptive coverage suggest that CPR varies greatly across the regions and facilities: there are no explicit performance targets conveyed to providers, and providers are not very concerned about improving CPR. During contraceptive shortages, providers ration the contraceptives (provide them mainly to risk groups), prescribe clients to purchase them at private pharmacies (retail outlets), and emphasize use of natural methods.

The Issyk Kul Oblast Reproductive Health Center also provides family planning services, and considers its staff to be more professional in this field than PHC providers, having the advantage of offering inpatient services (e.g., sterilization). Interviews with the center's staff suggested that reproductive health specialists would like to have a greater role in family planning, consider PHC to be a direct competitor, and seek various opportunities to attract more clients from the PHC. As a distributor of UNFPA humanitarian contraceptives, the health center appears to have made some irrational decisions that have led to shortages of contraceptives in PHC sites while securing stocks of contraceptives for the center's own use. This can be viewed as the manifestation of a broader primary-secondary care reform attitude: specialists express their desire to protect against PHC-driven reform, not well integrated into the system, and seek clarity about their role in it.

Policy Issues Affecting Private Sector Contraceptive Products and Services

Commercial Contraceptive Products. Unlike Kazakhstan, where the commercial market for OCs is well developed, the few percent of Kyrgyz women who use OCs seem to be supplied largely through donor sources. Gideon Richter, the principal supplier of commercially available contraceptives in Kyrgyzstan, reported annual sales of only 6,000 cycles. With such low demand for commercial products, regulatory issues regarding contraceptives are not a concern. Registration procedures are standard and not unduly burdensome, although because of low levels of demand, no contraceptives have been registered recently. Donors have taken on the responsibility for quality control in contraceptives. UNFPA is supporting condom testing to address concerns regarding the uneven quality and many different condom products on the market. The GOK currently

lacks the regulatory structures needed to support a larger commercial contraceptive market.

Imported contraceptives are subject to excise taxes; however, social marketing products, such as PSI's *Favorite* condom, are not well understood by local authorities that seek to treat them like fully commercial goods.

As is true throughout the region, brand-specific advertisement of contraceptives is not permitted using mass media channels. However, promotion of contraceptive use or of particular methods is permissible. Brochures and posters may be displayed within pharmacies.

For-profit and private contraceptive services

Few private providers exist in the republic of Kyrgyzstan. The Alliance for National Reproductive Health, the Krygyz affiliate of the International Planned Parenthood Federation Association, provides contraceptive training and promotion, especially targeted to youth, but provides clinical services through clinics operated by NGO partners.

The Family Group Practice Association (FGPA) was first established in 1998 with the objective of advocating PHC reform for FGPs in Kyrgyzstan. The FGPA has also provided clinical contraceptive training to physicians working in family medicine. Because *ZdravPlus* is not yet registered in Kyrgyzstan, the FGPA receives USAID-donated contraceptives and distributes them in the pilot sites where the project is working. The FGPA is represented both on the ADB board and in the Manas Taalimi principal meetings.

FGPs are structured to compete with each other for clients and revenue and, therefore, may be thought of as quasi-private. Although family physicians working in FGPs are intended to be able to provide IUD services, during site visits in Bishkek the team found that only family physicians that had specialized training in obstetrics and gynecology were providing the service. The FGPA also noted that this was standard practice. While this practice would not affect availability of IUD services in Bishkek where trained obstetricians and gynecologists are relatively abundant in the public health service, it could restrict access to this popular method in more remote regions.

Kyrgyzstan has a nascent accreditation process but currently there are few private institutions or doctors to accredit. One private provider with whom the team met had been granted special dispensation to set up a truly private and independent clinic and hospital. However, it seems unlikely that approval to establish commercial health enterprises would be granted on a broader scale soon.

KYRGYZ PUBLIC SECTOR SUPPLY CHAIN

Overview

The mix of contraceptive methods authorized for use in Kyrgyzstan includes 26 products: two condoms, 11 oral contraceptives, three IUDs, three injectable contraceptives, three barrier methods, three spermicides, and one implant. Of this number, six generic types are widely distributed through the MOH's services delivery system. They are male condoms, female condoms, injectable contraceptives, combined oral contraceptives, progestin-only oral contraceptives, and IUDs.

Kyrgyzstan has seven oblasts and two main cities. The oblasts are divided into 48 rayons, or about seven per oblast. Within this administrative framework, the MOH's services delivery system dispenses contraceptives from a central warehouse through a network of 1,128 clinical facilities, including hospitals and various PHC facilities such as family medicine centers (FMC), independent FGPs, and feldsher/midwife points (FAP). Tucked within the FMCs are 670 FGPs. The distribution of these facilities by oblast is given in Table 16. A few contraceptives are dispensed at the hospitals for nonfamily planning purposes, but the majority is dispensed at the PHC facilities.

TABLE 17: DISTRIBUTION OF CONTRACEPTIVE DISPENSING POINTS BY OBLAST

Oblast	Inpatient hospitals	FMCs	FGPs within FMCs	Independent FGPs	FAPs	
Kyrgyz Republic	145	85	670	31	867	
Republican facilities	21	.-	.-	.-	.-	
Bishkek city	10	19	94	.-	.-	
Osh city	3	7	40	.-		7
Batken oblast	11	8	84	.-		72
Jalalabat oblast	42	14	136		2	161
Issyk-Kul oblast	9	7	42		14	109
Naryn oblast	6	6	43		2	72
Osh oblast	22	9	110	.-		232
Talas oblast	8	5	31		5	48
Chui oblast	13	10	90		8	166

Source: Republican Health Information Center

Contraceptive Availability

Since 2000, UNFPA has been the primary supplier of contraceptives to the MOH. USAID-provided contraceptives have recently arrived at the warehouse and are intended to be supplied to pilot and roll-out sites for the *ZdravPlus* Project's family planning activities in five oblasts. The MOH is considering a plan to withdraw and redistribute non-USAID contraceptives in those oblasts. Both the UNFPA and USAID supplies are stored at the Department of Drug Provision's warehouse in Bishkek. UNFPA has made projections for annual consumption. Using these figures, Table 18

shows the quantities currently in stock from each of these donors, the average monthly consumption, and the number of months of stock for seven products.

TABLE 18: CONTRACEPTIVES IN STOCK AT THE CENTRAL WAREHOUSE

Contraceptive	UNFPA	USAID	Total	Monthly consumption	Months of stock
Male condom	2544953	1754600	4299533	250423	17
Female condom	0	0	0	282	0
Injectables	59643	20841	80484	3542	23
OC combined	53318	64350	117668	25000	5
OC pro only	19564	0	19564	2785	7
IUD C-T	64761	46906	111667	2584	43
IUD Multiload	26180	0	26180	3338	8

Source: UNFPA and USAID Missions to Kyrgyzstan

There are ample supplies of male condoms and IUDs, which account for 35 percent of the country's 39 percent CPR. The same is true for injectable contraceptives, which account for 1.5 percent.

OCs, which account for 2 percent of the CPR, are in very short supply. However, there may be a little more time to solve the OC shortage than Table 17 indicates. For male condoms, female condoms, injectables, and IUDs, UNFPA based its calculations on actual consumption for 2005. For OCs, however, the agency projected the monthly average consumption to be twice the amount consumed in 2005, that is, 27,785 cycles per month in place of 14,490. If the lower actual consumption figure is used, the estimate for months of stock rises from about six months to about nine. In addition, the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) provides both male and female condoms for control of HIV and sexually transmitted diseases. GFATM provides on the order of 10.5 million condoms per year. These are stored and distributed separately.

Procurement

Product Selection. Kyrgyzstan has an NDL containing 295 products, including contraceptives. In addition, there is a list of drugs available for purchase at a discount in authorized retail drug stores for people covered by the HIF's ADP. Contraceptives are included on the ADP list. The National Drug Committee (NDC), which has 30 members from the various medical specialties, revises the NDL every two years. As part of this process, the NDC sends questionnaires to health care facilities requesting input from their therapeutics committees. The ADP is revised according to need and may change from year to year.

Financing Contraceptives. As noted above, contraceptives are currently financed through donations from UNFPA, USAID, and GFATM. In addition, consumers purchase a very small amount through the HIF's ADP. The estimated annual cost of contraceptives dispensed through the public sector supply chain is \$181,770. Adding a 15 percent margin for transport gives an estimated annual landed cost of \$209,035. If, however, the monthly average for OCs is lowered, based on the discussion above, then

the annual cost would be about \$177,990. Adding 15 percent gives an estimated landed cost of \$204,688.

The discussion that follows addresses the four-tier distribution system: central, oblast, rayon, and clinical facility levels. Deliveries between tiers are quarterly. To absolutely minimize stockouts, the clinical facility, rayon, and oblast tiers should have minimum stocks of 3 months (one delivery interval) and maximum stocks of six months (two delivery intervals). If procurements are annual, the central warehouse needs at least 12 months. In sum, to completely fill the contraceptive pipeline, up to 30 months of stock are required.

The purpose of this digression is to point out that the investment required for optimizing contraceptive distribution is more than the cost of one year's consumption, that is, \$204,688. It may be up to two and one half times that sum, equaling \$511,720. The actual amount required will depend on how much stock is in the pipeline now and the minimum and maximum stock levels. These levels could be lowered somewhat if managers are diligent in spotting and correcting stock outs and procurements are managed efficiently and reliably. They could also be reduced if the number of tiers in the distribution system were reduced to three.

Based on interviews and documentation provided by UNFPA, USAID, and GFATM, the estimated donor financing for the five years beginning in 2006 is given in Table 19. Not considering the GFATM funding for condoms, which are distributed primarily through NGOs, it appears there will be significant deficits for every year after 2006.

TABLE 19: KNOWN FINANCING FOR CONTRACEPTIVES FROM 2006 THROUGH 2009

Donor	2006	2007	2008	2009	2009
UNFPA	\$52,000	\$52,000	\$52,000	\$52,000	\$52,000
USAID	\$271,000				
GFATM*	\$315,000	\$315,000	\$315,000		

Source: Interviews and documents provided by UNFPA, USAID, and GFATM staff.

* Condoms only.

Contraceptives. The RHIC operates a health information system that provides information on the number of consumers receiving contraceptives, according to method, at MOH facilities. The RHIC also operates LMIS for contraceptives. National reproductive health staff use this information to quantify quantities for UNFPA to procure from its suppliers. Two developments that should positively affect CS, and budgeting and procurement, are the formation of a CWG and the compilation of a reproductive health strategy.

Based at the RHIC, the working group consists of the MOH, UNFPA, USAID, WHO, KfW, GFATM's Project Implementation Unit (PIU), and City Hope. At this point, the

group's aims are only vaguely defined by members' common interest in contraceptives. It has met only once and has yet to draft a work plan.

The draft of the formal Reproductive Health Strategy contained no mention of CS or any hint at the role it plays in reproductive health. The list of indicators appended to the document contains nothing for contraceptive management.

Essential Drugs. Drug procurement is more complicated than simply procuring contraceptives. A number of different mechanisms, which parallel the five funding methods, are involved:

The Department of Drug Provision manages MOH's central procurement and buys from in-country suppliers. As noted, this amounts to about 20 products.

All health facilities may purchase the drugs they are authorized to dispense within the bounds of republican procurement procedures. Hospitals procure by far the greater variety and greater amounts, because most patients at outpatient sites receive their drugs at retail pharmacies through the HIF ADP mechanism. In some cases, as in Issyk Kul oblast, groups of hospitals come together and carry out pooled procurements on a regular basis, again with local suppliers.

The HIF currently works with pharmacies with which they have contracts, and which are authorized to dispense drugs at subsidized cost, based on an official ADP prescription. The HIF manages computer software that validates the prescriptions and processes payment information.

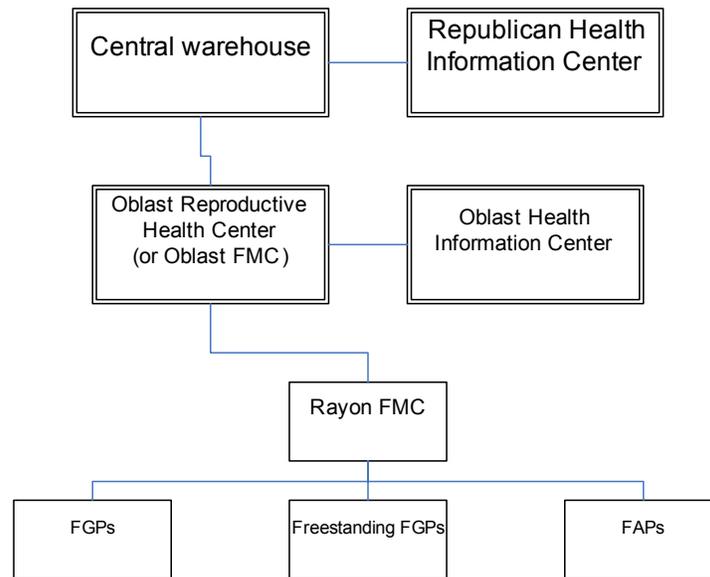
The various donors of drugs collaborate with MOH counterparts to quantify needs and then procure themselves the products they provide.

Distribution

The contraceptive distribution system consists of four tiers and operates for the most part on a push principle. That is, decisions about quantities to provide are made at higher levels and the stock is "pushed" down to lower levels. The four tiers, or points at which contraceptives are stored and redistributed, are the central, oblast, rayon, and clinical facility levels.

As noted above, central level RH staff have at their disposal relatively complete and up-to-date data on stock on hand and quantities dispensed to users for all sites providing family planning services. Using this information they make distribution plans and quarterly shipments to the oblast RHCs. Unfortunately, the system does not set minimum and maximum stock levels at this point in its evolution. This is an important weakness that should be addressed. The oblast RHCs, in turn, apportion the stock to FMCs and independent FGPs in the oblast capital and to the rayon FMCs. The rayon FMCs issue stock to the health facilities for which they are responsible. Table 16 has shown the number of rayons and health facilities in each oblast. Figure 7, below, shows the flow of contraceptives down through this system and the flow of information back up.

FIGURE 7: FLOW OF DRUGS AND INFORMATION



UNFPA funds the cost of transporting contraceptives to the oblast RHCs on a quarterly basis. From there, redistribution consists of recipients going to the next level to pick up their new stock. For example, rayon FMCs go to the oblast RHC, and the other FMCs, independent FGPs, and FAPS go to the rayon FMCs. Contraceptives are transported by bus or automobile for facilities that have them. Hospitals do not provide family planning counseling and do not, in most cases, receive contraceptives.

Logistics Management Information System

Although this topic could be covered within a discussion of distribution, MOH and UNFPA deserve special recognition for their work related to this vital logistic function. All clinical facilities submit to rayon FMCs quarterly reports, which are then consolidated at oblast level by the oblast Health Information Center. Transmission of data from clinical facilities to rayon to oblast is manual, but from oblast to central level it is electronic. At central level, the LMIS, called the Country Commodity Management System, is located within the RHIC.

The quarterly reports show opening balances, stock received, stock consumed (where “consumed” means dispensed to users), stock issued to other facilities (where this is relevant), and closing balance for each site. Supervisors at oblast and national levels have consolidated oblast reports within a few weeks of the end of the quarter. This information is used at national and oblast levels to develop and carry out contraceptive distribution plans. Site visits suggested that most health facilities usually follow good storage and stock control procedures, and this would promote the accuracy of the quarterly reports. Reporting rates are said to be very high, close to 100 percent. There are anecdotal accounts of inaccurate consolidated reports. The team did not examine the LMIS closely enough to support or refute such reports or validate reporting rates.

What may be said, however, is that every decision maker the team met at national and oblast levels was able to produce the most recent quarterly report. In addition to the quarterly reports on stock status and consumption, they were also able to simultaneously produce quarterly reports on the number of contraceptive users by method. This is no doubt due to the decision to locate the LMIS in the RHIC. Adding maximum and minimum stock levels and comparing these to stock on hand would make the system even more effective.

Supply Chain Issues. Although the system as it is designed is creditable, there are concerns as to how it actually functions. Two that the team observed illustrate the constant challenges that confront the contraceptive distribution system's managers.

At a large FMC in Bishkek, the chief nurse (chief nurses are always in charge of humanitarian aid supplies) reported that the facility had been out of condoms for two months. The reason, according to the nurse, was that the distribution plan had miscalculated the needs. In the meantime, ample stocks of condoms were available at the central warehouse. Apparently neither the nurse nor her supervisors thought to question the plan and ask for more stock.

In one case, the chief of the RHC, who is responsible for the redistribution of contraceptives, refused to issue contraceptives to clinical facilities located in the oblast capital on the grounds that FGP-based physicians are not competent to prescribe them safely and that patients requiring contraceptives should come to the RHC. The chief was, however, willing to issue stock to rayons. Although unusual, this problem is not unheard of. Staff at the central MOH are monitoring the situation and reported that the same problem has occurred in another oblast.

As the contraceptive distribution evolves and improves, problems like these will continue to arise, and an important challenge for system managers will be to use the LMIS, and supervision and training activities, to act as soon as possible to resolve them.

Site Visits. The team visited 14 sites in Bishkek and Issyk Kul oblast that stock contraceptives. This small sample was selected for convenience and cannot be considered representative of the contraceptive distribution system as a whole. It does, however, present the general state of contraceptive management in two accessible areas.

At each site the team collected a limited set of data on store keeping, stock recordkeeping, product availability, and stock outs. The findings below are taken from tabulations of these data.

- On the day team visited the sites, 10 of 14 sites had at least one condom, one oral contraceptive, and one IUD product in stock. Two sites were missing one product; one site was missing all three; and at one site, it was not possible to access either the stock or stock records.
- At 13 of 14 sites no expired products were present; it was not possible to verify this at the remaining site. Although there is a method for documenting expired drugs, the LMIS does not collect data and report on this matter. No procedure is in place by

which lower levels can report to higher levels when several products are six months from expiration.

- At 13 of 14 sites contraceptives were stored safely and securely with shelving in most cases. The system does not employ shelf labels.
- At most of the 14 sites respondents answered correctly when asked which of two packages of OCs with different expiration dates should be dispensed first. This indicates that the first expiry first out (FEFO) principle is widely understood.
- Stock records were present in all 14 sites. In almost all cases, records indicated most recent receipts and issues. In a few cases balances were not calculated. In one case the records were too disorganized to decipher.
- The team was able to obtain data on quantities of contraceptives dispensed to users during defined periods of time (two to six months): for condoms at 14 sites, for IUDs at 13 sites, and for OCs at 14 sites.
- Dividing quantities in stock on the day of the team's visit by average monthly consumption provided an estimate of the number of months those stocks will last. This was possible for 22, or about half, of all instances. Not considering the central warehouse but only clinical facilities, the team saw the following results:
 - The number of months of stock ranged from 0.12 (condoms at Tayup Rayon FMC) to 31.5 (condoms at Bishkek RHC).
 - The normal delivery interval is 3 months. For purposes of this report, an appropriate stock level may be defined as one that is sufficient for at least one delivery interval, but not more than two, that is, a minimum stock level should be 3 months and a maximum of six months. Using this criterion, only four sites were stocked at appropriate levels.
 - Nine of the sites for which useful consumption calculations could be made had excessive stocks, and nine had insufficient stocks. These deficiencies would be highlighted if maximum and minimum levels were formally set.

KYRGYZ CONTRACEPTIVE MARKET

Products

Condoms. Condom brands found in Kyrgyzstan pharmacies are very similar to those sold in Kazakhstan. *Innotex*, *Durex*, and *Lifestyles* are best sellers. *Favorite*, the mid-price condom brand marketed by PSI, has been unavailable since early 2006 because of custom clearance problems that remain unsolved. PSI typically sells about 500,000 condoms yearly.

Outside pharmacies, notably at Bishkek's Osh bazaar, a much wider variety of condoms are available at prices starting from 1.5kgs per condom. As in Kazakhstan, condoms are

distributed through distributors of pharmaceutical products and fast-moving consumer goods, but NGOs play a larger role as suppliers in this country. Many low-price brands are imported, probably informally from China, India, and Thailand. A large number of condoms provided as part of humanitarian aid programs in and outside Kyrgyzstan also find their way into the so-called black market. Condom kiosks at the Osh bazaar carry as many as 20 brands and appear to have a regular clientele that is mostly male and young. Table 20 provides more information about the types of condoms available and where.

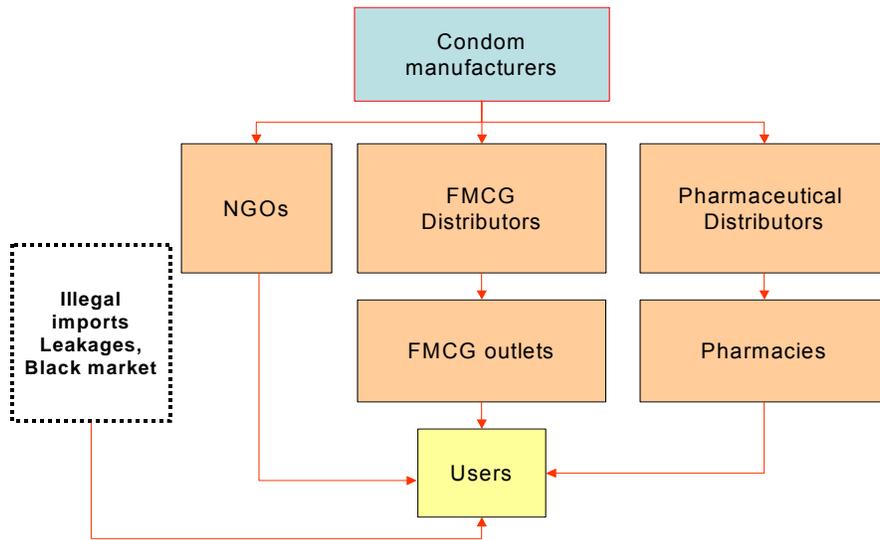
TABLE 20: SOME CONDOM BRANDS AVAILABLE IN KYRGYZSTAN

Brand	Country	Price per condom (kgs)
Pharmacies		
Durex	UK	30-43
Innotex	France	16-20
Favorite	USA	12-18
Gussarsky	Germany	17
Masculan	Germany	7-9
Lifestyles	Belgium	5
Bazaar		
Aphaw	Myanmar	2.5
Raja	India	1.5
Sana vita (for Global Fund)	Unknown	1.5
Suretex (for UNFPA)	Unknown	1.5

In contrast with Kazakhstan, where the condom market is almost entirely private, Kyrgyzstan receives substantial quantities of donated condoms, notably through the Global Fund. Products imported under humanitarian aid programs are exempt from certain regulations. In particular, they do not have to be registered with the MOH and do not need to be tested for safety or quality. These condoms typically do not provide any information about the location of the manufacturing plant. For example, it was not possible to determine the origin of condoms supplied to the Global Fund by Sanavita, a German distributor.

The Chief of Obstetrics and Gynecology at the MOH expressed concern about the quality of condoms imported through humanitarian aid programs. He stated that of the 20 or so NGOs that import condoms, many are procuring substandard products that would not pass the quality requirement for commercially imported brands. Many of these condoms find their way into the commercial supply through the black market. Although currently no law exists specifying the quality of condoms, the Drug Department is attempting to control the quality of the condom supply through occasional inspections and product testing. Recent tests of condoms imported by NGOs and found in the black market were reportedly alarming. The distribution of condoms in the private market is shown in Figure 8.

FIGURE 8: DISTRIBUTION OF CONDOMS IN THE KYRGYZSTAN PRIVATE MARKET



Hormonal contraceptives. OCs represent the bulk of hormonal contraceptives sold in Kyrgyzstan. The 3-month injectable, *Depo-Provera*, was found in only one Bishkek pharmacy where it was priced at 320kgs for one vial with syringe. The pharmacy attendant did not know much about the product and said there was very little demand for it. *Depo-Provera* is imported by Neman-Pharm, the largest local pharmaceutical distributor, but is not supported with training or detailing from Pfizer, its U.S.-based manufacturer. The most recent hormonal contraceptive methods, Janssen Cilag’s *Evra* patch, and Organon’s vaginal ring, *NuvaRing*, are not yet available in Kyrgyzstan.

The range of brands and prices available in Kyrgyzstan is similar to that of Kazakhstan. Pharmacies in Bishkek are still offering high dose OCs, such as *Non-Ovlon*, *Ovidon*, and *Anteovon*, which are no longer found in many countries and are mostly sold in former Soviet republics. Published sales data for Kyrgyzstan were not available but Gideon Richter reported total sales of 6,000 cycles in 2005, which is substantially lower than their turnover in Kazakhstan (almost 200,000 cycles). The Kyrgyz market appears undeveloped but representatives for Gideon Richter and Innotech were confident that much potential exists for moderately priced, resupply methods such as OCs and topical contraceptives.

Prices offered in Bishkek pharmacies varied widely. This was confirmed by a PSI price survey that revealed up to 250 percent price variations for a given product. The reason for this is unclear but may be due to irregular supply and/or marked differences in ability to pay between neighborhoods. Kyrgyzstan does not have as efficient a distribution system as Kazakhstan, as evidenced by the presence of a black market where drugs can be found that are not sold in registered pharmacies, or are too expensive for average users. There was no evidence, however, of any unregistered OC

brand being sold at the bazaar, though *Rigevidon* was widely available at prices as low as 35kgs. The brands of OCs available in private pharmacies are shown in Table 21.

TABLE 21: BRANDS OF ORAL CONTRACEPTIVES AVAILABLE IN PRIVATE PHARMACIES (BISHKEK)

Monophasic	Formulation	Manufacturer	Price per cycle (kgs)
Ovidon	Levonorgestrel 0.25 mg + ethinylestradiol 50mcg	Gideon Richter	65-85
Non-Ovlon	Norethisterone acetate 1 mg + ethinylestradiol 50mcg,	Jenapharm	160-190
Microgynon	Levonorgestrel 0.15 mg + ethinylestradiol 30mcg	Schering	175-215
Rigevidon	Levonorgestrel 0.15 mg + ethinylestradiol 30 mcg	Gideon Richter	130-195
Marvelon	Desogestrel 0.15 mg + ethinylestradiol 30 mcg	Organon	435-635
Regulon	Desogestrel 0.15 mg + ethinylestradiol 30 mcg	Gideon Richter	305-445
Novinette	Desogestrel 0.15 mg + ethinylestradiol 20 mcg	Gideon Richter	390-510
Minisiston	Levonorgestrel 0.125 mg + ethinylestradiol 30 mcg	Jenapharm	232
Logest	Gestodene 0.075 mg + ethinylestradiol 20 mcg	Schering	300-400
Lindynette 20	Gestodene 0.075 mg + ethinylestradiol 20 mcg	Gideon Richter	575-860
Jeanine	Dienogest 2 mg + ethinylestradiol 30 mcg	Schering	400-600
Diane 35	Cyproterone acetate 2 mg + ethinylestradiol 35 mcg	Schering	315-525
Multiphasic	Formulation	Manufacturer	Price per cycle (kgs)
Anteovin	Levonorgestrel 0.05/0.125 mg + ethinylestradiol 50 mcg	Gideon Richter	136-294
Tri-Regol	Levonorgestrel 0.05/0.075/0.125 mg + EE 30/40/30 mcg	Gideon Richter	145-220

TABLE 22: EMERGENCY CONTRACEPTION

Emergency Contraception	Formulation	Manufacturer	Price per pack (kgs)
Postinor	Levonorgestrel 0,75 mg	Gideon Richter	125-230
Escapel	Levonorgestrel 1.5mg	Gideon Richter	314-320

Intra-Uterine Devices (IUDs). IUDs were virtually absent from pharmacies in Bishkek. Pharmacy attendants reported that there is almost no demand for them. The pending introduction of *Mirena*, Schering's progestin-releasing IUD, may see increased demand for IUDs in the private sector because this product is unlikely to be offered in public clinics. A sample of IUDs, which were available in short supply in one Bishkek pharmacy, is shown in Table 23.

TABLE 23: SAMPLE OF IUDS

Brand	Manufacturer	Country	Price (kgs)
Multiload	Organon	Switzerland	200
Copper T 380A	Comtech Devices	India	100
Copper T 380A	Pregna	India	50

Other contraceptive products. As in Kazakhstan, topical contraceptives are widely available at various prices. *Kontraceptin T* and *Pharmatec* vaginal suppositories are especially popular, according to pharmacists. Table 24 presents further information on their availability in pharmacies.

TABLE 24: BRANDS OF TOPICAL CONTRACEPTIVES AVAILABLE IN BISHKEK PHARMACIES

Brand	Manufacturer	Country	Price (kgs)
Pharmatex vaginal capsules (6)	Innotech	France	195-345
Pharmatex suppositories (10)	Innotech	France	140
Pharmatex cream (18 applications)	Innotech	France	250-322
Kontraceptin T vaginal suppositories (10)	Nigfarm	Russia	65-80
Patentex Oval (6)	Merz	Germany	185-417
Monoxydol Lad y (10)		Germany	200

Marketing and Distribution

Manufacturers

Gideon Richter: Gideon Richter is the only contraceptive manufacturer whose brands have been included on the list of products covered under the HIF's Additional Benefits Package. This program allows users to obtain reimbursement for up to 50 percent of the cost of the drugs they purchase in private pharmacies. The list includes two high dose brands that have been scheduled for discontinuation (*Anteovin* and *Ovidon*), as well as *Rivevidon* and the popular triphasic *Tri-Regol*. Although Gideon Richter is drawing the bulk of its revenue from cardiovascular, hypertensive, and central nervous system drugs, it has a strong commitment to women's health. This company is obviously investing more than current sales (6,000 cycles last year) would seem to justify because it is looking at long-term growth.

Innotech: This company maintains a sales team composed of one manager and four representatives. The team focuses on providing support to providers (GPs and gynecologists) and organizing workshops and conferences. According to Innotech's local manager, there is a "deficit of information" among Kyrgyz practitioners. As in Kazakhstan, the company helps fund local seminars in cooperation with the MOH. Innotech products are not included on the EDL or reimbursed under the HIF's Additional Benefits Package.

Schering: Schering does not have a scientific office in Kyrgyzstan but is nonetheless well represented through local distributors. Schering brands do not enjoy the same popularity on this market as they do in Kazakhstan, assumedly because they are expensive compared with Gideon Richter's products. This situation may change as Schering develops its presence and product range in Kyrgyzstan.

Jenapharm: This subsidiary of Schering AG was originally the only producer of OCs in the former East Germany. The company focuses on generic products in several therapeutic areas, including contraception, fertility, and hormone replacement therapy. Jenapharm markets a limited range of low-priced contraceptive brands in Eastern Europe and Central Asia, including Minisiston (a third-generation OC) and Trisiston (a copy of Schering's triphasic OC Triquilar). Jenapharm does not have an office in Kyrgyzstan and works mostly through local distributors.

Organon: This company does not have an office in Kyrgyzstan but one of its brands, *Marvelon*, is brought in from Russia by a local distributor. Organon is currently concentrating on developing a presence in Kazakhstan, which offers a bigger market opportunity for their products (Dereviannykh, 2006).

Distribution

There are about 20 pharmaceutical distributors in Kyrgyzstan (PSI 2006) but a few large companies dominate the market. Having the ability to market products (through advertising, promotion, and provider detailing) is important because few manufacturers can justify having a local representative office in Kyrgyzstan. The largest company importing and marketing contraceptives is Neman-Pharm, which carries Gideon Richter, Innotech, and Schering brands. Three other distributors, Amanat Ltd., Interlizing, and Unihelp, also carry Gideon Richter brands, which appear to be the most widely distributed in the country.

Distributors interviewed for this assessment do not draw a significant amount of revenue from contraceptives but seem to agree that the market is growing. They do not currently import IUDs because they are distributed through humanitarian programs and are assumed to have limited sales potential.

As in Kazakhstan, city- and oblast-level tenders are a large part of the distribution business (up to 60 percent). Contraceptives, however, are not usually included in these tenders. Distributors were not aware of users ever taking advantage of the HIF's Additional Benefits Package for contraceptives. The fund does not appear to have a significant impact on the private sector business, as two of the four contraceptive brands covered under this plan are being discontinued. Distributors seemed more favorable to increased funding for local tenders than centralized insurance or procurement schemes. These companies are experienced with tenders, tend to distrust centralized "bureaucratic" programs, and have a preference for dealing directly with public health facilities.

PRIVATE SECTOR ROLE IN CONTRACEPTIVE SECURITY

Availability

Private sector manufacturers are essentially responding to existing demand for OCs and condoms. The only long-term investment in marketing is done by Gideon Richter and Innotech, which almost guarantees that the bulk of the supply will center on OCs and topical contraceptives for some time to come. There is no reason to believe at this time that any manufacturer or local distributor would import significant quantities of injectables or IUDs because they simply would not sell. The private sector is not currently a preferred channel for increasing the availability of these methods, unless it involves demand-side activities (see social marketing section below).

Affordability

Just as demand for certain methods of contraceptives affects their availability, it can also affect their affordability: condoms appear to be in high demand in Kyrgyzstan and are widely available at different prices. The demand for hormonal products, which is still nascent, is likely to come from the most educated and wealthiest socioeconomic group. As a result, the current supply of OCs in Kyrgyzstan responds to this group's preferences and ability to pay. The only way to assess a particular group's ability to pay is through population-based research; therefore, it is not possible to make a definite statement about the affordability of OCs to a wide range of potential users in Kyrgyzstan.

Quality

There appear to be no quality concerns about the OC supply: these products are made by reputable manufacturers and are subject to MOH registration requirements. Most of these products have also been approved for distribution in the United States, the European Union, and other countries with stringent regulations and testing requirements. The condom supply, in contrast, involves a wider variety of manufacturers, many of which are located in countries with less stringent regulatory environments, such as India and China. In the absence of local regulations and strict enforcement of testing protocols, it is impossible to issue a verdict about the quality of supply. In contrast with commercially registered condoms, donated products and those smuggled and sold on the black market may represent a health risk.

New Research & Development Suppliers

There are few incentives at the moment for new research and development (R&D) companies to enter the Kyrgyzstan market or increase their investment in that country. It is likely however that the range of brands marketed by Schering will increase and match that which is found in Kazakhstan. The primary limitation for Schering (as well as other R&D manufacturers) is the population's ability and willingness to pay for their brands. The presence of a well-established generic manufacturer (Gideon Richter) using similar marketing tactics is another disincentive for further expansion by these companies.

New Generic Suppliers

In contrast with Kazakhstan, where demand for contraceptives appears to dictate cost, Kyrgyzstan may offer opportunities for low-cost generic manufacturers to sell their products. Indian companies already supply IUDs to local distributors and may not encounter major difficulties in registering hormonal contraceptives. These manufacturers would be able to pursue both the tender and pharmaceutical business by appointing one or several local distributors in Kyrgyzstan.

Currently, the most significant disincentive for these companies is the very low demand for OCs in the private sector, together with the absence of any significant contraceptive tenders. Unless there is a significant increase in demand for these methods, new, low-cost suppliers will not emerge in either the public or private sector.

SOCIAL MARKETING

Kyrgyzstan could greatly benefit from a social marketing program to increase the use of family planning methods. Low demand for contraceptives in pharmacies and legal restrictions on advertising contribute to limited commercial activity in this country. Social marketing is one of the most effective ways to achieve simultaneous increases in demand and supply. It has also proven to have a halo effect on commercial product sales even in the presence of a subsidized brand (Green, 1988). A social marketing program in Kyrgyzstan could be combined with a partnership with a low-cost generic supplier, since the latter are unlikely to enter the market without committed local partners and substantial demand-side efforts. The following are two potential implementing organizations of social marketing programs:

- PSI/Kyrgyzstan, which manages the social marketing component of the CAPACITY project in collaboration with JSI. PSI has an interest in marketing low-cost OCs with a special focus on underserved areas.
- The Alliance for Reproductive Health, an affiliate of the International Planned Parenthood Federation. This NGO has combined experience in community-based educational programs and partnerships with pharmaceutical companies.

RECOMMENDATIONS FOR KYRGYZSTAN

The recommendations for Kyrgyzstan are based on the premise that the present donor-supported public distribution of contraceptives will switch to the availability of contraceptives through the ADP. While in theory the ADP can provide better targeting of public sector subsidies to the neediest contraceptive clients, a number of potential implementation issues needs to be managed to ensure product availability. Recommendations for funding and procurement are intended to provide actions during the transition until the ADP fully permits clients to access their contraceptives.

GOVERNMENT ACTION

The GOK can demonstrate its commitment toward securing both financial and predictable levels of funding for health commodities including potential contraceptives by following through on a number of actions:

- Fully executing budgeted allocations to health
- Increasing health expenditures in the state budget
- Enhancing representation of reproductive health-related interests in the Manas Taalimi/Sector-wide Approach (SWAp) decision-making structure
- Adhering to requirements in the SWAp agreements

In addition, improved CS requires more explicit recognition of its importance. Specifically, this requires the following:

- Recognize CS in the Reproductive Health Strategy and explicitly identify actions required to improve CS in Kyrgyzstan
- Provide a comprehensive CS strategy, including a CS transition plan and CS sustainability plan as part of the Reproductive Health Strategy that reflects a move away from donor dependence
- Ensure that contraceptives are included in the 2009 budget and subsequent years
- Integrate the financing component of the CS plan as a phased transition clearly assigning responsibility and targets for different sectors for funding contraceptives
- Gain better understanding of why the contraceptive option available under the ADB is so underutilized
- Ensure monitoring and evaluation of the transition plan to ensure that family planning commodities are being supplied with remedial action if they are not
- Solicit donors' support from the broader donor community for the entire transition to avoid the possibility of decreased product availability

A study of the private sector's capacity as well as a willingness-to-pay and ability-to-pay analysis should be conducted in 2006-2007. In addition, a CS budget and procurement plan(s) should be developed based on forecasting and cost requirements for different contraception methods, funding requirements, and funding commitments. Long-term contraceptive financing for CS sustainability should be incorporated as part of the health insurance system combined with private market purchasing. Small-scale research is needed to determine the awareness of providers and potential clients about the benefit of contraceptives, adequacy of the benefit, and reasons for non-use among those who have awareness.

Additional Drug Benefit: There are several viable directions in which the ADB mechanism can be strengthened to become an effective means of improving CS:

- Improve coverage of WRA by the mandatory health insurance scheme to provide access to contraception benefits
- Introduce effective public education programs on the ADB using various means to reach out to populations throughout the country, including the remote areas
- Ensure access to the ADB for rural clients
- Evaluate ADB reference pricing and ensure contraceptive products included are actually available on the market
- Study the impact of ADB reimbursements on affordability and consumption of prescribed drugs
- Monitor and evaluate ADB reimbursement practices in relation to the pharmaceutical market developments and prices
- Fulfill Manas Taalimi program of action on price setting
- Continue flexible redistribution of the capitated ADB budget
- Coordinate refinement of the ADB copayment policy with revisions in eligibility conditions of social benefits to effectively target the poor
- Adjust capitation to PHC provider organizations
- Determine the best procurement prices through negotiation between the MOH and MHIF for a national framework contract with suppliers for all contraceptive methods
- Consider using UNFPA to procure IUDs
- Ensure that public sector procurement and distribution recommendations apply to the period that public sector commodities are being procured before the ADP benefit is being applied
- Conduct a more thorough analysis of needs through the RHIC. The analysis should take into account pipeline capitalization requirements. For example, this will require putting more than 15 months' worth of commodities into the pipeline if order and delivery takes 3 months.
- Continue to procure IUDs and injectables through the MOH with UNFPA assistance to ensure their availability at public clinics
- Have the RHIC, working in collaboration with the CWG, develop a five-year procurement plan

- Revise the LMIS reports to include a column for losses and consumption. Calculations of average consumption and monthly stock on hand should become standardized to help identify over and under stock.
- Ensure the RHIC sets minimum and maximum stock levels for all sites in the system based on delivery periods
- Implement use of shelf labels in storage facilities
- Instruct staff to organize stock by expiration dates and lot numbers at stores
- Undertake maintenance and evaluation activities of product availability
- Undertake information, education, and communication (IEC) programs and continuous training and education for providers

DONOR SUPPORT

Donors will continue to be an important partner for the government as it seeks to improve CS. Coordination through participation in the CWG and the provision of technical assistance support to undertake analysis and monitoring of the ADB and public supply system represent two important areas. In addition, the following are recommended:

- Donors should support forecasting exercises of the CWG.
- UNFPA should take the lead in helping MOH and the CWG identify funding options and work out a full transition to the ADP.
- GFATM should continue to procure condoms for HIV and sexually transmitted infections STI prevention.
- The possibility of using UNFPA as a procurement agent should be reviewed during the transition plan, particularly for IUDs and *Depo-Provera*. A transfer to local procurement should be considered for OCs and eventually other methods following discussions with the private sector.
- Donors should support government IEC programs and continuous training and education for providers.

PRIVATE SECTOR RECOMMENDATIONS

Private sector suppliers are currently serving a very small percentage of the population with resupply methods, which is partly a result of low demand for these methods and humanitarian aid commodity donations. Improving the participation of the private sector in CS can be achieved by the following approaches:

- Contraceptives should be included in local drug procurement tenders.
- The HIF's Additional Benefits Package needs to include a wider and more updated range of contraceptives, and this should be publicized to providers and users.
- The quality of donated condoms, which are subject to frequent leakage in the commercial sector, should be controlled.
- The overall demand for contraceptives could increase through educational and/or social marketing programs.
- Contraceptive methods that require provider involvement, such as IUDs and injectables, are unlikely to become widely available in commercial pharmacies, even with concerted efforts to increase demand for these methods. It is therefore essential that the public sector develop strategies to ensure continued availability of these products, either by soliciting donations, or by including these products in tenders that can be supplied by private distributors.
- Kyrgyzstan could greatly benefit from a social marketing program to increase the use of family planning methods. Such a program could be combined with a partnership with a low-cost generic supplier, since the latter are unlikely to enter the market without committed local partners.
- Two organizations that could potentially partner with lower cost generic manufacturers in Kyrgyzstan are PSI and the Alliance for Reproductive Health, an affiliate of the International Planned Parenthood Federation.

**CONTRACEPTIVE SECURITY IN
THE CENTRAL ASIAN REPUBLICS:
TAJIKISTAN**

EXECUTIVE SUMMARY

The Republic of Tajikistan (RT) is the poorest of the former Soviet republics. Demographically and epidemiologically the RT more closely resembles its poorer southern neighbor Pakistan than it does Kyrgyzstan or Kazakhstan. Publicly distributed contraceptives in the RT are provided entirely by donors, principally the United Nations Family Planning Agency (UNFPA). Prospects for public funding of contraceptives for the poorest women seems unlikely to occur at the central level. Prospects for securing a notional line item for supplies in the state budgets are less dim, although unlikely unless and until such a practice is forced by an end to donated products. Alternative financing schemes, including Revolving Drug Funds (RDF), appear to have had some success in making essential drugs available to poor communities. None of the current RDFs, however, includes contraceptives. A broad range of contraceptive products, including relatively affordable products manufactured by Gideon Richter, are available through commercial channels but remain out of reach for most people. Low demand for contraceptive methods and persistent use of abortion for fertility regulation limit contraceptive use. Public sector providers continue to have out-of-date information and misperceptions regarding hormonal contraception.

The RT conducted an assessment that was an abridged version of those conducted in Kazakhstan and Kyrgyzstan. Because the assessment was conducted by a private sector policy expert, it did not address issues related to contraceptive distribution and storage. These issues, however, were the subject of a very recent UNFPA assessment (Beers, 2005).

The principal findings and recommendations for the RT are organized around the following topics:

INCLUDE CONTRACEPTIVES IN EXISTING AND PLANNED RDFS

High levels of household payments on health, including nonformal payments for ostensibly free products and services provided through the public sector and payments for drugs purchased from pharmacies, present a significant burden on the poor. In an effort to ensure the availability of high-quality affordable drugs for all, a number of donors in RT are exploring the use of RDFs. Such small-scale pilot efforts as the RDFs are likely to serve as models for scaling up drug financing in the future. Including contraceptives in at least one such RDF scheme will be very important if contraceptives are to be mainstreamed with the financing of other primary health care prevention products. An opportunity may currently exist to pursue the inclusion of contraceptives in the RDF supported by Project Sino in Varzob, which is in a position to add new products to those included in the scheme.

SECURE COMMITMENTS, HOWEVER SMALL, TO HELP SECURE EVENTUAL PUBLIC FINANCING OF CONTRACEPTIVES

Prospects for securing a dedicated budget line item for contraceptives in the RT's central budget are not likely. But, although prospects for any public financing for contraceptives are dim, there is at least precedent for financing contraceptives through the oblast health budget. In 2002-2003, shortfalls in UNFPA funding affected its donation to RT. At that time Khatlon oblast purchased a small quantity of contraceptives (approximately 10-15 percent of the oblast health authority's past year's donated supply) from local pharmacies. These products were then made available to "vulnerable groups." Currently, Soghd oblast includes a "symbolic" budget item for contraceptives in its health budget, but no actual funding has been provided. It would be useful to explore securing such line items, even if unfunded, to facilitate mobilizing oblast-level health funding in the event of a phase out of donated contraceptives. Securing the budget line item is a vital first step in securing actual funding.

EXPLORE OPTIONS TO EXPAND THE AVAILABILITY OF NONPRODUCT-DEPENDENT CONTRACEPTIVES

Nonsupply-dependent contraceptive options may have unrealized potential in RT. Many RT couples in rural areas appear to be using no contraception at all, and should the woman become pregnant unexpectedly, she is either keeping the pregnancy or seeking an abortion. While improvements in the availability of contraceptive supplies might contribute to an increase in the use of oral contraceptives (OCs) among rural women, factors such as the short periods when these women are sexually active and the persistent misperceptions of OCs by providers and clients may indicate a need to continue to explore both long- and short-term contraceptive alternatives. Most notably among these alternatives are female sterilization (mini-laparotomy), the Standard Days Method (SDM), and the Lactational Amenorrhea Method (LAM). As nonsupply-dependent methods, all three of these options have the added advantage of not being affected by the chronic shortages of contraceptives that seem to currently plague the country.

In response to a request from the Isfara rayon in Soghd oblast, UNFPA is supporting an initiative to build acceptance of female sterilization (mini-laparotomy). The opportunity to build upon this initiative to ensure the successful introduction of female sterilization by providing gold standard counseling, community education, informed consent, and quality of care should not be lost. In RT, female sterilization (mini-laparotomy) provides a potential platform for making substantial improvements in counseling, informed consent, and infection control, which would carry over to other contraceptive services in RT, notably IUDs. It also adds a potentially appealing, nonsupply-dependent contraceptive option to those presently available to Tajikistan women.

EXPLORE OPPORTUNITIES TO IMPROVE AWARENESS AND EDUCATE CONSUMERS AND PROVIDERS ABOUT ORAL CONTRACEPTIVES

Social marketing remains a poorly understood and nascent concept in RT. Pharmacists who were interviewed were very aware of PSI's social marketing condom, *Favorite*, and reported good sales when in stock, although none had had the product in stock in the past month or two⁸. Apparently, a dispute over import duties was keeping the product tied up in customs. Disputes and misunderstandings over taxation and local regulation also seem to affect private pharmacies, generally leading to their occasional closing and reopening.

Social marketing experts advise that generally speaking an OC product cannot be made commercially available for less than \$1 and still be financially sustainable (Armand, April 2006, personal communication). Currently, Gideon Richter's lowest priced OC sells for a little more than \$1 per cycle. Nonetheless, because of very low rates of OC use in RT overall, the total market for this product is small and probably mostly confined to urban areas. A significant increase in demand for OCs is not expected to occur in the future, absent significant demand-generation activities.

The positive experience surrounding *Favorite*, however, suggests that promotional and educational activities aimed at dispelling misperceptions about hormonal contraceptives (e.g., concerns about becoming "hormone dependent") among potential users and providers in urban areas would likely have a favorable impact in building acceptability and demand for this method, which is already available at a low price in the existing market.

⁸ Under the CAPACITY Project, PSI effectively supplied condoms to outlets in high-risk zones serving at-risk youth, sex-workers, and injecting drug-users.

OVERVIEW

Donors provide virtually all contraceptives in the RT; however, the country faces a likely and significant decline in donated contraceptives before the end of the decade.

Preparation for such a transition must follow a multi-pronged approach that cultivates a range of options to help secure the availability of contraceptive options. While some of these options may fail or be abandoned, others will succeed and be sustained. Since one cannot predict at this point which ones will thrive, it is important to ensure support for contraceptives and contraceptive services is included in as many of these options as reasonable. This is especially true for RDFs, which are being piloted in several regions of RT. To date, contraceptives have not been included in the RDFs (except briefly in one oblast during a severe contraceptive shortfall), although they are included on the national essential drug list. Similarly, one needs to secure commitments, even notional ones, to help facilitate eventual public financing for contraceptive supplies at the oblast level. Likewise, further testing of social marketing approaches to promote modern contraceptive use (“demand generation”) and expand the availability of contraceptive products through commercial channels needs to begin now. And, finally, nonmethod-dependent contraceptive options, including female sterilization (mini-laparotomy), LAM, and SDM would seem to occupy an important place in a country where contraceptive options are few and shortfalls of contraceptives and other drugs continue to be a serious problem. The issues associated with each of these options are discussed in the following paragraphs. Each discussion is followed by recommendations for short- (within the next six months) and long-term (12-18 months) actions.

INCLUDE CONTRACEPTIVES IN EXISTING AND PLANNED REVOLVING DRUG FUNDS

FINDINGS

RT households already spend a large share of private resources on health (Cashin, 2004). These payments include nonformal payments for ostensibly free products and services provided through the public sector and payments for drugs purchased from pharmacies. In an effort to ensure the availability of high-quality affordable drugs for all, a number of donors in RT are exploring the use of RDFs. Although the experience of RDFs under the Bamako Initiative was mixed, primarily in terms of equity in paying for drugs, highly respected authorities on drug financing and management believe this mechanism has strong potential in RT (Clary, 2004). Continued use of RDFs and their potential success may result in their becoming a primary financing mechanism for drugs in RT. Therefore, it is imperative that, even while donated products are available, contraceptives be included in at least some of RDF pilot efforts to create the precedent of including them among covered RDF products.

The Aga Khan Foundation (AKF) has had good experience managing an RDF in the Gorno-Badakhshan Autonomous oblast. AKF receives orders from local pharmacists

and then sells them the drugs they purchase on their behalf (presently, AKF purchases drugs through Pharmaciens Sans Frontiers (PSF)) at a subsidized price⁹. Their target is to recover 60 percent of the cost of the drugs, all of which are generics. Free products are made available to the poor. When asked why contraceptives were not included in the RDF, AKF appeared to suggest that it would not be possible to include them so long as UNFPA-donated contraceptives were available in the oblast. However, in 2002-2003, when UNFPA support for contraceptives dropped, AKF temporarily included contraceptives in the RDF. Once the humanitarian products were restored, however, it seems they no longer needed to be included in the RDF. Moreover, it seems there were some problems with expired contraceptives being mixed in with the purchased supplies made available through the RDF, which may have damaged provider and client confidence in AKF's RDF as a supply source. AKF expressed keen interest in ensuring contraceptive availability. The foundation indicated that staff were preparing a proposal to conduct a willingness-to-pay study that included contraceptives. Their RDF provides free products for the very poor and AKF expects to prepare a proposal to expand the RDF into certain rayons in Khatlon oblast.

Save the Children also supported an RDF in the RT communities of Panjakent and Aini through 2005; however, that RDF does not appear to ever have included contraceptives, most likely because USAID is providing donated contraceptives in the districts where Save the Children is working.

Recently, Project Sino¹⁰ launched an RDF in pilot areas within the rayons of Varzob and Dangara with plans to expand the RDF to the entire districts by the end of the year. Under this fund, drugs will be purchased through PSF until the National Drug Procurement Center is functioning, which is estimated to occur sometime after June 2006. Project Sino manages the RDF through a consultant who is responsible for supervision of the drug supply and finance management. Project Sino hopes that management functions can eventually be turned over to the communities. The Project Sino RDF aims to recover 60 percent of the cost of drugs, and it necessarily includes exemptions for the very poor¹¹. Although contraceptives are not now included among the drugs in the fund, Project Sino is open to having them included (Thompson, 2006). While contraceptives are, in principle, available for free in the pilot districts where the RDF is established, it seems that one may still make a convincing case to have them included in the RDF. It is widely recognized that one typically must pay a fee to get ostensibly free contraceptives, even if the fee is declared to be for the service rather than the product. Moreover, shortcomings in the contraceptive distribution system, product leakage, and other management weaknesses mean the supply of contraceptives at most government service delivery points is unreliable. Thus, even with an adequate supply of donated contraceptives, future sustainability of contraceptive supplies requires they be included in alternative financing schemes such as the RDF.

⁹ The author understands that AGF intends to continue indefinitely to provide the subsidy for the remaining 40 percent of the cost of the drugs as well as the cost of other associated costs.

¹⁰ Project Sino, or the Health Sector Reform and Family Medicine Support Project, is being implemented by the Swiss Tropical Institute with funding from the Swiss Agency for Development Cooperation. The second phase of funding, which is in effect now, lasts through March 2009.

¹¹ In the future, the cost of the exemptions for the very poor could be assumed by the oblast health authority.

USAID is paying a high price for not seeking to integrate contraceptives into other drug financing schemes. In RT the potential cost of NOT including contraceptives in the package of products it purchases is that contraceptive procurement and quality control continue to be managed separately by humanitarian organizations with minimal RT investment or responsibility (in short, minimal accountability) for their availability. While such experiences are not new to family planning assistance, one does well to heed the experience of those countries where opportunities to institutionalize support for contraceptive procurement and management were ignored.

In an April 25, 2006 email communication, Bruno Clary of Project Sino explained that in Varzob, the list of drugs to be covered or subsidized by the state budget is still under discussion. Furthermore, Clary indicated that if the RDF is successful, as many as 20 new drugs may be added. According to Clary, the process of adding a drug to the RDF depends on available funding to support its subsidy under the oblast budget and requires the approval of the Varzob Therapeutic Drug Committee and the RDF steering committee.

Experience under Integrated Management of Childhood Illnesses (IMCI) in RT suggests that even with nonformal (or “under the table”) payments, humanitarian products sold by doctors are still cheaper than subsidized drugs available for purchase through the RDF¹².

RECOMMENDATIONS FOR USAID AND ZDRAVPLUS II

- With Project Sino/Dushanbe identify requirements for having contraceptives included in the list of drugs covered by the RDF in the pilot zones of Varzob and Dangara rayons. In particular, discuss levels of government approval required given that contraceptives are ostensibly available for free in these rayons.
- Discuss with UNFPA headquarters, UNFPA/Central Asian Republics, and members of the global Reproductive Health Supplies Coalition options for donating products to the RDF or suspending donations in selected rayons/oblasts to permit inclusion of contraceptives in the RDFs. The Reproductive Health Supplies Coalition should be able to share how such situations have been managed in other settings.
- Discuss with UNFPA, AKF, and Khatlon oblast authorities options for including contraceptives in the proposed RDF to be piloted in yet-to-be-identified rayons.
- Provide technical assistance to AKF regarding contraceptive section of planned willingness-to-pay study.
- Maintain close contact with Project Sino, AKF, and Save the Children regarding implementation of RDFs (especially concerning management of drugs and funds) and their plans to expand pilot RDF programs.

¹² Note, however, this is not the case in all countries.

- Continue efforts to persuade the RT to suspend the donation of contraceptive products to selected rayons with sufficient exemptions for the very poor (which UNFPA might cover.)
- Secure (some) political commitment for public financing of contraceptives in oblast health budgets.

RECOMMENDATIONS FOR THE MINISTRY OF HEALTH

- Request UNFPA to restrict donated supplies in certain rayons to allow the integration of contraceptives into this financing mechanism. Given the greater prospect for sustaining the RDF mechanism and uncertainty regarding the future of UNFPA contraceptive commodity support in the region, both UNFPA and the Ministry of Health (MOH) should be inclined to at least allow some testing of such a model. This subject should be explored further with UNFPA and *ZdravPlus* and others.
- Discuss with UNFPA, AKF, and Khatlon oblast authorities options for including contraceptives in proposed RDF to be piloted in yet-to-be-identified rayons.

SECURE PUBLIC FINANCING FOR CONTRACEPTIVES

FINDINGS

Recent assessments of contraceptive security (CS) have looked at prospects for securing some public financing for contraceptive commodities. The most important of these was produced by a “core group” convened by the USAID-funded Healthy Families Project to look at CS in RT. The “core group” recommended that government financing for contraceptive commodities be increased to 20 percent (presumably, of the full cost of commodities needed for RT) and called for general improvements in the government’s capacity to procure and manage the distribution of contraceptive commodities. A number of the recommendations of the “core group” appear in the recently issued RT Strategic Plan for Reproductive Health, notably those related to estimating contraceptive needs. The reproductive health strategic plan focuses on the stewardship role of the Ministry of Health. It does not commit the RT to purchasing contraceptive commodities at this time. Although the “core group” report was somewhat circumspect on the subject, others interviewed for this assessment stated very clearly that prospects for financial support for the purchase of contraceptive commodities from the central government (which has never purchased contraceptives) were very unlikely and not worth pursuing in either the short or long term.

In 2002-2003 UNFPA experienced budget shortfalls that affected its ability to provide sufficient quantities of donated contraceptives to oblast health authorities in RT. At that time Khatlon oblast purchased a small quantity of contraceptives (approximately 10-15 percent of the oblast health authority’s past year’s donated supply) from local pharmacies. These products were then made available to vulnerable groups. The Khatlon oblast purchase has been frequently cited as one example of the RT purchasing contraceptives. According to UNFPA/Tajikistan, Soghd oblast includes a symbolic

budget line item for contraceptives in its health budget, although no actual funding is currently provided. The Chief Medical Officer in each oblast has discretion over a small amount of the oblast health budget, which he/she could draw upon in the event of a severe shortfall in contraceptives.

The Basic Benefits Package (BBP)¹³ for RT will not be finalized until after the 2006 elections. Presently, it includes condoms, hormonal contraceptives, and IUDs among its “free” services with commodities provided through humanitarian assistance. It was unclear who would cover the cost of contraceptive commodities under the BBP if the supply of donated contraceptives were to disappear.

RECOMMENDATIONS FOR USAID AND ZDRAVPLUS II

- Assign an individual or entity to stay abreast of developments regarding treatment of *contraceptive services/products* in the BBP, especially following 2006 elections and the beginning of health reform implementation.
- Clarify who is monitoring the BBP to ensure it includes a comprehensive set of contraceptive options in the category of “free” services.
- Request that planned UNFPA-supported reproductive health advocacy activities address CS issues.
- USAID with UNFPA should provide support to ensure continued monitoring and advocacy related to coverage of contraceptive commodities and services as the BBP is finalized and implementation of health reforms moves into full gear. This will include making sure a full set of contraceptive options is identified in the BBP’s “free service” category, for example, including LAM, female sterilization, spermicides, and emergency contraception.
- With respect to procurement, it makes sense to watch closely the experience of the new National Drug Procurement Bureau, especially regarding the purchase of contraceptives or related products. At this time, it is doubtful that central resources will be committed to purchasing contraceptives. The new procurement agency, however, may offer oblast health authorities a vehicle for purchasing such commodities at competitive prices.

RECOMMENDATIONS FOR THE MOH

- Based on the research, the authors recommend that the MOH request that planned UNFPA-supported reproductive health advocacy activities address CS issues.

¹³ The BBP refers to a package of free or heavily subsidized medicines and services. In RT the BBP will be financed with donor and RT resources.

EXPLORE OPTIONS TO EXPAND THE AVAILABILITY OF NONPRODUCT-DEPENDENT CONTRACEPTIVE OPTIONS

FINDINGS

CS requires ensuring the availability of a broad range of contraceptive options, including both supply- and nonsupply-dependent methods. Nonsupply-dependent contraceptive options may have unrealized potential as a contraceptive option in RT. In a country where women begin and complete their family formation at young ages, most of the population is rural, and many husbands are absent for long stretches of the year¹⁴, female sterilization (mini-laparotomy) would seem to be an attractive method for many couples. Similarly, for couples that have not completed childbearing but where the husband is away for long periods of time, SDM may be an appealing choice. In fact judging from the apparently low rate of OC use (See UNICEF, Multi-Indicator Cluster Survey, Tajikistan, 2000) and other spacing methods, especially in rural areas, many couples are probably using no method at all, and should the woman become pregnant unexpectedly, she is either keeping the pregnancy or seeking an abortion. While improvements in the availability of contraceptive supplies might contribute to an increase in OC use among rural women, factors such as the short periods when they are sexually active and the persistent misperceptions of OCs by providers and clients may indicate a need to continue to explore contraceptive alternatives. Another option that could be promoted is LAM, which promotes breastfeeding exclusively and, when practiced properly as a postpartum option, can provide protection against pregnancy for as long as nine months¹⁵. As nonsupply-dependent methods, all three of these options have the added advantage of not being affected by the chronic shortages of contraceptives that currently seem to plague the country.

Although legal, female sterilization seems not to be an acceptable contraceptive option in some Central Asian countries, notably in Kazakhstan and Kyrgyzstan, where it may continue to carry the eugenics cast it held in the days of the former Soviet Union. This seems to be less true in RT. Perhaps RT's linguistic and cultural ties to neighboring Iran, where nearly one-third of all couples using contraception are using female sterilization and vasectomy, may indicate that this contraceptive option has the potential to enjoy broader acceptance here than elsewhere in Central Asia.

According to UNFPA Assistant Country Director Dr. Ahmedova, UNFPA was asked by the Isfara rayon in Soghd oblast to provide technical assistance and support for the introduction of female sterilization in six or seven districts. The pilot program there includes community education and advocacy regarding the introduction of mini-laparotomy, which will be provided in a small number of facilities. Although not

¹⁴ UNFPA reports that 10 percent of the nation's "employable" population migrates out of the country to work; the percentage of rural working age men who migrate appears to be as high as 70 percent in some communities.

¹⁵ LAM has three criteria that need to be satisfied simultaneously: (1) Amenorrhea, defined as the absence of the menses (Menses return is defined as the first two sequential days of bleeding or spotting which may occur after two months postpartum); (2) full or nearly full breastfeeding, which includes exclusive breastfeeding, almost exclusive breastfeeding, and nearly fully breastfeeding, day and night, on demand by the infant; and (3) being less than six months postpartum. LAM has been demonstrated to be effective for nine and even 12 months, although its effectiveness declines as the months of postpartum increase. See Robert Hatcher et al, 1998, *Contraceptive Technology*, Ardent Media, Inc., New York. Pp. 592-594

confirmed at the time of this report, it appears that UNFPA is sponsoring a study tour to Tunis for religious leaders to focus on the role of family planning, likely including female sterilization, in Islam. However, UNFPA's country program for RT is small—approximately \$2 million over 5 years (less than their previous country program, which received actual funding of \$3.6 million over 5 years)—and includes a very small amount of international technical assistance¹⁶. To be successful, the introduction of female sterilization must meet gold standards in counseling, community education, informed consent, and quality of care. In RT, female sterilization (mini-laparotomy) provides a potential platform for making substantial improvements in counseling, informed consent, and infection control, which would carry over to other contraceptive services in RT, notably IUDs. It also adds a potentially appealing, nonsupply-dependent contraceptive option to those presently available to Tajikistan women.

According to the 2000 MICS, couples in RT are using LAM and periodic abstinence as family planning methods. While USAID's Healthy Families is providing LAM training in five rayons in Khatlon oblast, it is not clear that any training is being provided for this method in other locations or is included in current continuing medical education (CME) training. The 2003 baseline assessment for Healthy Families found that 12 percent of married women with at least one child were using LAM (Osborn, 2003). SDM does not seem to have been introduced, although periodic abstinence is the third most widely used method (2.5 percent) in the country after the IUD (25 percent) and withdrawal (3 percent).

In view of the small resources available to support international technical assistance in the UNFPA program, it would seem this would be an area where USAID could provide complementary support either through field or central resources. Investment in high-quality technical assistance would help ensure the smooth introduction of a new contraceptive option.

RECOMMENDATIONS FOR USAID AND ZDRAVPLUS II

- Clarify exactly what kind of training and other assistance UNFPA plans to provide in Isfara to accompany its advocacy and community education efforts related to the introduction of female sterilization.
- Review experience of Healthy Families in introducing LAM, with respect to both quality and extent of use; for example, drawing on data from end-of-project assessment.
- Draw on USAID central, mission, or regional resources to ensure the introduction of female sterilization services in the pilot area meets the absolute highest standards possible.
- Ensure AKF remains apprised of advocacy and community education efforts and clinical training related to a range of contraceptive methods, including mini-

¹⁶ UNFPA's 2006 annual workplan shows only one international technical assistance visit.

laparotomy, so the foundation may consider pilot efforts for introducing services in the RSBO.

- Ensure local offices of Aga Khan and UNFPA have current information about SDM and LAM.
- With Project Sino and *ZdravPlus*, explore options for expanding education efforts for female sterilization (mini-laparotomy), LAM, and SDM through CME and preservice physician education.
- Explore having female sterilization included as free service under the BBP, if it is NOT already, based on the pilot in Isfara. Similarly, if LAM and SDM are not included as free services, review steps needed to have them included.

RECOMMENDATIONS FOR THE MOH

- Explore ways to draw on the success of the Iran family planning program, which has flourished as a result of substantial technical assistance from UNFPA, and its sterilization program in particular, as a source of technical assistance and support.
- Clarify whether female sterilization, LAM, and SDM are included in the BBP and, if so, under what category of service.

EXPLORE OPPORTUNITIES TO IMPROVE AWARENESS AND EDUCATE CONSUMERS AND PROVIDERS ABOUT ORAL CONTRACEPTIVES

FINDINGS

More than 30 contraceptive products are available on the commercial market in RT. Prices vary considerably, even in Dushanbe. A few products are accessible to lower income users. Gideon Richter (GR), the principal supplier of commercial OCs in RT and the region, produces a range of generic products that are among the least expensive on the market and are widely available in urban pharmacies in Dushanbe. According to PSI/Tajikistan, the cheapest commercially available OC is GR's tri-phasic, *Tri-regol*, which sells for between 3.8 to 5.5 som per cycle (approximately \$1.19 to \$1.72 US per cycle). GR's *Regulon* is the least expensive monophasic on the market; it sells for 8.50 to 13 som (\$2.66 to \$4.06 US) per cycle. All GR hormonal products are taxed and unsubsidized. An Iranian hormonal contraceptive (manufactured by Aburaihan) is apparently available for sale from the vendor who supplies the MOH (although currently the MOH is not purchasing any contraceptive products) for 2.5 som (about \$0.75 US) per cycle, although the product was not found in PSI's assessment of the availability of contraceptives in the Tajikistan market¹⁷. Schering products are also available in Dushanbe pharmacies and are relatively expensive.

¹⁷ PSI/Tajikistan, Oral and local contraceptives at Tajikistan market, n.d.

Social marketing experts advise that generally speaking an OC product cannot be made commercially available for less than \$1 US and still be financially sustainable (Armand, April 2006, personal communication). GR products come in attractive packaging and appear to be supported by a somewhat effective marketing campaign, which includes TV advertisement. Nonetheless, because of very low rates of OC use in RT overall (1 percent of women used OCs in 2002, according to the 2002 MICS), the total market for this product is small and probably mostly confined to urban areas. Approximately 30 percent of OC users received their supplies from a pharmacy or store, according to the 2002 survey. Only 0.30 percent of women in RT, approximately 3,500 women, use oral contraceptives. If one assumes 13 cycles are used per woman per year, this equates to a total volume of 45,500 cycles of oral contraceptives. A significant increase in demand for OCs is not expected in the future, absent significant demand-generation activities.

Social marketing remains a poorly understood and nascent concept in RT. Pharmacists who were interviewed were very aware of PSI's social marketing condom, *Favorite*, and reported good sales when in stock, although none had had the product in stock in the past month or two¹⁸. Apparently, a dispute over import duties was keeping the product tied up in customs. Disputes and misunderstandings over taxation and local regulations also seem to affect private pharmacies, generally leading to their occasional closing and reopening.

The positive experience, however, suggests that promotional and educational activities aimed at dispelling misperceptions about hormonal contraceptives (e.g., concerns about becoming "hormone dependent") among potential users in urban areas would likely have a favorable impact. It also raises concerns about the prospects for social marketing efforts involving a donated or heavily subsidized contraceptive product. Furthermore, new, potentially lower cost suppliers are not likely to emerge soon given the small market for commercially provided OCs in the country, the absence of any significant contraceptive tenders, and the availability of relatively low-priced products already in the market. The good news, however, is that GR has an established presence in RT and is making available a variety of high-quality generic products at a fairly affordable price.

According to a recent PSI/TJ assessment¹⁹, conversations among friends may be the source of both positive and negative information about OCs, suggesting fairly widespread misperceptions about this method. Doctors and gynecologists also were seen to be supportive of and opposed to the method. Pharmacists were mostly a source of positive information about the method. Thus, it seems that in addition to information, education, and communication efforts aimed at urban populations there is a need to target general practitioners and gynecologists to educate them about contraceptive methods in general and hormonal methods in particular. This training could be integrated with ongoing CME efforts being implemented by *ZdravPlus*, for example.

¹⁸ Under the CAPACITY Project, PSI effectively supplied condoms to outlets in high-risk zones serving at-risk youth, sex-workers, and injecting drug-users.

MEDIUM-TERM RECOMMENDATIONS

- With Project Sino and *ZdravPlus*, explore options for expanding education efforts regarding hormonal contraceptives, especially pills, through CME and preservice physician education.
- Explore options for increasing demand for OCs. PSI, for example, could partner with local manufacturers, notably GR, to help promote OC use generally while ensuring broad distribution of its products. PSI has clearly demonstrated its capacity in educating consumers about healthy behaviors and in reaching underserved groups with its social marketing activities for other products.
- Before investing in any new social marketing products, assess ways in which GR's promotional and distribution systems might be strengthened through targeted and discrete investments.

ANNEX A: OVERVIEW OF PAST POLICIES IN KAZAKHSTAN AFFECTING CS

The family planning situation in Kazakhstan and subsequent contraceptive availability has undergone substantial changes over the past 15 years. The following section provides a timeline and overview of the key reforms and policy changes influencing the current status of CS.

UNDER THE USSR

Reproductive Health/Family Planning (RH/FP) Services: In general, the accessibility of contraceptives was poor, as the state tried to increase the birth rate. The state discouraged birth control programs and contraceptives were not administered for family planning.

Contraceptives: The state procured contraceptives centrally and dispensed them over the counter through retail pharmacies at a very low price with the assumption that every woman could afford to use a contraceptive method. Hospitals provided oral and injectable contraceptives at no charge to patients receiving treatment for hormonal imbalances (dysmenorrheas). IUDs were also provided without charge in women's consultations centers.

Procurement System: In the USSR, the Central Pharmaceutical Administration Body (Farmupravleniye "Pharmacia") procured contraceptives under the MOH. The USSR distributed drugs (procured by the USSR Foreign Trade Agency centrally) to its branches (named Aptekoupravleniye) in all republics including Kazakhstan. These republican-level bodies distributed drugs further to pharmacies, which were all public. Prescribed drugs were free of charge or had copayments (100 percent, 50 percent, and 25 percent by category of population). Nonprescribed drugs were fully paid.

1991: BEFORE AND IMMEDIATELY AFTER THE FALL OF THE USSR

RH/FP Services: USAID launched the Reproductive Health Service Expansion Project to introduce RH/FP services to the public system, train providers in new contraceptive technology, and encourage high level policy support for FP as a means to reduce reliance on abortion. The MOH became actively engaged in efforts to increase use of modern contraceptives. In 1994, the MOH approved an FP program and required that all medical institutions offer FP services. The GOK established a national FP program with a coordinating committee on RH.

Contraceptives: Immediately after the fall of communism, some contraceptives were available in the public sector but had little support, as hard currency to buy additional supplies was scarce. Contraceptives were still available in the retail public sector, but were much less accessible to the average consumer. Following a huge contraceptive shortage, UNFPA intervened to avoid a total crisis by providing limited supplies of contraceptives throughout the region.

Procurement System: Contraceptives are distributed through old Soviet system of “pharmatsia” entity.

1996–1999: THE PERIOD OF NASCENT HEALTH REFORMS

RH/FP Services: FP services are expanded throughout the entire MOH system, primarily through Women’s Consultation Centers and Family Group Practices. Kazakhstan experienced a rapid and dramatic increase in contraceptive prevalence and a concurrent decline in the number of total abortions. Contraceptive use increased by 50 percent since the early 1990s, with abortion decreasing equally. The Kazakh population experienced its greatest increase, from 53.5 percent in 1995 to 64 percent in 1999. The Russians, with the highest abortion rate, experienced the largest fall in TAR. IUDs are by far the most popular modern method. Relatively few women use the pill because of widespread misinformation about health risk effects.

Contraceptives: Kazakhstan receives mass influx of contraceptives through humanitarian aid. These contraceptives were widely distributed across the country. From 1994 through 1998, USAID provided contraceptives and the bulk of donations remained in Almaty. Donations included OCs, IUDs, injectables, and condoms. UNFPA also supplied contraceptives to south Kazakhstan and Karaganda oblasts. All donations ceased in 1998. Contraceptives are supposedly distributed free of charge in the public sector.

Drug procurement system: Around 1995-1996, approximately 97 percent of pharmacies in the country were privatized. Subsequently, only 3 percent of pharmacies have remained public; they are located under hospitals and cover inpatient services included into the BBP. In less than 4 years, the MOH has in essence moved from a public sector procurement and distribution system for contraceptives to a completely private one.

Health Reforms: In the meantime, Kazakhstan begins to experiment with different initiatives to reform the health sector. In 1995 they established a National Health Insurance Fund and test services and financing reform in limited oblast pilot sites. In less than 5 years, the MOH changes paths in its reform efforts and cancels the health insurance and oblast pilot tests. Despite retrenchment of health reforms, MOH remains a purchaser of services.

2000–2004: MORE HEALTH SECTOR REFORMS

RH/FP Services: According to MOH data, FP services are in steady state and contraceptive prevalence plateaus around the 1999 levels. FP programs are not reaching key population groups expressing unmet need. Rates of abortion also stabilize but are still at unacceptably high levels. Delicate balancing act emerges as MOH tries to improve access to contraception while

president publicly states intention to substantially increase country's population by 2030. Some resistance to FP program appears within the MOH, as a reflection of the president's pro-natalist policy. There is opposition to including contraception in the Essential Drug List and to allocating budgetary funds to purchase contraceptives.

Contraceptive Supplies: UNFPA remains the principle source of distributed contraceptives but ends donations in 2004. USAID only donates limited amounts to its project sites. The state has played no or little role in contraceptive supply.

Procurement System: Decentralized procurement has been a key feature of decentralized health management decision making. While humanitarian supplies remained in the system, there was no or limited need for local purchases of contraceptives and no procurement at the republican level.

Health Reforms: The MOH rolls out a new reform initiative – Law of Self Governance – that delegates decision-making authority to the rayon level. The decentralization reforms are implemented nationwide and meet resistance. Meanwhile, the Kazakhstan economy takes off, and for the first time, there is pronounced gaps in income levels.

2004 TO CURRENT: ON THE RIGHT ROAD TO REFORM

RH/FP Services: The RH/FP service delivery situation has not changed substantively since the beginning of the 21st century. The MDG report highlights the importance of reducing maternal mortality and emphasizes the link between abortion and maternal mortality. MOH data show abortions remain a major cause of MMR in some oblasts. Recent reports (UNFPA, World Bank) indicate TARs are again increasing. There is increasing awareness, again, that FP is an important strategy to reduce rising abortion rates and is increasingly being seen as important among health providers, policymakers, and influentials.

Contraceptives: OCs appear to be slowly but steadily gaining in popularity while IUD use is declining. Factors contributing to the rise in OCs popularity include free pills in public facilities (when available) but more significantly, widespread availability and access to pills in private pharmacies. The state has played no or little role in contraceptive supply. UNFPA, once the primary source of contraceptives, stops donations in 2004 while USAID only donates limited amounts. There are no shortage of OCs, IUDs, and condoms (both in terms of price and brands) in the private sector.

Procurement System: As humanitarian supplies have run out, local oblast administrations have relied increasingly on the private sector to supply and distribute contraceptives. Procurements are typically done in small volumes at local market prices, many times the prices paid by UNFPA.

Health Reforms: In 2005, the MOH approves sweeping health sector reforms to develop the health sector in a 5-year national program. Key features of the reforms that will affect CS include 1) investing in the health sector by increasing public investment from 2 percent to 4 percent, 2) establishing general health financing mechanism consisting of an oblast-level, single-payer system funding the BBP, 3) decentralizing budgetary procurement responsibilities to the

oblast level, and 4) aligning policies and systems in the pharmaceutical sector to resemble those in Western countries.

ANNEX B: KRYGYZ REPUBLIC HEALTH REFORM BACKGROUND

MANAS TAALIMI HEALTH SECTOR REFORM PROGRAM

The Kyrgyz Republic launched Manas Taalimi, its sector-wide approach (SWAp) mechanism that will pool external and domestic resources, to increase government financing of the health sector for implementation of the national strategies from 2006-2011. According to the Mandatory Health Insurance Fund (MHIF), donor SWAp participants will cover the shortfall between available state allocations for health and programmed costs by contributing \$45 million toward the total \$52 million cost over 5 years. Continued disbursement of SWAp funds is dependent on actual execution of allocations for the health sector by the Government of Kyrgyzstan (GOK) in accordance with Government Decree №280 “On Minimal Standard Financing.” Manas Taalimi is jointly funded by the GOK, pooled donor funding, and parallel funding from USAID and other donors. It calls for the national roll-out and institutionalization of health reforms, including the area of health financing.

High-level policymakers, including the Minister of Health, Shailoobek Niayozov, described maternal and child health and/or reproductive health as priority areas within the SWAp/Manas Taalimi health sector reform program. Indeed Task 1 under Priority Programs is to “reduce maternal and child mortality rates through increased coverage of evidence-based health care services.” The policy document further specifies the importance of upgrading skills of PHC personnel in family planning as a key strategy in carrying out this task.

While ambitious plans to mobilize and allocate increased resources for health have been adopted, their successful implementation faces several risks. These plans can be jeopardized by factors such as political instability, slow economic growth, and poor enforcement of endorsed priorities and decisions. For example, the decision on annual MHI premium increases adopted by the Government Concept on Health Financing (2003) has not been carried out. Unpredictability of financing continues in the first quarter of 2006. Health facilities in the Issyk-Kul oblast appear to be financially worse off than in 2005 – transfers will only cover salaries and some medication costs. It is hoped that the situation will change in the second quarter of 2006 and that the GOK issues adequate allocations as a result of agreements and conditions from the SWAp. These factors suggest potential implementation problems to increasing local funding of contraceptives.

For the past decade the financial burden on households has increased due to declines in public financing of health and increases in health care. Private financing in the form of OOP population payments, both formal and informal, contributes up to 59 percent of the health sector financial resources envelope. From 2000 to 2003, continued increases in household health expenditures were the greatest among the poorest quintile (7 percent). Up to 50 percent of household income was spent on healthcare raising equity issues (Policy Research Paper №31, WHO/DfID Health Policy Analysis Project, 2005, p.6)

REPRODUCTIVE HEALTH COORDINATION

The SWAp serves as the principal coordination vehicle for the Ministry of Health. A working group on Safe Motherhood, also referred to as a Working Group on Reproductive Health by some, has convened to monitor progress in this priority area under the program. However, based on the team's discussions, it is not clear how well reproductive health and, especially concerns related to the availability of contraceptive supplies and services, are represented in this important health coordination body.²¹ The National Coordinator for Reproductive Health, who is also the chief physician for the National Perinatology Center, is a principal in the Manas Taalimi decision-making body. However, she has responsibility for a broad range of maternal and child health issues, as well as for other reproductive health concerns (e.g., reproductive cancers). It is not clear how well she is able to represent concerns specific to family planning. Similarly, the Deputy Minister of Health for MCH also sits on the Manas Taalimi governing body. Family planning and reproductive health also seem to be covered by his department, although it is not clear how well placed he is to keep watch over family planning and CS matters.

The absence of a clear spokesperson for family planning generally and contraceptive supply specifically on the Manas Taalimi board is an obvious weakness. It thwarts progress toward mainstreaming support for family planning in the national health reforms now being rolled out across the country. Furthermore, continued heavy reliance on donated contraceptives may also allow decision makers to put off addressing the institutionalization of future support for contraceptive supplies and services.²² Trying to institutionalize support for family planning at that future time, no doubt, will be a far more difficult undertaking than doing it now as the reforms are being defined and implemented, and when SWAp resources are plentiful. Finally, lack of predictability in donor flows could conceivably lead to a situation where the Republic of Kyrgyzstan faces contraceptive stock outs. This is compounded by the fact that there appears to be no precedent and experience in the procurement of contraceptives, or a notional line item for contraceptives, at either the oblast or central government level.

The working group on reproductive health was convened to draft a national reproductive health strategy. A working group specifically focused on contraceptive supply issues is also planned. However, none of the participants involved in these activities either sits at the table of principals involved in SWAp/Manas Taalimi decision making or is well-positioned to influence the principals at that table. So, while such groups may provide useful mechanisms for addressing programmatic and operational issues relevant to reproductive health and family planning, they are unlikely to be very influential in affecting family planning as a matter of national health policy.

Without a national champion, there is limited scope for CS to become an integral part of national health policy; rather it will be seen as an externally driven concern.

BASIC BENEFIT PACKAGE

Republican budget resources are used for central procurements of the MOH (e.g., pharmaceuticals for treatment of diabetes and TB). Under sufficient financing this centralized

mechanism is able to ensure the availability of pharmaceuticals in the health system. However, uninterrupted access to these pharmaceuticals for patients can be guaranteed only in conjunction with appropriately functioning logistics, service delivery, and provider incentive systems. The MOH purchases a restricted list of drugs, which includes only insulin, vaccines, psychotropic drugs, and narcotics. There are a total of about 20 products, which the MOH distributes to clinical facilities.

Health facilities finance procurement of medications from their public and private revenues. Regulations on the management of public revenues offer facilities some flexibility on amounts and regularity of spending on pharmaceuticals. In recent years, due to the optimization of service delivery infrastructure, more resources were diverted to direct patient care expenses (e.g., drugs, medical supplies). From 2000 to 2003, the share of health expenditures allocated to direct patient care expenses increased from 16.4 percent to 36.6 percent. Irregularities in public financing create risks of drug shortages, however, and to ensure facilities have drugs and supplies, they may limit their spending on other inputs and/or refer to private sources such as revenues from paid services. One method health facilities use to secure pharmaceuticals involves collaborating with suppliers that offer lines of credit and hence will agree with retrospective and postponed reimbursement (e.g., Merged Issyk Kul Oblast Hospital). Often oblast facilities conduct “pooled” procurements combining requirements/requests from other facilities for one tender.

Hospitals purchase directly from country suppliers the drugs they need for inpatient services. These drugs are dispensed without charge to any hospitalized patient. The hospitals make these purchases from their revenues, which include state budget and HIF case-based payments and patient copayments for services. Ambulatory facilities regularly procure medications for outpatient emergency care and for in-facility use (during outpatient visits) and dispense them to patients without charge. In fact up to 30 percent of public revenues (from the budget) can be used for this purpose in outpatient facilities (e.g., FMCs).

The donor community and international NGOs finance the provision of some pharmaceuticals on an in-kind humanitarian aid basis. Three examples of donor-supplied drugs are the products provided by the U.S. State Department Humanitarian Assistance Program, TB drugs for DOTS provided by a GFATM TB grant, and STI drugs provided by the same GFATM grant that provides condoms. These drugs are distributed to all patients free of charge.

Contraceptives are available for free as part of the BBP so long as donors continue to provide a sufficient supply of orals, injectables, IUDs, and condoms. Interviewees suggested that little thought has been given to how these products might be supplied if donations end. With UNFPA saying it will continue to provide contraceptive supplies to the country through 2009, the medium security of contraceptives appears secured. However, as the experience of Kazakhstan has shown, once UNFPA donations end there is no concrete plan for national or local procurement. This has resulted in product stock outs and a haphazard response from local oblast health administrations with some finding funds to procure supplies but others not.

External donors, primarily UNFPA, USAID, and the GFATM, are the source of funding for contraceptives. UNFPA has had the longest history in funding contraceptives for the Kyrgyz Republic, with annual allocations reaching US \$104,000 between 2000 and 2004 and US \$52,000

since 2005. USAID's spending on contraceptives has been about US \$300,000 with smaller amounts purchased in 2006. Of its \$17.1 million obligation to support prevention and treatment of HIV/AIDS in the Kyrgyz Republic, the Global Fund provides condoms to HIV/AIDS risk groups annually, spending US \$315,000 for the period from 2006-2008.

ADDITIONAL DRUG BENEFIT

Mandatory health insurance benefits were expanded in 2000 to include the ADB that covers costs of outpatient care drugs prescribed to insured clients. The ADB is available to more than 80 percent of the population in principle. It provides partial coverage for an additional 52 drugs beyond those included in the BBP. Patients purchase these drugs at a discounted price in selected retail outlets that have applied to the HIF to be authorized suppliers. The ADB's share in recovering the cost of prescribed drugs has been steadily growing since 2001 and averaged 61.5 percent in 2004.

The ADB is intended to encourage people to seek (and get) health services at the primary health care level. Inclusion of contraceptives in the ADB seems to offer enormous potential for institutionalizing the supply of contraceptives within the national health reforms now being implemented. Currently, however, only four OCs are covered under the plan, including *Ovidon*, *Rigevidon*, and *Tri-regol*. In choosing to cover these products, price appears to have been the governing factor (Muhtarovna, 2006). *Depo-Provera* and IUDs are not offered under the ADB ostensibly because they are provided through donor assistance, although OCs are also available through donor assistance. Table 25 offers additional information on prescribed contraceptives covered by the ADB.

TABLE 25: PERCENT OF COST OF PRESCRIBED DRUGS COVERED BY THE ADB

	2000	2001	2002	2003	2004
Bishkek	57.2%	47.2%	50.8%	60.0%	66.2%
Issyk-Kul		35.4%	40.5%	55.1%	64.3%
Jalal-Abad			24.7%	50.7%	61.7%
Batken			24.0%	48.0%	51.7%
Naryn			36.9%	44.6%	56.4%
Osh		66.7%	44.5%	53.0%	67.8%
Talas		16.8%	35.2%	51.8%	55.8%
Chui	48.2%	50.8%	51.6%	63.5%	68.1%
KR	54.2%	38.8%	42.6%	54.9%	61.5%

Source: Manas Program M&E Report, 2005, p.41

The estimated cost of fully financing the ADB in 2006-2011 is \$26 million. If funding from both the GOK and SWAp sources for all priority programs does not cover the financing gap, the ADB may not be fully funded. In 2006, per capita financing for ADB was 30 som, which is 50 percent higher than in 2005.

The Asian Development bank (ADB) has been expanding recently, and is seen by health officials as a mechanism to improve access to effective pharmaceuticals and to strengthen drug

management. In 2006, ADB disbursement mechanisms were used for pharmaceuticals formerly available through centralized procurement and the MOH distribution mechanism.

In early 2005, 433,000 uninsured FGP enrollees did not have access to the ADB. It can be assumed that many in the reproductive age population – for example, students over 18 years of age and/or informally employed individuals – are at risk if they do not purchase the MHI plan at their own expense (400 som or US \$10 in 2006).

To establish equal access to the ADB for patients residing in different geographic areas, every FMG should be able to prescribe ADB medications. After starting on a small-scale basis in 2000, ADB was rolled out throughout the country in 2003. To ensure access to the ADB for residents of remote settlements, practitioners of FAPs are trained to prescribe medications to patients. Physical access to pharmacies in the rural areas has improved with 169 pharmaceutical suppliers in 2004 (with 612 outlets) compared to only 40 in 2001. There are still remote areas where access to pharmacies needs to be improved. With support from SIDA, the Naryn oblast is implementing a pilot program of setting up rural pharmacies with the involvement of the NGO Maksat and communities (rural health committees). During 2006–2010 almost US \$3 million will be directed by GOK, SWAp, and parallel financing parties to ensure access to drugs for the population living in remote villages, including US \$480,000 on drug procurement from public resources.

There are geographical cost differences in the level of pharmaceutical covered by the ADB. This observation suggests that the impact of ADB reimbursements on affordability and consumption of prescribed drugs should be a subject of consistent monitoring and evaluation, and that ADB reimbursement practices needs to be linked to pharmaceutical market developments and prices. Subsidized prices have to effectively encourage use of outpatient drugs and reduce demand for services of higher levels (e.g., hospital admissions). In the absence of formal regulations on private market prices for pharmaceuticals, Issyk-Kul MHIF specialists introduced “price advice” tactics with pharmacies, communicating information on commonly used market price levels for ADB drugs and suggesting price adjustments. Although this process will take time, further development of the rural market place with better consumer choice and more price competition between pharmacies can improve access to drug benefits and equity in consumption of ADB pharmaceuticals.

The level of spending on the ADB against the program’s budget was below 100 percent. In Issyk-Kul, only 73 percent of this program budget was utilized in 2005. There are several reasons for such under-utilization, including the ability to quantify demand and its budgeting, the number and location of contracted FGPs and pharmacies, prescription practices, availability and distribution of prescription forms, level of population awareness about availability of such benefits, and the parallel availability of lower price opportunities (e.g., through humanitarian aid). To improve the allocation and utilization of ADB funds in 2004, the MHIF started redistribution of funds within a capitated budget for ADB, retrospectively compensating pharmacies for sold prescriptions.

Outpatient drugs constitute 56 percent of total private health spending. These are mainly purchases of prescribed and nonprescribed items from private pharmacies. Studies suggest that increasing household spending on pharmaceuticals is the main contributor to the growth rate of

health expenditures. Private spending on pharmaceuticals can be attributed to both a price and a quantity effect. From 2000-2003 the per capita number of prescriptions increased by 14 percent, and the price-per-prescription increased by 60 percent. Average OOP per capita expenditures on outpatient drugs of 173 som in 2000 grew to 360.18 som in 2003. While such changes in private expenditures reflect better market choices and ability to pay, these higher prices also suggest increasing financial risks for poorer households. In this regard WHO/DfID Manas Health Policy Analysis Project recommended the Manas-II program to revise pharmaceutical pricing and rational drug prescription practices.

PHC clients can receive subsidized OCs from pharmacies that have contracts with the HIF with a prescription from their FGP doctor. Although prescriptions have increased over time, the number still remains very low, as shown by the following:

- In 2003, 125 prescriptions, with a value of 12,375 som covered by HIF, or 58 percent of the cost of the contraceptive
- In 2004, 83 prescriptions, with a value of 10,167 som, or 62 percent of the cost
- In 2005, 381 prescriptions, with a value of 60,810 som, or 56 percent of the cost

The number of prescriptions prescribed varies by oblast. The highest numbers are those in Batken, Osh, and Chui, while prescriptions are very low in Issyk-Kul, Talas, and Bishkek. The MHIF has not investigated the reasons for the variation in the number of prescriptions written for contraceptives in these regions. It is likely that demand for discounted contraceptives emerge only in cases when humanitarian supplies are stocked out and when providers' recommendations and clients' preferences are for certain brands available at discounted prices only through the ADB.

Private pharmacies procure contraceptives according to market demand. During times of temporary shortages in the public sector, pharmacies will procure larger quantities. Condoms can also be found in many retail stores, not necessarily only at pharmacies and their outlets, and, according to informants, are consumed by clients in urban and rural areas. Private spending on contraceptives (except for purchases at discounted prices within the MHI mechanism) is unknown. Presently, the overall demand for contraceptives in the private sector is relatively low due to the availability of donated goods, and, according to providers, the population takes advantage of contraceptives given free of charge.

To realize the potential of the ADB in ensuring future availability of contraceptive supplies, one needs to better understand why so few women use their contraceptive benefit. It is important to examine these issues more systematically to understand the reasons for the low utilization of ADB contraceptive benefits. This would help identify how to increase the attractiveness of the ADB as a principal source of supply for OCs and possibly other methods, especially in rural areas.

ANNEX C: SAMPLE DISTRIBUTION FORM

Form SD (Ver1.0 September 2004)

MINISTRY OF HEALTH CONTRACEPTIVE SUPPLIES DISTRIBUTION FORM for SDPs

Name Of Institution:

Date Of Visit:

Issued By:

Received By:

Supply	Amount									J Emergency Order Point (E/3)
	A Ending Balance of Previous Month	B Current Number of Stock on Hand	C Adjustments Increase(+) Decrease(-)	D Consumption (A - B ± C)	E Average Monthly Consumption (D / 2)	F Maximum Stock Level (E X 3)	G Calculated Need (F - B)	H Delivered In This Visit	I Ending Balance (B + H)	
Pill (Blister)										
Condom (Piece)										
IUD (Piece)										

Date of Next Distribution:

Remarks: _____

Source: Tajikistan, Reproductive health commodity security (RHCS), Contraceptive availability assessment, Kim O. Beer UNFPA, December 2005

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