Nepal: Contraceptive Security

Issues, Findings, and Recommendations

Raja Rao
Tanvi Pandit

January 2004

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Contents

Figures

Acronyms

CIDA	Canadian International Development Agency
CPR	contraceptive prevalence rate
CRS	Commercial Retail Sales
CS	contraceptive security
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
FHD	Family Health Division
FP	family planning
FPAN	Family Planning Association of Nepal
HMG	His Majesty's Government
HMIS	health management information system
HSR	health sector reform
IGF	internally generated funds
I/NGO	international nongovernmental organization
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JICA	Japan International Cooperation Agency
KfW	*Kreditanstalt für Wiederaufbau*
LMD	Logistics Management Division
LMIS	logistics management information system
MMR	maternal mortality rate
MoF	Ministry of Finance
MOH	Ministry of Health
MoPE	Ministry of Population and Environment
MSI/SPN	Marie Stopes International/Sunaulo Parivar Nepal
NFHP	Nepal Family Health Program
NGO	nongovernmental organization

NGOCC	Non-Governmental Organization Coordinating Committee
ORS	oral rehydration salts
PSI	Population Services International
RH	reproductive health
RHCC	Reproductive Health Coordinating Committee
SDP	service delivery point
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SPN	Sunaulo Parivar Nepal
SWAp	sector wide approach
TBA	traditional birth attendant
TFGI	The Futures Group International
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WRA	women of reproductive age

Acknowledgments

The authors of this report would like to thank Janardan Lamichane, Frank White, and the staff at the Nepal Family Health Program (NFHP) for their help in collecting valuable data and for organizing meetings and interviews with key Nepali health partners. We are also indebted to the generosity and support of a number of His Majesty's Government directors and staff at the Family Health and Logistics Management Divisions for their time in discussing with us, at length, contraceptive security issues. Several donors, technical partners, and nongovernmental organizations, notably the Family Planning Association of Nepal, provided important insights into the successes and challenges of a number of family planning and reproductive health programs. Finally, we wish to express our gratitude to the U.S. Agency for International Development (USAID) for funding this assessment and to USAID/Nepal for supporting this study and for recognizing the impact contraceptive security can have on the health of all Nepalis.

Executive Summary

Purpose and Objectives

To continue the significant progress made in contraceptive security (CS), His Majesty's Government (HMG), donors, nongovernmental organizations (NGOs), and other technical partners will need to develop a common set of priorities and a joint strategic plan to address the remaining challenges. To increase our understanding of the interventions needed to meet these challenges, and to strengthen ongoing CS efforts, the United States Agency for International Development (USAID) and the DELIVER project conducted a contraceptive security assessment using the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) technical framework The assessment included collection and analysis of demographic, family planning (FP), and reproductive health (RH) data, key informant interviews, and a limited number of health facility visits.

The team met the following objectives:

1. Increase awareness among stakeholders of the need for a multisectoral approach to CS.
2. Identify *big picture* CS issues, using the SPARHCS framework as the basis of inquiry.
3. Explore potential strategies with USAID/Nepal and other stakeholders.
4. Provide input and participate in the CS forecasting meeting.
5. Develop next steps for follow-on CS activities.

Findings and Recommendations

The following findings and recommendations are discussed in more detail in the body of the report; they are organized using the SPARHCS framework: capital (finance), stakeholder coordination, capacity, commitment (policy), and client utilization. While many elements of the SPARHCS framework are currently being addressed in Nepal, the potential exists for moving CS forward by strengthening ongoing efforts and by developing new approaches in the face of the changing environment.

Capital

One of the major issues facing Nepal is the projected financing gap between program requirements for contraceptives and funding commitments by donors and government. Nepal's combined financing shortfall for contraceptives will be U.S.$4.7–U.S.$6.7 million in 2007, which will increase to U.S.$13–U.S.$17 million by 2015, if there is no further support.

To help reduce the growing financing gap, the team recommends the following:

- Pursue financing commitments with existing in-country donors.
- Identify international financing sources.
- Support and strengthen cost recovery, sustainability, and the private market (e.g., commercial sector, social marketing, and NGOs).

- Expand community-based financing.
- Identify savings from improved procurement practices.

Coordination

Nepal CS decision makers participate in a number of committees lead by HMG, donors, and NGOs. At least five committees of stakeholders from a variety of FP and RH areas meet to discuss the status, ongoing implementation, and future planning related to many aspects of CS, e.g., financing, service delivery, and health sector reform (HSR). To some degree, information sharing occurs across elements, but it could be improved by using a more systematic approach.

Sharing information, coordinating efforts to identify and address interrelated issues, and establishing CS priorities can be enhanced by a cross-cutting contraceptive security task group that has the mandate to address the multiple inputs CS requires. This task group would be responsible for setting priorities and developing joint implementation strategies and for ensuring coordination of efforts among the committees. The existence of such a task group does not imply that a new entity should be created. Rather, the mandate of an existing FP/RH committee could be expanded to include the critical CS components.

Capacity

Procurement:

Nepal procures contraceptives using a number of financing mechanisms. The major players include USAID, which has its own procurement system and provides contraceptives directly to Population Services International (PSI). The Department for International Development (UK) (DFID) funds contraceptive procurement for the Ministry of Health (MOH) through the United Nations Population Fund (UNFPA). The German development bank, *Kreditanstalt für Wiederaufbau (*KfW), provides direct commodity financing support to the MOH and, by extension, the Family Planning Association of Nepal (FPAN).

A comparative analysis of UNFPA and MOH injectables procurement prices indicates that centralizing procurement functions within the MOH may allow Nepal to decrease the number of contraceptive brands and, perhaps more important, identify lower contraceptive unit prices—effectively reducing the overall financing burden.

Logistics:

Compared to other countries of similar size and development, the integrated Nepal public sector logistics system exceeds performance standards. However, some decline in national logistics system effectiveness has been noted, which, if left unchecked, could undermine the improvements made over the past several years. The reporting percentage from health facilities began to decline during the fourth quarter of 2001–2002; product availability has not met target indicators set by the NFHP. Monitoring of facilities has decreased, which, in some districts, resulted in a decline in reporting and affected storage conditions as well.

Based on these findings, it is suggested that the following activities be considered:

- Undertake an analysis of the key factors contributing to stockout levels at health facilities.
- Increase supervision of facility staff.
- Reintroduce storage standards checklists at facilities.
- Improve communication between Logistics Management Division (LMD) field staff and all partners.

Commitment:

Interviews with stakeholders revealed a number of competing viewpoints concerning an overall policy direction to address the role of providers and the contraceptive method mix. Development of a strategy to achieve a rationale method mix should consider government priorities relating to cost and coverage. However, these strategies should be carefully constructed so they do not interfere with client choice. Discussions surrounding method mix should also help stakeholders develop other implementation strategies to guide activities, which can help achieve increased prevalence while reducing costs to the public sector.

Related to the method mix, the MOH should also take the lead in discussing the role of contraceptive suppliers. An analysis of public sector use by income quintile revealed that the highest income group accesses the public sector for contraceptives at twice the rate of the poorest group of users. This evidence indicates that there is room for some segments of the population to use private and commercial sector sources, while allowing the MOH to serve poorer populations more effectively. Which suppliers are positioned to provide which methods, at what cost, and to what populations, are questions that the MOH and other partners should consider when determining the role of suppliers.

Client Utilization:

The prevalence rate for all contraceptive use in Nepal is 39.3 percent. However, that figure does not account for the total demand for contraception. A significant segment of the population of reproductive age has needs or demands that are not being met. It is recommended that both barriers to access and use of contraceptives should be addressed through a review of experience and recent analysis of ongoing efforts. Efforts should then be made to integrate client utilization strategies with national CS priorities that address unmet need. A coordinated approach among decision makers and public and private service providers can be used to help remedy a number of barriers to access and utilization.

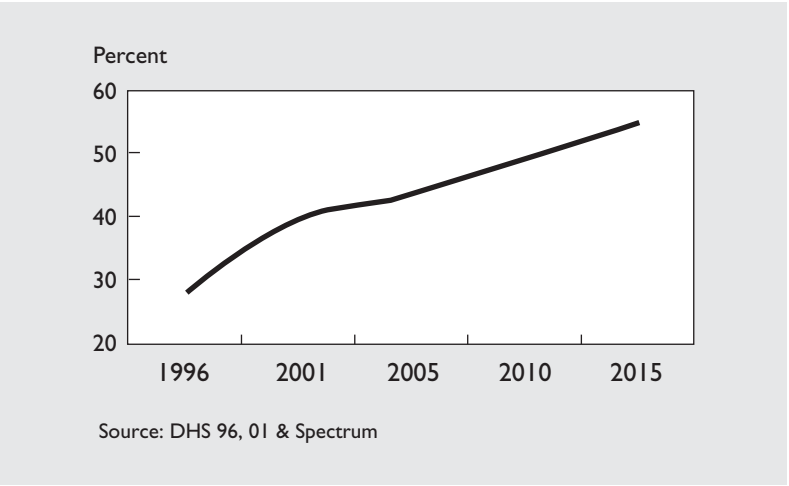
I. Background

Family Planning and Reproductive Health in Nepal

Since the 1950s, Nepal has witnessed significant improvements in its economic and health indicators. Access to social services, including primary health care, has increased, and related access to other services—electricity, infrastructure, and drinking water—has also become more prevalent. In reproductive health and family planning (FP), indicators suggest that greater access to, choice of, and use of FP commodities have been rising steadily. The total fertility rate (TFR) has declined from 7.1 births per women (CBS 1971–2002) to 4.1 in 2001 (MOH Nepal et al. 2002). This achievement is due, in large part, to the increased prevalence of the use of modern methods of contraception. The contraceptive prevalence rate (CPR) for modern methods was 2.9 percent in 1976 (Nepal MOH 1976). As figure 1 indicates, it has since risen dramatically, to 35.4 percent among women of reproductive age (DHS 2001)[1].

The success of HMG, donor agencies, and technical partners in marshalling resources and implementing sound FP programs has certainly contributed to this extraordinary achievement. In addition, access to information and education about FP (by both urban and rural women) has increased choice and spurred demand.

Figure 1: CPR 1996–2015

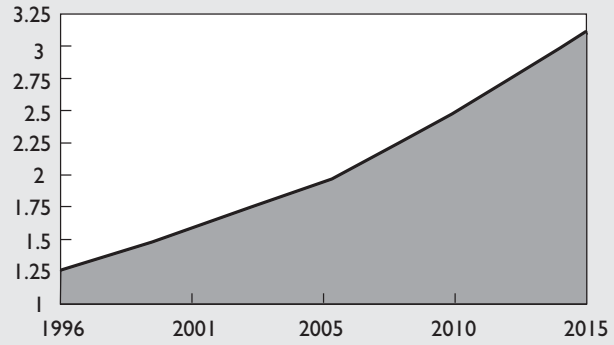


Projections based on SPECTRUM[2] suggest that CPR for all methods will reach more than 53 percent in 2015, with the number of users nearly doubling, from 1.56 million in 2001 to more than 3 million by 2015 (see figures 1 and 2). The reasons for this are twofold. First, an increasing number of couples of reproductive age are choosing to use contraception when they make FP decisions. Outreach, access, and better information are leading to greater utilization (as a percentage of overall population) by reproductive-age couples. Second, trends indicate that the general population will increase more than 25 percent,

1. Informal surveys suggest that CPR for modern contraceptive use was nearly 40 percent in 2003.
2. A software tool, developed by the Futures Group International, to develop FP use and other projections based on population data and established targets. The authors defined TFR based on HMG long-term targets.

to 31.2 million in 2015—with women of reproductive age (WRA) increasing from 5.1 million to more than 8 million during the same period.

Figure 2: Users Over Time (In Millions)



Source: DHS 96, 01 & Spectrum

Despite its progress, Nepal remains one of the poorest countries in the world. Per capita income is approximately U.S.$250 per annum (World Bank 2003), and literacy rates for women (43 percent) and men (65 percent) remain low. As a result of the rate of poverty and remaining obstacles surrounding health services and education, Nepal is also burdened with one of the highest maternal mortality rates (MMRs) in the world, at 830 deaths per 100,000 (UNFPA 2002). Even the impressive strides made in increasing CPR contain significant disparities between urban and rural (56.3 percent versus 33.2 percent) and educated and uneducated populations. Based on the 2001 Nepal Demographic and Health Survey, unmet need for contraception also poses a significant and unique challenge to national decision makers. More than 27 percent of women surveyed responded that they would like to use contraception for spacing or limiting but are presently unwilling or unable to utilize or access services. Factors related to this level of unmet need include fear of side effects, cultural and family barriers, geographic isolation, poor infrastructure, and health workers' attitude**.** In addition, contextual factors, such as the Maoist insurgency that began in 1996, which has claimed almost 8,000 lives as of this writing, is beginning to severely affect access to basic health services in rural and semi-rural areas.

Given the factors described above, it is essential that the MOH lead the effort to protect progress made in TFR and CPR, meet the rising demand for contraception, and respond to the growing financing gap. These challenges have created the basis for an analysis of the CS situation in Nepal, combined with specific recommendations for short- and medium-term actions.

Contraceptive Security

Many countries face the challenge of meeting current and future client demand for contraceptives. Globally, FP programs are confronted with the twin burdens of responding to the rising demand for commodities and services, while experiencing static and, in many cases, decreasing financial support for contraceptives and FP services. As the gap between supply and demand grows, how can countries ensure contraceptive security—a *client's ability to choose, obtain, and use contraceptives and condoms whenever he or she needs them*? Country partners, multilateral and bilateral donors, technical agencies, NGOs, and a host of other organizations are starting to take a comprehensive approach to strengthen CS by involving health partners working in logistics, service delivery, private, policy, financing, and other sectors. This approach requires stakeholders to recognize that the issues and challenges that affect CS are interrelated.

For example, adequate commodity *financing* requires a supportive *policy* environment; the availability of clinical *contraceptive* methods requires the availability of trained *service delivery* providers.

As illustrated above, family planning and availability of contraceptives are important public health priorities in Nepal. Decreases in the TFR and a rise in the use of modern contraception are a significant indication of both HMG's commitment to the issue and the effectiveness of its programs. Interviews conducted with NGOs, MOH officials, technical partners, and donors indicate that FP/RH partners understand the complex and integrated set of issues that affect *the ability of men and women to choose, obtain, and use quality contraceptives dispensed from service delivery points (SDPs)*. Forums and committees on FP/RH services, financing, logistics, and forecasting requirements meet regularly to discuss these issues and to plan and implement strategies that address the interrelated factors affecting contraceptive availability. On balance, these issues are addressed routinely among the numerous groups that work in the broad areas within reproductive health (RH). Yet, as this paper shows, further planning and implementation are required to strengthen CS and to meet targets set out in HMG's Second Long-Term Health Plan 1997–2017.[3]

The situation is mixed. Nepal has certainly made significant progress in ensuring access to and use of FP services and commodities; however, major challenges to FP/RH services remain. It is within this environment that HMG and its health partners have placed CS high on their public health agenda. The government recently stated that it intends to meet the challenge of unmet need, close the financing gap, and mobilize resources efficiently, effectively, and equitably to serve clients' needs (*Annapurna Post* 11-26-2003). In doing this, HMG should work with its FP/RH partners by leading the CS effort to—

- Establish consensus on key priority areas.
- Develop a multi partner strategy.
- Ensure that the strategy is adequately financed and implemented.
- Continually monitor and evaluate ongoing activities for effectiveness.

3. HMG/MOH Second Long-Term Health Plan (1997–2017) specifies health targets, including TFR, 3.05; CPR, 58.2; MMR 250; and IMR 34.4.

II. Methodology

Purpose and Objectives

The analysis and recommendations in this report provide stakeholders with an understanding of the key CS issues and assist stakeholders in supporting and strengthening ongoing efforts by Nepali health partners. A team of two consultants visited Nepal for three weeks during November and December 2003 to address, among other things, the following questions:

- Is value added by addressing CS within a multisectoral approach?
- Should there be an agreed upon set of priority CS issues that stakeholders can address through a concerted action?
- What are these issues?
- What strategies can be used to address these issues?

Before this visit, desk-based research was conducted to develop an initial analysis and provide quantitative data to inform the assessment. USAID/Nepal and DELIVER/Washington agreed to the following objectives for the subsequent field work:

1. Raise stakeholders' awareness of the multisectoral approach to CS.
2. Use the SPARHCS framework as the basis of inquiry to identify CS areas of focus.
3. Explore potential strategies with USAID/Nepal and other stakeholders.
4. Provide input and participate in the CS forecasting meeting.
5. Develop next steps for follow-on CS activities.
6. Work closely with the NFHP to ensure that the team was able to meet its purpose and objectives.

In addition, the team—

- Presented CS approaches in different countries at the semi-annual Consensus Forecasting Committee and the annual Non-Governmental Organization Coordinating Committee (NGOCC).
- Conducted site visits at the central, regional, and district levels.
- Conducted a series of key informant interviews.

The main reasons for presenting at the consensus forecasting meeting were to provide donors and the government with the global perspective on CS and to present illustrative examples of how other countries are successfully addressing their CS challenges. A revised presentation, including more Nepal-specific data, was delivered at the NGOCC meeting. This sparked a discussion on how NGOs, donors, and governments can coordinate their efforts to address serious public health challenges, including reducing maternal mortality, decreasing unmet need, and closing the short- and medium-term financing gap for contraceptives.

Site Visits

Central to the success of CS in Nepal is the integrated public sector logistics system. The team held discussions with the director and staff at the Logistics Management Division (LMD). Visits to the central warehouse in Kathmandu and a review of the logistics management information system (LMIS) were also undertaken with the LMD staff. In addition, the team visited a subregional and district warehouse, a health post, and a sub health post in the Western Region.

SPARHCS Framework and Diagnostic Tool

The team based its analysis on the SPARHCS framework. SPARHCS is based on a conceptual framework that identifies critical areas of attention for RH commodity security.[4] The framework addresses—

- *contextual* issues that challenge or provide opportunities for ensuring a full supply of contraceptives and condoms;
- *coordination* of key stakeholders;
- *capacity* of human resources and health and logistics systems;
- *commitment* of governments, donors, and other key stakeholders;
- *client* access to and choice of contraceptives;
- *capital* or finance required for purchasing contraceptives and condoms; and
- *contraceptive and condom* availability.

The SPARHCS Diagnostic Guide is a series of questions that collect data in each of the elements in the list above to help stakeholders assess the present situation, understand future trends, and provide a basis to begin the strategic planning process. SPARHCS provides a *first-cut* diagnosis of a country's contraceptive security that synthesizes multisectoral thinking about how to improve it. It does not offer the tools for more in-depth analyses of specific components, such as a logistics assessment or market segmentation analysis. Those tools are readily available, however, and the SPARHCS assessment can help identify where more detailed analyses are needed.

Stakeholder Interviews

A large percentage of time and effort was spent conducting a number of key informant interviews with all major stakeholders, i.e., donors, MOH offices, international nongovernmental organizations (I/NGOs), and technical partners. To facilitate this process and to ensure consistency among all interviews, the team developed a simple interview based on the SPARHCS diagnostic tool. A series of open-ended questions was categorized into the following CS component areas: *policy*, *coordination*, *financing*, *service delivery*, *private/NGO sector*, and *logistics and procurement*. Interviewees were not asked all of the questions; instead, certain component areas were applied to the interview based on the organization or person's area of expertise. Using these interviews, the team collected empirical data and stakeholder opinions on a number of CS component areas. This process allowed the team to further explore the obstacles to and opportunities for moving CS forward.[5]

4. SPARHCS was developed for application to contraceptives, condoms, and other essential reproductive health commodities. Its use, so far, has been primarily for contraceptives.
5. See appendix for a list of individuals and organizations interviewed for this report.

III. Findings

This section presents an overview of CS status in Nepal as it relates to the capital required to finance contraceptives, stakeholder coordination, human and systems capacity, commitment from the HMG and its partners, and client utilization of FP/RH services. The findings and recommendations discussed in the following sections are both broad and specific. They are broad in the sense that contextual factors (e.g., infrastructure, security situation, and politics) can and do affect CS. They are specific to the extent that we know donor and government financing are inadequate in the medium term and uncertain in the long term. As the elements of this approach are interrelated, the team has placed specific recommendations under categories where they are most likely to fit.

Financing

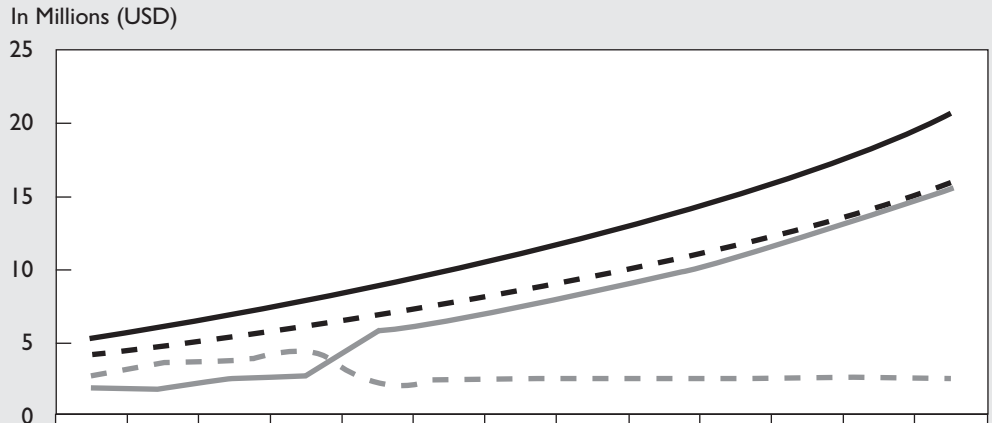
Funding Gap

The most common issue stakeholders identified as an obstacle to contraceptive security is the projected medium- and long-term financing gap for contraceptives. Of the three major contraceptive suppliers (MOH, social marketing, and NGOs), the MOH is not expected to have a financing shortfall until 2007. The major NGO provider, FPAN, also recently concluded an agreement with the MOH under which it will receive substantial supplies to avoid a shortfall through 2006. However, due to significant expected program growth by social marketing, a short- and medium-term gap exists between contraceptive requirements and present commitments by donors and government. As shown in figure 3, Nepal's combined financing shortfall for contraceptives will be U.S.$4.7–U.S.$6.7 million in 2007, depending on procurement prices. The black dashed line in the graph represents the average shortfall (requirements—commitments) of the highest and lowest contraceptive market prices. This gap will rise to U.S.$13–U.S.$17 million by 2015, if additional commitments are not made during that period.

One factor contributing to the sharp increase in financing requirements is the increasing use of modern contraception in Nepal. CPR has risen steadily since the 1980s, and it is approximately 40 percent for WRA. In addition to this rise in prevalence, however, the number of people entering reproductive age also contributes to the upward pressure on financing requirements for contraceptives. By 2007, the number of users of modern contraception is projected to increase to almost 2 million (based on current population estimates). In 2015, that number will exceed 3 million—nearly a threefold increase from 1996 levels.

As figure 4 indicates, Nepal is facing a potential threat of declining donor support for FP commodities. USAID funding will decrease its contribution to $500,000 in 2004 but is then projected to increase it slightly in 2005. However contributions, at least until 2007, will remain flat at $800,000. During the same period, 2005–2007, funding from KfW is expected to drop dramatically, from U.S.$1.2 million in 2004 to U.S.$100,000 in subsequent years. Although DFID's support will make up for some of this loss, the government and its partners are cautious; they understand that donor fluctuations eventually can lead to large funding constraints and potential shortages or stockouts. Therefore, FP stakeholders are considering

Figure 3: Contraceptive Financing Gap 2003–2015



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Req. high	5.26	5.99	6.95	7.92	8.95	9.90	10.97	12.15	13.48	14.96	16.62	18.47	20.55
Commitments	2.78	3.59	3.73	4.35	2.27	2.38	2.40	2.41	2.43	2.45	2.47	2.49	2.52
Req. low	4.21	4.79	5.51	6.24	7.02	7.76	8.58	9.50	10.52	11.65	12.91	14.32	15.88
Avg. gap	1.95	1.80	2.50	2.73	5.71	6.45	7.38	8.41	9.57	10.85	12.29	13.90	15.70

alternate approaches to financing for contraceptives. For this reason, the team examined the current system for contraceptive provision by interviewing donors, government, social marketing, and NGOs.

In-Country Donors

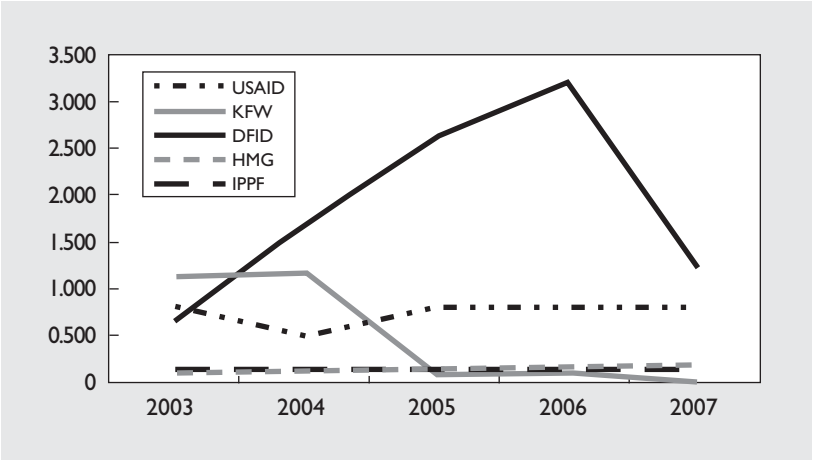
DFID, USAID, and KfW are the three major contraceptive donors. The organizations do not have a common *basket* approach to supporting health sector programs or commodity procurements. Rather, each donor provides contraceptives to different programs and procures from its own suppliers[6], sometimes with the result that more than one brand and/or a different unit price is paid for the same product.[7] Formal and informal discussions with stakeholders revealed that part of the solution to reduce the financing gap might include identifying new donors. Thus, in addition to meeting with existing contraceptive donors, interviews were held with potential new donors. This section focuses on findings from interviews with other in-country donors, including the Japan International Cooperation Agency (JICA), World Bank, UNFPA, and the Canadian International Development Agency (CIDA). These organizations are working with the MOH to support health sector programs, but, they are not currently financing contraceptives.

JICA is currently expanding its activities within the health sector by focusing on safe motherhood and HIV/AIDS. Its five *pillar* areas include advocacy, access, HIV/AIDS, adolescents, and safe abortion. Because JICA has a seven-year history of working with FPAN, and because family planning is integral to JICA's focus areas, it is possible that JICA can play a larger role in contraceptive financing. For example, although the public sector has agreed to provide FPAN with contraceptives to meet its requirements, it will probably experience a shortfall in the near term. International Planned Parenthood Federation (IPPF) donations are unlikely to increase over the next few years, and existing donor contributions are

6. KfW provides direct financing support to the MOH, which conducts its own procurements using KfW and public sector financing. See section on Findings—Capacity for a more detailed discussion.
7. Interviews conducted for this report indicate that this only applies to injectables in the public sector.

expected to focus on support to the public sector and social marketing programs. Unless new donors support FPAN, or a new financing scheme is implemented, FPAN's funding gap is likely to grow, resulting in a shift to the public sector system or an increase in unmet need. Considering that family planning commodities are integral to safe motherhood and HIV/AIDS prevention programs, JICA's main focus areas, the MOH and FPAN, should lead advocacy efforts for JICA's support for contraceptives in all FPAN programs.

Figure 4: Projected Donor Commitments 2003–2007 (In Millions, U.S. Dollars)



The World Bank, a potential source of financing assistance, expressed interest in and concern about the growing financing gap for contraceptives as well as for other health commodities. The bank's five intervention areas in health include safe motherhood/FP, child health/nutrition, communicable diseases, HIV/AIDS/TB/malaria, and outpatient services as well as capacity building to deliver services, improve health management information systems (HMISs), provide supplies, and explore alternate approaches to health care financing. The World Bank plans to carry out a resource mapping exercise in the near future to help determine the costs for these interventions, find out what resources are available, and identify financial gaps for these programs. Nepal has a common work plan for health that donors and the World Bank support through parallel funding streams. This arrangement may increase the government's management burden to ensure that resources are fully maximized, and program and funding gaps are adequately addressed. Furthermore, the Maoist conflict is broadly affecting access to all health services, and it is difficult to determine whether donor support for health in the future will grow at a fast enough pace to respond to the challenges posed by the conflict.

Thus, the World Bank has offered a loan for HMG assistance to ensure continued health services for clients. HMG would have 40 years to repay the loan; the first 10 years would be interest free, and after the 10th year, a 0.75 percent interest charge would be applied only to undisbursed funds. Considering that loans from the World Bank have been successful in reducing the funding gap in other countries—Ghana and Bangladesh—the financing challenges could be addressed with support from the World Bank. However, discussion with HMG stakeholders and donors indicated reluctance on the part of MOH to accept World Bank loans to close the contraceptive financing gap. While this decision is ultimately based on HMG policy preference, using World Bank loans as part of a sector wide approach (SWAp) has proven instrumental in closing the financing gap in Ghana. In 2001 and 2002, the Government of Ghana used more than U.S.$5 million in World Bank credits to procure contraceptives. Bangladesh relies almost entirely on loan credits to supply the public and social marketing programs. The World Bank can be a potential partner for addressing CS; the HMG should explore this further.

The UNFPA program in Nepal focuses on generating awareness and increasing use of services by providing support to (1) promotion and delivery of RH services and (2) strengthening management and training capacity to improve delivery of health services. In addition to supporting activities under these

strategies, UNFPA procures contraceptives for the MOH using DFID funds—this process is discussed in the following contraceptive procurement section. It is important to note that UNFPA does not provide support directly for provision of contraceptives in Nepal. However, in many other countries, UNFPA purchases contraceptives through its own funds. That said, the MOH and its partners should further investigate and possibly advocate for UNFPA to play a similar role in Nepal. Moreover, if the Nepal country program has limited resources available to procure contraceptives, UNFPA headquarters, which keeps a separate budget for procuring FP commodities, may have funding available to support provision of contraceptives in Nepal.

CIDA's assistance to Nepal takes on a somewhat different approach from that of donors such as JICA, USAID, and KfW. CIDA's health activities are integrated into community-based activities, which focus on empowerment, income generation, and support for drug-revolving schemes at the grass roots levels. Gender gaps and environmental issues are cross-cutting themes; they are mainstreamed into all project activities that include increasing the knowledge and skills of faith healers and traditional birth attendants (TBAs). Although the CIDA country office does not provide commodities, CIDA headquarters provides funds to UNFPA, which UNFPA uses to make emergency procurements for country programs.

Diversifying the financing base with additional donors and the World Bank will definitely help decrease the financing gap. However, as discussed in more detail below, working with multiple financing partners may add to the cost. Working with many donors can lead to an increased management burden for handling procurements and determining shipment schedules, especially if each organization brings its own unique procedures and guidelines for providing commodities.

The Commercial Sector

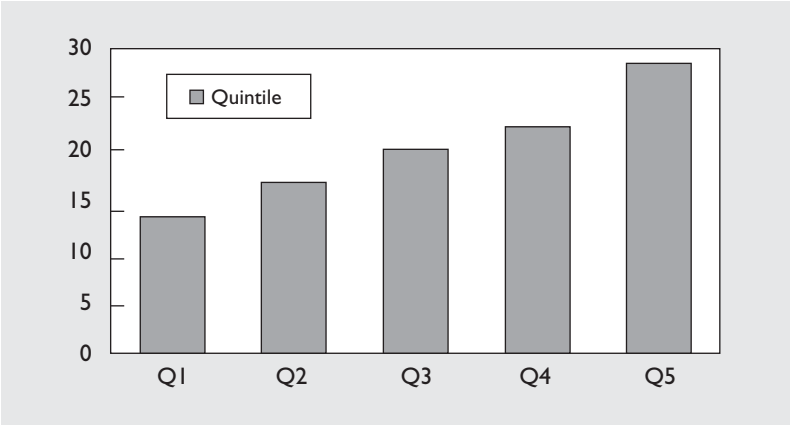
The World Bank (2003) reports that 75 percent of total health expenditures are sourced from individuals (World Bank, Nepal Country Progress Report, 2002). For every U.S.$10.50 spent on health per capita, donors and government together contribute U.S.$3.10. The remainder, U.S.$7.40, is through out-of-pocket expenditures—of this, 60 percent is spent at public sites. Although this does not present a specific picture of expenditure on FP/RH services, it does show that a significant number of individuals are seeking services in the nongovernmental sector, are paying unofficial fees, and, overall, are paying out-of-pocket for their health services. For this reason, it is important to look at the services offered and the programs that NGOs implement, including the for-profit sector, which is working in the family planning arena.

For-Profit Providers

In 2001 the public sector accounted for 79.4 percent of the contraceptive market (DHS 2001). Since then, social marketing, and, to a lesser extent, NGOs, has become more active. It appears that some clients in richer-income quintiles can be moved to the commercial sector; however, *just moving clients from the public to the commercial sector for condoms will not result in significant savings.* The evidence suggests that there is room for the growth of commercial sector providers that offer a range of contraceptive methods. Based on an analysis of DHS data, it was determined that the richest one-fifth of the population (quintile) is accessing the public sector at a rate nearly double that of the poorest quintile. If individuals in the richest quintile can be moved to the commercial sector, the public sector can better target its limited resources toward the poor by transferring a portion of the financing burden to wealthier populations.

Empirical studies and anecdotal information suggest that affluent individuals often seek services in the commercial sector. In Nepal, while richer-income groups do use the commercial sector at a greater rate than do the poorer groups, they also access the public sector at a higher rate than do populations in poorer income quintiles. This indicates that CPR is distributed unevenly, with CPR rising with each successive income quintile (see figure 5). With a modern CPR rate of 35.4 percent, what are the opportunities to increase both overall CPR and use among the poor? An analysis of CPR by quintile (see figure 6) indicates that the richest one-fifth of the population (or quintile) accounts for the highest CPR, nearly triple the poorest quintile[8] (World Bank 2001). The ability of the richer quintiles to pay more out of pocket should be investigated further as one way to increase the share of household sector financing for contraceptives, while, in all likelihood, reducing the burden on the public sector. This would allow the public sector to concentrate on reaching the poorest 40 percent of the population with a CPR of only 18 percent. The best way for HMG to do this should be examined in more detail.

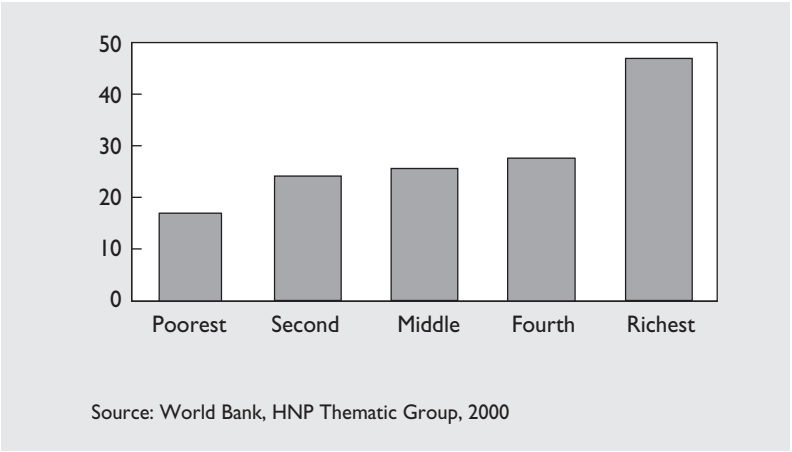
Figure 5: Distribution of Public Sector Clients across Quintiles



One focus could be to identify contraceptive intentions among the poorest with unmet need, and to determine how public services could be expanded to meet these needs.

The potential for growth in the for-profit sector will not be known until the willingness to pay for contraceptives among the richer quintiles can be determined. Market segmentation analysis could provide HMG with a better understanding of the market and the potential for greater private funding of commodities. If combined with a closer look at willingness to pay and ability to pay by comparing household expenditures with the cost per CYP for different methods, it could help identify the potential for increasing product costs for the commodities consumed predominantly by the richest quintile.

Figure 6: CPR by Quintile 1996



Source: World Bank, HNP Thematic Group, 2000

8. The CPR by quintile data is based on 1996 DHS figures. Prevalence for modern methods is significantly higher in 2001 (where the latest overall figures are available). Figure 6 illustrates the significant disparity in CPR among income quintiles.

Social Marketing

PSI and Commercial Retail Sales (CRS) are the two main social marketing groups in Nepal. Marie Stopes International/Sunaulo Parivar Nepal (MSI/SPN) also recently launched a new social marketing campaign, which is discussed later in this document. USAID's primary recipient for contraceptives is PSI, which subcontracts to CRS. CRS not only receives contraceptives from USAID but is also supported through KfW and relies, in part, on revenue generated from sales. Channeling KfW funds directly to PSI is currently being considered.

Using a combination of sales data, DHS figures, and census data from retailers, PSI estimates that its market share for condoms is close to 55 percent. The market share for *Dhaal* (Blue/Gold) is estimated at 30 percent; for *Panther* at 15 percent, and for *Number One* condom at 9 percent. PSI estimates a 20 percent growth per year for condoms, in general. The launch of the *Number One* has been successful in Nepal. The general feeling is that the steep growth in sales has contributed greatly to overall condom sales and an increase in market share. Due to recent shortages in supply, however, PSI has slowed down marketing efforts. Number One is currently sold for 59 paisa (U.S. $.008) to retailers, who usually resell condoms at Rs. 1/unit (100 paisa = 1 rupee). The total cost to PSI (including marketing, overhead, etc.) is Rs. 3 (U.S.$.04). PSI's cost is Rs. 5 (U.S.$.07); this includes the cost of the condom, which PSI receives free of charge from donors.

In addition to condoms, PSI currently plans to expand its market in pills, injectables, implants, and intrauterine devices (IUDs). Service providers must be adequately trained to provide Depo-Provera; the government regulates provision of Depo-Provera to SDPs. Only those facilities where staff have been trained receive the product. Thus, PSI now emphasizes training new providers and is working with NFHP to train paramedics. PSI is also in the process of launching a one-month injectable that has been popular with young women in urban and peri-urban settings.

The strategy for social marketing is to expand programmatic reach by increasing the number of new users, thereby increasing CPR and reducing unmet need. PSI has been involved in the forecasting committee meetings, but there should be further discussions with PSI to understand the steps it is taking to reach its target market. A market segmentation analysis will be useful to better understand each provider's comparative advantage.

Nongovernmental Organizations

The Family Planning Association of Nepal (FPAN), the local IPPF affiliate, has been experiencing a shortfall in financing for contraceptives due to the Mexico City Policy, which resulted in the termination of USAID support. HMG and FPAN have recently concluded discussions; the result calls for the MOH to provide 10 percent of its KfW-financed contraceptives to FPAN. While this is a positive, short-term development, FPAN and other NGOs—notably, the local Sunaulo Parivar Nepal (SPN)—must develop creative approaches to ensure that a full range of products and services is maintained for its clients. FPAN has implemented a cost recovery scheme to ensure that its clients have contraceptives available. FPAN charges a subsidized fee for resupply (except condoms) and clinical methods (excluding sterilization), based on ability to pay. Individuals who cannot pay are not charged. Costs for products vary among districts; they are determined based on local income levels. Oral contraceptives sell for 5 to 8 rupees per cycle and injectables for 5–20 rupees. All clients who want condoms must pay a two-rupee registration fee. After this initial charge, condoms are provided free of charge.

The revenue generated from FPAN and SPN cost recovery programs is used regularly to purchase contraceptives from the social marketing and commercial sectors. This is usually done, in the case of

FPAN, after its allotment of free government contraceptives has been dispensed. SPN does not receive any government-supplied contraceptives; instead, it relies on modest support from MSI, in addition to revenue from sales.

Stakeholder Coordination

Multisectoral Contraceptive Security Committee

Nepal CS decision makers participate in a number of committees led by HMG, donors, and NGOs. These committees separately address many of aspects of CS, e.g., financing, logistics, and service delivery.

The example below shows that at least five committees are established; stakeholders from a variety of FP and RH areas meet to discuss status, ongoing implementation, and future planning. On balance, many of these committees appear to be effective in coordinating the myriad FP/RH partners.

- The *Health Partners* group—donors and HMG—meet to discuss macro-level financing and policy issues. It usually convenes monthly.
- The *Reproductive Health Coordinating Committee* (RHCC), chaired by the Director General of Health Services, has a number of subcommittees, including one for FP, where donors, NGOs, and governments coordinate many aspects of Nepal's FP programs.
- The *Logistics Committee*, while presently inactive, addresses all aspects of supply chain issues and a broad range of commodities for the public sector.
- *The NGO Coordinating Committee* (NGOCC) coordinates aspects of CS that are related, primarily, to provision of services and barriers to access and utilization.
- The *Consensus Forecasting Group* meets biannually to review contraceptive requirements and financing commitments.

Each group plays a significant part in helping to create a strong environment for coordinating CS activities. The Health Partners (donor) forum addresses contextual policy and financing issues in the health sector. NGOCC members review and plan next steps in the delivery of RH services. The Forecasting Group provides information on financing requirements and a biannual review of donor financing commitments for contraceptives. However, this fragmented structure makes it difficult for stakeholders to collectively survey the broad landscape of issues that make up CS.

The authors also discovered that each group identified different CS strategic priorities. The various priorities, which emerged from discussions, include unmet need, the financing gap, access, advocacy, procurement, and the role of providers. It is unclear, however, whether specific groups of stakeholders or individuals have identified the same set of CS strategic priorities. For example, certain groups consider logistics management central to ensuring CS, while others tend to regard services or community-based advocacy as the main priority. Of course, these factors, along with many others, play a role in CS, but a consensus on these priorities should be established formally. (See the section on recommendations for information on how the HMG can begin to strengthen the coordination of CS priorities and activities.)

9. Until 2003, Commercial Retail Sales (CRS) was the sole social marketing agent in Nepal. Recently, USAID awarded a contract to PSI to manage the social marketing program. Presently, both CRS and PSI coordinate sales and marketing efforts. It is likely, however, that PSI will become the primary social marketing entity in Nepal.

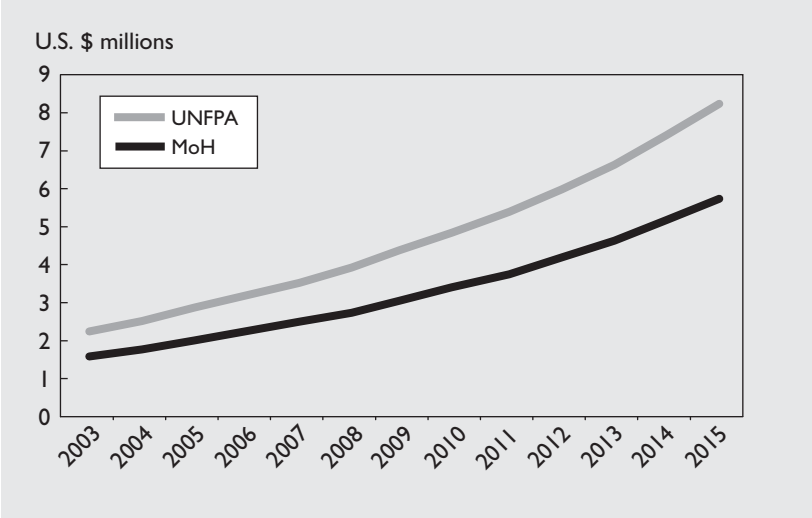
Capacity

Contraceptive Procurement

A number of financing mechanisms are used to procure contraceptives in Nepal. The German development bank, KfW, finances procurements that the MOH regularly carries out through a standard international tender process. Through the MOH, KfW also provides contraceptives to FPAN and PSI.[9] USAID procures and delivers contraceptives directly to the social marketing program, PSI. DFID uses UNFPA as a procurement agent to provide contraceptives to the public sector. Minor but significant procurements occur by IPPF through FPAN and, in 2003, HMG procured nearly U.S.$90,000 in contraceptives using internally generated funds (IGF). An analysis of the procurement system has identified the potential for significant savings.

First, two different brands of injectables flow through the public sector logistics system: UNFPA procures one, HMG procures the other. A number of studies and some anecdotal evidence, based on client interviews, suggest that the availability of a particular brand in one month, then a different brand three months later, may lead to unnecessary side effects and a greater likelihood of early discontinuation of the method.

Figure 7: Injectable Procurement Cost Comparison 2003–2015

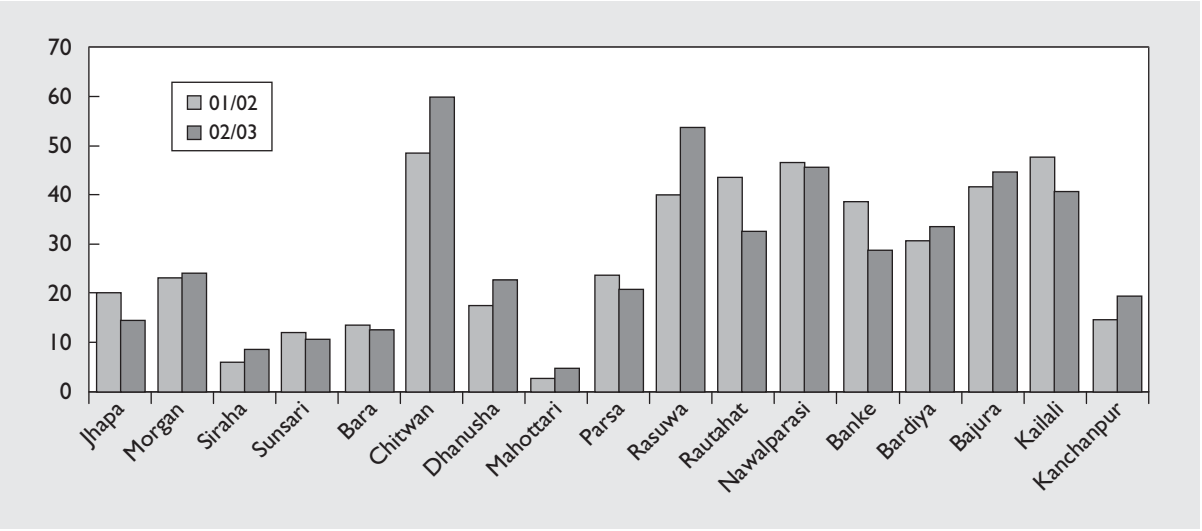


Second, the unit price difference between the two brands is significant. UNFPA-procured injectables are currently U.S.$1.01/unit[10], and KfW-financed MOH injectables procurements are much lower, U.S.$.72/unit.[11] The preliminary analysis indicates that the two reasons for this price disparity are brand and source. In addition, UNFPA charges an administrative fee for each procurement. The impact on cost savings by centralizing DFID-financed (UNFPA-procured) contraceptives within the MOH—as is the practice with KfW—is, as figure 7 indicates, significant.

In 2004, the procurement of all public sector injectables, using the unit pricing obtained by the MOH, would save U.S.$716,000, compared to prices obtained through UNFPA. At U.S.$.72/unit the MOH could procure an additional 1 million units of injectables in 2004, compared to the number that could be procured at the UNFPA price. In 2015, procurement of the lower-priced contraceptive could yield an

10. Based on unit price information provided by Nepal Family Health Program.
11. Both unit prices quoted are based on key informant interviews and a June 6, 2003, NFHP presentation to the Consensus Forecasting group.
12. The unit price calculated for UNFPA-procured injectables does not include the 5 percent–15 percent fee added to the purchase. If this were added, the price difference compared to MOH-procured injectables would be even greater.

Figure 8: Percentage of Health Facilities with All 7 Commodities



additional U.S.$2.3 million in savings. The 2003–2015 aggregated unit price differential is U.S.$18.4 million.[12]

The funds realized from the potential cost savings, obtained using a centralized MOH system (for injectables only) could, in theory, reduce the aggregated 2003–2015 financing gap by more than 20 percent.

Third, MOH capacity to procure contraceptives would also be increased by adding DFID financing to the public sector-based procurement system. Under this scenario, DFID may choose to monitor initial procurements conducted by the MOH to ensure that purchases are undertaken according to acceptable guidelines. A similar arrangement exists between KfW and the MOH, where KfW plans to maintain the technical assistance for contraceptive procurement it provides to the Ministry, so this transition would likely occur without significant procedural issues. However, the time line for such a change and the existing capacity, policy, and regulations of all parties would need to be explored further.

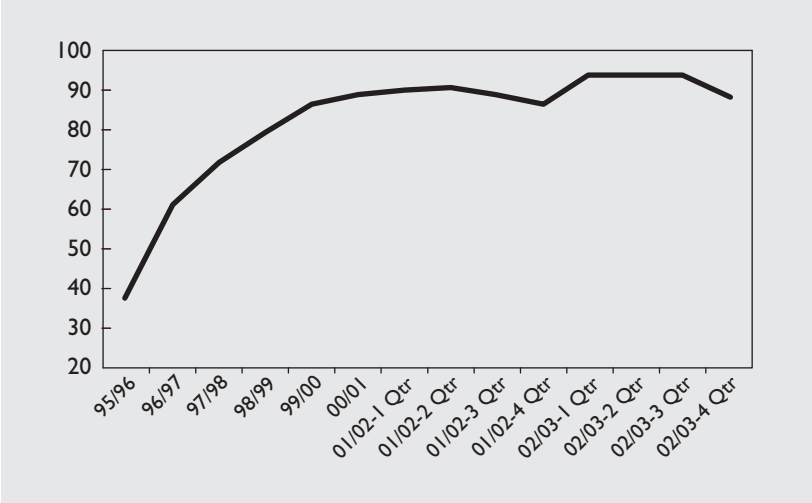
Logistics System

Compared to other countries of similar size and development, the integrated Nepal public sector logistics system exceeds performance standards. Successful partnerships among the LMD, Family Health Division (FHD), technical partnerships (NFHP), and donors have produced significant achievements, based on key logistics indicators: product availability and LMIS reporting, monitoring, and storage conditions. Contraceptive/commodity security cannot be achieved without effective and reliable distribution of contraceptives, medicines, and consumable supplies to the client. However, to increase product availability, it is suggested that a number of critical logistics indicators require discussion and potential action.

First, while the proportion of health facilities with *all* seven NFHP indicator commodities[13] has increased over the past three years, product availability at these facilities has not met the 32 percent target set out in the NFHP target indicator. Further, availability of these seven commodities varies widely by district. The extremes in 2002–2003 were Mahottari District at 4 percent and Chitwan District at 59 percent (see figure 8). In addition, Siraha, Sunsari, and Bara districts all fall at or below the 10 percent level for availability. To state with confidence that products are available to clients, the system must address the

13. Seven indicator commodities: condoms, injectables, pills, vitamin A, cotrimoxazole, oral rehydration salts (ORS), and iron tablets.

Figure 9: LMIS Reporting Percent as Submitted by District Stores and Health Facilities to Center



lack of product availability, not only in 17 core districts, but nationally as well, where logistics capacity building is being addressed on a less significant scale.

Second, the LMIS reporting rate from district stores and health facilities has been impressive. Since the 1995–1996 period, the rate of reporting has risen from 36 percent, peaking in the third quarter of 2002–2003 at 93 percent. The LMD's own LMIS capacity improvements and the support given to it by technical partners, e.g., NFHP/DELIVER, have contributed to these achievements. The reporting percentage began to decline during the fourth quarter of 2001/2002, however, during the beginning phase of NFHP. Now, with the recruitment of regional logistics officers and efforts at the central level by NFHP and the LMD, reporting rates have stabilized. The reporting data suggest that it is necessary to underscore the importance of support to the LMIS unit and regional logistics staff. See figure 9.

Third, monitoring of facilities has decreased, which, in some districts, has resulted in a decrease in reporting and has affected storage conditions. Further, as a result of decreased monitoring and supervision, storage standards checklists developed by the LMD are not being used in many storage facilities. This is likely to lead to expiry, waste, and generally poorer storage conditions.

Policy Commitment

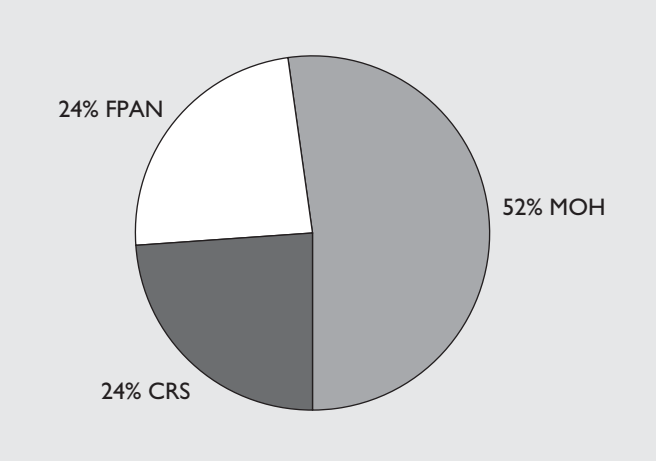
Stakeholders share the twin goals of providing a method mix of contraceptives that clients demand and defining the respective markets of public, NGO, social marketing, and private sectors to realize maximum coverage. Choice should be the first priority when addressing method mix. Yet, other factors, such as limited government resources to provide costlier methods and CPR targets, should also be considered during discussions about method mix. Likewise, when addressing the contraceptive source of supply, decision makers should ask:

- What sub populations should the public sector serve—only the poor and near poor?
- Should social marketing provide, all, most, or some of the resupply methods for those in Nepal willing and able to pay?
- Is it good policy for NGOs to focus primarily on clinical methods?
- Are NGOs and social marketing now competing for the same market? Is that useful? Does it provide choice or create unnecessary duplication?

While informed decision makers in Nepal can address these questions, experience suggests that policy makers naturally have different views and perspectives. Decision making must be guided by data, and data must be the basis for informed policy making. During key informant interviews, competing viewpoints

were expressed concerning the overall policy direction that addresses the role of suppliers and the contraceptive method mix.

Figure 10: Contraceptive Market, 2003



Several interviewees suggested that social marketing should eventually provide the majority of resupply methods (i.e., condoms, pills, injectables) for those willing to pay a subsidized price, while the public sector should focus on *the poorest of the poor*. Yet, HMG is also planning to roll out a program that will charge for contraceptives. Should the public and social marketing sector be competing in this area? One NGO staff member interviewed stated that they are now marketing their own brand of condoms.

- Is this the best use of resources?
- Does/should it compete with social marketing?

Figure 10 illustrates how the contraceptive market is shared based on financing requirements and projected consumption patterns for 2003.[14] The 2001 Nepal DHS details starkly different market figures: 79.4 percent public, 7.7 percent NGOs, and 7.3 percent private sector. Part of this difference can be attributed to the recent growth of the social marketing sector, different data collection techniques, and changes in the market between 2000 and 2003. Nonetheless, in both cases, the public sector remains the largest supplier of contraceptives. FPAN's share (an aggregation of NGO market share) is expected to shrink considerably in the coming years, and, as mentioned earlier, the projected market share for a number of social marketing brands (PSI/CRS) will probably continue to increase.

As part of the effort to help define the roles of suppliers, it is essential to be aware of the impact of the commercial or truly private sector. As mentioned earlier, data on the size of this market (as far as the authors are aware) are essentially non-existent. Estimates range between 5 percent and 8 percent, up to 10 percent. The role of the commercial sector in CS has not been formally addressed.

- How can the public and private sectors work together to increase use and availability?
- What methods are available to commercial sector clients?
- What are the prices?
- What segment of the population do commercial sector clients serve?

These questions can and should be answered through a market segmentation analysis and a private sector survey. The results not only will help bring commercial providers into the CS discussion, but also will give decision makers the opportunity to understand and shape the impact of the commercial sector on product availability and choice.

Based on anecdotal evidence and informant interviews with HMG stakeholders, some agreement has emerged that both IUD and implant prevalence should increase. The rationale for this, articulated by a

14. The percentage is an approximation of the size of each of the three main supply programs relative to each other. Programs purchasing costlier methods may distort the figures slightly. In addition, the private sector, which has an estimated 5 percent–8 percent of the market, is not represented due to a lack of data.

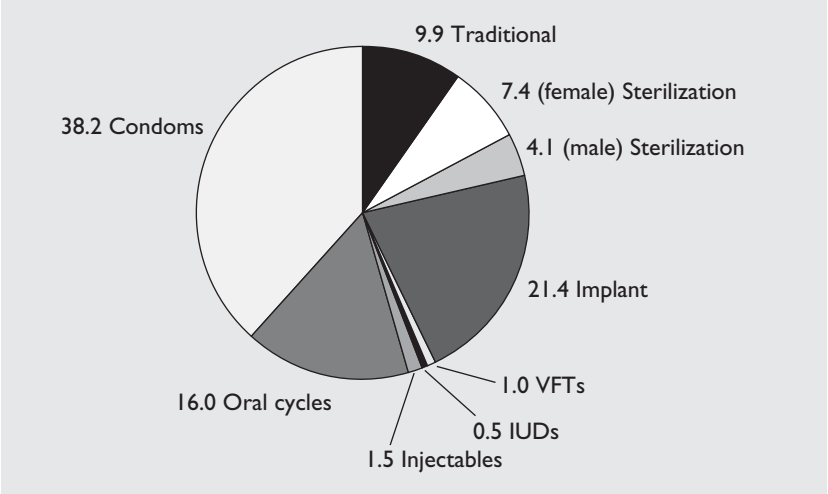
number of HMG stakeholders, is that the increased use of both of these long-term methods can decrease costs significantly, while affording clients reversible options that permanent methods do not provide. As figure 11 indicates, the current prevalence among WRA for IUDs and implants is only 1 percent and 1.5 percent, respectively.

Adoption of a strategy on method mix, while carefully avoiding interfering in issues of client choice, can assist stakeholders to increase prevalence, decrease costs, and meet targets set out in Nepal's Long-Term Health Plan. The definition of provider roles can help strengthen CS, because the government is able to target its finite resources on clients who cannot pay for either commercially priced or subsidized contraceptives. Individuals who are able to pay for (subsidized or commercially priced) contraceptives can be served by commercial market providers, thereby relieving the burden on the public sector.

Client Utilization

Barriers to Access and Utilization of Contraceptives

Figure 11: 2001 Nepal Contraceptive Method Mix



The contraceptive prevalence rate (CPR) in Nepal is 39.3 percent. However, that figure does not account for the total demand for contraception. A significant segment of the population of reproductive age has needs or demands that are not being met. Almost 28 percent of those surveyed in the 2001 Nepal DHS indicated that they have an unmet need for contraception. Taken together, CPR and unmet need total demand for contraception is a significant 67.1 percent. However, barriers to access and use prevent 41 percent clients from obtaining contraceptives.[15] Moreover, the *gap* in unmet need between rural and urban populations remains significant, at 29 percent and 15.8 percent, respectively. Certainly, these data are not perfect. Some individuals may have indicated to the interviewer demand for contraception where none exists, due to cultural or other reasons. Nonetheless, a segment of the population still has a significant unmet need. See figure 12.

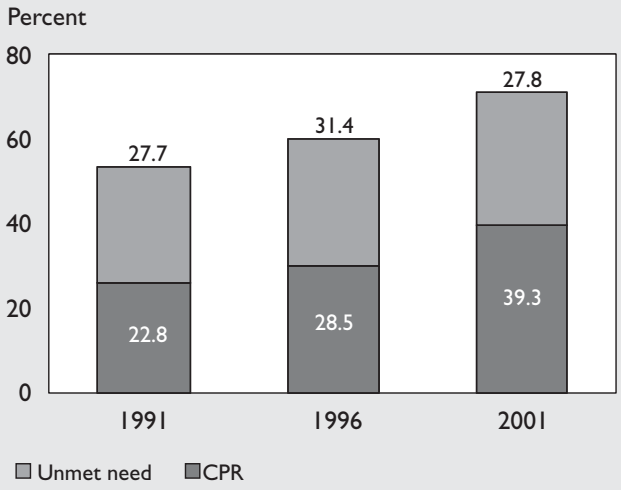
Since 1991, the ability of service provider channels (public sector, NGOs, social marketing, and commercial sector) to address this issue has not been adequate. Some progress has been seen in minimizing unmet need between 1996 and 2001, but providers' ability to satisfy total demand (CPR plus unmet need) has been muted, due to a variety of factors.

15. Precise figures are 27.8 (unmet need)/67.1 (total demand).

Barriers to access—

- poor terrain, bad roads, and lack of transportation;
- availability of retail, NGO, or public sector health facilities for supply and/or clinical methods; and
- civil conflict (the Maoist insurgency), which makes travel unsafe.

Figure 12: Total Demand for Contraception 1991–2001



Source: dhs 96, 01 & Nepal Pop Report, 2002

Barriers to utilization include—

- lack of information and knowledge about family planning;
- cultural beliefs held by society and family members that prevent the exercise of choice;
- low status of women in decision making;
- inadequate funds to purchase contraceptives;
- service provider attitudes; and
- facility capacity.

Certainly, stakeholders and service providers are aware of these issues. A recent example of this was a presentation delivered to the annual NGOCC meeting that addressed barriers related to access and use. The MOH and other NGOs are also responding to these issues by increasing training and supervision of service delivery providers and promoting awareness of contraception through advocacy campaigns. For example, in the Western Region, on a 20-kilometer stretch between Pokhara and two health posts, the team noted three billboards promoting the benefits of contraception. However, a significant challenge remains for decision makers and service providers to address these barriers and reduce the unmet demand for contraception.

The authors recommend that both barriers to access and use of contraceptives should be discussed by reviewing experience with and recent analysis of the issue. A number of Nepali NGOs and I/NGOs, HMG, and donors have been actively involved in developing community-based solutions to increase access and utilization. It is likely that a review of these ongoing efforts, in parallel with development of national CS priorities, can clarify and focus multisectoral strategies to address unmet need. There is no doubt that many of these barriers are contextual, e.g., civil conflict, infrastructure, and the low feasibility of addressing these issues. Yet, a coordinated approach among decision makers, public and private service, and retail providers might help remedy a number of barriers to access and utilization.

IV. Recommendations

The following recommendations do not include all of the potential strategies and activities discussed in this report. Rather, they represent major short- and medium-term priority actions. Implementation of these recommendations requires varying degrees of resources, time, and effort. The authors are not, at this point, attempting to assign greater or lesser value to any of the following suggested next steps, but they do provide decision makers with options that, if implemented, should lead to increased CS in Nepal. In this context, the following recommendations are presented based on their feasibility and likely support by some or all CS stakeholders.

1. Increase the Mandate of an Existing Committee to Include all Contraceptive Security Elements

As the findings indicate, Nepal has several forums where a number of FP/RH stakeholders regularly meet to address challenges in FP. In effect, the various elements of CS are fragmented across all of these groups. To strengthen information sharing, improve coordination efforts to identify and address interrelated issues, and establish CS priorities, the authors recommend increasing the mandate of an existing committee, possibly the Family Planning Subcommittee or the Consensus Forecasting Group, to coordinate the multiple aspects of CS. The MOH can take the following first steps to establish a central CS coordinating committee:

- Identify an existing committee that is already well positioned to address the various elements of CS.
- Determine whether the members of that committee are the most appropriate. Should other stakeholders, such as the Ministry of Health, Ministry of Planning, or NGOs, be involved?
- Design a initial terms of reference.

2. Establish Strategic Priorities

- The findings reveal a lack of consensus on strategic priorities as each FP/RH stakeholder identified a different sets of CS priorities. A common set of priorities, based on a multisectoral approach and agreed to by all stakeholders, can avoid duplication of efforts, promote better information sharing across stakeholders, and establish a common vision that can be integrated within national- and community-level work plans. After the CS committee has been identified, the next step is to reach consensus on which priorities can have the greatest impact on the short-, medium-, and long-term CS. It is suggested that the MOH convene a workshop, with other senior CS decision makers from the MOH, Ministry of Finance (MoF), Ministry of Population and Environment (MoPE), donors, NGOs, I/NGOs, and other technical partners, to review and reach a consensus on key priorities and activities. The workshop will provide an opportunity for the MOH to identify *champions* in key institutions in the public and private sectors (e.g., ministries of Health and Finance, parliamentary committees, employer associations) and provide them with information on CS trends and needs.

- Raise awareness, among other key stakeholders, of the importance of CS, not only for FP programs but also for safe motherhood, HIV/AIDS, and child health programs, to advocate for greater commitment and resources from new partners.
- Establish central leadership and coordination for developing, implementing, and monitoring a joint CS strategy. A CS strategy supported by all stakeholders helps answer questions:
- Who is responsible for what?
- What is the timing?
- Should certain activities happen simultaneously or sequentially?
- What are the outputs/outcomes of the activities?
- Who is going to finance implementation?

3. Increase and Diversify the Financing Base for Contraceptives

Many stakeholders interviewed for this report identified the gap between financing requirements for contraceptives and the current and projected commitments as a critical issue. However, simply stating that more money is needed misses the point. Rather, some specific areas that should be examined (detailed in the body of the report) include—

- MOH and partners advocate for increased short- and medium-term financing with existing Nepal donors (those that currently provide support and those that do not).
- Implement cost recovery schemes at public facilities (for those who can pay).
- Shift populations that have the ability to pay retail prices from the public to the commercial sector.
- Identify and use savings from improved procurement practices for contraceptive purchases.

4. Define the Role of Contraceptive Suppliers

To maximize coverage for segments of the population in need of contraceptives, it is crucial to identify all clients' needs and ability to pay before determining which supplier (public, NGO, social marketing, commercial) is best positioned to meet clients' needs. Evidence suggests that CPR is unevenly distributed across income quintiles in Nepal, with the richest group of users accounting for nearly three times the prevalence as the poorest group. Further, the richest quintile accesses contraceptives from public sources at twice the rate of the poorest quintile. Efficiencies can be gained and CS strengthened by allowing the commercial sector to serve those who can pay and allowing the public sector to focus on less affluent sub populations. Recommendations include—

- A market segmentation analysis (and private sector survey) that provides data and is the basis for making decisions about suppliers roles.

5. Investigate the Feasibility of Integrating Procurement within the MOH

The MOH and its partners should analyze the strengths and weaknesses of the current contraceptive procurement process, then make recommendations that, if implemented, can help increase procurement efficiencies and reduce costs. Such an analysis would describe how the full range of contraceptives are procured (e.g., by donor, price, quantity, brand). A cost-benefit analysis of the current process versus alternate procurement processes could then be made. Based on the outcome, policy-level talks can begin between HMG and donors to discuss the financial, capacity, and policy implications of integrating contraceptive procurement in Nepal.

The results of this analysis may allow the MOH to—

- Reduce the number of brands (of the same product) within the public sector.
- Maximize resources by procuring commodities at a more competitive price.
- Increase government capacity to procure contraceptives.

6. Ensure Logistics System Performance

In relative terms, the Nepal integrated logistics system has been able to provide a number of commodities regularly, including contraceptives, to clients. The challenge is not so much to improve logistics functions and indicators, as it is to maintain performance. To this end, the following steps should be undertaken:

- Conduct an analysis of the key factors that contribute to stockout levels at health facilities, e.g., logistics systems assessment.
- Increase supervision of facility staff.
- Reintroduce storage standards checklists at facilities.
- Improve communication between LMD field staff and all partners.

V. Conclusion

The vision for the Nepal health sector strategy is to improve the health status of the general population by increasing equity in, access to, and quality of health services. According to HMG's long-term health strategy, this goal is linked to the broader outcome of poverty reduction. Explicit in this relationship is the dependent nature between health and economic development through poverty reduction. The ability of the population to *choose*, *obtain*, and *use quality contraceptive products when people need them* is an important beginning of a causal chain that can assist in meeting HMG's health sector goal. Increasing choice of, access to, and use of contraceptives is a cornerstone of all FP programs. This, in turn, has an impact on health status by reducing unwanted pregnancies and maternal and infant mortality. As a result, health status will be improved, which can help reduce the burden of poverty among women and families.

As discussed throughout this paper, Nepal CS stakeholders clearly understand the significance of ensuring CS and its link to health status and poverty reduction. The purpose of the preceding analysis is not only to identify achievements to date but also to determine what additional steps are necessary to improve contraceptive security. This paper attempts to identify what issues or barriers affect CS outcomes in Nepal, including—

- medium- and long-term contraceptive financing;
- a multisectoral CS stakeholder group, national strategic priorities, and unified implementation plan;
- multiple contraceptive procurement systems and prices;
- product availability, information systems, and monitoring;
- method mix and roles of contraceptive suppliers; and
- barriers to access and use at the client level.

Based on these findings, a number of recommendations were discussed that attempted to address each CS issue area. They include, but are not limited to:

- Seek alternate new sources of financing and identify the sources.
- Establish national CS strategic priorities and develop an implementation plan.
- Integrate contraceptive procurement mechanisms and seek lower-cost products.
- Rationalize the method mix and define the roles of suppliers.
- Collect market segmentation data on the role of the private sector and engage private market providers in CS discussions.
- Increase supervision and reporting and broaden logistics focus nationally.

Each of these steps requires resources; neither the feasibility nor the levels of priority that should be assigned to each of them has been addressed. While the authors believe that the suggested steps are feasible, including establishment of priorities, the HMG stakeholders and health partners ultimately should make that determination. The hope is that the findings and recommendations discussed in this paper have added value to the CS discussion in Nepal, and that the information will be used to enhance planning and ongoing contraceptive security implementation activities in Nepal.

Appendix

Key Informants and Organizations

Canadian International Development Agency (CIDA)
- Prabin Manandhar, Director, Program and Projects

Department for International Development (DFID)
- Susan Clapham, Health Adviser, DFID/Nepal

Family Health International (FHI)
- Dr. James L. Ross, Country Director, HIV/AIDS Prevention, Control and Care Program

Family Planning Association of Nepal (FPAN)
- Dr. Nirmal K. Bista, Director General

Japanese International Cooperation Agency (JICA)
- K. Matsuo, Coordinator of JOCV
- Jhabindra Bhandari, Program Officer
- Kei Umetsu, Assistant Country Representative

KfW
- Mr. Dieter Nessler
- Ms. Aida Bayou

Marie Stopes International/ Sunaulo Parivar Nepal (MSI/SPN)
- D.P. Bhattarai, Sales Manager
- Ashok Kharel, Controller

Nepal Family Health Program (NFHP)
- Frank White, Deputy Chief of Party
- Janardan Lamachaine, Logistics Director
- Heem Shakya, Program Officer

Ministry of Health (MOH)

- Dr. Bishnu Prasad Pandit, Health Secretary for Policy, Planning and International Cooperation

MOH—Family Health Division (FHD)

- Dr. Y.V. Pradhan, Director, Family Health Division, Health Services
- Dr. Chetri, Director Logistics Management Division

The Futures Group International (TFGI)/POLICY II Project

- Policy Project Offices, Nepal

Population Services International (PSI)

- Chris Brady, Marketing Director
- Steven W. Honeyman, Country Representative

United Nations Population Fund (UNFPA)

- Dr. Hernando Agudelo, Acting Country Representative
- Dr. Peden Pradhan, Assistant Country Representative

World Bank (WB)

- Dr. Tirtha Rana, Senior Health Specialist HNPS

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