National Reproductive Health Commodity Security Strategy- 2015

Government of Nepal
Ministry of Health and Population
Department of Health Services
Logistics Management Division & Family Health Division
2015

NATIONAL REPRODUCTIVE HEALTH COMMODITY SECURITY STRATEGY

2015

Government of Nepal
Ministry of Health and Population
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Acronyms

ACDP	Annual Commodity Distribution Program
AHW	Auxiliary Health Worker
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ARV	Anti-Retroviral
ASL	Authorized Stock Level
ASRH	Adolescent Sexual and Reproductive Health
CBLP	Central Bidding Local Purchasing
CBS	Central Bureau of Statistics
CCSWG	Consensus Contraceptives Security Working Group
CDP	Community Drug Program
CEO	Chief Executive Officer
CHD	Child Health Division
CNCP	Chlorhexidine Navi Care Program
CoP	Chief of Party
COR	Contract Office Representative
CPR	Contraceptives Prevalence Rate
CR	Country Representative
CRS	Contraceptive Retail Sales
DCoP	Deputy Chief of Party
DDA	Department of Drug Administration
DDC	District Development Committee
DFID	Development Fund for International Development
DG	Director General
DHO	District Health Office
DHS	Demographic and Health Survey
DoHS	Department of Health Services
DPHO	District Public Health Office
EDCD	Epidemiology and Disease Control Division
EDL	Essential Drugs List
EDP	External Development Partners
EHCS	Essential Health Care Services
EOP	Emergency Order Point
EPI	Expanded Program on Immunization
ERHD	Eastern Region Health Directorate
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FHI	Family Health International
FNCCI	Federation of Nepalese Chambers of Commerce and Industry
FP	Family Planning
FP/MCH	Family Planning and Maternal Child Health
FPAN	Family Planning Association of Nepal
FY	Fiscal Year
GDP	Gross Domestic Product
GO	Governmental Organization
GoN	Government of Nepal
H4L	Health for Life
HA	Health Assistant
HC	Health Center
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HIV/AIDS	HumanImmunodeficiency Virus and Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HP	Health Post
HR	Human Resource
ICP	Inventory Control Procedure

ICPD	International Conference on Population and Development
IEC	Information Education and Communication
INGO	International Non-Governmental Organization
IUCD	Intra Uterine Contraceptive Device
JSI	John Snow Inc.
KfW	Kreditanstalt fur Wideraufbau
LMD	Logistics Management Division
LMIS	Logistics Management Information System
LWG	Logistics Working Group
MCHW	Maternal and Child Health Worker
MD	Management Division
MDG	Millennium Development Goal
MNH	Maternal Neonatal Health
MNCH	Maternal Neonatal and Child Health
MoF	Ministry of Finance
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MSI	Marie Stopes International
NCASC	National Center for AIDS and STD Control
NCPS	Nepal Contraceptive Prevalence Survey
NDHS	Nepal Demographic Health Survey
NFFPS	Nepal Fertility and Family Planning Survey
NFHS	Nepal Family Health Survey
NFS	Nepal Fertility Survey
NGO	Non-Governmental Organization
NGOCC	Non-Governmental Organization Coordination Committee
NHEICC	National Health Education, Information and Communication Center
NHSP	Nepal Health Sector Program
NHSSP	Nepal Health Sector Support Program
NML	National Medicine Laboratory
NPC	National Planning Commission
NPM	National Program Manager
NPO	National Program Officer
NTC	National Tuberculosis Center
OB/GYN	Obstetrics and Gynecology
OIs	Opportunistic Infections
PD	Project Director
PHA	Public Health Administrator
PHCC	Primary Health Care Center
PHCRD	Primary Health Care Revitalization Division
PO	Program Officer
PHO	Public Health Officer
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSC	Public Service Commission
PSI	Population Services International
RH	Reproductive Health
RH/FP	Reproductive Health/Family Planning
RHCC	Reproductive Health Coordination Committee
RHCS	Reproductive Health Commodity Security
RHD	Regional Health Directorate
RTI	Reproductive Tract Infection
SDG	Sustainable Development Goal
SDP	Service Delivery Points
SHP	Sub Health Post
SLTHP	Second Long Term Health Plan
SM	Safe Motherhood
SMNSC	Safe Motherhood and Neonatal Health Sub-Committee
SMO	Senior Medical Officer

SOPHYN	Society of Public Health Physicians Nepal
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SSMP	Support to Safe Motherhood Program
SSP	Saath Saath Project
STI	Sexually Transmitted Infection
TAC	Technical Advisory Committee
UNAIDS	United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
VCDP	Vulnerable Community Development Plan
VDC	Village Development Committee
VHW	Village Health Worker
VPP	Voluntarily Pooled Procurement
WB	World Bank
WG	Working Group
WHO	World Health Organization
WP	Work Plan
WSSD	World Summit for Social Development

Executive Summary

Nepal is a co-signatory to the International Conference on Population and Development (ICPD) in 1994, and has committed itself to improve the reproductive health status of people throughout the nation. The National Reproductive Health Strategy of Nepal recognized that RH is a crucial part of overall health and is central to human development.

Better availability and accessibility to quality RH commodities is critical to meet the ICPD and Sustainable Development Goals. Secure supply of affordable RH commodities is an essential driver of RH. Hence, the RHCS aims to ensure a secure supply and choice of quality contraceptives and other RH commodities to meet every person's needs at the right time and in the right place.

The objective of the National RHCS Strategy - 2015 is to address all elements of RHCS in a holistic manner and streamline the activities to meet ICPD's goal, the FP 20/20 Commitment and the Sustainable Development Goals (SDG) for ensuring universal access to sexual and RH rights. RHCS requires a multi-sectoral approach and continuous commitment; it needs to be addressed in a coordinated manner, capitalizing on partnerships with comparative advantages to mobilize resources and strengthen national capacity.

This RHCS Strategy 2015 is the outcome of hard work conducted by a wide range of partners and stakeholders. Implementation of the National RHCS Strategy (2007-2011) did not produce results as envisioned, due to a lack of clear, doable and achievable action plans. Therefore, UNFPA Nepal assigned the local NGO Lifeline Nepal, under the leadership of FHD/LMD, to review, revise and update the National RHCS strategy 2007-2011, defining key strategies and priority interventions to ensure the sustainable access to RH commodities, including estimation of financial requirements for implementing the strategy.

To guide development of the new strategy, a Technical Advisory Committee (TAC) was formed under the chairmanship of the Director General of DoHS, Dr. Senendra Raj Upreti, and a Working Group (WG) was formed under the chairmanship of LMD Director, Dr. Bhim Singh Tinkari.

Desk review of relevant documents, as well as extensive consultations with the individual stakeholders who are the experts in the field of RH, were carried out while framing the strategy. The issues and gaps identified during the RHCS situation analysis exercise were the basis for the revision of the existing RHCS strategy and formulation of strategic activities for the new strategy. The situation analysis identified gaps in the areas of **Context**, **Client Utilization and Demand**, **Commodities, Commitment, Capital, Capacity, Coordination and Communication,** the 8 "Cs". When it became apparent that people working in the system,

including policy level, program/planning level and implementation level, hardly knew about the existence of the RHCS Strategy 2007-2011, the Nepali experts added '**Communication**' as one of the important elements of the RHCS strategy. A series of meetings, workshops and discussions were held for revision, updating and validation of the developed strategy, thus bringing the National RHCS Strategy 2015 into final shape.

In comparison to the RHCS Strategy 2007-2011, this strategy is dynamic (has no tenure) and can be updated and revised as and when necessary. The strategies of RHCS 2007, which have become non-applicable or obsolete in the changed context have been removed and new strategies, as per the National Health Policy 2071 (2014) and other policies have been added. Arrangement of flexible or reserved funding to procure emergency

RH commodities (contraceptives) has been proposed. Based on the lessons learned, the action plan has been simplified and made doable. Institutional arrangements for the implementation of the strategy have been added.

Nepal has several policies, documents, and service delivery guidelines related to population and RH; all are supportive of certain elements of RHCS explicitly or implicitly. However, there is still a need to integrate RHCS in health-related policies, in line with securing all health commodities and additional RH commodities.

There are several barriers to accessing RH services, coupled with the utilization problems. Unmet need for family planning is still high and the discontinuation rate of contraceptives is also increasing. To address these issues, introduction of new contraceptives (female condoms, emergency contraceptives) and expansion of currently available methods should be considered. Disparity between rural and urban areas and between different geographic regions in the use of contraceptive methods and maternal health services is quite alarming. Similarly, for the deprived population in urban sector and the areas like urban slums, specific interventions to meet their needs have not been designed and implemented.

Unmet need and disparity in service utilization should be addressed through improving availability and accessibility of services, equity, reducing barriers to care, improving quality of care and market segmentation for public and private sectors. NGOs, social marketing agencies, private sectors and communities should be brought into the programs, with their specific roles, to cater to rural, disadvantaged and underserved groups.

Long-term commitment is the key to RHCS. In order to ensure commodity security, political leaders, policy makers, leaders of different groups such as donors, NGOs and local leaders must be convinced about the importance of commodities for quality RH services. Local level forces such as FCHVs, Mothers' Groups, VDCs and district-level RHCCs can be mobilized for advocating about RHCS to civil society entities. The role of media is also essential in increasing awareness on RH and FP services.

It is encouraging to see that the GoN/MoHP is committed to RHCS and now funds for almost all contraceptives and other RH commodities through the 'pool fund'. However, there is a critical need to advocate for allocating a reserve/flexible fund to procure RH commodities, in emergency situations and acute shortages.

National capacity building will strive to enable country programs to improve their ability to forecast requirements, develop the necessary financing, carry out efficient procurement and deliver the products to users where and when they are needed, thus achieving all six "Rights" of logistics management.

Needless to say, the coordination mechanism needs to be strengthened among all the partners involved in providing RH products and services, to take positive action for efficient use of resources in satisfying client demand. Similarly, vertical and horizontal communication of the strategy within the MoHP system and amongst donors and other stakeholders is essential.

The National Reproductive Health Commodity Security (RHCS) Strategy document 2015 outlines the priority strategies needed to ensure RHCS and consequently assure the success of the RH program in Nepal. The total estimated budget required for the implementation of the strategic action plan for the period of 2015-2020 is USD 6.8 million. The strategic action plans provides a basis and guidance for those persons working in the policy level, program/planning level and implementation level to address the issues and areas that need strengthening and define the actions that should be taken.

National Reproductive Health Commodity Security Strategy 2015

1. Introduction

1.1 Background

The National Reproductive Health Commodity Security (RHCS) Strategy document 2015 outlines the priority strategies needed to ensure RHCS for Nepal and consequently assure the success of the reproductive health (RH) program in Nepal.

Nepal is a landlocked country situated in between India and China. It occupies 147,181 square kilometers in area. According to the 2011 census, the total population of the country is 26,494,504 with 12,849,041 males and 13,645,463 females. Urban population has increased from 13.92 percent (2001) to 17 percent of total population in 2011. This increase in urban population is mainly due to the expansion of existing cities and formation of new cities with improvement in transportation, communication, health facilities, education, and other physical infrastructures in the country. During the decade 2001-2011, the annual population growth rate (National) remained about 1.35 percent. The population growth rate is continually decreasing, especially in the hill and mountain regions, due to migration (CBS, 2011).

Reproductive Health (RH) is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life, capability to reproduce and the freedom to decide if, when and how often to do so. After the International Conference on Population and Development (ICPD) held in Cairo in 1994, reproductive health has been recognized as crucial for overall health and is central to human development.

The World Summit for Social Development (WSSD), 1995 in Copenhagen was first global summit to address the resource problem and officially endorse the 20/20 Initiative in its Program of Action for Social Development. The 20/20 initiative is a significant modality being pursued to mobilize resources for faster sectoral development through the government budgetary process with a mutual commitment to allocate, on average, 20 percent of official development assistance and 20 percent of national budget to basic social programs[1].

At the 2012 London Summit on Family Planning, leaders from around the globe gathered to renew their commitment to the reproductive right. The stakeholders converged on the idea that it was time-past-time to put women's reproductive health front and center on the global agenda. They recognized that family planning is both a basic right and a transformative intervention: that it is the key that unlocks the ability to reach the development goals. A commitment was made to expand contraceptive access to an additional 120 million women and girls in the world's 69 poorest countries by the year 2020[2]. Nepal has endorsed the 2020 initiative as well as the FP 2020 commitment.

1 Implementing the 20/20 Initiative

2 FP 20/20 Progress report 2013-2014

After reviewing the progress made in the implementation of the WSSD Declaration, the Millennium Global Conference in 2000 directed a set of interconnected and mutually reinforcing development goals, the Millennium Development Goals (MDGs). The ICPD Program of Action and the MDGs both include universal access to RH as a key target for achieving the goals.

In line with the Program of Action of ICPD, Nepal has pursued several measures to strengthen RH and reproductive rights by 2015.

Nepal has experienced steady improvement in health outcomes and impact. The Nepal Health Sector Program (NHSP) - III (2015-2020) has envisioned the policy goal "to provide health services through equitable and accountable health system while increasing access of every citizen to quality health services to ensure health as a fundamental right of every citizen in line with free health services and social security." The guiding principles of NHSP III are:

- Universal health coverage
- Health in all policies, health as a development agenda
- Rights based approach - Equity
- Quality

This is guided by the policy element of the National Health Policy 2071 (2014).

1.2 Health Service Delivery System in Nepal

The Ministry of Health and Population (MoHP) underwent major structural change in 1987, in line with the decentralization policy of the government. This structural change in the MoHP led to the establishment of Regional Health Directorates (RHD) in each of the five development regions of the country.

The MoHP/DoHS was re-established in 1993 with the responsibility of implementing, monitoring, and supervising preventive, promotive, rehabilitative, and curative health programs through its Divisions and Centers, Regional Health Directorate (RHDs), and District Health Offices/District Public Health Offices (DHO/DPHOs). The Divisions and Centers are responsible for:

- Target setting for the specific programs in consultation with RHDs and DHO/DPHOs
- Preparation of operational plans and programs
- Supporting health facilities (HFs)
- At the regional level, RHDs are responsible for planning, programming, training, and supervision/monitoring

Policymaking and formulation of annual, five-year, and long-term planning, along with donor coordination, is a responsibility of the MoHP. The DoHS provides inputs for policymaking and plan formulation. Curative services are provided through central, regional, zonal and district hospitals up to the district level. Primary health care centers (PHCCs) and health posts (HPs) provide services below the district level.

District Health Offices are responsible for preventive, promotive, and curative services. Ayurvedic dispensaries

deliver health services in the Ayurvedic Sector. Homeopathic and Unani medical services are delivered through central hospitals and dispensaries located in Kathmandu. Nepal is fortunate to have the free drug policy following the Citizens' Right to Health, declared by the Interim Constitution 2063 (2007).

The Logistics Management Division (LMD) was established under the DoHS in 1993 with a network of two central and five regional medical stores as well as district level stores. In order to systematize the management of logistics, the Logistics Management Information System (LMIS) unit was established in 1994. LMIS Reports from all of the health facilities across the country are analysed quarterly (three monthly) and disseminated to:

- Forecast annual requirements of commodities for public health programs, including family planning, maternal, neonatal and child health, HIV and AIDS commodities, vaccines, and essential drugs;
- Help to ensure demand and supply of drugs, vaccines, contraceptives, essential medical supplies at all levels;
- Quarterly monitoring of the national pipeline and stock levels of key health commodities

1.2.1 Reproductive health services

Reproductive health services are provided throughout the country under the directives of the DoHS, which has the responsibility of delivering preventive and curative health services including promotional activities. The Sub Health Post (SHP) (now upgraded to health post) is the first contact point for the basic health care and referral services. In actual practice, HPs are the referral centers for Female Community Health Volunteers (FCHVs), as well as community-based activities such as PHC outreach and EPI clinics. Each level above the HP is a referral point in a hierarchical network. This referral hierarchical network is designed in a way to ensure that basic health services including curative services are accessible to the people. Logistical, financial, supervisory, and technical supports are provided to the lower level from those one level above.

The institutions involved in the delivery of basic health services in Nepal includes 104 public hospitals, 205 Primary Health Care Centers (PHCCs) / Health Centers (HCs) and 3,822 Health Posts (HPs). Additionally, services are provided through, 12,608 Primary Health Care Outreach clinics (PHC/ORC) and 50,007 Female Community Health Volunteers (FCHVs).[3]

An integrated package of RH services includes, among others, family planning (FP), safe motherhood, prevention and management of complications of abortion and reproductive tract infection/sexually transmitted illness (RTI/STI) and infertility (see Box 1 for the full list). Each of these interventions is implemented through the health institutions mentioned above. Activities under each intervention, however, are limited to the capacity of the personnel and the physical facilities.[4] The FHD of the DoHS is responsible for implementing RH strategies and programs. The LMD of the DoHS is responsible for procurement, warehousing, and distribution of RH commodities in addition to other health supplies and equipment.

3 DoHS Annual Report 2012/13
4 National RH Strategy, 1998

Box 1

Priority Issues for Reproductive Health

- Family Planning
- Safe Motherhood
- Child Health (new born care)
- Prevention and Management of Complications of Abortion
- RTI/STD/HIV/AIDS
- Prevention and Management of Sub-fertility
- Adolescent Reproductive Health
- Gender Based Violence
- Problems of Elderly Women i.e. uterine, cervical and breast cancer treatment at the tertiary level

Nepal's National Reproductive Health Strategy is well aligned with the policies adopted in the National Health Policy 2071 (2014), Second Long Term Health Plan (1997-2017) and NHSP-III, which aim at reducing infant, child and maternal morbidity and mortality and reducing total fertility rate. The National RH Strategy is adopted for an effective and efficient provision of quality RH services in Nepal. The following are the strategies that have been embraced:

- Implement the 'Integrated Reproductive Health Package' at all level of health institutions as well at the community level based on standardized and clinical protocols and operational guidelines
- Enhance integration of RH activities carried out by different divisions of MoHP
- Advocacy for the concept of RH, including creation of an environment of collaboration among all sectors
- Review and develop IEC materials to support all levels of interventions
- Review and update the existing training curricula of various health workers
- Ensure effective management systems by strengthening and revitalizing existing committees at all levels; Central and District level RH Coordination Committees (RHCCs)
- Construct/upgrade appropriate service delivery and training facilities at all levels
- Support institutional strengthening through structured planning, monitoring/supervision and performance review
- Develop an appropriate RH program for adolescents
- Support for national experts/consultants
- Promote inter-sectoral and multi-sectoral coordination

2. Reproductive Health Commodity Security (RHCS)

2.1 RHCS

Reproductive Health Commodity Security (RHCS) is defined as ensuring a secure supply and choice of quality contraceptives and other RH commodities to meet every person's needs at the right time and in the right place. RHCS exists when people are able to reliably choose, obtain, and use the contraceptives, condoms, and other essential RH supplies they want. Hence, the ultimate goal of RHCS centers on meeting the clients' needs.

Attention to RHCS first began when projections were shown to have shortfalls in financial requirements to meet the need. Many countries face serious challenges to meet people's rising demand for contraceptives and other essential RH supplies, especially due to limited in-country and donor resources combined with weak infrastructure. Every country faces challenges to meet the ICPD and the SDG for ensuring/achieving universal access to sexual and reproductive health rights, if RHCS does not exist.

UNFPA predicts that shortfalls in contraceptive assistance could have serious consequences in terms of maternal and child health (see box 2)[5].

Box 2

For every US$1 million shortfall in contraceptive commodity assistance:

- Increase in the number of unintended pregnancies: 360,000
- Additional induced abortions: 150,000
- Additional maternal deaths: 800
- Additional infant deaths: 11,000
- Additional deaths of children under 5: 14,000

Therefore, the consequences of failing to achieve RHCS aims are painful to contemplate. Since RHCS is a long-term goal, requiring a multi-sectoral approach and continuous commitment, it needs to be addressed in a coordinated manner, capitalizing on comparative advantages, to mobilize resources and strengthen national capacity. Strategic planning, as articulated in the RHCS strategy, will help to establish priorities and reach goals with clear institutional arrangements to monitor the implementation with ensured funding.

2.2 Rationale for National RHCS Strategy

The vision for RHCS depends upon the contextual settings of each country. Availability and accessibility of RH supplies are affected by policies and regulations that exist in a country which ultimately make a difference in meeting clients' needs for reproductive services and commodities. Factors such as social and economic conditions, political and religious practices and competing priorities within the country are responsible for smooth implementation of the National RHCS. Commitment of the government and partners for RHCS,

5 Reproductive Health Commodity Security Status Assessment Report, UNFPA 2008

together with strong leadership and focused advocacy are essential in order to work in a coordinated manner, while developing the necessary national capacity. Supportive policies must be in place, backed up by reliable resources (capital) available for commodity procurement. Since the focus of RHCS is the client, the ultimate beneficiary of RHCS, the utilization of services is central to demand for RH commodities.

All these elements – Context; Client Utilization; Commodities; Commitments; Capital; Capacity; Coordination; and Communication are to be addressed in ensuring RHCS through the development of a new or strengthening an existing RHCS strategy. Communication has also been identified by Nepalese experts as one of the important components of the RHCS strategy.

2.3 Objectives of National RHCS Strategy

The objective of the National RHCS Strategy, 2015 is to address all elements of RHCS in a holistic manner and streamline the activities to meet ICPD's goal, FP 2020 commitment and SDG for ensuring universal access to sexual and RH rights. The National RHCS Strategy has the following specific objectives relating to each element:

- **Context:** To create and promote a supportive policy and regulatory environment for the supply chain and reproductive health commodity security
- **Client Utilization and Demand:** To increase demand through participation of the public and private sector, including social marketing, for addressing the unmet needs and increasing accessibility of RH and FP services
- **Commodities**: To update and forecast RH commodities and equipment periodically
- **Commitment:** To improve and formalize collaborative commitments on RHCS within public, donors and private sector including social marketing
- **Capital:** To consolidate budgetary requirements for RH commodities/program and ensure funding commitments
- **Capacity:** To build capacity of stakeholders at all levels for RHCS management towards achieving the 6 "Rights" of logistics management
- **Coordination:** To ensure meaningful coordination among all the partners involved in providing RH products and services to take an action for efficient use of resources in satisfying client demand and need
- **Communication:** To establish vertical as well as horizontal communication within the MoHP System and among all stakeholders involved in RHCS

2.4 Process of Developing the National RHCS Strategy

This RHCS Strategy - 2015 is the outcome of hard work done by a Working Group (WG), set up by the DoHS, MoHP, partners and stakeholders with guidance from technical advisory committee (TAC). This WG is comprised of technical staff of government, donors, I/NGOs and others involved in RH program in the country. Contributions were made at various stages of the development of the draft document.

As a part of the development of the new strategy, a working group (WG) under the chairmanship of the LMD Director was formed and a Technical Advisory Committee (TAC) was formed under the chairmanship of the

Director General (DG) of the DoHS on December 26, 2014. The members of the WG and TAC are provided in Annex 1 and 2 respectively.

Box 3

Important policies/events leading to National RHCS:

- Second Long Term Health Plan, 1997-2017
- Annual Contraceptives Security Forecast - MoHP since 1998 leading to total commodities forecast
- Contraceptive Security Assessment using SPARHCS Framework, 2003
- National Reproductive Health Commodity Security (RHCS) Strategy (2007-2011)
- Free Health Care Services, 2007
- Nepal Health Sector Program - II, 2010-2015
- National Health Policy, 2071 (2014)
- Formation of Technical Advisory Committee (TAC), 2015
- Nepal Health Sector Program - III, 2015-2020

There were a number of important policies/events (listed in the box above) that led to the development of the National RHCS Strategy 2015. Due to the existence of strong and continuous collaboration among the MoHP, Divisions/Centers, EDPs and a number of other key stakeholders, there has been progress in the development of meaningful policies and plans, starting from the contraceptive security forecasts in the 1990s, to the development of the comprehensive RHCS 2015.

With the initiation of LMD/FHD, UNFPA and USAID Nepal, the National RHCS Strategy (2007-11) was materialized in September 2006. The WG, led by the DoHS, developed the National RHCS 2007-11 with issues, strategies and action plans, using the SPARHCS diagnostic tool.

The National RHCS (2007-11) was developed in the context of the Government of Nepal's commitment to ensure universal access to quality healthcare services, including for the poorest, vulnerable, and marginalized communities. Developed through expert consultations, the RHCS strategy outlined strategies for RH commodities security. There was consensus amongst the all stakeholders that the strategies identified were good. However, due to a lack of lack of clear, doable and achievable action plans, the implementation part did not result as envisioned. So, revision of the comprehensive National RHCS, with key strategies and priority interventions, to ensure the availability of sustainable, reliable and high quality RH commodities for all Nepali citizens including the poor, disadvantaged and vulnerable, was needed.

UNFPA Nepal assigned the local NGO, Lifeline Nepal under the leadership of FHD/LMD to review, revise and update the National RHCS 2007-11. The revised strategy addresses program management, service provision, supply chain management and community mobilization to ensure the sustainable access to RH commodities, and an estimation of financial requirements for implementing the strategy.

Individual stakeholder consultation with the experts in the field of RH was one of the key processes used in framing the strategy. The people consulted during this process are listed in Annex 3. A structured questionnaire was developed and shared with FHD, LMD, UNFPA and other experts for their feedback and inputs.

Stakeholder workshops were conducted to prioritize the strategies identified during the individual expert consultation and to develop additional strategies. Various experts closely reviewed, revised, and prioritized the strategies.

Desk review of various countries' RHCS strategies and numerous other documents was also carried out while drafting the strategy. Materials reviewed and citations are listed in the reference document (Annex 4).

This document has been prepared in a participatory manner, with the involvement of a wide range of stakeholders. Situation analysis helped in identifying issues and gaps which were the basis for the revision of the existing strategy and formulation of the new strategy.

A series of meetings and workshops were held for reviewing, discussing and validating the strategy thus bringing the National RHCS Strategy 2015 into final shape. As compared to the RHCS Strategy 2007-11, this strategy has been made dynamic (has no tenure) and can be updated and revised as and when necessary. The strategies of RHCS 2007, which have become non-applicable or obsolete in the changed context have been removed and new strategies as per the National Health Policy 2071 (2014) and other policies have been added. Arrangement of flexible or reserved funding to procure emergency RH commodities (contraceptives) has been proposed. Based on the lessons learned, the action plan is simplified and made doable. Institutional arrangements for the implementation of the strategy has been added.

A WG and TAC workshop was conducted on March 27, 2015 to finalize the Revised RHCS Strategy. The Revised Strategy was endorsed by the WG and TAC members at the end of the workshop.

3. Situation Analysis, Issues and Strategies

3.1 Context

Objective: *To create and promote a supportive policy and regulatory environment for the supply chain and RHCS*

3.1.1 Policy Environment

Nepal has several population and RH related policies, documents, and service delivery guidelines in place. Some of these are listed in the box below.

Box 4

Population and RH related policies/documents/guidelines of Nepal

- Second Long Term Health Plan (1997 - 2017)
- National Population Policy, 1998
- Poverty Reduction Strategy Paper (PRSP: 2002-2007)
- National Safe Motherhood Plan (2002 - 2017)
- Health Sector Strategy: An Agenda for Reform (2004)
- Nepal Health Sector Program - Implementation Plan (2004-09) - NHSP II
- Vulnerable Community Development Plan for Nepal Health Sector Program Implementation Plan (2004/5 - 2008/9)
- Interim Constitution of Nepal 2063 (2006/2007)
- National Reproductive Health Commodity Security Strategy (2007 - 2011)
- Nepal Health Sector Program-II (2010-2015)
- National Family Planning Strategy 2068 (2011/2012)
- National Health Policy, 2071 (2014)

Most of these documents are supportive of FP and RH, particularly in reducing stock outs of commodities for Essential Health Care Services (EHCS). The National RHCS Strategy, 2007 estimated a funding gap of USD 22 million for the 5 year period. However, the government of Nepal had started funding for contraceptives from the fiscal year 2001/2002, fiscal year with initially USD 99,000. Now the government allocates almost all funds for the health commodities, including FP and RH.

Concerning HIV and AIDS, the logistics system started in 2006 and had zero stock out of antiretroviral (ARV) drugs. Following MoHP decision, the integration process for HIV/AIDS and the general logistics system was initiated in July 2012. Despite the efforts made by the MoHP and external development partners (EDPs) to integrate both logistics systems, the pace of integration has been delayed. However, consolidated forecasting, including HIV/AIDs commodities, has already been initiated. LMD and NCASC will have to work closely for

the development of an integrated procurement plan and its implementation.

Contraceptives such as condoms, injectables, oral pills and other RH commodities are included in Essential Drug List (EDL). There is no barrier as such in terms of age and parity for clients to access contraceptives. No prescription is required to purchase contraceptives (condoms, pills, and injectables) in the market i.e. pharmacies. It is to be noted that pharmacies do need to obtain certification which they receive after undergoing training conducted by the Department of Drug Administration (DDA). Spousal consent is not required to obtain a permanent method of family planning. However, contraceptives, except condoms, have to be dispensed by trained health workers in service outlets. There are service protocols and guidelines available and service providers do obtain pre and in-service training on contraceptive use.

For the private sector to operate in the country, the government does provide a positive environment. Contraceptives promoted by the private sectors can be advertised (condoms and others). While importing contraceptives and vaccines, there is no tax levied; some essential items can be brought to the country with a minimum tax (1 percent). However, the private sector agencies do need to obtain a license before importing the products. The private sector, including NGOs and social marketing agencies are free to fix the prices for their commodities and there is no government's policy restriction on distribution of these products.

Although the Nepal government gives high priority to the social sector, the recent trend of budget allocated for health, in terms of percentage, is not encouraging. It has declined from 15.44% in 2011/12 to just 5.42% in 2014/15[6]. The budget announced for 2014/15 allocates Rs. 33.52 billion of a total budget of Rs. 618 billion for health. The increment in the health budget in recent years, in absolute value, is not encouraging given the volume and need of the services.

Table 1: Budget Allocation in Health Sector

FY	Budget (in Billion Rs.)		
	Total	Health	Percentage
2011/12	384.90	24.93	15.44
2012/13	404.82	20.12	5.00
2013/14	517.24	30.43	5.88
2014/15	618.10	33.51	5.42

Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), FP activities, nutrition activities, and emergency aid, designated for health, but does not include provision of water and sanitation[7].Comparing South Asian countries, with the exception of Afghanistan and Maldives, Nepal's health expenditure, as a percent of Gross Domestic Product (GDP), is higher than other countries (5.5 percent) in 2012.

6 Ministry of Finance, Budget Speech 2011-12, 2012-13, 2013-14, 2014-15

7 http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

Table 2: GDP of South Asian Countries

Country	2010	2011	2012
Afghanistan	8.7	8.4	8.6
Bangladesh	3.7	3.8	3.6
Bhutan	4.1	3.7	3.8
India	3.7	3.9	4
Maldives	5.8	8.1	8.5
Nepal	5.9	6.1	5.5
Pakistan	3	3	3.1
Sri Lanka	3.4	3.3	3.1

Nepal's Community Drug Program (CDP), which was in existence until 2007, applied certain fees for essential drugs, except contraceptives. However, in 2007, the Government of Nepal launched a program for free essential healthcare services and access to a number of essential drugs (free drug policy) for all citizens seeking care at government health facilities. For this, an effective and efficient supply chain system is needed. Unless the procurement reform is initiated and the supply chain is made more robust, problems will persist in procurement related delays, and bureaucratic constraints. Timely supply and efficient storage/distribution mechanisms are essential to ensure year-round availability of FP/RH and other essential drugs.

The Poverty Reduction Strategy Paper (PRSP) explicitly mentioned the importance of commodity availability. NHSP - III aims to reduce stock outs of tracer drugs to 0 percent by 2020 in health facilities. The Second Long Term Health Plan (SLTHP), recognizes the importance of alternative financing mechanisms, to bring in non-governmental funds, by increasing the public-private mix in financing and providing Essential Health Care Services (EHCS), which includes RH as one of the main interventions with specific targets. Several policy options under logistics have been identified to improve commodity security in the country. FP and Safe Motherhood (SM) programs, which are parts of RH, have been identified as program components to address social inclusion for health services, under the Vulnerable Community Development Plan (VCDP) as well.

The Health Sector Strategy, 2004 document has also identified the need to bring private sector and NGOs to play complementary roles in improving procurement and distribution of drugs, supplies and equipment. This issue has been clearly mentioned under the National RH Strategy, 1998 with specific roles of collaborating partners. The strengthening of this collaboration should be further explored for sustainable commodity security.

Box 5

Issues to be addressed under **Context** for the strategic actions (See Section 4 for details) are as follows:

- Second Long Term Health Plan (1997 - 2017)
- Policy and regulatory environment (Health Policy, FP Policy, RH Policy, Free Health Care Services Policy, Drug Policy, HIV/AIDS Policy, etc.)
- Structural framework for RHCS
- Institutional arrangements for RHCS
- Proposed key strategies are:
- Integrate RHCS explicitly in health-related policies in line with securing total health commodities and additional RH commodities
- Plan and conduct advocacy activities to increase awareness among national and local leaders, policy makers, and senior officials on the need to have favorable policies for private sectors, NGOs, social marketing agencies, civil societies, and communities to improve RHCS
- Strengthen National RHCC and include RHCS in its scope of work
- Strengthen District RHCC to address RHCS issues
- Work with MD to incorporate RH equipment and physical facilities in national maintenance plan and policy

3.2 Client Utilization and Demand

Objective: *To increase demand and utilization of RH services through participation of the public and private sector, including social marketing, for addressing the unmet needs and increasing accessibility to RH and FP services*

3.2.1 Service availability and utilization

The National RH Strategy aims to provide integrated RH services through five different levels: family/decision makers' level; community level; HP, PHCC and district levels. RH services, with selected components of FP, SM, prevention and management of complications of abortion, prevention and management of RTI/STI/HIV/AIDS, adolescent RH and problems of the elderly, are available from HPs, which are referral points for family decision makers and the community level, where the health workers conduct mostly information, education and communication (IEC) activities.

Though HPs are widely distributed throughout the country, ensuring equitable distribution of health facilities and services at community and village levels is still an issue. There is a problem in accessing essential RH services due to difficult terrains and insufficient transportation services. The major shortcomings in the public sector, therefore, in terms of service access and utilization, include facilities with inadequate infrastructure, insufficient trained service providers and inadequate quantities of commodities.

The Nepal Demographic and Health Survey (NDHS), 2011 showed significant improvements in utilization of some selected RH services. The NDHS 2011 revealed that 84.8 percent of pregnant women receive antenatal care (ANC) services compared to 49 percent in 2001. Data also showed that that there was a substantial difference in utilization of health services in rural and urban settings. For example, rural mothers are less likely to receive ANC services than their urban counterparts (83.9 percent in rural and 93.7 percent in urban). Nationwide, 63 percent of deliveries occurred at home, with 27.9 percent in urban and 66.7 percent in rural areas. Considering unmet need for FP among currently married women, there is vast difference between rural and urban areas, with 28.1 and 19.6 percent unmet need respectively.

3.2.2 Contraceptive use and trend

The contraceptive prevalence rate (CPR) for modern methods reached 43.2 percent in 2011. The most preferred contraceptive method, according to the NDHS 2011, is female sterilization followed by injectable contraceptives and male sterilization. At the beginning of the FP program, male sterilization was the most popular method but it was soon surpassed by female sterilization, which is still the most preferred method.

Over 25 years, the CPR has increased from 2.9 percent (1976) to 43.2 percent (2011). Methods such as condoms, IUCDs and Implant have increased slightly during the same period (Table 1).

Table 3: Current Use of Contraception among Non-Pregnant Women

Method	1976 NFS	1981 NCPS	1986 NFFPS	1991 NFFPS	1996 NFHS	2001 NDHS	2006 NDHS	2011 NDHS
Any modern method	2.9	7.6	15.1	24.1	28.8	38.9	44.2	43.2
Female sterilization	0.1	2.6	6.8	12.1	13.3	16.5	18.0	15.2
Male sterilization	1.9	3.2	6.2	7.5	6	7	6.3	7.8
Pill	0.5	1.2	0.9	1.1	1.5	1.8	3.5	4.1
Injectables	0	0.1	0.5	2.3	5	9.3	10.1	9.2
Condom	0.3	0.4	0.6	0.6	2.1	3.2	4.8	4.3
Implant	-	-	-	0.3	0.5	0.7	0.8	1.2
IUCD	0.1	0.1	0.1	0.2	0.3	0.4	0.7	1.3

Sources: Various sample surveys (Nepal Fertility Survey 1976, Nepal Contraceptive Prevalence Survey 1981, Nepal Fertility and Family Planning Survey 1986 and 1991, Nepal Family Health Survey 1996, and Nepal Demographic and Health Surveys 2001, 2006, and 2011) conducted since 1976.

A hindrance to increased use of contraception could be related to inadequate and inappropriate information available to women and couples. The table below depicts the reasons for discontinuation of contraceptive use (NDHS 2011).

Table 4: Reasons for Discontinuation of Contraceptives

Reasons for discontinuation	Percentage
Became pregnant while using	6.8
Wanted to become pregnant	12.8
Husband disapproved	1.5
Wanted a more effective method	6.1
Side effects/ health concerns	24.2
Lack of access/too far	0.6
Inconvenient to use	1.8
Difficult to get pregnant/ menopausal	0.6
Infrequent sex	2.7
Marital dissolution/ separation	0.3
Husband away	40.0
Other	2.4
Don't know	0.1

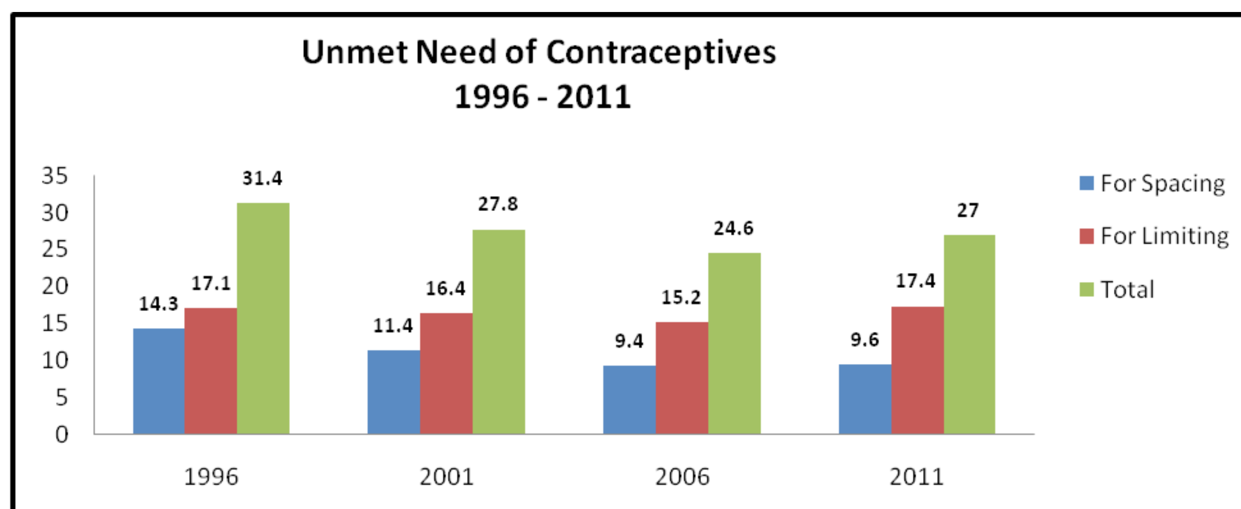
Source: NDHS 2011

Data reveals that spousal separation (husband away) (40 percent) and fear of side effects/health concerns (24.2 percent) were the two major reasons leading to discontinuation of contraceptives use. Programs should emphasize on improving quality of care, coupled with advocacy, IEC activities focusing on migrant workers and reducing fears and misconceptions about specific contraceptive methods. In this respect, introduction of new contraceptives (female condoms, emergency contraceptives) and expansion of currently available methods should be considered.

3.2.3 Unmet need for contraception

There is still a high unmet need for FP services. The NDHS 2011 indicates that 27 percent of currently married women have an unmet need (9.6 percent for spacing and 17.4 percent for limiting) in the country. Unmet need is higher among women living in rural areas compared to women in urban areas. From 2001 to 2011, the unmet need for FP, remained stagnant. Only 5.4 percent of currently married had met their spacing need for FP, while more than 44.3 percent met their limiting need. The percentage of currently married women with satisfied demand is disproportionate between urban (62.3 percent) and rural (54.9 percent) and between ecological regions (58.4 percent in mountain, 51.7 percent in hill and 58.8 percent in Terai).

Figure 1: Unmet Need of Contraception for Limiting and Spacing



Source: NDHS 2011

The unmet need for contraceptives for limiting pregnancies is greater than for spacing, and may result in unwanted pregnancies. This may increase demand for abortion care, and potentially impact the health of mothers.

In summary, there are multiple factors that influence access to and utilization of FP services including difficult terrain, over reliance on certain methods, inadequate human resources, quality of care, commodity availability, cost, social, cultural and religious barriers and provider competency (Table 5).

Table 5: Barriers to Access and Utilization of FP Services

Access	Utilization
• Difficult geographic condition • Over reliance on seasonal camps (sterilization) and injectables • Shortage of trained personnel and skewed distribution • Looming gap in contraceptive financing	• Lack of information/knowledge of FP options • Socio/cultural barrier on exercising choice • Service provider attitudes and skills • Cost of services • Availability of commodities

Source: NDHS 2011

Box 6

Issues to be addressed under **Client utilization and Demand** for the strategic actions (See Section 4 for details) are as follows:

- Availability, accessibility and choice of services/contraceptives
- Equity
- Health seeking behavior
- Provider bias
- Market segmentation to increase service utilization

Proposed key strategies are:

- Conduct studies:
- market segmentation
- user-profile
- reasons for non-use and discontinuation
- issues related to quality of care and recommendation for improvement
- feasibility and acceptability studies on additional contraceptive methods
- other studies as required
- Design and implement additional interventions to increase the range of contraceptive choices in a phase wise manner to promote utilization
- Coordinate with municipalities to meet the RH commodity needs of urban population including urban slums
- Design and implement targeted strategies and interventions to reach special population and communities
- Increase involvement of media for awareness on RH and FP services

3.3 Commodities

Objective: *To update and forecast RH commodities and equipment periodically*

3.3.1 Current Scenario

Major sources of RH commodities are public, NGO (Family Planning Association of Nepal), social marketing and commercial sectors. The public sector and NGO provide Pills, Condoms, Injectables (Depo), Implant (Jadelle), IUCDs and permanent methods. Social marketing offers Pills, Condoms and Injectables. Although these agencies are dependent on reliable financing mechanisms to keep programs in full supply, rationing has not occurred to date in commodity distribution. Distribution of RH commodities, including FP supplies, has been streamlined within the government framework, with minimal wastage and expiration of the products. The existing supply chain is not limiting the program expansion.

Table 6: Types of Contraceptives Distributed to Current Users (%) by Source and Method

Source	Female Sterilization	Male Sterilization	Pill	IUCD	Injectables	Implants	Condom	Total
Government Sector	77.8	83.6	50.9	57.9	69	66.6	32.3	69
NGO Sector and Social Marketing	13.6	8.7	1.1	13.8	4.8	12.3	2.1	8.5
Private Sector (pharmacies, private hospitals, dispensaries)	8.3	5.3	44.6	7.7	25.7	4.1	59.3	19.8
Other Source	0	0	2.7	0	0.5	0	4.8	0.8
Other	0.4	0.3	0.6	0	0.1	0	1.5	0.4
Don't Know	0	2.1	0	0	0	0	0	0.4
Missing	0	0	0	21	0	17	0	1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Nepal Demography and Health Survey 2011

Note: Figures for IUCD are based on un-weighted cases as reported in the DHS report. The total may not add up to 100 due to rounding and 'Don't know' cases.

As seen from the data presented in Table 6, users are heavily dependent upon the government sector. The NDHS reported that the public sector share remained constant over the last five years. Overall, 8.5 percent of users obtain contraceptive methods from the nongovernmental sector, mostly from the NGOs and Social Marketing, and 19.8 percent get their methods from the private sector, mostly pharmacies which sell social marketing products.

The female condom was piloted in the outskirts of Lalitpur district by a non-governmental organization in 2001. Female condoms were also distributed in Bhutanese refugee camps in Jhapa and Morang district. A study conducted in 2013/2014 to assess its acceptability revealed that it was well accepted by women residing in the camps. There is evidence that the female condom is in demand among certain populations to protect themselves from STIs. Therefore, it is important to address this issue by including female condoms in the Essential Drugs List (EDL)[8].

There is still no comprehensive RH commodities list in Nepal. While developing the RH commodities list, essential equipment for RH services should also be included, as per the WHO guidance (See Annex 5).

The quality of these RH commodities, including FP supplies is maintained throughout the supply chain. All commodities must be registered with the DDA, which requires a certificate of pharmaceutical products and WHO certification for each product for registration. Quality assurance of these commodities is also maintained through

8 National List of Essential Medicines 2011

pre-shipment inspection at manufacturing sites and provision of replacement of products, by the manufacturer, if found sub-standard at the time of post-shipment inspection. However, a quality assurance system, including post supply of RH commodities, should be developed and quality monitoring of RH commodities needs to be done in coordination with DDA. Preparation of quality monitoring guidelines, an annual sampling plan and schemes in coordination with LMD and FHD together with DDA/NML (National Medicine Laboratory) is necessary for quality assurance of commodities. Procurement of specific tools for onsite testing of the quality of RH commodities (chemical based) for identification and even quantification is needed.

All contraceptives must be imported as there are no local manufacturers for these commodities. No import duties are applied to RH supplies. Although the registration procedures and import mechanisms are transparent and well understood by the private sector, the procurement process by public sector is lengthy.

Prior to 2001, the contraceptives were entirely funded by donors. The government of Nepal started funding for contraceptives from fiscal year 2001/2002. Since the introduction of free health care services in 2007, the government has been increasing its contribution to contraceptive and other RH commodities and now the government funds almost all. Only during emergencies, the donors come forward to support the government, otherwise, the government fully funds for the health commodities, including FP and RH.

Social marketing in Nepal started back in 1978 but, yet still needs to gain momentum. The first social marketing approach was aimed at enhancing healthy behaviors by increasing the choice of quality products and also reaching underserved and vulnerable populations with more affordable, subsidized products and services in Nepal, through utilizing existing commercial networks. With initial focus on FP products, the program had aimed to offer an alternative approach to the consumer for obtaining quality contraceptives. Thus it complemented and augmented the free distribution of contraceptives through public health facilities. Strengthening of social marketing, with proper market segmentation, can play a crucial role in self-reliance, for example, marketing of the safe and clean Delivery Kit. The potential of the commercial sector is yet to be tapped for in-country manufacturing of selected commodities.

Box 7

Issues to be addressed under **Commodities** for the strategic actions (See Section 4 for details) are as follows:

- Revise list of RH commodities including equipment
- Funding/in-kind sources of RH commodities (Social Marketing, NGO)
- Effective and efficient procurement
- Emergency funding during crisis
- Tracking of all RH commodities by LMIS

Proposed key strategies are:

- Convene expert group to review and update the list of RH commodities and equipment (specification) on a periodic basis
- Expand coverage of additional contraceptives (including female condoms, emergency contraceptives, One-rod-implant etc.) through social marketing sector
- Develop alternative financing schemes for RH commodities to reduce/shift public sector burden in the long run
- Advocate with government and donor to increase share of total health budget in general and funding for RH commodities and equipment in particular
- Implement quality assurance plan for RH commodities
- Advocate for in-country quality testing of RH commodities

3.4 Commitment

Objective: *To improve and formalize collaborative commitments on RHCS within public, donor, and private sector including social marketing*

3.4.1 Current Scenario

As stated earlier in the "Context" section, there is a supportive policy and regulatory environment and increasing government's allocation of funds for RH commodities. Still, there are some questions that can be raised regarding political commitment from different sectors (government, private and donors). It is important to keep in mind that commitment to RHCS is not the same as commitment to FP/RH. Rather, it is about the policy level embracing the need to make and keep supplies available to clients; women and men, adolescents and youth, boys and girls.

The MoHP's commitment to RHCS has been reflected in the National Health Policy 2014 and Health Sector Program. RHCS is a priority program under RH in the FHD of DoHS. This commitment has been further strengthened as the Directors at FHD and LMD are the key leaders/champions for RHCS. This leadership initiated an effort to achieve RHCS through a coordination committee among all stakeholders, with an annual meeting including donors, MoHP divisions, NGOs and Social Marketing for long term forecasting of

contraceptives needs and pipeline monitoring. RHCS has been institutionalized within LMD.

Senior government officials are motivated to support RHCS, as this program has been identified as a priority program, and better health care services are linked with the poverty reduction plan of the country. The government's commitment is also reflected in its budget allocation for the health sector, which has increased overtime in absolute values, although it has decreased as a percent of total government budget (Table 1). Table 7 shows the trend of budget allocation in the health sector over the period from 2009/10 to 2014/15.

Table 7: Total Health Budget

FY	Total Health Budget (In Billion NPR)
2009/10	18.68
2010/11	23.81
2011/12	24.93
2012/13	20.12
2013/14	30.43
2014/15	33.51

Source: Ministry of Finance Annual Budget Speeches

Besides government commitment, a number of private sector/NGO leaders such as FPAN, social marketing agencies, health media, and other line agencies, like DDA, are active partners in RH and to some extent in contraceptive security. In order to ensure commodity security, political leaders, policy makers, leaders of different groups such as donors, NGOs and local leaders must be convinced through advocacy, on the importance of commodities for quality RH services. Local level forces such as FCHVs, Mothers' Groups, VDCs and district level RHCCs can be mobilized for advocating about RHCS to civil society representatives. Media advocacy was started and covered in all five regions during the period of 2005 and 2006 but has been discontinued due to lack of funding and a responsible agency to coordinate.

Commodity availability is also included in PRSP. According to the Interim Constitution 2063 (2007), the government has introduced Free Health Care Services as a constitutional right to every citizen and has the responsibility to meet the essential health commodity needs of its people. However, this is going to increase the public sector burden for health sector financing and it will be wise to plan for a gradual shift of public sector burden to the social marketing and private sectors.

Although the Interim Constitution 2063 (2007) has guaranteed the free health care to all citizens, the utilization of health services among the urban destitute is poor due to a complex composition of urban population and internal migration. The urban poor often reside in often deplorable conditions, which in some instances are worse than those in the rural areas that so many of them left behind (Brockerhoff and Brennan 1997). Women's status, youth issues, and RH concerns all take on a different complexion in the context of urban slums and informal settlements. Problems of social and economic exclusion, HIV/AIDS and violence are more pronounced in these areas than in rural or more affluent urban areas. Yet, because these slums and informal settlements are difficult to access, data and research that would assist in policy development and program design are often deficient[9].

9 Urban Population, Poverty and Sustainable Development: Emerging Issues for UNFPA, CIESIN, Columbia University 2005

Access to financial services is undeniably important to poor families, but it is insufficient on its own to address the multi-dimensional challenges of poverty. Ill health and the inability to access health care are key factors both leading to and resulting from poverty. Reducing the burden of illness, the associated costs and avoidable human suffering are all top priorities in the global health community. Policymakers and providers in the health sector fully understand that poverty is a root cause of ill health and that predictably improving health status globally can only be done in conjunction with poverty alleviation efforts[10]. If the poor and deprived sections of the population have the capacity to afford health services out of their pocket, it will lessen the burden of the public sector. However, until and unless the country's Gross Domestic Product (GDP) and per capita incomes reach to a satisfactory level, the public sector should take care of this activity and increase the share of the health budget.

Box 8

Issues to be addressed under **Commitment** for the strategic actions (See Section 4 for detail) are as follows:

- Inadequate advocacy
- Limited involvement/participation of NGOs, social marketing and private health institutions in RHCS
- Limited recognition of RH issues of urban poor and slum populations
- Ensuring robust health logistics system
- Limited recognition and promotion of social marketing

Proposed key strategies are:

- Advocate with parliamentarians (members of health committee) on the importance of RHCS
- Create favorable environment for NGOs, social marketing and private sectors to expand coverage beyond urban areas for capturing underserved people and for those who can and are willing to pay for the services

3.5 Capital

Objective: *To consolidate budgetary requirements for RH commodities/program and ensure funding commitments*

3.5.1 Current Scenario

Until fiscal year 2000/2001 fiscal year, contraceptive needs were fully met with donors' funding. The government of Nepal started sharing the cost of contraceptives from fiscal year 2001/2002. The Interim Constitution of Nepal 2063 (2007) stated for the first time, 'Every citizen shall have the right to get basic health services free of cost from the state as provided for in the law'[11]. This makes "health for all" a fundamental human right and given this commitment, the MoHP has implemented a policy aimed at providing free health services.

10 Integrating Microfinance and Health Benefits, Challenges and Reflections for Moving Forward, Sheila Leatherman, Working Paper, World Microcredit Summit, 2011

11 Interim Constitution of Nepal, 2007

FP contraceptives account for a major share of RH commodities. A significant proportion of the health budget is required for FP commodities. The total expenditure for contraceptives and supplies required for the FP scale up scenario, according to the "Costs and Impacts of Scaling Up Family Planning in Nepal" prepared by Oxford Policy Management in November 2014, is given in Table 8[12].

Table 8: Total Amount Required for Contraceptives

Commodities	2015	2016	2017	2018	2019	Total NPR	Total USD
Condom	80.3	83.2	85.9	88.7	91.6	429.7	4.8
Pills	153.3	157.9	162.5	166.9	171.5	812.1	9.1
Injectable	224.3	231.6	238.8	245.9	253.2	1,193.8	13.4
IUCD	70.7	74.9	79.2	84.1	88.7	397.6	4.5
Implant	137.1	148.0	159.2	171.6	183.5	799.4	9.0
Total	**665.7**	**695.6**	**725.6**	**757.2**	**788.5**	**3632.6**	**40.8**

Note: NPR values are shown in Lakhs (100,000) and USD in millions of dollars

The estimated figures are in constant NPR, so does not include inflation. According to this estimation, a total of 40.80 million USD will be required for the period 2015-2020. NGOs such as FPAN, MSI and some local NGOs charges nominal fees for services under social marketing programs for which they receive contraceptive supplies mostly from public sector. Information has been regularly fed in through the LMIS pipeline report, and HMIS.

Contraceptives are provided free of charge through the public sector outlets (hospitals, health center, HPs, outreach clinics, mobile camps and FCHVs. However, FP commodities like pills, injectables, IUCD, implant and condom can also be purchased by clients in private clinics/ outlets/NGO clinics and pharmacies. The majority of the urban population can afford to pay for the FP commodities but these groups are getting free supplies through the public sector. For the deprived population in the urban sector and the areas like urban slums, specific interventions to meet their needs have not been designed and implemented.

Community Drug Program (CDP) which was in practice until the Free Health Care Services for all was introduced by the government in 2007. It was quite effective in generating revenues. Now the Government of Nepal has developed the National Health Insurance Policy 2014[13]. The policy outlines that a household will pay some premium for getting the health services and there will be separate funds for the poor and targeted communities to ensure the services for them as well. Provision of special funds will be made available for the sustainability of this scheme. If this scheme can be effectively implemented, it will reduce the burden on the state for RH and health commodities and will also meet the needs of the sectors of the population who are not able to pay for the insurance.

At present, social marketing is heavily dependent on donors, while NGOs are dependent on government and donors. It is encouraging to see that the GoN/MoHP, as its commitment to RHCS, now funds for almost all contraceptives and other RH commodities through the 'pool fund'.

12 Costs and Impacts of Scaling Up of Family Planning Program in Nepal, Oxford Policy Management, 2014

13 National Health Insurance Policy 2014, MoHP

The MoHP has initiated a Local Health Governance Program. The goal is to empower the local community with additional resources, channeled through the Ministry of Federal Affairs and Local Development, to manage HFs and make them accountable to the people and the government. This is a good initiative, and it should be scaled up and continued in the future, as it is well aligned with the proposed system of federalism. However, the lack of elected local bodies is one of the challenges to successful implementation of this initiative and should be resolved once the elected bodies are in place.

Box 9

Issues to be addressed under **Capital** for the strategic actions (See Section 4 for details) are as follows:

- Funding mechanism - no flexible funding at times of emergencies, even from local level resources
- Strengthen social marketing
- Greater partnership needed with the private sector

Proposed key strategies are:

- Advocate to allocate reserve/flexible fund to procure RH commodities in situation of emergency and acute shortage
- Advocate with the private sector to run RH program in coordination with social marketing or independently
- Enhance existing collaborative support with DDC, Municipality, VDC, HFOMC, Civil society for RH commodities and services

3.6 Capacity

Objective: *To build capacity of stakeholders at all levels for RHCS management towards achieving the six "Rights" of logistics management*

3.6.1 Current Scenario

Supplies are best managed only when the principle of six "Rights" are applied in logistics management. The six "rights" are:

The **Right** goods
in the **Right** quantities
in the **Right** condition

delivered…

to the **Right** place
at the **Right** time
for the **Right** Cost

Logistics management often fails when the program is not able to fulfill one or more of the six "Rights". Capacity to properly handle these six "Rights" relate to different elements of supply chain management – service delivery; ability to provide right products; forecasting and procurement; inventory management (warehousing, distribution and transportation), information system and monitoring.

3.6.2 Service Provider Skills

In rural areas, clients access RH services from paramedics such as; Auxiliary Health Workers (AHWs), Sr. AHWs, Health Assistants (HA), Auxiliary Nurse Midwives (ANMs), nurses, FCHVs, medical doctors working in the PHCCs, pharmacists and so on. When clients perceive that a health problem is serious or complicated, they generally seek services from private clinics and government health facilities in the nearest city.

Urban clients have the privilege to consult at the private or public clinics of specialists in obstetrics and gynecology (OB/GYNs) and general practitioners to obtain services, whereas most of the rural population has no such access, due to poverty and unavailability of private sector services. The number of municipalities has been significantly increased by the government in the recent past, from 58 to 191, in 2014. The development of infrastructure in all these new municipalities will take time, however, there is a potential for growth of private sector.

The service providers have varying skill levels and they may be inadequate to provide some services. Training curricula for service providers includes counseling for informed choice, taking gender norms into account, logistics/reordering, and appropriate technical skills (e.g., IUCD or implant insertion and removal). Based on the skills of the RH/FP service providers, contraceptives and other RH supplies are provided to the service outlets, to ensure standards of care are maintained. Choice may be limited due to the unavailability of qualified providers. This is not RH security, by definition, so the system should ensure that skilled RH providers are stationed continuously in such sites. If the service is not available at the first point of contact, referral linkages for all service delivery points (SDPs) should be established.

There is no provider bias against particular client groups or methods, but some communities prefer specific types of contraceptives. Some clients prefer to go directly for FP permanent methods, rather than temporary. Supervisors review the quality of the providers' work and provide on-the-job training to improve their skills in service delivery, including counseling, where gender issues and the supply part of commodities (storage, ordering, record-keeping, etc.) are also discussed.

3.6.3 Logistics Management

Both push and pull systems exist in the MoHP's logistics management system. The distribution system from the Center to Districts is push and from health facilities (HFs) to District is Pull. There are four distribution levels i.e. Central to Regional, Regional to District and from district to health facilities, such as PHCCs and HPs.

There is a maximum/minimum inventory control system in place at different levels. Authorized Stock Level (ASL) and Emergency Order Point (EOP) are maintained at the lowest SDPs. At district level, ASL and EOP are maintained for 10 months and 3 months respectively, while at HFs level, ASL and EOP are 5 months and 1 month respectively. At regional level, 3 to 4 months of buffer stock is maintained. This is the standard

prescription of the system but practice differs due to many push and pull factors.

Over the last decade, new storerooms have been constructed in more than 70 districts. There is no significant loss of product through damage and theft at any level. However, the storage space at the district level is becoming inadequate, due to the increased volume of drugs and new programs. In some locations, stores are not exclusively used for medical products.

Transportation facilities are not adequate to deliver commodities from districts to health facilities and this has always remained a challenge, but it is satisfactory from center to region and to district level.

There was a practice of developing distribution schedules at the district level and this was working well. However, in the present scenario, this practice has been discontinued. LMIS is functioning well for logistics data about stock on hand, consumption and wastage. However, the use of LMIS data for supply decision-making at the district level is not optimal. There is a need for strengthening LMIS, through electronic means, for faster reporting and corrective action. Currently, the staff salaries of the LMIS unit of LMD, DoHS are fully supported by donor agencies.

There are guidelines in place for inventory management and handling of supplies to have minimum wastage of supplies due to damage and expiry of products.

For the public sector, the contraceptive logistics system does not stand alone. It is integrated with seven programs (Child Health, ARI, EPI, Malaria and Kalazar, Tuberculosis, Leprosy and FP). If donor support for the LMIS Unit is withdrawn abruptly, the possibility of LMIS being paralyzed remains.

The distribution infrastructure is improving. However, the topographical features and weather in various seasons in parts of the country sometimes limit the availability of supplies at SDPs. Transportation from district to peripheral level health facilities is still not regularized and not optimal. For certain remote and inaccessible areas, the annual commodity distribution program (ACDP), which was in practice earlier, should be continued in order to ensure uninterrupted supply at SDPs. ARVs and other HIV/AIDS commodities are critical components of RHCS. These are managed by NCASC at present, but integration of HIV/AIDS Logistics and General Logistics has already started. LMD and NCASC both are involved in supply and distribution. Quantification and forecasting is also integrated. Although the pace of integration is not as fast as expected, the effort is still directed towards integration.

A pull system is a demand-based approach for ensuring the reliable availability of health commodities at all service delivery points within a health system. Every quarter, all of the HFs place orders to the districts for replenishment. The pull system is in practice from peripheral level HFs to the districts only. This system worked well for some years, however, at present the pull system has become almost non-functional. A strong need is felt to revive the pull system from peripheral level HFs to districts and consolidate it across all distribution tiers. As Nepal is in the process of moving towards a federal state, the distribution system should be reviewed and redefined in context of federalism.

At present, storage spaces at the Center, Regions and Districts are becoming inadequate, since the introduction of the free drug policy and new programs. Major infrastructural expansion and improvement is required in the central and regional stores to cope with the volume and challenges related to proper storage of medicines. A

policy of exclusive use of stores for medical consumables is needed and must be reinforced.

To tap the vast potential of electronic information systems, the current paper-based LMIS Information System and manual processing should be gradually replaced, to get real time information for faster and reliable evidence based logistics decision-making.

3.6.4 Forecasting

Commodity security is essential for effective delivery of quality health services. Consensus forecast and quantification, which began with FP commodity security in 1998 under the leadership of LMD/DoHS, today includes quantification of Essential drugs, FP/Maternal and child health (MNCH) commodities, vaccines, syringes and HIV and AIDS related commodities. Forecasting data have been used for resource generation and to ensure contraceptive security for the country. There is still opportunity for further improvement in forecasting methodology, to capture changing demography within the government's program goals and targets, while minimizing the tendency to overestimate needs. The capacity to forecast accurately needs to be developed at central and district levels, to support the government's decentralization policy.

Forecasting of Essential drugs, FP commodities, MNCH commodities, vaccines, syringes and HIV and AIDS commodities is based on LMIS, HMIS, demographic data, consumption patterns, morbidity issues and some special programmatic considerations. The MoHP is responsible to procure health commodities, including Essential Drugs, FP commodities, MNCH commodities, vaccines, syringes, and HIV and AIDS related commodities except ARVs and Test Kits, which are procured by the Global Fund. The MoHP is funding almost all of the commodities and it is very encouraging to have this increase in financial commitment for procurement. Over the coming years, the MoHP should also start procuring ARV drugs and Test Kits.

3.6.5 Procurement

LMD is responsible for procurement of essential drugs, contraceptives and other RH commodities.

Data on the quantity of drugs dispensed are used in procurement planning. Procurement of drugs in the public sector in Nepal is both centralized and decentralized. As per the Central Bidding and Local Purchasing (CBLP) Guidelines (2009), all essential medicines for free distribution (including key RH medicines) are determined at the central level and 70 percent of the total procurement is done at this level. To maintain the buffer stock of medicines, or to avoid shortage of stock, 10 percent of the budget is allocated to the Regional Health Directorate (RHD) and 20 percent of the budget is allocated to the DHO/DPHO to prevent stock outs. District level training has been conducted in districts using the standard procurement training manual.

Family Planning commodities should be procured at the central level for economy of scale and quality, until the district level capacity for procurement and quality control is fully developed.

In order to correct the procurement-related anomalies and delayed procurement, the Government of Nepal enacted a Public Procurement Act in 2007 that addresses the procurement of commodities, works and services[14]. For the government, the procurement standard procedure are as follows: issuing tenders, evaluating bids, and monitoring supplier performance. There is a scope for efficiency and cost saving by centralizing the procurement

14 Nepal Health Sector Program II (2010-15)

process, which will reduce the price of the product. At the moment, districts are paying higher prices for the same drugs when compared to central level procurement.

Though the procurement process is transparent, actual procurement gets delayed very often due to organizational constraints, donor driven policies, non-comprehensive annual procurement planning, lack of information for strategic procurement, issues of financial management, fiduciary risks, distribution planning/schedule, long bureaucratic processes, etc. There are still some major issues to be addressed in the procurement process.

Organizational restructuring of LMD, creating and strengthening of capacities on different aspects of procurement functions, strengthening contract management, strengthening LMIS and linking with other information systems, and establishment of in-country quality control mechanisms are needed to strengthen the procurement.

The bidding procedures comply with international bidding procedures of funding agencies. In order to overcome procurement delays, pilferage and undue interference, the e-bidding process has been utilized, but it is not moving as expected.

Although there is a delay in procurement, the quality assurance process in procurement is maintained by following WHO standards and pre and post shipment inspections, including lab testing for quality.

When international procurement consultants assist the LMD in procurement, the process is often tied with donor driven guidelines. Hence development of the logistics system to generate local procurement specialists is becoming a must, to enhance the country's procurement capacity and to develop a consolidated procurement plan.

3.6.6 Monitoring and Evaluation

LMIS and HMIS data are routinely used in planning for RHCS commodity needs. There is good support from the policy level for HMIS and LMIS and the importance of such information systems is recognized by the Long Term Health Plan and the Health Sector Program. HMIS is mainly used for program planning and LMIS for logistics. In addition, findings from the annual performance review meetings have been a good source of information for policy makers. Similarly, trimester review meetings are held at district level. Population level data are collected through DHS every 5 years and a census is conducted every 10 years.

LMIS has been in place, since the inception of the Logistics System Improvement Plan in 1994. Over the years it has become a source of information for evidence based logistics decision-making. The paper-based LMIS form from the health facilities (PHCC, HP) is reported every quarter and takes considerable time in transit and data processing at the central level. At present, districts do not process LMIS data. To minimize the lead time of processing and to get timely information, it is necessary to process LMIS data at the district level, to enable districts to have real time information to make supply decisions within the district. To tap the vast potential of an electronic information system, the current paper-based LMIS System and manual processing needs to be gradually replaced, to get real time information for faster and reliable evidence based logistics decision-making.

Box 10

Issues to be addressed under **Capacity** for the strategic actions (See Section 4 for details) are as follows:

- Warehousing and Storage at the center, regions, districts and below
- Distribution and Transportation
- Logistics Management Information system
- Procurement
- Forecasting
- Technology advancement

Proposed key strategies are:

- Reorganize and capacitate LMD with adequate number of skilled HR
- Strengthen central level forecasting for all health commodities based on the accurate HMIS and LMIS data
  - Divisional forecasting (individual divisions)
  - Consolidated forecasting by LMD
- Develop and implement procedures for forecasting at district level to enable more accurate demand side forecast for health commodities in phase wise manner
- Expand web-based LMIS up to the peripheral level HFs to get real time information for supply chain management in phase wise manner.
- Advocate at higher level to strengthen the LMIS unit for optimal functioning
- Construct Warehouses at Regions and Center as per the Master Plan
- Use newly constructed district stores exclusively for medical supplies
- Strengthen DDA and NML capacity for RH commodities quality monitoring in the public and private sector supplies

3.7 Coordination

Objective: *To ensure meaningful coordination among all the partners involved in providing RH services and commodities to take an action for efficient use of resources in satisfying client demand and need*

3.7.1 Current Scenario

RHCS is based upon collaboration and joint action planning. Coordination is required at multiple levels: different stakeholders, different players within the government, among donors (internationally and in-country), and also across all sectors involved in RH programs. Needless to say, effective coordination helps avoid duplication of efforts and improves information sharing amongst the parties involved, including about cost.

There are several stakeholders in the field of RHCS. These include a number of government agencies (MoHP, DoHS, FHD, LMD, NCASC, DDA, NPC, MoF), I/NGOs (FPAN, Lifeline Nepal, CRS, MSI), donors

(USAID, DFID, KfW), international agencies (UNFPA, UNHCR, World Bank, UNICEF, WHO); private sector (Pharmacies, Private Service Providers, FNCCI) and Health Journalists.

There are number of committees where stakeholders from a variety of FP and RH areas meet to discuss the status, on-going implementation and future planning in the area of RH and HIV/AIDS. The Non-Governmental Organization Coordination Committee (NGOCC) which meets once a year to discuss RH related issues. Likewise, the FP Sub-Committee, Safe Motherhood and Neo-Natal Health Sub-Committee (SMNSC) and Adolescent Sexual Reproductive Health Sub-Committee (ASRH) in FHD meet each trimester and discuss RH related issues.

The Reproductive Health Coordinating Committee (RHCC), under the chairmanship of the Director General of DoHS was active in the past, but is currently inactive. However, RHCCs at the district level meet every quarter to discuss district level RH issues.

At present, there is no RHCS Coordinating Committee that oversees commodity security for RH including FP and HIV/AIDS.

In the past, the Consensus Contraceptive Security Working Group (CCSWG) used to meet regularly and included a wide group of stakeholders including donors, NPC and MoF to discuss, plan and implement RHCS activities. This type of meeting has not taken place for a long time and the CCSWG is virtually non-existent.

The Logistics Working Group (LWG) is formed within the LMD, under the chairmanship of the LMD Director, with representation from logistic experts and supporting partners, working together to achieve specific goals. Its mandate is to coordinate with different stakeholders on improving the performance of the supply chain for all health commodities, including RHCS, with focus on innovation, capacity, and stakeholder collaboration to enhance the health logistics activities in Nepal.

Although the LWG is supposed to strengthen the coordination within the government agencies (RH Committee in FHD, Logistics Management Division (LWG) in LMD and HIV/AIDS Logistics Committee in NCASC), between government and donors, between the Public, Private sectors, NGOs and the Social Marketing sector, it requires financial support and resources to function well. Within the MoHP, coordination needs to be strengthened.

The External Development Partners (EDPs) committee is functioning and they meet to discuss the program, but formal dissemination of information from the EDP's meetings to other stakeholders is not in practice.

Box 11

Issues to be addressed in **Coordination** for the strategic actions (See Section 4 for details) are as follows:

- Coordination at all levels within public sector between government and donors and between Public and Private sectors, NGOs and Social Marketing Agencies
- Coordination to implement the revised RHCS strategy

Proposed key strategies are:

- Formation of Logistics Working Group (LWG) to oversee RH commodity security
- Review RHCS issues during relevant fora including national and regional RH review meetings
- Advocate to build public-private partnerships for supply chain management (FNCCI, Pharmaceutical companies, private hospitals association and medical colleges)
- Promote PPP to strengthen below district supply chain management using various approaches

3.8 Communication

Objective: *To establish vertical as well as horizontal communication within the MoHP System, and among all stakeholders involved in RHCS*

3.8.1 Current Scenario

During the review of the RHCS 2007-2011, it became apparent that people in the system, including policy level, program/planning level and implementation level, hardly knew about the existence of the RHCS 2007-2011. As a result, the RHCS strategy and action plans were not efficiently implemented. Since the development of the strategy, no divisions or centers have reviewed the RHCS and developed an annual WP based on the strategy. The creation of a Planning and LMIS Unit under LMD and expansion of the pull system nationwide are the outcomes of ongoing donor support. Any document, study or assessment written/developed since 2007 to date has not mentioned the RHCS.

Hard copies of the strategy were not found in RDs and DHO/DPHOs, but the electronic version was found on the website of some organizations. The strategy was virtually overlooked in all program planning, implementation and monitoring and there was no institutional arrangement put in place to ensure that the strategy was implemented.

Therefore, vertical and horizontal communication of the strategy, within the MoHP system, donors and other stakeholders, as well as clients, has become an essential requirement of this revised strategy. The communication component has been added by the Nepal WG as one of the component of SPARHCS.

Box 12

Issues to be addressed in **Communication** for the strategic actions (See Section 4 for details) are as follows:

- Vertical and horizontal communication within MoHP and with stakeholders
- Advocacy on RHCS
- Use of media for communication

Proposed key strategies are:

- Disseminate the RHCS strategy at Ministerial level, Departmental Level, Regional and District level,
- Disseminate RHCS in all RH related trainings/workshops and FP/RH sub committees
- Conduct periodic reviews of implementation progress of the strategy4. Strategic Action Plans

4.1 Context

Objective: ***To create and promote a supportive policy and regulatory environment for the supply chain and reproductive health commodity security.***

Issues addressed:

- Policy and regulatory environment (Health Policy, FP Policy, RH Policy, Free Health Care Services Policy, Drug Policy, HIV/AIDS Policy, etc.)
- Structural framework for RHCS
- Institutional arrangements for RHCS

Implementing agency: Logistics Management Division and Family Health Division

Assumption:

- Federalism and political commitment will ensue
- Donor support for logistics management will continue and increase further
- Increased involvement of social marketing and private sector in RHCS

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Integrate RHCS explicitly in health-related policies in line with securing total health commodities and additional RH commodities	LMD, FHD	10,000	2015-2020	Number of meetings held List of areas requiring further attention/ action identified and addressed	Revised or updated health related policies include RHCS as a priority area
2. Plan and conduct advocacy activities to increase awareness among national and local leaders, policy makers, and senior officials on the need to have favorable policies for private sectors, NGOs, social marketing agencies, civil societies, and communities to improve RHCS	LMD FHD	5,000	2015-2020	Number of advocacy activities planned and conducted	Nepal health sector plan enables greater participation of private, social marketing, NGO sectors in improving RHCS

3. Strengthen National RHCC and include RHCS in its scope of work	FHD	3,000	2015-2020	Meeting minutes in place that provide evidence that RHCS issues are being addressed	National RHCC is actively functioning (committee meets at least once a year)
4. Strengthen District RHCC to address RHCS issues	DHO/DPHO	7,50,000 (10,000 per district)	2015-2020	Meeting minutes in place that support evidence that RHCS issues are being addressed	District level RHCC is actively functioning (committee meets at least once in every trimester)
5. Work with MD to incorporate RH equipment and physical facilities in national maintenance plan and policy	FHD, MD, LMD	1,00,000	2015-2020	Maintenance need of RH equipment identified and incorporated in repair and maintenance plan	Request for repair and maintenance of RH equipment timely fulfilled in a timely manner

4.2 Client Utilization and Demand

Objective: ***To increase demand and utilization of RH services through participation of the public and private sector including social marketing, for addressing the unmet needs and increasing accessibility to RH and FP services***

Issues addressed:

- Availability, accessibility and choice of services/contraceptives
- Equity
- Health seeking behavior
- Provider bias
- Market segmentation to increase service utilization

Implementing agency: Logistics Management Division and Family Health Division

Assumption:

- Required financial and human resources available
- Political commitment increases

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Conduct studies: a. market segmentation; b. user-profile c. reasons for non-use and discontinuation d. issues related to quality of care and recommendation for improvement e. feasibility and acceptability studies on additional contraceptive methods f. other studies as required	FHD/LMD	5,00,000	2015-2020	Reports of these studies in place	Strategies and interventions to reach excluded and marginalized people developed and implemented Greater participation of private sector and social marketing in provision of RH services
2. Design and implement additional interventions to increase the range of contraceptive choices in a phase wise manner to promote utilization	FHD, NHEICC	2,50,000	2015-2020	Increase training sites Train health workers	More contraceptive choices available Utilization increased
3. Coordinate with municipalities to meet the RH commodity needs of urban population including urban slums	PHCRD, FHD	5,000	2015-2020	Programs developed and implemented to address the RHCS needs in coordination with the municipality Range of RH services available in the slum area Availability of RH commodities in urban clinics increased	RHCS need of urban slums addressed Utilization of RH services increased in urban clinics
4. Design and implement targeted strategies and interventions to reach special populations and communities	FHD, LMD, PHCRD	10,00,000	2015-2020	Targeted interventions designed and implemented	RH service utilization increased among special groups

5. Increase involvement of media for awareness on RH and FP services	FHD, LMD, NHEICC	1,00,000	2015-2020	Number of media sensitization activities implemented	Number of articles in local newspapers published Number of programs aired in local FM, TV

4.3. Commodities

Objective: To update and forecast RH commodities and equipment periodically

Issues addressed:

- Revise list of RH commodities including equipment
- Funding/in-kind sources of RH commodities (social marketing, NGO)
- Effective and efficient procurement
- Emergency funding during crisis
- Tracking of all RH commodities by LMIS

Implementing agency: Family Health Division and Logistics Management Division

Assumption:

- Internal resources mobilized
- Donor support will continue

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Convene expert group to review and update the list of RH commodities and equipment (specification) on a periodic basis	FHD, LMD	25,000	2015-2020	Expert group formed	List and specification of RH commodities and equipment revised and updated in periodic basis
2. Expand coverage of additional contraceptives (including female condoms, emergency contraceptives, one-rod-implant etc.) through social marketing sector	FHD, LMD, NGOs, NCASC, social marketing	10,00,000	2015-2020	Female condoms distribution mechanism established Access to female condoms increased	Increased contraceptive choices and client satisfaction

3. Develop alternative financing schemes for RH commodities to reduce and/ or shift public sector burden in the long run	LMD, MoLD	5,000	2015-2020	Alternative financing schemes identified	Policy to implement the alternative financing schemes approved
4. Advocate with government and donors to increase funding for RH commodities and equipment	FHD, LMD, Donors	10,000	2015-2020	MoHP annual work plan with increased size of health budget (MoHP and donor)	Increased share of RH budget
5. Implement quality assurance plan for RH commodities	FHD, LMD, DDA	20,000	2015-2020	Sample testing guidelines and action plan developed and in use	Quality of RH commodities monitored
6.Advocate for in-country quality testing of RH commodities	FHD, DDA, LMD	20,000	2015-2020	Number of advocacy meetings Strengthened DDA lab and private sector labs	In-country quality testing capacity for RH commodities increased

4.4 Commitment

Objective: ***To improve and formalize collaborative commitments on RHCS within public, donor and private sector including social marketing***

Issues addressed:

- Inadequate advocacy
- Limited involvement/participation of NGOs, social marketing and private health institutions in RHCS
- Limited recognition of RH issues of urban poor and slum populations
- Ensuring robust health logistics system
- Limited recognition and promotion of social marketing

Implementing agency: Logistics Management Division and Family Health Division

Assumptions:

- Political environment will continue to be favorable.
- Donor support will continue.

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Advocate with parliamentarians (members of health committee) on the importance of RHCS	MoHP, FHD, LMD	25,000	2015-2020	Number of advocacy activities implemented	Funding from MoHP for RH and FP commodities increased
2. Create favorable environment for NGOs, social marketing and private sectors to expand coverage beyond urban areas for capturing underserved people and for those who can and are willing to pay for the services	MoHP	30,000	2015-2020	Service expansion by private sector and social marketing (subsidizing) to work in remote rural areas developed	Policy approved and implemented

4.5 Capital

Objective*: To consolidate budgetary requirements for RH commodities/program and ensure funding commitments*

Issues addressed:

- Funding mechanism - no flexible funding at times of emergencies, even from local level resources
- Strengthen social marketing
- Greater partnership needed with private sector

Implementing agency: Logistics Management Division and Family Health Division

Assumption:

- Political environment remains to be favorable
- Donor support will continue

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Advocate to allocate reserve/ flexible fund to procure RH commodities in situation of emergency and acute shortage	FHD, LMD, DoHS, MoHP, EDPs	25,000	2015-2020	Number of advocacy activities implemented	Provision of flexible fund by GoN, Donors made
2.Advocate with the private sector to run RH programs in coordination with social marketing or independently	MoHP, MoF	25,000	2015-2020	Number of consultative meetings	Policy approved and implemented
3. Enhance existing collaborative support with DDC, Municipality, VDC, HFOMC, Civil society for RH commodities and services	FHD, DHO, MoFLD, DHO/DDC	43,000	2015-2020	Collaboration mechanism established and utilized Encourage VDCs to allocate more funds for health commodities	Collaborative support increased

4.6 Capacity

Objective: ***To build capacity of stakeholders at all levels for RHCS management towards achieving the six "Rights" of logistics management***

Issues addressed:

- Warehousing and Storage at the center, regions, districts and below
- Distribution and Transportation
- Logistics Management Information System
- Procurement
- Forecasting
- Technology advancement

Implementing agency: Logistics Management Division and Family Health Division

Assumption:

- MoHP will fill-up vacant positions with qualified and skilled staff
- Health workers handle the medical store and logistics management
- Donor support will continue

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Reorganize and capacitate LMD with adequate number of skilled HR	LMD	5,00,000	2015-2020	LMD reorganized Designated skilled HR available for procurement, contract management and quality assurance	Efficiency in procurement and availability of quality drugs
2. Strengthen central level forecasting for all health commodities based on the accurate HMIS and LMIS data a. Divisional forecasting (individual divisions) b. Consolidated forecasting by LMD	LMD, FHD, PHCRD, CHD, NCASC, EDCD, MD, NTC	60,000	2015-2020	Government has in-house capacity and budget with skilled HR in LMD Arrangement of forecasting expert in LMD	Reliable and quality forecasting procedure in place
3. Develop and implement procedures for forecasting at district level to enable more accurate demand side forecasting for health commodities in phase-wise manner	LMD, RD, DHO/DPHO	50,000	2015-2020	Number of districts with decentralized forecasting	District level forecast for health commodities available
4. Expand web-based LMIS up to the peripheral level HFs to get real time information for supply chain management in phase-wise manner	LMD, DPHO/DHO and other stakeholders	10,00,000	2015-2020	Number of Districts	Year round availability of RH commodities in the service delivery sites
5. Advocate at higher level to strengthen the LMIS unit for optimal functioning	LMD, FHD, MoHP, MoF, MoGA, PSC	3,00,000	2015-2020	Number of sanctioned positions for LMIS unit increased and in place	Number of staff added in LMIS unit
6. Construct warehouses at Regions and Center as per the Master Plan	MoLD, MoF, MoHP	-	2015-2020	Number of warehouses constructed	Quality in storage improved
7. Use newly constructed district stores exclusively for medical supplies	LMD, DHO/DPHO	75,000	2015-2020	Number of district stores disposing non medical consumables	Wastage and expiry of medical consumables reduced

8. Strengthen DDA and NML capacity for RH commodities quality monitoring in the public and private sector supplies	FHD, DDA	1,00,000	2015-2020	Onsite RH medicines test tools for DDA, 3 branch offices and NML procured and base line data on procured RH commodities available	Quality of RH commodities improved

4.7 Coordination

Objective: ***To ensure meaningful coordination among all the partners involved in providing RH services and commodities to take an action for efficient use of resources in satisfying client demand and need***

Issues addressed:

- Coordination at all levels within the public sector between government and donors and between Public and Private sectors, NGOs and Social Marketing Agencies
- Coordination to implement the revised RHCS strategy

Implementing agency: MoHP, LMD, FHD, PHCRD, DDA

Assumption:

- Increased GoN's commitment to RHCS
- Increased Donor Support for RHCS
- Participation of private, social marketing and NGO sectors improved

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Formation of Logistics Working Group (LWG) to oversee RH commodity security	LMD, FHD, MD	20,000	2015-2020	LWG formed and functioning	RHCS strategy implementation in progress
2. Review RHCS issues during relevant fora including national and regional RH review meetings	LMD, MD, FHD	1,50,000 (for region and national)	2015-2020	RHCS Program reviewed	Actions to be taken identified and implemented
3. Advocate to strengthen public-private-partnerships for supply chain management (FNCCI, Pharmaceutical companies, private hospitals association and medical colleges)	DOHS, LMD	25,000	2015-2020	Advocacy activities conducted, report prepared and circulated	Innovative interventions to strengthen supply chain management through PPP piloted and evaluated
4. Promote PPP to strengthen below district supply chain management using various approaches	LMD, DHO/ DPHO and other stakeholders	5,00,000	2015-2020	Number of districts with transportation of health commodities managed by private sector	Year round availability of RH commodities in the service delivery sites

4. 8 Communication

Objective*: To establish vertical as well as horizontal communication within the MoHP System and among all stakeholders involved in RHCS*

Issues addressed:

- Vertical and horizontal communication within MoHP and with stakeholders
- Advocacy on RHCS
- Use of media for communication

Implementing agency: Logistics Management Division and Family Health Division

Assumption:

- Communication between concerned stakeholders will improve

Time Period: 5 years

Strategic Activity	Implementing Agency	Estimated Budget (USD)	Timing	Output Indicators	Outcome indicators
1. Disseminate RHCS strategy at Ministerial level, Departmental Level, Regional and District level	LMD, FHD, RD, DHO/ DPHO	50,000	2015-2020	Strategy shared at different levels	Awareness and familiarity on RHCS agendas increased
2. Disseminate RHCS in all RH related trainings/ workshops and FP/RH sub committees	FHD, LMD, NHEICC, DHO/DPHO	-	2015-2020	RHCS program reviewed	Actions to be taken identified and implemented
3. Conduct periodic reviews of implementation progress of the strategy	LMD, FHD, LWG, NHEICC	10,000	2017/18	Implementation progress reviewed and shared	Progress up to the mark documented and recommendations for further improvement provided

ANNEXES

Annex 1: Technical Advisory Committee (TAC) Members

Chairman: Director General, DoHS

S.N	Members
1	Director General, DoHS
2	Director, LMD
3	Director, FHD
4	Director, PHCRD
5	Director, MD
6	Director, NCASC
7	Director, CHD
8	Department of Drug Administration
9	Financial Chief, DoHS
10	DPHO , Kathmandu
11	DPHO, Lalitpur
12	DPHO, Bhaktapur
13	UNFPA
14	USAID
15	WHO
16	World Bank
17	DFID
18	KFW
19	NHSSP
20	H4L Core
21	PSI
22	FHI
23	FPAN
24	CRS
25	Ipas
26	MSI
27	CNCP

Annex 2: Working Group (WG) Members

Chairman: Director, LMD

S.N	Senior officials
1	LMD
2	FHD
3	PHCRD
4	CHD
5	NCASC
6	DPHO (Bhaktapur, Surkhet)
7	UNFPA
8	USAID
9	H4L Logistics
10	Lifeline Nepal

Others invited as and when necessary

Annex 3: List of Consulted Individuals (Stakeholder Consultation)

SN	Name of Consulted Individual	Designation	Organization
1	Dr. Asha Pun Thapa	MNH Specialist	UNICEF Nepal
2	Mr. Dirgha Raj Shrestha	National Program Manager	Ipas International
3	Mr. Sagar Dahal	Sr. PHA	MoHP
4	Mr. Bhogendra Dotel	Sr. PHA, FP Focal Person	FHD
5	Mr. KP Bista	General Director	FPAN
6	Mr. KB Rayamajhi	Director	CRS
7	Dr. Rajendra Gurung	FP Advisor	NHSSP
8	Dr. Shilu Aryal	Focal Person, Safe Motherhood	FHD
9	Mr. Shyam Sunder Sharma	Managing Director	MEH Consultancy
10	Dr. BD Chataut	Former DG, DoHS	Freelancer
11	Mr. Ramesh Adhikari	Sr. PHA	EDCD
12	Dr. Rajendra Bhadra	Team Leader, Service Delivery	H4L
13	Sita Ram Devakota	National Program Manager	PSI
14	Shankar Pandey	Chief of the Office	KfW
15	Tek Bdr Dangi	FP Program Expert	Freelancer
16	Sarad Raj Sharma	Demographer	Freelancer
17	Kanak Raj Shrestha	Program Officer	FHD
18	Dr. Laxmi Raj Pathak	Former DG, DoHS	Freelancer

Annex 4: References

National documents

- Annual Report 2012/13, Department of Health Services
- Drug list for Free Health Services, 2071
- Free health service guideline, Ministry of Health and Population, 2065
- Gender equity and social inclusion strategy in health (Health sector-GESI Strategy), Ministry of Health and Population, 2009
- Health Sector Strategy: An Agenda for Reform, MoHP, 2004
- Interim Constitution of Nepal, 2063
- Ministry of Finance, Budget Speech 2012-13, 2013-14, 2014
- National adolescent health and development strategy, MoH, DoHS, FHD, 2000
- National Drug Policy, 1995, 2007
- National Family Planning Strategy, 2068
- National Female Community Health Volunteer (FCHV) Program Strategy, Ministry of Health and Population, Department of Health Services, Family Health Division, 2010
- National Health Insurance Policy, MoHP, 2014
- National Health Policy, MoH, 1991
- National Health Policy, MoHP, 2071
- National List of Essential Medicines, 2011
- National Medicines Policy, 2007
- National Policy on SBA (Supplementary to Safe Motherhood Policy 1998), 2006
- National Population Policy,1998
- National Reproductive Health Strategy, FHD, DoHS, MoH, HMG, 2004
- National Safe Abortion Policy, FHD, DoHs, MoH, HMG, 2003
- National Safe Motherhood Plan, 2002 – 2017
- Nepal Demographic Health Survey, 2001, 2006, 2011
- Nepal Health Sector Program – II (2010-2015), Ministry of Health and Population
- Nepal Health Sector Program – Implementation Plan (2004-09)
- Nepal MDG Progress Report- GoN, NPC, UN Country Team Nepal, 2013
- Nepal National Advocacy Plan on HIV and AIDS, 2008-2011, NCASC, UNAIDS
- Nepal Population Report, Central Bureau of Statistics, 2011
- Population Perspective Plan (PPP) 2010-2031, MoHP, 2067
- Second Long Term Health Plan (1997 – 2017)
- Thirteenth Plan FY 2070/71-2072/73, National Planning Commission, 2071
- Three Year Interim Plan (2007/08 - 2009/10), NPC
- Urban Health Policy (2010-2014), MoHP, MoLD, GoN, 2010

International RHCS documents

- Reproductive Health Commodity Security Assessment, Yemen, 2007
- Reproductive Health Commodity Security Status Assessment Report, UNFPA, 2008

- Reproductive Health Commodity Security Status Assessment Report, Federated States Of Micronesia (FSM), 2008
- RHCS Country Case Study: Cambodia, February 2006
- RHCS: Partnership for Change, A global call to action, 2001
- Strategy for Contraceptive Security in Bangladesh, 2002
- RHCS Strategy Uganda, 2009
- A comprehensive guide to RHCS: mapping and analysis of the supply-chain and suggestion for improvements, Joakin Kembro, 2005
- Project Completion Review, Title: Global Programme to Enhance Reproductive Commodity Security (GPRHCS), 2013

Online sources:

- Health expenditure, total percent of GDP. Accessed at http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS
- Population Perspective Plan (PPP) on Nepali Times. Accessed at http://www.nepalitimes.com/blogs/thebrief/2011/07/11/population-perspective-plan/ on Monday, July 11th, 2011
- MDG- Still far off target - The Kathmandu Post, 27th January, 2015
- FP 20/20 Progress report 2013-2014. Accessed at http://progress.familyplanning2020.org

Other documents

- Health Logistics in Nepal-Two Decades of Investments in Public Health Supply Chain Management: How Access to Supplies Improved Health Outcomes in Nepal, USAID, 2014
- Differential Pricing-UNFPA's experience with contraceptives, Christian Saunders, UNFPA
- Adding It Up Report; The Costs and Benefits of Investing in Sexual and Reproductive Health, UNFPA, 2014
- Brockerhoff, Martin and Ellen Brennan. 1997. The Poverty of Cities in the Developing World. Population Council Working Paper No. 96. New York: Population Council.
- Implementing the 20/20 Initiative; Achieving universal access to basic social services, A joint publication of UNDP, UNESCO, UNFPA, UNICEF, WHO and the World Bank, 1998
- Nepal: Poverty Reduction Strategy Paper (2003), International Monetary Fund,
- Urban Population, Poverty and Sustainable Development: Emerging Issues for UNFPA, CIESIN, Columbia University, 2005
- Vulnerable Community Development Plan for Nepal Health Sector Program Implementation Plan (2004/5 – 2008/9)
- WHO RH Strategy, 2004
- WHO Strategic vision (SRH), 2010
- Costs and Impacts of Scaling Up of Family Planning Program in Nepal, Oxford Policy Management, 2014
- Integrating Microfinance and Health Benefits, Challenges and Reflections for Moving Forward, Sheila Leatherman, Working Paper, World Microcredit Summit, 2011

Annex 5: Comprehensive List of Reproductive Health Commodities Reference: RHCS Strategy 2007-2011

Existing Forecast of RH Commodities

FP commodities: Quantity and cost
(Condom, Injectables, Pills, IUCDs, and Implant)

Other Essential Commodities: Quantity and cost
(ORS, Vitamin A, Cotrim/ped, Iron Tablets, and Oxytocin)

The RH Commodities are grouped in three categories:

1. Key Essential RH Commodities (35 items)
2. Essential RH Commodities (57 items)
3. Supporting RH Commodities (44 items)

1. Key Essential RH Commodities

S.N.	Key Essential RH Commodities Name
1	Adrenaline Inj.
2	Albendazole Tab
3	Anti Malarial (Chloroquine, Premaquine, Sulfadoxin-pyrimethamine)
4	ARV Drugs (3 types)
5	BCG vaccine
6	Calcium Gluconate Inj.
7	Condom (male and female) (FP)
8	Sulphamethoxazole 100mg and Trimethoprim 20mg (Cotrimoxazole pediatrics)
9	Dexamethasone Inj.
10	DPT with Hep B vaccine
11	Emergency Contraceptive Pills (FP)
12	Ergometrine Inj.
13	Gentamycin Inj.
14	HIV Kit (HIV spot)
15	Hydrocortisone Inj.
16	Implant (FP)
17	Injectables (FP)

S.N.	Key Essential RH Commodities Name
18	Ferrous Salt 60 mg and Folic Acid 0.4 mg tablet
19	IUCD insertion and removal kit with alligator forceps
20	IUCD-CuT (FP)
21	Ketamine
22	Magnesium Sulphate 1 gm, Inj
23	Measles vaccine
24	ORS
25	Oxytocin
26	Metoclopramide Hydrochloride Inj.
27	Pills (FP)
28	PMTCT drugs
29	Polio vaccine
30	Misoprostol
31	Ring Pessaries (uterine prolapse)
32	Sodium Bi-carbonate Inj.
33	TT vaccine
34	Vitamin A
35	Xylocaine 1%

2. Essential RH Commodities

S.N.	Essential RH Commodities Name
1	Aminophylline Inj.
2	Ampicillin Inj.
3	Analgesic (paracetamol, ibuprofen)
4	Antibiotic (ampicillin, metronidazole, trimethoprim+sulfamethoxazole)
5	Atropine Inj.
6	Betadine scrub
7	Betadine solution (Idophores)
8	Blood transfusion kit
9	BP set
10	Bupivacaine 0.5%
11	Campose Inj.
12	Glutaraldehyde (Cidex)

S.N.	Essential RH Commodities Name
13	Cord clamp
14	Deriphylline
15	Dextrose 25% Inj.
16	Diazepam 100 mg Tab.
17	Diazepam Inj.
18	Diclophenic Sodium 100 mg
19	Diclopramide sodium
20	Diphenhydramine Inj.
21	Doxycycline 100 mg
22	Ethamsylate
23	Ether
24	Examination and sterile surgical gloves
25	Foetuscope
26	Fortwine
27	Halothene
28	Heavy xylocaine 2%
29	I/V drip (RL)
30	Kit for suture of vaginal and cervical tears
31	Lasix Inj.
32	Lignocaine 1% without epinephrine
33	Metoclopramide
34	Metronidazole Inj.
35	Mifepristone (anti progestogen)
36	Naloxin Inj.
37	Neostignine
38	Nifedepin 10 mg.
39	Normal saline
40	Pancuroneom
41	Pentazocine Inj.
42	Pethidine
43	Pregnancy testing kit
44	Professional midwife kit/EoC kit
45	Progesterone
46	Promethazine Inj.
47	Ranitidine Inj.

S.N.	Essential RH Commodities Name
48	Rapid plasma regain (RPP) testing set/VDRL
49	Ringer lactate solution
50	Bupivacaine HCI Injections (Sensorcaine 5%)
51	Succinyl Cholin
52	Test HIV 1+2, fast (HIV spot)
53	Thiopenthaothal
54	Trilene
55	Vacuum extraction delivery kit
56	0.5% chlorine solution (Virex)
57	Xylocaine 1%

3. Supporting RH Commodities

S.N.	Supporting RH Commodities Name
1	Ambu bag with mask (adult size)
2	Autoclave, drum
3	Baby suction machine
4	Blanket to wrap newborn
5	Boiler
6	Canula for endometrial biopsy
7	Catgut
8	Cathetar
9	Chittal forceps with jar
10	Diagnostic kit
11	Dialators
12	Disposable sterile syringe and needles (3ml, 5ml, 10ml, 20ml, 50ml)
13	Examination table
14	Fusion pump
15	Gauze, cotton, gloves
16	Gown, goggles, boot, slipper, plastic apron, mask
17	Height measure machine
18	I/V fluid and sets
19	I/V set + canula (adult + new born)

S.N.	Supporting RH Commodities Name
20	Laparotomy set
21	Lighting equipment (spot light)
22	Macantosh
23	Mini-laparatomy kit
24	MVA plus set with canulae
25	New born resuscitation set (ambu bag, air way, suction tube, NG tube)
26	New born resuscitation table
27	Non-scalpel vasectomy kit
28	Nosal canula
29	Oxygen cylinder
30	Oxygen mask
31	Post procedural recovery bed
32	Sonic kit
33	Speculum
34	Sponge holder
35	Steel bowl and bucket (bata, baltins)
36	Sterile towel for drying the newborn
37	Sterilizing equipment
38	Sub-dermal implant insertion and removal kit
39	Tape (leucoplast)
40	Trays, stool, sieve, view box
41	Tubal ligation kit (abdominal)
42	Ultra sound machine
43	Urine dipstick for protein
44	Weighing machine for baby and mother

Annex 6: List of Participants in the Working Group and Technical Advisory Committee Meetings/Workshops

First Workshop (Working Group) [19th December, 2014]

SN	Name	Designation	Organization
1	Krishna Prasad Gautam	Official Director	LMD
2	Achut Lamichhane	Sr. PHA	PHCRD
3	Ghana Shyam Pokharel	Sr. PHA	FHD
4	Dinesh Kumar Chapagain	Sr. PHA	DPHO Bhaktapur
5	Dr. Yadhu Chandra Ghimire	SMO	NCASC
6	Udev Maharjan	DCoP	H4L logistics
7	Ram Bahadur Shrestha	Activity Coordinator	Lifeline Nepal
8	Dr. Shilu Adhikari	RH Specialist	UNFPA
9	Usha Pokharel	Consultant	H4L Logistics
10	Hari Prasad Acharya	HA	LMD
11	Bishnu Baskota	HA	LMD
12	Gyan Bahadur B.C	PO	LMD
13	Dr. Janardan Lamichhane	Chairman	Lifeline Nepal
14	Ashish Kunwar	PHO	LMD
15	Sushil Karki	CEO	Lifeline Nepal
16	Bhogendra Raj Dotel	Sr. PHA	DHO, Surkhet
17	Nur Prasad Pant	Senior Health Advisor	USAID
18	Nirupama Rai	COR	H4L Logistics, USAID
19	Deepak Adhikari	HA	LMD

2nd Workshop (TAC) [9th January, 2015]

SN	Name	Designation	Organization
1	Dr. Senendra Raj Upreti	DG	DoHS
2	Dr. Bhim Singh Tinkari	Director	LMD
3	Dr. Puspa Chaudhary	Director	FHD
4	Dr. Dipendra Raman Singh	Director	NCASC
5	Krishna Sharma	HPM	MoHP/NHSSP
6	Dinesh Kumar Chapagain	Sr.PHA	DPHO Bhaktapur
7	Dr Niraj Nakarmi	SPO	JSI/CNCP
8	Krishna Prasad Gautam	Undersecretary	DoHS, LMD

SN	Name	Designation	Organization
9	Nirupama Rai	COR	USAID, Nepal
10	Ivana Lohar	Program Development Specialist	USAID, Nepal
11	Dr. Neeta Shrestha	Technical Advisor	SSP
12	Shazina Masud	CR	PSI
13	Puspa Lamichhane	CSD	MSI Nepal
14	Dr. Shilu Adhikari	RH Specialist	UNFPA
15	Chandra Mani Dhungana	RHCS Program Analyst	UNFPA
16	Dr. Damodar Adhikari	Team Leader, HS	H4L Core
17	Udev Maharjan	Vice Chairman	Lifeline Nepal
18	Ram Bahadur Shrestha	Program Coordinator	Lifeline Nepal
19	Dr. Pradhan Y.V	President	SOPHYN
20	Madhabi Bajracharya	Program Advisor	Ipas Nepal
21	Dhirgha R. Shrestha	NPM	Ipas
22	Dinesh H.S Pradhan	Program Manager	FPAN
23	Rishikesh Kafle	Logistics manager	CRS
24	Uttam Raj Regmi	Director	CRS
25	Dr. Ramesh Kumar Kharel	Director	PHCRD/DoHS
26	Latika Maskey Pradhan	Assistant Representative	UNFPA
27	Shree Krishna Bhatta	Chief PHA	DPHO, Kathmandu
28	Rishi Kesh Sharma	PO	H4L Logistics
29	Bishnu Banskota	HA	FHD
30	Hari Prasad Acharya	HA	LMD
31	Badri Nath Gyawali	Under Secretary	FHD
32	Narayan Prasad Dhakal	Drug Administrator	DDA
33	Gyan Bahadur B.C	PO	LMD
34	Kedar Parajuli	PHO	DPHO, Lalitpur
35	Dr. M Thapa	NPO	WHO
36	Dr. Janardan Lamichhane	Chairman	Lifeline Nepal
37	Usha Pokharel	Consultant	Lifeline Nepal

Third Workshop (Working Group) [23rd January, 2015]

SN	Name	Designation	Organization
1	Dr. Bhim Singh Tinkari	Director	LMD
2	Dr. YV Pradhan	Former DG	DOHS
3	Dr. R Gurung	FPA	NHSSP
4	Rishikesh Kafle	Logistics Manager	CRS
5	Shyam Sharma	Consultant	MEH
6	Ghanashyam Pokharel	Sr. PHA	FHD
7	Krishna Rayamaji	MD	CRS
8	Krishna Pd. Gautam	Under Secretary	DOHS/ LMD
9	Dhurba Thapa	Policy and Governance Advisor	H4L Core
10	Madhabi Bajracharya	Program Advisor	IPAS/Nepal
11	Chandra Mani Dhungana	RHCS Program Analyst	UNFPA
12	Ramesh Pd. Adhikary	Sr. PHA	MD, DOHS
13	Dr. Yadu Chandra Ghimire	Sr. Medical Officer	NCASC
14	Dinesh Kumar Chapagain	Sr. PHA	DPHO, Bhaktapur
15	Hari Pd. Acharya	HA	LMD
16	Deepak Adhikari	PHO	DOHS
17	Ram Bahadur Shrestha	RHCS Strategy Activities Coordinator	Lifeline Nepal
18	Gyan Bahadur BC	PO	LMD
19	Achyut Lamichhane	Sr. PHA	PHCRD, DOHS
20	Sagar Dahal	Sr. PHA	MOHP
21	Udev Maharjan	DCOP	H4L Logistics
22	Umesh K. Gupte	Program Manager	PSI/Nepal
23	Bikalpa Upadhyay	Member	Lifeline Nepal
24	Shilu Adhikari	RH Specialist	UNFPA
25	Bishnu Banskota	HA	FHD
26	Sushil Karki	CEO	Lifeline Nepal
27	Dr. Janardan Lamichhane	Chairman	Lifeline Nepal
28	Usha Pokharel	Consultant	Lifeline Nepal
29	Bonita Sharma	Volunteer	Lifeline Nepal

Fourth Workshop (Working Group) [27th February, 2015]

SN	Name	Designation	Organization
1	Dr. Bhim Singh Tinkari	LMD, Director	LMD
2	Dr. YV Pradhan	President	SOPHYN
3	Chandra Mani Dhungana	RHCS Program Analyst	UNFPA
4	Bishnu Banskota	HA	FHD
5	Bikalpa Upadhyay	Member	Lifeline Nepal
6	Ram Bahadur Shrestha	RHCS Strategy Activities Coordinator	Lifeline Nepal
7	Ramesh Pd. Adhikary	Sr. PHA	MD, DoHS
8	Dinesh Kumar Chapagain	Sr. PHA	DPHO, Bhaktapur
9	Hari Prasad Acharya	HA	LMD
10	Umesh Kumar Gupta	Program Manager	PSI/Nepal
11	Kanak Raj Shrestha	PO	FHD
12	Dr. Shilu Adhikari	RH Specialist	UNFPA
13	Ghana Shyam Pokharel	Sr. PHA	FHD
14	Gyan Bahadur BC	PO	LMD
15	Sagar Dahal	Sr. PHA	MoHP
16	Ashish Kunwar	PHO	LMD
17	Narayan Pd. Dhakal	Drug Administrator	DDA
18	Dr. Janardan Lamichhane	Chairman	Lifeline Nepal
19	Usha Pokharel	Consultant	H4L Logistics
20	Bonita Sharma	Volunteer	Lifeline Nepal

Fifth Workshop (WG and TAC) [27th March, 2015]

SN	Name	Designation	Organization
1	Dr. Bhim Singh Tinkari	LMD Director	LMD
2	Dr. Senendra Raj Upreti	DG	DoHS
3	Dr. YV Pradhan	SOPHYN	SOPHYN
4	Achyut Lamichhane	Sr. PHA	PHCRD
5	Deepak Adhikari	PHO	LMD
6	Om Nepal	Immunization Officer	LMD
7	Jhalak Sharma Paudel	Regional Health Director	ERHD
8	Chandra Mani Dhungana	RHCS Program Analyst	UNFPA
9	Bishnu Banskota	HA	FHD

SN	Name	Designation	Organization
10	Dr. Janardan Lamichhane	Chairman	Lifeline Nepal
11	Ram Bahadur Shrestha	RHCS Strategy Activities Coordinator	Lifeline Nepal
12	Dinesh Kumar Chapagain	Sr. PHA	LMD
13	Hari Prasad Acharya	HA	LMD
14	Umesh Kumar Gupta	Program Manager	PSI/Nepal
15	Kanak Raj Shrestha	PO	FHD
16	Dr. Shilu Adhikari	RH Specialist	UNFPA
17	Ghana Shyam Pokharel	Sr. PHA	FHD
18	Gyan Bahadur BC	PO	LMD
19	Narayan Pd. Dhakal	Drug Administrator	DDA
20	Sunil KC	Logistics officer	Nepal CRS
21	Dirgha Raj Shrestha	NPM	Ipas
22	Shazina Masud	CR	PSI
23	Krishna Rayamajhi	MD	CRS
24	Dr. Ramesh Kumar Khanal	Director	PHCRD
25	Leela Khanal	PD	JSI/CNCP
26	Dr. Niraj Nakarmi	SPO	JSI/CNCP
27	Shree Khrishna Bhatta	Chief Public Health Ad	DPHO
28	Bikalpa Upadhyay	Member	Lifeline Nepal
29	Bonita Sharma	Volunteer	Lifeline Nepal

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