National Family Planning Costed Implementation Plan 2015-2020

Government of Nepal
Ministry of Health and Population
Department of Health Services
Family Health Division
2015 (2072)

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November 2015

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DEPARTMENT OF HEALTH SERVICES

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Foreword

Voluntary family planning is a highly cost-effective program that has demonstrable poverty-reducing and development-promoting effects. They help women achieve their human rights to health, autonomy, and personal decision making about family size. Its role in preventing HIV infections and unintended pregnancies and thus reducing unplanned births, abortions, maternal and infant deaths is well recognized.

Family planning is one of the priority programs of the Ministry of Health and Population of Nepal. Through concerted and continuous efforts, supported by external development partners, we have made considerable progress in improving access to and utilization of family planning services since the 70's. A recent stagnation of contraceptive prevalence rate is an indication that we must increase our investment in family planning program; designing and implementing effective and focused interventions to reach those with highest needs.

This National Family Planning Costed Implementation Plan (CIP) 2015-2020 is a step towards the aforementioned goal and outlines national strategies and interventions that we must adopt to ensure that high quality family planning services are available and accessible to all Nepalese, as well as the tentative resources required to realize this vision. It is aligned with the Nepal Health Sector Plan III (2015-2020) and thus represents the national plan on family planning program of the Government of Nepal. As such continued support from our key development partners, including civil society organizations and organized private sector, in implementing this plan is solicited.

It is my sincere belief that this CIP will revitalize and reposition family planning program in Nepal. Having developed this plan the Government of Nepal is strongly committed to its successful implementation and I call on all the relevant stakeholders to adopt this CIP as the reference document during planning, implementing and evaluating all interventions that are aimed at increasing access and utilization of quality family planning services. I would like to thank all the organizations and individuals who have contributed in development of this document.

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Acknowledgments

This National Family Planning Costed Implementation Plan (CIP) 2015-2020 has been developed through extensive consultations at national, regional and district levels under the guidance of a committed Technical Working Group (TWG). The Family Health Division (FHD) would like to express sincere gratitude all the stakeholders who contributed at various stages of this process.

The collaboration and contribution of MoHP, DoHS, NHTC, LMD, NHEICC and NCASC in development of this document is noteworthy. FHD acknowledges the financial and technical support from the United Nations Population Fund (UNFPA) for coordinating all the activities that resulted in development of this CIP. UNFPA's support through Oxford Policy Management (OPM), UK for costing exercise and economic analysis; Dr Rita Columbia, Technical Advisor at UNFPA Headquarter for drafting and finalization of the CIP and through Dr Laxmi Raj Pathak, national consultant for this work, is highly appreciated. FHD would also like to thank Dr Shilu Adhikari, RH Specialist at UNFPA Nepal for her coordinating role and technical contributions. FHD acknowledges the contributions of Mr Howard Friedman, Mr Ben Light and Dr Kabir Ahmed, Technical Experts at UNFPA Headquarter, for their inputs into the document.

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Special recognition and gratitude is extended to all individuals, including those in the regions and districts, who participated and provided valuable inputs during a series of workshops and consultations that were undertaken during the CIP development process.

However, we believe that the true recognition of efforts put together by all stakeholders would be the successful implementation of this CIP for which we must all continue to work together.

.....Pushpa.....

Dr. Pushpa Chaudhary

Director

Family Health Division

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASFR	Age-Specific Fertility Rate
BCR	Benefit-Cost Ratio
CBA	Cost-Benefit Analysis
CDB	Curriculum Development Board
CHD	Child Health Division
CIP	Costed Implementation Plan
CAC	Comprehensive Abortion Care
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CTS	Clinical Training Skill
CYP	Couple Years of Protection
DDA	Department of Drug Administration
DFID	Department for International Development
DHS	Demographic and Health Survey
DHO	District Health Office
DoHS	Department of Health Services
DPHO	District Public Health Office
EDCD	Epidemiology and Disease Control Division
EDP	External Development Partners
EPI	Expanded Program on Immunization
FARHCS	Facility-based Assessment on Reproductive Health Commodities & Services
FCHV	Female Community Health Volunteers
FHD	Family Health Division
FHI360	Family Health International
FP	Family Planning
FPAN	Family Planning Association of Nepal
FPMCH	Family Planning, Maternal and Child Health
FSW	Female Sex Workers
FTE	Full-Time Equivalent
GDP	Gross Domestic Product
GBV	Gender Based Violence
GoN	Government of Nepal
HA	Health Assistants
HP	Health Post
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMG	Health Mother Groups
HRH	Human Resources for Health
ICPD	International Conference on Population Development
IFPSC	Integrated Family Planning Service Center
IMR	Infant Mortality Rate
INGO	International Non- Governmental Organisation
Ipas	International Post-abortal Care Services
IUCD	Intrauterine Contraceptive Device
LARC	Long-Acting Reversible Contraceptive
LAM	Lactational Amenorrhea Method
LMD	Logistics Management Division
LMIS	Logistics Management and Information System
mCPR	Modern Contraceptive Prevalence Rate
MD	Management Division

MDG	Millennium Development Goal
MICS	Multiple Indictor Cluster Survey
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Neonatal Health
MoE	Ministry of Education
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MSI	Marie Stopes International
NCASC	National Centre for AIDS and STD Control
NDHS	Nepal Demographic and Health Survey
NFHS	Nepal Family Health Survey
NGO	Non- Governmental Organisation
NGOCC	Non-Governmental Organization Coordination Committee
NHEICC	National Health Education, Information and Communication Centre
NHSP	Nepal Health Sector Program
NHSP IP	Nepal Health Sector Program Implementation Plan
NHTC	National Health Training Centre
NPC	National Planning Commission
NPHL	National Public Health Laboratory
NPR	Nepalese Rupees
NSV	Non Scalpel Vasectomy
NTC	National Tuberculosis Centre
OPM	Oxford Policy Management
PHCC	Primary HealthCare Centre
PHC/ORC	Primary Health Care Outreach Clinics
PHCRD	Primary Health Care Revitalization
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PPICD	Policy, Planning and International Cooperation Division
PPIUCD	Post-Partum Intrauterine Contraceptive Device
PPP	Private Public Partnership
PSI	Population Services International
RH	Reproductive Health
RHCC	Reproductive Health Coordination Committee
RHCS	Reproductive Health Commodity Security
RHD	Regional Health Directorate
RHSC	Reproductive Health Steering Committee
RHTC	Regional Health Training Center
SBCC	Social and Behavioural Change Communication
SCM	Supply Chain Management
SDP	Service Delivery Points
SHP	Sub-Health Post
SMNSC	Safe-motherhood and neonatal Sub-committee
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
STS	Service Tracking Survey
TFR	Total Fertility Rate
TSG	Target Setting Group
TWG	Technical Working Group
U5MR	Under-5 Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
VSC	Voluntary Surgical Contraception
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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Executive Summary

Nepal is aspiring to graduate from a 'Least Developed Country' to a 'Developing Country' by 2022 and is committed to improving the health status of its people through reduction in maternal, neonatal, infant and under-five mortality. In the area of Family Planning (FP), the Government of Nepal aims to enable women and couples to attain the desired family size and have healthy spacing of childbirths by improving access to rights-based FP services and reducing unmet need for contraceptives. The Family Health Division (FHD)/ Ministry of Health and Population (MoHP) revised the national FP program to devise strategies and interventions that will enable the country to increase access to and use of quality FP services by all—and in particular by poor, vulnerable and marginalized populations.

Under the leadership of the MoHP a national Costed Implementation Plan (CIP) on family planning was developed in close consultation with all stakeholders. The purpose of the CIP is to articulate national priorities for family planning and to provide guidance at national and district levels on evidence-based programming for family planning so as to achieve the expected results, as well as to identify the resources needed for CIP implementation. In addition, the CIP is intended to serve as a reference document for external development partners including donors and implementing agencies to understand and contribute to the national priorities on family planning outlined in the Plan to ensure coherence and harmonization of efforts in advancing family planning in Nepal. To address the existing challenges and opportunities for scaling up rights-based FP in the country, the CIP focuses on five strategic areas. They are Enabling Environment, Demand Generation, Service Delivery, Capacity Building and Research & Innovation. Through investment in these areas the country aims to increase demand satisfied for modern contraceptives from 56% (NDHS, 2011) to 62.9% and Contraceptive Prevalence Rate (CPR) for modern methods from 47% in 2014 (MICS) to 50% by 2020. Likewise it aims to reduce unmet need for FP from 25.2% in 2014 (MICS) to 22% which would allow the country to achieve a replacement level fertility of 2.1 births per women by 2021. These targets may appear relatively modest but were chosen to reflect the context of a country that has witnessed impressive gains in FP but has CPR that has been stagnant for some time in recent years. There are also significant variations in FP service use by age, geographic region, wealth quintile and spousal separation. The target therefore reflects a FP strategy that aims to give individual and couples a choice of contraceptive methods with a special emphasis on reaching the poor, vulnerable and marginalized groups. The strategy also includes changes in the method mix over time, with a balance between permanent, long-acting reversible methods and short-acting methods.

The total resources required for scaling up FP in Nepal for the period 2015-2020 is NPR 13,765.2 million (corresponding to approximately USD 154.2 million) for six years The majority (57%) of this total is due to the costs that are directly incurred in delivering FP interventions. One third (35%) is due to programme costs, or expenditures on activities at the wider population level that are required for FP interventions to be effectively implemented. The remainder (8%) is indirect costs, which predominately relate to health facility overhead costs such as administrative staff and utility bills. Among the programme costs the largest planned expenditure category over the period is Enhancing Service Delivery (1,836.9 million NPR), followed by Demand Generation (738.4 million NPR), Capacity Building (793.8 million NPR) and Enabling Environment (679.2 million NPR). General Programme Management

(303.1 million) and Research & Innovation (446.3 million NPR) constitute the remainder of the total projected expenditure of 4,797.7 million NPR.

The scale up of family planning in Nepal will contribute to further reduction in maternal mortality rate as well as reduction in infant and child mortality rates. It is estimated that there will be 230 fewer maternal deaths a year and approximately 3,000 fewer infant deaths each year by 2030 in the FP scale-up scenario compared to the counterfactual scenario. Likewise the number of couple years of protection (CYPs), which is a function of both population growth and increased contraceptive use, is estimated at 2.9 million by 2030 under the FP scale-up. The projected demographic impacts of FP scale up include a smaller increase in total population (32m by 2030 compared 33.5m under the counterfactual scenario) and a lower (total) dependency ratio that lead to achievement of 4.6% higher income per capita by 2030 catalyzed by the demographic dividend.

Slower rates of population growth translate into cost savings to the government as there are fewer people who need social services. A cumulative cost savings of 46,569.9 million NPR is estimated to be achieved over the time period (2015-2030) under the FP scale-up scenario compared to the counterfactual scenario in primary education, child immunization, treatment of child pneumonia, maternal health services and improved water sources. Over the time period 2015-2030, for every rupee spent on FP, Nepal is projected to save 3.1 rupees in the five sectors mentioned above if the FP scale-up scenario is achieved. There are likely to be cost savings to other sectors not included here – those related to health sector (like improved pregnancy outcomes, reduced unsafe abortion from unwanted pregnancies and improved protection from HIV and other STIs) and those outside the health sector (like cost saving in providing social services, climate change benefits and improvements in women's right, empowerment and gender equality).

Introduction

The historic people's movement in 2006 entrenched health as a fundamental human right in Nepal (National Development Plan, 2007/2008–2010/2011), but the country has long since recognized the benefits of scaling up Family Planning (FP). This can be seen in the prominence given to FP services throughout the country's development plans and strategies, including: the three-year Interim Development Plan, 2010/2011–2012/2013; the Eleventh Development Plan, 2008-2013; the Second Long-Term Health Plan, 2006-2017; the Population Perspective Plan, 2010-2031; and the Nepal Health Sector Program Implementation Plan II, 2010-2015 (NHSP-IP II) and NHSP III, currently being developed.

The intention behind these efforts is to develop a well-educated, skilled and healthy nation and graduate from a 'Least Develo ped Country' to a 'Developing Country' by 2022. To do so it will require not only that the economy grows by 8% per annum, but that the growth is inclusive. Given the level of inequality portrayed in the recently released Nepal Human Development Report 2014, substantial efforts are required to reduce inequality and increase levels of human development to sustain the peace that has only recently been achieved. Improving health is one of the goals with ambitious targets aimed at reducing maternal, neonatal, and infant and under-five mortality as well as number of underweight children. In the area of FP, the Government of Nepal aims to enable women and couples to attain the desired family size and have healthy spacing of childbirths by improving access to rights-based FP services and reducing unmet need for modern contraceptives.

To expand access to quality care FP services have been integrated into Reproductive health package (as a basic health service package) and provided free-of-charge to entire population in governmental clinics. For the past thirteen years Nepal has made remarkable progress in increasing utilization of modern methods among currently married women from 35% (NDHS, 2001) to 47.1 (MICS, 2014). Demand satisfied by modern methods has also increased up to 63% (MICS, 2014) and unmet need for FP declined from 31% in 1996 (NFHS) to 25.2 in 2014 (MICS).

Regardless of the overall progress in FP disparities in FP utilization rates are still visible among different sub-regions, and specific population groups such as adolescents, poor and marginalized women. If Nepal is to meet its domestic targets and its international obligations—notably the Millennium Development Goals (MDGs) and the targets of the 1994 International Conference on Population Development (ICPD)—then the country will need to broaden the reach and the scope of FP services.

The Family Health Division (FHD) of the Ministry of Health and Population (MoHP) has begun a process of reviewing and revising the country's FP program to devise strategies and interventions that will enable accelerated progress towards ensuring increased and equitable access to and utilization of quality FP information and services by all—and in particular by poor, vulnerable and marginalized populations.

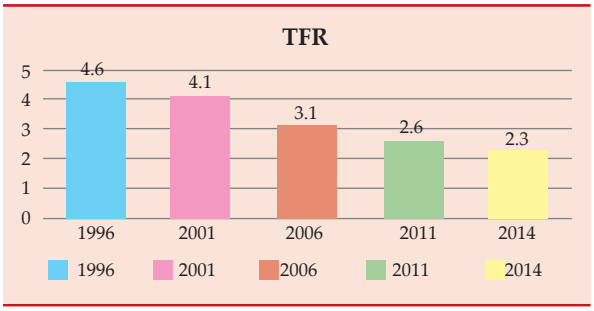
Current situation on Population and Family Planning

Population

The 2011 Population Census recorded the population of Nepal at 26.5 million, with 17% of the population living in urban areas. Population density (average number of population per square kilometre) has increased to 180 per km2, from 157 in 2001.

The country's population has grown by 3.3 million over the last decade—an annual average growth rate of 1.35%. Over the last 40 years; however, Nepal's population has more than doubled, growing rapidly between 1970 and 1980 but slowing down in recent years. An indication of that, is evident by the decrease of an average household size from 5.4 (2001) to 4.9 (2011). For the past eighteen years, the Total Fertility Rate (TFR) gradually reduced from 4.6 (NFHS1996) to 2.3 (MICS, 2014) as it is shown in Figure 1.

FIGURE 1: Trends in Fertility



The decline in fertility can be explained by several factors such as increased age at marriage, better access to education among girls including in rural areas; shift in ideal number of children among women from 2.9 in 1996 to 2.1 in 2011 (NDHS) and better access to modern contraception in order to space or limit childbearing to attain the desired number of children.

A large proportion (37%) of the Nepalese population is under the age of 15, although this proportion has declined from 41% in 2006. 11% of the population is under five years, a decrease since 2006. Both of these are indications of a declining trend in fertility. As is the fact, that people 65-and-older account for 6% of the total population (up from 4% in 2006). Examining the proportion of children-under-five in urban against rural areas suggests that recent declines in fertility are more evident in urban than rural areas and that the transition to lower fertility began with the urban population.

Contributing to the decline in household size is that almost 2 million Nepalese of working age (15-59 years) live abroad (up from 760,000 in 2001). 25% of households reported that at least one member of their household is absent or is living out of the country[1], while 57% of households reported that at least one person had migrated away from the household at some time in the past 10 years[2] . Among the households that reported migration of former residents, on average, about two people migrated. It is unsurprising, therefore, that the number of female-headed households has increased from 15% (2001) to 23% (2006) to 26% (2011).

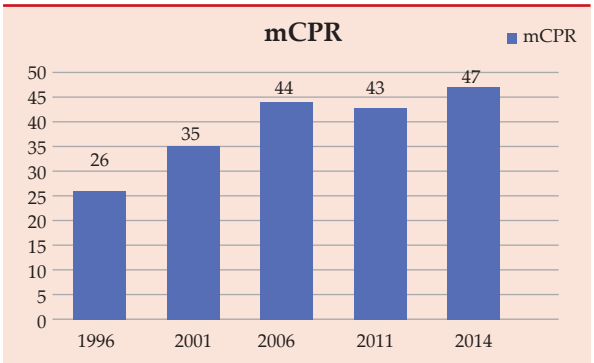
Impressive but unequal progress in Family Planning

FP has been a longstanding strategy of the Government of Nepal in order to promote the development of an educated and healthy population (National Planning Commission, 2002). To achieve this, the country has set itself ambitious goals aimed at increasing access to voluntary FP services with a focus on poor, vulnerable and marginalized populations.

1 Central Bureau of Statistics: Nepal Population Census 2011
2 MoHP: Nepal Demographic Health Survey, 2011

Nepal made a significant progress in increasing contraceptive prevalence rate for modern contraception among currently married women from 35% in 2001 to 43% in 2011 (NDHS) and 47.1 in 2014 (MICS). The trends are shown in Figure 2.

FIGURE 2: Trends in Contraceptive Prevalence Rate for Modern Methods



Regardless of the increased use of modern contraception, access to services is not yet universal across the country, and mCPR varies among the sub-regions with the highest rate at 55.1% in Far Western Terai to 32% in Eastern Hill. Factors affecting access to FP services are numerous including availability and capacity of service providers; availability of supplies; social and cultural beliefs; accessibility of health facilities. To address low utilization of FP services in sub-regions, a district level analysis of service delivery and needs of communities should be done.

Significant inequalities in using modern contraception still exist among poorest quintile and highest quintile of population (35.6% vs. 48.9%). Rural population has lower total contraceptive rate than urban residents, however, it has higher utilization of female and male sterilization, while more women living in urban areas use pills, condoms and traditional methods.

Migration complicates the interpretation of standard FP indictors for Nepal. For example, it is interesting to note that among married women who live with their husbands the CPR is 55.5%. This most likely indicates that overall CPR is influenced by the large number of women whose husbands live away from home and who are therefore not as likely to be using contraceptives. These women may eventually need contraceptives when their husbands return, therefore, should not be excluded from the data on family planning, neither from FP programmes.

Unmet Need

Unmet need measures women who do not want any more births or those who want to postpone the next birth at least two more years—birth limiting and birth spacing respectively, yet are not using a method of contraception. 25.2% of women in Nepal (just over one-in-four) have an unmet need for FP (MICS, 2014). While this has declined noticeably from 31% in 1996 (NFHS) the present level of unmet need (25.2%) is still at the same level as it was in 2006 (25%) and provides scope for the expansion of FP services.

Unmet need declines with age from 42% among adolescent girls to 13% among the oldest age group. For poorest quintile unmet need is 31% (9% for spacing and 22% for limiting) compared to 22% for the richest quintile (8% for spacing and 14% for limiting). Unmet need is also higher in rural areas and is highest in the hill zone.

Migration remains a significant factor in increasing unmet need in Nepal, as it is for the decline in TFR. The standard definition of unmet need counts a woman whose husband is away from home and who is therefore not using contraception as having an unmet need for FP if she says that she wants to delay or stop childbearing. In the context of the countries such as Nepal, where spousal separation is due to migration, it is common that unmet need statistics are more enlightening when disaggregated. The 2011 NDHS shows that unmet need for women living with their husbands is 16%, while it is 58% for women whose husband has lived elsewhere for more than a year. Clearly, FP programs need to be tailored, recognising the different contraceptive needs of these groups.

Unmet need also contributes to need for abortion. According to NDHS (2011), 20% of the interviewed women mentioned that the main reason for their most recent abortion was that they did not want any more children, while 12% said that their husband/partner did not want the child.

Demand Satisfied for modern contraception

Another good indicator is demand satisfied for modern contraception. International evidence suggests that for FP to achieve an impact on population development, this indicator should be

increased to at least 75%, including in rural areas (USAID 2013).

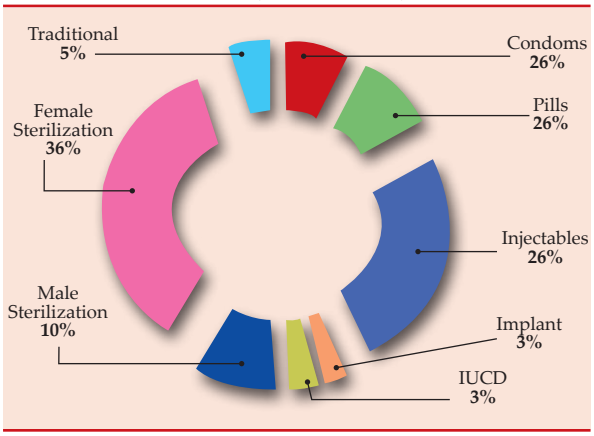
Overall, demand satisfied for modern methods in Nepal is relatively high, although there is still some way to go in achieving the 75% target, particularly when the indicator is disaggregated by socio-economic characteristics and sub-regions. For example, the lowest level of demand satisfied by modern contraceptives was recorded in Western Hill, Eastern Hill and Eastern Mountain.

The 2011 NDHS shows that demand satisfied for modern methods is 56%, but with adolescent girls (24.3%), those living in the Eastern Hills (42.7%) and Western Hill (44.2%) and those in the lowest wealth quintile (49.3%), have the lowest demand satisfied.

Contraceptive Method Mix

The period from 1996 to 2006 saw a remarkable increase in the use of female sterilisation, pill, injectables and male condoms, although the use has declined slightly in 2011 for female sterilisation and injectables, yet has increased for male sterilisation (Figure 4). While among the most effective methods, Intrauterine Contraceptive Device (IUCD) and implants continue to have a relatively low uptake rate, although this did double between 2006 and 2011. As shown in Figure 4, the use of traditional FP methods, although not promoted by the FP program, also doubled over the same period (from 3.7% to 6.5%) although the NMICS in 2015 showed a decline to 2.5% (Figure 3).

FIGURE 3: Method Mix (NMICS, 2015)



Exposure to family planning message

According to NDHS 2011, 55% of women and 70% of men (age 15-49) saw a FP message recently on a poster or hoarding board, while 52% of women and 59% of men heard FP messages broadcast through radio. NDHS results demonstrate that: exposure to FP messages is lower in rural areas than in urban and older age categories of women are exposed less to FP messages. This is an important finding since mothers and mothers-in-law can be a vital source of information on FP for young girls.

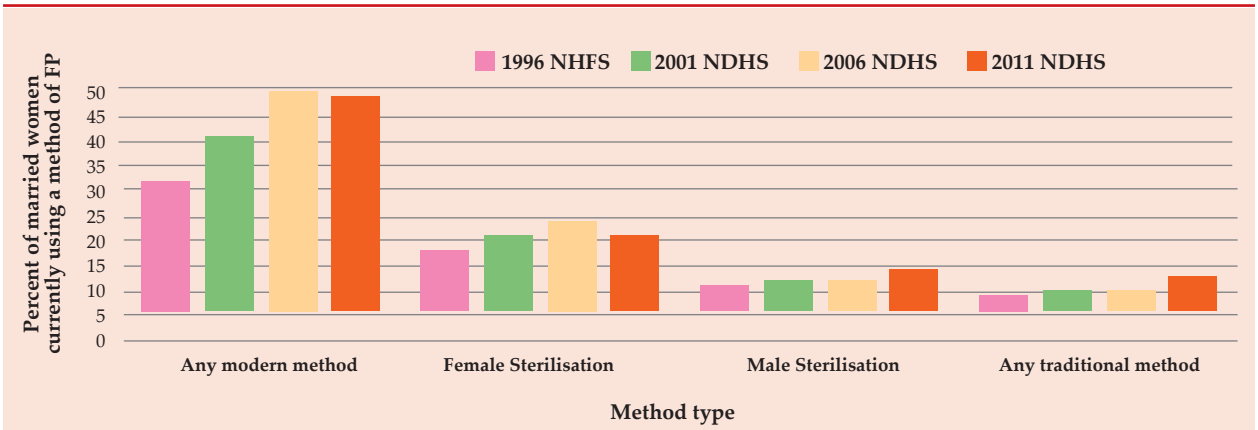
Availability of contraceptive services

The Family Health Division of the MoHP has noted the rapid expansion of the private sector and has committed to encourage the private sector and non-governmental organisations to play an expanded role in the national FP programme (NHSP-IP II).

Currently, short-acting FP methods (male condoms, pill, and injectables) are provided on a regular basis through all governmental health posts, sub health posts, Primary health Care Outreach Clinics (PHC-ORC), periphery level health workers and volunteers (Condoms and resupply of pills). Services such as IUCD and Implants are available only at limited number of Primary Health Care Centres (PHCC) and health posts where trained personnel are available. Depending on the district, sterilization services are provided at static sites or through scheduled "seasonal" or mobile outreach services. Almost all district Family Planning, Maternal and Child Health (FPMCH) clinics are providing all types of temporary FP methods regularly. FP services are also providing by INGOs (International Non- Governmental Organisations), NGOs (Non-Governmental Organisation), private service providers and social marketing system.

Sixty-nine percent (69%) of the population accesses their modern contraceptive method from the government sector, however this is a significant decline from the 77% recorded in the 2006 NDHS and does vary by method choice. Because method choice depends on the level of health facility, it defines where women go to obtain a preferred

FIGURE 4: Trends in Use of Family Planning



method. A risk is a limitation of choices if a woman hasn't received full information about all methods at the point of entry.

9% of users obtain their methods from the NGO sector, mostly from Marie Stopes International (6%) and the Family Planning Association of Nepal (2%). It is the commercial private sector that has seen the most marked increase, however—rising from just 14% in 2006 to 22% in 2011. Of particular note is the use of pharmacies for the short-term methods, with 32% of pill users, 12% of injectable users and 52% of condom users obtaining their methods from this source. Private sector pharmacies are widespread in Nepal and provide diagnosis and treatment including prescription of drugs. They are a major recipient of out-of-pocket spending by all income groups, although they are predominantly based in urban areas.

If FP is to reach those who are currently underserved or population groups that are not being adequately reached by current approaches, then the FP programme will need to make the best use of all resources available. This will require that considerable effort be devoted to strengthening partnerships with the private and NGO sectors[3] .

Adolescents' use of contraception

Adolescents and youth account for one-third of Nepal's population. Early marriage and early childbearing continue to be the norm in Nepal, although the median age at first marriage has increased over the years. Adolescent childbearing is still common, although decreasing – adolescent birth rate is 81 per 1000 women (MICS 2014 – 71).

Among adolescents and youth, contraceptive use can prevent unintended pregnancy and early childbearing and their consequences. In Nepal knowledge about FP is almost universal (99.9 percent) including among adolescents and youth. However, only 14percent of married adolescent girls age 15-19 and 24 percent of married women age 20-24 are currently using a modern contraceptive method. Unmet need for FP has been estimated to be highest (42 percent) for married girls age 15-19, followed by 37 percent among married women age 20-24 (MoHP et al., 2012). The data on contraceptive use and unmet need among young people is unavailable in Nepal. According to Demographic and Health Surveys (DHS) comparative report on adolescent sexual and reproductive health around the world, unmarried young women are more likely to use modern contraceptive methods and also to have higher levels of unmet need for FP than currently married young women (Khan and Mishra, 2008).

[3] NHSP-IP II – Mid-Term Review Report (2013)

Issues and Challenges of the current Family Planning Program

For effective scale-up of the FP program in Nepal, a number of challenges and issues must be addressed by 2021. Five program areas or components are essential for implementing a successful FP program: strong advocacy to increase visibility and support for the program, behavior change communication interventions to address the knowledge-use gap among FP clients; strong management to ensure efficient and effective program implementation; availability of broader range of contraceptive commodities at all levels of service delivery; sufficient numbers of skilled health providers to provide FP services effectively and appropriately equipped facilities to provide quality FP services.

Enhance Quality Family Planning Service Delivery

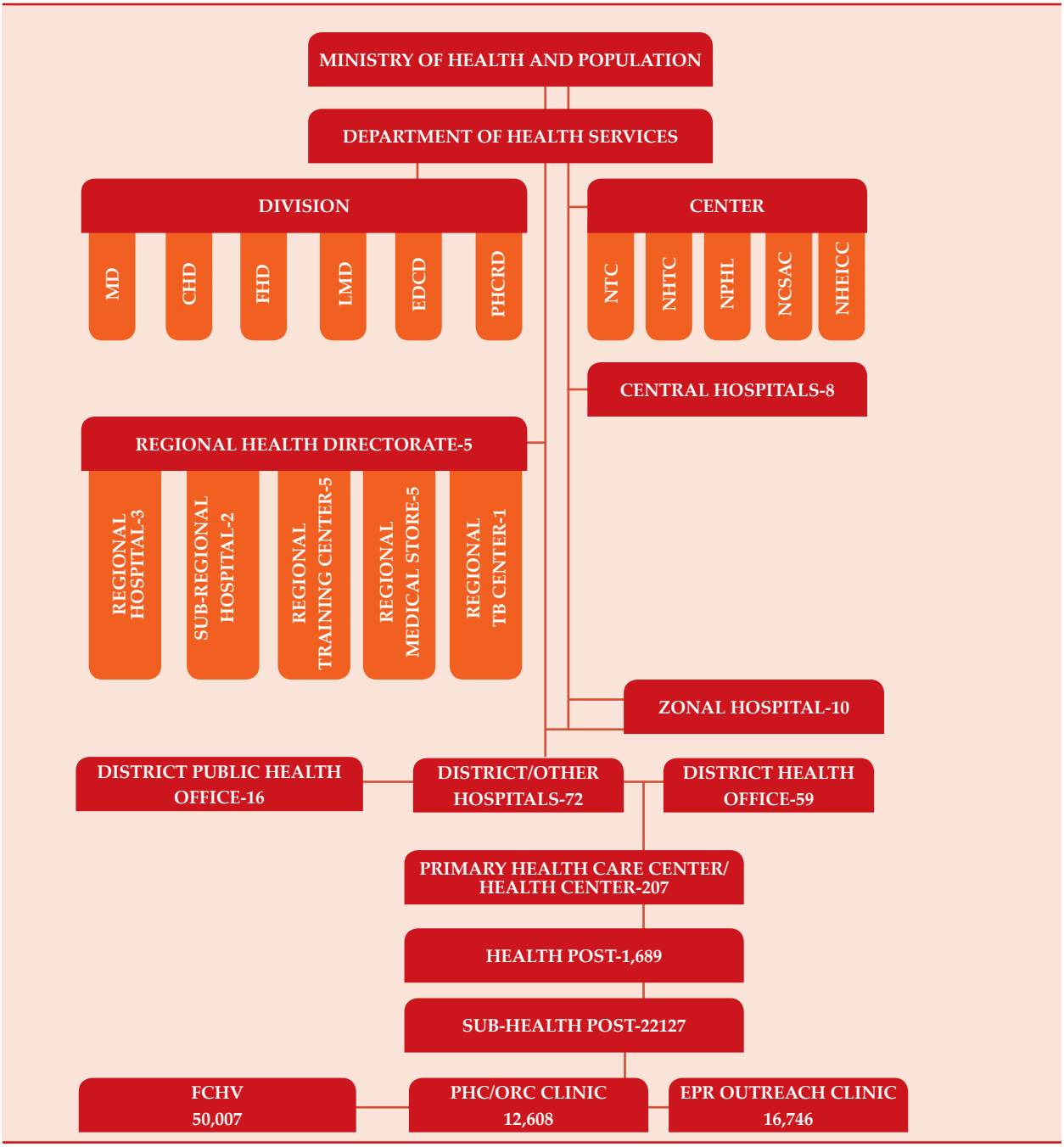
Access to high-quality FP services is a human right and should be provided without discrimination and coercion.

Family planning information and services are provided through government, social marketing, non-governmental organizations and private sectors. In government health system, currently, short-acting FP methods (male condoms, pill, and injectables) are provided on a regular basis through all levels of health facilities including health posts, sub health posts, PHC- Outreach clinics. Female Community Health Volunteers (FCHVs) provide information to community people, and distribute Condom and resupply pills. Services such as IUCD and Implants are available only at limited number of PHCCs and Health Posts (HPs) where trained personnel are available. Depending on the district, sterilization services are provided at static sites or through scheduled "seasonal" or mobile outreach services. Almost all district hospitals are providing all types of temporary and permanent FP methods regularly. Therefore, at central, regional and district level women can access all the 7 methods of FP while at primary health care accessibility to a full range of FP services is limited. Family Planning services are integrated at all levels of MoHP health care delivery, as shown in Figure 5.

Due to integrated nature of FP services, women should be able to access the services at any service delivery point and in any geographical district. However, "supply" and "demand" related challenges affecting the access still exist in the country. For example, shortage of human resources for health overall and in particular lack of skilled service providers, lack of supplies and contraceptives especially at primary health care level affect accessibility and quality of contraceptive services. Women experience challenges to access the services due to travel 2014 arrangements such as finding a means of transportation, time spent on travel, costs of travel; and sometimes due to costs of services (STS, 2013). In some cases, gender and culture related norms affect the access, for example in some cases women needed to get a permission from husband/other members of family to go to a health facility for healthcare services, including FP . (STS, 2013)

To reduce access barriers the Government of Nepal (GoN) provides free counseling and services including contraceptives of choice, in addition to a nominal wage compensation for clients undergoing Voluntary Surgical Contraception (VSC) and covers costs of services included in the essential health package. However, due to a lack of awareness about these entitlements, some groups of population have not used the incentives

FIGURE 5: **Organogram of MoHP Health Care Delivery**[4]



and continue paying out of pocket. Interventions on increasing awareness of clients and service providers about entitlements for free care at all levels of public-sector health care institutions should be delivered at communities.

By 2015 MoHP aimed to provide all 5 types of temporary FP methods at 60% of health post (NHSP IP – II). Likewise the government also planned to have regular VSC services available at all district hospitals and selected PHCCs. However only 18% of Health Posts were able to offer all five methods of FP in 2013 (STS) and this figure increased to only 20% in 2014 (UNFPA, 2014). The urban-rural disparity in access to services is also huge, compared to 82.5% of health facilities in the urban areas only 22.8% of health facilities in the rural areas are currently offering all five methods of temporary contraceptive methods (UNFPA, 2014).

[4] Annual Report, DoHS

To facilitate access to FP services, the GoN supported integration of FP in post-partum, post-abortion services, immunization program and promoted expansion of service sites offering long acting methods. At least five methods of contraception were available in 91.4% of health facilities providing safe abortion services (STS, 2013) while only 30% of women accepted any one method of contraception after an abortion (HMIS, 2013). Lack of proper counseling on FP during post-partum and post abortion visits contributed to low uptake of modern contraceptives. According to NDHS, 91% of post-partum women and 56 % of women who had abortion were not provided counseling on family planning. Although causes of low contraceptive use among women in post-abortion and post-partum period need to be analyzed further, one obvious reason is poor quality of counseling on family planning. Poor quality of counseling is an issue for private and NGO sectors as well as demonstrated by NDHS (2011).

Quality of service plays key role in accepting, rejecting and discontinuation of FP services. Overall, 51 percent of contraceptive users discontinued using a method within 12 months of starting its use (NDHS, 2011). Twenty-six percent of episodes of discontinuation occurred because the women's husbands were away, 12 percent was due to the fear of side effects or health concerns, and 5 percent because the woman wanted to become pregnant. The most common discontinued modern method was oral pills. Fear of side-effects and health concerns can be reduced through quality counseling that would also enable a couple or a woman to make informed choice of contraception. However, only 63% of women using contraception received full information on possible side-effects and 59% of them were informed on what to do if they experience side effects. Percentage of those who were informed about side effects was the lowest among women who chose oral pills and female sterilization.

MoHP/FHD has invested in improving quality of care through various interventions such as establishing competency based training, and training on infection prevention, conducting comprehensive FP training for all level of service providers and establishing/strengthening FP service center. However, these efforts require a long-term support including investments to have sustainable results. A systematic approach for improvement of quality of care including systematic review and update of clinical protocols and guidelines at national and clinic level, developing indicators on quality assurance, monitoring compliance with standards and clinical audit for solving problems through a team approach are needed to be in place. Education of communities about clients' rights and solicitation of clients' feedback on a regular basis need to be embedded in quality improvement process.

Capacity of service providers

Trained, competent and confident human resource is vital for providing integrated quality FP services. The GoN has started implementation of the Human Resource for Health -Strategic Plan (2011-2015) to address challenges and constraints related to distribution of skilled human resources for health. However, health facilitates at districts and primary health levels still experience significant shortage of health providers, particularly obstetrician/gynecologists and nurses (STS, 2013). The lack of skilled health providers, especially female health professionals, inhibits access and use of family planning. (PEER study, 2012). Existing challenges with lack of long-acting reversible methods or interruptions in supply in most sites are mainly due to lack of trained health providers (STS 2013). In some cases, misconceptions and negative perceptions harbored by healthcare providers themselves limits individuals' access to FP services of their choices. In order to increase understanding of health managers and services providers about the role of FP for improving women's health especially within the integrated service delivery modality and strengthen skills of service providers, support for continuous capacity building is vital.

Family Planning training is institutionalized in the country and delivered through a nationwide network of training health sites under the National Health Training Center (NHTC). The national training plan, developed in co-ordination with the Family Health Division, needs to be timely implemented. A challenge is insufficient pool of trainers and coverage of service providers including those from private sector. There is also

a need to institutionalize certain training like postpartum FP counseling and postpartum IUCD and to establish an integrated mechanism for post-training follow-up and supportive supervision. Another key area is to update training curricula and make it available as e-learning modular course to reduce off-site training duration and thus absenteeism from work, in addition to covering more service providers.

Contraceptive commodities and logistics

In Nepal Government procures most of the FP commodities required for public sector and often for NGOs. In 1993 MoHP established Logistics Management Division (LMD) to manage procurement and logistics management of all health commodities including contraceptives. Under the leadership of LMD national capacity on forecast, purchase and distribution of commodities has been significantly improved in the country. According to the FARHCS (UNFPA, 2014), "no stock out" of male condoms, oral pills and injectable was reported in 100% PHCCs and SHP; and 99% of hospitals and 99% HPs. In addition 80% of PHCCs and 72% of HP had no stock out of IUCD and implants.

Recognizing an increased demand for long-acting methods, MoHP/FHD has aimed to increase access to these methods in all health posts and primary health care centers by end of NHSP II (2015). However, the services are available only in limited sites due to lack of supplies and skilled personnel.

Factors contributing to stock outs of contraceptives at all levels of service delivery include long bureaucratic policies and procedures to purchase commodities. Likewise supply of commodities from regional stores to district and from district stores to health facility level is often interrupted. In cases when facilities have stock outs of IUCD and implants, it is mainly due to lack of trained health staff to provide services and as a result no request for the commodities

Strengthening FP service seeking behavior

Knowledge of contraceptive methods is an important factor for increasing uptake of FP services. Radio, television and posters are three main channels for FP messages that the majority of the population has been exposed to. Modern methods are more widely known than traditional method. Although most people have heard about at least one modern method of contraception (NDHS, 2011), this does not represent existence, among the entire population, of knowledge that is comprehensive enough to allow individuals and couples to choose and use FP services. This is demonstrated by However, uptake of modern contraceptives is hindered by existing misconceptions, myths and fear of side effects. Culture and religious ties such as a strong son preference, religious beliefs and concerns about side-effects (PEER Study 2012) also serve as substantial barriers to increasing the Modern Contraceptive Prevalence Rate (mCPR).

Regardless of almost universal knowledge about contraception, married adolescents (15-19 years old) has the lowest demand satisfied by modern methods among all age groups (24.3), while their unmet need for spacing is the highest (37.5). Married women whose husbands are away discontinue using contraception but in many cases fail to use FP when reunite with spouses.

Men play a significant role in decision making on family planning. Engagement and education of men about FP is crucial for reducing unmet need for family planning, especially for modern methods. Myths about contraception still exist among men. For example, about 20 percent of men think that women who use contraception may become promiscuous. Men living in rural areas, the Terai, and the Western region, particularly the Western hill sub-region, are more likely to have these perceptions than other men. Men with SLC and higher level of education and those in the highest wealth quintile are less likely to have these misconceptions regarding contraceptive use than other men.

Targeted communication and behavior change approaches are needed to address the existing challenges especially among adolescents and migrants' population. Increasing men involvement in FP will benefit elimination of myths and encouragement of service seeking behavior among women. Likewise demand and

utilization of FP services among special groups like postpartum mothers, Muslims and disadvantaged groups also need to be improved through targeted interventions.

Advocacy for family planning

While the overall policy environment for FP is positive, including the incorporation of FP/RH into the GoN's development and national health programmes, the government's strong policy and strategy commitments have not been accompanied by an equally commensurate dedication of national financial resources to meet the full need for FP program and contraceptives. Some decision makers, managers and service providers are of view that FP is a mature program in Nepal and hence does not need as much attention as new programs require. Such perception has to some extent negatively influenced financial and programmatic commitments to FP. In addition, advancing FP requires a multi-sectoral approach which means that engagement of other sectors such as education, youth, finance, women and social welfare, transportation needs to be strengthened.

Another aspect of creating enabling environment for FP is to ensure that policies and legislations are in place to facilitate access to services for most vulnerable populations such as adolescents and young people, women from poor settlements (urban or rural) and ethnic minorities. Although the GoN has in place policies and regulations related to safe motherhood, SRH and FP services, a regular update and communication of such policies to all relevant stakeholders, duty bearers and right-holders alike is needed to scale up FP.

Gender equality and cultural factors play a significant role in making decisions on uptake of contraceptives among women and especially girls. Advocacy interventions need to be in place to address men engagement in family planning, role of religious leaders and other community-gatekeepers.

Management, monitoring and evaluation

Clear leadership responsibility and authority are essential for scaling up FP in the multi-sectoral environment. Current bottlenecks in supervision, monitoring, and evaluation include limited dedicated staffing resources at the national and district levels as well as insufficient capacity to utilize available data and implement current guidelines and other tools. A need for strengthened co-ordination at central, regional and districts levels both within the government system as well as with external development partners cannot be over-emphasized.

Projecting Population Growth and Method Mix to Scale up Family Planning

To scale up FP in Nepal, demand satisfied for modern contraceptives is modelled to reach 62.9%, which reflects on Contraceptive Prevalence Rate (CPR) and unmet need. CPR for modern methods will reach 50% and unmet need will be reduced to 22 % by 2021. At this rate of contraceptive use, TFR will be at 2.1 births per women, which represent replacement level.

This target may appear relatively modest but was chosen to reflect the context of Nepal: a country that has made impressive gains in FP, but which has experienced a stalling CPR more recently, as well as significant variations in use by age, geographic region, wealth quintile and spousal separation. The target therefore reflects a FP strategy that aims to give women a choice in contraceptive method and to reach poor, vulnerable and marginalised groups. The strategy is also to make changes in the method mix over time, with a balance between permanent, long-acting reversible methods and short-acting methods. Previous analysis by the Nepal expert working group served as the basis for these changes, which reflect historical trends, shown in Table 1.

Table 1: Changes in Method Mix

	2015	2020	2025	2030
Pill	8.3%	8.3%	8.3%	8.3%
Condom	8.9%	9.1%	9.3%	9.5%
Injectable	18.7%	18.9%	19.1%	19.3%
IUD	3.1%	3.7%	4.4%	5.0%
Implant	3.2%	4.2%	5.2%	6.2%
Male sterilisation	15.7%	15.7%	15.7%	15.7%
Female sterilisation	29.1%	27.0%	25.0%	22.9%
Traditional	13.1%	13.1%	13.1%	13.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: OPM calculations based on Nepal working group projections and NDHS 2011.

National Costed Implementation Plan for Family Planning

Purpose

Recognizing the need to revive and scale up FP in Nepal, the Government has developed the Costed Implementation Plan (CIP) on FP. The development of the plan has been guided by the strategic directions developed through extensive consultations with relevant stakeholders at national, regional and district levels and is in line with the National Health Sector Program (NHSP III 2015-2020) which is currently being finalized. As did the previous health sector plans (NHSP I and II) the upcoming NHSP III has also recognized FP as a priority, and it is considered as a component of reproductive health package and essential health care services.

The purpose of the CIP is to strengthen the foundation for FP programming and service delivery at national and districts levels as well as to identify the activities to be implemented and resources needed for achieving the results.

The CIP clearly defines priorities for strategic actions, delineates the activities and inputs needed to achieve them, and estimates the costs associated with each as a basis for budgeting and mobilizing resources required for implementation at different levels by organizations and institutions over the 2015-2020 period. In addition, CIP is intended to serve as a guide for development partners and implementing agencies on areas of need to ensure the success of the national FP program.

More specifically, it will be used to:

- Inform policy dialogue, planning and budgeting to strengthen FP as a priority area
- Prioritize strategies on FP to be adopted over the next 6 years.
- Enable FHD, NHTC, LMD and NHEICC to develop their respective implementation plans with effective, efficient and actionable interventions/activities and timelines identified.
- Support Government and national partners to understand financial and technical support needs for scaling up FP in the country.
- Support advocacy efforts for FP with clear messages on impact of FP on health & non-health sectors including cost-savings to justify investments.
- Set benchmarks that can be used by the MoHP and external development partners to monitor and support the national FP programme.

Vision

Healthy, happy and prosperous individuals and families through fulfillment of their reproductive and sexual rights and needs

Goal:

Women and girls - in particular those that are poor, vulnerable and marginalised – exercise informed choice to access and use voluntary FP (through increased and equitable access to quality FP information and services).

Strategic action areas and objectives

The strategic objectives reflect the issues and challenges in FP that have to be addressed in order to scale up FP interventions in the country to reach the goal. The strategic objectives of the CIP ensure that limited available resources are directed to areas that have the highest need to reduce the unmet need for FP in Nepal. In the case of a funding gap between resources required and

those available, most effective activities should be prioritize to ensure the greatest impact and progress towards the objectives laid out.

Strategic Action Area and Objectives:
The Costed Implementation Plan on FP has five strategic areas for action to achieve its objectives in order to scale up FP in the country with a focus on rights of women and girls.

- Enabling Environment: Strengthen enabling environment for family planning
- Demand Generation: Increase health care seeking behavior among population with high unmet need for modern contraception
- Service Delivery: Enhance FP service delivery including commodities to respond to the needs of marginalized, rural residents, migrants, adolescents and other special groups.
- Capacity Building: Strengthen capacity of service providers to expand FP service delivery network
- Research and Innovation: Strengthen evidence base for effective programme implementation through research and innovations

General Programme Management:
Programme Management is an essential component of managing and overseeing the implementation of activities that the accelerated scale-up plan envisages. In short, programme management is critical for 'pulling everything together' and to make sure that each component of the programmatic interventions is working as it should and is aligned and coordinated with the full range of interventions.

General Programme Management covers the full costs of the government personnel required to implement programmatic activities, at the Central Level (FHD) and District/ Regional Level. The resource requirements / costs that are involved estimate the number of staffs by cadre for whom FP activities constitute a significant share of their daily work and then combine this with information on the share of their time allocated to FP and information on salaries / allowances. Estimated resources required for general programme management to implement the Costed Implementation Plan are shown in Annex B.

Each Strategic Action Area and General Programme Management has a set of costed activities. The activities were generated, under the leadership of FHD, through Key Informant Interviews and several rounds of consultations at central, regional and district levels involving a wide range of stakeholders in the government, donor communities, civil societies, professional organizations, social marketing and private sector. Cost estimation of the activities including commodities was done by an expert group including the Technical Working Group (TWG) member. The estimated costs that emerged were then reviewed by Oxford Policy Management (OPM) and technical experts at UNFPA Headquarter. This review involved ensuring that the strategic interventions planned are in line with global recommendations and best practices. OPM also checked for and corrected calculation errors; Scaling down observed over-estimates for certain

Table 2: Estimate of total resource requirements (millions)

	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
Direct intervention costs	1,229.6	1,258.9	1,289.3	1,336.1	1,365.8	1,363.6	7,843.3	87.9
							57%	
Programme costs	1,099.3	1,094.5	860.6	780.4	456.2	506.8	4,797.7	53.8
							35%	
Indirect costs	172.7	178.6	184.4	190.3	196.3	201.9	1,124.1	12.6
							8%	
Total	2,501.6	2,531.9	2,334.3	2,306.8	2,018.4	2,072.2	13,765.2	154.2
Year as % of total cost	18%	18%	17%	17%	15%	15%	100%	

Source: Multi-Year Costed Implementation Plan, OneHealth modeling and OPM calculations

activities; and Removing medical equipment and facility rehabilitation costs in order to eliminate double-counting.

As shown in Table 2 the total resources required for scaling up FP in Nepal are $ 154.2 million for six years that include:

1. Direct intervention costs - commodities and supplies and medical personnel (constituting 57% of the total cost).
2. Programme resources – activities at the wider population level that are required for an intervention to be implemented effectively (constituting 35% of the total cost).
3. Indirect costs – costs related to health facility overhead costs such as administrative staff and utilities bills (constituting 8% of the total cost).

Estimates for all required resources are presented in the Annexes.

Strategic Action Area: Enabling Environment

A policy environment that enables the above four Action Areas to be implemented effectively is key for a successful FP programme. Strategic interventions in this area include increasing advocacy at all levels for FP; addressing legal and socio-cultural barriers to young people accessing FP; strengthening the integration of services; and developing /updating national polices and strategies to facilitate task shifting. Estimated resources required to implement the key interventions are presented in Annex C.

KEY INTERVENTIONS:

- **Increase Advocacy for Family Planning.** Identify national champions for FP from multiple fields and support them to advocate for FP by providing advocacy materials/tools and conducting follow up meetings. Develop and distribute advocacy packages using global evidences and tools, including modeling exercises, (in English and Nepali) for key stakeholders. Support high level advocacy events at central level and districts engaging parliamentarians, governmental officials and donors as well as civil society organizations and media. Support advocacy events at community level including celebration of FP day at community level
- **Address legal and socio-cultural barriers to access to FP services for young people and other special groups.** Update the National ASRH strategy & review implementation of the strategy in 2019. Advocate with Ministry of Education (MoE), Curriculum Development Board (CDB) and key stakeholders to incorporate Comprehensive Sexuality Education (CSE) components in curriculum for Grade 9-10. Develop a national strategy on increasing access to voluntary FP services among disabled people and support its implementation ensuring multi-sectoral co-ordination and collaboration.
- **Advocate for integration of FP services.** Support development of national FP service integration strategy as part of the CIP for FP and NHSP III. Based on the strategy, develop operational guidelines and disseminate them at all levels of service delivery.
- **Promoting task shifting and sharing.** Develop a national strategy on task shifting/sharing.

Strategic Action Area: Demand Generation

The variation in the unmet need for FP in Nepal is an indication of significant scope for increasing access to FP, although it is also an indication that demand for FP services is not uniform and that promoting such access will require specific and targeted efforts. Demand generation strategy will focus on strengthening health service seeking behavior especially among adolescents and young people and marginalized populations.

Demand generation efforts will focus on targeted approaches to reach adolescents in and out of schools especially in urban areas; reduce fear of side effects of modern contraception as well as myths and misconceptions among women and men; strengthen community based work to provide full information on FP to marginalized population and use innovative financing to reduce financial barriers to the services. Estimated cost of key interventions for Demand Generation is presented in Annex D.

KEY INTERVENTIONS:

- **Support integration and implementation of Comprehensive Sexuality Education (CSE) in schools secondary and higher level.** Support will be provided to fully implement CSE curriculum in grades 6-10 and interactive sessions with students in grades 11-12 will be conducted. It will include advocacy with the Ministry of Education, training of educators/ teachers and updating teaching materials and other communication tools.
- **Reach adolescents with FP messages using innovative approaches.** Support promotion of FP among adolescents and young people using SMS and mobile technology. Mobile application on FP and health related issues will be developed and introduced in collaboration with phone companies with a focus on adolescents and young people needs. In addition a telephone hotline will be set up to provide information on emergency contraception and other SRH/FP related issues to young people. A program on access and use of contraceptives for adolescents living in urban areas will be supported for six years.
- **Design, implement and evaluate special programme to increase access and utilization of FP among adolescents and young people.** To support access to contraceptives information and services among adolescents and young people, a peer education programme will be developed and implemented both in- and out-of school. Strengthen program design, implementation and evaluation for Social and behavior change communication, that includes development of FP communication strategy, development of IEC materials and media messages, evaluation of FP Social and Behavioural Change Communication (SBCC), development of communication tools package focused on the targeted groups and building capacity of partners working in SBCC. Ensure that BCC interventions address needs of newly married young people to delay first pregnancy.
- **Increase knowledge about FP among individuals/couples to facilitate decision – making on contraceptive use.** BCC materials will be developed to target specific groups of population with higher unmet need for modern FP methods. Communication campaigns will be supported in 2015 and 2018.
- **Reduce socio-cultural barriers to access FP services.** Support community-based programmes on FP to strengthen communication skills and capacity on FP among FCHV and health workers.
- **Reduce fear of side effects, myths and misconceptions about FP** through various communication channels. Support development of IEC materials that emphasize value of daughters and clarify information about modern contraceptives to be used by FCHVs, health workers and community leaders. Organize forums and interactive sessions on clients' satisfaction in communities'.
- **Develop and implement micro-plans for specific groups.** Districts' micro-plans will be developed based on existing evidence on barriers to FP utilization among underserved groups of population.
- **Develop and implement a programme focused on needs for FP among migrants and their spouses.** The programme will provide information and services to returning migrants and their spouses to prevent unintended pregnancy. In addition integrated information on preventing STIs/HIV and unintended pregnancy will be provided to migrants prior to their departure.
- **Develop and implement FP programme targeting hard-to-reach people.** The program will use national guidelines for reaching the unreached population during development of targeted programmes. This would include a mapping exercise to identify communities with high unmet need for FP followed by designing of targeted approaches to reach out to marginalized population with information and counseling on FP through existing mechanisms including community mobilizers. The programme will be implemented in urban slums as well as in rural areas. Total Market Approach will be introduced to ensure that underserved target populations have access

to contraceptives. A market segmentation action plan will be developed.

- **Provide information on FP to women in post-partum and post-abortion period.** Support and strengthen group counseling and provision of contraceptive information for couples and women visiting Expanded Program on Immunization (EPI) clinics during vaccination days as well as promoted counseling among women in postpartum period in Health Mother Groups (HMGs). Incorporate information on FP into Comprehensive Abortion Care (CAC) services.

Strategic Action Area: Enhancing Quality Service Delivery

The key interventions are designed to increase access to services, particularly for vulnerable as well as hard to reach populations, and to increase the quality of services being provided. Such activities range from supporting NGOs who are providing FP services to strengthening coordination with the private sector to improve access and quality of services. Among government services activities designed to *enhance service delivery* include improving services across all levels (FCHV/ Community Level; PHC/ORC clinics; SHP/HP/ PHCs, including birthing centres; District Zonal & Regional and central level Hospitals) and enhancing coordination at the central and district levels. It is also designed to improve facility recording and reporting, to strengthen the management capacity of FP officers and to establish a dedicated Quality of Care unit. Additional activities will include supporting Medical College Teaching Hospitals, efforts to ensure contraceptive security and support to strengthening social marketing and private sector role.

Better quality FP, greater coordination of FP services, and an integration of the FP services across government, NGO and private providers combined with improvements in management and quality assurance will go a long way to enhancing the supply side of service delivery, thus stimulate demand for and increasing the uptake of FP services. Estimated resources required to implement the key interventions are presented in Annex E.

KEY INTERVENTIONS

- **Improve FP integrated services at FCHV/ Community Level.** Update FP orientation package including post-partum FP for FCHVs and conduct refresher training for FHCVs using the updated FP training package. In addition build capacity of FCHVs in conducting pregnancy test, counseling on family planning, antenatal care and post-abortion care. To increase access to condoms, especially among youth, support establishment of condom boxes at appropriate places in community. Mobilize and provide support to expand access to long-acting reversible contraceptives through satellite clinics and comprehensive FP camps. Support South-South Cooperation by organizing study-visits to countries with successful and effective community based programme son FP(e.g. Bangladesh, Indonesia)
- **Improve services at PHC/ORC clinics.** Conduct rapid assessment of PHC/ORC situation and develop 1-2 model PHC/ORCs per VDC (high unmet need districts), later to be static Service Delivery Points (SDP). Strengthen capacity of urban health clinics to deliver FP services (20 municipalities).
- **Improve services at HP/PHCs, including birthing centers.** Support health facilities with commodities (long-acting ad short-acting methods) and ensure that communities are properly informed about available services though appropriate communication channels. Launch a pilot programme on expanding use of Post-Partum Intrauterine Contraceptive Device (PPIUCD) in birthing centers. Promote task-shifting to expand services especially in districts with high unmet need.
- **Improve services in District Hospitals.** Expand availability of all short and long-acting reversible methods and one VSC method by supporting procurement and supply of contraceptives to district hospitals, conducing capacity building events for health providers and strengthening supportive supervision. Develop the 24 Integrated Family Planning Service Centers (IFPSCs) as comprehensive RH clinics. Support development of district-level FP micro-planning & commodity forecasting including situation analysis and training.

- **Improve services in Zonal and Regional Hospitals.** Strengthen integrated FP services in multi-disciplinary hospitals by conducting training, ensuring supportive supervision and introducing clinical guidelines/protocols on FP service provision. Expand training on recanalization.
- **Social marketing.** Revive private provider's network and implemented interventions through Private Public Partnership (PPP) models for strengthening supply chain commodity management.
- **Support NGOs providing FP services.** Revive work of Non-Governmental Organization Coordination Committee (NGOCC) to strengthen role of NGOs working in FP in coordination of national FP programmes. Support NGOs capacity building in family planning.
- **Support Medical College Teaching Hospitals** by establishing FP service centers in each medical college and including LAFP training in doctor and nurse pre-service curriculum.
- **Strengthen coordination of private sector.** Ensure that guidelines are in place for adequate coordination of reporting on FP services provided by private sector.
- **Improve integration of FP services with other services like immunization, HIV, Postpartum, Post-abortion, morbidities, urban health.** Develop national FP service integration strategy and operational guidelines to implement the strategy. Pilot new integration approaches in 2016 and scale up the effective models in following years.
- **Improve facility recording and reporting.** Strengthen and update recording/reporting system as well as coordination with HMIS. Develop M&E tools for private providers that are in line with HMIS tool
- **Establish Quality of Care unit.** Support establishment of quality of care unit within FHD.
- **Improve Quality of Contraceptives.** Continue the process of raising awareness of the importance of moving towards consistently high levels of quality of contraceptives across the whole method mix. This would include developing a national strategy and implementation plan to progress to a situation in which all contraceptives are: of certifiable quality [WHO pre-qualification scheme as desired global standard; national plan to move towards improved national standards for non-WHO prequalified RH medicines].
- **Strengthen management capacity of FP Officers.** Support development of training curriculum for building capacity of FP officers following by series of training and evaluation.
- **Support contraceptive security.** Strengthen coordination with LMD and capacity in Supply Chain Management (SCM) at all levels.
- **Enhance coordination at the central and district levels.** Support coordination mechanism at central and district levels to implement the FP interventions.

Strategic Action Area: Capacity Building

Capacity building is a critical component of ensuring that current staffs (managers and health care providers) are equipped to operate more efficiently and more effectively. Capacity building also provides for the realisation of cost-savings in the longer-term through task-shifting and task sharing activities. Such activities are going to be crucial if Nepal is to reduce unmet need and ultimately eliminate the existing inequalities in family planning. Estimated costs of key interventions are shown in Annex F.

KEY INTERVENTIONS

- **Strengthen training on contraceptive technology for service providers.** Update training curriculum on all FP methods for service providers. Support national training centers in developing training plan with travel schedule to cover all levels of service providers and ensure availability of printed training materials. Conduct trainings for enhancing service delivery, particularly on provision of quality FP counseling services. Support development and introduction of e-learning modality on family planning.
- **Task-shifting/sharing of Non Scalpel Vasectomy (NSV) training.** Support training of Health Assistants (HA) on NSV for task shifting/sharing.

- **Strengthen national FP training capacity** by renovating/upgrading/maintaining the existing FP clinical training sites, including the Regional Health Training Centers (RHTCs). Support establishment of new training sites where need exists.
- **Development of pool of FP trainers.** Support Clinical Training Skill (CTS) training; prepare clinical mentors in FP. Ensure availability of physician trainers and nurse trainers on family planning.
- **Recanalization training,** Strengthen and expand recanalization training (including microsurgery skills).
- **Strengthen Post training follow up.** Support trained service providers to practice new skills by establishing/strengthening regular follow up system.

Strategic Action Area: Research and Innovation

Research and innovation are key components of programming. The Research & Innovation activities included in the scale-up of FP services costed in this analysis deal with specific areas of the FP programme and are intended to contribute to efforts at improving outcomes; of iterating to find more effective and less costly means of reaching more patients with better quality services in a shorter period of time. Estimated costs of research and innovation interventions are presented in Annex G.

KEY INTERVENTIONS:

- **Generate evidence through operational research, to promote innovations in FP.** Support implementation research to understand the factors that lead to discontinuation of contraceptives including Long-Acting Reversible Contraceptive (LARC) as well as factors affecting FP care-seeking behavior among poor urban residents. Document cases of unintended pregnancy among Female Sex Workers (FSWs) including on incidence, causes, consequences and complications. Conduct analysis of barriers for FP uptake among specific communities, including youth and hard-to-reach population. Evaluate m-health approach, which is being implemented for reaching adolescents with FP information. Support a feasibility study on use of social media and health-apps for FP messages with focus on youth. Evaluate the existing program on Postpartum FP and PP-IUCD and make recommendation for national level implementation in 2015, conduct a review of the national program after 2 years of implementation. Conduct periodic reviews/evaluations of FP program (specific for advocacy and demand generation activities). Market segmentation study to describe the current market and service providers for FP. Support formative research on task-shifting; LARC, quality of care of integrated services, etc.

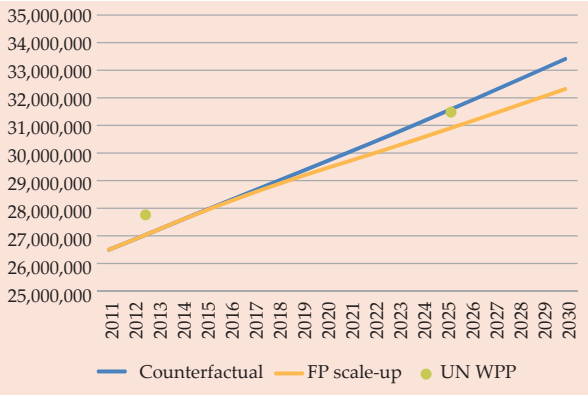
Costs and benefits of scaling up family planning

Demographic impact

TOTAL POPULATION

Figure 6 shows total population projections for Nepal. Under the counterfactual scenario, the total population is projected to rise to almost 33.5m by 2030. In contrast, the total population is projected to reach just over 32m by 2030 under the FP scale-up scenario. Population estimates from the latest UN World Population Prospects (green dots) are given as reference points for the available years of 2013 and 2025.

FIGURE 6: Total population projections for Nepal (2011-2030)



DEPENDENCY RATIO

In addition to a slower rate of population growth under the FP scale-up scenario, our modelling also shows important projected changes to the age structure of the population. Table 3 gives various dependency ratios, a key indicator of changing population dynamics. The (total) dependency ratio is declining over time under both scenarios; however the decline is more rapid under the FP scale-up scenario, with 58 children and older people for every 100 working age people in 2030 compared to a counterfactual of 63. A lower (total) dependency ratio means that there are fewer children and older people for every working age person, and therefore less of a burden to support those who are often economically dependent, allowing for greater investment to be made in ensuring that each child is educated, healthy and has the opportunity to develop the skills to contribute to a more prosperous society.

The (total) dependency ratio can be disaggregated into the youth dependency ratio and the old-age dependency ratio. As would be expected, the decline is almost entirely being driven by the

Table 3: Dependency ratios

	2015	2020	2025	2030
Total dependency ratio (A+B)				
Counterfactual	0.70	0.64	0.62	0.63
FP Scale-up	0.70	0.63	0.59	0.58
Youth dependency ratio (A)				
Counterfactual	0.55	0.49	0.46	0.45
FP Scale-up	0.55	0.48	0.43	0.40
Old-age dependency ratio (B)				
Counterfactual	0.14	0.15	0.16	0.18
FP Scale-up	0.14	0.15	0.16	0.18

Source: OneHealth modelling

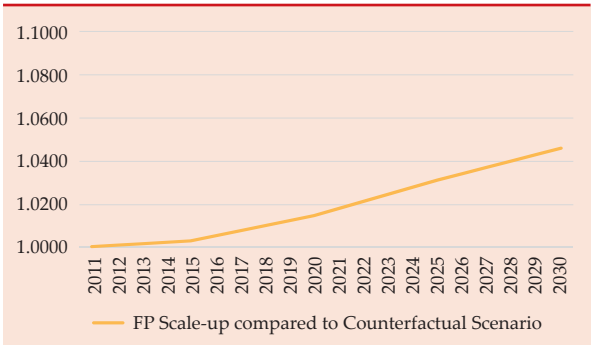
decline in the youth dependency ratio (fewer children for every working age person) than any change in the old-age dependency ratio (fewer older people for every working age person). In fact, the old-age dependency ratio has started to rise by 2030. The demographic dividend that could potentially be catalysed by a lower (total) dependency ratio is quantified and discussed further in the subsequent sections.

DEMOGRAPHIC DIVIDEND

Under certain social and economic circumstances, having a larger proportion of the population of working age can lead to economic benefit. Figure 7 illustrates the demographic dividend that could be catalysed by lower fertility rates if other policies are also in place. It shows the ratio of projected income per capita for the FP scale-up scenario compared to the counterfactual scenario. Income per capita is projected to be 4.6% higher by 2030.

This demographic dividend is coming about primarily from the lower dependency ratio but also from increased labour force participation by mothers, as well as, in the later years, higher savings, investment and productivity. This is not included in these benefit-cost calculations because it is not a guarantee. It will not come about from scaling up FP alone but requires investment in other areas—in particular, education, health, governance and the economy more widely—to be realised.

FIGURE 7: Increase in income per capita



COUPLE YEARS OF PROTECTION

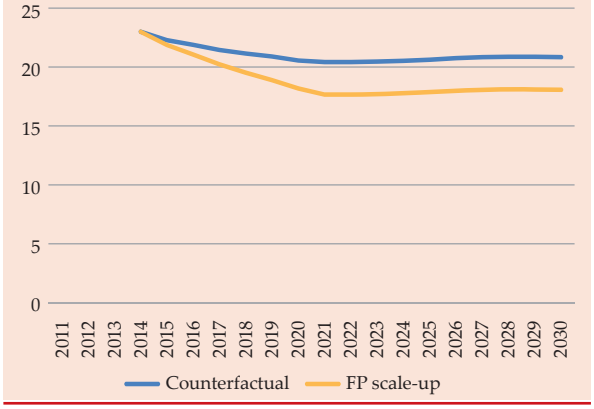
The number of couple years of protection (CYPs), which is a function of both population growth and increased contraceptive use, is estimated at 2.9 million by 2030 under the FP scale-up scenario, which is 0.24 million more than under the counterfactual scenario.

Health Benefits

MATERNAL HEALTH

The health benefit of scaling up FP services is positive. The modelling shows that there are projected to be 230 fewer maternal deaths a year by 2030 under the FP scale-up scenario compared to the counterfactual scenario. The maternal mortality rate is projected to decrease to 18.1 in 2030 under the FP scale-up scenario compared to the counterfactual scenario of 20.8 in 2030. (Figure 8) It should be noted that this is a conservative estimate of the impact on maternal mortality. This is because there is not enough of an evidence base to robustly quantify the impact of FP scale-up through other channels such as higher levels of maternal education.

FIGURE 8: Maternal mortality rate



INFANT AND CHILD HEALTH

There is currently not enough of an evidence base to robustly quantify the impact of FP on infant and child mortality. However, if we adopt the approach taken by the Guttmacher Institute in its Adding It Up report and simply apply the current Infant Mortality Rate (IMR) to the estimated number of births in each scenario, then by 2030 there would be approximately 3,000 fewer infant deaths a year in the FP scale-up scenario compared to the counterfactual scenario. This is a conservative estimate given that FP not only reduces the number of births but reduces the chance of children dying in their first year.

In terms of child mortality, FP can help a woman space her births. One study has found that child mortality can be reduced by 13% with birth spacing of two years or more and 25% with birth spacing of three years or more (Rustein, 2008). The Guttmacher Institute in its Adding It Up report

does not quantify this in terms of child deaths prevented and so we do not include that here.

Social and economic benefits

Slower rates of population growth and healthier population translate into sectoral cost savings as there are fewer people who need education and health services. In this section, the benefit is quantified in terms of:

- Fewer children age 6-10 requiring primary education;
- Fewer children under age 1 requiring immunisation;
- Fewer children under age 5 being treated for pneumonia;
- Fewer mothers requiring maternal health care; and
- Fewer people requiring access to clean drinking water.

Table 4 shows the cumulative cost savings (2015-2030) in primary education, child immunisation, child pneumonia, maternal health and the Water, Sanitation and Hygiene (WASH) sectors under the FP scale-up scenario compared to the counterfactual scenario.

Table 4: Cost savings in five sectors (millions)

Sector	Not discounted (NPR million)	Discounted at 3% (NPR million)
Primary education	20,231.9	13,629.0
Child immunization	10,057.0	7,530.4
Child pneumonia	1,865.2	1,384.7
Maternal health	13,511.9	10,081.9
WASH	904.0	641.1
Total	**46,569.9**	**33,267.1**

Source: OPM calculations

Both scenarios assume universal primary education by 2021, at a unit cost of 10,000 Nepalese Rupees (NPR) per child. Under the counterfactual scenario, primary education spending would increase from an estimated 29,127.9m NPR a year in 2015 to 30,215.6m NPR a year in 2030, whereas under the FP scale-up scenario, it would only increase to 26,219.8m NPR a year in 2030. The cumulative savings over the period of 2015-2030 would be 20,231.9m NPR, or 13,629.0m NPR if discounted at 3%.

Both scenarios assume that all children receive a full set of basic vaccinations by age 1 by 2021 at a unit cost of 9,187 NPR per child, at a total cost of 6,089.9m NPR a year by 2030 in the counterfactual scenario but only a cost of 5,271.1m NPR a year in the FP scale-up scenario. The cumulative savings over the 2015-2030 periods would be lower than that of primary education at 10,057.0m NPR, or 7,530.4m NPR if discounted at 3%.

Other cost savings in the health sector include those related to child pneumonia and maternal health. Assuming that by 2021, Nepal has reached the target of 80% of children with suspected pneumonia are taken to the appropriate health provider (as in Bhutta et al, 2013), total costs for treatment of children under 5 with severe pneumonia would reach 1,012.3m NPR a year by 2030 in the counterfactual scenario but only 876.6m NPR a year in the FP scale-up scenario. The cumulative savings over the period of 2015-2030 would be 1,865.2m NPR, or 1,384.7m NPR if discounted at 3%. It should be noted that to prevent double counting with other sectors, only the costs of treating severe pneumonia are included in the calculation, not the broader costs of preventative interventions for pneumonia.

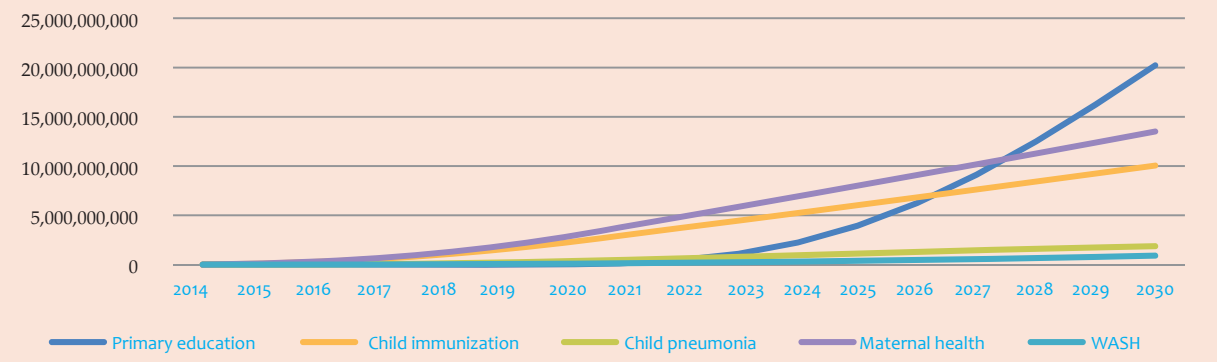
The unit cost of universal maternal health provision is higher at an estimated 12,206 NPR per birth and the cumulative cost savings are correspondingly higher, even though there is more children under-5 than new mothers in a year. The cumulative cost savings over the period of 2015-2030 would be 13,511.9m NPR, or 10,081.9m NPR if discounted at 3%. Annual costs would reach 8,324.7m NPR by 2030 under the counterfactual scenario and 7,205.7m NPR by 2030 under the FP scale-up scenario.

Finally, assuming that the proportion of people with access to an improved water source increases so that universal coverage is reached by 2021, total costs would reach 3,904.7m NPR a year in 2030 in the counterfactual scenario and 3,777.5m NPR a year in the FP scale-up scenario. This smaller discrepancy in cost is because universal coverage is assumed to have been reached by this time, and continuing to supply water to people is less expensive than connecting them in the first place. The cumulative cost savings over the period of 2015-2030 would be 903.0m NPR, or 641.1m NPR if discounted at 3%.

Figure 9 shows these cumulative cost savings over time. The main point to note here is the timing of the cost savings in the different sectors: in particular, cost savings in primary education take some time to materialise because it takes 6 years for the impact of FP on the population age 6-10 to occur. However, by 2030, cumulative cost savings are the largest for primary education.

Table 5 shows that in the FP scale-up scenario cost per CYP is 894 NPR in 2015 and declines to 693 NPR in 2020, rising somewhat to 845 NPR in 2030. Cost per user follows a similar pattern, starting at 853 NPR in 2015 and declining to 616 NPR in 2020 in rising to 667 NPR in 2030.

FIGURE 9: Cumulative cost savings



Investment requirements

PROJECTED TOTAL COSTS

Figure 10 shows the expenditure required to reach the FP scale-up scenario compared to the counterfactual scenario. Costs are in constant 2014 NPR, thus showing the results without inflation and, for the USD total, without exchange rate fluctuations. Whereas additional total expenditure is estimated at 1,081.8 million NPR a year in 2015, because programme expenditure is front-loaded, the model projects additional costs declining to 671.7 million NPR a year in 2020.

FIGURE 10: Projected expenditure under the FP Scale-up and Counter factual scenarios capita

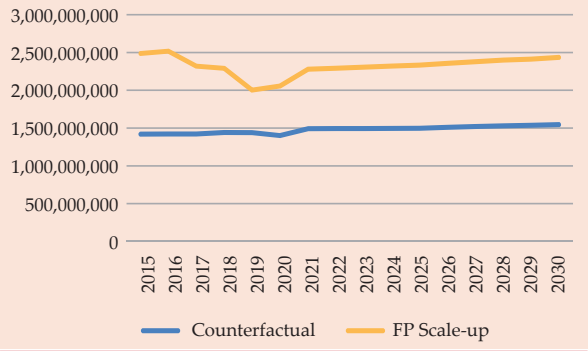


Table 5: Cost per CYP and cost per user

	2015	2020	2025	2030
Cost per CYP				
Counterfactual	583	590	586	586
FP Scale-up	894	693	843	845
Cost Per User				
Counterfactual	494	467	481	480
FP Scale-up	853	616	660	667

Source: One Health Modelling

In theory, it should be possible to compare our unit cost estimates (i.e. cost per user and cost per CYP) with those produced by other studies. For example, our annual cost per user estimate in the FP scale-up scenario is higher than 388 NPR, which the Guttmacher Institute's estimate for Asia as a whole (Singh and Darroch, 2012). However, our estimate includes a comprehensive costing of the programme costs required to achieve this scale up whereas many other cost-benefit analyses of FP programmes consider only direct intervention costs. We adopted this approach because we believe that it provides a far more realistic picture of all the costs involved in scaling up FP coverage.

Return on investment

The most commonly reported summary metric of a cost-benefit analysis is the Benefit-Cost Ratio (BCR). This simply divides total discounted benefits by total discounted costs. A BCR of greater than one therefore means that the benefits of the programme outweigh its costs. It is important to note that, as with all economic evaluations, there is an implicit counterfactual built into the BCR; in this case, it reports the benefits and costs to the FP scale-up scenario that are incremental to the Counterfactual scenario.

The net present value of a programme is another commonly reported metric. This is total discounted benefit minus total discounted costs to give the net benefit of the programme. For this metric, benefits outweighing costs is a value of greater than zero.

Table 6 gives the benefit-cost ratio and net present value at key time horizons for the FP scale-up scenario relative to the counterfactual scenario. These results all use a discount rate of 3% as base case, which is standard practice for health sector economic evaluation; in our sensitivity analysis, we calculated these metrics at other discount rates (5% and 7%), also shown below.

Table 6: Investment metrics

		2020	2025	2030
3%	Benefit- cost ratio	1.0	2.2	3.1
	Net present value (NPR Million)	-130	7,490	22,400
5%	Benefit- cost ratio	0.9	2.1	2.9
	Net present value (NPR Million)	-230	6,130	17,500
7%	Benefit- cost ratio	0.9	2.0	2.7
	Net present value (NPR Million)	-320	5,020	13,720

Source: OPM calculations

Looking at the longer time horizon (to 2030) and at discount rate of 3%, **for every rupee spent on family planning, Nepal would save 3.1 rupees in the five sectors: primary education, child immunisation, child pneumonia, maternal health and WASH.** This calculated by dividing the net present benefits of 33,267.1 million NPR by the net present costs of 10,661.6 million NPR. This is a conservative estimate of the return on investment on FP for Nepal because we are only including the cost savings to these sectors. There are likely to be cost savings to other sectors not included here – those related to health sector (like improved pregnancy outcomes, reduced unsafe abortion from unwanted pregnancies and improved protection from HIV and other STIs) and outside health sector (cost saving in providing social services, climate change benefits and improvement in women's right, empowerment and gender equality . There are also other benefits that we have not included in our benefit-cost calculations.

The way forward

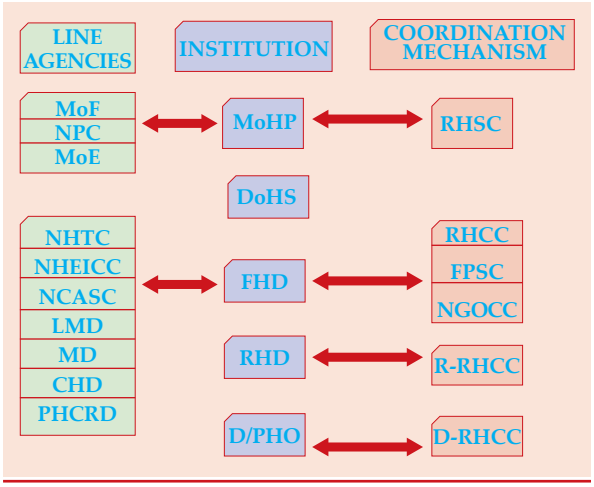
Institutional Arrangements for Implementation

The Government of Nepal has responsibility and leadership for ensuring that all women and girls are enabled to make informed decision on number and timing of having children through providing universal access to quality FP services. Operationally, implementation of the CIP requires multi-sectoral approach in the coordination and management of the national effort.

Based on stakeholders' consultation, a streamlined coordination and management structure is proposed for CIP implementation as shown in Figure 11. The purpose of the coordination mechanism is to ensure multi-sectoral approach; optimize financial and technical support to FP provided by donors/INGOs; ensure strong linkages and coordination with NHSP III; support effective implementation of the CIP and strengthen engagement of NGOs and other stakeholders, as well as to improve tracking/dissemination of results and lessons learned.

- The coordination and management mechanism is built on the existing coordination structure. Implementation of the CIP will be steered by MoHP (policy level) and coordinated by DoHS, while the execution of CIP will be overseen and managed under the leadership of FHD.
- Reproductive Health Steering Committee (RHSC) at the MoHP will be engaged in steering the CIP in order to ensure a multi-sectoral approach for the CIP implementation. To harmonize efforts on FP with national interventions on preventing HIV and ensuring gender equality, RHSC may include representatives of committees working on gender issues and HIV.
- National Reproductive Health Coordination Committee (RHCC) will be engaged in coordination of the CIP implementation using the existing processes such as regular meetings, updates, etc. Co-ordination and collaboration amongst divisions and centres particularly FHD, NHTC, NHEICC, LMD, PHCRD, NCASC and CHD will be enhanced for successful implementation of the CIP. NGOs participation will be strengthened though NGOCC.
- At the level of FHD, collaboration and coordination between FP, ASRH, safe motherhood and neonatal, Monitoring and Research units will be strengthened through existing for a particularly FPSC but also through SMNSC and Research sub-committee. In addition through implementation of the CIP, in particular, interventions related to Reporting and Monitoring and Evaluation, linkage with Management Division /HMIS unit will be enhanced.
- Collaboration and coordination amongst relevant stakeholders to implement and monitor the CIP at regional and district levels will be accomplished through Regional- RHCC (R-RHCC) and District-RHCC (D-RHCC) respectively.
- Focal Points will be part of coordination mechanism.
  - Policy level: Chief Policy, Planning and International Cooperation Division (PPICD) – facilitate coordination with line Ministries and Partners
  - Coordination: Director General, DoHS – ensure that other divisions are engaged in the CIP FP implementation
  - Management: Chief of FP section, FHD - ensure that the CIP is translated in AWP and support districts to develop their plans accordingly and support implementation through the QI unit.
  - Regional Director – monitor implementation of action plans at district level
  - FP Supervisor – with support from D/PHO and Public Health Nurse (PHN) coordinate and support implementation of the CIP FP at district and below levels and provide feedback to FHD.

FIGURE 11: CIP Coordination and Management Structure



District-level Planning

The Ministry of Health and Population developed the Costed Implementation Plan on Family Planning to provide a roadmap for reaching 62.9% of demand satisfied by modern contraceptives which brings CPR for modern contraceptives up to 50%. Reaching this goal will require significant district-level leadership and coordination in the planning and implementation process. This document provides a foundation and guidance for designing district micro-plans.

This undertaking will require for each district to conduct a situation analysis, and initiate a planning process in close collaboration with all partners. The 75 districts have different priorities for FP and require different interventions. For example, districts with a relatively high CPR and high unmet need will require a different strategy than those with a lower CPR and lower unmet need. Beyond FP statistics, other factors differentiate districts and how FP must be scaled up. For example, geographical access to services, the care-seeking behavior among residents, level of mass media exposure, availability of health staff and community workers, etc.

Ultimately, districts will follow a similar process to that of the MOHP in creating the CIP. Districts and community level health managers and health care providers will be enabled to develop micro-plans in order to implement the national costed implementation plan for family planning. Microplanning for FP services is an innovative approach that enables district managers and healthcare providers to generate and analyze local, disaggregated data; use them to identify pockets of inequity within the districts, in terms of both access to and utilization of FP services; identify context-specific strategies/approaches and implement them. MoHP/FHD initiated this in 7 districts in 2014 with support from partners including DFID and UNFPA and plans to expand it, in a phase-wise manner, to other districts with high unmet needs.

The planning process will follow the key steps such as: engage the appropriate stakeholders, diagnose specific priorities, set a district-wide goal for family planning, define the most appropriate interventions, and create a detailed and costed plan. This process will require substantial leadership at the district level from the MoHP as well as other government agencies and, crucially, the support of the governor/ other key stakeholders and champions.

District plans should build on existing FP programmes and identify other health initiatives and programmes for coordination or integration in order to ensure the effective use of resources and leveraging of opportunities to take advantage of successful interventions.

Resource Mobilization

The national CIP estimates that more than US$ 153 million is required to scale up FP in Nepal by 2020. Although the CIP provides costs of key interventions, it does not include information about allocated funding. A review and analysis of available domestic and donor resources for FP should be conducted to identify a funding gap and develop a resource mobilization plan.

The resource mobilization can address this funding gap in two ways. First, allocate already committed FP funds to the priority activities identified in the CIP and if possible to have a multi-year funding framework for all partners supporting FP in the country. This will help ensure that current donor funding and partner activities are aligned to the greatest areas of need. Second, identify sources for additional funding from local governments, private sector and donors.

The costed national- and district-level implementation plans will be used as key

Monitoring and Evaluation Framework

advocacy tools to demonstrate both the needs for and potential impacts of new funding.

The costed implementation plan (CIP) outlines the goal, purpose, objectives and strategic directions of family planning programme of Nepal for the period of 2015-2020, with details of interventions and costs of each intervention.

The scheme of the CIP is outlined as below:

GOAL:
Women and girls-in particular those that are poor, vulnerable and marginalized- exercise informed choice to access and use voluntary quality family planning services.

STRATEGIC OBJECTIVES:

a) To strengthen enabling environment for family planning.
b) To increase health care seeking behavior among population with high unmet need for modern contraception.
c) To enhance family planning service delivery including commodities to respond to the needs of marginalized, rural residents, migrants, adolescents and other special groups.
d) To strengthen capacity of service providers to expand FP service delivery network.
e) To strengthen evidence base for effective programme implementation through research and innovations.

RESULTS RELATED TO FIVE STRATEGIC AREAS:

1. Enabling environment
2. Demand generation
3. Service delivery
4. Capacity building
5. Research and innovation

IMPACT

OUTCOMES

OUTPUTS

Monitoring and Evaluation Indicators

IMPACT INDICATORS

Goal	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency	Disaggregation	Baseline value 2015	Target value 2020
Women and girls-in particular those that are poor, vulnerable and marginalized-exercise informed choice to access and use voluntary quality family planning services.	FPG1	Total fertility rate	NDHS, MICS	MoHP	Five years	Wealth quintile, urban/rural, eco-region, ethnicity	2.5	2.1
	FPG2	Adolescent fertility rate	NDHS, MICS	MoHP	Five years	Wealth quintile, urban/rural, eco-region, ethnicity	81 per 1000 (NDHS, 2011)	70 per 1000
	FPG3	Number of unintended pregnancies averted due to contraception use	Modeling	FHD	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	NA	TBD
	FPG4	Number of maternal deaths averted due to contraception use	Modeling	FHD	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	NA	TBD
	FPG5	Number of abortions averted due to contraception use	Modeling	FHD	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	NA	TBD

OUTCOME INDICATORS

Outcomes	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency	Disaggregation	Baseline value 2015	Target value 2020
OC1. Strengthened enabling environment for effective, equitable and sustainable family planning programming.	OC1.1	Percentage of total health budget allocated for FP programme	Budget analysis report	MoHP	Annually	-	NA	TBD
OC2. Increase FP service seeking behavior among population with high unmet need for modern contraception.	OC2.1	Contraceptive prevalence rate (disaggregated) (mCPR)	NDHS	MoHP	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	44.4	49.0
	OC2.2	Percentage of demand satisfied for Family Planning	NDHS	MoHP	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	65 (NDHS, 2011)	76
	OC2.3	Percentage of women with a unmet need for family planning	NDHS, MICS	MD	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	26.2	22.7
OC3. Improved and equitable FP service delivery.	OC3.1	Percentage of demand satisfied by modern method of contraception (disaggregated)	NDHS	MoHP	Five years	Wealth quintile, urban/rural, eco-region, ethnicity, age	55.9 (NDHS 2011)	62
OC4. Strengthened capacity of service providers to expand FP service delivery network.	OC4.1	Number/percentage of hospitals and PHCCs offering all seven family planning services	Programme report/ Health facility survey	FHD	Annually	PHCCs, hospitals		TBD
	OC4.2	Number/percentage of health posts providing all five temporary methods of family planning	Programme report	FHD	Annually	-		TBD
OC5. Improved availability and use of FP evidence in decision-making processes at all levels.	OC5.1	Evidence of research/study recommendations incorporated in the national FP programme/ plan	Programme report	MoHP	Five years	-	-	-

Output Indicators

ENABLING ENVIRONMENT

Outputs	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency
Increased advocacy for family planning	EE1	Number of FP sub-committee meetings conducted	Programme report	FHD	Annually
	EE2	Number of awareness/advocacy events conducted	Programme report	FHD	Annually
Legal and socio-cultural barriers addressed to ensure increased access to FP services	EE3	Development of national strategy on increasing access to voluntary LAPM services	Programme report	FHD	Five years
	EE4	National ASRH strategy updated	Programme report	FHD	Five years
Integration of FP services at all level of health care service delivery	EE5	Development of national FP service integration strategy and operational guidelines	Programme report	FHD	Five years
	EE6	Clinical protocols, standards and guidelines for FP services updated	Programme report	FHD	Five years
Task shifting in FP services delivery	EE7	Development of a national strategy on task shifting	Programme report	FHD/NHTC	Five years

DEMAND GENERATION

Outputs	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency
Integration of comprehensive sexuality education in education curriculum	DG1	Comprehensive sexuality education incorporated in school curriculum	Programme report	FHD/MoHP/ MoE	Five years
Increased access of adolescents to FP messages	DG2	Number of adolescents and young people reached by family planning promotion activities using SMS and mobile technology	Programme report/ Survey report	FHD/NHEICC	Annually
	DG3	Number of districts with hotline counseling services on FP/SRH	Programme report	FHD	Annually
	DG4	Percentage of health facilities certified as being adolescent friendly health facilities	Programme report	FHD	Annually
	DG5	FP communication strategy updated	Programme report	FHD	Five years
	DG6	Communication tools developed to reach targeted group (including newly married couples)	Programme report	NHEICC	Annually
Increased knowledge/evidence to facilitate decision making for FP	DG7	Rapid assessments of PHC/ORC conducted	Programme report	FHD	Five years
	DG8	Percentage of women with comprehensive knowledge on at least one method of FP*	Survey report	FHD	Five years
	DG9	Percentage of women who make family planning decisions alone or jointly with their husbands	NDHS	MoHP	Five years
	DG10	Percentage of men and women who were informed of the permanence of sterilization	Survey report	FHD	Five years
Targeted FP programmes developed and implemented	DG11	Percentage of women who were provided with information on FP during their last visit in health facility	Client exit survey report	FHD	Five years

* Comprehensive knowledge mean that the women had heard about the method, knows where to get it and how to use it.

SERVICE DELIVERY

Outputs	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency
Improved FP service delivery at all levels	SD1	Percentage of WRA new acceptors by modern methods	HMIS	MD	Annually
	SD2	Couple years of protection (CYP)	HMIS	MD	Annually
	SD3	Number of comprehensive FP camps organized per district	Programme report	FHD	Annually
	SD4	Number of model PHC/ORC clinics developed	Programme report	FHD	Annually
	SD5	Number of hospitals providing recanalization services	Programme report	FHD	Annually
	SD6	Number of birthing centers providing post-partum intra-uterine contraceptive device (PPIUCD) insertion services	Programme report	FHD	Annually
	SD7	Percentage of women who received long acting family planning contraceptives after abortion	HMIS	MD	Annually
	SD8	Percentage of safe abortion (surgical and medical) sites with post-abortion long acting family planning services	Programme report	FHD	Annually
Improved FP integrated service delivery (FP/EPI integration, ASRH/FP integration)	SD9	Number of integrated RH service centers developed	Programme report	FHD	Annually
	SD10	Number of adolescents reached with RH programme	HMIS	MD	Annually
Institutionalized quality of care in FP service delivery	SD11	Quality of care unit established at FHD	Programme report	FHD	Five years
	SD12	Number of RHCC meeting conducted at the center and district	Programme report	FHD	Annually
Improved recording and reporting systems across the sector	SD13	Number/percentage of registered private institutions reporting on FP service data	HMIS	MD	Annually
Improved availability of quality contraceptives at all health service delivery points	SD14	Number/percentage of health facilities reporting no stock out of FP commodities over the last three months	LMIS	LMD	Annually
	SD15	Percent distribution of users of modern contraceptive methods by most recent source of method, according to method, Nepal 2011	NDHS	MoHP	Five years

CAPACITY BUILDING

Outputs	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency
Strengthened training on contraceptives	CB1	FP training packages updated	Programme report	NHTC	Five years
	CB2	National training package on long acting and permanent f FP methods incorporated in the in-service curriculum of MDGP, DGO and MD (Gynecology & Obstetrics)	Programme report	NHTC	Five years
	CB4	Number of health workers trained on LAPM	Programme report	NHTC	Annually
	CB5	Number of doctors trained on recanalization	Programme report	NHTC	Annually
	CB6	Number of paramedics trained on non-scalpel vasectomy	Programme report	NHTC	Annually
	CB7	Number of health workers trained on PPIUCD	Programme report	NHTC	Annually
	CB8	PPIUCD package incorporated into SBA package	Programme report	NHTC/FHD	Five years
National capacity on FP training enhanced	CB9	E-learning package on FP developed	Programme report	NHTC/FHD	Five years
	CB10	Number of functional FP training sites	Programme report	NHTC/FHD	Annually
	CB11	Number of new FP training sites established	Programme report	NHTC/FHD	Annually
	CB12	Percentage of FP trainees followed up	Programme report	NHTC	Annually

RESEARCH AND INNOVATION

Outputs	Indicator code	Indicators	Data source	Responsible organization	Monitoring frequency
Operational research conducted to generate evidences	RI1	Number of studies and researches conducted on family planning	NHRC/Programme report	FHD	Annually
Use of FP evidences in plan and programme development	RI2	National programme on FP reviewed	Programme report	FHD	Five years
	RI3	Number of successful innovations scaled up at national level	Programme report	FHD	Five years

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Annex

ANNEX A

ESTIMATED TOTAL RESOURCES REQUIRED AND DISAGGREGATED BY AREA

Table 7: Estimated Total Resources (millions)

	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
Direct intervention costs	1,229.6	1,258.9	1,289.3	1,336.1	1,365.8	1,363.6	7,843.3	87.9
Programme costs	1,099.3	1,094.5	860.6	780.4	456.2	506.8	4,797.7	53.8
Indirect costs	172.7	178.6	184.4	190.3	196.3	201.9	1,124.1	12.6
Total	**2,501.6**	**2,531.9**	**2,334.3**	**2,306.8**	**2,018.4**	**2,072.2**	**13,765.2**	**154.2**

Source: OneHealth modelling and OPM calculations

Table 8: Estimated Costs for Strategic Areas and Programme Management (millions)

PROGRAMME COSTS	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1. Demand Generation	258.4	90.6	108.1	196.8	56.9	27.7	738.4	8.27
2. Enhancing Service Delivery	303.1	424.7	292.9	272.1	272.1	272.1	1,836.9	20.59
3. Capacity Building	188.6	207.8	183.6	71.8	71.3	70.8	793.8	8.89
4. Research & Innovation	150.8	103.5	91.5	98.5	2.0	0.0	446.3	5.00
5. Enabling Environment	147.9	217.4	134.0	90.7	3.4	85.8	679.2	7.61
6. General Programme Management	50.5	50.5	50.5	50.5	50.5	50.5	303.1	3.40
Total	**1,099.3**	**1,094.5**	**860.6**	**780.4**	**456.2**	**506.8**	**4,797.7**	**53.76**

Source: TWG estimates and OPM calculations

Table 9: Estimated drug and supply costs under the scale-up FP scenario (millions)

The table below shows the estimated expenditure on drugs and supplies required for the FP scale-up scenario. This is in constant NPR, so does not include inflation.

Source: OneHealth modelling	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
Pill	153.3	157.9	162.5	166.9	171.5	176.0	988.1	11.1
Condom	80.3	83.2	85.9	88.7	91.6	94.4	524.1	5.9
Injectable	224.3	231.6	238.8	245.9	253.2	260.4	1,454.3	16.3
IUD	70.7	74.9	79.2	84.1	88.7	92.2	489.8	5.5
Implant	137.1	148.0	159.2	171.6	183.5	194.1	993.5	11.1
Female sterilization	217.4	211.0	205.3	208.9	201.7	177.1	1,221.3	13.7
Male sterilization	156.0	156.7	157.6	163.0	163.4	155.0	951.7	10.7
Total	**1,039.0**	**1,063.3**	**1,088.6**	**1,129.0**	**1,153.7**	**1,149.1**	**6,622.8**	**74.2**

Source: OneHealth modelling

Table 10: Estimated number of FTE medical personnel required under FP scale-up scenario

	2015	2016	2017	2018	2019	2020
Community Health Workers	111	115	119	122	126	129
Auxillary Nurse Midwives	451	466	481	497	513	528
Staff Nurses	53	56	59	61	64	67
Medical Officers	57	56	56	57	56	51
Obstetricians/Gynaecologists	26	26	25	26	26	23
Total	**698**	**719**	**740**	**763**	**784**	**798**

Source: OneHealth modelling

Table 10 shows the estimated number of full-time equivalent [FTE] medical personnel required for the FP scale-up scenario. It must be remembered that the FTE numbers below assume that medical personal work full time on family planning. This is rarely the case. A more realistic assumption would be that staff task share and only spend some of their time on family planning. For example, if we assume that only 10% of time is spent on family planning, then these numbers would need to be multiplied by 10 to give the number of medical personnel who deliver FP interventions as part (10%) of their jobs.

Table 11: Estimated medical personnel costs under FP scale-up scenario (millions)

	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
Community Health Workers	17.2	17.7	18.3	18.8	19.4	19.9	111.3	1.2
Auxillary Nurse Midwives	120.3	124.4	128.5	132.6	136.8	140.9	783.7	8.8
Staff Nurses	16.9	17.8	18.6	19.5	20.4	21.2	114.3	1.3
Medical Officers	23.5	23.1	22.9	23.5	23.1	21.1	137.1	1.5
Obstetricians/Gynaecologists	12.7	12.5	12.4	12.7	12.5	11.4	74.2	0.8
Total	**190.6**	**195.6**	**200.7**	**207.1**	**212.2**	**214.5**	**1,220.6**	**13.7**

Source: OneHealth modelling

Table 11 shows the estimated expenditure on medical personnel required for the FP scale-up scenario. Again, this is constant NPR, so does not include inflation.

ESTIMATED INDIRECT COSTS

Table 12 shows the estimated indirect costs associated with outpatient visits at different levels of health service provision. The cost of the user in traveling is not included in the estimation; however, it can be additional costs for service delivery.

Table 12: Estimated indirect costs under FP scale-up scenario (millions)

	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
Community	14.1	14.6	15.0	15.5	16.0	16.4	91.6	1.0
Outreach	46.8	48.2	49.6	51.1	52.5	53.8	302.0	3.4
Clinic	66.3	68.6	70.8	73.1	75.4	77.6	431.8	4.8
Hospital	45.5	47.2	48.9	50.7	52.5	54.1	298.8	3.3
Total	**172.7**	**178.6**	**184.4**	**190.3**	**196.3**	**201.9**	**1,124.1**	**12.6**

Source: OneHealth modelling

ANNEX B

Estimated resource requirements of *General Programme Management*, by key interventions, related programmatic activities and year, (natural units)

GENERAL PROGRAMME MANAGEMENT	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
MOHP, District/Regional Level	48,379,695	48,379,695	48,379,695	48,379,695	48,379,695	48,379,695	290,278,170	3,252,781
FP Supervisor	24,107,200	24,107,200	24,107,200	24,107,200	24,107,200	24,107,200	144,643,200	1,620,834
Regional FP Officer	1,651,000	1,651,000	1,651,000	1,651,000	1,651,000	1,651,000	9,906,000	111,004
Public Health Nurse	4,896,775	4,896,775	4,896,775	4,896,775	4,896,775	4,896,775	29,380,650	329,232
District Health Officer	2,870,400	2,870,400	2,870,400	2,870,400	2,870,400	2,870,400	17,222,400	192,990
Facility Manager	12,053,600	12,053,600	12,053,600	12,053,600	12,053,600	12,053,600	72,321,600	810,417
Regional Safe Motherhood Officer	390,000	390,000	390,000	390,000	390,000	390,000	2,340,000	26,221
HMIS Officer	2,410,720	2,410,720	2,410,720	2,410,720	2,410,720	2,410,720	14,464,320	162,083
MOHP, Central Level (FHD)	2,134,470	2,134,470	2,134,470	2,134,470	2,134,470	2,134,470	12,806,820	143,510
Director	125,190	125,190	125,190	125,190	125,190	125,190	751,140	8,417
FP Focal Point	382,720	382,720	382,720	382,720	382,720	382,720	2,296,320	25,732
FP Support Staff	1,148,160	1,148,160	1,148,160	1,148,160	1,148,160	1,148,160	6,888,960	77,196
FCHV Focal Point	191,360	191,360	191,360	191,360	191,360	191,360	1,148,160	12,866
Demographer/Statisticians	229,632	229,632	229,632	229,632	229,632	229,632	1,377,792	15,439
Safe Motherhood Focal Point	57,408	57,408	57,408	57,408	57,408	57,408	344,448	3,860
Total	**50,514,165**	**50,514,165**	**50,514,165**	**50,514,165**	**50,514,165**	**50,514,165**	**303,084,990**	**3,396,291**

Source: TWG estimates and OPM calculations

Note: Includes programme staff for whom FP activities constitute a significant share of their current daily work at FTE. Personnel from NHEICC, NHTC, LMD, MD, Finance & Admin play cross-cutting roles & are not costed

ANNEX C

Estimated resource requirements of *Enabling Environment*, by key interventions, related programmatic activities and year, (natural units)

ENABLING ENVIRONMENT	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1. Increase Advocacy for Family Planning	**139,172,500**	**217,385,500**	**133,952,500**	**90,713,000**	**2,325,000**	**85,758,000**	**669,306,500**	**7,500,073**
1.1 Identify national level champions of FP from multiple fields and facilitate their advocacy role	450,000	450,000	450,000	450,000	450,000	450,000	2,700,000	30,255
1.2 Develop and distribute advocacy package (in English and Nepali) for key stakeholders	3,420,000	0	0	3,420,000	0	0	6,840,000	76,647
1.3 Organize advocacy events at central level	1,800,000	0	0	1,535,000	0	0	3,335,000	37,371
1.4 Organize advocacy events at district level	5,612,500	5,612,500	5,612,500	1,875,000	1,875,000	1,875,000	22,462,500	251,709
1.5 Organize advocacy events at community level	127,890,000	127,890,000	127,890,000	0	0	0	383,670,000	4,299,305
1.6 Celebrate FP day at community level	0	83,433,000	0	83,433,000	0	83,433,000	250,299,000	2,804,785
2. Address legal and socio-cultural barriers to access to FP for young people and other groups including people with disability	**2,620,500**	**0**	**0**	**0**	**1,100,000**	**0**	**3,720,500**	**41,691**
2.1 Update the National ASRH strategy	1100000	0	0	0	1100000	0	2200000	24652.62214
2.2 Advocate with MOE, CDB & others to incorporate CSE components in curriculum for Grade 9-10	220500	0	0	0	0	0	220500	2470.865083
2.3 Develop a national strategy on meeting RH/FP needs of disabled group and support implementation through multi-sectoral coordination	1300000						1300000	14567.45854
3. Strengthen integration of services	**4,650,000**	**0**	**0**	**0**	**0**	**0**	**4,650,000**	**52,107**
3.1 Develop national FP service integration strategy	2,950,000	0	0	0	0	0	2,950,000	33,057
3.2 Based on strategy, develop operational guidelines	1,700,000	0	0	0	0	0	1,700,000	19,050
4. Promote task shifting	**1,500,000**	**0**	**0**	**0**	**0**	**0**	**1,500,000**	**16,809**
4.1 Develop a national strategy on task shifting	1,500,000	0	0	0	0	0	1,500,000	16,809
Total	**147,943,000**	**217,385,500**	**133,952,500**	**90,713,000**	**3,425,000**	**85,758,000**	**679,177,000**	**7,610,679**

Source: TWG estimates and OPM calculations

ANNEX D

Estimated resource requirements of *Demand Generation*, by key interventions, related programmatic activities and year, (in natural units)

DEMAND GENERATION	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1. Support to enhance Comprehensive Sexuality Education for in-school and out-of-school young people.	**9,076,500**	**3,836,000**	**21,350,000**	**750,000**	**750,000**	**750,000**	**36,512,500**	**409,149**
1.1 Support implementation of CSE in Grades 6-10	8,226,500	3,086,000	20,600,000	0	0	0	31,912,500	357,603
1.2 Conduct interactive sessions with students on CSE, Grade 11-12	850,000	750,000	750,000	750,000	750,000	750,000	4,600,000	51,546
2. Increase knowledge of FP amongst individuals/ couples to facilitate decision-making on contraceptive use through designing, implementation and evaluation of high quality SBCC interventions	**38,375,000**	**0**	**0**	**38,375,000**	**0**	**0**	**76,750,000**	**860,040**
2.1 Develop and disseminate FP information through different media (in 2015 & 2018)	38,375,000	0	0	38,375,000	0	0	76,750,000	860,040
3. Reach adolescents with FP messages through innovative approaches (m-health & e-health)	**15,250,000**	**8,750,000**	**8,750,000**	**13,750,000**	**8,750,000**	**8,750,000**	**64,000,000**	**717,167**
3.1 Utilize SMS technology to promote FP use amongst adolescents/youth	2,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	7,000,000	78,440
3.2 Introduce FP messages through mobile health apps	4,500,000	0	0	4,500,000	0	0	9,000,000	100,852
3.3 Implement hotline telephone program for adolescents	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	45,000,000	504,258
3.4 Pilot & implement e-health FP program for adolescents in urban areas	1,250,000	250,000	250,000	750,000	250,000	250,000	3,000,000	33,617
4. Reduce socio-cultural barriers to accessing FP services	**90,500,000**	**15,000,000**	**15,000,000**	**90,500,000**	**15,000,000**	**15,000,000**	**241,000,000**	**2,700,583**
4.1 Implement community interaction programs with FCHVs/health workers providing detailed info	90,500,000	15,000,000	15,000,000	90,500,000	15,000,000	15,000,000	241,000,000	2,700,583
5. Address fear of side-effects (perceived and real), myths & misconceptions	**9,700,000**	**3,000,000**	**3,000,000**	**3,000,000**	**3,000,000**	**0**	**21,700,000**	**243,165**

DEMAND GENERATION	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
5.1 Develop IEC materials, including value of daughters	6,500,000	0	0	0	0	0	6,500,000	72,837
5.2 Orient HW, FCHVs, community leaders in various forums [no add. cost, merged with other activities]	0	0	0	0	0	0	0	0
5.3 Organize satisfied client interaction program at community level	3,200,000	3,000,000	3,000,000	3,000,000	3,000,000	0	15,200,000	170,327
6. Develop and implement micro-plan for specific groups	**25,202,500**	**21,000,000**	**21,000,000**	**21,000,000**	**0**	**0**	**88,202,500**	**988,374**
6.1 Review existing evidence on barriers to FP utilization for specific groups	4,202,500	0	0	0	0	0	4,202,500	47,092
6.2 Develop and implement district-specific action plan (for districts with lowest CPR)	21,000,000	21,000,000	21,000,000	21,000,000	0	0	84,000,000	941,282
7. Design, implement & evaluate special program for improved FP access & utilization of adolescents/youth	**31225000**	**29000000**	**29000000**	**29000000**	**29000000**	**2750000**	**149975000**	**1680580.46**
7.1 Develop age-specific peer education program (both in-school and out-of-school youth)	29,225,000	27,000,000	27,000,000	27,000,000	27,000,000	750,000	137,975,000	1,546,112
7.2 Implement targeted activities to delay first pregnancy for newly married young couples	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	12,000,000	134,469
7.3 Integrate FP into school health programme (no additional costs)	0	0	0	0	0	0	0	0
8. Special program for migrants and their spouses particularly focused on in districts with high seasonal out-migrations	**600000**	**600000**	**600000**	**400000**	**400000**	**400000**	**3000000**	**33617.212**
8.1 Ensure timely and correct dissemination of information for returnee to prevent unwanted pregnancy (pre-departure & upon arrival)	600,000	600,000	600,000	400,000	400,000	400,000	3,000,000	33,617
9. Special program for postpartum women	**26,785,000**	**0**	**0**	**0**	**0**	**0**	**26,785,000**	**300,146**
9.1 Group counseling for couples during vaccination days/EPI clinics on PP FP (esp. on myths)	2,175,000	0	0	0	0	0	2,175,000	24,372
9.2 Promote counseling among pregnant & postpartum women in HMGs	24,610,000	0	0	0	0	0	24,610,000	275,773
10. Special program for post-abortion women	**650,000**	**0**	**0**	**0**	**0**	**0**	**650,000**	**7,284**

DEMAND GENERATION	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
10.1 Incorporate FP info in the existing info packages on CAC services	650,000	0	0	0	0	0	650,000	7,284
11. Special program for individuals and couples in hard-to-reach communities	**10,755,000**	**9,405,000**	**9,405,000**	**0**	**0**	**0**	**29,565,000**	**331,298**
11.1 Identify communities/areas with low FP utilization (including l among MDAG population)	750,000	0	0	0	0	0	750,000	8,404
11.2 Implement community interaction program to identify clients for counseling (explore success stories)	8,430,000	7,830,000	7,830,000	0	0	0	24,090,000	269,946
11.3 Utilize community mobilisers (25 districts each year for 3 years)	1,375,000	1,375,000	1,375,000	0	0	0	4,125,000	46,224
11.4 Increase FP use amongst urban slum dwellers (in 20 municipalities)	200,000	200,000	200,000	0	0	0	600,000	6,723
Total	**258,119,000**	**90,591,000**	**108,105,000**	**196,775,000**	**56,900,000**	**27,650,000**	**738,140,000**	**8,271,403**

Source: TWG estimates and OPM calculations

ANNEX E

Estimated resource requirements of *Enhancing Service Delivery*, by key interventions, related programmatic activities and year, (natural units)

ENHANCING SERVICE DELIVERY	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1. Improving services at Community Level	**37,370,000**	**156,230,500**	**24,380,000**	**4,805,000**	**4,805,000**	**4,805,000**	**232,395,500**	**2,604,163**
1.1 Update FP orientation package for capacity building of FCHVs (including on PPFP)	12,990,000	0	0	0	0	0	12,990,000	145,563
1.2 Conduct refresher orientation for FHCVs, based on revised package	0	131,850,500	0	0	0	0	131,850,500	1,477,482
1.3 Establish condom boxes at appropriate places in community (shops, etc.)	20,880,000	20,880,000	20,880,000	1,305,000	1,305,000	1,305,000	66,555,000	745,798
1.4 Train FCHVs on urine pregnancy test kit, FP counseling, ANC, safe abortion services							-	
1.5 Organize visits to countries with strong community-based FP programs (e.g. Bangladesh, Indonesia)	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	21,000,000	235,320
2. Improving services through PHC/ORC clinics and other out-reach approaches	**168,065,250**	**164,900,000**	**164,900,000**	**164,900,000**	**164,900,000**	**164,900,000**	**992,565,250**	**11,127,382**
2.1 Rapid assessment of the situation of the PHC/ ORC Clinics across the country	1,800,000	0	0	0	0	0	1,800,000	20,170
2.2 Develop 1-2 model PHC/ORCs per VDC (low CPR districts), later to be static SDP	600,000	0	0	0	0	0	600,000	6,723
2.3 Utilize urban health clinics at each tole for FP services (20 municipalities)	1,265,250	500,000	500,000	500,000	500,000	500,000	3,765,250	42,192
2.4 Conduct comprehensive FP camps (focused on LAPM) in all 75 districts	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000	900,000,000	10,089,686
2.5 Conduct satellite clinics to improve the access to LARM among women residing in remote, rural areas.	14,400,000	14,400,000	14,400,000	14,400,000	14,400,000	14,400,000	86,400,000	968,610
3. Improving services at HP/PHCs, including birthing centers	**12,950,000**	**22,950,000**	**22,950,000**	**22,950,000**	**22,950,000**	**22,950,000**	**127,700,000**	**1,430,973**
3.1 Expand availability of all temporary FP methods	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	45,000,000	504,258
3.2 Reinforce availability of FP services							0	0
3.3 Expand PPIUCD in birthing centers: launch pilot program	5,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	80,000,000	896,459
3.4 Expand NSV to PHCC, promoting task-shifting (PHCs selected on lower CPR districts)	450,000	450,000	450,000	450,000	450,000	450,000	2,700,000	30,255

ENHANCING SERVICE DELIVERY	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
3.5 FP at all levels of HF (reporting and quality assurance in public, NGO and private sector, and inventory & stock management in HF). Use vaccinator in their free days for FP services 3.6 Add responsibilities to ANM/SN including for facilitation of community level meetings. 3.7 Focus on quality FP counseling during 3rd & 4th ANC, include this in the ANC card	0	0	0	0	0	0	0	0
4. Improving services in District Hospitals	**20,500,000**	**18,400,000**	**18,400,000**	**18,400,000**	**18,400,000**	**18,400,000**	**112,500,000**	**1,260,645**
4.1 Expand availability of all temporary FP methods & 1 VSC method	500,000	0	0	0	0	0	500,000	5,603
4.2 Develop 24 IFPSC as comprehensive RH clinics	1,300,000	0	0	0	0	0	1,300,000	14,567
4.3 Develop district-level FP micro-planning & commodity forecasting	18,700,000	18,400,000	18,400,000	18,400,000	18,400,000	18,400,000	110,700,000	1,240,475
5. Improving services in Zonal and Regional Hospitals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
5.1 Establish FP services in multi-disciplinary hospitals	0	0	0	0	0	0	0	0
5.2 Establish re-canalization services	0	0	0	0	0	0	0	0
6. Social marketing	**5,000,000**	**5,000,000**	**5,000,000**	**5,000,000**	**5,000,000**	**5,000,000**	**30,000,000**	**336,172**
6.1 Revive private provider's network (implemented through PPP model)	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	30,000,000	336,172
6.2 PPP for strengthening supply chain commodity management.	0	0	0	0	0	0	0	0
7. Support NGOs providing FP services	**260,000**	**160,000**	**160,000**	**160,000**	**160,000**	**160,000**	**1,060,000**	**11,878**
7.1 Revive NGOCC for organizations working in FP	250,000	150,000	150,000	150,000	150,000	150,000	1,000,000	11,206
7.2 Facilitate NGOs to provide FP services	10,000	10,000	10,000	10,000	10,000	10,000	60,000	672
8. Support Medical College Teaching Hospitals	**800,000**	**0**	**0**	**0**	**0**	**0**	**800,000**	**8,965**
8.1 Establish FP service centers in each medical college	500,000	0	0	0	0	0	500,000	5,603
8.2 Include LAFP training in doctor and nurse pre-service curriculum	300,000	0	0	0	0	0	300,000	3,362
9. Strengthen coordination of private sector	**25,000**	**25,000**	**25,000**	**25,000**	**25,000**	**25,000**	**150,000**	**1,681**

ENHANCING SERVICE DELIVERY	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
9.1 Strengthen coordination mechanism and reporting, to ensure functionality	25,000	25,000	25,000	25,000	25,000	25,000	150,000	1,681
10. Improved integration of FP services with EPI, HIV, and Postpartum, Post-abortion, RH-morbidities, urban health and other programs.	**10,000,000**	**10,000,000**	**10,000,000**	**10,000,000**	**10,000,000**	**10,000,000**	**60,000,000**	**672,344**
10.1 Pilot new integration approaches (10 approaches)	10,000,000	0	0	0	0	0	10,000,000	112,057
10.2 Scale-up proven models in next 5 years	0	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000	560,287
11. Improve facility recording and reporting	**100,000**	**100,000**	**100,000**	**100,000**	**100,000**	**100,000**	**600,000**	**6,723**
11.1 Strengthen and update recording/reporting system, coordination with HMIS	100,000	100,000	100,000	100,000	100,000	100,000	600,000	6,723
11.2 Develop M&E tools for private providers in line with HMIS tools							[in 11.1]	[in 11.1]
12. Establish Quality of Care unit	**3,500,000**	**3,500,000**	**3,500,000**	**3,500,000**	**3,500,000**	**3,500,000**	**21,000,000**	**235,320**
12.1 Establish quality of care unit	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	21,000,000	235,320
13. Strengthen management capacity of FP Officers	**5,700,000**	**4,700,000**	**4,700,000**	**3,500,000**	**3,500,000**	**3,500,000**	**25,600,000**	**286,867**
13.1 Development of training curriculum	1,000,000	0	0	0	0	0	1,000,000	11,206
13.2 Conducting training of FP officers	1,200,000	1,200,000	1,200,000	0	0	0	3,600,000	40,341
13.3 Conduct observation study tour	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	21,000,000	235,320
14. Help ensure contraceptive security	**25,000**	**25,000**	**25,000**	**25,000**	**25,000**	**25,000**	**150,000**	**1,681**
14.1 Coordination with LMD to ensure regular supply	25,000	25,000	25,000	25,000	25,000	25,000	150,000	1,681
15. Enhance coordination at the central and district levels	**38,730,000**	**38,730,000**	**38,730,000**	**38,730,000**	**38,730,000**	**38,730,000**	**232,380,000**	**2,603,989**
15.1 Improved coordination at central level	105,000	105,000	105,000	105,000	105,000	105,000	630,000	7,060
15.2 Improved coordination at district level	38,625,000	38,625,000	38,625,000	38,625,000	38,625,000	38,625,000	231,750,000	2,596,930
Total	**303,025,250**	**424,720,500**	**292,870,000**	**272,095,000**	**272,095,000**	**272,095,000**	**1,836,900,750**	**20,588,784**

Source: TWG estimates and OPM calculations

ANNEX F

Estimated resource requirements of Capacity Building, by key interventions, related programmatic activities and year, (natural units)

CAPACITY-BUILDING	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1. Core FP training to service providers (training/DSA cost)	**42,720,591**	**59,913,719**	**59,913,719**	**21,352,704**	**21,352,704**	**21,352,704**	**226,606,141**	**2,539,289**
1.1 IUCD	5,737,324	6,895,316	6,895,316	3,473,976	3,473,976	3,473,976	29,949,884	335,611
1.2 Implant	8,371,756	10,056,637	10,056,637	5,001,992	5,001,992	5,001,992	43,491,008	487,349
1.3 CoFP/C	14,492,100	19,322,800	19,322,800	6,473,138	6,473,138	6,473,138	72,557,114	813,056
1.4 NSV	3,226,260	3,858,860	3,858,860	1,897,800	1,897,800	1,897,800	16,637,380	186,434
1.5 Minilap	2,226,610	2,657,567	2,657,567	1,364,696	1,364,696	1,364,696	11,635,832	130,388
1.6 PPIUCD	263,180	315,816	315,816	157,908	157,908	157,908	1,368,536	15,335
1.7 Sangini/Depo	8,403,361	16,806,723	16,806,723	2,983,193	2,983,193	2,983,193	50,966,387	571,116
2. Core FP training to service providers (travel costs)	**76,771,247**	**111,588,629**	**111,588,629**	**38,277,495**	**38,277,495**	**38,277,495**	**414,780,990**	**4,647,927**
2.1 Travel cost (except Sangini)	63,152,321	91,793,233	91,793,233	31,487,214	31,487,214	31,487,214	341,200,427	3,823,402
2.2 Travel cost (Sangini)	13,618,926	19,795,396	19,795,396	6,790,281	6,790,281	6,790,281	73,580,563	824,524
3. Core FP training to service providers (printing of training material)	**20,366,124**	**10,031,076**	**0**	**0**	**0**	**0**	**30,397,200**	**340,623**
1.1 IUCD	1,756,740	865,260	0	0	0	0	2,622,000	29,381
1.2 Implant	2,557,524	1,259,676	0	0	0	0	3,817,200	42,775
1.3 CoFP/C	8,681,190	4,275,810	0	0	0	0	12,957,000	145,193
1.4 NSV	544,040	267,960	0	0	0	0	812,000	9,099
1.5 Minilap	662,630	326,370	0	0	0	0	989,000	11,082
1.6 PPIUCD	134,000	66,000	0	0	0	0	200,000	2,241
1.7 Sangini/Depo	6,030,000	2,970,000	0	0	0	0	9,000,000	100,852
4. FP training material development	**1,600,000**	**800,000**	**0**	**0**	**0**	**0**	**2,400,000**	**26,894**
4.1 Training material revision	1,600,000	800,000	0	0	0	0	2,400,000	26,894
5. Development and use of alternative training approaches	**8,250,000**	**8,250,000**	**0**	**0**	**0**	**0**	**16,500,000**	**184,895**
5.1 Material and implementation of modified computer/web-based learning	8,250,000	8,250,000	0	0	0	0	16,500,000	184,895
6. Task-shifting on NSV	**500,000**	**1,000,000**	**1,000,000**	**1,000,000**	**500,000**	**0**	**4,000,000**	**44,823**

CAPACITY-BUILDING	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
6.1 Train Health Assistants to provide NSV	500,000	1,000,000	1,000,000	1,000,000	500,000	0	4,000,000	44,823
7. Strengthen national FP training capacity	**17,740,000**	**740,000**	**740,000**	**740,000**	**740,000**	**740,000**	**21,440,000**	**240,251**
7.1 Renovation/upgrading of existing FP clinical training sites	11,000,000	0	0	0	0	0	11,000,000	123,263
7.2 Maintenance of sites	440,000	440,000	440,000	440,000	440,000	440,000	2,640,000	29,583
7.3 Establishment of new sites	6,000,000	0	0	0	0	0	6,000,000	67,234
7.4 Renovation/upgrading of existing RHTC	300,000	300,000	300,000	300,000	300,000	300,000	1,800,000	20,170
8. Development of pool of FP trainers	**10,291,200**	**5,068,800**	**0**	**0**	**0**	**0**	**15,360,000**	**172,120**
8.1 CTS training	1,206,000	594,000	0	0	0	0	1,800,000	20,170
8.2 Preparation of clinical mentors in FP	1,206,000	594,000	0	0	0	0	1,800,000	20,170
8.3 Physician trainers	4,596,200	2,263,800	0	0	0	0	6,860,000	76,871
8.4 Nurse trainers	3,283,000	1,617,000	0	0	0	0	4,900,000	54,908
9. Recanalization training	**390,000**	**390,000**	**390,000**	**390,000**	**390,000**	**390,000**	**2,340,000**	**26,221**
9.1 Recanalization training (including microsurgery skills)	390,000	390,000	390,000	390,000	390,000	390,000	2,340,000	26,221
10.Continue capacity building of health workers even after completion of formal training	**10,000,000**	**10,000,000**	**10,000,000**	**10,000,000**	**10,000,000**	**10,000,000**	**60,000,000**	**672,344**
10.1 Strengthen Post training follow up through on-site coaching and off-site supportive supervision	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	60,000,000	672,344
Total	**188,629,162**	**207,782,224**	**183,632,348**	**71,760,199**	**71,260,199**	**70,760,199**	**793,824,331**	**8,895,387**

Source: TWG estimates and OPM calculations

ANNEX G

Estimated resource requirements of *Research & Innovation*, by key interventions, related programmatic activities and year, (natural units)

RESEARCH AND INNOVATION	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1. Generate evidence through operational research, to promote innovations in FP	**150,840,000**	**103,500,000**	**91,500,000**	**98,500,000**	**2,000,000**	**0**	**446,340,000**	**5,001,569**
1.1 Understand the factors that lead to discontinuation of contraceptives including LARC	4,000,000	0	0	0	0	0	4,000,000	44,823
1.2 Document unintended pregnancy among FSWs (incidence, causes, consequences, complications)	0	2,000,000	0	0	0	0	2,000,000	22,411
1.3 Analysis of barriers for FP uptake among specific communities, including youth & hard to reach	0	2,000,000	0	0	0	0	2,000,000	22,411
1.4 Evaluate m-health approach (being implemented) for reaching adolescents with FP information	2,500,000	0	0	0	0	0	2,500,000	28,014
1.5 Feasibility study on use of social media and health-apps for FP messages, especially for youth	2,500,000			2,500,000	0	0	5,000,000	56,029
1.6 Evaluate the existing program on Postpartum FP and PP-IUCD.	1,500,000			1,500,000	0	0	3,000,000	33,617
1.7 Research on implementing PP FP/IUCD based on the best practices identified from evaluation	7,500,000	0	0	0	0	0	7,500,000	84,043
1.8 Periodic review/evaluation of FP program (specific for advocacy and demand generation activities)	5,000,000	0	0	5,000,000	0	0	10,000,000	112,057
1.9 Assessment of barriers in delivering CSE among school teachers	3,500,000	0	0	0	0	0	3,500,000	39,220
1.10 FP care-seeking behavior among urban slum dwellers	2,000,000	0	0	0	0	0	2,000,000	22,411
1.11 Using operational research findings to expand contraceptive choices	0	2,000,000	0	0	2,000,000		4,000,000	44,823
1.12 Using operational research to follow up PP women and defaulters	3,000,000	0	0	0	0	0	3,000,000	33,617
1.13 Conduct operational research on implementing task shifting in FP (minimum 1 year of complete implementation followed by evaluation of the outcome)	7,000,000	3,000,000					10,000,000	112,057
1.14 Performance evaluation of SBAs on provision of IUCD services	5,000,000						5,000,000	56,029

RESEARCH AND INNOVATION	2015	2016	2017	2018	2019	2020	Total NPR	Total USD
1.15 Performance evaluation of medical officer on provision of NSV services		5,000,000					5,000,000	56,029
1.16 Further analysis of NDHS 2016 on relevant issue			2,000,000				2,000,000	22,411
1.17 Improving women and men's understanding of the risk of pregnancy at different time during the life course and during the menstrual cycle (fertility awareness)	89,500,000	89,500,000	89,500,000	89,500,000	0	0	358,000,000	4,000,000
1.18 Market segmentation study to describe the current market and service providers for FP in Nepal	17,840,000						17,840,000	200,000
Total	**150,840,000**	**103,500,000**	**91,500,000**	**98,500,000**	**2,000,000**	**0**	**446,340,000**	**4,990,004**

Source: TWG estimates and OPM calculations

ANNEX H

SCENARIO MODELLED

Assumptions (50% MCPR by 2021)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
CPR, all methods	49.7	49.8	49.9	50.0	51.1	52.1	53.2	54.3	55.4	56.4	57.5
CPR, modern methods	43.2	43.3	43.4	43.5	44.4	45.3	46.2	47.2	48.1	49.0	50.0
TFR	2.6	2.6	2.6	2.5	2.5	2.4	2.3	2.3	2.2	2.1	2.1
Unmet need	27.0	26.9	26.9	26.8	26.2	25.5	24.8	24.2	23.5	22.7	22.0
Demand satisfied by modern methods	56.3	56.4	56.5	56.6	57.4	58.4	59.3	60.1	61.0	62.0	62.9

FP Method Mix	2016	2017	2018	2019	2020	2021
Condom	10.2	10.3	10.3	10.4	10.4	10.5
Female sterilization	30.9	29.9	28.9	27.9	27	26
Injectable	21.5	21.6	21.7	21.8	21.9	22
IUD	4.5	4.8	5.1	5.4	5.7	6
Male sterilization	18	18	18	18	18	18
Implant	5.3	5.8	6.3	6.8	7.3	7.8
Pills	9.7	9.7	9.7	9.7	9.7	9.7
Total	**100**	**100**	**100**	**100**	**100**	**100**

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