

**The Centre for
International
Public Health Policy**



DRUG PROCUREMENT IN NEPAL

Working paper 1b, prepared for Workshop on 'Tracing Pharmaceuticals in South Asia'

2-3 July 2007, University of Edinburgh

Funder: ESRC / DfID

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<http://www.health.ed.ac.uk/CIPHP/ourresearch/DFIDESRCtraps.htm>

1. Introduction

This paper is our first attempt to synthesise and summarise what we know of the drug procurement and distribution system(s) in Nepal. It is based on our interviews with retailers, wholesalers, company representatives and other key stakeholders in the process, as well as reports and other writings that we have tracked down in Nepal during visits to institutions and organizations that have commissioned reports and studies. Visits to government representatives and a field visit to the district of Kavre are also incorporated to fill out the scenario. While the public health system relies on vertical health programmes (in the context of Nepal various assemblages of international organizations support and assist a range of programmes), in 1993, the Ministry of Health established the Logistic Management Division (LMD) as a single unit dealing with logistic activities. This move has led to a partial consolidation of the public procurement system, which can thus be described in some detail. None-the-less the picture that emerges of the procurement system in Nepal is quite fragmented. We identify here for the purposes of discussion three inter-related procurement systems - government, NGOs/INGOs, and private – if they can be called systems at all. We highlight where we can the official regulatory structures, and what seems to be happening in practice

There remain, however, crucial differences that exist for the three drugs under our study that require further study. In the context of RIFLOX, rifampicin and oxytocin are on the Nepal essential drugs list. With rifampicin, the government currently applies for and receives grants from the Global Fund (GF) to pay for drugs procured through the Global Drug Facility (GDF), which mediates the procurement and quality control of rifampicin. The Nepali government, supported by the WHO and other multilateral, bi-lateral and INGOs, through the National Tuberculosis Programme (NTP) and the National Tuberculosis Centre (NTC) gets rifampicin and distributes it to public health facilities over the country via its DOTS programme. Oxytocin is procured by the government bodies and supplied to public health facilities with differing institutional support from organizations concerned with Maternal and Child Health issues. Fluoxetine is not included in any national programme and of the three drugs its procurement and distribution lies most outside of the any national and programmatic control.

2. Public procurement

For political and administrative purposes, Nepal is divided into five developmental regions: Eastern, Central, Western, Midwestern and Farwestern regions. Across regions there are 75 districts, 3,912 Village Development Committees (VDCs) and 58 Municipalities. The district health office has responsibility for the health outlets of each district; these include the district hospital, Primary Health Care Centres (PHCs), Health Posts (HPs) and Sub Health Posts (SHPs). Nepal's essential medicines list contains 310 items. Each facility, depending on its level in the system has a prescribed list that it is required to keep in stock. The essential list for District Hospitals, for example, contains medicines for advanced tertiary care, while SHPs are stocked with a limited range of medicine for outpatient primary care.

There are currently three mechanisms in place for government procurement to the system described above in Nepal:

- Central push system
- District level procurement
- Community Drug Programmes

2.1 Central push system

The Logistic Management Division (LMD) is responsible for all the supply of equipment, essential drugs, contraceptives and vaccines to government hospitals and to the primary health care facilities (Interview, LMD, Kathmandu, 26 January 2007). More specifically, the LMD is responsible for the purchase and supply of equipment, contraceptives, vaccines and essential drugs to health units over the country (Full Bright Consultancy, 2006). Annually, the LMD procures drugs for about 12 crores rupees and allocates additional 800 to 1000 thousand rupees to the districts to procure drugs (Full Bright Consultancy 2006). Drugs from these two channels are supplied to 4014 public health facilities over the country: 187 PHCs, 698 HPs, and 3129 SHPs. Their key partner in this is KFW Entwicklungsbank.¹ All the stock procured by the LMD is

¹See http://www.kfw-entwicklungsbank.de/EN_Home/Countries_and_Projects/Asia/South_and_Central_Asia/Nepal1/GPKD_2231%2b17500%2b18889_BasisgesundheitsprogrammI-III.pdf.

supplied to five Regional Medical Stores (RMS): Biratnagar, Hetauda, Butwal, Nepalgunj and Dhandadi, which are responsible for the supply of the supplies to the districts under their jurisdiction. The RMSs distribute drugs and equipment through a push system to all health units within their region, including primary health centres, health posts, and sub-health posts. In the push system, all health facilities of the same rank receive the same amount of drugs irrespective of their actual consumption. This, of course, led to oversupply of some units and undersupply of others. In 2003, a pull system was introduced, in which health facilities demand drugs from the District Public Health Office (DPHO) according to their consumption. According to the Full Bright (2006) report, the two systems are used simultaneously.

The public sector employs several supply channels:

- LMD -> RMS -> DPHO -> Health facilities
- NFHP -> DPHO -> Health facilities
- INGO -> DPHO -> Health facilities
- DPHO -> Health facilities
- INGO/NGOs -> Health facilities
- CDP -> Health facilities

Key: LMD – Logistic Management Division, RMS – Regional Medical Stores, NFHP - Nepal Family Health Program, DPHO – District Public Health Office, CDP – Community Drug Programme

Vertical programmes, like the malaria programme provide their drugs “in coordination” with this division by calling for tender for them according to their rules and regulations. Other drugs are provided “in kind” by donor agencies, and for their distribution the transportation this is put out to tender (Interview, LMD, Kathmandu, 26 January 2007). TB drugs, which are supplied in kind, and have a separate recording, reporting and ordering system have less difficulty with central supply than others.

The rules for tender have been laid out in the “citizen charter” which since the last two years each government division now has to have prominently displayed. The process is two fold; i)

sealed quotation and ii) sealed tender. Drugs worth less than one lakh are bought through quotation and above one lakh through tender. The companies and drugs should be registered with the Department of Drug Administration (DDA) and have WHO-GMP registration. However, the LMD still buys direct from Nepal Drugs Limited, but otherwise puts out to tender: “It is registered in the DDA and a state run company. We do not compare Nepal Ausadhi with other companies” stated the Chief of the LMD in interview (Interview, LMD, 15 April 2007). Besides the exception with Nepal Aushadi Ltd. the LMD have difficulty buying from other Nepali companies because so few have GMP certification. The main problem with Nepal Drugs is not with quality, but that they cannot produce the required quantities: “If we are buying medicine from Royal Drug Limited, we just request price list from there. It is the government company. Prices are fixed, and we are sure about the quality of the products. The problem with Nepal Aushadi Limited is that they can not supply as per our need or demand” Interview, LMD, 15 April 2007).

Sealed Quotation involves the purchase of the bid document (Rs 300), and the following documentation: Application form duly filled out and signed by the bidder; valid certificate of firm registration; valid income tax certificate; valid VAT registration certificate; bank guarantee paper or Earnest money deposit having 25% of the bid price; others as per sealed quotation notice published in newspaper. This should be supplied within 15 days of the first notice published in the papers. The remarks include non refundability of the cost of documents, and that 1.5% of total contractual price is to be deducted as advance tax.

Sealed tender has a tiered price for the bid document, depending on amount: 1500 Rs for 10 lakh to 1 crore bids; 2000 Rs for 1 crore to 3 crores; Rs 4000 for more than 3 crores. Documents required include: Application form duly filled out and signed by the bidder; valid certificate of firm registration; valid income tax certificate; valid VAT registration certificate; Manufacturer’s authorization letter as specified in the bid documents (for supplier); valid import license; manufacturing and product license (for supplier); valid import / marketing license; bank guarantee paper as Earnest money deposit having 2.5% of total bid price but in the case of KFW funded purchase 5% of the total bid price; bank guarantee paper as performance bond having 5% of total contract price but it shall be 10% in case of KFW funded purchase; others as per tender notice published in newspapers. This should be within 30 to 90 days of first notice published in

national newspaper. The remarks include non refundability of the cost of documents, and that 1.5% of payment made shall be deducted as advance tax deduction at source and 5% of the payment shall be retained as retention money, which will be released after 3 months to 1 year of completion of contractual work for all national and international bidders.

They have a recording and reporting system, as explained by the chief of the LMD:

“We have a management information system. As you know we have four thousand numbers of VDCs. In these four thousand VDCs, there is at least one health institution, be it health post or sub-health post. Every three months, they have to send us data on the access of these drugs and equipments. Based on this we form a pipeline report which we discuss with donor agencies as well. We have minimum stock level of all items. For example, for contraceptives we have minimum stock level for two years. We have separate level for essential emergency equipments. We have registers also. Well, I don't have those registers here right now. In these we have specified, Emergency order level, risks order level” (Interview, LMD, 26 January 2007).

This procurement system, however, is very inefficient. For example the media in Nepal regularly reports on the deficiencies in the system, including the following: A lack of medicines in the far west of Nepal, where health posts in Kanhanpur only had paracetamol and anacids (Gorkhapatra 2004); the absence of all medicines from the district hospital, and health posts of Mugu district, which with the resultant absence of medical staff has resulted in the facilities being used to keep cattle in (Kantipur 2005a); In Rolpa, Rukum and Salyan medical shops are looking like “tea stalls”, openly selling banned drugs that have come across the border from India (Samacharpatra 2003); Transportation blockades in the Mid and Farwestern districts leading to stockpiling of drugs in the central offices (Kantipur 2005b); Patients from Bhojpur district having to travel to other districts for treatment because of the absence of essential medicines due to lack of transportation (Kantipur 2005c, Kantipur 2004a); Demands that because of the lack of government drugs in Jumla Hospital that health workers be allowed to procure their drugs privately without interference (Kantipur 2004b). These are a few examples among many.

On a visit to Kavre district by the Nepal research team in April 2007, the centrally procured drugs due in October 2006 had not yet arrived. The store manager in the District Health office suggested that the delay was caused because the tender process was delayed; the government did not call for tender on time, and that further delays might have occurred because of the LMD has to approve the process (Interview, District Health Office, Kavre, April 2007). Another district worker said that the problem was with the “paperwork” of the companies that applied for through the tender and so the process has to be repeated three times.

The chief of the LMD was defensive when we said hat we had heard that some drugs arrive so late they have expired:

“No, no no... that’s a very wrong message; because one of the criteria when we buy drugs is that there should be 18 months time for its expiry. At times we also ask for the sample of drug and send it for quality testing sometimes in Delhi, and then only we buy these drugs. If some drugs go beyond our norms while testing its quality then we return those drugs and also keep them in our black list. It is a very strictly followed process” (Interview, LMD, 26 January 2007).

When we asked her specifically about the delay in Kavre district on our second visit to the LMD she again was defensive and answered with political expediency:

“Supply of medicine is a lengthy process. We plan for the next year. For example, we buy medicine this year and make supply arrangement for the next year. Planning process is very important. If we are procuring medicine from third country it takes four months for the supply process. Similarly, tendering and quotation process has its own standard rules and regulation. At least three suppliers are necessary to proceed further. If we don’t get three suppliers we have to re-tender it. After completion of this process, it takes three months for the national suppliers and four months for the international suppliers. The supplied medicine is checked randomly by the quality control division. To test the quality of supplied condom, for example, three different lab tests should be completed” (Interview, LMD, 15 April 2007).

Another problem is the quality of drugs, or perception of quality. For example Manoj used to get contracts, but health workers were always complaining of the standards of their drugs. But once that contract is agreed there is nothing that the ministry can do about it; to break the contract would result in legal action against the government (Interview, UNICEF, April 2007). During Ian Harper's fieldwork for his PhD in Palpa district there was a widespread perception that government drugs were of poor quality, prompting many to prefer the mission hospital drugs or to pay for private drugs.

On being asked what the three greatest difficulties the LMD faced, the Chief replied:

“The main difficulty of LMD is to make regular, effective and efficient supply of medicine from central level to district level. Year round availability of medicine is a major problem of LMD. We had done need analysis. If we are going to supply medicine and equipment as per need, we need Rs. 100,000,000. But if you look the budget of last year, we had the budget of only Rs. 40,000,000, only 40% of the demand. If we could not get above mentioned budget we would not be able to supply medicine and equipments as per need of the hospitals. Secondly, we have started to develop Logistic Management Information System (LMIS) in all districts. We also have Nepal Health Sector Plan (NHSP). If we get budget we can fulfill the mission and vision of LMIS and NHSP. If not, we are supposed to cut down the program” (Interview, LMD, 15 April 2007).

2.2 District Level Procurement

In addition to the drugs supplied by the centre, the government allocates an additional 8-10 lakhs per year for the districts to procure their own drugs. The district office is responsible for the procurement of these drugs through tender, ostensibly dependent on the demands of their health facilities. In our visit to Kavre this separate and decentralized component of drug procurement has been able to overcome some of the limitations with the inefficient central supply mechanisms. We were told that some medicines they tender from here; 8-9 companies apply after this tendering process and they choose which ever ones are “good and cheap”.

None-the-less all the drugs for the health posts pass through the district office and the system remains inefficient. We witnessed an exchange between two Community Medical Assistants (CMAs) from health posts who argued with the store keeper over drugs. He apologized for some of the medicines that were misplaced while being sent to the health posts. He explained to them that this was his first time as he himself is new to the job so he had given some of the medicines for someone to take and some of the medicines were missing. He also convinced the CMAs that such mistake would not be repeated. Following this we asked when and how goods got from the store out to the health posts and he said that when the staff come to collect their salaries, and at the same time they pick up the drugs from the stores.

2.3 Community Drug Programmes (CDPs)

In addition, since 1995 the government has been implementing CDPs as another mechanism to overcome the deficiencies in the system. These CDPs are supported by assemblages of organizations, including UNICEF and the Swiss Development Corporation (SDC). Other “partners” include GTZ, and others, making this national programme a complex of institutional assemblages. Some financial assistance comes from the World Bank “pool fund”.

For example UNICEF piloted one CDP in 1996 in Nuwakot District, which was a feasibility study for user fees (Interview, UNICEF, April 2007), along with BNMT who had also been piloting these ideas in East Nepal since the early 1990s. After this UNICEF started this in each district they worked, as a component of their Child Health Programme, to 12 districts (Nepal has 75 in total). This was supported with a “cascade of trainings”. Procurement is done at the district level, and is a “complex mechanism”. At each district they identify wholesalers, and this list is given to all the Village Development Committees (VDCs). While cost and quality are important so is how close it is to the VDC.

Current problems with this, according to UNICEF, include the lack of local level political bodies at the VDC level, and the Community Health Management Committees (CHMDs) should have elected representatives on them. Secondly, the Maoists have disrupted activities in some districts as well (this is a locally dependent phenomena, not central directive it seems). Thirdly, there is the question of whether user fees have restricted access to drugs for the poor (which RK

says studies show conflicting results). Their experience is that in discussion with people locally, the drugs may not be reaching the poorest, and that the stipulated “exemption mechanisms” for payment, may not be being implemented. Fourthly, there has been resistance to the whole programme from the health workers themselves, as they also have their own private shops and it is not in their financial interests to support these programmes. RK says that although health workers may say that it is the Maoists who insist that they shut these programmes down, it is not impossible that this is just an excuse. This has resulted in UNICEF rethinking its current support, and it is no longer expanding the programme. To top this off, the Minister of Health, from the Jana Morcha party, is pushing for user fees to be dropped (Interview, UNICEF, April 2007).

On asking the Chief of the LMD about these difficulties, she replied:

“Different people have different attitude about the CDP in Nepal. But the situation is not same in all districts. In some places Maoists have supported our program and in some place they are against the CDP. We have started to conduct the comparative study of CDP and it takes few months to get the actual situation. Secondly, people do not have right information about CDP. There are certain provisions for the socially and economically disadvantaged people. They can get medicine free of cost. We have started to develop logbook about it. If there are misunderstanding and problems on it, it should be reviewed, corrected, made the program for the future. We have started to do that” (Interview, LMD, 15 April 2007).

The SDC have also been conducting research into two districts (managers see their work as attempting to influence health Sector policy at National level). In their analysis of the situation they found that there were only 3-4 months of drugs available at health posts, and that in rural areas staff have their own medical shops as well using health post resources for their own use (Interview, SDC, April 2007a). The government introduced the community drug programme, so that “community people” could change the situation and develop a “revolving drug fund”, and come to buy from their own channels with discounts. From the “people’s” perspective they get some drugs, and facilitate change. The SDC support several components in two districts: training for the Health Facility Management Committee (at VDC level); training for health workers on

drug management; provide logistical support; and support on how to store drugs. They have conducted “action research” as well into perceptions of people, political parties and others into the programme.

Another slightly more detailed picture emerged from their health advisor (Interview, SDC, April 2007b). The SDC follow the government strategy, and start with the district level Training of Trainers (DTOT) which lasts five days and is paid for by the SDC. From the DTOT, 16-20 people make their plans and head to the health posts and provide trainings to these staff. They form a committee for the CDP (this is necessary as per central policy), one of a number of committees under the rubric of health (others include DOTS, HIV/AIDS etc.). From this start, 51 VDCs in Dolakaha district, and 24 out of 34 trained in Ramechhap district have started the CDP. They are taught how to buy drugs, how to get discounts, what is on the essential drug lists (although the CDP is not limited to essential drugs). There is the problem, for example, of selling vitamin tonics. In the health advisor’s opinion the success or not of these programmes depends on the commitment of the Health Post in Charge and their commitment to the idea (Interview, SDC, April 2007b).

3. NGO procurement

While the NGO involvement in drug procurement is small there are two significant sized organizations that do so. Both are off shoots of INGOs, and one was the largest INGO in the country (United Mission to Nepal, UMN).

Medical Services for Management Trust – Nepal (MSMT) supplies drugs to sixty one different outlets. In April 2007, the date of the interview it had been independent of UMN for two years, but still supplied the same organizations (Interview, MSMT, 3 April 2007).

Social Action for Rural Health and Development (SARDHAN) has also been running independently of its parent INGO, the Britain Nepal Medical Trust for the last two years (Interview, SARDHAN, 5 April 2007). Unlike MSMT that has its particular UMN related supply chain, SARDHAN will procure for anyone. Their perception of the government chain above is very negative, and that it could be more efficiently organised through the non-governmental

sector. The chairman of SARDHAN described how difficult it was for his NGO: that no-one wants to buy through his NGO – there are no incentives and no bonuses so they don't like it, stating that there is no corruption in the NGO sector. They buy drugs through those companies who give good – personal – benefits. They bribe absolutely everyone, and the government officials want to be bribed. He gave the example of when he was in Bhojpur working with BNMT, and BNMT were able to supply cetrimide for 270 rupees per bottle. The government had receipts for 2,700 rupees! They had just added an extra zero on the bill they submitted (he has kept a photocopy of the bill). This was supplied centrally. The minister, secretary – everyone in the chain takes a cut in the “bribing chain”. In his opinion drug procurement and distribution would be much better managed in the NGO sector. SARDHAN's rate is cheaper than the market rate (i.e. the wholesale price). But they get asked – what will we get from you if we buy from you? They get told nothing and so they do not come. This is always the first question.

4. Private sector: roles and statuses in the retailing of drugs

The major source of pharmaceuticals regulation in Nepal is the Drug Act, 2035 BS (1978) which, among other issues, specifies legal procedures and measures related to manufacture, import and export, distribution and sale of drugs. This act also empowers the Department of Drug Administration to implement the Drugs Act, Drug Regulations and Codes. Drug Regulations include for example Drug Registration Regulations 2038 BS (1981) specifying procedures and requirements for drugs manufacturing and Regulations on Standards of Drugs 2043 BS (1986). Codes were made under Regulations and focus on Drug import, Registration of retail shops/firms, industries and products, Procedures of enquiry and investigation, and Quality and standards of drugs (Dixit 2000). Codes include Code for Manufacture of Drugs 2041 BS (1986) and Code for Sale and Distribution of Drugs.

As in India, the distribution system in Nepal is complex and roles of agents in the chain are overlapping and a specific agent might take several roles in the distribution of drugs. Actors in the drug distribution system recognize three levels in the distribution chain: super-stockists, stockists and retailers. The DDA, however, provides certificates only for two categories: retail (*Khudra*) and wholesale (*Thok*) business.

For example, Indian companies supply their own “super-stockists”, or companies that they pay to do this. From here the distribution channel is to wholesalers (or stockists) and then to the retailers. The distinction between these terms however, and the channels of distribution is by no means clear, as the following interviews suggest:

A stockist explains:

“There are two distribution channels in Nepal. One is that a company produces its products and forwards it to super-stockist. Super-stockists distribute it to stockists. We stockists forward it to retailers and consumers buy drugs from retailers. The second channel is that a company produces medicines. They then supply it directly to the hospitals. A company supplies to the hospital and from hospital it goes to the consumer” (Interview, stockist, Kathmandu, 5 April 2007).

The Norvic hospital pharmacist expanded on these channels, explaining:

“Some manufacturers are using manufacturer direct to retailers. Very few manufacturers have the practices of this direct to retailer, but it is mainly used for the large volume parenterals. That is saline, ringers, dextrose, dialysis fluids ... This is large volume fluids. The companies use this channel to save on the the transit costs. The main factor is in this product the government has regulated the prices. If they have the different levels of channels and agents, then they may hike the prices. Most of the companies are practising like this; from manufacturers to super-stockist to stockist to retailers. This distribution channel is practised by most of the Indian companies marketing in Nepal. Manufacturers appoint super-stockist, from there products goes to stockist and then is forwarded to retailers. Super-stockist is the main agent of the manufacturer of the Indian companies. Few companies of Bangladesh and Pakistan also follow this channel” (Interview, Norvic pharmacist, April 2007).

In this section we focus on official definitions and registration requirements specified by DDA as well as sector’s perceptions of various roles in the distribution system. We also refer to profit margins for specific actors in the distribution chain as reported by Rao and Thapa (2005).

4.1 Super-stockists/importers

“Super-stockists”, the term used by most wholesalers and others we interviewed are “importers” (term used by the DDA) or those who stock, market and distribute products of foreign pharmaceutical companies. Foreign companies are not allowed to enter the Nepali pharmaceutical market, they have to authorize a Nepali company/agent that will act of their behalf and will be responsible for any problems caused by the producing company (Interview, drug inspector, DDA, 6 February 2007). The Soaltee Group, for example, acts as a super-stockist for Ranbaxy (<http://www.ranbaxy.com>) and Eli Lilly (who produce vaccines, diabetic drugs etc); that is for drugs that are specialist and expensive (Interview, Soaltee Group, 10 November 2006).

In the Norvic pharmacist’s words: “The Indian manufacturer, who wants to market in Nepal, chooses a good agent. Once they decide to “channelize” the marketing work through him, then the company appoints him as a super-stockist or an agent. In common world we use the term Agent. We use the word super-stockist in medical term... They must register in the DDA. After the registration at DDA, they have to register in tax office” (Interview, Norvic pharmacist, April 2007).

Officially, ‘Instruction for the registration of the Manufacturing Company and their products which are to be imported in Nepal’, the foreign company should register with the DDA and specify a Nepali company (importer) that will act on its behalf in Nepal (Interview, drug inspector, DDA, 6 February 2007; Interview, wholesaler, June 2007). Documents such as manufacturing license of the foreign company, list of products intended to be registered in Nepal, wholesale registration of the importer have to be submitted along with the application form (DDA 2007). According to representatives of the Nepal Medical Sales Representatives’ Association, importers have to register with the drug brand name and not with the name of the foreign drug producer. This causes problems, because if a particular drug harms patients then the DDA can only ban the import of this specific drug but can not claim any compensation for the harm (Interview, NMSRA, 27 February 2007).

Importers pay 5% import tax, and add a distribution margin of 2.5% and on the top of it, a profit margin of 4.5% (see Table 1, p.18).

4.2 Wholesalers and Stockists

Wholesalers have to be registered with the DDA and are supposed to get a Permanent Account Number from the Tax Office. The DDA specifies criteria for the wholesaler pharmaceutical business in terms of education and training: literacy for those who have Retailer registration and want to expand their business as wholesaler, 'Certificate in Pharmacy' for new registration; an experience letter from a medical shop and 72 hours of orientation training provided by the DDA. These are official requirements but the practice might be in many cases different. Some wholesalers are still untrained. Those actually working in the business may not have license on their own but run the business on behalf of family members.

Looking at official statistics provided by the DDA, there are 1,125 registered wholesalers with less than one-fourth (264) located in Katmandu (DDA, 2006; the respective numbers were 1,878 and 647 in July 2005, DDA, 2005). These numbers include allopathy (855), veterinary (166), ayurveda (78), homeopathy (22) and unani (4) wholesalers.

The term 'wholesaler' that is used by the DDA, seems to be equivalent to 'stockist' and 'distributor'. The definitions gathered through interviews, suggest some differentiation. For example, "stockists" as those who only stock and do not sell products of pharmaceutical companies, while "wholesalers" market and sell products (Interview, producer, Kathmandu, 24 January 2007); distributors as a level in the distribution chain that is lower than stockists (Interview, producer, Kathmandu, 30 January 2007).

The maximum profit margin allowed for this level of the drug distribution chain is 8.5% (see Table 1, p.18). Producers and government representatives refer to slightly higher margins of 10% (Interview, producer, Kathmandu, 30 January 2007; Interview, drug inspector, DDA, 6 February 2007) or even 12% (Interview, producer, Kathmandu, 15 January 2007; Interview, producer, Kathmandu, 4 February 2007). Stockists also receive bonuses in the form of free products in addition to the allowed profit margin, which can increase their profit margin to 12-

13% (Interview, producer, Kathmandu, 4 February 2007). Thus the difference in the allowed margin and the margin observed by those involved in the process could in part be possibly explained by the in kind bonuses.

4.3 Retailers

Retailers have to register with the DDA. Similar to wholesalers, retailers have to complete at least 72 hours of orientation training provided by the DDA. According to the Chief of DDA, the government is aware that this training is inadequate and is taking steps to address the issue (Interview, DDA, 29 November 2006). We have heard widespread complaint that this training is not more widely available.

Official data by the DDA indicate that the segment of pharmacy outlets comprises 6,303 registered units with 843 units in Katmandu (DDA, 2006; the respective numbers were 11,940 and 1,742 in 2005, DDA, 2005; the difference caused by the exclusion of those who did not renew their registration in the 2006 list). The total official number comprises allopathy (4,957), veterinary (997), ayurveda (256), homeopathy (76) and unani (17) units. The Nepal Druggist and Chemist Association (NDCA) however reports more than 20,000 medical shops in Nepal. Most of these outlets are not managed by trained pharmacists, and our initial interviews and meetings with retailers suggests that many who actually do the work and dispense medicines are indeed untrained (and may be relatives of those in whose name the shop is registered). It was even suggested in one interview that employing family in the shops was the only way of keeping corruption and theft of stock under control. Unofficially there are far more unregistered outlets, and many of those no longer registered almost certainly still do dispense.

Officially, retailers have 16% profit margin but in addition, they demand a share of wholesalers' profits which increases their profit to 20-22% (Interview, producer, Kathmandu, 4 February, 2007).

The problem with retailers mentioned by producers and also Nepal Medical Representatives' Association is that retailers frequently substitute drugs according to their profitability. One of the reasons is probably the rent they pay. Medical stores in Kathmandu public hospitals, for

instance, pay NRs 400,000 – 500,000 monthly, and shops outside the hospital pay NRs 180,000 monthly. Such high rents it is acknowledged encourage the practice of substitution of drugs (medical representatives have mentioned that they notice the practice in particular outside the large hospitals, and that it makes their job more difficult).

5. Discussion

With this paper, which remains tentative and provisional, we hope to generate discussion to clarify directions for the next stages of the research. The diagram at the end is an attempt to represent the material presented in a pictorial fashion. It helps to visualize the complexity and interactions of the three “systems” we have described. There are a number of issues that arise as with the India scenario. It seems that the boundaries between these levels of practitioners is quite fluid. In rural and urban Nepal many people locally see the retailer as the local “doctor”, from where they can receive diagnoses, prescriptions and have their drugs dispensed. We have also witnessed wholesalers selling direct to consumers in a retailing capacity when asked. Would it help to look more at the paper chains, including that of prescriptions, but also the ordering and procurement forms as a means of understanding these connections? Would we be better to spend more time doing local ethnography as a way of telling stories of these relationships, rather than building up the “big picture”?

One issue that impacts on Nepal is the question of the “foreign” (nearly exclusively Indian) producer and their relations with the Nepal system and the nascent Nepali industry. The question of how counterfeit drugs enter the system has also been represented to us as a problem of Indian products that enter into the system at the wholesaler or retailer levels. Should we frame this solely as a problem of regulation, or look in more ethnographic detail at the nationalist and other “protectionist” issues that arise in attempting to protect the Nepal industry? We have addressed the question of quality and regulation more specifically in Working Paper 3.

Possible further avenues for discussion could include the following:

- 1) What a specific focus on the three drugs might add. For example, fluoxetine seems to be procured entirely through the private system. Should we look at the specific issues around pricing, and price hikes for this drug?
- 2) The extent to which we are able, or should, arrive at data for rifampicin procurement and distribution outside of the government DOTS programme?
- 3) The degree to which we are able to arrive at accurate data for the numbers of retailers and wholesalers, given the wide discrepancy between official statistics and the figures reported through our interviews?
- 4) Is it worth looking further at the question of “counterfeits”, and how they enter into the Nepal scenario? Should this include the ways that actors in the system get around the official licensing and other regulations?

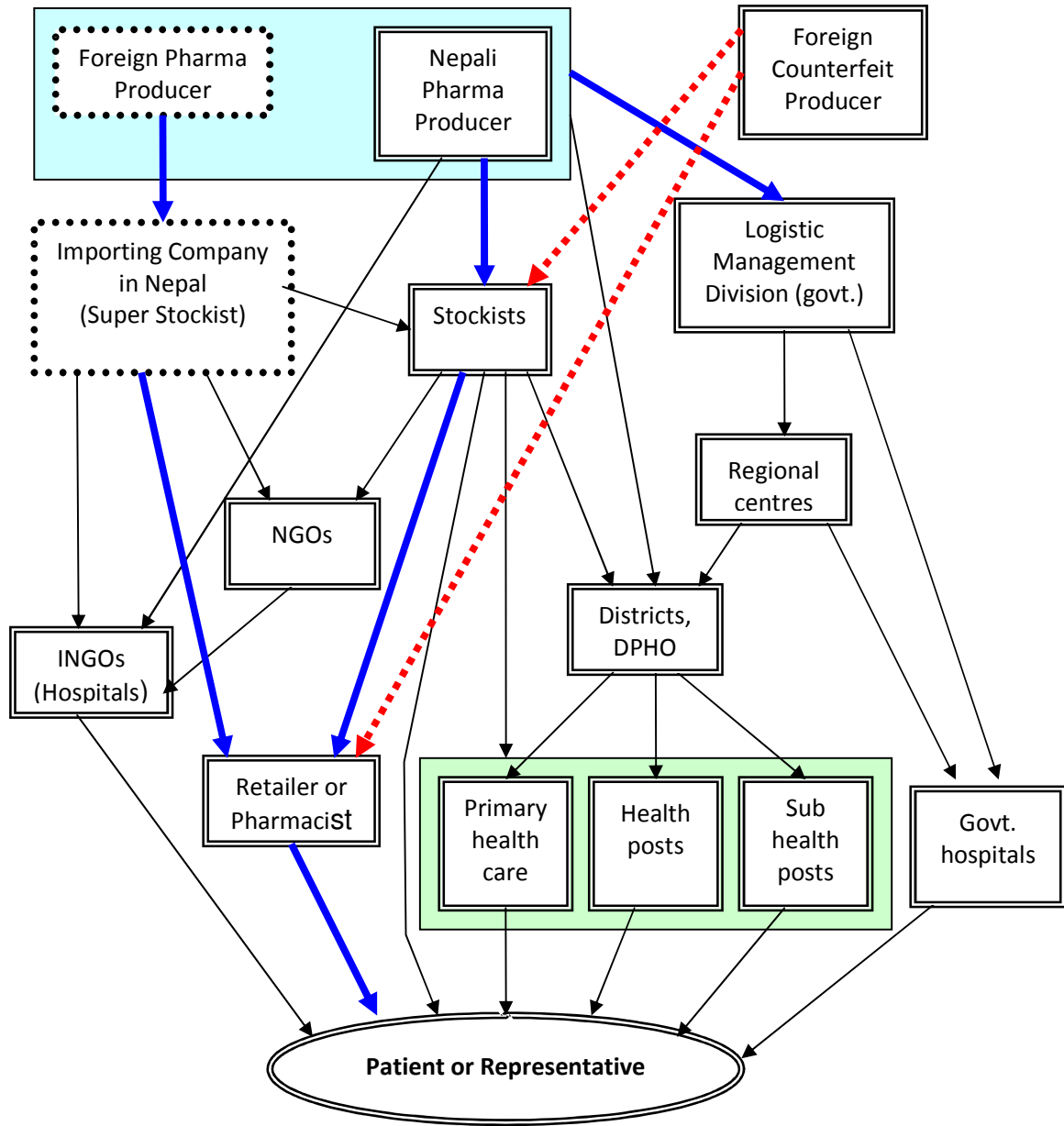
Table 1: Maximum Private Sector Margins

Entity	Price Component	% Mark-Up	Cumulative % on Price
International	CIF/CIP Index Price	0	100.0
HMG Nepal	Import Tax	5	105.0
Importer	Distribution Tax	2.5	107.6
Importer	Profit Margin	4.5	112.5
Wholesaler	Profit Margin	8.5	122.0
Retailer	Profit Margin	16	141.6
Cumulative Mark-Up		37	42.0

Source: Rao and Thapa (2005) ‘Nepal: Reproductive Health Commodity Pricing Survey

Notes: Cost, Insurance, and Freight (CIF)/ Carriage and Insurance Paid to (CIP)

Diagram: Patterns of distribution of pharmaceuticals in Nepal



Key

- ➔ Main channels
- ➔ Other channels
- ⋯➔ Channels for counterfeit drugs

References

- DDA (2005). 'Pharmaceutical Industries up to June 2005,' *Drug Bulletin of Nepal* **17**(1): 5-7.
- (2006). 'Number of registered Pharmacy Outlets (upto Ashad 2063).'
- (2007). 'Form No 1: Instructions for the registration of the Manufacturing Company and their products which are to be imported in Nepal.'
- Dixit, H. (2000), "Nepal's Quest for Health," (<http://www.hdixit.org.np/quest/ANNEX-1.pdf>), Last accessed on 22 June 2007.
- Full Bright Consultancy (2006). *A survey of availability, distribution, use and management of drugs, vaccines and medical supplies in government health facilities*, Report prepared for the Ministry of Health and Population, Government of Nepal, July 2006.
- Gorkhapatra (2004). "Deficiency of medicines since last year: Only Amgit and Cetamol available," Gorkhapatra, 2 May.
- Kantipur (2004a). "Insufficient medicines in Health Posts," Kantipur, 29 November.
- (2004b). "No medicines at Jumla Hospital," Kantipur, 5 December.
- (2005a). "Health Centers of Mugu: without any medicines," Kantipur, 3 April.
- (2005b). "Difficulties to deliver medicines to West Nepal," Kantipur, 24 February.
- (2005c). "Deficiency of medicines due to lack of transportations," Kantipur, 20 February.
- Samacharpatra (2003). "Irregular distribution of medicines in rural areas," Samacharpatra, 30 July.
- SAWTEE (2006). *WTO and public health policy priorities for Nepal*, Prepared for the Ministry of Health and Population, Government of Nepal, 10 February.
- USAID & DELIVER (2005). *Nepal: Reproductive health commodity pricing survey*, Presented to the Nepal RH Commodities Technical Advisory Group, 30 June.