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Rapid Assessment of the Demand Side Financing Schemes: AAMA Programme and 4ANC

FINAL REPORT

Strengthening Health Systems-Improving Services

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The Authors

EXECUTIVE SUMMARY

Nepal has made significant gains in maternal health. Improvements in maternal health services and the investment in safe motherhood programmes are believed to have contributed to these gains. Demand Side Financing schemes (DSF) in the Family Health Division's safe motherhood programme started under the name Maternity Incentive Scheme (MIS), which has now evolved into *Aama Surakshya Karyakram*, which has been implemented in government health facilities nationwide and in some accredited non-state hospitals. This Rapid Assessment (RA) is the sixth in a series conducted to assess the Aama programme and DSF schemes; it is the first to assess the 4 Antenatal Care (4ANC) programme implemented by the Ministry of Health and Population (MoHP). It is primarily a part of the monitoring of the programme, conducted to assess the current status of implementation of *Aama Surakshya Karyakram*.

The assessment was carried out by the Health Research and Social Development Forum (HERD). A research team from HERD was responsible for data collection, tool adaptation and development, training of enumerators, field implementation, data management and analysis, and report writing. Support for this process was provided at various stages by the Nepal Health Sector Support Programme (NHSSP) and the Family Health Division (FHD).

The assessment was conducted in six purposively selected districts of Nepal. A total of 48 health facilities were sampled comprising 24 Health Posts/Sub Health Posts (HP/SHPs), 12 Primary Health Care Centres (PHCCs), 7 public and 5 private hospitals. The main participants for this RA were women who had delivered in the last six months at a health facility and women who had delivered at home with assistance. For Institutional Delivery (ID) and Home Delivery (HD), cross verification was carried out at two levels: between the District/Public Health Office (D/PHO) and health facility records; and between the health facility records and women in the community. The sample also included women who had recently delivered and had not yet been discharged from the facility. Moreover, data was collected from different sources including district programme people, focal persons, health facility in-charges, care providers, health facility management committees and record reviews etc.

A five day training programme was provided to the enumerators and study team. After translation, the tools were pre-tested and finalised accordingly. Field work was conducted between 9th May 2012 and 7th June 2012. The central support team visited each of the districts to ensure quality control and to deal with any issues arising. All quantitative data from the questionnaire was double entered by a team of data clerks using 'EpiInfo', and provided to the enumerators and study team. After translation, the tools were pre-tested and finalised accordingly. Field work was conducted between 9th May 2012 and 7th June 2012. The central support team visited each of the districts

One of the findings of the assessment is that the current Aama guidelines do not address the 4ANC programme which is expected to be incorporated in the next Aama guidelines revision. The RA found inconsistent practices in terms of fund disbursement from D/PHOs to health facilities resulting in fund deficits at the D/PHO and health facility level. The procedures for these should be clearly detailed in the revised guidelines and practiced accordingly. Compared to the Aama programme, the 4ANC programme is poorly implemented in all facilities, primarily due to the difficulty in meeting the criteria required to receive the 4ANC incentive. This indicates a need to review the criteria while considering the women at delivery. Women have adequate knowledge about the Aama transport incentives and free delivery care but very limited awareness of the 4ANC programme and limited uptake; only 13% of women who had delivered in a health facility received the 4ANC incentive. Therefore, locally appropriate mechanisms should be maximised to reach women. A proper review of the Aama and 4ANC programmes within the private sector is required before considering scale-up because the programmes are being implemented with poor orientation and some institutions were found to be running them at a loss.

On the programme management level, Aama guidelines are not available in some districts while few of the district level or health facility staff had received specific orientation. Thus, wider dissemination and orientation are needed for proper implementation.

Not all women are receiving free delivery care; overall, 23% are still paying some costs for their delivery. Explanations provided by the Health Facility Management Committees (HFMCs) on how the unit costs are used to cover services and the distribution of the incentive among staff were not always clear. This may provide a grey area that could facilitate the misappropriation of funds. Hence, improved orientation to the HFMC chair and members on the uses of the institutional unit cost as specified in the Aama guidelines is immediately required. On the planning and budgeting aspects, this RA found that those districts involved in developing their own plans and budgets for the Aama programme were more likely to manage their budget well and have less fund deficits throughout the year. This indicates a need for the Department of Health Services/Family Health Division (DoHS/FHD) to consider engaging D/PHOs to develop locally appropriate and locally owned plans and budgets for the Aama and 4ANC programmes.

On reporting, monitoring and supervision, mismatches were found between districts and the health facilities within them (overall 10% of cases) and between the health facilities and the women (overall 5%), but this should not be interpreted as a misuse of funds since human error could be a factor. A strengthening of reporting systems and regular monitoring with cross verification are needed in order to deter any misuse of funds. Only a minority of facilities reported having regular monitoring and supervision in relation to the Aama programme which undermines the motivation to complete the annexes properly and to report on time. Health facilities should be regularly monitored and supported to ensure that all annexes are completed accurately and in a timely fashion. Overall, only 54% of facilities publicly display the Annex 10 (information of women delivered in a health facility) which limits public accountability of the Aama programme. This could be improved through routine monitoring and supervision visits and through the full engagement of HFMCs in the process. Likewise, monitoring and supervision support from the central and regional Aama Focal Persons (AFPs) was very limited and a review of central and regional monitoring and supervision arrangements is required to ensure that district staff are supported and supervised in implementing the Aama and 4ANC programmes with a focus on underperforming districts.

Review of the implementation aspects revealed that in the Tarai districts, and contrary to the Aama guidelines, most of the disbursed incentives are given to husbands or other relatives. This must be addressed by exploring appropriate ways to ensure that the guidelines are properly followed. It is found that home deliveries are still taking place without being reported. Therefore, health care providers assisting delivery at home should be encouraged to report assisted home births as a Health Management Information System (HMIS) reporting requirement, rather than solely as a means of accessing an incentive.

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LIST OF ACRONYMS

AFP	Aama Focal Person
ANC	Antenatal Care
APH	Antepartum Haemorrhage
AWPB	Annual Work Plan and Budget
CMR	Child Mortality Rate
CS	Caesarean Section
DoHS	Department of Health Services
D/PHO	District (Public) Health Office
DSF	Demand-side Financing Schemes
DTACO	District Treasury and Account Control Office
FCGO	Financial Comptroller General's Office
FCHV	Female Community Health Volunteer
FHD	Family Health Division
GDP	Gross Domestic Product
GoN	Government of Nepal
HDI	Human Development Index
HERD	Health Research and Social Development Forum
HFMC	Health Facility Management Committee
HDC	Hospital Development Committee
HPI	Human Poverty Index
HW	Health Worker
HF	Health Facility
HMIS	Health Management Information System
HP	Health Post
ID	Institutional Delivery
KII	Key Informant Interview
MDG	Millennium Development Goal
MIS	Management Information Section
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
NDHS	Nepal Demographic Health Survey
NHRC	Nepal Health Research Council
NHSSP	Nepal Health Sector Support Programme
NPC	National Planning Commission
NPR	Nepali Rupees
PHCC	Primary Health Care Centre
PNC	Post Natal Care
PPH	Postpartum Haemorrhage
PPS	Probability Proportionate to Size
RA	Rapid Assessments
RDW	Recently Delivered Women
SDIP	Safe Delivery Incentives Programme
SHP	Sub Health Post
SBA	Skilled Birth Attendant
SPSS	Statistical Package for Social Sciences
THW	Trained Health Worker
TL	Team Leader
TSA	Treasury Single Account
WRA	Women of Reproductive Age

SECTION ONE: BACKGROUND

1.0 BACKGROUND

Nepal has made significant gains in maternal health. Between 1997 and 2006 the Maternal Mortality Ratio (MMR) decreased from 539 to 281 per 100,000 live births (MoHP, New ERA, Macro Int. 2007). Notably, Nepal is one of the 10 countries to have already reached the Millennium Development Goal (MDG) target of reducing MMR by 75% between 1990 and 2015. Nepal achieved a 78% reduction by 2010 (WHO Trend in Mortality 2012). Improvements in maternal health services and the investment in safe motherhood programmes are believed to have contributed to this progress.

1.1 THE AAMA PROGRAMME AND 4ANC

The Government of Nepal (GoN) has made considerable headway in the development of national policies and programmes to promote safe motherhood, including Demand-side Financing Schemes (DSF). The Aama programme was established in 2005 under the name Maternity Incentive Scheme (MIS) and was later renamed as the Safe Delivery Incentives Programme (SDIP). It provides incentives to women to deliver in health facilities in order to improve their health outcomes and those of their babies. Furthermore, in January 2009, user fees were removed for all types of delivery in government health facilities nationwide and the scheme was extended to include some accredited non-state hospitals.

Antenatal Care (ANC) from a skilled provider is important to monitor the pregnancy and reduce the risk of morbidity for mother and baby during pregnancy and delivery. The quality of ANC can be monitored through the content of services received and the kind of information mothers are given during their visit. The World Health Organisation (WHO) recommends that a woman should have at least four ANC visits to detect health problems associated with pregnancy. In the event of any complications, more frequent visits are advised and admission to a health facility may be necessary. Over the past 15 years, there has been a five-fold increase in the percentage of women with four or more antenatal visits during their pregnancies (from 9% in 1996 to 50% in 2011). However, uptake of four or more ANC visits is higher in urban areas (75%) than in rural areas (48%) (NDHS, 2011). To further stimulate the uptake of ANC visits, the Government of Nepal (GoN) introduced the 4ANC incentive programme in July 2009. A mother is entitled to NPR 400 if she completes 4ANC visits as per the ANC protocol (first at 4th month, second at 6th month, third at 8th month and fourth at 9th month of pregnancy) and has an Institutional Delivery (ID) and a 1st Post Natal Care (PNC) visit (DoHS/FHD 2068/69).

1.2 DEMAND SIDE FINANCING IN MATERNAL HEALTH AND PREVIOUS RAPID ASSESSMENTS

Demand Side Financing aims to reduce barriers that prevent users from accessing care as required. The schemes typically target poor and underserved populations (Gupta, I 2010). DSF has been referred to in different ways throughout the literature: output-based aid, conditional cash transfers, vouchers, consumer-led DSF and provider-led DSF. Some reviews suggest that DSF is effective in reducing the financial barriers that prevent beneficiaries from using a particular service or intervention (Ensor, T 2005). Thus, DSF is gaining in popularity in developing countries, especially in Health and Education Services (Bhatia, M R 2006). For instance, in recent years, a number of low-income countries - Bangladesh, Bolivia, Cambodia, India, Kenya, Pakistan and Nepal - have adopted DSF schemes to increase access to essential maternal health services and to enhance equity in service utilisation (Ahmed, S 2010). Some schemes also introduce incentives to health-care providers to identify eligible women and provide maternal health services (Schmidt, J O 2010). Although DSF schemes have been found to be effective, many challenges to implementation remain. In particular, managing fiduciary risks is often a challenge, which is more complex when monitoring mechanisms are weak in the system.

Nepal's health sector has a long tradition of DSF-like schemes. In addition to the Aama programme, the MoHP now implements schemes for 4 ANC Visits, Multi-Drug Resistant TB, Kala Azar and Uterine Prolapse. These schemes typically consist of output-based payments to service providers and demand-

side payments to consumers. Each scheme is organised and operated by a separate division under the DoHS. However, the study reported here examines only the Aama and 4ANC DSF schemes.

Previously, various "Rapid Assessments" (RA) have been conducted (2008, 2009 and 2010) to cross verify institutional delivery and the incentives women receive. On cross verification of both institutional and home delivery claims, the percentage of mismatched claims for institutional deliveries fell from 24% to 14% (RA IV, June 2010) - a 10 point reduction, which is impressive but still represents a 14% mismatch. Likewise, the percentage of false claims for home deliveries fell from 54% in RA III to 38% in RA IV – a 16% reduction. The drop in mismatch in home deliveries could be explained by a combination of policy changes that occurred between the two surveys: a reduction in the incentive amount for the health facility staff from NPR 300 to NPR 200, and additional safeguard mechanisms i.e. the requirement to submit birth registration certificates. However, the lowest measured prevalence of a 38% mismatch between home deliveries reported by facilities and by women remains high and requires further improvements in governance and financial management systems.

The previous studies also found discrepancies in the timing of fund flow where mothers who knew about the transportation incentive before the delivery received the incentive immediately after delivery, whereas mothers who did not know about the scheme received the incentive later or not at all. While assessing the cross verification of institutional delivery cases, false claims still amounted to 4%; nearly 8% of payment dates (and nearly 4% of mode of payments) did not match the official records (DoHS 2066/67). There is also a risk of institutions over-reporting deliveries, double-charging for deliveries (a user charge to clients and a fee charge to MoHP) and over performing Caesarean Sections (CS) because the facility and provider incentives for CS are higher than those for normal deliveries. CS rates have increased from 20% in 2009/10 to over 33% in 2010/2011, with many being performed in private hospitals.

In 2010, Powell-Jackson et al provided an early evaluation of the Aama programme with the following key findings:

- Women's awareness of the cash incentive during pregnancy rose from 14% in July 2005 to 64% in February 2010.
- Awareness of free delivery care during pregnancy was low, estimated at 27% between July 2009 and February 2010.
- There is inequality in terms of who has heard about free delivery care. The women least likely to have heard of free delivery care live far from a health facility, and are comparatively uneducated, poor and Muslim.
- The proportion of facility births where women could receive the cash incentive rose from 20% in July 2005 to 67% in February 2010.
- Delays in receiving the money fell from an average of 93 days in July 2005 to 2 days in February 2010.
- The rate of institutional delivery care increased from 33% to 54% (a 21 point increase) from 2005 to 2010. In the low Human Development Index (HDI) districts, the rate increased from 6% to 21% (a 15 point increase) over the same period.

While causal linkages between the implementation of the Aama programme and the increase in institutional delivery cannot be assumed from this cross-sectional data, Powell-Jackson et al also conducted modelling which attributed increases in institutional deliveries to the introduction of free care in 2008, and then further increases to the introduction of financial incentives under the Aama programme.

In the Nepal Demographic Health Survey (NDHS) 2011, a series of questions on care and support during delivery were asked to women with respect to their last birth in the two years preceding the survey. This

data was used to determine the effectiveness of the government's programme promoting maternal health through the Aama programme. Information was collected when women received cash incentives for their most recent birth at any health facility (government, non-government or private) and when women gave cash payments to any health facility where their delivery took place. The study found that 71% of mothers received payment to cover the cost of transportation to a health facility. 73% of rural women received transportation incentives, compared to 60% of urban women. Similarly, women living in the mountain zone and the mid-western region were more likely to have received cash incentives than women in other areas. 40% of women reported paying cash to the health facility where they delivered. Urban women and women in the Tarai were more likely to pay cash for delivery services than rural and mountain women. As expected, women with higher levels of education and wealth were less likely to use the government provided free services (NDHS, 2011).

1.3 OUTLINE OF THE AAMA AND 4ANC PROGRAMMES

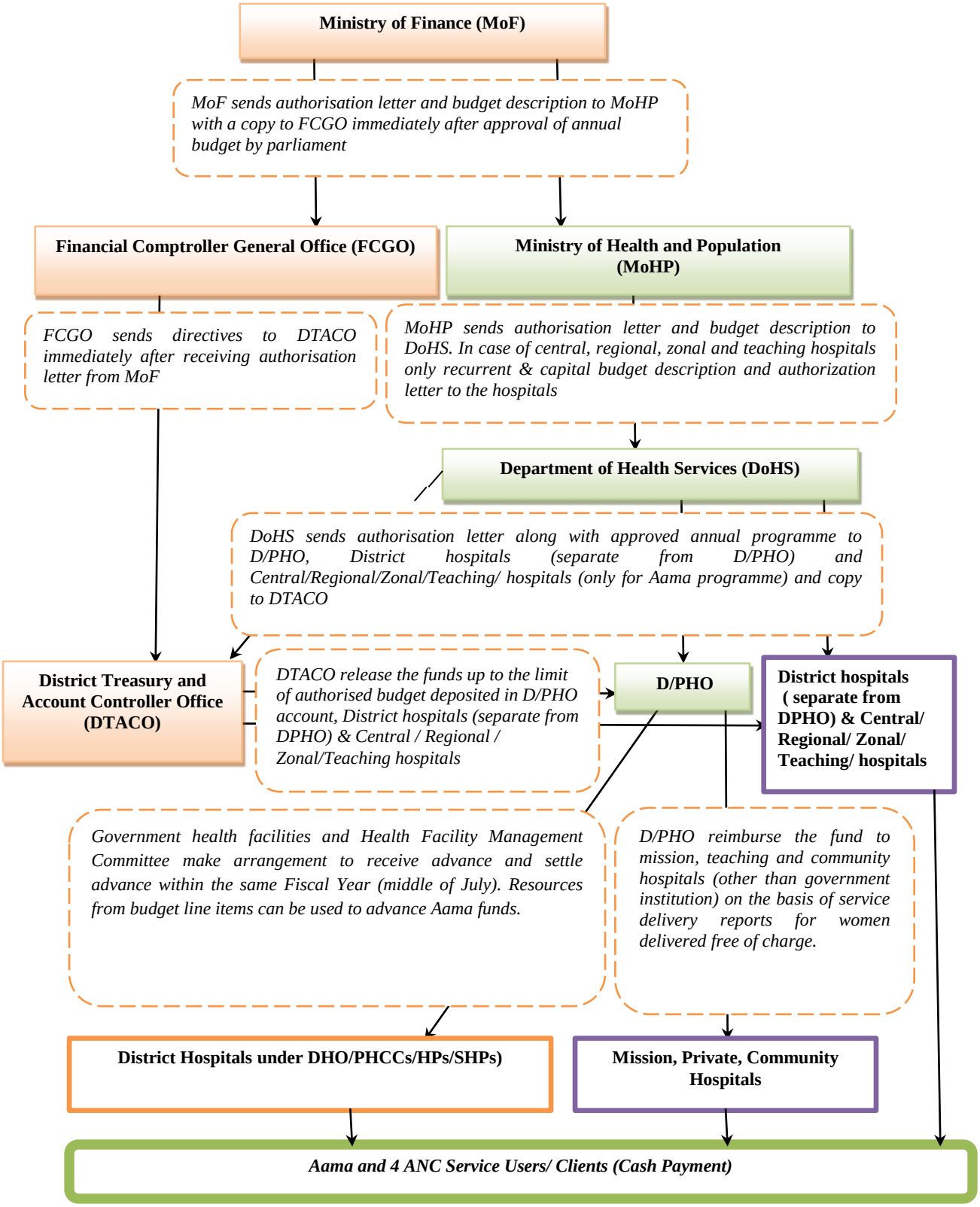
The implementation of the Aama programme is detailed in the Aama programme implementation guidelines (2009). The table below presents the incentives to be provided to women and to trained health workers:

Table 1: Aama and 4ANC Incentives according to the Guidelines

Cash Payment to Women	Incentives to the Health Facility	Incentives to the Health Worker
For Institutional Delivery (ID): NPR 1,500 in mountain districts NPR 1,000 in hill districts NPR 500 in Tarai districts	Amount reimbursed to facility: NPR 1,000 if < 25 beds for a normal birth NPR 1,500 if > 25 beds for a normal birth NPR 3,000 for a complicated birth NPR 7,000 for a caesarean section	Amount to health worker: NPR 300 per delivery at a health facility, paid out of reimbursement NPR 200 per delivery assisted at home
For 4ANC the woman must: Attend 4ANC sessions at the following times: 4 months 6 months 8 months 9 months Have an institutional delivery. Attend a first postnatal visit. She will then receive 400 NPR	This amount (NPR 1000, 1500, 3000 and 7000) includes the cost of drugs, supplies, instruments and the incentive to the health worker, and can be spent at the discretion of the Health Facility Management Committee	The provider incentive (NPR 200) for attendance at home deliveries requires a birth registration form as proof that the health worker was in attendance

According to the Aama programme guidelines (2009), Financial Rules & Regulations of the GoN (2008) and key informant interviews with account officers of government agencies, the diagram below shows how the funds should flow from the centre to front-line providers and users.

Figure 1: Fund flow of the Aama programme



1.3.1 Process of Annual Programming, Budgeting and Fund Flow from Central to D/PHO

The Aama programme is one of the major programmes of the Family Health Division (FHD). FHD prepares an Annual Work Plan and Budget (AWPB) related to the Aama programme and 4ANC scheme based on the previous year's AWPB. Figure 1 shows how the funds should flow to MoHP and DoHS. The MoHP compiles and submits the proposed AWPB to the National Planning Commission (NPC) and the Ministry of Finance (MoF). Following approval of the programme and budget by Parliament, the MoF provides details of the approved programme and allocated budget to the MoHP and Financial Comptroller General Office (FCGO) and the FCGO then provides details to the District Treasury Office (DTO). The MoHP supplies details about the approved programme and letters of authority to the DoHS, centre and divisions, and to all community hospitals, teaching hospitals, zonal hospitals, regional hospitals and central hospitals. Based on the letter from the MoHP, the DoHS sends details about the approved programme along with a letter of authority to the District (Public) Health Offices (D/PHO). Finally, Aama programme activities are approved and the budget is released to the district for implementation.

According to the Aama programme implementation guidelines (2009), the D/PHO releases the institutional unit costs to the Health Facility Management Committee (HFMC) in the case of PHCCs, HPs and SHPs, whereas for hospitals, the funds are released to the Hospital Development Committee (HDC). In case of a short fall or delay in receiving funds, the respective HFMC and HDC provide advance funds to the health institutions to pay women who have delivered.

1.3.2 Reporting from Health Facility to D/PHO and D/PHO to Regional & Central Level

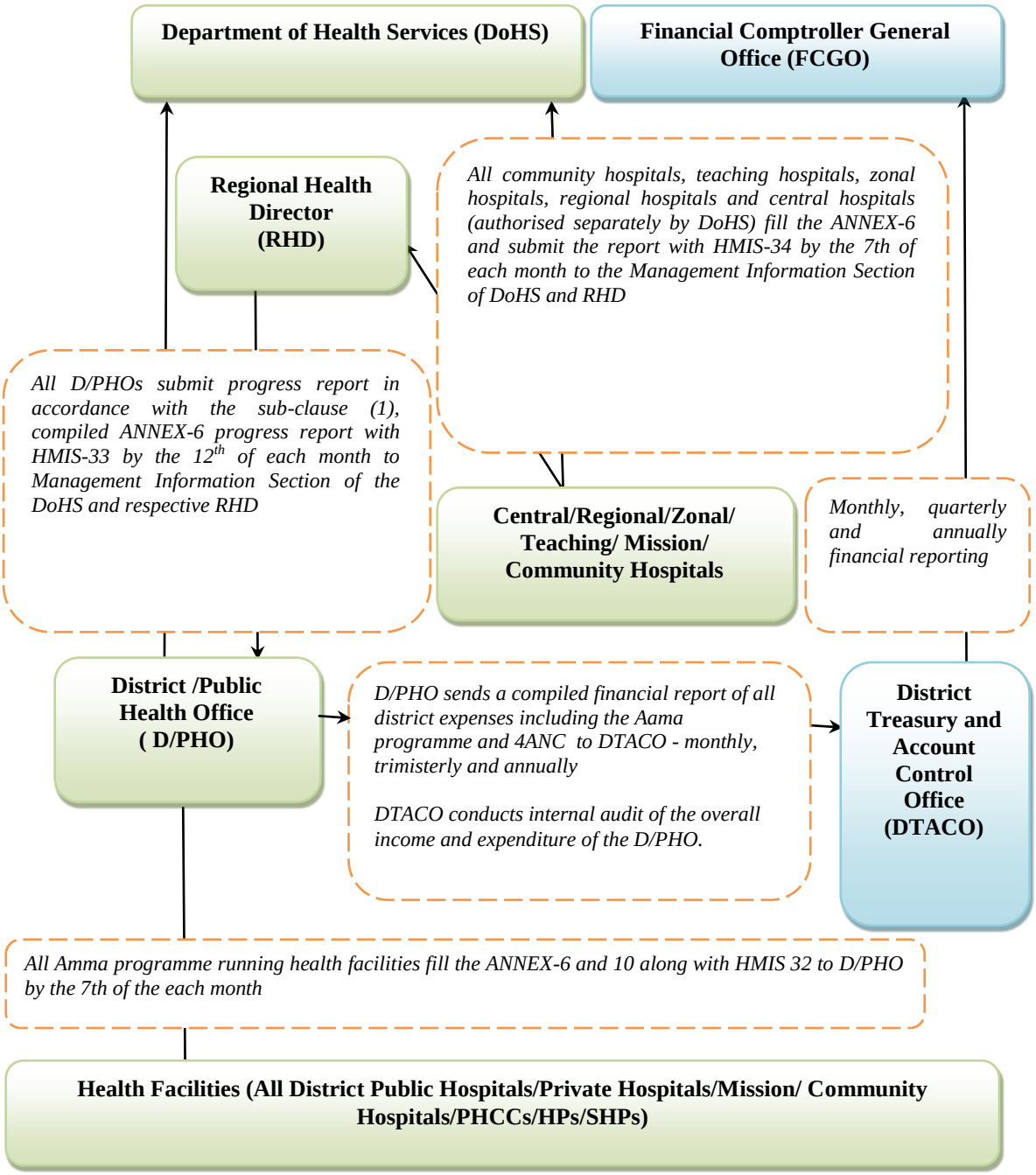
According to the Aama programme guidelines (2009), all health facilities within a district running the Aama programme have to submit forms ANNEX-6 and 10 along with the HMIS form 32 to the D/PHO by the 7th of the each month. All D/PHOs should submit a progress report in accordance with sub-clause (1), compiled ANNEX-6 progress report with the HMIS form 33 by the 12th of each month to the Management Information Section (MIS) of the Department of Health Services (DoHS) and the respective Regional Health Directorate (RHD). All community hospitals, teaching hospitals, zonal hospitals, regional hospitals and central hospitals (authorised separately by the DoHS) have to complete the ANNEX-6 form and send the report with the HMIS form 34 by the 7th of each month to the MIS of the DoHS and the RHD.

1.3.3 *Monitoring and Feedback at Different Levels*

According to the Aama Programme Guidelines (2009), there is provision for a monitoring/feedback mechanism by the RHD and the FHD to the D/PHO and from the D/PHO to the health facility level. It has been clearly stated that the RHD should ensure the receipt of progress reports in accordance with sub-clauses (1), (2) and (3) of the guidelines. Likewise, the Management Division (MD) and the FHD should ensure the receipt of reports at the MIS and the DoHS at the central level. It is also clearly mentioned in the guidelines that the budget allocated for the Aama programme can be restricted if there is no reporting for 4 months as per sub-clauses (2) and (3). Moreover, the responsibility for reporting is at the level of the Health Facility (HF).

As per GoN's Financial Act and Regulations, provision exists for monthly monitoring of the funds allocated to the D/PHO to be carried out by the District Treasury and Accounts Office (DTACO) through auditing. Furthermore, a quarterly and annual audit is carried out by the DTACO based on the approved programmes and allocated budget of the district. This is also a part of financial monitoring as per the Financial Act. The reporting mechanisms for Aama, as specified in the 2009 guidelines, Financial Rules and Regulations of GoN (2008) and as reported by key informants including account officers of government agencies, are shown in figure 2.

Figure 2: Aama Programme Reporting Channels



1.4 OBJECTIVES OF THE STUDY

The principal objective of the study is to assess whether the Aama and 4ANC programmes are being implemented as specified in the guidelines. In particular, to determine whether the funds are flowing as they should and reaching the women, the facilities and the health workers as specified. The specific objectives are:

Objective 1: Identify similarities and differences between the Aama programme and 4ANC visit schemes in the following areas:

- Assignment of focal persons;
- Timeliness of fund flow;
- Preparation of progress and financial reports;
- Compliance with guidelines on the disclosure of the names of service users on public notice boards;
- Opportunities for the misappropriation of funds.

Objective 2: Assess the overall management performance of the two schemes, including fund flow and opportunities for the misappropriation of funds.

Objective 3: Use Health Management Information System (HMIS) data to analyse changes in service use between January 2007 and January 2012 to include profiles of service users and providers, and to highlight ways in which financial incentives have been used to strengthen health institutions.

Objective 4: Compare HMIS and other facility data with exit interview data to identify any differences in the size of incentives provided and fund transfer modalities and conditions.

Objective 5: Make recommendations on ways to improve management of the two schemes.

1.5 ORGANISATION OF THE RA

This RA is the sixth in a series conducted to assess the Aama programme and DSF schemes and the first to assess the 4ANC programme implemented by the MoHP. The assessment was carried out by the Health Research and Social Development Forum (HERD). A research team from HERD was responsible for data collection, tool adaptation and development, training of enumerators, field implementation, data management, analysis and report writing. NHSSP and FHD provided support for this process.

SECTION TWO: STUDY METHODS

2.1 SAMPLING FRAME AND SAMPLE SELECTION

2.1.1 Districts

Six districts were purposively sampled for this RA based on ecological zone, the Human Development Index (HDI) and the number of deliveries. As the DSF incentives vary according to ecological regions - mountain, hill and Tarai (see Appendix 1), two districts from each region were sampled. Furthermore, districts were selected to provide a range of high and low HDI rankings. Districts with the highest number of deliveries recorded were also selected in order to recruit sufficient numbers of women who had delivered within the last six months. In this report, the names of the districts have been kept anonymous. A specific code has been applied to each district so they may be identified by ecological zone. This was done with a view to keeping the respondents anonymous in the report; in particular, district and facility level respondents could easily be identified if findings were reported by name of the district.

2.1.2 Health facilities

A total of 43 health facilities were sampled: 24 Health Posts/Sub Health Posts (HP/SHPs), 12 Primary Health Care Centres (PHCCs) and 7 hospitals. The facilities were selected from a sampling frame consisting of functioning birthing centres in identified study districts. The functionality of the facilities, i.e. whether they were still operating and able to conduct deliveries, was confirmed by the district teams when visiting the D/PHO. In addition, five private hospitals currently implementing the Aama programme were included in the survey, bringing the total of health facilities in the sample to 48. See table 2.

Table 2: Health Facilities Sampled for the RA

District	Ecological Zone	Regional Hospital	Zonal Hospital	District hospital	Private hospital	PHCC	HP	SHP	Total
A	Mountain	0	0	1	0	1	1	0	3
B	Mountain	0	0	1	0	2	5	1	9
C	Hill	0	0	1	1	1	4	3	10
D	Hill	1	0		1	2	4	1	9
E	Tarai	0	1	1	1	4	3	1	11
F	Tarai	0	0	1	2	2	1	0	6
Total		**1**	**1**	**5**	**5**	**12**	**18**	**6**	**48**

Description of sampling strategy

The sampling design for selecting the hospitals/PHCCs/HPs/SHPs involved the following stages:

A listing of hospitals/PHCCs/HPs/SHPs was created in the selected districts to obtain a list of all facilities with birthing centres.

From this list, a random selection was made of hospitals/PHCCs/HPs/SHPs providing delivery services (see description below).

Selection of public hospitals: Seven hospitals, at least one from each study district, were selected for the study. Five study districts had district hospitals; hence they were all included in the study with no random selection required. Moreover, one district had only one regional hospital, which was included. The remaining district had both zonal and district hospitals and both were included.

Selection of PHCCs: Out of sixteen PHCCs, twelve were selected from the six identified study districts.

Selection of HPs and SHPs: A Probability Proportionate to Size (PPS) sampling strategy was used to select HPs and SHPs. Eighteen HPs were sampled from fifty-five HPs. Six SHPs were sampled from twenty-six SHPs with birthing centres in the six study districts.

Selection of private hospitals: From a total of six private hospitals, five that provided delivery services under the Aama programme in the selected districts were included.

2.1.3 Women who had delivered at a health facility within the last six months

The main participants for this RA were women who had delivered at a health facility within the last six months. The sample included women who had delivered at home with a Skilled Birth Attendant (SBA) or a Trained Health Worker (THW) and women who had delivered in a health facility (private or government).

2.1.3.1 Sampling of Women delivered in the last six months

Information on women who had recently delivered in health facilities or at home was obtained from the DoHS Annual Report 2010/11. Based on these data, a sampling frame was developed of the women who had delivered in health facilities in the last six months. From the sampling frame, the appropriate sample size of women was estimated for cross verification. The sample size was based on assumptions that if the number of Institutional Deliveries is more than 1,000, then 5% of total deliveries is an appropriate sample size, and if the number of IDs is less than 1000, 10% of total deliveries is an appropriate sample size. The sample size was further increased by adding 5% to cover possible non-responses. Sample size was calculated using a similar approach to previous RA studies. However, as previous RAs did not use the incidence method for calculating the sample size, a proportion of total deliveries in health facilities has been used.

2.1.3.2 Sampling of Women Recently Delivered at Health Facilities

The sample also included women who had recently delivered and had not yet been discharged from the facility. Convenience sampling was used with these women who were recruited by the enumerators when they were visiting the health facilities.

2.2 TOOLS AND PARTICIPANTS

A suite of data collection tools from previous RAs was shared with HERD. These tools were adapted and some additional tools designed in order to collect data from District and Health Facilities for cross-verification. The tools were translated into Nepali and pre-tested as described in section 2.2.2.

2.2.1 Overview of Tools

The table below presents the different participants for the study, the respective tools and the team member who administered the tool.

Table 3: List of tools and respondents

Tools Administered	Level	Tool	Participant/Topic	Information Sought
District team Research lead	District Public Health Office	Tool 1A	District Public Health Officer	Implementation of the Aama and 4ANC programmes in the district, including planning, budgeting, reporting, monitoring, fund flow, training, guideline use, specific and district issues
District team Finance lead		Tool 1B	D/PHO Finance Section	Fund flow, involvement in planning and budgeting, specific district issues
District team Research lead		Tool 1C	D/PHO Aama focal person	Details of role, training, reporting, monitoring, fund flow, training, guideline use, specific district issues
District team and enumerators	District and Health Facility	Tool 1& 2D	Spread sheets	To collect delivery and ANC data at D/PHO and verify at health facility level
		1E	Verification between D/PHO and Health Facility records	To collect delivery and ANC data at D/PHO and verify at HF level
Enumerators	Health Facility	Tool 2A	Health provider (in-charge)	Knowledge and awareness of Aama and 4ANC programmes, recording, monitoring, display of Annex 10, fund flow, training, use of unit cost, local issues
		Tool 2B	Chair of Health Facility Management Committee	Knowledge and awareness of Aama and 4ANC, use of unit cost, display of Annex 10, fund flow, training, local issues
		Tool 2C	Health Facility Accounts Section	Fund flow, reporting, monitoring
Enumerators	Community	Tool 3A	Client exit: women at HF for delivery	Incentives received Satisfaction with service
		Tool 3B	Women who have delivered at home in last six months	Reasons for delivering at home, role of SBA and if they received incentive, documents required
		Tool 3C	Women who have delivered at HF in last six months	Incentives received, type of delivery, information on Aama, attitude on delivery at HF, satisfaction with services

2.2.2 *Training*

Before embarking on the field work, district leads and enumerators were trained to adequately administer the survey tools. Four days of out-of-office training for district leads and one day of in-house training for enumerators were organised. Sets of tools, a training schedule and required logistics were made available to the participants one day before the training session. Enumerators were hired based on their qualifications and experience in research work. The first day of training began with a formal programme. Representatives of the FHD and the NHSSP made opening remarks. There were two training groups, each with 19 participants (see Appendix 3). The training was facilitated by a research team of HERD, FHD/ MoHP, NHSSP and consultants. A NHSSP representative was present throughout the training session to monitor the training quality.

2.2.3 *Translation and Pre-Testing of Tools*

The tool was translated into Nepali before the pre-testing. Changes to the tool following the pre-testing were made directly to the Nepali version. Unfortunately, due to the limited time available before starting field work, the tools were not translated back into English. Pre-testing was conducted on 7th May 2012 in Kavre District by the district leads and HERD staff. Table 4 shows the interviews conducted and records reviewed during the pre-testing.

Table 4: Pre-Testing Interviews

Organisation	Interviews conducted	Records Reviewed
D/PHO Kavre	Public health nurse: Aama focal person (Tool 1C)	Annex 6 and 10
Dhulikhel Hospital	Nurse in-charge (Maternity Ward) (Tool 2A) 1 Recently delivered woman (Tool 3A)	Maternity Register
Dhulikhel PHCC	Staff Nurse (Tool 2A)	Maternity Register
Khopasi PHCC	Nurse in-charge (Tool 2A) Health Management Committee member (Tool 2B)	Maternity Register Maternal Health Register Annex 4
	Previous District PHO for Rasuwa District (Tool 1A)	

Following the pre-testing, a meeting was held with the pre-test team to identify the issues arising in the process and the tools themselves. The tools were accordingly adapted, printed and distributed to the district survey teams. The key changes made to the tools based on the pre-testing were:

- Reductions in the number of questions as some were repetitive and collected no new data.
- Improved clarity of the meaning of the questions in Nepali to ensure the same meaning as the English original.
- Some questions were more appropriately answered by different key informants and so were moved from one tool to another. For example, the Aama Focal Persons (AFPs) were not aware of programme finances so these were moved to the finance tool.
- Further issues for briefing the enumerators were identified. For example, clarifying who to meet with to view records in the D/PHO, clarifying definitions of words such as 'complications', and ideas on how to interview Recently Delivered Women (RDW) at health facilities in order to maintain privacy.

- Formatting changes were identified such as ensuring there was sufficient space for answers on the tool.

- The timing of interviews was noted in order to assist the district leads in their implementation planning.

2.2.3.1 Lessons Learnt from the Training, Translation and Pre-Testing

One of the main constraints facing the implementation team was the short period of time allowed for tool finalisation, translation, pre-testing and training before data collection began. The pre-testing was not conducted until after the enumerator training. To overcome this constraint, the district leads conducted the pre-testing and took careful note of issues arising so that they could brief their enumerators once in the field. More time is needed during the training for the enumerators to practice using the tools to ensure they understand the exact meaning of each question. This issue was picked up during data collection, particularly as considerable data was missing from the completed tools of some enumerators. District leads were able to identify and respond to these issues in the field.

Process of Cross-Verification

The design of this RA maximised opportunities for cross verification between data from facility records and user interviews. Data were initially collected from D/PHOs using the Aama annexes 4, 6 and 10. Details of the Aama annexes are given in Appendix 4. In the design phase of the RA, it was agreed that records should be classified as unmatched if one or more of the following fields were found to be different between the D/PHO Aama annexes and the health facility maternity register:

a) Address of mother;

b) Type of health facility;

c) Date of delivery;

d) Type of delivery;

e) Staff attending delivery.

Such discrepancies may be due to legitimate human error and do not necessarily equate to attempts to misuse funds.

Once the tools had been completed at the D/PHO, they were then taken to the facility level where the details were compared between the facility records and the Aama annexes to see if the above fields matched. Any discrepancies were noted. Hereafter, discrepancies are referred to as "mismatch". Women whose details were matched between the maternity register and the Aama annexes were then followed up at the address given and interviewed where possible.

The tool used to interview the women who had delivered in the last six months allowed cross verification of the information they provided with that obtained from the facility (i.e. whether normal, complicated or CS was performed, number of ANC visits, costs in reaching the facility and during delivery and incentives received). After data collection in the community with the women, the enumerators returned to the relevant health facility to double-check any inconsistencies between the data obtained from the women and the facility. The issues arising from this comparison process are reported in section 3.2.2 below.

2.3 FIELDWORK

The fieldwork was conducted between 9th May 2012 and 7th June 2012. Data collection was carried out by six teams, one team in each district with each team consisting of male and female interviewers and district leads (research and finance). All teams travelled to the districts immediately after completion of enumerators' training in Kathmandu. All team and management staff provided necessary support to the district teams as required.

2.3.1 *Supervision and Monitoring*

Once the district team leaders collected the district level data from the D/PHOs and district facilities, they kept in regular contact with and visited the enumerators at the health facilities to provide support and supervision and to cross verify district data with health facility data. They also checked data inconsistencies and discussed with the team members any problems they faced. Similarly, senior staff members from the FHD visited the districts to monitor the field implementation.

A central support team was scheduled to visit each of the districts to ensure quality control and deal with any issues arising.

2.4 ETHICAL APPROACH

As this study is a Rapid Assessment of the Aama and 4ANC programmes and not a piece of research, ethical approval from the Nepal Health Research Council (NHRC) was not sought. However, ethical principles underpinned the conduct of the research. The women interviewed in the community and at the health facility were under no obligation to participate in the study. Enumerators were trained to explain the purpose of the study before starting the interview and to clarify that the woman was under no obligation to participate, but that if she did, everything she said would remain confidential and all results would be anonymous. Based on this approach, consent was assumed if the woman agreed to complete the questionnaire. The enumerators were trained to do this by:

- Explaining the purpose of the study and the need for the woman's participation;
- Showing the woman a letter from the FHD providing the background to the study;
- Informing the woman that any information she provided would remain anonymous in the RA report.

2.5 DATA MANAGEMENT AND ANALYSIS

2.5.1 Quantitative Data

The database was designed once the tools had been finalised and the analysis plan agreed. All quantitative data from the questionnaire was double entered by a team of data clerks using 'EpiInfo'. The data was cleaned by the data manager before analysis began. This involved identifying any anomalies in the data and checking back with the original questionnaire and enumerator (if necessary) to identify the correct response. The data was then analysed using the Statistical Package for Social Sciences (SPSS) and the 'R' programme. Excel was used to analyse and present the finance and monitoring information.

2.5.2 Qualitative Data

Qualitative data were collected through semi-structured interviews with various respondents at each level: district health officers, focal persons, service providers, account officers and the Health Facility Management Committee. Due to the lack of district records of women who had delivered at home with the help of an SBA, the RA was unable to recruit these women as planned. In order to understand the perspective of women delivering at home, a small sample of qualitative interviews were conducted with women and with Female Community Health Volunteers (FCHV).

Data generated from these interviews were organised as follows: key issues and themes were identified and the answers to questions within these themes were grouped and summarised in data analysis frameworks. Quotations which illustrated the views of the majority of participants or were in contradiction with the majority were extracted from the interview. These issues were then summarised by district and health facility level and have been integrated within the relevant sections below. The data were then summarised by perusing all the original texts and listing all conceptual categories and

patterns. Relevant information was placed under these conceptual categories and relationships were identified between the categories.

2.6 QUALITY ASSURANCE

The first part of the quality assurance process began with the training of district leads and the enumerators. Details of the training are provided in Appendix 2. Supervision and communication between the centre and the district teams was conducted in order to pick up and respond to any issues in the field that might undermine the quality of data collected. The data entry clerks were supervised by the data manager whilst data was being entered. All data were double entered and then systematically cleaned to ensure that the data analysed was of robust quality.

Development of the coding frame and categories used in the qualitative data analysis was done by a team of three researchers working independently and then comparing their coding frames. The fact that the data comes from several different sources allows triangulation and further ensures quality.

2.7 LIMITATIONS OF THE STUDY

A number of limitations were experienced during the development and implementation phases and are summarised below. These are lessons learnt that we hope will be kept in mind when planning future rapid assessments:

- During the field work there were a number of strikes across the country which hampered data collection. No transport was allowed to run which meant that in many areas enumerators and district leads could not travel to visit health facilities and women on the desired dates. The data collection period had to be extended and the enumerators came under considerable strain. Moreover, some women who lived more than a day's walk from the health facility could not be contacted.
- The required data was often unavailable at the district level. Several districts did not have the Aama annexes (3, 4, 6 and 10) or the annual trend data available to enable the team to extract the required data. This also illustrates the limitations in reporting between facilities and districts (see below).

SECTION THREE: STUDY FINDINGS

3.0 STUDY FINDINGS

The findings of the Rapid Assessment (RA) are presented in this section. The first section (3.1) presents the characteristics of the study districts and the numbers of health facilities in those districts. The next section (3.2) presents the health facilities visited and the interviews conducted during the RA. This section also includes the details of any mismatches between records held at D/PHO level and at the health facility and any further discrepancies between the facility records and the women themselves. This section also presents the trends of institutional delivery, home deliveries and ante-natal care utilisation.

3.1 STUDY DISTRICTS AND THEIR CHARACTERISTICS

The wider socio-economic, demographic and health characteristics of the study districts are presented in Table 5. As described in the methodology section, the districts were purposively sampled to provide a range of ecological and socio-economic characteristics. This is revealed by the range shown below in Table 5. For example, districts A, C and F are the districts with the lowest development indices among the six sampled districts. The HDI includes life expectancy at birth, an education index (adult literacy rate and gross enrolment ratio) and Gross Domestic Product (GDP) per capita. While women's empowerment is on average lower in the two Tarai districts, it is also low in mountain district A and in hill district C. Tarai district E is doing particularly well in terms of health care performance as is the hill district D.

Table 5: Characteristics of Sampled Districts

District	Ecological Zone	HDI (2003)	Health care performance (MOHP) (2011/12)	Total population (2011/12)	Population WRA* (2011/12)	Expected pregnancies 2011/12)
A	Mountain	75	74	53783	12848	1318
B	Mountain	19	25	191029	49058	5097
C	Hill	72	32	279849	69977	7260
D	Hill	9	6	469359	132323	14042
E	Tarai	8	3	883845	228267	24128
F	Tarai	61	62	479291	165926	12926

** Women of reproductive age*
Source: HMIS 2011/12, NDHS 2011, MoHP 2011/12

Table 6 presents the total number of health facilities in the six districts which provided the study's sampling frame.

Table 6: Total Number of Health Facilities in the districts sampled

District	Ecological Zone	Government hospitals	I/NGO & Private hospitals	PHCC	HP	SHP	PHC ORC	EPI CLINIC	FCHV
A	Mountain	1	4	1	8	16	78	99	216
B	Mountain	1	5	2	11	25	164	199	324
C	Hill	1	0	2	12	60	227	225	941
D	Hill	2	14	3	11	34	158	186	864
E	Tarai	2	11	5	6	58	222	252	1290
F	Tarai	1	7	3	6	67	321	373	684
Total		**8**	**41**	**16**	**54**	**260**	**1170**	**1334**	**4319**

Source: DoHS Annual Report 2067/68 and District Development Profile of Nepal (2012)

I/NGOs: International/Non-government Organisation; PHCC: Primary Health Care Centre; HP: Health Post; SHP: Sub Health Post; PHC ORC: Primary Health Care Outreach Clinic; EPI Clinic: Expanded Programme of Immunisation clinic; FCHV: Female Community Health Volunteer.

3.2 FACILITIES, KEY INFORMANTS AND WOMEN SAMPLED AND INTERVIEWED

A total of 48 health facilities were visited for the study: one regional and one zonal hospital, five district hospitals and five private hospitals, 12 Primary Health Care Centres, 18 Health Posts and 6 Sub-health Posts.

3.2.1 District and Health Facility Interviews

Table 7 shows the respondents interviewed in each district by D/PHO and facility level. Across the districts, the total numbers of each level of staff interviewed were:

- Six District Public Health Officers;
- Six Aama Focal Persons;
- Six Finance Officers;
- Thirteen hospital in-charge, 10 PHCC in-charge, 16 HP in-charge, six SHP in-charge;
- Nine hospital service providers, 10 PHCC service providers, 13 HP service providers, three SHP service providers;
- Eleven chairpersons of Hospital Development Committees (HDC), 36 chairpersons of HFMCs;
- Twelve hospital accountants.

Table 7: Rapid Assessment District and Facility Interview Respondents

District	D/PHO level	Hospital level	PHCC level	HP level	SHP level
A Mountain		1 Hospital	1 PHCC	1 HP	Not in Sample
	1 D/PHO	1 Medical Superintendent	1 In-charge/Admin finance section	1 In-charge	
	1 Aama focal person	1 Chair of HDC§			
	1 Finance Officer	1 Accountant	1 Chair- HFMC*	1 Chair-HFMC*	
B Mountain		1 Hospital	2 PHCCs	5 HPs	1 SHP
	1 D/PHO	1 Medical Superintendent	2 In-charge/Admin-finance section	5 In-charge/finance section	1 In-charge/finance section
	1 Aama focal person	1 Service provider	2 service providers	5 service providers	1 service provider
	1 Finance Officer	1 Chair of HDC§	2 Chair of PHCC HFMC*	5 Chair of HP HFMC*	1 Chair of SHP HFMC*
		1 Finance chief			
C Hill		2 Hospitals	1 PHCC	4 HPs	3 SHPs
	1 D/PHO	2 Medical Superintendent	1 In-charge/Admin-finance section	4 In-charge/finance section	3 In-charge/finance section
	1 Aama focal person	2 Chair of HDC§			
	1 Finance Officer	2 Finance chief	1 Chair of PHCC HFMC*	4 Chair of HP HFMC*	3 Chair of HP HFMC*
D Hill		2 Hospitals	2 PHCCs	4 HPs	1 SHP
	1 D/PHO	2 Medical Superintendent	1 In-charge/Admin finance section	3 In-charge/Admin finance section	1 In-charge/finance section
	1 Aama focal person	2 Service providers	2 service providers	4 service providers	1 service provider
	1 Finance Officer	1 Chair of HDC§	2 Chair of PHCC HFMC*	4 Chair of HP HFMC*	1 Chair of SHP HFMC*
		2 Finance Officer			
E Tarai		3 Hospitals	4 PHCCs	3 HPs	1 SHP
	1 D/PHO	3 Medical Superintendent	4 In-charge/Admin-finance section	3 In-charge/finance section	1 In-charge/finance section
	1 Aama focal person	3Service providers	4 service providers	3 service providers	1 service provider
	1 Finance Officer	3 Chair of HDC§	4 Chair of HFMC*	3 Chair of HP HFMC*	1 Chair of SHP HFMC*
	1 D/PHO	3 Finance chief			
F Tarai		3 Hospitals	2 PHCCs	1 HP	None
	1 D/PHO	3 Medical Superintendents	1 In-charge/Admin-finance	1 Acting In-charge	
	1 Aama focal person	3 Service providers	2 service providers	1 service providers	
	1 Finance Officer	3 Chair of HDC§	2 Chair of HFMC*	1 Chair of HP HFMC*	
		3 Finance officer			

*Health Facility Management Committee Hospital Development Committee

3.2.2 Women sampled, mismatched, untraced and interviewed

Table 8 below shows the total number of women who had delivered in an institution in the last six months who were sampled, recruited for an interview, or untraced and whose records were mismatched between the D/PHO Aama annexes and the health facility records on the criteria mentioned in section 2.2.4. Untraced women included those whose records matched but who could not be traced in the community, as detailed in the section 3.2.3.

Table 8: Women sampled and interviewed

District	Sampled women	Unmatched women	Untraced women	Number of women interviewed
A Mountain	50	0	0	50
B Mountain	65	8	7	50
C Hill	101	6	7	88
D Hill	297	34	7	256
E Tarai	256	25	10	221
F Tarai	69	4	1	64
Total	**838**	**77**	**32**	**729**

Of the required sample size of 838, 729 (91%) women were interviewed.

3.2.3 Mismatched Women

Of these 838 women, the records of 78 women (9.3%) given in the Aama annexes at D/PHO level did not match with the records of the respective health facility maternity register. For the purpose of this RA, 'mismatched' has been defined as when one or more of the following fields are not the same between the D/PHO and health facility records:

a) Address of mother;

b) Type of health facility;

c) Date of delivery;

d) Type of delivery;

e) Staff attending delivery.

The RA found that across all districts, about 10% of records were mismatched. It should be noted with caution that the mismatched records may be due to human error and do not necessarily indicate an attempt to misuse funds.

The district with the highest proportion of mismatched women was district B - 14%, followed by district D - 12% and district E - 11%. The latter two districts had a high number of deliveries recorded and a high rate of mismatch was found in facilities where the number of deliveries was high. The other three districts either had all records matching or low numbers of mismatched.

The findings from key informant interviews and reviews of finance and reporting records presented below help to shed some light on the reasons for this mismatch. Possible reasons include:

- Lack of awareness of the Aama guidelines and the operational details of the programme;
- Lack of orientation on the use of Aama recording and reporting tools;
- Inadequate monitoring and supervision from higher authorities;
- Frequent transfer of staff members in the respective health facilities.

3.2.4 *Reasons for untraced women*

During the cross verification process, enumerators visited the community taking with them the names of women who had Institutionally Delivered, their husbands' names, addresses, types of delivery, dates of delivery and names of the health facilities where the women delivered. These records were collected from the D/PHOs and cross checked with the maternity registers of the concerned health facilities.

In total, 32 women out of the sample who had delivered in a health facility could not be traced. The section below presents some explanation for this.

3.2.5 *Women Traced but not Found*

The next stage of the cross verification process required enumerators to follow up matched (between district and facility) women in the community. This process allowed verification of the details of the woman's delivery and whether she had received the appropriate incentive. In the majority of cases women were traced to their homes and interviewed (87% of the desired sample). However, 32 women out of 838 could not be traced. The enumerators sought the assistance of the FCHVs in tracing the women and exploring the reason why the women could not be traced. The explanations given are presented in the Table 9.

Table 9: Explanations for Women Traced and Not Found

District	Found not to exist	Not found and presumed to have migrated	Found but had not had a baby	Woman is staying with family	Woman lived too far from facility to be interviewed within study time frame	Total Untraced Women
A Mountain	0	0	0	0	0	0
B Mountain	1	5	0	0	1	7
C Hill	4	0	1	2	0	7
D Hill	4	0	0	0	3	7
E Tarai	0	10	0	0	0	10
F Tarai	1	0	0	0	0	1
Total	**10**	**15**	**1**	**2**	**4**	**32**

3.2.6 *Exit Interviews with Recently Delivered Women*

In order to assess client satisfaction with delivery services, women who had recently delivered were interviewed by the enumerators whilst at the health facilities. Altogether 50 exit interviews were conducted in six districts (Table 10). No sample size was calculated for this group as their recruitment was done by convenience only.

Table 10: Number of Exit interviews conducted by district

ID	District	Exit interviews conducted
A	Mountain	0
B	Mountain	2
C	Hill	4
D	Hill	27
E	Tarai	12
F	Tarai	5
	Total	**50**

3.2.7 *Home Deliveries: Lack of Records and Qualitative Interviews*

During data collection, it was observed that records of assisted HD women were not reported to D/PHOs nor were they recorded in health facilities. While our required sample of women who had delivered at home with an SBA or trained health worker was 664 across all districts (the sample was estimated based on the previous year's HMIS record), only six women who had an assisted home delivery were actually recorded at the district level. The reasons for this are explored in the qualitative analysis below. In light of this, it was not possible to recruit the expected sample of 664 women. The six women who had delivery at home were from hill district D. However, these women had been supported by health workers who were not in our sampled facilities. Due to the lack of recorded women delivering at home, these six women were selected for an interview anyway.

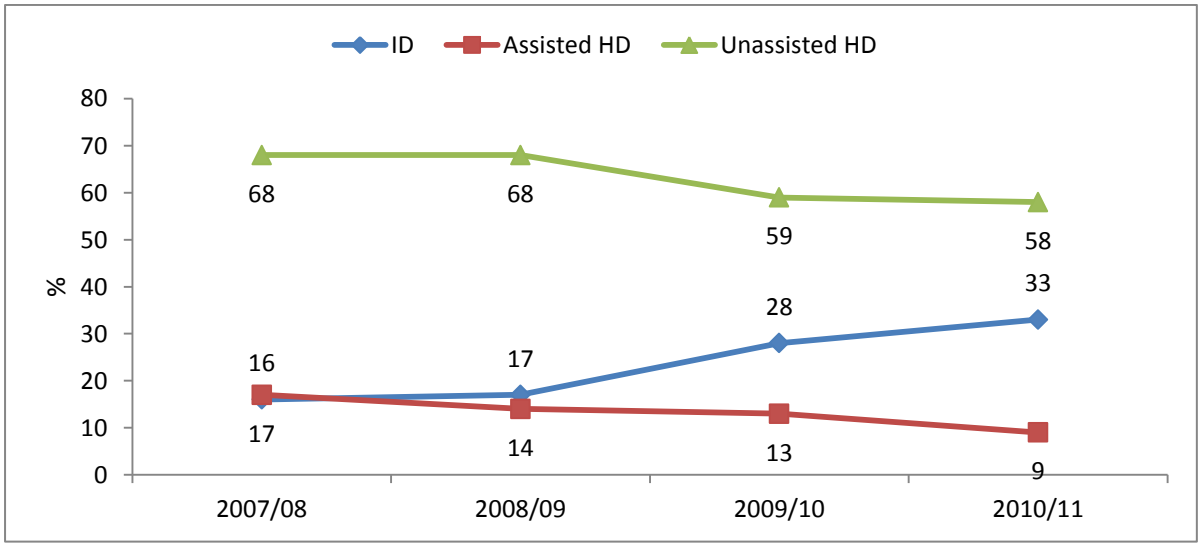
The purpose of these interviews was to understand the motivations for and the support provided for home delivery. A qualitative Key Informant Interview (KII) tool was developed and interviews were conducted with 13 HD women. These women were assisted by health workers at home but were not recorded as the same in the health facility record.

3.3 TRENDS IN INSTITUTIONAL DELIVERIES 2007/08 TO 2010/11

The following section presents the findings from HMIS data 2007/08 to 2010/11 from the six districts. Trends over these four years are given for each district and nationally to aid comparison. Hence, the trends depict the changes in programme output since the implementation of the Aama programme in 2009. It should also be noted that since unassisted home deliveries are not recorded, all expected pregnancies that were not delivered by a Health Worker (HW) or SBA at home or at a health facility have been assumed to be unassisted home deliveries.

The national level data and the district level data below (Figure 3) show an increase in IDs over the four-year period, from 16% to 33%. The increment was noticeably sharper following the introduction of the *Aama Surakshya* programme, but further studies are necessary to establish whether this association was indeed caused by the Aama programme. Along with the rise in IDs, at the national level there has been a gradual decline in unassisted and assisted HDs.

Figure 3: Trend in institutional and home delivery as % of total births, Nepal, 2007/08 – 2010/11

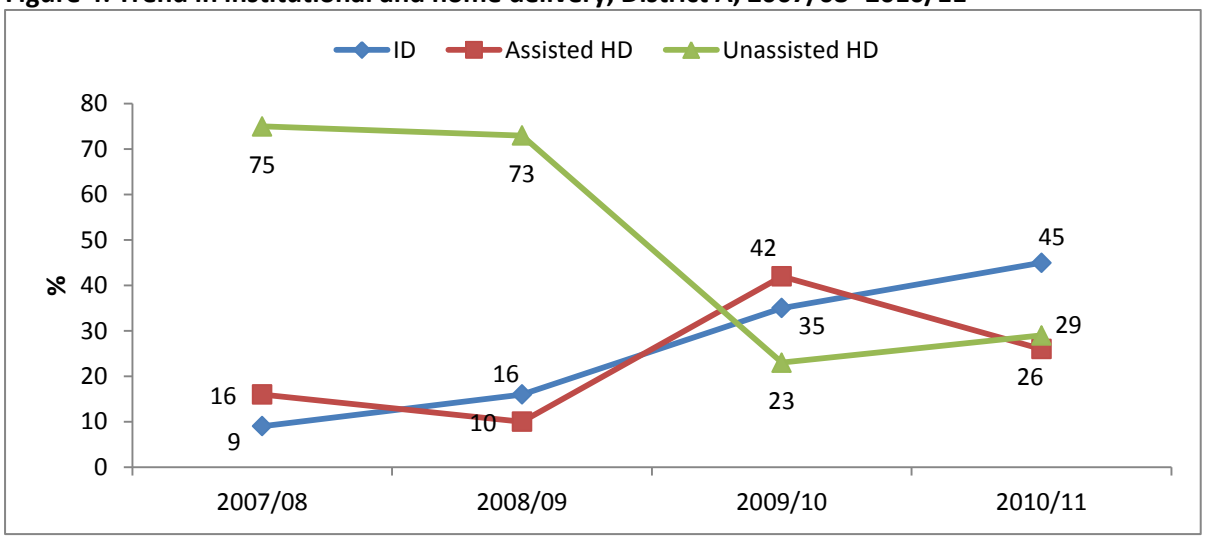


Source: HMIS data 2007/08 to 2010/11

3.5.1 *District Level Trends*

The following charts present more detailed information on the location and level of assistance during delivery for the districts sampled in the RA. Mountain district A has seen a sharp increase in IDs, from 9% in 2007/08 to 45% in 2010/11 (Figure 4). This has been matched by a sharp decrease in unassisted HDs, from 75% in 2007/08 to 29% in 2010/11, and a slight increase in assisted HDs.

Figure 4: Trend in institutional and home delivery, District A, 2007/08 -2010/11



District B, another mountainous district, also shows an increase in IDs, from 9% in 2007/08 to 25% in 2010/11 (Figure 5). However, district B has a very low rate of deliveries assisted by a HW or SBA either at home or in a facility. Even with the improvements in IDs, 73% of women are still delivering without any skilled assistance.

Figure 5: Trends in institutional and home delivery, District B, 2007/08 - 2010/11

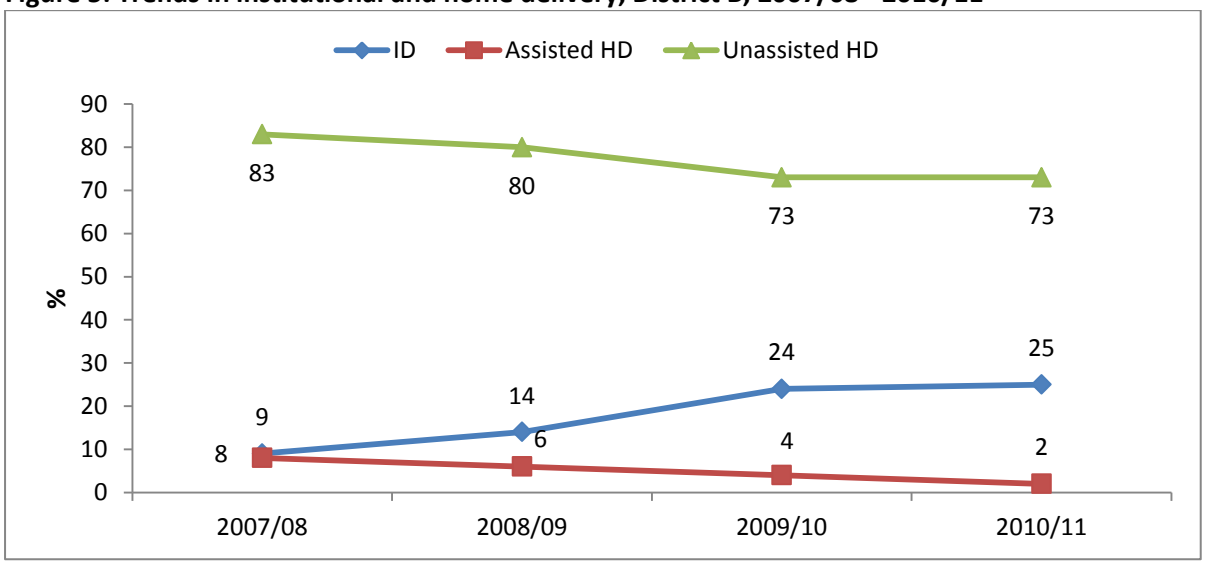
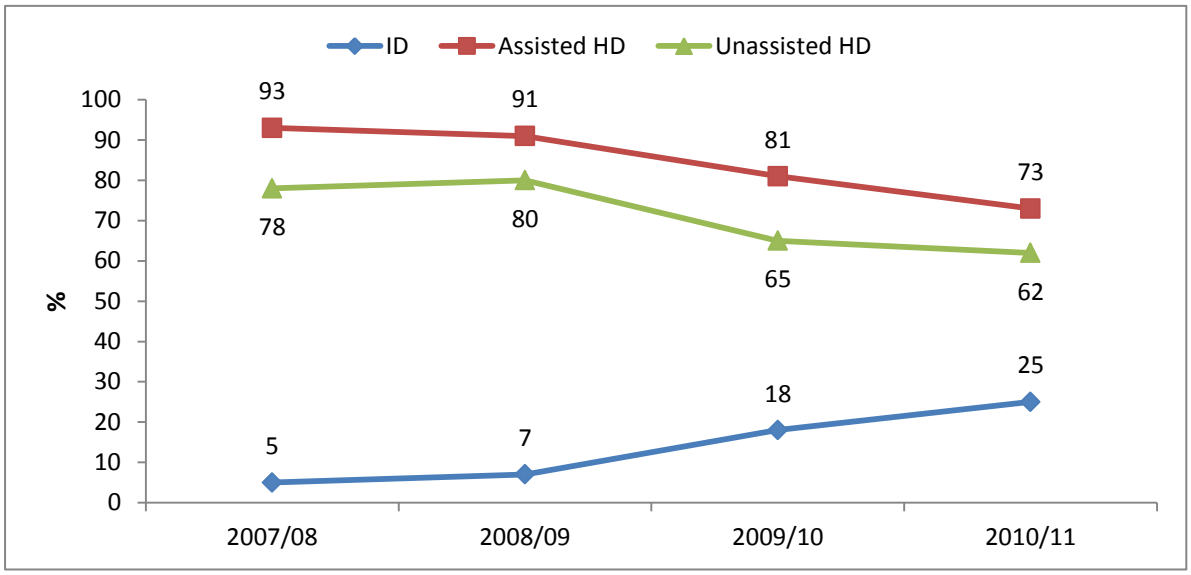


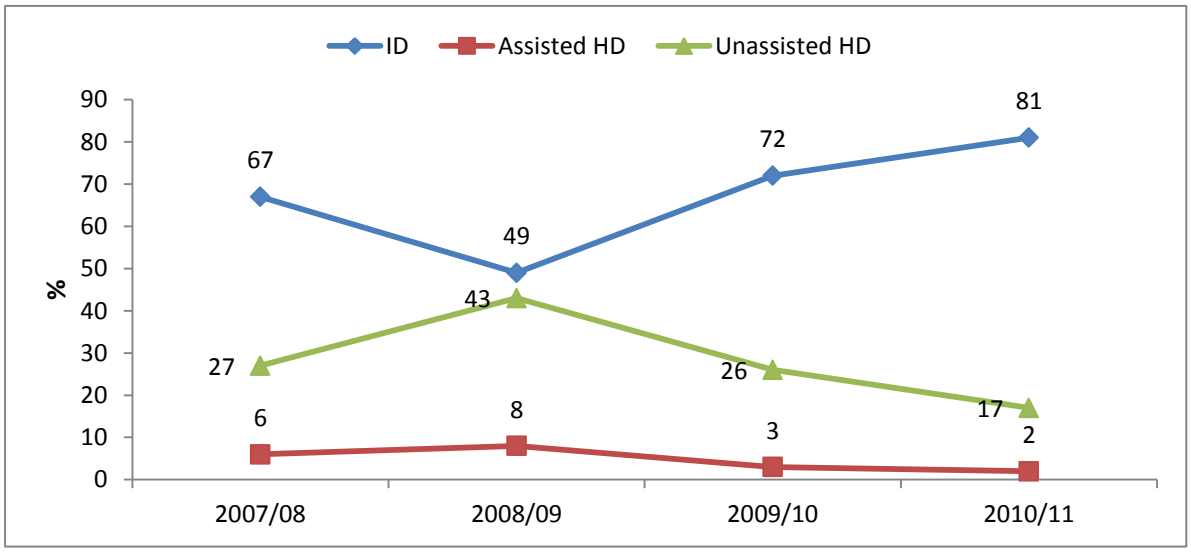
Figure 6 shows the trend in institutional and home delivery for 2007/08 to 2010/11 for hill district C. The results show an increase in IDs, from 5% to 25%. Assisted HDs have remained at a relatively stable level, although those assisted by a HW increased somewhat to 17% in 2010/11. Nevertheless, nearly two thirds (62%) of women are delivering at home without skilled assistance.

Figure 6: Trend in institutional and home delivery, District C, 2007/08 - 2010/11



District D presents a different picture overall, with 80% of expected pregnancies being delivered in a health facility (Figure 7). This reflects the higher level of economic development in this district as evidenced by its relatively high ranking of 4 on the Human Poverty Index (HPI), and the high level of women's empowerment, ranked at 3. The growth in the proportion of IDs has been impressive, increasing from 49 % in 2008/09 to 81% in 2010/11.

Figure 7: Trend in institutional and home delivery, District D, 2007/08 – 2010/11



District E in the Terai has shown a more modest increase in IDs, rising from 32% in 2007/08 to 40% in 2010/11 (Figure 8). Assisted HDs have been reported as zero in this district. Given that 41% of deliveries happened in an institution in 2010/11, approximately 59% of deliveries can be assumed to be occurring unassisted at home.

Figure 8: Trend in institutional and home delivery, District E, 2007/08 - 2010/11

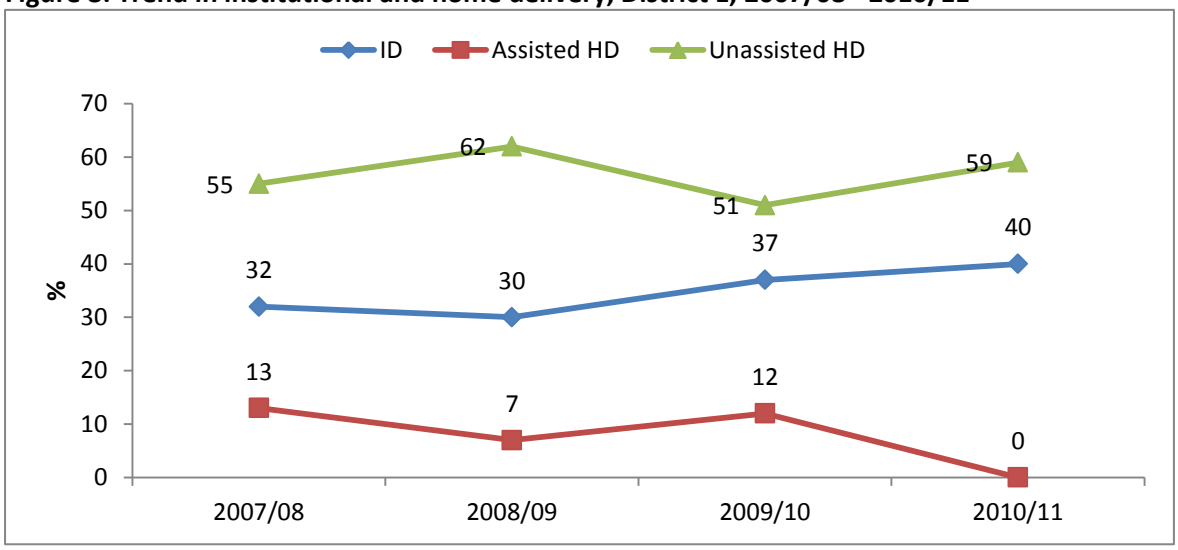
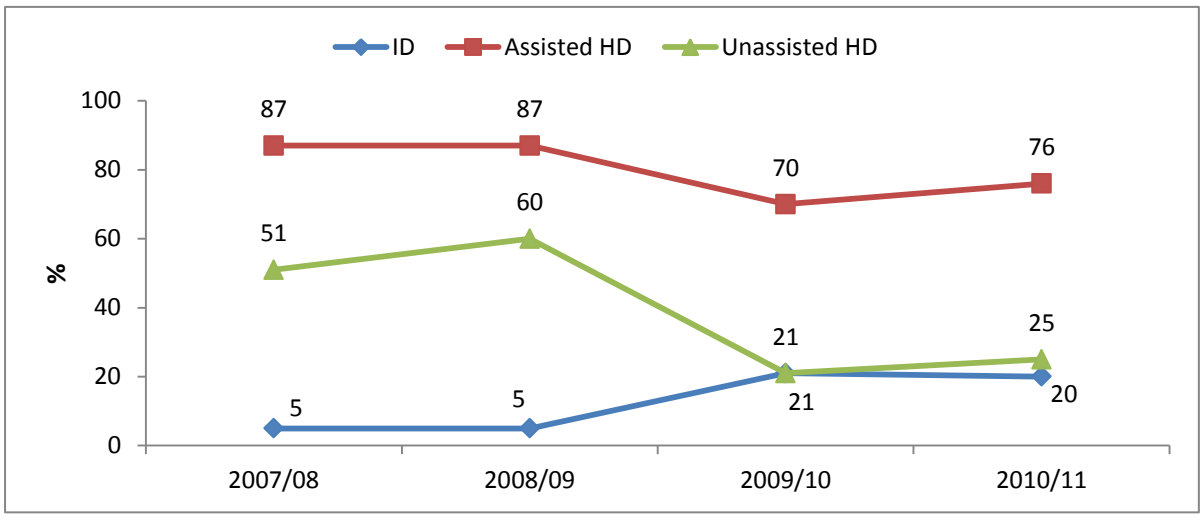


Figure 9 displays the trend in institutional and home delivery for Tarai district F. The results reveal a different picture, with the highest proportion of assisted deliveries taking place at home (76% in 2010/11). IDs have risen slightly, from 5% in 2007/08 to 20% in 2010/11. This situation is reflected in the district's low ranking on the women's empowerment index (71), a poor HPI ranking of 61 and a high rate of female illiteracy (37.2%).

Figure 9: Trend in institutional and home delivery, District F, 2007/08 – 2010/11



3.5.2 Trends in Utilisation of Ante-Natal Care

Trends in ANC utilisation are presented below based on national HMIS data for 2005/06 to 2010/11 in the selected districts (Table 11). Most districts have seen an increase in the proportion of pregnant women receiving at least one ANC visit. This increase appears to coincide with the initiation of the 4ANC programme in 2009. A sharp increase in ANC utilisation is observed in both mountain districts A and B although for most districts these increases began to tail off by 2010. District D, where the rise in ANC did not begin until a year after the other districts, is the exception.

Table 11: Trend of at least 1 ANC visit as percent of expected pregnancies, 2005/06 - 2010/11

	2005/06 (%)	2006/07 (%)	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)
District A Mountain	54	79	81	82	149	137
District B Mountain	52	49	42	48	74	64
District C Hill	78	76	71	75	124	114
District D Hill	80	82	131	88	81	106
District E Tarai	81	97	103	86	102	113
District F Tarai	95	84	77	75	152	146
National	**73**	**72**	**68**	**67**	**86**	**85**

Table 12 below shows the trend of completing all 4ANC visits over the years. According to the HMIS data, it appears that all expected pregnancies in district F (over 100%) have gone on to have all 4ANC visits. This may well be due to an under-estimation of the number of expected pregnancies which would artificially inflate the proportion receiving ANC visits. If this is the case, the proportion of IDs would also be less than would appear in the trend data presented above.

Table 12: Trend of 4th ANC visit as percentage of expected pregnancies, 2005/06 - 2010/11

	2005/06 (%)	2006/07 (%)	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)
District A Mountain	11	27	28	24	42	57
District B Mountain	23	22	18	20	31	29
District C Hill	49	53	49	56	75	64
District D Hill	45	43	42	52	60	80
District E Tarai	37	56	47	43	62	64
District F Tarai	70	58	60	57	114	115
National	35	36	35	38	49	48

The proportion of women who have one ANC visit and then go on to have the recommended four has stayed relatively similar across the time period with some exceptions (Table 13). Since 2007/08, even before the introduction of the 4ANC scheme, district D in the hills has witnessed a continual increase in women receiving all four ANC visits.

Table 13: Percentage of Women who complete 4 ANC Visits, 2005/06 - 2010/11

	2005/06 (%)	2006/07 (%)	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)
District A Mountain	20	34	34	29	28	41
District B Mountain	43	44	44	41	41	46
District C Hill	63	69	68	74	61	56
District D Hill	56	53	32	59	74	75
District E Tarai	46	58	46	50	60	57
District F Tarai	74	69	77	76	75	79
National	48	50	52	56	57	57

3.4 CHARACTERISTICS OF THE WOMEN INTERVIEWED

A total of 729 women who delivered in a health facility in the last six months were interviewed. Table 14 provides the key characteristics of these women. Most (61%) were between 21 and 30 years of age. 66% were housewives/homemakers, with only about 6% being employed. As compared to the NDHS 2011, the sample appears to be over-representative of women not earning: 17% were unemployed. However this may merely reflect the fact that the women in our sample have recently delivered and lost their source of income.

In terms of education, 41% of the women had been educated to secondary level and 21% were illiterate. Comparing these percentages to the levels of education among young women found in NDHS (2011) where 16% of 20-24 year old women had completed secondary school and 23% were uneducated (NDHS p.45), it appears that among women delivering in institutions, the more educated are over-represented compared to the illiterate and uneducated.

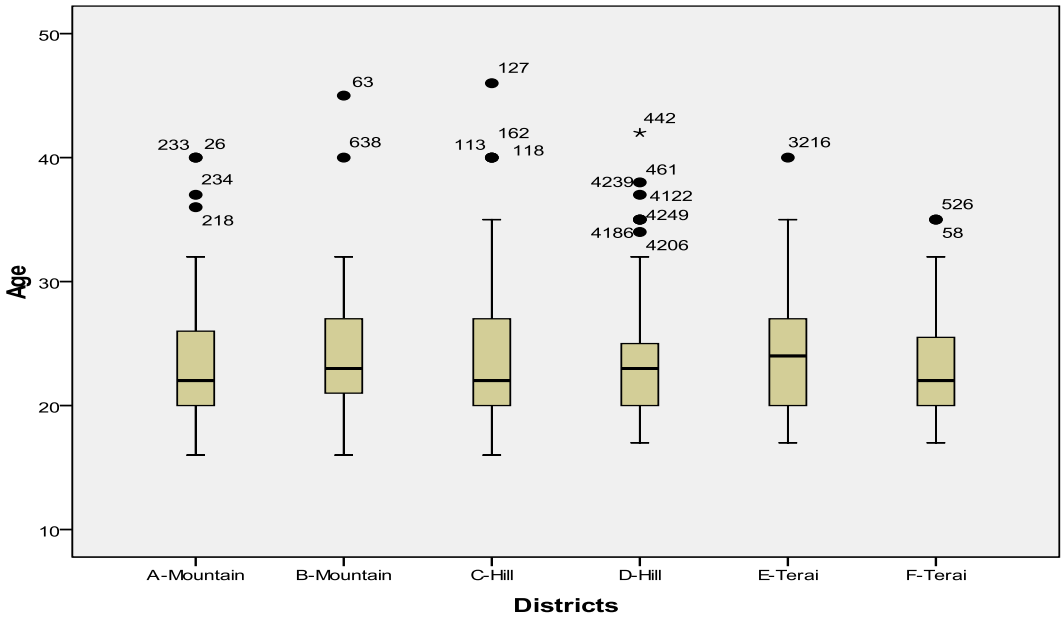
Table 14: Characteristics of Women Interviewed

Characteristics	Number (n= 729)	Percentage
Age		
Below 20 Years	222	30.5
21-30 Years	449	61.6
31- 40 Years	53	7.3
Above 40 Years	3	0.4
Missing	2	0.3
Educational Status		
Illiterate	150	20.6
Informal Education	60	8.2
Primary	97	13.3
Secondary	298	40.8
Higher Secondary	96	13.2
Bachelor and above	24	3.3
Missing	4	0.6
Occupation		
Employed	42	5.8
Petty Business	70	9.6
Labourer	27	3.7
Agriculture	98	13.4
Housewife/Homemaker	485	66.5
Missing	7	1.0
Caste/Ethnicity		
Brahmin/Chhetri	368	50.5
Tarai/Madhesi other caste	40	5.5
Dalit	140	19.2
Newar	22	3.0
Janajati	93	12.8
Muslim	32	4.4
Others*	27	3.7
Missing	7	1.0
Total	729	100.0

**Other castes include Sodari, Thakur, Rajbhar, Jarad, Lodh, Kurmi, Pasi, Ale*

The results presented in Figure 10 show that most women were in their early 20s when they delivered. Districts A, C and F have the lowest median age of delivery, possibly due to the higher proportion of illiterate and low educated women, as shown in Table 14. Districts A, B and C have particularly young women delivering as can be seen by the lowest figure in the ranges illustrated. In the figure, the dots and star represent the outliers or extreme values and is indicated by distinct value.

Figure 10: Current Median Age of Women Interviewed by District



3.5 AAMA TRANSPORT INCENTIVE

Overall, 95% of women who delivered in a health facility had received their Aama transport incentive (Table 15). District A had the lowest proportion receiving the incentive, with only 78% of women receiving the incentive. The confidence interval showed that the possible range of true values is relatively wide (i.e. it could be as low as 67% or as high as 89%). This reflects the small sample in this district and means that drawing any firm conclusions from this finding would be inappropriate. While the results show different proportions of women receiving the incentive in each district, the confidence intervals all overlap, so the differences cannot be said to be statistically significant.

Table 15: Proportion of Women Receiving Aama Transport Incentive

	Women receiving Transportation incentive			
District	%	n	95% CI	Total (N)
A Mountain	78	39	67 - 89	50
B Mountain	98	49	94 - 102	50
C Hill	97	85	93 - 101	88
D Hill	95	243	92 - 98	256
E Tarai	98	217	96 - 100	221
F Tarai	95	61	90 - 100	64
Mountain (A &B)	**88**	**888**	**82 - 94**	**100**
Hill (C & D)	**96**	**328**	**94 - 98**	**344**
Tarai (E & F)	**97**	**278**	**95 - 99**	**285**
Private hospitals	97	147	94 - 100	152
Government hospitals	95	317	93 - 97	333
PHCCs	89	88	83 - 95	99
HPs	92	109	87 - 97	112
SHPs	100	33	-	33
Total	**95%**	**694**	**93 - 97**	**729**

3.5.5.1 Transport Incentive by Caste and District

Table 16 shows the results of the receipt of the transport incentive in each district by caste. Since the numbers for some caste groups are very small, drawing firm conclusions from the data is not advisable. However, the overall distribution of the incentives by caste is informative. The number of women was reduced to 712 as information on some women's caste and other information on women receiving incentives was missing.

Overall, the caste group receiving the highest proportion of the transport incentive (51%) is Brahmin/Chhetri women. This figure is high in comparison to national estimations which put the proportion of Chhetris in the total population at 16% and Brahmins at 13%. The Dalits had the second highest proportion, with 19.4% of the transport incentives going to this group. This compares favourably with national estimations that Dalits constitute 4% of the population. Moreover, the district results suggest that a large proportion of Dalits in hill districts as well as Janajatis in mountain district B have benefitted from the Aama programme.

Table 16: Percentage of women receiving transport Incentives by Caste and District

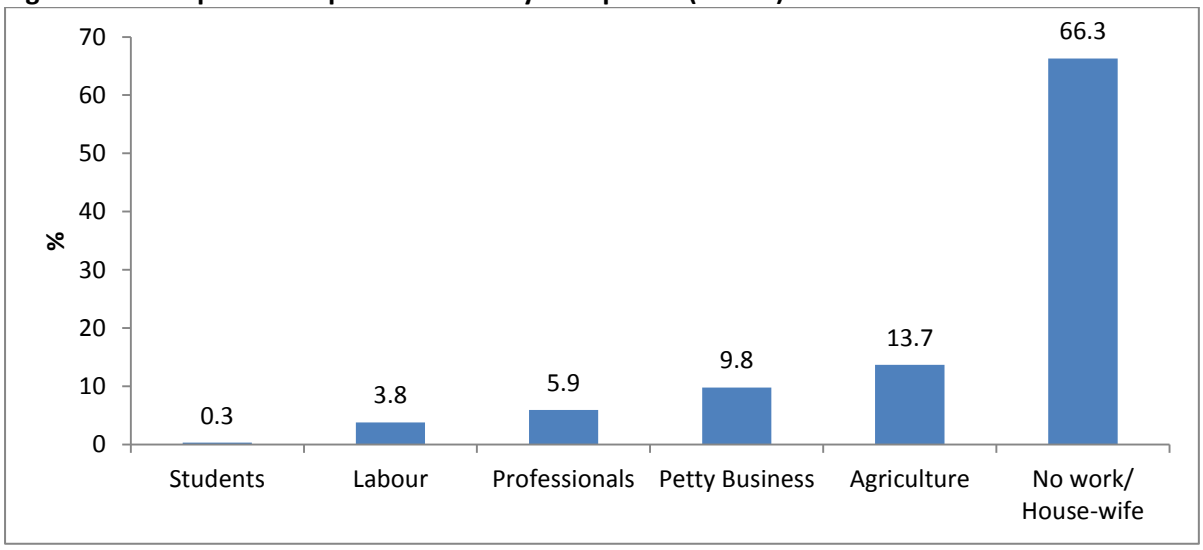
District	Brahmin /Chhetri (%)	Tarai/ Madhesi other (%)	Dalit (%)	Newar (%)	Janajati (%)	Muslim (%)	Others* (%)	Total (N)
A- Mountain	79.2	2.1	16.7	2.1	-	-	-	48
B- Mountain	39.6	4.2	4.2	12.5	37.5		2.1	48
C- Hill	62.5	2.3	27.3	2.3	1.1	-	4.5	88
D-Hill	53.4	0.8	25.9	1.6	16.6	-	1.6	247
E-Tarai	40.6	11.9	14.2	1.8	10	14.6	6.8	219
F-Tarai	50	9.7	14.5	6.5	16.1	-	3.2	62
Total	**51.1**	**5.5**	**19.4**	**2.9**	**12.9**	**4.5**	**3.7**	**712**

**Others: Other castes include Sodari, Thakur, Rajbhar, Jarad, lodh, Kurmi, Pasi, Ale*

3.5.5.2 Receipt of Transport Incentives by Occupation

Figure 11 shows receipt of the transport incentives in relation to the occupation of the women. The highest proportions (66%) of women receiving the transport incentive were women who did not work outside the home or were housewives. About 14% of women with an agriculture occupation reported receiving the incentive while less than one percentage of the transport recipients were students.

Figure 11: Receipt of Transport Incentive by Occupation (N=716)



3.5.1.3 Sufficiency of Transport Incentive

The questionnaire also asked the women whether they felt that the transport incentive was enough to cover their costs in reaching the health facility for delivery (Table 17). Across all districts, 78% of women felt that the incentive was sufficient. Satisfaction with the amount was highest in the mountain areas and lowest in the hill areas. In hill district D, 30% of women felt the incentive was not enough to cover their transport costs. This district has a large tourist industry and, as the HPI Index of 4 shows, is relatively better off, which may mean that transport costs are higher than elsewhere. However, hill district C, which does not have such a developed tourist industry, has the second lowest level of satisfaction (79%). Therefore, it seems warranted to assess whether the transport incentive is adequate for the hill districts.

Table 17: Percentage of women reporting transportation incentive to be sufficient

District	Women reporting incentive was sufficient (%)	Total (N)
A Mountain	80	50
B Mountain	98	50
C Hill	79	88
D Hill	70	256
E Tarai	80	221
F Tarai	81	64
Mountain (A &B)	**89**	**100**
Hill (C & D)	**77**	**344**
Tarai (E & F)	**80**	**285**
Private hospitals	72	152
Government hospitals	68	333
PHCCs	85	99
Ps	94	112
HPs	94	33
Total	**78**	**729**

3.5.1.4 Delays in Receiving the Transport Incentive

The Aama guidelines state that women should receive their transport incentive on the day they are discharged from the facility. Table 18 shows the percentage of women in each district who did receive their incentive on the day of discharge. Overall, 86% of women delivering in a health facility received their Aama transport incentive on the day they were discharged from the facility in accordance with the Aama guidelines. Mountain districts A and B appear to be the worse at giving the incentive at the time of discharge, with 70% and 72% respectively.

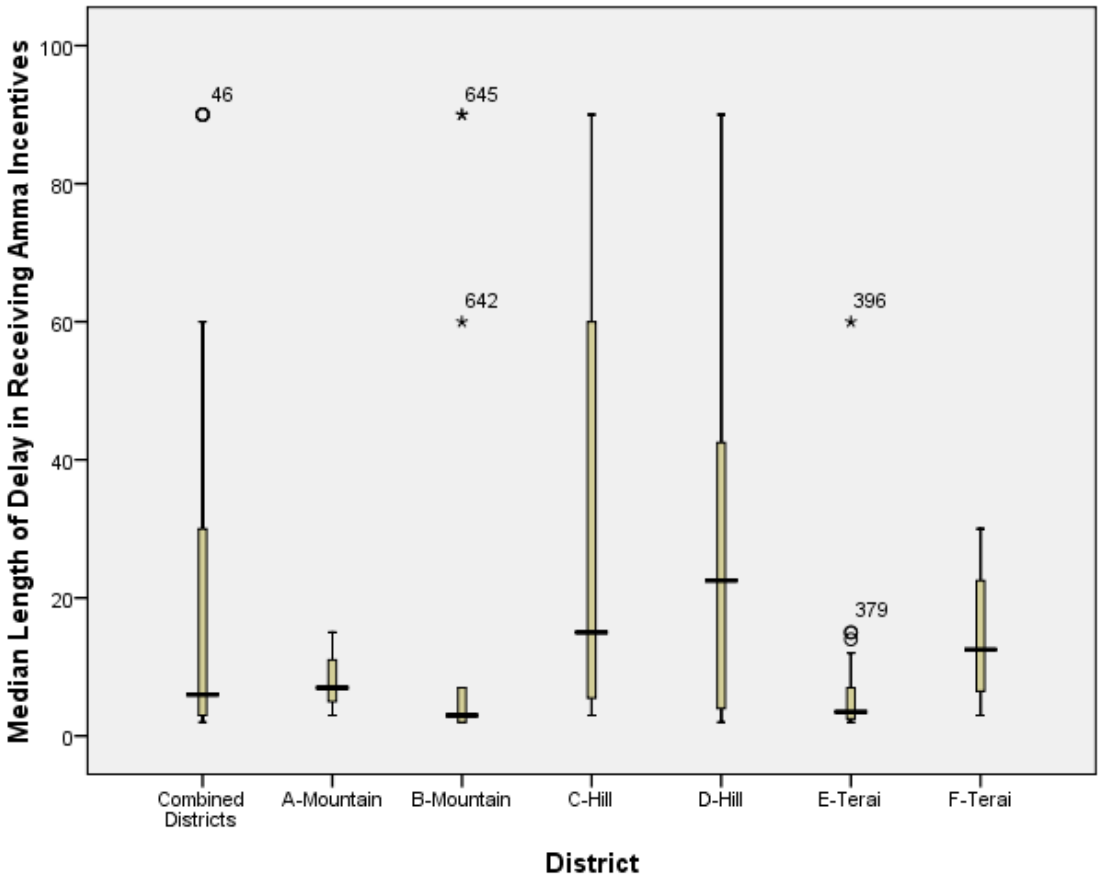
Table 18: Percentage of Women Receiving their Incentive on the Day of Discharge

Districts	Women receiving incentive on day of discharge (%)	Total (N)
A Mountain	70	50
B Mountain	72	50
C Hill	85	88
D Hill	89	256
E Tarai	88	221
F Tarai	92	64
Mountain (A &B)	**71**	**100**
Hill (C & D)	**87**	**344**
Tarai (E & F)	**90**	**285**
Private hospitals	93	152
Government hospitals	89	333
PHCCs	78	99

HPs	76	112
SHPs	85	33
Total	**86**	**729**

Examination of the length of delay for the 14% of women in table 18 who did not receive their incentive on the day of discharge was conducted. Figure 12 shows the median number of days that women had to wait to receive the incentive. This figure only applies to the proportion of women (14%, N=102) who did not receive their incentive at discharge. Hill district D had the longest median delay of 21 days, and some women at the end of the range had to wait 90 days. The situation in the other hill district (C) is similar, with a median delay of 17 days and the most extreme delay of 90 days; here the inter-quartile range (i.e. where the middle 50% of the data is found) is between 8 days and 59 days. Some districts had much more limited delays, for example districts B and E had a median of 6 days and an inter-quartile range between 5 days and 9 days. The stars on the chart show the 'outliers'. These women had to wait much longer than the majority and it may be that they are special cases in some way. The qualitative data highlights how the delayed receipt of Aama funding by the facilities undermines their ability to pay the incentive at the time of discharge as specified in the Aama guidelines.

Figure 12: Median Length of Delay in Receiving the Incentive



5.5.1.5 Inconsistencies between Women and Facilities in receipt of the Aama and 4ANC incentives

Women whose details matched in the Aama annexes at the D/PHOs and the health facility maternity registers were interviewed in their homes. The tool used asked the women whether they had received the Aama and/or 4ANC incentives. Their response was then linked to the details from the health facility on whether the incentive(s) had been given or not. Table 19 shows for each district the difference

between the number of women saying they received the incentive and the number of women the health facility says received the incentive.

The data here are collected from the cross verification tool used to compare information given by the women who had delivered in the last six months and the health facility records (annexes 6 and 10). The percentage of agreement shows that agreement between the health facilities and the women on whether the Aama transport incentive had been provided reached 95%. This means that in 5% of cases the health facility reported that the woman received the incentive but the woman said she did not receive it. The 95% confidence interval shows that we can be 95% confident that the true range lies between 93% and 96%. We can therefore declare a statistically significant mismatch whereby the facilities are reporting that they paid more incentives than the women reported.

Table 19: Inconsistencies between Women and Facilities on the receipt of transport incentive

District	Number of Women claiming to have received incentive	Number of women HF claims received the incentive	Percentage of Agreement*	95% CI	Total (N)
A Mountain	39	50	78	67 - 89	50
B Mountain	49	50	98	94 - 100	50
C Hill	85	88	97	93 - 100	88
D Hill	243	256	95	92 - 98	256
E Tarai	217	221	98	96 - 100	221
F Tarai	61	64	88	81 - 96	64
Mountain (A &B)	**88**	**100**	**88**	**82 - 94**	**100**
Hill (C & D)	**328**	**344**	**95**	**93 - 98**	**344**
Tarai (E & F)	**278**	**285**	**96**	**94 - 98**	**285**
Private hospitals	147	152	97	94 - 100	152
Government hospitals	317	333	95	93 - 97	333
PHCCs	88	99	89	83 - 95	99
HPs	109	112	97.3	94 - 100	112
SHPs	33	33	100	-	33
Total	**694**	**729**	**95**	**93 - 96**	**729**

* *NB The percentage of overall agreement is calculated by dividing the number of women who received the incentive by the number of women the facilities say received the incentive. If percentage is 100 then there is total agreement between the facility and the women; if it is less than 100% then the facilities have claimed that more incentives have been given than has been verified by the women.*

The confidence intervals also show non-significant results from districts B, C and E (as the 95% range includes the null value of 100%, i.e. total agreement between HF and the women). This is likely to be due to the smaller sample size in these districts. When the districts are combined in ecological zones, we see that all levels of mismatch are statistically significant. These results cannot, however, be interpreted as misuse of funds since several other issues could lead to differing information on the receipt of the incentive provided by the women and the facilities. For example, recording errors could occur in the health facility or women might not remember correctly or might even tend to deny that money was received. Although the consistency of the direction of the agreement could suggest that facilities over-report the disbursement of the incentive, this result would also be obtained if the women consistently under-reported receiving the incentive. Since in 40% of the cases the incentive was not paid to the women directly (contrary to the Aama programme implementation guidelines - see more on this below - the women were only aware that the incentive had been paid if they were told).

3.5.1.6 Information on Aama Incentives

The results relating to the provision of information on the Aama incentives are discussed in this sub-section. Women who had an ID in the last 6 months were asked whether they knew of the transport incentive before they delivered. This indicates an awareness of the scheme among pregnant women. Women were also asked whether they were aware of the scheme in the period of six months after delivery. Overall, most women (95%) who delivered at health facilities were aware of the transport incentives after delivery (Table 20). When asked if they knew about the Aama transport incentive before they had delivered, 81% said they did. Approximately 20% of pregnant women were thus not aware of the scheme at the time of delivery. If women do know of the scheme it cannot serve to encourage them to decide to deliver in a health facility rather than at home. The Tarai districts had the lowest levels of awareness: 76% before delivery and 95% after. Interestingly, not all facilities inform women about the Aama incentives at the time of delivery.

Table 20: Women Aware of Aama Transport Incentives Before and After Delivery

District	Women aware of incentive before delivery		Women aware of incentive after delivery		Total (N)
	%	n	%	n	
A Mountain	82	41	92	46	50
B Mountain	80	40	100	50	50
C Hill	89	78	98	86	88
D Hill	88	225	97	248	256
E Tarai	77	171	90	199	221
F Tarai	75	48	100	64	64
Mountain (A &B)	**81**	**81**	**96**	**96**	**100**
Hill (C & D)	**88**	**303**	**97**	**332**	**344**
Tarai (E & F)	**76**	**219**	**95**	**263**	**285**
Private hospitals	82	125	98	149	152
Government hospitals	84	279	94	314	333
PHCCs	76	75	93	92	99
HPs	87	97	97	109	112
SHPs	82	27	88	29	33
Total	**81**	**603**	**95**	693	**729**

Table 21 depicts the information sources that women reported for finding out about the Aama transport incentives. Health workers play an important role in informing women about Aama transport incentives. For instance, more than 54% of women reported the information source to be a health worker. Likewise, more than one-third (35%) stated the information source to be FCHVs. The pattern was similar across all ecological regions. The results showed that radio was reported to be the main information source by 21% of women in hill regions while it was less so in mountain and Terai regions. 13% of women from mountain regions reported that they got information about the transport incentive during ANC visits while only 9% in hill regions and less than 3% from Terai regions reported so.

Table 21: Information Sources on Aama Transport Incentives

Source of information on Transport incentive	Mountain (N=100)		Hill (N=344)		Terai (N=285)		Total (N=729)	
	n	%	n	%	n	%	n	%
Health Worker	62	62.0	210	61.0	127	44.6	399	54.7
Radio/ TV	9	9.0	74	21.5	35	12.3	118	16.2
Friends/Neighbors	24	24.0	79	23.0	83	29.1	186	25.5
Family members	14	14.0	65	18.9	35	12.3	114	15.6
Other relatives/friends	2	2.0	27	7.8	14	4.9	43	5.9
FCHVS	35	35.0	133	38.7	91	31.9	259	35.5
Poster pamphlets	2	2.0	13	3.8	0	-	15	2.1
During ANC visits	13	13.0	32	9.3	8	2.8	53	7.3

**Percentage exceeds 100 due to multiple responses*

3.5.1.7 Who Receives the Incentive?

The Aama implementation guidelines stipulate that the Aama incentives should be given directly to the woman who has delivered. In order to assess the extent to which this is practiced, the women who received the Aama incentive were interviewed. The results are presented in Table 22. More than three-fifths (61%) of the women questioned reported receiving the incentive themselves. Husbands next most commonly received the incentive (27%). Marked variations by district are found, with the two Tarai districts showing higher proportions of husbands receiving the incentive than the women themselves: 48% in district E (18% more than is given to women) and 45% (14% more than is given to women) in district F. District F has a low literacy level (37.2% of women are illiterate) and a relatively low proportion of women (62.8%) able to make decisions about their own health care. However, it should be noted that the mountain zone district A has the lowest proportion of women who make their own decisions about their health care (59.9%) and yet 70% of women in district A reported receiving the incentive themselves.

Table 22: Who Receives the Aama Transport Incentive by district and region

District	Self	Husband	Father-in-law/ Mother-in-law	Family Members	Others	Total
	%					
A Mountain	89.7	10.3	-	-	-	39
B Mountain	78.0	20.0	2.0	-	-	50
C Hill	91.9	5.8	1.2	-	1.2	86
D Hill	79.3	16.7	2.0	1.6	.4	246
E Tarai	30.6	47.9	9.6	11.9	-	219
F Tarai	31.7	46.0	17.5	4.8	-	63
Mountain	83.1	15.7	1.1	-	0.6	89
Hill	82.5	13.9	1.8	1.2	-	332
Terai	30.9	47.5	11.3	10.3	0.3	282
Total	**61.9**	**27.6**	**5.5**	**4.7**	**0.3**	**703**

3.6 THE FOUR ANC PROGRAMME

Table 23 shows the extent of ANC provision and awareness of the 4ANC incentives by district, by ecological zone and by health facility level. Across all districts, 13.3% or 111 women who had delivered in a health facility had also received the 4ANC incentive of 400 NPR. The two Tarai districts E and F had the lowest proportion of women receiving the incentive with 0.9% and 3.1% respectively. These districts did, however, manage to provide some level of ANC sessions (any sessions, not necessarily all 4) to 53.1% (district E) and 48% (district F). The number actually receiving all 4 ANC sessions is much lower, only 6.8% and 3.1%. The level of awareness about the scheme in the Tarai districts is extremely low (district E: 4.1% and district F: 0%). This does increase slightly after delivery (district E: 6.8% and district F: 3.1%) showing that women may hear about the scheme during pregnancy and delivery.

Table 23: Women's Awareness and Receipt of the 4ANC incentive

District	Women who delivered at HF who also received the 4ANC incentive %	Women who have had any ANC sessions at all %	Women aware of incentives before their ANC visits %	Women who were aware of ANC incentives %	Total (N)
A Mountain	10	70	48	58.0	50
B Mountain	60	64	60	86.0	50
C Hill	11	61	42	71.6	88
D Hill	19	68	47	60.5	256
E Tarai	1	80	4.1	6.8	221
F Tarai	3	53	0	3.1	64
Mountain (A & B)	**35**	**67**	**54**	**72.0**	**100**
Hill (C & D)	**15**	**64**	**44**	**66.5**	**344**
Tarai (E & F)	**2**	**66**	**2.05**	**4.9**	**285**
Private hospitals	1	68	23	27.6	152
Government hospitals	6	68	32	43.8	333
PHCCs	9	72	17.2	26.3	99
HPs	46	72	39.2	64.3	112
SHPs	39	84	51.5	63.6	33
Total	**13**	**69.1**	**32.6**	**42.1**	**729**

Mountain district B was able to provide the incentive to the highest proportion of women, with 60% benefitting from the incentive. District D had better uptake of all 4ANC sessions, possibly due to high awareness of the scheme as 60% of the women there were aware of the incentive scheme before they even had their first ANC session. This rose to 80% after delivery, indicating that those women that did not already know about the scheme learned about it during pregnancy or delivery, possibly during the ANC sessions.

The qualitative data shed some light on these findings as health facility staff in mountain district D consistently mentioned that women were well-informed about both the Aama and 4ANC programmes and that this resulted from the activities of the FCHVs who were effectively promoting the 4ANC scheme. Two out of the seven facilities in this district also identified mothers' groups and the radio as being influential in promoting both the Aama and the 4ANC programmes. The health facilities in this district all consistently mentioned the contribution of both the Aama and 4ANC programmes in reducing maternal mortality, showing their overall commitment and the value they placed on the scheme. The findings of poor ANC uptake came from the Tarai districts, where, for example, in district E, health facility staff consistently reported that the 4ANC programme was not being implemented. For example, the service provider in a PHCC noted that:

> *"The 4ANC programme is just not effective, the in-charge should provide an incentive for ANC visits, but the criteria are too much" (Service Provider. PHCC, District E).*

The Aama Focal Person (AFP) in district F also highlighted the low level of public awareness of both the Aama and the 4ANC programmes and the lack of ownership of the programmes at the community level, particularly at Village Development Committee (VDC) and District Development Committee (DDC) levels.

The differences in ANC uptake and awareness of the scheme by facility level show that receipt of the incentive, ANC uptake and awareness are higher at SHP and HP levels than at hospital and PHCC levels. Private hospitals provide only 1.3% of women with the ANC incentive while HPs provide 46.4% and SHPs 39.4% with the incentive. The qualitative data from D/PHO and health facility staff consistently highlights that women have to show their ANC card with details of their ANC schedule to prove that they have received the four sessions at the appropriate times, another provision stated in the 4ANC guidelines. One explanation may be that women who receive their ANC incentive in the SHPs and HPs where they deliver consider it "one package", whereas the higher level facilities are perhaps more bureaucratic. It could also depend on how many women claim the 4ANC incentive at higher level facilities because greater numbers would make it easier to claim.

However, it should also be noted that the level of awareness of women who delivered at the lower level facilities is also higher, with 39.2% of women who delivered at a HP and 51.5% of women who delivered at a SHP being aware of the 4ANC incentive scheme even before they had delivered. This is compared to 17% for PHCCs and 32% for the government hospital level.

3.6.1 4ANC by Caste

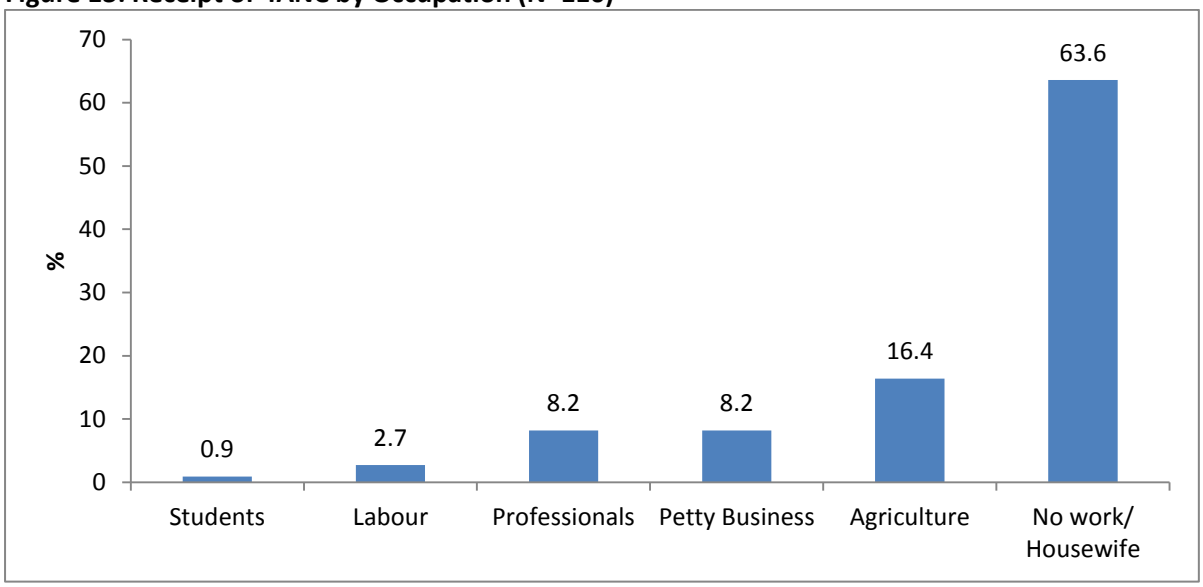
Table 24 shows the receipt of the 4ANC incentive by caste group. It should be noted that the number of women receiving the incentive is very small in some districts, particularly in the Tarai, so drawing conclusions within these districts is not possible. The data across districts have been combined to give the table below; it can be clearly observed that the Brahmin/Chhetri group represents the highest proportion receiving the 4ANC incentive, followed by Janajatis and then Dalits.

Table 24: Receipt of 4ANC by Caste and District

District	Brahmin/ Chhetri %	Tarai/ Madhesi other %	Dalit %	Newar %	Janajati %	Others %	Total (N)
A Mountain	67	0	33	-	-	-	6
B Mountain	43	3	6	12	33	3	33
C Hill	62	-	38	-	-	-	13
D Hill	39	2	43	-	14	2	56
E Tarai	-	50	50	-	-	-	2
F Tarai	100	-	-	-	-	-	1
Total	50	10	14	6	16	3	111

Figure 13 displays the women receiving the 4ANC incentive in terms of their occupation. The results on the receipt of the 4ANC incentive by occupation show that, like the Aama transport incentive, the highest proportion was of housewives or women with no work (63%). The lowest proportion was of students.

Figure 13: Receipt of 4ANC by Occupation (N=110)



3.7 COMPLICATIONS AND C-SECTIONS

According to the Aama programme implementation guidelines (2009), a facility receives NPR 1000/1500 for a normal delivery (1000 in a < 25 bed hospital and 1500 in > 25 bed hospital), NPR 3,000 for a birth which results in complications and NPR 7,000 for a Caesarean Section. In order to see whether these incentives were encouraging more complications and CS to be reported than are actually being conducted, the tool cross verified facility level data with information from the women (Table 25). Due to the small number of complications and CS, the numbers are too small to be confident of the findings. However, there are, overall, only relatively small differences between the accounts of the women and the health facilities. These findings are suggestive that facilities do not misreport the type of delivery in order to claim higher compensation.

Table 25: Normal and Complicated Deliveries: Agreement between Women and Facility

District/HI	Normal Delivery			Complicated			Caesarean Section		
	Women	HF	% of Agreement	Women	HF	% of Agreement	Women	HF	% of Agreement
A Mountain	42	43	98	6	4	150	0	0	100
B Mountain	48	47	102	1	3	33	1	0	200
C Hill	81	77	105	2	4	50	4	3	133
D Hill	214	216	99	11	10	110	26	26	100
E Tarai	192	190	101	5	5	100	22	22	100
F Tarai	55	56	98	4	3	133	1	2	50
Govt. Hospital	276	279	99	18	17	106	30	29	103
Private Hospital	126	124	102	5	7	71	20	20	100
PHCC	92	92	100	3	2	150	2	2	100
HP	107	105	102	1	1	100	2	2	100
SHP	31	29	107	2	2	100	0	0	100
Total	**632**	**629**	**100**	**29**	**29**	**100**	**54**	**53**	**102**

3.8 FREE DELIVERY CARE

The following section presents the results on women's knowledge about free care before delivery and at the time of interview, i.e. up to 6 months after delivery. Overall, 77% of deliveries were reported by women as being free implying that 23% of women paid some costs to the health facility for their delivery (Table 26). The proportion of deliveries that were free is particularly low in the two Tarai districts (55%). Tarai district F had a very low proportion of free deliveries, only 37.5%, so for most deliveries in a health facility in this district (62.5%), women paid. Awareness of free delivery care is also low in district F, with only 73.4% being aware of free delivery care during pregnancy. While this rose to 90.6% after delivery, this remains the lowest of all the districts.

Table 26: Women Receiving and Aware of Free Care

District/ Health Institution	% of HF Deliveries that are free	% of women aware of free care after they deliver	% of women aware of free care before delivery	Total (N)
A (Mountain)	92.0	94.0	82.0	50
B (Mountain)	84.0	94.0	76.0	50
C (Hill)	93.2	96.6	90.9	88
D (Hill)	80.9	95.7	89.8	256
E (Tarai)	72.4	96.4	83.7	221
F (Tarai)	37.5	90.6	73.4	64
Combined for Mountain	**88.0**	**94.0**	**79.0**	**100**
Combined for Hill	**87.1**	**96.2**	**90.4**	**344**
Combined for Tarai	**55.0**	**93.5**	**78.6**	**285**
Private hospitals	60.5	97.4	82.9	152
Government hospitals	73.3	92.8	85.9	333
PHCC	85.9	97.0	80.8	99
HPs	95.5	97.3	86.6	112
SHPs	100.0	100.0	97.0	33
Totals	**77**	**95**	**85**	**729**

As Table 27 below shows, district D is the most expensive district to deliver in a health facility: women pay on average NPR 2,293.10 to the health provider. Part of the explanation is that district D has a regional and a private hospital, both of which are considerably more expensive (NPR 1,661 per capita at the private hospital) than the lower level health facilities. As the facility level data reveals, HPs and SHPs also appear to be expensive, but the small sample size must be taken into consideration and no real conclusions can be drawn from these data at the lower level facilities.

Table 27: Per Capita Amount Paid for Delivery by District

District	Women who Paid at Delivery		Total amount (NPR)	Per Capita (NPR) (i.e. Total NPR/n)	Total (N)
	%	n			
A Mountain	10	5	2445	489.00	50
B Mountain	8	4	2400	600.00	50
C Hill	55	48	37790	787.29	88
D Hill	15	39	89431	2293.10	256
E Tarai	18	40	39260	981.50	221
F Tarai	11	7	4700	671.43	64
Mountain (A &B)	9	9	57420	844.41	**100**
Hill (C & D)	25	87	4750	633.33	**344**
Tarai (E & F)	16	47	47160	1924.90	**285**
Private hospitals	33	50	83050	1661.00	152
Government hospitals	21	72	79296	1101.33	333
PHCCs	14	14	6580	470.00	99
Ps	5	6	6950	1158.33	112
HPs	3	1	150	150.00	33
Total	**20**	**143**	**176026**	**1230.95**	**729**

3.8.1 Receipt of Free Delivery Care by Caste

Table 28 shows the receipt of free care broken down by caste/ethnicity. Since some of the numbers for specific caste groups are very small, no firm conclusions can be drawn from the data. Similar to the Aama transport incentives, the Brahmin/Chhetri groups receive the highest proportion of free care; again this seems disproportionate to their proportion in the population. Dalits, at 20%, are the next highest proportion to receive free care. As Dalits consistently have lower health outcomes than the general population, this is a good indication that the Aama programme is making progress in reaching this disadvantaged group.

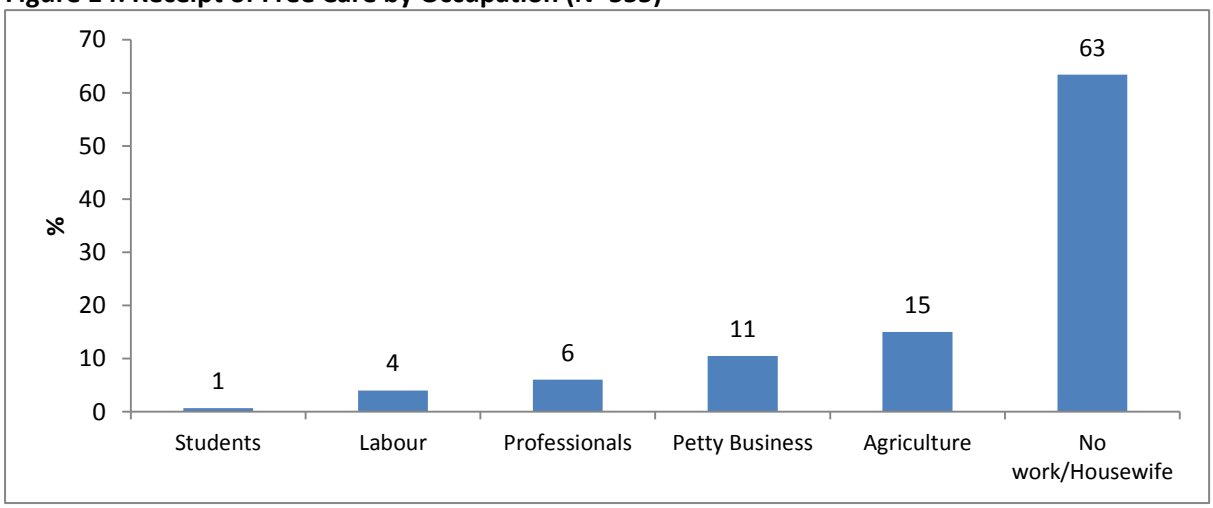
Table 28: Receipt of Free Delivery Care by Caste and District

District	Brahmin/Chhetri %	Tarai/ Madhesi other %	Dalit %	Newar %	Janajati %	Muslim %	Others %	Total (N)
A Mountain	80.4	2.2	15.2	2.2	-	-	-	46
B Mountain	39.0	2.4	2.4	14.6	39	-	2.4	41
C Hill	62.2	2.4	26.8	2.4	1.2	-	4.9	82
D Hill	51.5	1.0	26.7	1.5	17.0	-	2.4	206
E Tarai	40.3	11.3	12.6	1.9	11.3	15.7	6.9	159
F Tarai	62.5	20.8	16.7	-	-	-	-	24
Total	**51.8**	**5.2**	**19.5**	**2.7**	**12.5**	**4.5**	**3.8**	**558**

3.8.2 Receipt of Free Care by Occupation

Those with no paid work are the greatest recipients of free care, followed by those involved in agriculture and petty business (Figure 14). Professionals only make up six percent of those receiving free care, and this relates to the low number of women in this occupational group across the country.

Figure 14: Receipt of Free Care by Occupation (N=555)



3.8.2 Information on Free Delivery Care

Across all the districts, health workers were the most identified source of information on free care (Table 29). Encouragingly, across all the ecological regions, large proportions of women reported FCHVs as the information source on free delivery care.

Table 29: Sources of Information on Free Care

Source of information on Transport incentive	Mountain (N=100)		Hill (N=344)		Terai (N=285)		Total (N=729)	
	n	%	n	%	n	%	n	%
Health Worker	61	61.0	217	63.1	147	51.6	425	58.3
Radio/ TV	11	11.0	73	21.2	65	22.8	149	20.4
Friends/Neighbors	21	21.0	49	14.2	7	2.5	77	10.6
Family members	20	20.0	68	19.8	47	16.5	135	18.5
Other relatives/friends	4	4.0	22	6.4	9	3.2	35	4.8
FCHVS	41	41.0	132	38.4	90	31.6	263	36.1
Poster pamphlets	1	1.0	19	5.5	3	1.1	23	3.2
During ANC visits	14	14.0	38	11.0	7	2.5	59	8.1

**Percentage exceeds 100 due to multiple response*

3.9 HOME DELIVERIES

Across all six districts, this RA found only six home deliveries supported by an SBA who had then received the Aama incentive and recorded it at D/PHO level in annex 4.

The reason given for this by district level staff was that home deliveries have been discouraged. However, according to HMIS and the opinion of district staff, home deliveries are clearly still happening. While the HMIS shows that the number of home deliveries is still high, most service providers interviewed at the facility level reported that home deliveries were no longer practiced. Those that said they continued indicated that the numbers had dropped substantially.

All districts reported that due to the low incentive amount (NPR 170 excluding the tax) and the fact that the ANC Card and Birth Certificate are required, health workers have not been claiming the incentive. The six home deliveries were followed up, but due to the low sample size, these questionnaires have not been analysed.

As sufficient women who had delivered at home with an SBA could not be found for the sample as required, 13 qualitative interviews were conducted with women who had delivered at home and two with FCHVs. The key themes emerging from these interviews are presented briefly below.

3.9.1 Characteristics of Women who Delivered at Home

Most of the 13 interviewed women were illiterate with two completing secondary level of education i.e. grade 8. Many had delivered with only the help of their mother-in-law or neighbours. The FCHVs had helped when they were available. Most of the women had received some form of ANC; in one case this was provided in India. For those who had received ANC, approximately half had been informed about the importance of ID and a few had been told about the incentives offered by the 4ANC programmes.

3.9.2 Reasons for Home Delivery

Many of the women explained that they had delivered at home because the health facility was too far to travel to, or that they delivered on the way to the facility. For some, the unavailability of their husband or a male relative to take them to the facility was the reason, again highlighting the transport issues faced by women. The distance was still an influencing factor in delivering at an institution.

> *"It was my first delivery but it was not possible to go to the health facility because it was night time, the ambulance charge was expensive and my husband was not at home to carry me to the health facility."*
>
> *Woman who had home delivery, Grade 8 pass, hill district C*

Women's low autonomy, the inappropriate behaviour of health workers and previous experiences of women at health facilities were presented by women as de-motivating factors in delivering at a health institution. For instance, a woman from Tarai district F lamented why she did not want to deliver in a health facility:

> *"The behaviour of health workers is unfriendly and services and drugs are not free at public health facilities. My previous delivery was also at home so I did not visit the health facility. The quality of services there is too low."*
>
> Home delivery, illiterate housewife, Tarai district F

3.10 WHY WOMEN DELIVER IN HEALTH FACILITIES

The most popular reason for delivery in a health facility in districts D, E, A and B was that delivering in a facility was safer than delivering at home (Table 30). In districts C and F the free delivery service was most often selected as the main reason for choosing to deliver at the health facility. The transport incentive is identified as relatively important in the decision making process, but is less important for those living in the relatively better off hill district D.

Table 30: Reasons Given for Delivering in the Facility

Districts/Reason for Institutional Delivery	A-Mountain % (N=50)	B-Mountain % (N=50)	C-Hill % (N=88)	D-Hill % (N=256)	E-Tarai % (N=221)	F-Tarai % (N=64)	Total % (N=729)
Skilled Health Worker	24.0	48.0	48.9	44.5	43.9	51.6	44.3
Free Delivery Service	46.0	22.0	60.2	17.2	25.8	29.7	28.4
Transportation Incentive	30.0	16.0	39.8	3.5	8.1	23.4	13.7
Safe Deliveries	60.0	28.0	58.0	34.4	43.4	34.4	41.3
Advice from HW	16.0	16.0	13.6	10.5	4.1	3.1	9.1
Difficult to deliver at home	34.0	24.0	21.6	12.1	13.1	7.8	15.5
Absence of trained Health Worker at Home	2.0	6.0	2.3	1.6	2.3	0.0	2.1
Pregnancy complication	8.0	0.0	3.4	2.0	0.9	4.7	2.3

**Percentage may exceed 100 due to multiple responses*

3.10.1 Why Women Deliver in the Facility: Perspective of health facility staff

The qualitative interviews with health facility staff claimed that women prefer ID to home delivery and that they had seen an increase in IDs. They believed the reasons behind this increase in ID is the free service, transportation incentive, better facilities at health centres and effective counselling during the first ANC visit. They also added that people's awareness level has increased significantly so that people perceive ID as safe and good for the health of the child and mother.

However, still women deliver at home due to transportation difficulties, illiteracy, traditional norms and beliefs, delays in decision making and also because of the lack of anyone to accompany them. Some health facilities in the Tarai identified that this was particularly an issue for Muslim women.

> *"In the Muslim community, still women do not visit the health facility because of their religious belief; no touching is allowed by an outsider male during pregnancy and delivery"*
>
> PHCC, Service Provider Tarai district E

3.11 WOMEN'S EXPERIENCE OF DELIVERY SERVICES

Using exit interview guides, a total of 50 women were interviewed at the sampled health facilities to learn whether they received the incentive and benefits and to assess their immediate perception about the maternity service and the incentive scheme they experienced. All women discharged from the sampled health facilities during the day of the data collection were interviewed - 50 women from six districts.

This section of the findings only applies to a small proportion of the total sample and due to this small sample size limited conclusions can be drawn from the data. This also limits the value of undertaking more detailed analysis on the characteristics of the women (e.g. caste, occupation, age). Where data were missing from the exit interviews, these have been excluded from the number reported, thus the totals provided are not always 50. Since many of the questions had multiple possible answers, the total may exceed 100 %.

Table 31 below shows the respondents by facility type and whether they received the transport incentive. More than half of the respondents delivered at government hospitals (58%) followed by 28% who delivered at private hospitals. Due to the low case load in lower level health facilities, no women were discharged and prepared to take part in the interview on the day of data collection at the SHP level and only a few at the PHCC and HP level. All women interviewed at the PHCC and HP level had obtained the incentive while a few from the hospital had not. The incentive amount received by the women

differed even within the district, which could be due to some women getting the 4ANC incentive as well as the transport incentive. Among those claiming to have paid for the service, most of them had paid for registration, gloves and sanitary pads.

Table 31: Exit Interview of Women in Receipt of Transport Incentive

Type of facility	Women interviewed %	Women not receiving transport incentive %	Paid for delivery %
Government Hospital	58	11	54
Private Hospital	28	89	38
PHCC	12	0	8
HPs	2	0	0
Total (N)	**100 (50)**	**100 (9)**	**100 (13)**

Of the 50 women interviewed, 88% stated that the free delivery service and transport incentives were good. Furthermore, the ease of paying the transport cost (44%), there being no need to take a loan (5%) and also the chance of saving the life of the mother and child (23%) were cited as the reasons behind their satisfaction. Reasons for disliking the service were: 30% (11 women) found expenditure was higher than the incentive while 11% (4 women) said no free medicine was available. For a small proportion: 2% (2 women), late receipt of the transport incentive was the reason for disliking the service.

When asked more specifically about which components of the service were good, 36% (9 women) found the provision of the transport incentive to be good, 24% (6 women) found the free delivery service to be good, 20% (5 women) found the helpful nature of the health providers to be good and 20% (5 women) found sanitation of the health facility to be good. The major areas pointed out by the women as areas for improvement were: insufficiency of beds, unhygienic environment, late provision of incentive and the need to pay money to the sanitary (cleaning) staff.

3.12 FUND MANAGEMENT: PLANNING, BUDGETING AND FUND FLOW

3.12.1 Aama programme expenditure by district

Table 32 shows the expenditure on the Aama programme by district based on the financial report submitted to the Family Health Division (Personal Communication, Aama Monitoring Officer, FHD, 17 July 2012). The information is based on the reports sent to the FHD by districts up to 17 July 2012. The free care cost per woman in hill district D and Tarai district E were found to be the highest at NPR 2,712 and NPR 1,970 respectively. The average incentive provided per woman was found to be slightly higher than the allocated provision for mountain district B whereas it was lower for mountain district A. However, it needs to be noted that the reporting was incomplete for all the districts. For instance, mountain district A has only submitted a report for a single month of the fiscal year.

Table 32: Aama programme expenditure by district (NRs)

	Incentive provided to women	Number of women receiving incentive	Average incentive provided per woman	Payment made to health institution	Number of women receiving free care	Free care cost per woman
A Mountain	25500	19	1342.1	29000	19	1526.32
B Mountain	2349600	1475	1592.9	1726000	1364	1265.40
C Hill	1419000	1419	1000.0	1719000	1432	1200.42
D Hill	1820400	1833	993.1	4945000	1823	2712.56
E Tarai	3449500	6899	500.0	13592500	6899	1970.21
F Tarai	772000	1544	500.0	2056000	1544	1331.61

3.12.2 Planning and Budgeting at District Level

The Annual Work Plan and Budget (AWPB) for the Aama and 4ANC programmes was not developed in the same way across the districts. Three of the study districts (Districts D, F and E) developed their AWPB and sent it to the DoHS for consideration, while the other three districts merely relied on estimates calculated by the DoHS which were based on the previous year's number of deliveries in the respective districts. The districts that prepared their own AWPB based on institutional deliveries and local knowledge of expected increases in deliveries tended to receive the Aama programme annual budget they requested, barring some minor variations. Involvement of the district team in the Aama programme AWPB development process appeared to help in reducing the annual budget deficit in the programme. The annual budget deficit was high in districts which only relied on the DoHS annual estimate. However, it should be noted that the Aama guidelines do not encourage district involvement in developing the AWPB, as stated in section 3, clause 4.2.

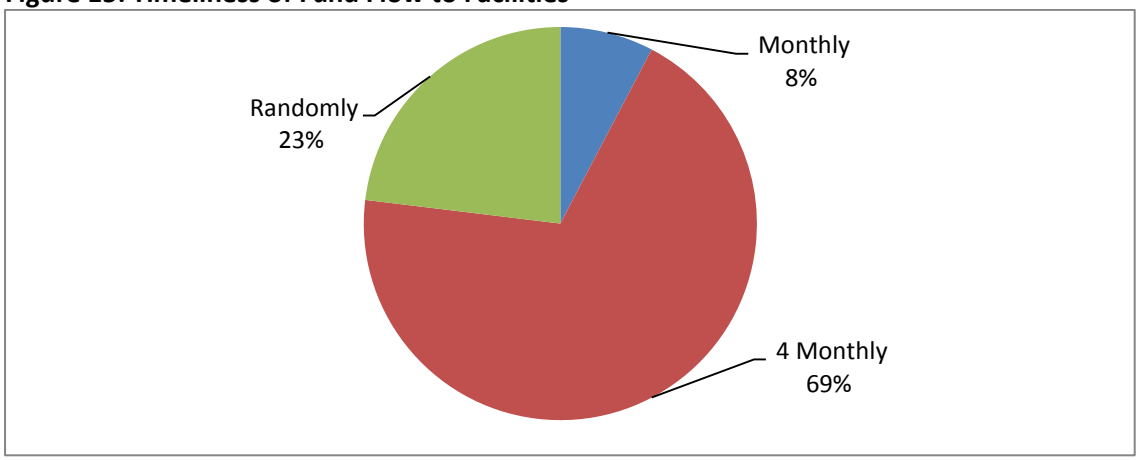
3.12.3 Delays in Budget Approval

There was a considerable delay in budget approval in all districts. In FY 2011/12, all districts received the approved budget sheet (Akhtiyari) from the DoHS after a delay of at least three months, as reported by the respective D/PHO account officers.

3.12.4 Delays in Fund Flow to Health Facilities

The timing of the disbursement of Aama programme funds by the D/PHO to the health facilities was not uniform across the facilities: 69% of health facilities received funds on a trimester basis; 8% on a monthly basis and 23% randomly as per review of the D/PHO records and interviews with respective account officers (Figure 15). Although the Aama programme guidelines do not specify the frequency of fund disbursement from the D/PHOs to the health facilities (government institutions), the guidelines state that all advances should be settled before the end of the fiscal year regardless of the implementing institution. For private hospitals implementing the Aama programme in a district, the fund reimbursement should be linked to their monthly report submitted to the D/PHO (section 3, clause 4.4).

Figure 15: Timeliness of Fund Flow to Facilities



3.12.5 Mechanisms for the Release of Funds to Health Facilities

The D/PHOs released funds to the respective health facilities using two different modes: bank deposits and cash advances to individual staff (applicable for GoN institutions). For the institutional unit costs, the D/PHOs either issued an AC payee cheque or deposited the funds into the health facilities' bank accounts. Mountain district A was an exception to this as the transport incentive was paid as cash in advance to the AFP's own personal bank account before being provided to the staff of the concerned health facility. The reason given was the unavailability of the Finance Officer; however the fund transaction between the AFP in the D/PHO and the health facility staff was not officially accounted for. The advanced amount was settled by individuals as and when appropriate, with no standard timeline.

3.12.6 Sufficiency and Flow of Funds at Health Facility Level

26% of health facilities reported they had insufficient funds (deficit) during implementation of the Aama programme. This deficit was managed in a number of ways within the health facility, for example through personal borrowing, use of institutional funds under any unspent line item, use of the HFMC's fund, (DC) and (DDC) support and use of the 4ANC incentives to pay the transport incentive to women. Some health facilities did not pay the transport incentive to the women at the time of discharge but informed the women they would receive the incentive once funds were released from the D/PHO. Similarly, more than 40% of health facilities stated that they had problems with fund disbursement from the D/PHO: they received funds after a delay, or inadequate amounts were advanced. The delay in disbursement was noted mostly at the beginning and end of the fiscal year. 68% of government health facilities received funds as an advance from the D/PHO.

In the case of budget deficits at the district level, priority was given by the D/PHO to pay the transport incentive to women, which is in line with the Aama programme guidelines. Institutional unit costs and payment to health service providers were made upon receiving additional funds from the DoHS. However, some districts with a budget deficit could not request the additional budget on time due to the late submission of financial reports (annex 6 and 10) from peripheral health facilities.

3.12.7 Financial Reporting

In this section we report on the frequency of financial reporting (annexes 6 and 10) from health facilities to the D/PHO using data collected from the D/PHOs' finance sections and the sampled health facilities. Responses were matched and the contradictions are detailed in Table 33. We verified responses received from the D/PHOs with the D/PHOs' finance sections, but we could not do the same with responses received from health facilities as the record keeping was relatively poor. Hence, we consider the D/PHOs responses the most reliable. Although the Aama programme guidelines demand monthly reporting from the health facilities to the D/PHOs, only 8% of the health facilities did so. In mountain

district B, all sampled health facilities stated that they sent the financial report to the D/PHOs every month, but this could not be verified with the D/PHOs' records. The untimely submission of the reports was also cross-checked with the reported fund deficit and the indication received was that most health facilities do not submit financial reports monthly so that fund disbursement was constrained.

Table 33: Financial Reporting Inconsistencies

Financial reporting frequency	Response from D/PHO %	Response from Health Facility %
Monthly	8	67
4 monthly	69	18
Half yearly	0	3
Randomly	23	13

The reporting frequency and completeness of the Aama programme reports (Annex 6) by the districts to the Family Health Division was analysed (Table 34). Results showed that mountain district A had submitted a report for only a single month while mountain district B, hill district D and Tarai district E had submitted reports for the 10 months of the year. The reporting frequency was found to be monthly for all districts except for mountain district A and hill district C who submitted reports randomly. The information submitted (Annex 6) was also found to be only partially complete for half of the districts.

Table 34: Reporting Status of Districts to Family Health Division

Districts	Reporting frequency	Completeness of report	Last report received for the month of
A Mountain	Randomly	Partially complete	Shrawan 2068
B Mountain	Monthly	Complete	Baisakh 2069
C Hill	Randomly	Complete	Poush 2068
D Hill	Monthly	Complete	Baisakh 2069
E Tarai	Monthly	Partially complete	Baisakh 2069
F Tarai	Monthly	Partially complete	Chaitra 2068

3.12.8 Financial Monitoring

All D/PHOs noted the provision of a four-monthly internal audit by the District Treasury and Account Control Office (DTACO). However, following the records of the audit report, the frequency of the internal audit varied from 2 months to 12 months, and one district (mountain B) had no internal audit in the last fiscal year. One of the reports of the internal audit stated that utilisation of the institutional unit cost deposited into the account of the HFMC was unaudited. Similarly, internal audit reports mostly noted that additional advances were issued without settlement of the previous advance, which was not in line with the Aama programme guidelines.

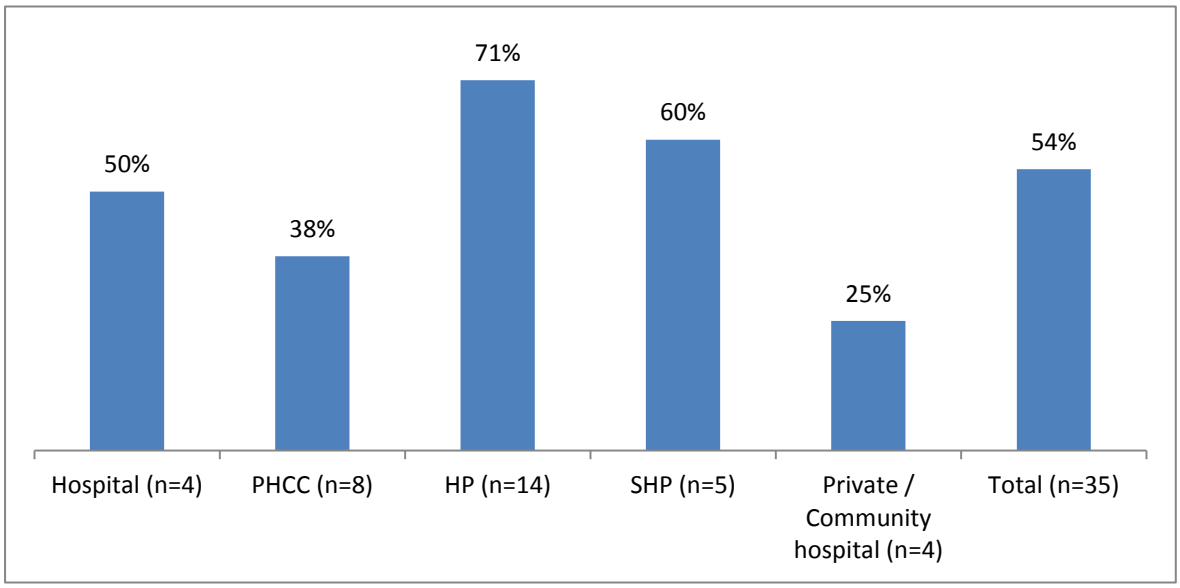
Regarding the financial audit of health facilities, 58% and 61% of health facilities stated that they had internal and external audits respectively. Key audit findings reported were: the incentive given to women should be accounted and must be shown in the income and expenditure statements of the health facilities; book keeping systems must be improved; institutional unit costs received under the Aama programme should be used according to the rational decision of the respective HFMC. These key findings were reported from a majority of health facilities.

3.12.9 Display Boards of Aama Beneficiaries

The Aama programme implementation guidelines (page 6, P2) recommends displaying the names of the beneficiaries and other details (Copy of Annex 10 of Aama guidelines) every month on the D/PHOs' and municipalities/VDCs' display boards. This survey found only 54% of the sampled health facilities to be publicly displaying the names of the beneficiaries of the Aama programme. Public displays were made on institutions' notice boards. Lower level health facilities generally displayed the names of the Aama

beneficiaries more often than hospitals: 71% and 61% respectively for HPs and SHPs, with only 50% for hospitals (Figure 16).

Figure 16: Proportion of Health Facilities with a Display Board of Aama Beneficiaries



In all districts, the AFP and other staff from the D/PHOs stated that they conducted supervision visits to health facilities. However, no supervision checklists (annex 7 – Aama programme supervision checklist) were filled in and no written feedback provided to the facilities. In response to questions asked to health facility staff on the effectiveness and frequency of supervisory visits from the D/PHO, they stated that visits were ad hoc and largely focused on fund utilisation. As stated by periphery level health facility staff, the issues they raised during the Aama programme supervisory visits were largely unaddressed, and instead the visits were related to budget deficits, irregular fund flow, lack of Aama and 4ANC programme guidelines and lack of orientation.

3.12.10 Qualitative Information on Fund Flow: From the Centre to Districts

Five out of the six districts explained that the budget amount was calculated based on the number of IDs in the last year. Two D/PHOs specifically mentioned that the number of ANC visits was also used to calculate the Aama programme budget. Only one district stated that this process was also determined by the proportion of women of reproductive age and the fertility rate. All districts also identified that this process was driven from the central level and one district pointed out their desire to become more involved in the budgeting process, saying that:

> *"If we had the chance to be involved in budgeting it might be very fruitful for implementation of Aama"*
>
> Aama Focal Person - district A mountain

Only mountain district A reported that the amount they were allocated from the central FHD was insufficient to meet the need in the district. While most districts did not raise this point, two specifically said that the amount was sufficient. Several D/PHOs mentioned making a request to the FHD for additional resources, although there was no indication of whether extra resources were received or not.

The main frustration raised by all districts was the late release of funds. All districts noted that the budget for the first quarter did not arrive until the second quarter. Those that specified the dates explained that the authority was received during Kartik but the budget was not released until Mangsir in 2068. This led to considerable difficulties in implementing the programme and disbursing funds to the facility level.

3.12.11 Qualitative Information on Fund Flow from Districts to the Facilities

3.12.11.1 District Views on Fund Flow to Facilities

Despite the challenges posed by the late arrival of Aama funds, all D/PHOs reported providing an advance of funds to the health facilities to cover transport incentives. It should be noted that none of the districts or health facilities received Aama and 4ANC funds as separate allocations. Two districts (hill district D and Tarai district F) were not providing an advance to private hospitals, which instead were reimbursed for payments made once funds arrived. One district (hill district C) paid an advance for three or four months to the hospital, but not to birthing centres, who were expected to pay mothers from their own budget and wait to be reimbursed by the district.

Two districts (mountain district B and Tarai district E) calculated the advance to birthing centres based on the previous period's records of IDs. No consistency was found in terms of the time periods for the provision of the advance, with one district specifying two months and another quarterly. The lack of consistency is evident in if, how, and when funds are advanced to facilities. Several of the district officers (D/PHOs and AFPs) identified how the delay in the disbursement of funds was detrimental to the Aama programme. One D/PHO stated:

> *"Delay in realising and receiving the budget at district level affects the process of providing the advance to the health facilities; it also affects the payments to mothers at the health facility level."* (District Public Health Officer, District A Mountain)

When considering who within the health facilities were receiving the funds, again districts varied. However, they all gave the funds to either the nursing staff or the in-charges. In one district, the AFP was responsible for providing the advance to facilities; however, for most districts this was done by the D/PHOs. One AFP pointed out that when funds were given to the in-charges, this led to difficulties in providing the incentive. All districts explained that the payment of unit cost funds was made directly into the health facilities' bank accounts.

3.12.11.2 Facilities' Views on Fund Flow

Facilities did not receive separate allocations for the Aama programme transport incentives and for the 4ANC programme. Most health staff interviewed stated that the untimely fund flow is the most important problem with the programmes. The delays in fund flow mean that many staff must use their own money or ask the mother to come back to the facility at a later date to collect the incentive. To deal with the problems of fund flow, many facilities admitted that:

> *"Mothers are given money from the pockets of the staff or the accounts of HFMC and after submission of the quarterly report to the district, the fund is reimbursed."*
> (PHCC, in-charge, Tarai district E)

The majority of facility level staff interviewed explained that they received an advance from the D/PHO based on the number of pregnancies in the previous quarterly report. Once they submitted the delivery report and the financial report, the clearance for the advance is made.

3.13 MANAGEMENT OF AAMA AND 4ANC

3.13.1 Overall Management of Aama and 4ANC

All interviewed staff at D/PHOs were positive about the aims of the Aama and 4ANC programmes, even though they all identified issues with the implementation of the programmes. These issues are reported below.

3.13.1.1 Possibilities for misuse of funds: District Perspective

At district level, when the D/PHOs and AFPs were asked about possibilities for the misuse of funds, only one AFP (mountain district A) identified the possibility of false reporting of deliveries with no actual delivery cases. The feeling was that misuse of the institutional unit cost funds was more likely than misuse of transport incentive funds. Several districts raised concerns that the unit cost paid to facilities might be more open to misuse. One example given was the unit cost being used for meeting allowances even though facilities were instructed not to do this. Most district staff identified mechanisms they had in place to overcome the misuse of funds. The mechanisms mentioned included:

- Ensuring that the "rules and regulations" were followed including those of the facility and of the Aama programme.
- Ensuring that facilities submit their monthly reports on time. This was particularly true for districts that based their advance on the submission of reports.
- Ensuring that monitoring and supervision were conducted.
- Raising public awareness of women's right to the incentive scheme.
- Tracking some women during supervision visits to facilities.
- Meeting with the in-charge to verify the records and submitted documents.

3.13.1.2 Role of Aama Focal Person

Only two of the districts had a PH nurse working as the AFP. Districts where the PH nurse position was vacant had assigned the role to either the Staff Nurse, Family Planning Officer or a senior ANM. All D/PHOs and AFPs identified supervision, monitoring, recording and reporting of the Aama programme as key elements of the AFP's role. Most also identified training, particularly of SBAs and FCHVs. Three of the six districts felt the AFPs should promote institutional delivery and discourage home delivery.

3.13.2 Implementing Aama: Guidelines and Instructions

3.12.2.1 Aama and 4ANC Guidelines and Training: At District Level

Only two of the six AFPs had, or had ever had, a copy of the Aama programme guidelines from the FHD (2069). Of the remaining four AFPs, two were delivering the Aama programme based on the district level implementation guidelines published by the FHD (068/069) and two were only working according to the instructions given to them by higher authorities, i.e. a letter of instruction from the FHD as per the Aama programme guidelines.

During the interviews with AFPs and D/PHOs, all districts described a similar process in information flow regarding the 4ANC programme. None of the districts had any detailed guidelines on the programme. Some had brief letters of instruction. The main way that most AFPs found out about the 4ANC programme was verbally from the D/PHOs after they had attended central or regional meetings or workshops. This lack of detailed information on the 4ANC programme was consistent across all districts. The result was that while AFPs and D/PHOs were aware that women who underwent 4ANC visits should be given the NPR 400 incentive, few knew any more details than this. None of the AFPs had received any training on the Aama programme or the 4ANC programme. This was consistently raised as a limitation to effective implementation of the programme. One AFP stated:

> *"There is lots of confusion on implementation of the programme. If I had training and support on Aama and 4ANC I would be able to run district trainings for facility staff so they could also learn about these programmes."* (Aama Focal Person, hill district D)

A further issue arising in hill district D concerned the regional hospital. Since the D/PHO has no authority over the regional hospital (as this lies directly with the FHD), the hospital had not agreed to implement the 4ANC programme.

3.13.2.2 Aama and 4ANC Guidelines and Orientation: At Facility Level

A similar picture can be seen at the facility level with only 65% of health facilities having a copy of the Aama programme guidelines and only 37% having the 4ANC programme guidelines (Table 35). 35% of health facilities are providing Aama services without guidelines in place. People who had seen the guidelines appeared to have a good knowledge of the content. A particularly poor situation was found in Tarai district E, where none of the facility staff interviewed had a copy of the Aama programme guidelines.

Table 35: Proportion of health facilities with Aama guidelines

Health facilty	Facilities having Aama guidelines %	Having 4ANC guidelines %	Total N
All types of health facility	65	37	43
District/Regional Hospital	83	50	6
PHCC	50	38	10
HP/SHP	64	35	22
Private/Teaching hospital	80	25	5

Out of all the facility staff interviewed, very few were aware of any instructions or guidelines on the 4ANC programme and 63% had not seen the 4ANC guidelines. Some districts (A, B and C) had a few facilities that had seen instructions on the 4ANC programme, but most knowledge of the NPR 400 for the 4ANC programme was derived from word of mouth. Many of those interviewed stated that the ANC guidelines need to be disseminated. People who had received some instruction on the 4ANC programme said:

> *"The activities specified are difficult, particularly regarding iron tablets, albendazole and ANC check-ups according to specific months".* (Government Hospital, medical superintendent Tarai district E).

Some health facilities raised concerns of specific omissions in the ANC programme guidelines for e.g. tax on the incentive to the health workers. Some private hospitals explained that they followed their own institutional guidelines when implementing the ANC programme. Many of those interviewed both at district and facility level questioned the need for women to provide their ANC and citizenship cards. These requirements severely hampered the ability of the women to claim their incentive for the 4ANC visits.

The HFMC members interviewed had little awareness of the Aama programme guidelines, with only six across all the facilities in all the districts having seen them. Most of these six confessed to not having studied the guidelines in detail. None of the HFMC members interviewed had seen any guidance or knew the details of the 4ANC programme.

3.14 THE UNIT COST INCENTIVES FOR FACILITIES

3.14.1 The Unit Cost: From District Perspective

When asked about the use of the unit cost, all D/PHOs and AFPs stated that this was to be determined by the HFMC. Most D/PHOs and AFPs stated that the unit costs were used for purchasing medicine and equipment for delivery, clothes and blankets for the babies, food (e.g. Jwano soup), hiring local staff and incentives for other staff involved with the delivery.

3.14.2 The Unit Cost: From the Facility Perspective

Almost all the health facility in-charges, finance officers and service providers reported that the unit cost is used to purchase essential medicine and equipment. Many also said that the unit cost was used for provider incentives. A few facilities admitted receiving some remuneration from the VDC as well. A few

respondents from private hospitals reported that the unit cost was a source of profit or earning for the hospital.

Several districts (A, B, E) said that the incentive was used for recruiting staff. Many facilities were using the money to maintain the delivery room, pay bills of electricity, water and other necessary utilities and for maintaining hygiene and sanitation. A few facilities provided food to the mothers and clothing to the infants. Some health workers reported saving part of the unit cost and depositing it into the HFMC's account for use in case of future need. One Finance Officer in a District Hospital noted that the unit cost paid to facilities to cover the costs of deliveries and complications was not sufficient to meet the costs.

3.15 MONITORING AND SUPERVISON

The description below summarises the information from the qualitative interviews with district staff on the monitoring and supervision provided by the regional and central level.

3.15.1 Monitoring from the Centre and Region: the District View

When interviewed, the AFPs in two districts (hill district C and mountain district B) stated that they received regular supervisory visits from the RHD and in particular from the regional AFP. Several districts commented that while they received fairly regular supervision from the regional level, this was not specifically for the Aama programme. Monitoring from the FHD at central level was much more irregular, with two districts stating that they had never had central level monitoring.

3.15.2 Monitoring from District to Health facilities

From the district perspective, most D/PHOs and AFPs mentioned some level of monitoring and supervision of health facilities. In one case, this was done by telephone due to the geographical terrain. Integrated supervision conducted by the FP officer was also frequently mentioned as was the role of the accounts section in programme monitoring.

3.15.3 Use of Aama Annexes and HMIS

Across all districts issues arose concerning the limited use of Aama programme recording and reporting forms (annexes as outlined in the Aama programme guidelines). In contrast, in hill district D the records were found to be well maintained, with annexes 3, 4 and 10 available and appropriately filled in at the district level. Particular issues were raised in mountain district A where it was observed that the facility level had no proper reporting system, including no signature or thumb stamp of the mother even though they had received the incentive. Furthermore, annexes 3 and 4 had not been filled in properly and annexes 6 and 10 had not been submitted since the beginning of this fiscal year (17 July 2011). Allocations were being made in this district without the annexes.

One particular issue arose in hill district D where the regional hospital was not submitting Aama programme annexes to the D/PHO but only the HMIS 32 form. This is because they report directly to the FHD and did not feel they needed to submit the Aama programme annexes to the district. Issues were found with annex 4 (which records home delivery) across all districts except hill district D. Obtaining trend data was a challenge in many districts as this was not available for the five years required by the study. The timeliness of receiving reports was identified in some districts. However, as many facilities were receiving their Aama programme reimbursements based on the annex reports, this issue was overcome in many areas. Hill district D identified some difficulties with SHP staff who do not normally come to the district on a monthly basis.

The qualitative interviews with D/PHOs and the AFPs highlighted some inconsistencies in the regularity of reporting. Four D/PHOs stated that reports were received monthly from the birthing centres, while two districts stated that reporting was done quarterly (mountain district A) and two said monthly (Tarai district E). Of those districts with monthly reporting, the AFPs indicated that this was often a challenge for birthing centres, particularly due to the geography of the district. In terms of the advance provided

from the D/PHOs to the birthing centres, reporting was often more irregular, with reports being submitted from birthing centres when the funds were spent or on a quarterly basis (hill district D), or irregularly (mountain district B). One district complained that:

> *"Few of the centres settle the advance by the end of the fiscal year"* (AFP mountain district B).

Poor quality of reporting was identified by all AFPs, but for some this was a particular issue for private facilities. Issues were raised with the completeness of annex 4 for reporting on home deliveries and payment to health workers. Among the health facility staff interviewed, only a few admitted to completely filling annexes 3, 4 and 10. Many complained that they had had no training on filling them in.

All those interviewed were asked what they felt were the main areas for improvement in the Aama programme. Only limited information was collected in this way and the data lacks detail of the suggested actions to be taken. Nevertheless, the following list provides a summary of the issues raised:

- the need for the timely release of the budget;
- regular and supportive supervision from the central and regional levels;
- implementing awareness raising programmes among the community, particularly for the 4ANC programme to include making use of local media;
- involvement of the VDCs and the DDCs in programme implementation and monitoring;
- performance management of facilities with rewards to those implementing the programme well, and
- mobilisation of local resources to ensure the sustainability of the programme.

SECTION FOUR: METHODS AND KEY FINDINGS OF PREVIOUS RAPID ASSESSMENTS

As noted in section 1.2, various RAs have been conducted to assess the Aama programme at different intervals. It should be noted that a straightforward comparison of RAs is not appropriate as they vary in their approach, methods and respondents. This section (Table 36) gives a simple description of the methods and key findings of various RAs carried out in the following areas:

a) Availability of programme implementation guidelines and their use;

b) Public display of information of recently delivered women in health facilities;

c) Fund flow and its management;

d) Mismatch of information concerning women delivered in the health facility;

e) Utilisation of institutional delivery.

Table 36: Methods and key findings of previous Rapid Assessments - a summary

RA1 (March 2008)	RA2 (December 2008)	RA3 (July 2009)	RA4 (March 2010)	RA5 (June 2010)	RA6 (July 2012)
1. Methods used (coverage, tools and participants)					
・ Four districts and 21 health facilities (1 Zonal and 4 district hospitals, 7 PHCCs, 7 HPs and 2 SHPs) ・ Semi-structured interviews, in-depth case studies, observation, financial records review, and cross verification ・ Exit clients, Key informants in the district, health facility staff, FCHVs, RDW at HF and home (assisted); and their family members	・ Six districts and 32 health facilities (1 regional, 1 Zonal and 5 district hospitals, 1 medical college, 10 PHCCs, 8 HPs and 6 SHPs) ・ Semi-structured interviews, in-depth interviews, cross verification and observation. ・ D(P)HOs, Accountants, Focal Person , FP Supervisors, THWs and focal person at HF, RDW at HF and home (assisted)	・ Six districts and 26 health facilities (1 Zonal and 6 district hospitals, 9 PHCCs, and 10 HPs) ・ Cross verification, semi-structured interviews, in-depth interviews, exit interviews and review of the financial data ・ D(P)HOs, Accountants, Focal Person , FP Supervisors, SBAs and focal persons at HF, ・ RDW at HF and home (assisted), FCHV, HFMC members	・ Six districts and 24 health facilities (6 district hospitals, 6 PHCCs, 6 HPs and 6 SHPs) ・ Cross verification, semi-structured interviews, in-depth interviews, exit interviews and review of the financial data and HMIS data/registers ・ D(P)HOs, Accountants, Focal Persons, FP Supervisors, in charge/managers and service providers at HF, recently delivered women at HF and home (assisted), FCHV, HFMC members, school teachers, exit clients	・ Six districts and 31 health facilities. (1 Zonal and 4 district hospital, 8 Mission/community/NGO hospitals, 7 PHCCs, 6 HPs, and 5 SHPs) ・ Semi-structured interviews, observation, exit interviews, review of records and cross-verification ・ D(P)HOs, PHNs, Accountants and Statisticians, HFMC, managers/in-charge and service providers at the HF, RDW at HF and home (assisted), exit clients	・ Six districts and 48 health facilities (1 regional, 1 Zonal and 5 district hospitals, 5 private hospitals, 12 PHCc, 18 HPs, and 6 SHPs) ・ Semi-structured interviews, observation, exit interviews, review of HMIS registers and financial records including claim forms, and cross-verification ・ D(P)HOs, PHNs, Accountants and Statisticians, HFMC, manager-in-charge and service providers at the health facilities, RDW at HF and home (assisted), exit clients

RA1 (March 2008)	RA2 (December 2008)	RA3 (July 2009)	RA4 (March 2010)	RA5 (June 2010)	RA6 (July 2012)
Findings 1: Availability of programme implementation guidelines and its use					
Not clear information about the guideline in the report	Not clear information about the guideline in the report	Guideline availability is not mentioned in the report. In depth knowledge on the new policy was found to be lacking among some of the health providers, confusion in filling the claims forms, and following up of amended policy was found e.g claiming NPR 300 for assisting in home delivery.	Not clear information about the guideline in the report	Not clear information about the guideline in the report	Only two out of six SHPs had/ever had, a copy of Aama programme guideline. Of the remaining, two were using the District Level Implementation guideline (068/069) and two were working only to the instructions. All districts described a similar process in information flow on the 4ANC. Only 65% of health facilities had a copy of the Aama guideline and 37% had the 4ANC guideline or instructions.
Findings 2: : Public display of information of recently delivered women in health facility					
No information about the public display in the report	Five out of 32 HF were found to be practicing the public display (four PHCCs and one HP)	Five out of 26 health facilities had practiced the public display; however not all were fully detailed and updated	Five health facilities (2 district hospitals, 2 PHCCs and 1 HP) out of 24 HF, had practiced the public display.	No information about the public display in the report	Only 54% of the health facilities practiced the public display Compared to hospitals, peripheral health facilities practiced the public display more – 71% and 61% HPs and SHPs respectively, see figure 18.

RA1 (March 2008)	RA2 (December 2008)	RA3 (July 2009)	RA4 (March 2010)	RA5 (June 2010)	RA6 (July 2012)
Findings 3: Fund flow of the programme					
The status of SDIP fund flow at the district level has improved. Each district had received certain amount of funds in advance. The district health office allocates funds to health institutions based on the previous quarter's caseloads. Delays in disbursement of the fund at PHCC and HP levels were reported in some districts.	A marked improvement in the status of fund flow was reported. However, most peripheral health facilities were not paying women the cash incentive instantly; especially during the beginning and end of the fiscal year. It shows that the peripheral health facilities are not in a position to utilise the management committee fund or other sources of funds to compensate for the delay.	Flow of funds has eased considerably in all the districts except one. One district marked the allocated amount of fund as "inadequate". Fund flow from the D(P)HO to the peripheral facilities varied as each had different provisions for providing funds. Reimbursement of the funds to the health facilities was similar to the Round II assessment.	Arrival of funds was delayed in all the districts. However, four districts were able to use the fund available with the DTCO. Fortunately, the delay did not affect the Aama programme as the peripheral HF used the HFMC fund for paying the transportation incentive. Almost all the districts were found to be reimbursing claim forms after the advance had been spent.	The fund flow has improved slightly. However the delay in national budget approval affected fund flow and many health facilities had difficulties in managing funds. Only one district studied was able to utilise the funds from the DTCO and distribute funds to all its health facilities on time. There was late receipt of incentive in peripheral health facilities. All HF except one PHCC seek reimbursement as and when they have used up the advance money.	All districts experienced late release of funds,, meaning that many staff have to use their own money or have to ask the mother to come back to the facility for the incentive. The process was found to be driven from the central level. Only one district reported the allocated amount to be insufficient. Some facilities identified particular issues in terms of reimbursement of ANC funds. All D/PHOs reported providing an advance of funds to the public health facilities to cover transport incentives.

RA1 (March 2008)	RA2 (December 2008)	RA3 (July 2009)	RA4 (March 2010)	RA5 (June 2010)	RA6 (July 2012)
Findings 4: Mismatch of information of women delivered in health facility					
Financial mismanagement and fiduciary risks was observed. Of 22 women, misuse was identified in six cases. E.g. names of few women appearing in the home delivery claim forms were actually women who had not sought the assistance.	It was revealed that health providers have been dishonest while making claims for provider's incentives. Of the 159 women recipients of institutional deliveries traced, 8% of the claims were false. On the contrary, only 19 out of 66 claims made for HD were found to be genuine.	False claims for both ID and HD in the periphery are high. Comparatively, false claims on ID were high in Tarai districts whereas in hill districts false home delivery claims were high. Provider's compliance with free delivery service" has been a challenge in almost all health facilities. Clients have been persuaded to purchase certain items.	Cross verification showed false claims for ID to be high in the hills, whereas mountain districts had high percentages of HD false claims. A large proportion of the false claims for ID were actually home deliveries. In a considerable number of cases, the THWs had deliberately persuaded women to deliver at home. A considerable proportion of women who had delivered at the health facilities had paid for the service.	A decline in fraud cases was shown, with only 7% of the ID claims forms found to be false. No false claims were found in the private sector health facilities.	Of 838 women, the records of 78 women given on the Aama Annexes at the D/PHO level did not match with health facility maternity register data. This may be due to human error, and does not necessarily equate to attempts to misuse funds. In 5% of cases the health facility reported that the woman received the incentive but the woman said she did not receive it.
Findings 5: Utilisation of institutional delivery					
No trend analysis was performed. Health care providers were found to believe that ID has considerably increased in their HF due to the incentive, and an increased level of awareness among the community.	No trend analysis was performed. Nearly all health providers perceived that the trend of institutional deliveries had increased over the years.	An upward trend in ID was visible at the hospital level and to some degree, at the PHCC level only. The trends in ID at the HP level have fluctuated over the past six months.	ID at the district hospitals has increased considerably in all the sample districts since the introduction of the Programme. Similarly, at the PHCC and HP level there is a slight increase in ID. The trends in ID in the mountain and hill zones have not improved as expected.	The overall trend in ID has increased over the past year, basically due to the increase in ID in private sector facilities. However, ID at the government hospitals (mountain and hill zones) has not increased much.	The national data shows an increase in ID from 16% to 33% over the four-year period. The mountainous districts have seen a sharp increase, and hill district show an increase in Institutional deliveries. One tarai district shows the highest proportion of assisted home deliveries.

SECTION FIVE: KEY FINDINGS AND RECOMMENDATIONS

5.1 POLICY IMPLICATIONS

The current Aama programme guidelines do not address the 4ANC programme. While the overall implementation guidelines of FHD do briefly cover the 4ANC programme, this is limited and those at district and facility level have limited instructions on how to implement the programme. Since the completion of this RA, the FHD has revised the Aama programme guidelines to include the 4ANC programme so addressing this concern.

Key Finding 1: There are inconsistent practices in terms of fund disbursement from D/PHOs to health facilities. This results in fund deficits at the D/PHO and health facility level.

> *Recommendation 1: The revision of the Aama programme guidelines should include detailed instructions on the fund flow mechanism in order to avoid delays in the disbursement of funds.*

Key Finding 2: Compared to the Aama programme, the 4ANC programme is poorly implemented in all facilities. One of the explanations for this is the difficulty women face in meeting the criteria required to obtain the 4ANC programme incentive.

> *Recommendation 2: A review of the criteria for accessing the incentive should be carried out, taking into consideration the practicalities for women at the time of delivery.*

Key Finding 3: While women have adequate knowledge about the Aama programme transport incentives and free care, there is very limited awareness of the 4ANC programme and limited uptake, with only 13% of women who had delivered in a HF receiving the 4ANC incentive.

> *Recommendation 3: The influence of health workers in providing information to women should be taken advantage of in campaigns to raise awareness of the Aama programme and other safe motherhood incentives. Campaigns must be adapted for inaccessible mountain areas to make use of more locally available information sources such as FCHVs and radio.*

Key Finding 4: Private hospitals are attempting to manage the Aama programme effectively but poor orientation to the Aama programme has led to limitations to the programme's implementation within the private sector.

> *Recommendation 4: Proper review of the Aama and 4ANC programmes within the private sector is required before considering scale up.*

5.2 PROGRAMME MANAGEMENT

5.2.1 Orientation on Aama and 4ANC

Key Finding 5: The Aama programme guidelines are not available in some districts and the majority of facilities. Only 65% of health facilities have a copy of the Aama programme guidelines and only 37% have a copy of the 4ANC programme instructions. Some D/PHOs did not have copies of the Aama programme guidelines.

> *Recommendation 5: Disseminate guidelines to all those institutions that have a role in implementing the Aama Programme.*

Key Finding 6: None of the district level or health facility level staff had had specific orientation on the Aama or 4ANC programmes. Much of what they knew came from word of mouth and occasionally from the guidelines, when available.

Recommendation 6: Provide orientation on the guidelines for all those involved in implementing the Aama Programme. The feasibility of a cascade approach, whereby AFPs provide training to health facility staff and HFMC members could be explored.

Key Finding 7: Not all women are receiving free care; overall, 23% are still paying some costs to health facilities for their deliveries. Explanations provided by the HFMCs of what the unit cost is used to cover and the distribution of the incentive among staff was not always clear. This may provide a grey area which may facilitate the misappropriation of funds.

Recommendation 7: Improve orientation to the HFMC chairperson and members on the uses of the unit cost as specified in the Aama programme guidelines.

5.2.2 Planning and Budgeting

Key Finding 8: Although the guidelines state that planning and budgeting for the Aama programme should be done centrally, this RA found that those districts involved in developing their own plans and budgets were more likely to manage their budget well and have less fund deficit throughout the year.

Recommendation 8: The FHD should engage the D/PHOs to develop locally appropriate and owned plans and budgets for the Aama and 4 ANC programmes.

5.2.3 Reporting, Monitoring and Supervision

Key Finding 9: Mismatches between the districts and health facilities (overall 10% of cases) and between the health facilities and the women (overall 5%) were found. As described above, these inconsistencies between facilities and D/PHOs and between facilities and women cannot be interpreted as misuse of funds, as legitimate reporting errors may be included here.

Recommendation 9: Strengthen the reporting systems between the health facilities and the districts and provide regular monitoring with cross verification in order to deter any misuse of funds.

Key finding 10: Only a minority of health facilities reported having regular monitoring and supervision in relation to the Aama programme. This may well undermine the motivation to complete the annexes properly and to report on time. Where districts were deeply involved in developing their own annual planning and budgeting plans, they were more likely to chase up annexes from health facilities and monitor implementation.

Recommendation 10: The health facilities should be regularly monitored and supported to ensure that all annexes are completed accurately and in a timely fashion.

Key Finding 11: Overall, only 54% of health facilities publicly displayed annex 10 showing Aama beneficiaries over the last month. This limits public accountability of the Aama programme.

Recommendation 11: Routine monitoring and supervision visits are needed to ensure that the display of Aama beneficiaries in health facilities becomes routine practice. The full engagement of the HFMC in the process is also required to ensure annex 10 is displayed as per the Aama programme guidelines.

Key Finding 12: There were very few districts that identified regular monitoring and supervision support from the central Safe Motherhood programme and the regional AFPs.

Recommendation 12: Review central and regional monitoring and supervision arrangements in order to ensure that district staff are supported and supervised in implementing the Aama and 4ANC programmes. Focus on districts that are underperforming within the Aama and 4ANC programmes and consider encouraging inter-district support from high performing to low performing districts.

5.3 IMPLEMENTATION

Key Finding 13: While the women in hill and mountain districts are commonly given the incentive themselves, in the Terai districts the majority of the incentives disbursed are handed to husbands or other relatives. This is in contradiction to the Aama programme guidelines.

> *Recommendation 13: Work with health workers in Tarai districts to explore culturally appropriate ways to ensure that the Aama incentives are given directly to women, rather than to husbands or other family members.*

Key Finding 14: The study found that while the aim of the Aama programme is to encourage institutional deliveries, home deliveries are still taking place without being reported. The explanation for this is that the criteria required for the SBA to claim the incentive is a disincentive to the reporting of home deliveries.

> *Recommendation 14: Encourage the SBAs to report assisted home births as an HMIS reporting requirement, rather than solely as a means of accessing an incentive.*

5.4 RECOMMENDATIONS FOR FUTURE RAPID ASSESSMENTS

Recommendation 15: Use the same methodology and the same matching and cross verification processes as in this RA in order to facilitate comparison between the RA results.

Recommendation 16: Focus the next RA on the recommendations made in this RA to identify progress made in overcoming current challenges.

****

ANNEXES

ANNEX 1: DISTRICT SAMPLING FRAME

ID	District code	Number of deliveries in last six months	HDI	ID	District code	Number of deliveries in last six months	HDI
1	Hill G	1307	0.472	39	Hill N	3025	0.467
2	Hill K	973	0.507	40	Tarai L	7157	0.437
3	Hill O	2019	0.521	41	Hill B	10390	0.593
4	Tarai I	12594	0.494	42	Hill U	1924	0.492
5	Hill S	2209	0.442	43	Mountain K	21	0.502
6	Tarai M	10166	0.531	44	Mountain L	103	0.482
7	Hill Y	1807	0.481	45	Hill W	1737	0.498
8	Hill AA	1456	0.484	46	Tarai N	3161	0.482
9	Mountain B	1390	0.481	47	Hill Z	2894	0.486
10	Tarai Q	9643	0.453	48	Hill AB	1344	0.504
11	Tarai S	8760	0.429	49	Tarai A	11790	0.546
12	Mountain O	1792	0.479	50	Hill AJ	1698	0.535
13	Tarai T	12622	0.5	51	Hill AK	1666	0.524
14	Mountain P	1582	0.467	52	Tarai C	8942	0.479
15	Hill AL	1078	0.523	53	Tarai E	4292	0.429
16	Hill AM	1843	0.488	54	Hill I	3397	0.381
17	Tarai D	10018	0.465	55	Tarai G	5726	0.409
18	Hill F	1236	0.595	56	Mountain G	203	0.371
19	Tarai F	7244	0.518	57	Mountain H	1018	0.367
20	Hill J	2642	0.41	58	Hill P	1278	0.343
21	Tarai H	16669	0.449	59	Mountain I	1141	0.348
22	Mountain F	1478	0.45	60	Mountain J	1016	0.322
23	Hill Q	25611	0.652	61	Mountain A	630	0.304
24	Hill R	3758	0.543	62	Hill AC	1632	0.416
25	Hill T	8411	0.588	63	Hill AE	1412	0.384
26	Tarai B	10131	0.407	64	Hill AF	2078	0.384
27	Hill V	2467	0.479	65	Hill AG	1412	0.399
28	Hill X	2426	0.463	66	Hill AI	5390	0.486
29	Tarai O	8536	0.448	67	Hill A	2555	0.35
30	Hill AD	1231	0.434	68	Hill E	1437	0.391
31	Mountain M	429	0.394	69	Mountain C	1656	0.331
32	Tarai P	8865	0.409	70	Mountain D	1180	0.31
33	Tarai R	7658	0.408	71	Hill H	2376	0.434
34	Hill AH	3046	0.469	72	Mountain E	954	0.424
35	Mountain N	1711	0.414	73	Hill L	2078	0.402
36	Hill C	1821	0.471	74	Tarai J	7339	0.442
37	Hill D	3364	0.492	75	Tarai K	4399	0.463
38	Hill M	2320	0.454				

***Note:** Selected districts are highlighted*

ANNEX 2: TRAINING SCHEDULE

Field Researchers Training Plan
Group: A
Venue: Union House Anamnagar
Time: 9:30 am to 5 pm
Date: 4th to 7th May 2012

Days	Session	Activity	Time		Responsibility
Day 1	Session 1	Registration	7:30	:8:00	All
		Tea/Coffee			
		Welcome programme and training objectives	8:00	8:10	HERD
		Welcome remarks and Brief about HERD	8:10	8:25	HERD/SK
		Brief about Aama and 4ANC Programme	8:25	8:50	Dr.Shilu Aryal-FHD
		Planning and monitoring of Ama Programme	8:50	9:10	Jhabindra Pandey-FHD
		Brief about Aama Rapid assessment and its objectives	9:10	9:30	Dr. Suresh Tiwari-NHSSP
		Overview of fund flow mechanism and financial reporting in Aama programme	9:30	10:00:00	Shiva Pandit–NHSSP
		Group division and break	10:00	10:20	MT/All
		Orientation on Annexes in Aama guideline: 1,3,4,5,6,10	10:20	12:30	KMJ/AS
		Lunch Break	12:30	1:00	All
	Session 2	Sampling and sample size	1:00	1:20	MT
		Orientation on Annexes in Ama guideline: 2, 7, 8, 9	1:20	2:30	AKP/SKc
		Role of Field Researcher and Introduction of tools	2:30	3:00	MT
		Tea/Coffee break	3:00	3:15	All
	Session 3	Aama Quiz	3:15	4:00	SKc/RP
Day 2	Session 1	Registration	9:30	10:00	All
		Tea			
		Revision of the Day-I	10:00	10:15	All
		Tool 3A: Exit client Interview Questionnaire	10:15	11:30	MT
		Tool 2D: Secondary Information from Facility	11:30	12:00	SKc
		Lunch Break	12:00	12:30	All
	Session 2	Tool 2C: Financial Information at Facility	12:30	1:15	KMJ/AS
		Tool 3B: Questionnaire Women Delivered at Home by HW	1:15	2:30	AKP
		Tool 2 A: Provider Interview guide	2:30	3:30	MT
		Tea/ coffee	3:30	3:45	
	Session 3	Demonstration	3:45	5:00	
Day 3	Session 1	Registration	9:30	9:50	All
		Tea /Coffee			
		Revision of the Day-II	10:00	10:15	All
		Tool 3C: Questionnaire Women Delivered at Health Facility	11:00	12:30	AKP
		Lunch Break	12:30	1:00	All
	Session 2	Tool 2B: Facility management committee interview guide	1:00	1:45	YA
		Tool1 A: D/PHO interview guide	1:45	2:15	Achham team
		Tool 1B: District Finance interview guide	2:15	2:45	Rupandehi team
		Tool1C: Aama focal person Interview guide	2:45	3:15	Sankhuwasabha team
		Tea/Coffee	3:15	3:30	All
	Session 3	Pretesting plan	3:30	3:45	MT
		Logistic arrangement and field movement Instruction	3:45	4:15	RP
		Demonstration	4:15	5:00	All
Day 4	Session 1	Pre-testing (Field practice)	9:30	1:00	All
		Lunch Break	1:00	1:30	All
	Session 2	Feedback session and Finalisation of Questionnaire	1:30	5:00	All

Field Researchers Training Plan
Group: B
Venue: Union House Anamnagar
Time: 9:30 am to 5 pm
Date: 4th to 7th May 2012

Days	Session	Activity	Time		Responsibility
Day 1		Registration	7:30	:8:00	All
		Tea/Coffee			
		Welcome programme and training objectives	8:00	8:10	HERD
		Welcome remarks and Brief about HERD	8:10	8:25	HERD/SK
		Brief about Aama and 4ANC Programme	8:25	8:50	Dr.Shilu Aryal FHD
	Session 1	Planning and monitoring of Aama Programme	8:50	9:10	Jhabindra Pandey-FHD
		Brief about Aama Rapid assessment and its objectives	9:10	9:30	Dr. Suresh Tiwari NHSSP
		Overview of fund flow mechanism and financial reporting in Aama programme	9:30	10:00	ShivaPandit NHSSP
		Group division and break	10:00	10:20	MT/All
		Role of field Researchers	10:20	10:45	MT
		Orientation on Annexes in Aama guideline: 2, 7, 8, 9	11:00	12:00	AKP/SKc
		Lunch Break	12:00	12:30	All
	Session 2	Introduction of Tools	12:30	12:50	MT
		Orientation on Annexes in Aama guideline: 1,3,4,5,6,10	12:50	3:00	KMJ/AS
		Tea/Coffee break	3:00	3:15	All
	Session 3	Aama Quiz	3:15	4:00	HE/MT
Day 2		Registration			
	Session 1	Tea/Coffee	9:30	10:00	All
		Revision of the Day-I	10:00	10:15	All
		Tool 3C: Questionnaire Women Delivered at Health Facility	11:00	12:30	AKP
		Lunch Break	12:30	1:00	All
		Tool 3 A: Exit client Interview Questionnaire	1:00	2:10	MT
		Tool 2 D: Secondary Information from Facility	2:10	2:30	SKc
	Session 2	Tool 2 C: Financial Information at Facility	2:30	3:30	KMJ/AS
		Tea/ coffee	3:30	3:45	All
	Session 3	Demonstration	3:45	5:00	
Day 3		Registration	9:30	9:50	
		Tea /Coffee	9.50	10.00	All
		Revision of the Day-II	10:00	10:15	All
		Tool 1 D: Secondary data district level	10.15	11:00	SKc
	Session 1	Tool 2 A: Provider Interview guide	11:00	12:30	MT
		Lunch Break	12:30	1:15	All
		Tool 2 B: Facility management committee interview guide	1:15	1:45	YA
		Tool 1 A: D/PHO interview guide	1:45	2:15	Mugu team
		Tool 1 B: District Finance interview guide	2:15	2:45	Kaski team
		Tool 1 C: Aama focal person Interview guide	2:45	3:15	Mohattarai team
		Pretesting plan	3:15	3:30	YA
		Tea/Coffee	3:30	4:00	All
		Logistic arrangement and field movement Instruction	4.00	4:15	AS
	Session 2	Demonstration	4.15	5.00	All
Day 4	Session 1	Pre-testing (Field practice)	9:30	1:00	All
		Lunch Break	1:00	1.30	All
	Session 2	Feedback session and Finalisation of Questionnaire	1:30	5.00	All

ANNEX 3: LIST OF RESOURCE PERSONS/TRAINERS

From HERD	**From FHD/MoHP/NHSSP**
Dr. Sushil Chandra Baral –SCB Dr. Helen Elsey- HE Dr. Sampurna Kakchapati–SKc Mr. Kumar Jung Malla–KJM Mr. Ashok K Paudel –AKP Ms. MeeraTandan–MT Ms. YeshodaAryal–YA Mr. Anup Shrestha –AS Mr. Ramesh Pathak–RP	Dr. Shilu Aryal Mr. Jhabindra Pandey Dr. Suresh Tiwari Mr. Shiva Pandit

ANNEX 4: IMPLEMENTATION TEAM

Name of District Leads and Field Researchers

Districts	District Leads	Name of Field Researchers
1. Accham (Far West)	Research Lead: Pankaj Joshi Finance Lead: Deepak Lamichhane	Manoj Khadka (Team Leader - TL) Samjhana Nepali Krishna K.C. Hem Raj Joshi Basanta Thapa Shraddha Manandhar
2. Mugu (Mid West)	Research Lead: Tilak Mahatara Finance Lead: Anup Shrestha	Laxam KC (TL) Emee Awai Rai SantoshGiri Manisha Singh
3.Rupandehi (Western)	Research Lead: Dr.Sampurna Kakchhapati Finance Lead: Jyoti Prakash Pandey	Sudeep Devkota (TL) Chetan K.C Bishanu Thapa Abdul Khan Arjun Neupane Raj Kumar Paudel Bibek Praksh Shrestha Namuna Shrestha Subina Upadhya Shreeya Shrestha
4. Kaski (Western)	Research Lead: Yeshoda Aryal Finance Lead: Sushil Aryal	Mayur Sharma (TL) Bimal Chandra Pun Bishal Gole Nikita Gauchan Sailaja Ghimire Santosh Pahari Pawan Pandeya Baburam Acharya Astha kasaju Deepa Pokhrel
5. Mohattari (Central)	Research Lead: Ashok Kumar Paudel Finance Lead: Kumar Jung Malla	Sudhir Mishra (TL) Saurabh KishorSah Manisha Singh Amit Lal Yadev Narendra Narayan Chaudhary Dilip Kr. Saha Samita Kila Neha Deo MD Kafullwara Shailendra Patel Uttam Gautam
6. Sankhuwasava (Eastern)	Research Lead: Meera Tandan Finance Lead: Ramesh Pathak	Krishana Prasad Bajagain (TL) Sanju Karki Roma Karki Pritha Manandhar Kendra Mani Niraula Arpan D.C Ashok Pandey

ANNEX 5: AAMA ANNEXES

<table>
<tr><th>Forms related to Implementat'n guideline</th><th>Use of the Forms</th><th>Available at</th></tr>
<tr><td>Annex:1
Related to clause 3 of guideline</td><td>a) Provision for the transportation expense and other benefits to the service client-woman
<table><tr><td>Sankhuwasabha</td><td>NPR: 1500.00/delivery</td></tr><tr><td>Mugu</td><td>NPR: 1500.00/delivery</td></tr><tr><td>Accham</td><td>NPR: 1000.00/delivery</td></tr><tr><td>Kaski</td><td>NPR: 1000.00/delivery</td></tr><tr><td>Rupandehi</td><td>NPR: 500.00/delivery</td></tr><tr><td>Mahottari</td><td>NPR: 500.00/delivery</td></tr></table>b) Incentive for the service provider paid by HFMC for providing free delivery service at home: NPR. 200.00 per delivery for providing free delivery service at home of service client woman (submission of duplicate of birth certificate of the delivered baby is most).
c) Incentive for the service provider paid by HFMC for providing free delivery service at health facility not more than NPR. 300.00 per delivery for providing free delivery service at health facility.
d) “Unit Price” indicates the amount (monetary) provided to health facility by Nepal Government for providing delivery service to each service client-woman.
(i) Normal Delivery Service:
• NPR: 1000.00 per delivery to all approved private & public health facilities (Hospitals, PHCCs, HPs, SHPs & clinics) having less than 25 beds
• NPR: 1500.00 per delivery to all approved private & public district, zonal and specialized Hospitals having capacity to provide delivery Service with complication management BEOC
(ii) Delivery Service with complication management-BEOC: NPR.3000.00 per delivery to all health facilities for BEOC service.
(iii) Delivery with Caesarean Section (C/S or operation): NPR.7000.00 per delivery to health facility for C/S service.</td><td>1. Hospitals
2. At Private/NGO Facility
3. At PHCC
4. At HP and SHP
5. Other health institutions/ hospitals/clinics etc. involved in Aama programme</td></tr>
<tr><td>Annex: 2
Related to clause 2(b)</td><td>a) “Delivery Service” indicates all activities including normal delivery, delivery service of a mother with complications and delivery service that requires Caesarean Section (C/S).
b) Delivery service with complications includes following services of complications:
i. Antepartum Haemorrhage-APH
ii. Postpartum Haemorrhage-PPH
iii. Ectopic Pregnancy:
iv. Prolonged labour/obstructed labour
v. Ruptured Uterus:
vi. Severe Pre-eclampcia:
vii. Eclampcia:
viii. Retained placenta:</td><td>1. Hospitals and Other BEOC service centres involved in the management of complication and C/S</td></tr>
</table>

	ix. Purperal sepsis x. Multiple pregnancy & Breech presentation	
Annex:3 ***Related to clause 5 (2) and 6 (1)***	Application form to be filled for the transportation expense by women and health facility	1. Hospitals 2. At Private/NGO Facility 3. At PHCC 4. At HP and SHP 5. Other health institutions/ hospitals/clinics etc. involved in Aama programme
Annex: 4 ***Related to clause 7***	Recommendation form for giving incentive to service provider for providing delivery service at home	1. At PHCC 2. At HP and SHP 3. Other rural health institutions etc. involved in Aama programme
Annex: 5 ***Related to clause 5 (4)***	Request and receipt form for donation money on account of service provided by implementing the Aama Programme at health facility. *(Health facility should fill the form monthly and request for money)*	1. Hospitals 2. At Private/NGO Facility 3. At PHCC 4. At HP and SHP 5. Other health institutions/ hospitals/clinics etc. involved in Aama programme.
Annex: 6 ***Related to clause 10***	Aama Programme monthly report form *(Aama Programme implementing health facility should fill monthly report and send to district health office, and district health office should compile and send monthly report to Department of Health Services, Management Information Section and Family Health Division)*	1. Hospitals 2. At Private/NGO Facility 3. At PHCC 4. At HP and SHP 5. Other health institutions/ hospitals/clinics etc. involved in Aama programme
Annex:7 ***Related to clause 9***	Supervision checklist for Aama programme	1. RHD 2. D/PHO 3. Hospital management committee
Annex:8 ***Related to Clause 8(2)***	Memorandum Of Understanding (MOU) between District (Public) Health Office and NGO/private health facility in order to implement Aama Surakchha Krayakram at the NGO and private health facilities	1. D/PHO 2. Aama programme implementing private health institutions
Annex: 9 ***Related to clause 2 (e)***	Required or essential criteria for Birthing Units	1. D/PHO 2. ALL public and private birthing centres
Annex:10	Form to be filled by Health Facility while claiming Unit Cost	1. Hospitals

Related to clause 5, sub-clause 4 (b)	2. At Private/NGO Facility 3. At PHCC 4. At HP and SHP 5. Other health institutions/ hospitals/clinics etc. involved in Aama programme

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