



Ministry of Health & Population



Progress Report on the Aama/4ANC Demand Side Financing Programme

Prabhat Lamichane and Dr. Suresh Tiwari

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List of Acronyms

ANC	Antenatal Care
BEOC	Basic Emergency Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
CS	Caesarean Section
DoHS	Department of Health Services
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FY	Fiscal Year
GoN	Government of Nepal
HMIS	Health Management Information System
MoHP	Ministry of Health and Population
NDHS	Nepal Demographic and Health Survey
SBA	Skilled Birth Attendant
SLC	School Leaving Certificate
STS	Service Tracking Survey

Summary

Recognising that public subsidies for health care will serve as a cornerstone in improving health service utilisation, six demand side financing schemes are currently under implementation in Nepal. Of these, the *Aama* Programme and the programme for 4ANC (Antenatal Care) visits both aim to increase maternal health service utilisation, thereby reducing maternal and neonatal morbidity and mortality. This report reviews progress made recently using *Aama* Programme and 4ANC related studies and information from the financial monitoring system. Key highlights are:

- **Integration of the 4ANC protocols within the *Aama* guideline:** The protocols for the provision of the 4ANC incentive and information on the monthly expenditure have been integrated with the *Aama* Programme Implementation Guideline, including in reporting and recording forms such as Annex 6 of the *Aama Surakshya* Programme.
- **Expansion of the *Aama* Programme in the Private Sector:** A total of 48 private facilities are currently implementing the *Aama* Programme, representing a gradual increase as per government policy.
- **More health facilities are providing Basic/Comprehensive Emergency Obstetric Care (B/CEOC) services:** Altogether, as of May 2012 there were 144 BEOC Centres, 133 CEOC Centres, and more than 1100 Birthing Centres throughout Nepal [Family Health Division (FHD), 2012].
- **Utilisation of the *Aama* Programme:** Altogether a total of 295,949 women received free delivery care and 293,901 women received the transportation incentive in FY 2011/12 [*Aama* Programme Recording, FHD, 2012]. Likewise, findings from the Nepal Demographic Health Survey (NDHS) 2011 show that more poor, rural and illiterate women are benefitting from the *Aama* Programme.
- **More women are delivering at public health institutions:** Institutional deliveries conducted by Skilled Birth Attendants (SBAs) have increased to 34% in FY 2011/12 from 15% in FY 2008/09. Deliveries conducted in B/CEOCs, as a proportion of total health facility deliveries, have increased steadily over the years from 28% in 2008/09 to 46% in 2011/12 [HMIS section, Management Division].
- **Increase in Awareness of *Aama* Programme/4ANC:** According to the recent Service Tracking Survey (STS), 84% of women knew about the transport incentive and 79% were aware that delivery services should be free [Subedi et al 2012].

I. Background

The Ministry of Health and Population (MoHP) in collaboration with DFID has initiated and implemented the *Aama* Programme in Nepal. The *Aama* Programme design rests on the assumption that by pooling both the financial and health risks across the country, public health care can be used as an effective instrument for poverty reduction and resource redistribution through the provision of direct cash transfers. For instance, benefit incidence analysis carried out using Nepal Living Standard Survey data and public expenditure data show that utilisation of public health services is high among Dalits and people residing in remote areas [1].

The *Aama* Programme is a national priority programme that aims to reduce maternal and neonatal mortality and morbidity through demand and supply side incentives and free delivery care. *Aama* is an innovative, evidence-based financing scheme designed to mitigate the high costs of giving birth by providing free institutional delivery care and incentivising deliveries through cash payments to women to compensate for transport (and other indirect) costs. Its main goal is to reduce maternal mortality in line with the Government of Nepal's (GoN's) National Safe Motherhood and Newborn Health - Long Term Plan 2006-2017. More broadly, it contributes to poverty reduction by reducing the likelihood of catastrophic expenditure. It has been envisaged that through the programme the financial burden of delivery on household finance will be reduced, especially in the poorest quintile of the population, thereby increasing service utilisation. Similarly, conditional cash transfers on completion of four ANC visits are provided to women to encourage take up of this service.

The *Aama* Programme provides funds to participating institutions and covers the following:

Incentives to Women: Cash payments are made to women immediately following institutional delivery. These are: NRs. 1,500 (US \$19)¹ in the mountains, NRs. 1,000 (US \$13) in the hills and NRs. 500 (US \$7) in the terai.

Free Institutional Delivery Services: Payments are made to health facilities for the provision of free care. For a normal delivery, health facilities with less than 25 beds receive NRs. 1,000 (US \$13); health facilities with 25 or more beds receive NRs. 1,500 (US \$19). For complicated deliveries health facilities receive NRs. 3,000 (US \$38); for caesarean sections (CS) NRs. 7,000 (US \$88).

Incentives to Health Workers for Home Deliveries: These are in the process of being phased out in order both to emphasise the importance of institutional delivery and because this incentive is difficult to implement and monitor. Incentive payments to health workers for home deliveries have been reduced to NRs. 100 (US \$1.2) from NRs. 200 (US \$2.5).

4ANC: A sum of NRs. 400 (US \$5) is provided to women on completion of four ANC visits in the fourth, sixth, eighth and ninth months of pregnancy.

This progress report summarises the key developments in the *Aama* Programme along with the 4ANC incentive, using findings from various studies and information from the financial monitoring system.

¹ US \$1= NRs. 80

II. Progress made

Integration of the *Aama* guideline with the 4ANC incentive

The protocol for the provision of the 4ANC incentive and information on the monthly expenditure of the 4ANC incentive has been integrated in the *Aama* Programme Implementation Guideline, including in reporting and recording forms such as Annex 6. Annex 6 has been added to the guideline to provide monthly details on the types of obstetric cases. In addition, the conditions that private and community based health organisations need to fulfil in order to be able to implement the *Aama* Programme have also been added to the guideline.

The *Aama* Programme in the private sector

As of May 2012, 54 private facilities had been approved to implement the *Aama* Programme. Of these, two have discontinued, one hospital has been closed, and five are yet to begin implementation. One facility discontinued due to insufficiency of funds to cover the delivery costs while another discontinued after an issue was raised concerning inappropriate use of funds. Hence, only 46 private facilities implemented the programme in FY 2011/12.

Expansion of service outlets

Aiming to reach a wider population, the government increased the service outlets which provide safe maternity services, mainly through upgrading existing facilities. Table 1 shows the number of facilities that provide Comprehensive Emergency Obstetric Care (CEOC), Basic Emergency Obstetric Care (BEOC) and 24-hour Birthing Centres, as of May 2012. Overall, the total number of safe delivery sites increased from 1,199 in July 2011 to 1,415 in May 2012, an 18% increase [2]. Out of the current 1,415 safe delivery sites across the country, 133 are CEOC sites, 144 are BEOC sites and 1,138 are Birthing Centres. Initially, the *Aama* Programme was only available in government facilities, but has been gradually expanded to private facilities.

Table 1: Number of CEOC, BEOC, and 24-hour safe delivery sites by development region

Facility type/ Region	CEOC		BEOC			24-hour Birthing Centres				Total
	Govt	Private	Govt Hospital	PHCC	Private	PHCC	HP	SHP	Private	
Eastern	14	16	2	33	3	19	117	74	4	282
Central	11	43	0	21	0	35	114	105	7	336
Western	11	20	10	18	0	20	111	37	0	227
Mid-western	7	4	8	22	1	4	145	153	0	344
Far-western	5	2	4	18	4	1	87	105	0	226
Sub-Total	48	85	24	112	8	79	574	474	11	1,415
Total	133		144			1,138				1,415

Source: Family Health Division, 2012

More women are benefitting from the *Aama* Programme

Table 2 shows that altogether a total of 295,949 women have received free delivery care and 293,901 women have received the transport incentive in FY 2011/12 [*Aama* Programme Recording, FHD, September 2012]. This number is expected to increase as complete reports are still missing from 12 reporting sites as of 30 September 2012. In FY 2010/11 the total number of women receiving free delivery care and the transportation incentive was 238,797 and 229,959 respectively, representing increases of 24% and 28%. It should be noted that complete reports had been obtained

only from 50 sites for FY 2010/11, so some of the increase is due to better reporting. Furthermore, the results show that the proportion of normal delivery, complicated delivery and CS have remained constant. A total of 20,675 home deliveries were reported in FY 2010/11 compared to 27,094 home deliveries in FY 2011/12. This may also be due to the better reporting in FY 2011/12.

Table 2: Women receiving free delivery care and transportation incentive for two fiscal years with dissimilar reporting

Type of Delivery/ Fiscal Year	2010/11 (Complete report from 50 sites out of 98 sites)				2011/12 (Complete report from 86 sites out of 98 sites)			
	Women receiving free delivery care		Women receiving the transportation incentive		Women receiving free delivery care		Women receiving the transportation incentive	
	N	%	N	%	N	%	N	%
Normal Delivery	183,949	77.0	179,906	78.2	231,245	78.1	230,450	78.4
Complicated Delivery	27,778	11.6	26,159	11.4	33,992	11.5	33,765	11.5
CS	25,038	10.5	22,923	10.0	29,279	9.9	29,250	10.0
Post-abortion Care	828	0.3	703	0.3	541	0.2	128	0.0
Referral cases	1,204	0.5	268	0.1	892	0.3	308	0.1
Total	238,797	100.0	229,959	100.0	295,949	100.0	293,901	100.0

Source: Aama Programme Recording, FHD, 2012

Table 3 shows the number of women receiving the free delivery and transportation incentives by development region. At the national level, out of the total number of expected pregnancies, 38% of women received free delivery care. Encouragingly, the results suggest that the Mid-western and Far-western regions have the highest proportion of women receiving free delivery care (45.7% and 45.5%). Similar to our study results, the 2011 NDHS findings had also showed that a relatively smaller proportion of women from the Mid-western and Far-western regions had paid cash to health facilities (14.4% and 22.1% respectively) than women from other regions (39.4% for the Eastern, 57.8% for the Central and 36.6% for the Western) [3].

Table 3: Women receiving free delivery care and transportation incentive by region, FY 2011-12

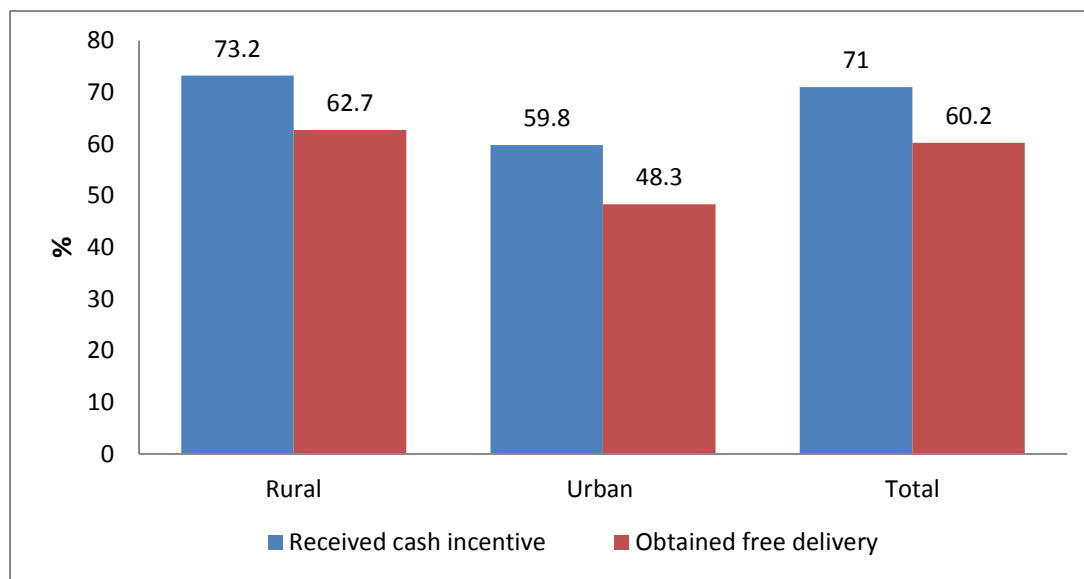
	Expected pregnancies	Women receiving free delivery	Women receiving the transportation incentive	Women receiving free delivery as % of expected pregnancies	Women receiving the transportation incentive as % of expected pregnancies
Eastern	180,701	65,993	65,831	36.5	36.4
Central	258,257	96,497	95,435	37.4	37.0
Western	152,925	52,297	52,029	34.2	34.0
Mid-western	103,857	47,498	47,271	45.7	45.5
Far-western	73,959	33,664	33,335	45.5	45.1
Total	769,699	295,949	293,901	38.4	38.2

Source: Aama Programme Recording, FHD, 2012 and HMIS section, Management Division

Poor, rural and illiterate women are benefitting from the Aama Programme

The recent Nepal Demographic Health Survey (2011) included questions directed at women with a live birth in the two years preceding the survey, to assess the utilisation of the *Aama* Programme [3]. The results show that nearly three quarters (71%) of women who had a live birth in a health facility in the two years preceding the survey had received the cash incentive (Figure 1), and 60% of women had received free delivery care from the facility. A higher proportion of rural women received the cash incentive than urban women (73.2% vs. 59.8%). Although different in design, in the Rapid Assessment study which was conducted in only six districts in May and June 2012, 77% of women reported that their deliveries were free [4].

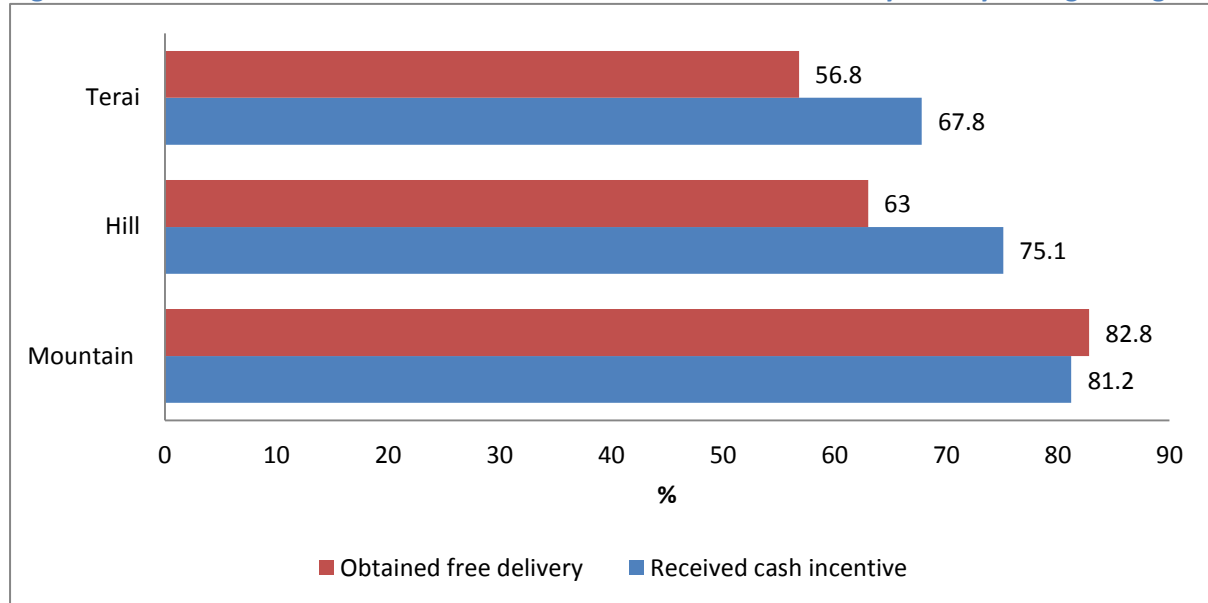
Figure 1: Women who received cash incentive and obtained free delivery by residence



Source: NDHS 2011

Figure 2 shows women who received the cash incentive and obtained free delivery care by ecological region. The results showed that a high proportion of women residing in mountain zones (81%) received the incentive to offset transportation costs, followed by women from the hills (75%) and the terai (68%). Likewise, a higher proportion of women living in mountain regions (82%), followed by the hills (63%) and the terai (56%) had obtained free delivery care.

Figure 2: Women who received cash incentive and obtained free delivery care by ecological region

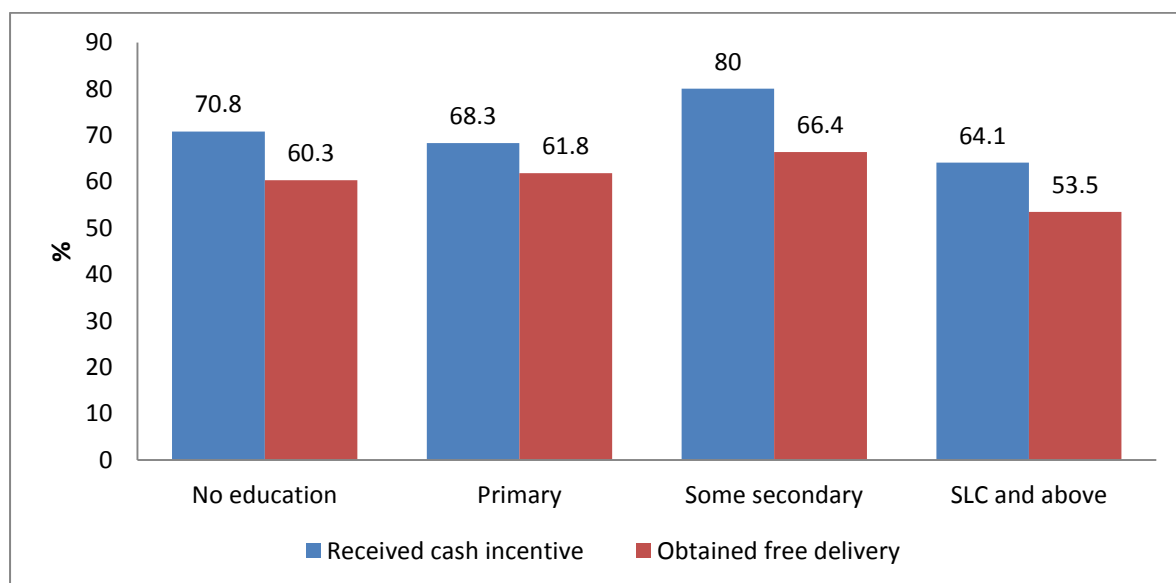


Source: NDHS 2011

These results are in line with those from the Rapid Assessment which showed that the proportion of free deliveries was lower in the terai districts (55%). Eighty eight percent of women in the mountains and 87% in the hills reported having had free delivery care at a health facility [4].

When examined by educational status, the NDHS shows that about 70% of women with no education, or only primary education, who had a live birth in the two years preceding the survey, reported receiving the cash incentive (Figure 3) to cover their transportation cost while 80% of women with a secondary level of education reported receiving it. However, only two thirds of women with an education level of School Leaving Certificate (SLC) and above reported receiving the cash incentive. This may suggest that fewer women with higher education deliver in public facilities as they might have a better income with options of accessing private care.

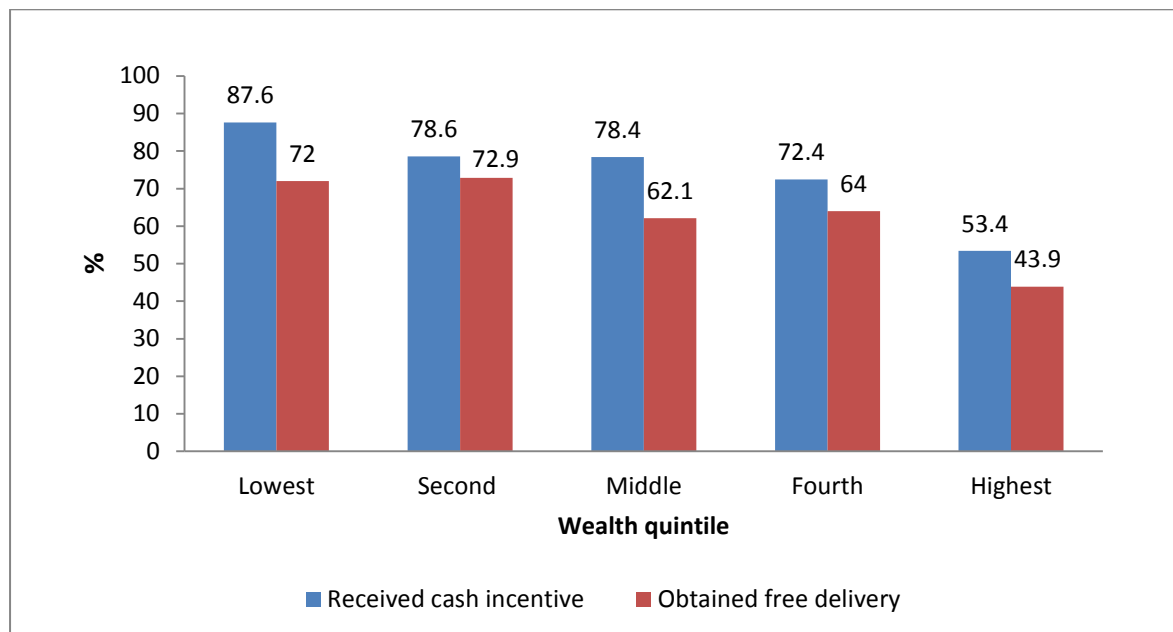
Figure 3: Women who received cash incentive and obtained free delivery care by education



Source: NDHS 2011

When analysed by wealth status, the results from the NDHS reveal that nearly 90% of women in the lowest quintile had received the cash incentive while among women in the highest quintile the proportion was 53% (Figure 4). Similarly, the proportion of women obtaining free delivery care was high in the poorest quintile and lowest in the richest quintile. These findings suggest that women in the richest quintile deliver in private facilities that do not provide the *Aama* incentives.

Figure 4: Women who received cash incentive and obtained free delivery care by wealth status



Source: NDHS 2011

Regarding ethnicity, results from the Rapid Assessment showed that out of 712 women who received the *Aama* incentive, 51% were Brahmin/Chhetri, 19% were Dalit, almost 13% were Janajati and 5% belonged to the Terai/Madhesi caste [4]. 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.

Overall, according to the Rapid Assessment, 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* Programme guideline. The mountain districts performed comparatively poorly, with only 71% of women receiving their *Aama* incentive at the time of discharge as compared to hill and terai districts, where 87% and 90% of women respectively received the incentive on the day of discharge.

Women benefitting from the 4ANC incentive

For the first time, the Rapid Assessment also included questions on the 4ANC incentive. The findings from the Rapid Assessment [4] showed that across all six districts 13% of women who had delivered in a health facility (111 women) had also received the 4ANC incentive of NRs. 400. When analysed by ecological region, the findings showed that only 2% of the 285 women from the terai had received the 4ANC incentive. Out of 344 women residing in hill areas, 15% received the 4ANC incentive while the proportion was 35% out of 100 women in the mountain region. Overall, 42% of women who delivered in a health facility were aware of the 4ANC incentive, with 32% being aware of the scheme before they started their ANC visits. The awareness was lowest among women from the terai. The

Brahmin/Chhetri group represented the highest proportion (50%) receiving the 4ANC incentive, followed by Janajatis (16%) and then Dalits (14%). 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%, while Dalits constitute 4% of the national population.

Improved Safe Motherhood Indicators

The indicators of safe motherhood show that the country has been making steady progress in terms of maternal health service utilisation (Table 4) [5]. The met need of Emergency Obstetric Care² was found to have increased from 14% in 2009/10 to 15% in 2010/11. Deliveries conducted in B/CEOCs as a share of total health facility deliveries has increased steadily over the years, from 28% in 2008/09 to 47% in 2011/12. The findings also show that of the total number of expected pregnancies, deliveries conducted by SBAs, i.e. doctors, nurses and midwives at health facilities, increased from 26% in FY 2009/10 to 34% in FY 2011/12. The proportion of women completing four ANC visits as a percentage of expected pregnancies was found to be 46% for FY 2011/12.

Table 4: Indicators of the Safe Motherhood Programme for the last three fiscal years

Indicator	2009/10	2010/11	2011/12
Expected pregnancies	757,686	766,156	769,699
Met need of EOC	14.7	15.76	-
Deliveries conducted at B/CEOCs among total health facility deliveries	35.73	43.02	46.56
% of obstetric complications among total deliveries	4.89	4.83	5.02
Deliveries conducted by SBAs at health facilities as % of expected pregnancies	26.1	30.8	33.8
Completion of 4 ANC visits as % of expected pregnancies	49.64	48.37	46.27
Total deliveries	312,764	326,857	337,420

Source: HMIS section, Management Division, September 2012

Awareness of the Aama Programme/4ANC incentive

The STS³ conducted in 2011 found that 84% of the maternity clients i.e. recently delivered women or those who experienced complications post-delivery, were aware of the transport incentive and 79% knew that delivery services should be free [6]. Moreover, no major difference was found between different castes and ethnic groups regarding awareness of the transport incentive. Awareness of free delivery care was highest among Dalits (95%) and lowest among Newars (60%). By ecological region, the study findings show that mountain dwellers were more aware of the Aama Programme and the transport incentive than hill and terai dwellers. This may be because of a precursor programme to the current free delivery policy which was mostly implemented in mountain districts. These findings are in line with those from the Rapid Assessment which show high levels of awareness about the Aama transport incentives and free delivery care while awareness of the 4ANC incentive was

² Met need of Emergency Obstetric Care is the total number of obstetric complications managed out of the total expected number of obstetric complications, i.e. 15 % of the expected pregnancies.

³ The STS 2011 was implemented by MoHP with technical assistance from NHSSP. It was designed to collect information to monitor indicators in the NHSP-2 logical framework, identify inputs for the national Health Financing Strategy, and monitor the implementation of the Aama Programme and free health care. It also assessed the financial management capacity of health facilities and collected information on functionality, client experience and quality of care.

generally lower [4]. The study showed that only one-third of women were aware of the 4ANC incentive before they started their ANC visits.

Results from the Rapid Assessment reinforced the perception that health workers play an important role in informing women about the *Aama* transport incentives (Table 5). Fifty-five percent of women reported that health workers were the information source through which they learned about the *Aama* programme; and more than one-third (35%) referred to the Female Community Health Volunteers (FCHVs), making health workers the most cited source of information for *Aama*. The pattern was similar across all ecological regions. Although the percentage of women receiving information from health workers is high across all regions, a smaller proportion reported receiving information during ANC visits. This could be due to interviewer or questionnaire design limitations.

Table 5: Information Sources on *Aama* Transport Incentives

Source of information	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/ neighbours	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

Source: Rapid Assessment, 2012

Budgeting and expenditure

The Family Health Division of the Department of Health Services (DoHS) carries out regular monitoring of the expenditure of the *Aama* programme. Table 6 shows the total allocated funds as well as the expenditure for the last two fiscal years. Based on the reports received, NRs. 800 million of the 900 million allocated have been spent for FY 2011/12. The government contribution to the *Aama* budget of FY 2011/12 is 27% (NRs. 250 million) while 73% (NRs. 650 million) is contributed from the pool fund for the *Aama* Programme budget. In FY 2010/11 NRs. 728 million was spent out of NRs. 850 million allocated.

Table 6: Funds allocated and expenditure for the *Aama* Programme

Fiscal Year	Allocated (NRs.)	Expenditure (NRs.)
2011/12	900,000,000	800,629,700
2010/11	850,000,000	727,777,000

Source: *Aama* Programme Recording, FHD and Finance Section, DoHS

A total of NRs. 70 million had been allocated for the 4ANC incentive for FY 2011/12. The programme was fully funded by the GoN.

Aama Programme expenses were examined for the two last fiscal years (2010/11 and 2011/12) by payments made to women, institutions and health workers (Table 7). The results show that a higher

proportion of the budget was paid to health institutions in both fiscal years. The amount provided to health workers as an incentive for home delivery has declined proportionately.

Table 7: Expenditure breakdown of the Aama Programme in the last two fiscal years with dissimilar reporting

	2010/11 (complete report from 50 sites out of 98 sites)		2011/12 (complete report from 86 sites out of 98 sites)	
	NRs.	%	NRs.	%
Transportation incentive provided to women	171,654,900	26.39	218,536,300	26.98
Payments made to health institutions	475,944,500	73.18	591,139,500	72.98
Home delivery payments	2,781,500	0.43	288,800	0.04
Total	650,380,900	100.0	809,964,600	100.00

Source: Aama Programme Recording, FHD, 2012

Table 8 shows the expenditure breakdown for the Aama Programme by region, except for the large institutional hospitals, for the FY 2011/12. In the Far-western region two-fifths (40%) of the total expenditure was provided as transportation incentive to women while in the Eastern region only one-quarter (25%) was provided as transportation incentive. The results showed that the proportion of the total budget amount paid to women increased gradually from the Eastern to the Far-western region. A total of NRs. 364 million was spent in hospitals. Nearly 80% was for institutional costs, while the remainder was paid to women. The 2011 Service Tracking Survey also found that hospitals provided delivery services to a much larger number of women than any other facility type, across all types of deliveries.

Table 8: Expenditure breakdown of the Aama Programme by region, FY 2011/12

Region	Payment made to women		Payment made to health facilities		Payment made to health workers		Total	
	NRs.	%	NRs.	%	NRs.	%	NRs.	%
Eastern	32,677,300	25.6	94,782,500	74.3	78,200	0.06	127,538,000	100.0
Central	35,688,000	30.7	80,617,000	69.3	79,000	0.07	116,384,000	100.0
Western	24,284,500	32.5	50,445,000	67.4	106,600	0.14	74,836,100	100.0
Mid-western	26,830,500	36.8	46,065,000	63.2	25,000	0.03	72,920,500	100.0
Far-western	21,726,500	40.1	32,389,000	59.9	0	0.00	54,115,500	100.0
Total	141,206,800	31.7	304,298,500	68.3	288,800	0.06	445,794,100	100

Source: Aama Programme Recording, FHD, 2012

Publications in international and national peer-reviewed journals

A number of articles relating to the Aama Programme were published in international and national peer-reviewed journals, and magazines. The list of major publications in the last three years is given below:

- Powell-Jackson T, Hanson K. **Financial Incentives for Maternal Health: Impact of a national programme in Nepal.** *Journal of Health Economics*; 31(2012) 271-284.
- Witter S, Khadka S, Nath H, Tiwari S. **The national free delivery policy in Nepal: Early evidence of its effect on health facilities.** *Health policy and planning* 2011; 26:ii84-ii91.

- Bhandari A, Gordon M, Shakya G. **Reducing Maternal Mortality in Nepal.** *BJOG* 2011; 118 (Suppl 2): 26-30.
- Powell-Jackson T, Tiwari S, Neupane BD, and Dangol M. **An Early Evaluation of the Aama “Free Delivery Care” Programme. Final Report of the Evaluation.** 2010; Kathmandu: Support to the Safe Motherhood Programme, Nepal.
- **In Nepal, a women’s reproductive system is her greatest vulnerability.** *Canadian Medical Association Journal.* 182 (12). 2010.
- Powell-Jackson T, Morrison J, Tiwari S, Neupane BD, Costello AM. **The experiences of districts in implementing a national incentive programme to promote safe delivery in Nepal.** *BMC Health Services Research* 2009, 9:97.

III. The Way Forward

Implementation of the revised *Aama*/4ANC guideline

The integrated *Aama* guideline (*Aama*/4ANC) will be rolled out across the country. The guideline has been published and is being circulated by the Department of Health Services Logistics Management Division as well as in the regional review meetings. A circular on the revised guideline has been distributed to all the *Aama* implementing facilities. In addition, a workshop on the *Aama Surakshya* Programme Guideline - Second Revision 2069 was organised on 17th August 2012 to disseminate the key changes made in the guideline to key stakeholders. Necessary steps will be taken to ensure that the guideline is distributed across all the facilities implementing the *Aama* Programme.

Regular monitoring of district level health facilities and private facilities

Very few districts in the Rapid Assessment reported receiving regular monitoring and supervision support from the central level and the regional *Aama* focal persons. More frequent and effective monitoring of the programme is necessary.

Recording of the *Aama* Programme and the 4ANC incentive

With the implementation of the revised *Aama* guideline, recording on the 4ANC programme will also be initiated. The system will be developed to ensure that the information obtained from Annex 6 of the *Aama* guideline will be used to inform coverage and effectiveness of the *Aama* Programme along with monitoring the programme for financial purposes.

Periodic Assessment

Continuity will be given to the periodic rapid assessments of the *Aama* Programme and the 4ANC incentive. The tools and strategy will be revised based on the previous experience from the Rapid Assessment and the implementation guideline of the *Aama* Programme.

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