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RAPID ASSESSMENT OF THE DEMAND SIDE FINANCING SCHEMES: AAMA AND YANC PROGRAMMES (The Seventh Rapid Assessment)



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EXECUTIVE SUMMARY

A. Background and methodology

In the past decade, Nepal has made significant progress in improving maternal health as reflected in the more than 75% reduction in the maternal mortality ratio. Several government interventions have contributed to this, with one of the most important being the Aama Programme. This programme, which was launched in 2009, currently has five components: free deliveries for women, transport incentives for all women who deliver in a health facility, incentives for health workers, incentives to institutions and incentives to women for completing four antenatal care (ANC) visits.

The institutional delivery incentive scheme was introduced in 2005 as the Maternity Incentive Scheme (MIS). In 2009, the government removed user fees for delivery services for all types of deliveries at government health institutions nationwide and merged the two schemes. These two components and the 4ANC incentive were merged in 2012 and are now commonly known as the Aama Programme.

This Rapid Assessment is the seventh in a series that is monitoring the implementation of the Aama Programme. The assessment was conducted in six districts representing Nepal's three ecological regions. A total of 44 health facilities were sampled: 2 zonal hospitals, 4 private hospitals, 4 district hospitals, 11 primary health care centres, 15 health posts and 8 sub-health posts.

It should be noted that this assessment is not nationally representative but is conceived as a monitoring activity to generate suggestions for practical improvements in operations to programme managers and policy makers. Several rounds of RAs have been conducted, and while comparisons over years are sometimes drawn in this report, this is for illustrative purposes only, as the samples of the various RAs are not representative of the same populations.

The main objective of this assessment was to monitor the implementation of the Aama Programme in relation to the most recent Aama Guidelines (revised 2012). The study carried out a cross-verification exercise to explore opportunities for the misappropriation of Aama Programme funds and assessed financial management issues, compliance with programme guidelines and the extent of use of the programme.

Cross verification was carried out:

- of district (public) health office (D(P)HO) records against health facility records; and
- by matching health facility and D(P)HO records (hereafter referred to as 'matched health facility records') against the reports of 801 women who had delivered at those facilities in the previous six months.

Data was also collected from Aama focal persons, health facility and D(P)HO accountants, health care providers, health facility management committee members, health facility records and the Health Management Information System (HMIS). Data collected from the health facilities for cross-verification and on financial management was for the six month period from mid-June to mid-December, 2012.

B. Findings

B.1 Cross-verification findings

- Ninety-five per cent of interviewed women agreed with the matched health facility records that they had been given the Aama transport incentives.
- On type of delivery, almost all cases matched between the women's reports and health facility records.
- Ninety-four per cent of interviewed women agreed with the matched health facility records that they had received the 4ANC incentive.

For the receipt of transport incentives, although the percentage of mismatches was relatively low, more than a half of them were from one of the six districts (Tarai district E, see Table 15). The mismatches could be due to delays in budget receipt, recording errors, reporting errors or fund misuse.

B.2 Financial management findings (of the Aama Programme at district and health facility level):

- Fewer of the 44 health facilities received their Aama funds on a trimesterly basis (every four months) than in the previous rapid assessment (Rapid Assessment VI of July 2012). This could be attributed to late budget release by central government and its eventual receipt in three tranches unevenly spaced towards the end of the year.
- The health facilities received their Aama programme funding based on unit costs in three different ways: 60% through account payee cheques; 20% through cash bearer cheques and 20% in cash. This non-uniformity makes it difficult to monitor fund flow and to ensure fund availability and the timely submission of progress and financial reports.
- Health facilities receive funding for the Aama Programme in two ways: approximately half get funds from the centre in advance while the remainder are reimbursed having used other resources to pre-fund the scheme. Health facilities reported that they normally received sufficient funds to cover all Aama outgoings by the end of the fiscal year.

B.3 Compliance with the Aama guidelines (2012):

- Around 25% of women had to wait for longer than three months to receive their incentive payments. Only three-quarters of the interviewed women had received their transport incentives on the day of discharge as required by the 2012 guidelines. This may have been largely due to the delayed budget mentioned above.
- Only a third of health facilities possessed a copy of the latest Aama Programme guidelines (2012), and so most were following the 2008/9 guidelines. This suggests that planned improvements in programme implementation have been hindered by a lack of awareness of recent changes.
- Only 57% of facilities were displaying the name of transport incentive recipients as required by the guidelines (Annex 10). Zonal and private hospitals were least compliant in this respect.

B.4 Utilisation of the Aama Programme

- Only 43% of interviewed women had received free delivery care. This is a low proportion as all the assessed facilities are implementing Aama through which they receive unit cost payments for providing delivery services.
- Only 9% of women who had a complicated delivery and 3% of women who had a caesarean delivery received free delivery care. The average amount paid for normal and complicated deliveries was NPR 1,883 and NPR 6,322 respectively. Most commonly women reported paying to cleaners and for some medicine.

- The percentage of caesarean sections was high at 16% of total deliveries — three times the expected rate of 5% as per the World Health Organisation (WHO). The proportion was particularly high in Tarai and private facilities. However, the data do not allow us to conclude that this was due to supplier-induced demand.
- Ninety per cent of interviewed women said they had received the full transport incentive. Proportionately more women from government facilities had not received the incentive which could have been due to the delay in fund flow leading to a shortage of cash.
- Of the 289 women claimed by facilities to have completed the four ANC visits needed to receive the 4ANC incentive, only 16% of them had actually received this incentive. Service providers said that the low utilisation of this incentive was due to difficulties in meeting the 4ANC protocol (visits in specified months), the unavailability of funds, lack of awareness of the scheme, and the lack of provision for this incentive at private facilities.

C. Ways forward

1. Explore in more detail the reasons why women are still paying for delivery care especially in public hospitals and intensify the managerial instruction to all Aama programme implementation facilities to comply with the provision of 'Free Delivery Care' and provision of 'Incentive' at the time of discharge.
2. Examine in detail the mismatches between the matched health facility records and women's reports on the receipt of incentives, focussing on those districts where mismatches are highest.
3. FHD and the DoHS Finance section should improve collaboration with district treasury and account controller offices (DTACOs) to ensure timely Aama fund flow and to standardise the fund release mechanism.
4. Investigate the reasons for the very high number of caesarean cases reported in public and private hospitals in the Tarai and at referral facilities, and set up a mechanism to audit the mode of delivery. Only then will it be possible to determine whether or not supplier-induced demand is a factor here.
5. Strengthen the fund flow system for the Aama Programme through more timely reporting, more accurate projections of the number of deliveries and improved coordination with local authorities (VDCs and DDCs). Carry out a study to explore payment delays in mountain districts.
6. Improve distribution of the revised guidelines and brief implementers on changes from the 2008/9 version.
7. Monitor the public display of Aama Programme beneficiaries on the revised Annex 10 format of the guidelines, especially at referral hospitals and peripheral health facilities. The district should monitor peripheral and private facilities while peripheral, district and referral hospitals should be monitored by regional and central level officials.
8. Develop a more robust and comprehensive monitoring mechanism to understand why some women have to pay for deliveries in public and private facilities, particularly in the Tarai, despite the free care scheme.

9. Examine the adequacy of the unit cost payments to health facilities to cover the actual costs of complicated and caesarean deliveries.
10. Examine the reasons for low utilisation of the 4ANC incentive including the appropriateness of payment modalities and adequacy of the incentive payment. Furthermore, make sure health workers are well informed about the 4ANC incentive scheme.

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LIST OF ACRONYMS

ANC	antenatal care
AWPB	annual work plan and budget
CS	caesarean section
DoHS	Department of Health Services
DHO	District Health Office
DPHO	District Public Health Office
DSF	demand-side financing
DTACO	District Treasury and Account Controller Office
FCGO	Financial Comptroller General's Office
FCHV	female community health volunteer
FHD	Family Health Division
FY	fiscal year
HDI	Human Development Index
HERD	Health Research and Social Development Forum
HFMC	Health Facility Management Committee
HHS	Household Survey
HDC	Hospital Development Committee
HPI	Human Poverty Index
HF	health facility
HMIS	Health Management Information System
HP	Health Post
MIS	Management Information System
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	Nepalese rupee
PHCC	Primary Health Care Centre
PNC	post natal care
PPH	postpartum haemorrhage
RA	rapid assessment
RDW	recently delivered women
SDIP	Safe Delivery Incentives Programme
SHP	Sub-health Post
SBA	skilled birth attendant
SPSS	IBM SPSS Statistics
STS	Service Tracking Survey
THW	trained health worker
TSA	treasury single account
WRA	women of reproductive age

1 BACKGROUND

1.1 BACKGROUND

Nepal has made large gains in maternal health with the maternal mortality ratio (MMR) decreasing from 539 in 1996 to 170 per 100,000 live births in 2010 (WHO 2012). Nepal is one of the ten countries that have already reached the Millennium Development Goal target of reducing the MMR by 75% between 1990 and 2015 (Nepal achieved a 78% reduction to 2010) (WHO 2012). This progress is attributable to several interventions and efforts implemented by government and non-governmental organizations to strengthen maternal health services and use (SSMP 2008/09). Among these interventions, the Aama programme is widely recognized as an important contributor to increasing institutional delivery rates.

The Aama Programme — The Government of Nepal has made good progress developing national policies and programmes to promote safe motherhood including demand-side financing schemes (DSF). It introduced the Maternity Incentive Scheme (MIS) in 2005 and renamed it the Safe Delivery Incentives Programme (SDIP) in 2006 (Upreti et al. 2012). This programme incentivised women to deliver in health institutions in order to improve health outcomes for themselves and their babies. The Aama Programme (also known as the Aama Surakshya Karyakram), which was launched in January 2009, removed user fees for all types of deliveries in government health facilities and incorporated SDIP (Upreti et al 2012 and FHD 2012).

The Government of Nepal introduced the 4ANC (four antenatal care visits) incentive programme in July 2009 to increase access to antenatal care. Although, over the past 15 years there has been a five-fold increase in the percentage of women carrying out four or more antenatal visits during their pregnancies (from 9% in 1996 to 50% in 2011), use has varied by geography and among excluded population groups. The 4ANC programme was initiated to provide 400 Nepalese rupees (NPR) to prospective mothers who:

1. complete four ANC visits as per the ANC protocol (visits in fourth, sixth, eighth and ninth months of pregnancy);
2. deliver at a health institution; and
3. make at least one postnatal care (PNC) visit (FHD 2012).

The Aama Programme provisions are detailed in the Aama Programme guidelines. The original 2008/09 guidelines were revised in 2012 (FHD 2012). The current guidelines incorporate provisions for the 4ANC programme including a protocol for providing the incentive and reporting on incentive related expenditure. These integrated guidelines have been implemented since financial year 2012/13.

The incentive rates for prospective women and the unit costs for health institutions and health workers are shown in Table 1.

Table 1: Aama and 4ANC incentives as per the 2012 guidelines

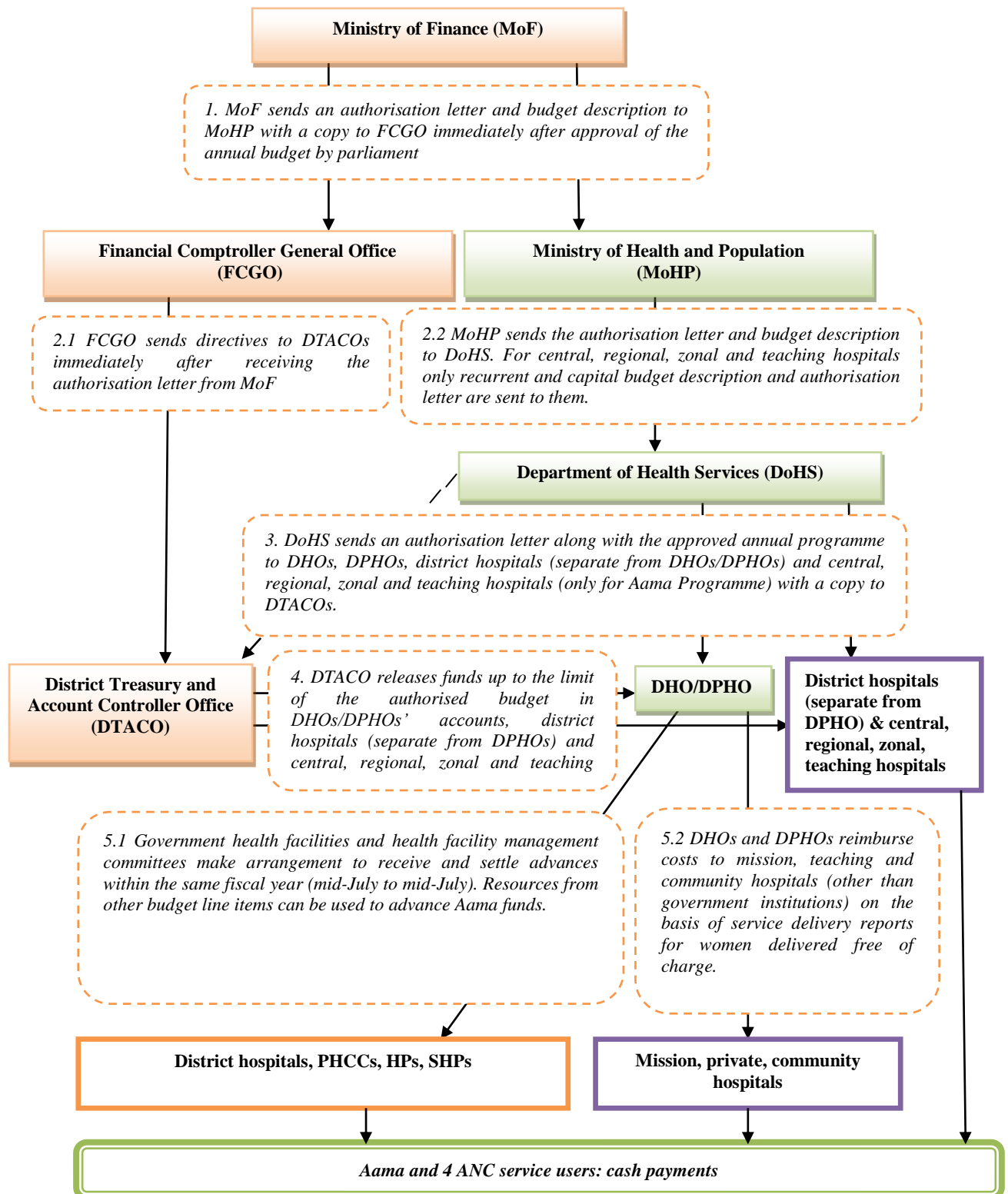
Cash payments to women	Unit costs to health facilities	Incentives to health workers
<p>'Transport incentives' for all women delivering in an institution:</p> <p>NPR 1,500 in mountain districts NPR 1,000 in hill districts NPR 500 in Tarai districts</p> <p>For 4 ANC visits: Women receive NPR 400 for completing 4 ANC visits (in months 4, 6, 8 and 9 of pregnancy), delivering in a health institution and completing one post-natal care visit</p>	<p>Amounts reimbursed to facilities per delivery:</p> <p>NPR 1,000 if <25 beds for normal births NPR 1,500 if >25 beds for normal births NPR 3,000 for complicated births NPR 7,000 for caesarean sections.</p> <p>These amounts are meant to cover the cost of drugs, supplies, instruments and health worker incentives, and can be spent at the discretion of health facility management committees.</p>	<p>Amounts to health workers:</p> <p>NPR 300 per delivery at a health facility — paid out of the unit costs to health facilities.</p> <p>NPR 100 per home delivery.</p> <p>To claim the home delivery incentive providers must show the babies' birth registration forms as proof of attendance at the birth or a death certificate in the case of still births.</p>

Aama Programme budgeting and fund flow — The Family Health Division (FHD) of the Department of Health Services (DoHS) is the focal institution for the Aama Programme. It prepares annual work plans and budgets (AWPB) for the programme, including 4ANC, based on district and facility (referral facilities) expenditure in the previous fiscal year. The AWPB is submitted to DoHS and MoHP, which compile the budget requests from different units for submission to the National Planning Commission (NPC) and the Ministry of Finance (MoF). After Parliament approves the national budget, MoF provides details of approved programmes and allocated budgets to MoHP and the Financial Comptroller General Office (FCGO). The FCGO passes these on to the district treasury and account controller offices (DTACO). MoHP provides details of approved programmes and letters of authority to DoHS, centres and divisions and zonal, regional and central hospitals. Based on these letters, DoHS sends details of approved programmes along with authorisation letters to District (Public) Health Offices (D(P)HOs). Finally, the approved Aama Programme activities and budgets are released to D(P)HOs. See Figure 1 for a diagram of fund flow in the Aama Programme.

According to the revised Aama guidelines (2012), DHOs and DPHOs should transfer the amounts for institutional unit costs (reimbursement for Aama provision) to the Health Facility Management Committees (HFMC) of PHCCs, HPs and listed SHPs and the Hospital Development Committees (HDC) of hospitals. In cases of shortfalls or delays in receiving funds, HFMCs and HDCs usually provide advances to the institutions to provide the incentive to eligible women.

Reporting — The Aama Programme Guidelines (2012) state that all health facilities implementing the programme must submit the forms at Annexes 6, 6 ka and 10 of the guidelines along with completed HMIS format 32 (HMIS 32) to their D(P)HO by the seventh of each month. All D(P)HOs should submit this progress report in accordance with sub-clause (1) of the Annex 6 progress reports along with completed HMIS 33 by the twelfth of each month to the Health Management Information Section of the Management Division (DoHS) with a copy to their Regional Health Directorate (RHD) and FHD. All zonal, sub-regional, regional and central hospitals (that are authorised separately by DoHS) have to complete the Annex 6 and Annex 6 ka forms and send them along with HMIS 34 by the seventh of each month to the Health Management Information Section, RHD and FHD. See Annex 1 for the various reporting formats in the latest Aama guidelines.

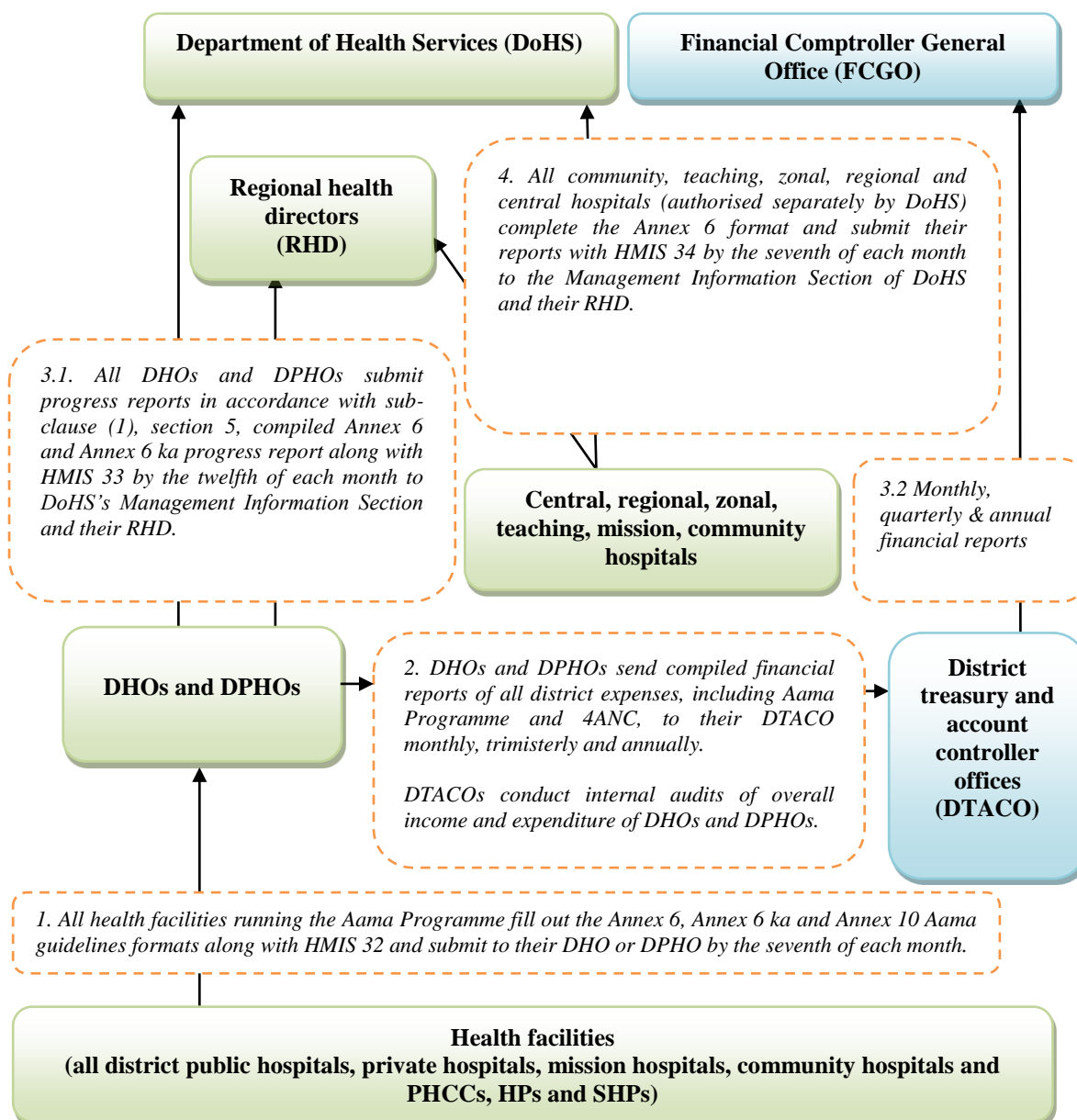
Figure 1: Fund flow in the Aama Programme



Monitoring and feedback — The revised Aama guidelines note that programme supervision and monitoring is the responsibility of DHOs and DPHOs for facilities at district level and below (primary health care centres, health post, sub-health post) including private facilities. RHD, FHD and DoHS are also accountable for monitoring the Aama Programme at district-level, referral and private facilities. The guidelines say that RHDs should ensure the receipt of progress reports in accordance with sub-clauses 1, 2 and 3 of the guidelines. They also state that the budget allocated for the Aama Programme can be restricted if no reports are received for four months (sub-clauses 2 and 3). The responsibility for reporting lies with health facilities.

The Financial Act and Regulations (2008) provide for monthly, quarterly and annual monitoring of funds allocated to D(P)HOs by DTACOs based on approved programmes and allocated budgets. Figure 2 illustrates the reporting mechanisms for Aama as per the revised guidelines (2012), the government’s Financial Rules and Regulations, and as reported by key informants including government account officers.

Figure 2: Reporting mechanism of the Aama Programme



1.2 STUDY OBJECTIVES

The principal objective of this study is to assess whether the Aama Programme, including the 4ANC scheme, is being implemented as per the current guidelines in terms of programme use and financial management. The objectives of the assessment, the assessed indicators and, and whether or not they are included in this report are detailed in Table 2.

The core indicators are indicators that have not been investigated by other surveys including cross-verification, management and compliance of the programme with the guidelines. Other rapid assessment indicators or 'supplementary' indicators are generally captured more effectively by other surveys. These include utilisation, awareness of, and access to, the programme.

The current assessment is the seventh in an on-going series of Rapid Assessments. The first was published in March 2008 while its predecessor (number 6) was published in July 2012. The assessment is not nationally representative and has been carried out to inform programme managers and policy makers on areas for operation improvement and to give an overview of the programme's situation. Although several rounds of RAs have been conducted, results are not comparable as their samples are not representative to the same populations.

Table 2: Rapid Assessment VII (7): objectives and details of indicators

	Objective of Rapid Assessment	Indicators	Type (quantitative or qualitative)	Priority (core or supplementary)	Status in the report
1	Cross-verify utilisation of the Aama Programme between health facilities and target groups to explore opportunities for misappropriation of the Aama Programme fund	% match between health facility records and women on receipt of transport incentives	Quantitative	Core	Included
		% match between health facility records and women on receipt of 4ANC incentive	Quantitative	Core	Included
		% match between health providers and women on receipt of home delivery incentive by a health worker	Quantitative	Core	Not included
		% match between health facilities and women on type of delivery (normal/complicated/caesarean)	Quantitative	Core	Included
2	Assess the management including fund flow of Aama and 4ANC visit schemes & corresponding opportunities for fund misappropriation.	Timeliness of Aama fund flow to health facilities	Quantitative/qualitative	Core	Included
		Mechanism for release of funds to health facilities	Quantitative/qualitative	Core	Included
		Sufficiency and flow of Aama funds at health facility	Quantitative/qualitative	Core	Included
		Frequency of financial reporting	Quantitative/qualitative	Core	Included
3	Assess compliance of programme implementation with revised Aama guidelines	% of women receiving transport incentive on day of discharge	Quantitative	Core	Included
		% of health facilities with display boards showing lists of Aama beneficiaries	Quantitative	Core	Included
		% of health facilities with a copy of the revised Aama guidelines	Quantitative	Core	Included
		Procedure requested by facilities to claim Aama and 4ANC incentives	Quantitative	Core	Not included
4	Assess utilisation – receipt of free delivery care and incentives	% of women receiving transport incentives as per the guidelines	Quantitative	Supplementary	Also included in HHS, STS, NDHS
		% of women who did not pay any cash at health facility for their deliveries	Quantitative	Supplementary	Also included in HHS, STS, NDHS
		% of women receiving 4ANC incentive of total women completing four ANC visits	Quantitative	Supplementary	Also included in HHS, STS
5	Assess awareness of Aama Programme among target group	% of women aware of transport incentive	Quantitative	Supplementary	Not included: covered by HHS.
		% of women aware of free delivery care	Quantitative	Supplementary	Not included: covered by HHS, STS.
		% of women aware of 4ANC incentive	Quantitative	Supplementary	Not included: covered by HHS, STS.
		Source of information on Aama incentive, free delivery care and 4ANC incentive	Quantitative	Supplementary	Not included: covered by HHS, STS.
6	Explore perceptions towards Aama Programme	% of women who feel Aama and 4ANC incentives are sufficient	Quantitative	Supplementary	Not included: covered by HHS
		Perceptions of women on reasons for health facility delivery	Quantitative	Supplementary	Not included: covered by STS, HHS.
		Perceptions of free delivery, Aama and 4ANC incentives	Quantitative	Supplementary	Not included: covered by STS.
7	Assess trends in utilisation of delivery care using routine information systems	Trend of institutional deliveries (district and national)	Quantitative	Supplementary	Included
		Trend of home deliveries (district and national)	Quantitative	Supplementary	Included
		Trend of fourth ANC visit (district and national)	Quantitative	Supplementary	Included

2 STUDY METHODS

2.1 SAMPLING FRAME AND SAMPLE SELECTION

Districts — Six districts were purposively sampled for this assessment based on ecological zone and number of deliveries. The districts were selected purposively to include districts with the highest number of deliveries in the past six months to enable the recruitment of a sufficient numbers of women for the study and to avoid as far as possible the selection of districts covered in previous rapid assessments. The transport incentive varies by ecological regions (mountain, hill and Tarai as in Table 1); hence two districts were sampled from each region. In this report, the names of the districts are kept anonymous with a code (ecozone and then A to F) applied to each district to identify it. This was done to preserve the anonymity of participants as district and facility-level respondents could be identified if findings were reported by district name.

Health facilities — Forty government health facilities were sampled including 15 Health Posts, 8 Sub-health Posts, 11 Primary Health Care Centres (PHCCs), and 6 hospitals (4 district and 2 zonal hospitals) (Table 2). In addition, four private hospitals currently implementing the Aama Programme in two Tarai districts were included, bringing the total to 44. The facilities were selected from a sampling frame consisting of functioning birthing centres in identified districts (see Annex 2 of this report). Whether or not facilities were operating and able to conduct deliveries was confirmed by the district teams when visiting the DHOs/DPHOs.

Table 3: Health facilities sampled for Rapid Assessment VII

Ecozone	Districts	Zonal hospitals	District hospitals	Private hospitals	PHCCs	Health posts	SHPs	Total
Mountain	A	0	1	0	0	1	1	3
Mountain	B	0	1	0	2	2	3	8
Hill	C	0	1	0	2	3	1	7
Hill	D	0	1	0	2	4	2	9
Tarai	E	1	0	2	2	2	0	7
Tarai	F	1	0	2	3	3	1	10
Total		2	4	4	11	15	8	44

Health facility sampling strategy — The hospitals, PHCCs, HPs and SHPs were sampled by listing all such facilities in the selected districts with birthing centres, and from this list, selecting hospitals, PHCCs, HPs and SHPs providing delivery services as follows:

- Six public hospitals, with at least one from each study district, were selected. Two districts had zonal hospitals and four had district hospitals and so they were all included with no random selection required;
- Only two survey districts had private hospitals providing delivery services under the Aama Programme. These four private hospitals, two from each district, were selected with no random selection needed. Besides these four hospitals, a private hospital that had withdrawn from the Aama Programme was visited to investigate why the programme had been discontinued.
- 11 PHCCs were selected purposively from among the 20 PHCCs in the six districts. The sampling strategy was purposive to include the PHCCs with the highest number of deliveries.

- Fifteen HPs were selected from among the 47 HPs, and 8 SHPs were selected from among the 57 SHPs with birthing centres in the six districts. Similar to PHCCs, the facilities with the highest number of deliveries were selected.

Sampling of women who had recently delivered — The main participants of this assessment were women who had delivered at a health facility within the last six months — at either private or public health facilities.

Information on women who had recently delivered in health facilities or at home was obtained from FHD and the HMIS Section for fiscal year 2012/13. Based on this, a sampling frame was developed of the women who had delivered in health facilities in the last six months and the appropriate sample size of women was estimated for cross-verifying their reports with the matched health facility records. The sample size was calculated using an approach similar to that used in Rapid Assessment VI. This assumed that if the number of institutional deliveries was more than 1,000, then 5% of total deliveries would be an appropriate sample size, and if the number of institutional deliveries was less than 1,000, then 10% of total deliveries would be an appropriate sample size. The sample size was increased by adding 5% to cover possible non-responses. The number of women to be interviewed at each facility was distributed proportionate to the total number of deliveries in each type of facility.

2.2 CROSS VERIFICATION PROCESS

As in Rapid Assessment VI, the cross-verification of the Aama Programme data on delivered women was carried out at the following two levels:

- *District to health facility level:* In the first stage, detailed information (i.e. address of women; type of health facility; date of delivery; type of delivery; staff attending delivery) was recorded from the claim form (Annex 3 of the guidelines) at the D(P)HO. This information was then cross-verified with the maternity register at the sampled health facilities. Records were classified as unmatched if one or more of the following fields differed between the claim form in the D(P)HO and the health facility maternity register: mother's address, type of health facility, date of delivery, type of delivery. The matched records are hereafter referred to as 'matched health facility records'.
- *Health facility maternity register to women's report:* Cross-verified stage 1 cases were then verified with the women themselves in their communities (women's reports).

It was recognised that mismatches could be due to legitimate human errors and did not necessarily reflect attempts to misuse funds.

The tool used to interview 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 a normal, complicated or caesarean section was performed; the number of ANC visits; and direct and indirect costs associated with delivery and incentives received). After data was collected from the interviewed women, the enumerators returned to the concerned health facility to re-check any inconsistencies between the data obtained from the women and facility data.

2.3 STUDY TOOLS

The data collection tools from Rapid Assessment VI were used with a few minor modifications (Table 4). Because they have previously been shown to add little or no value, the exit client interviews, district public health officer interviews and secondary data reviews from peripheral health facilities were omitted in this survey/report in agreement with MoHP, NHSSP and HERD¹.

Table 4: List of tools and respondent categories

Responsible persons	Level	Tool	Participant/topic	Information sought
District lead	D(P)HO	1A	D(P)HO, Aama focal person	Details of role, training, reporting, monitoring, fund flow, training guideline use, specific district issues
Research and finance lead	D(P)HO	1B	D(P)HO finance section	Fund flow, involvement in planning and budgeting, specific district issues
Research team and enumerators	D(P)HO, health facility	1C	Cross verify between D(P)HO and health facility records for institutional deliveries	Collect delivery and ANC data from Annex 3 claim forms at D(P)HO and verify at health facility level from maternity registers for institutional deliveries
		1D	Cross verify between D(P)HO and health facility record for home deliveries	Collect delivery data from Annex 4 form reported at D(P)HOs and verify against home delivery records at health facilities
	D(P)HO	1E	Secondary data review (spreadsheet)	To collect secondary data of the past 5 years for trend analysis
	Zonal hospitals, private hospitals, PHCCs, HPs, SHPs	2A	Delivery service providers	Knowledge and awareness of Aama and 4ANC programmes, recording, monitoring, display of Annex 10 forms on noticeboards, fund flow, training, use of unit cost, local issues
		2B	Chair of Health Facility Management Committees	Knowledge and awareness of Aama and 4ANC, use of unit cost, display of Annex 10 forms, fund flows, training, local issues
		2C	Health facility account sections	Fund flow, reporting, monitoring
	Communities	3A	Women who delivered at a health facility in last 6 months	Incentives received, type of delivery, information on Aama, views on delivery at health facility, satisfaction with services
		3B	Women who delivered at home in last 6 months	Reasons for delivering at home, role of skilled birth attendant (SBA) and if received incentive, documents required

¹ Exit client interviews are also included in Service Tracking Survey (STS). The indicators that can be obtained from exit client interviews are measured more accurately by STS as compared to RA because of its design and sample size. Moreover, a STS was conducted in 2012 and is planned for in 2013 so allowing exit interviews to be omitted from this RA. Likewise, based on the experience of RA-VI, DPHO interviews were not included as almost all information on the Aama programme was obtained from interviews with the Aama focal person and accountant. Secondary data was collected from DHOs/DPHOs but not from peripheral health facilities as this round of rapid assessment focused primarily on core indicators.

2.4 SELECTION OF FIELD RESEARCHERS AND SUPERVISORS

Six supervisors and 21 field researchers were recruited following written and oral interviews. The selection criteria used were qualifications and experience of the Aama Programme. As far as possible, supervisors who had worked in Rapid Assessment VI were recruited. See Annex 3 for a list of all members of the research team.

2.5 TRAINING AND ORIENTATION

A three day training course was delivered at HERD's training hall for the 8 districts' research leads, 6 field supervisors and 21 field enumerators (see Annex 4 for schedule). The lead district researchers were senior officers of HERD's research and finance team. They were responsible for co-ordination and collecting district level information on the implementation of the Aama Programme and fund flow mechanisms and for quality assurance of the field work. Trainees were informed about Aama Programme implementation modalities, sampling procedures, tool contents, the data collection process, data safety and other issues that could arise in the field and measures to tackle them. Sets of tools, a training schedule and required logistics were presented to participants a day before the course. The training was facilitated by a research team from HERD, FHD, NHSSP and consultants. NHSSP and FHD representatives were present throughout the course to monitor training quality. A half day workshop was also organised with district leads and supervisors to revisit process coordination, strategy implementation and data collection monitoring.

A two-day training course was organised for data entry clerks who were oriented on the tools, the CSPro software (Census and Survey Processing System software), the format for data entry under CSPro and on maintaining consistency in data entry. Participants were also made aware of the most likely types of error that can occur while entering the data.

2.6 FIELD IMPLEMENTATION

The data was collected from the six districts between 20 February and 12 March, 2013 with one team assigned to each district. These teams consisted of between two to nine field enumerators depending on the volume of interviews to be conducted and, as far as possible, a balance of male and female enumerators was sought. For each team a research lead and a finance lead was sent to the field along with the enumerators. The district leads were responsible for district level coordination and collecting information about the implementation of the Aama Programme and fund flow issues. They also collected suggestions from focal persons, accountants and management committee chairs at D(P)HOs, private hospitals and zonal hospitals. The field supervisors supervised the field enumerators, coordinated with the sub-district health facilities, facilitated data collection, controlled quality, and checked and verified the completed tools and interviews with the women who had delivered at health facilities. The field researchers were responsible for cross verifying district data at health facilities, interviewing the women and maintaining data quality.

The field implementation happened over the following three stages:

- It started by sampling women from the sample frame developed from the Annex 3 claim forms;

- Then study tool 1C was used to compare the records of the 11 types of information to be verified about the women (mother's name, age, address, date of delivery, type of delivery, type of health institution, type of health worker assisting delivery, outcome of baby, date of discharge, receipt of Aama and 4ANC incentives) between the claim forms held at the D(P)HOs and the health facility maternity registers.
- All women for whom the claim form and maternity register records matched were then visited at their homes by enumerators and their accounts of the 11 types of information were collected for cross-verification purposes using Tool 3A.

In one day an enumerator could interview between four and eight women depending on the availability of the women and their geographical distribution. All facility level key informant interviews were carried out by the field enumerators while interviews at zonal, district and private hospitals were conducted by the lead district researcher.

2.7 SUPERVISION AND MONITORING

A supervision plan was developed detailing the role of supervisors before the supervisory team moved to the field. The supervisory team included members from FHD and NHSSP who observed data collection at the district and facility level. They also checked for data inconsistencies and discussed problems faced by members and helped them to manage issues arising during data collection. A central support team from HERD visited each district to ensure quality control and deal with any major issues. A monitoring desk at HERD's central office provided regular communication with field researchers and technical backup. The district leads and district supervisors were also responsible for supervising and supporting the field enumerators.

2.8 ETHICAL CONSIDERATIONS

Potential respondents were under no obligation to participate and verbal consensus was obtained from them all prior to the interviews. All enumerators were trained on making the following clear to potential respondents:

- the purpose of the study before starting the interview;
- that they were under no obligation to participate;
- that if they did participate that everything they said would remain confidential and all published results would be anonymous.

Based on this approach, consent was assumed if the woman agreed to complete the questionnaire.

2.9 DATA MANAGEMENT AND ANALYSIS

Quantitative data — All completed forms were stored separately in a confidential place at HERD's office. Questions with open-ended responses were coded manually. A database was designed using CPro 5.0 version and MS-Excel. All data was entered by trained personnel. Ten per cent of each day's entered data was checked by the data manager to control for errors. Data was checked for out-of-range values and inconsistencies between variables. The data was then transferred to the IBM SPSS Statistics version 13 software (SPSS), and data analysis and tabulation carried out. Finance and

monitoring information was managed using MS-Excel under direct supervision of the financial team. District level information was managed manually due to the low number of questionnaires.

Qualitative data — Qualitative data were collected through key informant interviews with respondents at each level: Aama district focal persons, service providers, account officers and health facility management committee members.

Data generated from these interviews were organised by key issues and themes and the answers to questions within the themes were grouped and summarised in data analysis frameworks. Verbatim quotes that illustrated the views of the majority of participants or contradicted the majority view were extracted from the interviews and several of which have been included in this report. These issues were then summarised by district and health facility level and have been included within the relevant sections in the findings chapter of this report (Section 3).

2.10 QUALITY ASSURANCE

Quality assurance began with the training of district leads, supervisors and field enumerators. Supervision and communication between the centre and the district teams was assured in order to pick up and respond to any issues that might undermine the quality of data collected. The data entry clerks were supervised by the data manager during data entry. All data was double entered and then cleaned to ensure that the data analysed was of robust quality. The development of the coding frame and categories used in the qualitative data analysis was done by a team of two researchers working independently and then comparing their coding frames. The fact that the data came from several different sources allowed triangulation and further ensured quality.

2.11 CHALLENGES AND LIMITATIONS

A number of challenges and limitations were experienced during the assessment:

- In urban settings, the addresses of some women in the records were different to their actual addresses. This caused the field work to take longer than planned.
- The lack of easy availability of the Annex 3 claim forms at some D(P)HOs hindered the data collection process. Health facilities are required to submit Annex 3 claim forms to D(P)HOs. However in some study districts health facilities were asked to keep the Annex 3 forms with them until the budget was received by the districts from the central level. The enumerators therefore had to collect these at health facility level.
- Some of the required data sources, in particular Aama annex forms and financial information, were unavailable or disorganised at the district level. Some districts did not have the Aama Annex 3, 4 and 10 forms, nor the annual trend data.
- The design of the study means that it is not nationally representative. Nevertheless, the results can yield important insights and information to improve implementation of the Aama Programme.

3 STUDY FINDINGS

3.1 SUMMARY FINDINGS AGAINST CORE INDICATORS

This Rapid Assessment mainly collected information on ten core indicators on the progress of the Aama Programme (Table 5). Table 5 also lists the four objectives of the assessment and shows results from current and previous assessments. It is important to note that caution must be exercised while drawing comparisons between the results of current and previous assessments. Since the surveys are not representative, a comparison of results between different survey rounds can be misleading. Comparisons are therefore drawn for illustrative purposes only. It should also be stressed that this assessment has been carried out primarily to inform programme managers and policy makers of areas for improvement and to give an overview of the programme's situation.

3.1.1 Cross-verification on receipt of incentives

The details of cases of women who had delivered in the last six months at health facilities were compared between D(P)HO records and health facility maternity registers. The matched D(P)HO to health facility records (matched health facility records) were then verified through interviews with the women in question at their homes. The main findings were as follows:

- Ninety-five per cent of interviewed women agreed with the matched health facility records that they had received the Aama transport incentives. This is similar to the findings of Rapid Assessment VI. The 5% gap could be due to either: 1) errors in record keeping in the maternity registers or claim forms; 2) women actually being denied transport incentives, or 3) women misreporting or having forgotten that they had received the incentive. Although the percentage of mismatches was relatively low, more than a half of all mismatches were from one of the six districts (Tarai district E). A context-specific examination of the mismatches is necessary to identify reasons for the mismatches.
- Regarding type of delivery, almost all cases (99%) matched between the maternity registers and the women's reports.
- Ninety four per cent of interviewed women agreed with the matched health facility records that they had received the 4ANC incentive. All of the three mismatch cases were from hill district D.

3.1.2 Financial management

- The percentage of health facilities receiving funds to run the Aama Programme on a trimesterly (four monthly) basis in the first half of 2012/13 (33.3%) was less than half the number who had received it in this way during Rapid Assessment VI (69%). This was attributed to the budget release being delayed and funds being released in three tranches towards the end of the fiscal year. Normally funds are released earlier and as a single lump sum amount. Although the budget was released in three portions it was untimely and not trimesterly. Consequently, D(P)HOs were unable to distribute the budget to health facilities on a trimesterly basis.
- It was also found that health facilities received their Aama programme funding in three different ways. 60% received unit costs through account payee cheques, 20% through cash bearer cheques and 20% directly in cash.

- Both advance- and reimbursement- based systems were used by health facilities for claiming Aama incentives and payments. Some health facilities took an advance from the D(P)HO while others claimed reimbursement after expenditure. Nevertheless, all health facilities reported that they usually received sufficient funding by the end of the fiscal year. Approximately half of all health facilities took an advance to cover the transport incentives while the other half sought reimbursement.

3.1.3 *Compliance with Aama guidelines*

- The proportion of women who had received the transport incentives on the day of discharge (as required by the guidelines) decreased from 86% in Rapid Assessment VI to 75% in Rapid Assessment VII. This may have been largely due to the delayed budget release and meant that around 25% of surveyed women had to wait to receive their incentives.
- There was a small increase in compliance with the requirement to display the names of Aama Programme beneficiaries at health facilities (on the Annex 10 format of the guidelines) from 54% of health facilities in assessment VI to 57% of them in assessment VII. Referral facilities such as zonal and private hospitals were the least compliant with this requirement.
- Only a third of the health facilities had a copy of the revised Aama Programme guidelines (FHD 2012), meaning that most facilities were following the earlier 2008/9 version.

Table 5: Results against indicators of Rapid Assessments VI and VII

	Indicators	RA VI (July 2012)	RA VII (April 2013)	Indicator type
Objective 1: Cross-verification of health facility information and women's reports				
1	% match between health facility records and women on receipt of transport incentives	95%	95%	Core
2	% match between health facility records and women on receipt of 4ANC incentives	NA	94%	Core
3	% match between health facility records and women on type of delivery (normal/complicated/caesarean)	NA	99%	Core
Objective 2: Aama Programme fund management				
4	% of health facilities receiving funds trimesterly	69%	33%	Core
5	% of health facilities received fund through account pay cheque for unit cost (institutional cost)	NA	60%	Core
6	% of health facilities receiving advances for transport cost	NA	49%	Core
7	% of health facilities submitting financial reports monthly as reported by health facility	67%	66%	Core
Objective 3: Compliance with Aama guidelines				
8	% of women receiving incentives on day of discharge	86%	76%	Core
9	% of health facilities with display boards showing lists of Aama Programme beneficiaries	54%	57%	Core
10	% of health facilities with a copy of Aama guidelines	65%	31%	Core
Objective 4: Utilisation of free delivery care and incentives				
	% of women receiving transport incentive as per the guidelines	86%	76%	Supplementary
	% of women who did not pay any cash at health facilities for their deliveries	77%	43%	Supplementary
	% of women receiving 4ANC incentive of total women completing four ANC visits	NA	16%	Supplementary

Note: NA not available

3.1.4 Utilisation of the Aama programme

- Only 43% of all interviewed women had received completely free delivery care from the health institution where they gave birth. This happened in spite of the fact that all the facilities were implementing Aama and should therefore have provided free delivery services.
- Encouragingly 90% of interviewed women said they had received the full transport incentive. However, comparatively more women at government facilities had not received the full incentive, which may be due in part to the delayed budget release.
- Only 16% of the 289 women whom health facilities claimed had completed four ANC visits had received the 4ANC incentive. (Note that meeting the four visits requirement was used as a proxy indicator). Service providers said that the low level of use of the 4ANC incentive was due to the difficulty of meeting the protocol, the unavailability of funds and a lack of awareness of the 4ANC incentive scheme.

3.2 BACKGROUND CHARACTERISTICS OF STUDY DISTRICTS AND PARTICIPANTS

3.2.1 Study district characteristics

As described in Chapter 2, study districts were purposively sampled to provide a range of ecological and socioeconomic characteristics (Table 6). Socioeconomic development is measured by Human Development Index (HDI) and the sampled districts ranked from high to low (18 to 72). The HDI is an index of life expectancy at birth, education and gross domestic product per capita. Mountain districts A and B are among the lowest ranking districts in Nepal while Tarai district F is a high ranking district. Tarai district F had the highest population (864,917) and the most deliveries (9,875) in financial year 2012/13.

Table 6: Characteristics of sample districts

Districts	HDI rank (2003)	Total population (FY 2012/13)	Population of women of reproductive age (FY 2012/13)	Expected live-births (FY 2012/13)	No. institutional and assisted home deliveries (FY 2012/13)
Mountain A	68	49,418	12,291	1,936	535
Mountain B	72	203,477	51,996	4,759	1,902
Hill C	32	238,354	62,862	5,658	927
Hill D	35	354,897	95,729	8,631	3,534
Tarai E	43	823,150	207,579	17,937	5,135
Tarai F	18	864,917	251,647	24,077	9,875
Total		2,534,213	682,104	62,998	21,908

Source: HMIS 2013 and UNDP 2004

Table 7 presents the total number of health facilities in the six districts. Of the six districts, the treasury single account (TSA) system had been implemented in three of them. Both Tarai districts had zonal hospitals and a large number of non-government hospitals, especially Tarai F (40 including 24 NGO run and 16 private hospitals). There were no private hospitals in mountain district B while the rest of the districts had at least two private hospitals each. However, only four hospitals from the two Tarai districts were implementing Aama.

There were no PHCCs in mountain district A while Tarai district F had the most PHCCs. Every PHCC had a birthing centre as per government norms. There were 47 HPs implementing the Aama Programme out of the 56 HPs in the six districts with all the HPs in mountain districts A and B and hill districts C and D implementing the Aama Programme. Of the 292 SHPs, 57 were implementing Aama (functioning birthing centres). Hill district C had the largest number of SHPs implementing Aama.

Table 7: Total number of health facilities in the sampled districts

District	TSA implem- ented districts	Government hospitals		Private, mission, NGO hospitals	PHCCs	Health posts	Aama implementing health posts	SHPs	Aama implementing SHPs
		Zonal hosp.	District hosp.						
Mountain A	1	0	1	2	0	10	10	16	5
Mountain B	0	0	1	0	2	10	10	35	17
Hill C	0	0	1	2	3	9	9	51	21
Hill D	0	0	1	2	4	12	12	64	12
Tarai E	1	1	0	5	5	9	2	88	0
Tarai F	1	1	0	40	6	6	4	38	2
Total	3	2	4	51	20	56	47	292	57

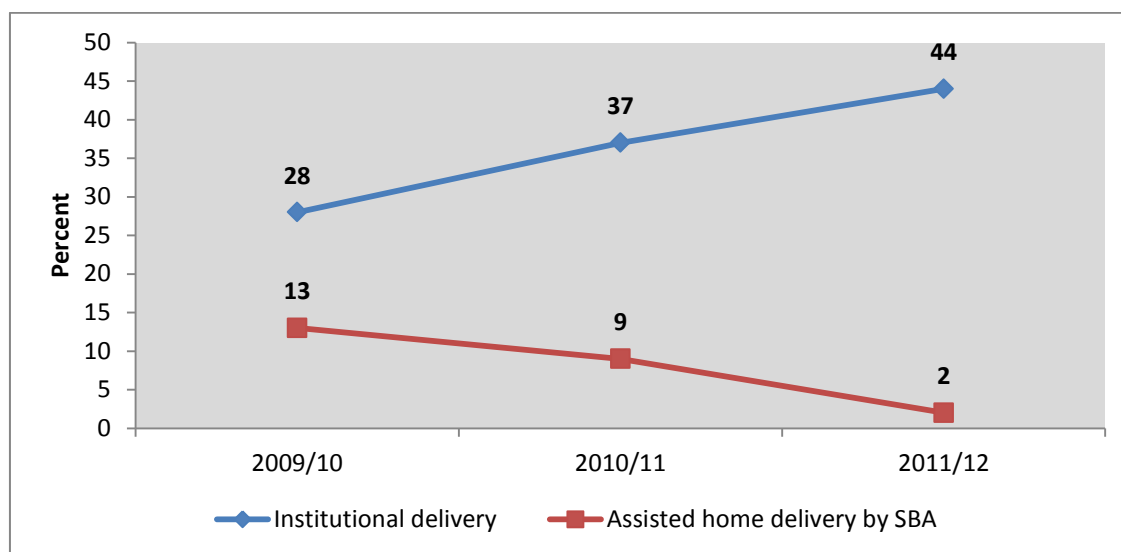
Source: HMIS 2013. TSA = treasury single account

3.2.2 Trend of maternal health service use

There has been a large increase in the proportion of deliveries in health institutions in Nepal from 28% in 2009/10 to 44% in and 2011/12 (Figure 3). A large part of this increase is often attributed to the introduction of demand-side financing schemes for maternity services and free delivery under the Aama Programme that began in 2009. However, further evidence is needed to assess whether or not these schemes are the main independent factors associated with this increment.

On the other hand, there has been a large decline in reported home deliveries assisted by skilled birth attendants (SBAs), from 13% in 2009/10 to only 2% in 2011/12. It is assumed that this decrease is related to 1) the reduced incentives for SBAs to attend these deliveries (it was previously worth more) and 2) the difficult process of collecting the required proof of claim documents. There is evidence that some assisted home deliveries are neither reported nor claimed for.

Figure 3: Percentage of Institutional deliveries and SBA-assisted home deliveries, Nepal (2009/10–2011/12)



Source: HMIS 2013

Table 8 gives detailed information on the trend of institutional deliveries and home deliveries for the sampled districts over the 2009/10 to 2011/12 period.

- Institutional delivery was found to be increasing in Mountain district A;
- Mountain district B had a large increase in the number of institutional deliveries to a rate just below the national average alongside a gradual decline in assisted home deliveries;
- The number of assisted home deliveries was largely unchanged in hill district C;
- There was a small increase in institutional deliveries in hill district D alongside a decline in assisted home deliveries;
- Tarai districts E and F had large increases in 2010/11 in institutional deliveries following the 2009 introduction of the Aama Programme, while in 2011/12 there was a reversal of this trend.

The declines in reported assisted home deliveries alongside the increases in institutional deliveries could well be due to policies and interventions that specifically promote institutional deliveries as opposed to assisted home deliveries.

Table 8: Trend of institutional and assisted home deliveries in study districts (2009/10 to 2011/12)

Districts	2009/10		2010/11		2011/12	
	Institutional deliveries* (%)	Assisted home deliveries by SBAs (%)	Institutional deliveries# (%)	Assisted home deliveries by SBAs (%)	Institutional deliveries# (%)	Assisted home deliveries by SBAs (%)
Mountain A	31	7	32	12	35	4
Mountain B	24	2	27	2	42	1
Hill C	9	0	10	0	13	0
Hill D	15	6	19	6	21	5
Tarai E	42	5	65	3	50	4
Tarai F	43	3	63	1	46	1
National	28	3	37	2	44	2

Source: HMIS 2013

* calculated out of expected pregnancies, # calculated out of expected live-births

Trends in utilisation of antenatal care

The trends in antenatal care (ANC) utilisation are presented in Table 9 for the 2007/08 to 2010/11 period in the six districts (Table 9). Most of these districts have seen an increase in the proportion of pregnant women who attended at least one ANC visit in this period. The over 100% achievements in districts A, B and F are probably due to under-estimations of the number of expected pregnancies. This would have artificially inflated the proportion receiving ANC visits.

The large increases in uptake in 2009/10 coincided with the initiation of the 4ANC programme (in 2009), after which the data plateaus for four of the districts. Four districts (two mountain, one hill and one Tarai) have seen a decrease in first ANC visits since 2010/11. The uptake of the first ANC visit is considerably lower in hill districts C and D compared to other districts. This needs further investigation.

Table 9: Trend of first ANC visit as a percentage of expected pregnancies (2007/08 to 2011/12)

District	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)	2011/12 (%)
Mountain A	60	87	144	84	68
Mountain B	63	60	111	109	110
Hill C	44	46	58	52	53
Hill D	56	53	69	73	73
Tarai E	71	73	94	101	83
Tarai F	71	78	116	92	76
National	68	67	87	85	83

Source: HMIS 2013

It is recommended that pregnant women make ANC visits in their fourth, sixth, eighth and ninth months of pregnancy. The data indicate that the proportion of women completing four ANC visits is significantly lower than those making their first ANC visit. Similar to the trend of first ANC visits, there was a large increase in pregnant women making four ANC visits for all six districts between 2008/09

and 2009/10, coinciding with the introduction of the 4ANC scheme (Table 10). Thereafter, the uptake of four ANC visits declined except for mountain district B and hill district D.

Table 10: Trend of fourth ANC visit as percentage of expected pregnancies (2007/08-2011/12)

District	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)	2011/12 (%)
Mountain A	24	46	89	49	40
Mountain B	24	23	39	43	56
Hill C	27	24	26	23	25
Hill D	31	33	52	48	55
Tarai E	37	42	54	48	41
Tarai F	39	39	48	60	38
National	35	38	50	48	47

Source: HMIS 2013

3.2.3 *Key informants*

Table 11 shows the number of interviews with key informants conducted for the study. All D(P)HO and health facility accountants and Aama focal persons were interviewed using tools 1A and 1B. Altogether 44 health facilities were sampled for the study with one service provider from each health facility was interviewed using tool 2A. The providers included auxiliary nurse midwives (ANM), staff nurses, auxiliary health workers and maternity in-charges. Forty-two key informant interviews were conducted with HFMC members using tools 2B and 35 and with accountants at health facilities. Nine of the accountants were not available for interview.

Table 11: Details of interviews conducted, women and key informants

		Mountain A	Mountain B	Hill C	Hill D	Tarai E	Tarai F	Total
Key informant interviews								
DHOs/ DPHOs	Aama focal persons	1	1	1	1	1	1	6
	Accountants	1	1	1	1	1	1	6
Zonal hospitals	Service providers	No zonal hospital				1	1	2
	Accountants					1	1	2
	HFMC members					1	0	1
District hospitals	Service provider	1	1	1	1	NA		4
	Accountants	0	0	1	1			2
	HFMC members	1	1	1	1			4
Private, mission and INGO hospitals	Service providers	No private hospital				2	2	4
	Accountants					2	2	4
	HFMC members					2	1	3
PHCCs	Service providers	NA	2	2	2	2	3	11
	Accountants		2	2	2	2	1	9
	HFMC members		2	2	2	2	3	11
Health posts	Service providers	1	3	3	3	2	3	15
	Accountants	1	2	3	2	1	3	12
	HFMC members	1	3	3	3	2	3	15
SHPs	Service providers	1	3	2	1	0	1	8
	Accountants	1	3	1	1	0	0	6
	HFMC members	1	3	2	1	0	1	8
Questionnaire								
Women who had delivered at a health facility in the last six months		56	83	93	91	81	397	801

Not available (NA), health facility management committee (HFMC)

3.2.4 Sampling of women who had delivered at a health facility

To cross-verify the records, field enumerators visited the homes of women with the following information on their cases: name, name of husband, address, type of delivery, date of delivery and name of health facility where delivered. This information was taken from the Annex 3 claim forms at the D(P)HOs, verified with the maternity register of the concerned health facilities. Only cases where the claim forms and maternity registers matched were followed up with the women in question (= matched health facility records).

It was planned to interview 985 women who had delivered at one of the sample health facilities in the previous six months, as a fixed number of samples were assigned to each facility (Table 12). To identify the required 985 cases, 1,105 institutional deliveries were reviewed from D(P)HO Annex 3 claim forms. Overall, 801 of these cases matched health facility maternity registers and were subsequently interviewed using study tool 3A.

Of the 1,105 cases reviewed:

- 3% (37) were not in the health facility maternity registers;

- 12% (135) did not match between the D(P)HO Annex 3 claim forms and the maternity registers;
- 3.5% (39) could not be traced at their given address in spite of enumerators mobilizing local female community health volunteers, community people and ward chairpersons to find them;
- 4.3% (48) of the women were not available at their homes during the data collection period: 32 were said to be at their maternal homes, 13 were to have moved to another address, and 3 were away for other reasons;
- 45 of the matched case women were not interviewed as they lived too far away from the facility to be interviewed within the study time-frame.

Table 12: Details on the targeted, reviewed and interviewed women

Districts	Target no. interviews with institutional delivery women	No. women reviewed from D(P)HO records	No. women not found in health facility maternity registers (n)	No. unmatched cases with maternity registers	No. untraced women	No. women traced but not available to interview (n)	No. women interviewed (n)	No. women matched but not interviewed (n)
Mountain A	56	92	0	1	0	0	56	35
Mountain B	100	139	13	26	0	7	93	0
Hill C	96	96	3	9	0	0	83	1
Hill D	110	120	0	6	4	10	91	9
Tarai E	105	112	2	6	16	7	81	0
Tarai F	518	546	19	87	19	24	397	0
Total	985	1,105	37	135	39	48	801	45

3.2.5 Background characteristics of interviewed women

Table 13 shows the characteristics of the 801 interviewed women by district. Overall, the highest proportion of these women were upper caste women and between 20 and 24 years old age. Twenty-eight per cent of the women were disadvantaged Janajatis (ethnic group) while only 3% were from religious minorities. More than four-fifths of the interviewed women belonged to disadvantaged janajatis or upper castes in Tarai District F. Mountain district B had slightly less than one-third dalit women while Hill district D had more than one-quarter.

Ninety per cent of the women were literate, with 34% having studied to at least school leaving certificate (SLC) level. Mountain districts had the highest proportion of illiterate women while Tarai districts had the lowest. The majority (59%) did not have paid work while 23% were engaged in agriculture.

Table 13: Background characteristics of interviewed women by district

Characteristic	Mountain District A % (N=56)	Mountain District B % (N=93)	Hill District C % (N=83)	Hill District D % (N=91)	Tarai District E % (N=81)	Tarai District F % (N=397)	Total % (N=801)
Age							
15-19	17.9	28.0	18.1	14.3	18.5	17.9	18.7
20-24	41.1	33.3	41.0	49.5	58.0	43.6	44.1
25-29	28.6	25.8	27.7	26.4	19.8	28.0	26.7
30-34	8.9	7.5	7.2	7.7	3.7	7.8	7.4
35-41	3.6	5.4	6.0	2.2	-	2.8	3.1
Caste and ethnicity							
Dalit	10.7	30.1	14.5	28.6	3.7	4.5	11.6
Disadvantaged Janajatis (ethnic groups)	8.9	3.2	28.9	23.1	14.8	40.8	28.3
Disadvantaged non-Dalit Tarai castes	7.1	3.2	1.2	1.1	61.7	4.0	9.4
Religious minorities	-	-	-	1.1	7.4	4.8	3.2
Relatively advantaged Janajatis	-	-	16.9	7.7	3.7	6.3	6.1
Upper caste	73.2	63.4	38.6	38.5	8.6	39.5	41.3
Education							
Illiterate	53.6	24.7	10.8	8.8	1.2	2.5	10.1
Non-formal education	19.6	22.6	9.6	5.5	40.7	9.1	14.2
Up to 5 years of education	1.8	14.0	25.3	16.5	7.4	11.3	12.6
6 to 9 years of education	1.8	15.1	34.9	38.5	27.2	34.0	29.5
SLC and above	23.2	23.7	19.3	30.8	23.5	43.1	33.6
Occupation							
Not in paid work	21.4	26.9	49.4	46.2	93.8	69.3	58.8
Labouring work	1.8	5.4	-	2.2	2.5	3.0	2.7
Agriculture	55.4	64.5	37.3	41.8	-	7.1	23.5
Petty business	5.4	2.2	10.8	5.5	2.5	14.6	9.9
Service	16.1	1.1	2.4	4.4	1.2	6.0	5.1
Place of residence							
Urban	-	-	-	-	11.1	30.5	16.2
Rural	100.0	100.0	100.0	100.0	88.9	69.5	83.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

3.2.6 Home deliveries

The required sample of women who had delivered at home with a service provider was 375 in the two districts that had reported home deliveries (the others had not reported any). The enumerators found that although health workers were assisting home deliveries, they had not reported these cases to their DHOs/DPHOs. One service provider explained the situation:

We hardly assist 10-15 home deliveries in a year. [To get the incentive of NPR 100] we need to submit the recommendation letter from the VDC as well as the child's birth certificate. It is a time consuming and tedious task. Though we assisted these deliveries we do not claim for them.

— Service provider, hill D

Similar reasons were given by health facility workers in another health post and SHP in the same district. The stated reasons were that the incentive is too low (NPR 100) and too much effort is needed to furnish the required documents to make the claim. Hence, no results on matching health providers' claims and women's reports for assisted home deliveries can be presented.

3.3 CROSS-VERIFICATION BETWEEN HEALTH FACILITY RECORDS AND WOMEN'S REPORTS

This section presents the results under study objective 1 of cross-verifying the matching health facility records and women's reports on the receipt of transport incentives, 4ANC incentives and type of delivery. The results are based on quantitative information obtained from 801 interviewed women and 1,105 records of deliveries reviewed in health facilities.

Table 14 shows the results on the matching of delivery cases in D(P)HO records with health facility maternity registers. Of the 1,105 cases reviewed from D(P)HO records, 37 were not found in the maternity registers and 152 did not match what was written in the maternity register. (Note the definition of not matched was if one or more of the following fields differed: mother's address, type of health facility, date of delivery, type of delivery).

These findings could be due to recording errors or the misappropriation of incentive funds and further exploration is needed of the reasons for these mismatches before conclusions can be drawn. These findings suggest the need for better recording and reporting at facilities and the need for more detailed investigations in future rapid assessments.

Table 14: Matching of D(P)HO records and health facility maternity registers

Districts	Cases reviewed from claim forms at DHOs/DPHOs	Not found in health facility maternity registers		Unmatched cases with health facility registers	
		n	%	N	%
Mountain A	92	0	0	1	1.1
Mountain B	139	13	9.4	31	22.3
Hill C	96	3	3.1	9	9.4
Hill D	120	0	0	6	5.0
Tarai E	112	2	1.0	7	6.3
Tarai F	546	19	3.5	98	17.9
Total	1,105	37	3.4	152	13.8

3.3.1 Receipt of transport incentive

A total of 735 women had received the Aama transport incentive either in full or in part, but only 717 had received it in full.

The health facility records and women's reports matched for 717 of the 756 cases on the receipt of the full transport incentive (Table 15). Thus, 5% of the women disagreed with the health facility records that they had been given this incentive, a similar figure to that found in Rapid Assessment VI in 2012. The percentage of cases that matched was 100% in districts A and C and more than 90% in districts B and F. Most of the unmatched cases were from districts E and D with more than a half of the total mismatches (21 out of 39) from Tarai district E. By facility type, the lowest level of matches was at the health posts.

Table 15: Comparison of facility records and women’s reports on receipt of transport incentives

	Health facility records: no. women given full transport incentive	Interviewed women: said received full incentive	Matched percentage
Districts			
Mountain A	47	47	100
Mountain B	82	80	97.6
Hill C	82	82	100
Hill D	91	80	87.9
Tarai E	64	43	67.2
Tarai F	390	385	98.7
Types of health facility			
Government hospital	221	200	90.5
Private hospital	279	278	99.6
Primary health care centre	91	91	100
Health post	114	98	86.0
Sub-health post	51	50	98.0
Total	756	717	94.8

The health facility maternity registers recorded that 94% of the 801 delivered women had been provided with the full transport incentive, while only 89% of interviewed women said they had received the full incentive (Table 16). Five per cent of the interviewed women reported being asked to return later to pick up their incentives, 3% said they had not received any incentive, while 2% (all at Tarai District E) said they had only received a partial amount. See Section 3.5.2 for the findings on timing of the receipt of transport incentive (either at the time of discharge or later).

The largest discrepancies between the health facility records and interviewed women’s reports were in districts D and E. According to the matched health facility/D(P)HO records, all women who delivered in Hill district D had received the full incentive, while 12% of the interviewed women said they had either not received the incentive or had been told to come back later to collect it. Likewise, according to the matched health facility records, 79% of women who delivered in Tarai district E had been given the full transport incentive. In this district only 53% of women reported receiving the full incentive while a further 25% had been told to come back later to collect it. Even though 53% plus 25% is almost 79% there still could be discrepancies as there are no guidelines or instructions on providing the incentive amount on an instalment basis. Districts D (16%) and A (14%) had the highest proportion of women who had not received the full incentive according to matched health facility records. By facility, the mismatch was higher on the receipt of incentives at government hospitals and health posts.

Further examination of the reasons for this need to be explored with health facility staff. It could be due to either late receipt of budgeted funds by health facilities or the misuse of funds.

Table 16: Comparison of matched facility records and women’s reports on full or partial receipt of transport incentives

Districts	Health facility records: provision of transport incentive (%)				Women’s reports: receipt of transport incentive (%)					Total (N)
	Fully received	Not received	Told would get later	Total	Fully received	Partially received	Not received	Told would get later	Total	
Districts										
Mountain A	83.9	14.3	1.8	100	83.9	0	14.3	1.8	100	56
Mountain B	88.2	1.1	10.8	100	86.0	0	1.1	12.9	100	93
Hill C	98.8	1.2	0	100	98.8	0	1.2	0	100	83
Hill D	100	0	0	100	87.9	0	3.3	8.8	100	91
Tarai E	79.0	14.8	6.2	100	53.1	24.7	16.0	6.2	100	81
Tarai F	98.2	0.3	1.5	100	97.0	0	0.3	2.8	100	397
Type of health facility										
Government hospitals	95.7	3.5	0.9	100	86.6	8.7	3.9	0.9	100	231
Private hospitals	100	0	0	100	99.6	0	0.4	0	100	279
Primary health care centres	89.2	10.8	0	100	89.2	0	8.8	2.0	100	102
Health posts	85.1	2.2	12.7	100	73.1	0	5.2	21.6	100	134
Sub-health posts	92.7	1.8	5.5	100	90.9	0	1.8	7.3	100	55
Total	94.4	2.9	2.7	100	89.5	2.5	3.4	4.6	100	801

The Aama guidelines say that all participating health facilities should display a list of women who have been given the transport incentive on the Annex 10 format. There were fewer mismatches between matched facility records and women’s reports on the receipt of the transport incentive in health facilities that were found publicly displaying incentive recipients (1.3%) compared to facilities that did not display them (8.5%) (Table 17). In government hospitals there was 100% agreement on the receipt of the incentives between women’s reports and hospital records where recipients’ names were publicly displayed compared to an 11% mismatch at hospitals that had not publically displayed the recipients’ names. This suggests that social auditing or maintaining transparency promotes actual receipt of the incentive.

Table 17: Comparison of matched facility records and women’s reports on receipt and public display of transport incentive

	Matched facility records: no. women given incentive	Women’s reports: receipt of incentive	Match percentage (%)
All health facilities			
Display	306	302	98.7
Didn't display	354	324	91.5
Government hospital			
Display	32	32	100
Didn't display	189	168	88.9

Note: Due to data limitations, the sample size for this analysis is limited to 660 as public display practice in some facilities was not captured.

3.3.2 *Receipt of 4ANC incentives*

Only 46 of the 289 interviewed women had received the 4ANC incentive (Table 18). This incentive is worth NPR 400 (this issue is dealt with in detail in Section 3.6 below). Overall, 94% of matched health facility records and women’s reports on receipt of the 4ANC incentive matched. Only in health posts in hill district D was there a mismatch between the records and women’s reports. The matched records and women’s reports agreed that no women had received the 4ANC incentive in mountain district A and Tarai district E.

Table 18: Comparison of health facility records and women’s reports on receipt of the 4 ANC incentive.

Characteristics	Matched health facility records: no. women provided with 4ANC incentive	Women’s reports: no. received 4 ANC incentives	Match percentage (%)
District			
Mountain A	0	0	0
Mountain B	7	7	100
Hill C	2	2	100
Hill D	30	27	90.0
Tarai E	0	0	0
Tarai F	10	10	100
Type of health facilities			
Government hospitals	2	2	100
Primary health care centres	31	31	100
Health posts	7	4	57.1
Sub-health posts	9	9	100
Total N	49	46	93.9

3.3.3 *Types of delivery*

The details on type of delivery were noted from matched health facility records and checked against the women’s reports. There were very few and only minor discrepancies between these two sources of information (Tables 19 and 20). The mismatches were reported in the hill C, hill D, Tarai E, government hospitals and PHCCs. For instance, health facilities of hill C reported that 96% were normal, 2% complicated and 1% caesarean while women’s reports indicated that 95% were normal, 3% complicated and 1% caesarean. It should be noted that the women may mistake what is clinically spoken of as a normal delivery for a complicated one, but even so the number of mismatches remains very small. Overall the results suggest that 99% of the delivery types reported by the matched health facility records matched women’s reports (not shown in table). Further findings on the types of delivery are given in Section 3.6.

Table 19: Comparison of health facility records and women's reports on type of delivery by district

Characteristics	Mountain A N=56	Mountain B N=93	Hill C N=83	Hill D N=91	Tarai E N=81	Tarai F N=397
Normal deliveries						
Women's reports (%)	100.0	100.0	95.2	95.6	93.8	60.2
Health facility records (%)	100.0	100.0	96.4	95.6	92.6	60.2
% matched	100.0	100.0	98.8	100.0	101.3	100.0
Complicated deliveries						
Women's reports (%)	0.0	0.0	3.6	1.1	1.2	9.6
Health facility records (%)	0.0	0.0	2.4	2.2	2.5	9.6
% matched	NA	NA	150.0	50.0	50.0	100.0
Caesarean sections						
Women's reports (%)	0.0	0.0	1.2	3.3	4.9	30.2
Health facility records (%)	0.0	0.0	1.2	2.2	4.9	30.2
% matched	NA	NA	100.0	150.0	100.0	100.0

Table 20: Comparison of health facility records and women's reports on type of delivery by facility type

Characteristics	Government hospitals (N=231)	Private hospitals (N=279)	PHCCs (N=102)	Health posts (N=134)	Sub-health posts (N=55)
Normal delivery					
Women's reports (%)	82.3	54.8	96.1	100.0	100.0
Health facility records (%)	81.4	55.2	97.1	100.0	100.0
% matched	101.1	99.4	99.0	100.0	100.0
Complicated delivery					
Women's reports (%)	2.6	11.8	3.9	0.0	0.0
Health facility records (%)	3.9	11.5	2.9	0.0	0.0
% matched	66.7	103.1	133.3	NA	NA
C/S					
Women's reports (%)	15.2	33.3	0.0	0.0	0.0
Health facility records (%)	14.7	33.3	0.0	0.0	0.0
% matched	102.9	100.0	NA	NA	NA

3.4 FINANCIAL MANAGEMENT

This section presents the results under study objective 2 on the timeliness of fund flows, the mechanisms for releasing funds to health facilities, the use of unit cost money by health facilities and financial monitoring mechanisms for the period mid-June to mid-December 2012. The results are based on qualitative and quantitative data obtained from 6 D(P)HO Aama focal persons, 6 D(P)HO finance sections, 35 health facility account sections (the 9 other accountants were unavailable for interview), 42 health facility management committees and 44 service providers.

3.4.1 Timeliness of fund flow to health facilities

Of the 35 health facility accountants interviewed, 50% had received funds randomly, 33% received them trimesterly and 17% received them annually (table not shown). This may have been due to the delayed budget release. Note that the budget for the assessed health facilities was initially released only for the first quarter at the start of fiscal year 2012/13 (mid-July 2012), while the full budget was announced by the government only nine months into this fiscal year. This must have impacted fund disbursement to health facilities and subsequently the distribution of incentives to mothers. Moreover, untimely reimbursement of expenditure was cited as the reason for discontinuation of the Aama programme by the private hospital visited.

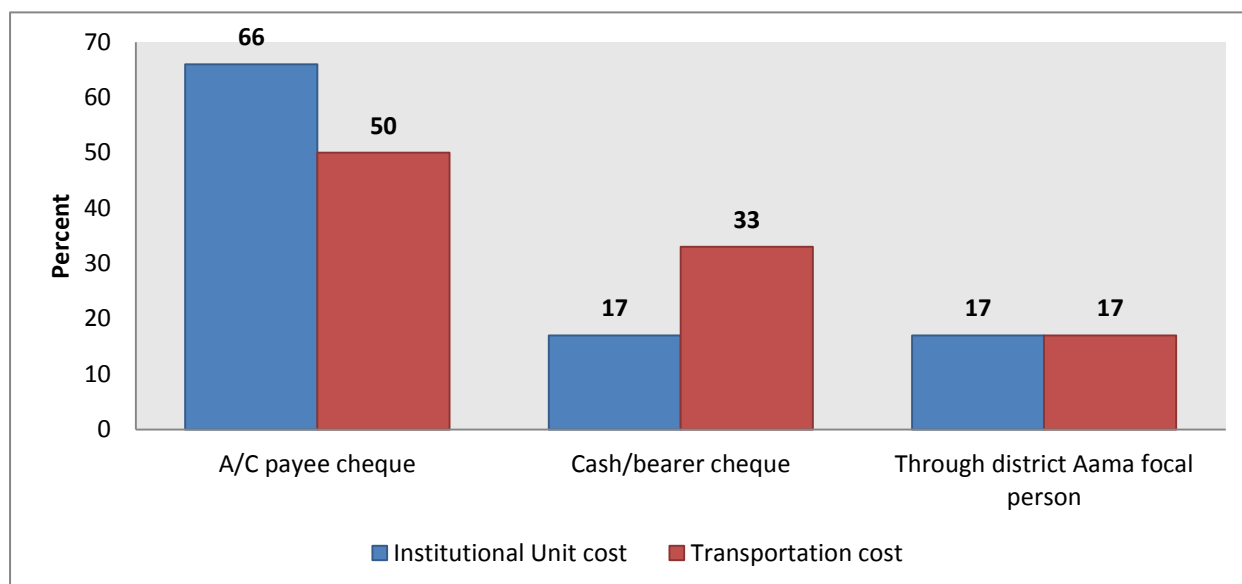
3.4.2 Mechanisms for fund release to health facilities

The D(P)HOs released funds for the transport incentive and unit costs to their health facilities using the following three modes:

- bank deposits through account (a/c) payee cheques to health institutions;
- cash bearer cheques to health facility staff; and
- cash advances to Aama focal persons.

For the Aama transport incentives, three of the D(P)HOs paid the health facilities by bank deposits through account payee cheques, two paid by cash bearer cheques to facility staff and one paid by cash via the district Aama focal person (Figure 4). Likewise, for the institutional unit costs, four D(P)HOs paid their facilities by bank deposits through account payee cheques, one by cash bearer cheque to facility staff and one by cash via the district Aama focal person. All the private hospitals were paid through account payee cheques for the transport and institutional costs.

Figure 4: Mechanism of releasing funds to health facilities (N=6 districts)



On the other hand, of the 35 health facilities, 60% said they had received account payee cheques for their unit cost payments, 20% said they had received cash bearer cheques and 20% reported receiving cash through their staff or through the Aama focal person (Table not shown). Likewise, for transportation costs 37% reported receiving it through account payee cheques, 6% through cash bearer cheques and the remaining large percentage (57%) reported receiving in cash (Table not shown).

shown). These results show that there is no uniform mechanism for disbursing funds. Although it may be context-specific, the standardisation of the fund release mechanism could help in monitoring and in the effective implementation of the Aama Programme.

3.4.3 Use of unit cost money

Aama focal persons, service providers and HFMC representative were asked about the use of the institutional cost money that health facilities receive under the Aama Programme. Most respondents said that this money mostly went to purchase medicines and essential equipment for deliveries, utensils (buckets, jugs etc.), boots for maternity staff, and clothes and blankets for babies. Eleven of the 42 interviewed HFMC representatives said that it also went on hiring local staff such as auxiliary nurse midwives, staff nurses, and support staff for helping with deliveries. Some service providers and HFMC representatives said it also went on building infrastructure and for printing safe motherhood programme recording and reporting forms. Only 3 of the 35 facilities reported spending the unit cost money on activities other than safe motherhood — on waste management, incentives for female community health volunteers, purchasing gas and providing food supplements to mothers. One HFMC representative said that the use of unit cost money was decided at HFMC meetings.

District Aama focal persons were also asked whether the health facilities were instructed on how to use the unit cost money. All except the focal person from hill district C said that they had given such instructions to lower level health facilities. Two said they had instructed a health facility in-charge to spend the money on things that benefit mothers and babies such as blankets and clothes for babies, managing maternity rooms and beds, maintaining an autoclave and on fuel and buying medicine and utensils. The focal persons from districts F and D said they had told health facilities to use the money according to the instructions in the latest Aama guidelines. All focal persons said they carried out regular site visits to monitor the programme including the effective use of the funds. The guidelines do not, however, clearly indicate how the unit cost money that is left after bearing delivery expenses should be spent, except that it should be spent for developing the facility.

These results suggest that clearer messages need to be provided on the use of unit cost money. Although the needs of facilities may vary and only a few reported using Aama funds for non-safe motherhood purposes, standardisation on the use of institutional costs may help reduce the possible misappropriation of these funds.

3.4.4 Sufficiency and flow of funds to health facilities

Among the 35 health facilities, 24 (68%) said that the budget provision was sufficient for implementing the Aama programme. The other 11 said that the funds were insufficient and they had been using budget from the previous fiscal year and from the HFMC to overcome the shortfalls.

Seventy four per cent of facilities said they had problems with receiving funds from their D(P)HO and reported not getting funds on time. They said that the delayed receipt of funds led to health workers using their own money and health facilities' unspent funds to meet Aama costs.

D(P)HOs used both advances and reimbursement to disburse Aama funds to health facilities. Some facilities took advances from their D(P)HO while others were reimbursed after expenditure. A half (49%) of health facilities reported receiving transport incentive money in advance while 26% reported receiving institutional unit cost payments in advance. The remaining health facilities were reimbursed the unit cost money and transport costs after the expenditure had happened. Nonetheless, health

facilities reported that they usually received sufficient budget by the end of the fiscal year for the Aama programme.

One key informant identified the separate fund disbursement for Aama and 4ANC as problematic:

The 4ANC and transportation cost is given separately, which is very problematic for us.

— Tarai district E, PHCC in-charge

3.4.5 Frequency of financial reporting

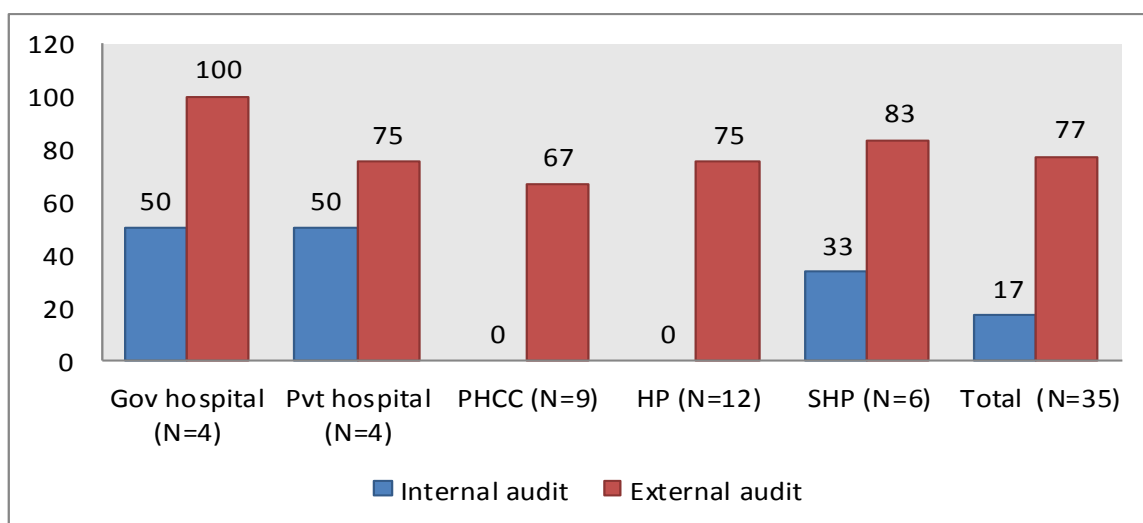
Although the Aama guidelines state that health facilities should report to their D(P)HO every month, only two-thirds (66%) of the 35 facilities had submitted monthly reports as per Annexes 6 and 10 of the guidelines to their D(P)HOs in the study period (mid-June to mid-December 2012). One-tenth (11%) of the facilities had submitted trimesterly reports and the remaining 23% had submitted them irregularly.

The Aama guidelines (2012) say that reporting should be monthly, replacing the trimesterly system in the previous guidelines. The results suggest that a number of health facilities are still following the old guidelines and are either complacent about sending reports or are unaware of the changed requirement.

3.4.6 Financial monitoring

All D(P)HOs knew about the requirement for four-monthly internal audits by the DTACO. However, an internal audit had not been carried out in any of the six DHOs/DPHOs for financial year 2012/13 as of the third week of February 2013 – the second trimester of 2012/2013. The D(P)HO accountants said that the Auditor General’s Office had carried out an external audit of their accounts in the previous year. These audits had recommended the proper implementation of the Aama guidelines. Only 17% of health facilities said they had carried out internal audits while 77% reported external audits (Figure 5). All government hospitals and 75% of the private hospitals had been externally audited. They said that there were no important recommendations arising from these audits. This needs further investigation.

Figure 5: Internal and external audit practices



3.5 COMPLIANCE WITH AAMA GUIDELINES ON SERVICE DELIVERY

This section presents the results under study objective 3 on compliance with the Aama guidelines including the receipt of transport incentives, timing of receipt of transport incentives, public display practices and whether or not facilities possess the revised guidelines. The results are based on the 735 women who reported receiving the transport incentive and interviews with 6 D(P)HO Aama focal persons, 6 D(P)HO finance sections, 35 health facility account sections, 42 health facility management committee representatives and 44 service providers.

3.5.1 Receipt of transport incentives

The Aama guidelines state that the Aama incentives should be given directly to recently delivered clients. The study found that 71% of the interviewed women had received the incentive directly while in 22% of cases it was received by their husbands (Table 21). More women clients had received the incentives than in the previous rapid assessment (71% vs. 62% in 2012).

Table 21: Recipient of transport incentives

	Mountain A % (N=47)	Mountain B % (N=80)	Hill C % (N=81)	Hill D % (N=79)	Tarai E % (N=63)	Tarai F % (N=385)	Total 735
Self (interviewed women)	95.7	77.5	91.4	88.6	77.8	57.1	70.7
Husband	4.3	12.5	6.2	7.6	9.5	34.3	21.9
Father/mother-in-law	0	6.3	1.2	2.5	6.3	3.1	3.3
Other family member	0	2.5	1.2	1.3	4.8	5.5	3.8
Mother	0	0	0	0	1.6	0	0.1
Friend	0	1.3	0	0	0	0	0.1
Total (%)	100	100	100	100	100	100	100

There was a large variation across the six districts in the proportion of interviewed women who had received the transport incentives directly. Mountain district A (96%) and hill district C (91%) had the highest proportion while Tarai district F had the lowest (57%). In the Tarai district F, 43% of incentives were given to a husband or relative. This finding is similar to the previous Rapid Assessment (2012) demonstrating the more patriarchal society in the Tarai where many women are controlled by their husbands and in-laws.

Table 22 reports further disaggregation of those women that did not receive the incentive directly. The proportion of women receiving incentives themselves was highest among women of 30-34 years while it was least among those of 35-41. Dalit women were more likely to receive the incentives directly. Noticeably, a higher proportion of women from religious minorities and disadvantaged janajatis did not receive the incentive themselves. More illiterate women were likely to receive incentives themselves compared to educated women. Likewise, a higher proportion of women in agricultural occupations and from rural areas received the incentives themselves. The results indicate that the proportion of women not receiving incentives was particularly high among women with higher education, those from urban areas and those in service or business and among women who do not earn an income. The incentive may have carried lesser value among women with higher education and in better occupations. However, the findings that a higher proportion of woman who do not earn

and women from religious minorities and disadvantaged janajatis are not receiving the incentive themselves suggests that further examination of this issue may be necessary.

Table 22: Recipient of incentive by background characteristics

Characteristics	Women N	Other than women, %	Total N
Age			
15-19	70.2	29.8	141
20-24	71.3	28.7	321
25-29	68.7	31.3	195
30-34	78.6	21.4	56
35-41	63.6	36.4	22
Caste/Ethnicity			
Dalit	80.7	19.3	88
Disadvantaged janajatis	62.9	37.1	213
Disadvantaged non dalit tarai caste groups	72.3	27.7	65
Religious minorities	42.1	57.9	19
Relatively advantaged janajatis	75.0	25.0	44
Upper caste group	74.2	25.8	306
Education			
Illiterate	83.8	16.2	74
Non formal education	72.3	27.7	94
Up to 5 years of education	77.9	22.1	95
Six to 9 years of education	68.3	31.7	221
SLC and more	65.7	34.3	251
Occupation			
Do not earn	64.9	35.1	433
Labour	70.6	29.4	17
Agriculture	87.1	12.9	170
Petty business	67.5	32.5	77
Services	71.1	28.9	38
Place of residence			
Urban	56.9	43.1	130
Rural	73.7	26.3	605
Total	70.7	29.3	735

3.5.2 Timing of receipt of transport incentives

Overall 76% of women had received their transport incentives by, or on the, day of discharge whereas 11% only received it after three months or later (Table 23). This was a decrease from the previous assessment where 86% had received it by, or on the day, of discharge. A major factor behind these delays mentioned by key informants was delayed budget release from the central level. The interview results suggest that service providers were often compelled to ask women to visit later to receive the incentive because of unavailability of funds.

By district, the highest proportion of women who received the transport incentive on the day of delivery or of discharge was in Tarai district F (97%), Tarai district E (92%) and hill district D (91%).

These districts are comparatively more developed (see Table 6 that shows them as relatively high HDI-ranked districts) and have a good transport situation throughout most of the districts. On the other hand, it took considerable time in mountain districts B and A for interviewed women to receive their transport incentives with a half receiving them more than three months after giving birth. Almost all the women who delivered in private hospitals (99%) received their incentives on the day of delivery or discharge, which is higher than in other types of health institutions. In government hospitals only 76% and in PHCCs only 71% of women received them by or on the day of discharge. The percentage declined with the level of facility. Private institutions are reimbursed and they pre-finance the payment of the incentive to women. In government facilities where the HFMC is not functioning well and budgets were delayed, the problem of delayed payments was worse. Although, delayed budget receipt could be one factor, the results suggest that it is necessary to have separate provisions from the central level to avoid such delays.

Table 23: Timing of receipt of transport incentives by women

Characteristics	Day of discharge (%)	Within a month (%)	1 to 3 months (%)	>3 months (%)	Total (N)
District					
Mountain A	6.4	19.1	25.5	48.9	47
Mountain B	7.5	13.8	27.5	51.3	80
Hill C	54.3	22.2	11.1	12.3	81
Hill D	91.1	2.5	1.3	5.1	79
Tarai E	92.1	7.9	0	0	63
Tarai F	96.9	2.6	0.5	0	385
Types of health facility					
Government hospital	76.4	10.5	5.0	8.2	220
Private hospital	98.6	1.4			278
PHCC	71.1	5.6	12.2	11.1	90
Health post	39.2	12.4	16.5	32.0	97
Sub-health post	24.0	22.0	16.0	38.0	50
Total	75.6	7.5	6.3	10.6	735

It is important to note that delays in distributing the incentives prevents the achievement of programme objectives as women may be compelled to take loans to bear transport and other indirect expenses of delivery care.

Interview results suggested that incentives distribution was dependent on the availability of budget. For instance, a considerable number of institutions (13 out of 44) said they provide incentives on the day of discharge if funds are available. They added that incentives are only provided after funds become available from their D(P)HO. Some facilities said that they provided incentives quarterly due to the quarterly disbursement of the budget to them. Staff from two facilities in Tarai district F reported not providing incentives for more than six months due to the unavailability of funds.

Transport incentives and ANC incentives are distributed to the delivered women only after receiving money from the DHO. Money is delivered to health facilities every trimester.

— PHCC staff nurse mountain district B

3.5.3 Transparency mechanisms (public display mechanisms)

The Aama Programme guidelines (FHD 2012) call for displaying the names of beneficiaries and other details using the Annex 10 format every month on municipality and VDC display boards and at the concerned health facilities. This survey found that more than half (57%) of the facilities had displayed such notices. Only one out of the four government hospitals, one of the four private hospitals, six of the nine PHCCs, seven of the twelve HPs and five of the six SHPs were displaying these notices in public (table not shown).

Other transparency mechanisms were also used by the health facilities (Table 24). Seventy-four per cent of them discussed the use of the Aama fund at HFMC meetings, 17% had held public hearings, 17% had conducted a social audit while radio broadcasts and newspaper reports were also used to give information on expenditure and progress. Fourteen per cent of facilities had practiced no type of transparency mechanism.

Table 24: Transparency mechanisms for the Aama programme in the 35 health facilities

Types of facility	Public hearings	Social audits	Discussions at HFMC meetings	Radio broadcasts	Newspaper reports	Other	Nothing	N
Govt hospitals	0	0	50.0	25.0	25.0	25.0	25.0	4
Private hospitals	0	25.0	25.0	25.0	25.0	0	25.0	4
PHCCs	11.1	11.1	88.9	0	0	0	11.1	9
Health posts	25.0	16.7	100	8.3	0	17.0	0	12
SHPs	33.3	33.3	50.0	0	0	17.0	33.3	6
Total	17.1	17.1	74.3	8.6	5.7	2.9	14.3	35

Percentage total may exceed 100 due to multiple responses.

Demand-side financing schemes such as the Aama Programme have fiduciary risks and transparency mechanisms are needed to reduce such risks. The results suggest that there is scope for encouraging health facilities to use these mechanisms more.

3.5.4 Possession of Aama guidelines

The second revised Aama guidelines were implemented from fiscal year 2012/13. However, only 32% of the health facilities and DHOs/DPHOs said they had a copy. This could be a contributory factor to non-compliance with the revised procedures on recording, reporting and the public display of beneficiaries. When asked about any difficulties in the guidelines, a service provider from Tarai district E said that they should specify what share of the unit cost money should go to service providers. Another provider (hill district D) reported that complicated deliveries are inadequately defined. Three respondents said they had received the new guidelines but had not read them properly.

Although it is in my institution, I have not seen it and am still referring to the first 2065 (2008/09) edition.

— Auxiliary nurse midwife at hill district D health post

3.6 UTILISATION OF AAMA PROGRAMME

This section reports the findings under study objective 4 of the use of the Aama Programme components including free delivery care, transport incentives and the 4ANC incentives by background characteristics. The results are based on the 796 women who delivered in a health institution. Note

that of the 801 women interviewed, five had reportedly delivered on their way to the health facility or at home and so were excluded from the analysis.

3.6.1 Free institutional delivery care

Forty-three per cent of the 796 women received free delivery care from a health institution (Table 25). This proportion is low as all these facilities implement the Aama programme and receive unit costs for providing free delivery services. Women from Tarai district E (35%) and Tarai district F (15%) were most deprived of free deliveries while all women from mountain district A received free institutional deliveries. More than half of the women who had normal deliveries received free care while only 9% of women who had complicated deliveries and 3% who had caesarean sections received free care.

Only a few (3%) of the women delivering in private institutions reported having received free delivery care, while 46% of women who delivered in government hospitals said they received free delivery care (Table 25). Further discussion on the items paid for has been explored in Table 28.

Table 25: Women who received free delivery by district, type of delivery and facility

Characteristics	Received free care N	Received free care %	Total delivery cases N
District			
Mountain A	56	100	56
Mountain B	80	86.0	93
Hill C	56	69.1	81
Hill D	66	74.2	89
Tarai E	28	35.0	80
Tarai F	60	15.1	397
Type of delivery			
Normal	338	54.1	625
Complicated	4	9.3	43
Caesarean section	4	3.1	128
Type of health facility			
Government hospital	107	46.3	231
Private hospital	9	3.2	279
Primary health care centre	75	74.3	101
Health post	109	83.2	131
Sub-health post	46	85.2	54
Total	346	43.5	796

Most (79%) deliveries were normal but the percentage of caesareans was high (16%) — three times the WHO's normal rate of 5% caesarean sections. The proportion delivering by caesarean section was higher in Tarai district F (30%) which may be due to the presence of referral and higher level health facilities in that district (Table not shown). Moreover, private hospitals accounted for many of the caesarean deliveries (33%). The overall proportion was slightly higher as compared to the national figure (13.4%) for fiscal year 2011/12. On the other hand, the population based survey, NDHS 2011, found that that only 4.6% of all births had been delivered by caesarean section. The survey shows that the share of caesarean sections was particularly high in urban compared to rural areas (15.3% vs 3.5%), richest compared to lowest expenditure quintile (14.1% vs 1%), and women with SLC and above

education compared to women with no education (12.9% vs 1.8%). The finding that a large proportion of hospital deliveries are by caesarean section calls for investigation of the authenticity or otherwise of these cases and an assessment of whether supplier-induced demand is a causative factor.

While enquiring about the high number of caesarean sections in private hospitals in Tarai district F, one senior doctor said that most patients were from hill districts and would not have come unless they had a complication requiring immediate surgery. He stressed that the Aama unit cost amount for caesarean sections did not cover the actual costs of providing the service.

Most health workers in district, private and zonal hospitals mentioned that for RH negative blood type cases the unit cost of NPR 3,000 provided for complicated case management was insufficient. This causes health staff to refer such cases to other centres, which is a serious issue that needs to be addressed. Likewise, the private hospital visited to explore its discontinuation of the Aama programme mentioned that the unit cost provided was insufficient to deliver quality health services.

Table 26 shows utilisation of free delivery by background characteristics of women. A higher proportion of Dalits (74%) and religious minorities (54%) received free delivery care than did other groups. This is encouraging as the Aama Programme aims to target such populations. A high percentage of illiterate women received free delivery care (81%) while only 32% of women educated to SLC or higher level received it. A high proportion of women in agricultural occupations and in rural areas received free delivery. However, only 28% of disadvantaged Janajatis received free care.

Table 26: Women who received free delivery by background characteristics

Characteristics	N	%	Total N
Caste/ethnicity			
Dalit	69	74.2	93
Disadvantaged Janajatis	62	27.7	224
Disadvantaged non-Dalit Tarai castes	29	38.7	75
Religious minorities	14	53.8	26
Relatively advantaged Janajatis	20	41.7	48
Upper caste	152	46.1	330
Education			
Illiterate	66	81.5	81
Non formal education	63	55.3	114
Up to 5 years education	50	50.5	99
6 to 9 years education	82	35.0	234
SLC and more	85	31.7	268
Occupation			
Do not get paid for work	157	33.7	466
Labour	12	54.5	22
Agriculture	136	72.3	188
Petty business	26	32.9	79
Services	15	36.6	41
Place of residence			
Urban	8	6.2	130
Rural	338	50.8	666
Total	346	43.5	796

Five cases were excluded due to delivery on the way or at home.

The average amount paid for normal and complicated deliveries was NPR 1,883 and NPR 6,322 for caesarean sections (Table 27). Women from Tarai districts paid more than those from other districts. There was no single facility type where women did not pay for deliveries and they paid most in private hospitals – an average of NPR 6,977 for c-sections and NPR 2,577 for normal or complicated deliveries.

Table 27: Average amount paid for normal and complicated and caesarean delivery

	n	Average amount paid for normal and complicated deliveries (NPR)	n	Average amount paid for caesarean sections (NPR)
Districts				
Mountain A	-	0	-	0
Mountain B	12	700	-	0
Hill C	21	534	1	5,000
Hill D	20	622	3	1,500
Tarai E	45	1,916	2	5,000
Tarai F	192	2,228	110	6,489
Types of facility				
Government hospital	80	1,231	26	4,054
Private hospital	158	2,577	90	6977
PHCC	25	582	-	-
Health post	21	1,109	-	-
Sub-health post	6	422	-	-
Total/average	290[#]	1,883	116^{##}	6,322

**Three outlier cases paying NPR 35,000, 45,000 and 50,000 were excluded from the analysis*

women who could not tell the exact amount were excluded from the analysis

Further analysis was conducted to explore why women are still paying for deliveries and to identify the items paid for (Table 28). More than three-quarters reported paying cleaners (average NPR 221) while half reported paying for medicine (average NPR 161). Similarly of those who had a caesarean, 74% reported paying cleaners and 53% reported paying for medicine. A limited number of women reported paying registration fees (2% in normal or complicated and 4% in caesarean).

Table 28: Items paid for at the time of delivery

Items	Normal or complicated delivery (N=290)*			Caesarean-Section (N=116)*#		
	N	%	Average amount (NPR)	n	%	Average amount (NPR)
Registration fee	6	2.1	535	5	4.3	822
Medicine	161	55.5	972	62	53.4	2380
Gloves	9	3.1	133	1	0.9	240
Complication management fee	0	0.0	0.0	0	0.0	0
Informal payment to the provider	11	3.8	682	2	1.7	250
Delivery items required	5	1.7	577	2	1.7	1440
Sweets	80	27.6	293	45	38.8	358
Payment to cleaner	221	76.2	288	86	74.1	292
Total/average	290		1,883	116		6,322

** women who could not tell the exact amount were excluded from the analysis*

#Three outlier cases have been excluded from the analysis

3.6.2 Receipt of transport incentives

Overall, 90% of interviewed women reported receiving the full transport incentive (Table 29). All women from hill district C said they had received the full incentive while just over half from Tarai E district (54%) reported receiving the same. Note that 25% of interviewed women from Tarai E district reported receiving only part of the incentive.

Fewer disadvantaged non-Dalit Tarai castes (67%) and religious minorities (73%) received the full transport incentive. A considerable proportion of disadvantaged non-Dalit Tarai castes (20%) said they had only received a partial amount. Only 74% of women who delivered at a health post said they had received the full incentive. Comparatively more women in private facilities received the full incentive, which was probably a result of fund flow problems at public facilities.

Table 29: Women who received the transport incentive by background characteristics

	Received full incentive	Received only partial	Received incentive (full and partial)	Total N
District				
Mountain A	83.9	0	83.9	56
Mountain B	86.0	0	86.0	93
Hill C	100	0	100	81
Hill D	88.8	0	88.8	89
Tarai E	53.8	25.0	78.8	80
Tarai F	97.0	0	97.0	397
Caste/ethnicity				
Dalit	94.6	0	94.6	93
Disadvantaged Janajatis	94.2	0.9	95.1	224
Disadvantaged non-Dalit Tarai castes	66.7	20.0	86.7	75
Religious minorities	73.1	0	73.1	26
Relatively advantaged Janajatis	89.6	2.1	91.7	48
Upper caste	92.1	0.6	92.7	330
Education				
Illiterate	91.4	0	91.4	81
Non formal education	76.3	6.1	82.5	114
Up to years of education	92.9	3.0	96.0	99
Six to 9 years of education	93.2	1.3	94.4	234
SLC and more	91.0	2.6	93.7	268
Place of residence				
Urban	94.6	5.4	100	130
Rural	88.9	2.0	90.8	666
Type of health facility				
Government hospital	86.6	8.7	95.2	231
Private hospital	99.6	0	99.6	279
Primary health care centre	89.1	0	89.1	101
Health post	74.0	0	74.0	131
Sub-health post	92.6	0	92.6	54
Total	89.8	2.5	92.3	796

Five women were excluded in this analysis due to home delivery or road delivery

3.6.3 *Receipt of the 4ANC incentive*

Of the 289 women who were claimed by health facilities to have completed four ANC visits, only 16% had received the 4ANC incentive (Table 30).

Table 30: Percentage of women who received 4 ANC incentives by selected characteristics

Characteristics	Women's status of receiving 4ANC incentive				Total
	Did not receive		Received		
District	N	%	n	%	N
Mountain A	8	100	0	0	8
Mountain B	28	80.0	7	20.0	35
Hill C	28	93.3	2	6.7	30
Hill D	34	55.7	27	44.3	61
Tarai E	1	100	0	0	1
Tarai F	144	93.5	10	6.5	154
Caste/ethnicity					
Dalit	25	61.0	16	39.0	41
Disadvantaged Janajatis	67	89.3	8	10.7	75
Disadvantaged non-Dalit Tarai castes	4	80.0	1	20.0	5
Religious minorities	4	66.7	2	33.3	6
Relatively advantaged Janajatis	21	91.3	2	8.7	23
Upper castes	122	87.8	17	12.2	139
Types of health facilities					
Government hospitals	24	92.3	2	7.7	26
Private hospitals	129	100	-	-	129
Primary health centres	21	40.4	31	59.6	52
Health posts	48	92.3	4	7.7	52
Sub-health posts	21	70.0	9	30.0	30
Total	243	84.1	46	15.9	289

**The analysis was limited to women who had four ANC visits*

More women in hill districts D (44.3%) and C (20%) had received this incentive than those in other districts. In Tarai district E and mountain district A, very few or no women received the 4ANC incentive. This may have been due to poor recording or reporting, a lack of awareness on the programme, or women finding it difficult to meet the stringent criteria.

Surprisingly, health workers in 11 facilities said that there was no provision for 4ANC incentives when in fact there should have been. This lack of awareness could be a reason behind the low level of take up of the 4ANC incentive scheme. Service providers also mentioned difficulties experienced by women in meeting the 4ANC protocol and the unavailability of funds as reasons for low usage. Although unavailability of funds could account for low take-up in private institutions, all government institutions should be providing the 4ANC incentive. No records or receipts of 4ANC incentive payments were found in the private hospitals. It should be noted that the Aama guidelines provide no clear statement on whether or not the 4ANC incentive scheme should be implemented by private hospitals.

4 KEY FINDINGS AND WAYS FORWARD

Key finding 1: Overall, 95% of interviewed women agreed with the matched health facility records that they had received transport incentives. More than half of these mismatches were in Tarai district E. Likewise, 94% of women agreed with the matched health facility records that they had received the 4ANC incentive. The mismatches could be due to reporting errors, recording errors or fund misuse.

Way forward: Carry out a context-specific examination of mismatches between women's reports and health facility records on the receipt of incentives with a particular focus on examining the claim forms.

Key finding 2: There was a lack of uniformity in how D(P)HOs disbursed Aama funds to health facilities (via bank deposits, cash bearer cheques and cash advances). In addition, health facility informants said that insufficient and untimely budget release had impeded the smooth implementation of the Aama Programme.

Way forward:

- Place a greater focus on ensuring sufficient and timely Aama fund flow from D(P)HOs to peripheral health facilities with better adherence to Aama programme guidelines and financial rules and regulations and on a further standardisation of the fund release mechanism. This could happen by FHD and the DoHS finance section collaborating more closely with DTACOs for timely fund flow.

Key finding 3: The number of women receiving the transport incentive on the day of discharge declined from the last rapid assessment. About a quarter of women received the incentive late with 11% having to wait three months or more for it. The delay was higher in mountain districts. The reasons for this were delayed fund flow from the D(P)HOs to health facilities - particularly to health posts and sub-health posts.

Ways forward:

- Strengthen the fund flow system for the Aama Programme through more timely reporting, more accurate projections of the number of deliveries and improved coordination with local authorities (VDCs and DDCs).
- Carry out research to explore the payment delays in mountain districts.

Key finding 4: The percentage of deliveries by caesarean section was high (16%) — three times the WHO recommended rate of 5% of births. It was particularly high in Tarai districts and private hospitals.

Ways forward:

- Investigate the reasons for the very high number of caesarean sections in Tarai districts and higher level public and private hospitals.
- Develop and implement a mechanism for auditing the mode of delivery in private and referral facilities in collaboration with an independent authority.

Key findings 5: Fifty-seven per cent of facilities had posted the names of Aama transport incentive recipients on their public display boards. The zonal and private hospitals were least compliant with this practice. This finding raises questions about accountability, transparency and good governance of the programme which are central to the proper functioning of demand side incentive programmes. One reason for this could be a lack of awareness about the revised guidelines.

Ways forward:

- Improve distribution of the revised guidelines and brief implementers on changes from the previous version.
- Carry out regular district, regional and central level monitoring of the public display of Aama Programme beneficiaries on the revised Annex 10 of the guidelines especially at referral hospitals and peripheral health facilities.
- Build the capacity of health facility management committees and hospital development committees through periodic orientations on good governance, accountability and transparency for running the Aama Programme.

Key findings 6: Forty-three per cent of interviewed women had received free delivery care. While more than half of those who had normal deliveries received free care only 9% of women who had complicated deliveries and only 3% of women who had caesarean sections had received free care. On average women paid NPR 1,883 for normal or complicated deliveries and NPR 6,322 for caesarean deliveries. Some women also paid for registration fees.

Ways forward:

- Establish a robust and comprehensive monitoring mechanism for higher level public hospitals and private hospitals that implement the Aama Programme, especially in Tarai districts, to understand why so many women have to pay for their deliveries when free care should be available.
- Conduct further research on why and what specifically women are paying for, especially in public hospitals and Tarai districts.
- Examine the sufficiency of the unit costs to cover the actual expenses incurred by health institutions in carrying out deliveries especially complicated and caesarean deliveries.

Key findings 7: Although 4ANC has already been integrated with Aama in fiscal year 2012/13, findings suggest that utilisation of 4ANC is very low.

Ways forward:

- Examine the reasons for low utilisation of 4ANC incentive including the appropriateness and sufficiency of the incentive amount. Topographical variation in setting the incentive may need to be considered. Furthermore, orient health workers on the 4ANC incentive scheme.

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ANNEXES

ANNEX 1: STANDARD AAMA REPORTING AND CLAIM FORMS (AAMA GUIDELINES, 2012)

Location	Use
<i>Annex 3 (related to clauses 5 (2) and 6 (1))</i>	Application form for women to claim the transport and 4ANC incentive
<i>Annex 4 (related to clause 7)</i>	Recommendation form for service providers incentive for home deliveries
<i>Annex 6 (related to clause 10)</i>	Aama monthly report form
<i>Annex 6 ka (related to clause 10)</i>	Aama monthly report form (monthly obstetric report form)
<i>Annex 10 (related to clause 5, sub-clause 4 (b))</i>	Form to be filled by health facilities to claim unit costs

ANNEX 2: SAMPLING FRAME

Districts	Types of facility	No. total sample from institutional deliveries	No. total sample by type of facility	No. of sample facilities	No. of total sample from home deliveries	Estimated average cases per facility
Tarai F	Govt hosp.	518	94	1		94
	Pvt hosp.		340	3		113
	PHCCs		34	3		11
	HPs/SHPs		50	4		13
Hill D	Govt hosp.	110	48	1	76	48
	PHCC		24	2		12
	HP/SHP		38	4		10
Hill C	Govt hosp.	96	27	1		27
	PHCC		22	2		11
	HP/SHP		47	6		8
Mountain B	Govt hosp.	100	31	1		31
	PHCC		19	2		9
	HP/SHP		50	5		10
Tarai E	Govt hosp.	105	59	1	299	59
	Pvt hosp.		25	2		13
	PHCC		11	2		5
	HP/SHP		11	3		4
A Mountain	Govt hosp.	56	36	1		36
	PHCC		9	1		9
	HP/SHP		11	2		6
Total		985	985	47	375	

ANNEX 3: THE RESEARCH TEAM

District	Enumerators	District leader
District F	Chandana Rajopadhya	Meera Tandan Rekha Khatri
	Rajesh Giri	
	Keshav Shrestha	
	Sanju Karki	
	Samita Killa	
	Sudesh Chaudhary	
	Namuna Shreshta	
Hill C	Ram Bahadur Shrestha	Ramesh Pathak
	Karishmal Sunwar	
	Roma Karki	
	Bonika Thapa	
Tarai E	Dilip Sah	Anup Shrestha and Kapil Dahal
	Pramod Kumar Mahato	
	Saurav Kishore Sah	
	Rabina Rajak	
	Sanotshi Thapa	
	Rajesh Prasad Chaudhary	
Hill D	Amrit Dangi	Ramila Bhandari
	Samjhana Shrestha	
	Sweta Pathak	
	Binod Dulal	
Mountain A	Ganga Bdr Basnet	Ganga Bdr Basnet
	Umesh Giri	
Mountain B	Hemraj Ojha	Bharat Raj Bhatta
	Santaram Chaudhary	
	Shreya Shrestha	
	Radhika Pokherel	

ANNEX 4: FIELD RESEARCHERS' TRAINING SCHEDULE

<p align="center">Field Researchers' Training Schedule Health Research and Social Development Forum Rapid Assessment Demand side Financing (DSF)</p> <p align="center">Venue: Training Hall HERD</p> <p align="center">Time : 9am to 5pm</p> <p align="center">Date: 14th to 17th February 2013</p>					
Days	Activities	Time		Responsibility	Remarks
Day I (14th Feb 2013)	Registration	9:00 am	9:15 am	All	
	Welcome remarks and training objectives	9:15 am	9:40 am	HERD	
	Brief about Aama Surakshya Karykaram, Rapid assessment and its objectives and field context	9:40 am	10:40 am	Dr Suresh Tiwari, NHSSP	
	Planning and monitoring of Aama Programme (annexes used for monitoring)	10:40 am	11:10 am	Mukti Khanal, FHD	
	Tea Break	11:00 am	11:30 am		
	Overview of fund flow mechanism and financial reporting in Aama Programme	11:30 am	12:00 am	Mani Neupane, FHD	
	Orientation on Aama guideline	12:00 am	12:30 pm	SCB/KJM	
	Lunch Break			All	
	Research process, sampling, introduction of tools	1:00 pm	1:30 pm	MT/BD	
	Tool 2C: Key informant interview: health facility account sections	1:30 pm	2:45 pm	KJM/AS/RP	
	Tool 1C: Cross verification of institutional deliveries (health facilities) Tool 1D: Cross verification of home deliveries (health facilities)	2:45 pm	3:15 pm	MT/RSB	
	Tea/Coffee break	3:15 pm	3:30 pm	All	
	Tool 2A: Key informant interviews: health service providers Tool 2B: Key informant interviews: health facility management committees	3:30 pm	4:30 pm	BD/BB/MT	
	Mock interviews	4:30 pm	5:00 pm	RSB/BB	

Day II (15th Feb 2013)	Registration	9:00 am	9:15 am	All	
	Brief about Aama Programme	9:15 am	9:45 am	Dr Shilu Aryal FHD	
	Revision of the day	9:45 am	10:30 am	All	
	Tool 3A: Community level: Cross- verification of Women institutional delivery Questionnaires	10:30 am	12:30 am	AKP/MT/BD	
	Lunch Break	12:30 pm	1:00 pm	All	
	Tool 3B: Community Level: Cross verification of Women home delivery questionnaires	1:00 pm	2:00 pm	MT/AKP/RSB	
	Tool 1E: Secondary data review DHOs/DPHOs	2:00 pm	3:15 pm	RSB	
	Tea/coffee	3:15 pm	3:30 pm	All	
	Mock interviews	3:30 pm	5:00 pm	RSB/BB	
16th February 2013 - Saturday holiday					
Day III (17th Feb 2013)	Registration	9:00 am	9:15 am	All	
	Revision of days 1 and 2 (whole process including solving confusions)	9:15 am	10:30 am	All	
	Group division and role of field researchers	10:30 am	11:00 am	MT	
	Ethics, data quality and field work management	11:00 am	12:30 pm	SCB	
	Lunch break	12:30 pm	1:00 pm	All	
	Data management and monitoring of field activities	1:00 pm	2:00 pm	BD	
	Logistic arrangements and field movement instructions	2:00 pm	3:15 pm	KJM	
	Tea/coffee	3:15 pm	3:30 pm	All	
	Any other business	3:30 pm	5:00 pm		