Health Sector Transition and Recovery Programme

Stocktake Assessment of the Aama Programme in Fourteen Earthquake-Affected Districts

District Specific Plans for Ramechhap, Dolakha and Sindhupalchowk

Payment Deliverable: NHSSP 4

April 2014

NHSSP

UKaid
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This report is submitted in accordance with Transition and Recovery Programme (TRP) payment deliverable PD NHSSP 4: 'Detailed plan for restoration of Aama programme to at least pre-earthquake situation for three focal districts agreed with DHOs/FHD and assessment completed for all 14 districts'.

The document has been funded by UKaid from the UK government's Department for International Development (DFID); however the views expressed do not necessarily reflect the UK government's official policies.

Recommended citation: Bhatt, Hema; Suresh Tiwari; Bal Krishna Suvedi; Binaya Chalise and Shilu Aryal (2016). Stocktake Assessment of the Aama Programme in Fourteen Earthquake-Affected Districts: District Specific Plans for Ramechhap, Dolakha and Sindhupalchowk. Kathmandu: Family Health Division (Ministry of Health) and Nepal Health Sector Support Programme.

Cover photo courtesy DFID

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ACKNOWLEDGEMENTS

The study team is grateful to the heads of the district health offices and district public health offices, the district level Aama Programme focal persons, in-charges of the health facilities, information providers from private hospitals, and other officials who provided their valuable inputs during the assessment process. We appreciate the efforts of the field assistants who worked hard to collect the information from the 14 earthquake-affected districts. We are grateful to all the officials for giving their time to discuss financial allocation and expenditure issues. We also thank all the participants of the district planning workshops in Ramechhap, Dolakha and Sindhupalchowk districts.

The study team would like to thank Dr Pushpa Choudhary, Director General of DoHS, for encouraging us to conduct this assessment while she was director of the Family Health Division. Our special thanks go to Dr RP Bichha, FHD director for his support. The study team also thanks DFID for providing the financial support and NHSSP for providing the support functions for field implementation.

Study Team

March 2016

EXECUTIVE SUMMARY

A. Introduction

Nepal has made impressive headway on increasing the number of women who deliver their babies in health institutions and in reducing the number of maternal deaths. The Aama Programme, which began in 2005, has been a major contributor to this success. The programme's provision of incentives to mothers, and unit cost payments to health facilities, have not only contributed to increasing the number of institutional deliveries but also supported the strengthening and expansion of delivery services in peripheral health facilities. Very few health posts were functioning as birthing centres before the Aama Programme. The unit costs of the Aama Programme, which go into facilities' non-freezable accounts, have made a great contribution to encouraging local authorities to invest in delivery care. As a result, hundreds of health posts have been able to manage their infrastructure and human resources to provide delivery care. However, these achievements were threatened by the damage wrought by the devastating earthquakes of April and May 2015 beginning with the Gorkha earthquake of 25 April 2015. The earthquakes caused many deaths, injuries and damage to physical infrastructure. Fourteen districts were severely affected. The earthquakes destroyed physical infrastructure, displaced tens of thousands of people and severely affected the health care delivery system, including the smooth implementation of the Aama Programme.

A descriptive mix-method approach was used to conduct a stocktake assessment of the Aama Programme in November and December, 2015 in the fourteen most affected districts. It looked at the functioning of public and private health facilities under the Aama Programme. The assessment was made against the provisions included in the Aama Programme guidelines. A health facility questionnaire, district statistical data, in-depth interviews with Aama focal persons at FHD and in the districts, and a hospital tally sheet were used to carry out the study. Fifty Aama implementing health facilities were purposively sampled from the 14 districts. These facilities were selected as a representative sample of central level hospitals, district hospitals, primary health care centre (PHCCs) and health posts.

B. Findings

The assessment found that the number of Aama Programme implementing health facilities did not change significantly before and after the earthquakes. Delivery services were immediately interrupted by the earthquakes, but services were quickly restored with support from local communities, local government, international agencies and partner organizations. More than 85% of surveyed facilities were either completely or partially damaged by the earthquakes. Among the 50, the entire buildings were completely damaged in 14 facilities and partially damaged at 21 facilities. The delivery rooms were totally damaged in 17 of the facilities and partially damaged in 12 facilities. Equipment and furniture was affected in 44% of facilities. Thirty-four percent of the facilities were providing delivery services under a tent or temporary shelter and 16% were functioning from another public or rented building at the time of the assessment. Only 8% of the 50 facilities were providing services from their original buildings. This shows that the earthquakes did not stop the provision of delivery services from health facilities,

although the quality of care and the security of the health workers are matters of concern.

At the time of the assessment, delivery services were being provided in the absence of basic support services such as delivery rooms, drinking water, electricity, toilets, equipment, furniture and essential delivery drugs. This raises concerns on the quality of services provided. Also, the allocated budget for the Aama Programme decreased from FY 2014/15 to 2015/2016 (mid-July to mid-July) and the budget for the 4 ANC (4 antenatal care visits) incentive programme was severely reduced. This can be attributed to the low rate of budget absorption in the previous year and the priority given to funding the response to the earthquakes. This is imposing a major challenge on service providers and programme managers to ensure service provision despite reduced budgets that may be insufficient to provide services as per the Aama guidelines.

Six months after the earthquakes the number of women using delivery services had decreased. This may have been because many peripheral level institutions were damaged and services had been interrupted. At the same time the earthquakes may have imposed new geographical barriers for women to access institutional delivery services. On the other hand some of the 14 districts saw an increased number of institutional deliveries after the earthquakes, which could be attributed to the intermediate support provided by foreign medical teams.

The sampled health facilities were found to have issues with compliance with the Aama Programme guidelines. The free delivery component was largely misunderstood or misinterpreted by public and private facilities. Similarly, the 4 ANC component of the Aama Programme was only being partially implemented. The use of unit cost funds and service provider incentives is an emerging issue which needs special attention. It was encouraging to note that the earthquakes had not hampered human resource availability in the health facilities. This might be due to the Ministry of Health's (MoH's) decision to retain health workers employed in the affected districts through incentives and performance appraisals. It may also be that health workers felt ethical and humanitarian obligations to continue providing services for earthquake victims.

The earthquakes were found to have had a minimal effect on the distribution of the Aama Programme budget. However, there are long-standing problems in budget distribution including delays in receiving budgets and expenditure authorizations, delays in budget release from the district level (from DHOs/DPHOs and district treasury controller's offices) and delays in health facilities reporting service provision. This may have impacted the timely distribution of transport incentives to women. The earthquakes also affected the 24 hour availability of services, which has hampered budget absorption and affected the governance of the Aama Programme.

C. District Plans

Based on the assessment's findings, Aama Programme planning workshops were held in three of the fourteen districts (Ramechhap, Dolakha and Sindhupalchowk) to gain a more in-depth understanding of how the earthquakes had affected the Aama Programme. Three district specific plans were prepared, to promote compliance with the Aama Programme guidelines and provide a mechanism to engage with health facility management and operation committees (HFMOCs) for the smooth implementation of

the programme. The plans outline the provision of basic support services essential for delivery care.

D. Recommendations

The main recommendations arising from the assessment are as follows:

- A specific monitoring mechanism needs to be developed by FHD and implemented at the district level to ensure compliance with the Aama Programme guidelines.
- Policy harmonization is important to minimize policy contradictions (Aama and HFMOC guidelines) and to smoothen the implementation of priority programmes.
- The quality of the monitoring of health facilities needs to be improved by developing a mechanism to ensure that observations are written down and specific suggestions and feedback are documented and followed up in a timely way.
- Prioritise the rebuilding of health facilities and the restoration of services.

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ACRONYMS

4 ANC	four antenatal visits
ASAP	as soon as possible
ANC	antenatal care
ASAP	as soon as possible
AusAID	Australian Agency for International Development
AWPB	annual work plan and budget
BC	birthing centre
BEONC	basic emergency obstetrics and newborn (neonatal) care
CEONC	comprehensive emergency obstetrics and newborn (neonatal) care
CS	caesarean section
DDC	district development committee
DHO	district health office
DPHO	district public health office
DFID	Department of International Development
DTCO	district treasury controller's office
EDP	external development partner
FHD	Family Health Division
FY	fiscal year
GAVI	Global Alliance for Vaccine and Immunization
GoN	Government of Nepal
HF	health facility
HFOMC	health facility operation and management committee
HP	health post
IDI	in-depth interview
KfW	Kreditanstalt fur Wiederaufbau
KII	key informant interview
LMIS	Logistics Management Information System
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	non-government organization
NHSSP	Nepal Health Sector Support Programme
NHTC	Nepal Health Training Centre
NPR	Nepalese rupees
PDNA	Post Disaster Needs Assessment
PHCC	primary health care centre
RHD	regional health directorate
SBA	skilled birth attendant
SWAp	sector wide approach
TABUCS	Transaction Accounting and Budget Control System
USG	ultrasonogram

1 INTRODUCTION

The Government of Nepal (GoN) and its Ministry of Health (MoH)[1] are committed to improving the health status of Nepali citizens and have made remarkable gains in maternal health. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004 and ended in mid-July 2010. NHSP-1 was highly successful in achieving improvements in health outcomes. Building on its success, the Ministry of Health and Population (MoHP) and its external development partners (EDPs) designed a second phase of the Nepal Health Sector Programme (NHSP-2) that was implemented from mid-July 2010 to mid-July 2015.

Nepal experienced devastating earthquakes in April and May 2015 that seriously damaged the health provision infrastructure.[2] There was thus a major need to regularise the provision of basic health services in the affected areas. In this context, DFID has provided financial and technical aid to MoH to regularise basic health services in the affected districts. The support is being provided up to July 2016. One important task for MoH and its Family Health Division (FHD) is to ensure that the Aama Programme is fully functional in the earthquake-affected districts.

1.1 Specific Background

In 2005, studies demonstrated that the high cost of institutional deliveries was associated with persistently high rates of home delivery (Borghi et al., 2006). In July 2005, GoN introduced the Aama Programme to reduce the financial barriers associated with institutional delivery care in order to increase the proportion of institutional deliveries and thereby reduce maternal morbidity and mortality. Studies have shown that the programme has had a positive impact on increasing institutional deliveries and improving maternal health (Powell-Jackson et al. 2010; Powell-Jackson and Hanson 2012).

Figure 1.1 shows the evolution of the Aama Programme and Box I the programme's components.

During NHSP-1 and NHSP-2, the Aama Programme was regarded by the government as a high priority programme. During this period, NHSSP provided technical inputs to design, implement, monitor, and integrate the 4 antenatal care visits programme (4 ANC) with the Aama Programme to assure allocative efficiency.

MoH understands that the earthquakes have caused some problems in the smooth implementation of the Aama Programme. The major question is around the overall management status of the programme.

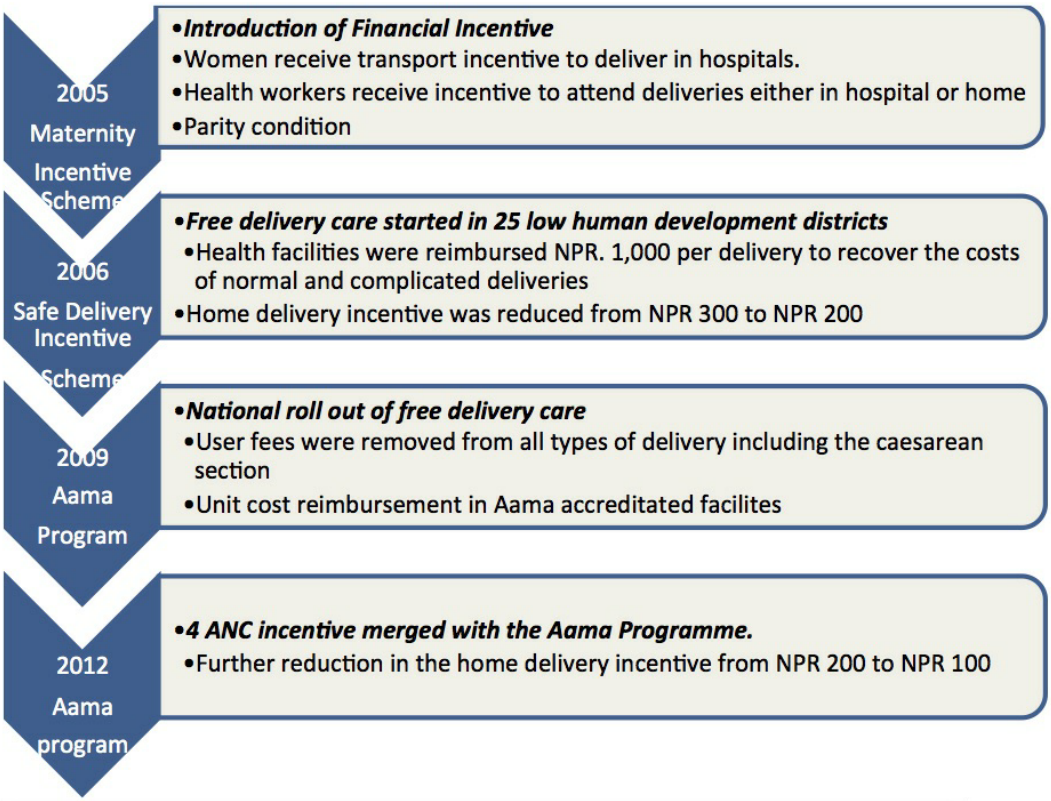
A stocktake was thus carried out to capture the current status of Aama Programme in the earthquake-affected districts and to compares key indicators with last year's data. This informs the action plans to improve the overall management of Aama against its

[1] The Ministry of Health was called the Ministry of Health and Population (MoHP) untilearly 2016

[2] Note that this report refers to the major earthquakes and their aftershocks as' earthquakes' without distinguishing between earthquakes and aftershocks. The term earthquakes is used to refer to April and May earthquakes that caused the damage although aftershocks continue at the time of the finalisation of this report in April 2016.

guidelines.

Figure 1.1: Evolution of the Aama Programme (2005– 2012)



BOX I: Component of Aama programmeme

A. Incentive to Women			
	Tarai	**Hill**	**Mountain**
Delivery in a facility	NPR.500 (US$5)	NPR.1,000 (US$10)	NPR.1,500 (US$15)
4 ANC incentive	400 (US$4) *for complete four ANC visits (at the 4th, 6th, 8th and 9th months of pregnancy*		

B. Reimbursement to health facility			
Type of delivery	**Normal**	**Complicated**	**CS**
Unit cost	NPR.1,000-1,500 (US$ 10-15)	NPR.3,000 (US$30)	NPR.7,000 (US$70)
Health worker	NPR.300 (US$3) to be paid from the unit cost for facility delivery		
	NPR.100 (US$1) to be paid separately for home delivery		
Unit cost should cover the cost of medical commodities (such as essential medicines, test and supplies) personnel and other associated cost (electricity, water).			

Source: Aama Programme Guidelines 2012

1.2 Structure of Assessment Report

The assessment report has six chapters, including this introductory chapter. The first

chapter outlines the evolution of the Aama Programme and discusses the rationale for the stocktake assessment in the context of the post-earthquakes scenario. Chapter 2 analyses the effect of the earthquakes on the smooth implementation of the Aama Programme. Chapter 3 discusses and describes the strategies used to conduct the assessment. The fourth chapter presents the findings of the study under three sections. The first section is an overview of the Aama Programme in the 14 earthquake-affected districts. The second analyses the implementation status of the Aama Programme by facility levels and before and after the earthquakes. The third section is a summary of the findings from the three specific districts (Dolakha, Ramechhap and Sindhupalchowk) where in-depth assessments took place focusing on the implementation challenges of the Aama Programme in these districts. Chapter 5 is a brief summary of the entire report that concludes with suggestions for future policies and practices. Chapter 6 outlines action plans for the three districts of Dolakha, Ramechhap and Sindhupalchowk.

2 CONTEXTUAL ANALYSIS

This chapter describes the overall consequences of the earthquakes on health care delivery systems in the 14 highly-affected districts. Documents were reviewed and expert opinions captured to understand the local context that helped regularise the health care delivery system in the post-earthquakes period. The analysis describes how the national recovery plan, disaster relief support, district level disaster support functions and local formal and informal systems have contributed to regularising the health care delivery services. The focus of analysis was on the effects of the earthquakes on the smooth implementation of the Aama Programme.

2.1 Health Service Delivery in Earthquake-affected Districts

The 7.8 magnitude Gorkha earthquake of 25 April 2016 and its many after-shocks claimed the lives of nearly 9,000 people and left more than 22,000 people injured. Fourteen districts were severely affected, covering a population of more than 5,600,000, with reports that almost 500,000 houses had been completely destroyed and 260,000 partially destroyed. The risks of landslides during the monsoon months of June and July were an ongoing concern, particularly with aftershocks further destabilising the steep and mountainous terrain.

Health and the health care delivery system was severely affected as evident from the damage to the health infrastructure, the death of 8,702 persons (45% male, 55% female) and the 22,303 injured. A total of 446 public health facilities, including administrative building (5 hospitals, 12 primary health care centres, 417 health posts, and 12 others) and 16 private facilities were completely destroyed while 765 health facilities and administrative (701 public and 64 private) structures were partially damaged. Nearly 84% (375 out of 446) of the completely damaged health facilities were from the 14 most affected districts. As a result, the ability of the health facilities to respond to healthcare needs was affected by the destruction and the discontinuation of service delivery. A total of 18 health workers and volunteers lost their lives and 75 health workers were injured adding a further challenge to regularising service delivery. Similarly, the capacity of the Ministry of Health and Population in general and that of district health offices and district public offices (DHOs and DPHOs) was stretched trying to resume disrupted basic services, coordination with concerned agencies and stakeholders and managing the increased case load for treating earthquake victims including trauma cases (MoH, 2015). In the absence of, or irregularity of, basic health services delivery, services were affected across the 14 most earthquake-affected districts. In this situation, the service purchasing function of the Aama Programme was severely affected.

Rapid humanitarian support was provided by MoH, the Department for International Development (DFID), other donors, the private sector, foundations and individuals, and by the mobilization of 73 foreign medical teams. MoH took the lead role in securing NPR 30,000 per case from the Prime Minister's Relief Fund, which was used to treat the injured. The private sector was very active in treating trauma cases.

MoH's recovery and transition plan was included in the Government of Nepal's Post Disaster Need Assessment (GoN 2015). The Post Disaster Needs Assessment (PDNA), produced under the leadership of the National Planning Commission, collected and collated information on damage, losses, and post-disaster needs for rebuilding the

health system under the principle of 'building back better'.

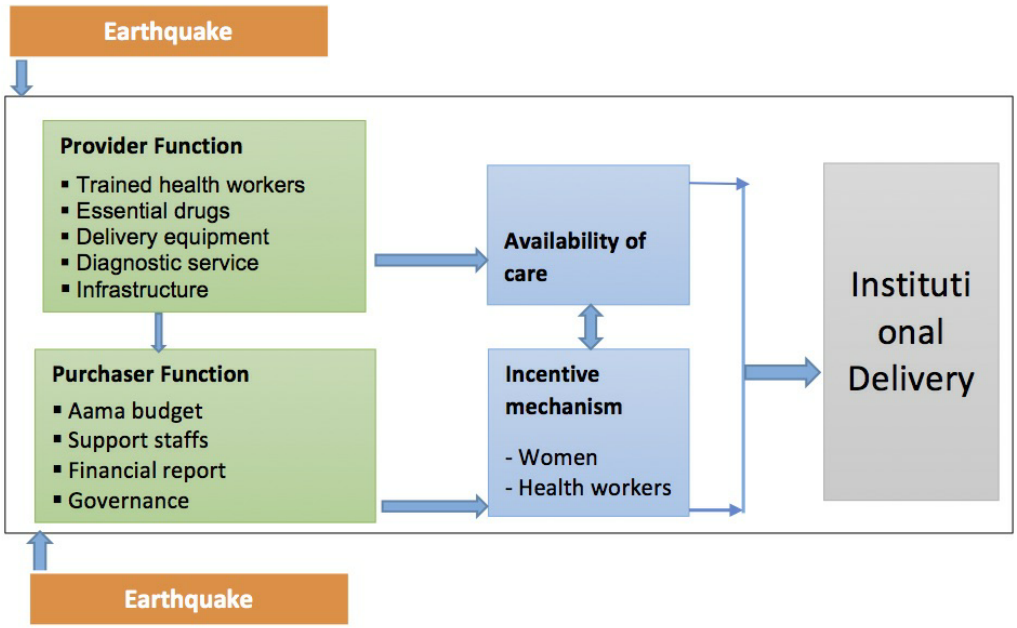
In this context, the study team explored the effect of the earthquakes on the smooth implementation of the Aama Programme despite difficulties caused by the blockade on the Indian border.

2.2 Effect of the Earthquakes on Aama Programme Implementation

The Aama Programme consists of provider and purchaser functions both of which are essential to increase the number of institutional deliveries. Although the purchaser function is the major component, the Aama Programme is considered as a broad system that provides the right mix of provider functions.

The earthquakes affected all the provider functions of the Aama Programme. For example, the demand for institutional deliveries may have been inflated in the affected areas where health workforces were intensively supplied. Conversely, the number of institutional deliveries may have declined due to interrupted drug supplies and damaged infrastructure.

Figure 2.1: Effect of the Earthquakes on the Implementation of the Aama Programme



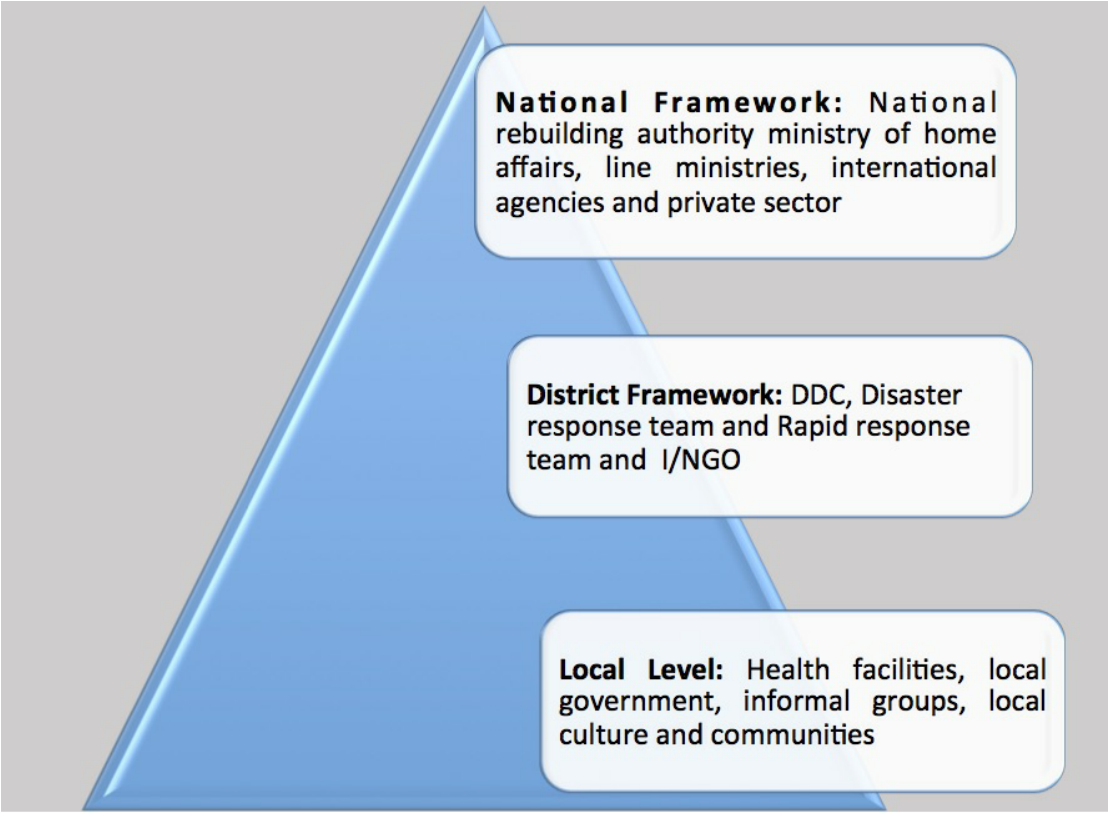
After the initial large earthquake, the Ministry of Health prioritised the availability of basic logistical support and human resources which helped to ensure the treatment of the injured and the resumption of basic health services. It is important to note that the objective of the Aama Programme to increase the institutional deliveries can only be achieved if the 'provider functions' are available at health facilities. Figure 2.1 shows that the earthquakes hampered both the provider and purchaser functions of the health care delivery system. As described above, the earthquakes impacted the health infrastructure and claimed the lives of some health workers. In such difficult situations the availability of health workers, drugs, equipment and diagnostic services was highly compromised at damaged health facilities. The availability of funds, support staff, reporting, and governance were also affected. In this context, the objective of increasing the number

institutional delivery was very likely comprised. The national, district and local formal and informal systems contributed to continuing health services after the earthquakes.

2.3 National, District and Local Frameworks

During and after the earthquakes the Ministry of Home Affairs (MoHA) as the national focal point for disaster management took the initiative to address the issues related to disaster prevention and management. It works under the national disaster management framework (2013) through its national disaster management section, policy networks and district administrative offices (Figure 2.2).

Figure 2.2: National, District and Local Framework to Respond to Disasters in Nepal



2.3.1 National framework, structure and plan

After the 25 April 2015 earthquake the Government of Nepal formed a National Rebuilding Authority (NRA). Line ministries, including MoH, formed national and local committees to respond to the effects of disasters. The committees under MoH were most active in preventing the outbreak of epidemics. There was an important presence of donors, multilateral agencies, international agencies and private sector, who provided immediate post-earthquake support.

The Ministry of Health adopted a three pillar strategy for a recovery and reconstruction plan which called for immediate (until mid-July 2015), intermediate (over FY 2015/16) and medium term (2015/16 – 2019/20) measures.

- The immediate response was to furnish districts with necessary logistics and human resources by mid-July 2015 to ensure follow-up treatment of the injured, to restore health services and to support districts offices and facilities to deal

with foreseen immediate risks and vulnerabilities by providing logistics such as drugs and supplies and budget for preparedness and rapid response.

- The intermediate response is to replace temporary arrangements such as tents with short term arrangements to ensure the continuity of service delivery, cater for the changing pattern of health care needs, and provide routine uninterrupted services. This includes demolishing damaged buildings, accomplishing repair works and reinstituting peripheral health facilities by setting up pre-fabricated structures. Similarly, the plan calls for setting up hospitals and rehabilitation centres and strengthening the institutional capacity for disaster preparedness.
- The medium term (2015/16 – 2019/20) measures are concerned with rebuilding by building back better, which entails setting up new permanent health infrastructures and equipment.

Discussions with various stakeholders suggests that MoH's recovery and reconstruction plan has not been fully implemented in the affected districts and health facilities. Fragmented support has been provided by international and local non-governmental organisations. However, there has been the lack of a clear plan and budget for specific district and specific programmes. There is no specific plan to restore the Aama Programme in the annual workplan and budget (AWPB) of FY 2015/16 and in MoH's 'recovery and reconstruction plan'.

2.3.2 District level structures and plans

At the district level, district disaster response committees are responsible for preparing district response plans and identifying and mobilizing resources to execute plans at the district level and below. These main overall responsible committees function under the leadership of chief district officers. In the health sector, rapid response committees were formed with the membership of district health officers, district public health officers, other line agency chiefs and representatives of NGOs, INGOs, private sector hospital, consumer networks and civil society organisations.

There was a clear visibility of government line agencies, international medical teams, international development agencies and district level NGOs at the district headquarters. The study found that district disaster response teams were actively managing all types of resources. However, there were no district specific plans to address specific district needs and to guide responses. DHOs and DPHOs thus had the additional work burden of managing the support system and creating harmony. The district teams had not been trained to manage resources in the disaster situation.

The study found that there were no district specific plans to address local needs. The capacity of district teams had only a limited understanding of MoH's 'transition and recovery plan', on integrating available resources and mobilising district level resources to regularise basic health services. The study found that none of the 14 earthquake-affected districts had prepared a plan for the resumption of the Aama Programme in earthquake-affected birthing centres.

2.3.3 Local level structures and plans

At the local level, rapid response teams were responsible for the immediate response, local resource sharing, resource mobilization and rebuilding the local health system. The

rapid response teams included representatives from health facilities, local government, local groups, cultural groups and local communities. The assessment explored the availability of formal structures and plans to address local needs. The support from international agencies, foreign medical team and government supply system were available at the local level. However, there was no specific structure and plan that addressed local needs. The study noticed that the local needs differed from one place to another. In some places people suffered from a lack of clean drinking water and food whereas in other places food was shared by people who had stocks.

In summary, there was a need to prepare local level disaster preparedness plans and put structures in place to address the consequences of the disaster. There was no formal or systematic plan to restore the health facilities in the case of damage and no plan to incentivise health workers to stay at the local level. Finally, no systematic plan was observed for regularising basic health care services including the Aama Programme.

2.3.4 Informal systems

The study observed an impressive informal systems and culture that are not reflected in any plans or reports. These informal system and cultures were very productive in supporting outsiders (who came to help) and mobilising locally available resources. The national and the district level systems were not effectively established at the time of the initial major earthquake and were not fully effective to mobilize local systems and culture.

The following factors and contributors helped regularize the health system in the aftermath of the earthquakes:

- Outside medical teams supported by local communities.
- The government incentivising human resources for health.
- The government decision to provide unit costs for trauma care.
- The government decision to activate performance indicators for health workers.
- The humanitarian and ethical understanding of health workers.
- Local response mechanisms were introduced by local communities.
- Local community participation and contribution from forestry user groups, micro finance groups and other local groups.
- Private sector involvement.
- The temporary transfer of human resources from non-affected to affected areas.

The stocktake focused on the analysis of the aforementioned context that helped regularise the health system including the Aama Programme.

3 METHODOLOGY

The chapter describes and discusses the methods used for carrying out the assessment.

3.1 Objectives

The stocktake assessment was conducted in the 14 district most affected by the earthquakes, in both public and private health facilities accredited under the Aama Programme. The study used gathered descriptions to capture the implementation status of Aama Programme in these districts. The assessment was carried out against the provisions of the Aama Programme guidelines.

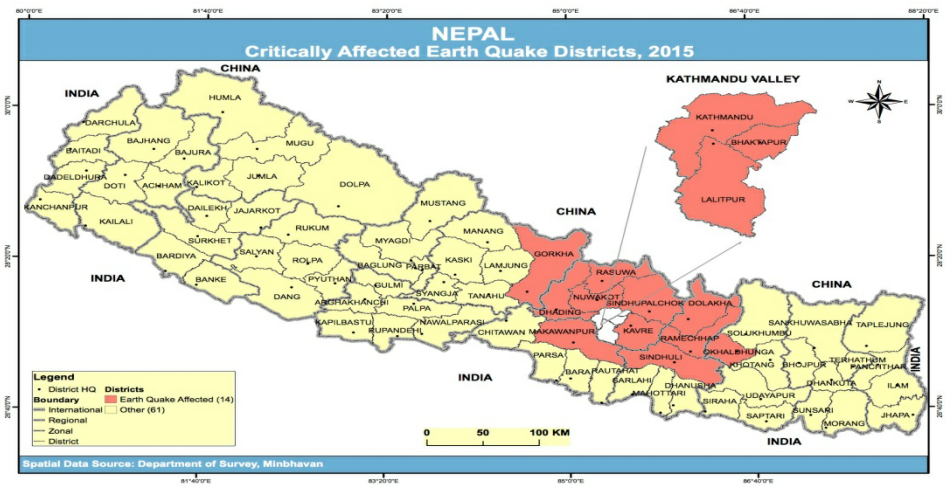
The specific objectives were as follows:

- Assess the process of planning, budgeting and expenditure of Aama Programme at all levels.
- Review FHD activities in the earthquake-affected districts and check whether or not any Aama Programme specific activities were included in recovery plans.
- Assess the service delivery and implementation of various components of the Aama Programme in the earthquake-affected districts.
- Analyse the monthly use data of Dhulikhel Hospital and the Maternity Hospital (Kathmandu) covering the six months before and after the Gorkha earthquake.
- Prepare district specific action plans to improve the implementation of the Aama Programme in three earthquake-affected districts.

3.2 Study Districts

The assessment was carried out in 14 highly earthquake-affected districts (Bhaktapur, Dhading, Dolakha, Gorkha, Kathmandu, Kavre Palanchok, Lalitpur, Makwanpur, Nuwakot, Okhaldhunga, Ramechhap, Rasuwa, Sindhuli and Sindhupalchowk (see Figure 3.1).

Figure 3.1: Fourteen Earthquake-affected Districts of Nepal (2015)



3.3 Sampling

Table 3.1 shows the study's sample health facilities. A total of 50 health facilities were selected to represent all types and level of health facilities within each district. The study

included a central level hospital, 12 district hospitals, 15 primary health care centres (PHCCs), 13 health posts, four mission hospitals and five private hospitals. The facilities were selected from a sampling frame, which consisted of a list of Aama implementing health facilities in the affected districts. Health facilities were included in the study if the facilities met either of the following criteria:

- The earthquakes had partially or completely damaged the facility.
- The facilities were at least three hours' travel distance from the district headquarters.
- The facilities had not received any supervision from the district and/or central health authority after the earthquake.

Table 3.1: Health Facilities Sampled for the Stocktake Assessment

Districts	Level of Health Facilities						
	Central Hospitals	District Hospitals	PHCCs	Health Posts	Mission/NGO Hospital	Private Hospital	Total
Bhaktapur	0	1	1	0	0	0	2
Dhading	0	1	1	1	0	0	3
Dolakha	0	1	2	1	0	0	4
Gorkha	0	1	1	1	1	0	4
Kathmandu	1	0	1	1	0	2	5
Kavre	0	1	1	1	0	2	5
Lalitpur	0	0	1	1	1	1	4
Makwanpur	0	1	1	1	0	0	3
Nuwakot	0	1	1	1	1	0	4
Okhaldhunga	0	1	1	1	1	0	4
Ramechhap	0	1	1	1	0	0	3
Rasuwa	0	1	1	1	0	0	3
Sindhuli	0	1	1	1	0	0	3
Sindhupalchowk	0	1	1	1	0	0	3
Total	1	12	15	13	4	5	50

3.4 Data Collection

The study captured qualitative and quantitative information about the status of the Aama Programme in the affected districts. Quantitative data was gathered primarily through a health facility survey whereas key informant interviews (KII) and in-depth interview (IDI) were carried out to collect qualitative data.

Health facility survey — A health facility survey was conducted in 51 health facilities to gather information about the effects of the earthquakes on the Aama Programme. The study team developed facility survey questionnaire based on a tool used in previous studies and rapid assessments conducted by the Nepal Health Sector Support Programme. The questionnaire elicited information on the Aama Programme, physical infrastructure, human resource, drugs supply, financial management, governance and service statistics (Annex I of Aama guidelines). The questionnaire was administered to the concerned health facility staff. Records of the DHOs and the Maternity and Dhulikhel hospitals were reviewed separately using service statistics review guidelines (Annex IV of guidelines).

Interviews — KIIs were conducted with 51 health facility in-charges. IDIs were conducted with the Aama Programme focal persons of the 14 earthquake-affected districts and

with FHD's Aama focal person and Aama monitoring officer. Both KIIs and IDIs elicited information on Aama Programme implementation, compliance with Aama guidelines, the effects of the earthquake, reporting and supervision.

3.5 Training and Fieldwork

A three day long training of field assistants was organized in Kathmandu. The training orientated field assistants on administrating the study tools. The training began by introducing the Aama Programme and the study methodology. Participants were divided into groups and were trained to administer study tools in simulated situations. Participants were provided with the opportunity to clarify confusions at the end of each simulation exercise. The training schedule and participants background are included in the Annexes.

The fieldwork was conducted between 17 November and 2 December 2015. Seven groups consisting of two field assistants per group collected data from the study districts. All groups were assigned to the field immediately after their training in Kathmandu. The study team supervised and supported the field assistants during the fieldwork. The study team checked data consistency and clarified the confusions and queries of the field assistants.

3.6 Data Management and Analysis

Analysis of the quantitative data began with the development of dataset in Microsoft Excel. All the administered questionnaires were checked for completeness, correctness and internal consistency. Unique identification numbers were assigned to each questionnaire. The study team, with the help of a data entry clerk, fed data into the dataset using Microsoft Excel. The data were cleaned before conducting the analysis. For the purpose of analysis, the dataset was exported to the Statistical Programme for Service Solutions (SPSS), version 18. Frequency tables were generated, cross-tabulated and presented as tables, graphs and charts.

Qualitative data were obtained from the KIIs and IDIs. Field assistants noted down the responses obtained during the interviews. Interview transcripts were produced based on the notes. The study team read and reread the interview transcripts thoroughly to become acquainted with the interview responses. A list of preliminary coding categories was determined from the answers in the first few interview transcripts. The preliminary coding categories were amended to adjust for the emerging codes. Microsoft Excel was used to organize and code the interview responses. Coded responses were then reorganized to identify pattern and themes. The most prominent quotes were identified for use in the presentation of findings.

Field assistants were assigned as interviewers and note takers after assessing their competency in conducting interviews. Draft notes were prepared and discussed with the interviewers and feedback was included. Based on the draft notes, transcripts were prepared in line with the interview guidelines. Thematic areas were identified and issues listed and cross verified by an analyst. The study team listed quotes relevant to the thematic areas. Finally, thematic analysis with quotes were integrated with the quantitative findings.

The study monitored the effects of the earthquakes on the implementation of the Aama

Programme. Information on this was obtained from Aama records, the Health Management Information System (HMIS) and service providers. Responses were kept confidential. The gathered information is intended for use to improve planning processes by DHOs, DPHOs, health facilities and FHD. Accordingly, the study does not require ethical review.

3.7 Quality Assurance

The study team took a number of approaches to ensure that quality data was gathered throughout the study:

- Field assistants were trained on study tools.
- Periodic supervision and regular communication were established between the study team, DHO/DPHO personnel and field assistant to identify and address issues that might compromise the quality of data and information collected.
- Study tools were carefully checked for completeness and accuracy before feeding the data into the dataset.
- Field assistants were invited to clarify confusions and provide additional information while entering the data.
- All data were systematically cleaned to ensure the quality of data analysed.

The members of the study team independently develop coding categories to analyse the qualitative data. Later, these categories were compared and combined to form a final coding list. One team members took the role of auditor to check the consistency of data. Furthermore, multiple sources of evidence were sought to integrate information and ensure quality.

4 STUDY FINDINGS

This chapter gives the findings from the stocktake assessment conducted in November and December 2015 in 14 highly earthquake-affected districts. The district level findings are presented at first followed by health facility level findings. Qualitative findings are integrated across the chapter. The findings are structured around the effect of the earthquakes on the availability and use of delivery services, physical infrastructure, human resources, drugs, health facility governance and compliance with the Aama Programme guidelines.

4.1 District Level Findings

This section describes the status of Aama Programme implementation in the 14 earthquake-affected districts.

4.1.1 Aama Programme implementation

Table 4.1 gives an overview of the number of Aama Programme implementing health facilities in the 14 earthquake-affected districts. It can be seen that the number of facilities implementing the programme has not been changed before (November/ December 2014) and after (November/ December 2015) the earthquakes.

Table 4.1: Status of Aama Programme Implementing Health Facilities in 14 Earthquake-affected Districts

	Hospitals		PHCCs		Health posts		NGO/private/mission facilities	
District	**Before**	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**
Bhaktapur	1	1	1	1	0	0	1*	1
Dhading	1	1	2	2	49	49	0	0
Dolakha	1	1	2	2	19	19	0	0
Gorkha	1	1	3	3	27	28	1	1
Kathmandu	1	1	5	5	7	6	5	5
Kavre	1	1	3	3	27	27	7	7
Lalitpur	0	0	4	4	16	16	2	2
Makwanpur	1	1	4	4	40	40	0	0
Nuwakot	1	1	3	3	18	24	1	1
Okhaldhunga	1	1	1	1	38	38	1	1
Ramechhap	1	1	3	3	22	22	0	0
Rasuwa	1	1	1	1	11	10	0	0
Sindhuli	1	1	4	4	15	15	0	0
Sindhupalchowk	1	1	3	3	16	16	1	0
Facility Total	13	13	39	39	305	310	19	18

**Part of Kathmandu Medical College, service provided in Bhaktapur district*

The few changes were as follows:

- Delivery services could not be restored in Nanglebhare Health Post of Kathmandu district as the health facility was damaged and it was decided to discontinue delivery services as no cases had sought delivery care there for a long time preceding the earthquakes.
- Hakku Health Post of Rasuwa could no longer function as it was completely destroyed and much of the surrounding human settlement had moved outside its catchment.
- Some districts increased their number of birthing centres after the earthquakes as per the national annual work plan to expand birthing services in existing facilities.
- Sindu Sadabahar, a private facility in Sindhupalchowk, discontinued Aama Programme implementation in 2015 due to administrative reasons.

4.1.2 Availability of support services and infrastructure

A health facility should be providing basic support services (see column headings of Table 4.2)in order to function as a birthing centre. Table 4.2 describes the availability of basic support services in Aama implementing health facilities in the 14 earthquake-affected districts. The analysis only includes health facilities reporting to DHOs/DPHOs. Note that private implementing Aama Programme also report to DHOs/DPHOs.

Table 4.2: Availability of Support Services in Health Facilities under DHOs/DPHOs (No. Facilities)

	Separate delivery room		Electricity & drinking water		Equipment & furniture		Drugs for delivery care	
District	Before	After	Before	After	Before	After	Before	After
Bhaktapur	2	2	2	2	2	2	2	2
Dhading	52	52	52	52	52	52	52	52
Dolakha	21	16	21	20	21	20	21	21
Gorkha*	30	11	30	11	30	11	30	18
Kathmandu	17	16	17	16	17	16	17	16
Kavre	37	22	37	37	37	37	37	37
Lalitpur	22	22	22	16	22	16	22	19
Makwanpur	44	44	44	38	44	38	44	44
Nuwakot	22	28	22	28	22	28	22	28
Okhaldhunga	41	41	41	41	41	41	41	41
Ramechhap	26	24	26	26	26	26	26	26
Rasuwa	13	5	13	4	13	10	13	12
Sindhuli	19	19	19	19	19	19	19	18
Sindhupalchowk	21	16	21	15	21	15	21	19
Total	**367**	**318**	**367**	**325**	**367**	**331**	**367**	**353**

Almost 14% of the sampled health facilities did not have a separate room for delivery, 12% did not have provision for electricity/drinking water and toilet, and 4% health facilities were short of essential drugs for delivery. There had been some damage to

essential support services, which indicates that some level of compromise was being made to resume delivery services in the absence of necessary infrastructure, drugs and equipment.

The results show a large decline in the availability of basic services and infrastructure especially in Gorkha, Rasuwa and Sindhupalchowk districts. This raises the question of whether or not the absence of basic support services and infrastructure negatively affect the proper implementation of the Aama Programme.

4.1.3 Status of skilled birth attendance

Table 4.3 gives an overview of the status of skilled birth attendance in the 14 earthquake-affected districts. The numbers of skilled birth attendants (SBAs) increased after the earthquakes from 402 to 446. This increment could mainly be due to regular training conducted by FHD/National Health Training Centre. In some cases donors and partners organization have been supporting the training of nursing staff. For example, in Sindhupalchowk district, some NGOs have supported the training of contracted nursing staff. SBA trained nurses had been contracted in Gorkha district. Some SBA trained nurses have been transferred out of Kavre district.

Table 4.3: Status of Skilled Birth Attendants in the 14 Earthquake-affected Districts

District	No. skilled birth attendants	
	Before earthquakes	After earthquakes
Bhaktapur	3	4
Dhading	50	48
Dolakha	19	24
Gorkha	40	46
Kathmandu	34	36
Kavre	28	25
Lalitpur	24	26
Makwanpur	35	39
Nuwakot	27	34
Okhaldhunga	46	57
Ramechhap	44	50
Rasuwa	17	19
Sindhuli	12	13
Sindhupalchowk	23	25
Total	402	446

The data in Table 4.3 does not necessarily indicate that there has been an increase in the total number of SBAs. It may indicate that some nursing staff were trained after the earthquake.

4.1.4 Aama Programme budget

Table 4.4 summarizes the budget allocation pattern between FY 2014/15 and FY 2015/2016. The data shows that the total allocated budget for the Aama Programme decreased in FY 2015/16 compared to the previous year. Note that hospitals that receive separate budgets for the Aama Programme are not included in this data.

The data also shows a large reduction in the budget allocation for 4 ANC incentives. This

decline can be attributed to the low absorption in the previous FY. More importantly, in the current FY (2015/16) priority is going to rebuild the infrastructure rather than regular programme interventions.

Table 4.4: Aama Programme Budget in the 14 Earthquake-affected Districts (in NPR 1,000s)

Districts	Allocated budget (in NPR 1,000s)					
	FY 2014/15			FY 2015/16		
	Transport incentive + unit cost	4 ANC incentive	Total	Transport incentive + unit cost	4 ANC incentive	Total
Bhaktapur	300	16	316	300	6	306
Dhading	9,600	1280	10,880	8,500	828	9,328
Dolakha	2,324	140	2,464	2,328	68	2,396
Gorkha	3,380	440	3,820	2,800	188	2,988
Kathmandu	31,500	920	32,420	29,247	120	29,367
Kavre	20,600	1,400	22,000	18,800	252	19,052
Lalitpur	5,300	480	5,780	6,000	312	6,312
Makwanpur	3,000	760	3,760	3,800	1,160	4,960
Nuwakot	2,000	280	2,280	1,500	140	1,640
Okhaldhunga	5,000	480	5,480	5,000	172	5,172
Ramechhap	4,500	520	5,020	4,000	360	4,360
Rasuwa	1,300	120	1,420	1,300	192	1,492
Sindhuli	2,870	126	2,996	4,500	180	4680
Sindhupalchowk	4,000	440	4,440	1,300	400	1700
Total	**95,674**	**7,402**	**103,076**	**89,375**	**4,378**	**93,753**

Source: MoHP annual work plan and budget, 2014/15 and MoH annual work plan and budget, 2015/16

The service statistics show an increasing number of women using delivery services each year. The continuation of this trend will challenge programme managers to provide delivery services if allocated budgets are insufficient to ensure service provision as per the Aama Programme guidelines.

4.1.5 Delivery services in earthquake-affected districts

Table 4.5 gives an overview of delivery services six months before and after the Gorkha earthquake in the sampled health facilities. Service statistics are included only from health facilities that received the Aama Programme budget and reported progress to the DHO/DPHO. The data shows fewer deliveries after the earthquakes, which could be due to women going for delivery services at higher level facilities or delivering at home.

There was, however, an increase in the number of deliveries in Dolakha and Rasuwa

districts. This could have been due to additional efforts from international agencies including Médecins Sans Frontières (MSF) in Dolakha and the Canadian Red Cross in Rasuwa who provided delivery services through skilled health workers.

Table 4.5: Deliveries in Health Facilities under DHOs/DPHOs in Six Months Before and After the Gorkha Earthquake (October/November 2014 and September/October 2015)

	Before Earthquakes				After Earthquakes			
Name of District	**Normal**	**Complicated**	**CS**	**Total**	**Normal**	**Complicated**	**CS**	**Total**
Bhaktapur	13	0	0	13	4	1	0	5
Dhading	1491	42	3	1536	1464	54	24	1542
Sindhuli	533	29	24	586	483	27	28	538
Dolakha	234	6	0	240	405	16	26	447
Gorkha	471	18	0	489	378	9	7*	394
Kathmandu	1,717	148	968	2,833	1,759	92	904	2,755
Kavre	2,023	161	497	2,681	1,972	124	617	2,713
Lalitpur	500	28	219	747	480	27	198	705
Makwanpur	433	13	0	446	206	18	0	224
Nuwakot	212	34	0	246	220	33	0	253
Okhaldhunga	782	74	48	904	758	91	42	891
Ramechhap	511	85	0	596	441	78	0	519
Rasuwa	84	0	0	84	113	3	6*	122
Sindhupalchowk	663	9	0	672	454	10	0	464
Total	**9,667**	**647**	**1,759**	**12,073**	**9,137**	**583**	**1,853**	**11,572**

Caesarean sections (CSs) conducted by the foreign medical tem medical team after the earthquake

The qualitative data indicates that delivery services have increased in the districts where foreign medical teams established medical camps. For example, one participant from a PHCC in Rasuwa described the availability of delivery services after the earthquakes:

> *"There is no effect on the provision of services as such [...] after the disaster donors [foreign medical team] set up a medical camp. They also established a shelter home that provided lunch and nursing care for women. It was an opportunity for us to organize caesarean sections because there was a medical team. Overall, the implementation of the Aama Programme has improved after the earthquake."*

The above quote brings the policy question that the discontinuation of skilled delivery services could negatively affect the service seeking behaviour of pregnant women. This may also indicate that there must be some damage to peripheral level institution and some time might be needed to resume delivery services.

Resuming delivery services in remote facilities in the earthquake-affected districts should be a priority for MoH. The reduction in the Aama Programme budget challenges the provision of free delivery care and of transport incentives at the time of discharge.

4.2 Health Facility Level Findings

This section describes the implementation of various Aama Programme components in 50 health facilities in the 14 earthquake-affected districts. This section provides in-depth information on service availability, use, physical infrastructure, human resource, drugs, budget provision and governance. The below findings were captured by the study's

health facility tool.

4.2.1 Type of health facilities

Table 4.6 summarizes the type and level of health facilities included in the study. Altogether 50 Aama implementing health facilities were selected from the 14 earthquake-affected districts. One central level hospital, 12 district hospitals, 15 PHCCs, 13 health posts, 4 NGO/mission run facilities and 5 private for profit facilities were selected. Almost 30% of facilities were providing comprehensive emergency obstetric and neonatal care (CEONC), 32% basic emergency obstetric and neonatal care and 38% were providing birthing centre level care.

Table 4.6: Type and Level of Health Facilities

Facility characteristics	Frequency (n = 50)	Percent
Types of facility		
Central hospital	1	2
District hospitals	12	24
PHCCs	15	30
Health posts	13	26
NGO/mission facilities	4	8
Private hospitals	5	10
Level of delivery care		
CEONC	15	30
BEONC	16	32
Birthing centre	19	38

Note: all sub-health posts were upgraded to health posts from FY 2015/16

4.2.2 Status of Aama Programme implementation

Tale 4.7 summarizes compliance with the Aama Programme. Almost all the facilities were providing free delivery services and transport incentives to women while only 90% of them were providing the 4 ANC incentive. No health facility was providing a home delivery incentive.

The transport incentive has been provided to women giving birth in health facilities for the past ten years; but only 80% of the facilities were handing over the payment at the time of discharge (Table 4.7). The data indicates that district hospitals and grassroots level health facilities were not providing incentives to women at the time of discharge. Only 75% of the district hospitals, 73% of PHCCs and 85% of the health posts were handing over the incentive at the time of discharge.

The usual delay in the receipt of budgets at the beginning of each fiscal year means that facilities usually have inadequate resources to provide the transport incentive at the time of discharge. For facilities under DHOs/DPHOs, some types of delays in the receipt of budgeted funds are almost inevitable. This mainly revolves around the delayed issuing of advances to health facilities by DHOs/DPHOs and delayed facility progress reporting to their DHO/DPHO. The following quote from a facility-based health worker says that the inability to distribute incentives to women at the time of discharge is due to the untimely release of funds to the facility by the DHO/DPHO. The quote reflects similar views related to delays in distributing incentives to women:

"Being a government employee there is no point criticizing the government; but I must say that the budget is usually delayed [delayed from the DHO]. In a few cases, women only receive the incentive by the time the baby has started walking! We feel very sorry for that."

Table 4.7: Compliance with the Aama Programme Guidelines

	Central hospital (n = 1)	District hospitals (n = 12)	PHCCs (n = 15)	Health posts (n = 13)	NGO/private/ mission facilities (N = 9)	Total
Availability of free delivery service:						
Yes (available)	1 100%	12 100%	15 100%	13 100%	9 100%	50 100%
No (not available)	0 0%	0 0%	0 0%	0 0%	0 0%	0 0%
Availability of transport incentive:						
At time of discharge	1 100.0%	9 75.0%	11 73.3%	11 84.6%	8 88.8%	40 80.0%
Later	0 0.0%	3 25.0%	4 26.7%	2 15.4%	1 11.2%	10 20.0%
Facilities providing 4 ANC incentive:						
Yes (providing)	1* 100.0%	12 100.0%	15 100.0%	11 84.6%	6 66.6%	45 90.0%
No (not providing)	0 0.0%	0 0.0%	0 0.0%	2 15.4%	3 33.4%	5 10%
Provision of home delivery incentive:						
Yes (provision)	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%
No (no provision)	1 100.0%	12 100.0%	15 100.0%	13 100.0%	9 100.0%	50 100.0%

**Partial implementation of 4 ANC*

Another kind of observed delay was where Aama Programme advances sit with health facility in-charge and not the service providers and so the absence of the in-charge entails the unavailability of the incentive at the time of discharge.

The 4 ANC incentive was added to the Aama Programme in 2012 to promote ANC and for allocative and technical efficiency. A woman needs to provide her original completed ANC card to obtain the claim. However, this scheme component was not being fully implemented by many private facilities, and was only being partially implemented by the central hospital and some health posts. According to the Maternity Hospital, only those who have had their ANC check-ups at the hospital are entitled to the incentive. Some private facilities use the same excuse not to provide the 4 ANC incentive. The personnel of Sisneri Health Post, Okhaldhunga were found to have used this reason for not providing the 4 ANC incentive. According to them no women can comply with the administrative demands necessary to obtain the 4 ANC incentive as they require them to submit a copy of their citizenship certificate, a recommendation from the village development committee, five local people certifying place of residence and a birth registration certificate. This demonstrates a problem with the 4 ANC guidelines.

Personnel at all 50 facilities claimed that they provided free delivery services. However,

further analysis shows that the majority of these facilities were charging women (see Table 4.8). This raises the question of compliance with the Aama guidelines and the policy level concern of double charging to the government and women. The latter challenges the objective of reducing out-of-pocket spending by women and inflates the cost of care. Despite the provision of additional blood transfusion cost in AWPBs, public facilities are charging women for this service. Private facilities are imposing charges for other kinds of services.

Table 4.8: Type of Charges by Health Facilities for Delivery Services

	Central hospital (n = 1)	District hospitals (n = 12)	PHCCs (n = 15)	Health posts (n = 13)	NGO/private/ mission facilities (n = 9)	Total
Registration fees	1	2	1	0	4	8
	100.0%	16.7%	6.7%	0.0%	44.4%	16.0%
Admission fees, deposits	0	0	0	0	2	2
	0.0%	0.0%	0.0%	0.0%	22.2%	4.0%
Pads, gloves, syringes	0	3	1	2	4	10
	0.0%	25.0%	6.7%	15.4%	44.4%	20.0%
Drug charges	0	2	0	2	4	8
	0.0%	16.7%	0.0%	15.4%	44.4%	16.0%
Blood bag & transfusions	1	2	1	0	3	7
	100.0%	16.7%	6.7%	0.0%	33.3%	14.0%
Lab tests	1	6	9	3	7	26
	100.0%	50.0%	60.0%	23.1%	77.8%	52.0%
Radiology (USG)	1	8	6	2	6	23
	100.0%	66.7%	40.0%	15.4%	66.7%	46.0%
Helper's incentives	0	1	0	0	0	1
	0.0%	8.3%	0.0%	0.0%	0.0%	2.0%
Doctors fee	0	0	0	0	1	1
	0.0%	0.0%	0.0%	0.0%	11.1%	2.0%

Note: Facilities that did not charge a fee or did not have services are not presented in this table

4.2.3 Extent of damage to physical infrastructure

More than 85% of the facilities implementing the Aama Programme were damaged either completely or partially due to the earthquakes (Table 4.9). The entire building had been completely damaged in 14 of the 50 facilities and partially damaged at 21 facilities. The delivery rooms were totally damaged at 17 facilities and partially damages at 12 facilities. The equipment and furniture were damaged at 44% of the facilities. The earthquakes affected all level of health facilities except for the central hospital with the most damage among health posts. This is probably due to there being more health posts and because they have been mostly operating since the 1980s with some of them built using local resources and technology.

The data in Table 4.9 indicates that the earthquakes damaged many delivery rooms, which will hamper the resumption of delivery services. However, support from local communities and international agencies has contributed to restoring delivery services in

the absence of a delivery rooms.

Table 4.9: Extent of Damage to the Physical Infrastructure of the 50 Facilities

Damage to	Centre hospitals (n = 1)	District hospitals (n = 12)	PHCCs (n =15)	Health posts (n = 13)	NGO/private/ mission hospitals (n = 9)	Total
Entire buildings						
Complete	0	3	2	8	1	14
	0.0%	25.0%	13.3%	61.5%	11.1%	28.0 %
Partial	1	5	7	4	4	21
	100.0%	41.7%	46.7%	30.8%	44.4%	42.0 %
No Damage	0	4	6	1	4	15
	0.0%	33.3%	60.0%	7.7%	44.5%	30.0 %
Delivery rooms						
Complete	1	4	3	8	1	17
	100.0%	33.3%	20.0%	61.5%	11.1%	34.0 %
Partial	0	1	4	5	2	12
	0.0%	8.3%	26.7%	38.5%	22.2%	24.0 %
No Damage	0	7	8	0	6	21
	0.0%	58.4%	53.3%	0.0%	66.7%	22.0 %
Equipment						
Complete	0	2	2	4	1	9
	0.0%	16.7%	13.3%	30.8%	11.1%	18.0 %
Partial	1	3	3	4	2	13
	100.0%	25.0%	20.0%	30.8%	22.2%	26.0 %
No Damage	0	7	10	5	6	28
	0.0%	58.3%	66.7%	38.5%	66.7%	56.0 %
Furniture						
Complete	0	1	0	5	1	7
	0.0%	8.3%	0.0%	38.5%	11.1%	14.0 %
Partial	1	3	6	3	2	15
	100.0%	25.0%	40.0%	23.1%	22.2%	30.0 %
No Damage	0	8	9	5	6	28
	0.0%	66.7%	60.0%	38.5%	66.7%	56.0 %

4.2.4 Provision of delivery services in damaged facilities

Table 4.10 shows the availability of delivery services after the earthquakes at the 50 health facilities. Twenty-nine of the 50 facilities suffered some form of damage to their delivery rooms. Thirty-four percent of them facilities were providing delivery services under a tent or temporary shelter and 16% from another public building or rented

accommodation. Only 8% of facilities were providing services from their original building.

The trend is probably explained by the fact that donor agencies and NGOs had supported most of the health facilities to restore services. For example, an NGO in Sindhupalchowk district had supported a PHCC and the district hospital to restore services in prefabricated buildings.

Thus delivery services are continuing to be provided and so DHOs/DPHOs should continue to provide unit cost payments and transport incentive funds.

Table 4.10: Availability of Delivery Services After the Earthquakes (N = 50 Facilities)

	Central hospital (n = 1)	District hospitals (n = 12)	PHCCs (n = 15)	Health posts (n = 13)	NGO/private/ mission hospitals (n = 9)	Total
Tents and temporary shelters	0	4	5	6	2	17
	0.0%	33.3%	33.3%	46.2%	22.2%	34.0%
Original building	1	1	1	1	0	4
	100.0%	8.3%	6.7%	7.7%	0.0%	8.0%
Other public and rented buildings	0	0	1	6	1	8
	0.0%	0.0%	6.7%	46.2%	11.1%	16.0%
No damage	0	7	8	0	6	21
	0.0%	58.3%	53.3%	0.0%	66.7%	42.0%

4.2.5 Functional maternity beds

Table 4.11 shows the number of maternity beds functioning in the 50 facilities. The total number of beds decreased from 768 before to 690 after the earthquakes. The decline bed was mainly in the district hospitals, including in Gorkha where the delivery room badly damaged.

Table 4.11: Number of Maternity Beds in the 50 Health Facilities

	Total Number of Beds	
	Before Earthquakes	After Earthquakes
Central hospital	355	290
District hospitals	130	118
PHCCs	40	40
Health posts	25	24
NGO/mission/private facilities	218	218
Total	**768**	**690**

On the contrary some qualitative data indicates an increased number of maternity beds in some areas, including in Rasuwa district where services were being provided from tents. The Maternity Hospital lost almost 18% of its maternity beds after the earthquakes,

which could well have decreased patient flow because of increased waiting times.

4.2.6 Human resources situation

The number of health workers increased slightly from 1,826 health workers (doctors, nurses and paramedics) in the 50 health facilities before the earthquakes to 1,852 after the earthquakes (Table 4.12). Ninety-nine health workers left the facilities while 125 had joined after the earthquakes. The number of doctors and nurses leaving and joining the facilities significantly increased after the earthquakes. One possible reason for this could be the high renewal rate for medical officers and nursing staff in medical colleges and private hospitals. Other reasons could be the secondment of medical officers by MoH in the affected districts.

Table 4.12: Human Resource Mobility in the 50 Health Facilities During and After the Earthquakes

	Before earthquakes	Added after earthquakes	Left after earthquakes	After earthquakes
Central hospital (n = 1)				
Doctors	51	3	0	54
Nurses	179	1	4	176
Paramedics	25	0	0	25
Sub-total	255	4	4	255
District hospitals (n = 12)				
Doctors	77	29	16	90
Nurses	138	16	11	143
Paramedics	109	12	3	118
Sub-total	324	57	30	351
PHCCs (n = 15)				
Doctors	23	14	9	28
Nurses	68	9	9	68
Paramedics	68	3	9	62
Sub-total	159	26	27	158
Health posts (n = 13)				
Doctors	0	2	0	2
Nurses	25	3	6	22
Paramedics	31	1	6	26
Sub-total	56	6	12	50
NGO/mission/private (n = 9)				
Doctors	242	18	14	246
Nurses	626	13	12	627
Paramedics	164	1	0	165
Sub-total	1032	32	26	1,038
All Total	**1,826**	**125**	**99**	**1,852**

Note: The data excludes temporary health workers recruited by counterpart agencies

The study found that 48 of the 125 health workers joining the health facilities had been recruited by management boards or and facility development committee, particularly in private health facilities and district hospitals. Also, the government had recruited 54

health workers, while a further 22 had been temporarily contracted by MoH.

Regarding discontinuation of health workers, 62 of the 99 health workers leaving the facilities had left as their contracts had ended. Only three health workers (a paramedic and two doctors) had left their facilities due to the earthquakes, while the others had retired or been transferred elsewhere. This implies that the earthquakes had a negligible impact on human resource continuation. The observed mobility of health workers was mainly due to administrative reasons and the discontinuation of their contracts. It is possible that this finding is due to MoH deciding to retain health workers employed in the affected districts through incentives and performance appraisals. It may also be possible that the health workers had felt ethical and humanitarian obligations to serve the victims of the earthquakes.

4.2.7 Damage to drugs

Table 4.13 shows the damage to drug caused by the earthquakes in the 50 health facilities. Only 18% of the health facilities reported some form of damage to their drugs due to the earthquakes.

Table 4.13: Effect of the Earthquakes on Drug Availability (N = 50 Facilities)

	Central hospital (n = 1)	District hospitals (n = 12)	PHCCs (n = 15)	Health posts (n = 13)	NGO/private/ mission hospitals (n = 9)	Total
Damage	0	0	2	6	1	9
	0.0%	0.0%	13.3%	46.2%	11.1%	18.0 %
No damage	1	12	13	7	8	41
	100.0%	100.0%	86.7%	53.8%	88.9%	82.0 %

Table 4.14 depicts the stock of essential drugs required for delivery services in the 50 health facilities. The majority of facilities had the required stocks of essential drugs to conduct delivery services for a month. This may have been due to the active engagement of government and non-government organizations in maintaining drug supplies.

Table 4.14: Current Stock of Essential Drugs for Delivery Services for a Month (N = 50 Facilities) (as of November/December 2015)

	Central Hospital (n = 1)	District Hospitals (n = 12)	PHCCs (n = 15)	Health Posts (n = 13)	NGO/Private/ Mission Hospitals (n = 9)	Total
Injection Magnesium Sulphate						
Yes (in stock)	1	10	12	7	6	36
	100.0%	83.3%	80.0%	53.8%	66.7%	72.0 %
No	0	2	3	6	3	14
	0.0%	16.7%	20.0%	46.2%	33.3%	28.0 %
Injection Oxytocin						

Yes	1 100.0%	10 83.3%	11 73.3%	9 69.2%	9 100.0%	40 80.0%
No	0 0.0%	2 16.7%	4 26.7%	4 30.8%	0 0.0%	10 20.0%
Injection Ringer lactate						
Yes	1 100.0%	10 83.3%	13 86.7%	12 92.3%	9 100.0%	45 90.0%
No	0 0.0%	2 16.7%	2 13.3%	1 7.7%	0 0.0%	5 10.0%
Injection Nifedipine						
Yes	1 100.0%	8 66.7%	10 66.7%	1 7.7%	8 88.9%	28 56.0%
No	0 0.0%	4 33.3%	5 33.3%	12 92.3%	1 11.1%	22 44.0%
Injection Gentamycin						
Yes	1 100.0%	10 83.3%	11 73.3%	7 53.8%	8 88.9%	37 74.0%
No	0 0.0%	2 16.7%	4 26.7%	6 46.2%	1 11.1%	13 26.0%

The qualitative data also indicates that almost all health facilities received essential drugs in the form of donations after the earthquakes. However, the usability of the donated drugs must be treated with caution as a few participants at the assessment workshops described the quality of drugs as compromised. Some expressed difficulty in prescribing drugs as some drugs were labelled in unfamiliar scripts.

The number of facilities with limited stocks of oxytocin and emergency medications raised concern on the maintenance of the stock of these drugs during the September 2015 to January 2016 blockade on the Nepal-India border where few goods came through. This led to many DHOs and DPHOs being unable to maintain adequate supplies of essential drug. Some facilities said they had used the institutional reimbursements from the Aama Programme to buy drugs during this period while others had been instructed to buy from their DHO/DPHO and were planning to do this.

4.2.8 Budget allocations

FHD estimates the annual budget for the Aama Programme based on the use of institutional delivery and 4 ANC incentives in the previous fiscal year. The actual budget is determined by adjusting the estimated budget for a 10% growth in service use. The allocated budget is then distributed to DHOs/DPHOs and selected hospitals through district treasury controller offices (DTCO), which is followed by the release of authorizations to spend.

Health facilities that are under DHOs/DPHOs receive their budgets from their DHO/DPHO based on their delivery record and ANC service statistics. Health facilities that do not fall

under the purview of the DHO/DPHO receive their budgets directly from the DTCO based on their estimated/actual delivery and 4 ANC use statistics.

Table 4.15 summarizes the budget allocation pattern over FY 2014/15 and FY 2015/2016 for eight hospitals that receive separate budget and authorizations for the Aama Programme (in NPR 1,000s). The total budget for FY 2014/15 in these hospitals was NPR 111,596,000, which decreased to NPR 104,420,000 in FY 2015/16.

Table 4.15: Allocated Budget for the Aama Programme for Eight Hospital in FYs 2014/15 and 2015/16 (in NPR 1,000s)

	Allocated Budgets (in NPR 1,000s)					
	FY 2014/15			FY 2015/16		
Facilities	Transport+ unit costs	4 ANC	Total	Transport+ unit costs	4 ANC	Total
Paropakar Maternity Hospital	85,700	2,800	88,500	80,000	1,000	81,000
Hetauda District Hospital	7,500	920	84,200	7,500	160	7,660
Bhaktapur District Hospital	3,500	200	3,700	3,500	80	3,580
Gorkha District Hospital	5,800	440	6,240	4,000	160	4,160
Amppipal Hospital, Gorkha	620	80	700	620	60	680
Trishuli District Hospital	6,500	720	7,220	5,500	240	5,740
Methinkot Hospital, Kavre	800	80	880	500	40	540
Jiri District Hospital	1,176	80	1,256	1,000	60	1,060
Total	111,596	5,320	192,696	102,620	1,800	104,420

Source: FHD AWPBS for FY 2014/15 and FY 2015/16

The total allocated budget for both the transport incentive and 4 ANC also decreased in FY 2015/16. The decrease can be attributed to the reduced levels of expenditure of the health facilities in the previous fiscal year. Almost 50% of the overall budget cut happened to the 4 ANC programme. (Note that the figures for the planned budgets for transport plus unit cost and 4 ANC incentives could not be obtained for the assessment because of other competing ministry priorities notably the response to the earthquakes.)

4.2.9 Budget distribution

The majority of the 50 facilities (62%) that were receiving separate budgets and authorizations provided transport incentive as advances to recipients. The unit cost and transport incentive were later reimbursed to health facility accounts. The study's findings also suggest that the distribution of budgets to health facilities is often hampered, especially during the first quarter of the fiscal year.

Table 4.16 summarizes the reasons given for budget delays in the health facilities. The data suggests that delays in receiving budget authorization are the major factors responsible for delays in releasing budgets to facilities having separate budgets and authorization for the Aama Programme. For facilities under the authority of DHOs/DPHOs, budget release from DTCOs was given as the major reason for delays in facilities receiving their Aama Programme budgets and thereby hampering compliance

with the Aama guidelines. However, this finding should be interpreted with caution as it only represents the views of the sampled health facilities, which might mask delays from the facility level such as delays in reporting and clearing advances.

No effects of the earthquakes on budget distribution were noticed. Possible explanations for this might be that the facilities had already received their budgets for the last quarter of FY 2014/15 when the Gorkha earthquake struck and that the facilities were due reimbursements.

Findings from the qualitative data highlight similar reasons for delays in budget distribution:

> *"Yes, there are problems with budget distribution. The distribution is delayed from the central level, so women do not receive the incentive on time. In some situation facility in-charges are absent. They do not report to us [DHO] on time [...], they submit their reports as convenient to them. We cannot distribute budget to them unless we receive updated records. [Also] Sometimes there is no focal person at the District Treasury Controller Office to release the budget [...]. These factors are responsible for the delays in distribution."—A DHO/DPHO Aama Programme focal person*

The responses from Aama Programme focal persons suggests that the difficulties in distributing budgets to peripheral health facilities are partly due to delays in receiving budget authorizations, delays in budget release, and delays in reporting including financial reports overdue from the health facilities. The findings indicate the need for more regular reporting from facilities.

Table 4.16: Reasons Given for Budget Delays in the 50 Health Facilities

Reasons for delay	Central Hospital (n = 1)	District Hospitals (n = 12)	PHCCs (n = 15)	Health Posts (n = 13)	NGO/Private/ Mission Hospitals (n = 9)	Total
Budget expenditure authorization						
Yes (received)	1	8	8	4	2	23
	100.0%	66.7%	53.3%	30.8%	22.2%	46.0%
No (not received)	0	4	7	9	7	27
	0.0%	33.3%	46.7%	69.2%	77.8%	54.0%
Budget release from district						
Yes	0	4	13	11	7	35
	0.0%	33.3%	86.7%	84.6%	77.8%	70.0%
No	1	8	2	2	2	15
	100.0%	66.7%	13.3%	15.4%	22.2%	30.0%
Due to earthquakes						
Yes	0	0	1	0	1	2
	0.0%	0.0%	6.7%	0.0%	11.1%	4.0%
No	1	12	14	13	8	48
	100.0%	100.0%	93.3%	100.0%	88.9%	98.0%
Reporting delays						
Yes	0	1	1	2	0	4
	0.0%	8.3%	6.7%	15.4%	0.0%	8.0%
No	1	11	14	11	9	46
	100.0%	91.7%	93.3%	84.6%	100.0%	92.0%
Staff transfers						
Yes	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
No	1	12	15	13	9	50
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

4.2.10 Budget sufficiency

The budgets allocated for the Aama Programme were sufficient for majority of the health facilities. The budget of the eight hospitals that received separate budgets and expenditure authorizations for Aama Programme budgets were found to be sufficient at all the hospitals. However, 3 out of the 41 health facilities under the authority of the DHO/DPHO reported that their budget was insufficient (Kathmandu Medical College, Adharbhut Prasuti Sewa Kendra, and Barhabise PHCC). It was interesting to note the budget insufficiency of facilities under the authority of DHOs/DPHOs as they receive case-based payment. The reason to this might be because their claims get cut by DHOs/DPHOs while reviewing them, as a result of which they might not receive their unit cost and transport incentive as per their claims. A similar indication was also noted from the qualitative data as a service provider from a PHCC in Dolakha district said:

> *"The budget for 4 ANC and free delivery is sufficient, though we do not receive the budget on time. If the budget is inadequate for the programme, then we will*

demand with the district [DHO]. We note the total number of institutional deliveries. We also record on a report sheet the number of women that are not getting incentives at the time of discharge. We then attach a demand slip while requesting the additional budget. Yes, we use our internal sources to provide the incentive to women coming from remote areas. We reimburse later [within our budget] when we receive payment from the district. For women in the vicinity of our PHCC, we keep their contact details. We call them when we have the budget."

This quote implies that the allocated budget is sufficient in most cases. It also suggests facilities to manage their internal sources when budge is delayed during the first quarter of the year.

4.2.11 Budget spending

Table 4.17 depicts the spending status of the Aama Programme budget at the 50 health facilities. This data indicates that majority of the 50 health facilities (86%) had spent their entire programme budgets during the previous fiscal year. Fourteen percent had not spent their Aama Programme budgets.

Table 4.17: Spending of the Aama Programme Budget by Facility Type (N = 50)

	Central Hospital (n = 1)	District Hospitals (n = 12)	PHCCs (n = 15)	Health Posts (n = 13)	NGO/Private/ Mission Hospitals (n = 9)	Total
Yes (spent it)	0	8	14	12	9	43
	0.0%	66.7%	93.3%	92.3%	100.0%	86.0%
No (did not spend it)	1	4	1	1	0	7
	100.0%	33.3%	6.7%	7.7%	0.0%	14.0%

Table 4.18 shows the reasons for not having spent the Aama Programme budget. The data suggests that the inability to spent Aama Programme budget in the previous fiscal year was unrelated to the earthquakes. The health facilities, especially the central hospital and some district hospitals (Makwanpur, Gorkha, Amppipal) were unable to spend their budgets due to high targets for free delivery services. Some health facilities, such as Methinkot hospital, Sallimaidan Health Post and Paanchkhal PHCC, could not spend their allocated money because they could not provide 24 hour delivery services because nurses were not provided with night allowances. Also, the buildings and staff quarters had been damaged In Panchkhaal PHCC and Sallimaidan.

Table 4.18: Reasons for not Spending Aama Programme Budgets

	Central Hospital (n = 1)	District Hospitals (n = 12)	PHCCs (n = 15)	Health Posts (n = 13)	NGO/Private/ Mission Hospitals (n = 9)	Total
Due to earthquakes	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0

						%
Lack of health workers	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0 %
Too high targets	1	3	0	0	0	4
	100.0%	25.0%	0.0%	0.0%	0.0%	8.0 %
No 24 hours service	0	1	1	1	0	3
	0.0%	8.3%	6.7%	7.7%	0.0%	6.0 %

Regarding the spending of the institutional unit cost money, the majority of the service providers claimed that they had used the unit cost money to support the availability of free delivery care. For example, when asked to categorize how they had spent the unit cost money, the majority of the facilities (94%) said they had used it for purchasing drugs and equipment. However, no specific evidence of purchasing drugs and equipment was obtained during the KIIs and in-depth interviews except from a PHCC in Bhaktapur district. It had purchased ring forceps and a plain catheter costing around NPR 500 in the last fiscal year. The actual use of institutional unit cost is described in the following quote:

> *"We are not sure how facilities have exactly used their budgets. They might purchase drugs and equipment needed for delivery services, but that is just a small proportion of the money. The large amount goes to activities that are not related to Aama Programme. There is no rational use of the money. We might wish to stop the unit cost some day."—An Aama focal person of a DHO/DPHO.*

This statement implies that the use of the institutional unit cost money does not comply with the Aama guidelines. It also suggests that DHOs/DPHOs should monitor the actual use of the unit cost money.

4.2.12 Effect on financial information

The data in Table 4.19 shows that financial information was lost due to the earthquakes in only 14% of the 50 health facilities. The loss was particularly observed in PHCCs and health posts. This could be partly explained by the fact that health facilities functioning as cost centres under MoH use the Transaction Accounting and Budget Control System (TABUCS) to record financial information (which is thus held on central level servers) or financial information could be retrieved in facilities even after the damage.

Table 4.19: Loss of Financial Information due to the Earthquakes in the 50 Facilities

	Central Hospital (n = 1)	District Hospitals (n = 12)	PHCCs (n = 15)	Health Posts (n = 13)	NGO/Private/ Mission Hospitals (n = 9)	Total
Yes (loss of information)	0	0	3	4	0	7
	0.0%	0.0%	20.0%	30.8%	0.0%	14.0 %
No (no loss)	1	12	12	9	9	43
	100.0%	100.0%	80.0%	69.2%	100.0%	46.0

%

4.2.13 Governance

The data in Table 4.20 shows the governance status of the 50 sampled health facilities that were implementing the Aama Programme. The Aama Programme guidelines stipulate that all implementing health facilities maintain citizen charters and display Aama Programme beneficiaries on their notice boards. Contrary to the provision, only 21 of the 50 facilities had citizen charters of which 20 facilities had updated charters including details of the Aama Programme. The absence of charters was observed more in private health facilities. While the Aama guidelines require facilities to disclose the name of beneficiaries on their notice boards, only 24% of facilities were complying with this provision. The common reason for non-compliance was given as a lack of space due to the earthquakes at most of the sampled PHCCs and health posts. The majority of district and private hospitals mentioned that there were too many deliveries to be able to display the names of beneficiaries.

The data also shows that the practice of social auditing was less common in most facilities — only 18 (36%) facilities had carried out social audits in the last fiscal year. Although 18 facilities had carried out social audits, only a few facilities had discussed issues related to Aama Programme incentives at their audits.

Table 4.20: Governance of the Aama Programme

	Central hospital (n = 1)	District hospitals (n = 12)	PHCCs (n = 15)	Health posts (n = 13)	NGO/private/ mission hospitals (n = 9)	Total
Presence of citizen charters in the facility						
Yes	1	6	7	5	2	21
	100.0%	50.0%	46.7%	38.5%	22.2%	42.0%%
No	0	6	8	8	7	29
	0.0%	50.0%	53.3%	61.5%	77.8%	58.0%
Location of citizens charters in the facility						
In visible place	1	5	7	5	2	20
	100.0%	41.7%	46.7%	38.5%	22.2%	40.0%
Not in visible place	0	1	0	0	0	1
	0.0%	8.3%	0.0%	0.0%	0.0%	2.0%
No citizens charter	0	6	8	8	7	29
	0.0%	50.0%	53.3%	61.5%	77.8%	58.0%
Updated citizen charters including Aama Programme details						
Yes	1	6	6	4	1	18
	100.0%	50.0%	40.0%	30.8%	11.1%	36.0%
No	0	0	1	1	1	3
	0.0%	0.0%	6.7%	7.7%	11.1%	6.0%
No citizens charter	0	6	8	8	7	29
	0.0%	50.0%	53.3%	61.5%	77.8%	58.0%
Disclosure of Aama beneficiaries on facility noticeboard						

Yes	0	1	6	5	0	12
	0.0%	8.3%	40.0%	38.5%	0.0%	24.0%
No	1	11	9	8	9	38
	100.0%	91.7%	60.0%	61.5%	100.0%	76.0%
Social audit of Aama Programme in last fiscal year						
Yes	0	4	9	4	1	18
	0.0%	33.3%	60.0%	30.8%	11.1%	36.0%
No	1	8	6	9	8	23
	100.0%	66.7%	40.0%	69.2%	88.9%	64.0%

4.2.14 Reporting and supervision

Table 4.21 shows the reporting and supervision of the Aama Programme in the 50 health facilities in the 14 earthquake-affected districts. Eighty-four percent of the facilities were regularly reporting the Aama annex on the seventh of each month, as required by the guidelines. Eight percent of the health facilities were still reporting the Aama annexes every four months after the earthquakes while the others were found to reporting either only six monthly or once a year. Almost the same proportion of health facilities (82%) were reporting regularly after the earthquakes. Kharanitar PHCC (Nuwakot district) personnel mentioned that they had been irregular with reporting on the Aama annex in the previous four months because the nursing staff had not prepared the report as they were not receiving night allowances. Only nine facilities were not up to date with their reporting after the earthquakes because of either reporting forms and records being destroyed or not being available (i.e. used up). Most such facilities were located far away from their DHO/DPHO with no way of getting the forms.

The data in Table 4.20 above suggests that facilities are in accordance with the mandatory provision of the Aama guidelines to report the Aama annex on the seventh of each month. However, a note of caution is due here because qualitative findings and workshop discussions reveal that facilities are not up to date in reporting against the Aama annex. The following interview quotes by Aama focal persons of Makwanpur and Okhaldhunga districts is evidence of irregular reporting:

> *"Some health facilities report monthly while others reports quarterly. Few even report annually. We ask some facilities to submit their reports once or twice a year because we are not regular in receiving a budget. These facilities have few delivery cases round the year. So, we ask them to submit their reports only when we have the budget."*

> *"Almost all health facilities in our district submit the reports on the first week of every month. Facilities from the western part are irregular because they are far from the district health office. Facility in-charges from these areas have to travel a few days to come to the office, but do not receive a travel allowance for visiting the DHO to submit their reports. It is, however, practical for them to report every few months."*

The above quotes describes the causes of irregular reporting as being the untimely distribution of the budget to health facilities, having only a few delivery cases and the remoteness of health facilities. The quotes also highlight the need for instructions from

the DHO on the need for regular reporting.

Table 4.21 summarizes the findings on the supervision status of the Aama Programme. Almost 60% of the facilities receive supervision from the DHO/DPHO at least every four to six months. This result is in accordance with responses obtained from the KIIs indicating that most PHCCs and health posts are supervised every four to six months. Most supervision visits check if health facilities are keeping updated records. In a few cases, the Aama Programme records are also verified to confirm whether women actually received reported incentives. However, it was found that six facilities had never been supervised for their conduct of the Aama Programme (Bhaktapur Hospital; Bamti Health Post, Ramechhap; Kutungsang Community Hospital, Nuwakot; Kathmandu Medical College; Methinkot Hospital, Kavre; Sisneri Health Post, Okhaldhunga.

Table 4.21: Reporting and Supervision of the Aama Programme at the 50 Health Facilities

	Central hospital (n = 1)	District hospitals (n = 12)	PHCCs (n = 15)	Health posts (n = 13)	NGO/private/ mission hospitals (n = 9)	Total
Regular reporting of Aama annex on 7th of each month						
Monthly	1	9	13	10	9	42
	100.0%	75.0%	86.7%	76.9%	100.0%	84.0 %
4 Monthly	0	1	0	3	0	4
	0.0%	8.3%	0.0%	23.1%	0.0%	8.0%
6 to 12 Month	0	2	2	0	0	4
	0.0%	16.7%	13.3%	0.0%	0.0%	8.0%
Supervision of Aama Programme by DHO/DPHO						
Every month	0	1	2	1	0	4
	0.0%	8.3%	13.3%	7.7%	0.0%	8.0%
Every 4 to 6 months	0	8	12	7	3	30
	0.0%	66.7%	80.0%	53.8%	33.3%	60.0 %
Every 12 months	1	1	1	3	4	10
	100.0%	8.3%	6.7%	23.1%	44.4%	20.0 %
No Supervision	0	2	0	2	2	6
	0.0%	16.7%	0.0%	15.4%	22.2%	12.0 %
Supervision of Aama Programme after earthquakes						
Yes	1	7	11	8	3	30
	100.0%	58.3%	73.30%	61.5%	33.3%	62.0 %
No	0	5	4	5	6	20
	0.0%	41.7%	27.6%	38.5%	66.7%	38.0 %

Sixty percent of the facilities had received supervision from their DHO/DPHO and MoH after the earthquake. When asked to mention the feedback of post-earthquake

supervision visits, the majority (60%) stated that there was no particular suggestions given in relation to the Aama Programme. Health workers provided examples of suggestions such as maintaining staff coordination and relationships, maintaining cleanliness of delivery rooms, maintaining drugs and supplies, and continuing service. These pose an important question over the quality of supervisory support provided by higher level authorities.

4.2.15 Service use

The data in Table 4.22 gives an overview of delivery services at the eight hospitals (that separately receive separate budget approval) for the six months before and after earthquake. The number of deliveries after the earthquakes decreased at the majority of the hospitals including the Maternity Hospital. This may have been due to earthquake damage at these hospitals, which temporarily interrupted services. It might also be possible that the earthquakes posed new geographical barriers to women to access institutional delivery services. For example, participants in the qualitative interviews from Dolakha, Gorkha, Nuwakot, Rasuwa and Ramechhap districts stated that landslides and damaged roads prevented women from receiving institutional delivery services leading to some cases of home deliveries. However, evidence of home deliveries was not found while reviewing the delivery trend of the affected districts for six months before and after the earthquakes.

Table 4.22: Service Use from Eight Hospitals Before and After the Earthquakes

	Normal		Complicated deliveries		Caesarean sections	
Name of Hospital	Before	After	Before	After	Before	After
Paropakar Maternity Hospital	5,735	6,196	1,477	1,522	2,326	2,558
Hetauda District Hospital	846	1,255	142	178	138	222
Bhaktapur District Hospital	463	437	43	34	53	54
District Hospital Gorkha	256	510	21	31	15	14
Amppipal Hospital	65	66	23	17	8	10
District Hospital (Trishuli)	480	475	57	60	35	33
Methinkot Hospital	53	60	6	2	0	0
District Hospital (Jiri)	60	90	8	11	15	36
Total	**7,958**	**7,520**	**1,766**	**1,542**	**2,590**	**2,543**

4.3 District Specific Findings

This section describes the overall Aama Programme implementation status in the three in-depth sampled earthquake-affected districts of Dolakha, Ramechhap and Sindhupalchowk.

4.3.1 Dolakha District

The section uses the findings from the health facility assessment and the planning workshop to analyse the implementation status of the Aama Programme in Dolakha district. It focuses on compliance with the Aama Programme guidelines in relation to

free delivery services, transport incentives, the 4 ANC incentive, use of institutional unit cost and the effects of the earthquakes on service delivery, human resource, drugs, health facility governance and reporting.

a. Background — Table 4.23 shows the health facilities implementing the Aama Programme in the district before and after the earthquake. Altogether 22 health facilities were implemented the Aama Programme before and after the earthquakes with 19 health posts, 2 PHCCs and a district hospital providing free delivery services.

Table 4.23: Number of Dolakha Health Facilities Implementing Aama Programme Before and After the Earthquake

Number of Health Facilities	Before Earthquakes	After Earthquakes
Hospital	1	1
PHCCs	2	2
Health posts	19	19
Total Health Facilities	**22**	**22**

Table 4.24 summarizes the characteristics of the surveyed facilities. The assessment was carried out in a district hospital, two PHCCs and a health post. Out of these four facilities, normal and complicated delivery services were available in the district hospital and the PHCCs.

Table 4.24: Characteristics of the Surveyed Health Facilities (Dolakha)

Facility Characteristics	Frequency (n = 4)	Percent
Level of Facility		
District Hospital	1	25.0
PHCC	2	50.0
Health Post	1	25.0
Type of Facility		
CEONC	2	50.0
BEONC	1	25.0
BC	1	25.0

b. Service use —Table 4.25 shows the service use by delivery type covering six months before and after the Gorkha earthquake. The data presented in the table also includes the delivery record of Jiri Hospital. The data suggests that delivery services increased for normal deliveries, complicated deliveries and caesarean sections after the earthquakes. However, contrary to the findings, it was noted during the workshop that institutional delivery services had decreased after the earthquakes because as almost all health facilities in the district were damaged due to the April– May 2015 earthquakes.

Table 4.25: Delivery Service Use 6 Months Before & After Gorkha Earthquake (Dolakha)

	Dolakha	
	Before Earthquakes	After Earthquakes
Normal	294	495
Complicated	14	27
Caesarean section	15	62
Total	**323**	**584**

c. Free delivery services —Table 4.26 shows the availability of free delivery services in the surveyed health facilities. The data suggests that 50% of the surveyed health facilities were charging additional fees to women receiving delivery services. Women seeking service had to pay for medicines, lab tests, blood transfusions and radiological diagnosis. Furthermore, women had to pay transport costs if they were referred to higher-level facilities. The majority of the participants at the workshop explained that neither the institutional unit cost nor the ambulance incentive provided by the DHO covered the actual cost of referral.

Women delivering in Jiri hospital were paying NPR 3,000–5,000 for caesarean section deliveries. The hospital's development committee had decided to cover costs of up to NPR 4,000 for medicines and supplies required for caesarean section deliveries. However, institutional reimbursement for caesarean sections is NPR 7,000. For a normal/complicated delivery the hospital has designed delivery packs which consist of the items in Box 4.1.

Box 4.1: Delivery pack items

Items	Unit
Gloves	4
Suction tube	1
Cord clamp	1
IV cannula No.20	1
IV set	1
Syringe, 10ml	1
Syringe, 5ml	1
NS/RL	2
Oxytocin	3
Catgut	1
Sanitary pads (packet)	1

Any extra items required had to be paid for by the women. Medicines that come under free supply are provided for free. But women had to pay for injectable medicines, expensive medicines such as megapen, and medicines that are out of stock. Laboratory services at any time during the ANC period and labour are charged for (NPR 1,050-1,500) and USGs are charged for (NPR 500) the first time, while they are free for consecutive times.

Table 4.26: Availability of Free Delivery Services (Dolakha)

	Frequency (n = 4)	Percent
Availability of free delivery services		
Yes	4	100.0
No	0	0.0
Facilities charging any form of additional fees to women		
Yes	2	50.0
No	2	50.0
Charge for medicines		
Yes	1	25.0
No	3	75.0
Charge for blood bags and transfusions		
Yes	0	0.0
No	1	25.0
Service not available	3	75.0
Charge for lab tests		
Yes	2	50.0
No	0	0.0
Service not available	2	50.0
Charge for radiology diagnosis (USG)		
Yes	2	50.0

No	0	0.0
Service not available	2	50.0

d. Incentives for women — Table 4.27 indicates that all surveyed facilities were distributing ANC incentives and transport costs to women at the time of discharge. However, this was not particularly the case for all health facilities in the district. Women receiving services in some facilities had not received their incentives even six months after delivery. These delays were said to be due to irregular reporting and lack of coordination between health facility in-charges, management committees and nursing staff. Although the DHO had already released the Aama Programme budget to health facility in-charges, the in-charges had not given the money to the nursing staff to hand over to clients. The nursing staffs thus faced challenges in distributing incentives to women at the time of discharge.

In most cases, the facility in charges had received the budget, but nursing staffs had not been informed about it. So, the nursing staff were unaware if the delay was actually caused by late release by the DHO or the attitude of the in charge. The nursing staff claimed that in-charges are not sincere in managing Aama Programme funds. They also criticized the DHO for its disinclination to provide advance money to nursing staff. They were suspicious that the accountant was also not sincere. Note that some health facilities were found paying transport incentive to women who had been referred out.

Table 4.27: Distribution of Incentives to Delivered Women (Dolakha)

	Frequency (n = 4)	Percent
Facilities offering transport and 4 ANC incentives		
Yes	4	100.0
No	0	0.0
Time when women received incentives		
At time of discharge	3	75.0
Later	1	25.0

e. Incentives to health service providers and use of unit cost —Regarding health worker incentives, the study findings suggest that all health facilities in the district provided an incentive of NPR 300 to health workers per delivery. However, the finding must be interpreted with caution because the workshop revealed that service providers had a strong sense of discontent about the provision of this incentive as stipulated in the Aama guideline. One service provider said that he is willing to refer complicated delivery and caesarean section cases if the incentive is NPR 300 per case for all type of deliveries. Such a view was particularly prominent among the participants from Jiri Hospital.

The workshop revealed that some management committees have allocated incentives on a proportional basis for complicated deliveries and caesarean sections. For example, in Jiri hospital doctors are allocated NPR 2,100 per caesarean section. Similar rates exist for other staff including as NPR 1,000 for anaesthetic assistants and scrub nurses, NPR 350 for circulating nurses and NPR 200 for helpers. The workshop also revealed that women receiving caesarean section from Jiri Hospital had to pay an additional amount if their case exceeded the established celling of NPR 4,000 for a caesarean section. When asked to explain this celling, a member of Jiri hospital management committee said that his facility had to bear a loss of NPR 1,000 per caesarean section case while implementing the Aama Programme. He thus justified charging additional amounts to women as an attempt to address providers' complaints and to adjust for losses.

f. Reporting — Table 4.28 shows the reporting of the Aama annex in Dolakha district. This data suggests that all health facilities are up to date in reporting the Aama annex to the DHO. However, the workshop revealed that all facilities were not regular in this reporting and this caused delays in releasing budget to some health facilities. The data also shows that three out of the four surveyed facilities were regular in reporting after the earthquakes although the earthquakes had destroyed reporting forms and financial information in 75% of these facilities.

Table 4.28: Reporting of Aama Annex (Dolakha)

	Frequency (n = 4)	Percent
Reporting of Aama annex on 7th of each month		
Regularly	4	100.0
Irregularly	0	0.0
Regular reporting of Aama annex after earthquakes		
Yes	3	75.0
No	1	25.0
Loss of financial information due to earthquakes		

Yes	3	75.0
No	1	25.0

g. Effect of the earthquakes — Table 4.29 summaries the effect of the earthquakes in the Aama implementing health facilities of Dolakha district. The earthquakes damaged physical infrastructure, drugs, and equipment in most health facilities. The delivery room was completely damaged in one out of four of the surveyed facilities and partly damaged in two of them. These findings are in line with the views expressed by workshop participants. They stated that the earthquakes had destroyed buildings, drugs and equipment. The delivery rooms had become congested and thus birthing centres were currently run under tents. Furthermore, women were being discharged in a too short period after delivery due to congested space. Institutional delivery services were found to have decreased after the earthquakes because health facilities were unable to organize space for women to stay for a few days after delivering.

Table 4.29: Effect of the Earthquakes (Dolakha)

Damage	Frequency (n = 4)	Percent
Physical infrastructure		
Yes	4	100.0
No	0	0.0
Entire buildings		
Completely damaged	2	50.0
Partial damage	2	50.0
No Damage	0	0.0
Delivery rooms		
Completely damaged	1	25.0
Partial damage	2	50.0
No Damage	1	25.0
Location of delivery room after earthquakes		
Tent/ temporary shelter	2	50.0
Old building of the facility	2	50.0
Equipment		
Completely damaged	3	75.0
Partially damaged	0	0.0
No damage	1	25.0
Damage to essential drugs for delivery services		
Yes	2	50.0
No	2	50.0

4.3.2 Ramechhap District

This section presents findings from the health facility tool and the planning workshop held to analyse the implementation status of the Aama Programme in Ramechhap district. It focuses on compliance with the Aama Programme guidelines in relation to free delivery services, transport incentives, 4 ANC incentive, and the use of institutional unit cost and the effects of the earthquakes on service delivery, human resource, drugs, health facility governance and reporting.

a. Background information — Table 4.30 shows the health facilities implementing the Aama Programme in Ramechhap district before and after the earthquakes. Altogether 26

health facilities were implementing the Aama Programme before and after the earthquakes. There are 22 health post, 3 PHCC and a district hospital providing free delivery services.

Table 4.30: Number of Ramechhap Health Facilities Implementing Aama Programme Before and After the Earthquakes

Health Facilities	Before Earthquakes	After Earthquakes
Hospital	1	1
PHCCs	3	3
Health posts	22	22
Total Health Facility	**26**	**26**

Table 4.31 summarizes the characteristics of the surveyed health facilities. The assessment was carried out in the district hospital, a PHCC and a health post. Out of the three facilities, normal and complicated delivery services were available in the district hospital and the PHCC.

Table 4.31: Characteristics of the Surveyed Health Facilities (Ramechhap)

	Frequency (n = 3)	Percent
Level of Facility		
District hospital	1	33
PHCC	1	33
Health post	1	34
Type of Facility		
BEONC	2	67
BC	1	33

b. **Service use —** Table 4.32 shows service use by delivery type covering the six months before and after the Gorkha earthquake. The data suggests that the number of deliveries has slightly decreased for normal and complicated delivery after the earthquakes. This may be explained by the fact that delivery services were affected in most health facilities due to the earthquakes.

Table 4.32: Service use by Delivery Type 6 Months Before and After Earthquakes (Ramechhap)

	Ramechhap	
	Before Earthquakes	After Earthquakes
Normal	511	441
Complicated	85	78
Caesarean section	0	0
Total	**596**	**519**

c. Free delivery services — Table 4.33 shows the availability of free delivery service in the surveyed health facilities. The data suggests that women did not have to pay while receiving delivery services from the Aama Programme implementing health facilities. Although the study findings revealed the availability of free delivery services, workshop participants reported that women had to pay an additional charge for drugs and

consumable supplies at most surveyed facilities. For example, in Namadi Health Post the cost of consumable supplies (like pads, cannula, and catgut) and the incentive of the office assistant were deducted from the transport incentive. Participants also explained that women had to pay up to NPR 800 for lab tests because nursing staff were unaware about the fund available for this from the Aama Programme in HFMOCs' accounts. When asked about purchasing drugs and equipment, facility in-charges were ignorant. Nursing staff thus face challenges in providing free delivery services.

Table 4.33: Availability of Free Delivery Services (Ramechhap)

Free Delivery Service	Frequency (n = 3)	Percent
Availability of free delivery services		
Yes	3	100.0
No	0	0.0
Facilities charging any form of additional fees to women		
Yes	0	0.0
No	3	100.0

d. Transport and 4 ANC incentives — The data in Table 4.34 indicates that all the surveyed facilities were distributing the 4 ANC incentive and transport costs to women at the time of discharge. However, this was not particularly the case for all health facilities in the district. For example, ten women receiving delivery service from Khimti PHCC during January 2016 had not received their incentives until mid-February 2016. Two comparable reasons emerged during the workshop:

- First, the communication gap between health post in-charges and nursing staff had caused a delay in the distribution of incentives and travel costs in some facilities. This was particularly the case at a health facility in Nagdaha VDC. In these facilities, health post in-charges manage funds whereas nursing staff deals with the distribution of incentives to women. The in-charges are absent while distributing incentives to women.
- Second, lack of coordination exists between health facility in charges and member of HFMOCs. Some of the health management committees are non-functional. These committees have seldom met for the meetings. As a result service providers were unable to mobilize Aama fund that sits in the health facility HFMOC's account to be used during delay in receiving transport incentive from the facility.

Table 4.34: Distribution of Incentives to Women (Ramechhap)

Timely Incentives to Women	Frequency (n= 3)	Percent
Facilities offering transport and 4 ANC incentives		
Yes	3	100.0
No	0	0.0
Time when women received incentives		
At time of discharge	3	100.0
Later	0	0,0

While cases of untimely distribution of the 4 ANC and transport incentive were prominent at the workshop, a few innovative practices were evident. For instance, a few health facilities in coordination with local women's saving group offer nutritious food and additional allowances of NPR 500 for women from remote villages delivering in there, on top of the Aama Programme incentives. Such innovative practice open up avenues for engaging local communities in managing local resources for the Aama Programme.

e. Health worker incentives and use of institutional unit costs — Regarding health worker's incentives, the study findings suggest that all health facilities in the district provide an incentive of NPR 300 to health workers. Service providers attending the workshop said that they had received NPR 300, excluding tax, although the incentive is taxable under the Aama guidelines. Upon a decision of its HFMOC, the health workers of Manthali PHCC were receiving NPR 500 for every complicated delivery they attended. This flags up a serious implication that the institutional reimbursement (or unit cost money) is increasingly being used to incentivize health workers rather than spending it on strengthening maternity services at facilities.

f. Reporting — Table 4.35 shows reporting of the Aama annex in Ramechhap district. The data suggests that all health facilities were up to date in reporting the Aama annex to the DHO/DPHO. However, the workshop revealed that all facilities were not regularly reporting against the Aama annex, which caused delays in releasing the budget to some facilities.

The data also shows that one out of the three surveyed facilities had not been regularly reporting after the earthquakes although the earthquakes had no effect on reporting forms and financial information.

Table 4.35: Reporting of the Aama Programme (Ramechhap)

	Frequency (N = 3)	Percent
Reporting of Aama annex on 7th of each month		
Regularly	3	100.0
Irregularly	0	0.0
Regular reporting of Aama annex after the earthquakes		
Yes	2	67.0
No	1	33.0
Loss of financial information due to the earthquakes		
Yes	0	0.0
No	3	100.0

g. Effect of the earthquakes — Table 4.36 summaries the effect of the earthquakes on the Aama implementing facilities of Ramechhap district. The earthquakes damaged physical infrastructure, drugs, and equipment in all the surveyed facilities. For example, the delivery room was completely damaged in one of the three facilities. These findings are in line with the views expressed by the workshop participants who stated that the earthquakes had destroyed buildings, drugs and equipment. They also said that the delivery rooms are congested and thus birthing centres were running under tents or the space had been within the same building. The district hospital was providing ANC and deliveries in the same room.

Table 4.36: Effects of the Earthquakes (Ramechhap)

	Frequency (n = 3)	Percent
Damage to physical infrastructure		
Yes	3	100.0
No	0	0.0
Damage to entire buildings		
Complete	1	33.3
Partial	1	33.3
No damage	1	33.4
Damage to delivery room		
Complete	1	66.7
Partial	0	0.0
No damage	2	33.3
Location of delivery room after the earthquakes		
Tent/temporary shelter	1	33.3
Old building of the facility	2	66.7
Damage to equipment		
Complete	0	0.0
Partial	0	0.0
No damage	3	100.0
Damage to essential drugs for delivery services		
Yes	0	0.0
No	3	100.0

4.3.3 Sindhupalchowk District

The section uses the findings from the health facility tool and the planning workshop to analyse the implementation status of the Aama Programme in Sindhupalchowk district. It focuses on compliance to Aama Programme guidelines in relation to free delivery services, transport incentives, 4 ANC incentive, and the use of institutional unit cost money, and the effect of the earthquakes on service delivery, human resource, drugs, health facility governance and reporting.

a. Background information —Table 4.37 shows the health facilities implementing Aama Programme in Sindhupalchowk district before and after the earthquakes. Twenty-one facilities were implementing the programme before the earthquakes and one less afterwards. There are 16 health posts, 3 PHCCs, a district hospital and a private health facility providing free delivery services. The private health facility Sindhusadabar Community Hospital) stopped offering free delivery services from the fiscal year 2015/16 for administrative reasons.

Table 4.37: Number of Sindhupalchowk Health Facilities Implementing Aama Programme Before and After the Earthquakes

Status of Health Facilities	Before Earthquakes	After Earthquakes
Hospital	1	1
Primary Health Care Centre	3	3
Health Post	16	16
Private Health Facility	1	0
Total Health Facility	21	20

Table 4.38 summarizes the characteristics of the three surveyed health facilities. The assessment was carried out in a district hospital, a PHCC and a health post. Out of the three facilities, normal and complicated delivery services were available in the district hospital and the PHCC.

Table 4.38: Characteristics of the Surveyed Health Facilities (Sindhupalchowk)

Facility Characteristics	Frequency (n = 3)	Percent
Level of Facility		
District hospital	1	25
PHCC	1	25
Health post	1	25
Type of Facility		
BEONC	2	66.7
BC	1	33.3

b. Service use —Table 39 shows service use by delivery type six months before and six months after the earthquakes. The data suggests that delivery services had decreased for normal after the earthquakes but increased for complicated and caesarean sections. This may be explained by earthquake damage affecting service delivery.

Table 4.39: Delivery Service Use 6 Months Before and After Earthquakes (Sindhupalchowk)

	Sindhupalchowk	
	Before Earthquakes	After Earthquakes
Normal	663	454
Complicated	9	10
Caesarean Section	0	0
Total	**672**	**464**

c. Free delivery services —Table 4.40 shows the availability of free delivery service in the surveyed health facilities. The data suggests that one of the three facilities was charging additional fees to women receiving delivery services. Women had to pay for lab tests, medicines, blood transfusion and radiological diagnosis because these services were unavailable. Furthermore, women had to pay for transport if they were referred to higher-level facilities. The majority of the service providers at the district workshop explained that the transport incentive was insufficient to pay for referred women to travel to higher-level facilities. Service providers thus suggested that hospital committees and HFMOCs bear these costs. Participants representing HFMOCs and hospital committees, on the other hand, wondered if the Aama guidelines said that they were responsible for covering such costs. They further expressed the view that the committees might face difficulty in managing the fund for Aama Programme unless there are separate operational guidelines that outline their responsibilities under the Aama Programme.

Table 4.40: Availability of Free Delivery Services (Sindhupalchowk)

Free Delivery Service	Frequency (n = 3)	Percent
Availability of free delivery services		
Yes	3	100.0
No	0	0.0
Facilities charging any form of additional fees to women		
Yes	1	33.3
No	2	33.7
Charge for medicine		
No	2	66.7
Yes	1	33.3
Charge for blood bags and transfusions		
Yes	0	0.0
No	0	0.0
Service not available	3	100.0
Charge for lab tests		
Yes	1	33.3
No	1	33.3
Service not available	1	33.4
Charge for radiology diagnosis (USG)		
Yes	0	0.0
No	0	0.0
Service not available	3	100.0

d. Use of transport and 4 ANC incentives — Table 4.41 indicates that two of the three facilities were not distributing the 4 ANC and transport incentives to women at the time of discharge. It is possible that a lack of coordination between in-charges, nursing staff and the management committees was delaying the distribution of incentives. For example, a few nursing staff had not been informed whether the in charge had received the budget. The nursing staffs were thus unable to distribute incentives to women at discharge. Similarly, some health management committees have seldom met. As a result service providers had been unable to mobilize the fund. These findings, however, should be interpreted with caution because all participants at the workshop agreed that health facilities in the district were up-to-date in providing incentives to women at the time of discharge. Participants explained that they mobilized funds from their committees' accounts and even from their own pockets in case of budget delays. Participants also said that they offered incentive to women completing at least 4 ANC visits at any time during their pregnancies although the guidelines stipulate the provision of 4 ANC incentives as per the timing in terms of number of weeks pregnant as laid out in the 4 ANC protocol.

Table 4.41: Distribution of Incentives to Women (Sindhupalchowk)

Timely Incentives to Women	Frequency (n = 3)	Percent
Facilities offering incentives for women taking 4 ANC		
Yes	3	100.0
No	0	0.0
Time when women received incentives		
At time of discharge	1	33.3

Later	2	66.7

e. Health worker incentives and use of institutional unit costs — The study findings suggest that all health facilities implementing the Aama Programme in the district provide an incentive of NPR 300 to their health workers. However, this is not the case for the District Hospital, Chautara. It was found that service providers in the hospital had not received their incentive for a few months. Regarding the use of the institutional unit cost money, workshop participants mentioned that this money was used to purchase drugs and equipment. A few participants also said that the money was used to incentivize office assistants.

f. Reporting — Table 4.42 shows reporting of the Aama annex in the district. The data shows that two out of three of the health facilities were up to date in reporting on the Aama annex to the DHO. The data also shows that two facilities were not reporting regularly after the earthquakes. This might have been due to the effect of the earthquakes on reporting forms and financial information.

Table 4.42: Reporting of the Aama Annex (Sindhupalchowk)

	Frequency (n = 3)	Percent
Reporting of Aama annex on 7th of each month		
Regularly	2	66.7
Irregularly	1	33.3
Regular reporting of Aama annex after earthquakes		
Yes	1	33.3
No	2	66.7
Loss of financial information due to earthquakes		
Yes	2	66.7
No	1	33.3

g. Effect of the earthquakes — Table 4.43 summaries the effect of the earthquakes in the Aama implementing health facilities of Sindhupalchowk district. The earthquakes damaged physical infrastructure, drugs, and equipment in almost all health facilities. These findings are in line with the views expressed by the participants of the district workshop. Participants stated that the earthquakes had destroyed buildings, drugs and equipment. They also told how the functioning of birthing centres had been temporarily interrupted for several months leading to a reduced number of institutional delivery cases. However, in some facilities, for example in Melamchi, the number of women seeking institutional delivery services increased after the earthquakes due to the temporary shelter home established by donors.

Table 4.43: Effect of the Earthquakes (Sindhupalchowk)

	Frequency (n = 4)	Percent
Damage to physical infrastructure		
Yes	3	100
No	0	0
Damage to entire buildings		
Complete	2	66.7
Partial	1	33.3
No Damage	0	0.0
Damage to delivery rooms		
Complete	2	66.7
Partial	0	0.0
No Damage	1	33.3
Location of delivery room after the earthquakes		
Tent/ temporary shelter	2	66.7
Old building of the facility	1	33.3
Damage to equipment		
Complete	3	100.0
Partial	0	0.0
No damage	0	0.0
Damage to essential drugs for delivery services		
Yes	1	33.3
No	2	66.7
Received donated drugs after earthquakes		
Yes	3	100.0
No	0	0.0

4.4 Service Use Trend of the Maternity Hospital

Figures 4.1 and 4.2 show the total number of normal and caesarean section deliveries of women from the 13 earthquake affected districts at the central Maternity Hospital six months before and after the earthquakes. Figure 4.1 indicates that the total number of normal deliveries of women from Nuwakot, Gorkha and Dolakha districts slightly declined after the earthquakes. This might be due to medical services to manage normal deliveries being available in these districts after the earthquakes. It could also be possible that the earthquakes had created new geographical barriers preventing women from the most affected districts travelling to the Maternity Hospital in Kathmandu. On the other hand, there was no or very little in the situation relating to women from Bhaktapur, Dhading and Rasuwa after the earthquakes. It might be possible that women from these Bhaktapur and Dhading had decided to seek services in the hospital due to its geographical proximity.

Figure 4.1: Total Normal Deliveries at the Maternity Hospital by Women from Affected

District Before and After the Earthquakes

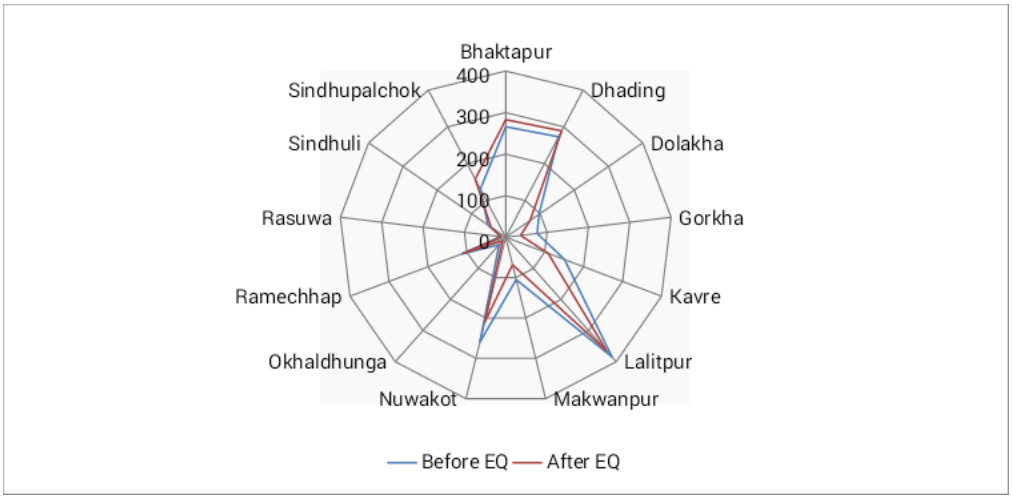
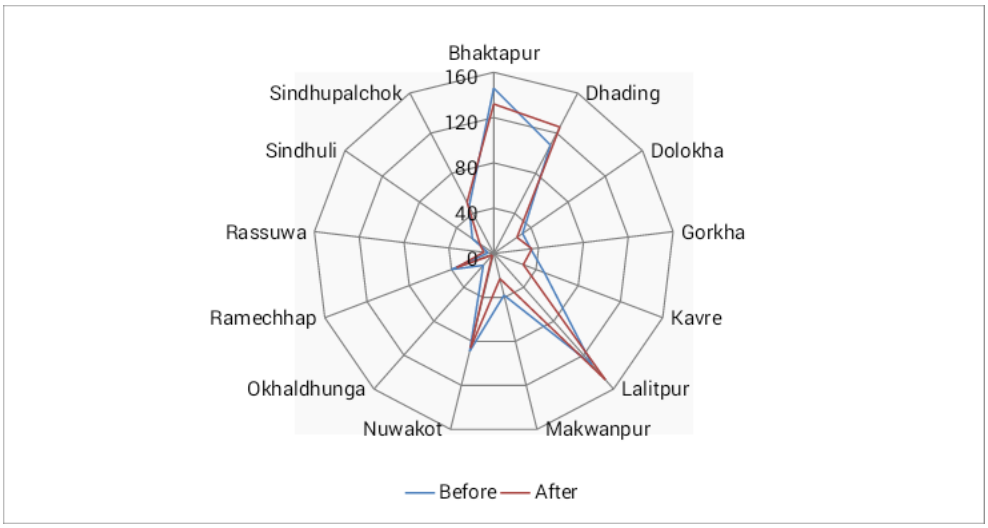


Figure 4.2 indicates that the number of caesarean section deliveries at the hospital remained almost the same by district of origin after the earthquakes. It could be possible that caesarean sections services were available at the higher-level facilities in the affected districts after the earthquakes.

Figure 4.2: Total Caesarean Sections in the Maternity Hospital by Women from Affected Districts Before and After the Earthquakes



4.5 Service Use Trend at Dhulikhel Hospital

Figures 4.3 and 4.4 show the total number of normal and caesarean section delivery cases at Dhulikhel Hospital by origin of women six months before and after the earthquakes. Figures 4.1 and 4.2 show only women from Bhaktapur and Sindhupalchowk using the hospital. The number of normal and caesarean section deliveries from Bhaktapur district slightly decreased after the earthquakes. It might be possible that women had decided to seek services within the district or higher level facilities in the adjoining districts. The data also shows a few referral cases from Bhaktapur district after the earthquakes. Interestingly, there was a sharp rise in

caesarean section cases from Lalitpur district after the earthquakes.

Figure 4.3: Total Number of Normal Deliveries in Dhulikhel Hospital by Women from Affected Districts Before and After the Earthquakes

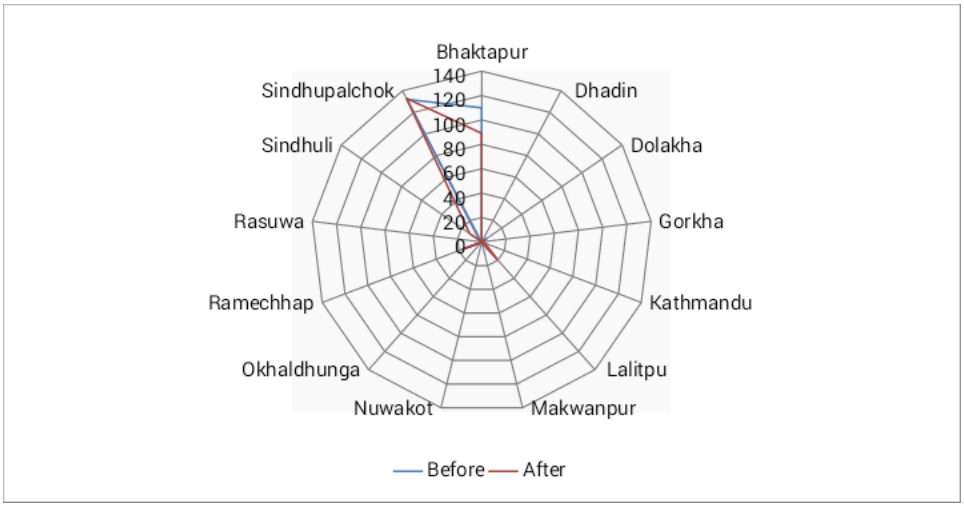
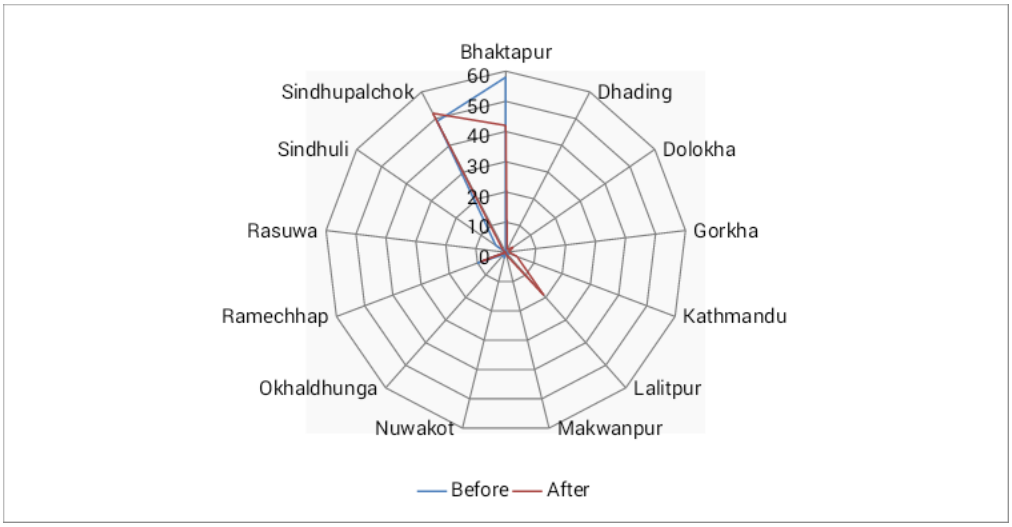


Figure 4.4: Total Number of Caesarean Section Deliveries in Dhulikhel Hospital by Women from Affected Districts Before and After the Earthquakes



5 CONCLUSIONS AND RECOMMENDATIONS

This chapter summarises the key findings from the Aama Programme stocktake assessment and planning workshops. These findings provide contextual understanding of Aama Programme implementation (the ***know-what*** of the situation). The conclusions and way forward are devised based on the ***know-what*** from the findings supported by the ***know-how*** from system experts.

5.1 Service Availability in 14 Earthquake-affected Districts

This sub section summarizes the effect of earthquakes on the availability and use of delivery services, and budget allocation to the Aama Programme.

a) The number of Aama Programme implementing health facilities (delivery services) had not changed much before and after the earthquakes. One probable explanations of this is that safe motherhood is a priority programme of the government and external development partners. Thus, prompt arrangements were made to restore delivery services in earthquake-affected health facilities as quickly as possible. However, the immediate effect of the earthquakes could not be ignored and as a result delivery services were interrupted for some time in facilities that were completely or partially damaged.
b) It is encouraging to note that service availability was ensured through immediate responses. At the same time it is critical to question the availability of services in the absence of basic support services. It is observed that even six months after the earthquakes there were still 49 facilities without separate delivery rooms, 42 facilities without electricity, drinking water and toilets, 36 facilities without equipment and furniture and 14 facilities were short of essential delivery care drugs. This indicates that services were available with some degree of compromise.
c) The numbers of SBA-trained nursing staff was found to have increased after the earthquakes. This could mainly be due to the regular training of nursing staff by FHD/NHTC.
d) The budget allocated for the Aama Programme in FY 2015/2016 has decreased from the previous year and the budget for the 4 ANC incentive has been severely cut. The decrease can be attributed to the limited budget absorption of the previous year (as this provides the basis for the following year's budget). Nevertheless, the effects of the earthquakes were evident as responses to earthquake-response-focussed programmes have been prioritized over regular priority programmes. This could be imposing important challenges to service providers and programme managers as an increasing number of women are coming for institutional delivery every year. It will be difficult to ensure service provision if budgets are insufficient to provide service as per the guidelines.
e) The number of women using delivery services decreased in the six months after the earthquakes. This may have been because many peripheral level institutions were damaged and services interrupted for some time. At the same time the earthquakes may have imposed new geographical barriers to women accessing institutional delivery services.

5.2 Implementation of Aama Programme Components in Health Facilities

This sub-section summarizes the implementation of Aama Programme components in

surveyed health facilities.

a) Some problems in relation to compliance with the guidelines were observed at many health facilities. This kind of situation is pertinent when there is a lack of understanding of the guidelines or the implementing agency is weak in monitoring and supervision as a result of which facilities implement their own versions of the programme. The free delivery component is the most misunderstood and non-uniformly implemented component across public and private facilities. Similarly, the 4 ANC component of the Aama Programme is only being partially implemented. The use of unit cost money and service provider incentives is an emerging issue which needs special attention. This indicates that serious programmatic actions need to be taken to clarify service provision under the programme and measure compliance against the guidelines. Policy discussions need to be initiated on whether or not to continue authorizing private facilities to implement the Aama Programme or revise this programme component.
b) Almost all the surveyed facilities were providing free delivery care. However, further information confirms that most of them were charging women in some way.
c) More than half of the surveyed health facilities had some form of damage to their delivery rooms caused by the earthquakes. However, many of them continued service delivery by operating under tents or in the existing or other buildings. Similarly, essential drugs for delivery were available in almost all facilities. This implies that immediate efforts from local communities and government and non-government partners had supported the restoration of delivery services. Nevertheless, this raises the important concern of how long services can continue to be delivered in an emergency situation. The restoration of permanent arrangements is needed to smoothen service delivery.
d) Some human resource mobility was observed after the earthquakes but it has not impacted service provision. This may be due to MoH's decision to retain health workers employed in the affected districts through incentives and performance appraisals. It might also be possible that the health workers in the affected districts felt ethical and humanitarian obligations to provide service in the aftermath of the earthquakes.
e) The earthquakes had no effect on the distribution of the Aama Programme budget. This was mainly because facilities had either already received their budgets for the last quarter of the year or were due to receive their budgets. However, there are continuing inherent problems in budget distribution in Nepal's public health system including delays in receiving budget and expenditure authorizations until part way through the first quarter, delays in budget release within districts and delays in physical and financial reporting by health facilities. This may have impacted the timely distribution of transport incentives to women. However, the earthquakes affected 24 hour service delivery in many facilities which will have hampered budget absorption. There was some effect of the earthquakes in relation to governance of the Aama Programme with many PHCCs and health posts not displaying the names of Aama beneficiaries due to a lack of space.
f) The earthquakes affected regular reporting on the Aama annexes. In a few facilities the Aama annex formats were destroyed while in others they were either used up or health workers were reporting late because they received no travel allowances to submit their reports.

5.3 Way Forwards

a) **Compliance against Aama Programme guidelines —** Almost all of the surveyed health facilities claimed to be providing free delivery care service. However, it was found that most were charging women in some way. In this situation, clear instructions, the distribution of the Aama Programme guidelines and strong monitoring is needed to ensure compliance. The earthquakes could have compromised local monitoring and in this context, FHD may need to design a specific monitoring mechanism such as monitoring by independent third parties.

b) **Harmonization of different policies —** The Aama Programme guidelines clearly stipulate the provision of free delivery care. To address local demands, FHD has started providing lump sums for blood transfusions. This indicates a policy intention to offer 100% free care; however, the assessment found that most of the health facilities were charging women giving the reason that HFMOCs had the authority to impose different forms of user fees. National level discussion is needed to address this policy contradiction. MoH needs to issue a uniform policy to assure the provision of fully free delivery care.

c) **Improved monitoring with improved reports —**The overall monitoring function of the Aama Programme implementing agency both at the centre and district is weak. Very few officials fill in the monitoring forms that are included in Aama Programme guidelines, and if filled up, there is no practice to follow-up on issues raised and recommendations. Those who are involved in monitoring do not write reports nor provide accurate feedback in facilities' visitors books. A monitoring instruction should be given to all involved in Aama monitoring. Officials should take along a copy of the Aama guidelines on every monitoring visit and ensure compliance against these guidelines.

d) **Rebuild infrastructure —** Many health facilities were offering delivery services even after they had sustained considerable damage to their physical infrastructure. However, in some facilities 24 hour services could not be restored. This raises an important concern regarding the quality of services offered in compromised conditions. These facilities need to be given priority for rebuilding as soon as possible or women will seek alternative options for delivery care resulting in increased out-of-pocket expenditure. Similarly, peripheral level facilities might lose confidence to attract women to receive care within their catchment areas.

6 ACTION PLANS

This chapter presents the action plan developed for Ramechhap, Dolakha and Sindhupalchowk districts to overcome shortcomings in the implementation of the Aama Programme in the aftermath of the earthquakes. These plans covers Aama Programme-related issues and suggestions identified by members of HFMOCs, service providers and DHO personnel during the district workshops.

Note the following:

- The proposed action plans are meant to be rolling documents for updating.
- Some of the issues identified by workshop participants have already been addressed. For example, Ramechhap district has issued a circular instructing health facilities to provide free delivery services and hand over transport incentives to women at the time of discharge.
- The plans also envisage activities that need ongoing commitment from FHD and MoH. The plans are thus budgeted based on the planning experiences of the members of the study team and previous district plans. The proposed budget are implicit. It is expected that FHD will gradually incorporate the proposed plans into its annual budget.

6.1 Methodology

Three one day district level planning workshops were organized in the selected study districts (Dolakha, Ramechhap and Sindhupalchowk) during February 2016. The workshops engaged service providers and active members of HFMOCs from Aama implementing health facilities to:

- discuss the implementation status of the Aama Programme in the district;
- identify implementation challenges faced by implementing facilities;
- determine ways forward in successfully implementing the programme; and
- explore local commitments to implementing the Aama Programme.

The planning workshops were organized and facilitated by the respective DHO/DPHOs with technical and administrative support from the study team. The list of participating facilities are included at Annex 3. Workshop participants were divided into small groups to reflect on implementation challenges faced by them and their facilities. The workshop discussions focused on the:

- distribution of incentives to women
- availability of free delivery services
- use of institutional unit cost
- reporting against Aama annex
- effect of the earthquakes.

The major issues discussed in the workshop were the implementation status of the Aama programme as per the guidelines and the effect of the earthquakes on providing delivery services. The workshops ended with group presentations and explorations of local commitments from participants. At the end of each workshop, participants developed action plans of tasks to carry out in the near future. Synthesized version of the plans are given in subsequent sections.

6.2 Dolakha District

The planning workshop in Dolakha was organized on 16 February 2016 at the district headquarters, Charikot. DHO chief Dr Madav Lamsal chaired the meeting. The DHO Aama focal person facilitated the workshop. Forty-eight participants participated in the development of the action plan. The workshop identified the following pertinent issues related to the Aama Programme.

a) Most health facilities were damaged by the earthquakes and services were being provided in tents.
b) Health services were temporarily interrupted following the earthquakes, but services were normalized after about one month. However, the quality of services was compromised.
c) In some health facilities, mothers were having to pay for delivery services.
d) Only a few health facilities provided transport and 4 ANC incentives to women at the time of discharge. It was reported that the delay in handing over incentive money was mostly due to late budget allocation and disbursement as well as the handling of incentive money by health facility in-charges.
e) Reporting on the Aama programme to the DHO was irregular.
f) HFMOCs were not clear about their role in the Aama Programme.
g) Client were having difficulties in receiving support money for the cost of travelling to referral hospitals in other districts (mostly Kabhre Palanchok and Kathmandu).
h) Very little funding was available for DHO monitoring visits.

Workshop objectives:

- To assure the availability of quality services in health facilities implementing Aama Programme
- To ensure free delivery care is available at all Aama implementing facilities within the district.
- To strengthen monitoring, reporting and drug supply system in Aama implementing health facilities.
- To enhance referral systems for providing comprehensive services for complicated deliveries and caesarean sections.

Table 6.1: Action Plan of Dolakha District (February 2016)

SN	Activities	Timeline	Responsibility	Means of verification	Budget (NPR)	Remarks
Objective 1: Ensure regular and quality services to women and children						
1.1	Reconstruct all damaged health facilities	ASAP	GoN/MoH	Building	Shared cost with DHO/FHD	
1.2	Provide all health facilities with necessary equipment	ASAP	DHO	Report		
1.3	Train new health workers and personnel on contract on quality of care for ANC,	March 2016 onwards	DHO/FHD	Training Report	5,000 X 40 = 100,000	Estimated 20 participants

SN	Activities	Timeline	Responsibility	Means of verification	Budget (NPR)	Remarks
	PNC, counselling and delivery					
1.4	Supply stretchers to health facilities in inaccessible VDCs for timely transport of women in labour	April 2015 onwards	DHO	Availability of stretchers	1,000 X 22 = 22,000	
Objective 2: Ensure the provision of Aama Programme for free delivery care						
2.1	Send an instructive letter to all Aama health facilities to provide free delivery services	March 2016	DHO	Letters received		
2.2	Provide transport and 4 ANC incentives to all mothers at time of discharge	March onwards	HFs	Report		
2.3	Orientate HFMOC members and service providers on Aama Programme guidelines	March onwards	DHO/FHD	Report	5,000 X 22 = 110,000	
2.4	Send Aama Programme guidelines to all health facilities	March	DHO/FHD	Availability of guidelines		
2.5	Allocate advance money to nursing staff for timely distribution of incentives to mothers	March onwards	HFMOCs/HFs	Report		
Objective 3: Strengthen monitoring, reporting and drug supply system						
3.1	Increase monitoring visits to ensure proper implementation of Aama Programme and to support quality assurance of delivery services	April 2016 onwards	DHO	Report	5,000 X 22 = 110,000	
3.2	Regularize timely and complete reporting of delivery services (by seventh day of each month)	April onwards	HFs	Reports available at DHO		
3.3	Supply drugs and equipment to all	April onward	DHO	No stock-out		

SN	Activities	Timeline	Responsibility	Means of verification	Budget (NPR)	Remarks
	health facilities regularly	s		situation (LMIS)		
Objective 4: Enhance services for delivery care and referral						
4.1	Start caesarean section services at Charikot PHCC	ASAP	DHO/FHD	Service availability		Service has already been extended and is under operation
4.2	Instruct hospitals to provide free delivery services as per Aama Programme guidelines	ASAP	FHD/MoH	Instruction letter		
4.3	Train health workers on quality ANC and PNC services and counselling	July 2016 onwards	FHD/DHO	Training report	5,000 X 22 participants per facility = 110,000	
4.4	Facilitate the contracting of SBAs in first month of each fiscal year	July onwards	FHD/DHO	Contract letter	*	
Objective 5: Enhance governance and referral system for providing comprehensive services						
5.1	Supply ambulances to major health facilities to enable timely referrals	July 2016 onwards	MoH	HFs have ambulances	1,000,000 X 5 = 5,000,000	Estimated 5 facilities with road access
5.2	Develop guidelines for referrals (based on experiences of two earthquake-affected districts)	July onwards	DHO/FHD	guidelines		
5.3	Display name lists of mothers who receive transport and 4 ANC incentives	March onwards	HFMOCs	Lists displayed	-	
5.4	HFMOCs to meet regularly and review progress of Aama Programme and incentive distribution	March onwards	HFMOCs	Meeting minutes	3,000 X 22 = 66,000	

6.3 Ramechhap District

The planning workshop in Ramechhap was held on 14 February 2016 at the district headquarters, Manthali. DHO chief, Dr Prakash Shah chaired the meeting and the DHO Aama focal person facilitated the workshop. Fifty-six participants participated in developing the action plan. The workshop identified the following pertinent issues related to the Aama Programme:

- Delays in paying travel and 4 ANC incentives to mothers by a few health facilities.
- Not every health facilities displayed the name list of mothers receiving travel and 4 ANC incentives.
- Low levels of knowledge of the Aama Programme guidelines, especially among HFMOC members and some service providers.
- Not all mothers were receiving free delivery care as per the Aama Programme guidelines.
- Irregular reporting of services to the DHO.
- Weak mechanism for monitoring the Aama Programme.
- Stretchers were not available in many inaccessible villages to transport women in labour to health facilities.

Workshop objectives:

- To ensure the provision of free delivery care at all level of Aama implementing facilities in the district.
- To ensure transparency of the health facilities in relation to managing Aama programme activities.
- To assure the availability of quality service in health facilities implementing the Aama Programme.
- To ensure the availability of women-friendly services in Aama implementing health facilities in the aftermath of the earthquakes.
- To enhance the referral system for providing comprehensive services for the complicated deliveries and caesarean section cases.

Table 6.2: Action Plan of Ramechhap District (February 2016)

	Activities	Timeline	Responsibility	Means of verification	Budget (NPR)	Remarks
Objective 1: Ensure the provision of free delivery care at all level of facilities						
1.1	Send an instructive letter to all Aama health facilities to provide free delivery services	March 2016	DHO	Letter received	Shared cost with FHD/DHO	Letters sent from DHO (Annex VIII)
1.2	Provide transport and 4 ANC incentives to all mothers at time of discharge	March onwards	HFs	Report		
1.3	Orient HFMOC members and service providers on Aama Programme	March onwards	DHO/FHD	Report	NPR 5,000 X 26 = 130,000	

	Activities	Timeline	Responsibility	Means of verification	Budget (NPR)	Remarks
	guidelines					
1.4	Send Aama Programme guidelines to all health facilities	March 2016	DHO/FHD	Availability of guidelines	5,000	
1.5	Allocate advance money to nursing staff for timely distribution of incentives to mothers	March onwards	HFMOCs/HFs	Report		
Objective 2: Ensure transparency of the Aama programme activities						
2.1	Display lists of names of mothers receiving transport and 4 ANC incentives	March 2016 onwards	HFMOCs	Lists are displayed		
2.2	HFMOCs to meet regularly and review progress of Aama Programme and incentive distribution	March onwards	HFMOCs	Meeting minutes		Already reflected in 2014/15 AWPB
Objective 3: Assure quality service and enhance the capacity to monitor activities						
3.1	Increase number of monitoring visits to ensure Aama Programme and to support quality assurance of delivery services.	April onwards	DHO	Report	3,000 X 26 = 78,000 per year	
3.2	Regularize timely and complete reporting of delivery services (by seventh of each month)	April onwards	HFs	Reports available at DHO		
3.3	Supply drugs and equipment to all health facilities regularly	April onwards	DHO	No stock-out situations (LMIS)		
3.4	Supply stretcher to health facilities in inaccessible VDCs for timely transport of women in labour	February 2016	DHO	Availability of stretchers	1,000 X 26 = 26,000	
Objective 4: Ensure quality and friendly services to mothers and children in the aftermath of the earthquakes						
4.1	Rebuild all health facilities damaged by the earthquakes	ASAP	GoN/EDPs	Construction reports		Being looked after by MoH and Reconstruction Authority
4.	Supply necessary	ASAP	GoN/EDPs	Supply		Being looked

	Activities	Timeline	Responsibility	Means of verification	Budget (NPR)	Remarks
2	equipment to health facilities			reports		after by MoH and Reconstruction Authority
4.3	Train health workers on quality ANC and PNC services and counselling	July 2016 onwards	FHD/DHO	Training reports	5,000 X 26 participants from each birthing centre = 130,000	Number of participants estimated at 26 per training
4.4	Facilitate the contracts of SBAs in first month of each fiscal year	July onwards	FHD/DHO	Contract letters		
Objective 5: Enhance referral systems for providing comprehensive services						
5.1	Supply ambulances to major health facilities for timely referrals	July 2016 onwards	MoH	Number of health facilities with ambulances	1,000,000 X 5 facilities = 5,000,000	Five facilities estimated to have road access
5.2	Develop guidelines for referrals (based on experiences from two earthquake-affected district)	July onwards	DHO/FHD	Guidelines produced	1,500,000	One-off activities. Two workshops with participation from hospitals and RHD

6.4 Sindhupalchowk District

The planning workshop in Sindhupalchowk district was held on 18 February 2016 in the district headquarters, Chautara. The Senior public health officer, Ms Mangala Manandhar chaired the meeting. The DHO Aama focal person facilitated the workshop. Fifty-three participants participated in developing the action plan. The workshop identified the following pertinent issues related to the Aama Programme:

- Not all health facilities providing transport and 4 ANC incentives at time of discharge.
- Delivery services compromised by being provided in tents with only a few delivery instruments.
- Irregular reporting of delivery services.
- Only a few ambulances being available in the district makes timely referral challenging.
- Private hospitals not very keen to offer free delivery services.
- Advance money not given to nurses at a few health facilities and so, handing over incentives to mothers at time of discharge is difficult.
- Members of HFMOCs are poorly informed about their role in the Aama

Programme.

Workshop objectives:

- To ensure the provision of free delivery care at all levels of Aama implementing facilities in the district.
- To ensure transparency of the health facilities in relation to the management of Aama programme activities.
- To assure the availability of quality service in health facilities implementing the Aama Programme
- To ensure the availability of women-friendly services in Aama implementing health facilities in the aftermath of the earthquakes.
- To enhance the referral system for providing comprehensive services for complicated deliveries and caesarean section cases.
- To engage with private health facilities to promote public-private partnerships for implementing the Aama Programme

Table 6.3: Action Plan of Sindhupalchowk District (February 2016)

SN	Activities	Timeline	Responsibility	Means of Verification	Budget	Remarks
Objective 1: Ensure the provision of Aama Programme Guidelines						
1.1	Issue instructive letters to health facilities to comply with Aama guidelines	March 2016	DHO	Letters received	Shared cost with DHO/FHD*	
1.2	Provide transport and 4 ANC incentives to all mothers at time of discharge	March onwards	HFs	Report		
1.3	Orient HFMOC members and service providers on Aama Programme guidelines	March onwards	DHO/FHD	Report	5,000 X 22 = 110,000	
1.4	Send Aama programme guidelines to all health facilities	March 2016	DHO/FHD	Availability of guidelines		
1.5	Instruct in-charges to give advance money to nursing staff for timely distribution of incentives to mothers	March onwards	HFMOCs/HFs	Report		
Objective 2: Ensure transparency of the Aama programme activities						
2.1	Display name lists of mothers	March 2016	HFMOCs	Lists displayed	2,000 X 22 = 44,000	

SN	Activities	Timeline	Responsibility	Means of Verification	Budget	Remarks
	receiving the transport and 4 ANC incentives	onwards				
2.2	HFMOCs meet regularly and review progress of Aama Programme and incentive distribution	March onwards	HFMOCs	Meeting minutes	3,000 X 22 = 66,000	
Objective 3: Assure quality service and enhance the services						
3.1	Train health workers on quality ANC and PNC services and counselling	July 2016 onwards	FHD/DHO	Training report	5,000 X 22 (participants) = 110,000	Number of participants expected to be 22
3.2	Facilitate the contracting of SBAs in the first month of each fiscal year	July onwards	FHD/DHO	Contract letters		
Objective 4: Ensure quality and friendly services to mothers and children in aftermath of the earthquakes						
4.1	Rebuild all health facilities damaged by the earthquakes	ASAP	GoN/EDPs	Buildings		Shared cost with MoH
4.2	Supply necessary equipment to all health facilities	ASAP	GoN/EDPs	Equipment available		Shared costs with MoH
4.3	Supply ambulances to major health facilities	July onwards	MoH/FHD	health facilities have ambulances	10,00,000 X 5 = 50,00,000	Estimated 5 facilities have road access
4.4	Network with referral hospitals in other districts for timely services	July onwards	DHO			
Objective 5: Enhance reporting and monitoring of Aama Programme						
5.1	Report the provision of delivery services timely and completely (by seventh day of each month)	April 2016 onwards	HFs	Reports available at DHO		
5.2	Increase monitoring visits for proper implementation of Aama	April onwards	DHO	Report	5,000 X 22 = 110,000	

SN	Activities	Timeline	Responsibility	Means of Verification	Budget	Remarks
	Programme and support quality assurance of delivery services					
Objective 6: To enhance public-private partnerships to implement the Aama Programme						
6.1	Strengthen capacity of private hospitals to provide free delivery services through meetings and training	July 2016 onwards	DHO/FHD	Training report, meeting minutes	20,000 X 2 = 40,000	
6.2	The timely reimbursement to health facilities of costs incurred in providing free delivery services	July Onwards	DHO	Report		

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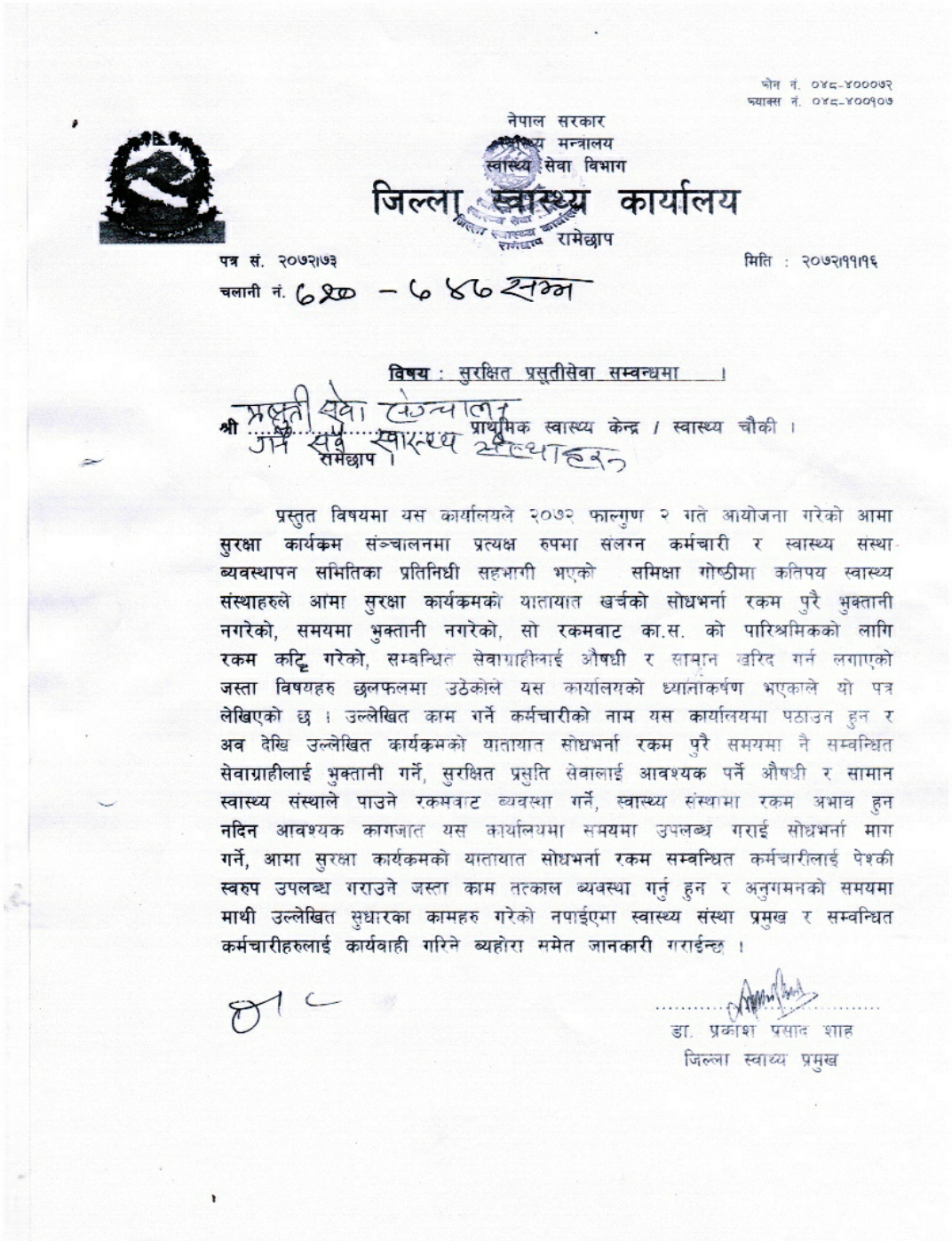
Annex 1: Study Enumerators

	Name	Education
1	Susila Kumari Joshi	Nursing, ANM
2	Purnima Chand	Nursing
3	Ruchi Singh	BPH, health assistant
4	Ashma Joshi	Nursing
5	Bishwa Shanti Dakal	Nursing, ANM
6	Bed Parsad Regmi	Health assistant
7	Deepa Nepal	Nursing
8	Bishesta Ghimire	Nursing
9	Anurada GC	MBA
10	Balaram Adikari	BBA
11	Sandip Dakal	BBS
12	Kamala Pandit	BBA
13	Ashish Ghimire	Master in Economics

Annex 2: Circular from Ramechhap DHO



फोन नं. ०४८-४००७२
फ्याक्स नं. ०४८-४००१०७

नेपाल सरकार
स्वास्थ्य मन्त्रालय
स्वास्थ्य सेवा विभाग

जिल्ला स्वास्थ्य कार्यालय

रामेछाप

पत्र सं. २०७२।७३ मिति : २०७२।११।१६

चलानी नं. ६४० - ६४६ सम्म

विषय : सुरक्षित प्रसूतीसेवा सम्वन्धमा ।

श्री प्रसूती सेवा सञ्चालन गर्ने सबै स्वास्थ्य संस्थाहरु प्राथमिक स्वास्थ्य केन्द्र / स्वास्थ्य चौकी ।
रामेछाप ।

प्रस्तुत विषयमा यस कार्यालयले २०७२ फाल्गुण २ गते आयोजना गरेको आमा सुरक्षा कार्यक्रम संञ्चालनमा प्रत्यक्ष रुपमा संलग्न कर्मचारी र स्वास्थ्य संस्था व्यवस्थापन समितिका प्रतिनिधी सहभागी भएको समिक्षा गोष्ठीमा कतिपय स्वास्थ्य संस्थाहरुले आमा सुरक्षा कार्यक्रमको यातायात खर्चको सोधभर्ना रकम पुरै भुक्तानी नगरेको, समयमा भुक्तानी नगरेको, सो रकमवाट का.स. को पारिश्रमिकको लागि रकम कट्टि गरेको, सम्वन्धित सेवाग्राहीलाई औषधी र सामान खरिद गर्न लगाएको जस्ता विषयहरु छलफलमा उठेकोले यस कार्यालयको ध्यानाकर्षण भएकाले यो पत्र लेखिएको छ । उल्लेखित काम गर्ने कर्मचारीको नाम यस कार्यालयमा पठाउन हुन र अव देखि उल्लेखित कार्यक्रमको यातायात सोधभर्ना रकम पुरै समयमा नै सम्वन्धित सेवाग्राहीलाई भुक्तानी गर्ने, सुरक्षित प्रसुति सेवालाई आवश्यक पर्ने औषधी र सामान स्वास्थ्य संस्थाले पाउने रकमवाट व्यवस्था गर्ने, स्वास्थ्य संस्थामा रकम अभाव हुन नदिन आवश्यक कागजात यस कार्यालयमा समयमा उपलब्ध गराई सोधभर्ना माग गर्ने, आमा सुरक्षा कार्यक्रमको यातायात सोधभर्ना रकम सम्वन्धित कर्मचारीलाई पेश्की स्वरुप उपलब्ध गराउने जस्ता काम तत्काल व्यवस्था गर्नु हुन र अनुगमनको समयमा माथी उल्लेखित सुधारका कामहरु गरेको नपाईएमा स्वास्थ्य संस्था प्रमुख र सम्वन्धित कर्मचारीहरुलाई कार्यवाही गरिने व्यहोरा समेत जानकारी गराईन्छ ।

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डा. प्रकाश प्रसाद शाह
जिल्ला स्वास्थ्य प्रमुख

Annex 3: Participating Health Facilities in the Aama Programme Planning Workshop

Dolakha	Ramechhap	Sindhupalchowk
District (Public) Health Office	District (Public) Health Office	District (Public) Health Office
District Hospital Dolakha (Jiri)	Manthali PHCC	Sindhupalchowk District Hospital
Suri PHCC	Khimti PHCC	Bharabise PHCC
Charikot PHCC	Gelu PHCC	Jalbire PHCC
Namdu Health Post	Bamti Health Post	Melamchi PHCC
Phasku Health Post	Betali Health Post	Tatopani Health Post
Gogar Health Post	Bhirpani Health Post	Dadapakhar Health Post
Khopachangu Health Post	Bhuji Health Post	Devisthan Health Post
Laduk Health Post	Doramba Health Post	Lisankhu Health Post
Melung Health Post	Gunshi Health Post	Piskar Health Post
Bocha Health Post	Kathjor Health Post	Selang Health Post
Dolakha Health Post	Puranagau Health Post	Banskharka Health Post
Magapouwa Health Post	Saghutar Health Post	Bhimtar Health Post
Jhule Health Post	Those Health Post	Nawalpur Health Post
Chankhu Health Post	Salu Health Post	Sindhukot Health Post
Aalampu Health Post	Bijulikot Health Post	Badegaun Health Post
Bhirkot Health Post	Nagdaha Health Post	Bhotsipa Health Post
Babare Health Post	Pharpu Health Post	Dubachour Health Post
Kavre Health Post	Kubhukasthali Health Post	Lagarche Health Post
Chyama Health Post	Namadi Health Post	Barahbishe Health Post
Pabati Health Post	Khaniyapani Health Post	Thulosirubari Health Post
Jhyaku Health Post	Hildevi Health Post	Thokarpa Health Post
Syama Health Post	Okhreni Health Post	Phulpingdada Health Post
	Deurali Health Post	
	Gothgau Health Post	
	Prittee Health Post	
	Ramechhap District Hospital	