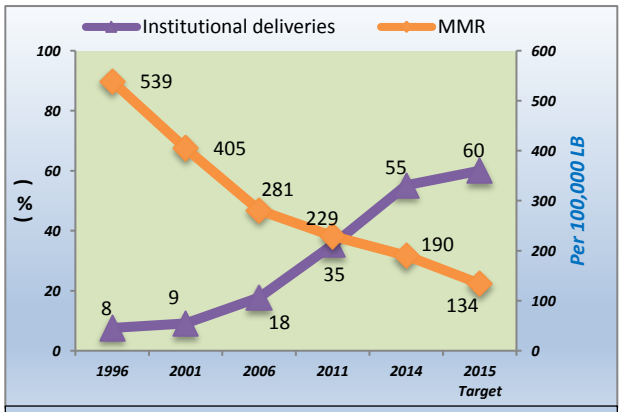

# Implementation of Aama Programme in Post Earthquake Situation

## (FHD)

## Implementation of Aama Programme in Nepal's Post-Earthquake Situation[1]

### 1. Aama Contributed Better Results through Health Systems Strengthening

Twenty years ago in Nepal one woman every two hours used to die from pregnancy related conditions. Pregnancy and child birth was considered as ordinary event in a woman's life requiring no clinical interventions. A woman had no choice but to deliver at home and should the complication arises death was the only end. Women in pregnancy, child birth and post-partum are always at risk of complications which can result in unintended death. Today, women in Nepal are aware of reproductive choices. They can plan when to give birth and what to do if the baby is unwanted. Women can choose where to deliver in a nearby health post, district hospital or tertiary care hospitals without being worried of the cost of care. Aama is a programme for all Nepali women regardless of their income, caste, ethnicity and geographical locations.




*Source: NFHS 1996, NDHS 2001-2011 MICS 2014, UN estimate 2014*

Millions of women so far have enjoyed the state benefit of free delivery care and transport incentive. A decade back, delivery services were limited to a few hundreds of health facilities but now delivery services have been made available in more than 2000 public health facilities across the country. Services are reaching closer to where women live. As a result, increasing number of women from mountain, hill and tarai areas now have improved access to services. This indicates that the Nepali health system is increasingly showing its capacity to leave no one behind. Nepal has become one of the countries to be on track to improve maternal health outcomes. However, the Gorkha earthquake of April 2015, raised serious concerns around ***'halting or probably reversing'*** the present day momentum in maternal health. The 7.8 magnitude earthquake claimed nine thousand lives and left 22,000 injured. The ability of the health care delivery system to respond to basic healthcare needs was severely affected

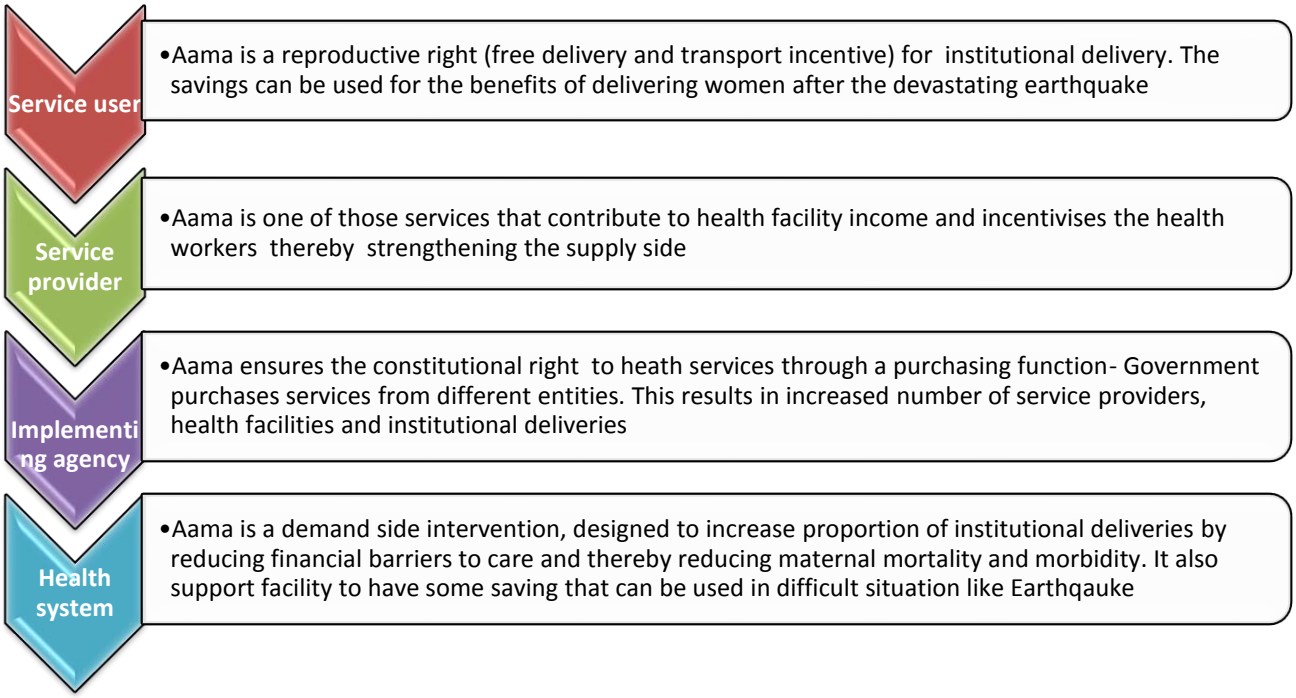
> ***We (women) nowadays have more benefits than ever before…we receive incentive for transport, free delivery care, cloths for babies…there were no such provisions in my mother's/mother in laws time! I also received transport incentive and free care after devastating Earthquake-A woman from Dolakha***

[1] ***Bhatt Hema, Tiwari S and Sharma S (2017). Implementation of Aama in Nepal's Post Earthquake Situation. FHD, NHSSP, Kathmandu Nepal.***

by the destruction of 1,227 health facilities. Service users, researchers, managers and implementers raised questions on the capacity of Ministry of Health (MoH) in disaster planning and financing. Would the financing of priority interventions be compromised in the fiscal year (FY 2015/16) given only 5.29% allocation of the national budget to MoH post-earthquake? However, Nepal Health Sector Support (NHSSP) supported MoH through evidence generation, engaging implementers in preparing action plans and ensuring Aama budget in annual work plan and budget (AWPB). Consequently, unlike many interventions that failed to secure financing in the FY 2015/16, Aama (well owned by Government of Nepal) was able to secure required financing in Nepal's post – earthquake situation. This case study begins with introducing Aama: how and when it started, how policies evolved, how it is financed, what are the achievements and finally unpacks the story behind securing required budget in the post-earthquake situation.

## 2. What is Aama?

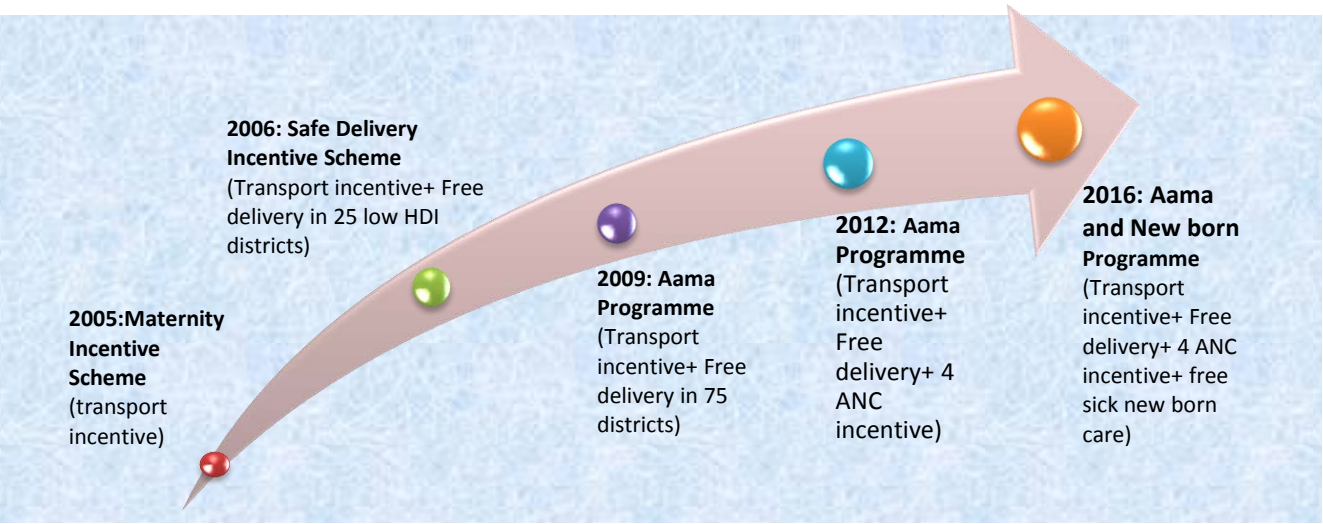
Aama has different definitions/ understanding for different levels of the system.




## 3. Aama is a Best Example of Evidence Based Policy Development and Implementation

In July 2005, the Government of Nepal launched Aama named as the Maternity Incentive Scheme (MIS) (FHD, 2005) following a study that suggested that costs associated with delivery were discouraging women from having institutional delivery; reaching a facility accounted for around two-thirds of these costs (Borghi et al., 2006). Women were entitled to receive a share of the transport cost to reach health facilities NPR. 1,500 in mountain,

NPR. 1,000 in hill and NPR. 500 in tarai. MIS was further revised as the Safe Delivery Incentive (SDIP) in 2006 with the addition of free institutional delivery services in 25 districts with low human development index (FHD, 2006).

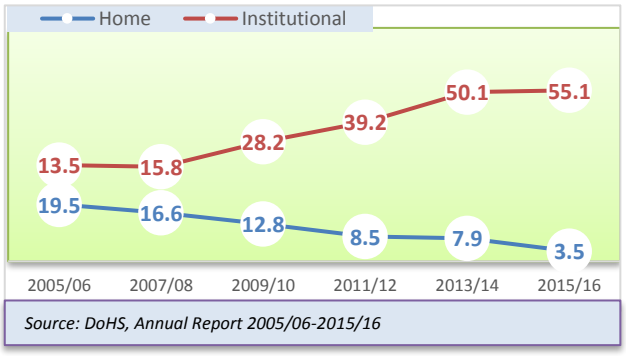



The programme further progressed to become the Aama in January 2009, characterized by the removal of user fees for all types of deliveries (FHD, 2009). In 2012, the 4 ANC incentives, which provided cash incentives to women for completing four ANC visits, was merged with Aama (FHD, 2012). Again in 2016, the free new born care programme was incorporated into Aama programme making it the Aama and New Born Care programme (FHD, 2016). Before the birth of Aama, the Nepalese health care delivery system had already tested demand side financing (DSF) intervention some 25 years ago in the form of incentive for family planning sterilization. Many DSF s proliferated around 2005. In 2008 the National Free Drug programme was initiated which ensured the provision of free drugs including those required during delivery such as oxytocin, gentamycin and Magnesium Sulfate (MgSO4). With the introduction of Aama in 2009, health facilities started receiving reimbursement for delivery care in addition to the drugs for delivery from the Free Drug. Each DSF scheme is implemented with its own objective however an important policy question will be how to better harmonize different schemes and ensure allocative efficiency. NHSSP has been providing technical support to Ministry of Health (MoH) in having better understanding of policy messages from relevant studies, writing management notes to improve implementation and revising the policies to ensure allocative efficiencies and bring value for money. Health care delivery systems generally struggle to regularize the basic health care system in aftermath of an earthquake, however, ***Nepal has set an impressive example of ensuring an enhanced policy integration immediately after the earthquake situation.*** The integration of Aama together with the New Born guidelines in post EQ situation (2016) is an example that illustrates the seriousness of publically implemented programmes in assuring the achievement of national targets and international commitments. The integration of the two programmes will

contribute in saving the time of health workers during planning, budgeting, monitoring and reporting. It also contributes in reducing bureaucratic transaction costs, strengthening communication and improving the use of maternal health care delivery system in Nepal.

### 4. Achieving the Unusual from a Publicly Funded Programme

Global studies have raised the questions on the success of publically funded programmes implemented through national systems. Aama comes with the answer that publically implemented programmes can work and are able to not only achieve the usual targets but also reach unusual levels of achievement. Aama in Nepal was meant to increase demand but it has also contributed in strengthening the supply side function of Nepali maternal health care delivery system. Before Aama the institutional delivery in Nepal was 9 percent (NDHS, 2001) which has increased by more than six fold by the year 2016. It is one of the biggest DSF schemes in the South Asia with an annual turnover of USD 10 million. Aama is highly regarded as an innovative health financing scheme managed by the public sector. As a result Aama received ***Resolve award for financing in 2012***. The award presented by the global leaders council for reproductive health (available at: http://www.who.int/pmnch/media/news/2012/20120522_resolve_award_flyer.pdf )



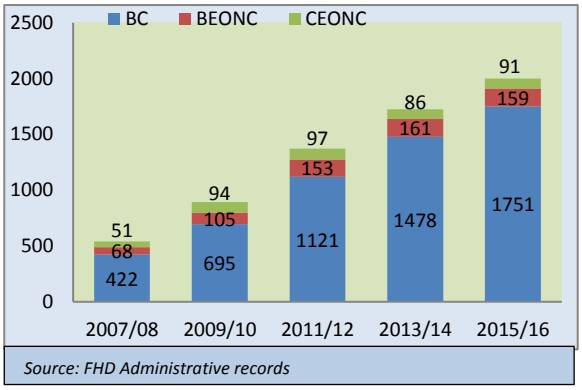

### 4.1 Nearly 2 Million Nepali Women have Benefitted from Aama

The Aama programme is encouraging women to visit health facilities and use safe delivery services. As evident in the above figure, the number of institutional deliveries has increased more than four times in the last seven years and the number of women giving birth at home has halved.

A total of 1.92 million women have received the free delivery care and transport incentive so far. The Household Survey in 2012 revealed that 91 percent of entitled women had received transport incentive and 87 percent women who delivered in a health facility had received the service free of cost (MoH, 2012).

### 4.2 Aama Contributed in Bringing 24/7 Delivery Services Closure to Nepali Women

In order to function as a birthing center, the Aama guideline sets provisions for minimum standards. Aama also facilitated in leveraging local ownership by making health facility management committee (HFOMC) responsible to manage the Aama budget. This served as a stepping stone to strengthen partnership with local government including District Development Committee (DDC) and Village Development Committee (VDC). Sustainable support from local government started coming in the form of capital budget such as building a delivery room, providing the birthing table or recurrent budget such as hiring a nursing staff. Support from the local government became instrumental in starting delivery services in many sub/health posts across the country ensuring the provision of around o'clock delivery services. Over the years, the number of health facilities providing delivery care has increased from 541 in FY 2007/08, 894 in FY 2009/10, 1371 in FY 2011/12, 1725 in 2013/14 and 2001 in FY 2015/16. Especially the lower level of health facilities providing delivery care has drastically increased from a few hundred to more than two thousand, moreover the trend of increasing number of lower level health facilities continued after the earthquake. This has facilitated service accessibility and availability in hard-to-reach areas resulting in improved acceptance of public health services. The demand from lower level health facilities to start an Aama program is relatively high because the Aama guidelines allow the health facility to keep the money they gain in their bank account that can be used in future. It is important to note that generally speaking in the government system any Treasury money that is unspent goes back to central Treasury.

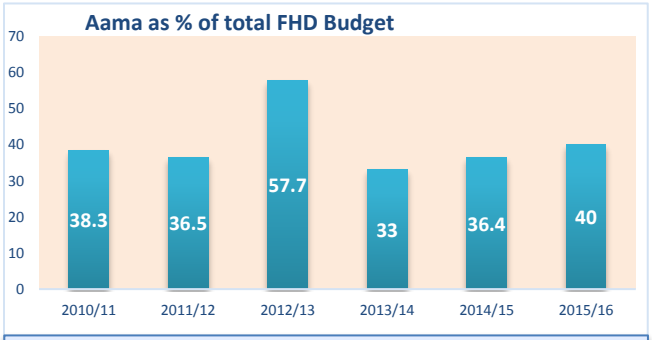



Aama not only contributed in harmonizing the relationship with local government but also reformed the health care delivery system by bringing health services closer to where women live. Increase in the number of health facilities was made possible by continuous policy dialogue at the national level. Aama also provides an example of engaging the private sector to implement a publicly funded programme. In the present context, 58 non-state partners are implementing Aama across the country. Economic principle suggests that it is the market that determines the price and if actors are willing to provide services at the cost, more and more actors should be invited to provide services**.** It was assumed that Aama would initiate competition in providing quality care. Many private actors are implementing Aama as a part of their corporate social responsibility. Some are attracted to implement Aama in order to have enough cases for teaching/learning activities and make indirect gains from future engagement with the facility. The private sector has acted as an entity to share the increasing demand for

delivery services. ***Aama has been successful in harmonizing the public private partnership in providing delivery care in Nepal***.

### 4.3 Aama Started with DFID Support: Now Fully Owned by Ministry of Health

Aama initially started with 100% financing from Department for International Development (DFID). By 2010/11 Aama was able to secure financing from both the government and the pooled donors. Aama is an example of a donor support becoming completely institutionalized into the system and owned by the government. Aama has been able to secure sustainable financing from government sources over the years. As seen in the bar graph, Aama alone holds significant portion of the FHD's total budget. Depending upon the total budget allocated for FHD in different years, Aama shares a significant portion ranging 33 to almost 58 percent. It should also be noted that the budget allocated for Aama is incremental in nature. In FY 2015/16 FHDs budget decreased by 9 percent compared to FY 2014/15. This would mean that the budget for priority programmes may have been compromised however Aama still manage to secure required budget in FY 2015/16. In absolute terms the budget might appear reduced by 3.08 percent as compared to FY 2014/15 however in real terms the budget was more than sufficient to enable 85 percent absorption. The policy level advocacy and increase in uptake of institutional deliveries has been the key factor for the Aama to obtain sustained and increased financing over the years. In FY 2015/16, NHSSP, using Transaction Accounting and Budget Control System (TABUCS) supported MoH to capture the need of additional funding requirement to Family Health Division (FHD). As a result FHD received NPR 15 million which was sufficient to cover the increased cost due increased cases from EQ affected districts going to Maternity, Bhaktapur and Dhulikhel hospitals.



*Source: FHD AWPB FY 2010/11-FY2015/16*

### 4.4 Improved Absorptive Capacity

In 7 years of implementation (2009/10-2015/16), NPR 6.57 billion has been allocated for health facility reimbursement and transport incentive under Aama . In an average FHD has absorbed more than 85% of the allocated budget, which is higher than the budget absorption capacity overall of the Ministry of Health. Aama sets a best example

> ***"There is no problem with absorption of Aama budget….It is the only family health programme which so far has very good absorptive capacity, as a result, MoF is happy to allocate the required budget."- DoHS, Finance*** **Section**

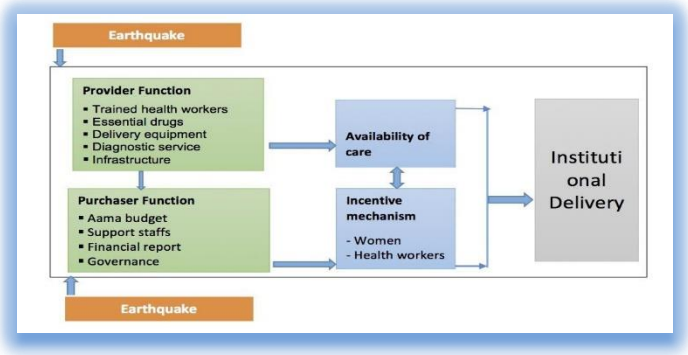
in terms of improved absorptive capacity in a publicly implemented programme. This is one of the reasons that the programme was not deprived of funding in the aftermath of the Gorkha EQ.

## 5. Resourcing Aama in Post-Earthquake: Aama Secured the Budget in Highly Affected Districts

There was a serious concern among the MoH divisions regarding financing of the ongoing Priority One programmes like Aama in the post-earthquake situation. Basic services were interrupted for some time however quickly restored as a part of the emergency response. Although services were restored, due to earthquake damage in many cases they were operating in the absence of basic support systems such as absence of separate delivery room, electricity, water, toilet, shelter and some were even short of essential drugs for delivery. There was speculation that some form of compromised budget would be allocated as the post-earthquake overall reconstruction response became a priority for the government. It was felt that evidence was required to understand and document the effect of the earthquake on Aama implementation so as to ensure required budget in the Annual Work Plan and Budget (AWBP). A management survey or stock-take of the Aama in 14 earthquake affected districts was thus designed and implemented to capture the status of Aama and compare it with the key indicators from the previous year.

### 5.1 Supply Side Functions are Essential

The Aama 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 is considered as a broad system that provides the right mix of provider functions. The earthquakes affected all the provider functions of the Aama. The stock take assessment questioned for example, whether 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. Some degree of compromise was inevitable with the need to resume service in the disaster situation. In some places the delivery services were provided from tents, temporary shelters or even a local's house and on a normal bed. The health workers' dedication and commitment to ensure service provision in such a crisis situation was commendable.



### 5.2 Local Support and Mobilisation of Aama Funds

At the local level, rapid response teams were responsible for the immediate response, local resource sharing, resource mobilization, communication 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 stock-take assessment study explored the availability of formal structures and plans to address local needs. The support from international agencies, foreign medical team and the government supply system were available at the local level. However, there was no specific and systematic plan that addressed local needs. The study observed impressive informal systems and response culture that are not reflected in any official plans or reports. These informal systems and cultures were very productive in supporting outsiders (who came to help) and mobilizing locally available resources.

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 sufficient stocks. About 12 health facilities from Sindhupalchowk, Dolakha and Ramechhap had provided blankets, cloths and foods supports to women who were delivering. The saving from the Aama facility reimbursement was used to provide such practical support. NHSSP encouraged the local health facilities to use the saving for the delivery purpose. The support included helping them understand the mandates of Aama guidelines, keeping the record of management committee's decision and maintaining the financial records for audit purpose. This was a great help for the women delivering from EQ affected districts. It was discussed during the process of developing the AWPB. This was one of the powerful messages from the implementation level which contributed in continuing the required Aama funds from within the FHD AWPB.

> *I cannot be so selfish even thinking about going home! This is the time people need health worker. They are giving me safe place and food!-AHW, Ramechhap*

### 5.3 Central and Districts Level Support

MoH formed national and local committees to respond to the effects of the earthquakes. The committees under MoH were particularly 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. At the district level, 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 emergency response plans available to address specific district needs and to guide the response. DHOs and DPHOs thus had the additional work burden of managing the support system and facilitating harmonisation of external support. The district teams had not been trained to manage resources in this kind of disaster situation.

**Key Highlights from Stock take Assessment in 14 EQ affected districts**

- Number of health facilities providing Aama did not change;
- Health facilities could not operate 24 hours;
- Health facilities were providing services in the absence of basic logistic and infrastructure support and as a result quality of services may have been compromised;
- Delivery services were immediately interrupted however quickly restored; resuming Aama did not take long;
- There was a minimal reduction of 6.5% in budget for health facility reimbursement and transport incentive and 41% reduction in 4 ANC incentive; and
- Human resources were available and providing services

In fact the earthquakes were found to have had a minimal effect on the Aama budget. Thus it is important to note that the number of women who received the free care and transport incentive has not been reduced after the earthquakes. However, there were long-standing problems in budget distribution including delays in receiving budgets and 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 on the timely distribution of transport incentives to women.

National level discussions on the timely fund release in the EQ affected districts facilitated the process of faster Aama fund release at district level.

There was active engagement of the tertiary level health facilities located nearby the EQ affected districts. The additional funds required to cater the increased number of deliveries from EQ districts was provided to the hospitals including Maternity hospital, Bhaktapur hospital and Dhulikhel hospital. MoH instructed central level hospitals, which were over crowded by taking delivery cases from EQ affected districts, to implement the Aama programme effectively.

**5.4 District Planning**

Based on the stock take assessment's findings, Aama 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. Three district specific plans were prepared, to promote compliance with the Aama guidelines and provide a mechanism to engage with health facility management and operation committees (HFMOCs) for the smooth implementation of the programme. The plans outlined the provision of basic support services essential for delivery care. The workshops were successful in emphasizing the importance of Aama, regularizing the delivery services and managing the required funds. As a result of the workshop the three districts sent an instruction letter to Aama implementing health facilities to provide free delivery and transport incentive at the time of discharge. Local level commitment was sought for successful implementation of Aama in EQ affected districts. To facilitate this process, the districts instructed the health facility to delegate the responsibility of the Aama budget to the nursing staff so that mothers can receive the transport incentive at the time of discharge. Three one day district level follow-up workshops were organized in the selected study districts during February 2016. The workshops engaged service providers and active members of HFMOCs from Aama implementing health facilities to further discuss the implementation status of the Aama in the district; identify implementation challenges faced by implementing facilities; determine ways forward in successfully implementing the programme and explore local commitments to implementing Aama .

### 5.5 Aama Secured the Required Funds

In FY 2015/16, Nepal's national budget was increased by 34.41 percent. Allocation around ministries varied dramatically with Ministries of Home Affairs receiving 19.22 percent increase followed by education 14.66 percent, defense 13.46 percent and health only secured 10.77 percent increase. In FY 2014/15, before the earthquake, percentage of health budget against national budget was 6.42 percent which decreased to 5.29 percent in FY 2015/16 further down to 4.36 percent in FY 2016/17. The cuts in health sector budget also contributed in reduction of budget for the priority health interventions. In FY 2015/16 FHD's budget decreased by 9 percent compared to FY 2014/15. This would mean that the budget for priority programs could have been compromised however Aama still managed to secure the required budget in FY 2015/16.

In absolute terms, the Aama budget reduced by 3.08 percent as compared to FY 2014/15. However, in real terms the budget was more than sufficient to support 85 percent absorption. More importantly, MoH has provided additional required budget for the Aama in 14 EQ affected districts. This has been possible by capturing the actual expenditure on the Aama using the EQ module included in TABUCS. This shows that the Government of Nepal is committed to the Aama through sustained budget allocation over time and securing the required budget in the post EQ situation. This level of achievement has been possible through the generation of right evidence in right time and bridging the important information into the policy and government's AWPB. This level of skillful evidence-based advocacy by the Aama team at the centre has supported FHD to continue the same level of Aama budget in EQ affected districts in FY 2016/17.

> ***"Until few years ago managers used answer many questions to get budget for Aama … Acceptance of Aama at NPC and MoF has been improved in such a way that the budget for Aama is never compromised- see the Aama budget after EQ"!! Former FHD Director***

## 6 Conclusion and Way Forward

This case study summarizes the impact of the 2015 earthquakes on MoH in terms of securing the required budget to sustain the current health sector achievements and fulfill the targets laid out in NHSS and SDG. Additionally, Nepal has signed Abuja Declaration which recommends the governments to allocate 15 percent annual budget in health sector. Nepal's MoH received only 4.36 percent budget in FY 2016/17. This damaging figure came as a result of the devastating earthquakes and the priority given to reconstruction, however, other ministries were able to secure a higher budget than that of MoH.

MoH needs to prepare a costed disaster financing policy, disaster planning and develop the capacity of MoH officials to advocate to secure the required budget in coming fiscal years. The required skills need to be present in MoH officials in advocating to MoF the need of increased budget for health. The example of Aama can be taken as a successful evidence-based advocacy for the need of increased budget for the health sector. Advocacy skills will also contribute to the development of a costed health financing strategy which will provide the required budgetary framework for the health sector.

At the same time, as evident in graphs above, Aama will require an increased budget as more women are coming for institutional deliveries. This means financing Aama in the long term will be challenging especially in relation to competing and emerging priorities of the country. Aama is a part of the wider social security and there are several other programmes with similar nature and being implemented by the Department of Health Services. It is imperative to merge all social security programmes under the bigger umbrella of social health protection. Technical and policy level discussions are required to integrate Aama within national social health insurance which would be an important step towards achieving Universal Health Coverage in Nepal.

MoH has been successful in bringing more and more women into the maternal health care delivery system through Aama. This has paved an important pathway to assuring country's commitment in ***Leaving No One Behind***. Very significantly MoH has succeeded doing this and maintaining access to safe delivery despite the challenges and massive disruption caused by the 2015 earthquakes. This case study illustrates some of the ways in which system support and advocacy was provided for the Aama programme post-earthquake and which helped to safeguard its continuing achievements.

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