

Rapid Assessment of the Demand Side Financing Scheme: Aama Surakshya Programme  
(The Ninth Rapid Assessment)

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## Family Health Division

Department of Health Services  
Ministry of Health and Population  
Teku, Kathmandu, Nepal  
Telephone: (977-1) 4262273, 4262155  
Email: [info@fhd.gov.np](mailto:info@fhd.gov.np)

## Nepal Health Sector Support Programme (NHSSP)

Ministry of Health  
Ramshahpath, Kathmandu, Nepal  
Telephone: (977-1) 4264250  
Email: [mail@nhssp.org.np](mailto:mail@nhssp.org.np)

## Disclaimer

This 'Rapid Assessment of the Demand Side Financing Schemes: Aama Surakshya Programme (The Ninth Rapid Assessment) - 2016' was carried out by the Nepal Health Sector Support Programme under the guidance of the Family Health Division of the Ministry of Health). The opinions expressed here are those of the authors and do not necessarily reflect the views of MoH/FHD or NHSSP.

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Study Team  
August 2016

## EXECUTIVE SUMMARY

### A. Introduction

The Aama Surakshya Programme is a national flagship programme implemented by Nepal's Department of Health Services, Family Health Division. The Aama Programme aims to reduce the barriers (financial and non-financial) that prevent pregnant women from accessing quality delivery care services. The main objective of this ninth rapid assessment (RA) was to assess compliance of Aama Programme implementation with programme implementation guidelines, 2012 (FHD 2012). The specific objectives were to assess the utilization of free delivery care, transport and ante-natal care (ANC) incentives and to analyse trends in institutional deliveries and 4ANC check-ups, the sufficiency of incentives and compliance with the programme guidelines across different aspects of the programme. This assessment also cross verified the provision of services at health facilities with service seekers' perspectives.

This assessment used both qualitative and quantitative methods to evaluate the effectiveness of the programme. Qualitative information was obtained from in-depth interviews conducted with the programme manager, focal persons, service providers, accountants and health facility management committee members while quantitative information was obtained through structured interviews with recently delivered women (RDW) — women who had delivered in the six months period of 17 July 2015 to 14 January 2016, and client exit interviews at the time of data collection. The assessment was conducted in ten districts across one mountain and nine hill districts. A total of 52 health facilities were sampled: 9 government hospitals, 3 private or community hospitals, 16 primary health care centre and 24 health posts. Altogether 1,265 RDW and 69 exit interview women were interviewed to assess the implementation status of the programme. It should be noted that this assessment is not nationally representative, but the results and findings can generate valuable suggestions from the managerial perspective which are helpful to programme managers and policymakers to implement the programme more successfully.

The Aama Programme is becoming increasingly popular among women of reproductive age across Nepal. The services are well acknowledged by key informants, mothers and all sections of society. Its significance is observed in the increasing trend of 4ANC visits, institutional deliveries and deliveries in the presence of skill birth attendants.

### B. Key findings of the assessment

Institutional delivery has increased from 14% in FY 2005/06 to 52% in FY 2014/15. At the same time home deliveries have decreased from 20% to 5%. While there has been a rapid increase in institutional deliveries, the decrease in home deliveries has been slow. This suggests that a lot of home deliveries are not being reported in the health care M&E system. Attendance for the recommended four antenatal care visits (4ANC) has slowly increased from 47.7% in FY 2005/6 to 54% in FY 2014/15. Both institutional delivery and 4ANC visits were found to have increased in Dhankuta, Okhaldhunga, Gorkha and Sindhupalchowk districts in the period FY 2011/12 to FY 2013/14. The proportion of institutional deliveries has also increased in Lalitpur, Dhading and Lamjung districts but 4ANC visits have decreased. The proportion of institutional deliveries had slightly increased in Makawanpur district while 4ANC visits were little changed.

This assessment looked at the timeliness of fund flows from central to district levels and from the district to health facility levels as this is a longstanding and major concern. However, the use of local

revenue in providing the incentive to women and ensuring free delivery care has improved over the years. The timely reporting of financial data from health facilities to the district and from districts to the centre was also found to be an issue. It is recommended that in order to address delays in reporting and funds release, the Transaction Accounting and Budget Control System (TABUCS) should be used.

Almost 90 percent of sampled entitled women had received the transport incentive. The women from Makawanpur and Dhankuta were less likely to have received the transport incentive compared to women from elsewhere. Almost 97% of the entitled sampled women from Dhading and Gorkha had received their transport incentives. One hundred percent of the sampled women who delivered in private facilities had received transport incentive whereas between only 95% and 81% had received it in public hospitals and primary health care centres (PHCCs) respectively. There was no discrepancy in the receipt of transport incentive in terms of caste and ethnicity, place of residence, level of education and type of occupation. Fifty-one percent of total sampled women had done 4 ANC visits as per the protocol. Only about 35% of these 608 women had received the 4ANC incentive. The entitled women from Dhankuta and Okhaldhunga districts were least likely to have received the 4ANC incentive whereas almost 54% of sampled women from Arghakhanchi had received it. None of the women who had delivered in a private facility had received the 4ANC incentive. At the public facilities, the sampled women who had delivered in a hospital were least likely to have received the 4ANC incentive (28%) compared to the women who had delivered in PHCC (32%) or health posts (HPs) (41%). Almost 85% of the women who had received the transport incentive had received it on the day of discharge. Still, 14% of the women had to wait between one and three months to receive their incentive. All of the women from Arghakhanchi district had received their transport incentive. Almost 48% of women from Makawanpur district had to wait between one and more than three months to receive their incentives. Almost 92% of the sampled women had received their transport incentive on the day of discharge in private facilities whereas the percentage of women receiving it on the day of discharge was only 80% for public facilities. The women who had delivered in a PHCC were more likely to have received their incentive on the day of discharge compared to HPs (82%) and government hospitals (80%).

Not all the women who had accessed delivery services from Aama Programme accredited facilities had received their delivery care for free. On average, around 29% of the women had paid for free services, varying between 14% and 57% across the districts. Women receiving service from health facilities of Dhading (87%) and Makawanpur (83%) districts were relatively better off in receiving free care compared to at the health facilities in Lalitpur (43%), Baglung (57%) and Dhankuta (61%). The women undergoing all type of delivery services from normal to complicated and caesarean sections (CS) were found to have paid for free services. Almost 80% of complicated deliveries and 64% of CS services were charged to women. Few of the women (19%) who accessed services from private facilities had received completely free services. At the public facilities the women were paying at all levels of facility. Almost 24% of women receiving care from hospitals were found paying for free services followed by 22% at the PHCCs, and 18% at the HPs. Women from all caste/ethnicity background, education level, occupation and residing in both rural and urban areas were paying for free services.

The average amount paid for normal and complicated delivery services in the 10 districts was NPR 1,002<sup>1</sup>. There was a variation in the amount paid for normal and complicated delivery service across the sampled districts ranging from NPR 650 in Dhankuta to NPR 1600 in Lalitpur. The cost of normal and complicated deliveries was as high as NPR 1,750 in private facilities followed by NPR 1,093 in government hospitals and NPR 700 in PHCCs. An average CS delivery cost NPR 9,200 with the cost varying across districts from NPR 4,125 in Dhankuta to NPR 12,250 in Lalitpur district. At the sampled private facilities an average of NPR 11,400 was spent on CS deliveries, which is almost two times higher than the charges at government hospital (NPR 4,500). Drugs accounted for the major portion of these payments followed by supplies, registration fees and lab tests.

A total of 29 health facilities of the sampled 52 were found to be displaying the names of Aama Programme beneficiaries. The number of health facilities displaying Aama beneficiaries ranged from 40–50% by district. None of the private facilities were displaying the names of Aama beneficiaries. Three of the eight government health facilities were complying to disclose Aama beneficiaries. Only 60% of the below-district level facilities were found disclosing name of the beneficiaries.

On average an around 3.4% mismatch was observed on the receipt of the transport incentive by entitled women. The degree of mismatch varied across the districts ranging from 0.9% to 8%. At the health facility level no mismatches were found on the receipt of transport incentives at the private facilities. The public PHCCs and HPs were found to have almost 5% mismatches. An average 2.3% mismatch was observed on receipt for normal deliveries, 18% for complicated deliveries and 17% for CS deliveries. The degree of mismatch varied across districts ranging from 1.2 to 6% for normal deliveries, 20 to 63% for complicated deliveries and 9 to 50% for CS deliveries.

An average 53.6% mismatch was observed for the receipt of entitled 4ANC incentives. The percentage mismatch varied across the districts between 49% and 68%. At the health facility level the highest percentage of mismatch was observed at the PHCC level (53.8%), followed by the HPs (49.2%) and the district hospitals (41.8%).

The assessment reported that 99% of the sampled client exit interview women were satisfied with the services provided by the health facilities. For the women the reason for satisfaction was the provision of free delivery service (40%), staff cooperation (25%) and transport incentive (15%). Almost all the women had some dissatisfaction with the provisions under Aama Programme. Thirty-nine percent complained that drugs were not provided for free, 35% thought that the incentive was inadequate to support the costs borne by poor people and 15% complained that services were not provided for free.

The Aama Programme is the single biggest demand side financing programme of the Ministry of Health (MoH). In 2015/16 the programme had a budget of NPR 1.12 billion for about 2,000 health facilities. The programme is also a priority 1 programme of MoH. In this context, policy level engagement to define the next generation of Aama, management improvement plan, improving the financial reporting system and strengthening the monitoring and supervision functions are key areas requiring improvement. As indicated by previous rounds of the rapid assessment and findings from other studies, this RA also brings forward issues of mismatch in terms of the receipt of transport incentive and types of delivery services provided. Still many women are not provided with the transport and 4ANC incentive even after being recorded as having received the appropriate

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<sup>1</sup> Official exchange rate of \$106.5:\$1 on 8 August 2016

incentive. A probable reason for this could be that the health facilities might not have received the budgeted amounts for the transport incentives from their district health offices. While they carry out all official procedures to give the impression that they have provided the incentives to all women at the time of discharge, some facilities seem not to have providing full entitlements to women. It may also be the case some women do not turn up to receive the transport incentive post discharge. The discrepancy in the level of receipt of the 4ANC incentive is alarming and needs more exploration. Similarly, the observed mismatch in terms of actual and reported types of delivery is a concern with normal deliveries often being reported as complicated and C section deliveries, and complicated deliveries reported as C section deliveries. Some of these mismatch cases could be due to women being unaware of the complication treated but it is hard to deny the link between financial incentives and the mismatches observed.

The overall recommendation of RA-IX is that DoHS and FHD need to improve the monitoring of health facilities in relation to their compliance against the Aama Programme Guidelines, 2012. They also need to do the following:

1. Add a specific section on compliance against the Aama Programme Guidelines with some performance related indicators and specific measures to those who have been failed to achieve the indicators.
2. Issue instruction letters to facilities to comply with the Aama Programme Guidelines with failure to do so comply should leading to discontinuation of Aama programme accreditation.
3. Conduct a programme workshop with hospitals, lower level health facility providers and management committee members in relation to the provisions of the Aama Programme and the use of Aama Programme reimbursement money.
4. Improve awareness of Aama Programme in terms of service entitlements. This will help people to demand services they are entitled to and prevent payment for services that should be freely provided.
5. Conduct a design workshop to improve methodology and instruments of future rapid assessment to be better able to measure emerging challenges.

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## ABBREVIATIONS

4ANC	four ante-natal care visits
ANC	antenatal care
AWPB	annual workplan and budget
CBS	Central Bureau of Statistics
CS	caesarean section
CSPro	Census and Survey Processing System
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
DSF	demand side financing
DTACO	district treasury and account controller office
FCGO	Financial Comptroller General Office
FCHV	female community health volunteer
FHD	Family Health Division
FY	fiscal year
HF	health facility
HHS	household survey
HP	health post
KII	key informant interview
MoF	Ministry of Finance
MoH	Ministry of Health
NDHS	Nepal Demographic Health Survey
NHSSP	Nepal Health Sector Support Programme
NPC	National Planning Commission
NPHC	National Population and Housing Census
NPR	Nepalese rupee
NSI	National Statistical Institute
PHCC	primary health care centre
PHN	public health nurse
PPH	post-partum haemorrhage
RA	Rapid Assessment
RDW	recently delivered women
RHD	regional health directorate
SBA	skilled birth attendants
SLC	school leaving certificate
STATA	Stata Software Corporation
STS	service tracking survey
TABUCS	Transaction Accounting and Budget Control System

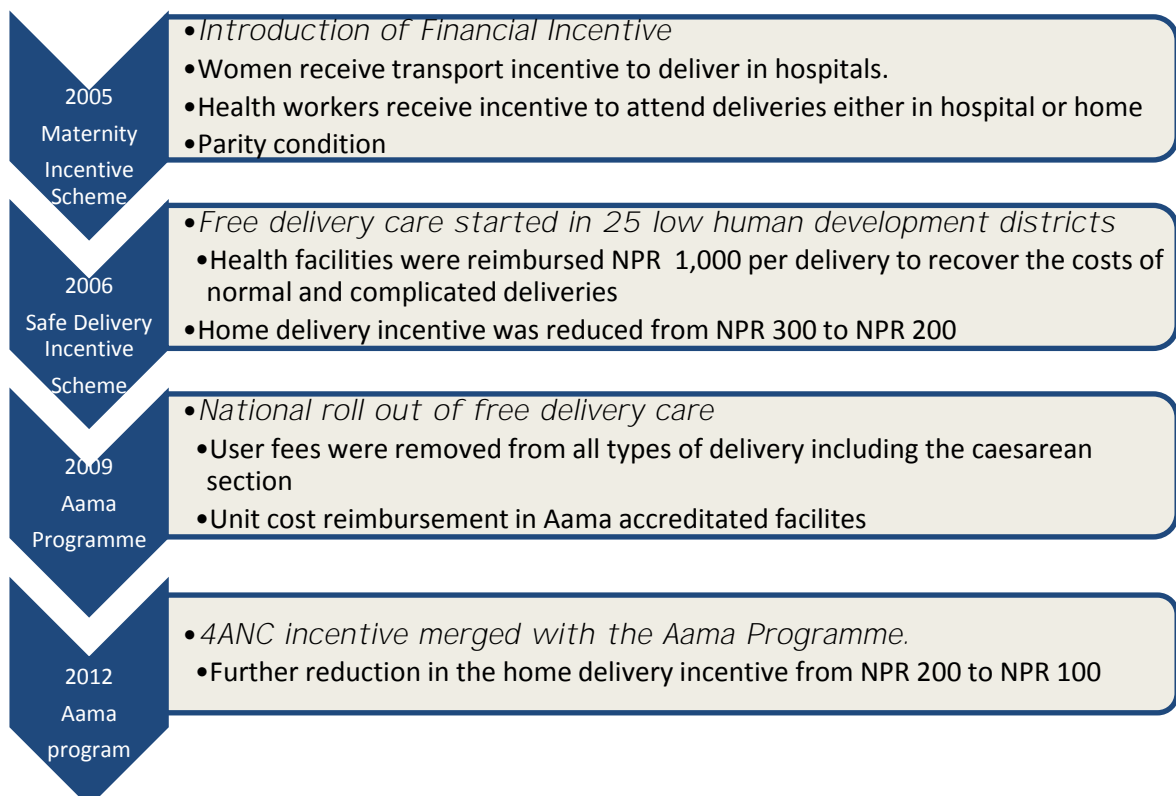
# 1 INTRODUCTION

## 1.1 Background

Maternal death is a leading cause of death for Nepalese women in the reproductive age group. The Nepal Demographic and Health Survey, 2006 reported a decrease in the maternal mortality ratio (MMR) from 539 per 100,000 live births in 1996 to 281 per 100,000 live births in 2006. A United Nations estimate indicates a notable decrease in the maternal mortality ratio from 380 per 100,000 live births in 2008 to 220 per 100,000 live births in 2015. The decrease in the MMR is due to the contribution of the government sector along with its bilateral, multilateral and non-governmental partners who have played an effective role in improving access to maternity health care. In 2005, a study found that the high cost of institutional delivery was associated with the persistently high rates of home delivery (Borghi et al., 2006).

In July 2005, the Government of Nepal introduced the Aama Programme with the aim of reducing financial barriers associated with seeking 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 describes the evolution of the Aama programme and Box 1.1 shows the programme component.

Figure 11: Evolution of Aama programme over years



Box 1.1: Components of the Aama Programme

A. Incentive to Women			
Delivery in a facility	Tarai	Hill	Mountain
	NPR 500 (US\$5)	NPR 1,000 (US\$10)	NPR 1,500 (US\$15)
4ANC incentive	NPR 400 (US\$4) for completing four ANC visits (at 4 <sup>th</sup> , 8 <sup>th</sup> and 9 <sup>th</sup> months of pregnancy)		
B. Reimbursement to health facilities			
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		
Home deliveries	NPR 100 (US\$1) to be paid separately for home deliveries		
<i>The unit cost should cover the cost of medical commodities (such as essential medicines and supplies) personnel and other associated costs (electricity, water).</i>			

During the first and second Nepal Health Sector Programmes (NHSP-1 and NHSP-2, 2006–2015), the Aama Programme was regarded by government as a high priority programme. During this period, the Nepal Health Sector Support Programme (NHSSP) provide the technical inputs to design, implement, monitor, and integrate the 4ANC scheme with the Aama Programme, which is considered as the best way of assuring both technical and allocative efficiency. The major question for the Department of Health Services (DoHS) and its Family Health Division (FHD) concerns the overall management status Aama programme. The rapid assessment that is reported here aims to capture the current status of Aama Programme implementation in selected districts and compare key indicators. The aim is to inform the overall management of the programme against the Aama Programme Guidelines, 2012 (FHD 2012).

## 1.2 Rationale of the Rapid Assessment

The rapid assessments of the Aama Programme measure the effectiveness of the programme against its objectives, especially, the receipt of free care and the transport incentive by beneficiaries; assess the fund flow mechanism and assess financial management at various stages since the days of the Safe Delivery Incentives Programme (SDIP).

The first RA was conducted in five districts in 2008. Since then MoH/FHD have been conducting RAs of the Aama programme with technical support from NHSSP/DFID. Eight rounds of RA have been conducted and many of the recommendations from these assessments have been used to inform policy and programme decisions. Examples of this have included the reduction in the home delivery incentive to health worker, changes in the complications criteria for the reimbursement of unit costs and changes in the financial management process as recommended by previous RAs.

Likewise, RAs have been instrumental in not only identifying the implementation challenges but have also successfully recommended managerial solutions. For example, the identification of administrative bottlenecks such as the unavailability of funds for payments to women at the time of discharge, delays in fund flow and reporting and recording errors identified in previous RAs have been influential in changing the programme implementation guidelines. Additionally, the Aama Programme is susceptible to fiduciary risks as it consists of direct cash transfers, and RAs have been the only mechanism to trace these risks by cross-verifying recorded payments against actual payments received by users. The process of verification helps identify phantom claims, misappropriation and other causes of data distortion. Besides, the limited monitoring capacity of the government and the

huge amount of investment in the programme (US\$ 10 million for a single fiscal year) further stress the importance of carrying out periodic RAs. Hence, periodic RAs are essential for the Aama Programme to identify any deviations from the programme objectives and guidelines and to address such deviations on time.

All MoH demand side financing schemes (DSF) are operated under the Department of Health Services and, as such, joint assessment and evaluation should reduce operating and transactional costs. Since MoH's service tracking surveys (STS) and household surveys (HHS) also cover some aspects of DSF utilisation the added value of a further RA needs to be justified. RAs are programme monitoring surveys designed to improve scheme implementation and impact while the Nepal Demographic Health Survey (NDHS) and the HHS aim to assess sector outputs and impacts. The STS, by contrast, tracks both output and process indicators. While all these surveys monitor some elements of the Aama Programme, RAs are the only survey to use cross-verification in order to investigate suspected false claims. For this reason, it is able to provide critical insights into how, and to what extent, the misappropriation of funds is occurring. In addition, RAs are the only surveys that examine fund flow and fund management using both qualitative and quantitative tools.

The terms of reference was prepared for the ninth round of RA to assess compliance of Aama Programme implementation according to its programme implementation guideline. The aftermath of the 2015 earthquakes has resulted in sharp budget cuts in some areas of the health sector with shifts of budget to new priority areas. As, a result in FY 2015/16 MoH did not receive sufficient budget to conduct RA round IX (9) and requested the Nepal Health Sector Support Programme to provide technical and financial support.

The round 9 rapid assessment also served as an opportunity to access any management complications that resulted from the response to the 2015 earthquakes concerning the Aama Programme especially in relation to the delivery of services (receipt of free care and transport incentives).

### 1.3 Objectives of the Study

The main objective of this assessment was to monitor the overall implementation status of the Aama Programme. The specific objectives were to:

1. Assess the three years trend in delivery care using Health Management Information System (HMIS) data.
2. Assess the management of the Aama Programme including the timeliness of fund flow and the preparation of progress and financial reports.
3. Assess compliance of programme implementation against the Aama guidelines 2012 concerning women's receipt of free delivery care, transport and 4ANC incentives at the time of discharge; the use of financial incentives including distribution among health workers and the disclosure of the names of service users on public notice boards.
4. Cross-verify the information on the use of the Aama Programme between health facility records and interviews with beneficiaries to identify mismatches.
5. Make recommendations on ways to improve management of the Aama Programme.

The objectives and tools used with different stakeholders, managers and clients to carry out the assessment are shown in Table 1.1.

Table 1.1: Objectives and indicator used for the rapid assessment of DSF

	Objective of rapid assessment	Indicator	Type (quantitative or qualitative)	Priority (core or supplementary)
1	Assess trends in utilisation of delivery care using routine information systems	Trend of institutional deliveries (district and national)	Quantitative	Supplementary
		Trend of fourth ANC visit (district and national)	Quantitative	Supplementary
2	Assess the management of Aama Programme including assignment of timeliness of fund flow and the preparation of progress and financial reports	Timeliness of Aama fund flow to health facilities	Quantitative/ qualitative	Core
		Mechanism for release of funds to health facilities	Quantitative/ qualitative	Core
		Sufficiency and flow of Aama funds at health facilities	Quantitative/ qualitative	Core
		Frequency of financial reporting	Quantitative/ qualitative	Core
3	Compliance against Aama Programme Guidelines, 2012	% of women receiving transport incentive as per the guidelines	Quantitative	Core
		% of women who did not pay any cash at health facility for their deliveries	Quantitative	Core
		% of women receiving 4ANC incentive of total women completing four ANC visits	Quantitative	Core
		% of health facilities with display boards showing lists of Aama beneficiaries	Quantitative	Core
		% of health facilities with a copy of the revised Aama guidelines	Quantitative	Core
4	Cross-verify utilisation of the Aama Programme between health facility records and women's actual receipt	% match between health facility records and women's interview on receipt of transport incentive	Quantitative	Core
		% match between health facility records and interviews on women's receipt of 4ANC incentive	Quantitative	Core
		% match between health facility records and women's interview reports on type of delivery (normal/complicated/CS)	Quantitative	Core

## 2 METHODOLOGY

This chapter presents the study design, districts included in the study, sampling and field implantation. This is the ninth RA and the same study design and methodology were used as in previous assessments.

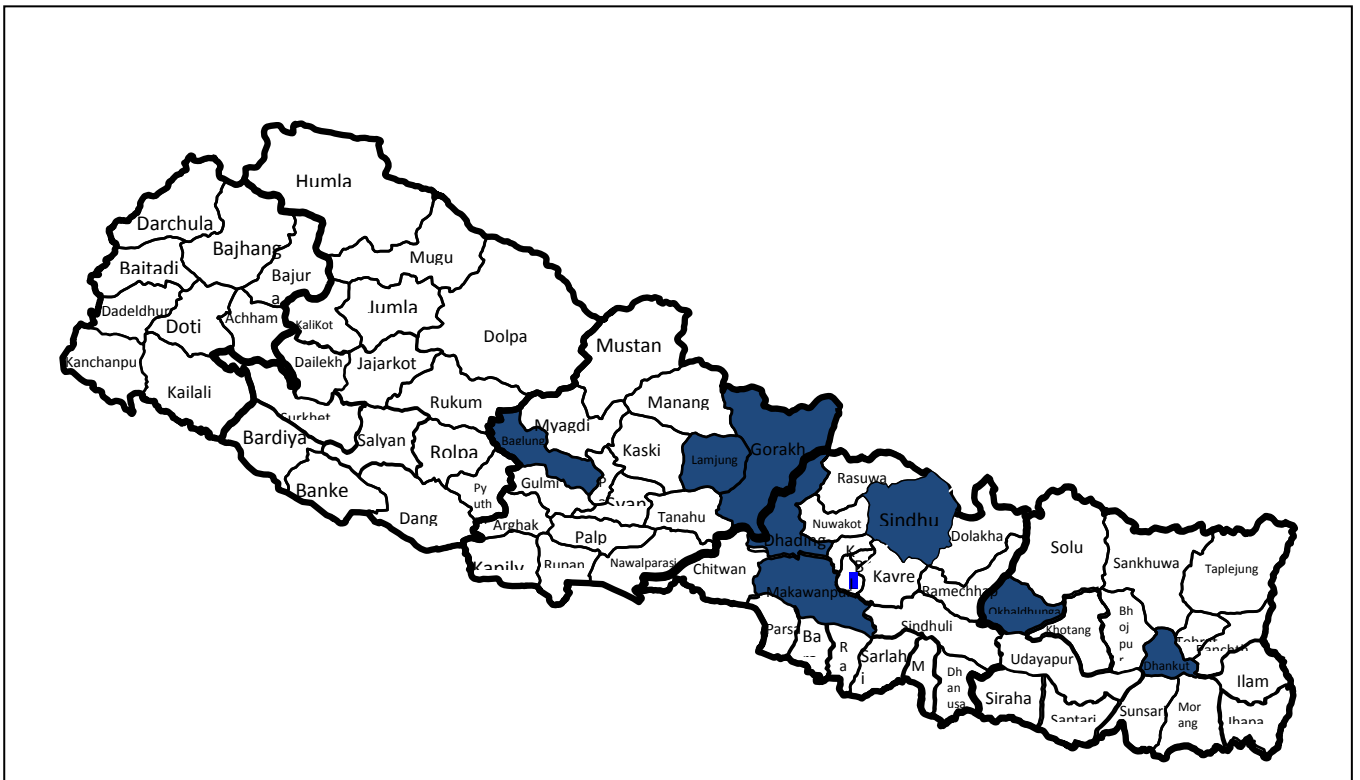
### 2.1 Study Design and Methodology

The study had a cross-sectional descriptive design with an analytical lens on it. A mixed method approach was used to achieve the objectives outlined in Chapter 1. Both qualitative and quantitative methods were used to get valid and reliable information from service providers and users.

### 2.2 Selection of the Districts

The ten districts of Dhankuta, Okhaldhunga (from eastern region), Sindhupalchowk, Lalitpur, Dhading, Makawanpur (from central region), and Gorkha, Lamjung, Baglung and Arghakhanchi (from western region) were selected for the assessment (see Figure 2.1). Some of these districts were affected by the 2015 earthquakes and had not been covered by the previous rapid assessments.

Figure 2.1: Districts covered for the ninth rapid assessment of the Aama Programme



### 2.3 Sampling Method

The sample size in each district was identified according to the proportion of expected deliveries in each of the selected districts.. The total sample size was calculated by assuming the probability level of institutional delivery data taken from the Nepal Demographic and Health Survey, 2011 (MoH et al. 2012). The variation was assumed to be at 4% from the population parameter by using the following formula:

Sample Size =  $n / [1 + (n/\text{population})]$

In which  $n = Z * Z [P (1-P)/(D*D)]$

P = True proportion of factor in the population, or the expected frequency value

D = Maximum difference between the sample mean and the population mean,  
or Expected Frequency Value minus (-) worst Acceptable Value

Z = Area under normal curve corresponding to the desired confidence level

A total sample size of 1,265 clients from all 10 districts was identified in this study. The total sample size was distributed between the 10 districts using probability sampling based on the total number of clients visited in all health facilities of each district during the period of six months. For cross-verification with clients at the household level, sample respondents were selected using systematic sampling with replacement. The sample size was based on the variability of the population which was collected from the selected health facilities in the selected districts. The combined list of clients that had visited the selected health facilities in the selected districts during the previous six months (the period from 1<sup>st</sup> of Shrawan 2072 [17 July 2015] to 30<sup>th</sup> Poush 2072 [14 January 2016]) was prepared as a sample frame and a systematic sample of desired sample size from each selected facility was selected using systematic sampling. The sampling started by selecting an element from the list at random and then selecting every kth element in the frame, where k was the sampling interval. This was calculated thus:

$$k = \frac{N}{n}$$

where n was the sample size, and N was the population size.

## 2.4 Sample Selection

Ten districts were purposively sampled for this assessment based on ecological zone and number of deliveries. The districts were purposively selected to include districts which were most affected by the 2015 earthquakes and had not been covered by the previous rounds of rapid assessments (rounds 1 to 8). Fifty-two health facilities were sampled including 9 government hospitals, 3 private/mission hospitals, 16 primary health care centres (PHCCs) and 24 health posts (Table 2.1).

Table 2.1: Number of health facilities selected

District	Government Hospital	Private Hospital/mission	PHCC	HP	Total
Dhankuta	1	0	2	2	5
Okhaldhunga	1	1	1	3	6
Sindhupalchowk	1	0	1	3	5
Lalitpur	0	1	3	0	4
Dhading	1	0	2	3	6
Makawanpur	1	0	2	3	6
Gorkha	1	1	1	2	5
Lamjung	1	0	1	4	6
Baglung	1	0	2	1	4
Arghakhanchi	1	0	1	3	5
Total	9	3	16	24	52

The facilities were selected from a sampling frame consisting of birthing centres in the sampled districts. Whether or not facilities were operating and able to conduct deliveries was confirmed by the district teams when visiting the district health offices (DHOs) and district public health offices (DPHOs). The selected health facilities are kept anonymous to maintain the privacy of the health personnel who were interviewed or interacted with during this study.

Individuals: Based on the number of deliveries in the past six months, health facility clients were selected using systematic sampling. A total of 1,265 women needed to be cross-verified in the study (Table 2.2).

Table 2.2: Number of individual clients (RDW) selected

District	Sample Size
Dhankuta	104
Okhaldhunga	121
Sindhupalchowk	94
Lalitpur	67
Dhading	160
Makawanpur	187
Gorkha	130
Lamjung	154
Baglung	123
Arghakhanchi	126
Total	1,265

*RDW: Recently delivered women*

In addition, all women who exited from all the selected health facilities during the three days period of data collection at each facility were included in client exit interviews.

### 2.5 Cross Verification

District to health facility verification In the first stage of cross-verification, detailed information (i.e. address of woman [who had delivered a baby], type of health facility, date of delivery, type of delivery, staff who attended delivery) were recorded from the claim forms (Annex 3 of the Aama guidelines) kept at the DHO/DPHO. This information was then cross-verified with the maternity register at the sampled health facilities. Records were classified as unmatched if one or more of the following fields differed between the claim form at the DHO/DPHO and the health facility maternity register: mother’s address, type of health facility, date of delivery, type of delivery. The matched records are hereafter referred to as ‘matched health facility records’.

Health facility maternity verification Cross-verified stage 1 cases were then verified with the women themselves in their households. The tool used to interview women who had delivered in the last six months allowed cross-verification of the information they provided with that obtained from the facilities (i.e. whether a normal, complicated or caesarean section was performed; number of ANC visits; and direct and indirect costs associated with delivery and incentives received). After data was collected from the interviewed women, the enumerators returned to the concerned health facility to check any inconsistencies between the data obtained from the women and facility data.



The tool used to interview the women who had delivered in the last six months allowed cross-verification of the information they provided with that obtained from the facility (i.e. whether a normal, complicated or caesarean section was performed; the number of ANC visits; and direct and indirect costs associated with delivery and incentives received). After data was collected from the interviewed women, the enumerators returned to the concerned health facility to double-check any inconsistencies between the data obtained from the women and facility data.

## 2.6 Review financial fund flow and Financial Status

Fund flow and financial status were reviewed by asking questions of the head of finance sections at DHOs/DPHOs and capturing information from the Transaction Accounting and Budget Control System (TABUCS). This review has given some idea about financial management issues and practices based on the financial monitoring records and reports and helped to verify the flow of funds in practice and explore if there were any serious or persistent bottlenecks in the system.

## 2.7 In-depth Interviews

In-depth interviews were carried out with health care providers and managers in the selected districts. In each district a public health nurse and a finance chief were interviewed. At facility level in-charges, Aama focal persons and representative of health facility management were interviewed.

## 2.8 Client Exit Interviews

Clients who had exited from the selected health facilities during the three day time period of data collection were interviewed using a structured questionnaire. In total only 69 such women were interviewed during this assessment. They were asked whether or not they were happy with the services received and if they had received the transport incentives as well as the 4ANC incentive they were entitled to when they were discharged from the facilities and availed of free delivery services.

## 2.9 Study Tools

The data collection tools used in Rapid Assessment IX were the same as those used in previous assessments with a few minor modifications (Table 2.3).

Table 2.3: List of tools and respondent categories

Responsible Persons	Level	Tool used	Participant/topic	Information sought
Chief of DHO/DPHO, focal person	DHO/DPHO	1A	DHO/DPHO, Aama focal person	Details of role, training, reporting, monitoring, fund flow, training guidelines use, specific district issues
Finance chief	DHO/DPHO	1B	DHO/DPHO finance section	Fund flow, involvement in planning and budgeting, specific district issues
Research team and enumerators	DHO/DPHO, health facility	1C	Cross verification between DHO/DPHO and health facility records for institutional deliveries	Collect delivery and ANC data from Aama guidelines Annex 3 claim forms at DHO/DPHO and verify at health facility level from maternity registers for institutional deliveries
	Zonal hospitals, district/community hospitals, private	2A	Delivery service providers	Knowledge and awareness of Aama and 4ANC programmes, recording, monitoring, display of Annex 10 forms on noticeboards,

Responsible Persons	Level	Tool used	Participant/topic	Information sought
	hospitals, PHCCs, HPs			fund flow, training, use of unit cost, local issues.
		2B	Chairs of health facility management committees	Knowledge and awareness of Aama and 4ANC, use of unit costs, display of Annex 10 forms, fund flows, training, local issues
		2C	Health facility account sections	Fund flow, reporting, monitoring
	Communities	3A	Women who delivered at a health facility in last 6 months	Incentives received, type of delivery, information on Aama, views on delivery at health facility, satisfaction with services
		3C	Exit clients from health facilities	Incentives received, type of delivery, information on Aama, views on delivery at health facility, satisfaction with services

## 2.10 Training

The field researchers comprised of fifteen research enumerators. The enumerators were university graduates with previous experience in conducting data collection in different sectors and priority was given to those who had previous experience in assessing the Aama Programme and in reproductive health. The assistants were grouped into five teams. The field researchers were given four days of intensive training on different aspects of the study, orientation on tools, including in-depth interviewing techniques, how to take field notes, discussion on the guidelines and issues surrounding confidentiality and ethical procedures during data collection. Representatives from FHD and NHSSP briefed on the design, process, key implementation features and tools of the RA. The training was conducted in the training hall of the Local Development Training Centre at Jawalakhel, Lalitpur (see the training schedule at Annex B of this report).

## 2.11 Fieldwork

The data was collected from ten districts between 15 February and 10 April 2016 with each team assigned to two districts. The research assistants were deployed to the field after their training. The research assistants coordinated with the selected health facilities, conducted data collection, controlled quality, and checked and verified the completeness and consistency of the collected information.

## 2.12 Field Monitoring and Supervision

The overall quality of survey data depends upon the monitoring and supervision of field work from the early stages to the end of data recording in the field. Day-to-day of supervision in the field was done by the supervision team of the National Statistical Institute (NSI). The NHSSP and FHD team also visited some districts to supervise field implementation. The study team visited enumerators in the field and helped them maintain data quality. The month of February was the best season for data collection, but unrest in the Tarai region and ongoing fuel shortages caused transportation problems everywhere in the field. Despite this, the field work continued throughout its three weeks.

### 2.13 Data Entry and Analysis

All the information obtained at field level was recorded in questionnaires, interview guidelines, and checklists. Data collection, editing, coding, data entry, inconsistency checking and error removing were done at the central level. NSI did the initial data entry. NHSSP cleaned the data and ensured the quality. NHSSP conducted analysis using STATA 14 software. The tables were prepared as per the objectives and indicators shown in Table 2.3.

### 2.14 Quality Assurance

Quality assurance began with the training of the field assistants. Strong monitoring and supervision from an experienced and qualified central level researcher and programme managers helped maintain the quality of data collected. Supervision and communication between the centre and the district teams was assured in order to respond to issues that might undermine the quality of collected data. The data entry assistant was supervised by the data manager during data entry. A sample of 10% of questionnaires were re-entered to check the accuracy and consistency of data entry.

### 2.15 Challenges and Limitations

The following challenges and limitations were experienced during the ninth RA:

- < Due to the nationwide fuel crisis difficulties were faced while travelling to the districts and from district centres to health facilities.
- < In some DHOs/DPHOs, the completed Annex 3 claim forms were not available. In such cases, the women were listed from the selected health facilities. It was found that some women's maternal home addresses had been written down (instead of their married homes). In such cases, they were replaced by the subsequent women from the list.
- < In the earthquake affected districts, including Sindhupalchowk, Gorkha, Lalitpur and Okhaldhunga, it was very difficult to get the Aama annex forms and financial information. Some districts did not have the Aama Annex 3 and 10 forms and HMIS reporting data. This was due to damage caused to health facilities by the earthquakes.
- < It proved difficult to trace women in urban areas like Lalitpur. This was mainly due to incomplete addresses recorded, the temporary nature of residence of some women, high levels of mobility and large population size with a lack of house numbers.
- < Recent changes in upgrading village development committees to municipalities caused difficulties to trace the exact ward and *to* of some women.

### 3 ASSESSMENT FINDINGS

This chapter describes the findings on trends in the use of delivery care, the management of the Aama Programme including funds flow, compliance against the Aama guidelines 2012, cross-verification of the receipt of free delivery care and transport incentive.

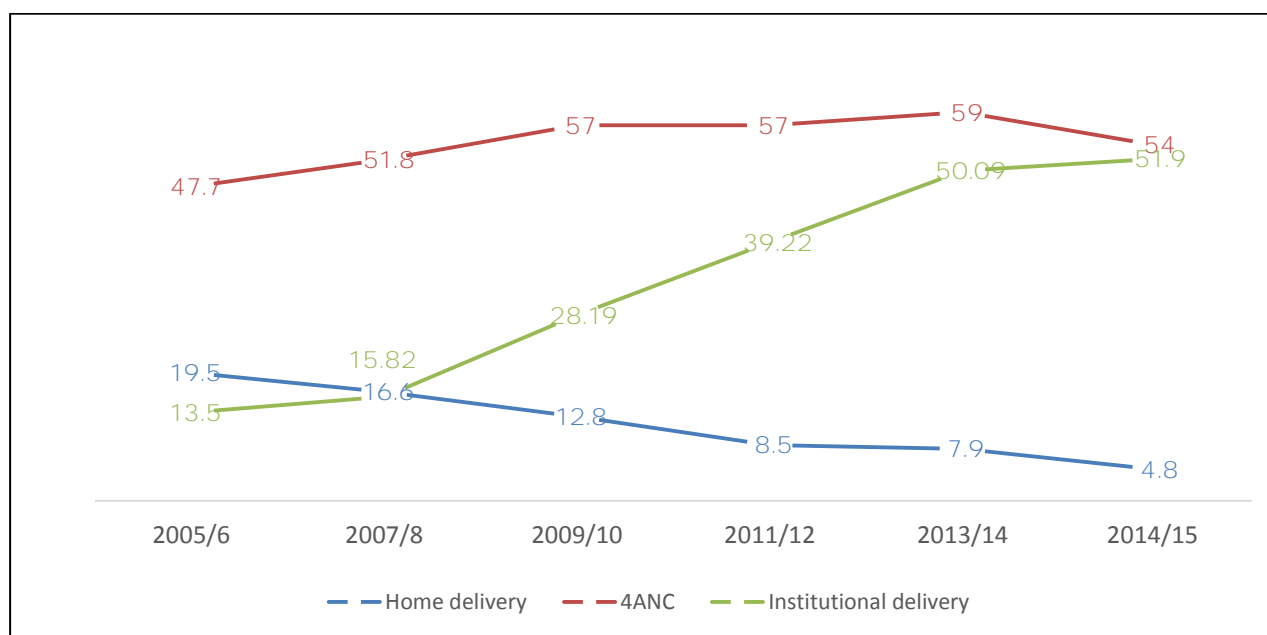
#### 3.1 Trend in Utilization of Delivery Care

This section covers the trend in the utilization of delivery care at the national level and in the study districts.

##### 3.1.1 Utilization of institutional delivery, home delivery and 4ANC

The trends shown in Figure 3.1 suggest that institutional deliveries have been growing over the years from 14% in FY 2005/06 to 52% in FY 2014/15. Similarly, it is encouraging to see that home deliveries have decreased from 20% in FY 2005/06 to 5% in FY 2014/15. Attendance at the recommended 4 ANC visits as per the protocol delivery has slowly increased from 47.7% in FY 2005/06 to 59% in FY 2013/14 (Figure 3.1).

Figure 3:1 National Trend in utilization of Institutional delivery, home delivery and 4ANC



Source: HMIS, 2014/15

In FY 2014/15 the percentage of 4ANC attendance was found to have decreased. The reason for the decrease is unlikely to have been due to weak programme implementation but could be due to data reporting errors.

##### 3.1.2 Trends of institutional deliveries and antenatal cares among study districts

Table 3.1 gives detailed information on the trend of institutional deliveries and four ANC visits as a percentage of expected pregnancies for the sample districts in the FY 2011/12 to FY 2013/14 period. Institutional deliveries for FY 2012/13 and FY 2013/14 are calculated as a percentage of live births.

Table 3.1: Trend (%) of institutional deliveries and 4ANC visits as percentage of expected pregnancies in study districts (2011/12 to 2013/14)

Districts	2011/12		2012/13		2013/14	
	Institutional deliveries	Four ANC visits	Institutional deliveries*	Four ANC visits	Institutional deliveries*	Four ANC visits
Dhankuta	12.2	35.6	15.6	48.8	17.1	54.5
Okhaldhunga	26.5	34.0	42.4	44.5	51.9	48.0
Sindhupalchowk	14.4	22.4	18.9	29.9	21.4	32.9
Lalitpur	70.8	77.7	71.3	67.6	76.6	79.0
Dhading	29.7	46.1	41.9	54.3	42.6	51.1
Makawanpur	21.6	29.6	23.8	29.3	27.0	29.6
Gorkha	18.7	29.4	23.2	38.3	31.5	42.5
Lamjung	28.9	59.8	41.4	85.2	44.7	73.7
Baglung	24.8	47.4	31.8	54.7	38.2	63.3
Arghakhanchi	19.1	29.0	24.0	36.9	30.4	44.1
Total	44.0	50.0	46.0	49.7	50.0	51.0

\* percentage of live births Source: DoHS annual reports

The trends were as follows:

- ◁ Both institutional delivery and 4ANC visits increased in Dhankuta district in the period FY 2011/12 to FY 2013/14. Okhaldhunga and Sindhupalchowk also show the same pattern in the same period.
- ◁ In Lalitpur district, institutional deliveries increased, but 4ANC visits decreased from 77.7% of expected pregnancies in FY 2011/12 to 67.6% in FY 2012/13 increasing to 79% in FY 2013/14. Similarly in Dhading district, institutional deliveries increased, but 4ANC visits reduced to 51% in FY 2013/14 from 54% in FY 2012/13.
- ◁ In Makawanpur district, institutional deliveries slightly increased while 4ANC visits were almost found constant over the period.
- ◁ Gorkha district had an increase in both institutional deliveries as well as 4ANC visits.
- ◁ Lamjung district had increased institutional deliveries over the time, but the proportion of 4ANC visits decreased to 73.7% in FY 2013/14 from 85.2% in FY 2012/13 although these figures are quite good compared to other districts.

The increases in institutional deliveries and 4ANC visits could be due to policies and interventions that promote ANC visits and institutional deliveries as opposed to assisted home deliveries.

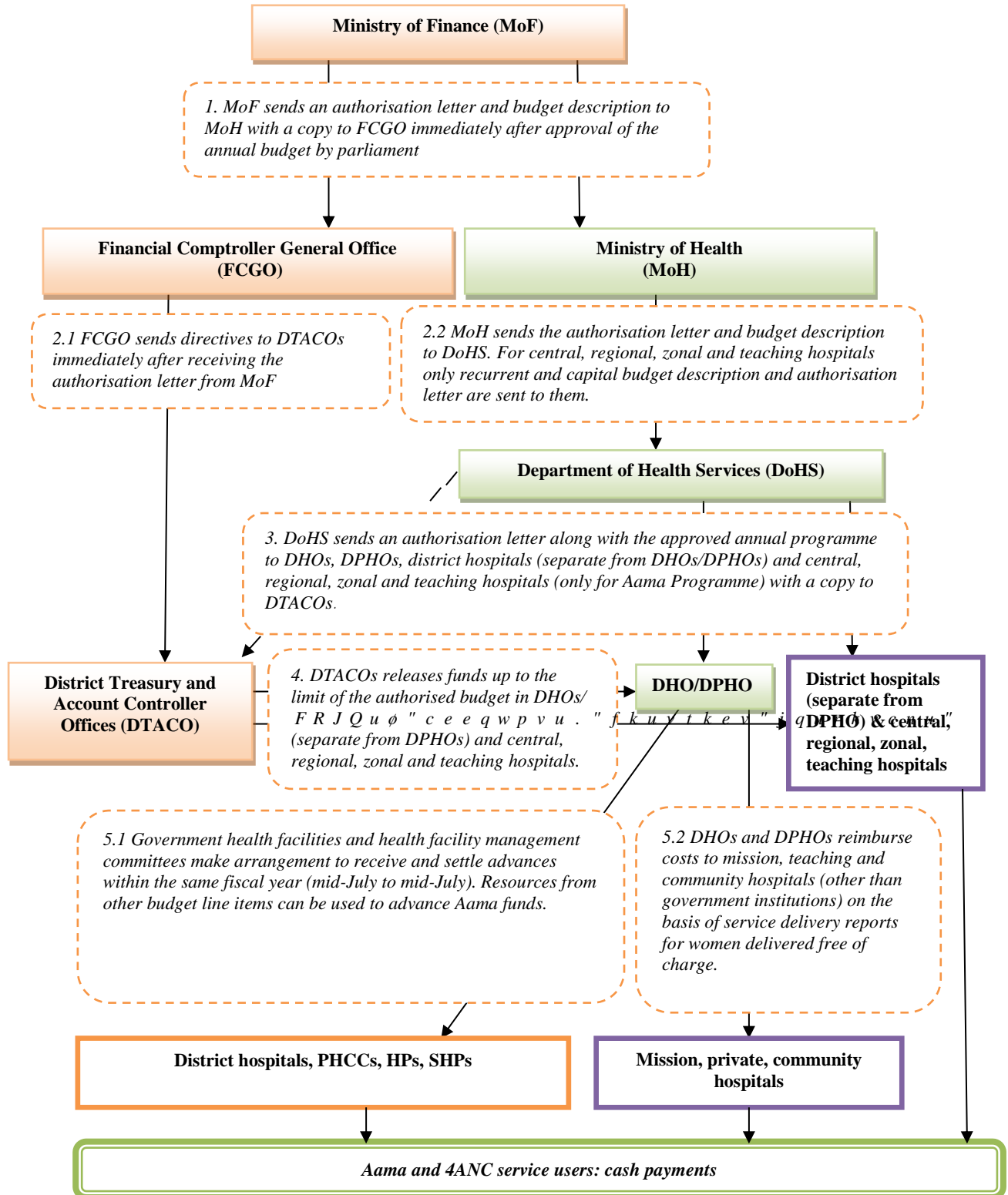
## 3.2 Management of Aama Programme Including Assignment of Timeliness of Funds Flow

### 3.2.1 Aama Programme budgeting and fund flow

The Family Health Division (FHD) at the Department of Health Services (DoHS) is the focal institution for the Aama Programme. It prepares annual work plans and budgets (AWPB) for the programme, including 4ANC, based on district and facility (referral facilities) expenditure in the previous fiscal year. The AWPB is submitted to DoHS and MoH, which compiles budget requests from different units for submission to the National Planning Commission and the Ministry of Finance (MoF). After Parliament approves the national budget, MoF provides details of approved programmes and allocated budgets to MoH and the Financial Comptroller General Office (FCGO). The FCGO passes these on to district treasury and account controller offices (DTACO). MoH provides details about approved programmes

and the letters of authority to DoHS, centres and divisions and zonal, regional and central hospitals. Based on these letters, DoHS sends details about approved programmes along with authorisation letters to DHOs and DPHOs. Finally, the approved Aama Programme activities and budgets are released to DHOs and DPHOs. See Figure 3.2 for a diagram of Aama Programme fund flow.

Figure 3.2: Fund flow in the Aama Programme



According to the revised Aama guidelines (2012), DHOs and DPHOs should transfer the amounts for institutional unit costs (reimbursement for facilities to provide Aama Programme services and

incentives) to health facility management and operation committee (HFOMCs) of PHCCs, HPs and listed SHPs and the hospital development committees (HDC) of hospitals. In cases of shortfalls or delays in receiving funds, HFOMCs and HDCs usually provide advances to their institutions to provide the incentives to eligible women.

### 3.2.2 Reporting of expenditure – Aama Programme

The Aama Programme Guidelines (2012) say that all health facilities implementing the programme must submit the forms at Annexes 6, 6ka and 10 of the guidelines along with the completed HMIS format (HMIS 9.3) to their DHO or DPHO by the seventh of each month. In turn, all DHOs and DPHOs should submit this progress report in accordance with sub-clause (1) of the Annex 6 progress reports along with completed HMIS 9.3 by the twelfth of each month to the Health Management Information Section of the Management Division (DoHS) with a copy to their regional health directorate (RHD) and FHD. All zonal, sub-regional, regional and central hospitals (that are authorised separately by DoHS) have to complete the Annex 6 and Annex 6ka forms and send them along with the HMIS forms by the seventh of each month to the Health Management Information Section, RHD and FHD.

### 3.2.3 Monitoring and feedback

The revised Aama guidelines (2012) say that programme supervision and monitoring is the responsibility of DHOs and DPHOs for district level and below facilities (primary health care centres, health posts, sub-health posts) including private facilities.

RHD, FHD and DoHS are also accountable for monitoring the Aama Programme at district-level, and at referral and private facilities. The guidelines say that RHDs should ensure the receipt of progress reports in accordance with sub-clauses 1, 2 and 3 of the guidelines. They also state that the budget allocated for the Aama Programme can be restricted if no reports are received for four months (sub-clauses 2 and 3). The responsibility for reporting lies with health facilities.

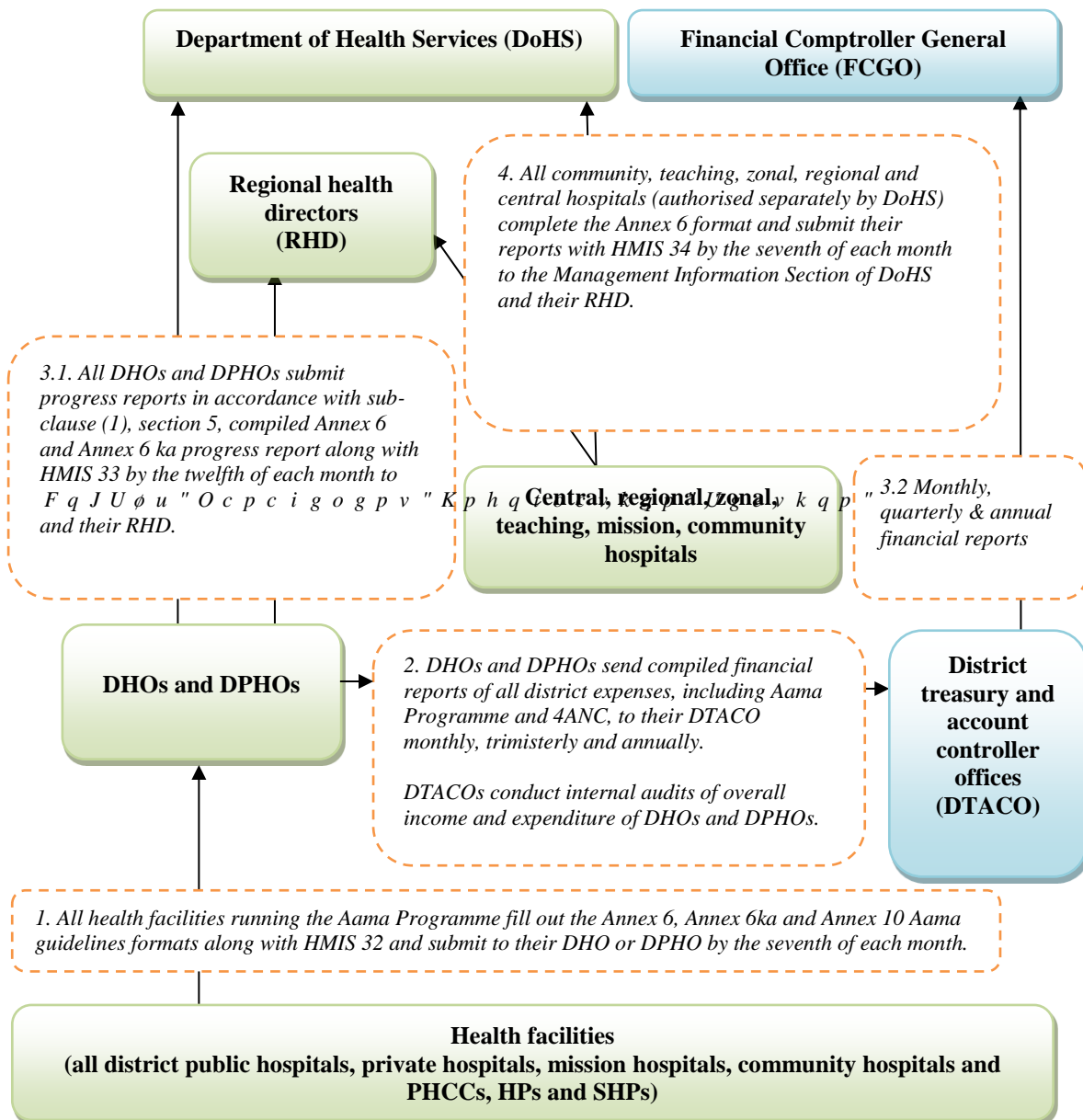
The Financial Act and its regulations (2008) provide for the monthly, quarterly and annual monitoring of funds allocated to DHOs and DPHOs by DTACOs based on approved programmes and allocated budgets. Figure 3.3 shows the reporting mechanisms for Aama as per the revised guidelines (2012), the government's Financial Rules and regulations, and as reported by key informants including government account officers.

### 3.2.4 District level

The key persons at district health offices DPHOs/DHOs, accountants and the Aama focal persons (usually the public health nurse, PHN) are responsible for the management and distribution of the Aama Programme. DHOs/DPHOs allocate funds to approved health institutions for delivering Aama related services. Most DHOs and DPHOs provide funds in advance to health facilities based on the recommendations of focal persons, and in some cases they provide refunds after reports come back to the DPHO/DHO. The release of funds for the subsequent quarter is contingent upon the receipt of the financial/expenditure statement from the respective health institution.

*"Though we requested the FHD to allocate us additional ~~additional~~ did not receive it. So, some health facilities did not receive the required ~~the last~~ ~~the last~~ quarter of the last fiscal year and so we were unable to pay the mother ~~Public health nurse, Lalitpur~~*

Figure 3.3: Reporting mechanism of the Aama Programme



When the district (public) health office receives the authorization from the department of health services, the DHO allocates it to various health facilities based on last year's performance in their treatment's public health nursing (Gorkha and Dhading)

"The budget allocation system should be changed. Advance money should be provided to the staff in the month of (same/July) skilled birth attendants (Sindhupalchowki health facility Makawanpur Dhading, Dhankuta and others

Disbursement of funds from the DHO/DPHO to district-based hospitals was found to be done promptly or when the fund was available. However, delays in disbursement of the fund to PHCCs and HPs was reported in some of the districts visited by the study team. For instance, a few PHCCs and HPs of some districts complained that due to the absence of the district health officer, the incentive fund was delayed for 2 to 3 months. Details about the Aama Programme fund allocations by the district health



offices could not be obtained for Gorkha and Lamjung districts because of the absence of the focal person and the accountants at the time of the field visits.

*"The new guidelines have incorporated the Aama programme and 4ANC together. It has simplified the work and made the job easier to perform. It is simple and less burdensome for the release of funds to peripheral health facilities. This will definitely increase the motivation for us as well as to the women for institutional deliveries."* Financial officer

Table 3.2 shows the allocation and expenditure of funds provided under the Aama Programme covering transport incentives, free delivery and 4ANC costs.

Table 3.2: Funds provided to the districts (FY 2013/14 to 2015/16)

SN	Districts	2013/14		2014/15		2015/16	
		Allocation	Expenditure	Allocation	Expenditure	Allocation	Expenditure
1	Dhankuta	3,530	3,346	3,755	3,357	3,510	2,928
2	Okhaldhunga	5,710	4,597	7,370	7,270.00	7,082	6,907
3	Sindhupalchowk	6,080	5,092	6,230	5,425	5,870	5,308
4	Lalitpur	5,960	5,733	6,500	6,457	6,722	6,592
5	Dhading	14,450	13,482	14,750	14,382	13,638	13,344
6	Makawanpur	15,130	13,338	16,320	15,766	17,028	16,035
7	Gorkha	7,040	7,020	5,870	4,984	10,654	9,821
8	Lamjung	7,906	6,160	8,763	8,688	8,305	8,212
9	Baglung	8,960	8,628	9,260	9,095	10,740	9,913
10	Arghakhanchi	5,086	4,999.00	5,210	4,877.00	5,435	5,374

Source: TABUCS, 2011

Table 3.2 shows that almost all 10 districts had spent more than 90% of the funds allocated under the Aama Programme. This does not indicate whether allocated funds were sufficient or not. The expenditure shown could be under reported. The qualitative information suggests that some districts do not receive sufficient funds for the Aama Programme. Some stakeholders raised the question on the budget allocation practices.

### 3.2.5 Health facilities

Some health facilities report monthly while others report quarterly. Some even report only annually. Some facilities are instructed by their DHOs/DPHOs to submit reports late because of delays in receiving budget from central level. Health facilities report quarterly to receive advances and reimbursement. Some facilities report only every six-months due to having only a few delivery cases.

*"We receive reports regularly. Some health facilities send it monthly and others send it every four months. So allocating budget regularly becomes difficult and some mothers might not be receiving the money on time. We have requested health workers to keep record of Aama service users at their facilities."* Lalitpur and Sindhupalchowk DHOs

*"Late budget release from DHO/DPHOs makes paying the transport incentives and 4ANC incentives to mothers difficult. We have to request mothers to come when the money is available."* PHNs, Makawanpur and Sindhupalchowk

The task of fund management and the distribution of transport incentives to mothers is usually assigned to a staff nurses or auxiliary nurse-midwife (ANM) who is identified as the Aama Programme focal person. However, in hospitals, the budget was not released in time and the focal persons had asked mothers to come later for their incentives. For example, the Sindhupalchowk district hospital was unable to distribute the transport incentive since the hospital focal person had not received funds on time due to the circumstances created by the earthquakes of April and May 2015.

*"If they have an account the money is deposited in the account health facility. If no account is available, the focal person receives the money as PHN, Sindhupalchowk"*

The practice of handing over the incentive money (some amount as per the caseloads) to fellow ANMs/staff nurse by the Aama focal person on a day she was off-duty was observed in the hospitals visited by the study team. This practice ensured instant payment of the incentives to every woman who came to the hospital for delivery. Private hospitals either do not have strong recording systems or did not respond to our study team properly to enable the obtaining of accurate information. The district hospital in Arghakhanchi was found to provide incentives at the time of discharge even if the budget is not received on time. They manage the money from the hospital development board and regularly report to the district health office.

*"Health facility management committee requested to use their fund from the mothers in time and the district will reimburse the amount later when the labor is available." PHN, Sindhupalchowk DHO*

*"Budget is sufficient but sometime some health facilities do not report on time so it create problem." PHN, Gorkha*

In Baglung district, the zonal hospital accountant controls of the Aama funds although this hospital has an Aama focal person (a nursing officer). As a zonal hospital, this hospital receives the programme and fund authority directly from FHD. The accountant receives fund from the district treasury control office and hands over the money to the focal person only when she demands an advance every two or three months for paying transport and 4ANC incentives. Therefore, almost all women who deliver their babies at this hospital are paid their incentives at the time of their discharge. In case the fund is not available on time, this hospital manages funds from the hospital development board.

Health workers are entitled to receive NPR 300 (NPR 255 after deduction of tax) as an incentive for each delivery performed, irrespective of the type of delivery while office assistants who help for the management of deliveries receive NPR 50. Some private and community hospital health workers do not receive incentives for assisting in the delivery, even though the facilities receive the institutional incentives from the government.

*"We have not received any incentives other than salary although the hospital receives incentive from the Aama Programme it would be better if helping in Aama received some incentive; even I am not provided such incentive" A health worker at a community hospital*

None of the surveyed hospitals displayed the list of mothers who had received the Aama incentives on their noticeboards as they didn't know they should publish the names and addresses of incentive receivers every month. Zonal and district hospitals HFOMC members said that medicines, bed charges, laboratory test and cleaning were free. Private hospital normally provided free services but sometimes

charged for medicine, tests, cleaning, new staff salaries and bed charges. Expendable items and blood transfusion were not free.

In PHCCs, Aama Programme focal persons are responsible for keeping the records of clients who receive institutional delivery incentives. They usually participate in the meetings of health facilities, but some focal persons complained that they have not participated in health facility management committee meetings and only facility in charges participated.

Some of the PHCCs are creating awareness among women who are likely to become mothers about the Aama Programme through different media. Because of the delay in fund flow at PHCCs, the practice of issuing receipts to women or making verbal assurances to them that they would be informed when to collect their incentives was reported by both PHCC staff and recently delivered women (RDW).

*"There is irregular fund flow to health facilities. That is why we are unable to provide transport incentives to mothers immediately after delivery. It is especially difficult months of the Sawan (July/August) and Bhadra (August/September) SBAs, Lamjung, Baglung, Arghakhanchi*

In a few PHCCs visited by the study team, the provider usually told their clients that they can receive the maternity incentives towards the beginning of the next quarter. The RDW contacted by the study team also revealed this situation.

### 3.3 Compliance of Programme Implementation with Aama Guidelines 2012

This section presents the results under objective 3 on compliance against the Aama guidelines including the receipt of transport incentives, who received the incentives, and the timing of receipt of transport incentives. The results are based on the 1,185 women who reported receiving the transport incentive and interviews with DHO/DPHO Aama focal persons, DHO/DPHO finance sections, health facility account sections, health facility management committee representatives and service providers.

#### 3.3.1 Comparison of key indicators with previous assessment

The data in Table 3.3 shows the improvements in terms of percentage of matched cases between health facility records and women on receipt of transport incentive. It also suggests an improvement in the provision of free delivery in comparison to previous RAs. Important questions remains though on funds management and compliance with provisions of the guidelines.

Table 3.3: Results against indicators of rapid assessment 7, 8 and 9

	Indicator	RA VI April 2013	RA VIII Sep. 201	RA IX Mar. 2016	Indicator type
Cross verification of health facility information					
1	% match between health facility records and women on receipt of transport incentives	95	93.9	96.6	Core
2	% match between health facility records and women on receipt of 4ANC incentive	94	99.6	46.4	Core
3	% match between health facilities and women on type of delivery (normal/complicated/caesarean)	99	94.8	87.56	Core
Compliance with Aama guidelines					
4	% of women receiving transport incentive on	76	89.3	84.5	Core

	day of discharge				
5	% of health facilities with display boards showing lists of Aama beneficiaries	57	60	55.7	Core
6	% of health facilities with a copy of the revised Aama guidelines	31	37.8	55.8	Core
Utilisation of free delivery care and incentives					
7	% of women receiving transport incentives as per the guidelines	76	86.4	90	Supplementary
8	% of women who did not pay any cash at health facility for their deliveries	43	61.4	71	Supplementary
9	% of women receiving 4ANC incentive of total women completing four ANC visits	16	35.1	34.7	Supplementary

### 3.3.2 Receipt of transport incentive

Table 3.4 shows the receipt of transport incentive by recently delivered women. Almost 90 percent of the sampled women had received their due transport incentives. The women from Makawanpur and Dhankuta were less likely to receive the incentive compared to women from elsewhere.

Table 3.4 Receipt of transport incentive by district and type of health facility (N=1185)

Districts	Number of women interviewed (N)	Number of women receiving transport incentive	Percentage (%)
Dhankuta	97	70	72.2
Okhaldhunga	113	109	96.5
Sindhupalchowk	88	80	90.9
Lalitpur	63	51	81.0
Dhading	150	150	100.0
Makawanpur	175	116	66.3
Gorkha	122	120	98.4
Lamjung	144	139	96.5
Baglung	115	115	100.0
Arghakhanchi	118	116	98.3
Total	1,185	1,066	90.0
By type of health facility			
Government hospital	228	216	94.74
Private hospital	116	116	100.00
PHCC	366	300	81.97
HP	475	400	84.21

Almost 97% of the surveyed women from Dhading and Gorkha received their transport incentive. All of the women delivering in private facilities received their incentive while only 95% of women delivering in public hospitals and 81% in PHCCs received the incentive.

### 3.3.3 Receipt of transport incentive by background characteristics of women

Table 3.5 describes the background characteristics of women receiving a transport incentive. The data shows that overall there was no discrepancy in receiving transport incentive by the different characteristics.

Table 3.5 Background characteristics of women receiving transport incentive (N=1185).

Background Characteristic	Number of Women receiving transport incentive	Number of Women receiving transport incentive	Percentage
<b>Caste/ethnicity</b>			
Dalit	208	195	93.75
Disadvantaged Janajatis (ethnic groups)	277	245	88.45
Disadvantaged non-Dalit Tarai castes	6	3	50
Religious minorities	5	5	100
Relatively advantaged Janajatis	330	280	84.8
Upper castes	359	338	94.15
Total	1,185	1,066	89.96
<b>Level of education</b>			
Illiterate	46	43	93.48
Non formal education	71	56	78.87
Primary education	156	136	87.18
Secondary education	453	417	92.05
School leaving certificate (SLC) and above	459	414	90.20
Total	1,185	1,066	89.96
<b>Occupation</b>			
Did not earn	714	646	90.48
Labour	12	9	75.00
Agriculture	325	283	87.08
Petty business	106	102	96.23
Services	28	26	92.86
Total	1,185	1066	89.96
<b>Place of residence</b>			
Rural	857	769	89.73
Urban	328	297	90.55
Total	1,185	1,066	89.96

Dalit and upper caste women and women from religious minorities, were more likely to receive the transport incentive than other women. On the other hand disadvantaged non-Dalit Tarai women were relatively worse off (only 50% of total sample) on receipt of the transport incentive. No major difference is noticed on receipt of the transport incentive terms of place of residence, level of education and by occupational group.

### 3.3.4 Receipt of 4ANC incentive by women

Table 3.6 shows the receipt of 4ANC incentive by women. Out of the 1,185 women who had received the transport incentive only 608 women (51%) had made 4ANC visits as per the protocol. Almost 35% of these 608 women had received the 4ANC incentive money. The women from Dhankuta and Okhaldhunga were the least likely to receive the 4ANC incentive (11% and 13%) while almost 52% of the women from Arghakanchi received the 4ANC incentive.

Table 3.6 Receipt of 4ANC incentive by district and type of health facility (N=1185)

Districts	Number of Women Interviewed (N)	Number of women completing 4ANC as per protocol	Number of women receiving 4ANC incentive (n)	Percentage (%)
Dhankuta	97	37	4	10.81
Okhaldhunga	113	45	6	13.33
Sindhupalchowk	88	51	21	41.18
Lalitpur	63	38	12	31.58
Dhading	150	115	52	45.22
Makawanpur	175	87	18	20.69
Gorkha	122	50	16	32.00
Lamjung	144	91	41	45.05
Baglung	115	46	17	36.96
Arghakhanchi	118	48	25	52.08
Total	1,185	608	212	34.87
By type of health facility				
Government hospital	228	137	39	28.47
Private hospital	116	0	0	0.00
PHCC	366	229	73	31.88
HP	475	242	100	41.32

None of the women who had delivered in a private facility had received the 4ANC incentive. At the public facilities the women who delivered at a hospital (28%) were less likely to receive the 4ANC incentive compared to women who delivered at a PHCC (32%) or HP (41%).

*"We are happy to give 4ANC incentives to mothers at the time of discharge. The only thing required is their 4ANC card when their 4ANC visits are documented". Health service provider, Dhading*

*"I received only NPR 1000 from the health facility. I did not get 4ANC incentive. I learned that the facility was privately owned and they do not provide this incentive". RDW, Lalitpur*

### 3.3.5 Receipt of transport incentive on day of discharge

Table 3.7 shows the timing of the receipt of transport incentives. Almost 85% of the entitled women received it on the day of discharge. About 14% of the women had to wait for between one and three months to receive it. All the women from Arghakhanchi received their transport incentive. Almost 48% women from Makawanpur district had to wait a month or more to receive their transport incentives.

Table 3.7 Timing of receipt of transport incentive, (N=1066)

District	On day of discharge (n)	Within a month (n)	1 to 3 months (n)	>3 months (n)	Total (N)
Dhankuta	44	8	14	4	70
Okhaldhunga	79	14	12	4	109
Sindhupalchowk	63	11	6	0	80
Lalitpur	50	0	1	0	51
Dhading	145	3	2	0	150
Makawanpur	56	16	38	6	116
Gorkha	113	5	2	0	120
Lamjung	121	17	1	0	139
Baglung	114	1	0	0	115
Arghakhanchi	116	0	0	0	116
Total	901	75	76	14	1,066
Percentage	84.52	7.04	7.13	1.31	100.00
By type of health facility					
Government hospital	172	14	24	6	216
Private hospital	107	9	0	0	116
PHCC	265	16	18	1	300
HP	357	36	34	7	434

Almost 92% of the women at the private facilities had received their transport incentive on the day of discharge from private facilities while only 80% of the women at the public facilities had received their transport incentive on the day of discharge. Women delivering in PHCC are more likely to receive incentive on the day of discharge compared to HP (82%) and government hospitals (80%).

"I received the incentive (900) at the time of discharge. It was good to get it in time of discharge. I will use it to buy nourishing foods like eggs and other Melamchi

"The sister (nurse) told me that the money is available at this time. So, have to come again to get the incentive. Mother, PHC

### 3.3.6 Receipt of transport incentive by women

Table 3.8 shows the findings on who received the transport incentive. Eighty-four percent of the mothers received the incentives themselves while husbands and family members received it in the other cases. The mothers were less likely to receive it themselves in Gorkha and Lamjung as compared to Dhading, Baglung and Arghakanchi district.

Table 3.8 Receipt of transport incentive by mothers

Districts	Self (interviewed women)	Husband	Father/mother in-law	Other family member	Total
Dhankuta	63	5	0	2	70
Okhaldhunga	88	12	5	4	109
Sindhupalchowk	79	1	0	0	80
Lalitpur	30	11	5	5	51
Dhading	149	1	0	0	150

Districts	Self (interviewed women)	Husband	Father/mother in-law	Other family member	Total
Makawanpur	112	3	0	1	116
Gorkha	65	51	1	3	120
Lamjung	85	50	2	2	139
Baglung	113	2	0	0	115
Arghakhanchi	113	3	0	0	116
Total	897	139	13	17	1066
Percentage	84.1	13.0	1.2	1.6	100.0

### 3.3.7 Receipt of free delivery care

Table 3.9 shows the number of surveyed women who received free care. The findings show that not all women who received delivery services at Aama Programme accredited facilities received it for free. On average around 29% of the surveyed women paid for 'free' services varying from 14% to 57% of the women across the ten districts. The women who received services at the Dhading (87%) and Makawanpur (83%) facilities were most likely to receive actual free care while the women from Lalitpur (43%), Baglung (57%) and Dhankuta (61%) were least likely.

Table 3.9 Receipt of actually free delivery care

District	No. women interviewed	No. women receiving free care	Percentage who actually received free care
Dhankuta	97	59	60.82
Okhaldhunga	113	75	66.37
Sindhupalchowk	88	77	87.50
Lalitpur	63	27	42.86
Dhading	150	130	86.67
Makawanpur	175	145	82.86
Gorkha	122	83	68.03
Lamjung	144	102	70.83
Baglung	115	66	57.39
Arghakhanchi	118	79	66.95
Total	1,185	843	71.14
Type of delivery			
Normal	1,054	814	77.23
Complicated	86	17	19.77
CS	45	12	26.67
Total	1185	843	71.14
Type of health facility			
Government hospital	228	145	63.60
Private hospital	116	22	18.97
PHCC	366	287	78.42
HP	475	389	81.89
Total	1,185	843	71.14



Women who had undergone all three types of delivery services (normal, complicated and CS) had paid for 'free' services. Almost 80% of complicated delivery and 64% CS service women had been charged. Very few women (19%) at the private facilities had actually received the delivery services for free. The qualitative findings also suggest that some women were asked to pay for different type of services:

"I received all the services free. The sister was very kind Mother, Gorkha PHC

"I had to pay for the services like blood and sanitary pads. The health workers told me that it was not available at the health facility." Mother, hospital

"I paid for the blood bag and tests. They told me that it was not covered by the incentives scheme" Mother

"I had to buy calcium and sanitary pad was not covered by the free drug" Mother, Gorkha hospital

The women were paying at all levels of the public facilities. Almost 24% of women receiving care from hospitals had paid for the 'free' services followed by 22% of the PHCC women and 18% of the HP women.

Sixty-seven percent of the exit interview women said they had received actual free care. Most of those who had paid for services were from the private hospitals followed by public hospitals.

3.3.8 Background characteristics of women paying for services

Table 3.10 shows the characteristics of women paying for services. Women from all caste/ethnicity backgrounds, education levels, occupations and residing in both rural and urban areas had paid for so-called free services. Women from religious minorities, with only non-formal education, doing labouring work and living in urban areas paid the most often for 'free' services.

Table 3.10 Background characteristics of women paying for services

Characteristics	Number of women interviewed	Number of women paying for services	Percentage
<b>Caste/ethnicity</b>			
Dalit	208	62	29.81
Disadvantaged Janajatis	277	85	30.69
Disadvantaged non-Dalit Tarai castes	6	0	0.00
Religious minorities	5	3	60.00
Relatively advantaged Janajatis	330	72	21.82
Upper castes	359	120	33.43
Total	1,185	342	28.86
<b>Education</b>			
Illiterate	46	7	15.22
Non formal education	71	26	36.62
Primary education	156	44	28.21
Secondary education	453	121	26.71
SLC and above	459	144	31.37
Total	1,185	342	28.86

Characteristics	Number of women interviewed	Number of women paying for services	Percentage
Occupation			
Do not earn	714	208	29.13
Labour	12	7	58.33
Agriculture	325	87	26.77
Petty business	106	29	27.36
Services	28	11	39.29
Total	1,185	342	28.86
Place of residence			
Rural	857	215	25.09
Urban	328	127	38.72
Total	1,185	342	28.86

### 3.3.9 Average amount paid for normal and complicated delivery services

Table 3.11 shows the average amount paid by the women for normal and complicated delivery services. The average amount paid for normal and complicated delivery services in the 10 districts was NPR 1,002. The average amount paid for normal and complicated delivery service varied from NPR 650 in Dhankuta to NPR 1600 in Lalitpur. It must be noted that the cost of care in a facility for complicated cases depends on the type and severity of the complication.

Table 3.11: Average amount paid for normal and complicated delivery services (N=308)

Districts	Number of women paying for services (N)	Average amount paid for normal and complicated deliveries (NPR)
Dhankuta	36	640.56
Okhaldhunga	37	1,150.14
Sindhupalchowk	11	823.18
Lalitpur	32	1,582.97
Dhading	18	761.67
Makawanpur	27	753.70
Gorkha	30	1,288.73
Lamjung	33	1,114.85
Baglung	45	1,027.60
Arghakhanchi	39	706.54
Total	308	1,002.05
Types of facility		
Government hospital	74	1,093.31
Private hospital	71	1,752.14
PHCC	77	700.81
HP	86	574.01
Total	308	1,002.05

The women were found paying more in the private facilities compared to the public facilities. Charges as high as NPR 1750 were paid for normal and complicated deliveries at the private facilities followed

by government hospitals (NPR 1093) and PHCCs (NPR 700). Table 3.21 shows the items and services that were charged to women. Out of 308 women who had paid for free services almost all (n=304) had paid for drugs, followed by supplies, registration fees and lab tests. The average amount spent on drugs was almost NPR 400, lab tests NPR 300 and supplies NPR 250. The women at the private facilities were being charged for health worker and complication management fees. The average amount paid for this NPR 350 and NPR 1075 respectively. Note that the amount of the health worker fee depends on the complication treated.

Table 3.12 Average amount paid by women

Items	Number of women paying for serv	Average amount (NPR)
Registration fees	222	32.18
Drugs	304	386.86
Supplies	296	235.81
Complication management fees	12	1075.00
Health worker's fees	71	320.42
Payments to cleaner	146	164.38
Lab tests	139	287.29
Anti-D costs	3	4833.33
Total (N)	308	1002.06

Almost all of the 69 exit client interview women had paid for drugs, followed by supplies such as pads and then laboratory services.

### 3.3.10 Average amount paid for CS delivery services

Table 3.13 shows the average amount paid for CS delivery services. On average CS delivery women were charged NPR 9,200. The amount charged for CS delivery services varied from NPR 4,125 in Dhankuta to NPR 12,250 in Lalitpur district. This large variation could be due to the varying district-wise availability of private facilities providing CS delivery.

Table 3.13 Average amount paid for CS delivery

Districts	Number of women payin	Average amount paid for caesarean sec
Dhankuta	2	4,125
Okhaldhunga	3	12,650
Sindhupalchowk	0	NA*
Lalitpur	4	12,250
Dhading	2	4,575
Makawanpur	3	4,508.33
Gorkha	9	10,188.89
Lamjung	9	11,817.78
Baglung	4	3,917.50
Arghakhanchi	0	NA*
Total	36	9,211.25
Types of facility		
Government hospital	9	4421.67
Private hospital	25	11,400.40

Districts	Number of women paying	Average amount paid for caesarean section
PHCC**	2	3,400.00
HP	0	0
Total	36	9,211.25

\*Districts with no CS facility, \*\*Burtibang PHCC in Baglung district

The women who received CS service from private facilities were charged higher rates than at public facilities. At the private facilities women spent an average of NPR 11,400 on a CS delivery, almost twice as much as at the government hospitals (NPR 4500). Table 3.14 gives an overview of the items and services charged by facilities for CS deliveries. Out of the 36 women who paid for CS services, all (100%) paid for drugs, supplies and registration fees while 25 of them paid for lab tests and complication management fees (69%). The average amount spent on drugs was NPR 2,200, supplies NPR 2,100, lab and diagnostics NPR 1100 for and registration NPR 50. Complication management fees accounted for the greatest part of the costs of CS deliveries.

Table 3.14 Average amount paid by women for CS service in different categories

Items	Number of women paying	Average amount (NPR)
Registration fee	36	49.31
Drugs	36	2,161.11
Supplies	36	2,097.22
Complication management fee	25	5,584.00
Payments to cleaner	19	553.68
Lab test and diagnostics	25	1,056.40
Anti-D cost	0	0
Total/Average	36	9,211.25

### 3.3.11 Disclosure of Aama Programme beneficiaries

Table 3.15 summarizes the number of health facilities that were disclosing/displaying the names of mothers. Twenty-nine of the 52 facilities were found displaying Aama Programme beneficiaries on their noticeboards. The number of facilities displaying Aama beneficiaries ranged from 40% to 50% by district.

Table 3.15 Number of facilities disclosing names of mothers receiving Aama benefits

District	Number of health facilities	No. facilities disclosing Aama Beneficiaries
Dhankuta	5	3
Okhaldhunga	6	3
Sindhupalchowk	5	3
Lalitpur	4	2
Dhading	6	3
Makawanpur	6	4
Gorkha	5	2
Lamjung	6	4
Baglung	4	2
Arghakhanchi	5	3
Total	52	29

District	Number of health facilities	No. facilities disclosing Aama Beneficiaries
Types of facility		
Government hospital	8	3
Private hospital	4	0
PHCC	16	10
HP	24	16

No private facilities were found displaying the name of Aama beneficiaries. Three out of eight government hospitals were displaying Aama beneficiaries. Only 60% of the below district level facilities were found displaying beneficiary names.

*"The new guidelines have incorporated the Aama Programme and ANCs together. It is simplified to work and perform the job. It is simple and less burdensome for the release of funds to peripheral health facilities. It will definitely increase the motivation for us as well to the women for institutional delivery".*

### 3.4 Cross verification

This section gives the results of the cross-verification of the receipt of Aama Programme benefits between health facilities and target groups to explore opportunities of misappropriation of Aama Programme funds. The results are based on quantitative information obtained from 1,192 interviewed women and 1,185 delivery records reviewed in health facilities.

#### 3.4.1 Cross verification of Aama Programme beneficiaries

Table 3.16 shows the results on the matching of delivery cases obtained from DHO/DPHO records against the same information in health facility maternity registers. To obtain the required sample size of 1,265 women, almost 7,202 cases from the previous six months were reviewed from DHO/DPHO records in the districts. Out of 1,265 women, 1,200 women could only be traced in the health facility maternity register. Of those 1,200 only 1,185 women could be interviewed. Three out of the 15 who could not be interviewed had left the given place of residence and almost all the rest could not be traced. Most of these cases were women residing in urban area such as in the Kathmandu Valley in Lalitpur district.

Table 3.16: Number of deliveries in records and number of women interviewed.

District	Sample Size	No of women interviewed
Dhankuta	104	97
Okhaldhunga	121	113
Sindhupalchowk	94	88
Lalitpur	67	63
Dhading	160	150
Makawanpur	187	175
Gorkha	130	122
Lamjung	154	144
Baglung	123	115
Arghakhanchi	126	118
Total	1,265	1,185

These findings could be due to errors in recording or the misappropriation of incentives. Before any conclusion is drawn further exploration is needed to identify the actual reasons for these mismatches. Errors in recording and reporting and events of misappropriation can be minimized through extensive monitoring and supervision. The misappropriation of benefits requires more detailed investigation in future rapid assessments.

### 3.4.2 Cross verification on receipt of transport incentive

Table 3.17 shows the number of women who received their full transport incentives against health facility records on the same.

- ◁ Out of 1,185 eligible women, the health facility records showed that only 1,102 women had received their full transport incentive — 9 women did not receive any incentive and 74 were told to collect it later.
- ◁ However, few women, only 1066 out of 1102 (96.6%) confirmed to have received the full transport incentive — 114 said they had not received the transport incentive at all (compared to 9 in the facility records) and only 5 out of 74 (6.7%) were told would get later.

On average around 3.4% mismatch was observed on the receipt of transport incentive. The degree of mismatch varied across districts between 0.9% and 8%.

Table 3.1:7 Cross verification on the receipt of transport incentive

Districts	Health facility records			Women's rep			Total (N)
	Number of women received transport incentive (n)			Number of women received transport incentive (n)			
	Fully received	Not received	Told would get later	Fully received	Not received	Told would get later	
Dhankuta	72	3	22	70	25	2	97
Okhaldhunga	112	0	1	109	4	0	113
Sindhupalchowk	86	0	2	80	8	0	88
Lalitpur	59	3	1	51	12	0	63
Dhading	150	0	0	150	0	0	150
Makawanpur	126	2	47	116	58	1	175
Gorkha	122	0	0	120	1	1	122
Lamjung	143	0	1	139	4	1	144
Baglung	115	0	0	115	0	0	115
Arghakhanchi	117	1	0	116	2	0	118
Total	1102	9	74	1066	114	5	1185
Type of health facility							
Government hospital	220	2	6	216	12	0	228
Private hospital	116	0	0	116	0	0	116
PHC	315	4	47	300	64	2	366
HP	451	3	21	434	38	3	475
Total	1102	9	74	1066	114	5	1185

At the health facility level no mismatches on the receipt of transport incentives were at the private facilities. For public facilities PHCCs and HPs had 3.9 and 5% mismatches.

### 3.4.3 Crossverification of type of delivery

Table 3.18 shows the receipt of type of delivery care by women against the health facility records of the provision of this care.

- < Of the 1,185 eligible women, the facility records showed that 1,022 women had received normal delivery care, 107 complicated delivery care and 56 CS delivery services.
- < However, only 1,047 women confirmed to have received normal delivery services, 90 complicated delivery services and 48 CS delivery services.

There was an average 2.3% mismatch on the receipt of normal delivery, 18% on complicated delivery and 17% on CS delivery services. The degree of mismatch varied across districts ranging from 1.2% to 6% for normal deliveries, 20% to 63% for complicated deliveries, 9% to 50% for CS deliveries.

Table 3.18 Comparison of health facility records and women's report on type of delivery care (N=1185)

Districts	Health facility records:			Women's report			
	Type of delivery (n)			Type of delivery (n)			
	Normal	Complicated	C/S	Normal	Complicated	C/S	Total
Dhankuta	80	11	6	83	9	5	97
Okhaldhunga	96	13	4	99	11	3	113
Sindhupalchowk	82	6	NA	83	5	NA	88
Lalitpur	51	7	5	51	8	4	63
Dhading	133	11	6	136	10	4	150
Makawanpur	156	12	7	157	12	6	175
Gorkha	96	14	12	99	12	11	122
Lamjung	125	10	9	127	8	9	144
Baglung	95	13	7	101	8	6	115
Arghakhanchi	108	10	NA	111	7	NA	118
Total	1,022	107	56	1,047	90	48	1,185
Type of health facility							
Government hospital	175	27	26	182	25	21	228
Private hospital	75	14	27	77	14	25	116
PHC	326	37	3	332	32	2	366
HP	446	29	0	456	19	0	475
Total	1,022	107	56	1,047	90	48	1,185

\ -charge keeps the incentive with him. He is not around most of the time and we are not able to give the women their incentive immediately. We have to call them time and again. Most delivery cases come when he is not around so it is very difficult

Health service provider, Gorkha

### 3.4.4 Crossverification of receipt of 4ANC incentive

Table 3.19 shows the findings on the receipt of 4ANC incentives by women against the health facilities records of the same. Six hundred and forty of the 1,185 women had completed four antenatal visits, while only 583 had completed antenatal care as per the protocol for receiving the incentive.

There was an average 53.6% mismatch on the receipt of 4ANC incentive by the women's and the facilities' reports:

- < According to the health facilities' records, 457 women had received the 4ANC incentive.
- < However, the women themselves reported that only 212 of them had received it.

The percentage mismatch varied across districts between 49% and 68%. At the health facility level the highest percentage mismatch was observed at the PHCC level (53.8%), followed by HPs (49.2%) and district hospitals (41.8%). One of the reasons for such high discrepancies could be that the women were unaware about the availability of the 4ANC incentive.

Table 3.19: Health facility records and receipt of 4ANC incentives by women

District	Matched health facility records:	Women's report	Match percentage (%)
	No. women provided with 4ANC incentive	No. received 4ANC incentives	
Dhankuta	7	4	57.1
Okhaldhunga	15	6	40.0
Sindhupalchowk	51	21	41.2
Lalitpur	38	12	31.6
Dhading	101	52	51.5
Makawanpur	31	18	58.1
Gorkha	40	16	40.0
Lamjung	91	41	45.1
Baglung	35	17	48.6
Arghakhanchi	48	25	52.1
Total	457	212	46.4
Type of health facility			
Government hospital	67	39	58.2
Private hospital	35	0	-
PHCC	158	73	46.2
HP	197	100	50.8

### 3.5 Levels of Satisfaction

#### 3.5.1 Satisfaction on the services from facility

Table 3.20 shows client satisfaction with the services provided by the health facilities. The exit client tool was used to measure user satisfaction. Sixty-eight of the 69 exit interviewed clients said they were satisfied with the services provided by the health facility. Forty percent of the women were satisfied because the delivery services were provided free by the health facility. Almost 25% said that the staff were cooperative and 15% were satisfied because they receive transport incentive.

The reason for the dissatisfaction of the one women was that she had been attended by nurses undergoing training and that she had to pay for cleaning and delivery services.



Table 3.20 Client satisfaction on the services from the health facility (N=69)

Reasons for satisfaction	Frequency	Percentage
Cooperative staff	21	45.65
Free delivery service	34	73.91
Transportation incentive	13	28.26
Clean health facility	2	4.35
Clothes for children	9	19.57
Sufficient beds in health institution	4	8.7
Delivery without complications	1	2.17
Nothing satisfactory	1	2.17
Total	85	184.78

\*Multiple responses therefore figures do not add up to 100

### 3.5.2 Satisfaction on the provision of transport incentive and free care

Table 3.21 shows the findings on client satisfaction on the provision of the transport incentives and free care. 67 women out of 69 interview felt that the provision of transport incentive and free care was good. Forty-five percent of the 67 women were satisfied with the transport incentive as it 'helped to save the life of both mother and children'; 43% as it helped to reach the health facility and 37% as shared some cost of the delivery care. Two of the 69 women felt that the provision of a transport incentive and free care was not good at all.

Table 3.21 Client satisfaction on the provision of transport incentive and free care (N=67)

Reasons for satisfaction	Frequency	Percentage*
Transport incentive helps to share cost of delivery	25	37.31
Helps to reach health institution	29	43.28
Helps to save life of mother and child	30	44.78
Reduces maternal and neonatal death	10	14.93
No need to borrow money for transport	5	7.46
Total	99	147.76

\*Multiple responses therefore totals are more than 100

### 3.5.3 Dissatisfaction on the provision of transport incentive and free care

Table 3.22 shows client dissatisfaction with the provision of transport incentives and free care. All 69 women had some dissatisfaction with the provisions under the Aama Programme.

Thirty-nine percent complained that all drugs were not provided free; 35% thought the incentive was too small to support poor people while 15% felt that the services were not provided free.

Table 3.2.2 Client satisfaction on the provision of transport incentive and free care (N=69)

Reason for dissatisfaction	Frequency	Percent
Expenses are higher in health facility than programme benefits	6	8.7
Small incentive doesn't actually help poor	24	34.78
Did not get incentive on time	2	2.9
No free medicine	27	39.13
No free services	10	14.49
Total	69	100

#### 3.5.4 Suggest friends to go to health facility for delivery

Of the 69 women, only one said that she would not recommend her friends to go to the health facility for their deliveries (data not shown). Sixty-seven percent of the women suggested they should visit a health facility for a safe delivery service, 25% felt that the facility provided good facilities and 15% said that the services are free and transport incentives are provided.

## 4 CONCLUSIONS AND WAYS FORWARD

This chapter presents the conclusions and ways forward on the use of delivery care, fund management, compliance against the guidelines and on the receipt of free care and transport incentives. The ninth round of the RA resonates some of the findings from previous RAs and the Aama stocktake analysis 2016. Some of the positive findings are the increase in institutional deliveries, the expansion of health facilities implementing the Aama Programme, and the improved uptake of the 4ANC incentive. However, challenges remain on the timely release of funds, the receipt of transport incentives at the time of discharge, the provision of free delivery care, the disclosure of beneficiaries, the timely reporting of financial and fiscal progress, and the availability of Aama Programme Guidelines 2012. The following sections highlight the conclusion of the study under each of the objective and the way forward.

### 4.1 The Use of Delivery Care

#### 4.1.1 Conclusion

Since its inception in 2005, the Aama Programme has made a large contribution to the improved uptake of institutional deliveries in Nepal. In FY 2005/06 institutional deliveries accounted for only 14% of all deliveries while the proportion increased to 52% in FY 2014/15. It is encouraging to see that home deliveries have decreased from 20% of deliveries in FY 2005/06 to 5% in FY 2014/15. Attendance at 4ANC visits has slowly increased from 47.7% in FY 2014/15 to 59% in FY 2013/14. Similarly, analysis of three year data of institutional delivery in the assessment study district also shows a consistent increase in use. However, it is also noted that the increase has not been the same across all ten districts. The following are the recommended ways to sustain and improve institutional delivery.

#### 4.1.2 Ways forward

- a) Improve the supply side functions of health facilities implementing the Aama Programme. These functions include the provision of 24/7 delivery services, SBA trained health workers, infrastructure and essential drugs and supplies.
- b) Strengthen the quality of care in all birthing centres by following the standard protocols and guidelines.
- c) Improve the current birthing centre expansion guidelines and ensure the expansion of birthing centres as per the distribution of population.

### 4.2 Management of Aama Programme Including Timeliness of Fund Flow

#### 4.2.1 Conclusion

This ninth RA confirmed that the untimely flow of funds from the centre to district health offices and hospitals is a major barrier to providing transport incentives at the time of discharge. This delay significantly contributes to the charging of women for delivery services. Delays in preparing fiscal and financial reports also cause delays in the release of funds from the centre and the distribution by DHOs/DPHOs to health facilities. It was also observed that the provision of advances and their timely clearance adds to the complexity in managing Aama funds. The reluctance to use locally available funds to provide the transport incentive was also observed to be a problem. The qualitative findings suggest the following ways to resolve issues related to fund management.

#### 4.2.2 Ways forward

- a) DoHS/FHD to send an instruction letter to all Aama Programme implementing health facilities to use their local funds to provide transport incentive at the time of discharge if they have not yet received their Aama funds.
- b) MoH, DoHS and FHD to ensure the timely flow of funds for the Aama programme to all Aama implementing health facilities.
- c) FHD to send instruction letters to all Aama implementing health facilities to submit their fiscal and financial progress reports on time.
- d) DoHS/FHD to discourage the provision of cash advances to health workers. DHOs/DPHOs should provide such advances to the bank accounts of the respective health facilities.
- e) DHOs/DPHOs and hospitals to enter financial and progress data in TABUCS.

### 4.3 Compliance of Programme Implementation with Aama Guidelines 2012

#### 4.3.1 Conclusion

As indicated by previous rounds of RA and findings from various studies, this RA confirms the presence of compliance issues on programme implementation. One major issue observed was the receipt of transport incentives by women at the time of discharge. Further, the provision of free delivery care is being interpreted differently by different health facilities. Thus, most of the health facilities end up charging women in one or another way. Similarly, the provision of the 4ANC incentive was poorly understood at most facilities leading some facilities to request women to submit their citizenship cards. The display of beneficiaries' names on a public noticeboard has also been ignored by many health facilities. It was found that almost all higher level health facilities did not comply with this requirement. Additionally, the provision to use locally available funds to pay incentives has not been universally understood. The effect of the 2015 earthquakes on the regular reporting of Aama annexes was seen to be negligible. In a few facilities the Aama annexes (completed forms) had been destroyed while in others the forms had either been used up or health workers had reported after the submission date because they had received no travel allowance to allow them to submit their reports. In summary, there are issues around non-compliance with the Aama Guidelines 2012 among most health professionals at health facilities.

#### 4.3.2 Ways forward

- a) Serious programmatic actions need to be taken to clarify service provision under the programme and ensure compliance with the guidelines. DoHS/FHD/RHD need to send a letter to all Aama implementing facilities including private hospitals highlighting the key provisions of the Aama Programme Guidelines 2012.
- b) The Aama guidelines should be made available to key stakeholders. Transparency is a key strategy to bring accountability and participation in financial matters. In this regard it is suggested to conduct compulsory public audits or public hearings in the catchment areas of health institutions, with the representative participation of the DHOs/DPHOs.
- c) A policy discussion must be initiated on whether to authorize private facilities to implement the Aama Programme or whether to revise this programme component.
- d) The Aama Programme Guidelines clearly state that delivery care is to be provided free of cost. In order to address the local demands for all types of delivery care FHD has started providing lump sums to cover the cost of blood transfusions. This depicts the policy intention to offer 100% free care. However, the study found that most of the health facilities were charging women for blood transfusions with the justification that HFOMCs have the authority to

impose different types of user fees. A national level discussion is needed to address this policy contradiction. MoH needs to issue a uniform policy that assures the provision of complete free delivery care.

#### 4.4 Cross-verification of Types of Delivery and Receipt of Transport Incentive

##### 4.4.1 Conclusion

As indicated by previous RAs and findings from different studies, this RA identified a mismatch in facilities' records and actual receipt of transport incentives and type of delivery service by clients. Many women are still not being provided with their transport incentives when facilities record them as having received it.

Almost all women from Dhading and Gorkha received their transport incentive. All women who delivered at private facilities received their transport incentive while only 95% of women who delivered at a hospital received it and 81% at a PHCC. Women belonging to religious minority, Dalit and upper caste were better off in receiving the transport incentive compared to others. On the other hand disadvantaged non-Dalit Tarai women were relatively worse off (only 50% of total sample) in receiving their due transport incentive. No major difference was found on the receipt of the transport incentive by place of residence, education and occupation group.

Only 18% of women who delivered at a health facility had received 4ANC incentive. Women from Dhankuta and Okhaldhunga were least likely to receive their 4ANC incentive whereas almost 35% of women from Dhading had received their 4ANC incentive. No women delivering in a private facility had received the 4ANC incentive. The women who had delivered at a public hospitals were least likely to have received their 4ANC incentive compared to PHCC (20%) and HP (21%). Women were paying for delivery care at all levels of public facilities. Almost 24% of women receiving care from hospitals were found paying for free services followed by PHCC (22%), and HP (18%).

##### 4.4.2 Ways forward

- < Some discrepancies were seen between health facility records and women's responses receipt of benefits. Regular monitoring should be done by higher level authorities. DHOs/DPHO should ensure that all health facilities provide incentives at the time of discharge in order to build trust among the community women.
- < The overall monitoring function of the implementing agency both at the centre and district is weak. Very few officials complete the appropriate monitoring form included in Aama Programme Guidelines and if filled up there is hardly ever any follow up on points raised. Those who are involved in monitoring usually do not write reports on their findings or provide accurate feedback in visitor books. Monitoring instructions should be given to all involved in monitoring the implementation of the Aama Programme. In every monitoring visit an official should bring a copy of the Aama guidelines and ensure compliance against them.
- < Examine the reasons for the low utilization of the 4ANC incentive including the appropriateness and sufficiency of the incentive amount. Furthermore, orient health worker on the 4ANC incentive scheme. Identify barriers to the use of the 4ANC scheme and intervene accordingly.

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## AnnexA: Field Researchers

Group	Name of enumerator	District assigned to	Supervision by
1	Jayanti Mala Gautam	Okhaldhunga and Dhankuta	Shiva Hari Lamichhane
1	Kamala Dong	„	
1	Bed Prasad Regmi	„	
2	Pyari Maya Gurung	Gorkha and Lamjung	Jhalak Naraya Timilsena
2	Aarati Sigdel	„	
2	Jit Bahadur Adhikari	„	
3	Pratikshya Rai Bhat	Baglung and Arghakanchi	Hari Har Pandey and Mahesh Chalise
3	Hira Lamichhane	„	
3	Goma Adhikari	„	
4	Annu Baidhya	Lalitpur and Sindupalchowk	Hem Raj Pandey
4	Deepa Joshi	„	
4	Bisistha Ghimire	„	
5	Bodh Prasad Nepal	Dhading and Makawanpur	Madan Murari Ghimire & Jhabindra Pandey
5	Tara Pandey	„	
5	Indira Pant	„	

AnnexB: Training Schedule

Time : 9:00 am to 5pm Venue: Local Development Training Centre, Lalitpur Date: Jan 27-30, 2016				
Days	Activity	Time		Responsibility
January 27	Registration	9:00AM	9:15 AM	
	Welcome remarks and training objectives	9:15 AM	9:40 AM	Ms. Hema
	Brief about Aama Surakshya Karykaram	9:40 AM	10:00 AM	Dr Shilu
	Tea Break	10: 00 AM	10: 30 AM	
	Planning and monitoring of Aama Programme	10:30 AM	11: 00 AM	Rishi Sigdel
	Overview of fund flow mechanism and financial reporting in Aama Programme	11: 00 AM	12: 00 AM	Jhabindra
	Lunch Break	12: 00 PM	01: 30 PM	
	Orientation on Aama guidelines and Annexes	01: 30 PM	01: 50 PM	Ms. Hema
	Research Process, Sampling Introduction of tools	1: 50 PM	02:50 PM	Jhabindra
	Tea/Coffee break	2:50 PM	03: 10 PM	
	Tool: 1C Key Informant Interview Aama Focal Person/PHN-D/PHO	03: 10 PM	04: 10 PM	Jhabindra
	Tool: 1B- Accounts D/PHO	04.10 PM	05.00 PM	Sigdel RR
January 28	Revision of Previous RA	10.00 AM	10.20 AM	Jhabindra
	Tool 3A: Cross Verification of Women Delivered at Health Facility	09: 20 AM	10: 20 AM	Jhabindra
	Tool 3A: Cross Verification of Women Delivered at Health Facility	10: 20 AM	11: 20 AM	Sigdel RR
	Tea break	11: 20 AM	11: 50 AM	
	Tool 2A: KII Health Service Provider	11.50 PM	01: 00 PM	Jhabindra
	Lunch Break	01: 00 PM	02: 00 PM	
	Tool 2B: Semi-Structured interview with Chairperson or member of Hospital Management Committee/HFOMC	02:00 PM	02:50 PM	Jhabindra
	Tool 2B: Semi-Structured interview with Chairperson or member of Hospital Management Committee/HFOMC	02:50 PM	03:40 PM	Jhabindra
	Tea/Coffee break	03: 40 PM	04: 00 PM	
	Tool 2C: Account Section, Health Facilities	4.00 PM	4.50 PM	Jhalak
January 29	Revision of the previous day	09:00AM	09:20 AM	Dr Jishnu
	Tool 3A: Community Level: Cross verification of Women ID Questionnaire	09:20AM	10:10AM	Jhabindra P



	Tool3A: Community Level: Cross verification of Women ID Questionnaire	10.10 AM	11.00 AM	Dr Balakrishna
	Tea break	11: 00 AM	11: 20 AM	
	Community Level: Cross verification of Women ID Questionnaire: Purpose of the Study	11:20 AM	12:10 PM	Dr Suresh
	Tool3A: Community Level: Cross verification of Women ID Questionnaire	12:00 PM	01:00 PM	Sigdel RR
	Lunch Break	01: 00 PM	02: 00 PM	
	Mock Interview	02:00 PM	03: 40 PM	Participants
	Tea/Coffee break	03: 40 PM	04: 00 PM	
	Discussion	04:00PM	04:50 PM	All
January 30	Tools 1 E: Secondary Data Review	09.00 AM	09.20 AM	Jhabindra
	Group Division and role of Field Researcher	09:20AM	10:10AM	Dr Jishnu
	Ethics, Data quality and Field work management	10:10AM	11:00 AM	Jhabindra
	Tea Break	11:00 AM	11:20 AM	
	Data management and Monitoring of field activities	11:20 AM	12:10 PM	Timilsena Jhalak