Rapid Assessment of Aama Surkashya Programmeme: Round X

Family Health Division (FHD)
Department of Health Services (DoHS)
Kathmandu, Nepal
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Rapid Assessment of Aama Surakshya Programmeme round- X is a continuation of previous serieses. Inorder to institutionalize the RA Family Health Division (FHD), Department of Health Services (DoHS) has taken lead role in implementing and finalising RA report. We would like to offer our sincere thanks to Director General for his guidance while conducting RA. FHD is thankful to NHSSP for technical support in designing, field monitoring and finailizing the RA report. We appreciate the contribution of field researchers and information provided by health facilities from Ilam, Saptari, Bara, Khotang, Salyan, Rolpa, Pyuthan, Jajarkot, Dolpa, and Baitadi. We are thankful to district public health officers, medical officers, focal persons for *Aama Surakshya* programmeme, and all health workers who have directly or indirectly contributed by providing their invaluable time and insight for this study.

The Study Team

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ABBREVIATIONS

ANC	Antenatal Care visits
4ANC	Four Antenatal Care visits
AWPB	Annual Workpla and Budget
CS	Caesarian Section
CSPro	Census and Survey Processing System
DoHS	Department of Health Services
D(P)HO	District (Public) Health Office
ECI	Exit Client Interview
FCGO	Financial Comptroller General Office
FHD	Family Health Division
FY	Fiscal Year
GoN	Government of Nepal
HD	Home Delivery
HDI	Human Development Index
HF	Health Fcaility
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HP	Health Post
IDs	Intitutional Deliveries
KII	Key Informant Interviews
MoH	Ministry of Health
MIS	Maternity Incentives Scheme
MMR	Maternal Mortality Ratio
NHSSP	Nepal Health Sector Support Programmeme
NPC	National Planning Commission
NPR	Nepalese Rupee
PHCC	Primary Health Care Centre
PHN	Public Health Nurse
RA	Rapid Assessment
RDW	Recently Delivered Women
RHD	Regional Health Directorate
SAIPAL	South Asian Institute for Policy Analysis and Leadership
SBAs	Skilled Birth Attendants
SDIP	Safe Delivery Incentive Programmeme
SLC	School Leaving Certificate
STATA	Stata Software Corporation
TABUCS	Transaction Accounting and Budget Control System

EXECUTIVE SUMMARY

Aama Surakshya Programmeme is a national priority one programmeme implemented by the Department of Health Services, Family Health Division. Aama Programmeme aims to reduce financial barriers that prevent women from accessing quality delivery care services. The primary objective of this X round rapid assessment is to assess compliance of Aama programmeme according to programmeme implementation guideline 2065 third edition 2073.

A cross-sectional descriptive study using both quantitative and qualitative approaches was applied to get valid and reliable information from both the services providers and service users. Eleven districts were purposively selected for this RA based on the guidance provided by FHD. A total of 69 health facilities (12 government hospitals, 15 PHCCs and 42 HPs) were sampled for this RA from the list of all public and private facilitiesimplementing Aama Programmeme. . In-depth interviews were carried out among 1561 recently delivered women. In addition, 72 exit client interviews were carried out to understand women's perception on the receipt of delivery service received. Qualitative information was obtained from in-depth interviews conducted with 219 key informant interviews which included Aama Surakshya Programme focal person, service provider, account officer, and health facility management committee members. The key findings of this RA are:

Use of delivery care

At the national level institutional delivery has increased from 14% in 2005/06 t.o 55% in 2015/16 and during the same period, the home delivery has been declined from 20% to 4%.

Management of Aama Programme

Budget for Aama Surakshya programme was adequate in the sampled districts, however issues of delay in receiving budget was reported by PHCC and HP level mainly due to delay in receiving authorization from center. Women were still provided with transport incentive using health facility reimbursement made under Aama programmeme deposited in the health facility management committee account. Almost one-third of the health facilities did not send the Aama Surakshya Programme financial report to D(P)HO on time as a result some delay in disbursement of programme budget was reported and a few clients had to come to facility again to collect the incentive and some did not get the incentive. The use of Aama unit cost is not different to the conditions stipulated in the guideline.

Receipt of transportation incentive

Women giving birth in hospital (45%) were less likely to receive 4ANC incentive than women giving birth in PHCC (57%) or HP (58%). But women giving birth in hospital (89%) were more likely to get transportation incentive on the day of discharge than those who give birth in PHCC (65%) and HP (64%). About 87% women giving birth at selected health facilities received deliveryservice free of cost. This percentage was highest in Jajarkot (100%) and lowest in Pyuthan (41%). Women giving birth in HP were most likely to receive the delivery care free of cost (95%) and women giving birth in PHCC were least likely to receive free delivery care (75%).

Cross-verification

Overall, in an average less than 0.5% mismatch was observed between facility record and women interview for normal delivery, 6% for complicated delivery and 4% for CS delivery, however the mismatch varies across districts.

DoHS/FHD to ensure availability of Aama guideline in implementing facility, timely flow of funds to all spending units, and send letter to D(P)HO and health facilities requesting them to use the facility management committees fund in case of delay in receiving budget. Clear instruction on timely reporting of financial progress should be made from FHD to D(P)HO and D(P)HO to the health facilities. All health facilities should send the Aama programmeme progress every month and also update the progress in Transaction Accounting and Budget Control System (TABUCS). Ensure the compliance of Aama guideline interms of providing incentive in day of discharge, provided to women, displaying the name of Aama beneficiaries and use of unit cost in improving the overall quality of the services.

CHAPTER 1 – INTRODUCTION

This chapter provides a brief overview of the Aama Programmeme, 4ANC programmeme, rationale, and objective of the assessment.

1.1 Background

Nepal has made significant improvement in maternal health over the last two decades. Between 1997 and 2015, the Maternal Mortality Ratio (MMR) decreased from 539 to 259 per 100,000 live births (MoHP, New ERA, 2017). Improvements in general living conditions and investment in safe motherhood programmemes such as Aama programmeme, safe abortion, family planning, and other safemothehood initiatives are believed to have contributed in reducing maternal mortality. Despite significant gain in improving maternal health, current level of MMR is far behind to achieve the Nepal Health Sector Strategy (NHSS) target of achieving MMR of 125 per 100,000 live births by 2020 (Ministry of Health, 2015) and further reduce to 70 as committed in Sustainable Development Goal (SDG) by 2030 (National Planning Commission, 2015).

1.2.1 Aama Programmeme

Aama Surakshya Programmeme is one of the major Demand Side Financing (DSF) schemes implemented by the Family Health Division. Aama programmeme aims to reduce financial barriers that prevent users from accessing quality health services. In order to improve skilled care at the point of delivery and influence care seeking behavior of women and families, the Government of Nepal launched the Aama Surakshya Programmeme in 2005. The development of Aama Surakshya Programmeme have been summarized in Table 1.

Table 1: 1 Stages of development of Aama Surakshya Programmeme

Year	Name of the Programme/	Key highlights
2005	Maternity Incentive Scheme (MIS)	Women receive transport incentive to deliver in hospitals. Health workers receive incentive to attend deliveries either in hospital or home.
2006	Safe Delivery Incentive Programmeme (SDIP)	Free delivery care started in 25 districts with low human development index (HDI).Health facilities were reimbursed NPR 1,000 per delivery to recover the costs of normal and complicated deliveries.
2009	Aama Surakshya Programmeme	National roll out of free delivery care. User fees were removed from all types of delivery including caesarean section
2012	Aama Surakshya Programmeme	Separate demand-side financing scheme, 4 ANC (4 antenatal care visits) was merged with the Aama programmeme.
2016	Aama and New born Surakshya Programmeme	Separate demand-side financing scheme, free sick newborn care was merged with the Aama Surakshya Programmeme.

2017	Aama Surakshya Programmeme	Free sick new born care was removed from Aama programmeme

Source: Family Health Division, 2017

1.2.1 The four Antenatal Care Incentive Programmeme:

In the context of unacceptably high pregnancy-related preventable morbidity and mortality, importance of quality ANC has been viewed as a means to maximizing women's health. Within the continuum of reproductive health care, ANC is seen as an important platform for health promotion, screening, diagnosis, and disease prevention (World Health Organization, 2016a). The World Health Organisation (WHO) recommends that a woman should have at least four ANC visits to detect health problems associated with pregnancy. First visit during the 4 month (12-16 weeks of pregnancy), the second in 6 month (20- 24 weeks of pregnancy), third in 8th month (28-32 weeks of pregnancy), the fourth in 9 month (36-40 weeks of pregnancy). Inorder to improve the uptake of 4 ANC visit, the GoN introduced the 4ANC incentive programmeme in July 2009. A mother is entitled to NPR 400 if she completes 4ANC visits as per the ANC protocol (first at 4th month, second at 6th month, third at 8th month and fourth at 9th month of pregnancy) and has an Institutional Delivery (ID) and a 1st Post Natal Care (PNC) visit (Upreti, et al, 2012).

1.2 Rationale

FHD has been conducting RA from technical support of NHSSP/DFID since the inception of the programme. RA seeks to ensure that the women are getting free care and incentives as entitled in the guideline, facilities are properly utilising health facility reimbursement. RA also provides information on fund flow, and financial management mechanism (Upreti, et al., 2012). The RAs have also been instrumental in identifying the implementation challenges as well as successful in offering managerial solutions. For example, 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 as identified from previous RA's have been influential in changing the programmeme implementation guideline. Additionally, Aama is susceptible to fiduciary risks as it consists of direct cash transfers and RAs have been the only mechanism to trace these risks through cross verification from the user group. The process of verification helps to identify phantom claims, misappropriation and other forms of data distortion. Besides, the limited monitoring capacity of FHD and huge amount of investment in the programmeme about NPR 1.2 billion further stresses the need for periodic RA (FHD, 2017).

1.3 Objectives

The primary objective of X round of RA is to assess compliance of Aama programmeme implementation according to programmeme implementation guideline 2065 third edition 2073.

The proposed RA has the following objectives;

- Cross-verify utilisation of the Aama Programmeme between health facilities and recently delivered women to explore opportunities for misappropriation of the Aama Programmeme fund ;

- Assess the management of the Aama Programme including timeliness of fund flow; preparation of progress and financial reports;
- Trend analysis of institutional deliveries using HMIS;
- Assess compliance of programmeme implementation with revised Aama guidelines, especially in the following areas: receipt of free delivery care, transport and 4 ANC incentives at the time of discharge, free sick new born care, utilization of financial incentives including distribution among health workers and disclosure of the names of service users on public notice boards; and
- Make recommendations on ways to improve management of the Aama Programmeme.

CHAPTER 2 – METHODOLOGY

2.1. Study Design

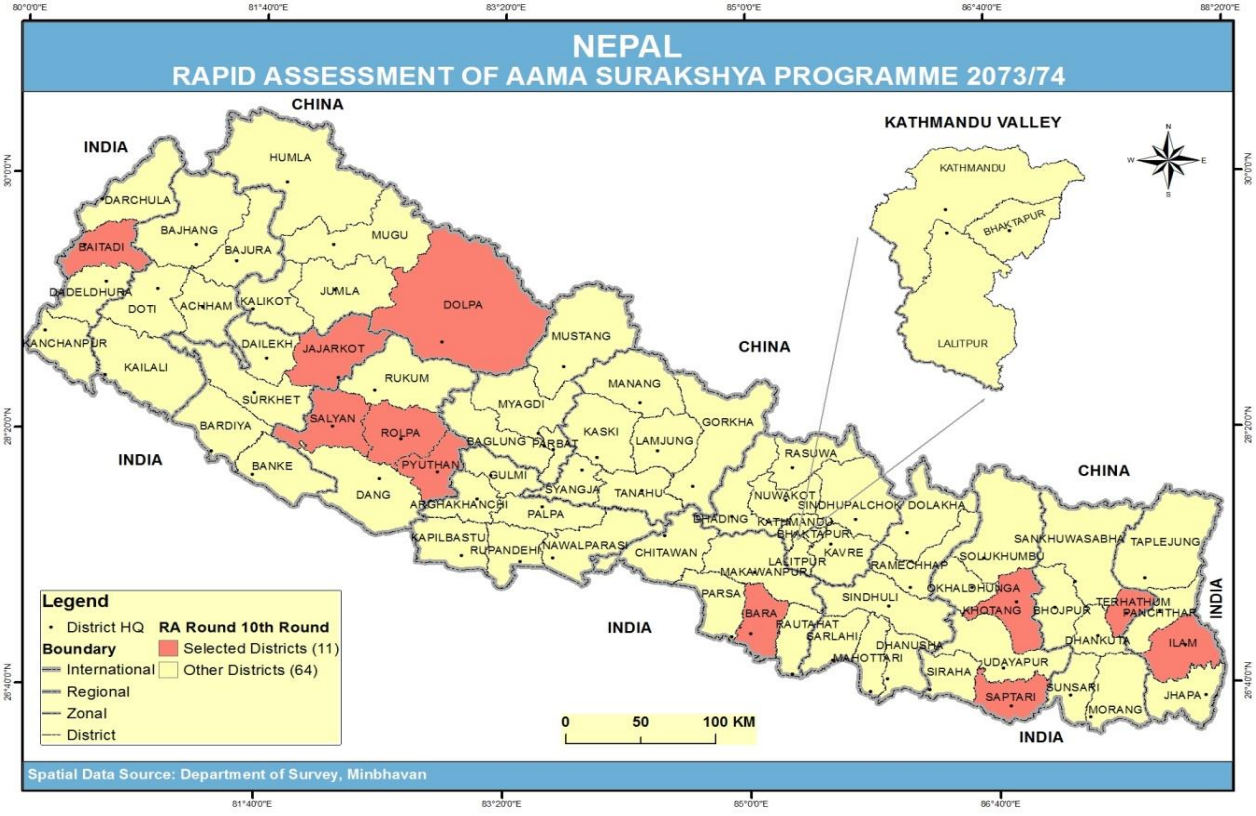
A cross-sectional descriptive study using both quantitative and qualitative approaches was applied to get valid and reliable information from both service providers and service users group.

2.2. Sampling Frame and Sample Selection

2.2.1. Selection of Rapid Assessment Districts

Eleven districts were purposively selected for this RA based on the guidance provided by FHD. The proposed districts covered all three ecological zones; the Mountain, Hill and Terai, the five development regions, and covered districts with diverse HDI rankings and institutional delivery. The RA districts are as shown in Figure2.1.

Figure 2.1 Sampled districts in RA



2.2.2. Selection of Health Facilities for Rapid Assessment

A total of 69 health facilities (12 government hospitals, 15 PHCCs and 42 HPs) were sampled for this RA from the list of Aama implementing facilities. These eleven districts have only public facilities implementing Aama programmeme. Facilities were selected based on following criteria;

- All public hospitals viz: Central/Regional/Sub-regional/Zonal/District hospitals implementing Aama programmeme from the sampled districts;

- At least one Primary Health Care Center (PHCC) from the selected district was also included in the assessment. In case of districts having two PHCCs, the PHCC with highest number of deliveries in last year FY2072/73 was included in the sample;
- In case of two to three PHCCs, PHCCs with both the highest and the lowest number of deliveries were included in the sample;
- In case of more than four PHCCCs, PHCCs with highest, medium and lowest number of deliveries were included in the sample;
- Four Health Posts (HP) with highest number of deliveries conducted in last fiscal year (FY2072/73) were also selected as sample in this assessment.

The facilities meeting above criteria were selected from a sampling frame consisting of functioning birthing centres in the districts selected for RA. The functionality of the facilities, i.e. whether they were still operating and able to conduct deliveries, was assessed using HMIS data and was re-confirmed by district teams when visiting the D(P)HO. Using the above selection criteria and sampling frame, the number of facilities by districts are presented in Table2.1 shown below.

Table 2.1 Health Facilities Included in Sample for RA

District	Region	Gov. Hospital	PHCC	HP	Total
Ilam	Eastern	1	3	4	8
Terhathum	Easterrn	1	1	4	6
Khotang	Eastern	1	1	4	6
Saptari	Eastern	2	2	4	8
Bara	Central	1	2	4	7
Pyuthan	Midwestern	1	1	4	6
Rolpa	Midwestern	1	1	4	6
Salyan	Midwestern	1	1	4	6
Dolpa	Midwestern	1	0	3	4
Jajarkot	Midwestern	1	2	3	6
Baitadi	Farwestern	1	1	4	6
Total		**12**	**15**	**42**	**69**

Description of selected health facility

Selection of government hospitals: Out of eleven sampled RA districts, Saptari had one Zonal-level hospital and one district hospital rest of the 10 districts has one district-level hospitals. Therefore, altogether 12 government hospitals (At least one from each selected district) were selected as sample hospitals.

Selection of PHCCs: Out of total 29 PHCCs in the sample districts, 16 PHCCs were selected. Three PHCCs were selected as sample from one district, two PHCCs were selected from four districts and one PHCC was selected from 5 districts. In Dolpa, no PHCCs were available therefore; no PHCCs were included from Dolpa.

Selection of HPs: Out of total 643 HPs, only 42 HPs were selected. Four HPs with highest number of institutional delivery were included in the sample from nine districts and three HPs were selected as

RA sample from two districts.

While selecting the HPs and PHCCs, first the institutional delivery conducted in FY2072/73 were listed. The institutional delivery was then sorted out by district and facility-type. Finally the respective facilities with highest or lowest or medium number of institutional delivery were included in the Sample. The list of sampled health facilities included in the assessment is presented in Table 2.2 given below.

Table 2.2: List of Sample Health Facilities included in the assessment

District	Name of Health Facility	District	Name of Health Facility
Ilam	Illam District Hospital	Rolpa	Rolpa District Hospital
Ilam	Phiccal PHCC	Rolpa	Sulichaur PHCC
Ilam	Mangalbare PHCC	Rolpa	Jinawang HP
Ilam	Pashupatinagar PHCC	Rolpa	Thawang HP
Ilam	Chisapani HP	Rolpa	Masina HP
Ilam	Danabari HP	Rolpa	Ghodagaun HP
Ilam	Jeetpur HP	Salyan	Salyan District Hospital
Ilam	Chulachuli HP	Salyan	Tharmare PHCC
Terhathum	Tehrathum District Hospital	Salyan	Bhalchaur HP
Terhathum	Basantapur PHC	Salyan	Triveni HP
Terhathum	Hamarjung HP	Salyan	Kavra HP
Terhathum	Poklabung HP	Salyan	Kotbara HP
Terhathum	Fakchamara HP	Dolpa	Dolpa District Hospital
Terhathum	Chaudanda HP	Dolpa	Dolpa District Hospital
Khotang	Khotang District Hospital	Khotang	Juphal HP
Khotang	Aiselukhark PHCC	Khotang	Liku HP
Khotang	Durchhim HP	Khotang	Tripurakot HP
Khotang	Baksila HP	Jajarkot	Jajarkot District Hospital
Khotang	Okhre HP	Jajarkot	Garrkhakot PHCC
Khotang	Halesi HP	Jajarkot	Dalli PHCC
Saptari	Sagarmatha Zonal Hospital	Jajarkot	Sakala HP
Saptari	Vhardaha Hospital	Jajarkot	Karkaigaun HP
Saptari	Kanchanpur PHCC	Jajarkot	Ramidanda HP
Saptari	Kaderbona PHCC	Baitadi	Baitadi District Hospital
Saptari	Hanumannagar HP	Baitadi	Melauli PHCC
Saptari	Barmajiya HP	Baitadi	Talladehi HP
Saptari	Bodebarshain HP	Baitadi	Siddheswor HP
Saptari	Brahampur HP	Baitadi	Kotpetara HP
Bara	Kalaiya District Hospital	Baitadi	Sreekot HP
Bara	Bhawanipur PHCC	Pyuthan	Pyuthan District Hospital
Bara	Nijgadh PHCC	Pyuthan	Bhingree PHCC
Bara	Amritgunj HP	Pyuthan	Bangeshal HP
Bara	Bariharpur HP	Pyuthan	Baraula HP
Bara	Rampurwa HP	Pyuthan	Tiram HP
Bara	Dumurwana HP	Pyuthan	Dhuwang HP

2.2.3. Selection of Women for Cross-Verification

The main respondent for corss-verification were women who had delivered at a health facility six months prior to the assessment. The sample size in each district was identified based on the insititutional deliveries in the proportion ofactual deliveries conducted. The Total sample size was calculated by assuming 50% of the institutional delivery (Central Bureau of Statistics, 2015) and variation was assumed to be at 9% from the population parameter by using the following formula,

Sample size = $Z^2*P*Q/(D^2)$, where

Z is the area under normal curve corresponding to the desired confidence level = 1.96 at 95% confidence level, P is the true proportion of institutional delivery, q is (1-P) and D is the maximum difference between the sample mean and the population mean, or Expected Frequency Value minus (-) worst acceptable value. Using the above formula minimum sample size required for this RA was 119 for each of the selected districts. Therefore, total minimum sample required for 11 districts was 1309. By adding 12% of non-response and 10% of refusal, total sample required for this assessment was 1591.

The total sample size for recently delivered women was distributed to 11 districts using probability proportional to size of women giving birth to the selected facilities during the six months period preceding the RA.

For cross verification with clients at household, sample respondents were selected by using systematic sampling with replacement approach. The combined list of women giving birth at selected health facilities in the selected districts during last six months from assessment was prepared as sample frame and desired sample size from each selected facility were selected by using systematic sampling. The sampling process was started by selecting an element from the list at random and then every k^{th} element in the frame was selected, where k, the sampling interval to be calculated as k=n/N where n is the sample size, and N is the population size. Based on the percentage share of the total institutional deliveries conducted during FY2072/73 at selected districts, the sample size of 1591 proposed for the interview with RDW for cross-verification by districts is distributed. However actual data collection was completed only among 1561 RDW. The proposed sample of RDW and number of RDW with whom the data collection was completed is as shown in Table 2.3.

Table 2.1: Sample size for interview with RDW for cross-verification delivering

SN	Districts	Total proposed sample	Data collection completed	Percent
1	Ilam	150	150	100
2	Teharthum	87	74	85
3	Khotang	119	116	97
4	Saptari	177	171	97
5	Bara	201	195	97
6	Pyuthan	165	163	99
7	Rolpa	178	178	100
8	Salyan	173	173	100

9	Jajarkot	105	105	100
10	Dolpa	30	30	100
11	Baitadi	206	206	100
Total		**1,591**	**1,561**	**98**

2.2.4. Exit Interview with Women Giving Birth at Facility

In addition to the cross-verification with RDW, all women who exit from all selected health facilities during three days period of data collection were covered for exit client interview (ECI). Altogether 72 exit client interviews were carried out to understand the perception of women towards service received from respective facilities.

2.2.5. Key Informant Interview

To assess the status of Aama programme implementation from programme managers and provider's perspective, key informant interviews were conducted. Aama programmeme focal persons, and Accountants from the D(P)HO and service providers of Aama programmeme (nursing staffs) and in-charge/accountant (the person deals with the financial related matters of Aama programmeme) from the health facilities were interviewed as key informants. At least 3 KII including service provider, account officer and Aama programmeme focal person from each selected district were interviewed. Total number of KII and ECI conducted per district is presented in Table 2.4.

Table 2.4 Number of ECI and KII conducted by district

S.N	Districts	ECI	PHN	DPHO Account	Service Provider	MGMT Committee	HF Account
1	Ilam	6	1	1	8	8	8
2	Teharthum	5	1	1	6	6	5
3	Khotang	5	1	1	6	6	5
4	Saptari	12	2	1	8	8	8
5	Bara	5	1	1	7	7	7
6	Pyuthan	6	1	1	6	6	4
7	Rolpa	6	1	1	6	6	5
8	Salyan	6	1	1	6	6	6
9	Jajarkot	5	1	1	6	6	5
10	Dolpa	2	1	1	3	3	3
11	Baitadi	15	1	1	5	6	5
Total		**73**	**12**	**11**	**67**	**68**	**61**

2.2.6. Cross Verification

District to health facility level: In the first stage, detailed information (i.e. address of women; type of health facility; date of delivery; type of delivery; staff attending delivery) were recorded from the claim form (Annex 3 of the Aama guidelines) at the D(P)HO. This information was then cross-verified with the maternity register at the sampled health facilities. Records were classified as unmatched if one or more of the following fields differ between the claim form in the D(P)HO and the health facility maternity register: mother's address, type of health facility, date of delivery, type of delivery. The

matched records were referred to as 'matched health facility records'.

Health facility maternity register to women's report: Cross-verified stage 1 cases were then verified with the women themselves in their households. An interview questionnaire for RDW was used for cross-verification of the information from the facility (i.e. whether a normal, complicated or caesarean section was performed; the number of ANC visits; receipt of transport incentives and free delivery care).

2.2.7. Review of fund flow and financial management

Review of fund flow and financial management was carried out by asking the questions to head of finance sections and capture information on allocated budget and expenditure from TABUCS. This review is expected to provide some insight on financial management practice at the district level such as financial monitoring record/reports keeping, process of verification etc.

2.3. Tools Used in RA

A set of data collection tools used in previous RAs were adopted for this RA. In addition, tools were modified by adding and delecting questions to suit the changing context in consultation with FHD.

2.3.1 Overview of Tools

The table below presents the list of objective of this RA, the indicators related to the objectives and the proposed tools to collect the required information is presented in Table2.5.

Table 2.2: List of Tools

SN	Objective of Rapid Assessment	Indicators	Question Type	Tools Used
1	Cross-verify utilisation of the Aama Surakshya Programmeme between health facilities and target groups	% match between health facility records and women on receipt of transport incentives	Quantitative	Cross Verification Checklist/ Form RDW questionnaire
		% match between health facility records and women on receipt of 4ANC incentive		
		% match between health facilities and women on type of delivery (normal/complicated/caesarean)		
2	Assess the management of Aama programme including fund flow and corresponding opportunities for fund misappropriation.	Timeliness of Aama fund flow to health facilities	Both quantitative & Qualitative	KII guideline (DPHO/DHO/Accountant/ Aama focal person/ service provider) Secondary data review tool
		Mechanism for release of funds to health facilities		
		Sufficiency and flow of Aama funds at health facility		
		Frequency of financial reporting		
3	Assess compliance of programmeme implementation with revised Aama	% of women receiving transport incentive on day of discharge	Quantitative	Exit interview Guideline
		% of health facilities with display boards showing lists of Aama beneficiaries		

	guidelines	% of health facilities with a copy of the revised Aama guidelines		Secondary data review tool RDW questionnaire
4	Assess utilisation – receipt of free delivery care and incentives	% of women receiving transport incentives as per the guidelines	Quantitative	Exit interview Guideline Secondary data review tool RDW questionnaire
		% of women who did not pay any cash at health facility for their deliveries		
		% of women receiving 4ANC incentive of total women completing four ANC visits		
5	Assess trends in utilisation of delivery care using routine information systems	Trend of institutional deliveries (district and national)	Quantitative	1. Secondary data review tools
		Trend of home deliveries (district and national)		
		Trend of fourth ANC visit (district and national)		

2.3.2. Training

District supervisors and enumerators were trained to adequately administer the RA tools. Four days intensive training for district supervisor and enumerators was organised during 8th, May to 11th May, 2017. Sets of tools, a training schedule and required logistics were made available to the participants one day before the training session. Enumerators were hired based on their qualifications and experience in research work. The training was facilitated by a research team of SAIPAL, FHD/ MoH, NHSSP and consultants.

2.3.3. Translation and pretesting of tools

The tools were translated into Nepali before the pre-testing. Following the pre-testing the tool were revised directly to the Nepali version. Following the pre-testing, a meeting was held with the pre-test team to identify the issues arising in the process and the tools themselves. The tools were accordingly adapted, printed and distributed to the district survey teams.

2.4. Field Work

The fieldwork was conducted immediately after the training of supervisors and enumerators. Data collection was carried out by 11 teams over the period of about one month during 16th May to 24th June, 2017. Each team consist of male and female interviewers and district supervisors (research and finance). All teams were mobilized to the districts immediately after completion of enumerators' training in Kathmandu. All team and management staff also received need based support from district teams.

2.5. Supervision and Monitoring

Once the district supervisors completed collecting necessary information from D/PHOs and health

facilities, the enumerators were mobilized to visit sampled health facilities. The district supervisors were instructed to provide support and supervision and to cross verify district data with health facility data. They also cross-checked to collected data for inconsistencies and discuss with the team members if they found any problems. Similarly, FHD and NHSSP staff was also invited to visit the districts to monitor the field implementation. A central support team was scheduled to visit each of the districts to ensure quality data collection and deal with any issues.

2.6. Ethical Approval

As this study was a Rapid Assessment of the Aama programmemes but not a research, ethical approval from the Nepal Health Research Council (NHRC) was not sought. However, ethical principles were maintained during the data collection. The women selected for interview in the community and at the health facility were asked to voluntarily participate in the study. Enumerators were trained to explain the purpose of the study before starting the interview and to clarify that the woman will not be forced to participate, but that if she was willing to participate, everything she wanted to share will remain confidential and all results will be anonymous.

2.7. Data Management and Analysis

2.7.1. Quantitative data analysis

The database was designed after finalization of the tools and the analysis plan was agreed in coordination with FHD. All quantitative data were double entered using 'CSPro'. The data was cleaned by the data manager before analysis. This process helped to identify few inconsistencies were corrected in line with the filled questionnaire. Data analysis was done using Stata13. Excel was used to analyze the finance and monitoring information.

2.7.2. Qualitative data analysis

Qualitative data were collected using semi-structured interviews with various respondents at each level: district health officers, focal persons, service providers, account officers and the Health Facility Management Committee.

Data generated from these interviews were organised using thematic analysis approach. First, key issues and themes were identified and the answers to questions within these themes were grouped and summarised in data analysis frameworks. Quotations illustrating the views of the majority of participants or which are in contradiction with the majority were extracted from the interview. These issues were then summarised by district and health facility level and finally integrated within the relevant sections. The data were then summarised by using all the original texts and listing all conceptual categories and patterns. Relevant information was placed under these conceptual categories and relationships were identified between the categories.

2.7.3. Quality Assurance

The first part of the quality assurance process began with the training of district supervisors and the enumerators. Supervision and communication between the centre and the district teams was conducted in order to pick up and respond to any issues in the field that might undermine the quality of data collected. The data entry clerks were supervised by the data manager during data entry. All data were be double entered and then systematically cleaned to ensure that the analyzed data is of good quality. Development of the coding frame and categories used in the qualitative data analysis was done by a team of three researchers working independently and then comparing their coding frames. The fact that the data comes from several different sources allows triangulation and further ensures quality.

CHAPTER 3 - FINDINGS AND DISCUSSIONS

This chapter provides an overview of availability, and utilization of services provided through Aama Surakshya programme in 11 districts. It explores the following key issues relating to provision of Aama Surakshya programme at the selected health facilities.

- **National and district trend in utilization of delivery care**. This section includes Figure 3.1 and Table 3.2 and examines the trend of utilization of maternal health services; including institutional delivery, home delivery and utilization of four times antenatal care (ANC).
- **Management of Aama Surakshya programme**. This section include Figure 3.2, Figure 3.3 and Table 3.2 and provides information on Aama programme budgeting, fund flow and reporting mechanism from center to district and facilities and vice versa as well as trend of budget allocation and expenditure.
- **Compliance of Aama Surakshya programme implementation with Aama Surakshya programme guideline**. This section include Table 3.3 through Table 3.15 and summarizes the compliance of Aama Surakshya programme implementation against Aama Surakshya programme guideline
- **Cross verification of the receipt of free care and transport incentive**. This section include Table 3.16 through Table 3.19 and presents the finding of cross verification of service reported by health facility and woman receiving delivery and antenatal care as well as receipt of transportation incentive
- **Quality of care provided and level of satisfaction**. This section includes Table 3.20 through Table 3.26 and includes information about perceived quality of service provided to client and level of satisfaction over the service received.

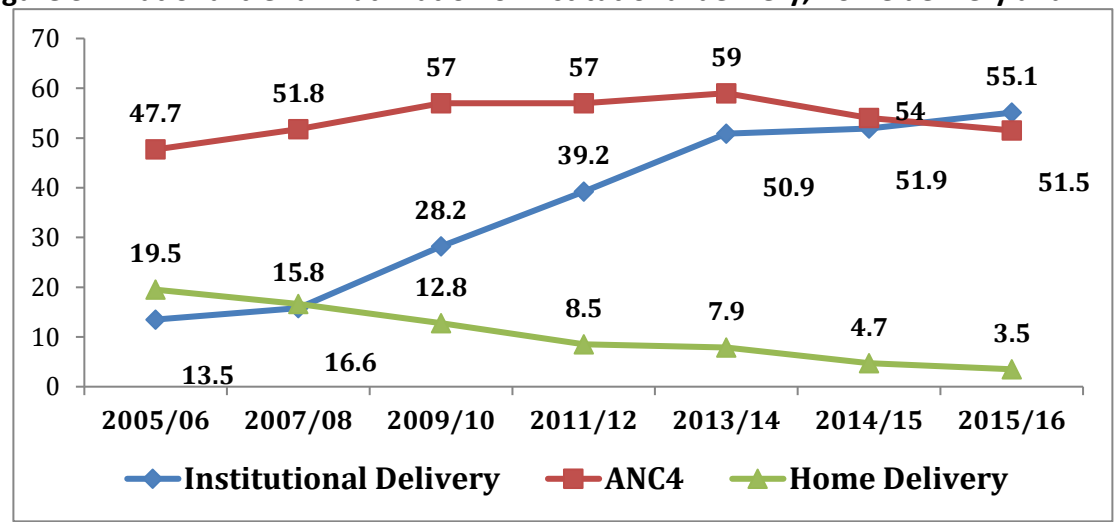
3.1 Trend in Utilization of Delivery Care

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

3.3.1 National trend in utilization of Institutional delivery, and 4ANC

The figure below suggests that institutional delivery has substantially increased from 14% in FY 2005/6 to 55% in FY 2015/16. At the same time, home delivery has decreased from 20% in FY 2005/6 and 3.5% in FY 2015/16. However, 4ANC service has been observed to have a slow increase from 48% in FY2005/6 to 59% in FY 2013/14 and gradually decreased then after reaching to 52% in 2015/16 (Figure3.1).

Figure 3.1 National trend in utilization of Institutional delivery, home delivery and 4ANC



Source: HMIS, 2005/06-2015/16

Reason for observed decreased in 4ANC visit is mainly due to the change in definition of the indicator.

3. 3.2 Trends of Institutional deliveries and antenatal care among study districts

Table 3.1 gives detailed information on the trend of institutional deliveries and four ANC visits as percentage of expected pregnancies for the sampled districts over the FY 2013/14 to FY 2015/16 period. Institutional deliveries for FY 2013/14 to FY 2015/16 are calculated as percentage of live births.

Table 3.1: Trend of institutional deliveries and four ANC visits as percentage of expected pregnancies in study districts (2013/14 to 2015/16)

Districts	2013/14		2014/15		2015/16	
	Institutional deliveries*	Four ANC visits†	Institutional deliveries*	Four ANC visits†	Institutional deliveries*	Four ANC visits†
Ilam	23.6	46.1	24.9	42.9	19.0	34.0
Terhathum	30.7	42.7	25.9	34.6	24.9	33.0
Khotang	26.2	58.1	21.2	53.0	21.9	56.3
Saptari	56.0	78.9	32.7	79.1	55.1	74.8
Bara	33.5	41.0	16.6	44.5	39.8	40.3
Pyuthan	27.5	32.6	48.0	43.2	53.2	45.7
Rolpa	36.5	33.2	46.5	42.5	48.1	41.8
Salyan	29.6	29.6	49.0	44.2	52.9	50.2
Jajarkot	21.5	26.1	30.1	29.4	29.4	25.6
Dolpa	17.7	31.1	10.8	18.3	25.6	23.2
Baitadi	42.2	56.1	57.0	63.6	66.1	67.2
Total	**50.0**	**50.9**	**51.9**	**51.9**	**55.1**	**51.5**

**As Percentage of Expected Live Births; † As percentage of Expected Pregnancy*

Source: HMIS, DoHS, Annual reports

- Overall, the institutional delivery as percentage of expected live births has slightly increased from 50% to 55% between FY 2013/14 to FY2015/16; however the 4ANC visit as percentage of expected pregnancy has been stagnant around 52%.
- 4ANC visit as percentage of expected pregnancy has been in decreasing trend in Ilam, Terhathum, Khotang, Saptari, Bara and Dolpa districts. Similarly, the percentage of institutional delivery as percentage of expected live births has decreased in Ilam, Terhathu and Saptari districts in FY 2015/16 than in the previous years.
- In Pyuthan, Rolpa, Salyan, Jajarkot and Baitadi districts, both institutional deliveries as well as 4ANC visits have increased over the assessment period.
- Institutional delivery as percentage of expected live birth appeared to be highest in Baitadi followed by Saptari and Salyan. While the 4ANC visit as percentage of expected pregnancy is highest in Saptari followed by Baitadi and Khotang respectively in FY 2015/16.

The increases in institutional deliveries and 4 ANC visits could be due to community- as well as facility-level activities promoting importance of adequate antenatal care and institutional deliveries as opposed to assisted home deliveries. Likewise, the decreasing trend of institutional delivery and 4ANC visit in few districts might reflect the under-reporting of maternal health services due to recently changed provision of online reporting of HMIS forms and inclusion of 4ANC as per protocol in the online reporting system. In order to improve status of these indicators, D(P)HOs should ensure that all the reports coming from reporting units under the D(P)HO are entered in the online reporting system.

3.2. Management of Aama Programmeme

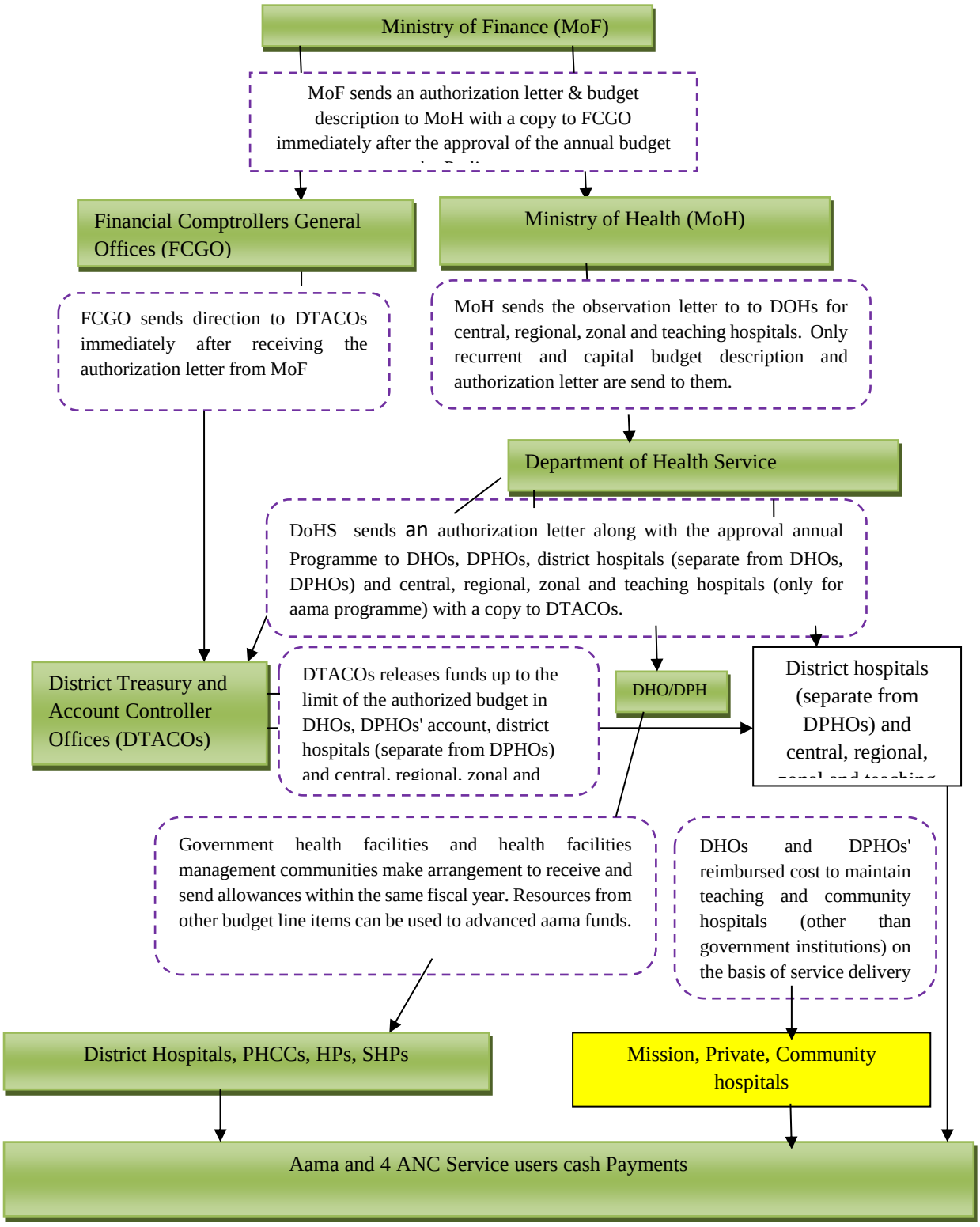
3.2.1 Aama Programmeme Budgeting and Fund Flow

At the start of a fiscal year, Ministry of Finance sends budget items, source of expenditure and letter of authorization to every ministry, CC to the Financial Comptroller General Office (FCGO) and Office of Auditor General (OAG). Similarly, MoH sends detail budget and letter of authorization to DoHS. DoHS sends the budget, source of expenditure and letters of authorization to respective spending units and CC to the District Treasure Comptroller Office (DTCO) within 15 days of the date of receipt of the authorization from MoH. The spending units submit the budget detail, approved programme and letter of authorization to DTCO and DTCO releases the budget. Spending units can however get budget released up to the one sixth of previous year's budget for the recurrent budget. However, the actual time spend between budget speech and arrival of necessary document to the district takes much longer than expected.

FHD prepares annual work planand budgets (AWPB) for the Aama programmeme based on district and referral facilities expenditure record from previous fiscal year. The AWPB is submitted to DoHS and MoH, which compile the budget requests from different units for submission to the National Planning Commission (NPC) and the Ministry of Finance (MoF). The approved Aama Programmeme activities and budgets are released to D(P)HOs together with the other district-level activities

approved for the fiscal year. See Figure 3.2 for a diagram of fund flow in the Aama programmeme. According to the Aama guidelines, D(P)HOs should transfer the amounts for institutional unit costs to the account of Management Committees or development board of PHCCs, HPs and hospitals implementing Aama programmeme. In cases of shortfalls or delays in receiving funds, the Aama guideline has made health facility management committee (HFMCs) and hospital development committee (HDC) responsible to provide transport incentive.

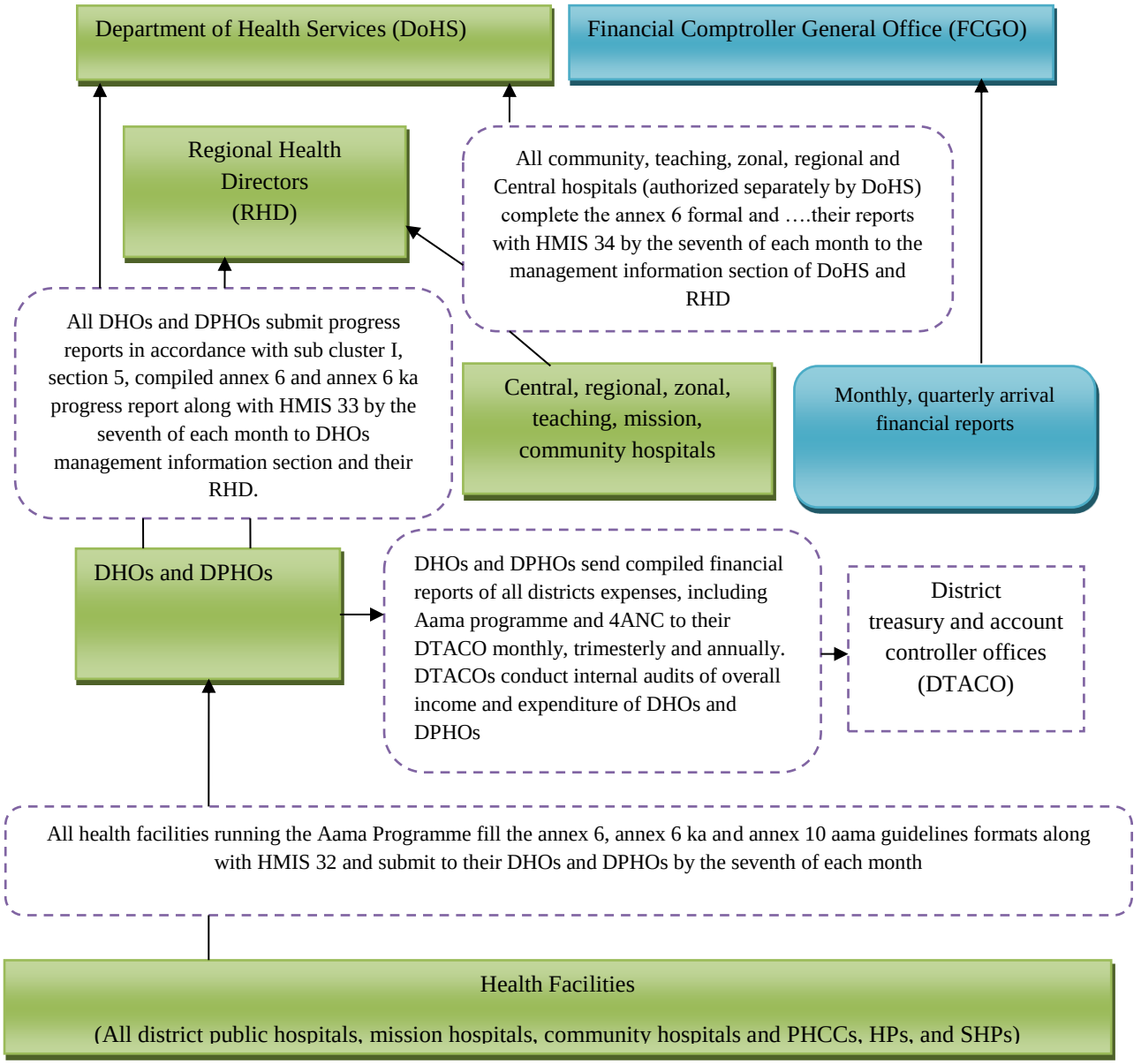
Figure 3.2: Fund flow in the Aama Programmeme



3.2.2 Reporting of the Expenditure in Aama Programmeme

The Aama Programmeme Guidelines (2016) state that all health facilities implementing the programmeme must submit the forms at Annexes ***6, 6 ka and 10*** of the guidelines along with completed HMIS format (HMIS 9.3) to their D(P)HO by the seventh day of each month. All DHOs and DPHOs should submit this progress report by twelfth of each month to FHD. All zonal, sub-regional, regional and central hospitals (that are authorised separately by DoHS) have to complete the Annex 6 and Annex 6 ka forms and send them along with HMIS forms by the seventh of each month to the Health Management Information Section, RHD and FHD.

Figure 3.3: Aama programmeme Reporting and Monitoring



The revised Aama guideline also suggests that programmeme supervision and monitoring is the responsibility of D(P)HOs for district and below level facilities (hospitals, primary health care centres, and health post) including private facilities. RHD, FHD and DoHS shall provide need based monitoring

visits for Aama programmeme at district-level as well as at referral and private facilities. The guideline says 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 Programmeme can be suspended 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 the monthly, quarterly and annual monitoring of funds allocated to D(P)HOs by DTCOs based on approved programmemes and allocated budgets. Figure 3.3 shows the reporting mechanisms for Aama as per the revised guideline (2016), the government's Financial Rules and regulations, and as reported by key informants including government account officers.

3.2.3 District level

The key persons responsible for the management and distribution of Aama Programmeme budget in the D(P)HO is the accountant and Aama focal person (usually PHN). Most D(P)HOs provide fund for transport incentive in advance to the health facilities based on the last year record on insitutional delivery and 4ANC visits. Generally, unit cost to health facilities get reimbursed only after Aama Annexes (3, 6 and 10) are reported. Release of the fund for the subsequent quarter is contingent upon receipt of the financial/expenditure statement from respective health institutions.

"...we distribute budget for Aama Surakshya Programme to health facilities according to the number of delivery and 4ANC service provided during the previous fiscal year...." (DPHO/SAP, DHO/KHOT)

"...for timely provision of Aama incentive, we suggest health facilities to provide the incentive using health facility management fund and reimburse it back after receiving money from the D(P)HO..." (DHO/PYU, DPHO/ROL)

In principle, disbursement of fund from district health office to hospitals and other health facilities should be done as soon as the budget is available. However, delay in sending authorization from center to district makes it diffuclt to channel Aama budget to the health facilities in the first quarter of the new fiscal year. The Aama guideline made health facility management committee or hospital development committee responsible to manage continue provision of transport incentive.

"...we did not receive budget and authorization on time from center, we request health facilities to manage themselves utilising management committee fund. Those who have money do it and those who don't have money cannot do anything. Some are also skeptical to use management committee fund thinking that the Aama budget might not come...." (DPHO/JAJ, DHO/SAL).

"...during budget distribution first priority is given to the transportation and ANC4 incentive and then only to incentive for service provider and unit cost to the facility..." (DHO/PYU, DPHO/ROL).

Most of the sampled districts (80%) did not raise issue of delay in getting budget and authorization. Majority of them (80%) managed to send Aama programmeme budget in advance to the facilities based on the previous year's delivery, recommendation from PHN and request from health facilities

with adequate justification. Trend of budget allocation and expenditure in the sampled district indicate that they do not have serious problem in relation to budget shortage. Table 3.2 below shows the allocation and expenditure of budget provided under Aama programmeme (Transport incentive, free delivery and 4 ANC).

Table 3.2: Budget provided for Aama programmeme to districts (NPR in '000')

SN	Districts	FY 2071/72			FY 2072/73			FY 2073/74		
		Allocation	Expenditure	% Exp	Allocation	Expenditure	% Exp	Allocation	Expenditure	% Exp
1	Ilam	7405	6739	91	7381	6200	84	7741	1474	19
2	Terhathu	3068	2144	70	3146	2370	75	2703	2337	86
3	Khotang	5160	4124	80	4590	3621	79	4247	3780	89
4	Saptari	29360	10492	36	29243	21495	74	26825	17588	66
5	Bara	21310	6316	30	19694	15661	80	15318	11328	74
6	Pyuthan	10190	9735	96	11892	11080	93	10115	9915	98
7	Rolpa	9490	9510	10	8460	7949	94	8385	6965	83
8	Salyan	8525	8522	10	12590	11821	94	11104	9586	86
9	Jajarkot	5560	4894	88	4966	4892	99	4441	4426	10
1	Dolpa	1275	217	17	1340	429	32	1168	409	35
1	Baitadi	13990	12423	89	15760	13483	86	15910	10806	68
Total		115333	75115	65	119062	99001	83	107957	78614	73

(Source: TABUCS, 2017)

Table 3.2 shows that the budget allocated in Aama programmeme is not fully utilized in the last three consecutive years. However, not all Aama implementing facility and D(P)HOs enter their complete expenditure in TABCUS. The key informant interview confirmed that districts were allocated adequate budget for the Aama programmeme. However, the only concern raised in relation to budget management was delay in receiving authorization from center. Simialrly, some district authroties also mentioned that delay in clearing advances and receiving reports cause delay in disbursing budget to the health facilities. However, at the facility level some concerns are also rasied in delay in disbursing fund from districst.

"... sometimes, we have to resend the request letter to D(P)HO for the release of Aama Programme budget.. they keep on loosing reports, we had to request them to send budget on time..." (KAVRE HP/SAL).

3.2.4 Health Facilities

According to Aama Surakshya Programme Guideline, all health facilities implementing Aama programmeme should do monthly reports to D(P)HO. For private facilities implementing Aama Programmeme, a copy of monthly reporting should be submitted to FHD. Majority health facilities (62%) have submitted service delivery and financial report in monthly basis together with HMIS

reports. Some facilities were found submitting reports either quarterly or six monthly (32%) or yearly (14%) basis. Very few (2%) facilities send reports only when asked.

"...most health facilities submit the Aama report by the first week of every month but some facilities do not send report till the end of the fiscal year, we make telephone call and record number of deliveries and request them to submit the report..." (DHO/PYU, DPHO/ROL, DHO/SAL).

"... budget releasing process from district is very slow, they deposit money in health facility account, and incharge collect the amount in Ashoj (September/October)) only as a result women delivering in Shrawan (June/July)can only receive money in Mangsir (November/December) only for their delivery service received in Srawan..." (MASINA HP/ROL).

In majority health facilities, incharge manages the Aama programmeme including budget and monthly financial reports. For un-interrupted supply of the transportation incentive, incharge should hand over cash to the nursing staff including ANM. This kind practice has been observed in the hospitals and other birthing centers which ensures instant payment of the incentives to every woman who came to the health facility for delivery.

"... when we were not able to provide transport incentive on time, we make radio announcements or publish in newspaper so as to inform women to come and receive their entitlements....." (D/PHO/ROL).

In some districts, the district hospital accountant takes control of the fund even though the Aama programmeme focal person is Nursing Officer. The accountant receives fund from district treasury control office and hands over to the focal person when demanded. Therefore, almost all women who deliver their babies at referral hospitals are paid incentives at the time of discharge. In case, the fund is not available on time, the hospital manages budget from the hospital development board. No uniform rule exists towards the distribution of incentive to service provider. It is up to the facility management committee to develop their own strategy to provide incentive to the health workers involved in service delivery which is very different to what is mentioned in the guideline.

The unit cost received from Aama programmeme is used in variety of ways. Majority facilities reported that unit cost is used to provide transport and 4ANC incentives to the women giving birth at the facility.

"... in case of delay in releasing budget from district, we manage the problem by getting advance from facility management committee fund..." (TRIVENI HP/SA).

Majority respondents (90%) indicated that the health facility management committee meeting is the place where decision is made on how to spend the unit cost. However, in lower level facilities incharge is the key player who decides the areas where the budget should be spent and service provider have little role in decision to spend the money. Around 60% facilities said they use unit cost money to buy medicines and supplies that are not covered by central and district supplies and also

recruited human resource.

"...unit cost is decided in the meeting and the main responsible person is the facility incharge…" (THARMARE PHCC/SAL).

"... we provide NPR. 300 to health provider from the unit cost and remaining amount is used to purchase necessary goods for example medicine/supplies that are not supplied from center like cadgud, oxytocin, virax, soap… alll members of management committee are involved in discussing unit cost use … (BHINGRI HP/PYU).

"... we were able to recruit additional staff from the Aama unit cost and additional fund from the VDC … the decision was made from management committee..." (MAHACHAUR HP/SAL).

There is very limited role of D(P)HO in ensuring compliance on the use of unit cost money as per the guideline. Few respondents also reported that decision on spending should be made during facility staff meeting.

"….as unit cost make up the part of the revenue of the facility, the decision regarding where to use and how to use it falls completely under the decision of management committee which is beyond our jurisdiction and control….(DHO/PYU).

"... incharge and management committee decides on how to use unit cost money…nursing staff are hardly involved in these meetings…..most of the time they buy running out medicines some also use it for incentivising health worker and covering meeting expenses... (DHO/ILA)."

"...the focal person and management committee decide how to use the unit cost under Aama Surakshya Programme....majority part of it goes in incentivising health workers...For example in hospitals, for a CS performed half of the amount goes in incentivising health workers…(DHO/SAP)

At the hospital level it was difficult to ascertain the use of Aama unit cost.

"…we donot know where Aama money is used in hospitals….we request store to buy essential things required to improve maternity ward however they always point out shortage of funds and when inquired about Aama unit cost in management committee meetings they say it is used as salary for staff of hospital development committee .." (HOS/PYU, HOS/SAP)

Few management committee (40%) member are aware of the Aama unit cost reimbursement to the facility.

... " I have some knowledge that women receive money but was not aware that facilities receive money for delivery services..." (PHC/BAI).

"... I have heard that facilities receive some money but donot know detail as I am new.." (DHO/ILA).

More than two-third (67%) health facilities included in the sample had displayed name of the women receiving free delivery care and transportation incentive. All the facilities know that unit cost and transportation incentive are provided on case basis. However, few facilities have not displayed the name of the delivery service recipient. Information received from KII indicates that facilities are either not aware or not complying to disclose the name of the Aama beneficiary as per the guideline.

"...we have now prepared the notice board to display names earlier we did not display the name of beneficiaries on board because we did not know it is necessary to display on board..." (KOTBARA HP/SAL, MAHACHAUR HP/SAL).

"...no, we do not display the name of beneficiaries we thought it is just an extra burden….if we have to we will publish their names from this month..." (JUPHAL HP/DOL).

3.3 Compliance of programmeme implementation against Aama guideline 2016

The results are based on the interview with 1,561 recently delivered women and interviews with D(P)HO Aama focal persons, finance sections, health facility account sections, health facility management committee representatives and service providers.

3.3.1 Comparison of key indicators with previous RA

The Table 3.3 shows that there has been a gradual improvement in over all indicators in RA round X. Indicators for cross-verification such as receipt of 4ANC incentive, types of delivery are reported to be above 90% where as there is a cent percent match in the receipt of transport incentive which is a good sign. There is still a discrepancy between the facility record and interview for display of record showing list of Aama beneficiaries, availability of Aama programmeme guideline and women receiving 4ANC incentive.

Table 3.3: Results against indicator of Rapid Assessments VIII, IX and X

SN	Indicator	RA VIII	RA IX	RA X
1	% match between health facility records and women on receipt of transport incentives	93.9	96.6	100.0
2	% match between health facility records and women on receipt of 4ANC incentive	99.6	46.4	98.6
3	% match between health facilities and women on type of delivery (normal/complicated/caesarean)	94.8	87.56	92.4
4	% of women receiving transport incentive on day of discharge	89.3	84.5	94.4
5	% of health facilities with display boards showing lists of Aama	60	55.7	58.2
6	% of health facilities with a copy of the revised Aama guidelines	37.8	55.8	83.3
7	% of women receiving transport incentives as per the guidelines	86.4	90	98.1
8	% of women who did not pay any cash at health facility for their deliveries	61.4	71	87.4
9	% of women receiving 4ANC incentive of total women completing four ANC visits	35.1	34.7	51.0

3.3.2 Receipt of transport incentive

Table 3.4 shows the receipt of transport incentive by recently delivered women. Out of 1,561 recently delivered women interviewed, 98 percent women reported that they have received transport incentive. While all the women interviewed from Ilam, Saptari, Pyuthan and Jajarkot had received transportation incentive, this percentage appeared to be lowest in Rolpa (95%) followed by Bara (96%), Salyan, Khotang, Dolpa (97%), Terhathum and Baitadi (99%). Women giving birth in PHCCs were most likely to receive transportation incentive (100%), followed by those giving birth in Hospitals (99%) and Health Posts (95%).

Table 3.4: Receipt of transport incentive by district and type of health facility (N=1,561)

Districts	Number of Women Interviewed (N)	Number of Women receiving full transport incentive (n)	Percentage (%)
Ilam	150	150	**100**
Tehrathum	74	73	**98.6**
Khotang	116	113	**97.4**
Saptari	171	171	**100**
Bara	195	188	**96.4**
Pyuthan	163	163	**100**
Rolpa	178	169	**94.9**
Salyan	173	167	**96.5**
Dolpa	30	29	**96.7**
Jajarkot	105	105	**100**
Baitadi	206	203	**98.5**
Total	**1561**	**1531**	**98.1**
Type of Health Facility			
Hospital	867	860	**99.2**
PHCC	257	257	**100**
HP	437	414	**94.7**

3.3.3 Receipt of transport incentive by background characteristics of women

Table 3.5 describes background characteristics of women receiving transport incentive. Women belonging to religious minority, Dalit and Janjatis were less likely to receive the transport incentive compared to other ethnic groups. Similarly, women working in government and private sector were also less likely to receive transport incentive. No major difference in the receipt of transport incentive is noticed in terms of place of residence and education groups. The reason for relatively less percentage of working women and Dalit women receiving transport incentive is not clear.

"... In case of delay in receiving money for transport incentive, we manage from our own pocket… so that no mother have to come here again and return home with empty hand ...we get reimburse later" (OKHARA HP/KHO).

Table 3.5: Background characteristics of women receiving transport incentive (N=1,561)

Background characteristics	Total number of women interviewed	Number of women receiving transport incentives	Percentage
Educational Status			
Illiterate	164	161	**98.2**
Informal	99	98	**99.0**
Class 1-9	698	682	**97.7**
SLC	354	346	**97.7**
Intermediate	208	206	**99.0**
Bachelor	34	34	**100**
Master and +	4	4	**100**
Total	**1561**	**1531**	**98.1**
Occupation			
Teacher	32	32	**100**
Daily wage/ Labor	33	31	**93.9**
Government Service	8	7	**87.5**
Private Service	18	17	**94.4**
Petty Business	119	119	**100**
Agriculture	489	485	**99.2**
Skilled Labor	71	70	**98.6**
Housewife/ Do not Earn	783	762	**97.3**
Other	8	8	**100**
Total	**1561**	**1531**	**98.1**
Caste/ Ethnicity			
Brahman	171	167	**97.7**
Chhetri	502	498	**99.2**
Janjati	353	343	**97.2**
Madheshi	144	142	**98.6**
Dalit	327	317	**96.9**
Muslim	64	64	**100**
Total	**1561**	**1531**	**98.1**
Place of Residence			
Rural	1324	1295	**97.8**
Urban	237	236	**99.6**
Total	**1561**	**1531**	**98.1**

3.3.4 Receipt of transport incentive on the day of discharge

Out of 1,561 women, 1,533 (98%) received transport incentive. Table 3.6 shows the timing on the receipt of transport incentive. Almost 78% women received transport incentive on the day of discharge. Still 14% women had to wait for a month, 3% had to wait for about 2 months, 1% had to wait for 3 months and 4% had to wait for more than four months to receive transport incentive. All women from Ilam, Pyuthan and Dolpa district received incentive within a month. Percentage of women incentive even after 3 months was highest in Bara, Salyan (11%) and Jajarkot (8%).

Percentage of women receiving transportation incentive on the day of discharge was highest in Hospital (89%) followed by PHCC (65%) and HP (64%).

"...budget releasing process from district is very slow; therefore we could not provide transportation incentive in time to the clients..." (BALCHOUR HP/SAL, KANCHANPUR PHCC/SAP)

Table 3.6: Percent timing on the receipt of transport incentive (N=1,533)

District	On the day of discharge	Within a Month	Within 2 months	Within 3 months	More than 3 months	n
Ilam	82.7	17.3	0.0	0.0	0.0	150
Tehrathum	69.9	19.2	6.9	2.7	1.4	73
Khotang	72.6	26.6	0.9	0.0	0.0	113
Saptari	74.3	25.2	0.6	0.0	0.0	171
Bara	73.7	10.5	1.6	3.2	11.1	190
Pyuthan	95.1	1.2	0.0	0.0	3.7	163
Rolpa	78.1	10.1	5.9	0.6	5.3	169
Salyan	67.1	17.4	2.4	2.4	10.8	167
Dolpa	82.8	17.2	0.0	0.0	0.0	29
Jajarkot	63.8	15.2	7.6	5.7	7.6	105
Baitadi	89.7	3.9	5.9	0.5	0.0	203
Total	**78.0**	**13.7**	**2.9**	**1.3**	**4.1**	**1,533**
Type of health facility						
Hospital	88.6	10.0	<1	<1	1	860
PHCC	65.0	17.1	7.0	2.7	8.2	257
HP	64.1	19.2	5.3	2.4	8.9	416

3.3.5 Receipt of transport incentive by women

Table 3.8 provides information on receipt of transport incentive. Out of 1,533 women receiving transportation incentive, only about 86% women received transport incentive by themselves. For remaining 14% women, transport incentive was received by their husband (8%) and other family members (6%). Women from Bara, Jajarkot and Khotang were relatively less likely to receive transport incentive themselves compared to women from Baitadi, Dolpa, Ilam, Pyuthan and Rolpa.

"... sometimes the Aama Programme incentive is received by the relatives and the clients come and claim to us again..." (THARMARE PHCC/SAL).

Table 3.6: Receipt of transport incentive by women

Districts	Women	Husband	In-law	Family member	Others	Total
Ilam	136	13	0	1	0	**150**
Tehrathum	62	7	0	4	0	**73**
Khotang	86	15	3	9	0	**113**
Saptari	152	11	4	4	0	**171**
Bara	111	51	22	6	0	**190**
Pyuthan	155	1	4	3	0	**163**
Rolpa	162	1	2	4	0	**169**
Salyan	149	12	4	2	0	**167**
Dolpa	27	1	1	0	0	**29**
Jajarkot	76	12	6	8	3	**105**
Baitadi	202	1	0	0	0	**203**
Percentage	**85.98**	**8.15**	**3**	**2.67**	**0.19**	**100**
Total	**1,318**	**125**	**46**	**41**	**3**	**1,533**
Note: Transport Incentive full received: 1,531 and partial received: 2, So all together: 1,533						

3.3.5 Receipt of 4ANC incentive by women

Table 3.8 shows the receipt of 4ANC incentive by women included in the assessment. Out of 1,561 women interviewed during this rapid assessment, only 994 women (54%) had done 4 ANC visit as per the protocol, while only 796 about 80% had received the 4 ANC incentives.

Table 3.8: Receipt of 4ANC incentive by district and type of health facility (N=1,561)

District	Women interviewed	Women completing 4 ANC	women receiving 4 ANC incentive	(%) of women getting 4 ANC incentives
Ilam	150	76	59	78
Tehrathum	74	61	59	97
Khotang	116	88	82	93
Saptari	171	67	17	25
Bara	195	67	40	60
Pyuthan	163	140	107	76
Rolpa	178	136	118	87
Salyan	173	106	96	91
Dolpa	30	15	14	93
Jajarkot	105	70	52	74
Baitadi	206	168	152	90
Total	**1561**	**994**	**796**	**80**
Types of health facility				
Public Hospital	867	520	394	76
PHCC	257	174	146	84
Health Post	437	300	256	85

Women from Saptari were lowest of all in receiving transport incentive followed by Bara. Women from Terhathum, Khotang and Baitadi were most likely to receive 4ANC incentive (90% or over). Women giving birth in hospital were less likely to receive 4ANC incentive (45%) than women giving birth in PHCC (57%) or HP (58%). This might be due to the fact that women who come for institutional delivery in a hospital donot bring ANC card (ANC services received at PHHCs or HPs). Shortage of budget for 4ANC incentive could also be another reason.

"...we requested for additional 4ANC budget to FHD…. we were said that there is no chance of sending additional budget so we could not give 4ANC incentive to those who were eligible…. " (HO/PYU, HO/ROL)

3.3.7 Receipt of free delivery care

Table 3.9 shows the number of women receiving free delivery care. The table indicates that about 87% of women giving birth at the selected health facilities received delivery service free of cost. The percentage of women receiving free delivery care varies across districts. The percentage of women receiving free delivery care is highest in Jajarkot (100%), followed by Baitadi (99%), Salyan (99%), Saptari (99%), and Ilam (99%), while this percentage is lowest in Pyuthan (41%), and followed by Rolpa (66%).

Table 3.6: Receipt of free delivery care

District	Number of women interviewed	Number of women receiving free care	Percentage
Total	**1561**	**1355**	**86.8**
Ilam	150	149	99.3
Tehrathum	74	60	81.1
Khotang	116	113	97.4
Saptari	171	170	99.4
Bara	195	170	87.2
Pyuthan	163	67	41.1
Rolpa	178	117	65.7
Salyan	173	171	98.8
Dolpa	30	29	96.7
Jajarkot	105	105	100
Baitadi	206	204	99.0
Total	**1561**	**1355**	**86.8**
Type of health facility			
Hospital	867	745	85.9
PHCC	257	193	75.1
HP	437	417	95.4
Type of delivery			
Normal	1413	1237	87.5
Complicated	90	79	87.8
C/S	58	39	67.2

Women giving birth at Health Post were most likely to receive the delivery care free of care (95%) and women giving birth at PHCC were least likely to receive the delivery care free of cost (75%). Even in the public facilities women were asked to pay for all levels of care. Almost 24% of women receiving care from hospitals were found paying for free services followed by PHCC (25%), and HP (5%). Overall 86% women reported that they have received free delivery care.

"I had to pay for the services like blood test, and sanitary pads. They health workers told me that it was not available at the health facility." (Mother/Saptari/hosp)

3.3.8 Background characteristics of women paying for services

Table 3.10 shows the characteristics of women paying for services. It is observed that women from all caste/ethnicity background, education level, occupation and those residing in both rural and urban areas had paid some amount for delivery care.

Table 3.7: Background characteristics of women paying for services

Characteristics	Number of women interviewed	Number of women paying for service	Percentage
Caste/ethnicity			
Brahman	171	18	10.5
Chhetri	502	65	12.9
Janjati	353	51	14.4
Madheshi	144	6	4.2
Dalit	327	45	13.8
Muslim	64	12	18.8
Total	**1,561**	**197**	**12.6**
Education			
Illiterate	164	19	11.6
Informal	99	3	3.0
Class 1-9	698	106	15.2
SLC	354	37	10.5
Intermediate	208	26	12.5
Bachelor	34	4	11.8
Master and +	4	2	50.0
Total	**1,561**	**197**	**12.6**
Occupation			
Teacher	32	6	18.8
Daily wage/ Labor	33	3	9.1
Government Service	8	1	12.5
Private Service	18	2	11.1
Petty Business	119	21	17.6
Agriculture	489	17	3.5
Skilled Labor	71	8	11.3
Housewife/ Do not Earn	791	139	17.57
Total	**1,561**	**197**	**12.6**
Place of residence			

Rural	1324	195	14.7
Urban	237	2	0.8
Total	**1561**	**197**	**12.6**

No specific pattern of paying fee for delivery care is observed across women with different background characteristics. However, women from rural areas (15%) were more likely to pay for delivery care than their urban counterparts (1%).

3.3.9 Women paying for different delivery services

Women undergoing all type of delivery services such as normal, complicated and CS were found to be paying for free services. Almost about 12% of complicated and normal deliveries and about one-third (33%) of CS services were provided by charging some user fees to women.

Table 3.11: Number of women paying for delivery service (N=197)

Districts	Number of women paying for normal delivery	Number of women paying for complicated delivery	Number of women paying for CS	Total
Ilam	0	0	1	1
Tehrathum	10	1	3	14
Khotang	3	0	0	3
Saptari	0	0	1	1
Bara	23	1	1	25
Pyuthan	82	4	10	96
Rolpa	46	4	2	52
Salyan	0	1	1	2
Dolpa	1	0	0	1
Baitadi	2	0	0	2
Total	**167**	**11**	**19**	**197**
Types of facility				
Hospital	98	5	19	122
PHCC	58	6	0	64
HP	11	0	0	11

Out of 197 women who have paid for free services almost 85% have paid for normal delivery service. Similarly, 6% have paid for complicated delivery and 10% have paid for Caesarean Section (CS) service. Pyuthan, Rolpa and Bara are the districts where majority of the women were charged for delivery care.

Average amount paid for normal and complicated delivery services

Table 3.12 shows the average amount paid for normal and complicated delivery services. Out of 11 districts, health facilities from seven districts were found charging women. The average amount paid

for normal and complicated delivery service in the 7 districts is NPR. 624. The average amount paid for normal and complicated delivery care varied across the districts, ranging from NPR. 452 in Rolpa and NPR. 1,090 in Bara.

Table 3.12: Average amount paid for normal and complicated delivery services (N=178)

Districts	Number of women paying for services (n)		Average amount paid for normal and complicated deliveries (NPR)
	Amount Know	Amount Don't Know	
Ilam	-	-	-
Terhathum	8	2	609
Khotang	3	0	692
Saptari	-	2	-
Bara	24	0	1,090
Pyuthan	28	2	590
Rolpa	50	0	452
Salyan	1	0	500
Jajarkot	-	-	-
Dolpa	-	-	-
Baitadi	2	0	820
Total	**172**	**6**	**624**
Types of facility			
Government Hospital	97	6	624
PHCC	64	0	665
HP	11	0	387

Table 3.13 shows information about the items/services that were charged to women giving birth at facility. Majority women were found paying for cleanliness serviceThe services include the cloths for mother and baby, procedural fee for complication management, sweets, cleanliness, laboratory fee, gloves, medicine, and registration fees. Health facilities providing delivery services should manage these services from the unit cost provided to the facility through Aama Surakshya Programme. Family Health Division therefore should provide clear instruction to all health facilities not to charge any fee from women giving birth to the respective facilities.

Table 3.13: Average Amount paid by women for different services

Items	Numberof women paying for services	Average amount (NPR)
Registration fee	7	10
Medicine/ gloves	87	305
Laboratory fee	74	381
Procedural fee (complicated)	1	600
Clothes for mother and baby	4	1,000
Sweets	11	500
Cleanliness (placenta, etc.)	104	320
Others	15	487
Amount - don't know	29	-
Total	**197**	**628**

3.3.10 Average amount paid for CS delivery services

Table 3.14 shows the average amount paid for CS delivery services. In an average a woman was charged a total of NPR. 1,195 for CS delivery. The amount charged for CS delivery service varies across districts and ranging from NPR. 875 in Rolpa to NPR.1,700 in Pyuthan. This varaiation could be due to the decision of the management committee to charge for certain services.

Table 3: 14 Average amount paid for CS delivery

Districts	Number of women paying		Average amount paid for caesarean sections
	Amount known	Amount not known	
Ilam	1	0	1500
Terhathum	2	1	1100
Khotang	-	-	
Saptari	1	0	1020
Bara	0	1	
Pyuthan	9	1	1700
Rolpa	2	0	875
Salyan	1	0	975
Jajarkot	-	-	-
Dolpa	-	-	-
Baitadi	-	-	-
Total	**16**	**3**	**1,195**
Types of facility			
Hospital	16	3	1,195

Table 3.15 provides an overview of the items/services that are charged by health facility for CS delivery service. Out of 16 who paid for CS services, all most all (100%) had paid for drugs, one had paid for registration fee, 5 women had paid for cleanliness, 7 had paid for lab test, one had paid for sweets and two had paid for other services. As a number of women are paying for the service which they were supposed to get free of cost, there should be monitoring from center and region and clear instruction should be provided to the health facility to strictly comply the Aama programmeme guideline.

Table 3.15: Average amount paid by women for CS service in different categories

Items	Number of women paying	Average amount (NPR)
Registration fee	1	20
Drugs	15	396
Payments to cleaner	5	380
Lab test and diagnostics	9	1114
Sweet	1	250
Other	2	200

3.3.11 Disclosure of Aama Programmeme Beneficiary

Table 3.16 shows the number of health facilities disclosing name of mothers. 44 out of 67 (66%)

health facilities had displayed name of women receiving free delivery care. All sampled facilities from Ilam, Terhathum, Dolpa and Baitadi districts had displayed the name list of Aama programmeme beneficiaries, whereas only one facility from Rolpa, Salyan and only 2 facilities in Khotang displayed name of the Aama programmeme beneficiaries. Compliance over displaying name list of beneficiaries was highest in Primary Health Care Centers (80%) followed by hospital (75%) and the Health Posts (66%).

Table 3.16 Number of facilities disclosing names of Aama beneficiaries

District	Number of health facilities	Number of facilities disclosing name of Aama Beneficiaries
Baitadi	5	5
Bara	7	4
Dolpa	3	2
Ilam	8	8
Jajarkot	6	5
Khotang	6	3
Pyuthan	6	3
Rolpa	6	1
Salyan	6	1
Saptari	8	6
Terhathum	6	6
Total	**67**	**44**
Types of facility		
Hospital	12	9
PHCC	15	12
HP	42	28

3.4 Cross-verification of the receipt of free care and transport incentive

This section cross-verifies information between health facility record and interview with the women giving birth at the facility. The results are based on quantitative information obtained from 1,561 interviewee.

3.4.1 Cross verification Aama Programmeme Beneficiary

Table 3.17 shows the number of women records reviewed in the districts and the number of women interviewed. Records of almost 9,678 women were reviewed at the D(P)HO to obtain a sample size of 1,591 women. Out of 1,591 women to be interviewed, 1,561 women could only be traced back in the community. 3 out of 30 have already left the place and rest of them could not be traced. Most of these women were residing in urban area.

Table 3.17: Number of deliveries in records and number of women interviewed

District	Number of Institutional Delivery in sampled Facility	Number of Women Interviewed	Sample Size
Ilam	547	150	150
Tehrathum	285	74	87
Khotang	342	116	119
Saptari	2,985	171	177
Bara	2,498	195	201
Pyuthan	949	163	165
Rolpa	403	178	178
Salyan	944	173	173
Dolpa	79	30	30
Jajarkot	253	105	105
Baitadi	393	206	206
Total	**9,678**	**1561**	**1591**

3.4.2 Cross verification on the receipt of transport incentive

Table 3.18 shows the comparison on the number of women receiving full transport incentive between health facility record and women's interview. Out of 1,561 women eligible for the receipt of transport incetive, 1,530 women had fully received the transportation incentive. Two out of 31, 3 women were simply not provided the incentive however rest of them were told to get later.

Table 3.18: Cross verification on the receipt of full transport incentive

Districts	Facility records: numberof women receiving transport incentive (n)		Women's reports: number of women receiving transport incentive (n)			(N)
	Fully received	Not received	Fully received	Not received	Told would get later	
Ilam	150	0	150	0	0	**150**
Tehrathum	73	1	73	1	1	**74**
Khotang	113	3	113	3	3	**116**
Saptari	171	0	171	0	0	**171**
Bara	188	7	188	7	6	**195**
Pyuthan	163	0	163	0	0	**163**
Rolpa	169	9	169	9	7	**178**
Salyan	167	6	167	6	6	**173**
Dolpa	28	2	28	2	2	**30**
Jajarkot	105	0	105	0	0	**105**
Baitadi	203	3	203	3	3	**206**
Total	**1530**	**31**	**1530**	**31**	**28**	**1561**
Type of health facility						
Hospital	860	0	860	0	0	**867**
PHCC	257	7	257	7	7	**257**
HP	413	24	413	24	21	**437**

There were no mis-match observed on the receipt of transport incentive between the two data sources. At the types of health facility level, no discrepancy appeared in the receipt of transport incentive.

3.4.3 Cross-verification on type of delivery

Table 3.19 shows comparison on the receipt of type of delivery care by women against the health facility record. Out of 1,561 eligible women, health facility record shows that 1,413 women have received normal delivery service 90 received complicated delivery service and 58 received CS delivery services. However, from women's interview only 1,420 women confirm to have received normal delivery, 85 recived complicated delivery and 56 received CS delivery services. Overall 3.1 percent mismatch has been observed. 0.5% mismatch is observed on the receipt of normal delivery, 6% in complicated delivery and 4% in CS delivery. The degree of mismatch varies across districts, for example, no discrepancy observed in 5 districts and in rest of the 6 districts the discrepancies appeared. The information suggests that the observed discrepancy was mainly due to recording error.

Table 3.19 Comparison with health facility record and women's receive on type of delivery care (N=1,561)

Districts	Facility records: Type of Delivery			Women's reports: Type of Delivery		
	Normal	Complicated	C/S	Normal	Complicated	C/S
Ilam	124	19	7	124	19	7
Tehrathum	62	4	8	65	2	7
Khotang	94	16	6	94	16	6
Saptari	164	1	6	163	1	7
Bara	190	3	2	191	3	1
Pyuthan	142	5	16	139	8	16
Rolpa	169	5	4	170	4	4
Salyan	144	22	7	149	17	7
Dolpa	30	0	0	30	0	0
Jajarkot	101	4	0	101	4	0
Baitadi	193	11	2	194	11	1
Total	**1413**	**90**	**58**	**1420**	**85**	**56**
Type of Health Facility						
Hospital	740	70	57	749	62	56
PHCC	242	15	0	239	18	0
HP	432	5	0	431	6	0

3.4.4 Cross-verification on the receipt of 4 ANC incentives

Table 3.20 shows the comparison of receipt of 4 ANC incentives by women against health facility records. Out of 1,561 women giving birth at the health facilities, records show that only 807 were provided with 4ANC incentive. 796 out of 807 women confirmed to have received 4 ANC incentive. 1.4 percent mis-matches was observed between the two data sources on the receipt of 4 ANC incentive. The percentage of mis-match however varies across district ranging from 0

to 7 percent. A reason for the minor discrepancy observed could be due to the fact that women are aware on the receipt of transport incentive but not 4ANC incentives or it can also be attributed to the compilation error. Relatively high percentage of mismatch in 4ANC incentive is observed in Khotang (7%) and Saptari (6%). Similarly, higher percentage of mismatch is observed in HP (6%) than in PHCC and Hospitals.

Table 3.20 Health Facility records and receipt of 4 ANC incentives by women

District	Facility records: Receipt of 4ANC incentive	Women's reports: Receipt of 4ANC incentive	Mis Match (%)
Ilam	59	59	0.0
Tehrathum	59	59	0.0
Khotang	88	82	7.3
Saptari	18	17	5.9
Bara	39	40	2.5
Pyuthan	108	107	0.9
Rolpa	119	118	0.8
Salyan	99	96	3.1
Dolpa	14	14	0.0
Jajarkot	51	52	1.9
Baitadi	153	152	0.7
Total	**807**	**796**	**1.4**
Type of health facility			
Hospital	391	394	0.8
PHCC	145	146	0.7
HP	271	256	5.9

At the health facility level highest percentage of miss-match was observed at the HP (5%) and records of PHCC and Hospitals were also show some mis- matched. This could also suggest that records in the hospitals and PHCCs are poorly mainted.

3.4 Level of satisfaction

Exit client interviews were used to examine client's satisfaction over services provision at the health facilities, provision of free delivery care and transport incentive and recomending a friend for facility delivery. A total of 72 exit interviews were carried out among women receiving delivery service at the health facility during the period of visit to the health facility.

3.4.1 Satisfaction on the services from facility

Table 3.21 shows reasons of client satisfaction. All 72 women expressed satisfaction over services received on the day of interview. Most frequently cited reasons for the satisfaction were cooperative staff (79%), provision of free delivery service (72%) and transport incentive (42%).

Table 3.21 Client satisfaction on the services from the health facility (N=72)

Reasons for satisfaction	Frequency	Percentage
Cooperative staff	57	79.2
Free delivery service	52	72.2
Transportation incentive	30	41.7
Clean health facility	22	30.6
Clothes for children	5	6.9
Sufficient beds in health institution	3	4.2
Delivery without complications	19	26.4
Free food (lunch/dinner)	12	16.7
Nothing satisfactory	0	0
Total	**72**	**100**

**Multiple responses does not add up to 100*

3.5.2 Satisfaction on the provision of transport incentive and free care

Out of 72 women, almost 70 percent (50 women) were satisfied with the provision of transport incentive and free care. More than a half (51%) of the women were satisfied with the provision of transportation incentives and free delivery care as it helped to save lives of mothers and babies (tables not shown). Similarly, about one-third women (33%) were satisfied because the programmeme supported to cover majority costs associated with delivery care. Arround 30% women felt that the programme helped them not to take loan for delivery expenses. Other frequently cited reasons for women's satisfaction include support to reduce maternal and neonatal death (23%), to reach the health facilities on time (29%).

3.5.3 Dissatisfaction on the provision of transport incentive and free care

Out of 72 women, around 30% (22 women) were dissatisfied with the provision of transport incentive and free care. The main reasons for dissatisfaction was that women did not receive incentive on time (60%), medicens were not free and the women had to pay (60%). 30% women felt that the incentive is too little to help poor women.

Table 3: Client disatisfaction on provision of transport incentive and free care (N=22)

Reasons for dissatisfaction	Frequency	Percent
Incentive is too little to help poor	7	31.8
Incentive does not received timely	13	59.0
No free medicine	12	54.5
Total	72	100.0

**Multiple responses does not add up to 100*

3.5.4 Suggest friends to go to health facility for delivery

Out of 72 women interviewed, only one woman said that she will not suggest her friends to go to the health facility for delivery (table not shown). Women were asked for reason on sending their friends to visit health facility and 67% reported for a safe delivery service, 40% mentioned of receiving free care and transport incentives for a facility delivery and 30% also stated that the facility provided good service.

CHAPTER 4–KEY FINDINGS AND WAYS FORWARD

This chapter provides key findings 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. Some of the findings of tenth round of the RA are similar to the findings from previous rounds of the assessment. Some of the positive findings are the increase in institutional deliveries, and over all improvement alongside major indicators for Aama programmeme. However, the 4 ANC visit has not increased as expected in the national-level as well as in the sampled districts. As in previous assessments, the tenth round of the RA revealed some 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 Programmeme Guidelines 2016. The following sections highlight the key findings of the rapid assessment under each of the objective and the way forward.

4.1 The Use of Delivery Care

4.1.1 Key findings

- At the national level institutional delivery has increased from 14% in 2005/06 to 55% in 2015/16 and during the same period, the home delivery has been declined from 20% to 2%.
- Findings from the sampled districts also corroborate with national level data suggesting increase in institutional delivery over last three years from 50% in 2013/14 to 55% in 2015/16.
- Level of institutional delivery varies across the sampled districts with highest (66%) in Baitadi to lowest (19%) in Ilam.
- 4ANC visits as percentage of expected pregnancy remain stagnant around 52% over the last three fiscal years (2013/14 to 2015/16).

4.1.2 Ways forward

- The discouraging trend of institutional delivery and 4 ANC visits in some districts could be due to under-reporting of maternal health services due to recently changed online reporting of HMIS, therefore to improve the status of these indicators D(P)HO should ensure that all the reports coming from the reporting units are entered.
- Improve the supply side functions of health facilities implementing the Aama Surakshya Programmeme, including the provision of 24/7 delivery services, deploy SBA trained health persons in all the birthing centers, and ensure uninterrupted supply of essential drugs and logistics.
- Strengthen the quality of care in all birthing centers through onsite coaching and mentoring and by supplying the standard protocols and guidelines.

4.2 Management of Aama Programmeme Including Timeliness of Fund Flow

4.2.1 Key findings

- Budget for Aama Surakshya programme was adequate in the sampled districts, however issue of delay in receiving the budget was reported by PHCC and HP level mainly due to delay in

receiving authorization from center and some delays at the district. The problem was managed by using unit cost money at the management committee.

- Almost one-third of the health facilities did not send the Aama Surakshya Programme financial report to D(P)HO on time as a result some delay in disbursement programme budget was reported and few clients had to come to facility again to collect the incentive and some did not get the incentive.
- Some confusion persists at the facility level over the contents of Aama Surakshya Programme guideline and use of unit cost received from the programme. Few facilities used the unit cost to pay the transportation incentive to the client and about one-third facilities did not display the name of women giving birth at the facility.
- Use of Aama unit cost money is found to be different to the condition stipulated in the guideline. Aama programmeme focal person at facility are hardly consulted in making the decision on the use of unit cost.

4.2.2 Ways forward

- DoHS/FHD to ensure the timely flow of funds for the Aama programmeme to all costing centers and send letter to D(P)HO and hospitals requesting them to use the facility management committee fund in case of delay in receiving budget.
- Clear instruction should be given and follow up on timely reporting of financial progress should be made from FHD and D(P)HO to the health facilities and all the health facilities should send the Aama Surakshya Programme progress every month to DPHO and FHD and also update the progress in TABUCS .
- Re-orientation on the content of Aama Surakshya Programme guideline should be provided to Aama focal person, facility incharge and accountants
- Improve utilization of Aama unit cost in improving quality of services by encouraging management committee comply to conditons stipulated in the guideline. Aama Surakshya Programme focal persons should be engaged in decision making process of utilizing the unit cost received from the programme

4.3 Compliance of Programmeme Implementation with Aama Guidelines 2012

4.3.1 Key Findings

4.3.1.1 Receipt of transportation incentive

- About 5% women giving birth at the sampled health facility (particularly in health posts) were not able to get transportation incentive.
- Women belonging to religious minority, Dalit and Janjatis were less likely to receive the transportation incentive.

4.3.1.2 ANC4 incentive

- Only about 54% of women had done 4ANC visits as per protocol and only about 51% had receive ANC4 incentive and women from Ilam, Saptari and Bara were least likely to receive ANC4 incentive.

- Women giving birth in hospital (45%) were less likely to receive ANC4 incentive than women giving birth in PHCC (57%) or HP (58%). But women giving birth in hospital (89%) were more likely to get transportation incentive on the day of discharge than those who give birth in PHCC (65%) and HP (64%).

4.3.1.3 Timing of receipt of incentive

- Only about 78% women had receive transportation incentive at the day of discharge and over 22% had to wait more than one month to get the incentive.
- Women giving birth in facilities in Bara, Salyan and Jajarkot were more likely to wait to get transportation incentive.

4.3.1.4 Person who received the incentive

- About 86% women received the transportation incentive by themselves while husband received incentive for 8%; other family member received the incentive for 6% women giving birth in health facility.

5.3.1.5 Status of Free delivery care

- About 87% women giving birth at selected health facilities received the service free of cost. This percentage was highest in Jajarkot (100%) and lowest in Pyuthan (41%). Women giving birth in HP were most likely to receive the delivery care free of cost (95%) and women giving birth in PHCC were least likely to receive free delivery care (75%).
- About 12% of normal and complicated delivery and 33% of CS delivery clients had to pay some money for the respective care. Women giving birth in health facility had to pay in an average of NRs. 624 for normal and complicated delivery and NRs. 1195 for CS delivery.

4.3.2 Ways forward

- FHD should ensure that all the facilities should have at least one Aama Surakshya Guideline available in the maternity ward.
- FHD should give clear guidance to the health facilities to display list of women giving birth to the facility so as to improve community trust towards the facility and client satisfaction.
- Re-orientation on Aama programmeme guideline should be provided to the service provider so as to improve their knowledge towards the conditions under which women are eligible to get the 4 ANC incentive.
- FHD should allocate adequate budget to the health facilities for 4ANC incentive. Re-enforce compliance on the instruction provided in programme implementation guideline to use Aama unit cost from the facility management committee to manage during delay in getting receiving budget from district.
- Clarifying programmeme implementation guideline interms of service provision, use of unit cost and over all management of the programmeme. Improving monitoring to 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

Programmeme Guidelines 2016.

- 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.
- The Aama Programmeme Guidelines clearly state that delivery care is to be provided free of cost. However, many health facilities were charging women for normal, complicated as well as CS delivery with 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 Incentives

4.4.1 Key findings

- There has been a gradual improvement in the discrepancy of selected indicators between facility record and women's interview.
- Information about receipt of transportation incentive was fully matched between the facility record and women interview.
- Overall in an average less than 0.5% mismatch was observed between facility record and women interview for normal delivery, 6% in complicated delivery and 4% in CS delivery, however the mismatch varies across districts.
- Information about receipt of 4ANC incentive, type of delivery, receipt of transportation incentive at the day of discharge and receipt of transportation incentive as per guideline matched between facility record and women interview among more than 90% of the cases.
- Still a large number of facility donot display Aama programme beneficiary, availability of Aama programme guideline is still a challenge.

4.4.2 Ways forward

- Regular monitoring should be done by higher level authorities. D(P)HO should ensure that all health facilities provide incentives at the time of discharge in order to build trust among community women.
- Process of monitoring of the Aama programmeme implementation both from the centre and district should be strengthened. All the supervisors visiting health facilities for monitoring should compulsorily use monitoring checklists, submit report to the office and make follow up to the facilities to ensure the action points are implemented.
- 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. Furthermore, orient health worker on the 4ANC incentive scheme. Identify barriers to the use of the 4ANC scheme and imply changes in the guideline for uniformity.

4.5 Level of satisfaction

4.5.1 Key findings

- None of the exit client expressed lack of satisfaction over the service they received on the day of visit. Most common reasons for the satisfaction were; cooperation of staff, provision of transportation incentive, cleanliness of health facility, and no complication faced provision of free food.
- About a half of the women perceive that the transportation incentive and free delivery care helps mother and baby to get life saving care at hospital. Other common reasons for satisfaction over transportation incentive were; ability to reach facility on time, support maternal and new born death and prevent from taking loan for institutional delivery.
- 30% women have some dissatisfaction about provision of Aama programme. Main reasons for dissatisfaction include: not getting incentive on time, the incentive is too little to help poor women, no free medicine.
- Almost all women said that they will tell their friends to get free delivery care at the health facility, 67% said that they will visit health facility again for safe delivery, about a quarter (25%) said that they received good service.

4.5.2 Ways forward

- Programme managers and providers must comply the programme guideline, for example; the incentive should be provided on the day of discharge, no cost should be charged in any form, including friendly behavior from provider.
- Effective and supportive supervision, monitoring visit should be made on regular basis to the facilities providing maternal health care services.

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