Report on Rapid Assessment of Aama Surakshya Programme: Round XI

Family Welfare Division (FWD)
Department of Health Services (DoHS)
Ministry of Health and Population
Kathmandu, Nepal
2018

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Rapid Assessment (RA) of Aama Surakshya Programme round XI is a continuation of previous series. In order to institutionalise the RA, the Family Welfare Division (FWD), Department of Health Services (DoHS), has taken a lead role in implementing and finalising the RA report. We would like to offer our sincere thanks to the Director General (DG) for his guidance while conducting the RA. FHD is thankful to the Department for International Development/Nepal Health Sector Support Programme (DFID / NHSSP) for technical support in designing, field monitoring and finalising 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 the Aama Surakshya Programme, and all health workers who have directly or indirectly contributed by providing their invaluable time and insight for this study.

The Study Team

EXECUTIVE SUMMARY

The Aama Surakshya Programme (abbreviated as the Aama Programme) is a national priority-one programme implemented by the Department of Health Services (DoHS), Family Health Division (FHD). The Aama Programme aims to reduce financial barriers that prevent women from accessing quality delivery care services. The primary objective of this round XI Rapid Assessment (RA) is to assess the compliance of the Aama Programme with Programme Implementation Guidelines 2069, third edition 2073, particuarlly within the new federal context. This is the first RA designed to capture the status of implemention of the Aama Programme in the federal context. RA is a cross-sectional descriptive study that employs quantitative and qualitative approaches to obtain valid and reliable information from both service providers and service users. Thirteen districts were randomly selected, excluding those that were assessed in recent rounds of RA. The study covered information for FY 2017/18; data collection took place from 20 May to 4 June 2018. A total of 54 Health Facilities (HFs) from 49 palikas were sampled for this RA, chosen from the list of all public and private facilities implementing the Aama Programme. One thousand one hundred and eleven delivery records from different types of HF were cross-verified by interviewing women in their homes. A total of 1,070 Recently Delivered Women (RDW) could be traced in the community. In addition, 159 Exit Client Interviews (ECIs) were carried out to understand women's perceptions of delivery services received. Qualitative information was obtained from in-depth interviews conducted with 127 key informants, including health coordinators, service providers, account officers, and Health Facility Management Committee (HFMC) members. The key findings and recommendations of this RA are:

Management of the Aama Programme

The budget allocated for the Aama Programme was found to be adequate; however, delay in receiving the budget was still an issue for facilities. Overburdened palika accountants and their lack of awareness of health-related programmes were referred to by facilities as important causes of delay in receiving funds. Some palikas (14%) complained of insufficient budget allocation to the Aama Programme. No palikas were found to have allocated additional budget for the Aama Programme other than that provided through conditional grants. However, some palikas (6%) managed to pay transport incentives and HF reimbursements from their own sources. At the same time, some Palikas had communicated the budget insufficiency to FHD and were awaiting additional budget to reimburse outstanding payments. Budget flow was not an issue for hospitals above district level as the fund flow process has not changed and budget allocated to them was sufficient. Around two-thirds of HFs had received transport and Four Antenatal Care Visits (4ANC) incentives as advances, but almost one-third of HFs had not received the HF reimbursement. Fifty-seven percent of HFs sent their Aama reports on a monthly basis; a lack of clear instruction on where to send physical and financial reports was one of the main reasons for those not sending them. Around 21 percent of palikas had the latest copy of the Aama Programme Guidelines. The majority of palikas relied on the Programme Implementation Guidelines from FHD. Only 61 percent of HFs were displaying the name of the Aama beneficiary, as per the guidelines.

Recommendations on the management of the Aama Programme:

- Family Welfare Division (FWD) to prepare evidence-based Aama budget allocation for palikas. This can be done using the expenditure data from the Transaction Accounting and Budget Control System (TABUCS) and utilisation data from the Health Management Information System (HMIS). The process should be started by December each year.

- Ministry of Federal Affairs and General Administration (MoFAGA) to ensure timely flow of funds to palikas, with similar instructions from the Financial Comptroller General Office (FCGO) to the District Treasury Controller Office (DTCO) to facilitate timely release of funds.
- FWD and palikas to send clear instructions on accurate recording, timely reporting and proper use of the Aama reimbursement fund to implementing HFs.
- All Aama-implementing HFs to send an Aama Programme Progress Report every month to their reporting authority. Hospitals should enter the number of Aama Programme beneficiaries by type of delivery along with the expenditure data in TABUCS.
- FWD to Prepare, disseminate and distribute the Aama Programme Reference Guidelines for palikas to facilitate programme implementation.

Compliance with Aama Guidelines: receipt of transportation and 4ANC incentives and free care

Almost 96 percent of women giving birth at sampled HFs were able to receive the transportation incentive, with 89 percent of women receiving the incentive on the day of discharge. Only 66 percent of women had completed four Antenal Care (ANC) visits as per protocol, of which only 65 percent had received the 4ANC incentive. Similarly, only around 56 percent of women giving birth at selected HFs received services free of cost. Women giving birth in Health Posts (HPs) and Public Health Care Centres (PHCCs) were more likely to receive delivery care free of cost (95%) compared to women giving birth in hospitals. Forty percent of normal-delivery, 47 percent of complicated-delivery and 66 percent of Caesarian-Section- (CS-) delivery clients had to pay some money to receive care. Women giving birth in HFs had to pay an average of 1,568 Nepalese Rupees (NPR) for normal deliveries, NPR 3,727 for complicated deliveries and NPR 6,051 for CS deliveries. Women were found to have been paying for registration, medicine, laboratory services, complicated delivery management and blood transfusions.

Recommendations on compliance with Aama Guidelines: receipt of transportation and 4ANC incentives and free care

- The Aama Programme Guidelines clearly state that delivery care is to be provided free of cost. The Ministry of Health and Population (MoHP), DoHS, FWD and palikas should take necessary actions to explore the reasons behind charging fees for delivery services. Clear instructions on the use of standard treatment protocols need to be provided to all Aama-implementing HFs. FWD would require Technial Assistance (TA) in updating treatment protocols and preparing a monitoring framework to ensure compliance. It would be useful to send instructions at the beginning of each Fiscal Year (FY).
- FWD to update Aama Programme Implementation Guidelines in terms of: service provision; use of Aama HF reimbursement; and recording, reporting, monitoring and overall management of the programme. This update should also include reference documents for sub-national governments.

Cross-verification of receipt of transport and 4ANC incentives and of type of delivery received

One thousand one hundred and eleven HF records were cross-verified by interviewing RDW in their homes about the transport incentive, the 4ANC incentive and the type of delivery service received. Findings are based on interviews with the 1,070 women who could be traced back in the community.

Comparing HF records with RDW interviews, discrepancies of 4 percent (transport) and 21 percent (4ANC) were observed in the receipt of incentives: some women who were reported to have received transport incentives in HF records could not be verified from interviews. Similarly, a 15 percent mismatch was observed in the type of delivery service received between HF records and interviews with RDW: 4 percent for normal delivery, 34 percent for complicated delivery and 9 percent for CS delivery. Discrepancies varied across

districts. This means that some women who were recorded as having had complicated or CS deliveries in HF records identified themselves as having had either normal or complicated deliveries respectively.

Recommendations on cross-verification of receipt of transport and 4ANC incentives and of type of delivery received

- The discrepancies identified during cross-verification could be the result of human error while recording and reporting the data. At the same time, this may indicate a potential fiduciary risk in Aama fund use. FWD and palikas shoud regularly provide supportive supervision and effective monitoring to ensure compliance against the policy provision. Both FWD and palikas should instruct implementing HFs to ensure accurate recording and reporting. This can be achieved through data verification from HMIS and TABUCS. More importantly, MoHP/DoHS and palikas can take necessary action for further investigation and provide specific instruction to both facilities and individuals.

- TA is required for FWD and Palikas to analyse the audit observations related to the Aama Programme and provide a management note to prevent pertinent audit observations in the future.

- Process monitoring of the Aama Programme implementation should be strengthened at all levels, from federal to local. All supervisors visiting HFs for monitoring should compulsorily use the monitoring checklists, submit reports to the office and make follow-up visits to the facilities to ensure that action points are implemented. FWD should provide reference documents to palikas in the beginning of every FY.

Transparency is a key strategy in bringing accountability. In this regard it is suggested that compulsory public audits or public hearings be conducted in the catchment areas of HFs, with the participation of the palikas.

ABBREVIATIONS

ANC	Antenatal Care
4ANC	Four Antenatal Care Visits
ANM	Auxiliary Nurse Midwife
AWPB	Annual Work Plan and Budget
BEONC	Basic Obstetric and Neonatal Care
CEONC	Comprehensive Obstetric and Neonatal Care
CS	Caesarian Section
DFID	UK Department for International Development
DHO	District Health Office
DTCO	District Treasury Office
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
FWD	Family Welfare Division
FY	Fiscal Year
GoN	Government of Nepal
H4L	Health for Life
HDI	Human Development Index
HF	Health Facility
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HP	Health Post
ID	Institutional Delivery
KII	Key Informant Interview
LG	Local Government
MMR	Maternal Mortality Ratio
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Ministry of Health and Population
MMR	Maternal Mortality Ratio
MSNP	Multisector Nutrition Plan
NHRC	Nepal Health Research Council
NHSS	Nepal Health Sector Support
NHSSP	Nepal Health Sector Support Programme
NPC	National Planning Commission
NPR	Nepalese Rupee
PG	Provincial Government
PHCC	Primary Health Care Centre
PNC	Postnatal Care
PSD	Partnership for Sustainable Development
RA	Rapid Assessment
RDW	Recently Delivered Women
SDG	Sustainable Development Goal
SLC	School Leaving Certificate
TA	Technical Assistance
TABUCS	Transaction Accounting and Budget Control System
UNICEF	United Nations Children's Fund
USD	United States Dollars
WHO	World Health Organization

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CHAPTER 1 – INTRODUCTION

This chapter provides a brief overview of the Aama and Four Antenatal Care Visits (4ANC) Programmes, and the rationale and objective of the Rapid Assessment (RA).

1.1 Background

The Constitution of Nepal 2015 mandates health as a fundamental right of the people (Government of Nepal (GoN), 2015). The National Health Policy 2014, which comes under the overarching framework of the Constitution, aims to implement this right by ensuring equitable access to quality health care services for all (GoN, 2014). The Nepal Health Sector Strategy (NHSS) 2015–2020 lays out the strategic direction and specific roadmap to implement the constitutional mandate (GoN, 2016). The Ministry of Health and Population (MoHP) has endorsed the NHSS implementation plan, which provides the budgetary framework to ensure Nepal's commitment to achieve universal health coverage and Sustainable Development Goals (SDGs) by 2030.

Nepal has made significant improvements 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 Programmes such as the Aama Programme, safe abortion, family planning and other safe motherhood initiatives are believed to have contributed to reducing maternal mortality. Despite significant gains in improving maternal health, the current level of MMR is far behind the NHSS target of achieving MMR of 125 per 100,000 live births by 2020 (MoHP, 2015) and to further reduce to 70 by 2030, as committed to in SDG 3 (National Planning Commission (NPC), 2015).

In Fiscal Year (FY) 2017/18, Nepal entered into a new era of polity, transitioning from the unitary system of governance to a federal system. The State is restructured at three levels of governance viz: the federal, provincial and local. Health as a ***'concurrent right'*** falls under the joint responsibility of all three level of governments. Along with three other sectors, basic health service delivery was devolved to Local Governments (LGs). As such, the delivery of the majority of reproductive and maternal health programmes were devolved to LGs.

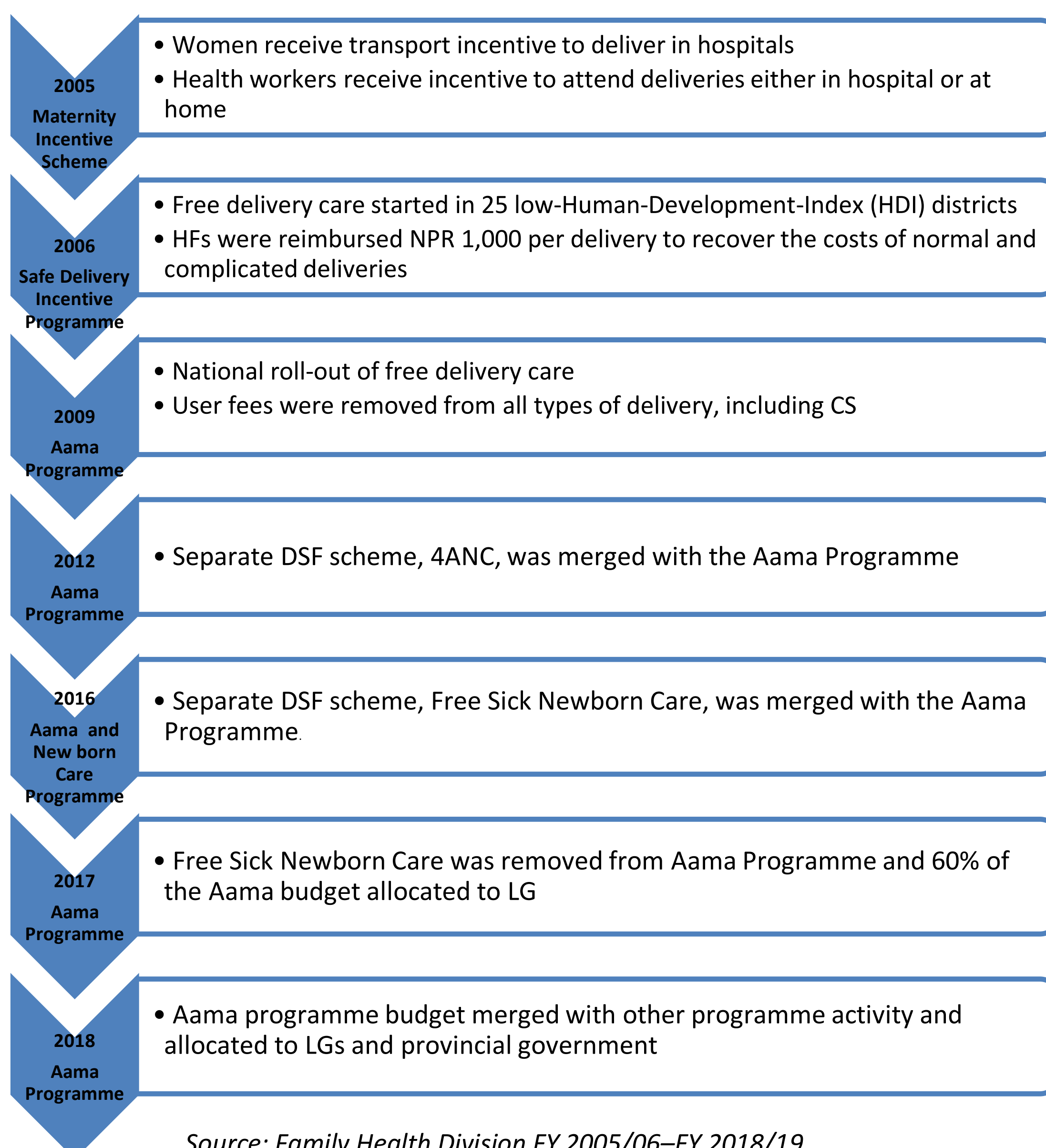
1.2.1 Aama and the 4ANC incentive Programmes

The Aama Programme is one of the major demand-side financing schemes implemented by the Family Health Division (FHD), now the Family Welfare Division (FWD). The Aama Programme aims to reduce financial barriers associated with seeking facility delivery. In order to improve skilled care at the point of delivery and influence care-seeking behaviour of women and families, the GoN launched the Aama Surakshya Programme in 2005. The evolution of the Aama Programme is summarised in Figure 1.

In the context of unacceptably high pregnancy-related preventable morbidity and mortality of the mother and newborn, the importance of high-quality Antenatal Care (ANC) has been viewed as a means to maximising women's and newborn health. The World Health Organization (WHO) recommends that a woman should have at least four ANC visits, in the fourth, sixth, eighth an ninth months of gestation, to detect health problems associated with pregnancy. In order to improve the uptake of ANC visits, the GoN introduced the 4ANC Incentive Programme in July 2009. In 2012, the 4ANC Programme was merged with the Aama Programme: a woman would receive 400 Nepalese Rupees (NPR) on the condition that she complete four ANC 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), have an Institutional Delivery (ID) and attend her first Post Natal Care (PNC) visit (Upreti, et al, 2012).

Figure 1: Evolution of the Aama Programme



Source: Family Health Division FY 2005/06–FY 2018/19

The LGs and the Federal Government have been jointly implementing the Aama Programme in FY 2017/18. As of July 2017, the Aama Programme budget was sent to the LGs as part of the health conditional grant. LGs were allocated NPR 0.69 bn and were responsible for implementing the Aama Programme in district hospitals and Health Facilities (HFs) below, including accredited private facilities. The Federal Government, FHD/MoHP managed the Aama Programme in zonal and tertiary-level hospitals with a budget of NPR 0.68bn. In FY 2018/19, this arrangement was changed and management of district-level hospitals and above was given to the Provincial Governments (PGs). The Aama Programme budget is now spread across three levels, viz: NPR 1.08bn to the LGs, NPR 0.63bn to the PGs, and NPR 0.22bn to the MoHP/FWD. A total of NPR 1.94bn has been

allocated for the Aama, Nyano Jhola[1], and Safe Abortion Programmes, all under one sub-activity. At the same time, the GoN announced the doubling of the transport and 4ANC incentives. Details on the latest additions to the Aama Programme are provided in Table 1.1.

Table 1.1: Aama Programme Components Based on Budget Speech FY 2018/19

1. Transport Incentive to Women		
Ecological Belt	**ID Incentive**	**4ANC Incentive**
Mountain	NPR 3,000	NPR 800
Hill	NPR 2,000	NPR 800
Tarai	NPR 1,000	NPR 800
2. HF Reimbursement		
Type of Delivery	**Reimbursement**	**Health Worker Incentive**
Normal	<25 bed, NPR 1,000; >25 bed, NPR 1,500	NPR 300
Complicated	NPR 3,000	NPR 300
CS	NPR 700	NPR 300

1.2 Rationale

FHD has been conducting a RA with technical support from the UK Department for International Development (DFID) and the Nepal Health Sector Support Programme (NHSSP) since the inception of the programme. This RA seeks to assess the effectiveness of the Aama Programme in ensuring that women are receiving the free care and incentives to which they are entitled in the guidelines, and that facilities are properly utilising HF reimbursements. The RA also provides information on fund flows, and financial management mechanisms (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 flows, and reporting and recording errors as identified from previous RAs, have been influential in changing the Programme Implementation Guidelines. Additionally, the Aama Programme is susceptible to fiduciary risks as it consists of direct cash transfers; RAs have been a critical mechanism in identifying and monitoring these risks, through cross-verification from the user group, and in informing risk mitigation strategies. The process of verification helps to identify phantom claims, misappropriation and other forms of data distortion. The need for periodic RA cannot be stressed enough as the Aama Programme has an annual turnover of more than USD 10.5 million. The RA is also crucial this year as LGs are implementing Aama Programme for the first time. They are responsible for implementing 46.6% of the total Aama budget. It is particularly important to assess local-level understanding of the programme and its implementation, including flow of funds, fund transfers, payment mechanisms, record keeping and reporting.

[1] Clothes for newborn baby. The programme is only implemented at district hospitals and lower-level HFs such as HPs and PHCCs.

1.3 Objectives

The primary objective of round XI of the RA is to assess the compliance of Aama Programme implementation with the Programme Implementation Guidelines 2065, third edition 2073.

The proposed RA has the following objectives, to:

- Assess compliance of programme implementation with the latest Aama Guidelines, especially in the following areas: recipt by women of free delivery services and transport and 4ANC incentives at the time of discharge; utilisation of financial incentives, including distribution among health workers; and disclosure of the names of service users on public notice boards;
- Assess the management of the Aama Programme including timeliness of fund flows, fund transfers, payment mechanisms, preparation of progress and financial reports;
- Cross-verify the utilisation of Aama Programme between palikas/districts, HF records and target groups;
- Make recommendations on the ways to improve management, fund flows, payment mechanisms and planning of the Aama Programme at all levels.

CHAPTER 2 – METHODOLOGY

This section provides a detailed methodology, describing the tools used and the process utilised to explore the objectives of this round of RA.

2.1. Study Design

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

2.2. Sampling Frame and Sample Selection

Forty-nine urban and rural palikas were randomly selected from thirteen districts. Figure 2 maps the distribution of the study districts. A series of steps were followed to select the districts and palikas.

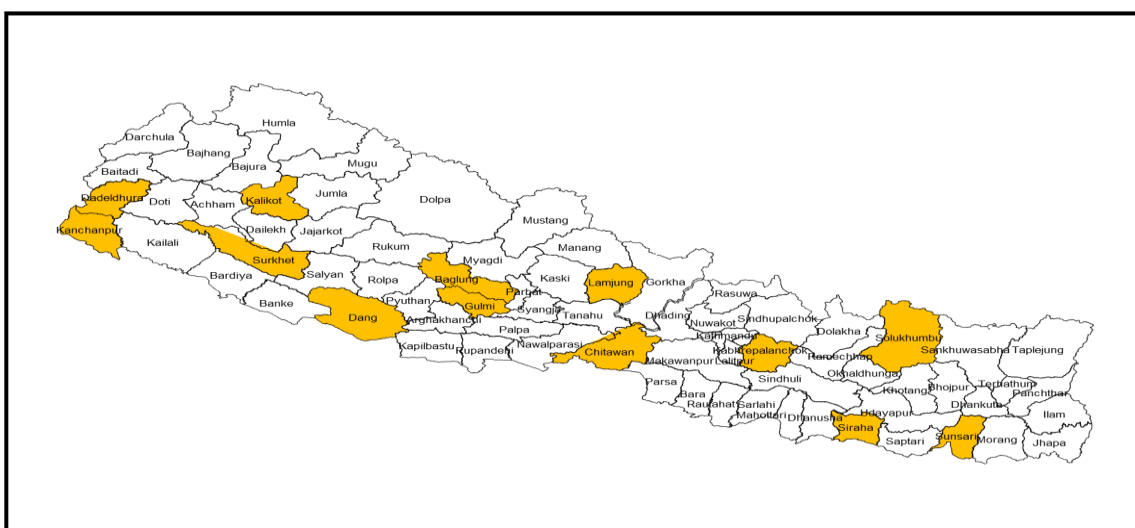


Figure 2: Study districts for RA round XI

2.2.1 Selection of study districts

At first, districts were listed according to ecological zones for each province. Secondly, two ecological zones were then randomly selected from each province except Province Two, which consists solely of Tarai zones. Thirdly, one district was randomly selected from each selected ecological zone using the lottery method. Finally, 13 districts were selected from three ecological zones and seven provinces. Districts that were included in recent rounds of RA (until round IX) were excluded.

2.2.2 Selection of s and HFs

From each of the selected districts, palikas were selected purposively to ensure representation from both urban and rural palikas. Additional consideration was made to include different levels of HFs in selected palikas. From each sampled palika, all hospitals were included by default in the study. Final selection of districts, palikas and HFs was carried out in consultation with FHD. The palikas and HFs included in the study are listed in Table 2.1.

Table 2.1. HFs by Province, District and Palika

Province	District	Urban palikas		Rural palikas		Total	
		Palikas	HFs	Palikas	HFs	Palikas	HFs
Province 1	Solukhumbu	1	1	1	1	2	2
	Sunsari	2	2	2	2	4	4
Province 2	Siraha	3	3	3	3	6	6
Province 3	Kavre	3	4	1	1	5	5
	Chitwan	3	5	0	0	5	5
Gandaki	Lamjung	3	3	1	1	1	4
	Baglung	3	3	1	1	4	4
Province 5	Gulmi	2	2	2	2	4	4
	Dang	2	4	2	2	4	6
Karnali	Kalikot	1	1	1	1	2	2
	Surkhet	3	3	1	1	4	4
Sudurpachhim	Dadeldhura	2	2	2	2	4	4
	Kanchanpur	4	4	0	0	4	4
Total		**32**	**37**	**17**	**17**	**49**	**54**

2.2.3 Sampled HFs

Sampled hospitals included regional, sub-regional, zonal and district hospitals, medical colleges and private hospitals implementing the Aama Programme. Twenty hospitals were by default included from selected districts. From each selected palika, one HF, either a Primary Health Care Centre (PHCC) or a Health Post (HP), was selected purposively based on the number of deliveries conducted in the last year. Thirteen PHCCs and 21 HPs were selected for the study; a total of 54 HFs were included (Table 2.2), a detailed list of which is found in Annex 1.

Table 2.2 Type of HF from Each Selected District And Palika

Province	District	Government Hospitals	Private Hospitals	PHCC	HP	Total
Province 1	Solukhumbu	1		1		2
	Sunsari	1		1	2	4
Province 2	Siraha	1		3	2	6
Province 3	Kavre	1	2	1	1	5
	Chitwan	2	1	1	1	5
Province 4	Lamjung	1			3	4
	Baglung	1		1	2	4
Province 5	Gulmi	1		2	1	4
	Dang	2		1	3	6
Karnali	Kalikot	1		0	1	2
	Surkhet	2		1	1	4
Sudurpachhim	Dadeldhura	2		0	2	4
	Kanchanpur	1		1	2	4
Total		**17**	**3**	**13**	**21**	**54**

2.2.4. Selection of Women for Cross-Verification

The respondents for cross-verification were Recently Delivered Women (RDW), defined as *'a woman who has given birth in a health facility six months prior to the assessment'*. The total sample size for each district was calculated based on the proportion of IDs in the respective district. The minimum sample size for each district was calculated by taking the national average of IDs (57%) and using the following formula in OpenEpi software version 3.01.

Sample size $n = [DEFF*Np(1-p)]/[(d^2/Z^2_{1-\alpha/2}*(N-1)+p*(1-p)]$

Where,

Population size is considered more than 100 thousand (N) =	>100,000
Hypothesised % frequency of outcome factor in the population (p) =	57%+/-5
Confidence limits as % of 100(absolute +/- %) (d) =	5%
Design effect (for cluster surveys-DEFF) =	2
Non-response rate=	20%

Thus, the required sample size for the study was 904. Again, an increment of 23 percent was done to obtain the final final sample size of 1,111.

The total sample size for RDW was distributed across 13 districts using probability proportional to the numbers of women having given birth at the selected facilities in the six months prior to the RA. A complete list of women that had given birth in selected HFs over the six months before the RA was used as the sampling frame. The required sample was drawn from this sampling frame according to systematic random sampling until the required number of participants at each facility was obtained. The sampling interval was determined as k=N/n, where k was sthe ample interval, n was the required sample size from a respective health facility and N was the total number of women that had given birth in the respective HF within the past six months. The sampling process began by selecting an element from the list at random and then every k^{th} element in the frame was selected as the next participant of the study. A total of 1,111 women were selected for cross-verification. Women selected from HF records were visited for cross-verification at their homes. Women were selected using systematic sampling without replacement.

2.2.5 Selection of participants for Exit Client Interviews

In addition to household-level interviews with RDWs, Exit Client Interviews (ECIs) were conducted with mothers recently discharged from each selected HF. The purpose was to capture clients' perspectives on service provision, including receipt of services as per the Aama Guidelines. The number of ECIs was determined according the proportion of deliveries conducted in each HF. One-hundred and sixty ECIs were scheduled for the survey, to be conducted over two days in each HF. A total of 159 mothers were interviewed once discharged from HFs. The number of women interviewed under cross-verification and ECIs is presented in Table 2.3.

Table 2.3. Sample Size for Cross-Verification and ECIs

Province	Districts	Sample for Cross-verification	Data collected Cross-verification	Sample for ECI	Data collected
Province 1	Solukhumbu	7	8	1	0
	Sunsari	55	44	7	7
Province 2	Siraha	35	29	5	5
	Kavre	129	128	18	18
	Chitwan	344	325	50	50
Gandaki	Lamjung	36	34	5	5
	Baglung	48	47	7	7
Province 5	Gulmi	28	25	4	4
	Dang	194	196	28	28
Karnali	Surkhet	111	109	16	16
	Kalikot	12	13	2	2
Sudurpachhim	Dadeldhura	46	45	7	7
	Kanchanpur	66	67	10	10
Total		**1,111**	**1,070**	**160**	**159**

2.2.6 Selection of participants for Key Informant Interviews

To understand issues with programme implementation in the federal context, programme managers, accountants, service providers, and members or chairpersons of Health Facility Management Committees (HFMCs)/Hospital Development Committees (HDCs) were interviewed in the palikas and HFs selected. Major focus was given in identifying fund flow mechanisms, such as disbursement of funds to HFs from palikas, physical and financial reporting and supervision. Based on the number HFs, a total of 156 Key Informant Interviews (KIIs) were proposed. Details of the proposed and completed KIIs are included in Table 2.4.

Table 2.4: KIIs Conducted by District

District	Number of proposed KII					Number of KII conducted				
	I*	II*	III*	IV*	V*	I*	II*	III*	IV*	V*
Solukhumbu	2	2	2	2	2	2	-	2	2	-
Sunsari	2	2	2	2	2	2	1	2	2	-
Siraha	3	3	3	3	3	3	1	3	3	-
Kavre	2	2	3	3	3	1	-	3	1	3
Chitwan	2	2	4	4	4	2	2	4	3	3
Lamjung	2	2	2	2	2	1	-	2	1	1
Baglung	2	2	3	3	3	2	-	3	3	3
Gulmi	2	2	2	2	2	2	2	2	2	2
Dang	2	2	3	3	3	3	2	3	3	3
Surkhet	2	2	2	2	2	2	2	2	2	1
Kalikot	2	2	3	3	3	2	2	3	3	3
Dadeldhura	2	2	2	2	2	2	2	2	2	2
Kanchanpur	2	2	3	3	2	1	2	2	2	3
Total	**27**	**27**	**34**	**34**	**34**	**25**	**16**	**33**	**29**	**24**

I Health Coordinator of palika, II* Accountant of palika, III* Service providers, IV* FOMC/HDC Chairperson or Member, V* HF In-charge/Accountant of Hospital*

1.3. Cross-verification

Cross-verification was performed at two levels: from palika to HF level and from HF maternity registers to reports from RDW.

Palika to HF level: In the first stage, detailed information (i.e. address of women; type of HF; date of delivery; type of delivery; staff attending delivery) was recorded from the claim form (Annex 3 of the Aama Guidelines) at the palika. This information was then cross-verified with the maternity register at the sampled HFs. Records were classified as unmatched if one or more of the following fields differed between the claim form at the palikas and the HF maternity register: mother's address, type of HF, date of delivery, type of delivery. The matched records were referred to as 'matched health facility records'.

HF maternity register to women's reports: Cases that had been cross-verified in the first stage 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 the delivery was normal, complicated or by CS; the number of ANC visits; receipt of transport incentives and free delivery care).

1.4. Review of fund flows and financial management

Review of fund flows and financial management was carried out by asking questions to the Heads of the Accounts Sections in Palikas, Health Coordinators, Hospital Accountants and HF In-charges. The review of fund flows was focused on the disbursement of the Aama budget from palika to selected HFs, and financial compliance maintained by HFs.

1.5. Tools Used in RA

A set of data collection tools used in previous RAs were adopted for this RA (presented in Table 2.5). In addition, tools were modified in consultation with FHD by adding and deleting questions to suit the changing context.

Table 2.5. Tools Used in the RA

SN	Tool number and name	Study participants	Nature
1	1A: KII	Palika Health Coordinator	Qualitative
2	1B: KII	Focal person of Accounts Section (palika)	Qualitative
3	1C: Cross-verification (ID)	Statistics/Health Coordinator of palikas and Nursing Chief of HFs	Quantitative
4	1D: Secondary data review – palikas	Health Coordinator	Quantitative
5	2A: KII	Health Service Provider	Qualitative
6	2B: KII	Chairperson or Member of HDC/HFOMC	Qualitative
7	2C: KII	Accountant of Hospitals and HF In-charges	Qualitative
8	3A: Cross-verification tool	RDW	Quantitative

9	3B: ECI	Mothers being discharged from HFs	Quantitative

2.5.1 Overview of Tools

Table 2.6 presents the list of objectives of this RA, the indicators related to the objectives and the tools proposed to collect the required information.

Table 2.6: RA Objectives, Indicators and Tools

SN	Objective of assessment	Indicators	Nature	Tools
1	Assess compliance of programme implementation with the latest Aama Guidelines	% of women receiving transport incentive on the day of discharge	Quantitative	• RDW questionnaire • ECI guideline • Secondary data review tool
		% of HFs with display boards showing lists of Aama beneficiaries		
		% of HFs with a copy of the revised Aama Guidelines		
		% of women receiving 4ANC incentive as per protocol		
2	Assess the management of the Aama Programme, including timeliness of fund flows, fund transfers, payment mechanisms, and preparation of progress and financial reports	Timeliness of Aama fund flow to HFs	Both Quantitative and Qualitative	• KII guidelines (District (Public) Health Office (D(P)HO)/ District Health Office (DHO)/ Accountant/Aama focal person/service provider) • Secondary data review tool
		Mechanism of fund release to HFs		
		Sufficiency and flow of Aama funds at HFs		
		Frequency of financial reporting		
3	Assess the utilisation of the Aama Programme between palika/districts, HF records and target groups	% of women receiving transport incentives as per the guidelines	Quantitative	• ECI guideline • Secondary data review tool • RDW questionnaire
		% of women who did not pay any cash at a HF for their deliveries		
		% of women receiving a 4ANC incentive of total women completing four ANC visits		
4	Cross-verify utilisation of the Aama Programme between HFs and target groups	% match between HF records and women's reports on receipt of transport incentives	Quantitative	• Cross-verification checklist/form • RDW questionnaire
		% match between HF records and women's reports on receipt of 4ANC incentives		
		% match between HF records and women's reports on the type of delivery		

2.5.2. Updating of tools

The tools were updated to the changed context prior to the training. Update of tools was facilitated by FHD/NHSSP. The tools were thoroughly checked for translation errors, printed and then distributed to the district survey teams.

2.6 Training, Fieldwork, Supervision and Monitoring

District supervisors and enumerators were trained to adequately administer the RA tools. Three days' intensive training for district supervisors and enumerators was organised from 11 to 13 May 2018. 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 Partnership for Sustainable Development (PSD) Nepal, FHD/MoHP, NHSSP and consultants.

The fieldwork was conducted immediately after the training of supervisors and enumerators. Data collection was carried out over the period of about one month from 16 May to 16 June 2018. Each team consisted of male and female interviewers and district supervisors (research and finance). Six teams, consisting of four to nine members, were mobilised to the districts immediately after completion of enumerators' training. The teams finished one district from their assigned province before travelling on to the next district.

Once the district supervisors had collected the necessary information from palikas and HFs, the enumerators were mobilised to visit sampled HFs. District supervisors were instructed to provide support and supervision and to cross-verify district data with HF data. They also cross-checked data for inconsistencies and discussed with the team members for errors. The FHD/NHSSP team also monitored the field implementation. A central support team was scheduled to visit each of the districts to ensure that the quality of data collection was sufficient and to deal with any issues.

2.7. Data Management and Analysis

2.7.1. Quantitative data analysis

First, a data analysis plan was developed in consultation with FHD. After finalisation of the tools, a database was designed using Epidata version 3.1. It was then transferred to IBM SPSS version 20 and analysed. The data were cleaned by the data manager before analysis.

2.7.2. Qualitative data analysis

Qualitative data were collected using semi-structured interviews with various respondents at each level: health coordinators, account officers, HF in charge service providers, and the HFMC. Data generated from these interviews were organised using a 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 both the views of the majority of participants and those in contradiction of the majority were extracted from the interviews. These issues were then presented by district and HF 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 quality assurance process began with training of district supervisors and enumerators. Regular supervision and communication between the centre and the district teams helped to address pertinent issues, responding rapidly to ensure data quality. Data entry assistants were supervised by the data manager during data entry. All data were entered once and then systematically cleaned to ensure their quality. A coding frame and categories were developed for qualitative data analysis, which was performed by a team of three researchers working independently. These codes were then compared and contrasted and finalised. This allowed for triangulation, which further ensured the quality of data.

2.8. Ethical Approval

The RA of the Aama Programme is part of the regular monitoring specified under the FHD Annual Work Plan and Budget (AWPB). As it is not a research project, ethical approval from the Nepal Health Research Council (NHRC) was not required. However, ethical principles of truthfulness, confidentiality, autonomy and informed consent were maintained during the data collection. The women selected for interview in the community and at HFs 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 no woman would be forced to participate, but that if she were willing to participate, the information would be made confidential and all results anonymised.

CHAPTER 3 – QUANTITATIVE FINDINGS

This chapter provides findings regarding cross-verification and compliance with Aama Programme Guidelines 2073. Results are based on findings from cross-verification interviews and Exit client interview findings.

3.1 Compliance of Programme Implementation with Aama Programme Guidelines 2073

3.1.1 Comparison of key indicators with previous RA

Table 3.1 provides summary information on key indicators across consecutive RAs (rounds IX, X and XI). It is important to interpret findings with caution as RA districts in each round are different, as are the types of HF assessed. Cross-verification indicators, such as receipt of transport incentives and type of delivery, were reported to be more than 80 percent. Compliance indicators, such as women receiving free care and 4ANC incentives, palikas with revised Aama Guidelines, and HFs displaying names of Aama beneficiaries, require serious improvement.

Table 3.1: Results against Indicators of RAs Round IX, X and XI

SN	Indicator	RA IX	RA X	RA XI
1	% match between HF records and women on receipt of transport incentives	97	100	96
2	% match between HF records and women on receipt of 4ANC incentives	46	99	81
3	% match between HFs and women on type of delivery (normal/complicated/CS)	88	92	84
4	% of women receiving transport incentives on day of discharge	85	94	89
5	% of HFs with display boards showing lists of Aama beneficiaries	56	58	61
6	% of HFs with a copy of the revised Aama Guidelines	56	83	56
7	% of palikas with a copy of the revised Aama Guidelines	-	-	21
8	% of women receiving transport incentives as per the guidelines	90	98	96
9	% of women who did not pay cash at HFs for their deliveries	71	87	56
10	% of women receiving 4ANC incentives of total women completing four ANC visits	35	51	65

3.1.2 Sociodemographic characteristics of sampled women

Table 3.2 describes the background characteristics of women included in the study. Thirty-three percent of the sampled women were from Brahmin, Chhetri, Thakuri, or Sanyasi castes, followed by Hill Adhibasi (32%), Madhesi origin (15%), Hill Dalit (14%) and Tarai Dalit (5%). Almost 80 percent of women were more than 20 years old. The mean and median ages of the women were 24.34 ± 4.38 years and 24 years respectively. More than half (57%) of women had obtained their School Leaving Certificate (SLC) or a higher level of education; four percent of women were illiterate. The majority (70%) of women worked in agriculture, with 13 percent employed in service shops and market sales, 10 percent as technicans and professionals, and seven percent as production workers. The Sociodemographic characteristics illustrated in Table 3.2 show a fair degree of agreement with the population characteristics described in the 2011 Population Census. However, some deviation is observed in educational status, which could be due to progress in education over the years following the Census.

Table 3.2: Background Characteristics of Women in the RA (N=1,070)

Characteristics	Number (n)	Percentage (%)	National (%)*
Age			
<20 years	139	13	21
>20 years	931	87	79
Caste/ Ethnicity[1]			
Brahmin Chhetry Thakuri Sanyasi	350	33	31
Hill Adibashi Janajati group	343	32	27
Madhesi caste origin group	158	15	22
Hill Dalit	147	14	8
Tarai Dalit	38	4	5
Minority group	34	3	4
Educational status[1]			
Illiterate	46	4	23
Literate but not schooling	32	3	24
Below SLC	381	36	43
SLC and intermediate	490	46	9
Graduate and postgraduate	121	11	2
Occupational status[1]			
Agriculture[2]	753	70	71
Service shops and market sales workers[3]	141	13	6
Production workers[4]	71	7	14
Technicians and professionals[5]	105	10	10

1 *Census data on caste/ethnicity obtained from total population, educational and occupational data from women recorded in the Census*
2 *includes housewife, agriculture*
3 *small business or grocery shop*
4 *daily wage worker, creative jobs*
5 *teaching, government service, private service*

3.2 Receipt of transport incentives

3.2.1 Receipt of full transport incentive

Table 3.3 shows the receipt of transport incentives by RDW. Out of 1,070 RDW interviewed, 96 percent reported that they had received the transport incentive. All women interviewed from Solukhumbu, Lamjung, Gulmi, Kalikot, Dadeldhura and Kanchanpur received the full transportation incentive. Chitwan was the district with the lowest proportion (92%) of women receiving transport incentives. Women giving birth in private hospitals (92%) and PHCCs (95%) were less likely to receive transportation incentives than those in government hospitals (97%).

Table 3.3: Receipt of Full Transport Incentives by District and Type of Health Facility (N=1,070)

Districts	Number of women interviewed (N)	Number of women receiving full transport incentive (n)	Percentage (%)
Solukhumbu	8	8	100
Sunsari	44	41	93
Siraha	29	26	90
Kavre	128	123	96
Chitwan	325	300	92
Lamjung	34	34	100
Baglung	47	46	98
Gulmi	25	25	100
Dang	196	194	99
Kalikot	13	13	100
Surkhet	109	108	99
Dadeldhura	45	45	100
Kanchanpur	67	67	100
Total	**1,070**	**1,030**	**96**
Type of HF			
Government Hospital	812	788	97
Private Hospital	142	131	92
PHCC	59	56	95
HP	57	55	96
Total	**1,070**	**1,030**	**96**

3.2.2 Receipt of transport incentives on the day of discharge

Out of the 1,030 women who had received the full transport incentive, only 914 (89%) received it on the day of discharge (Table 3.4); eleven percent of women had to wait for a month or two to receive the transport incentive. More than 90 percent of women from Dadeldhura, Kanchanpur and Kavre received transport incentives on the day of discharge. The percentage of women receiving transport incentives on the day of discharge was highest in private hospitals (95%) followed by government hospitals and PHCCs (88%).

Table 3.4: Timing of the Receipt of Transport Incentive by District and HF (N=1,030)

District	On the day of discharge	Beyond day of discharge	Total	% of women receiving transport incentive on day of discharge
Solukhumbu	7	1	8	88
Sunsari	36	5	41	88
Siraha	23	3	26	88
Kavre	111	12	123	90
Chitwan	262	38	300	87
Lamjung	28	6	34	82
Baglung	40	6	46	88
Gulmi	22	3	25	88
Dang	172	22	194	88

Kalikot	11	2	13	85
Surkhet	96	12	108	89
Dadeldhura	43	2	45	96
Kanchanpur	63	4	67	94
Total	**914**	**116**	**1,030**	**89**
Type of HF				
Government Hospital	695	93	788	88
Private Hospital	124	7	131	95
PHCC	49	7	56	88
HP	46	9	55	84
Total	**914**	**116**	**1,030**	**89**

3.3.3 Receipt of transport incentive by women and other members of their families

Table 3.5 provides information on who received the transport incentive allocated to each woman. Out of the 1,030 women who received the full transportation incentive, only 46 percent received the incentive themselves. In 37 percent of cases, women's husbands received the transport incentive on their behalf, with ten percent received by family members. Women from Chitwan (18%), Sunsari (27%) and Dang (29%) were relatively less likely to receive the transport incentive themselves compared to women from Kavre (92%), Gulmi (96%), Dadeldhura (96%) and Solukhumbu (88%).

Table 3.5: Receipt of Transport Incentives by Women and Other Members of Their Families (N=1,030)

Districts	Women	Husband	In-law	Family member	% of women receiving transport incentive themselves	Total
Solukhumbu	7	0	0	1	88	8
Sunsari	11	19	6	5	27	41
Siraha	10	9	7	0	38	26
Kavre	113	8	2	0	92	123
Chitwan	54	192	18	36	18	300
Lamjung	12	10	0	12	35	34
Baglung	35	7	1	3	76	46
Gulmi	24	0	0	1	96	25
Dang	56	92	17	29	29	194
Kalikot	9	3	0	1	69	13
Surkhet	48	31	17	12	44	108
Dadeldhura	43	2	0	0	96	45
Kanchanpur	55	7	2	3	82	67
Total	**477**	**380**	**70**	**103**	**46**	**1,030**

3.3.4 Receipt of 4ANC incentives by women

Table 3.6 shows the receipt of 4ANC incentives by women by district and type of HF. Out of 1,070 women interviewed, only 708 women (66%) had attended four ANC visits as per the protocol, of which only 461 (65%)

had received the 4ANC incentive. Chitwan was the district in which women were least likely to have received 4ANC incentives: only 21 percent had, compared to over 85% of women from Dadeldhura, Surkhet and Kanchanpur districts. More than two-fifths of women who had given birth in private hospitals did not receive 4ANC incentives. At the same time, women delivering in public hospitals were less likely to receive 4ANC incentives (64%) than those giving birth in PHCCs (91%) and HPs (94%).

Table 3.6: Receipt of 4ANC Incentive by District and Type of HF (N=1,070)

District	Women interviewed	Women completing 4ANC	Women receiving 4ANC incentive	(%) of women getting 4ANC incentives
Solukhumbu	8	7	5	71
Sunsari	44	33	27	82
Siraha	29	14	10	71
Kavre	128	69	28	41
Chitwan	325	121	25	21
Lamjung	34	22	11	50
Baglung	47	35	28	80
Gulmi	25	22	18	82
Dang	196	186	136	73
Kalikot	13	9	7	78
Surkhet	109	90	79	88
Dadeldhura	45	40	35	88
Kanchanpur	67	60	52	87
Total	**1,070**	**708**	**461**	**65**
Type of HF				
Government Hospital	812	554	352	64
Private Hospital	142	60	22	37
PHCC	59	45	41	91
HP	57	49	46	94

An important reason for this could be that in FY 2017/18 the entire budget for the 4ANC incentive was sent to palikas. Hospitals above district level had to coordinate with palikas for the 4ANC budget. Many hospitals find it difficult to do so, and as a result women delivering in these hospitals might not have received the 4ANC incentive.

3.3 Receipt of free care

3.3.1 Number of women paying for delivery service

Table 3.7 provides information on women who stated that they had paid for different delivery services. A total of 582 women reported having paid for delivery services; however, only 471 of them could recall the money paid to access services. For the purpose of this analysis, only those women who could recall the amount of money paid for delivery services are treated as actually having paid.

Table 3.7: Number of Women Paying for Delivery Services (N=471)

Districts	Number of women paying for normal delivery	Number of women paying for complicated delivery	Number of women paying for CS delivery	Total # of women who can recall the amount to be paid	Number of women who don't know amount paid	Number of women who reported having paid
Solukhumbu	2	0	1	3	0	2
Sunsari	20	3	4	27	4	36
Siraha	3	2	5	10	1	20
Kavre	58	3	17	78	47	110
Chitwan	120	2	50	172	43	274
Lamjung	6	3	2	11	6	15
Baglung	27	0	1	28	1	12
Gulmi	14	N/A	2	16	0	1
Dang	69	2	8	79	6	67
Kalikot	6	N/A	1	7	1	4
Surkhet	16	2	10	28	2	34
Dadeldhura	5	N/A	1	6	0	6
Kanchanpur	4	0	2	6	0	1
Total	**350**	**17**	**104**	**471**	**111**	**582**

3.3.3 Number of women receiving free delivery care

Table 3.8 shows the number of women receiving free delivery care. The table indicates that only 56 percent of women giving birth at the selected HFs received delivery service free of cost. The percentage of women receiving free delivery care varies across districts: it is highest in Kanchanpur (91%), followed by Dadeldhura (87%), and lowest in Gulmi (36%), followed by Kavre (39%) and Sunsari (39%).

Table 3.8: Number of Women Receiving Free Delivery Care

District	Number of women interviewed	Number of women receiving free care	Percentage of women receiving free care (%)
Solukhumbu	8	5	63
Sunsari	44	17	39
Siraha	29	19	66
Kavre	128	50	39
Chitwan	325	153	47
Lamjung	34	23	68
Baglung	47	19	40
Gulmi	25	9	36
Dang	196	117	60
Kalikot	13	6	46
Surkhet	109	81	74
Dadeldhura	45	39	87
Kanchanpur	67	61	91
Total	**1,070**	**599**	**56**
Type of HF			

Government Hospital	812	476	59
Private Hospital	142	14	10
PHCC	59	55	93
HP	57	54	95
Total	**1,070**	**599**	**56**
Type of delivery			
Normal	876	526	60
Complicated	36	19	53
CS	158	54	34
Total	**1,070**	**599**	**56**

Women giving birth at HPs were most likely to receive delivery care free of cost (95%), while women giving birth at private hospitals were the least likely (10%). Even in public facilities, women were asked to pay for delivery services at all levels of care. Almost 41 percent of women receiving care from hospitals were found to have paid for services that should be free.

3.3.3 Average amount paid for normal delivery

Table 3.9 shows the average amount paid for normal deliveries based on the number of women who remembered paying for different services/items. Women from all 13 districts were found to have paid for some services/items during their time at the HF. The average amount paid for normal delivery services varies between districts, ranging from NPR 625 in Gulmi to NPR 3,039 in Kavre. The average amount paid for normal delivery was NPR 1,568, ranging from NPR 25 to NPR 8,500. The median amount paid for normal delivery was NPR 1,200.

Table 3.9: Average Amount Paid for Normal Delivery Based on the Number of Women who Remembered Paying for Different Services/Items

Districts	Number of women paying for services (n)		Average amount paid for normal delivery (NPR)	Minimum amount paid (NPR)	Maximum amount paid (NPR)	Median (NPR)
	Paid	Amount known				
Solukhumbu	2	0	0	0	0	0
Sunsari	20	20	1,118	300	3,000	1,050
Siraha	3	3	1,300	500	2,050	1,350
Kavre	58	28	3,039	500	8,500	3,000
Chitwan	120	81	1,749	60	5,000	1,500
Lamjung	6	4	763	300	2,000	400
Baglung	27	6	1021	350	1,525	1,225
Gulmi	14	1	625	625	625	625
Dang	69	46	1,013	25	3,200	763
Kalikot	6	1	1,500	1,500	1,500	1,500
Surkhet	16	14	957	150	3,100	775
Dadeldhura	5	5	700	500	1,000	500
Kanchanpur	4	0	0	0	0	0

3.3.4 Average amount paid for complicated delivery

Table 3.10 shows the average amount paid for complicated delivery services. There were no complicated delivery cases in Gulmi, Kalikot and Dadeldhura. No women from Solukhumbu, Baglung and Kanchanpur districts were found to have paid for complicated deliveries. The average amount paid for complicated delivery services varies between districts, ranging from NPR 1,000 in Lamjung to NPR 7,750 in Kavre. The average amount paid for complicated delivery was NPR 3,727 and ranges from NPR 425 to NPR 12,000. The median amount paid for complicated delivery was NPR 2,550.

Table 3.10: Average Amount Paid for Complicated Delivery Based on the Number of Women Who Remembered Paying for Services

Districts	Number of women paying for services (n)		Average amount paid for Complicated delivery (NPR)	Minimum amount paid (NPR)	Maximum amount paid (NPR)	Median amount paid for Complicated delivery (NPR)
	Paid	Amount known				
Solukhumbu	0	0	0	0	0	0
Sunsari	3	3	1,158	425	2,550	500
Siraha	2	2	4,330	1,110	7,550	4,330
Kavre	3	2	7,750	3,500	12,000	7,750
Chitwan	2	2	2,900	2,300	3,500	2,900
Lamjung	3	1	1,000	1,000	1,000	1,000
Baglung	0	0	0	0	0	0
Gulmi	N/A	N/A	N/A	N/A	N/A	N/A
Dang	2	2	5,810	5,620	6,000	5,810
Kalikot	N/A	N/A	N/A	N/A	N/A	N/A
Surkhet	2	1	2,400	2,400	2,400	2,400
Dadeldhura	N/A	N/A	N/A	N/A	N/A	N/A
Kanchanpur	0	0	0	0	0	0

3.3.5 Average amount paid for CS delivery

Table 3.11 shows the average amount paid for CS delivery services. All 13 districts were found to have charged some form of fee to some women. The average amount paid varied between districts, from NPR 500 in Dadeldhura to NPR 9,000 in Kavre. The average amount paid for CS deliveries was NPR 6,051 and the amount paid ranged from NPR 200 to NPR 40,000. The median amount paid for CS deliveries was NPR 4,025.

Table 3.9: Average Amount Paid for CS Delivery Based on the Number of Women who Remembered Paying for Services

Districts	Number of women paying for services (n)		Average amount paid for CS delivery (NPR)	Minimum amount paid (NPR)	Maximum amount paid (NPR)	Median amount paid for CS delivery(NPR)
	Paid	Amount known				
Solukhumbu	1	1	6,000	6,000	6,000	6,000
Sunsari	4	4	1,075	200	3,400	350
Siraha	5	5	2,681	1,600	4,500	2,500
Kavre	17	13	9,000	4,500	14,000	8,500
Chitwan	50	34	8,013	1,100	40,000	5,000
Lamjung	2	1	2,060	2,060	2,060	2,060
Baglung	1	1	7,000	7,000	7,000	7,000
Gulmi	2	0	0	0	0	0
Dang	8	8	4,559	1,000	10,200	4,013
Kalikot	1	1	2,000	2,000	2000	2,000
Surkhet	10	10	1,685	800	3,400	1,150
Dadeldhura	1	1	500	500	500	500
Kanchanpur	2	0	0	0	0	0

3.3.4 Average amount paid for items and services

Table 3.10 provides information on various items/services that were charged to women giving birth at Aama-implementing HFs. Women were most frequently found to be paying for medicines, followed by laboratory and diagnostic services, and registration fees.

Table 3.10: Average Amount Paid by Women for Different Services

Items	Number of women paying for services	Average amount (NPR)	Median Amount (NPR)	Minimum Amount (NPR)	Maximum Amount (NPR)
Registration fee	101	300	230	10	1,200
Medicine	254	2331	1,500	150	30,000
Supplies	12	475	500	100	1000
Laboratory and diagnostic fee	113	1,565	1,000	100	10,000
Procedural fee (complicated)	3	2,233	1,200	500	5,000
Health worker fee	4	188	200	150	200
Sanitation charge	48	332	250	100	1000
Blood transfusion	26	998	750	100	3000

According to the Aama Programme, a woman should not be charged anything for delivery services. However, these data should be interpreted carefully as women have reported paying for services that are not covered by the programme, such as sanitation charges.

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

One of the key objectives of RA is to cross-verify information between HF records and interviews with the

women who had given birth at the selected HFs. The results are based on quantitative information obtained from 1,070 interviewees.

3.4.1 Cross-verification of Aama Programme beneficiaries

Table 3.11 shows the number of women's records reviewed in the selected districts and the number of women interviewed. The records of 16,014 women were reviewed at the D(P)HO to obtain a sample size of 1,111 women. Out of 1,111 women to be interviewed, only 1,070 women could be traced back in the community. Forty-one women could not be traced as they had already left the address given in their records; the majority of these women were residing in urban areas.

Table 3.11: Sample Universe, Sample Size and Number of Women Interviewed for Cross-verification

District	Number of IDs in sampled HFs in previous six months	Sample size	Number of women interviewed	% of women interviewed
Solukhumbu	90	7	8	114
Sunsari	731	55	44	80
Siraha	1219	35	29	83
Kavre	2127	129	128	99
Chitwan	5705	344	325	94
Lamjung	413	36	34	94
Baglung	550	48	47	98
Gulmi	434	28	25	89
Dang	1844	194	196	101
Kalikot	101	12	13	108
Surkhet	1262	111	109	98
Dadeldhura	550	46	45	98
Kanchanpur	990	66	67	102
Total	**16,014**	**1,111**	**1,070**	**96**

3.4.2 Cross-verification of the receipt of transport incentives

Table 3.12 shows shows the cross-verification of HF records with women's interviews regarding receipt of transport incentives. Of the 1,070 women eligible for the receipt of transport incentives, 1,070 women were reported to have received the full transport incentive. However, table shows a clear mismatch across the type of deliveries between facility records and women's reports. The major mismatch has been observed in complicated delivery. This can be due to the knowledge gap among women. However, the mismatch in CS has signalled a different meaning.

Table 3.12 Comparison between HF Records and Women's Reports Regarding Type of Delivery Received (N=1,070)

Districts	Facility records: Type of Delivery (n)			Women's reports: Type of Delivery (n)		
	Normal	Complicated	CS	Normal	Complicated	CS
Solukhumbu	5	1	2	5	1	2
Sunsari	32	4	8	33	4	7
Siraha	17	5	7	22	2	5
Kavre	100	7	21	106	5	17
Chitwan	245	10	70	252	6	67
Lamjung	25	5	4	27	3	4
Baglung	41	3	3	41	3	3
Gulmi	20	1	4	21	0	4
Dang	162	9	25	171	5	20
Kalikot	10	1	2	11	0	2
Surkhet	84	7	18	87	5	17
Dadeldhura	41	0	4	41	0	4
Kanchanpur	59	2	6	59	2	6
Total	**841**	**55**	**174**	**876**	**36**	**158**
Type of HF						
Government	661	28	123	676	22	114
Private Hospital	82	9	51	95	3	44
PHCC	50	9	0	53	6	0
HP	48	9	0	52	5	0
Total	**841**	**55**	**174**	**876**	**36**	**158**

3.4.3 Cross-verification of the receipt of 4ANC incentives

Table 3.13 shows the comparison of women's reports of receiving 4ANC incentives against HF records. Out of 1,070 women giving birth at the selected HFs, records show that only 708 had completed four ANC visits (see Table 3.6). Of these, 566 had been provided with the 4ANC incentive; however, only 461 women (81%) confirmed that they had received it. A mismatch of 19 percent was observed between the two data sources on the receipt of 4ANC incentives; the percentage discrepancy varied across districts, ranging from 0 to 62 percent. The highest discrepancies were recorded in Chitwan (62%) and Kavre districts (51%). Very few women from Chitwan had received the transport incentive themselves, which might be a possible explanation for the observed discrepancy.

Table 3.13 HF Records and Receipt of 4ANC Incentives by Women

District	Facility records: Receipt of 4ANC incentive	Women's reports: Receipt of 4ANC incentive	Mismatch (%)
Solukhumbu	5	5	0
Sunsari	30	27	10
Siraha	12	10	17
Kavre	57	28	51
Chitwan	65	25	62
Lamjung	14	11	21
Baglung	33	28	15
Gulmi	20	18	10
Dang	143	136	5
Kalikot	7	7	0
Surkhet	85	79	7
Dadeldhura	37	35	5
Kanchanpur	58	52	10
Total	**566**	**461**	**19**
Type of HF			
Government Hospital	449	352	22
Private Hospital	27	22	19
PHCC	42	41	2
HP	48	46	4

At the HF level, the highest discrepancies were observed at public hospitals (22%) and private hospitals (19%). One reason for this could be that some facilities had paid extra incentives from the palika budget (more than the amount stipulated in the Aama Guidelines), which were found to be recorded in the Annex 3 of Aama guidelines. These payments could be misrecorded as receipt of 4ANC incentives but further investigation is required.

3.4.4 Cross-verification on type of delivery

Table 3.14 shows the comparison of women's reports of the type of delivery care received against HF records. Out of 1,070 eligible women, HF records show that 841 women had undergone normal deliveries, 55 women had had complicated deliveries and 174 had received CS delivery services. However, from women's interviews, 876 women confirmed that they had undergone normal deliveries, while 36 reported having had complicated deliveries with 158 having received CS delivery services. Overall, a mismatch of 16 percent has been observed. A four-percent mismatch was observed on the receipt of normal deliveries, 35 percent in complicated deliveries and 9 percent in CS deliveries. The degree of mismatch varies across districts; no discrepancy was observed in four districts (Solukhumbu, Baglung, Dadeldhura and Kanchanpur) while in the rest of the districts some discrepancies appeared. One reason for high discrepancies in reported/recorded complicated deliveries could be that women were not able to differentiate accurately between normal and complicated deliveries. Similarly, some discrepancy could be attributed to recording errors. However, it is important to note that there are higher rates of reimbursement attached to complicated and CS deliveries (NPR 3,000-5,000 for complicated and NPR 7,000 for CS deliveries).

Table 3.14 Comparison between HF Records and Women's Reports of Type of Delivery Care Received (N=1,070)

Districts	Facility records: Type of Delivery (n)			Women's reports: Type of Delivery (n)		
	Normal	**Complicated**	**CS**	**Normal**	**Complicated**	**CS**
Solukhumbu	5	1	2	5	1	2
Sunsari	32	4	8	33	4	7
Siraha	17	5	7	22	2	5
Kavre	100	7	21	106	5	17
Chitwan	245	10	70	252	6	67
Lamjung	25	5	4	27	3	4
Baglung	41	3	3	41	3	3
Gulmi	20	1	4	21	0	4
Dang	162	9	25	171	5	20
Kalikot	10	1	2	11	0	2
Surkhet	84	7	18	87	5	17
Dadeldhura	41	0	4	41	0	4
Kanchanpur	59	2	6	59	2	6
Total	**841**	**55**	**174**	**876**	**36**	**158**
Type of HF						
Government	667	25	120	676	22	114
Private Hospital	76	12	54	95	3	44
PHCC	50	9	0	53	6	0
HP	48	9	0	52	5	0
Total	**841**	**55**	**174**	**876**	**36**	**158**

3.5 Findings from ECIs

A total of 160 ECIs were planned; however, only 158 interviews could be completed and two women could not continue the interview.

3.5.1 Reasons for visiting HFs

Almost all (98%) participants visited HFs for delivery services and a few of them (2%) visited to manage complications after delivery.

Table 3.15. Reasons for Visiting HFs

Districts	Reason to visit HF	
	Delivery	**PNC complications**
Solukhumbu	1	0
Sunsari	8	1
Siraha	5	0
Kavre	18	0
Chitwan	49	0
Lamjung	5	0
Baglung	5	1
Gulmi	4	0
Dang	27	0
Kalikot	1	0

Surkhet	16	0
Dadeldhura	6	0
Kanchanpur	10	1
Total	**155**	**3**

3.5.2 Means of transportation to reach HFs

Most women used ambulances (33%) to reach facilities for delivery, with public transport (27.8%), rickshaws (14.6%) and taxis (8.2%) the next most common modes of transport. Only a few women visited HFs by private vehicles and on foot. The transportation costs paid by women in hilly or mountain palikas was significantly higher than that paid by women from Tarai palikas. Ambulances were the popular means of transport in these palikas, leading to higher transport costs. The highest average transport cost was observed in Dadeldhura (NPR 6,075) compared to Kalikot a mountain district (NPR 500).

Table 3.16. Average Transportation Cost for Reaching HFs

Districts	Average transportation cost (NPR)
Solukhumbu	4,500.00
Sunsari	394.44
Siraha	450.00
Kavre	1,022.78
Chitwan	991.56
Lamjung	1,337.50
Baglung	4,180.00
Gulmi	972.50
Dang	1,051.25
Kalikot	500.00
Surkhet	570.00
Dadeldhura	6,075.00
Kanchanpur	618.00

3.5.3 Receipt of transport and 4ANC incentives and free care

Among the mothers interviewed, 99 percent had received full transport incentives but only 88 percent of women had received the 4ANC incentive. The Aama Programme policy provisions state that women are to be provided with free delivery services. However, it was found that women were being charged for different items such as medicines, registration, laboratory, diagnostics, and blood transfusions at all level of HFs except for HPs. It is of note that user fees have not been directly issued to service provision, such as service provider fees, complicated management fees and surgery fees; rather, fees have been incurred in registration, medicine and supplies. Women delivering in private facilities were found to have paid significantly more money for registration, medicines, supplies, and laboratory fees than those using public facilities. Furthermore, private facilities were found to be asking for deposits to manage complicated and CS deliveries. In the majority of cases, the deposit was never returned.

Table 3.17. Average Amount Paid for Different Services by Level of HF

Type of HF	Registration	Medicine	Supplies	Complication managment fee	Service provider's fee	Sanitation	Laboratory services	Pads	Deposit
Government Hospital	190	890	0	0	0	200	980	180	0
Private Hospital	1,700	1,980	2,750	0	0	0	1,900	500	7500
PHCC	100	1,325	0	0	0	0	100	0	0
HP	0	0	0	0	0	0	0	0	0

3.5.4 Reasons for selecting HFs for delivery care services

The most common reasons given by women for selecting a given HF in which to deliver their child were the availability of skilled health workers (25%) and the provision of free care and transport incentives (20%). Around 16 percent of mothers visited HFs to manage complications. Fifty-six percent of mothers reported the behaviour of health workers involved in delivery to be good, while 43 percent deemed it satisfactory; a few women described behaviour as not good (0.6%). Ninety-three percent of mothers said that they considered the health workers conducting delivery services to be skilful. More than two-thirds (69%) of mothers were informed about their delivery status, while the rest were not.

3.5.5 Perceptions of HFs' cleanliness

Around one-third of participants (34%) reported that HFs were clean, 63 percent described them as satisfactory and three percent reported facilities to be dirty. Private hospitals were considered cleaner than public hospitals.

Table 3.18. Perceptions of the Cleanliness of HFs

Type of HF	Cleanliness status of the HF			Total
	Clean	Satisfactory	Dirty	
Government hospital	27	80	3	110
Private hospital	18	10	0	28
PHCC	3	3	0	6
HP	6	7	1	14
Total	**54**	**100**	**4**	**158**

3.5.6 Perceptions of Aama programme incentives

The majority of women reported Aama Programme provision to be good, while only four percent did not feel positively about the programme. The most common reason given for liking the programme was the provision of incentives and free care. Mothers who did not like the programme reported that hospitals were cold places in which to deliver, that there were no facilities for a visitor to stay or in which to cook food, and that the transport incentive was too low to cover costs.

CHAPTER 4– FINDINGS QUALITATIVE

This section provides a brief overview of the implementation of the Aama Programme in the federal governance system. At the palika level, the sole responsibility for managing health programmes has shifted to the health unit, which is run by health coordinators. Palikas are responsible for implementing the Aama Programme at district hospitals, PHCCs and HPs, including accredited private facilities. At the same time, the federal level manages the implementation of the Aama Programme in hospitals above district level. Findings in this section are based on the key in-depth interviews with palika health coordinators, finance sections, service providers, health facility account sections, and HFMC representatives.

4.1 Budget release and fund flow mechanism of Aama Programme in the federal system

With the implementation of the federal governance system, the Ministry of Finace provides authorisation to the Financial Comptroller General Office (FCGO) and related ministries. FCGO sends authorisation to all District Treasury Controller Offices (DTCOs) to release funds. The MoHP provides authorisation to hospitals and academia. Each palika receives the budget for the Aama Programme through the DTCOs. The Aama budget is part of the conditional grant for health provided to the palikas. Palikas prepare a trimesterly budget summary for each programme and receive the budget from the DTCO. Palikas are then provided with cash in their bank accounts. Palikas either provide an advance to or reimburse HFs to implement the Aama Programme. HFs are required to submit physical and financial reports at the end of each month to palika health units. The fund release process for the Aama budget at hospitals above district level remains the same as in previous years. The DTCO receives a copy of the annual programme and budget for authorisation and channels money directly to the hospital account as per the budget summary sheet submitted each trimester.

4.2 Availability of Aama Guidelines (3rd edition) at palikas and HFs

The Aama Programme Guidelines is the key document for managing the programme and adhering to the provisions of the policy. The availability of the guidelines in HFs and palikas is mandatory. Only 21 percent of palikas and 56 percent of HFs had a copy of the Aama Programme Guidelines. The palikas who had the guidelines available had managed to obtain them from the D(P)HO; however, many palikas were managing the programme based on their experience. Some health coordinators were found to be using the local-level Health Programme Implementation Guidelines 2074/75 to implement the Aama Programme.

"... we are not referring to any guidelines. We are running Aama Programme as per the direction of D(P)HO, Dang." (Public Health Officer, Ghorahi Sub Metropolitan, Dang)

"... I have not heard about Aama Programme. I am hearing it for the first time. I don't know anything about this. We just know about total budget and expenditure. We are not oriented about this." (Account Officer, Ghorahi Sub Metropolitan, Dang)

".... We have a guideline on conditional budget implementation and use it for implementation any programme including Aama Programme. In case of additional information, we consult with health coordinator for guidance." (Accountant, Raskot, Kalikot)

Some health workers did not know about the separate Aama Programme Guidelines. Most HFs were implementing the programme by referring to previous guidelines (1st and 2nd edition) or through consultation

with a public health nurse. Some of them were also updated during skilled birth attendant and maternal and newborn health training. Only 56 percent of HFs were found to have the latest issue (3rd edition) of the guidelines. Very few health workers were found to have actually read the guidelines.

"... we have the second edition only. We did not know about the third edition. Now we will call D(P)HO Gulmi and ask for the third edition." (Auxiliary Nurse Midwife (ANM), Dhurkot PHCC, Gulmi)

"... detail regarding complicated delivery is not included in that guideline. It does not mention about post-surgical sepsis, puerperal sepsis, and post-abortion care." (Nursing Officer, District Hospital Tamghas, Gulmi)

4.3 Orientation and training about the Aama Programme

The majority of service providers (74 percent) were implementing the Aama Programme without orientation or training. Service providers were either using programme guidelines or relying on their own experience during on-the-job training and through work.

"We are implementing Aama Surakashya Programme based on local-level Health Programme Implementation Guideline 2072/73 and past experience in the health sector, in case of confusion we seek help from the public health nurse." (*Health Coordinator, Soludhudhakunda Urban Municipality)*

"Yes, I have a soft copy of third edition and hard copy of the second edition. But I have not gone through that guideline in detail. I have not received any orientation regarding the implementation of that guideline." (Accountant, Dhaulagiri Zonal Hospital, Baglung)

4.4 Allocation of Aama Budget

Almost all palikas have passed their Aama budget as per the conditional grant workplan. Some palikas, such as Panchpuri, were found to be giving additional incentives to mothers and to female community health volunteers to bring pregnant women to HFs from their own sources. Eighty-six percent of palikas reported that they had sufficient Aama budget. Two palikas with insufficient Aama budget managed the gap using their own resources, whereas others requested that the FHD send additional budget.

"I would say additional budget for Aama Surakshya Programme was allocated as we give away additional incentive of NPR 2000… however, I am not sure why was this done and how the budget was planned for this… I was appointed only after municipal council meeting. We stopped paying additional incentive because of shortage of budget..." (Health Coordinator, Panchapuri Municipality, Surkhet)

"We did not make additional allocation for Aama Programme during the council meeting. However, we have used palika's unallocated budget to pay women transport incentive as the conditional budget was completely used up." (health Coordinator, Dhurkot Rural Municipality, Gulmi)

"Budget for us is sufficient and in fact too much … as not many deliveries are conducted in birthing centres. Only two health posts out of eight conduct deliveries. Most pregnant mothers prefer to go to Rapti Sub-Regional Hospital for delivery. Health posts also refer majority cases..." (Public Health Officer, Ghorahi Sub-Metropolitan, Dang)

4.5 Distribution of Aama Budget to HFs

The majority of HFs (80%) stated that the Aama HF reimbursement was paid through reimbursement whereas the transport and 4ANC incentives were provided as advances. The basis to provide advance budget was based on the number of deliveries conducted in the health facility last year. Only 20% of health facility in-charge stated of not having any problem in the release of the budget.

"We plan and distribute the budget based on the number of institutional delivery of previous year and provide advance to health facilities as per the recommendation of health coordinator and ward chairperson." (Accountant, Rapti Rural Municipality, Dang)

"On the basis of request letter, palika allocates the budget considering number of deliveries conducted in last year breaking it down in quarters. Palika then provides advance to health facilities." (Account Assistant, Mirchaiya, Siraha)

"Firstly, we do analyses Aama reports from previous year which gives ideas on the flow of clients in a health facility. Next, we prepare a tentative budget for each facility from Shrawan to Kartik on basis of estimated delivery. Then, we deposit the budget to health facility account on four-monthly basis. After completion of the first four months, we analyse reports and verify how much expenditure has been made. This will give us an idea on whether to increase or decrease the advance amount for the next four months. At the final four months, all reports are analysed and verified with the expenditure made and finally advance is issued based on the institutional delivery reports." (Health Co-coordinator, Surkhet)

"It's difficult to handle all section of the municipality by a single person. It's necessary to provide orientation. If the government does not provide the budget in time, it will be difficult to provide an advance to the health facility." (Accountant, Raskot, Kalikot)

"Need orientation at first. We have a practice of providing an advance to municipal health section that provides an advance to a respective health facility. If we could provide an advance to respective health facility directly, it would have been easier." (Accountant, Aalital, Dadeldhura)

"Budget is sufficient for Aama Programme. We are receiving the amount as requested from palika. We manage from committee's account in case of some delay. Later the amount is claimed back." (Accountant, District Hospital Tamghas, Gulmi)

"There was insufficient budget for four ANC and transportation incentives. Aama health facility reimbursement for caesarian section is also inadequate. We managed incentives from the hospital's internal fund for normal delivery. Similarly, CS services were being managed through charity fund. Accountant of palika remained unavailable for most of the time". (Administration/finance coordinator, Beshisahar District Community Hospital, Lamjung)

4.6 Problems in budget distribution

It frequently emerged in the interviews that the palika accountants were overburdened as they were responsible for the management of all units, such as health, agriculture, education, forestry, etc. This has created some complexity as they need to know the different programme activities spread across the sector. These difficulties are reflected in the budget release process, as accountants could not prioritise between sectors. Palika accountants suggested opening an account section for each unit, which would support them by

sharing the workload and making their work a lot easier. Some accountants also reported problems in budget distribution because they did not have the Aama Programme Guidelines available. Around one-third (34%) of HFs had not received the HF reimbursement under the Aama Programme for this FY: there is a widespread practice of providing Aama HF reimbursements on a yearly basis towards the end of the FY.

"Currently it is easier as facilities can directly receive budget from the municipality. However, the challenge is that cheque could not be cashed in Raskot municipality and health facilities need to reach Manma for which a whole day is spared … and if the cheque is not cashed in a day, then they would need to stay another day." (Health Coordinator, Gurvakot Municipality, Surkhet)

"In the current federal system, budget is transferred from DTCO to the municipality which is different from previous budget flow system i.e. DTCO to DHPO/DHO. The DTCO did not issue health budget on time to palikas because of some confusion." (Health Coordinator, Panchapuri Municipality)

"There is no problem in budget flow from DTCO. The only problem is that budget is not sufficient. There is no relation of DTCO with Health Coordinator. Palika's account section is responsible for this." (health worker, Rapti rural municipality, Dang)

"There is a problem in clearance of the previous advance and late reporting of financial documents. We have made frequent communications to clear advance." (Accountant, Panchapuri, Surkhet)

"We had some problem in the months of Shrawan, Bhadra, and Ashoj as there was a delay in the release of the budget. We managed from our hospital's fund at that time." (Nursing Supervisor, Bharatpur Hospital, Chitwan)

"Budget is not released on time. This happens every year. We got our advance in the month of Kartik in this Fiscal Year. We are managing from our internal fund, which comes from ambulance charge, laboratory fee… We have done several communications to release the budget on time." (In-charge, Narayanpur Health Post, Dang)

"Budget is released only after 15th of Shrawan. It is difficult to manage in 15 days. Budget management is difficult in last of Asar too." (Accountant, Dhaulagiri Zonal Hospital, Baglung)

4.7 Reporting and recording of the programme

Fifty-seven percent of HFs said that physical and financial reports were submitted monthly; however, some interviewees reported that they had no specific timeframe around report submission. Similarly, very few reported that they had submitted the report quarterly and after six months. Many stated that there is no clear instruction on the submission of reports from HFs to palikas or districts. Important reasons cited for not submitting monthly reports included: its structure, a lack of instruction on how to keep reports, unmanaged reporting systems, and unknown reporting mechanisms. Thirty-four percent of HFs sent financial reports quarterly and 16% reported only sending reports at the end of the FY.

"Report is submitted monthly. As we disburse advance four-monthly, we also settle advance four-monthly. Every health facility brings report monthly." (Health Co-coordinator, Surkhet)

"The reporting is done monthly from all health facilities. Usually, reimbursement is made only after clearing the advance." (Health Coordinator, Soludhudhakunda Urban Municipality)

"There is no specific time for report submission. Usually, the submission of the report is done at the time of advance clearance. There is no clear report submission guidelines available for health facility. We have no idea where to submit the report, to palika or district..." (Health assistant, PHCC, Mirchaiya, Siraha)

"If the report is sent every month there will be additional work burden in account section and we are told not to submit report on a monthly basis." (Health Coordinator, Madi Municipality, Chitwan)

Similarly, all interviewees reported a lack of rules or punishments regarding the late or non-submission of reports.

"When the expenditure amount equals the advance amount then report will be sent along with supportive payment document, annexes related to Aama Programme and other reports." (Account Assistant, Mirchaiya, Siraha)

"I did not know that reporting should be done to palika. I did not know about that. All the reports were with co-health coordinator and ANM of PHCC". (Accountant, Durkhot Gulmi)

4.8 Use of Aama HF reimbursement at HFs

The Aama HF reimbursement has not been provided to all HFs in the current FY: only 66% had received it. These facilities will be provided with HF reimbursement only at the end of the FY, depending on the remaining budget. It was found that 58 percent of HFs had recruited staff (ANMs, staff nurses, doctors and office helpers) from both the Aama HF reimbursement and local-level budget allocations. The monthly salary of doctors ranged from NPR 40,000 to NPR 60,000. The salary of staff nurses ranged from NPR 14,720 to NPR 24,000. Similarly, the monthly salary of ANMs ranged from NPR 11,000 to NPR 21,000. Likewise, the salary of office helpers ranged from NPR 10,120 to NPR 12,300. In some facilities, the Aama HF reimbursement was found to be spent on buying medicines and materials and also in staff motivation, as discussed below in detail.

"Yes, the Aama health facility reimbursement has been sent till the month of Falgun... The Aama health facility reimbursement after tax deduction was sent from here for two quarters." (Health Coordinator, Harju Rural Municipality, Sunsari)

"No, we haven't provided the Aama health facility reimbursement to any health facility because the annual budget is insufficient." (Health Coordinator, Solu Dhudhakunda Urban Municipality, Solukhumbu)

"Health facilities do complain of not receiving the Aama health facility reimbursement on time. But this used to happen in previous fiscal years too. So, they understand" (Public Health Officer, Ghorahi Sub-Metropolitan, Dang)

"Yes, they complain about not having medicines and other necessary materials and they are facing difficulty managing medicines/materials like oxytocin, gloves, cord clamp, etc. We ask them to use Aama money." (Acting Health Coordinator, Dhorpatan, Baglung)

"The Aama health facility reimbursement goes to the account section of this hospital. Not much is spent on staff's motivation. Some is spent on buying medicines and instruments. I don't know details of Aama health facility reimbursement." (Nursing Officer, Dhaulagiri Zonal Hospital, Baglung)

"Out of total 1,000 rupees from normal delivery, NPR 300 is used for staff motivation and remaining NPR 700 is used for buying oxytocin, suction, gloves, medicines, etc. Out of NPR 300, sisters receive NPR 160, the doctor receives NPR 110 and office helper receives NPR 30. Similarly, in the case of CS, out of total NPR 7,000, NPR

3,500 is used for staff motivation, NPR 3,500 is used for buying medicine." (Nursing In-charge, Regional Hospital, Dang)

"With that amount we purchase medicines necessary for Aama Programme. We also use that amount in purchasing materials and equipment. Besides that NPR 255 after tax deduction is given to nursing staffs." (Staff Nurse, PHCC, Surkhet)

4.9 Medicines, staff and other equipment

Eighty-seven percent of interviewees reported having sufficient medicines and materials in their HF to fulfil their duties in accordance with the Aama Programme. However, the remaining 13 percent of participants mentioned insufficiency of equipment and supplies such as delivery sets, vacuum sets, suture sets, gloves, oxytocin, catgut etc.

"We spent Aama health facility reimbursement on health workers' motivation, buying medicines and essential supplies… however, it is not sufficient to provide quality delivery service. Without additional budget to maintain supply-side function Aama money is just not sufficient…" (Account Officer, Mehalkuna Hospital, Surkhet)

"NPR 300 is given to staff who conducted delivery. Support staff receives NPR 100 and the remaining amount is used in buying medicines and other materials needed for delivery… We used to receive budget to main delivery service before on top of Aama budget. In recent years we are asked to manage everything from Aama budget which is not possible." (In-charge, Ayodhyapuri Health Post, Chitwan)

"The entire Aama health facility reimbursement goes to Hospital Management Committee's account. Majority of it is used in incentivising health workers … we cannot just spend Aama Programme money in strengthening delivery service. This is a comprehensive hospital and money is spent where required…" (Accountant, Dhaulagiri Zonal Hospital, Baglung)

"The entire amount goes in HFOMC account. Details of expenditure from Aama Programme cannot be separated. Expenses are done in staff motivation, medicine, buying of equipment and furniture. We cannot earmark it to just spend on delivery services…" (Account Officer, Rapti Sub-Regional Hospital, Dang)

4.10 Monitoring and supervision of the programme

The majority of health coordinators (89%) reported that they had not perfomed supervision of the Aama Programme this FY. Some visited HFs for supervision but not for the express purpose of Aama Programme monitoring. The supervision covered general issues, such as maintenance of hygiene and sanitation in the facility, maintenance of attendance record, book-keeping, and Health Management Information System (HMIS) etc.

"We go on supervision in regular time interval. We have not done supervision specific to Aama Programme. We might have covered it when we asked about HMIS reporting." (Health Co-coordinator, Surkhet)

"We haven't supervised health facility focusing specifically on Aama Programme. Besides that, we supervise integrating with other programmes. Last month on 5th and 6th during IP training, we have made some visit." (Co-Health Coordinator, Khadachakra, Kalikot)

"Health Coordinator and Co-Health Coordinator go too alternatively for supervision visit. Last supervision was done in Baisakh at Salkot PHCC, in Chaitra at Tatopani HP, in Falgun at Chhapre HP. Problems were identified

in service provision. Suggestions were given to provide necessary attention on sanitation, drug storage and management, maintenance of records and reporting." (Health Coordinator, Panchapuri Municipality)

Eleven percent of Health Co-ordinators stated that they had monitored the Aama Programme by asking specific questions about, for example, reporting, budget availability and the number of women receiving transport incentives. Almost half (47%) of HFs had received supervision from the D(P)HO, region, FHD or from donors. In the majority of cases, supervisions were found to have covered broad topics and suggestions were made accordingly. Instructions and suggestions were not targeted to specifically address any issues. Fifty-eight percent of Health Coordinators also mentioned having received telephonic monitoring from FHD staff regarding the implementation of the programme and its challenges.

"Yes, there are frequent monitoring visits from FHD and D(P)HO. I don't remember the exact date. They supervise on overall service provision and reporting…." (Health Coordinator, Resunga Municipality, Gulmi)

"Supervisions are done from District, UNICEF, H4L, MSNP in this fiscal year. During supervision they have suggested on sending reports timely, timely sending HMIS to respective facility." (Health Coordinator, Raskot, Kalikot)

"We received telephone call from FHD… They asked us on the number of women receiving incentive, sufficiency of budget, reporting mechanism… .I found it very helpful as I discussed some confusion in programme implementation such as where to send report, how to request budget if it is not sufficient and also requested for Aama guideline… I would encourage this sort of support even not physical monitoring and supervision..." (Health Co-coordinator, Panchapuri, Surkhet)

4.11 Displaying Aama Programme beneficiary

About 25 percent of Health Coordinators reported to have known that names of Aama beneficiaries should be displayed. However, many were not sure whether this was carried out in practice as most of them had not visited the HFs in question. Similarly, many of them were not sure whether they could take any action to ensure that the list of beneficiaries be displayed. Only 61 percent of HFs were found to display the names of Aama beneficiaries.

"I didn't know name list of Aama beneficiaries should be displayed. In fact I have not visited any health facilities to inspect whether name lists of mothers are displayed or not. So, I don't know. But it is a misfortune. Health facilities should display name list." (Public Health Officer, Ghorahi, Dang)

"What sort of action should I take? My own health post (Boharagaun Health Post) has not displayed the names of women. I am tired of telling them..." (Health Coordinator, Nishikhola Rural municipality, Baglung)

"We have not taken any action but is suggested to display name list of Aama beneficiary… some made lame excuse of not having notice board." (Health Coordinator, Dhulikhel Municipality)

"No, we have not displayed the names of women. We conducted a large number of deliveries in this hospital. So, it is almost difficult to display all names." (Nursing Supervisor, Bharatpur Hospital, Chitwan/Dhulikhel Hospital, Kavre)

"We did not know that the record of women who received incentive has to be displayed at a visible place." (Assistant Matron, Chitwan Medical College, Chitwan)

"We know it must be displayed but do not have notice board." (ANM, Baghauda Health Post, Chitwan)

4.12 Challenges in implementing the Aama Programme

Findings from KIIs have highlighted some specific issues that might hamper effective implementation of the Aama Programme. Strengthening of the supply-side remains particularly important: facilities have reported shortages in trained human resources, essential equipment and medicines;facilities operating without sufficient resources were also greatly stretched with overcrowding. Chronic issues, such as delay of budget release and irrelevant budget planning, were still prominent in the changed context. Geographical remoteness, service availability and transportation availability still pose huge economic burdens. Staff motivation, patients' ever-increasing expectation of receiving services free of cost and a lack of clarity regarding which services are to be provided for free emerged as new challenges in implementing the Aama Programme.

"Women also request to provide free calcium tablets, Ultrasound services, and lab services. We cannot fulfil women's expectation… we only provide service that is mentioned in the guideline… Is there a protocol of service what to provide and what not to… facilities vary dramatically in their service provision." (Health Coordinator, Resunga, Gulmi)

"Approved budget is not sufficient. Palika has not received any orientation programme for running Aama Programme. We have not received Aama Programme guideline. It is difficult to go for monitoring in health facilities because they are located very far away and palika has not done any activities regarding Aama Programme as such. So, no work no challenges." (Acting Health Coordinator, Dhorpatan, Baglung)

"Work burden of focal person, insufficient budget, lack of supervision and a lot of paperwork were found as major barriers of the Aama Programme. For improving the Aama Programme there should be the provision of motivating staff such as night allowance; payment through the banking system could reduce paper work." (Health Coordinator, Madi Municipality, Chitwan)

"We don't have adequate trained health worker." (ANM, Health Post, Kalikot)

*"When doctors are not there in our hospital, we have to refer many complicated cases... Many referred cases have died on the way to other hospital. This is very sad. As patient do not know there is no doctor and think that the service is still available..." (Nursing In-charge, Dhaulagiri Hospital, Ba***glung)**

4.13 Suggestions for improving Aama Programme implementation

An important suggestion that emerged from the interviews was to provide updated Aama Programme guidelines for palikas. These guidelines should make clear mention of budget planning, flow and reporting provision, which would be useful in effective implementation of the programme. Other suggestions included: orienting palika's accountants on health programmes, adequate supply of trained human resources and medicines, timely distribution of budget, additional budget to maintain supply-side functions and effective supervision.

"It would have been good if we could receive the Aama Programme Guideline for implementation at palika level as it is the changed context and there is dramatic change in the structure and functions. FHD or MoFAGA who has to initiate this need to do this ASAP as this is the most important need…" (Health Co-coordinator, Surkhet)

“Programme should be under D(P)HO just like previous years. Palika should not be handed with all the health-related responsibilities. We could not do all the work. D(P)HO has to do the work and palika can monitor their work; for example, we could spend on increasing institutional delivery through a unique pregnant mother tracking system...” (Health Coordinator, Nishikhola, Baglung)

“Annual budget should be released on time with the addition of 10%. Timely monitoring and supervision from higher level should be done. The number of staffs should be increased to ensure 24-hour service availability. CEONC and BEONC service should be implemented in all HFs working under palika.” (Health Coordinator, Solukhumbu)

“We need additional money like before to strengthen the supply-side functions… We cannot just rely on Aama Programme reimbursement to improve service delivery.” (HW Burtibang PHCC, Baglung)

“There should be a focal person for Aama. Need sufficient budget on time. We also need enough budget for supervision. Electronic recording and reporting should be initiated to prevent delay. The guideline should be updated to explicitly indicate whose responsibility this is – either DHO or palika. Infrastructure development, skilled human resources, and orientation on Aama Programme would be necessary.” (Health Coordinator, Inarwa, Sunsari)

“There are not enough staffs to provide 24-hour service. So, it would be better if the numbers of staff are increased. Four ANC incentives should be increased. Ambulance services should be free of cost.” (Sishaniya Health Post, Dang)

“Aama health facility reimbursement should be increased. Twins, breech and mother should be included in complicated deliveries.” (Nursing Supervisor, Bharatpur Hospital, Chitwan)

“Women living in rural areas must also be looked after. Safe motherhood services should be provided to poor women as well. They must be provided with free ambulance services, lodging and food.” (HFOMC Chairperson, Dhaulagiri Hospital, Baglung)

“Ultra-poor households should be prioritised. 10% of the budget of local level must be separated for the health sector.” (HFOMC Chairperson, Narayanpur HP, Dang)

CHAPTER 5 – KEY FINDINGS AND WAY FORWARD

This chapter provides key findings and ways forward on the receipt of free care and transport incentives, fund management and compliance with Aama Programme Guidelines. This eleventh round of RA is the first assessment after the implementation of federal system in Nepal.

5.1 Management of Aama Programme including Timeliness of Fund Flows

5.1.1 Key findings

- No palikas were found to be making an additional allocation to Aama Programme budget. However, some palikas managed to cope with insufficient Aama budget from their internal resources.
- Budget for the Aama Programme was adequate in most of the palikas; however, the issue of delay in receiving budget was reported by district hospitals, PHCCs and HPs. This is mainly due to delay in the fund release from federal level.
- The limited human resources working at palikas and their limited knowledge of Aama Programme implementation was found to be challenging the smooth implementation of the programme.
- More than half of HFs send their Aama report on monthly basis. Lack of clear instruction on where to send physical and financial reports was one of the main reasons for their not being sent. Some facilities send reports only during advance clearance.
- Only 21 percent of palikas had a copy of the latest Aama Programme Guidelines. The majority relied on the Programme Implementation Guidelines from FWD to implement the programme.
- Only 61 percent of HFs were displaying the names of Aama beneficiaries.

5.1.2 Ways forward

- FWD to prepare the evidence-based Aama budget allocation to the palikas. This can be performed using the expenditure data from the Transaction Accounting and Budget Control System (TABUCS) and utilisation data from HMIS. The process should be started by December each year.
- MoFAGA to ensure the timely flow of funds at the palikas; a similar instruction needs to come from FCGO to the DTCO to facilitate the timely release of funds.
- FWD and palikas to send a clear instruction on accurate recording, timely reporting and proper use of the Aama reimbursement fund to implementing HFs.
- All Aama-implementing HFs to send the Aama Programme progress report every month to their reporting authority. Hospitals should enter the number of Aama Programme beneficiaries by type of delivery along with the expenditure data in TABUCS.
- FWD to prepare, disseminate and distribute the Aama Programme Reference Guidelines for palikas to facilitate programme implementation.

5.2 Compliance of Programme Implementation with Aama Guidelines 2016

5.2.1 Receipt of transportation and 4ANC incentive

- Ninety-six percent of women giving birth at sampled HFs were reported to have received the transport incentive.
- Sixty-six percent of women had attended four ANC visits as per the protocol, of which only 65 percent reported having received the 4ANC incentive.
- Women giving birth in hospitals (64%) were less likely to receive the 4ANC incentive than women giving birth in PHCCs and HPs (94%).

5.2.2 Timing of receipt of incentive

- Eighty-nine percent of women reported having received the transportation incentive on the day of discharge, while 11 percent had to wait more than one month to receive it.
- Women giving birth in PHCCs and HPs were more likely to wait to receive the transportation incentive than women delivering in hospitals.

5.2.3 Person who received the incentive

- Forty-six percent of women reported receiving the transportation incentives by themselves; in 37 percent of cases it was received by their husbands, and in 10 percent by other family members.

5.3.1 Status of Free delivery care

- Fifty-six percent of women giving birth at selected HFs reported receiving services free of cost. Women giving birth in HPs were most likely to receive delivery care free of cost (95%) compared to only 10 percent of those women giving birth in private hospitals.
- Forty percent of normal delivery, 47 percent of complicated delivery and 66 percent of CS delivery clients reported having paid some money to receive care. Women giving birth in HFs had to pay an average of NPR 1,568 for normal, NPR 3,727 for complicated, and NPR 6,051 for CS deliveries. It is to be noted that both the funds and fees received by HFs are recorded as income.

5.3.2 Ways forward

- The Aama Programme Guidelines clearly state that delivery care should be provided free of cost. The Department of Health Services (DoHS), MoHP, FWD and palikas should take necessary actions to explore the reasons behind charging fees for delivery services. Clear instructions on the use of the standard treatment protocol need to be provided to all Aama-implementing HFs. FWD will require TA in updating the treatment protocol and preparing a monitoring framework to ensure compliance. It would be useful to send the instruction at the beginning of each FY.
- FWD to update the Aama Programme Implementation Guidelines in terms of service provision, use of Aama HF reimbursement, recording, reporting, monitoring and overall management of the programme. This update should also include reference documents for sub-national governments.

5.4 Cross-verification on Types of Delivery and Receipt of Transport Incentives

5.4.1 Key findings

- A mismatch of four percent was observed in the receipt of transportation incentives between the facility records and interviews with women.
- A discrepancy of four percent was observed between facility records and interviews with women for

normal delivery, rising to nine percent for CS delivery and 34 percent for complicated delivery. Mismatches varied across districts.

- Similarly, a 21 percent mismatch was observed in receipt of 4ANC incentives between the facility records and interviews with women.

5.4.2 Ways forward

- The mismatch in cross-verification might be due to human error while recording and reporting the data. At the same time, the discrepancy may indicate a potential fiduciary risk in Aama fund use. Supportive supervision and effective monitoring should be regularly performed by FWD and palikas to ensure compliance against the policy provision. Both FWD and palikas should instruct the implementing HFs to ensure accurate recording and reporting. One approach to achieve this would be through data verification from HMIS and TABUCS. More importantly, MoHP/DoHS and palikas can take necessary action for further investigation and provide specific instruction to the facilities and individuals.

- TA is required for FWD and palikas to analyse the audit observations related to the Aama Programme and provide a management note to prevent such observations in the future.

- Process monitoring of the Aama Programme implementation to be strengthened at all levels from federal to local. All supervisors visiting HFs for monitoring should compulsorily use monitoring checklists, submit reports to the office and make follow-up visits to the facilities to ensure that action points are implemented. FWD to provide monitoring reference documents to palikas in the beginning of every FY.

- Transparency is a key strategy to bring accountability. In this regard it is suggested that compulsory public audits or public hearings be conducted in the catchment areas of HFs, with the participation of the palikas. Palikas and FWD to ensure display of Aama beneficiaries through Aama guidelines Annex 10.

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ANNEXURE

Annex 1: Selected Districts, Facilities and the Required Number of CEIs and KIIs

Local Level Name	Local Level Type	Name of HF
Province-1: Solukhumbu (2)		
Solu Dudhakunda	Municipality	District Hospital
Necha Salyan	Rural Municipality	Salyan PHC
Province-1: Sunsari (4)		
Inaruwa	Municipality	District Hospital
Barah Kshetra	Municipality	Madhuwan PHC
Barju	Rural Municipality	Chimdi HP
Bhokraha Narasingha	Rural Municipality	Narshinha HP
Province-2: Siraha (6)		
Siraha	Municipality	District Hospital
Mirchaya	Municipality	PHC Mirchya
Bhagwanpur	Rural Municipality	PHC Bhagwanpur
Golbazar	Municipality	HP Golbazar
Nawrajpur	Rural Municipality	PHC Nawrajpur
Arnama	Rural Municipality	HP Arnama
Province-3: Kavre (5)		
Banepa	Municipality	Scheer Memorial Hospital
Dhulikhel	Municipality	Dhulikhel Hospital
Namobuddha	Municipality	Methinkot Hospital
Panauti	Municipality	Khopasi PHC
Bethanchowk	Rural Municipality	Dhunkharka HP
Province-3: Chitwan (5)		
Bharatpur	Metropolitan City	Bharatpur Hospital
Bharatpur	Metropolitan City	Chitwan Medical College
Madi	Municipality	Baghauda Hosptial
Kalika	Municipality	Jutpani PHC
Madi	Municipality	Ayodhyapuri HP
Province-4: Lamjung (4)		
Beshi Shahar	Municipality	District Community Hospital
Marsyangdi	Rural Municipality	Khudi HP
Madhya Nepal	Municipality	Bhorletar HP
Sundarbazar	Municipality	Sundarbazar HP
Province-4: Baglung (4)		
Baglung	Municipality	Dhaulagiri Zonal Hospital
Dhorpatan	Municipality	Burtibang PHC
Galkot	Municipality	Hatiya HP
Nisikhola	Rural Municipality	Boharagaun HP
Province-5: Gulmi (4)		
Resunga	Municipality	Tamghas Hospital
Chhatrakot	Rural Municipality	Shringa PHC
Dhurkot	Rural Municipality	Dhurkot PHC

Musikot	Municipality	Badagaun HP
Province-5: Dang (6)		
Ghorahi	Sub-Metropolitan City	Rapti Sub Regional Hospital
Tulsipur	Sub-Metropolitan City	Rapti Zonal Hospital
Lamahi	Municipality	Lamahi PHC
Ghorahi	Sub-Metropolitan City	Narayanpur HP
Rapti	Rural Municipality	Sisahaniya HP
Gadhawa	Rural Municipality	Gadhawa HP
Karnali: Kalikot(2)		
Khadachakra	Municipality	District hospital Manma
Seuna	Rual Municipality	Seuna HP
Karnali: Surkhet (4)		
Birendranagar	Municipality	Mid-Western Regional Hospital
Gurbhakot	Municipality	Mehelkuna Hospital
Panchapuri	Municipality	Salkot PHC
Simta	Rural Municipality	Rakam HP
Provicne-7: Dadeldhura (4)		
Amargadhi	Municipality	Sub Regional Hospital
Parashuram	Municipality	Jogbuda Hospital
Aalital	Rural Municipality	Alital HP
Nawadurga	Rural Municipality	Belapur HP
Provicne-7: Kanchanpur (4)		
Bhimdatta	Municipality	Mahakali Zonal Hospital
Mahakali	Municipality	Dodhara PHC
Krishnapur	Municipality	Krishnapur HP
Bedkot	Municipality	Daijee HP