Aama and New Born Programme: A Programme for Saving Lives of Women and New Born in Nepal

Nowadays an increasing number of Nepalese women are delivering their babies at health facilities. Six in every 10 women know about the free care and transport incentive that is available for delivering at a health facility. Locals know this as the ***Aama Programme,*** meaning the programme for **MOTHERS.**

The Aama Programme was introduced to reduce financial barriers to women seeking institutional delivery. It aims to increase the number of institutional deliveries and thereby reduce maternal morbidity and mortality. The Aama Programme has evolved and matured over the years.

In 2005, with major funding from DFID, the programme was launched as the Maternity Incentive Scheme (MIS), which was further revised as the Safe Delivery Incentive Programme (SDIP) in 2006 with a greater focus on reducing the high costs associated with accessing care at childbirth. The programme further progressed to become the Aama Programme in 2009, characterized by the removal of user fees for all types of deliveries. In 2012, the 4 ANC incentives programme, which provided cash incentives to women for completing four ANC visits, was merged with the Aama Programme. Again in 2016, free new born care programme was incorporated to the Aama Programme making it the Aama and New Born Care Programme.

The Aama and New Born Program is implemented by the Family Health Division under Department of Health Services. The programme has provision for free care to both the mother and the new born. The component for women consists of three parts:

Transport Incentive to women: Transport incentive for all women in delivering in health institutions (segregated by geographic region) and completing four ANC attendances in 4, 6, 8 and 9th month of pregnancy.

Geographic terrain	Amount
Mountain	NPR 1,500 (£11.10)
Hill	NPR 1,000 (£7.40)
Tarai	NPR 500 (£3.70)
NPR 400 (£2.90) as 4 ANC incentive	

Health Facility Reimbursement: Payment to health facility to provide free delivery care.

Condition	Amount
Normal delivery <25 beds	NPR 1,000 (£7.40)
Normal delivery >25 beds	NPR 1,500 (£11.10)
Complicated delivery	NPR 3,000 (£22.20)
Rh Anti-D	NPR 5,000 (£37)
CS delivery	NPR 7,000 (£51.80)

Incentive to Health Worker: A payment of NPR. 300 is provided to the health worker providing all forms of delivery care (viz: normal, complicated and CS delivery). To be managed from facility reimbursement. Similarly, the new born component consists of the following;

Health Facility Reimbursement: Payment to health facility to provide free care for ***sick new born***.

Condition	Amount
Package 0	NPR 0
Package A	NPR 1,000 (£7.40)
Package B	NPR 2,000 (£14.80)
Package C	NPR 5,000 (£37)

Incentive to Health Worker: A payment of NPR. 300 is provided to the health worker providing all forms of packaged care for sick new born.

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Budget Allocation and Absorption

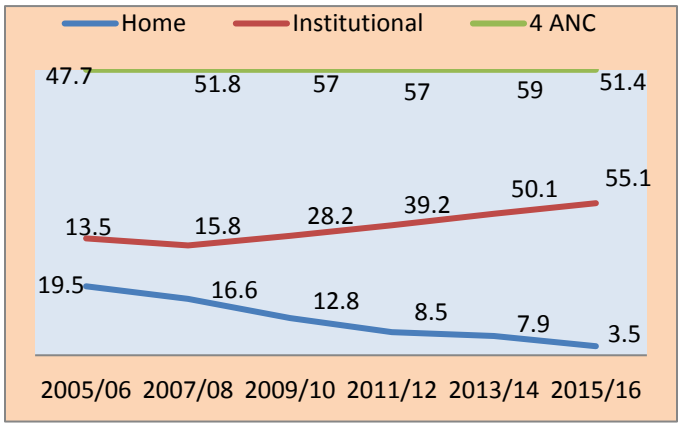
In the first 7 years of implementation (2009/10-2015/16), NPR 6.57 billion has been allocated for health facility reimbursement and transport incentive excluding incentives for 4 ANC. Over its seven years implementation, on an average the programme has absorbed 85 percent of the allocated budget, which is higher than the budget absorption capacity of the MoH. The FHD budget for the care of sick new born last year (FY 2015/16) was NPR 48 million out of which only NPR 7 million was spent over two years. Another, 4 million budget was allocated from the Child Health Division to four tertiary level hospitals including Koshi, Gandaki, Lumbini and Seti.

How Many Women and New Born have benefitted?

1.99 million Women have so far received the free delivery care and transport incentive. The Household Survey of 2012 found that 91 percent of entitled women had received the transport incentive and 87 percent of women who delivered in a health facility had received the service free of charge.

Contribution of Aama and New Born

The Aama and New Born programme is encouraging women to visit health facilities and use safe delivery services. Similarly, it has ensured the provision of free care for the sick newborn. As evident in the next figure, the number of institutional deliveries has almost doubled in the last five years and the number of women giving birth at home has halved.



Besides, the Aama Programme has resulted in more service delivery sites and has also contributed in harmonizing public private partnership in providing delivery care. An increasing number of peripheral level health facilities, namely health posts (from 543 in 2009/10 to 1,751 in 2015/16), are providing delivery services in the most hard-to-reach areas and to poor women. Additionally, 58 non-state partners are providing Aama services. The Programme has made an important contribution in reducing maternal mortality from 539 in 1996 to 170 per 100,000 live births in 2012. Aama is considered as one of the innovative financing schemes managed by public sector and received the ***Resolve Award in 2012.***

Policy Integration and Programme Implementation

The Aama Programme has been well designed, owned and implemented by the FHD. As a result it has been running smoothly in its 8 years of implementation. It will be interesting to see how the free new born care programme added in Aama Programme will be implemented. This is mainly because there is no single institutional home responsible for the free care of sick new born. Currently, both FHD and CHD are funding for new born care programme with majority budget coming from FHD. The FHD's new born care programme is implemented in all 75 districts and hospitals while the CHD is piloting free new born care in 4 tertiary level hospitals. In its first year of program implementation no information on number of new born treated could be retrieved from the system. Though new born has been merged into the Aama Programme, it appears that the new born care programme has not fully harmonized in terms of planning, budgeting, recording and reporting the progress with Aama programme. The new born care programme need to mention the conditions to be treated under the sick newborn care and subscribe the appropriate recording formats to capture conditions that do get treated. Additionally, there is no incentive at the lower level health facility to treat 'package 0' conditions and as a result higher centers may get overcrowded by less serious conditions or minor cases. Separate recording and reporting of sick new born programme may increase the time cost of technical staff doing non-technical tasks.

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Series of technical discussions are required to improve the recording, reporting, planning, budgeting and ways to cross verify the treatment provided or received.

WAY FORWARD

The Aama Programme has had a positive impact in bringing more women into the system and assuring the greater value for money for the government and its external development partners. Addition of the new born component in Aama programme requires some time to be properly implemented. Technical discussions are required to delineate how this integration will contribute in strengthening the purchasing function of FHD and assuring the allocative efficiency in the maternal health care delivery system.

A clear programme implementation framework needs to be developed and implemented to plan and to report the progress. FHD and CHD need to ensure the proper planning, accurate record keeping, reporting and periodic monitoring of the new born care component. For this, the respective divisions need to identify and provide a clear ToR to the responsible officials/focal persons at the implementation level. A functional linkage in recording and reporting needs to be maintained within Aama and the new born programme.

In addition, both divisions need to instruct focal persons to enter progress in TABUCS and eAWPB. There are still rooms for improvements in new born care which could be incorporated through the learning from Aama Programme. Aama Programme itself is implemented with challenges in response to the provision of the free care component which needs proper monitoring, especially in private facilities. The continued development of the social security programme in-line with national social health protection programme is another important task. Technical and policy level discussions are required to integrate Aama and new born care with national social health insurance programme which would be an important step towards achieving Universal Health Coverage in Nepal and assuring ' Leave No One Behind.'

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Key highlights of the New Aama Guideline

Introduction of the Free New Born Care Package and Health Facility Reimbursement

Package	Services	Unit cost reimbursement
Package 0	Resuscitation	**No cost**
	Kangaroo Mother Care	
	Antibiotics as per IMCI protocol	
Package A	**Medicines-**Antibiotics and other drugs as per National Neonatal Clinical Protocol, NS, RL, 5% dextrose, 10% dextrose, 1/5 NS with 5% or 10% dextrose, Potassium chloride, Adrenaline, Buro set, IV Canula	**NPR 1,000**
	Laboratory services- Blood TC, DC, Hb, Micro ESR, CRP, Blood Sugar, blood grouping, Serum Bilirubin (total and direct).	
	Oxygen Supply by hood box /nasal prong	
	X-ray / USG	
Package B	Photo therapy	**NPR 2,000**
	Laboratory Services- Blood culture, RFT (Sodium, Potassium, Urea createnine), Serum calcium	
	Lumber Puncture and CSF Analysis	
	Medicines- Dopamine, Dobutamine, Phenobarbitone, Phenytoin, Midazolam, Calcium Gluconate, Aminophylene	
	Bubble CPAP (Continuous Positive Airway Pressure)	
Package C	NICU Admission (Must)	**NPR 5,000**
	NICU bedside Ultrasonography (USG)	
	NICU bedside Portable X-Ray	
	Laboratory services: ABG, Magnesium, Chloride, Serum Osmolarity, Urine Specific Gravity , Urine Electrolyte	
	Double Volume Exchange Transfusion, Blood transfusion	
	Medicine: Caffine	
	Mechanical Ventilation	

Note: This does not include transport incentive to reach to health facility. Health workers are entitled for incentive which should not exceed NPR.300. Health worker incentive should be managed from health facility reimbursement.

1. Home delivery incentive for health worker i.e. NPR 100 have been deducted.
2. Health facility reimbursements for Anti D have been increased from NPR 3,000 to NPR 5,000.
3. Health facility reimbursements for multiple and breech pregnancy have been reduced from NPR 3000 to NPR 1, 000/1,500.