



**SSMP/NEPAL**

Support to the Safe Motherhood Programme

# **Support to Safe Motherhood Programme, Nepal**

**A part of HMGN Nepal National Safe Motherhood Programme (NNSMP)**

## **Cost Sharing System for Alleviating Financial Barriers to Delivery Care: Review of the Proposed Scheme**

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**DFID** Department for International Development

**Options**



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## **ACRONYMS**

ANM	Auxiliary Nurse Midwife
BEOC	Basic Essential Obstetric Care Facility
CEOC	Comprehensive Essential Obstetric Care Facility
DHO	District Health Office
DoHS	Department of Health Services
FCHV	Female Community Health Volunteer
FHD	Family Health Division
GBP	British Pounds
HDI	Human Development Index
HEFU	Health Economics and Financing Unit
HMGN	His Majesty's Government Nepal
IMPACT	Initiative for Maternal Mortality Programme Assessment
MCHW	Maternal and Child Health Worker
NRS	Nepali Rupees
PHCC	Primary Health Care Centres
SSMP	Support to the Safe Motherhood Programme

## **EXECUTIVE SUMMARY**

### **Description of policy and key issues**

The high financial cost of delivery is an important barrier to accessing skilled attendance in Nepal. To help mitigate this barrier HMG Nepal has decided to implement a strategy to provide financial assistance through cost sharing to women seeking skilled delivery care. Although there were, and remain, sound reasons for piloting the strategy, or at least phasing it in, the Government believe that in the interests of equity the strategy should be implemented for the entire country at the same time.

There are three main components to the new strategy:

1. A cash payment to women presenting for delivery at a recognised BEOC or GEOC facility. These vary according to ecological area; NRS 500 in the Terai, NRS 1,000 in hill and NRS 1,500 in mountain areas
2. A payment of NRS 300 to staff classified as trained health workers for attending a delivery either at home or in a facility
3. In selected districts (25 classified as of low human development) free delivery services at facilities for both normal and complicated deliveries

### **Mechanisms for providing financial aid for deliveries**

Funding for each of the components of the strategy will be allocated to district health offices and autonomous facilities such as zonal and central hospitals. Districts will oversee reimbursement of individual facilities. Where primary health care centres or health posts that are permitted to undertake normal deliveries do not have assigned spending authority, a cash advance will be made available, reconciled and supplemented on a monthly basis. The practitioner incentive will be added to the facility salary allocation on a monthly basis.

Cash availability is crucial to the success of scheme. Although monthly reimbursement of the provider incentive may function effectively, women must receive the cash payment immediately after delivery. This raises the need to maintain a cash float within all facilities and has both security and accounting implications.

It is intended that free delivery be made available in 25 low HDI districts. Facilities will receive NRS 1,000 per delivery, designed to provide an average of the cost of normal and complicated delivery. Many of the low HDI districts lack a GEOC facility so that women will have to seek care for complications in adjacent districts with higher human development. They will qualify to receive the reimbursement only for women coming from the qualifying districts. A number of important issues arise.

- Referral facilities in adjacent districts will receive a disproportionately high level of complicated deliveries for which they will still only receive the average NRS 1,000 payment. They may be disinclined to provide services.
- In order to receive reimbursement, these facilities must show that the women receiving treatment originated from the qualifying 25 districts. This may be difficult to verify.
- The need for women to trek to other districts may mean that women are not physically able to access services and the policy may fail to impact significantly on utilisation. This possibility is increased by the determination to introduce the policy in all districts immediately without regard to the ability of districts to deliver services to its population.

If implemented successfully the scheme could have a significant impact on the costs of services to women. The potential cost reduction is most substantial for women in low HDI areas, particularly for those with complications. But this is dependent on women being able to physically reach services.

## **Projected funding required**

Based on a series of assumptions about increased utilisation, the service only cost of the scheme is estimated at NRS 907 million (GBP 6.9 m) over a five-year period. This is reduced slightly if the policy to exclude higher parity births (>2) is adhered to. In addition to the basic service element a number of other items will add to the cost of the scheme.

*Management and supervision* - the system will impose a series of new supervisory and reporting requirements on district, facility and national level staff. It is difficult to quantify the full extent of the costs of these tasks and some will be absorbed into overhead administration. Yet some financial provision should be made for the additional costs of supervision and training as well as the advisory role of DoHS.

*Monitoring and evaluation* – regular supervision will only provide a partial picture of the impact of the scheme. Rigorous evaluation in a number of selected districts both at start-up and once the scheme is well established should be undertaken by an agency external to Government. The evaluation should focus on a number of key questions including:

1. Is the scheme known about and valued amongst women and health workers?
2. Has funding been allocated and received by facilities, health workers and women (for the individual subsidy)?
3. Has the financing scheme contributed to a change in utilisation, type of services used and mix of home versus institutional care?
4. Has the scheme increased the availability of trained health workers, particularly within the community?
5. What impact has the scheme had on the user costs of delivery?
6. What other barriers might be acting to reduce the impact of the financing scheme (such as supply constraints)?

A number of opportunities to link in with international research projects now exist that may provide a basis for the evaluation. In addition good local capabilities to undertake the necessary fieldwork will be required.

*Publicising the scheme* – the scheme will fail if women do not know how to access the subsidies and free services. A substantial effort will be required to publicise the scheme using a variety of media.

It is estimated that the costs of management, evaluation and publicity will add a further NRS 41 million over the five year period, a total of NRS 948 million (GBP 7.3 million) including the service element of the strategy. Assuming rather higher growth in trained attendance approaching what is required to meet the targets set in the current Nepal Development Plan, this budget increased to NRS 1.3 billion.

### **Next steps**

A series of key issues must be followed up with some urgency if the policy is to be implemented in a satisfactory way from the start of the next financial year. These include:

1. financial management and cash flow to ensure that cash can be made available to women and practitioners in a timely way
2. strategy for 25 low HDI districts to ensure that services can be made available to women living in these districts
3. a certification process to determine those facilities qualifying for the scheme
4. dissemination to women and households on the entitlement and operation of the scheme
5. a reputable complaints procedure to provide redress for women who feel that they have not received the benefits to which they are entitled
6. a strategy for supervision and training of health service staff
7. intensive evaluation strategy in selected districts.

It is recommended that local technical assistance is provided to FHD of the Department of Health Services to assist them in implementing the scheme.

## **ACKNOWLEDGEMENTS**

I am most grateful for the assistance of the family health division, DoHS, HEFU and staff of SSMP during my short visit to Nepal. The stimulating discussions made my trip most informative and contributed substantially to the finalisation of this report.

## **INTRODUCTION**

The high cost of delivery care has been shown to represent a substantial barrier to accessing skilled attendance in Nepal. One study showed that the cost of normal delivery exceeds NRS 5,000 and caesarean section NRS 11,000 (Borghi, Ensor et al. 2004). For normal delivery the official charge represented 12% with transport 54%, additional charges 25% and opportunity costs 9%. For caesarean section and other complications the official charge made up 49% with transport accounting for 27%, additional charges 9% and opportunity costs 15%. The same study suggested that exemption mechanisms designed to alleviate these costs to the poor are not working effectively because institutions do not have sufficient funds to pay for exemptions, poor women are not correctly identified and because the cost at an institution constitutes only a small fraction of the total cost of delivery.

To help mitigate the financial barrier to obtaining skilled delivery care, HMG Nepal has decided to implement a strategy to provide financial assistance through cost sharing to women seeking skilled delivery care. The policy includes elements of universal benefit together with geographic targeting. This approach largely avoids the problem of trying to identify individuals who qualify, which has generally proved ineffective in Nepal and indeed in most other low-income countries. There is still a problem of identification for free delivery benefit where a woman has crossed a district boundary for service. This will be discussed later.

This report is structured as follows. The first section provides a brief description of the proposed scheme while the second section discusses key issues relating to the implementation at the local level. The third section discusses the likely cost and activities involved in providing effective management, supervision and evaluation of the scheme. The final section discusses next steps required to implement the mechanism.

## **SECTION 1: BRIEF DESCRIPTION OF THE POLICY**

Although there were, and remain, sound reasons for piloting this strategy or at least phasing it in, the Government believe that in the interests of equity the strategy should be implemented for the entire country at the same time. This raises important issues about the ability to manage such a scheme and ensure that supervision and monitoring are in place. The Government has recently developed a document that sets out how the policy will be implemented.

The intention of the policy is to increase access to trained health workers and skilled attendance. Skilled attendance is usually defined as a trained midwife providing assistance at delivery and access to referral to a comprehensive obstetric care facility (CEOC) for treatment of complications. Access requires both physical proximity to the CEOC facility, knowledge of when referral is required and minimisation of barriers, including financial barriers, to using these services. The delivery financing policy of government mainly addresses the financial barrier but will be combined with other interventions that address other access and information barriers. It should be noted that HMGN considers that trained obstetric health worker includes both doctors, nurses, midwives and ANMs with midwifery training and also includes female maternal and child health workers (MCHWs) and, in some areas, male health assistants.

There are three main components to the new strategy:

1. A subsidy (sometimes described as an incentive) payable to all women when presenting for delivery at a recognised BEOC or CEOC institution. To reflect the differences in cost of accessing services in different areas, the subsidy varies according to ecological region: NRS 500 in the terai, NRS 1000 in the hills and NRS 1,500 in the mountain areas. The Government recognises that these subsidies only partly cover the user costs of accessing care. The subsidy is at the facility the woman first presents at for delivery (must be BEOC equipped) even if she is subsequently referred to a higher level facility for surgical intervention or other complications. In the case of normal deliveries, the payment will only be given to women for the first two children. It will be provided to all women with complicated deliveries or complications of pregnancy irrespective of parity.
2. A payment (provider incentive) of NRS 300 made to staff classified as trained health workers for attending a delivery either at home or at a facility. Initially trained health workers have been defined as doctors, staff nurses, ANMs and MCHWs and, in areas where there is no trained female worker, health assistants.
3. In selected (low human development) districts free delivery services will be provided in addition to the subsidy. A facility will receive a fixed per delivery payment of NRS 1,000 regardless of whether there are complications. The payment is designed to represent average costs of service with some most deliveries (vaginal, uncomplicated) costing less and some others, such as surgical intervention, costing the facility substantially more.

With the exception of free delivery, which will only be provided in 25 districts, the benefits will be available for all women across the country, both rural and urban areas and in all public facilities. In addition, to ensure coverage in under-served areas some NGO facilities will be incorporated into the scheme.

**Table one: summary of financing scheme for delivery care**

		Note
1	Subsidy to women NRS 500 Terai NRS 1,000 Hill NRS 1,500 Mountain	Up to 2 normal deliveries.
2	Practitioner incentives NRS 300 per delivery to trained health workers	Goes directly to practitioner or practitioner group (facilities)
3	Free delivery in 25 low HDI districts NRS 1000 per delivery	Fixed regardless of type of delivery or complication

It is planned that the scheme will be implemented across the country from the beginning of the next financial year (July 2005). Before this, mechanisms for implementation, a plan for publicising the scheme and a monitoring framework is required. The Department of Health Services (DoHS) and Health Economics and Financing Unit (HEFU) in the Ministry of Health have developed proposals for implementing the scheme. These are discussed in the next section.

## **SECTION 2: MECHANISMS FOR PROVIDING FINANCIAL AID FOR DELIVERIES**

### **2.1 National mechanism for allocating funding**

The procedure for financing the mechanism at national level, will follow the usual procedures used to formulate and track other HMGN spending. The Ministry of Health and Department of Health Services will formulate a budget based on historic numbers of deliveries adjusted for any expected increase. A district wise budget for 2005/2006 (Nepali calendar 2062/063) has been calculated based on population, expected crude birth rate (30/1000) and anticipated deliveries in institutions and by trained health workers at home (at present 55% of attended deliveries are in institutions). The budget, which will be reflected in the red-book and subject to government rules on distribution, is divided between the three components of the financing strategy. Once approved by the Ministry of Finance, an authority to spend will be sent to the Ministry of Health, which is delegated to DoHS to administer the scheme across the country.

### **2.2 District level allocation**

Authority to use the budget for each district is de-concentrated to each DHO or, in the case of self-managed hospitals (such as zonal hospitals) directly to the facility directly, by DoHS. This authority gives the DHO access to funds allocated to district treasuries for this programme. The DHO will oversee the reimbursement of individual facilities under its control<sup>1</sup>.

Facilities will be reimbursed on a monthly basis based on the number of deliveries conducted during the month. Facilities will submit a report detailing the number of deliveries conducted divided into normal, complicated, surgical and referred. This report will form the basis for reimbursement. Reports will be kept by all practitioners undertaking deliveries which will then be counter-signed by their supervisors. It is anticipated that heads of primary care centres will come to deliver reports and obtain reimbursement at the same time as collecting monthly salaries. The DHO will collate the monthly returns and send a report to DoHS on a quarterly basis that details the numbers of deliveries by type and the amount of funding disbursed under each of the three categories of service subsidy. The Ministry of Health has already authorised facilities with spending authority to use the line item reserved for social assistance for patients (line 303) for spending under the scheme. In case of autonomous facilities (zonal, regional and central hospitals) they have been asked to make use of the allocation (around 5%) for social assistance to finance the scheme.

The issue of cash availability and accountability should not be underestimated. If the system is to function effectively it is essential that women can be paid at time of delivery. The proposed system raises some important issues of cash flow. While larger facilities have their own cash balances with bank accounts, smaller facilities such as PHCC (Primary Health Care Centres) do not. Under the financing mechanism they will need to advance women the delivery subsidy that they can claim back at the end of the month with the practitioner incentive. It remains unclear to what extent health facilities will have access to cash for paying women. While discussions with DoHS and one district official suggests that in most cases the management committees of health facilities maintain a bank account and a petty cash balance, other discussions suggest that these are often not functional. A related issue is one of governance. A relatively large cash balance at lower level facilities that requires only the signature of a woman and member of health staff is likely to tempt fraudulent claims in areas of the country where staff remuneration is extremely low. A further issue is whether staff will be willing to take responsibility for looking after and disbursing the money,

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<sup>1</sup> It should be noted that in a small minority of cases where the facility has been placed under the control of the local development committee, spending authority will have to be given to the development committee for deliveries taking place in these facilities rather than the DHO.

running the risk of being accused of a misdemeanour if the cash is not properly accounted for or is stolen. The security of cash kept in facilities also remains a concern.

It has been proposed by the finance department of the Ministry of Health that where facilities, some PHCCs and health posts (only around 25 health posts are likely to be eligible to offer BEOC services) offering delivery care, do not have their own accounting and spending authority a cash advance will be made operating as imprest account – accounted for monthly and topped up as required. It is recommended that support be provided by a suitably qualified local consultant to help the Family Health Division implement the system at district level<sup>2</sup>. A related study being undertaken by DFID on sector decentralisation and financing could also provide useful information on the functioning of the decentralised system. Once the results of this study are ready around early May, FHD will benefit from a discussion of the findings and implications for the delivery scheme with the study authors.

### **2.3 The subsidy for women**

The subsidy available for all women will be paid by the facility at the time of discharge. The woman will have to fill in a form (form 4) to claim the benefit. The form is reasonably simple requiring name, a signature and district and sub-district of residence. In the case of a normal delivery, the subsidy is only available for the first two deliveries (live births) and the woman is asked to declare the number of previous births on the form. This is designed to stop the subsidy acting as an incentive to have more children. Any kind of self-declaration where there is little possibility of verifying the information is clearly liable to mis-reporting. There is no limitation on the subsidy where the delivery is not classified as normal.

The limitation appears rather artificial and unlikely to be complied with in practice. It imposes an additional administrative requirement without substantial gain. The idea that the incentive may induce households to have additional children is unconvincing given that for most women, the subsidy only represents an extremely small proportion of the total 'price' to the household (see section 2.6).

### **2.4 The practitioner incentive**

The NRS 300 per delivery incentive to health professionals was conceived as a way of encouraging trained health workers to attend women at home for delivery given that this is, and will remain for sometime, the main place of delivery. There was some concern that this may encourage professionals to persuade women to deliver at home rather than at a facility. It was decided, therefore, that the incentive should be extended to facility based deliveries. Several issues are important.

At a facility level the incentive will be pooled by the management committee of the hospital and then shared out amongst staff contributing to maternal health care. This recognises the fact that it is not only the person attending the delivery that contributes to the delivery service of the facility. For a home delivery the attending midwife or other worker will be able to claim the entire NRS 300. She will submit a report to her supervisor at the health facility who will submit a joint claim on a monthly basis to the DHO.

It is unclear whether for a home delivery the NRS 300 will cover all the costs or only represents the incentive for staff time. Districts may have discretion to decide whether the NRS 300 will include the basic supplies such as safe-delivery kit. Other supplies including medicines will be charged extra but at a fixed tariff provided to the client in advance.

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<sup>2</sup> This is likely to be someone with a good knowledge of financial management issues in the public sector including decentralised systems at regional and district level. It would be preferable although not essential that the person also has a good knowledge of the health sector.

## 2.5 Free delivery in 25 low HDI districts

Twenty-five districts with low human development, based on the human development index (HDI<sup>3</sup>), have been selected to benefit from the subsidy to facilities to provide free delivery services for all women resident in those districts. The district budget for incentives will be augmented to include an allowance of NRS 1,000 per delivery. The hospital charge for a normal delivery is estimated to be around NRS 650 while for a caesarean section it is more than NRS 5,000. A facility receiving funding will not be allowed to make any further charge to patients for the costs of staff time, medicines, supplies or overnight stay. If food is provided by the hospital this will also be provided free to the woman. At the moment there are no guidelines on what a facility should do with the funding which can, in principle, be used for equipment, materials or even additional staff.

One of the key issues is that many of the low HDI districts lack a government CEOC facility. In some areas, NGO such as mission facilities may be able to provide these services and will be eligible to be reimbursed by the scheme. In other cases women will have no choice but be referred to another district. The suggested procedure is that a woman would present to a BEOC district facility and receive the subsidy, after which she would be directed to a CEOC facility in another district. These facilities would receive NRS 1,000 for providing services per delivery. There are three potential problems.

A first issue is that these referral facilities will receive a disproportionately high level of complicated deliveries for which they will still only receive NRS 1,000. The system is designed to work by providing facilities with a mix of low and high cost cases. In some cases the districts will lie outside the 25 low HDI areas and so will only receive complex deliveries from neighbouring high HDI districts that they will be required to provide service. Hospitals may refuse to take these cases, provide inferior services, attempt to charge the women or risk suffering financially. The government is well aware of this issue but feels that it is likely to be a relatively small burden that can be managed by individual facilities. Monitoring activities should examine whether this is actually the case. A second issue is that districts receiving referrals from low HDI districts, but who are not themselves classified as low HDI must show that these referrals were actually from qualifying districts in order to receive reimbursement. This may require recording of details of district of residence. There is an issue that this could lead to misreporting in order to receive additional funding. Again this requires monitoring.

A third issue, is that the lack of a CEOC facility in the district or close by will simply mean that a woman is not physically able to reach an appropriate facility. Substantial investments will be required in many districts in order to provide CEOC or even sufficient BEOC facilities (see section 3.3). Most of the low HDI districts do not appear to have CEOC facilities. This represents a substantial challenge for the new scheme. Serious consideration should be given to introducing supply criteria into choosing the districts for free delivery. At a minimum the district should have an NGO partner of the national safe motherhood programme that will be able to help develop CEOC facilities in the district within the next couple of years.

One approach is to review the list of 25 districts to ensure that either there is a CEOC (and adequate BEOC) facilities in the district or a well-established referral route (adequate transport etc) to a hospital in an adjoining district. A further question is whether the NRS 1,000 will be sufficient to provide services for these cross-boundary flows of patients. If not then either the scheme could be opened up to everyone on these referring districts or consideration might be made to paying a higher level of reimbursement to these facilities for these patients.

A process for certifying facilities that are eligible to receive reimbursement for CEOC and BEOC services is required. Selection by districts needs to be verified by DoHS before any funding is

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<sup>3</sup> The Human Development Index is a composite of literacy, life expectancy and per capita national income. See Human Development Report of Nepal, UNDP.

made. It will also be important that women are aware of which facilities are eligible to provide these free services.

## 2.6 How much difference does the scheme make to the cost of service?

An important question to ask is how much difference the scheme is likely to make to households receiving these benefits. Clearly, any judgement at this stage is provisional, but some estimate of the financial impact of the scheme can be made by comparing the costs of care in different areas to the subsidy received. Estimated total subsidies and percentage subsidies are provided in table two.

**Table two: estimated implied subsidies resulting from the scheme (Nepali rupees)**

	Terai	Hill	Mountain
<b>Home</b>			
Cost	693	693	693
Subsidy	300	300	300
% subsidy	43%	43%	43%
<b>Normal</b>			
Cost	3,843	6,303	5,905
Subsidy	800	1300	1800
% subsidy	21%	21%	30%
<b>Low HDI</b>			
Subsidy	2,098	2,598	3,098
% subsidy	55%	41%	52%
<b>C-section</b>			
Cost	9,948	12,408	12,010
Subsidy	800	1300	1800
% subsidy	8%	10%	15%
<b>Low HDI</b>			
Subsidy	6,973	7,473	7,973
% subsidy	70%	60%	66%

Several caveats are in order here. These subsidies represent the 'best case'. We assume that women are not deterred by the administrative procedures required to claim and therefore take up all the subsidies provided. We further assume that in low HDI areas the reimbursement to facilities is sufficient to cover all the formal charges and costs of drugs that women were previously required to buy. Finally, we assume that no further incentives are paid by women to staff. For home deliveries we assume that the incentive of NRS 300 is deducted from the payments usually made to the attendant. Clearly all these assumptions can be challenged. In particular, it remains to be seen whether staff will continue to extract payments from women in addition to the incentive received from the scheme (this behaviour is alleged to occur in a similar scheme in Andhra Pradesh).

Subject to these qualifications, it is clear that the mechanisms broadly impact on poor areas more than richer areas. The subsidy in the low HDI areas, particularly for complications, represents a substantial fraction of the 'price' of services to the client. The subsidy appears likely to have least impact for women with complications in higher HDI areas where it represents only a small fraction of the total 'price' of services to clients.

It is evident that the scheme will only have the impact on costs described above, if the benefits are actually made available to women at the time of birth. A massive effort to publicise the scheme will have little impact if women feel that they will not actually receive the benefits. Consideration must be given to developing a system of complaints and redress for women who feel that have not received the subsidy when they are entitled, or are asked to pay for services that should be

provided at zero cost. One possibility is to utilise the Woman's Development Officer in the district as the focal point for addressing these complains. Although in government, her position outside the Ministry means that she may be seen as an independent arbiter. Another possibility is to utilise the development committees where they are operating. Further thought needs to be given to this important issue. Consideration might also be given to involving the woman's officer in the regular supervision and monitoring of the scheme.

## SECTION 3: PROJECTED FINANCING REQUIRED FOR SCHEME

### 3.1 Projected service cost of financing scheme

The budget as currently formulated only covers the 'service' element of the scheme and makes no allowance for management, supervision, monitoring and evaluation and publicity. For 2005/2006, it is estimated that NRS139.8 million will be required to finance the scheme across the country. This budget is attached as annex one.

At present there is no budget for the second and subsequent years of operation. Estimating a budget is dependent largely on the assumption about how much attended delivery will increase during the years and on the division between home and institutional deliveries. Current forward projections are based on a 2 percent increase in attended delivery. This rate is based on recent historical trends in attended deliveries and makes no allowance for the impact of the scheme itself on the uptake of services. In particular a 'price effect' is to be expected whereby women are more willing to seek services because the subsidy implies a lower user price. Estimating such an effect is hampered by a lack of evidence on the effect in Nepal. The price elasticity<sup>4</sup> for maternal and other essential health services vary substantially throughout low-income countries from 0.2 to 1.5. A recent study in Nepal, for child health services suggests an elasticity of 0.2, although up to 0.4 for low-income households. Using the range 0.2 to 0.4 suggests an increase in attendance, as a result of the price change, of between 0.8% and 2.2%. We assume that this impact on utilisation is spread over three years and that, therefore, the natural rate of increase should be augmented by around 0.7% per year over a three-year period.

Population is projected to increase at 2.24% per year while the crude birth rate is assumed to remain constant at 30 per 1000.

Based on the above assumptions, this suggests a budget for the service element over a period of five years of NRS 907 m (GBP 6.9 million). The exclusion of normal deliveries where women have more than 2 children could, assuming that women make an accurate declaration, reduce the costs for the subsidy element of the scheme. The DHS (2001) found that 44 percent of deliveries are for women with 2 or fewer children (HMGN 2001). Yet there are a higher proportion of primigravidas that deliver at a facility. Making this adjustment, and also including complicated deliveries<sup>5</sup> increases the proportion of facility based births of women delivering for the first or second time to around 70%. If the system functions as intended, this reduces the five-year projection to around NRS 763 million (GBP 5.87 million).

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<sup>4</sup> Defined as proportionate increase in use of a service when the price of the service falls by one percent.

<sup>5</sup> Rate of complications is assumed to be three times the c-section rate that is suggested by hospital records.

**Table three: summary projections for delivery care financing scheme**

	2005/06	2006/07	2007/08	2008/09	2009/10	Total 5 years
1 Subsidy for women	74,407,500	85,295,369	96,633,681	108,437,151	118,257,232	483,030,933
2 Provider incentive	51,255,600	58,755,708	66,566,103	74,696,922	81,461,484	332,735,817
3 Free delivery	14,188,055	16,264,586	18,426,637	20,677,387	22,549,934	92,106,600
Sub-total services	139,851,155	160,315,664	181,626,421	203,811,460	222,268,651	907,873,351
Sub-total services (GBP)	1,075,778	1,233,197	1,397,126	1,567,780	1,709,759	6,983,641
Excluding children>2	117,528,905	134,727,053	152,636,317	171,280,315	186,791,481	762,964,071
Total (GBP)	904,069	1,036,362	1,174,126	1,317,541	1,436,858	5,868,954
Attended deliveries	22.0%	24.7%	27.3%	30.0%	32.0%	
Management supervision &	2,208,000	1,758,000	1,050,000	1,050,000	1,050,000	7,116,000
In-depth evaluation Dissemination and publicity	13,976,300 1,530,600	- 801,578	13,976,300 908,132	- -	- -	27,952,600 3,240,310
<b>Total</b>	<b>158,166,055</b>	<b>163,145,242</b>	<b>198,160,853</b>	<b>205,461,460</b>	<b>223,918,651</b>	<b>948,852,261</b>
Total (GBP)	1,216,662	1,254,963	1,524,314	1,580,473	1,722,451	7,298,864
Excluding children>2	135,843,805	137,556,631	169,170,749	172,930,315	188,441,481	803,942,981
Total (GBP)	1,044,952	1,058,128	1,301,313	1,330,233	1,449,550	6,184,177
Total (high scenario)	<b>158,166,055</b>	<b>195,804,215</b>	<b>264,941,921</b>	<b>307,367,376</b>	<b>362,836,795</b>	<b>1,289,116,361</b>
Total (GBP)	1,216,662	1,506,186	2,038,015	2,364,364	2,791,052	9,916,280

One final scenario is offered in table three. It is well understood that the current rate of increase in deliveries by trained attendants, will not be sufficient to attain the millennium development goal or indeed targets set in the current Nepalese Development Plan. For these to be achieved a much more rapid increase of more than 7 percent (an extra seven percent of deliveries are attended each year) will be required. If we assume that, through a combination of other interventions, seven percent is achieved then the cost of the scheme over five years would increase to almost than NRS 1.3 billion (GBP 10 million<sup>6</sup>).

<sup>6</sup> Total makes no allowance for excluding women with more than two children.

### **3.2 Administrative, supervision, evaluation and publicity costs**

Estimating a budget for management, supervision and monitoring and publicity is hampered by the fact that many of these components are considered core functions (super-overhead) of DoHS and district health offices and it has proved difficult to separate the budget or to say to what extent additional resources are required for this scheme. The following is a first attempt at constructing an incremental budget for the scheme; this will need to be refined during the start-up phase.

#### *i) Management and supervision*

The mechanism imposes management, administrative and supervision costs at all levels of the system. At the national level there are new activities of formulating the annual budget, informing districts of the scheme and receiving monitoring reports. At the district level DHOs will have an additional workload imposed in ensuring that facilities are informed of the scheme, disseminating reporting formats and administering reimbursement of facilities with the help of district treasuries. It is important to distinguish between regular administration and supervision of the system, relying on the existing structure of supervision and management information from more intensive evaluation that is conducted independently and makes use of a much wider range of data than is available on a regular basis. The latter will be dealt with in the next section.

DoHS has developed a series of reporting forms that will be completed by health workers, compiled by health facilities and submitted to district and national levels. These will provide basic management information that can be used to report on the scheme and help to identify potential problems: for example where take-up of the scheme appears particularly low or where the balance of complicated and normal deliveries appears wrong. A series of reporting formats have been developed to provide the information required for reimbursement and regular monitoring. These are:

- Form 1: List of low HDI districts
- Form 2: List of districts classified as terai, hill and mountainous
- Form 3: 4 monthly reporting by district to DoHS on number of deliveries and distribution of incentives to women in the district.
- Form 4: client completed form to claim incentive from health care institution
- Form 5: monthly reporting by health workers on numbers of home delivery verified by the client, FCHV and head of health institution to form the basis for reimbursement of incentives to practitioners
- Form 6: to be filled in by supervisors when monitoring activity at regional and district level.

Supervision is provided to safe-motherhood programmes both by DoHS, regionally and at district level. Supervision activities will be based upon reporting information obtained from the forms. In particular the regional director and DoHS will use the information submitted on form 6 as way of auditing actual services delivered in selected districts.

An important issue here relates to the extent to which this reporting can be integrated with the standard HMIS, which operates on a monthly basis. This would be highly desirable. SSMP may contract a consultant to carry out an assessment of this issue and what changes might be required in order to permit this integration.

There is a feeling that existing budgets are sufficient to finance regular supervision visits from the national level. In fact there has been some difficulty in using up supervision budgets in recent years because staff are not available or are not able to visit district programmes. It is not thought necessary to provide a separate budget for supervision and monitoring to be assigned to the delivery care financing scheme.

What does appear to be required at the national level, is strong local technical assistance to help the family health division implement the scheme. A particular concern is the method of ensuring that cash is available for women and staff and a clear system for verifying reports received from districts. It is strongly suggested that such assistance be considered part of the management cost of the scheme and provided through financial aid.

At the district level, supervision budgets are arguably not sufficient and additional resources are required. Initially it is suggested to include bi-monthly supervision visits to ensure that facility staff are aware of the new procedures and operating them correctly. Training of facility staff in the new procedures can mostly be managed through the supervision system, although some training of district level staff in the new mechanism is suggested. Some additional allowance for printing and duplication of the new forms will also be required. It is thought that other management activities can be absorbed within the current staffing complement. In fact the main issue of workload relates not to the number of posts but difficulties in filling vacancies, particularly in more remote areas. This in turn is likely to be strongly related to financial and non-financial incentives of taking up such a post and clearly involves wider issues than can be addressed through one sub-programme.

Management and administration costs typically amount to between 3 and 8 percent of the cost of programme. The budget mentioned here is much lower, mainly because much of the administrative cost is actually absorbed into the general government budget. A concern is that, in fact, these administrative functions do not work function well in practice, often because the structure of staff incentives are insufficient to attract and motivate good administrators.

#### ii) Monitoring and evaluation

More intensive evaluation is likely to be required to investigate the impact of the scheme on the health system and on women and households. Such evaluation should go beyond the standard reports to test the veracity of the reporting systems, the impact of household costs and the effect on referral behaviour. Because this evaluation will be relatively intensive it is suggested that it is only undertaken in a sample of districts and at regular (annual) intervals during the first three years of the project.

It is suggested that evaluation should seek to answer six central questions.

7. Is the scheme known about and valued amongst women and health workers?
8. Has funding been allocated and received by facilities, health workers and women (for the individual subsidy)?
9. Has the financing scheme contributed to a change in utilisation, type of services used and mix of home versus institutional care?
10. Has the scheme increased the availability of trained health workers, particularly within the community?
11. What impact has the scheme had on the user costs of delivery?
12. What other barriers might be acting to reduce the impact of the financing scheme (such as supply constraints)?

It will be important to disaggregate the results by ethnic group, poverty level and population living in remote areas to assess to what extent the mechanism has a differential impact on these groups.

One of the core problems with evaluation of this type is attributing causation to the scheme under review. The system will be implemented in all 75 districts that means that it will not be possible to assess the impact on certain districts against matched control areas. It is likely that the evaluation will have to rely on time series comparisons, such as the change in cost to households over time, and also a comparison in the relative intensity of the scheme introduction in different areas. It is suggested that evaluation be undertaken in nine districts, divided between terai, hill and mountain areas.

The lack of baseline data presents something of a problem. The study undertaken by NSMP on costs of delivery provides some baseline data although this is a relatively small-scale study (700 deliveries or which only around 100 were institutional deliveries across seven districts). It may be appropriate to include some or all of the districts included in that study in the evaluation of the new scheme.

Answering the above questions is likely to require the development and use of the following instruments (applied in each district):

1. Survey of recently delivered women	<p>Examining costs of delivery, whether subsidy were received, what payments were made to facilities and practitioners, knowledge of mechanisms and perceived attitudes of providers, where services were obtained including cross-district flows, distance and time travelled to obtain services, views on whether the systems are operating effectively and discussion of other barriers to access.</p> <p>Survey should look at both those delivering in institutions and at home. The latter would include the type of trained health worker or other attendant providing support during delivery. Previous studies have used female health workers in villages to compile a list of women.</p>
2. Facility record survey (all CEOC facilities and sample of BEOC facilities)	Based on facility record extraction examine numbers of delivery by type, numbers of surgical intervention, possible use of skilled attendance index as a proxy for quality.
3. Analysis of funding flows and provider workload (national, regional and district level, all district CEOC facilities and sample of BEOC facilities)	<p>Study of funding disbursed and received at district level, cash-flow blockages and effectiveness of reimbursement mechanism, regularity of other forms of funding</p> <p>Suggests that the survey also looks at any supply constraints, particularly those associated with a lack of capacity.</p>
4. Practitioner survey	Examine to what extent funding is reaching health workers. How long do they have to wait for reimbursement and whether it has affected the number of deliveries they undertake and their willingness to visit underserved remote areas. Also look at the distribution and availability of skilled attendants at facilities and in communities.

It is suggested that this evaluation effort be repeated twice in the same districts during a period of three years. This will allow some monitoring of the development of the scheme in different types of districts and comparison with available baseline indicators.

It seems clear that neither DoHS nor the Ministry of Health itself has the capacity to provide this type of intensive evaluation of programme impact. Indeed it could be argued that an independent evaluation that did not rely mainly upon routine information systems would be more appropriate given widespread distrust of government monitoring mechanisms. It will, therefore, be necessary to contract an agency external to government to undertake this activity.

There are a few agencies in Nepal able to undertake the fieldwork and analysis. One possibility is the National Family Health Programme which is financed by USAID and undertakes work across a range of districts. There may also be a role for the Initiative for Maternal Mortality Programme Assessment (IMMPACT) managed by the University of Aberdeen (Dugald Baird Centre). IMMPACT has developed a series of evaluation instruments that are designed to be used together to assess the effect of safe motherhood programme interventions. In particular, impending work to

evaluate the new 'free delivery' policy in Ghana is extremely close to the mechanism to be used in Nepal and a similar approach to evaluation could be used. IMMPACT works by developing a close working relationship with a national (usually academic) institution and such a partnership offers a way of developing local capacity through the evaluation of the intervention.

A draft estimated budget of at least NRS 13.9 million (GBP 100,000) is likely to be required for each round of the evaluation (details in annex 3). This assumes that the survey instruments can be adapted from other similar evaluations. If it is decided to develop them from scratch then further financial provision may be required.

### *iii) Publicity and dissemination*

The size and uncertainty of financial barriers are an important deterrent to care seeking. The scheme will only function if women and household financial decision makers are aware of the financial subsidies provided in different districts and how to claim them. The following messages must be conveyed:

- All are entitled to the institutional delivery incentive, different rates for different areas
- How to obtain the subsidy
- All providers will receive an incentive for home and facility based delivery
- All additional charges should be transparent and stated before the delivery takes place in the form of a tariff
- Which are the low HDI areas? In these areas no further charge will be made by the facility for normal or complicated delivery?
- Who to complain to if the above are not adhered to

Wide and appropriate nationwide and local publicity will be required to ensure that the scheme is utilised. It is recommended that the equivalent of around 1 percent of the initial service cost of the scheme is set aside to initially publicise the scheme. Suggested methods of communication include:

- Intensive schedule (3 times daily for up to a week), 30-second national broadcasts describing the scheme and how women can benefit. There may also be a possibility of including relevant messages into the health soap opera 'Sumata' that has been produced by JHU (Diane Summers).
- Supplement national with regional broadcasts in local languages
- Production of pamphlets and posters describing the scheme for distribution to health facilities and health workers and women during pregnancy. The Posters would be highly visual with a minimum of words so that the key message can be conveyed to those that cannot read
- National and local newspaper adverts
- Involvement of NGOs in publicising the scheme

There has been some discussion about whether regional workshops should be held for health workers to explain and discuss the scheme. It is felt, however, that there are already too many workshops and more should not be added. It is vital though that health workers at all levels should understand the system. The main modality for providing this information is likely to be the monthly meeting of the facility management committee that is often attended by a district level official.

Although the main effort to publicise the scheme will be required during start-up, it is important that publicity continue in subsequent years to remind women and staff of the benefits available. Some budget will be required for this activity. An allowance equivalent to 0.5% of the total service cost is suggested.

### **3.3 Other costs: investments in supply**

It is important to recognise that the success of the maternal health financing scheme is partly dependent the mitigation of other barriers to accessing service. These include barriers in knowledge about when and where to seek service and supply barriers to delivering effective services. Both these barriers are being addressed through other elements of the safe motherhood strategy. An important concern remains, however, that supply of services, particularly trained health workers at home in remote areas and physical access to CEOC services, remains extremely scarce in many areas of the country. This is particularly true in the 25 low HDI districts. Experience in other countries, for example the prevention of maternal mortality network in West Africa, and also previous studies in Nepal, reinforce the point that demand side measures to boost access only work when the quality and quantity of service supply is also improved (Maine 1997; Hotchkiss, Rous et al. 1998).

The costs of improving supply are complex to compute. There remains substantial excess capacity in many district and zonal hospitals so that the marginal cost of increasing institutional deliveries is relatively low and will probably be covered by the average of NRS 1000 provided that the services actually exist. Financing issues remain around the improvement of blood supplies and other support services necessary to raise the standard of CEOC services. Some work was done on this by the former NSMP project which suggested that it would cost an initial \$0.47 per capita and annualised costs of \$0.2 per capita to provide this necessary infrastructure in underserved areas ((Poudyal 2004) and discussed further in (Ensor 2004)). In addition, further costs of improving information available to communities and in developing further risk-pooling mechanisms were also envisaged.

These are questions that go beyond the current financing scheme, and address problems with the general provision safe motherhood services in Nepal. As such we do not attempt to address these issues further and no allowance is made in the budget presented here. These issues do, however, remain important and will have to be addressed if the safe motherhood targets are to be achieved.

## SECTION 4: NEXT STEPS

The new delivery-care financing scheme is a bold initiative of government. If implemented well it could have a far-reaching impact on reducing the financial barrier to obtaining services. Yet there are substantial logistical and management issues that still confront the scheme. These will need to be overcome soon given the very tight timetable to implement the scheme countrywide for the next financial year.

The earlier text has highlighted some of the core issues that may arise during implementation. Some of these, such as the issue of the lack of incentive for CEOC receiving emergency cases outside the district, might be addressed during modification of the scheme after the first round of evaluation. Others are more fundamental to the initial success and integrity of the scheme and require urgent attention now. The core issues are:

1. **financial management and cash flow** - a satisfactory system for disbursing, and monitoring disbursement, of the cash subsidy to women. Unless women can be confident of receiving the cash subsidy in full immediately after delivery it is hard to see how the system can function. Plans for making cash available in PHCCs and health posts are well advanced. Technical advice to help ensure availability and security of these funds will be required, particularly in remote communities and conflict areas.
2. **strategy for 25 low HDI districts** - a clear strategy for ensuring that both BEOC and CEOC facilities are available in the high-deprivation areas where free delivery is being introduced. Ensuring supply of services in these areas represents a major challenge and the government should perhaps consider modifying the criteria to include fewer districts without access to these facilities or even staggering the introduction of free delivery to these districts. SSMP will assist FHD in undertaking a rapid appraisal of the 25 districts. It is suggested that they are categorised into at least three groups :
  - o those with CEOC facilities
  - o those where good referral links already exist to other districts
  - o those districts where there are neither CEOC facilities nor realistic (timely) referral to other districts

The appraisal should indicate what support will be required for each type of district to strengthen service supply. Where CEOC facilities in other districts are identified, it should also indicate where these facilities are adequate given the increase in utilisation and, where not, what type of assistance will be required to bring them up to the required standard and capacity.

3. **certifying qualifying facilities** - a process is required to certify the facilities eligible to be reimbursed under the 'free delivery' scheme in deprived areas; both women and health workers need to be aware of which facilities qualify
4. **dissemination of the scheme** - and a strategy for publicising the scheme to health staff and particularly women and their families is required; a variety of different methods should be used to ensure that most of the country is informed of the scheme and how to access benefits
5. **complaints procedure** - a complaints procedure, that is seen as independent of the health sector, for women who feel that they have not received the benefits to which they are entitled
6. **supervising and training** - a strategy for supervising the scheme on a routine basis, including training facility managers, is required quickly so that the scheme can operate effectively during the next financial year.
7. **intensive evaluation** - a programme of in-depth and independent evaluation must be put in place that will track the impact of the scheme in different areas and help the government to make modifications to the system where required.

Some district discretion remains in the scheme. This includes what the NRS 1,000 for health facilities in poor areas can be used for and what additional charges will have to be met by women

at home (and tariffs for these services). There is no reason why the scheme should not develop slightly differently in areas responding to local characteristics, needs and norms. It will be important, however, to monitor these variations during evaluation to understand the effect of local variations on service access.

This paper has also highlighted a number of wider, systemic issues that could effect the operation of the scheme but which can only be addressed through health sector and public sector action. These include:

- Issues of incentives to health workers to manage and account for cash-budgets in health services at the periphery
- Lack of supervision provided to district level services
- Problems in attracting, retaining and motivating good administrative and clinical staff particularly at the periphery
- The integrity of the public health sector information and reporting system
- The availability of good quality CEOC and BEOC services in districts in which the scheme is implemented – demand interventions may not be matched by adequate supply of services

There remains considerable work to be done in designing the scheme and preparing for implementation. Some local technical assistance in the areas of local government budgeting and financial information systems to FHD is strongly recommended at this stage to help ensure that the scheme is able to function in an effective way. SSMP has also proposed hiring a consultant to advise on the integration of the reporting mechanism into the regular MIS. The objectives of this assistance include:

- Assess the suitability of management and financial systems at district and below district level
- Advise districts on implementation of the new system taking into account local circumstances
- Assist in developing and monitoring guidelines for management and monitoring
- Help integrate the new reporting formats used into the regular MIS
- Develop and monitor a training plan for the new system.

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**ANNEX ONE: DETAILED DISTRICT-WISE BUDGET FOR DELIVERY FINANCING SCHEME**

{This table was supplied by Dr Ganga as hardcopy only}

Source: Department of Health Services

## ANNEX TWO: PROJECTED BUDGET FOR FINANCING SCHEME FOR DELIVERIES

### A2.1: projections of attended deliveries and service cost of scheme

		2005/06	2006/07	2007/08	2008/09	2009/10
		Population structure				
	National	25,886,731	26,466,594	27,059,445	27,665,577	28,285,286
	Mountain	1,856,922	1,898,517	1,941,044	1,984,523	2,028,977
	Hill	11,395,129	11,650,380	11,911,348	12,178,163	12,450,953
	Terai	12,634,680	12,917,697	13,207,053	13,502,891	13,805,356
	Population growth	2.24%	2.24%	2.24%	2.24%	2.24%
	CBR	30	30	30	30	30
	Expected pregnancies	776,602	793,998	811,783	829,967	848,559
	Expected births	698,942	714,598	730,605	746,971	763,703
		Attended deliveries				
300	Attended deliveries	170,852	195,852	221,887	248,990	271,538
55%	Institutional deliveries	93,969	107,719	122,038	136,944	149,346
1,500	Mountain	6,741	7,727	8,755	9,824	10,714
1,000	Mountain (low HDI)	6,741	7,727	8,755	9,824	10,714
1,000	Hill	41,364	47,417	53,720	60,281	65,741
1,000	Hill (low HDI)	7,447	8,537	9,672	10,853	11,836
500	Terai	45,864	52,575	59,564	66,840	72,893
45%	Home deliveries	76,883	88,134	99,849	112,045	122,192
	Mountain	5,515	6,322	7,162	8,037	8,765
	Hill	33,844	38,796	43,954	49,322	53,789
	Terai	37,525	43,016	48,734	54,687	59,639
		Growth assumptions				
	Attended deliveries	22%	25%	27%	30%	32%
	Natural rate of increase	2%	2%	2%	2%	2%
	Increase above natural		0.67%	0.67%	0.67%	
		Service delivery budget projections				
	Incentive	74,407,500	85,295,369	96,633,681	108,437,151	118,257,232
	Provider incentive	51,255,600	58,755,708	66,566,103	74,696,922	81,461,484
	Free delivery	14,188,055	16,264,586	18,426,637	20,677,387	22,549,934
	<b>Total</b>	<b>139,851,155</b>	<b>160,315,664</b>	<b>181,626,421</b>	<b>203,811,460</b>	<b>222,268,651</b>

**A2.2: Five year budget for service, management, M & E and publicity**

	Unit type	Unit cost	Year one		Year two		Year three		Year Four		Year five	
			Units	NRS	Units	NRS	Units	NRS	Units	NRS	Units	NRS
1 Service delivery												
Incentive				74,407,500		85,295,369		96,633,681		108,437,151		118,257,232
Provider incentive				51,255,600		58,755,708		66,566,103		74,696,922		81,461,484
Free delivery				14,188,055		16,264,586		18,426,637		20,677,387		22,549,934
<b>Total service delivery</b>				139,851,155		160,315,664		181,626,421	-	203,811,460	-	222,268,651
				88.4%		98.3%		91.7%		99.2%		99.3%
2 Management & supervision												
District level supervision	Bi-monthly supervision	12000	75	900,000	75	900,000	75	900,000	75	900,000	75	900,000
District level training	half day training for up to 30 district staff	6000	75	450,000								
National level supervision												
Reproduction of service report forms	District level	10,000	75	750,000	75	750,000	75	750,000	75	750,000	75	750,000
Assistance to Dr Ganga (finance, admin, M & E)	Local TA, per month, national level	55000	12	660,000	6	330,000		-		-		-
Communications	National level	4000	12	48,000	12	48,000		-		-		-
<b>Sub-total management</b>				2,808,000		2,028,000		1,650,000	150	1,650,000	150	1,650,000
				1.8%		1.2%		0.8%		0.8%		0.7%
3 Monitoring and evaluation												
Survey of recently delivered women	200 women per district, Per district	464,556	9	4,181,000		-	9	4,181,000				
Facility record survey	Referral hospital + 8 BEOC facilities, Per district	164,222	9	1,478,000		-	9	1,478,000				
Analysis of funding flows	MOH, DHS, DHO, referral hospital, Per district	152,444	9	1,372,000		-	9	1,372,000				
Practitioner survey	40 practitioners per district	173,556	9	1,562,000		-	9	1,562,000				
Overall survey coordination		5,383,300	1	5,383,300		-	1	5,383,300				
<b>Sub-total in-depth evaluation</b>				13,976,300		-		13,976,300	-	-	-	-
				8.8%		0.0%		7.1%		0.0%		0.0%
4 Dissemination & information												
Radio broadcasts	Per broadcast (peak time)	7,000	21	147,000		0						
Regional radio broadcasts	Per broadcast (peak time)	1,600	21	33,600		0						
Production of pamphlets	Per leaflet	0.5	500000	250,000		0						
Posters etc				100,000								
Newspaper adverts	Per advert	20000	10	200,000		0						
Other dissemination				800,000		801,578		908,132				
<b>Sub-total dissemination</b>				1,530,600		801,578		908,132	-	-		-
				1.0%		0.5%		0.5%		0.0%		0.0%
<b>Total (NRS)</b>				158,166,055	-	163,145,242	-	198,160,853		205,461,460		223,918,651
<b>Total (GBP)</b>				1,216,662		1,254,963		1,524,314		1,580,473		1,722,451

ANNEX THREE: DRAFT BUDGET FOR EVALUATION<sup>7</sup>

Unit type		Unit cost	Units	Cost
<b>International budget (GBP)</b>				
<b>International TA</b>	<b>Per day</b>	500	30	15,000
<b>Local TA</b>	<b>national level experts, per day</b>	150	60	9,000
<b>Flights</b>		2000	4	8,000
<b>Per diems</b>		70	40	2,800
<b>Miscellaneous</b>				6,610
<b>Sub-total (GBP)</b>				41,410
<b>1 Survey of recently delivered women</b>				
Overhead				
Translation	Translation of 30 page questionnaire	4000	6	24,000
Data entry	formats for data entry + entry	80000	1	80,000
<b>Sub-total</b>				104,000
Per district				
Supplies				20,000
Interviewers	Number of days, 2 questionnaires per day, 20% extra for training	2000	120	240,000
Supervisors	Number of days, 1 per district supervising 5 interviewers	4000	25	100,000
Travel		5000	4	30,000
Training of interviewers	3 day training workshop	9000	7	63,000
				-
<b>Sub-total (per district)</b>				453,000
<b>Sub-total (9 districts)</b>				4,181,000
<b>2 Facility record survey</b>				
Overhead				
Translation	Translation of 20 page questionnaire	4000	5	20,000
Data entry	questionnaires, 8 per day	2000	45	90,000
<b>Sub-total</b>				110,000
Per district				
Supplies	Questionnaire printing			20,000
Interviewers	Number of days, 2 days per facility, 10 facilities, 20% extra for training	2000	24	48,000
Supervisors	Number of days, 1 per district supervising 4 interviewers	4000	8	32,000
Travel		5000	18	10,000
Training of interviewers	2 day training workshop	6000	7	42,000
				-
<b>Sub-total (per district)</b>				152,000
<b>Sub-total (9 districts)</b>				1,478,000
<b>3 Analysis of funding flows</b>				
<b>Interviews</b>	<b>Interviews at DoHS, 9 district offices, 9 district CG offices</b>			-
	<b>2 Local consultants undertake, 10 facilities per district</b>	8000	140	1,120,000
	<b>Travel - 9 districts, interviewers</b>	7000	18	126,000
	<b>per diems, 14 days per district</b>	1000	126	126,000
<b>Sub-total</b>				1,372,000
<b>4 Practitioner survey</b>				
Overhead				
Translation	Translation of 20 page questionnaire	8000	4	32,000
Data entry	360 questionnaires, 8 per day	2000	45	90,000
<b>Sub-total</b>				122,000
Per district				
Supplies				20,000
Interviewers	Number of days, 2 questionnaires per day, 20% extra for training	2000	24	48,000
Supervisors	Number of days, 1 per district supervising 4 interviewers	4000	5	20,000
Travel		5000	9	30,000
Training of interviewers	2 day training workshop	6000	7	42,000
				-
<b>Sub-total (per district)</b>				160,000
<b>Sub-total (9 districts)</b>				1,562,000
<b>GRAND TOTAL (9 districts) NRS</b>				13,976,300
<b>GRAND TOTAL (9 districts) GBP</b>				107,510

<sup>7</sup> Very tentative, will require substantial revision