SSMP/NEPAL
Support to the Safe Motherhood Programme

SUPPORT TO SAFE MOTHERHOOD PROGRAMME, NEPAL

The Financial Assessment of Maternity Incentives Scheme

By
Organisation Development Centre (ODC)

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EXECUTIVE SUMMARY

The DFID-supported Support to Safe Motherhood Programme (SSMP) supports Government of Nepal's National Safe Motherhood Programme (NSMP) by contributing to improved maternal & neonatal health. This support includes among others, inputs to enable the Family Health Division (FHD) to develop/review the long term National SM plan. The FHD has the responsibility to plan, manage, monitor and review maternity incentives scheme. The high financial cost of delivery is an important barrier to accessing skilled attendance in Nepal. To help mitigate this barrier Government of Nepal has decided to implement a strategy to provide financial assistance through maternity incentives scheme to women seeking skilled delivery care, skilled birth attendants. The scheme also provides subsidy to health institutions on the basis of deliveries conducted.

This financial assessment of the maternity incentive scheme has been carried out to assess financial records, reports and expenditure of the cost-sharing scheme and provide recommendations for improvements for the financial management of the scheme. Various health facilities in five different districts (Saptari, Rasuwa, Baglung, Kailali and Surkhet) throughout Nepal were visited for the study. During the field visits, interviews were carried out with a sample of health workers and also with beneficiary women for verification of the selected financial records. Assessment of the fund flow and disbursement mechanisms and reimbursement system was also conducted. The key findings of the assessment have been summarised below:

- There has been tremendous gratitude shown by the mothers who have received payment as per the maternity scheme. The staff members of the health facilities who have received the incentive also expressed their satisfaction and suggested that this scheme should be continued as this scheme directly benefits the mothers and also provides motivation for them to promote institutional delivery in their communities.

- The delay in flow of funds have the following implications:

    a. If the payment is not made immediately after the delivery, it decreases the potential value of the benefit for the target beneficiaries.

    b. Due to lack of funds to be disbursed to beneficiaries, the efforts for publicity, awareness building and promotion of the scheme have been significantly limited by health facilities.

    c. Once the funds are released, the service providers have received their share of the incentives, however, a large majority of the eligible beneficiaries (in most cases less than 50%) have not been receiving the incentive money due to various reasons.

    d. Some have not come as they were not informed.

    e. Those that did receive information and did not come to collect the money did so due to reasons such as cost of transportation, health reasons or lack of time. Some did not go due to lack of confidence that the money will be paid.

    f. Due to the delays in funds, when the funds become available, the payment due to the beneficiaries is higher than the funds available – creating challenges for the service providers in publicity and informing the beneficiaries.

- The consultants observed that there is less potential for fraud at the district hospitals than in PHCC and HPs. This is because the hospitals have relatively well established systems and clear documentation of the processes involved.

- In PHCCs and HPs, the possibility of fraud is mainly due to lack of monitoring. Some of the main concerns include, lack of proper documentation and falsification of documents to claim reimbursement by the service provider.

- There is a lack of clarity and understanding of the guidelines for the scheme. Many of the definitions are not clear and are often interpreted differently by different institutions, thus making the implementation of the scheme inconsistent. This gives room for error by lack of understanding of the guidelines.

- The consultants also felt the need to orient the health service providers on the scheme: why it has been implemented and what are its objectives? There also needs to be clear and more uniform understanding of the guidelines for the scheme.

- The consultants felt that the effect of conflict has actually increased the level of transparency in the operations of the scheme. This is because due to the conflict, many of the rural health facilities have started practices of public audits and sharing of financial information with the community in order to enhance transparency of their operations and to remain in operations.

RECOMMENDATIONS

- The consultants feel that the maternity incentive scheme needs to continue in order to motivate and support women in visiting a health care centre for deliveries.

- However, there needs to be greater effort in promoting the scheme to ensure that the intended beneficiaries are aware of the scheme to have the desired impact.

- The delay in the funds needs to be managed and minimised in order to make the scheme more effective. In addition there is an urgent need of monitoring and guidance team to support the implementation of the scheme effectively. The consultants recommend that a four person team be established for this purpose with 2 individuals from the government and 2 from SSMP in the form of technical assistance.

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LIST OF ANNEX

ABBREVIATIONS

AHWs	Auxiliary Health Workers
BCC	Behaviour Change Communication
DFID	Department for International Development
DPHO	District Public Health Office
FHD	Family Health Division
GoN	Government of Nepal
HDI	Human Development Index
HP	Health Posts
LMD	Logistics Management Division
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MoHP	Ministry of Health and Population
NHEICC	National Health Education Information and Communication Centre
NHTC	National Health Training Centre
PHCC	Primary Health Care Centres
PRSP	Poverty Reduction Strategy Paper
SBA	Skilled Birth Attendants
SHP	Sub Health Posts
SMP	Safe Motherhood Programme
SSMP	Support to Safe Motherhood Programme

1. BACKGROUND

The National Safe Motherhood Programme (NSMP) is a priority within Government of Nepal's (GoN) Nepal Health Sector Strategy which works towards meeting the Tenth 5-year Plan/Poverty Reduction Strategy Paper (PRSP) and the health sector targets set out in the Millennium Development Goals (MDG). The target for maternal health is to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. The framework for implementation of the SMP is the National Safe Motherhood Plan 2002-2017; the goal of which is, "maternal and neonatal health improved" and the purpose is, "sustained increase in utilisation of quality maternal health services".

The DFID-supported Support to Safe Motherhood Programme (SSMP) supports GoN's National Safe Motherhood Programme (NSMP) by contributing to improved maternal & neonatal health. SSMP support for improved maternal and newborn health (MNH) includes inputs to enable the Family Health Division (FHD) to develop/review the long term National SM plan, strategies, the Logistics Management Division (LMD) to ensure drugs & supplies, the National Health Training Centre (NHTC)/Ministry of Health (MoH) to manage human resource development, the National Health Education Information and Communication Centre (NHEICC) to manage Behaviour Change Communication (BCC) activities; and the Management Division to upgrade infrastructure towards ensuring effective delivery of MNH essential service packages.

The FHD has the responsibility to plan, manage, monitor and review maternity incentives scheme. A working committee has been formed at FHD to discuss on the policy and implementation related issues.

1.1 A Brief Summary of the Maternity Incentive Scheme

The high financial cost of delivery is an important barrier to accessing skilled attendance in Nepal. To help mitigate this barrier Government of Nepal has decided to implement a strategy to provide financial assistance through maternity incentives scheme to women seeking skilled delivery care, skilled birth attendants. The scheme also provides subsidy to health institutions on the basis of deliveries conducted.

The overarching goal of this cost-sharing scheme is to reduce maternal mortality and morbidity, in line with the Millennium Development Goals (MDG) and Poverty Reduction Strategy Paper (PRSP). The objectives of the scheme are to increase access to safe delivery services and promote the use of Skilled Birth Attendants (SBA) through providing incentives to the mother, to the Skilled Birth Attendants (SBAs) and to health facilities. The scheme contributes to poverty reduction efforts by reducing household costs and preventing deaths and disabilities, which also add to the financial burdens of households.

The scheme provides the following financial benefits:

- Transport allowance to women – women, with up to two living children, delivering at eligible district hospitals, primary health care centres or health posts receive a fixed sum of 1,500 NRs in mountain areas, 1,000 NRs in hill areas, and 500 NRs in the terai to cover transport and other costs. In cases of obstetric complications, these amounts are payable irrespective of parity.

- Financial incentives to health workers – the 'skilled birth attendant' – medical doctor,

auxiliary nurse midwife, health assistant, or maternal and child health worker – and her/his team receive an incentive of 300 NRs for each delivery they assist, either at a public facility or at the woman's home. This is payable regardless of the woman's parity.

- Free delivery care to women – in the 25 districts with the lowest Human Development Index (HDI) value, free delivery care is provided at public health institutions for both normal and complicated cases in addition to the cash payment to women. Health facilities in these districts as well as facilities from outside receiving referral cases are reimbursed 1,000 NRs per delivery for all types of delivery to recover their costs. It is expected that the money will be used to improve quality of care and contribute to renovations in the facility.

The scheme has been initiated in 33 districts in the first trimester and 42 in the last trimester of the fiscal year 2062/2063 (2006). The scheme is waiting for external assessment in order to refine and promote the scheme.

1.2 Rationale for Financial Assessment

The rationale for the proposed financial assessments was as follows:

- Delay in fund flow may have implications in payment arrangement and expenditure and why and how do delays occur in fund flow. Assessment of expenditure as per the guidelines, financial rules and regulations is deemed necessary

- There is growing concern of policy makers and donors on the right use of funds. It is necessary to see whether the eligible beneficiaries received payment in time and if funds were properly accounted for is the common concern of all stakeholders.

- Maternity incentives scheme has the provision of cash transfer, it has the risk of misuse of funds because cash transfer has inherent fiduciary risks. There is the risk of loss from error or fraud through cash transfer of the maternity incentives scheme.

1.3 Objective of the financial assessment

The aim of the financial assessment is to assess financial records, reports and expenditure of the cost-sharing scheme and provide recommendations for improvements for the financial management of the scheme.

The specific objectives of the assessment are:

- To assess the financial records, reports and expenditures of maternity incentives scheme.
- To assess the delay in fund flow and its implication in the payments arrangement and expenditure.
- To assess the risks of loss from error or fraud in fund management
- To verify the financial records with the selected clients in the community

1.4 Methodology

The assessment was conducted by a team of two consultants assisted by a research associate. The process of the assessment included the following activities:

- Literature review
- Assessment of forms, financial records and reports
- Assessment of additional supporting/verifying documents
- Field visits to five districts: interviews were carried out with a sample of health workers and recipients (women) for verification of the selected financial records and forms
- Assessment of the fund flow and disbursement mechanisms and reimbursement system was also conducted

1.5 Scope of the field work

The team first visited Saptari district of Eastern region for piloting of the assessment. Then the consultants split and each covered two districts; Surkhet and Kailali in Mid and Far West and Rasuwa and Baglung in Central and Western regions.

Initial consultations were held with the advisors of SSMP who had carried out initial survey during their monitoring visits to district health facilities for clarifying the Terms of Reference and expectations of SSMP. The advisors provided list of literature relevant to the study. The advisors has also provided insights on existing situation of the incentive scheme in the districts they visited and also the difficulties the team may face.

In the districts, the District Hospitals including the District Public Health Office (DPHO) were visited. In these, the Superintendent/District Public Health Officer, Heads and nurses of the gynaecological department and finance and administration staff were interviewed. Similarly, in the Primary Health Care Centres (PHCC) visited, the facility head, nurses, health assistants and finance/administration personnel were interviewed. A sample of Health Posts (HP) and Sub-Health Posts (SHP) operating under the DPHO visited were also visited. A total of 64 people were interviewed in 3 Hospitals (District and Zonal), 5 District Public Health Office, 5 PHCC, 3 HP/SHP including 1 District Treasury Controller Office.

In order to conduct interviews with the recipient mothers of the maternity scheme, interviews were arranged at the hospitals. In the case of those who had received services at HP/SHP level, the recipients were contacted at their contact addresses as provided in the records. All together 17 beneficiaries were interviewed. 6 other relevant stakeholder were also interviewed to get additional inputs and validate information.

(Refer to Annex 1 for ToR for Financial Assessment, Annex 2 for Institutions Visited and Respondent Details, Annex 3 for List of Beneficiaries Interviewed, Annex 4 for List of Service Provider Interviewed and Annex 5 for List of Stakeholder Interviewed)

2. FINDINGS

2.1 Contextual Assessment

Nepal has been engulfed in conflict since 1996. During the last few years political instability and violent conflict have had a significant impact on the economy and social activity: young men and women flee from their villages to towns, mobility of people across Nepal were restricted- government employees were not able to visit to rural areas for supporting and monitoring service facilities, schools and health-posts in the rural areas were almost non-operational, and economic activities in inner terai and rural villages of hills were almost halted. In addition, there were no elected representatives in the local authorities both in DDC's and VDC's since 2001. In this context of violent conflict and political instability, there were fewer people visiting health-post or other health facilities in the rural areas and outside towns and districts centres of terai. There were almost no supervision and monitoring visit to these health facilities, even though it was said that these facilities were in operation. It was also difficult to verify and certify beneficiaries and their entitlement as per the criteria developed for maternity scheme. Although this requirement of certification can be a hassle for the beneficiary in receiving the benefits of the scheme, it can be useful in minimising possible fraud or misappropriation of funds from the service provider side.

However, after the reinstatement of parliament on April 24, 2006 and the ceasefire declared by the state and CPN Maoist (rebel), the socio-political situation has improved dramatically. It has drastically checked the political and civil rights violations and as the nation enters into peace building process: there is almost no barriers to movement, people are returning to their villages and economic activities are starting to pick up. As a result, there is an increased inflow of clients in the health facilities in the two districts visited (Saptari and Kailali).

2.2 Benefit to the Mothers and Service Providers

- There has been tremendous gratitude shown by the mothers who have received payment as per the maternity scheme. They were delighted to receive such a payment directly especially those mothers from rural villages and poor families and stated that they have used the money for the nourishment of their baby. As one mother (Mrs. Krishna Sawat, age 18 of Tikapur Municipality, Dhangadhi District) told the consultants that they do not have any money in their disposal for the welfare of her baby.

- The staff members of the health facilities who have received the incentive also expressed their satisfaction and suggested that this scheme should be continued as this scheme directly benefits the mothers and also provides motivation for them to promote institutional delivery in their communities.

2.3 Fund Flow System

- There was delay in sending the request for release of funding by the MoHP to DFID, and consequently the funds were available only at the end of the fiscal year 2062/2063 (2006).

- It takes more than three months to collect all the information related to the maternity scheme from all the districts including details of expenditure to be submitted to the Comptroller Generals Office by DoH for final verification of actual expenditure verses budget, as there are few individuals specifically looking after this matter in the MoHP. MoHP has not been able to furnish accurate details of expenditure for the last fiscal year 2062/063 to DFID even after

four months of the fiscal year ended. As a result, DFID have not deposited money for this year as per the request in the account for government to use for this fiscal year 2063/064 (2006/07).

- Due to lack of funds, the government agencies (Office of Comptroller General of Finance) are unable to authorise district offices (DHO/DPHO) to spend funds on maternity scheme for this fiscal year as per the approved budget, after first quarter of the fiscal year has already been completed. As a result, the district health offices and health facilities have not been able to pay to the mothers as per the maternity scheme.

- The forms and formats used for the use of funds are appropriate, but some districts did not have sufficient numbers for distribution. However, there is a need for a standardised receipt form/voucher (to be signed by beneficiaries both mothers and service providers) to be developed and distributed.

2.4 Delay in Flow of Funds

- There has been delay in the flow of funds to the health facilities, affecting the efficacy of the scheme. The delay is due to the gap in the timing of the approval and release of fund. The funds for the fiscal year 2062/63 were only released towards the end of the year, two months before the fiscal year end. However, the fund was approved in November/December of the previous year.

- For the current fiscal year starting in Shrawan (June/July), the budget has already been approved by the government and the concerned Department of the Ministry of Health. The letter of approval was issued in Bhadra end (July/August). However, the letter for fund release has not arrived at the District Health Office (DHO/DPHO). Hence the first quarter instalment for the current fiscal year has not been received.

Implications of the Delay

- Availability of cash and timing of the payment are crucial factors for the effectiveness of the scheme. Lack of cash to pay for the medicine and other costs involved in delivery is a big deterrent for women to go to the hospital as the patients are required to pay for the medicines immediately. The other preferred alternative is to go to a private clinic where they can get the necessary service and medicine on deferred payments. Hence, the payment made by the scheme is a significant incentive for patients as for many, it helps in covering the cost of medicine (if not transport). Therefore, if the payment is not made immediately after the delivery, it decreases the potential value of the benefit for the target beneficiaries.

- Since there was no cash available to be disbursed to the qualified women immediately after the delivery as required by the scheme, the efforts for publicity, awareness building and promotion of the scheme were significantly limited by such institutions.

- In some of the health facilities, the eligible women were asked to sign the forms to receive the payments although cash payments were not made immediately. When the funds were released, few notified the public through print media, newspapers. However, some of the institutions did not make such public announcements. This pattern raises several concerns:

    - The service providers have been receiving their share of the incentives through reimbursements but the women, who are the primary targets of this benefit scheme, have not received the money. For example, at the Saptari zonal hospital, in the FY

2062/2063, a total of 1375 deliveries were made at the hospital where the women were eligible for the payments. The total released budget was NRs. 915,000 of which only NRs. 605,500 was expended. Of that amount only NRs. 196,000 (32% of total expended) was disbursed to the women. At the rate of Rs. 500 each, this amount was paid to only 392 beneficiary mothers (28% of total delivery). Either they did not have information or even if they had information, they may have difficulties to come to health facilities to receive the payment (those mothers may have difficulty to travel because of their health conditions or the cost of travel is bigger than what they could receive in payment) Whereas a larger portion, 68 % was paid to the SBA. The provider incentive payment of Rs. 409,500 covers a total of 1365 individuals which means almost all of the SBAs received their incentive. For more information on incentive receipts between beneficiaries and service providers refer to Annex 6 and Annex 7.

- In all the districts visited, for the total forms that have been signed by the women, only around 50% have come to collect the payments. Those that have come to collect were mostly informed through the health networks they were associated with.

- This also raises some serious concerns regarding transparency as all the beneficiaries are not informed – only those that have the proper channels or networks get information and thus the access to the payments.

- Some of those that did receive information, however, did not come to collect the payments due to the following reasons:

  - The cost of transportation to come and collect the payment – in some cases, is as much as or even more than the payment received.

  - The scheme requires the mothers themselves to be present for cash receipts; the travel required is not possible for the mothers, especially for those in the hills due to physical reasons or sometimes they simply cannot afford the time.

- The delays in the funds and inability of the facilities to make the payments immediately after delivery although the women sign the forms, has lead to lack of confidence in the scheme. Many women, even after being informed about the payments, do not bother to go as they are not sure if the payments will actually be paid to them.

- The payment forms pile up without any payments being made. By the time the funds are available, the amount of payment due is much higher than the allocated budget. Hence, the providers are unable to make payments to all the beneficiaries that have signed the forms. This has raised concerns among the general public with negative publicity about the scheme coupled with allegations that the doctors and health facilities have taken the money instead. This further discourages the health facilities to conduct any publicity or promotion of the scheme when the funds become available. In some cases, and where possible, the facilities have taken cash advances from the hospital board to make the payments on time to the women. This helps to maintain the credibility of the scheme to some extent. However, for those who are not able to do so, lack of funds has become a real challenge in promoting the scheme.

- Finally, due to budgetary constraints, the total fund that has been channelled to Government of Nepal from DFID is less than the originally budgeted amount, which has also created problems in making the necessary payment to the qualified women.

2.5 Risk of Loss from Fraud or Error

- The consultants observed that there is less potential for fraud at the district hospitals than in PHCC and HPs. This is because the hospitals have relatively well established systems and clear documentation of the processes involved. Also, the staff that receive the signed forms and prepare documents are different than those that actually disburse the payments to the women. A sample of women whose documents existed indicating payments of cash were randomly selected and questioned; all of whom confirmed that they did receive the payments.

- In the case of PHCCs, the ones that were operating in full scale like a hospital have clear protocols and documentations. The patient inflow and cases taken support the documentation; indicating less likelihood of any misappropriation of funds or fraud involved. However, at some of the PHCCs in rural areas, all the documents supporting payments made to the beneficiaries existed, but the authenticity of those documents is questionable based on the following observations:

    - Many of the documents showed an increase in the number of patients, with corresponding records showing similar increases in the payments made out to the women. This shows the positive impact of the scheme. However, in some of the health facilities, the trend of sharp increase in patients is much higher than the trend of ANC visits of patients. This sharp increasing trend is questionable given the demographics and limited population of the locality (PHCC in Surkhet) of the health facility – the low increase in population in the area could not create such an increase in the patient inflow.

    - In one of the PHCCs in Saptari district and one in Kailali district, the consultants found that some of the patients that were documented as beneficiaries of the scheme were non-existent when crosschecks were made.

    - Also due to the remoteness of the PHCCs, it was found that no monitoring was done of the facility by the DHO/DPHO. Lack of monitoring further increases the possibility of misappropriation of funds.

- In the case of HPs in rural areas, the supporting documents were not sufficient to verify that the amounts indicated had actually been disbursed to the beneficiaries. In a visit made in Kailali district at the HP, the documentation was complete. However, further exploration revealed that some of the women in the list as beneficiaries in fact had not had delivery at the health facility. The women had visited the HP for antenatal checkups, however, due to various reasons, the women had had their delivery at the local private health facility. In some cases, the private health facility was owned and run by the staff at the HP.

- The monitoring mechanisms and means of verifications are much weaker in HPs in comparison to district hospitals and it is even weaker when it comes to checking the records or documents related to deliveries made by SBAs outside health facilities, i.e. deliveries at home. In many cases, there are no documents at all.

- There is a lack of clarity and understanding of the guidelines for the scheme. Many of the definitions are not clear and are often interpreted differently by different institutions, thus making the implementation of the scheme inconsistent. This gives room for error by lack of understanding of the guidelines.

    - The term “complications” has not been well defined – making it difficult for health workers to classify cases and determine which women qualify for benefits and which

would not. Hence, the service providers often rely on their own understanding – leading to inconsistent implementation of the scheme. However, recently Department of Health has issued a letter defining criteria for "complications".

- The SBAs assisting in deliveries at home are not clear if they qualify for the incentives if the women they have assisted in delivery do not qualify for the payments. In such cases, the SBAs have applied for their payment. However, the DHO makes their interpretation of the guidelines and the claims are processed accordingly. This poses as a source of conflict between the SBAs and the DHO staff processing the claims.

- Another issue is the status of Auxiliary Health Workers (AHWs) who also often are required to assist in deliveries. According to the guidelines the AHWs are not recognised as SBAs, hence they do not qualify for the incentives for assisting in birth delivery. It was found that some of the AHWs then partner with a SBA (although they are not present at the delivery) to make the claims for the service provider incentive. Recently DoH has also defined the "team" of service delivery.

- Regarding the monetary incentives to the provider side, the disbursement of the money varies from hospital to hospital according to the hospital's own guidelines. In most hospitals and PHCCs, it was found that how the money was to be shared was decided by the management committee. The general mechanism involved that the nurse who assisted the delivery would claim the Rs. 300. But when the reimbursement was made, the money was shared with a group of other staff members which included the doctors, other nurses working in the same department and other staff including the accountants and administration staffs. The main issue of grievance in sharing the incentive money for some is the fact that the money has to be shared with doctors of the health facility (in most cases who also head the facility) although they had no role or contribution in the delivery process. In HPs there were no such formal guidelines as to how the money would be shared. In practice it was found that the money sharing mechanisms were based on the patterns of authority and power in the facility, whoever wielded the most power received the highest share, sometimes even regardless of the formal authority. It was found that the incentive money was also shared with the administration staff at the DPHO.

Issues in Verification of Required Documents

- With the documents submitted by the service providers, there are no certification documents (except for the forms of receipts signed by the women, which can easily be fabricated). The forms and documents are designed to be monitored by the local government authorities, however, due to absence of local government in most areas, no monitoring has been done and the documents either are not verified or are not certified as required.

- On the beneficiary side, it has been challenging to verify whether the beneficiary has already had two children or not. This is also sometimes simply due to limitations in communication skills of the service providers as they may not be proficient in local languages or aware of the local colloquial terms. There are no supporting documents required to verify what is told by the beneficiary themselves. Some of the means of verifying used include:

    - If it is at a HP or a SHP, and the woman is from the local area, usually the service provider would be able to verify through their own networks or by simply asking around.
    - Sometimes service providers have verified the number of children the woman has had from age for women aged 18 or below. For those above this age, it is difficult to do so.

3. CONCLUSIONS

- The maternity incentive mechanism has directly benefited the mothers and has helped promote institutional delivery.

- The incentive amount provided to the beneficiaries does make a difference in their choice to visit a health facility for delivery by a SBA. However, due to lack of confidence that payments will be made and inconsistencies in the implementation of the scheme, there are women who are not taking the benefit of the scheme.

- There has not been full scale promotion of the scheme by the health facilities in the district as they were not fully assured of the availability of funds due to delays in fund flow.

- There are appropriate forms and formats available but need to develop standardised receipt form.

- There is a possibility of fraud and misappropriation of funds in HP/SHPs as there is no check and balance system due to absence of local authorities.

- The consultants also felt the need to orient the health service providers on the scheme: why it has been implemented and what are its objectives? There also needs to be clear and more uniform understanding of the guidelines for the scheme.

- The consultants felt that the effect of conflict has actually increased the level of transparency in the operations of the scheme. This is because due to the conflict, many of the rural health facilities have started practices of public audits and sharing of financial information with the community in order to enhance transparency of their operations and to remain in operations.

4. RECOMMENDATIONS

- The consultants feel that the maternity incentive scheme needs to continue in order to motivate and support women in visiting a health care centre for deliveries.

- However, there needs to be greater effort in promoting the scheme to ensure that the intended beneficiaries are aware of the scheme to have the desired impact.

- The delay in the funds needs to be managed and minimised in order to make the scheme more effective. In addition there is an urgent need of monitoring and guidance team to support the implementation of the scheme effectively. The consultants recommend that a four person team be established for this purpose with 2 individuals from the government and 2 from SSMP in the form of technical assistance.

ANNEX