DFID Department for International Development

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Case Study

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**This is one of a series of notes on how the use of good statistics has made a difference to policy making.**

# Costs of seeking assistance during child birth – magnitude and household impact in Nepal

## Summary

There has been considerable interest in the methods of financing health care for pregnant women, and the economic impact of different methods on the household. Based on a large scale household survey in rural Nepal, we measured the costs of delivery care to households, and investigated coping strategies to pay for care, and women's preferences for care at birth. The results indicated that households spend considerable sums, and resulted in the government introduction of a cash transfer programme, compensating women attending facilities for care during delivery.

## Background

Increasing coverage of maternal health services is an essential step to reducing maternal and neonatal mortality, and addressing MDGs 4 and 5. Access to maternal health services can be constrained in a number of ways. In Nepal, limited geographic access to health services impedes use of services particularly in hill and mountain areas, where road access is limited, and households can be up to eight hours or more walking time from the nearest hospital. Studies of utilisation of rural services have found that this can be a significant determinant of service use but its impact is modest given the current configuration of low performing and often inadequate public services available to rural communities (Acharya and Cleland 2000; Hotchkiss 2001) (Jahn, Darlang et al. 2000). The high cost of services relative to income was also felt to acts as a further barrier to care seeking. There had however, been no systematic attempt at quantifying the financial costs to households or the coping strategies used by households requiring delivery care in Nepal.

A survey of 720 women who had given birth in the previous year was carried out in order to examine the financial implications of delivering at home compared to in a facility. A second general survey of 720 women was also undertaken to quantify preferences for maternal health services. These surveys were conducted between September and November 2003 in eight districts of Nepal.

The cost to households of a home delivery was found to range from 410 RS (with a friend or relative) to 879 RS (with a health worker). At a health facility, the formal cost

of a normal delivery was found to be 678 RS but unofficial charges, opportunity and transport costs meant that the total cost exceeded 5,400 RS. For a caesarean section, the total cost exceeded 11,000 RS.

For those in the poorest fifth of households, the cost of a normal delivery in a facility represented three months household income compared to just over one month in the least poor group. In the case of obstetric complications, the financial implications of care for the poorest were catastrophic. More than a fifth of women delivering at home said that cost was the major reason for not delivering at a facility. Most women preferred to give birth at home, in the absence of complications, as they valued the flexible payment mechanism allowed by informal attendants and the home environment as well as care from females who were known to them.

Whilst most public hospitals claim to fully or partially exempt poor women from charges, in practice, the actual cost to households was found to vary little by economic group. This suggested that the exemption system was not working. Furthermore, even if the exemption system worked effectively, it would only apply to a minority part of the total cost incurred by women as payment to the facility (12% of the cost of normal delivery and 49% of the cost of a caesarean)

## How did the use of good statistics make a difference to policy-making?

### GUIDANCE FOR COMPLETING CASE STUDY

Headings have been provided to give you a broad outline of what to include. The notes below should also help you.

It is helpful if you can consider which of the following areas statistics helped with and then clearly identify this in your case study:

1. Statistics to help identify issues
2. Statistics to inform the design and choice of policy
3. Statistics to forecast the future
4. Statistics to monitor policy implementation
5. Statistics to evaluate policy impact

You may also want to consider the ways in which statistics helped to:

- Increase Transparency
- Improve Accountability

You may also like to consider how good statistics have changed the criteria for policy-making. Alternative criteria for policy-making include:

- Power and influence of vested interests
- Corruption
- Political ideology
- Arbitrariness
- Use of anecdotal evidence

The findings of the study were presented to government and hospital directors in Nepal. In addition to a report of the findings, a series of policy briefs were also developed in lay language highlighting the main findings from the study and were circulated amongst key stakeholders.

Prompted by the results of the study, the government began planning the introduction of a cash transfer programme to help alleviate the cost burden on households: a payment of between RS 500 and RS 1500 upon arrival to the facility in all districts (dependent on geographic terrain); free care plus the payment in the 25 low human development index districts (which also receive a flat payment of RS 1000 per delivery to cover these costs); and a payment of RS 350 to health staff attending deliveries at home or in a health facility. The new policy was introduced in July 2006, and is currently being evaluated.