Research Article

The Safe Delivery Incentive Program in Nepal: towards women's empowerment

Asmita Bhattarai[1], Dinesh Dharel[2], Nalin Kumar[1]

[1]Department of Public Health, School of Public Health, SRM University, Chennai, Tamil Nadu, India.
[2]Department of Pediatrics and Adolescent Medicine, BP Koirala Institute of Health Sciences, Dharan, Sunsari, Nepal.
Correspondence to: Nalin Kumar, E-mail: ph.nalin@gmail.com

Received March 03, 2016. Accepted March 16, 2016

Abstract

Background: Providing equal opportunities for the newborn to survive requires a comprehensive approach. One of the approaches to provide equal opportunities for the new born is by promoting birth at the institutions. Nepal faces its unique challenges for meeting the public health goals. While some of the most common barriers toward safe delivery are related to access, cultural practices, lack of healthcare human resource, and inadequate healthcare financing. The government of Nepal in 2005 has initiated an incentive scheme, for the women to deliver at the health facility and to the provider for each delivery attended.

Objective: To assess the perspectives of the beneficiaries of Safe Delivery Incentive Program on the domains of benefits, difficulties, use of the cash incentive, and any recommended changes in the program.

Materials and Methods: This study utilizes a qualitative methodology by the use of in-depth interviews to learn about the perception of women about the scheme. Thirty in-depth interviews were conducted with the beneficiaries in randomly selected three wards in Khandbari Municipality. Manual qualitative data analysis was carried out using open coding and axial coding techniques according to Grounded Theory approach to derive a conceptual framework eliciting the perceptions.

Result: Beneficiaries in this study perceive this program as beneficial but not adequate to address the economic burden of childbirth to poor families and to those who are living in the distant health facilities. They find difficulty in availing the scheme in terms of delay in getting money and lack of proper information about the program. Decision-making was mainly by husband and pattern of utilization hugely deviated from the intended purpose (i.e., transportation). They also suggest providing the incentive beforehand and relaxing the clause of ANC as a part of the incentive. Empowerment, both financial and awareness based, emerged as a dominant theme that the women perceived as a benefit of the program.

Conclusion: The findings of the study mention cash transfer mechanism in the program has significantly empowered women. This model for women's empowerment in developing countries should be explored in greater depth.

KEY WORDS: Cash incentive, institutional delivery, Safe Delivery Incentive Program, women's empowerment

Introduction

The maternal mortality ratio (MMR) of Nepal remains quite high as 229 per 100,000 per live birth. Most studies have suggested that cost is a major barrier in utilizing professional care at childbirth (almost 50% from transportation cost) and countries who have been able to reduce MMR significantly such as Sri Lanka, China, Malaysia, and India have provided free delivery services and transportation cost.[1] Studies have also suggested that conditional cash transfer has been effective in increasing use of preventive services as well as encouraging healthy behaviors.[2–3]

Access this article online	
Website: http://www.ijmsph.com	Quick Response Code:
DOI: 10.5455/ijmsph.2016.03032016420	

Safe Delivery Incentive Program (SDIP) launched by Government of Nepal in 2005 is an initiative to address the financial barrier through conditional cash transfer mechanism. It provides cash incentive to women who give birth at health facility and incentive for service provider for each delivery

attended either at home or hospital.[4,5] The amount of incentive varies according to the geographical region. In Terai, women get Rs 500, in Hills Rs 1000, and Rs 1500 in Himalayan region. Added in 2009–2010, women get Rs 400 extra for four complete antenatal checkup visits, institutional delivery and first post natal checkup.[6]

The SDIP has proved to be effective as evidenced by increasing trend of delivery attended by health worker—rise of 3.2% in the first full year of implementation compared to 2% for previous 2 years.[1] Women who were given the SDIP were 24% more likely to deliver at government health facilities, 5% less likely to deliver at home, and 13% more likely to have skilled attendant during delivery.[7]

Nepal Demographic and Health Survey, 2011 showed that 35% deliveries were in hospitals and 36% deliveries were attended by skilled birth attendants. There has been substantial increase in the number of SDIP beneficiaries and institutional deliveries compared to previous years.[8] The SDIP has been taken as a well-meaning, legitimate policy by the health-care providers and accepted well by the community especially from rural villages and poor families. However, there still are issues of delay in flow of funds, failure to pay on time, mismanagement of funds, lack of clarity about SDIP among the providers, consequence of which have been reported by the beneficiaries as well.[2]

Even providers have suggested that incentive amount should be increased and provided on time preferably beforehand so as to enable the women to come to hospital.[5] Keeping these in mind, this exploratory study was carried out to assess the perspectives of the beneficiaries of SDIP on the domains of benefits, difficulties, use of the cash incentive, and any recommended changes in the program.

Materials and Methods

For the purpose of feasibility as the researcher 1 is a resident from Nepal, the study was conducted in Nepal. The ethical approval toward the study was obtained by the Institutional Review Board of SRM University, Chennai. The study was as a part of the academic curriculum of MPH. The design of the study was exploratory. Sankhuwasabha, a mountainous district was chosen for the study and the region is performing relatively lower in terms of institutional delivery. Khandbari municipality was purposively chosen as it covers the largest population and from the municipality three wards were chosen randomly. All women who had delivered within past 1 year from the date of interview, had received the monetary benefit from SDIP; and permanent residents of Khandbari Municipality were eligible for the study. Convenience sampling was carried out to select samples from the list of beneficiaries obtained from the District Public Health Office.

A total of 30 in-depth interviews were conducted till data saturation were reached. An in-depth interview guide was prepared which clearly addressed the objective of the study. Guidelines were first drafted in English and then translated to Nepali. Pretest was conducted to check for appropriateness and comprehensibility of language used, ability to recall information and the sequence and structure.

Women were identified in their households with the help of female community health volunteers. The researcher took verbal informed consent from them and the interview was audio taped. She conducted the interviews in the houses of beneficiaries, two interviews in a day, each lasting for 30–45 min. The researcher explored their perceptions of the scheme probing as necessary; focusing on the predetermined domains. The study was approved by Institutional Review Board at the School of Public Health, SRM University, Tamil Nadu, India.

The researcher analyzed the data thematically. The tape recorded data were transcribed in Nepali first and then translated to English for the purpose of analysis. The responses were first categorized under the domains from the interview guide. Categories were refined based on the themes emerging and open coding was done. The codes in each domain were analyzed for meaningful relationship among them to derive the perceptions through axial coding. A conceptual framework was derived as a result of analysis arranging the themes emerged from open and axial coding.

Result

Statistics

A total of 30 beneficiaries were interviewed with mean age of 24.03 years. Majority were primi mothers (63%), Hindu (93%), Janajati in ethnicity (43%), literate (73%), and homemaker (73%) [Table 1]. The analysis of the in-depth interviews and the themes emerged through open and axial coding [Table 2] resulted in a conceptual framework that depicted the perception of beneficiaries towards Safe Delivery Incentive Program [Figure 1].

The perceptions that emerged can be discussed as follows:

Women find the incentive very beneficial. The most important benefit of the incentive which emerged from the interviews is that it enhances the confidence of women by giving them financial empowerment.

"This incentive money which is given by government makes women confident enough, when they have some money in hand. They can be free to spend it on themselves and the child's betterment mostly on nutritious food and baby clothes."

"It gives us the confidence to take good care of ourselves and the baby also. We do not have to be scared of asking our husband or mother-in-law for better care thinking of economic burden on them. Now we have our own money."

Women find this incentive as a great economic help to poor families and also has influenced women to deliver at hospital.

"It is of course very beneficial. Many mothers die during delivery in the absence of medical help. One of my neighbor's wife died after delivery. There was massive bleeding after delivery and she died on the way to the hospital. Due to this incentive program most mothers go the hospital for delivery and such incidents are rare in my place now. Mothers don't

have to die due to such conditions untimely. Money given after delivery is also a great help for the poor mother. She can buy clothes for her child and buy food for her."

However, women have faced difficulties as well, while availing the service. In many instances, women did not get the incentive money on time (i.e., during discharge from the hospital as per the guidelines), rather they were asked to collect it later. Women felt this is impractical in most of the cases. Some women felt that the clause of antenatal care (ANC) card to avail the part of incentive was difficult to comply in cases of emergency, and was unfair to withhold some part of incentive just because they did not bring the ANC card.

"I didn't get the incentive on time. They said they do not have funds right now and asked me to get it when I come back for immunization of my child. But it was not practical because I came to hospital from far place being referred from health post .I would not come to hospital again rather go to nearby health post for immunization of my child. So my husband had to come a month later so far just to get the incentive money."

Some women feel that the amount is not adequate. They say it is not sufficient enough to serve its purpose, that is, transportation cost, more so at such time of emergency. They feel that the amount given is not appropriate to the economic status of family as well as the distance from facility.

"I don't think the amount adequate for the transportation cost because in case of emergencies ambulances charge more than Rs 3000 and other vehicles more than that because the roads are not quite good. But still it's a great help in times of need."

The pattern of utilization varies a lot and in many instances women feel that they still do not have autonomy to decide on how to spend the money, it is mostly done by husband/ mother-in-law. Many women did not know why the incentive is given and perceived that it is given for post-delivery expenses and were mostly ignorant about the real purpose (i.e., transportation cost).

"My husband himself decides most of the times at home so I do not question him. This time also he decided how to spend it. He paid the rent of the room we rented near hospital as we live very far from the hospital"

"My mother in law decided how to spend it. She spent on household expenses like rice, vegetables etc."

Women gave some inputs for the program to improve and better serve them. In their perception, increasing the amount of incentive, providing it without delay on time or even before delivery by some mechanisms, increasing awareness about the incentive; would be more effective strategies. They also think that the need to submit ANC card should be relaxed.

"I don't know what to say. Whatever they are doing is also fine. But I think they should provide it at home itself before delivery so that we don't need to look for loan in emergency. Actually we are at most need of money while preparing for any complications at the time of delivery. Money only comes after the delivery. It is helpful later on but more at need is the time of delivery."

One of the strong and consistent themes that emerged during analysis was empowerment. This was not part of the original conceptual framework. From various domains such as the demand for more information about the SDIP, strong vocalization of the need for changes in the SDIP, felt autonomy and power due to cash incentive the theme of empowerment emerged in the data.

Discussion

The government's initiative of providing cash incentive to women so as to attract them to seek professional care at childbirth has proved to be an effective strategy as established by various studies. It has increased the rate of institutional delivery in the country. It has been well-received by the community as well.

Women who were given the SDIP were 24% more likely to deliver at government health facilities, 5% less likely to deliver at home, and 13% more likely to have skilled attendant during delivery.[7] Women feel that this money is useful and it empowers them. However, it has not been spared from criticism. It is seen that delay in providing money to women, lack of awareness about the program, and utilization of money in other purposes than transportation are some of the issues in implementation and uptake of the program in view of provider as well as beneficiaries.[6] It was shown that only 6% used the money for transportation, two-fifth women spent on delivery care expense, and 35% on food.[2]

Similar studies have been carried out in Madhya Pradesh (MP), Bihar, Uttar Pradesh (UP), and Orissa on Janani Suraksha Yojna (JSY) which revealed that women beneficiaries are satisfied with the program but still decision of expenditure of the money depends upon husband in one-third of the cases in MP and in 13% cases in Orissa. Although most of the women intend to use it for purchasing nutrients for herself but almost two-fifths and one-fourth end up spending on household consumables in MP and Orissa, respectively. One-fifth of the beneficiaries in MP and one-third in UP felt that the amount of incentive needs to be increased.[9–12]

It has been well proved that mere establishment of facilities does not change health-seeking behavior; other factors such as awareness, attitude, utilization pattern, and satisfaction of beneficiaries also influence success of any program.[9]

Findings of this study also correlate with the previous studies. Beneficiaries in this study also perceive this program as beneficial but not adequate in amount. They feel that the amount does not provide much relief from the actual expense after childbirth. They also feel that this amount should be given according to the economic status of the family as well as according to the distance from facility. Difficulty in availing the benefit in terms of delay in getting the incentive, lack of proper information about the program (especially the clause of showing the completed and filled ANC card to get a part of incentive) were perceived as regressive measures. Some women also felt that they still did not have autonomy to spend the money on their own.

Table 1: Background characteristics of beneficiaries (n = 30)

Characteristics	Frequency	Percentage (%)
Mean age	24.03 years	
Parity		
Primi	19	63.33
Multi	11	36.66
Ethnicity		
Brahmin/Chhetri	8	26.66
Janajati	13	43.33
Newar	2	6.66
Dalit	7	23.33
Educational status		
Illiterate	8	26.66
Primary	3	10
Secondary	6	20
SLC and above	13	43.33
Occupation		
Homemaker	22	73.33
Business	3	10
Teacher	4	13.33
Government service	1	3.33
Religion		
Hindu	28	93.33
Buddhist	2	6.66

Table 2: Open code and axial code definitions

Domain	Open code definitions	Axial code definition
Felt benefits	Helps in hospital delivery	Beneficial but not adequate
	Can buy clothes for child	Not given in time
	Can buy nutritious food for mother	Antenatal care (ANC) card mandatory for a part of incentive
	helps in transportation	
	helps to maintain health of baby	No difficulties
	ensures clean delivery	Decision by self
	ensures safe delivery	Decision by husband/mother-in-law
	increases confidence of mother	
	economic help to poor families	
	beneficial but not adequate	
	helps in emergencies	
Felt difficulties	Not much difficulty	
	Not given in time	
	ANC card mandatory for part of the incentive	
Pattern of utilization	Used for food for mother	
	Paid rent of room	
	Transportation	
	Bought clothes for baby	
	Bought ornaments for baby	
	Saved in bank for child	
	Household expenses	
Decision maker	Husband	
	Self	
	Mother-in-law	
	Both husband and self	
Suggestions for program modification	More information needed	
	Should be given before delivery	
	Amount to be increased	
	Amount to be decided according to economic status	
	Amount to be decided according to distance to facility	
	Amount to be given on time, not after discharge	
	No suggestions	
	Alternatives to ANC card to avail the benefit	

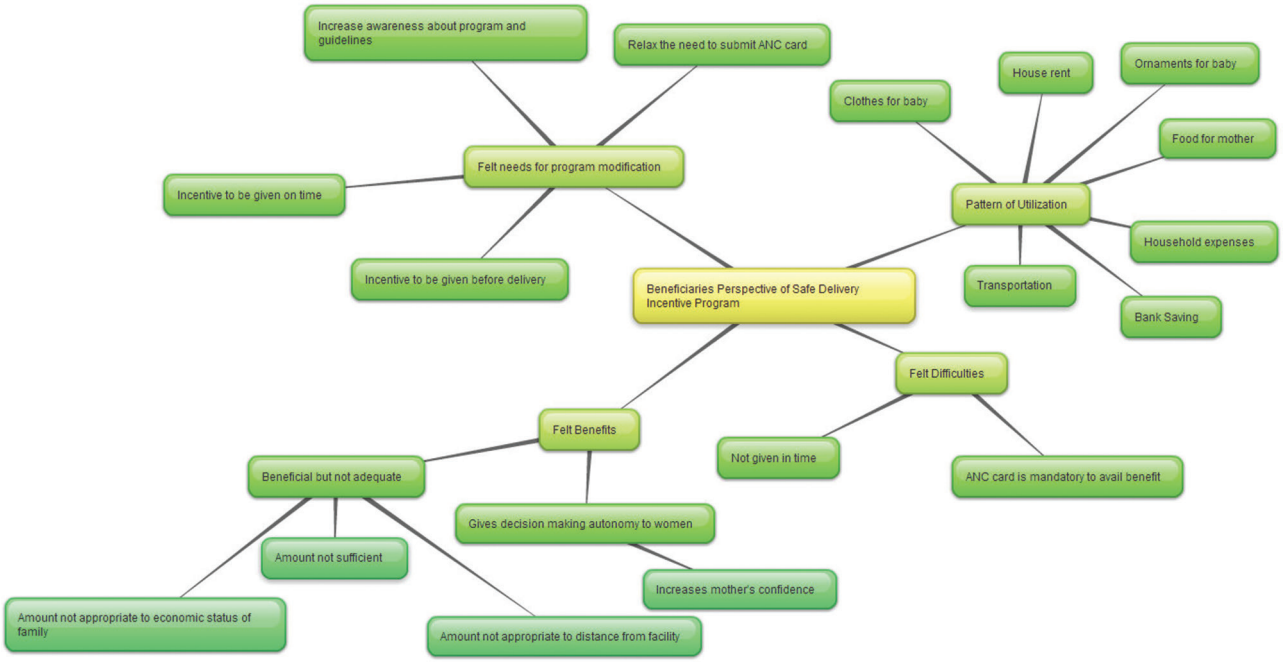

Figure 1: Conceptual framework of Beneficiaries' Perspective about Safe Delivery Incentive Program.

Despite these findings, one strong theme that emerged during analysis was empowerment of women. Women said that the incentive money has helped them a lot in gaining self-confidence and having autonomy in decision-making. They reported that with the cash in hand, they can confidently ask their family for better care for themselves and their child in the postnatal period. Besides, the very fact those women were able to identify and verbalize the inadequacy of the incentive amount to address the financial barrier as well as the fact that they are providing feedback for program modification, suggest that women have become empowered to identify their need and negotiate rather than just accepting passively whatever they get. Also women have asked to be provided with more information regarding the program, which reflects the empowerment effect the program has had on them as women have now understood that being informed make them confident and competent enough to ask for better services from the provider as well.

These findings corroborate with the qualitative and quantitative study carried out in Mexico on their conditional cash transfer program called "Opportunidades" which revealed that it might be the empowering aspect of the program that women beneficiaries have become active health consumers and have shown increased tendency toward seeking information. The beneficiaries of that study reported on personal changes including self-confidence, freedom of movement and association which was perceived by the caregivers as well.[13,14] A similar trend has been observed in this qualitative exploration.

Reproductive and child health is an important aspect of women's empowerment. Various conventions on women's empowerment such as Convention Eliminating All Forms of Discrimination Against Women (CEDAW) and the International Conference on Population and Development have emphasized the importance of sexual and reproductive health and rights as an important determinant of women's empowerment. Conditional cash transfer programs address two dimensions of this empowerment. On one hand, they provide health-care services and make them accessible to women and on the other hand, the cash empowers women economically and on awareness.

Considering the current challenges with the delivery of health-care system in Nepal and making safe deliveries. The provisions of incentives related to the promotion of uptake of maternal and child health services are a welcoming step by the government. But at the same time, there is a need to focus on mainstreaming the funds transfer timely. There are various evidences reported where the delay in funds have acted as a demotivator. There should be a robust process always to prevent this delay. The policy strategies should involve a process which involves the people from all communities and which also takes into account of the various barriers and methods by which the barriers may be overcome. At the same time, a lot needs to be done for the process of community mobilization. This would be required to make communities aware of the scheme. This would involve multiple ways in which the larger dissemination of the information to be done at the communities level.

Conclusion

Though there are some important findings from the study which need to be addressed with respect to improvement of the SDIP, one of the strongest points which has emerged is that SDIP is a source of women's empowerment. This theme has to be explored further by qualitative and quantitative studies and analysis of secondary data. The linkage between the SDIP, women's empowerment, and other social determinants of health needs to be explored and reported.

Acknowledgments

The researcher expresses gratitude to Dr Vijayaprasad Gopichandran and Dr Rajan Patil for their valuable guidance throughout the research work. I thank T. Kannan for his valuable inputs and mentorship. Data collection was carried out by the researcher herself from June 5th to June 23rd 2012. The researcher is equally thankful to the team of District Health Office and District Hospital, Sankhuwasabha for their cooperation. The researcher is indebted to all the beneficiaries who have participated in the study and not forgetting the researcher's own friends and family.

References

1. Ranganathan M, Lagarde M. Promoting healthy behaviours and improving health outcomes in low and middle income countries: a review of the impact of conditional cash transfer programmes. Prev Med 2012;55:S95–S105.
2. Powell-Jackson T, Neupane B, Tiwari S, Morrison J, Costello A. *Final Report of the Evaluation of the Safe Delivery Incentive Programme*. London: DFID, 2008.
3. Ravindran TS. Universal access: making health systems work for women. BMC Public Health 2012;12(Suppl 1):S4.
4. Powell-Jackson T, Morrison J, Tiwari S, Neupane BD, Costello AM. The experiences of districts in implementing a national incentive programme to promote safe delivery in Nepal. BMC Health Serv Res 2009;9(1):97.
5. Powell-Jackson T, Neupane BD, Tiwari S, Tumbahangphe K, Manandhar D, Costello AM. The impact of Nepal's national incentive programme to promote safe delivery in the district of Makwanpur. Adv Health Econ Health Serv Res 2009;21:221–49.
6. Department of Health Services. Annual Report. Kathmandu. Ministry of Health and Population, Government of Nepal, 2011.
7. Chatterjee M, Levine R, Murthy N, Rao-Seshadri S. Sparing Lives: Better Reproductive Health for Poor Women in South Asia, 2008.
8. Population Division. Nepal Demographic and Health Survey 2011. Kathmandu. Ministry of Health and Population, Government of Nepal, 2011.
9. Gupta SK, Pal DK, Tiwari R, Garg R, Sarawagi R. Assessment of Janani Suraksha Yojana (JSY) in Jabalpur, Madhya Pradesh: knowledge, attitude and utilization pattern of beneficiaries: a descriptive study. Int J Curr Biol Med Sci (IJCBMS). 2011;1(2):06–11.
10. Kumari V, Dhawan D, Singh AR. Advantages as perceived by the beneficiaries of Janani Suraksha Yojana (JSY) in Bikaner District. J Dairy Foods Home Sci 2009;28(3/4):247–9.
11. Paul VK. India: conditional cash transfers for in-facility deliveries. Lancet 2010;375(9730):1943–4.
12. Varma DS, Khan ME, Hazra A. Increasing institutional delivery and access to emergency obstetric care services in rural Uttar Pradesh. J Fam Welfare 2010;56:23–30.
13. Barber SL, Gertler PJ. Empowering women to obtain high quality care: evidence from an evaluation of Mexico's conditional cash transfer programme. Health Policy Planning. 2009;24(1):18–25.
14. Molyneux M. Conditional cash transfers: a pathway to womens empowerment? Pathways Brief 2009;5.

How to cite this article: Bhattarai A, Dharel D, Kumar N. The Safe Delivery Incentive Program in Nepal: towards women's empowerment. Int J Med Sci Public Health 2016;5:2108-2113

Source of Support: Nil, **Conflict of Interest:** None declared.