



International Labour Office

# EXTENDING MATERNITY PROTECTION TO WOMEN IN THE INFORMAL ECONOMY

## THE CASE OF NEPAL

*Working Paper*



Strategies and  
Tools against social  
Exclusion and  
Poverty

**Social Security Policy and  
Development Branch**

**Conditions of Work Branch**

### ***Strategies and Tools against Social Exclusion and Poverty (STEP)***

The programme "**Strategies and Tools against Social Exclusion and Poverty**" (STEP) of the International Labour Organization is an instrument for extending the coverage and effectiveness of social protection throughout the world.

Following the conclusions of the World Summit for Social Development in Copenhagen, the STEP programme promotes the design and the implementation of innovative systems of social protection for excluded populations. Based on the principles of equity, efficiency and solidarity, these systems contribute to social justice and cohesion.

In its works, STEP combines different types of activities: knowledge development, the production of methodological tools and reference documents, concrete actions in the field and technical assistance for policy development and implementation.

#### **STEP Programme**

Social Security Policy and Development Branch

Social Protection Sector

International Labour Office

4, route des Morillons

CH – 1211 Geneva 22

Switzerland

Tél. : (41 22) 799 65 44

Fax : (41 22) 799 66 44

e-mail : [step@ilo.org](mailto:step@ilo.org)

Internet : [www.ilo.org/step/pubs](http://www.ilo.org/step/pubs)

### ***Conditions of Work Branch (CONDIT)***

*Decent work* carries with it a concern both for jobs and for the quality of those jobs. People's conditions of work can have an important impact on their performance at work, as well as more broadly on their lives. The hours they must work, the ways in which their work is organized, whether they are able to balance their work with their family and other personal obligations, and their freedom from harassment and violence at work, are some of the ways in which their working lives are defined and experienced.

The Conditions of Work Branch encourages and assists governments, employers' and workers' organizations to adopt policies and practices aimed at the progressive improvement of conditions of work and respect for workers' dignity. The Branch's programme is a blend of continuity and change: traditional working conditions areas are examined to seek innovative ways to tackle long-standing problems while, at the same time, new and emerging issues are addressed.

The main technical areas of work are: working time and work organization; work and family; maternity protection; improving working conditions of informal economy and rural workers and workers in small enterprises; wages; sexual harassment and violence at work.

#### **Conditions of Work Branch**

Social Protection Sector

International Labour Office

4, route des Morillons

CH-1211 Geneva 22

Switzerland

Tél. : (41 22) 799 6754

Fax : (41 22) 799 8451

e-mail : [condit@ilo.org](mailto:condit@ilo.org)

Internet : [www.ilo.org/public/english/protection/condtrav](http://www.ilo.org/public/english/protection/condtrav)

**EXTENDING MATERNITY PROTECTION TO WOMEN  
IN THE INFORMAL ECONOMY**

**THE CASE OF NEPAL**

**International Labour Office**

Copyright © International Labour Organization 2002

Publications of the International Labour Office enjoy copyright under Protocol 2 of the Universal Copyright Convention. Nevertheless, short excerpts from them may be reproduced without authorization, on condition that the source is indicated. For rights of reproduction or translation, application should be made to the Publications Bureau (Rights and Permissions), International Labour Office, CH-1211 Geneva 22, Switzerland. The International Labour Office welcomes such applications.

---

ISBN 92-2-113459-8

---

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers. The responsibility for opinions expressed in signed articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them. Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval. This publication can be obtained, free of charge from:

Strategies and Tools against social Exclusion and Poverty  
Social Security Policy and Development Branch  
Social Protection Sector  
International Labour Office  
4, route des Morillons  
CH-1211 Geneva 22  
Switzerland  
Tel: +41.22.799.65.44  
Fax: +41.22.799.66.44  
E-mail: [step@ilo.org](mailto:step@ilo.org)  
<http://www.ilo.org/step/pubs>

Conditions of Work Branch  
Social Protection Sector  
International Labour Office  
4, route des Morillons  
CH – 1211 Geneva 22  
Switzerland  
Tel: +41.22.799.67.54  
Fax: +41.22.799.84.51  
E-mail: [condit@ilo.org](mailto:condit@ilo.org)  
<http://www.ilo.org/public/english/protection/condtrav/>

---

Photograph : woman of the Kamaiya group by Binod Shrestha

## PREFACE



Social protection for all workers is a human rights issue for the International Labour Organization (ILO). The ILO actively promotes all countries to extend social protection to all groups in society across the full range of contingencies and to improve working conditions and safety at work.

Maternity protection has been a priority for the ILO since the year of its founding, 1919, when it adopted the first Maternity Protection Convention. Recently, the ILO adopted the Maternity Protection Convention, 2000 (No. 183), greatly broadening the scope of protection and specifically encompassing for the first time, women employed in the informal economy, including those in atypical forms of work and the self-employed. Since these are amongst the most vulnerable workers, extending protection to them is of immense significance.

During the general discussion on social security of the 89<sup>th</sup> Session in June 2001, the International Labour Conference reached a new consensus. It places the extension of social protection, including health care, to those who are not covered by existing statutory systems as one of ILO's highest priorities. The recommended action also ensures that gender equality is promoted in all of the ILO's activities on social protection.

One of the contingencies to be addressed by social protection is maternity protection. The Social Security (Minimum Standards) Convention, 1952 (No. 102) and Maternity Protection Convention, 2000 (No. 183) spell out specific provisions for extending maternity protection to all women workers. These two Conventions are a step forward for advancing the well being of all working women during their maternity period.

As part of the ILO's mandate and major campaign to extend social security coverage to all workers, the Social Security Policy and Development Branch, through its Global Programme STEP (Strategies and Tools against social Exclusion and Poverty), is involved in identifying concrete ways to extend effectively social protection, especially for health care, to workers excluded from access to statutory social security schemes. This pursuit has led to examine various micro-insurance schemes and other community-based social protection initiatives around the world.

Promotion of maternity protection is one of the priority goals of the Conditions of Work Branch. The overall goal is to ensure and extend maternity protection to as many women as possible. The strategy is three-pronged:

1. Secure ratification of the Maternity Protection Convention 2000 (No. 183);
2. Where ratification is not yet feasible, secure improvements in maternity protection by implementing elements of the Convention, including measures to reach out to women in the informal economy;
3. Secure general improvements in the overall employment situation of women.

The ILO is therefore exploring possibilities to extend maternity protection to women in the informal economy through micro-insurance and other community-based health-financing schemes. Initial exploratory research has been carried out, which looks into how these community-based initiatives have integrated maternity protection within their offered services to their members and their families.

Information on how maternity benefits are included in different community-based health-financing systems has been gathered in nine countries from Africa, Asia and Latin America. The countries are Argentina, Chile, Colombia, India, Nepal, Philippines, Senegal, Tanzania and Uganda. The collected information and the subsequent analysis have provided the evidence-base for the development of practical guidelines to be used as a tool to promote community-based health financing schemes that embody relevant maternity protection services.

This paper, prepared by Ms. Nirmala Sharma, forms part of the initial research. The responsibility for opinions expressed in this document rests solely with the author.

---

## **Table of Contents**

<b>General Introduction</b>	<b>1</b>
<b>Chapter 1 Background</b>	<b>3</b>
1.1 Purpose of study	3
1.2 Methodology and limitations	3
1.3 Women workers in Nepal	3
<b>Chapter 2 A presentation of three community-based health-financing schemes with maternity protection services</b>	<b>7</b>
2.1 Community-based Health Post Model: Lalitpur Medical Insurance Scheme under the Community Development and Health Programme of United Mission to Nepal (CDHP/ UMN)	8
2.2 Health Cooperative Model: General Federation of Nepalese Trade Unions (GEFONT)	10
2.3 Emergency Fund of Mothers' Groups/ Nepal Safe Motherhood Project	11
<b>Chapter 3 Analysis of three health micro-insurance schemes providing maternity protection services</b>	<b>13</b>
3.1 Bikalpa Multipurpose Cooperative/ Kirtipur: Health Micro-Insurance Scheme	13
3.2 Vijaya Youth Club Cooperative Union, Navalparasi: <i>Sutkeri Subidha</i> Delivery Support: maternity protection programme for women shareholders	14
3.3 Social Health Insurance Model: BP Koirala Institute of Health Science, Dharan	16
<b>Chapter 4 A summary of the findings</b>	<b>21</b>
<b>Chapter 5 Recommendations</b>	<b>23</b>
<b>Chapter 6 Conclusion</b>	<b>25</b>
<b>Bibliography</b>	<b>27</b>
<b>Annex I: Public Health Concern Trust (PHECT/ Nepal): Health Micro-Insurance Scheme</b>	<b>29</b>
<b>Annex II: List of organizations visited</b>	<b>31</b>
<b>Annex III: Preliminary listings of institutions for the study</b>	<b>33</b>
<b>Annex IV(a): Questionnaire for beneficiaries on maternity protection services at community level</b>	<b>35</b>
<b>Annex IV(b): Questionnaire for non-beneficiaries on maternity protection services at community level</b>	<b>37</b>

---

---

## List of acronyms

BPHKS	BP Memorial Institute of Health Science
CDHP	Community Development and Health program
C183	ILO Convention 183
GEFONT	General Federation of Nepalese Trade Unions
HISC	Health Information Service Center
ILO	International Labour Organization
MCH	Maternal and Child Health
MOH	Ministry of Health
NSMHP	Nepal Safer Motherhood Project
PHECT	Public Health Care trust
STEP	Strategy and Tools against all forms of Exclusion Program
UMN	United Mission to Nepal
VYCCU	Vijay Youth Club Cooperative Union
VDC	Village Development Committee
WHC	Women Health Cooperative

---

## Acknowledgement

This study has contributions from several organizations and persons. The author, Ms. Nirmala Sharma, wishes to express her sincere appreciation and thanks to all those who have given their time and provided valuable information for the study:

Special thanks to Ms. Ismène Stalpers, Associate expert/STEP at the ILO Area Office in Kathmandu for her motivation, encouragement, and cooperation during the study period;

Mr. Umesh Upadhyay, Head, Foreign Affairs/GEFONT for his willingness to help and to supply the needed information concerning the trade union sector; Mr. Pranay Manandhar, Krishna das Maharjan and Dr. Sharad Onta of PHECT/Nepal, Ms. Mina Bajracharya and women members from Tikathali Women Health Cooperative, Lalitpur, Ms. Bishnu Devi Shrestha, and executive members of Bikalpa Multipurpose Cooperative, Kirtipur for sharing experiences, information and making arrangements for field based meetings;

The team of Social Health Insurance Department of BP Memorial Hospital, Dharan, Mr. Devi Payangu, and Narayan Chapagain for their help in arranging interactions with in-patients, and other beneficiaries, as well as non- beneficiaries.

Dr. Narayan Kumar, Director, BPKIH for his cooperation and willingness to help during the study;

The executive members of Jhi Pu Cha (a Nepal Bhasha and Cultural Association), Biratnagar, Mr. Lokendra Kumar Malla, Mr. Rajan Shrestha, and Raj kumar Shrestha and other members, for sharing information about their organization, and arranging meetings with beneficiaries, even at short notice;

Mr. Ram Prasad Poudyal (Former Executive Member), and Mr. Prem Sagar Subedi, Executive Members, Vijaya Youth Club Credit Union (VYCCU), Gaindakot, Navalparasi for facilitating the interactions with executive members of VYCCU and collection of field information through interviews with beneficiaries. Without their support, the information from the field would have been difficult to obtain; The executive members of VYCCU, Mr. Buddhi Poudyal, Hom Nath Subedi, and Ramraj Pokharel for sharing information about their program approach and benefits;

Mr. Krishna Man Shakya, Coordinator of CDHP, UMN, Ms. Deepa Pokharel, IEC Coordinator of Nepal Safe Motherhood Program at Kathmandu, for sharing information about their program approaches.

Thanks are also due to several officials from various Health Micro Schemes for helping the consultant to select the relevant institutions for the study, and to her husband, Mr. Binoy Sharma for editing this report.

Finally, the consultant wishes to extend her deep appreciation to all the women and men respondents under the Health Micro-Insurance Schemes in Tikathali, Kirtipur, BPKIH/Dharan, Sunderpur VDC, and Jhi Pu Cha, Biratnagar for being patients and answering her queries.



---

## General Introduction

In Nepal, some 86 percent of women work in the informal economy. This means that a large majority of working women have no access to any statutory maternity protection.

At the community level, a number of health organizations (NGOs, and hospitals) are asserting the idea that "Health is the right of people, so they should not be devoid of health care due to lack of money". Therefore, these organizations have recently introduced the concept of health micro-insurance scheme to their target beneficiaries. Some of the existing health micro-insurance schemes and other informal health-financing systems are fairly new, whereby general health care benefits and services, especially maternity care, are offered on a non-profit basis by member-based organizations. These health micro-insurance schemes provide basic health care services, for example drugs and hospitalisation, for all acute and chronic diseases, which are within the expertise of the service providing hospitals in Nepal.

Maternity care is at times included as part of health care services provided by the existing health micro-insurance packages. While analysing the functioning of existing maternity protection schemes in Nepal, it has been found that no scheme exists as a specific support for the maternity care of women workers in the informal economy. The organizations, providing health micro-insurance at the community level, have concerns for maternity care but those are limited to hospital-based treatment. Preventive maternity care such as awareness creation, antenatal care and postnatal care are not directly attached to the services under the insurance scheme, nor in the overall health service package of a referral hospital. Insured women usually go for antenatal care or postnatal care only when they fall ill or they have problems during pregnancy but not for routine check-ups. Women are found to be utilising the maternity service under the scheme only at the time of child delivery, and this too depends upon the area and level of awareness on safe delivery, distance to referral hospital, etc.

However, organizations such as Nepal Safe Motherhood (NSMH) Programme, and Community Development and Health Program (CDHP) of United Mission to Nepal (UMN) programme have priority focus on preventive aspects of maternity protection. But the intervention mechanism and service package of these organizations are different from those of actual insurance schemes.

The common perception in Nepal, and many other countries on maternity care is that since giving birth is a natural process and expected in the life of women, maternity care is not important unless there are complications. This is not only the perception of health care providers but also of the women, their families and communities. Therefore in most of the schemes, maternity care is often viewed as an "ad-hoc" intervention and not as a continuum of care for women's overall well-being and health. Nepal's health schemes also give similar impression, which is why despite several attempts to reduce maternal death, maternal mortality ratio still stands at 539 for every 100,000 live births (UNICEF 98'), which is one of the highest in the world.

Efforts to provide affordable health care through health micro-insurance and other health-financing systems at the community level are underway. There is a need to encourage such efforts and help the institutions, such as micro-credit/finance institutions, to improve their services and coverage in order to provide quality health care to a wider section of the population. Some micro-credit/finance institutions, in their efforts to uplift the status of women, are already thinking of introducing health micro-insurance schemes within their working communities in many parts of the country. Furthermore, in the formal economy, attention should be paid to the enforcement of labour laws so that all women workers can effectively exercise their labour rights. In order to allow more women working in the informal economy to enjoy one of the most basic human rights, such as adequate and quality health care services, especially maternity care, necessary amendments in the present legislation should be made.

---

## Chapter 1 Background

### 1.1 Purpose of study

The purposes of the study are as follows:

- To carry out a survey on organizations that manage their own health micro-insurance schemes with maternity care components.
- To explore ways to include maternity care in health micro-insurance schemes, managed by community based structures, trade unions or any other organizations such as hospitals and NGOs whose members belong to the informal economy.
- To identify major gaps and areas for improvements in existing maternity protection provisions in the micro health insurance approach, and recommend possible strategies for future action.

### 1.2 Methodology and limitations

#### Methodology:

A desk study was carried out which included reviewing policy papers on the Maternity Protection Convention, 2000 (No. 183), and other relevant reports on maternity benefit services.

A list of 20 organizations running health micro-insurance, health cooperatives, and social health insurance in Nepal was prepared. A preliminary screening was carried out and it was identified that 6 out of the 20 organizations, were found to be actually running a health micro-insurance scheme with a maternity care component. Some schemes had provisions for maternity protection at the community level.

Interactions were held through four rounds of meetings with the concerned officials of those six organizations. Relevant information was gathered about their approaches, major strengths and weaknesses and the challenges they were facing at the implementation level.

Furthermore, three out of six organizations were selected for an in-depth study. Two among the three organizations provided health micro-insurance to their own members within their catchment area. The third organization was an exception, as it did not have any insurance scheme but contributed to maternity support in a different manner.

Apart from holding discussions with executives of concerned organizations about their programme's approach and strategies, field visits were carried out and discussions were held with the beneficiaries of the schemes. During the field visits opinions of non-beneficiaries were also gathered.

#### Limitations of the study:

Soon after undertaking the study contract, the country's situation became tense due to the imposition of a state of emergency in November 23, 2001. This hampered adequate interactions with beneficiaries of health insurance schemes of the selected three organizations. Due to the above reason, the sample size (beneficiaries and non-beneficiaries) was not large enough to make the outcome of the study fully representative. Furthermore, the scheme being quite new, the information gathered from beneficiaries was rather repetitive and limited.

### 1.3 Women workers in Nepal

Globally, more women are now in the work force than before. Women are contributing to an increasing proportion of family income and often work throughout their childbearing period. In Nepal, a fairly high proportion of women are reported as being economically active. The figures from World

Development Report 1999/ 2000 revealed that women aged between 15 and 64 constituted 40 percent of the total labour force in Nepal.

Women's contribution to economic activities, even by conventional definitions, is estimated to be much higher than those reported in census data. For example, unremunerated work carried out by women; and, particularly those related to domestic chores and agriculture, is at best under-valued and under- recorded.

As noted earlier, some 86 percent of women in Nepal work in the informal economy, within which the majority of them work in a progressively feminised agricultural sector. The proportion of female labour force in the agricultural sector, as compared to their male counterparts, increased from 30.4 percent in 1971 to 45 percent in 1991. However, many women engaged in family farms are still reported as economically not active. (ADB/ Nepal, 1999)

There is an increasing number of women in this country that enter into formal manufacturing sector. The proportion of women working in this sector rose from 11.2 percent in 1977 to 23 percent in 1991. However, women are mainly concentrated in low-skill, manual and repetitive jobs, within the lower echelons of the industrial hierarchy. Lack of education and training opportunity, employment biases and limited mobility due to social responsibilities keep them at these lower echelons. According to, the 1987 Survey of the Manufacturing Sector, a greater number of women workers were employed in manufacturing in the more isolated mountainous region than in Terai. In addition, female employment was concentrated in those industries where the fixed capital investment was the lowest, such as textiles. This meant that the majority of female workers received lower pay than their male counterparts.

**Table 1: Trends in employment and wages in Nepal (NLSS 1996)**

Sex	Wage employment ( percent)		Self employment Informal economy ( percent)		Average Wage ( percent)	
	Agriculture sector	non-agriculture sector	Agriculture sector	non-agriculture sector	Agriculture sector	non-agriculture sector
Male	13.2	16.3	59.8	10.7	44	76
Female	11.1	2.7	81.6	4.6	35	57

Most women reported as self-employed were actually working as unpaid family workers, especially in the agriculture sector. Those women who worked as paid workers, usually earned less than NRs. 2000 per month.

There are some special rights for women workers incorporated in the Labour Act and Labour Regulations 1993. Women are legally entitled to equal pay for similar jobs and to enjoy a series of gender related privileges, such as maternity leave, feeding intervals during working hours and crèche facilities.

But in practice, women do not enjoy such rights, as most of them are concentrated in the informal economy. Moreover, women are often considered as unskilled labour despite the job requiring specific skills such as carpet weaving.

The Nepalese Labour Act and Regulations 1993 covers only those women workers who are in permanent pay roll, which is not the case with most of the women workers. Thus it has limited scope of coverage in relation to maternity protection provisions. The Labour Act 1993 is

**Major Provisions for Women Workers' Special Rights in Labour Act and Regulations 1993**

- ◆ 52 days of paid maternity leave up to two pregnancies
- ◆ Crèche facilities with necessary equipment and trained staff (caretakers) for babies and children of women workers in case where the factories employ more than 50 women
- ◆ Allowable feeding intervals during working hours
- ◆ Separate toilet facilities for women in factories having more than 50 women workers
- ◆ Current minimum wages including allowances fixed by the Government range between Rs. 1400 (for minor workers) and Rs. 2,150 (for highly skilled workers)
- ◆ Working hours fixed at 48 hours/week or 8 hr/day including half-an-hour lunch break and some rest breaks after 5 hours of continuous work

---

silent on issues related to pregnancies, cash benefits, dismissal from work and all the discrimination in employment relating to maternity.

Appropriate maternity protection is considered to be a necessary condition for equality. High percentage rates of maternal and infant mortality and morbidity lead to a diminished workforce. Maternity protection benefits are of particular importance to the reproduction of a healthy workforce as well as the maintenance of the health of working mothers. With so many women working in the formal and informal economies, a country's economic productivity is intricately linked to the health of working women.

It is a well-recognized fact that access to health services is inadequate among the majority of people in most low and middle-income countries, including Nepal. The Government in such countries cannot keep up with the health needs of their population and consequently private health providers are increasingly playing an important role. But the services are too expensive for the majority of the people. Most of the women workers in Nepal, in particular those working in informal economy, face various and significant constraints in accessing affordable and quality maternity care. The well-known barriers for many women in obtaining timely and appropriate maternity care are as follows:

- ❖ Lack of awareness on the basic Labour Rights that provide essential health protections to working women of child bearing age
- ❖ Lack of knowledge on complications and need to acquire timely care during pregnancy, delivery and lactating period
- ❖ Lack of access to health care facilities, e.g. distance
- ❖ Lack of adequate time and job security
- ❖ Unaffordable health care services compared to income capabilities
- ❖ Prevailing attitudes towards maternity care in society

---

## Chapter 2

### A presentation of three community-based health-financing schemes with maternity protection services

In response to unaffordable private health care, there has been a steady growth of health micro-insurance schemes worldwide. Health micro-insurance is a mechanism to pool both risks and resources of groups to provide health protection to all members against financial consequences of the various risks. The term “micro” refers to the limited size of the benefit package and the limited contribution capacity of members, and not to the size of the scheme. Therefore, the existing health micro-insurance schemes do not often offer comprehensive health care coverage, which could include coverage for transportation costs, extensive pre-natal, delivery and postnatal care.

The health micro-insurance concept is relatively new in Nepal. While analysing these insurance schemes for workers in the informal economy, in most of the cases, it has been found that health micro-insurance has been introduced as an added benefit by the health institutions to their target beneficiaries. There are less than a dozen of organizations that are currently providing health insurance services under their micro-insurance schemes. During the study, six health insurance schemes were looked into; of which, three were selected for in-depth analysis with details given in the following chapter.

In Nepal, health insurance services are rendered to the community people under three models. These are: Community-based Health Post (e.g. Lalitpur Medical Insurance/UMN), Health Cooperative (e.g. PHECT-Nepal) and Social Health Insurance (e.g. BP Memorial Hospital).

#### Health Insurance Models in Nepal

##### **a. Community based Health Post Model:**

*Offers medical insurance to support local health posts making them active and effective in their services to local communities. The insurance covers purchase of essential drugs for the targeted Health Posts (HP). In return, all the people from HP's catchments areas get quality care at the local level. Serious illness and high-risk pregnancy are referred to a hospital for specialized treatment with a discounted rate. But high-risk delivery is treated by the hospital free of charge. This is the model used by Patan Hospital/ Lalitpur Medical Insurance Scheme.*

##### **b. Health Cooperative Model:**

*This model offers health insurance for communities through health cooperatives. In this, insurance covers the treatment of referred cases on discounted rates. Minor illnesses are treated at the local level under the health cooperative system, which is managed by local people with technical assistance from the insurance providers. PHECT/Nepal works under this model.*

##### **C. Social Health Insurance Model:**

*Offers health insurance to rural as well as urban communities through cooperatives, business associations, Village Development Committee (VDC) or any other institutions working at the community level. The insurance covers tertiary level treatment on all minor and major illnesses free of charge. B P Memorial Hospital uses this model.*

The similarity among all these models is that they are operated on a non-profit basis and implemented through community-based groups, NGOs, cooperatives, or business associations. However, the service delivery approaches and coverages are different. For example, the Health Cooperative Model works with health institutions/cooperatives, and provides subsidies for certain services for referral cases only. Whereas for the Community-based Health Post model, the premium is

used to strengthen the operational capacity of health posts in the catchment area, as well as to improve the supply of essential drugs. This, in turn, enables the proper functioning of health posts and ensuring their capacity to offer primary health care to the beneficiaries. Under the Community-based Health Post model, serious illnesses including complicated delivery are covered by the micro-insurance at reduced prices at the hospital. With the first two models, primary health care is provided at the community for small user fees and only referral cases are covered by the micro-insurance schemes at discounted prices. The third model, -the Social Health Insurance Model- provides a wide range of treatment services by covering all major as well as minor illnesses among the insured members at a designated hospital.<sup>1</sup>

## 2.1 Community-based Health Post Model: Lalitpur Medical Insurance Scheme under the Community Development and Health Programme of United Mission to Nepal (CDHP/ UMN)

Lalitpur medical insurance scheme is the oldest health micro-insurance scheme in Nepal, initiated in 1976 by United Mission to Nepal. The scheme covers the costs of essential drugs supplied to the health posts that the Community Development and Health Programme (CDHP) works with. Under this scheme, the beneficiaries pay an annual premium to receive free essential drugs and other primary health care services at nominal fees. These primary health care services are provided at Village Development Committee (VDC)-based mother child health clinic and to individual households in the area. They focus mainly on maternal and child health, awareness creation and health education on safe motherhood. Regular antenatal care is offered at the health posts for routine check-ups and screening for high risk or potential complications in pregnancy. Normal deliveries are conducted at the health posts or at home with the assistance from health staff.

The major objectives of the Lalitpur Medical insurance scheme are:

- To ensure a continuous drug supply (supplementary to government's drug supply plus new purchase) at the health posts.
- To promote equity and equal opportunity to obtain health care for all men and women from the location.
- To increase awareness on the available health services, and ways for their utilization/creating demand for health services.

The Health Post has a provision for referring patients with serious illnesses, including pregnancy related problems, to Patan Hospital. The referred patients are categorized into two levels:

- a) General cases: most sicknesses, a discount of Rs. 150 is offered for outpatient care, and Rs. 400 for inpatient care, and,
- b) Special cases: treatment and care is free of charge for high-risk pregnancies.

### Maternity care provided by Lalitpur Medical Insurance Scheme

- Free essential drugs at health posts
- Antenatal and normal delivery care at nominal fees at health posts
- Free treatment and care for high risk pregnancies and delivery with complications at Patan Hospital
- Other illnesses that are referred to Patan Hospital from the health posts are entitled to Rs.150 discount on outpatient care and Rs.400 on in-patient care

<sup>1</sup> Apart from these three models, there are also other approaches for providing maternity protection in Nepal. They are in the form of a fixed grants or emergency fund offered by community-based organizations. Vijaya Youth Club Cooperative Union (VYCCU) provides a fixed amount of grant to eligible women members to supplement their expenses during delivery. The Nepal Safe Motherhood Project (NSMP) helps mothers' groups in its working districts to raise their own money for emergency expenses. The Project also helps the mothers' groups to supplement their funds by mobilising various local funds, including the Village Development Committee (VDC) Funds, by requesting those institutions to allocate partially their financial resources for the purpose of maternity care. One of the common features of all the existing health micro-insurance approaches is that maternity care is included as a general health component rather than a special or exclusive service.

- Awareness creation and health education on safe motherhood at health posts, mother child health clinics and individual households
- Other primary health care services at nominal fees at health posts and mother child health clinics

Therefore, the scheme provides various health care services, not only to the insured individuals, but also to the entire community.

The CDHP currently works in 10 VDCs of Lalitpur District and has partnership program with three health posts. The insurance agreement is done between the CDHP/UMN and the Health Post Management Committee. The Committee, comprised of a chairperson of the VDC, representatives from communities and health post staff, handles the fee collection, manages the generated fund, develops management rules and regulations of the scheme, supports the health posts' staff, markets the program and also provides necessary charitable services to the poorest in the community.

#### The premium:

The annual premium varies according to the economic condition of the family. Therefore, each VDC has fixed its own rates, ranging from Rs. 75 to Rs.175 per family depending upon the economic condition of the family. Each member pays Rs. 2 to Rs. 5 per visit (the lower the economic condition of a family, the lower the fee). The funds generated are used for the purchase of medicines and to enable the CDHP/UMN gradually phase out its subsidies, which at the moment are given in the form of health staff and supply of medicines.

#### Major strengths:

While analysing the strengths of the institution, Lalitpur Medical Insurance Scheme is found to be capable of:

- Developing a sense of ownership as it is a community initiative for its own health care needs,
- Leading the initiative towards attaining financial sustainability by involving the health posts and instilling in them the responsibility of taking care of the health care needs of their communities.
- Implementing direct intervention to reduce maternal morbidity and mortality by placing heavy emphasis on maternity care (antenatal care, delivery and postnatal care), both at community and at hospital level.

#### Major weaknesses:

- The health micro-insurance scheme has limited coverage. This is due to the limited number of people interested in joining the scheme, especially those living in semi-urban areas where other options for health care exist. The small amount of premiums collected is inadequate to sustain the health post services independently.

#### The challenge:

- The supply of essential drugs to the health posts could be improved greatly once the CDHP/UMN phases out from the area. The collected premiums alone may not be enough to fulfill the demand of drugs due to strong awareness on health care among the community people.
- In order to provide such services continuously, there is a need for recognizing the contribution of the scheme to health care improvement in local communities, as well as obtaining financial support from the Ministry of Health.

## 2.2 Health Cooperative Model: General Federation of Nepalese Trade Unions (GEFONT)

GEFONT is a Confederation of 15 national federations of trade unions dedicated to the rights, welfare and dignity of workers from different economic sectors, such as carpet, textiles, tourism, public and civil construction etc. GEFONT has been carrying out various activities on workers' issues ranging from policy development to its implementation since the year 2000. Recently, it has been implementing various programmes related to micro-insurance through the formation of workers' cooperatives. The health cooperative has been initiated as a first step towards the workers' cooperative movement aiming at providing affordable health care to its members. In addition to clinical services, the health cooperative is keen to train its health campaigners (representatives from all 15 national federations) so as to prepare them to create awareness on general health care as well as maternity care issues in their respective federations. Plans are underway to obtain technical support from Public Health Concern Trust (PHECT/Nepal).

GEFONT has an Occupational Safety & Health programme which was supported by the International Labour Organization. Under this programme, GEFONT has trained 50 persons to give orientation to the concerned committees of the member federations, on the importance of occupational safety and health, including maternity protection.

The Health Cooperative was established in 2000, after realising the poor health conditions of its workers and their inability to access expensive health care services. There was also a need to create a public health care movement and awareness on occupational health and safety among workers. In order to address the health care needs of its members, the health cooperative initiated a health insurance scheme in collaboration with the Model Hospital in Kathmandu, which serves as a referral centre for the insured members. The major beneficiaries of this scheme are workers from various national federations of trade unions, such as manufacturing, textiles, carpet, transportation, construction, agriculture and a few central committee members of GEFONT.

### Premium and its usage

The Health Cooperative in Kathmandu has a membership of 500 men and women workers. Each member contributes an initial Rs. 100 as membership fee for the health cooperative, and Rs. 30 per month as health insurance premium. Each insured person can include one member from the family under the same premium. GEFONT contributes Rs. 1,500 every month to the health cooperative fund as institutional support to the scheme. All the membership fees, premiums and contributions collected are deposited in a Health Cooperative fund, which is used partly for running the daily clinic and a medical store within GEFONT complex, and partly to pay the insurance premium to Kathmandu Model Hospital.

#### **Maternity benefits provided by 'the Health Cooperative' health micro-insurance of GEFONT**

- Routine antenatal care at the Health Cooperative's clinic or Kathmandu Model Hospital
- Normal delivery and delivery with complications at Kathmandu Model Hospital
- Postnatal care at the health cooperative's clinic or Kathmandu Model Hospital

There is a daily clinic service (two hours) run by a medical doctor and a pharmacist at GEFONT building in Kathmandu. The clinic provides routine health check-ups, including antenatal care for its cooperative members and their family. Normal delivery and delivery with complications, as well as other serious illnesses, are referred to Kathmandu Model Hospital, where the insurance member gets specialized treatment with subsidized rates, i.e. 75 percent reduction on doctor's consultation fee, and 50 percent reduction on hospital bed and surgical costs. In addition, GEFONT plans to include gynaecological service, maternity care education and other services within this health micro-insurance scheme.



#### Major Strengths:

- The workers who do not have access to health care services previously are benefiting from the scheme
- GEFONT, being a confederation of 15 national federations of trade unions, has a very wide coverage of beneficiaries
- GEFONT has also a representative body of all three trade union associations to address gender issues of informal economy workers that include health issues in general and maternity protection in particular

GEFONT is expanding its health micro-insurance cooperative scheme to 10 districts in the country, which will broaden the coverage to a larger group of informal economy workers.

#### Major weaknesses:

- Although GEFONT is a national institution, its health micro-insurance scheme for now is limited to the Kathmandu Valley. Despite a total membership of over 300,000, only 500 members have subscribed to this health micro-insurance scheme
- The Gender Equity Department of GEFONT (TUCOGEP) has been playing a limited role to address the issue of gender equality at work, and maternity protection in particular

#### Challenges:

- Scaling up the successful health cooperative model to another 50,000 informal economy workers in 9 other districts in Nepal
- Expanding the insurance service to all its member workers

## **2.3 Emergency Fund of Mothers' Groups / Nepal Safer Motherhood Project**

The Nepal Safer Motherhood Project (NSMP) has established an Emergency Fund with contributions from members of mothers' groups and other funds in the community for the purpose of providing maternity protection to women in rural communities. This Emergency Fund is not a micro-insurance scheme but an alternative way to help prevent unnecessary maternal death due to five barriers<sup>2</sup> identified by the local community in receiving obstetric care and care required before, during and after delivery period. This approach brings one step forward in ensuring maternity protection within the communities.

The NSMP is jointly executed by the Department for International Development (DFID/Nepal) and the Department of Family Health Services of the Ministry of Health to address the problem of the high maternal mortality ratio in Nepal. The strategy taken by NSMP in this initiative is to make the community responsible for its own community's maternity protection through extensive awareness creation, backed up by effective service delivery at local health facilities. It raises awareness among the community to demand better maternity care.

At the community level, NSMP focuses on strengthening local health facilities through appropriate training/orientation, supplying required equipment and making the health personnel accountable to community's health care needs.

Awareness creation on maternal and child health issues, involving both men and women, are the prime focus of this community-based intervention. Men and women are empowered to demand for their right to health care and also make necessary arrangements for any possible crisis related to a person's life and death at the local level. Men are oriented about the possible crisis during a woman's

---

<sup>2</sup> The five barriers to women's access to maternity care are: knowledge about complications and services; prevailing attitudes; limited access to medical facilities; financial constraints; and inefficient referral system/quality service.

pregnancy and delivery; they are trained to become responsible and save women's lives with prompt decision, transport and other necessary arrangements, when needed.

NSMP promotes mothers' groups in their working area with appropriate training on safe motherhood. One of the major tasks of the mothers' groups is to establish an Emergency Fund for various benefits. Every mothers' group allocates a certain proportion of collected fund exclusively for crisis during pregnancy and delivery. The remaining amount is invested as loans to be lent out among the members for income-generating activities or any urgency at the household level. Other efforts of NSMP mobilize locally available funds such as forestry users' group fund, and the savings and credit fund, to allocate a certain percentage of these funds for maternity crisis. The VDCs also contribute to emergency transportation and meeting the costs of Emergency Obstetric Care.

#### Strengths of the Emergency Fund

- Immediate access to money during any crisis
- Community's willingness to meet the local's health care needs and its sense of ownership of the Emergency Fund
- Active support from men and VDCs
- Instrumental in protecting the lives of the sick including pregnant mothers

#### Major weaknesses

- Non-members and poor women in the communities who can not contribute to the fund are excluded from support given at crisis
- An increase in fund is not accompanied by a proper management and planning for utilization
- Created as a social fund, it lacks management guidelines which can be further developed for financial accountability

#### Challenges

- Inclusion of the poorest of the poor women in the Emergency Fund
- Proper management of the growing fund by the local men and women at the communities

---

## Chapter 3

### Analysis of three health micro-insurance schemes providing maternity protection services

#### 3.1 Bikalpa Multipurpose Cooperative/ Kirtipur: Health Micro-Insurance Scheme

Bikalpa Cooperative, established in 1998 by some like-minded men and women of Kirtipur with the help of PHECT/ Nepal (See Annex I for further details), is a multi-purpose cooperative. Its prime objective is to unite local people and lead them to better lives using their own efforts. The aim is to improve the livelihood of the members and help each other during crisis. The cooperative was started with 45 men and women, and its membership has grown to 152. It has a small saving programme for members, whereby the money can be withdrawn from the bank at times of emergency for any member and their families.

Bikalpa Cooperative also addresses various socio-cultural issues that are prevailing in society. It has been able to bring out women who were confined to domestic tasks, to seek an alternative source of income to sustain their livelihood. The women are also empowered and convinced to seek alternative ways of living their lives. As the members' families are gradually giving up the harmful practices and modifying their lifestyle, this ensures equal treatment to women members. The result is that women's status within the family has risen in that community.

Bikalpa Cooperative also realised that health care is an important aspect to every family. Health care requires a lot of money and proper information on how to cope with illness, which was often difficult to obtain. They realized that the only way to address such needs was by forming a Health Cooperative as part of their overall activities. Hence, they established a Health Cooperative in 1999. The Health Cooperative initiated health education at the community level targeted at women, a subsidized health check-up service at a local clinic, and periodic health campaigns with the help of PHECT/Nepal.

In the year 2000, Bikalpa Cooperative introduced a health micro-insurance scheme for its members in collaboration with PHECT/Nepal and the Kathmandu Model Hospital. It is mandatory for members of Bikalpa Cooperative to join the health micro-insurance scheme. At present, there are 452 members in this scheme.

##### Services, premium and usage

The Bikalpa Cooperative raises the premium and pays the hospital in advance (in the beginning of contract). Each member pays the premium of Rs. 90 per year, and becomes entitled to the following benefits:

- 80 percent discount on specialist's consultation
- 50 percent discount on bed charge and operation charge

##### **Maternity benefits covered by the health micro-insurance scheme**

- Antenatal and post natal cares
- Normal delivery and delivery with complications in 50% subsidy
- Cheaper rate treatment in all the hospitalised cases

The cooperative has also tried to facilitate mothers' access to maternity care during their pregnancy and delivery. There is an official working linkage with the PHECT's Reproductive Health Initiative program where mothers can visit for any consultation. The Reproductive Health Initiative refers the serious cases to Kathmandu Model Hospital. In emergency and even normal delivery cases, members can directly

go to the Kathmandu Model Hospital without obtaining the referral order. Mothers are getting easy and prompt care during their pregnancy and delivery under the health micro-insurance scheme.

#### Summary of interactions with the beneficiaries

The visit to Bikalpa Cooperative at Kirtipur served two purposes: meeting with Cooperative Executives and the insurance beneficiaries. Altogether nine women beneficiaries were interviewed using the open-ended questionnaire. One respondent was not a beneficiary but her family was covered by the health micro-insurance. All the beneficiaries who met during the interview reported the scheme's usefulness as stated below:

- ❖ They are now fully aware about where to go at times of illness so that they do not have to spend time in deciding where to go and get worried unnecessarily

- ❖ They are happy with the services provided, including maternity care that is given under the scheme at the Kathmandu Model Hospital. They also feel relieved and confident about getting a good treatment during any serious illness.

**Lila Devi Kayastha, Bikalpa  
Cooperative Kirtipur**

We used to worry a lot thinking of falling sick from serious illness and the possible expenditures. But now we know where to go for health care, we are relieved as we have a micro-insurance scheme connected with the Kathmandu Model Hospital

- ❖ There is a feeling of satisfaction on the services covered by the scheme, as it has provided them a sense of security during illness and a feeling of cooperation among members.

- ❖ Another benefit is that the insured persons now have easy access to health care and reduction in prices for treatment of illnesses.

**Gita Maharjan, Bikalpa Cooperative  
Kirtipur**

The cost of child delivery is cheap now. The process of joining the health micro-insurance scheme is very simple. I joined the scheme and now I have access to good quality health care!!

As stated above, the health micro-insurance scheme also covers antenatal care and delivery. Any insured women can go to the Kathmandu Model Hospital, even for a normal delivery. If delivery is considered as an emergency case, it does not require a referral order.

#### Major constraints

- The insurance scheme does not cover pathology, other investigations and medicines. This has put a heavy economic burden on members
- The cooperative is not getting any profit from its work. This has a serious impact on the sustainability of the cooperative
- Many poorest of the poor are barred from these low cost health care services, including maternity care, as it is mandatory to become a member of the cooperative before one is eligible to join the health micro-insurance scheme

### **3.2 Vijaya Youth Club Cooperative Union, Navalparasi: *Sutkeri Subidha* Delivery Support: Maternity Protection Programme for Women Shareholders**

The *Sutkeri Subidha* (literally means delivery support) package is not a health micro-insurance scheme, but an incentive offered by Vijaya Youth Club Cooperative Union (VYCCU) to its women shareholders, to support them during pregnancy and delivery. The VYCCU, established in 1992 at Navalparasi district, is one of the largest saving and credit cooperatives in Nepal with more than 35,000 members. It has two types of memberships: the shareholders and general members. There are 1600 shareholders, of which 49 percent are women, who are eligible for *Sutkeri Subidha*. The delivery

support package is offered to the shareholders only. Since its establishment, VYCCU has initiated several income-generating activities for its members,<sup>3</sup> and it is also sensitive towards member's health care needs. This has resulted in the programme working closely with the area's Health Post.

The project location has access to various hospitals and health facilities in Narayangadh and Bharatpur. The local people have basic level of awareness about their health needs. There is a Health Post and Female Community Health Volunteers working in the area. Each month the Health Post organises health camps in addition to their regular services. The women get health-awareness training and receive iron tablets and toxoid tetanus vaccines as part of antenatal care. Pregnancies with complications are referred to the Bharatpur hospital.

#### Maternity protection offered by Vijava

- Rs 300 cash benefit as delivery support
- Emergency loan up to Rs.10,000 with interest free for up to 15 days to help women with complications during pregnancy and delivery

In order to increase women's involvement in the credit union, VYCCU initiated *Sutkeri Subidha* delivery support to pregnant women in 1997. The support is in the form of a cash benefit of Rs. 300. The allocation is limited to mothers with up to two children in order to discourage women having more children.

The eligible women can obtain this amount any time during pregnancy or within 35 days of the childbirth. The amount has proved useful to the poor women, who use it to meet the cost of normal delivery at the hospital, which is approximately Rs. 250. Some women are also found to be using the amount to buy vitamins or food items right after the delivery.

#### Emergency-loan facility

In addition to *Sutkeri Subidha*, VYCCU also has an emergency loan for up to Rs. 10,000 to help women members with complications during pregnancy and delivery. But since these complications do not occur frequently, VYCCU has allowed the loan to be borrowed for other household emergencies, such as any accident, serious illness of a family member or death in family, and natural calamities such as fire etc. In case of any emergency, this money is made available immediately. The loan is interest free for up to 15 days, but beyond that, the borrower has to pay 16 percent interest on the loan amount.

#### Summary of beneficiaries' opinion:

The service package is well appreciated by the beneficiaries. All the 7 women interviewed, expressed they are particularly relieved after getting the amount. Though the amount is small, they use it for the transportation cost to the hospital at the time of delivery or buying some nutritious food items such as butter, meat and some vitamins after delivery.

**Usha Sharma VYCCU, Gaidakot VDC,  
Nawalparas**

I really appreciate *Sutkeri Subidha* but I suggest that the amount should be increased to meet the total delivery costs.

The members have a choice to either take the amount before or after the delivery. The common practice is taking the amount after delivery, as it can be used for the sole purpose of delivery and not for other household requirements. The process to obtain this cash benefit is quite simple. They just need to inform VYCCU verbally about the delivery. All women interviewed expressed that the service should be provided to other members of the savings and credit programme and not only to the shareholders.

<sup>3</sup> This is a project the ILO has supported to expand the employment opportunities for women at local level.

The beneficiaries appreciated the attempt of VYCCU in providing "Sutkeri Subidha" but felt strongly that if VYCCU really wants to support poor women's reproductive health, they should increase the "subidha" support amount.

Lalita Poudel VYCCU, Gaindakot,  
Nawalparasi

Even though the amount of support is low, it allows pregnant mothers to buy some nutritious food as we do not have access to cash during the time of sickness and delivery.

In addition to the delivery support package, the women expressed interest in getting regular health related counselling and information before and after delivery. They showed interest in a health micro-insurance scheme for family members. They have also expressed the need for ambulance service and discount on other types of treatment.

Some information was also gathered from non-beneficiaries. One of the respondents, who happened to spend a large amount during her delivery and on maternity care in a private clinic, responded on a query whether she wishes to be included in the scheme. She stated that the present support amount is too low and she lives quite a distance from the VYCCU, so it is not worth coming all the way to receive it, even though she needs it. However, in order to have maternity protection, she wishes to get regular health check-ups during pregnancy, maternity education free of charge. Another respondent said that the delivery support package is a good initiative by VYCCU, but she feels if any organization wishes to provide help for those who are in difficult circumstances, the support should be increased. She is one of the beneficiaries in a VYCCU's Saving & Credit program but she is not a shareholder; therefore she could not get the amount for her delivery.

#### Major Strengths:

- Those who are really poor, are able to meet some urgent expenses from the delivery support amount
- The support has created a realisation within the community about the need for low-cost health care facilities including health micro-insurance for the family, and emergency transportation service

#### Major Weaknesses:

- The delivery support amount is appreciated but all the beneficiaries feel the benefits are too low to supplement the expenses during delivery.
- The delivery support is only applicable to VYCCU's women shareholders, and for the first two childbirths. Hence it has excluded lots of needy women from getting the benefits.

While discussing with executive members concerning their interest in the health micro-insurance scheme, they seemed to be quite keen to introduce health micro-insurance to provide a wider range of health care to their members, and to explore an appropriate partner and ways to collaborate.

### 3.3 Social Health Insurance Model: BP Koirala Institute of Health Science, Dharan

The BP Koirala Institute of Health Science (BPKIHS), located in Dharan (Eastern Nepal), started its work in 1993. While providing health care services in both rural and urban areas, it realised that there is a need for social health insurance to deliver low-cost, quality health care. This was based on the finding of a study, which the Institute carried out internally to know how much a person had to spend for his/her health care. According to the study, the health expenditure came out to be approximately Rs. 1000 per person per year, which is a substantial amount, given the economic condition and an estimated average annual income at less than Rs. 16,000 per year (HDR 2000). Hence, the study also found that about 35 percent of patients attending the hospital could not afford tertiary level treatment.

Therefore the BPKIHS introduced a social health insurance scheme in the year 2000. The Institute strongly felt that people should not remain devoid of basic health care services just because they have no money. The institute also believed that people should have the right to get treatment during ill health, for which they should invest some money when in good health.

The insurance scheme is marketed and promoted through local non-governmental organizations, international non-governmental organizations (INGOs) and VDCs, and other organised groups. In this way, it avoids administrative hassles by enrolling individuals or families directly in the Institute. The process of going through various organizations has the benefit of not only mobilizing the available resources, but also making them accountable to their members' health care needs. As an example, a VDC can contribute a certain amount from its health budget and can recommend the hospital to provide free treatment to the poorest people. Similarly, NGOs/INGOs/cooperatives can also deposit some money as premium (from their own source or by raising funds from the interested families) so as to provide health care to their target families. These organizations play a leading role in identifying interested and needy families/groups and in promoting affordable quality health care in the communities they work in.

#### Target groups

Any organised groups, such as VDC, municipality, socio-cultural organizations, schools and colleges, companies and associations, all are eligible to enrol their members together with their families into the social health insurance scheme. So far BPKIHS has 17 different groups/organizations (with over 1,500 families) benefiting from the social health insurance scheme. The demand for joining the scheme from new groups/organizations is also on the rise, as more and more people know about the scheme.

#### Process to enter into the scheme

Interested groups and organizations negotiate with BPKIHS once a year for the premium amounts, health care coverage and all the necessary conditions to be fulfilled under the agreement. All the communications and information to beneficiaries are channelled through these groups and organizations during the insured period.

#### Premium and benefits

The premium has been classified under two categories: urban and rural residents, regardless of the economic condition of beneficiaries. The Institute also has provisions to help marginalized communities, disabled and elderly people who are ignored by their families and cannot pay the full premium. The premiums of these groups are shared evenly among the Institute, the VDC and the needy person.

The premium rates for the urban and rural population are listed below:

Urban:	Within the Municipality:	Rs. 600/person/year for an adult Rs. 300/person/year for a child
Rural:	VDCs	Rs. 180/person/year for an adult Rs. 90/person/year for a child

The insured member is entitled to the following services:

- Out-patient care: consultation and investigation are free of charge and unlimited
- In-patient care: consultation, investigation, and hospital beds are unlimited. Beneficiaries can also get free medicines worth of Rs. 2,500-3,500 per year
- Surgery cost: up to Rs. 10,000 per year

### Maternity Benefits covered by the BPKHS

- Regular antenatal care (at the hospital clinic)
- Normal delivery and delivery with complications at the hospital
- Postnatal care (at the hospital clinic)
- Free medicines worth of Rs 2,500-3,500 per year for delivery at the hospital
- Laboratory tests and analysis
- Information on reproductive health

Some major investigations such as Computed Axial Tomography (CAT scan), magnetic resonance imaging (MRI), Echocardiogram treadmill testing (TMT), echography, and haemodialysis are not covered under the package. But the hospital is considering some discounts in such investigations. As regard to the coverage of the micro-insurance scheme, all acute cases, hospital based delivery, normal or caesarean are included along with several other chronic diseases and problems. The hospital has a provision of community-based health services in areas where the number of insurance beneficiaries is over 200 families.

### Summary of beneficiaries' opinion

Interviews were carried out with 18 beneficiaries from six groups that come from Sunsari and Morang districts. All of them have yet to utilise the services covered by the health micro-insurance but they are certain of getting proper treatment at times of illness. In addition, they expressed their satisfaction with the range of health care services covered by the scheme.

The most common attractive factor of the scheme is quick and attentive services at the hospital. The insured patients do not have to stand in a long queue as the hospital has made special arrangements to attend the insured patients as promptly as possible.

#### **BPKHS. Representatives from Dulari and Sundarpur VDC**

There is a sense of independence among women, as they do not have to wait for men to decide when to seek health care. She can just pick up the card and visit the hospital whenever she is ill. The sense of independence is stronger among women from Marwari community who are usually confined to the house.

#### **BPKHS, Representative, Marwari Sewa Samiti, Dharan**

The insured families are relieved since they are certain of getting treatment during the illness, for all family members. The services are affordable and good. So even distance does not hinder rural women from joining the scheme.

#### **Tirtha Kumari Dangal Samabika Women's Group, Mahendra Nagar, Sunsari**

The scheme has helped individuals to develop a habit of seeking medical help more often, including antenatal care. It also encourages women to go to the hospital for delivery. Insured women in child-bearing age obtain more advantages from the scheme as they can attend the hospital's antenatal care clinic regularly, thus avoiding most complications at the last minute. This has helped women to develop the habit of going for regular health check-ups and obtain all necessary information concerning the reproductive health issues and ways to prevent complications.

It is just a matter of having adequate health care awareness and ensuring that health care services are secured during illness by investing in micro-insurance scheme when one is in good health!

The scheme has many other advantages. For example, women feel secure and independent as they can visit the hospital whenever they are ill. It also develops a habit of seeking prompt health care before falling seriously ill.

The scheme is affordable and the care we get is of high quality. Therefore, we do not mind the distance to the hospital.



It was revealed during the study that insured persons have to spend Rs. 200-3000 on medicines outside the scheme. Though the scheme covers a number of services at low premium, 40 percent of the respondents observed that more essential drugs should be included under the scheme. A few respondents suggested that even if medicines are not given under the scheme, it should be made available at the hospital pharmacy so that patients, especially those with special and serious illnesses, can buy it easily without wasting time.

#### Summary of beneficiaries' opinion - "Jhi Pucha", Biratnagar:

The group, "Jhi Pucha" is a *Newari Guthi*,<sup>4</sup> based in Biratnagar (Morang District) in Eastern Nepal. There are 600 health micro-insurance members in an area with a population of 30,000. Most of the members are from middle class families. The *Guthi* carries out some welfare activities, such as health camps, also for people from other ethnic groups. The *Guthi* was concerned about its members' health care needs. Realising the poor quality of services at the Biratnagar Hospital and expensive services in private sector, the *Guthi* entered into an agreement with BPKIHS for a health micro-insurance scheme in 2000.

There are 140 families currently covered by the scheme, and they are quite satisfied with the good care and prompt services at the hospital. They expect the number of families joining the scheme in the coming year will increase.

The factors that attract us to the scheme are the prompt and good service and quality care at low cost!.

#### **BPKIHS, Puspa Shrestha, JHIPUCHA Guthi Biratnagar**

Their views and feedback on the schemes from Sunsari District are similar to those of Biratnagar. The distance from Biratnagar to Dharan, the availability of transport and the cost and amount of time it takes are the major concerns of the beneficiaries from Biratnagar. In response to this, the executive members of the *Guthi* have arranged emergency transport services from Biratnagar to Dharan. The interviews with non-beneficiaries revealed that they are in dire need of the health micro-insurance scheme. However, by the hospital's criterion, one has to be affiliated to an organised group, or otherwise prevented from joining the scheme. It has also been found that factors like economic condition and the level of awareness have influenced the decisions made by non-beneficiaries when seeking maternity care. In case of emergency, non-beneficiaries tend to borrow money from relatives and friends. It has also been found that the distance between home and clinics, their quality of care and its related costs play an important role in the decisions made by women about seeking maternity care.

#### Major strengths:

- It is a relatively large scheme covering various types of beneficiaries
- The scheme covers the entire family, rather than individuals
- The benefits package of the insurance scheme is wider; hence the insured people can really get the health care services needed by investing a minimum amount of money while in good health
- The rate of premium is lower for poor people in the rural area than those from the urban area, who usually have higher income. This is an attempt of the Institute to address the issue of equity in obtaining health care at times of sickness
- The scheme has helped people to develop a habit to seek medical help even in minor illnesses, and also for regular antenatal care and delivery at hospital

#### Major weaknesses

- In the long run, there lies a big challenge for the Institute to continue such a wide range of services at low premium, especially when the funding from the government and donors runs out. At this point of time, this funding covers of 65 percent of the total budget.

<sup>4</sup> Guthi is a cultural association of Newar people, formed to provide mutual assistance in social and cultural functions and events.

- The families that are not affiliated to an organised group, which is the majority of the population, are excluded from joining the scheme.
- A high drop-out rate is another major challenge being faced by the scheme. According to the figures obtained from the Institute, in one of the VDCs, 18 percent of the insured have dropped out of the scheme at the end of the first year. The major reasons given were: lack of money (7 percent), difficulty to get to hospital service (4 percent), and unsatisfactory health service (3.6 percent).
- The criteria for eligibility under the scheme for urban and rural families are the same. The fact that the defined premium rates disregard the health conditions of subscribing members have led to adverse selection. Those members of families who are old and chronically ill were insured instead of healthy ones. It was also revealed that women who need maternity care might not be insured.

The overall impression based on discussions with various stakeholders, is that the scheme is extremely useful for the community. However, the urban-rural differentiation for premium rates may lead the health micro-insurance scheme into financial difficulty. With the present organised group affiliation criteria, the scheme also risks excluding the real needy from membership instead of giving more membership opportunities to those families who are slightly better off.

---

## Chapter 4

### A summary of the findings

At present, an ever-increasing need for health care services has started to be addressed by community-based, non-statutory, health micro-insurance schemes and community-based health-financing initiatives. These are not only new initiatives but also small in terms of scope, coverage and the contribution capacity of their members. The maternity care component is often not treated as a specific area of concern by these initiatives; rather it is included as part of the general health services provided to the members.

It seems that no specific governmental measure has been taken to address the need of maternity protection of women workers in the informal economy. At the community level, organizations like GEFONT, have initiated some measures to address the maternity care need of their women workers in the formal and informal economy. However, these initiatives are still at a preliminary stage and require a lot of support to make them fully operational. The other health micro-insurance schemes presented in this report have focused on the community as a whole rather than workers in the informal economy.

The existing health micro-insurance schemes can be broadly categorised into three models, namely: health cooperatives, community-based health post, and social health insurance models. The three models offer health services at the community level. In all the schemes, subsidies are given for certain health care services, such as consultation, surgery, and medicines to the insured families. The premium rates in all three schemes are quite low. This shows that there is a strong support from the health care providers to get health care services delivered to their local communities. The health cooperative model and the community health-post model also provide basic care at the community level and only referral cases are managed at the hospital for which premium is paid. Whereas in the social health insurance (BPKIHS), the premium covers unlimited health care services, basic as well as specialised treatments at the hospital level, but it does not provide community based services. BPKIHS only provides community-based services in areas where the number of beneficiaries are over 200 families.

It was revealed during the study that some effort has been made to address the maternity care needs of women beneficiaries. Bikalpa Cooperative and BPKIHS have a maternity protection component in their scheme whereas VYCCU has a special delivery support, *Sutkeri Subidha*.

The hospitals that offer insurance service target mainly the population in their catchment areas. In all three models, health micro-insurance schemes are carried out through existing groups or organizations. This has resulted in the exclusion of some needy individuals from the insurance schemes. Other reasons for exclusion include the lack of awareness on the availability of the scheme, and/or the institutional criterion imposed.

All entities mentioned in this report have incorporated child delivery (normal or complicated) as an integral part of their health schemes. The modality of support is different for VYCCU as it provides a fixed amount as delivery support and an emergency loan to eligible expecting mothers but no other facilities are offered under its scheme. Although these provisions made by VYCCU might not be adequate, it shows however, institutional concern towards women members and recognises their reproductive health needs, especially during pregnancy and delivery period.

In the case of social health model (BPKIHS), there is no community-based health care arrangement and referral system, thus all illnesses are directly treated at the hospital. Due to goodwill and available facilities, women beneficiaries visit antenatal clinic at the hospital, when necessary. The inclusion of antenatal care and delivery service in the insurance scheme has motivated women to have their delivery at the hospital even in case of normal condition of pregnancy.

Maternity care is limited to hospital-based treatment, particularly in the BPKIH scheme. Preventive services under antenatal and postnatal care, such as awareness creation, regular check-ups, nutrition education, etc. at the community level are not included in the insurance package despite it being a community-based insurance scheme. But the community health post model (CDHP/UMN) includes all

essential care at the community level along with delivery services for high-risk pregnancy at the referral hospital. This model can be quite appropriate for the replication by other institutions working in rural areas.

The concept of promoting health cooperatives and health micro-insurance schemes among the members of the cooperatives is encouraging under PHECT program. The BPKIHS encourages existing groups and cooperatives to join the scheme and not to create its own groups. However, both approaches have genuine interest in providing health care to the communities at an affordable cost. The subsidies given in health care have facilitated the low-income people living in peri-urban areas, urban areas and rural communities to have better and prompt health care services.

The major challenge faced by health insurance schemes is affordability of the beneficiaries to pay the premium. The low premium rate has resulted in limited coverage under the insurance scheme. This has led to limited expansion of the insurance scheme to the larger section of the population. On the other hand, availability of a variety of health care services at urban and peri-urban areas have also influenced the effectiveness of the insurance scheme. The beneficiaries tend to give lesser value to the services from the insurance scheme, as they have a number of other options available to them in terms of services, cost, distance etc.

In terms of the quality of services, the insured beneficiaries are fully satisfied with the quality of treatment and services. Here, the quality of service refers to prompt services, positive attitude and behavior of health personnel and the treatment of any illness at the hospital level. As observed during field interactions, no complaints were noted concerning the quality of medicines and medical treatments. This indicates that quality care has been maintained by the insurance providing hospitals.

In relation to maternity protection services, it is imperative to look at the situation in the labour market, and the country's existing labour laws in which women workers are supposed to get adequate protection, especially during the maternity period. As reported in the Status of Labour Act enforcement in Nepal, concerning the basic health care provisions, only 50 percent of enterprises have the provision of sick leave, and only 33 percent of enterprises have the facility for maternity leave for 45 days (GEFONT 2001). There is no provision for leave to women workers during pregnancy. As 83 percent of the enterprises do not have provisions for paid sick leave, there is a danger of losing their earning or even dismissal from their job, if they fall sick, due to pregnancy related problems.

A previous study has revealed that many enterprises have ignored parts of the labour laws even in those areas where trade unions are very active, such as Kathmandu Valley (GEFONT, 2001). According to the same study, the type of enterprises defying basic labour rights are carpet industries (52 percent), followed by manufacturing industries (30 percent). It is important to note that the majority of workers in carpet industries are women.

As stated in the beginning of this chapter, some maternity protection efforts have been put in place by health institutions at the community level. Though it is not adequate in terms of coverage, it is an initiative in the right direction that can be built upon for replication for a larger section of the population in the future. Very limited steps have been taken in targeting the women workers in the informal economy.

The situation in the formal sector is slightly different from that in the informal economy. Though the conditions in the formal sector do not meet all the conditions as stated in the Maternity Protection Convention, 2000 (No. 183) there are some provisions for maternity protection. To mention a few, women workers with permanent contracts in the formal economy get maternity leave for 52 days, and are considered for light work during pregnancy. There is also a provision for unpaid leave if they fall sick during the maternity period. In some cases, the women workers also get some medical support, depending on the type of enterprise she works with. In the public sector, there is a provision of maternity leave for 60 days with the flexibility to take before or after the delivery. All the permanent staff members get medical benefits as stipulated under the Civil Service Act. The Ministry of Health gives substitute leave to those women staff that work in hospitals. Besides, if any complications occur in staff's health, including women staff during pregnancy and child delivery period, they can apply to the Medical Board for the necessary financial support.

---

## Chapter 5

### Recommendations

As stated in the previous chapters, steps have been taken in the positive direction through health micro-insurance schemes to address maternity care needs at the community level. But they still need be improved in terms of the service and geographical coverage. His Majesty's Government of Nepal has not ratified the Maternity Protection Convention, 2000 (No. 183), but the articles within the Convention still may prove to be useful as guidelines for improving Nepalese women's access to maternity protection.

There is a growing awareness on health care needs, and the concept of health micro-insurance is coming up as an appropriate option for health care among the poor. It has been shown that maternity care can be incorporated in health micro-insurance schemes, which may give poor women working in the informal economy a chance to have proper and timely care during pregnancy.

Based on the above observations, the following recommendations for existing health micro-insurance schemes are proposed:

- Encouraging institutions that are providing health micro-insurance at community level to integrate comprehensive and quality maternity benefits under a combination of preventive services provided at the community and a good referral system to tertiary treatment at a hospital. The preventive services could include: early and regular antenatal care, screening for high-risk pregnancies, and nutritional education. A good referral system will ensure safe delivery.
- Encouraging existing micro-finance institutions, micro enterprises and trade unions to include the component of health micro-insurance in their economic package.
- Developing a mechanism to extend quality maternity benefits to all women regardless of age and parity in the catchment area of any institutions having a health micro-insurance scheme.
- Developing a strategy for the promotion of health micro-insurance scheme, with integrated and quality maternity benefits, through periodic talks and exchanges between the insured and non-insured families at the institution level.
- The community-based health post model which is currently being implemented by CDHP/UMN in Lalitpur district is worth serious consideration for replication. Similar schemes could potentially offer many communities the opportunities to obtain both preventive and curative health care within their communities when tertiary level of care is at a distance and costly to rural residents.
- Creating greater awareness regarding the importance of integrating quality maternity protection services within a health micro-insurance scheme, as a vital element in the successful implementation of the scheme.
- The concept of "Emergency Fund" initiated by Nepal Safe Motherhood Programme in remote districts can be considered for further replication in communities where health micro-insurance schemes are not in existence.

---

## Chapter 6

### Conclusion

The current deteriorating economy and the effects of globalisation have left very few options in providing social and health security in the country. Privatisation of health facilities is taking place at a faster pace. The often inadequate quality of public health care services and expensive health care services in the private sector have made the self-financing of health care for families really difficult. The introduction of the health micro-insurance concept by several organizations mentioned in this paper was born out of a real necessity of the majority of people to get better access to prompt and quality health care services at affordable costs. This is just a beginning since investing for future health is still not a common practice and not a priority for many people at the moment.

Innovative health micro-insurance schemes are being tested by various health institutions to provide health care to their catchment population at a reasonable and affordable price. Until now the number of such micro-insurance schemes are still limited, but they give scope for further testing.

Maternity protection services are not available to the majority of women in the reproductive age group. This is why all the existing health micro-insurance schemes in Nepal try to include maternity protection by providing health care services to their insured families. The maternity care included in the schemes forms a part of the general health care package; and therefore, it is often not comprehensive. These schemes usually cover the health care services for complicated and normal deliveries at the referral hospitals.

There is a scope for expanding the health micro-insurance initiative. We can learn from the weaknesses and build upon the strengths of the existing health micro-insurance models and try to create an even more appropriate model while adapting them to the operating environment. Health micro-insurance schemes with a comprehensive maternity protection component would help to secure better health among poor women in the informal economy. Therefore, provision for maternity care in a community-based health micro-insurance scheme is one of the strategies that can be used to fight the chain of events leading to maternal death.

---

## Bibliography

1. "Public Health Concern Trust (PHECT): An Introduction", The EC/UNFPA Reproductive Health Initiative project in Nepal, 2001.
2. Asian Development Bank , "Women in Nepal, 1999", Country Briefing Paper, 1999.
3. CECI Nepal, ILO STEP, CMF Nepal (2000) "Seminar and Workshop Report on Micro-Insurance, Nepal, June 2000".
4. Dr. Narayan Kumar "BPKIHS's Social Health Insurance: A Trial to Cater Common Health Risks", Workshop paper presented by BPKIHS, June 2001.
5. "Trade Union Adhikar: Trade Union Aandolanko ek dasakko sarwekchan pratiwedan" a publication of GEFONT, 2000.
6. "Trade Union Adhikar - Nepal ma Shram Kanun Karyanwayan ko Stithi" - 2057 GEFONT (Implementation of Basic Provisions of Labour Law, GEFONT, 2001.
7. Swasthya Sahakakari Sanstha Limited. GEFONT Leaflet – 2001.
8. "Maternity Protection at Work". A concept note from website of ILO, 2000.
9. Nepal Safe Motherhood Project, an Introductory Paper, 2001.
10. A case study on "Lalitpur Medical Insurance Scheme, Nepal", A working Paper of ILO-STEP, 2002.
11. UNDP Human Development Report, 2000.

---

## Annex I

### Public Health Concern Trust (PHECT/ Nepal): Health Micro-Insurance Scheme

PHECT/ Nepal, based in Kathmandu, came into existence as an NGO in 1991, with a goal to create an environment where people themselves have the right and ability to maintain and decide for their health. It started health care activities with a small clinic in Tikathali VDC in 1992. It was just an experiment to learn how health services can best be provided to the communities and achieve this goal. In 1993, they started a 18-bed hospital in Kathmandu, the "Model Hospital" aiming at making it a referral centre for their target community.

PHECT/Nepal has established Health Information and Service Centres (HISC), which are constituted by members from local people, at 8 different locations in Kathmandu Valley, of which two are already phased out. Through HISCs in its project locations, PHECT/ Nepal initiated a health micro-insurance scheme with the following objectives:

- To make the community health services self-sustainable
- To create a sense of community ownership on the health care services

It has also opened an avenue for collaboration with other organizations on health micro-insurance. GEFONT/ Kathmandu, Baireni Rajmarg Cooperative at Dhading, and Bikalpa Cooperative at Kirtipur/Kathmandu all have health related activities. They are now collaborating with PHECT/ Nepal's Kathmandu Model Hospital on health micro-insurance.

PHECT/Nepal started a health micro-insurance scheme at Tikathali VDC together with Women's Health Cooperative (WHC) in 1999. Even before the introduction of this scheme, the local community used to pay for their health care on an annual basis, a provision initiated by HISC. During that time, each member used to contribute Rs. 150-250 per year per family. The fund was managed by the community for the purpose of buying medicines and paying the salary of the health assistant at their daily clinics.

Upon the introduction of the health micro-insurance scheme in 1999, Women's Health Cooperative collects the premium from its members on an annual basis. Of this, two-third is paid to the Kathmandu Model Hospital as premium, with the remaining one-third used to operate a medical store in the cooperative building, and to pay partially the salary of the health worker who works in cooperative's clinic. So far, PHECT/Nepal has initiated health micro-insurance in four health cooperatives<sup>5</sup> and one HISC (i.e. Lamatar HISC). With all the collaborative partners, Kathmandu Model Hospital receives the agreed amount as premium and renders treatment to the insured members. In addition to the referral services for insured members, PHECT/Nepal also provides technical assistance, such as training to the collaborating cooperatives for their community health activities. The discounts given to health care services for participating cooperatives and other organizations are the same.

For the health micro-insurance scheme of PHECT/Nepal, two cooperatives were selected for this particular study: Bikalpa Multipurpose Cooperative and Tikathali Women's Health Cooperative. Some beneficiaries and non-beneficiaries were randomly chosen and interviewed using open-ended questionnaires. Efforts have been made to analyse the responses from the beneficiaries and non-beneficiaries, and to draw the perception of the population on health micro-insurance scheme and its utilization.

#### Target groups

PHECT/Nepal works with group of families with at least 25 families. The group must be involved in health related activities with primary level care provisions. The health micro-insurance coverage is only for the secondary and tertiary level care.

---

<sup>5</sup> The four Health Cooperatives are: Tikathali's Women Health Cooperative, Bikalpa Health Cooperative, GEFONT , and Baireni Rajmarg Health Cooperative.



### The process to enter into insurance scheme

There is an annual agreement with the health cooperatives and HISC's committees for the health micro-insurance scheme. The committee has to pay the premium for a whole year or half a year depending upon its financial position. No new member can join the group once the agreement has been signed until the time it expires.

### Services, premium and its usage

At present, about 1,000 families from HISC area and other organizations are benefiting from the health micro-insurance scheme with the Kathmandu Model Hospital.

At the community level, the Health Cooperative runs health awareness classes (Health literacy) so as to make them aware of the importance of antenatal care, delivery by trained person, postnatal care, childcare and disease prevention and control. PHECT/ Nepal also provides training to traditional birth attendants on safe delivery and first aid for basic care, organises medical campaigns and a doctor's visit for weekly clinics. Thus, all the primary health care needs are attended at the community level. Only complicated cases are referred to Kathmandu Model Hospital.

The referred patients obtain the following discounts from the hospital:

- 75 percent discount on doctor's consultation fee
- 50 percent discount on hospital bed and surgery costs

Each cooperative that is a member to the health micro-insurance collects the agreed premium amount and pays it to the hospital while signing the insurance agreement. Since the premium amounts are not the same for all the collaborators, the actual amount is stated under each cooperative's description.

---

## Annex II

### List of organizations visited

- Nepal Trade Union Congress
- General Federation Of Nepalese Trade Union
- Nepal Safe Motherhood Project
- The Department of Family Health Services of the Ministry of Health
- Rural Reconstruction Nepal
- Community development and Health Program (UMN/CHDP)
- BP Memorial Hospital, Dharan
- Marwari sewa Samiti, The Reyukai Nepal, Hotel association, Samabika Women's cooperative, and Sunderpur VDC
- Jhi Pu cha, (Nepal Bhasha and Cultural center), Biratnagar
- Vijaya Youth Club/VYCCU, Navalparasi
- Public Health Care Trust (PHECT/Nepal)
- Tikathali Women Health Cooperative (WHC), Lalitpur
- Bikalpa Multipurpose Cooperative, Kirtipur
- Federation of Nepalese Chamber of Commerce and Industries/ Kathmandu

### Annex III

#### Preliminary listings of institutions for the study

S N	Organizations visited/contacted	Target groups	Services related to maternity protection	Mechanism to deliver services
1	Nepal Trade Union Congress	Men and women Workers at various factories and industries	Advocacy on the protection of worker's rights - work is in the preliminary stage	Creating awareness on the rights of the workers in all its member organizations
2	GEFONT	Workers from various labour federations	Health cooperative, health insurance for all illness, which includes maternity care component as well	Regular check-ups, subsidized medicines and hospitalisation
3	Aama Milan Kendra	Women at reproductive age	Advocacy and training on SMH. No special service to women's health care	Training, information, education and communication
4	The Department of Family Health Services of the Ministry of Health	Women at communities - nine working districts	Supporting health service delivery (Health Post, Primary Health Care) Helping women to create and manage emergency fund to combat complications during pregnancy and delivery	-Technical support -Support to emergency fund raise and management
5	Rural Reconstruction Nepal/ CHDP Surkhet	Communities in Surkhet	Various community health activities	Not known
6	UMN/CHDP	3 Health Posts in Lalitpur districts	Health insurance for essential drug supply	-Regular supply of essential drugs in Health Posts - Maternity care is prime focus -High risk delivery is done at Patan hospital on free of cost
7	BP Memorial Hospital, Dharan	Various groups and organizations	Social health insurance scheme	-a wider range of services at hospital for all type of illness including maternity care
8	Vijaya Youth Club/VYCCU, Navalparasi	Women members of credit union	Sutkeri subidha (Delivery support)	A lump sum amount to women members for pregnancy or delivery
9	PHECT/Nepal	Various cooperative members in Kathmandu, and Dhading district	Specialized treatment to all types of illness and child delivery as referral center	-Discounted services for referral cases: -Technical support for awareness creation to member organizations
10	Bikalpa Multipurpose Cooperative, Kirtipur	Cooperative members in Kirtipur	Health Insurance with Kathmandu Model Hospital	Subsidized health care in major illness
11	Tikathali Women Health Cooperative, Lalitpur	Cooperative members plus others from the community	Health Insurance with Kathmandu Model Hospital	Subsidized health care in major illness
12	Nirdhan Grameen bank	Various groups (women/men) in working area	Indirect help against maternal health deterioration	Cancellation of loan and a lump sum grants for women borrower if spouse dies
13	Associate Craft producers (ACP)	Factory workers (all women)	Medical allowance on regular basis	Monthly medical allowances of Rs. 250 to each worker added in salary

---

## Annex: IV (a)

### Questionnaires for beneficiaries on maternity protection services at community level

Name of respondent:

Sex:                      Age:

No of children:

Main occupation:

Side occupation:

Yearly income/Wealth ranking:

District:                      Village:

Institution providing the service:

1. Are you a member of Health Cooperative/Health insurance scheme?

Yes/No

If Yes,

- a. Since when?
  - b. Who else in your family is included in the scheme?
  - c. Reasons for choosing to be the member/recipient of the service
2. What are the services/benefits you have received from the scheme? e.g, health awareness, FP information, care and treatments
3. How much do you pay per month/year?
4. How do you provide resources to pay?
5. What other services/benefits do you expect from the scheme?
6. Does this scheme cover maternity care?
- If yes, what are they? List the type of services (services or cash)
- a. Before delivery: Antenatal care; Describe:
  - b. Delivery care: Any services/facilities for home based delivery? e.g. arrangement of birth attendant, ambulance, or transportation cost
  - c. After delivery (Postnatal care): routine check-up, nutritional education, micronutrient supplementation, essential medicines
7. Delivery
- a. Place of childbirth
    - ☐ Private hospital: \_\_\_\_\_
    - ☐ Government hospital: \_\_\_\_\_
    - ☐ Health Centre
    - ☐ Sub-Health/Health Post
    - ☐ Hospital and home
    - ☐ Home, by trained birth attendant
    - ☐ Home, by family member/relative/friend
    - ☐ Home, by traditional midwife
    - ☐ Cowshed
    - ☐ Other: \_\_\_\_\_
  - b. How much did you spend for the childbirth? \_\_\_\_\_ NRS
  - c. How much did you spend for transportation? \_\_\_\_\_ NRS

- d. Was the delivery under guidance of medically trained persons? Yes/No
- e. Do you have access to a health institution? Yes/No
- 8. How useful is the scheme for you and your family's health? Describe briefly
- 9. What is the process to obtain maternity care from the scheme?
- 10. Accessibility and affordability to the scheme
  - a. What are the main constraints in accessing the required services from the scheme?
  - b. In your opinion, how can the problem/constraints be solved?
- 11. What is your suggestion to other women of reproductive age, who are not covered by the scheme?
- 12. Researcher's observations

---

## Annex: IV (b)

### Questionnaires for non-beneficiaries on maternity protection services at community level

Name of respondent:

Sex:                      Age:

No of children:

Main occupation:

Side occupation:

Yearly income/Wealth ranking:

District:

Village:

Institution providing the service:

1. You are not a member of the a community-based organization maternity services  
Why?
2. What are the main health problems you have had, especially during pregnancy and delivery?
3. Do you go for antenatal care?  
If yes, where?  
How often?
4. Delivery
  - a. Place of childbirth
    - ☐ Private hospital: \_\_\_\_\_
    - ☐ Government hospital: \_\_\_\_\_
    - ☐ Health Centre
    - ☐ Sub-Health/Health Post
    - ☐ Hospital and home
    - ☐ Home, by trained birth attendant
    - ☐ Home, by family member/relative/friend
    - ☐ Home, by traditional midwife
    - ☐ Cowshed
    - ☐ Other: \_\_\_\_\_
  - b. How much did you spend for the childbirth? \_\_\_\_\_ NRS
  - c. How much did you spend for transportation? \_\_\_\_\_ NRS
  - d. Was the delivery under guidance of medically trained persons? Yes/No
  - e. Do you have access to a health institution? Yes/No
  - f. Do you have access to Family Planning information/education or services? Yes/No  
If yes, explain:
5. Where do you go to seek health care at the time of emergency?
6. How do you manage the cost of health care? Especially for the antenatal care, delivery and postnatal care?
7. What do you do if you cannot manage the money at the time of emergency health needs?

8. Do you know other women who are covered by health insurance?  
If yes, what do you think about such services?
9. Do you also wish to be included in the scheme?  
Yes/No  
Why?
10. What kind of services would you want to be covered by?