

Rethinking cash transfers to promote maternal health: good practice from developing countries

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Quality maternal health care is a fundamental right for all women. Its links to child survival and development, to health care strengthening and environmental sustainability make it imperative for broader development goals, including the achievement of the Millennium Development Goals (MDGs).

Each year between 350,000 (Hogan et al., 2010, estimate from 2008) and 500,000 (UN, 2011, estimate from 2005) women die as a result of pregnancy and childbirth. Nearly all of these deaths – 99% – are in developing countries, with the vast majority in sub-Saharan Africa. For every woman who dies, ‘at least 30 more suffer a debilitating illness or permanent disability’ (BADAS/Ekjut, 2011). Each year, up to 100,000 women develop obstetric fistula, primarily as a result of prolonged, obstructed labour; up to two million women in Africa and Asia are thought to need treatment (WHO, 2010).

Finance, or the lack of it, is key to women’s reproductive health care. In 2007, 37% of all health official development assistance (ODA) went to maternal, newborn, and child health (Huntington, 2010). Funding for family planning has, however, plummeted over the past decade, despite a 25% increase in the number of women of reproductive age (UNFPA, 2009), leaving healthcare users with severe financial burdens. A normal hospital delivery in Nepal, for example, costs 26% of average yearly earnings; complications in rural Bangladesh can cost 90% to 138% (Borghi et al., 2006).

Understanding the so-called ‘three delays’ is vital to grasp the obstacles that women face in obtaining

the care that is often needed to save their lives and those of their infants (Thaddeus and Maine, 1994).

The first is recognising the need for care and deciding to seek out that care. In poorly educated communities the early signs of complications may be missed. Moreover, in the context of social institutions and cultural practices that devalue women, deciding to spend scarce resources to protect women’s reproductive health may, at best, take time and, at worst, be inconceivable.

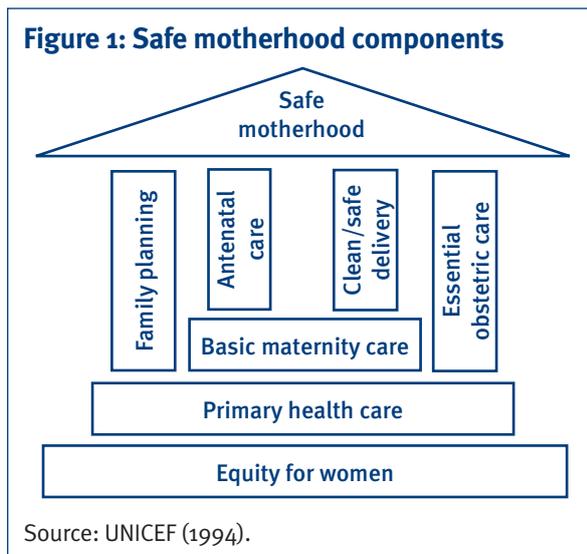
The second delay is women’s ability to access care. Poor infrastructure, lack of transportation and long travel times prevent care even for those women, and their families, who seek it.

Third, many women face delays in obtaining quality care even if they reach a clinic or provider. Low funding, or mismanagement of funds, has left many hospitals short of staff and vital supplies.

A wide variety of programming has aimed to minimise these three delays. Community-based initiatives have built community support for women’s health, training local midwives and providing clean delivery kits. Social marketing approaches have educated women about their health care needs – and targeted men to change their attitudes on gender equity. Cost-sharing schemes, including subsidies and obstetric insurance, have spread financial risk. Indeed, evidence increasingly suggests that maternal health interventions should be highly contextualised and embedded in an integrated service package (USAID and HSSII, 2011).

Cash transfers, long used in Latin America to improve children’s health and education outcomes, have taken on a new role. Conditionalities on antenatal care (ANC) and facility delivery are being built into programmes to improve uptake of maternal health care. Such programmes often offer broader support with more integrated benefits, and have the potential to assume a

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critical role in addressing maternal health care deficits.

This Background Note reviews the evidence on conditional cash transfers (CCTs) to promote safe motherhood (Figure 1) – a concept that spans not only care during pregnancy and childbirth, but access to family planning and equitable health services (UNFPA, 2011) – comparing them to other approaches to maternal health programming in developing countries.

Conditional cash transfers to promote safe motherhood

Conditional Cash Transfers (CCTs) – regular social transfers for vulnerable households if they comply with certain conditions (especially service uptake and behavioural change) – have been used for decades to improve health and educational outcomes for children. Cash transfer programmes can be conditional or unconditional, but we are unaware of any unconditional programmes related to maternal health with one exception: a pilot by Interact with ODI, funded by the UK Department for International Development in 2011 (Samuel et al., 2011). This Background Note, however, focuses on conditional programmes.

CCTs are becoming increasingly widespread in the developing world, including in low-income countries, and are seen as a mechanism to mitigate immediate disadvantage, and a way to improve the longer-term development of human capital and reduce the inter-generational transmission of poverty. Most CCTs have emphasised child nutrition, immunisation and school attendance rather than safe motherhood (SM), but many do target pregnant/lactating women, thereby encompassing SM objectives. India and Nepal have recently rolled out CCTs that have SM at their core.

As de Brauw (2011) notes, CCTs may impact maternal health through a variety of mechanisms (see Table 1 overleaf). First, programmes such as Mexico’s *Oportunidades* include free health care to incentivise service use. Second, programmes that build maternal health care into CCT conditionalities engage women in

a contract to use health care. Third, CCTs that include training in nutrition, sanitation and health maintenance may stimulate demand for health care services. Fourth, CCTs may address supply-side constraints; geographical targeting often includes investments in community health infrastructure. Finally, CCTs not only improve a family’s financial status, but – as women usually receive the benefit – they may also impact on women’s status within the family and their ability to make decisions about their reproductive health care.

While CCTs are diverse in terms of who qualifies and what they receive, programmes have some similarities. By definition, all issue a cash benefit in exchange for recipients meeting conditionalities that encourage behaviour changes ranging from appropriate infant weight gain to attendance at prenatal clinics. There is evidence that the success of a CCT depends on three main features (Elamon, 2010: 4):

- the money must be transferred to women as directly as possible (not to the family in general or men in the family), and with the least number of intermediaries
- the amount of money should equal about 30% of total household income to provide adequate positive incentives while minimising perverse incentives and dependency
- the woman should get the money from the time her child is born until the child is 36 months old and preferably also during pregnancy (with her first ANC visit as the qualifier).

Supply-side incentives to promote quality service provision can be critical. Some CCTs, for example Brazil’s *Bolsa Familia* (‘Family Grant’), provide municipalities with funds for administration to partially reimburse them for implementing the scheme, with the amount conditional on the municipality’s score on a decentralised management index (Lindert et al., 2007). There is a risk, however, that this could create perverse incentives for municipalities to take shortcuts in reporting to get the subsidy, pointing to the need for better oversight of this element.

In India and Nepal, providers also receive incentives: from \$4 to \$13 for facility deliveries in India, with rural deliveries reimbursed at higher rates than urban deliveries. In Nepal, on the other hand, trained health workers receive an incentive whether the delivery takes place in a facility or at home, and facilities also receive institutional delivery incentives.

Evidence suggests, however, that CCTs can be costly in terms of time, money and effort (Elamon, 2010). This is especially true of conditionalities related to ‘antenatal care, exclusive breastfeeding, and maternal care’, which involve complex monitoring procedures (ibid: 4). Given that lack of money is only one of the reasons for not following SM practices, CCTs that lack explicit conditionalities to encourage behaviour change may have limited impact.

CCTs also struggle to address birth spacing. Pregnancies that are too early and too close together

are neglected even though young mothers are more vulnerable than older mothers to maternal morbidity and mortality. To avoid incentivising pregnancy and to encourage healthier birth spacing, it is suggested that CCTs add both family planning benefits and birth spacing incentives (Elamon, 2010).

A third key challenge is supply-side deficits. Where healthcare delivery systems are weak, there is a clear need for additional and well-resourced supply-side measures to ensure the availability and quality of relevant services in response to increased demand from social transfers or other community mobilisation initiatives. This is recognised by some CCT schemes (Brazil's *Bolsa Familia*, India's *Janani Suraksha Yojana* and Nepal's Service Delivery Incentive Programme).

CCTs with safe motherhood elements

A considerable number of CCTs include SM elements as part of a broader set of conditionalities to improve maternal and child well-being (Table 1 overleaf). Many require pre- and postnatal appointments, clinic-based deliveries and training sessions covering aspects of maternal health and nutrition. Pregnant women are required to attend meetings about prenatal care consultations, with clinical content including care, maternal nutrition and other reproductive health information (Barber and Gertler, 2009).

Brazil's *Bolsa Familia* programme, for example, requires pregnant and lactating women to attend educational workshops and have regular check-ups. Mexico's *Progresa* requires education and training sessions, while CCT programmes in El Salvador, Guatemala and Nicaragua provide regular but optional information sessions where topics include maternal health and nutrition (de Brauw and Peterman, 2011; Gaia, 2009; Maluccio and Flores, 2004). Others make additional stipulations related to delivery. The *Pantawid Pamilyang Pilipino* CCT programme in the Philippines states that 'childbirth shall be attended by skilled/trained health personnel' (Pablo, 2009).

Targeting

Various targeting methods are used by such CCTs, with most programmes combining (1) a first stage of geographical targeting with (2) some form of mean testing to confirm selected households meet poverty criteria, and (3) demographic eligibility criteria, most commonly the existence of a pregnant/lactating woman and young children.

In the Philippines, for example, the *Pantawid Pamilyang Pilipino* programme covers a total of 700,000 households, representing nearly 15% of all poor households in the country. The three-stage selection process targets first the poorest provinces, using the 2006 Family Income and Expenditure Survey; next the poorest municipalities, based on Small Area Estimates (SAE) of the National Statistical Coordination Board (NSCB); and finally the poorest

households ascertained through a proxy means test (Department of Social Welfare and Development, n.d.). Peru's *Juntos* programme also follows a three-stage targeting scheme. First, districts are selected on the basis of criteria ranging from rates of extreme poverty to exposure to violence. Second, a census is taken of all households and a proxy means formula ascertains eligibility based on poverty; eligible households are then screened for demographic fit (i.e., pregnant women or children under the age of 14). Third, a community validation exercise is undertaken (Perova and Vakis, 2009).

There are pros and cons to different methodologies. More complex procedures carry a higher opportunity cost in time and money and can be subject to elite capture despite their intention to focus programme benefits on the most deserving. Universal approaches can be useful for political buy-in, but benefits are often skewed towards higher socioeconomic groups (Lim et al., 2010).

Impacts on maternal health

There is a wealth of evaluative material available on the human capital-related dimensions of many of these broad CCTs, but surprisingly little documentation on their impacts on maternal health. There are exceptions. Mexico's *Oportunidades* programme requires the completion of holistic prenatal plans that include nutritional supplements and health classes as part of programme conditionalities, and this has been shown to increase uptake of ANC, skilled delivery, institutional birth, postnatal care, vaccinations and micro-nutrients. Programme participation is also linked to improvements in the quality of care that women receive, and in women's status – engendering decision-making skills and the space in which to use those skills (Freedman et al., 2007). However, Urquieta et al. (2009) found that *Oportunidades* had no significant impact on the probability of using a skilled birth attendant except among women who had one birth before programme enrolment and another after: women who had experienced a difficult birth were more likely to use skilled care when they had the funding to do so.

While Barber and Gertler (2009) found no programme impact on the number of antenatal visits, they found that beneficiaries received 12.2% more prenatal procedures than non-beneficiaries: 20.1% more procedures for history-taking and diagnostics, 11.3% more for physical examination, and 8.8% more for prevention and case management. They attribute the former to supply-side limitations and the latter to the fact that women in the programme are more active in their consumption of health care and have more disposable income. Lastly, Rivera-Dommarco et al. (2006) found a significant reduction in anaemia between 1999 and 2006 among programme participants living in extreme poverty as a result of nutritional supplementation (a fortified beverage for pregnant women).

Table 1: CCTs encompassing SM elements

Country	Programme	Objectives	Recipients	Coverage	Amount received	Conditionalities	Reference
Bolivia	<i>Bono Madre Niño and Bono Juana Azurduy de Padilla</i>	To reduce infant and maternal mortality rates and rate of chronic malnutrition in children 0-2 years old.	Women and their families without medical insurance or access to the breastfeeding grant.	Once launched nationwide, aims to cover 74% of the population: around 550,000 beneficiaries a year.	<ul style="list-style-type: none"> 50 Bolivianos (approx. \$7.14) received at each of four prenatal exams provided; 120 Bolivianos (approx. \$17) when receiving childbirth assistance from municipal health centres; 125 Bolivianos (approx. \$17.84) at each bimonthly postnatal control of their babies until the age of two; 1,820 Bolivianos (approx. \$260) in total during 33 months (poor families in Bolivia have incomes of 300-1,500 Bolivianos per month). 	Attending prenatal exams, institutional delivery and postnatal exams (as per outline under 'amount received').	Barrientos et al. (2010)
Brazil	<i>Bolsa Familia</i>	Two central objectives: (1) reduce hunger, poverty and inequality through income transfers linked to education, health and nutrition services; (2) reduce social exclusion by facilitating empowerment of poor and vulnerable households.	The programme covers all poor families with children up to the age of 15 and all extremely poor families, regardless of their composition.	2009: 12.5 million households, 2008: 11 million households – this equates to around 25% of the population.	Two types of benefits: basic and variable, according to family composition (number of children, capped at three and whether the mother is pregnant/breastfeeding) and income, up to \$18.25, or \$6.25 per beneficiary in the household (approx. 8% of household family income).	For pregnant and lactating women: attending educational workshops, regular check-ups and vaccinations up-to-date.	Lindert et al. (2007); Barrientos et al. (2010)
El Salvador	<i>Comunidades Solidarias Rurales</i> (formerly <i>Red Solidaria</i>)	To assist extremely poor households through short-term improvements in child and maternal health and nutrition; basic education, and drinking water, sanitation, electricity and road improvements to the poorest rural communities.	Health stipend received by children under 15 and expectant women from families in extreme poverty.	2008: 80,000 beneficiary households, about 380,000 individuals.	Bimonthly transfers of \$15 to families eligible for health component only, \$20 if eligible for both health and education components and \$10 if eligible for education component only, i.e. between 15% and 18% of the minimum rural salary.	Attending maternal health checks according to Ministry of Health's protocols.	Britto (2007); De Brauw (2011); Barrientos et al. (2010)
Guatemala	<i>Mi Familia Progresá</i>	To improve maternal health, universal basic education and reduce child mortality.	Mothers of children under the age of six, to pregnant women and to breast-feeding mothers.	477,746 beneficiary households in 2009 – this is 46.7% of the extreme poor and 13.6% of the total population.	A monthly health and nutrition transfer of around \$18 (Quetzales 150), i.e. 10% of the average monthly consumption of an extreme poor household.	Attend health centres to receive a basic package of nutritional and preventive maternal-child health care services.	Gaia (2009); Barrientos et al. (2010)
Indonesia	<i>Program Keluarga Harapan</i>	To improve households' socioeconomic conditions; educational levels; health and nutritional status of pregnant women, postnatal women, and children under five in recipient households; and access to and quality of education and health services.	Eligible households must be classified as chronically poor (<i>Rumah Tangga Sangat Miskin</i>), and meet one of the following conditions: have a child aged 6-15 years; have a child under 18 years who has not completed primary school; have a child aged 0-6 years; or have a pregnant/lactating mother.	Targets 6.5 million households with pregnant women and children between 0-14. In 2009, 720,000 poor households in 14 provinces received the transfer and in 2010 it is estimated that 1 million households will receive the benefit. The programme aims to reach 6.5 million chronically poor households by 2015.	Transfer for poor families who have a pregnant/lactating mother – 800,000 Rp. i.e. \$67 per quarter (versus a national poverty line of \$1.55 per day (ILO, 2008); additional transfers of various amounts related to having children of various ages).	<ol style="list-style-type: none"> Four prenatal care visits for pregnant women at health institutions; Taking iron tablets during pregnancy; Delivery assisted by a trained health professional; Two postnatal care visits. Recipients receive a transfer based on their particular circumstances. Cash is given as a quarterly transfer collected at the local post office. The non-use of applicable services is reported by health services and schools. If a recipient fails to comply with conditions after a few warnings the transfer is stopped. 	Social Protection in Asia (2009); Barrientos et al. (2010)

Mexico	<i>Oportunidades</i> (formerly PROGRESA)	Improve the educational, health and nutritional status of poor children.	Pregnant or lactating women, children under 2 and under-nourished children 2-4 years old (supplements).	Expanded from an initial coverage of 300,000 families to 5.8 million households as of 2010.	Monthly health stipend is fixed at approximately \$15 per household per month (20% of household income – Bastagli, 2007); nutritional supplements with vitamins and minerals.	Pregnant women completing a prescribed prenatal care plan, obtaining nutritional supplements, and attending an educational programme about health and nutritional topics. Households must prove compliance via certification at public clinics.	Gertler (2000); Gobierno Federal (2010)
Nicaragua	<i>Red de Protección Social</i>	Supplement household income for up to three years to increase expenditure on food; and increase school enrolment and attendance among children aged 7-13; to increase health care provision and nutritional status amongst children under 9, and improve prenatal and postnatal care for women.	Poor households with children and/or pregnant women.	Estimated to cover 3% of the population or around 30,000 households but was discontinued after three years.	Health grant of up to \$90 per family per year to cover payments to private providers of health-related services (transfers covered around 20% of household income).	Pregnant women attend health check-ups.	Maluccio and Flores (2004); Bastagli (2007); Barrionos et al. (2010)
Paraguay	<i>Red de Protección Social</i>	Reduced extreme poverty and increasing human and social capital in beneficiary families.	Children aged 0–14 (including street children), and pregnant women in extreme poverty.	9,000 beneficiary households in 2006.	<ul style="list-style-type: none"> • Food bonus: G. \$60,000 (US \$10) • Health and education bonus: G. \$30,000 (US \$5) per child aged 0 to 14 years old, up to 4 children per household. • Minimum amount: G. \$90,000 (family with one child) (US \$15) • Maximum amount: G. \$180,000 (family with four or more children) (US \$30). 	For pregnant and lactating women: visits to health facility for pregnancy check-ups and post-partum control.	Paraguay Profile (2006)
Peru	<i>Juntos</i>	Reduce poverty and build human capital. Improve maternal and child health status; decrease school dropouts; and promote registration and identification.	Impoverished households with children under 14 years and/or a pregnant woman.	454,000 households in 668 districts in 2009. Ultimately planned to extend to all 880 of the poorest districts.	Eligible households receive a fixed monthly cash transfer of 100 soles (approximately \$30) per month. Unlike other CCT programmes this is a lump-sum payment and does not differ across households (e.g. with a different number of children).	For pregnant and breast-feeding mothers: Attend prenatal and postnatal checks (tetanus vaccination, folic acid and iron supplements and anti-parasite checks).	Perova and Vakis (2009); Barrionos et al. (2010)
Philippines	<i>Pantawid Pamilyang Pilipino Programme</i>	Dual objectives: Social Assistance – to provide income assistance to the poor (short-term poverty alleviation), and Social development – to break the intergenerational poverty cycle through investments in human capital.	Poorest households with children up to 14 and/or pregnant women.	At the end of 2009, 700,000 households or 14.8 % of the total poor households in 45 provinces, 15 cities and 255 municipalities. Now operates in 80 provinces covering 734 municipalities and 62 key cities. Aims to cover 2.3 million households by end of 2011.	Health cash grant of package (for the preventive health check-ups and vaccines of pregnant women and children aged five years old and below) of PhP500.00 (approximately \$10.64) per month or PhP6,000.00 (\$127.65) a year per household (by 2008 standards, a family of five is considered poor if they have a monthly income of P10,000 or P120,000 annually).	Pregnant women must get prenatal care, must be delivered by a skilled birth attendant and must get postnatal care. Mothers must attend mothers' classes. Parents must attend Parent Effectiveness Seminars and Responsible Parenthood Seminars.	Pablo (2009) Programme website: http://pantawid.dswd.gov.ph/index.php/about-us?start=1

El Salvador's *Comunidades Solidarias Rurales* (CSR) has also had positive impacts on maternal health. De Brauw and Peterman (2011) found that even though the programme did not condition either ANC or delivery details, CSR impacted birth location and skilled attendance. They attribute these effects, to some extent, to supply-side improvements in health systems and, to a larger degree, to increases in women's empowerment.

Common programming challenges

There are a number of common challenges among these programmes. One key concern is women's time poverty and the risk that CCTs may exacerbate this. In the case of Guatemala's *Mi Familiar Progresá*, beneficiaries face significant time burdens as a result of having to attend events as part of the programme's conditionalities (Gaia, 2009).

Another challenge is that women are often the only programme targets when other household members may play a key role in decisions on reproductive health. There is, therefore, scope to expand strategies to include other household members, as evidence suggests that a woman's delivery decisions are 'heavily influenced by significant others, especially her mother-in-law, her mother, or her husband' (Freyermuth, 1999, in Urquieta et al., 2009).

While service uptake may increase as a result of CCT conditionalities, impacts on outcomes such as maternal malnutrition or anaemia appear more limited in some cases due to an inadequate supply of complementary health services. An evaluation of Peru's *Juntos* programme, which includes attending prenatal and postnatal checks as part of its conditionalities, found minimal change in maternal nutrition and health largely because of the limited supply (quantity and quality) of health services (Perova and Vakis, 2009).

CCTs with safe motherhood as their core focus

A smaller number of CCTs have SM as their core focus. Nepal's Safe Delivery Incentive Programme (SDIP) and India's *Janani Suraksha Yojana* (JSY, 'Safe Motherhood Scheme) have common goals of reducing maternal and neonatal deaths by incentivising poor women to give birth in a health facility, but also have some key differences. The SDIP was initially conditional on giving birth in a public health facility but that criterion was later relaxed (see Table 2 overleaf) (Powell-Jackson et al., 2008, 2009), whilst JSY also requires attendance at three antenatal and post-birth check-ups, with benefits also extended to women giving birth in private facilities (Lim et al., 2010).

The national JSY is the largest CCT in the world in terms of numbers of pregnant women served, with a budget to cover 9.5 million pregnancies a year (ibid.). It is implemented at grassroots level through community-level health workers, such as accredited

social health activists (ASHAs) who identify pregnant women, help them get to a health facility for antenatal and postnatal care visits and to get their new babies immunised (ibid.). In Nepal, the programme issues guidelines to decentralised health offices and hospitals, and trains and contracts private providers to deliver the health services required (Powell-Jackson et al., 2008, 2009).

Targeting

Initially, the Government of Nepal targeted all pregnant women with no more than two living children or an obstetric complication in its Safe Delivery Incentive Programme, rather than targeting the poorest, to gain political popularity (ibid.). In India, the transfer is received by all women in the ten high-focus states and those below the poverty line in low-focus states. The JSY transfer is given for the first two live births only, unless women have a government-issued below-the-poverty-line card or are from a scheduled (low) caste or tribe. In both cases, the amount provided varies geographically. In Nepal it ranges from \$7 in the lowlands to \$21 in the mountains, reflecting differences in the accessibility of health care facilities. In India it varies from \$13 for urban women in low-focus states to \$31 for rural women in high-focus states. Providers also receive incentives, ranging from \$4 to \$13 (Lim et al., 2010; Powell-Jackson et al., 2008, 2009).

Impacts on maternal health

Impacts have been positive, given the age of these programmes. In Nepal, women exposed to the SDIP were 24% more likely to use government health institutions, 5% less likely to deliver at home and 13% more likely to have a skilled attendant at delivery (Powell-Jackson et al., 2008). Impacts varied by wealth quintile, with the greatest effect found amongst those in the middle quintile, who were 93% more likely to use government delivery care services and 66% more likely to use a skilled attendant at delivery (ibid.). Encouragingly, while the impact was slightly less among the poorest two-fifths of women, they were still 64% more likely to use a skilled attendant at delivery (ibid.).

There were clear impacts even though the programme struggled initially with publicity; only 27% of surveyed women knew about the SDIP during pregnancy, with the figures higher for women who were wealthier, more educated and less marginalised by caste (ibid.). Popular awareness has grown, enhanced by the restructuring mentioned above in 2007, and the overall percentage of women receiving the incentive increased from an estimated 34% in the first year to 59% by the third year of implementation, alongside a substantial decrease in late payment (Powell-Jackson et al., 2008, 2009).

Evaluation of the JSF scheme showed a positive impact on receipt of antenatal care and in-facility births, which rose from 30% to 38% after implementation (Lim et al., 2010). One midwife noted,

Table 2: CCTs with SM core focus

Country	Programme	Objectives	Who receives transfers	Coverage	Amount received	Conditionalities	Reference
India	<i>Janani Suraksha Yojana</i>	Reduce number of maternal and neonatal deaths by incentivising low socio-economic status women to give birth in a health facility.	All women in high-focus states and those below the poverty line in low-focus states. Benefit covers first two live births only, unless the mother has a poverty card or is from a scheduled caste.	2009-2010 financial year: funding available for 26 million women.	The benefit varies geographically. Urban women in low-focus states receive \$13, rural women in low-focus states receive \$15. Urban women in high-focus states receive \$22 and rural women in high-focus states receive \$31. Providers also receive incentives for facility deliveries.	Pregnant women must receive three antenatal check-ups. Women must give birth in a health facility; both public and private clinics are permissible. New mothers must receive one postnatal check-up.	Lim (2010)
Nepal	Safe Delivery Incentive Programme	Increase use of professional care at childbirth and skilled birth attendance.	Initial criteria: all pregnant women with no more than two living children or an obstetric complication. From 2007 this condition was removed to simplify the programme.	Covers all women. SDIP increased the probability of a woman delivering in a government health institution by 24% (4 percentage points) and increased the probability of a woman delivering with a skilled attendant by 13% (3.4 percentage points).	The benefit varies geographically to account for differences in accessibility. In the mountains the benefit is \$21, in the hill areas it is \$14 and in the lowlands it is \$7. Providers also receive incentives for deliveries – both in facility and at home.	Initially women had to give birth in a public health facility. However, the programme was expanded in 2007 to include not-for-profit hospitals in order to address concerns about the availability of obstetric services. More recently, the government announced further changes, including removing user fees for delivery care at all public health facilities while continuing to provide the SDIP conditional cash transfer to women.	Powell-Jackson (2009, 2008)

‘Everyone goes to the institutions now – not because of the money, but because they are afraid of complications’ (Blake, 2011). Rates of postnatal care and advice on breastfeeding are also increasing (Gol, n.d.). Even more encouragingly, ethnic minority populations appear to be using services at rates similar to non-minorities, with the highest uptake among first-time pregnant adolescent mothers who had less than a secondary education (Lim et al., 2010). There was less variation between rural and urban areas and with distance to a health facility, although the highest rates of payments were to women living in rural areas but close to a health facility. State variability, on the other hand, was significant – the percentage of women receiving a transfer varied from 5% to 44% (Lim et al., 2010).

Challenges

Both the Nepali and Indian maternal CCTs are young and suffering from growing pains. The former has been characterised by delays in transferring central funds to the districts and lack of clarity amongst implementers, due to a combination of programme complexity and the lack of a national media campaign to raise awareness. Consequently, there have been ‘variations in the interpretation of the eligibility criteria and the administration of the cash. The former included cases where health facilities simply ignored the eligibility criteria altogether’ (Powell-Jackson et al., 2011).

Since 2007 programme changes have been made, including expanding the programme to include not-for-profit hospitals to address concerns about the availability of obstetric services, and a national information campaign and district-level training of staff to improve awareness and understanding of the programme. Central procedures to manage and disperse funds have also been streamlined (Powell-Jackson et al., 2009).

In India, Paul (2010) notes that ‘JSY implementation is still immature’. The programme suffers from a lack of information availability, state-by-state variation in eligibility guidelines and uptake, delays in payments, quality control issues in health infrastructure, and impeded access to health facilities in some districts due to difficult terrain. Targeting is weak, with the poorest and least educated women not always most likely to receive payments (Lim et al., 2010). Finally, Blake (2011) notes that JSY implementation needs to balance incentivising institutional births with ensuring respect for women’s birthing traditions. Many Indian women return to their families of origin for childbirth – and a break from their wife/daughter-in-law duties – but JSY does not yet accommodate this flexibility.

Complementary programmes

While CCTs address maternal health by embedding interventions in larger packages that aim for changes in broader well-being and service uptake, the economic and political conditions are not always

right for such ground-breaking schemes. There are, however, other options, including voucher schemes, cost-sharing mechanisms, social marketing and community based initiatives. These can be used as stand-alone alternatives to CCTs, or can support a larger CCT programme.

Voucher schemes

Voucher schemes provide women with vouchers that they can exchange for a service. A recent meta-analysis of reproductive health voucher programmes across Latin America, Asia and Africa found that they are effective in increasing health service use, quality of care, and health outcomes (Bellows et al., 2010).

They have varied designs. In Bangladesh, Kenya and Uganda they focus on SM and cover pregnancy care and, variably, sexually transmitted infections (STI) reduction, long-term family planning, and recovery from gender-based violence. In Kenya and Uganda clients pay a small co-payment. In Kenya, the SM voucher, which covers costs ranging from hospital transport to caesarean section, is billed at \$2.70 to women. In Uganda, the Healthy Baby voucher costs \$1.50 and covers all pregnancy-related care. Both programmes start with geographical targeting and then use poverty grading tools within areas to identify the poorest and most vulnerable.

In contrast, the Honduran *Programa de Asignación Familiar* (PRAF, 'Family Allowance Programme') goes further in approach (supply-side interventions are included) and aim. It was originally intended to target poor households only, but has evolved to focus on general human capital development.

In Bangladesh, the Demand-Side Financing scheme covers all normal maternity care and provides an allowance for transport, food and a baby gift. All women in the poorest sub-districts are eligible, with women in other districts subject to means testing. Vouchers are only distributed to women for first and second births and who use family planning to ensure two years between births to avoid introducing an incentive to conceive. These conditions have been criticised as being difficult to monitor and penalising women who have the most vulnerable pregnancies (Helal and Saikhul, n.d.).

Evaluation data on the impacts of voucher schemes on maternal health outcomes are extremely limited. The Bangladeshi scheme, while suffering from targeting problems, appears to have doubled the rate of skilled attendance and increased the rate of postnatal care, even though it did not eliminate out of pocket expenditures (Schmidta et al., 2010). In Kenya, anecdotal evidence suggests that women purchased the vouchers as insurance against delivery complications rather than to use for normal deliveries (RHVouchers, 2011). However, other evidence shows that facility deliveries are universally up and quality of care has increased, as providers use voucher income to invest in infrastructure and staff.

Fee exemption policies

Delivery fee exemption schemes, such as those of Ghana and Senegal, have addressed financial barriers prohibiting SM (Ghana's programme ended in 2008 with the goal of providing maternity care through the new National Health Insurance System). Both schemes were piloted initially in the poorest regions before being scaled up nationwide. Both set reimbursement rates based on the type of delivery (Witter et al., 2008). In Ghana, private facilities were reimbursed at a higher rate as they received fewer public subsidies. In Senegal, kits, rather than money, were provided for caesarean sections carried out in district hospitals.

Senegal saw a rise in both institutional deliveries and caesarean sections. Quality was maintained, with no increase in the stillborn rate (3.3% in 2004; 3.1% in 2005) (Witter et al., 2008). In Ghana, a household survey found a significant – more than 25% – fall in mean delivery fees for caesarean sections and normal deliveries after the policy was introduced (Asante et al., 2007; Witter et al., 2008).

While the removal of user fees can have dramatic results, it is crucial to prepare the health system in advance. Adequate funding is vital to replace the loss of health system revenue and ensure adequate supplies and medicines to deal with increased demand (Borghi et al., 2006). User fee removal alone will not address physical and indirect financial barriers (such as the cost of transport) that prevent the poorest women accessing services.

Cost-sharing mechanisms

Cost-sharing mechanisms, such as community health insurance, have the advantage of flexible complementarity with other interventions. As Soors (2008) notes, 'risk sharing eases the financial burden for the individual household and prepayment ensures quick access at the time of need'. Burkina Faso's cost-sharing system covers all major emergency interventions related to pregnancy, with costs shared between four parties: 1) the woman and her family, 2) the management committees of health centres, 3) the local authorities, and 4) the health district. Surplus funds are used to treat the district's poorest inhabitants. It is a success: skilled attendance, the number of interventions and the percentage of recovery have all soared and early perinatal mortality has declined (Ouédraogo et al., 2008).

Obstetric risk insurance programmes, such as the *Mutuelle de Santé Communautaire de Dar-Naïm* (MSCDN) in Mauritania, also aim to improve access to – and the quality of – emergency obstetric care. MSCDN began by estimating local needs and costs and provides all women with care throughout pregnancy for a flat-rate ticket of \$22, which is between two and ten times lower than the fees in other public sector maternity wards. All patients attending their first ANC consultation are informed of their options.

MSCDN has had ‘a highly positive impact: the population’s massive adherence in all four areas has led to a growing number of services delivered and a consequent twofold increase in assisted deliveries in rural areas’ (Renaudin et al., 2008). Maternal deaths are also decreasing.

Social insurance schemes have achieved widespread coverage, enhanced the uptake of services, and reduced the financial burdens of maternal health care for women in some countries (Impact, 2007; Borghi et al., 2006). However, such schemes are not well developed in poorer regions of sub-Saharan Africa and South Asia, due to issues of the geographical dispersion of households, low incomes that preclude payment of premium rates, limited formal sector employment and minimal health care infrastructure to support insurance scheme members. In these contexts, equity and sustainability issues are significant in rolling out medical insurance schemes (Borghi et al., 2006).

Social marketing approaches

Social marketing approaches to behaviour change in maternal, reproductive and sexual health address SM issues by targeting both pregnant women and their partners. In Southeast Asia a programme promoting the weekly use of preventive supplementation of iron-folic acid to women of reproductive age took a social marketing approach, through information, education and communication materials and events, and mobilising community leaders. Positive results highlight the need for strong public/private partnerships to maintain consistent educational messages (Nguyen et al., 2005).

In Jordan, the *Mabrouk!* (Congratulations!) initiative targets newlyweds and new parents, intervening at critical decision-making moments. It combines a multimedia campaign with interpersonal and community empowerment approaches. Information kits on spousal communication, gender equity, child care, family planning, spacing between pregnancies and breastfeeding reach over 70,000 couples each year (JHCP, 2011).

In Indonesia, a campaign to increase the involvement of husbands in maternal care and SM calls on husbands to attend to their wives’ needs during pregnancy and delivery and work with them to prepare a plan in case of an obstetric emergency. Evaluation indicates that knowledge acquisition and taking action were more likely among men engaged in interpersonal communication about the campaign messages than those simply exposed to the campaign (Shefer-Rogers and Sood, 2004).

Community-based initiatives

Community-based initiatives (CBIs) to enhance SM include programmes to train community-based health personnel, using information, education and communication (IEC), and more recently behaviour change communications (BCC) materials, mobilisation through women’s groups and developing transport

systems to get women to emergency delivery facilities and pre-/postnatal care.

The 2006 *Lancet* series on maternal survival asserted that the ‘best bet’ was health centre-based intrapartum-care by midwives supported by a team of assistants, with access to effective referral level care. Improvements in midwifery training, education, supervision and remuneration are seen as key to ensuring the improvement of service coverage and quality (UNFPA and ICM, 2009).

The Midwife in the Village programme, implemented in Indonesia in 1989, aimed to reduce maternal death by assigning a residential midwife to each village. By 1996, 54,000 midwives had been trained and deployed. An evaluation, however, found that only 29% of villages in the surveyed areas actually had a resident midwife, with much higher coverage in urban areas. Midwives preferred to live in urban areas, suggesting the need for incentives, such as increased payments, to entice them to more remote areas (Impact, 2007). Furthermore, as the cost of a midwife was three times the cost of a traditional birth attendant (TBA), women were still delivering at home and only used a midwife in the event of complications.

Clean delivery kit (CDK) interventions in Egypt and Tanzania represent successful CBIs. Aimed at reducing mortality due to infection, CDKs were found to be highly effective in low-resource settings where home birth is common and clean delivery supplies are scarce. Free kits were distributed through health centre staff. In Egypt birth attendants received training in their use, in Tanzania mothers were trained directly through Mother and Child Aides.

In Pakistan, the Population Council-led SMART programme was an operations research study to test the hypothesis that reducing ‘the three delays through a combination of community-based interventions (CBI) and health systems interventions (HSI), would be more effective than reducing the ‘third delay’ alone’. Female Health Workers were used to train TBAs, educate and mobilise communities, and establish transport systems for emergency obstetric and neonatal care. They emphasised their work with men and created community savings schemes to make emergency funds available to women in need. Wajjid et al. (2006) found that prenatal mortality declined by about 22% after this intervention.

A fourth approach with a growing evidence base in South Asia is mobilisation through women’s groups to improve maternal and infant health. Programmes in Bangladesh, India and Nepal have worked with women’s groups to raise awareness, provide pregnant women with advice and support, establish emergency funds to cover transport and medical fees, and promote CDKs. In India, there has been a 45% drop in newborn deaths and a reduction in maternal deaths (Rath et al., 2010), and declines in neonatal and maternal mortality in rural Bangladesh (Azad et al., 2010).

Conclusions and policy and practice implications

Meeting women's needs for safe motherhood is a critical development goal – both as a human right and in terms of the key role that healthy mothers play in reducing child mortality, fighting poverty and keeping children in school. MDG 5 requires a reduction in maternal mortality rates (MMR) of 75% between 1990 and 2015 but, as of 2008, MMR had fallen by only 35% (UN, 2011). The vast majority of these deaths are preventable, stemming from haemorrhage during delivery, eclampsia or infection. Most happen in sub-Saharan Africa and South Asia, where women are undervalued, contraceptive use is low, health and transport infrastructure is weak, and poverty rampant.

Recognising the inter-related problems that women face, Bhutta et al. (2005) emphasise that interventions must be integrated with 'ancillary measures such as poverty alleviation, improved opportunities for female education and improvement of women's social status'. While these go beyond SM programming, a recognition that motherhood does not take place in a vacuum leads to more robust interventions. There is growing recognition of the interdependence between community and individual attitudes towards maternal health; health workers' location, motivation and competency; management and supervisory structures; and policy and regulatory frameworks. Addressing one strand of this relationship 'web' is not enough to overcome barriers elsewhere, and may end up wasting inputs over time.

Depending on the context, CCTs may offer a value-added approach to meeting SM needs. While evaluative data are slim, there is evidence that CCTs can and do have significant impacts on SM goals and on broader human development goals. The 'basket' of CCT services reflects the inter-relatedness of today's needs and those of tomorrow. CCTs typically offer nutritional support, antenatal care and access to skilled delivery, all of them critical to infant and maternal health, and invest more broadly in the development of household human capital through access to, and supply of, improved education and health services.

This review of evidence suggests a number of practice and policy implications:

- **Programmes should be contextualised**, given the sensitive cultural-linguistic, social and economic supply-side barriers that women face, and varying levels of human resources, capacities, health systems and policy and regulation frameworks. Interventions that succeed in one context may not be transferable to another. A strong vulnerability and needs assessment on which to build interventions and to scale up is, therefore, critical. It may also be wise to be cognisant of the political culture surrounding social protection in a given context – in countries with a history of rights/equity/social cohesion agendas the options for programme design and roll-out may be distinct from those

where social protection is more of a donor-led and funded intervention.

- **Appropriate infrastructure – including personnel – processes and systems are critical.** In several countries the introduction of conditionalities for ANC has had no impact on uptake because of a lack of skilled providers and convenient health clinics. Systematic reporting, monitoring and evaluation, training of health staff and appropriate drug supplies and transport are all essential to maximise the benefits of CCTs. Increasing demand without increasing supply will have limited results at best.
- **Adequate funding is critical.** A major impediment to meeting SM goals remains finance, which needs urgent action. As the population of women of childbearing age grows, existing budgets are overstretched. Social protection initiatives are already vulnerable and, as the recent financial crisis limits donor budgets and pushes more families into extreme poverty, programming for SM could fall further behind without coordinated efforts to keep maternal health on the development agenda.
- **The nature of funding matters.** At least two streams are necessary and complementary: (1) donor funding for piloting, identifying best practices and success stories, relatively rapid development and scale up; (2) domestic funding for long-term stability.
- **Targeting is crucial.** Given budgetary constraints, careful consideration of how, when and whom to target is necessary, especially to reach the most vulnerable women. An approach combining geographic location and means-testing seems promising in many countries.
- **Conditionalities, if included, need to be tailored to context.** Given the lack of evidence on unconditional transfers for maternal health, further work is needed to assess the relative contribution of conditional transfers. If conditions are included, the sequencing of conditions and transfers should be considered carefully. For instance, rather than a simple requirement of three antenatal visits, it may be better to specify that one visit should be during the first trimester of pregnancy when developmental risks are highest. Or, to avoid incentivising pregnancy, tighter requirements for family planning may need to be woven into programming in ways that avoid penalising the most disadvantaged women.
- **Complementary programmes are important, especially those linked to behaviour change (e.g. social marketing and women's groups).** These may represent an easier route into CCT schemes, which may be politically sensitive in many countries, but may also provide complementary services and skills, vital to maximise the potential benefits of a CCT for maternal health.
- **Government ownership and political commitment are critical.** To ensure that CCTs for safe maternal health outcomes are effective, scale-able and sustainable, national-level structures should

be involved from the beginning and supported through capacity-strengthening initiatives. The scale of problems in many countries has exerted pressure to develop and scale up visible single interventions rapidly on the basis of limited situation analyses and without a focus on monitoring and evaluation. The lack of coordination between interventions, the exclusion of the poorest and most vulnerable women, and lack of focus on the interdependence of supply and demand can lead to widening inequalities and poor quality services. The challenge is to integrate an equity approach (UNICEF, 2010) that ensures the most vulnerable are reached, and develop interventions within a coordinated health-systems strengthening frame-

work that can tackle demand and supply barriers simultaneously (Freedman et al., 2007).

- **Monitoring, evaluation and learning are integral to progress.** To maximise learning among the array of actors in maternal health interventions (from NGOs to national and local governments to donors), it is critical that all programmes are monitored and evaluated carefully, and research evidence disseminated as widely as possible across countries.

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