



Strategies to increase  
health facility deliveries:  
Three case studies

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# Introduction

The past few decades have seen a growing number of women delivering in facilities around the globe. Facility deliveries are known, in more developed countries, to be associated with improved maternal and child health outcomes. Complications may arise with any birth, in which case even a well-trained attendant at home cannot provide adequate care. In many rural areas distances to facilities are great and roads poor, making transfer after onset of delivery difficult and dangerous.

According to the most recent Demographic and Health Surveys (DHS) in Sub-Saharan Africa and Asia, more than 75% of women combined in both regions now deliver in facilities (Montagu et al., 2014). This change did not occur without impetus, as many countries, often with the support and encouragement of the international community, have pursued strategies, programs and policies aiming to increase the number of women delivering in facilities, ranging from small scale interventions to national policies and laws. Many different approaches have been used. These approaches can be thought of as targeting different determinants of why women fail to deliver in health facilities, which have been characterized into four major categories by Gabrysch and Campbell (2009) (Gabrysch and Campbell, 2009). Some strategies target sociocultural determinants (for example, banning or integrating traditional birth attendants), some try to increase perceived need (such as through pregnancy counseling), some target economic barriers (such as conditional cash transfers, fee removal, or vouchers), and others address physical barriers (such as improving facility infrastructure and staff).

Understanding the challenges and successes of these policy approaches, and the factors that facilitate successful implementation, can inform decision makers interested in increasing the number of facility deliveries, and ultimately improving maternal and child health outcomes. To this end, we conducted in-depth case studies in India, Malawi, and Nigeria, three countries that have implemented policies to increase facility deliveries. India and Malawi have both experienced a large increase in the number of women delivering in facilities following the implementation of their policies. Early findings also show that Nigeria's policy is increasing facility deliveries, although it is still too new for any country-level analysis. Through interviews with key informants, including policy makers, maternal health experts, implementers and providers, we gathered information about the history, successes, challenges, changes, and future of policies.

In this synthesis, we analyze the factors that contributed to the successful creation and implementation of maternal health policies, and assess the challenges faced in implementing and sustaining these policies. This report draws out crosscutting themes and lessons learned from three unique country experiences to provide insight relevant for policy-makers and advocates on strategies and considerations for policy and programmatic approaches to increasing facility deliveries.

We identified five key lessons learned about effective policies to increase facility delivery, including: 1) the importance of political will; 2) the need to balance supply, demand, and quality; 3) the importance of addressing access to the health system; 4) the important contribution of community engagement, and finally 5) the need to create changes in social norms.

# Methods

## Country selection process

To select the case study countries, we first conducted a review of policies aimed to increase facility deliveries, with a focus on Asia and Sub-Saharan Africa. We focused on countries where policies were accompanied by increases in the percent of women delivering in facilities. From this, we selected India, Malawi, and Nigeria to explore policies across different developmental timelines. India and Malawi both experienced large increases in the rates of facility delivery in the past 10 years using very different policy approaches: India introduced a conditional cash transfer program, while Malawi instituted a ban on traditional birth attendants. Given the variation in implementation across states in India, we focus our study specifically on Uttar Pradesh state, where maternal and neonatal mortality indicators lag behind other states in India. Nigeria recently initiated a maternal health program, which includes a conditional cash transfer program similar to that in India. Although this is a new program, and the impacts on national facility delivery rates are yet unknown, the policy provides a useful comparison with India on effective finance-based approaches.

## Interviews and recruitment

Interviews were conducted with three broad groups of people: 1) maternal health experts including both in-country and international representatives of donor and development agencies, NGOs, and academic/research institutions; 2) health officials and policy makers from case study countries; and 3) people involved in policy implementation, including program staff and high-level personnel at implementing health facilities. Interviews were conducted using semi-structured guides that included questions about the policy development and implementation processes, and the outcomes and effects of the policy, including on-going and expected modifications to implementation plans.

Respondents were recruited through directly contacting government and other agencies involved in the creation and implementation of the policies of interest, as well as research and program staff involved in supporting or evaluating implementation. Snowball sampling was then used to expand our sample to other relevant individuals and organizations.

The study received exempt IRB approval from the University of California, San Francisco. Consent was received from all respondents prior to their participation. Two personnel from UCSF conducted each case study, with a total of three UCSF staff involved in data collection, analysis, and write up. We conducted a total of 15 interviews in India, 16 in Nigeria and 16 in Malawi. The findings presented below are based on analysis of these interviews.



# Description of each case study

Each policy is described briefly below. For a more detailed description, please see the Appendices.

## Malawi

In the mid-2000s, deliveries by traditional birth attendants (TBA) in Malawi were banned by the Malawian president, with the support of the Ministry of Health (MOH). TBA's roles were refocused from being birth attendants to being community resources who would advise women and refer them in to health facilities. The TBA ban was effective and popular, however in 2010, the then-president of Malawi made a proclamation that effectively reversed the ban (due to international pressure). This was done without consultation with the MOH and was contrary to their program and work plan. In 2012, the subsequent president launched an initiative called the Presidential Initiative for Safe Motherhood which had three pillars, including a reinstatement of the ban on TBAs, which was implemented through mobilization of community members (mainly chiefs). The other two pillars are the expansion of maternity waiting homes and training and employing a new cadre of community midwives.

## Nigeria

The Subsidy Re-Investment and Empowerment Program (SURE-P) was created in 2012 following large-scale protests about the fuel subsidy reduction in Nigeria. In response, President Goodluck Jonathan announced the re-investment of fuel subsidy funds into infrastructure and social safety net programs. Maternal health is one of nine priority social safety net programs funded through SURE-P.

The SURE-P MCH program is designed to increase access to maternal health services and improve the quality of maternal health care through a number of supply- and demand-side interventions. The program includes the

following components: health facility staffing and renovations; supply chain for essential maternal health commodities; conditional cash transfers for ANC, facility-delivery, and post-natal care attendance; and community mobilization through village health workers and leadership committees. The program focuses on rural and high need areas.

The SURE-P MCH program is dually managed by a federal-level implementing unit affiliated with the National Primary Health Care Development Agency (NPHCDA), and presidentially appointed oversight committee responsible for approving fund allocation and monitoring implementation. States are engaged through state-level steering committees, and agreements to contribute to SURE-P health worker salaries.

## India

In 2005, India began the National Rural Health Mission, one key component of which is to provide financial incentives for women to deliver in facilities. This component, called Janani Suraksha Yojana (JSY), provides financial incentives to women for delivering in a health facility, and also provides financial incentives for Accredited Social Health Activists (ASHAs) to help incentivize, arrange transport for, and accompany women to facilities for delivery. In low performing states, women are also given an incentive for delivering in accredited private facilities. The main goals of JSY are to increase early registration of women, identify complicated cases, ensure women receive at least 3 antenatal care visits (ANC) and post delivery visits, organize referrals and transportation for delivery and referrals. In 2011 JSY was expanded with a program called Janani Shishu Suraksha Karyakram (JSSK) to cover more services free of charge and provide additional services, mainly targeting getting women to facilities sooner (ambulances), and keeping women in facilities for 48 hours after delivery (free food and transportation).

# Summary of themes

Although each country utilized different strategies and activities to increase facility delivery, there were common approaches across these policies that can be useful to policy-makers and advocates in other settings. These lessons learned provide important insight into strategies decision-makers should consider when thinking about how to pass maternal health policies, how to successfully implement facility-based policies, and how to sustain program impact over time.

## Lesson learned #1: Political will

In each country, the ability to pass and to effectively implement a policy resulted from a high level of political will among a small number of policy makers and community stakeholders. Political will is particularly important in the realm of maternal health, as women are often less powerful and less valued members of society, which can translate into harmful programs and policies, and inadequate resources for implementation of strong maternal health programs. In Malawi, Nigeria, and India, maternal health “champions” were able to articulate the importance of facility delivery to maternal health, effectively pushing for greater attention to policies focusing on facility delivery including the dedication of significant social and financial resources.

In Nigeria, then State Minister for Health, Dr Muhammed Ali Pate, was a strong advocate for maternal health. He spearheaded a predecessor program called the Midwives Service Scheme from which many elements were pulled for the SURE-P MCH program. In addition he was a savvy politician. He participated in several key government committees, particularly within the Ministry of Finance, and he effectively stated the investment case for maternal health—bringing attention to the issue beyond the health community, and highlighting the importance of maternal health financing to the broader goals of the country. Minister Pate also positioned the NPHCDA to be able to capture the financial opportunity presented by the creation of the Subsidy Reinvestment Program (SURE-P). He prepared a clear program plan and investment case—leading to the prioritization of maternal health over other social safety net programs during the allocation of SURE-P funds. The ability to see and take advantage of this policy window is the classic mark of a champion or advocate.

In Malawi, when Joyce Banda was Vice President, she was named Malawi’s Ambassador to CARRMA (the Campaign for Accelerated Reduction of Maternal Mortality in Africa) in 2009. She was very active as a CARMMA Ambassador and brought international attention to the

cause of Safe Motherhood. Later when she became President she used her position to create a new central initiative for safe motherhood, including the ban on TBAs. The Presidential Initiative for Safe Motherhood worked through the system of traditional chiefs and religious leaders, educating them and sensitizing them to the importance of facility delivery. This effort created leadership and champions at the local level as well.

All three countries in some way used the power of the executive, or central government to push forward the agenda. This is particularly clear in the case of India. JSY is a completely federally funded program and the federal

## Ongoing evaluation and the use of evidence for program implementation

All three programs studied rely, to varying degrees, on evaluation and evidence-based feedback for ongoing program adjustments. Researchers from India and around the world, have studied the JSY Conditional Cash Transfer (CCT) configurations and outcomes achieved extensively and there is a rich body of literature on JSY. Further, program modifications in India (the addition of JSSK in particular) appear to be a direct response to concerns raised in evaluations of the program in the first few years.

In Malawi, policy makers drew on international and domestic evidence that TBA integration was not improving maternal health outcomes in formulating the ban and the repurposing of the TBAs to new roles.

In Nigeria, the SURE-P MCH program included a widespread supply side element, with a more limited demand-side intervention that was rigorously tested in fewer communities. Some supply side elements, such as monetary or non-monetary incentives to improve staff retention, are being tested before being rolled out, all in the context of a robust program-wide evaluation framework. When the SURE-P MCH program began in 2012, a staff member from the Oportunidades program in Mexico was seconded to Nigeria for 6 months to help design the CCT component.



government of India set clear parameters and guidelines for implementation. Both India and Nigeria, large countries with substantial national resources, have financed these programs largely from national sources. Nigeria's contribution to just the salaries of the midwives deployed to the first 1000 facilities comes to around USD1 million per month. The SURE-P MCH investment by the Nigerian Government is a substantial one that dwarfs much donor funding. India's contribution is similarly impressive; in 2011 the program cost the Indian government US\$333 million (Kapur and Chowdhury, 2012) These large national investments are, perhaps, the ultimate expression of political will. SURE-P MCH has also been run by a federal agency, although the program makes a concerted effort to partner with the states. Malawi has also used the convening power of the executive branch to organize and prioritize its efforts, but it is a much smaller, more centrally run country than the other two.

Creation of political will can be aided by the leadership of an advocate or champion. That champion must have the ability to spot opportunities, or policy windows, and take advantage of them to advance the cause, such as Minister Pate did in Nigeria. External pressure can also create political will, such as the creation of the Millennium Development Goals (MDGs) with clear targets and close monitoring of countries' progress toward those goals. The MDGs also created fiscal space for work on key targets by providing debt relief money to free up resources specifically for these targets.

Political will, in the context of policies to increase facility delivery, is important in order to get policies in place, to have needed resources allocated to implement policies, and to ensure things happen. Although political will manifested in a different way in each country, it was central to getting maternal health on the agenda, and ensuring the financial resources were made available for implementation.

## **Lesson learned #2: Balancing supply, demand and quality**

In our three case studies we saw many different configurations of targeting supply, demand or quality, leading us to conclude that the most successful strategies incorporate elements of all three.

India's JSY program, the oldest and most established program of the three policies, is a demand-focused program. While it has been successful at increasing the rates of facility delivery, issues of quality emerged because supply side factors such as number of beds, staff, staff training, and supplies were not addressed. The federal government emphasized the state's role in setting and attaining numerical targets, which resulted in greater attention to

merely driving demand to increase the number of births in facilities rather than a focus on the quality of the services provided. Although JSY is part of the overarching National Rural Health Mission that was intended to address some supply elements, these were insufficient and underemphasized. There were two conflicting viewpoints about India's approach to prioritizing demand-side interventions before addressing supply. One group of respondents felt that supply and demand should have been addressed together, perhaps through a slower rollout, starting with piloting the program, and then expanding it. Some in this group felt that encouraging women to come into facilities when the facilities were not prepared was unethical. The second group of respondents felt that the government had to start somewhere, and that it made sense that they began by focusing on demand, and that now that people were coming in, the government was starting to focus on improving supply.

SURE-P MCH in Nigeria, in contrast, put a higher emphasis on supply side elements, while also including some demand side interventions. SURE-P MCH's supply side component had reached 1250 facilities by early 2014, in comparison to just 46 PHC's where demand side incentives, similar to those in JSY, were offered. In addition the supply side focus of SURE-P MCH is very comprehensive, including: physical renovations, including boreholes for clean water; increased numbers of qualified providers; ongoing supply of drugs and consumables; and construction of staff accommodation to support staff retention. As a result of the improved physical facilities and expanded staff capacity, SURE-P MCH facilities do not seem to complain of being overwhelmed or inundated the way some facilities in India were. In addition, respondents in Nigeria said that facility delivery rates were increasing even in sites that received only supply side interventions, which suggests that high quality supply can also draw demand.

Malawi's policies represent a different approach to dealing with both demand and supply. Rather than incentivizing women to deliver in a facility, the implementation of local bylaws effectively punishes women who fail to do so with a fine. Our respondents were comfortable with the coercive nature of fines because of the intended health benefit for women, however issues of equity may raise concerns that poor women are the least likely to be able to afford both transport to a facility or the fine for a home delivery. However, for a poor country like Malawi, this type of fine-based disincentive to home delivery is clearly more affordable and thus sustainable. On the supply side Malawi has focused on increasing skilled staff and adding maternity waiting homes. The increases in skilled staff have been incremental and take time, however the building of waiting homes has been a visible achievement in a number of sites and they are very well received in the communities where they have been constructed. The one area not

explicitly addressed by the policy we examined in Malawi is quality. Concerns have been raised that driving demand with the TBA ban may result in overcrowding at facilities that are already low in resources, which would negatively affect quality. Given the concerns raised in India about the impact of increased volume on quality, this is likely a valid concern.

Each of the cases we examined had different strengths and weaknesses, but all of them, individually and together serve to highlight that supply, demand, and quality are deeply intertwined. Policy makers wishing to increase facility delivery should take stock of their supply and demand, and strive to keep those in balance while working to achieve optimal quality. It may be important to assess the reasons for lack of demand, as these may be related to transport difficulties, poor quality services, or other barriers. Understanding the context in one's country is an important preliminary step to deciding between supply side and demand side interventions. The process may also be dynamic and iterative as shifts in one may be reflected in the other, and quality can be an intervening factor that affects that balance.

### Challenges with conditional cash transfer payment mechanisms

Lessons from India and Nigeria illustrate some of the challenges in implementing a conditional cash transfer program. India began JSY with a commitment of giving cash to a woman before she left the facility. Subsequent complaints showed the money did not all get to women so a series of other mechanisms including bearer cheques and account pay checks have been tried. These reduce corruption but made it difficult for poor rural women without bank accounts to receive the incentive. In addition, the one-time payment in India means only the conditionality of facility delivery is emphasized, and only available to poor women after delivery. It has been suggested that this is partly responsible for the lackluster increase in antenatal care.

Nigeria has avoided the pitfalls of provider corruption by having central program staff disburse money directly. This is done quarterly and payments are broken up in tranches to ensure emphasis on antenatal care and postnatal care conditionalities. However central verification and quarterly disbursement days result in long waits for some women, eroding confidence in the program. Nigeria is working on piloting a mobile money option to overcome these challenges.

### Getting supply-side interventions right

The SURE-P MCH program in Nigeria highlighted some challenges and best practices in addressing the supply side needs in order to increase facility delivery.

- **Problem:** The program has had difficulties recruiting and maintaining midwives, particularly in Northern states where there is a smaller health workforce and more security concerns.
- **Solution:** Construction of staff accommodations at participating facilities is designed to minimize this problem.
- **Problem:** The package of resources is fixed, and not easily tailored to the needs of the facility/community. For example, staffing is based on program guidelines not on service numbers.
- **Solution:** A flexible resource package implemented based on recurring needs assessments might better address this.
- **Problem:** Stock outs. The program is not integrated into the existing state-level drug supply chains, because the states often charge for the drugs they distribute. This can at times result in poor stocking at facilities and causes tension between state and federal agencies.
- **Solution:** SURE-P is currently working on improving the logistics chain to begin addressing this.
- **Problem:** Staff intensive—SURE-P MCH found it was challenging to train and supervise 12,000 new health workers, and there was no pre-existing monitoring system for CHEWs and VHWs.
- **Solution:** Still in development

### Lesson learned #3: Improving access to facility deliveries

A major barrier to facility-based delivery is the accessibility of facilities—for many communities, the difficulties in reaching a facility is a deterrent to seeking maternal health care and results in delayed care in case of emergencies. Although closely related to the supply-side issues of making sure there are existing, staffed facilities, improving access goes a bit further and looks at how women will get there. The case study programs highlight the importance

of including components designed to reduce the barriers to access—on their own, strategies to generate demand or improve quality are not sufficient. These programs each included elements designed to reduce the challenges in reaching facilities for delivery after initial implementation demonstrated the access gap between communities and facilities, and in each case, this component has been considered of central importance.

All three countries now include ambulances in their program. In India, the majority of facilities have an ambulance or can link patients to an ambulance service that will provide free transport to any woman in labor; while in Nigeria and Malawi ambulances are placed only at the referral facilities and are intended for use in the case of a complication for transport from the primary health center to the hospital. Both India and Nigeria added this transportation component after the initial program rollout in response to the challenges women faced in reaching facilities. The addition of transportation is considered to be a crucial addition in both locations. In India, adding ambulances is thought to have increased the number of women coming to facilities for delivery and for post-natal care services, and it is likewise expected that the ambulances in Nigeria will improve access to emergency services. However, no country has reached universal coverage with ambulance services.

Malawi has primarily addressed access in a different way: through the construction and renovation of maternal waiting homes at 130 of the 300 facilities in Malawi that attend deliveries. Rather than invest resources in adding facilities or providing ambulances to bring women in labor in to the facilities, Malawi provides a place for the women to stay, so that they may travel by normal, more affordable means of transportation to the facility before she is in labor and wait there for labor to begin. Since travel during labor is difficult, and women are charged more for transportation in an emergency, this option is attractive to many women. The waiting homes concept draws from an existing system in Malawi of “guardian shelters” that hospitals already had available for people to stay at the facility while their relatives were admitted.

Although these programs focus primarily on generating demand for facility delivery and/or improving the quality of maternal health care at facilities, it is clear that ensuring access to facilities both for delivery and emergency services is crucial to the long-term success of these programs. Countries considering policies to increase facility-based delivery need to consider strategies that improve accessibility of health facilities, including the availability of transportation, in order to increase demand and ensure service utilization. Reducing the barriers to reaching health facilities improves the ability of women to access facilities for normal delivery, and can minimize delays in accessing care in case of complications.

## Lesson learned #4: Community engagement

Community engagement was an important component of all three case studies. In India, the ASHA program incentivized village health workers to help get women into facilities. In Nigeria, village health workers and ward development committees (not paid) helped incentivize women and act as an accountability mechanism and advocacy organizations raised awareness of the program in communities where they work. In Malawi, local chiefs and other leaders motivated women to deliver in facilities and enacted bylaws involving fines for both women and TBAs who

### **The role of the private sector: An opportunity to expand access?**

Another way to expand access includes adding in additional facilities, not by building facilities, but by giving poor women who use government facilities affordable access to private facilities that already exist. In Malawi, the private not-for-profit sector, primarily the Christian Health Association of Malawi (CHAM), plays a large role in MCH care provision. The health districts in Malawi have created service-level agreements with CHAM facilities to provide care where government facilities lack capacity or are nonexistent. In Uttar Pradesh, India, private providers participate in JSY and can be reimbursed for incentives paid to women below the poverty line who deliver in their facilities. Elsewhere in India, private providers play an even larger role in provision of care under JSY. To date, Nigeria, which has a large number of existing government health facilities, has not engaged the private sector health facilities under SURE-P MCH.

delivered at home. Malawi also engaged local women at the village level to serve as “Secret Mothers” and mentor women by encouraging them to seek antenatal care and facility delivery.

All three countries used local (village) level individuals to strengthen the program. In Malawi, the local engagement was at the religious and traditional leadership level, in India it was local women, similar to the women who would be delivering, and Nigeria had both of these components. The ASHAs in India and the VHWs in Nigeria received some payment for their efforts, while the Ward Development Committees in Nigeria and the Chiefs, Traditional

Leaders, and Secret Mothers in Malawi did not. While payment was not used in all cases, some type of recognition or honor was associated with the position. This helped incentivize the community members to want to participate, even if they did not receive monetary compensation for their time.

In all three countries there were previous systems in place through which community members were involved in promoting healthy behavior, and therefore, there was a precedent (and in some cases structure) for this type of community involvement. This allowed for a more natural acceptance of community involvement by local populations, but may not make the findings transferrable to other settings. Notably, the chiefs system in Malawi is successfully encouraging women to deliver in facilities by fining them for delivering at home using a system of bylaws that are used for other social behaviors and therefore accepted. Fining women for delivering at home might not be as socially acceptable in other settings where this was not already the norm.

### **Federal versus state control: Challenges and opportunities**

#### **Federal Control**

**Challenge:** Individual states or facilities in Nigeria, were unhappy with one-size fits all programming. Malawi's federally run program has limited staff to cover the whole country.

**Opportunity:** Federal funding and control in all three countries increased the coordination and cohesiveness of the program

#### **State Control**

**Challenge:** State policies in some states in Nigeria include charging users fees for medication and supplies; allowing state policies to prevail in the SURE-P MCH program would erode some of the equity goals of the program.

**Opportunity:** States in India have had some flexibility in how to implement JSY such as whether to engage the private sector, which has improved adoption within India's complex political system.

In summary, community engagement was a key component of each policy, and in all countries community involvement was seen as an important piece to the success of the policy in increasing the number of women delivering in facilities. Payment is not the only possible motivator for community leaders or volunteers to encourage women to deliver in facilities, as the honor of a leadership/special role was compelling in all cases.

### **Lesson learned #5: Norm change**

In order for policies to have a lasting effect, they need to remain in place, or create a societal change in norms away from home deliveries to facility deliveries. If this can be achieved, the more expensive demand-creation policies can be phased out over time. The cases studied differed on the level of norm change that had accompanied each policy. It appeared that there has been a normative shift in Malawi: women would continue delivering in facilities without the TBA ban. This did not happen in India: women would deliver at home without JSY. It is unclear in Nigeria.

Community involvement was an important part of the reason for norm change in Malawi and possibly in Nigeria—where the local leaders and ward development committees were helping to create a normative change in people's expectations about what they should do and also what should be provided to them in terms of services.

In India and also possibly in Nigeria, the problems with the policies/programs or failures in implementation were reasons that people would revert back to delivering at home if the policies ended. The poor quality of care and patient-provider interactions, lack of supply to match demand, and problems in payments, were making women actively not want to deliver in facilities.

In summary, a certain policy succeeding in increasing the number of women delivering in facilities does not necessarily mean that norms had changed to accept this practice without the incentive or policy. Where community leaders were involved, norm change seemed to be easier to achieve. However, where serious problems arose with women's experiences while at facilities, norms did not change and a preference for home births remained.

# Other policy implementation issues

In addition to the above-mentioned lessons learned about policies to increase facility deliveries, our cases provided insights on topics applicable to a wider spectrum of policy initiatives.

## Transparency and accountability

The ability of policy-makers and program implementers to develop structures for ensuring greater transparency and accountability appears to be important to maintain the acceptability of the program among government and community stakeholders. Without buy-in from these groups, the sustainability of the program in terms of on-going funding and continued utilization of services is uncertain. Accountability, at the policy level and at the level of program implementation, was a challenge faced by each of these programs, and each program used different strategies to increase accountability at different levels.

Nigeria's SURE-P program includes multiple mechanisms to ensure accountability and transparency in implementation and resource allocation. This is in response to the origin of the program as an answer to protests about the allocation of government revenue as well as the history of corruption in the country. At the national level, there are two mechanisms to improve accountability in public funds allocation. First, the program is overseen by a committee of non-politically-affiliated individuals who are responsible for making decisions about resource allocation and verifying the appropriate utilization of these funds. Second, the organization responsible for program implementation sits outside of existing government agencies. By placing SURE-P outside of the traditional funding and implementation pathways, there is greater transparency about where public funding is spent, and accountability to ensure that program funds are used to provide the intended services. SURE-P also instituted community-level

mechanisms through which residents can monitor implementation of program activities. The program has revitalized community based leadership committees (known as ward development committees), which communicate directly with the federal oversight and implementation bodies, and are encouraged to verify that promised resources are made available to the community. For example, committee members may be called upon to check the supply of drugs to health facilities or report on health worker absenteeism.

In India, efforts to improve accountability occurred primarily at the level of implementation. There were concerns that the cash incentives were not reaching the intended beneficiaries due to corruption in the payments. In both of the initial payment models—cash and bearer check—women were frequently required to pay part of their incentive to the provider in order to receive the money. To address this problem the program has made several modifications to the disbursement system. The current system of using account checks reduces the amount of bribery, increasing the amount of cash that women are able to keep. However, it introduced the challenge that many women do not have access to bank accounts. In addition, there are some concerns that the facilities are inflating the number of recorded facility deliveries, such that the facilities, women, and ASHAs each receive a part of a false incentive payment.

Though financial incentives are generally effective in driving behavior change, payment systems need to be carefully implemented to avoid corruption and inflation of service numbers. While Nigeria's payment system has effectively reduced corruption, the implementation is potentially un-scalable due to the staff intensive model. Likewise, it remains unclear the scale at which Malawi's policy will be implemented, given the reliance on local leaders rather than a centralized implementation strategy.

# Conclusion

## Scale and sustainability

The policies in the three case studies were enacted at various levels: India was at the country level, Malawi was mostly at a country level, although traditional chief involvement was not everywhere. Nigeria was federally implemented in all 36 states, but only includes 1,250 out of 26,000 facilities across the country, and is also the newest policy. It appears thus far that the slower, step-wise approach that Nigeria is taking to rolling out the program is helping it have fewer problems than India's similar program. However, Nigeria's program is only funded for a few more years, therefore, there we do not know if it will be scaled up, or even if the existing program will be sustainable over time. Some efforts have been made in increase the possibility of sustainability, including engaging states, which receive most of the federal funds for health, in committing some of their resources to staff salaries to ensure retention.

Malawi's initial announcement of the TBA ban was at the nation-wide level, however, how it is implemented depends on the level of engagement of the chiefs. Therefore, in some ways it is more similar to Nigeria, in that it is scaling up the policy more slowly, by reaching out to different chiefs and trying to bring them on-board over time. It is interesting to note that although the government officials in Malawi have gone back and forth on their support for the TBA ban, lower level support for the policy has remained, and hence it appears to be fairly sustainable over time. However, Malawi's policy is not a program in the same way that Nigeria or India's is (requiring a lot of funding, infrastructure, etc.), therefore the effort to scale up and to sustain is much smaller than in the other two countries.

Despite the problems faced by India which have been well-documented in the literature, it is important to highlight that it has increased access to facility deliveries for a nation of over a billion people in a very short time period, and increased the percent of women delivering in all states by substantial percentages. Not only this, but the policy has been sustained for almost 10 years, and still has strong governmental support, suggesting that it will be sustained in the coming years. India has continued to make changes to the policy to address problems, and increase access in less well-performing states and sub-populations.

It seems that there may be a tradeoff between scale and quality, at least in the early stages of policy rollout. Slower scaling up allows for more careful rollout, and allows for tweaks to be made earlier on to the system. The issue of sustainability is still up in the air for all of these. Policy makers should consider issues of sustainability at the outset of a policy, and consider it in the scale that things are implemented at. Implementing a new policy nationwide can vary in degree of difficulty, depending on the cost and nature of the interventions. Regulatory policies like the TBA ban are easier to implement nationwide, but may not be effective without a widespread community support. Large complex programs may benefit from step-wise implementation, if leaders are committed to learning from the problems that arise and making adjustments. National simultaneous roll-out may be the most effective in creating widespread measureable impact.

## Summary

In examining these three different cases, with widely different approaches to increasing facility delivery, we found a number of important commonalities. The first was the importance of getting maternal health on the policy agenda and being able to use policy windows to generate the political will to implement new policies. Next, we found that implementation is central to the success of a strategy and that policy makers need to take great care to balance supply, demand, and quality; to ensure access to services; and to engage communities as part of the implementation process. Finally, if policies are to be sustainable and affordable it is critical to work to make facility delivery the social norm. Additionally these policies, like other policy initiatives should be transparent and accountable to the population and carefully consider the scale of a policy with an eye toward potential for sustainability.

While these three case studies are only a snapshot of the types of policies that have been implemented around the globe with the aim to increase the number of women delivering in facilities, they provide insight that might help future policy makers create successful policies. Lessons learned from these three countries and their policies have broader applicability, not only in India, Nigeria, and Malawi relating to maternal health, but to other countries and regions, and to policies related to similarly complex other health interventions and improvements.

# Appendix

## Malawi: TBA Ban

### Background

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In the 1990s Malawi invested in formal training of TBAs and in trying to connect them to the formal health system as a strategy for improving women's health. By the mid 2000's the international consensus was that the evidence did not support using TBAs to try to improve maternal health outcomes. Malawi MOH staff also reviewed Malawi's evidence on TBAs and reached the same conclusion. With the support of the reproductive health directorate, TBA deliveries in Malawi were banned by the Malawian president. This policy was what some call a podium policy, a pronouncement by the executive, but the MOH supported it and internally they shifted away from all work supporting and engaging TBAs as birth attendants and tried to refocus their roles as community resources who would advise women and refer them in to health facilities.

The TBA ban was effective and popular, however in 2010 after attending an event at the UN, the then-president of Malawi made a proclamation that effectively reversed the ban. This was done without consultation with the MOH and was contrary to their program and workplan. This was an example again of a podium policy, which although not codified in law, made it difficult for MOH staff to make progress toward their goals of having all women deliver in the hands of a skilled birth attendant.

### Current policy

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In 2012, the Malawian president died suddenly and Joyce Banda, the then-Vice President ascended to the presidency. She launched an initiative called the Presidential Initiative for Safe Motherhood which includes three pillars:

1. **Community mobilization to increase facility based deliveries.** This is primarily done through working with traditional (chiefs) and religious leaders, educating them about safe motherhood. They in turn educate other traditional leaders and their community members, and they have also taken the initiative to pass local bylaws formally prohibiting TBA deliveries. These local bylaws generally include punishment (a fine of a goat or a chicken) for any pregnant woman who delivers with a TBA, and the TBA who delivers her. The chiefs or community leaders also recruit community volunteers to serve as “secret mothers” to track all the pregnant women in the community and direct them to attend prenatal care and deliver at the nearest health facility. Where possible, they have tried

to redefine the role of the TBAs to be “secret mothers” instead, but not all TBAs had the literacy skills required for the tracking of pregnant women.

2. **Construction/expansion of maternity waiting homes at health facilities.** Maternity waiting homes—in either a 24 bed or 36 bed design—are being constructed or expanded across the country so that women can come to the health facility when they reach their 9th month of pregnancy (36 weeks) and wait their until labor happens and they deliver. This eases the burden of women in labor trying to find transport. Women are frequently accompanied by a female relative who stays in the facility's guardian shelter—a simple shelter designed to provide housing for family members of inpatients. The time during which women are in residence at the waiting homes facilitates their regular check ups in the final weeks of pregnancy and presents an opportunity for additional health education.
3. **Community midwives.** The final strategy being implemented is training of a new cadre of midwives known as “community midwives.” This program is shorter than the traditional midwifery training program—18 months rather than 3 years. As these midwives will be less experienced, the plan is that they be placed where they can be supervised by fully qualified midwives. There are some challenges related to this as there is an overall very high vacancy rate in the midwifery posts. Furthermore, when the program was initiated it was envisioned these midwives would be placed in the community, but there is no infrastructure at that level—no buildings for them to use as delivery centers, no connection to ensure quick safe referral when needed. So, the actual role and how they will be used seems to be part of an ongoing discussion. At least two cohorts have completed training so far, and to date it appears these are being placed at health facilities.

### Policy focus: Community mobilization to increase facility based deliveries

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Our primary area of interest was the banning or refocusing of TBAs on other tasks. This is implemented through the community mobilization element of the Presidential Safe Motherhood Initiative. However, the other two pillars are important complementary policies.

The strategy of community mobilization is centrally driven and leverages the traditional ruling structures in Malawi for both diffusing the messages and making community members accountable for complying with them. This

strategy is run from the Ministry of Local Government, which targets traditional chiefs, religious leaders and other community leaders and the works with them and the District Assembly, Area Development Committees, Village Development Committees and community committees and members (Republic Of Malawi, Presidential Initiative on Safe Motherhood, Strategic Plan 2012–2016). Chiefs and other local leaders are trained on Safe Motherhood issues, and then encouraged to train other chiefs including their under-chiefs and their local committees. As part of this process the chiefs pass local bylaws which assert that all women in the community should deliver in a health facility and that anyone who does not will pay some fine or penalty, such as a goat or a chicken. This strategy builds on existing community structures in which community members already participate.

Some key aspects of the community mobilization strategy to consider include:

#### **Demand-side elements**

This strategy is a demand side strategy, driving demand through community mobilization and education about the advantages of facility birth, creating social norms around facility delivery, and enforcing those social norms with penalties if necessary.

#### **Supply-side elements**

While the community mobilization strategy does not address the supply side, the two other pillars of the Presidential Initiative on Safe Motherhood do. The community mobilization strategy is clearly complemented by efforts to improve the supply side through provision of maternity waiting homes and training of community midwives which are also included in the Initiative

#### **Community engagement efforts**

The Malawi strategy also exhibits strong community engagement. Because it works through existing traditional ruling structures it engages community members in a way that is familiar and comfortable to them. In some areas, as part of the community sensitization campaign, community members are encouraged to think about what was one of the key messages they learned and the committee members ask them if they are willing to paint that message on the outside wall of the house. This way they share the message with passersby and the chiefs and village leadership can, at a glance, see what messages have been really taken in by the community and which ones may need further emphasis. The structure of the community mobilization efforts also presents opportunities for community members to play a specific role in Safe Motherhood, by taking on the role of “Secret Mothers” or Distributors of Family Planning methods.

#### **Access to care**

Issues of access to care are addressed in this policy primarily by the complementary elements of maternity waiting homes. Malawi is striving to ensure every Malawian lives within 8 km of a primary health center, but that goal has not yet been reached. In addition, the road and transport networks are very poor, making reaching a facility especially difficult for a woman in labor. Malawi has tried to reduce this burden by building maternity waiting homes adjacent to the health centers and encouraging women to come stay there and wait for delivery once they reach their 9th month of pregnancy.

#### **Scale**

The community mobilization strategy has a national focus. Priority has been given to some key strategic areas, and only chiefs who are willing to participate are included, but the initiative aims to reach as many communities as it can. In the first Safe Motherhood Chief Workshop in 2012 39 traditional leaders from 21 of Malawi’s 28 districts were present. (Republic Of Malawi, Presidential Initiative on Safe Motherhood, Strategic Plan 2012–2016).

#### **Resources**

Resources for the Presidential Safe Motherhood Initiative come from a variety of sources. These include development partners, the private sector, the Ministry of Finance, USAID, and the Bill and Melinda Gates Foundation. (Republic Of Malawi, Presidential Initiative on Safe Motherhood, Strategic Plan 2012–2016).

#### **Political context**

Malawi has strong political will to reduce maternal mortality. Malawi was one of 8 countries to launch CARMMA (the Campaign for Accelerated Reduction of Maternal Mortality in Africa) in 2009 (others joined in 2010 and 2011). The then-Vice president Joyce Banda was named then CARMMA Ambassador for Malawi. Later, after the sudden death of the Malawian president Joyce Banda ascended to the presidency and used her position to further the cause of Safe Motherhood by establishing the Presidential Initiative for Safe Motherhood. Recent elections have resulted in a change in leadership in Malawi, which leaves some question about whether Safe Motherhood will continue to be a priority. However, Malawi has a long-standing commitment to free maternal and child health services. Many services at public facilities are free and the key maternal and child health services never have any user fees attached. The government commitment to this has even led to some public-private partnerships (see below) in which the government subsidizes the cost of care in private facilities and insists on users not being charged any user fees under these agreements.



## Complementary programs

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Malawi has a number of complementary programs, that support the goal of increasing facility-based delivery in direct or indirect ways. The other pillars of the Presidential Initiative for Safe Motherhood mentioned above, directly support the goal by strengthening the supply side through construction of maternity waiting homes and training of community midwives. The Strategic Plan for the Initiative also includes other supply-side improvements such as EMONC training, and recruitment and retention of skilled personnel. (*Republic Of Malawi, Presidential Initiative on Safe Motherhood, Strategic Plan 2012–2016.*, n.d.) Outside of the initiative there are also other strategies that reinforce the goal of increased facility delivery.

**Public-private partnership:** Service Level Agreements with the Christian Health Association of Malawi. Malawi is a poor country with a largely rural population. The government's goal is to have a public health facility within 8 km of every person, however, this has not yet been achieved. As a way to extend the reach to where facilities are inadequate to meet demand, some districts have been empowered to enter into service level agreements (SLAs) with a network of private health providers known as the Christian Health Association of Malawi (CHAM). CHAM is a network of church owned private facilities that typically provide care for a (subsidized) fee. Under the Service Level Agreements, districts have contracted with individual CHAM facilities to provide key maternal and child health services free of charge to the population. While these agreements are not without their challenges, they have effectively extended the capacity of the public sector. CHAM association members also run a significant portion of the health worker training institutions in the country.

**OPTIONS- Results Based Financing.** Malawi currently has 4 districts participating in a results based financing program for maternal and newborn health called Options. The program includes 3 main components

- **Immediate investments in minor infrastructure and equipment** for participating facilities to bring them up to a minimum operating level to participate in the project
- **Supply-side component:** provide financial rewards to facility-based teams at both district level and below and district health management teams
- **Demand-side component:** a conditional cash transfer to women delivering in an approved health facility.

## Impact

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The TBA ban per se has not been formally evaluated. However, there is some objective evidence that it has been effective in increasing facility based deliveries. According to the 2010 Malawi DHS, the facility delivery rate was up to 73.2% in 2010 compared to 56.4% in 2004 (National Statistical Office (NSO) and ICF Macro, 2011; National Statistical Office (NSO) [Malawi], and ORC Macro., 2005). In addition, in an evaluation of another community based intervention to decrease maternal and neonatal mortality, facility delivery statistics were collected and there was a strong temporal association between the TBA ban and increases in facility delivery (Barker, 2014). In addition to the quantitative evidence, our key informants clearly felt that norms in Malawi had shifted from home delivery to facility delivery.

**Future direction:** As of June 2014, Joyce Banda lost a bid for re-election. Maternal and child health issues including safe motherhood specific interventions are still a priority in the current health sector strategic plan. The new government has not dismantled the Presidential initiative on Safe Motherhood, but new officials have been appointed to the program. The former First Lady has been appointed to be the National Coordinator and her chief role will be to continue advocacy and resource mobilization for safe motherhood. To ensure alignment, the Presidential Safe Motherhood Initiative reports to the Minister of Health whose responsibility is to ensure access and availability of health services to all Malawians.

## Nigeria: Subsidy re-investment and empowerment program

### History and background (political context)

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The Subsidy Re-Investment and Empowerment Program (SURE-P) is a federally-run social safety net program in Nigeria. The SURE-P program was initiated in 2012, following large-scale protests over the government's decision to reduce the fuel subsidies. In response to public dissent, President Goodluck Jonathan announced the re-investment of the Federal Government's savings from the subsidy reduction into programs intended to reduce the effect of subsidy removal, with a focus on infrastructure projects and social safety net programs.

Maternal health is one of the priority social safety net programs funded through SURE-P, alongside vocational training, mass transit, community service, youth and empowerment, HIV/AIDS, polio eradication, and a heart/stroke center. The program is designed to increase access to maternal health services and improve the quality of maternal health care through a number of supply- and demand-side interventions. The program focuses on rural and high need areas: communities and facilities are selected for inclusion through discussion with state- and LGA-level health departments, with a focus on selecting high-need facilities in areas with poor maternal health outcomes.

The structure of the SURE-P MCH program is based on a previously implemented maternal health intervention—the Midwifery Service Scheme (MSS). The MSS program placed midwives to work in rural primary health centers throughout the country, and provided a one-time supply of maternal health commodities to participating facilities. The MSS is believed to have increased the rates of ANC attendance while not significantly changing rates of facility-based delivery. Learning from that experience, the SURE-P MCH program added on-going supply chain for essential health commodities, facility upgrades, supplemental staff programs, and a demand-side component, in an effort to increase the impact on maternal and post-natal health services utilization.

### Program description

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#### Demand-side elements

The SURE-P MCH demand-side component consists of a conditional cash transfer to incentivize antenatal and post-natal care attendance and facility delivery. The maximum incentive is 5000 Nigerian Naira (NGN), with payments made based on completion of a number of co-responsibilities. Women receive 1000 Naira for registration and attendance at first ANC; 1000 NGN pro-rated for attendance at 2nd, 3rd, and 4th ANC; 2000 NGN for facility delivery; and 1000 NGN for attendance at the first

post-natal appointment and child immunization with the first dose of BCG. Payments for the CCT program are made once every three months, and payment days are advertised in the community and through text messages to enrolled women. The quarterly cash payment system minimizes corruption, however it is staff intensive and results in delayed payments to beneficiaries. Alternative payment models—such as mobile money—are being piloted in 2 Northern States.

#### Supply-side elements

The SURE-P MCH supply-side work includes human resources, supply chain, and infrastructure components. Each participating facility is staffed with an additional four midwives and two Community Health Extension Workers (CHEWs). The CHEWs are primarily employed to do community outreach and education to encourage use of maternal health services. This outreach is done in coordination with Village Health Workers who are selected by the community and paid a monthly stipend by the SURE-P program. Where required, participating facilities are renovated and upgraded. Upgrades include clinic expansions, installation of solar electricity, and provision of boreholes for clean water. In addition, health worker accommodations are being constructed to reduce staff attrition. All facilities receive essential maternal and child health commodities; SURE-P is partnering with USAID/Deliver to manage the supply chain of essential medicines to participating facilities. Women that deliver at SURE-P facilities also receive MAMA kits containing a set of supplies and materials for delivery and infant care.

#### Community engagement

SURE-P staff and community organizations conduct outreach and advocacy activities in participating communities both to introduce the program and to encourage use of the services. The Village Health Workers (VHWs) are also intended to provide on-going community-based education and encourage utilization of the services. SURE-P has re-established or supported the Ward Development Committees that operate in each health center catchment area, and the members of this committee are responsible for monitoring and oversight of the program as well as increasing awareness of the program at the community level.

#### Accessibility

SURE-P MCH is in the process of introducing transportation services, through partnership with Riders International. Through this partnership, the program is purchasing ambulances to be stationed at each of the referral facilities; however to date only 50 ambulances have been procured. In addition, the SURE-P MCH program pays for the cost of any services received at the referral hospital, as well as transportation for complicated deliveries to reach the referral facility.

## Program structure

The SURE-P MCH program is dually managed by the Program Implementation Unit (PIU)—a federal-level implementing unit affiliated with the National Primary Health Care Development Agency—and the SURE-P Committee, a presidentially-appointed oversight committee tasked with approving work plans and budgetary allocations, as well as monitoring the activity of the PIU. At the state level, each state has a steering committee that is intended to provide input to and oversight of the program. States are also expected to contribute a percentage of the SURE-P health worker salaries. In practice, the level of state engagement varies widely.

## Scale

Currently, the supply-side components of the MCH program are being implemented in all 36 states as well as the FCT, while the demand-side elements are being implemented in 9 states and the FCT. Within the states, the program is implemented in selected Local Government Areas (LGA) in a cluster model. In each LGA, four Primary Health Centers and one referral hospital are selected for participation. To date, 1200 PHCs have received supplies of essential drugs and commodities, 500 PHCs have been renovated, with 628 boreholes installed and 128 general hospitals have been upgraded (SUREP website). There are 12,000 Midwives, CHEWs, and VHWs working under the program.

## Complementary programs

The Midwives Service Scheme (MSS) on which the SURE-P MCH human resources component is based, continues to staff PHCs throughout the country, though there is no overlap between MSS and SURE-P MSS sites. Together, these programs are increasing the coverage for facility-based deliveries by improving access to better staffed and equipped health facilities. In addition, a number of other national initiatives, such as Saving One Million Lives and Primary Health Care Under One Roof, are also working on improving the quality of services provided at Primary Health Centers and conducting policy advocacy to increase awareness of and engagement on maternal and child health issues at the state and federal level.

## Impact

Given the program's recent initiation, there is little evidence available on the impacts of the SURE-P MCH, however interviews with program staff indicate that the program is well-received in the communities, including those communities who receive only supply-side interventions. Initial program data also indicates that the program is

improving service quality and access to services. According to a SURE-P MCH Status Report from March 2014:

- The SURE-P MCH program has placed an additional 12,000 health staff in participating facilities
- 519,539 women have received ANC services; 88,982 women delivered in SURE-P facilities, and the program enrolled 19,399 new FP clients
- The CCT program provided payment to 16,447 women for facility delivery

Rates of maternal and child health service utilization have also increased in participating communities. Comparing current rates to those prior to program implementation, the program has resulted in a 67% increase in ANC attendance, a 55% increase in facility-based deliveries, and a 64% increase in post-natal care attendance. There is also good retention in the CCT program, with 80% of women completing all conditionalities. This has increased since the initial pilots, and it is thought that this may be the result of restructuring the payments into only 2 installments, with the larger payment following delivery and post-natal care.

## Sustainability

The SURE-P funding is set to end in December 2015, and although there is lots of interest and positive feedback about the program, given the upcoming elections and unsure funding future there are questions about the sustainability of the program. Despite this, there is the potential to sustain some program elements. The SURE-P MCH program is providing many lessons learned that can be drawn into other national MCH initiatives, and provides proof of concept for these ideas. The SURE-P program, together with the World Bank, is currently evaluating the program, including conducting several RCTs of the health worker incentive, CCT, and supply chain components. This evaluation will provide more information about the program's impact and the essential components for program success and continuation. As the majority of implementing staff are employed by government agencies responsible for MCH program, the lessons learned from SURE-P can be utilized in on-going programs.

In addition, the vast majority of the resources for the SURE-P MCH program are from the federal government. Although the existing resource allocation mechanism may not be permanent, there are domestic resources available that can continue to be invested in health.

## Uttar Pradesh, India: Janani Suraksha Yojana (JSY) program

### Elements of program

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#### Basic description of the program

In 2005, India began the National Rural Health Mission, of which one key component is the Janani Suraksha Yojana (JSY) Program. JSY provides financial incentives to women for delivering in a government health facility, and also provides financial incentives for Accredited Social Health Activists (ASHA's) to help incentivize, arrange transport for, and accompany women to facilities for delivery. In low performing states, women are also given an incentive for delivering in accredited private facilities. The amount of the incentive differs by rural/urban status and whether the woman lives in a low performing or high performing state. In low performing states, like Uttar Pradesh, rural women receive 1400 Indian Rupees (INR) upon delivering in a facility and urban women 1000 INR, and the ASHA's receive 600 INR in rural and 200 INR in urban areas when they bring a woman into the facility to deliver. In high performing states, incentives are only available to women who are below poverty line, had  $\leq 2$  live births and over 19 years old.

The main goals of JSY are to increase early registration of women, identify complicated cases, ensure women receive at least 3 antenatal care visits (ANC) and post delivery visits, organize for referrals and transportation for delivery and referrals. In addition to the cash incentives for women and ASHA workers, JSY includes the payment of 1500 INR to private providers to do caesarean sections in cases where the government facilities cannot provide a C-section. JSY also includes a partnership with the private sector, where accredited private sector institutions can provide care to JSY beneficiaries and receive compensation for those deliveries.

In 2011 some changes were made to JSY to expand the program to cover more services free of charge and provide additional services, mainly targeting getting women to facilities sooner, and keeping women in facilities for 48 hours after delivery. The new scheme, called Janani Shishu Suraksha Karyakram (JSSK) includes ambulances at facilities that can pick up women free of charge when she is in labor and bring her to the facility, free meals for women while in the hospital for 2 days after delivery, free drop back home from the facility 2 days after delivery, free referral services, free treatment for the newborn for 30 days after birth and free treatment of postpartum complications for 40 days after delivery.

#### Demand-side elements

JSY is primarily a demand side program. By incentivizing women to deliver in facilities and ASHAs to bring women to facilities the program has led to a large increase in the number of women delivering in facilities. However, facilities were not prepared for the influx of patients. JSY focused on creating demand, without providing additional staff, infrastructure, supplies, etc. This was perceived to have led to the inability to provide high quality care, and in some cases, an inability to even provide any care (leaving women to deliver unattended, but in a facility).

#### Supply-side elements

The addition of the ASHAs to the health workforce has been the most significant supply-side contribution of the JSY program. Prior to JSY the ASHAs did not exist and they have made an important contribution linking the community to the facility. Also when the JSSK program was added to JSY in 2011, it included facilities for transport and food in PHCs, which were important upgrades to the supply side.

#### Resources (financing)

JSY (and JSSK) is a 100% centrally sponsored program. At the national level, there is a Mission Steering Group, chaired by the Minister of Health and Family Welfare to oversee implementation. At the state level, there is a State Health Mission, which oversees the implementation and is responsible for guiding an Implementation Committee that makes the State Action Plan for JSY. Each State's Government must monitor the expenditure. The District Health Mission is responsible for actually implementing JSY, has a District Implementation Committee, which oversees this process (Janani Suraksha Yojana: Guidelines for Implementation, n.d.). In 2011, JSY/JSSK constituted 11% of the National Rural Health Mission budget, which came to 1998.92 crores (1 crore=10,000,000) INR (about 333,000,000 USD) (Kapur and Chowdhury, 2012).

#### Community engagement

The primary interface for community engagement in JSY is the ASHA. Having a community health worker cadre as outreach workers has been effective, especially since ASHA's are incentivized. ASHAs do receive incentives for many other health promotion activities as well, and therefore they may become or already be overburdened. There is heterogeneity in the commitment/quality of ASHAs, and some cases where ASHAs might be acting unethically (allowing women to deliver at home, but recording the birth as being in a facility, so everyone receives the incentive). Another positive outcome of JSY is the fact that being an ASHA is potentially a pathway for women's empowerment and economic independence for village women who otherwise might not have such opportunities.

## Scale

The JSY program achieved an impressive goal of rolling out a fairly complex program to an entire country of a billion people virtually simultaneously. There is heterogeneity both within and across states in terms of the level of uptake of JSY and many implementation problems remain, however, the program does exist across the country. Some respondents suggested that it would have been better if the program had been piloted first, and rolled out in a phased manner, so as to better address problems as they occurred.

## Transport

The provision of reliable and affordable transport was one of the key pieces missing in the initial JSY program; JSSK has added transportation (ambulances), and this is helping to get women into facility. The ambulances are one of the most positive pieces of and improvements to JSY/JSSK across the board. Issues remain with not enough ambulances, but it is clear that transportation is helping to get women to the facility to deliver, and increasing the number of women bringing newborns back for check-ups and emergencies.

## Political context

JSY was enacted in the context of the NHRM—a very large, comprehensive national program to improve access to health in rural areas. There was a lot of political will behind the NRHM to make health services available to the poor all over India. The NRHM is a large program with many components, however due to general political will for maternal health, JSY became a real centerpiece of NHRM. Maternal health had become a higher political priority due to the large number of maternal deaths that occur there. Part of the reason that maternal health became a priority was that delegates from India went to an international meeting about progress toward the MDGs and realized that Bangladesh, its poorer neighbor, was making more progress towards reducing maternal mortality than India. Generally, there is a lot of pressure to achieve the MDGs in India, as India lags in term of maternal mortality.

## Complementary programs

JSY is in many ways a multi-pronged program, involving not just the conditional cash transfer for women, but for the ASHAs too, and including the transport to and from the facility, and the incentive to stay for 48 hours post-delivery (food and transportation). JSY is part of the National Rural Health Mission which is an overarching policy designed to provide universal access to quality health services for India's rural poor population. The NHRM includes a number of strategies across multiple sectors and

includes infrastructure improvement, and human resource provision and training among other things.(nhrm.gov.in) India is currently in the process of launching the National Urban Health Mission. This will involve USHAs (like the ASHAs but for urban women) to help motivate poor urban women to use ANC and deliver in facilities, and will complement the already existing JSY program.

There are other programs under various Ministries in India which target maternal and child health, such as nutrition for children and women through the Anganwadi centers, free Iron Folic Acid tablets, nutrition for teenage girls, etc., but no other national program specifically targeting improvement of facility delivery (either from the supply or demand side, such as training midwives, etc.) that are at the national level. These programs and policies also act to improve maternal and child health, but do not directly impact deliveries in facilities.

## Impact

JSY has been credited with increasing the number of women delivering in facilities throughout India, though the amount of increase varies by state dramatically. In India as a whole, the number of facility based deliveries increased from 20% to 49% in 5 years (Randive et al., 2013).

Uttar Pradesh is one of the states that showed the least improvement in rates of facility-based delivery. There is mixed evidence as to whether JSY has led to an improvement or decline (or no association) in perinatal, neonatal, and maternal mortality (Das et al., 2011; Lim et al., 2010; Randive et al., 2013; Rv, 2011). Several problems have been identified relating to informal payments, out of pocket expenditures, delay in payments being made, low utilization of the ASHA's, the cash incentive perhaps not being large enough, facility overcrowding, no additional supplies or training for providers and facilities, etc. (Dongre and Kapur, 2013; Gopalan and Durairaj, 2012; Mazumdar et al., 2012).

Overwhelmingly, respondents felt that if the cash incentive portion of JSY/JSSK was discontinued, the majority of women would not continue delivering in health facilities. This was because respondents felt that women thought that they were receiving poor quality of care: not enough providers, not enough beds, not enough supplies, etc. Additionally, women felt that they were treated disrespectfully at facilities by the staff at all levels. These factors, coupled with anecdotal evidence of women gaming the system to deliver at home if possible, led respondents to think that norms had not changed for the most part and women still had a preference for delivering at home.

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## The Global Health Group

The Global Health Group (GHG) at the University of California, San Francisco (UCSF) is an “action tank” dedicated to translating major new paradigms and approaches into large-scale action to positively impact the lives of millions of people. Led by Sir Richard Feachem, the founding and former executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GHG works across the spectrum—from analysis, through policy formulation and consensus building, to comprehensive implementation of programs in collaborating low- and middle-income countries.

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