Demand-side financing measures to increase maternal health service utilisation and improve health outcomes: a systematic review of evidence from low- and middle-income countries

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Executive summary

Background

In many countries financing for health services has traditionally been disbursed directly from governmental and non-governmental funding agencies to providers of services: the „supply-side" of healthcare markets. Demand-side financing offers a supplementary model in which some funds are instead channelled through, or to, prospective users. In this review we considered evidence on five forms of demand-side financing that have been used to promote maternal health in developing countries:

- *unconditional cash transfers*
- *conditional cash transfers*
- *short-term cash payments to offset the cost of accessing maternal health services*
- *vouchers for maternal health services*
- *vouchers for „merit" goods that promote maternal health*.

Objectives

The overall review objective was to assess the effects of demand-side financing interventions on maternal health service utilisation and on maternal health outcomes in low- and middle-income countries. Broader effects on perinatal and infant health, the situation of underprivileged women and the health care system were also assessed.

Inclusion criteria

Types of participants

This review considered poor, rural or socially excluded women of all ages who were either pregnant or within 42 days of the conclusion of pregnancy, the limit for postnatal care as defined by the World Health Organization. The review also considered the providers of services.

Types of intervention(s)/phenomena of interest

The intervention of interest was any programme that incorporated demand-side financing as a mechanism to increase the consumption of goods and services that could impact on maternal health outcomes. This included the direct consumption of maternal health care goods and services as well as related „merit goods" such as improved nutrition. We included systems in which potential users of maternal health services are financially empowered to make restricted decisions on buying maternal health-related goods or services – sometimes known as consumer-led demand-side financing. We also included programmes that provided unconditional cash benefits to pregnant women (for example in the form of maternity allowances), or to families with children under five years of age where there was evidence concerning maternal health outcomes.

Types of studies

We aimed to include quantitative studies (experimental, observational and descriptive), qualitative studies (including designs based on phenomenology, grounded theory, ethnography, action research and feminist research), and economic studies (cost-effectiveness, cost-utility and costs studies).

Search strategy

The Joanna Briggs Institute methodology for mixed-method systematic reviews was adopted. A three-step systematic search strategy was used to: 1) identify key terms, 2) search bibliographic

databases and 3) retrieve additional publications from reference lists and sources of grey literature.

Data Collection

Data were extracted from papers included in the review using the standardised data extraction tools for quantitative, qualitative and economic data from the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information.

Data Synthesis

The quantitative and economic findings are presented in narrative form. Qualitative research findings were pooled using the Joanna Briggs Institute Qualitative Assessment and Review Instrument. This involved the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings (Level 1 findings), and categorising these findings on the basis of similarity in meaning (Level 2 findings). These categories were then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesised findings (Level 3 findings) that can be used as a basis for evidence-based practice or policy.

Conclusions

Seventy-two studies were included in the review. Drawing on work from several continents, many of the included studies were reports and evaluations for relevant government or funding agencies and represented important lesson-learning about implementation issues. However, fewer than half were published in peer reviewed journals and few were of high research quality.

For three modes of demand-side financing (conditional cash transfers, payments to offset costs of access to maternal healthcare, and vouchers for maternity services) we found evidence relevant to review questions on the utilisation of maternal health services, barriers to the provision of demand-side financing and supply-side preconditions to implementing demand-side financing schemes. There was insufficient evidence to provide comprehensive answers for review questions on the effect of demand-side financing interventions on maternal, perinatal and infant health outcomes and on the social and financial situation of underprivileged women. There was also insufficient evidence on the cost-effectiveness of demand-side financing interventions and preconditions for sustainability and scale-up of demand-side financing schemes.

Implications for practice

Salient recommendations for policymakers regarding demand-side financing for maternal health derived from the current evidence are:

- Streamlined policy goals focused on increasing utilisation of services are most effective
- Careful design of incentives for skilled practitioners is required
- Demand-side financing mechanisms cannot on their own improve quality of services; supply-side measures are required to complement these
- Simple and transparent processes for administering and disbursing benefits are more likely to be successful in improving uptake of services
- Careful planning for initial and scaled up demand-side financing is essential to success, including input from women"s organisations and other user representatives
- Demand-side financing can be an effective targeting mechanism but only if it does not require substantially new systems for identifying beneficiaries
- Policy should recognise that even well designed demand-side financing schemes may fail to function as intended unless other barriers to access are addressed.

Implications for research

There is a pressing need for large, robust studies on the short- and longer-term impact of demand-side financing on maternal and infant mortality and morbidity, which should also reflect „good practice" indicators such as the uptake and duration of exclusive breastfeeding and compliance with infant immunisation programmes. It is also important that the impact on outcomes of subsequent pregnancies is evaluated. Moderate and large-sized demand-side financing programmes that have recently or will soon be scaled up, such as those in Kenya, Uganda and Bangladesh, represent the most obvious sites for such evaluations, and lessons may be learnt from Mexico"s PROGRESA/ Oportunidades about how to establish a well-embedded monitoring and rigorous evaluation structure.

Other important areas that require further study include:

- The effects of unconditional cash transfers and vouchers for food on maternal health and other outcomes;
- The quality of services that are provided to beneficiaries of demand-side financing schemes, the maternity care experience for the user, and how these can be optimised;
- The specific effects of demand-side financing schemes for poor, rural and socially excluded women;
- Mechanisms to involve women"s organisations and other user representatives in design and implementation and monitoring of demand-side financing schemes;
- Any effect of demand-side financing interventions on competition in markets for the provision of health services;

- The cost-effectiveness of demand-side financing interventions, comparing with similar investment in supply-side financing mechanisms;
- The optimal and most practical administration systems for demand-side financing programmes at different stages of scale up, to avoid duplication and undue expense while maintaining efficiency and transparency;
- Wider effects of adoption of demand-side financing interventions on quality of life for women, household poverty, social organisation of maternity care, and notions of state obligation and women"s entitlement.

Keywords

Maternal health, Demand-side financing, Voucher, Cash transfer

List of acronyms

ASHA	Accredited social health activist
AusAID	Australian Agency for International Development
BDT	Bangladeshi taka
DFID	UK Department for International Development
DSF	Demand-side financing
INR	Indian rupee
JBI-ACTUARI	Joanna Briggs Institute Analysis of Cost, Technology and Utilisation Assessment and Review Instrument
JBI-MAStARI	Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument
JBI-QARI	Joanna Briggs Institute Qualitative Assessment and Review Instrument
JSY	Janani Suraksha Yojana
PROGRESA	Programa de Educación, Salud y Alimentación [Education, Health and Nutrition Programme]
USAID	US Agency for International Development
US$	US dollar
WHO	World Health Organization

Glossary

Accredited social health activist	Cadre of community health worker in India
Marz	Armenian term relating to an administrative division, similar to province
Neonatal	Of, or relating, to the first 28 days of an infant‟s life
Perinatal	Of, or relating to, the period beginning at 28 weeks gestation and ending one week after childbirth
Union	Bangladeshi term for administrative level below „upazila‟
Upazila	Bangladeshi term for sub-district

Background

Maternal health is defined by the World Health Organization (WHO) as „the health of women during pregnancy, childbirth and the postpartum period".[1] Improving maternal health is a priority issue in health and development, as indicated by its inclusion as one of the eight Millennium Development Goals.[2] Since 1990 there have been advances in this area and by 2008 there had been an estimated 34% decrease in the maternal mortality ratio worldwide, a measure commonly used as a proxy for maternal health status.[3] However, while some countries have made strides to improve maternal health others remain considerably far from the target set by Millennium Development Goal 5 to „reduce by three quarters, between 1990 and 2015, the maternal mortality ratio".

Description of the problem

Governments, donors, civil society and other organisations have made substantial contributions towards interventions to improve maternal health in low- and middle-income countries but in most low-income settings these investments have been insufficient to support the development of comprehensive maternal health programmes.[4] In settings where supply of clinical services is adequate, demand may still be low as a result of the barriers to access faced by women and their families when seeking care; these barriers include those of a geographical, social or financial nature.[5] Attempts to overcome financial barriers represented by the costs of transport, costs of treatment and loss of earnings can result in the sale of household assets, depletion of savings or incurring of loans, and can cause poor families to slip further into poverty.[4, 6]

Description of the intervention

„Demand-side" financing (DSF) has been described as „a means of transferring purchasing power to specified groups for the purchase of defined goods or services'.[7] In many countries financing for health services has traditionally been disbursed directly from governmental and non-governmental funding agencies to providers of services: the „supply-side" of health care markets. In this situation DSF offers a supplementary model in which some funds are instead channelled through, or to, prospective users. In maternal health care programmes focussed on increasing utilisation such DSF measures typically take the form of cash incentives upon service use, longer-term social cash transfers or schemes giving vouchers, coupons or cards directly to users, sometimes in conjunction with a choice between providers.[8-10] While many DSF-for-health schemes are conditional, some schemes leave the actual purchase of the goods or services to user discretion, and others use unconditional cash transfers to improve the purchasing power of poor households.

In this review we consider evidence on five forms of demand-side financing that have been used to promote maternal health in developing countries:

• unconditional cash transfers

• conditional cash transfers

• short term payments to offset the cost of accessing maternal health services

• vouchers for maternal health services

• vouchers for „merit" goods that promote maternal health.

Unconditional cash transfers targeted at pregnant women are also referred to as „maternity benefits" or „maternity allowances". Where such schemes exist in low- and middle-income countries, they are often limited to statutory benefits for employees within the formal sector, and do not include poor, rural or socially excluded women. In Asia, exceptions to this included the Dr Muthulakshmi Reddy Memorial Maternity Assistance Scheme in the Indian state of Tamil Nadu, operational as an unconditional cash transfer scheme between 1987 and 2012* and the National Maternity Benefit Scheme which ran nationwide in India from 1995 until 2005.[11] The Dr Muthulakshmi Reddy Memorial scheme provided unconditional payments of 6,000 Indian rupees (INR) (worth approximately US$ 133 when this amount was set in 2006) to women from poor households. Of this, INR 3,000 (US$ 67) was paid before the birth and INR 3,000 afterwards. The National Maternity Benefit Scheme offered an „unconditional" payment of INR 500 (equivalent of US$ 14 in 1996) to a sub-set of poor pregnant women during the third trimester. Although not conditional on any specific behaviour or activity during the pregnancy, the targeting of this benefit was intended to encourage specific reproductive choices in the population at large. Eligible women were those who were aged over 19, who had no more than one previous live birth and possessed a „below poverty line" card.

Unconditional cash transfers to poor, rural or socially excluded pregnant women have also been used in countries in Northern and sub-Saharan Africa. A programme operated by the Ministry of Social Solidarity in Egypt provides a monthly cash payment to poor pregnant women to assist adequate nutrition.[12] Similar programmes have been introduced in Mozambique and Ethiopia.[13] A pilot scheme recently introduced in Ethiopia, Malawi and Uganda is testing an arrangement where unconditional cash transfers to pregnant women are provided alongside cash transfers that are conditional on uptake of maternal health services.[14]

Conditional cash transfers, or „social transfers"[15] have been a popular tool in human development and poverty alleviation programmes since the launch of Programa de Educación, Salud y Alimentación (PROGRESA, now known as Oportunidades) in Mexico in 1997. These are typically targeted at poor households who must fulfil a series of conditionalities focused primarily on child health and school attendance in order to receive the payments. The aim is to reduce poverty by improving the health and education of the poorest groups, and the cash transfers usually go to the mother.[16] Oportunidades is considered by many policy-makers to have demonstrated the success of conditional cash transfers, and similar programmes have been introduced across countries in Latin America (Bolsa Familia in Brazil,

* This was converted into a conditional payment in 2012, when attendance at antenatal and child health check-ups became required and the payment was increased to INR 12,000 (US$ 226).

Programa Familias in Argentina, Bono Juana Azurduy in Bolivia, Programa de Asignacion Familiar in Honduras, Juntos in Peru), sub-Saharan Africa (Care of the Poor programme in Nigeria, the Ghana-Luxembourg Social Trust project in Ghana and a project in Ethiopia, Malawi and Uganda introduced by Interact Worldwide and the Overseas Development Institute), Central Asia and the Middle-East (the BOTA Conditional Cash Transfer Program in Kazakhstan and the Social Risk Mitigation Project in Turkey), South Asia (the Indira Gandhi Matritava Sahayog Yojana in India), and South-East Asia (Program Keluarga Harapan in Indonesia and Pantawid Pamilyang Pilipino Program in the Philippines).[17] Although these schemes‟ primary focus is not maternal health the conditionalities frequently include maternal health components, for example obliging pregnant women to attend a series of check-ups at a health facility, and in some countries attendance at health facilities to give birth.

Schemes providing short term payments to offset the cost of accessing maternal health services, on the other hand, are focused interventions targeted specifically at pregnant women and aimed at reducing financial barriers to their utilisation of specific services. These have been offered in a smaller number of developing countries, sometimes along with package of other measures. The Safe Delivery Incentive Scheme in Nepal[18] and the Janani Suraksha Yojana (JSY) in India,[19] both launched in 2005, pay women cash if they give birth in a health facility or with a skilled health attendant. In both schemes the amount payable varies according to geographical constraints on access, larger payments are made to women in rural areas as a reflection of the higher costs of accessing health services.

Vouchers for maternal health services have generated considerable interest among policymakers in the last few years. Typically targeted voucher schemes are used to provide poor women with specific elements of maternity care. In many contexts these programmes have also sought to create incentives for the private sector to provide services for poor women in areas where publicly funded health care is limited or under-resourced, for example parts of Pakistan, Bangladesh, Indonesia, the Philippines, Cambodia, Laos, Vietnam, Kenya, Uganda and South Sudan.[21-25] While many such voucher schemes focus on rural areas with weak public health infrastructure, recent programmes in urban areas of India and Kenya have sought to improve service uptake among poor pregnant women in urban slums.[26-28] The programmes in India include voucher schemes in the National Capital Territory of Delhi and the states of Haryana, Jharkhand, Uttarakhand, and Uttar Pradesh.

Voucher-style programmes may involve distribution of coupons to eligible pregnant women (the coupon is then used by the provider as proof of use of the service for reimbursement purposes) or may require women to carry an eligibility certificate or an entitlement card. The Obstetric Care State Certificate Program in Armenia, for example, allows a pregnant woman who presents the state certificate to access free obstetric health care at government hospitals.[29] The Chiranjeevi scheme in Gujarat, India, is one of the most well-known voucher programmes and has been replicated in other Indian states such as the Thayi Bhagya scheme in Karnataka, the Janani Sahayogi Yojana in Madhya Pradesh and Ayushmati scheme in West Bengal.[30] These schemes allow pregnant women holding a „below poverty line‟ card to avail themselves of maternal health services at accredited private providers.

Vouchers for the purchase of merit goods have also been used with the aim of promoting maternal health. In many African countries, the purchase of insecticide-treated nets for malaria prevention in pregnancy is encouraged by voucher-based subsidies. The Tanzanian National Voucher Scheme is one of the most established programmes and „Netmark" schemes exist in Zambia, Ghana, Mali, Ethiopia, Senegal and Nigeria.[31, 32] Vouchers have also been used to promote better nutrition for pregnant women. The Sweetpotato Action for Security and Health in Africa, providing women attending antenatal care with a voucher for 10 kilograms of sweet potatoes, is being implemented in several countries.[33] Similarly the Kenya Emergency Drought Response programme in 2006 distributed vouchers for food to pregnant women through health centres.

The case for a systematic review

There have been three systematic reviews in recent years on DSF mechanisms for services that have included schemes directed at maternal health, each review considering only one form of DSF. Lagarde et al. assessed evidence on the effectiveness of conditional cash transfers for any health intervention.[10] Meyer et al. assessed the effectiveness of vouchers for health interventions,[34] while Bellows et al. focussed on the effectiveness of vouchers for reproductive health services.[8]

The rationale for a new systematic review was threefold. First, the review"s specific focus allowed due attention to be paid to the distinctive features of maternal health and maternal health care. Maternal health care is sometimes said to be a uniquely useful tracer for a functioning health care system. This is because maternal health requires a mix of promotion, protection, prevention, emotional support and respect, reinforcement of physiological processes, vigilance for and timely management of complications, and rapid access to medical intervention when emergencies arise. Pregnancy complications, labour and birth care require skilled human resources and supplies that are available 24 hours per day, plus emergency access to higher level care for more complex cases. DSF measures have been used to provide or reinforce several components of this continuum of care. Examples include basic provisions for promoting good health such as nutrition, adequate rest; preventive merit goods such as insecticide-treated bed nets; preventive and vigilance measures combined with the content of antenatal and postnatal contacts, vigilance and timely intervention measures via skilled attendance at birth. Second, by applying a single set of questions across a range of modes of DSF, their relative contribution to improving maternal health can be explored. Third, previously published reviews, systematic and non-systematic, had focussed largely on the effectiveness of DSF mechanisms in terms of coverage and cost outcomes. The Joanna Briggs Institute methodology encourages consideration of evidence on other dimensions of implementation alongside effectiveness. We examined the Cochrane Library, Joanna Briggs Institute Library of Systematic Reviews, PROSPERO register of systematic reviews, MEDLINE, CINAHL and SCOPUS and did not identify any current or planned systematic reviews that matched this broad scope.

The Joanna Briggs Institute"s Model of Evidence-Based Health care and its methodology of systematic reviews offer four key facets through which to examine an intervention:

• Feasibility – the extent to which an activity is practical and practicable (including its cost-effectiveness);

• Appropriateness – the extent to which an activity fits with or is apt in a situation;

• Meaningfulness – the extent to which an intervention or activity is positively experienced by the patient;

• Effectiveness – the extent to which an intervention, when used appropriately, achieves the intended effect.[35]

We incorporated all four facets to provide a rigorous comprehensive review of broad scope. Our approach was as inclusive as possible in order to collect and present findings related to these four facets; quantitative, qualitative and economic studies were considered.

Objectives

The overall review objective was to assess the effects of demand-side financing (DSF) interventions on maternal health service utilisation and on maternal health outcomes in low- and middle-income countries. Broader effects on perinatal and infant health, the situation of underprivileged women and the health care system were also assessed. For example, we examined evidence on the appropriateness and meaningfulness of DSF for meeting the needs of rural, poor or socially excluded women, and evidence on the feasibility and appropriateness of DSF in terms of quality of care, sustainability and institutional capacity to run such schemes.

Specific review questions

This review aimed to address the following questions with reference to DSF interventions that seek to improve maternal health:

- *What are the effects of different DSF interventions on maternal morbidity and mortality?*

2. *What are the effects of different DSF interventions on perinatal and infant morbidity and mortality?*

3. *What are the effects of different DSF interventions on uptake of maternal health services?*

4. *What are the effects of different DSF interventions on the quality of care provided?*

5. *What are the effects of different DSF interventions on the choice of provider offered to consumers and competitiveness of the market?*

6. *What are the effects of different DSF interventions on the quality of life of expectant and new mothers?*

7. *What are the effects of different DSF interventions on out of pocket expenditure and household poverty?*

8. *What are the effects of different DSF interventions on the responsiveness of providers (in terms of the scope of services, the number of providers and the way that services are provided)?*

9. *Can DSF measures provide a cost-effective approach to increase utilisation of maternal health services and improve health outcomes among rural, poor or socially excluded women?*

10. *What barriers are there to the provision of DSF measures and what are the most appropriate ways to ensure that they are optimally delivered and administered among rural, poor or socially excluded women in different contexts?*

11. *What are the experiences of those who provide services through DSF schemes for maternal health?*

12. *Are there any ethical issues that arise from specific components of DSF measures, for example conditionalities?*

13. *What is the social meaning (in terms of empowerment, entitlement and combating stigma) of DSF measures for women in low- and middle-income countries?*

14. *What are the supply-side and other preconditions for successful DSF implementation?*

15. *What are the preconditions to sustain and scale up DSF mechanisms?*

Inclusion criteria

Types of participants

This review considered poor, rural or socially excluded women of all ages who were either pregnant or within 42 days of the conclusion of pregnancy, the limit for postnatal care as defined by WHO.[1] Definitions for „poor", „rural" and „socially excluded" vary between and within countries as they are relative terms founded in cultural and political contexts. For the purposes of this review we documented the definitions employed by authors to describe target populations, and took note of any differences in the synthesis. Providers of services through DSF mechanisms were also considered.

Types of intervention(s)/phenomena of interest

The intervention of interest was any programme that incorporated DSF as a mechanism to increase the consumption of goods and services that could impact on maternal health outcomes. This included the direct consumption of maternal health care goods and services as well as related „merit goods" such as improved nutrition. Our review did not include conventional insurance systems as a form of DSF because they have been the subject of other reviews.[36]

We included systems in which potential users of maternal health services are financially empowered to make restricted decisions on buying maternal health-related goods or services – sometimes known as consumer-led demand-side financing.[9] These typically take the form of conditional cash transfers, or schemes in which prospective users are given vouchers, coupons or cards, sometimes in conjunction with a choice between providers. We also included programmes that provided unconditional cash benefits to pregnant women (for example in the form of maternity allowances), or to families with children under five years of age where there was evidence concerning maternal health outcomes. We did not, however, include more general employment-related interventions such as statutory maternity or

unemployment benefit, tax credits or rebates which are usually part of more general social security systems.

Types of studies

We aimed to include quantitative studies (experimental, observational and descriptive), qualitative studies (including designs based on phenomenology, grounded theory, ethnography, action research and feminist research), and economic studies (cost-effectiveness, cost-utility and costs studies). In the absence of qualitative research studies, it was planned to consider other text such as opinion papers and reports.

Types of outcomes

Quantitative

The quantitative outcomes used in research on this topic varied by study aim and objectives. A primary outcome of interest was maternal (antenatal, intrapartum, and postnatal) and infant (perinatal, neonatal and infant) mortality and morbidity. The maternal mortality ratio and infant mortality ratio are commonly used indicators, while measures of morbidity are more varied.

Other outcomes relevant to the utilisation of maternal health services were included in the review as a primary outcome, using terms such as coverage, uptake and access. Many studies on utilisation of maternal health services used the proportion of deliveries at a health facility or births with a skilled birth attendant present.

Secondary outcomes for the review included changes in the number of health service providers, changes in out of pocket expenditure, for example as a proportion of household income, and changes in household poverty, such as the proportion of households in the bottom quintile. Measures of quality of life for pregnant and postnatal women were also included.

Although the review includes schemes directed at families with children under five years of age we only focused on maternal, and consequent perinatal and infant outcomes, rather than the broader effect of these interventions on the welfare of families.

Qualitative

Outcomes of qualitative studies were variable and particular outcomes of interest included information on:

- *factors that are responsible for the success or failure of DSF mechanisms;*
- *if there has been a perceived broader impact of DSF schemes on the status of women in their society;*
- *costs of activities that it is felt should or should not be paid for through DSF mechanisms;*
- *whether or not there has been a perceived impact on the quality of health care provided and the choice of providers;*
- *any change in the way services are provided and the responsiveness of providers; and*
- *experiences of patients and providers of services paid for through DSF initiatives.*

Economic

Outcomes measures relating to the unit costs of DSF programmes or to cost-effectiveness (such as cost per institutional delivery) and to cost-utility (such as per quality- or disability-adjusted life year gained) were included in the review.

Search strategy

The aim of the search strategy was to identify both published and unpublished studies. A three-step search strategy was utilised:

1. an initial limited search of MEDLINE, CINAHL and SCOPUS was undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe articles;

2. a second search using all identified keywords and index terms was then undertaken across all included databases; and

3. thirdly, the reference list of all identified reports and articles was searched for additional studies.

We considered studies published between January 1990 and June 2012. Since DSF measures have been incorporated into maternal health strategies in low- and middle-income countries in the last 10-15 years,[7, 9] our review sought to include evidence arising during this period of time and discussions of the DSF approach in the years preceding this period. We were, however, unable to identify any relevant and suitable studies completed before 2000. Aside from the search of Indian grey literature discussed in more detail later, only studies with abstracts in English were considered for inclusion in this review. The sources searched are listed in Table 1.

Initial key words used in our search were:

“Abortion”	“Antenatal”
“Birth”	“Cash transfer”
“Child benefit”	“Cost”
“Cost-effective”	“Cost-utility”
“Demand side financing”	“Demand-side financing”
“Family allowance”	“Food stamps”
“Health service utilisation”	“Incentive”
“Infant”	“Maternal”
“Maternity allowance”	“Maternity benefit”
“Midwifery”	“Monetary transfer”
“Neonatal”	“Morbidity”
“Mortality”	“Obstetric”
“Output-based aid”	“Perinatal”
“Postnatal”	“Pregnancy”
“Reimbursement mechanism”	“Voucher”

Further details of the search strategy are provided in Appendix I.

Table 1. Sources searched

Databases and e-journal services searched	**Sources of unpublished studies searched**
Applied Social Sciences Index and Abstracts	Websites of governmental and non-governmental organisations and development banks (see Appendix I)
ArticleFirst	Intute
British Development Library Services	Nexis UK
CINAHL	Mednar
Cochrane Central Register of Controlled Trials	ProQuest Dissertations and Theses
EconLit	Qual Page
Electronic Collections Online	Scirus
HealthSource: Nursing/Academic Edition	WorldWideScience.org
International Bibliography of the Social Sciences	
Latin American and Caribbean Health Sciences	
Sage Journals Online	
ScienceDirect	
SCOPUS	
Social Policy and Practice	
Social Services Abstracts	
Sociological Abstracts	
SpringerLink	
Web of Knowledge	
Wiley Online Library	

Search of Indian grey literature

Previous systematic reviews and other reviews of the literature on DSF schemes for maternal health have predominantly relied upon electronic literature databases to identify relevant studies, yet researchers and health care professionals in low- and middle-income countries face a number of barriers to publishing their findings in indexed journals. In order to address this shortcoming, we collaborated with researchers in India to obtain relevant studies in Indian journals and archives. India, a growing contributor to global health research, was selected for this search because it contributes significantly towards global figures for maternal mortality; 63,000 women died as a consequence of pregnancy in India during 2008, more than in any other country.[3] Policy-makers at the state and national level in India have introduced a number of DSF initiatives in the last decade to increase utilisation of maternal health services by the poorest women and to improve their health outcomes. There are however only a few studies available on these initiatives in indexed journals.

Members of the review team based at Jawaharlal Nehru University in New Delhi conducted the search of Indian grey literature. This was composed of four stages:

1. A series of meetings were held with Delhi-based non-governmental organisations that work on maternal health in order to identify and obtain literature on maternal health programmes in India that use DSF. The names of additional organisations and researchers in India to contact by e-mail or post were also obtained in these meetings.

2. Websites for non-governmental organisations known to work in maternal health were searched for documents on DSF initiatives

3. Websites of state health departments and societies were searched for documents on maternal health programmes with DSF schemes

4. Back-catalogues of Indian journals were examined for relevant articles and six libraries were visited to identify books that contained relevant studies. No books containing relevant studies were found.

Lists of the websites searched, the journals examined, and the libraries visited are provided in Appendix I. The list of studies selected for retrieval is presented in Appendix II.

Methods of the review

Critical Appraisal

The primary (BH) and secondary reviewers (SFM and DB) independently reviewed all papers and conferred. Discrepancies were resolved by discussion and where agreement could not be reached, other review team members (TE and RB) were asked for their opinion. Assessment was done using standardised critical appraisal instruments from the Joanna Briggs Institute (see Appendix III). These are:

• the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI) for quantitative studies;

• the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) for qualitative studies; and

• the Joanna Briggs Institute Analysis of Cost, Technology and Utilisation Assessment and Review Instrument (JBI-ACTUARI) for economic studies.

Data Collection

Data were extracted from papers included in the review using the standardised data extraction tools from JBI-MAStARI, JBI-QARI or JBI-ACTUARI for quantitative, qualitative or economic data, respectively (see Appendix IV). The data extracted included details on the following:

• Author/year

• Study details, sample size, setting

• Interventions

• Study method

• Statistical data

• Interventions

• Populations

• Programme theory

• Outcomes of significance relevant to the review questions.

Data Synthesis

Quantitative

Statistical pooling by meta-analysis was not possible due to the variety of study settings and measures used. The findings are presented in narrative form including tables and figures to aid in data presentation where appropriate. Findings from descriptive studies were, where possible, synthesised and presented in a tabular summary with the aid of narrative and figures where appropriate.

Qualitative

Qualitative research findings were pooled using JBI-QARI. This involved the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings (Level 1 findings) rated according to their quality, and categorising these findings on the basis of similarity in meaning (Level 2 findings). These categories were then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesised findings (Level 3 findings) that can be used as a basis for evidence-based practice or policy.

The approach taken to extracting Level 1 findings within this review is atypical for a JBI systematic review. Due to the style of reporting in many of the included studies, themes were often not easily identifiable so findings were extracted and worded in a way that had meaning, and related to, the review questions asked. To facilitate the aggregative process and assist in the development of synthesised findings, similar findings from across different studies were phrased as closely as possible to each other. For clarity, findings from individual studies were annotated with the intervention of interest for ease of reference. Level 1 findings and supporting illustrations from all included studies can be found in Appendix VII.

Economic

Economic findings were to be, where possible, pooled using JBI-ACTUARI and presented in a tabular summary. Where this was not possible, findings were presented in narrative form.

Results

Description of studies

The initial database search identified 9,378 articles, of which 7,061 were from published and 2,317 from unpublished sources. The title and abstract of each study were examined for relevance to the review and 9,139 articles were excluded on this basis. The full text articles for 172 papers were retrieved to determine whether they met the inclusion and exclusion criteria of our review. A total of 54 papers met our inclusion criteria and were assessed for methodological quality. From these 54 papers, 45 were included in the review.

The search of Indian grey literature identified an additional 134 articles and 54 were critically appraised for methodological quality. Of these, 27 were considered to be of appropriate quality to include in the review.

Combining the studies retrieved through the database search and the Indian grey literature search, 306 articles were retrieved for further examination and ultimately 72 articles were included in our review (33 quantitative studies, 4 economic studies and 46 qualitative studies). The study selection process is shown in Figure 1. Details of each included study are provided in Appendix V. Studies excluded from the review based on methodological quality are listed in Appendix VI.

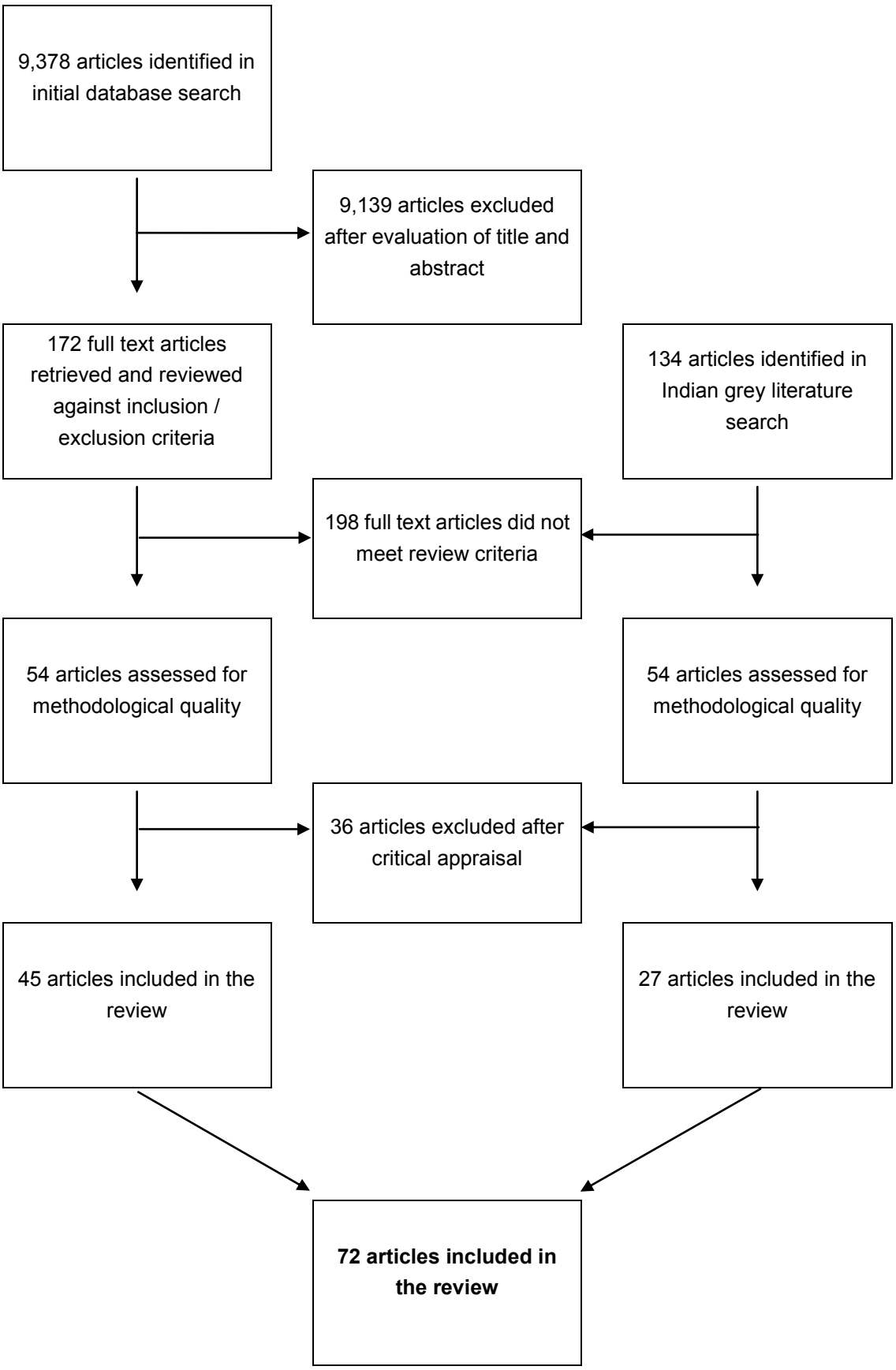


Figure 1. Flow chart of identification and selection of studies

Methodological quality

The studies identified had many shortcomings and were generally of poor quality. Descriptions of study methods were often incomplete and in some studies it was difficult to clearly identify the evidence for each reported finding, particularly in evaluation studies that employed diverse mixed methods. The quantitative studies tended to use narrow time periods and many were based on data from a single household survey. It was not possible to conduct a meta-analysis due to a lack of uniformity in the outcome measures and comparators. Most of the „qualitative studies" included in the review were qualitative elements of larger programmatic evaluations and used data collected through interviews and focus group discussions. The reporting of methods and findings often lacked clarity. Few economic evaluations were identified and most of these used estimations based on limited or ill-defined cost data. Those that were more rigorous used incongruent measures of cost-effectiveness which precluded meaningful comparison.

Qualitative studies

Table 2. Number of studies included and excluded

Number of studies included	Number of studies excluded
46	15

Table 3. Final assessment of qualitative studies

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Adato, M. et al., 2011 [37]	Y	Y	Y	Y	Y	Y	N	Y	U	Y
Ahmed S and MN Khan, 2011 [22]	U	Y	Y	Y	Y	N	N	Y	U	Y
Koehlmoos et al., 2008 [38]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Nandan et al., 2008 [39]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Nandan et al, 2010 [28]	U	Y	U	Y	Y	N	N	Y	U	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Powell-Jackson et al., 2009 [40]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Tami et al, 2006 [41]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Truzyan, N., 2010 [29]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Chaturvedi and Randive, 2009 [42]	U	Y	Y	Y	Y	N	N	Y	U	Y
Molyneux, M. and Thomson, M., 2011 [43]	U	Y	Y	Y	Y	N	N	Y	U	Y
Arur, A. et al, 2009 [23]	U	Y	Y	Y	Y	N	N	Y	U	Y
Ir et al., 2010 [25]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Kweku et al, 2007 [44]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Jega, F.M., 2007 [45]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Mubyazi et al., 2010 [46]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Mushi et al., 2003 [47]	U	Y	Y	Y	Y	N	N	Y	U	Y
Rob et al., 2009 [48]	U	Y	Y	Y	Y	N	N	Y	U	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Reproductive Health Vouchers Evaluation Team, 2011 [49]	U	Y	Y	Y	Y	N	N	N	Y	Y
Reproductive Health Vouchers Evaluation Team, 2011 [50]	U	Y	Y	Y	Y	N	N	N	Y	Y
Pariyo et al, 2011 [51]	U	U	Y	Y	Y	N	N	Y	Y	Y
Reproductive Health Vouchers Evaluation Team, 2012 [52]	U	U	Y	Y	Y	N	N	Y	U	Y
Hatt et al, 2010 [53]	U	U	Y	Y	Y	N	N	Y	Y	Y
Human Rights Watch, 2009 [54]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Nandan et al, 2008 [55]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Chaturvedi and Randive, 2011 [56]	U	Y	Y	Y	Y	N	N	Y	U	Y
Febriany et al, 2011 [57]	U	Y	Y	Y	Y	N	N	Y	U	Y
Devadasan et al., 2008 [58]	U	Y	Y	Y	Y	N	N	Y	U	Y
Khan et al, 2010 [59]	U	Y	Y	Y	Y	N	N	Y	U	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Public Health Resource Network, 2010 [11]	U	Y	Y	Y	Y	N	N	Y	U	Y
Rai et al., 2012 [60]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Santhya et al., 2011 [61]	U	Y	Y	Y	Y	N	N	Y	U	Y
Uttekar et al., 2008 [62]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2007 [63]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2007 [64]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2007 [65]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2008 [66]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2007 [67]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2007 [68]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Uttekar et al., 2007 [69]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Krishna and Ananthpur, 2011 [70]	U	Y	Y	Y	Y	N	N	Y	U	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Dasgupta, J., 2007 [71]	Y	Y	Y	Y	Y	N	N	Y	U	Y
Gupta, A., 2007 [72]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Hangmi and Kuki, 2009 [73]	U	Y	Y	Y	Y	N	N	Y	U	Y
Kumar et al., 2009 [74]	U	Y	Y	Y	Y	N	N	Y	U	Y
Lodh et al., 2009 [75]	U	Y	Y	Y	Y	N	N	Y	U	Y
Singh and Chaturvedi, 2007 [76]	U	Y	Y	Y	Y	N	N	Y	U	Y
% 'yes' responses	**8.7**	**93.5**	**97.8**	**100.0**	**100.0**	**2.2**	**0.0**	**95.7**	**54.4**	**100.0**

Notes: Y=Yes; N=No; U=Unclear; see Appendix III for list of questions used to appraise qualitative studies

Quantitative studies

Table 4. Number of studies included and excluded

Number of studies included	Number of studies excluded
33	23

Table 5. Final assessment of comparable cohort / case control studies

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Agha, S., 2011 [21]	Y	Y	N	Y	Y	Y	N	Y	Y
Agha, S., 2011 [77]	Y	Y	Y	Y	Y	Y	N	Y	Y
Ahmed, S. and M.M. Khan, 2011 [78]	Y	Y	Y	Y	Y	Y	N	Y	Y
Bhat, R. et al., 2009 [30]	Y	Y	N	N	N	Y	N/A	Y	Y
Nguyen et al, 2012 [79]	Y	Y	Y	Y	Y	Y	N	Y	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Rob et al., 2009 [48]	Y	Y	U	N	Y	Y	N	Y	Y
Bellows et al, 2011 [26]	U	U	U	Y	Y	Y	N	Y	Y
Obare et al, 2012 [80]	Y	Y	N	Y	Y	Y	N	Y	Y
Reproductive Health Vouchers Evaluation Team, 2012 [52]	Y	Y	Y	N	Y	Y	N	Y	Y
Barber S.L. and P.J. Gertler, 2009 [81]	Y	Y	Y	Y	Y	Y	N	Y	Y
Barber, S.L., 2010 [82]	Y	Y	Y	Y	Y	Y	N	Y	Y
Barber, S.L. and P.J. Gertler, 2008 [83]	Y	Y	Y	Y	Y	Y	N	Y	Y
Barham, T., 2011 [84]	Y	Y	Y	Y	Y	Y	N	Y	Y
Hernandez Prado et al., 2004 [85]	Y	Y	Y	Y	Y	Y	N	Y	Y
de Brauw et al, 2011 [86]	Y	Y	Y	Y	Y	Y	N	Y	Y
Lim et al., 2010 [19]	Y	Y	Y	Y	Y	Y	N	Y	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Morris et al., 2004 [87]	Y	Y	Y	N	Y	Y	N	Y	Y
National Health Systems Resource Centre, 2011 [88]	Y	Y	N	Y	Y	Y	N	Y	Y
Powell-Jackson and Hanson, 2012 [18]	Y	Y	Y	Y	Y	Y	N	Y	Y
Powell-Jackson et al., 2009 [89]	Y	Y	U	Y	Y	Y	N	Y	Y
Hernandez Prado et al., 2004 [90]	Y	Y	U	Y	Y	Y	N	Y	Y
Santhya et al., 2011 [61]	U	Y	N	Y	Y	Y	N	Y	Y
Powell-Jackson et al., 2011 [91]	U	Y	U	Y	Y	Y	N	Y	Y
Sosa-Rubai et al., 2011 [92]	Y	U	N/A	Y	Y	Y	N	Y	Y
UNFPA India, 2009 [93]	Y	Y	N	Y	N/A	Y	N	Y	N
Urquieta et al., 2009 [94]	Y	Y	U	Y	Y	Y	Y	Y	Y
Uttekar et al., 2007 [63]	U	Y	N	Y	N/A	Y	N	Y	Y
Uttekar et al., 2007 [65]	U	Y	N	Y	N/A	Y	N	Y	Y

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Uttekar et al., 2007 [68]	U	Y	N	Y	N/A	Y	N	Y	Y
Uttekar et al., 2007 [69]	U	Y	N	Y	N/A	Y	N	Y	Y
Hatt et al, 2010 [53]	Y	Y	Y	Y	Y	Y	N	Y	Y
% 'yes' responses	**77.4**	**93.6**	**46.7**	**87.1**	**96.2**	**100.0**	**3.3**	**100.0**	**96.8**

Notes: Y=Yes; N=No; U=Unclear; N/A=Not applicable; see Appendix III for list of questions used to appraise comparable cohort / case control studies

Table 6. Final assessment of descriptive / case series studies

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Hanson et al., 2009 [32]	Y	Y	Y	Y	Y	Y	N	Y	Y
Nandan et al, 2010 [28]	N	Y	N	Y	N/A	Y	N	Y	Y
% 'yes' responses	**50.0**	**100.0**	**50.0**	**100.0**	**100.0**	**100.0**	**0.0**	**100.0**	**100.0**

Notes: Y=Yes; N=No; U=Unclear; N/A=Not applicable; see Appendix III for list of questions used to appraise descriptive / case series studies

Economic studies

Table 7. Number of studies included and excluded

Number of studies included	Number of studies excluded
4	2

Table 8. Final assessment of economic studies

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11
Nandan et al, 2010 [28]	U	N	Y	N	Y	U	N	N	N	U	N
Mulligan et al., 2008 [95]	Y	N	N	Y	Y	Y	Y	Y	Y	Y	U
IFPS Technical Assistance Project, 2012 [27]	N	N	Y	N	Y	Y	U	N	N	U	Y
Hatt et al, 2010 [53]	U	N	Y	U	Y	Y	U	U	N	N	Y

% 'yes' responses	**25.0**	**0.0**	**75.0**	**25.0**	**100.0**	**75.0**	**25.0**	**25.0**	**25.0**	**25.0**	**50.0**

Notes: Y=Yes; N=No; U=Unclear; see Appendix III for list of questions used to appraise economic studies

Review question 1. What are the effects of different DSF interventions on maternal mortality and morbidity?

Summary of quantitative evidence for review question 1

We found limited evidence in two reports on the effect of DSF interventions on maternal *mortality*. The evidence that was available was inconsistent. One study on Oportunidades showed a reduction in maternal *mortality* and one study on the Maternal Health Voucher Scheme in Bangladesh showed no effect on maternal mortality. No studies were identified which considered effects on maternal *morbidity*.

Evidence for review question 1 by mode of DSF

Conditional cash transfers

Hernandez Prado et al. considered the effects on maternal mortality of roll out of the Oportunidades programme, which was launched in Mexico in 1997.[85] The health component of Oportunidades, a large scale conditional cash transfer programme, includes access to a package of health services, food supplements for pregnant and lactating women, for infants aged 4 to 23 months and for children aged 2 to 4 years identified as malnourished. Recipients are expected to attend education sessions on family health promotion. Data for this study were collected from 1995 - 2002 using a retrospective longitudinal study approach, to compare maternal and infant mortality rates before and after the programme launch, with deaths reported at the municipal level included in the analysis (the dependent variable). Data were available from a total of 2,445 municipalities.

The main exposure variable was incorporation into Oportunidades. Three variables were constructed to indicate exposure to the programme by municipality: number of households included; number of people included; and percentage of the population who were beneficiaries of the programme. Potential confounding or modifier variables were also included in statistical models, namely, level of poverty; households in states already included in the Equal Start in Life Programme; and number of primary, secondary and tertiary health facilities in each municipality. After adjusting for these variables, the Oportunidades program was associated with an overall 11% reduction in maternal mortality ($p<0.05$). When the impact of the program at municipal level, stratified by level of poverty, was assessed, the effect was stronger in areas defined as being of medium and very high poverty. Furthermore, the effect on mortality increased in line with the number of beneficiaries within the programme. The effect on maternal mortality was seen immediately after programme roll out rather than as a consequence of implementation over time.

Vouchers for maternity services

Hatt et al. completed an economic evaluation during June to December 2009 of a mixed-mode DSF pilot scheme in Bangladesh.[53] Poor pregnant women received vouchers entitling them to free maternity care, transport subsidies, a cash incentive for delivery with a qualified provider (at home or in a designated facility) and a gift box. Providers received incentives to distribute vouchers and provide services covered by the vouchers. There were several objectives of the evaluation, which included a comprehensive assessment of the voucher programme operation, and impacts on both the demand- and supply-side. The demand side impact was measured using a household survey of 16 DSF upazilas and 16 matched control upazilas which included 2,208 women who gave birth between February 2009 and July 2009. The supply side impact was measured using data from eight primary level upazila health complexes in DSF upazilas and eight in matched control upazilas. Matching was based on hospital bed numbers where possible. Data collected from upazila health complexes on maternal deaths during this period showed no statistically significant difference (0.05% in the intervention upazila health complexes and 0.0% in controls, p=0.42).

Review question 2. What are the effects of different DSF interventions on perinatal and infant morbidity and mortality?

Summary of quantitative evidence for review question 2

Six studies included findings on perinatal *mortality*. There was evidence of reduced rates of infant *mortality* associated with Oportunidades in Mexico, but contrasting results for JSY in India and no evidence of effect of the Safe Delivery Incentive Programme in Nepal. The Maternal Health Voucher Scheme in Bangladesh was associated with reduced rates of stillbirth.

There was limited evidence on the effect of DSF interventions on perinatal *morbidity*. Evidence was restricted to two studies on Oportunidades in Mexico. Results were mixed, with one study showing evidence of increased average birthweight and decreased incidence of low birthweight, and the other showing no effect.

Evidence for review question 2 by outcome and mode of DSF

Perinatal and infant mortality

Conditional cash transfers

Two studies examined the effect of Oportunidades on perinatal and infant mortality.[84, 85] Hernandez Prado et al. found an overall reduction in infant mortality of 2% in municipalities exposed to the Oportunidades program.[85]

Barham used national registers for births and deaths to construct neonatal and infant mortality rates for urban and rural municipalities in Mexico.[84] The proportion of households enrolled in Oportunidades was used as a measure of „programme intensity" for each municipality. The effect of Oportunidades programme intensity on neonatal and infant mortality rates was estimated using regression analyses.

Enrolment in Oportunidades was associated with a 17% decline in the infant mortality rate in rural areas, from 17.5 to 14.5 deaths per 1,000 live births ($p<0.01$). There was no statistically significant change in the infant mortality rate in urban areas, which was 16.5 deaths per 1,000 live births ($p>0.1$). There was no statistically significant effect of Oportunidades on the neonatal mortality rate in rural or urban municipalities, which were 8.8 and 9.5 deaths per 1,000 live births respectively ($p>0.1$).

Short term payments to offset costs of access

Powell-Jackson et al. assessed the impact of Nepal"s Safe Delivery Incentive Programme, introduced nationwide in 2005, on neonatal mortality and health seeking behaviour at childbirth in one district (Makwanpur) in Nepal.[89] The Safe Delivery Incentive Programme combines three types of incentive, a short term payment to women who give birth in a public health facility, exemption from user fees for those residing in the least developed one-third of districts, and an incentive to health staff for each birth they attend. Every woman in the district who had given birth in a health facility over a six month period was interviewed one month post-birth about her health seeking behaviour at childbirth, if her infant was alive and well, her household"s socioeconomic status and receipt of the short term payment to offset costs of accessing maternal health services. An interrupted time series approach to analysis was used, applied to household data. A model was developed, linking level of each outcome at a point in time to the start of the programme, demographic controls, a vector of time-variables and community-level fixed effects. There was no impact on neonatal mortality, despite an increase in utilisation of maternity services and uptake of the short term payments.

Two studies presented contrasting findings from the JSY in India.[19, 91] Lim et al. assessed the effect of JSY, a short term payment scheme implemented in India to incentivise women to give birth in a health facility, on a range of outcomes, including perinatal and neonatal mortality. Data were obtained from nationwide District Level Household and Facility Surveys conducted in 2002–2004 and 2007–2009 to assess receipt of cash payments as a function of socioeconomic and demographic characteristics. The quality and completeness of data were not described. Three analytical approaches were used; matching, with-versus-without comparison, and differences-in-differences to assess effects of JSY on predetermined outcomes. Implementation of JSY was highly variable by state, from less than 5% to 44% of women giving birth receiving cash payments from JSY. In the matching analysis, JSY payment was associated with a reduction of 3.7 (95% CI 2.2 – 5.2) perinatal deaths per 1,000 pregnancies and 2.3 (95% CI 0.9 – 3.7) neonatal deaths per 1000 live births, suggesting a potential causal effect from implementation of JSY. In the with-versus-without comparison, the reductions were 4.1 (95% CI 2.5 – 5.7) perinatal deaths per 1,000 pregnancies and 2.4 (95% CI 0.7 – 4.1) neonatal deaths per 1,000 live births. Although results appeared encouraging, the authors recommended the need for improved targeting of the poorest women and attention to quality of obstetric care provided in health facilities.

Powell-Jackson et al. identified the effect of JSY on health behaviour and health status by exploiting variation in the timing of the introduction of the programme to districts.[91] Using data on women who gave birth using the District Level Household and Facility surveys as used in the Lim study, the researchers examined whether JSY accounted for cross-district patterns in health care utilisation and health status over time. In contrast to the Lim study, they found no statistically significant effect on neonatal mortality (death of an infant within 28 days) or early neonatal mortality (death of an infant within 24 hours of birth) despite increased access to maternity services. Poor quality of care was one of the potential explanations offered by the authors for the lack of effect.

Vouchers for maternity services

Hatt et al. included the incidence of stillbirth and newborn deaths in their evaluation of the supply-side impact of the DSF programme in Bangladesh.[53] The incidence of stillbirth was significantly lower in DSF programme upazila health complexes than in control upazila health complexes (1.54% of total births compared with 2.45%, p<0.001). The incidence of newborn deaths was also lower although this was not statistically significant (0.05% of live births compared with 1.15%, p=0.15).

Perinatal and infant morbidity

Conditional cash transfers

Two studies considered effects of conditional cash transfer programmes on infant birth weight, which could be used as an indicator of perinatal and infant morbidity.[83, 90] Barber and Gertler evaluated the impact of Oportunidades on infant birth weight using retrospective reports from 840 pregnant women from poor rural communities, randomised to incorporation into the program in 1998 or 1999 across seven Mexican states as part of a large randomised trial.[83] Pregnant women randomised to the intervention (n=666) received nutrition supplements, health care and accepted cash transfers. The impact of the programme on infant birth weight and low infant birth weight (<2,500g), receipt of antenatal care and number of antenatal visits was estimated. Receipt of the programme was associated with a 127.3g increase in infant birth weight (p=0.02) and a 4.6 percentage point reduction in incidence of low infant birth weight (p=0.05). Which aspects of the package of care offered resulted in these improvements are difficult to elicit, as there were no differences in odds of seeking antenatal care or number of antenatal contacts. It is also important to consider that infant birth weight may not be a robust indicator of health, as growth anomalies may be difficult to detect and large infants could be growth restricted. Maternal recall and time interval since birth could have introduced potential bias, although the researchers did not detect this when recall was evaluated using dummy variables for infant year of birth.

Hernandez Prado et al. in a later study used prevalence of low infant birth weight (defined as infants weighing <2,500 grams) as one of the indicators to assess impact of the Oportunidades programme on fertility, knowledge and use of family planning methods, antenatal care, birth care and pregnancy outcomes.[90] The Oportunidades programme includes cash transfers to households with pregnant or lactating women, conditional on regular check-ups at health facilities and attendance at training workshops. Data were used from a series of longitudinal surveys conducted in areas where payments were distributed from the launch of the programme (early intervention areas), and areas where payments were introduced at a later date (late intervention areas). Propensity score matching was used to compare uptake of maternal health services in intervention areas based on survey data from 1998 and 2000. Multivariate regression models were used to compare uptake in intervention and control areas based on cross-sectional analysis of 2003 survey data, controlling for household variables. Separate analyses were conducted for rural and urban areas as urban areas were only included in the scheme in 2003. For rural areas, early intervention groups (households incorporated in 1998) were compared to late-intervention groups (households incorporated at the end of 1999 and early 2000).

Infant birth weight was only included as an outcome for women giving birth in rural areas due to a high percentage of missing data from urban areas. There were no significant differences in the proportion of infants born <2,500 grams between the early (8.9%) and late intervention (8.5%) groups.

Review question 3. What are the effects of different DSF interventions on uptake of maternal health services?

Summary of quantitative evidence for review question 3

Twenty-three studies examined the effect of DSF measures on the uptake of maternal health services, though evidence was almost entirely limited to the effects of conditional cash transfers, short term payments to offset costs of access and vouchers for maternity services. There was robust evidence of a positive effect of short term payments and vouchers for maternity services on the uptake of antenatal care, institutional delivery, skilled birth attendance and postnatal care. Studies on conditional cash transfers contained limited evidence of increased uptake of these services; most evidence showed no effect. The effect of DSF on rates of caesarean section contrasted with some evidence of increases due to conditional cash transfers and short term payments, and other studies showing no effect for conditional cash transfers, short term payments and vouchers for maternity services. One study showed that vouchers for maternity services increased uptake of treatment for obstetric complications. Another demonstrated that vouchers for insecticide-treated nets increased the proportion of pregnant women sleeping under an insecticide-treated net.

Evidence for review question 3 by outcome and mode of DSF

The following outcomes were included:

- Antenatal care [19, 21, 26, 48, 52, 53, 61, 77-80, 83, 86, 87, 90-92]
- Institutional delivery [18, 19, 21, 26, 48, 52, 53, 61, 77-80, 86, 89-91]
- Skilled birth attendance [18, 19, 26, 48, 53, 61, 78-80, 86, 89-91, 94]
- Caesarean sections [18, 53, 79, 82, 89-91]
- Treatment of obstetric complications [78]
- Postnatal care [21, 30, 48, 52, 53, 61, 77-80, 86, 87]
- Sleeping under an insecticide-treated net. [32]

Antenatal care

Conditional cash transfers

Morris et al. conducted a study of the Programa de Asignación Familiar in Honduras.[87] Municipalities were allocated to one of four interventions: monetary vouchers to households with pregnant women, new mothers or young children; a supply-side package to strengthen local health services; both monetary vouchers and the supply-side package; or control municipalities with neither vouchers nor supply-side funds. The monetary vouchers were worth 55 Honduran lempira per month (US$ 3.10) for a household with a pregnant woman or child under 3 years old, conditional on attending antenatal care and giving birth in a health facility among other things.

Two cross-sectional surveys were conducted among around 5,600 households to determine any effect on use of maternal and child health services. The first was undertaken in late-2000, the second in late-2002. Data were analysed using mixed effects regression models.

The proportion of women attending five or more antenatal care sessions increased by 18.7 percentage points in municipalities where vouchers were distributed ($p<0.01$), and 18.4 percentage points in municipalities where both vouchers and supply-side funds were used ($p<0.01$). This compared favourably to a 13.2 percentage point increase in municipalities with the supply-side package alone ($p>0.05$), and a 0.7 percentage point decrease in municipalities with no interventions ($p>0.05$).

Hernandez Prado et al. focused on the health component of Oportunidades.[90] Between 1998 and 2000 in rural areas, the proportion of women receiving any antenatal care did not increase significantly in early intervention areas ($p>0.05$), and it declined in late-intervention areas, from 92.6% to 87.9% ($p<0.05$). There was no significant change in the mean number of antenatal care visits in either intervention group ($p>0.05$). Results from regression analyses using this data showed that Oportunidades increased the proportion of women receiving any antenatal care by 6.7% in late-intervention areas ($p<0.05$).

In contrast to the above, analyses of survey data from 2003 showed no change in the proportion of women attending any antenatal care compared to control areas ($p>0.1$). The data did however show an 11.9% increase in the average number of antenatal care contacts in early intervention areas compared to control areas ($p<0.05$), but no change in late intervention areas ($p>0.1$). In early- and late-intervention areas, the proportion of women attending five or more antenatal care contacts compared to control areas increased by 24.6% ($p<0.05$) and 27.9% ($p<0.01$) respectively. It is unclear why there was so much variation in the findings. This may relate to changes in targeting of the Oportunidades payments, or the use of several comparators.

In urban areas, Hernandez Prado et al. showed that the proportion of women recipients attending antenatal care increased from 82.6% in 2002 to 93.6% in 2003.[90] A difference-in-difference model showed that this was significantly higher than eligible women in non-intervention areas ($p<0.05$), though not significantly different from non-recipients in intervention areas ($p>0.1$). There was no significant difference in the average number of antenatal care visits by any of the groups.

Barber and Gertler used multivariate regression models to show that enrolment in Oportunidades had no statistically significant effect on the odds of uptake of any antenatal care, uptake of at least five antenatal care sessions, or the average number of antenatal visits (all p>0.1).[83]

Sosa-Rubai et al. examined any impact of Oportunidades on uptake of antenatal care.[92] The study used data from a 2007 household survey of 4,757 women who had given birth in the previous 24 months. The progressive expansion of Oportunidades allowed calculation of an exposure effect. Multivariate probit regression analyses were conducted on data for antenatal care uptake and multivariate logit regression models were conducted on data for skilled attendance at delivery. There was no difference in the number of antenatal care visits between Oportunidades beneficiaries and non-beneficiaries (p>0.1). There was a difference of 2.1% in the number of antenatal visits by women who lived in areas that had been part of Oportunidades since 2000, compared to women who lived in areas that had only been part of Oportunidades since 2003-2007 (p<0.1). In contrast, there was no difference between the number of antenatal visits when women in areas that had been part of Oportunidades since 1998 were compared with those in areas that had been part of Oportunidades since 2003-2007 (p>0.1). There was also no significant difference between women who self-reported receipt of Oportunidades payments and women who had not received payments.

The Comunidades Solidarias Rurales in El Salvador was the subject of a study by De Brauw and Peterman.[86] As part of the programme, eligible households with pregnant women were offered US$ 15 per month, conditional on regular visits for antenatal monitoring. The first municipalities to enter the programme did so in 2005, followed by additional municipalities in 2006 and 2007. Household survey data were collected in early-2008 and in late-2008. Data for delivery care were obtained on 530 women, with antenatal and postnatal care data available on 494 women. A regression discontinuity framework approach was employed to analyse difference-in-differences for the data, using a variety of sample sizes (to restrict data points to those closest to the calculated implicit threshold), two different kernels and adjusting for maternal and household characteristics. The study showed no statistically significant impact of Comunidades Solidarias Rurales on the proportion of women attending five or more antenatal care sessions (p>0.1).

Short term payments to offset costs of access

Lim et al. considered the effect of JSY on antenatal care uptake.[19] Women who received JSY benefits had odds of attending at least three antenatal care sessions 10.7-11.1% higher than a woman who did not receive the benefits (p<0.05).

The association between JSY and uptake of antenatal care was considered by Santhya et al. in a study from the Indian state of Rajasthan.[61] The study used data from a household survey conducted in late-2009 to early-2010 among women aged below 35 years who had given birth in the preceding 12 months. Data from 3,434 women were analysed using propensity score matching and bivariate statistical tests of significance between beneficiaries and non-beneficiaries, and regression models

were used to account for additional household and district characteristics. Additional analyses were performed on data from 1,207 women who had also given birth before JSY was launched. Propensity score matching and difference-in-difference models were used on these data to determine any effect of JSY on the utilisation of maternal health services.

A significantly higher proportion of beneficiaries received three or more antenatal check-ups than non-beneficiaries, 79% compared to 64% ($p<0.001$). Stratifying this by type of environment, in rural areas the proportions were 74% and 59% ($p<0.001$), and in urban areas they were 94% and 80% ($p<0.001$). Regression analyses showed that a beneficiary had odds of attending three or more antenatal check-ups 2.2 times higher than non-beneficiaries ($p<0.001$). Stratifying by environment, this was 2.0 in rural areas and 3.9 in urban areas (both $p<0.001$). Difference-in-difference analyses on data from women who had given birth before and after the introduction of JSY showed that the programme has contributed to a 7% increase in the proportion of women attending three or more antenatal care check-ups ($p<0.05$). This increase comprised an 8% increase in rural areas ($p<0.05$), and an increase in urban areas that was not statistically significant ($p>0.05$).

Powell-Jackson et al.[91] showed that the JSY programme was associated with a 3.9 percentage point increase in the proportion of women attending three or more antenatal check-ups, from a baseline mean of 44.5% ($p<0.1$).

Vouchers for maternity services

Two studies reported findings from pilot voucher schemes in Pakistan, conducted in two areas in the state of Punjab: Jhang, a rural district,[21] and Dera Ghazi Khan City, an urban area.[77] The voucher scheme in Dera Ghazi Khan City ran for 12 months from October 2008 to September 2009, during which time outreach workers visited eligible households and sold voucher booklets for US$ 1.25. Each booklet contained vouchers that entitled the holder to the following services at an accredited health facility: three antenatal care visits including blood tests and ultrasound examination, delivery care including referral for caesarean section, one postnatal follow-up visit, and a set amount for transport to and from each service.

The study in Dera Ghazi Khan City was based on a survey of women who had given birth either during the voucher distribution period, or in the 12 months prior to this.[77] Interviews were conducted with 681 women who gave birth in the pre-intervention period and 741 women who gave birth during the intervention period. Logistic regression models were used to control for each woman"s age, education, parity and autonomy, and household wealth quintile, travel time to the nearest facility and exposure to forms of mass media. Attendance at three or more antenatal care sessions increased significantly in all wealth quintiles except the least poor. Overall, women sold a voucher booklet had five times higher odds of attending three antenatal care sessions ($p<0.001$). Results should be interpreted with some

caution because there was no study control area and, as the authors highlight, there is a risk that unobserved variables may have influenced the findings. Recall bias may also have influenced findings.

Distribution of vouchers for the second pilot voucher scheme in Jhang district began in November 2009 and continued until each outreach worker had identified 300 eligible women.[21] The outreach workers used a poverty scorecard developed by the World Bank to assess household wealth and determine eligibility. Eligible women were visited, repeatedly if necessary, to encourage them to buy vouchers that could be used for three antenatal care visits including tetanus immunisation, blood tests and an ultrasound examination, delivery care including referral for caesarean section, a postnatal care visit and a family planning visit. Transportation costs were reimbursed up to a limit for all services except the postnatal care visit. Each voucher booklet was sold for 100 Pakistani rupees (US$ 1.20).

Agha used data from two household surveys, one conducted in November 2009 prior to commencement of voucher distribution and the second in December 2010.[21] Households were selected randomly from ten intervention and ten adjacent control areas and one woman from each household who was eligible for the vouchers was selected. 2,018 women were surveyed in 2009 and 2,033 in the follow-up survey. Logistic regression was used to determine the impact of the scheme on the uptake of selected maternal health services, controlling for age, parity, education, travel time to the nearest health facility and television viewership.

In intervention areas, the proportion of women attending three or more antenatal care sessions increased significantly in the poorest (fifth) wealth quintile from 23.4% to 38.6% ($p<0.01$), from 30.9% to 49.5% in the fourth quintile ($p<0.001$), from 37.3% to 49.8% in the third quintile ($p<0.05$), and from 46.5% to 58.1% in the second quintile ($p<0.05$). There were no statistically significant increases in the fifth, fourth or third wealth quintiles in control areas, although there were significant increases in the second and first wealth quintiles in these areas. The multivariate regression model demonstrated that the odds of a woman attending three antenatal care sessions were 1.6 times higher in the intervention group compared to the control group ($p<0.01$). It should be noted that selection of the intervention areas was done purposively to ensure the presence of providers that had been trained by a non-governmental organisation called Greenstar Social Marketing. Control areas were selected on the basis that they were adjacent to an intervention area. It was not possible to differentiate any effect of repeated visits by outreach workers on the uptake of antenatal care from that of the voucher.

Four studies were based on voucher programmes in Bangladesh: one on a pilot voucher scheme in the Bausha and Gaznaipur unions of Nabiganj upazila,[48] and three on the Maternal Health Voucher Scheme which operated in unions across Bangladesh.[53, 78, 79] Rob et al. focused on a one year pilot voucher scheme that ran from mid-2007 to mid-2008.[48] Vouchers were distributed to women by fieldworkers who were selected based on criteria of extreme poverty and verification by community support groups. A voucher booklet entitled women to three antenatal care visits including blood and

urine tests, delivery care including caesarean section, and a postnatal care visit. Costs of transportation to and from each service were also reimbursed to the woman.

Data came from two household surveys conducted in the intervention unions. A baseline survey was conducted in mid-2007 among 436 randomly selected women who had given birth in the previous 12 months in a voucher area. An endline survey was conducted in mid-2008 among 414 randomly selected women who had received a voucher booklet and given birth during the intervention period. The proportion of women who attended three or more antenatal care sessions increased from 30.2% to 63.4% during the distribution of vouchers ($p<0.01$). Although the authors reported no significant differences in the demographic characteristics of women in each survey, there were no control areas that might rule out the effect of unobserved factors. The validity of the findings beyond the voucher population is limited because the endline survey was conducted only amongst women who had received vouchers.

Hatt et al. used data from a household survey of 2,208 women in 32 sub-districts across Bangladesh, conducted in 2009.[53] Attendance at three or more antenatal care contacts was 54.7% in the intervention areas (universal and means-tested distribution areas) compared to 33.6% in control areas ($p<0.001$). The proportion of women who had at least one antenatal visit was also significantly higher in the intervention areas. The authors note that any comparison between universal voucher distribution areas and means-tested distribution areas is difficult as means testing was not effective in some areas, however they identified some differences through multivariate logistic regression analyses.

Multivariate analyses controlled for variables including birth order, complications during the birth, woman"s age and education. Women living in a universal distribution area were 17.8% more likely to access antenatal care with a qualified provider than those in a control area ($p<0.05$), while women living in means-tested areas were 30.8% more likely ($p<0.01$). Nguyen et al. used the same data and a similar model to show that women living in the intervention areas were 24.1% more likely to have at least three antenatal care visits than women living in control areas ($p<0.01$).[79] The authors noted that leakage of vouchers into the control areas was unlikely due to required validation. They also noted that there was a risk that the effect was overestimated due to a pre-existing elevated level of service uptake in the intervention area compared to the control areas.

Ahmed and Khan sought to assess the effect of the Maternal Health Voucher Scheme on the uptake of maternal health services.[78] Data were obtained from a survey of 3,600 women in Jamalpur district, undertaken in mid-2008 approximately one year after the launch of the voucher scheme. The district was divided into the intervention sub-district, with vouchers available to all women, and five other sub-districts acted as controls. The survey was conducted among 600 women in all six sub-districts and the women were selected using random sampling methods. Multivariate logistic regression models controlled for variables such as household size and expenditure and maternal age, parity and

education. Voucher recipients were 1.9 times more likely to receive at least three antenatal care sessions from a trained provider than women who did not receive vouchers.

Two studies focused on the effect of the Vouchers for Health programme in Kenya on uptake of maternal health services.[26, 80] Launched in 2006, vouchers for maternal health care were sold to women in three districts of Kenya (Kisumu, Kitui and Kimbu) and two informal settlements in Nairobi (Korogocho and Viwandani). A book of vouchers, costing 200 Kenyan shillings (US$ 2.50) entitled a woman to four antenatal care visits, delivery care including caesarean section, and postnatal care up to 6 weeks. Vouchers were also available for sexual- and gender-based violence recovery free-of-charge and for family planning services for 100 Kenyan shillings (US$ 1.25). Incentives were provided to distributors from non-governmental organisations during the first two years of the programme (2006-2008), resulting in the sale of vouchers to non-eligible women. After two years of operation, salaries were introduced for distributors to combat this. In late-2008 and early 2009 the programme was suspended for six months due to administrative difficulties in contracting the voucher management agency. In the following three years the number of contracted health facilities increased from 54 to 74, while in 2011 the programme expanded to two additional districts, Kilifi and Kaloleni.

Obare et al. used data from a household survey conducted in 2010 in the initial three districts of implementation: Kisumu, Kitui and Kimbu.[80] Within each district, 14 sub-locations within 5 kilometres of contracted or similar non-contracted health facilities were randomly selected. Within each sub-location, three enumeration areas were randomly selected and households considered the poorest by community leaders were visited. In total, 2527 women were interviewed: 887 who lived in one of the original 2006 voucher areas, 449 who lived in one of the voucher areas added in 2010, and 1191 women who lived in areas that had never been part of the voucher scheme. Data used for maternal health usage came from women who had given birth during the previous five years and was analysed using multi-level logit models.

There were no statistically significant differences in the odds of attending four or more antenatal care visits or on the timing of the first visit. The authors cited several limitations including leakage of vouchers to non-poor women, failure to include women who lived further than 5 kilometres from health facilities and lack of random sampling of women within communities. They also drew attention to the temporary suspension of the programme in 2008 that reduced voucher sales.

Bellows et al. assessed the impact of the Kenyan Vouchers for Heath programme in two informal settlements in Nairobi: Korogocho and Viwandani.[26] Data were taken from two surveys that were nested in the longitudinal Nairobi Urban Health and Demographic Surveillance System. The first survey was conducted in mid-2006, from which data were taken from 1,927 interviews with women who had given birth during 2004 or 2005. The second survey was conducted in 2009, from which data were taken from 2,448 women who had given birth between mid-2006 and late-2008. Women in the first survey gave birth prior to the introduction of the voucher scheme while women in the second survey gave birth after

its introduction. Data were analysed using multivariate logistic regression models. No control areas were included, with the potential that unobserved variables may have influenced the results, although the authors referred to the lack of change in infant immunisation during the study period to demonstrate the absence of underlying trends in the uptake of maternal and child health services.

Bellows et al. found that the odds of a woman attending four or more antenatal care contacts was lower during the voucher distribution period ($p<0.001$).[26] The odds of attending any antenatal care was also lower for a woman giving birth during the voucher period ($p<0.1$), and a woman had lower odds of attending antenatal care during the first trimester ($p<0.05$). Women who received a voucher during the 2006-2008 period had odds of attending four or more antenatal care sessions 1.9 times higher than those who did not receive a voucher ($p<0.001$). They also had odds for obtaining any antenatal care 16.5 times higher than women who did not receive vouchers ($p<0.001$), though there was no statistically significant difference in the odds of attending the first antenatal care session during the first trimester.

One study assessed the effect of the HealthyBaby voucher scheme in Uganda on the uptake of maternal health services.[52] The HealthyBaby voucher scheme was launched in late-2008 as a maternal and reproductive health expansion to the HealthyLife voucher programme. Vouchers were distributed by community-based workers to pregnant women identified using a poverty grading tool which had been customised to each district. Each woman paid 3,000 Tanzanian shillings (US$ 1.40) for a booklet of vouchers which then entitled her to the following services free-of-charge: four antenatal care visits, delivery care and postnatal care for up to 6 weeks. The vouchers could only be used at accredited providers.

Two household surveys conducted in 2008 and 2010 provided data. A two-stage cluster sample design was used in six districts: Mbarara, Ibanda, Isingiro, Kiruhura, Kamwenge and Bushenyi. In total, 2,266 women and 177 men were interviewed in the 2008 baseline survey while 2,313 women and 582 men were interviewed during the late-2010 follow-up survey. Bivariate analyses compared the proportion of women using maternal health care services in the two years before the programme began, compared to the two years during the programme.

The proportion of women who attended at least four antenatal contacts was significantly higher during the voucher distribution than before the programme began, 60% versus 50% respectively ($p<0.01$). The proportion of women attending at least four antenatal contacts was also significantly higher among women who had used a voucher, and among women in villages in which there were voucher users compared to women from villages without voucher users ($p<0.01$ in both comparisons).

Institutional delivery

Conditional cash transfers

Regression analyses using 2003 survey data showed no statistically significant change in the proportion of women giving birth in health facilities as a result of Oportunidades ($p>0.05$).[90] In urban areas, the proportion of women giving birth in a health facility fell slightly among Oportunidades recipients. By contrast, the measure increased among non-recipients in the intervention areas and eligible women living in non-intervention areas. This difference-in-differences was significant when recipients and non-recipients in intervention areas were compared ($p<0.05$).

De Brauw and Peterman on the Comunidades Solidarias Rurales in El Salvador,[86] estimated any effect on the proportion of women giving birth in hospitals but did not include births in health centres or mobile health clinics. Comunidades Solidarias Rurales increased the proportion of women giving birth in hospitals by 15.3-22.8 percentage points (with p-values ranging from $p<0.1$ to $p<0.01$).

Short term payments to offset costs of access

Powell-Jackson et al. focused on the impact of the Safe Delivery Incentive Programme in Nepal.[89] Regression analyses on community surveillance data showed that participation in the programme increased the probability of giving birth in a government health facility by 2.6 percentage points (no p-value given). Conversely there was a decreased probability of giving birth at home by 4.2 percentage points (no p-value given). These changes were largest in villages with women"s groups, rising to 6.3 percentage points and 9.1 percentage points, respectively. There was no statistically significant change reported for the probability of giving birth in a private health facility.

Powell-Jackson and Hanson used household survey data to assess the impact of Nepal"s Safe Delivery Incentive Programme on uptake of maternal health services.[18] The survey was conducted in a range of geographical locations in Nepal to reflect variation in the size of payments offered in different areas. Data from women who had given birth during the 3 years before the survey and who had heard of the programme were compared to data from women who had given birth during the same time period but had not heard of the programme. This was done using propensity score matching, based on maternal, household and village variables. Data were included for 5,903 births. The authors note that study generalisability is limited, given that the survey was conducted in a selection of districts and relatively early in the implementation of the programme.

The probability of giving birth in a health facility increased by 4.0 percentage points as a result of the Safe Delivery Incentive Programme ($p<0.01$). The average proportion of women giving birth in a health facility was 26.3% in intervention areas and 15.5% in control areas. Breaking this down by type of facility, the study showed that the Programme increased the probability of giving birth in a government health facility by 4.3 percentage points ($p<0.01$), and decreased the probability of giving birth in a

non-government organisation facility by 1.1 percentage points (p<0.1). There was no statistically significant change in the probability of giving birth in a private health facility (p>0.1). Comparing women who knew about the Safe Delivery Incentive Programme to the matched control group, the former were 17.8% more likely to give birth in any health facility and 25.8% more likely to give birth in a government health facility.

Lim et al.[19] found that a woman who received JSY benefits had odds of giving birth in a health facility 43.5-49.2% higher than those of a woman who did not receive the benefits.

Santhya et al. [61] showed that 98% of beneficiaries gave birth in a health facility compared to 32% of non-beneficiaries (p<0.001). In rural areas this was 97% compared to 23% (p<0.001), and in urban areas it was 100% compared to 62% (p<0.001). Among women who had given birth both before and after the introduction of JSY, the proportion of beneficiaries giving birth in a health facility increased from 41.1% to 97.6% (p<0.001). The proportion of non-beneficiaries giving birth in a health facility decreased from 26.2% to 22.7% (p<0.05). There were large statistically significant increases in both rural and urban areas, however there was only a statistically significant change among non-beneficiaries in rural areas – a decrease from 18.5% to 14.2% (p<0.05).

Powell-Jackson et al.[91] showed that JSY had led to a 12 percentage point increase, from a baseline mean of 39.4%, in the proportion of women giving birth in a health facility (p<0.01). This was stratified into a 19 percentage point increase in the proportion of women giving birth in a public health facility (p<0.01), and a 7.2 percentage point decrease in the proportion giving birth in a private health facility (p<0.01), both from baseline means of 19.7%. The effect of JSY on institutional delivery was higher among women who had no education, lived in households in the poorest quintile, belonged to a scheduled tribe or caste, or lived in districts that were considered as high-priority.

Vouchers for maternity services

In the pilot voucher scheme in Dera Ghazi Khan City,[77] only in the poorest quintile was the proportion of women who gave birth in a health facility significantly higher in the endline survey than in the baseline survey, 53.5% compared to 31.8% (p<0.001). The proportion of women giving birth in a health facility for the other four quintiles did not differ significantly between the baseline and the endline surveys. The odds of giving birth in a health facility were four times higher for women sold a voucher booklet compared to those not exposed to the programme (p<0.001).

The second pilot study in Pakistan,[21] in Jhang district, showed that the proportion of women giving birth in a health facility was higher in the follow-up survey for three wealth quintiles in the intervention areas: 46.8% compared to 30.8% in the poorest (fifth) quintile (p<0.01), 57.7% compared to 36.6% in the fourth quintile (p<0.001), and 59.1% compared to 48.0% in the second quintile (p<0.05). In the control

areas there was only a statistically significant increase in the third quintile (p<0.01). There was no significant difference between intervention and control groups in the odds of giving birth in a health facility (p=0.05).

Rob et al. collected data from baseline (N=436) and endline (N=414) cross-sectional surveys in mid-2007 and mid-2008 respectively.[48] They used bivariate analyses to identify any change in the proportion of women who gave birth in a health facility in the endline survey compared to the baseline survey. The authors found that the proportion of women giving birth in a health facility was higher in the endline survey, 18.3% compared to 2.3% (p<0.01). These increases occurred in district hospitals and in upazila health complexes. Conversely, the proportion of women giving birth at home was 81.7% in the endline survey, compared to 97.7% in the baseline survey (p<0.01).

Three studies assessed the effect of the Maternal Health Voucher Scheme in Bangladesh on the place of birth. A study by Ahmed and Khan used a multivariate logistic regression model to analyse household survey data from 2008, collected in intervention and non-intervention sub-districts in Jamalpur, Bangladesh.[78] They showed that a woman who received a voucher was 2.5 times more likely to give birth in a health facility (p<0.001). A higher proportion of women in the poorest tercile who lived in intervention areas gave birth in a health facility (11.7%) than those in control areas (0.7%) (p<0.001).

Hatt et al. found that the proportion of women giving birth in a health facility was higher in areas where vouchers were distributed compared to areas where they were not distributed, 37.5% compared to 18.7% (p<0.001).[53] A woman living in an area where means testing was used for voucher distribution did not have a statistically significant higher probability of giving birth in a health facility compared to a non-intervention area (p>0.1). In contrast, a woman living in areas where voucher distribution was universal had a 20.0% higher probability of giving birth in a health facility (p<0.01). In control areas there were significant differences between the proportion of women giving birth in a health facility in the poorest quintile compared to the other four quintiles (p<0.001). There was no statistically significant difference in intervention areas.

Nguyen et al. found that in areas where the Maternal Health Voucher Scheme was implemented, including means tested and universal voucher distribution areas, a woman had a 13.6% higher probability of giving birth in a health facility compared to a woman living in a non-intervention area (p<0.01).[79] The multivariate regression analysis used data on the most recent deliveries of women who were surveyed (N=2,208). A difference-in-differences model was used to extend the analysis to data on previous births and births that occurred before the voucher programme was introduced (N=2,861). This was done to account for unmeasured and systematic differences between intervention and non-intervention areas. The difference-in-differences model was only used to examine any effect of the voucher scheme on the probability of giving birth in the presence of a skilled provider, giving birth in a health facility, or giving birth by caesarean section. The model showed that the probability of a woman

giving birth in a health facility was 18.2% higher in areas where vouchers were distributed compared to those where vouchers were not distributed ($p<0.05$).

One study examined the effect of vouchers on the uptake of maternal health services in India.[30] This study was conducted in the state of Gujarat and focused on the pilot implementation of the Chiranjeevi Scheme in Dahod district. The Chiranjeevi Scheme is a voucher-like, or pseudo-voucher, scheme in which poor women can receive maternal health services free-of-charge at designated „empanelled" private providers and transportation costs are reimbursed. Women are eligible to register if they meet one of a number of criteria, including possession of a „below poverty line" card.

The study was based on a household survey of 656 women in three talukas (sub-districts) of Dahod district. Included in the survey were 262 women who had given birth in a private facility and benefited from the Chiranjeevi Scheme, and 394 poor women who had given birth and not benefited from the scheme. Comparing the two groups, 97.3% of beneficiaries gave birth in a private health facility and 77.2% of non-beneficiaries gave birth in a private facility. In both groups the proportion of women giving birth in public health facilities was low, at 2.7% among the beneficiaries and 1.8% among the non-beneficiaries. The proportion of women giving birth at home was 0.4% among beneficiaries and 21.1% among non-beneficiaries. No tests for statistical significance were conducted for these indicators by the authors.

Obare et al. found in their study of three districts in Kenya that a woman exposed to the voucher scheme since 2006 was 2.1 times as likely to have given birth in health facility compared to a woman who had not been exposed to the vouchers at all ($p<0.01$).[80] The probability of a woman who had not been exposed to the voucher scheme until it expanded in 2010 giving birth in a health facility did not differ significantly from a woman who had not been exposed at all ($p>0.05$).

Bellows et al. showed that a woman who gave birth after the introduction of the voucher scheme had odds 1.4 times higher of giving birth in a health facility compared to a woman who gave birth before the scheme was introduced ($p<0.001$).[26] A woman who received a voucher had odds of giving birth in a health facility that were 14.5 times higher than a woman who had not received a voucher ($p<0.001$).

The Reproductive Health Vouchers Evaluation Team in Uganda used data from baseline and follow-up surveys of women who gave birth in the 12 months preceding each survey. They used bivariate analyses to calculate the statistical significance of differences between those giving birth before and after the introduction of the HealthyBaby voucher programme. The study showed that the proportion of women giving birth in a health facility was higher during the implementation of the voucher programme than during the two years before the programme, 67% compared to 58% ($p<0.01$).[52] A higher proportion of women who had ever used a voucher gave birth in a health facility when compared to women who

had never used a voucher, 75% compared to 61% (p<0.01). In villages where there were no voucher users, the proportion of women who had given birth in a health facility was lower than villages where there were voucher users, 57% compared to 66% (p<0.01).

Skilled attendance at birth

Conditional cash transfers

Hernandez Prado et al. showed no increase between 1998 and 2000 in the proportion of women giving birth in the presence of a doctor in either early- or late-implementation areas (p>0.05).[90] Regression models using 2003 survey data showed that, compared to control areas, the proportion of women giving birth in the presence of a doctor increased by 20.1% in late-intervention areas (p<0.05), with no significant change in early-intervention areas. In urban areas, the proportion of women giving birth with a doctor among the Oportunidades recipients fell slightly between 2002 and 2003. In contrast, it increased among non-recipients in intervention areas and women in non-intervention areas. The difference between changes in use by the latter two and the (lack of) change in use by recipients was statistically significant (p<0.05).

Urquieta et al. examined any early impact of Oportunidades on the proportion of eligible woman giving birth in the presence of a skilled heath worker.[94] Data were used from surveys conducted in 1998 and 2000, among households in intervention and non-intervention areas. Regression discontinuity analysis and difference-in-difference models were used to calculate the effect of Oportunidades. The difference-in-difference analysis did not show a statistically significant effect on skilled attendance at birth for eligible women (p>0.1), however there was an effect of 11.4% for eligible women who had given birth before and after the introduction of Oportunidades (p<0.05). The regression discontinuity analysis showed a small but statistically insignificant effect on skilled attendance at birth (p>0.1).

Sosa-Rubai et al. used a logit multilevel regression model to analyse household survey data from Mexico.[92] In areas where Oportunidades was introduced in 1998 and 2000, women had 240% and 332% higher probability (respectively) of giving birth in the presence of a physician or nurse when compared to women living in areas where Oportunidades was introduced later (2003-2007).

The effect of El Salvador"s Comunidades Solidarias Rurales on skilled attendance at birth was examined by De Brauw and Peterman.[86] Almost all models used in the study demonstrated a positive impact on the proportion of women giving birth in the presence of general practitioner, obstetrician or gynaecologist. Increases ranged from 12.3-17.8 percentage points (with p-values ranging from p<0.1 to p<0.01). The only exceptions were two models using local linear regression and the lowest bandwidth of inclusion (N=365), which showed no statistically significant increase (p>0.1).

Short term payments to offset costs of access

Powell-Jackson et al.[89] found that Nepal"s Safe Delivery Incentive Programme increased the probability of giving birth in the presence of a skilled health worker by 2.3 percentage points (no p-value given). This increase was 5.3 percentage points in villages with women"s groups (no p-value given).

Powell-Jackson and Hanson in a later paper found that the Safe Delivery Incentive Programme increased the probability of giving birth in the presence of a skilled health worker by 4.2 percentage points (p<0.01).[18] Comparing matched controls, a woman who knew about the Safe Delivery Incentive Programme was 16.6% more likely to give birth in the presence of a skilled health worker than a woman who had not heard of the programme.

Lim et al. used national household survey data to determine any effect of India"s JSY on skilled attendance at delivery.[19] A woman who received JSY benefits had odds of giving birth in the presence of a skilled health worker 36.2-39.3% higher than the odds for a woman who had not received JSY benefits.

The effect of JSY on skilled attendance at birth was also estimated by Santhya et al. in Rajasthan.[61] The proportion of all beneficiaries giving birth in the presence of a skilled health worker was significantly higher than the proportion of all non-beneficiaries, 98% compared to 49% (p<0.001). In rural areas this was 97% compared to 40% and in urban areas it was 99% compared to 76% (both p<0.001). Data from women who had given birth before and after the introduction of JSY were also analysed to examine the effect of the programme. Among women who had been beneficiaries of the programme for their most recent birth, 97.3% gave birth in the presence of a skilled birth attendant. This was a significant increase from the 54.6% of these women who had a skilled birth attendant when they gave birth before the programme was launched (p<0.001). Among non-beneficiaries for their recent birth, there was no significant change between the rate of skilled attendance before and after the launch of JSY (p>0.05). The trends for increased skilled birth attendance among beneficiaries and no change among non-beneficiaries were similar in rural and urban areas.

A study by Powell-Jackson et al. found that JSY was associated with an 8 percentage point increase, from a baseline mean of 46.3%, in the proportion of women who gave birth in the presence of a skilled health worker (p<0.01).[91]

Vouchers for maternity services

Six studies considered the effect of vouchers for maternity services on the presence of skilled birth attendance during delivery, of which four were based in Bangladesh[48, 53, 78, 79] and two in Kenya.[26, 80]

One study focused on a pilot voucher scheme in Bangladesh,[48] using data from surveys conducted at either end of a one year implementation period in 2006. Study findings showed that the proportion of women who gave birth in the presence of a skilled birth attendant increased from 5.5% in the baseline survey to 21.6% by the endline survey ($p<0.01$).

Ahmed and Khan used a multivariate logistic regression to show that a woman who was a voucher recipient was 3.6 times more likely to give birth in the presence of a skilled attendant than a woman who did not receive a voucher ($p<0.001$).[78]

Hatt et al. showed that only 27.1% of women in the control areas gave birth in the presence of a skilled attendant , compared to 63.7% in the intervention areas ($p<0.001$).[53] Multivariate logistic regression analyses showed that a woman living in a means-tested voucher distribution area was 49.7% more likely to give birth in the presence of a skilled attendant than a woman living in a non-intervention area ($p<0.01$). In areas where vouchers were distributed universally, a woman was 41.8% more likely to give birth in the presence of a skilled attendant ($p<0.01$). Nguyen et al. showed that a woman living in an intervention area was 46.4% more likely to give birth in the presence of a qualified provider than a woman living in a control area ($p<0.01$).[79] When births that occurred before the introduction of the voucher scheme were included, using a difference-in-differences model, a woman living in a voucher area was shown to be 35.2% more likely to give birth in the presence of a qualified provider than a woman in a control area ($p<0.01$).

Obare et al. showed that a woman who had lived in a voucher distribution area since 2006 when the scheme was launched, had odds of giving birth in the presence of a skilled birth attendant double those of a woman who lived in a non-intervention area ($p<0.01$).[80] By contrast, a woman who lived in an area to which the scheme expanded in 2010 would not have a statistically significant difference in the odds of giving birth in the presence of a skilled birth attendant compared to a woman from a control area ($p>0.05$).

Bellows et al used multivariate logistic regression models which showed that the odds of a woman giving birth in the presence of a skilled attendant were 1.2 times higher following the introduction of the Vouchers for Health programme ($p<0.01$).[26] A woman who had received a voucher had odds of giving birth in the presence of a skilled attendant 12.9 times higher than a woman who had not received a voucher ($p<0.001$).

Caesarean section

Conditional cash transfers

Two studies examined the effect of conditional cash transfers on the rate of caesarean sections.[82, 90] Hernandez Prado et al. used 2003 survey data to show that Oportunidades had no statistically significant effect on the proportion of women having a caesarean birth (p>0.05).[90]

Barber sought to identify any impact of Oportunidades on the odds of a woman giving birth by caesarean section.[82] The study used data from a 2003 survey of women living in areas that were either intervention or non-intervention areas during early implementation of the programme. Analysis was performed using multivariate linear regression models. These models were adjusted for maternal and household characteristics. The findings showed that the rate of caesarean section births among beneficiaries of Oportunidades was 5.1 percentage points higher than non-beneficiaries (p=0.05). The increase was 7.5 percentage points higher among women who have been beneficiaries for at least 6 months (p<0.01). Despite this increase, the average rate of giving birth by caesarean section for women in the programme for at least 6 months was 14.5%.

Short term payments to offset costs of access

Powell-Jackson et al. on Nepal"s Safe Delivery Incentive Programme used community surveillance data to determine any effect on the proportion of women giving birth by caesarean section.[89] The findings showed that there was no significant effect of the programme on caesarean section rates (no p-value given).

Powell-Jackson and Hanson considered the effect of the Safe Delivery Incentive Programme on caesarean section rates using data from a household survey.[18] The programme increased the probability of birth by caesarean section by 36% (p<0.1) and of birth by caesarean section or assisted delivery by 24% (p<0.05). The mean rate of caesarean section was 4.7% in the treated group and 2.5% in the comparison group. Women who had heard of the programme were 35.5% more likely to give birth by caesarean section than those who had not and 23.9% more likely to give birth by caesarean section or assisted delivery.

The effect of India"s JSY on use of caesarean sections and assisted deliveries was examined by Powell-Jackson et al. using national survey data from India.[91] The study showed no statistically significant change in the rate of caesarean sections from a baseline mean of 7.6% (p>0.1). The proportion of women giving birth by assisted delivery rose by 1.5 percentage points from a baseline mean of 2.4% (p<0.1).

Vouchers for maternity services

Two studies investigated the effect of vouchers for maternity services on the use of caesarean sections or other forms of assisted delivery,[53, 79] and both focused on the Maternal Health Voucher Scheme in Bangladesh. Hatt et al. found no statistically significant difference between the proportion of women giving birth by caesarean section in intervention and control areas, 10.4% to 9.1% respectively (p=0.44).[53] A probit regression model demonstrated that a woman living in either a universal or a means-tested voucher distribution area was no more likely to give birth by caesarean section than a woman living in a non-intervention area. Nguyen et al. using a difference-in-differences model, confirmed that a woman in an intervention area would have the same probability of giving birth by caesarean section as a woman in a control area (p>0.05).[79]

Treatment of obstetric complications

Vouchers for maternity services

One study, relating to the Maternal Health Voucher Scheme in Bangladesh,[78] examined the effect of a voucher scheme on the probability of seeking treatment for obstetric complications. A woman who received a voucher was 42.9% more likely to seek treatment for obstetric complications than a woman who had not received a voucher (p<0.01).

Postnatal care

Conditional cash transfers

Two studies considered the effect of conditional cash transfers on uptake of postnatal care. Morris et al. showed that there was no statistically significant change in the proportion of women attending a 10-day post-partum check-up in any of the four intervention arms (p>0.05).[87]

De Brauw and Peterman[86] found no statistically significant change in the proportion of women attending postnatal care in the two weeks following birth (p>0.1) as a consequence of El Salvador"s Comunidades Solidarias Rurales.

Short term payments to offset costs of access

The effect of JSY on uptake of postnatal care was examined by Santhya et al.[61] The proportion of beneficiaries who attended a post-partum check-up with a health professional was 81%, compared to 38% of non-beneficiaries (p<0.001). In rural areas these proportions were 76% and 29% respectively (p<0.001), and in urban areas they were 97% and 65% respectively (p<0.001). Women who received JSY benefits had odds of attending a post-partum check-up 8.2 times larger than non-beneficiaries. In rural areas the odds for beneficiaries were 7.5 times higher than for non-beneficiaries (p<0.001), and in urban areas they were 20.7 times higher than for non-beneficiaries (p<0.001). Data from women who

had gave birth before and after the introduction of JSY showed the programme increased the proportion of women attending postnatal care by 39% (p<0.001). In rural areas the programme caused a 42% increase while in urban areas this was a 27% increase (both p<0.001).

Vouchers for maternity services

Nine studies considered the effect of vouchers for maternity health services on the uptake of postnatal care.[21, 26, 30, 48, 52, 53, 77-80] Agha, in their pilot study from Pakistan,[77] showed that postnatal care use by the poorest two wealth quintiles and the least poor quintile was significantly higher than in the baseline study: in the (fifth) poorest quintile the proportion of women accessing postnatal care increased from 12.1% to 22.9%, in the fourth quintile it increased from 17.0% to 27.8% and in the first quintile it increased from 46.3% to 58.6% (all p<0.05). There was no statistically significant change in the third and second wealth quintiles. A woman sold a voucher booklet was 5.8 times more likely to use postnatal care than a woman who had given birth before the pilot voucher scheme was introduced (p<0.001).

A similar voucher scheme showed that postnatal care use in the intervention areas was significantly higher in the follow-up survey amongst the poorest two wealth quintiles than in the baseline survey, 13.2% compared to 7.0% in the fifth quintile (p<0.05) and 23.2% compared to 12.4% in the fourth quintile (p<0.01).[21] There were no statistically significant changes in postnatal care use among the other three wealth quintiles in the intervention area, nor among any quintiles in the control areas. There was no statistically significant difference in the odds of attending postnatal care for a woman in an intervention group compared to a woman in a control group.

Rob et al. focused on a pilot voucher scheme implemented in 2007/8 in the Bausha and Gaznaipur unions of Nabiganj upazila in Bangladesh,[48] and found that the proportion of women who received postnatal care was significantly higher in the endline survey than in the baseline survey, 60.1% compared to 45.2% (p<0.01). The proportion of women visiting traditional providers, pharmacies or receiving care at home both fell to 0%, from 40.6% and 44.2% respectively (p<0.01). In contrast, the proportion of women visiting formal settings for postnatal care rose, from 13.2% to 19.2% in hospitals (p<0.1) and from 2.0% to 80.8% in Health and Family Welfare Centres (p<0.01).

Ahmed and Khan in their study from the Jamalpur district of Bangladesh found using logistic regression models that a woman who had received a voucher was 2.8 times more likely to receive postnatal care than a woman who had not (P<0.001).[78]

Hatt et al. found that the proportion of women who received any postnatal care was higher in the intervention areas than in the control areas,[53] 35.6% versus 20.7% (p<0.001). There was also a proportion of women receiving care from a qualified practitioner in the intervention areas, 87.1% as opposed to 72.9% (p<0.01). A woman living in an intervention area was 19.6% more likely to receive

postnatal care from a qualified provider than a woman living in a control area. The increase was 19% in universal voucher distribution areas and 25.4% in means tested distribution areas (both p<0.01). Nguyen et al. (2012), in their extension study, showed that the probability of receiving postnatal care from a qualified provider was 19.1% higher for a woman living in an intervention area (p<0.01).

Bhat et al. showed that there was no significant difference between the proportion of women accessing postnatal care among the beneficiaries and the non-beneficiaries, which were 28.2% and 30.7% respectively (p>0.05).[30]

Obare et al. reported no statistically significant difference in the odds of a woman receiving postnatal care in having been exposed to the voucher scheme since 2006, since 2010, or not at all (p>0.05).[80]

The Reproductive Health Vouchers Evaluation Team in Uganda showed that the proportion of women receiving postnatal care services was higher in the endline survey than in the baseline survey, 57% compared to 49% (p<0.01).[52] The proportion of women receiving postnatal care was higher among those who had ever used a voucher than among those who had not, 65% compared to 50% (p<0.01), and among women from a village with a voucher user compared to those from a village without any voucher users, 55% compared 49% (p<0.05).

Sleeping under an insecticide-treated net

Vouchers for merit goods

One study measured the effect of vouchers for merit goods on the uptake of maternal health services.[32] The study used data from three nationally representative household surveys to determine any effect of the Tanzania National Voucher Scheme on the proportion of households owing and using an insecticide-treated net. The surveys were conducted in 2005, 2006 and 2007 in 21 districts, determined by stratified random sampling, in the period immediately following the rainy season. In the 2005 survey 6,199 household were interviewed, of whom 779 were pregnant women; in the 2006 survey 6,260 households were interviewed, of whom 584 were pregnant women; and in the 2007 survey 6,198 women were interviewed, of whom 707 were pregnant women.

Statistical tests for significance and a multivariate regression model were used to analyse the data. The regression model included variables to control for potential confounding factors such as initial net ownership as a proxy for socioeconomic status, whether the district was epidemic prone, and whether the district had been included in a separate net distribution in 2005. The authors noted that although they attempted to control for a number of variables, it was difficult to rule out the effect of unobserved variables. They also point to a possible underestimation of effect in ten districts where the baseline survey was conducted a number of months after the scheme had been introduced.

The proportion of households who owned an insecticide-treated net was significantly higher in 2007 compared to 2005, 65% versus 44% ($p<0.001$). The findings also showed that of the pregnant women that were interviewed, the proportion who had slept under an insecticide-treated net increased from 11% in 2005 to 23% in 2007 ($p<0.001$). The regression analysis demonstrated that longer exposure to the Tanzania National Voucher Scheme was associated with a larger increase in household ownership of an insecticide-treated net ($p<0.1$).

Review question 4. What are the effects of different DSF interventions on the quality of care provided?

Summary of quantitative evidence for review question 4

We found limited evidence on the effects of DSF measures on quality of care provided, and none from studies of unconditional cash transfers or vouchers for merit goods. A range of indicators were used in studies to measure quality of care. These included the number of procedures received during contacts with health services, the provision of information on signs and symptoms of ill-health for pregnant and postpartum women, and access to a clean, well-staffed and well-equipped health facility. There was some indication that the care provided to recipients of DSF schemes scored higher against a number of these indicators, however for many indicators there was no such difference.

Evidence for review question 4 by mode of DSF

Conditional cash transfers

Hernandez Prado et al. considered the impact of Oportunidades on quality of antenatal care.[90] Indicators included number of visits, month of pregnancy at time of first antenatal contact and attendance at first contact in the first trimester of pregnancy. Data were obtained from longitudinal surveys in rural and urban areas. In rural areas, the sample comprised 506 localities in seven of the states where the programme had been launched; 320 early intervention and 186 late intervention localities. Localities were randomly selected and every household (24,000) included in the survey. Since all poor households in the 186 late intervention localities had been incorporated in the programme in 2000, an additional group of households in 152 localities not covered by the Program was incorporated into the evaluation, to enable the impact of Oportunidades to be evaluated in the short (two years) and medium (five years) term in rural areas.

In urban areas, a quasi-experimental evaluation model was used, based on a sample of localities, city blocks and households in areas where the Program became operational in 2002 (intervention zones). Data were collected from zones on households eligible for incorporation. A comparison group of non-intervention zones was identified, where the Program was not planned to commence until 2004. Data from the urban areas only enabled a short term (one year) evaluation to be conducted.

The number of recommended procedures performed at contacts (including urinalysis, breast examination and screening for syphilis), were also considered. After adjusting for potential confounding factors, medium term analysis of data from *rural* areas indicated that the Program significantly impacted on the percentage of live births with antenatal care attendance, and influenced women"s decisions to commence antenatal care earlier in pregnancy. There was also an increase in

the number of women who had procedures performed during a contact. With respect to *urban* areas, the number of women who attended for antenatal care increased among women incorporated into the Program during 2002 – 2003 but this was not a statistically significant difference. There was no increase in number of procedures performed during antenatal contacts.

Short term payments to offset costs of access

Uttekar et al. assessed the roll out of JSY in three districts in the Indian state of Orissa and the role of local accredited social health activists (ASHAs – community health workers in rural areas of India), appointed from villages to negotiate access to health care for poor women and children.[69] Using semi-structured interviews, 178 ASHAs and 245 JSY beneficiaries were interviewed as part of an evaluation to consider impacts of JSY. Several components were considered to determine the impact of JSY on the quality of services at the place of birth, including person conducting the delivery, promptness in attending the birth, waiting time and average stay in hospital following the birth. Around 82% of births were conducted by a doctor. There was an average of 17.2 minutes to complete registration processes and another 15 minutes to wait to be seen. On average, women were discharged 22 hours following the birth, considerably less than the 48 hours recommended by the Government of India. Baseline data for these outcomes were not presented.

Women"s experiences of receipt of JSY in Rajasthan were considered by Santhya et al.,[61] which included as a study objective, the effect of the programme on the quality of maternal health services. Quality was assessed using five components of care in an effort to capture data on multiple dimensions of quality: the extent to which women seeking antenatal services had received comprehensive information on pregnancy care; the extent to which women received comprehensive antenatal services; the nature of client-provider interaction; the technical quality of services; and continuity of care.

Data from the cross sectional survey were collected from women in rural and urban areas of two districts (Alwar and Jodhpur) which represented the state averages in selected socio-demographic and reproductive health indicators, for example male and female literacy rates and percentage of girls married below the legal minimum age for marriage. From the two districts, 196 sampling units were selected, following a two stage stratified systematic random sampling procedure. Survey respondents comprised women under 35 years of age who gave birth in the 12 months prior to the study commencing. In-depth interviews were conducted with women identified from the survey who fell into one of four categories; women who had benefited from JSY and were satisfied with the scheme; women who had benefited from JSY and were not satisfied with the scheme; women who had a home birth and had not received JSY benefits; and women who gave birth in eligible public or private health facilities and had not received JSY benefits.

All women eligible to participate were invited to join the study, irrespective of whether they were usual members of the household or a visitor. A total of 4,770 women were interviewed for the survey (2,372

urban and 2,398 rural), and 48 women completed in-depth interviews. To assess quality of care, the researchers used an unmatched sub-sample of women who were (n=795) or were not beneficiaries of JSY (n=857) on an assumption that quality of services would not be affected by a woman"s propensity to avail herself of JSY benefits. Findings of impacts on aspects of quality of care were mixed. After controlling for potential confounding factors, women who were beneficiaries of JSY were more likely to receive information on danger signs for adverse health during and after pregnancy (95% CI 0.01 – 0.09, p<0.05) and to have received four or more health checks during pregnancy (95% CI 0.03 – 0.12, p<0.01). There was also a statistically significant difference in women discharged from hospital 24 hours after giving birth (95% CI 0.04 – 0.27, p<0.01). However, there were no differences in use of harmful practices during labour (fundal pressure applied during a contraction or intra-muscular oxytocin to expedite birth), in information provided on postnatal care and neonatal health, or in the frequency with which facilities were reported to be clean and members of staff respectful. Women who were JSY beneficiaries were more likely to report that they had been allowed to have a companion with them during their labour and birth (95% CI 0.03 to 0.21, p<0.01). No change in quality of postpartum services was observed.

Vouchers for maternity services

One study considered the effects of a DSF intervention on the quality of care.[53] Determinants of quality used by the authors included staffing, infrastructure, supplies, equipment, medicines, knowledge and skills. There were no differences in number of key personnel employed per facility or availability of staff to provide maternity and newborn care in line with the WHO Mother Baby Package (which requires an adequately staffed facility to manage abortion complications, antenatal care and potential adverse outcomes including haemorrhage, obstructed labour and sepsis). Educational sessions for women on pregnancy, postnatal and reproductive health issues were held more frequently in voucher areas, but this was not statistically significant. Time to reach a referral facility was similar between voucher and control facilities (56 compared with 52 minutes), and although not statistically significant, this could be clinically significant. There were no differences in provision of equipment recommended to care for women and their infants, supplies to manage maternal or infant health needs or medication supply capacity.

Data from a supplementary household survey informed beneficiary reported indicators of quality. Women in the voucher areas were more likely to report having their blood pressure checked at their first antenatal visit during their last pregnancy, to have received a blood test and to have had their height measured. Neonatal quality indicators were not significant with respect to time to first breastfeed or how long after the birth babies were wiped, dried and wrapped. There were differences in use of an instrument that had been boiled before cutting the cord (p=0.05) and giving of colostrum to the newborn immediately following birth (p=0.006), these more likely to take place in voucher facilities.

Review question 5. What are the effects of different DSF interventions on the choice of provider offered to consumers and competitiveness of the market?

Summary of quantitative evidence for review question 5

One study, on a programme that offers short term payments to offset costs of access, presented findings relevant to the choice of provider and competitiveness of the market. Findings suggested that the Safe Delivery Incentive Programme in Nepal had 'crowded-out' hospitals run by not-for-profit private organisations by encouraging women to use government facilities.

Evidence for review question 5 by mode of DSF

Short term payments to offset costs of access

One study presented findings on the choice of provider, from the Safe Delivery Incentive Programme in Nepal.[18] The study found a 26% increase in the probability of giving birth in a government facility ($p<0.01$) coincided with a 31% decrease in the probability of giving birth in a non-governmental sector hospital ($p<0.1$). There was no evidence for a change in the probability of giving birth in a private for-profit hospital ($p>0.1$). The authors suggested this may be an indication of „crowding out of the private not-for-profit sector".

Review question 6. What are the effects of different DSF interventions on the quality of life of expectant and new mothers?

No quantitative studies included in the review answered this question.

Review question 7. What are the effects of different DSF interventions on out of pocket expenditure and household poverty?

Summary of quantitative evidence for review question 7

There was some evidence on the effect of DSF measures on out of pocket expenditure, based on findings from seven studies. A number of studies on JSY in India and a study on the Safe Delivery Incentive Programme in Nepal found evidence of increased out of pocket expenditure for recipients compared to non-recipients. Other studies found recipients made a small net profit. The effect was clearer in studies on voucher schemes for maternity services, which showed decreased out of pocket expenditure for recipients of the Maternal Health Voucher Scheme in Bangladesh and the HealthyBaby scheme in Uganda.

Evidence for review question 7 by mode of DSF

Short term payments to offset costs of access

Powell-Jackson et al. used community surveillance data from the district of Makwanpur in Nepal to determine any effect of the Safe Delivery Incentive Programme on out of pocket expenditure.[89] Despite the introduction of the programme, out of pocket payments for normal birth care (i.e. spontaneous vaginal births) accounted for 3.6% of total annual household consumption (N=271) and care for caesarean section births accounted for 19.3% (N=29). In the poorest wealth quintile these were 5.1% and 22.9% respectively. The incidence of catastrophic expenditure (>10% of total annual household consumption) across all wealth quintiles was 7.4% for normal birth care and 72.4% for caesarean section births. For women who received the Safe Delivery Incentive Programme benefits, the mean out of pocket expenditure was higher than for those who did not receive the benefits ($p<0.05$), 1,774 Nepalese rupees (US$ 22.90) compared to 968 Nepalese rupees (US$ 12.50).

Uttekar et al. used a survey of 237 women in the Indian state of Himanchal Pradesh to determine any net out of pocket expenditure on antenatal care, transport and birth care by beneficiaries of JSY.[63] The findings showed that 43.8% of women spent more money than they received, of whom the vast majority gave birth in a health facility. Women who gave birth in a health facility had an average net loss of INR 2,830 (US$ 64.20). Women who gave birth at home had an average net gain of INR 175 (US$ 4.00).

Uttekar et al. used a survey of 240 women in the Indian state of Assam to assess out of pocket expenditure by beneficiaries of JSY.[65] The study showed that 61.3% of beneficiaries spent more than they received, almost all of whom gave birth in a health facility. Those who gave birth in a health facility had an average net loss of INR 1,018 (US$ 23.10) while those who gave birth at home had an average net gain of INR 300 (US$ 6.80).

A survey of 480 women in the Indian state of West Bengal was used by Uttekar et al. to determine out of pocket expenditure of JSY beneficiaries.[68] The study found that 32.4% of beneficiaries spent more on antenatal care, transport and delivery care than they received from JSY benefits. Women who gave birth in a health facility faced an average net loss of INR 411 (US$ 9.30) while women who gave birth at home faced an average net gain of INR 224 (US$ 5.10).

A mixed-method study by the United Nations Population Fund (UNFPA) included a quantitative component based on a survey of 6,002 women from rural areas of five states in India: Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.[93] A three stage sampling design was used to collect data from women who had given birth in the 12 months preceding the survey. The results showed that an average of 47% of women received money through JSY, ranging from 37% in Uttar Pradesh to 68% in Madhya Pradesh. Of those who received some money, over 90% received the full INR 1,400 that they were entitled to, ranging from 91% in Bihar to 98% in each of Madhya Pradesh and Orissa. The proportion of women who had to pay for care in the facilities ranged from 28% in Bihar to 60% in Uttar Pradesh. The average amount spent by these women ranged from INR 299 (US$ 6.10) in Madhya Pradesh to INR 1,639 (US$ 33.60) in Orissa.

A study by the National Health System Resource Centre used survey data from eight high-focus Indian states to measure out of pocket expenditure by women using JSY.[88] The survey focused on women who had given birth in the 12 months preceding the survey and received benefits through the programme. Of the 2,759 women who gave birth in a health facility, 86% received money through JSY and 95% of these women got at least INR 1,400 (US$ 31.30). The average out of pocket expenditure for women who gave birth in a health facility was INR 1,028 (US$ 23.00), of which the cost of drugs, surgery and auxiliary nurse-midwives/nurses accounted for 60%. However 28% of women paid more than INR 1,200 (US$ 26.80) and 22% paid more than INR 1,600 (US$ 35.80).

Santhya et al. used data from their survey of women in Rajasthan to assess the degree to which JSY payments reimbursed women for the expenses that they incurred during delivery.[61] These costs included provider fees, drugs and other medical supplies, and laboratory tests. 54.8% of women covered their costs or made a net gain while 23.4% made a net loss. Data were reported as missing for the remaining women. In rural areas these proportions were 59.4% and 19.5%, respectively, while in urban areas they were 41.9% and 34.8%, respectively. The largest proportion of expenditure for JSY payments was medical care at the facility (70.0%).

Vouchers for maternity services

Hatt et al. reported that after adjusting for potential confounding factors, women in voucher areas in Bangladesh had significantly less out of pocket expenses for delivery care than women in control areas, differences in payment constituting nearly 10% of total household per capita expenditure per month.[53] The effect was larger when antenatal and postnatal care expenses were included. There were no

statistically significant differences between groups and total amounts spent on laboratory tests, drugs or supplies, transportation or other items. Sub-analyses were conducted to compare effects of DSF between wealthier and poorer women, with the sample stratified into wealth quintile groups (Quintile 1 vs Quintiles 2-5). In the control upazilas, poor women were significantly less likely to use maternal health services than those in non-poor groups. In the intervention areas, this finding was replicated although differences were smaller and non-significant.

Based on descriptive data, the Reproductive Health Vouchers Evaluation Team reported that women in Uganda who had used „HealthyBaby" vouchers in the 12 months preceding the 2010 – 2011 survey were less likely to have paid out of pocket for services in the year prior to the survey compared to those who had never used the vouchers (181 women (23%) compared with 238 (69%)).[52]

Review question 8. What are the effects of different DSF intervention on the responsiveness of providers (in terms of the scope of services, the number of providers and the way that services are provided)?

No quantitative studies included in the review answered this question.

Review question 9. Can DSF measures provide a cost-effective approach to increase utilisation of maternal health services and improve health outcomes among rural, poor or socially excluded women?

Summary of economic evidence for review question 9

Four studies included findings linked to the cost-effectiveness of DSF interventions. The evidence presented in these studies focused on average or incremental costs for vouchers for maternity services in Bangladesh and India and vouchers for merit goods in Tanzania. There were no studies included in the review that examined the cost or cost-effectiveness of unconditional cash transfers, conditional cash transfers or short term payments to offset costs of access. Findings from a study on the Tanzania National Voucher Scheme demonstrated that the cost per insecticide-treated net delivered was comparable to, though higher than, other methods of distribution. It was not possible to draw any conclusions regarding the cost-effectiveness of voucher schemes for maternity services due to insufficient comparison with alternative funding arrangements.

Evidence for review question 9 by mode of DSF

Vouchers for maternity services

A study by the IFPS Technical Assistance Project on the Sambhav voucher scheme for maternal health services in Jharkhand, India,[27] determined the average cost per voucher for four services over the two year duration of the pilot programme: antenatal care, delivery care, postnatal care and family planning services. The evaluation used an extensive list of provider and programme costs from a mix of primary and secondary sources. Interviews were conducted with health administrators, staff at the voucher management agency and community leaders and midwives. Focus group discussions were conducted among community health workers and beneficiaries. Secondary data were collected from baseline and endline surveys and from programme budget/expenditure statements, focusing on programme impact and costs, and recipient satisfaction.

A costing analysis was conducted by the IFPS Technical Assistance Project to calculate the cost of establishing and delivering the programme. This was used to estimate the weighted average cost per service used. It showed that the average cost per voucher for: antenatal care was INR 276 (US$ 5.20), an institutional delivery was INR 3,533 (US$ 66.60), postnatal care was INR 173 (US$ 3.30), and surgical family planning interventions was INR 1,913 (US$ 36.10). The findings may be generalisable to similar voucher schemes in India. The research assumes clinical effectiveness for skilled birth attendants at delivery as no evidence is provided to support this.

An economic evaluation of the Maternal Health Voucher Scheme in Bangladesh by Hatt et al. had two findings relevant to the cost-effectiveness of voucher programmes.[53] The first related to the total programme costs and the average cost per voucher distributed. Four sets of expenditure data were collected: expenditure on incentives and subsidies by the Ministry of Health and Family Welfare; the length of time Ministry of Health and Family Welfare staff spent working on the programme; the cost of printing vouchers; and expenditures on the programme by the WHO and by DFID. The costs faced by women who use the scheme were not included. The costs were collected for 16 intervention upazilas (leading to a total of 251.26 million Bangladeshi Taka – BDT, equivalent to US$ 3.67 million) and then divided by the total number of vouchers distributed in these upazilas (88,601). The result was an average cost of BDT 2,836 (US$ 41) per voucher distributed.

The second finding related to the incremental cost per additional delivery in the presence of a skilled birth attendant attributable to the voucher programme. This was compared to the incremental cost in control areas where vouchers were not distributed. The number of deliveries in the presence of a skilled birth attendant attributable to the voucher programme was estimated using a multivariate probit regression of household survey data which is described in more detail in review question 3 of this report. An allocation ratio of approximately 90% was applied to the total programme costs described above, reflecting the allocation of approximately 90% of programme resources (BDT 224.44 million) to delivery in the presence of a skilled birth attendant including care for complications. The resulting

cost-effectiveness ratio showed that the incremental cost per additional delivery in the presence of a skilled birth attendant was BDT 4,788 (US$ 70). The 95% confidence interval was BDT 3,991–5,982 (US$ 58–87).

A study by Nandan et al. included a cost analysis of the MAMTA voucher-like scheme in Delhi.[28] The analysis was conducted internally by a hospital accredited to provide services to poor women through the scheme. Costs were included for services at the facility, wages for dedicated staff and room charges. It was calculated that after reimbursement the facility lost an average of INR 3919 (US$ 84.10) for each woman who received delivery care in the hospital. The generalisability of the results is limited as charges for women not in the MAMTA scheme will be specific to the hospital, a large private facility in Delhi.

Vouchers for merit goods

The remaining study, by Mulligan et al.,[95] was centred on the Tanzanian National Voucher Scheme to promote the use of insecticide-treated nets among pregnant women and young children. The cost-effectiveness of the scheme was estimated using standardised guidelines for costing insecticide-treated net distribution systems and past estimates for the effectiveness of insecticide-treated nets. Data on programmatic costs and user costs were collected for the analysis using budgets, a household survey and semi-structured interviews with key stakeholders and project staff. Costs were adjusted for the differential timing and sensitivity analyses were conducted for parameters including discount rate for nets, retail price, and the proportion of retreated. The study calculated that the cost of the voucher scheme was US$ 7.57 per insecticide-treated net delivered. Start-up costs accounted for 8% of all costs.

Results of metasynthesis of qualitative research findings

Metasynthesis of studies included in the review generated 37 synthesised findings. These synthesised findings were derived from 218 study findings that were subsequently aggregated into 86 categories. The study findings are listed in Appendix VII and are classed as unequivocal or credible according to JBI-QARI levels of credibility. The strength of evidence supporting each synthesised finding is described as modest, good or robust, depending on the quantity and clarity of the evidence, and the range of contexts in which it has arisen.

Review question 10. What barriers are there to the provision of DSF measures and what are the most appropriate ways to ensure that they are optimally delivered and administered among rural, poor or socially excluded women?

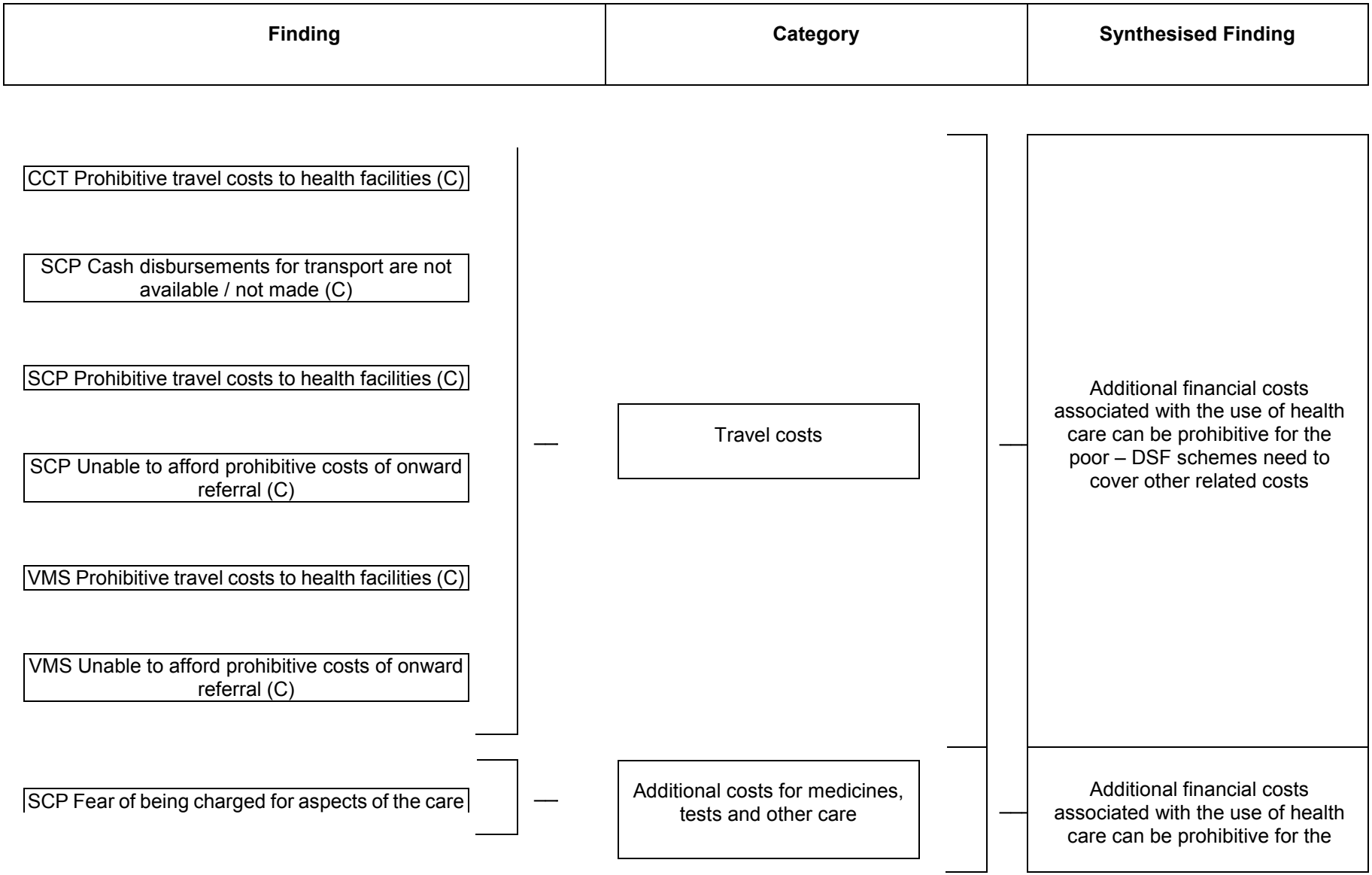
Forty-two qualitative studies reported findings relevant to this review question, divided among the five types of DSF as follows:

- *One study on an unconditional cash transfer programme*[11]
- *Three studies on conditional cash transfers*[37, 43, 57]
- *Twenty-five studies on short term payments to offset the cost of accessing maternal health services*[39, 40, 42, 54-56, 58-76]
- *Nine studies on vouchers for maternity services reported findings relevant to this review question,*[22, 25, 28, 38, 45, 48, 50, 52, 53]
- *Four studies on vouchers for merit goods.*[41, 44, 46, 47]

The unconditional cash transfer programme of interest was the Dr Muthulakshmi Maternity Assistance Scheme in the Indian state of Tamil Nadu.[11] Studies on conditional cash transfers focused on the Oportunidades programme in Mexico, Social Risk Mitigation Program in Turkey and Red Solidaria in El Salvador;[37] the Juntos programme in Peru and Bono Juana Azurduy in Bolivia;[43] and the Program Keluarga Harapan in Indonesia.[57] Short term payments to offset costs of access were focused on Janani Suraksha Yojana in India,[39, 42, 54-56, 58-76] and the Safe Delivery Incentive Programme in Nepal.[40]

Studies on voucher schemes for maternity services were focused on schemes in five countries: a pilot voucher scheme and the Maternal Health Voucher Scheme in Bangladesh,[22, 38, 48, 53] Chiranjeevi Scheme and MAMTA Scheme in India,[28, 45] a voucher scheme in Cambodia,[25] the Vouchers for Health programme in Kenya,[50] and the HealthyBaby vouchers in Uganda.[52] Studies on two voucher schemes for merit goods were included in this question, both for insecticide-treated nets: a scheme in Volta, Ghana,[44] and the Tanzania National Voucher Scheme.[41, 46, 47]

This was a highly researched area and there were 66 findings in these studies that related to barriers for the delivery of DSF schemes and what these indicate for strategies for optimal delivery. These findings were grouped into 28 categories and then into ten syntheses. Figure 2 shows these relationships.


Finding
Category
Synthesised Finding
CCT Prohibitive travel costs to health facilities (C)
SCP Cash disbursements for transport are not available / not made (C)
SCP Prohibitive travel costs to health facilities (C)
SCP Unable to afford prohibitive costs of onward referral (C)
VMS Prohibitive travel costs to health facilities (C)
VMS Unable to afford prohibitive costs of onward referral (C)
Travel costs
SCP Fear of being charged for aspects of the care
Additional costs for medicines, tests and other care
Additional financial costs associated with the use of health care can be prohibitive for the poor – DSF schemes need to cover other related costs
Additional financial costs associated with the use of health care can be prohibitive for the

(C)

SCP Price of medicines and other tests not covered by voucher (C)

SCP Prohibitive costs of treatment of complications not covered by scheme (C)

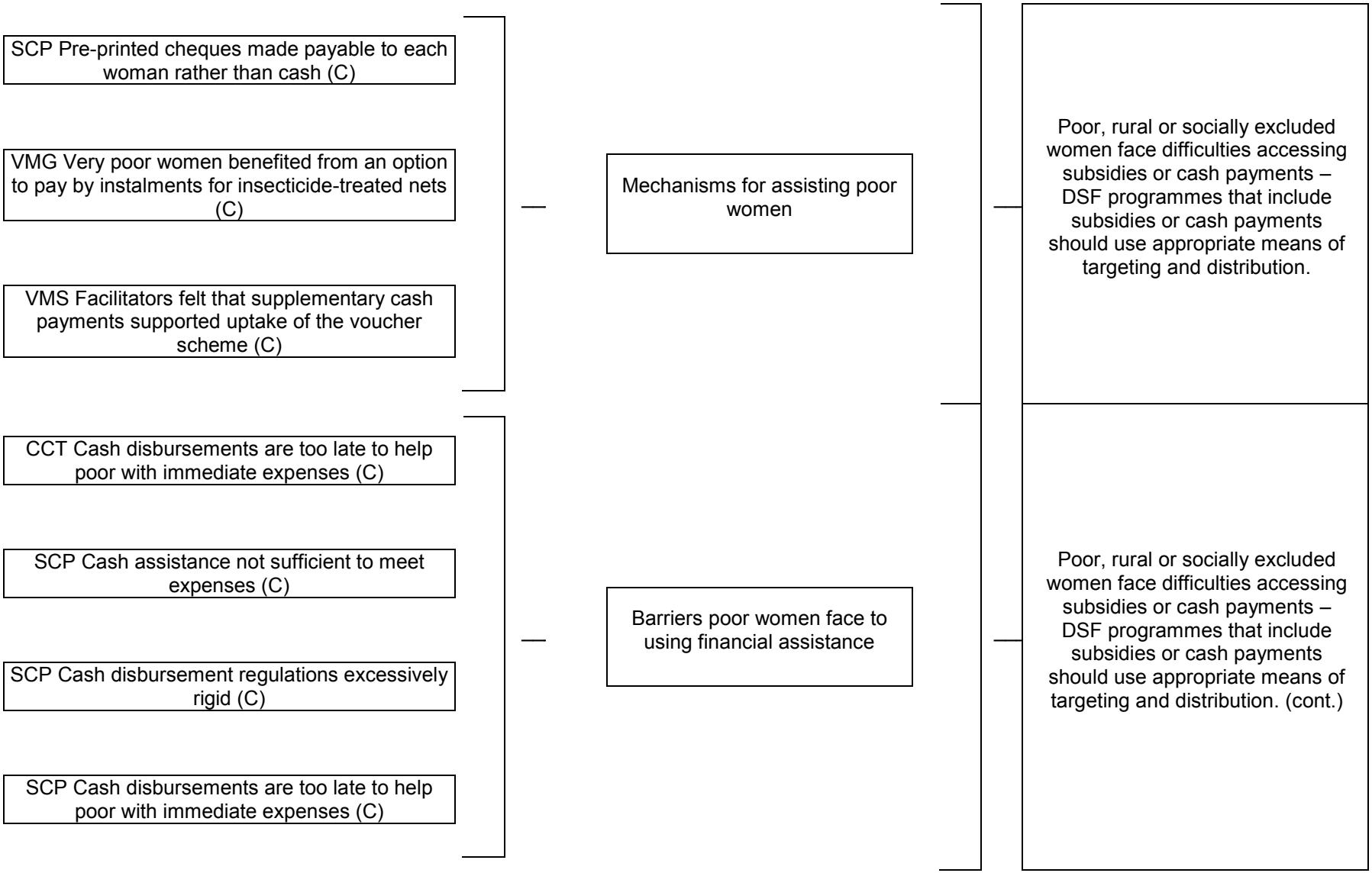
VMG Insufficient cash to use the voucher to buy an insecticide-treated net (C)

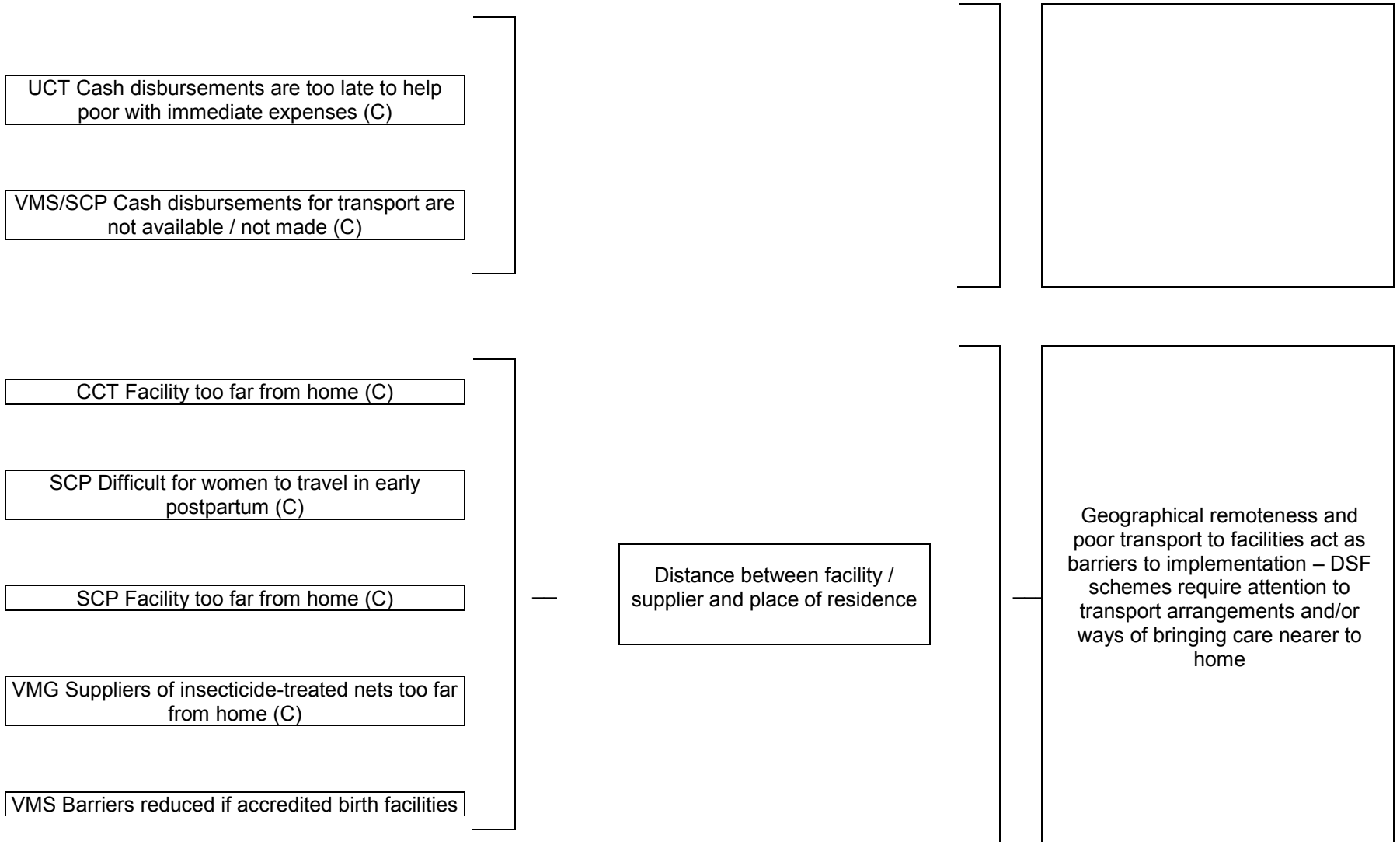
VMS Fear of being charged for aspects of the care (C)

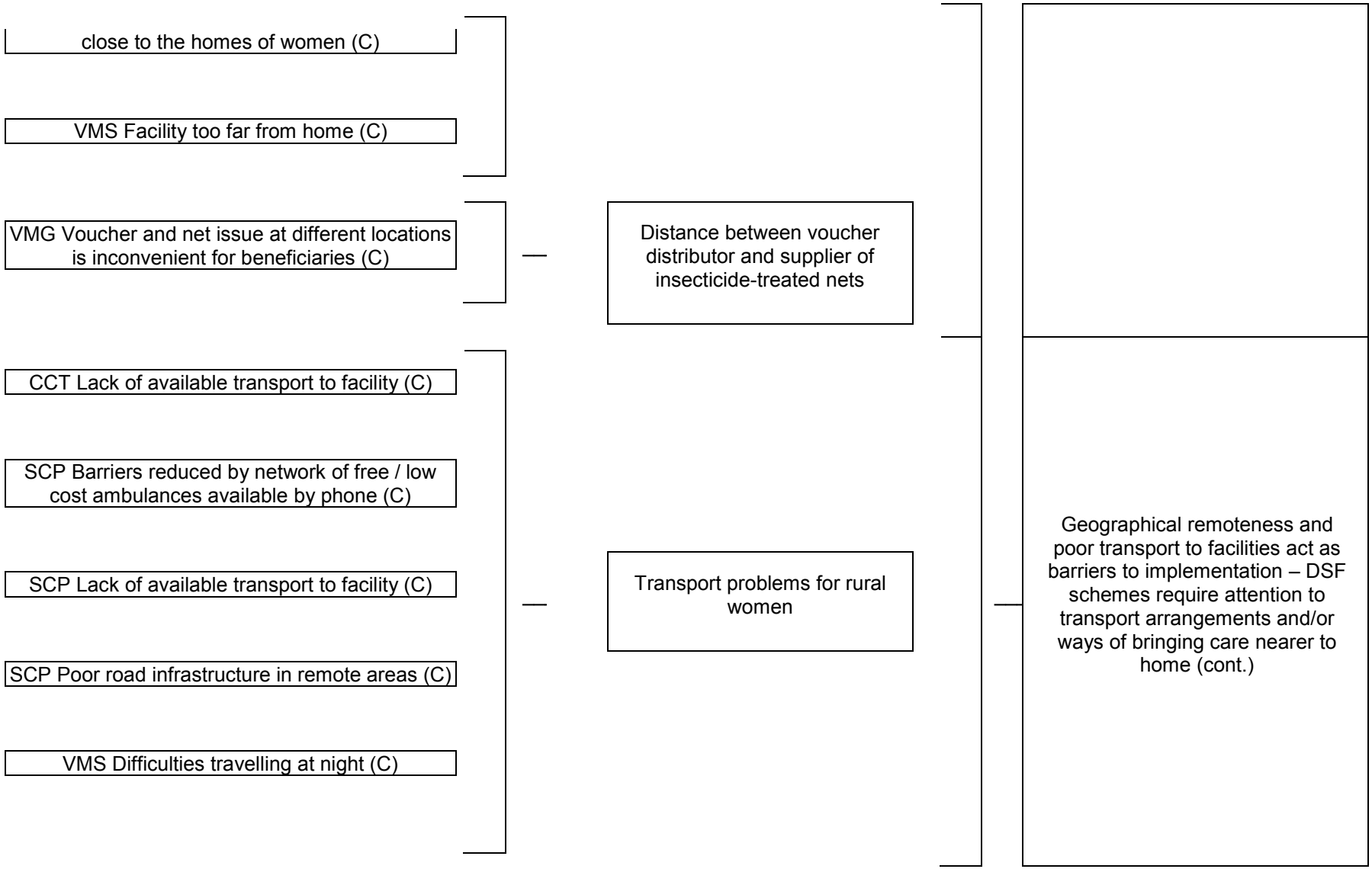
VMS Price of medicines and other tests not covered by voucher (C)

VMS Stipulate prescription of generic medicines under scheme (C)

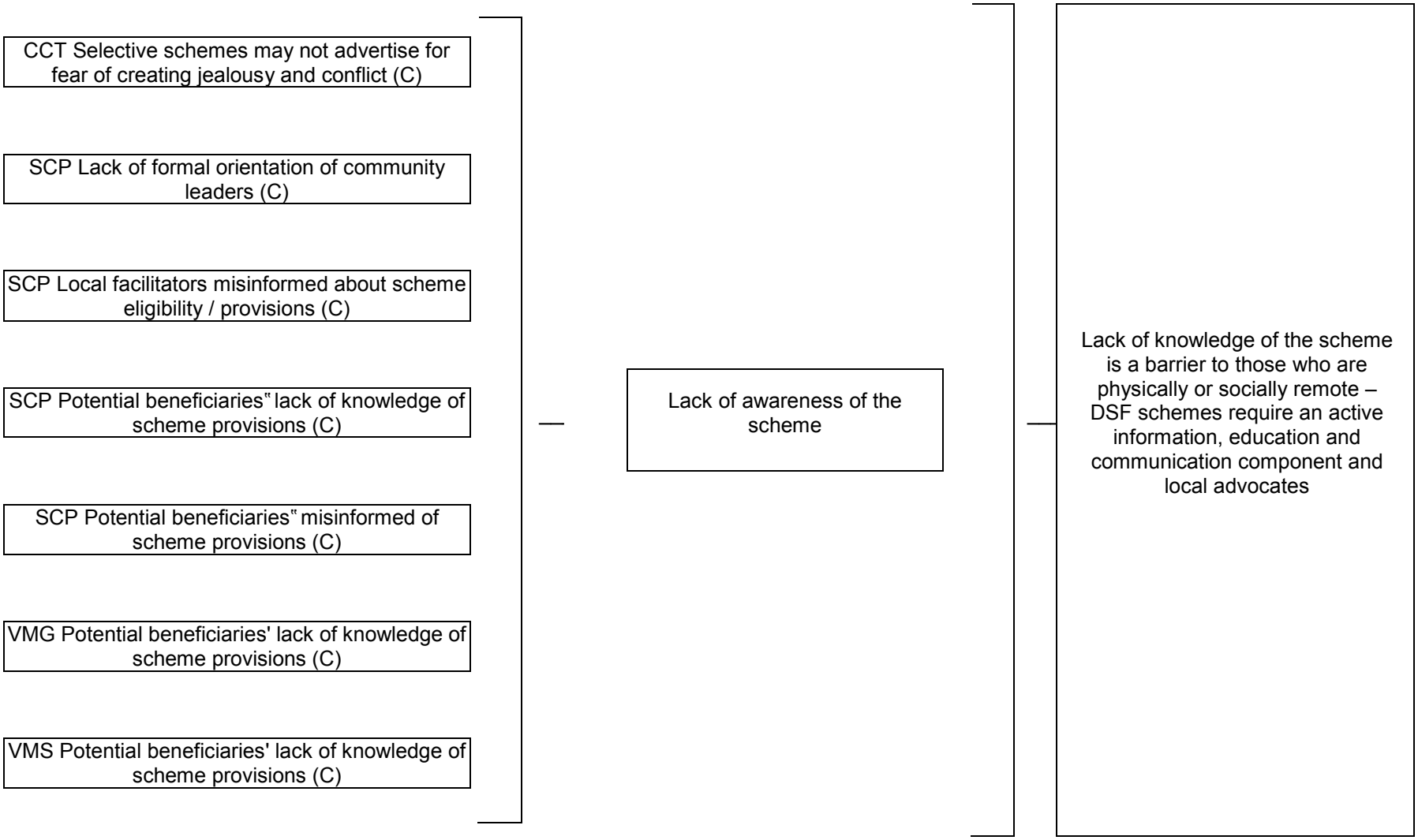
poor – DSF schemes need to cover other related costs (cont.)

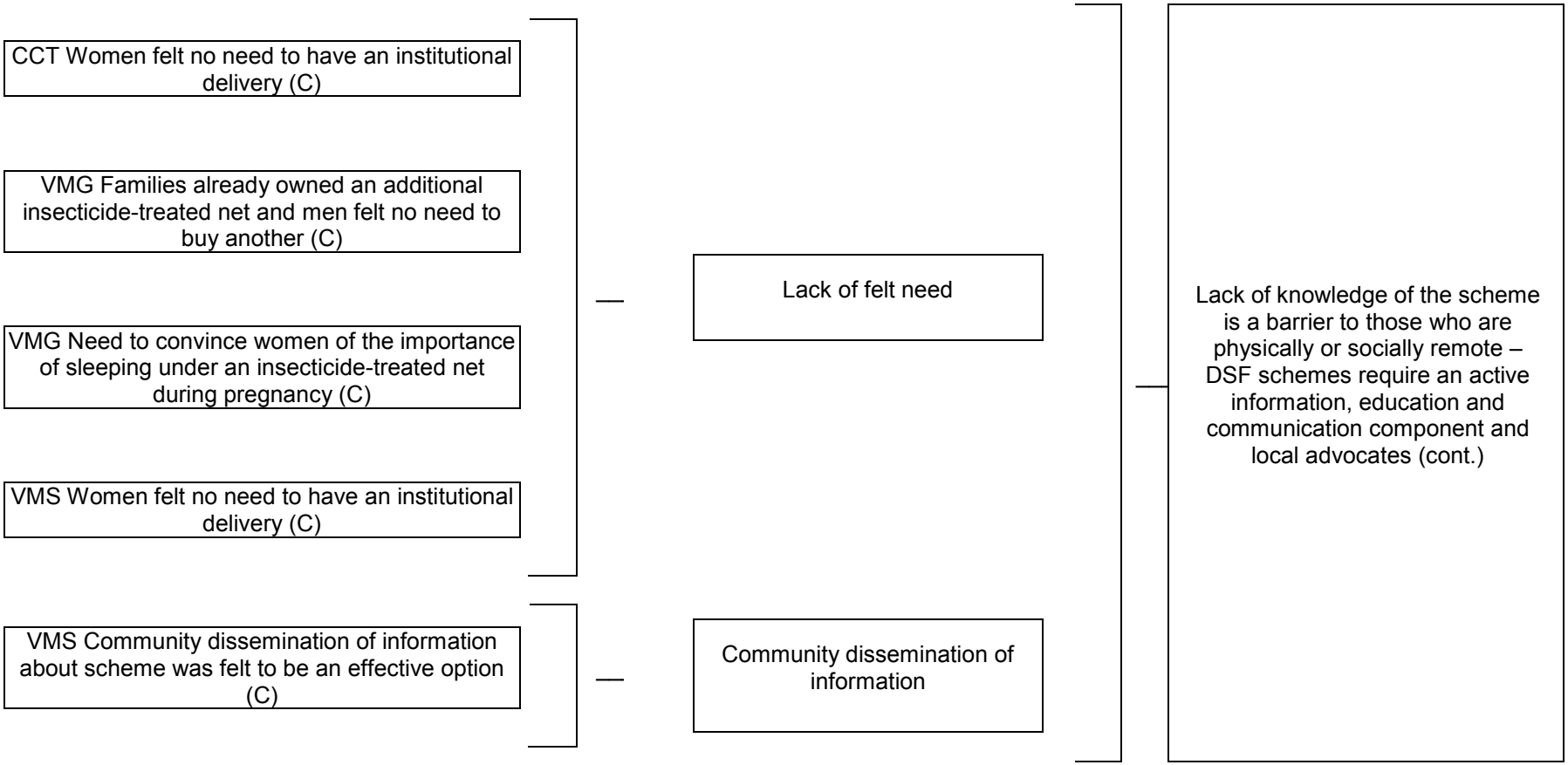


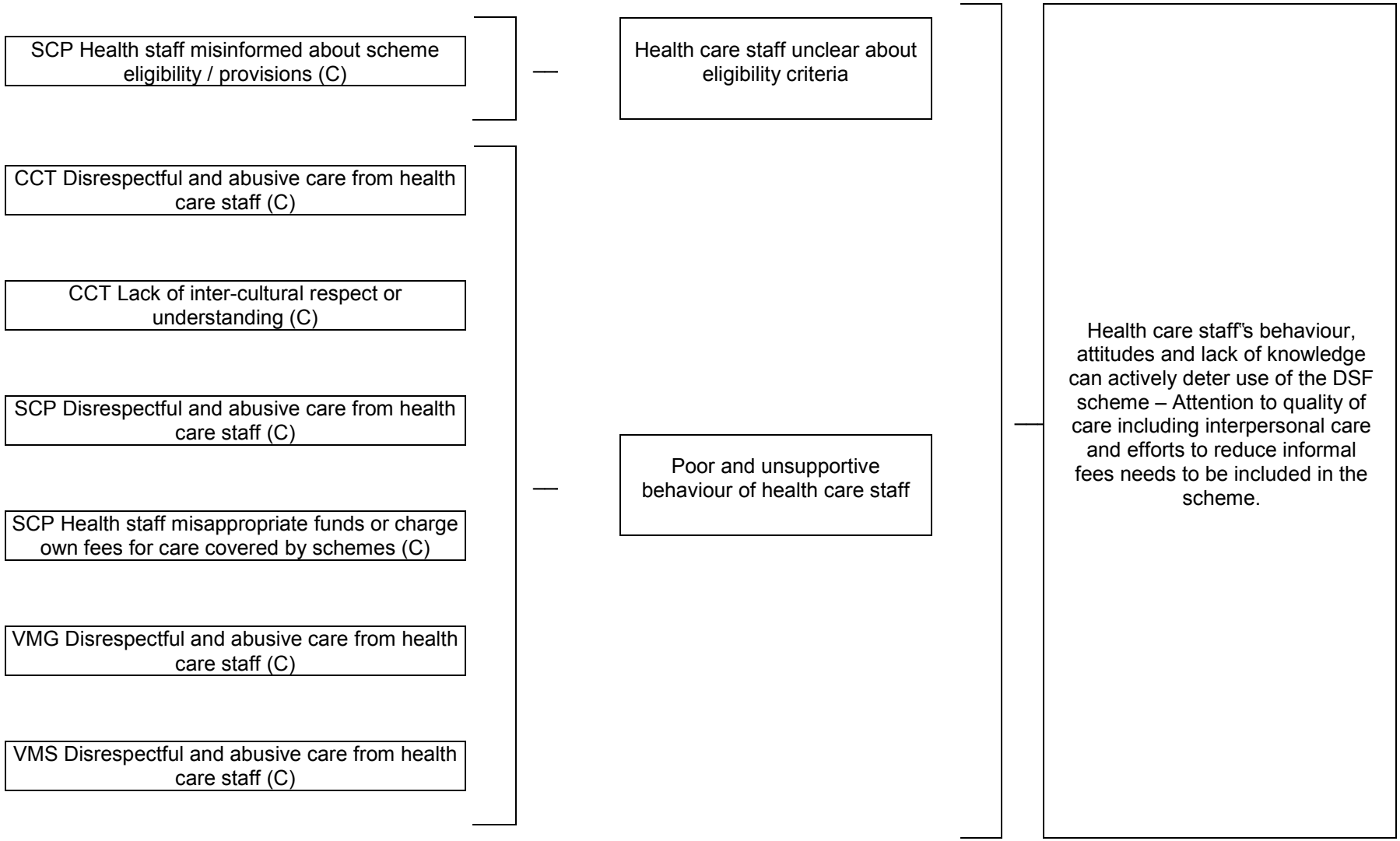

UCT Cash disbursements are too late to help poor with immediate expenses (C)
VMS/SCP Cash disbursements for transport are not available / not made (C)
CCT Facility too far from home (C)
SCP Difficult for women to travel in early postpartum (C)
SCP Facility too far from home (C)
VMG Suppliers of insecticide-treated nets too far from home (C)
VMS Barriers reduced if accredited birth facilities
Distance between facility / supplier and place of residence
Geographical remoteness and poor transport to facilities act as barriers to implementation – DSF schemes require attention to transport arrangements and/or ways of bringing care nearer to home

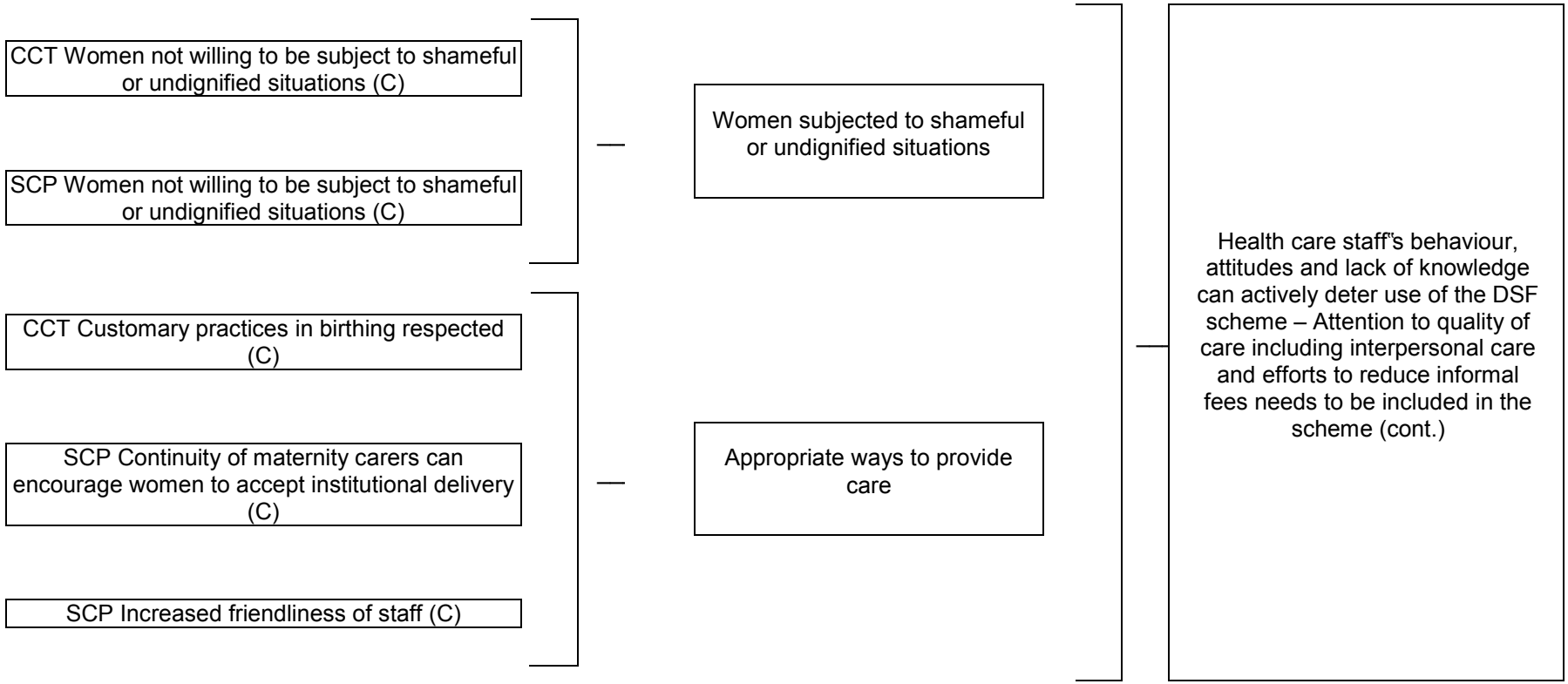

close to the homes of women (C)
VMS Facility too far from home (C)
VMG Voucher and net issue at different locations is inconvenient for beneficiaries (C)
Distance between voucher distributor and supplier of insecticide-treated nets
CCT Lack of available transport to facility (C)
SCP Barriers reduced by network of free / low cost ambulances available by phone (C)
SCP Lack of available transport to facility (C)
SCP Poor road infrastructure in remote areas (C)
VMS Difficulties travelling at night (C)
Transport problems for rural women
Geographical remoteness and poor transport to facilities act as barriers to implementation – DSF schemes require attention to transport arrangements and/or ways of bringing care nearer to home (cont.)

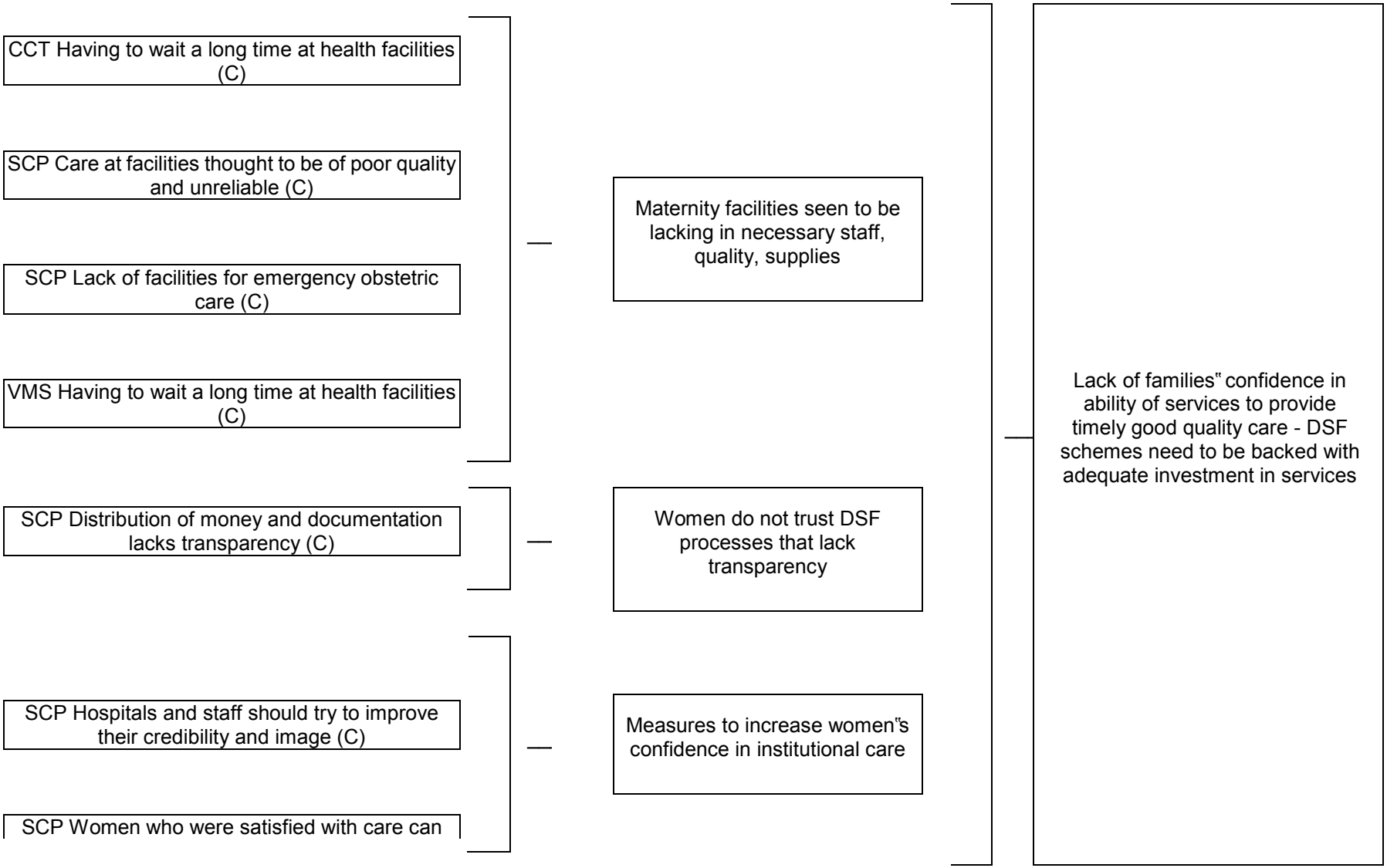

VMS Lack of available transport to facility (C)
VMS Poor road infrastructure in remote areas (C)


CCT Selective schemes may not advertise for fear of creating jealousy and conflict (C)
SCP Lack of formal orientation of community leaders (C)
SCP Local facilitators misinformed about scheme eligibility / provisions (C)
SCP Potential beneficiaries‟ lack of knowledge of scheme provisions (C)
SCP Potential beneficiaries‟ misinformed of scheme provisions (C)
VMG Potential beneficiaries' lack of knowledge of scheme provisions (C)
VMS Potential beneficiaries' lack of knowledge of scheme provisions (C)
Lack of awareness of the scheme
Lack of knowledge of the scheme is a barrier to those who are physically or socially remote – DSF schemes require an active information, education and communication component and local advocates

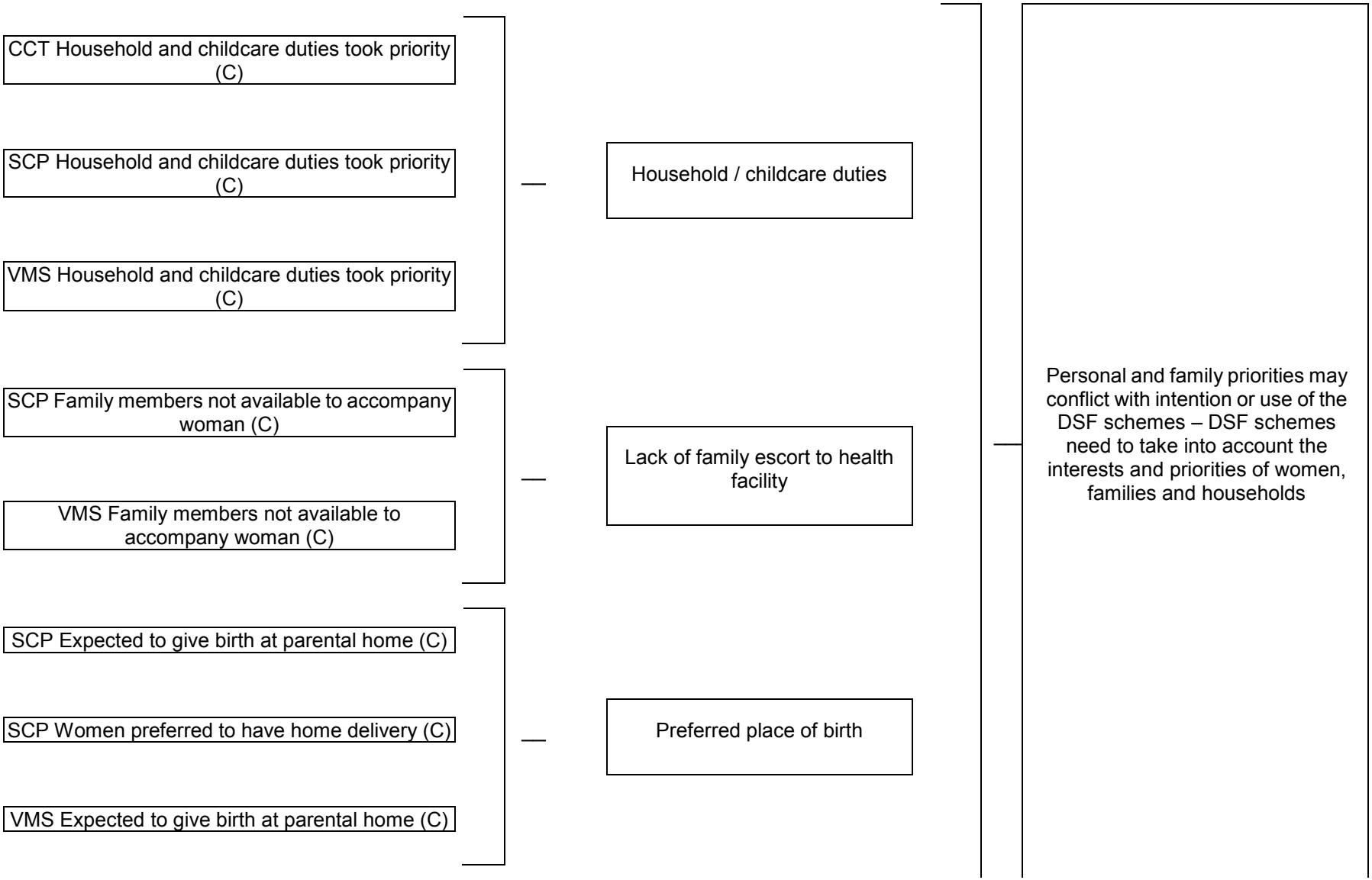

CCT Women felt no need to have an institutional delivery (C)
VMG Families already owned an additional insecticide-treated net and men felt no need to buy another (C)
VMG Need to convince women of the importance of sleeping under an insecticide-treated net during pregnancy (C)
VMS Women felt no need to have an institutional delivery (C)
VMS Community dissemination of information about scheme was felt to be an effective option (C)
Lack of felt need
Community dissemination of information
Lack of knowledge of the scheme is a barrier to those who are physically or socially remote – DSF schemes require an active information, education and communication component and local advocates (cont.)

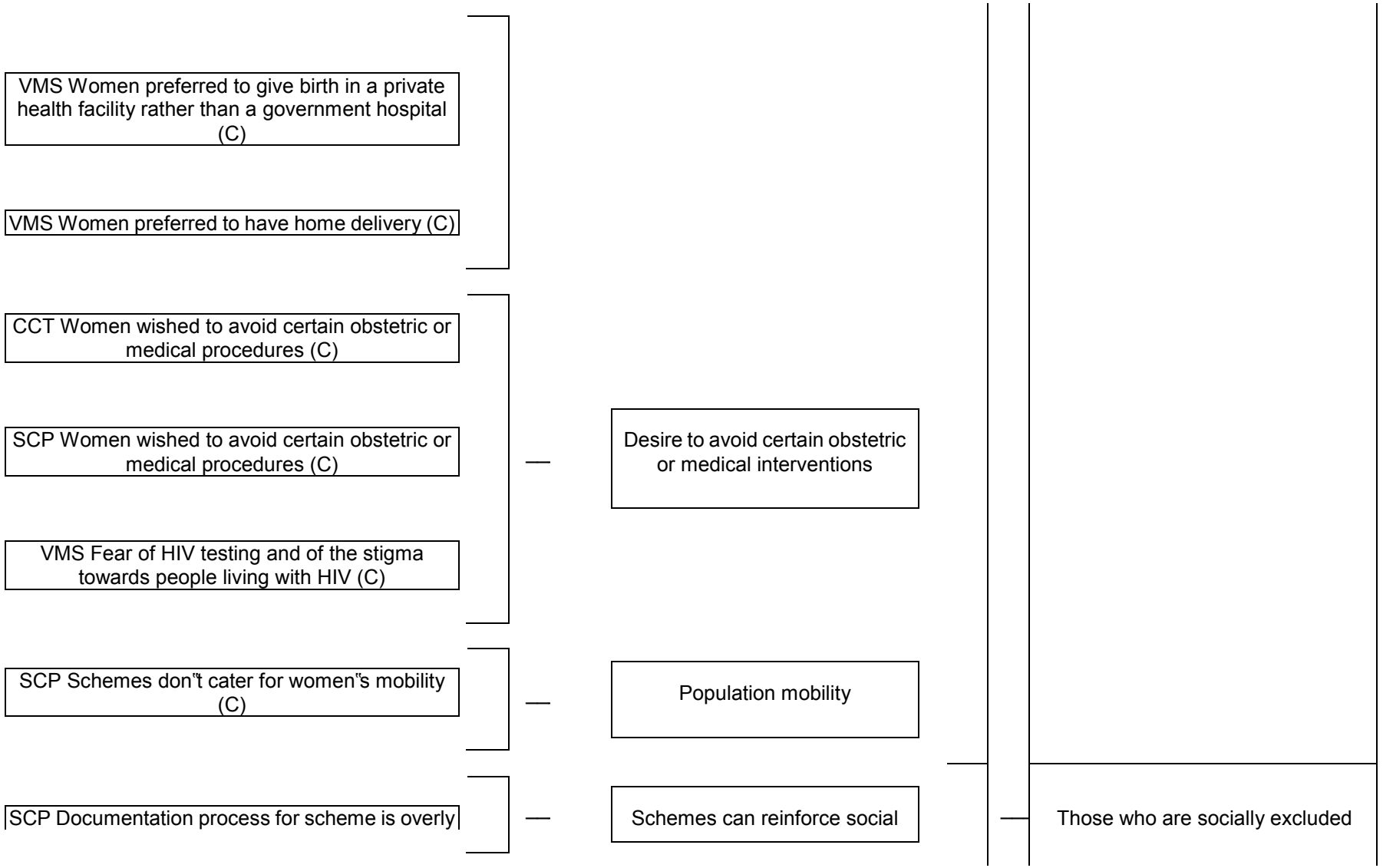

SCP Health staff misinformed about scheme eligibility / provisions (C)
Health care staff unclear about eligibility criteria
CCT Disrespectful and abusive care from health care staff (C)
CCT Lack of inter-cultural respect or understanding (C)
SCP Disrespectful and abusive care from health care staff (C)
SCP Health staff misappropriate funds or charge own fees for care covered by schemes (C)
VMG Disrespectful and abusive care from health care staff (C)
VMS Disrespectful and abusive care from health care staff (C)
Poor and unsupportive behaviour of health care staff
Health care staff's behaviour, attitudes and lack of knowledge can actively deter use of the DSF scheme – Attention to quality of care including interpersonal care and efforts to reduce informal fees needs to be included in the scheme.

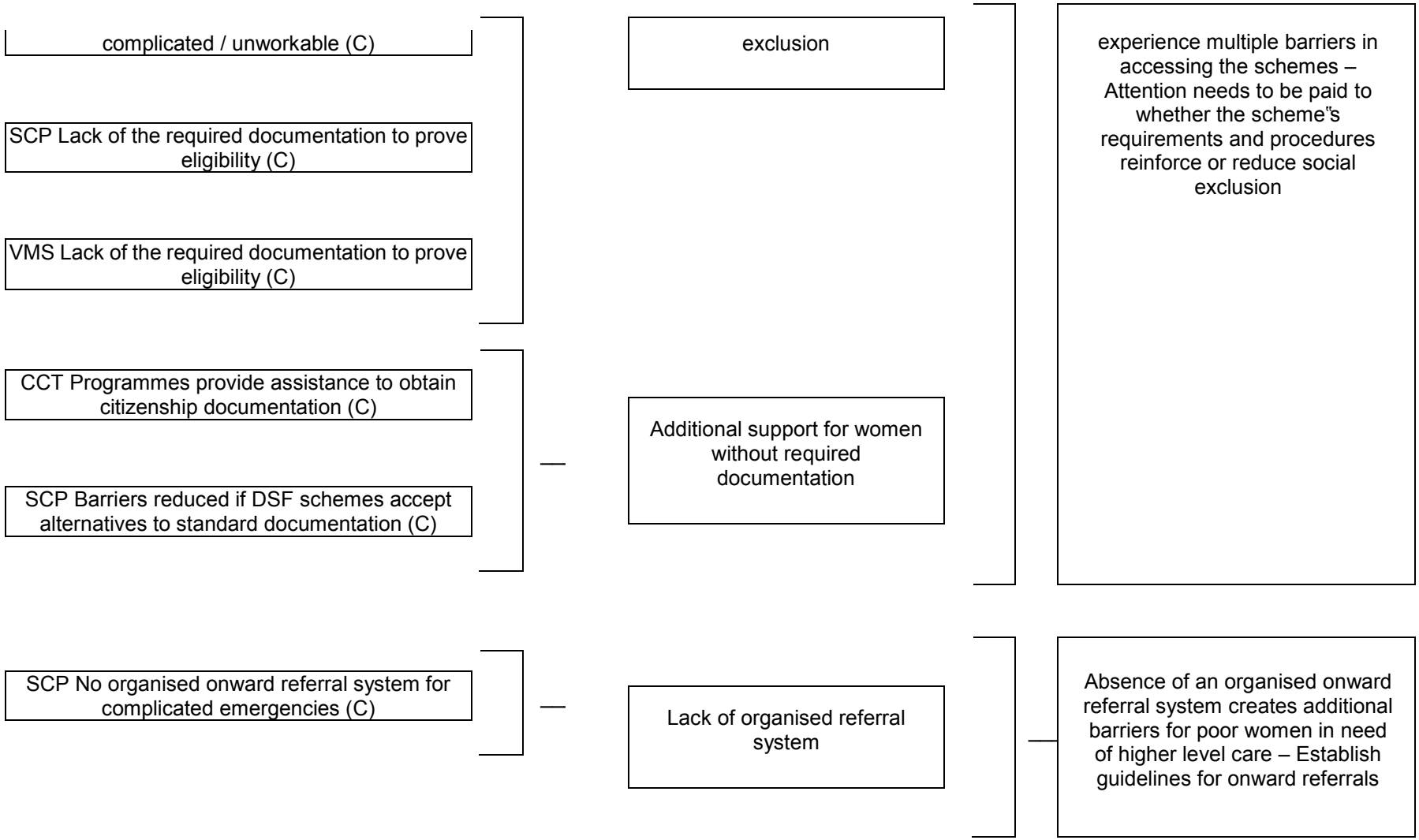

CCT Women not willing to be subject to shameful or undignified situations (C)
SCP Women not willing to be subject to shameful or undignified situations (C)
Women subjected to shameful or undignified situations
CCT Customary practices in birthing respected (C)
SCP Continuity of maternity carers can encourage women to accept institutional delivery (C)
SCP Increased friendliness of staff (C)
Appropriate ways to provide care
Health care staff's behaviour, attitudes and lack of knowledge can actively deter use of the DSF scheme – Attention to quality of care including interpersonal care and efforts to reduce informal fees needs to be included in the scheme (cont.)

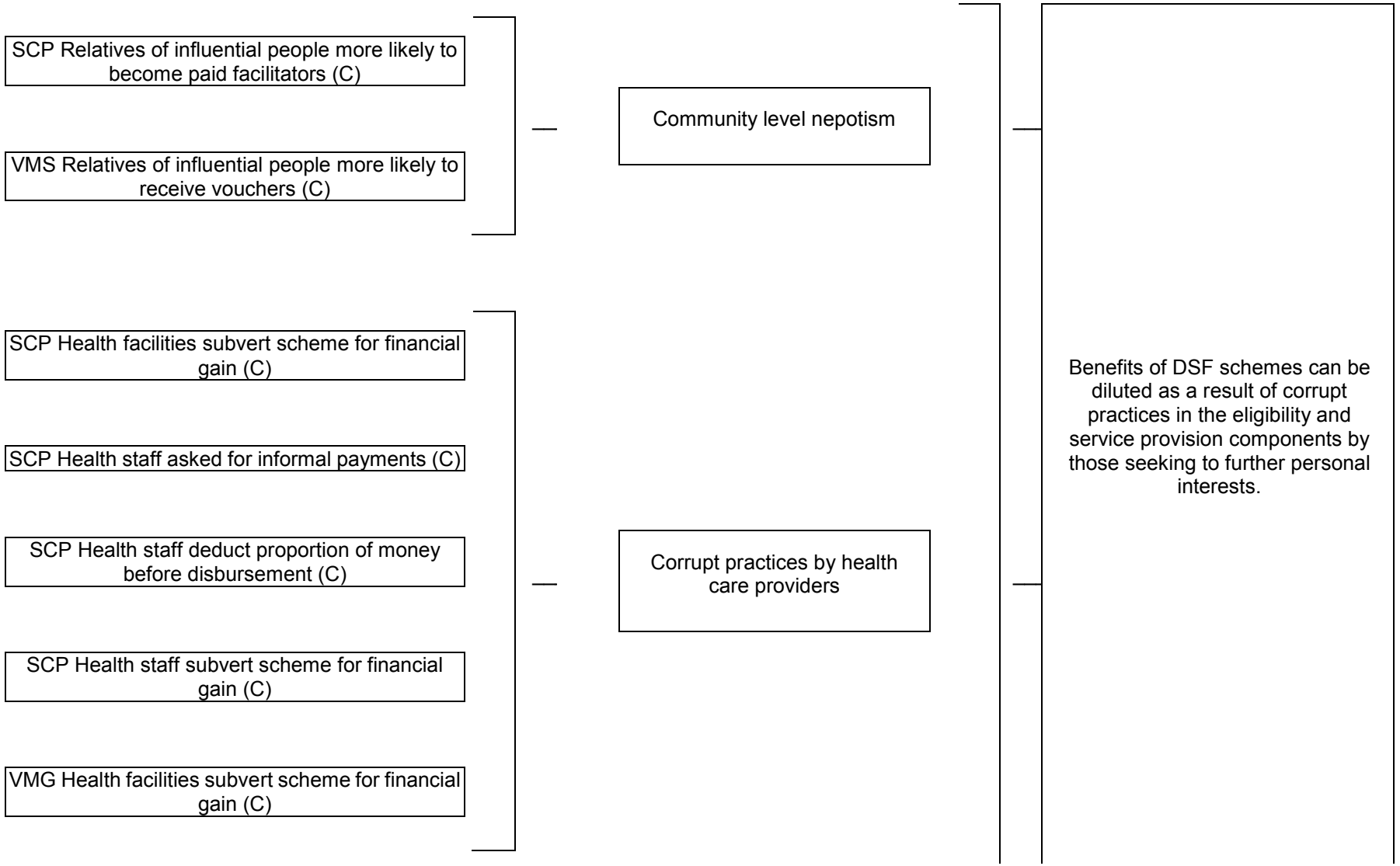

CCT Having to wait a long time at health facilities (C)
SCP Care at facilities thought to be of poor quality and unreliable (C)
SCP Lack of facilities for emergency obstetric care (C)
VMS Having to wait a long time at health facilities (C)
Maternity facilities seen to be lacking in necessary staff, quality, supplies
SCP Distribution of money and documentation lacks transparency (C)
Women do not trust DSF processes that lack transparency
SCP Hospitals and staff should try to improve their credibility and image (C)
Measures to increase women"s confidence in institutional care
SCP Women who were satisfied with care can
Lack of families" confidence in ability of services to provide timely good quality care - DSF schemes need to be backed with adequate investment in services


encourage others (C)


CCT Household and childcare duties took priority (C)
SCP Household and childcare duties took priority (C)
VMS Household and childcare duties took priority (C)
Household / childcare duties
SCP Family members not available to accompany woman (C)
VMS Family members not available to accompany woman (C)
Lack of family escort to health facility
SCP Expected to give birth at parental home (C)
SCP Women preferred to have home delivery (C)
VMS Expected to give birth at parental home (C)
Preferred place of birth
Personal and family priorities may conflict with intention or use of the DSF schemes – DSF schemes need to take into account the interests and priorities of women, families and households


VMS Women preferred to give birth in a private health facility rather than a government hospital (C)
VMS Women preferred to have home delivery (C)
CCT Women wished to avoid certain obstetric or medical procedures (C)
SCP Women wished to avoid certain obstetric or medical procedures (C)
VMS Fear of HIV testing and of the stigma towards people living with HIV (C)
Desire to avoid certain obstetric or medical interventions
SCP Schemes don"t cater for women"s mobility (C)
Population mobility
SCP Documentation process for scheme is overly
Schemes can reinforce social
Those who are socially excluded


complicated / unworkable (C)
SCP Lack of the required documentation to prove eligibility (C)
VMS Lack of the required documentation to prove eligibility (C)
exclusion
CCT Programmes provide assistance to obtain citizenship documentation (C)
SCP Barriers reduced if DSF schemes accept alternatives to standard documentation (C)
Additional support for women without required documentation
experience multiple barriers in accessing the schemes – Attention needs to be paid to whether the scheme"s requirements and procedures reinforce or reduce social exclusion
SCP No organised onward referral system for complicated emergencies (C)
Lack of organised referral system
Absence of an organised onward referral system creates additional barriers for poor women in need of higher level care – Establish guidelines for onward referrals


SCP Relatives of influential people more likely to become paid facilitators (C)
VMS Relatives of influential people more likely to receive vouchers (C)
Community level nepotism
SCP Health facilities subvert scheme for financial gain (C)
SCP Health staff asked for informal payments (C)
SCP Health staff deduct proportion of money before disbursement (C)
SCP Health staff subvert scheme for financial gain (C)
VMG Health facilities subvert scheme for financial gain (C)
Corrupt practices by health care providers
Benefits of DSF schemes can be diluted as a result of corrupt practices in the eligibility and service provision components by those seeking to further personal interests.

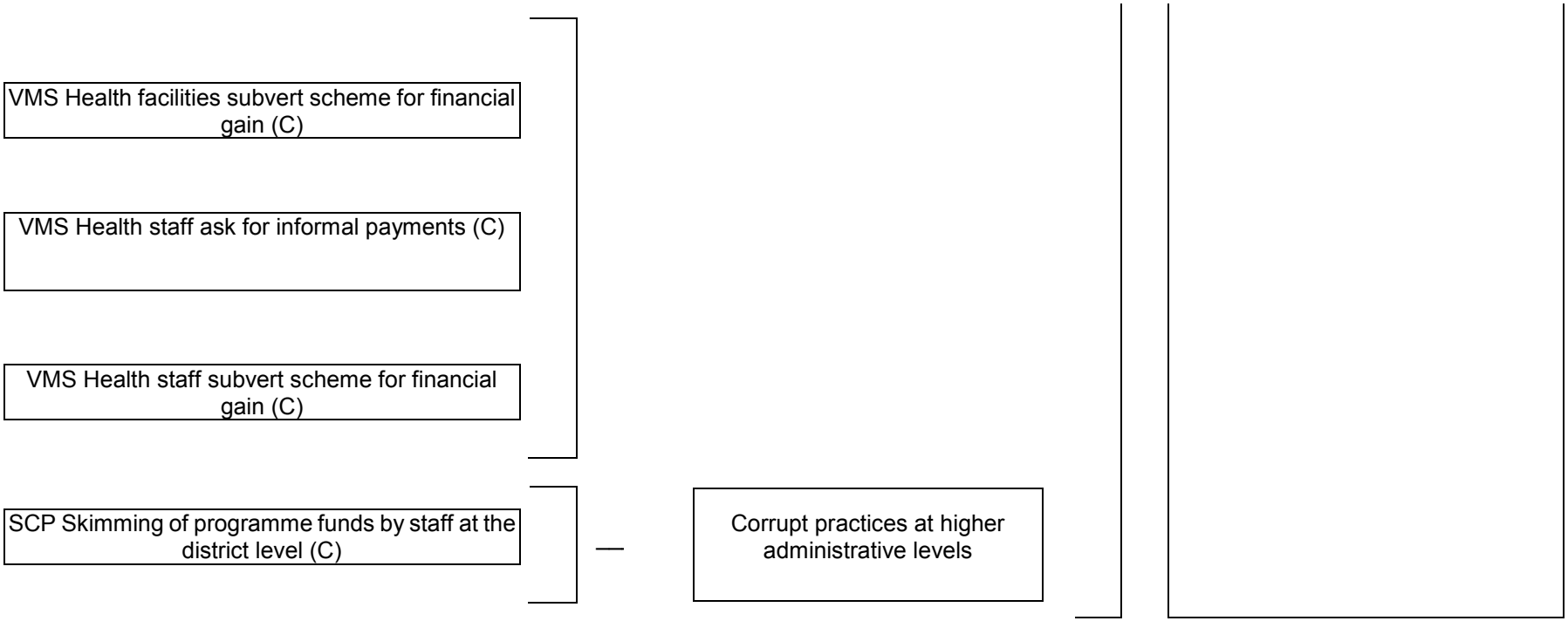


Figure 2. Meta-synthesis of findings on barriers to the provision of DSF (Question 10)

Notes: UCT refers to unconditional cash transfers; CCT refers to conditional cash transfers; SCP refers to short term payments to offset the cost of accessing maternal health services; VMS refers to vouchers for maternal health services; VMG refers to vouchers for merit goods for maternal health; (C) refers to credible, as per JBI-QARI levels of credibility

Categorisation and Synthesis of Findings (Q 10)

The composition of each synthesised finding is described below.

Barrier: Additional financial costs associated with the use of health care can be prohibitive for the poor

Implication: DSF schemes need to cover other related costs

A synthesised finding on financial costs drew on good evidence from seven findings grouped into two categories. The first category related to the prohibitive costs of travel to maternity services and onward referrals. The second category related to the additional costs faced by poor women using vouchers for maternity services or merit goods. These categories were supported by evidence from a range of contexts: a cash transfer programme in El Salvador, a short term payment programme to offset costs of access in India, voucher schemes for maternity services in Bangladesh, India and Kenya, and a voucher scheme for merit goods in Tanzania. For example, the following excerpt came from an evaluation of the Vouchers for Health programme in Kenya:

> *„Referral of clients requiring emergency obstetric care further impacted on the services received: Some of these referrals were to non-accredited facilities where clients have to pay for services. In some cases where referrals were made to accredited facilities, voucher clients were unable to meet the transport costs. In addition some lower lever facilities would refer clients that could have actually been managed in that facility. One voucher client in Kitui reported during FGD [a focus group discussion] that: You are told to go to [name of facility] for referral and you don't have bus fare. You are now forced to go back home to look for money or look for another cheaper facility."*[50] *(p. 12)*

There was a specific finding in the second category that related to the fees charged for vouchers in the Tanzania National Voucher Scheme, as respondents noted that poor women could not afford the vouchers:

> *'there was general agreement in the FGDs [focus group discussions] that many eligible women had not used the vouchers because of a lack of cash, partly due to the poor harvests in three consecutive years. As one community leader lamented: There is famine and there are mosquitoes. What can I do then while there is no money?"*[47] *(p. 168)*

Barrier: Poor, rural or socially excluded women face difficulties accessing subsidies or cash payments

Implication: DSF programmes that include subsidies or cash payments should use appropriate means of targeting and distribution

This synthesised finding grouped two categories on mechanisms for assisting poor, rural or socially excluded women. The first category included mechanisms that have been used to overcome barriers for poor women, including cheques made payable to recipients and cash payments to support use of vouchers for maternity services. A suggestion specific to user fees to buy vouchers came from a study on the Tanzania National Voucher Scheme, „women could pay by instalments and this seemed to have increased net purchases, especially by very poor women.“[41] (p. 6)

The second category included findings on barriers to the distribution and use of cash transfers. Studies on short term payments to offset costs of access in India highlighted problems with the amount of money paid to women and the difficulty overcoming bureaucratic hurdles to access it:

> *„While discussing the JSY with a NGO [non-governmental organisation] staff member, he commented on the cash assistance, "People think medical expenses are very high and the cash assistance under JSY is very low".“[68] (p. 16)*

> *„A common problem women face while availing JSY benefit, is the time limit of 7 days given to claim the benefit. This study could not identify a single participant who received the benefit within the stipulated period of 7 days after delivery. This period varied from a low of 0 days for a participant to 5 months for another, the average being 3 months after delivery. A participant who had her delivery by Caesarean section in her mother's place tried to avail Rs. 1,500 when she returned to her marital home mentions of the inconvenience in collecting the documents required as "…we have spent about Rs. 500 just for this, it cost us each time at least Rs. 100 to go and come… how many times we have done that?... Once she would give him the white paper, then the yellow one, then she asked the doctors signature, then my school certificate, one at a time…“[42] (p. 131)*

Problems with the timing of cash payments were reported in studies on unconditional cash transfers, conditional cash transfers, short term payments to offset costs of access, and a voucher scheme for maternity services that included reimbursement for transport costs. It was often felt that cash payments were received too long after expenditure and were therefore of little help to cope with the burden of immediate costs, as evidenced in studies on the Maternal Health Voucher Scheme in Bangladesh and the Program Keluarga Harapan in Indonesia:

> *„Both the graduated beneficiaries recommended that the disbursement of money should be made before delivery. They said that, while in labour, many women and their families have to borrow money to meet immediate expenses.“[38] (p. 18)*

> *„Using PKH [Program Keluarga Harapan] funds for MCH [maternal and child health] utilization was rare, almost non-existent because the timing of payments were often not at the same time as the funds were needed (for example during childbirth). Therefore mothers tended to ignore aspects of MCH [maternal and child health] despite receiving PKH [Program Keluarga Harapan] funds for infants or pregnant women."* [57] *(p. 42)*

Barrier: Geographical remoteness and poor transport to facilities act as barriers to implementation

Implication: DSF schemes require attention to transport arrangements and/or ways of bringing care nearer to home

Nine findings were grouped into three categories to support a robust synthesised finding on geographical barriers to access. The first category related to the distance between the homes of women and the provider of goods or services. This was supported by evidence on conditional cash transfers, short term payments to offset costs of access, and both types of vouchers. For example, the authors of a study on the Tanzania National Voucher Scheme noted,

> *'Respondents in both districts commended the government for introducing the national ITN [insecticide-treated net] voucher system. However, concerns were expressed about the need to approach accredited retailers, often located far away, for redeeming the ITN [insecticide-treated net] vouchers.'* [46] *(p. 10)*

A second category related to the distance between places where vouchers are distributed and places where vouchers can be exchanged for merit goods. This was supported by a finding from the Tanzania National Voucher Scheme, *„In FGDs [focus group discussions], it was suggested that nets should be sold by all MCH [maternal and child health] clinics: "getting a voucher from one place and a net from another is very inconvenient".* [41] (p. 6)

The third category related to the practical difficulties that women may encounter while trying to access and use transport to and from providers. This was supported by findings on conditional cash transfers, short term payments to offset costs of access and vouchers for maternity services. The four findings included in the category were on a lack of transport, poor road infrastructure and difficulties travelling at night. A study from India described the following solution that has been adopted to overcome some of these problems:

> *„A significant development is the introduction of the 108-ambulance service, a public-private partnership project that has had a positive impact since it was introduced in some among (sic) these villages starting in 2008. Each 108-ambulance service is expected to cover a population of 100,000 over distances of no more than 30 kilometers. It seems important to note, however,*

> *that despite the introduction of the 108-ambulance service only a small proportion of all women who obtained institutional deliveries were brought to the hospital or clinic in an ambulance. The majority utilized hired means of transportation, including, most often, tractors, auto rickshaws, and trucks, and less frequently, buses and cars. Vastly expanding the network of free or low-cost ambulance services is essential to reduce the human misery and often ruinous costs associated with institutional health care."*[70] *(p. 14)*

Barrier: Lack of knowledge of the scheme is a barrier to those who are physically or socially remote

Implication: DSF schemes require an active information, education and communication component and local advocates

Eight findings were grouped into three categories with good evidence to support a synthesised finding on lack of awareness providing a barrier to the provision of voucher schemes. The first category related to lack of awareness and was supported by five findings, such as a lack of orientation for community leaders and misinformed local facilitators and beneficiaries. The authors of a study on Program Keluarga Harapan in Indonesia noted that the programme had not been advertised due to fears of jealousy and conflict in communities:

> *„At the community level, especially in West Java and in urban areas in NTT [East Nusa Tenggara province], the presence of PKH was not too well known. Due to the small number of beneficiaries and the subsequent potential for jealousy and conflict to arise between beneficiaries and non-beneficiaries the program was implemented almost as if it were a secret."*[57] *(p. 41)*

The importance of adequate information for recipients was highlighted by a respondent from a pilot voucher scheme for maternity services in Bangladesh:

> *„The fieldworker of our locality did not inform me how to use the voucher book. I did not know that she (fieldworker) had listed my name as one of the poor. She just called me to her home and gave me the book and did not provide any information regarding it. So, I did not use it."*[48] *(p. 306)*

The second category related to a perceived lack of need for a good or service. Three findings supported this, derived from studies of voucher schemes for maternity services and schemes for merit goods. For example, it was noted in a study on the Tanzania National Voucher Scheme for insecticide-treated nets that families with a bed net would not buy another, *„Several FGD [focus group discussion] participants mentioned that they already owned nets and therefore had no need to use the scheme."*[47] (p. 167)

The third category was supported by one finding on the importance of community-based dissemination of information:

> *'Most key informants felt that this system for informing the community about the voucher program was effective. The involvement of local government officials and religious leaders through community meetings was highlighted as particularly useful, as were door-to-door visits by field health workers: "Paying door-to-door visits by field workers to inform the community about voucher program is especially effective. This has resulted in an increasing trend of hospital-based delivery." – FWA/HA [Family Welfare Assistant/Health Assistant]."* [53] *(p. 33)*

> *"The courtyard meetings in the community with the mothers which are facilitated by the local government representatives…In the meetings, pregnant mothers and their guardians are informed and motivated about safe delivery. The difference between the delivery at home and the institutional delivery is explained in the meeting." – DSF Coordinator'* [53] *(p. 33)*

Barrier: Behaviour and attitudes of health care staff can actively deter use of the DSF scheme.

Implication: Attention to quality of care including interpersonal care needs to be included in the scheme.

The fifth synthesised finding under this review question concerned the activities and behaviour of staff at health facilities, and was supported by good evidence from eight findings and four categories.

Evidence from short term payments to offset costs of access in the Indian state of Bihar supported the first category, on misinformed staff in health facilities, *„The study shows that there were still some ANMs [auxiliary nurse-midwives] who were confused about the eligibility criteria for getting JBSY [Janani avam Bal Suraksha Yojana] benefits."* [66] (p. 33)

The second category in this synthesised finding related to the poor and unsupportive behaviour of staff at facilities, and drew on evidence from studies on conditional cash transfers, short term payments to offset costs of access, vouchers for maternity services and vouchers for merit goods. An activist in the Indian state of Uttar Pradesh reported the following:

> *„"One man I know had taken his wife for delivery to the CHC [Community Health Centre]. He had sold 10 kilos of wheat that he had bought to get money to bring his wife for delivery. He had some 200-300 rupees [US$4-6]. Now in the CHC [Community Health Centre] they asked him for a minimum of 500 rupees [US$10]. Another 50 [rupees] to cut the cord and 50 [rupees] for the sweeper. So he started begging and saying he did not have more money and that they should help for his wife's delivery. I... asked them why they were demanding money. The*

> *nurse started giving us such dirty abuses that even I was getting embarrassed and wanted to leave. You imagine how an ordinary person must feel who wants help.""*[54] *(p. 12)*

The third category related to shameful and undignified situations that women might be subjected to, supported by evidence on conditional cash transfers and short term payments to offset costs of access. The following excerpt comes from a study on the Red Solidaria in El Salvador:

> *„The barrier of shame and body-centered embarrassment extended to giving birth in the hospital and pre-natal exams. In the El Salvador study, some women said they had never been to a prenatal check-up for this reason. In public hospitals it is common for medical students to make rounds through the rooms where women are in labour, which the women found embarrassing: "a male doctor comes through, then a female doctor, then another male doctor, and in a manner that everyone is seeing us like this." This is another reason why seeing a midwife for pre-natal exams and giving birth at home is preferred."*[37] *(p. 1927)*

The fourth category drew together ways in which care can be provided appropriately. Measures that have been adopted included continuity of maternity carers and the respect of customary practices, for example:

> *„The programme does include some measures to follow customs and cultural practices in hospital births. For instance, women are permitted to give birth in a standing position, traditional medicinal herbs may be used, and the presence of a close relative during the birth is allowed."*[43] *(p. 205)*

Barrier: Lack of families' confidence in ability of services to provide timely good quality care

Implication: DSF schemes need to be backed with adequate investment in services

This synthesised finding was supported by three categories and six findings, on conditional cash transfers, short term payments to offset costs of access and vouchers for maternity payments. The first category related to a lack of confidence in quality of care at health facilities, including long waiting times and lack of facilities for emergency obstetric care. The following example comes from a study of short term payments to offset costs of access in India:

> *„Majority of the non-users and PRI [Panchyati Raj Institution] members state that non-availability of 24x7 health centres and lack of staff in treatment centres are major deterrents for prospective mothers in accessing the JSY services. Also, according to approximately half of the BMOs [Block Medical Officers] and majority of PRIs [Panchyati Raj Institutions], poor institutional facilities and inadequate supply of essential materials like drugs, IV [intravenous] fluids and surgical materials are major roadblocks. Majority of the non-users say that the unavailability of ASHAs and ANMs [auxiliary nurse-midwives] as escorts at the time of need creates apprehension amongst mothers in negotiating or communicating with the health staff."*[39] *(p. 30)*

The second category focused on a lack of trust in the distribution of money and cards by health facilities for short term payments to offset costs of access: „*Most of the non-users see also lack of transparency on the part of the health staff in the money distribution, as well as in issuance of the JSY Card*."[39] (p. 28)

The third category brought together two suggestions on how to improve women"s perceptions of institutional health care, and both are evidenced in the extract below:

> *„There are women who are satisfied with the services available at the clinic, and had good experience at the hospitals. They could be utilized to come forward and motivate women to go for institutional deliveries. On the other hand, hospitals and staff also should constantly thrive to improve their credibility and image, so that women could access services without unnecessary fears. Further, a district official expressed one challenge to be embedded in traditions. He said: "The reluctance, the age-old traditional belief that the women, the mother, the mother-in-law have who all used to deliver at homes is there. The social barrier to institutional delivery is the greatest challenge"."*[68] *(p. 13)*

Barrier: Personal and family priorities may conflict with use of the DSF schemes

Implication: DSF schemes need to take into account the interests and priorities of families and households

A synthesised finding on the barriers posed by personal and household attitudes drew on good evidence from eight findings, grouped into five categories. The first category related to household and childcare duties of women presenting a barrier to accessing services, supported by very similar evidence from Cambodia, India, Peru and Bolivia. In one example, a beneficiary of the Chiranjeevi Scheme in India described why she did not give birth in a hospital,

> *"…they gave me an injection and the doctor said it will take two days. But I have small children at home alone. My eldest daughter who is 12 years old is blind, that is why I couldn"t stay in the hospital. I came back home in the late evening but instead of two days, at midnight on the same night I delivered a baby girl with the assistance of Shantiben (a TBA [traditional birth attendant]). …"*[45] *(p. 31)*

A second category related to a lack of family escort to health facilities as being a barrier, with similar evidence from Cambodia and India. The authors of a study on vouchers for maternity services in Cambodia described how „*women claimed that if they came to deliver at health centres, nobody would look after their house and take care of their children or that nobody could accompany them to health centres.*"[25] (p. 8)

A third category related to the preference of women to give birth in their home or at the home of their relatives. Evidence from Bangladesh and India supported this. The following excerpt came from a study of the MAMTA scheme in Delhi, India:

> *„All the women, counseled by ANMs have not opted for institutional delivery. A significant number of them did not have institutional delivery, due to certain reasons which include distance of hospital from home, non-encouragement from family members, preference for home delivery, poverty are the major reasons."* [28] *(p. 36)*

The desire to avoid certain obstetric and medical interventions was the subject of the fourth category, for example the fear of HIV testing:

> *'Some voucher clients feared being tested for HIV: Some women who had bought the vouchers feared they would be tested for HIV and therefore delivered at home or with traditional birth attendants. One voucher client in Kitui noted that: "There is this other one that when women are pregnant, they are afraid to go to the hospital because of HIV testing so some have that fear so they are afraid to go to the hospital as they will be asked to take the test. At times you find there are those women who used to assist there before, back in the community, they are now afraid of AIDS, and when a woman gets to deliver they are afraid to assist, the woman is neglected and she dies due to their fear." Although this problem is not unique to vouchers, the program can contribute towards addressing it by enhancing the capacity of the distributors and providers to offer clients more information on the importance of HIV testing and counseling during antenatal care or delivery visit.'* [50] *(p. 16)*

Barrier: Those who are socially excluded experience multiple barriers in accessing the schemes

Implication: Attention needs to be paid to whether the scheme's requirements and procedures reinforce or reduce social exclusion

Four findings were used to support two categories as modest evidence for a synthesised finding on social exclusion as a barrier to the provision of voucher schemes. The first category related to the social exclusion of potential beneficiaries based on requirements for documentation, and supporting evidence came from JSY in India, and the MAMTA and the Voucher for Health schemes in India and Kenya respectively. Respondents in a study on the MAMTA scheme in Delhi reported,

> *„It is very difficult to identify and register BPL/SC/ST [below poverty line / scheduled caste / scheduled tribe] women as many of them do not have caste certificates in their name. Many of them also do not have proof of residence and income."* [28] *(p. 33)*

> *„Many of the eligible women could not avail the benefit of the scheme due to the fact that they were unable to procure caste certificate in their name. This was mainly reported among the women of migrant families from states like UP [Uttar Pradesh], Bihar, MP [Madhya Pradesh]*

and Rajasthan."[28] (p. 33)

An evaluation of the Vouchers for Health scheme in Kenya described the following barrier:

„Lack of formal identification prevents some eligible women from purchasing vouchers: Some pregnant adolescent girls aged below 18 years were unable to purchase vouchers because they had no formal identification documents. In Kenya, the identification (ID) cards are only issued at age 18 years. Moreover, the government has issued only limited numbers of ID cards in the last three years. There is therefore need to explore alternative forms of identification for those seeking vouchers but lack formal identification."[50] (p. 6)

A second category was used to group together evidence for mechanisms that can support women without the required documentation. A study from India described how women in Karnataka could use a photograph of themselves with the baby, while a study of conditional cash transfers in Peru and Bolivia highlighted the following:

„An element of the programme in all three countries is that in order to obtain the cash transfer, women must hold an identity document. However, indigenous and poor rural women often have no official documentation, and children are not registered at birth. The programmes provide assistance to obtain such documentation, which is an important contribution to women"s inclusion and citizenship and supports their access to rights. But this requirement also excludes some women and children, especially living in more distant communities from gaining access to these same rights. The requirements of the programme that women should attend meetings and travel into town to collect their benefits themselves, means increased freedom for some women, despite adding to the list of tasks and obligations to be fitted into their working day. This is especially so for those living in isolated communities, as they are able to gain new information and knowledge, by going to talks and networking with other women."[43] (p. 207)

Barrier: Absence of an organised onward referral system creates additional barriers for poor women in need of higher level care

Implication: Establish guidelines for onward referrals

Similar findings from Nepal and India supported a synthesised finding on referrals from one health facility to another, based on one category. In the event of obstetric complication, inadequate referral systems can have dire consequences for poor women, as evidenced in a report on the Janani Suraksha Yojana in India:

„Poor referral systems leave women running from pillar to post even during emergencies. Of

> *the nine deceased pregnant women's families that Human Rights Watch spoke to, five recounted serious obstacles in even reaching a health facility and being referred from one to another without any support. For women who develop complications during pregnancy and childbirth and in need of life-saving interventions, time is crucial."* [54] *(p. 48)*

Barrier: Benefits of the scheme can be diluted as a result of corrupt practices in the eligibility and service provision components by those seeking to further personal interests.

Implication: Target anti-corruption measures to vulnerable

The final synthesised finding focused on corruption. Good evidence to support this came from seven findings relating to corruption, grouped into three categories. The first category related to community level nepotism in voucher distribution, supported by a repeated finding in evaluation of the Bangladesh Maternal Health Voucher Scheme, for example:

> *„In two upazilas, a small number of providers mentioned that they had been pressured by local government officials to distribute vouchers to ineligible women. …"Sometimes, even mothers of three children insist on [getting] the voucher. People who are not permanent residents also try to get the voucher card. Sometimes the influential people in society pressure us to get the voucher card."* [53] *(p. 44)*

Evidence from India highlighted community level nepotism in the selection of facilitators for Janani Suraksha Yojana, a programme that includes short term payments to offset costs of access:

> *„The DPMUs [District Programme Management Unit] had their version on the selection of ASHAs. For instance, one DPMU [District Programme Management Unit] said, "The government has started ASHA scheme because ANMs [auxiliary nurse-midwives] can't reach out to every village. With the help of ASHA, people will get total benefit of the health services. But his objective is still a distant goal as AHSA have not been selected in a transparent way. Political parties are playing a big role in selection and they are trying to place their own wives, daughters-in-laws and other relatives as ASHA. For example, at the Panchayat level, if Gram Pradhan has made his wife an ASHA, we all have to rethink how much work she will do for the community. On second thoughts, until the ASHA starts working unselfishly, the health system will not improve.""* [76] *(p. 99)*

The second category related to corrupt practices of health care providers. Evidence for this came from a range of sources including studies of short term payments to offset costs of access in India and Nepal, and of vouchers for maternity services in Cambodia, Kenya and Armenia. Corrupt practices by health care providers included keeping cash payments meant for women, asking for informal payments for services provided, asking for additional money for medicines or cleaning, or false claims to the programme management agency. There was evidence of voucher leakage in a study on the Tanzania

National Voucher Scheme for insecticide-treated nets and of concerns over corruption in the Obstetric Care State Certificate programme in Armenia:

> *„We have shown minimal misuse of vouchers that reached the women and children for whom they were intended; that up to half of vouchers issued had been misused at MCH [Maternal and Child Health] clinics that issued them; and that large-scale misuse was found in only three of 21 clinics. Our findings indicate that vouchers are a feasible system to deliver targeting subsidies to vulnerable populations, but that leakage during the delivery process was the main form of misuse."*[41] *(p. 7)*

> *„Study participants who were physicians indicated that the reported number of deliveries by a particular physician may be manipulated by the heads of maternity hospitals for a financial benefit. Physicians also believed that much of the state allocated designated salary funds from the Program do not reach the providers. Physicians from both marzes and Yerevan indicated that they cannot get information on how their salaries are calculated and that the calculations at facility level lack transparency."*[29] *(p. 21)*

The final category in this synthesised finding was based on a finding on corruption at higher levels of DSF schemes. Evidence to support this was described alongside other forms of corruption in a study of the Safe Delivery Incentive Programme in Nepal:

> *„Respondents in several districts were concerned about misuse of SDIP [Safe Delivery Incentive Programme] funds. Different types of misuse were described, including: false claims by health workers for deliveries that never took place; claims by health workers for assisting deliveries in private clinics; claims for money by women with more than two children; and skimming of money by staff at the district level. Occasionally reports of false claims were followed up, but the lack of a budget provision hindered verification of parity or if a birth actually took place. "HWs [Health workers] are claiming incentives for deliveries that they have attended in the local market place, and registering them as institutional deliveries. And there is no mechanism to check." (District stakeholders, Plains, Focus group discussion)"*[40] *(p. 7)*
>
> *"You know, sometimes the district level people keep up to fifty percent of the incentive. I heard they make false claims too." (Health post, Hill, Key informant interview)"*[40] *(p. 7)*

Review question 11. What are the experiences of those who provide services through DSF schemes for maternal health?

Twenty-four qualitative studies reported findings relevant to this review question, divided among the five modes of DSF as follows:

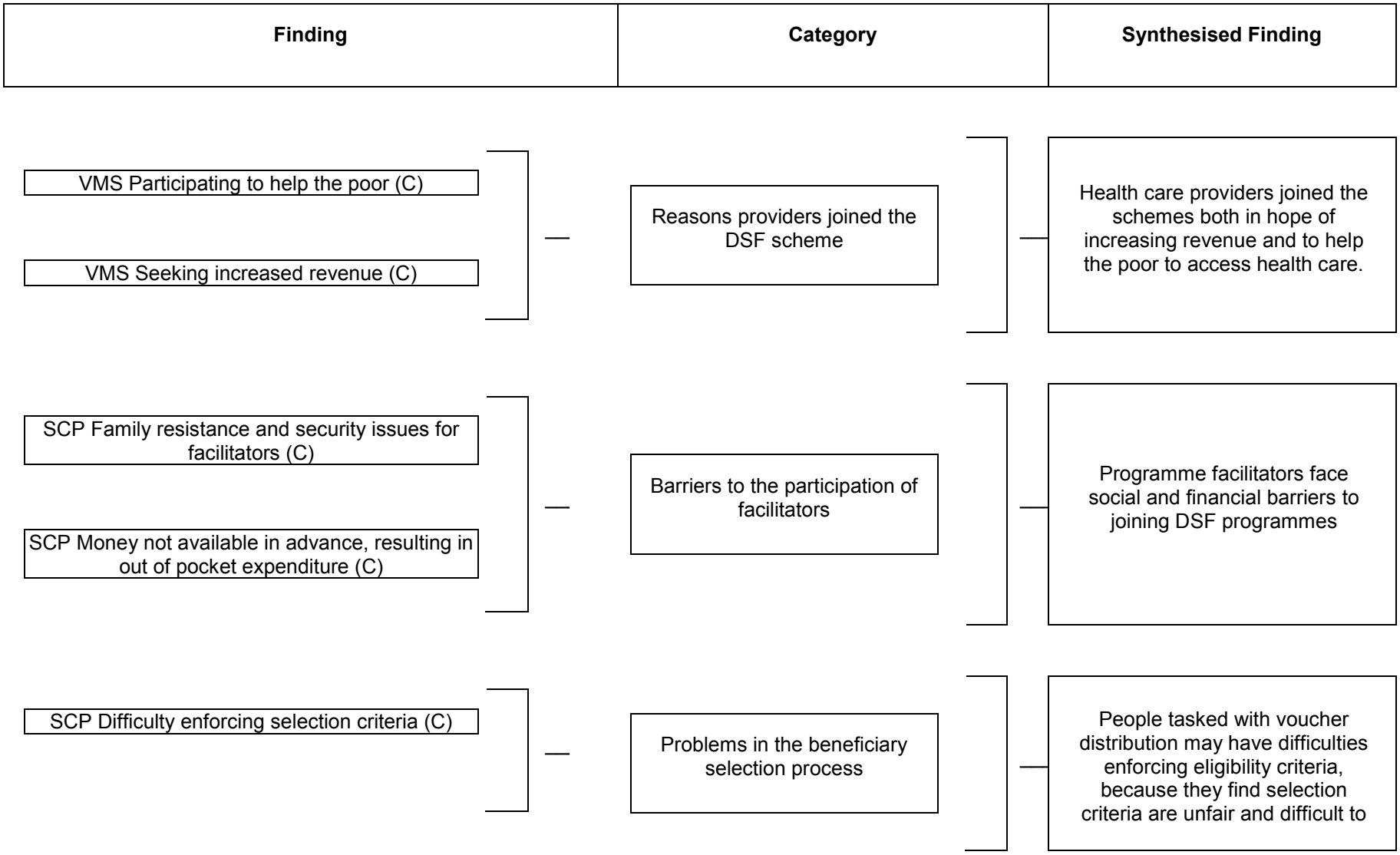
- *One study on unconditional cash transfers*[11]
- *One study on conditional cash transfers*[57]

- *Thirteen studies on short term payments to offset costs of access*[39, 40, 54-56, 58, 64, 70, 72-76]
- *Nine studies on vouchers for maternity services*[22, 28, 29, 38, 45, 50-53]
- *No studies on vouchers for merit goods.*

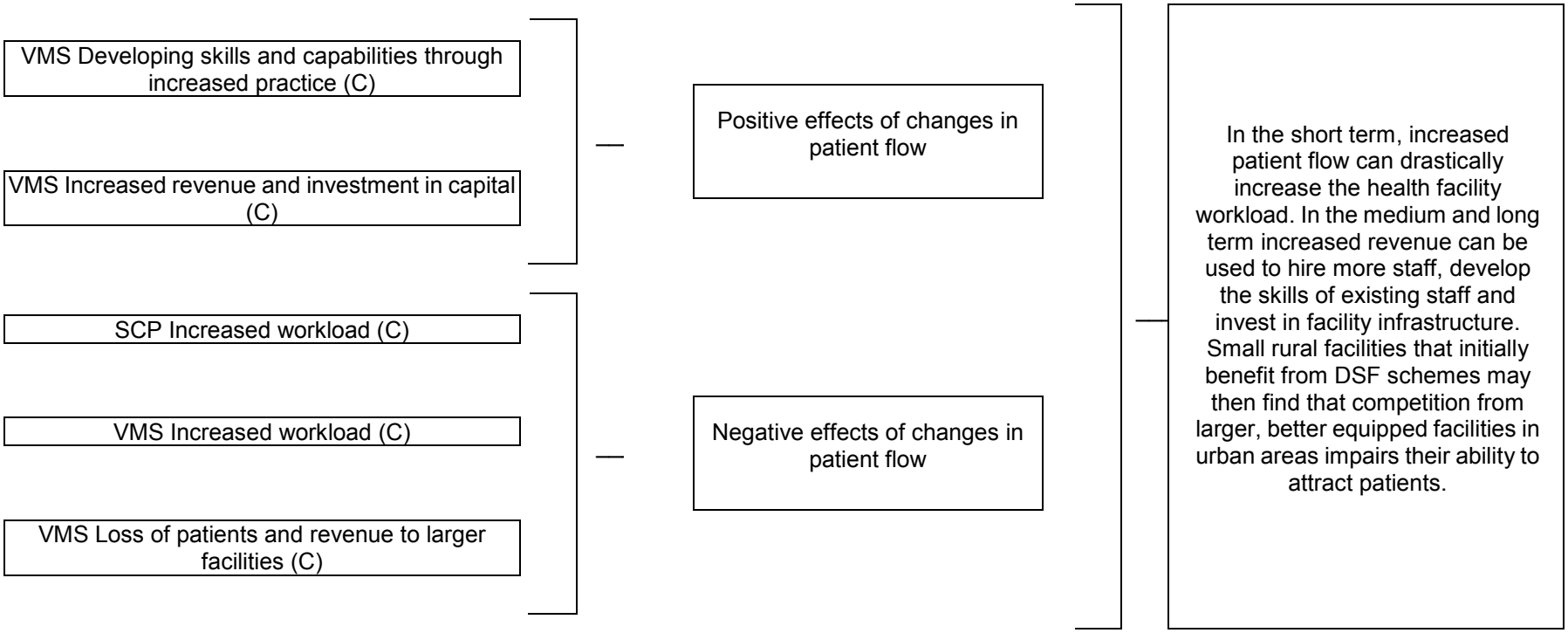
The unconditional cash transfer included was the Dr Muthulakshmi Reddy Memorial Maternity Assistance Scheme in the Indian state of Tamil Nadu,[11] and the conditional cash transfer was Program Keluarga Harapan in Indonesia.[57] Twelve studies on short term payments to offset costs of access focused on Janani Suraksha Yojana in India,[39, 54-56, 58, 64, 70, 72-76] and the remaining one was on the Safe Delivery Incentive Programme in Nepal.[40]

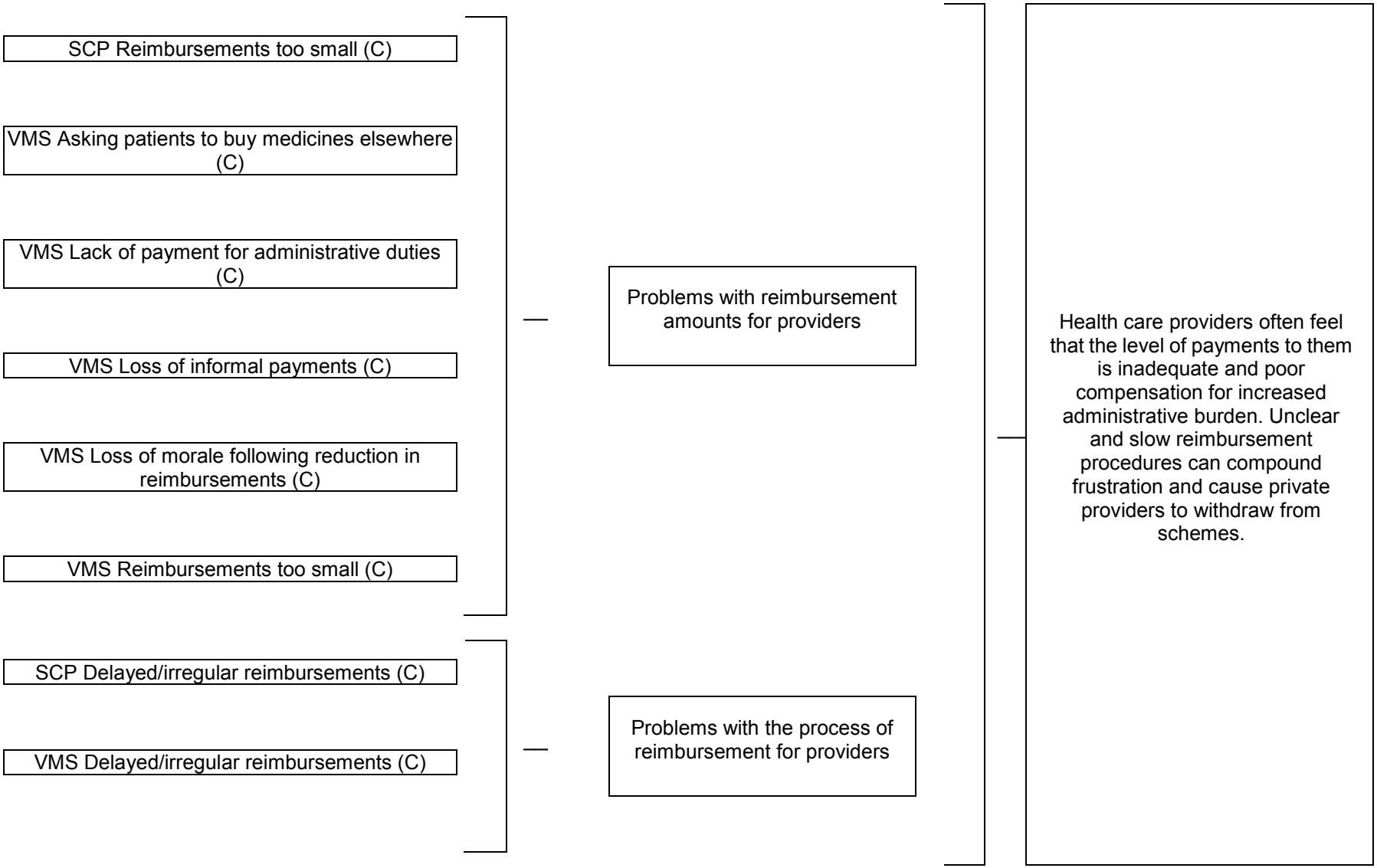
Three studies were on the Maternal Health Voucher Scheme in Bangladesh,[22, 38, 53] one on the Chiranjeevi Scheme,[45] and one on the MAMTA scheme in India,[28] one on the Vouchers for Health programme in Kenya,[50] one on the Makerere University voucher scheme,[51] and one on the HealthyBaby scheme in Uganda,[52] and one on the Obstetric Care State Certificate programme in Armenia.[29]

The topic of this review question was frequently discussed in included studies. There were 28 findings that related to the experiences of those who provide services through voucher schemes. These were analysed and placed into nine categories, from which five synthesised findings were produced. Figure 3 shows these relationships.

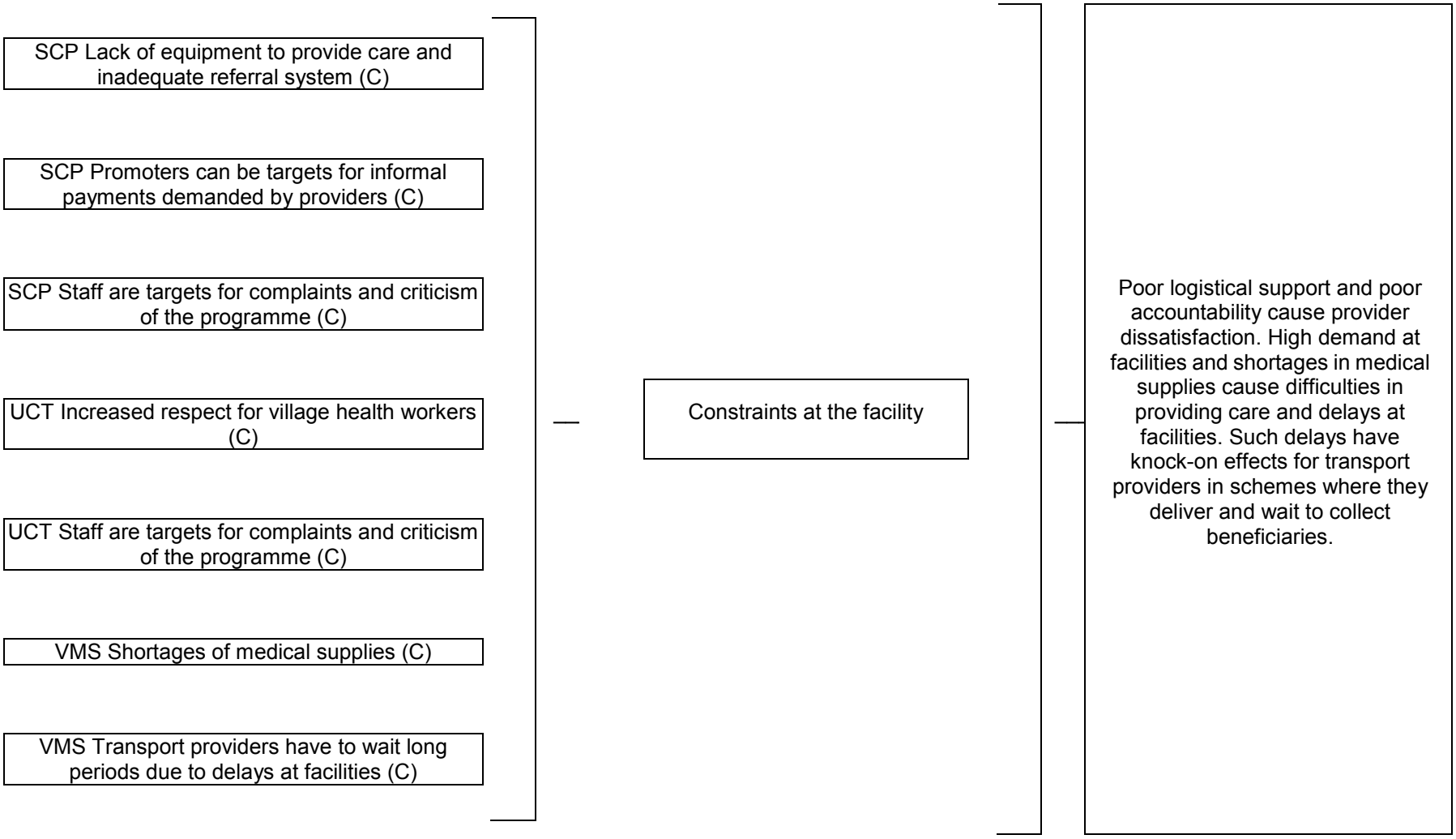

Finding
Category
Synthesised Finding
VMS Participating to help the poor (C)
VMS Seeking increased revenue (C)
Reasons providers joined the DSF scheme
Health care providers joined the schemes both in hope of increasing revenue and to help the poor to access health care.
SCP Family resistance and security issues for facilitators (C)
SCP Money not available in advance, resulting in out of pocket expenditure (C)
Barriers to the participation of facilitators
Programme facilitators face social and financial barriers to joining DSF programmes
SCP Difficulty enforcing selection criteria (C)
Problems in the beneficiary selection process
People tasked with voucher distribution may have difficulties enforcing eligibility criteria, because they find selection criteria are unfair and difficult to


UCT Difficulty enforcing selection criteria (C)
VMS Difficulty enforcing selection criteria (C)
VMS Local government interference in selection of beneficiaries (C)
enforce (e.g. exclusion of high parity women) or because they encounter pressure from local politicians to ignore scheme criteria and favour non-eligible women.




SCP Reimbursements too small (C)
VMS Asking patients to buy medicines elsewhere (C)
VMS Lack of payment for administrative duties (C)
VMS Loss of informal payments (C)
VMS Loss of morale following reduction in reimbursements (C)
VMS Reimbursements too small (C)
SCP Delayed/irregular reimbursements (C)
VMS Delayed/irregular reimbursements (C)
Problems with reimbursement amounts for providers
Problems with the process of reimbursement for providers
Health care providers often feel that the level of payments to them is inadequate and poor compensation for increased administrative burden. Unclear and slow reimbursement procedures can compound frustration and cause private providers to withdraw from schemes.


VMS Inadequate/unauthenticated documents submitted by providers to demonstrate client eligibility and proof of services provided (C)
VMS Lack of guidelines and procedures (C)


SCP Lack of equipment to provide care and inadequate referral system (C)
SCP Promoters can be targets for informal payments demanded by providers (C)
SCP Staff are targets for complaints and criticism of the programme (C)
UCT Increased respect for village health workers (C)
UCT Staff are targets for complaints and criticism of the programme (C)
VMS Shortages of medical supplies (C)
VMS Transport providers have to wait long periods due to delays at facilities (C)
Constraints at the facility
Poor logistical support and poor accountability cause provider dissatisfaction. High demand at facilities and shortages in medical supplies cause difficulties in providing care and delays at facilities. Such delays have knock-on effects for transport providers in schemes where they deliver and wait to collect beneficiaries.

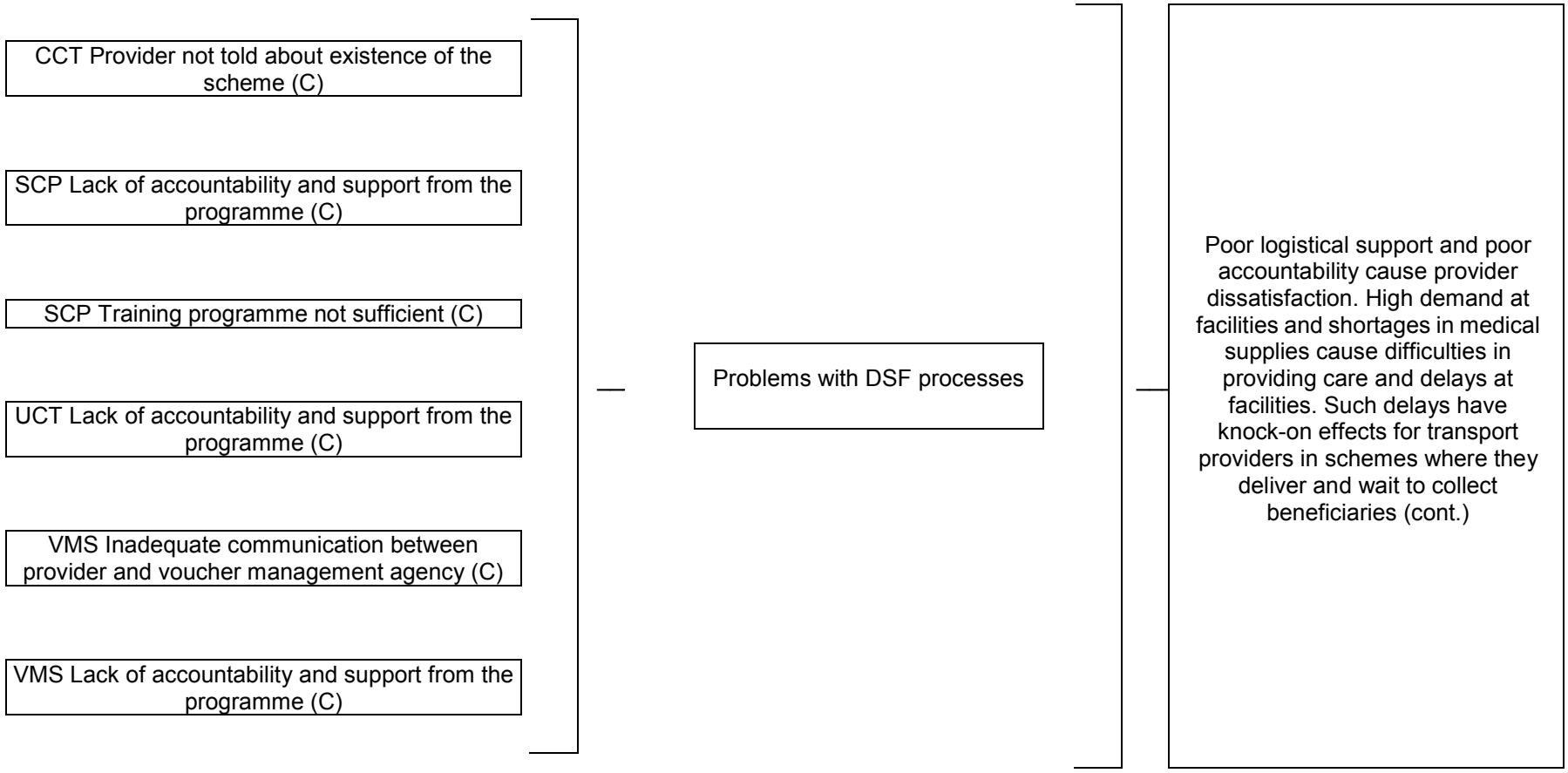


Figure 3. Meta-synthesis of findings on experiences of those who provide services through DSF (Question 11)

Notes: UCT refers to unconditional cash transfers; CCT refers to conditional cash transfers; SCP refers to short term payments to offset the cost of accessing maternal health services; VMS refers to vouchers for maternal health services; (C) refers to „credible", as per JBI-QARI levels of credibility

Categorisation and Synthesis of Findings (Question 11)

The composition of each synthesised finding is described below.

Health care providers joined the schemes both in hope of increasing revenue and to help the poor to access health care.

A synthesised finding on why service providers joined the voucher scheme was supported by modest evidence from one category on motivation for joining the scheme. This category consisted of two findings, helping the poor and increasing revenue, supported by similar evidence from Bangladesh and India. An extract from a study on the Maternal Health Voucher Scheme in Bangladesh refers to both findings:

> *„About three-quarters of the providers we interviewed said they enjoy working with the voucher program. Some of the reasons they shared were that poor patients were now receiving services; that child and maternal mortality had decreased; that family planning activities had increased; and that the reputation of the UHC [upazila health complex] had benefited. "Though we are doing hard work, we are satisfied that the poor patients are receiving services." – Senior staff nurse"*[53] *(p. 116)*

> *„Though the amount is small, we get some money for conducting normal delivery, cesarean delivery, providing PNC [postnatal care] services, which is extra income. – Gynae [gynaecology] consultant"*[53] *(p. 116)*

> *„Due to this DSF program, the number of patients at our health center has comparatively increased. Mothers are getting money and for this (sic) poverty is decreasing to some extent. – Family Welfare Visitor"*[53] *(p. 116)*

Programme facilitators face social and financial barriers to joining DSF programmes.

This synthesised finding was supported by two findings from studies of JSY in India, resistance from family members and out of pocket expenditure. An example of the latter came from a study of JSY in the Indian state of Bihar:

> *„ASHAs said that they do not get monetary assistance in advance to pay for the expenditure incurred for taking and getting an institutional delivery done, whereas the women who is about to deliver does not want to spend any money because she feels that institutional delivery at*

> *government hospitals are "free" and she is not supposed to pay. ASHAs reported that they should be remunerated at every stage starting from registration itself, which will encourage them to work more."*[75] *(p. 206)*

People tasked with voucher distribution may have difficulties enforcing eligibility criteria, because they find selection criteria are unfair and difficult to enforce (e.g. exclusion of high parity women) or because they encounter pressure from local politicians to ignore scheme criteria and favour non-eligible women.

Two findings were used to form a category on problems in the process of beneficiary selection. This category was used as modest evidence for a synthesised finding on challenges faced applying selection criteria for voucher distribution. The findings, on difficulties applying selection criteria and interference from local officials, came from studies of the Dr Muthulakshmi Maternity Assistance Scheme in India, the Safe Delivery Incentive Programme in Nepal and the Maternal Health Voucher Scheme in Bangladesh. An excerpt from one study supported both findings:

> *„The main challenge in distributing vouchers mentioned by providers was handling pressure from ineligible recipients. This type of pressure was experienced especially by FWAs [Family Welfare Assistants], CSBAs [Community Skilled Birth Attendants], and FWVs [Family Welfare Visitors] in all the sampled upazilas; one provider even noted that she had been threatened by an ineligible recipient. In two upazilas, a small number of providers mentioned that they had been pressured by local government officials to distribute vouchers to ineligible women. In contrast, one nurse reported that local government representatives were blocking the distribution of vouchers to eligible poor women."*[53] *(p. 44)*

In the short term, increased patient flow can drastically increase the health facility workload. In the medium and long term increased revenue can be used to hire more staff, develop the skills of existing staff and invest in facility infrastructure. Small rural facilities that initially benefit from DSF schemes may then find that competition from larger, better equipped facilities in urban areas impairs their ability to attract patients.

A synthesised finding on the effects of changes in the number of patients was supported by good evidence in two categories, each comprising two findings. Evidence to support these came from studies of short term payments to offset costs of access and voucher schemes for maternity services. The first category related to positive effects resulting from changes in patient flow, such as increased revenue and improved development of capacity and capabilities. Both findings came from studies in Uganda, one focusing on health facilities and the other on transport providers:

> *„some providers reported increased revenue as a result of increased workload which enabled them to retain or hire more staff and improve facility infrastructure. Other providers reported gaining more experience and improving their skills as a result of the increased number of clients."* [52] *(p. 10)*

> *„Transporters generally reported that they were happy with the project and had benefitted financially from the scheme as illustrated by the selected quotes below from the focus group discussions conducted with transporters. "…….for me my life has greatly changed as a result of this project. Before this project I was badly off but I have now managed to secure another motorcycle out of this project, I have bought 2 cows out of this project; I am also plastering my house and I am managing to pay fees for my children out of the money I am getting from this project and I have managed to sustain my family very well……."* [51] *(p. 5)*

The second category related to negative effects, supported by findings on increased workload in some facilities, or the loss of patients in other facilities. Providers in six studies reported increased workload as a result of DSF schemes in Bangladesh, India and Uganda. In one example in Bangladesh a „respondent" described the following:

> *"Our work load is too much compared to before. This problem can be solved by providing manpower from the NGOs [non-governmental organisations] to assist our work." – CSBA [Community Skilled Birth Attendant] "More vaginal deliveries are taking place in our health complex since the voucher program started. As a result we have to follow up different problems of the newborns also. We cannot give enough time to the inpatient and outpatient departments as we are to concentrate on the voucher program. More efficient workforce should be appointed."* [53] *(p. 50)*

In contrast, some providers in rural areas (the marzes) in Armenia described how the Obstetric Care State Certificate programme had resulted in a fall in the number of patients that they saw:

> *'The problem is that the total number of deliveries is very low, thus the bonus mechanism does not work [for the marzes]. At the beginning [of the Program], for example, when women did not consider the possibility of delivering in Yerevan, all the expecting mothers came to our hospital and I was paid half-a-million drams for the first month. Now I am paid about 120,000 drams per month – nothing comparable.'* [29] *(p. 16)*

Health care providers often feel that the level of payments to them is inadequate and poor compensation for increased administrative burden. Unclear and slow reimbursement procedures can compound frustration and cause private providers to withdraw from schemes.

Nine findings were grouped into two categories with good evidence to support a synthesised finding on reimbursements for providers. The first category related to issues with the amount of money reimbursed to providers, drawing on findings from Bangladesh, India, Kenya, Uganda and Armenia. Most commonly providers complained that the amount reimbursed was below that normally charged, as explained in a study on the Vouchers for Health programme in Kenya:

> *'Some private providers still felt that the reimbursable amount was not enough: Although the actual reimbursement rates were negotiated, some private providers felt that the ceiling set was too low. One private provider in Kiambu reported that: "I also feel the amount of money they are giving us is not enough…When it comes to normal delivery, our normal delivery ranges from five to around eight or ten thousands but the OBA [out-based aid programme] they are giving us four thousands…Come to CS [caesarean section], our CS [caesarean section] ranges from about twenty one to around thirty. They are only giving us twenty thousand."[50] (p. 13)*

A finding specific to the Makerere Voucher scheme was the fall in morale among transport providers following a reduction in reimbursement rates:

> *„In March 2010, the payment rates were reduced to between 2,000 and 5,000 Ug sh [Ugandan Shillings] (US$ $0.90 and US$ $2.27) in an attempt to reduce the project costs. Consequently the earnings of the transporters decreased and some of them expressed disappointment with these rates as noted in the flowing expression below from the focus group discussion with transporters: "…….at first this project was good because the payment was good, but when they reduced it, we have also lost morale because of the small pay."[51] (p. 6)*

A finding specific to the Obstetric Care State Certificate programme in Armenia was the loss of informal payments to providers due to increased regulation, as reported below,

> *„the overall income of delivery care obstetrician/gynecologists in both Yerevan and marzes has decreased because informal payments have declined or been eliminated. Overall, all obstetrician/gynecologists of delivery services who participated in the study reported that they and their colleagues are not satisfied with their salaries."[29] (p. 17)*

The second category related to problems with the system of reimbursement for vouchers for maternity services. Evidence from the Safe Delivery Incentive Programme in Nepal, JSY and the MAMTA scheme in India, the Maternal Health Voucher Scheme in Bangladesh, and the Vouchers for Health programme in Kenya pointed to the slow speed of reimbursements. The authors of a study on the MAMTA scheme highlighted problems with documentation as a cause of delays:

> *„There are problems in compiling of all documents for submission of claims. There have been inordinate delays in reimbursement of claims by the districts due to inadequate documents as per guidelines. Some of the claims have not been reimbursed for want of required documents like lab report, ultrasound report, justification for referral, proof of caste and residence etc."[28]*

(p. 72)

The authors of an evaluation on the Vouchers for Health programme in Kenya highlighted a lack of guidance and communication between the voucher management agency and providers:

> *„Lack of proper communication between the VMA [voucher management agency] and the providers further undermined the claims and reimbursement process: In-depth interviews with providers showed that they did not receive information detailing what is reimbursed and what is not and the reasons for rejected claims. One provider in Kiambu noted that: "Feedback is not good at all because you write to them, you communicate through the mobiles, you call them for meetings but you just discuss. There is no solution to it." For effective implementation, there is need for continuous flow of information not only between the VMA [voucher management agency] and the service providers but among all partners involved in the program."*[50] *(p. 8)*

Health care providers in Nepal described a number of mechanisms to ensure that women received at least some of the money they were entitled to through the Safe Delivery Incentive Programme:

> *„A number of ways to deal with the unpredictability of funds were described. These included: making payment on a first come first served basis; providing money out of one's own pocket; giving a smaller amount of money to share the cash across a larger number of women; and borrowing from other sources. Some district health offices used funds from other health programmes, whilst some health institutions borrowed from their own account. Some district officials, who were reluctant to borrow, worried that donor funds may not materialise, or felt it was risky to borrow without approval."*[40] *(p. 6)*

Poor logistical support and poor accountability cause provider dissatisfaction. High demand at facilities and shortages in medical supplies cause difficulties in providing care and delays at facilities. Such delays have knock-on effects for transport providers in schemes where they deliver and wait to collect beneficiaries.

The final synthesis on the views of providers focused on their experiences of supply-side constraints in voucher schemes. Ten findings were analysed in two categories to provide good evidence for this synthesis. The first category related to constraints at the facility level, which providers referred to in ten studies. In an evaluation of the Maternal Health Voucher Scheme in Bangladesh, the authors described shortages in medical supplies:

> *'Most providers noted that shortages of medicines, supplies and equipment hindered their ability to provide services to voucher recipients. When asked how they coped with these shortages, the most common response was that they encouraged patients to purchase prescribed medicines from an outside source. These purchases, of course, would not be*

subsidized by the DSF program."[53] (p. 50)

The knock-on effect of such delays was described by transport providers in the Makerere Voucher Scheme in Uganda:

„The transport providers also complained about the delays that they encountered at the health facilities. They would have preferred to take the mother to the unit, wait for them and then return her back home. However, as a result of the high turn up of mothers and the shortage of health workers, at times the transporters had to wait for long periods for the mothers to be attended to."[51] (p. 9)

Respondents in a number of studies described the difficult role they had as the interface between women and the DSF scheme, for example:

„according to a Medical Officer, his PHCs [Primary Health Clinics] had no funds for the last three months and approximately 100-150 new mothers had to return empty handed, creating a sense of dissatisfaction among them. They would constantly come to demand money from the ANM [auxiliary nurse-midwife] and the hospital staff, causing problems."[72] (p. 46)

The final category within this synthesis related to structural problems in the DSF scheme, for example insufficient training of facilitators, lack of accountability and poor communication between agencies and providers. The excerpts came from studies of the Safe Delivery Incentive Programme in Nepal and the Maternal Health Voucher Scheme in Bangladesh, respectively:

„Many respondents were unclear about aspects of the policy. They reported that there had been inadequate dissemination of information to the districts. The confusion created variations in implementation and affected the ability of health workers to disseminate information in communities, potentially hampering the effectiveness of the programme. District officials and health workers were often confused about how to implement the programme, finding the official guidelines issued by central government unhelpful, confusing and lacking in detail. There were reports of late distribution of guidelines and insufficient copies, which restricted their ability to implement the policy: "The centre was so miserly to send only one guideline. How do they think that this is sufficient to run [the programme] in such a big district?" (District stakeholders, Plains, Focus group discussion) "Most importantly, the staff should be properly oriented before launching the programme." (Health post, Mountain, Key informant interview)"[40] (p. 6)

„A few individuals mentioned that they did not enjoy receiving criticism and pressure from ineligible women and local politicians. A lack of accountability and a lack of logistical support were also mentioned."[53] (p. 116)

Review question 12. Are there any ethical issues that arise from specific components of DSF measures, for example conditionalities?

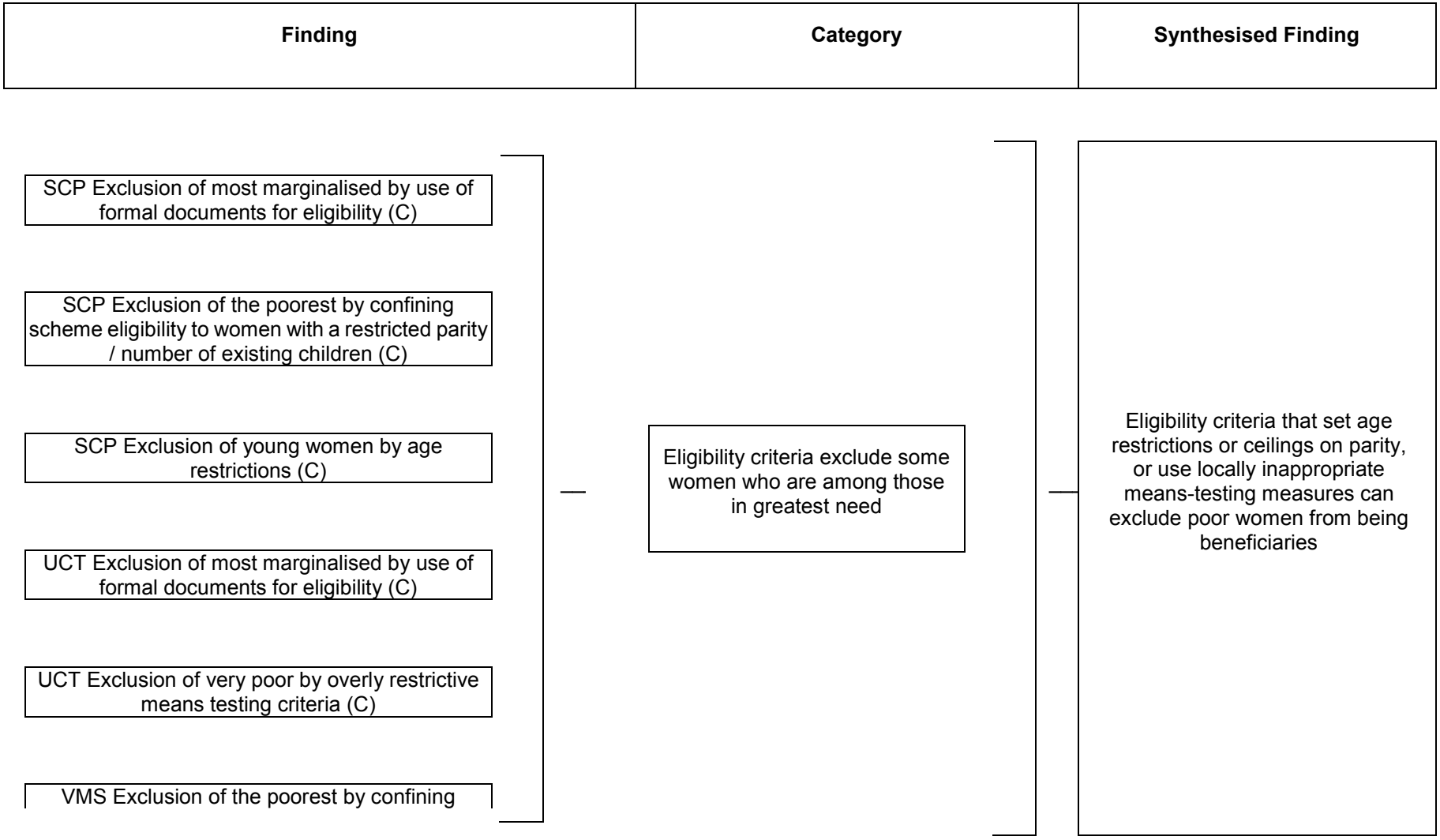
Twenty-two qualitative studies reported findings relevant to this review question, although this was not the main focus of any of the included studies. They were divided among the five modes of DSF as follows:

- *No studies on unconditional cash transfers*
- *Two studies on conditional cash transfers*[43, 57]
- *Eleven studies on short term payments to offset costs of access*[40, 42, 54, 58, 61, 70-72, 74-76]
- *Eight studies on vouchers for maternity services*[22, 25, 28, 29, 38, 50, 52, 53]
- *One study on vouchers for merit goods.*[41]

Evidence on ethical issues in conditional cash transfers came from studies on the Juntos Programme in Peru and the Bono Juana Azurduy in Bolivia,[43] and the Program Keluarga Harapan in Indonesia.[57] The short term payments to offset costs of access included in this review question were the Safe Delivery Incentive Programme in Nepal,[40] and JSY in India.[42, 54, 58, 61, 70-72, 74-76]

The voucher studies were focused on the Maternal Health Voucher Scheme in Bangladesh,[22, 38, 53] the MAMTA scheme in India,[28] a voucher scheme in Cambodia,[25] the Vouchers for Health programme in Kenya,[50] the HealthyBaby scheme in Uganda,[52] the Obstetric Care State Certificate programme in Armenia,[29] and the Tanzania National Voucher Scheme.[41]

Nine findings related to ethical issues arising from DSF schemes. These were grouped into three categories and two synthesised findings. Figure 4 shows these relationships.



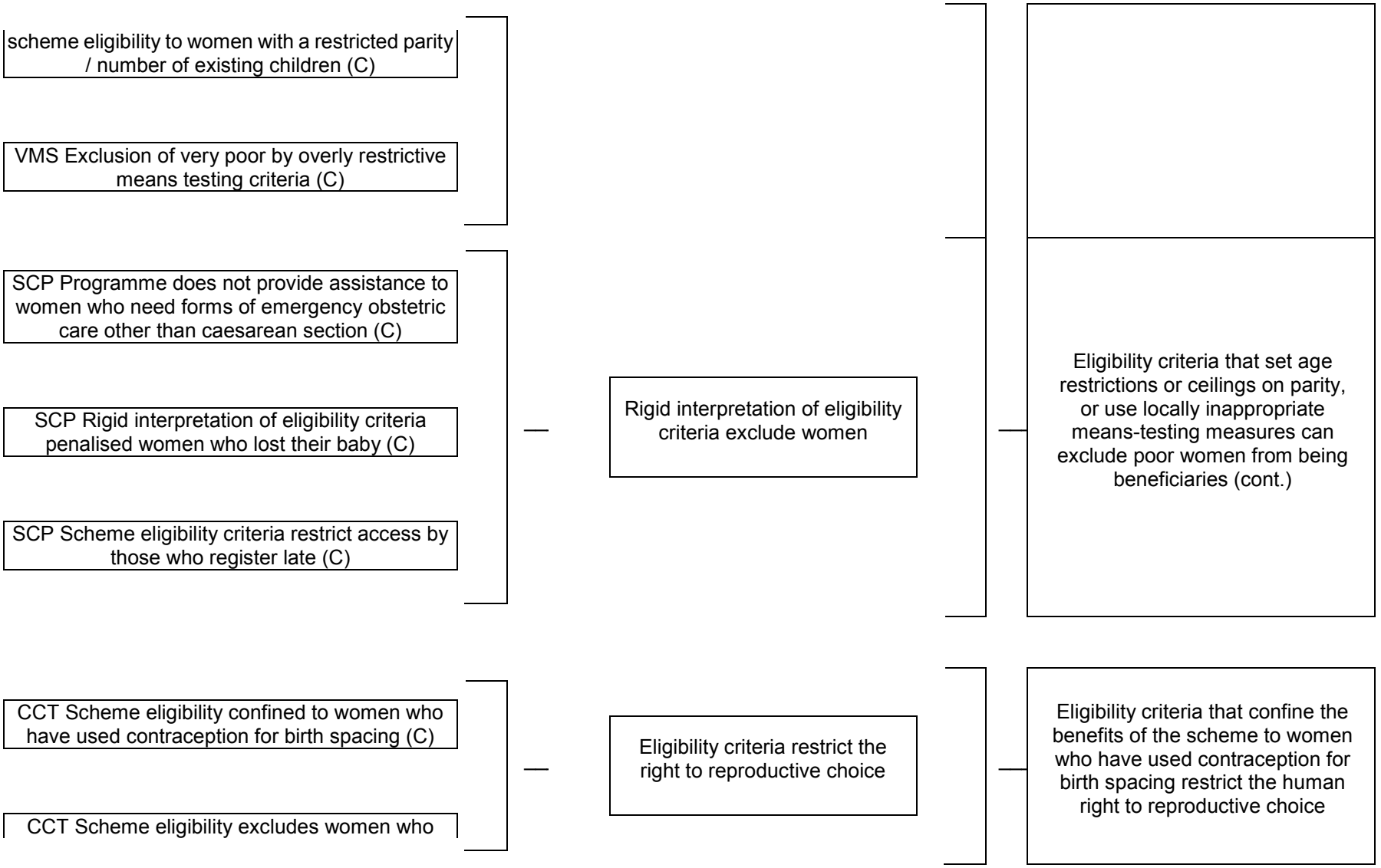

scheme eligibility to women with a restricted parity / number of existing children (C)
VMS Exclusion of very poor by overly restrictive means testing criteria (C)
SCP Programme does not provide assistance to women who need forms of emergency obstetric care other than caesarean section (C)
SCP Rigid interpretation of eligibility criteria penalised women who lost their baby (C)
SCP Scheme eligibility criteria restrict access by those who register late (C)
Rigid interpretation of eligibility criteria exclude women
Eligibility criteria that set age restrictions or ceilings on parity, or use locally inappropriate means-testing measures can exclude poor women from being beneficiaries (cont.)
CCT Scheme eligibility confined to women who have used contraception for birth spacing (C)
CCT Scheme eligibility excludes women who
Eligibility criteria restrict the right to reproductive choice
Eligibility criteria that confine the benefits of the scheme to women who have used contraception for birth spacing restrict the human right to reproductive choice

Figure 4. Meta-synthesis of findings on ethical issues associated with DSF (Question 12)

Notes: UCT refers to unconditional cash transfers; CCT refers to conditional cash transfers; SCP refers to short term cash payments to offset the cost of accessing maternal health services; VMS refers to vouchers for maternal health services; (C) refers to „credible", as per JBI-QARI levels of credibility

Categorisation and Synthesis of Findings (Q12)

The composition of each synthesised finding is described below.

Eligibility criteria that set age restrictions or ceilings on parity, or use inappropriate means-testing in the local context can exclude poor women from being beneficiaries

Two categories provided modest evidence to support a synthesised finding on the ethical implications of means testing criteria, age restrictions and parity ceilings that resulted in the exclusion of poor women. Four findings were used to form the first category, from studies on the Dr Muthulakshmi Maternity Assistance Scheme in the Indian state of Tamil Nadu, JSY in India, the Safe Delivery Incentive Programme in Nepal, and the Maternal Health Voucher Scheme in Bangladesh. The first finding related to overly restrictive targeting criteria, as described below:

> *„Among respondents from means-tested areas, about one-third supported the criteria while two-thirds found them to be unreasonable. The main criticisms were that the land ownership and income criteria were too strict. Representative quotes included: "The land ownership criterion of 0.15 [acres] should be raised to 0.30, because people from the lowest economic quintile have more land." – Civil Surgeon.[53] (p. 29)*

> *"Those who are considered to be ultra poor in the present context need more than Tk. [Bangladesh Taka] 2,500 to survive, eating even only rice and pulses.…these ultra poor people are excluded from the program. That is why it is better to change it and raise the [income threshold] to Tk. [Bangladesh Taka] 4000." – other respondent".[53] (p. 29)*

The second and third findings related to the exclusion of young women and those women who had more than two children, both of which are evidenced below:

> *The "population control" approach has found its way into the JSY as well. In the non-Empowered Action Group states, JSY benefits are restricted to women above age 19 for up to two live births. This short changes the medical needs of young mothers and pregnant women with multiple pregnancies. [54] (p. 41)*

The final finding related to the requirement for formal documents from women and the consequent exclusion of the most marginalised, for example:

> *„Explaining how she finds it hard to help poor women, one ASHA said, "The people who are really poor don't have these things [below poverty line cards] and many others who are better off have BPL [below poverty line cards] cards. So that is a big problem.""[54] (p. 56)*

Eligibility criteria that confine the benefits of the scheme to women who have used contraception for birth spacing restrict the human right to reproductive choice

The final synthesis on ethical issues focused on women"s right to reproductive choice. This was supported by modest evidence from one category for restrictions in reproductive choice as a result of the Bono Juana Azurduy in Bolivia and the Maternal Health Voucher Scheme in Bangladesh. The first finding that was included in this category related to eligibility requirements for birth spacing and the use of contraception, as evidenced below.

> *„Several responses mentioned that the 2-child maximum for voucher eligibility has also discouraged women from having larger families. "As they are adopting family planning between 1st and 2nd child they are getting voucher card. Some of them are doing ligation during caesarean." – FWV [Family Welfare Visitor"[53] (p. 116)*

> *"During the implementation of the DSF program, it is also said that the mothers who have more than 2 children will not receive the benefits of the DSF; they are discouraged. Thus the family planning program is benefited." – DSF Coordinator"[53] (p. 116)*

The second finding related to the exclusion of women who had recently had an abortion. Both findings are evident in the excerpt below:

> *„In Bolivia, the conditionalities with which women had to comply to receive the bono were seen as controlling women"s reproductive choices and some of the key informants considered that the BJA [Bono Juana Azurduy] violates women"s sexual and reproductive rights. For example, the programme tries to impose birth spacing by not allowing women to claim a second cash transfer if they become pregnant again within two years of a previous birth. When women have an abortion or miscarriage they are not allowed to apply for a transfer for another three years, they are told this is for medical reasons but informants considered it was unfairly penalising these women."[43] (p. 205)*

Review question 13. What is the social meaning (in terms of empowerment, entitlement and combating stigma) of DSF measures for women in low- and middle-income countries?

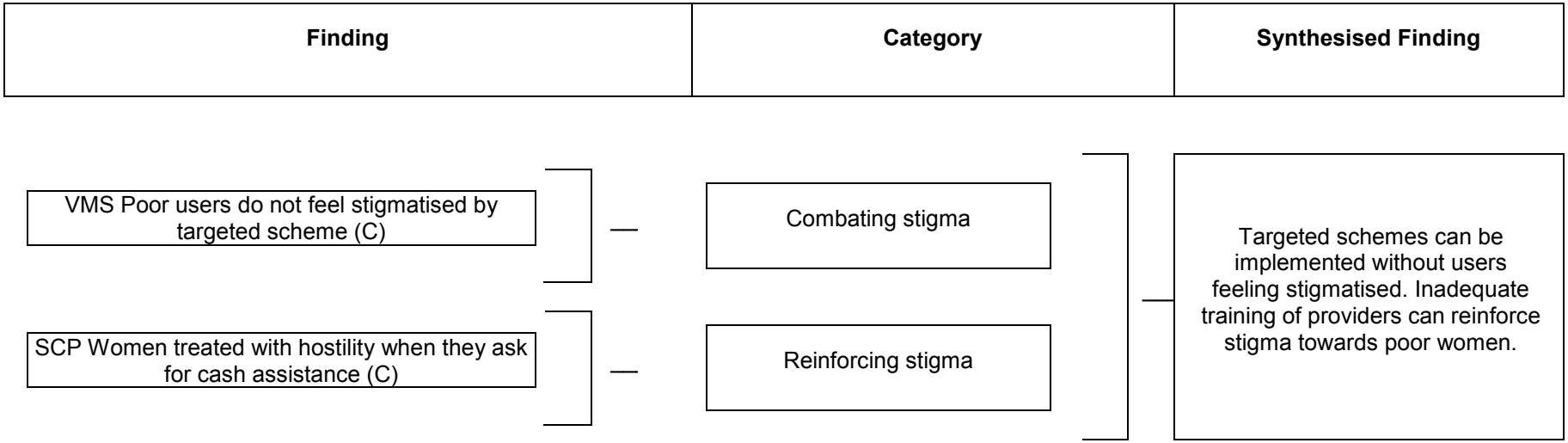
Twenty-two qualitative studies reported findings relevant to this review question, although none had this question as its primary focus. Studies were categorised by the five modes of DSF as follows:

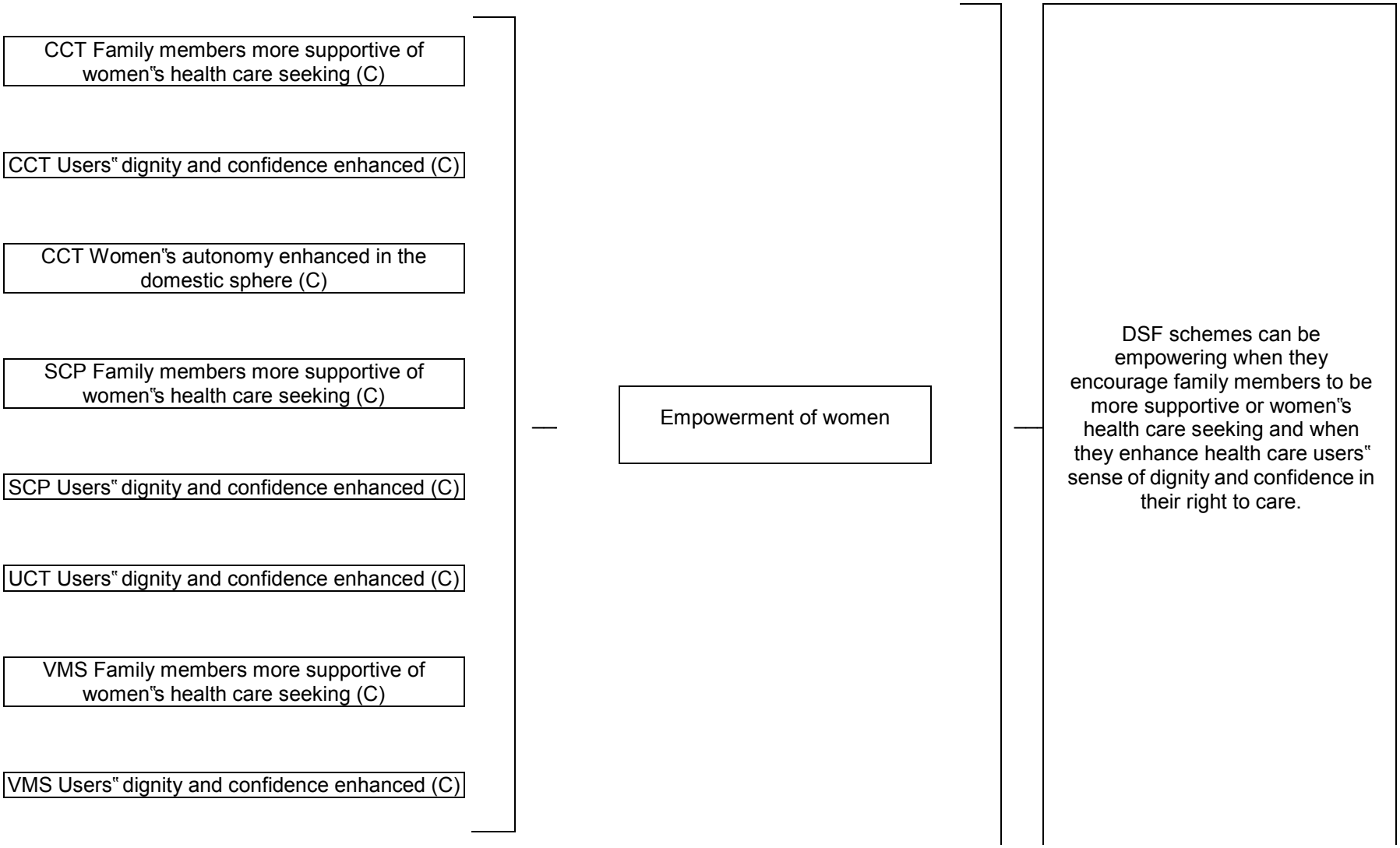
- *One study on unconditional cash transfers*[11]
- *Two studies on conditional cash transfers*[43, 57]
- *Six studies on short term payments to offset costs of access*[39, 42, 54, 61, 72, 74]
- *Six studies on vouchers for maternity services,*[22, 25, 29, 38, 48, 53]
- *One study on vouchers for merit goods.*[46]

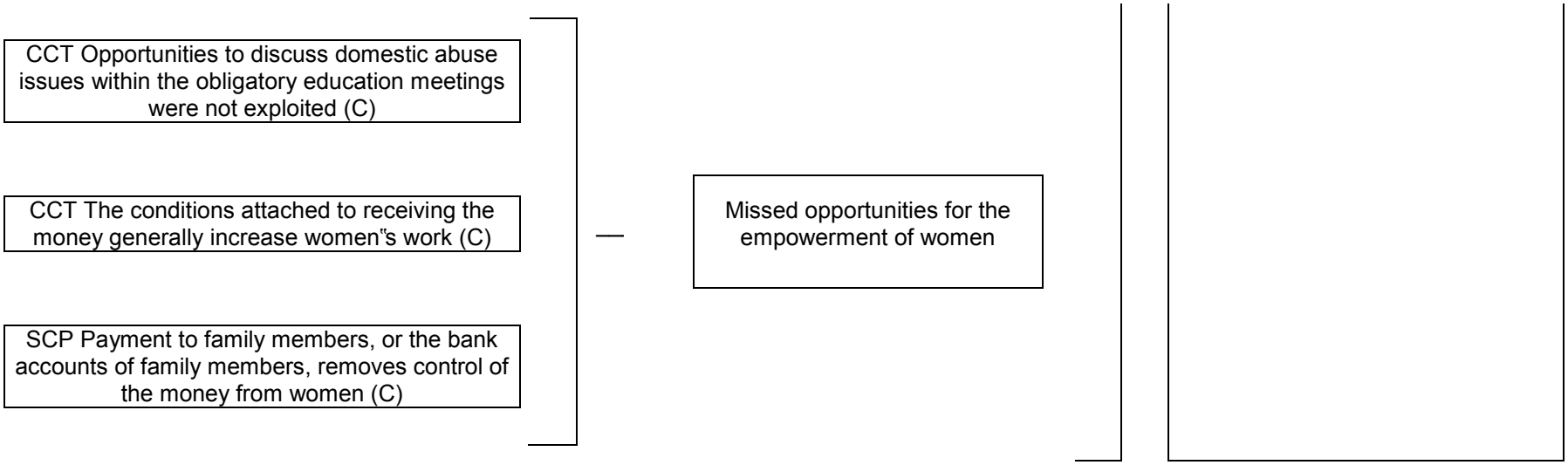
The unconditional cash transfer included in the review was the Dr Muthulakshmi Reddy Memorial Maternity Assistance Scheme in the Indian state of Tamil Nadu.[11] The conditional cash transfers were the Juntos Programme in Peru and the Bono Juana Azurduy in Bolivia, and Program Keluarga Harapan in Indonesia.[43, 57] The studies on short term payments to offset costs of access were all on JSY in India.[51, 66, 71, 75, 77, 78]

The voucher schemes included in this question were: a pilot voucher scheme in Bangladesh,[48] the Bangladesh Maternal Health Voucher Scheme,[22, 38, 53] a voucher scheme in Cambodia,[25] the Obstetric Care State Certificate programme in Armenia,[29] and the Tanzania National Voucher Scheme.[46]

This was not a well-researched area and only twelve findings were identified. These were used to form six categories relating to the social meaning of voucher schemes for women in low- and middle-income countries. The analysis of these six categories led to three synthesised findings. This is shown in Figure 4.




CCT Family members more supportive of women"s health care seeking (C)
CCT Users" dignity and confidence enhanced (C)
CCT Women"s autonomy enhanced in the domestic sphere (C)
SCP Family members more supportive of women"s health care seeking (C)
SCP Users" dignity and confidence enhanced (C)
UCT Users" dignity and confidence enhanced (C)
VMS Family members more supportive of women"s health care seeking (C)
VMS Users" dignity and confidence enhanced (C)
Empowerment of women
DSF schemes can be empowering when they encourage family members to be more supportive or women"s health care seeking and when they enhance health care users" sense of dignity and confidence in their right to care.


CCT Opportunities to discuss domestic abuse issues within the obligatory education meetings were not exploited (C)
CCT The conditions attached to receiving the money generally increase women"s work (C)
SCP Payment to family members, or the bank accounts of family members, removes control of the money from women (C)
Missed opportunities for the empowerment of women

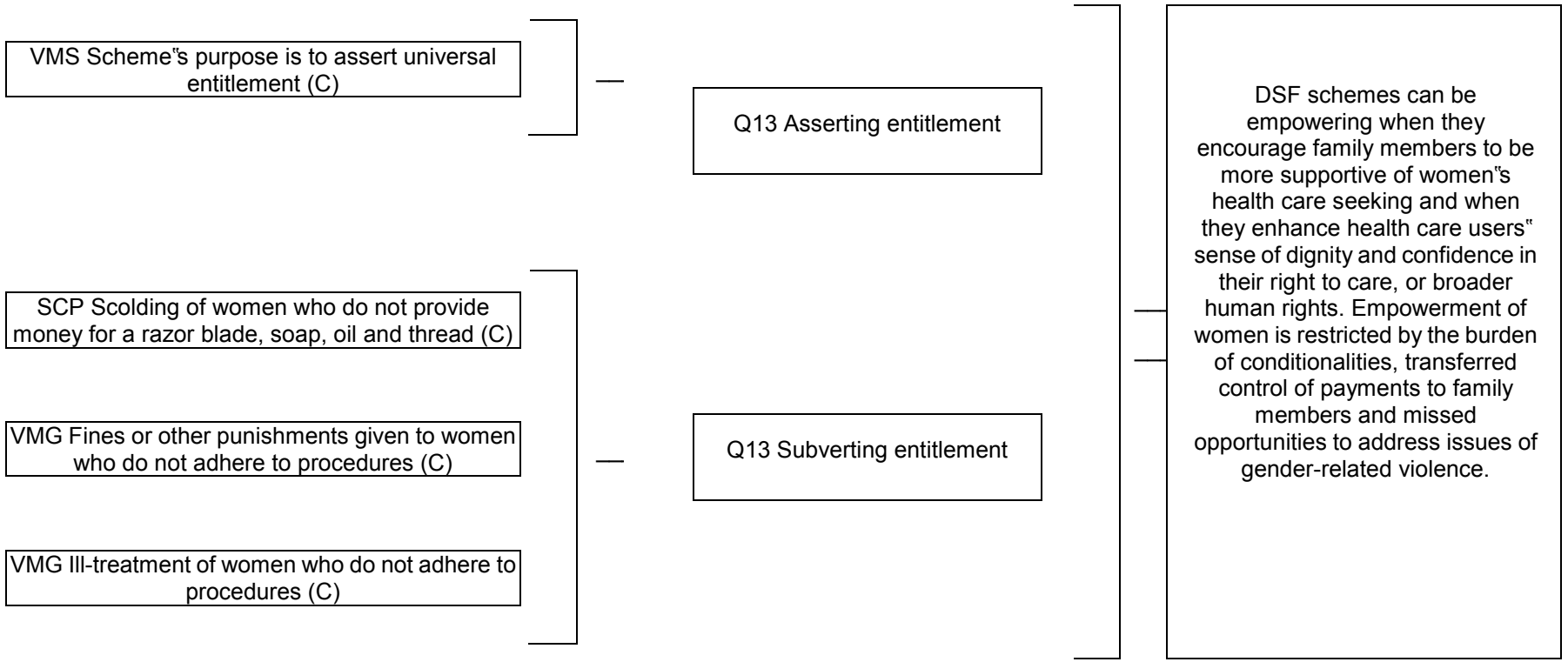


Figure 5. Meta-synthesis of findings on the social meaning of DSF (Question 13)

Notes: UCT refers to unconditional cash transfers; CCT refers to conditional cash transfers; SCP refers to short term payments to offset the cost of accessing maternal health services; VMS refers to vouchers for maternal health services; VMG refers to vouchers for merit goods for maternal health; (C) refers to „credible", as per JBI-QARI levels of credibility

Categorisation and Synthesis of Findings (Q 13)

The composition of each synthesised finding is described below.

DSF schemes can be empowering when they encourage family members to be more supportive of women's health care seeking and when they enhance health care users' sense of dignity and confidence in their right to care, or broader human rights. Empowerment of women is restricted by the burden of conditionalities, transferred control of payments to family members and missed opportunities to address issues of gender-related violence.

Six findings were used to create two categories on empowerment associated with DSF schemes. This provided modest evidence for a synthesised finding on the empowerment of women through voucher schemes. The first category brought together findings that provided examples of the empowerment of women as a result of DSF schemes. Evidence came from all modes of DSF except vouchers for merit goods, in Indonesia, Bolivia, India, Bangladesh and Armenia. The findings related to increased confidence, more support from family members and greater autonomy, as evidenced below:

> *„According to participants, the Program not only provides the patients with free services but also improves the patients" and providers" dignity. Participants indicated that with the Certificate as a state guarantee of free maternity services, women feel more relaxed and self-confident. Moreover, the providers receive their money only through official routes and do not have informal financial relationships with patients or their relatives."*[29] *(p. 15)*

> *„Interestingly, there was universal agreement – across all respondents in all ten upazilas – regarding the positive impact the voucher program has had on the attitudes of husbands and in-laws towards seeking care for pregnant women. Without exception, women indicated that their husbands and mothers-in-law were more likely to support careseeking for antenatal, delivery and postnatal care from health facilities."*[53] *(p. 88)*

> *„Although overall PKH funds were not used appropriately, in terms of management the funds were mostly in the hands of mothers or women in the family. Mothers withdrew funds directly from the post office and usually they spent some of that money directly at the market. In one village in NTT [East Nusa Tenggara province] the fact that PKH [Program Keluarga Harapan] funds were managed by the women lead to jealousy by the men. These men hoped that the unconditional cash transfer (BLT) could be dispersed again and be managed by the head of the family."*[57] *(p. 43)*

The second category related to missed opportunities for the empowerment of women and included three findings, based on evidence from Bono Juana Azurduy in Bolivia and JSY in India. The first finding was on the additional work women must do to fulfil conditions for the Bono Juana Azurduy in Bolivia:

> *„the programmes did not help women address the unequal gender division of labour at home, since .... the conditions attached to receiving the money generally increase women"s work, and do not encourage men"s involvement in child care."*[43] *(p. 207)*

Like many conditional cash transfers in Latin America, women receiving the Bono Juana Azurduy must attend education meetings. A study on this programme highlighted the failure to include issues of domestic abuse in such meetings:

> *„A few women mentioned that men had been involved in training activities, mainly meetings on reducing conflicts in the family. This is part of the remit of gender units in government departments. However, these units do not co-ordinate with the BJA [Bono Juana Azurduy], and the beneficiaries are not generally targeted for these trainings. In our research, only one example was cited of information on the protocols and services relating to gender based violence being given to mothers who attended the clinics. According to one beneficiary who had attended these workshops: „They talk to women about vitamins and iron ... They don"t talk to them about their rights. They should at least have a module on violence and pregnancy" (interview with key informant, La Paz, 29 September 2010)."*[43] *(p. 201)*

The final finding included in this category was on the missed opportunities for greater autonomy among women if payments are given to family members, for example:

> *„Women also reported that they have heard of JSY beneficiaries having difficulty in obtaining the cash incentive. They cited that in the absence of any bank account and required documents, women are forced to open a joint account with other family members, and therefore lose control over the spending of the monetary incentive for their own nutrition or treatment. They said that there are so many cases where the amount is being utilized for other purposes, mainly by the men folk of their families without the consent of the women. "Money is used to get household items. There were also some cases where the husbands used the JSY money to buy liquor."*[74] *(p. 27)*

DSF schemes can be used to assert the principle of universal entitlement, but conversely the principle of entitlement becomes subverted if health care staff ill-treat women who failed to conform with scheme procedures or expectations.

The second synthesised finding on the social meaning of voucher schemes related to issues of entitlement, for which there was modest evidence. Two categories were used to support this synthesised finding, each formed from one finding. The first category related to the assertion of

universal entitlement that voucher schemes can provide, as described for the Obstetric Care State Certificate programme in Armenia:

> *„The purpose of this program was to provide the population access to high quality services without considering their social status. Women receive many benefits from this Program: they can give birth to many children without worrying about the costs; they can come to Yerevan for delivery and stay in the best hospitals receiving the highest quality services for free, that before they could only dream about.“*[29] *(p. 24)*

The second category related to the subversion of entitlement by health care providers, drawing on evidence from JSY in India and the Tanzania National Voucher Scheme. Examples included were the ill-treatment and use of fines for women who did not adhere to procedures, and verbal abuse of women who did not buy their own medical accessories for childbirth:

> *„Psychologically, it would be humiliating to report lack of money for redeeming the ITN [insecticide-treated net] voucher: “If the nurses note that you are still having the voucher provided during the last visit they shout at you, so at times we wait until we get cash for the net before coming back to the clinic”*[46] *(p. 10)*

> *'Moreover, pregnant women risked being penalized in terms of being fined or given some cleaning tasks if they did not adhere to their ANC [antenatal care] schedules. At an FGD [focus group discussion] in Ihalimba village, Mufindi, it was complained that women who registered for ANC [antenatal care] services late in their pregnancy risked receiving a fine of 1000 shilling. This discouraged women who, for any reason, had not registered in time to do so later in their pregnancy“*[46] *(p. 8)*

> *„The relatives of the women who had previously delivered in institutions said they had to buy a new blade, soap, oil, thread and so forth, as these were not provided by the hospital. If the relatives of the woman did not fetch the same, they were chastised by the nurses, who often told them if they wanted „royal“ treatment they should go to a private hospital. Moreover, they also said they were asked to buy medicines from outside and sometimes even saline bottles for which they had to spend extra money. This caused problems because they were not prepared to spend so much money.“*[72] *(p. 45)*

Targeted schemes can be implemented without users feeling stigmatised. Inadequate training of providers can reinforce stigma towards poor women.

The final synthesised finding related to a small amount of information on whether targeting in DSF schemes causes stigma, supported by modest evidence from two categories. The first category

included evidence that DSF schemes do not stigmatise users, from a pilot voucher scheme in Bangladesh:

> *„The voucher users were asked whether they felt stigmatized because the vouchers were intended for the poorest of the poor; the respondents reported that they did not face discrimination.“*[48] *(p. 306)*

The second category included evidence to the contrary, based on a finding from JSY in India:

> *„The cash benefits provided under JSY are also eluding women and during the FGD [focus group discussion] women expressed their deep anger towards the hostility of the system. One of the women said that, “We (poor women) are treated like beggars at these PHCs [Primary Health Clinics]” when they approach PHC [Primary Health Clinic] for JSY money. Women narrated how they were kept waiting for hours, as the person concerned was busy in some other work.“*[74] *(p. 26)*

Review question 14. What are the supply-side and other preconditions for successful DSF implementation?

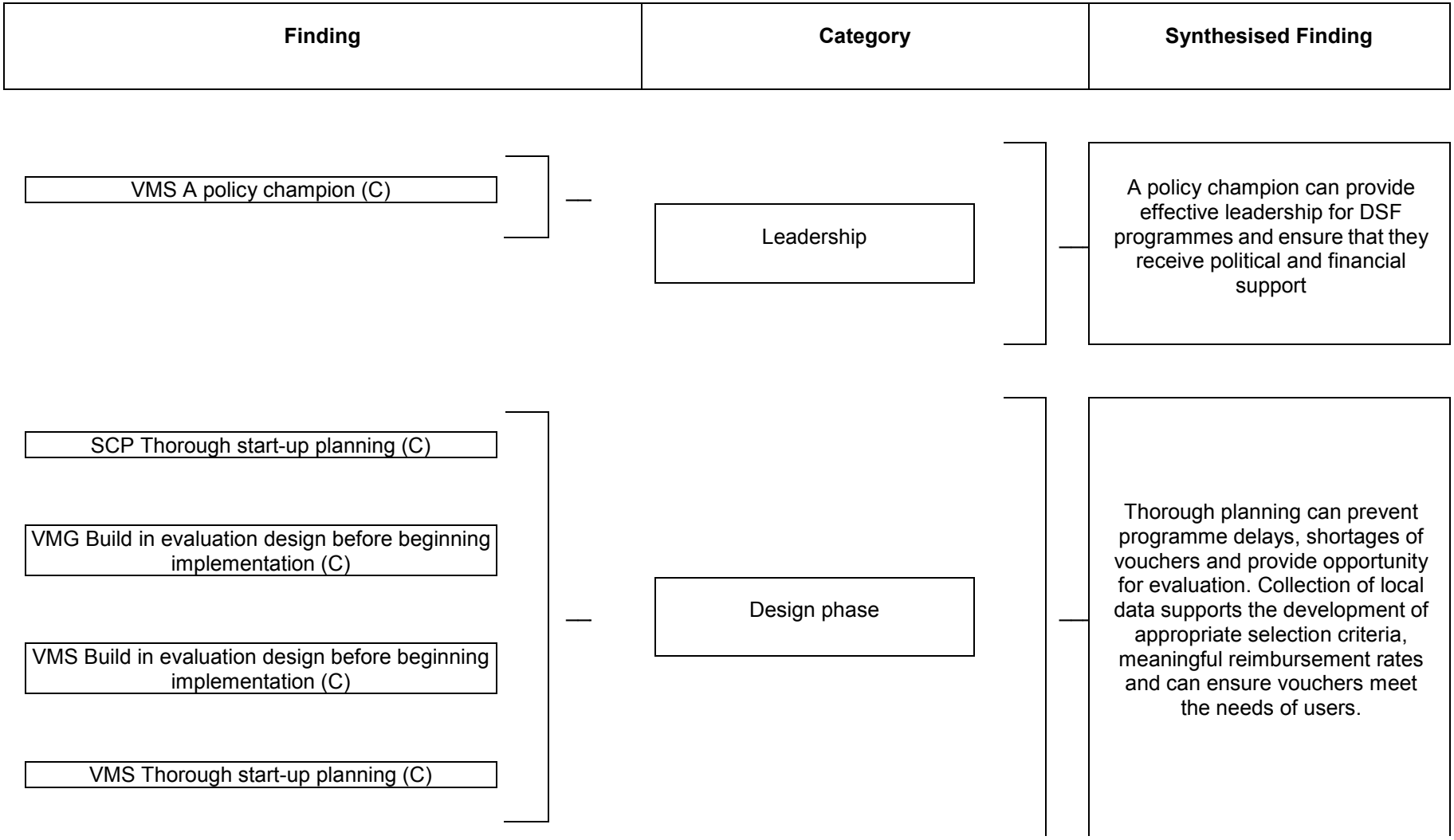
Forty-three qualitative studies reported findings relevant to this review question, divided among the five modes of DSF as follows:

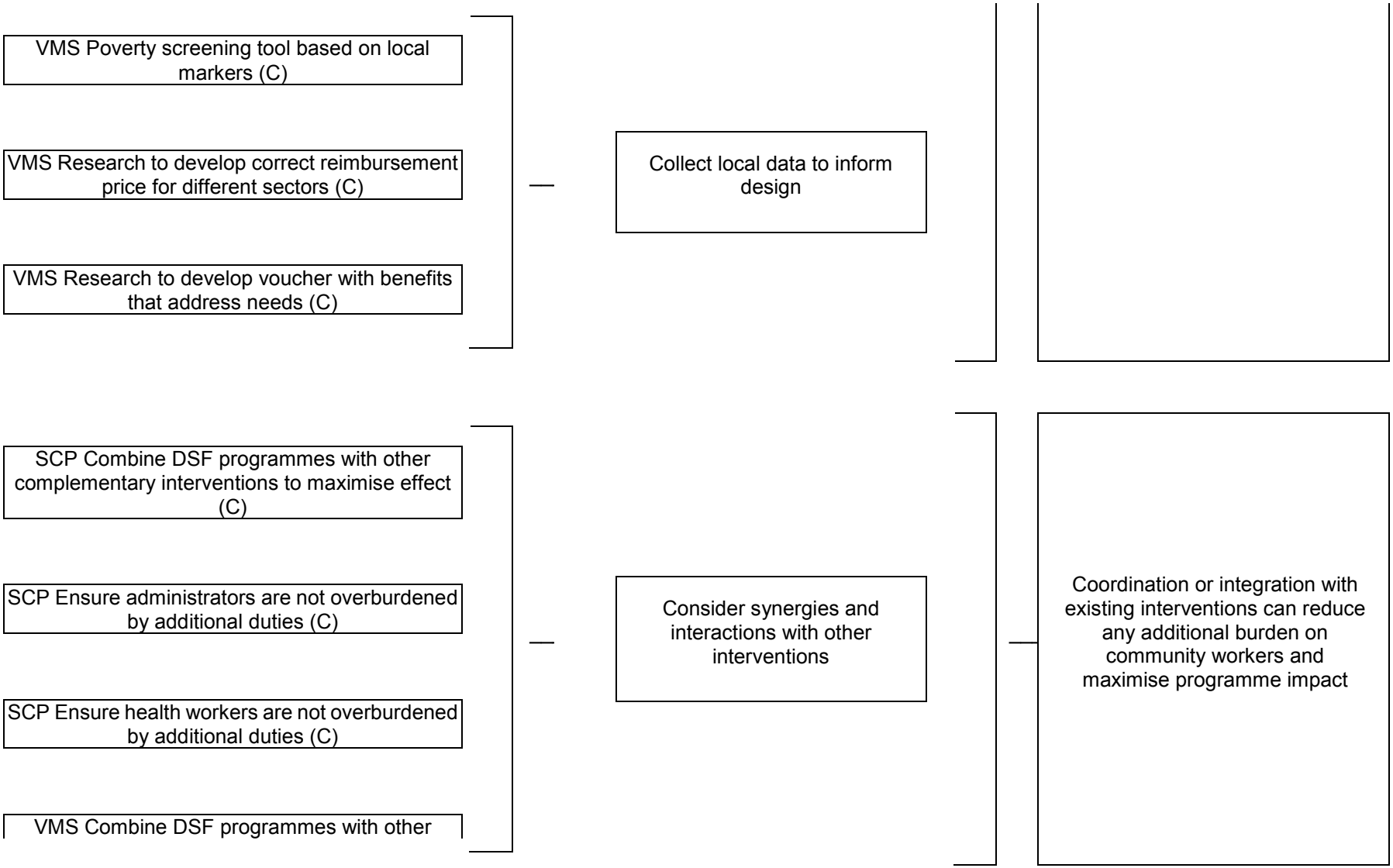
- *No studies on unconditional cash transfers*
- *Two studies on conditional cash transfers*[43, 57]
- *Twenty five studies on short term payments to offset costs of access*[39, 40, 42, 54-56, 58-76]
- *Thirteen on vouchers for maternity,*[22, 23, 25, 28, 29, 38, 45, 48-53]
- *Three with vouchers for merit goods.*[41, 44, 47]

The conditional cash transfers included in this question are the Juntos Programme in Peru and the Bono Juana Azurduy in Bolivia,[43] and Program Keluarga Harapan in Indonesia.[57] The schemes that include short term payments to offset costs of access were the Safe Delivery Incentive Programme in Nepal,[40] and JSY in India.[39, 42, 54-56, 58-76]

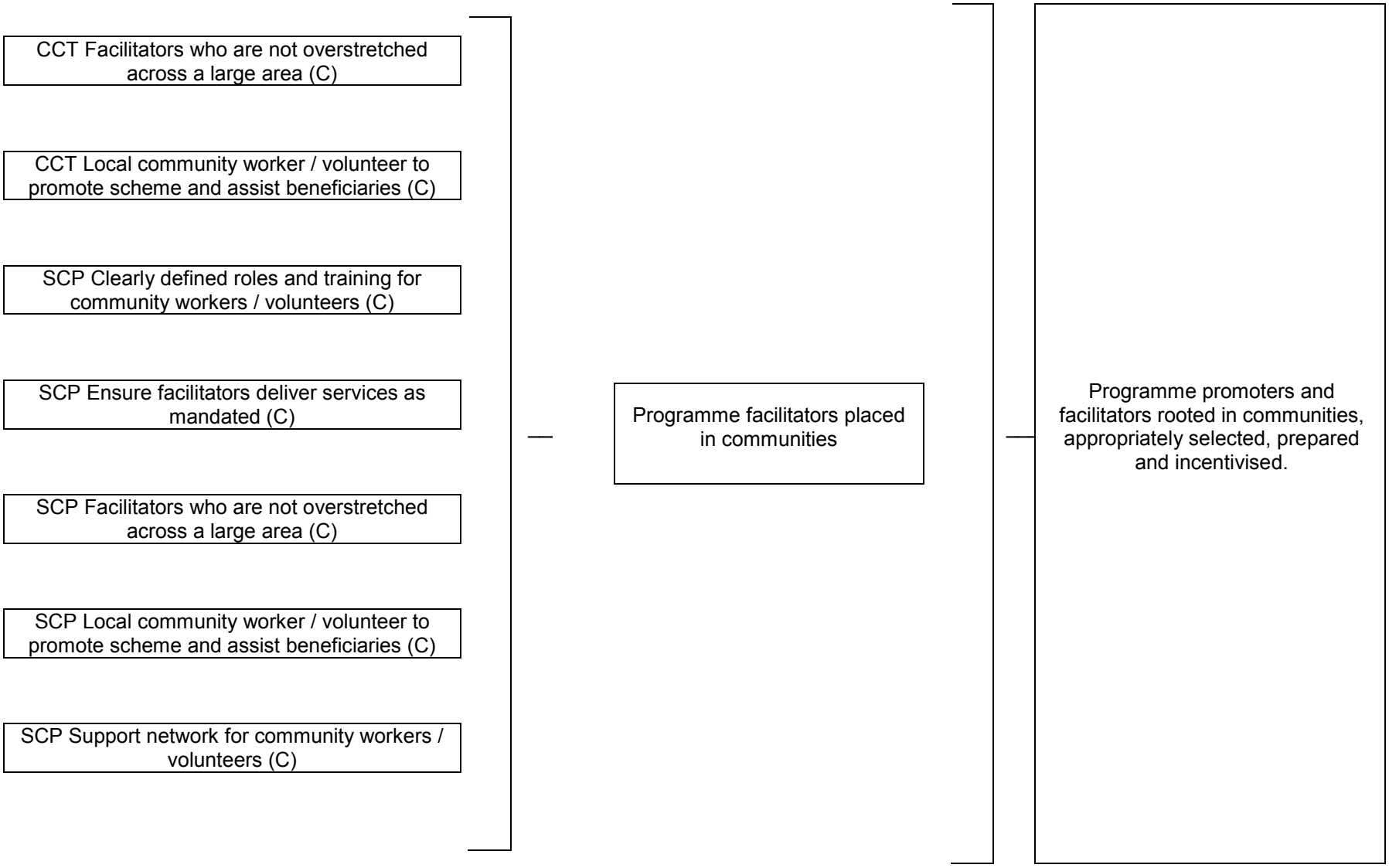
The voucher schemes included in this question are: a pilot voucher scheme and the Maternal Health Voucher Scheme in Bangladesh,[22, 38, 48, 49, 53] Chiranjeevi and MAMTA schemes in India,[28, 45] a voucher scheme in Cambodia,[25] the Vouchers for Health programme in Kenya,[23, 50] the Makerere and HealthyBaby voucher schemes in Uganda,[23, 51, 52] the Obstetric Care State Certificate programme in Armenia,[29] a pilot voucher scheme in the Volta region of Ghana,[44] and the Tanzania National Voucher Scheme.[41, 47]

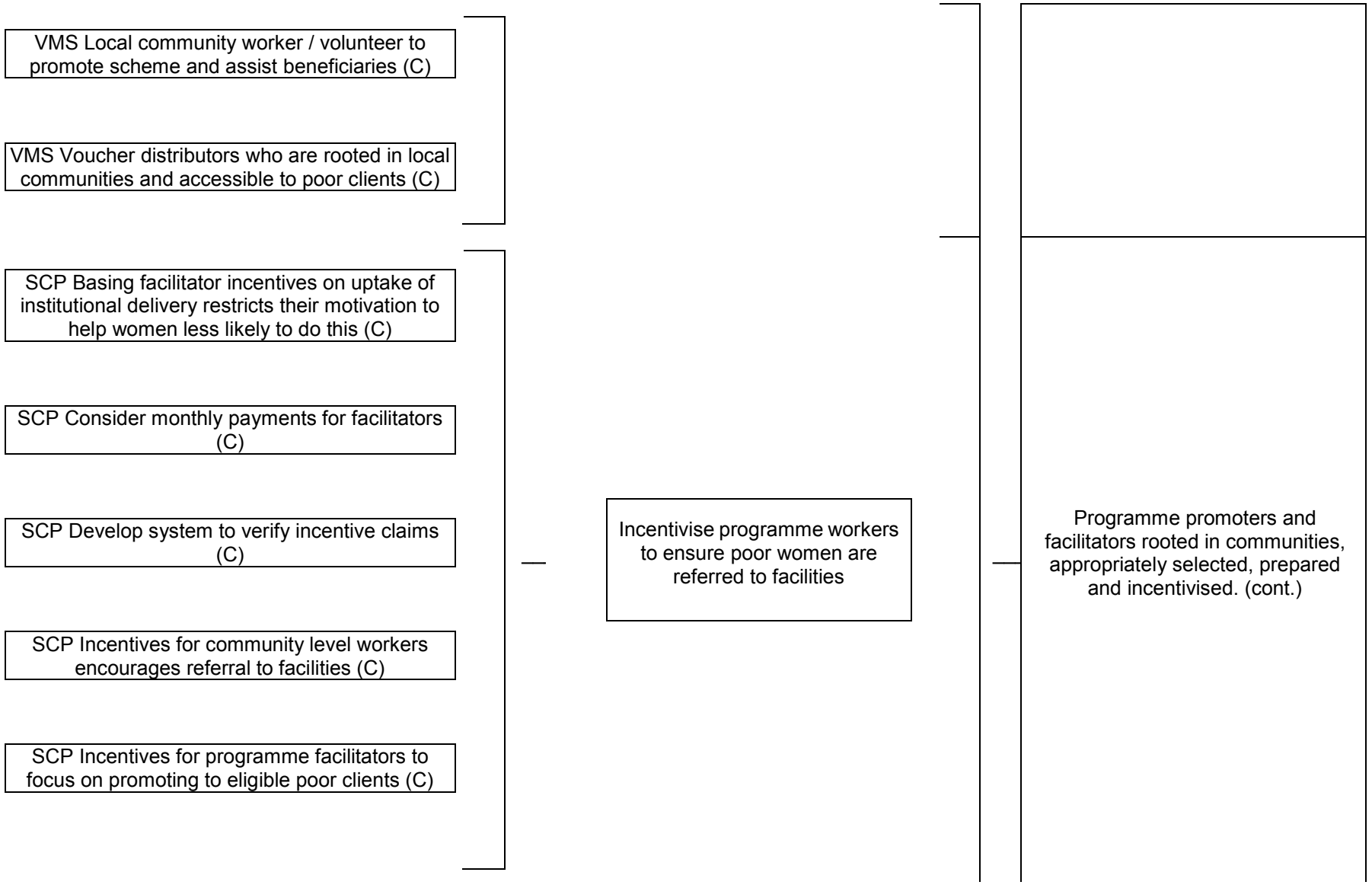
There was good evidence on the preconditions for successful DSF implementation and 92 findings were related to this review question. These were used to create 35 categories which led to 13 synthesised findings. Figure 5 shows these relationships.

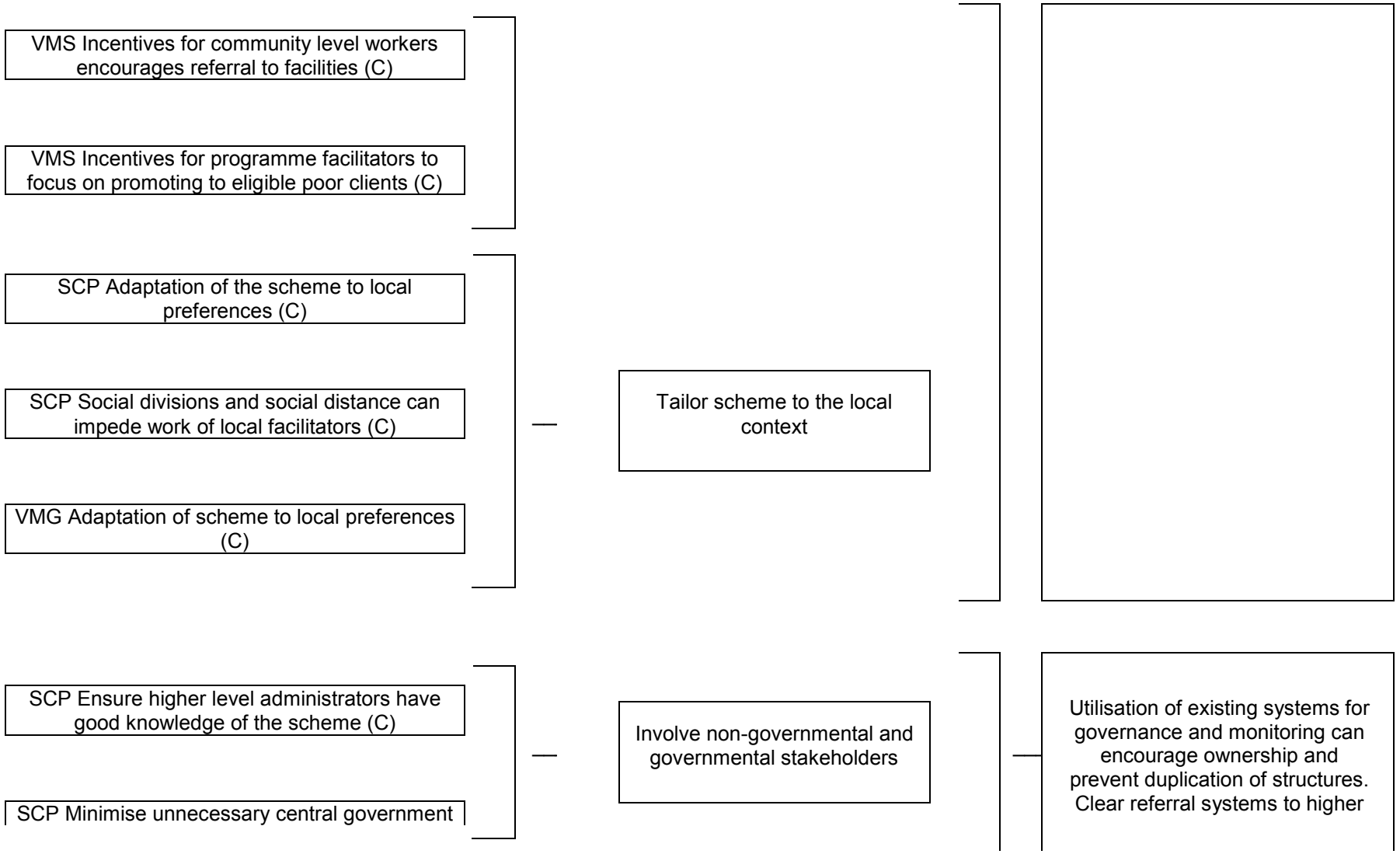

Finding
Category
Synthesised Finding
VMS A policy champion (C)
Leadership
A policy champion can provide effective leadership for DSF programmes and ensure that they receive political and financial support
SCP Thorough start-up planning (C)
VMG Build in evaluation design before beginning implementation (C)
VMS Build in evaluation design before beginning implementation (C)
VMS Thorough start-up planning (C)
Design phase
Thorough planning can prevent programme delays, shortages of vouchers and provide opportunity for evaluation. Collection of local data supports the development of appropriate selection criteria, meaningful reimbursement rates and can ensure vouchers meet the needs of users.

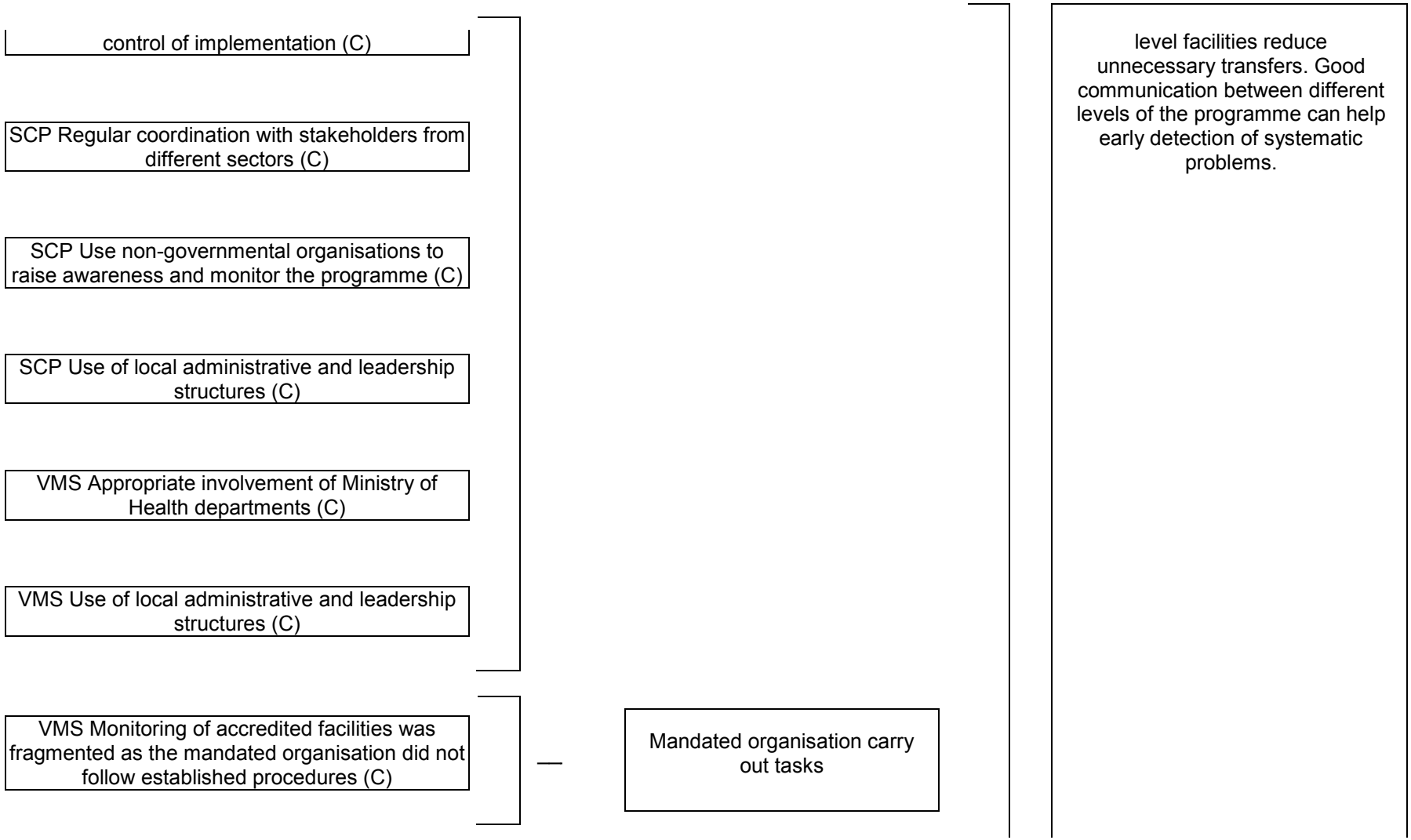

VMS Poverty screening tool based on local markers (C)
VMS Research to develop correct reimbursement price for different sectors (C)
VMS Research to develop voucher with benefits that address needs (C)
Collect local data to inform design
SCP Combine DSF programmes with other complementary interventions to maximise effect (C)
SCP Ensure administrators are not overburdened by additional duties (C)
SCP Ensure health workers are not overburdened by additional duties (C)
VMS Combine DSF programmes with other
Consider synergies and interactions with other interventions
Coordination or integration with existing interventions can reduce any additional burden on community workers and maximise programme impact

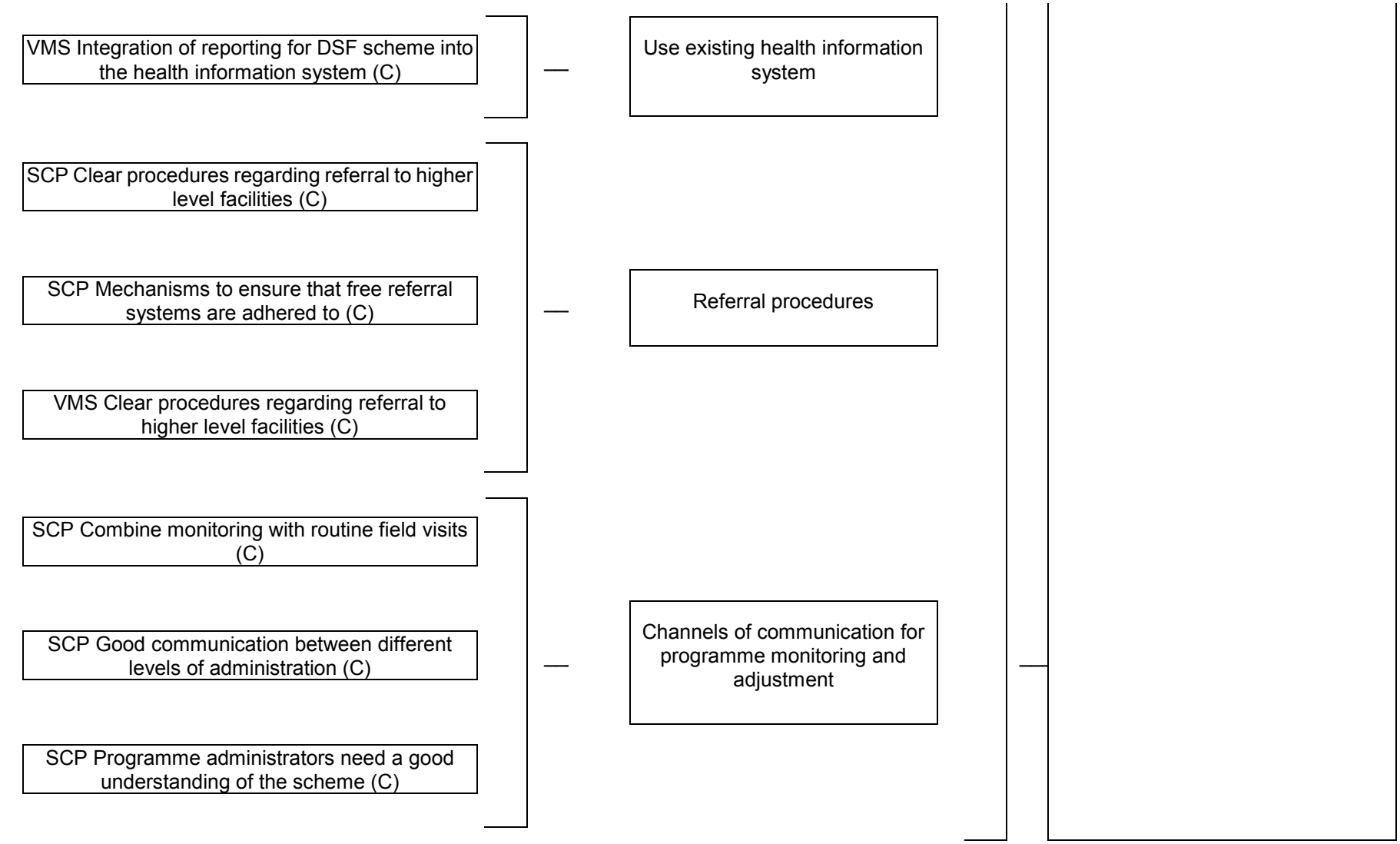

complementary interventions to maximise effect (C)
VMS Vouchers schemes can be promoted during house visits scheduled for other programmes (C)



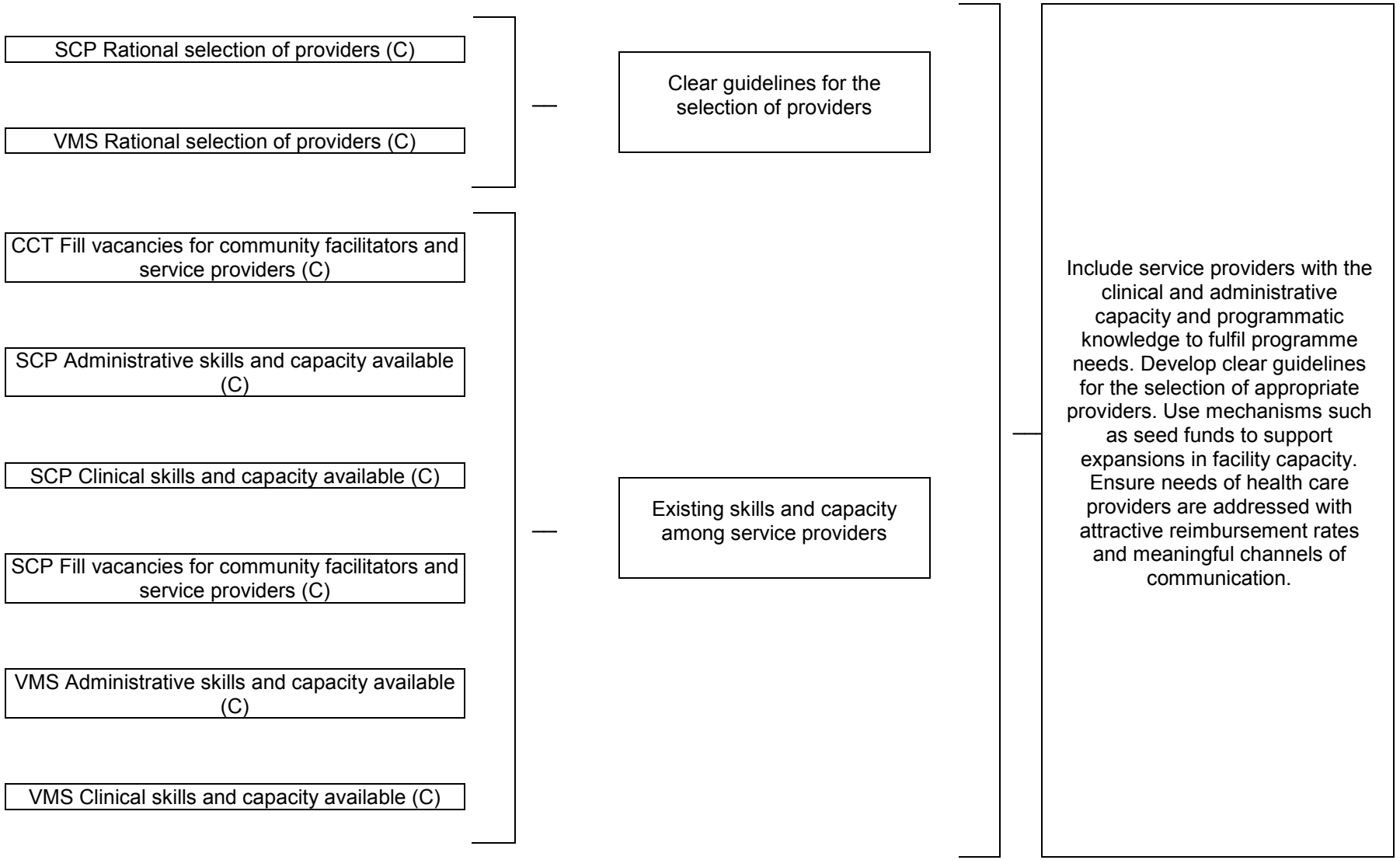



VMS Incentives for community level workers encourages referral to facilities (C)
VMS Incentives for programme facilitators to focus on promoting to eligible poor clients (C)
SCP Adaptation of the scheme to local preferences (C)
SCP Social divisions and social distance can impede work of local facilitators (C)
VMG Adaptation of scheme to local preferences (C)
Tailor scheme to the local context
SCP Ensure higher level administrators have good knowledge of the scheme (C)
SCP Minimise unnecessary central government
Involve non-governmental and governmental stakeholders
Utilisation of existing systems for governance and monitoring can encourage ownership and prevent duplication of structures. Clear referral systems to higher

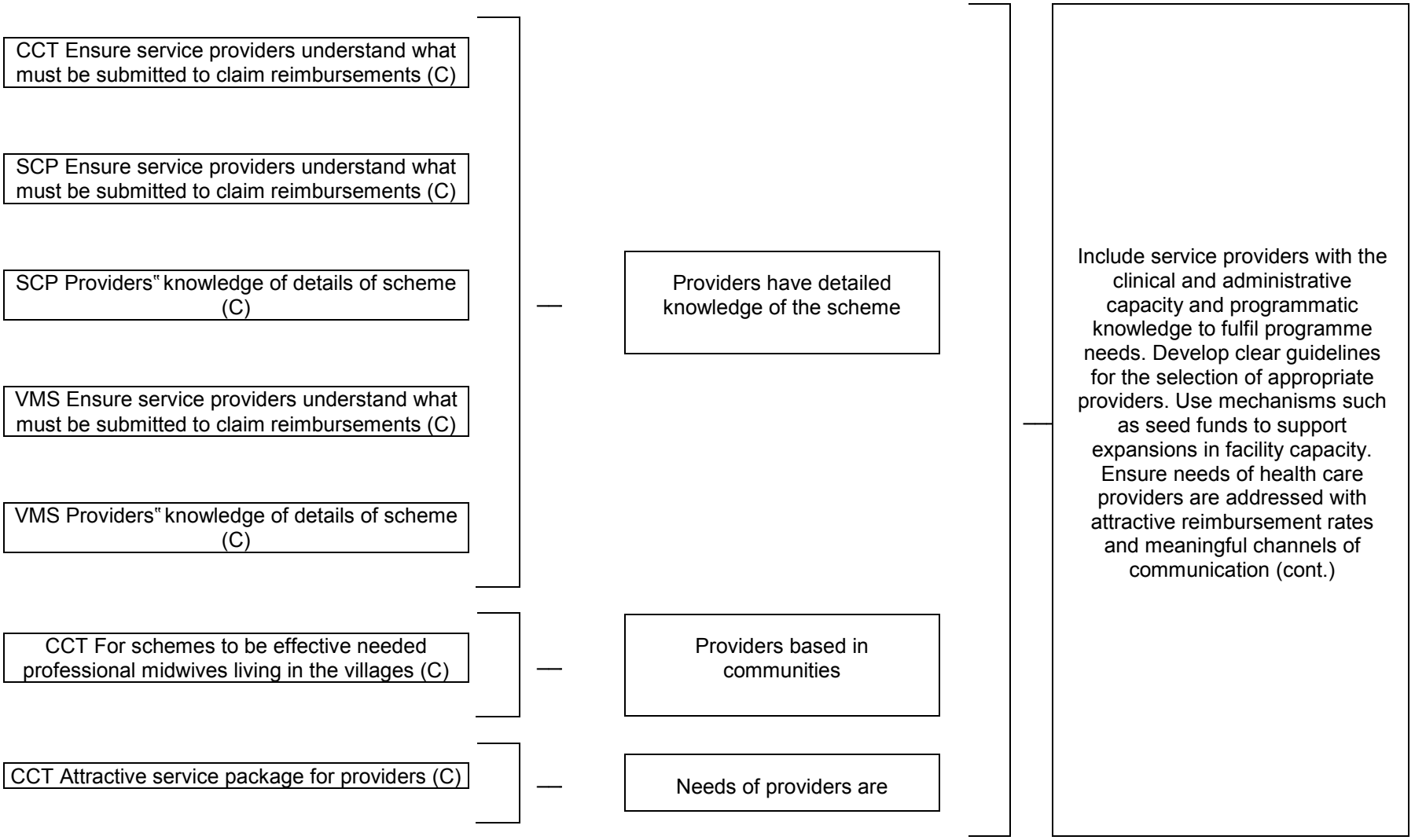

control of implementation (C)
SCP Regular coordination with stakeholders from different sectors (C)
SCP Use non-governmental organisations to raise awareness and monitor the programme (C)
SCP Use of local administrative and leadership structures (C)
VMS Appropriate involvement of Ministry of Health departments (C)
VMS Use of local administrative and leadership structures (C)
VMS Monitoring of accredited facilities was fragmented as the mandated organisation did not follow established procedures (C)
Mandated organisation carry out tasks
level facilities reduce unnecessary transfers. Good communication between different levels of the programme can help early detection of systematic problems.

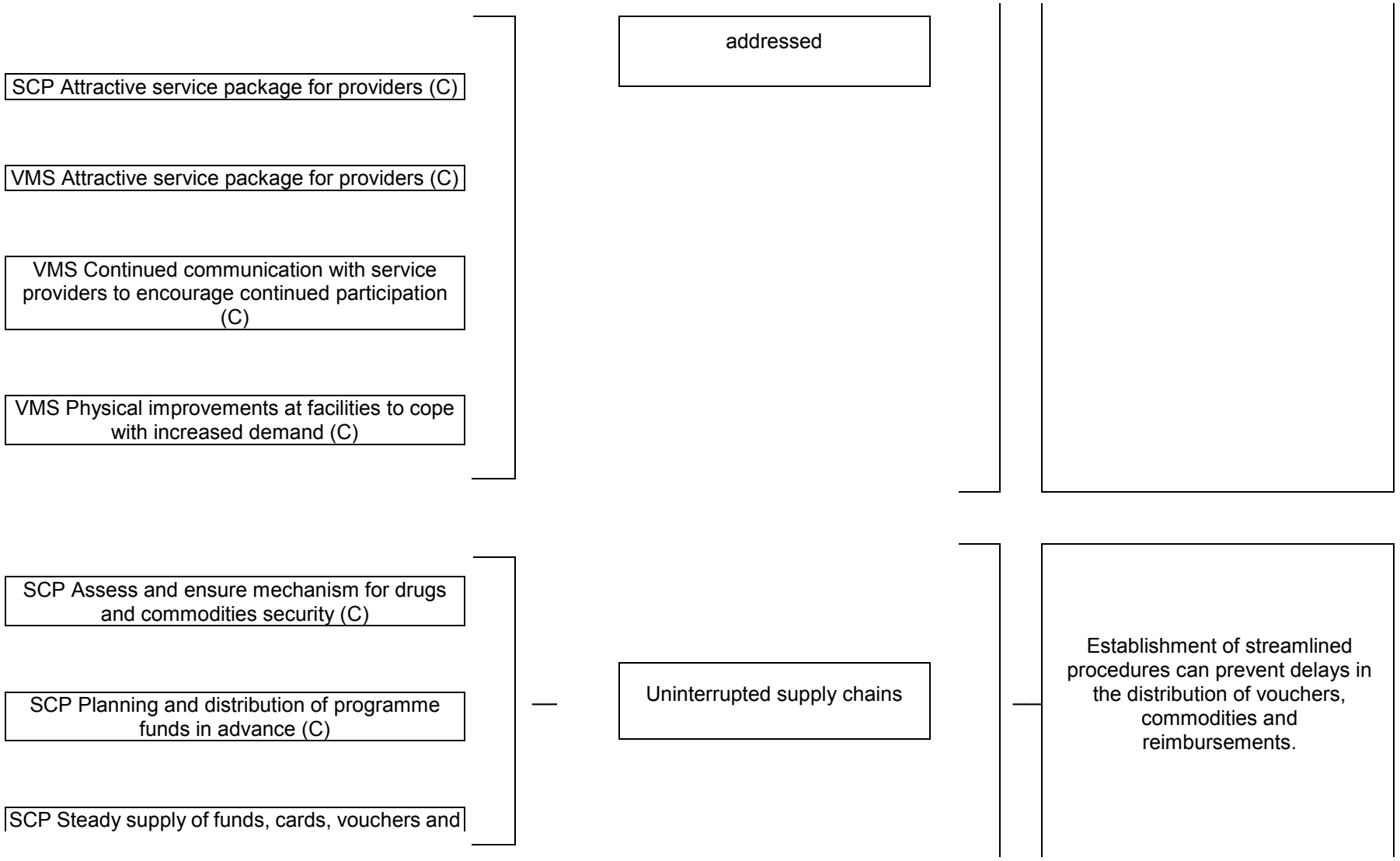

VMS Integration of reporting for DSF scheme into the health information system (C)
Use existing health information system
SCP Clear procedures regarding referral to higher level facilities (C)
SCP Mechanisms to ensure that free referral systems are adhered to (C)
VMS Clear procedures regarding referral to higher level facilities (C)
Referral procedures
SCP Combine monitoring with routine field visits (C)
SCP Good communication between different levels of administration (C)
SCP Programme administrators need a good understanding of the scheme (C)
Channels of communication for programme monitoring and adjustment

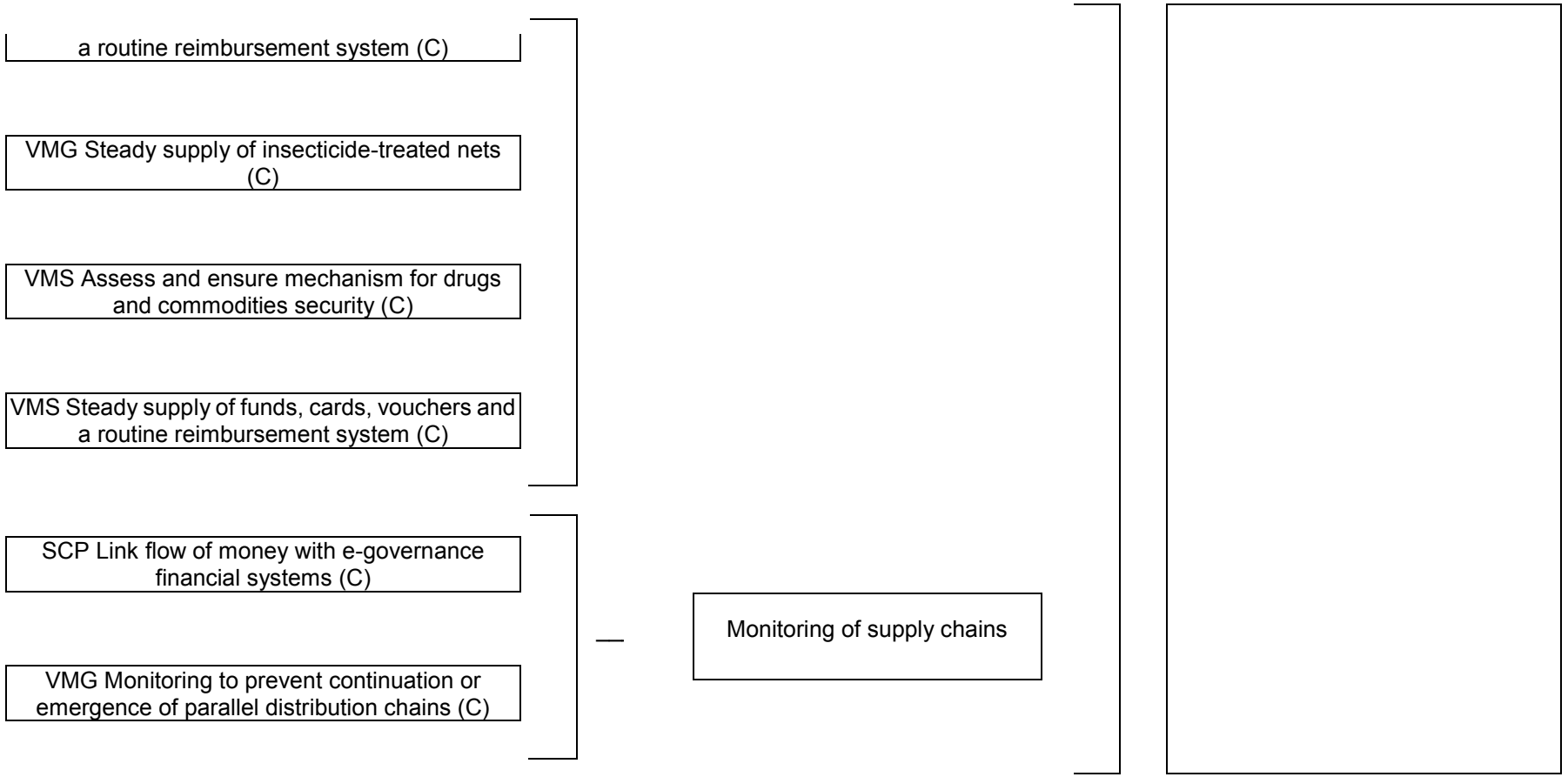

VMS Good communication between different levels of administration (C)
VMS Use claims data to monitor and adjust programme (C)

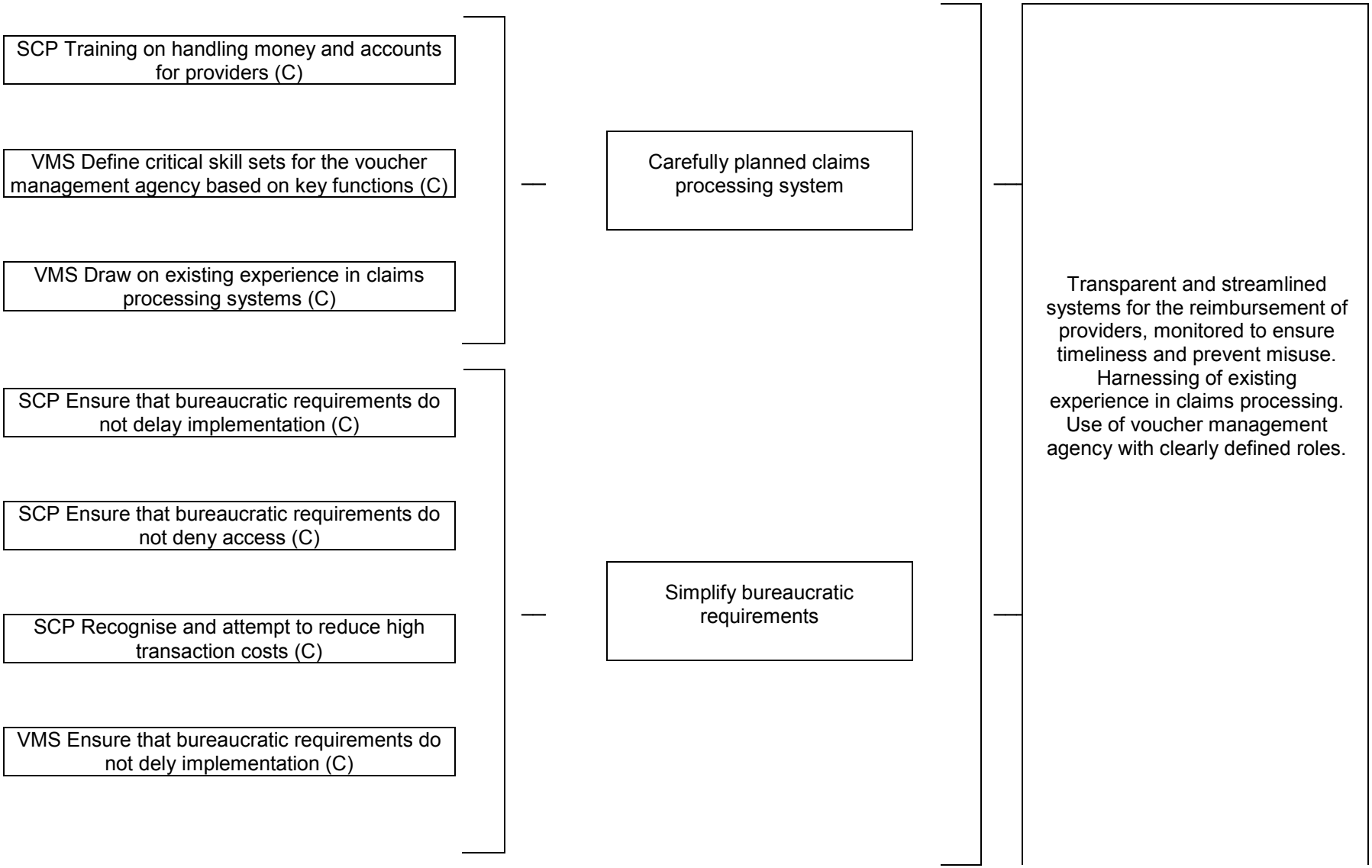


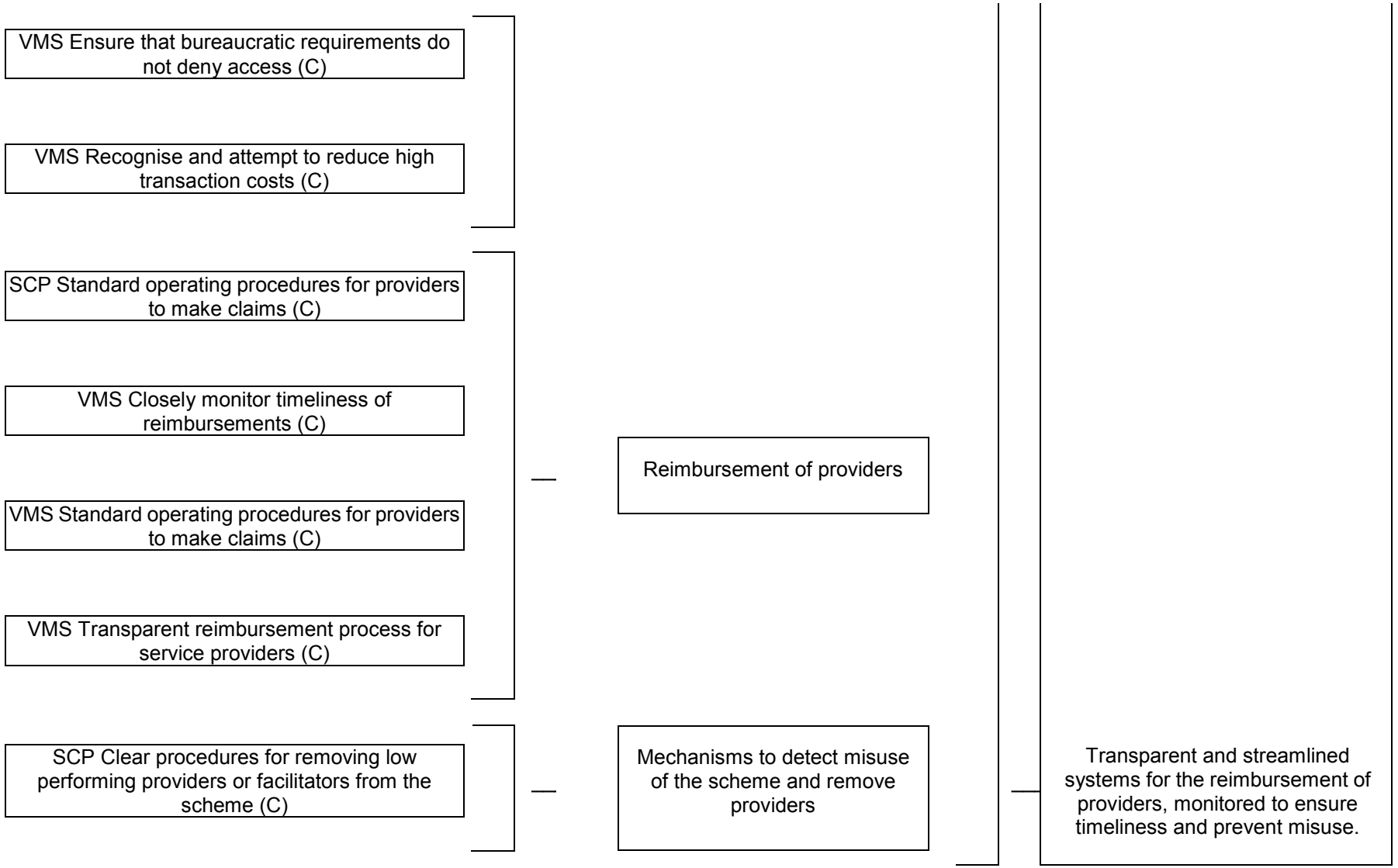

VMS Ensure transport providers are licensed (C)


CCT Ensure service providers understand what must be submitted to claim reimbursements (C)
SCP Ensure service providers understand what must be submitted to claim reimbursements (C)
SCP Providers‟ knowledge of details of scheme (C)
VMS Ensure service providers understand what must be submitted to claim reimbursements (C)
VMS Providers‟ knowledge of details of scheme (C)
Providers have detailed knowledge of the scheme
CCT For schemes to be effective needed professional midwives living in the villages (C)
Providers based in communities
CCT Attractive service package for providers (C)
Needs of providers are
Include service providers with the clinical and administrative capacity and programmatic knowledge to fulfil programme needs. Develop clear guidelines for the selection of appropriate providers. Use mechanisms such as seed funds to support expansions in facility capacity. Ensure needs of health care providers are addressed with attractive reimbursement rates and meaningful channels of communication (cont.)


addressed
SCP Attractive service package for providers (C)
VMS Attractive service package for providers (C)
VMS Continued communication with service providers to encourage continued participation (C)
VMS Physical improvements at facilities to cope with increased demand (C)
SCP Assess and ensure mechanism for drugs and commodities security (C)
SCP Planning and distribution of programme funds in advance (C)
SCP Steady supply of funds, cards, vouchers and
Uninterrupted supply chains
Establishment of streamlined procedures can prevent delays in the distribution of vouchers, commodities and reimbursements.


a routine reimbursement system (C)
VMG Steady supply of insecticide-treated nets (C)
VMS Assess and ensure mechanism for drugs and commodities security (C)
VMS Steady supply of funds, cards, vouchers and a routine reimbursement system (C)
SCP Link flow of money with e-governance financial systems (C)
VMG Monitoring to prevent continuation or emergence of parallel distribution chains (C)
Monitoring of supply chains




VMS Ensure that bureaucratic requirements do not deny access (C)
VMS Recognise and attempt to reduce high transaction costs (C)
SCP Standard operating procedures for providers to make claims (C)
VMS Closely monitor timeliness of reimbursements (C)
VMS Standard operating procedures for providers to make claims (C)
VMS Transparent reimbursement process for service providers (C)
SCP Clear procedures for removing low performing providers or facilitators from the scheme (C)
Reimbursement of providers
Mechanisms to detect misuse of the scheme and remove providers
Transparent and streamlined systems for the reimbursement of providers, monitored to ensure timeliness and prevent misuse.

SCP Mechanisms to deter unnecessary referral-on of complicated cases (C)

SCP Monitoring to detect false claims by providers and ineligible women (C)

SCP System to detect informal payments and corruption (C)

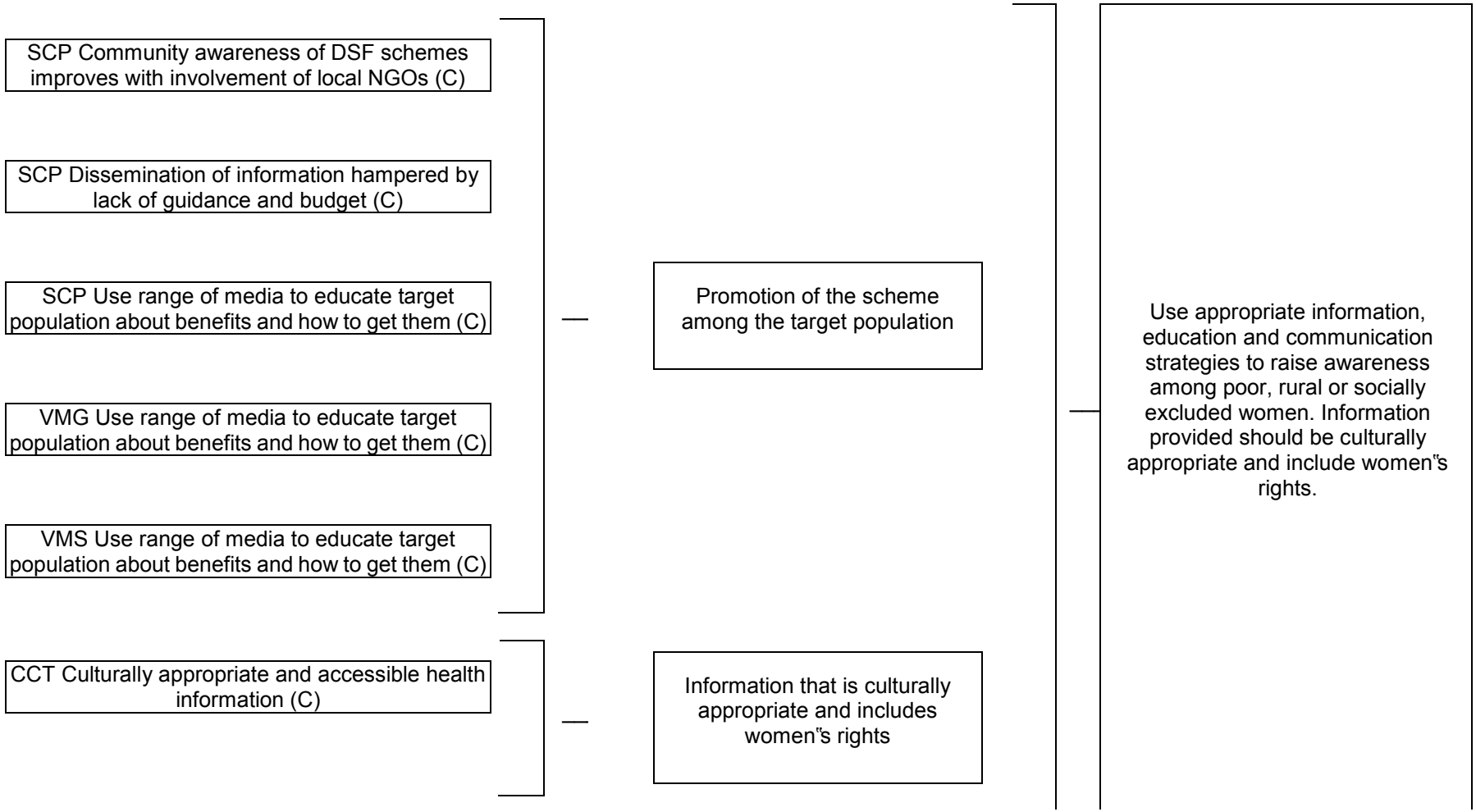
VMG System to detect informal payments and corruption (C)

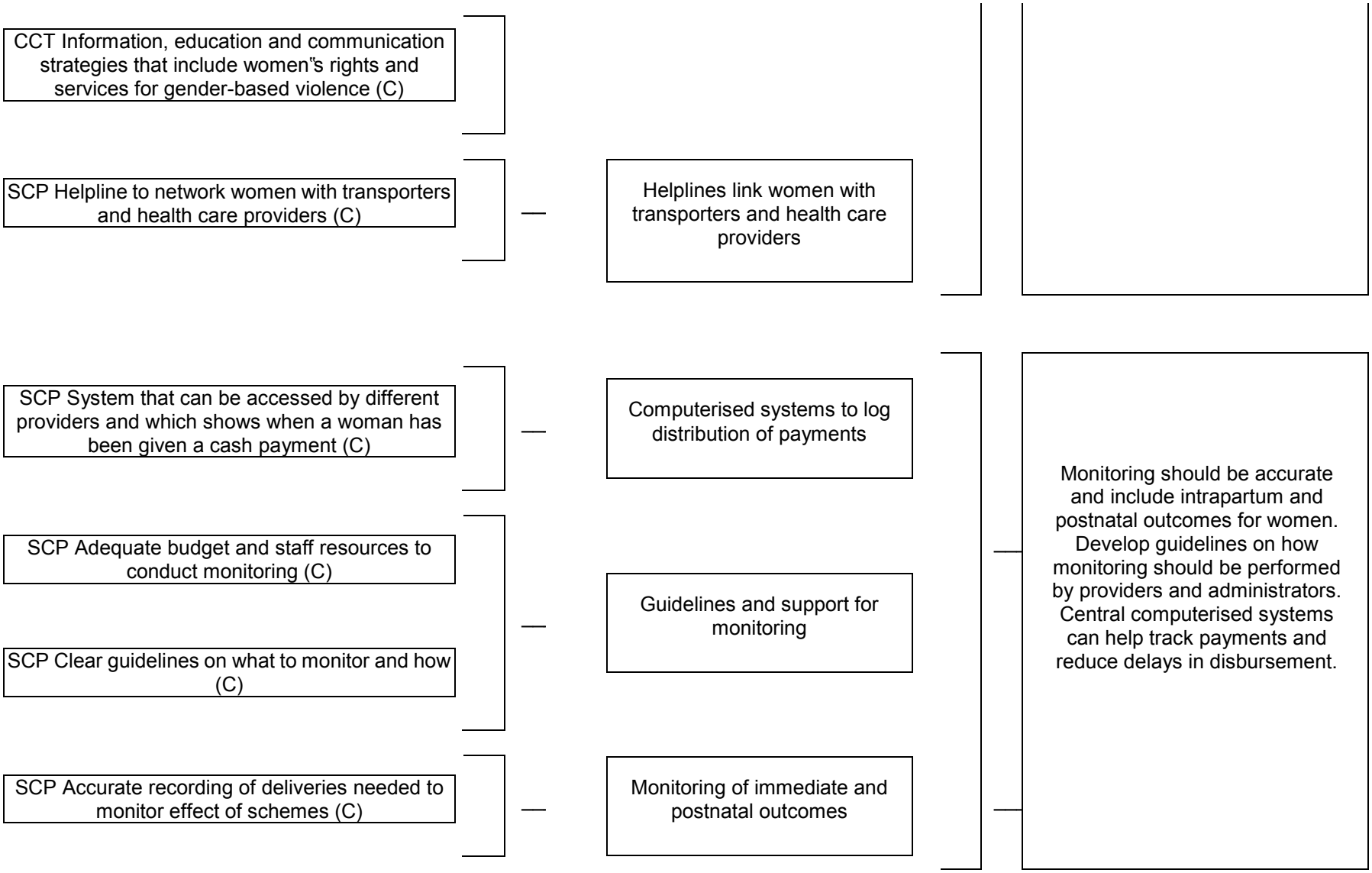
VMS Clear procedures for removing low performing providers or facilitators from the scheme (C)

VMS Mechanisms to deter unnecessary referral-on of complicated cases (C)

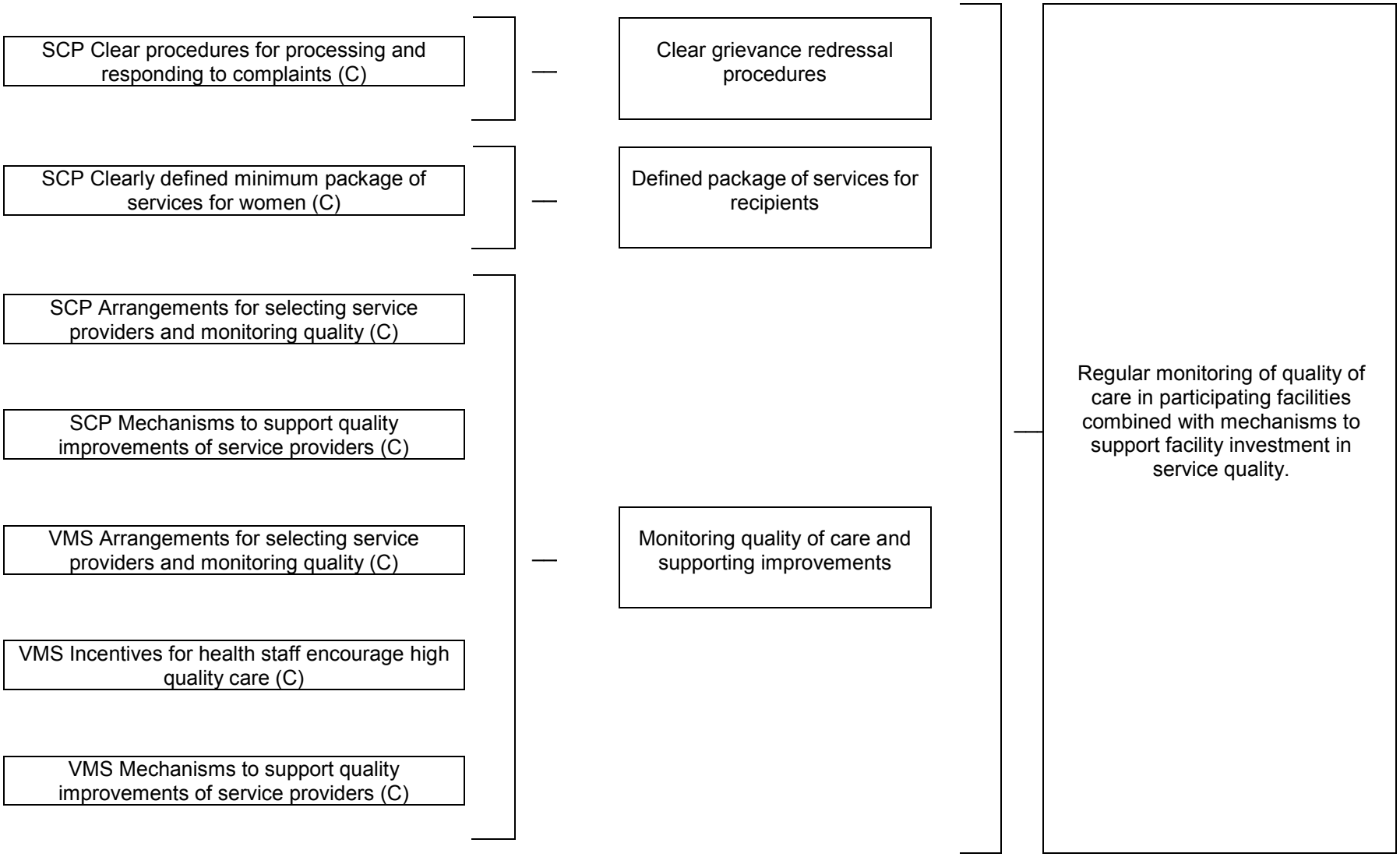
VMS System to detect informal payments and corruption (C)

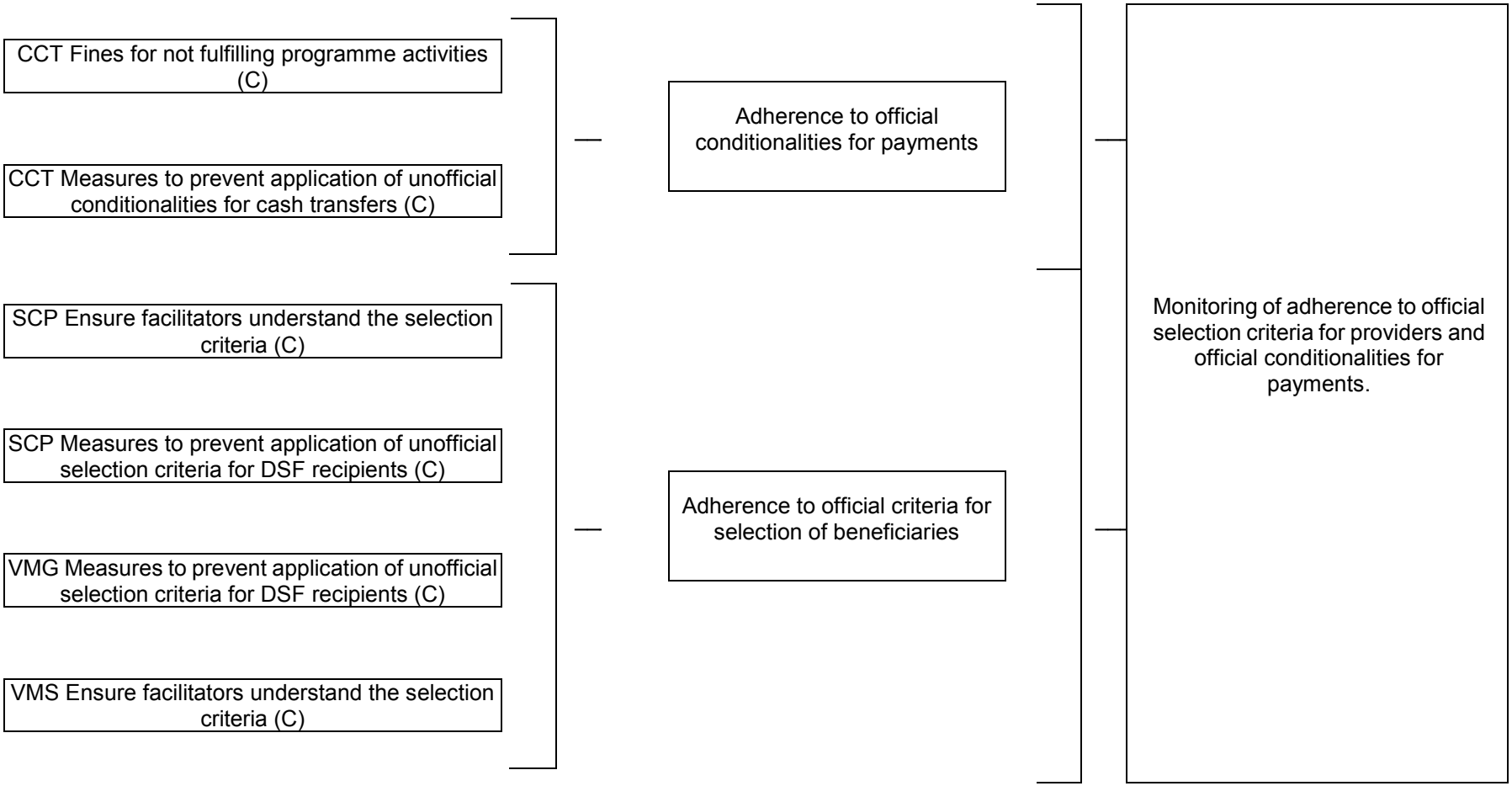
Harnessing of existing experience in claims processing. Use of voucher management agency with clearly defined roles (cont.)


SCP Community awareness of DSF schemes improves with involvement of local NGOs (C)
SCP Dissemination of information hampered by lack of guidance and budget (C)
SCP Use range of media to educate target population about benefits and how to get them (C)
VMG Use range of media to educate target population about benefits and how to get them (C)
VMS Use range of media to educate target population about benefits and how to get them (C)
CCT Culturally appropriate and accessible health information (C)
Promotion of the scheme among the target population
Information that is culturally appropriate and includes women"s rights
Use appropriate information, education and communication strategies to raise awareness among poor, rural or socially excluded women. Information provided should be culturally appropriate and include women"s rights.


CCT Information, education and communication strategies that include women"s rights and services for gender-based violence (C)
SCP Helpline to network women with transporters and health care providers (C)
Helplines link women with transporters and health care providers
SCP System that can be accessed by different providers and which shows when a woman has been given a cash payment (C)
Computerised systems to log distribution of payments
SCP Adequate budget and staff resources to conduct monitoring (C)
SCP Clear guidelines on what to monitor and how (C)
Guidelines and support for monitoring
SCP Accurate recording of deliveries needed to monitor effect of schemes (C)
Monitoring of immediate and postnatal outcomes
Monitoring should be accurate and include intrapartum and postnatal outcomes for women. Develop guidelines on how monitoring should be performed by providers and administrators. Central computerised systems can help track payments and reduce delays in disbursement.


SCP Monitoring system that can track morbidity and mortality during the post-partum period (C)


SCP Clear procedures for processing and responding to complaints (C)
Clear grievance redressal procedures
SCP Clearly defined minimum package of services for women (C)
Defined package of services for recipients
SCP Arrangements for selecting service providers and monitoring quality (C)
SCP Mechanisms to support quality improvements of service providers (C)
VMS Arrangements for selecting service providers and monitoring quality (C)
Monitoring quality of care and supporting improvements
VMS Incentives for health staff encourage high quality care (C)
VMS Mechanisms to support quality improvements of service providers (C)
Regular monitoring of quality of care in participating facilities combined with mechanisms to support facility investment in service quality.


CCT Fines for not fulfilling programme activities (C)
CCT Measures to prevent application of unofficial conditionalities for cash transfers (C)
SCP Ensure facilitators understand the selection criteria (C)
SCP Measures to prevent application of unofficial selection criteria for DSF recipients (C)
VMG Measures to prevent application of unofficial selection criteria for DSF recipients (C)
VMS Ensure facilitators understand the selection criteria (C)
Adherence to official conditionalities for payments
Adherence to official criteria for selection of beneficiaries
Monitoring of adherence to official selection criteria for providers and official conditionalities for payments.

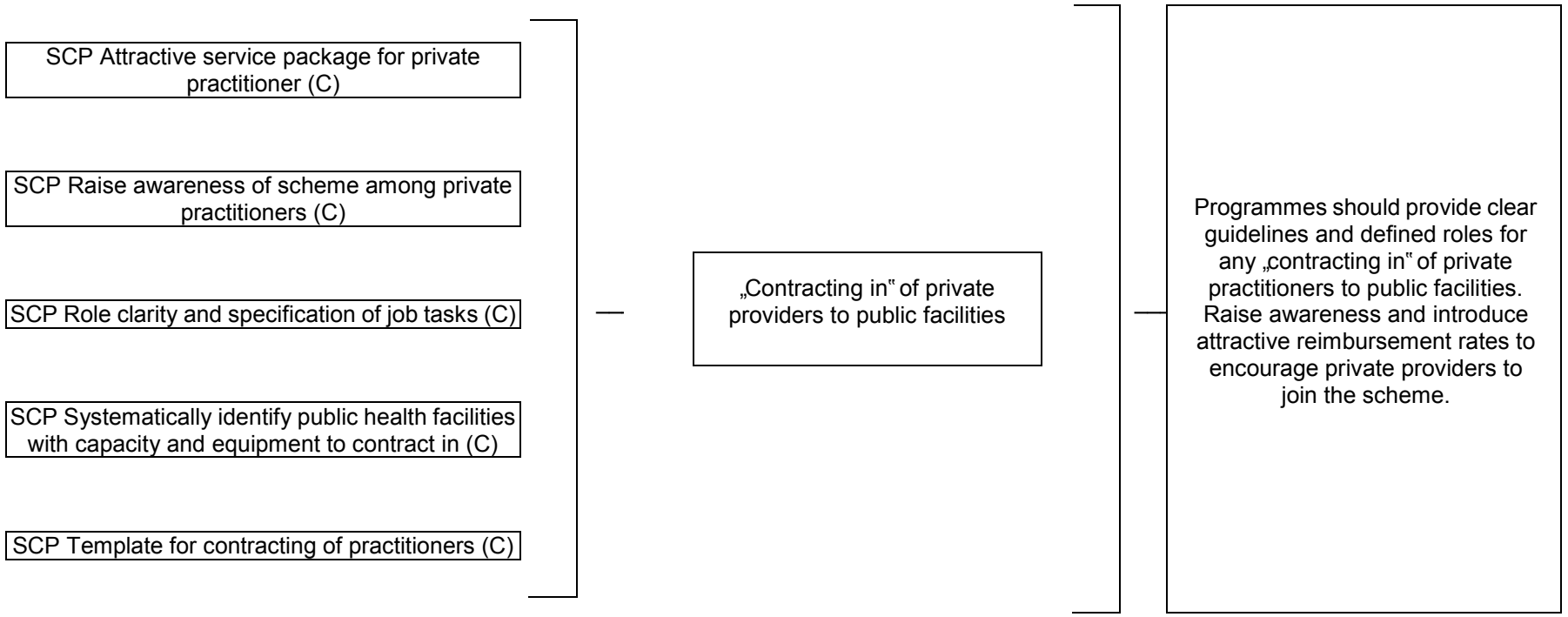


Figure 6. Meta-synthesis of findings on supply-side preconditions for the successful implementation of DSF (Question 14)

Notes: CCT refers to conditional cash transfers; SCP refers to short term payments to offset the cost of accessing maternal health services; VMS refers to vouchers for maternal health services; VMG refers to vouchers for merit goods for maternal health; (c) refers to „credible", as per JBI-QARI levels of credibility

Categorisation and Synthesis of Findings (Q 14)

The composition of each synthesised finding is described below.

A policy champion can provide effective leadership for DSF programmes and ensure that they receive political and financial support

The first synthesis related to the identification of a policy champion to support and promote the voucher scheme at the highest levels. This was supported by modest evidence from one category and one finding on the leadership provided by a policy champion, based on similar evidence from Kenya and Uganda for example:

> *„Effective leadership and implementation: Having a policy champion at the lead executing agency for Phases I and II of the program (the National Coordinating Agency for Population and Development, NCAPD) ensured effective leadership and implementation of the program. This was achieved through popularizing the program within government and donor circles that in turn ensured appropriate political and financial support for it."*[50] *(p. 4)*

Thorough planning can prevent programme delays, shortages of vouchers and provide opportunity for evaluation. Collection of local data supports the development of appropriate selection criteria, meaningful reimbursement rates and can ensure vouchers meet the needs of users.

A synthesis on the need for thorough planning was based on modest evidence from two categories. The first category referred to a thorough design phase and was supported by evidence from the Safe Delivery Incentive Programme in Nepal, voucher schemes for maternity services in Kenya and Uganda, and the Tanzania National Voucher Scheme. The findings highlighted a need for thorough planning, as described in the planning for the HealthyBaby voucher scheme in Uganda for example:

> *„There was delayed roll-out of the voucher programs: The implementation process for the HealthyLife and HealthyBaby vouchers began in 2004 and 2005 respectively. However, actual roll-out of the respective vouchers started in late 2006 and late 2008. This was occasioned by the time needed for program planning, accrediting and contracting providers, developing a referral network, and putting in place strong anti-fraud procedures."*[52] *(p. 3)*

The consequences of inadequate planning are described for the Safe Delivery Incentive Programme:

> *„Political expediency to ensure the policy was adopted quickly [18] may have meant there was inadequate preparation in the planning of resources and development of certain mechanisms. Respondents frequently spoke about the inadequacy of funds and acknowledged that the means to verify the eligibility of women and monitor the programme were lacking."*[40] *(p. 9)*

In another study, on the Vouchers for Health scheme in Kenya and the HealthyBaby vouchers in Uganda, the authors suggested the importance of including an evaluation component:

> *„Marry the two approaches [of analysing claims data and evaluating survey data] to generate empirical evidence on effectiveness of voucher strategies. Use claims data for monitoring and adjusting voucher program. Build in a strong evaluation design before beginning implementation"*[23] *(p.33)*

The second category related to the collection of local data during the design phase and was supported by three findings. Evidence to support these findings came from evaluations on the Vouchers for Health programme in Kenya and the HealthyBaby scheme in Uganda. The evaluations suggest that context-specific data should be used to create a voucher that meets the needs of clients. The authors noted that the use of such data to design poverty grading tools was effective but that they should be updated periodically, while it could also be used to inform reimbursement rates:

> *„Instances of some eligible clients missing out: Distributors and community members reported during FGDs [focus group discussions] that the poverty grading tool had some shortcomings in its scoring system as it sometimes left out genuine needy cases. For example, one FGD [focus group discussion] participant in Kiambu noted that: "…for me, my husband lost his job and I do not work. Now we have no money and we live in this small room. We thought living in this small room as squatters made us voucher client but they refused." This suggests the need for periodically assessing the eligibility criteria and revising the poverty grading tool to reflect the changing poverty levels given that poverty indicators are not static. There is also need to explore how community members can be involved in vetting the poor"*[50] *(p. 6)*

> *„Collect data at the design stage to ensure that the reimbursement price is right for providers. Public sector providers typically receive supply-side subsidies for voucher services. Reimbursement rates acceptable to public providers may not be adequate for private sector providers. Clear payments terms are essential, particularly for not- and for-profit providers."*[23] *(p. 33)*

Coordination or integration with existing interventions can reduce any additional burden on community workers and maximise programme impact.

The third synthesised finding under this review question concerns coordination of DSF schemes with other interventions. The only category related to achieving synergies and interactions with other interventions and was supported by modest evidence from Bangladesh, India and Cambodia. A study on JSY in the Indian state of Orissa demonstrated the need for coordination with other programmes:

> *„For appropriate and timely delivery of quality ante -natal, intra-natal and postnatal services, there is a need for well coordinated and synergistic effort of the key field level functionaries like the HW(F) [female health workers], the AWWs [anganwadi community health workers], the ASHAs as well as district and block level stakeholders. Thus intra and inter-sectoral coordination facilitates smooth functioning and efficient operationalisation of the JSY programme."*[55] *(p. 25)*

Other studies from India highlighted the need to ensure health workers and administrators are not overburdened by programme activities above and beyond their previous workload, for example:

> *„There is a lack of manpower to supervise, particularly with respect to checking the accounts and linking it with the performance, as realized by the state official, "We are not able to supervise properly. So many programmes are there and like this (JSY) are linked with money. We have to record properly, check properly. We need one more person who could check the accounts."*[63] *(p. 57)*

Programme promoters and facilitators rooted in communities, appropriately selected, prepared and incentivised.

This synthesis drew on good evidence from three categories. The first category related to the placement of promoters and facilitators in communities, and was supported by similar findings from conditional cash transfers, short term payments to offset costs of access and vouchers for maternity services in Indonesia, Bangladesh, India, Kenya and Uganda. A study of the Vouchers for Health and HealthyBaby schemes in Kenya and Uganda respectively described the following experience:

> *„Kenya"s RH-OBA [Reproductive Health – Output-Based Aid] and Ugandan RHVP [Reproductive Health Voucher Programme] vouchers are both targeted at the poor, and both programs have identified and recruited VDs [voucher distributors] who are rooted in local communities and accessible to poor clients. In Kenya, VMA [the voucher management agency] PWC [PricewaterhouseCoopers] initially recruited organizations to act as VDs [voucher distributors]. However, it found that using organizations dispersed accountability across the organization, making it difficult to hold any one individual responsible for*

> *performance; subsequently PWC [PricewaterhouseCoopers] shifted to contracting individuals to act as VDs [voucher distributors]. By contrast, in Uganda, VD [voucher distributor] selection is based solely on recommendations from the local communities and VSPs [voucher service providers]. VDs [Voucher distributors] can include a wide variety of players including commercial outlets, community groups, and faith-based organizations."*[23] *(p. 21)*

Other findings included in this category included the need to ensure facilitators are not expected to cover an overly large area and that they are adequately supported by the programme. This is evidenced in studies on JSY in Bihar, India:

> *„The ANMs [auxiliary nurse-midwives] also complained that since they have a very vast coverage area, it becomes difficult for them to provide quality services. Those who have to go to remote interiors also said that since the roads are in piteous condition and it is unsafe to travel alone, they have to depend on a male member (either from the family or a hired person with a two-wheeler for the purpose) to commute to these areas. Thus, according to them, devoting quality time at the centre suffers because of the time spent in commuting. In addition, sometimes women have to return from the centre without receiving the vaccination because by the time they reach, the ANM [auxiliary nurse-midwife] has already left. Moreover, the ANMs [auxiliary nurse-midwives] said that from time to time, there are polio drives and distribution of medicines for Filaria, each of which requires their active participation which affects routine immunisation."*[72] *(p. 42)*

> *„We have tried our level best to get good ASHAs, and they are very much enthusiastic. But this enthusiasm has to be maintained and we need to provide other facilities to translate it into action. At present, only 1 – 2 persons are there at the state level to support ASHA. But, we need the whole network to support ASHA. If ASHA resource network is there, they will function very well. This is first opportunity to females in Bihar of serving the people of their village. They are trying to prove it."*[66] *(p. 11)*

The second category related to the use of incentives to improve targeting of poor women and encourage referrals to higher level facilities, and was supported by findings from Cambodia, India, Kenya and Uganda. In Cambodia and India, community health workers and traditional birth attendants were given incentives to refer women to health facilities. Studies from India suggested the need for systems to verify claims for incentives and to consider monthly payments. A risk of bias was described if community workers receive money only for women who use maternal health services:

> *„In depth interviews reveal that the ASHA selects those women to motivate for ANC [antenatal care] and institutional delivery whom she is reasonably sure will go for institutional delivery as she gets paid only if the woman delivers in an institution."*[59] *(p. 14)*

The experiences of providing incentives to voucher distributors in Kenya and Uganda are described below:

> *„Balancing incentives for VDs [voucher distributors] is also important given their critical gatekeeping role. VDs [Voucher distributors] need to be motivated to promote vouchers, but only to eligible clients. The Kenya program initially paid VDs [voucher distributors] a commission for every voucher sold. This proved to be a high motivator to sell vouchers indiscriminately, and voucher sales to the non-poor increased. In response, [the voucher management agency] PWC changed the payment strategy and now pays [voucher distributors] a salary retainer. VDs [Voucher distributors] are contracted for short (three-month) terms, and their contracts are renewed only if PWC deems the number of voucher sales to eligible poor clients to be satisfactory. The Ugandan VDs [voucher distributors] earn a specified mark-up on the voucher price."*[23] *(p. 22)*

The final category was related to tailoring the scheme to the local context and was supported by two findings, from studies on JSY in India and a study on the Tanzania National Voucher Scheme. The first finding drew on evidence of social divisions impeding the work of facilitators in India, for example:

> *„Another factor for low contact between the ASHA and pregnant women is the social distance, measured in terms of caste, class, religion and education of the ASHA and the beneficiaries. Quantitative and qualitative data show that the majority of ASHAs (74 percent) belong to general caste or other backward caste families, and often are relatives of village leaders and hence hesitate to visit scheduled caste/ tribe women. In some cases, the perceived hostility towards or non- acceptance of ASHAs by Muslim families also deprives Muslim families from receiving advice from the ASHA."*[59] *(p. 14)*

The second finding in this category emphasised the importance of adapting DSF schemes to the local context. A study on the Tanzania National Voucher Scheme provided evidence of programme implementers adapting the voucher distribution process:

> *„Staff interviewed at three clinics that sold discounted nets were asked why they did not issue vouchers. They said that it allowed them to check eligibility, avoided women accidentally destroying or losing the vouchers, and reduced the women's workload as they did not need to walk to another place to redeem the voucher. They thought that their approach motivated women to find the money to purchase a net. In one clinic, women could pay by instalments and this seemed to have increased net purchases, especially by very poor women. When queried why vouchers were not given to all eligible women, answers ranged from „the scheme was not clear to me" to „such a system was already in place". Staff interviewed at two clinics that did not sell nets said they only gave vouchers to women who specifically wished to buy a net, and who were required to show their antenatal or child health cards."*[41] *(p. 6)*

Utilisation of existing systems for governance and monitoring can encourage ownership and prevent duplication of structures. Clear referral systems to higher level facilities reduce unnecessary transfers. Good communication between different levels of the programme can help early detection of systematic problems.

The first category brought together findings on the involvement of appropriate governmental and non-governmental stakeholders in DSF schemes. Evidence to support this category came from Bangladesh, India, Nepal and Kenya. An evaluation of the Vouchers for Health programme in Kenya noted that the Ministry of Health had played an important, albeit limited, role:

> *„Limited involvement of the Ministry of Health: Although the Division of Reproductive Health was a member of the Advisory Board and Steering Committee there was little involvement during Phase 1. This may have resulted in missed opportunities in the needed reproductive health expertise. However they played a key role as the coordination of the Technical Committee on Quality Assurance in monitoring existing facilities and accrediting new ones."*[50] *(p. 4)*

Evaluations in Kenya and Bangladesh highlighted the importance of involving local administration and leaders however the authors of an evaluation in Bangladesh noted difficulties with this:

> *„Use of the Local administration vital for creating awareness and for distribution: Using local administrative structures including community and opinion leaders who were trained on DSF program played a vital role in marketing the program. At the end of 2010, local government elections took place and candidates mentioned the DSF program during their election campaign. Many of the previous trained chairman and members could not win in election and there are many new faces after election who do not have training on DSF program criteria to explain the recipients properly. They often did not explain the selection criteria well and as a result created unsustainable expectations among clients regarding the DSF program."*[49] *(p. 4)*

The various stakeholders in DSF programmes should be brought together in regular meetings, as noted in a study from Orissa, India:

> *„Majority of ASHAs, ANMs [auxiliary nurse-midwives] and BMOs [Block Medical Officers] cite lack of regular meetings, inadequate briefing about the programme, work overload and financial expectations by civil society organisations as the principal reasons for the weak inter-sectoral coordination. The JSY programme managers should encourage involvement of such sectors for meeting the JSY objective of communitisation as well as better uptake of the services under the scheme."*[39] *(p. 31)*

The second category focused on ensuring that organisations carried out mandated tasks. This arose from a specific situation highlighted in a study of the Vouchers for Health programme in Kenya:

> *„Fragmented monitoring of accredited facilities by National Hospital Insurance Fund (NHIF): This parastatal institution was given the mandate to carry out accreditation of health facilities and Quality Assurance (QA) on a six monthly basis. Although a QA manual was developed for the program, NHIF rarely used it. Fortunately the Steering Committee supported the [Technical Committee on Quality Assurance] to carry out the QA activities in Phase 2."*[50] *(p. 4)*

The third category related to the integration of monitoring with the existing health information system. This drew on evidence regarding a lack of integration in Bangladesh and Kenya, such as the example from an evaluation of the Bangladesh Maternal Health Voucher Scheme:

> *„Lack of clarity regarding the role of MOHFW [Ministry of Health and Family Welfare] in information system: Centrally, the Government has implemented a Health Management Information System (HMIS), although such a system does not track DSF utilization separately. From the existing HMIS, it is not possible to track voucher and non-voucher recipients. In the DSF program only voucher recipient"s information is recorded from participating facilities. Other than HMIS report, EOC [Emergency Obstetric Care] report collected from accredited facilities doesn"t distinguish between voucher and non-voucher recipients. Though there is a plan to acquire new software to improve [monitoring and evaluation] by tracking each pregnant woman who receives a voucher from antenatal to postnatal care. Such a program is expected to be integrated into the HMIS. Currently WHO has planned to develop this type of software in collaboration with MIS, DGHS [Directorate General of Health Services]."*[49] *(p. 6)*

The fourth category was on the need for clear referral procedures, based on evidence from JSY and the MAMTA scheme in India, for example:

> *„the study found that almost all cases are direct self-referrals to the private specialists, or via smaller private centres. The medical officers and ANMs [auxiliary nurse-midwives] at the PHCs [Primary Health Clinics] have no specific referral chains, they prefer to leave it to the patient to choose a higher centre. There is no accreditation of centres done for this scheme; hence, there exist no measures to ensure the continuum of care and minimize delays. One ANM [auxiliary nurse-midwife] mentioned of having referred and accompanied two EmOC [emergency obstetric care] cases to a sub-district hospital. However, they were diverted to the private hospital of the consultant appointed on call in the sub-district hospital. Public providers from all the study blocks revealed that CHCs [Community Health Centres] in their block do not have EmOC [emergency obstetric care] services and thus were forced to refer poor patients to nearby charity hospitals."*[42] *(p. 129)*
>
> *„Even though efforts were made by few of the districts to link the government hospitals with MAMTA Friendly Hospitals, still this is a major area of concern. Therefore it is recommended that a strong systematic referral mechanism should be developed between Government hospitals and MFHs [MAMTA Friendly Hospitals] in the event of complications during pregnancy, medical illness during pregnancy, neonatal and postnatal complications by respective districts. In case of emergencies some MFH [MAMTA Friendly Hospitals] are well equipped and adept at handling. So it may be recommended that there should be a cross referral system to pass on the client to another MFH [MAMTA Friendly Hospital] that can handle the case appropriately. An internal referral would not only strengthen the service quality but would also ensure a good reputation of the scheme."*[28] *(p. 82)*

The final category in this meta-synthesis referred to channels of communication for programme adjustment. This was based on evidence on short term payments to offset costs of access in India and voucher schemes for maternity services in Bangladesh and India. The authors of a report on the MAMTA scheme in India describe a lack of coordination between private providers and government dispensaries.[28] The authors of an evaluation on the Maternal Health Voucher Scheme in Bangladesh noted that committees created for coordination do not meet regularly but that there is some communication through other means.[53] An example of the consequences of poor communication is provided in a study on the Maternal Health Voucher Scheme:

> *„The implementation of the programme at the local level mistakenly assumed that all pregnant women are eligible to receive the vouchers irrespective of their socio-economic status. This is an indication of lack of planning of the start-up activities and breakdown of communication between the upper and lower levels of administrative units. This lack of communication between the local and district DSF committees created another significant problem: temporary suspension of voucher distribution for a few months due to shortage of voucher books."*[22] *(p. 28)*

Include service providers with the clinical and administrative capacity and programmatic knowledge to fulfil programme needs. Develop clear guidelines for the selection of appropriate providers. Use mechanisms such as seed funds to support expansions in facility capacity. Ensure needs of health care providers are addressed with attractive reimbursement rates and meaningful channels of communication.

Good evidence from five categories led to a synthesis on the preconditions for each service provider in the programme. The first category related to guidelines for the selection of providers and was supported by one finding from studies in Bangladesh and India. A study on the Maternal Health Voucher Scheme in Bangladesh highlighted the need for a rational selection of providers:

> *„In our interviews, personnel involved with the implementation of the scheme thought that use of medical care services jumped significantly in the last 3 to 4 months of the first year compared with previous months. A new order issued by the Government of Bangladesh towards the end of the first year allowed public sector health care providers to get reimbursements through the voucher scheme. In the original plan, public sector providers were not allowed to receive reimbursements for the vouchers; after the policy change, government facilities became interested in generating extra funding through the vouchers."*[22] *(p. 29)*

The second category related to the existing clinical and administrative capacity of the provider and was supported by four findings. Evidence from DSF schemes for maternity services in Bangladesh, India, Indonesia and Uganda provided suggestions of preconditions for service providers. These ranged from driving licences for transport providers in Uganda,[51] to detailed job descriptions for staff at health facilities in Bangladesh.[49] The need for blood facilities and adequate staffing levels, particularly

anaesthetists and obstetricians, was mentioned in studies, for example in a study on the Chiranjeevi scheme in India:

> *„Lack of blood facilities and anaesthetists The major problems the doctors appear to be having in managing emergencies are lack of blood transfusion facilities and anaesthetists."*[45] *(p. 29)*

> *„All the doctors interviewed said they had arrangements with private anaesthetists to attend in emergencies; however those with clinics located in rural settings said there are usually some problems getting these anaesthetists, most of whom they said lived in urban areas."*[45] *(p. 29)*

A third category related to the in-depth knowledge of programme details required and was supported by two findings. Studies on DSF schemes in India, Indonesia and Kenya described the difficulties in processing claims that have not been adequately documented due to lack of adherence to guidelines by providers. In Kenya this is associated with providers trained in the programme moving elsewhere and being replaced by providers with limited training:

> *„Staff transfers posed additional challenges to the claims and reimbursement process: Once providers who were trained on the voucher process moved elsewhere, there was limited or no additional training or updates for new staff. This resulted in poorly completed claims forms which were then rejected by the VMA [voucher management agency]. This in turn delayed the reimbursement process as the VMA [voucher management agency] sent back the claims forms for amendments. Coupled with problems of lack of adherence to program guidelines, this suggests the need for continuously training service providers on the voucher process."*[50] *(p. 9)*

The fourth category drew on one finding from a study of Program Keluarga Harapan in Indonesia. The study found that use of programme benefits for improving maternal and child health was limited by the lack of midwife in some villages. This implied a need for professional midwives to live in villages for the programme to effectively improve maternal and child health, for example:

> *„in one village the use of PKH [Program Keluarga Harapan] for MCH [maternal and child health] was hampered due to the lack of a village midwife. In this village the majority of PKH [Program Keluarga Harapan] recipients had no access to midwifery services for childbirth."*[57] *(p. 42)*

The final category stressed the importance of meeting the needs of providers and was based on three findings on the need for an attractive service package. A study on the Vouchers for Health programme in Kenya described the consequences of an unattractive package:

> *„Concerns about reimbursable amount, delays in reimbursement, and client volumes undermined service quality in private facilities: Some private providers were concerned that the ceiling set for reimbursement for various services was too little. Others raised concerns*

> *about delays in reimbursement while others were so overwhelmed by the demand of voucher clients that they could not serve their regular clients as they did before. This led to some of the private providers pulling out, limiting access for voucher clients or giving preference to those who can pay higher prices. One voucher client in Kiambu noted during FGD [focus group discussion] that: "The reception when you go to deliver is bad. Once they see the voucher, you are not lucky…There is a problem there because you cannot be received the same way as a person who has money."* [50] *(p. 11)*

Studies from Bangladesh, Kenya and Uganda described the assistance needed by providers to improve health facilities. An evaluation of the Vouchers for Health programme in Kenya noted the difficulty in providing this:

> *„Public health facilities faced challenges utilizing money from the program to improve service quality: Public health facilities did not initially have direct control of funds generated from the program given the government policy of managing such funds through the District Health Management Teams (DHMTs). The bureaucracy of accessing the funds therefore limited its use for exclusively improving service quality. One provider in Kitui reported during in-depth interview that: "I am telling you now this money we are not able to use it as the OBA [Vouchers for Health programme] money. It is consolidated as the hospital money so trying to push it back to the facility like now the maternity it is a struggle."* [50] *(p. 12)*

Establishment of streamlined procedures can prevent delays in the distribution of vouchers, commodities and reimbursements

This synthesis finding was based on six findings, organised into two categories. The first category drew the need for uninterrupted distribution chains for the supply of medicines, money and vouchers. Evidence from JSY in India highlighted problems with the flow of funds to community health workers and it was suggested that funding be distributed in advance so that it is available when needed:

> *„To enable local availability of money, ANMs [auxiliary nurse-midwives] are given advance money which is kept in a joint account with the Sarpanch or the Naib Srapanch whoever is a woman. This money is replenished on time-to-time basis on submission of bills and vouchers of the last round of disbursements. Two out of three CDMOs [Chief District Medical Officers] and four out of six BMOs [Block Medical Officers] inform that most of the times the funds flow at various levels (from state to district and below) are interrupted because of delayed submission of bills and vouchers. This delay results in lack of money at operational levels which in turn affects the release to money to ASHAs and eventually to the beneficiaries. All the money required should be planned in advance depending on the expected number of deliveries at each level of institutions and necessary amounts should be parked in the budget for them in one go so that the operationalising on the scheme does not get blocked due to lack of money at the ANM [auxiliary nurse-midwife] level."* [39] *(p. 24)*

Studies in Ghana and Tanzania cited the importance of a steady supply of insecticide-treated nets. The difficulty in achieving this was described in a study on a voucher scheme piloted in Ghana:

> *'Retailers' greatest concern about the voucher scheme as found during each round of interviews was low stock levels of ITNs [insecticide-treated nets]. The retailers receive their ITNs [insecticide-treated nets] from distributors, as mentioned above, the scheme started with just two distributors and increased to three. The financial capacity of each of these distributors was limited, as therefore was their capacity to allow long periods during which their capital was tied up. ITNs [Insecticide-treated nets] were given to retailers on credit and therefore the risks involved dictated initial small stock levels in the majority of outlets.'* [44] *(p. 8)*

For schemes that employ vouchers for maternity services, evidence from Bangladesh, India, Kenya and Uganda highlighted the importance of steady supplies of funds and vouchers. An evaluation of the Vouchers for Health programme in Kenya noted the consequences of delays on programme implementation:

> *„Unpredictability of context and bureaucratic processes may cause delays in implementation process: The implementation of the program has, however, been characterized by delays. The launching of the initial phase was delayed for four months due to the availability of funds. This caused subsequent delays in finalizing contracts for marketing, accreditation of facilities, and quality assurance. There were also further delays due to a gap in funding in 2008 pending final contracts for Phase II of the program. Through this experience, there may be need to factor in sufficient time to account for unpredictability of events."* [50] *(p. 5)*

Findings on the monitoring of supply chains were included in a second category under this synthesised finding. Evidence from a voucher scheme for insecticide-treated nets in the Volta region of Ghana suggested the need to prevent the continuation or emergence of parallel distribution chains for nets:

> *„Approximately seven months into the scheme, retail outlets in Volta Region suffered an acute shortage of ITNs [insecticide-treated nets]. This was partly due to poor experience in forward planning by the distributors, and their limited financial capacity in terms of credit availability, but was significantly exacerbated by a limited duration voucher scheme project in the two largest urban areas of the country, Accra and Kumasi. The rapid sales available in these two urban areas were a much more attractive business proposition than the slower sales in the voucher pilot region, to the extent that the limited ITNs [insecticide-treated nets] available in the country were diverted away from the Volta Region. At this point the management agent suspended supplies of vouchers to the clinics, and voucher scheme activities were severely impeded for a period of two months until supplies of ITNs [insecticide-treated nets] were again introduced into retail outlets in the region."* [44] *(p. 8)*

The authors of a study on JSY in Orissa, India, suggested that short term payments through the scheme be monitored by a central system:

> *„Now, the payments are given through cheques, therefore an effort should be made to link the flow of money with the e-governance financial reporting systems, which are used in the Treasuries of many states so that it becomes more transparent and quick. A core banking system with its own dedicated computerised reporting network can create space for the JSY financial system as well."*[39] *(p. 24)*

Transparent and streamlined systems for the reimbursement of providers, monitored to ensure timeliness and prevent misuse. Harnessing of existing experience in claims processing. Use of voucher management agency with clearly defined roles.

Four categories provided good evidence for a synthesis on the preconditions for a provider reimbursement system. The first category related to careful planning for the claims reimbursement system, drawing on findings from Bangladesh, India, Kenya and Uganda. The authors of a study on Vouchers for Health and HealthyBaby schemes in Kenya and Uganda, respectively, recommended a thorough consideration of functions for the voucher management agency, and a separate evaluation of the HealthyBaby scheme recommended drawing on prior experience:

> *„Define critical skill sets for the VMA [voucher management agency] based on key functions needed for an effective voucher program and support available from the larger health system. Decide if one single organization can carry out all VMA [voucher management agency] functions or if VMA [voucher management agency] functions should be split across many organizations to ensure that all the necessary expertise is available to effectively carry out all voucher program functions."*[23] *(p. 32)*

> *'Prior experience of the voucher management agency gave it some advantages in program management: MSI-U [Marie Stopes International – Uganda] was awarded the role of the VMA [voucher management agency] based on its previous experience with KfW [the German Development Bank] in condom social marketing and with running a network of reproductive health clinics.'*[52] *(p. 3)*

A finding on the need for training providers in how to handle programme accounts and money came from a study of JSY in Rajasthan, India:

> *„At the block level, an accounts officer suggested that 2 days orientation training needs to be organized for the stakeholders including ANM [auxiliary nurse-midwives] who handle accounts and money for the first time."*[64] *(p. 13)*

The second category related to the needs for a simplified process for the reimbursement of providers, and was supported by three findings. Evidence to support this category came from Bangladesh and

India. In India for example, excessive bureaucratic requirements have denied access to otherwise eligible women:

> *„The scheme could not reach the intended target group due to several schematic and system specific problems. Stringent requirement for production of BPL [below poverty line] card, certificate of caste, proof of residence, age etc during registration of ANC [antenatal care] under the scheme has reduced its popularity."*[28] *(p. 66)*

In Bangladesh, studies have described the difficulties faced by providers seeking reimbursement and how this delayed scale up of the Maternal Health Voucher Scheme:

> *„The informants perceived that there are high transaction costs in the DSF scheme. The providers and administrators may not be fully recompensed for their time and resources. Further, the deferred and/or irregular disbursement of payment becomes an issue for both providers and beneficiaries of the DSF scheme. Some provider-participants reported irregularities of a 10% reduction in the reimbursement rate of their cash entitlements by the distributor although this is not part of the DSF scheme."*[38] *(p. 31)*

> *„Bureaucratic processes may cause delays in implementation process: The implementation of the program has been characterized by delays. The launching of the 3rd phase was delayed for four months from August to December 2010 due to disbursement delays."*[49] *(p. 4)*

The third category related to the implementation of the reimbursement system for providers. Evidence from Kenya highlighted the need for standard operating procedures, *„Lack of standard operating procedures that could provide guidance on the claims process: There was lack of standard operating procedures to guide the claims process. Putting in place such procedures could have minimized the chances of rejections attributable to poor documentation."*[50] (p. 9)

Evidence from India, Kenya, Uganda and Armenia highlighted the need for transparency and close monitoring of the reimbursement process:

> *„Ensure efficient claims processing systems. Contract out design to an organization with expertise and closely monitor timeliness of reimbursements."*[23] *(p. 33)*

> *„The same analyses identified existing weaknesses in the Obstetric Care State Certificate Program. One of the major weaknesses is the inadequate monitoring of the financial flow of Program funds, leading to potential manipulation by hospital administrations and unofficial payments. There is currently a lack of transparency and accountability in how salaries are calculated and a serious concern that not all designated funds for salaries actually reach the providers. Major concerns were expressed that a reported universal dissatisfaction by maternity hospital doctors with their salaries could reestablish a higher level of informal*

payments and worsen the quality of provided services."[29] (p. 44)

The final category related to mechanisms that can detect misuse of the voucher scheme and remove providers, and was supported by four findings. Mechanisms to combat misuse have varied between DSF programmes and evidence came from studies on short term payments to offset costs of access in India and Nepal, vouchers for maternity services in India, Uganda and Armenia, and studies of vouchers for merit goods in Tanzania. A study of the MAMTA scheme in India highlighted a need to include a clause in the Memorandum of Understanding to prevent unnecessary referrals.[28] Studies of programmes in Armenia and Uganda have described experiences with monitoring claims and performing spot-checks:

'We [the government] need an assessment and more serious monitoring mechanisms. In the beginning of the Program we signed a statement with the heads of the facilities to minimize the risk of corruption. This year we have a new approach. We signed an agreement only for three months. Then we will update it based on their indicators and the results of monitoring. If the facility does not address government requirements, the Minister [of Health] can cancel the next agreement. But for this we need a valid and objective assessment of the Program. The Minister is attempting to find money from the budget to assign an NGO [non-governmental organisation] to conduct an assessment."[29] (p. 38)

„Verification of claims to ensure compliance with medical and financial standards went through different stages: Initially in 2006, the database was intended to red flag questionable claims for manual review. However, the system identified a very high proportion of claims as problematic, which reduced the usefulness of the program as a great majority of claims required manual review. By late 2006, the regional VMA [voucher management agency] office in Mbarara hired a medical expert to vet the claims. In the expansion since 2009, vetting teams do spot checks on samples of claims to check for compliance with medical and financial standards in order to control fraud. In cases where fraud was evident or highly probable, the claims were rejected, the providers were paid a fraction of the claimed amount, or they were suspended from the program."[52] (p. 6)

A study of the Tanzania National Voucher Scheme suggested further steps to combat misuse of vouchers:

„Supervision of the scheme at clinic level was relatively poor. Regular supervision and checking is likely to reduce misuse at clinic level. Secondly, training of MCH [maternal and child health] staff and ongoing promotion of the voucher scheme may need to focus on the right of each woman to receive a voucher. Greater awareness among women might have made it less easy for MCH [maternal and child health] staff to withhold vouchers."[41] (p. 7)

Use appropriate information, education and communication strategies to raise awareness among poor, rural or socially excluded women. Information provided should be culturally appropriate and include women's rights.

Three categories, comprising six findings, were used to form a synthesised finding on appropriate strategies for information, education and communication. The first category related to the need to promote DSF schemes among the target population and was based on evidence on short term payments to offset costs of access in India and Nepal, voucher schemes for maternity services in India, Kenya and Uganda, and a voucher scheme for merit goods in Tanzania. Suggestions for information dissemination included local television, newspapers and brochures. In some contexts non-governmental organisations have been used to raise awareness of DSF programmes.[39, 64] A study on the Tanzania National Voucher Scheme that subsidises insecticide-treated nets to pregnant women provided further information based on focus groups with men in a target village:

> *„FGD [Focus group discussion] participants had heard about the scheme through local employers, MCH [Maternal and Child Health] clinic staff and the TNVS [Tanzania National Voucher Scheme] Zuia Mbu sales and treatment agents in the villages. Zuia Mbu IEC [information, education and communication] campaigns during a sponsored football tournament had also played a role, as mentioned by one of the FGD [focus group discussion] participants: That is where most of us would like to go after coming from the shamba (farm) . . . and especially if you don't want to follow beer at local drinking places. (males, central sub-village, phase 1 area)"[47] (p. 168)*

Evidence from the Safe Delivery Incentive Programme in Nepal described information dissemination activities used, but noted difficulties faced during this process:

> *„Districts disseminated information to the community using various means, such as FM radio or through female community health volunteers. However, district stakeholders felt communication was hampered by a lack of guidance on how to promote the policy, and the absence of any budget allocation. Moreover, some respondents felt it difficult to disseminate information about a programme that they themselves did not fully understand."[40] (p. 7)*

The second category comprised findings on the need for culturally appropriate information that includes women's rights. Evidence to support these findings came from a study on the Juntos Programme in Peru and the Bono Juara Azurduy in Bolivia, for example:

> *„In Peru and Bolivia, state health services were criticised by our respondents for failing to promote any awareness of rights, for the lack of respectful intercultural relations, appropriate forms of information delivery, and proper treatment of women. Complaints were also made about the lack of culturally-appropriate and accessible health information."[43] (p. 208)*

The final category was based on one finding from a study on JSY in Rajasthan, India. The authors noted that a helpline has been introduced to link women with health care providers and appropriate transport:

> *„Rajasthan has tried out an innovation in JSY implementation. The state has launched JSY Helpline on experimental basis in one block of each district with the help of NGO [non-governmental organisation]. JSY helpline aims at promoting emergency referral and ensuring safe delivery of women with obstetric emergencies at the identified block health facilities. The NGOs [non-governmental organisations] ensure networking with transporters and health care providers. This intervention is in operation for several months and the state officials seem to be happy with the progress. The intervention is regularly monitored but it would be worthwhile to undertake an independent assessment of how this intervention has fulfilled its objectives. It is to be noted that JSY help-line blocks were not a part of the study sample."*[64] *(p. 14)*

Monitoring of adherence to official selection criteria for providers. Regular monitoring of quality of care in participating facilities combined with mechanisms to support facility investment in service quality.

The tenth synthesised finding related to the need for effective programme monitoring. Three categories provided modest evidence for this synthesis. The first category was based on a finding from a study in India, which suggested a solution to the delays caused when health providers checked if a women had already received JSY benefits from another provider:

> *„Use of information technology so that update is available to any provider about payments made by other institutes. This would do away with the need to confirm non-receipt in other areas before disbursement of money which causes delays."*[42] *(p. 133)*

The second category brought together suggestions for the monitoring of programme impact. Evidence from a number of studies in India suggested that programmes need to accurately record deliveries throughout the post-partum period, for example:

> *„The monitoring of the scheme is currently done by the District Programme Manager (NRHM) and the RCH [Reproductive and Child Health] officer at the district level. There is a need to strengthen the monitoring mechanism at the field level to make sure the scheme is implemented effectively. Currently the variables monitored are "the number of beneficiaries" and the "amount disbursed." As stated earlier, this does not permit the policy maker to understand whether the JSY has met its original objectives, those of increasing institutional delivery and reducing maternal and neonatal deaths. A real problem with monitoring the incentive scheme is that it encourages overreporting on utilisation data. An independent agency could monitor the scheme to provide timely and accurate reports of its performance. There is no formal evaluation being undertaken."*[58] *(p. 271)*

Findings used to develop the third category related to the need for guidelines and financial and administrative support to monitor DSF programmes. These findings came from a study on the Safe Delivery Incentive Programme in Nepal and are evidenced below:

> *„In almost all districts, respondents were unclear about what was expected of them in terms of monitoring the programme. There was a lack of guidance on how to monitor and there was no separate budget or time allocation to carry out these activities. Many felt that monitoring the distribution of financial incentives was important, but guidance had been insufficient. "So far we have not monitored the programme and no one has raised any question about this. However, this now stands as a big issue." (District hospital, Hill, Key informant interview) "A separate budget for supervision and monitoring of this scheme should be made available. The integrated budget for monitoring is just not enough." (District stakeholders, Hill, Focus group discussion)"*[40] *(p. 7)*

Regular monitoring of quality of care in participating facilities combined with mechanisms to support facility investment in service quality.

Three categories were used to form a synthesised finding on the precondition for monitoring quality of care, supported by five findings. The first category related to a precondition for a defined package of services to which recipients of DSF schemes are eligible and mechanisms to ensure it is adhered to. A study from India described how such a package was in place but was often ignored by health workers:

> *„According to women who had recently gone through childbirth and their relatives and members of the community, ANC [antenatal care] services are restricted only to immunisations (i.e. giving 2 injections of TT [tetanus toxoid vaccine] to the pregnant woman). Even abdominal check-ups are not conducted."*[72] *(p. 41)*

The second category focused on systems for monitoring quality of care and supporting improvements at the facility level, and was based on three findings. Evidence from studies in India, Kenya and Uganda emphasised the importance of monitoring quality of care and a study in Cambodia suggested that cash incentives had been helpful in maintaining quality of care, *„thanks to the cash incentives from the PBC [performance-based contracting] and delivery incentive scheme, midwives and health centre personnel had become more committed to ensuring 24-hour services at health centres"*[25] (p. 8)

An additional method of promoting investment in capacity and quality of care has been the „seed fund" used in the Maternal Health Voucher Scheme in Bangladesh:

> *„The "seed fund" accounts were generally perceived to be useful and appropriately used. These accounts are to be used for reimbursing public providers, paying FWAs [Family Welfare Assistants] and HAs [Health Assistants] for each woman registered in the voucher*

> *program, paying facility staff for daily DSF work, procuring drugs and supplies, and covering emergency referral transport costs. "The money of the seed fund is spent in procurement of medicines for the pregnant mothers, stationery, fuel, gift vouchers worth Tk. [Bangladesh Taka] 500, and registration fees for the fieldworkers. Through the approval of the upazila committee, the seed fund is also used for procuring other relevant necessary things." – DSF Coordinator. Complaints were made, both at the upazila level and central level, about the fact that unused seed fund money had to be returned to the government at the end of the year. "They even take away the seed fund money at the end of the year. If they would not take the seed fund money or could provide us an advance, then we would be able to pay the money [to women] early. " – UHFPO [Upazila Health and Family Planning Officer] "At the end of one financial year if any money left we can not keep it for the next financial year. We have to send it back." – Central-level key informant"*[53] *(p. 54)*

The third category drew on one finding from a study in India. This study highlighted the precondition of clear processes for lodging complaints:

> *„Even women who are aware of their entitlements and feel aggrieved by the treatment meted out to them in health facilities can find they have no way of registering and processing complaints. Government officials gave Human Rights Watch conflicting accounts of procedures for grievance redressal. Some stated that women could make complaints to superintendents or medical officers in charge of hospitals, while others stated that district chief medical officers could receive complaints."*[54] *(p. 103)*

Monitoring of adherence to official selection criteria for providers and official conditionalities for payments

A synthesised finding on the precondition of monitoring adherence to selection criteria and conditionalities was based on two categories, each comprising two findings. The first category focused on measures that ensure adherence to official selection criteria for beneficiaries, and was supported by evidence from short term payments to offset costs of access, voucher schemes for maternity services and schemes for merit goods. Studies in Bangladesh described examples confusion and improper selection of voucher recipients due to local officials not understanding the details of the Maternal Health Voucher Scheme.[38, 49] There was evidence on the application of unofficial selection criteria for the distribution of vouchers for insecticide-treated nets in Ghana and Tanzania. For example in a study on a pilot voucher scheme in Ghana, the authors described the following experiences:

> *„Interviews with health facility staff and with pregnant women suggest that the major reasons for women not taking a voucher varied over the one year period. Initially, midwives did not offer a voucher to all pregnant women, unless they could show that they were able to pay the topup amount required to buy the ITN [insecticide-treated net]. This 'screening' or imposition of eligibility criteria has been noted in other voucher schemes in Senegal [14] and in Zambia [24]. Knowledge of issues encountered in previous voucher schemes meant that non-imposition of eligibility criteria was stressed during the training programme in Volta*

> *Region. However, problems in attendance at training sessions reduced the effectiveness of the messages. Dissemination of monitoring findings four months into the scheme prompted further training and strengthened supervision, resulting in a marked decrease in the imposition of eligibility criteria as assessed during monitoring at 6 and 12 months into the scheme."[44] (p. 7)*

The second category focused on ensuring only official conditionalities are applied to DSF programmes. Evidence to support this category came from studies on conditional cash transfers. A study on Program Keluarga Harapan described how fines did not discourage women from failing to fulfil commitments for an institutional delivery because other supply-side factors limited uptake:

> *„The utilization of midwifery services during childbirth differed between the two treatment villages in NTT [East Nusa Tenggara]. In one treatment village, the use of midwives increased significantly because of which required mothers to give birth in polindes. If they did not they were subject to fines of Rp [Indonesian Rupiahs] 500,000. Conversely, in the other treatment village, despite fines amounting to Rp [Indonesian Rupiahs] 250,000, midwife services utilization rates were unchanged as there was no village midwife."[57] (p. 51)*

The authors of a study in Bolivia also described unofficial conditionalities that had been applied to cash payments:

> *„In Peru and Bolivia, women complained of frequent mistreatment and long waiting times at the health centres, which is especially problematic for those who have to walk for several hours to get to the services. There were also tensions with respect to the requirement that women should give birth in the health centre. Although having a hospital birth is not an official condition of the programme in Bolivia, in practice, women can be temporarily suspended if they have a home birth".[43] (p. 205)*

Programmes should provide clear guidelines and defined roles for any 'contracting in' of private practitioners to public facilities. Raise awareness and introduce attractive reimbursement rates to encourage private providers to join the scheme

The final synthesised finding under this review question focused on programmes that include provisions for „contracting in" private practitioners to public health facilities. This was based on one category and five findings, all from studies of short term payments to offset costs of access in India. Findings suggested the need for leadership and guidelines for contracting in private practitioners, and the precondition of an attractive reimbursement package:

> *„This study finds that there were no public private partnerships executed for EmOC [emergency obstetric care] provision in the study district. There is lack of ownership of the*

> *scheme among the administrators at the district and block level who did not take any initiative to implement the scheme. We could not find any documents regarding the design of the contract like the specification of services, performance measurement, incentives and penalties, etc. The district health officer, who according to the guidelines is responsible for execution of the PPP [public-private partnership] scheme in the district, calls this as a special accreditation to be done by the civil surgeon and not a PPP [public-private partnership]. A medical officer at a PHC [primary health clinic] questions the interest of any private specialist to contract-in pointing that this arrangement would only reduce their revenue at the private center"*[56] *(p. 23)*

It was also suggested that public health facilities be systematically assessed to determine which have facilities to support „contracting-in":

> *„A systematic effort to identify centers where contracting in could be feasible and a strategy accordingly would have resulted in at least few public sector options and real increase in outreach rather than ad hoc guidelines to be followed."*[56] *(p. 25)*

Review question 15. What are the preconditions to sustain and scale up DSF mechanisms?

Summary of quantitative evidence

Vouchers for maternity services

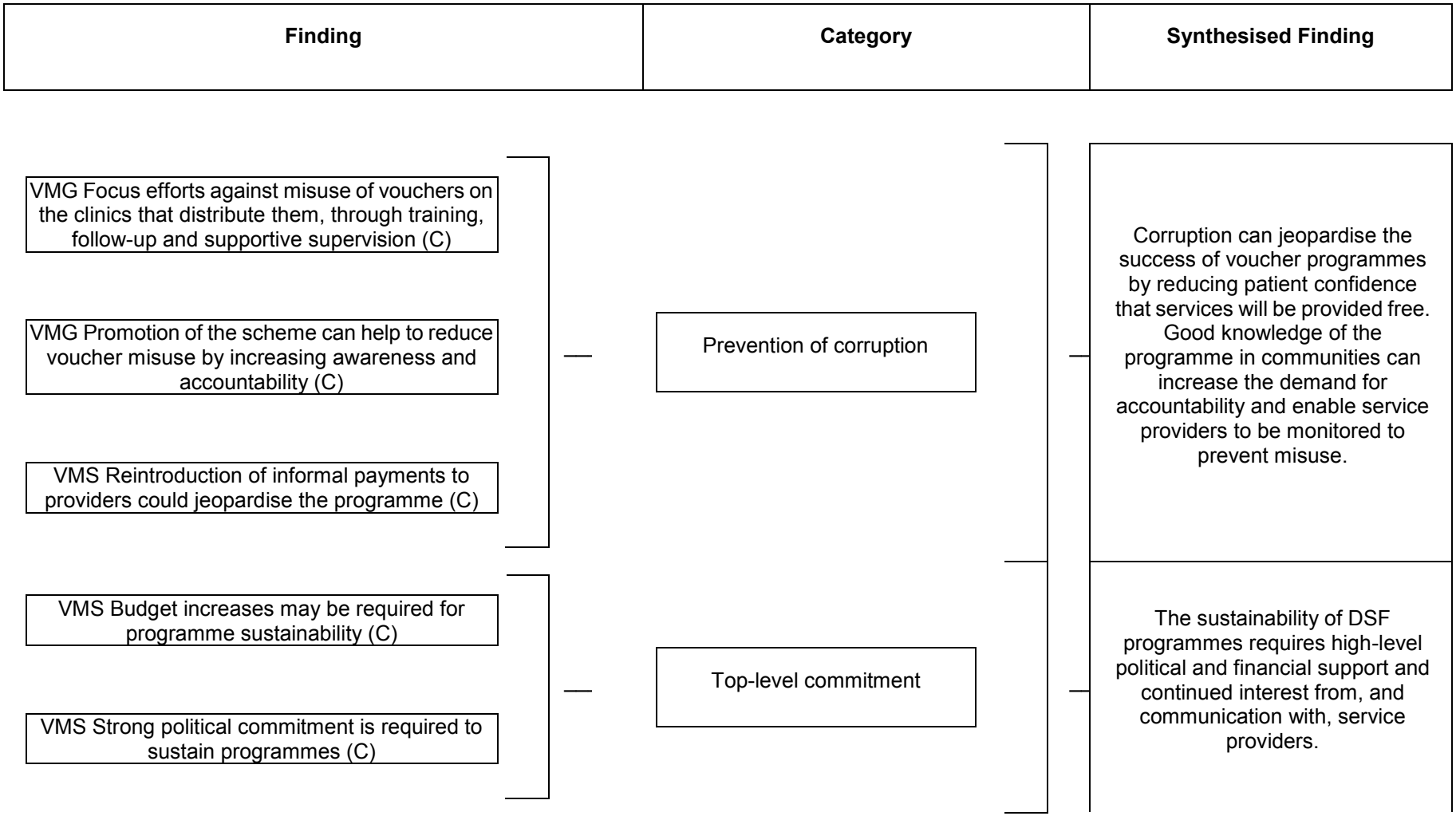
One quantitative study referred to preconditions to sustain and scale up DSF mechanisms.[28] Nandan et al. conducted an evaluation of the MAMTA scheme launched in 2008 in the New Capital Territory of Delhi, with a long-term objective to reduce maternal and infant mortality amongst populations in slum areas. The scheme enabled private hospitals and nursing homes to provide a comprehensive package of maternal health services, including institutional births. Hospitals and clinics were paid a fixed rate for each institutional birth for women eligible as a beneficiary under the scheme. The aim of the evaluation, conducted in six districts of Delhi in November-December 2009, was to understand the experiences of implementation and scope for modification to make the scheme more effective. Data were collected from a range of stakeholder interviews and a review of records at state, district, facility and field level. Only descriptive data were reported, with limited details of study methods, data analysis and selection of study participants.

Implementation was reported as unsatisfactory by many stakeholders (numbers not given), reasons including reluctance of private providers to join the scheme, lack of publicity and overburdening of existing staff. Of 35 hospitals/nursing homes included in the evaluation out of 36 which had signed a memorandum of understanding, over half reported that they did not wish to continue with the scheme in its present form. Several reasons were reported. For 23 (66%) providers, this included low remuneration for services provided, for 17 (49%) the high cost of caesarean sections and 15 (43%) providers reported problems reaching those eligible to be included in the scheme. Twelve facilities which reported that they would continue with the scheme would only do so as a social responsibility to serve the poor. Interviews with stakeholders, which included 15 medical officers, 10 Auxiliary Nurse Midwives and 21 ASHAs provided their perceptions of barriers and facilitators to the scheme, including a shortage of human resources at district level, inadequate and unauthenticated documents relating to the age, caste, income and residence of a woman, poor awareness among the community about the scheme and poor coordination with other agencies working in the sector. Numbers of interviewees reporting particular problems was not provided. Based on their evaluation, the researchers made several recommendations to sustain and scale up the programme. These included that remuneration for packages of service offered under the scheme should be enhanced, that remuneration fee should be revised at least every two years and that there should be provision in each Memorandum of Understanding to protect facilities against untoward events. Strengthening of referral mechanisms for emergency and neonatal care and of the monitoring system was also recommended.

Summary of qualitative evidence

Six studies included qualitative findings on preconditions to sustain and scale up DSF mechanisms, five of which focused on vouchers for maternity services,[22, 25, 28, 29, 38] and one on vouchers for merit goods.[41]

Evidence to support the synthesised findings was modest. There were ten findings that described preconditions to the sustainability or scale up of voucher schemes. These were grouped into five categories and three synthesised findings. These relationships are shown in Figure 6.



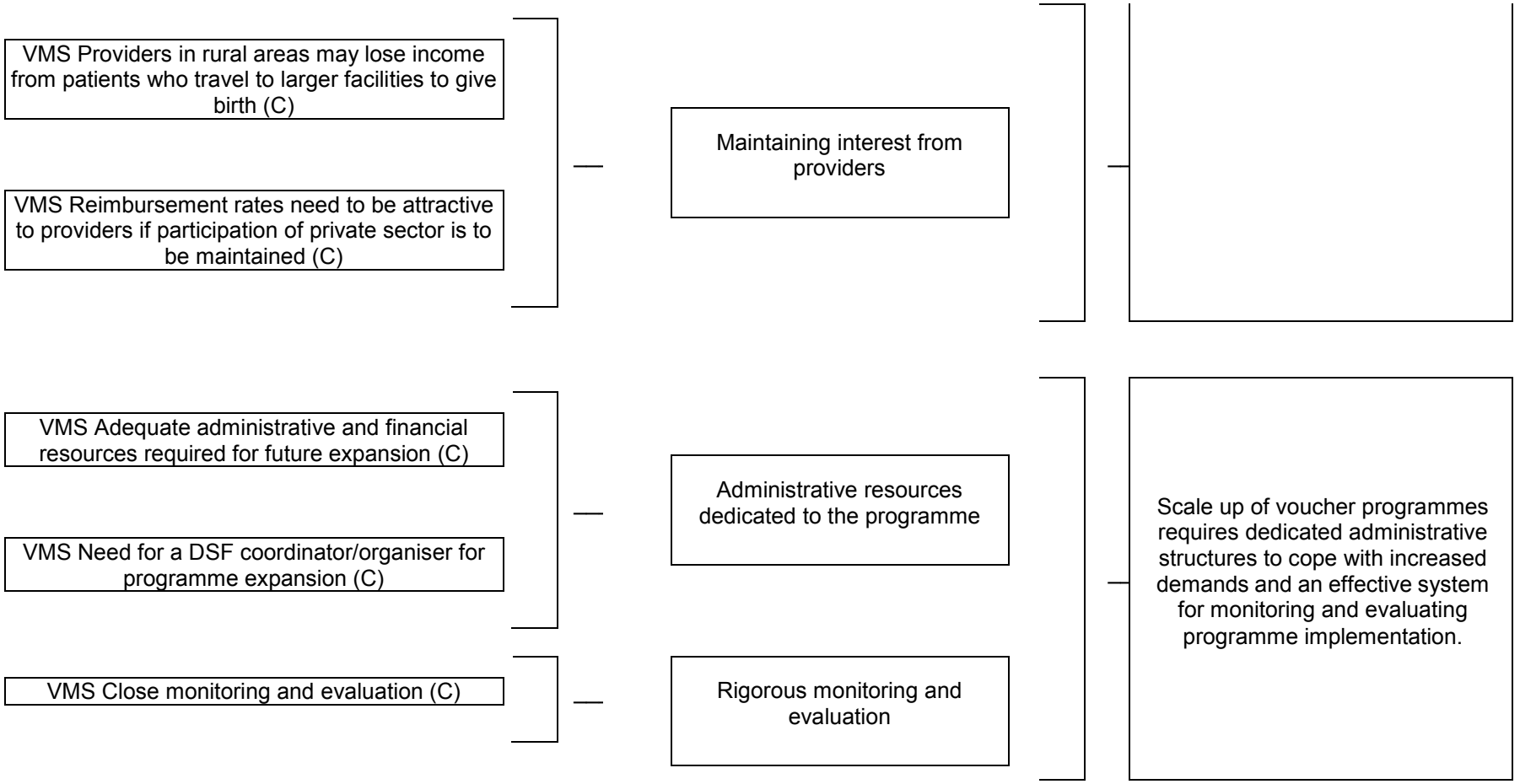


Figure 7. Meta-synthesis of findings on preconditions to sustain and scale up DSF (Question 15)

Notes: VMS refers to vouchers for maternal health services; VMG refers to vouchers for merit goods for maternal health; (c) refers to „credible", as per JBI-QARI levels of credibility

Categorisation and Synthesis of Findings (Q 15)

The composition of each synthesised finding is described below.

Corruption can jeopardise the success of voucher programmes by reducing patient confidence that services will be provided free. Good knowledge of the programme in communities can increase the demand for accountability and enable service providers to be monitored to prevent misuse.

The negative effect of corruption on perceptions of voucher schemes, and potential ways to combat corruption, was the focus of the first synthesis. This was supported by modest evidence from one category on the prevention of corruption, and three findings. Evidence was draw from a voucher scheme for merit goods in Tanzania and a voucher scheme for maternity services in Armenia. „Respondents" in a study on the Obstetric Care State Certificate programme in Armenia described the reintroduction of informal payments as the greatest threat to the voucher scheme.[29] In Tanzania, a study on corruption in the Tanzania National Voucher Scheme suggested the following measures:

> *„First, this study would suggest that efforts to minimize voucher misuse might be focused at MCH [maternal and child health] clinics, and to a lesser extent at commercial sales agents. Where vouchers are distributed by MCH [maternal and child health] staff, particular attention might be paid to their training, follow-up and supportive supervision."*[41] *(p. 8)*

> *„Secondly, major promotion of the scheme is likely to help reduce misuse, including awareness of the right of every pregnant woman and mother of a young child to a voucher. This awareness campaign should include community leaders and men as well as women, so that they can exert their authority to control voucher misuse."*[41] *(p. 8)*

Scale up of voucher programmes requires dedicated administrative structures to cope with increased demands and an effective system for monitoring and evaluating programme implementation.

The second synthesis related to preconditions to scale up of the voucher programme. Two categories were used to provide modest evidence for this synthesis. The first category related to rigorous monitoring and evaluation and was supported by one finding from a voucher scheme for maternity services in Cambodia:

> *„Voucher and HEF [health equity fund] schemes can be scaled up to areas with reasonably good public health services, but close monitoring and evaluation are needed to ensure further improvement"[25] (p. 10)*

The second category related to dedicated resources for programme administration and was supported by two findings from the Maternal Health Voucher Scheme in Bangladesh. A study by Koehlmoos et al described the need for a programme coordinator,[38] while a later study cited the need for adequate programme resources:

> *„Another problem of the programme was discontinuation of voucher distribution for few months. The implementation of the scheme could have been much more efficient if the voucher distribution was not discontinued in late 2007. Therefore, future expansion of the scheme should carefully plan the needs of the programme to ensure that adequate administrative and financial resources are mobilized for timely processing and disbursement of vouchers and incentive payments."[22] (p. 30)*

The sustainability of DSF programmes requires high-level political and financial support and continued interest from service providers.

The final synthesis under this review question related to preconditions for the sustainability of voucher schemes and was supported by modest evidence from two categories. The first category was high-level commitment in terms of political and financial support, based on two findings on the Obstetric Care State Certificate programme in Armenia:

> *„According to expert-participants there is a strong political commitment by the Government to the Obstetric Care State Certificate Program, assuring sustainability."[29] (p. 16)*

> *„Participants also indicated about a need to increase the budget of the Program to improve its effectiveness and sustainability." (p. 23)*

The second category was maintaining the interest of providers and was based on evidence from voucher schemes for maternity services in India and Armenia. In both situations, providers have been unhappy with the voucher schemes due to problems with reimbursements and patient flows. For example, a large proportion of contracted private facilities were no longer providing services through the MAMTA scheme:

> *„The scheme has become unattractive to the private providers. A total number of 36 private hospitals/nursing homes had signed MOU [Memorandum of Understanding] with the government, since the inception of the scheme, out of which 35 were contacted during the*

evaluation. However, only one–third hospitals/nursing homes are currently providing services under the scheme, but they may also withdraw from the scheme in near future. They are reluctant to continue with the scheme mainly due to unattractive service package, too much paper work and lack of publicity about the scheme and delay in reimbursement of claim. In order to make the scheme attractive to providers, these issues need to be addressed by the Government.' [28] *(p. 67)*

Discussion

This review set out to consider the evidence on schemes ranging across five modes of DSF: unconditional cash transfers, conditional cash transfers, payments to offset costs of access to maternity services, vouchers for maternity services and vouchers for the purchase of merit goods. DSF schemes have tended to be supplementary add-ons to existing supply-side financing, and are intended to incentivise behaviour change and increase affordability of specific services.[15] The mechanisms by which different DSF modes are expected to work are given in Table 9.

Table 9. Assumed mechanism for modes of demand-side financing

Unconditional cash transfers	*Alleviates deleterious effects of poverty on health during period of pregnancy*
Conditional cash transfers	*Use of conditionality improves utilisation of specified maternity services*
Payments to offset costs of access to maternity services	*Alleviates deleterious effects of poverty on access to maternity services*
Vouchers for maternity services	*Removes/ reduces cost of specified maternity services at point of use*
Vouchers for merit goods	*Removes/ reduces cost of merit good at point of use*

Some schemes such as the JSY scheme in India focused strongly on the targets set for Millennium Development Goal 5, specifically increasing rates of skilled attendance at birth, while others had broader maternal health goals. Other schemes evaluated in the included studies were established national cash transfer schemes (Mexico, El Salvador, Honduras, Peru, Bolivia and Turkey) which focused mainly on providing income support linked to child health and development, and in which maternal health was a small component.[37, 43, 81-84, 86, 87, 92] Most voucher schemes for maternal health care services (large scale in Bangladesh, small scale in India, Pakistan, Cambodia, Kenya and Uganda) and short term payments to offset costs of access (large scale in India and Nepal), were implemented to target the poorest and improve their access to care during pregnancy, labour and birth and postpartum.[18, 19, 21, 22, 25, 26, 28, 30, 38, 51-53, 80] In one setting (Armenia) a voucher-style scheme was introduced to establish the principle of universal entitlement to care and to remove unregulated payments of user fees.[29] The studies on vouchers for merit goods (Ghana and Tanzania) were confined to schemes using vouchers to subsidise purchase of insecticide-treated nets during pregnancy.[32, 41, 44, 46, 47] There was only one study of an unconditional cash transfer scheme for pregnant women (Tamil Nadu, India) identified for inclusion in the review.[11]

The primary objective of this review was to assess the effects of DSF interventions on maternal health service utilisation and on maternal health outcomes in low- and middle-income countries. It also aimed to identify broader effects on perinatal and infant health, the situation of underprivileged women and the health care system. These aims were achieved in part for three modes of DSF (conditional cash

transfers, cash payments to offset costs of access to maternal healthcare, and vouchers for maternity services), where we found evidence relevant to review questions on the utilisation of maternal health services, barriers to the provision of DSF and supply-side preconditions to implementing DSF schemes. There was insufficient evidence to provide comprehensive answers for review questions on the effect of DSF interventions on maternal, perinatal and infant health outcomes and on the social and financial situation of underprivileged women. There was also insufficient evidence on the cost-effectiveness of DSF interventions and preconditions for sustainability and scale-up of DSF schemes.

The review has drawn on a fairly large body of work from several continents. Many of the included studies were reports and evaluations for the relevant government or funding agency, and less than half were published in peer reviewed journals. Studies ranged from evaluations of state or national level implementation to reports of small pilot schemes. Many studies were evaluations of the early years of implementation of schemes and some were conducted to inform modifications for the next planned phase of implementation. It is too early to know whether subsequent modifications occurred and were successful, but there are many lessons regarding barriers and facilitators to implementation, as indicated in more detail in the Results section.

Issues relating to the quality of the research

Studies included in this review had many shortcomings and were generally of poor methodological quality. Descriptions of study methods were often incomplete and in some reports it was difficult to clearly identify the supporting evidence for each reported finding. This was particularly the case in evaluations that employed diverse mixed methods. Most evidence from the quantitative studies was observational. They tended to use narrow time periods and many were based on data from cross-sectional household surveys. It was not possible to conduct a meta-analysis due to a lack of uniformity in the outcome measures and comparators. Most of the evidence reported here under „qualitative studies" were qualitative elements of larger programmatic evaluations. These typically used data collected through interviews and focus group discussions to add meaning and aid interpretation of other findings, but with little explicit reference to theory. Very few economic evaluations were identified and most of these used estimations based on limited or ill-defined cost data. Incongruent measures of cost-effectiveness also precluded meaningful comparison across the studies.

The Joanna Briggs Institute model of evidence-based healthcare specifies four facets through which to examine the evidence on an intervention: *feasibility*, *appropriateness*, *meaningfulness* and *effectiveness*. In this section we summarise key findings according to these four facets, highlight other key issues of relevance, and consider what is known about the strengths and weaknesses of the five different modes of DSF for maternal health. Finally we offer recommendations for policy and practice and for future research. Underlying this discussion is an understanding, flagged up in the introductory section of this report, that achievement of optimal maternal health will require a mix of promotion, protection, and prevention activities along with timely intervention, and that these should be provided within a continuum of care for reproductive, maternal, neonatal, and child health.[96]

Feasibility of DSF interventions for maternal health

Feasibility is considered to refer to the extent to which an activity is practical and practicable in a specific context.[35] Key aspects include affordability of costs and availability of supporting infrastructure. Conditional cash transfer schemes were operational in middle-income countries which had sufficient resources and infrastructure to support them and were not led by, or confined to, the health care system. Other DSF schemes operated with varying degrees of integration within existing health care structures in low- and middle-income countries. Schemes that offered short term payments to offset costs of access tended to operate through existing structures of government health care, which could result in erratic implementation. Voucher schemes, which were primarily externally funded, have tended to work through complex and more costly parallel administration structures for voucher management and distribution, accreditation of providers, setting of reimbursement rates, claims processing, and mechanisms for monitoring, all of which require competent human resources. Vouchers for single merit goods such as insecticide-treated nets can be incorporated relatively easily within existing structures although decisions have to be made as to whether it is preferable to distribute the vouchers via antenatal care providers or other providers such as pharmacies, and how to monitor for distortions or corruption.

No evidence was found on costs of unconditional cash transfers or on the maternal health component of conditional cash transfers. Overall programme costs were provided only by a small number of economic evaluations of voucher schemes, and costs across countries and schemes are hard to compare. For instance, a two year pilot of the Sambhav voucher scheme for maternal health services in Uttarakhand, India,[27] had programme costs of around INR 15.0 million (US$ 282,000) related to the utilisation of around 14,000 vouchers. Programme costs for the larger Maternal Health Voucher Scheme in Bangladesh were BDT 251.3 million (US$ 3.7 million) for one year, during which time around 90,000 vouchers were distributed, of which incentives and subsidies accounted for BDT 235.1 (US$ 3.4 million).[53] For the Tanzania National Voucher Scheme to subsidise insecticide-treated nets, total costs including those for users and staff, were US$ 10.5 million over a two year period.[95] Of this, 8% were 'start up' costs, and 28% were the costs of subsidies and user contributions.

Generally, the lack of clear benchmarks means that it was not possible to assess whether modes of DSF can be considered low cost interventions. In practice, feasibility of schemes was frequently reduced by delays caused by extensive bureaucratic procedures, and inefficiencies in voucher distribution and provider reimbursement. Costs of vouchers that subsidise purchase of insecticide-treated nets seemed to be quite low.[95] Vouchers for maternal health care services appeared to have low incremental costs,[27, 53] however such schemes carry additional costs related to parallel administrative systems and community voucher distribution. The studies of these included no direct comparison with other ways of achieving the same objective, such as similar investment in supply-side interventions. Short term payments to offset costs of access have been criticised by authors such as Powell-Jackson and Hanson because of their relatively high expense.[18]

Across many of the studies of vouchers for maternity services, we found strong qualitative evidence concerning demand- and supply-side barriers to the effective provision of the benefits to the specified target groups. These need to be tackled if the aims to reach and benefit the poorest or most disadvantaged are to be attained. On the demand-side, there is clear evidence of continued geographical, social and financial barriers that prevented or delayed access for some poor, rural or otherwise socially excluded women (see Results: Review question 10). Issues related to geographical remoteness and poor transportation links fall outside the remit of DSF schemes. These increase the costs of identification and distribution, as well as limiting their uptake, thus restricting their practicability in some settings.

The point of approach to beneficiaries varied in different modes of DSF. Typically, in cash transfer schemes the user was informed about the maternity services and obliged to use them as one of the various conditionalities imposed by the broader scheme. Vouchers for maternity services tended to be distributed prior to clinic attendance to encourage early use of services and use by new beneficiaries, a situation that required community level distribution mechanisms. Payments to offset costs of access to health care and vouchers for insecticide-treated nets tended to be distributed via the health care facilities or providers once these had been accessed, creating the risk that these would only benefit existing service users. JSY in India addressed this by using community based ASHAs to specifically promote the scheme to potential beneficiaries. Many of the studies in other settings argued for community-based agents, either to encourage women to visit health facilities and claim cash payments or for the distribution of vouchers for maternity services. There is some evidence that such scheme promotion and voucher marketing can raise family and community awareness of the importance of giving birth with a skilled attendant. However, social barriers to the uptake of care or that cause early self-discharge from hospital, such as women"s household and family responsibilities, also need to be addressed in the context of other wider social interventions.

Other commonly reported barriers could be addressed in the design and initial implementation phases to potentially increase the feasibility of the schemes. Among these three stand out as common and important barriers found across a range of schemes. The first is the exposure of beneficiaries to new financial costs because of their uptake of the scheme. In the case of payments to offset costs of accessing maternity services there was a mixed picture that depended on the level of cash payment, on the complexity and costs of an individual"s care, and on what health care they would have accessed without the scheme"s encouragement. Overall, net loss to a household was more common than net gain (see Table 10). In the case of vouchers for maternity services it is often assumed that these act in a similar way to removal of user fees, fully covering the costs of services, but the evidence reviewed here suggests that additional out of pocket expenditure was frequently incurred by families when women used a voucher scheme to give birth in a health care facility.[28, 38] There is evidence that such costs are difficult to meet and that fear of these costs or uncertainty about their likely size can be prohibitive for women in the poorest sections of a community. Typically the studies cited payments for transport to get to the facility, fees for aspects of health care such as medicines, tests and complex care not covered by voucher / free service arrangements, and tips and bribes demanded by staff.

Table 10. Effect of DSF modes on poverty

	Unconditional cash transfers	**Conditional cash transfers**	**Payments to offset costs of access**	**Vouchers for maternity services**	**Vouchers for merit goods**
Effects on household out of pocket expenditure	No studies	No studies	Mixed picture, net loss more common than net gain	Out of pocket expenditure on health care reduced	No studies
Extent of evidence			*Multiple studies:* *Nepal, India*	*Two studies:* *Bangladesh, Uganda*	

Appropriateness of DSF interventions for maternal health

Appropriateness is the extent to which an intervention fits with or is apt in a situation.[35] The evidence suggests that there are at least three aspects to this. DSF schemes can be considered in terms of appropriateness for population health or other social justice needs, appropriateness to the personal situations of the intended beneficiaries, and appropriateness for the providers who are intended to deliver the care or goods.

In situations where there is a policy drive to increase use of different components of maternity services or other merit goods, marketing, information and distribution strategies for DSF interventions could be used to raise awareness of the existence of maternal health services and of their importance. Vouchers towards the purchase of insecticide-treated nets were distributed at antenatal care consultations, for example, to emphasise the importance of their use during pregnancy. Obligatory attendance at education sessions within cash transfer schemes may make poor women more aware of their own health needs as well as their children"s. There is good evidence of the importance of paying attention to local context in the design of DSF schemes. Inappropriate eligibility criteria or distribution channels, for example, restricted access for poor, rural or socially excluded women in Bangladesh, India and Nepal,[22, 40, 53, 54] and the partial nature of the voucher subsidy for the bed nets limited purchase by some poor women in Tanzania.[47]

Assessment of appropriateness of the DSF schemes is somewhat more complex when viewed from a social justice perspective. An emphasis on the human right to safe motherhood was an important driver for inclusion of maternal health as a Millennium Development Goal and for the target for „skilled attendance at delivery" within this. Many DSF schemes that facilitate skilled attendance were established in response to that ambition.[98] Some of these schemes, most notably the Obstetric Care

State Certificate Program in Armenia, were reported to give women a greater sense of dignity and of their entitlement to care.[29] However qualitative findings indicated that the eligibility criteria employed in a range of other DSF schemes could be controversial and problematic. For example, in order to reward family planning some schemes confined eligibility to women who had used contraception for birth spacing, and in doing so restricted women"s right to reproductive choice.[43, 53] Criteria that confined eligibility to women with a small number of pregnancies or live children were also reported by those who had to implement them to effectively exclude many of the poorest women.[40] Due attention also needs to be paid to whether the scheme"s requirements and procedures actively reinforce or reduce social exclusion. Schemes that used existing bureaucratic means, such as „below poverty line" (BPL) cards in India, to confirm eligibility greatly facilitated ease of scale-up, but risked excluding migrant and undocumented women.[11, 54]

There is some evidence of providers" experiences with DSF schemes (see Results: Review question 11), and the design of DSF schemes for maternity services and for merit goods distributed through them needs to take into consideration the appropriateness of the scheme for the service providers. This includes synergy with their interests (for example, increased workload may need to be balanced with other rewards) and prevention of perverse incentives. Poor behaviour by staff in government facilities where schemes increase service utilisation without increasing resources has already been alluded to. In voucher schemes providers may be public, private or not-for-profit and their institutional and personal interests in the schemes therefore vary. It is clear that, while payment mechanisms for voucher schemes are output based and should allow easy tracking of outputs, weaknesses in monitoring allowed distortions to take place. Over-reporting of activity by facilities and practitioners is a particular danger in order to benefit from the new funding. Reluctance to deal with complicated cases seems to be a particular problem for schemes that attempt to involve private sector providers in birth care. For example, the ground breaking Chiranjeevi scheme in India was designed to enable poor women to access private sector maternity provision. However there was evidence that some „cream-skimming" occurred in which private doctors accepted charge of uncomplicated deliveries but unnecessarily referred-on complicated cases to government facilities. This was compounded by what the private providers felt were inadequate reimbursement rates for complicated deliveries.[45] Schemes involving the opt-in of private providers are particularly vulnerable to attrition if they prove to be less rewarding than initially anticipated, and there are some questions about the long term sustainability of this approach.

Meaningfulness of DSF interventions for maternal health

Meaningfulness is the extent to which an intervention is positively experienced by the user.[35] There was limited and conflicting evidence that targeted schemes can be implemented without the user feeling stigmatised by the targeting. Evaluations of voucher schemes and of payments to offset costs of access contained many positive views from users. For example, in Bangladesh, India, Indonesia and Armenia, women reported that they benefited because the scheme meant that their needs were given greater consideration by family members and health facility staff.[29, 53, 57, 61] However there were also many accounts of poor and disrespectful treatment by healthcare providers when they used DSF schemes to access services.[25, 43, 46, 50, 52-54, 59-61, 73-75] Poor treatment by providers is known to be one of the non-financial reasons why poor and socially marginalised people make less use of public services and

complementary action to address such factors are a necessary adjunct to DSF schemes. Failure to conform to a scheme‟s procedures could even occasion new reasons for the ill-treatment. In a Tanzanian scheme, nurses‟ scolding of women who had not gathered the additional money to purchase their subsidised bed net reportedly caused some women to delay returning for their antenatal care. Another facility in the same study produced a radically different solution – a system whereby poor women could pay for their net in instalments.[41] Where private facilities were perceived to be of better quality than those in the public sector, users appreciated the access to services that would otherwise have been unavailable to them.[28]

Advocates of voucher schemes often emphasise choice of provider as a key advantage of this mode. However, this aspect was rarely a visible feature in the accounts of maternal health voucher schemes (see Results: Review question 5). In practice there was little, if any, choice between providers in rural areas. Nor did we find evidence to substantiate the „increased choice‟ argument in the few urban schemes that have been evaluated. These studies indicate that private providers tended to be reluctant to sign up or lost interest after an initial commitment because they saw insufficient rewards (see Table 11).

Table 11: Effects of DSF modes on offer of maternal health goods and services

	Unconditional cash transfers	**Conditional cash transfers**	**Payments to offset costs of access**	**Vouchers for maternity services**	**Vouchers for merit goods**
Effects on choice of provider offered and market competitiveness *Extent of evidence*	No studies	No studies	Increased use of government facilities for birth relative to non-government *Single study:* *Nepal*	No studies	No studies
Effect on scope, quantity or type of services offered *Extent of evidence*	No studies	No studies	No studies	No studies	No studies

Finally, several of the studies critiqued lost opportunities for schemes to contribute to the greater strengthening of women"s position in the household and society, citing instances such as the giving out of cash intended for women to family members (short-term cash payment scheme), the increased work that conditionalities imposed on women (conditional cash transfer), failure to actively involve women"s organisations in the design of the schemes, and failure to take on major social issues such as gender-based violence within obligatory health education sessions (conditional cash transfer).[42, 43, 74]

Effectiveness of DSF to promote maternal health, and perinatal and infant outcomes

There is reasonable evidence that DSF for maternal health increased uptake of antenatal care, ownership and use of insecticide-treated nets, and uptake of institutional delivery, skilled attendance at the birth and postnatal care in most settings in which they were introduced (See Results: Review question 3). This is summarised in Table 12. The effect on caesarean section rates needs to be interpreted with caution. In settings where insufficient women have timely intervention, increases in population level caesarean section rates that are below the WHO recommended rate of 15% of deliveries can be expected to be positive. However the data is not detailed enough to confirm that the intervention was justified in these cases.

Table 12. Effect of DSF modes on uptake of maternal health goods and services

	Unconditional cash transfers	**Conditional cash transfers**	**Payments to offset costs of access**	**Vouchers for maternity services**	**Vouchers for merit goods**
Effects on uptake of antenatal care *Extent of evidence*	No studies	Mixed picture of positive and no effect *Multiple studies:* *Latin America*	Positive effect *Multiple studies:* *India*	Positive effect (one no effect, one negative – same scheme) *Multiple studies:* *South Asia, East Africa*	No studies
Effects on usage of insecticide-treated nets during pregnancy *Extent of evidence*	No studies	No studies	No studies	No studies	Positive effect *Single study,* *Tanzania*
Effects on uptake of institutional delivery care *Extent of evidence*	No studies	Mixed picture of positive and no effect *Two studies:* *Mexico, El Salvador*	Positive effect *Multiple studies:* *South Asia*	Positive effect (one no effect) *Multiple studies:* *South Asia, East Africa*	No studies
Effects on uptake of skilled attendance at delivery *Extent of evidence*	No studies	Mixed picture of positive and no effect *Multiple studies:* *Mexico, El Salvador*	Positive effect *Multiple studies:* *India, Nepal*	Positive effect *Multiple studies:* *Bangladesh, Kenya*	No studies
Effect on seeking treatment for obstetric complications *Extent of evidence*	No studies	No studies	No studies	Positive effect *Single study* *Bangladesh*	No studies

Effects on caesarean section rates *Extent of evidence*	No studies	Mixed picture of positive and no effect *Two studies:* *Mexico*	Mixed picture of positive and no effect *Multiple studies:* *India, Nepal*	No effect *Two studies:* *Bangladesh*	No studies
Effects on uptake of postnatal care *Extent of evidence*	No studies	No effect *Two studies:* *Honduras, El Salvador*	Positive effect *Single study:* *Rajasthan, India*	Positive effect (one no effect) *Multiple studies:* *South Asia, East Africa*	No studies

Evidence of any effect of DSF on maternal and infant mortality and morbidity outcomes was sparse, as shown in Table 13. Only two studies investigated maternal mortality. The first, of the Mexican Oportunidades conditional cash transfer programme, showed an overall 11% reduction in maternal mortality ($p<0.05$) over 1995 – 2002 as well as reduction in infant mortality but not neonatal.[85] The second, a well-designed evaluation of the Bangladesh Maternal Health Voucher Scheme,[53] showed no impact on this although the small number of deaths across study groups may not have enabled a difference in mortality outcomes to be detected. There was however a fall in perinatal mortality due to a decrease in stillbirth rates. No studies were identified which considered impact on maternal morbidity.

Table 13. Effect of DSF modes on mortality and morbidity

	Unconditional cash transfers	**Conditional cash transfers**	**Payments to offset costs of access**	**Vouchers for maternity services**	**Vouchers for merit goods**
Effects on maternal mortality *Extent of evidence*	No studies	Positive effect *Single study:* *Mexico*	No studies	No effect *Single study:* *Bangladesh*	No studies
Effects on maternal morbidity *Extent of evidence*	No studies	No studies	No studies	No studies	No studies
Effects on perinatal and infant mortality *Extent of evidence*	No studies	Positive on infant mortality rate; no effect on neonatal mortality *Two studies:* *Mexico*	Mixed picture of positive and no effect on neonatal mortality *Multiple studies:* *South Asia*	Positive effect on stillbirth rate *Single study:* *Bangladesh*	No studies
Effects on perinatal and infant morbidity *Extent of evidence*	No studies	Mixed picture of positive and no effect on birth weight *Two studies:* *Mexico*	No studies	No studies	No studies

Other issues of relevance

Targeting

Pregnant women represent a relatively well defined target group to identify for DSF schemes, as compared to some other population groups in need of reproductive health services. [15] The DSF programmes included in this systematic review have all targeted poor women and many have targeted those in rural areas or who are socially excluded. For example, Oportunidades was initially introduced (as PROGRESA) for poor families in rural areas of Mexico and was later expanded to include urban areas. Women in India who are eligible for JSY include those who have a „below poverty line" card and those with certification of membership in specific ethnic groups referred to as the „scheduled castes" and the „scheduled tribes". Voucher schemes for maternity services have also specifically targeted poor and socially excluded pregnant women.

Barriers to effective targeting include leakage of programme benefits to non-poor women and programme requirements that result in restricted access for poor and other socially excluded women. In the latter case, schemes that incorporate existing targeting mechanisms such as the „below poverty line" card in India will require safeguards to ensure that undocumented women are not unfairly excluded. Given that considerable administrative capacity is required for means testing in the absence of such a national scheme, due consideration needs to be given to the appropriateness and feasibility of means testing when designing schemes. Identifying the poor from scratch is expensive and can miss those that should benefit since household poverty is dynamic. Policy makers should consider whether systems that target based on simple local characteristics, such as all pregnant women living in an area known to be generally deprived, could provide an acceptable, lost-cost alternative to individual targeting. In the case of vouchers that subsidise but do not cover the costs of merit goods, evidence has shown that such user contributions can restrict equity gains.

Many of the quantitative studies included in this review examined the coverage of specific maternal health services for target groups in an intervention area. This approach is important to determine the wider impact of DSF interventions however it may not reveal inequities within the target groups which were often highlighted in the qualitative elements of studies. Our review sought to identify the effect of DSF for poor, rural or socially excluded women. Of the 33 quantitative studies included in the review, only 11 referred specifically to poor, rural or socially excluded women and relevant findings from these studies are summarised below.

Effects for the poorest women

Evidence on the effect of DSF interventions for women in the poorest households was limited to seven studies. Evidence from Mexico showed that Oportunidades, a conditional cash transfer, had a more profound effect on maternal and infant mortality in areas of higher deprivation,[85] and studies in Bangladesh and Pakistan showed that voucher schemes for maternity services had a greater effect on

uptake of maternal health services among women in the poorest quintiles or terciles.[21, 53, 77-79] Ahmed and Khan"s study of the Maternal Health Voucher Scheme in Bangladesh is an example of an evaluation that focused very specifically on equity of effects.[78] It showed that the Maternal Health Voucher Scheme in Bangladesh had reduced out of pocket expenditure for women in the bottom four wealth quintiles but not those in the least poor quintile. A study in Nepal showed that expenditure on giving birth represented a higher proportion of total annual household consumption for the poorest quintiles, despite the introduction of the Safe Delivery Incentive Programme to offset the costs of access.[89]

Effects of women in rural areas

The effect of DSF for women in rural areas was limited to findings from five studies.[21, 61, 84, 90, 92] Studies that used survey data from the early (rural) stages of Oportunidades showed a reduction in infant mortality and neonatal morbidity, but not infant morbidity or neonatal mortality.[84] The effect of DSF on utilisation of maternal health care services in rural areas was mixed. Evidence from studies on Oportunidades showed positive or no effect.[90, 92] One study on JSY, a scheme to offset costs of accessing maternal health care services, showed increased uptake of antenatal care, institutional delivery, skilled attendance at birth and postnatal care for women in rural areas.[61] Difference-in-difference models used for antenatal and postnatal care (but not the other indicators) showed a greater impact in rural areas than in urban areas. Findings from a study on vouchers for maternity services in a rural district of Pakistan showed uptake of antenatal care increased but institutional delivery and postnatal care did not.[21]

Effects for socially excluded women

None of the quantitative studies in the review considered the effect of DSF interventions on socially excluded women. A selection of studies from Mexico and India included membership of „indigenous" population groups or „scheduled castes" and „scheduled tribes" as a variable in regression analyses. However, this did not extend to stratifying the effect of DSF for these population groups compared to the wider population.

Quality of care, demand and competition

High quality, safe maternal health care requires a complex balance of support and respect, reinforcement of normal physiological processes in pregnancy and birthing, vigilance that pregnancy and labour are progressing as planned, and vigilance for and timely treatment of complications with referral as necessary to a higher level. Quality of care as defined within the Institute of Medicine's six domains of safety, effectiveness, patient-centredness, efficiency, timeliness and equity is relevant here,[99] yet the effect of DSF schemes on quality of maternity care was under-researched.

Table 14: Effects on Quality of Care					
	Unconditional cash transfers	**Conditional cash transfers**	**Payments to offset costs of access**	**Vouchers for maternity services**	**Vouchers for merit goods**
Effects on Quality of Care *Extent of evidence*	No studies	Mixed picture of positive and no effect *Single study:* *Mexico*	Mixed picture of positive and no effect *Two studies:* *India*	Mixed picture of positive and no effect *Single study:* *Bangladesh*	No studies

Only four studies in the review attempted to quantify the effect of DSF schemes on quality of care (Table 14), showing inconsistent effects for aspects of care considered.[53, 61, 69, 90] Qualitative data from a range of settings suggested that increased demand on services placed considerable additional strain on existing staff and resources. It seems likely that such conditions can have a detrimental impact on health effects as well as the long waiting times and poor treatment reported in the qualitative data. There is a need for robust studies to examine the effect of voucher schemes on the quality and safety of care using a comprehensive set of aspects that go beyond simple coverage indicators. When interventions become framed in an episodic format (four antenatal contacts, attendance for the birth, two postnatal contacts, etc.) and metrics based on utilisation predominate, it is possible to lose sight of the complex support that an individual woman and her infant may require.

A recent systematic review reported modest evidence that voucher programmes can improve the quality of reproductive health services.[34] There is currently insufficient evidence on vouchers for maternal health to draw any conclusions on this, but it would be incorrect to assume that maternity services behave in the same way as all other reproductive health services. For example, the commonly voiced expectation that competition between providers is expected to increase quality for voucher goods/services[34] was not born out in the studies reviewed here. Accredited providers in the maternal health care voucher schemes tended to be reimbursed at a standard rate and were not competing on price. Competition on quality would require households to have reliable information on, and access to, multiple providers who are, in turn, responsive to quality of care issues. There was no evidence to show increased choice or responsiveness of maternity providers as a result of DSF interventions.

Sustainability

There was little evidence to inform how sustainability of DSF Schemes could be attained. Qualitative findings across the DSF modes pointed to the importance of high-level political and financial support. This carries certain risks if associated politicians fall out of favour, but the advantages are also borne out

by the long-serving conditional cash transfer schemes in Latin America which have relied on the support of successive governments.[100]

There is a very real risk that after the Millennium Development Goal deadline of 2015 many of the policies initiated in response to Millennium Development Goal 5 targets, focussing specifically on maternal health, may lose support and this is an important reason to emphasise its place within a continuum of reproductive, maternal, infant and child health care.[15] Many voucher schemes are externally funded, raising questions about their sustainability. It will be important to learn from the progress of programmes such as the Sambhav voucher scheme in Uttar Pradesh, India, which was initially funded by USAID but then handed over to the state to continue to administer using semi-state apparatus.[27, 101] Local preconditions to sustain voucher schemes for maternity services were indicated by quantitative and qualitative findings in Bangladesh and qualitative studies in India and Armenia, and findings highlighted the importance of motivated and incentivised suppliers of the services or merit goods.[28, 29, 53]

Scale up

Oportunidades in Mexico provides an example of government managed, sustained programmatic scale up over a period of 15 years, with an inbuilt evaluation component that provides robust data. The JSY scheme provides an example of scale up of a cash incentive scheme which was driven by the National Rural Health Mission and integrated within the public health care sector, but which has also allowed state level variations in implementation. However our literature searches did not identify detailed research analyses of the policy processes involved in these developments.

Most voucher schemes tended to be quite small scale, with the exception of that of Bangladesh. Some of the preconditions to scale up voucher schemes for maternity services were highlighted in qualitative evidence reviewed from Bangladesh and Cambodia (Results: Review question 15).[22, 25] For example, DSF schemes require some degree of autonomous fund management and in most of the schemes this was carried out by a third party organisation. It is possible that these could be undertaken within the relevant Ministry if dedicated administrative structures and funding is in place for programme expansion. However, these administrative mechanisms bring additional burdens as do the continued monitoring and evaluation of the scheme that studies suggest is necessary.

Complementary elements and combined DSF approaches to maternal health

The use of DSF to persuade and enable poor or otherwise marginalised women to avail themselves of antenatal and postnatal care and to give birth in health facilities requires attention to the differing elements that need to be in place to facilitate this trajectory of maternity care. Some schemes incorporated incentive payments to health workers and cash payments to women intended to offset

other costs, for example the Safe Delivery Incentive Programme in Nepal.[18] Others included additional maternal health components such as a cash incentive for nutrition during pregnancy, for example the Indira Gandhi Matritava Sahayog Yojana in India. While such schemes go some greater way to meeting maternal health needs their complexity does introduce new challenges for smooth administration and the evidence suggest that women might often receive some components but not all, due to bottlenecks in the system.

Potential limitations of the review

Included studies reflected a variety of contexts and interventions. There are therefore limits to which findings and recommendations drawn can be generalised to other contexts and interventions. Conducting a systematic review of such breadth carries an inherent risk that details specific to particular modes of DSF will be lost during analysis and reporting.

The systematic electronic bibliographic searches conducted for the review used search terms in English and English language databases were used. Abstracts were limited to those in English and it is possible that studies published in other languages were missed due to this stipulation. One Spanish language report on Oportunidades was included after being identified through a reference in an English language study.[85] This report detailed important findings for the effect of Oportunidades on maternal and infant mortality. The study was retrieved and translated for appraisal and inclusion in the systematic review.

Systematic searches were limited to studies published between January 1990 and June 2012. There are examples of DSF modes in use in low- and middle-income countries prior to this, for example voucher schemes for reproductive health in Taiwan and Korea during the 1960s and 1970s. We are however unaware of any DSF schemes that would have qualified for our systematic review were this time restriction not in place.

We used standardised procedures to document the methods of this systematic review however there are value judgements that are inevitable in any existing systematic review methodology. The critical appraisal of studies was conducted using a list of key questions but the final decision of what to include or reject was made by the reviewers. It is possible that different reviewers may have included a different set of studies and therefore reached different conclusions.

Conclusions

Implications for research

There is a pressing need for *large, robust studies on the impact of DSF on maternal and infant mortality and short and longer-term morbidity*, which should also reflect „good practice" indicators such as the uptake and duration of exclusive breastfeeding and uptake of infant immunisation programmes. It is also important that the impact on outcomes of subsequent pregnancies is evaluated. Large or moderately sized DSF programmes that have recently or will soon be scaled up, such as those in Bangladesh, Kenya and Uganda, represent the most obvious sites for such evaluations, and lessons may be learnt from Mexico"s PROGRESA/ Oportunidades about how to establish a well-embedded monitoring and rigorous evaluation structure.

Voucher schemes hold particular appeal to external funders because they lend themselves to ease of monitoring of effects such as uptake of services. This should not allow the *possible potential for DSF in the promotion and prevention aspects of maternal health such as nutrition and adequate rest* to go unexplored. Unconditional cash transfers for maternal health are gaining in popularity,[12, 13, 102] but while they require far less administrative structure to implement they are harder to track for effects. The lack of quantitative and qualitative evidence on this mode indicates a pressing need for well-designed research studies in this area.

Similarly the review revealed a lack of evidence regarding effects on maternal health of vouchers for merit goods other than insecticide-treated nets. Renewed policy interest in *the potential of vouchers for food*,[33] needs to be informed by well-conducted research in this area.

The extent to which DSF schemes succeed in promoting maternal health for poor, rural or socially excluded women is unclear in many studies. Future research should, where possible, consider the *equity implications of DSF interventions*. Efforts should be made to generate findings specific to different wealth quintiles, geographical locations, and ethnic background.

We identified no quantitative research on the effect of vouchers for maternity services on competitiveness in the market or the responsiveness of providers. *User choice and inter-provider competition* are common objectives of voucher schemes for maternity services and evidence is needed to support such claims.

High quality quantitative and qualitative research is needed on wider impacts of vouchers for maternity services. We found some evidence on the social meaning of these schemes but no information on

whether there is an effect on the *quality of life* of women, or on *household poverty*, and only limited evidence of the *impact on the quality of services* provided.

Much of the qualitative evidence that was reviewed related to views on barriers to the provision of voucher schemes or supply-side preconditions for successful implementation. Such evidence represents an important source of information on processes for policy makers and implementers. However there is also a need for well-designed in-depth social science studies using ethnographic and other methods exploring such issues as the implications of DSF schemes have on *social organisation of maternity care*, on *women"s experiences of pregnancy and birth care*, on *notions of state obligation and women"s entitlement*.

There remains a paucity of research on the cost-effectiveness of DSF schemes. Some costing has been done and one or two studies examine incremental cost-effectiveness. Only one study compared the *cost per intervention with other interventions to achieve similar goals*.

A further and important issue here is to ensure that comparisons are made on a „level playing field". Changes in utilisation and resulting cost-effectiveness are made by comparing the investment in DSF with the current system (counterfactual). An alternative and possibly fairer comparison would be to *compare the DSF scheme with a similar investment in the current (supply-side) mechanism*. Such comparisons have been undertaken in other health system evaluations (e.g. Performance-Based Finance)[103] but have not, to our knowledge, been undertaken in DSF schemes.

Implications for policy and practice

Much of the evidence comes from studies of DSF schemes that identified bottlenecks in schemes and what modifications would be needed to resolve these. From these one may extrapolate the characteristics of a large scale scheme that is more likely to succeed. Such features include political commitment and leadership, mechanisms to involve women"s organisations and other user representatives in design and implementation and monitoring of DSF schemes, an appropriately designed package tailored to the local circumstances, a locally relevant information and communication strategy, adequate supply-side capacity and quality, motivated and incentivised providers, institutional capacity to manage and streamline complex schemes, and on-going evaluation built into the programme design.

- **Streamlined policy goals focused on increasing utilisation of services are most effective**

There is good evidence that DSF helps to increase utilisation of priority maternal services particularly use of institutional delivery. The evidence is strongest for short term payments to offset costs of access and vouchers for schemes that develop a direct link between use of services and resources.

There is a temptation to utilise DSF to achieve complex and multiple policy objectives such as changes in health seeking behaviour, choice of family size and improvements in quality of care. The literature suggests that objectives should be kept simple and that more ambitious objectives are unlikely to be achieved and may have unintended consequences. Efforts to control family size, for example, by restricting schemes to low parity or younger women limit access to households with larger numbers of children who are often the most vulnerable in health and economic terms. They also often mean that the mechanisms become more complex to administer.

- **Careful design of incentives for skilled practitioners is required**

Voucher schemes offer some advantage over cash incentive schemes in that the increased workload caused by increased demand should be rewarded by increased reimbursement income. Also DSF schemes such as vouchers that direct funding to facilities can in theory help to reduce the dependence of staff on unofficial and official user charges by providing a source of money to supplement low wages. But there are potential hazards in this approach. Delays in facility payments from DSF funds may mean that practitioners see an initial fall in their income while at the same time managing potentially higher demand for services. Furthermore, if payments to practitioners are linked too closely to the number of DSF patients staff may compete to record patients and possibly over-report the number seen. Careful design of a practitioner incentive scheme is important. If funds can be made available in advance then accreditation of facilities into the scheme can trigger the regular payment of salary additions funded out of funds received from DSF.

- **DSF mechanisms cannot on their own improve quality of services, supply-side measures are required to complement these**

There is little theoretical justification or practical experience of DSF mechanisms improving quality of care. Conditional cash transfers and short term payments for services provided are not intended to incentivise providers. Vouchers could, in principle, improve quality of services by directing funding to facilities that offer good quality services. In practice the limited choice of providers combined with the crowding effect on services mean quality of services may go down rather than up. The funding flow from DSF to facilities is generally not sufficient to permit substantive investment in capacity.

Investment on the supply side to support DSF is particularly required for referral systems, expensive support services such as blood banking that is needed for complicated cases, as well as basic bed capacity. There is currently no evidence to indicate whether success in the accreditation process for DSF facilities could be used to trigger investment funding to permit services to expand.

- **Simple and transparent processes for administering and disbursing benefits are more likely to be successful in improving uptake of services**

It is likely to be much easier to scale up schemes that are easy to understand, transparent and well publicised. Many of the logistical problems in administering DSF arise because people do not know about schemes or do not understand the way they function and their eligibility. Schemes also suffer where it is difficult for benefits to be obtained (e.g. money not available for short term payments to offset costs of access, vouchers that are difficult to exchange for service). Corruption debilitates schemes by reducing their impact on beneficiaries out of pocket expenditure and by reducing user trust. Transparent and simple arrangements are needed to reduce the likelihood of corruption.

This suggests that substantial preparation is required in ensuring that facilities are able to administer a scheme. There is also evidence that involving community and fieldworkers in campaigns to inform households about the scheme is important in improving transparency and uptake of benefits by priority groups.

- **Careful planning for initial and scaled up DSF is essential to success**

DSF schemes often necessitate a substantial change in the way in which funds and services are administered. Success in scaling up and sustaining schemes is highly dependent on initial planning for these changes. Short and longer term planning is required. Short term planning should focus on how to administer the systems during and initial (possibly pilot) phase. This may necessitate contracting out the organisation to a non-government body with expertise in identification of beneficiaries and funds disbursement. In the longer term, thought should be given as to how to incorporate a scaled up system. DSF mechanisms, such as retention of unspent funds at the end of a financial year or the right to allocate money across line items, may not sit comfortably with government rules on budgeting and spending. Policy makers will need to decide whether a scaled up system can be incorporated into the government system or whether it will be more cost-effective to administer a larger scheme through a separate agency.

- **DSF can be an effective targeting mechanism but only if it does not require substantially new systems for identifying beneficiaries**

DSF can be an efficient means of targeting to stimulate service uptake particularly if they utilise existing systems for identifying the poor and vulnerable, and additional efforts are made to ensure that these do not result in social exclusion of an undocumented minority.

- **Policy should recognise that even well designed DSF schemes may fail to function as intended unless other barriers to access are addressed**

Inadequate supply side investment can reduce the impact of DSF through over-crowding and poor quality. Barriers at the household level may also reduce use of DSF mechanisms. Vouchers, for example, may not be utilised if women cannot reach services because of long and expensive travel or

because no one is available to accompany them. Policymakers need to consider a range of potential barriers to services when designing schemes to encourage service uptake.

Conflict of Interest

No known conflict of interest for SFM, BH, RB and DB.

TE was involved in some of the early design work of DSF schemes in Nepal and also in Bangladesh, and more recently was involved in commissioning and commenting on the evaluation of both schemes. No other conflicts of interest.

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Appendix I - Search Strategy

Demand-side financing mechanisms

Group 1: 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7

1. *"Child benefit"*
2. *"Demand side financing"*
3. *"Demand-side financing"*
4. *"Family allowance"*
5. *"Food stamp"*
6. *"Maternity allowance"*
7. *"Maternity benefit"*

Group 2: 8 OR 9 OR 10 OR 11 OR 12 OR 13

8. *"Cash transfer"*
9. *"Monetary transfer"*
10. *"Output-based aid"*
11. *"Reimbursement"*
12. *"Voucher"*
13. *"Incentive"*

Outcomes of interest

Group 3: 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24

14. *"Abortion"*
15. *"Antenatal"*
16. *"Birth"*
17. *"Infant"*
18. *"Matern$"*
19. *"Midwi$"*
20. *"Neonat$"*
21. *"Obstetric"*
22. *"Perinatal"*
23. *"Postnatal"*
24. *"Pregnan$"*

Group 4: 25 OR 26 OR 27 OR 28 OR 29

25. "Cost-effectiv$"

26. "Cost-utility"

27. "service utili$"

28. "Morbidity"

29. "Mortality"

These were consolidated in the search history as follows:

(a) *Group 1 AND (Group 3 OR Group 4)*

(b) *Group 3 AND Group 2*

Finally, **(a)** OR **(b)**

List of websites searched:

Asian Development Bank (www.adb.org)

Australian Agency for International Development (www.ausaid.gov.au)

Bill & Melinda Gates Foundation (http://www.gatesfoundation.org)

Canadian International Development Agency (www.cida.gc.ca)

Eldis (www.eldis.org)

HLSP (www.hlsp.org)

Inter-American Development Bank (www.iadb.org)

International Food Policy Research Institute (www.ifpri.org)

International Initiative for Impact Evaluation (www.3ieimpact.org)

Marie Stopes International (www.mariestopes.org)

Overseas Development Institute (www.odi.org.uk)

Oxford Policy Management (www.opml.co.uk)

Population Council (www.popcouncil.org)

Population Services International (www.psi.org)

Reproductive Health Matters (www.rhmjournal.org.uk)

Research for Development (www.dfid.gov.uk/r4d)

UK Department for International Development (www.dfid.gov.uk)

United Nations Children"s Fund (www.unicef.org)

United Nations Population Fund (www.unfpa.org)

United Nations Women (www.unwomen.org)

United Nations World Food Programme (www.wfp.org)

US Agency for International Development (www.usaid.gov)

Women Deliver (www.womendeliver.org)

World Bank (www.worldbank.org)

World Health Organization (www.who.int)

World Health Organization regional offices:

- Africa (www.afro.who.int)
- Americas (www.paho.org)
- Eastern Mediterranean (www.emro.who.int)
- Europe (www.euro.who.int)
- South-East Asia (www.searo.who.int)
- Western Pacific (www.wpro.who.int)

White Ribbon Alliance (www.whiteribbonalliance.org)

Zunia (www.zunia.org)

List of websites searched for Indian grey literature:

1. www.hphealth.nic.in/pdf/GUIDELINES-%20JSY.pdf

2. www.nrhmassam.in/jsy.php

3. www.pbhealth.gov.in/JSY%20Note-520web%20site.doc

4. www.arogyakerlam.gov.in/index.php/programmes/jsy

5. www.delhi.gov.in/wps/wcm/connect/.../mamta.doc?MOD

6. http://cghealth.nic.in/ehealth/2011/jssk/JSSKGuideline.pdf

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8. http://ambala.nic.in/pdf/Various-Schemes-of-Government.pdf

9. http://mohfw.nic.in/NRHM/Documents/Non_High_Focus_Reports/Haryana_Report.pdf

10. http://health.bih.nic.in/Docs/HD-BestPractices-JBSY.pdf

11. http://statehealthsocietybihar.org/nrhmschemes.html

12. http://uphealth.up.nic.in/index.htm

13. http://rajswasthya.nic.in/

14. http://nrhmrajasthan.nic.in/Programmes.htm

15. http://www.wbhealth.gov.in/

16. http://www.tnhealth.org/

17. http://www.nrhmtn.gov.in/cashlessdel.html

18. http://www.tnhealth.org/dfwincen.htm

19. http://www.maha-arogya.gov.in/

20. http://www.maha-arogya.gov.in/programs/nhp/jsy/default.htm

21. http://www.mp.gov.in/health/nrhm.htm

22. http://www.health.mp.gov.in/nrhm/Innovative-nrhm.pdf

23. http://www.mp.gov.in/health/nrhm/Revised%20Janani%20Sehyogi%20Yojana.pdf

24. http://ukhfws.org/

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26. www.nihfw.org

27. www.planningcommission.nic.in

28. www.nhsrcindia.org

29. www.abtassociates.com

30. www.sambodhi.co.in

31. www.3ieimpact.org

32. www.cohesiveindia.org
33. www.rbfhealth.org
34. www.indiahealthtast.org
35. www.mchip.net
36. www.psi.org/india
37. www.solutionexhange-un.net.in
38. www.icrier.org
39. www.iegindia.org
40. www.righttofoodindia.org
41. www.maternalhealthtaskforce.org
42. www.rahp.chsj.org
43. www.iphindia.org
44. www.phfi.org
45. www.searo.who.int
46. www.futuresgroup.com
47. www.cehat.org
48. www.cortindia.com
49. www.jaipur.iihmr.org

List of journals examined for Indian grey literature

Peer reviewed

1. Contributions to Indian Sociology 2000-2011 Hand search of hard copies. Also available online: http://cis.sagepub.com
2. Economic & Political Weekly 2000-2011 Online search at: www.epw.org.in
3. Indian Journal of Community Medicine 1998-2011Online search at: www.ijcm.org.in

4. Indian Journal of Gender Studies 1994 -2011 online: http://intl-ijg.sagepub.com

5. Indian Journal of Public Health 1990 -2011 Online search: available on website of Indian Public Health Association www.iphaonline.org

6. Journal of Health and Development: 2005, 2006, 2007, 2008. Started publication in 2005; not published since 2009.

7. Journal of Health Management: 2000-2011

8. National Medical Journal of India 1998 -2011 Online search at: www.nmji.in

9. Social Scientist 2000-2011 Hand search of hard copies.

Non-peer reviewed

1. Indian Journal of Medical Ethics 1994-2011 Online search: www.issuesinmedicalethics.org

2. Journal of Health Studies available only for 2008, 2009 Online search at: www.jhs.co.in

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Appendix II - Studies selected for retrieval

Acharya and McNamee. Assessing Gujarat's 'Chiranjeevi' Scheme. EPW.2009; 44(48): 13-15

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Barber S.L. and P.J. Gertler. Empowering women to obtain high quality care: evidence from an evaluation of Mexico's conditional cash transfer programme. Health Policy and Planning.2009; 24(1): 18-25.

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Bhat, R. et al.. Maternal Healthcare Financing: Gujarat's Chiranjeevi Scheme and Its Beneficiaries. Journal of Health, Population and Nutrition.2009; 27(2): 249-259.

Biswas and Vivek. Implementation of the NRHM in Jharkhand: A Case Study of Achievements and Challenges. CHSJ. 2007.

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Ekirapa-Kiracho et al.. Increasing access to institutional deliveries using demand and supply side incentives: Early results from a quasi-experimental study. BMC International Health and Human Rights.2011; 11(Suppl. 1): S11.

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Appendix III - Appraisal instruments

JBI-QARI appraisal instrument

	Criteria	Yes	No	Unclear	Not Applicable
1)	There is congruity between the stated philosophical perspective and the research methodology.	○	○	○	○
2)	There is congruity between the research methodology and the research question or objectives.	○	○	○	○
3)	There is congruity between the research methodology and the methods used to collect data.	○	○	○	○
4)	There is congruity between the research methodology and the representation and analysis of data.	○	○	○	○
5)	There is congruity between the research methodology and the interpretation of results.	○	○	○	○
6)	There is a statement locating the researcher culturally or theoretically.	○	○	○	○
7)	The influence of the researcher on the research, and vice-versa, is addressed.	○	○	○	○
8)	Participants, and their voices, are adequately represented.	○	○	○	○
9)	The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.	○	○	○	○
10)	Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.	○	○	○	○

JBI-MAStARI appraisal instruments

Design: Comparable Cohort / Case Control Studies

Criteria	Yes	No	Unclear	Not Applicable
1) Is sample representative of patients in the population as a whole?	○	○	○	○
2) Are the patients at a similar point in the course of their condition/illness?	○	○	○	○
3) Has bias been minimised in relation to selection of cases and of controls?	○	○	○	○
4) Are confounding factors identified and strategies to deal with them stated?	○	○	○	○
5) Are outcomes assessed using objective criteria?	○	○	○	○
6) Was follow up carried out over a sufficient time period?	○	○	○	○
7) Were the outcomes of people who withdrew described and included in the analysis?	○	○	○	○
8) Were outcomes measured in a reliable way?	○	○	○	○
9) Was appropriate statistical analysis used?	○	○	○	○

Design: Descriptive / Case Series Studies

Criteria	Yes	No	Unclear	Not Applicable
1) Was study based on a random or pseudo-random sample?	○	○	○	○
2) Were the criteria for inclusion in the sample clearly defined?	○	○	○	○
3) Were confounding factors identified and strategies to deal with them stated?	○	○	○	○
4) Were outcomes assessed using objective criteria?	○	○	○	○
5) If comparisons are being made, was there sufficient descriptions of the groups?	○	○	○	○
6) Was follow up carried out over a sufficient time period?	○	○	○	○
7) Were the outcomes of people who withdrew described and included in the analysis?	○	○	○	○
8) Were outcomes measured in a reliable way?	○	○	○	○
9) Was appropriate statistical analysis used?	○	○	○	○

JBI-ACTUARI Appraisal instrument

Criteria	Yes	No	Unclear	Not applicable
1) Is there a well defined question?	○	○	○	○
2) Is there comprehensive description of alternatives?	○	○	○	○
3) Are all important and relevant costs and outcomes for each alternative identified?	○	○	○	○
4) Has clinical effectiveness been established?	○	○	○	○
5) Are costs and outcomes measured accurately?	○	○	○	○
6) Are costs and outcomes valued credibly?	○	○	○	○
7) Are costs and outcomes adjusted for differential timing?	○	○	○	○
8) Is there an incremental analysis of costs and consequences?	○	○	○	○
9) Were sensitivity analyses conducted to investigate uncertainty in estimates of cost or consequences?	○	○	○	○
10) Do study results include all issues of concern to users?	○	○	○	○
11) Are the results generalisable to the setting of interest in the review?	○	○	○	○

Appendix IV - Data extraction instruments

JBI-QARI data extraction instrument

Extraction Details: Extraction - Name (2011)

* denotes field which will appear in report appendix

Methodology:	
Method: *	
Phenomena of Interest: *	
Setting:	
Geographical:	
Cultural:	
Participants: *	
Data Analysis:	
Authors Conclusion: *	
Reviewers Comments: *	
Complete	Yes

JBI-MAStARI data extraction instruments

Extraction Details: Extraction - Name (2011) - Randomised Control Trial / Pseudo-randomised Trial Study Information

* denotes field which will appear in report appendix

Method *		
Setting		
Participants *		
# Participants	Group A:	Group B:
Interventions	Interventions A: *	
	Interventions B: *	
Authors Conclusion		
Reviewers Comments *		
Complete	No	

Extraction Details: Extraction - Name (2011) - Comparable Cohort / Case Control Studies
Study Information

* denotes field which will appear in report appendix

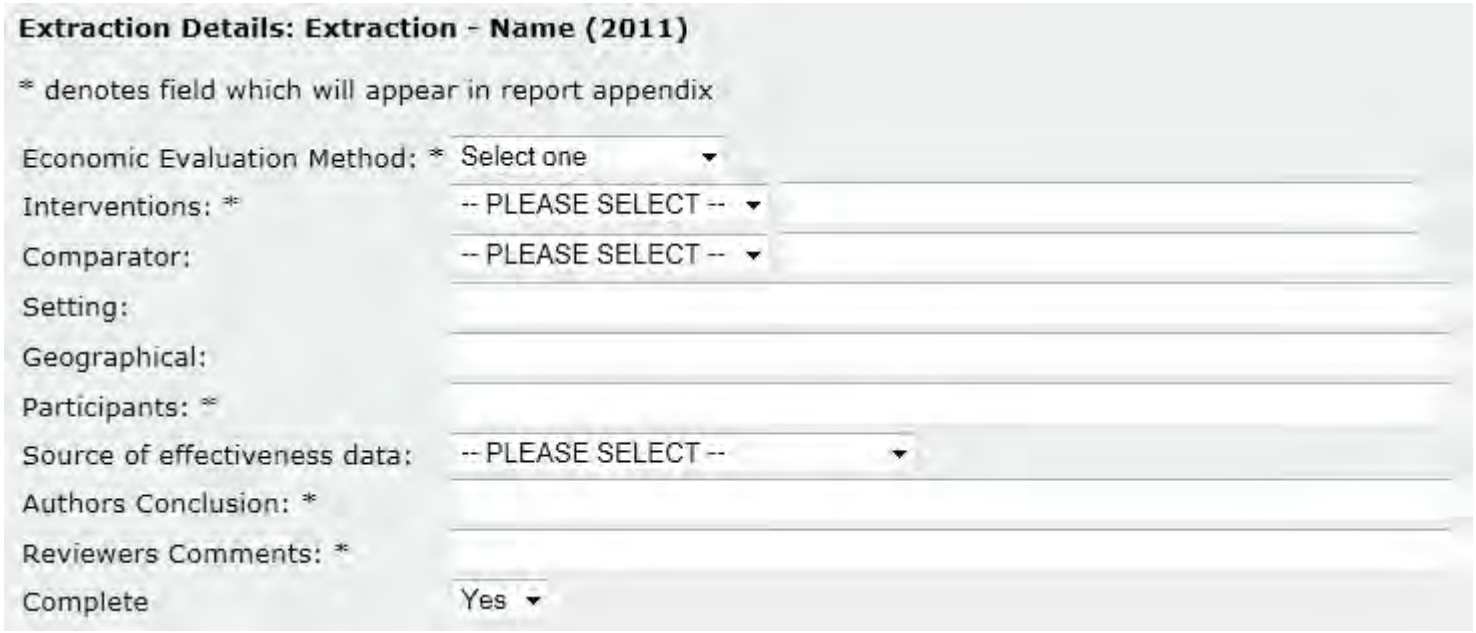
Method *	
Setting	
Participants *	
# Participants	Group A: Group B:
Interventions	Interventions A: *
	Interventions B: *
Authors Conclusion	
Reviewers Comments *	
Complete	No

Extraction Details: Extraction - Name (2011) - Descriptive / Case Series Studies
Study Information

* denotes field which will appear in report appendix

Method *	
Setting	
Participants *	
# Participants	
Interventions *	
Authors Conclusion	
Reviewers Comments *	
Complete	No

JBI-ACTUARI data extraction instrument



Extraction Details: Extraction - Name (2011)

* denotes field which will appear in report appendix

Economic Evaluation Method: *	Select one
Interventions: *	-- PLEASE SELECT --
Comparator:	-- PLEASE SELECT --
Setting:	
Geographical:	
Participants: *	
Source of effectiveness data:	-- PLEASE SELECT --
Authors Conclusion: *	
Reviewers Comments: *	
Complete	Yes

Appendix V - Included Studies

Details of qualitative studies

Study	Methods	Participants	Intervention	Authors' conclusions
Adato, M. et al., 2011 [37]	Teams of social scientists doing ethnographic work in four countries	Poor women	Oportunidades in Mexico, Red Solidaria in El Salvador and the Social Risk Mitigation Project in Turkey	'In Mexico, the CCT program has had a significant positive impact on knowledge about and use contraceptives' (p. 1926)
Ahmed S and MN Khan, 2011 [22]	Semi-structured interviews	Managers, Union Committee members, service providers, voucher distributors and beneficiaries	Maternal Health Voucher Scheme, Bangladesh	'In poor developing countries, a demand-side strategy may not be very effective without significant expansion of the service delivery capacity of health facilities at the sub-district level.' (p. 25)
Arur, A. et al, 2009 [23]	Semi-structured interviews	The technical support teams associated with each programme	HealthyBaby voucher scheme in Uganda and the Vouchers for Health programme in Kenya	'In less than five years, the two voucher programs have shown promise in achieving their stated objectives of increasing poor women's access to quality health services.' (p. 2)
Chaturvedi and Randive, 2011 [56]	Semi-structured interviews and focus group discussions	Pregnant women who are BPL/ST/SC, over 19 years of age and parity no more than two	Janani Suraksha Yojana, India	'The PPPs for EmOC under the JSY have minimally influenced the out of pocket payments for EmOC. Infrastructural inadequacies and passive support of the implementers are major barriers to the implementation of contracting-in model of PPPs. Capacities in the public health system are inadequate to design and manage PPPs.' (p. 21)

Study	Methods	Participants	Intervention	Authors' conclusions
Chaturvedi and Randive, 2009 [42]	Semi-structured interviews and focus group discussions	Semi-structured interviews with public and private providers, beneficiaries and non-beneficiaries; focus group discussions with public providers (DHO, THO M. S., ANMs, MOs)	Janani Suraksha Yojana, India	'The experience of JSY however raises a much larger issue – institutionalizing PPP, if successful to provide EmOC and reduce maternal deaths does not however address the root cause. The issue of lack of specialists in the public sector remains unaddressed.' (p. 139)
Dasgupta, J., 2007 [71]	Case studies	Cases of women who had experienced adverse maternal health outcomes, including neonatal death, maternal death and maternal morbidities	Janani Suraksha Yojana, India	'The case studies indicate that even after the launch of the NRHM and the implementation of the JSY scheme, the contact with providers for TT injections is not leading to registration and counselling for safe child birth or tracking fatal outcomes or near-misses. The ANMs continue to withhold information and engage in illegal and fatal practices, and are still not referring the women to institutions.' (p. 155)
Devadasan et al., 2008 [58]	Semi-structured interviews	District health officers, primary health clinic medical officers, nurses and beneficiaries	Janani Suraksha Yojana, India	'We found that some of the poor women were not aware of the programme; that the documentation processes had become very cumbersome and that there was a considerable delay in the women getting the cash benefit. Some women also mentioned that they received only partial amounts - the rest being pocketed by the health staff. The most significant issue was that the scheme has been changed to permit the cash benefit to go to all women who deliver, irrespective of the site of delivery. This has resulted in this scheme actually promoting home deliveries, a perversion of the original objective.' (p. 257)

Study	Methods	Participants	Intervention	Authors' conclusions
Febriany et al, 2011 [57]	Structured interviews, focus group discussions and observations	Service providers, program implementers, community leaders and program beneficiaries	Program Keluaga Harapan, Indonesia	'PKH contribution to the improvement in service utilization was evident only in NTT [East Nusa Tenggara] Province. Improvements were indicated by the increase in mothers' attendance at posyandu (integrated health service posts) and of students attendance in class. These increases were encouraged by the role of PKH facilitators in motivating the beneficiaries, the possible consequences of PKH fund deduction or fund withdrawal, and the relatively large proportion of beneficiaries in each village. However, a number of problems regarding the provision and the utilization of MCH and basic education services were still evident, especially in NTT [East Nusa Tenggara province]. The problems included geographical and economic barriers, unavailability of service providers (of village midwives and teachers), and the villagers' beliefs in traditional customs.' (p. ii)

Study	Methods	Participants	Intervention	Authors' conclusions
Gupta, A., 2007 [72]	In-depth interviews and focus group discussions	In-depth interviews with poor rural women who had recently gone through childbirth, rural women who were intended beneficiaries and ASHAs, ANMs, staff at the local PHC and CHC. Focus group discussions with poor rural women who had recently gone through childbirth	Janani avam Bal Suraksha Yojana (Janani Suraksha Yojana in Bihar), India	• 'ASHAs in most areas are in a state of flux' • 'There is often a latent enmity between the villagers and the ASHAs' • 'The concept of volunteerism has been marred by the institutionalised selection procedure and the education criteria' • 'The ANM and the ASHA have a power hierarchy' • 'The provisions of JSY had undergone change thrice' • 'Irregular flow of funds under JSY is creating dissatisfaction among people and problems for the medical staff • 'JSY was aimed at promoting institutional delivery through incentives. However, institutions are still ill-equipped for the purpose' • The issue of unavailability of medicines is giving rise to a latent hostility between the ANMs and the villagers (p. 48)
Hangmi and Kuki, 2009 [73]	Semi-structured questionnaires and focus group discussions	Semi-structured questionnaires with women who had delivered babies at home or in an institution; semi-structured questionnaires with ANMs and doctors; focus group discussions with mothers who delivered at home, institutions and with the selected ASHAs	Janani Suraksha Yojana, India	'The study reveals that though Saikawt block had better road connectivity, it did not result in better implementation of the JSY programme in particular or MCH service delivery by the government in general. Serious gaps especially with regard to fund disbursement under the scheme, restricted most of the families from availing the public facilities for delivery. Moreover, lack of public transport and bad road connectivity added to problems in accessing services from the government facilities.' (p. 299)

Study	Methods	Participants	Intervention	Authors' conclusions
Hatt et al, 2010 [53]	Key informant interviews, provider interviews and focus group discussions	Interviews with programme oversight committees, voucher distributors, field health workers, Ngo and private sector representatives, community health workers and service providers; focus group discussions with voucher recipients and non-recipients	Maternal Health Voucher Scheme, Bangladesh	'The overall conclusion of this evaluation is that the DSF program has had an unprecedented positive effect on the utilization of maternal health services in the short time since its initiation.' (p. xvii)
Human Rights Watch, 2009 [54]	Individual and group interviews	Beneficiaries and non-beneficiaries, service providers, officials, journalists and activists	Janani Suraksha Yojana, India	'Our research identified four important reasons for the continuing high maternal mortality rate in Uttar Pradesh: barriers to emergency care, poor referral practices, gaps in continuity of care, and improper demands for payment as a condition for delivery of healthcare services. We also found serious shortcomings in the tools used by authorities to monitor healthcare system performance, identify flaws, and intervene in time to make a difference. While accountability measures may seem dry or abstract, they literally can be a matter of life and death.' (p. 8)
Ir et al., 2010 [25]	Focus groups and key informant interviews	Voucher recipients who did not use their voucher for delivery; voucher recipients who did use their voucher	Vouchers and Health Equity Funds in Cambodia	'Vouchers plus HEFs, if carefully designed and implemented, have a strong potential for reducing financial barriers and hence improving access to skilled birth attendants for poor women. To achieve their full potential, vouchers and HEFs require other interventions to ensure the supply of sufficient quality maternity services and to address other non-financial barriers to demand.' (p. 1)

Study	Methods	Participants	Intervention	Authors' conclusions
Jega, F.M., 2007 [45]	Semi-structured interviews	Doctors and beneficiaries	Chiranjeevi Scheme, India	These findings have obvious implications for policy and practice, and the following strategic options are worth considering in improving the scheme: • Setting up more blood transfusion facilities in the districts. • Integrating antenatal as well as postnatal care into the scheme, which will ensure continuity of care and also help to allay the women's apprehension about hospital delivery • Decentralising decision-making on fixing the payment system to the district level, so that differences in complication rates between districts is taken into account. • Contracting non-specialist doctors especially in areas where there are few or no specialist obstetricians • Formal monitoring of the scheme. (p. ix)
Khan et al, 2010 [59]	In-depth interviews	Beneficiaries and their families, staff at health facilities, ASHAs, AWWs, ANMs and village committee members	Janani Suraksha Yojana, India	'To get the maximum benefit from the JSY, a number of systematic changes are necessary. Improvements in infrastructure and essential facilities at health institutions are critical to ensure that women stay at the clinic for at least 24 hours and get postnatal care. Improvements in staff behavior, availability of skilled staff to manage basic EmOC and supply of essential drugs and equipment are also needed to improve the quality of services. Providing JSY incentives and improving quality of care would yield the best results.' (p. 20)

Study	Methods	Participants	Intervention	Authors' conclusions
Koehlmoos et al., 2008 [38]	Structured interviews, in-depth interviews, focus group discussions	Structured interviews with beneficiaries; in-depth interviews with local GoB managers, an NGO manager, a school teacher, the chairperson of the UnDSF Committee, the executives of the designated private for-profit sector service provider, and the locally-based WHO representative for the DSF scheme; focus groups with voucher distributors and service providers.	Maternal Health Voucher scheme, Bangladesh	'The findings indicated an increase in institutional delivery. Concerns were expressed by all stakeholders about the availability of higher financial incentives for institutional deliveries compared to current financial incentives for sterilization, which many fear will negate the success of the national family-planning programme. Further improvement in the physical infrastructure of the existing public-sector facilities is likely to contribute to higher use. The opportunity exists to further engage the non-state sector providers and facilities for involvement with the scheme. The potential for an increase in the use of caesarian sections, changes in the physical infrastructure, and appropriate posting of human resources in the public sector should be monitored. The existence of financial incentives and the availability of technical assistance by a third party in the DSF scheme require a close examination in terms of sustainability and scale-up.' (p. 5)

Study	Methods	Participants	Intervention	Authors' conclusions
Krishna and Ananthpur, 2011 [70]	Focus groups, interviews, pregnancy monitoring	Households in villages selected through two stage stratified sampling; a subset of 47 women who were followed during pregnancy; focus groups including village elders, Gram Panchayat members, youth leaders, members of women self-help groups, village level health professionals and NGO workers; 42 government-employed health care professionals serving the villages	Janani Suraksha Yojana, India	'These findings indicate that access, both physical and financial, continues to be major factor influencing the health seeking behavior of these rural citizens. Physical distance to facilities, poor transportation, poor quality of service, lack of specialized care even at block level, and negligence of the medical staff are among the major barriers faced by them. Often, in times of crisis, these interacting factors push rural citizens into debt and poverty, at times occasioning avoidable loss of life.' (p. 19)
Kumar et al., 2009 [74]	Focus group discussions	Women who had availed JSY services; health practitioners and service providers (incl. doctors, ANMs, dais and RMPs)	Janani Suraksha Yojana, India	'The findings reveal that none of the women who delivered cited that the JSY provisions motivated or even contributed to their choice of home delivery. Leaving aside the fact the cash incentive given under JSY is much lower than what woman spent when they go for institutional delivery and that the reimbursement process is very cumbersome, the bad quality of care received by people at public health institutions is the major hindrance that the government needs to address if it wants to make delivery safe through institutional care and achieve the goals set by the government in the MDGs or in various other health policy documents.' (p. 30)

Study	Methods	Participants	Intervention	Authors' conclusions
Kweku et al, 2007 [44]	Interviews with ANC staff, midwives, retailers, first time attendees at ANC sessions and multiple visit attendees.	Pregnant women attending ANC	Vouchers subsidising insecticide-treated nets in the Volta region of Ghana	'Both issuing and redemption of vouchers should be monitored as factors assumed to influence voucher redemption had an influence on issuing, and vice versa. More evidence is needed on how specific contextual factors influence the success of voucher schemes and other models of delivery of ITNs.' (p. 1)
Lodh et al., 2009 [75]	In-depth interviews and focus group discussions	In-depth interviews with ASHAs, ANMs and AWWs; focus group discussions with potential beneficiaries	Janani avam Bal Suraksha Yojana (Janani Suraksha Yojana in Bihar), India	• 'The ASHA…struggling to establish her identity' • 'Inadequate health provisioning' • 'Inadequate compensation for the services and time volunteered by the ASHA' • 'The front line health workers such as the ANM and the AWW are not clear about the roles and responsibilities of ASHA' • 'those belonging to the marginalized lower castes face a strong and significant social exclusion and have been largely left out of the benefits provided by the ASHA' • 'lack of community participation has ensured that such health services are only in the domain of either the service provider or the recipient (p. 207)
Molyneux, M. and Thomson, M., 2011 [43]	Qualitative and participatory research	Women beneficiaries and other key informants	Juntos Programme in Peru, Bono de Desarrollo Humano in Ecuador, and Bono Juana Azurduy in Bolivia	'Our research found that existing polices and legislation to support commitments to gender equity and empowerment principles are not mainstreamed in CCT programmes.' (p. 208)

Study	Methods	Participants	Intervention	Authors' conclusions
Mubyazi et al., 2010 [46]	Focus group discussions at the community level, semi-structured exit interviews at health facilities and observations in health facilities	Pregnant women and mothers with infants	Tanzanian National Voucher Scheme (for insecticide-treated nets)	'Thus, accessibility to ANC services was hampered by direct and indirect costs, travel distances and waiting time. Strengthening of user-fee exemption practices and bringing services closer to the users, for example by promoting community-directed control of selected public health services, including IPTp, are urgently needed measures for increasing equity in health services in Tanzania.' (p. 1)
Mushi et al., 2003 [47]	Focus group discussions (with community leaders, parents of children under 5 and women) and in-depth interviews (with MCH staff and retail agents)	Focus group discussions (with community leaders, parents of children under 5 and women) and in-depth interviews (with MCH staff and retail agents)	Tanzania National Voucher Scheme (for insecticide-treated nets)	'Discount vouchers are a feasible system for targeted subsidies, although a substantial amount of time and effort may be needed to achieve high awareness and uptake - by which we mean the proportion of eligible women who used the vouchers - among those targeted. Within a poor society, vouchers may not necessarily increase health equity unless they cover a high proportion of the total cost: since some cash is needed when using a voucher as part-payment, poorer women among the target group are likely to have lower uptake than richer women. The vouchers have two important additional functions: strengthening the role of public health services in the context of a social marketing programme and forming an IEC tool to demonstrate the group at most risk of severe malaria.' (p. 163)

Study	Methods	Participants	Intervention	Authors' conclusions
Nandan et al, 2008 [39]	Cross-sectional: semi-structured interviews, in-depth interviews and focus group discussions	District medical officers, district programme managers, medical officers, female health care workers, ASHAs, beneficiaries and non-beneficiaries, PRI members, teachers and SHG members	Janani Suraksha Yojana, India	• 'the lack of orientation of the health staff other than ASHAs on JSY is a significant finding emerging from this study. • Less than half of both beneficiary as well non-beneficiary mothers knew about the various aspects of the JSY scheme • The JSY scheme has a continuum of services to be availed of by the mothers. • Majority of the stakeholders perceive monetary assistance as a big advantage for mothers • there is a lack of transparency in money distribution • Most of the respondents feel that there are problem s of communication and transport • There is very little or no involvement of PRI members in the scheme.' (p. vii)

Study	Methods	Participants	Intervention	Authors' conclusions
Nandan et al, 2010 [28]	Interviews and focus group discussions	Programme managers, service providers, medical officers, field health functionaries (ASHAs and ANMs), beneficiaries, non-beneficiaries and potential beneficiaries	MAMTA scheme, India	• 'Efforts were made to make the public aware of the scheme, the elements of the scheme were not properly disseminated and a large number of target population were found to be not aware of the scheme.' • 'The scheme has become unattractive to the private providers.' • 'the scheme has increased number of institutional deliveries among the target women in some localities, where it is functional.' • 'The evaluation brought out many issues in the implementation like cumbersome process of submission of claims for reimbursement, delay in reimbursement by districts due to inadequate documents as per guidelines, lack of free access to Government or private blood banks, referral of complicated cases by few MFHs, treatment of medical illness during pregnancy, last minute referral of cases, admission for false pain, lack of provision for drugs/medicines during pregnancy, treatment of postnatal and neonatal complications and lack of coordination and linkages between MFHs and nearby primary health care units etc.' (p. xiv)

Study	Methods	Participants	Intervention	Authors' conclusions
Nandan et al., 2008 [55]	Cross-sectional: focus group discussions, in-depth interviews and semi-structured interviews	Mothers who have and have not used JSY, ASHAs, ANMs, block medical officers, chief district medical officers and PRI members	Janani Suraksha Yojana, India	• „There was a shortage of medical and paramedical staff posing a major hindrance to the programme.' • 'It is encouraging to note that 92 per cent of the ASHAs in the study district had received modular training on JSY.' • 'The district and block health authorities have indicated some gaps in the sensitization programme.' • 'Beneficiaries revealed that HW (F) and the ASHAs were playing the key roles in generating awareness regarding JSY. Still many non - beneficiaries were not aware of the JSY.' • 'With regard to monitoring and supervision of the JSY, inadequate staff strength was a major impediment.' • 'Study in the six PHC/CHCs revealed that there was significant and sudden spurt in the percentage of institutional deliveries during 2005 - 06 to 2006 – 07, thanks to the introduction of JSY.' (p. 9)
Pariyo et al, 2011 [51]	Focus group discussions	Motorcycle riders who are contracted to transport pregnant women to health facilities	Makerere University Voucher scheme for maternity services, Uganda	'The findings indicate that locally existing resources such as motorcycle riders, also known as 'boda boda' can be used innovatively to reduce challenges caused by geographical inaccessibility and a poor transport network with resultant increases in the utilization of maternal health services. However, care must be taken to mobilize the resources needed and to ensure that there is enforcement of laws that will ensure the safety of clients and the transport providers themselves.' (p. 1)

Study	Methods	Participants	Intervention	Authors' conclusions
Powell-Jackson et al., 2009 [40]	Key informant interviews and focus group discussions	The most senior health professional available, the district health office and focus groups with health personnel, accountants, NGO workers and management committee members	Safe Delivery Incentives Programme in Nepal	'The success of conditional cash transfer programmes in Latin America has led to a wave of enthusiasm for their adoption in other parts of the world. However, context matters and proponents of similar programmes in south Asia should give due attention to the challenges to implementation when capacity is weak and health services inadequate.' (p. 1)
Public Health Resource Network, 2010 [11]	In-depth interviews	Village health nurses/auxiliary nurse midwives and anganwadi workers	Dr. Muthulakshmi Maternity Assistance Scheme	• 'Schemes for maternity entitlements need to understand and acknowledge the full scope of the conceptual framework of this particular right to be able to do justice with all its objectives as well as to be able to provide equity with other women working in the formal sector' • 'There should be no confusion between the objectives of a maternity entitlements scheme and schemes to promote institutional delivery, supplementary nutrition during breast feeding and pregnancy, immunisation, family planning ,etc.' (p. 40)
Rai et al., 2012 [60]	In-depth interviews and focus group discussions	In-depth interviews with mothers (both home birth and institutional) and Village Health Committees/Rogi Kalyan Samitis; focus group discussions with husbands and fathers-in-law, and with mothers-in-law	Mukhya Mantri Janani Shishu Swasthya Abhiyan (Janani Suraksha Yojana in Jharkhand), India	'Although people indicated willingness for institutional deliveries (generally perceived to be safe deliveries), several barriers emerged as critical obstacles. These included poor infrastructure, lack of quality of care, difficulties while availing incentives, corruption in disbursement of incentives, behavior of the healthcare personnel and lack of information about MMJSSA.' (p. 252)

Study	Methods	Participants	Intervention	Authors' conclusions
Reproductive Health Vouchers Evaluation Team, 2011 [49]	Health facility assessment including observations of provider-client interactions, exit interviews with clients and provider interviews	Service providers and clients	Maternal Health Voucher Scheme, Bangladesh	• 'Delays in reimbursement undermined service quality' • 'To improve RH status of voucher clients requires incorporating FP services' • 'Clients need to inform detail description of the available services, referral mechanism , and incentive' (p. 11)
Reproductive Health Vouchers Evaluation Team, 2011 [50]	Health facility assessment (observations, exit interviews, provider interviews), focus group discussions, in-depth interviews and social and verbal autopsy interviews	Focus group discussions with women and men, chiefs, local leaders and voucher distributors; in-depth interviews with facility in-charges, providers, local administration, and VSP/field managers	Vouchers for Health, Kenya	'The challenges that the program faces suggest the need for: • a system of continuous flow of information among partners; • improved sensitization of vouchers including enhanced community engagement; • improved distribution system including vetting and verification; • building the capacity of service providers in claims and reimbursement process and technical skills; • ensuring a continuous monitoring of quality of care; and • appropriate measures to address distance and transport issues' (p. 20)

Study	Methods	Participants	Intervention	Authors' conclusions
Reproductive Health Vouchers Evaluation Team, 2012 [52]	Observations of provider-client interactions, exit interviews, provider interviews, facility assessments	Providers and clients in health facilities	HealthyBaby scheme, Uganda	• 'Need for regular interaction between the voucher management agency and policy makers in order to ensure sustainability of the program; • Need to invest in efficient claims and reimbursement process, including initial administrative system, robust database, and community-based verification of service delivery; • Need to constantly build the capacity of providers in the claims and reimbursement process to minimize non-compliance with program regulations; • Need to ensure continuous training of providers and monitoring of quality of care in contracted facilities; • Need to explore the possibility of providing transport reimbursement to HealthyBaby voucher clients; • Need to explore the inclusion of public sector providers as voucher service providers in order to improve service utilization in both sectors (public and private).' (p. vii)
Rob et al., 2009 [48]	In-depth interviews	15 women who used the maximum number of vouchers and 15 women who didn't use any vouchers	Pilot voucher scheme for maternity services in Bangladesh	'Findings show that institutional deliveries have increased from 2% to 18%. Utilization of ANC from trained providers has increased from 42% to 89%. Similarly, utilization of PNC from trained providers has increased from 10% to 60%.' (p. 293)

Study	Methods	Participants	Intervention	Authors' conclusions
Santhya et al., 2011 [61]	In-depth interviews	Women beneficiaries (satisfied and not satisfied), women who delivered in an eligible facility but didn't receive JSY benefits, and women who delivered at home and didn't get JSY benefits	Janani Suraksha Yojana, India	'The findings of our study reiterate the need for programmatic attention to ensure the reach of the JSY to the most vulnerable and to improve the quality of maternal and newborn health services.' (p. xvi)
Singh and Chaturvedi, 2007 [76]	Interviews, focus group discussions and observations	Interviews with auxiliary nurse-midwives, anganwadi workers and ASHAs; interviews with women who have gone through child birth 6 months preceding the interview, gram pradhans, ASHA candidates, patients; interviews with medical superintendents, medical officers, village health centre members, District Programme Management Unit, Block Project Management Unit and State Rural Health Mission; focus group discussions with communities; observations in community health centres, primary health clinics and sub-centres	Janani Suraksha Yojana, India	'The findings of this social audit in the five districts revealed alarming realities of the NRHM implementation. It is nearly impossible to achieve the NRHM goals and objectives if certain issues are not resolved as soon as possible. Two years have already passed and time is limited.' (p. 106)

Study	Methods	Participants	Intervention	Authors' conclusions
Tami et al, 2006 [41]	Focus group discussions and in-depth interviews	Focus group discussions with pregnant women and mothers attending maternal and child health clinics; in-depth interviews with maternal and child health staff responsible for distributing discount vouchers	Zuia Mbu voucher scheme for insecticide-treated nets, Tanzania	Our findings suggest that vouchers are properly used by the target population, and that to minimize voucher leakage, control measures are needed at MCH clinics and to a certain extent for commercial sales agents. Increased awareness among the whole community on the right to receive a discount voucher may also help to control misuse at health facilities.
Truzyan, N., 2010 [29]	Focus groups and in-depth interviews	Focus groups of mothers and interviews with providers, administrators and policy-makers	Obstetric Care State Certificate Program, Armenia	'The Government could use the model of this Program for other health services in Armenia that are offered within the Basic Benefit Package and share the experience of the program in the countries in transition as an effective tool to reduce informal payments.' (p. iv)

Study	Methods	Participants	Intervention	Authors' conclusions
Uttekar et al., 2007 [63]	In-depth interviews	State officials, district level officers, block level providers, trainers of ASHAs, Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, members of community based organisations, and community members	Janani Suraksha Yojana, India	„JSY beneficiaries perceived that despite cash assistance paid under JSY, women still prefer to deliver at home because of extreme poverty, shyness, hospital expenses, fear of doctors, and clinics located far away. The process of programme implementation such as selection and training of ASHAs was yet to be initiated. In the absence of ASHA anganwadi centers are bridging the gap though the role of anganwadi workers in JSY is minimal. Seven percent of the interviewed beneficiaries said that AWWs actually decided for institutional delivery on behalf of the JSY beneficiary; five percent arranged transport and two percent AWWs accompanied women to the health institution. Besides, the quality of care and infrastructure at the facilities particularly PHCs and sub-centre needs to be improved to provide services for normal deliveries.' (p. vi)
Uttekar et al., 2008 [62]	In-depth interviews	State officials, district level officers, block level providers, trainers of ASHAs, Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, members of community based organisations, and community members	Janani Suraksha Yojana, India	'It can be said that JSY has shown impact in Uttar Pradesh. However, the quality of care at the hospitals and particularly at PHC and sub-centres needs to be improved to provide services for normal deliveries. The state needs to reach the unreached and motivate the poorest of the poor for institutional delivery by proper campaigning, making arrangement for transport and making due payments on time to the beneficiaries.' (p. vi)

Study	Methods	Participants	Intervention	Authors' conclusions
Uttekar et al., 2007 [64]	In-depth interviews	State officials, district level officers, block level providers, Panchayat Raj Institutions, non-governmental organisations, self-help groups, auxiliary nurse-midwives, community members	Janani Suraksha Yojana, India	The study also shows that the women with no formal education or those who had studied up to primary level and those belonging to SC/ST go for home deliveries. Even among literate and high caste Hindus, one in every 5–6 women deliver at home. Study revealed that grassroots level health functionaries were reaching this group to motivate them for ANC and institutional delivery, but it is a challenge to motivate them for institutional delivery. (p. vi)
Uttekar et al., 2007 [65]	In-depth interviews	State officials; district level officers; block level providers; trainers of ASHAs; members of Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, community based organisations; community members	Janani Suraksha Yojana, India	'It can be said that JSY has shown impact in Assam. However, the quality of care at the hospitals and particularly at PHC and sub-centres needs to be improved to provide services for normal deliveries. The state needs to reach the unreached and motivate the poorest of the poor for institutional delivery by proper campaigning, addressing their fears regarding hospital setting and staff, making arrangement for transport and making due payments on time to the beneficiaries.' (p. vi)

Study	Methods	Participants	Intervention	Authors' conclusions
Uttekar et al., 2007 [67]	In-depth interviews	State officials, district level officers, block level providers, trainers of ASHAs, Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, members of community based organisations, and community members	Janani Suraksha Yojana, India	'The process of paying cash assistance to the JSY beneficiary was simple. The accountant at the place of delivery checked ANC card to ensure that the women received full ANC care. Requirement of the ANC card showing full ANC services could be one of the reasons for high levels of ANC check-ups. Most of the women were satisfied with JSY and would recommend relatives or friends/ neighbours to be a beneficiary under the JSY, mainly because they did receive cash on filling up form to meet expenses incurred at hospital. Besides, they had safe delivery in the hospital. Major reasons perceived for not preferring institutional delivery despite cash assistance paid under the JSY were fear - fear of doctor, nurse, hospital expenses, unavailability of transport facility, and fear of hospital, injection, needles, equipments. Shyness, prefer home delivery by dai, no importance of institutional delivery, perceived better care at home were the other reasons for preferring home delivery.' (p. v)
Uttekar et al., 2007 [68]	In-depth interviews	State officials, district level officers, block level providers, trainers of ASHAs, Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, members of community based organisations, and community members	Janani Suraksha Yojana, India	'In spite of JSY only one-fifth of the deliveries are institutional deliveries. The state need to motivate more women for institutional delivery by proper campaigning, addressing their fears regarding hospital setting and staff, making alternative arrangements for transport and making due payments on time to the beneficiaries. The quality of care at the hospital particularly PHCs and sub-centres needs to be improved to provide services for normal deliveries.' (p. v)

Study	Methods	Participants	Intervention	Authors' conclusions
Uttekar et al., 2008 [66]	In-depth interviews	State officials, district level officers, block level providers, trainers of ASHAs, Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, and community members	Janani avam Bal Suraksha Yojana (Janani Suraksha Yojana in Bihar), India	'It can be said that JBSY has shown impact in Bihar and ASHAs have started functioning enthusiastically. However, the readiness of the facilities and quality of care offered particularly at PHC and sub-centres needs to be improved to provide services for normal deliveries. The state needs to ensure that cash assistance due to the poor women is paid on time and the process of payment need to be simple.' (p. vi)
Uttekar et al., 2007 [69]	In-depth interviews	State officials, district level officers, block level providers, trainers of ASHAs, Panchayat Raj Institutions, non-governmental organisations, self-help groups, anganwadi workers, auxiliary nurse-midwives, members of community based organisations, and community members	Janani Suraksha Yojana, India	'With overall 33 percent increase in demand for institutional deliveries at public health centres, the quality of care at the hospital particularly PHC (70 percent increase), CHC (44 percent increase) and sub-centre (25 percent increase) needs to be improved to provide services for normal deliveries. State needs to reach the unreached and motivate all poorest of the poor women for institutional delivery by proper campaigning, removing their fears regarding hospital setting and staff, making alternative arrangement for transport and making due payments on time to the beneficiaries.' (p. vi)

Details of quantitative studies

Study	Methods	Participants	Intervention A	Intervention B
Agha, S., 2011 [21]	Household surveys and bivariate analyses	Randomly selected women who had given birth in the 12 months preceding the survey	Control areas where vouchers were not distributed	Intervention areas where vouchers were distributed
Agha, S., 2011 [77]	Household survey and bivariate analyses	Randomly selected women who had given birth in the 12 months preceding each survey	Women in the area who had given birth before the pilot voucher scheme was introduced	Women in the area who had given birth after the pilot voucher scheme was introduced
Ahmed, S. and M.M. Khan, 2011 [78]	Household survey and logistic regression analyses	Women who had given birth within a year prior to the survey	Women who had not received a voucher	Women who had received a voucher
Barber S.L. and P.J. Gertler, 2009 [81]	Household surveys and regression analyses	Poor women aged 15-49 in poor rural communities	Women who had not received conditional cash transfers	Women who had received conditional cash transfers
Barber, S.L., 2010 [82]	Household surveys and regression analyses	Poor women aged 15-49 in poor rural communities	Women who had not received conditional cash transfers	Women who had received conditional cash transfers
Barber, S.L. and P.J. Gertler, 2008 [83]	Household surveys and regression analyses	Poor women aged 15-49 in poor rural communities	Women who had not received conditional cash transfers	Women who had received conditional cash transfers
Barham, T., 2011 [84]	Household surveys and regression analyses	Poor women aged 15-49 in poor rural communities	Women who had not received conditional cash transfers	Women who had received conditional cash transfers

Study	Methods	Participants	Intervention A	Intervention B
Bellows et al, 2011 [26]	Household surveys and logistic regression analyses	Females aged 12–54 years who had given birth during the two years preceding the surveys	Women who gave birth before the voucher scheme was introduced	Women who gave birth after the voucher scheme was introduced
Bhat, R. et al., 2009 [30]	Household survey and bivariate analyses	Women in households selected from an intervention district	Poor women who did benefit from the scheme	Women who gave birth in a private facility and benefited from the scheme
de Brauw et al, 2011 [86]	Household surveys and regression discontinuity analyses	Households with children under 3 years old or a pregnant woman	Households in areas where Comunidades Solidarias Rurales was introduced in 2007	Households in areas where Comunidades Solidarias Rurales was introduced in 2006
Hanson et al., 2009 [32]	Household surveys and regression analyses	Women aged 15-49	Women giving birth before the introduction of the voucher scheme	Women giving birth after the introduction of the voucher scheme
Hatt et al, 2010 [53]	Household survey and probit regression analyses	Eligible women who had delivered in the six months preceding the survey	Women in control areas where no vouchers were distributed	Intervention B: Women in areas where vouchers were distributed universally; Intervention C: Women in areas where vouchers were distributed by means testing
Hernandez Prado et al., 2004 [85]	Household surveys and mortality databases. Analysis was done using linear mixed models	Households in rural, semi-urban and urban areas	Households in municipalities with no Oportunidades recipients	Households in municipalities with at least one Oportunidades recipient

Study	Methods	Participants	Intervention A	Intervention B
Hernandez Prado et al., 2004 [90]	Household surveys and regression analyses	All poor women aged 15-49 eligible to be incorporated into Oportunidades	Women living in areas where Oportunidades had not been introduced by 2003	Intervention B: Women living in areas where Oportunidades was introduced in 1998 Inervention C: Women living in areas where Oportunidades was introduced in 1999-2000
Lim et al., 2010 [19]	Household surveys and multivariate regression models using matching, with-versus-without comparison, and differences-in-difference analyses	Ever-married women aged 15-44	Births that did not receive JSY payments	Births that did receive JSY payments
Morris et al., 2004 [87]	Household surveys and mixed effects regression analyses	Pregnant women and mothers of children younger than 3 years old	Households in areas where standard services were continued	Intervention B: Households in areas where money was distributed; Intervention C: Households in areas with supply-side strengthening; Intervention D: Households in areas where both of the above occurred
NHSRC, 2011 [88]	Household survey data and descriptive statistical analyses	Women who had given birth in the 12 months preceding the survey and received benefits through JSY	Not applicable – no comparison made	Receipt of JSY benefits
Nandan et al, 2010 [28]	Structured interviews	Representatives from private providers involved in the MAMTA scheme	Not applicable – no comparison made	Participation in the MAMTA scheme

Study	Methods	Participants	Intervention A	Intervention B
Nguyen et al, 2012 [79]	Household survey and probit and linear regression analyses (with difference-in-difference analyses)	Women who gave birth in the 6 months preceding the survey	Women living in sub-districts where the Maternal Health Voucher Scheme was not introduced	Women living in sub-districts where the Maternal Health Voucher Scheme was introduced
Obare et al, 2012 [80]	Household survey and analyses using Chi-square tests and logit models	Women aged 15-49 who gave birth in the 12 months preceding the survey (or was pregnant at the time of the survey)	Women living within 5 kilometres of a health facility that was in an intervention district, but not included in the Vouchers for Health programme, or who lived in non-intervention districts	Women who lived within 5 kilometres of a health facility that was included in the Vouchers for Health programme
Powell-Jackson and Hanson, 2012 [18]	Household survey, propensity score matching and regression analyses	Women who had given birth during the 3 years before the survey	Women who had not heard of the Safe Delivery Incentive Programme	Women who had heard of the Safe Delivery Incentive Programme
Powell-Jackson et al., 2011 [91]	Household surveys and difference-in-difference models	Ever-married women aged 15-44	Women living in areas where the increase in women receiving a facility cash payment was less than 10 percent compared to the level at the time of the first survey	Women living in areas where the increase in women receiving a facility cash payment was at least 10 percent compared to the level at the time of the first survey
Powell-Jackson et al., 2009 [89]	Community surveillance data and regression analyses	Every woman who gave birth in the study district	Women who did not receive money through the Safe Delivery Incentive Programme	Women who did receive money through the Safe Delivery Incentive Programme

Study	Methods	Participants	Intervention A	Intervention B
Reproductive Health Vouchers Evaluation Team, 2012 [52]	Household surveys and bivariate analyses	Women aged 15-49 years who had a pregnancy or birth during the 12 months preceding the survey and men of similar age group whose partner was pregnant or gave birth over the same period	Women who had a pregnancy or gave birth before the introduction of the HeathyBaby voucher programme	Women who had a pregnancy or gave birth after the introduction of the HeathyBaby voucher programme
Rob et al., 2009 [48]	Cross-sectional surveys and bivariate analyses	Baseline survey: Poor women who had given birth in the 12 months preceding the survey Endline survey: Poor women who had received a voucher booklet and given birth in the 12 months preceding the survey	Women who had given birth before the introduction of the voucher scheme	Women who had given birth after the introduction of the voucher scheme and received a voucher booklet
Santhya et al., 2011 [61]	Household survey data and propensity score matching. Analyses performed using bivariate significance testing and difference-in-difference models	Women aged below 35 years who had given birth in the 12 months preceding the survey	Bivariate analyses: Women who had not received JSY benefits Difference-in-difference analyses: Women who gave birth before and after the introduction of JSY, and who did not receive JSY benefits for the latter pregnancy	Bivariate analyses: Women who had received JSY benefits Difference-in-difference analyses: Women who gave birth before and after the introduction of JSY, and who had received JSY benefits for the latter pregnancy

Study	Methods	Participants	Intervention A	Intervention B
Sosa-Rubai et al., 2011 [92]	Household surveys and logit and probit regression models	Women aged 15-49 years, with at least one child aged less than 24 months, and living in rural areas	Women living in areas that had benefited from Oportunidades since 2003-7	Intervention B: Women living in areas that had benefited from Oportunidades since 1998 Intervention C: Women living in areas that had benefited from Oportunidades since 2000
UNFPA India, 2009 [93]	Survey data and descriptive statistical analyses	Women in rural areas who had given birth in the 12 months preceding the survey	Not applicable – no comparison made	Women who received JSY benefits
Urquieta et al., 2009 [94]	Household surveys and analyses using regression discontinuity analysis and difference-in-difference models	Women aged 15-49 years in poor rural communities	Women living in areas where Oportunidades had not been introduced	Women living in areas where Oportunidades had been introduced
Uttekar et al., 2007 [69]	Structured interviews and descriptive statistical analyses	Community health workers (ASHAs) and recipients of JSY benefits	Not applicable – no comparison made	Women who received JSY benefits
Uttekar et al., 2007 [63]	Survey and descriptive statistical analyses	Women who received money through JSY	Women who gave birth at home	Women who gave birth in a health facility
Uttekar et al., 2007 [65]	Survey and descriptive statistical analyses	Women who received money through JSY	Women who gave birth at home	Women who gave birth in a health facility
Uttekar et al., 2007 [68]	Survey and descriptive statistical analyses	Women who received money through JSY	Women who gave birth at home	Women who gave birth in a health facility

Details of economic studies

Study	Methods	Participants	Intervention	Outcome(s)
Hatt et al, 2010 [53]	Total expenditure analysis Collected expenditure data for the following: • expenditure on incentives and subsidies by the Ministry of Health and Family Welfare; • the length of time Ministry of Health and Family Welfare staff spent working on the programme; • the cost of printing vouchers; and • expenditures on the programme by the WHO and by DFID.	Representatives of the Ministry of Health and Family Welfare, WHO and DFID, and programme administrators	Maternal Health Voucher Scheme, Bangladesh	Total programme costs
	Incremental cost analysis Multivariate probit regression of household survey data combined with programme costs derived from the total expenditure analysis	Eligible women who had delivered in the six months preceding the survey		Incremental cost of giving birth in the presence of a skilled birth attendant that is attributable to the programme
IFPS Technical Assistance Project, 2012 [27]	Costs were estimated using interviews, focus group discussions, survey data and programme budgets / expenditure statements	Health service administrators, staff at the voucher management agency, community leaders, midwives, community health workers and women who received vouchers	Sambhav voucher scheme in the Indian state of Uttarakhand	Weighted average cost of a voucher for each service

Study	Methods	Participants	Intervention	Outcome(s)
Mulligan et al., 2008 [95]	Programmatic costs and user costs were collected for the analysis using budgets, a household survey and semi-structured interviews. Costs were adjusted for the differential timing and sensitivity analyses were conducted for parameters including discount rate for nets, retail price, and the proportion of retreated.	Project staff, providers and women who used the vouchers	Tanzania National Voucher Scheme	Cost per insecticide-treated net delivered
Nandan et al, 2010 [28]	Cost analysis conducted by a hospital.	Not clear	MAMTA voucher scheme in Delhi, India	Cost per woman treated through the MAMTA scheme

Appendix VI - Excluded Studies

Qualitative studies

Acharya and McNamee, Assessing Gujarat's 'Chiranjeevi' Scheme

> **Reason for exclusion: Very little detail provided on methods used for data collection and analysis**

Bashir, H. et al., Pay for performance: improving maternal health services in Pakistan

> **Reason for exclusion: There is very little information given on how the data were collected and analysed and it is not clear how the information on 'Operational Challenges' was obtained**

Biswas and Vivek, Implementation of the NRHM in Jharkhand: A Case Study of Achievements and Challenges

> **Reason for exclusion: Insufficient detail provided on study methods**

Donaldson et al., Vouchers to improve access by the poor to reproductive health services: design and early implementation experience of a pilot voucher scheme in Agra district, Uttar Pradesh, India

> **Reason for exclusion: The methods were poorly described and it was difficult to identify the source of some findings**

James et al., Rapid appraisal of NRHM implementation

> **Reason for exclusion: Very little detail provided on methods used for qualitative component**

Maal and Wadehra, NIPI - Norway India Partnership Institute - quality maternal and newborn care

> **Reason for exclusion: Insufficient discussion of methods used for data collection and analysis**

Robinson, N., A report on the implementation of the National Maternity Benefit Scheme & JSY in four districts of Madhya Pradesh

> **Reason for exclusion: Insufficient discussion of methods used**

Schmidt et al., Vouchers as demand side financing instruments for health care: A review of the Bangladesh maternal voucher scheme

> **Reason for exclusion: Very little reference to the qualitative component of this study**

Shahi et al., Meeting the Health Needs of the Poor: Two Years of the NRHM in Uttarakhand

> **Reason for exclusion: Lack of detail provided on methods of data collection and analysis**

Sharma et al., A Quality Assessment of Institutional Deliveries in Jaipur, Rajasthan

Reason for exclusion: Unclear what information was collected from respondents and how this informed the study findings

Sharma, R., Janani Suraksha Yojana: A study of the implementation status in selected districts of Rajasthan

Reason for exclusion: Insufficient description of the qualitative methods

Tan et al., Making services work for the poor in Indonesia. Case study 2: Vouchers for Midwife Services in Pemalang District, Central Java Province

Reason for exclusion: The stakeholders approached for the qualitative component are listed, however it is difficult to determine from the text what findings correspond to which groups of stakeholders

Umamani KS, Functioning of NRHM in a Specific Rural context in Karnataka: An Appraisal

Reason for exclusion: Very limited discussion of the methods used

Varma et al., Increasing institutional delivery and access to emergency obstetric care services in rural Uttar Pradesh

Reason for exclusion: Very little discussion of study methods

We the People, Initial assessment of JSY in Orissa

Reason for exclusion: No discussion of study methods

Quantitative studies

De Costa, A. et al., Financial incentives to influence maternal mortality in a low-income setting: making available money to transport: experiences from Amarpatan, India

Reason for exclusion: There was very little consideration of confounding factors and no baseline data were taken from the adjacent district

Dongre, A., Effect of Monetary Incentives on Institutional Deliveries: Evidence from the Janani Suraksha Yojna in India

Reason for exclusion: Complex statistical methods used, however the article has not been peer-reviewed or published. Difficult to be sure that the methods are robust.

Ekirapa-Kiracho et al., Increasing access to institutional deliveries using demand and supply side incentives: Early results from a quasi-experimental study

Reason for exclusion: Insufficient description or statistical analysis of the data

IFPS Technical Assistance Project, Sambhav: Vouchers Make High-Quality Reproductive Health Services Possible for Indias Poor

Reason for exclusion: Very little information was provided on how data has been collected for each of the monitoring mechanisms.

Ir et al., Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: A case study in three rural health districts in Cambodia

Reason for exclusion: Impossible to distinguish between the effect of the health equity funds and the effect of the vouchers

James et al., Rapid appraisal of NRHM implementation

Reason for exclusion: The methods of analysis are not described in detail and are largely descriptive. It is unclear if any significance testing was done on the quantitative data. The survey methods have also not been described in much detail.

Khan et al, Impact of Janani Suraksha Yojana on selected family health behaviours in rural Uttar Pradesh

Reason for exclusion: The methods of analysis are not described in detail and are largely descriptive. It is unclear if any significance testing was done on the quantitative data. The survey methods have also not been described in much detail.

Krishna and Ananthpur, Reasons for seeking (and not seeking) institutional health care: A qualitative examination in 12 villages of Karnataka

Reason for exclusion: No statistical testing of significance

Kumar et al., A Study of the implementation of the food related schemes of the government of India in Maharashtra

Reason for exclusion: Little consideration of confounding factors and no detailed discussion of the findings.

Lahariya et al., Additional cash incentive within a conditional cash transfer scheme: a 'controlled before and during' design evaluation study from India

Reason for exclusion: Insufficient statistical analysis of differences between pre-implementation and during implementation. Also no consideration of confounding factors.

Mavalankar et al., Saving mothers and newborns through an innovative partnership with private sector obstetricians: Chiranjeevi scheme of Gujarat, India

> **Reason for exclusion: There is a lack of consideration of confounding factors and the analysis is largely descriptive. When comparisons are made, e.g. between beneficiaries and non-beneficiaries, there are no tests for significance.**

Mishra et al., An assessment of process and performance of Vijaya Raje Janani Kalyan Bima Yojana in Madhya Pradesh

> **Reason for exclusion: Description of methods was limited and no statistical testing of differences**

Nair et al., Monitoring expenditure and outcomes to improve health services for urban poor women in Bangalore

> **Reason for exclusion: Almost no description of the methods and unclear who was interviewed and where/why**

Pariyo et al, Exploring new health markets: experiences from informal providers of transport for maternal health services in Eastern Uganda

> **Reason for exclusion: Insufficient description or statistical analysis of the data**

Public Health Resource Network, Towards Universalisation of Maternity Entitlements: An Exploratory Case Study of the Dr. Muthulakshmi Maternity Assistance Scheme, Tamil Nadu

> **Reason for exclusion: Insufficient statistical significance testing of the data**

Ram et al., Future demand for maternal and child health services from public health facilities in Uttar Pradesh

> **Reason for exclusion: Insufficient details given on the data and methods used. No statistical analyses.**

SIHFW, Janani Suraksha Yojana: II concurrent evaluation

> **Reason for exclusion: Only able to find Executive Summary which did not detail the study methods sufficiently. Even then, only descriptive statistics have been used.**

Schmidt et al., Vouchers as demand side financing instruments for health care: A review of the Bangladesh maternal voucher scheme

> **Reason for exclusion: Very little description of quantitative methods**

Tan et al., Making services work for the poor in Indonesia. Case study 2: Vouchers for Midwife Services in Pemalang District, Central Java Province

Reason for exclusion: Insufficient detail on methods used for data collection. Descriptive statistics used for analysis.

Varma et al., Increasing institutional delivery and access to emergency obstetric care services in rural Uttar Pradesh

Reason for exclusion: Very little description of methods for data collection.

Appendix VII - List of extracted qualitative findings

Understanding use of health services in conditional cash transfer programs: Insights from qualitative research in Latin America and Turkey

Finding1	CCT Women felt no need to have an institutional delivery
Illustration	In El Salvador, the CCT program encourages women to give birth in hospitals, though it does not have a conditioned grant for this as does Turkey. Many women in our study, however, especially the older ones, gave birth in their homes. Among these, most said that they felt no need to go to a hospital, and that pre-natal check-ups were sufficient to find out if there were problems with the pregnancy. Many women preferred to visit a midwife in the community to determine through a pre-natal massage how the pregnancy was going, and whether there could be a possible complication at the time of birth.
Finding2	CCT Women wished to avoid certain obstetric or medical procedures
Illustration	Fear of a C-section or episiotomy at the time of birth was one of the principle reasons for not going to the hospital. Interestingly, many who held these opinions and gave birth at home also explained that a hospital birth was the safest for both the mother and the baby, especially in the case of an emergency. They appear to know this from information received, but do not necessarily want to practice it themselves.
Finding3	CCT Women wished to avoid certain obstetric or medical procedures
Illustration	The barrier of shame and body-centered embarrassment extended to giving birth in the hospital and pre-natal exams. In the El Salvador study, some women said they had never been to a prenatal check-up for this reason. In public hospitals it is common for medical students to make rounds through the rooms where women are in labour, which the women find embarrassing: “a male doctor comes through, then a female doctor, then another male doctor, and in a manner that everyone is seeing us like this.” This is another reason why seeing a midwife for pre-natal exams and giving birth at home is preferred.
Finding4	CCT Women not willing to be subject to shameful or undignified situations
Illustration	The barrier of shame and body-centered embarrassment extended to giving birth in the hospital and pre-natal exams. In the El Salvador study, some women said they had never been to a prenatal check-up for this reason. In public hospitals it is common for medical students to make rounds through the rooms where women are in labour, which the women find embarrassing: “a male doctor comes through, then a female doctor, then another male doctor, and in a manner that everyone is seeing us like this.” This is another reason why seeing a midwife for pre-natal exams and giving birth at home is preferred.
Finding5	CCT Facility too far from home
Illustration	Long distances and lack of money for transportation was one of the most frequently cited reasons why women in our most remote study community in El Salvador did attend their health appointments. The CCT should do best at directly addressing these types of obstacles, but in practice cash is still short and people often feel they cannot spend it.
Finding6	CCT Prohibitive travel costs to health facilities

Illustration	Long distances and lack of money for transportation was one of the most frequently cited reasons why women in our most remote study community in El Salvador did attend their health appointments. The CCT should do best at directly addressing these types of obstacles, but in practice cash is still short and people often feel they cannot spend it.

A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh?

Finding1	VMS Prohibitive travel costs to health facilities
Illustration	The travel time and costs associated with emergency delivery cases may become prohibitively high if women need to travel to the district town for the service. One of the beneficiaries mentioned: 'I had to go outside Sarishabari sub-district for services. My family paid for travel, food and accommodation costs for me and for others accompanying me to the district facility. We had to take out loans to pay for all the costs incurred.'
Finding2	VMS Adequate administrative and financial resources required for future expansion
Illustration	The implementation of the scheme could have been much more efficient if the voucher distribution was not discontinued in late 2007. Therefore, future expansion of the scheme should carefully plan the needs of the programme to ensure that adequate administrative and financial resources are mobilized for timely processing and disbursement of vouchers and incentive payments.
Finding3	VMS Good communication between different levels of administration
Illustration	'During the first year of implementation, the number of vouchers distributed in the area was much higher than the expected number (7161 vouchers were distributed). About 60% of all vouchers distributed in the year were given out during the first 6 months of the scheme (April-September 2007). The implementation of the programme at the local level mistakenly assumed that all pregnant women are eligible to receive the vouchers irrespective of their socio-economic status. This is an indication of lack of planning of the start-up activities and breakdown of communication between the upper and lower levels of administrative units. This lack of communication between the local and district DSF committees created another significant problem: temporary suspension of voucher distribution for a few months due to shortage of voucher books.'
Finding4	VMS Difficulty enforcing selection criteria
Illustration	The poorest among the pregnant women had more than two children but the scheme defined a target pregnancy as either the first or the second pregnancy. Many local administrative staff considered the selection criteria unfair and difficult to enforce at the field level.
Finding5	VMS Increased workload
Illustration	'Most of the individuals responsible for implementing the programme complained that the new scheme represented significant additional work for them on the top of their regular job. The scheme did not increase the supply of health care providers or management personnel, and therefore, the existing staff and health care providers had to assume a higher workload. Although the service providers received extra incentive payments, it appears that neither the providers nor the administrative personnel were happy with the incentive structure. The providers interviewed complained that the reimbursements were much lower than the fair level of payment for the services rendered. Among the administrative personnel, the source of dissatisfaction was lack of any extra payment for organizing, managing and supervising MHVS activities at the community level. Some the interviewees argued that although the administrative personnel are not directly involved in service provision, they play a very important role in ensuring proper implementation and functioning

	of the scheme.'
Finding6	VMS Reimbursements too small
Illustration	'Most of the individuals responsible for implementing the programme complained that the new scheme represented significant additional work for them on the top of their regular job. The scheme did not increase the supply of health care providers or management personnel, and therefore, the existing staff and health care providers had to assume a higher workload. Although the service providers received extra incentive payments, it appears that neither the providers nor the administrative personnel were happy with the incentive structure. The providers interviewed complained that the reimbursements were much lower than the fair level of payment for the services rendered. Among the administrative personnel, the source of dissatisfaction was lack of any extra payment for organizing, managing and supervising MHVS activities at the community level. Some the interviewees argued that although the administrative personnel are not directly involved in service provision, they play a very important role in ensuring proper implementation and functioning of the scheme.'
Finding7	VMS Lack of payment for administrative duties
Illustration	'Most of the individuals responsible for implementing the programme complained that the new scheme represented significant additional work for them on the top of their regular job. The scheme did not increase the supply of health care providers or management personnel, and therefore, the existing staff and health care providers had to assume a higher workload. Although the service providers received extra incentive payments, it appears that neither the providers nor the administrative personnel were happy with the incentive structure. The providers interviewed complained that the reimbursements were much lower than the fair level of payment for the services rendered. Among the administrative personnel, the source of dissatisfaction was lack of any extra payment for organizing, managing and supervising MHVS activities at the community level. Some the interviewees argued that although the administrative personnel are not directly involved in service provision, they play a very important role in ensuring proper implementation and functioning of the scheme.'
Finding8	VMS Thorough start-up planning
Illustration	'During the first year of implementation, the number of vouchers distributed in the area was much higher than the expected number (7161 vouchers were distributed). About 60% of all vouchers distributed in the year were given out during the first 6 months of the scheme (April-September 2007). The implementation of the programme at the local level mistakenly assumed that all pregnant women are eligible to receive the vouchers irrespective of their socio-economic status. This is an indication of lack of planning of the start-up activities and breakdown of communication between the upper and lower levels of administrative units. This lack of communication between the local and district DSF committees created another significant problem: temporary suspension of voucher distribution for a few months due to shortage of voucher books.'
Finding9	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	Another problem faced by the scheme during its implementation phase was the delay in the release of funds which delayed the reimbursements. Due to late allocation of funds, voucher-supported service activities were hampered as both the beneficiaries and the health care providers did not receive the money they were supposed to get through the vouchers.
Finding10	VMS Rational selection of providers
Illustration	'In our interviews, personnel involved with the implementation of the scheme thought that use of medical care services jumped significantly in the last 3 to 4 months of the first year compared with

	previous months. A new order issued by the Government of Bangladesh towards the end of the first year allowed public sector health care providers to get reimbursements through the voucher scheme. In the original plan, public sector providers were not allowed to receive reimbursements for the vouchers; after the policy change, government facilities became interested in generating extra funding through the vouchers.'
Finding11	VMS Clinical skills and capacity available
Illustration	'The sub-district health complex could not perform caesarean sections for several months within the project period due to non-availability of an anaesthesia consultant. The voucher scheme supported 43 caesarean sections, only 10 of which were conducted at the health complex during the first year of the scheme. The remaining 33 caesarean sections funded by the DSF vouchers were conducted at the referral facilities in Jamalpur town.'
Finding12	VMS Exclusion of the poorest by confining scheme eligibility to women with a restricted parity / number of existing children
Illustration	'The poorest among the pregnant women had more than two children but the scheme defined a target pregnancy as either the first or the second pregnancy. Many local administrative staff considered the selection criteria unfair and difficult to enforce at the field level'

Insights from innovations: lessons from designing and implementing family planning/reproductive health voucher programs in Kenya and Uganda

Finding1	VMS Poverty screening tool based on local markers
Illustration	'The FP and SM vouchers in Kenya and the SM vouchers in Uganda are poverty targeted. In both programs, eligible recipients are identified using an easily implemented poverty screening tool developed by Marie Stopes International (MSI) modeled on community-based research; the tool is customized to each district to capture local markers of poverty. It is implemented by community-level voucher distributors (VDs). No data are available on the sensitivity and specificity of the tool, i.e., on how well the tool sorts the program-eligible poor from non-poor. However, Kenya RH-OBA program staff appear satisfied with the tool and report no major concerns with targeting. In Uganda, RHVP staff and VDs are also satisfied with the tool for the SM voucher and report no major concerns.'
Finding2	VMS Voucher distributors who are rooted in local communities and accessible to poor clients
Illustration	'Kenya"s RH-OBA and Ugandan RHVP vouchers are both targeted at the poor, and both programs have identified and recruited VDs who are rooted in local communities and accessible to poor clients. In Kenya, PWC initially recruited organizations to act as VDs. However, it found that using organizations dispersed accountability across the organization, making it difficult to hold any one individual responsible for performance; subsequently PWC shifted to contracting individuals to act as VDs. By contrast, in Uganda, VD selection is based solely on recommendations from the local communities and VSPs. VDs can include a wide variety of players including commercial outlets, community groups, and faith-based organizations.'
Finding3	VMS Incentives for voucher distributors to focus on promoting to eligible poor clients
Illustration	'Balancing incentives for VDs is also important given their critical gatekeeping role. VDs need to be motivated to promote vouchers, but only to eligible clients. The Kenya program initially paid VDs a commission for every voucher sold. This proved to be a high motivator to sell vouchers indiscriminately, and voucher sales to the non-poor increased. In response, PWC changed the payment strategy and now pays VDs a salary retainer. VDs are contracted for short (three-month)

	terms, and their contracts are renewed only if PWC deems the number of voucher sales to eligible poor clients to be satisfactory. The Ugandan VDs earn a specified mark-up on the voucher price.'
Finding4	VMS Define critical skill sets for the voucher management agency based on key functions
Illustration	'Define critical skill sets for the VMA based on key functions needed for an effective voucher program and support available from the larger health system. Decide if one single organization can carry out all VMA functions or if VMA functions should be split across many organizations to ensure that all the necessary expertise is available to effectively carry out all voucher program functions.'
Finding5	VMS Research to develop voucher with benefits that address needs
Illustration	'Knowing your target audience is important to design programs that are „valued" by clients. Invest in audience research to develop a voucher with benefits that address audience needs.'
Finding6	VMS Draw on existing experience in claims processing systems
Illustration	'Consider contracting out design and implementation of claims processing systems to an organization with strong or prior experience in this domain. Learn and borrow claims administration lessons from existing health insurance firms, both public and private.'
Finding7	VMS Use claims data to monitor and adjust programme
Illustration	'Marry the two approaches to generate empirical evidence on effectiveness of voucher strategies. Use claims data for monitoring and adjusting voucher program. Build in a strong evaluation design before beginning implementation.'
Finding8	VMS Build in evaluation design before beginning implementation
Illustration	'Marry the two approaches to generate empirical evidence on effectiveness of voucher strategies. Use claims data for monitoring and adjusting voucher program. Build in a strong evaluation design before beginning implementation'
Finding9	VMS 'Arrangements for selecting service providers and monitoring quality'
Illustration	'Assess effectiveness of existing health system mechanisms to monitor quality of VSPs. If inadequate, quality monitoring should be part of the VMA"s role assuming in-house capacity exists. If not, VMA should contract-out quality monitoring and ensure implementation of this function'
Finding10	VMS Research to develop correct reimbursement price for different sectors
Illustration	'Collect data at the design stage to ensure that the reimbursement price is right for providers. Public sector providers typically receive supply-side subsidies for voucher services. Reimbursement rates acceptable to public providers may not be adequate for private sector providers. Clear payments terms are essential, particularly for not- and for-profit providers.'

Finding11	VMS Closely monitor timeliness of reimbursements
Illustration	'Ensure efficient claims processing systems. Contract out design to an organization with expertise and closely monitor timeliness of reimbursements.'
Finding12	VMS Mechanisms to support quality improvements of service providers
Illustration	'Ensure that at least one of the VMA entities has capacity to assess and monitor VSP quality. Also need mechanisms to support quality improvements. Explore a sliding scale of reimbursement rates based on quality scoring or performance payments linked to quality improvements as a further incentive for providers to improve all aspects of quality.'
Finding13	VMS Assess and ensure mechanism for drugs and commodities security
Illustration	'Public, for-profit, and non-profit VSPs in the voucher programs rely on the government distribution systems for subsidized FP-related drugs and supplies (in Kenya) and SM-related drugs and supplies (in Kenya and Uganda).While both programs report problems with stock-outs of drugs and supplies, neither has set up mechanisms to provide drugs and supplies in the event of stock-outs in government distribution systems although VSPs can buy those drugs and FP supplies from private distributors or retail pharmacies. Kenyan public and private VSPs complain about stock-outs of supplies from the Kenya Medical Supplies Agency, and this has constrained their capacity to provide quality FP services.'
Finding14	VMS Assess and ensure mechanism for drugs and commodities security
Illustration	'Assess drugs/FP commodities security when designing the voucher program. Where stock-outs are routine, consider an emergency mechanism to procure or finance procurement while long-term solutions are identified.'
Finding15	VMS Use range of media to educate target population about benefits and how to get them
Illustration	'All vouchers, irrespective of type of service, must be supported by marketing and BCC that educates the target population about the benefits of vouchers and how to obtain voucher services.'

Public private partnerships for emergency obstetric care: lessons from Maharashtra

Finding1	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	„we poor do not have the money at that time to pay for the hospital, what if the government gives us the aid later on"
Finding2	SCP Reimbursements too small
Illustration	The implementers and also the private providers find the monetary provision of Rs. 1500 per service episode made by the scheme inadequate for hiring specialists with the prevailing rates crossing Rs. 3000.

Finding3	SCP Attractive service package for private practitioner
Illustration	No PPPs This study finds that there were no public private partnerships executed for EmOC provision in the study district. There is lack of ownership of the scheme among the administrators at the district and block level who did not take any initiative to implement the scheme. We could not find any documents regarding the design of the contract like the specification of services, performance measurement, incentives and penalties, etc. The district health officer, who according to the guidelines is responsible for execution of the PPP scheme in the district, calls this as a special accreditation to be done by the civil surgeon and not a PPP. A medical officer at a PHC questions the interest of any private specialist to contract-in pointing that this arrangement would only reduce their revenue at the private center
Finding4	SCP Template for contracting of practitioners
Illustration	No PPPs This study finds that there were no public private partnerships executed for EmOC provision in the study district. There is lack of ownership of the scheme among the administrators at the district and block level who did not take any initiative to implement the scheme. We could not find any documents regarding the design of the contract like the specification of services, performance measurement, incentives and penalties, etc. The district health officer, who according to the guidelines is responsible for execution of the PPP scheme in the district, calls this as a special accreditation to be done by the civil surgeon and not a PPP. A medical officer at a PHC questions the interest of any private specialist to contract-in pointing that this arrangement would only reduce their revenue at the private center
Finding5	SCP Raise awareness of scheme among private practitioners
Illustration	Private providers unaware of the PPP scheme The private EmOC providers were unaware of the partnership scheme and there was no formal communication to inform them. They mentioned of patients" relatives coming in after a CS to ask for payment receipts and thus had a vague idea of a subsidy being provided.
Finding6	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	Issues of flow of funds The administrators at block and higher levels find no problems with the fund flow; however, ANMs mentioned of shortages for even up to 6 months in a block. The reasons for the discrepancies could not be explained since district officials reported of adequate funds.
Finding7	SCP Role clarity and specification of job tasks
Illustration	The findings reveal the lack of role clarity and specification of job tasks, clear guidelines and dedicated experts the prerequisites for effective PPPs. The findings reveal that the administrators do not have clarity about their roles in implementation of the PPP initiative and there remains much space for improvement in terms of specification of job tasks, clarity of guidelines and expertise for management of contracts, which are essential pre requisites for the success of PPPs. The lack of public health thinking in the managerial and administrative cadre warrants serious and urgent attention. Capacity building and skill development of district-level personnel in negotiation, consultation, and networking is essential and Government"s role lies in providing an enabling environment for this. At the same time, efforts are required to stimulate private providers to participate in the scheme.
Finding8	SCP Attractive service package for private practitioner

Illustration	The findings reveal the lack of role clarity and specification of job tasks, clear guidelines and dedicated experts the prerequisites for effective PPPs. The findings reveal that the administrators do not have clarity about their roles in implementation of the PPP initiative and there remains much space for improvement in terms of specification of job tasks, clarity of guidelines and expertise for management of contracts, which are essential pre requisites for the success of PPPs. The lack of public health thinking in the managerial and administrative cadre warrants serious and urgent attention. Capacity building and skill development of district-level personnel in negotiation, consultation, and networking is essential and Government"s role lies in providing an enabling environment for this. At the same time, efforts are required to stimulate private providers to participate in the scheme.
Finding9	SCP Systematically identify public health facilities with capacity and equipment to contract in
Illustration	The administrators who did not attempt the contracting-in option find it unfeasible in view of lacking infrastructure especially power backup for blood storage facility due to 8-12 h of power cuts in rural areas most of the times.
Finding10	SCP Attractive service package for private practitioner
Illustration	allow loss of own profits and clients while performing services under a contract when there remain profitable opportunities for expansion within the private sector. A modest monetary incentive that is insufficient to attract private specialists into partnership needs reconsideration.
Finding11	SCP Systematically identify public health facilities with capacity and equipment to contract in
Illustration	A systematic effort to identify centers where contracting in could be feasible and a strategy accordingly would have resulted in at least few public sector options and real increase in outreach rather than ad hoc guidelines to be followed.
Finding12	SCP Arrangements for selecting service providers and monitoring quality
Illustration	The subsidization option has no mechanisms as in any formal contract like for accreditation, quality control, accounting, and information systems. These concerns are important given the highly unregulated nature of the Indian private sector.
Finding13	SCP Fill vacancies for community facilitators and service providers
Illustration	While developing the interim measures it is also essential to bring about the long-awaited changes in human resource policies to attract and retain specialists in public system. Training of basic medical officers in providing EmOC and anesthesia is being undertaken so far with limited success.(16) Even if adequate contracting-in of specialists is achieved in rural areas, the resilience of the public health system in continuing such arrangements needs to be addressed.

Are Arrangements for Public Private Partnerships for Emergency Obstetric Care Services Adequate under JSY? A study in Ahmednagar District, Maharashtra

Finding1	SCP Monetary assistance, including cheques, cash and bank transfers, entrusted to another family member may be misspent
Illustration	Besides the amount of JSY benefit, the mode of payment also created difficulties for women. The JSY amount is paid to woman by cheque in most places to reduce corruption associated with cash

	payment. As one ANM expressed: “Women do not even know what a cheque means. I have to accompany them to the bank, but this is possible for me because the bank here is nearby, but what about those working in sub-centres? The woman then has to give the cheque to her husband, and in most instances the money does not reach the woman.” An administrator also said that the bearer cheque given within 7 days of delivery is inconvenient. “How can a recently delivered woman go to the bank? She is in a different mindset that time, she gives off the cheque to someone, and then you know what happens to the money.”
Finding2	SCP Expected to give birth at parental home
Illustration	go to their maternal homes for delivery, usually in the 7th month of pregnancy and return about 6-8 weeks after the delivery. This creates problems while claiming JSY benefits. The women eligible for JSY are expected to carry their JSY card when they go for delivery. ANMs in the maternal homes, (whenever they come to know of the delivery - sometimes at the time of the child"s immunization), consider her to be from out of their service area and direct her to avail benefit in her usual residence area.
Finding3	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	A common problem women face while availing JSY benefit, is the time limit of 7 days given to claim the benefit. This study could not identify a single participant who received the benefit within the stipulated period of 7 days after delivery. This period varied from a low of 0 days for a participant to 5 months for another, the average being 3 months after delivery. A participant who had her delivery by Caesarean section in her mother"s place tried to avail Rs. 1,500 when she returned to her marital home mentions of the inconvenience in collecting the documents required as we have spent about Rs. 500 just for this, it cost us each time at least Rs. 100 to go and come- how many times we have done that?... Once she would give him the white paper, then the yellow one, then she asked the doctors signature, then my school certificate, one at a time"
Finding4	SCP Cash disbursement regulations excessively rigid
Illustration	A common problem women face while availing JSY benefit, is the time limit of 7 days given to claim the benefit. This study could not identify a single participant who received the benefit within the stipulated period of 7 days after delivery. This period varied from a low of 0 days for a participant to 5 months for another, the average being 3 months after delivery. A participant who had her delivery by Caesarean section in her mother"s place tried to avail Rs. 1,500 when she returned to her marital home mentions of the inconvenience in collecting the documents required as we have spent about Rs. 500 just for this, it cost us each time at least Rs. 100 to go and come- how many times we have done that?... Once she would give him the white paper, then the yellow one, then she asked the doctors signature, then my school certificate, one at a time"
Finding5	SCP Expected to give birth at parental home
Illustration	While in another case, a woman in the study, in accordance to the JSY rules, produced her JSY card in a government hospital near her natal home, four days after her caesarean operation, was denied the benefit, as according to the officials she could avail it only in her residence area.
Finding6	SCP Cash disbursement regulations excessively rigid
Illustration	When she attempted to seek benefit in her area, on her return, after she was discharged on the 12th day of her delivery, she was denied the benefit as it was past 7 days of delivery.

Finding7	SCP Lack of the required documentation to prove eligibility
Illustration	Quite a few implementers noted that JSY benefits are not provided to the migrant populations as the pregnancy is not register. Women are expected to produce their JSY card for availing the benefit, but it is often the case that women are missing their cards. One medical officer said that the norm being followed is that a woman coming for delivery from outside the PHC"s service area has to produce a certificate from the PHC of that area, that she has not availed the benefit there.
Finding8	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	The bottlenecks in availing the scheme that this study identifies are lack of information and awareness of the scheme, difficulties in producing the required documents within 7 days of delivery and delay in registration of pregnancy.
Finding9	SCP Cash disbursement regulations excessively rigid
Illustration	The bottlenecks in availing the scheme that this study identifies are lack of information and awareness of the scheme, difficulties in producing the required documents within 7 days of delivery and delay in registration of pregnancy.
Finding10	SCP Lack of the required documentation to prove eligibility
Illustration	The bottlenecks in availing the scheme that this study identifies are lack of information and awareness of the scheme, difficulties in producing the required documents within 7 days of delivery and delay in registration of pregnancy.
Finding11	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	There were wide variations of information level of the JSY scheme among potential beneficiaries. The study found that women who had received JSY cards, but were not aware of what it was and assumed it to be an immunization card. As women were not made aware of the potential benefit of the JSY card, they therefore forget to take the card with them during delivery, though they take other relevant documents with them like their laboratory and ultrasound reports.
Finding12	SCP Documentation process for scheme is overly complicated / unworkable
Illustration	The JSY is a conditional cash transfer scheme. Three ANC checkups with early registration of pregnancy (before twelve weeks of pregnancy) are important conditions for cash assistance. In one of the PHC areas visited, we found registration beyond 12 weeks as a reason for denial of benefit of the scheme whereas this condition is not strictly followed in other PHCs in the block and the district. Women held the ANM responsible for delay in registration and even mistakes in noting the pregnancy period that resulted in denial of benefit to them.
Finding13	SCP Cash assistance not sufficient to meet expenses
Illustration	Subsidization of the cost of services is by payment of Rs. 1,500 to specialists conducting CS in private facilities. This amount being far below the cost incurred in a private facility, the guideline clarifies that rest of the hospital charges are to be borne by the patient. This defeats the purpose of the scheme to increase easy access to EmOC services (only CS in this case). The family having to pay the entire hospital bill before discharge, is thus unaffected by the scheme at the time of

	payment, which question the utility of the scheme. Though the guidelines strictly state disbursement of money within 7 days of delivery, but as the information of the delivery occurring reaches the system much later, as found by this study, the 7 day norm becomes irrelevant. The delay in reimbursement and small amount received as compared to money spent in CS, significantly do not help a poor woman"s family to avail safe and quality delivery care services.
Finding14	SCP Scheme eligibility criteria restrict access by those who register late
Illustration	In one of the PHC areas visited, we found registration beyond 12 weeks as a reason for denial of benefit of the scheme whereas this condition is not strictly followed in other PHCs in the block and the district. Women held the ANM responsible for delay in registration and even mistakes in noting the pregnancy period that resulted in denial of benefit to them.
Finding15	SCP Programme does not provide assistance to women who need forms of emergency obstetric care other than caesarean section
Illustration	Nationally, 15 percent of all deliveries are expected to be complicated ones requiring EmOC and a minimum of 5 percent need caesarean section operation. The Maharashtra state JSY guidelines provide assistance of Rs. 1,500 to women who will have a CS done, and not for other EmOC treatment, in violation of national JSY guidelines. Thus, by avoiding the term obstetric complications in the state guidelines, two-third of women in need of EmOC have been barred from the eligibility to the JSY benefit.
Finding16	SCP Payment to family members, or the bank accounts of family members, removes control of the money from women
Illustration	Besides the amount of JSY benefit, the mode of payment also created difficulties for women. The JSY amount is paid to woman by cheque in most places to reduce corruption associated with cash payment. As one ANM expressed: “Women do not even know what a cheque means. I have to accompany them to the bank, but this is possible for me because the bank here is nearby, but what about those working in sub-centres? The woman then has to give the cheque to her husband, and in most instances the money does not reach the woman.” An administrator also said that the bearer cheque given within 7 days of delivery is inconvenient. “How can a recently delivered woman go to the bank? She is in a different mindset that time, she gives off the cheque to someone, and then you know what happens to the money.”
Finding17	SCP Template for contracting of practitioners
Illustration	None of the public providers have any list of accredited facilities for maternal health in the area, in contravention to the NRHM guidelines. A medical officer noted that accreditation is expected but not mandatory for the doctors whose services are being covered under the scheme. Certain providers mentioned of denying the benefit in case of the hospital being non-accredited.
Finding18	SCP Attractive service package for private practitioner
Illustration	an MO opined about the lack of motivated doctors who would come to the rural hospital for just Rs. 1,500. This is so because the prevailing rates for hiring a surgeon are Rs. 3,100 and that for the anaesthetist Rs. 2,200 for a Caesarean section. A member of the Rogi Kalyan Samiti (RKS) of a sub-district hospital pointed out an experience of hiring a specialist from the private sector: “Dr, a private gynecologist who is usually appointed on an on call basis in the hospital, is unwilling to come here, because of his interests in his own private hospital. The doctor feels that if he comes to the sub-district hospital, all his patients will not go to his own hospital. Who will want to spoil their own practice?” Beneficiaries have pointed out that they have spent about ten times the JSY benefit amount. They said that the amount is not sufficient even for tablets and medications that were

	required during CS
Finding19	SCP Clear procedures regarding referral to higher level facilities
Illustration	Instead the study found that almost all cases are direct self-referrals to the private specialists, or via smaller private centres. The medical officers and ANMs at the PHCs have no specific referral chains, they prefer to leave it to the patient to choose a higher centre. There is no accreditation of centres done for this scheme; hence, there exist no measures to ensure the continuum of care and minimize delays. One ANM mentioned of having referred and accompanied two EmOC cases to a sub-district hospital. However, they were diverted to the private hospital of the consultant appointed on call in the sub-district hospital. Public providers from all the study blocks revealed that CHCs in their block do not have EmOC services and thus were forced to refer poor patients to nearby charity hospitals.
Finding20	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	The JSY guidelines talks of provision of free transport for EmOC. Differences in norms regarding provision of transport for EmOC were noticed. The amount is up to Rs. 250 for a patient according to some implementer while others mentioned it to be Rs. 500. A block administrator mentioned of wall paintings displaying phone numbers of vehicle owners whom the patient can contact in need of emergency transport and use the vehicle without payment, which are directly made to the transporter by the PHC later. In another PHC, the understanding is that the patient has to spend for the transport first and it can be reimbursed later from the Village Health and Sanitation Committee or from the Rogi Kalyan Samiti money if the medical officer feels the need to do so. In a few places the norm is to spend for transport from the money available from sub-centre strengthening. However, this study found no participant who benefited from transport provided from the PHC or reimbursement for the same. Transport facilities used by women were private vehicles hired at high rates.
Finding21	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	In all the blocks, the officials at the block office feel the funds are adequate for implementing the scheme, though grassroots workers in two blocks mentioned shortages. ANMs reported they many times do not get the amount of Rs. 5,000 that they are supposed to get. In one block, a delay of 6 months was reported. Road blocks in processing payments like the case of a Block Medical Officer who withheld payment to those women who delivered before he joined in July 2008 posed a significant problem.
Finding22	SCP Ensure that bureaucratic requirements do not deny access
Illustration	Other suggestions include: - Clarity of guidelines - Changes in the criteria for eligibility to benefit from the scheme viz., the poor not having BPL cards and who are not from SC/ST should be included - Relaxation of the two-child norm, especially for EmOC - Replacement of the caste criteria with income criteria - Timely supply of JSY cards to PHCs - No shortage of funds at grassroots level - Use of information technology so that update is available to any provider about payments made by other institutes. This would do away with the need to confirm non-receipt in other areas before disbursement of money which causes delays - Private providers of EmOC suggested that the scheme should be displayed in their hospital premises and that private practitioners could inform the public health system of the eligible patients availing EmOC services from them with the expectation of payments of the subsidy to them before the patient. In this way, the poor patient will have to pay less.
Finding23	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system

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Finding24	SCP System that can be accessed by different providers and which shows when a woman has been given a cash payment
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Finding25	SCP Template for contracting of practitioners
Illustration	The provision of Rs. 1,500 is for a PPP, i.e., for hiring specialist from the private sector, is a PPP by contract in services. Contracting in services would mean contracting in specialist obstetric services from the private sector to the public facility. This implies utilization of the public infrastructure and drugs and supplies and hence free care to the patient. Thus, this form of PPP would provide cashless services to patients to improve access, as financial barriers are important reasons to defer treatment. This strategy could strengthen the public health system by filling the gap of skilled personnel. Monitoring the quality of care is comparatively easier in a public facility than in the private sector which is well known to be unregulated. However, implementers also have the option of cost subsidization where services from the private facilities are utilized and a certain amount of reimbursement given. This study finds that the second option was the one most preferred by all the implementers. The subsidy option, i.e., which is currently practiced, has no formal mechanisms, such as a formal contract, accreditation, quality control, accounting or information system. This is in a sense getting rid of the responsibility of EmOC provision.
Finding26	SCP Attractive service package for private practitioner
Illustration	With long hours of power cuts in rural areas, 8-12 hours a day, providing electric backups to the available blood storage facilities has itself become a major difficulty. With th prevailing high rates of CSs and also the doubt whether a private specialist would risk losing clients by contracting in his/her services, it is doubtful that a private specialist would offer services for a meagre Rs. 1,500 provided by this scheme.
Finding27	SCP Fill vacancies for community facilitators and service providers
Illustration	The experience of JSY however raises a much larger issue - institutionalizing PPP, if successful to provide EmOC and reduce maternal deaths does not however address the root cause. The issue of lack of specialists in the public sector remains unaddressed. India has more than 20,000 obstetricians, of whom, only 780 work in the public health system at sub-district level in rural areas.12 Hiring specialists from the private sector can only be an interim measure, the long-awaited

	changes in human resource policies need to be brought about to make the public sector capable enough to attract and retain specialists. The present study raises serious concerns about the following enabling conditions for successful PPPs: - Capacity and expertise of the government at different levels in designing and managing contracts (partnership) - Appropriate organizational and management systems for partnerships - Strong management information system - Clarity on incentives and penalties
Finding28	SCP Role clarity and specification of job tasks
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Finding30	SCP Ensure facilitators understand the selection criteria
Illustration	The scheme expects the ANMs, when they register the pregnancy and conduct antenatal checkups, to ensure that the eligible women keep their BPL/caste certificates ready. This however is found to be missing.
Finding31	SCP System that can be accessed by different providers and which shows when a woman has been given a cash payment
Illustration	Use of information technology so that update is available to any provider about payments made by other institutes. This would do away with the need to confirm non-receipt in other areas before disbursement of money which causes delays

Experiences with Janani Suraksha Yojana in Uttar Pradesh: Analysis of case studies by SAHAYOG and partners.

Finding1	SCP Potential beneficiaries" lack of knowledge of scheme provisions

Illustration	At the outset it appears several women do have contact with a provider as they get TT injections and are presumable registers with an ANM. However, women and / or their families in UP do not receive adequate information about routine care, danger signs or where to seek services in pregnancy, abortion, childbirth and post-partum stages. The women are also not receiving counselling or information about contraception which leads to unwanted multiple pregnancies, sometimes with fatal consequences.
Finding2	SCP Health staff asked for informal payments
Illustration	Informal payments - Babita of Chandauli (March 2007) was asked for Rs 500 as a share of the JSY money by the ANM at the PHC - Sharmila of Kushinagar was asked for Rs 500 by the ANM at the PHC for her delivery but never given the JSY - Jaydevi of Mirzapur (August 2006) was asked for Rs 600 by the ANM at the PHC to manage the retained placenta - Nirmala of Kushinagar was asked for Rs 500 by the ANM at the PHC to do her abortion and the Rs 1,000 by another ANM to treat post-abortion complications - Durmati of Kushinagar was asked for Rs 1,000 by the ANM at the PHC for doing her delivery - Alimun-nisha of Chandauli (October 2005) was asked for Rs 5000 by the doctor at BHU before he took her case - Manju of Lucknow (January 2007) was asked for Rs 10,000 by the doctor at the urban maternal health centre before her case could be admitted to hospital Despite the trouble women take to reach the institutions for maternal health services, the emand for informal payments continues to be fairly high. Whether it is a normal child birth, a post-partum complication, an abortion or an operation, women are invariably expected to pay providers. Families who earn daily wages for a living cannot afford these payments and are pushed deep into debt when they try to access maternal health services, as with the families of Savita and Alimun. The demand for informal payments is also linked to denial of services, as with Manju (Lucknow).
Finding3	SCP Clear procedures regarding referral to higher level facilities
Illustration	It is of concern that families do not have accurate information on where to seek care in emergency or when complications occur and this has not changed even after the NRHM has been launched. The first provider contacted is often the one not capable of handling the complication; more often than not it is a local ANM or private doctor/quack. Thus precious time is wasted moving the women from one provider to another, in a situation of lack of proper transport and resources.
Finding4	SCP Mechanisms to deter unnecessary referral-on of complicated cases
Illustration	Quality of institutional care a. Refusal to admit into the institution - Rani of Banda (April 2007) was an obvious high-risk case in her ninth delivery yet the CHC staff refused to admit or refer her. - Gita and Rani of Banda had to deliver their babies at home since the CHC staff refused to admit them in labour. - Manju of Lucknow and Mamta of Chandauli had to deliver their babies on the street despite attending hospitals for delivery.
Finding5	SCP Clear procedures regarding referral to higher level facilities
Illustration	Lack of diagnostic skill and absence of timely referral - 18-year-old Nirmala of Azamgarh (Feb 2007) and Jaydevi of Mirzapur (August 2006) both died because the ANM was unable to recognize a life-threatening complication (retained placenta) or refer it in time; in both cases the ANMs preferred to manually remove the placenta without anaesthesia, leading to almost immediate death. - Hazrat died after her seventh delivery at the PHC because the providers were unable to refer her in time as a high-risk case. - Asha of Chandauli died because the ANM consulted was unable to recognize her life-threatening ante-natal complication or refer her in time. - Maya of Kushinagar died (December 2006) because the PHC was unable to treat her post-abortion complication. - Savita and Mamta of Chandauli both lost their babies because the ANM was unable to recognize that labour had started. - Parvati of Banda lost her baby because the ANM and the local informal provider (quack doctor) gave her an IV line for four hours causing shivering and discomfort, but not facilitating the delivery

Finding6	SCP Arrangements for selecting service providers and monitoring quality
Illustration	When providers are consulted or when women do reach institutions, they are either denied services, or the available services are largely unskilled or irrational. There is also a high incidence of the use of an injection for the woman in labour, which is possibly oxytocin. There continues to be poor diagnosis and management of complications in pregnancy, abortion, childbirth and the post-partum stage. Women continue to die of conditions that could have been managed if the providers had been prepared, willing and skilled. Unfortunately, this is similar to the pre-NRHM scenario where routine and emergency services for pregnancy, abortion, child birth and post-partum stage were not available, accessible, affordable, appropriate or sensitive. In addition, they were neither effective in saving lives nor ethical.
Finding7	SCP Monitoring system that can track morbidity and mortality during the post-partum period
Illustration	Women who have had contact with providers for routine ANC (TT injections) do not receive proper PNC and follow-up, and are often compelled to seek post-partum care from private providers at their own cost. This indicates that the pregnant women have not been tracked for recording the outcome of the pregnancy, and their contact with the provider is an opportunity lost. Those women who had no contact with a provider during their pregnancy (for routine ante-natal care) also lost their lives, like some of those who did have contact with a provider: Asha of Azamgarh (September 2006) and Nanhaki of Mirzapur (August 2006) developed post-natal complication after her fourth delivery and died.
Finding8	SCP Mechanisms to support quality improvements of service providers
Illustration	Improvement of the quality of institutional care, including - Systems of community monitoring of the services, facilities, service providers and feedback mechanisms. - Community monitoring of demands for informal payments, irrational drug use etc.; strict departmental action upon feedback. - Periodic social audit with the involvement of people"s representatives. - Skill-building of ANMs and PHC staff to recognize and deal with complications and management of timely referral.
Finding9	SCP System to detect informal payments and corruption
Illustration	Improvement of the quality of institutional care, including - Systems of community monitoring of the services, facilities, service providers and feedback mechanisms. - Community monitoring of demands for informal payments, irrational drug use etc.; strict departmental action upon feedback. - Periodic social audit with the involvement of people"s representatives. - Skill-building of ANMs and PHC staff to recognize and deal with complications and management of timely referral.
Finding10	SCP Monitoring system that can track morbidity and mortality during the post-partum period
Illustration	Creating a method to track each pregnancy and follow it through to six weeks after child birth or post-abortion, recording of adverse outcomes on a no-fault basis (ANMs will not disclose information that leads to punitive action).
Finding11	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Based on the analysis of case studies mentioned above, the following recommendations are suggested in order to strengthen the provision of maternal health services under the NRHM: 1. At the point of first provider contact (such as routine ANM), the following information may be given to women and their families: - Entitlements under NRHM to women and their families, including the JSY and support of the ASHA. - Comprehensive information on safeguarding maternal health; this should include adequate information about routine care and danger signs. - Where to seek

	appropriate services in pregnancy, abortion, child-birth and post-partum stages. - Information about the dangers of oxytocin used without medical supervision to hasten child birth. - Couples and women also need counselling, information and services about contraception
Finding12	SCP Clear procedures regarding referral to higher level facilities
Illustration	Susheela of Kushinagar (January 2006) visited a CHC, a private nursing home and a hospital during labour. Asha of Azamgarh (September 2006) visited three providers before she died of ante-partum complication. Meena of Mirzapur (October 2006) visited three providers while in labour. Alimun-nisha of Chandauli (October 2005) was treated by four provider for prolonged labour. Urmila of Mirzapur (August 2006) consulted three providers before she died of post-partum complications. Mamta of Chandauli (April 2006) was attempting to reach her third provider when she delivered her dead baby on the road.

A conditional cash assistance programme for promoting institutional deliveries among the poor in India: process evaluation results

Finding1	SCP Barriers reduced if DSF schemes accept alternatives to standard documentation
Illustration	In all the states, the „BPL card" was the main document required to avail of the benefits of this scheme, especially if the woman delivers at home. Where BPL cards had not yet been issued or had not been updated, alternate documents had been specified, which vary from state to state. In Karnataka, the new parents were expected to furnish a photograph of themselves with the baby to receive the cash assistance.
Finding2	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	In Maharashtra, the women said that they received the benefit the moment they had submitted the documents. However, women from other states said that there was considerable delay in receiving the benefit. As stated earlier, in Karnataka, the money was disbursed up to one year after the child was born. The most common reason for this delay was the fact that the advance was not replenished by the district/state (as per the nurses and medical officers). On the other hand, the state level officers said that this delay was because the nurses did not submit the utilisation certificates in time. In all the facilities conducting institutional deliveries, there is a huge backlog of JSY payments. During the survey, a nurse reported that in her area, out of 20 institutional deliveries, only 8 women and village health workers have received the JSY entitlement. The remaining 12 have not yet been paid due to paucity of funds.
Finding3	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	The level of awareness about the scheme was low in Chattisgarh and Karnataka compared to Maharashtra and Orissa. Beneficiaries interviewed from the state of Maharashtra reported that the scheme was good as it benefits the poor and it should be continued. To quote a beneficiary, “this is a good scheme, [we receive] financial support for maternal expenses and there is no need to borrow money”. But the majority of the BPL mothers who had delivered in the past six months from Chattisgarh and Karnataka mentioned that they had not heard about this scheme.
Finding4	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	Corruption is another issue of serious concern. According to the Jan Swasthya Abhiyan report, “there are instances of negligence on the part of the block level health officials in Chattisgarh whereby the full entitlement does not reach the beneficiaries” (People's health movement 2007). In Karnataka beneficiaries interviewed stated that they did not receive the full amount. All the beneficiaries interviewed from Orissa reported that they received only Rs 350 instead of Rs 700.

	The rest was apparently distributed among the facility staff.
Finding5	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
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Finding6	SCP Price of medicines and other tests not covered by voucher
Illustration	The pregnant women suggested that the coverage of the scheme has to be extended to all women and up to 3 live births. The payment has to be made on time, and the procedure for documentation has to be simplified. They felt that the amount should be increased as they spend more money associated with delivery (hospital charges, medicines, transportation charges etc). They also suggested that the assistance has to be given for the new born baby"s treatment also. They felt the information regarding the scheme has to be provided a long time before the delivery so that the documents can be arranged in time. If an application is rejected, the reason for rejection has to be explained also.
Finding7	SCP Documentation process for scheme is overly complicated / unworkable
Illustration	The pregnant women suggested that the coverage of the scheme has to be extended to all women and up to 3 live births. The payment has to be made on time, and the procedure for documentation has to be simplified.... They felt the information regarding the scheme has to be provided a long time before the delivery so that the documents can be arranged in time. If an application is rejected, the reason for rejection has to be explained also.
Finding8	SCP Increased workload
Illustration	Most of the medical officers in the health centres reported that the work load has definitely increased since the introduction of this scheme. The number of institutional deliveries increased but at the same time many hospitals did not have the adequate infrastructure and staff facilities required to handle this extra load. They reported that due to this, they are often forced to discharge the women within a day of the delivery. They also stressed that necessary training has to be given to village health workers and other field staff to improve the quality of their work.
Finding9	SCP Health staff deduct proportion of money before disbursement
Illustration	Corruption is another issue of serious concern. ...In Karnataka beneficiaries interviewed stated that they did not receive the full amount. All the beneficiaries interviewed from Orissa reported that they received only Rs 350 instead of Rs 700. The rest was apparently distributed among the facility staff.
Finding10	SCP Clinical skills and capacity available
Illustration	Most of the medical officers in the health centres reported that the work load has definitely increased since the introduction of this scheme. The number of institutional deliveries increased but at the same time many hospitals did not have the adequate infrastructure and staff facilities required to handle this extra load. They reported that due to this, they are often forced to discharge the women within a day of the delivery. They also stressed that necessary training has to be given to village

	health workers and other field staff to improve the quality of their work.
Finding11	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	The medical officers suggested that the fund flow has to be more streamlined so that the delay in payment can be avoided. They reported that the village health worker (ASHA) has a heavy work load and she does not get rewarded for her performance on time. They felt that due to this she might lose her motivation and that in turn will affect the success of the scheme.
Finding12	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	The pregnant women suggested that the coverage of the scheme has to be extended to all women and up to 3 live births. The payment has to be made on time, and the procedure for documentation has to be simplified.
Finding13	SCP Ensure that bureaucratic requirements do not delay implementation
Illustration	The pregnant women suggested that the coverage of the scheme has to be extended to all women and up to 3 live births. The payment has to be made on time, and the procedure for documentation has to be simplified.
Finding14	SCP Monitoring system that can track morbidity and mortality during the post-partum period
Illustration	The monitoring of the scheme is currently done by the District Programme Manager (NRHM) and the RCH officer at the district level. There is a need to strengthen the monitoring mechanism at the field level to make sure the scheme is implemented effectively. Currently the variables monitored are „the number of beneficiaries" and the „amount disbursed." As stated earlier, this does not permit the policy maker to understand whether the JSY has met its original objectives, those of increasing institutional delivery and reducing maternal and neonatal deaths. A real problem with monitoring the incentive scheme is that it encourages overreporting on utilisation data. An independent agency could monitor the scheme to provide timely and accurate reports of its performance. There is no formal evaluation being undertaken.

Qualitative Impact Study for PNPM-Generasi and PKH on the Provision and the Utilization of the Maternal and Child Health Services and Basic Education Services in the Provinces of West Java and East Nusa Tenggara

Finding1	CCT Selective schemes may not advertise for fear of creating jealousy and conflict
Illustration	At the community level, especially in West Java and in urban areas in NTT [East Nusa Tenggara province], the presence of PKH was not too well known. Due to the small number of beneficiaries and the subsequent potential for jealousy and conflict to arise between beneficiaries and non-beneficiaries the program was implemented almost as if it were a secret.
Finding2	CCT Women not willing to be subject to shameful or undignified situations
Illustration	Other problems in the services were the lack of permanent buildings dedicated to in some sample villages. This meant that the delivery of services were still conducted at cadres" houses or village offices. As a result, mothers and children felt less comfortable during their visits to posyandu.

Finding3	CCT Facility too far from home
Illustration	In addition, households who lived in remote RT had to walk for hours to access the nearest posyandu
Finding4	CCT Women not willing to be subject to shameful or undignified situations
Illustration	Some women were also ashamed, or believed it taboo to show their genitals to the midwives
Finding5	CCT Cash disbursements are too late to help poor with immediate expenses
Illustration	Using PKH funds for MCH utilization was rare, almost non-existent because the timing of payments were often not at the same time as the funds were needed (for example during childbirth). Therefore mothers tended to ignore aspects of MCH despite receiving PKH funds for infants or pregnant women.
Finding6	CCT Lack of available transport to facility
Illustration	In all sample villages in West Java, posyandu services were available in every hamlet or RW. In NTT [East Nusa Tenggara province] posyandu services were still difficult to access from remote areas or villages, one control village had only one available posyandu. The limited number of posyandu was due to the small number of targeted beneficiaries (pregnant women and infants) and the vast spread of populations. In addition there were a limited number of posyandu cadres and village midwives to provide services at posyndu. As found in the baseline study of 2007, posyandu were the primary healthcare facility servicing children under the age of five.
Finding7	CCT Cash disbursements are too late to help poor with immediate expenses
Illustration	The cost of giving birth with assistance from a midwife was quite expensive, especially in West Java and in urban areas in NTT [East Nusa Tenggara province] (see table 19). For this reason some women used the services of dukun beranak. PKH did not reduce the cost barriers for women in accessing midwifery services. This was partly because the dispersal of PKH funds often did not coincide at the time that funds were needed (for example during childbirth). Therefore, PKH funds were generally used for other purposes deemed more urgent such as the fulfillment of daily household consumption.
Finding8	CCT Provider not told about existence of the scheme
Illustration	The village/hamlet apparatus and MCH and basic education service providers tended to be dissatisfied with PKH because they were not involved. In five PKH treatment villages, all midwives interviewed complained that they were not involved in PKH. One midwife did not even know about the existence of PKH in her village. “Fortunately, the PKH money was directly transferred to beneficiaries through the post office, so we can say that the village officials were not involved in PKH. It was via the village office so there could be conflicts in the community “(Head of Village-West Java). “The only people who know about PKH in this village are the beneficiaries because the implementation of the program is done secretly” (Head of Village -NTT-Urban). “There should be coordination with midwives regarding the issues of pregnant women in posyandu, but there was none” (Midwife-NTT). “... Is our only task to collect data? Even the district health office was not informed, how were we supposed to know “ (Midwife-NTT).
Finding9	CCT Women"s autonomy enhanced in the domestic sphere

Illustration	Although overall PKH funds were not used appropriately, in terms of management the funds were mostly in the hands of mothers or women in the family. Mothers withdrew funds directly from the post office and usually they spent some of that money directly at the market. In one village in NTT [East Nusa Tenggara province] the fact that PKH funds were managed by the women lead to jealousy by the men. These men hoped that the unconditional cash transfer (BLT) could be dispersed again and be managed by the head of the family.
Finding10	CCT Users" dignity and confidence enhanced
Illustration	where there were no midwives, women"s raised awareness had resulted in increased efforts to access midwives via the puskesmas. “I recently reported to the puskesmas and requested that they assign a midwife in this village because people here have it difficult” (Community Leader-NTT). Increased awareness of women tended to be more dominant than men because women were subjected to various MCH programs. However, there were increasing numbers of husbands who accompanied wives to pregnancy checkups and brought them to posyandu. There were no longer any husbands who prevented their wives from accessing MCH services.
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Finding12	CCT Family members more supportive of women"s health care seeking
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Finding13	CCT For schemes to be effective needed professional midwives living in the villages
Illustration	In addition, in one village the use of PKH for MCH was hampered due to the lack of a village midwife. In this village the majority of PKH recipients had no access to midwifery services for childbirth.
Finding14	CCT Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	The presence and activity of PKH facilitators played an important role in motivating the recipients to comply with the 12 indicators of achievement in the allocation of the PKH funds. Facilitators often instructed recipients to comply with the conditionality of the program and use the funds for MCH and educational purposes.
Finding15	CCT Facilitators who are not overstretched across a large area

Illustration	However, PKH facilitators were not always available and active in all treatment villages. The number of villages to be monitored was one cause of facilitators being neither focused nor active. The small number of PKH recipients per village in West Java and in urban areas in NTT [East Nusa Tenggara province] resulted in facilitators having to facilitate several villages. In fact, there was a facilitator who was responsible for facilitating up to seven villages. In addition, in one sample village in NTT [East Nusa Tenggara province], one facilitator resigned in 2009, so facilitation for that village was covered by a facilitator from other village.
Finding16	CCT Fill vacancies for community facilitators and service providers
Illustration	Although there were some improvements in some sample villages, both treatment and control, services were constrained due to the frequent turnover of cadres. The main cause of this turnover was the lack of adequate incentives for the cadres. In West Java, the former cadres preferred to become laborers or maids. The substitution of cadres was also directly related to the change of village heads. In one control village in West Java, each posyandu was run by 2-3 cadres as it was difficult to recruit cadres. In fact, the five platform service system should involve a minimum of 5 cadres for every posyandu.
Finding17	CCT Attractive service package for providers
Illustration	Yet the availability of MCH services in another treatment village and a control village remained relatively unchanged. In these two villages there were no village midwives and in the treatment village pusling services had been terminated since 2008 due to a lack of operational funds. In the treatment village no midwives had been available since 2002. In addition to the shortage of midwives, it was difficult to find midwives willing to live in the villages. Reasons for this were that midwives did not want to live in the villages because there was no clean water or electricity and locations were far from health centers and only accessible via damaged roads and severe (mountainous) terrain. Midwifery services were also limited by the sparse population spread over vast areas, the lack of rural infrastructure which was exacerbated in the rainy season, and the continued lack of service facilities (buildings and equipment for posyandu/polindes).
Finding18	CCT Fines for not fulfilling programme activities
Illustration	PKH contributed to the increased use of posyandu in rural areas in NTT [East Nusa Tenggara province] because there were a more significant number of PKH recipients and facilitators threatened to cut Rp50,000 of PKH funding to recipients if they did not routinely attend posyandu. “I explained to the PKH recipient that if they do not come to posyandu they will receive a fine of Rp. 50,000, if they are not present at posyandu three times in a row they will be terminated as a PKH beneficiary “(PKH Facilitator-NTT).
Finding19	CCT Fines for not fulfilling programme activities
Illustration	The utilization of midwifery services during childbirth differed between the two treatment villages in NTT [East Nusa Tenggara province]. In one treatment village, the use of midwives increased significantly because of which required mothers to give birth in polindes. If they did not they were subject to fines of Rp500,000. Conversely, in the other treatment village, despite fines amounting to Rp250,000, midwife services utilization rates were unchanged as there was no village midwife. Consequently most of the PKH recipients still gave birth assisted by dukun beranak because there was no village midwife. In a remote hamlet in another control village the community"s level of trust and confidence in dukun beranak was still high, so they continued to rely on dukun beranak even though midwives were available. “Dukun beranak are close, whereas midwives are far away, midwives do not exist in Falas”; “We need a midwife but midwife is too far away” (FGD Female-NTT). “In 2007, almost all (women) used dukun beranak. in 2008 and mid 2009 they accessed village midwife, but now because the village midwife have moved away they go back to dukun beranak” (Posyandu cadre, NTT).

Finding20	CCT Fill vacancies for community facilitators and service providers
Illustration	The utilization of midwifery services during childbirth differed between the two treatment villages in NTT [East Nusa Tenggara province]. In one treatment village, the use of midwives increased significantly because of which required mothers to give birth in polindes. If they did not they were subject to fines of Rp500,000. Conversely, in the other treatment village, despite fines amounting to Rp250,000, midwife services utilization rates were unchanged as there was no village midwife. Consequently most of the PKH recipients still gave birth assisted by dukun beranak because there was no village midwife. In a remote hamlet in another control village the community"s level of trust and confidence in dukun beranak was still high, so they continued to rely on dukun beranak even though midwives were available. “Dukun beranak are close, whereas midwives are far away, midwives do not exist in Falas”; “We need a midwife but midwife is too far away” (FGD Female-NTT). “In 2007, almost all (women) used dukun beranak. in 2008 and mid 2009 they accessed village midwife, but now because the village midwife have moved away they go back to dukun beranak” (Posyandu cadre, NTT).
Finding21	CCT For schemes to be effective needed professional midwives living in the villages
Illustration	In one treatment village and two control villages in NTT [East Nusa Tenggara province] midwifery services were not available so most women, including PKH beneficiaries, gave birth assisted by [dukun]. In fact, there were instances where births were only attended by husbands or parents.
Finding22	CCT Fill vacancies for community facilitators and service providers
Illustration	Yet the availability of MCH services in another treatment village and a control village remained relatively unchanged. In these two villages there were no village midwives and in the treatment village pusling services had been terminated since 2008 due to a lack of operational funds. In the treatment village no midwives had been available since 2002. In addition to the shortage of midwives, it was difficult to find midwives willing to live in the villages. Reasons for this were that midwives did not want to live in the villages because there was no clean water or electricity and locations were far from health centers and only accessible via damaged roads and severe (mountainous) terrain. Midwifery services were also limited by the sparse population spread over vast areas, the lack of rural infrastructure which was exacerbated in the rainy season, and the continued lack of service facilities (buildings and equipment for posyandu/polindes).
Finding23	CCT Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	PKH facilitators" roles in influencing the use of MCH services was only visible in two rural sample villages in NTT [East Nusa Tenggara province]. This was because the facilitators in these two villages were only in charge of one village and the facilitators were active in providing direction and pressure regarding the importance of MCH. In contrast, in rural areas in NTT [East Nusa Tenggara province] and urban areas in West Java, the small number of recipients per village caused the work area of facilitators to cover many villages. Consequently these facilitators were more preoccupied with administrative tasks and less able to focus on mentoring.
Finding24	CCT Ensure service providers understand what must be submitted to claim reimbursements
Illustration	Monitoring the compliance of PKH recipients in achieving the12 indicators of the program did not run properly. Some teachers, principles, midwives, and staff did not understand the process of completing verification forms which were sent and collected by the post office because they were never informed of the purpose of the forms or how to fill them out. To overcome this, some facilitators admitted to filling the verification forms on their own after obtaining information from schools, midwives or health clinics to fulfil the administrative requirements. However, some teachers, principals, midwives and puskesmas staff interviewed claimed that facilitators had never asked for data.

Study of Maternal Health Care Services for the Rural Poor in Bihar.

Finding1	SCP Potential beneficiaries" misinformed of scheme provisions
Illustration	The ASHAs who had been selected and trained said they had also been given a list of tasks and the incentives thereof. However, other than receiving money for training, they got occasional monetary benefit under JSY, that too after a long wait. Neither had they received the monetary incentives for attending the meetings at the beginning of every month, nor were they given the amount of Rs 100 for gather a certain number of women for immunisation as mentioned in the list of incentives. In fact, ASHAs also lamented that due to the problems regarding the receipt of money under JSY, even women who opted for institutional childbirth preferred not to inform them because they thought the ASHA"s incentives were being deducted from the cash assistance to which they were entitled. Due to this miscommunication, ASHAs were losing out on their incentives under JSY as well.
Finding2	SCP Potential beneficiaries" misinformed of scheme provisions
Illustration	Some of the other issues and views around JBSY from both the beneficiaries and the service providers are as follows: i) During interviews and FGDs, women and their family members were asked why they did not avail of the JSY scheme. They said they thought the monetary benefits were available only in the case of the birth of the first or the second child and others would not be eligible for it. They also said if the scheme had changed, the ANM had not mentioned it. So they decided not to spend money on commuting to the hospital.
Finding3	SCP Women preferred to have home delivery
Illustration	According to those living in remote and interior areas, it was difficult to bring pregnant women all the way to the PHC due to poor road conditions. They said the woman could deliver midway and they would lose the JSY incentive. Also, hiring a vehicle to take the woman would cost up to Rs 200 during daytime and even more at night. Thus, they said they preferred home births.
Finding4	SCP Prohibitive travel costs to health facilities
Illustration	According to those living in remote and interior areas, it was difficult to bring pregnant women all the way to the PHC due to poor road conditions. They said the woman could deliver midway and they would lose the JSY incentive. Also, hiring a vehicle to take the woman would cost up to Rs 200 during daytime and even more at night. Thus, they said they preferred home births.
Finding5	SCP Poor road infrastructure in remote areas
Illustration	According to those living in remote and interior areas, it was difficult to bring pregnant women all the way to the PHC due to poor road conditions. They said the woman could deliver midway and they would lose the JSY incentive. Also, hiring a vehicle to take the woman would cost up to Rs 200 during daytime and even more at night. Thus, they said they preferred home births.
Finding6	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Irregular flow of funds under JSY is creating dissatisfaction among people and problems for the medical staff. It often happens that beneficiaries do not come to the PHC for delivery as they have heard from others that there is no money available. In fact, even those who finally got money under JSY do not have a pleasant experience to share. They had to spend money and put in a lot of time and energy in getting the cash assistance.

Finding7	SCP Delayed/irregular reimbursements
Illustration	vii) Medical officers in PHCs also complained about the irregular flow of funds for JBSY. For example, according to a Medical Officer, his PHCs had no funds for the last three months and approximately 100-150 new mothers had to return empty handed, creating a sense of dissatisfaction among them. They would constantly come to demand money from the ANM and the hospital staff, causing problems.
Finding8	SCP Staff are targets for complaints and criticism of the programme
Illustration	vii) Medical officers in PHCs also complained about the irregular flow of funds for JBSY. For example, according to a Medical Officer, his PHCs had no funds for the last three months and approximately 100-150 new mothers had to return empty handed, creating a sense of dissatisfaction among them. They would constantly come to demand money from the ANM and the hospital staff, causing problems.
Finding9	SCP Health staff asked for informal payments
Illustration	Family members of women who had been allured by the money incentive of JSY, to go to a government health institution for childbirth complained that the nurse/dai who delivered the baby asked for „neg" (gift). This could be Rs 100-500 or even a sari. If they were unable to give anything, the nurses threatened they would not hand over the baby.
Finding10	SCP Health staff asked for informal payments
Illustration	The family members of women who had received monetary benefits under JSY had a different story. They said that while they had received the money after 2-3 months. Even after receiving funds, they had to give some amount of money as bribe either to the PHC staff or the service providers who helped them. According to them, this process ended up costing as much money as they received.
Finding11	SCP Relatives of influential people more likely to become paid facilitators
Illustration	A PRI member stated that since he had some authority in ASHA selection, he helped a woman, he knew get selected. But this woman did not work as there was no fixed monthly remuneration.
Finding12	SCP Scolding of women who do not provide money for a razor blade, soap, oil and thread
Illustration	The relatives of the women who had previously delivered in institutions said they had to buy a new blade, soap, oil, thread and so forth, as these were not provided by the hospital. If the relatives of the woman did not fetch the same, they were chastised by the nurses, who often told them if they wanted „royal" treatment they should go to a private hospital. Moreover, they also said they were asked to buy medicines from outside and sometimes even saline bottles for which they had to spend extra money. This caused problems because they were not prepared to spend so much money.
Finding13	SCP Clearly defined minimum package of services for women
Illustration	Service guarantees for ANC under NRHM i) Early registration of all patients ideally in the first trimester (before 12th week of pregnancy). However, even if a woman comes for registration late in her pregnancy, she should be registered and care should be given to her according to gestational age. ii) There should be a minimum of four antenatal checkups and provision of complete package

	of services. The first visit should be as soon as the pregnancy is suspected, the second between the 4th and 6th month (around 26 weeks), the third visit at the 8th month (around 32 weeks) and the fourth at the 9th month (around 36 weeks). Associated services lie providing iron and folic acid tablets (IFA), TT injections, etc. (as per the guidelines for ANC and skilled attendance at birth by ANMs and LHVs). iii) Minimum laboratory investigations such as haemoglobin, urine albumin, sugar and RPR test for syphilis should be conducted. iv) Nutrition and health counseling should be done. v) Identification of high-risk pregnancies with appropriate management. vi) Chemoprophylaxis for malaria in high malaria endemic areas as per the National Vector Born Diseases Control Program (NVBDCP) guidelines. vii) Referral of high-risk pregnancy beyond the capability of the MO of PHC to manage to FRU.
Finding14	SCP Clearly defined minimum package of services for women
Illustration	The ANC services are available at the Sub-Centre or at fixed areas where the ANM visits either on Wednesday or Saturday (as these two days are fixed as immunisation days for the districts of Nalanda and West Champaran and possibly for entire state as well). According to women who had recently gone through childbirth and their relatives and members of the community, ANC services are restricted only to immunisations (i.e. giving 2 injections of TT to the pregnant woman). Even abdominal check-ups are not conducted.
Finding15	SCP Facilitators who are not overstretched across a large area
Illustration	The ANMs also complained that since they have a very vast coverage area, it becomes ifficult for them to provider quality services. Those who have to go to remote interiors also said that since the roads are in piteous condition and it is unsafe to travel alone, they have to depend on a male member (either from the family or a hired person with a two-wheeler for the purpose) to commute to these areas. Thus, according to them, devoting quality time at the centre suffers because of the time spent in commuting. In addition, sometimes women have to return from the centre without receiving the vaccination because by the time they reach, the ANM has already left. Moreover, the ANMs said that from time to time, there are polio drives and distribution of medicines for Filaria, each of which requires their active participation which affects routine immunisation. According to the ANMs, the hideous state of Sub-Centres also affects work. They say (and it was also observed by the researcher) that Sub-Centres consist of small rooms with only a chair and a table, a thatch and leaking roof and often with no ventilation. In addition, there is hardly any place for the women to sit and for the ANM to do her paperwork.
Finding16	SCP Ensure health workers are not overburdened by additional duties
Illustration	The ANMs also complained that since they have a very vast coverage area, it becomes ifficult for them to provider quality services. Those who have to go to remote interiors also said that since the roads are in piteous condition and it is unsafe to travel alone, they have to depend on a male member (either from the family or a hired person with a two-wheeler for the purpose) to commute to these areas. Thus, according to them, devoting quality time at the centre suffers because of the time spent in commuting. In addition, sometimes women have to return from the centre without receiving the vaccination because by the time they reach, the ANM has already left. Moreover, the ANMs said that from time to time, there are polio drives and distribution of medicines for Filaria, each of which requires their active participation which affects routine immunisation. According to the ANMs, the hideous state of Sub-Centres also affects work. They say (and it was also observed by the researcher) that Sub-Centres consist of small rooms with only a chair and a table, a thatch and leaking roof and often with no ventilation. In addition, there is hardly any place for the women to sit and for the ANM to do her paperwork.
Finding17	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	The ASHAs who has been selected and trained said that they had also been given a list of tasks and the incentives thereof. However, other than receiving money for training, they got occasional monetary benefit under JSY, that too after a long wait. Neither had the received the monetary incentives for attending the meetings at the beginning of every month, nor were they given the

	amount of Rs 100 for gathering a certain number of women for immunisation as mentioned in the list of incentives. In fact, ASHAs also lamented that due to the problems regarding the receipt of money under JSY, even women who opted for institutional childbirth preferred not to inform them because they thought the ASHA"s incentives were being deducted from the cash assistance to which they were entitled. Due to this miscommunication, AHSAs were losing out on their incentives under JSY as well. ASHAs said they were working in spite of such problems because they believed that with time, they might get a fixed rmuneration. This feeling is echoed in the following lines, spoken by an ASHA: "ASHA is asha se bani hai ki agey jakar kuch milega?" (One has become an ASHA with the hope that later she will surely get something in future).
Finding18	SCP Clinical skills and capacity available
Illustration	As the hospitals were not well-equipped for the women to stay for long periods of time, the pregnant woman could be taken to the hospital only when her labour pains start. There is no provision for food and the number of beds was inadequate.
Finding19	SCP Clinical skills and capacity available
Illustration	The situation was still wanting in terms of other facilities as the PHC did not even have an instrument to record blood pressure. When the doctors were asked why they were asking the patients to get their pressure checked from outside, they either replied that the blood pressure machine had broken some weeks ago and it was not replaced (in spite of having submitted a requisition for it) or there was no blood pressure machine available in the facility. Even regarding the provision of ambulance facility, the hospital staff said that since they did not have adequate funds for the petrol, only those who could afford to pay for the fuel could avail the service.
Finding20	SCP Mechanisms to support quality improvements of service providers
Illustration	Also, there was a lack of basic services like running water. An ANM explained that since the delivery room did not have running water and the contractor was not listening to their demands, it was difficult for her to wash her hands during delivery. In fact, a senior government health official commented on the infrastructural situation: "NRHM is allotting money for improving institutional infrastructure, but here institutions are in such a dilapidated state. What about cases where the PHC has no proper building, is the money adequate to make a new building?"
Finding21	SCP Attractive service package for providers
Illustration	In terms of the staffing and availability of doctors, there was a lack of qualified doctors, according to higher government health officials. Doctors also said that the lack of housing facility within or near the PHC premises made it unsafe for them to do night duty in rural areas. Moreover, they stated that they did not get adequate incentive to do their best. They did not have a proper seating room or a separate OPD area, and as one of the senior doctors of a district hospital said: "Dal ko swadist nana eke liye ghee dalna padta hai, par sarkar to ghe dallne ko taiyar hi nahin hai" (To make the curry tasty, one needs to add butter, but the government is not ready to put butter).
Finding22	SCP Clinical skills and capacity available
Illustration	Since most PHCs and district hospitals now have to run 24x7, the doctors had to do shift duties, but as per the ANMs, it was they who stayed overnight. They also said that in case of any complications, the doctors could be contacted at their residence for help. The ANMs however complained about the dismal state of generators in the hospitals. According to the hospital staff, the generators were either not working or had been stolen.

Finding23	SCP Assess and ensure mechanism for drugs and commodities security
Illustration	In most hospitals and PHCs, it was observed that the OPD was running full swing, with a long line of patients everyday. As per the doctors, around 150-200 patients avail the services of an OPD everyday. However, there was usually a dearth of medicines as the hospital officials said that the demand greatly exceeded the supply. Moreover, they said that the procedure for replenishing medical stock was also very time-consuming and complicated, requiring the approval of the civil surgeon and in some cases, the signatures of the DM (District Magistrate). Hence, in most situations, not only the OPD patients, but even maternity patients have to procure medicines at their own cost, which led to a feeling of dissatisfaction and hostility towards the hospital officials and also the ANMs. An elderly village woman expressed this feeling as: “Sarkari mein jaante hain ki muft mein dawayi milti hai, phir bhi who log bahar ki dawayi likh deten hain, to kya fayda hua sarkari haspatal jaane se?” (We know that government hospitals should provider free medicines but when we go, they ask us to buy medicines from outside, then what is the use of going to a government hospital?)
Finding24	SCP Clinical skills and capacity available
Illustration	JSY was aimed at promoting institutional delivery through incentives. However, institutions are still ill-equipped for the purpose of handling so many maternity case at the same time (PHCs still do not have an adequate number of beds and the delivery room is barren) or of handling complications. There is minimal or almost no-existent postnatal care services in the hospital and the women are discharged shortly after child birth mostly due to lack of beds.
Finding25	SCP Social divisions and social distance can impede work of local facilitators
Illustration	When asked whether people listened to them, ASHAs claimed it was difficult because before being selected as ASHAs, they had been confined to their homes. Sometimes, the villages (especially the higher caste people or the elders of the village) chastised them saying that by crossing the threshold of their homes and doing this kind of work, they have brought shame upon the family. Therefore, they called only those women who were ready to listen to them.
Finding26	SCP Social divisions and social distance can impede work of local facilitators
Illustration	There is often a latent enmity between the villagers and AHSAs, as they think that she has grabbed a „sarkari" (government) post by bribing the PRI member of the village and she does not do any work.

Role of JSY in Institutional Delivery. A Study in Churachandpur District, Manipur.

Finding1	SCP Care at facilities thought to be of poor quality and unreliable
Illustration	Majority of the women felt that high costs incurred in availing services from public facilities, including transport and improper implementation of the JSY programme are the two main reasons for not accessing government institutions. Poor quality of care at government institutions is yet another cause cited by women for preferring home delivery.
Finding2	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Majority of the women felt that high costs incurred in availing services from public facilities, including transport and improper implementation of the JSY programme are the two main reasons for not accessing government institutions. Poor quality of care at government institutions is yet another

	cause cited by women for preferring home delivery.
Finding3	SCP Women preferred to have home delivery
Illustration	Case 1: I preferred home delivery because, I have my mother, sisters to serve me hot water, make the place warm and comfortable. In hospitals, we get bad words from nurses.
Finding4	SCP Disrespectful and abusive care from health care staff
Illustration	Case 1: I preferred home delivery because, I have my mother, sisters to serve me hot water, make the place warm and comfortable. In hospitals, we get bad words from nurses
Finding5	SCP Cash assistance not sufficient to meet expenses
Illustration	Case 2: I preferred home delivery because hospital delivery is costly and expensive. The doctors and nurses have their own pharmacy adjacent to the hospital and prescribe a lot of medicines to purchase.
Finding6	SCP Poor road infrastructure in remote areas
Illustration	Case 4: I wanted to deliver at hospital but for that I have to travel/walk miles on foot crossing riverlets, hill terrains. I am afraid of leeches. Arranging transport would have been very expensive. So I delivered at home
Finding7	SCP Lack of available transport to facility
Illustration	Case 5: We are poor, though we want to deliver at institution/hospital we are from far-flung villages and have no money and alternative means to travel. On the other hand, we learned that no compensation has been paid to other who earlier delivered at District Hospitals/ Institutions as told by our ASHAs.
Finding8	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Case 5: We are poor, though we want to deliver at institution/hospital we are from far-flung villages and have no money and alternative means to travel. On the other hand, we learned that no compensation has been paid to other who earlier delivered at District Hospitals/ Institutions as told by our ASHAs.
Finding9	SCP Poor road infrastructure in remote areas
Illustration	The study reveals that though Saikawt block had better road connectivity, it did not result in better implementation of the JSY programme in particular or MCH service delivery by the government in general. Serious gaps especially with regard to fund disbursement under the scheme, restricted most of the families from availing the public facilities for delivery. Moreover, lack of public transport and bad road connectivity added to problems in accessing services from the government facilities.

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Finding11	SCP Staff are targets for complaints and criticism of the programme
Illustration	Views of Healthcare Providers The study revealed that the post of ASHA was not a source of prestige in the village, largely because of the failure of the JSY programme to deliver on its promises. Most ASHAs interviewed expressed with shame that, “We registered, counselled and made awareness of the JSY scheme to all village mothers during the village meetings (especially to pregnant women) but when women are denied their JSY money it"s shameful for us.” ASHAs during the FGD reported that “Ever since our appointment and training we have been faithfully discharging our assigned duties but in spite of that we are being betrayed by the authority concerned by not paying incentives and compensation to mothers” “Mothers think that we are cheating them. We are ashamed and reluctant to mention about JSY benefits to our women now.”
Finding12	SCP Clearly defined roles and training for community workers / volunteers
Illustration	All ASHAs said that they had undergone training. Eight of them had undergone training for more than three times, two of them two times and the rest one time. Yet the study finds that the ASHAs were not clear about their roles. Most of the ASHAs were not satisfied with their trainings. They said that they couldn"t understand what they were taught because the trainers were Manipuris while they spoke a tribal dialect. Hence they did not understand that language. One of them expressed that, “We did not understand what they taught us in the training because of the language. It would be good if we were trained by our PHC staffs.” It was also found that the trainings were organized by the Malaria Department and not by the concerned Health Department.
Finding13	SCP Fill vacancies for community facilitators and service providers
Illustration	The doctors also spoke about the lack of human resource, especially about many vacant posts of ANMs at Henglep block, hampering proper outreach services.

Economic Evaluation of Demand-Side Financing (DSF) for Maternal Health in Bangladesh

Finding1	VMS Community dissemination of information about scheme was felt to be an effective option
Illustration	'Most key informants felt that this system for informing the community about the voucher program was effective. The involvement of local government officials and religious leaders through community meetings was highlighted as particularly useful, as were door-to-door visits by field health workers: „Paying door-to-door visits by field workers to inform the community about voucher program is especially effective. This has resulted in an increasing trend of hospital-based delivery." - FWA/HA. „The courtyard meetings in the community with the mothers which are facilitated by the local government representatives. In the meetings, pregnant mothers and their guardians are informed and motivated about safe delivery. The difference between the delivery at home and the institutional delivery is explained in the meeting." - DSF Coordinator'
Finding2	VMS Community dissemination of information about scheme was felt to be an effective option

Illustration	'A smaller group of key informants from across upazilas and respondent types felt that better communication efforts were needed. Some suggested increased use of media (posters, leaflets, videos, theater sketches); a few felt that field workers lacked motivation and training; and a few mentioned the need for greater involvement by community leaders. I suggest publicizing the benefits of the DSF program in the girl"s schools, village markets through People"s Theater, organizing refresher trainings for DSF committee members, and DSFrelated training for youths and religious leaders." - DSF Coordinator'
Finding3	VMS Potential beneficiaries lack of knowledge of scheme provisions
Illustration	'A smaller group of key informants from across upazilas and respondent types felt that better communication efforts were needed. A few felt that field workers lacked motivation and training; and a few mentioned the need for greater involvement by community leaders'
Finding4	VMS Corruption
Illustration	'About three-fifths of providers we interviewed believed that eligible women were receiving vouchers. But some providers felt that eligible women were being missed, mainly because the selection process was not implemented properly and because relatives of influential people were more likely to be selected. A few providers noted that some women are not properly informed of eligibility criteria. „The selection of DSF women is not properly done. Cards are distributed among the relatives of influential persons. Monitoring is not properly done. The FWAs and CSBAs do not inform properly the poor women of the area about their eligibility to receive the voucher." - FWV. In three of the four universal voucher upazilas, focus group discussants felt that both poor and nonpoor women were receiving vouchers. In one universal intervention upazila, respondents felt that richer women were more likely to receive vouchers. Comments such as „Those who have acquaintances and relatives in the hospital are getting cards" and „Those who have power are getting cards" were expressed. Respondents in most of the means-tested upazilas generally felt that the poor were receiving vouchers, although some noted that wealthier women were receiving vouchers in some cases.'
Finding5	VMS Disrespectful and abusive care from health care staff
Illustration	'In contrast, respondents in four upazilas noted substantial problems accessing services and in the remaining group responses were mixed. The main complaints were crowding, long wait times, and rude treatment by health care providers. „They did not check- up properly.We have to wait for a long time. If we want to know the reason for waiting then they behave roughly." We do not receive service from hospital even after getting cards; they scold us and make us get out from the hospital if we do not take cards with us. "It is of no use even if we take the cards with us. The doctors and nurses talk in abusive language. Even they say what kind of trouble the Government has created „ [respondents in universal upazila] „The problem is that we have to wait to receive treatment because the number of patient is high." [respondent in means-tested upazila] „When their acquaintances come they keep us waiting without providing check up services. They give priority to their known person to provide check up services." [respondent in meanstested upazila'
Finding6	VMS Having to wait a long time at health facilities
Illustration	'In contrast, respondents in four upazilas noted substantial problems accessing services and in the remaining group responses were mixed. The main complaints were crowding, long wait times, and rude treatment by health care providers. „They did not check- up properly. We have to wait for a long time. If we want to know the reason for waiting then they behave roughly." We do not receive service from hospital even after getting cards; they scold us and make us get out from the hospital if we do not take cards with us."It is of no use even if we take the cards with us. The doctors and nurses talk in abusive language. Even they say what kind of trouble the Government has created" - [respondents in universal upazila] „The problem is that we have to wait to receive treatment because the number of patient is high. „ [respondent in means-tested upazila]'

Finding7	VMS Potential beneficiaries lack of knowledge of scheme provisions
Illustration	'In two of these upazilas, respondents also reported that they did not know what services were provided under the voucher program: „We do not know what services are provided. Doctors do not tell us. „ [respondent in meanstested upazila] „We do not know what services we can get after receiving cards. „ [respondent in universal upazila]'
Finding8	VMS Poor road infrastructure in remote areas
Illustration	'In three upazilas, there was some indication that vouchers were somewhat more likely to be used for ANC services than delivery or postpartum services. In one means-tested upazila, for instance, respondents noted that voucher holders tend to seek the first ANC visit but not other covered services because the road to the hospital is very bad and health workers do not come to the subcenters regularly'
Finding9	VMS Difficulty enforcing selection criteria
Illustration	'The main challenge in distributing vouchers mentioned by providers was handling pressure from ineligible recipients. This type of pressure was experienced especially by FWAs, CSBAs, and FWVs in all the sampled upazilas; one provider even noted that she had been threatened by an ineligible recipient. In two upazilas, a small number of providers mentioned that they had been pressured by local government officials to distribute vouchers to ineligible women. In contrast, one nurse reported that local government representatives were blocking the distribution of vouchers to eligible poor women. „The poor people who have more than two children Beneficiary receipt of transport stipends and cash incentives create pressure to get the voucher. „ -FWA „Sometimes, even mothers of three children insist on [getting] the voucher. People who are not permanent residents also try to get the voucher card. Sometimes the influential people in society pressure us to get the voucher card. „ - FWA „the interference of the local [parishad] chairman does not allow us to give the card to all deserving beneficiaries. „ - Senior staff nurse'
Finding10	VMS Local government interference in selection of beneficiaries
Illustration	'The main challenge in distributing vouchers mentioned by providers was handling pressure from ineligible recipients. This type of pressure was experienced especially by FWAs, CSBAs, and FWVs in all the sampled upazilas; one provider even noted that she had been threatened by an ineligible recipient. In two upazilas, a small number of providers mentioned that they had been pressured by local government officials to distribute vouchers to ineligible women. In contrast, one nurse reported that local government representatives were blocking the distribution of vouchers to eligible poor women. „The poor people who have more than two children Beneficiary receipt of transport stipends and cash incentives create pressure to get the voucher. „ -FWA „Sometimes, even mothers of three children insist on [getting] the voucher. People who are not permanent residents also try to get the voucher card. Sometimes the influential people in society pressure us to get the voucher card. „ - FWA „the interference of the local [parishad] chairman does not allow us to give the card to all deserving beneficiaries. „ - Senior staff nurse'
Finding11	VMS Increased workload
Illustration	'Almost all providers interviewed stated that their workload had increased because of the voucher program. The nature of the increase was described as „double workload„ (1 respondent), „increased number of deliveries„ (4), „increased check-ups„ (5), and „increased paperwork„ (6). The most common suggestion to improve the situation was simply to hire more health workers and increase the efficiency of existing workers. Another suggestion was to increase DSF program participation by NGO providers: „Our work load is too much compared to before. This problem can be solved by providing manpower from the NGOs to assist our work„ - CSBA More vaginal deliveries are taking place in our health complex since the voucher program started. As a result we have to follow up different problems of the newborns also. We cannot give enough time to the inpatient and outpatient

	departments as we are to concentrate on the voucher program. More efficient workforce should be appointed.„ - Medical Officer
Finding12	VMS Shortages of medical supplies
Illustration	'Most providers noted that shortages of medicines, supplies and equipment hindered their ability to provide services to voucher recipients. When asked how they coped with these shortages, the most common response was that they encouraged patients to purchase prescribed medicines from an outside source. These purchases, of course, would not be subsidized by the DSF program. A gynecologist and a nurse in one upazila mentioned that they were using the „seed fund„ to fund the purchase of new supplies. Others noted that they tried to make do with old equipment, and sometimes referred patients to other clinics that had the necessary inputs. „We do our work with the old equipment „and the problem of the medicines is also solved from the „seed fund„ – Senior staff nurse „We ask the attendants of the pregnant mothers to buy medicines and other equipment from outside, or we have to procure them in advance on our own.„ - CSBA „We cannot provide proper services due to shortages of medicines and instruments. In such situations we refer patients to the UHC.„ - FWV'
Finding13	VMS Asking patients to buy medicines elsewhere
Illustration	'Most providers noted that shortages of medicines, supplies and equipment hindered their ability to provide services to voucher recipients. When asked how they coped with these shortages, the most common response was that they encouraged patients to purchase prescribed medicines from an outside source. These purchases, of course, would not be subsidized by the DSF program. A gynecologist and a nurse in one upazila mentioned that they were using the „seed fund „to fund the purchase of new supplies. Others noted that they tried to make do with old equipment, and sometimes referred patients to other clinics that had the necessary inputs. „We do our work with the old equipment „and the problem of the medicines is also solved from the „seed fund„ - Senior staff nurse „We ask the attendants of the pregnant mothers to buy medicines and other equipment from outside, or we have to procure them in advance on our own.„ - CSBA We cannot provide proper services due to shortages of medicines and instruments. In such situations we refer patients to the UHC.„ - FWV'
Finding14	VMS Participating to help the poor
Illustration	'About three-quarters of the providers we interviewed said they enjoy working with the voucher program. Some of the reasons they shared were that poor patients were now receiving services; that child and maternal mortality had decreased; that family planning activities had increased; and that the reputation of the UHC had benefited. „Though we are doing hard work, we are satisfied that the poor patients are receiving services. „ - Senior staff nurse „Though the amount is small, we get some money for conducting normal delivery, cesarean delivery, providing PNC services, which is extra income. „ - Gynae consultant „Due to this DSF program, the number of patients at our health center has comparatively increased. Mothers are getting money and for this poverty is decreasing to some extent.„ - FWV'
Finding15	VMS Seeking increased revenue
Illustration	About three-quarters of the providers we interviewed said they enjoy working with the voucher program. Some of the reasons they shared were that poor patients were now receiving services; that child and maternal mortality had decreased; that family planning activities had increased; and that the reputation of the UHC had benefited. „Though we are doing hard work, we are satisfied that the poor patients are receiving services. „ - Senior staff nurse „Though the amount is small, we get some money for conducting normal delivery, cesarean delivery, providing PNC services, which is extra income. „ Gynae consultant „Due to this DSF program, the number of patients at our health center has comparatively increased. Mothers are getting money and for this poverty is decreasing to some extent.„ – FWV

Finding16	VMS Lack of accountability and support from the programme
Illustration	'The majority of dissatisfied providers felt they were not being adequately compensated, given the amount of work. A few individuals mentioned that they did not enjoy receiving criticism and pressure from ineligible women and local politicians. A lack of accountability and a lack of logistical support were also mentioned. „The incentive is not compatible to the labor given. There is a need to increase the incentive „ Senior staff nurse „Sometimes we are subject to criticism by those who are not given voucher as they are not eligible. They think we are not giving them intentionally.„ – FWA. When asked specifically whether they were satisfied with the incentives they received, only one-third of providers said yes.'
Finding17	VMS Reimbursements too small
Illustration	'The majority of dissatisfied providers felt they were not being adequately compensated, given the amount of work. A few individuals mentioned that they did not enjoy receiving criticism and pressure from ineligible women and local politicians. A lack of accountability and a lack of logistical support were also mentioned. „The incentive is not compatible to the labor given. There is a need to increase the incentive.„ - Senior staff nurse „Sometimes we are subject to criticism by those who are not given voucher as they are not eligible. They think we are not giving them intentionally. „ - FWA When asked specifically whether they were satisfied with the incentives they received, only one-third of providers said yes.'
Finding18	VMS Exclusion of very poor by overly restrictive means testing criteria
Illustration	'In „universal„ intervention upazilas, all pregnant women on their first or second pregnancy who are permanent residents of the upazila are eligible for the DSF program. Women on their second pregnancy must have used contraception in between pregnancies. In means-tested upazilas, eligibility is further limited to extremely poor women only: those whose family income is not more than Tk. 2,500 per month, who own less than 0.15 acres of land, and who do not receive income from a cow, poultry, fisheries, orchards, rickshaw, or van. Key informants in the 8 sampled intervention upazilas (which included 4 means-tested and 4 universal upazilas) were asked whether they felt these eligibility criteria were reasonable. Almost all respondents from the universal areas felt that the criteria were appropriate. Among respondents from means-tested areas, about one-third supported the criteria while two-thirds found them to be unreasonable. The main criticisms were that the land ownership and income criteria were too strict. Representative quotes included: „The land ownership criterion of 0.15 [acres] should be raised to 0.30, because people from the lowest economic quintile have more land. „ - Civil Surgeon. „Those who are considered to be ultra poor in the present context need more than Tk. 2,500 to survive, eating even only rice and pulses. „these ultra poor people are excluded from the program. That is why it is better to change it and raise the [income threshold] to Tk. 4000. „ – „other respondent'
Finding19	VMS Relatives of influential people more likely to receive vouchers
Illustration	'About three-fifths of providers we interviewed believed that eligible women were receiving vouchers. But some providers felt that eligible women were being missed, mainly because the selection process was not implemented properly and because relatives of influential people were more likely to be selected.„ - The selection of DSF women is not properly done. Cards are distributed among the relatives of influential persons. Monitoring is not properly done. The FWAs and CSBAs do not inform properly the poor women of the area about their eligibility to receive the voucher.„ - FWV. In three of the four universal voucher upazilas, focus group discussants felt that both poor and nonpoor women were receiving vouchers. In one universal intervention upazila, respondents felt that richer women were more likely to receive vouchers. Comments such as „Those who have acquaintances and relatives in the hospital are getting cards „ and „Those who have power are getting cards„ were expressed.'
Finding20	VMS Relatives of influential people more likely to receive vouchers

Illustration	'In two upazilas, a small number of providers mentioned that they had been pressured by local government officials to distribute vouchers to ineligible women. „Sometimes, even mothers of three children insist on [getting] the voucher. People who are not permanent residents also try to get the voucher card. Sometimes the influential people in society pressure us to get the voucher card. „ - FWA'
Finding21	VMS Scheme eligibility confined to women who have used contraception for birth spacing
Illustration	'Several responses mentioned that the 2-child maximum for voucher eligibility has also discouraged women from having larger families. „As they are adopting family planning between 1st and 2nd child they are getting voucher card. Some of them are doing ligation during caesarean.„ - FWV „During the implementation of the DSF program, it is also said that the mothers who have more than 2 children will not receive the benefits of the DSF; they are discouraged. Thus the family planning program is benefited. „ „ DSF Coordinator'
Finding22	VMS Family members more supportive of women „s health care seeking
Illustration	'Interestingly, there was universal agreement „ across all respondents in all ten upazilas „ regarding the positive impact the voucher program has had on the attitudes of husbands and in-laws towards seeking care for pregnant women. Without exception, women indicated that their husbands and mothers-in-law were more likely to support careseeking for antenatal, delivery and postnatal care from health facilities. „My mother-in-law took me to the hospital. „ [respondent in universal upazila] „After the voucher program, the mindset of the in- laws or husband has changed. They think if free treatment can be obtained without spending money, then they do not have any problem to send us to the hospital. „ [respondent in means-tested upazila] „Fathers in law, mothers in law and husbands do not resist. „ [respondent in means-tested upazila]'
Finding23	VMS Mechanisms to support quality improvements of service providers
Illustration	'Continued investment in EOC upgrades is recommended. Greater efforts should be made to encourage facilities to use the seed fund for quality improvements, as well as to procure drugs, supplies, labor beds, and equipment.'
Finding24	VMS Define critical skill sets for the voucher management agency based on key functions
Illustration	'More broadly, we recommend that the currently small DSF program office be expanded to serve as a full-fledged Voucher Management Agency. Several full-time technical staff will be needed to ensure smooth operations, track finances, monitor adherence to policy and program results, and report to the MOHFW. A Deputy Program Manager from DGHS can chair the DSF voucher management unit; however a full-time manager should be responsible for overseeing all activities. The role of the voucher management unit may be outsourced as it is in done in some other countries, but this should be carefully considered in the Bangladeshi context.'
Finding25	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Key informants from all 8 upazilas reported difficulties with the provision of cash and in-kind benefits to beneficiaries. The problems were particularly concentrated in two upazilas. The most common difficulties mentioned were long delays in receiving cash advances from the government, resulting in long delays in paying beneficiaries; and lack of sufficient administrative staff to distribute cash benefits, resulting in long lines at health facilities on distribution days. „Because of the lack of fund the beneficiaries cannot be reimbursed in a timely manner and a lot of questions have to be faced from them. The providers also lose interest in the work because of the delay getting the incentives. „ „ NGO/private sector member'

Finding26	VMS Physical improvements at facilities to cope with increased demand
Illustration	'One widespread concern about interventions that stimulate demand for health services is that health facilities and health care providers will not be able to handle the influx of new patients. Simultaneously expanding supply-side capacity is an ongoing challenge for the Bangladesh DSF program, given the success it has had in increasing service utilization. Almost all of the upazila-level key informants interviewed expressed concerns about human resource shortages at health facilities, including shortages of clinical staff, shortages of administrative and support staff (cleaners, accountants, office administrators), and a lack of sufficient training for clinicians. They mentioned long lines among consumers seeking services and difficulties among staff in managing their workload: „The beneficiaries have to wait for a long time to receive ANC/PNC due to shortage of providers. „For providers, due to shortage of providers they have to spend more time on DSF voucher program. As a consequence they face problems in performing their day to day regular activities. „ „FWA „We tell many pregnant women to come to the hospital in order to receive ANC-2 and ANC-3 services and sometimes it happens that many comes on the same date which results in a big crowd. Due to the shortage of sufficient manpower it takes a long time to provide the service. Staffs and doctors become very busy due to excessive patient load which results in delays in providing services. „ „NGO/private sector member „If there is a crowd of ANC or PNC care seekers in the UHFWC and UHC, then the doctors, nurses, FWAs, and cleaners become really busy and it takes a long time to provide services. The number of skilled workers should be adequate. „ „FWV A national-level key informant echoed these concerns, highlighting problems with the quality of services: „Our service quality is not that good. In private hospitals there is a shortage of qualified doctors and equipment. In Government hospitals there is a shortage of equipment. In some places there is not a single trolley available. Shortage of human resources is a big problem. „Service providers expressed similar concerns, with three out of four providers noting that human resource shortages limit smooth functioning of the DSF program. The shortages reportedly impact not only the direct provision of services to women, but affect the ability of the UHFPO and MO to manage DSF financial accounts and make payments to providers and beneficiaries in a timely manner. Some field workers noted that they were having difficulties registering beneficiaries and disseminating information about the voucher program. A few providers commented that there is a problem filling key vacant positions, specifically mentioning trained CSBAs and skilled accounting staff.'
Finding27	VMS Mechanisms to support quality improvements of service providers
Illustration	'One widespread concern about interventions that stimulate demand for health services is that health facilities and health care providers will not be able to handle the influx of new patients. Simultaneously expanding supply-side capacity is an ongoing challenge for the Bangladesh DSF program, given the success it has had in increasing service utilization. Almost all of the upazila-level key informants interviewed expressed concerns about human resource shortages at health facilities, including shortages of clinical staff, shortages of administrative and support staff (cleaners, accountants, office administrators), and a lack of sufficient training for clinicians. They mentioned long lines among consumers seeking services and difficulties among staff in managing their workload: „The beneficiaries have to wait for a long time to receive ANC/PNC due to shortage of providers. „For providers, due to shortage of providers they have to spend more time on DSF voucher program. As a consequence they face problems in performing their day to day regular activities. „ „FWA „We tell many pregnant women to come to the hospital in order to receive ANC-2 and ANC-3 services and sometimes it happens that many comes on the same date which results in a big crowd. Due to the shortage of sufficient manpower it takes a long time to provide the service. Staffs and doctors become very busy due to excessive patient load which results in delays in providing services. „ „NGO/private sector member „If there is a crowd of ANC or PNC care seekers in the UHFWC and UHC, then the doctors, nurses, FWAs, and cleaners become really busy and it takes a long time to provide services. The number of skilled workers should be adequate. „ „FWV A national-level key informant echoed these concerns, highlighting problems with the quality of services: „Our service quality is not that good. In private hospitals there is a shortage of qualified doctors and equipment. In Government hospitals there is a shortage of equipment. In some places there is not a single trolley available. Shortage of human resources is a big problem. „Service providers expressed similar concerns, with three out of four providers noting that human resource shortages limit smooth functioning of the DSF program. The shortages reportedly impact not only the direct provision of services to women, but affect the ability of the UHFPO and MO to manage DSF financial accounts and make payments to providers and beneficiaries in a timely manner. Some field workers noted that they were having difficulties registering beneficiaries and disseminating information about the voucher program. A few providers commented that there is a problem filling key vacant positions, specifically mentioning trained

	CSBAs and skilled accounting staff.'
Finding28	VMS Integration of reporting for DSF scheme into the health information system
Illustration	'There is limited capacity for monitoring DSF pilot program activities. To the extent that it is done, monitoring is primarily conducted by the WHO- and DFID-sponsored upazila-level DSF Coordinators, who have administrative responsibilities for the program. They collect voucher distribution and service utilization statistics, primarily for reporting to the National DSF Office. The information they collect is not integrated with the regular facility Management Information Systems (MIS). Upazila DSF Coordinators submit monthly reports to the National DSF Coordinator, who cross-checks reports during his field visits and monitors progress compared to targets. Currently there is no prescribed format for monitoring reports or any structured checklist for monitoring. Two central-level key informants noted that some monitoring is also done by the civil surgeons, UHFPOs, and upazila officers within the upazila DSF committees, but it was generally felt that the monitoring system was not effective. The central-level key informants suggested that the number of monitoring and evaluation staff be increased, and that the MOHFW (especially at the district and upazila levels) take on more monitoring responsibilities. One respondent suggested that CSBAs should be more involved in monitoring. Other suggestions included establishing a separate monitoring group, appointing a Deputy Program Manager (DPM) from the Directorate General of Health Services to be responsible for routine supervision and monitoring, establishing a systematic monitoring system, and strengthening MIS overall (including developing monitoring software, charts and checklists). When asked whether they thought the current system of monitoring the voucher program was efficient, about one-third of upazila-level key informants felt that it was not. These respondents were distributed across all 8 sampled upazilas. The most common suggestion for improving the monitoring system was to designate (and pay a salary to) a person specifically responsible for monitoring in each union or upazila. Another common suggestion was to provide some type of incentives for monitoring, though it was unclear exactly to whom these incentives should be paid. A third idea was to increase oversight at the field level by having more supervisors in the field. „Each union should have a monitor. If one monitor along with one or two Union DSF Committee members jointly does the monitoring, the monitoring situation can be improved. „ -Union parishad chairman „Separate manpower should be appointed for the monitoring at the central level. „ „ RMO, Upazila DSF committee Central-level stakeholders also expressed concern that little effective supervision is occurring at the field level, with only the WHO- and DFID-sponsored DSF Coordinators making field visits for supervision. Specifically, it was felt that supervision of the voucher distribution process needed to be improved, since the criteria for distributing vouchers were not being followed in some areas. However, almost all providers interviewed reported that their DSF activities were routinely supervised, usually by staff at the UHC. Most reported that supervision occurred monthly. Interestingly, in one upazila, 5 of the 6 providers interviewed stated that they were not subject to any monitoring.'
Finding29	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'As reported in the 2008 rapid assessment, there are still significant problems with delays in disbursement of central funds for the DSF program „ funds for the cash incentives to be paid to women and for reimbursements and incentives to providers. More than half of all key informants (from all 8 sampled upazilas and representing all types of respondents) and several central-level key informants complained about these delays, noting that they diminish the impact of the voucher program on maternal health behaviors and reduce the willingness of providers to participate in the program. Facilities were forced to delay paying incentives to women until the funds were received. „The main problem is the late arrival of funds. The purpose for which financial benefits are given to mothers after delivery is thwarted because of delays in disbursement of money.„ „NGO/private sector member „Because of the lack of funds the beneficiaries cannot be reimbursed timely and lot of questions have to be faced from them. The providers also lose interest in work because of the delay getting the incentives „ „NGO/private sector member „It takes 3 months to get the advance money. This mechanism should be simpler.„ „ central level key informant „As there are delays in the accounting of the money from one fiscal year, so there are also delays in the disbursement of the money for the next fiscal year.„ „central-level key informant. Central-level informants reported ongoing problems withdrawing money from the advance fund, including requirements for multiple layers of approval within the government and World Bank bureaucracies that slow disbursements: „It is difficult to draw money from the advance fund. We have to convince the AG [Accountant General]. It is then sent to the Finance Ministry with the signature of the Health Secretary which takes time. This problem occurs as there is no full-time DPM [Deputy Program Manager within the DGHS]. „We cannot ensure that money will be on time

	because of the system. We send a prayer for the advance, then it goes to the AG. From there it goes to the [Finance] Ministry. The cycle is too long. We want a simpler way. There have been so many discussions about this matter, but we have not gotten any results.„ „The pooled fund mechanism is a very complicated method for disbursing funds. After releasing the first instalment of funds from the Ministry, we have to meet the accounting formalities of the Line Director‚s office and the AG ‚s office before asking for the second instalment of funds. Then we send it to the World Bank, if they are satisfied with it then they will provide the same amount of money. „'
Finding30	VMS Mechanisms to support quality improvements of service providers
Illustration	'The „seed fund„ accounts were generally perceived to be useful and appropriately used. These accounts are to be used for reimbursing public providers, paying FWAs and HAs for each woman registered in the voucher program, paying facility staff for daily DSF work, procuring drugs and supplies, and covering emergency referral transport costs. „The money of the seed fund is spent in procurement of medicines for the pregnant mothers, stationery, fuel, gift vouchers worth Tk. 500, and registration fees for the fieldworkers. Through the approval of the upazila committee, the seed fund is also used for procuring other relevant necessary things. „ „DSF Coordinator Complaints were made, both at the upazila level and central level, about the fact that unused seed fund money had to be returned to the government at the end of the year. „They even take away the seed fund money at the end of the year. If they would not take the seed fund money or could provide us an advance, then we would be able to pay the money [to women] early. „ „UHFPO „At the end of one financial year if any money left we can not keep it for the next financial year. We have to send it back. „ „Central-level key informant'
Finding31	VMS Good communication between different levels of administration
Illustration	'About two-thirds of the key informants interviewed in this evaluation felt that this current organizational structure of the DSF program was effective, while one-third (distributed across all 8 upazilas) felt that it was somewhat or not effective. Some reasons for the perceived lack of effectiveness included shortages of human resources to manage the program and a need for increased monitoring. Upazila-level respondents did not provide much in-depth information on organizational challenges. Key informants were also asked how the committees at different levels were coordinated. This question was also difficult for respondents to answer. In general, responses indicated that the Upazila DSF committee serves as the coordination center, liaising with both the District-and Union-level bodies. Several respondents indicated that coordination occurs through regular meetings, phone calls, and letters. Central-level key informants felt that the organizational structure of the DSF program was only somewhat effective. One mentioned that the National DSF Program Implementation committee and the Technical Subcommittee do not meet regularly but only on an as-needed basis. Another noted that the District Designation Bodies also do not meet regularly and are not functional. A third respondent felt that local government representatives do not willingly attend DSF committee meetings. More generally, respondents noted that the lack of separate, designated staff to manage and implement the DSF program is a problem, given existing human resource shortages within the Bangladesh health system. It was suggested that someone be appointed specifically for monitoring program activities at the district and upazila levels.'
Finding32	VMS Administrative skills and capacity available
Illustration	'About two-thirds of the key informants interviewed in this evaluation felt that this current organizational structure of the DSF program was effective, while one-third (distributed across all 8 upazilas) felt that it was somewhat or not effective. Some reasons for the perceived lack of effectiveness included shortages of human resources to manage the program and a need for increased monitoring. Upazila-level respondents did not provide much in-depth information on organizational challenges. Key informants were also asked how the committees at different levels were coordinated. This question was also difficult for respondents to answer. In general, responses indicated that the Upazila DSF committee serves as the coordination center, liaising with both the District-and Union-level bodies. Several respondents indicated that coordination occurs through regular meetings, phone calls, and letters. Central-level key informants felt that the organizational structure of the DSF program was only somewhat effective. One mentioned that the National DSF Program Implementation committee and the Technical Subcommittee do not meet regularly but only on an as-needed basis. Another noted that the District Designation Bodies also do not meet regularly and are not functional. A third respondent felt that local government representatives do not

	willingly attend DSF committee meetings. More generally, respondents noted that the lack of separate, designated staff to manage and implement the DSF program is a problem, given existing human resource shortages within the Bangladesh health system. It was suggested that someone be appointed specifically for monitoring program activities at the district and upazila levels.'
Finding33	VMS Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	'We asked key informants and providers to what extent local government representatives were involved in DSF program activities. Most felt that local government officials were highly or moderately involved, while a smaller number felt that they had limited involvement (generally concentrated in one universal upazila). Their main role in means-tested upazilas was reportedly certifying the poverty status and residential eligibility of pregnant women. Some noted that they generally play a role in publicizing and promoting the DSF program locally and in recruiting eligible women. „[Local government representatives] are 100% involved. They oversee whether the eligible poor women are getting the benefits of the voucher program at the time of registration and whether the eligible poor women are selected or not. „ „DSF Coordinator „The representatives of the Local Government are involved with the voucher program. They are the chairmen of the [upazila] DSF committee or union committee. They verify the cards which are distributed at village level. They also inform the people about the vouchers. „ „UHFPO, „They are involved to some extent. They only attend the monthly meeting otherwise they do not play any role. „ „FWA/HA'
Finding34	VMS Use of local administrative and leadership structures
Illustration	'We asked key informants and providers to what extent local government representatives were involved in DSF program activities. Most felt that local government officials were highly or moderately involved, while a smaller number felt that they had limited involvement (generally concentrated in one universal upazila). Their main role in means-tested upazilas was reportedly certifying the poverty status and residential eligibility of pregnant women. Some noted that they generally play a role in publicizing and promoting the DSF program locally and in recruiting eligible women. „[Local government representatives] are 100% involved. They oversee whether the eligible poor women are getting the benefits of the voucher program at the time of registration and whether the eligible poor women are selected or not. „ „DSF Coordinator „The representatives of the Local Government are involved with the voucher program. They are the chairmen of the [upazila] DSF committee or union committee. They verify the cards which are distributed at village level. They also inform the people about the vouchers. „ „UHFPO, „They are involved to some extent. They only attend the monthly meeting otherwise they do not play any role. „ „FWA/HA'
Finding35	VMS Consider effect on other health programmes
Illustration	'We asked key informants at the upazila and central level whether they thought that voucher program responsibilities might negatively impact the routine family planning and health outreach activities of FWAs and HAs. This concern had been raised in the 2008 rapid assessment report. Almost all respondents felt that FWAs „ and HAs „ regular activities were not affected; a small number felt that FWA/HA services to beneficiaries had actually been improved by the DSF program: „As the FWAs and HAs are involved with the DSF activities, their work load has increased, but their regular activities are not hampered. The HAs and FWAs do the DSF activities „during their door-to-door visits for disseminating information on immunization and family planning. „ „DSF Coordinator'

No tall of the anguish: accountability in maternal health care in India

Finding1	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	Many activists, women from rural areas, and ASHAs in Uttar Pradesh consistently complained to Human Rights Watch that staff in government health facilities demand money for supposedly free services under the NRHM, including out-patient and in-patient care, and drugs.

Finding2	SCP Prohibitive costs of treatment of complications not covered by scheme
Illustration	Even where there are blood transfusion facilities, it appears that affordability is a significant barrier to access. Human Rights Watch spoke with one pregnant woman who was receiving a blood transfusion at a district hospital in Uttar Pradesh, and found that she was not able to afford the six units of blood that she needed. Each bottle of blood cost her family 900 rupees (US$18).
Finding3	SCP No organised onward referral system for complicated emergencies
Illustration	Poor referral systems leave women running from pillar to post even during emergencies. Of the nine deceased pregnant women"s families that Human Rights Watch spoke to, five recounted serious obstacles in even reaching a health facility and being referred from one to another without any support. For women who develop complications during pregnancy and childbirth and in need of life-saving interventions, time is crucial.
Finding4	SCP Lack of available transport to facility
Illustration	Pregnant women use bicycles, motorcycles, theliyas (handcarts) auto-rickshaws (motorcycle taxis), tractors, and jeeps to reach health facilities. Often, families living in interior areas are unable to afford tractors or jeeps or find it difficult to organize such transport from their villages. In such cases the women deliver at home without any referral support.
Finding5	SCP Lack of the required documentation to prove eligibility
Illustration	SCP Explaining how she finds it hard to help poor women, one ASHA said, “The people who are really poor don"t have these things [BPL cards] and many others who are better off have BPL cards. So that is a big problem.”
Finding6	SCP Disrespectful and abusive care from health care staff
Illustration	One activist who unsuccessfully intervened when a staff nurse at a CHC demanded money said, One man I know had taken his wife for delivery to the CHC. He had sold 10 kilos of wheat that he had bought to get money to bring his wife for delivery. He had some 200-300 rupees [US$4-6]. Now in the CHC they asked him for a minimum of 500 rupees [US$10]. Another 50 [rupees] to cut the cord and 50 [rupees] for the sweeper. So he started begging and saying he did not have more money and that they should help for his wife"s delivery. I... asked them why they were demanding money. The nurse started giving us such dirty abuses that even I was getting embarrassed and wanted to leave. You imagine how an ordinary person must feel who wants help.
Finding7	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	One activist who unsuccessfully intervened when a staff nurse at a CHC demanded money said, One man I know had taken his wife for delivery to the CHC. He had sold 10 kilos of wheat that he had bought to get money to bring his wife for delivery. He had some 200-300 rupees [US$4-6]. Now in the CHC they asked him for a minimum of 500 rupees [US$10]. Another 50 [rupees] to cut the cord and 50 [rupees] for the sweeper. So he started begging and saying he did not have more money and that they should help for his wife"s delivery. I... asked them why they were demanding money. The nurse started giving us such dirty abuses that even I was getting embarrassed and wanted to leave. You imagine how an ordinary person must feel who wants help.
Finding8	SCP Potential beneficiaries" lack of knowledge of scheme provisions

Illustration	Poor awareness of services offered under government schemes is the first barrier to making a complaint. On paper, the NRHM provides a host of service guarantees, but these are seldom effectively communicated to pregnant women in rural areas. For example, even though community health centers visited by Human Rights Watch had big painted walls providing some information about the JSY and the duties of the ASHAs in Hindi, most families, especially pregnant women, were unaware of their entitlements under the JSY or the NRHM service guarantees. They only seemed aware of the 1400 rupees (US$28) cash incentive that would be given to them for a facility-based delivery.
Finding9	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	Another district official said that about five or six women had made written complaints earlier this year around April to the office of the Unnao district chief medical officer. They claimed that health facility staff had demanded money at the time of delivery or had taken money from their JSY payments.
Finding10	SCP Lack of equipment to provide care and inadequate referral system
Illustration	Poor access to affordable transport is exacerbated by repeated referrals from one facility to another. Even when families reach health facilities, it is often not equipped to provide the required care. Several doctors and nurses described how families of pregnant women often fell at their feet, begging to be admitted into the health facility because they could not arrange to go elsewhere for appropriate care.
Finding11	SCP Lack of equipment to provide care and inadequate referral system
Illustration	Nirmala was there when the family came back, begging to be readmitted. She explained that the staff in the female ward refused readmission because they lacked the requisite expertise and facilities. She said, But they [family] started falling at the doctor"s [superintendent of the community health center] feet and holding his hand and leg. So out of mercy he took her and got her admitted. Not into our ward [female ward]. We said no. So he took her into the male ward. She died. He did not want her to die on the road. There is nothing we could have done in that case. We do not have the facilities here.
Finding12	SCP Lack of equipment to provide care and inadequate referral system
Illustration	Several district chief medical officers said that the Uttar Pradesh government has piloted referral transport through a network of ambulances in a few areas. We spoke with one such ambulance driver who explained how he was permitted to transport patients only up to the district hospital and if the patients were turned away he was not authorized to drive them to another hospital within or outside the district. He said, “If the patients beg me, out of mercy I take them to a nearby private facility. They have to pay me extra money.”
Finding13	SCP Promoters can be targets for informal payments demanded by providers
Illustration	Niraja N., an ASHA explained: Nothing is free for anyone. What happens when we take a woman for delivery to the hospital is that she will have to pay for her cord to be cut... for medicines, some more money for the cleaning. The staff nurse will also ask for money. They do not ask the family directly ... We have to take it from the family and give it to them [staff nurses] ... And those of us [ASHAs] who don"t listen to the staff nurse or if we threaten to complain, they make a note of us. They remember our faces and then the next time we go they don"t treat our [delivery] cases well. They will look at us and say „referral" even if it is a normal case.

Finding14	SCP Staff are targets for complaints and criticism of the programme
Illustration	In one case in 2008 where a pregnant woman was referred out of a community health center and delivered on the road, a staff nurse at the health facility was suspended. Human Rights Watch was able to trace the nurse. “I was not even on duty when it all happened,” she claimed. “In fact I was the one who took her [the mother] back inside after she had delivered on the road, helped her when she was delivering the placenta, and cleaned her,” she said.
Finding15	SCP Exclusion of young women by age restrictions
Illustration	The „population control" approach has found its way into the JSY as well. In the nonEmpowered Action Group states, JSY benefits are restricted to women above age 19 for up to two live births. This short changes the medical needs of young mothers and pregnant women with multiple pregnancies.
Finding16	SCP Exclusion of the poorest by confining scheme eligibility to women with a restricted parity / number of existing children
Illustration	The „population control" approach has found its way into the JSY as well. In the nonEmpowered Action Group states, JSY benefits are restricted to women above age 19 for up to two live births. This short changes the medical needs of young mothers and pregnant women with multiple pregnancies.
Finding17	SCP Exclusion of most marginalised by use of formal documents for eligibility
Illustration	Explaining how she finds it hard to help poor women, one ASHA said, “The people who are really poor don"t have these things [BPL cards] and many others who are better off have BPL cards. So that is a big problem.”
Finding18	SCP Health staff asked for informal payments
Illustration	Niraja N., an ASHA explained: Nothing is free for anyone. What happens when we take a woman for delivery to the hospital is that she will have to pay for her cord to be cut... for medicines, some more money for the cleaning. The staff nurse will also ask for money. They do not ask the family directly ... We have to take it from the family and give it to them [staff nurses] ... And those of us [ASHAs] who don"t listen to the staff nurse or if we threaten to complain, they make a note of us. They remember our faces and then the next time we go they don"t treat our [delivery] cases well. They will look at us and say „referral" even if it is a normal case
Finding19	SCP Health staff subvert scheme for financial gain
Illustration	The accuracy of the reported number of facility-based deliveries in Uttar Pradesh is questionable. The pressure to demonstrate increased institutional deliveries has resulted in spurious payment practices in many cases, skewing the JSY data. Several rural women reported that ASHAs or ANMs had approached them to show their deliveries as facility-based even though they were home-based.
Finding20	SCP Clear procedures regarding referral to higher level facilities
Illustration	Contrary to the official claim, activists, health workers and doctors, and families from two districts neighboring Lucknow city, the capital of Uttar Pradesh, reported that women requiring blood transfusions or cesarean sections were routinely referred to Lucknow city about 100 kilometers

	away.
Finding21	SCP Clear procedures regarding referral to higher level facilities
Illustration	Munira M., belonging to the Chamar caste (a Dalit community), was a mother of two children. Both her deliveries were conducted at home. She started bleeding in the eighth month of her third pregnancy, that is, in June 2008. No ASHA or ANM had visited the village and her relatives believed it was because no one was appointed for the village. Her family rented a tractor and took her to a private hospital nearby, where she was referred to yet another private health facility. Saying that she needed a blood transfusion that they could not provide her in Chitrakoot district, the staff at the second private hospital asked the family to take Munira to Allahabad, more than 100 kilometers away. Both mother and baby died in the Allahabad medical college hospital.
Finding22	SCP Fill vacancies for community facilitators and service providers
Illustration	Munira M., belonging to the Chamar caste (a Dalit community), was a mother of two children. Both her deliveries were conducted at home. She started bleeding in the eighth month of her third pregnancy, that is, in June 2008. No ASHA or ANM had visited the village and her relatives believed it was because no one was appointed for the village. Her family rented a tractor and took her to a private hospital nearby, where she was referred to yet another private health facility. Saying that she needed a blood transfusion that they could not provide her in Chitrakoot district, the staff at the second private hospital asked the family to take Munira to Allahabad, more than 100 kilometers away. Both mother and baby died in the Allahabad medical college hospital.
Finding23	SCP Ensure health workers are not overburdened by additional duties
Illustration	Many factors contribute to the poor state of antenatal and postnatal care, and a discussion of all of them is beyond the scope of this paper. Nevertheless, we were struck by the frequency with which doctors and activists mentioned the amount of healthcare worker time taken up by polio eradication and sterilization programs as cause for concern.
Finding24	SCP Monitoring system that can track morbidity and mortality during the post-partum period
Illustration	While the government can show that a woman delivered in a health facility, they are not tracking whether every registered pregnant woman actually delivered safely, developed complications, or died during the post-partum period. For example, if there are 50 facility-based deliveries and 10 women eventually died due to post-partum complications, the latter fact may never show up in government records.
Finding25	SCP Monitoring system that can track morbidity and mortality during the post-partum period
Illustration	There is also no clear breakdown of the number of institutional deliveries by type of care, basic care or comprehensive emergency care. When sharing the data collated under the JSY, district medical officers showed figures for facility-based deliveries. In some cases, these were broken down by place of delivery/home or health facility (sub-health center, primary health center, community health center, or district women"s hospital). But they had no concrete information about the percentage of such deliveries that successfully addressed pregnancy complications. Many health staff in community health centers reported that they largely conducted „normal deliveries." Former senior state health officials, doctors, and activists say that it is precisely for this reason that the extent of JSY"s impact on maternal mortality is unknown. Government NRHM review reports raise similar concerns that remain A former senior health official in Uttar Pradesh was doubtful whether the women who actually needed emergency medical care for pregnancy-related complications were in fact benefiting from the JSY scheme.

Finding26	SCP Clinical skills and capacity available
Illustration	Dr. Chandravati, former professor of gynecology at the medical college hospital in Lucknow and an advisor to the Uttar Pradesh state health department, said that the JSY had not yet resulted in “an identifiable decrease in cases of complications and deaths.” She felt that it would possibly take more time to show results, and cautioned that gaps in the scheme would need to be addressed to achieve progress. She expressed concern about the scheme, saying that “lots of gaps are there- the facilities are not upgraded and suddenly the load on these institutions has increased.”
Finding27	SCP Clinical skills and capacity available
Illustration	Concerns about the quality of maternal health care, availability of health workers with midwifery skills, and the level of support afforded to such health workers to perform lifesaving interventions indicate that the government"s assumption that all institutional deliveries are safe is not well supported. Several government officials and doctors in Uttar Pradesh consistently maintained that they did not have the facilities to meet the „demands" for institutional delivery. One senior health official said, “JSY has opened up the gates for institutional deliveries ... Quality is lacking. Once you create the demand, then your facilities have to be ready.”
Finding28	SCP Mechanisms to ensure that free referral systems are adhered to
Illustration	One of the nurses at the community health center confirmed Sita"s story. According to her, the health staff had asked that Pragya be taken to the Rae Bareilly district hospital about 30 kilometres away. The staff nurse claimed that there was an ambulance, but stated that it was left to the families to negotiate the payment with the ambulance driver, in violation of the free referral guarantee.
Finding29	SCP Ensure facilitators deliver services as mandated
Illustration	Women in Uttar Pradesh seldom receive continuous care during and after termination of pregnancy, through the postnatal period (extending 42 days from termination of pregnancy). Contrary to NRHM standards which require every pregnant woman be registered, provided with antenatal care, and taken to a pre-identified health facility for delivery, many pregnant women and women who had recently delivered told Human Rights Watch that they seldom had regular contact with ASHAs or nurse-midwives in the antenatal period.
Finding30	SCP Clear procedures for processing and responding to complaints
Illustration	Even women who are aware of their entitlements and feel aggrieved by the treatment meted out to them in health facilities can find they have no way of registering and processing complaints. Government officials gave Human Rights Watch conflicting accounts of procedures for grievance redressal. Some stated that women could make complaints to superintendents or medical officers in charge of hospitals, while others stated that district chief medical officers could receive complaints.
Finding31	SCP Clear procedures for processing and responding to complaints
Illustration	no inquiry or further action was initiated by the Unnao chief medical officer. One district official who spoke with Human Rights Watch believed that because the complaints lodged were against doctors and would be considered by the Chief Medical Officer, also a medical doctor, the complaints would effectively be ignored. He proposed that a better structure would be to submit complaints to a committee under the district magistrate

Finding32	SCP Clinical skills and capacity available
Illustration	In southern Chitrakoot district, the district hospital that is supposed to be equipped with comprehensive emergency obstetric facilities did not have them in March 2009. at the hospital described their predicament: We do not have a gynecologist now. No blood facility. So if there is any case that needs blood we refer the case to Allahabad hospital-Sadguru Sewa Trust ... Only normal cases [unassisted deliveries and episiotomy cases] are taken here. We do not take critical cases. In my time [more than two years], we have had only one cesar case [cesarean] performed
Finding33	SCP Clinical skills and capacity available
Illustration	Manasa M., an ANM, had attended to Renu R."s delivery in late May 2009 at a primary health center. Renu delivered but started hemorrhaging soon after and needed to be taken more than 30 kilometers away for a blood transfusion. Underscoring the importance of improving the availability of blood transfusion facilities, Manasa said: There is no facility for blood over here. It is in Barabanki. Barabanki I think has only one blood bank. Sometimes whenever there is an emergency, [there is not enough blood in Barabanki] and the patient has to go to Lucknow, if in a PPH [post partum hemorrhage] case they have to go all the way there

Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: A case study in three rural health districts in Cambodia

Finding1	VMS Lack of available transport to facility
Illustration	Women participating in the non-user group reported several reasons for the non-use of their vouchers for delivery at health centres. Transportation and intrahousehold constraints were mentioned as the two main reasons. First, some women lived in remote areas far away from the health centres. Although they knew that transportation costs would be paid for by the voucher scheme, they could seldom find appropriate means of transport when the deliveries happened in the middle of the night. If they did manage to find transport, they anticipated that the price would be much higher than the day time price approved by the voucher scheme.
Finding2	VMS Household and childcare duties took priority
Illustration	women claimed that if they came to deliver at health centres, nobody would look after their house and take care of their children or that nobody could accompany them to health centres.
Finding3	VMS Family members not available to accompany woman
Illustration	women claimed that if they came to deliver at health centres, nobody would look after their house and take care of their children or that nobody could accompany them to health centres
Finding4	VMS Disrespectful and abusive care from health care staff
Illustration	In addition, many of them expressed dissatisfaction with health centre services and staff. Some women reported poor staff attitudes and extra payments hinted by midwives. Some doubted the midwife „s availability at night for delivery.
Finding5	VMS Close monitoring and evaluation

Illustration	'Voucher and HEF schemes can be scaled up to areas with reasonably good public health services, but close monitoring and evaluation are needed to ensure further improvement'
Finding6	VMS Incentives for health staff encourage high quality care
Illustration	'thanks to the cash incentives from the PBC and delivery incentive scheme, midwives and health centre personnel had become more committed to ensuring 24-hour services at health centres'
Finding7	VMS Incentives for community level workers encourages referral to facilities
Illustration	'village health volunteers and traditional birth attendants also received cash incentives from the health centre for referrals of pregnant women for delivery at the health centre.'
Finding8	VMS Mechanisms to support quality improvements of service providers
Illustration	'the district and provincial health management teams applied stronger monitoring and stricter rules for 24-hour services. Informal payments were no longer allowed.'
Finding9	VMS Combine vouchers with other complementary interventions to maximise effect
Illustration	'In the Cambodian context, vouchers and HEFs require other interventions, such as PBC and delivery incentive scheme, to improve provider performance to a level necessary for ensuring the supply of reasonable quality maternity services for potential users. Moreover, vouchers and HEFs cannot overcome many other non-financial barriers, such as distance, intra-household constraints and socio-cultural practices. '
Finding10	VMS Health staff ask for informal payments
Illustration	'In addition, many of them expressed dissatisfaction with health centre services and staff. Some women reported poor staff attitudes and extra payments hinted by midwives. Some doubted the midwife „s availability at night for delivery.'

Contracting out to improve maternal health: evaluating the quality of care under the Chiranjeevi Yojana in Gujarat, India

Finding1	VMS Potential beneficiaries lack of knowledge of scheme provisions
Illustration	Another charge taken by the some doctors relate to complicated deliveries, particularly caesarean section. This is not helped by the women „s lack of full knowledge of the provisions of the Chiranjeevi scheme. „There is no provision in the BPL scheme for the operation so we had to pay 5000 rupees. „(IDI 18)
Finding2	VMS Household and childcare duties took priority
Illustration	„ „they gave me an injection and the doctor said it will take two days. But I have small children at home alone. My eldest daughter who is 12 years old is blind, that is why I couldn „t stay in the hospital. I came back home in the late evening but instead of two days, at midnight on the same night I delivered a baby girl with the assistance of Shantiben (a TBA). „ „Most of the women who

	delivered in the private clinics under the Chiranjeevi scheme were being discharged from hospital less than 24 hours after delivery; sometimes it was the women who were requesting to be discharged: „I was admitted at 8.30 a.m. and at 9.45 a.m. I got a boy. There is nobody to look after the animals at home so we asked for discharge and the same day after one hour, we came back (home).”
Finding3	VMS Reimbursements too small
Illustration	'There were anecdotal reports of some doctors referring women under the Chiranjeevi scheme who require operative delivery in order to save costs. This is because these doctors think what they spend on such operative deliveries is much higher than what the government reimburses them (ref: AJ, Key informant, informal interview). Only one doctor said he referred patients solely for this reason. In his words: „Everybody takes extra charges (from the Chiranjeevi client). Since I don „t do this, I send them (complicated cases) to the District Hospital since I won „t be paid differently „ (PI 7) Another doctor with a practice in the district capital presented evidence to support his claim that some of his colleagues avoid doing operative deliveries in order to cut costs by referring complicated cases to other clinics, under the pretext that they do not have anaesthetist cover. He showed me a referral letter written by a doctor claiming to have difficulty getting an anaesthetist. The same doctor who had written that referral had earlier said he didn „t have such difficulties getting an anaesthetist.'
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Illustration	'There were anecdotal reports of some doctors referring women under the Chiranjeevi scheme who require operative delivery in order to save costs. This is because these doctors think what they spend on such operative deliveries is much higher than what the government reimburses them (ref: AJ, Key informant, informal interview). Only one doctor said he referred patients solely for this reason. In his words: „Everybody takes extra charges (from the Chiranjeevi client). Since I don „t do this, I send them (complicated cases) to the District Hospital since I won „t be paid differently „ (PI 7) Another doctor with a practice in the district capital presented evidence to support his claim that some of his colleagues avoid doing operative deliveries in order to cut costs by referring complicated cases to other clinics, under the pretext that they do not have anaesthetist cover. He showed me a referral letter written by a doctor claiming to have difficulty getting an anaesthetist. The same doctor who had written that referral had earlier said he didn „t have such difficulties getting an anaesthetist.'
Finding5	VMS Participating to help the poor
Illustration	'Only a few of the doctors said they are happy with the payment system, particularly for caesarean section, because they see other motives in their participation in the scheme other than monetary gains. One of such doctors said: „The whole aim of this (scheme) is to help the poor, so what we are paid does not really matter. „(PI 6)'
Finding6	VMS Mechanisms to deter unnecessary referral-on of complicated cases
Illustration	'There were anecdotal reports of some doctors referring women under the Chiranjeevi scheme who require operative delivery in order to save costs. This is because these doctors think what they spend on such operative deliveries is much higher than what the government reimburses them (ref: AJ, Key informant, informal interview). Only one doctor said he referred patients solely for this reason. In his words: „Everybody takes extra charges (from the Chiranjeevi client). Since I don „t do this, I send them (complicated cases) to the District Hospital since I won „t be paid differently „ (PI 7) Another doctor with a practice in the district capital presented evidence to support his claim that some of his colleagues avoid doing operative deliveries in order to cut costs by referring complicated cases to other clinics, under the pretext that they do not have anaesthetist cover. He showed me a referral letter written by a doctor claiming to have difficulty getting an anaesthetist. The same doctor who had written that referral had earlier said he didn „t have such difficulties getting an anaesthetist.'

Finding7	VMS Attractive service package for institutional provider
Illustration	'The doctors also believe that the assumption of a 7% caesarean section rate in calculating the service charges was wrong, and causes them to be short-changed. The belief is that the Chiranjeevi clients, being poor women, do not have access to routine antenatal care in pregnancy and may therefore be more prone to having complications in labour.'
Finding8	VMS Clinical skills and capacity available
Illustration	'Lack of blood facilities and anaesthetists The major problems the doctors appear to be having in managing emergencies are lack of blood transfusion facilities and anaesthetists. In district A, the doctors informed me that there are two blood banks-one owned by the government and the other operated by the Red Cross Society; both are located in the district capital. Doctors in District B said there are blood banks in two other blocks apart from the 2 in the district capital. These blood banks are accessible to all medical facilities in the districts but the long distances between some of the blocks and the district headquarters means that only clinics in the headquarters or those that are close by can have access to these blood banks in emergencies. Therefore, almost all the doctors with practices located far from the district headquarters said they refer cases of severe anaemia in pregnancy or those with bleeding during childbirth to facilities in the district headquarters. These referrals are usually to the District Hospital but a few of the doctors refer to other Chiranjeevi private clinics. Often, the client being referred is given the option of choosing where she wants to go.'
Finding9	VMS Clinical skills and capacity available
Illustration	'All the doctors interviewed said they had arrangements with private anaesthetists to attend in emergencies; however those with clinics located in rural settings said there are usually some problems getting these anaesthetists, most of whom they said lived in urban areas. According to the doctors, these anaesthetists charge between 3000 to 5000 rupees for a caesarean section, and they often insist on taking their fees upfront. Because they will have to travel long distances in order to attend to emergencies in clinics outside of the district capitals, often at late hours of the night, they usually do not respond to such calls, particularly if they know that they will not get paid immediately. A doctor practicing in a town about 70 kilometres away from the capital of district A said: „When you call them (the anaesthetists) for an emergency, they first ask if the patient is BPL (Below Poverty Line) and if you answer yes, they usually give an excuse (for not coming). „(PI 8; district A, rural setting)'
Finding10	VMS Clinical skills and capacity available
Illustration	'Lack of adequate back-up to manage serious obstetric complications like severe hypertensive disorders is one of the reasons the doctors gave for referral. One doctor with a practice located in the capital of district A said he usually refers cases of severe pre-eclampsia and eclampsia to the District Hospital because he does not have a High Dependency Unit which these patients require for optimal care of their conditions. The same doctor also said he refers medical complications in pregnancy like cardiac and kidney conditions to the District Hospital.'

Impact of Janani Suraksha Yojana on selected family health behaviours in rural Uttar Pradesh

Finding1	SCP Women preferred to have home delivery
Illustration	In the qualitative study, this issue of delivering in an unknown place assisted by a stranger was observed as an important barrier to institutional delivery.

Finding2	SCP Continuity of maternity carers can encourage women to accept institutional delivery
Illustration	In the qualitative study, this issue of delivering in an unknown place assisted by a stranger was observed as an important barrier to institutional delivery. Thus three ANC check-ups, it appears, is a proxy variable for contact with providers. The counseling and advice women receive during these ANC check-ups, and the process of getting acquainted with the facility and its providers, reduces women"s fear regarding institutional delivery.
Finding3	SCP Household and childcare duties took priority
Illustration	in less than one-third of the cases women or their family members asked for discharge, mainly because of family concerns, such as children being left behind at home, and because there was no place at the facility for them to stay.
Finding4	SCP Disrespectful and abusive care from health care staff
Illustration	being scolded during the delivery process, lack of privacy, not being provided a bed even though it was available and shifting women to the floor of the veranda or ward to save the bed from getting dirty and asking women and their family to purchase all the items required for delivery, even a blade to cut the cord were frequently mentioned issues.
Finding5	SCP Difficult for women to travel in early postpartum
Illustration	is difficult to expect that women to come to a facility within seven days of delivery for a check-up. Postnatal care should be provided at home by the ASHA and to ensure that these services are provided, a fee should be paid to the ASHA.
Finding6	SCP Household and childcare duties took priority
Illustration	Further analysis shows that in two-thirds of the cases it was the health providers (doctors, nurses) who asked the women to go back home whereas in less than one-third of the cases women or their family members asked for discharge, mainly because of family concerns, such as children being left behind at home, and because there was no place at the facility for them to stay.
Finding7	SCP Basing facilitator incentives on uptake of institutional delivery restricts their motivation to help women less likely to do this
Illustration	Indepth interviews reveal that the ASHA selects those women to motivate for ANC and institutional delivery whom she is reasonably sure will go for institutional delivery as she gets paid only if the woman delivers in an institution
Finding8	SCP Develop system to verify incentive claims
Illustration	One reason for the poor rate of postnatal care is that ASHAs get paid a very small fee (` 50 for three visits) for this service. In many cases, this fee has not been paid as this is a state-introduced special fee and a system of verification has not been established.
Finding9	SCP Local community worker / volunteer to promote scheme and assist beneficiaries

Illustration	It appears that the ASHA"s counseling efforts have succeeded in convincing women and their families of the health benefits of institutional delivery over home delivery. Many women mentioned that they were advised by the ASHA or ANM about institutional delivery during ANC.
Finding10	SCP Combine DSF programmes with other complementary interventions to maximise effect
Illustration	is difficult to expect that women to come to a facility within seven days of delivery for a check-up. Postnatal care should be provided at home by the ASHA and to ensure that these services are provided, a fee should be paid to the ASHA.
Finding11	SCP Social divisions and social distance can impede work of local facilitators
Illustration	Another factor for low contact between the ASHA and pregnant women is the social distance, measured in terms of caste, class, religion and education of the ASHA and the beneficiaries. Quantitative and qualitative data show that the majority of ASHAs (74 percent) belong to general caste or other backward caste families, and often are relatives of village leaders and hence hesitate to visit scheduled caste/ tribe women. In some cases, the perceived hostility towards or non-acceptance of ASHAs by Muslim families also deprives Muslim families from receiving advice from the ASHA.
Finding12	SCP Social divisions and social distance can impede work of local facilitators
Illustration	In rural areas, particularly in larger villages, population segments are concentrated in different parts of the village, a Muslim mohallah or remote hamlets (often located 0.5-1 km from the main village) inhabited by scheduled caste/ tribe families. It is difficult for ASHAs to visit these hamlets because of both the physical and social distance

Rapid Assessment of Demand-side Financing Experiences in Bangladesh

Finding1	VMS Need for a DSF coordinator/organiser for programme expansion
Illustration	'He did not see a strong role for the UnDSF Committee and opined that organizing meetings of the UnDSF Committee is dif „cult. He expressed that the UNO has been made chairperson of the UzDSF Committee, but he has no responsibilities for the functioning of DSF activities. He was concerned that the UzDSF Committee gives approval of expenses for the DSF scheme, but with the exception of the UHFPO, no other members are likely to be questioned by an audit. This could be a potential problem. However, he opined that absolute power and the absence of oversight have the potential to make someone authoritarian and possibly corrupt. He repeatedly expressed his concerns about not having a DSF coordinator/organizer if the GoB should decide to expand the DSF scheme throughout Bangladesh.'
Finding2	VMS Price of medicines and other tests not covered by voucher
Illustration	They suggested that the cost of the full course of medicines before and after delivery and newborn child health care needs should be included in the DSF scheme.
Finding3	VMS Reimbursements too small
Illustration	'The informants perceived that there are high transaction costs in the DSF scheme. The providers and administrators may not be fully recompensed for their time and resources. Further, the deferred and/or irregular disbursement of payment becomes an issue for both providers and beneficiaries of

	the DSF scheme. Some provider-participants reported irregularities of a 10% reduction in the reimbursement rate of their cash entitlements by the distributor although this is not part of the DSF scheme.'
Finding4	VMS Delayed/irregular reimbursements
Illustration	'The informants perceived that there are high transaction costs in the DSF scheme. The providers and administrators may not be fully recompensed for their time and resources. Further, the deferred and/or irregular disbursement of payment becomes an issue for both providers and beneficiaries of the DSF scheme. Some provider-participants reported irregularities of a 10% reduction in the reimbursement rate of their cash entitlements by the distributor although this is not part of the DSF scheme.'
Finding5	VMS Physical improvements at facilities to cope with increased demand
Illustration	'Specific physical improvements to accommodate the surge in demand that were revealed in the case studies of the six graduated beneficiaries and from providers in FGDs included the need for government facilities to improve cleanliness, hold more beds for pregnant women, and establish/build easy-to-reach toilet facilities for women in labour.'
Finding6	VMS Clinical skills and capacity available
Illustration	'An additional supply-side issue that was raised across upazilas and among various participants was the shortage of facilities with an available Obstetrician/Gynaecologist and an Anaesthesiologist at each UzHC.'
Finding7	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Further, the eligibility requirements, particularly having less than two children, have not been strictly enforced. The respondents reported that there should be a steady supply of vouchers at all times to avoid delays in the enrolment of pregnant women and that a routine schedule for reimbursements of vouchers should be developed and maintained for the voucher scheme to fulfil the needs of both providers and clients. The MIS or registration of the voucher scheme beneficiaries presented another challenge to the HAs and other providers in the system who received vouchers. The current MIS does not include reporting requirements for the DSF scheme'
Finding8	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Further, the deferred and/or irregular disbursement of payment becomes an issue for both providers and beneficiaries of the DSF scheme. Some provider-participants reported irregularities of a 10% reduction in the reimbursement rate of their cash entitlements by the distributor although this is not part of the DSF scheme'
Finding9	VMS Integration of reporting for DSF scheme into the health information system
Illustration	'The MIS or registration of the voucher scheme beneficiaries presented another challenge to the HAs and other providers in the system who received vouchers. The current MIS does not include reporting requirements for the DSF scheme. Further, one manager pointed out that the PPR monthly ceiling of Tk 15,000 limited disbursement to only 30 beneficiaries per month. He stated that the need exists for more cash to be available for disbursement, especially with institutional deliveries on the rise in across the upazilas covered by the DSF programme. This issue was

	addressed in only one upazila but may emerge as a crosscutting issue.'
Finding10	VMS 'Recognise and attempt to reduce high transaction costs'
Illustration	'The informants perceived that there are high transaction costs in the DSF scheme. The providers and administrators may not be fully recompensed for their time and resources. Further, the deferred and/or irregular disbursement of payment becomes an issue for both providers and beneficiaries of the DSF scheme. Some provider-participants reported irregularities of a 10% reduction in the reimbursement rate of their cash entitlements by the distributor although this is not part of the DSF scheme.'
Finding11	VMS Ensure voucher distributors understand the selection criteria
Illustration	'One management concern that was highlighted at several levels was that programmatic changes in the upazilas from means tested to universal availability created confusion among distributors of vouchers'
Finding12	VMS Exclusion of the poorest by confining scheme eligibility to women with a restricted parity / number of existing children
Illustration	'He opined that the DSF scheme should be universal because reduction of maternal mortality is the MDG goal. Therefore, all mothers should be brought under coverage of the DSF scheme. He cited the example of a fisherman community having more mothers with more than two children but the present definition of poor does not allow them to have access to the DSF scheme. However, there has to be a balance because the cash incentive for safe delivery is greater than the cash incentive for sterilization and could produce a perverse outcome.'

Reasons for seeking (and not seeking) institutional health care: A qualitative examination in 12 villages of Karnataka

Finding1	SCP No organised onward referral system for complicated emergencies
Illustration	22 yr old Mary is unemployed. This was her first pregnancy. She underwent basic ANC with the help of her local ASHA worker. Her husband works as an electrician, but the family is poor, below the official poverty line, and registered as BPL. When her labor pains started, a neighbor helped them to hire an auto and reached CHC in Kalagi, eight kilometers from her village. It cost about 100 rupees. After an examination the doctor referred Mary to the district hospital in Gulbarga, which is nearly 50 kilometers away; he felt that she would require C-section, and they did not have this facility at the CHC. An ambulance was not available at the CHC. The doctor advised the family to shift the patient to the district hospital immediately, and not wait for an ambulance, as delay would further aggravate Mary"s condition. So her father-in-law went back to the village, and took out a loan or 7,000 rupees. Mary was in a lot of pain during this time. Seeing their problem, the doctor called different places, and at last succeeded in arranging for a 108-ambulance. It took 2 hours to arrive, and Mary was shifted to the district hospital another 2 hours later, as the condition of the road was bad. She gave birth to baby boy after a normal delivery. They had to spend another 8500 rupees, because the baby was kept in the ICU after delivery. Although Mary is eligible to get financial benefits under government schemes, she did not receive any benefits, reportedly due to lack of resources at the facilities to which she went.
Finding2	SCP Lack of available transport to facility
Illustration	Another among our sample villages, Mallapur, is separated by a big pond from the main road. During the summer, when the pond is empty of water, people walk through it and reach the main road, just one kilometer away. However, during and especially after the monsoon, when the pond is

	full, villagers are constrained to walk 2.5 kilometers on a very uneven path to reach an unpaved road, 5 kilometers away from the main arterial road. This creates a major problem for women in labor, as the only means of transportation available on these bad roads is either bullock carts or expensive jeeps and autos. Two others villages in our sample have similar seasonal problems of access.
Finding3	SCP Poor road infrastructure in remote areas
Illustration	Another among our sample villages, Mallapur, is separated by a big pond from the main road. During the summer, when the pond is empty of water, people walk through it and reach the main road, just one kilometer away. However, during and especially after the monsoon, when the pond is full, villagers are constrained to walk 2.5 kilometers on a very uneven path to reach an unpaved road, 5 kilometers away from the main arterial road. This creates a major problem for women in labor, as the only means of transportation available on these bad roads is either bullock carts or expensive jeeps and autos. Two others villages in our sample have similar seasonal problems of access.
Finding4	SCP Barriers reduced by network of free / low cost ambulances available by phone
Illustration	A significant development is the introduction of the 108-ambulance service, a public-private partnership project that has had a positive impact since it was introduced in some among these villages starting in 2008. Each 108-ambulance service is expected to cover a population of 100,000 over distances of no more than 30 kilometers. It seems important to note, however, that despite the introduction of the 108-ambulance service only a small proportion of all women who obtained institutional deliveries were brought to the hospital or clinic in an ambulance. The majority utilized hired means of transportation, including, most often, tractors, auto rickshaws, and trucks, and less frequently, buses and cars. Vastly expanding the network of free or low-cost ambulance services is essential to reduce the human misery and often ruinous costs associated with institutional health care.
Finding5	SCP Local facilitators misinformed about scheme eligibility / provisions
Illustration	Sometimes ASHA worker has taken the patients to hospitals that were not part of the scheme causing further delays.
Finding6	SCP Facility too far from home
Illustration	we found only district level hospitals participating in this scheme. Many of our respondents, including village-level health care professionals felt that hospitals at the taluka (sub-district) level should also be included within this scheme. Doing so would make more manageable the acute problems of distance and access faced by villagers. Care at facilities thought to be poor and unreliable
Finding7	SCP Facility too far from home
Illustration	The poor quality of health care services emerged from our interviews to be a second major factor deterring people in these villages from seeking institutional health care. The problems range from bad quality of services, lack of equipment, negligence, incompetence, corruption, and leakages. The dubious quality of service provisioning is not restricted to public health providers but even to private providers. Among the ones we interviewed, and the ones about whom we heard second-hand accounts from our interviewees, we found only a small sub-set of public health service providers committed or concerned about the quality of the care given to the rural population. Very often, specialists are not available at PHC and taluka (sub-district) hospitals. There is an acute shortage of obstetricians and gynecologists everywhere. Facilities available at PHC are not

	sufficient and the quality of care provided is poor.
Finding8	SCP Reimbursements too small
Illustration	ASHA workers have had an impact in increasing the number of institutional deliveries in rural areas. But they do not feel that they are being adequately compensated (or recognized) for the work that they are doing. In order to achieve the targets of referrals given them by the government, ASHAs and ANMs put a lot of pressure on pregnant women to visit PHCs. However, once having arrived at the PHC, they are not responsible for taking patients to a higher-level facility. Such higher-level referrals are required in many cases, especially when supplies and personnel are not available at PHCs, which is often the case. But escorting the patient beyond the PHC is not part of the ANMs" and ASHAs" responsibilities.
Finding9	SCP Reimbursements too small
Illustration	One of our tasks was to uncover the need for mediation in accessing institutional health services. In this regard, there is not a great deal to report. The need for mediators for accessing health care services does not seem to be a major problem in these villages. For regular health problems, people access public or private service providers directly. It is only when accessing higher levels of specialized care, e.g., for complicated surgeries, that some villagers seek help from city-based relatives, local leaders, or ASHA workers and ANMs. In general, we did not find incidences of people paying fees to such mediators, beyond taking care of their travel and food expenses. ASHA workers are expected to accompany pregnant women to the nearest public health institution (PHC, taluka or district hospitals) as part of their duties. However, their expenses on transportation, food, lodging, etc., are paid for neither by the patients" families nor by the government, which results in financial difficulties for many ASHA workers.
Finding10	SCP Health staff deduct proportion of money before disbursement
Illustration	Allegations of corruption were also reported. We heard that for every 1,000 rupees given out in JSY cash incentives, a sum of 400 rupees was taken as kickbacks by public health officials. The regularity with which the same figure „of four hundred rupees" was mentioned would seem to suggest that a fixed rate has come into being.
Finding11	SCP Rigid interpretation of eligibility criteria penalised women who lost their baby
Illustration	Several points came to our notice that might help explain this pattern of behavior. JSY offers incentives for institutional deliveries only up to the second child; no incentives are given out for third and subsequent deliveries. We also heard accounts of women eligible for incentives who were not given these amounts because, reportedly, no budgets for these purposes were available with the concerned PHCs. Other women, who lost the baby at birth or immediately after birth, were told that they were not any longer entitled to these amounts.
Finding12	SCP Exclusion of most marginalised by use of formal documents for eligibility
Illustration	A number of private hospitals that were originally part of this scheme have since opted out. Citing lack of facilities, the government has also discontinued the partnership with some of the smaller private hospitals. We also heard from reliable sources that pregnant women who arrive without reports and other documentation are refused treatment in both public and private hospitals. Sometimes ASHA worker has taken the patients to hospitals that were not part of the scheme causing further delays.

Finding13	SCP Rational selection of providers
Illustration	However, villagers who know about the existence of the Thayi Bhagya scheme often refuse to make any additional payments. A number of private hospitals that were originally part of this scheme have since opted out. Citing lack of facilities, the government has also discontinued the partnership with some of the smaller private hospitals. We also heard from reliable sources that pregnant women who arrive without reports and other documentation are refused treatment in both public and private hospitals. Sometimes ASHA worker has taken the patients to hospitals that were not part of the scheme causing further delays. Partly for the reasons mentioned above, we found only district level hospitals participating in this scheme. Many of our respondents, including village-level health care professionals felt that hospitals at the taluka (sub-district) level should also be included within this scheme. Doing so would make more manageable the acute problems of distance and access faced by villagers. Procedural aspects and documentation need to be simplified.
Finding14	SCP Ensure that bureaucratic requirements do not deny access
Illustration	However, villagers who know about the existence of the Thayi Bhagya scheme often refuse to make any additional payments. A number of private hospitals that were originally part of this scheme have since opted out. Citing lack of facilities, the government has also discontinued the partnership with some of the smaller private hospitals. We also heard from reliable sources that pregnant women who arrive without reports and other documentation are refused treatment in both public and private hospitals. Sometimes ASHA worker has taken the patients to hospitals that were not part of the scheme causing further delays. Partly for the reasons mentioned above, we found only district level hospitals participating in this scheme. Many of our respondents, including village-level health care professionals felt that hospitals at the taluka (sub-district) level should also be included within this scheme. Doing so would make more manageable the acute problems of distance and access faced by villagers. Procedural aspects and documentation need to be simplified.

Has Janani Suraksha Yojana stimulated institutional delivery? A study in Una district of Himachal Pradesh

Finding1	SCP Women preferred to have home delivery
Illustration	Feeling of safety at home: We found that women who delivered at home expressed that they felt safe and secure at home for delivery. This is evident from the fact that only six women availed the JSY benefits for institutional delivery. Most of the women were of the view that unless there is nobody at home to look after or there is some complication it is not advisable to go to hospital for delivery. One woman shared her experience of one of her earlier pregnancies for which she went to the PHC, where she was put in a store room as suddenly an accident case arrived and all doctors rushed to attend that case and she was left all alone in a filthy store room. She said that “such things don't happen at home; there are always elder women and relatives to take care of them.”
Finding2	SCP Disrespectful and abusive care from health care staff
Illustration	Feeling of safety at home: We found that women who delivered at home expressed that they felt safe and secure at home for delivery. This is evident from the fact that only six women availed the JSY benefits for institutional delivery. Most of the women were of the view that unless there is nobody at home to look after or there is some complication it is not advisable to go to hospital for delivery. One woman shared her experience of one of her earlier pregnancies for which she went to the PHC, where she was put in a store room as suddenly an accident case arrived and all doctors rushed to attend that case and she was left all alone in a filthy store room. She said that “such things don't happen at home; there are always elder women and relatives to take care of them.”
Finding3	SCP Disrespectful and abusive care from health care staff

Illustration	Lack of confidence in health institutions: Another important attitude that women shared in the FGD was the lack of confidence in the public health system. Women who delivered at home were of the strong opinion that unless you have a friend or acquaintance in the hospital, the treatment by the staff is very poor. To get proper attention and treatment, it is important to know some staff personally who can help in getting respectable treatment at the PHC or any other public health facility. They also felt that the staff at the institution lacked sensitivity towards their pain and need. They expressed that the only reason they would go for institutional delivery is if there is a complication, which the dai (Traditional Birth Attendant) is unable to handle.
Finding4	SCP Disrespectful and abusive care from health care staff
Illustration	Antipathy of the system: The cash benefits provided under JSY are also eluding women and during the FGD women expressed their deep anger towards the hostility of the system. One of the women said that, “We (poor women) are treated like beggars at these PHCs" when they approach PHC for JSY money. Women narrated how they were kept waiting for house, as the person concerned was busy in some other work.
Finding5	SCP Monetary assistance, including cheques, cash and bank transfers, entrusted to another family member may be misspent
Illustration	Unable to use JSY incentives: Women also reported that they have heard of JSY beneficiaries having difficulty in obtaining the cash incentive. They cited that in the absence of any bank account and required documents, women are forced to open a joint account with other family members, and therefore lose control over the spending of the monetary incentive for their own nutrition or treatment. They said that there are so many cases where the amount is being utilized for other purposes, mainly by the men folk of their families without the consent of the women. “Money is used to get household items. There were also some cases where the husbands used the JSY money to buy liquor.”
Finding6	SCP Documentation process for scheme is overly complicated / unworkable
Illustration	Unable to use JSY incentives: Women also reported that they have heard of JSY beneficiaries having difficulty in obtaining the cash incentive. They cited that in the absence of any bank account and required documents, women are forced to open a joint account with other family members, and therefore lose control over the spending of the monetary incentive for their own nutrition or treatment. They said that there are so many cases where the amount is being utilized for other purposes, mainly by the men folk of their families without the consent of the women. “Money is used to get household items. There were also some cases where the husbands used the JSY money to buy liquor.”
Finding7	SCP Unable to afford prohibitive costs of onward referral
Illustration	Referral without support: In case of emergencies, women told that they were referred to the higher institutions without any support of ambulance or other transport facility. They said that poor women generally are not prepared for this emergency and thus often opt to go back to their homes.
Finding8	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Communication gap between beneficiaries and the service providers: In absence of AHSA, there is no one at the field level to ensure timely delivery of health services specific to maternal health needs as specified in the JSY. This becomes more important in the context of emergency cases as there is no support system available at the village level to deal with such cases.

Finding9	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Cumbersome process for getting incentives: The flow of cash from the Block Medical Officer (BMO) to the beneficiaries is also very time-consuming and cumbersome. Doctors informed that the beneficiary had to fill in a form at the sub-centre level and the payment was made at the Block level. The amount spent on travelling to get the reimbursement often exceeds the amount they receive under the JSY. The mechanism specified in the JSY guidelines that the amount shall be paid through ANM in cash before the last days of delivery is not practiced.
Finding10	SCP Cash assistance not sufficient to meet expenses
Illustration	Cumbersome process for getting incentives: The flow of cash from the Block Medical Officer (BMO) to the beneficiaries is also very time-consuming and cumbersome. Doctors informed that the beneficiary had to fill in a form at the sub-centre level and the payment was made at the Block level. The amount spent on travelling to get the reimbursement often exceeds the amount they receive under the JSY. The mechanism specified in the JSY guidelines that the amount shall be paid through ANM in cash before the last days of delivery is not practiced.
Finding11	SCP Lack of facilities for emergency obstetric care
Illustration	Perception about the cause behind home deliveries: Doctors at the PHCs reported that the major factor affecting women"s decision for not coming for institutional delivery is that the health facilities are not equipped with the emergency obstetric care. If the institutions are equipped for emergency care, trust will be developed among the villagers towards the institution. They said that facilities need to be equipped with all medicines, blood bank and trained staff.
Finding12	SCP Lack of accountability and support from the programme
Illustration	Perceptions of about the systems: Health practitioners expressed that the JSY failed to deliver as the administration could not decide between ASHA and AWW as to who would be the accredited activist under this scheme. The main purpose of appointment of the ASHA was to develop a vital link between the health facilities and the beneficiaries. The ANM posted at the sub-centre level covers a population of more than 4,000. However, this functionary is also not available during the odd hours as she is not local posted. Appointment of AHSA or AWW would have solved the problem. Limited knowledge of doctors about JSY: Most of the doctors at the public health facilities admitted that their knowledge about the JSY is limited to its monetary benefits. They also mentioned that there was no special staff to maintain cash flow of JSY money and it is an extra burden on them.
Finding13	SCP Increased workload
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Finding14	SCP Women treated with hostility when they ask for cash assistance

Illustration	Antipathy of the system: The cash benefits provided under JSY are also eluding women and during the FGD women expressed their deep anger towards the hostility of the system. One of the women said that, “We (poor women) are treated like beggars at these PHCs” when they approach PHC for JSY money. Women narrated how they were kept waiting for house, as the person concerned was busy in some other work.
Finding15	SCP Payment to family members, or the bank accounts of family members, removes control of the money from women
Illustration	Unable to use JSY incentives: Women also reported that they have heard of JSY beneficiaries having difficulty in obtaining the cash incentive. They cited that in the absence of any bank account and required documents, women are forced to open a joint account with other family members, and therefore lose control over the spending of the monetary incentive for their own nutrition or treatment. They said that there are so many cases where the amount is being utilized for other purposes, mainly by the men folk of their families without the consent of the women. “Money is used to get household items. There were also some cases where the husbands used the JSY money to buy liquor.”
Finding16	SCP Template for contracting of practitioners
Illustration	Private services have not been designated by the government: There is a provision under the JSY scheme of NRHM that if the public health facilities are not equipped with emergency obstetric care or do not have sufficient staff to take care of emergencies, they can take the services of private doctor/clinic/nursing homes. But to-date the government has not designated any private nursing home/doctors/clinic to provide such facilities to poor women. In the study area, there are two nursing homes that provide such facilities, but these institutions are not accredited for these facilities. Women informed that because these private facilities were not accredited, women were bound to go to public health facility which is very far from their houses. In some cases, women even delivered on the way while trying to reach a PHC for emergency care. In this scenario, it would have been very useful if some private doctors/clinics were not accredited so that women could reach out to them much easily and timely.
Finding17	SCP Providers" knowledge of details of scheme
Illustration	Limited knowledge of doctors about JSY: Most of the doctors at the public health facilities admitted that their knowledge about the JSY is limited to its monetary benefits. They also mentioned that there was no special staff to maintain cash flow of JSY money and it is an extra burden on them.
Finding18	SCP Recognise and attempt to reduce high transaction costs
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Finding19	SCP Clearly defined roles and training for community workers / volunteers
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	as she is not local posted. Appointment of AHSA or AWW would have solved the problem.

Public-private delivery of insecticide-treated nets: A voucher scheme in Volta Region, Ghana

Finding1	VMG Need to convince women of the importance of sleeping under an insecticide-treated net during pregnancy
Illustration	'The high voucher redemption rates over the one year period compared to the voucher issuing rates suggest that most of the decision making on whether women were going to use a voucher to buy an ITN was at the voucher issuing stage. Those who were not likely to buy (or whom the midwife felt was not likely to buy), did not take (or were not offered) a voucher. The majority of those who took a voucher intended to use it to buy an ITN. Non-uptake of vouchers by those pregnant women who do not intend to use an ITN avoids wastage of the value of the subsidy. Escalated information and education is needed to convince those without nets on the importance of sleeping under an ITN during their pregnancy.'
Finding2	VMG Measures to prevent imposition of unofficial selection criteria
Illustration	'Interviews with health facility staff and with pregnant women suggest that the major reasons for women not taking a voucher varied over the one year period. Initially, midwives did not offer a voucher to all pregnant women, unless they could show that they were able to pay the topup amount required to buy the ITN. This 'screening' or imposition of eligibility criteria has been noted in other voucher schemes in Senegal [14] and in Zambia [24]. Knowledge of issues encountered in previous voucher schemes meant that non-imposition of eligibility criteria was stressed during the training programme in Volta Region. However, problems in attendance at training sessions reduced the effectiveness of the messages. Dissemination of monitoring findings four months into the scheme prompted further training and strengthened supervision, resulting in a marked decrease in the imposition of eligibility criteria as assessed during monitoring at 6 and 12 months into the scheme.'
Finding3	VMG Monitoring to prevent continuation or emergence of parallel distribution chains
Illustration	'Interviews with health staff highlighted two issues: firstly several health facilities were still selling ITNs after the start of the voucher scheme from distributions of ITNs that they had received previously. Secondly, commercial partners had approached midwives to sell ITNs directly from health facilities rather than sending clients to retail outlets with their vouchers.'
Finding4	VMG Steady supply of insecticide-treated nets
Illustration	'At the voucher issuing stage, 'lack of ITNs' as a reason for pregnant women not taking a voucher was mainly a decision of the midwife. Midwives were trained to direct pregnant women to outlets where they could exchange the voucher for an ITN. When the midwives knew, or perceived, that there were no ITNs available in the outlets within the vicinity of the health facility, they did not offer a voucher.'
Finding5	VMG Steady supply of insecticide-treated nets
Illustration	'Retailers' greatest concern about the voucher scheme as found during each round of interviews was low stock levels of ITNs. The retailers receive their ITNs from distributors, as mentioned above, the scheme started with just two distributors and increased to three. The financial capacity of each of these distributors was limited, as therefore was their capacity to allow long periods during which their capital was tied up. ITNs were given to retailers on credit and therefore the risks involved dictated initial small stock levels in the majority of outlets. Credit limits and penalties also limited the ability of distributors to reach 'hard-to-reach' areas where leaving large numbers of ITNs means

	tying up capital for long periods of time as sales are likely to be slow in such areas. Tying up of capital leaves the distributor liable to credit penalties. The alternative of visiting such areas regularly incurs prohibitive transport costs in terms of fuel and wear-and-tear of vehicles.'
Finding6	VMG Steady supply of insecticide-treated nets
Illustration	'Approximately seven months into the scheme, retail outlets in Volta Region suffered an acute shortage of ITNs. This was partly due to poor experience in forward planning by the distributors, and their limited financial capacity in terms of credit availability, but was significantly exacerbated by a limited duration voucher scheme project in the two largest urban areas of the country, Accra and Kumasi. The rapid sales available in these two urban areas were a much more attractive business proposition than the slower sales in the voucher pilot region, to the extent that the limited ITNs available in the country were diverted away from the Volta Region. At this point the management agent suspended supplies of vouchers to the clinics, and voucher scheme activities were severely impeded for a period of two months until supplies of ITNs were again introduced into retail outlets in the region. This shortage of ITNs posed problems for the Volta Regional Health Directorate who in response to this shortage requested ITNs from the NMCP to fill this gap. ITNs were then supplied to all districts within the region to be sold to pregnant women from ANC.'
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To what Extent Are ASHAs Able to Perform Their Assigned Roles? A Study of Muzaffarpur District in Bihar.

Finding1	SCP Disrespectful and abusive care from health care staff
Illustration	The AHSAs, on the other hand, stated that they have referred delivery cases to institutions, but the numbers average between one to three cases per AHSA during the entire study period. They said that though they want to take women for institutional delivery, most of the times for various reason the delivery takes place at home only. One ASHA stated that though she sends cases for review by the doctor, the doctor does not properly check the woman and this discourage them to go again.
Finding2	SCP Cash assistance not sufficient to meet expenses
Illustration	Also the fact that even in a government health facility they have to incur high expenses for institutional delivery, compels poor and marginalized families to seek healthcare from unqualified and informal private practitioners (like Bengali doctor).
Finding3	SCP Lack of available transport to facility

Illustration	Harassment by PHC staff, inadequate infrastructure, lack of transportation were said to be the other causes that discourage women to go for institutional delivery at government facilities, as reported by another ASHA. She said that then she had to coax and take them by spending her own money. Such instances of spending their own money were reported by few other ASHAs also. This has stopped other ASHAs from taking women for check-ups or institutional delivery with their own money. One AHSA recounted how she had to spend her own money while escorting a pregnant woman for availing health check-up services and that she could not recover her dues as the woman delivered at home later and she was refused the benefits on grounds of home delivery.
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Finding5	SCP Lack of available transport to facility
Illustration	Transportation: Both ASHAs and AWWs shared that non-availability of cheap transport at the village level hinders ASHAs in taking a woman for institutional delivery
Finding6	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Lack of awareness: The study found that both ASHAs and women were not aware about the various benefits and requirements under JSY. Many ASHAs also reported that they are not aware what services ANMs are supposed to provide at village or sub-centre level.
Finding7	SCP Reimbursements too small
Illustration	Harassment by PHC staff, inadequate infrastructure, lack of transportation were said to be the other causes that discourage women to go for institutional delivery at government facilities, as reported by another ASHA. She said that then she had to coax and take them by spending her own money. Such instances of spending their own money were reported by few other ASHAs also. This has stopped other ASHAs from taking women for check-ups or institutional delivery with their own money. One AHSA recounted how she had to spend her own money while escorting a pregnant woman for availing health check-up services and that she could not recover her dues as the woman delivered at home later and she was refused the benefits on grounds of home delivery.
Finding8	SCP Staff are targets for complaints and criticism of the programme
Illustration	The study found that the ASHAs face a wide array of challenges and constraints in their work. They are list as follows: - Demand of money by the service providers: AWWs reported that when the ASHA take women for delivery to the PHC, the ANM demands money from her. One ASHA recollected an incident where one of the PHC staff threatened to not register the mother"s name unless the ASHA paid up. - Inadequate compensation: After completion of delivery if the beneficiary does not get her money then she blames the AHSA for taking away all her money. Some AWWs reported that when the beneficiary does not receive the JSY benefits in time she usually misbehaves with the ASHA.

Finding9	SCP Promoters can be targets for informal payments demanded by providers
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Finding10	SCP Family resistance and security issues for facilitators
Illustration	Family resistance and security issues: Some ASHAs said that she faces resistance from her family as she does not get any payment. She also has restriction on her travel, especially during night.
Finding11	SCP Money not available in advance, resulting in out of pocket expenditure
Illustration	Monetary assistance under JSY: ASHAs said that they do not get monetary assistance in advance to pay for the expenditure incurred for taking and getting an institutional delivery done, whereas the women who is about to deliver does not want to spend any money because she feels that institutional delivery at government hospitals are „free" and she is not supposed to pay. ASHAs reported that they should be remunerated at every stage starting from registration itself, which will encourage them to work more.
Finding12	SCP Health staff asked for informal payments
Illustration	The study found that the ASHAs face a wide array of challenges and constraints in their work. They are listed as follows: Demand of money by the service providers: AWWs reported that when the ASHA takes women for delivery to the PHC, the ANM demands money from her. One ASHA recollected an incident where one of the PHC staff threatened to not register the mother"s name unless the ASHA paid up.
Finding13	SCP Clearly defined roles and training for community workers / volunteers
Illustration	While few ASHAs were satisfied with the training, others were not. Those who were unsatisfied said that the training was not properly done and that they could not understand anything. One ASHA said that they expected the training to address early childhood care so that she can extend such services to the babies in her community. Some opined that joint trainings with the AWW and the ANM would have ensured that they also know what is to be done and would have helped in future work collaboration. The ANMs and AWWs were also of the same opinion. Few ASHAs said that there should be a periodic training. With regard to the mode of training one ASHA commented that there should be more demonstration rather than theoretical trainings. Few ASHAs said that they are yet to get the total training. Like the ASHAs, ANMs and AWWs were also of the opinion that they should be involved in the training process.
Finding14	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Most of the AWWs described the primary function of the ASHA as identifying pregnant women in the village and providing ANC care. They feel all the other workers such as the ANM or the immunization volunteers (Polio) only serve partially and do not provide comprehensive services. They feel that ASHAs are able to reach out to people better than them as they are based in the

	centre
Finding15	SCP Social divisions and social distance can impede work of local facilitators
Illustration	During the FGDs, women said that ASHA rarely takes women for delivery to the PHC. One woman said that ASHA is the one who apparently registers their name and facilitates release of money from the hospital, but she also said that the ASHA does not come to her area as it belongs to a lower caste section

Cash transfers, gender equity and women's empowerment in Peru, Ecuador and Bolivia

Finding1	CCT Disrespectful and abusive care from health care staff
Illustration	In Peru and Bolivia, women complained of frequent mistreatment and long waiting times at the health centres, which is especially problematic for those who have to walk for several hours to get to the services. There were also tensions with respect to the requirement that women should give birth in the health centre. Although having a hospital birth is not an official condition of the programme in Bolivia, in practice, women can be temporarily suspended if they have a home birth.
Finding2	CCT Having to wait a long time at health facilities
Illustration	In Peru and Bolivia, women complained of frequent mistreatment and long waiting times at the health centres, which is especially problematic for those who have to walk for several hours to get to the services. There were also tensions with respect to the requirement that women should give birth in the health centre. Although having a hospital birth is not an official condition of the programme in Bolivia, in practice, women can be temporarily suspended if they have a home birth.
Finding3	CCT Household and childcare duties took priority
Illustration	There are „waiting houses", which allow women from distant communities to stay close to the health centre until they go into labour. But these are not always accepted because it means that women have to leave their families and daily chores such as looking after the animals.
Finding4	CCT Customary practices in birthing respected
Illustration	The programme does include some measures to follow customs and cultural practices in hospital births. For instance, women are permitted to give birth in a standing position, traditional medicinal herbs may be used, and the presence of a close relative during the birth is allowed.
Finding5	CCT Disrespectful and abusive care from health care staff
Illustration	respect for some cultural practices did little to offset women"s sense of a lack of understanding between them and the hospital staff. Our research indicated that the lack of trust and fear of mistreatment means that some indigenous women prefer to give birth at home, where they also have access to traditional birthing assistants
Finding6	CCT Programmes provide assistance to obtain citizenship documentation

Illustration	An element of the programme in all three countries is that in order to obtain the cash transfer, women must hold an identity document. However, indigenous and poor rural women often have no official documentation, and children are not registered at birth. The programmes provide assistance to obtain such documentation, which is an important contribution to women"s inclusion and citizenship and supports their access to rights. But this requirement also excludes some women and children, especially living in more distant communities from gaining access to these same rights. The requirements of the programme that women should attend meetings and travel into town to collect their benefits themselves, means increased freedom for some women, despite adding to the list of tasks and obligations to be fitted into their working day. This is especially so for those living in isolated communities, as they are able to gain new information and knowledge, by going to talks and networking with other women.
Finding7	CCT Lack of inter-cultural respect or understanding
Illustration	In Peru and Bolivia, state health services were criticised by our respondents for failing to promote any awareness of rights, for the lack of respectful intercultural relations, appropriate forms of information delivery, and proper treatment of women. Complaints were also made about the lack of culturally-appropriate and accessible health information.
Finding8	CCT Scheme eligibility confined to women who have used contraception for birth spacing
Illustration	In Bolivia, the conditionalities with which women had to comply to receive the bono were seen as controlling women"s reproductive choices and some of the key informants considered that the BJA violates women"s sexual and reproductive rights. For example, the programme tries to impose birth spacing by not allowing women to claim a second cash transfer if they become pregnant again within two years of a previous birth.
Finding9	CCT Scheme eligibility excludes women who have had recent abortion
Illustration	In Bolivia, the conditionalities with which women had to comply to receive the bono were seen as controlling women"s reproductive choices and some of the key informants considered that the BJA violates women"s sexual and reproductive rights. For example, the programme tries to impose birth spacing by not allowing women to claim a second cash transfer if they become pregnant again within two years of a previous birth. When women have an abortion or miscarriage they are not allowed to apply for a transfer for another three years, they are told this is for medical reasons but informants considered it was unfairly penalising these women.
Finding10	CCT Opportunities to discuss domestic abuse issues within the obligatory education meetings were not exploited
Illustration	In Bolivia, the responsibilities of the beneficiaries of the BJA include attending routine educational sessions and activities promoted by the health centres, such as on maternal and child health and family planning. In general, these sessions are exclusively for women. A few women mentioned that men had been involved in training activities, mainly meetings on reducing conflicts in the family. This is part of the remit of gender units in government departments. However, these units do not co-ordinate with the BJA, and the beneficiaries are not generally targeted for these trainings. In our research, only one example was cited of information on the protocols and services relating to gender based violence being given to mothers who attended the clinics. According to one beneficiary who had attended these workshops: “They talk to women about vitamins and iron ... They don"t talk to them about their rights. They should at least have a module on violence and pregnancy” (interview with key informant, La Paz, 29 September 2010). As the BJA is still a relatively new programme, the impact on the beneficiaries and their families of the information received by the women has yet to be evaluated. Hopefully different information, education, and communications strategies will be integrated into the structure of the programme in the future.

Finding11	CCT Users" dignity and confidence enhanced
Illustration	In the course of the research, we did identify a number of ways in which participation in the CCT programmes supported women"s sense of empowerment in their own lives. One of the positive effects was that the tasks required of women for them to take advantage of the programme (for example, applying for and obtaining the bono, going to the bank, and gaining access to financial services) had helped to strengthen their self-esteem. The funds are generally paid directly to the women, and many women said this had increased their decision-making powers in the home, putting them in a stronger negotiating position with their husbands on day-to-day matters, such as what to spend their money on. Nevertheless, the programmes did not help women address the unequal gender division of labour at home, since – as discussed earlier – as the conditions attached to receiving the money generally increase women"s work, and do not encourage men"s involvement in child care.
Finding12	CCT The conditions attached to receiving the money generally increase women"s work
Illustration	In the course of the research, we did identify a number of ways in which participation in the CCT programmes supported women"s sense of empowerment in their own lives. One of the positive effects was that the tasks required of women for them to take advantage of the programme (for example, applying for and obtaining the bono, going to the bank, and gaining access to financial services) had helped to strengthen their self-esteem. The funds are generally paid directly to the women, and many women said this had increased their decision-making powers in the home, putting them in a stronger negotiating position with their husbands on day-to-day matters, such as what to spend their money on. Nevertheless, the programmes did not help women address the unequal gender division of labour at home, since – as discussed earlier – as the conditions attached to receiving the money generally increase women"s work, and do not encourage men"s involvement in child care.
Finding13	CCT Information, education and communication strategies that include women"s rights and services for gender-based violence
Illustration	In Bolivia, the responsibilities of the beneficiaries of the BJA include attending routine educational sessions and activities promoted by the health centres, such as on maternal and child health and family planning. In general, these sessions are exclusively for women. A few women mentioned that men had been involved in training activities, mainly meetings on reducing conflicts in the family. This is part of the remit of gender units in government departments. However, these units do not co-ordinate with the BJA, and the beneficiaries are not generally targeted for these trainings. In our research, only one example was cited of information on the protocols and services relating to gender based violence being given to mothers who attended the clinics. According to one beneficiary who had attended these workshops: “They talk to women about vitamins and iron ... They don"t talk to them about their rights. They should at least have a module on violence and pregnancy” (interview with key informant, La Paz, 29 September 2010). As the BJA is still a relatively new programme, the impact on the beneficiaries and their families of the information received by the women has yet to be evaluated. Hopefully different information, education, and communications strategies will be integrated into the structure of the programme in the future.
Finding14	CCT Measures to prevent application of unofficial conditionalities for cash transfers
Illustration	In Peru and Bolivia, women complained of frequent mistreatment and long waiting times at the health centres, which is especially problematic for those who have to walk for several hours to get to the services. There were also tensions with respect to the requirement that women should give birth in the health centre. Although having a hospital birth is not an official condition of the programme in Bolivia, in practice, women can be temporarily suspended if they have a home birth.
Finding15	CCT Culturally appropriate and accessible health information

Illustration	In Peru and Bolivia, state health services were criticised by our respondents for failing to promote any awareness of rights, for the lack of respectful intercultural relations, appropriate forms of information delivery, and proper treatment of women. Complaints were also made about the lack of culturally-appropriate and accessible health information.

Women's experiences and views about costs of seeking malaria chemoprevention and other antenatal services: a qualitative study from two districts in rural Tanzania

Finding1	VMG Supplier too far from home
Illustration	'Respondents in both districts commended the government for introducing the national ITN voucher system. However, concerns were expressed about the need to approach accredited retailers, often located far away, for redeeming the ITN vouchers.'
Finding2	VMG Disrespectful and abusive care from health care staff
Illustration	'Psychologically, it would be humiliating to report lack of money for redeeming the ITN voucher: „If the nurses note that you are still having the voucher provided during the last visit they shout at you, so at times we wait until we get cash for the net before coming back to the clinic" (a respondent aged 23, at one public dispensary, Mkuranga).'
Finding3	VMG Ill-treatment of women who do not adhere to procedures
Illustration	'Moreover, pregnant women risked being penalized in terms of being fined or given some cleaning tasks if they did not adhere to their ANC schedules. At an FGD in Ihalimba village, Mufindi, it was complained that women who registered for ANC services late in their pregnancy risked receiving a fine of 1000 shilling. This discouraged women who, for any reason, had not registered in time to do so later in their pregnancy.'
Finding4	VMG Ill-treatment of women who do not adhere to procedures
Illustration	'Psychologically, it would be humiliating to report lack of money for redeeming the ITN voucher: „If the nurses note that you are still having the voucher provided during the last visit they shout at you, so at times we wait until we get cash for the net before coming back to the clinic" (a respondent aged 23, at one public dispensary, Mkuranga).'

Targeted subsidy for malaria control with treated nets using a discount voucher system in Tanzania

Finding1	VMG Families already owned an additional insecticide-treated net and men felt no need to buy another
Illustration	'Several FGD participants mentioned that they already owned nets and therefore had no need to use the scheme. As one old man commented: We had another type of net before this system was introduced, and my wife has used the same while she was pregnant and is now using it with our 6-month-old baby. (men, central sub-village, phase 2 areas)'
Finding2	VMG Insufficient cash to use the voucher to buy an insecticide-treated net

Illustration	'However, there was general agreement in the FGDs that many eligible women had not used the vouchers because of a lack of cash, partly due to the poor harvests in three consecutive years. As one community leader lamented: There is famine and there are mosquitoes. What can I do then while there is no money" (community leaders, phase 1 area)'
Finding3	VMG Insufficient cash to use the voucher to buy an insecticide-treated net
Illustration	'In all FGDs there was a perception that married women had benefited more from the discounted nets than the unmarried women, because they were thought to have better access to cash.'
Finding4	VMG Potential beneficiaries lack of knowledge of scheme provisions
Illustration	Awareness and uptake increased with time but were still relatively low 2 years after launching the scheme, despite an exceptionally high return rate among those who had been given a voucher.
Finding5	VMG Use range of media to educate target population about benefits and how to get them
Illustration	'FGD participants had heard about the scheme through local employers, MCH clinic staff and the Zuia Mbu sales and treatment agents in the villages. Zuia Mbu IEC campaigns during a sponsored football tournament had also played a role, as mentioned by one of the FGD participants: That is where most of us would like to go after coming from the shamba (farm) . . . and especially if you don't want to follow beer at local drinking places. (males, central sub-village, phase 1 area)'
Finding6	VMG Build in evaluation design before beginning implementation
Illustration	'Very close monitoring - designed in the light of our evidence that people are not generally very willing to discuss voucher use freely - would be necessary from the start so that barriers to uptake can be understood and appropriate action taken. It should also be added that given the extremely high household net ownership (72% of households with children under 5 years in the phase 1 area in 1999: data not shown), the majority of householders can clearly afford a non-discounted net and it could be questioned whether the scheme is necessary at all.'
Finding7	VMG Steady supply of insecticide-treated nets
Illustration	'Other reasons for poor response to the voucher scheme included breaks in net supply: Even if you get that voucher the nets are not available when we have money. (unmarried women, remote subvillage, phase 2 area)'

An assessment of functioning and impact of Janani Suraksha Yojana in Orissa

Finding1	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Impact of IEC activities regarding the JSY at the community level was assessed in the FGD organized among PRI members, school teachers, village heads, women SHG members etc. It was revealed from the interviews with the non -beneficiaries that 27% of them did not know about the JSY programme. Though a good deal of effort was made at different levels, there still exists certain gaps in the level of awareness which needs to be addressed appropriately

Finding2	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Three out of the six HWs expressed that the funds flow is irregular and delayed. According to 10 out of the 12 ASHAs, there is a usual delay of 15 days to two months in the disbursement of incentives to the beneficiaries. However, two ASHAs in the district of Balasore had stated that the payment to beneficiaries was immediate after delivery.
Finding3	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	On enquiring about the utilization of the JSY money to the beneficiaries, 58% were utilizing the money for purchase of drugs, 44% for food, and 33% for travel. As much as 12 % beneficiaries had asserted that they had to make payment to nurses, while 6% to the doctors. During the course of interviews, they had indicated that in certain in stances the hospital staff like doctors, nurses, and sweepers were demanding money for the services. However, 19% had deposited the money for the child in the bank.
Finding4	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	The non-beneficiaries were asked about the reasons for not availing the services under the JSY scheme. The most important reasons were that they were not aware of the JSY (27%) and the non-availability of transportation facility (19%).
Finding5	SCP Lack of available transport to facility
Illustration	The non-beneficiaries were asked about the reasons for not availing the services under the JSY scheme. The most important reasons were that they were not aware of the JSY (27%) and the non-availability of transportation facility (19%).
Finding6	SCP Health staff deduct proportion of money before disbursement
Illustration	Out of the seven beneficiaries of home delivery, three had received amount less than Rs 500. With the beneficiaries getting money less than the stipulated norm, there seems to be some pilferage in the disbursement processes.
Finding7	SCP Fill vacancies for community facilitators and service providers
Illustration	All the ADMOs(FW) who were interviewed had the apprehension that the shortage of medical and paramedical workforce may pose a great hindrance to the ultimate success of the programme.
Finding8	SCP Fill vacancies for community facilitators and service providers
Illustration	It was revealed that in some places, a single medical officer was posted as against the sanctioned strength of three, thus leading to the overburden of work and job responsibilities. The non-availability of staff nurses and the LHVs further aggravated the problem of regular and quality service delivery. It was observed that the shortage/non-availability of the ASHAs has become the weakest link and posed a challenge in all the three districts.
Finding9	SCP Administrative skills and capacity available

Illustration	With regard to the JSY programme, adequate logistic support in terms of forms and registers, labour room facility, instruments and equipments in the labour room, essential medicines, emergency delivery kits, and IEC materials are of primary importance.
Finding10	SCP Clinical skills and capacity available
Illustration	With regard to the JSY programme, adequate logistic support in terms of forms and registers, labour room facility, instruments and equipments in the labour room, essential medicines, emergency delivery kits, and IEC materials are of primary importance.
Finding11	SCP Clinical skills and capacity available
Illustration	At the district level, the key stakeholders commented on the availability of the labour room facilities which were inadequate in terms of numbers (delivery tables, instruments and equipments) to meet the increased delivery load following the implementation of the JSY programme. Thus the service delivery was suffering a setback both in terms of quantity and quality.
Finding12	SCP Assess and ensure mechanism for drugs and commodities security
Illustration	At Balasore, non-availability of vehicles at PHC/CHC level was posing a challenge for effective supervision and monitoring of the programme. “The major bottlenecks in the smooth implementation of the JSY programme were poor quality of IFA tablets, short supply of IFA tablets and other quality medicines and non-availability of duty room and staff quarters”, MO I/C Kujanga said.
Finding13	SCP Clinical skills and capacity available
Illustration	Absence of a sub-centre building, non-supply of required medicines, and ill -equipped labour rooms are some of the major obstacles in providing quality delivery services at these institutions. Provision of cash assistance alone, without inadequate logistics, will not be of use to improve the efficacy of institutional deliveries.
Finding14	SCP Programme administrators need a good understanding of the scheme
Illustration	It is the evident from the above table that out of the three ADMOs (FW) interviewed, two had poor and one had average knowledge regarding the key components of the JSY whereas two out of the three DPMs had good and one had average level of knowledge. The ADMO (FW), being the nodal functionary for family welfare activities in the district, needs to have better understanding of the programme to ensure effective implementation along with regular monitoring and supervision.
Finding15	SCP Programme administrators need a good understanding of the scheme
Illustration	At the block levels, the MO I/C was identified as the key stakeholder of the programme. Three out of the six MOs interviewed had good, two had average, and one had poor level of knowledge. As effective functioning of the programme depends to a large extent on the expertise and exposure of the MOs, there is an urgent need to address these issues in an appropriate manner.
Finding16	SCP Providers" knowledge of details of scheme

Illustration	At the sub-centre level, the HW (F) is most often the first contact for the community member. In order to ensure proper implementation and optimum utilization of services or benefits, the HW (F) needs to have adequate knowledge about different key components of the JSY programme. The findings reveal that out of the six HW (F)s, three had good and the other three had average level of knowledge. Hence it is of prime relevance that the HW (F)s need regular orientation and training on key areas to ensure the desired performance. Supportive supervision and on-the-job training by the supervising officers will also help in the improvement of the overall programme.
Finding17	SCP Providers" knowledge of details of scheme
Illustration	Out of the 12 ASHAs interviewed, five had good, six had average, and one had poor level of knowledge regarding the JSY. The ASHAs are the key facilitators under the JSY programme at the village level. Right from the identification of a pregnant woman, early registration at the SC, ensuring minimum 3 antenatal checkups, 2 doses of TT immunization, 100 IFA tablets, institutional delivery and postnatal care with BCG to the baby of 6 weeks. They also act as first links of many prospective beneficiaries. It is therefore important that their knowledge levels should be kept at the optimum levels through frequent and repeated training inputs.
Finding18	SCP Providers" knowledge of details of scheme
Illustration	Out of 30 service providers interviewed, nearly half (47%) had good, 40% average, and 13% had poor level of knowledge. As knowledge is a critical area of concern, there is an urgent need for repeated sensitization, periodic capacity building, and continued motivation for the service providers so that the programme can perform optimal in ensuring more and more safe institutional deliveries.
Finding19	SCP Programme administrators need a good understanding of the scheme
Illustration	An urgent requirement is the availability of motivated and trained individuals to take the programme in the desired direction. Regular sensitization and capacity building are the two main components which will ensure effective implementation of the programme. At the same time, the community can reap the benefits of a programme only if there are extensive awareness generation activities and a communication strategy in place for the community. Due to awareness generation campaigns, demand for institutional deliveries services/ANC/PNC check-ups has also increased.
Finding20	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	An urgent requirement is the availability of motivated and trained individuals to take the programme in the desired direction. Regular sensitization and capacity building are the two main components which will ensure effective implementation of the programme. At the same time, the community can reap the benefits of a programme only if there are extensive awareness generation activities and a communication strategy in place for the community. Due to awareness generation campaigns, demand for institutional deliveries services/ANC/PNC check-ups has also increased.
Finding21	SCP Arrangements for selecting service providers and monitoring quality
Illustration	A grievance cell has been formed consisting of members like the ADMO (FW), the DPM, the DAM, and the DHIO. One or two members of this cell will make surprise visits to each block at least once a month to supervise the JSY related activities like disbursement of funds to beneficiaries and the ASHAs, maintenance of JSY cashbook and payment registers and timely submission of SOE,– DPM , Nayagarh. “I have not made any visit for supervision of JSY activities as I"m the only medical officer at the block PHC”,- MO I/C, PHC Bhapur. “Due to lack of time there was no supervision to review the activities of the ASHAs at the village level”,- MO I/C, CHC Remuna “There is no field level supervision. But the health -related programmes and activities are reviewed monthly at the block PHC meeting”,- MO I/C, PHC Badapandusara. These observations show that in all the sample districts there was no schedule for monitoring and supervision of field activities by the sectoral

	medical officers and the DPM and conducted either as a desk review during the weekly or monthly meetings at PHCs or as an additional activity whenever convenient. However all the HW(F)s expressed that they supervise the performance of the ASHAs in relation to the JSY programme at the village levels.
Finding22	SCP Combine DSF programmes with other complementary interventions to maximise effect
Illustration	For appropriate and timely delivery of quality ante -natal, intra-natal and postnatal services, there is a need for well coordinated and synergistic effort of the key field level functionaries like the HW(F), the AWWs, the ASHAs as well as district and block level stakeholders. Thus intra and inter-sectoral coordination facilitates smooth functioning and efficient operationalisation of the JSY programme.
Finding23	SCP Administrative skills and capacity available
Illustration	This assessment highlights some of the best practices that were followed or adopted under the JSY. At DHH, Nayagarh, at times payments to the beneficiaries were delayed. The officials adopted a system of sending out intimation letters to the beneficiaries for collection of payment. At DHH, Balasore, there was provision for a separate counter to disburse the JSY money to the beneficiaries on every working day between 10 AM to 1 PM which ensured hassle free, prompt and timely disbursement. In district Jagatsinghpur, cash prize of Rs. 300 is given to the best performing ASHA in the respective sector. In district Nayagarh, local TV channels were utilized to air information/ advertisements on the JSY.
Finding24	SCP Incentives for programme facilitators to focus on promoting to eligible poor clients
Illustration	This assessment highlights some of the best practices that were followed or adopted under the JSY. At DHH, Nayagarh, at times payments to the beneficiaries were delayed. The officials adopted a system of sending out intimation letters to the beneficiaries for collection of payment. At DHH, Balasore, there was provision for a separate counter to disburse the JSY money to the beneficiaries on every working day between 10 AM to 1 PM which ensured hassle free, prompt and timely disbursement. In district Jagatsinghpur, cash prize of Rs. 300 is given to the best performing ASHA in the respective sector. In district Nayagarh, local TV channels were utilized to air information/ advertisements on the JSY.
Finding25	SCP Use range of media to educate target population about benefits and how to get them
Illustration	This assessment highlights some of the best practices that were followed or adopted under the JSY. At DHH, Nayagarh, at times payments to the beneficiaries were delayed. The officials adopted a system of sending out intimation letters to the beneficiaries for collection of payment. At DHH, Balasore, there was provision for a separate counter to disburse the JSY money to the beneficiaries on every working day between 10 AM to 1 PM which ensured hassle free, prompt and timely disbursement. In district Jagatsinghpur, cash prize of Rs. 300 is given to the best performing ASHA in the respective sector. In district Nayagarh, local TV channels were utilized to air information/ advertisements on the JSY.
Finding26	SCP Incentives for community level workers encourages referral to facilities
Illustration	This assessment highlights some of the best practices that were followed or adopted under the JSY. In district Jagatsinghpur, cash prize of Rs. 300 is given to the best performing ASHA in the respective sector.
Finding27	SCP Use range of media to educate target population about benefits and how to get them

Illustration	This assessment highlights some of the best practices that were followed or adopted under the JSY. In district Jagatsinghpur, cash prize of Rs. 300 is given to the best performing ASHA in the respective sector.
Finding28	SCP Administrative skills and capacity available
Illustration	This assessment highlights some of the best practices that were followed or adopted under the JSY. At DHH, Nayagarh, at times payments to the beneficiaries were delayed. The officials adopted a system of sending out intimation letters to the beneficiaries for collection of payment. At DHH, Balasore, there was provision for a separate counter to disburse the JSY money to the beneficiaries on every working day between 10 AM to 1 PM which ensured hassle free, prompt and timely disbursement
Finding29	SCP Clinical skills and capacity available
Illustration	“The labour rooms were not well equipped, not well-ventilated, and cleanliness was not at all maintained. This problem further is aggravated by inadequate supply and under-stocking of medicines such as antibiotics, IFA tablets, multivitamin tablets etc.”, noted ADMO (FW), Nayagarh
Finding30	SCP Assess and ensure mechanism for drugs and commodities security
Illustration	“The labour rooms were not well equipped, not well-ventilated, and cleanliness was not at all maintained. This problem further is aggravated by inadequate supply and under-stocking of medicines such as antibiotics, IFA tablets, multivitamin tablets etc.”, noted ADMO (FW), Nayagarh

Evaluation of MAMTA scheme in National Capital Territory of Delhi

Finding1	VMS Reimbursement rates need to be attractive to providers if participation of private sector is to be maintained
Illustration	'The scheme has become unattractive to the private providers. A total number of 36 private hospitals/nursing homes had signed MOU with the government, since the inception of the scheme, out of which 35 were contacted during the evaluation. However, only one third hospitals/nursing homes are currently providing services under the scheme, but they may also withdraw from the scheme in near future. They are reluctant to continue with the scheme mainly due to unattractive service package, too much paper work and lack of publicity about the scheme and delay in reimbursement of claim. In order to make the scheme attractive to providers, these issues need to be addressed by the Government.'
Finding2	VMS Potential beneficiaries lack of knowledge of scheme provisions
Illustration	'Some of the constraints faced by the nodal officers include: „ Poor awareness among community about the scheme.' 'According to 50 percent of ANMs, the majority of target population do not go to MF Hospitals, as they find it difficult to submit proof of residence, income, caste etc. so they prefer to deliver at home. They felt that real poor are not getting the benefits under the scheme. Most of them have the opinion that awareness about the scheme among the target population is also low.' 'The findings of FGDs revealed that more than 60 percent of the respondents were not aware of the MAMTA scheme. While about 30 percent of them had heard about the scheme, but they did not have clear idea about the services available under the scheme, eligibility criteria and the documents required for registration under the scheme. Among those who were aware about the scheme, 20 percent of them were not satisfied with the scheme as the target population could not avail the benefits of the scheme due to lack of necessary documents for registration like BPL card, certificate of caste, proof of residence etc. They were also unhappy with the scheme as some of the MAMTA

	Friendly Hospitals refused to register the cases due to incomplete documents.'
Finding3	VMS Lack of the required documentation to prove eligibility
Illustration	'It is very difficult to identify and register BPL/SC/ST women as many of them do not have caste certificates in their name. Many of them also do not have proof of residence and income.' 'According to 50 percent of ANMs, the majority of target population do not go to MF Hospitals, as they find it difficult to submit proof of residence, income, caste etc. so they prefer to deliver at home.' 'According to some ASHAs women who had difficulty in producing caste certificate and proof of residence found problem in registration with the MFHs' 'The findings of FGDs revealed that more than 60 percent of the respondents were not aware of the MAMTA scheme. While about 30 percent of them had heard about the scheme, but they did not have clear idea about the services available under the scheme, eligibility criteria and the documents required for registration under the scheme. Among those who were aware about the scheme, 20 percent of them were not satisfied with the scheme as the target population could not avail the benefits of the scheme due to lack of necessary documents for registration like BPL card, certificate of caste, proof of residence etc. They were also unhappy with the scheme as some of the MAMTA Friendly Hospitals refused to register the cases due to incomplete documents' 'The scheme could not reach the intended target group due to several schematic and system specific problems. Stringent requirement for production of BPL card, certificate of caste, proof of residence, age etc during registration of ANC under the scheme has reduced its popularity. The revised guidelines for eligibility criteria for beneficiary under MAMTA scheme vide letter No.F4/RCH & Immunisation/MAMTA /3/DSHM/200809/797 dated 8/4/09 from Delhi State Health Mission has created further confusion which hindered easy access to services. Many of the eligible women could not avail the benefit of the scheme due to the fact that they were unable to procure caste certificate in their name. This was mainly reported among the women of migrant families from states like UP, Bihar, MP and Rajasthan.'
Finding4	VMS Facility too far from home
Illustration	'All the women, counseled by ANMs have not opted for institutional delivery. A significant number of them did not have institutional delivery, due to certain reasons which include distance of hospital from home, non-encouragement from family members, preference for home delivery, poverty are the major reasons. Due to non-availability of required documents, a few of eligible women also could not register under MAMTA scheme.' 'According to some ASHAs... Many of the women delivered at home due to reasons such as poverty, distance of hospitals, untimely services in hospitals, etc.' 'Delhi has a huge influx of migrant population, who mostly stay in slum areas; J.J. clusters, unauthorised colonies, resettlement colonies and Janta flats. However, many of the MFHs are located in better-off areas of the districts'
Finding5	VMS Women preferred to have home delivery
Illustration	'All the women, counseled by ANMs have not opted for institutional delivery. A significant number of them did not have institutional delivery, due to certain reasons which include distance of hospital from home, non-encouragement from family members, preference for home delivery, poverty are the major reasons'
Finding6	VMS Price of medicines and other tests not covered by voucher
Illustration	'According to 50 percent of ANMs, the majority of target population do not go to MF Hospitals, as they find it difficult to submit proof of residence, income, caste etc. so they prefer to deliver at home. They felt that real poor are not getting the benefits under the scheme". They also complained that some MFHs charge the patients for ultrasound and medicines.'
Finding7	VMS Expected to give birth at parental home

Illustration	'According to some ASHAs „Some of them prefer to go to their parental home to have delivery, especially first delivery.'
Finding8	VMS Women preferred to give birth in a private health facility rather than a government hospital
Illustration	'Out of 21 ASHAs, 12 ASHAs were of the opinion that institutional deliveries have increased after the implementation of MAMTA Scheme. Major reasons given by them were: „ MF Hospitals are close to the residence. „ Women prefer to deliver in private hospitals over government hospitals. „ Better and free care is being provided by MF Hospitals. „ The beneficiaries also get Rs. 600 as incentive of JSY Scheme. However, 33 percent of the ASHAs had expressed in negative. According to them the beneficiaries are not availing the services primarily due to non-availability of proof of residence and problem in procuring certificate of caste and BPL status.'
Finding9	VMS Accredited birth facilities were close to the homes of women
Illustration	'Out of 21 ASHAs, 12 ASHAs were of the opinion that institutional deliveries have increased after the implementation of MAMTA Scheme. Major reasons given by them were: „ MF Hospitals are close to the residence. „ Women prefer to deliver in private hospitals over government hospitals. „ Better and free care is being provided by MF Hospitals. „ The beneficiaries also get Rs. 600 as incentive of JSY Scheme. However, 33 percent of the ASHAs had expressed in negative. According to them the beneficiaries are not availing the services primarily due to non-availability of proof of residence and problem in procuring certificate of caste and BPL status.'
Finding10	VMS Facilitators felt that supplementary cash payments supported uptake of the voucher scheme
Illustration	'Out of 21 ASHAs, 12 ASHAs were of the opinion that institutional deliveries have increased after the implementation of MAMTA Scheme. Major reasons given by them were: „ MF Hospitals are close to the residence. „ Women prefer to deliver in private hospitals over government hospitals. „ Better and free care is being provided by MF Hospitals. „ The beneficiaries also get Rs. 600 as incentive of JSY Scheme. However, 33 percent of the ASHAs had expressed in negative. According to them the beneficiaries are not availing the services primarily due to non-availability of proof of residence and problem in procuring certificate of caste and BPL status.'
Finding11	VMS Fear of being charged for aspects of the care
Illustration	'Delhi has a huge influx of migrant population, who mostly stay in slum areas; J.J. clusters, unauthorised colonies, resettlement colonies and Janta flats. However, many of the MFHs are located in better-off areas of the districts. Poor population fear treatment as they are apprehensive of some latent charges, even if the scheme is free. ASHAs play a very crucial role in linking the potential beneficiaries with MFHs as they suggest opting for free ANC and delivery services under the scheme rather than choosing home delivery. Nonetheless, there are reports of MFHs demanding additional money from the clients, which clearly breaks the trust between the clients and ASHAs. This situation does not augur well for the continued functioning of the scheme.'
Finding12	VMS Increased workload
Illustration	'There are many problems/constraints on the way to the implementation and monitoring of MAMTA scheme in the districts. Some of the constraints faced by the nodal officers include: „ Multifarious activities by the Nodal Officers, who have been given many charges at the district level. „ Shortage of human resources at the district level to assist the Nodal Officer in the implementation of the scheme . „ Problems in the assessing/scrutinizing the claims submitted by MFHs due to inadequate and unauthenticated documents supporting age/caste/income/residence of the woman. the „ Lack specific format and procedure while referring the beneficiaries to higher facilities under the scheme. „ Poor awareness among community about the scheme. 30 Evaluation of MAMTA Scheme in

	National Capital Territory of Delhi „Poor coordination with other agencies working in this sector.'
Finding13	VMS Inadequate/unauthenticated documents submitted by providers to demonstrate client eligibility and proof of services provided
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Finding14	VMS Lack of guidelines and procedures
Illustration	'There are many problems/constraints on the way to the implementation and monitoring of MAMTA scheme in the districts. Some of the constraints faced by the nodal officers include: „Multifarious activities by the Nodal Officers, who have been given many charges at the district level. „Shortage of human resources at the district level to assist the Nodal Officer in the implementation of the scheme . „Problems in the assessing/scrutinizing the claims submitted by MFHs due to inadequate and unauthenticated documents supporting age/caste/income/residence of the woman. the „Lack specific format and procedure while referring the beneficiaries to higher facilities under the scheme. „Poor awareness among community about the scheme. 30 „Poor coordination with other agencies working in this sector.'
Finding15	VMS Delayed/irregular reimbursements
Illustration	'The issue of eligibility criteria and proof of documents during registration of clients in the scheme was discussed by the respondents from almost all hospital/nursing homes. There are problems in compiling of all documents for submission of claims. There have been inordinate delays in reimbursement of claims by the districts due to inadequate documents as per guidelines. Some of the claims have not been reimbursed for want of required documents like lab report, ultrasound report, justification for referral, proof of caste and residence etc. During the submission of the claims to the districts, all MFHs may be asked to submit the lab reports, report of ultrasound and acknowledgement from the patient that nothing was charged by the hospitals may be obtained to ascertain that no payments were made against those procedures. High risk factors should be mentioned and clarified with adequate justification. In case there was requirement to refer the patient for higher level, the date of the referral may also be mentioned for justification. In such circumstances it is easy to rationalize the process of case.'
Finding16	VMS Inadequate/unauthenticated documents submitted by providers to demonstrate client eligibility and proof of services provided
Illustration	'The issue of eligibility criteria and proof of documents during registration of clients in the scheme was discussed by the respondents from almost all hospital/nursing homes. There are problems in compiling of all documents for submission of claims. There have been inordinate delays in reimbursement of claims by the districts due to inadequate documents as per guidelines. Some of the claims have not been reimbursed for want of required documents like lab report, ultrasound report, justification for referral, proof of caste and residence etc. During the submission of the claims to the districts, all MFHs may be asked to submit the lab reports, report of ultrasound and acknowledgement from the patient that nothing was charged by the hospitals may be obtained to ascertain that no payments were made against those procedures. High risk factors should be mentioned and clarified with adequate justification. In case there was requirement to refer the patient for higher level, the date of the referral may also be mentioned for justification. In such circumstances it is easy to rationalize the process of case'

Finding17	VMS Attractive service package for institutional provider
Illustration	'the pace of progress of implementation of the scheme was not satisfactory. Discussion with stakeholders revealed that initial reluctance of private hospitals/nursing homes to join the scheme, lack of publicity, requirement of proof of income/residence, caste certificate, overburdening of existing staff, unattractive service package etc were the reason for its slow progress.'
Finding18	VMS Recognise and attempt to reduce high transaction costs
Illustration	'Some of the constraints faced by the nodal officers include: „ Multifarious activities by the Nodal Officers, who have been given many charges at the district level. „ Shortage of human resources at the district level to assist the Nodal Officer in the implementation of the scheme . „ Problems in the assessing/scrutinizing the claims submitted by MFHs due to inadequate and unauthenticated documents supporting age/caste/income/residence of the woman.'
Finding19	VMS Recognise and attempt to reduce high transaction costs
Illustration	'5.1.2 Suggestions Given by the District Officials „ Simplify the reimbursement procedure by removing unnecessary documentation.'
Finding20	VMS Clear procedures regarding referral to higher level facilities
Illustration	'Some of the constraints faced by the nodal officers include: „ Lack specific format and procedure while referring the beneficiaries to higher facilities under the scheme.'
Finding21	VMS Clear procedures regarding referral to higher level facilities
Illustration	'5.1.2 Suggestions Given by the District Officials „ Provision for good referral linkage in each district and prompt action for referral cases. „ Introduce special packages for neonatal referral for few hospitals in each district'
Finding22	VMS Clear procedures regarding referral to higher level facilities
Illustration	'5.2.4 Suggestions by the Medical Officers „ Evolve proper tie up with other government hospitals for emergency care, postnatal complications, and neonatal problems'
Finding23	VMS Clear procedures regarding referral to higher level facilities
Illustration	'ASHAS: A majority (three-fourths) of the opinion that the scheme should be modified on the following grounds: Clear-cut mechanism should be built in for referral of complicated cases and care of newborn babies'
Finding24	VMS Clear procedures regarding referral to higher level facilities
Illustration	'Most of the hospitals/nursing homes have complained about the pregnant women presenting with medical complications like anaemia, diabetes, hepatitis, fever and requiring admission during antenatal period. Many of them are also not providing services in case of sick newborns and

	postnatal complications. Even though efforts were made by few of the districts to link the government hospitals with MAMTA Friendly Hospitals, still this is a major area of concern. Therefore it is recommended that a strong systematic referral mechanism should be developed between Government hospitals and MFHs in the event of complications during pregnancy, medical illness during pregnancy, neonatal and postnatal complications by respective districts. In case of emergencies some MFH are well equipped and adept at handling. So it may be recommended that there should be a cross referral system to pass on the client to another MFH that can handle the case appropriately. An internal referral would not only strengthen the service quality but would also ensure a good reputation of the scheme. In order to facilitate the referred cases, a „MAMTA help desk" similar to Yeshaswini scheme in Karnataka may be set up at all leading Government hospitals.'
Finding25	VMS Clear procedures for removing low performing providers from the scheme
Illustration	'5.1.2 Suggestions Given by the District Officials . „ Delinking of hospitals/nursing homes which are doing unscrupulous practices.'
Finding26	VMS Attractive service package for institutional provider
Illustration	'5.1.2 Suggestions Given by the District Officials Release advance payment to hospitals/nursing homes which are doing well in the scheme. MOU should be signed for at least three years. Adopt uniform reporting format by all in the scheme. „ Provision of display boards at MFHs by the Government. „ Setup a desk at each tertiary hospitals to facilitate the MAMTA patients.'
Finding27	VMS Ensure that bureaucratic requirements do not deny access
Illustration	'The scheme could not reach the intended target group due to several schematic and system specific problems. Stringent requirement for production of BPL card, certificate of caste, proof of residence, age etc during registration of ANC under the scheme has reduced its popularity. The revised guidelines for eligibility criteria for beneficiary under MAMTA scheme vide letter No.F4/RCH & Immunisation/MAMTA /3/DSHM/200809/797 dated 8/4/09 from Delhi State Health Mission has created further confusion which hindered easy access to services. Many of the eligible women could not avail the benefit of the scheme due to the fact that they were unable to procure caste certificate in their name. This was mainly reported among the women of migrant families from states like UP, Bihar, MP and Rajasthan.'
Finding28	VMS Ensure that bureaucratic requirements do not deny access
Illustration	'5.1.2 Suggestions Given by the District Officials „ CDMO of the district should be given discretionary power to allow pregnant women in the target group to register with the scheme even if required certificates/documents are not available. ASHA/ANM must bring such case to concerned dispensary which can forward the case to nodal officer and CDMO.'
Finding29	VMS Ensure that bureaucratic requirements do not deny access
Illustration	'5.2.4 Suggestions by the Medical Officers „ Benefit of the scheme should be available to all poor women irrespective of caste and religion so as to reduce MMR and IMR [infant mortality rate] in Delhi. Caste certificate of husband/ father/ father-in-law should be accepted. „ Certificate from house owners may be accepted as proof of address for tenants.'
Finding30	VMS Ensure that bureaucratic requirements do not deny access

Illustration	'ASHAS: A majority (three-fourths) of the opinion that the scheme should be modified on the following grounds: „ Simplify the eligibility requirement and proof of documents. Government should accept the SC/ST/BPL certificate of husband of the pregnant women. „ MFHs should not refuse eligible cases, if they have proper documents. „ Genuine beneficiaries should be given the services even if they are not having BPL Card and in such cases, certificates by ward members may be considered.'
Finding31	VMS Ensure that bureaucratic requirements do not deny access
Illustration	'It is very difficult to identify and register BPL/SC/ST women as many of them do not have caste certificates in their name. Many of them also do not have proof of residence and income.'
Finding32	VMS Ensure that bureaucratic requirements do not deny access
Illustration	'It was also observed from the study that some of the clients after taking ANC services from the MFHs leave for delivery to their parental places while few of the clients due to various reasons visited MFHs only for availing delivery services. Since, MFHs have been facing problems in reimbursement of claims from the government (especially for delivery services) they often reluctant to entertain such clients. Therefore it may be made mandatory for the MFHs to entertain all cases whoever approach them in accordance with the part-payment provision made in the package'
Finding33	VMS Use range of media to educate target population about benefits and how to get them
Illustration	'5.1.2 Suggestions Given by the District Officials „ Disseminate information about the scheme, eligibility criteria, services provided, list of hospitals etc. through local cable TV, newspapers, brochures, and hoardings etc. „ Provision of display boards at MFHs by the Government. „ Setup a desk at each tertiary hospitals to facilitate the MAMTA patients'
Finding34	VMS Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	'All the medical officers who were interviewed during the study mentioned ASHAs as a link worker in the community, plays a significant role in the MAMTA scheme, they are providing information about MAMTA scheme to the pregnant women and the community. They identify pregnant women who belong to SC/ST/BPL categories and facilitate their registration with the scheme. They also help them in procuring necessary documents to be submitted to MFHs at the time of registration'
Finding35	VMS Arrangements for selecting service providers and monitoring quality
Illustration	'5.3.6 Suggestions by ANMs „ Monitoring and quality check should be introduced for MFH as quite often they do not provide proper care to patients. In case of normal deliveries some of the MFHs discharge the patients within 3-4 hours of delivery. In order to avoid any postnatal complications, all MFHs should keep the patients at least a minimum of 24 hours in the hospitals.'
Finding36	VMS Recognise and attempt to reduce high transaction costs
Illustration	'5.3.6 Suggestions by ANMs „ Reduce paper work in the scheme. The scheme may be made available to all the poor and SC/ST women irrespective of whether they possess the SC/ST certificate in their name.'

Finding37	VMS Stipulate prescription of generic medicines under scheme
Illustration	'Under the scheme there is no provision for drugs/medicines during medical illness. Many of the hospitals/nursing homes do not prescribe generic drugs/medicines. It will be helpful for the clients registered under the scheme, if only generic drugs/medicines are prescribed so that they could make those available from the public dispensaries as well.'
Finding38	VMS Good communication between different levels of administration
Illustration	'There is lack of coordination between the government dispensaries and the MFHs. Pregnant women who have all documentary evidences are referred to MF Hospitals so that they can avail ANC and delivery services under the scheme. They coordinate with MF Hospitals whenever they receive any complaints from beneficiaries. For improving the coordination and linkages with MF Hospitals, some of the MOs suggested that regular meetings should be arranged with the MFHs and they should also be involved in the selection of MFHs in their jurisdiction'
Finding39	VMS Mechanisms to deter unnecessary referral-on of complicated cases
Illustration	'Many private service providers have not done enough caesarean section, meaning thereby that referrals are made to Government Hospitals. It is expected that there should be a minimum of 3-5 percent caesarean section out of total deliveries conducted by any institution. Therefore, there is a need to include a clause in the MOU that they should also conduct caesarean sections if required.'
Finding40	VMS Attractive service package for institutional provider
Illustration	'There should be provision in the MOU to protect private hospitals/nursing homes towards any untoward event. Grievance redressal mechanism should also be included in the MOU.'
Finding41	VMS Attractive service package for institutional provider
Illustration	'According to a majority of MOs (about 80 percent) MFHs provide ANC and delivery services, but they do not provide essential PNC and Newborn care. 20 percent of them reported that MFHs were not providing free ultrasound facilities to the clients under the scheme. According to them some of the problems encountered in the scheme include the following: „ Initially lot of counseling had to be done for MF Hospitals as they were reluctant to register in this scheme as they feel the amount for delivery for them is very low.'
Finding42	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Online payment system may be introduced on the pattern of Rashtriya Swasthya Bhima Yojana (RSBY). CDMO office can settle all eligible claims and pay the sum to the MFHs within fifteen days of receipt of claim documents. Districts can open a dedicated bank account for the scheme. The claim amount payable by the district to the MFH shall be on fortnightly basis and as far as possible through electronic transfer.'
Finding43	VMS Ensure service providers understand what must be submitted to voucher management agency for reimbursements
Illustration	'MFH would be required to submit claims on a monthly basis to the district for receiving payments under the scheme along with the necessary documents and the districts make payments in respect of deliveries conducted by MFHs, at the package rate on a monthly basis. All the nodal officers of

	the scheme informed about the problems faced by them in assessing the claims due to inadequate documents submitted by MFHs and delay in submission of claims'
Finding44	VMS Arrangements for selecting service providers and monitoring quality
Illustration	'Monitoring system in the scheme should need strengthening. All MFHs should submit a monthly report on prescribed format issued by respective CDMOs. A copy of the monthly report should also be submitted to nearby primary health care unit. Each MFH should entrust the responsibility of compilation and submission of monthly report to one of its senior staff. Compiled report of all MFHs at the district should be submitted to Delhi State Health Mission before 7th of each month. The district monitoring team should conduct regular monitoring visit to MFHs to provide proper guidance and support.'
Finding45	VMS System to detect informal payments and corruption
Illustration	'„ Few of the MFHs collect charges from the MAMTA clients which causes damage to the scheme.'
Finding46	VMS Health staff ask for informal payments
Illustration	'Respondents of families who availed the benefits of MAMTA scheme had mixed reaction. Nearly two-thirds of the respondents informed that they were satisfied with the services availed from MFH. „According to them the behaviour of doctors, nurses and other staffs were also good. They had to spend some amount of money in the MFHs. However, other group, about one-third of respondents were not satisfied with the services. According to them, during ANC and delivery, the families had to incur expenditure on medicines and ultrasound tests. They were also not happy as MFHs refer the cases at last moment on emergency grounds, which caused hardship to the families. Other issues like rude attitude of staff in the hospitals/nursing homes, early discharge from hospital after delivery, no provision of diet during hospital admission, payment of tips to hospital staff were also raised by respondents.'

A Rapid Appraisal on Functioning of Janani Suraksha Yojana In South Orissa

Finding1	SCP Lack of the required documentation to prove eligibility
Illustration	For 94.2% users, the place of delivery was government health institutions and very few deliveries happened at home. Notably, no delivery took place at accredited private clinics and charitable hospitals. But when it comes to non -users, as many as 57.5% deliveries happened at home, while a few (20.9%) went to private clinics and charitable hospitals. A significant finding is that 21.6% of the non -users delivered in government hospitals but did not receive JSY compensation. This was pr imarily because of the non-availability of JSY Card with these mothers.
Finding2	SCP Lack of the required documentation to prove eligibility
Illustration	In 51.6% of the cases, the JSY Card was made in 3-6 months of pregnancy, providing sufficient time for the mothers to obtain information about the JSY scheme from the ASHAs and also undergo ANC. However, in 48.4% of the users, registration was delayed beyond 6 months , thereby reducing the time available to ASHAs to interact with the potential beneficiary and initiate ANC check-ups.
Finding3	SCP Distribution of money and documentation lacks transparency

Illustration	Most of the non-users see also lack of transparency on the part of the health staff in the money distribution, as well as in issuance of the JSY Card.
Finding4	SCP Schemes don"t cater for women"s mobility
Illustration	Another major problem, seen particularly in Ganjam and other bordering districts of the state is of temporarily shifting maternity homes to neighbouring states like Andhra Pradesh. In Gajapati district that is bordering Andhra, the JSY guidelines and registration cards are different. The different set of rules in the bordering state creates hurdles in getting cash assistance to users who are registered in Orissa but deliver in the neighbouring states.
Finding5	SCP Women wished to avoid certain obstetric or medical procedures
Illustration	Poverty and illiteracy compound the problem. Most of the non-users are reluctant to go for institutional delivery for fear of expenses. Another major fear is that there will either be referral or some surgical procedure to be done. This indicates the need for a more strengthened referral network. It also reveals the reluctance of field staff to take up cases and their tendency to shift cases to the next level to avoid work. Also, there is a tendency of family members to go in for home delivery. Most of the ASHAs say that the decision to go in for institutional delivery or not, doesn"t depend on the in-laws, husbands and other elder family members but it is decided by the local dais if complications arise.
Finding6	SCP Fear of being charged for aspects of the care
Illustration	Poverty and illiteracy compound the problem. Most of the non-users are reluctant to go for institutional delivery for fear of expenses. Another major fear is that there will either be referral or some surgical procedure to be done. This indicates the need for a more strengthened referral network. It also reveals the reluctance of field staff to take up cases and their tendency to shift cases to the next level to avoid work. Also, there is a tendency of family members to go in for home delivery. Most of the ASHAs say that the decision to go in for institutional delivery or not, doesn"t depend on the in-laws, husbands and other elder family members but it is decided by the local dais if complications arise.
Finding7	SCP Women not willing to be subject to shameful or undignified situations
Illustration	Another major reason behind their reluctance for institutional delivery is the embarrassment of being assisted by a male doctor.
Finding8	SCP Lack of available transport to facility
Illustration	Nearly all the stakeholders report poor accessibility to hospitals due to lack of communication and transport. The blocks of Mohana and Gurandi in Gajapati district are hilly areas far away from the hospital. Here the problem of transport to the hospital is acute.
Finding9	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	Though, all the services in government hospitals are free, majority of the non-users say that they hear that users often incur more expenses than what they get through the JSY cash assistance, also at times are forced to pay for services that are promised free. Majority of the non -users think that hospital services are costly and the JSY assistance is insufficient in meeting delivery expenses. Most of these expenses, according to non-users, are purchase of drugs, IV fluids and other hospital

	materials, lab tests etc.
Finding10	SCP Fear of being charged for aspects of the care
Illustration	Though, all the services in government hospitals are free, majority of the non-users say that they hear that users often incur more expenses than what they get through the JSY cash assistance, also at times are forced to pay for services that are promised free. Majority of the non -users think that hospital services are costly and the JSY assistance is insufficient in meeting delivery expenses. Most of these expenses, according to non-users, are purchase of drugs, IV fluids and other hospital materials, lab tests etc.
Finding11	SCP Care at facilities thought to be of poor quality and unreliable
Illustration	Majority of the non-users and PRI members state that non-availability of 24x7 health centres and lack of staff in treatment centres are major deterrents for prospective mothers in accessing the JSY services. Also, according to approximately half of the BMOs and majority of PRIs, poor institutional facilities and inadequate supply of essential materials like drugs, IV fluids and surgical materials are major roadblocks. Majority of the non -users say that the unavailability of ASHAs and ANMs as escorts at the time of need creates apprehension amongst mothers in negotiating or communicating with the health staff.
Finding12	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	To make the scheme more widely accepted and transparent, the target community should be made aware of the various components of the scheme. It has been found that less than half of non-users have knowledge about what the JSY offers, such as, registration, issue of JSY Card, institutional delivery, provision of escort (ASHA), cash assistance, PNC and immunization, etc. This point towards the need for wider and better dissemination of information about the JSY scheme to ensure wider acceptance and usage as well as to ensure transparency in the whole programme.
Finding13	SCP Training programme not sufficient
Illustration	In the FGDs with the ASHAs, training was done for approximately half of them in Ganjam and the Kandhamal districts and most of them in Gajapati district received training. Knowledge imparted by the training is considered useful by most of the ASHAs; also most of them are of the view that further training is required focusing on feedback and discussions about practical problems they face in the field. There should be refresher training on a regular basis. But the majoriy have been given only the government guidelines regarding implementation of the scheme during the training.
Finding14	SCP Staff are targets for complaints and criticism of the programme
Illustration	Also, since ASHAs are the link and interface between the beneficiaries and health services, any delay in providing cash assistance to user may lower their credibility in the community thereby decreasing their effectiveness in the very first years of the work.
Finding15	SCP Money not available in advance, resulting in out of pocket expenditure
Illustration	The ASHAs do not have advance money with them and in some cases where they have to bear the cost of transport from their own pocket it often results in a personal loss to them, thereby discouraging them to extend help in future

Finding16	SCP Users" dignity and confidence enhanced
Illustration	Almost all of the user mothers feel that the scheme has made the peripheral health staff such as ASHAs and ANMs more helpful and friendly in terms of making frequent contacts, in promptly issuing the JSY Cards and motivating prospective mothers to avail of the benefits of the scheme.
Finding17	SCP Link flow of money with e-governance financial systems
Illustration	Now, the payments are given through cheques, therefore an effort should be made to link the flow of money with the e-governance financial reporting systems, which are used in the Treasuries of many states so that it becomes more transparent and quick. A core banking system with its own dedicated computerised reporting network can create space for the JSY financial system as well.
Finding18	SCP Ensure higher level administrators have good knowledge of the scheme
Illustration	Human resources are a major necessity for any scheme to operate smoothly. On analysing the provider"s perspective on awareness about implementation arrangements for the JSY, majority of BMOs and CDMOs are aware of the various processes involved in running the scheme. However, as lead -managers of the scheme, every one of them should be fully aware of it. This draws attention towards the need of instituting a mechanism for periodic orientation and updating of personnel at this level.
Finding19	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	The ASHAs play a pivotal role in motivating and facilitating users for antenatal services, institutional delivery, postnatal care, and care of the newborn. Therefore for the smooth running of the scheme, they need to be adequately trained. The ASHAs in the six blocks have been assessed for various aspects of the JSY training such as extent and utility of training, and need for further training.
Finding20	SCP Fill vacancies for community facilitators and service providers
Illustration	Majority of the non-users and PRI members state that non-availability of 24x7 health centres and lack of staff in treatment centres are major deterrents for prospective mothers in accessing the JSY services. Also, according to approximately half of the BMOs and majority of PRIs, poor institutional facilities and inadequate supply of essential materials like drugs, IV fluids and surgical materials are major roadblocks. Majority of the non -users say that the unavailability of ASHAs and ANMs as escorts at the time of need creates apprehension amongst mothers in negotiating or communicating with the health staff.
Finding21	SCP Assess and ensure mechanism for drugs and commodities security
Illustration	Majority of the non-users and PRI members state that non-availability of 24x7 health centres and lack of staff in treatment centres are major deterrents for prospective mothers in accessing the JSY services. Also, according to approximately half of the BMOs and majority of PRIs, poor institutional facilities and inadequate supply of essential materials like drugs, IV fluids and surgical materials are major roadblocks. Majority of the non -users say that the unavailability of ASHAs and ANMs as escorts at the time of need creates apprehension amongst mothers in negotiating or communicating with the health staff.
Finding22	SCP Fill vacancies for community facilitators and service providers

Illustration	Available programme data indicate that ASHAs are yet to be posted in many villages. Many are still not trained and therefore are unable to work effectively. Doctors and staff are sometimes not present at the hospitals, thereby leaving the quality services poor. Most of the PRI members and some of the ASHAs and ANMs state that government hospitals are not clean and patient friendly.
Finding23	SCP Regular coordination with stakeholders from different sectors
Illustration	Majority of ASHAs, ANMs and BMOs cite lack of regular meetings, inadequate briefing about the programme, work overload and financial expectations by civil society organisations as the principal reasons for the weak inter-sectoral coordination. The JSY programme managers should encourage involvement of such sectors for meeting the JSY objective of communitisation as well as better uptake of the services under the scheme.
Finding24	SCP Community awareness of DSF schemes improves with involvement of local NGOs
Illustration	There is very little involvement of PRI members in the scheme. So is the case with community leaders. Women groups are also poorly involved with it, which may be the reason behind poor awareness of the scheme among the community members. Involvement of local NGOs has been observed in some places where they are actively working.
Finding25	SCP Accurate recording of deliveries needed to monitor effect of schemes
Illustration	Also, the recorded delivery data for 200 4-05 from some of the blocks are incomplete thus making it difficult to analyse the achievement status of the subsequent years. Considering the population of the block, the total reported deliveries recorded by the district authorities versus the expected deliveries are grossly mismatching during 2004 -05. For example, in Kukudakhandi block, expected versus recorded deliveries in 2004 -05 were 3,254/261, in Gurandi 1,715/947, in Tikabali 1,064/596 and in Chakapada it was 1,003/108. It indicates a need to improve the registration mechanism of the vital events in the area. However, in Khallikote it was 2,696/3,017 and in Mohana 1,465/2,198 indicating over-reporting.
Finding26	SCP Fill vacancies for community facilitators and service providers
Illustration	In spite of the launch of JSY in Orissa in 2006, selection of ASHAs is still in progress. Training is also not complete for selected ASHAs in all the six blocks, which may be a reason for low ANC coverage and predominance of home deliveries. This is particularly true among tribal populations of Mohana and Gurandi blocks in Gajapati district where home deliveries were the norm.
Finding27	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	To enable local availability of money, ANMs are given advance money which is kept in a joint account with the Sarpanch or the Naib Srapanch whoever is a woman. This money is replenished on time-to-time basis on submission of bills and vouchers of the last round of disbursements. Two out of three CDMOs and four out of six BMOs inform that most of the times the funds flow at various levels (from state to district and below) are interrupted because of delayed submission of bills and vouchers. This delay results in lack of money at operational levels which in turn affects the release to money to ASHAs and eventually to the beneficiaries. All the money required should be planned in advance depending on the expected number of deliveries at each level of institutions and necessary amounts should be parked in the budget for them in one go so that the operationalising on the scheme does not get blocked due to lack of money at the ANM level.
Finding28	SCP Planning and distribution of programme funds in advance

Illustration	To enable local availability of money, ANMs are given advance money which is kept in a joint account with the Sarpanch or the Naib Srapanch whoever is a woman. This money is replenished on time-to-time basis on submission of bills and vouchers of the last round of disbursements. Two out of three CDMOs and four out of six BMOs inform that most of the times the funds flow at various levels (from state to district and below) are interrupted because of delayed submission of bills and vouchers. This delay results in lack of money at operational levels which in turn affects the release to money to ASHAs and eventually to the beneficiaries. All the money required should be planned in advance depending on the expected number of deliveries at each level of institutions and necessary amounts should be parked in the budget for them in one go so that the operationalising on the scheme does not get blocked due to lack of money at the ANM level.
Finding29	SCP Clinical skills and capacity available
Illustration	While monetary benefits of the scheme as well as increased friendliness of the heath staff is increasing the number of JSY users in the state, the service delivery is not found attractive by the users. Majority of them are of the opinion that lack of 24-hour services, absence of staff at hospitals, dirty conditions, poor supplies of medicines and rough attitude of the clinical staff, referrals to higher centres, and tests from outside as major problems
Finding30	SCP Increased friendliness of staff
Illustration	While monetary benefits of the scheme as well as increased friendliness of the heath staff is increasing the number of JSY users in the state, the service delivery is not found attractive by the users. Majority of them are of the opinion that lack of 24-hour services, absence of staff at hospitals, dirty conditions, poor supplies of medicines and rough attitude of the clinical staff, referrals to higher centres, and tests from outside as major problems.

Exploring new health markets: experiences from informal providers of transport for maternal health services in Eastern Uganda

Finding1	VMS Increased revenue and investment in capital
Illustration	'Transporters generally reported that they were happy with the project and had benefitted financially from the scheme as illustrated by the selected quotes below from the Focus Group discussions conducted with transporters. „this project helped us to sustain my family, I have managed to buy a bicycle from this project and other people have managed to buy motorcycles out of this project. Some people have opened up small loan schemes whereby we give ourselves loans amongst ourselves. So before this project came, our lives were not doing well but we are doing very well now" [FGD Motorcycle riders Kamuli District] „for me my life has greatly changed as a result of this project. Before this project I was badly off but I have now managed to secure another motorcycle out of this project, I have bought 2 cows out of this project; I am also plastering my house and I am managing to pay fees for my children out of the money I am getting from this project and I have managed to sustain my family very well" [FGD Motorcycle riders Kamuli District]'
Finding2	VMS Loss of morale following reduction in reimbursements
Illustration	'In March 2010, the payment rates were reduced to between 2,000 and 5,000 Ug sh (US$ $0.90 and US$ $2.27) in an attempt to reduce the project costs. Consequently the earnings of the transporters decreased and some of them expressed disappointment with these rates as noted in the flowing expression below from the focus group discussion with transporters: „at first this project was good because the payment was good, but when they reduced it, we have also lost morale because of the small pay." [FGD Motorcycle riders Kamuli District]'
Finding3	VMS Reimbursements too small

Illustration	'The costs incurred by the transporters included fuel, repairing their bicycles and motor cycles and paying their bosses (owners of the bicycles and motorcycles). The cost of fuel increased during the study from about Ug.sh 2,500 (US$ $1.13) per litre to Ug.Sh 3,400 (US$ $1.50) per litre, mainly due to the depreciation of the Uganda Shilling against the United States dollar against which fuel prices are denominated.".in the past fuel was not very expensive like these days, but now fuel is very expensive but the charges are very low because we used to buy fuel at Ug.Shs 2,500 but it is now Ug.Shs 3,400. So we are not working on the project now." (FGD Motorcycles Kamuli)'
Finding4	VMS Transport providers have to wait long periods due to delays at facilities
Illustration	'The transport providers also complained about the delays that they encountered at the health facilities. They would have preferred to take the mother to the unit, wait for them and then return her back home. However, as a result of the high turn up of mothers and the shortage of health workers, at times the transporters had to wait for long periods for the mothers to be attended to.'
Finding5	VMS Attractive service package for institutional provider
Illustration	'The costs incurred by the transporters included fuel, repairing their bicycles and motor cycles and paying their bosses (owners of the bicycles and motorcycles). The cost of fuel increased during the study from about Ug.sh 2,500 (US$ $1.13) per litre to Ug.Sh 3,400 (US$ $1.50) per litre, mainly due to the depreciation of the Uganda Shilling against the United States dollar against which fuel prices are denominated. „in the past fuel was not very expensive like these days, but now fuel is very expensive but the charges are very low because we used to buy fuel at Ug.Shs 2,500 but it is now Ug.Shs 3,400. So we are not working on the project now." (FGD Motorcycles Kamuli)'
Finding6	VMS System to detect informal payments and corruption
Illustration	'Method of payment and verification of vouchers The easiest method of reimbursement would have been to use bank accounts. However, the banks are located in the more urban areas of the district so they were not easily accessible to the majority of the transporters. Secondly, some of the transporters don"t own the transport vehicles that they use, so they used to hire them and make payments very frequently, in some cases even daily. Therefore they thought the use of a bank would create mistrust between them and their bosses. Having preferred cash payments, it was always challenging to process payments, given the administrative processes involved that often delayed the payments. The administrative processes involved auditing and verifying vouchers for claims to avoid duplication and forgery, visiting the field for each round of payment, among others.'
Finding7	VMS Ensure providers are licensed
Illustration	'Many of the transport providers did not have all the required legal documentation. They argued that it is a very expensive process and requires a lot of time. Secondly, because they usually operate deep in the villages where law enforcement officers are not within their reach, they are reluctant to process the licenses. However, when they have to transport mothers to urban centers, they get arrested. The study team subsequently undertook measures to ensure that all the transporters registered with the study obtain licenses. Below are some quotations from the focus group discussions with transporters. „with the license we are not incurring any cost but it is our responsibility to pay for it because we operate in the village here they don"t ask for the license, but when you go to Kamuli they ask for it. One day they gave me a lady who was referred to Kamuli but as I was approaching Namalamba, they told me not to continue to Kamuli that the traffic officers were very serious arresting whoever could pass. So I had problems taking this woman up to Kamuli; I had to pay another person who had license to take this woman up to Kamuli" [FGD Motorcycles, Kamuli District] „We are supposed to pay for the license but we don"t pay; they don"t arrest us, there are not many police traffic officers here unless you go to Kamuli. „ „ the moment you reach Buyende, they arrest you." [FGD Motorcycles, Kamuli District]'

Finding8	VMS Continued communication with service providers to encourage continued participation
Illustration	'Contracts with the transporters were signed for a predetermined period. However, changes in external conditions may occur and have an immediate effect that affects the suggested transport rates, making them appear unacceptably low. For instance there was a hike in the fuel prices that lasted over a month. Local changes such as increased rainfall during the Elnino rains also complicated the process further. Some transporters therefore stopped working as a result of this and the project had to continue negotiating with the providers. This was expressed in the quotations below. „when the project came we said that let us transport these people because they are in problems as we also get some money but since they changed the prices of the transport we have also resorted to our old system of transporting whoever comes because you cannot work in losses because you are buying fuel Ug. Shs 3,400 a litre you can't transport someone at Ug. Sh 3,000 yet some of us we are not the owners of of the motorcycles; we have our bosses who need their money at the end of the week." (FGD Motorcycles Kamuli)'

The experiences of districts in implementing a national incentive programme to promote safe delivery in Nepal

Finding1	SCP Monetary assistance, including cheques, cash and bank transfers, entrusted to another family member may be misspent
Illustration	Administration of the cash varied in terms of: the amount of cash given; to whom the cash was given; and the time at which the cash was given. The practice of giving cash to husbands was a particular concern to some respondents who were worried that the money might be misspent.
Finding2	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Administration of the cash varied in terms of: the amount of cash given; to whom the cash was given; and the time at which the cash was given. The practice of giving cash to husbands was a particular concern to some respondents who were worried that the money might be misspent. Most commonly, women were given no money at all or given it at a later date after being discharged from the health facility
Finding3	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Respondents at all levels of the health system expressed concern that women were not getting the incentive immediately after delivery. Often, money was not given to women in time because of delays in money reaching districts, inadequate funds or a combination of these factors. Delays occurred because of the late arrival of fund release
Finding4	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	When money was not available to give to eligible women at the time of delivery, a number of issues arose. First, it was difficult to find or contact women in order to give them the money, particularly those in remote areas or those whose whereabouts were unknown. Outstanding debts accumulated and many women, at the time of this study, were yet to be paid: “Since we have no money during the time of delivery we have to ask [women] to come later to collect the incentive. It will be difficult to find them later on, and many do not contact us. You see the problem?” (Health post, Hill, Key informant interview) “Women come from 60 kilometres away for delivery. If they do not receive the money immediately after delivery, how many times can they come from so far, just for 500 rupees, and how many times can they call?” (District stakeholders, Plains, Focus group discussion)

Finding5	SCP No organised onward referral system for complicated emergencies
Illustration	There was particular confusion about the eligibility of health workers to receive the incentive, and the process of reimbursement to health institutions for free delivery care. Respondents did not know the cadres of health worker and the place of delivery that ensured eligibility to receive the money. Data suggest that the conditional cash transfer to women was more clearly understood, but there were still some issues of confusion that led to deviations from the stated policy. Sometimes cash was distributed to women at ineligible health facilities and women were not paid when they were referred:
Finding6	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Respondents felt that poorer women who tended to live in more remote areas were disadvantaged because they were less likely to know about the programme. Women in more remote areas who had not received the cash at delivery were also disadvantaged as they were less likely to find out that the budget had been released: “Only advantaged women received the incentive as they are better informed and are able to visit the health facilities. The poor ones were not informed properly and did not receive the incentive.” (District stakeholders, Plains, Focus group discussion) “I am sure people in town know about the scheme but I am not sure about in the villages” (District stakeholders, Plains, Focus group discussion)
Finding7	SCP Documentation process for scheme is overly complicated / unworkable
Illustration	Other respondents were concerned about the practicalities of reliably verifying the parity (and therefore eligibility) of women and methods of verification were ineffective and sometimes restrictive: “How can a woman go to the Village Development Committee and get a certificate (of parity) before going to the health institution for delivery?”
Finding8	SCP Staff are targets for complaints and criticism of the programme
Illustration	Second, a failure to give the incentive created a perception that health institutions were withholding money, leading to friction and mistrust of health personnel: “We started working with a tentative plan but as the number of deliveries increased, women who delivered in the beginning got the incentive and others were left out. About 40 to 50 women did not get the incentive. Those who did not get [the money] started fighting with us.” (District stakeholders, Hill, Focus group discussion)
Finding9	SCP Staff are targets for complaints and criticism of the programme
Illustration	In one place, the programme was put on hold because there were inadequate funds, and staff were worried about the consequences of only giving cash to some women: “If we distribute the outstanding incentive of last year from February onwards we need about five hundred thousand rupees but we have received only one hundred thousand. If we distribute this amount we are sure to be beaten by women.” (District stakeholders, Mountain, Focus group discussion)
Finding10	SCP Delayed/irregular reimbursements
Illustration	A number of ways to deal with the unpredictability of funds were described. These included: making payment on a first come first served basis; providing money out of one's own pocket; giving a smaller amount of money to share the cash across a larger number of women; and borrowing from other sources. Some district health offices used funds from other health programmes, whilst some

	health institutions borrowed from their own account. Some district officials, who were reluctant to borrow, worried that donor funds may not materialise, or felt it was risky to borrow without approval. “If we spend money from the regular budget head funded by foreign donors we are questioned. If we spend even after receiving an authorisation letter we are questioned: 'why did we spend without receiving the letter of release?' Even those taking risks are trapped sometimes.” (District health office, Plains, Key informant interview) “I am reluctant to use money from the hospital committee fund because donor funds are highly unpredictable and we do not know when they will come.” (District health office, Mountain, Key informant interview)
Finding11	SCP Lack of accountability and support from the programme
Illustration	Confusion about the policy Many respondents were unclear about aspects of the policy. They reported that there had been inadequate dissemination of information to the districts. The confusion created variations in implementation and affected the ability of health workers to disseminate information in communities, potentially hampering the effectiveness of the programme. District officials and health workers were often confused about how to implement the programme, finding the official guidelines issued by central government unhelpful, confusing and lacking in detail. There were reports of late distribution of guidelines and insufficient copies, which restricted their ability to implement the policy: “The centre was so miserly to send only one guideline. How do they think that this is sufficient to run [the programme] in such a big district?” (District stakeholders, Plains, Focus group discussion) “Most importantly, the staff should be properly oriented before launching the programme.” (Health post, Mountain, Key informant interview)
Finding12	SCP Lack of accountability and support from the programme
Illustration	Sometimes cash was distributed to women at ineligible health facilities and women were not paid when they were referred: “I am not sure about getting the incentive when referring the women to another facility after I attended her first. And I am also not sure from which facility the women will get the incentive...” (Primary health centre, Plains, Key informant interviews) “We were all confused about how to distribute the incentive and we were not sure whom to give, [and] how much to give” (District stakeholders, Mountain, Focus group discussion)
Finding13	SCP Lack of accountability and support from the programme
Illustration	Districts disseminated information to the community using various means, such as FM radio or through female community health volunteers. However, district stakeholders felt communication was hampered by a lack of guidance on how to promote the policy, and the absence of any budget allocation. Moreover, some respondents felt it difficult to disseminate information about a programme that they themselves did not fully understand.
Finding14	SCP Difficulty enforcing selection criteria
Illustration	Health workers sometimes found themselves in difficult situations, either being unable to provide the cash to poorer women with greater need because they had more than two children, or purposively ignoring the parity restriction: “Women with 4 or 5 babies must also have been paid the incentive, because I have paid the incentive to women with 3 babies” (District stakeholders, Plains, Focus group discussion) “It is difficult if rich people get money and poor people do not get money...for example, a rich woman came to the health institution for delivery and got the incentive. A poor woman found out about the incentive from that person but we could not give her the incentive because she had more than two babies...(this) makes me feel uneasy.” (Primary health centre, Hill, Key informant interview)

Finding15	SCP Difficulty enforcing selection criteria
Illustration	Other respondents were concerned about the practicalities of reliably verifying the parity (and therefore eligibility) of women and methods of verification were ineffective and sometimes restrictive: “How can a woman go to the Village Development Committee and get a certificate (of parity) before going to the health institution for delivery? Currently there is no local political representative, how can it be”
Finding16	SCP Exclusion of the poorest by confining scheme eligibility to women with a restricted parity / number of existing children
Illustration	Most respondents welcomed the idea of giving cash to women delivering in a health facility and felt it was both legitimate and helpful. However, they had specific concerns with the eligibility criteria, questioning the logic of only giving the cash to women with two or fewer children. Respondents felt that this indirect discrimination, particularly against poorer women, opposed the overall aim of the programme - to increase institutional deliveries and reduce mortality: “The poorest of the poor are excluded from the incentive because the poor are the ones who have more than two children. So there should not be any parity condition” (District health office, Hill, Key informant interview) “Women having more babies are subject to higher risks and they are deprived of the incentive.” (District stakeholders, Plains, Focus group discussion) “If safe motherhood is women's right, then what about the rights of women having more than two children?” (District stakeholders, Plains, Focus group discussion) Health workers sometimes found themselves in difficult situations, either being unable to provide the cash to poorer women with greater need because they had more than two children, or purposively ignoring the parity restriction: “Women with 4 or 5 babies must also have been paid the incentive, because I have paid the incentive to women with 3 babies” (District stakeholders, Plains, Focus group discussion) “It is difficult if rich people get money and poor people do not get money...for example, a rich woman came to the health institution for delivery and got the incentive. A poor woman found out about the incentive from that person but we could not give her the incentive because she had more than two babies...(this) makes me feel uneasy.” (Primary health centre, Hill, Key informant interview)
Finding17	SCP Health staff subvert scheme for financial gain
Illustration	Respondents in several districts were concerned about misuse of SDIP funds. Different types of misuse were described, including: false claims by health workers for deliveries that never took place; claims by health workers for assisting deliveries in private clinics; claims for money by women with more than two children; and skimming of money by staff at the district level. Occasionally reports of false claims were followed up, but the lack of a budget provision hindered verification of parity or if a birth actually took place. “ [Health workers] are claiming incentives for deliveries that they have attended in the local market place, and registering them as institutional deliveries. And there is no mechanism to check.” (District stakeholders, Plains, Focus group discussion) “You know, sometimes the district level people keep up to fifty percent of the incentive. I heard they make false claims too.” (Health post, Hill, Key informant interview)
Finding18	SCP Health facilities subvert scheme for financial gain
Illustration	Respondents in several districts were concerned about misuse of SDIP funds. Different types of misuse were described, including: false claims by health workers for deliveries that never took place; claims by health workers for assisting deliveries in private clinics; claims for money by women with more than two children; and skimming of money by staff at the district level. Occasionally reports of false claims were followed up, but the lack of a budget provision hindered verification of parity or if a birth actually took place. “ [Health workers] are claiming incentives for deliveries that they have attended in the local market place, and registering them as institutional deliveries. And there is no mechanism to check.” (District stakeholders, Plains, Focus group discussion) “You know, sometimes the district level people keep up to fifty percent of the incentive. I heard they make false claims too.” (Health post, Hill, Key informant interview)

Finding19	SCP Skimming of programme funds by staff at the district level
Illustration	Respondents in several districts were concerned about misuse of SDIP funds. Different types of misuse were described, including: false claims by health workers for deliveries that never took place; claims by health workers for assisting deliveries in private clinics; claims for money by women with more than two children; and skimming of money by staff at the district level. Occasionally reports of false claims were followed up, but the lack of a budget provision hindered verification of parity or if a birth actually took place. " [Health workers] are claiming incentives for deliveries that they have attended in the local market place, and registering them as institutional deliveries. And there is no mechanism to check." (District stakeholders, Plains, Focus group discussion) "You know, sometimes the district level people keep up to fifty percent of the incentive. I heard they make false claims too." (Health post, Hill, Key informant interview)
Finding20	SCP Dissemination of information hampered by lack of guidance and budget
Illustration	Districts disseminated information to the community using various means, such as FM radio or through female community health volunteers. However, district stakeholders felt communication was hampered by a lack of guidance on how to promote the policy, and the absence of any budget allocation. Moreover, some respondents felt it difficult to disseminate information about a programme that they themselves did not fully understand.
Finding21	SCP Measures to prevent application of unofficial selection criteria for DSF recipients
Illustration	There were numerous practices in the implementation of the conditional cash transfer to the women. There were 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, making the cash available to all women delivering in a public health facility.
Finding22	SCP Ensure facilitators understand the selection criteria
Illustration	More serious deviations from policy were apparent when an entire district, for example, gave cash to women delivering at home. Such practices might be expected to have the opposite effect to the SDIP's intended objective of increasing skilled birth attendance
Finding23	SCP Dissemination of information hampered by lack of guidance and budget
Illustration	Many respondents were unclear about aspects of the policy. They reported that there had been inadequate dissemination of information to the districts. The confusion created variations in implementation and affected the ability of health workers to disseminate information in communities, potentially hampering the effectiveness of the programme. District officials and health workers were often confused about how to implement the programme, finding the official guidelines issued by central government unhelpful, confusing and lacking in detail. There were reports of late distribution of guidelines and insufficient copies, which restricted their ability to implement the policy: "The centre was so miserly to send only one guideline. How do they think that this is sufficient to run [the programme] in such a big district?" (District stakeholders, Plains, Focus group discussion) "Most importantly, the staff should be properly oriented before launching the programme." (Health post, Mountain, Key informant interview)
Finding24	SCP Monitoring to detect false claims by providers and ineligible women

Illustration	Respondents in several districts were concerned about misuse of SDIP funds. Different types of misuse were described, including: false claims by health workers for deliveries that never took place; claims by health workers for assisting deliveries in private clinics; claims for money by women with more than two children; and skimming of money by staff at the district level. Occasionally reports of false claims were followed up, but the lack of a budget provision hindered verification of parity or if a birth actually took place. " [Health workers] are claiming incentives for deliveries that they have attended in the local market place, and registering them as institutional deliveries. And there is no mechanism to check." (District stakeholders, Plains, Focus group discussion) "You know, sometimes the district level people keep up to fifty percent of the incentive. I heard they make false claims too." (Health post, Hill, Key informant interview)
Finding25	SCP Clear guidelines on what to monitor and how
Illustration	In almost all districts, respondents were unclear about what was expected of them in terms of monitoring the programme. There was a lack of guidance on how to monitor and there was no separate budget or time allocation to carry out these activities. Many felt that monitoring the distribution of financial incentives was important, but guidance had been insufficient. "So far we have not monitored the programme and no one has raised any question about this. However, this now stands as a big issue." (District hospital, Hill, Key informant interview) "A separate budget for supervision and monitoring of this scheme should be made available. The integrated budget for monitoring is just not enough." (District stakeholders, Hill, Focus group discussion)
Finding26	SCP Adequate budget and staff resources to conduct monitoring
Illustration	In almost all districts, respondents were unclear about what was expected of them in terms of monitoring the programme. There was a lack of guidance on how to monitor and there was no separate budget or time allocation to carry out these activities. Many felt that monitoring the distribution of financial incentives was important, but guidance had been insufficient. "So far we have not monitored the programme and no one has raised any question about this. However, this now stands as a big issue." (District hospital, Hill, Key informant interview) "A separate budget for supervision and monitoring of this scheme should be made available. The integrated budget for monitoring is just not enough." (District stakeholders, Hill, Focus group discussion)
Finding27	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	"In my opinion, the incentive should be given to the woman immediately after she delivers...if she does not get the money in her hand she may not be able to borrow and then she will face problems." (District hospital, Hill, Key informant interview) "We sometimes feel that this scheme should be stopped. Either the money should arrive on time otherwise it does not have any meaning." (District hospital, Hill, Key informant interview)
Finding28	SCP Thorough start-up planning
Illustration	Political expediency to ensure the policy was adopted quickly [18] may have meant there was inadequate preparation in the planning of resources and development of certain mechanisms. Respondents frequently spoke about the inadequacy of funds and acknowledged that the means to verify the eligibility of women and monitor the programme were lacking. Moreover, efforts by the central level to retain substantial control of the implementation process - by using an earmarked budget, providing prescriptive (yet unclear) guidance on the policy, and offering few opportunities for feedback - may have exacerbated problems and contributed further to the programme's low uptake.

Finding29	SCP Minimise unnecessary central government control of implementation
Illustration	Political expediency to ensure the policy was adopted quickly [18] may have meant there was inadequate preparation in the planning of resources and development of certain mechanisms. Respondents frequently spoke about the inadequacy of funds and acknowledged that the means to verify the eligibility of women and monitor the programme were lacking. Moreover, efforts by the central level to retain substantial control of the implementation process - by using an earmarked budget, providing prescriptive (yet unclear) guidance on the policy, and offering few opportunities for feedback - may have exacerbated problems and contributed further to the programme's low uptake.

Towards Universalisation of Maternity Entitlements: An Exploratory Case Study of the Dr. Muthulakshmi Maternity Assistance Scheme, Tamil Nadu

Finding1	UCT Increased respect for village health workers
Illustration	Some VHNs / ANMs mentioned certain other specific points as impacts of the scheme: - Increases the respect for VHNs (1 VHN / ANM)
Finding2	UCT Staff are targets for complaints and criticism of the programme
Illustration	A few VHNs / ANMs felt that in many places VHN / ANM general public relationship has reached a low because of this scheme. There are too many issues in identifying the women/mothers and paying them the assistance timely.
Finding3	UCT Lack of accountability and support from the programme
Illustration	Some said there was lack of clarity in the guidelines of selecting a woman or mother who would receive the financial assistance. There were contradictions - while almost everyone (31 out of 32) said that they were able to easily identify poor women, 23 VHNs / ANMs said that only 60 percent of the women/mothers selected, fulfilled the eligibility criteria, and 9 felt that the scheme was not benefiting eligible women.
Finding4	UCT Difficulty enforcing selection criteria
Illustration	The scheme has elaborate guideline for the VHNs / ANMs to identify poor families and differentiate them from rich households. Almost all respondents replied that people in BPL category are the eligible people for the scheme. The BPL category households can be identified through the BPL ration cards and farmer ration cards in rural areas. The VHNs / ANMs also identified the women through the nature of housing, income certificate (indicating less than Rs. 12,000 per annum), type of employment, social background (SC/ST) and landholding patterns Similarly the VHNs / ANMs were quite clear that the scheme is meant only for mothers who have only two children or less. Nine VHNs / ANMs though the guidelines were not very clear. A few others had problems identifying poor people in urban areas. Two VHNs / ANMs felt that they were not certain whether to exclude families with mobiles and two wheelers.
Finding5	UCT Cash disbursements are too late to help poor with immediate expenses

Illustration	28 out of 33 AWWs felt that the scheme helped in promoting breast feeding. One mentioned that since the money reaches women after 6 months after delivery it is not useful.
Finding6	UCT Exclusion of most marginalised by use of formal documents for eligibility
Illustration	BPL category households are identified through the BPL ration cards, nature of housing, income certificate, type of employment, social background and landholding patterns. Some said there was lack of clarity in the guidelines of selecting a woman or mother who would receive the financial assistance. There were contradictions - while almost everyone (31 out of 32) said that they were able to easily identify poor women, 23 VHNs / ANMs said that only 60 percent of the women/mother selected, fulfilled the eligibility criteria, and 9 felt that the scheme was not benefiting eligible women.
Finding7	UCT Exclusion of very poor by overly restrictive means testing criteria
Illustration	BPL category households are identified through the BPL ration cards, nature of housing, income certificate, type of employment, social background and landholding patterns. Some said there was lack of clarity in the guidelines of selecting a woman or mother who would receive the financial assistance. There were contradictions - while almost everyone (31 out of 32) said that they were able to easily identify poor women, 23 VHNs / ANMs said that only 60 percent of the women/mother selected, fulfilled the eligibility criteria, and 9 felt that the scheme was not benefiting eligible women.
Finding8	UCT Users" dignity and confidence enhanced
Illustration	All feel that the scheme is useful and helpful in many ways - for healthy diet and nutritious food, for healthy mother and child, to help poor BPL women, to meet hospital expenses during delivery, to invest in jewels. Some even said it gives confidence to poor women.
Finding9	UCT Users" dignity and confidence enhanced
Illustration	Some VHNs / ANMs mentioned certain other specific points as impacts of the scheme: - Increases self-confidence among poor people (1 VHN / ANM)

Determinants of utilization of services under MMJSSA scheme in Jharkhand 'Client Perspective': A qualitative study in a low performing state of India

Finding1	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	birthing at home, but due to exigencies shifted to the hospital. Some of the mothers were motivated for institutional delivery during ANC by the Sahiya, ANM or AWW. Lack of resources emerged as the principal reason for giving birth at home though a large proportion felt institutional deliveries were safer and would want to avail of the facilities. Majority of mothers who gave birth at home had not decided about the place of delivery and about half of them had arranged for money.
Finding2	SCP Potential beneficiaries" lack of knowledge of scheme provisions

Illustration	“Many people do not know about the plan run by the government. That"s why they are unable to reach there.” (husband) “We don"t know. We go out very morning for our work, and return in the evening. We work as coolies, as daily laborers; that"s why we don"t know. “ (father-in-law)
Finding3	SCP Disrespectful and abusive care from health care staff
Illustration	Adverse experiences of public facilities included nonavailability of medicine and injections, poor attention, misbehavior of staff and higher out-of-pocket expenditure. No antenatal checkups and lack of responsiveness in disbursement of incentives were also the reported reasons. Fear of injections and surgery emerged as an important reason for not opting for institutions.
Finding4	SCP Women wished to avoid certain obstetric or medical procedures
Illustration	Adverse experiences of public facilities included nonavailability of medicine and injections, poor attention, misbehavior of staff and higher out-of-pocket expenditure. No antenatal checkups and lack of responsiveness in disbursement of incentives were also the reported reasons. Fear of injections and surgery emerged as an important reason for not opting for institutions.
Finding5	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Most respondents were unaware of the MMJSSA/JSY scheme, by name; however, they were aware of an initiative for maternal benefits though and the majority recalled when probed specifically about monetary incentive. The few who had heard about the scheme had no knowledge of its specific provisions. ANC registration and care were overwhelmingly perceived as benefits from scheme. Other key benefits were identified as financial incentives, availability of (ICDS) rations, IFA tablets, vitamins and vaccinations.
Finding6	SCP Documentation process for scheme is overly complicated / unworkable
Illustration	were fewer complaints about payment of the first installment (for ANC). Difficulties experienced in accessing the incentive included repeated visits, demand for various documents, rent-seeking behavior (bribe or incomplete payment) of staff and bank-related procedures.
Finding7	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	were fewer complaints about payment of the first installment (for ANC). Difficulties experienced in accessing the incentive included repeated visits, demand for various documents, rent-seeking behavior (bribe or incomplete payment) of staff and bank-related procedures
Finding8	SCP Care at facilities thought to be of poor quality and unreliable
Illustration	Unequivocally, financial incentives were perceived to be a relatively weak pull factor; the emphasis and demand being on quality of care. Poor infrastructure, rude behavior of staff and purchase of medicines emerged as critical quality issues. With recent increases in institutional delivery, government hospitals were stretched beyond their capacities and that could have further aggravated quality issues. Women who preferred birthing at home did so on the basis of adverse community experiences regarding access and quality of care, as well as their socio-cultural beliefs.

Finding9	SCP Lack of available transport to facility
Illustration	We found compelling evidence that despite willingness for institutional deliveries (generally perceived to be safe deliveries), several barriers emerged as critical obstacles. These included poor infrastructure, lack of quality of care, difficulties while availing incentives (read: corruption), behavior of the healthcare personnel and lack of information about MMJSSA. Poor (and expensive) transport facilities and difficult terrain made geographical access difficult. These have to be seen in the context of chronic poverty and shortage of younger males (due to large-scale migration), in many cases the prospective fathers. The level of utilization of maternal healthcare among women in Jharkhand is thus understandably low.
Finding10	SCP Poor road infrastructure in remote areas
Illustration	We found compelling evidence that despite willingness for institutional deliveries (generally perceived to be safe deliveries), several barriers emerged as critical obstacles. These included poor infrastructure, lack of quality of care, difficulties while availing incentives (read: corruption), behavior of the healthcare personnel and lack of information about MMJSSA. Poor (and expensive) transport facilities and difficult terrain made geographical access difficult. These have to be seen in the context of chronic poverty and shortage of younger males (due to large-scale migration), in many cases the prospective fathers. The level of utilization of maternal healthcare among women in Jharkhand is thus understandably low.
Finding11	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Very few among them had planned for birthing at home, but due to exigencies shifted to the hospital. Some of the mothers were motivated for institutional delivery during ANC by the Sahiya, ANM or AWW
Finding12	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Very few respondents mentioned financial incentive as a key reason. Recent improvements in the health facilities and availability of emergency services were cited as reasons by some of the mothers. Table 6: Awareness of MMJSSA In-depth interviews “No, I have not heard.” (mother given birth at home) “People are informed through house visit through this scheme. Sahiya was selected from this area. This area is not too big. So whatever happens is informed through household visit. People come together in Anganwadi and get information on the day of immunization.”(VHSC member) “Sahiya told me that on going to the government hospital one gets free injection, medicines, and money also. So I went.” (mother given birth at institution) Focus group discussions “Many people do not know about the plan run by the government. That"s why they are unable to reach there.” (husband) “We don"t know. We go out very morning for our work, and return in the evening. We work as coolies, as daily laborers; that"s why we don"t know. “ (father-in-law)
Finding13	SCP Adaptation of the scheme to local preferences
Illustration	There was general agreement that the process of issuing coupons had minimized corrupt practices.
Finding14	SCP Clinical skills and capacity available

Illustration	There was an overwhelming demand for energizing sub-centers (including for deliveries) in order to serve the mother and community in a more meaningful way. Having the full complement of second ANMs will go a long way in achieving this end. The MMJSSA scheme will thus have to re-invent itself within the overall framework of the NRHM.
Finding15	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	“People are informed through house visit through this scheme. Sahiya was selected from this area. This area is not too big. So whatever happens is informed through household visit. People come together in Anganwadi and get information on the day of immunization.”(VHSC member) “Sahiya told me that on going to the government hospital one gets free injection, medicines, and money also. So I went.” (mother given birth at institution)

The reproductive health vouchers program in Bangladesh. Summary of findings from baseline evaluation survey

Finding1	VMS Appropriate involvement of Ministry of Health departments
Illustration	'Limited involvement of the Government is a significant managerial problem: DSF is one of many other ongoing projects at the program manager level; therefore DSF work is done in addition to the routine tasks. Besides that, lack of proper job description for the DSF program and frequent turnover of the program managers at national level affect DSF program. In practice, WHO technical coordinators based in the national level and upazila/facility level provide assistance to implement the program. The new 11 DSF areas do not have such coordinators. The unavailability of medically trained providers like anesthetists and surgeons hinders management of complications at some facilities.'
Finding2	VMS Integration of reporting for DSF scheme into the health information system
Illustration	'Fragmented monitoring of accredited facilities by Demand Side Finance Cell (DSF cell): As part of National Health, Nutrition and Population Sector Programme (HNPSP), monitoring and evaluation should be done by the ministry. But there is no DSF specific recruitment either at program level or at field level from Government side. Service utilization data of DSF program is not integrated with routine management information systems in health facilities. As a result there is a gap in monitoring DSF program from Government side. WHO reDSF Field coordinators monitor the program and send monthly reports to the central coordination office.'
Finding3	VMS Ensure that bureaucratic requirements do not deny access
Illustration	'Bureaucratic processes may cause delays in implementation process: The implementation of the program has been characterized by delays. The launching of the 3rd phase was delayed for four months from August to December 2010 due to disbursement delays.'
Finding4	VMS Use of local administrative and leadership structures
Illustration	'Use of the Local administration vital for creating awareness and for distribution: Using local administrative structures including community and opinion leaders who were trained on DSF program played a vital role in marketing the program. At the end of 2010, local government elections took place and candidates mentioned the DSF program during their election campaign. Many of the previous trained chairman and members could not win in election and there are many new faces

	after election who do not have training on DSF program criteria to explain the recipients properly. They often did not explain the selection criteria well and as a result created unsustainable expectations among clients regarding the DSF program.'
Finding5	VMS Ensure voucher distributors understand the selection criteria
Illustration	'Use of poverty grading tool does not ensure always appropriate targeting of the poor: There are criteria developed by the program to include the landless, poor and helpless pregnant women in the DSF program. But the provision of only first and second pregnancy excludes some poor women. newly elected local government officials" poor knowledge of selection criteria and the absence of a WHO field coordinator in the 11 new upazilas often leads to include solvent pregnant women into the program.'
Finding6	VMS Arrangements for selecting service providers and monitoring quality
Illustration	'4.3.1 Accreditation and Quality Assurance „ Evidence of exceptions in the accreditation process: Facility accreditation was done according to criteria developed by the Ministry of Health and Family Welfare (MOHFW), with technical support from World Health Organization (WHO). The selection criteria were population density, literacy rate, poverty level, quality of care, infrastructure, availability of equipment etc. Some of the facilities were accredited due to higher level recommendations even though they did not meet some standards of accreditation criteria.'
Finding7	VMS Integration of reporting for DSF scheme into the health information system
Illustration	'Lack of clarity regarding the role of MOHFW in information system: Centrally, the Government has implemented a Health Management Information System (HMIS), although such a system does not track DSF utilization separately. From the existing HMIS, it is not possible to track voucher and non-voucher recipients. In the DSF program only voucher recipient"s information is recorded from participating facilities. Other than HMIS report, EOC report collected from accredited facilities doesn"t distinguish between voucher and non-voucher recipients. Though there is a plan to acquire new software to improve M&E by tracking each pregnant woman who receives a voucher from antenatal to postnatal care. Such a program is expected to be integrated into the HMIS. Currently WHO has planned to develop this type of software in collaboration with MIS, DGHS.'
Finding8	VMS Administrative skills and capacity available
Illustration	'Lack of proper job description for staff at DSF facilities can undermine the quality of care: There is no clearly defined, transparent and competitive staff recruitment process. Usually additional responsibilities are allocated amongst existing staff members as there has not been any internal DSF specific recruitment. Human resources under the MOHFW at upazila level are skilled and qualified but not sufficient in number. Therefore, job descriptions may not take account of the requirements of DSF as the DSF work is done in addition to the routine tasks. DSF is one of many other ongoing projects even at the current program manager and deputy program manager level. Such situation may decrease the quality of care.'

The reproductive health vouchers program in Kenya. Summary of findings from program evaluation

Finding1	VMS Potential beneficiaries lack of knowledge of scheme provisions

Illustration	'Limited knowledge of vouchers and poor distribution in remote areas: Partly because of poor sensitization and accessibility in remote areas, there was limited knowledge and distribution of the vouchers in these settings. Especially around the facilities that were only accredited in 2010. For example, one FGD participant in Kitui noted that: „We have distribution points but there are areas that have not been well penetrated, so clients don't know well of the services.''
Finding2	VMS Lack of the required documentation to prove eligibility
Illustration	'Lack of formal identification prevents some eligible women from purchasing vouchers: Some pregnant adolescent girls aged below 18 years were unable to purchase vouchers because they had no formal identification documents. In Kenya, the identification (ID) cards are only issued at age 18. Moreover, the government has issued only limited numbers of ID cards in the last three years. There is therefore need to explore alternative forms of identification for those seeking vouchers but lack formal identification.'
Finding3	VMS Unable to afford prohibitive costs of onward referral
Illustration	'Referral of clients requiring emergency obstetric care further impacted on the services received: Some of these referrals were to non-accredited facilities where clients have to pay for services. In some cases where referrals were made to accredited facilities, voucher clients were unable to meet the transport costs. In addition some lower lever facilities would refer clients that could have actually been managed in that facility. One voucher client in Kitui reported during FGD that: „You are told to go to [name of facility] for referral and you don't have bus fare. You are now forced to go back home to look for money or look for another cheaper facility.''
Finding4	VMS Poor road infrastructure in remote areas
Illustration	'Distance to the accredited facilities and lack of support for transport posed challenges to some voucher clients: Voucher clients who participated in the FGDs reported that poor road infrastructure and high transport costs to accredited facilities hindered them from seeking services at contracted facilities. For example, according to one voucher client in Kiambu: „Even if you have a voucher, the taxi charges about 3,000 shillings to hospital, you would rather pay 1,200 they charge delivery here rather than take a taxi [to accredited facility].'' The program therefore needs to explore the possibility of covering transport costs for voucher clients as is the case with similar programs in Bangladesh and Cambodia.'
Finding5	VMS Prohibitive travel costs to health facilities
Illustration	'Distance to the accredited facilities and lack of support for transport posed challenges to some voucher clients: Voucher clients who participated in the FGDs reported that poor road infrastructure and high transport costs to accredited facilities hindered them from seeking services at contracted facilities. For example, according to one voucher client in Kiambu: „Even if you have a voucher, the taxi charges about 3,000 shillings to hospital, you would rather pay 1,200 they charge delivery here rather than take a taxi [to accredited facility].'' The program therefore needs to explore the possibility of covering transport costs for voucher clients as is the case with similar programs in Bangladesh and Cambodia.'
Finding6	VMS Fear of HIV testing and stigma towards people living with HIV
Illustration	'Some voucher clients feared being tested for HIV: Some women who had bought the vouchers feared they would be tested for HIV and therefore delivered at home or with traditional birth

	attendants. One voucher client in Kitui noted that: „There is this other one that when women are pregnant, they are afraid to go to the hospital because of HIV testing so some have that fear so they are afraid to go to the hospital as they will be asked to take the test. At times you find there are those women who used to assist there before, back in the community, they are now afraid of AIDS, and when a woman gets to deliver they are afraid to assist, the woman is neglected and she dies due to their fear." Although this problem is not unique to vouchers, the program can contribute towards addressing it by enhancing the capacity of the distributors and providers to offer clients more information on the importance of HIV testing and counseling during antenatal care or delivery visit.'
Finding7	VMS Delayed/irregular reimbursements
Illustration	'Perceptions among providers that the claims and reimbursement process is slow: There was a perception among providers that the claims and reimbursement process was slow and cumbersome. One provider in Kiambu noted that: „I think the process of reimbursement takes too long. There"s a time you claim and the time you are receiving this money it takes quite a while." Some of the delays were occasioned by challenges to the claims processing system within the VMA'
Finding8	VMS Inadequate communication between provider and voucher management agency
Illustration	'Lack of proper communication between the VMA and the providers further undermined the claims and reimbursement process: In-depth interviews with providers showed that they did not receive information detailing what is reimbursed and what is not and the reasons for rejected claims. One provider in Kiambu noted that: „Feedback is not good at all because you write to them, you communicate through the mobiles, you call them for meetings but you just discuss. There is no solution to it." For effective implementation, there is need for continuous flow of information not only between the VMA and the service providers but among all partners involved in the program.'
Finding9	VMS Reimbursements too small
Illustration	'Some private providers still felt that the reimbursable amount was not enough: Although the actual reimbursement rates were negotiated, some private providers felt that the ceiling set was too low. One private provider in Kiambu reported that: „I also feel the amount of money they are giving us is not enough" When it comes to normal delivery, our normal delivery ranges from five to around eight or ten thousands but the OBA they are giving us four thousands Come to C/S, our C/S ranges from about twenty one to around thirty. They are only giving us twenty thousand."'
Finding10	VMS A policy champion
Illustration	'Effective leadership and implementation: Having a policy champion at the lead executing agency for Phases I and II of the program (the National Coordinating Agency for Population and Development, NCAPD) ensured effective leadership and implementation of the program. This was achieved through popularizing the program within government and donor circles that in turn ensured appropriate political and financial support for it.'
Finding11	VMS Appropriate involvement of Ministry of Health departments
Illustration	'Limited involvement of the Ministry of Health: Although the Division of Reproductive Health was a member of the Advisory Board and Steering Committee there was little involvement during Phase 1. This may have resulted in missed opportunities in the needed reproductive health expertise. However they played a key role as the coordination of the Technical Committee on Quality Assurance in monitoring existing facilities and accrediting new ones.'

Finding12	VMS Monitoring of accredited facilities was fragmented as the mandated organisation did not follow established procedures
Illustration	'Fragmented monitoring of accredited facilities by National Hospital Insurance Fund (NHIF): This parastatal institution was given the mandate to carry out accreditation of health facilities and Quality Assurance (QA) on a six monthly basis. Although a QA manual was developed for the program, NHIF rarely used it. Fortunately the Steering Committee supported the TCQA to carry out the QA activities in Phase 2.'
Finding13	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Unpredictability of context and bureaucratic processes may cause delays in implementation process: The implementation of the program has, however, been characterized by delays. The launching of the initial phase was delayed for four months due to the availability of funds. This caused subsequent delays in finalizing contracts for marketing, accreditation of facilities, and quality assurance. There were also further delays due to a gap in funding in 2008 pending final contracts for Phase II of the program. Through this experience, there may be need to factor in sufficient time to account for unpredictability of events.'
Finding14	VMS Use of local administrative and leadership structures
Illustration	'Use of the provincial administration vital for creating awareness and for distribution: Using local administrative structures including community and opinion leaders played a vital role in creating awareness about the program. The local administrative structures further served as fixed distribution points for the vouchers.'
Finding15	VMS Poverty screening tool based on local markers
Illustration	'Use of poverty grading tool ensured appropriate targeting of the poor: The use of the poverty grading tool to identify beneficiaries coupled with visits to potential beneficiaries" homes to confirm the information provided resulted in adequate targeting in some sites. As one elder noted during FGD in Nairobi: „I think they have reached the poor. If the intention is to reach the poorest of the poor, vetting must be done" As I told you, no complaints about discrimination or other underhand practices have reached our offices so far as I am concerned."'
Finding16	VMS Poverty screening tool based on local markers
Illustration	'Instances of leakage: Despite the use of the poverty grading tool in targeting of beneficiaries, there was evidence of leakage of the vouchers to non-poor women. For instance, 20% of non-poor women (according to the grading tool) living near facilities that have implemented the program since 2006 reported having ever used the vouchers'
Finding17	VMS Poverty screening tool based on local markers
Illustration	'Instances of some eligible clients missing out: Distributors and community members reported during FGDs that the poverty grading tool had some shortcomings in its scoring system as it sometimes left out genuine needy cases. For example, one FGD participant in Kiambu noted that: „„for me, my husband lost his job and I do not work. Now we have no money and we live in this small room. We thought living in this small room as squatters made us voucher client but they refused." This suggests the need for periodically assessing the eligibility criteria and revising the poverty

	grading tool to reflect the changing poverty levels given that poverty indicators are not static. There is also need to explore how community members can be involved in vetting the poor'
Finding18	VMS Use range of media to educate target population about benefits and how to get them
Illustration	'Use of multiple marketing campaigns had varied levels of success: Initial plans to use multiple marketing campaign strategies such as local radio advertisement, road shows and information materials had varied levels of success. For instance, radio broadcasts worked well in Kisumu but not in Kiambu where it attracted many people from Nairobi who were not the target population and had to be discontinued.'
Finding19	VMS Use of local administrative and leadership structures
Illustration	'However, weak marketing strategy especially in remote rural settings led to inadequate information on the program: The VMA contracted an agency, Lowe Scanad, to undertake the marketing activities with a view to creating demand. The marketing agency"s role was limited by budgetary and time constraints as well as the complex strategies required in Phase 1 only. Their role was reduced to a one-off activity with limited interactions across sites. For effective implementation, there is need for the program to have a continuous social marketing strategy that involves community members such as using local leaders to identify distributors.'
Finding20	VMS Providers" knowledge of details of scheme
Illustration	'Lack of adherence to guidelines by providers partly contributed to delays in claims processing and reimbursement: Some providers violated the guidelines by attending to clients for conditions not included in the benefit package resulting in rejections of claims. Other claims were rejected because the claim forms were signed by hospital staff on behalf of the clients, the providers tampered with the voucher details, incomplete or inconsistent documentation, and late submission.'
Finding21	VMS Providers" knowledge of details of scheme
Illustration	'Staff transfers posed additional challenges to the claims and reimbursement process: Once providers who were trained on the voucher process moved elsewhere, there was limited or no additional training or updates for new staff. This resulted in poorly completed claims forms which were then rejected by the VMA. This in turn delayed the reimbursement process as the VMA sent back the claims forms for amendments. Coupled with problems of lack of adherence to program guidelines, this suggests the need for continuously training service providers on the voucher process.'
Finding22	VMS Standard operating procedures for claims process
Illustration	'Lack of standard operating procedures that could provide guidance on the claims process: There was lack of standard operating procedures to guide the claims process. Putting in place such procedures could have minimized the chances of rejections attributable to poor documentation.'
Finding23	VMS Mechanisms to support quality improvements of service providers

Illustration	'Evidence of exceptions in the accreditation process: Some facilities were, however, accredited due to their remote location even though they did not meet set standards in order to enhance competition and client choice with the understanding that service quality would improve over time. Such facilities were given a grace period to improve quality and achieve requisite score for accreditation.'
Finding24	VMS Mechanisms to support quality improvements of service providers
Illustration	'Lack of clarity regarding the role of NHIF in accreditation undermined quality assurance: It was evident that there was lack of clarity regarding the role of NHIF in the accreditation process. Quality assurance inspection was also not implemented fully: Although quality assurance inspection was to be conducted every six months, this was not fully implemented. In addition, the accreditation process was not well synchronized with a feedback mechanism to the providers, especially regarding the areas that needed improvement.'
Finding25	VMS Attractive service package for institutional provider
Illustration	'Concerns about reimbursable amount, delays in reimbursement, and client volumes undermined service quality in private facilities: Some private providers were concerned that the ceiling set for reimbursement for various services was too little. Others raised concerns about delays in reimbursement while others were so overwhelmed by the demand of voucher clients that they could not serve their regular clients as they did before. This led to some of the private providers pulling out, limiting access for voucher clients or giving preference to those who can pay higher prices. One voucher client in Kiambu noted during FGD that: „The reception when you go to deliver is bad. Once they see the voucher, you are not lucky" There is a problem there because you cannot be received the same way as a person who has money."'
Finding26	VMS Physical improvements at facilities to cope with increased demand
Illustration	'Public health facilities faced challenges utilizing money from the program to improve service quality: Public health facilities did not initially have direct control of funds generated from the program given the government policy of managing such funds through the District Health Management Teams (DHMTs). The bureaucracy of accessing the funds therefore limited its use for exclusively improving service quality. One provider in Kitui reported during in-depth interview that: „I am telling you now this money we are not able to use it as the OBA money. It is consolidated as the hospital money so trying to push it back to the facility like now the maternity it is a struggle."'
Finding27	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Decline in voucher sales after initial increase due to funding gap: In spite of the initial dramatic increase in voucher sales, the number of vouchers sold stopped between October 2008 and May 2009 due to a nine-month gap in funding'
Finding28	VMS Health staff ask for informal payments
Illustration	'Dishonesty on the part of clients and some retailers provided additional challenge for effective distribution of vouchers: Participants in the FGDs reported how some women would provide false information and even rent a poor woman"s house in order to be eligible for the vouchers. In addition, some community health workers who were distributors sold the vouchers to non-poor women at higher prices. As one FGD participant in Kisumu noted: „Community health workers don"t charge the

	vouchers for 200/-, they will charge for 1,000/- to 1,500/- ."
Finding29	VMS Disrespectful and abusive care from health care staff
Illustration	'Instances of disrespectful and abusive care accorded some voucher holders in some sites: Although voucher clients were generally satisfied with the services, some reported poor service although indications were that this depended on the provider. As one voucher client in Kiambu noted during FGD: „Let me just say that the problems are many" When you go to the clinic you'll encounter them. When you went for services using the voucher, you would be told at the gate „Was I there when you got pregnant!" So when you go there you don't even talk, you just pray that you get served so you can leave."

The reproductive health vouchers program in Uganda. Summary of findings from program evaluation

Finding1	VMS Lack of available transport to facility
Illustration	'There were significant variations in the uptake of the HealthyBaby vouchers by district: Of the 104,547 HealthyBaby vouchers sold by June 2011, 56% had been redeemed for delivery services while 81% had been redeemed for at least one antenatal care visit. There were, however, significant variations between districts in the proportions of HealthyBaby vouchers that were redeemed for delivery services during the period, ranging from 96% in Kyenjojo to 15% in Hoima district (Table 2). Variations in the uptake of the vouchers by district could be due to availability of transport, distance to accredited facilities, perceived poor treatment by providers, or individuals in some areas purchasing the voucher for insurance.'
Finding2	VMS Facility too far from home
Illustration	'There were significant variations in the uptake of the HealthyBaby vouchers by district: Of the 104,547 HealthyBaby vouchers sold by June 2011, 56% had been redeemed for delivery services while 81% had been redeemed for at least one antenatal care visit. There were, however, significant variations between districts in the proportions of HealthyBaby vouchers that were redeemed for delivery services during the period, ranging from 96% in Kyenjojo to 15% in Hoima district (Table 2). Variations in the uptake of the vouchers by district could be due to availability of transport, distance to accredited facilities, perceived poor treatment by providers, or individuals in some areas purchasing the voucher for insurance.'
Finding3	VMS Disrespectful and abusive care from health care staff
Illustration	'There were significant variations in the uptake of the HealthyBaby vouchers by district: Of the 104,547 HealthyBaby vouchers sold by June 2011, 56% had been redeemed for delivery services while 81% had been redeemed for at least one antenatal care visit. There were, however, significant variations between districts in the proportions of HealthyBaby vouchers that were redeemed for delivery services during the period, ranging from 96% in Kyenjojo to 15% in Hoima district (Table 2). Variations in the uptake of the vouchers by district could be due to availability of transport, distance to accredited facilities, perceived poor treatment by providers, or individuals in some areas purchasing the voucher for insurance.'
Finding4	VMS Increased revenue and investment in capital

Illustration	'Significantly higher proportion of providers from voucher facilities reported increased workload compared to those from non-voucher facilities with varied consequences: To examine the impact of the voucher program on provider"s job satisfaction, interviews were conducted with 56 providers from 22 voucher (HealthyBaby and HealthyLife) facilities and 20 providers from 13 non-voucher facilities in 2010. Nearly all (98%) of the providers from voucher facilities reported an increase in the number of clients during the past year compared to 30% of providers from non-voucher facilities. This, however, had varied consequences. On the one hand, some providers reported increased revenue as a result of increased workload which enabled them to retain or hire more staff and improve facility infrastructure. Other providers reported gaining more experience and improving their skills as a result of the increased number of clients. On the other hand, 30% of the providers complained of being overworked as they were attending to double or triple the number of clients.'
Finding5	VMS Developing skills and capabilities through increased practice
Illustration	'Significantly higher proportion of providers from voucher facilities reported increased workload compared to those from non-voucher facilities with varied consequences: To examine the impact of the voucher program on provider"s job satisfaction, interviews were conducted with 56 providers from 22 voucher (HealthyBaby and HealthyLife) facilities and 20 providers from 13 non-voucher facilities in 2010. Nearly all (98%) of the providers from voucher facilities reported an increase in the number of clients during the past year compared to 30% of providers from non-voucher facilities. This, however, had varied consequences. On the one hand, some providers reported increased revenue as a result of increased workload which enabled them to retain or hire more staff and improve facility infrastructure. Other providers reported gaining more experience and improving their skills as a result of the increased number of clients. On the other hand, 30% of the providers complained of being overworked as they were attending to double or triple the number of clients.'
Finding6	VMS Increased workload
Illustration	'Significantly higher proportion of providers from voucher facilities reported increased workload compared to those from non-voucher facilities with varied consequences: To examine the impact of the voucher program on provider"s job satisfaction, interviews were conducted with 56 providers from 22 voucher (HealthyBaby and HealthyLife) facilities and 20 providers from 13 non-voucher facilities in 2010. Nearly all (98%) of the providers from voucher facilities reported an increase in the number of clients during the past year compared to 30% of providers from non-voucher facilities. This, however, had varied consequences. On the one hand, some providers reported increased revenue as a result of increased workload which enabled them to retain or hire more staff and improve facility infrastructure. Other providers reported gaining more experience and improving their skills as a result of the increased number of clients. On the other hand, 30% of the providers complained of being overworked as they were attending to double or triple the number of clients.'
Finding7	VMS A policy champion
Illustration	'Wider buy-in for the voucher program among key actors was crucial for its successful inception: The voucher program was conceptualized against the backdrop of poor careseeking patterns and high STI prevalence in Uganda. It was also informed by KfW"s prior experience financing social marketing of condoms through MSI-U. The program therefore met the strategic interests of KfW, which viewed it as a promising health financing strategy, and MOH, which considered it a promising strategy for removing financial barriers to accessing reproductive health care.'
Finding8	VMS A policy champion
Illustration	'Successful establishment of the program was also dependent on policy champions: Policy champions from the National STD/AIDS Control Program and the Commissioner for Reproductive Health were instrumental in the initial establishment of the voucher program. They not only popularized the program within government circles but also worked closely with the VMA to ensure

	that its design was in line with the MOH policy objectives.'
Finding9	VMS Draw on existing experience in claims processing systems
Illustration	'Prior experience of the voucher management agency gave it some advantages in program management: MSI-U was awarded the role of the VMA based on its previous experience with KfW in condom social marketing and with running a network of reproductive health clinics.'
Finding10	VMS Thorough start-up planning
Illustration	'There was delayed roll-out of the voucher programs: The implementation process for the HealthyLife and HealthyBaby vouchers began in 2004 and 2005 respectively. However, actual roll-out of the respective vouchers started in late 2006 and late 2008. This was occasioned by the time needed for program planning, accrediting and contracting providers, developing a referral network, and putting in place strong anti-fraud procedures.'
Finding11	VMS Poverty screening tool based on local markers
Illustration	'Use of poverty grading tool in the HealthyBaby voucher program ensured appropriate targeting of the poor: The use of the poverty grading tool to identify beneficiaries of the HealthyBaby vouchers resulted in adequate targeting. For instance, of the 48,986 HealthyBaby vouchers sold between December 2008 and July 2010, 98% of the sales were to those who scored less than 10 points on the poverty grading tool and hence considered poor.'
Finding12	VMS Steady supply of funds, vouchers and a routine reimbursement system
Illustration	'Need for fraud control and timely reimbursement created delays and complications in processing claims: In 2006, the VMA outsourced claims processing with Microcare; data was being processed manually, which resulted in many claims being flagged as non-compliant leading to a backlog of unpaid claims. Moreover, internal uncertainty on the reliability of the process led to its temporary suspension between February and October 2008. The current Claims Processing Database Management System (CPDMS) was developed in 2009 but the system began to function early 2010, leading to a backlog of data to be processed. Although the VMA took steps to improve on the process, it still took on average two months from seeing the client to approval of electronic payment for both HealthyLife and HealthyBaby vouchers.'
Finding13	VMS Clear procedures for removing low performing providers from the scheme
Illustration	'Verification of claims to ensure compliance with medical and financial standards went through different stages: Initially in 2006, the database was intended to red flag questionable claims for manual review. However, the system identified a very high proportion of claims as problematic, which reduced the usefulness of the program as a great majority of claims required manual review. By late 2006, the regional VMA office in Mbarara hired a medical expert to vet the claims. In the expansion since 2009, vetting teams do spot checks on samples of claims to check for compliance with medical and financial standards in order to control fraud. In cases where fraud was evident or highly probable, the claims were rejected, the providers were paid a fraction of the claimed amount, or they were suspended from the program.'
Finding14	VMS System to detect informal payments and corruption

Illustration	'Verification of claims to ensure compliance with medical and financial standards went through different stages: Initially in 2006, the database was intended to red flag questionable claims for manual review. However, the system identified a very high proportion of claims as problematic, which reduced the usefulness of the program as a great majority of claims required manual review. By late 2006, the regional VMA office in Mbarara hired a medical expert to vet the claims. In the expansion since 2009, vetting teams do spot checks on samples of claims to check for compliance with medical and financial standards in order to control fraud. In cases where fraud was evident or highly probable, the claims were rejected, the providers were paid a fraction of the claimed amount, or they were suspended from the program.'

Using vouchers to increase access to maternal healthcare in Bangladesh

Finding1	VMS Price of medicines and other tests not covered by voucher
Illustration	'Approximately, two-thirds of the women showed interest to receive more services from the health facility and all the respondents wanted to receive delivery care from the facility. Six respondents cited financial difficulties related to transport and medicines during ANC, PNC, and delivery.'
Finding2	VMS Prohibitive travel costs to health facilities
Illustration	Approximately, two-thirds of the women showed interest to receive more services from the health facility and all the respondents wanted to receive delivery care from the facility. Six respondents cited financial difficulties related to transport and medicines during ANC, PNC, and delivery
Finding3	VMS Potential beneficiaries lack of knowledge of scheme provisions
Illustration	'One voucher recipient said, „The fieldworker of our locality did not inform me how to use the voucher book. I did not know that she (fieldworker) had listed my name as one of the poor. She just called me to her home and gave me the book and did not provide any information regarding it. So, I did not use it.‟ The more frequent cited reasons for not accessing delivery care from a health facility included: „ Women were not informed that delivery care could be accessed in exchange for a voucher.' 'Similar comments were made concerning PNC services. Half of the women had not been informed that they could access PNC services using the voucher book. Others reported not seeing a need for the service, anticipating a delay in treatment by the service provider, and having to wait a long time at the facility.'
Finding4	VMS Women felt no need to have an institutional delivery
Illustration	The more frequent cited reasons for not accessing delivery care from a health facility included: „ Women did not feel there was a need for this service. „ Labor pains started suddenly, often in the night, and there was no opportunity to visit the facility. „ Family members were not available to accompany the women to the health facility. „Women were not informed that delivery care could be accessed in exchange for a voucher.
Finding5	VMS Difficulties travelling at night
Illustration	'The more frequent cited reasons for not accessing delivery care from a health facility included: „ Women did not feel there was a need for this service. „ Labor pains started suddenly, often in the night, and there was no opportunity to visit the facility. „ Family members were not available to accompany the women to the health facility. „Women were not informed that delivery care could be

	accessed in exchange for a voucher.'
Finding6	VMS Family members not available to accompany woman
Illustration	'The more frequent cited reasons for not accessing delivery care from a health facility included: „ Family members were not available to accompany the women to the health facility.'
Finding7	VMS Expected to give birth at parental home
Illustration	'In addition, other cited reasons were as follows: „Previous experience (e.g., unavailability of service provider/health facility closed) discouraged pregnant woman from visiting the facility. „ Traditional birth attendant (dai) was more convenient and performed the delivery at home. „Stayed at parent"s house during delivery. „ Felt that the service provider might delay treatment and not provide medicine.'
Finding8	VMS Women preferred to have home delivery
Illustration	'In addition, other cited reasons were as follows: „Previous experience (e.g., unavailability of service provider/health facility closed) discouraged pregnant woman from visiting the facility. „ Traditional birth attendant (dai) was more convenient and performed the delivery at home. „Stayed at parent"s house during delivery. „ Felt that the service provider might delay treatment and not provide medicine. Similar comments were made concerning PNC services. Half of the women had not been informed that they could access PNC services using the voucher book. Others reported not seeing a need for the service, anticipating a delay in treatment by the service provider, and having to wait a long time at the facility.'
Finding9	VMS Having to wait a long time at health facilities
Illustration	'Similar comments were made concerning PNC services. Half of the women had not been informed that they could access PNC services using the voucher book. Others reported not seeing a need for the service, anticipating a delay in treatment by the service provider, and having to wait a long time at the facility'
Finding10	VMS Clinical skills and capacity available
Illustration	'About 10% of voucher recipients did not utilize any type of vouchers for maternal health care services. In-depth interviews with 15 non-users indicated the following reasons for not using the vouchers for ANC: „Health facility was closed. „Service providers were not available at the facility. „ Women visited the health facility but did not access the service because of long queues.'
Finding11	VMS Poor users do not feel stigmatised by targeted scheme
Illustration	'The voucher users were asked whether they felt stigmatized because the vouchers were intended for the poorest of the poor; the respondents reported that they did not face discrimination.'

Effects of the Janani Suraksha Yojana on maternal and newborn care practices: women's experiences in Rajasthan

Finding1	SCP Potential beneficiaries" misinformed of scheme provisions
Illustration	Evidence from in-depth interviews indicates that notwithstanding its source, the information received by women regarding the JSY was skewed and, at times, incorrect. Of the 48 women who were interviewed in-depth, 27 reported being told that they would qualify for the cash benefit if they delivered in a government facility and another 10, if they opted for an institutional delivery. None of the women reported being informed that they could avail of JSY benefits if they delivered in an accredited private facility, or at home if they meet selected conditions. Indeed, some (six women) were emphatically told that they would not get any money if they delivered at home. For ex ample: She (ASHA) told me that "all those who deliver in the hospital can avail of the benefits of the scheme; those who give birth to their child at home cannot". [25 years, rural Alwar, received information from ASHA, ANM, medical officer, neighbours] "At the government hospital; they did not tell me about any other hospital. [24 years, rural Alwar, received information from an AWW] The dai (traditional birth attendant) told me that I could get Rs.1,400 if I deliver my child in the hospital; she only informed me about the money... (She said) those who deliver their child at Mundawar (Community Health Centre) get money. That"s all I was told... [23 years, rural Alwar, received information from ASHA, traditional birth attendant and neighbours] Findings, moreover, suggest that those who were informed that deliveries at government health facilities were eligible for JSY benefits were rarely informed about the different types of government facilities where they could (for example, PHC, CHC, district hospital) or could not (for example, normal sub-centre) avail of these benefits: The nurse said that whatever we spend on the delivery of the child, we get it back.... One doesn"t get money from the private hospital, we have to spend money in private hospitals. That"s all she said. [27 years, urban Jodhpur, received information from an ANM]
Finding2	SCP Potential beneficiaries" misinformed of scheme provisions
Illustration	As many as 34 of the 48 in-depth interviews contained discussions about whether women were informed about the amount of money that they are entitled to under the JSY. Of these, while 20 reported the correct amount, others did not seem to have been given any information or had been told that they would receive an amount other than that stipulated in the scheme as the following excepts illustrate: She did not tell me anything about the amount; she just told me that I would receive money. [25 years, rural Jodhpur, received information from a neighbour] The nurse told me that a woman receives money there (hospital)"I don"t know how much money a woman gets, she didn"t tell me anything about it. [21 years, rural Jodhpur, received information from an ANM] She informed me that I would get money if I deliver my child in the government hospital; she told me that I would get Rs.1,400 for a boy child and Rs.1,600 for a girl child. [21 years, rural Alwar, received information from an ASHA]
Finding3	SCP Health staff misappropriate funds or charge own fees for care covered by schemes
Illustration	A small minority of women (7%) reported having paid a bribe or made an unauthorised payment to the ASHA or a health care provider to get their cash entitlement; slightly more rural than urban women so reported (8% versus 2%). As evident from the excerpts given below, this included cases in which a health care provider had misappropriated the money under the pretext of fees and cost of medicines as well as women who had paid the health care provider voluntarily: They had not given it (cheque) immediately; they told me that I could not get it soon. When they gave the money to me, they had given me a cheque for Rs.1,300. He (doctor) told me that he had charged Rs.100 toward his fees. [21 years, rural Alwar] I had received Rs.1,400, but she (nurse) took Rs.400. for attending the delivery. We gave her Rs.200, but she refused page27 Effects of the Janani Suraksha Yojana on maternal and newborn care practices: Women"s experiences in Rajasthan would take Rs.400 only. She told us that she takes money from everyone whose delivery she attends. [21 years, rural Alwar]
Finding4	SCP Care at facilities thought to be of poor quality and unreliable
Illustration	During in-depth interviews, nonbeneficiaries cited several dimensions of poor quality of delivery care, including verbal abuse, denial of proper and timely care, not paying attention to women"s

	concerns and non-availability of the service provider, that had deterred them from seeking delivery services at public sector health facilities and therefore, from obtaining JSY cash assistance: I wanted to deliver my child at home because one of my sisters who had delivered a girl child had suffered badly at the government hospital because they had left the „dirt" in her stomach after the birth of the child; she had to go to the hospital again for a „clean up". After seeing her (plight), I lost the courage to deliver my child at the hospital. My mother-in-law had also seen my sister"s condition, that"s why they (in-laws) did not pressurise me. It happened with my neighbour too. They (health care providers) don"t give proper attention. They attend to the woman only after the head of the child is visible, and don"t touch the woman after the birth of the child. They scold and shout when the woman is suffering from pain; they don"t handle the woman correctly or encourage her. [24 years, urban Alwar, nonbeneficiary, delivered at home]
Finding5	SCP Disrespectful and abusive care from health care staff
Illustration	During in-depth interviews, nonbeneficiaries cited several dimensions of poor quality of delivery care, including verbal abuse, denial of proper and timely care, not paying attention to women"s concerns and non-availability of the service provider, that had deterred them from seeking delivery services at public sector health facilities and therefore, from obtaining JSY cash assistance: I wanted to deliver my child at home because one of my sisters who had delivered a girl child had suffered badly at the government hospital because they had left the „dirt" in her stomach after the birth of the child; she had to go to the hospital again for a „clean up". After seeing her (plight), I lost the courage to deliver my child at the hospital. My mother-in-law had also seen my sister"s condition, that"s why they (in-laws) did not pressurise me. It happened with my neighbour too. They (health care providers) don"t give proper attention. They attend to the woman only after the head of the child is visible, and don"t touch the woman after the birth of the child. They scold and shout when the woman is suffering from pain; they don"t handle the woman correctly or encourage her. [24 years, urban Alwar, nonbeneficiary, delivered at home] My family members wished that I should deliver in a health facility, but I refused.. I was scared because the nurses there do not take care of women properly. [20 years, urban Alwar, nonbeneficiary, delivered at home] My family members had asked me to deliver at the government hospital, but I did not go there. I am scared of hospitals and that"s why I decided to deliver my child at home. They keep women alone (do not allow them to bring a companion into the labour room). The doctors and nurses scold women. [25 years, urban Jodhpur, nonbeneficiary, delivered at home]
Finding6	SCP Family members not available to accompany woman
Illustration	The preference of women or their family members for a home delivery and the constraints faced by women at the family level, including lack of an escort and time to visit a health facility for delivery were cited by 19 percent of nonbeneficiaries, and slightly more rural than urban women so reported (20% versus 13%): If my family members had taken me to the hospital, I would have gone. [22 years, rural Jodhpur, non-beneficiary, delivered at home] It was my wish because the child is delivered better at home. My family members also wished that I should deliver my child at home. [19 years, rural Jodhpur, non-beneficiary, delivered at home]
Finding7	SCP Women preferred to have home delivery
Illustration	The preference of women or their family members for a home delivery It was my wish because the child is delivered better at home. My family members also wished that I should deliver my child at home. [19 years, rural Jodhpur, non-beneficiary, delivered at home]
Finding8	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	I didn"t know about it (JSY) at the time of the birth of my daughter; I came to know after her birth. As I didn"t know, I had gone to a private hospital for delivery. Had I known earlier, I would have gone to

	a government hospital. [25 years, rural Alwar, non-beneficiary, delivered in a private hospital]
Finding9	SCP Health facilities subvert scheme for financial gain
Illustration	Other reasons cited by non-beneficiaries included those related to access to a health facility, the family"s economic status, non-compliance with the formalities required to receive the cash assistance and wrong assessment of the expected time or date of delivery, as indicated by the following excerpts: They told us that we would not get money as we had taken the cottage ward (private ward where one pays for services). [20 years, urban Jodhpur, non-beneficiary, delivered in a government hospital] I didn"t know that the child would be born that day; that"s why I couldn"t avail of the benefits of the scheme. I had gone for a sonography and she (health care provider) told me that I would deliver on the 21st and there was still one more month for the child to arrive. However, she (my daughter) was born before the expected date of delivery given to me. [26 years, rural Alwar, non-beneficiary, delivered at home] I had been vaccinated at a private hospital, so I didn"t have the mother and child card. They (staff at the government hospital) told me that I would not get money as I didn"t have the card. [25 years, rural Jodhpur, non-beneficiary, delivered in a government hospital]
Finding10	SCP Health staff deduct proportion of money before disbursement
Illustration	A small minority of women (7%) reported having paid a bribe or made an unauthorised payment to the ASHA or a health care provider to get their cash entitlement; slightly more rural than urban women so reported (8% versus 2%). As evident from the excerpts given below, this included cases in which a health care provider had misappropriated the money under the pretext of fees and cost of medicines as well as women who had paid the health care provider voluntarily: They had not given it (cheque) immediately; they told me that I could not get it soon. When they gave the money to me, they had given me a cheque for Rs.1,300. He (doctor) told me that he had charged Rs.100 toward his fees. [21 years, rural Alwar] I had received Rs.1,400, but she (nurse) took Rs.400. for attending the delivery. We gave her Rs.200, but she refused and told us that she would take Rs.400 only. She told us that she takes money from everyone whose delivery she attends. [21 years, rural Alwar]
Finding11	SCP Family members more supportive of women"s health care seeking
Illustration	A couple of women observed improvements even at the family level, as evident from the excerpts below: Family members take care of the woman in case she experiences any problem because one gets a cash benefit. [25 years, rural Alwar]
Finding12	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Qualitative data indicate that such assistance included getting the „mother and child card" prepared, completing various formalities at the health facility, accompanying women or family members to the facility to collect the cheque for the JSY entitlement and escorting women to the bank to encash the cheque: No, I didn"t face any problem at the bank as didi (ASHA) was with me- I deposited the cheque in the bank and got the money. [25 years, rural Alwar] I didn"t get time to go to the hospital to collect the cheque; my husband went with her (ASHA) and brought the cheque. [24 years, rural Jodhpur] She had done everything nicely. She helped me in getting my card (mother and child card); she had filled out the form and taken it to the doctor. [21 years, urban Jodhpur]

Meeting the Health Needs of the Poor: Social Audit in Uttar Pradesh

Finding1	SCP Potential beneficiaries" lack of knowledge of scheme provisions

Illustration	The findings reveal that most of the women were not aware of JSY and almost all of them did not receive any cash assistances. Regarding JSY, the same question was asked from the ASHA and ANM - whether they knew if a woman was entitled to the JSY money and if AHSA was entitled to receive cash assistance from the scheme.
Finding2	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Ground Reality - 4: A woman who went through child birth six months preceding the interview said, “Who is the ASHA? I don"t know her, I only know the ANM. During child birth, the ANM took Rs 30 from me to take me to the PHC. The PHC doctor was asking for Rs 500. I had no money so I came back home. Later, the ANM came to assist in the child birth. I had to give her Rs 300. After that nobody came to see me.”
Finding3	SCP Training programme not sufficient
Illustration	Problems faced by the ASHAs (a) People in village don"t think we are important and the don"t like to discuss their problems with us. (b) We don"t have full knowledge about our work because our full 24 days of training has not been completed (c) We are unclear about what we have to do and how we are supposed to do it (d) The ANM takes money for immunisation. (e) The ANM does not cooperate with us. In fact, she treats us like her assistant. (f) The women don"t get the JSY benefit, so there is a lot of pressure on us. The community thinks we have taken the money. (g) Our role is not clear (h) We don"t have any information about the JSY. (i) Problem in coordination with the ANM and AWW (j) We visit every house and still don"t get any money. (k) We lack practical knowledge (l) The training was not very practical. It was bookish and not interactive.
Finding4	SCP Promoters can be targets for informal payments demanded by providers
Illustration	Problems faced by the ASHAs (a) People in village don"t think we are important and the don"t like to discuss their problems with us. (b) We don"t have full knowledge about our work because our full 24 days of training has not been completed (c) We are unclear about what we have to do and how we are supposed to do it (d) The ANM takes money for immunisation. (e) The ANM does not cooperate with us. In fact, she treats us like her assistant. (f) The women don"t get the JSY benefit, so there is a lot of pressure on us. The community thinks we have taken the money. (g) Our role is not clear (h) We don"t have any information about the JSY. (i) Problem in coordination with the ANM and AWW (j) We visit every house and still don"t get any money. (k) We lack practical knowledge (l) The training was not very practical. It was bookish and not interactive.
Finding5	SCP Staff are targets for complaints and criticism of the programme
Illustration	Problems faced by the ASHAs (a) People in village don"t think we are important and the don"t like to discuss their problems with us. (b) We don"t have full knowledge about our work because our full 24 days of training has not been completed (c) We are unclear about what we have to do and how we are supposed to do it (d) The ANM takes money for immunisation. (e) The ANM does not cooperate with us. In fact, she treats us like her assistant. (f) The women don"t get the JSY benefit, so there is a lot of pressure on us. The community thinks we have taken the money. (g) Our role is not clear (h) We don"t have any information about the JSY. (i) Problem in coordination with the ANM and AWW (j) We visit every house and still don"t get any money. (k) We lack practical knowledge (l) The training was not very practical. It was bookish and not interactive.
Finding6	SCP Relatives of influential people more likely to become paid facilitators

Illustration	The DPMUs had their version on the selection of ASHAs. For instance, one DPMU said, "The government has started ASHA scheme because ANMs can't reach out to every village. With the help of ASHA, people will get total benefit of the health services. But his objective is still a distant goal as AHSA have not been selected in a transparent way. Political parties are playing a big role in selection and they are trying to place their own wives, daughters-in-laws and other relatives as ASHA. For example, at the Panchayat level, if Gram Pradhan has made his wife an ASHA, we all have to rethink how much work she will do for the community. On second thoughts, until the ASHA starts working unselfishly, the health system will not improve."
Finding7	SCP Health staff subvert scheme for financial gain
Illustration	In every district, the social audit reveals that ASHAs were lied to and told that they would be salaried employees of the government and in return were asked to pay anything between Rs 2,000 to 7,000 for their selection. One of the ASHAs said, "I had to sell off my cooking utensils and silver payal (anklet) that was around 250 grams as they (the ANM and Health Inspector) asked Rs 7,000 from me, but I was only able to give Rs 2,000 to them. They told me that I will get Rs 3,000 per month as salary." Another ASHA had to borrow Rs 7,000 from the bank as she was told she would get paid Rs 3,500 per month and would have to give two months salary. The audit reveals that those who were not abe to pay the money on tie were sent for training a day late as punishment. The audit also states that ASHAs are selected from higher socio-economic groups, which will affect their work performance negatively as they would be less likely to visit poor, Dalits and underprivileged women and families.
Finding8	SCP Recognise and attempt to reduce high transaction costs
Illustration	Most of the ASHAs did not get their share of Rs 600 and those who did receive some money stated that the time and energy spent was not equivalent to the amount they were paid. The ANM also said that not all women who had opted for institutional childbirths have obtained the JSY assistance. Asked why women have not gotten the money, the ANM said, "The money has not yet come."
Finding9	SCP Clearly defined roles and training for community workers / volunteers
Illustration	The ASHAs were asked for suggestions for their effective involvement in the programme. They said: (a) After selection, the full 24 days of training is very important. This will help us understand our role and responsibilities. (b) Economic support is vital as this gives us incentive to work. We must get paid for our service as soon as possible. (c) People should be willing to share their problems with us. (d) The training should be held in the same area we live as we don't want to commute every day. It involves time and energy. (e) The PHC should provide us with clear guidelines as soon as possible. (f) The ANM should visit the village on a regular basis. (g) The ASHAs should get selected in open meetings. (h) The ASHA, AWW and ANM should meet every Wednesday at the AWC. (i) There needs to be better coordination between the AWW and ANM. (j) The ANM should give advice to the ASHA from time to time. (k) The training should be more practical
Finding10	SCP Clinical skills and capacity available
Illustration	i) Sub-Centre The findings reveal that - Not every Sub-Center has a female health worker. - Most of the centres do not have a male health worker. - Not all of the centres are running in a pukka makan (brick houses). - Not every centre has a safe drinking water facility. - Most of the centres don't have a toilet facility. - Most of the centres are not very clean. - Most of the centres lack the following equipment: BP machine, Weighing machine, Blood test kit, Test tube for urine test, Delivery facility, Fetascope, ORS packets, Iron tablets, Vitamin A syrup, Copper-T facility. But most of the centres did have: - Registration for pregnant women. - Birth and death register. - JSY register. None of the centres had a notice board where working hours could be displayed. It has been observed that most of the centres have very poor infrastructure and are not up to the mark.

Finding11	SCP Clinical skills and capacity available
Illustration	ii) Primary Health Centres It was observed that all of the PHCs had notice boards and working hours of the PHC was written on it. - Most of the centres had a medical officer. - None of the centres has a staff nurse. - Most of the centres are running in government-owned buildings. - None of the centres were clean. - None of the centres had a 24-hour facility. - Most of the centres don't have a drinking water facility. - Toilets were not clean. - Most of the centres don't have an ambulance facility.
Finding12	SCP Clinical skills and capacity available
Illustration	Interview with the Medical Officers The views and responses from them are listed below (district wise). Banda "The PHC doesn't have a doctor. Therefore, the compounder sometimes works as the doctor. The centre does not have electricity or water facility so we can only admit a patient for a day. In the village, one surgeon and female doctor must be appointed. We don't have any money for maintenance. The people from the CHC do everything, thus, we have to depend on them." Barabanki "In Barabanki district, the PHC does not have its own building, but some how we are managing. There isn't a facility for safe childbirth at the centre. There isn't even a medical facility at the centre." Mirzapur "There are not enough doctors in some places. Only one doctor is running the entire centre." Muzaffarnagar "Since there is a shortage of female health workers, women don't come here for child birth. The ANM comes to the centre once a week. Women talk about their problems only with the ANM and only the ANM knows about it."
Finding13	SCP Clinical skills and capacity available
Illustration	iii) Community Health Centre The conditions of most of the CHCs were not up to the mark. The findings reveal that centres do not have: - Electricity - Drinking water - Toilet facilities - Female doctors - Specialists - Surgeon - Gynaecologist - Paediatrician - General physician - The centres don't have 24-hour services for child births (normal or complicated). - A 24-hour facility where people can get medication.
Finding14	SCP Clinical skills and capacity available
Illustration	Proper maternal healthcare is still out of reach in the state. Since 60 per cent of maternal deaths occur during the postpartum period, the care during this period is crucial. There is a great need for a health system where community and health personal collaborate in order to meet the goals of the NRHM. Health facilities at the Sub-Centre, PHC and CHC level are not up to the mark and hence unable to meet the needs of the people.

Use and misuse of a discount voucher scheme as a subsidy for insecticide-treated nets for malaria control in southern Tanzania

Finding1	VMG Focus efforts against misuse of vouchers on the clinics that distribute them, through training, follow-up and supportive supervision
Illustration	Our results may be of some use to those planning ITN voucher schemes on a national scale. First, this study would suggest that efforts to minimize voucher misuse might be focused at MCH clinics, and to a lesser extent at commercial sales agents. Where vouchers are distributed by MCH staff, particular attention might be paid to their training, follow-up and supportive supervision. Although voucher distribution adds to the work-load of MCH staff, it should be noted that selling ITNs is typically a much larger burden; and that a number of MCH clinics in our study who were selling ITNs were overcharging their clients.

Finding2	VMG Promotion of the scheme can help to reduce voucher misuse by increasing awareness and accountability
Illustration	'Secondly, major promotion of the scheme is likely to help reduce misuse, including awareness of the right of every pregnant woman and mother of a young child to a voucher. This awareness campaign should include community leaders and men as well as women, so that they can exert their authority to control voucher misuse.'
Finding3	VMG Very poor women benefited from an option to pay by instalments for insecticide-treated nets
Illustration	'Staff interviewed at three clinics that sold discounted nets were asked why they did not issue vouchers. They said that it allowed them to check eligibility, avoided women accidentally destroying or losing the vouchers, and reduced the women"s workload as they did not need to walk to another place to redeem the voucher. They thought that their approach motivated women to find the money to purchase a net. In one clinic, women could pay by instalments and this seemed to have increased net purchases, especially by very poor women.'
Finding4	VMG Voucher and net issue at different locations is inconvenient for beneficiaries
Illustration	'When asked „„should the value of the voucher be changed"", 84/104 (81%) said it should be increased, to TSh1000 (41, 49%), Tsh1500 (24, 29%) and Tsh2000 (19, 23%). In FGDs, it was suggested that nets should be sold by all MCH clinics: „„getting a voucher from one place and a net from another is very inconvenient"" (Ulanga village, phase 1 area).'
Finding5	VMG Measures to prevent imposition of unofficial selection criteria
Illustration	'Staff interviewed at three clinics that sold discounted nets were asked why they did not issue vouchers. They said that it allowed them to check eligibility, avoided women accidentally destroying or losing the vouchers, and reduced the women"s workload as they did not need to walk to another place to redeem the voucher. They thought that their approach motivated women to find the money to purchase a net. In one clinic, women could pay by instalments and this seemed to have increased net purchases, especially by very poor women. When queried why vouchers were not given to all eligible women, answers ranged from „„the scheme was not clear to me"" to „„such a system was already in place"". Staff interviewed at two clinics that did not sell nets said they only gave vouchers to women who specifically wished to buy a net, and who were required to show their antenatal or child health cards.'
Finding6	VMG Adaptation of scheme to local preferences
Illustration	'Staff interviewed at three clinics that sold discounted nets were asked why they did not issue vouchers. They said that it allowed them to check eligibility, avoided women accidentally destroying or losing the vouchers, and reduced the women"s workload as they did not need to walk to another place to redeem the voucher. They thought that their approach motivated women to find the money to purchase a net. In one clinic, women could pay by instalments and this seemed to have increased net purchases, especially by very poor women. When queried why vouchers were not given to all eligible women, answers ranged from „„the scheme was not clear to me"" to „„such a system was already in place"". Staff interviewed at two clinics that did not sell nets said they only gave vouchers to women who specifically wished to buy a net, and who were required to show their antenatal or child health cards'

Finding7	VMG Build in evaluation design before beginning implementation
Illustration	'When asked „should the value of the voucher be changed"", 84/104 (81%) said it should be increased, to TSh1000 (41, 49%), Tsh1500 (24, 29%) and Tsh2000 (19, 23%). In FGDs, it was suggested that nets should be sold by all MCH clinics: „getting a voucher from one place and a net from another is very inconvenient""(Ulanga village, phase 1 area).'
Finding8	VMG System to detect informal payments and corruption
Illustration	'Supervision of the scheme at clinic level was relatively poor. Regular supervision and checking is likely to reduce misuse at clinic level. Secondly, training of MCH staff and ongoing promotion of the voucher scheme may need to focus on the right of each woman to receive a voucher. Greater awareness among women might have made it less easy for MCH staff to withhold vouchers.'
Finding9	VMG Use range of media to educate target population about benefits and how to get them
Illustration	'Supervision of the scheme at clinic level was relatively poor. Regular supervision and checking is likely to reduce misuse at clinic level. Secondly, training of MCH staff and ongoing promotion of the voucher scheme may need to focus on the right of each woman to receive a voucher. Greater awareness among women might have made it less easy for MCH staff to withhold vouchers.'
Finding10	VMG Health facilities subvert scheme for financial gain
Illustration	'We have shown minimal misuse of vouchers that reached the women and children for whom they were intended; that up to half of vouchers issued had been misused at MCH clinics that issued them; and that large-scale misuse was found in only three of 21 clinics. Our findings indicate that vouchers are a feasible system to deliver targeting subsidies to vulnerable populations, but that leakage during the delivery process was the main form of misuse'
Finding11	VMG Measures to prevent imposition of unofficial selection criteria
Illustration	'Some women interviewed, and those in all FGDs, said that MCH staff did not give vouchers to all eligible women, but only to those who brought money with them to the clinic to buy a net. At MCH clinics that also sold nets, vouchers were given out for redemption at shops only if the MCH had run out of nets'

Protecting the right of women to affordable and quality health care in Armenia: analysis of the Obstetric Care State Certificate Program

Finding1	VMS Strong political commitment is required to sustain programmes
Illustration	'The Program also assures that more expectant mothers utilize their antenatal centers in marzes because they receive their certificate for maternity services there; as a result, the salaries of antenatal care obstetrician/gynecologists increased. According to expert-participants there is a strong political commitment by the Government to the Obstetric Care State Certificate Program, assuring sustainability.'

Finding2	VMS Budget increases may be required for programme sustainability
Illustration	The expert participants indicated that policy-makers decided to restrict the flow of expectant mothers from marzes to Yerevan for birthing services without a referral from their obstetrician/gynecologist in their marz - a draft order for this mechanism has been prepared but not approved yet. Participants also indicated about a need to increase the budget of the Program to improve its effectiveness and sustainability.
Finding3	VMS Reintroduction of informal payments to providers could jeopardise the programme
Illustration	'The providers and participants holding administrative positions emphasized that the biggest threat to the Program is the reestablishment of informal payments because physicians in the Program are dissatisfied with their salaries. A concern was raised that this dissatisfaction may also eventually reduce the quality of services. Some providers also indicated a concern about declining financial transparency in the Program.'
Finding4	VMS Providers in rural areas may lose income from patients who travel to larger facilities to give birth
Illustration	'Another concern raised by providers in the marzes was their potential loss of income due to expectant mothers who travel to Yerevan to give birth and are advised in Yerevan to have their next antenatal care for future pregnancies provided in Yerevan.'
Finding5	VMS Loss of patients and revenue to larger facilities
Illustration	'The problem is that the total number of deliveries is very low, thus the bonus mechanism does not work [for the marzes]. At the beginning [of the Program], for example, when women did not consider the possibility of delivering in Yerevan, all the expecting mothers came to our hospital and I was paid half-a-million drams for the first month. Now I am paid about 120,000 drams per month „ nothing comparable.'
Finding6	VMS Loss of patients and revenue to larger facilities
Illustration	'Doctors have lost income, because before this Program they were managing all money flows and had higher incomes.'
Finding7	VMS Loss of patients and revenue to larger facilities
Illustration	'The monthly salary now is about 140,000 drams [for maternity service physicians]. Before the Program we received 70,000 drams per month plus extra payments, totaling twice or even three times the salary we receive today...'
Finding8	VMS Loss of informal payments
Illustration	'The flow of expectant mothers also reduced the salaries of obstetrician/gynecologists of marz maternity hospitals close to Yerevan. According to obstetrician/gynecologist participants from the

	marzes, their colleagues in the marzes have fewer patients because they cannot compete with the services in Yerevan. Moreover, the overall income of delivery care obstetrician/gynecologists in both Yerevan and marzes has decreased because informal payments have declined or been eliminated. Overall, all obstetrician/gynecologists of delivery services who participated in the study reported that they and their colleagues are not satisfied with their salaries. The increased percent of C-section out of all births with the start of the Program has increased the financial burden of the government because the costs of C-section are higher than for natural childbirth.'
Finding9	VMS Loss of informal payments
Illustration	'Just after the beginning of the Certificate Program, physicians earned very high salaries. Now the salaries have declined by a third though the patient-load is still the same because processes were put in place [by the hospital administration] to „regulate" the salaries of physicians.'
Finding10	VMS Loss of patients and revenue to larger facilities
Illustration	'Because of the expectant-mother flow for birthing services from the marzes in proximity with Yerevan, the obstetrician/gynecologist participants reported an immediate increase and then a decline in personal income in the longer term, leading to dissatisfaction among these physicians. Though obstetrician/gynecologist participants from nearby Ararat and Armavir marzes indicated dissatisfaction with salary levels and assumed that their low salaries are due to the patient flow to Yerevan. However, the providers from Tavush marz (which does not face the issue of patient flow because of its remoteness from Yerevan) and Yerevan were also unhappy about their salaries.'
Finding11	VMS Transparent reimbursement process for service providers
Illustration	'Study participants who were physicians indicated that the reported number of deliveries by a particular physician may be manipulated by the heads of maternity hospitals for a financial benefit. Physicians also believed that much of the state allocated designated salary funds from the Program do not reach the providers. Physicians from both marzes and Yerevan indicated that they cannot get information on how their salaries are calculated and that the calculations at facility level lack transparency.'
Finding12	VMS Transparent reimbursement process for service providers
Illustration	'Study participants who were physicians indicated that the reported number of deliveries by a particular physician may be manipulated by the heads of maternity hospitals for a financial benefit. Physicians also believed that much of the state allocated designated salary funds from the Program do not reach the providers. Physicians from both marzes and Yerevan indicated that they cannot get information on how their salaries are calculated and that the calculations at facility level lack transparency.'
Finding13	VMS Physical improvements at facilities to cope with increased demand
Illustration	'Study participants emphasized the need for improving condition of hospitals and hospital rooms, equipment and the quality of personnel, particularly in the marzes.'
Finding14	VMS System to detect informal payments and corruption

Illustration	'All study experts indicated that there is a major problem of internal management in the maternity hospitals. Some providers described how informal payments could be hidden from the current Program monitoring systems.'
Finding15	VMS System to detect informal payments and corruption
Illustration	'We [the government] need an assessment and more serious monitoring mechanisms. In the beginning of the Program we signed a statement with the heads of the facilities to minimize the risk of corruption. This year we have a new approach. We signed an agreement only for three months. Then we will update it based on their indicators and the results of monitoring. If the facility does not address government requirements, the Minister [of Health] can cancel the next agreement. But for this we need a valid and objective assessment of the Program. The Minister is attempting to find money from the budget to assign an NGO to conduct an assessment. Expert'
Finding16	VMS Transparent reimbursement process for service providers
Illustration	'The same analyses identified existing weaknesses in the Obstetric Care State Certificate Program. One of the major weaknesses is the inadequate monitoring of the financial flow of Program funds, leading to potential manipulation by hospital administrations and unofficial payments. There is currently a lack of transparency and accountability in how salaries are calculated and a serious concern that not all designated funds for salaries actually reach the providers. Major concerns were expressed that a reported universal dissatisfaction by maternity hospital doctors with their salaries could reestablish a higher level of informal payments and worsen the quality of provided services.'
Finding17	VMS Providers in rural areas may lose income from patients who travel to larger facilities to give birth
Illustration	'An additional weakness in the Program is the flow of normal deliveries from the marz maternity hospitals in close proximity to Yerevan to Yerevan maternity hospitals because of better quality facilities and services. This flow reduces the salaries of the obstetrician/gynecologists in the marz maternity hospitals near Yerevan and increases the costs to the government due to more expensive services in Yerevan tertiary centers. This threatens the financial viability of the maternity hospitals in those marzes.'
Finding18	VMS Health staff ask for informal payments
Illustration	'Paying for services was not enough - I also had to pay for an improvement in attitude because the personnel are not kind if they are not paid. I delivered in a hospital in Yerevan and I was in the paid ward because they told me that there was no free space.'
Finding19	VMS Health staff ask for informal payments
Illustration	'In the beginning of the Certificate Program there were no informal payments. Now there are informal payments. Physicians now know who will pay and who will not. Ob/gyn intrantal'
Finding20	VMS Health staff ask for informal payments

Illustration	'I was ready to pay a lot of money since I had a complicated pregnancy. The situation was very hard, but doctors saved my baby and me. They asked for 60,000 drams and we were ready to pay even more. In the Infant Department, the physician told me to pay the nurses so they would be more attentive. I paid 1,000 drams to the nurses for every visit. My room was free-of-charge. Mother'
Finding21	VMS Health staff subvert scheme for financial gain
Illustration	'There are mechanisms to take money from the patients especially from the marzes. When they register at the hospital they are offered a private room for a fee immediately, though there are free-of-charge rooms available as well. So they don"t lie but they don"t provide the whole truth" The hospital should give full information to the patients regarding free-of-charge and private rooms for a fee. But they do not provide full information and this only benefits [financially] the head of the hospital. Ob/gyn intrantal'
Finding22	VMS Health staff subvert scheme for financial gain
Illustration	'When I told my doctor [in a maternity hospital in Yerevan] that I want him/her to manage my delivery she/he agreed - in this case you have to pay 60,000 drams („non medical costs")for two nights in our hospital which includes room, mother and child utilities and food" I was supposed to have a room by myself, but because many women were giving birth, they asked me to share the other bed in my room with another woman" Before the monitoring committee came to check the services, they [the maternity hospital] asked me to tell the committee that I paid for non-medical services and not for choosing the doctor. Also they removed the other woman from the room and told me to tell the committee that I was alone in the room. Mother'
Finding23	VMS Health facilities subvert scheme for financial gain
Illustration	'Study participants who were physicians indicated that the reported number of deliveries by a particular physician may be manipulated by the heads of maternity hospitals for a financial benefit. Physicians also believed that much of the state allocated designated salary funds from the Program do not reach the providers. Physicians from both marzes and Yerevan indicated that they cannot get information on how their salaries are calculated and that the calculations at facility level lack transparency.'
Finding24	VMS Loss of informal payments
Illustration	'We are dissatisfied, which can lead to informal payments. Doctors are currently afraid to take informal payments but as soon as the control weakens they will take these payments because salaries are inadequate. Ob/gyn intrantal'
Finding25	VMS Loss of informal payments
Illustration	'If the current situation continues, informal payments will start again. Now doctors are afraid of being penalized for taking bribes but it is impossible to live with these salaries. Ob/gyn intrantal'
Finding26	VMS Users" dignity and confidence enhanced

Illustration	'According to participants, the Program not only provides the patients with free services but also improves the patients" and providers" dignity. Participants indicated that with the Certificate as a state guarantee of free maternity services, women feel more relaxed and self-confident. Moreover, the providers receive their money only through official routes and do not have informal financial relationships with patients or their relatives.'
Finding27	VMS Users" dignity and confidence enhanced
Illustration	'The Program impacted expectant mothers positively - now they are more self-confident and self assuredly showing their Certificate in the hospital that protects their rights. Ob/gyn intranatal'
Finding28	VMS Scheme"s purpose is to assert universal entitlement
Illustration	'The purpose of this program was to provide the population access to high quality services without considering their social status. Women receive many benefits from this Program: they can give birth to many children without worrying about the costs; they can come to Yerevan for delivery and stay in the best hospitals receiving the highest quality services for free, that before they could only dream about. Expert'

Assessment of Janani Suraksha Yojana in West Bengal

Finding1	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	Half of the community members had not heard anything about ASHA or JSY, while others had some information about the scheme. They said to the field investigators, “I have not heard about the word ASHA”. “First time I am listening about JSY from you, I have no idea about the scheme”. “Only 60-70 percent people in the community know about the scheme”. “Only those who go for institutional delivery can get the benefit of Rs. 700 and she must belong to BPL group. Three ANC check-ups is a must. One should visit sub-centre o contact ANM during the pregnancy period”.
Finding2	SCP Local facilitators misinformed about scheme eligibility / provisions
Illustration	While the PRI members were aware of the JSY and process of giving cash assistance, several of them had incomplete or wrong information. A PRI member commented, “The cash incentive goes to the pregnant women for both institutional delivery and home delivery like Rs 700 and Rs 500. The process is very simple, if she has completed her three ANC check-ups and belongs to BPL family, has up to two live births and the last child is below 1 year, cash assistance is given”.
Finding3	SCP Cash assistance not sufficient to meet expenses
Illustration	While MNGO had a major role to play, other NGOs were not much involved in the administering of the scheme in West Bengal. While discussing the JSY with a NGO staff member, he commented on the cash assistance, “People think medical expenses are very high and the cash assistance under JSY is very low”.
Finding4	SCP Lack of available transport to facility

Illustration	The community members suggested for pucca roads to ensure institutional deliveries for all. Transport facilities including car, van, tempo, rickshaw and ambulance are mostly available within the village, but it takes 30 - 40 minutes to reach the nearest health centre. In Mal Bazaar block of Jalpaiguri, a village leader said, “We have no transport facility in emergency. We call vehicle from 8 km away and it takes 1½ hour to reach the nearest heath centre.” Another villager from the block said “If transportation is not available on time and sometimes family members are also not available. In these cases, women deliver at home”.
Finding5	SCP Family members not available to accompany woman
Illustration	The community members suggested for pucca roads to ensure institutional deliveries for all. Transport facilities including car, van, tempo, rickshaw and ambulance are mostly available within the village, but it takes 30 - 40 minutes to reach the nearest health centre. In Mal Bazaar block of Jalpaiguri, a village leader said, “We have no transport facility in emergency. We call vehicle from 8 km away and it takes 1½ hour to reach the nearest heath centre.” Another villager from the block said “If transportation is not available on time and sometimes family members are also not available. In these cases, women deliver at home”.
Finding6	SCP Women wished to avoid certain obstetric or medical procedures
Illustration	Community members were asked about the reasons why women prefer home delivery. Almost all the informants talked about fears of doctor, caesarean or injections among others. They further mentioned lack of time, absence of transport facilities, shyness, distance of the facility as well as poor quality of services at the hospital as reasons for women to prefer home deliveries. Almost all the informants appreciated the scheme. In their words, “The scheme is good and takes care of women before delivery and mother and baby after delivery. Mothers and babies get nutritious food, medical help, and financial help”. A woman in the community suggested, “All women who benefited from the scheme should mobilize others for institutional delivery and every one in the community should ensure that every delivery in our village is conducted in hospital”.
Finding7	SCP Facility too far from home
Illustration	Community members were asked about the reasons why women prefer home delivery. Almost all the informants talked about fears of doctor, caesarean or injections among others. They further mentioned lack of time, absence of transport facilities, shyness, distance of the facility as well as poor quality of services at the hospital as reasons for women to prefer home deliveries. Almost all the informants appreciated the scheme. In their words, “The scheme is good and takes care of women before delivery and mother and baby after delivery. Mothers and babies get nutritious food, medical help, and financial help”. A woman in the community suggested, “All women who benefited from the scheme should mobilize others for institutional delivery and every one in the community should ensure that every delivery in our village is conducted in hospital”.
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Finding9	SCP Care at facilities thought to be of poor quality and unreliable
Illustration	Community members were asked about the reasons why women prefer home delivery. Almost all the informants talked about fears of doctor, caesarean or injections among others. They further mentioned lack of time, absence of transport facilities, shyness, distance of the facility as well as poor quality of services at the hospital as reasons for women to prefer home deliveries. Almost all the informants appreciated the scheme. In their words, “The scheme is good and takes care of women before delivery and mother and baby after delivery. Mothers and babies get nutritious food, medical help, and financial help”. A woman in the community suggested, “All women who benefited from the scheme should mobilize others for institutional delivery and every one in the community should ensure that every delivery in our village is conducted in hospital”.
Finding10	SCP Women wished to avoid certain obstetric or medical procedures
Illustration	Despite cash assistance paid under JSY for institutional delivery, many women prefer to deliver at home. A major reason is fear of all kinds including fear of caesarean section. Many women believed and said that “If I go to the hospital, they would opt for Caesarean section instead of waiting for a normal delivery”. Women further fear hospital equipment as well as doctors and/or nurses. It is crucial to address those fears; otherwise a large number of women will not come forward for institutional deliveries. There are women who are satisfied with the services available at the clinic, and had good experience at the hospitals. They could be utilized to come forward and motivate women to go for institutional deliveries. On the other hand, hospitals and staff also should constantly thrive to improve their credibility and image, so that women could access services without unnecessary fears. Further, a district official expressed one challenge to be embedded in traditions. He said: “The reluctance, the age-old traditional belief that the women, the mother, the mother-in-law have who all used to deliver at homes is the e. The social barrier to institutional delivery is the greatest challenge”.
Finding11	SCP Encourage women using those who were satisfied with their care
Illustration	Despite cash assistance paid under JSY for institutional delivery, many women prefer to deliver at home. A major reason is fear of all kinds including fear of caesarean section. Many women believed and said that “If I go to the hospital, they would opt for Caesarean section instead of waiting for a normal delivery”. Women further fear hospital equipment as well as doctors and/or nurses. It is crucial to address those fears; otherwise a large number of women will not come forward for institutional deliveries. There are women who are satisfied with the services available at the clinic, and had good experience at the hospitals. They could be utilized to come forward and motivate women to go for institutional deliveries. On the other hand, hospitals and staff also should constantly thrive to improve their credibility and image, so that women could access services without unnecessary fears. Further, a district official expressed one challenge to be embedded in traditions. He said: “The reluctance, the age-old traditional belief that the women, the mother, the mother-in-law have who all used to deliver at homes is the e. The social barrier to institutional delivery is the greatest challenge”.
Finding12	SCP Hospitals and staff should try to improve their credibility and image
Illustration	Despite cash assistance paid under JSY for institutional delivery, many women prefer to deliver at home. A major reason is fear of all kinds including fear of caesarean section. Many women believed and said that “If I go to the hospital, they would opt for Caesarean section instead of waiting for a normal delivery”. Women further fear hospital equipment as well as doctors and/or nurses. It is crucial to address those fears; otherwise a large number of women will not come forward for institutional deliveries. There are women who are satisfied with the services available at the clinic, and had good experience at the hospitals. They could be utilized to come forward and motivate women to go for institutional deliveries. On the other hand, hospitals and staff also should constantly thrive to improve their credibility and image, so that women could access services without unnecessary fears. Further, a district official expressed one challenge to be embedded in traditions. He said: “The reluctance, the age-old traditional belief that the women, the mother, the

	mother-in-law have who all used to deliver at homes is the e. The social barrier to institutional delivery is the greatest challenge".
Finding13	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	ANMs had to suggest that "If the money is provided during pregnancy and the amount is increased then the programme will be much more effective".
Finding14	SCP Cash assistance not sufficient to meet expenses
Illustration	ANMs had to suggest that "If the money is provided during pregnancy and the amount is increased then the programme will be much more effective".
Finding15	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	However, many did not get any cash or did not get their due amount. It is necessary that PRIs who are involved in the payment of cash ensure that women at least get their due payment including cash assistance for delivery and transportation. Often payments are delayed which causes a burden on the family and hampers the success of the program. The first payment of cash assistance is linked with three ANC check-ups. A district official mentioned, "I have noticed that only 90 percent of the JSY beneficiaries who had institutional delivery received money at the place of delivery. Besides, on an average, only 80 percent received money after the third ANC checkup".
Finding16	SCP Facility too far from home
Illustration	Further, a district officer puts forth, "Women do not want to travel far distance for institutional delivery. They are used to home deliveries. The before, we are trying to take the facilities as close as possible. Before promoting institutional deliveries sub-centres have to be upgraded, ANMs and Dais are being recruited at the sub-centre. Besides, women do not want to be examined outside".

Assessment of Janani Suraksha Yojana in Uttar Pradesh

Finding1	SCP Women who were satisfied with care can encourage others
Illustration	The issue of whether people in the remote rural areas were aware of the JSY and ASHA component was also raised by the district official. Even when the programme is well propagated, there is a need for strengthening the campaign. He said, "To promote the scheme further, these should be propagated at community (Janata) level. Moreover, satisfied beneficiaries could further promote the scheme to the mass community in the rural and urban areas."
Finding2	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	Irregularity of fund flow causes problems in the effective implementation of the programme. The district officials said that the funds received are adequate but not regular. A DHO said, "Till 2006, we were getting funds regularly, but in 2007, we did not get funds. Therefore we had problems in making payment to JSY beneficiary and ASHAs."

Finding3	SCP Clearly defined roles and training for community workers / volunteers
Illustration	With reference to the fund-flow, as per the NRHM guidelines, based on the requirement of each block, the CMO office disbursed money on suggestions from the District Nodal Officer. The state/district health officer advanced Rs. 10,000/- to each ANM as imprest money for JSY. All funds came through MOIC to the ANMs and through ANMs to the ASHAs. This money was used as untied funds and kept in the joint account of ANM and Sarpanch/Gram Pradhan for ANM to further advance Rs. 1,500-2,500 to ASHA/AWW or other link person for accompanying delivery cases and for arranging the referral transport for pregnant women to the place of delivery. Money is reimbursed on providing details of utilization. Rogi Kalyan Samiti is involved in monitoring of the untied fund at the PHC/CHC level. ANMs were responsible for accounting of the amount. To make the payment process easy and simple, a nodal officer explained, “JSY beneficiaries who deliver at an institution are paid by the hospital authorities at the time of discharge, while home delivery cases are paid by ANM with 7 days of delivery.”
Finding4	SCP Use of local administrative and leadership structures
Illustration	Decentralization of the financial management and monitoring of the activities was carried out by panchayat members. Except in few places, the involvement of PRIs was well appreciated. In words of a stakeholder at the district level, “Panchayat is doing very good work. Besides, NGOs, FBOs also provide support in implementing ASHA component.” However, another DHO had a different opinion. He said, “Some Gram Pradhan do not easily sign cheques or give money to ANMs and create problems. At present, the joint account is held by MOIC and ANMs in some blocks. ASHAs are paid by the ANMs according to their performances”. Another senior district official said, “Currently funds are not monitored or controlled through Panchayat, as there are some problems in doing so.”
Finding5	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	Irregularity of fund flow causes problems in the effective implementation of the programme. The district officials said that the funds received are adequate but not regular. A DHO said, “Till 2006, we were getting funds regularly, but in 2007, we did not get funds. Therefore we had problems in making payment to JSY beneficiary and ASHAs.”
Finding6	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	PRIs knew about the roles of ASHAs. According to the PRIs, community appreciates ASHAs presence in the village as they get updated information through ASHAs. PRIs associated themselves with the programme and met ASHAs regularly. However, some of the PRIs were not clear about the eligibility criteria for availing JSY benefits but knew about the amount of cash assistance.
Finding7	SCP Clear procedures for removing low performing providers or facilitators from the scheme
Illustration	According to the ANMs, a few ASHAs dropped out, as the community complained to the MO PHC/ CDPO about her not accompanying the pregnant women. An ANM said, "In my area ASHA discontinued her work as she wanted monthly fixed salary and more incentives. Besides, she did not like the job.
Finding8	SCP Local community worker / volunteer to promote scheme and assist beneficiaries

Illustration	Another CBO member said, “In my opinion, presence of ASHAs has helped in reducing the misconception and promoting institutional deliveries”.”We think ASHAs would be in our community for lifetime.”

Assessment of Janani Suraksha Yojana in Himanchal Pradesh

Finding1	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	None of the community members had heard about ASHA. They said, “I have not heard anything about the word AHSA”. “We have no idea about ASHA”. While regarding JSY the community members said, “We know something about the scheme. I have heard about it from ANM”. “Yes, Anganwadi worker told me when I met her a the Anganwadi centre. But I do not remember the details”. “We have not seen any propaganda of the scheme”.
Finding2	SCP Potential beneficiaries" lack of knowledge of scheme provisions
Illustration	The community members suggested that people in the community should be made aware of the scheme to increase the number of beneficiaries. In Una, a young female said, “As people are less aware about the scheme, they have not availed its benefits. All should be told about the details of the scheme”
Finding3	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	JSY beneficaries received their cash assistance at varying times starting from during pregnancy to much later after the delivery. Some of the problems stated in receiving the money included repeat follow up request for the money, receiving the money in installments, payment not received when needed and delays in payment. The cash assistance received was not considered sufficient to meet their expenses especially taking into account transport related expenses.
Finding4	SCP Administrative skills and capacity available
Illustration	A health supervisor said, “We are not able to supervise properly. So many programmes are there and like this (JSY) are linked with money. We have to record properly, check properly. We need one more person who could check the accounts.”
Finding5	SCP Ensure administrators are not overburdened by additional duties
Illustration	There is a lack of manpower to supervise, particularly with respect to checking the accounts and linking it with the performance, as realized by the state official, “We are not able to supervise properly. So many programmes are there and like this (JSY) are linked with money. We have to record properly, check properly. We need one more person who could check the accounts.”
Finding6	SCP Clinical skills and capacity available
Illustration	Another nodal officer said, “Many of the family health centres in Himachal Pradesh are not able to provide services of institutional deliveries. Sub-centres are not equipped for institutional deliveries, only few PHCs and some CHCs have institutional delivery facilities. Some PHCs have vacancy of

	MO. In our district, 20 SCs are without any female health workers".

Assessment of ASHA and Janani Suraksha Yojana in Rajasthan

Finding1	SCP Cash disbursements for transport are not available / not made
Illustration	The state officials had discussions with GOI after the new guidelines came into effect in November 2006 and the payment within a week of delivery was agreed upon. During discussions, it came to our notice that transport payment to beneficiaries in cases where ASHA had not accompanied for institutional delivery, was not made to the beneficiary. With the revision of guidelines, the amount of Rs. 300/- was to be paid to the beneficiary even in case ASHA do not accompany pregnant women for institutional delivery. Since, the cut-off of selection of beneficiaries was six months prior to the survey, this element of transport reimbursement in accordance with the new guidelines could not be effected.
Finding2	SCP Ensure health workers are not overburdened by additional duties
Illustration	As the state had taken a lead in demonstrating inter-sectoral convergence, we were curious to know how it was translated at the field level. The block-level functionaries commented that convergence and appropriate mechanisms were in place. However, one of them stated: "Sahyogini being an employee on the pay-rolls of DWCD is more loyal and committed to her department and its officials. Instructions from her parent department are honoured first and the others follow later, however, important it may be. The informal instruction in the field is that forenoon should be devoted for Anganwadi work and the afternoon for motivational work as ASHA. In the process, Sahyogini is putting very little time in the afternoon, as she in inundated with registers and reports supplied by her department. Instructions by health department on meeting with clients and motivating them for services gets neglected and more importantly, accompanying pregnant women for institutional delivery on working days is restricted. This has resulted in some undercurrents between the two departments".
Finding3	SCP Good communication between different levels of administration
Illustration	In the context of revised guidelines, a state officer said: "Improving the guidelines is good for the programme but practically changing now and then creates confusion not only at the field level but even at programme le el. Dissemination of previous guidelines by the state followed a process. Districts were communicated through circulars and responsible authorities were asked to share the information with staff members during monthly meetings or similar interactions. Trainers of ASHAs were informed too and were asked to include in the training curricula. With the revision, we have repeated this process and have explained about the changes. However, during field visits, we often hear about different amounts being quoted. It will take some time for new guidelines to sink in."
Finding4	SCP Helpline to network women with transporters and health care providers
Illustration	Rajasthan has tried out an innovation in JSY implementation. The state has launched JSY Helpline on experimental basis in one block of each district with the help of NGO. JSY helpline aims at promoting emergency referral and ensuring safe delivery of women with obstetric emergencies at the identified block health facilities. The NGOs ensure networking with transporters and health care providers. This intervention is in operation for several months and the state officials seem to be happy with the progress. The intervention is regularly monitored but it would be worthwhile to undertake an independent assessment of how this intervention has fulfilled its objectives. It is to be noted that JSY help-line blocks were not a part of the study sample.

Finding5	SCP Combine monitoring with routine field visits
Illustration	Concerning the monitoring of JSY, the CMO of Jaisalmer district said: “In our district, we have tied up JSY monitoring with routine monthly field visits of my officers and DPMU. Whenever my staff and I visit the field, we look into their cashbook register, tally it with delivery register and talk with the beneficiaries if they are available at the facility on the day of visit. In addition, we also undertake random check of JSY beneficiary in the field and find out details about cash assistance, amount received, when received and so on, whether ASHA accompanied or not and any problems faced in the facility and so on.”
Finding6	SCP Arrangements for selecting service providers and monitoring quality
Illustration	On the quality care of deliveries happening in institutions, the state has done very little. With the uptake of institutional delivery services expected to increase under JSY and human resources being constant, it becomes important to monitor the quality of services rendered by the public health facility. Hence, it is necessary to set-up an appropriate system for monitoring quality of services within JSY. Regarding the quality, CMO of Jaisalmer district stated: “As long we don"t get to hear of major complications o eventuality, the services can be presumed to be reasonably good. Up gradation and strengthening of facilities and capacity building of human resource are underway and we are certain, that would be able to ensure good quality of care”. Other districts reiterated this view as well. Regarding quarterly progress and financial reports, the statistical assistants and account persons at district and blocks levels were of the view that each time data on beneficiaries was collated, reconciliation between performance and disbursement had to be made. An integrated format that could cover both performance and disbursement was recommended by Udaipur district. The DPMU of the district felt that this would reduce the time in reconciliation and running around and both information could be maintained and shared. The integrated format has been recommended to the State Government and the idea has been well received.
Finding7	SCP Clinical skills and capacity available
Illustration	Another option provided in the national JSY guidelines is related accreditation of private institutions for delivery services. The guideline for accreditation could not be accessed, but it was mentioned by a state official that it should be a 24x7 days service having services of a gynaecologist, an anaesthetist, and a surgeon who could perform caesarean section. Further, the facility should have blood transfusion facility; proper OT and labour room with power back up. In Rajasthan, the process of accreditation of private institution has just begun with the listing exercise and this aspect has been highlighted in the revised JSY guidelines circulated in November 2006. The guideline suggests listing of private facilities not only at district headquarter but also at sub-district and block levels. According to the state official: “Efforts are underway but we are finding difficulty to even identify one such institution per district in Rajasthan that comply with the accreditation norms.”
Finding8	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	In addition, inter-personal and group communication was given priority to publicize JSY activities and was reinforced through mass media activities such as hoardings at strategic locations, posters, wall paintings at health facilities and public places. Survey teams mentioned having seen paintings on JSY specifically, on payment of cash assistance to the beneficiary. This apart, NGO"s and ASHAs were also given IEC materials and were asked to publicize the scheme in their area of work.
Finding9	SCP Community awareness of DSF schemes improves with involvement of local NGOs
Illustration	In addition, inter-personal and group communication was given priority to publicize JSY activities and was reinforced through mass media activities such as hoardings at strategic locations, posters,

	wall paintings at health facilities and public places. Survey teams mentioned having seen paintings on JSY specifically, on payment of cash assistance to the beneficiary. This apart, NGO"s and ASHAs were also given IEC materials and were asked to publicize the scheme in their area of work.
Finding10	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	In each block, ANM was contacted to get the names of the ASHAs and discuss the role of ASHAs and their interactions. ANMs confirmed that ASHAs took part in all the stated activities. In words of an ANM, "It is beneficial to have ASHAs. Earlier when I was alone, I was not able to cover all the areas. Now though ASHAs we are able to cover the entire area. She goes there and motivates people to avail service. Most benefit till now has been for immunization programme and antenatal check ups ". Another ANM said: "Most important is that she is from the same village. So she enjoys good cooperation from the people in the village. For example, it has helped me a lot and I could reach out to women from the tribal (Bhil) community with the help of ASHA and explain about the national health programmes and the benefits under it. ASHA followed up with my visits and was able to motivate women for institutional delivery. "
Finding11	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	All the six Anganwadi workers interviewed knew about JSY and ASHA programme in detail. They met ASHAs almost every day or every alternate day. Every first Thursday of the month was observed as immunization day jointly by ANM, AWW and ASHA. ASHAs came to AWW regularly for getting records checked. Both, AWW and ASHA worked together during Swasthya Chetna Yatra. AWWs opined that such an arrangement was beneficial, mainly for ensuring better coverage of women; poor women got quality services and nutritional food, and all the benefits of JSY. A demand for services was created as was reflected by an AWW: "Now people understand and have started coming to us on their own. They ask for immunization, IFA tablets, and are prepared to go for institutional delivery". Intersectoral linkages were evident at the grassroots level. Such linkages and networking had an advantage in creating demand by bringing about community awareness, on the one hand, and increasing utilization of the services on the other. Both implementation and monitoring of the scheme at the village level would prove beneficial to the community and could lead to community mobilization and better uptake of health services and overall development of the villages.
Finding12	SCP Training on handling money and accounts for providers
Illustration	With reference to the fundflow, the state worked out its mechanism along the guideline of the national government. However, at the field level, there have been some modifications in terms of payment of advance recoupable money to the ANMs. The national guidelines provided that advancing recoupable money in the range of Rs. 5,000 to 10,000 to ANMs, should be deposited in the joint account of ANM and Sarpanch. The state felt otherwise and instead suggested that the untied money given as part of NRHM could be used and upon submission of expenses, the ANMs could be reimbursed immediately (Refer Fund Flow Chart). When this issue was discussed with the block level officer, he suggested: "ANMs are handling accounts and substantial money for the first time. They have not been oriented of how to handle and what transactions are involved and how to maintain the expenditure statement and cash book. Moreover, ANMs find it difficult to withdraw money due to fixed ceiling amount. Beyond that ceiling amount, ANM has to seek signature of the joint signatory who in this case is the Sarpanch. Experience has been that Sarpanch are reluctant to sign and have lot of queries. It would be good if ANMs and Sarpanch are jointly imparted training on how to manage the funds and maintain the expenditure"
Finding13	SCP Lack of formal orientation of community leaders
Illustration	Even though efforts were made by the state to generate demand for services, there has not been any formal orientation of the scheme to PRI Representatives, who are the source of information at

	the community level. This is a matter of concern. JSY guideline proposed that the money should be placed in the joint account of Sarpanch and ANM. Hence, it becomes imperative to equip them with the minute details of the scheme, revisions, how the funds would be drawn from the account etc. and above all for seeking their support in promotion of institutional deliveries.

Assessment of ASHA and Janani Suraksha Yojana in Orissa

Finding1	SCP Cash disbursements are too late to help poor with immediate expenses
Illustration	On similar lines, PRI members knew about JSY and benefits available under it. One of them said that there was a meeting called by the block medical officer to inform the stakeholders about the scheme. According to different PRIs, between 40 and 70 percent of the people in the community could be aware about the scheme. The PRI members did urge for timely payment saying, “The problem is JSY beneficiaries and ASHAs do not get any incentive properly. Neither they get money on time nor do they get all the money they are entitled to”.
Finding2	SCP Women wished to avoid certain obstetric or medical procedures
Illustration	The CBO members also knew about the JSY scheme through radio, ANM, TV and from ASHAs in block meetings. They knew about the details of the payment for institutional and home deliveries. They said that women in their area do not go for institutional deliveries as they have fear of stitches and sterilization, fear of doctors, and fear of instruments, caesarean. Besides, there are hospital expenses and lack of transport facilities. Women could be explained importance of the institutional delivery through interpersonal communication, involvement of doctors in creating awareness, and explaining all the villagers about benefits of institutional deliveries during regular home visits.
Finding3	SCP Lack of available transport to facility
Illustration	The CBO members also knew about the JSY scheme through radio, ANM, TV and from ASHAs in block meetings. They knew about the details of the payment for institutional and home deliveries. They said that women in their area do not go for institutional deliveries as they have fear of stitches and sterilization, fear of doctors, and fear of instruments, caesarean. Besides, there are hospital expenses and lack of transport facilities. Women could be explained importance of the institutional delivery through interpersonal communication, involvement of doctors in creating awareness, and explaining all the villagers about benefits of institutional deliveries during regular home visits.
Finding4	SCP Steady supply of funds, cards, vouchers and a routine reimbursement system
Illustration	On similar lines, PRI members knew about JSY and benefits available under it. One of them said that there was a meeting called by the block medical officer to inform the stakeholders about the scheme. According to different PRIs, between 40 and 70 percent of the people in the community could be aware about the scheme. The PRI members did urge for timely payment saying, “The problem is JSY beneficiaries and ASHAs do not get any incentive properly. Neither they get money on time nor do they get all the money they are entitled to”.
Finding5	SCP Clearly defined roles and training for community workers / volunteers
Illustration	As per the flow of fund, ANMs received amount from MO PHC, to distribute to the JSY beneficiaries and ASHAs. Except four ANMs, all the others had opened a bank account jointly with the sarpanch. Most of the ANMs made payment directly, got a form filled, and made such payment within last 15 days to one month. However, only half of the ANMs said that they had rolling money to make the

	payment. The details maintained by ANMs include date of payment, address of JSY beneficiaries, EDD, age, date of immunization; cash received, and voucher number. Besides, they also noted gravida, sex of the child, delivery date, place of delivery, and signature of ASHAs on Revenue stamp.
Finding6	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	ANMs applauded ASHAs" work in the community and said, “She reaches the unreached and the target population o JSY and has been getting good response from the community.” “Poor women have faith in ASHAs.” “She (ASHAs) works as a medium of communication bridging between community and me and provides them with all necessary information. Then we work together and resolve problems encountered by either of us.” “ASHAs have been very helpful in handling emergency situations. Complication during pregnancy have been addressed by timely arrangement of transportation by her. Community people understand her better and relate well with he and people in the villages have started availing institutional deliveries more than before.”
Finding7	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Only half of the community members knew about ASHA, and those who knew could mention by her name. Most of the community members interviewed were aware about who was selected and the selection process. They also appreciated the process of selection. They were aware about the roles and responsibilities of ASHAs and said that, “Presence of ASHAs is very beneficial to the community, as they create awareness, and accompany women for delivery”. “Pregnant women get proper care and some money”.
Finding8	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Only half of the community members knew about ASHA, and those who knew could mention by her name. Most of the community members interviewed were aware about who was selected and the selection process. They also appreciated the process of selection. They were aware about the roles and responsibilities of ASHAs and said that, “Presence of ASHAs is very beneficial to the community, as they create awareness, and accompany women for delivery”. “Pregnant women get proper care and some money”.
Finding9	SCP Use range of media to educate target population about benefits and how to get them
Illustration	The CBO members also knew about the JSY scheme through radio, ANM, TV and from ASHAs in block meetings. They knew about the details of the payment for institutional and home deliveries. They said that women in their area do not go for institutional deliveries as they have fear of stitches and sterilization, fear of doctors, and fear of instruments, caesarean. Besides, there are hospital expenses and lack of transport facilities. Women could be explained importance of the institutional delivery through interpersonal communication, involvement of doctors in creating awareness, and explaining all the villagers about benefits of institutional deliveries during regular home visits.

Assessment of Janani Suraksha Yojana in Assam

Finding1	SCP Use range of media to educate target population about benefits and how to get them
Illustration	To promote the JSY, the state started specific programmes and IEC activities. Besides circulars and e-mails, discussions are held regularly to inform the health staff members about the JSY and any modifications in the guidelines thereafter. The JSY implementation guidelines and the section on

	frequently asked questions was translated in local languages and was circulated to all the stakeholders at the state, district and block level including medical, paramedical and a few beneficiaries. The scheme was widely publicized through print media, radio, TV, hoardings, wall paintings and writings at strategic locations. Besides, special programmes were frequently and regularly (weekly twice) broad caste through All India Radio targeting the ASHAs. The survey team during their visits to PCH, SC and distant remote villages confirmed that the scheme was widely publicized. A senior state officer said, "Through advertisements on radio and TV, we are targeting the key stakeholder. We are advertising about the roles of ASHA and targeting sometimes the women, sometime the husbands, sometimes the mother-in-law, and like that propagating the scheme- Inter-personal communication is also very important".
Finding2	SCP Training on handling money and accounts for providers
Illustration	At the block level, an accounts officer suggested that 2 days orientation training needs to be organized for the stakeholders including ANM who handle accounts and money for the first time.
Finding3	SCP Clear procedures regarding referral to higher level facilities
Illustration	Besides, it is important that each ASHA should know where they could refer or escort the case for institutional delivery or emergency obstetric care. During training, all the ASHAs were specifically told about the health facilities where they could refer the patient. ASHAs in Assam knew about the linkages hospitals available under JSY.
Finding4	SCP Providers" knowledge of details of scheme
Illustration	The success of JSY to a great extent depends on understanding of the scheme amongst the various stakeholders and their networking. At the state and district level, the concerned officers were aware of the objectives of JSY, their role and ASHA"s role in the implementation of JSY. The other stakeholders at block, district and village level were also aware of JSY, which was evident while investigating the involvement of stakeholders in implementing JSY. A state officer said "The biggest challenge we are facing is that we have to ensure that the ANM stays in the sub-centre. If we ensure that the ANM stays in the sub-centre and the doctors stay in the PHCs, well, that is the biggest challenge. Money, equipment, infrastructure is not an issue, we can take any number of contracts with people, but unless and until we assure that those people stay there."
Finding5	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	Talking about the ways to publicize the programme, PRI members had to say, "In our villages people do not read newspaper o see television. We listen to radio, but if you want to inform women about the scheme then you have to explain each of them individually. When they come to access services at the health camp".
Finding6	SCP Rational selection of providers
Illustration	It was difficult for the state to find women fulfilling the selection criteria, particularly in the tribal and hilly areas. Therefore, the guideline was modified for tribal and hilly areas and the educational attainment was reduced from 8th to 5th grade.
Finding7	SCP Standard operating procedures for providers to make claims

Illustration	For implementing JSY, advance money is given to the districts, which in turn gives money to all the health institutions related to JSY. The JSY beneficiaries are paid in the institution where they deliver. In the institution, they do not have to do much of paper work; they maintain the register and pay the money. They also have a month-wise JSY beneficiary report with details on number of institutional deliveries, number paid and number to be paid. The institution itself pays the money from the funds available with them. A district official said, "We are trying to ensure that the mother leaves the hospital with the money. If a woman delivers at home she gets 500 Rs from the ANM."

Assessment of Janani avam Bal Suraksha Yojana in Bihar

Finding1	SCP No organised onward referral system for complicated emergencies
Illustration	For linkage with nearest functional health facility for referral services, ASHAs have been asked to get all the patients to the PHCs where they attended training. This seems to be a point of concern in avoiding delays for providing emergency obstetric care, as ASHAs should have been linked with referral services to meet the requirements for emergency obstetric services, as most of the PHCs are not fully equipped to attend emergency obstetric cases and not working for 24 x 7 hours.
Finding2	SCP Expected to give birth at parental home
Illustration	Women often return to their maternal homes for delivery. In that case, ASHAs at their natal place would take care of their antenatal services, accompany women to the place of delivery and women get JBSY cash benefits at the place of delivery. A state official said, "Whenever a woman goe for hospital delive y, anywhere in the entire state she will be given the JBSY benefits."
Finding3	SCP Expected to give birth at parental home
Illustration	Discussing about the issue of such payment, another state official said, "Only those ASHAs who deliver in our institution receive the benefit. If a woman goes to her natal place and is not likely to deliver at our institution, we are discouraging them and not giving them any money. We encourage our ASHAs to get these people to our institutions for delivery. The payment is made as per register numbers; you can verify any case from our records."
Finding4	SCP Pre-printed cheques made payable to each woman rather than cash
Illustration	Talking about their future plans, a senior state official said, "The SHS, Bihar is also exploring the possibility and negotiating with the State Bank of India, if they can give pre-printed cheques so that there is minimum of cash handling and monitoring system is already the e as a third party is involved. We also hope that the transaction will be smoother and easier."
Finding5	SCP Health staff misinformed about scheme eligibility / provisions
Illustration	The study shows that there were still some ANMs who were confused about the eligibility criteria for getting JBSY benefits.
Finding6	SCP Women preferred to have home delivery

Illustration	Another difficulty is motivating people to have institutional delivery. Traditionally women have been delivering at home. So, a district officer said, "In a traditional society, like Bihar, people had to be convinced for institutional delivery. Now they are convinced and most come for institutional deliveries, but our facilities are not ready to provide quality services. To attract people, the health facility centres need to provide appropriate facilities. The state has done very little to provide quality care for meeting the increased demand for women having institutional deliveries.
Finding7	SCP Lack of available transport to facility
Illustration	Raising her concerns regarding lack of transport facilities, another AWW perceived, "We reach all but only 50 percent take benefit of scheme and are able to go for institutional delivery, as there is no transport facility in our village."
Finding8	SCP Support network for community workers / volunteers
Illustration	Appreciating the programme and working of ASHAs, a state officer opined, "We have tried our level best to get good ASHAs, and they are very much enthusiastic. But this enthusiasm has to be maintained and we need to provide other facilities to translate it into action. At present, only 1 - 2 persons are the e at the state level to support ASHA. But, we need the whole network to support ASHA. If ASHA resource network is there, they will function very well. This is first opportunity to females in Bihar o serving the people of their village. They are trying to prove it."
Finding9	SCP Use non-governmental organisations to raise awareness and monitor the programme
Illustration	Credible NGOs with good track record need to be included in the institutional arrangements at various stages of implementation of the programme such as selection and training of ASHAs, monitoring and evaluation of the performance. For this, MNGOs and FNGOs could be included in the network and implementation.
Finding10	SCP Clear procedures regarding referral to higher level facilities
Illustration	The success of the programme to a great extent depends on performance of ASHAs and their linkage with functional health system. The health system has to take prompt action on the referrals made by her; otherwise the system cannot be sustained. ASHAs need to be familiar with the identified functional health facility in the respective area where they can refer or escort the patients for specific services. The State & District Health Societies should provide support to ASHAs at all the levels.
Finding11	SCP Ensure service providers understand what must be submitted to claim reimbursements
Illustration	Project management cost for all the districts is covered under the finances of RCH-II. Amount for payment to ASHAs and JBSY beneficiaries is reimbursed on providing statement of expenditure. PHC Medical Officers and Accountants were involved in monitoring of the untied fund at the PHC/CHC level. ANMs were responsible for accounting of the amount. Talking about giving money to the PHC and village Panchayat, a district official said, "At the ANM level and public health centre there is no difficulty as such, but at district level we do not receive their SOE (statement of expenditure). Everybody is expected to submit SOE to us, they spend the money but simultaneously they do not submit the SOE. Hence, there is a delay at the district level."

Finding12	SCP Recognise and attempt to reduce high transaction costs
Illustration	Talking about their future plans, a senior state official said, “The SHS, Bihar is also exploring the possibility and negotiating with the State Bank of India, if they can give pre-printed cheques so that there is minimum of cash handling and monitoring system is already the e as a third party is involved. We also hope that the transaction will be smoother and easier.”
Finding13	SCP Consider monthly payments for facilitators
Illustration	PRIs suggested that to promote JBSY there should be door-to-door visit and propaganda, besides regular meetings and discussions with the women. ASHAs should get regular (monthly), timely and more payment and doctor should be regularly available at the health centre. PRIs also suggested that both, government and community should provide them adequate support. For promoting institutional deliveries, PRIs also suggested that transport facilities should be arranged within the village. They said, “If transport facilities are arranged, this would help ASHAs in arranging easy transport for institutional deliveries even in the middle of the night, and it would be beneficial to the poor pregnant women.”
Finding14	SCP Local community worker / volunteer to promote scheme and assist beneficiaries
Illustration	PRIs suggested that to promote JBSY there should be door-to-door visit and propaganda, besides regular meetings and discussions with the women. ASHAs should get regular (monthly), timely and more payment and doctor should be regularly available at the health centre. PRIs also suggested that both, government and community should provide them adequate support. For promoting institutional deliveries, PRIs also suggested that transport facilities should be arranged within the village. They said, “If transport facilities are arranged, this would help ASHAs in arranging easy transport for institutional deliveries even in the middle of the night, and it would be beneficial to the poor pregnant women.”

Assessment of ASHA and Janani Suraksha Yojana in Madhya Pradesh

Finding1	SCP System to detect informal payments and corruption
Illustration	As per the National guidelines it is envisaged that money should be made available at the village level so that the beneficiaries could be reimbursed on time. Hence, a Joint account of ANM and Gram Pradhan was proposed and accordingly an account was opened in a bank with an initial deposit of Rs 10,000 provided through RCH II/NRHM funding. Though flexibility of using funds was provided to the ANMs and instructions to pay JSY beneficiaries for transport and delivery were communicated, there were several operational problems. The operational problems observed were: PRIs refusing to sign the cheque resulting in delay in payments or non-payments. Besides, few providers were charging for certain services during delivery and taking commission during disbursements of JSY money. Hence, the state introduced cheque payment mechanism across all the districts.
Finding2	SCP Clearly defined roles and training for community workers / volunteers
Illustration	However, with these positive remarks, there were ANMs, who were not happy with the ASHAs and said, “ASHAs do not cooperate. Moreover, there is always a fight for motivator"s money”.

