

Project Briefing

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Cash transfers for maternal health: design opportunities and challenges in low-resource settings

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'A woman in labour came to the health post ... I saw that she had a foot showing [a baby in breach position]. I advised her family to quickly take her to the health centre. The woman did not go right away. The family had to raise money for transportation and other costs. When she went to the health centre they told her to go to the hospital 100 km away. Finally she went to the hospital. She survived but lost her baby.' Bizunesh Megersa, Health Extension worker, Chiri Kebele, Ethiopia.

The story above, from Ethiopia, illustrates some of the barriers women face in accessing and using maternal health services in low-income countries, despite increasing evidence about, and commitment to, maternal and child health.

In 2010/2011, an operations research project on Cash Transfers (CT) for Safe Motherhood (SM) led by Interact Worldwide and supported by ODI was set-up with the aim being to provide cash transfers to vulnerable women to increase their access to, and use of, maternal health services. The rationale was that such services, i.e. antenatal care, skilled delivery at birth and postnatal care, reduce maternal and neonatal mortality and morbidity (Jones et al., 2011). The pilot project built on existing work by Interact with organisations in three countries: Amhara Development Association (ADA) in Ethiopia, Adventist Health Service (AHS) in Malawi, and Uganda Protestant Medical Bureau (UPMB) in Uganda. It included participatory assessments in each country to identify key barriers to accessing maternal health services.

A key aspect of the project was the design of the cash transfer programme. Based on a review of best practice, this Project Briefing outlines the components that were taken into consideration during the cash transfer

design process for this project. It will be complemented by a Project Briefing on the project outcomes.

Maternal health in the study countries

In Ethiopia only 34% of pregnant women visit healthcare facilities for antenatal care and only 10% deliver with the assistance of a health professional (EDHS, 2011). Around 22,000 women aged 15-49 are thought to die annually as a result of pregnancy or childbirth causes (WHO et al., 2007). The situation in Uganda is slightly better, but still only 42% of total births are attended by skilled health personnel, with wide variations by wealth quintile. The Maternal Mortality Ratio (MMR) is reported as 435 deaths per 100,000 live-births (UDHS, 2006). In Malawi, MMR was 807 per 100,000 live births with 13 mothers dying every day, and the neonatal mortality rate was 33 per 1,000 live births, with 52 newborns dying every day (MICS, 2006). More recently, 73% of births were attended by medical professionals, but again there are disparities between wealth quintiles, regions and urban and rural areas (MDHS, 2011).

Why cash transfers?

Social protection is an increasingly popular option to address the vulnerabilities of the poorest people in developing countries. It aims to reduce risks, mitigate their impacts and increase the capacity of households to cope and respond (Devereux and Sabates-Wheeler, 2004). Social or cash transfers are part of social protection approaches, often targeting particularly vulnerable households. Cash transfers, and in particular conditional cash transfers (CCTS), where households must meet certain conditions to receive the cash, have also been included in a number of programmes that have a direct or indirect focus on maternal health outcomes (Barber and Gertler, 2009; Powell-Jackson et al., 2008, 2009; Lim et al., 2010).

Key points

- Lack of effective maternal health care services can undermine progress on broader human development
- Well-designed cash transfers that aim to be sustainable and have adequate resourcing can improve maternal health
- Complementary awareness-raising activities are critical for changing behaviour and attitudes at individual, household and community levels

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Box 1: The three delays

Barriers and obstacles that limit maternal health outcomes are often called the 'three delays' (Thaddeus and Maine, 1994):

Delay 1: Making the decision to get help. Women may be unaware of the need to access maternal health services or their benefits, or lack the power to make decisions on their own maternal health care. According to one female respondent in Uganda: *'In most cases men decide a lot of the things alone, the men make decisions regarding ANC, delivery, family planning and child related sickness, this is so because our men are not like the men in towns they are very difficult people'*.

Delay 2: Getting to the health facility. Even if a woman makes the decision, she may not have the resources to travel to the clinic or to cover her costs once there. There may be no roads or transport to get her there, and most women lack the resources to buy food and other items needed while at the clinic. One woman in Uganda said: *'I do not go to the hospital because I do not have money and my husband does not provide for me money to go to the hospital'*.

Delay 3: Getting good quality maternal health care. Even if a woman makes it to the clinic she may face poor quality care, untrained or unsupportive staff and under-resourced clinics. A woman in Uganda commented: *'We have a small hospital ... I missed antenatal care because the nurses are few and there are no drugs so they send you back home...'*

Box 2: Site selection indicators

- Population size
- Number of health facilities by type /level per district
- Catchment area/population of partner health facility
- Health facility staffing (in district and in partner facility)
- Distance to health facility (average and specific for partner facility)
- Depth of poverty/other poverty indicators where available (income date, wealth quintiles, etc.)
- Maternal Mortality Rate
- Neonatal, Infant and Child Mortality Rates
- Deliveries at clinic/hospital vs at home
- Contraceptive prevalence rate
- Other characteristics of the district: livelihoods, challenges, etc.
- Socio-cultural indicators – ethnic group, language, religion
- Presence of ongoing anti-poverty or social protection programmes (for potential linkages and complementarities)

Although data are patchy, there is some evidence that such CCTs can have beneficial impacts on maternal health through, for instance, increasing the number of women using skilled birth attendants and similarly, declines in home deliveries (Lim et al., 2010; Powell-Jackson et al., 2008, 2009; Jones et al., 2011). Nevertheless, a number of challenges remain, including how to target appropriately to ensure that poor women are captured in the programme, and how, more generally, to ensure that such programmes have positive impacts on maternal health outcomes and address the so-called 'three delays' (Box 1). These challenges are part of a wider debate on whether conditions are necessary, and here the literature remains inconclusive – according to Fiszbein and Schady (2009: 163) 'there is limited evidence on exactly which feature of CCT programmes matters most – the cash, the conditions, the social marketing of the programme.

The evidence tells us (see Jones et al., 2011),

that successful cash transfer projects are context-specific and, to promote sustainability, embedded in existing community or government structures. The project reviewed existing social protection and maternal health programming in each country to identify possible synergies with the pilot intervention. In Ethiopia there was an attempt to link the pilot to membership of the Productive Safety Net Programme (PSNP) targeted at food-insecure households, to promote synergies and enhance future potential for scaling up. Similarly, in Malawi efforts were made to link to an existing cash transfer project funded by UNICEF, the UK Department for International Development (DFID) and the World Bank to protect livelihoods and welfare against shocks and risks.

Existing good practice also suggests careful consideration needs to be paid to the form conditionalities should take, if any, and what additional support structures and complementary services need to be in place for a cash transfer to improve maternal health outcomes in particular, and human well-being more generally.

Cash transfer design components

Coverage and selection of sites. Given that this was a pilot project, and for rigorous analysis of the impact of the intervention, we developed an experimental evaluation design in a subset of the overall project districts with one control site and two treatment sites. In each country one treatment site provided an unconditional cash transfer (UCT) and the other a conditional cash transfer (CCT), to contribute data for the ongoing debate on their relative merits (Fiszbein and Schady, 2009).

Districts needed to be similar on a number of vulnerability and poverty criteria or indicators; Box 2 shows the information used to identify appropriate districts. Boundaries between the districts also needed to be clear to prevent unintended spill-over effects between the different arms of the study – from a methodological perspective and to minimise any political sensitivities. All of this was challenging in practice, pointing to the need for comprehensive and timely design, planning and management of the project.

Selection of programme participants. Pregnant women were the main target group; if any were under the age of 15, their carer would also be considered a member of the target group. Within this group it was decided to focus on the most vulnerable pregnant women referred to also as the 'ultra poor'. Our initial preference was to work in districts where there was overlap with social protection programming where vulnerability targeting had already been carried out. Where this was not possible, to identify such women, a set of questions – a vulnerability assessment tool – was developed based on internationally accepted measures. While there was a need for standardisation across countries for research purposes, this tool was also tailored to the specific context. Women were asked these ques-

tions before being included in the baseline survey in the research sites, and in the other sites before inclusion in the cash transfer project. Box 3 shows the vulnerability questions used in Uganda; if the total score for a pregnant woman was five or over, she would be considered eligible to participate, particularly vulnerable or 'ultra poor'.

Conditionalities. One site in the research districts in each country would provide a conditional cash transfer to promote safe motherhood practices. Timing had to be carefully woven into the conditions, given the finite nature of pregnancy and the following conditions were stipulated, based on the evidence of Jones et al. (2011):

- Women attend four antenatal visits from the fourth month/second trimester
- They have an institutional delivery, or are at least attended to by a skilled birth attendant
- They attend two postnatal appointments in the first and sixth week after birth.

Amount of cash. In the unconditional arm of the study, women were to receive four payments every two months from the fourth month, with the third and fourth payment being higher given the likely costs linked to delivery and postpartum care. The total amount given to women in the unconditional arm would be equivalent to that given to women in the conditional arm, including the bonus (see below). It was also proposed that an emergency community fund be set up in the unconditional arm for women facing complicated deliveries. This would cover the difference in costs between a normal and a complicated delivery. Where this emergency fund is held is likely to vary by country: options could include at the health facility or in an existing community-based structure, e.g. a woman's group.

Costings for the conditional arm were more complex. First, the costs of normal and complicated delivery packages were costed for each of the sub-regions where the pilot would be implemented, assuming that 20% of deliveries are complicated (WHO, 2010). These included the costs for antenatal, delivery and postnatal visits, for medication (if not provided free of charge), transport, food, accommodation for people accompanying the women as well as the opportunity costs for the women of giving birth, e.g. the time lost on livelihood related activities. In Ethiopia, the total cost for a normal delivery package was £25 and for a complicated one was £70. In Malawi it was £50 and £89 respectively, and in Uganda it was £66 and £78.

Also based on best practice, the amount given had to equate to between 10% and 30% of monthly household income for people below the poverty line (the World Bank estimate of \$1.25 per day was used as the poverty line) (Elamon, 2010) to encourage participation while avoiding perverse incentives. In Ethiopia, total delivery packages were topped up if they were below 10% of monthly household income.

The amount each women should receive every

Box 3: Vulnerability assessment questions

Does the woman live in a single room, or house with earth/dirt/straw floor or mud/straw/corrugated sheet roofing?	Yes = 1, No = 0
Does she have no more than 0.5 ha plot of land?	Yes = 1, No = 0
Does she have less than two livestock (cows or goats)?	Yes = 1, No = 0
Is she illiterate or with education only up to primary school?	Yes = 1, No = 0
Is she often or occasionally having fewer than three meals a day?	Yes = 1, No = 0
Is she or anyone in her household suffering from chronic or regular illness?	Yes = 1, No = 0
Does she have disabled children/husband/household member living with her?	Yes = 1, No = 0
Is she widowed/single/separated/divorced?	Yes = 1, No = 0
Does the household have over four dependents? (five or more)	Yes = 1 No = 0
Does each household member have at least two complete sets of clothing?	Yes = 1 No = 0

visit was calculated based on the total delivery package cost. Again, based on good practice, a bonus was offered to women who made all the visits – this was to be 20% of the poverty line monthly mean income over a period of six months. Since the transfers in Uganda and Malawi were above the poverty line it was suggested that women also be offered a flat bonus if they attended all visits.

Incentives for providers. Good practice also shows that incentives for providers have positive impacts on maternal health (Lim et al., 2010; Powell-Jackson et al., 2008, 2009). It was recommended that providers receive incentives in the form of, for instance, cash, training opportunities or positive performance reviews if programme participants have a) institutional deliveries and b) make all the required visits.

Programme planning, management and cash distribution. Given the large numbers of partners involved, with different organisational mandates and aims, clear programme planning, management and implementation arrangements are critical, allowing also for efficient project start-up processes. In all three countries, Interact partners managed the intervention, including monitoring activities. In terms of who distributes the cash, a number of possible channels were proposed: existing women's groups, local credit and savings associations, local government partners or health centre staff – all three country pilots opted for health centre staff.

Awareness-raising and capacity-building. To ensure uptake of the cash transfer and longer-term improvements in maternal health and broader human development, it was proposed that awareness-raising activities be developed or expanded to include safe motherhood components and knowledge of cash transfers. The target group would not only be women and mothers, but also men, mothers-in-law, community leaders and other stakehold-



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ers who can, alongside community norms, prevent women accessing and using maternal health services (UNFPA, 2009). Such activities could be carried out by women's groups, by community facilitators or other influential community members. Information could be provided verbally, or through audio visual materials. Capacity-building activities are also necessary for health staff and project implementers on the project modalities and, critically, on why cash transfers are needed to support positive maternal health outcomes.

Complementary programmes. There is growing evidence that cash transfers need to link to existing and complementary programmes to be effective (Holmes and Jones, 2010). So, women attending clinics also receive maternal health education and nutritional supplements (usually free of charge where they exist) during their visits. A community fund, as mentioned above, would provide a fall-back for women, particularly those in the unconditional sites facing complicated deliveries, and could be developed as a community-based initiative. Finally, as already mentioned, it was important that the pilot linked to existing cash protection programmes, and efforts were made to do this in Ethiopia and Malawi.

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Conclusions

This is an outline of the key elements to be considered when designing a cash transfer project that aims to improve maternal health outcomes in low-resource settings. They were proposed for the project in Ethiopia, Malawi and Uganda, and the results are reviewed in a companion Project Briefing.

What is clear from a design perspective is that timing is critical to engage a woman before she gives birth, during delivery and after she gives birth. Other forms of cash transfers, while facing implementation challenges, do not have to contend with this nine-month-plus timeframe. An additional layer of complexity was trying to measure the impacts of different interventions (conditional versus unconditional transfers). This demanded intensive communication and coordination among research and implementation partners. The challenge of project design is not, therefore, just one of content but also one of process.

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