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DEMAND-SIDE FINANCING AND PROMOTION OF MATERNAL HEALTH: WHAT HAS INDIA LEARNT?

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Introduction

Use of demand-side financing has become increasingly common in maternal healthcare and India has been a leading example with large-scale programmes such as the Janani Suraksha Yojana and Indira Gandhi Matritva Sahyog Yojana. This paper undertakes a systematic review of the evidence to consider how demand-side financing has been used and whether there has been any impact on maternal health service utilisation, maternal health, or other outcomes. The findings suggest that a relatively narrow focus on achieving targets has often overburdened health facilities, while inadequate referral systems and unethical practices present overwhelming barriers for women with obstetric complications. The limited evidence available also suggests that little has been done to challenge the low status of poor women at home and in the health system.

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Maternal mortality, defined as death during pregnancy or the post-partum period, is commonly used to indicate levels of maternal health and development. The United Nations (UN) General Assembly's millennium declaration, and subsequently the Millennium Development Goals (MDGs), committed India, along with other signatories, to a 75% reduction in maternal mortality between 1990 and 2015 (UN General Assembly 2001). "Skilled attendance" during childbirth, often equated with childbirth in health facilities, has become a core component of efforts to reduce maternal mortality.

India is considered by many to be at the forefront of using "demand-side" financing (DSF) to promote skilled attendance (Murray et al 2012). These interventions - most typically cash incentives or voucher schemes - are intended to supplement traditional "supply-side" financing by channeling resources directly to service users. Or, in other words, by a transfer of "purchasing power" (Pearson 2001; Ensor 2004; Witter 2011). This paper presents findings from a mixed-methods systematic review of the research and evaluation literature to highlight lessons so far, the challenges of this approach, and the limitations of what is known.

Policy on Maternal Healthcare

Government policy on maternal healthcare in independent India can be divided into four periods. During the first period, which ran for approximately 15 years, the government promoted an integrated approach to maternal and child healthcare and brought together different strands of public health to achieve this (Qadeer 2005). Policy during this period was guided by the recommendations of the Bhore Committee's report on health services (Health Survey and Development Committee 1946). It was at this time that the cadre of auxiliary nurse midwives (ANMS) was introduced to provide community healthcare and that the role of dais (traditional midwives), who were previously key maternal health careers within communities, was greatly reduced (Sadgopal 2009).

The second period began during the 1960s, as policymakers became focused on concerns about accelerating population growth. The department of family planning was created within the Ministry of Health and Family Planning, and maternal health services were subsumed within this new department. In the lead up to the Emergency, any broader notion of maternal health became overshadowed by policies that encouraged sterilisation using a toxic mix of cash incentives and coercion (Banerji 1972; Visaria 1976).

A transition from family planning to family welfare programmes in the late-iczos marked the beginning of the third period, although family planning activities continued to play a dominant role. The programme devoted greater attention to child mortality (as policymakers considered it a crucial determinant of fertility) though maternal healthcare continued to be neglected by policymakers through the 1980s (Sharma 1991). Training for ANMs was reduced from 24 to 18 months in response to pressures to quickly increase numbers (Mavalankar and Vora 2008). It was during the 1980s that maternal mortality attracted increasing attention at an international level, resulting in the launch of the safe motherhood initiative by a group of UN agencies in 1987 (Rosenfield and Maine 1985; Mahler 1987). By 1992, policymakers in India had consolidated strategies for nutrition, immunisation, and maternal healthcare into the child survival and safe motherhood programme. The

maternal health component of the programme aimed to improve access to "essential" maternity services by training dais and ANMs to detect signs of high-risk pregnancies and by developing referral systems for women with obstetric complications. An end of project report by the World Bank indicated backlogs in the training of dais and weak or absent referral systems in many areas (World Bank 1997).

The fourth period emerged following the 1994 International Conference on Population and Development in Cairo. The Ministry of Health and Family Welfare's reproductive and child health programme was launched in 1997 as an integrated approach to family welfare that included sexual, maternal, and child healthcare. It provided the foundations for the national population policy in 2000 and the national health policy in 2002 (Srinivasan et al 2007). The National Rural Health Mission (NRHM) was launched in 2005 to accelerate progress towards health-related MDGs, with the aim of improving "the availability of and access to quality health care" in high-focus states (Government of India 2005). Maternal health policy during this fourth period has had an increased profile, but has continued to be characterised by a medical understanding of maternal health that focuses on mortality reduction, and on improving access to clinical care at facilities through reducing the "three delays" (Thaddeus and Maine 1994). Community-level care continues to depend on ANMs, but it has been estimated that most ANMs receive just three months of midwifery training and that students at many training schools do not see enough patients to develop the necessary practical experience to be able practitioners (Mavalankar and Vora 2008).

Table 1: Description of Demand-side Financing Schemes That Promote Maternal Health in India

Unconditional cash transfers	
National Maternity Benefit Scheme	A single payment of Rs 500 provided by the Ministry of Health and Family Welfare until merger into the JSY in 2005. Created in 1995 by the Ministry of Rural Development with payments originally of Rs 300.
Dr Muthulaksnm Maternity Benefit Scheme	Reddy Began in Tami Nadu in 1986 with unconditional payments of Rs 200. By 2006, women received payments of Rs 6,000. Conditions have since been added to this programme.
Conditional cash transfers	Introduced in 2011 by the Ministry of Women and Child Development.
Indira Gandhi Matritva Sahyog Yojana	Payment of Rs 4,000 in three instalments (one before birth, two after), conditional upon antenatal care and vaccinations/check-ups for the child
Dr Muthulakshmi Reddy Scheme	Payment of Rs 12,000 made by the Tamil Nadu state government, Maternity Benefit conditional on antenatal and an institutional delivery.
Prasuti Aaraike	Introduced in 2008 by the Karnataka state government. Payment of Rs 2,000 conditional on antenatal care and an institutional delivery.
Mamata	Introduced by the Odisha state government in 2011. The programme increases the total amount paid through IGMSY by Rs 1,000.
Short-term payments to offset costs of access	
Janani Suraksha Yojana*	Introduced by the Ministry of Health and Family Welfare in 2005. In "low performing" states women receive Rs 1,400 for institutional deliveries in rural areas and Rs 1,000 in urban areas. In "high performing" states women receive Rs 700 for institutional deliveries in rural areas and Rs 600 in urban areas. Eligible women giving birth at home with a skilled attendant receive Rs 500.
Vijaya Raje Janani Kalyan Bima Yojana	Payment of Rs 1,000 from the Madhya Pradesh state government, conditional on giving birth in a government hospital. Closed after one year (2006-07) due to duplication with the JSY.
Prasav Hetu Parivahan Evam Upchar Yojana	Payment of Rs 300 from the Madhya Pradesh state government to women from the specific tribes and castes. Ran from 2004 to 2007, conditional on institutional delivery in a government hospital.
Voucher and voucher-like schemes for the purchase of maternity services	
Chiranjeevi Yojana	Cashless scheme introduced by the Gujarat state government in 2005. Allows eligible women to receive antenatal, intrapartum and postnatal care in accredited private facilities.

Sambhav vouchers	Voucher scheme piloted since 2007 by state governments in Jharkand, Uttar Pradesh and Uttarakhand. Women in urban slums receive vouchers for antenatal, intrapartum and postnatal care, family planning and other health services at accredited private facilities.
Sewa Mandir	Voucher scheme focused on areas with large scheduled tribe populations in Rajasthan.
MAMTA Scheme	Cashless scheme introduced in 2008 by the state government in Delhi. Entitles women from urban slums to antenatal, intrapartum and postnatal care in an accredited facility.
Janani Suvidha Yojana	Vouchers for women in specific urban slums in Haryana to use private health facilities for antenatal and intrapartum care. Implemented by the Haryana state government from 2006 to 2008.
Thayi Bhagya	State government scheme in Karnataka to provide eligible women with cashless access to private health facilities. Includes payment of Rs 1,000 to the woman.
Janani Sahyogi Yojana	Scheme to allow eligible women to use private facilities for intrapartum care in Madhya Pradesh.

Programme details reflect the most recent identified for the scheme; * some state governments have supplemented JSY payments to increase the total amount or have provided insecticide-treated nets to recipients, but these have not been listed separately here.

As maternal health programmes during the fourth period have strived towards reductions in maternal mortality, monitoring progress against targets has been undermined by weaknesses in reporting systems. The most recent estimates available are for 2010 and show a national maternal mortality ratio of 200 maternal deaths per 1,00,000 live births, which, while an improvement on previous levels (of 600 in 1990 and 390 in 2000), is three to five times higher than those of the other BRIC countries - Brazil (56), Russia (34) and China (37) (World Health Organisation et al 2012). The current rate of progress suggests that India is unlikely to achieve its MDG target by 2015. Estimates at the state level from the 2008 figures indicate wide disparities within the country, ranging from 81 and 97 maternal deaths per 1,00,000 live births in Kerala and Tamil Nadu, respectively, to 359 in Uttar Pradesh and 390 in Assam (Office of Registrar General India 2011).

The United Progressive Alliance government's primary strategy to reduce maternal mortality has been the Janani Suraksha Yojana (JSY), administered by the NRHM, in which cash payments are offered to offset the costs of accessing intrapartum care. A new cadre of health workers, accredited social health activists (ASHAS), was created to facilitate NRHM community activities. The JSY is one of the best known DSF schemes in the maternal health field, though a range of others have been introduced at the national and state levels (Table 1, p 66). Examples at the national level include the National Maternity Benefit Scheme and the recently launched Indira Gandhi Matritva Sahyog Yojana (IGMSY). Contracting and voucher arrangements such as the Chiranjeevi scheme in Gujarat have also received a lot of attention. In the remainder of this article we use findings from a systematic review of research and evaluation literature to describe the effect of Indian DSF schemes on the utilisation of maternity services and on maternal health and other outcomes. We also consider the evidence on the challenges to implementation and limitations of these approaches to improving maternal health.

Review Methodology

This paper draws on evidence from India collected as part of a systematic review of DSF in maternal health programmes in low- and middle-income countries (Murray et al 2012). That systematic review identified studies which had an English language abstract, using 19 bibliographic databases, a series of online sources of international grey literature, and a detailed search of the grey literature in India. Each retrieved study was examined against a set of predetermined inclusion criteria for population and intervention of interest, location of study, and date of research (January 1990-June 2012).

Thirty-three studies from India met the inclusion criteria after quality appraisal and data extraction using tools developed by the Joanna Briggs Institute, an organisation that specialises in mixed-methods reviews. The types of study ranged from a small selection of maternal death reviews to larger programmatic evaluations involving surveys, semi-structured interviews, and focus group discussions with stakeholders. The standard of the research was variable and methods of data collection and of analysis were often not well described.

The Whole Range of Demand-side Financing

The DSF schemes employed to promote maternal health in India can be divided into four distinct modes - unconditional cash transfers (sometimes referred to as maternity benefits), conditional cash transfers, short-term payments to offset the costs of accessing services, and vouchers for maternity services (Murray et al 2012). No Indian studies of a fifth mode, vouchers for "merit" goods such as food or insecticide-treated bed nets, were identified.

Use of Unconditional Cash Transfers

India is one of the few settings outside high-income countries in which unconditional cash transfers have been used to promote maternal health. "Unconditional" in this context refers to benefits that do not require proof of any specific activities to be received, but they are conditional on being pregnant and are targeted at poor women. The Dr Muthulakshmi Reddy Memorial Maternity Assistance Scheme (DMRMMAS) was introduced in 1986 by the Tamil Nadu state government to extend maternity benefits to women in the informal sector (Public Health Resource Network et al 2010). Unconditional payments were initially just Rs 200, but were raised to Rs 6,000 in 2006 in recognition of the greater support required by women to compensate for lost earnings and their dietary needs.

The National Maternity Benefit Scheme was launched in 1995, drawing on the aims and methods of the DMRMMAS. The programme provided unconditional payments to women until 2005, when it was merged with the JSY and payments then became conditional on skilled attendance at birth (either at home or in a health facility). Despite a Supreme Court ruling in 2007 to reinstate National Maternity Benefit Scheme payments, there has in practice been no national programme offering unconditional cash transfers to support rest and nutrition among poor women since the launch of the JSY.

Unfortunately there have been very few studies on unconditional cash transfers and those that are available have been limited in scope. The only study included in our review, on the DMRMMAS in Tamil Nadu, highlighted issues such as eligibility criteria that excluded vulnerable women, delays in payments, and the lack of concurrent capacity building among community health workers (Public Health Resource Network et al 2010). In 2012, payments from the DMRMMAS in Tamil Nadu were increased to Rs 12,000 and became conditional on uptake of antenatal care and check-ups for neonates. It is unclear if and how this will affect the programme.

Use of Conditional Cash Transfers

Conditional cash transfer schemes have only recently been adopted in India to promote maternal health. Like unconditional cash transfers, these schemes typically aim to improve the diet of pregnant and breastfeeding women and to encourage rest for several weeks up to and after childbirth. Unlike unconditional cash transfers, women are obliged to attend antenatal care and check-ups for neonates to qualify for the payments. The central government launched the IGMSY in 2011. This scheme, implemented by the Ministry of Women and Child Development, provides Rs 4,000 to poor women on the condition that they attend antenatal care. State-level schemes such as the Prasuti Aaraike, Mamata, and DMRMMAS have been introduced in Karnataka, Odisha, and Tamil Nadu, respectively. Payments range from Rs 2,000 from the Prasuti Aaraike to Rs 12,000 from the DMRMMAS.

To date, little research has been done on conditional cash transfers in India, reflecting the limited scale of state programmes and the short time since most were launched. A recent qualitative study on the IGMSY highlighted supply-side problems of coverage and capacity that have not been addressed, the insufficient amount of money provided, and eligibility criteria that unfairly excluded vulnerable women (SAHAYOG 2012).

Use of Short-term Payment

These interventions have been introduced in a handful of countries and national programmes exist in only Nepal and India. The JSY (and its various state-specific manifestations) is the most well-known scheme to offset maternal health service costs in India. While many studies refer to the JSY as a conditional cash transfer scheme, it is important to differentiate it from the longer-term human development-focused conditional cash transfer programmes. The JSY provides a short term intervention around pregnancy and birth, with retrospective payments and has a highly focused aim. Payments range from Rs 500 to Rs 1,400 depending on whether a woman gives birth at home or in a health facility, and depending on the state that she lives in. The Madhya Pradesh government offered similar payments during the mid-2000s, but these were discontinued as the JSY was rolled out by the central government.

The JSY is the best documented DSF programme in India and a number of high-quality studies have been conducted on it. These fall into two categories - quantitative studies that focus on health service utilisation, health outcomes, and levels of personal expenditure (Lim et al 2010; Powell-Jackson et al 2011; Santhya et al 2011), and qualitative studies that focus on barriers to implementation (Dasgupta 2007; Gupta 2007; Chaturvedi and Randive 2009; Human Rights Watch 2009)

Use of Vouchers for Maternal Health Services

A number of state-level maternal health programmes have incorporated private facilities for the provision of "cashless" antenatal, intrapartum, and postnatal services to poor women. Vouchers and voucher-like schemes (in which providers are contracted to deliver services to women who possess a below the poverty line card or caste/tribe certificate) have proved one of the most popular DSF mechanisms in India.

The Chiranjeevi scheme in Gujarat is one of the better documented voucher-like programmes, It was introduced with the aim of empanelling the formal private sector to provide maternal health services in (typically rural) areas where public services are largely unavailable, unlike the Sambhav voucher scheme in Uttar Pradesh, which has been introduced in urban areas to ensure access to high-quality healthcare in the private sector. The few high-quality studies available on the Chiranjeevi .scheme have linked it to increased rates of institutional delivery (Bhat et al 2009), but described the emergence of unethical practices due to regulatory weaknesses (Jega 2007).

Evidence on the Use of DSF Schemes

Maternal health programmes that use DSF typically aim to increase utilisation of key maternity services and reduce maternal mortality. The JSY is primarily focused on improving coverage of maternity care in poor populations and evidence has linked it with increases in the use of antenatal, intrapartum, and postnatal care. Studies using data from the second and third rounds of the District Level Household and Facility Survey (DLHS-2 and DLHS-3) showed that the JSY increased uptake of three antenatal care visits by 9%-11%, institutional delivery by 31%-49%, and skilled attendance at delivery by 17%-39% (Lim et al 2010; Powell-Jackson et al 2011). Large household surveys conducted in Rajasthan indicated that recipients of JSY money were twice as likely to have three or more antenatal care visits compared to non-recipients, three times more likely to have an institutional delivery, twice as likely to have a skilled attendant during childbirth, and eight times more likely to attend postnatal care (Santhya et al 2011). Meanwhile a smaller study in Gujarat showed that the proportion of institutional deliveries was 26% higher among women who used the Chiranjeevi Yojana compared to those who did not (Bhat et al 2009). None of the studies included in the review considered the effects of unconditional or conditional cash transfers on health service utilisation.

A number of studies described critical limitations to monitoring systems for the JSY (Dasgupta 2007; Devadasan et al 2008; Nandan et al 2008a; Human Rights Watch 2009). They reported that data has been collected on the number of institutional deliveries and the amount of money disbursed to each woman, and not on health outcomes. Postnatal follow-up was absent for many women described in the studies and authors explained that there is little incentive for ANMs to report adverse outcomes in their communities. This creates an obstacle to monitoring the impact beyond health service utilisation. None of the studies eligible for the review presented findings showing the equity of changes in health service utilisation or effects of DSF modes on maternal mortality or morbidity. Lim et al (2010) attempted to show the effect of the JSY on maternal mortality but noted that DLHS data lacked sufficient statistical power to detect anything other than large changes. As a consequence, they found no statistically significant change in maternal mortality.

Programme Costs, Payment Systems and Costs to Users

Only one study in the review presented unit costs for DSF, drawing on data from a two-year Sambhav voucher pilot in Jharkhand. The study found that the average programme cost per service used (including user costs) was Rs 276 for an antenatal care visit, Rs 3,533 for an institutional delivery, and Rs 173 for a postnatal care visit (IFPS Technical Assistance Project 2012). The authors concluded that programme costs were lower than market prices and that unit costs would fall further as utilisation increased, but also noted that unit costs would begin to rise again if voucher utilisation increased by 50%.

The cost of DSF from the perspective of enrolled health facilities was examined by a study on a MAMTA voucher-like scheme in Delhi (Nandan et al 2010). The study used data from a private hospital enrolled in the scheme to show that their costs exceeded the rate of reimbursement by an average of Rs 3,919 per institutional delivery, concluding that reimbursement rates were too low for providers to remain interested in the scheme. There is some evidence that reimbursement methods for voucher schemes have led to unscrupulous activities by contracted private facilities. Flatrates of reimbursement in the Chiranjeevi scheme have provided an incentive for facilities to minimise costs by reducing the quality of supplies used (Jega 2007). The scheme provides the same level of reimbursement to providers regardless of whether a delivery is complicated or not and there is evidence that this has led to some providers requesting informal payments or referring complicated cases unnecessarily - "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" (ibid: 27).

Conditional cash transfer programmes and short-term payment schemes distribute payments to women through health facilities or community health workers. Delays in the distribution of payments from government agencies can damage the reputation and work of health providers if they mean that women do not receive the payments they are entitled to (Gupta 2007; Hangmi and Kuki 2009; Public Health Resource Network et al 2010). In some cases, community health workers accompanying women to health facilities have been asked for informal payments on behalf of the women's families, undermining the position of trust that these workers rely on to work with families (Human Rights Watch 2009).

The only studies that considered the effect of DSF on out of-pocket expenditure were state-level studies of the JSY. Their findings raise some concern about the scheme's limitations in protecting poor households from incurring costs at maternity facilities. Between 22% and 61% of women paid more money than they received (Uttekar et al 2007a, 2007b, 2007c; National Health System Resource Centre 2011; Santhya et al 2011). Three of the studies found that JSY recipients who gave birth in health facilities made a net loss, yet JSY recipients who gave birth at home made a net .gain (Uttekar et al 2007a, 2007b, 2007c). Further, a large multi-state study on the JSY found that while more than 90% of the women surveyed had received Rs 1,400 in each of the five states studied, average expenditure ranged from Rs 299 in Madhya Pradesh to Rs 1,639 in Odisha (UN Population Fund 2009).

Availability and Quality of Maternal Health Services

Conditional cash transfer programmes and short-term payment schemes to offset costs of access, such as the IGMSY and JSY, require that women use formal healthcare providers for antenatal and intrapartum care. However, at the community level in rural areas this is undermined by gaps in antenatal care coverage and delays to the referral of women suffering intrapartum or post-partum complications (Dasgupta 2007; Gupta 2007; Chaturvedi and Randive 2009; Human Rights Watch 2009; Rai et al 2011). The role of ANMs as community level maternal healthcare providers has been undermined by limitations to their training and an ANM is not always posted to lower-level facilities. Where ANMs have been posted, their midwifery activities may be constrained by concurrent commitments for family planning and child health and a large catchment area (Dasgupta 2007; Gupta 2007; Human Rights Watch 2009).

Only two of the studies included in the review attempted to quantify the effect of using a DSF scheme on quality of care received, and both focused on the JSY (Uttekar et al 2007d; Santhya et al 2011). The first, based on interviews with JSY recipients in Odisha, yielded mixed findings. On the positive side, the average length of time spent waiting to be seen was around 30 minutes, including registration. However, many women were discharged early - on average 22 hours after giving birth though the government guideline is 48 hours (Uttekar et al 2007d). The second study, using survey data from before and after the introduction of JSY in Rajasthan, showed that the JSY increased the likelihood of receiving information on danger signs during pregnancy, of having four or more antenatal check-ups, of being allowed a companion present during labour and childbirth, and of discharge from hospital after at least 24 hours (Santhya et al 2011). The study showed no impact on information provided on postnatal care or neonatal health and no impact on use of harmful practices during delivery, reported cleanliness of facilities, and the extent of respectful behaviour by the staff. The majority of respondents, both JSY recipients and non-recipients, felt that their healthcare provider was clean and that the staff members were respectful. Yet, heavy fundal pressure was applied during the care of one-third of the women and more than 70% received an intra-muscular oxytocin injection.

Qualitative studies indicate that in some settings the increased utilisation of maternal health services overburdened government and private facilities (Devadasan et al 2008; Nandan et al 2008b, 2010; Human Rights Watch 2009). In some areas there was a chronic shortage of resources for emergency obstetric care such as obstetricians, anaesthetists, and blood banks, particularly at the lower levels (Gupta 2007; Jega 2007; Singh and Chaturvedi 2007; Nandan et al 2008a; Human Rights Watch 2009). This was compounded by an absence of clear referral systems, leading to multiple referrals for some women until they reached a tertiary centre with the required skills and equipment (Dasgupta 2007; Nandan et al 2008a, 2010; Chaturvedi and Randive 2009; Human Rights Watch 2009; Krishna and Ananthpur 2011).

Effects on the Social Status of Poor Women

Evidence from other settings has indicated that DSF can be used to improve women's social status in small but important ways (Murray et al 2012). For example, a voucher scheme in Armenia that emphasised women's right to healthcare services increased dignity and awareness of entitlement (Truzyan et al 2010). Oportunidades, a conditional cash transfer programme in Mexico, focuses primarily on child health and education conditionalities, with some maternal healthcare requirements and has the mother as the recipient of cash payments. It has increased the income of poor women and thereby enhanced their capacity for autonomy within the family (Latapí and De la Rocha 2008). However, the effects depend greatly not only on the aims of the schemes, but also on the details of how they are organised, and the amount of thought given to obstacles. This

section summarises qualitative evidence from Indian DSF schemes that indicates some deep-seated barriers to entitlement, dignity, and choice for poor women.

The first barriers are over simplistic targeting mechanisms and exclusionary eligibility criteria. Most DSF schemes use the existing "below poverty line" (BPL) card system or tribe/caste certification to determine eligibility and this may be the most realistic mechanism in large statewide schemes. However, there is evidence from several studies that the use of BPL cards and tribe/caste certificates without additional supplementary mechanisms risks excluding women without the necessary documents, especially migrants and some of the poorest families (Charurvedi and Randive 2009; Human Rights Watch 2009; Nandan et al 2008a, 2010).

Exclusionary criteria for age and parity reflect the continued influence of family planning in maternal health policies (Lingam and Yelamanchili 2011), and are counterproductive to the aim of reaching the poorest. They are more commonly employed in states with better health outcomes. Parity restrictions typically restrict eligibility to women with no more than one or two previous live births. Age-based criteria, for example, that any recipient must be aged over 19 years, are less common but have been used in national government schemes such as the IGMSY and JSY. In all states, JSY payments for skilled attendance during a home birth are given only to women aged over 19 years and with no more than one previous live birth. There is no evidence on the effect of these restrictions on maternal health, though Lingam and Yelaman-chili (2011) noted that 63% of poor women would be ineligible for IGMSY payments due to parity and age restrictions.

The second set of barriers relate to the erosion of entitlements once they have been claimed. Like Latin American schemes, India's cash transfer schemes assume the woman to be the recipient of the cash. However, the positive impact of this depends in part on the mechanism used for distribution. Where cheques are used to reduce corruption, women without bank accounts and the required documents to open them may have to cede control of the money to family members who may not use it for their nutrition or treatment (Chaturvedi and Randive 2009; Kumar et al 2009). Women's entitlement to free healthcare has also been undermined by shortages in medical supplies at government facilities, requests for informal payments, and poor attitudes from staff (Devadasan et al 2008; Nandan et al 2008a, 2008b, 2010; Hangmi and Kuki 2009; Human Rights Watch 2009; Kumar et a12009; Lodh et a12009; Khan et al 2010; Krishna and Ananthpur 2011; Rai et al 2011; Santhya et al 2011). Studies on the JSY have demonstrated how these problems have reinforced the stigma of poverty when poor women are unable to meet nurses' demands for supplies (Gupta 2007), or are disrespected at primary health centre (PHC) facilities, and treated like beggars simply for asking for the JSY money (Kumar et al 2009).

Finally, the exercise of choice is often mooted as one of the advantages of voucher schemes in healthcare. However, evidence on the MAMTA voucher scheme in Delhi indicates that even in a densely populated urban setting it can be difficult to provide a genuine choice of providers to poor women (Nandan et al 2010). Not only did women have insufficient information to use the scheme in this way, but the scheme was also not considered lucrative enough to attract and retain large numbers of private providers. Therefore women simply tended to use the enrolled provider that was nearest to their home (Nandan et al 2010),

Conclusion

Recent maternal health policy in India, as globally, has tended to focus on a set of narrow targets of mortality reduction and the uptake of specific health services. This has been an unfortunate and contradictory byproduct of the political success of bringing maternal health to the MDG table, and the challenge of then framing complex needs for health and wellbeing in measurable "smart" indicators to track progress. This has been compounded by the fragmentation of maternal health policy between the Ministry of Health and Family Welfare, the Ministry of Women and Child Development, and state-level policymakers. The recent policy focus on providing maternal healthcare in facilities, for example, has failed to integrate the role of home-based care and dais in communities. Despite the MDGs' overall concern with elimination of poverty, a fixation with institutional deliveries has diverted attention from the need to provide a continuum of care for poor mothers before, during, and following pregnancy, and from their broader needs for good nutrition, personal safety, decent work and living conditions, and adequate rest.

The influence of MDG indicators can be seen in the shift over the last 10 years from unconditional cash transfers concerned with broader, indirect determinants of maternal health such as rest and nutrition, to conditional cash transfers and short term payment schemes that encourage women to access formal antenatal and intrapartum care. The assumption that such measures will increase health service utilisation and translate into improved maternal health has proved problematic, given the challenges facing the Indian health system. The equity of changes in utilisation remains unclear and payments conditional on the use of poorly resourced public health facilities have exposed women to underlying problems in the health system, such as

gaps in coverage, insufficient expertise and capacity in communities and facilities, and poor attitudes towards women. The entitlement to decent healthcare is subverted by a culture of disrespect towards poor families in an overburdened and under-resourced health system (Mavalankar et al 2008; Sri et al 2012).

The future role of the private sector in healthcare provisions is one of the key debates among plans to achieve universal access to healthcare (Sen 2012). Experiences with voucher schemes to access private sector maternity services should inform these discussions. Our review has highlighted at least three critical issues. First, research indicates the need for effective regulatory frameworks to protect quality of care from a "race to the bottom" as for-profit providers seek to reduce costs (Jega 2007). Second, there are concerns about private sector contracting in urban areas that bypasses existing government health services rather than working to strengthen these (Ravindran 20n). Third, fragmented services result in inadequate access to timely and affordable care for women who develop obstetric complications. Shifts in government policy towards private healthcare provisions, as envisaged in the Twelfth Five-Year Plan (2012-17), will risk further weakening obstetric referral systems if private hospitals see little benefit in providing expensive treatments for obstetric complications. Much more research and evaluation is required before conclusions can be drawn on the suitability of private sector contracting to provide maternal health services in India.

References

1. Banerji, D (1972): "Prospects of Controlling Population in India", *Economic & Political Weekly*, 7(41): 2067-74.
2. Bhat, R, D V Mavalankar, P V Singh and N Singh (2009): "Maternal Healthcare Financing: Gujarat's Chiranjeevi Scheme and Its Beneficiaries", *Journal of Health, Population, Nutrition*, 27 (2), 249-58.
3. Chaturvedi, Sand B Randive (2009): "Are Arrangements for Public Private Partnerships for Emergency Obstetric Care Services Adequate under JSY? A Study in Ahmednagar District, Maharashtra" in *Reaching the Unreached* (New Delhi: Centre for Health and Social Science; Nidhi Books), 115-41.
4. Dasgupta, J (2007): "Experiences with Janani Suraksha Yojana in Uttar Pradesh: Analysis of Case Studies by SAHAYOG and Partners" in *Reviewing Two Years of NRHM* (New Delhi: Centre for Health and Social Justice), 109-17.
5. Devadasan, N, M A Elias, D John, S Grahacharya and L Ralte (2008): "A Conditional Cash Assistance Programme for Promoting Institutional Deliveries among the Poor in India: Process Evaluation Results", *Studies in Health Services Organisation and Policy*, 24: 257-73.
6. Ensor, T (2004): "Consumer-led Demand Side Financing in Health and Education and Its Relevance for Low and Middle Income Countries", *International Journal of Health Planning and Management*, 19 (3): 267-85.
7. Government of India (2005): *National Rural Health Mission* (2005-2012): *Mission Document* (New Delhi: Government of India).