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GLOBAL HEALTH POLICY

By Jessica Cohen, Claire Rothschild, Ginger Golub, George N. Omondi, Margaret E. Kruk, and Margaret McConnell

Measuring The Impact Of Cash Transfers And Behavioral 'Nudges' On Maternity Care In Nairobi, Kenya

ABSTRACT Many patients in low-income countries express preferences for high-quality health care but often end up with low-quality providers. We conducted a randomized controlled trial with pregnant women in Nairobi, Kenya, to analyze whether cash transfers, enhanced with behavioral "nudges," can help women deliver in facilities that are consistent with their preferences and are of higher quality. We tested two interventions. The first was a labeled cash transfer (LCT), which explained that the cash was to help women deliver where they wanted. The second was a cash transfer that combined labeling and a commitment by the recipient to deliver in a prespecified desired facility as a condition of receiving the final payment (L-CCT). The L-CCT improved patient-perceived quality of interpersonal care but not perceived technical quality of care. It also increased women's likelihood of delivering in facilities that met standards for routine and emergency newborn care but not the likelihood of delivering in facilities that met standards for obstetric care. The LCT had fewer measured benefits. Women preferred facilities with high technical and interpersonal care quality, but these quality measures were often negatively correlated within facilities. Even with cash transfers, many women still used poor-quality facilities. A larger study is warranted to determine whether the L-CCT can improve maternal and newborn outcomes.

Every year in sub-Saharan Africa, 1.3 million women and newborns die in delivery or shortly thereafter.[1,2] For delivery complications to be managed effectively, women must deliver in facilities that have essential medicines and supplies, well-trained health care workers, and functioning referral systems. Studies of African maternity facilities have found extremely insufficient quality of routine and emergency care.[3] In Kenya only 5 percent of maternity facilities perform cesarean sections, only 49 percent have referral capacity, and many lack antibiotics and injectable anticonvulsants.[4]

Beyond these technical components of care quality, many Kenyan facilities perform poorly in nontechnical interpersonal aspects of care, with 20 percent of women reporting that they experienced disrespect or abuse during delivery.[5]

Many policy approaches to improving the quality of maternal care focus on the supply side—for example, by training providers or upgrading facility infrastructure and equipment.[6] Demand-side financing programs have focused on improving patient access to facilities through reducing costs or providing financial assistance in the form of cash transfers.[7,8] Cash transfer programs have been used in low-income coun-

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