What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

by Ernestina Coast, David McDaid, Tiziana Leone, Valentina Iemmi, Emma Pitchforth, Zoe Matthews, Atsumi Hirose, Rowena Macrae-Gibson, Jane Secker, Eleri Jones

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# Abbreviations

## List of abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>APHRC</td>
<td>African Population and Health Research Center</td>
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<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guerin</td>
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<tr>
<td>CS</td>
<td>Caesarean section</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability-Adjusted Life Year</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DSS</td>
<td>Demographic Surveillance System</td>
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<tr>
<td>DTP</td>
<td>Diphtheria-Tetanus-Pertussis</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency obstetric care</td>
</tr>
<tr>
<td>ENC</td>
<td>Essential newborn care</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>EPPI</td>
<td>Evidence for Policy and Practice Information</td>
</tr>
<tr>
<td>EV</td>
<td>External validity</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly active antiretroviral treatment</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B vaccine</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant mortality rate</td>
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<tr>
<td>IV</td>
<td>Internal validity</td>
</tr>
<tr>
<td>JSY</td>
<td>Janani Suraksha Yojana</td>
</tr>
<tr>
<td>KMC</td>
<td>Kangaroo mother care</td>
</tr>
<tr>
<td>LBW</td>
<td>Low birthweight</td>
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<tr>
<td>LIC</td>
<td>Low income country</td>
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<tr>
<td>LMC</td>
<td>Lower middle income country</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MDR</td>
<td>Maternal death review</td>
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<tr>
<td>MeSH</td>
<td>Medical subject headings</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>MMR</td>
<td>Maternal mortality ratio</td>
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<td>MR</td>
<td>Mortality rate</td>
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<tr>
<td>MTCT</td>
<td>Mother to child transmission</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NASG</td>
<td>Non-pneumatic anti-shock garment</td>
</tr>
<tr>
<td>NFHS</td>
<td>National Family Health Survey</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NMMS</td>
<td>National Maternal Mortality Study</td>
</tr>
<tr>
<td>NPI</td>
<td>National Programme on Immunization</td>
</tr>
<tr>
<td>NSCU</td>
<td>Neonatal special care unit</td>
</tr>
<tr>
<td>OPV</td>
<td>Oral polio vaccination</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral rehydration salts</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>RPR</td>
<td>Rapid plasma reagin</td>
</tr>
<tr>
<td>SAMM</td>
<td>Severe acute maternal morbidity</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled birth attendance</td>
</tr>
<tr>
<td>SSA</td>
<td>sub-Saharan Africa</td>
</tr>
<tr>
<td>SFH</td>
<td>Symphyseal-fundal height</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
</tr>
<tr>
<td>UCP</td>
<td>Umbilical cord prolapse</td>
</tr>
<tr>
<td>VAS</td>
<td>Vitamin A supplementation</td>
</tr>
<tr>
<td>VBAC</td>
<td>Vaginal birth after Caesarean</td>
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<tr>
<td>VLBW</td>
<td>Very low birthweight</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

Background
The burden of maternal and infant deaths falls disproportionately on low income countries (LICs) and lower middle income countries (LMCs1) and among the poorest within these countries. The causes of maternal and infant mortality and morbidity are well established, yet knowledge on effective management of conditions has not been translated into significantly improved outcomes because of a lack of resources and effective models of service delivery. Urban populations are often assumed to have better access to health care than those living in rural areas. However, urban health systems in many LICs and LMCs have a weak to non-existent public health structure and lack uniform implementation of strategies and necessary infrastructures. Given rapid urbanisation in many LICs and LMCs it is now crucial to establish evidence-based approaches to improving access to and uptake of maternal and infant care models in urban areas and improving quality of services in order to improve maternal and child outcomes. Whilst the medical solutions for preventing maternal and infant mortality are known, delivering these solutions is a considerable challenge in proximity to urban slums.

Objectives
This systematic review addresses the question:

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?’

Methods
Our systematic review focused on explicit evaluations of interventions aimed at improving health outcomes for poor people in urban areas. The review focused on maternal, infant, neonatal, perinatal and post-neonatal mortality outcomes, but also included maternal and infant health outcomes. Our review team, including information scientists and information retrieval experts, developed a search protocol and search terms that were subject to external peer review. Our search includes major databases that cover literature on this topic; these cover both English and non-English language material, including specialist health and development databases, as well as those focusing on specific geographical areas. A comprehensive search was conducted of published and unpublished materials. The search followed the study protocol, which set out the search strategy and selection methods. The study used multiple approaches to data analysis (including: narrative; cost-effectiveness; understanding links between the cause, approaches, outcomes and sustainability of change as part of a causal chain analysis) to assess not only which interventions are effective (or not), but how and under what circumstances. Quantitative and qualitative data were collected from and coded for included items, and each item was coded for a range of variables. Interventions were grouped into clinical and non-clinical categories. We collected qualitative evidence on contextual factors and causal pathways that may help to explain why interventions were (in)effective.

1 We used the World Bank classification: http://data.worldbank.org/about/country-classifications (accessed 10 March 2011).

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Details of included studies
The searches returned 9,025 potentially relevant items of evidence, including 9,010 from database searches and 15 from handsearches. Of these papers, 98% were excluded after reviewing titles; the abstracts of the remaining 114 studies date from 1989 to 2010. Our search strategy was limited to LICs and LMCs, and certain countries were prominent in the resulting database of evidence. A quality assessment was made on all items including the evaluation of both internal and external validity by means of standard tools. Internal validity concerns the accuracy of results; for example results could be inaccurate if samples were not selected randomly. External validity concerns the generalisability of the findings to the population.

Synthesis results
There are few published studies looking at interventions that specifically target the urban poor’s access to and use of maternal and child health (MCH) services, and even fewer that use mortality indicators as one of their outcomes. No items were found that explicitly assessed the effectiveness of different models of service delivery to reduce maternal and infant mortality among poor urban populations. However it should also be acknowledged that studies that have been excluded from this analysis because they do not specifically focus on urban, poor populations will contain evidence on the effectiveness of different intervention models that could potentially be targeted at the urban poor. It is important to consider the extent to which these interventions could be applied to our target population.

Of the items returned, 56% were classified as individual clinical interventions, leaving 44% in the non-clinical category. Of the ‘non-clinical’ interventions, most consisted of systemic interventions such as provider models, information, audits, investment and scaling up, and financial protection. Of the non-clinical items, 26% included established groups of non-clinical interventions such as Kangaroo Mother Care and nutrition approaches such as breastfeeding promotion. Most of the studies that concerned purely clinical interventions - although pertaining to urban populations - are applicable in rural areas. Interest in our review focused mainly on the non-clinical findings - as these are judged to be closer to the wider conceptualisation of ‘models of delivery’ which has been key to implementation but less of a focus among researchers.

Conclusions and recommendations
Our analyses form a convincing case that there is a need for high-quality evidence on maternal and infant interventions that specifically target the urban poor. The existing evidence base is minuscule compared to the rapidly growing and large urban poor population. Much of the existing evidence is of poor quality, with little emphasis on baselines and follow-up studies, and almost no qualitative (how? why?) evidence to complement the limited quantitative (what?) data. This small evidence base is out of step with the growing interest in urban poor people and the size of this population. Interventions supported by the review are already present in existing WHO guidelines. However, there is a need for research that specifically addresses the effectiveness of different models of service delivery, including how sub-populations (e.g., urban poor) are targeted.

Although the evidence base appears limited, there are in fact a number of ways in which it might be strengthened in the short term. We suggest one way of strengthening the evidence base on the cost-effectiveness of different strategies to promote better access and use of maternal and infant health services. This would

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be to retrospectively make use of data looking at the uptake and effectiveness of actions that help increase uptake from papers identified in this review, then estimate the costs of implementation, including their impact on the future use of health services or on other economic costs if mortality (and morbidity) were avoided.
1. Background

Summary
The global burden of maternal and infant deaths falls disproportionately on low income countries (LICs) and lower middle income countries (LMCs) and among the poorest within these countries.

Urban growth is changing population health, particularly among the urban poor. The number of births taking place in urban areas in LICs and LMCs is increasing; services must accommodate this because large populations and high population density in urban areas influence options for service organisation.

It is crucial to establish evidence-based ways of improving models of service delivery and access to and uptake of maternal and infant care.

This systematic review addresses the question:

“What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?”

1.1 Aims and rationale for the review
The Millennium Development Goals (MDGs) have focused global attention on significantly improving maternal and infant health. In 2008, 70 percent of around 8.8 million under-five deaths occurred during the first year of life (World Health Organization, 2010). Estimates suggest that there are around 350,000-500,000 maternal deaths per year (Ban Ki-moon, 2010) with 15 million more women suffering long-lasting injury or illness from preventable pregnancy-related causes (Ban Ki-moon, 2010) and many more suffering related mental morbidities. These figures represent improvements over the last two decades in some countries but further significant mortality reductions will be required to meet the MDGs’ targets of reducing under-five mortality by two-thirds from 1990-2015 and reducing maternal deaths by three-quarters (United Nations, 2009) in the same timeframe.

The burden of maternal and infant deaths falls disproportionately on low income countries and lower middle income countries and among the poorest within these countries. The causes of maternal and infant mortality and morbidity are well established (Ronsmans and Graham, 2006) yet knowledge on effective management of conditions has not been translated into significantly improved outcomes because of a lack of resources and effective models of service delivery (Campbell and Graham, 2006; Filippi et al., 2006). Urban populations are often assumed to have better access to health care than those living in rural areas. However, urban health systems in many LICs and LMCs have a weak to non-existent public health structure and lack uniform implementation of strategies and necessary infrastructures.

Sub-optimal health outcomes are evident among the urban poor with the lowest access to and use of health care facilities. With respect to maternity services, urban women tend to be more likely than rural women to give birth in health facilities. However, urban inequalities in maternal-newborn health care are huge in many poor countries (Matthews et al., 2010). Poor quality of care in many urban facilities plays a significant role in counteracting the positive effects of skilled birth attendance (SBA) (More et al., 2009a, 2009b). Given rapid urbanisation in
many LICs and LMCs, it is now crucial to establish evidence-based ways of improving models of service delivery and access to and uptake of maternal and infant care in order to improve maternal and child outcomes.

Levels of infant mortality are often lower in urban areas than in rural at the aggregate level (UNSD, 2008). However recent trends have shown mortality improvements in the rural areas and increases in the urban areas with the exception of a few South Asian countries (UNSD, 2008). Central American and central Asian countries often show a higher level of mortality in urban areas than rural. This is possibly due to the rapid urbanisation, which often occurs without appropriate planning for infrastructure and health services. The differences become even more striking when we consider the gap between the poor and the rich. While we have a more even distribution in rural areas, the inequality within urban areas is often striking. A recent study in sub-Saharan African (SSA) countries (Anyamele, 2011) showed a considerably higher level of infant mortality in rural areas, but also a high level of variation within urban areas when considering level of wealth. However, data on maternal mortality by residence is very hard to estimate due to the small numbers. One recent study by Matthews et al. (2010) shows how the urban advantage is almost non-existent when we account for wealth levels within areas. In urban areas, they remark that this is mainly due to poverty marginalisation, which prevents access to care.

Despite growing evidence of poor maternal and infant health outcomes and inequalities within urban areas of low income countries, a systematic analysis and synthesis of evidence as to effective models of service delivery is lacking. The aim of our study was to conduct a robust systematic review to address the question:

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

Through the systematic review we aim to provide important information and draw out key recommendations for policy makers at international, national and sub-national levels.

1.2 Definitional and conceptual issues

1.2.1 The urban poor: who and where?

Urban growth - including the absolute and relative number of urban dwellers and the physical expansion of urban areas - is ‘reshaping’ population health, particularly among the urban poor (Commission on Social Determinants of Health, 2008, p.4). By 2050, there will be an estimated 6.4 billion urban dwellers, compared to 3.4 billion in 2009 (UNHABITAT, 2010), and the global future has been described as a ‘planet of cities’ (Angel et al., 2011).

By 2050 it is estimated that seven out of every ten people will live in a city, with almost all of this growth taking place in developing countries. It is estimated that one in three urban dwellers lives in a slum, meaning that an estimated 828 million people are currently living in informal settlements, producing so-called ‘hidden cities’ (UNHABITAT, 2010). More than 90 percent of slums are located in cities in developing countries, and those cities that are the fastest growing are most likely to have informal settlements. In sub-Saharan Africa, it is estimated that more than 60 percent of city dwellers inhabit slums (UNHABITAT, 2010).

2 Unless stated otherwise, all data are drawn from United Nations Department of Economic and Social Affairs (2010) and UNHABITAT (2010).

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An estimated one-third of all urban residents are poor, representing one-quarter of the world’s total poor (Baker, 2008; Ravallion et al., 2007). Poverty is multidimensional and complex; its conceptualisation and measurement is beyond the scope of this review. Related debates accompany the conceptualisation and measurement of urban poverty (Baker, 2008), for example, discussions around how to account for the higher cost of living in urban areas in national-level poverty estimates. Evidence suggests that current poverty levels might underestimate the levels of urban poverty in low and middle income countries (Satterthwaite, 2004). Debates about the definition of what is ‘urban’ also affect estimates of urban poverty (Satterthwaite, 2007).

We know that there are fuzzy boundaries between urban and rural, boundaries that continually evolve – both planned and unplanned. Rates of expansion of urban land cover in LICs and LMCs are high, although the absolute amount of land cover accounted for by urban areas remains low. Whilst it is beyond the scope of this review to debate what is meant by urban, and our methodology takes an inclusive approach, the issues around types of urban setting are important, and reflected not only in the substantive findings, but also the volume of published work on different sorts of urban settings.

Concern is increasingly expressed about the low levels of research and policy attention to smaller cities (> 1 million and <10 million inhabitants), of which it is estimated there are 500 globally (Commission on Social Determinants of Health, 2008, p.60; Montgomery, 2008). Analyses suggest that smaller cities, despite the research focus on mega-cities (>10 million inhabitants), might have even higher rates of poverty (Baker, 2008; National Research Council, 2003).

The urban poor as a population sub-group are spatially and temporally heterogeneous (Mabogunje, 2007), even when fairly straightforward sub-groups are identified, such as urban natives or migrants (rural-urban and urban-urban). The characteristics of where the urban poor live are equally heterogeneous - neighbourhoods are not necessarily consistently poor (Montgomery and Hewett, 2005). Slum residents are not the only urban poor, although they do represent a spatial clustering of living conditions within any single city. As projected rates of urbanisation continue, even if the relative levels of urban poor remain constant, the absolute numbers will rise, making poverty an increasingly urban phenomenon.

1.2.2 Data on the health of the urban poor

Rapid urban growth in developing countries – both in terms of population and land coverage – places increased demands on already overstretched agencies to collect data from and about the urban poor. Even aggregate ‘headcount’ data can fail to keep up with the speed and location of population growth in many settings. In addition, we know that slum residents tend to be less likely to be included in censuses and surveys; they might want to remain hidden if their residence is illegal; slums are difficult places to send enumerators to work in; and slum households tend to be less likely to be included in routine mapping and listing exercises (World Health Organization, 2008; Shetty, 2011). Many urban poor can be characterised as ‘hard to reach’ populations from the perspectives of censuses and surveys.

Routine data dealing with the health of the urban poor, where they exist, tend to be aggregated, ignoring differentials within cities and between neighbourhoods. There are increasing calls for disaggregated data to be available (Harpham, 2009; UNHABITAT, 2010, p.xiii). Similarly, health information that is produced tends to be aggregated, ignoring health and wealth differentials within cities and between neighbourhoods.

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Cross-sectional surveys such as the Demographic and Health Surveys (DHS), National Family Health Survey (NFHS) in India, and Multiple Indicator Cluster Surveys (MICS) are an important source of data that allow disaggregation, for example, by wealth quintile of urban populations. These sorts of analyses have driven much of the bulk of descriptive evidence that exists about the health of the urban poor (Hazarika, 2009; Antai and Morad, 2010; Matthews et al., 2010).

Whilst an important source of disaggregated information for those settings where there are no other data sources, this sort of approach is not without its critics. Montgomery (2009) outlines three major shortcomings of reliance on these sorts of datasets and analyses: low reliability of estimates of health among the poor in any given city; insufficient spatial information to identify small- and medium-sized cities; and, over-reliance on proxy variables to construct measures of living standards due to the absence of information on income or consumption expenditures.

There are calls (Harpham, 2009) for greater investment in longitudinal, prospective studies that deal specifically with the urban poor. Demographic Surveillance Systems (DSS) such as those covered by the In-Depth network\(^3\) are one such source, and in Africa include sites such as the Nairobi Urban Health and Demographic Surveillance System\(^4\) in Kenya and Bandim Health Project\(^5\) in Guinea Bissau, which are fully established and producing data and research. A new DSS site in Ouagadougou\(^6\) has started to collect data which are not yet available for analyses. Emergent research agendas focusing on health in LICs include the Urban Health Resource Centre in India\(^7\) (Urban Health Resource Centre, 2006). Specific online foci for gathering relevant research have recently been developed, including the Measurement, Learning and Evaluation Project for the Urban Reproductive Health Initiative.\(^8\)

### 1.3 Policy and practice background

#### 1.3.1 What are models of service delivery?

Models of service delivery are concerned with how interventions are delivered. They specify the component intervention package, target groups and means of distribution (Campbell and Graham 2006). Their impact depends not only on the effectiveness of the package of interventions, but also on the coverage achieved by the means of distribution, its uptake by the target population, and quality (Campbell and Graham 2006). Furthermore, models of service delivery are influenced enormously by context and must consider the local epidemiology; economic, geographical and cultural barriers; and the local health system’s infrastructural and human resource capacity (Lawn et al., 2009).

Whilst the medical solutions for preventing maternal and infant mortality are known, delivering these solutions is a considerable challenge. Despite variation across regions, most maternal deaths in LICs and LMCs are due to a handful of causes, including haemorrhage, hypertensive disorders, sepsis/infections,

\(^3\) http://www.indepth-network.org/ (accessed 17 January 2012)

\(^4\) http://www.aphrc.org/insidepage/?articleid=470 (accessed 17 January 2012)

\(^5\) http://www.bandim.org/ (accessed 17 January 2012)

\(^6\) http://www.issp.bf/OPO/ (accessed 17 January 2012)

\(^7\) http://www.uhrc.in/ (accessed 17 January 2012)

\(^8\) http://www.urbanreproductivehealth.org/ (accessed 17 January 2012)
obstructed labour, and in certain regions, unsafe abortion and HIV/AIDS (Khan et al., 2006). Maternal deaths are clustered in the period during labour, delivery and the immediate postpartum period because complications arise in around 15 percent of births in any context, which are largely unpredictable and can rapidly become life-threatening (Ronsmans and Graham 2006; White Ribbon Alliance, 2010).

Maternal and infant outcomes are closely connected. A substantial proportion of infant deaths are clustered in the early neonatal period, particularly in the first 24 hours (Lawn et al., 2005). Causes of death include obstetric complications before or during the birth and their management, preterm births and congenital abnormalities. Harmful practices after birth can also lead to severe infections in the neonatal period (World Health Organization, 2006). The epidemiology of infant deaths is different after the first month of life, however, when pneumonia, diarrhoea, malaria and vaccine-preventable conditions become the main causes (Lawn et al., 2005; World Health Organization, 2006).

Clearly, major reductions in maternal and neonatal deaths depend on the functioning of the whole health system because no single intervention can address the diverse range of causes, and many causes have medical solutions that require prompt and skilled action (Koblinsky et al., 1999). In contrast, many infant deaths in the post-neonatal period can be prevented through public health or vertical programmes, along with clinical case management for episodes of illness (Lawn et al., 2005). Models of service delivery for reduction in maternal and infant mortality are thus complex and vary across several dimensions.

There is a general consensus that care during the intrapartum period is of key importance given the epidemiology of maternal and early neonatal deaths, but antenatal care, postnatal care, newborn baby and child care, and reproductive health care may also contribute to mortality reductions (Ronsmans and Graham, 2006; Kerber et al., 2007). Types of intervention may be clinical and/or non-clinical in focus and packages may include information, financial assistance, community mobilisation, commodities, drugs or health care. Models also differ according to the means of distribution: where the service is provided and by whom. For example, services may be delivered to individuals at home, at primary health care facilities or at hospitals by various health professionals or non-professionals, or to whole communities through mass media. The level of involvement of public, private and non-governmental sectors in distribution will vary between countries (Baqui et al., 2008; Bhattacharyya et al., 2010). However, there is interdependence between the means of distribution and the content of intervention packages (Campbell and Graham, 2006). Finally, subgroups of the population may be targeted or the aim may be to reach the whole population.

1.3.2 Models of service delivery and the urban poor

A review focusing on the urban poor population is necessary because, despite difficulties in generalising across settings, there are specific characteristics of the urban environment, population and health system that have potential implications for models of service delivery. Rapid urban population growth means that the number of births taking place in urban areas in LICs and LMCs is increasing, and services must accommodate this. Furthermore, large populations and high population density in urban areas influence options for service organisation. Many of these births are among the urban poor, a large proportion of whom live in slum areas that have tended to be underserved by public services (Matthews et al., 2010). Given the considerable inequality in urban areas in many regions, decisions need to be made on how services can best be prioritised to reach the poorest and most vulnerable segments of the population to reduce maternal and infant deaths.

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
For some causes of maternal and infant deaths, the urban environment poses specific risks. For example, the distribution of factors linked with maternal mortality, such as malnutrition, obesity, age at first birth and fertility, may differ in urban areas. Certainly, HIV/AIDS, which makes a substantial contribution to both maternal and infant mortality in SSA, disproportionately affects urban areas (Khan et al., 2006; UNAIDS and World Health Organization, 2009). For infants in particular, the pollution in many cities, and the lack of sanitation and overcrowding in slum areas, also raise certain health risks (Hardoy et al., 2001). These epidemiological considerations need to be addressed in the development of intervention packages.

Demand may also differ in urban areas. Urban living is perceived to be associated with modernity; levels of education tend to be higher; and urban areas may provide greater opportunities for exposure to health-related information (More et al., 2009a, 2009b). Nonetheless, the 'urban poor' are heterogeneous both within and across urban areas. Alongside socio-economic inequalities, people from diverse cultural backgrounds live in proximity, with potential implications for both health-related needs, expectations and demands. In particular, rural-urban migrants may be influenced by their present context whilst also retaining influences from their previous context. Traditional social connections may be broken and new ones formed when an individual or group migrates, which may have positive or negative effects on health risks, health-related attitudes and behaviour, and health-related support (Harpham, 2009). This diversity in urban areas must be addressed in the development of models of service delivery.

Whilst the environment and characteristics of the population in urban areas have implications for models of service delivery, implications also arise from the existing health system. Urban areas tend to be served by a wide range of providers (Parkhurst and Rahman, 2007; More et al., 2009a, 2009b). In particular, private health services are prominent in many LICs and LMCs, which are even used by the poor when circumstances allow (Matthews et al., 2010; Bhattacharyya et al., 2010). In these settings, public sector provision increasingly deals with the poorest and most vulnerable urban residents (Matthews et al., 2010).

1.4 Research background

1.4.1 What is different about the health of the urban poor?

Much is known about the descriptive differences between urban poor health (versus urban non-poor or rural) in developing countries, and reviews include: Ruel et al., 1999; McMichael, 2000; Harpham and Molyneux, 2001; Galea and Vlahov, 2005; Montgomery and Ezeh, 2005; Harpham, 2009. Debates continue about the characteristics of urban health: advantages, disadvantages, penalties, urban sprawl, and double burden of communicable and non-communicable diseases (Agyei-Mensah and Aikins, 2010).

Within an individual country, maternal and infant survival is generally better on average in urban than in rural areas (Dye, 2008; Matthews et al., 2010), although the National Research Council (2003) shows that aggregate urban-rural differences in health outcomes can diminish once wealth is controlled for. Indeed, with the exception of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), ‘in most low- and middle-income countries, the urban advantage in terms of average health levels is too well documented to dispute’ (Montgomery, 2009, p.5).

The comparison of urban with rural is a crude one - and masks potentially different urban (dis)advantages dependent on what is being studied (Harpham, 2009). The What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Background

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

Heterogeneity of urban areas and populations means that averages based on the aggregate of rural-urban can disguise broad variations, not just in terms of health outcomes, but also in terms of health systems and services. Recent analyses suggest that changing urban populations are eroding any urban health advantage and replacing it with an ‘urban penalty’ (Matthews et al., 2010). Cities can raise some health risks, not least because rapid urban growth in many LICs and LMCs has exceeded the capacity of health systems to serve rapidly growing urban populations. It could also potentially mask a service located in an urban agglomerate but used by a large rural population, hence not specifically targeted at urban populations.

Rice and Rice’s (2009) analyses of aggregate national-level data show crude but statistically significant relationships between the infant mortality rate (IMR) and maternal mortality ratio (MMR) and the level of urban slum prevalence for 99 countries. They point out that ‘urban slum prevalence exhibits moderately strong and statistically significant deleterious associations with the mortality indicators, net the influence of level of economic development and pace of urbanization’, and conclude that their findings support the existence of an urban penalty for slum population, especially women.

1.4.2 Poor urban women and infants: lower chances of survival?

Comparing urban and rural populations

- When compared with their rural counterparts in the aggregate, urban dwellers tend to have, on average, better access to health care services. This can be reflected in lower levels of maternal and infant mortality for urban compared with rural settings in many countries.
- Analysis of 90 DHS showed lower levels of child mortality in urban than rural populations, with similar differences by residence for several health indicators (National Research Council, 2003).
- In Latin America and the Caribbean, infant mortality is about the same among the rural and urban poor (Fay, 2005).
- The poorest migrants from rural areas and slum dwellers may have maternal, newborn and child mortality rates as high as or even higher than the rural poor (Madise et al., 2003; Madise and Diamond, 1995; Van de Poel et al., 2007).
- Much of the aggregate difference in maternal and infant mortality between urban and rural areas is attributable to greater access to health care services available to urban residents.

Comparing within urban areas by wealth status

- World Health Organization (WHO) analyses of DHS data for 2000-7 show a clear gradient in the rate of under-five mortality by wealth quintile for Africa, Asia, and the Americas, with highest risks for the poorest urban wealth quintile and lowest risk for the wealthiest quintile (UNHABITAT, 2010, Figure ES.2, p.xiv).
- Analyses of the Indian National Family and Health Survey (UNHABITAT, 2010, Box 7.1, p.84) show that the poorest urban wealth quartile has an IMR of 54.6/1,000 compared with 35.5/1,000 among urban non-poor.
- Work by the African Population and Health Research Centre (APHRC) (2002a, 2002b) estimates IMR to range from 164/1,000 in Embakasi slum, to 91/1,000 in...
informal settlements on average, to <10/1,000 in high-income areas of Nairobi. The nationally comparable urban (excluding Nairobi) and rural IMR are 57/1,000 and 76/1,000, respectively.

- Slum dwellers compare unfavourably with other urban sub-groups with respect to mortality in both Nairobi and Mumbai.
- The disaggregation - usually based on availability of DHS or MICS data - of analysis by wealth status in urban areas in developing countries tends to be unable to incorporate data that show the complexities of the implications of who is ‘poor’ and ‘non-poor’. Montgomery (2009) gives this useful example: non-poor households in urban neighbourhoods that lack drinking water and sanitation face a daily assault of health threats that household income alone cannot always fend off. Even those who can pay for health care may receive services of such low quality that they do little to restore health.

**Comparing urban and rural and wealth status**
Fewer studies include analysis which compares urban-rural and rich-poor status:

- Garenne’s (2006) analysis of 47 DHS surveys (1986-2000) shows disaggregated early age (before fifth birthday) mortality by urban-rural and rich-poor status. The highest rates of mortality aggregated across countries were found in the poorer rural grouping, followed by the poorer urban grouping.

**Why are poor urban women and infants disadvantaged in terms of risk of dying?**

- Explanations for between- and within-place of residence differentials in maternal and infant mortality outcomes are complex. For example, the mortality risk of a poor individual living in an urban slum is likely to be attributable to both household-level poverty and the community-level spatial concentration of poverty in the slum itself. The urban poor are likely to be least well served in terms of access to health services, but the absence of disaggregated data means that relatively little is known about differentials in accessing services by neighbourhood, the effectiveness and quality of those services notwithstanding.
- Health and social services in urban areas have not kept pace with urban population growth (Montgomery, 2009; Fotso et al., 2007; Ziraba et al., 2009a, 2009b).
- WHO calculations (2010, p.63 Figures 5.6-5.7) of projected trends towards achieving MDG5 (SBA) disaggregated by urban wealth quintile for Bolivia and India show the least progress to date, and therefore the most rapid improvement required, for the poorest urban wealth quintile.
- Poor urban women are more likely to have a SBA than poor rural women, although there is not much difference between the percentage of women with SBA in the richer strata (Channon et al., 2010, p.83).
- Wang’ombe (1995) suggests that the unavailability and inaccessibility of maternal and child health (MCH) services in unplanned urban slums in rapidly growing cities has resulted in poor child health in these settlements.
- Despite good geographic access, slum residents can be unable to access nearby health services. Women in slum communities can find care difficult to access even though a well-functioning health infrastructure is located nearby, and in
some cases the urban poor have less access to services than people who live in rural areas (Gupta et al., 2008; African Population and Health Research Center, 2002a, 2002b; UNHABITAT, 2006). In some cities, this inaccessibility might be explained by the poor urbanites’ spatial concentration in areas outside ‘official’ city zones or limits.

- In a sample survey of poor urban street and slum dwellers in Calcutta, Ray et al. (2001) found that of 108 mothers who gave birth in the previous year, 40 percent received three or more antenatal checkups, and only 16 percent received postnatal care. The authors of the study suggest that urban health programmes are inaccessible to poor migrants as they are not recognised as residents of Calcutta (Channon et al., 2010, citing Ray et al., 2001).

- Cities create an especially complex range of factors that can influence health outcomes (KNUS, 2008, Fig 5, p.9). Matthews et al. (2010) develop a typology based on analyses of DHS - of urban coverage of maternal and newborn services (Figure 1.1). This typology begins to unpack some of the heterogeneity in the experience of poor urban populations in accessing services at the national level.

**Figure 1.1:** Typologies for urban coverage of maternal-newborn services

![Typology A: Substantial urban exclusion](image)

<table>
<thead>
<tr>
<th>Group A1</th>
<th>Substantial urban exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large urban inequalities</td>
<td></td>
</tr>
<tr>
<td>Massive urban rich advantage</td>
<td></td>
</tr>
<tr>
<td>Most urban dwellers have low levels of service</td>
<td></td>
</tr>
<tr>
<td>Rural areas have no services</td>
<td></td>
</tr>
<tr>
<td>Chad, Ethiopia, Niger</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Group A2</th>
<th>Large urban inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial urban rich advantage</td>
<td></td>
</tr>
<tr>
<td>Rural rich have some services</td>
<td></td>
</tr>
<tr>
<td>Large inequalities in rural areas</td>
<td></td>
</tr>
<tr>
<td>Bangladesh, Cambodia, Haiti, Nepal, Nigeria, Rwanda</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group A3</th>
<th>Large urban inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial urban rich advantage</td>
<td></td>
</tr>
<tr>
<td>Rural areas have large inequalities</td>
<td></td>
</tr>
<tr>
<td>Rural poor disadvantaged compared with urban poor</td>
<td></td>
</tr>
<tr>
<td>India, Indonesia, Pakistan, Philippines</td>
<td></td>
</tr>
</tbody>
</table>

![Typology B: Marginalisation of urban poor](image)

<table>
<thead>
<tr>
<th>Group B1</th>
<th>Marginalisation of urban poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban poor excluded from services</td>
<td></td>
</tr>
<tr>
<td>Urban rich have high access to services</td>
<td></td>
</tr>
<tr>
<td>Substantial rural rich advantage</td>
<td></td>
</tr>
<tr>
<td>Bolivia, Ghana, Guinea, Liberia, Peru, Tanzania, Zambia</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Group B2</th>
<th>Urban poor excluded from services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban rich have almost universal coverage</td>
<td></td>
</tr>
<tr>
<td>Large inequalities in rural areas</td>
<td></td>
</tr>
<tr>
<td>Rural poor marginalised</td>
<td></td>
</tr>
<tr>
<td>DR Congo, Egypt, Honduras, Malawi, Switzerland</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Group C1</th>
<th>Minimal exclusion or marginalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only the poorest have low access</td>
<td></td>
</tr>
<tr>
<td>Some inequalities in rural areas</td>
<td></td>
</tr>
<tr>
<td>Rural poorest marginalised</td>
<td></td>
</tr>
<tr>
<td>Colombia, Dominican Republic, Namibia, Vietnam, Zimbabwe</td>
<td></td>
</tr>
</tbody>
</table>

Source: Fig 2, Matthews et al., 2010.

### 1.5 Objectives

Before presenting the methodology and results of our systematic review, it is important to consider the focus and scope of our research question, ‘What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?’ Addressing this question provides useful lessons for decision makers as both positive and negative effects are considered. Previous knowledge of this area led us to conclude that a systematic review focusing on effective models would provide a tighter and narrower review but with less useful findings from which to draw policy recommendations. Our protocol based on this revised question was agreed by the funding body, DFID, and reviewed by two external expert reviewers.

Maternal and infant health of poor people in urban areas may be improved through many different mechanisms. Evidence pertaining to different ‘models of service delivery’ is vital but, based on previous knowledge, also likely to be scarce. Our

*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
review focused on explicit evaluations of interventions aimed at improving health outcomes for poor people in urban areas. We did not seek to exclude any particular types of intervention and as such our review was designed to identify evaluation of models of delivery but also discrete interventions that might be part of a wider model of delivery. These could include clinical or non-clinical interventions, such as changes in financing, regulation and service organisation. They might also range in focus from the individual to health systems reform. The review aimed not only to draw lessons from the stated effect of interventions, but to provide causal chain analysis for these effects as well as to draw lessons from how, where, and why different models of delivery showed effects.

Given the likely paucity of evidence from urban areas in LICs we also aimed to include LMCs and to be non-restrictive in defining poor and urban populations. The methodology and appendices set out exact definitions, but ‘urban’ was essentially defined as ‘non-rural’. With regard to poverty, we sought to include any study making explicit reference to models of delivery for identified poor or socio-economically disadvantaged groups at the sub-national level, irrespective of the definition of poverty. We feel that our inclusive approach is most appropriate as a first measure in establishing the evidence base for the effects of interventions aimed at improving maternal and infant outcomes in poor urban populations.
2. Methods used in the review

Summary
The types of studies, interventions, outcomes and participants for inclusion are described.

Our review team, including information scientists and information retrieval experts, developed a search protocol that was subject to external peer review. Our search strategy was limited to LICs and LMCs, and certain countries were prominent in the resulting database of evidence.

Quality checks - both in terms of internal quality assurance processes and the assessment of the quality of included studies - are described. The synthesis of evidence includes both a wider narrative synthesis and a detailed causal chain analysis of high-quality items. Decisions about what the results meant for policy, practice and research were based on discussions within the review team, set against the wider knowledge base.

2.1 User involvement
2.1.1 Approach and rationale
The protocol was finalised following review from the DFID and two additional experts in field.

In order to engage a wide range of stakeholders, the following methods were/will be used:

- Online publishing of: the protocol; the final report; a research brief; and a web summary.
- To maximise exposure, links to the published report will be established with major e-lists and websites
- Publication of articles in peer-reviewed journals
- Presentation and networking of findings at academic conferences

2.2 Identifying and describing studies
2.2.1 Defining relevant studies: inclusion and exclusion criteria
Types of study
The following types of intervention study were included in the analysis:

- Randomised controlled trials
- Non-randomised controlled trials
- Observational studies with control groups
- Longitudinal time series studies
- Systematic reviews of these interventions
- Economic evaluations and modelling studies of relevant interventions
- Qualitative evaluations looking at implementation of relevant interventions
Types of intervention
Interventions were broadly defined as actions concerned with improving the access, utilisation or effectiveness of maternal and infant health services in areas serving urban poor populations. These interventions could be concerned either with clinical or non clinical services. Studies that did not clearly distinguish effects from other non-targeted health interventions, such as the provision of potable water, were excluded.

Types of participant
Mothers and infants up to the age of 24 months. Studies had to address specific poor populations in urban, semi-urban or peri-urban settings. Studies that estimated only maternal morbidity (other than severe acute maternal morbidity – SAMM) or only infant morbidity were excluded. While it should be acknowledged that studies set in rural areas may well be transferable to urban-poor settings, in this review we excluded these studies that only dealt with this population from our analysis. Studies that dealt only with non-poor urban populations were also excluded from the analysis.

The World Bank definition of low income and lower middle income countries was used, with the additional restriction that countries in Europe were excluded from the analysis (World Bank, 2011). It should however be acknowledged that there may be interventions in upper middle income countries, particularly those that have high levels of income inequality that could be used in low and middle income country settings.

2.2.2 Identification of potential studies: search strategy
Our review team, including information scientists and information retrieval experts, developed a search protocol that was subject to external peer review and agreement of the study funders for approval. Our search includes major databases that cover literature on this topic; these cover both English and non-English language material, including specialist health and development databases, as well as those focusing on specific geographical (Box 2.1).

Box 2.1: Electronic databases searched
African Index Medicus
African Journals On-Line
ASSIA (Applied Social Sciences Index and Abstracts)
Campbell Collaboration
Cochrane
Database of Abstracts of Reviews of Effectiveness (University of York)
Office of Health Economics, Health Economic Evaluation Database
NHS Economic Evaluation Database (University of York)
Econlit
EMBASE
Geobase
Global Health
Health evidence.ca
In addition to the databases included in our search protocol, a number of additional databases were examined and were excluded on the basis of lack of functionality, country or topic coverage, and in a few cases because of a lack of access (Appendix 2.9). Relevant studies were identified by searching electronic databases, combining terms for (1) included maternal and infant health outcomes and (2) included countries. We decided not to narrow down by urban terms, but instead to determine whether studies took place in an urban environment through analysis of abstracts and the keywords used. A full detailed list of terms used is provided in Appendix 2.2. Editorials, letters, commentaries, book reviews and non-systematic literature reviews were excluded from the analysis.

Given the very broad nature of this review, we relied on a wide range of appropriate keywords, descriptors and indexing terms, e.g. the medical subjects headings (MeSH) keywords for the US National of Library PubMed/Medline database, and descriptors, where these we available. In databases where such terms were limited we had to rely on a broad range of free text terms. Relevant search terms were identified both from the expert input of members of the research team, analysis of terms used in papers identified in handsearches and pilot database searches, as well as analysis of keyword and indexing hierarchies where available in the different databases searched. Details of the databases searched and the search strategies used, specifying keywords, descriptors and free text terms are in Appendix 2.2.

One limitation of our search however, was that we did not replicate our search strategy in terms other than English, which potentially could have increased the number of relevant papers found in some databases that carry more non-English language journals. We did not conduct a specific search for conference proceedings, theses or other dissertations.

Google Advanced Search\(^9\) was used to search organisation websites (Appendix 2.3). These included some government websites for overseas development aid departments, as well as international agencies (Box 2.2). The search strings were ‘infant mortality’ and/or ‘maternal mortality’. Only items in English were sought, and the first 20 items were reviewed for relevance. All of the websites that were searched have been tagged as LSEDFID_SysRev2011 in Diigo\(^10\) to facilitate sharing.

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\(^9\) [http://www.google.co.uk/advanced_search](http://www.google.co.uk/advanced_search)

\(^10\) [http://www.diigo.com/user/LSE_DFID](http://www.diigo.com/user/LSE_DFID)
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

Box 2.2: Websites searched

AFD (Agence Française de Développement)
APHRC (African Population and Health Research Center)
Center for International Health and Development
Cochrane LMIC
COOPITA (Cooperazione Italiana allo Sviluppo)
DFID (UK Department for International Development)
EADI (European Association of Development Research and Training Institutes)
ELDIS
EU Development (European Commission Development and Relations with African Caribbean and Pacific States)
EU Humanitarian Aid and Civil Protection (European Commission Humanitarian Aid and Civil Protection)
EuropeAid (European Commission Cooperation Office)
Family Care International
Irish Aid
London School of Hygiene and Tropical Medicine library
Measurement, Learning and Evaluation Project for the Urban Reproductive Health Initiative
NORAD (Norwegian Agency for Development Cooperation)
Pan American Health Organisation Library
PMNCH (Partnership for Maternal, Newborn and Child Health)
R4D (Research 4 Development)
SDC (Swiss Agency for Development and Cooperation)
SIDA (Swedish International Development Cooperation Agency)
UNDP (United Nations Development Programme)
UNFPA (United Nations Population Fund)
UNHCR (United Nations High Commissioner for Refugees)
UNICEF (United Nations Children's Fund)
Urban Health Resource Centre
USAID (United States Agency for International Development)
WB (World Bank)
WHO (World Health Organization)
MLE Programme
Open SIGLE
WHO International Trial registry portal
A handsearch of 11 journals was performed from 2008, electronically where possible, so as to include papers accepted and available online pre-publication but not yet in print (Appendix 2.4). When the electronic version was not available, relevant shelves at the British Library of Political and Economic Science were handsearched.

Due to time constraints, we restricted studies to those published from 1987 onwards, the year of the Nairobi Conference on Safe Motherhood (Cohen, 1987).

References produced by electronic database searches were stored into a first EndNote bibliographic database and duplicate records were discarded. The approach designed by the Evidence for Policy and Practice Information Co-ordinating Centre (EPPI-Centre), Social Science Research Unit, Institute of Education, University of London (Gough and Elbourne, 2002) and its program EPPI-Reviewer 4 were used to record extracted data from eligible articles and make them available for analysis.

2.2.3 Screening studies: applying inclusion and exclusion criteria

In the first stage, titles and abstracts were screened for inclusion, using four short questions on key inclusion criteria (country, urbanity, evaluation of maternal and infant interventions) (Box 2.3).

| Box 2.3: Screening questions |
|-------------------------------|---------------------------|
| Questions                     | Answers                   |
| Is it a study in a country in the list of WB LICs and LMCs (from Africa, Asia, Latin America and the Caribbean)? | Yes/no/unclear |
| Does the study include poor, urban populations? | Yes/no/unclear |
| Is it a study dealing with evaluation of MCH interventions? | Yes/no/unclear |
| Do the data deal with access to, utilisation of, or effectiveness of MCH interventions? | Yes/no/unclear |

Full texts were obtained for studies screened for inclusion and stored in a second EndNote bibliographic database. In the second stage, full texts were screened for inclusion, using all inclusion and exclusion criteria (Appendix 2.1). References meeting all inclusion criteria were imported into EPPI-Reviewer 4\(^\text{11}\) for coding. Excluded references were stored in a third EndNote bibliographic database. Interesting references excluded during the first or second stage were stored in a separate EndNote bibliographic library for discussion. References with full text in foreign languages (other than English, French, Spanish or Italian) were stored into a separate EndNote bibliographic library for record keeping.

References from websites searches were managed using the bookmarking tool Diigo.\(^\text{12}\) The first 20 items of each website search were compared with records stored in the first EndNote bibliographic database. Records not already found through electronic database searches were screened for inclusion following the first and the

\(^{11}\) http://eppi.ioe.ac.uk/cms/Default.aspx?alias=eppi.ioe.ac.uk/cms/er4

\(^{12}\) http://www.diigo.com/user/LSE_DFID
second stage previously described for electronic databases. References from handsearching were compared with records stored in the first EndNote bibliographic database and screened for inclusion, as for references from websites searches.

2.2.4 Characterising included studies

We first created and entered into EPPI-Reviewer 4 a coding tool to extract and record information on generalities, context, intervention, study design, outcomes, findings, comments, quality assessment and meta-analysis inclusion (Appendix 2.5).

2.2.5 Identifying and describing studies: quality assurance process

Two reviewers screened the results of searches independently. Before starting screening, a cross-check on a sample of 100 references was conducted to test for inter-reviewer variability, and where there was disagreement on inclusion, reviewers consulted with each other until consensus was reached. When consensus could not be reached, a decision was made after discussion by the team as a whole.

Included studies stored in EPPI-Reviewer4 were randomly allocated to reviewers for coding. Reviewers coded the results of searches independently. A cross-check on coding was conducted to test for inter-reviewer variability, and where there was disagreement on inclusion, reviewers consulted with each other until consensus was reached. When consensus could not be reached, a decision was made after discussion within the team.

2.3 Methods for synthesis

2.3.1 Assessing the quality of studies

We reviewed the quality for quantitative and qualitative studies making use of new revised guidelines for both quantitative and qualitative studies published by the National Institute for Health and Clinical Excellence’s Centre for Public Health (2009). In the case of quantitative studies, these checklists (Appendix 2.6) allowed us to separately make an assessment of internal and external validity using objective criteria. In terms of external validity, we assessed whether the source population or study area was well described, whether the eligible study population was representative of the study population or study area and finally whether the actual participants were representative of the study population. We evaluated, for example, whether studies used theoretical perspectives, had clear aims and discussed the limitations and possible biases. Most of the evaluation of the methods concerned: whether the randomised controlled trial or the baseline of quantitative or review methodologies were laid out clearly, for instance, the methods of randomisation, participant blinding, sample size based on power calculations to detect significant effects; and whether the conclusions were appropriately justified by the methods and data. If most of these criteria were fulfilled, then the analysis would be judged to have a high degree of internal validity (++); if some of the criteria had been fulfilled, then it would be coded as (+), whilst those studies where few criteria were met would be coded as (-).

In the case of qualitative studies, the focus was on whether a theoretical approach could be identified, and whether a clear explanation and justification for the study design, and information on data collection methods, contexts and discussion of conclusions and findings were provided, using NICE (2009) guidelines (Appendix 2.7). Studies would be rated as (++) if they fulfilled most criteria appropriately, (+) for some criteria and (-) if few criteria were met. In addition, we made use of a combination of criteria from two different economic evaluation checklists for economic studies conducted prospectively or retrospectively alongside effectiveness studies (Drummond and Jefferson, 1996; Evers et al., 2005). A separate checklist
Methods

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

2004 was available to assess the quality of economic evaluations based on a synthesis of effectiveness data from a range of papers and the construction of different forms of economic evaluation (Appendix 2.8).

2.3.2 Overall approach to and process of synthesis

The approach to synthesis was driven by the research question, the types and quality of studies and the data included in the review. Heterogeneity of study design, population and intervention precluded statistical meta-analysis. The most appropriate approach - a textual narrative synthesis - was conducted. Because our review question involves two linked but distinct populations - mothers and infants - we have structured our review accordingly. For a subset of high-quality items, we conducted a causal chain analysis, also separated according to whether the outcome was maternal or infant mortality.

2.3.3 Selection of studies for synthesis

The narrative synthesis includes all eligible studies on the basis of the inclusion/exclusion criteria. The causal change analyses are restricted to studies identified as high quality.

2.3.4 Selection of outcome data for synthesis

Outcomes included maternal and infant health outcomes: maternal, infant, neonatal, perinatal, post-neonatal mortality, and stillbirth; and severe acute maternal morbidity (SAMM) (haemorrhage, dystocia, hypertension, sepsis, incomplete abortion, Caesarean section (CS), hysterectomy and blood transfusion) (World Health Organization, 2011b).

This review focuses on maternal and infant mortality outcomes. Process indicators, such as skilled care at birth, are often used as substitutes for mortality outcomes whose measurement poses considerable challenges. However, mortality outcomes are not necessarily improved where gains in individual process indicators are not accompanied by broader changes (Koblinsky et al., 1999). A focus on mortality outcomes is thus crucial, particularly in areas where the mortality burden is high (Campbell and Graham, 2006; Bhutta et al., 2008; Lawn et al., 2009).

2.3.5 Synthesis of evidence

All eligible studies were included within the qualitative analysis to establish a detailed picture of the available evidence. We first analysed the data using EPPI-Reviewer 4 and generated comprehensive tables for each code. All tables were then exported and merged in Excel\(^\text{13}\) to produce a unique results table.

Narrative synthesis was the principal approach used. Eligible studies were grouped into type of interventions - broadly grouped into clinical and non-clinical - as described later on in the report. Findings were analysed within each category for the two main target populations: mothers and infants, including neonates. While most systematic reviews focus on synthesising evidence on effectiveness from quantitative research, we wanted to develop the contribution that can be made by different types of evidence, including that involving qualitative data.

In addition, causal chain analysis was performed on included studies identified as high quality to allow the extraction and illustration of the casual path emerging from our review, linking reasoning for intervention, with experience, implementation and sustainability. We used an approach based on White’s (2009) theory-based impact evaluation, and drawing on the realist review approach of Pawson et al. (2005),

\(^{13}\) http://office.microsoft.com/en-us/excel/
using qualitative analysis to attempt to provide an analysis of how and why complex interventions can work (Lewin et al., 2009). For each item included in the causal chain analysis, we identify the root causes of the issue, the intervention, the final outcome(s) and the intervention sustainability.

2.4 Deriving conclusions and implications

Decisions about what the results meant for policy, practice and research were based on discussions within the review team, set against the wider knowledge base.
3. Search results

Summary

The searches returned 9,025 potentially relevant items of evidence, 98% of which were excluded after reviewing titles and abstracts.

We did not identify a single item that both had a qualitative focus and also had a discussion of change in mortality outcomes.

31 per cent of the included quantitative studies were identified as ‘low quality’.

Our causal chain analyses are restricted to medium- and high-quality items only. We assessed item quality after completion of the searches, and to avoid exclusion of potentially valid items, quality was not part of the inclusion criteria.

Of particular note was the lack of clarity or depth surrounding the ethical conduct of research that involved human subjects.

Electronic databases searches produced over 9,000 potentially relevant papers. All searches were downloaded into EndNote and duplicates were excluded. This left 7,324 records to be examined. Two reviewers systematically screened all references by title/abstract using the screening short questions: the majority of papers were discarded and the remaining 703 references were downloaded into another EndNote library and full text obtained. After multiple searches, we were unable to locate 16 references (Appendix 3.3).

3.1 Studies included from searching and screening

Full-text references were screened for inclusion/exclusion criteria: 114 were included in the final review and downloaded into EPPI-Reviewer 4 for coding. Articles were excluded because they were published in a foreign language other than English, French, Spanish or Italian, they did not present separate outcomes for urban and rural populations, were editorials/commentaries/book reviews/literature reviews, or did not present data on our outcomes of interest (Appendix 3.2).

Searches of websites did not lead to new references. Handsearching journals produced 15 new references, all successively discarded during the full-text screening. The screening cross-check, to test for inter-reviewer variability, resulted in final agreement rates between 82 and 92 percent.

Figure 3.1 provides a detailed representation of the search strategy and review process. Separate appendices (3.1 and 3.2) detail included and those excluded after full-text screening, respectively. Additional appendices (3.4 and 3.5) list interesting references excluded during the first or the second stage and references with full text in languages other than English, French, Spanish or Italian.

14 http://www.endnote.com
**3.2 Details of included studies**

The searches returned 9,025 potentially relevant items, including 9,010 from database searches and 15 from handsearches. The majority (98 percent) of papers were excluded after reviewing titles, and the abstracts of the remaining 114 items were downloaded into EndNote. All included studies date from 1989 (Figure 3.2).
**Figure 3.2:** Distribution of included studies by publication date

Our search strategy was limited to LICs and LMCs, and the distribution of items included in the review reflects clustering of evidence at the country level. For example, 56 percent of the included items from sub-Saharan Africa are accounted for by items from just two countries, Nigeria and Guinea Bissau (Table 3.1).

**Table 3.1:** Country distribution of included items

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>N*</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Asia and Pacific (10%)</td>
<td>China</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Indonesia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Papua New Guinea</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Thailand</td>
<td>3</td>
</tr>
<tr>
<td>Latin America and Caribbean (2%)</td>
<td>Guatemala</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Haiti</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nicaragua</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 1. Countries included in the review with the number of included studies.

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>Number of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle East and North Africa</td>
<td>Egypt</td>
<td>6</td>
</tr>
<tr>
<td>(8%)</td>
<td>Jordan</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Tunisia</td>
<td>1</td>
</tr>
<tr>
<td>South Asia (24%)</td>
<td>Bangladesh</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>India</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Pakistan</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Sri Lanka</td>
<td>1</td>
</tr>
<tr>
<td>Sub-Saharan Africa (56%)</td>
<td>Angola</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Burkina Faso</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Central African Republic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Cote d'Ivoire</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Ethiopia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Ghana</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Guinea-Bissau</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Kenya</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Madagascar</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Malawi</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Mozambique</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Nigeria</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Senegal</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sierra Leone</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sudan</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tanzania</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Uganda</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Zambia</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Zimbabwe</td>
<td>4</td>
</tr>
</tbody>
</table>

Notes: % refers to the regional distribution of all included items. *Number of studies not mutually exclusive.

The types of study designs included in the review were highly variable, ranging from randomised controlled trials (RCTs) (e.g., Malaba et al., 2005 (++)/(++); Kuhn et al., 2008 (++)/(++)) to observational studies (e.g., Colonna et al., 1990 (-)/(-); Campbell et al., 2005 (+)/(+)). Of the 11 included studies, 34 were RCTs.

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15 The two symbols relate to internal and external validity respectively.

*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?* 25
Included items were coded on the basis of whether they reported on interventions that dealt with the supply and/or demand side, and on the basis of the main focus of that intervention (multiple responses allowed) to reduce maternal and/or child mortality in poor, urban populations (Table 3.2). Just two items included in our review (Orji and Ajenifuja, 2003 (-)/(-); Padmanaban et al., 2009 (-)/(+)) did not report on specific interventions, but reviewed intervention strategies and lessons learned. The majority (55 percent) of included items dealt with supply-side interventions.

**Table 3.2: Distribution of included items by intervention focus**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
</tr>
<tr>
<td>Surgical/instrumental procedure</td>
<td>6</td>
</tr>
<tr>
<td>Drug treatments (including micronutrient supplementation)</td>
<td>30</td>
</tr>
<tr>
<td>Vaccination</td>
<td>11</td>
</tr>
<tr>
<td>Other clinical management</td>
<td>17</td>
</tr>
<tr>
<td>Non-clinical</td>
<td></td>
</tr>
<tr>
<td>Training and audits</td>
<td>12</td>
</tr>
<tr>
<td>Provider models</td>
<td>1</td>
</tr>
<tr>
<td>Financing</td>
<td>4</td>
</tr>
<tr>
<td>Investment and scaling up</td>
<td>3</td>
</tr>
<tr>
<td>Discharge and admissions policies</td>
<td>5</td>
</tr>
<tr>
<td>Kangaroo Mother Care</td>
<td>6</td>
</tr>
<tr>
<td>Nutrition (including breastfeeding)</td>
<td>6</td>
</tr>
<tr>
<td>Service organisation</td>
<td>1</td>
</tr>
<tr>
<td>Complex interventions</td>
<td>12</td>
</tr>
</tbody>
</table>

All of the included items directly addressed maternal and/or infant (including neonate) mortality, and seven items dealt with interventions that explicitly focused on both maternal and infant mortality outcomes (de Muylde and Thiery, 1989 (-)/(-); Bugalho and Bergstrom, 1993 (-)/(-); Shihadeh and Najdawi, 2001 (-)/(+); Bakr and Karkour, 2005 (+)/(-); Abdul et al., 2007 (-)/(+); Saleem et al., 2007 (+)/(+); Deschamps et al., 2009 (+)/(-)).

Typically in order to run a meta-analysis we should have been able to say whether the population from which the sample was drawn was clearly defined; whether (and how) the sample was representative of the population, whether the participants who agreed to participate were different from those who refused and whether the response rate was adequate; and whether the methods were standardised and the statistical methods adequate.

When analysing our results, we did not identify a single paper that both had a qualitative focus and also had a discussion of change in outcomes, although many qualitative papers that looked at impacts on process (e.g. perceptions of barriers to
access or satisfaction with services) were identified but excluded from our review. All included studies in the review were therefore assessed using quantitative checklist criteria (in the case of two economic evaluations, we were able to assess the quality of the empirical trial and separately use economic evaluation checklists).

Almost a third (31 percent) of the included quantitative studies were identified as ‘low quality’ by the team which meant both external and internal validity were scored as (·) low. Our causal chain analyses are restricted to medium- and high-quality items only. We assessed item quality after completion of the searches, and to avoid exclusion of potentially valid items, quality was not part of the inclusion criteria. Of particular note was the lack of clarity or depth surrounding the ethical conduct of research that involved human subjects.

Out of 114 studies, 21 were identified as high quality (++/++) and 14 medium quality (either ++/+ or ++/+). For those high- or medium-quality studies which included specific interventions with clearly identified outcomes, we considered whether the study could be potentially included for meta-analysis. We obtained nine items of high quality and 8 of medium quality that met these criteria.

Meta-analysis is particularly common in the analysis of studies which include clinical trials when the samples and results of individual studies are not conclusive enough to be able to generalise the overall results. It is also commonly used to remove bias from the conclusions as it combines the results of many trials and allows more transparency in the interpretation of the results. Despite the many advantages, it needs careful coding of the studies as well a careful evaluation of the quality of the papers. One of the key requirements above all for meta-analysis is a complete, unbiased collection of all the original studies of acceptable quality that examine the same therapeutic question (Crombie and Davies, 2009). This systematic review aimed for breadth rather than depth, given the lack of studies in the field.

In Table 3.3, we show the distribution of the high-quality papers which were suitable for meta-analysis. The overall number of studies was nine, although in a few instances more than one outcome was included in the analysis.

### Table 3.3: Distribution of items coded as ‘high quality’ and suitable for metadata by outcome and focus

<table>
<thead>
<tr>
<th>Intervention outcome</th>
<th>Clinical</th>
<th>Non-clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality</td>
<td></td>
<td>Dumont et al. (2005)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dumont et al. (2006)</td>
</tr>
<tr>
<td>Neonatal mortality</td>
<td>Darmstadt et al. (2008)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kaestel et al. (2005)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kuhn et al. (2008)</td>
<td>Mbori-Ngacha et al. (2001)</td>
</tr>
<tr>
<td></td>
<td>Martins et al. (2008)</td>
<td></td>
</tr>
</tbody>
</table>
Given the heterogeneity of the populations, interventions and sample selection, meta-analysis was not deemed feasible. If we consider the cell with the highest number of studies (infant health with clinical intervention), the range of types of interventions was too high and the number of studies too small to derive a significant statistical analysis. In addition most of the clinical interventions related to urban hospitals and not necessarily to urban poor populations. When looking at the second-highest frequency (neonatal health with clinical interventions), no two interventions related to the same type (e.g., vitamin intake, vaccination, skin emollient). In general, the studies differed in interventions, approach, population, and outcome. If we cross-tabulated all those variables, we would end up with a level of heterogeneity that would invalidate any type of meta regression. It is for this reason that this review includes narrative only.
4. Synthesis results

Summary
No items were found that specifically tested the effectiveness of different models of service delivery to reduce maternal and infant mortality among poor urban populations. Items relevant to interventions targeting poor urban women and infants were heterogeneous in their focus and study design.

Audit (death reviews) are a low-cost non-clinical intervention that appears to have positive mortality outcomes for both women and infants.

Kangaroo Mother Care (KMC) was the most tested non-clinical intervention for infants, with cautious positive impacts on infant mortality.

Complex interventions with positive mortality impacts were localised and heterogeneous in their impact, even within the study community.

No study looked at the impact that intervention had on poverty nor at how the intervention was less or more successful because of the poor setting.

Just one study, from Senegal (de Bernis et al., 2000) (+)/(+), used a comparative study design and showed lower mortality in an area where women had SBA.

4.1 Further details of studies included in the synthesis
The review did not find any items that tested the effectiveness of different models of service delivery to reduce maternal and infant mortality among poor urban populations. To the best of our knowledge, there are no studies that address this issue for this population sub-group. However, we did identify a wide range of interventions that, whilst not testing different models of service delivery, were relevant for the research question. The review found extensive heterogeneity of interventions in terms of both target population and type of intervention. In order to deal with this heterogeneity, we present our description and discussion of interventions using four headings for interventions addressing:

- Clinical interventions
  - Surgical/instrumental procedures
  - Drug treatment (including micronutrient supplementation)
  - Management of labour (and induction)
  - Vaccinations
  - Other clinical management

- Non-clinical interventions
  - Service organisation
  - Training
  - Audit
  - Provider models
  - Financing
  - Nutrition (including breastfeeding)
Synthesis results

- Complex interventions (interventions that involved multiple components across a range of domains)
  - Cost-effectiveness.

Each of these sections deals with maternal and infant mortality separately.

In doing this, it is important to note that our focus was on the improvements in delivery and access to services for the urban poor population rather than on specific clinical interventions per se. However our review illustrates that few of the effectiveness studies that may be identified, for instance through Cochrane reviews, have focused specifically on delivering services and reducing mortality in this specific target population group.

4.1.1 Clinical interventions: maternal mortality

In total, 42 papers focused on clinical interventions as a means to reduce maternal mortality (Appendix 4.1). Clinical interventions targeted at mothers formed three main groups:

- Surgical/instrumental procedures
- Drug treatments (including micronutrient supplementation)
- Other clinical management

Surgical/instrumental procedures

Five papers focused on surgical/instrumental procedures. Four papers provide comparison of Caesarean sections and vaginal delivery. In three cases, this comparison was made in the context of optimal management of breech delivery (Malhotra et al., 1994 (+/-); Ziadeh et al., 1997 (-/ ); Orji and Ajenifuja, 2003 (-/-)). All conclude that Caesarean section does not seem to offer advantages over vaginal delivery in terms of perinatal mortality, neonatal deaths and still births. Agarwal et al. (2007a) (+/++) compared outcomes from Caesarean section with those following vaginal births for women with a post-Caesarean pregnancy. In the context of Lucknow, India, vaginal birth after Caesarean (VBAC) was found to be associated with higher perinatal mortality and maternal morbidity. In a comparison of modes of instrumental delivery in Jordan, Shihadeh and Al Najdawi (2001) (-/-) found that forceps and vacuum extraction were associated with differing adverse events but that overall vacuum extraction may be preferable to forceps because of reduced birth trauma and blood loss.

Drug treatments (including micronutrient supplementation)

Twenty-four papers focused on drug treatments. Seven studies focused on anticonvulsants in the management of eclampsia. Six of these concentrated on magnesium sulphate (Chinayon, 1998 (+)/(+); Adewole et al., 2000 (-)/(-); Begum et al., 2000 (-)/(-); Kamilya et al., 2005 (-)/(-); Naz et al., 2005 (++)/(++); Tukur and Muhammad, 2010 (-)/(-)). Based on observational data, all provide favourable conclusions regarding the use of magnesium sulphate. Benefits were reported in terms of maternal mortality (Adewole et al., 2000 (-)/(+); Begum et al., 2000 (-)/(-); Kamilya et al., 2005(-)/(-); Tukur and Muhammad, 2010 (-)/(-)) and perinatal mortality (Kamilya et al., 2005 (-)/(-)). Chaudhuri et al. (1994) (+)/(+) studied the outcomes of babies born to eclamptic mothers in India. A comparison of three treatment regimens found that babies of mothers treated with a combination of diazepam, chlorpromazine and phenargan had the best outcomes in terms of perinatal deaths and still births. Magnesium sulphate was not considered as a treatment in this study. However, in a more recent study in Nigeria, Tukur and Muhammad (2010) (-)/( ) found that magnesium sulphate was superior to the use of diazepam in reducing maternal morbidity and mortality.
Four studies focused on the induction of labour. Two of these focused on induction for women with eclampsia (Nahar et al., 2004 (-)/(+); Tukur et al., 2007 (+)/(-)). They did not appear to be any advantage of misoprostol in terms of mortality in either study, although Nahar et al. (2004) (-)/(+) was able to conclude that intravaginal misoprostol was well tolerated and effective in the induction of labour. The third study considered induction of labour in the context of women going beyond 42 weeks gestation (Bergsjo et al., 1989) (-)/(+). Induction by stripping of membranes and intravenous oxytocin infusion in this context offered no advantage as measured by perinatal mortality. Abdul et al. (2007) (-)/(+) compared misoprostol to oxytocin as drugs for induction during the third stage of labour. No deaths were recorded in either group and the efficacy of misoprostol was judged to be comparable to oxytocin.

Three studies concerned the assessment of micronutrient supplements. These have been classified under ‘drug treatments’ as they were prescribed within a clinical setting. Fawzi et al. (2007) (++)/(++) compared daily multivitamins (vitamins B, C, E) with a placebo group in HIV-negative women in Tanzania. No benefits were found in terms of risk of prematurity and foetal death in the treatment group but there was significantly reduced risk of low birthweight (LBW) compared to the placebo group. Kaestel et al. (2005) (++)/(++) compared different levels of micronutrient supplements for pregnant women in Guinea-Bissau but found no differences in perinatal or neonatal mortality. Kupka et al. (2008) (++)/(+) also found no significant effect of selenium supplementation for HIV-infected pregnant women in terms of maternal or neonatal mortality.

Ndibazza et al. (2010) (++)/(+) and de Silva et al. (1999) (+)/(++) evaluated the impact of the use of anthelmintics to expel parasitic worms by women during pregnancy on perinatal mortality. In Sri Lanka, de Silva et al. (1999) (+)/(++) found perinatal deaths to be lower in the anthelmintic group, whereas Ndibazza et al. (2010) (++)/(+) found no overall effect in an area in Uganda where helminth prevalence was high but infection intensity low.

Two studies focused on the use of antiretrovirals in HIV-infected pregnant women (Ekouevi et al., 2008 (+)/(+); Walter et al., 2006 (+)/(+)). The use of highly active antiretroviral treatment (HAART) was found to have no benefit as measured by stillbirths among women with advanced HIV (Ekouevi et al., 2008) (+)/(+) but antiretroviral treatment for HIV-infected pregnant women with low CD4 counts was found to significantly decrease neonatal mortality in a study in Zambia.

Two studies focused on the use of antibiotics, but in different contexts. Aboud et al. (2009) (++)/(+) assessed the effect of giving antibiotics to HIV-infected pregnant women. No benefits were found in terms of maternal morbidity or mortality. Bergstrom (1991) (+)/(+) assessed the use of antibiotics in the conservative management of women with preterm rupture of membranes. Neonatal mortality was found to be significantly lower than in a control group in which no pharmaceutical treatment was given but labour was induced.

The remaining papers involved single studies looking at different aspects of drug treatment: the use of steroids in women with high-risk premature delivery (Fekih et al., 2002) (+)/(+); use of misoprostol in the active management of third stage of labour (Afolabi et al., 2010) (+)/(+); use of injectable contraceptive during pregnancy (Gray and Pardthaisong, 1991) (+)/(+); and administration of the antimalarial, quinine hydrochloride, for pregnant women with malaria (Kietinun et al., 1993) (-)/(+). All except Gray and Pardthaisong (1991) reported favourable outcomes for the drug treatment evaluated.
Other clinical management
Thirteen papers focused on other issues related to clinical management. Certain studies could not be classified under the three clinical categories above. Five studies (Munjanka et al., 1996 (++)/(++); Etuk et al., 2000a (-)/(-); Etuk et al., 2000b (-)/(-); Enakpene et al., 2010 (+)/(-); Fabamwo et al., 2010 (-)/(-)) concerned antenatal care provision. Enakpene et al. (2010) (+)/(-) evaluated the effect of adequate prenatal care on perinatal outcomes for women with umbilical cord prolapse. Adequate care was defined as at least four prenatal visits in index pregnancy and/or at least one prenatal visit within the 2-4 weeks preceding the occurrence of umbilical cord prolapse. Lower perinatal death was found among women receiving adequate antenatal care compared to those without prenatal care. Focusing on pregnant women in general, Munjanka et al. (1996) (++)/(++) found that an antenatal care programme in Zimbabwe with fewer, more objective oriented visits and fewer interventions during visits, could be introduced without having an adverse impact on perinatal or maternal mortality. In two Nigerian studies, Etuk et al. (2000a and 2000b) found that there was a significant increase in both maternal and perinatal mortality for pregnancies that were booked for antenatal care but delivered outside health facilities.

Abdel et al. (2010) (+)/(-) assessed the effectiveness of uterine massage as a means of preventing postpartum haemorrhage in a trial set in Egypt and South Africa. The authors found that massage alone was associated with more blood loss after 30 minutes compared to treatment with oxytocin (with or without massage). Miller et al. (2009) (+)/(++) also looked at non-pharmaceutical management of obstetric haemorrhage through the use of non-pneumatic anti-shock garments (NASG) and concluded that it showed potential for reducing blood loss and maternal mortality. Training of doctors in dealing with emergency Caesarean section (CS) was the focus for the study by Pereira et al. (1996). While there were no substantial differences in the mortality outcomes, they still recommended the training of doctors in areas served by low levels of health personnel. In a Malawian study, Fenton (1999) (+)/(-) looked at women requiring Caesarean section and compared those who received a blood transfusion with those who did not. No significant difference in mortality was found between the two groups.

Antisepsis and vaginal cleansing were shown in three studies to be safe and to reduce neonatal and maternal infections (Taha et al., 1997 (++)/(++); Bakr and Karkour, 2005 (+)/(-); Saleem et al., 2007 (+)/(+)). In a study in squatter settlements in Karachi, Pakistan, Saleem et al. (2007) evaluated the use of chlorhexidine vaginal and neonatal wipes by traditional birth attendants (TBAs) at home births. The study was not powered to show differences in mortality but the use of wipes was found to be acceptable and no concerns regarding safety were found. These interventions to reduce sepsis were ultimately targeted at reducing maternal and neonatal mortality, but the studies lacked power to demonstrate this. Iqbal (2004) (+)/(-) compared strategies in a maternity hospital in Karachi, Pakistan, to manage prolonged labour. The strategy was the focus of comparison rather than the effectiveness of a particular drug. In a comparison of induction of labour at 42 weeks and expectant management (non-intervention, careful monitoring), active management resulted in lower perinatal mortality.

4.1.2 Clinical interventions: infant mortality outcomes
In total, 22 papers focused on clinical interventions as a means to reduce infant mortality (Appendix 4.2). Again, clinical interventions focused on infant mortality can be categorised into:

- Surgical/instrumental procedures
Synthesis results

- Drug treatments (including micronutrient supplementation)
- Vaccinations
- Other clinical management

**Surgical/instrumental procedures**

Only one study aimed at improving infant mortality outcomes was focused on surgical intervention. In a retrospective study based in Amman, Jordan, Ziadeh (2000) (-)/(-) sought to determine the perinatal outcomes associated with triplet pregnancies and compare outcomes for Caesarean section with vaginal delivery. Caesarean section was not found to be advantageous but the sample size was very small (n=41).

**Drug treatments (including micronutrient supplementation)**

Six papers focused on drug treatments. One study focused on the use of drug treatments to improve infant outcomes (Kumwenda et al., 2008) (++)/(++). This randomised controlled trial in Malawi evaluated extended antiretroviral prophylaxis to reduce breast-milk HIV-1 transmission. Extended prophylaxis for the first 14 weeks of life significantly reduced postnatal HIV-1 transmission at 9 months but there was not a significant difference in mortality at this stage of follow-up.

Five studies focused on micronutrient supplementation to improve infant mortality outcomes. A randomised controlled trial in urban Zimbabwe (Malaba et al., 2005) (++)/(++) measured the effect on infant mortality of supplementing neonates and their HIV-negative mothers with single, large doses of vitamin A during the immediate postpartum period, but found no significant impact. A controlled experimental study located in a peri-urban Indonesian community (Cobra et al., 1997) (++)/(++) showed a positive impact on infant mortality outcomes as a result of oral iodine supplementation. The study concluded that in populations at risk of iodine deficiency, oral iodized oil supplementation of infants may reduce infant mortality. Furthermore, a study from China examined the effect of water treatment with iodine on infant and neonatal mortality (de Long et al., 1997) (+)/(+). The authors concluded that iodine replacement through iodination of irrigation water was possibly an important factor in the recorded decline in infant mortality in China in areas with severe iodine deficiency. Finally, in Egypt, increased availability of oral rehydration salts (ORS) was associated with an improvement in the case management of, and mortality from, diarrhoea (Miller et al., 1994) (+)/(++). Finally, Joshi et al. (2007) (-)/(-) showed that inhalational nitric oxide (INO) can be life saving and cost-effective in a LIC setting such as India.

**Vaccinations**

Eleven papers focused on vaccinations. All studies on vaccinations included in this review focused on infant outcomes. Vaccination remains a key prevention tool to reduce IMR in low resource settings. This review found 10 studies looking at ways to implement vaccination programmes to improve infant and neonatal mortality. Amin et al. (1992) (-)/(-) looked at the impact of the Expanded Program on Immunization in Sierra Leone and found that immunisation had a dramatic effect on infant mortality declines between 1975 and 1990. A series of studies from Guinea Bissau provide evidence relating to measles and BCG vaccinations and their impact on infant mortality. Aaby et al. (2002) (+)/(+), working in urban, peri-urban and rural areas of Guinea Bissau, compared measles-vaccinated children with those not vaccinated, and the former showed significantly lower levels of mortality. Martins Cesario et al. (2008) (++)/(+++) further confirmed the results, showing that outbreaks of measles can be curtailed by giving the measles vaccine as early as 4.5 months of age. Bacillus Calmette-Guerin (BCG) vaccine on the other hand does not show straightforward results. Garly et al. (2003) (+)/(+), also working in a peri-urban area
of Guinea Bissau, showed significantly higher levels of mortality for BCG non-vaccinated infants. The timing of vaccination was an important issue in the Roth et al. (2004) (+)/(++) study in urban Guinea-Bissau, where vaccination of LBW in the first week of life seemed to have a stronger protective effect in terms of mortality compared to those receiving vaccination later on.

The only paper to report a negative or no significant difference at the end of a large-scale immunisation programme is the study by Fetuga et al. (2010) (+)/(+) in Nigeria. The study focused on the impact of moving from an expanded programme of immunisation to a national programme that was supported solely by the Nigerian government. It hypothesised that this absence of effect was due to poor access to health facilities and to the lack of ante-natal care for mothers and that despite efforts being made in increase community participation, the delivery of tetanus vaccinations remained clinic-based. Further work by Garly et al. (2004) (+)/(++) in urban Guinea-Bissau showed that hepatitis B vaccine (HBV) did not have a specific impact on mortality decline, but simply changed between girl and boys’ mortality. HBV-vaccinated infants 7½-12 months of age had higher mortality than cohorts who had not received HBV, the difference being particularly strong for girls. Aaby et al. (2005) (++)/(++) showed how national immunisation days had a positive impact, mainly if polio vaccination was conducted below 6 months of age. Overall vaccination has a positive impact on infant mortality, but the timing and mode of delivery are crucial. Three studies by Benn et al. (2008a (+)/(++); 2008b (++)/(++); 2010 (++)/(++)), also from Guinea-Bissau, looked at vitamin A supplementation at the time of vaccination. All three studies showed that there were no significant results and recommended against its implementation in an African setting.

Other clinical management

Four papers focused on other aspects of clinical management. Two papers focused on clinical interventions but could not be classified as surgical interventions, drug treatments or vaccinations (Mandelbrot et al., 2002 (++)/(+); Le Fevre et al., 2010 (++)/(+)). The topical application of skin emollients as a skin barrier was evaluated as part of a strategy to improve survival among hospitalised infants through the prevention of infection (Darmstadt et al., 2008) (++)/(++). The randomised controlled trial in Dhaka, Bangladesh found that both sesame seed oil and Aquaphor significantly reduced mortality rates among preterm hospitalised infants, compared to those receiving no topical emollient. The cost-effectiveness of this intervention was also reported in Le Fevre et al., 2010) (++)/(+); (see section 4.1.8). The study by Darmstadt et al., 2004 (+)/(+) in Egypt, which found good (but not significant) results for reductions in neonatal mortality due to sepsis, paved the way for the subsequent larger (and significant) study in 2008. The study by Mandelbrot et al. (2002) (++)/(+) drew on data from urban Cote d’Ivoire and Burkina Faso to consider the effect of vaginal cleansing with benzalkonium chloride during late pregnancy and delivery for infants born to HIV infected mothers. The intervention showed no particular benefit for infant mortality.

4.1.3 Non-clinical interventions: maternal mortality outcomes

In total, 14 papers focused on changes in aspects of service organisation as a means to reduce maternal mortality (Appendix 4.3). These could be further classified into papers dealing with:

- Training and audits
- Provider models
- Financing

No papers were found to focus on regulation, commodities or logistics.

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Training and audit
Nine papers focused on training and audit. Several studies evaluated the impact of training and/or audit (or death review) on maternal and neonatal deaths. These facility-based quality improvement measures seemed to be associated with improved maternal health outcomes (Bugalho and Bergstrom, 1993 (-)/(-); Dumont et al., 2005 (++)/(++); Dumont et al., 2006 (++)/(++); Kongnyuy et al., 2008 (+)/(+)).

Audit was the most frequently reported service intervention for reducing maternal mortality. A study by Awan et al. (1989) (+)/(-) in Lahore, Pakistan, evaluated a complex intervention (staff increases, peer review and feedback), and used trend analysis with before-intervention and during- and post-intervention outcomes for a range of reproductive health outcomes, including IMR and MMR. They demonstrated how audits can be used to develop professional responsibility. Comprehensive audit systems with periodical checks were also found to be significant in reducing waiting times, emergency cases and ultimately maternal mortality. A pre- and post-test study in urban Angola by Strand et al. (2009) (-)/(+) specifically considered the audit of obstetric emergencies. A substantial decline in the number of maternal deaths occurred alongside the use of improved partogrammes, reduced waiting times, improved vigilance and increased awareness of the birthing process, but the study design was unable to show causality. De Muylder and Thiery (1989) (-)/(-) reported time trend analyses of rates of C-section following the introduction of guidelines for the management of dystocia, previous C-section, foetal distress and breech presentation in Zimbabwe. They showed a decline in rates of C-section and maternal mortality over two years, and attributed this to implementation of the guidelines, in the absence of any new technology introduced over the same period. Bhatt (1989) (-)/(-) considered how a drop in maternal deaths from 1967-8 to 1983-4 at a teaching hospital in Baroda, India, might have been due to the initiation of medical audit and maternity death review. The paper showed a decline in maternal deaths from 43 in 1967-8 to 36 in 1983-4 despite a growing case load over that period. The audit was able to highlight problems such as lack of supervision for junior staff and high-risk times when senior staff were away at weekends and holidays. In general, audit meetings appeared to be low-cost interventions to identify avoidable deaths and gaps in the human resource performance.

A note of caution must be introduced, however, regarding the impact of audits and reviews. Although not one of our included papers, Filippi et al. (2004), based on a four-country study (Benin, Côte d'Ivoire, Ghana and Morocco), demonstrate the difficulties involved in sustaining this kind of initiative. The majority of papers in our review did not consider the sustainability of the intervention and we can only speculate that they would be sustainable due to the reported low cost in some studies.

Training is the focus of an intervention in Guatemala (O’Rourke, 1995) (+)/(-). The programme’s goals were to institute standards of care for obstetric and neonatal patients as well as to improve relations between hospital staff and TBAs in both rural and urban areas. Despite increasing referral and improving satisfaction, the programme did not result in a statistically significant reduction in mortality.

Provider models
Only one paper (de Bernis et al., 2000) (+)/(+) looked specifically at the link between service delivery and maternal mortality and morbidity in urban populations with contrasting availability of health care. This study, from Senegal, showed that an area where women were more likely to deliver in hospitals with trained midwives had lower levels of maternal mortality than an area where most women gave birth in district health centres, usually assisted by TBAs, implying that access to skilled health care is fundamental. Given that the distribution of women by socio-economic
groups was very similar in both communities, most of the effect could be attributed to these differentials in service provision.

**Financing**

Four papers focused on financing, which includes, among other things, cash vouchers, pumping into existing resources and lifting user fees. Financing mechanisms played a role in four studies (Bashir et al., 1991 (-)/(-); Ahmed et al., 2004 (-)/(-); Ronsmans et al., 2001 (+)/(+); Lim et al., 2010 (++)/(++)), and the scale of these financing mechanisms ranged from a single-hospital loan scheme (Ahmed et al., 2004) (-)/(-) to a single city (Bashir et al., 1991) (-)/(+) to regional (Ronsmans et al., 2001) (+)/(+), and national programmes (Lim et al., 2010) (++)/(++). The analyses of secondary survey data in Lim et al. did not establish causality between India’s Janani Suraksha Yojana (JSY) conditional cash transfer scheme and maternal and neonatal health outcomes, although the study design might not have been powered to detect changes in mortality. At a much smaller scale, the description by Ahmed et al. (2004) (-)/(-) of a hospital’s short-term loan facility (financed by hospital doctors) to women presenting with a ruptured uterus in Nigeria, suggested reduced maternal and SAMM rates but, again, was unable to confirm causality due to its design. Of note was the high rate of loan payback (94 percent); in order to qualify for a loan, women undertook to repay it prior to discharge.

4.1.4 **Non-clinical interventions: infant mortality outcomes**

Twenty-six studies deal with a wide range of interventions related to service provision aimed at improving neonatal and infant mortality (Appendix 4.4). Again, these interventions can be categorised into:

- Service organisation
- Nutrition (including breastfeeding).

**Service organisation**

Within service organisation, papers dealt with training and audit, increased investment and scaling up of interventions and changes in hospital admissions and discharge procedures. A distinct group of papers then looked at Kangaroo Mother Care (KMC) as an intervention to reduce infant mortality.

Only one study in urban Mozambique considered both maternal and infant health outcomes (Bugalho and Bergstrom, 1993) (-)/(−). Facility-based quality improvement measures, including the introduction of audit measures, showed a significant but transient improvement in perinatal mortality, alongside an increase in C-sections.

**Training and Audit**

Three studies considered the impact of training and/or auditing on infant mortality outcomes. Two studies, one from Uganda and one from China, focused on evaluating the impact of training for neonatal resuscitation. In a Kampala hospital in Uganda, enhanced training in neonatal resuscitation was provided so that a specialist team could be formed which would be available at deliveries (O’Hare et al., 2006) (-)/(−). The intervention led to a decrease in mortality and improved outcomes for babies weighing more than 2kg at birth. Although the authors pointed out that this type of training would be feasible only in big teaching hospitals that could justify the presence of a permanent team, this model might be replicable in similar settings. Training in the Neonatal Resuscitation Program Guidelines in a hospital in China also led to a statistically significant decline in the perinatal neonatal mortality rate (Zhu et al., 1997) (-)/(−). In Nicaragua, following the introduction of a hospital-based system to register births and deaths (and cause of death) in one hospital, neonatal mortality declined from 56/1,000 live births in 1985 to 11/1,000 in 1993 (Aleman et al., 1998) (-)/(−). The authors noted, however, that the registration system, in
order to be effective, could not operate in isolation and required continued and active involvement of healthcare staff in order to review and improve neonatal care routines.

**INCREASING INVESTMENT AND SCALING UP**

Three studies considered the impact of increasing investment and scaling up on infant mortality outcomes. The scaling up of facility-based neonatal care in a district in southern India showed benefits in perinatal and neonatal mortality (Shantharam Baliga *et al.*, 2007) (+)/(++). Using a pre- and post-study design, the authors show a significant decline in early neonatal and perinatal mortality rates, together with a significant decline in case fatality rates for LBW, sepsis and birth asphyxia. They noted that, without sufficient community and health worker motivation, the scaling up was unlikely to have been so successful in reducing early age mortality. Similarly, Enweronu *et al.* (2008) (+)/(-) showed the benefits of investment in infrastructural and staff improvements in neonatal care for the survival of lower birthweight babies in Ghana. In urban Zambia, Essential Newborn Care training reduced early neonatal mortality (Chomba *et al.*, 2008) (+)/(++) However, there was a differential impact of improved service organisation by educational status of the mother, with the greatest impact among women with no secondary education.

**DISCHARGE AND ADMISSION PROCEDURES IN NEONATAL UNITS**

Five papers involved the evaluation of improved hospital discharge and admissions procedures for neonates. Three studies considered this specifically for LBW babies, albeit with different definitions of LBW. Bhakhoo *et al.* (1989) (+)/(+ in India, Bhutta *et al.* (2004) (+)/(-) in Pakistan and Blencowe *et al.* (2009) (+)/(+) in Malawi all suggested that early discharge of neonates was safe and did not lead to an increase in adverse neonatal mortality outcomes. Among these, the study by Blencowe *et al.* (2009) (+)/(+) looked at the early discharge with Kangaroo Mother Care (KMC) as an alternative to routine hospitalisation of low-birthweight babies. The study suggested that early discharge was safe and feasible and that, if rolled out to all levels of health facilities, Kangaroo Mother Care might help to overcome existing problems in access to care. Agarwal *et al.* (2007b) also looked early discharge and rational admissions among other low-cost interventions in a resource-limited teaching hospital in India. The findings of the study suggested that simple interventions such as these could result in a significant decline of neonatal mortality.

In an Indian-based study, Sasidharan *et al.* (2005) (-)/(-) looked wider than admissions and discharges and considered the impact of changed practices in terms of maternal and newborn contact for high-risk neonates in a hospital newborn unit. Prior to the intervention, mothers and their newborns were physically separated, with only occasional breastfeeding permitted. The intervention changed this regime, and permitted mothers (or their substitutes) to breastfeed on demand, alongside other service changes. This can be categorised as a low-cost intervention where increased maternal involvement in the neonatal period proved to be successful in reducing neonatal mortality.

**KANGAROO MOTHER CARE**

A total of six studies specifically addressed Kangaroo Mother Care (KMC), which is a method of care for preterm infants usually involving the infant being carried by the mother, with skin to skin contact (World Health Organization, 2003). The study by Colonna *et al.* (1990) (-)/(+) in urban Mozambique recommended KMC as a low-cost effective intervention. Three other papers were specifically on KMC as a method of infant care rather than simply service reorganisation. Whilst Lincetto *et al.* (2000) reported significant reductions in neonatal mortality following the introduction of KMC in a low-resource setting in Mozambique, evidence from the other studies was
less conclusive (Cattaneo et al., 1998 (++)/(++) in Ethiopia, Indonesia, Mexico; Nagai et al., 2010 (++)/(-) in Madagascar). Two further studies in Zimbabwe and Ethiopia (Bergman and Jurisoo, 1994 (-)/(-); Worku and Kassie, 2005 (-)/(+) reported interventions aimed at improving infant and neonatal care which included the introduction of KMC. Both reported positive mortality outcomes, especially for LBW infants. However, both studies stressed the importance for the success and sustainability of the intervention of continued support and advice to the mother until the recommended infant weight was achieved.

**Nutrition (including breastfeeding practice and guidelines)**

Six studies considered the impact of nutrition interventions on infant mortality outcomes. The promotion of exclusive breastfeeding in Guinea-Bissau (Jakobsen et al., 2008) (++)/(++) for the first 4-6 months of life according to WHO recommendations at the time of the study had no significant impact on infant mortality in a traditional setting which relied on exclusive breastfeeding. The final conclusion was not to discourage local practices, as long as they work.

A specific sub-group of papers dealt with the prevention of mother-to-child transmission (PMTCT), of which only one involved observation of both maternal and infant outcomes (Nduati et al., 2001) (++)/(+). Four key studies looked at the ongoing debate on breastfeeding for HIV-positive mothers. Three of these (Mbong-Ngacha et al., 2001 (++)/(++); Becquet et al., 2007 (++)/(++); Deschamps et al., 2009 (++)/(-)) agreed that in resource-poor settings, given appropriate nutritional counselling and care, access to clean water and a supply of breastmilk substitutes, alternatives to breastfeeding could lower considerably the levels of infant mortality. Furthermore, Kuh et al. (2008) (++)/(++) reported that early, abrupt cessation of breastfeeding by HIV-infected women in a low resource setting, such as Lusaka, Zambia, did not improve the rate of HIV-free survival among children born to HIV-infected mothers and was harmful to HIV-infected infants. Taken together, the results suggest that it is not only the type of feeding but the timing of feeding choices that may be important.

### 4.1.5 Complex interventions: maternal mortality outcomes

Complex interventions are those that include several components, and their evaluation is challenging because the different components of the intervention, and their outcomes, need to be independently and summatively evaluated (Campbell et al., 2000). Methodologies for reviewing data from complex interventions are still developing (Petticrew, 2003). Few interventions are simple, and levels of complexity can vary, but the primary question is whether the intervention works in everyday practice (Haynes, 1999; Medical Research Council, 2008). A further level of complexity for this review is introduced by the fact that most of the complex interventions we identified included rural, as well as urban, populations. In the review, only one item (Borulkar et al., 1998) (-)/(-) made explicit reference to replicability and sustainability. In general there was a sense of interventions being quite localised and heterogeneous in their impact, even within their community (Mirghani and Saheed, 2000) (-)/(-).

Our review identified eight interventions for maternal mortality that we coded as sufficiently complex to merit reporting separately (Appendix 4.5). In this instance, we consider complex those interventions which include more than one aspect of the overall health care process: from clinical intervention to service reorganisation to staff training, etc. In some cases, interventions were multi-sectoral, involving sectors beyond health. By considering the key themes that emerge from these interventions, we can strengthen understanding of how interventions cause change (or not). The interventions we have included were often implemented at a
government administration, regional or national levels, and as such include rural and urban populations.

One study focused entirely on an urban population (Bashir et al., 1995) (−)/(−). A combination of low-cost services or free services for deserving cases, obstetric flying squad services, training for TBAs, antenatal check-ups and intensive community education had a positive impact on maternal mortality levels in a major city in Pakistan. A key to the uptake and success of services such as the flying squad was the community events and radio education campaigns highlighting their availability.

Three studies published over the last decade focused on evaluation of Safe Motherhood or Mother Care interventions as a whole. These complex programmes involved many different types of interventions which present particular challenges for evaluation. Studies in Egypt and Tanzania assessed the impact of national programmes on maternal mortality, and found that reductions in mortality over time were evident (Mbaruku and Bergstrom (1995) (−)/(−); Msxia et al., 2003 (+)/(+++); Alwen et al., 2005 (−)/(+); Campbell et al., 2005 (+)/(+)), although attributing causality was poor. In Nigeria, Okaro et al. (2001) (−)/(−) showed that the Safe Motherhood Initiative had not succeeded, with the MMR increasing fivefold since its start. This was attributed to a deterioration in general living standards which had wiped out any improvements due to better maternal health care. This highlights that health sector investment alone is unlikely to reduce maternal deaths.

Two further studies have considered how interventions at a national or state level may have contributed to declining maternal mortality over time. Padmanaban et al. (2009) (−)/(+) outlined the interventions that were judged to have contributed to the significant decrease in maternal mortality in the Indian state of Tamil Nadu. The MMR in the state reduced from 380 to 90 per 100,000 live births in the period from 1993 to 2007. The paper drew on the observations of the authors, based within the Ministry of Health and Family Welfare, as well as secondary data and literature where available. The paper described wide-ranging interventions from improvements in availability of human resources; availability of key drugs, blood and supplies; improved management capacity; and better surveillance and analysis of maternal deaths. It is not possible from the paper to quantify the effect of the interventions directly but it does highlight the importance of political will and leadership, and engagement of directorates across governments, not just health. For China, Yan (1989) (−)/(−) showed how improved training and services under a national programme had helped to reduce maternal mortality in the country since the 1950s. Starting with training of TBAs, then with referral systems in 1952, up to recruitment and training of midwives and obstetricians alongside TBAs, the Chinese MMRs declined sharply in the 1950s and 1960s. However, no specific reference is made in this study to specific interventions in poor urban areas.

4.1.6 Complex interventions: infant mortality outcomes

Only three papers focused on complex interventions for infant mortality (Appendix 4.6). Section 4.1.5 showed that the complex interventions for maternal mortality focused mainly on national or large scale programmes. Two of the complex interventions for infant mortality focused more closely on addressing a specific area of clinical care through a package of interventions. The areas of focus were special care for infants (Borulkar et al., 1998) (−)/(−) and management for mothers with diabetes during pregnancy and labour (Mirghani and Saeed, 2000) (−)/(−).

The study by Borulkar et al. (1998) (−)/(−) in India reported on the development of a model for the special care of newborns at a community hospital in a predominantly tribal block in an urban area. The key interventions included: adequate warmth; prompt resuscitation; proper feeding; and oxygen administration when necessary.

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries? 39
This facility was developed with existing staff and infrastructure, and minimal material inputs, which made this intervention low cost and sustainable. The authors also suggested that this model was replicable and had the potential for developing horizontal links with perinatal care and child survival programmes to be delivered through community hospitals.

The other study, based in Sudan, focused on simplified management of mothers with diabetes during pregnancy and labour (Mirghani and Saeed, 2000) (-)/(-). There were multiple strands to the intervention. After testing for diabetes, patients were monitored during pregnancy, labour was induced at 38 weeks, basic resuscitation was carried out for all babies, and early breastfeeding was made the norm. Treatment was sought for complications immediately. This simplified management led to significant improvement in perinatal and neonatal mortality, although impact depended on the socio-economic characteristics of the patient.

Brown (1996) followed a cohort of newborn in a hospital in Papua New Guinea over a year from birth to either death or discharge. His study looked at the impact of following Paediatric Standard Treatment book guidelines, which included warming, intravenous fluids, nasopharyngeal oxygen for respiratory distress and phototherapy and/or exchange transfusion for jaundice. Despite different results for different treatments and the non-total uptake of services, he showed that simple and cheap management alone could result in higher survival rates. In his view the results were not generalisable though and possibly only feasible within the context of Papua New Guinea.

4.1.7 Complex interventions: maternal and infant mortality outcomes

Richard et al. (2008) (++)/(++) was the only study focused on complex interventions for maternal and infant mortality (Appendix 4.7). It was a comprehensive intervention to improve access to quality caesarean delivery in an urban district of Burkina Faso involving: staff training; equipment; internal clinical audits; implementation of a cost sharing system; and patients-providers meetings. It was an experimental study without control and represented a facility-based quality improvement intervention. It resulted in increased rates of women receiving needed CS with no negative mortality outcomes for maternal or perinatal mortality. The increased rate was as a result of different factors including improved access to CS and improved diagnosis and management. The authors underline the need for a holistic approach, involving technical, operational, socio-cultural and political components in order to achieve a successful intervention.

4.1.8 Cost-effectiveness

While it is critical to increase our knowledge about what actions and interventions can help improve access to services that will improve maternal and infant health, it is also important to identify the costs of delivering these changes. In all societies, but especially in low and middle income countries where resources for health systems are very limited, it is important to assess the cost-effectiveness of interventions, that is, identifying what level of additional resources are required to generate improvements in health outcomes. There are several different approaches to undertaking economic evaluation, all involving measuring costs in the same way, whilst outcomes may be recorded using natural measures, e.g. number of lives saved, deaths due to pregnancy complications avoided etc., as well as common metrics such as the Disability Adjusted Life Year (DALY) or the Quality Adjusted Life Year (QALY). Where evaluations make use of such common metrics, it then becomes possible to compare all potential uses of resources to improve health outcomes; thus improvements in maternal and child health can be compared with interventions to improve mental health or reduce the consequences of infectious diseases such as
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HIV/AIDS and Malaria, as well as non-communicable diseases like diabetes or cardiovascular disease.

When assessing whether studies met our inclusion criteria, not only did we want therefore to identify whether some studies looked at the costs of implementing interventions, but also whether we could identify any economic evaluations synthesising cost and effects data. In doing this we were interested not only in economic evaluations linked to empirical studies, but also those studies that constructed models drawing on effectiveness and resource use data from many sources to make a judgement on potential cost-effectiveness. The quality of evaluations included in our review was assessed using both the Drummond and Jefferson (1996) and Evers et al. (2005) checklists as recommended in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins and Green, 2011).

Results

It is important to note that there is an ever-increasing evidence base looking at the cost-effectiveness of interventions related to maternal and infant health in low income country contexts (e.g. Jowett, 2000; Rouse, 2003; Adam et al., 2005; Vos et al., 2006; Darmstadt et al., 2008 (++)/++; Goldie et al., 2010). For instance, Adam et al. (2005) drew together a range of data on the effectiveness of interventions to look at potential cost-effectiveness in sub-Saharan Africa and south-east Asia, coming to the conclusion that improving access to preventive measures and early care would all be cost effective in all settings. These would include antenatal care (tetanus toxoid, screening for pre-eclampsia, screening and treatment of asymptomatic bacteria and syphilis); skilled attendance at birth, offering first-level maternal and neonatal care around childbirth; and emergency obstetric and neonatal care.

Despite this increase in the broad cost-effectiveness evidence base, our analysis suggests that few economic evaluations that explicitly met our inclusion criteria have been undertaken. Little work has been undertaken to look at issues of access, uptake and use of effective interventions in our study population. As part of our review, 11 potential economic evaluations were identified by the study team. However after reading the full text, only four met our inclusion criteria (Appendix 4.8). Seven other studies were excluded because they did not have some focus on an urban poor population, although they did provide some further economic evidence for interventions to tackle maternal and infant mortality in low income country settings. For instance, Hounton et al. (2008) reported on the cost-effectiveness of improving access to skilled birthing care in a rural area of Burkina Faso. Meantime Hutton et al. (2009) reported that the administration of three sessions of sulfadoxine-pyrimethamine treatment to prevent malaria in infants up to the age of nine months in rural Tanzania and Mozambique had a cost per death averted of US $100 and US $300 respectively. Thus this intervention would be considered cost effective in these two populations. Tsu et al. (2009) suggested that increased use of oxytocin during the third stage of labour would be cost effective in reducing the risk of postpartum haemorrhage in rural Vietnam.

From our original set of studies, we did identify some papers that had some limited information on the costs of some services, but without any discussion of the consequences for health services and other resource use going forward. We also identified several additional economic evaluations at the abstract screening stage that all focused on rural populations. For example, Rydzak (2008) and colleagues looked at the economic case for prenatal syphilis screening in sub-Saharan Africa as a whole, suggesting overall that some screening programmes could not only reduce stillbirths and infant deaths, but also reduce costs overall. Sutherland et al. (2009 and 2010) modelled the potential cost-effectiveness of prenatal iron
supplementation and misoprostol use on maternal mortality rates in India, but focused solely on the rural population.

In addition, some papers, most of which did not meet the terms of our inclusion criteria, looked at the importance of financing arrangements and cost as a barrier to service access in some settings. One study that did meet these criteria looked at the Indian conditional cash transfer scheme and is discussed in detail elsewhere in this chapter (Lim et al., 2010) (++)/(++) . Another example is one excluded qualitative study in Bangladesh looked at the hidden costs of apparently free access to maternal services in Dhaka, including transport costs to and from hospital and additional food costs while in hospital. It explored the willingness of women to pay these costs, reporting that 21 percent were having to spend between 50 percent and 100 percent of all their monthly income on this (Nahar and Costello, 1998). Another excluded study Chiwuzie et al. (1997) also reported on the potential benefits of community-established and -run emergency loan funds to pay for obstetric care in Nigeria.

**Analysis of specific studies**

Appendix 4.8 provides a summary of key information on economic analysis in the four studies identified that met the inclusion criteria for this review. These are all now briefly discussed in turn.

**Modelling the long-term benefits of a micronutritional intervention**

One of these studies (Sharieff et al., 2008) (+)/(-), making use of data from two empirical studies, was able to take a modelling approach to demonstrate that there were lifetime economic benefits that could arise as a result of the avoidance of premature mortality during the first year of life of a hypothetical urban slum dwelling population in Karachi, Pakistan. In terms of the quality of the economic analysis, the study scores well on both the Drummond and Evers checklists, although evidence on effectiveness of the intervention comes from two previous studies of the authors, but is not detailed in this economic analysis.

The intervention was the use of a nutritional supplement containing iron and zinc that could be sprinkled over food in a home setting. The authors modelled the long-term payoffs over 55 years that would arise from reducing the risk of mortality in the first year of life, coupled with a lower risk of cognitive impairment. They estimated both the costs of intervention and the costs of treatment for diarrhoea in the first year of life. Their simulated study population was developed making use of local data on an urban population to determine potential mortality benefits, as well as risk of diarrhoea and cognitive impairment. Their model suggested that in nearly all scenarios, investment in home-based nutrition supplements would have long-term benefits.

It is important to recognise that these long-term benefits were not just health related, but had an impact on human resources (through better potential to benefit from education) and greater participation in employment. The study projected the impact of better health on participation in employment in adulthood and in the level of earnings achieved. In doing this the authors were able to demonstrate a long-term net return on investment to society as a whole of up to $800 per child.

While generating a positive return on investment, the model is in fact conservative as it does not take account of health-related benefits in adulthood. It is also acknowledged that these benefits would be greatest for low income individuals; those with high incomes in low income settings would be unlikely to benefit as they would not experience nutritional deficiencies. The intervention has now been rolled out throughout the country through the Lady Health Workers Scheme.
ASSESSING THE COST-EFFECTIVENESS OF SKIN BARRIER ENHANCING EMOLLIENTS
The second study looked at the cost-effectiveness of skin barrier enhancing emollients in Bangladesh (Le Fevre et al., 2010) (++)/(+). Unlike the previous study, this is an economic evaluation conducted retrospectively alongside a randomised controlled trial that is also included in our systematic review (Darmstadt et al., 2008) (++)/(++). It is a well-designed study, also scoring well on the two economic evaluation checklists.

The clinical trial compared the use of sunflower seed oil (SSO) or a synthetic skin emollient called Aquaphor against no treatment in order to assess impact on the risk of sepsis and mortality for low birthweight babies at a tertiary hospital in Dhaka. The study highlighted the very good cost-effectiveness of both interventions, compared to other published estimates of cost effective interventions; moreover it also looked at budgetary impact, assuming that it might be difficult for the health care system to fund these interventions.

A detailed breakdown of the costs of providing the intervention, including separate identification of start-up and implementation costs was provided. In total for a 20-bed facility at the hospital start-up and implementation costs came to $1,833.32. Costs per infant treated at the hospital by either of the two interventions or receiving standard care were also provided: on average, costs for SSO were $99.47 compared with $125.35 for Aquaphor and $93.39 for controls receiving usual care. The economic analysis then reported the incremental cost per Year of Life Lost (YLL) averted between the different intervention groups.

The study found that both sunflower seed oil and Aquaphor were highly cost effective in reducing mortality. But Aquaphor was relatively much more expensive - the cost per Year of Life Lost (YLL) averted for Aquaphor was $5.74 compared to do nothing; cost per YLL averted for SSO versus do nothing was $2.15; incremental cost per YLL using Aquaphor compared with SSO was $20.74. A similar study was conducted by the same author in Egypt (Darmstadt et al., 2004) (+)/(+), which paved the way for the implementation of this larger scale cost-effectiveness study.

All of these estimates of cost-effectiveness make good comparison with other potential cost effective interventions highlighted in the World Bank’s Disease Control Priorities Project (Musgrove and Fox-Rushby, 2006). Investment in these skin-barrier enhancing emollients appears more cost effective than all of the interventions in a South Asian context. They also make good comparison with the work of the WHO Choosing Interventions that are Cost Effective (WHO-CHOICE) Programme, where cost-effective interventions in South Asia range from $6 per DALY averted for support for breast feeding to reach 50 percent coverage to $16,930 per DALY averted for a comprehensive package of maternal and infant care at 95 percent coverage (World Health Organization, 2011a). It should, however, be noted that this latter analysis does not take distributional issues into account, so a direct comparison of cost-effectiveness for interventions targeted at the urban poor is not possible. Nor does it look at the impact on costs beyond the health sector.

Cost effective interventions can sometimes be expensive; importantly, this study also looks at the costs of obtaining the two interventions. Given the low likelihood of public funding in the short term in Bangladesh, the use of sunflower seed oil (albeit not as effective as Aquaphor) is likely to be more sustainable as treatments costs are at a level that is much more affordable to people in Bangladesh paying out of pocket for medicine - $1.55 per month compared with $29 per month for Aquaphor (the average monthly salary is $39). There is a strong case, however, for public funding of Aquaphor, given the highly favourable cost-effectiveness ratio.

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
EXAMINING THE COST-EFFECTIVENESS OF KANGAROO MOTHER CARE FOR LOW BIRTHWEIGHT INFANTS

Kangaroo Mother Care (KMC) has often been cited as a low-cost intervention from a health system perspective, particularly as much of the cost is borne by mothers (and other family members) in maintaining skin-to-skin contact with their infants. A previous systematic review looking for evidence from high-income country contexts on this intervention reported that effectiveness studies that looked at physical and mental health impacts rarely considered cost impacts; they simply assumed these to be low (McDaid and Park, 2011). The same appears to be true in the case of KMC interventions in low income country settings, although we were able to identify one randomised controlled trial of KMC versus conventional care (warm room or incubator care) that also looked at the costs associated with care (Cattaneo et al., 1998) (++/++). This study was set in urban hospitals in three cities, but only results from Addis Ababa in Ethiopia, where it was indicated that the poor population would make use of services, were eligible for our analysis. Low birthweight infants were randomised to KMC or conventional care and monitored for up to 30 days. The study sample size was not sufficient to generate statistically significant differences in infant mortality between the two groups, but it was observed that the costs of care, both in terms of salaries and other hospital-related costs were lower in the KMC group. One limitation of this analysis however, was that only overall cost data across all three study cities, rather than data for Addis Ababa alone were presented, although the authors did not note any difference in cost trends between the three study sites.

Assessing the cost impacts of antenatal maternal corticosteroid treatment on risk of neonate mortality

One small RCT in Tunisia of 118 women (Fekih et al., 2002 (+)/(-)) looked both at the effectiveness and the cost implications of targeting women at high risk of premature delivery for antenatal maternal corticosteroid treatment. The comparator group did not receive any additional intervention. Corticosteroid treatment, it was hypothesised, would reduce the respiratory distress syndrome in newborn infants which increased the risk of mortality. The economic analysis was conducted from a health system perspective; infant mortality rates were significantly lower in the intervention group, whilst costs to the health care system, despite the additional cost of corticosteroid treatment for the group (Tunisian $2,000), were Tunisian $21,000 less in the intervention group as a result of having to treat fewer neonates with symptoms of acute respiratory distress.

Strengthening the economics evidence base

Although the evidence base appears limited, there are in fact a number of ways in which it might be strengthened in the short term. For instance, one could retrospectively make use of data looking at uptake and effectiveness of actions that help increase uptake from papers identified in this review; the costs of implementation could then be estimated, including their impact on the future use of health services, or on other economic costs if mortality (and morbidity) were avoided.

Although our review recognises the very different circumstances that are to be found in urban compared to rural areas, this does not necessarily mean that some of the economic studies that we identified in rural areas cannot be adapted to urban settings. Economic models could also be used to estimate some of the longer-term costs and benefits of a reduction in maternal and/or infant mortality. These models could be subject to a series of sensitivity analyses, so as to take account of different potential levels of effectiveness and uptake in different contexts. There may also be existing data that can help with some of these analyses; for instance we identified one detailed analysis of the costs of replicating the scaling up of skilled maternal
and birthing care services, including the costs of promoting behaviour change to encourage the use of skilled care in different districts of Tanzania and Kenya (Boulenger and Dmytraczenko, 2007).

It is also possible to use economic modelling techniques to look at the economic case for scaling up access to a package of appropriate services. One excellent example of a high-quality modelling study, by Goldie et al. (2010), sought to look at this across rural and urban areas in India. While it does not indicate methods by which access would be increased, nor look specifically at the urban poor population, it does illustrate that scaling up services can be very cost effective. Reducing the level of unmet need for family planning services alone, or coupled with the elimination of unmet need for safe abortion services, would be very cost effective, reducing the lifetime risk of death due to maternal complications in urban India from 1 in 119 to 1 in 155 or 1 in 173 respectively. Projected costs avoided for a single cohort of 15-year-old women over their lifetimes could be as much as US$ 120 million. A package of measures to scale up fully integrated services, including intrapartum care as well as family planning and abortion services, would have an incremental cost per year of life saved of between US$200 and $900. This would be considered cost effective in an Indian context. Darmstadt et al. (2008) also modelled the cost-effectiveness of scaling up 16 interventions to tackle infant mortality in 60 low income countries in sub-Saharan Africa and south-east Asia. Scaling up of intrapartum care, in particular given the more limited availability of services in these countries was shown in this economic modelling exercise to be the most cost effective strategy if a step-wise approach to scaling up was required due to limited resources. Similarly Adam et al. (2005), in observing that there are a number of cost effective maternal and child health interventions, suggested that scaling these up to 95 percent population coverage would halve neonatal and maternal deaths.

The evidence base might also be strengthened by looking at literature from countries that were excluded on the grounds of their World Bank classification, but that nonetheless have large disparities in income and access to maternal and infant health services. For example, Horton et al. (1996) looked at the cost-effectiveness of breastfeeding promotion programmes in Brazil and Mexico, concluding that they are among the best value buys for policy makers who wished to reduce the incidence and number of diarrhoea-related deaths. As this study noted, ‘maternity services that have already eliminated formula [through promotion of breast feeding] can, by investing from $2 to $3 per birth, prevent diarrhoea cases and deaths for $3.50 to $6.75 per case, and $550 to $800 per death respectively, with DALYs gained at $12 to $19 each’. The results of this economic analysis might be adapted to low and middle income country settings to provide further information on the potential cost-effectiveness of promotion programmes.

4.2 Synthesis of evidence: causal chain analysis

The causal chain analysis included papers of high quality only (n=21). These were studies that scored ++ in both the internal and external validity checklist. For the reasons highlighted in Section 3.2, we will only conduct a narrative causal chain analysis based on these 21 studies. They are subdivided for neonatal/infant and maternal interventions.
### Table 4.1: Distribution of high-quality items included in causal chain analysis by intervention type and target group

<table>
<thead>
<tr>
<th>Intervention outcome</th>
<th>Intervention focus</th>
<th>Clinical</th>
<th>Non-clinical</th>
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<td>Kaestel et al. (2005)</td>
<td>Dumont et al. (2006)</td>
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<td></td>
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<td>Munjanja et al. (1996)</td>
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<td>Taha et al. (1997)</td>
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<tr>
<td>Infant mortality</td>
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<td>Taha et al. (1997)</td>
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<td>Benn et al. (2008b)</td>
<td>Becquet et al. (2007)</td>
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<td>Cobra et al. (1997)</td>
<td>Jakobsen et al. (2008)</td>
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<td>Kumwenda et al. (2008)</td>
<td>Kuhn et al. (2008)</td>
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<td></td>
<td></td>
<td>Malaba et al. (2005)</td>
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Only seven (Bergsjo, 1989; Cobra et al. (1997); Taha et al. (1997); Dumont et al. (2005); Dumont et al. (2006); Darmstadt et al. (2008); Lim et al. (2010)) out of the 21 studies were identified as successful and four had a negative outcome (Malaba et al., 2005; Jakobsen, 2008; Benn et al, 2010); the remaining 11 were either inconclusive or did not have a major swing towards positive or negative.

#### 4.2.1 Root causes

Most maternal deaths occur during the intrapartum or a few hours after delivery; few papers explicitly discussed the root causes of the obstetric complications which had an impact on both maternal and infant outcome (these were Taha et al., 1997; Darmstadt et al., 2008; Richard et al., 2008). Lack of staff training combined with low levels of knowledge were identified as dominant causes for the lack of implementation of protocols and obstetric care procedures. Social norms in a variety
of settings were also identified as a cause of non-implementation of breastfeeding and obstetric care. One example of this was the practice in some countries of new mothers sequestering themselves from most people during a culturally determined period after delivery, as in parts of India (Lim et al., 2010). Micronutrient shortage in pregnant women in LICs linked to low birthweight for infants was associated with morbidity and mortality (Kaestel et al., 2005).

Cultural barriers remain a key determinant to lack of access to services (Lim et al., 2010) and to the implementation of appropriate health services/interventions (Jakobsen et al., 2008). Only one study (Lim et al., 2010) highlighted the inequalities in access to care to explain high rates of maternal mortality. The root causes of infant and neonatal negative outcomes were identified as pneumonia and diarrhoea mainly because of delays in vaccination (Martins et al., 2008), lack of antenatal care (Munjana et al., 1996), and general lack of guidelines in breastfeeding for HIV positive women (Becquet et al., 2007; Kumwenda et al., 2008). Children born prematurely had compromised barrier functions which increased their risk of infection and of hypothermia (Darmstadt et al., 2008).

4.2.2 Impact on health outcomes

Only 7 out of the 21 studies reported a positive impact on health outcomes (Cobra et al., 1997; Taha et al., 1997; Dumont et al., 2005; Dumont et al., 2006; Darmstadt et al., 2008; Richard et al., 2008; Lim et al., 2010), of which five were related to maternal outcomes and three to infant and neonatal ones. The interventions included: skin barrier methods (Darmstadt et al., 2008); death reviews and financial regulations (Dumont et al., 2005; Dumont et al., 2006; Richard et al., 2008); oral iodine supplementation for infants (Cobra et al., 1997); cash transfer schemes to improve institutionalised deliveries (Lim et al., 2010); and birth canal cleansing to reduce infections (Taha et al., 1997). Although we consider Kumwenda et al. (2008) as an overall neutral study, some of the clinical interventions did result in a positive impact on postnatal mortality.

The range of interventions and specificity of the settings shows that no general conclusion can be reached on successful impact on health. Vaccination remains a key determinant of curbing infant mortality rates in resource poor settings. However what still needs to be further studied is the timing of vaccination. Martins Cesario et al. (2008) found no significant reduction in post-natal mortality in infants vaccinated before 9 months of age in resource-poor settings. However they suggested that an early two-dose strategy providing Edmonston-Zagreb vaccination (measles) as early as 4.5 months of age might be used in humanitarian emergencies or during outbreaks with a high risk of measles infection. A few studies suggested that there was insufficient evidence that changes in feeding practices did significantly reduce infection rates, as overall the effects might be counterbalanced (Kuhn et al., 2008). However Becquet (2008) stressed that given appropriate nutritional counselling and care, access to clean water, and a supply of breastmilk substitutes, these alternatives to prolonged breastfeeding could be safe interventions to prevent mother-to-child transmission of HIV in urban African settings.

4.2.3 Poverty and impact (sustainability)

One study looked at the sustainability of intervention in low-resource urban settings (Figures 4.1 and 4.2): one controlled trial in Bangladesh identified a low-cost intervention that could be funded if necessary through out-of-pocket payments, for emollient skin barrier therapy, although this still needs further testing (Darmstadt et al., 2008). Other interventions such as vaginal wash (Taha et al., 1997) were deemed to be low cost and sustainable, although this study is now over a decade old.

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In general, no overall change of policy was reported. In only one study (Malaba et al., 2005) was it considered that the Zimbabwean government might have started recommending postpartum vitamin supplementation as a result of the study (not confirmed though). Audit was reported to be low cost and high impact (Dumont et al., 2005; Dumont et al., 2006).

Kangaroo Mother Care is a feasible, low-cost and successful intervention, and sustainable in resource-poor settings (Cattaneo et al., 1998). However no recent studies have been found which look at more recent initiatives. More evidence is needed to assess whether administration of micronutrients for pregnant women might be sustainable in African countries (Kaestel et al., 2005), although the approach (in a paper of medium quality) has been shown to be cost effective in a south Asian context (Karachi, Pakistan) (Sharieff et al., 2008) (+)/(-).

Jakobsen et al. (2008) highlighted the waste of resource of policies aimed at breastfeeding-only practices in countries with strong breastfeeding practices. 

Poverty and intervention causality: No study looked at the impact that an intervention had on poverty nor at how the intervention was less or more successful because of the poor setting.

Intervention because of poverty: Only one paper considered cash transfers as an intervention to decrease infant and maternal mortality (Lim et al., 2010). The paper highlighted the difficulty in reaching the most disadvantaged groups despite their being the key focus of the intervention. Infants of urban-based mothers benefited less from the scheme than mothers in rural areas; similarly, the poorest decile of the study population benefited least from the cash-transfer scheme.

4.2.4 Urbanity and impact (sustainability)

No study reported a specific intervention which was purposefully done for urban areas alone. In most cases, the key focus was the poor/low-resource setting. Urban areas were mostly identified by the location of the hospital/health centre where the study was conducted. In general there was a lack of reflection on the issues linked to urban areas and what this entailed for the type of intervention conducted. Possibly underlying all the studies was the idea that some of the interventions were only feasible in urban settings. Lim et al. (2010) highlighted the relative lack of progress in Indian urban areas where it should be easier to get access to services because of the big investments made through the cash-transfer scheme. Disadvantaged groups are hard to reach despite regardless of the residence.

Overall the responses seemed to be focused on the short-term impact of the trials on the key outcomes. Even studies that looked at the impact that audit might have in the long term did not specifically report on changes in policy. The range of studies we have considered highlight the need for more long-term evaluations as well as analysis of the potential effectiveness of interventions that have been evaluated in low income country settings, but not specifically considered in the context of urban, poor populations.
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4.3 Summary of results of causal chain analysis

We identified seven high-quality items with evidence of successful interventions in terms of maternal and infant outcomes. The heterogeneity of the successful interventions we report here reflects our deliberately inclusive search and inclusion strategy. There are four studies (Appendix 4.9) where the positive mortality outcome was clearly targeting or, with disaggregation, could be shown to have a beneficial effect for poor urban populations. In keeping with our inclusive approach to addressing this question, however, we also present a second table (Appendix 4.10) to show those high-quality studies (n=3) with positive impact(s) on maternal and infant outcomes that (based on circumstantial evidence, for example the site of intervention) we have every reason to believe addressed a poor urban population, though this was either not stated explicitly or was unclear.

Returning to the four studies, generalising from so few is inadvisable, and just one of the papers (Darmstadt et al., 2008) dealt with infant mortality. Notable, however, is that two out of the four involved service (re)organisation in some form for maternal healthcare (Munjanga et al., 1996; Dumont et al., 2006), albeit with rather different recommendations. Munjanga et al.’s (1996) study in Zimbabwe tested whether reducing the number of routine antenatal visits and tests for routine pregnancies might have had a negative impact on mortality outcomes. Their study, using a RCT design, found no significant change in perinatal and maternal mortality. Dumont et al.’s (2006) Senegalese study using before and after study design showed that, when applied to qualified professionals (physicians, midwives, managers), the Maternal Deaths Review (MDR) helped to improve the organisation of care, leading to significant decline in overall mortality over the study’s three year period.16

The Darmstadt et al. (2008) study in Bangladesh, using a prospective, randomised controlled design, showed significant reductions in neonatal mortality rates for preterm neonates (≤33 weeks) at risk of skin infections who received emollient skin-barrier therapy. A companion paper (Le Fevre et al., 2010) (+++)/(+) on the cost-effectiveness of this intervention is reviewed elsewhere in this report.

Whilst all of these three interventions showed significant impact on maternal or neonatal mortality, none dealt with the issues involved in accessing the services where the interventions were provided, although the economic evaluation accompanying the last study did look at issues of sustainability. The one study that did deal with issues around accessing health services is that by Lim et al. (2010), which considered the impact of India’s JSY conditional cash-transfer scheme on maternal health outcomes through analyses of the National Family Health Service (NFHS). The claims made for the JSY programme in India by Lim et al. (2010) are not without critique (Das et al., 2010), some of which the authors have acknowledged (Lim et al., 2011), in particular that their analyses of demand-side interventions such as the JSY cannot deal with supply-side issues such as facility readiness.

Turning to the studies that did not specifically report on urban areas, the three successful high-quality interventions identified to impact on infant mortality involved four very different kinds of intervention. Studies by Cobra et al. (1997) and Taha et al. (1997) targeted infants in general. The study by Taha et al. (1997) on vaginal cleansing to reduce bacterial infections, which are substantial in many

16 A linked, but separate study by Dumont et al. (2005) using a similar approach is listed in Appendix 4.10 for high-quality, positive interventions, but ones without explicit application to poor urban populations.

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resource-poor settings, whilst not a controlled experimental study, provided convincing evidence for significant impact on early neonatal mortality rates.

The final successful intervention addressing maternal mortality involved a change to service intervention in Senegal (Dumont et al., 2005), and it is worth noting that it referred to the same setting as that in Dumont et al. (2006) in Table 4.1, namely, the introduction of routine audits of maternal deaths as a tool to improve service delivery, underlining the importance of facility-based quality improvement measures. MDR does appear to be another relatively low cost and high impact intervention.
5. Strengths and limitations

Summary

Limitations include:

- Bias towards English language literature
- Bias against modelling-based economic evaluations
- Restriction to maternal or infant mortality outcomes, excluding non-mortality health outcomes for mothers and infants
- Problems in identifying ‘poor’ populations and reliance on the use of proxies for ‘poor’

5.1 Search strategy

There are a number of limitations in our review. One key issue is a bias towards English language literature. By restricting our search strategy to largely English language databases, we may have missed relevant studies in other languages, this is despite the fact that some databases do provide English language abstracts for non-English language papers. We have tried to mitigate against this by examining relevant papers in French, Spanish and Italian. Moreover, while we do not have the resources for additional translation, we have also sought to identify potentially relevant papers in other languages whose English language abstracts appear relevant.

In developing and refining our search strategy, it became clear that it would be difficult to come up with a comprehensive set of terms to cover the many different definitions of poverty and urbanicity. We sought to counter this risk by not including any specific poverty or urbanicity terms in our search strategy, and instead sought to identify studies that looked at maternal and child health in our target countries and then to determine whether these studies did focus on our target population. Our study protocol indicated that we would make our initial decisions on inclusion/exclusion on the basis of study abstracts/summaries. However it had to be acknowledged that relevant papers might not provide sufficient detail on target population to judge whether a paper focused on urban, poor populations from the abstract alone. We tried to account for this by erring on the side of retrieval of full text papers where a study appeared relevant in all respects other than having an indication of geographical location or socio-economic status of the target population.

Our primary search strategy may also not have been sensitive enough to pick up economic evaluations which were based on modelling rather than empirical studies; while we did search both Econlit and the NHS Economic Evaluation Database, a supplemental search of several key databases making use of key economic evaluation terms was conducted to see whether any additional studies could be identified, including the Office of Health Economics Health Economics Evaluation Database (HEED). Given the limited number of effectiveness studies that looked at interventions specifically for urban populations and reported maternal and/or infant mortality outcomes, this is not surprising.

Another challenge has been the limited functionality of some databases, which in some cases have made it difficult to construct complex search strategies and/or to import records electronically into EndNote. In some cases, the lack of functionality
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
6. Conclusions and recommendations

Summary

Interventions supported by the review are already present in existing WHO guidelines, but do not specifically address the effectiveness of different models of service delivery.

Interventions in urban areas need to specifically consider the question ‘Who gains?’ or ‘Who loses?’ as a result of an intervention.

Research should be clearer about the definitions used for common measures (e.g., urban, poor, poverty) in the reporting of interventions in the literature.

In order to understand what works to reduce maternal and infant mortality among poor urban people in LICs and LMCs, there is a need for interventions (and their robust evaluation) that specifically target this group. There will be more to learn from studies that do not explicitly mention whether they target urban populations, possibly contacting study authors to obtain more information on target populations in order to consider the potential relevance of approaches in an urban context. There are a very limited number of interventions targeting the urban poor’s access to and use of MCH services, and even fewer that use mortality indicators as their outcomes. This small evidence base is out of step with the growing interest in, and scale of, urban poor people (ref major reports e.g. UNHABITAT, 2010) and there are growing calls, which this review adds to, for a move from description to evaluation (Freudenberg et al., 2005; Harpham, 2009). We know that MCH interventions are complex and difficult to evaluate (Ronsmans et al., 2003). Set against the backdrop of rapidly growing and highly mobile urban poor populations, their evaluation becomes even more complex. We suggest that future interventions in urban areas (even those not necessarily targeting the urban poor) need to specifically consider the question ‘Who gains?’ or ‘Who loses?’ as a result of an intervention. In addition there is a need to address the question of sustainability in low resource environments such as urban slums. Most of the studies we looked at did not consider the long-term implications and how the interventions might have had an impact on policies or on behavioural changes.

Our approach, reflecting our pre-review mapping of the possible evidence, is that the best available evidence is preferable to not using any evidence. Despite the inclusivity of our approach, both in terms of item identification, study design, data type and definitions (for example, a broad approach to defining ‘poor’), we know very little about the most effective models to reduce maternal and infant (including neonate) mortality among poor, urban populations. For example, despite the volume of work that shows that geographic access to health services for the urban poor tends to be lower than that of their rural counterparts, our search did not yield one intervention considering the mortality outcomes of differential access, such as access to EmOC, for the urban poor; however, the Lim et al. (2010) (++)/(++) study did separately look at urbanicity and poverty and impacts on infant mortality rates. To make sure that we were not unnecessarily restricting our searches, and mindful of the relative rarity of maternal mortality events, we also included severe acute maternal morbidity (SAMM) (haemorrhage, dystocia, hypertension, sepsis, incomplete abortion, Caesarean section (CS), hysterectomy, and blood transfusion) (World Health Organization, 2011b), but this still yielded...
very little. Only one paper (de Bernis et al., 2000) (+)/(+) looked specifically at the link between service delivery and maternal mortality and morbidity for urban populations with contrasting health care service provision. This study, from Senegal, showed that an area where women were more likely to deliver in hospitals with trained midwives had lower levels of maternal mortality than an area where most women gave birth in district health centres, usually assisted by TBAs, implying that access to skilled health care is fundamental. Given that the distribution of women by socio-economic groups was very similar in both communities, most of the effect could be attributed to these differentials in service provision.

Our searches and analyses encountered major problems in identifying ‘poor’ populations. Whilst we took an inclusive strategy and included measures that are frequently used as proxies for ‘poor’ (e.g., material ownership indices), much of the evidence uncovered by our searches treated terms such as ‘poor’ and ‘poverty’ as unproblematic - especially that produced in the medical literature. There is a need for greater clarity about the definitions used for common measures (e.g., urban, poor, poverty) in the reporting of interventions in the literature. Without this clarity, the potential usefulness of high-quality studies for understanding what works to improve the health of the urban poor is greatly reduced.

Secondary analyses of datasets such as the DHS and MICS are widely used in the study of the urban poor (and many were identified in our initial searches but excluded from the review). Such datasets represent an important source of descriptive information, but their explanatory power is very limited, even when data are disaggregated to identify the urban poor in wealth quintiles based on material ownership. The evidence base, where it does disaggregate and identify (however loosely) the urban poor, tends to compare and contrast with rural populations. Whilst this approach is intuitive and relatively easy to operationalise, especially for secondary analyses of large-scale datasets such as the DHS, we need to remember that ‘the urban health goal is not simply to be better on average than rural areas. The ambition must be to attain good health for all absolutely’ (Dye, 2008, p.768).

What, then, are the methodological issues involved in studying the health of poor urban people? Our review found few studies for inclusion that acknowledged and studied the urban poor as an individual (highly heterogeneous) group. Many descriptive studies either compare urban poor with urban non-poor and/or rural populations. Poor urban settings can introduce methodological issues that make intervention delivery and evaluation difficult, above and beyond those limitations that might exist in a LIC setting. However, it is important to remember that poor urban populations do not just live in slums or informal settlements. There are many poor urbanites who do not live within slums. Non-slum dwelling urban poor are just as ‘invisible’ in the evidence our search produced.

There is a lag between researchers’ (and funders’) intervention research interests, but also, we would argue, a degree of inertia. Long-term funding for non-urban poor settings that evaluate health interventions make compelling arguments for continued funding, in part to protect time series data. Many longitudinal study sites in more rural settings have made efforts to capture population movements to and from urban areas (Collinson and Adazu, 2006). However, the continued concentration of, for example, Demographic Surveillance Sites in LICs and LMCs in largely rural settings means that data with explanatory power continue to be absent for many urban poor.

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Urban upgrading programmes (also called slum upgrading or improvement programmes) are complex interventions and can include better provision of health services in general and MCH services in particular as part of a bundle of services (Field and Kremer, 2006). Given that MDG7 Target 11 ‘By 2020, to have achieved a significant improvement in lives of at least 100 million slum dwellers’ has generated the production and consumption of much data about slum dwellers’ lives, it was surprising that we found no relevant MCH evidence produced by evaluations before and after urban upgrading. Urban upgrading evaluations have tended to rely on changes in tenure and access to water and sanitation. Even when health outcomes are the focus, research has tended to evaluate the impact on infectious diseases (for example, Butala et al., 2010). One forthcoming item we did identify was the proposed 3ie synthetic review *Slum Upgrading Strategies and Their Effects on Health and Social Outcomes* by Saith et al. (forthcoming), as yet not released.
7. References

7.1 Studies included in review


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### 7.2 Other references used in the text of the technical report


*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*


Butala N M, VanRooyen J, Patel RB (2010) Improved health outcomes in urban slums through infrastructure upgrading *Social Science and Medicine, 71*(5), 935-940.


What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?


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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

References


Appendices

Appendix 1.1: Authorship of this report

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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Conflicts of interest

The authors declare no conflicts of interest.

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### Appendix 2.1: Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of studies</td>
<td>Randomised controlled trials</td>
<td>Editorial, commentaries or book reviews</td>
</tr>
<tr>
<td></td>
<td>Non-randomised controlled trials</td>
<td>Policy analyses</td>
</tr>
<tr>
<td></td>
<td>Observational studies with control groups</td>
<td>Qualitative secondary analyses</td>
</tr>
<tr>
<td></td>
<td>Longitudinal time series studies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Systematic reviews of these interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Economic evaluations and modelling studies of relevant interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Qualitative evaluations looking at implementation of relevant interventions</td>
<td></td>
</tr>
<tr>
<td>Types of participants</td>
<td>Studies including: Mothers and/or infants up to age of 24 months</td>
<td>Studies that include only: Children aged more than 24 months</td>
</tr>
<tr>
<td></td>
<td>AND</td>
<td>OR</td>
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<td></td>
<td>poor populations; AND</td>
<td>non-poor urban populations</td>
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<td>AND</td>
<td>OR</td>
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<tr>
<td></td>
<td>urban, or semi-urban, or peri-urban settings</td>
<td>rural settings</td>
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<td></td>
<td>AND</td>
<td>OR</td>
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<td></td>
<td>low income and lower middle income countries</td>
<td>upper middle-income countries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>countries in Europe</td>
</tr>
<tr>
<td>Types of intervention</td>
<td>Studies on interventions broadly defined as actions concerned with improving the access, utilisation or effectiveness of maternal and infant health services in areas serving urban poor populations</td>
<td>Studies that did not clearly distinguish effects from other non-targeted health interventions, such as the provision of potable water</td>
</tr>
<tr>
<td>Types of outcomes</td>
<td>Studies which have one or more of the following indicators as outcomes:</td>
<td>Studies which have one or more of the following indicators as outcomes:</td>
</tr>
<tr>
<td></td>
<td>maternal, infant, neonatal, perinatal, post-neonatal mortality, and still-birth; severe acute maternal morbidity (SAMM) (haemorrhage, dystocia, hypertension, sepsis, incomplete abortion, Caesarean section (CS), hysterectomy, and blood transfusion)</td>
<td>Children mortality where the age is not specified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maternal morbidity other than SAMM</td>
</tr>
</tbody>
</table>

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*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Language</th>
<th>Studies published in English, French, Spanish and Italian</th>
<th>Studies published in languages other than English, French, Spanish or Italian.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Studies published from 1987 onwards</td>
<td>Studies published before 1987</td>
</tr>
</tbody>
</table>
Appendix 2.2: Search strategy for electronic databases

Medline/PubMed and PsychINFO

Maternal Health Services /
Pregnancy /
Infant /
Abortion, Induced /
Obstetric Surgical Procedures /
Pregnancy Complications /
Vaginal Fistula /
OR / 1-7
Infant Mortality /
Maternal Mortality /
Perinatal Mortality /
OR / 9-11
Africa /
Central America /
China /
India /
Melanesia /

(Afghanistan OR Guinea OR Nepal OR Bangladesh OR Guinea-Bissau OR Niger OR Benin OR Haiti OR Rwanda OR Burkina Faso OR Kenya OR Sierra Leone OR Burundi OR Korea (NOT South Korea OR Republic of Korea) OR Solomon Islands OR Cambodia OR Kyrgyz OR Somalia OR Central African Republic OR Lao OR Tajikistan OR Chad OR Liberia OR Tanzania OR Comoros OR Madagascar OR Togo OR Congo OR Malawi OR Uganda OR Eritrea OR Mali OR Zambia OR Ethiopia OR Mauritania OR Zimbabwe OR Gambia OR Mozambique OR Ghana OR Myanmar OR Burma OR Angola OR India OR Sào Tomé OR Armenia OR Iraq OR Senegal OR Belize OR Jordan OR Sri Lanka OR Bhutan OR Kiribati OR Sudan OR Bolivia OR Kosovo OR Swaziland OR Cameroon OR Lesotho OR Syria OR Cape Verde OR Maldives OR Thailand OR China OR Marshall Islands OR Timor OR Micronesia OR Tonga OR Côte d'Ivoire OR Ivory Coast OR Moldova OR Tunisia OR Djibouti OR Mongolia OR Turkmenistan OR Ecuador OR Morocco OR Tuvalu OR Egypt OR Nicaragua OR Ukraine OR El Salvador OR Nigeria OR Uzbekistan OR Georgia OR Pakistan OR Vanuatu OR Guatemala OR Papua New Guinea OR Vietnam OR Guyana OR Paraguay OR West Bank OR Gaza OR Honduras OR Philippines OR Yemen OR Indonesia OR Samoa).ti, ab

OR / 13-18
8 AND 12 AND 19
Limit 20 to year 1987-

Embase
Maternal-Care /

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.2

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.2

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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OR/ 12-13
11 AND 14
Limit 15 to publications after 1996
ECONLIT
Infant mortality, ti, ab, kw
Maternal mortality, ti, ab, kw
Perinatal mortality, ti, ab, kw
Neonatal mortality, ti, ab, kw
Birth, ti, ab. kw
Abortion, ti, ab, kw
Obstetric*
Appendix 2.3: Search strategy for websites

To facilitate website searches, Google Advanced was used to search individual domains. The search strings were

Infant mortality
Maternal mortality

Only items in English were sought, and the first 20 items were reviewed for relevance. All of the websites that were searched have been tagged as LSDFID_SysRev2011 in Diigo (http://www.diigo.com/user/LSE_DFID) to facilitate sharing.
Appendix 2.4: Journals handsearched

All issues of the following journals published online between 1 January 2008 and 1 October 2010 were handsearched electronically:

- Bulletin of the World Health Organization
- BMC Pregnancy and Childbirth
- BMC Health Services Research
- BMC Public Health
- BMC Women's Health
- British Medical Journal
- Health Policy and Planning
- Journal of Tropical Pediatrics
- Social Science and Medicine
- PLoS ONE
- PLoS Medicine

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.5: Coding tool

**GENERAL**

**ID**
Unique study ID

**AUTHORS**
Authors Surname, Initial
(e.g. Coast E; Leone T)

**PUB DATE**
Publication date (Year)
(e.g. 1978)

**PUB TYPE**
Type of publication.
Select as many responses as required.
peer-reviewed journal article
non-peer-reviewed journal article/evaluation
book/book chapter
none of the above (please enter details)

**FUNDING**
What is the source of funding for the intervention?
Select as many responses as required.
public
(e.g. government, including government-funded research councils)
private
(e.g. company)
third sector
(e.g. NGOs, INGOs, charities, civil societies)
unclear/not stated
N/A

**CONTEXT**

**COUNTRY**
In which country(ies) or region(s) was the study conducted? Give the list of countries. Detail regions if individual countries are not listed.

(e.g. Nepal, Bangladesh OR Sub-Saharan Africa, South-East Asia)

**URBANITY**
In which settings is the study conducted?
Select as many responses as required
urban
peri-urban
rural

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*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

POOR PROFILE
Is the study population identified as "poor"?

yes
no
unclear/not stated
N/A

POOR CLASSIFICATION
On what bases is the study population identified as “poor”?
Select as many responses as required

absolute income
relative income (self-defined/researcher-defined/wealth index)
place of residence
education
SES/"class"
none of the above (please enter details)
unclear/not stated
N/A

INTERVENTION
INTERVENTION FOCUS (CATEGORIES)
What categories the intervention belongs to? Select as many response as required.

prevention
(e.g. education, immunization, nutrition)

improving the quality of care
(e.g. training, curricula, devices, drugs)

improving the access to care
(e.g. physical access, financial access)

INTERVENTION SUPPLY-DEMAND
Is the intervention focused on supply- or demand-side factors?
Select as many responses as required

supply-side
(e.g. training of service provider, changes in type of staffing, use of lay or community workers, reduction in distance to available facilities)

demand-side
(e.g. education of women, reduction in fees, vouchers, incentives, cash transfers, peer encouragement for service use)

unclear/not stated

INTERVENTION FOCUS (HEALTH)
What is the focus of the intervention?
Select as many responses as required

maternal health
neonatal health
(1-28 days)

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infant health
(<1 year)
none of the above (please enter details)

MORBIDITY TARGET (MATERNAL HEALTH)
Which morbidity is the intervention set out to prevent maternal death from? Select as many response as required.
complication of unsafe abortion
hypertensive disorders
(e.g. pre-eclampsia, eclampsia)
postpartum haemorrhage
antepartum haemorrhage
dystocia
(e.g. abnormal foetal lie or presentation, rupture of uterus)
puerperal sepsis
direct obstetric causes not specified
malaria
HIV/AIDS
none of the above (please enter details)

MORBIDITY TARGET (NEONATAL/INFANT HEALTH)
Which morbidity is the intervention set out to prevent newborn death from? Select as many responses as required.
intra-partum related
(e.g. 'birth asphyxia')
preterm
(e.g. immaturity, low birth weight, and complications of pre-term birth)
sepsis/pneumonia
tetanus
congenital abnormalities
diarrhoea
neonatal morbidity (not specified)
infant morbidity (not specified)
none of the above (please enter details)

INTERVENTION TARGET POPULATION
Who is the intervention targeting? Select as many responses as required.
women in general
specific sub-group of women (please enter details)
(e.g. HIV-positive pregnant women)
neonates in general
specific sub-group of neonates (please enter details)
(e.g. high risk babies such as low-birth babies)

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infants
(<1 year)
specific sub-group of infants (please enter details)
(e.g. high risk infants such as HIV-exposed)
none of the above (please enter details)

AGENT
Who delivered the MCH intervention?
Select as many responses as required.
(please enter details on each agent role)
obstetrician
non-specialised doctor
midwife
nurse-midwife
nurse
auxiliary midwife
community health worker
lady health worker
traditional birth attendant
shopkeeper
pharmacist
family member/mother
women’s group
none of the above (please enter details)
unclear/not stated
N/A

SETTING TYPE
What sort of setting was the MCH intervention delivered in?
government
not-for-profit
(e.g. FBO, charity, PNFP)
for profit
none of the above (please enter details)
unclear/not stated

SETTING SPECIFY
Where the MCH intervention was delivered? Select as many responses as required.
central hospital
district hospital
primary health centre
community health post
community
home
shops
pharmacy
none of the above (please enter details)
unclear/not stated
N/A

INTERVENTION
What is delivered as MCH intervention? Select as many responses as required.
education
surgical procedure
drug treatment
vaccination
nutrition
other types of care (not included above)
\textit{(e.g. Kangaroo Mother Care)}
commodities
\textit{(e.g. bed net, birth kit)}
financing
regulating
service organization
none of the above (please enter details)
unclear/not stated
N/A

Intervention (education)
What type of education is delivered as MCH intervention? Select as many as required.
hygiene-cord
breast feeding
newborn care seeking
newborn emergency (danger sign)
newborn warmth
birth planning (maternal emergency)
post natal home self-care
post natal maternal emergencies
counselling and testing for HIV
none of the above (please enter details)
unclear/not stated

\textit{What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?}
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

Intervention (surgical procedure)
What type of surgical procedure is delivered as MCH intervention? Select as many responses as required.
destructive operation
episiotomy
hysterectomy
c-section
none of the above (please enter details)
unclear/not stated

Intervention (drug treatment)
What type of drug treatment is delivered as MCH intervention? Select as many as required.
antibiotics
(please specify if known - e.g., penicillin)
antihypertensives
(please specify if known)
ARV
vermicidal
(e.g. albendazole)
intermittent presumptive treatment
uterotonics
(e.g. misoprostol)
none of the above (please enter details)
unclear/not stated

Intervention (vaccination)
What type of vaccination is delivered as MCH intervention? Select as many responses as required.
BCG
(Tuberculosis)
Polio
DTP
(Diphtheria, Tetanus, Pertussis)
HBV
(Hepatitis B Virus)
none of the above (please enter details)
unclear/not stated

Intervention (nutrition)
What type of nutrition is delivered as MCH intervention? Select as many responses as required.
macronutrients
(e.g. protein, carbohydrates, fat)
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

single micronutrient
(e.g. vitamin A, zinc, iron, folic acid, magnesium, calcium)

multiple micronutrient
(please enter details of types of micronutrients)

none of the above (please enter details)

unclear/not stated

Intervention (other type of care not specified above)
What type of care was delivered as MCH intervention? Select as many responses as required.

care during the antenatal period (please enter details)

care during labour and delivery (please enter details)
(e.g. clean delivery technique, uterine massage)

postpartum care (please enter details)
(e.g. include newborn warmth, hygiene cord care.)

none of the above (please enter details)

unclear/not stated

Intervention (commodities)
What type of commodity was delivered as MCH intervention? Select as many responses as required.

Bed net

birth kit

none of the above (please enter details)

Intervention (financing)
what type of financing was delivered as MCH intervention? Select as many responses as required.

tax credit

subsidy

user fee reduction

user fee abolition

cash transfer

cash voucher

none of the above (please enter details)

unclear/not stated

Intervention (regulating)
What type of regulating was introduced as MCH intervention? Select as many responses as required.

law

professional regulation

curricula

none of the above (please enter details)

unclear/not stated

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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

Intervention (service organization)
What type of service organization was introduced as MCH intervention? Select as many responses as required.

- introduction of specialised services
- reduction in distance to facilities
- training
- new staff
- staff role reduction
- none of the above (please enter details)

Intervention (details)
INTERVENTION START
Start date (Month/Year)
(###/#### OR 00/####)
(e.g. 12/2010, 00/2010)

month/year
###/#### OR 00/#### (if only year stated)
(e.g. 12/2008, 00/2008 if only year stated)

unclear/not stated
N/A

INTERVENTION END
End date (Month/Year)
(###/#### OR 00/####)
(e.g. 12/2010, 00/2010)

month/year
###/#### OR 00/#### (if only year stated)
(e.g. 12/2008, 00/2008 if only year stated)

unclear/not stated
N/A

INTERVENTION DURATION
What is the length of the intervention? (Number of months)

number of months
#
(e.g. 4, 12)

unclear/not stated
N/A

INTERVENTION DETAILS
Give details (not reported elsewhere) about the intervention (e.g., intensity)

Intervention (comparison group)
(applied to controlled experimental study, experimental study without concurrent control, observational studies with comparison group)

INTERVENTION COMPARISON SPECIFIC
What is delivered to the comparison group (specific to the comparison group)?

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
normal/existing service/financing mechanism/regulation (please enter details)
alternative interventions/service/financing mechanism/regulation (please enter details)
no intervention

INTERVENTION COMPARISON COMMON
Were common MCH services/financial mechanism/regulation delivered to both the exposure and comparison groups?
yes (please enter details)
no
unclear/not stated

STUDY DESIGN
STUDY TYPE
What is the design of the study?
Select as many responses as required
controlled experimental study
(e.g. randomised controlled trial, cluster randomised trials, non-randomised controlled trials)
experimental study without concurrent control
(e.g. interrupted time series, pre/post-test)
observational studies with comparison group
(e.g. cohort studies, case-control studies, cross-sectional studies)
observational studies without comparison group
(e.g. descriptive)
economic evaluation/modelling studies
qualitative studies
(e.g. focus groups)
review
(e.g. systematic review, rapid evidence appraisal, systematic mapping etc.)
none of the above (please enter details)
(e.g. ecological studies)

DATA TYPE

DATA LONGITUDINAL
Are the data longitudinal?
yes
no
unclear/not stated

OUTCOMES
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
MORTALITY OUTCOME TYPES
Which mortality outcomes are measured in this study?
Select as many responses as required

VARIABLES
Prioritise binary variables (e.g. death and survivors).
If not then enter continuous variable (e.g. ratio=number of death/number of live births).

DENOMINATORS
For ‘maternal mortality rate’ the denominator will be 100,000 live births.
For the other mortalities 1,000 live births.

COMMENTS
When data are available for number of ‘survivors’, then transform it and enter the number of ‘death’.

maternal mortality
(during pregnancy and within 42 days of termination of pregnancy)

perinatal mortality
(stillbirth and <7 days)

early neonatal mortality
(<7 days)

late neonatal mortality
(7-28 days)

neonatal mortality
(1-28 days)

post-neonatal mortality
(28 days - 1st birthday)

infant mortality
(<1 year)

late maternal mortality
(more than 42 days but less than one year after termination of pregnancy)

SAMA
please specify which maternal morbidity was measured (e.g., haemorrhage, dystocia, hypertension, sepsis, incomplete abortion) or which signs were used (e.g., C-section, hysterectomy, blood transfusion)

stillbirth
none of the above (please enter details)

BASELINE OUTCOME
Are data presented on outcome(s) prior to intervention?

yes

no

Outcomes (experimental study without concurrent control)

M&E WAVES
Please enter details

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.5

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

At how many points in time was outcome measured (baseline included)?
(e.g. 3)

M&E WAVE FIRST
Date of the first wave (Month/Year)
(###/#### OR 00/####)
(e.g. 12/2010, 00/2010)

M&E WAVE LAST
Date of the last wave (Month/Year)
(###/#### OR 00/####)
(e.g. 12/2010, 00/2010)

M&E DURATION SPACE
Were waves equally spaced?

yes

no

unclear/not stated

N/A

M&E DURATION PERIODICITY
what was the periodicity of waves? (number of months)
(e.g. 6)

OUTCOMES (observational studies with comparison group)

DATASET AGE: OLDEST
Date of the oldest dataset used in the analyses (Year)
(e.g. 1990)

DATASET AGE: RECENT
Date of the most recent dataset used in the analyses (Year)
(e.g. 2010)

OUTCOMES (observational studies without comparison group)

DATASET AGE: OLDEST
Date of the oldest dataset used in the analyses (Year)
(e.g. 1990)

DATASET AGE: RECENT
Date of the most recent dataset used in the analyses (Year)
(e.g. 2010)

OUTCOMES (review)

ITEM AGE: OLDEST
Date of the oldest item included in the review (Year)
(e.g. 1990)

ITEM AGE: RECENT
Date of the most recent item included in the review (Year)
(e.g. 2010)

FINDINGS

INTERVENTION CLAIMS
What claims are made for the effects of the intervention?
Select as many responses as required

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
positive
neutral
negative
unclear/not stated
N/A

MORTALITY OUTCOME FINDINGS: SUMMARY
What are the findings with relation to impact on mortality outcomes? (please enter details)

COMMENTS
Any general comments on study not coded elsewhere

QUALITY ASSESSMENT

THEORY
Does the study use a particular theoretical perspective? (e.g. community-based approach, peer involvement, psychological support, network)

yes (please enter details)
no
unclear/not stated

AIMS

Is there a clear statement of the aims of the research?

yes
no

AIMS DETAILS
Describe the aims of the research

STUDY DESIGN
Study design (controlled experimental study)

RANDOMISATION TYPE
At what level are the randomised assignments done?
Select as many responses as required

individual
household
community/administrative grouping
facility
allocation not randomised
none of the above (please enter details)
unclear/not stated
N/A

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

T&C SELECTION
Give details about the selection criteria for T&C groups (e.g. population, facility - dependent on unit of study)

T&C MATCHING
Are T&C groups matched on explicit criteria?

yes
no
unclear/not stated
N/A

T&C MATCHING LIST
On what variables are T&C groups matched?
Select as many responses as required
socio-demographic variables (e.g. SES, ethnicity etc.)
access to service/intervention
geographic location
none of the above (please enter details)

T&C GEOGRAPHY
Is the control group geographically separate from the treatment group?

yes
no
unclear/not stated
N/A

T&C CONTAMINATION
Is control contamination addressed in the item being reviewed (e.g. article)?
Control contamination here refers to interaction between the T&C groups (e.g. the intervention group passes on information to the control group in a health education intervention)

yes (please enter details) (e.g. intention to treat)
no
unclear/not stated
N/A

PARTICIPANT BLINDING
Were the participants blinded?

yes
no
unclear/not stated
N/A

OBSERVER BLINDING
Were the observers blinded?

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
GROUPS SELECTION
Was the group selection specified?
(e.g. inclusion/exclusion criteria)

yes (please enter details)
Give selection criteria for groups (e.g. population, facility - dependent on unit of study)

no
unclear/not stated
N/A

DATASET TYPE
What kind of dataset was used?
Select as many responses as required
nationally representative survey
ad hoc survey
in depth qualitative interviews
civil registration
census
hospital records
surveillance system
none of the above (please enter details)

DATASET LIMITATIONS
Does the study discuss the limitations of the datasets used?

yes
no
unclear/not stated

DATASET BIAS DISCUSSION
Does the study discuss possible biases or caveats or limitations?

yes
no
unclear/not stated

Study design (observational studies without comparison group)

DATASET TYPE
What kind of dataset was used?
Select as many responses as required
nationally representative survey
ad hoc survey
in depth qualitative interviews
civil registration
census
hospital records

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
surveillance system
none of the above (please enter details)

**DATASET LIMITATIONS**
Does the study discuss the limitations of the datasets used?

yes
no
unclear/not stated

**DATASET BIAS DISCUSSION**
Does the study discuss possible biases or caveats or limitations?

yes
no
unclear/not stated

**Study design (economic evaluation/modelling studies)**

**ECONOMIC EVALUATION/MODELLING**
Separate validated criteria for economic evaluations used by Evers et al (2005) will be used; supplemented by Philips et al (2004) guidance for modelling

**Study design (qualitative studies)**

**QUALITATIVE DATA**
What method(s) is(are) used to produce the qualitative data?
Select as many responses as required

in-depth interviews
focus groups
observation
none of the above (please enter details)
N/A

**Study design (review)**

**PEER REVIEW**
Has the review study been subject to peer review?

yes
no
unclear/not stated

**REVIEW TYPE**
What kind of review?

systematic review
synthetic review
systematic mapping
none of the above (please enter details)
unclear/not stated

**PEER REVIEW**
Has the review study been subject to peer review?

*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.5

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

SELECTION CHARACTERISTICS
Is information given on the characteristics of the study participants?  
(e.g. possible sources of confounders)

yes (please enter details)

no

SELECTION (SAMPLING)  
(applied if selection=sampling)

SAMPLING METHOD
What sampling method was used? Please describe the method of sampling.

stratified
random
systematic
convenience
judgement
quota
snowball
RDS
none of the above (please enter details)
unclear/not stated
Selection (overall population)

SELECTION DETAIL
Please describe the method of selection.

DATA

DATA COLLECTION
Is it explicit how the data were collected?

yes

no

DATA COLLECTION Justification
Is explicit justification given for collecting the data in this way?  
(e.g. sentence)

yes

no

DATA RECORDS
Is it explicit how the data were recorded?

yes

no

DATA MODIFIED
Were the data collection methods modified during the process?

yes
Appendix 2.5

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

no

**DATA MODIFIED JUSTIFICATION**
If data collection methods were modified during the process, then is justification provided?
yes
no
N/A

**DATA COLLECTOR**
Is it explicit who collected the data?
yes
no

**ANALYSES**

**DATA ANALYSES**
Is it explicit how the analysis was done?
yes
no

**ANALYTIC APPROACH**
Is there an explicit justification for the analytic approach?
yes
no
unclear/not stated

**DATA TRIANGULATION**
Have different sources of data about the same issue been compared (triangulation)?
yes
no
unclear/not stated

**ANALYSIS REPEAT**
Was analysis repeated by more than one researcher to ensure reliability?
yes
no
unclear/not stated

**ANALYSES** (controlled experimental study, experimental study without concurrent control, observational studies with comparison group)

**QUANTITATIVE DATA BASELINE**
Were exposure and comparison groups similar at baseline?
yes
no
unclear/not stated
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

**QUANTITATIVE DATA ADJUSTED**
If exposure and comparison groups were not similar at baseline, then were data adjusted for confounders?

- yes
- no
- N/A

**QUANTITATIVE DATA CONFOUNDERS**
If data were adjusted for confounders, then what groups of confounder were included? Select as many responses as required

- residence
- wealth
- ethnic group
- age
- education
- parity
- none of the above (please enter details)

- N/A

**ETHICS**
Does the study provide evidence that it has been granted ethical clearance by an appropriate authority?

- yes
- no

**ETHICS EXPLAINED**
Is it explicit how the purpose of the research was explained and presented to participants?

- yes
- no

**FEEDBACK**
Have/will attempts be made to feedback results to participants?

- yes
- no
- unclear/not stated

**REFUSAL**
**REFUSAL RATE**
Is participation refusal rate explicit?

- yes
- no

**REFUSAL JUSTIFICATION**
Is it explicit why some participants chose not to take part?
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.6: Quality appraisal checklist: quantitative studies

*Quantitative studies checklist for NICE (2009)*

<table>
<thead>
<tr>
<th>Study identification</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Include full citation details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study design:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidance topic:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Section 1: Population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Is the source population or source area well described?</td>
<td>++</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural), population demographics etc. adequately described?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>−</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Is the eligible population or area representative of the source population or area?</td>
<td>++</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was the recruitment of individuals/clusters/areas well defined (e.g. advertisement, birth register)?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>−</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Do the selected participants or areas represent the eligible population or area?</td>
<td>++</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was the method of selection of participants from the eligible population well described?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>−</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>What % of selected individuals/clusters agreed to participate? Were there any sources of bias?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**
### Appendix 2.6

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

<table>
<thead>
<tr>
<th>Section 2: Method of selection of exposure (or comparison) group</th>
<th></th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Selection of exposure (or comparison) group. How was selection bias minimised?</td>
<td>++</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>−</td>
<td></td>
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<tr>
<td></td>
<td>NR</td>
<td></td>
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<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

| 2.2 Was the selection of explanatory variables based on a sound theoretical basis? | ++ | Comments: |
| | + | |
| | − | |
| | NR | |
| | NA | |

| 2.3 Was the contamination acceptably low? | ++ | Comments: |
| | + | |
| | − | |
| | NR | |
| | NA | |

| 2.4 How well were likely confounding factors identified and controlled? | ++ | Comments: |
| | + | |
| | − | |
| | NR | |
| | NA | |

| 2.5 Is the setting applicable to the UK? | ++ | Comments: |
| | + | |
| | − | |
| | NR | |
| | NA | |
### Section 3: Outcomes

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Were the outcome measures and procedures reliable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels [++] vs self-reported smoking [−]). How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? Was there any indication that measures had been validated (e.g. against a gold standard measure or assessed for content validity)?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>3.2 Were the outcome measurements complete?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>3.3 Were all the important outcomes assessed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were all the important benefits and harms assessed?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>3.4 Was there a similar follow-up time in exposure and comparison groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using</td>
<td>++</td>
<td></td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Section 4: Analyses

#### 4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?

- **A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard.**
- Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?

<table>
<thead>
<tr>
<th></th>
<th>++</th>
<th>+</th>
<th>−</th>
<th>NR</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

#### 4.2 Were multiple explanatory variables considered in the analyses?

- Were there sufficient explanatory variables considered in the analysis?

<table>
<thead>
<tr>
<th></th>
<th>++</th>
<th>+</th>
<th>−</th>
<th>NR</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
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</tbody>
</table>

#### 4.3 Were the analytical methods appropriate?

- Were important differences in follow-up time and likely confounders adjusted for?

<table>
<thead>
<tr>
<th></th>
<th>++</th>
<th>+</th>
<th>−</th>
<th>NR</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
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</tbody>
</table>

#### 4.4 Was the precision of association given or calculable? Is association meaningful?

- Were confidence intervals (CIs) and/or p-values for effect estimates given or

<table>
<thead>
<tr>
<th></th>
<th>++</th>
<th>+</th>
<th>−</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**
Appendix 2.6

<table>
<thead>
<tr>
<th>possible to calculate?</th>
<th>NA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 5: Summary

<table>
<thead>
<tr>
<th>5.1 Are the study results internally valid (i.e. unbiased)?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well did the study minimise sources of bias (i.e. adjusting for potential confounders)?</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Were there significant flaws in the study design?</td>
<td>−</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2 Are the findings generalisable to the source population (i.e. externally valid)?</th>
<th>++</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>−</td>
<td></td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.7: Quality appraisal checklist: qualitative studies

**Qualitative studies checklist for NICE (2009)**

<table>
<thead>
<tr>
<th>Study identification</th>
<th>Guidance topic:</th>
<th>Checklist completed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include author, title, reference, year of publication</td>
<td>Key research question/aim:</td>
<td></td>
</tr>
</tbody>
</table>

**Theoretical approach**

<table>
<thead>
<tr>
<th>1. Is a qualitative approach appropriate?</th>
<th></th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example: Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could a quantitative approach better have addressed the research question?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Is the study clear in what it seeks to do? For example:</th>
<th></th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the purpose of the study discussed - aims/objectives/research question/s?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there adequate/appropriate reference to the literature?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are underpinning values/assumptions/theory discussed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Study design**

<table>
<thead>
<tr>
<th>3. How defensible/rigorous is the research design/methodology?</th>
<th></th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example: Is the design appropriate to the research question?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is a rationale given for using a qualitative approach?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

Appendix 2.7

| Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? |
| Is the selection of cases/sampling strategy theoretically justified? |
| Data collection |
| 4. How well was the data collection carried out? |
| For example: |
| Are the data collection methods clearly described? |
| Were the appropriate data collected to address the research question? |
| Was the data collection and record keeping systematic? |
|  | Appropriately | Inappropriately | Not sure/inadequately reported |
| Trustworthiness |
| 5. Is the role of the researcher clearly described? |
| For example: |
| Has the relationship between the researcher and the participants been adequately considered? |
| Does the paper describe how the research was explained and presented to the participants? |
|  | Clearly described | Unclear | Not described |
| 6. Is the context clearly described? For example: |
| Are the characteristics of the participants and settings clearly defined? |
| Were observations made in a sufficient variety of circumstances? |
| Was context bias considered? |
|  | Clear | Unclear | Not sure |
| 7. Were the methods reliable? For example: |
| Was data collected by more than one method? |
| Is there justification for |
|  | Reliable | Unreliable | Not sure |

Comments:
Appendix 2.7

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Analysis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Is the data analysis sufficiently rigorous? For example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Is the procedure explicit - i.e. is it clear how the data was analysed to arrive at the results?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How systematic is the analysis, is the procedure reliable/dependable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Is it clear how the themes and concepts were derived from the data?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Are the data ‘rich’? For example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How well are the contexts of the data described?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Has the diversity of perspective and content been explored?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How well has the detail and depth been demonstrated?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are responses compared and contrasted across groups/sites?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Is the analysis reliable? For example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Did more than one researcher theme and code transcripts/data?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- If so, how were differences resolved?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Did participants feed back on the transcripts/data if possible and relevant?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Were negative/discrepant results addressed or ignored?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Are the findings convincing? For example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2.7

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the findings clearly presented?</td>
<td>Not sure</td>
<td></td>
</tr>
<tr>
<td>Are the findings internally coherent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are extracts from the original data included?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the data appropriately referenced? Is the reporting clear and coherent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the findings relevant to the aims of the study?</td>
<td>Relevant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irrelevant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partially relevant</td>
<td></td>
</tr>
<tr>
<td>12. Conclusions For example:</td>
<td>Adequate</td>
<td></td>
</tr>
<tr>
<td>How clear are the links between data, interpretation and conclusions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the conclusions plausible and coherent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have alternative explanations been explored and discounted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does this enhance understanding of the research topic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the implications of the research clearly defined?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there adequate discussion of any limitations encountered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. How clear and coherent is the reporting of ethics?</td>
<td>Appropriate</td>
<td></td>
</tr>
<tr>
<td>For example:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have ethical issues been taken into consideration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are they adequately discussed e.g. do they address consent and anonymity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have the consequences of the research been considered i.e. raising expectations, changing behaviour?</td>
<td>Not sure/not reported</td>
<td></td>
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</tbody>
</table>
Appendix 2.7

<table>
<thead>
<tr>
<th>Was the study approved by an ethics committee?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Overall assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>As far as can be ascertained from the paper, how well was the study conducted (see guidance notes)?</td>
</tr>
<tr>
<td>++</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>−</td>
</tr>
</tbody>
</table>

Comments:
Appendix 2.8: Quality appraisal checklist: cost-effectiveness studies

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the study population clearly described?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are competing alternatives clearly described?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is a well-defined research question posed in answerable form?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is the economic study design appropriate to the stated objective?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is the chosen time horizon appropriate to include relevant costs and consequences?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is the actual perspective chosen appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are all important and relevant costs for each alternative identified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are all costs measured appropriately in physical units?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Are costs valued appropriately?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Are all important and relevant outcomes for each alternative identified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Are all outcomes measured appropriately?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Are outcomes valued appropriately?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Is an incremental analysis of costs and outcomes of alternatives performed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Are all future costs and outcomes discounted appropriately?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Are all important variables, whose values are uncertain, appropriately subjected to sensitivity analysis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do the conclusions follow from the data reported?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Does the study discuss the generalizability of the results to other settings and patient/client groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Does the article indicate that there is no potential conflict of interest of study researcher(s) and funder(s)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Are ethical and distributional issues discussed appropriately?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Not clear</th>
<th>Not appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study design</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The research question is stated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The economic importance of the research question is stated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 2.8

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Not clear</th>
<th>Not appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. The viewpoint(s) of the analysis are clearly stated and justified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The rationale for choosing alternative programmes or interventions compared is stated.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>5. The alternatives being compared are clearly described.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. The form of economic evaluation used is stated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The choice of form of economic evaluation is justified in relation to the questions addressed.</td>
<td></td>
<td></td>
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</table>

**Data collection**

<table>
<thead>
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<th>Yes</th>
<th>No</th>
<th>Not clear</th>
<th>Not appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. The source(s) of effectiveness estimates used are stated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Details of the design and results of effectiveness study are given (if based on a single study).</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Details of the methods of synthesis or meta-analysis of estimates are given (if based on a synthesis of a number of effectiveness studies).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. The primary outcome measure(s) for the economic evaluation are clearly stated.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12. Methods to value benefits are stated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Details of the subjects from whom valuations were obtained were given.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Productivity changes (if included) are reported separately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. The relevance of productivity changes to the study question is discussed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Quantities of resource use are reported separately from their unit costs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Methods for the estimation of quantities and unit costs are described.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18. Currency and price data are recorded.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19. Details of currency of price adjustments for inflation or currency conversion are given.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Details of any model used are given.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. The choice of model used and the key parameters on which it is based are</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2.8

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Not clear</th>
<th>Not appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis and interpretation of results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Time horizon of costs and benefits is stated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>The discount rate(s) is stated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>The choice of discount rate(s) is justified.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>An explanation is given if costs and benefits are not discounted.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Details of statistical tests and confidence intervals are given for stochastic data.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>The approach to sensitivity analysis is given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>The choice of variables for sensitivity analysis is justified.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>The ranges over which the variables are varied are justified.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Relevant alternatives are compared.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Incremental analysis is reported.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>Major outcomes are presented in a disaggregated as well as aggregated form.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>The answer to the study question is given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Conclusions follow from the data reported.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Conclusions are accompanied by the appropriate caveats.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2.9: Electronic databases excluded

In addition to databases included in our search protocol, 22 further databases were examined and were excluded on the basis of lack of functionality (in particular the lack of MeSH terms or key words, and the lack of a reference manager tool to export references), country or topic coverage, or lack of access.

<table>
<thead>
<tr>
<th>Database</th>
<th>MeSH terms/ key words</th>
<th>Reference manager export</th>
<th>Comments</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>AfricaBib</td>
<td>No</td>
<td>No</td>
<td>No abstract</td>
<td><a href="http://www.africabib.org/">http://www.africabib.org/</a></td>
</tr>
<tr>
<td>African Studies Centre, Leiden</td>
<td>Not clear</td>
<td>No</td>
<td>-</td>
<td><a href="http://opc4-ascl.pica.nl/LNG=EN/">http://opc4-ascl.pica.nl/LNG=EN/</a></td>
</tr>
<tr>
<td>CAB Direct (was Rural Development Abstract)</td>
<td>Yes</td>
<td>Yes</td>
<td>-</td>
<td><a href="http://www.cabdirect.org/">http://www.cabdirect.org/</a></td>
</tr>
<tr>
<td>Cross searcher</td>
<td>Not clear</td>
<td>Yes</td>
<td>-</td>
<td><a href="http://zw4gk5cr3l.cs.serialssolutions.com/?S_S_LibHash=ZW4GK5CR3L&amp;authRedirect=1">http://zw4gk5cr3l.cs.serialssolutions.com/?S_S_LibHash=ZW4GK5CR3L&amp;authRedirect=1</a></td>
</tr>
<tr>
<td>EthOS</td>
<td>No</td>
<td>No</td>
<td>-</td>
<td><a href="http://ethos.bl.uk/Home.do;jsessionid=311101362EZAEAE41F73A605EB834BBE">http://ethos.bl.uk/Home.do;jsessionid=311101362EZAEAE41F73A605EB834BBE</a></td>
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<tr>
<td>Google Scholar</td>
<td>No</td>
<td>No</td>
<td>No abstract</td>
<td><a href="http://scholar.google.co.uk/">http://scholar.google.co.uk/</a></td>
</tr>
<tr>
<td>Google Search (Advanced)</td>
<td>No</td>
<td>No</td>
<td>-</td>
<td><a href="http://www.google.co.uk/advanced_search?hl=en">http://www.google.co.uk/advanced_search?hl=en</a></td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 2.9

<table>
<thead>
<tr>
<th>Database Name</th>
<th>Access to Full Text</th>
<th>Access to Abstract</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Medicus for South East Asia Region (IMSEAR)</td>
<td>Yes</td>
<td>No</td>
<td><a href="http://imsear.hellis.org/">http://imsear.hellis.org/</a></td>
</tr>
<tr>
<td>Index to Theses</td>
<td>No</td>
<td>No</td>
<td><a href="http://www.theses.com/">http://www.theses.com/</a></td>
</tr>
<tr>
<td>IndMed</td>
<td>No</td>
<td>No</td>
<td><a href="http://indmed.nic.in/">http://indmed.nic.in/</a></td>
</tr>
<tr>
<td>MedCarib</td>
<td>Yes</td>
<td>No</td>
<td><a href="http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/">http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/</a></td>
</tr>
<tr>
<td>OPENSIGLE</td>
<td>No</td>
<td>Unclear</td>
<td><a href="http://www.greynet.org/opensiglerepository.html">http://www.greynet.org/opensiglerepository.html</a></td>
</tr>
<tr>
<td>Proquest Dissertations and Theses</td>
<td>No</td>
<td>Yes</td>
<td><a href="http://proquest.umi.com.gate2.library.lse.ac.uk/login">http://proquest.umi.com.gate2.library.lse.ac.uk/login</a></td>
</tr>
<tr>
<td>Quarterly Index of African Periodical Literature</td>
<td>No</td>
<td>No</td>
<td><a href="http://memory.loc.gov/misc/qsihtml/">http://memory.loc.gov/misc/qsihtml/</a></td>
</tr>
<tr>
<td>Social Care Online (former Care Data)</td>
<td>No</td>
<td>Yes</td>
<td><a href="http://www.scie-socialcareonline.org.uk/">http://www.scie-socialcareonline.org.uk/</a></td>
</tr>
<tr>
<td>SocIndex</td>
<td>Not accessible</td>
<td>Not accessible</td>
<td>Not accessible</td>
</tr>
<tr>
<td>South Africa Medical Database (SAME)</td>
<td>Yes</td>
<td>Unclear</td>
<td><a href="http://www.mrc.ac.za/SamedSearch/">http://www.mrc.ac.za/SamedSearch/</a></td>
</tr>
</tbody>
</table>

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 3.1: Details of studies included in the review

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaby (2002)</td>
<td>Guinea-Bissau peri-urban</td>
<td>Clinical Vaccinations</td>
<td>No intervention</td>
<td>Observationa l studies with comparison group</td>
<td>Children up to 20 months in a war situation</td>
<td>313</td>
<td>N/ A</td>
<td>neutral</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Aaby (2005)</td>
<td>Guinea-Bissau urban/peri-urban/rural</td>
<td>Clinical Vaccinations</td>
<td>No intervention</td>
<td>Observationa l studies with comparison group</td>
<td>Infants in general</td>
<td>6,159</td>
<td>N/ A</td>
<td>neutral</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Abdel (2010)</td>
<td>Egypt, South Africa; urban</td>
<td>Clinical Other clinical management: uterine massage</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimenta l study</td>
<td>Women in general</td>
<td>951 (Egypt)</td>
<td>30</td>
<td>negative</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Abdul (2007)</td>
<td>Nigeria peri-urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation) : induction of labour</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimenta l study</td>
<td>Women needing induction</td>
<td>62</td>
<td>12</td>
<td>neutral</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
## Appendix 3.1

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboud (2009)</td>
<td>Malawi, Tanzania, Zambia urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation): antibiotics</td>
<td>No intervention</td>
<td>Controlled experimental study</td>
<td>HIV-infected pregnant women</td>
<td>1,829</td>
<td>20</td>
<td>neutral</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Adewole (2000)</td>
<td>Nigeria urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation): anti-convulsant</td>
<td>N/A</td>
<td>Observationa l studies without comparison group</td>
<td>Women with eclampsia</td>
<td>21</td>
<td>17</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Afolabi (2010)</td>
<td>Nigeria urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation): active management of third stage of labour</td>
<td>Alternative intervention/ service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Women in labour with term pregnancies and having vaginal delivery</td>
<td>200</td>
<td>unclear/not stated</td>
<td>positive</td>
<td>+</td>
<td>-</td>
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</tbody>
</table>
### What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agarwal (2007a)</td>
<td>India urban</td>
<td>Clinical Surgical/instrumental procedures</td>
<td>Normal/ existing service/financing mechanism/regulation</td>
<td>Observational studies with comparison group</td>
<td>Women with post-Caesarean pregnancy</td>
<td>424</td>
<td>12</td>
<td>positive</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Agarwal (2007b)</td>
<td>India urban</td>
<td>Non-clinical Service organization: discharge and admission procedure in neonatal units</td>
<td>N/A</td>
<td>Experimental study without concurrent control</td>
<td>Women in general</td>
<td>7,938</td>
<td>8</td>
<td>positive</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Ahmed (2004)</td>
<td>Nigeria urban</td>
<td>Non-clinical Service organization: financing</td>
<td>Normal/ existing service/financing mechanism/regulation</td>
<td>Observational studies with comparison group</td>
<td>Poor women with uterine rupture</td>
<td>1,360</td>
<td>11</td>
<td>positive</td>
<td>-</td>
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<td>Nicaragua urban</td>
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<th>Study</th>
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<th>Study design</th>
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<th>Length (months)</th>
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<td>positive</td>
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<td>Becquet (2007)</td>
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<td>557</td>
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 3.1

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<td>Benn (2010)</td>
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<td>Bergman (1994)</td>
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<td>Bergsjo (1989)</td>
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<td>Women with uncomplicated pregnancies going beyond 42 weeks gestation</td>
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</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<tr>
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<td>High-risk neonates</td>
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<td>Bhatt (1989)</td>
<td>India urban/ peri-urban</td>
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<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observational studies with comparison group</td>
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<td>Bhutta (2004)</td>
<td>Pakistan urban</td>
<td>Non-clinical Service organization: discharge and admission procedure in neonatal units</td>
<td>No intervention</td>
<td>Observational studies with comparison group</td>
<td>Neonates with LBW (&lt;1,500g)</td>
<td>509</td>
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<td>positive</td>
<td>+</td>
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<td>Study</td>
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<td>Intervention type</td>
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<td>Study design</td>
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<td>Sample size</td>
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<td>Intervention claims</td>
<td>Internal validity</td>
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<tr>
<td>Blencowe (2009)</td>
<td>Malawi urban</td>
<td>Non-clinical Service organization: discharge and admission procedure in neonatal units</td>
<td>No intervention</td>
<td>Observational studies with comparison group</td>
<td>Neonates with LBW (&lt;2000g)</td>
<td>256</td>
<td>6</td>
<td>unclear/ not stated</td>
<td>+</td>
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<td>Borulkar (1998)</td>
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<td>Observational studies without comparison group</td>
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<td>unclear/ not stated</td>
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<td>Brown (1996)</td>
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<td>Observational studies without comparison group</td>
<td>Neonates with LBW (&lt;1,500g)</td>
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<tr>
<td>Bugalho (1993)</td>
<td>Mozambique urban</td>
<td>Non-clinical Service organization</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observational studies with comparison group</td>
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<td>Campbell (2005)</td>
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<td>Normal/ existing service/ financing mechanism/ regulation</td>
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<td>unclear/ not stated</td>
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 3.1

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

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<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
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<tr>
<td>Cattaneo (1998)</td>
<td>Ethiopia, Indonesia, Mexico urban</td>
<td>Non-clinical Service organization: Kangaroo Mother Care</td>
<td>Normal/ existing service/ financing mechanism/regulation</td>
<td>Controlled experimental study economic evaluation/ modelling studies</td>
<td>Infants with LBW (1,000-1,999g)</td>
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<td>12</td>
<td>neutral</td>
<td>++</td>
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<td>Chaudhari (1994)</td>
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<td>Alternative intervention/ service/ financing mechanism/regulation</td>
<td>Controlled experimental study</td>
<td>Women with history of eclampsia</td>
<td>59</td>
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<td>positive negative</td>
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<td>+</td>
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<td>Chinayon (1998)</td>
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<td>Observationa l studies without comparison group</td>
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<td>+</td>
<td>+</td>
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<td>Non-clinical Service organization: increasing investment and scaling up</td>
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<td>Observationa l studies with comparison group</td>
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<td>positive</td>
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### Appendix 3.1

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<td>Clinical Other clinical management</td>
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<td>Controlled experiment study</td>
<td>Preterm infants</td>
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<tr>
<td>De Bernis</td>
<td>Senegal urban/</td>
<td>Non-clinical Service organization:</td>
<td>Alternative intervention/ service/ financing</td>
<td>Observationa l studies with</td>
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<td>mechanism/ regulation</td>
<td>comparison group</td>
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<td>No intervention</td>
<td>Observationa l studies with</td>
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<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
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<td>Non-clinical Service organization: training and audit</td>
<td>alternative intervention s/ service/ financing mechanism/ regulation</td>
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<td>++</td>
<td>++</td>
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<td>++</td>
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<td>Length (months)</td>
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</tr>
<tr>
<td>Enakpene (2010)</td>
<td>Nigeria urban</td>
<td>Clinical</td>
<td>No intervention</td>
<td>Observationa l studies with comparison group</td>
<td>Women with umbilical cord prolapse (UCP)</td>
<td>72</td>
<td>120</td>
<td>positive</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Enweronu (2008)</td>
<td>Ghana urban</td>
<td>Non-clinical Service organization:</td>
<td>Increasing investment and scaling up</td>
<td>Observationa l studies with comparison group</td>
<td>Neonates requiring intensive care</td>
<td>3,893</td>
<td>N/ A</td>
<td>positive neutral</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Etuk (2000a)</td>
<td>Nigeria urban</td>
<td>Clinical</td>
<td>Normal/ existing service/ financing</td>
<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
<td>672</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Etuk (2000b)</td>
<td>Nigeria urban</td>
<td>Clinical</td>
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<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
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<td>positive</td>
<td>-</td>
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</tr>
<tr>
<td>Fabamwo (2010)</td>
<td>Nigeria urban</td>
<td>Clinical</td>
<td>Normal/ existing service/ financing</td>
<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
<td>1,133</td>
<td>6</td>
<td>positive</td>
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</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
<table>
<thead>
<tr>
<th>Study</th>
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<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
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<tbody>
<tr>
<td>Fawzi (2007)</td>
<td>Tanzania urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>No intervention</td>
<td>Controlled experiment study</td>
<td>HIV-negative pregnant women</td>
<td>8,137</td>
<td>36</td>
<td>neutral</td>
<td>++</td>
<td>++</td>
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<tr>
<td>Fekih (2002)</td>
<td>Tunisia urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation) : steroids</td>
<td>No intervention</td>
<td>Controlled experiment study</td>
<td>Women 26-34 weeks gestation at high-risk of premature delivery</td>
<td>118</td>
<td>18</td>
<td>positive</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Fenton (1999)</td>
<td>Malawi urban</td>
<td>Clinical Other clinical management</td>
<td>No intervention</td>
<td>Observationa l studies with comparison group</td>
<td>Women needing Caesarean section</td>
<td>3,665</td>
<td>18</td>
<td>neutral</td>
<td>+</td>
<td>-</td>
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<tr>
<td>Fetuga (2010)</td>
<td>Nigeria urban</td>
<td>Clinical Vaccinations</td>
<td>alternative intervention s/ service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Neonates in general</td>
<td>175</td>
<td>N/ A</td>
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<tbody>
<tr>
<td>Garly (2003)</td>
<td>Guinea-Bissau peri-urban</td>
<td>Clinical Vaccinations</td>
<td>alternative interventions/ services/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Neonates in general, Infants in general</td>
<td>1,813</td>
<td>unclear/not stated</td>
<td>positive</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Garly (2004)</td>
<td>Guinea-Bissau urban</td>
<td>Clinical Vaccinations</td>
<td>Normal/ existing services/ financing mechanism/ regulation</td>
<td>Observational studies with comparison group</td>
<td>Infants in general</td>
<td>5,441</td>
<td>5</td>
<td>negative</td>
<td>+</td>
<td>++</td>
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<tr>
<td>Gray (1991)</td>
<td>Thailand urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>oral contraceptive</td>
<td>No intervention</td>
<td>Observational studies with comparison group</td>
<td>Women in general</td>
<td>4,303</td>
<td>unclear/not stated</td>
<td>negative</td>
<td>+</td>
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<tr>
<td>Iqbal (2004)</td>
<td>India urban</td>
<td>Clinical Other clinical management</td>
<td>No intervention</td>
<td>Observational studies with comparison group</td>
<td>Women with prolonged pregnancy (&gt; or = 294 days)</td>
<td>100</td>
<td>12</td>
<td>positive</td>
<td>+</td>
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<tbody>
<tr>
<td>Jakobsen</td>
<td>Guinea-Bissau urban/peri-urban</td>
<td>Non-clinical Nutrition (including breastfeeding)</td>
<td>No intervention</td>
<td>Controlled experimental study</td>
<td>Infants in general</td>
<td>1,721</td>
<td>unclear/not stated</td>
<td>negative</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Joshi</td>
<td>India urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>N/A</td>
<td>Observation studies without comparison group</td>
<td>Neonates with primary pulmonary hypertension</td>
<td>18</td>
<td>unclear/not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kaestel</td>
<td>Guinea Bissau urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Pregnant women</td>
<td>1,670</td>
<td>22</td>
<td>neutral</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Kamilya</td>
<td>India urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observation studies with comparison group</td>
<td>Women with eclampsia</td>
<td>1,646</td>
<td>26</td>
<td>positive</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
## Appendix 3.1

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kietinun (1993)</td>
<td>Thailand urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation): antimalarial</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Pregnant women with malaria</td>
<td>678</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kongnyuy (2008)</td>
<td>Malawi urban/ peri-urban</td>
<td>Non-clinical Service organization: training and audit</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Experimental study without concurrent control</td>
<td>Women receiving EmOC</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Kuhn (2008)</td>
<td>Zambia urban</td>
<td>Non-clinical Nutrition (including breastfeeding)</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>HIV-infected women</td>
<td>958</td>
<td>40</td>
<td>negative</td>
<td>++</td>
<td>++</td>
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<tr>
<td>Kumwenda (2008)</td>
<td>Malawi urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Infants born to HIV-infected mothers</td>
<td>3,276</td>
<td>3</td>
<td>neutral</td>
<td>++</td>
<td>++</td>
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</tbody>
</table>
### Appendix 3.1

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison intervention type/ service/ financing mechanism/ regulation</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kupka (2008)</td>
<td>Tanzania urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>Alternative intervention s/ service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>HIV-infected pregnant women</td>
<td>915</td>
<td>unclear/ not stated</td>
<td>negative</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td>Le Fevre (2010)</td>
<td>Bangladesh urban/ peri-urban/ rural</td>
<td>Clinical Other clinical management</td>
<td>Alternative intervention s/ service/ financing mechanism/ regulation</td>
<td>Economic evaluation/ modelling studies</td>
<td>Preterm neonates</td>
<td>497</td>
<td>1</td>
<td>positive</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Lim (2010)</td>
<td>India urban/ peri-urban/ rural</td>
<td>Non-clinical Service organization: financing</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>In some Indian states, all women were eligible for the intervention. In others, only women with a below the poverty line card were eligible.</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>++</td>
<td>++</td>
</tr>
</tbody>
</table>
### What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<tr>
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<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincetto (2000)</td>
<td>Mozambique urban</td>
<td>Non-clinical Service organization: Kangaroo Mother Care</td>
<td>N/A</td>
<td>Observational studies without comparison group</td>
<td>Neonates with LBW (&lt;1800g)</td>
<td>32</td>
<td>unclear/not stated</td>
<td>neutral</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Malaba (2005)</td>
<td>Zimbabwe urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation)</td>
<td>No intervention</td>
<td>Controlled experimental study</td>
<td>Neonates born to HIV negative mothers</td>
<td>14,110</td>
<td>26</td>
<td>negative</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Malhotra (1994)</td>
<td>India urban</td>
<td>Clinical Surgical/instrumental procedures</td>
<td>Normal/existing service/financing mechanism/regulation</td>
<td>Observational studies with comparison group</td>
<td>Women with preterm breech delivery</td>
<td>224</td>
<td>48</td>
<td>neutral</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Mandelbrot (2002)</td>
<td>Cote d'Ivoire Burkina Faso; urban</td>
<td>Clinical Other clinical management</td>
<td>No intervention</td>
<td>Controlled experimental study</td>
<td>Infants born to HIV infected mothers</td>
<td>111</td>
<td>9</td>
<td>neutral</td>
<td>++</td>
<td>+</td>
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</tbody>
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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</tr>
</thead>
<tbody>
<tr>
<td>Martins Cesario (2008)</td>
<td>Guinea Bissau</td>
<td>Clinical Vaccinations</td>
<td>alternative intervention service/financing mechanism/regulation</td>
<td>Controlled experimenta l study</td>
<td>Neonates in general</td>
<td>1333</td>
<td>10</td>
<td>neutral</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Mbaruku (1995)</td>
<td>Tanzania</td>
<td>Non-clinical Service organization</td>
<td>No intervention</td>
<td>Observational studies</td>
<td>Women in general</td>
<td>132 maternal deaths</td>
<td>unclear/not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mbori-Ngacha (2001)</td>
<td>Kenya</td>
<td>Non-clinical Nutrition (including breastfeeding)</td>
<td>Normal/ existing service/financing mechanism/regulation</td>
<td>Controlled experimenta l study</td>
<td>HIV-1 infected women</td>
<td>425</td>
<td>78</td>
<td>neutral</td>
<td>++</td>
<td>++</td>
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<tr>
<td>Miller (1994)</td>
<td>Egypt</td>
<td>Clinical Drug treatment</td>
<td>Normal/existing service/financing mechanism/regulation</td>
<td>Observational studies</td>
<td>Infants in general</td>
<td>1,038</td>
<td>unclear/not stated</td>
<td>positive</td>
<td>+</td>
<td>++</td>
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<tbody>
<tr>
<td>Miller (2009)</td>
<td>China</td>
<td>Clinical Other clinical management:</td>
<td>Alternative intervention/s/ service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Women with obstetric haemorrhage</td>
<td>960</td>
<td>20</td>
<td>positive</td>
<td>+</td>
<td>++</td>
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<tr>
<td>Mirghani (2000)</td>
<td>Sudan</td>
<td>Complex</td>
<td>N/ A</td>
<td>Observation studies without comparison group</td>
<td>Pregnant women with diabetes in Sudan</td>
<td>74</td>
<td>24</td>
<td>positive</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Mswia (2003)</td>
<td>Tanzania</td>
<td>Complex</td>
<td>No intervention</td>
<td>Observation studies with comparison group</td>
<td>Women in general</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Munjanja (1996)</td>
<td>Zimbabwe</td>
<td>Clinical Other clinical management:</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Women in general</td>
<td>15,532</td>
<td>24</td>
<td>neutral</td>
<td>++</td>
<td>++</td>
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<tr>
<td>Nagai (2010)</td>
<td>Madagascar</td>
<td>Non-clinical Service organization: Kangaroo Mother Care</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Neonates with LBW (&lt;2500g)</td>
<td>73</td>
<td>12</td>
<td>neutral</td>
<td>++</td>
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<tr>
<td>Nahar (2004)</td>
<td>Bangladesh urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation: induction of labour)</td>
<td>N/A</td>
<td>Observational studies without comparison group</td>
<td>Women with eclampsia or pre-eclampsia</td>
<td>135</td>
<td>22</td>
<td>unclear/ not stated</td>
<td>-</td>
<td>-</td>
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<td>Naz (2005)</td>
<td>Pakistan urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation): anti-convulsant</td>
<td>N/A</td>
<td>Observational studies without comparison group</td>
<td>Women with eclampsia</td>
<td>52</td>
<td>16</td>
<td>N/A</td>
<td>++</td>
<td>++</td>
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<tr>
<td>Ndibazza (2010)</td>
<td>Uganda peri-urban/rural</td>
<td>Clinical Drug treatment (including micronutrient supplementation): anthelmintics</td>
<td>Alternative intervention/s/ service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>Pregnant women in second or third trimester</td>
<td>2,507</td>
<td>31</td>
<td>negative</td>
<td>++</td>
<td>+</td>
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</table>
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<tr>
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<tbody>
<tr>
<td>Nduati (2001)</td>
<td>Kenya urban</td>
<td>Non-clinical Nutrition (including breastfeeding)</td>
<td>Alternative interventions/ service/ financing mechanism/ regulation</td>
<td>Controlled experimental study</td>
<td>HIV-1 infected women</td>
<td>425</td>
<td>59</td>
<td>negative</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td>O’Hare (2006)</td>
<td>Uganda urban</td>
<td>Non-clinical Service organization: training and audit</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>experimental study without concurrent control</td>
<td>Neonates in general</td>
<td>420</td>
<td>1</td>
<td>positive</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Okaro (2001)</td>
<td>Nigeria urban</td>
<td>Complex</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
<td>60,310</td>
<td>unclear/ not stated</td>
<td>negative</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Orji (2003)</td>
<td>Nigeria urban</td>
<td>Clinical Surgical/ instrumental procedures</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Singleton mothers with breech delivery</td>
<td>244</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>O’Rourke (1995)</td>
<td>Guatemala urban</td>
<td>Non-clinical Service organization: training and audit</td>
<td>No intervention</td>
<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
<td>733</td>
<td>12</td>
<td>neutral</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 3.1

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Padmanaban (2009)</td>
<td>India urban/peri-urban/rural</td>
<td>Complex</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
<td>unclear/ not stated</td>
<td>N/ A</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Pereira (1996)</td>
<td>Mozambique urban</td>
<td>Clinical</td>
<td>Surgical/ instrumental procedures</td>
<td>Observationa l studies with comparison group</td>
<td>Women with Caesarean section</td>
<td>2,071</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Richard (2008)</td>
<td>Burkina Faso urban</td>
<td>Non-clinical</td>
<td>Service organization: training and audit</td>
<td>Experimental study without concurrent control</td>
<td>Women needing CS</td>
<td>1,371</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>++</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Ronsmans (2001)</td>
<td>Indonesia peri-urban/rural</td>
<td>Non-clinical</td>
<td>Service organization: financing</td>
<td>Experimental study without concurrent control</td>
<td>Women in general</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>positive negative</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Roth (2004)</td>
<td>Guinea-Bissau urban</td>
<td>Clinical</td>
<td>Vaccinations</td>
<td>Observationa l studies with comparison group</td>
<td>Neonates in general</td>
<td>7,138</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Setting</td>
<td>Intervention type</td>
<td>Comparison</td>
<td>Study design</td>
<td>Target population</td>
<td>Sample size</td>
<td>Length (months)</td>
<td>Intervention claims</td>
<td>Internal validity</td>
<td>External validity</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------</td>
<td>------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>--------------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Saleem (2007)</td>
<td>Pakistan urban</td>
<td>Clinical Other clinical management</td>
<td>No intervention</td>
<td>Controlled experimental study</td>
<td>Women in general</td>
<td>197</td>
<td>unclear/ not stated</td>
<td>neutral</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Sasidharan (2005)</td>
<td>India urban</td>
<td>Non-clinical Service organization: discharge and admission procedure in neonatal units</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>High risk neonates</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Shantharam Baliga (2007)</td>
<td>India urban</td>
<td>Non-clinical Service organization: increasing investment and scaling up</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Experimental study without concurrent control</td>
<td>Neonates requiring special care</td>
<td>8,051</td>
<td>36</td>
<td>positive</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Sharieff (2008)</td>
<td>Pakistan urban</td>
<td>Non-clinical Nutrition (including breastfeeding)</td>
<td>No intervention</td>
<td>Economic evaluation/ modelling studies</td>
<td>Infants in general</td>
<td>N/ A</td>
<td>4</td>
<td>positive</td>
<td>+</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Shihadeh (2001)</td>
<td>Jordan urban</td>
<td>Clinical Surgical/ instrumental procedures</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Mothers with instrumental deliveries</td>
<td>570</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 3.1

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<thead>
<tr>
<th>Study</th>
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<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strand (2009)</td>
<td>Angola urban</td>
<td>Non-clinical Service organization: training and audit</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Experimental study without concurrent control</td>
<td>Women referred for obstetric emergencies</td>
<td>249</td>
<td>7</td>
<td>positive</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Taha (1997)</td>
<td>Malawi urban</td>
<td>Clinical Other clinical management</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimenta l study</td>
<td>Women in general</td>
<td>6,968</td>
<td>6</td>
<td>positive</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Tukur (2007)</td>
<td>Nigeria urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation) : induction of labour</td>
<td>Alternative intervention s/ service/ financing mechanism/ regulation</td>
<td>Controlled experimenta l study</td>
<td>Women with antepartum eclampsia</td>
<td>50</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Tukur (2010)</td>
<td>Nigeria urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation) : anti-convulsant</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Women with eclampsia</td>
<td>131</td>
<td>36</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
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<th>Intervention type</th>
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<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walter (2006)</td>
<td>Zambia urban</td>
<td>Clinical Drug treatment (including micronutrient supplementation) : antiretrovirals</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>HIV-infected women</td>
<td>255</td>
<td>11</td>
<td>positive</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Worku (2005)</td>
<td>Ethiopia urban</td>
<td>Non-clinical Service organization: Kangaroo Mother Care</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Controlled experimenta l study</td>
<td>Neonates with LBW</td>
<td>123</td>
<td>12</td>
<td>positive</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Yan (1989)</td>
<td>China urban</td>
<td>Complex</td>
<td>No intervention</td>
<td>Observationa l studies with comparison group</td>
<td>Women in general</td>
<td>unclear/ not stated</td>
<td>unclear/ not stated</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Zhu (1997)</td>
<td>China urban</td>
<td>Non-clinical Service organization: training and audit</td>
<td>Alternative intervention s/ service/ financing mechanism/ regulation</td>
<td>Observationa l studies with comparison group</td>
<td>Neonates in general</td>
<td>4,751</td>
<td>24</td>
<td>positive</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Intervention type</th>
<th>Comparison</th>
<th>Study design</th>
<th>Target population</th>
<th>Sample size</th>
<th>Length (months)</th>
<th>Intervention claims</th>
<th>Internal validity</th>
<th>External validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ziadeh (1997)</td>
<td>Jordan urban</td>
<td>Clinical Surgical/instrumental procedures</td>
<td>Normal/ existing service/ financing mechanism/ regulation</td>
<td>Observational studies with comparison group</td>
<td>Women with preterm breech presentation</td>
<td>98</td>
<td>12</td>
<td>neutral</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ziadeh (2000)</td>
<td>Jordan urban</td>
<td>Clinical Surgical/instrumental procedures</td>
<td>N/A</td>
<td>Observational studies without comparison group</td>
<td>Triplets</td>
<td>41</td>
<td>66</td>
<td>negative</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Appendix 3.2: Studies excluded after full-text screening

Anonymous works


Authored works


What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?


*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*


Andriamady R C, Ravaonarivo A R, Ranjalaly R J (1999) [Internal version maneuvers at the maternity hospital of Befelatanana--Antananarivo University Hospital Center (Madagascar): 177 cases]. *Archives de l'Institut Pasteur de Madagascar*, 65(1-2), 96-99.


*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*


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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 3.2


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Appendix 3.2


What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 3.3: Unobtainable studies


*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
Appendix 3.4: Studies identified as interesting and relevant, but not included in review

Anonymous works


*Authored works*


What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?


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*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*  
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 3.4


What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 3.5: Studies screened by title/abstract, but not by full-text (in an excluded foreign language)


Lu X H, Huang X H (1994) [Relation between Cesarean section rate and perinatal mortality rate]. Zhonghua Fu Chan Ke Za Zhi, 29(8), 453-455, 508.


What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 4.1: Included items dealing with clinical interventions and maternal mortality

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Target population</th>
<th>Brief intervention description</th>
<th>Targeted outcome(s)</th>
<th>Findings summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malhotra (1994) (+)/(-)</td>
<td>Women with preterm breech delivery</td>
<td>CS: The general policy of this hospital does not favour routine use of CS for a preterm breech foetus. Before 33 completed weeks of gestation, CS is occasionally performed for foetal indication unless associated with adverse obstetric factors. The indications for CS for a preterm breech after 33 weeks are the same as for a singleton term breech foetus. All the CS and a majority of the vaginal deliveries were attended by a paediatrician who assessed the newborn for gestational age, congenital abnormality and birth injury, and assigned the Apgar score.</td>
<td>Combined intrapartum and neonatal deaths</td>
<td>Although the combined intrapartum and neonatal mortality was significantly higher for vaginal delivery (35.9% vs 17.7%), there was no significant difference when the data was correlated with birthweight or gestational age.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
### Appendix 4.1

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orji (2003)</td>
<td>Singleton mothers with breech delivery</td>
<td>Planned vaginal delivery vs planned CS delivery for breech delivery.</td>
<td>Perinatal mortality</td>
<td>Claims that the outcomes for planned vaginal deliveries may be no worse than planned Caesarean sections, given appropriate selection criteria and management. There was no difference in perinatal mortality. Low Apgar scores were more common on vaginal delivery group but traumatic morbidity was not. Maternal morbidity was higher in Caesarean section group.</td>
</tr>
<tr>
<td>Shihadeh (2001)</td>
<td>Mothers with instrumental deliveries</td>
<td>Retrospective comparison of forceps and vacuum extraction delivery.</td>
<td>Perinatal mortality</td>
<td>Maternal birth canal and genital tract lacerations were significantly more common in forceps delivery. There was increased infant morbidity and mortality from vacuum extraction deliveries but overall vacuum extraction was recommended.</td>
</tr>
<tr>
<td>Ziadeh (1997)</td>
<td>Women with preterm breech presentation</td>
<td>Abdominal vs vaginal delivery for singleton preterm breech.</td>
<td>Early neonatal mortality Stillbirth</td>
<td>There was no significant difference in intrapartum death and early neonatal mortality between those who delivered vaginally and those who delivered by Caesarean section (16.6 vs 15.6%). So even with optimum neonatal care facilities, Caesarean section does not offer any advantage over vaginal delivery in a developing country.</td>
</tr>
</tbody>
</table>
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Drug treatment (including micronutrient supplementation)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-convulsant</strong></td>
</tr>
<tr>
<td><strong>Addewole (2000) (-)/(-)</strong> Women with eclampsia</td>
</tr>
<tr>
<td><strong>Begum (2000) (-)/(-)</strong> Women with eclampsia</td>
</tr>
</tbody>
</table>
| **Chaudhuri (1994) (+)/(+)** Women with history of eclampsia | All the mothers with history of eclampsia were included in the study. The cases were thoroughly examined at the time of admission and babies were followed up regularly during the hospital stay. The cases were divided into three treatment groups:  
  - group I (diazepam)  
  - group II (diazepam, chlorpromazine, phenargan)  
  - group III (chlorpromazine, phenargan, pethidine). | Stillbirths Perinatal mortality | Combination of diazepam, chlorpromazine, phenargan (group II) was best for treatment of eclampsia. Combination of chlorpromazine, phenargan, pethidine (group III) led to high perinatal mortality, particularly stillbirths. |
Appendix 4.1

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Women with eclampsia</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinayon (1998) (+)/(+)</td>
<td></td>
<td>Revised administration of magnesium sulphate</td>
<td>Neonatal mortality, Perinatal mortality, Maternal mortality, Stillbirth</td>
<td>A retrospective review of 90 eclamptic patients between 1987 and 1996 found three maternal deaths (3.3%). Perinatal deaths and neonatal deaths were 9 and 5 out of 75 (cases of eclampsia before pregnancy) respectively. The authors conclude that magnesium sulphate should be used routinely for eclampsia patients, ideally with intravenous loading dose followed by intramuscular injections.</td>
</tr>
<tr>
<td>Kamilya (2005) (-)/(-)</td>
<td></td>
<td>Liberalisation of Caesarean section, New guidelines to promote routine use of magnesium sulphate</td>
<td>Perinatal mortality, Maternal mortality</td>
<td>From 1995 - 1997, the case fatality rate of eclampsia fell from 11.3% to 5.3%. The perinatal mortality also fell from 54.8% to 24.3%. The Caesarean section rate for eclampsia increased from near 10% to 49.7%.</td>
</tr>
<tr>
<td>Naz (2005) (++)/(++)</td>
<td></td>
<td>Use of magnesium sulphate as anticonvulsant in management of eclampsia cases.</td>
<td>Maternal mortality</td>
<td>There was no comparison group to assess the effectiveness of magnesium sulphate. From observational data, the authors believed it to be an effective anticonvulsant in control and prophylaxis of seizures. There were 4 maternal deaths from eclampsia from 52 patients admitted.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
<table>
<thead>
<tr>
<th>Source</th>
<th>Condition/Status</th>
<th>Method of Induction</th>
<th>Maternal Mortality</th>
<th>Neonatal Mortality</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tukur (2010)</td>
<td>(-)/(-)</td>
<td>Magnesium sulphate</td>
<td>Maternal mortality</td>
<td>Perinatal mortality</td>
<td>This study is in support of the findings that magnesium sulphate is superior to diazepam in the reduction of maternal morbidity and mortality. However, the benefit to the infant was not statistically significant.</td>
</tr>
<tr>
<td>(women with eclampsia)</td>
<td>Magnesium sulphate was administered following the Zuspan regimen (in which the maintenance doses are given intravenously).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdul (2007)</td>
<td>(-)/(+)</td>
<td>Induction of labour by misoprostol (intravaginal 50 microg. 6-hourly to a maximum of four doses) or oxytocin (maximum of 48 iu/min).</td>
<td>Maternal mortality</td>
<td>Stillbirth</td>
<td>No case of maternal mortality was recorded. The efficacy of misoprostol in the induction of third trimester labour is comparable to oxytocin.</td>
</tr>
<tr>
<td>(women needing induction)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bergsjo (1989)</td>
<td>(-)/(-)</td>
<td>Induction of labour by stripping of membranes and intravenous oxytocin infusion, with artificial rupture of membranes when the cervical opening was 3 cm or more in diameter. The control group was followed with clinical, biochemical and electronic tests, intervention being applied according to needs.</td>
<td>Neonatal mortality</td>
<td>Maternal complications and perinatal morbidity rates were equally distributed between the groups. There was one perinatal death in the induction group and two deaths among the controls. No advantage of induction shown.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 4.1

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Population</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nahar (2004) (+)/(-)</td>
<td>Women with eclampsia or pre-eclampsia</td>
<td>Misoprostol in severe pre-eclampsia (group 1) and eclampsia patients (group 2) with unripe cervix. 50mg of misoprostol was used every 4 hours in cases of unripe cervix (Bishop score &lt; or = 6). Magnesium sulphate was used routinely for patients with eclampsia.</td>
<td>Maternal mortality, Perinatal mortality</td>
<td>The groups were compared to each other but no control so impact on mortality not clear. No maternal deaths recorded. Neonatal deaths were 11% in severe pre-eclampsia group and 12% in eclampsia group. Study concludes that intravaginal misoprostol is well tolerated and very effective for the induction of labour in severe pre-eclampsia and eclampsia patients with unripe cervix.</td>
</tr>
<tr>
<td>Tukur (2007) (+)/(-)</td>
<td>Women with antepartum eclampsia</td>
<td>Misoprostol. If the patient did not go into labour within four hours of inserting misoprostol, the induction was considered to have failed and emergency CS offered. CS was also offered if any other complication that warranted a CS such as foetal distress arose.</td>
<td>Maternal mortality, Perinatal mortality</td>
<td>There were more maternal complications and admissions of babies into the neonatal special care unit (NSCU) in the CS group compared to misoprostol group. Maternal mortality in the two groups was similar (2% each).</td>
</tr>
<tr>
<td>Micronutrient supplementation</td>
<td>HIV-negative pregnant women</td>
<td>Daily multivitamins vs placebo (all women received iron and folic acid supplements).</td>
<td>Perinatal mortality, Neonatal mortality</td>
<td>HIV-negative Tanzanian women who received prenatal supplementation with vitamin B complex and vitamins C and E did not have significantly reduced risks of prematurity and foetal death, but they did have significantly reduced risk of LBW.</td>
</tr>
</tbody>
</table>

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*Appendix 4.1*
### Appendix 4.1

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaestel (2005)</td>
<td>Pregnant women</td>
<td>Daily micronutrient supplementation in Guinea-Bissau. Identical capsules - group 1 with one RDA of 15 micronutrients, group 2 with two RDA of 15 micronutrients, group 3 conventional prenatal iron-folic acid supplement.</td>
<td>Perinatal mortality, Neonatal mortality</td>
<td>There were no overall differences in either peri- or neonatal mortality between supplementation groups and the control group. There was no effect modification by anaemia, malaria parasitaemia, infant sex, or season of birth.</td>
</tr>
<tr>
<td>Kupka (2008)</td>
<td>HIV-infected pregnant women</td>
<td>Selenium supplementation - daily tablet of 200ug elemental selenium (as selenomethionine).</td>
<td>Maternal mortality, Perinatal mortality, Neonatal mortality, Infant mortality, Stillbirth</td>
<td>Selenium had no significant effect on maternal mortality, neonatal or infant mortality. Marginal association with reduced risk of low birthweight (LBW) and increased risk of foetal death.</td>
</tr>
<tr>
<td>Anthelmintics</td>
<td>Women in general</td>
<td>Mebendazole during pregnancy vs no anthelmintic (controls).</td>
<td>Perinatal mortality</td>
<td>The proportions of stillbirths and perinatal deaths were significantly lower in the mebendazole group, as was the proportion of LBW babies.</td>
</tr>
</tbody>
</table>

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*Note: All studies represent empirical evidence in their respective contexts.*
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Primary Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ndibazza (2010) ++/+</td>
<td>Pregnant women in second or third trimester</td>
<td>Randomised, double-blind, placebo controlled trial investigating albendazole and praziquantel. Hematinics and sulphadoxine-pyrimethamine for presumptive treatment of malaria were provided routinely.</td>
<td>Perinatal mortality</td>
<td>In the study area, where helminth prevalence was high but infection intensity was low, there was no overall effect of anthelminthic use during pregnancy on maternal anaemia, birthweight, perinatal mortality or congenital anomalies.</td>
</tr>
<tr>
<td>Antiretrovirals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ekouevi (2008) +/(-)</td>
<td>Women with advanced HIV disease</td>
<td>HAART</td>
<td>Stillbirth</td>
<td>Among 326 singleton infants, the overall stillbirth rate was 3.1%. There was no significant difference between the HAART and the prevention of mother-to-child transmission (PMTCT) groups.</td>
</tr>
<tr>
<td>Walter (2006) +/-</td>
<td>HIV-infected women</td>
<td>Antiretrovirals. All women with CD4 cell counts &lt;200 cells/mL who were at 14 weeks of gestation began receiving 2 single-strength tablets (400 mg of sulfamethoxazole and 80 mg of trimethoprim) daily. Treatment was delayed until 14 weeks of gestation for those who enrolled during the first trimester.</td>
<td>Neonatal mortality</td>
<td>There was a significant decrease in neonatal mortality. Antenatal provision of cotrimoxazole for HIV-infected pregnant women with low CD4 cell counts may have indirect benefits for neonatal health.</td>
</tr>
</tbody>
</table>
**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**

### Steroids

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Description</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fekih (2002)</td>
<td>Women 26-34 weeks gestation at high risk of premature delivery</td>
<td>Antenatal maternal corticosteroid treatment. Group 1 received intramuscularly 24 mg of betamethasone. Group 2 received no antenatal corticosteroids.</td>
<td>Neonatal mortality due to respiratory distress syndrome was statistically less in group 1 than in group 2 (22.9% vs 57%). Maternal administration of corticosteroids before preterm delivery resulted in a decrease in the incidence and severity of respiratory distress syndrome and a decrease in neonatal mortality rate among premature neonates born to mothers treated versus untreated at 26-34 weeks’ gestation.</td>
</tr>
</tbody>
</table>

### Antibiotics

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Description</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboud (2009)</td>
<td>Pregnant women (between 20 and 24 weeks of pregnancy) were randomized to receive either antibiotics (250 mg of metronidazole 3 times a day and 250 mg of erythromycin orally 3 times a day for 7 days) or placebo.</td>
<td>Maternal mortality administration of study antibiotics (metronidazole, erythromycin) during pregnancy had no effect on maternal morbidity and mortality among HIV-infected pregnant women.</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 4.1

### What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
<thead>
<tr>
<th>Author</th>
<th>Study Description</th>
<th>Details</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bergstrom (1991) (+)/(+)</td>
<td>Women with preterm rupture of membranes</td>
<td>The intervention group received amoxicillin (100mg) and metronidazole (500mg), both drugs given three times daily. All patients were also routinely treated with an antimalarial dose of chloroquine. The control group was not given any pharmaceutical treatment, and labour was induced 3-24h after membrane rupture.</td>
<td>Maternal mortality&lt;br&gt;Neonatal mortality&lt;br&gt;Perinatal mortality&lt;br&gt;Stillbirth &lt;br&gt;While intrauterine mortality was approximately the same in both groups, neonatal mortality differed significantly (2.6 vs 19.2%). It is concluded that an expectant attitude, rather than an active and induction-oriented one, is most favourable in cases with preterm rupture of membranes, also in settings in which prevalence figures of sexually transmitted diseases and other genital infections are high.</td>
</tr>
<tr>
<td>Afolabi (2010) (+)/(-)</td>
<td>Women in labour with term pregnancies and having vaginal delivery</td>
<td>Use of misoprostol in active management of third stage of labour to prevent primary postpartum haemorrhage. Group 1 received oral misoprostol. Group 2 received intramuscular oxytocin.</td>
<td>Primary postpartum haemorrhage&lt;br&gt;No occurrence of postpartum haemorrhage and no difference in secondary outcomes. Misoprostol judged as safe and effective as oxytocin.</td>
</tr>
<tr>
<td>Kietinun (1993) (-)/(-)</td>
<td>Pregnant women with malaria</td>
<td>Malaria cases were treated with a loading dose of quinine hydrochloride given intravenously at 20mg/Kg diluted in 250 ml 5% dextrose in four hours, and then doses of 10 mg/Kg given at intervals of eight hours with the same dilution and rate until the patients were able to take the drug orally; 600 mg quinine sulphate was then given orally at eight-hourly intervals for seven days.</td>
<td>Maternal mortality&lt;br&gt;The overall maternal mortality rate in the obstetric department fell from 341 per 100,000 live births to 54 per 100,000 within five years, partly because of the improved care of pregnant women with malaria. Whereas in 1981 there were eight deaths among 379 pregnant women with the disease, in 1986 there were no deaths among 299 such cases.</td>
</tr>
</tbody>
</table>

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### Active management of third stage of labour

- **Afolabi (2010)**
  - (+)/(-)
  - Women in labour with term pregnancies and having vaginal delivery
  - Use of misoprostol in active management of third stage of labour to prevent primary postpartum haemorrhage. Group 1 received oral misoprostol. Group 2 received intramuscular oxytocin.
  - Primary postpartum haemorrhage
  - No occurrence of postpartum haemorrhage and no difference in secondary outcomes. Misoprostol judged as safe and effective as oxytocin.

### Antimalarial

- **Kietinun (1993)**
  - (-)/(-)
  - Pregnant women with malaria
  - Malaria cases were treated with a loading dose of quinine hydrochloride given intravenously at 20mg/Kg diluted in 250 ml 5% dextrose in four hours, and then doses of 10 mg/Kg given at intervals of eight hours with the same dilution and rate until the patients were able to take the drug orally; 600 mg quinine sulphate was then given orally at eight-hourly intervals for seven days.
  - Maternal mortality
  - The overall maternal mortality rate in the obstetric department fell from 341 per 100,000 live births to 54 per 100,000 within five years, partly because of the improved care of pregnant women with malaria. Whereas in 1981 there were eight deaths among 379 pregnant women with the disease, in 1986 there were no deaths among 299 such cases.
### Oral contraceptive

<table>
<thead>
<tr>
<th>Study</th>
<th>Group</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Notes</th>
</tr>
</thead>
</table>

### Other clinical management

<table>
<thead>
<tr>
<th>Study</th>
<th>Group</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdel (2010) (+)/(-)</td>
<td>Women in general</td>
<td>Uterine massage was used as a means of preventing postpartum haemorrhage. It was done shortly after delivery by the research midwives. Injections of oxytocin were delayed until after the 30-minute period of massage and blood collection, unless blood loss of 500 mL was measured before that time.</td>
<td>Maternal mortality</td>
<td>Uterine massage alone was associated with more blood loss within 30 minutes after delivery compared with treatment with oxytocin with or without massage.</td>
</tr>
<tr>
<td>Bakr (2005) (+)/(-)</td>
<td>Women in general Neonates in general</td>
<td>Antiseptic intervention consisted of manually wiping the maternal birth canal with a 0.25% chlorhexidine solution in sterile water. The cleansing procedure was done at admission and at every vaginal examination before delivery. Babies born during the intervention phase were wiped all over the body with pads soaked in 0.25% chlorhexidine immediately after delivery.</td>
<td>Maternal mortality Neonatal mortality</td>
<td>Cleansing the birth canal with chlorhexidine reduced neonatal and maternal postpartum infections.</td>
</tr>
</tbody>
</table>

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*What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?*
### Appendix 4.1

<table>
<thead>
<tr>
<th>Study Reference</th>
<th>Women in General</th>
<th>Outcomes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enakpene (2010) (+)/(-)</td>
<td>Women with umbilical cord prolapse (UCP)</td>
<td>ANC. Adequate prenatal care was defined as consisting of at least four prenatal visits in the index pregnancy and/or at least one prenatal visit within the 2-4 weeks preceding the occurrence of UCP. Inadequate prenatal, or no prenatal care, is defined as poor compliance with prenatal clinic visits or non-attendance at the prenatal clinic in the four weeks preceding occurrence of UCP.</td>
<td>Perinatal mortality</td>
</tr>
<tr>
<td>Etuk (2000a) (-)/(-)</td>
<td>Women in general</td>
<td>Pregnancies were booked for antenatal care but delivered outside the health facilities.</td>
<td>Perinatal mortality</td>
</tr>
<tr>
<td>Etuk (2000b) (-)/(-)</td>
<td>Women in general</td>
<td>Pregnancies were booked for antenatal care but delivered outside the health facilities.</td>
<td>Maternal mortality</td>
</tr>
<tr>
<td>Fenton (1999) (+)/(-)</td>
<td>Women needing Caesarean section</td>
<td>Blood transfusion during CS.</td>
<td>Maternal mortality</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Condition</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Preventable Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iqbal (2004) (+)/(-)</td>
<td>Women with prolonged pregnancy (&gt; or = 294 days)</td>
<td>Group A, Induction of labour was done at 42 weeks of gestation. Intervention was done if any of the factors became abnormal. Group B, pregnancies allowed to run course up to 43 weeks.</td>
<td>Perinatal mortality Stillbirth</td>
<td>Active early intervention at 42 weeks is warranted to reduce perinatal morbidity and mortality.</td>
</tr>
<tr>
<td>Munjanja (1996) (++)/(++)</td>
<td>Women in general</td>
<td>Reduced antepartum care visits. In the new programme, routine maternal weight-change measurements were not done and routine urinalysis was done only at the first visit. Urinalysis was done only at follow-up visits in the new programme if the blood pressure was raised, or if there was a suspected urinary-tract infection.</td>
<td>Perinatal mortality</td>
<td>An ANC programme with fewer more objective-oriented visits can be introduced without adverse effects on the main intermediate outcome pregnancy variables. No significant difference in perinatal or maternal mortality.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
<table>
<thead>
<tr>
<th>Author</th>
<th>Study Design</th>
<th>Intervention Description</th>
<th>Outcomes</th>
<th>Study Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pereira (1996)</td>
<td>(-)/(-)</td>
<td>Assistant medical officers were employed to support EmOC and the study compares outcomes of Caesareans by medical officers with those performed by obstetricians.</td>
<td>Maternal mortality, Early neonatal mortality, Stillbirth</td>
<td>No significant differences in the number of maternal deaths, in the duration of post-operative hospital stay, in the indications for Caesarean delivery, or the surgical interventions associated with Caesarean delivery between the two groups. The only significant difference was in superficial wound separation due to haematoma, which was slightly more common (0.35% vs 0.05%) in the group operated on by assistant medical officers (odds ratio 2.2; 95% confidence interval 1.3-3.9).</td>
</tr>
<tr>
<td>Saleem (2007)</td>
<td>(+)/(+)</td>
<td>Antisepsis intervention administered by TBAs in home deliveries to improve perinatal outcomes consisting of 0.6% chlorhexidine vaginal and neonatal wipes.</td>
<td>Maternal mortality, Early neonatal mortality, Neonatal mortality</td>
<td>Use of 0.6% chlorhexidine vaginal and neonatal wipes for the prevention of neonatal infection is well tolerated and seems safe. Not powered to show differences in mortality.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 4.2: Included items dealing with clinical interventions and infant mortality

<table>
<thead>
<tr>
<th>Author (year) (IV)/(EV)</th>
<th>Target Population</th>
<th>Brief intervention description</th>
<th>Targeted outcome(s)</th>
<th>Findings summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical/instrumental procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziadeh (2000) (-)/(-)</td>
<td>Triplets</td>
<td>Caesarean section.</td>
<td>Perinatal mortality</td>
<td>Caesarean section not advantageous. Perinatal mortality was greater among C-section group but very small sample size.</td>
</tr>
<tr>
<td>Drug treatment (including micronutrient supplementation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cobra (1997) (++)/(++)</td>
<td>Infants in general</td>
<td>Oral iodized oil (100 mg) administered at around 6 weeks of age and infants followed to 6 months of age.</td>
<td>Infant mortality</td>
<td>Reduction in mortality in the iodized oil group during the first 2 months of follow-up and a delay in the mean time to death among infants who died in the iodized oil group compared with infants who died in the placebo group.</td>
</tr>
<tr>
<td>de Long (1997) (+)/(+)</td>
<td>Women in general Neonates in general Infants in general</td>
<td>Potassium iodate added to irrigation water over a 2 to 4 week period.</td>
<td>Neonatal mortality Infant mortality</td>
<td>Infant mortality rates decreased in the treated areas. Similar results were seen for neonatal mortality.</td>
</tr>
<tr>
<td>Author (year) (IV)/(EV)</td>
<td>Target Population</td>
<td>Brief intervention description</td>
<td>Targeted outcome(s)</td>
<td>Findings summary</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------</td>
<td>--------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Joshi (2007) (-)/(-)</td>
<td>Neonates with primary pulmonary hypertension</td>
<td>Introduction of nitric oxide (iNO) therapy.</td>
<td>Neonatal mortality</td>
<td>Out of 18 babies treated with iNO, 2 babies, both transported from another hospital in a critical condition, died within an hour of initiation of iNO therapy. Three babies did not show any improvement in oxygenation following initial 2 hours of iNO therapy. Therefore iNO was discontinued and all 3 of them died. Of the remaining 13 babies who had shown a significant improvement in oxygenation after initial 2 hours of iNO therapy, 6 (46 %) survived and 7 died (54 %).</td>
</tr>
<tr>
<td>Kumwenda (2008) (++)/(+++</td>
<td>Infants born to HIV infected mothers</td>
<td>Antiretroviral prophylaxis to reduce breast-milk HIV transmission. Drugs for infants in the two extended-prophylaxis groups were dispensed to the mothers starting at the 1-week study visit and at subsequent visits until the infant completed the 14-week regimen. In the extended-prophylaxis groups, the oral dose of nevirapine was 2 mg per kilogram once daily during week 2, then 4 mg per kilogram once daily during weeks 3 through 14. The oral dose of zidovudine was 4 mg per kilogram twice daily during weeks 2 through 5, 4 mg per kilogram three times daily during weeks 6 through 8, and 6 mg per kilogram three times daily during weeks 9 through 14.</td>
<td>Infant mortality</td>
<td>At 9 months, although mortality in the control group exceeded that in the intervention groups, the differences were not significant.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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</tr>
</thead>
<tbody>
<tr>
<td>Malaba 2005 (++)/(+++)</td>
<td>Neonates born to HIV negative mothers</td>
<td>A single large dose of vitamin A during the immediate postpartum period. Infants were randomly assigned to 1 of 4 treatment groups: mothers and infants received vitamin A (Aa), mothers received vitamin A and infants received placebo (Ap), mothers received placebo and infants received vitamin A (Pa), and both mothers and infants received placebo (Pp). The vitamin A dose in the mothers was 400,000 IU and in the infants was 50,000 IU. The mother-infant pairs were followed to 12 months.</td>
<td>Infant mortality</td>
<td>No significant effect in any of the intervention groups compared with the control group receiving a placebo.</td>
</tr>
<tr>
<td>Miller (1994) (+)/(+++)</td>
<td>Infants in general</td>
<td>Widened availability of ORS</td>
<td>Infant mortality</td>
<td>Improvement in case management and mortality decline following increased ORS availability.</td>
</tr>
</tbody>
</table>

**Vaccinations**

<table>
<thead>
<tr>
<th>Author (year) (IV)/(EV)</th>
<th>Target Population</th>
<th>Brief intervention description</th>
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</thead>
<tbody>
<tr>
<td>Aaby (2002) (+)/(+)</td>
<td>Children up to 20 months in a war situation</td>
<td>Diphtheria, tetanus, pertussis (DTP); polio vaccines; and measles vaccines.</td>
<td>Infant mortality</td>
<td>Measles-vaccinated children had lower mortality than measles non-vaccinated children, but the difference was more marked for girls. The reduction was unrelated to prevention against measles infection. DTP and polio-vaccinated children did not have lower mortality than non-vaccinated children.</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>Aaby (2005) (++)/ (+)</td>
<td>Infants in general</td>
<td>National immunisation days for oral polio vaccine (OPV) administered alone.</td>
<td>Infant mortality</td>
<td>OPV was associated with a beneficial effect for children under 6 months of age at the time of the campaign, but the difference was not significant for all children under 5 years of age. The effect of OPV among children less than 6 months of age could be due to selection bias but might also represent a non-specific beneficial immune stimulation.</td>
</tr>
<tr>
<td>Amin (1992) (-)/(-)</td>
<td>Infants in general</td>
<td>Expanded Programme on Immunization (EPI).</td>
<td>Infant mortality</td>
<td>There was a decline in infant mortality in 1988-89 compared to earlier periods. The decline seemed to have been the result of immunisation coverage, which had considerably increased by 1989-90, reaching above 70% of children under age 5.</td>
</tr>
<tr>
<td>Benn (2008a) (+)/(++)</td>
<td>Neonates in general</td>
<td>Infant vitamin A supplementation (VAS). Normal birthweight infants were administered 50,000 IU VAS or placebo with BCG.</td>
<td>Infant mortality</td>
<td>VAS administered with BCG vaccine at birth had no significant effect on infant mortality in this African setting.</td>
</tr>
<tr>
<td>Benn (2008b) (++)/ (++)</td>
<td>Neonates in general</td>
<td>Infant VAS. Normal birthweight infants were administered 50,000 IU VAS or placebo with BCG.</td>
<td>Infant mortality</td>
<td>VAS administered with BCG vaccine at birth had no significant effect on infant mortality in this African setting.</td>
</tr>
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</thead>
<tbody>
<tr>
<td>Benn (2010) (++)/(++)</td>
<td>Low birthweight neonates</td>
<td>Infant VAS. Infants were administered 50,000 IU vitamin A or placebo and followed to 12 months.</td>
<td>Infant mortality</td>
<td>VAS at birth was not significantly associated with infant mortality among low birthweight neonates. A significant association was revealed between VAS and gender: mortality decreased in boys but increased in girls.</td>
</tr>
<tr>
<td>Garly (2004) (+)/(++)</td>
<td>Infants in general</td>
<td>Hepatitis B vaccine (HBV) alongside measles vaccine.</td>
<td>Infant mortality</td>
<td>Among children enrolled in a measles vaccination trial, HBV-vaccinated children 7½-12 months of age had higher mortality than cohorts that had not received HBV, the difference being particularly strong for girls.</td>
</tr>
<tr>
<td>Fetuga (2010) (+)/(+)</td>
<td>Neonates in general</td>
<td>Expanded Programme on Immunization (EPI) and the National Programme on Immunization (NPI).</td>
<td>Neonatal tetanus (NNT) case fatality</td>
<td>Although the percentage prevalence of neonatal tetanus was lower in the later NPI period, the case fatality rate for the NPI period was higher than for the EPI period. The prevalence and mortality of NNT remains high in Nigeria despite a change in immunisation programme.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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</tr>
</thead>
<tbody>
<tr>
<td>Martins (2008) (++)/(++)</td>
<td>Neonates in general</td>
<td>Standard Edmonston-Zagreb measles. Vaccination was administered to infants aged 4.5 months.</td>
<td>Post-neonatal mortality</td>
<td>The reduction in post-neonatal mortality was not significant.</td>
</tr>
<tr>
<td>Roth (2004) (+)/(+)</td>
<td>Neonates in general</td>
<td>Early BCG vaccination.</td>
<td>Infant mortality</td>
<td>Mortality was lower for BCG-vaccinated than for unvaccinated LBW children controlling for available background factors. The beneficial effect on survival may not be explained by protection against tuberculosis.</td>
</tr>
</tbody>
</table>

### Other clinical management

<table>
<thead>
<tr>
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<th>Targeted outcome(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Darmstadt (2004) (+)/(+)</td>
<td>Preterm infants</td>
<td>Topical application of sunflower seed oil 3 times daily during neonatal period.</td>
<td>Neonatal mortality</td>
<td>A significant reduction in mortality due to sepsis was not demonstrated in preterm infants treated by topical therapy with SSO in Egypt.</td>
</tr>
<tr>
<td>Darmstadt (2008) (++)/(++)</td>
<td>Preterm infants</td>
<td>Topical application of skin emollients as skin barrier during neonatal period.</td>
<td>Neonatal mortality</td>
<td>Both sesame seed oil (SSO) and Aquaphor significantly reduced mortality rates among preterm hospitalised infants with gestational age of 33 weeks in Bangladesh.</td>
</tr>
<tr>
<td>Le Fevre (2010) (++)/(+)</td>
<td>Preterm neonates</td>
<td>Topical application of skin emollients as skin barrier during neonatal period.</td>
<td>Neonatal mortality</td>
<td>Topical therapy with SSO or Aquaphor was highly cost-effective in reducing deaths from infection among the preterm neonates in Bangladesh.</td>
</tr>
<tr>
<td>Mandelbrot (2002) (++)/(+)</td>
<td>Infants born to HIV infected mothers</td>
<td>Vaginal cleansing with benzalkonium chloride during late pregnancy and delivery.</td>
<td>Infant mortality</td>
<td>No benefit of cleansing on mother-to-child transmission (MTCT) of HIV, perinatal mortality or infant mortality.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
## Appendix 4.3: Included items dealing with non-clinical interventions and maternal mortality

<table>
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<tr>
<td><strong>Service organisation</strong></td>
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</tr>
<tr>
<td><strong>Training and audit</strong></td>
<td></td>
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</tr>
<tr>
<td>Awan (1989) (+)/(-)</td>
<td>Women in general</td>
<td>Comprehensive MCH programme in Lahore, Pakistan, with the provision of one MCH centre in each of 8 urban and 2 rural settings, with targeted staff supervision and peer review.</td>
<td>Maternal mortality Infant mortality</td>
<td>Declines in both MMR and IMR in the intervention areas, with end-point rates for IMR lower in the intervention area than the national average.</td>
</tr>
<tr>
<td>Bugalho (1993) (-)/(+)</td>
<td>Women in general Neonates in general</td>
<td>Routine daily and weekly perinatal audit. Information was documented visibly on a board on the wall in the delivery room in which staff associated with a perinatal death were indicated by name.</td>
<td>Neonatal mortality Perinatal mortality Stillbirth</td>
<td>Perinatal mortality showed a significant but transient improvement during the observation period 1982-1991.</td>
</tr>
</tbody>
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<tr>
<td>de Muylder (1989) (-)/(-)</td>
<td>Women in general</td>
<td>Introduction of guidelines for management of dystocia, foetal distress, breech birth and Caesarean history at a maternity ward in Gweru, Zimbabwe.</td>
<td>Maternal mortality Perinatal mortality</td>
<td>Comparison of the two-year periods before and after the intervention showed that the maternal mortality rate declined from 2.0 to 0.5%, and the perinatal mortality rate from 71.9 to 56.2%, alongside a decline in the C-section rate.</td>
</tr>
<tr>
<td>Dumont (2005) (++)/(++)</td>
<td>Pregnant women with haemorrhagc and hypertensive complications</td>
<td>Implementation of obstetric guidelines using volunteer professionals at an obstetric unit in Senegal.</td>
<td>Case fatality for haemorrhage Case fatality for hypertension Case fatality for haemorrhage and hypertension</td>
<td>Patients characteristic-adjusted case fatality decreased during the intervention period compared with the baseline periods. Outcome improvements were more marked for hypertension than haemorrhage.</td>
</tr>
<tr>
<td>Dumont (2006) (++)/(++)</td>
<td>Pregnant women admitted to hospital for childbirth</td>
<td>Facility-based maternal death reviews (MDRs) of a district maternity hospital in Senegal.</td>
<td>Maternal mortality</td>
<td>MDR helped to improve the organisation of care, with a marked effect on the availability of life-saving interventions. Data on clinical outcomes showed a significant decrease in maternal mortality within a 3-year intervention period, in particular for deaths related to haemorrhage and hypertensive disorders.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<tbody>
<tr>
<td>Kongnyuy 2008 (+)/(+)</td>
<td>Women receiving EmOC</td>
<td>Facility based MDRs and criterion-based clinical audit.</td>
<td>Maternal mortality</td>
<td>Maternal mortality decreased significantly from 250 per 100,000 women in 2005 to 222 in 2006 and 182 in 2007 (p&lt;0.001).</td>
</tr>
<tr>
<td>O’Rourke (1995) (+)/(-)</td>
<td>Women in general</td>
<td>Training programme in Guatemala.</td>
<td>Perinatal mortality</td>
<td>There was no statistically significant reduction in mortality.</td>
</tr>
<tr>
<td>Strand (2009) (-)/(+)</td>
<td>Women referred for obstetric emergencies</td>
<td>Audit of records of women referred for obstetric emergencies to central hospitals in Luanda, Angola. Courses for midwives and doctors were implemented.</td>
<td>Maternal mortality</td>
<td>Following audit, maternal mortality decreased from 17.8% to nil.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Provider models</strong></td>
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</tr>
<tr>
<td>de Bernis (2000) (+)/(+)</td>
<td>Women in general</td>
<td>2 areas with contrasting availability of health care in Senegal: (1) where women giving birth in health centres went principally to the regional hospital and were usually assisted by trained midwives and (2) where most women gave birth in district health centres, usually assisted by TBAs.</td>
<td>Maternal mortality</td>
<td>Maternal mortality was higher in area 2 than in area 1 (874 and 151 maternal deaths per 100,000 live births, respectively).</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ahmed (2004) (-)/(-)</td>
<td>Poor women with uterine rupture</td>
<td>Loan scheme from a hospital in Nigeria for women to purchase emergency surgical pack (loan to be paid back before discharge).</td>
<td>Maternal mortality</td>
<td>Case fatality of 38% found in a previous study from the hospital declined to 11% during the intervention. The difference was statistically significant.</td>
</tr>
<tr>
<td>Bashir (1991) (-)/(-)</td>
<td>Women in general</td>
<td>Introduction of specialised ‘obstetric flying squad’ which deals with emergencies at home.</td>
<td>Maternal mortality</td>
<td>In Faisalabad (Pakistan), the maternal mortality rate of 0.86/1,000 in 1989 was below the maternal mortality rate of 10.1/1,000 in 1977.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<tr>
<td>Lim (2010) (++)/(++)</td>
<td>In some Indian states, all women were eligible for the intervention. In others, only women with a below the poverty line card were eligible.</td>
<td>Janani Suraksha Yojana (translated as safe motherhood scheme), a national conditional cash transfer scheme to incentivise women of low socioeconomic status to give birth in a health facility.</td>
<td>Maternal mortality Neonatal mortality Perinatal mortality</td>
<td>Findings suggest that the programme is reducing perinatal and neonatal mortality but its effect on maternal mortality remains unknown. (Note: the study may not have been powered to detect differences in maternal mortality).</td>
</tr>
<tr>
<td>Ronsmans (2001) (+)/(+)</td>
<td>Women in general</td>
<td>Safe Motherhood programme implemented by Mother Care and Ministry of Health in Indonesia. Interventions included training, deployment and supervision of a large number of professional midwives in villages; an information, education and communication (IEC) strategy to increase use of village midwives for birth; and a district-based maternal and perinatal audit (MPA).</td>
<td>Births admitted to hospital requiring CS or other life-saving intervention</td>
<td>The programme did not increase the use of specialised obstetric care for those in need. The proportion admitted to hospital for a Caesarean section declined from 1.7 to 1.4% and the proportion admitted to hospital with a complication requiring a life-saving intervention declined from 1.1% to 0.7%.</td>
</tr>
</tbody>
</table>
Appendix 4.4: Included items dealing with non-clinical interventions and infant mortality

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<tr>
<td>Bugalho (1993) (-)/( -)</td>
<td>Women in general</td>
<td>Routine daily and weekly perinatal audit. Information was documented visibly on a board on the wall in the delivery room in which staff associated with a perinatal death were indicated by name.</td>
<td>Neonatal mortality</td>
<td>Perinatal mortality showed a significant but transient change during the observation period 1982-1991.</td>
</tr>
<tr>
<td>Training and audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O’ Hare (2006) (-)/( -)</td>
<td>Neonates in general</td>
<td>Establishment of dedicated trained nurse team for neonatal resuscitation in a hospital in Kampala, Uganda. Five day training programme for nurses.</td>
<td>Neonatal mortality</td>
<td>Positive decrease in newborn deaths in babies weighing &gt;2kg attributed to the nurse training.</td>
</tr>
<tr>
<td>Zhu (1997) (-)/( -)</td>
<td>Neonates in general</td>
<td>Training in the Neonatal Resuscitation Program Guidelines in a hospital in China.</td>
<td>Perinatal and neonatal mortality</td>
<td>Reduction in perinatal and neonatal mortality from 9.9 per 1,000 live births to 3.4 per 1,000 live births.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<tr>
<td><strong>Increasing investment and scaling up</strong></td>
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</tr>
<tr>
<td>Chomba (2008) (+)/(++)</td>
<td>Neonates in general</td>
<td>Protocol- and ENC-certified research nurses trained college-educated midwives from 18 low-risk, first-level urban community health centres, Zambia, in data collection and ENC.</td>
<td>Early neonatal mortality</td>
<td>ENC training is associated with significant decreases in early neonatal mortality: rates decreased from 11.2 per 1,000 live births to 6.2 per 1,000 following ENC implementation. Mortality for infants of mothers with 7 years of education decreased from 12.4 to 6.0 per 1,000 (P &lt;0.0001) but did not change significantly for those with 8 or more years of education (8.7 to 6.3 per 1,000, p = 0.14).</td>
</tr>
<tr>
<td>Enweronu (2008) (+)/(-)</td>
<td>Neonates requiring intensive care</td>
<td>Refurbishment of NSCU in Ghana.</td>
<td>Neonatal mortality</td>
<td>Improved facilities significantly improved survival of newborns &lt;2,500 g, but was of no benefit for newborns ≥2,500 g.</td>
</tr>
<tr>
<td>Shantharam Baliga (2007) (+)/(++)</td>
<td>Neonates requiring special care</td>
<td>Scaling up of facility-based neonatal care in a district in southern India.</td>
<td>Neonatal mortality Perinatal mortality</td>
<td>Hospital perinatal and early neonatal mortality declined, as well as district-level perinatal mortality.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Bhakoo (1989)</td>
<td>High risk neonates</td>
<td>In a hospital in India, reduction in admissions to NSCU of babies with birthweight more than 1,500g. Early discharge of babies to home from NSCU. Involvement of mothers in the care of high risk babies. Care of babies with specific complications outside NSCU.</td>
<td>Neonatal mortality</td>
<td>A significant fall in neonatal mortality in babies weighing less than 2 kg during 1986 as compared to 1973 (7.94% vs 12.88%; p less than 0.005), and in preterm babies the mortality fell from 26.88 to 11.5% (p less than 0.001) during 1986 due to the intervention.</td>
</tr>
<tr>
<td>Bhutta (2004)</td>
<td>Neonates with LBW</td>
<td>Intervention to reduce hospital stay in Pakistan. Mothers providing all basic nursing care for their infants before being discharged under supervision by a midwife or nurse following guidelines. Weekly outpatient visits after discharge was usually instituted for the first four to six weeks, with follow-up visits at longer intervals thereafter.</td>
<td>Infant mortality</td>
<td>Of 509 consecutive, very LBW infants, 494 (97%) preterm and 140 (28%) weighing &lt; 1,000g at birth), 391 (76%) survived to discharge from the hospital. Readmission rates or adverse outcomes did not increase with early discharge.</td>
</tr>
</tbody>
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<tr>
<td>Blencowe (2009) (+)/(+)</td>
<td>Neonates with LBW (&lt;2,000g)</td>
<td>Revised discharge policy for babies with LBW in Malawi, which differed from existing WHO international guidelines.</td>
<td>Infant mortality</td>
<td>Mortality was higher amongst those discharged home at a weight &lt;1,500g compared to those weighing more.</td>
</tr>
<tr>
<td>Sasidharan (2005) (-)/(-)</td>
<td>High-risk neonates</td>
<td>Training of mother to increase maternal involvement in care of high-risk neonates in India.</td>
<td>Neonatal mortality</td>
<td>In spite of an increase in the number of admissions during this period, significant and sustainable reduction in neonatal deaths.</td>
</tr>
</tbody>
</table>

**Kangaroo Mother Care**

<table>
<thead>
<tr>
<th>Author (year) (IV)/(EV)</th>
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<tr>
<td>Bergman (1994) (-)/(-)</td>
<td>Neonates with LBW</td>
<td>KMC in Zimbabwe. Feeding is started from the first day, using small volumes. The mother is taught to feed weak and very LBW babies with a nasogastric tube. VLWB babies are also given a 10-day course of prophylactic antibiotics. Education to the mother was continuous. Mothers were encouraged to keep the infant in KMC until it reached 2,000g.</td>
<td>Infant mortality</td>
<td>The survival of babies born under 1,500g improved from 10% to 50%, whereas that of babies 1,500-1,999g improved from 70% to 90%.</td>
</tr>
<tr>
<td>Cattaneo (1998) (++)/(++)</td>
<td>Infants with LBW (1,000-1,999g)</td>
<td>KMC in several country contexts. Delivered for an average of about 20 hours per day, including in hospital. Mothers were encouraged to continue with KMC at home after discharge. After discharge, infants were followed up as outpatients at least four times, at 3, 10, 20 and 30 days.</td>
<td>Infant mortality</td>
<td>Deaths were recorded but the study design did not allow identification of differences in mortality.</td>
</tr>
</tbody>
</table>
## Appendix 4.4

### What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<tr>
<td>Colonna (1990) (-)/(-)</td>
<td>Infants with LBW</td>
<td>Kangaroo Mother Care - nursing babies by continuously keeping them wrapped at the mothers’ breasts.</td>
<td>Neonatal mortality</td>
<td>5 of the 100 newborn infants died before discharge. Almost all the remaining 95 were being breastfed at discharge and had gained on average 200g weight.</td>
</tr>
<tr>
<td>Lincetto (2000) (-)/(-)</td>
<td>Neonates with LBW (&lt;1,800g)</td>
<td>Introduction of KMC for LBW infants in Mozambique. Staff training and ward reorganisation.</td>
<td>Neonatal mortality</td>
<td>27% death rate in babies receiving KMC versus 80% death rate for babies not receiving KMC. Survival rates increased.</td>
</tr>
<tr>
<td>Nagai (2010) (++)/(-)</td>
<td>Neonates with LBW (&lt;2,500g)</td>
<td>Early KMC in Madagascar beginning as soon as possible in 24 hours after birth.</td>
<td>Neonatal mortality</td>
<td>Earlier continuous KMC had higher but no statistically different mortality in the first 28 days after birth.</td>
</tr>
<tr>
<td>Worku (2005) (-)/(+)</td>
<td>Neonates with LBW</td>
<td>KMC in Ethiopia.</td>
<td>Neonatal mortality</td>
<td>Survival was remarkably better for the early KMC group than babies in the conventional method of care in the first 12 hours and thereafter.</td>
</tr>
</tbody>
</table>
### Nutrition (including breastfeeding practice and guidelines)

<table>
<thead>
<tr>
<th>Author (year)</th>
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<tbody>
<tr>
<td>Becquet (2007) (++)/(++).</td>
<td>HIV-infected mothers</td>
<td>HIV-infected pregnant women in Abidjan, Côte d'Ivoire, who received peripartum antiretroviral prophylaxis were presented antenatally with infant feeding interventions: either artificial feeding, or exclusive breastfeeding and then early cessation from 4 months of age. Nutritional counselling and clinical management were provided for 2 years. Breastmilk substitutes were provided free.</td>
<td>Infant mortality</td>
<td>Mortality rates did not differ significantly between the short-term breastfed and formula-fed groups. After adjustment for paediatric HIV status, they were similar to those observed among long-term breast-fed children.</td>
</tr>
<tr>
<td>Deschamps (2009) (+)/(−).</td>
<td>Pregnant, HIV-positive women Neonates born to HIV-positive mothers</td>
<td>All participants in Port-au-Prince, Haiti, received cotrimoxazole prophylaxis and infant formula for their children.</td>
<td>Infant mortality</td>
<td>The PMTCT programme described proved to be feasible and effective in reducing vertical HIV transmission in Haiti.</td>
</tr>
<tr>
<td>Jakobsen (2008) (++)/(++).</td>
<td>Infants in general</td>
<td>Promotion of exclusive breastfeeding for the first 4-6 months of life according to WHO recommendations at the time of the study. All children were followed from birth to 6 months of age.</td>
<td>Infant mortality</td>
<td>No significant reduction in mortality in the intervention group compared with the control group.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<tbody>
<tr>
<td>Kuhn (2008) (++)/(++)</td>
<td>HIV-infected women HIV-infected infants</td>
<td>Abrupt weaning at 4 months compared with the standard practice.</td>
<td>HIV-free survival</td>
<td>Early, abrupt cessation of breastfeeding by HIV-infected women in a low-resource setting, such as Lusaka, Zambia, did not improve the rate of HIV-free survival among children born to HIV-infected mothers and was harmful to HIV-infected infants.</td>
</tr>
<tr>
<td>Mbori-Ngacha (2001) (++)/(++)</td>
<td>HIV-1 infected women</td>
<td>Formula feeding of infants of HIV-infected women compared with breastfeeding.</td>
<td>Infant mortality</td>
<td>Similar mortality rates during the first 2 years of life. However, HIV-1-free survival at 2 years was significantly higher in the formula arm.</td>
</tr>
<tr>
<td>Nduati (2001) (++)/(-)</td>
<td>HIV-1 infected women</td>
<td>Breastfeeding and formula.</td>
<td>Maternal mortality Infant mortality</td>
<td>Mortality among mothers was higher in the breastfeeding group than in the formula group. There was an association between maternal death and subsequent infant death.</td>
</tr>
</tbody>
</table>
Appendix 4.5: Included items dealing with complex interventions and maternal mortality

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<tbody>
<tr>
<td>Bashir (1995) (-)/(-)</td>
<td>Women in general</td>
<td>Free access to obstetric care for ‘deserving cases’; subsidies; training and refresher courses for TBAs; community education; introduction of specialised services; obstetric flying squad.</td>
<td>Maternal mortality</td>
<td>Trends in city-level (Faisalabad, Pakistan) maternal mortality, from 0.86/1,000 live births in 1989 to 0.64/1,000 live births in 1993.</td>
</tr>
<tr>
<td>Campbell (2005) (+)/(+)</td>
<td>Women in general</td>
<td>Safe Motherhood programmes.</td>
<td>Maternal mortality</td>
<td>The maternal mortality ratio (MMR) declined from 174 to 84/100,000 live births between 1992-93 and 2000. Improvements in parts of Egypt were due in part to extensive training, revised curricula, the publication of medical protocols and services standards, the upgrading of facilities, and successful community outreach programmes and media campaigns.</td>
</tr>
<tr>
<td>Mbaruku (1995) (-)/(-)</td>
<td>Women in general</td>
<td>There were 22 parts to the intervention: 1. Obstetrician nominated leader for intervention, change of traditional hierarchy, greater delegation to nurses and midwives.</td>
<td>Maternal mortality</td>
<td>Average maternal mortality ratio for two years before intervention was 849/100,000 live births and 275/100,000 in the period following implementation of intervention.</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2. Regular monthly meetings were arranged to enable staff to be informed and receive feedback</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3. Efforts made to utilise available resources and refer to outside donors only when local resources exhausted, e.g. using local carpenters</td>
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<td></td>
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<td>4. Schedules for regular maintenance were started in order to prevent breakdown.</td>
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<td></td>
<td></td>
<td>5. Maintenance of working skills was guaranteed by a number of activities.</td>
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<td></td>
<td></td>
<td>6. Improvement of patient management by early diagnosis and treatment of diseases known to be common causes of death.</td>
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<tr>
<td></td>
<td></td>
<td>7. Efforts made to improve resuscitation of patients - training auxiliaries</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>8. Use of broad-spectrum antibiotics preoperatives was emphasised</td>
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<td></td>
<td></td>
<td>9. Peripheral antenatal clinics were instructed to refer all cases of clinical anaemia early for correction</td>
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<tr>
<td></td>
<td></td>
<td>10. Better management routines in cases of severe anaemia introduced</td>
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</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
## Appendix 4.5

### What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>11. Regular staff evaluation</td>
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<td></td>
<td>12. Public complaints taken into consideration</td>
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<td></td>
<td></td>
<td>13. Resolved to accommodate all essential staff in houses within hospital compound</td>
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<td></td>
<td></td>
<td>14. Detailed plan for supply of essential drugs made in order to prioritise. Sub-store of drugs initiated in maternity ward</td>
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<tr>
<td></td>
<td></td>
<td>15. Small infusion production unit started</td>
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<td></td>
<td></td>
<td>16. Vigorous campaign to encourage blood donation</td>
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<td></td>
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<td>17. Early provision of blood for transfusion from bank guaranteed</td>
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<td></td>
<td></td>
<td>18. Strict norms were elaborated regarding minimum requirements to receive blood</td>
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<tr>
<td></td>
<td></td>
<td>19. Blood bottles prepared locally and donor sets made from the resterilised needles of used sets</td>
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<tr>
<td></td>
<td></td>
<td>20. Culture facilities restored</td>
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<tr>
<td></td>
<td></td>
<td>21. Local fundraising allowed the operating theatre to be repaired</td>
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<tr>
<td></td>
<td></td>
<td>22. Attention paid to proper sterilisation and</td>
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</tr>
</tbody>
</table>

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### Appendix 4.5

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Mswia (2003) (+)/(++)</td>
<td>Women in general</td>
<td>disinfection of equipment</td>
<td>Maternal mortality</td>
<td>In Tanzania, the maternal mortality rates in 1999 were substantially lower than at the start of surveillance (1992 for rural districts, 1993 for the urban area), although trends during the period were statistically significant at the 90% level only in the urban site.</td>
</tr>
<tr>
<td>Okaro (2001) (-)/(-)</td>
<td>Women in general</td>
<td>Raising the status of women; increasing the amount of health education; improving access to FP and EmOC.</td>
<td>Maternal mortality</td>
<td>Maternal mortality increased in the teaching hospital in Enugu, Nigeria, following implementation of the Safe Motherhood Initiative.</td>
</tr>
<tr>
<td>Padmanaban (2009) (-)/(+)</td>
<td>Women in general</td>
<td>Promotion of institutional delivery; improved antenatal and postpartum care; surveillance of deaths; reviews of maternal deaths; near-miss audit; enhanced skilled care in rural areas; birth-companion programmes; and increasing the availability of blood. The state developed and added innovations to national-level programmes.</td>
<td>Maternal mortality</td>
<td>In Tamil Nadu, India, the MMR reduced from 380 per 100,000 births in 1993 to 90 in 2007.</td>
</tr>
</tbody>
</table>

**What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?**
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

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<tbody>
<tr>
<td>Yan (1989) (-)/(-)</td>
<td>Women in general</td>
<td>National programme in China starting in the 1950s. Interventions included: training and equipping TBAs; increasing the number of trained midwives and obstetricians; increasing the number of maternity beds; setting up a network for the care and referral of abnormal obstetric cases; introduction of ambulances.</td>
<td>Maternal mortality</td>
<td>The MMR declined sharply in China in the 1950s and 1960s. Direct obstetric deaths dropped from the average value of 82.1% of all maternal deaths in the period 1949-54 to 39.1% in the period 1979-83.</td>
</tr>
</tbody>
</table>
Appendix 4.6: Included items dealing with complex interventions and infant mortality

<table>
<thead>
<tr>
<th>Author (year) (IV)/(EV)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Borulkar et al (1998) (-)/(-)</td>
<td>Neonates requiring special care</td>
<td>Special care for newborns including optimum warmth, feeding, oxygen administration, resuscitation of asphyxiated babies and training.</td>
<td>Neonatal mortality</td>
<td>Neonatal survival was 61.5% in the 1,000-1,500g category and 92.5% in the 1,520-2,000g category over a five-year period. Intervention was judged to be replicable and affordable.</td>
</tr>
<tr>
<td>Brown (1996) (-)/(-)</td>
<td>Neonates with LBW (&lt;1,500g)</td>
<td>Special care nursery. The infants were managed with warming, ‘blind’ antibiotic prophylaxis, intravenous fluids, nasopharyngeal oxygen for respiratory distress, and phototherapy and/or exchange transfusion for jaundice.</td>
<td>Infant mortality</td>
<td>Overall mortality was 54% and markedly inversely associated with birthweight.</td>
</tr>
<tr>
<td>Mirghani (2000) (-)/(-)</td>
<td>Pregnant women with diabetes</td>
<td>Simplified management of diabetes in pregnancy. Patients were controlled by insulin and monitored; labour was induced or C-section was performed at 38 weeks; basic resuscitation was carried out for all; hypoglycaemia was addressed in neonates; and early breastfeeding was made the norm. Babies who developed complications were managed at the special care unit.</td>
<td>Perinatal mortality</td>
<td>Perinatal mortality was higher among women with poor blood glucose control.</td>
</tr>
</tbody>
</table>
### Appendix 4.7: Included items dealing with complex interventions and both maternal and infant mortality

<table>
<thead>
<tr>
<th>Author (year) (IV)/(EV)</th>
<th>Target population</th>
<th>Brief intervention description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Richard (2008) (++)/ (++)</td>
<td>Women with Caesarean section</td>
<td>Comprehensive intervention in a district hospital in Burkina Faso to improve Caesarean delivery access and quality, including staff training, equipment, internal clinical audits, cost-sharing system, patient-provider meetings.</td>
<td>Maternal mortality Perinatal mortality</td>
<td>In this hospital, the number of C-sections increased. Hospital maternal deaths remained stable.</td>
</tr>
</tbody>
</table>
Appendix 4.8: Economic analyses of interventions targeted at urban dwelling poor populations to reduce maternal and infant mortality

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Intervention (I) and comparator (C)</th>
<th>Target population and duration of economic analysis</th>
<th>Study design</th>
<th>Cost results</th>
<th>Mortality-related effectiveness results</th>
<th>Perspective/price year</th>
<th>Synthesis of costs and effectiveness data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cattaneo (1998) (++/++)</td>
<td>I: Kangaroo Mother Care (KMC) C: Warm room or incubator care</td>
<td>100 low-birthweight babies - 1,000g-1,999g with no other major complicating factors and mother willing to collaborate. Mothers from all social groups. 30 days</td>
<td>RCT CEA</td>
<td>Cost data not reported separately for Ethiopia, but no differences in findings across countries noted. Overall across the three study areas salary costs were $11,788 in KMC group and $29,888 in comparator. Other hospital costs also lower $7,501 versus $9,876. P values not reported.</td>
<td>There were two deaths in the KMC group and three in the comparator group. This difference was not significant.</td>
<td>Health sector costs US $ price year not stated</td>
<td>No synthesis of costs and benefits as costs for intervention group were lower and outcomes similar.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author (year)</th>
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<td>There were two deaths in the KMC group and three in the comparator group. This difference was not significant.</td>
<td>Health sector costs US $ price year not stated</td>
<td>No synthesis of costs and benefits as costs for intervention group were lower and outcomes similar.</td>
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What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<th>Author (year) (IV)/(EV) and settings</th>
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<th>Target population and duration of economic analysis</th>
<th>Study design</th>
<th>Cost results</th>
<th>Mortality-related effectiveness results</th>
<th>Perspective/price year</th>
<th>Synthesis of costs and effectiveness data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fekih (2002) (+)/(-) Tunisia</td>
<td>I: Antenatal maternal corticosteroid treatment to prevent respiratory distress syndrome in premature neonates C: No treatment</td>
<td>118 women (26-34 weeks gestation) at high risk of premature delivery</td>
<td>RCT/ CEA</td>
<td>Cost of intervention $Tunisian 2,000 Cost savings in study group of $Tunisian 21,000</td>
<td>Significantly lower neonatal mortality rates due to respiratory stress syndrome in intervention compared to control group (22.9% versus 57%).</td>
<td>Health sector costs Tunisian $</td>
<td>No synthesis of costs and benefits as costs for intervention group were lower and outcomes similar.</td>
</tr>
</tbody>
</table>

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<th>Perspective/price year</th>
<th>Synthesis of costs and effectiveness data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Le Fevre (2010) (++)/(+), Bangladesh</td>
<td>I: Topical emollients - synthetic Aquaphor or sunflower seed oil C: No treatment</td>
<td>497 low birthweight babies &lt; 1,500 g. Pre-term infants only receiving hospital care within 72 hours of birth. 28 days</td>
<td>RCT CEA</td>
<td>Annualised total intervention costs for programme, including start-up costs US$1,834. Average cost per patient in Aquaphor, SSO and No treatment groups were $125.35, $99.47 and $93.39 respectively. P values not reported.</td>
<td>26% reduction in mortality with SSO compared to no treatment; or 523 years of life lost (YLL) averted. 32% reduction in mortality with Aquaphor compared to no treatment; or 649 YLL averted.</td>
<td>Health sector costs, including start-up costs US$ 2006 prices</td>
<td>For SSO, incremental cost compared to no treatment of US$ 61 per death averted or $2.15 per YLL averted. For Aquaphor incremental cost compared to no treatment of US$ 162 per death averted or $5.74 per YLL averted.</td>
</tr>
<tr>
<td>Author (year) (IV)/(EV) and settings</td>
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<td>Target population and duration of economic analysis</td>
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<tr>
<td>Sharieff (2008) (+)/(-) Pakistan</td>
<td>I: Nutritional supplement containing iron and zinc in form of sprinkles</td>
<td>Hypothetical cohort of 5,000 6-12 month infants</td>
<td>Modelling study</td>
<td>Net cost per child was $10 - $473 in the Sprinkles group and $1.31 - $512 in the placebo group.</td>
<td>Based on data in effectiveness studies, estimated risk ratio in mortality for intervention group at 1 year was 0.82. Present value of net benefits including earnings from productivity in adulthood almost $800.</td>
<td>Health sector costs; impact on future productivity in adulthood</td>
<td>Overall the present value of lifetime benefits was greater than the present value of costs of intervention.</td>
</tr>
<tr>
<td></td>
<td>C: Placebo product</td>
<td>Effectiveness data from two RCTs Resource use data from Pakistan Sprinkles Diarrhoea study</td>
<td>CBA Modelled outcomes until age 55</td>
<td></td>
<td></td>
<td>International $ 2003 prices</td>
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</table>

Key: RCT - Randomised Controlled Trial; CEA - Cost-effectiveness Analysis; CBA - Cost-Benefit Analysis.

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 4.9: Included items identified as high quality, with positive outcome(s) for maternal and/or infant mortality

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Poor urban identification</th>
<th>Brief intervention description</th>
<th>Target population</th>
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<th>Effect(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
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<tr>
<td>Darmstadt (2008) (++)/(++)</td>
<td>Relative income: mean ±SD, 1,000 taka Maternal education Paternal education</td>
<td>Preterm infants (gestational age: ≤33 weeks) received daily topical applications of sunflower seed oil (SSO) or Aquaphor ointment.</td>
<td>Preterm infants</td>
<td>Clinical Other clinical management skin therapy</td>
<td>Special care nursery</td>
<td>Neonatal mortality</td>
<td>Both SSO and Aquaphor significantly reduced mortality rates among preterm hospitalised infants with gestational ages of 33 weeks in Bangladesh, by 25% to 30%.</td>
</tr>
<tr>
<td>Maternal</td>
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<tr>
<td>Dumont (2006) (++)/(++)</td>
<td>Resource-poor setting</td>
<td>Midwives were responsible for identifying maternal deaths in the facility and they reported each case via a specific maternal deaths register. A senior gynaecologist-</td>
<td>Pregnant women admitted to hospital for childbirth</td>
<td>Non-clinical Service organisation Maternal deaths review (MDR)</td>
<td>District hospital</td>
<td>Maternal mortality</td>
<td>Significant decrease in maternal mortality within a 3-year intervention period, in</td>
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</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
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<tbody>
<tr>
<td></td>
<td></td>
<td>Obstetrician reviewed all patients’ charts and partographs on a daily basis, including the maternal death cases, to ensure quality of care, to provide continuous staff education and to assist with data collection. In the case of maternal death, the same gynaecologist-obstetrician interviewed the staff and the patient’s family to collect information about the circumstances surrounding the death and completed a chart to capture this information. Next steps included: (1) Once a year, review of the charts by two senior obstetricians to classify the causes of death, and to identify any factors that contributed to the death that could have</td>
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<td>particular for deaths related to haemorrhage and hypertensive disorders.</td>
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</table>
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<tr>
<td></td>
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<td>been avoided; (2) The obstetricians prepared a detailed report with their main findings and recommendations; (3) These findings were presented to the audit committee (composed of staff, local and national health authorities, and community representatives) and to representatives of international agencies and donors; (4) Agreed recommendations were implemented by the executive coordination team (composed of doctors, midwives and nurses), under the supervision of the district health manager; and (5) The following year,</td>
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<tr>
<td>Author (year)</td>
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<tr>
<td>Lim (2010)</td>
<td>Place of residence Type of house Education SES/’class’ Caste/tribe Wealth index based on material goods ownership</td>
<td>Janani Suraksha Yojana (JSY; translated as safe motherhood scheme) - a national conditional cash transfer scheme - to incentivise women of low socio-economic status to give birth in a health facility.</td>
<td>In some Indian states the conditional cash transfer system was available to all women whereas in other states it was only available to women who had a government card, issued to those below the poverty line</td>
<td>Non-clinical Service organisation Financing: Janani Suraksha Yojana</td>
<td>Community</td>
<td>Maternal mortality Neonatal mortality Perinatal mortality</td>
<td>Findings suggest that the programme is reducing perinatal and neonatal mortality; however, its effect on maternal mortality remains unknown. (Noted that study may not have been powered to detect differences in maternal mortality)</td>
</tr>
<tr>
<td>Munjanja (1996)</td>
<td>Relative income</td>
<td>Service organisation: reduced visits for antepartum care. Routine maternal weight-change measurements were not</td>
<td>Women in general</td>
<td>Clinical Other clinical management</td>
<td>District hospital</td>
<td>Perinatal mortality</td>
<td>An antenatal care programme with fewer more objectively oriented visits can</td>
</tr>
<tr>
<td>Author (year) (IV)/(EV)</td>
<td>Poor urban identification</td>
<td>Brief intervention description</td>
<td>Target population</td>
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<td>done and routine urinalysis was done only at the first visit. Urinalysis was done only at follow-up visits in the new programme if the blood pressure was raised, or if there was a suspected urinary tract infection. Blood pressure was measured at all visits except the second one, and symphyseal-fundal height (SFH) measurements were introduced into the new programme. At the second visit, the results of laboratory investigations were reviewed with the woman, but no clinical procedures were done. Based on the results of these investigations, any action needed was</td>
<td>antepartum care</td>
<td></td>
<td></td>
<td>be introduced without adverse effects on the main intermediate outcome pregnancy variables. No significant difference in perinatal or maternal mortality.</td>
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</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 4.9

<table>
<thead>
<tr>
<th>Author (year)</th>
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</tr>
</thead>
</table>

- recommended at this visit. Patients in whom risk factors were detected later than the first visit remained in the study even if they were referred to Harare Central Hospital. The criteria for referral to hospital remained the same as in the standard programme, except for women with unknown dates and SFH measurements. In addition to palpation, the diagnosis of a large-for-dates or small-for-dates foetus was made if two consecutive readings at least 4 weeks apart were above the 95th or below the 5th centiles for gestation on the SFH nomogram for Central Africa.

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
Appendix 4.10: High-quality included items with successful mortality outcomes, but not explicitly targeting urban poor populations

<table>
<thead>
<tr>
<th>Author (year) (IV)/(EV)</th>
<th>Brief intervention description</th>
<th>Target population</th>
<th>Intervention type</th>
<th>Setting</th>
<th>Targeted Outcome(s)</th>
<th>Effect(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cobra (1997) (++)/(++)</td>
<td>Infants were allocated to receive placebo or oral iodised oil (100 mg) at about 6 weeks of age and were followed to 6 months of age.</td>
<td>Infants in general</td>
<td>Clinical Drug treatment (including micronutrient supplementation) <em>single micronutrient</em></td>
<td>Home</td>
<td>Infant mortality</td>
<td>Oral iodised oil supplementation of infants may reduce infant mortality in populations at risk for iodine deficiency.</td>
</tr>
<tr>
<td><strong>Maternal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dumont (2005) (++)/(++)</td>
<td>Emergency obstetric guidelines introduction in the Centre de Santé Roi Baudouin, Guédiawaye, Dakar, Senegal.</td>
<td>Women in general</td>
<td>Non-clinical Service organisation <em>obstetric guidelines</em></td>
<td>District hospital</td>
<td>Case fatality for haemorrhage</td>
<td>While staff daily supervision may have improved maternal outcome before the intervention period, audit and feedback produced marked effects on emergency obstetric care, especially for complications requiring highly trained management (e.g. pre-eclampsia).</td>
</tr>
</tbody>
</table>

What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?
What are the effects of different models of delivery for improving maternal and infant health outcomes for poor people in urban areas in low income and lower middle income countries?

| Taha (1997) (++)/(++) | Manual cleansing of the birth canal with a 0.25% chlorhexidine gluconate solution in sterile water. Babies born during the intervention phase were wiped with pads soaked in 0.25% chlorhexidine immediately after delivery. | Women in general | Clinical Other clinical management cleansing of the birth canal | Central hospital | Neonatal mortality Perinatal mortality Stillbirth | Perinatal mortality showed a significant but transient change during the observation period 1982-1991. |
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