Maternity Protection Resource Package

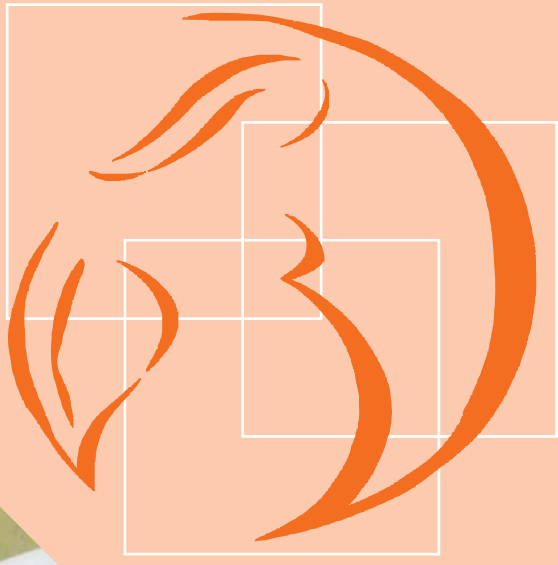
From Aspiration to Reality for All

International Labour Organization

PART TWO

Module 7

Cash and medical benefits



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INTERNATIONAL LABOUR ORGANIZATION

Maternity Protection Resource Package

From Aspiration to Reality for All

Module 7:
Cash and medical benefits

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Module 7:
Cash and medical benefits[1]

Key contents

This module summarizes the importance of cash and medical benefits for maternity protection. Because of their complexity, this module can only provide a broad overview of some of the key issues and principles relating to this subject. Further resources are provided at the end of the module. This module covers:

- The risks related to maternity and the importance of social protection, including cash and medical benefits
- Broad estimates of access to social protection, including maternity cash and medical benefits
- International frameworks and approaches to maternity benefits, with focus on the Social Protection Floor initiative and up-to-date ILO social security standards
- Coverage, key features and financing mechanisms for medical benefits during maternity
- The administration of maternity benefits in social security schemes
- Key considerations in extending maternity benefits through social insurance for atypical workers and workers in the informal economy
- The importance of social dialogue and the roles of key stakeholders

[1] This module draws heavily from the following sources:
E. Fultz: *Guidelines for the extension of maternity protection to developing countries*, Working Paper (Geneva, 2011) unpublished.
ILO: *Safe maternity and the world of work* (Geneva, 2007).
— *Social health protection, an ILO strategy towards universal access to health care,* Social Security Department, Social Security Policy Briefings, Paper 1 (Geneva, 2008a).
— *World Social Security Report 2010/11* (Geneva, 2010a).
— *Conclusions concerning the recurrent discussion on social protection (social security)*, Provisional Record No. 24, International Labour Conference (ILC), 100th session (Geneva, 2011a).
K. Pal et al.: "Can low income countries afford basic social protection?" *Social Security Policy Briefings*, No. 3 (Geneva, ILO, 2005).
X. Scheil-Adlung and L. Sandner: *Wage continuation during sickness: Observations on paid sick leave provisions in times of crises*. (Geneva, ILO, 2010).

The right to "social protection" has been universally recognized as a fundamental human right that guarantees a secure, healthy and decent standard of living for every individual.[2] In this module, the term **"social protection"** is used to mean protection provided by social security systems in the case of social risks and needs. **"Social security"** refers to the measures that provide benefits, whether in cash or in kind, that secure **protection**, inter alia, from:

- lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;
- lack of access or unaffordable access to health care;
- insufficient family support, particularly for children and adult dependants;
- poverty and social exclusion.[3]

Social security schemes can be of a contributory (social insurance) or non-contributory nature. Maternity is one of the ten branches of social security,[4] and includes medical benefits and income replacement throughout maternity leave.

In recognition of the wide global disparities in access that individuals have to social protection, the concept of the "Social Protection Floor" (SPF) was developed to refer to a basic set of social rights, services and facilities that every individual should enjoy. The SPF consists of a basic set of **essential guarantees**, in cash and in kind, as aid to the poor and vulnerable to provide minimum income security during childhood, working age and old age, as well as affordable access to essential health care. These guarantees set the minimum levels of protection that all members of a society should be entitled to in case of need.[5]

Strengthening and extending social protection is as crucial for the health of women and their children during and just after pregnancy, as it is to the lifelong health of all women, men, and children. Cash benefits to replace lost income during the weeks immediately before and after childbirth, and access to health care throughout maternity are essential to facilitate the mother's rest and recovery, nutrition, economic security, and the health and well-being of mothers and their children. These directly contribute to the aspirations of Millennium Development Goal (MDG) 3 on gender equality and MDG 5 on improving maternal health. Social security measures to provide maternity leave benefits and access to medical care also have major benefits for newborns. They contribute to reductions in infant mortality, the promotion of physical and mental development and reductions in mother-to-child HIV and AIDS transmission through access to health-care services, all of which contribute to the aims of MDG 4 (improving child health) and MDG 6 (combating HIV, AIDS and other diseases).[6]

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2 Several international instruments affirm the right of every individual to social security. These include the Universal Declaration of Human Rights, 1948; the International Covenant on Economic, Social and Cultural Rights, 1966; the ILO Declaration of Philadelphia, 1944; and the Income Security Recommendation, 1944 (No. 67). See, for example, ILC: *Social Security as a Human Right and Duty of the State*, Report III, Part 1B, 100th Session (Geneva, 2011).

3 ILO, 2010a, op. cit., p. 13.

4 Other elements of social security include sickness (medical care and income support), disability, old age, survivors, unemployment, employment injury, poverty and social exclusion and the "responsibility for the maintenance of *children*, including the provision in kind to, or in respect of, children, of food, clothing, housing, holidays or domestic help" and of cash income support family benefits as defined by Part VII of Convention No.102". ILO, 2010a, op. cit., p. 20.

5 See ILO, 2010a, op. cit., p.17 and ILO, 2011a, op. cit., p.22.

6 See, for example, WHO: *Technical Consultation on Postpartum and Postnatal Care* (Geneva, 2010a), p. 4.

Unfortunately, just 20 per cent of the world's working-age population and their families currently enjoy access to comprehensive social protection systems, while at least 40 per cent[7] lack access to even basic social protection.[8] This means that cash and medical benefits for maternity remain well beyond the reach of vast numbers of women. There is an urgent need for governments and other stakeholders to step-up action to strengthen and extend social protection, including maternity protection, if the MDGs are to be met.

Maternity-related risks and the importance of leave, cash and medical benefits

An important risk associated with childbirth and maternity is the loss of income. Mothers are not able to work for limited periods of time before, during and after delivery.[9] Cash benefits provided during maternity leave or, for women not entitled to paid or unpaid leave, during any work interruptions related to childbirth, are intended to replace a portion of the income lost due to the interruption of the woman's economic activities and partially offset maternity-related costs. Without such support, the woman's loss of earnings, inability to generate income, or inability to engage in non-monetary activities around childbirth or during absence on leave, coupled with increased expenditures associated with pregnancy, birth and parenthood, would pose financial hardship for many families. The loss of income may be particularly problematic for mothers, such as single mothers, who are the main breadwinners for their families. In such circumstances, women might feel compelled to return to work before it is medically advisable to do so or before their entitlement to leave is exhausted. For women on maternity leave, cash benefits replace some or all of the wages lost during time off from employment and help to make the right to leave an economically viable option.

Pregnancy, childbirth and the early months of life are a particularly vulnerable time, when both mother and child are exposed to a series of potential health risks. Most developing countries have particularly high maternal and infant mortality rates and care services and facilities are, unfortunately, of low quality, unavailable and out of reach for most families. Approximately 40 per cent of under-five deaths occur within the first month, and some 70 per cent occur within the first year of life. MDGs 4, 5 and 6 target much-needed reductions in maternal, neonatal and under-5 mortality. However, achieving progress towards these global goals is particularly challenging and an estimated 8.1 million children die before the age of five. More than 343,000 mothers die during maternity.[10]

The major medical causes of maternal mortality globally are obstructed labour, haemorrhage, infections, unsafe abortions and hypertensive disorders.[11] Overall, unsafe abortions account for a considerable number of maternal deaths. In sub-Saharan countries, HIV and AIDS is an important factor that increases women's risk of dying from

7 Estimated as being people who fall under the international poverty line of US$2 per day. ILO, 2010a, op. cit., p. 33.

8 ILO, 2010a, op. cit., p.33.

9 In most countries, this period of time is fixed by law and varies from country to country. Convention No. 183 calls for 14 weeks of leave, with a compulsory period of six weeks following childbirth. See **Module 6** on maternity leave.

10 ILO: "Improve maternal health" in *Decent Work and the Millennium Development Goals*, (Geneva, 2010b), 6 pp. See also: WHO: *World Health Statistics 2011* (Geneva, 2011b).

11 K.S Khan et al.: "WHO systematic review of causes of maternal deaths", in *The Lancet*, 2006, Vol. 367, pp. 1066–1074.

pregnancy complications and from greater susceptibility to opportunistic infections.[12] The risk factors are compounded in countries where pregnancies come too often, too close together, too early or too late in the life cycle. Cultural factors, educational level, socio-economic factors and gender inequality also play a strong role and often influence decisions on whether, where and when pregnant women receive or look for care.

Medical benefits are intended to protect the health of both mother and baby by ensuring that women receive necessary maternity services that are either free of charge or partially subsidized at the point of delivery. Regular health monitoring during pregnancy (often referred to as antenatal care or ANC) is an effective means of ensuring the health of the mother and child, including preventing abnormalities and trying to mitigate possible complications at birth.[13] Services usually include a certain number of prenatal and postnatal visits by skilled health professionals, the provision of a health-care facility before and following birth, care and hospitalization during childbirth, as well as any prescribed medication. Medical benefits to pregnant women to mitigate the effects of HIV and AIDS are also critical, as they enable women to take steps to protect and secure care for themselves and to prevent mother-to-child transmission (MTCT).

Depending on the financing mechanism in place, all or some of the costs of maternal health care may be covered by a national health system. Where **social health protection**[14] is not provided, some women might contribute to local health schemes or private insurance that cover some of the costs of maternity. Many women are not covered at all and they have to pay for all of these services themselves, if they can. Women who cannot afford to pay for medical assistance are far less likely to receive pre- and postnatal care and may give birth without adequate supervision.

Social health protection that provides universal access to health care and financial protection against direct and indirect health-related costs is critical for mitigating the health risks associated with maternity and ensuring that all women have access to the preventive and curative health care they need.

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12 Each year, over 25 million women undergo unsafe abortions, 70,000 of whom die from induced complications. A further five million suffer disabilities related to unsafe abortions. See WHO: *Packages of interventions for family planning, safe abortion care, maternal, newborn and child health* (Geneva, 2010b). See also J. van Dillen, T. Meguid and J. van Roosmalen: "Maternal mortality audit in a hospital in Northern Namibia: The impact of HIV/AIDS", in *Acta Obstetricia et Gynecologica Scandinavica*, 2006, Vol. 85, No. 4, pp. 499-500, and J. McIntyre: "Maternal health and HIV", in *Reproductive Health Matters*, 2005, Vol. 13, No. 25, pp. 129-135.

13 J. Paul: *Healthy Beginnings: Guidance on safe maternity at work* (Geneva, ILO, 2004), 108 pp.

14 **Social health protection**, as defined by the ILO, comprises a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health.

The realities: Gaps in access to maternity cash and medical benefits[15]

Despite the importance of social protection for the social, economic and physical well-being of all individuals throughout their life cycle, social protection remains beyond the reach of much of the world's population. As is the case for other social security schemes, the risk of being excluded from maternity cash and medical benefits coverage is particularly high among certain groups. This includes workers in the informal economy and atypical forms of employment, vulnerable workers in rural and urban areas, domestic workers, migrant workers and unskilled workers. It also includes people with disabilities and chronic illnesses, and those affected by HIV and AIDS, who are more likely to be excluded from formal employment. Overall, women tend to face a higher incidence of exclusion from social security than men, due to discrimination throughout the life cycle and the ubiquitously unbalanced gender distribution of family and care responsibilities.[16] This condition particularly affects women's access to social protection throughout the reproductive years of their working lives, during which social transfers in connection with the costs of pregnancy, childbirth and bringing up children are essential.

Coverage gaps are particularly large in countries with low levels of labour market formalization. This is because social security systems are income transfer schemes, funded by income generated in national, mainly formal, economies. At the same time, the degree of formalization of the labour market determines how many people can be covered by the different branches of social security and how many contribute to financing social transfers through employment-related contributions and taxes. Tax-financed **social assistance** (poverty alleviation systems for citizens or residents in special need) and **universal benefits** (benefit schemes for all citizens or residents) may reach people in informal employment. However, in a largely informal economy it may not be possible for a nation to maintain a tax and contribution base for comprehensive protection for the majority of the population with higher level benefits.[17]

Estimates of exactly how many women have access to cash or medical benefits throughout maternity are not available and are difficult to calculate.[18] However, there are several indicators which provide complementary coverage statistics, all of which point to the conclusion that current coverage is quite low globally. One such indicator is to estimate social security access in terms of the rate of formal wage and salary employment. Contributory social insurance and other statutory schemes in most countries cover only those who are employees (that is, those in formal wage or salary employment) and, sometimes, their dependants. For this reason, both legal and effective coverage by these schemes is strongly correlated with the percentage of formal employees among those employed.

Globally, over one-fourth of the world's adult population (one-third of adult men and one-fifth of adult women) are in formal or informal paid work. Of women who have some kind of employment, approximately half (51 per cent) are wage or salary workers. However,

[15] This section is largely adapted from ILO, 2010a, op. cit.

[16] ILO, 2011a, op. cit., p. 4.

[17] ILO, 2010a, op. cit., p. 27.

[18] The ILO is currently developing new indicators on maternity protection coverage in law and practice, including cash benefits coverage. The results of this research work will be available by the end of 2012 at **www.ilo.org/travail**. See also **Modules 12 and 13** for more information on maternity protection-related indicators.

while 90 and 82 per cent of all employed women in developed economies and Central and South-Eastern Europe (non-EU) and the Commonwealth of Independent States (CIS), respectively, are in this way employed, the figure is 17 per cent in Africa, 21 per cent in Asia and the Pacific, 53 per cent in the Middle East and 63 per cent in Latin America and the Caribbean.[19] However, even among these, not all are in formal employment where they would have access to statutory social security benefits. Moreover, not all countries have statutory programmes covering maternity under their social security systems; hence these figures represent likely overestimates of coverage.[20]

Another way of estimating the rate of access to maternity-related cash and medical benefits is to look at countries with comprehensive social protection systems that cover all branches of social security (plus social assistance), including maternity. Just one-third of countries globally have such systems. Within those countries, only those who work in formal employment as wage or salary workers are covered (i.e. 70 per cent). When controlling for the non-economically active population, the global coverage rate drops to approximately 20 per cent. In other words, one-fifth of the working-age population (and their families) has effective access to comprehensive social protection systems.[21]

Many countries without comprehensive social protection systems still have statutory programmes for maternity protection. In fact, legal provision for maternity protection ranks third among social security branches providing cash benefits. Some kind of legal provision exists in a majority of countries – 90 per cent of high-income countries, 80 per cent of middle-income countries, and over 50 per cent of low-income countries. However, these provisions usually apply only to women employed in the formal economy, and among these women, not all may meet eligibility criteria for benefits (see **Module 2** for more information on eligibility requirements and legal and effective exclusion from maternity protection). This means that only a minority of women enjoy benefits from maternity protection schemes, particularly in low- and middle-income countries where formal employment is low.

The ILO has also estimated that individuals living below the international poverty line of US$2 per day (i.e. about 40 per cent of the global population) have no effective basic social protection. This in all likelihood constitutes a minimum calculation since those living just above the absolute poverty threshold are considered vulnerable and often do not have access to protection.[22]

Taken together, these indicators point to very wide-ranging estimates of women who lack access to social protection throughout maternity, including cash and medical benefits. At least 40 per cent (i.e. those under the international poverty line) and up to 80 per cent (i.e. those not among the 20 per cent with effective access to comprehensive social protection systems) of women lack access to social protection that includes maternity coverage. However, even the lower-bound estimate (i.e. 40 per cent), the lack of access to social protection is widespread and a major hindrance to achieving the MDG goals.

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19 ILO: *Key Indicators of the Labour Market (KILM)*, Sixth edition, (Geneva, 2011c), **www.ilo.org/kilm** [accessed Sep. 15 2011].

20 However, it should be noted that some forms of health insurance through community-based schemes have been developed in many developing countries. These schemes indeed try to target informal workers and in some cases the benefit package includes maternity-related benefits (see below).

21 This figure disaggregated by sex is not available; however, because women tend to be in more vulnerable forms of employment, such as casual labour, homework and self-employment, and are less likely to be in the formal sector with access to social security than men, the figure is likely to be somewhat lower for women.

22 ILO, 2010a, op. cit., p. 33.

Data and analyses also suggest major gaps and challenges in women's access to medical benefits during maternity. Although a larger percentage of the world's population has access to health-care services than to various cash benefits, the ILO estimates that nearly one-third does not have access to any health facilities or services.[23] More than half of the births in sub-Saharan Africa are not attended by skilled health personnel. Additionally, the health effects of HIV, malaria and other diseases increase the risk of maternal death. These diseases are particularly widespread in Africa where two-thirds of the total HIV-positive population live, the majority of whom are women. For many households around the world, expenditure on health care can result in financial catastrophe because they lack adequate social health protection which would cover or refund such expenditure.[24]

Clearly, there is poor access to social protection and poor coverage of social security schemes across the globe, and this lack of access is problematic for the health and well-being of men, women and children, as well as that of women and their babies during maternity. This module describes major frameworks for extending social protection, and constitutes a broad overview of key issues and considerations with regard to cash and medical benefits.

International frameworks and approaches[25]

A number of international instruments, including ILO standards, provide the framework to promote universal access to health care and financial protection in case of maternity, sickness, disability or other contingencies. They include the following:

- The 1948 **Universal Declaration of Human Rights** (UDHR, Articles 22 and 25), and the 1966 **International Covenant on Economic, Social and Cultural Rights** (ICESCR, Article 9), ratified by 160 States, provide for the universal right to social security. The General Comment No. 19[26] of the Committee on Economic, Social and Cultural Rights[27] on Article 9 of the ICESCR defines the right to social security as access to and the maintenance of benefits without discrimination in order to ensure protection from, for example, lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member. These objectives demand the establishment of measures to provide support to those who are unable to make sufficient contributions for their own protection. In other words, with respect to maternity in particular, it calls for the continuation of salary payments or income replacement.
- Maternity health benefits and income replacement also constitute key components of the **ILO Social Security (Minimum Standards) Convention, 1952 (No. 102),** which sets out medical benefits in case of pregnancy and confinement and their consequences. These include at least prenatal, confinement and postnatal care either by medical practitioners or by qualified midwives, as well as hospitalization where necessary, plus periodical payments with respect to pregnancy, confinement and its consequences, compensating for suspended earnings. **Maternity Protection**

[23] ILO, 2010a, op. cit., p. 1.
[24] ILO, 2010a, op. cit., p. 2.
[25] This section is largely adapted from X. Scheil-Adlung and L. Sandner, 2010, op. cit.
[26] UN: Doc. E/C.12/GC/19, 4 Feb. 2008.
[27] The Committee on Economic, Social and Cultural Rights is the United Nations body responsible for monitoring the application of the ICESCR in national law and in practice.

Conventions No. 103 and No. 183 set out a higher standard of benefits, particularly with respect to cash benefits (see **Box 7.1** for the provisions and guidance set out by C183 and R191).

Box 7.1 Maternity cash and medical benefits

Convention No. 183, Article 6

(1) *Cash benefits shall be provided, in accordance with national laws and regulations, or in any other manner consistent with national practice, to women who are absent from work on leave.*

(2) *Cash benefits shall be at a level which ensures that the woman can maintain herself and the child in proper conditions of health and with a suitable standard of living.*

(3) *Where, under national law or practice, cash benefits paid with respect to leave referred to in Article 4 are based on previous earnings, the amount of such benefits shall not be less than two-thirds of the woman's previous earnings or of such of those earnings as are taken into account for the purpose of computing benefits.*

(4) *Where, under national law or practice, other methods are used to determine the cash benefits paid with respect to leave referred to in Article 4, the amount of such benefits shall be comparable to the amount resulting on average from the application of the preceding paragraph.*

(5) *Each Member shall ensure that the conditions to qualify for cash benefits can be satisfied by a large majority of the women to whom this Convention applies.*

(6) *Where a woman does not meet the conditions to qualify for cash benefits under national laws and regulations or in any other manner consistent with national practice, she shall be entitled to adequate benefits out of social assistance funds, subject to the means test for such assistance.*

(7) *Medical benefits shall be provided for the woman and her child in accordance with national laws and regulations or in any manner consistent with national practice. Medical benefits shall include prenatal, childbirth and postnatal care, as well as hospitalisation care when necessary.*

Recommendation No. 191, Paragraph 2

Where practicable, and after consultation with the representative organizations of employers and workers, the cash benefits to which a woman is entitled during leave referred to in Articles 4 and 5 of the Convention should be raised to the full amount of the woman's previous earnings or of such of those earnings as are taken into account for the purpose of computing benefits.

- The ILO **Medical Care and Sickness Benefits Convention, 1969 (No. 130)** provides rules governing national legislation that protects employees through the provision of medical care of a curative or preventive nature and through the provision of sickness benefits.
- The ILO **Decent Work Agenda** defines "decent work" as work of acceptable quality that ensures, amongst others, basic security.[28] The consensus on social security reached at the 89th International Labour Conference (ILC) in 2001, gave the highest priority to policies and initiatives that can bring social security to those who are not covered by existing schemes. Consequently, in 2003 the ILO launched the Global Campaign on Social Security and Coverage for All. The ILO 2008 **Declaration on Social Justice for a Fair Globalization** again reaffirmed the tripartite

[28] ILO Decent Work Agenda website, http://www.ilo.org/global/about-the-ilo/decent-work-agenda/lang—en/index.htm.

commitment to extend social security to all in need of such protection in the framework of the Decent Work Agenda.

- The new ILO **Recommendation concerning HIV and AIDS and the World of Work, 2010, (No. 200)** states that "*Members should ensure that workers living with HIV and their dependants benefit from full access to health care, whether this is provided under public health, social security systems or private insurance or other schemes*" (Paragraph 17, Treatment and Care) and that there should be no discrimination against workers or their dependants based on real or perceived HIV status in access to social security systems and occupational insurance schemes, or in relation to benefits under such schemes, including for health care and disability, and death and survivors' benefits. (Paragraph 20, Treatment and Care).

- The **Social Protection Floor**[29] (**SPF**) initiative, launched by the UN Chief Executives Board in 2009 in the context of the One-UN response to the economic crisis, requests countries to build adequate social protection for all through basic social guarantees for every citizen.[30] The concept was endorsed by the **Global Jobs Pact** adopted by the ILC in June 2009. The High-level Plenary Meeting of the UN General Assembly on the Millennium Development Goals (**MDG Summit**) in September 2010 recognized that "*promoting universal access to social services and providing social protection floors can make an important contribution to consolidating and achieving further development gains*" and hence endorsed the SPF Initiative.[31]

- In June 2011, the **Conclusions of the 100th ILC on the recurrent discussion on social protection (social security)** identifies the establishment of nationally designed social protection floors that guarantee minimum income security and essential health care as the priority for the extension of social security.[32] In the light of this, ILO member States have placed the discussion of a possible Recommendation on Social Protection Floors on the agenda of the 101st Session of the ILC in 2012.

- In June 2011, the ILC adopted a new Convention and Recommendation concerning Decent Work for Domestic Workers, a category of workers often excluded from social security protection, including for maternity (see **Box 7.27**).

29 UN System Chief Executive Board for Coordination (CEB), New York, 2008, **http://www.unsceb.org/ceb/home**, [accessed 19 Sep. 2011].

30 ILO: *Strategies for the Extension of Social Security Coverage*, Tripartite Meeting of Experts on Strategies for the Extension of Social Security Coverage (Geneva, 2009).

31 ILO, 2011a, op. cit., p. 1.

32 ILO, 2011a, op. cit., para 9.

Maternity Protection and the Social Protection Floor

The SPF initiative offers promise for extending social protection to those that currently lack access altogether, particularly in the one-third of the world's countries that experience high or very high vulnerability in terms of poverty and informal employment.[33] In support of the Global Campaign on Social Security and Coverage for All, the ILO developed a two dimensional strategy in moving towards comprehensive social security coverage, the "social security staircase". In line with this policy paradigm, member States should develop effective national strategies to extend social security in line with national priorities, administrative feasibility and affordability. These national strategies should aim to achieve universal coverage of the population with at least minimum levels of protection (**horizontal dimension**) and progressively ensure higher levels of protection guided by up-to-date ILO social security standards (**vertical dimension**). The two dimensions of the extension of coverage are equally important and should be pursued simultaneously where possible. [34]

The **horizontal dimension** (yellow area of **Figure 7.1**) should aim for the rapid implementation of national social protection floors, which contain basic social security guarantees. These ensure that those in need can afford and have access to essential health care over their life cycle and have income security at least at a nationally defined minimum level. The SPF policies aim to ensure that two fundamental needs are met for all: access to **essential health care** and **income security** for those who cannot or should not work (i.e. children, pregnant and postpartum women, the elderly and, in some cases, individuals with disabilities).

These four basic social security guarantees are nationally-defined minimum levels of income security during childhood, working age and above, in addition to affordable access to health care. These correspond to the core content of the general elements of the right to social security as laid down in the UDHR and ICESCR. On this basis, in order to ensure protection against major risks throughout the life cycle the set of essential guarantees provided under national social protection floors must aim to extend:

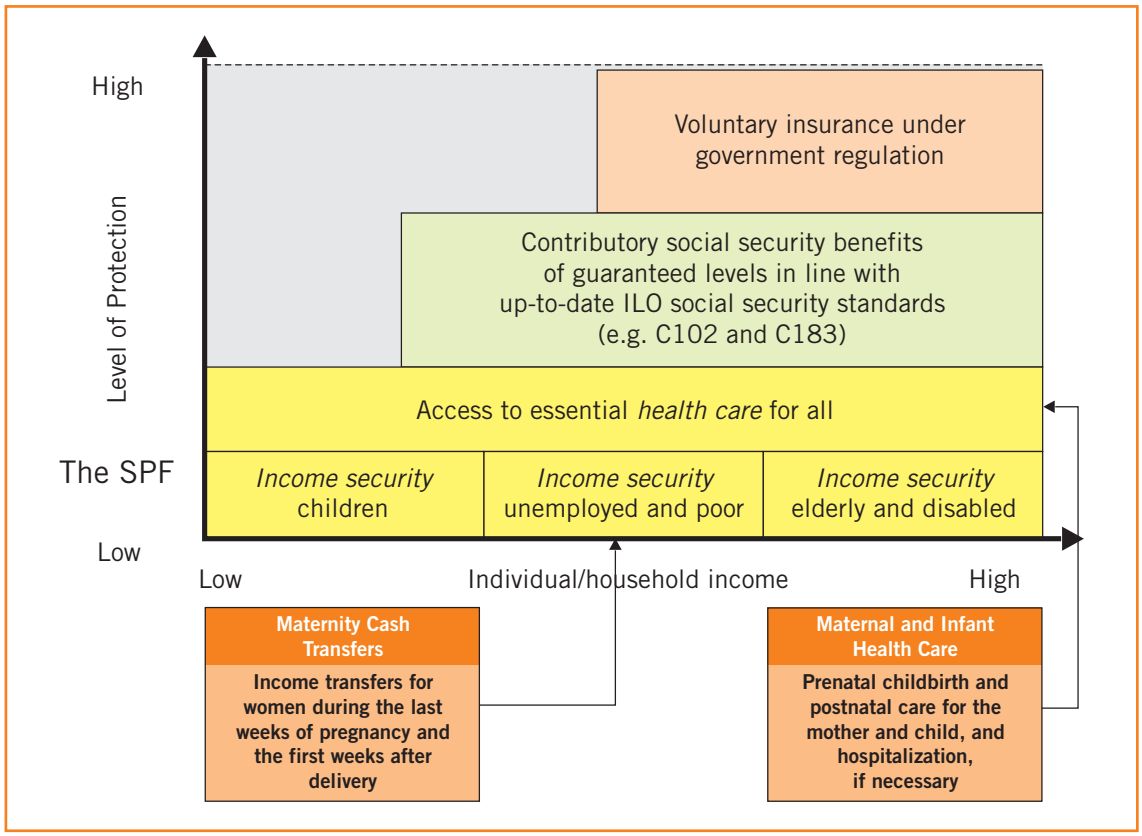
- the necessary financial protection for all residents to afford and have access to a nationally defined set of essential health care, including maternal health;
- income security, at least at a nationally defined minimum level, through family/child benefits in cash or in kind aimed at facilitating access to nutrition, education and care for children;
- minimum income security through social assistance, maternity benefits, other social transfer schemes in cash or in kind, or public employment programmes to all residents in active age groups who are unable to earn sufficient income on the labour market; and

[33] The concept of the vulnerability status of countries is laid out in: ILO, 2010a, op. cit., p. 30. Vulnerability is assessed by the proportion of people in the country living on less than US$2 PPP per day, and the level of informality, approximated as the proportion of those who are not employed persons (in wage/salary employment) in the total number of employed. Under these criteria, 40 countries are categorized as very "highly vulnerable" and 18 as "highly vulnerable", corresponding to one-third of all countries. Most of these are in Asia and Africa.

[34] ILO, 2011a, op. cit., p. 4.

- income security for all residents, at least at a nationally defined minimum level, through benefits in cash or in kind for old age and disability to all eligible residents.[35]

Figure 7.1 Maternity benefits in the Social Security Staircase Model



Sources:
ILO: *Extending social security to all: A guide through challenges and options*, Social Security Department (Geneva, 2010c), p. 20.
— *Social security for social justice and a fair globalization* (Geneva, 2011e), p. 135.

As shown in **Figure 7.1**, maternity-related health care and cash transfers form an important part of the SPF, as essential elements to ensure the following minimum guarantees to all women residents: 1) basic prenatal, childbirth and postnatal health care for the mother and her child, either by medical practitioners or by qualified midwives, and hospitalization where necessary; 2) income support for women during the last weeks of pregnancy and the first weeks after delivery.[36] Thus, the progressive establishment of national social protection floors offers a promising framework for reaching women who are self-employed in rural agriculture or the urban informal economy. These national initiatives would include ensuring their effective access to medical care and to maternity cash benefits. The latter could be achieved through the incorporation of these groups under the umbrella of existing social insurance systems through well-designed strategies,

[35] ILO: *Law and practice report,* Recommendation on national Social Protection Floors, No. 202 (Geneva, 2011d), p. 23.
[36] ILO, 2011e, op. cit., p. 71.

the establishment of new contributory schemes adapted to the specific needs of these groups, or the provision of non-contributory maternity benefits.[37]

Finally, maternity benefits are also essential to the **vertical dimension** of the social security staircase paradigm (blue area of **Figure 7.1**). As countries achieve higher levels of economic development and thereby gain fiscal space, it is expected that additional categories of people and higher levels of protection will be put in place progressively. This is in accordance with up-to-date international social security standards, as well as on a voluntary basis. As regards maternity, these provisions will comprise adequate cash and medical benefits set at the levels guaranteed by Conventions No. 102 and No. 183 (see subsequent sections) and financed through mandatory social insurance. For non-qualifying women, these are provided via social assistance public funds, subject to the means test required for such assistance (Article 6.6 of Convention No. 183). Voluntary insurance schemes, supervised by the public authorities or administered by joint operations of employers and workers, can also be set up to further the protections provided by mandatory programmes.

[37] The SPF relies on universal and means-tested benefits rather than social insurance, since it is aimed at extending protection to people who live and work beyond the reach of social insurance collection agents.

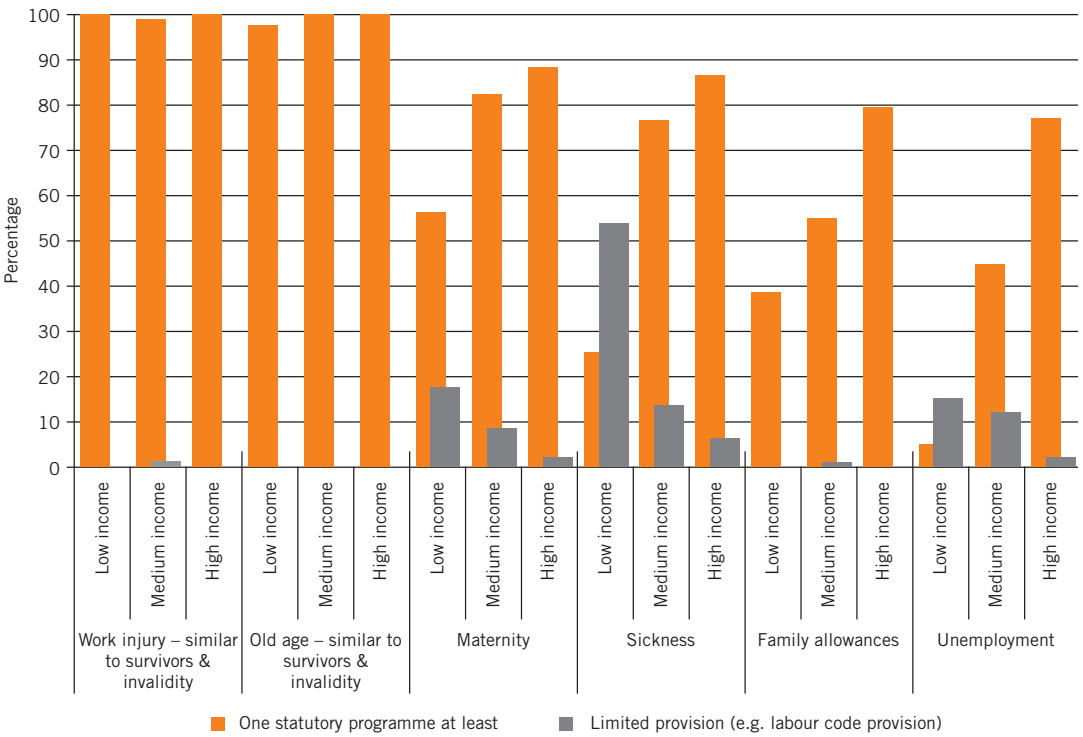
Cash benefits

Coverage and benefits

Maternity cash benefits help to replace the income that women lose due to time away from paid work in the weeks immediately before and after childbirth. Cash benefits serve as a crucial buffer against financial hardship.

Today, legal provision for maternity protection ranks third among social security branches providing cash benefits, after employment injury and retirement pensions (see **Figure 7.2**). However, the extent of mandatory provision by individual employers (which is not in accordance with the principles of international labour standards as discussed below) is significant; higher than that found in all other forms of social security except sickness benefits. As shown in **Figure 7.2**, legal provision exists in a majority of countries (i.e. 90, 80 and over 50 per cent of high-, middle- and low-income countries, respectively). However, these provisions usually apply only to women employed in the formal economy. Thus only a minority of women in many low- and middle-income countries enjoy benefits from maternity protection schemes.

Figure 7.2. Percentages of high-, medium-, and low-income countries with maternity and other cash benefits



Source: ILO, 2010a, op. cit.

The up-to-date ILO social security Conventions set coverage standards, although the provisions of Convention No. 102 and No. 183 do so in different ways, which reflects the different eras in which they were adopted.

Convention No. 102 treats maternity benefits as one of nine social security contingencies[38] (see **Box 7.2**), only three of which must be addressed to satisfy this Convention's minimum standard. Maternity benefits are not among the compulsory provisions according to Article 2 of Convention No. 102. Thus, it is possible for a government to comply with Convention No. 102 by covering maternity along with two other contingencies, or by covering a minimum of three contingencies that do not include maternity.

Box 7.2 Social Security (Minimum Standards) Convention, 1952 (No. 102)

Convention No. 102 defines social security as the protection that a society provides its members, through a series of public measures, against:

- Loss of work-related income (or insufficient income), caused by:
  - sickness
  - disability
  - **maternity**
  - employment injury
  - unemployment
  - old age
  - death of a family breadwinner
- Lack of access to health care, because it is unavailable or unaffordable; and
- Insufficient support for childrearing.

Source: ILOLEX Database of International Labour Standards, http://www.ilo.org/ilolex/english/index.htm.

For those governments that ratify Convention No. 102 and opt to provide maternity benefits, the Convention requires that:

- in the case of a scheme that targets employees, at least 50 per cent of all employees in the country must be covered and all the women in this coverage group must receive maternity protection, as well as the wives of all covered men; and
- in the case of a scheme that targets the economically active population (including employees, the self-employed, workers in informal employment, and the unemployed), at least 20 per cent of all residents of the country must be covered; and all women in this coverage group must receive maternity benefits, as well as the wives of all covered men.

Convention No. 183, in contrast, requires coverage of all employed women, including those in atypical forms of dependent work. The latter phrase refers to self-employed women who deliver their services or products to a single entrepreneur or enterprise, including those in casual and seasonal work, fixed-term and temporary agency work, and home-based work (see **Box 7.3**).

[38] The ILO has since added general income support or social assistance schemes as a tenth branch of social security. See ILO, 2010a, op. cit., p. 20.

Box 7.3 Maternity scheme coverage standards in ILO Conventions

C102	C183
For a scheme targeting employees: All women in a coverage group which shall not be less than 50 per cent of all employees in the country, as well as the wives of all men in this group. **For a scheme targeting the economically active:** All women in a coverage group which shall not be less than 20 per cent of all residents of the country, as well as the wives of all men in this group.	**All employed** women in the country, including those in **atypical forms of dependent work.**

The requirement in Convention No. 102 for coverage of at least 20 per cent of the residents in a country may at first glance seem low. However, in practice this standard is rarely reached by developing countries. This is because the number of workers in formal employment in these countries is a small portion of their economically active populations, and they have few means-tested or universal schemes.

The requirement in Convention No. 183 for coverage of all women in atypical forms of dependent work is in some sense a logical step for extending social insurance beyond the formal sector, since these groups, like employees, work for one enterprise or employer. However, this extension poses major challenges for social insurance. As discussed in the next section, social insurance relies heavily on employers. Without official wage reports, it is difficult for social insurance institutions to identify workers who are required to contribute to a scheme. Furthermore, if an informal (and thus unregistered) enterprise decides to evade the contribution requirement, the social insurance institution will have few ways of knowing this and few tools for enforcement. Thus, for social insurance to successfully cover women in atypical forms of dependent work, it will be necessary to make the scheme both attractive and affordable for them and for men. Some initiatives to do so are highlighted in boxes throughout this module and also discussed under the section on extending and improving coverage and benefits.

Ensuring that cash benefits are adequate lies at the core of the ILO Conventions, and it is here that they provide the most detailed guidance. With respect to maternity, they address the minimum duration of leave and benefits, as well as benefit amounts. **Box 7.4** sets out the standards for maternity leave and corresponding cash benefits (for more on maternity leave, see **Module 6**).

Box 7.4 ILO minimum standards for maternity leave with cash benefits	
C102	**C183**
Leave: • **12 weeks**, with a compulsory period of **six weeks** after the birth of the child	**Leave:** • **14 weeks**, with a compulsory period of **six weeks** after the birth of the child – if a birth occurs later than expected, the full six weeks still applies • A woman's job cannot be terminated during leave, as well as during a period thereafter to be defined in national regulations, except on grounds unrelated to the pregnancy and childbirth • A woman is entitled to return to the same job or an equivalent position after leave
Cash benefits: • Benefits should extend throughout the leave period • For schemes covering the economically active: flat-rate benefits (to cover the cost of subsistence) must equal at least **45 per cent of the wage of an unskilled worker** • For schemes covering employees: Benefits must be at least **45 per cent of the woman's wage prior to taking leave**	**Cash benefits:** • The benefits should extend throughout the period of leave • They should be adequate to maintain the health and living standard of a woman and her child • Where they are based on previous earnings, they should not be less than **two-thirds of the woman's wage** prior to taking leave

The Maternity Protection Recommendation, 2000 (No. 191) encourages states to raise the level of the maternity benefit to the full amount of the women's previous earnings, or at least the portion of such earnings that are taken into account in computing benefits.

The Conventions do not contain explicit definitions of previous earnings and countries have defined such earnings in different ways. For example, in Iceland, the percentage is applied to the worker's average wage during a 12-month consecutive period ending two months prior to the first day of the maternity/paternity leave. In Senegal, the rate of 100 per cent is applied to the daily wage received on the last pay day, including allowances directly related to the nature of the work. Different methods for calculating and providing cash benefits are summarized in **Table 7.1**.

Table 7.1
Types of Cash Benefit Provision

	Provided by employer	Provided by third party
Flat Rate	Employers can either provide these benefits directly or pay for a private insurance.	This can be social insurance or private insurance, on a voluntary or compulsory basis.
Scaled		
Depending on Salary		

In the simplest case benefits are provided at a flat rate, which is a uniform benefit for all beneficiaries that can possibly be related to the minimum wage. In this case, the replacement rate tends to be very low. In systems where contributions are paid depending on the level of income, flat rate benefits are likely to penalize the income replacement rate of women with higher salaries. On the other hand, this type of benefit is easy to administer, it may serve as a step toward strengthening and extending social security in challenging economic and labour market contexts, and may be an effective way to reach vulnerable workers (see **Box 7.5** for an example of a flat rate benefit for vulnerable populations in Argentina).

Box 7.5 Cash Benefits in Argentina

In Argentina, Decreto Nº 406/2011 set up a new social protection programme, the Pregnancy Universal Allowance for Social Protection (*Asignación Universal por Embarazo para Protección Social*), which provides that pregnant women from the 12th week of pregnancy until delivery or miscarriage have access to cash benefits. The conditions to receive the benefit are: being unemployed, having contributed to social security and not receiving any other benefits, or working in the informal sector with a salary below the minimum wage. The beneficiary must be a legal citizen of Argentina or a legal resident. The benefit consists of a monthly cash benefit of 220 Argentine Pesos (approximately US$50). The programme plans to cover about 180,000 women per year.

Source: Argentina, *Administración Nacional de la Seguridad Social*: **http://www.anses.gob.ar/prensa/noticia.php?id=213**.

A more sophisticated method is for benefits to be calculated based on a woman's past earnings and to be constant during the entire leave period. This is the most common way of calculating cash benefits, and in these cases it is easy to verify that the payment reaches the required level of two-thirds of past earnings. The period of calculation may be for example, the salary earned over the past 12 months, but it can be shorter (e.g. three or six months of employment, or a number of weeks during a number of previous months). The level of the benefit can be capped (which has a digressive effect in relation to the salary), or minimum benefits can be paid to support low-income earners.

Another option is that the amount paid is scaled (e.g. higher at the beginning than at the end of the leave period). The few countries that follow this method include: Albania (80 per cent of previous earnings during the first 150 days and 50 per cent for the last 215 days); Belgium (82 per cent for the first 30 days and 75 per cent up to a ceiling for the remaining 11 weeks); Thailand (100 per cent for the first 45 days and 50 per cent over the last 45 days); and the United Kingdom (six weeks paid at 90 per cent, weeks seven to 39 paid at a flat rate, and weeks 40 to 52 unpaid).[39]

The fact that countries use different methods for calculating cash benefits makes it difficult to assess what proportion of countries are in compliance with the standard of replacing two-thirds of a woman's previous income for at least 14 weeks, as set out by

[39] ILO: *Maternity at work: A review of national legislation*, Findings from the ILO Database of Conditions of Work and Employment Laws, Second Edition (Geneva, 2010d), pp. 96-99.

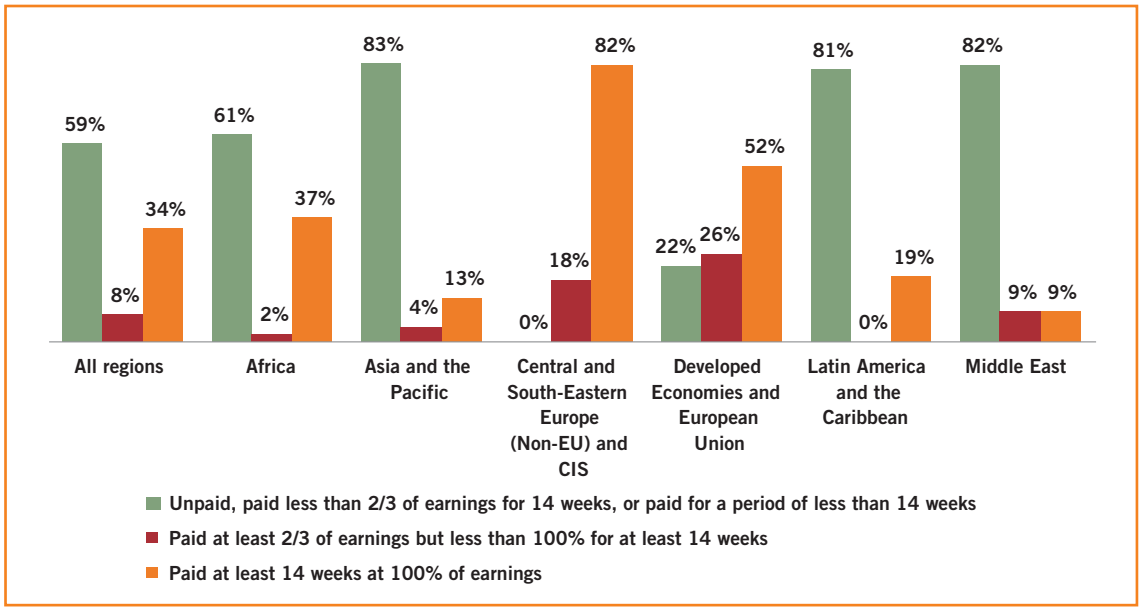
Convention No. 183. **Figure 7.3** summarizes the percentage of countries by region according to this standard.[40]

Just 30 per cent of countries globally meet the standards set out by Convention No. 183, the majority of them in developed economies, in the European Union (EU), in Central and South-Eastern Europe and in CIS countries. Regional trends in the provision of benefits vary.

Nearly all **African** countries calculate maternity benefits as a percentage of prior earnings. Of 50 African countries studied, 39 per cent provided at least two-thirds of earnings for 14 weeks. Among the remaining countries that did not provide at least two-thirds of earnings for 14 weeks, some paid 100 per cent of prior earnings but for a period of less than 14 weeks. Others provided at least 14 weeks of maternity leave but with lower levels of compensation.

All but two of 23 studied countries in **Asia and the Pacific** provided benefits as a percentage of prior earnings; only two provided at least two-thirds of earnings for 14 weeks. Among the remaining countries, a large number provided full earnings during maternity leave, but for less than 14 weeks. Among the 13 **Central and South-Eastern Europe (non-EU)** and **CIS** countries, 82 per cent exceeded the duration and payment standards in Convention No. 183.

Figure 7.3
Cash benefits and leave duration, by region, 2009 (157 countries)



Note: Figures may not add up to 100 per cent due to rounding.
Source: ILO, 2010d, op. cit.

Many of the 27 **Developed Economies** and **EU** countries also met the standards of Convention No. 183 on both dimensions, with 78 per cent of countries meeting or exceeding the standards. Roughly one in four (22 per cent) of these countries provided lower cash benefits than Convention No. 183 calls for.

[40] The figure excludes 15 countries which cannot be adequately assessed against the two-thirds replacement standard, because they pay flat rates or place limits on cash benefits.

Thirty-one out of 32 **Latin American and Caribbean** countries calculated benefits as a percentage of earnings. One country used a flat rate plus a percentage of prior earnings. Among the Latin American countries, 22 per cent met or exceeded the standards on duration and level of pay. Many of the remaining countries provided at least two-thirds of earnings but for less than 14 weeks.

Among 11 **Middle Eastern** countries, all calculated benefits based on prior earnings. Two of these countries met the ILO standards. Nearly all of the remaining countries provided 100 per cent of earnings but for fewer than 14 weeks.

Between 1994 and 2009, there has been notable progress in improving lengths of maternity leave and payment levels. For example, the level of payment during maternity leave increased in 17 countries during this time and the number of countries not providing any cash benefits during maternity leave declined from seven to five. There are, however, a few countries in which the level of payments has decreased.

It is important to note that access to maternity cash benefits may be restricted by certain eligibility or qualification criteria. Qualifying periods are a means of guaranteeing the financial sustainability of a scheme by limiting the costs of abuse due to "adverse selection", that is to avoid attracting a high percentage of members who may join a scheme in anticipation of an impending pregnancy. Recognizing the challenge of adverse selection, Convention No. 102 allows governments to set qualifying periods "to the extent necessary to preclude abuse" (see **Box 7.6**). Convention No. 183 strikes a similar balance, also allowing qualifying conditions, but only if they can be satisfied by a large majority of women covered by the Convention.

Box 7.6 Qualifying periods under ILO Conventions

C102	C183
Allows the setting of a qualifying period but only so long as considered necessary by national authorities to preclude abuse.	Requires that the conditions set to qualify for cash benefits should be such that they can be satisfied by the large majority of women to whom the Convention applies.

Some countries also limit benefits depending on the number of children, in efforts to either limit the costs of the scheme, as an instrument to influence family planning, or to try to ensure that access to maternity benefits does not encourage higher birth rates. For example, in the United Republic of Tanzania, the Labour Act provides maternity leave only for four births per woman; and the National Social Security Fund will pay maternity benefits only once every three years. In the Philippines, cash benefits are provided for up to four deliveries or miscarriages.[41] However, there is little hard evidence that the extent of maternity benefits affect a woman's decision to have a child. Such decisions tend to be influenced more by the availability of contraception as well as social expectations related to marriage and the optimal number of children. The ILO Committee of Experts on the Application of Conventions and Recommendations has highlighted the need to ensure full maternity leave, irrespective of the number of previous children.[42]

41 ILO Database of Conditions of Work and Employment Laws, available at: www.ilo.org/travail.

42 ILC Observation of the Committee of Experts on the report by the government of Sri Lanka on the application of Convention No. 103 Geneva 2004.

The ILO benefit standards described apply to women in dependent work (i.e. women who are in an employment relationship, either typical or atypical). They do not apply to women in self-employment, which is in fact the most common work situation in developing countries. For self-employed women, the most relevant international guidance comes from the SPF initiative, described earlier (see **Figure 7.1** and related text). Here, as part of the set of essential guarantees during working age set out in the 2011 ILC Conclusions, the ILO calls for social transfers during "the last weeks of pregnancy and first weeks after delivery," set at a level that provides "minimum income security."[43]

Since the definitions of "minimum income security" and of "the last weeks of pregnancy and the first weeks after delivery" are left to governments, it should be mentioned that the length and amount of maternal cash benefits have an impact on the probability of households falling into poverty. This might also be useful when defining the benefit package and choosing the most suitable financing mechanism. Useful reference points for setting these parameters could be the median cost of a birth in a hospital or other health facility, the national minimum wage, the national poverty level and the internationally recognized threshold for extreme poverty (i.e. US$1.25 per day).

Financing

Standards and principles

ILO Conventions assign the responsibility for sound financing of social security to governments. This responsibility entails both monitoring of schemes' financial reserves and commissioning regular actuarial valuations to predict future balance between benefits and available resources.

In addition, both Conventions No. 102 and 183 call for the financing of maternity benefits to be **collective**. This means that the resources of a group should be pooled and used to pay benefits to all members. See **Box 7.7**.

Box 7.7 Financing maternity protection under ILO Conventions

C102	C183
The cost of benefits and administration shall be borne **collectively by way of insurance contributions or taxation or both** .... (Article 71).	Benefits in respect of leave shall be provided through **compulsory social insurance or public funds,** or in a manner determined by national law and practice. An individual employer shall not be individually liable for the direct cost of any such monetary benefit to a woman employed without that employer's specific agreement except where: a) such is provided for in a national law or practice in a member state prior to the ILO's adoption of this convention; or b) it is subsequently agreed by a government and the representative organization of workers and employers (Article 6, Paragraph 8).

[43] ILO, 2011a, op. cit., para. 20(h).

Recommendation No. 191 goes further, specifying how a collective resource pool should be comprised. It states:

Any contribution due under compulsory social insurance providing maternity benefits and any tax based on payrolls which is raised for the purpose of providing such benefits, whether paid by both the employer and the employees or by the employers, should be paid in respect of the total number of men and women employed, without distinction of sex.

(Paragraph 4)

In this way, the Recommendation ensures a broad pooling of resources that avoids adverse selection and ensures fair distribution of the costs and responsibilities for reproduction.

Financing mechanisms around the world

Social insurance covers workers in the formal economy and provides medical care and replacement wages for income lost due to childbearing. In most countries, social insurance benefits are financed by worker and employer contributions, sometimes with a government subsidy (see **Box 7.8**).[44] Employers usually play a role in administration (i.e. collecting and transmitting contributions to the social insurance institution and informing it of the identity and wages of insured workers). Maternity benefits are often provided along with, or as part of, another social insurance scheme, such as sickness, health insurance, unemployment compensation, or employment injury and disease benefits.

The principle of solidarity in financing maternity benefits is inherent in earnings-related contributions. In general, a national social insurance programme aims at a triple cross-subsidization: from healthy to ill individuals, from high- to low-income persons, and from single persons or small families to larger families.[45] Individual health risks (e.g. pre-existing conditions, age and gender) should not influence the level of contributions, nor should they inevitably lead to exclusion from protection. Under this arrangement, it is typical that all workers, including men, pay contributions to finance maternity benefits, as set out in Paragraph 4 of Recommendation No. 191. Finally, the principle of solidarity in financing maternity benefits is also essential to promote non-discrimination at work, preventing employers from bearing the direct cost of maternity benefits, as it occurs in employer liability schemes.

[44] ILO: *Introduction to social security* (Geneva, 1984), p. 4.

[45] M. Cichon et al.: *Modelling in health care finance: A compendium of quantitative techniques for health care financing* (Geneva, ILO, 1999), pp. 51-52.

Box 7.8 Social insurance cash benefits for maternity in Namibia

All Namibian women who work for an employer for at least two days per week are covered by the national Maternity, Sickness, and Death (MSD) scheme. Benefits are financed by a mandatory contribution of 1.8 per cent of wages up to a ceiling, of which 0.7 per cent (0.35 per cent each from employer and employee) fund maternity cash benefits. All covered employees, including men, must pay the contribution. Voluntary coverage of the self-employed is possible, in which case the worker must pay the entire 1.8 per cent contribution. To qualify for a cash maternity benefit, a woman must have made prior contributions for at least six months and take maternity leave. The benefit equals 100 per cent of her previous wage up to a ceiling. Payments generally extend for 12 weeks, four weeks before giving birth, and eight thereafter. In 2007, the MSD Fund paid over 5,000 maternity claims, with the benefit amount averaging 3,670 Namibian dollars (about US$500).[46]

Source: Namibian Social Security Commission, http://www.ssc.org.na/ [accessed 13 Sep. 2011].

Shared contributions between employers and employees jointly funding maternity benefits are the most common pattern in the vast majority of countries, both developed and developing (e.g. Algeria, Belize, Cyprus, Greece, France, Lithuania, Morocco, Pakistan and Tunisia).[47] Maternity insurance schemes funded solely by employers' contributions are rare, but still can be found in countries such as Peru, where only public and private sector employers contribute to the maternity fund.[48]

There are some countries in which the state pays a specific percentage of the insurable wages, as a supplementary contribution. This practice aims to protect low-income employees and/or employers of small and medium enterprises.

Tripartite funding of maternity insurance schemes through contributions paid by employers, employees and government are very rare but can be found in certain countries like Honduras and Mexico.[49]

Special arrangements apply to **self-employed women**, for whom there are four possible scenarios:[50] 1) they are excluded from compulsory and voluntary coverage; 2) they are entitled to compulsory coverage; 3) voluntary affiliation to the social insurance system is available for them; 4) they are eligible for special insurance systems.[51] In some countries where the social insurance coverage has been extended to the self-employed, these workers are required to pay both the employer and employee contributions. To alleviate the financial burden for low-income self-employed workers, some governments subsidize such programmes or require certain categories of self-employed workers to make only a minimum flat-rate payment or premium.

46 To put the number of beneficiaries into a national perspective, Namibia has 48,000 births per year.

47 United States Social Security Administration (SSA)/ISSA: *Social Security Programs throughout the World*, 2011, http://www.ssa.gov/policy/docs/progdesc/ssptw/ [accessed 15 Sep. 2011].

48 SSA/ISSA, 2011, op. cit.

49 SSA/ISSA, 2011, op. cit.

50 Ibid.

51 "Special social insurance system" is an insurance scheme, mostly regulated and supervised by the State, regulated by a special law. The contribution rates in these special systems are usually different from those rates applicable to formal employees in the private sector.

Box 7.9 Extending social health insurance to the self-employed

Under the social insurance programmes of Cyprus and the Libyan Arab Jamahiriya, coverage of self-employed female workers for maternity benefits is compulsory. In Libya, the government pays a complementary contribution on behalf of the self-employed, whereas the self-employed are required to pay both the employer and employee contributions in Cyprus.

In France, self-employed workers are covered under a special social insurance system whereby the government assigns the revenue from certain taxes to subsidize the sickness and maternity benefits of the general population. In Mexico, voluntary affiliation is possible and the government pays a complementary contribution on behalf of the self-employed.

Source: SSA/ISSA, 2011, op. cit.

Individual employer liability schemes place liability for providing cash maternity benefits on individual employers (see **Box 7.10**). Some governments require employers to purchase private insurance to ensure their fulfilment of this obligation.

Box 7.10 Individual employer liability for maternity cash benefits in Malaysia

In Malaysia, working women are entitled to 60 days of maternity leave with full pay. The law covers employees thus excluding the self-employed, and places responsibility for payment on the employer of the individual worker. To qualify, a woman has to be employed at any time during the four months prior to childbirth and for a period of not less than 90 days in the nine months prior to her confinement. An employee is not eligible for cash benefits if she already has five or more surviving children.

Source: ILO Database of Conditions of Work and Employment Laws.

Social assistance schemes base benefit eligibility on some level of financial need on the part of the woman (or her household). It is not necessary that the woman is, or was previously, an employee and no previous contributions are necessary, though means tests are usually applied. Social assistance is typically financed by public funds (i.e. state general revenues and/or earmarked taxes) and administered by governments alone, often at the local level. In national laws and social protection programmes, cash benefits for social assistance are generally flat rate and lower than those provided by social insurance. Some conditionality related to the recipient's behaviour may apply (e.g. the mother may be required to undergo regular medical check-ups during pregnancy or to give birth in a health facility). For more on such conditional cash transfer schemes (CCTs), see "Financing mechanisms" under "Medical benefits", later in this module.

Convention No. 183 asserts that eligible women shall be entitled to adequate benefits out of social assistance funds, subject to the requisite means test, when they do not meet the conditions to qualify for cash benefits of social insurance (Article 6, Paragraph 6). The ILO Committee of Experts on the Application of Conventions and Recommendations (CEACR) has indicated that Convention No. 183 "*requires social assistance benefits to be of an adequate level and to allow for the needs of the mother and her child to be met throughout the period of leave provided for in the Convention, namely 14 weeks*".[52]

[52] CEACR: Individual direct request concerning Maternity Protection Convention, 2000 (No. 183) Cuba (ratification: 2004) Submitted: 2008.

Box 7.11 Social assistance benefits for maternity in Brazil

The *Bolsa Familia* programme makes conditional cash transfers to 11.3 million Brazilian families, or one-fourth of the population, at a cost of US$4.5 billion, or 0.4 per cent of GDP in this upper middle-income country.[53] About 93 per cent of recipients are female and 27 per cent are single mothers. Payments are conditional on pregnant women undergoing prenatal and postnatal tests and parents sending children to school and getting them vaccinated.

The eligibility threshold is set at approximately one-fourth of the minimum wage, or 40 per cent of the urban poverty line. An extremely poor family receives a monthly amount ranging from the local equivalent of US$27–79, while poor households receive US$17–52. Evidence shows that the programme has significantly reduced poverty and raised the social status of poor women.

Source: ILO: Bolsa Familia *in Brazil: Context, concept, and impacts* (Geneva, 2009).

Universal benefits are available to all women who are citizens or residents of a country and meet certain requirements, such as being pregnant, without prior paid contributions. Like social assistance, benefits tend to be lower than social insurance, are financed from state budgets, and are administered by either national or local governments alone. In contrast to social assistance, there is no means or income test.

Box 7.12 Cash benefits and universal medical benefits in New Zealand

The state finances a cash maternity benefit for all women residing in New Zealand who have worked for the same employer for at least six months (at least ten hours per week, including at least one hour per week, or 40 per month). The benefit, which applies to the birth or adoption of a child, replaces 100 per cent of prior wages or up to a prescribed ceiling. It extends for 14 weeks, the duration of statutory maternity leave.

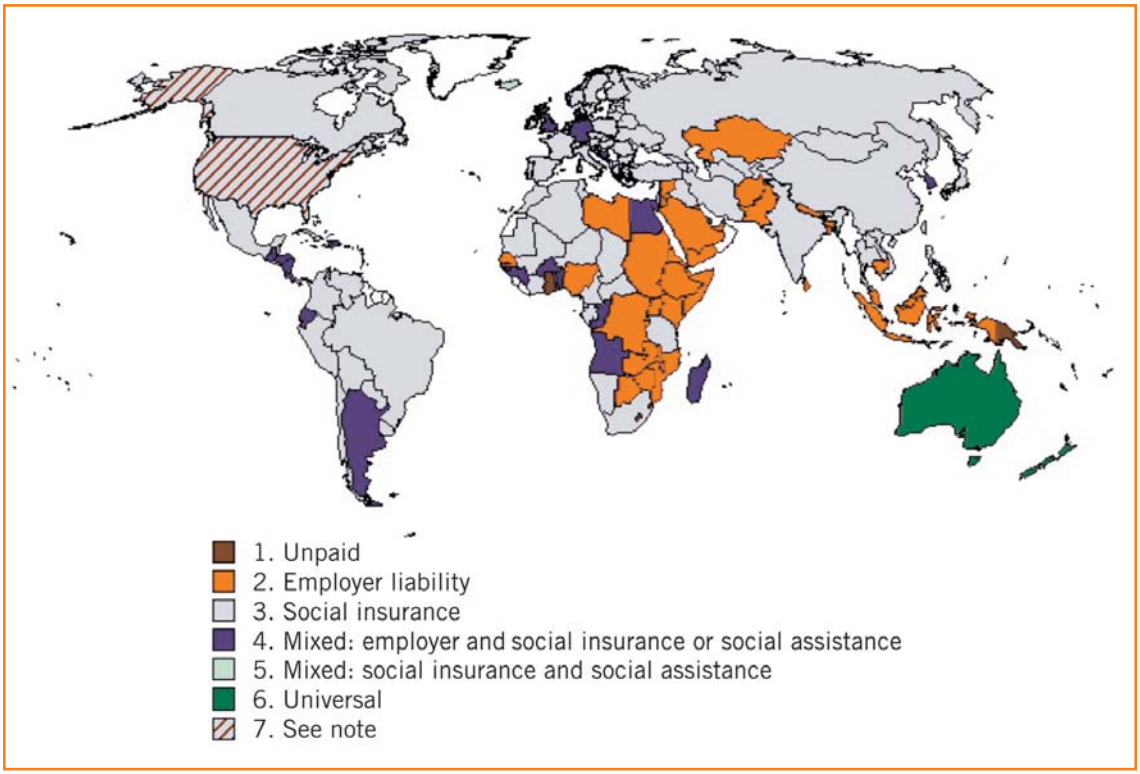
The state also finances universal medical care for maternity through the public health system. For citizens of New Zealand and residents of two or more years, most medical services for maternity are free of charge.

Source: SSA/ISSA: *Social Security Programs throughout the World*, 2008 http://www.ssa.gov [accessed 20 Sep. 2011].

[53] According to the World Bank's *World Development Indicators*, http://data.worldbank.org/data-catalog/world-development-indicators, in 2009 Brazil had a per capita gross national income (GNI) of US$ 8,040.

Figure 7.4 shows the scope and types of cash maternity benefits that exist in 180 countries for which information is available.[54]

Figure 7.4
Cash maternity benefits, by legal provision, types of programme and by country (2009)



Source: ILO, 2010a, op. cit.[55]

As can be observed from **Figure 7.4**:

- just over 50 per cent of countries provide maternity benefits as social insurance;
- in about one-quarter of countries, such protection is provided by individual employers;
- a few countries have designed maternity protection as social assistance or universal payments; and
- a few countries require employers to provide maternity leave only, with no cash or medical benefits.

[54] Fifteen countries are excluded for lack of information.

[55] In the United States, there is no national programme. Under the Family and Medical Leave Act, maternity leave is unpaid as a general rule; however, subject to certain conditions an employee may choose or an employer may require the employee, to use accrued paid leave (e.g. vacation, personal leave, medical or sick leave or paid medical leave) to cover some or all of the leave that he/she is entitled to under the Act. A cash benefit may be provided at the state level. For example, since 2004 in California, female and male employees have been entitled to receive up to 55 per cent of their salary for six weeks to take care of a newborn or adopted child. This is financed by a 0.08 per cent increment in the state disability insurance contribution which is deducted from employee paychecks.

Many countries combine these approaches, as shown below.

A note on employer liability schemes

It is worth re-emphasizing the importance of maternity cash benefit schemes funded through public funds or insurance contributions, which are based on the principles of solidarity and on the pooling of responsibility. Employer liability schemes do not meet these standards, obliging individual employers to pay wage replacement directly during the maternity leave period.

According to worldwide experience, employer liability schemes work against the interests of women workers, as employers may be reluctant to hire women who are pregnant or may seek to find reasons to discharge pregnant employees in order to avoid paying the costs of wage replacement during the maternity leave period. In many cases, this simply means not hiring women of childbearing age at all. Moreover, compliance with individual employer liability schemes is often problematic, particularly in developing countries, where employers often do not pay the wage replacement and legislation is not enforced. Individual employers' liability can also impose an excessive cost on small enterprises. In this respect, employers' liability schemes have long been viewed as detrimental to the promotion of equal treatment for men and women in the labour market.

Over the last 15 years there has been a shift away from employer liability systems to finance maternity benefits. The percentage of countries that finance cash benefits through employer liability systems decreased from 31 per cent in 1994 to 26 per cent in 2009. Jordan is an example of such a recent shift from an employer liability to a social security system (**Box 7.13**).

Box 7.13 Shifting from employer liability to maternity insurance in Jordan

In 2010, **Jordan** moved from an employer liability system to a maternity insurance scheme following the creation of a new social security branch within the framework of the social security law reform. This new scheme covers all private sector employees, including those working in small enterprises of less than five employees, and provides cash benefits in the case of maternity at the level of a woman's previous earnings for a period of 12 weeks, in line with Convention No. 102.

Source: ILO: *Social Security and the rule of law – General survey concerning social security instruments in light of the 2008 Declaration on Social Justice for a Fair Globalization*, ILC, 100th session (Geneva, 2011f), paras. 304, 312.

Table 7.2 summarizes the different financing mechanisms for statutory maternity cash benefits and compares their key characteristics in terms of financing source, distribution of responsibilities and risks, benefits determination and eligibility for coverage.

Table 7.2
Key characteristics of financing mechanisms for statutory maternity cash benefits

	Social insurance	Universal schemes	Social assistance	Hybrid systems (Social + employer liability)	Employer liability
Financing source	Contributions	Taxation	Taxation	Financing maternity benefits shared between social security and the employer. The percentage required of each party varies according to national legislation	Financed directly by the employer
Distribution of responsibility	Pooling of risks and finances	Redistributive	Solidarity		Individual employer provision
Benefits provided	Prescribed in social security law	Flat-rate	Discretionary (means-tested)		Benefits prescribed in labour law or collective contracts
Eligibility	Based on employment contribution history	Based on residence or citizenship	Based on need		Based on continued employment relationship between individual employer and employee

Source: A.T. Carrion: *Information guide on setting-up, financing and administering maternity protection schemes* (Geneva, ILO, 2007), unpublished.

Extending and improving coverage and benefits

Despite the lack of access to cash benefits for income replacement during maternity in many countries, there are notable efforts to incorporate maternity cash benefits into existing social security systems, or to find innovative ways to extend benefits to more women. To this end, a body of best practices is emerging. Examples of this include extending social security through voluntary membership in El Salvador (**Box 7.14**), a provincial scheme in China (**Box 7.15**), the efforts of a social providence fund in Burkina Faso (**Box 7.16**), supported by the Danish International Development Agency (DANIDA) and the ILO, to incorporate a maternity benefit for women, and a community-based health insurance scheme in Cambodia (**Box 7.17**) that incorporated a safe motherhood programme and a cash maternity grant into its benefits package. This last example received assistance from GTZ (German Agency for Technical Cooperation), the WHO and the ILO.

Box 7.14 Extending social security through voluntary membership in El Salvador

In July 2010, the government of El Salvador launched a national campaign to extend social security coverage to domestic workers. The new scheme includes the provision of maternity cash benefits at 100 per cent of the insured salary for 12 weeks, plus access to out-patient health-care services for the worker and her/his children up to the age of 12 years. The scheme is based on voluntary monthly contributions by both the worker (US$7.27) and the employer (US$21.80) and provides income tax breaks for employers in order to promote take-up rates. The goal of government is to extend maternity protection benefits to uncovered domestic workers, with the aim of covering up to 27,000 domestic workers in five years (25 per cent).

Source: ILO*: Decent work for domestic workers,* Report of the Committee on Domestic Workers and Statement of El Salvador Representative, ILC, 99th session (Geneva, 2010e).

Box 7.15 Maternity insurance scheme and its coverage in China

In China the *Social Insurance Law of the People's Republic of China* was issued in 2010 and came into force in July 2011. A general policy entitles female workers to 90 days of maternity leave. In 2007, provincial maternity insurance policies were developed in Hebei and Guangxi provinces in order to pay maternity leave and reimburse health care during maternity. In 2009, the All China Federation of Trade Unions (ACFTU) undertook a survey of the new system to evaluate progress and problems. The survey found higher maternity insurance coverage among state-owned enterprises and employers with well-established employment systems, while coverage was lower in the informal employment sector and among migrant workers. The survey also called for a more prominent role for funding systems based on solidarity and increased government funding, instead of relying on employers to take full responsibility for the cost of maternity insurance.

Source: ACFTU: *The Survey of Workers' Maternity Insurance in China (Hebei and Guangxi*), (Dept. of Female Workers, Sep. 2009).

Box 7.16 Social providence fund, Burkina Faso

Salissa is a market gardener and a young mother. Her second child is four weeks old. Just 10 days after giving birth, she was already at work doing 10 hours of gardening per day. She has no right to maternity leave and no alternative if she wants to feed her family. In Burkina Faso, 80 per cent of the economically active population works in the informal economy. For these women like Salissa, maternity leave remains a luxury enjoyed only by the few women with social security coverage.

However, this is set to change with the formation of the new national union of fruit, vegetable and associated workers, SYNATRAFLA. This is part of a project carried out by trade unions in the country to create five sectoral trade unions in the informal economy, with the support of the ILO and DANIDA.

As a member of the union, Salissa will benefit from the Social Providence Fund for Informal Economy Workers (MUPRESSI), established under the project, which extends social coverage for health care and occupational diseases. The fund is set to include paid maternity leave benefits after surveys of members identified this as a priority. As a result, other new mothers like Salissa will be able to realize their rights to maternity leave.

Source: International Trade Union Conference website **http://www.ituc-csi.org** [accessed 20 Sep. 2011].

Box 7.17 Improving maternity cash and medical benefits in Cambodia

Incorporating maternity cash grants into community based health insurance (CBHI) under Providing for Health (P4H). P4H, comprised of the WHO, the ILO, the World Bank, Germany and France, is an initiative aiming to support countries with the development of social health protection systems to achieve universal coverage, protect against out-of-pocket payments and increase effective access to health services. The ILO, one of the lead agencies, has been active in improving maternity protection at work in Cambodia for many years and in promoting maternal benefits in insurance schemes in the context of P4H.

Although maternal mortality has declined, the World Bank estimate for Cambodia of 290 maternal deaths per 100,000 live births in 2008 is still one of the highest in the region. Also, as of 2005, only 44 per cent of deliveries were attended by skilled health staff.

The Social Health Insurance Master Plan, launched by the Cambodian government in 2005, lists maternity as one of the contingencies to be covered by compulsory social health insurance for formal sector workers. The master plan also gives clear recommendations for CBHI schemes to develop a safe motherhood programme entitling women to access all maternity services under the condition of adherence to a specific mother and child protocol.

In this context, the ILO together with the P4H partner GTZ, has provided technical assistance for the development of a safe motherhood programme, which was included in the benefit package of the community-based health insurance scheme SKY (Health to our Families) in 2006. The extensive programme covers antenatal care, referral of high-risk pregnancies, medically necessary abortions and post-abortion care, (caesarean section) deliveries, referral to family-planning services, essential drugs, micronutrients and advice on nutrition, including the promotion of exclusive and continued breastfeeding, postnatal care, and referral to immunization services for the newborn. Furthermore, the Safe Motherhood Programme entails a maternity grant of US$15 per month for three months following delivery as an incentive to mothers to fully comply with the safe motherhood protocol. Until the CBHI is financially sustainable and the cash grant can be included in the premium contribution, the grant is subsidized by GTZ.

Improving maternity benefits in the private sector. As part of the programme Better Factories Cambodia, the ILO has also been promoting maternity protection at work. Particularly in the garment sector, the ILO has been supporting enterprises in improving maternity protection in line with the Cambodian Labour Law. This grants women the right to 90 days maternity leave, foresees only light work for women during the first two months upon returning to work after maternity leave, protects women from being laid off during maternity leave, and grants half the salary and benefits in cash as well as in kind, if the worker has been employed by the enterprise for one year. Educational programmes on maternity protection inform employees and employers about entitlements, as well as specific issues of mother and child health, and the respective benefits for both sides. While maternity benefits provide protection for working women's health and from losing their jobs, employers benefit from a healthier workforce, less health-related absence from work and less attrition. Such work programmes have resulted in significant improvements in participating enterprises. Some important achievements include the provision of childcare at the workplace and the entitlement of working mothers to one hour per day to breastfeed their child.

Sources:
ILO: *Decent Work for Women and Men in the Informal Economy: Profile and Good Practices in Cambodia.* (Bangkok and Phnom Penh, 2006).
ILO/Better Factories Cambodia: *Seventeenth Synthesis Report on Working Conditions in Cambodia's Garment Sector* (Cambodia, Oct. 2006).
ILO Sub-regional Office for East Asia: *Cambodia: Sky Health Insurance Scheme,* Social Security Extension Initiatives in East Asia (Bangkok, 2008).

Medical benefits[56]

Context and coverage

Nearly one-third of the world's population has no access to any health facilities or services at all. For many more, private out-of-pocket (OOP) health care expenditures often prove financially catastrophic, due to the lack of adequate social health protection that would cover or refund such expenditure.[57] The risk is particularly high for maternity-related costs.

During pregnancy, OOP payments and indirect costs (e.g. transportation) required for maternal and obstetric services exclude many women from access to appropriate care. Maternity care may not only be expensive for poor households (see **Box 7.18**), but may also be a low priority in the use of scarce household resources. The decision about which family member warrants OOP spending, particularly when the costs of care are high and unpredictable, creates another barrier in access to timely maternity care. The problem is exacerbated by the fact that in many poor households, health care for men and boys is generally prioritized over health care for women and girls.[58]

[56] Major parts of this section originate from:
E. Fultz, 2011, op. cit.
ILO, 2010a, op. cit., Chs. 3 and 6.
—: Strategy towards universal health care.

[57] ILO, 2010a, op. cit., pp.1–2.

[58] ILO, 2007, op. cit., p. 28.

Box 7.18 Maternity expenditure where health protection is not widespread

Nepal. For Nepal's poorest families, a normal delivery in a hospital costs well over three months' household income, while a home delivery still costs up to 36 per cent of monthly income. More than one out of five women who delivered at home cited cost as the main reason for not going to a hospital.

Bangladesh. While the median cost of a normal hospital delivery in Bangladesh costs just two per cent of annual income for poor households, a caesarean section consumes approximately 21 per cent. In the case of birth complications, costs can increase by a factor of two.

India. In a study conducted in a Mumbai slum, maternity and delivery costs were considered to be catastrophic (i.e. more than 40 per cent of annual non-food expenditure) for 41 per cent of survey respondents.

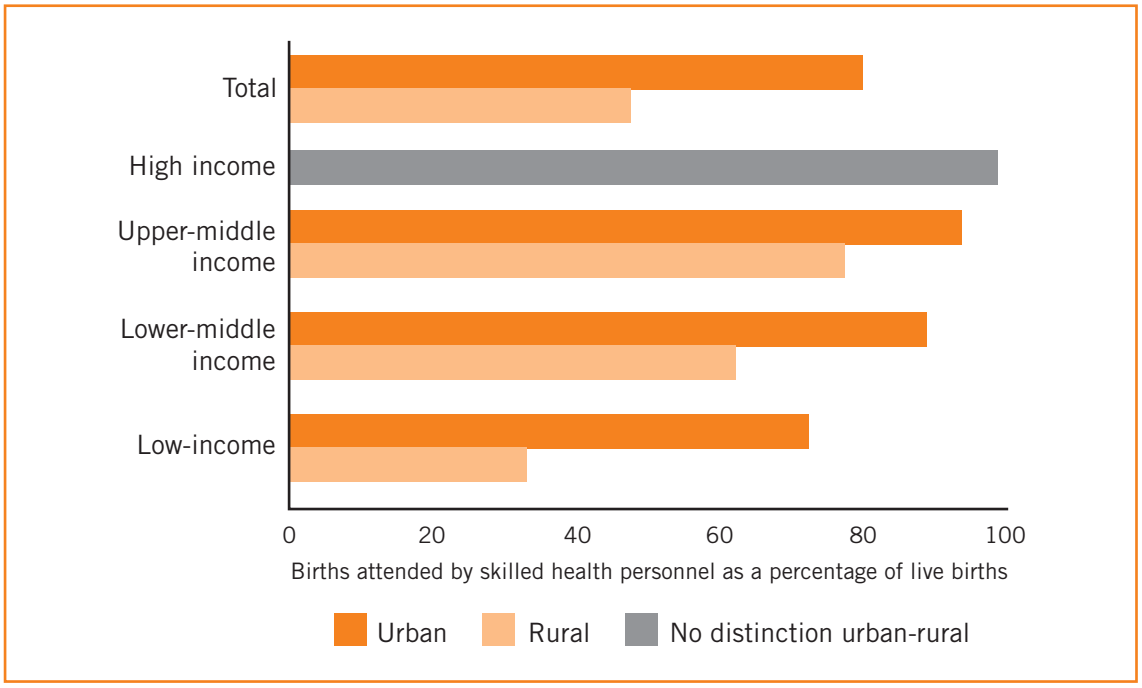
Sources:
Borghi et al., 2006, quoted in ILO, 2007, op. cit., p. 12.
M.N.U. Khan et al.: "Household costs of obtaining maternal and newborn care in rural Bangladesh: Baseline survey", *BRAC Research and Evaluation Division Research Monograph Series*, No. 43 (Dhaka, BRAC, 2009).
Skordis-Worral et al.: "Maternal and neonatal health expenditure in Mumbai slums (India): A cross sectional study", in *BMC Public Health* (2011, Vol. 11, No. 150).

Most countries show significant inequities in access to maternal health care as a result of place of residence, as illustrated in **Figure 7.5**. It shows inequities between urban and rural areas in countries at different levels of income. In lower-income countries, differences between rural and urban areas in terms of greater access to maternal health services, are much greater than in higher-income countries (a ratio of 3.3 as opposed to 1.7). Gaps in financial protection[59] and poor availability of quality services, with qualified staff working in decent conditions, and modern and functional medical equipment and supplies, are among the core reasons for the under-utilization of health services in developing countries.

In addition, low levels of female literacy and subsequent poverty or unemployment create financial barriers for women to access health care independently of their families. In many countries, the female unemployment rate is much higher than for men, which points to a high degree of women's dependency. In particular, women are often not able to acquire or spend the necessary financial resources for health care and instead have to depend on their husbands or families.

[59] **Financial protection** aims to address risks of impoverishment due to catastrophic health events and the capacity to finance any kind of OOP payments: those to be paid directly to providers, for example user fees or co-payments required by health insurance arrangements, other direct payments for health services and goods, and related costs such as the transport necessary to reach health-care facilities, particularly in rural areas. It is also important that financial protection prevents people from falling into poverty as a result of loss of income due to sickness.

Figure 7.5
Inequities in access to maternal health services*



Source: ILO, 2010a, op. cit., p. 69.

Consequently, extending and improving social health protection for women is an important strategy for increasing women's access to maternal health services. This requires an integrated approach towards the demand and supply of health care, the availability of health infrastructure and maternal health services, and the sector's own health workforce, employment opportunities and administrative capacity. Supply side factors to a large extent determine potential access to quality health-care services in a country. Echoing this need, a recent study of maternity protection in India concluded that *"Maternity protection … would only be fulfilled if the necessary health infrastructure were available and accessible … So policies and programmes have to go hand in hand with improved and accessible health infrastructures. This is linked to increasing the health budgets for health infrastructure."*[60]

This lack of physical access affects women in particular, since the main factors of maternal mortality are obstetric and unsafe abortion complications, both of which are avoidable through better access to good quality reproductive health care, antenatal care, skilled birth attendance and access to emergency obstetric care.

As shown in the following sections, a possible approach to address these barriers is to define essential health-care benefit packages that guarantee access to maternal health services for all women and include, at least, prenatal, childbirth and postnatal care by medical practitioners or by qualified midwives, as well as hospitalization when necessary.

[60] Tata Institute of Social Sciences: *Assessing the coverage and effectiveness of national efforts to provide quality maternity protection: A qualitative study in Uttar Pradesh, India* (Mumbai, 2010).

Benefits

Under both Conventions, medical benefits can be provided through insurance or the general health services, depending on the health system design in the country. **Box 7.19** provides examples of benefits included in the social security provisions of several countries.

Box 7.19 Maternity medical benefits

In **Egypt**, medical benefits include general and specialist care, surgery, hospitalization, maternity care, dental care, laboratory services, medicines, rehabilitation services, and appliances. Health services are provided by public institutions or other medical facilities under contract with the Egyptian Health Insurance Organization, which pays the benefits directly.

Medical services are normally provided directly to patients through the medical facilities of the Social Security Institute of **Guatemala**. Benefits include general, specialist, and maternity care, surgery, hospitalization, pharmaceuticals, laboratory services, X-rays, appliances, transportation and rehabilitation.

In **Uruguay**, collective medical assistance or mutual health institutions contracted by the Social Security Bank provide medical benefits. Medical services include prenatal and postnatal medical assistance, surgery, and pharmaceutical products.

Source: SSA/ISSA, 2011, op. cit.

The Maternity Protection Recommendation No. 191 (Paragraph 3), provides more detail on the quality of the minimum medical package. It calls, to the extent feasible, for:

- care by a general practitioner or specialist in a doctor's office, at home, in a hospital or other medical establishment;
- care by a qualified midwife or by another maternity service at home, in a hospital or other medical establishment;
- maintenance in a hospital or other medical establishment;
- any necessary pharmaceutical and medical supplies, examinations and tests prescribed by a medical practitioner or other qualified person; and
- dental and surgical care.

Financing mechanisms around the world[61]

Extending medical benefits throughout maternity is an important part of larger efforts to extend universal access to social health protection. A key challenge is financing health services, which is addressed in this section. Integrated approaches to address more than one of the population's health needs are preferable to those focusing on only one need. Given the urgency of reducing maternal mortality, the immediate and short-term needs related to maternity care are discussed later in this section.

There are various mechanisms for financing health services. These include: tax-funded national health services, vouchers and cash benefits (conditional or not), contribution-based

[61] Drawn largely from: ILO, 2008a, op. cit.

mandatory social health insurance; mandated or regulated private non-profit health insurance schemes (with a clearly defined role in a pluralistic national health-financing system comprising a number of different subsystems); and mutual and community-based non-profit health insurance schemes. These mechanisms normally involve the pooling of risks between covered persons – and many of them explicitly include cross-subsidizations between the rich and the poor. Some form of cross subsidization between the rich and the poor exists in all social health protection systems; otherwise the goal of universal access could not be pursued or attained.

Generally, the following resources may be used for funding.

Taxes

Social health protection may be funded from general government revenue such as direct or indirect taxes from various levels, including national and local taxes in addition to general or earmarked taxes. Direct taxes are normally levied on individuals, households and enterprises and may comprise property taxes, personal income tax and corporate profit taxes. Indirect taxes, on the other hand, are obtained from goods and services (e.g. excise or "sin tax" on the consumption of tobacco or alcohol products). Payments related to indirect tax are based on consumption and not on overall income. General taxes can be raised from different sources and therefore have a broad revenue base. Nevertheless, allocations for health care are normally subject to annual public spending negotiations. Hypothecated taxes earmarked for health may be less susceptible to political influence.

Often, taxes are used for various forms of social health protection funding. Besides financing national health services, vouchers, cash benefits or transfers (see **Boxes 7.20**, **7.21** and **7.22** for examples of conditional cash transfers), taxes are used as subsidies for mixed health protection schemes such as national health insurances. In this case government revenues are used to subsidize the poor (see **Box 7.20** for examples of tax funded and mixed schemes). In addition, government revenues may be used as subsidies for social health insurance, community-based and private health insurance. Subsidies may cover costs for the poor, deficits, specific services and start-up or investment costs.

Box 7.20 Examples of tax-funded national health services and mixed social health schemes

The **United Kingdom** has a national health service that provides medical benefits to all persons residing in the country, irrespective of nationality or the payment of contributions or income tax. It likewise includes short-term incapacity benefit, statutory sick pay, maternity allowance and paternity and adoption allowances. Through this tax-funded mechanism, the government covers 92 per cent of statutory maternity and paternity pay, a part of the statutory sick pay and most of the medical benefits under the National Health Service.

The **Philippines** has a health insurance scheme that combines public and private financing. For the non-poor, contributions are paid by employees, employers and the self-employed. For the poor, the contributions are paid by the state from general revenue. Currently, approximately 70 per cent of Filipinos are covered by Philippine Health Insurance.

Source: SSA/ISSA, 2006, quoted in ILO, 2008a, op. cit., pp. 13, 64.

Box 7.21 Conditional Cash Transfers (CCTs)

Some governments have established CCT programmes that base eligibility on certain behaviour. In recent years, CCTs have become popular in many national and local programmes, from Brazil to Ghana to New York City. Some of these schemes pay maternity benefits and others base family benefit payments on certain behaviour related to maternity. For example:

- In **Brazil**, *Bolsa Familia* requires pregnant women to submit to certain medical tests as a condition of receiving a social assistance payment.
- In **Ghana**, an ILO-sponsored CCT requires women to make use of pre and postnatal health services and to have a skilled delivery.
- **Nepal**'s Safe Delivery Incentive Programme has a similar requirement.
- In **Mexico**, the *Oportunidades* CCT makes benefits contingent on medical check-ups, including for expectant mothers.

On the positive side, CCTs may result in higher rates of desired behaviour; and they may win political support for a new or expanded scheme because they do so. On the negative side, CCTs are often criticized for being paternalistic and their success is contingent upon an adequate supply of desired services (i.e. doctors and nurses) which is often lacking in most developing countries.

Source: E. Fultz, 2011, op. cit.

Box 7.22 CCTs in India

The *Janani Suraksha Yojana* (JSY) is the oldest cash transfer scheme in India and its primary aim is to increase the rate of childbirth in institutions, a significant challenge in India, where home-based delivery is the norm for both economic and cultural reasons. JSY has been shown to increase coverage of antenatal care and the proportion of births taking place in health facilities. However, one implementation-related difficulty has been to ensure that women remain in the hospital for at least 24 hours to prevent maternal deaths immediately after delivery. Also, rates of early initiation of breastfeeding were extremely low. Finally, up-take was limited among the poorest households.

In view of these limitations, the Ministry of Health and Family Welfare launched a national cash transfer scheme, *Navjat Sishu Suraksha Yojana* (NSSY), in June 2011. The main components of this scheme are:

- to ensure that women delivering in hospitals stay at the facilities for three days to take care of mothers and newborn infants and reduce neonatal mortality rates and maternal deaths;
- free hospitalization and medical care of low birth weight and sick infants until one month of age.

In addition, the *Indira Gandhi Matritva Sahyog Yojana* (IGMSY) is a CCT pilot programme in 52 districts across the country. The main objective of IGMSY is to improve the health and nutrition status of pregnant and breastfeeding women and their infants by:

- promoting appropriate practices, care and service utilization during pregnancy, safe delivery and breastfeeding;
- encouraging women to follow optimal infant and young child feeding practices for the first six months;
- contributing to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and breastfeeding mothers.

Presently IGMSY reaches out to nearly 1.3 million pregnant and lactating mothers. On the fulfilment of certain conditions relating to optimal maternal or child care practices, a total of INR 4,000 (nearly US$100) is given to the mothers as partial wage compensation and as an incentive to promote self-caring behaviour.

Sources:
S. Lim et al.: "India's *Janani Sukaksha Yojana*, a conditional cash transfer programme to increase births in health facilities: an impact evaluation", in The Lancet (2010, Vol. 375, No. 9730, 5 June). D. Mavalankar et al.: "Saving mothers and newborns through an innovative partnership with private sector obstetricians: *Chiranjeevi* scheme of Gujarat, India", in the *International Journal of Gynaecological Obstetrics* (2009, Vol. 107), pp. 271-276.

Social health insurance

Contributions or payroll taxes are collected to fund social health insurance schemes,[62] which as a rule are related to wages or earnings, although flat rates are sometimes applied. Contributions are normally shared between employers and workers with, for example, state participation in the form of a supplementary contribution or other subsidy from the general revenue. (See also Financing Mechanisms under Cash Benefits for more details and examples).

The principle of solidarity in financing maternity benefits is inherent in earnings-related contributions. A national social insurance programme aims at a triple cross-subsidization: from healthy to ill individuals, from high- to low-income people, and from single people or small families to larger families.[63] Individual health risks (e.g. pre-existing conditions, age and gender) do not influence the level of contributions or do not inevitably lead to exclusion from protection.

Premiums

Premiums are collected by private insurance schemes, including community-based health insurance schemes and private commercial funds. Community-based schemes are usually voluntary and managed by organizations of informal economy workers, community based and non-government entities, cooperatives, trade unions and faith-based groups. Often, the premiums are flat-rate and services limited. Premiums for private commercial health insurance funds are usually voluntary and risk-based. People in high-risk groups pay more while those with lower risks pay less. Benefits and services vary depending on the insurance company and insured persons. See **Box 7.23** for more information and examples on community-based health insurance schemes.

62 ILO: *Introduction to social security* (Geneva, 1989), p.4.
63 M. Cichon et al., 1999, op. cit., pp. 51–52.

Box 7.23 Community-based health insurance

Community-based health insurance schemes are voluntary and non-governmental in character. They are financed by worker contributions, sometimes with a subsidy from a donor or, in a few cases, a government. The schemes cover specific groups – e.g. communities, cooperatives, self-employed vendors in a market. As membership is voluntary, these schemes must offer benefits that are sufficiently attractive to induce workers to join, and their contributions must be affordable for workers with low incomes. Most frequently this is basic health insurance, sometimes coupled with employment injury benefits or funeral benefits. Many micro-health insurance schemes cover some medical care for pregnancy and childbirth, but few provide cash maternity benefits. In those that do so, benefits are low.

In **India**, the Self-Employed Women's Association (SEWA) in the state of Gujarat began to offer a maternity benefit as part of a larger microinsurance scheme, known as VimoSEWA, in 1992. Under this scheme, women obtain insurance either by paying an annual contribution or making a fixed deposit; the interest on this pays the contribution. In return, the woman is provided with a benefit package that includes life, medical and asset insurance. As an incentive for women to pay by fixed deposit, members who do so are provided with "free" maternity benefits paid out of a fund established by GTZ. The maternity benefit consists of: (1) a small cash payment (Rs. 300); (2) antenatal care including weighing, iron, and folic acid tablets; and (3) information on nutrition and education, based on a local diet and household budget. The maternity benefit package is available to 250,000 women in India's informal economy, including hawkers, vendors, and home-based workers.

Source: World Bank: *World's progress on maternal health and family planning is insufficient*, World Bank News Broadcast (Washington, D.C., 2009), 9 July.

Out-of-pocket payments (OOPs)

Although they are often used as a source of funding, the ILO does not consider OOPs as a viable means to finance social health protection. They involve payments made directly to the health care providers at the point of delivery, are based on the services utilized and may be paid in full or partially subsidized. They may additionally take the form of direct payments, formal cost sharing or informal payments. Reference is made to direct payments when the consumer pays the full amount of health services not covered by any form of protection. Formal cost sharing (i.e. user fees), on the other hand, involves expenditures on health services which are included in the benefit package but are not fully covered in order to set incentives.

Each funding mechanism is characterized by specific forms of collecting funds, risk pooling and purchasing of health services. The **collection of funds** involves: an entity that pays (e.g. citizen, insured); a specific type or means of payment (e.g. taxes, contributions, and premiums); and an institution which collects the payment (i.e. the central, regional or local government); social security institutions; and private insurance funds or health providers. **Risk pooling** refers to the sharing of financial risks and accumulating funds for health services. The purchasing of health services involves the shifting of the funds to health service providers for, and on behalf of, the covered population.

Almost all countries have established systems based on multiple financing mechanisms that combine two or more of the mentioned sources of funding. The ILO explicitly recognizes the pluralistic nature of national health protection systems and advises the promotion of coordinated combinations of national financing systems that provide:

- universal and equitable access to health services;
- financial protection in case of sickness; and
- overall efficient and effective delivery of health services.

When striving to achieve universal social health protection, organizing and financing health protection are not enough in themselves; economic and social factors also play a pivotal role and attempts must be made to address poverty, support the formalization of the informal economy and create decent workplaces. Social health protection thus cannot be pursued in isolation; it is, and should always be seen as part and parcel of an overall national social protection strategy.

Furthermore, achieving universal coverage involves developing specific regulations and arrangements that focus on organizational efficiency including: purchasing and provider payments; distribution of resources and services across different categories of care and geographic areas; quality and the participation of social partners and civil society. The concrete nature of these related arrangements significantly impacts on the adequacy and availability of care, access to health services, and ultimately on the overall cost of the social health protection system. A key to achieving this is to engage in social and national dialogue.

Extending and improving coverage and benefits

Given the persistent lack of access to adequate maternal health care and the high reliance on out-of-pocket payments to finance it, approaches that improve access in the shorter term while building national health budgets in the longer term need to be found as a matter of urgency. A current trend in low-income countries is to increase the role of mutual health organizations and create voluntary and community-based schemes as a preliminary step to social health insurance. Maternal health care is increasingly part of these schemes. Success and sustainability depend on the benefit packages, the financial protection and quality of services.

A possible approach to address these barriers is to define essential benefit packages that guarantee access to health services. This was observed in 2007 in 55 out of 69 low- and middle-income countries.[64] The benefit packages provided through health protection schemes were reformed to be more equitable and effective, and to address the inherent conflicts between universality and progressive targeting, as well as between care rationing and quality. However, many of the reforms resulted in limited access to health care which is the key for achieving global health priorities, such as those established by the MDGs on maternal and child health care. They also missed adjustments to demographic and epidemiological changes, needs and perceptions and resulted in inefficiencies in the provision of services.[65] Countries where benefit packages have been successful have focused on integrated approaches without limiting packages to low-cost or very basic interventions (see **Box 7.24**).[66]

64 WHO, 2008, cited in ILO, 2010a, op. cit., p. 70.

65 Ibid.

66 ILO: *Extending social protection in the Asia-Pacific region: Progress and challenges*, paper presented at the Asia-Pacific Regional High-Level Meeting on Socially Inclusive Strategies to Extend Social Security Coverage, New Delhi, India, 19-20 May 2008b.

Box 7.24 Integrated packages for health services

In **Thailand**, a universal health-care scheme (UC Scheme or earlier known as the "30 Baht" scheme) was introduced in 2001 and provides access to health services for any Thai citizen who is not covered under the contributory health insurance scheme. The benefit package provides for a comprehensive range of health services, including ambulatory services, in-patient services, free choice of providers, maternal benefits, and prevention and rehabilitation benefits provided by public and private providers. As a result, overall legal coverage for health care in Thailand reached almost 98 per cent of the population in 2006–07, 75 per cent of which was guaranteed by the universal health-care scheme.

In **Ghana**, the benefit package of the National Health Insurance Scheme (NHIS) recently implemented for all residents includes general out-patient services, in-patient services, oral health, eye care, emergencies and maternity care. The latter includes prenatal care, normal delivery and some complicated deliveries. Only specialized services (e.g. HIV antiretroviral drugs, VIP accommodation) are excluded from the health insurance package. According to the legislative instrument about 95 per cent of all essential or common health problems in Ghana are covered.

Sources:
ILO, 2010a, op. cit., p. 71.
ILO, 2011f, op. cit., p. 132.

In some low-income countries, microinsurance (see examples in **Boxes 7.17** and **7.23**) has proved effective in reaching groups excluded from statutory social insurance, mobilizing supplementary resources (financial and human); contributing to the participation of civil society and empowering traditionally marginalized groups, including women. Despite these advances, stand-alone, self-financed microinsurance schemes have major limitations vis-à-vis sustainability, efficiency and the ability to reach the poorest. Their impact could be increased by developing functional linkages (e.g. subsidizing premiums paid by low-income members, underwriting microinsurance schemes or providing technical expertise for improving management) with national social insurance systems.

The urgency of the HIV and AIDS crisis has also spurred efforts to identify approaches for extending services for care and prevention. **Box 7.25** provides an example of a maternity-benefits programme for HIV-positive mothers in India.

Box 7.25 Maternity benefits for HIV-positive mothers in West Bengal State, India

In December 2009, the West Bengal State AIDS Prevention and Control Society (WBSAPCS) launched a maternity-benefit scheme to encourage institutional delivery among HIV-positive women and to prevent the transmission of the virus from the mother to the child.

The current Prevention of Parent to Child Transmission (PPTCT) programme covers only antenatal checkups and screening for HIV antibody reactivity of HIV-positive mothers. Under this new scheme (*Jagrity*), the Health Department will provide anti-retroviral treatment for HIV-positive mothers to reduce the probability of transmitting HIV to their newborns.

The WBSAPCS provides a one-time payment of Rs 1,000 (approximately US$20) to all pregnant women who are HIV-positive, irrespective of their economic status, to give birth in any state-run hospital. Under the scheme, a card containing details of check-up dates, expected date of delivery and the name of the hospital where she plans to go for delivery, is issued to the woman. These women also receive free medication.

Source: Express News Service: "Maternity benefit scheme for positives", in *Express India*, 9 Nov. 2009

Administration[67]

ILO Convention No. 102 offers two simple, powerful directives on administration. First, it holds governments responsible for adequately managing and financing social security institutions. These obligations cannot be abdicated or delegated. While a government may assign certain aspects of administration to private entities, it cannot divest itself of its duty under Convention No. 102 to ensure that a social security scheme is well run and delivers what the law promises.

Second, Convention No. 102 calls for governments to give all stakeholders a voice in scheme management. This can be achieved by establishing a tripartite board of directors for a social security institution or an advisory group.[68] Other arrangements are also possible, as long as they include a formal means for representatives of workers and employers to express their views.

These two requirements (i.e. governments take general responsibility for the proper provision of maternity protection and they create mechanisms of accountability to constituents), can go a long way towards ensuring sound administration. They should be explicit parts of a blueprint for extending maternity protection.

In addition, two issues that are not covered explicitly by ILO Conventions deserve early consideration.

67 E. Fultz, 2011, op. cit.

68 Board or advisory group members may need some support in understanding and asserting their roles. The ILO has developed a handbook for this purpose, see E. Fultz and S. Ward: *Social security governance: A practical guide for board members of social security institutions in Central and Eastern Europe* (Budapest, ILO, 2005).

A legal framework

Social security administration, including maternity protection, should not be affected by the income or influence of benefit applicants, the proximity of national elections, changes in government, or the government's short-term cash flows. To help insulate administration from these factors, a legal framework (preferably a law, statute or other appropriate legal instrument) is needed. Such a framework should spell out the rights and obligations of government, as well as those of scheme constituents. In addition to being widely available to workers, employers, and beneficiaries, it should serve as a basis for administration and a focal point for the training and subsequent decision-making of all administrators.[69]

Administrative costs

In countries where functional systems are in place, maternity protection schemes are usually incorporated into social security schemes and are thus administered by the responsible national institution. This tends to reduce incremental administrative costs, as these institutions already have mechanisms in place for registering employers and insured persons, collecting contributions and paying benefits due. Therefore, additional administrative costs for administering maternity benefits schemes mainly relate to the payment of the staff in charge of processing the claims and assisting contributors and beneficiaries. Some minor costs may also arise from the creation and maintenance of a database for the maternity contributions and benefits (as part of the existing benefits and their databases).

However, social security administrative costs tend to be high in developing countries. With low levels of government transparency, scheme salaries and benefits may increase over time, consuming greater amounts of revenue intended for maternity protection. In rural areas, long distances between scheme offices make delivering benefits costly. A further challenge has human dimensions: how to address fund "leakages", as many of those in charge of implementing maternity protection are poorly paid and themselves in need of assistance.[70] For all these reasons, social security administrative costs in sub-Saharan Africa, including those for maternity schemes, are often in the range of one-third to two-thirds of total benefit payments.[71]

With this high overhead, additional funding for new forms of maternity protection can be seriously eroded. It is thus important to determine whether new benefits can be delivered in a manner that the population of the country would support, if they knew the administrative cost ratio. With this issue in mind, strategies to consider for limiting administrative costs include the following:

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69 Recent analysis shows that benefits provided in this manner tend to create a "positive politicization" of social security. That is, citizens may take greater interest in holding government officials accountable, benefits may figure increasingly in election debates, and these phenomena may lead those in power to strengthen social security, even when election challenges are unsuccessful. While most of these studies have focused on old age benefits, the same logic applies to improvements in maternity protection. S. Cook and N. Kabeer: *Socio-economic security over the life course: A global review of social protection* (UK, Institute of Development Studies, 2009), p. 17.

70 F. Ellis, S. Devereux and P. White: *Social Protection in Africa* (Cheltenham, Edward Elgar, 2009).

71 E. Fultz and B. Pieris: *Social security schemes in Southern Africa: An overview and proposals for future directions*, ILO SAMAT Policy Paper No. 11 (Harare, ILO, 1999), Ch. 3.
ILO: *Social Protection Expenditure Review, Tanzania* (Geneva, 2008c), Table 5.9.
Forbes, A.: *Actuarial evaluation of the maternity, sickness, and death benefit (MSD) fund* (Namibia, 2010), Table 3.

- **Piggybacking**. This involves administering a new maternity benefit through an existing scheme whose infrastructure (i.e. offices, records, computers, and collection capacity, if relevant) are already in place. For example, maternity benefits were added to the long-term benefits administered by the Tanzanian National Social Security Fund, operating from 2008, and in Namibia they were launched as part of a larger scheme covering sickness and death. However, this strategy is often not available with respect to informal sector workers, since they have little or no social security. In addition, the administering agency will no doubt insist that any new benefit should contribute its pro rata share to administration eventually, if not right away. Thus, it is important to discern the current costs as a proportion of annual benefit payments before agreeing to any such piggybacking arrangement. The institutions' annual reports and actuarial studies are the most reliable sources in this regard.
- **Streamlining administration** involves putting in place special measures to keep administrative costs low. These can involve, for example, paying higher benefits at less frequent intervals, requiring beneficiaries to travel to central pay points, or using proxy indicators of need in social assistance schemes (e.g. region or neighbourhood) to simplify eligibility determination. Creative use of technology can also limit administrative costs (e.g. making benefit payments through the banking, post office system or even cell phones, where possible).[72] Limiting staff numbers, salaries and fringe benefits, investments in buildings, international travel as well as employing international consultants can also save considerable administrative funds. Training can be provided in an effort to give staff a sense of "trusteeship" in protecting scheme funds, and public examples can be made of those who waste funds or abscond with them.

However, administrative streamlining is not easy in developing countries since some of the pressures that drive up administrative costs stem from weak governance.[73] Thus, it is important to realistically assess the potential for streamlining in any given national context and to assess the likelihood that interventions will actually reduce costs or if they will instead transfer them to scheme members, which should be avoided.

[72] In Rwanda, for example, the government is attempting to digitize all social security data in order to ameliorate the speed of and access to information.

[73] When governments lack the commitment or resources to enforce the law, collection of contributions is compromised. When government or its agents themselves fail to follow the rules, social protection becomes vulnerable to the misdirection of funds. Furthermore, lack of transparency in state governance often spills over, affecting the transparency of employment-related protection. Thus, many social security schemes in developing countries decline to publish their administrative costs or place them on their websites.

Additional considerations for extending maternity protection to unprotected workers[74]

A number of ILO instruments refer to the extension of social security to specific categories of workers, such as agricultural workers, homeworkers, migrant workers and part-time workers (see **Module 5**). In 2011, the ILO Committee of Experts noted that some countries (e.g. Estonia and the United States) reported that they do not distinguish specific categories of persons in terms of social security protection. Others, particularly high-income countries, have already established universal social security schemes covering all residents (e.g. Australia, the Netherlands, New Zealand, Norway and Sweden). However, in countries where the informal economy is predominant, specific schemes for certain categories of workers may be necessary to provide protection for these particular groups who would otherwise be excluded. Alternatively, qualifying conditions of existing schemes may need to be adjusted to take account of the specific needs and circumstances of particular categories of workers.

Countries have adopted a variety of measures to incorporate unprotected persons into the existing compulsory or voluntary schemes through the introduction of new, sometimes more favourable, conditions which allow them to join the schemes. The most common include the relaxation of certain qualifying conditions: reducing the required number of years of service or contribution periods; decreasing the amount of requisite contribution payments; waiving outstanding payments; the possibility to "buy back" missing contribution periods; and reducing the number of employees required for a company to fall within the scope of the social security scheme.

In addition to the approaches and examples described so far, this section offers additional considerations related to the extension of maternity benefits' coverage to workers in atypical forms of dependent work, with focus on domestic workers.

Atypical forms of dependent work

Atypical forms of dependent work are hybrid arrangements in which workers have some characteristics of both employees and the self-employed. Like employees, workers in atypical forms of dependent work deliver outputs to an entrepreneur or enterprise. But like the self-employed, they may work somewhere other than that enterprise's premises, without set hours, instructions, supervision, or employer-provided equipment. Similarly, domestic workers fall into a grey area between employment and self-employment. A domestic worker may work for a single household, a few or many households. She/he may work independently with private equipment, or under the close supervision of the homeowner using equipment provided in the home.

As both these categories of work have features of employment, those seeking to extend social security and maternity protection find it attractive to include them under a social insurance scheme, either mandatory or voluntary. The advantages are: first, that social insurance is more widespread than universal or means-tested schemes; second, it is largely self-funding; and third, it usually pays higher benefits. However, differences between atypical dependent work and traditional dependent work are also significant and make "stretching" social insurance to reach these groups difficult. Unless a social

[74] ILO, 2011f, op. cit. and E. Fultz, 2011, op. cit.

insurance scheme makes some accommodations to the needs and characteristics of these workers, simply changing the law to include them is unlikely to have any significant impact on coverage levels. Specifically:

- **With mandatory coverage**: The contribution rate may be too high for these groups or the benefits ill-designed to meet their highest priorities for protection. If so, they may simply collude with those to whom they deliver their work to evade the contribution requirement. This will not be difficult, since atypical dependent workers and domestic workers are largely invisible to governments. Enforcement agents usually lack records of their identities, workplaces or earnings. Without this information, the cost of enforcement could well exceed the contributions collected as a result. Administrative costs would soar with little positive impact on the number of workers covered.
- **With voluntary coverage**: Under a voluntary social insurance scheme, the few workers who would come forward would be those likely to need maternity benefits soon. There would be no reason for men to join the scheme and women who are beyond reproductive age would be unlikely to join. This would result in adverse selection. For this reason, the achieved coverage increase through voluntary membership would not only be low, but the small number of new scheme members would also be a costly per capita addition to scheme coverage.

Box 7.26 Avoiding adverse selection in voluntary schemes: examples from microinsurance

Microinsurance schemes that provide maternity benefits have put in place various measures to prevent adverse selection.

- In India, the SEWA scheme provides maternity benefits only to those women who insure themselves against other contingencies (i.e. ill health, employment injury and death). In this case, the maternity benefits are a "free" add-on. Women cannot insure for maternity alone.
- The CIDR micro-health insurance scheme operating in Guinea requires an entire village to join as a group and each family to make a small contribution for the maternity protection of all pregnant women. Effectively, through requiring a group decision to join or not, CIDR converts a voluntary scheme into a mandatory one, where adverse selection ceases to be a threat.

In all the countries examined, microinsurance benefits are low, which limits the attractiveness of the scheme and thus serves to limit adverse selection. In some cases, scheme designers have avoided the problem by excluding maternity protection entirely.

Source: E. Fultz, 2011, op. cit.

Given both of these sets of difficulties, non-contributory schemes, such as conditional or non-conditional cash transfers or SPF guarantees, may be more viable approaches than social insurance for covering these groups of women. However, if the political will exists to cover them under social insurance on either a mandatory or voluntary basis, actions on three fronts need to be taken to raise the chances of success.

(i) **Administration**: The scheme should make it easy for the "employers" of these women to register and pay contributions. This could be done by allowing them to file as part of any interaction that they normally have with government (e.g. income tax returns, export licences, property registration, building permits). The forms can be amended to ask if

the applicant receives services from a domestic worker or a worker in an atypical form of dependent work and, if so, to include easy instructions for registration and payment. These options will not appeal to all such "employers". But since it is likely that some of them are operating formally, they may respond positively if the process is clear and simple.

(ii) **Benefit design and finance**: To attract workers in domestic and atypical dependent work, the benefit package must be both relevant and affordable. Since these workers are generally not well paid and have many pressing needs, essential health care tends to be their highest priority, before long-term contingencies (e.g. old age protection). If the scheme into which they are to be included provides more than maternity benefits, the strategies for accommodation are two fold:

- extend coverage only with respect to maternity benefits and essential health care (the benefit that they usually find most appealing), with a reduced contribution rate; or
- reduce their contributions and provide a subsidy to fill the gap, either a cross subsidy within the scheme or a government contribution.

Such subsidies may meet with objections from scheme members who must pay the full contribution rate. Yet an attractive and affordable benefit package is essential to extend coverage beyond formal employment, for reasons already made clear. There is thus a need for close consultations with scheme constituents to arrive at a strategy that is regarded as equitable.

(iii) **Outreach**: Carrying out an information campaign that stresses the value of maternity protection for workers in atypical forms of dependent work, engaging national trade union confederations and employer associations in the effort; at the same time, stressing the responsibility of those enterprises to which they deliver their work to pay contributions, and the penalties for failure to do so, if detected.

In June 2011, the ILC adopted a Convention and Recommendation concerning Decent Work for Domestic Workers, which set international standards related to the provision of social security protection, including maternity, to this category of workers (see **Box 7.27**).

Box 7.27 Maternity benefits in the new ILO Convention and Recommendation concerning Decent Work for Domestic Workers

Convention No. 189, Article 14

(1) *Each Member shall take appropriate measures, in accordance with national laws and regulations and with due regard for the specific characteristics of domestic work, to ensure that domestic workers enjoy conditions that are not less favourable than those applicable to workers generally in respect of social security protection, including with respect to maternity.*

(2) *The measures referred to in the preceding paragraph may be applied progressively, in consultation with the most representative organizations of employers and workers and, where they exist, with organizations representative of domestic workers and those representative of employers of domestic workers.*

Recommendation No. 201, Paragraph 20

(1) Members should consider, in accordance with national laws and regulations, means to facilitate the payment of social security contributions, including in respect of domestic workers working for multiple employers, for instance through a system of simplified payment.

(2) *Members should consider concluding bilateral, regional or multilateral agreements to provide, for migrant domestic workers covered by such agreements, equality of treatment in respect of social security, as well as access to and preservation or portability of social security entitlements.*

The costs of cash and medical benefits: Is Maternity Protection affordable?[75]

A key objection to extending maternity protection often relates to concerns about the cost of cash and medical benefits associated with maternity. This concern can be addressed by looking at the costs of social security more generally, and by considering the costs of maternity protection benefits directly. It is also important to look at the costs of providing maternity protection relative to the cost of not providing it.

According to ILO calculations, less than two per cent of global Gross Domestic Product (GDP) would be necessary to provide a basic set of social security benefits to the world's poor and six per cent of global GDP (i.e. less than 10 per cent of the global investment in tangible assets) would provide a basic set of benefits to all who lack access to social security.[76] Most of the resources needed would obviously stem from national governments.

Costing estimates by the ILO for twelve countries in Africa and Asia showed that the cost of a minimum package of essential health care would require between 1.5 and 5.5 per cent of GDP in 2010. A broader package of social security benefits that includes old age pensions, health care, child benefits, social assistance/employment schemes (but not maternity), and administrative costs would cost between 3.7 and 10.1 per cent of GDP for the countries studied. This would require a level of resources that is higher than current spending in the majority of low-income countries, which rarely spend more than three per cent of GDP on health care and one per cent of GDP on non-health social security measures. ILO estimates in developing countries indicate that this would be affordable if governments would commit a larger proportion of their budgets to social protection and if the international community would provide some temporary support.[77]

With respect to maternity cash and medical benefits in particular, the cost of financing maternity protection is low relative to other forms of social security. In most contexts, **it is possible to finance a social insurance scheme providing cash maternity benefits for less than 0.7 per cent of covered wages**.[78] Thus, in Namibia, the Social Security Administration's Maternity, Sickness, and Death (MSD) cash benefit programme is

[75] This section is drawn from: K. Pal et al., 2005, op. cit. and E. Fultz, 2011, op. cit.

[76] K. Pal et al., 2005, op. cit.

[77] K. Pal et al., 2005, op. cit.
F. Gassman and C. Behrendt: *Cash benefits in low-income countries: Simulating the effects on poverty reduction for Senegal and Tanzania*, Discussion Paper No. 15 (Geneva, ILO, 2006).

[78] Based on US SSA/ISSA, op. cit., Maternity medical care, though not measured as a percentage of wages, is also of relatively low cost compared to other medical needs.

financed by a 1.8 per cent contribution rate, of which 0.35 per cent is allocated to maternity. In the United Republic of Tanzania, the National Social Security Fund plans to earmark just 0.5 per cent of its 20 per cent contribution rate for maternity (today it pays out maternity benefits from far less than this). In schemes that combine maternity and sickness benefits, the contribution rate is often in the range of one to three per cent, with sickness expenditures consuming the major share of scheme revenues.

The costs of providing maternity care benefits cannot easily be separated from general health care costs unless there is detailed reporting. In general, however, maternity costs tend to comprise only a fraction of total health care costs. The extent of these costs depends on the level of benefits provided, the frequency of cases and the level of co-payments. Referring to the ILO costing studies above, a basic social protection package that includes health services is affordable to all countries, and this package should include maternal health services.

In designing and implementing cash and medical benefits for maternal protection a number of variables should be taken into account, which might include:

- availability and costs of infrastructures and a professional health workforce to sustain antenatal, postnatal care and deliveries;
- socio-demographic characteristics: fertility rate, development of family planning, female labour market participation, family structure;
- identification of vulnerable groups (individuals/households): unemployed or employed in the informal sector, divorced or abandoned women, women with dependants, women "breadwinners", etc.

In thinking about the costs of providing maternity cash and medical benefits, as well as social security for all contingencies, it is important to also consider the costs of **not** providing such benefits. The lack of social protection for large portions of the world's population today is a major factor in increasing poverty, inequality and social conflict. Out-of-pocket financing and catastrophic health expenditures push many families into poverty, while poverty contributes further to poor health, illness and disease, creating a vicious circle, and eroding productivity and prospects for economic growth.

In terms of the costs of not providing maternity cash and benefits more specifically, the facts are sobering. When a woman dies or becomes ill, her family and community lose the fruits of her productivity and her income. Her children are much more likely to drop out of school, to suffer poor health, and even to die.[79] On an international level, it has been estimated that the global economic impact of maternal and newborn mortality amounts to $US15 billion in lost productivity every year.[80]

[79] Women deliver: *Focus on five: Women's health and the MDGs* (New York, n.d.).

[80] USAID: "Program, performance and prospects", in *Budget Justification FY 2002*, **http://www.usaid.gov/pubs/cbj2002/prog_pref2002.html** [accessed 12 Oct. 2011].

Social dialogue and the role of the stakeholders[81]

The ILO promotes a strong role for government and its social partners, which include civil society, the insured and other stakeholders, through social dialogue and broad participation in policy processes and the governance of social health protection schemes. National governments have a leadership role to play in setting policy and creating a climate favourable to social dialogue on maternity protection. Their key partners at the national level in all industrial relations and employment matters are employers, represented by employers' organizations, and workers, represented by trade unions. These tripartite partners together elaborate the legislative and social security context, and each takes forward the implementation of national laws and policies through their respective means of action.

Social dialogue can play a major role in the development and reform of social security by providing the social partners with the opportunity to express their own interests and concerns. Maternity protection can be highly controversial, with different opinions being held not only by employers and workers but also by religious groups, women's NGOs, health NGOs and others. Such groups can be important in supporting or opposing government policies. Thus, apart from social partners, it is important to identify other stakeholders and find ways of consulting them. This inclusionary approach allows different stakeholders to advance together when they have many common interests and may also help them to reach compromises about matters on which they have different views.

It is important to enhance the technical capacities of public authorities, social partners and other stakeholders, not only to improve governance and supervision of social protection schemes, but also to improve their participation in and contributions towards social and national dialogue. Evidence from many countries demonstrates that successfully extending social health protection to the poor requires the consensus of various levels of and entities within government, social partners, civil society and others. Given the diverse interests of stakeholders, obtaining the necessary support is a complex and challenging task. Problems often arise when stakeholders and social partners feel: that they have been ignored in the design and provision of social health protection; that their concerns have been misunderstood; or that the quality and depth of participatory decision-making was limited. This can result in a lack of support in implementation, enforcement, funding, and compliance with new laws and regulations, which can in turn lead to the failure of important reform activities. With respect to improving maternity protection, strengthening social dialogue requires a thorough understanding of the international labour standards on maternity protection and social security and a clear picture of the maternity-related economic and health outcomes for women, children, families and communities in the country.

[81] ILO, 2008a, op. cit.

Box 7.28 Overcoming disagreements about maternity benefits through social dialogue in Malta

In Malta, discussions at the European and national levels on extending maternity leave led to strong objections from the employers' associations, whose main concern was that in the current economic situation, increasing maternity leave would constitute an additional cost for employers to bear and would undermine their profitability and ability to survive and compete in the international market.

The National Council of Women of Malta organized a public dialogue on women in employment, and on proposals to extend maternity and parental leaves. At a public dialogue forum, the social partners, identifying the current employer liability system for maternity leave as a major stumbling block for gaining employers' agreement, found a way forward by agreeing to a formula that would place part of the cost of maternity leave onto the government – a cost which is currently borne by the employer. While employers would be required to continue bearing the costs of maternity leave for the first fourteen weeks, the forum considered the possibility of a new formula for 'burden-sharing' of proposed increases in the length of maternity leave.

Source: European Network of Legal Experts in the field of Gender Equality: *European Gender Equality Law Review* (Brussels, 2010), pp. 105, 107.

Key points

- Pregnancy, childbirth and the postnatal period carry a number of economic and health risks for women and their babies.
- Maternity-related economic and health risks can be mitigated by social security measures that extend social protection to women and their children during maternity. However, access to social protection, including maternity cash and medical benefits, is limited and characterized by high levels of inequality across and within countries.
- ILO standards offer guidance for developing and implementing social security measures and maternity cash and medical benefits.
- The Social Protection Floor is a new UN initiative to support governments in helping their residents to cope with hardship and economic crisis. It seeks to extend a basic set of social security guarantees comprised of essential health care and income security for vulnerable and unprotected people, including pregnant women and mothers.
- Cash benefits can be financed through universal schemes, social insurance, social assistance, employer liability schemes and hybrids of them. Employer liability schemes raise particular concerns regarding unfair distribution of responsibilities for the costs of reproduction and potential discrimination against women on the basis of actual or potential maternity.
- Financing for medical benefits comes from taxation and general revenues, social insurance, premiums-based schemes, and out-of-pocket payments. The latter are particularly inequitable, placing a heavy burden on poor families and increasing the risks of catastrophic health spending and poverty.
- Extending maternity cash and medical benefits to vulnerable and unprotected women remains challenging, especially in low-income countries. However, cash transfer schemes, community-based health insurance and basic health benefits packages represent promising approaches when integrated as part of the broader national social protection system.
- Maternity cash and medical benefits are not costly; rather, their costs are relatively low when compared with other forms of social security. In general, costing exercises show that a basic social protection package that includes health services is affordable in all countries.
- In contrast, the costs of not providing maternity cash and benefits are high. When a woman dies or becomes ill, her family and community lose her income and her children are much more likely to drop out of school, suffer poor health, or die.
- Despite its benefits, designing, implementing and monitoring social protection is challenging, since it involves many stakeholders and diverse perspectives. Social dialogue that includes all stakeholders is essential for determining schemes and approaches that are best suited to the national context.

Key resources

ILO: Law and Practice Report: Recommendation on National Social Protection Floors (No. 202) (Geneva, 2011).

This report covers examples of existing law and practice in ILO member States across different regions and different legal systems and traditions, and with different circumstances (levels of income and development). The report provides a comparative analysis of the main developments and emerging trends in the establishment of social protection floors, or elements thereof, at national level.

Available at: http://www.ilo.org/public/english/protection/secsoc/info/index.htm

ILO: Social security and the rule of law: General Survey concerning social security instruments in light of the 2008 Declaration on Social Justice for a Fair Globalization (Geneva, 2011).

The Committee of Experts on the Application of Conventions and Recommendations has published a General Survey on Social Security Instruments, which is the second General Survey linked to the follow-up of the ILO Declaration on Social Justice for a Fair Globalization adopted in 2008. It provides an up-to-date complete assessment of social security instruments throughout the world.

Available at: http://www.ilo.org/global/standards/WCMS_152909/lang—en/index.htm

ILO: Social security for social justice and a fair globalization (Geneva, 2011).

This report informed the debate during the 100th Session of the International Labour Conference by providing: (a) an overview of the present state of social security around the world; (b) an identification of the main social security challenges; (c) an overview of national and ILO responses to the challenges; and (d) suggestions for the direction of future ILO action.

Available at:
http://www.ilo.org/ilc/ILCSessions/100thSession/reports/reports-submitted/WCMS_152819/lang—en/index.htm

ILO: Maternity at Work: A review of national legislation. Second Edition. Findings from the ILO Database of Conditions of Work and Employment Laws (Geneva, 2010).

This book provides the most recent data on maternity protection throughout the world. It contains information on how cash and medical benefits are distributed in various regions, and gives examples of good practices. It is a useful tool to compare practices on a global level, as well as to gain knowledge on what can be done to improve cash and medical benefit distribution at the government level.

Available at:
http://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_124442.pdf

ILO: World Social Security Report 2010/2011: Providing coverage in times of crisis and beyond (Geneva, 2010).

This is the first in a new series of biennial reports that aim to map social security coverage globally, to present various methods and approaches for assessing coverage, and to identify gaps in coverage. Backed by much comparative statistical data, this first report takes a comprehensive look at how countries are investing in social security, how they are financing it, and how effective their approaches are.

Available at:
http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_146566/lang—en/index.htm

X. Scheil-Adlung and L. Sandner: Wage continuation during sickness: Observations on paid sick leave provisions in times of crises (Geneva, ILO, 2010).

This short paper elaborates upon the economic cost of sick leave and provides policy advice on its implementation. It offers an assessment of the implementation of sick leave provisions throughout the world, with a focus on economic repercussions. This paper concludes with lessons learned including on sick leave in the national social protection floor.

Available at:
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=17463

G. Carrin, I. Mathauer, K. Xu and D.B. Evans: "Universal coverage of health services: Tailoring its implementation", *Bulletin of the World Health Organization*, 2008, Vol. 86, No. 11, Nov., pp. 817-908 (Geneva, WHO).

Financing the universal coverage of health care is becoming an increasingly important issue for all countries. This paper goes over key questions countries will need to address when initiating this process. It provides certain answers and how they can be tailored to country-specific contexts. In addition, this paper highlights the important role institutional arrangements and organizations have to play in this process.

Available at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/

ILO: Social Health Protection: An ILO strategy towards universal access to health care, Social Security Policy Briefings, Paper 1, Social Security Department (Geneva, 2008).

This paper provides guidelines on universalizing health protection, including providing cash and medical benefits to pregnant women. It goes into detail on the importance of health protection, the most frequent obstacles to its extension, and how such obstacles can be overcome. It provides a concrete plan of action with a regional analysis regarding its implementation.

Available at:
http://www.ilo.org/public/english/protection/secsoc/downloads/policy/policy1e.pdf

ILO: Feasibility study on the implementation of a maternity cash benefits scheme: Hashemite Kingdom of Jordan, Report to the Government, Social Security Department, Regional Office for the Arab States (Geneva/Beirut, 2007).

This report, based on an assessment conducted by the ILO Regional Office for the Arab States, provides guidelines for the implementation of a maternity cash benefit scheme in Jordan. It is a practical document with concrete recommendations and can serve as an example of good practice for those wishing to implement such a scheme.

Available at:
http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=2531

ILO: Safe maternity and the world of work (Geneva, 2007).

This book covers the importance of offering safe maternity conditions to women workers, not only to avoid maternal and child mortality, but also to foster gender equality and productivity. It sets three priority areas for the ILO in promoting safe maternity: maternity protection, social health protection and decent work for health care professionals. It describes the importance of these areas as well as details on how to create a safer working environment for women in maternity.

Available at:
http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_104862/lang—en/index.htm

K. Pal et al.: "Can low income countries afford basic social protection?" Social Security Policy Briefings, Paper 3, Social Security Department (Geneva, ILO, 2005).

This paper addresses a major concern for low income countries: the cost of providing basic social protection to all citizens. It provides a short analysis of the fundamental importance of having basic social security provisions, and shatters the myth that such social security is unaffordable. It provides concrete evidence on the cost-effectiveness of social security and the positive effects it can have on any country.

Available at: http://www.ilo.org/public/libdoc/ilo/2008/108B09_73_engl.pdf

ILO: Extending social security to all: A guide through challenges and options, Social Security Department (Geneva, 2010).

This recent publication elaborates upon the importance of extending social security to all workers, obstacles to this extension and possible solutions. It provides concrete answers to the general concerns policy makers have when considering the extension of social security. It supports its conclusions with evidence drawn from a dozen case studies taken from developing countries.

Available at:
http://www.ilo.org/public/english/protection/secsoc/downloads/policy/guide.pdf

ILO: ABC of women workers' rights and gender equality, Second edition, (Geneva, 2007).

This book provides a detailed list of important definitions regarding labour and gender. It goes over important elements of the interaction between women and the world of work. It also elaborates upon the importance of maternity protection, cash benefits and medical benefits. It is a practical and user-friendly tool that is easily accessible.

Available at: http://www.ilo.org/public/libdoc/ilo/2007/107B09_255_engl.pdf

ILO: Social protection for all men and women: A sourcebook for extending social security coverage in Samoa – options and plans (Suva, 2006).

This report published by the regional office of the ILO in Fiji, provides a walkthrough process of extending social security. It provides an assessment of the state of social security in the targeted region and a list of important steps that can be taken to improve it. It also contains a more theoretical approach by articulating the importance of extending social security.

Available at:
http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-suva/documents/publication/wcms_156318.pdf

ILO: Guidelines on the Extension of Maternity Protection in Developing Countries (Geneva, 2011), unpublished.

These guidelines are the product of collaboration within several ILO departments working in the fields of maternity protection and social security. They review and assess current maternity protection coverage, raise awareness of maternity protection, particularly within the informal economy, formulate new comprehensive policy options and provide guidelines for their effective implementation.

Forthcoming at: www.ilo.org/travail

GESS Global Extension of Social Security

GESS is a global knowledge sharing platform on the extension of social security and aims to facilitate the exchange of information and ideas; capture and document experiences; identify knowledge gaps; create new knowledge and promote innovation. To achieve this goal, GESS relies on the contributions of its users and the dialogue and exchange between them. This platform, developed and run by the **ILO Social Security Department**,provides an international interdisciplinary knowledge sharing environment and technical assistance services for the extension of social security.

Available at: http://www.ilo.org/gimi/gess/ShowWiki.do?wid=9

International Social Security Association (ISSA)

The International Social Security Association is the principal international institution bringing together social security agencies and organizations. The ISSA's aim is to promote dynamic social security as the social dimension in a globalizing world by supporting excellence in social security administration. The ISSA provides access to information,

expert advice, business standards, practical guidelines and platforms for members to build and promote dynamic social security systems worldwide.

Available at: http://www.issa.int/

P4H Providing for Health

The P4H initiative is aimed at addressing the needs of poor people living in low- and middle-income countries when it comes to accessing quality health care. This includes coordinated support for social health protection (SHP) policy and strategy development, as well as harmonized international collaboration at country, regional and global levels for establishing equitable and efficient health financing systems based on prepayment and financial risk protection.

Available at: http://www.who.int/providingforhealth/en/

ILO Social Security Department (SECSOC)

The Social Security Department, with its long experience in the field of technical cooperation activities, research and policy development on issues dealing with social security, provides ILO member States with tools and assistance to achieve and maintain for their people the right to basic social security. Its key publications and policy advice can be found on its website.

Available at: http://www.ilo.org/public/english/protection/secsoc/

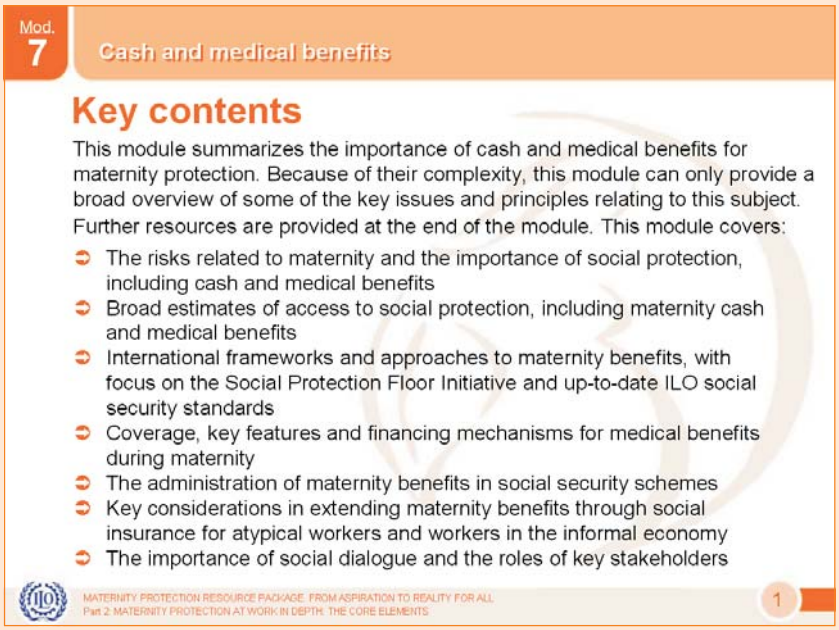
World Bank website on Resources related to Conditional Cash Transfers

Conditional Cash Transfers are of growing importance in providing a social security safety net. The World Bank has been active in promoting such programmes, as well as evaluating their results mainly in developing countries. Details of these programmes, their importance and key results can be found on the World Bank website.

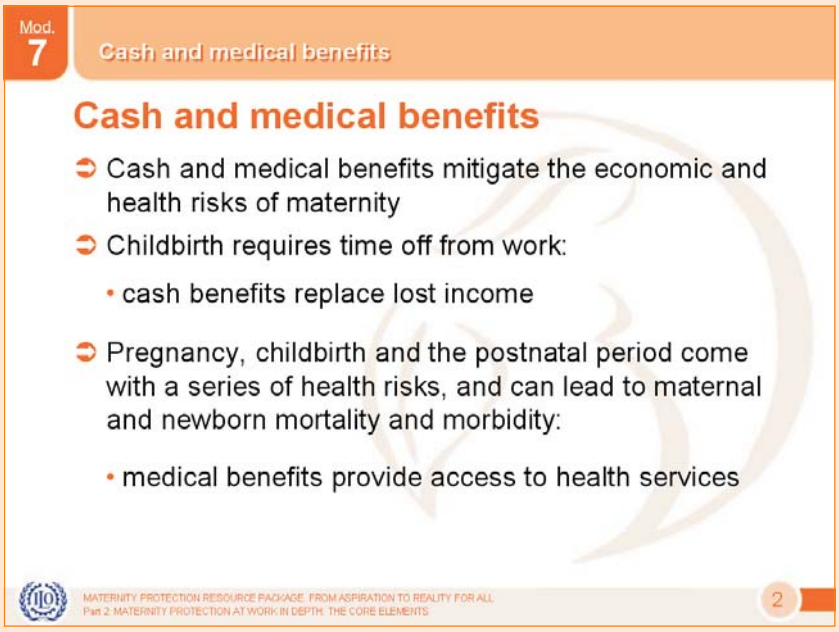
Available at:
http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/BRAZILEXTN/0,,contentMDK:21447054~pagePK:141137~piPK:141127~theSitePK:322341,00.html

Visual presentation model

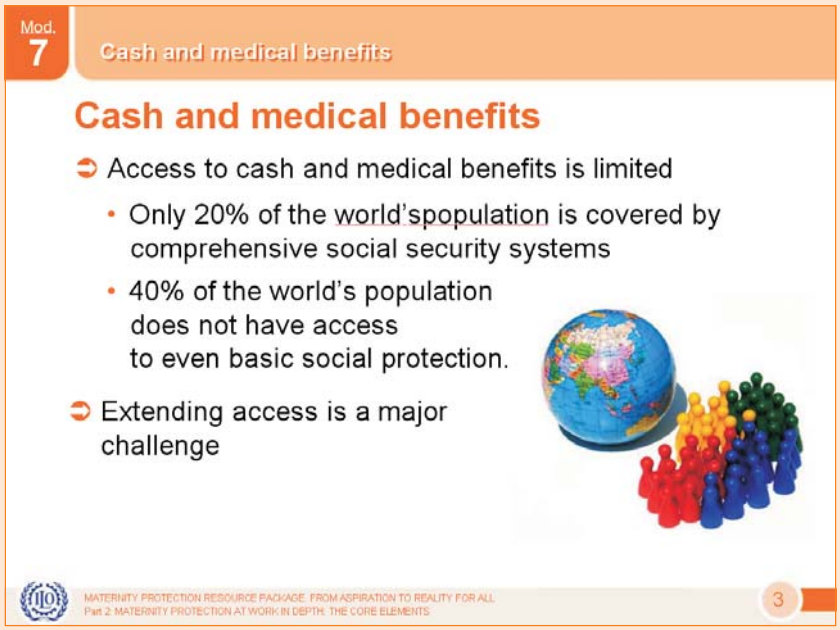
SLIDE 1: Key contents



SLIDE 2: Cash and medical benefits



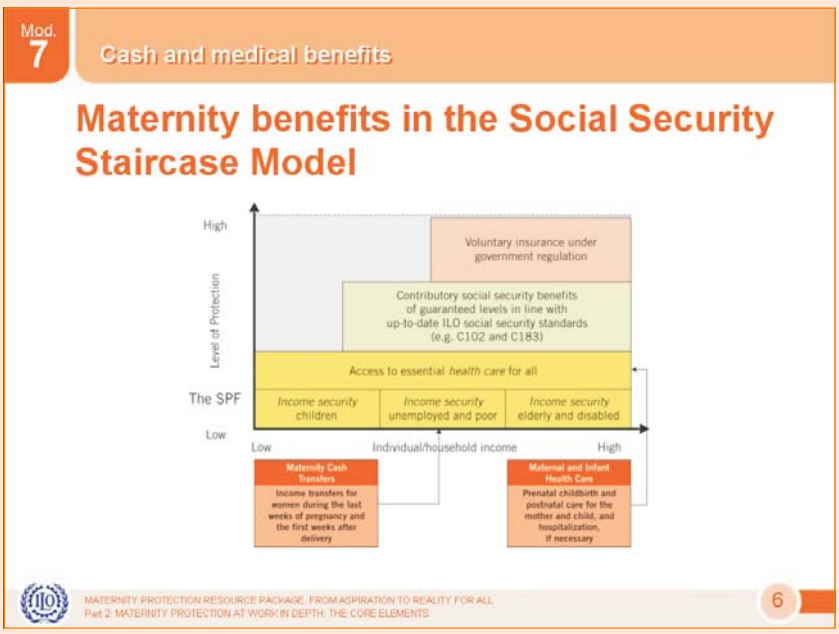
SLIDE 3: Cash and medical benefits



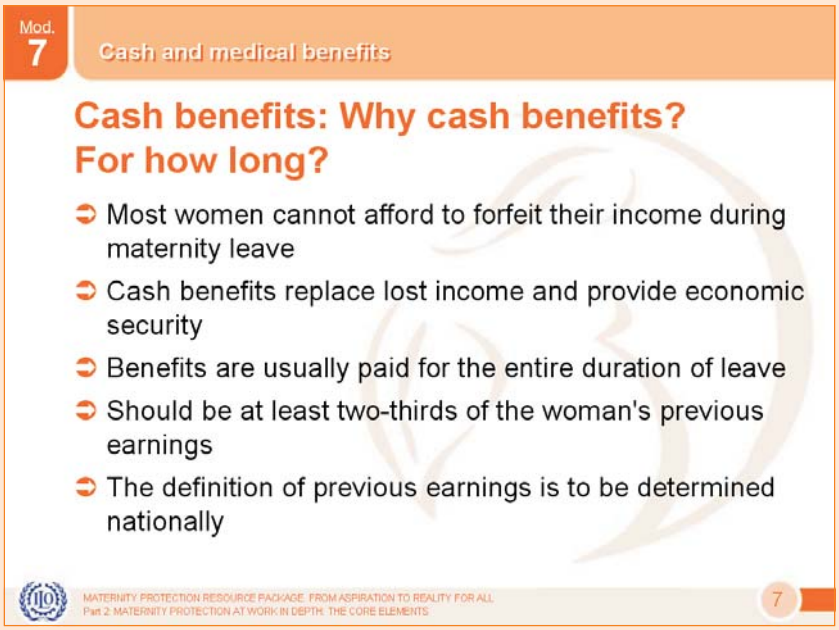
SLIDE 4: International frameworks and approaches

SLIDE 5: International frameworks and approaches

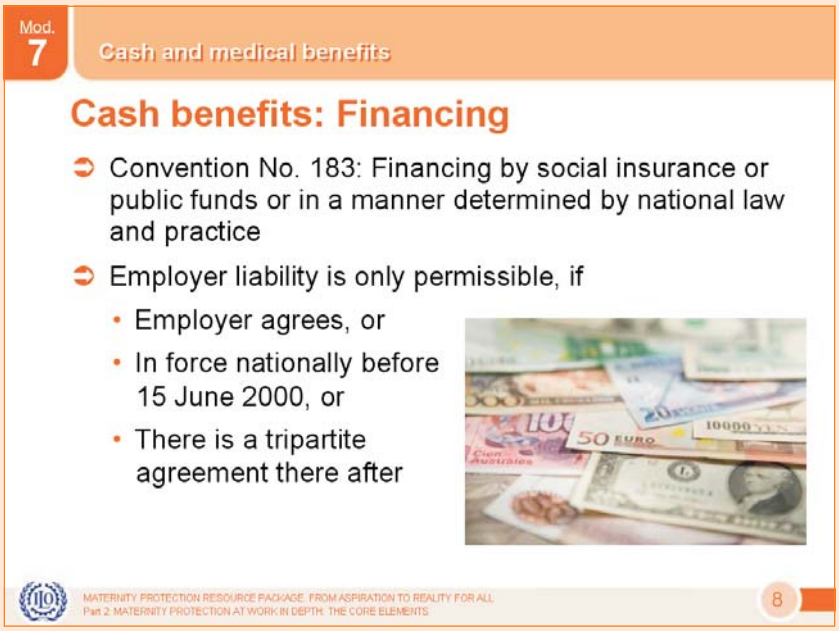
SLIDE 6: Maternity benefits in the Social Security Staircase Model



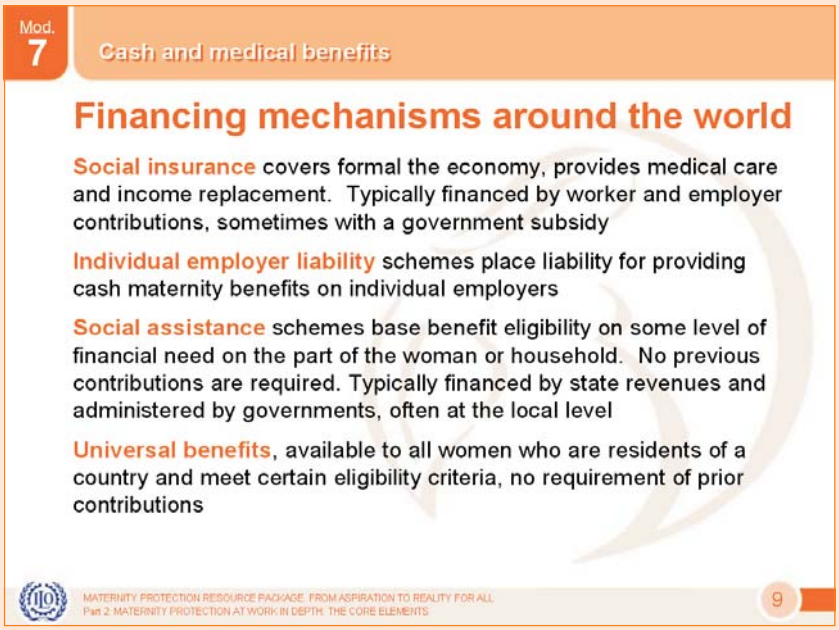
SLIDE 7: Cash benefits: Why cash benefits? For how long?



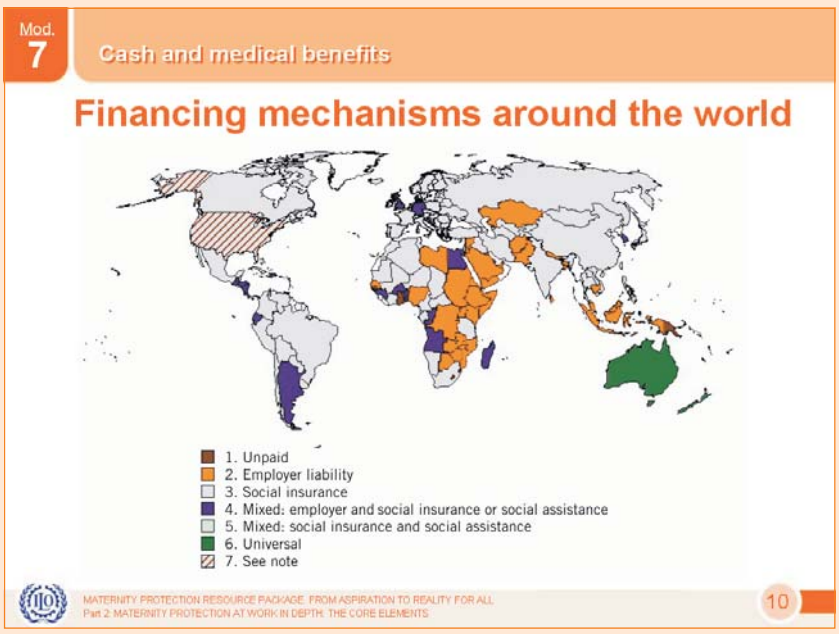
SLIDE 8: Cash benefits: Financing



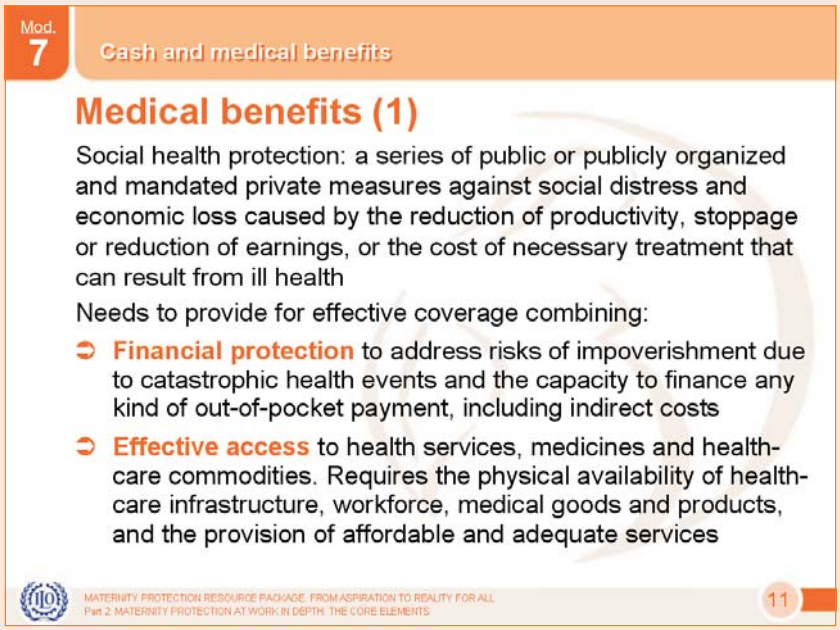
SLIDE 9: Financing mechanisms around the world



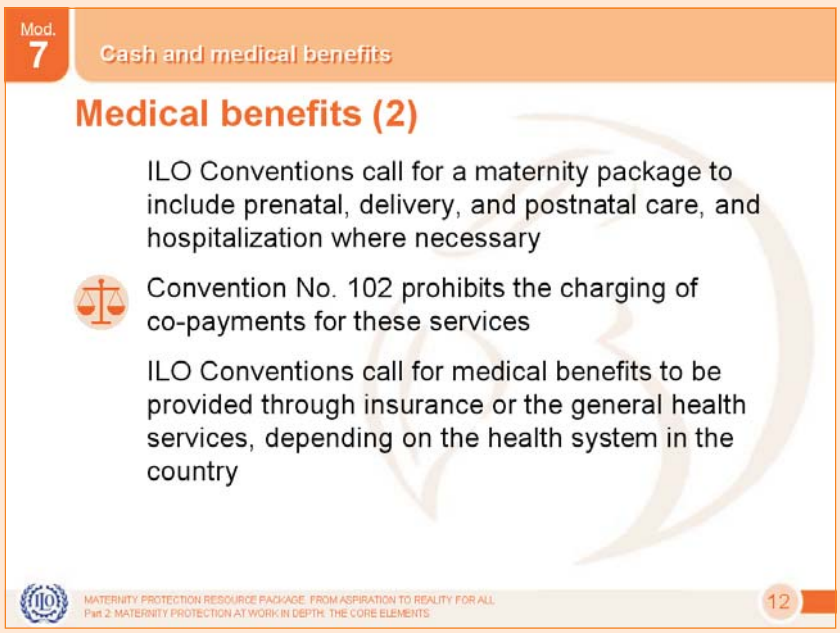
SLIDE 10: Financing mechanisms around the world



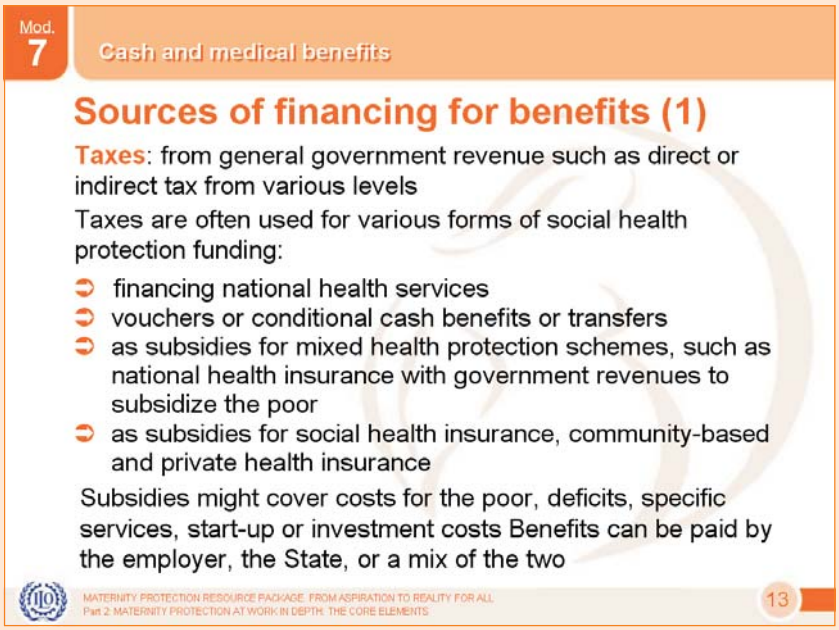
SLIDE 11: Medical benefits (1)



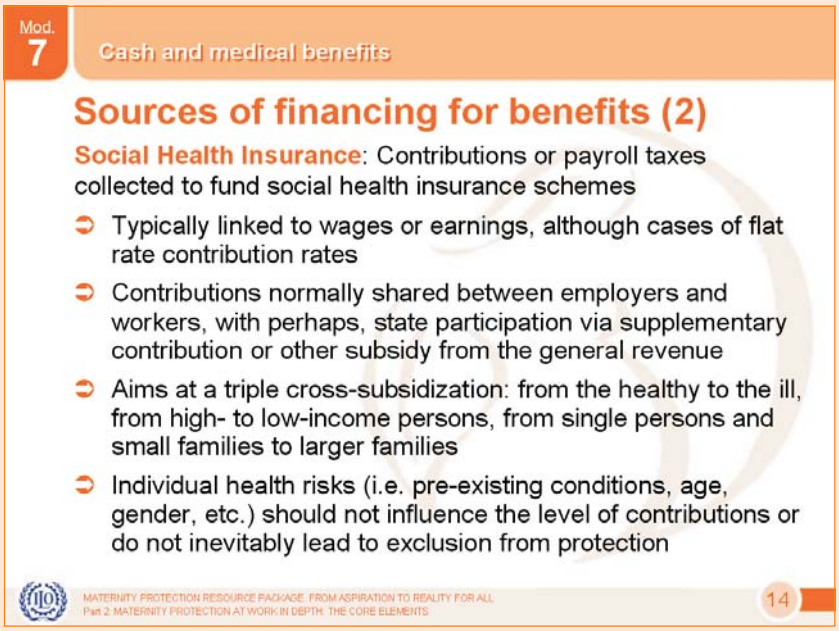
SLIDE 12: Medical benefits (2)



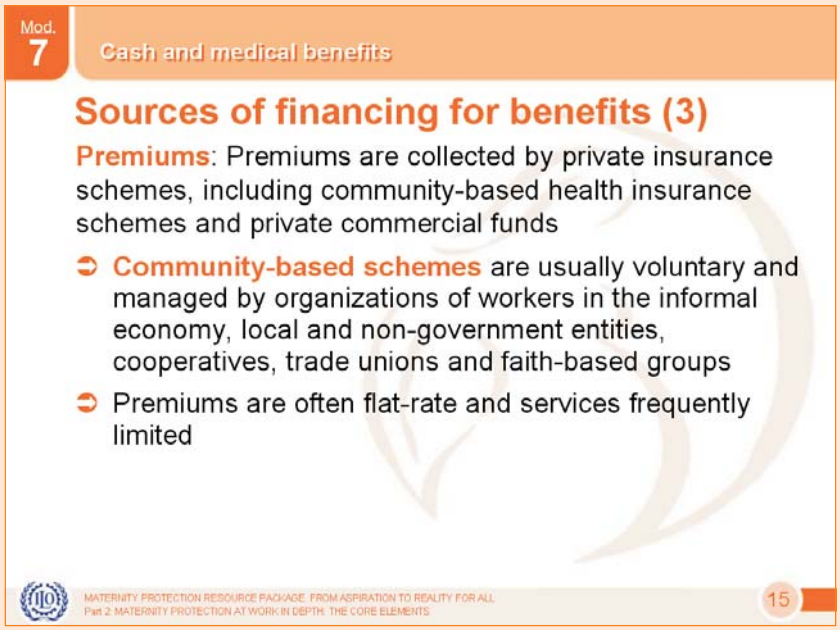
SLIDE 13: Sources of financing for benefits (1)



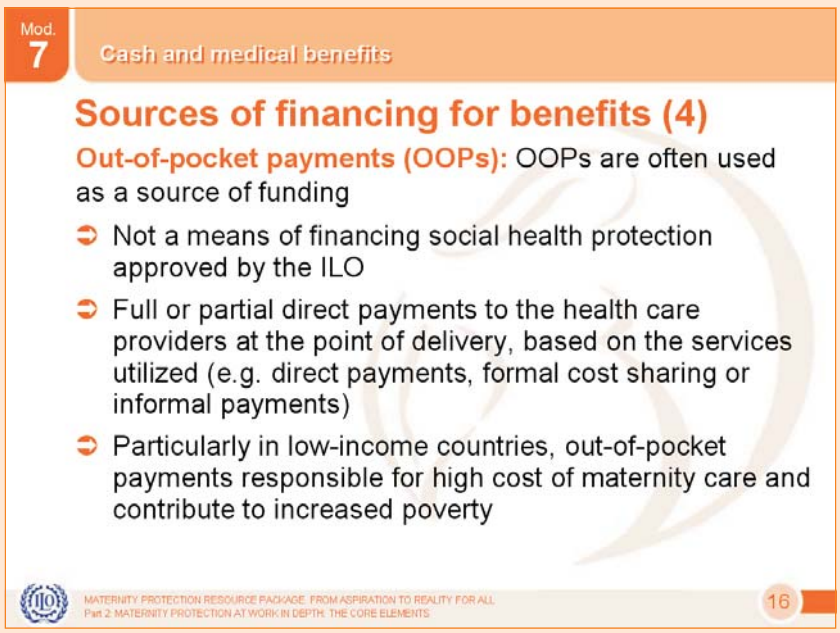
SLIDE 14: Sources of financing for benefits (2)



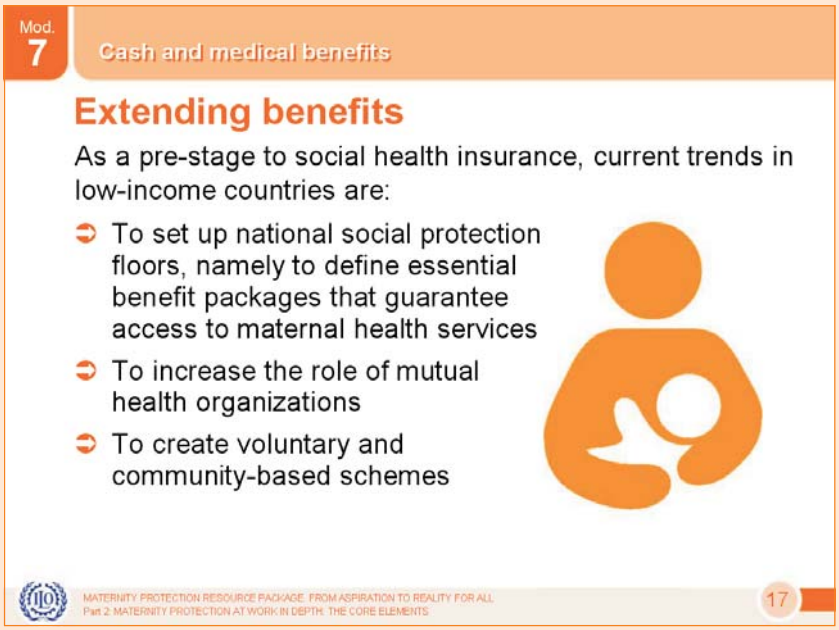
SLIDE 15: Sources of financing for benefits (3)



SLIDE 16: Sources of financing for benefits (4)

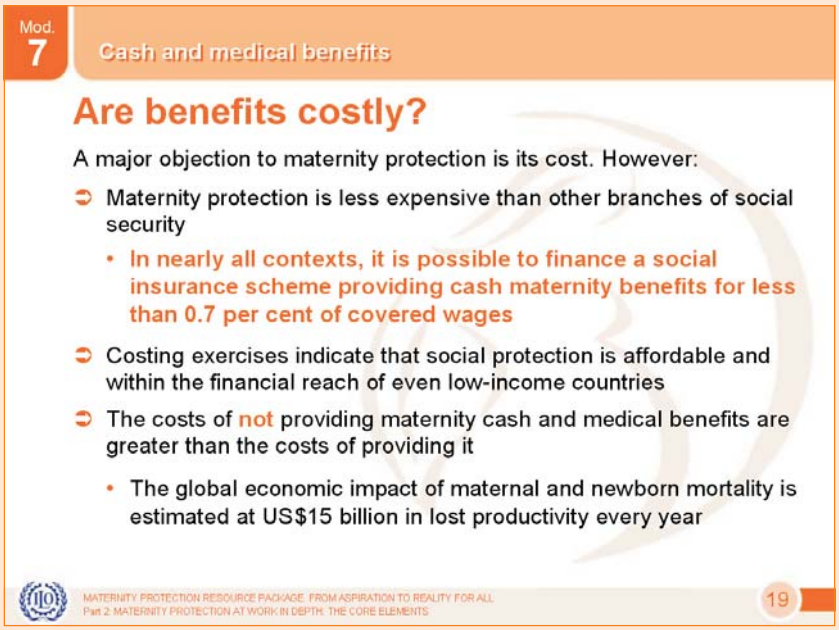


SLIDE 17: Extending benefits



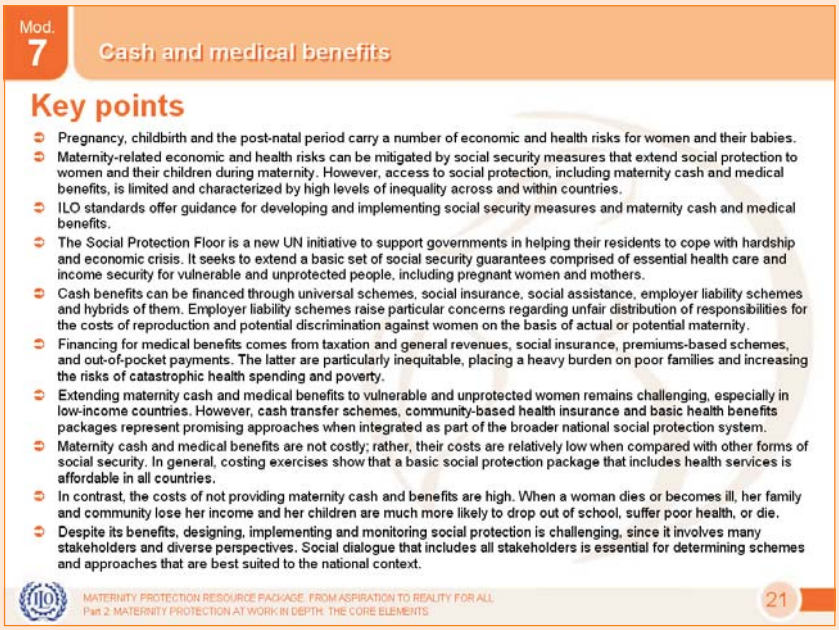
SLIDE 18: Administration

SLIDE 19: Are benefits costly?



SLIDE 20: Social dialogue

SLIDE 21: Key points



- Part 1: Maternity Protection at work: The basics
- Part 2: Maternity Protection at work in depth: The core elements
- Part 3: Taking action on Maternity Protection at work

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