

Financing Maternal Health Self-Care: Benefits for Health Systems and Households

Policy Paper

Lead Author: Dr. Jocelyn Kelly

Contributing Author: Dr. Nicole Goldin



UNU
CPR



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Bios

Dr. Jocelyn Kelly, Lead Author is Consulting Senior Fellow with UNU-CPR; Dr. Nicole Goldin, Project Director and Contributing Author, is Head, Equitable Development at UNU-CPR.

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Acronyms and Abbreviations

ASHA	Accredited Social Health Activist (India)
DALY	Disability-Adjusted Life Year
GDP	Gross Domestic Product
IFA	Iron and Folic Acid
INT\$	International Dollar (purchasing-power-adjusted)
LMIC	Low- and Middle-Income Country
MMR	Maternal Mortality Ratio
MMS	Multiple Micronutrient Supplements
SDG	Sustainable Development Goal
TeCHO+	Technology for Community Health Operations-Plus (Gujarat, India)
UHC	Universal Health Coverage
WHO	World Health Organization

1. Introduction

Maternal health investment in low- and middle-income countries (LMICs) is concentrated on what happens at the point of clinical contact: the antenatal visit, the clinic or the delivery room, and care in the weeks after pregnancy.¹ The much larger interval between those clinical visits remains comparatively unaddressed and unfinanced. Yet, most of pregnancy is lived outside a facility. It is at home that a woman makes decisions about her diet, whether she takes a daily supplement, and whether transport, money, permission and support are in place if an emergency occurs.

Self-care for maternal health is the ability of women, their families and communities to promote and maintain health, prevent complications and respond to health needs during pregnancy, childbirth and the postnatal period, with or without the support of a health worker. It includes self-awareness, self-monitoring and self-management, alongside timely access to quality professional care when needed.

This definition was adapted from the World Health Organization's definition of self-care² and maternal health,³ and its classification of interventions into self-awareness, self-testing and self-management.⁴

The quality of facility care remains indispensable. But facility-based interventions can only be fully realized when women have the capacity and knowledge to complement clinic-based interventions with ongoing home-based self-care. This gap is directly relevant to the *Compromiso de*

Sevilla,⁵ which places the effective and efficient use of domestic public resources at the centre of financing for sustainable development, and reaffirms the importance of investment in universal health coverage (UHC)⁶ and quality health systems.⁷

There is clear urgency for improving maternal well-being outcomes and continuity of care. In 2023, an estimated 260,000 women globally died from causes related to pregnancy and childbirth, representing roughly the death of one woman every two minutes. While the global maternal mortality ratio (MMR) has declined by 40 per cent since 2000, most of this progress occurred before 2016. Since then, the annual rate of reduction has stalled at 1.6 per cent. The Sustainable Development Goal (SDG) of reducing the global MMR to fewer than 70 deaths per 100,000 live births by 2030 now requires annual reductions of close to 15 per cent.⁸ Self-care is among the effective responses to narrowing the maternal mortality gap that does not depend on potentially costly, long-term investments in new infrastructure and workforce capacity.⁹

Moreover, interventions during and immediately after pregnancy not only benefit the mother but can have long-term impacts for her baby. Roughly one-quarter of babies born alive in 2020 were preterm, small for gestational age or of low birthweight. These conditions also accounted for just over half of all neonatal deaths. Long-running birth cohorts link these outcomes to reduced adult height, schooling, earnings and to higher adult blood pressure and glucose. A modelling analysis estimated that achieving full coverage of eight proven antenatal interventions in 81 LMICs could

1 Mary Kinney and others, "Global Financing Facility Investments for Vulnerable Populations: Content Analysis Regarding Maternal and Newborn Health and Stillbirths in 11 African Countries, 2015 to 2019", *Global Health Action*, vol. 17, No. 1 (2024). Available at <https://doi.org/10.1080/16549716.2024.2329369>; Jesper Sundewall and others, "Self-care Interventions for Sexual and Reproductive Health: A Strategic Health Systems Investment", *BMJ Global Health*, vol. 10, suppl. 6 (2025). Available at <https://doi.org/10.1136/bmjgh-2025-019030>.

2 World Health Organization, "Self-care interventions" (accessed 10 September 2026).

3 World Health Organization, "Maternal health" (accessed 10 September 2026).

4 World Health Organization, *Self-care competency framework. Volume 2: Knowledge guide for health and care workers to support people's self-care* (Geneva, 2023).

5 The Sevilla Commitment is the outcome document of the Fourth International Conference on Financing for Development (Sevilla, 30 June to 3 July 2025), endorsed by the General Assembly on 25 August 2025 as A/RES/79/323; paragraph 19 is its dedicated health provision.

6 WHO defines UHC as access for all people to the full range of quality health services they need, without financial hardship, across the continuum from promotion to palliative care. SDG target 3.8 commits States to achieve it by 2030, tracked by indicator 3.8.1, an index of 14 tracer service coverage indicators reported on a 0 to 100 scale, and indicator 3.8.2, the proportion of the population whose out-of-pocket health spending exceeds 40 per cent of household discretionary budget.

7 World Health Organization, *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience* (Geneva, 2016); World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022); and United Nations, *Compromiso de Sevilla* (2025), paras. 19 and 26–27.

8 World Health Organization and others, *Trends in Maternal Mortality 2000 to 2023* (Geneva, 2025).

9 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022). The WHO identifies self-care interventions as a critical component on the path to UHC and as a complement to, rather than a replacement for, health services.

prevent approximately 5.2 million preterm or small-for-gestational-age births each year.¹⁰ While these estimates relate to interventions beyond self-care alone, improving a women's ability to care for herself and her child in this sensitive time could have long-term benefits for individuals, families and countries as a whole.

The World Health Organization (WHO) defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker. Its 2022 Guideline on Self-Care Interventions for Health and Well-being sets out recommendations for the drugs, devices, diagnostics and digital tools through which that ability is exercised.¹¹ Maternal self-care is the ability of women, their families and communities to promote and maintain health, prevent complications and respond to health needs during pregnancy, childbirth and the postnatal period.¹² Maternal health self-care means not only that a woman attended an antenatal care visit, for instance, but that she left that interaction with the knowledge, support and resources to manage her pregnancy effectively until the next contact.¹³

Building on documented health benefits of maternal self-care interventions, this brief explores the still emerging evidence of further fiscal and economic returns from these interventions. In doing so, this brief explores how making maternal self-care visible, measurable and financeable could be an avenue for economic return for LMIC governments and their development partners. An advisor who tracks national self-care policy across multiple countries notes that the field's frontier is now shifting toward maternal health: the 2022 WHO Guideline on Self-Care Interventions for Health and Well-being reaches well beyond its sexual and reproductive health and rights-focused predecessor, and a growing number of governments want to extend self-care into maternal care specifically.¹⁴

1.1 Maternal Health Self-Care: A Key Investment Between Clinical Touchpoints

Maternal health spending produces a return only when a woman's contact with the health system leads to an effective intervention and, ultimately, better health. Supported maternal self-care can help complete this pathway by enabling women to understand and use recommended interventions between contacts, and to seek clinical care when risks arise. This links maternal self-care to UHC, which requires access to needed, good-quality services without financial hardship, and to the Compromiso de Sevilla's call for domestic resources to be used effectively and invested in equitable, resilient and high-quality health systems.

However, there is often a mismatch between how pregnancy is experienced and how maternal health is financed. The key question is not only how many clinical visits governments finance, but whether budgets fund the full pathway that helps women achieve health and well-being.

Public maternal health budgets generally allocate funds to antenatal services and to the staff, medicines, supplies and facilities used to deliver them.¹⁵ Most of pregnancy, however, is lived between those contacts. The return on publicly financed inputs depends not only on what happens during a clinical visit, but also what happens before and between clinical visits. This includes whether a woman can take a supplement each day, recognize a danger sign and seek timely care, monitor a potentially serious condition or reach a provider when needed. If that continuity is missing, the system has paid for contact at a clinic but has not financed the additional elements needed to realize its full health and fiscal benefits.

Supported self-care enables women to manage their health safely between clinic visits, while remaining connected to the health system. This could include counseling, reliable access to medicines and supplements, household and community support, accessible communication and a referral system that responds when a woman seeks help.

10 G. Justus Hofmeyr and others, "Evidence-based antenatal interventions to reduce the incidence of small vulnerable newborns and their associated poor outcomes," *The Lancet*, vol. 40, No. 10389 (2023): 1733–1744. Available at [https://doi.org/10.1016/S0140-6736\(23\)00355-0](https://doi.org/10.1016/S0140-6736(23)00355-0).

11 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022).

12 The WHO defines maternal health as pregnancy, childbirth and the first six-weeks postpartum.

13 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022); and Anam Shahil Feroz and others, "Strengthening self-care agency in pregnancy: a new approach to improve maternal health outcomes in low- and middle-income countries", *Frontiers in Public Health* (2022).

14 Key informant interview, conducted via Microsoft Teams, 27 July 2026.

15 Organisation for Economic Co-operation and Development, Eurostat and World Health Organization, *A System of Health Accounts 2011: Revised Edition* (Paris and Geneva, OECD Publishing and World Health Organization, 2017); World Health Organization, *WHO Recommendations on Antenatal Care* (2016); and World Health Organization, *List of Key WHO-Recommended Maternal and Newborn Health Commodities* (Geneva, 2024).

To realize the full health and economic returns on maternal health, public budgets should consider covering the staff time, training, supervision, communications and clinical services that safe self-care depends on. Without these elements, governments risk shifting costs and risks to women. One maternal and newborn health specialist cautioned that many women cannot practice self-care at home unaided, and that the community engagement and support they need is routinely underemphasized in programming.¹⁶ Women affected by poverty, who live in a remote location, who cannot read, are living with a disability or face safety concerns or limited control over

household resources will likely be the most adversely affected by this gap.

Maternal self-care represents a key pathway for realizing UHC and the Compromiso de Sevilla. UHC means people receive the quality services they need without undue financial hardship, while the Compromiso de Sevilla provides a corresponding public finance mandate.

The table below outlines key examples of maternal self-care interventions and corresponding fiscal evidence.¹⁷

Intervention	How It Supports Self-Care	Fiscal Evidence Base	Fiscal Returns
Multiple Micronutrient Supplements ¹⁸	Women take a daily over-the-counter supplement at home during pregnancy.	• 1 Cochrane systematic review. • 1 individual-participant-data meta-analysis of randomized trials. • 1 cluster-randomized effectiveness trial through routine antenatal care. • Cost-effectiveness models in at least 6 LMICs and 2 multi-country tools. • 1 Copenhagen Consensus benefit-cost estimate. • A 2025 systematic review identified only 5 LMIC cost-effectiveness studies.	• A 2023 study estimated a 37.5 to 1 benefit-cost ratio for replacing iron and folic acid with MMS across 40 LMICs • Produces health gains at relatively low cost. • Returns depend on regular use.
Digital Tools	Reminders and mobile support help women follow clinical advice, keep appointments and seek care when needed.	• 3 economic evaluations: 1 of ReMiND and 2 of mCARE. • All rely on modelled health outcomes rather than audited savings.	• The ReMiND programme lowered total costs by reducing household spending. • The mCARE programme was projected to avert 3,076 deaths and stillbirths and became more cost-effective as it expanded.

¹⁶ Key informant interview, conducted via Microsoft Teams, 5 August 2026.

¹⁷ There may be additional maternal health self-care interventions that do not currently have a fiscal evidence base, even though their clinical benefits are established.

¹⁸ In this brief, multiple micronutrient supplementation (MMS) refers to antenatal supplements containing iron and folic acid together with additional vitamins and minerals. Formulations in the WHO evidence base generally contained 13–15 micronutrients and included, but were not limited to, the standardized 15-micronutrient UNIMMAP formulation. UNIMMAP is the standardized 15-micronutrient formulation developed by UNICEF, WHO and the United Nations University; it contains 30 mg of iron and 400 µg of folic acid and is the formulation reflected in the WHO Model List of Essential Medicines. WHO’s antenatal-care recommendation is broader: it covers MMS containing iron and folic acid, drawing on trials of formulations with 13–15 micronutrients, including UNIMMAP.

Intervention	How It Supports Self-Care	Fiscal Evidence Base	Fiscal Returns
Community Health Workers and Women's Groups	Health workers and peer groups help women learn, plan and act between clinic visits.	• 3 economic analyses. • Evidence includes a large nonrandomized programme evaluation, 4 randomized women's-group trials and 1 cluster-randomized trial.	• The Jharkhand programme cost about \$9 per birth and \$41 per life-year saved. • Home visits in Mali delivered antenatal care more efficiently.
Home Monitoring and Self-Management of Blood Glucose, Blood Pressure and Weight	Women monitor blood pressure or manage conditions such as gestational diabetes between visits.	• No LMIC economic evaluations were available. • The WHO guidance draws on high-income-country evidence of moderate to very low certainty.	• Earlier detection could reduce emergency care. • No reliable LMIC estimate of costs or savings is available.

2. Tracing Maternal Self-Care Returns Through Three Fiscal Pathways

This section will trace the existing evidence on fiscal returns for maternal care across the three pathways identified in the first paper in this series, *Self-Care Pathways to Universal Health Coverage and Financing Equitable Development*: health system savings and value for money; household financial security; and opportunity for sustainable growth. The pathways operate over different time horizons and accrue to different stakeholders. A programme may raise the health budget in the current year, reduce household spending during pregnancy and generate a larger productivity return decades later. Considering these pathways together, therefore, helps give a more holistic picture of the potential economic and financial returns on maternal health self-care investments and policies.

2.1 Health System Cost-Containment and Value for Money

The first pathway explores how self-care can improve the value of health system spending, or contain costs, by preventing complications, detecting them earlier or delivering care at lower cost. Prevention and earlier detection can reduce the need for expensive care later in pregnancy. A systematic review of studies from sub-Saharan Africa reported health system costs of \$8–\$73 for an uncomplicated vaginal delivery, \$80–\$562 for a cesarean delivery, \$120–\$190 to treat eclampsia and about \$500 to care for a infant. The estimates span different countries, years and costing methods. They should not be read as

current prices, but they show how sharply costs can rise when a birth requires surgery or complications require treatment.¹⁹

MMS may improve the value of antenatal spending by reducing low birthweight and small-for-gestational-age births at a modest additional cost. The added cost is \$0.17–\$1.42 per pregnancy, depending on purchasing assumptions, and a comprehensive review found that MMS reduced low birthweight births by 12 per cent. The efficiency benefits of MMS therefore appear large relative to its added cost, although they may not translate into budget savings in the immediate term.

Community and digital programmes may improve value by bringing counseling, pregnancy monitoring and referral closer to women. Whether they increase or reduce public spending depends on how each programme is designed and what services are already available. For example, in rural Uttar Pradesh, India, ReMiND equipped community health workers (CHWs) with a mobile app to guide counseling and referral. Modelling projected reductions in maternal and neonatal illness and deaths. Over 10 years, the model estimated a 0.2 per cent reduction in maternal deaths and a 5.3 per cent reduction in neonatal deaths. The programme increased health system spending but was cost-effective at the study's stated threshold and cost-saving once household and other societal costs were included. It cost the health system \$205 per disability-adjusted life year

19 Amani Thomas Mori and others, "Patient and health system costs of managing pregnancy and birth-related complications in sub-Saharan Africa: a systematic review", *Health Policy and Planning*, vol. 35, No. 9 (2020). Costs were standardized to 2018 United States dollars.

(DALY) averted but saved \$90 per DALY from a societal perspective.

In rural Bangladesh, the mCARE initiative combined digital pregnancy surveillance with text and home-visit reminders to encourage antenatal, delivery and postnatal care. In a modelled expansion from 1 million to 10 million people, the cost per DALY averted fell from \$1,152 over five years to \$462 over 10 years. Although it required additional spending, its projected cost per healthy year gained fell as the programme expanded and fixed costs were spread across more people. In Mali, proactive home visits by CHWs cost less per additional antenatal contact than fixed-site care. Women receiving proactive visits averaged 2.71 antenatal contacts, compared with 1.62 under fixed-site care, while the cost per CHW contact was \$4.03 rather than \$14.51.

These findings support the argument that self-care may improve the value and productivity of health system spending, though evidence of direct, near-term budget savings remains limited. Ministries of finance would still need to estimate the annual cost of each intervention, whether it reduces emergency or inpatient care, when those reductions occur, and how much of the avoided expenditure would otherwise have been paid by government.

2.2 Household Financial Security

The second pathway considers out-of-pocket costs borne by women and their households. This can reduce household costs by shifting some care to the home – saving women travel and clinic expenses and time away from work – and by preventing complications that can lead to catastrophic spending.

Earlier advice may help a woman obtain care before a condition becomes more serious and remote support can result in savings by averting the costs of traveling to and paying for clinic visits. In the Reducing Maternal and Newborn Deaths (ReMiND) programme, a mobile health initiative supporting CHWs' maternal and newborn counselling, tracking and referrals in rural Uttar Pradesh, India, households spent less on medicines, procedures,

lodging and transport. While the programme required more public spending, the estimated household savings were large enough to offset the increase in health system costs, leaving total costs lower from a societal perspective.²⁰

Yet, higher use of needed care can also increase household spending when coverage is incomplete. In the Bangladesh mCARE scale-up model, user costs were projected at \$40 million under the full mCARE programme, compared with \$24 million under paper-based practice, because surveillance and reminders led more women to use antenatal, delivery and postnatal services. User costs accounted for about 35 per cent of the full programme's total societal cost. However, a digital reminder may not provide financial protection when the service it recommends still requires unaffordable transport, fees or time away from paid and unpaid work.

Delivery complications impose substantial costs on families and health systems; across studies from sub-Saharan Africa, caesarean delivery costs approximately seven times more than vaginal delivery.²¹ Supported blood-glucose self-monitoring for gestational diabetes reduced pre-eclampsia, macrosomia and shoulder dystocia.²² Postpartum blood-pressure programmes have also reduced readmissions and medical costs when home monitoring was linked to clinical action.²³ These findings establish a plausible pathway from supported self-care to lower expenditure through complications averted.

2.3 Opportunity for Sustainable Growth Dividend and Intergenerational Returns

As part of maternal health, holistic self-care can contribute, directly and indirectly, to economic returns, both during a woman's own life course and for the next generation. Protecting women's reproductive health and newborns' early-life health contributes to productivity over a much longer horizon. A model covering 45 countries in the WHO African Region estimated that maternal deaths in 2010 were associated with approximately \$4.5 billion in foregone non-health gross domestic product. The calculation valued market production and excluded much of women's unpaid care and household production; it is an estimate of

20 Shankar Prinja and others, "Cost effectiveness of mHealth intervention by community health workers for reducing maternal and newborn mortality in rural Uttar Pradesh, India", *Cost Effectiveness and Resource Allocation*, vol. 16 (2018). The societal perspective included household out-of-pocket payments for medicines, procedures, lodging and transport; productivity losses were excluded.

21 Amani Thomas Mori and others, "Patient and health system costs of managing pregnancy and birth-related complications in sub-Saharan Africa: a systematic review", *Health Economics Review*, vol. 10 (2020).

22 Ping Teresa Yeh and others, "Self-monitoring of blood glucose levels among pregnant individuals with gestational diabetes: a systematic review and meta-analysis", *Frontiers in Global Women's Health*, vol. 4 (2023).

23 Adi Hirshberg and others, "Association of a remote blood pressure monitoring program with postpartum adverse outcomes", *Obstetrics and Gynecology*, vol. 141, No. 6 (2023).

one economic channel rather than the full social cost of maternal mortality.²⁴

The longer-term potential dividends run through fetal growth and early development. MMS reduces the risk of low birthweight relative to iron and folic acid (IFA) supplementation. In the 25 countries accounting for 87 per cent of low birthweight births across LMICs, a 2026 model estimated that replacing IFA with MMS at current IFA coverage would avert 3.5 million births with low birthweight over five years, rising to 7.3 million if MMS reached all women attending at least one antenatal visit.²⁵ Evidence from cohorts in Brazil, Guatemala, India, the Philippines and South Africa links impaired fetal and early-childhood growth with less schooling, weaker adult economic outcomes and lower birthweight in the next generation, undermining their earning potential. A study from Norway used comparisons within twin pairs to reduce confounding from family background and other shared circumstances. It estimated that a 10 per cent increase in birthweight was associated with approximately 1 per cent higher full-time earnings. The design strengthens the causal interpretation of the birthweight channel. This estimate, however, comes from a high-income country and the effects in LMICs may yield different results.²⁶

The World Bank has estimated a \$23 return for each dollar invested in maternal and child undernutrition. This takes into account combined mortality reduction, lower morbidity and future productivity across a package of interventions. Since the model covers a package of interventions, it does not provide an MMS-specific return. A separate analysis of 40 low- and lower-middle-income countries estimated that replacing IFA with MMS would generate \$37.50 in benefits for each \$1 spent, using an 8 per cent discount rate for

lifetime income gains.²⁷ The MMS estimate is modelled rather than observed over time.²⁸ No single study yet follows publicly supported antenatal self-care through supplement use, birth outcomes, schooling and adult productivity in an LMIC population.²⁹

Postpartum health can also affect women's ability to resume paid and unpaid work. In rural India, women who experienced severe complications around childbirth were more likely to report difficulty resuming household work. They were also more likely to report financial hardship during the following year.³⁰ Among low-income women in Cape Town, maternal depression was associated at 12 months postpartum with unemployment, lower per-capita household income and catastrophic health spending.³¹ The association between mental health and economic hardship also has plausible causal pathways that run in both directions, with hardship causing mental distress and with mental health problems leading to economic hardship. Further exploring this link, and the role of self-care in mitigating associated effects, could be an avenue for future research.

2.4 Equity and Reach in the Realization of Fiscal Returns

Equity considerations are fundamental to self-care for improving maternal health. In 2023, 61.4 per cent of maternal deaths occurred in the 37 countries affected by violent conflict or high institutional and social fragility and where clinical access or service delivery could be particularly challenging or disrupted. Within countries, women facing poverty, displacement, distance, low literacy, disability or limited control over phones and money are also more likely to be missed by facility and digital delivery. These are the populations among whom

24 Joses Muthuri Kirigia and others, "Indirect cost of maternal deaths in the WHO African Region in 2010". The model used a human-capital approach and a 3 per cent discount rate.

25 Bjorn Larsen, John Hoddinott and Saleema Razvi, "Investing in nutrition: a global best investment case", *Journal of Benefit-Cost Analysis*, vol. 14, Suppl. 1 (2023).

26 Cesar G. Victora and others, "Maternal and child undernutrition"; and Sandra E. Black, Paul J. Devereux and Kjell Salvanes, "From the cradle to the labor market? The effect of birth weight on adult outcomes", *The Quarterly Journal of Economics*, vol. 122, No. 1 (2007).

27 Bjorn Larsen, John Hoddinott and Saleema Razvi, "Investing in nutrition: a global best investment case", *Journal of Benefit-Cost Analysis*, vol. 14, Suppl. 1 (2023).

28 Bjorn Larsen, John Hoddinott and Saleema Razvi, "Investing in nutrition: a global best investment case", *Journal of Benefit-Cost Analysis*, vol. 14, Suppl. 1 (2023).

29 World Bank, *Investment Framework for Nutrition 2024* (Washington, D.C., 2024); Allison M. J. Verney and others, "Multiple micronutrient supplementation cost-benefit tool" (2023); Sandra E. Black, Paul J. Devereux and Kjell Salvanes, "From the cradle to the labor market?" (2007); and Cesar G. Victora and others, "Maternal and child undernutrition". These sources cover different interventions, populations and time horizons and do not constitute a single longitudinal causal estimate.

30 Kirti Iyengar, Ranjana Yadav and Swapnaleen Sen, "Consequences of maternal complications in women's lives in the first postpartum year: a prospective cohort study", *Journal of Health, Population and Nutrition*, vol. 30, No. 2 (2012).

31 Susan Cleary and others, "Economic burden of maternal depression among women with a low income in Cape Town, South Africa", *BJPsych Open*, vol. 6, No. 3 (2020).

preventable complications and household financial shocks are most concentrated.³²

Self-care may be especially suited to reducing access barriers for people living in poverty, remote communities and displaced populations, but equitable benefits are not a given. Realizing these benefits requires access to commodities, usable information, referral and clinical follow-up.³³ New interventions may instead be more likely to reach wealthier groups first and widen inequalities during early expansion.³⁴ Public financing and delivery systems

must therefore direct these supports toward populations poorly served by facility-based care.

A self-care programme that reaches women already connected to services may be cost-effective but will not close the care gap envisaged by UHC. Public financing will be more inclusive and therefore impactful when it prices and commits to the additional cost of reaching remote and excluded populations, including through offline communication, paid community outreach, translation and disability access, confidential use, transport and referral capacity.

3. Maternal Self-Care in Country Contexts: Fiscal Pathways in Policy Practice

3.1 Ethiopia: How Routine Antenatal Care Converts a Low-Cost Commodity Into a Fiscal Return

Ethiopia's MMR fell from 870 deaths per 100,000 live births in 2000 to 195 in 2023. But, in absolute numbers the country still recorded an estimated 7,460 maternal deaths that year.³⁵ Ethiopia formalized a national framework for self-care in 2024, when the Ministry of Health issued guidance for integrating reproductive, maternal, newborn, child, adolescent and youth health and nutrition self-care interventions into service delivery, with provisions for equitable access and referral to formal care.³⁶ Ethiopia illustrates the difference between financing a commodity and financing effective coverage. Rather than creating a new delivery system for MMS, it used routine antenatal care to support sustained daily use between clinical contacts.

Evidence from Ethiopia indicates that replacing IFA with MMS modestly increases birthweight, while economic models project that the transition could offer substantial value for money. A 2026 cluster-randomized trial found that MMS increased mean birthweight by 38 grams relative to IFA across 42 Ethiopian districts.³⁷ The trial confirms a modest improvement in birthweight, but it did not measure

costs. A 2019 model produced by Nutrition International estimated that replacing IFA with MMS at 30 per cent coverage would require an additional \$15 million over ten years. It projected 19,677 fewer child deaths and valued the resulting health gains at \$171 for every dollar invested.³⁸ The evidence therefore suggests that MMS may offer good value for money, but does not show that it necessarily reduces government spending.

Both the 2019 projection and the 2026 study illustrate gains through the health system efficiency pathway and the sustainable growth pathway. The trial provides country-level evidence that replacing IFA with MMS through routine antenatal care can improve birthweight. Birthweight also links the trial to the longer-term pathway through child development and later economic participation.

3.2 India: How Public Community Platforms Convert Self-Care Support Into Savings

India's commitment to supported maternal self-care is expressed through the National Health Mission's postnatal-care system. Its 2023 Optimizing Postnatal Care initiative provides for six home visits after an institutional delivery and seven after a home delivery during the first six

32 World Health Organization and others, *Trends in Maternal Mortality 2000 to 2023* (2025); and Angela Dawson and others, "Self-care interventions for sexual and reproductive health in humanitarian and fragile settings: a scoping review", *Conflict and Health* (2022).

33 World Health Organization, *WHO Guideline on Self-Care Interventions for Health and Well-being* (2022).

34 Cesar G. Victora and others, "Maternal and child undernutrition".

35 World Health Organization and others, *Trends in Maternal Mortality 2000 to 2023* (2025); and Ethiopia, Ministry of Health, *Annual Performance Report of 2017 EFY* (2026), p. 25.

36 Ethiopia, Ministry of Health, *National RMNCAYH-N Self-Care Intervention Guideline* (2024).

37 Masresha Tessema and others, "Effect on birthweight of an antenatal multiple micronutrient supplementation programme compared with iron-folic acid supplementation: a cluster-randomised, controlled trial in 85,698 Ethiopian women", *The Lancet Global Health*, vol. 14, No. 5 (2026).

38 Nutrition International, *Cost-Effectiveness of Transitioning from Iron and Folic Acid to Multiple Micronutrient Supplementation for Pregnancy: Ethiopia* (Ottawa, 2019).

weeks. The initiative combines counselling and support for micronutrient supplementation with maternal danger sign screening, transport and referral.³⁹

India combines a high volume of pregnancies with a public community health workforce already responsible for maternal and newborn care. The fiscal gains may rest on using that existing platform to reduce the cost of later illness. In rural Uttar Pradesh, the ReMiND programme equipped Accredited Social Health Activists (ASHAs) with a mobile app for pregnancy tracking, counseling, service reminders and follow-up.

A model of statewide implementation from 2011 to 2020 estimated that the state health system and implementing partners would spend an additional \$982 million as more women used preventive services and facility-based care. However, treatment costs fell as maternal and neonatal illness declined. Household out-of-pocket spending was projected to fall by approximately \$1.41 billion because families required less treatment and used public facilities more often. After the additional provider costs were deducted, the model estimated net societal savings of about \$425 million. Expressed per health outcome, the programme cost providers \$205 per DALY averted while reducing total societal costs by \$90 per DALY. These are modelled estimates based on extrapolation from the district pilot, rather than changes observed in state or household accounts. This is an example of a programme that may increase health spending in the short term, but results in longer-term societal savings and better health outcomes while offsetting household costs.⁴⁰ The results were modelled from a quasi-experimental impact evaluation and should be interpreted as projected savings rather than measured actual results.

Gujarat provides a second state-level example of public support for maternal self-care. In 2019, Gujarat's Department of Health and Family Welfare introduced Technology for Community Health Operations-Plus (TeCHO+) across the public health system. The platform allows frontline workers to register services when they are delivered, identify high-risk pregnancies and refer women for further care when needed. In a two-district evaluation conducted one year after its introduction, full antenatal-care coverage rose from 67.9 to 75.6 per cent, the proportion of women who reported taking at least 180 IFA tablets rose from 77 to 93 per cent, and early initiation of breastfeeding rose from 24.2 to 42.7 per cent.

Frontline workers also reported saving an average of 1.7 hours a day on documentation.

While the programme did require additional public spending, an analysis showed that the intervention was cost-effective relative to Indian GDP per capita. Compared with an earlier system, TeCHO+ cost an additional \$20.91 per beneficiary, but averted \$24.33 in costs after combining modelled changes in maternal and child health. It is worth noting that the model considered the generationally-accruing returns, combining maternal with child health gains (maternal anemia, pregnancy-induced hypertension, low birthweight and child undernutrition).⁴¹

In Jharkhand, women's groups extended preventive support beyond health facilities. ASHAs helped women identify maternal and newborn health problems, improve care at home and seek clinical care when needed. A six-district evaluation found that neonatal mortality was 24 per cent lower in those districts that started the evaluation earlier. The programme later reached an estimated 1.6 million livebirths across 20 districts. Over 42 months, it cost approximately \$4.3 million in 2020, or \$2.70 per livebirth covered. Delivery became less expensive as the programme expanded, partly because it paid existing frontline workers incentives rather than hiring a separate salaried workforce. The study estimated a cost of approximately \$12 per life-year saved but did not measure whether better prevention reduced later spending by hospitals or households. Improved neonatal survival could contribute to later human development and economic participation, although this outcome was not followed explicitly in this study.⁴²

These programmes act on both the health system and household pathways. ReMiND shows that an intervention can increase public expenditure and still lower total societal costs when preventive care displaces household spending on illness. TeCHO+ shows that the additional cost of identifying and managing high-risk pregnancies can remain low relative to the health produced. Jharkhand shows that supported agency can be delivered through the public system for less than \$10 per birth. While they show directional evidence or returns to maternal health self-care, the state studies do not establish a single national return because two rely on modelled outcomes, administrative capacity differs across states, and several estimates combine maternal, neonatal and child benefits.

39 India, Ministry of Health and Family Welfare, *Guidance Note on Optimizing Post-natal Care* (2023).

40 Prinja and others, "Cost effectiveness of mHealth intervention by community health workers".

41 Somen Saha and others, "Cost-effectiveness of mHealth intervention (TeCHO+) for improving maternal and child health indicators in Gujarat, India", *Indian Journal of Community Medicine*, vol. 47, No. 4 (2022).

42 Hassan Haghparast-Bidgoli and others, "Economic evaluation of participatory women's groups scaled up by the public health system to improve birth outcomes in Jharkhand, eastern India", *PLOS Global Public Health*, vol. 3, No. 6 (2023).

4. Recommendations and Way Forward

Publicly supported, incentivized and regulated self-care may improve what antenatal spending can achieve. This is most likely to occur when women can use low-cost supplies and manage parts of their care between appointments, while continuing to have access to clinical services and without taking on additional costs. The recommendations below emerge from the evidence and experiences presented through the brief's three fiscal pathways and its cross-cutting concern with equity, reach and measurement. They also respond to the Compromiso de Sevilla's call for efficient use of domestic public resources and continued investment in UHC and quality health systems.⁴³

4.1 Recommendations

Finance Effective Coverage

Ministries of health:

- **Budget for the full self-care cycle, not procurement alone.** Cost MMS and comparable commodities as a package, including uninterrupted supply, counseling, follow-up and measurement of use, rather than as tablets distributed.
- **Use existing public community platforms where they function.** Extend antenatal services through CHWs and connected digital tools that are already embedded in referral or primary-care systems.

Ministries of finance

- **Require a budget impact analysis alongside each cost-effectiveness estimate.** For each maternal health self-care intervention, report provider cost, household cost, the timing of any averted emergency use and the government's share of avoided cost.⁴⁴

Protect Household Financial Security

National governments and UHC purchasers

- **Finance the care pathway a self-care tool activates, not just the tool.** Where an intervention increases referrals, financing plans should address the additional costs borne by patients and households through measures such as transport support, fee removal,

community delivery or cash and social protection mechanisms.

Appraise Sustainable Growth Returns Over an Explicit Time Horizon

Ministries of finance and national planning authorities

- **Report long-term benefits separately from near-term returns; trace financial and economic returns** from antenatal self-care through to adult labour-market outcomes. Investment cases should present near-term health system and household effects alongside a separate, discounted estimate of long-run benefits.

Ensure Self-Care is Measurable and Equitable

National governments

- **Measure effective coverage rather than contacts alone.** Track the sequence from pregnant women reached, to intervention received, sustained use or successful action, clinical outcome, service utilization and household cost.

United Nations Secretariat and agencies

- **Consider the multiple financial pathways for maternal self-care in the Compromiso de Sevilla follow-up.** United Nations-supported investment should report annual public budget impact, household costs and longer-term economic returns for maternal self-care separately.
- **Support member governments to finance the full public delivery pathway.** United Nations-supported maternal health programmes should fund supply continuity, workforce, follow-up, referral and any transport or fee support.

WHO and development partners

- **Fund prospective economic evaluation, cross-country and comparative, where maternal fiscal evidence is absent.** Prioritize implementation of blood pressure self-monitoring and gestational-diabetes self-management in LMICs, measuring device and training costs, follow-up, referral, severe complications, facility use, household expenditure and provider workload.

43 United Nations, *Compromiso de Sevilla* (2025), paras. 19 and 26–27; and World Health Organization and World Bank, *Tracking Universal Health Coverage: 2025 Global Monitoring Report* (Geneva, 2025).

44 Prinja and others, "Cost effectiveness of mHealth intervention by community health workers"; Youngji Jo and others, "Costs and cost-effectiveness analyses of mCARE strategies for promoting care seeking of maternal and newborn health services in rural Bangladesh", *PLOS ONE*, vol. 14, No. 10 (2019); and Youngji Jo and others, "mCARE, a digital health intervention package on pregnancy surveillance and care-seeking reminders from 2018 to 2027 in Bangladesh", *BMJ Open*, vol. 11 (2021).

4.2 Conclusions and Way Forward

Maternal health self-care can help improve health system cost-containment and ease costs for families, but the size and timing of these gains depend on the intervention and on who pays. MMS can be added to routine antenatal care at a small incremental commodity cost and produce health at favourable modelled cost-effectiveness ratios. Community and digital programmes can improve the productivity of an existing public workforce. The state-level India evidence also shows that additional public expenditure can reduce household spending enough to lower total societal costs. These findings support the Compromiso de Sevilla's call to "spend better" by using domestic public resources efficiently while continuing to invest in UHC and quality health systems. Ensuring safe, accessible care for mothers and their babies can provide returns for societies not only in the near-term but for generations.

The three fiscal pathways accrue differently. Prevention of poor maternal and newborn outcomes and earlier action

can improve health system value in the current budget period. Public coverage of the care pathway can protect households from transport, service and emergency costs. Maternal survival and better early-life health can contribute to productivity over a much longer horizon, although the intergenerational estimate is assembled across studies and should remain separate from near-term budget effects. Equity affects each return because a cost-effective programme cannot close the care gap envisaged by UHC among women who are unable to receive or use it.

Several concrete actions to support maternal self-care can also lead to fiscal savings or long-term returns: integrating supported self-care within maternal health and UHC benefit packages, financing the recurring functions that make use possible, protecting households from the costs that clinical care-seeking generates, and measuring what coverage and spending actually reach women. These actions keep responsibility with the health system while extending the value of maternal health investment into the weeks between clinical contacts.

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cpr.unu.edu

New York (Headquarters)
One Dag Hammarskjöld Plaza
885 2nd Avenue, 14th Floor
New York, NY 10017
United States
Tel: +1-646-905-5225
Email: comms-cpr@unu.edu

Geneva
Maison de la Paix
Chemin Eugène-Rigot 2E
Geneva, Switzerland
Tel: +1-917-225-0199
Email: comms-cpr@unu.edu