



Beyond Solutions: Capability, Development Frontiers, and the Process of Good Change

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Abstract

This article conceptualizes development as a process of ‘good change’, or durable improvements achieved through adaptive problem-solving within specific social contexts. It argues that such results depend less on adopting correct policies than on building capability—the empowered ability of individuals, organizations, and societies to act effectively. Drawing on insights from development economics, organizational theory, and political economy, the article proposes that development unfolds across successive capability frontiers, where progress increasingly depends on locally embedded learning and coordination. The argument is illustrated through a process-tracing analysis of India’s reduction in maternal mortality from the 1980s to the present. The evidence shows that sustained improvements resulted from sequential expansions in system capability rather than the implementation of a single solution. The findings suggest that international development practice should prioritize strengthening capabilities rather than transferring technical interventions.

Introduction

With McGillivray (2012), I define development as *good change*—a process through which societies adapt to address problems they care about in ways that endure. This definition emphasizes two essential features. First, development is inherently contextual: what counts as ‘good’ depends on socially defined priorities within particular societies. Second, development is fundamentally dynamic: it involves continuous adaptation as conditions, constraints, and aspirations evolve. International development, in turn, can be understood as the efforts external actors make to help emerging societies achieve durable improvements in the things they value.

Much international development practice remains oriented toward funding best practice ideas about *what* emerging societies should do to experience these improvements—what policies to adopt, what institutional forms to emulate, and what interventions to implement. I see this in the solutions development agencies frequently prescribe, like liberalizing markets to foster growth, constructing clinics to reduce maternal mortality, strengthening transparency mechanisms to improve governance, or adopting digital technologies to enhance service delivery. Many of these recommendations are sensible and potentially beneficial. Yet they often prove insufficient—and sometimes wholly ineffective—in producing sustained improvements in real outcomes. In many cases, countries succeed only in adopting these solutions in form—changing the appearance of institutions or policies without transforming how systems function, resulting in reforms that are formally adopted but weakly implemented and rarely sustained (Andrews, 2013).

The gap between adopted solutions and durable results reflects the fact that development should not be fundamentally about selecting the best *what*—or technical solution—to a contextual challenge. Rather, it should be about building the contextual capability to identify, implement, and continuously improve such solutions over time. Without this capability, even well-designed interventions fail to translate into meaningful change. Conversely, societies that possess strong capabilities can often achieve progress even when starting with imperfect or evolving solutions.

I define capability as the *empowered ability to do*: the sustained and demonstrated ability of individuals, organizations, and societies to achieve valued outcomes through effective action. Highly capable societies are characterized not simply by formal institutions or resources, but by

the presence of actors who are authorized, motivated, and able to discover and implement solutions to the problems they face. These societies are able to adapt when conditions change, learn from experience, and progressively improve their performance. Less capable societies, by contrast, may adopt formal structures or policies yet lack the underlying ability and empowerment required to translate them into sustained results.

This perspective implies a shift in how international development should be understood and practiced. Rather than focusing primarily on providing resources (“giving fish”) or transferring technical solutions (“teaching how to fish”), international development actors should prioritize strengthening the capability of societies to learn, adapt, and solve problems themselves (“learning how to learn—how to fish, and more”). This involves helping contexts build the institutional, organizational, and human foundations necessary to sustain continuous processes of good change. International organizations can do this, and have done this, but need to do it more.

This article advances this argument by integrating insights from multiple literatures on capability and applying them to an empirical case of long-term development progress. Section one clarifies what is meant by capability, drawing on work from development economics, organizational theory, and political economy. Section two illustrates development as a capability-building process through a process-tracing analysis of India’s reduction in maternal mortality over four decades. The analysis shows that progress did not result from the simple adoption of policy solutions, but from successive expansions of capability that enabled the health system to address increasingly complex challenges over time. A concluding section discusses the implications of this perspective for international development practice, arguing that sustainable progress depends less on identifying optimal solutions than on strengthening societies’ ability to continually generate and implement them.

Ideas About Capability

As noted, capability is central to my understanding of development. I draw on complementary literatures to clarify the concept across different levels of analysis. At the individual level, Sen (1999) defines capability as the freedom people possess to achieve valued ways of being and doing. At the level of organizations and firms, capability is associated with productive and innovative performance. Schumpeter (1934) locates it in entrepreneurial capacity—the ability to

recombine knowledge and resources in novel ways—while Teece and colleagues (Teece et al., 1997; Teece, 2009) distinguish between *ordinary capabilities*, which enable firms to perform established tasks reliably, and *dynamic capabilities*, which allow them to adapt and transform in changing environments. At the level of states and societies, capability refers to the institutional arrangements that facilitate private initiative and enable effective collective action (North, 1990; Acemoglu and Robinson, 2012; Andrews et al., 2017).

Drawing on these perspectives, I define capability as the sustained ability of people, organizations, and societies to achieve valued outcomes through effective action. The emphasis is on performance rather than formal structure or stated intent. A law only expands capability if it changes behavior; a new technology only expands capability if it is used; a policy vision only expands capability if it empowers actors to act differently.

I conceptualize capability as comprising two inseparable elements, ability and empowerment:

- Ability, or competence, refers to the knowledge and skills required to determine what to do and how to do it in the face of development challenges. This includes technical knowledge ('know-what') and experiential, tacit understanding ('know-how'), which is built through training, practice, and iterative learning. While some aspects of ability can be transferred through formal instruction, much of it must be developed in context through experience.
- Empowerment refers to the authority and motivation to act. Individuals and organizations may possess technical ability yet lack the mandate, resources, or incentives to apply it. External authority derives from formal mandates, resource allocation, and institutional structures, while intrinsic motivation arises from identity, purpose, ownership, and confidence. Both forms are essential to effective action.

Capability exists only when these elements align. Skill without authority remains inert; authority without skill produces ineffective action; and incentives without intrinsic commitment often result in superficial compliance rather than meaningful change.

Operational and Dynamic Capability

It is useful to distinguish capability from the related concept of capacity. Capacity is often defined as the maximum volume of activity an entity can sustain. Capability—the ability to act effectively—is what determines a context's capacity and what must be strengthened to expand it.

Building on Nelson and Winter (1982) and Teece et al. (1997), I differentiate between two types of capability. Ordinary capabilities enable organizations to perform established tasks reliably and at scale. They underpin existing service delivery systems—for example, a tax authority’s ability to process returns or a health system’s ability to distribute routine vaccinations. These capabilities provide stability and predictability. Dynamic capabilities, by contrast, enable adaptation when conditions change. They involve sensing emerging challenges, mobilizing resources to respond, and transforming routines as necessary (Teece, 2009). In development contexts, dynamic capabilities allow actors to address new problems, respond to shocks, and innovate in response to evolving needs.

Development requires both. Societies must embed ordinary capabilities to ensure reliable performance while simultaneously cultivating dynamic capabilities to continually but appropriately expand what they are able to do. This dual requirement makes development inherently iterative: it involves stabilizing existing competencies while continually building new ones.

Capability Demands Across Development Frontiers

The literature suggests that capability building proceeds through successive frontiers, each characterized by distinct challenges and capability demands. At the individual level, Sen (1999) emphasizes that development begins with foundational capabilities—such as health and education—before enabling more complex freedoms. At the organizational level, firms first establish operational reliability before developing adaptive and innovative capacities (Teece et al., 1997). At the societal level, economic historians show that early development relies on administrative consolidation and imitation, while later stages require innovation, coordination, and institutional learning (Gerschenkron, 1962; North, 1990; Aghion and Howitt, 2006; Kharas and Kohli, 2011).

These insights suggest that early development challenges are typically systemic and visible: inadequate infrastructure, limited-service coverage, weak administrative reach, and shortages of skilled personnel. Progress at this stage depends largely on building logistical and technical capabilities, often through standardized and transferable solutions. As these constraints are addressed, however, the nature of development challenges changes. Problems increasingly shift toward quality, coordination, and adaptation—for example, improving learning outcomes after achieving universal school enrollment, strengthening tax compliance in complex economies, or

managing sophisticated financial systems. These challenges require capabilities that are less technical and more socially embedded, relying on judgment, coordination, and continuous learning.

Recognizing these shifting capability demands helps explain why development progress often accelerates in early stages but slows at later ones. Early gains frequently reflect the deployment of technical solutions, while later progress depends on building complex, adaptive capabilities that take longer to cultivate. This perspective also helps explain why international development actors have generally been more effective at supporting early-stage capability building than at assisting countries in addressing advanced frontier challenges, which depend heavily on locally embedded learning and adaptation.

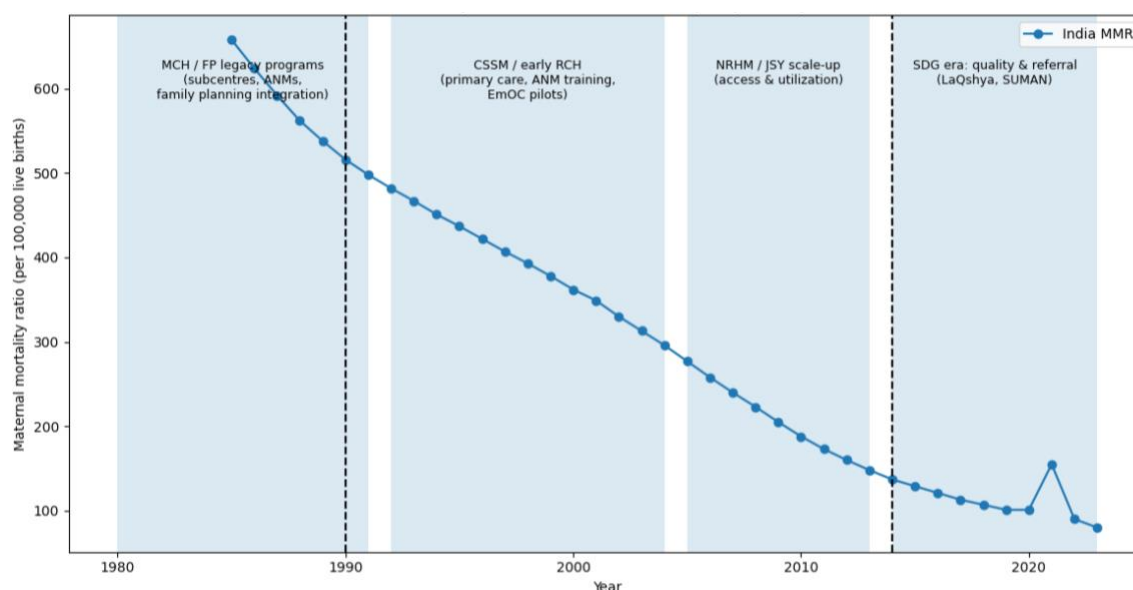
An Example of Development as a Capability Journey

India's long-run reduction in maternal mortality provides a clear empirical illustration of development as progressive capability building—and how international development entities can partner in this process. Over four decades, maternal mortality rates in India declined from levels exceeding 600 deaths per 100,000 live births to below 100. This improvement did not occur through the adoption of a single policy solution or through a linear scaling of known interventions. Rather, it reflects a sequence of capability expansions in which the nature of the problem shifted as earlier constraints were relaxed (Joe et al., 2015; O'Neil et al., 2017). This process emerged from work by the Government of India but supported by external actors—like the World Bank, WHO, UNICEF, and UNFPA—who provided financing, technical assistance, data systems, and implementation support that strengthened national capabilities rather than replacing such (Singh and Paul, 1997; WHO, UNICEF, UNFPA and The World Bank, 2014).

Interestingly, most countries with maternal mortality rates (MMR) around 600 in 1985 did not see the same kind of improvement as is evident in India. This is not because the international development community lacked the 'solutions' (or answers about 'what' to do). It is, instead, because most of these countries failed to build capabilities to turn these 'what' answers into real, durable capabilities in the way I see India has done. I show the Indian trajectory using process tracing mechanisms, of policy reforms alongside outcome trends (in Figure 1), which illustrate that each major phase of MMR decline corresponds to movement across a distinct capability frontier (George & Bennett, 2005; Beach & Pedersen, 2013; Bennett & Checkel,

2015). This interpretation is reinforced by statistical evidence: Bai–Perron structural break tests identify discrete shifts in the trajectory of maternal mortality decline (in 1990 and 2014), indicating periods in which the rate of improvement changed significantly (Bai & Perron, 1998, 2003). These breakpoints align closely with major shifts in policy focus and system functioning, suggesting that they reflect transitions in the binding constraints facing the health system—and in the capability journey inferred in addressing these constraints.

Figure 1. Tracing the Process of Maternal Mortality Reduction in India, 1985 to 2023



Building Capability to Reach the Access Frontier

In the 1980s, maternal mortality in India reflected systemic failures of reach. Most births occurred outside facilities, skilled attendance was limited, and emergency obstetric services were largely inaccessible to rural populations (Bhatia & Cleland, 1995; Joe et al., 2015). Women frequently lacked access to even basic antenatal care, and delays in recognizing complications or reaching care were common. Maternal deaths therefore often resulted from the absence of contact with the health system rather than failures within it. The binding constraint was logistical: the health system lacked the ability to reliably identify pregnancies, monitor risk, and provide routine maternal services across dispersed populations.

Policy responses during this period focused on constructing this foundational capability. National investments expanded primary health infrastructure through the establishment of Primary Health Centres and sub-centres, while training and deployment of Auxiliary Nurse Midwives and

multipurpose health workers created a permanent frontline maternal care workforce (Government of India, 1983; O'Neil et al., 2017). Outreach programs such as the Universal Immunization Programme strengthened routine contact between communities and health services, improving antenatal monitoring and early risk detection. External partners reinforced these efforts through World Bank Population Projects, which financed rural health infrastructure, workforce training, and maternal and child health service delivery during the 1980s and early 1990s.

Together, these initiatives built ordinary capability by strengthening the system's empowered ability to provide routine maternal services at scale. The effects were visible in rapid mortality reductions during the late 1980s, when extending basic services produced large gains given high baseline mortality (WHO, UNICEF, UNFPA and The World Bank, 2014). Yet success in expanding access also altered the nature of the problem. As more women contacted the health system, maternal deaths increasingly resulted from complications that routine care alone could not address. Crossing this access frontier exposed new constraints, shifting the capability challenge from logistical expansion toward organizational reliability and emergency response.

Building Capability for Operational Reliability

During the 1990s, maternal mortality became less a problem of absence and more one of inconsistency. Services existed in many locations, but quality varied widely, referral processes were unreliable, and clinical protocols were unevenly applied (Joe et al., 2015; O'Neil et al., 2017). Women often reached facilities but did not receive timely or effective care, reflecting weaknesses in supervision, monitoring, and coordination. The binding constraint thus shifted from reach to operational reliability.

Policy reforms during this period sought to strengthen coherence within the maternal health system. The Child Survival and Safe Motherhood Programme and the subsequent Reproductive and Child Health Programme introduced standardized obstetric care protocols, improved supervisory structures, strengthened reporting systems, and sought to establish referral linkages between primary and higher-level facilities (Government of India, 1992; Reddy et al., 2011). These reforms were supported by substantial donor engagement, including World Bank financing for reproductive health system strengthening and technical assistance from UNICEF and UNFPA to improve service quality and training (World Bank, 1997; UNICEF, 2009).

These efforts expanded ordinary capability by enhancing the system's empowered ability to deliver routine maternal care more consistently. Supervisory mechanisms improved, clinical guidelines became clearer, and monitoring systems strengthened.

Yet the period also revealed critical capability gaps. While routine service delivery became more reliable, the system remained weak in managing obstetric emergencies, coordinating rapid referrals, and ensuring effective escalation across levels of care (Kruk et al., 2018; O'Neil et al., 2017). Mortality declines continued but at a slower pace, reflecting the increasing organizational complexity of remaining constraints and the shift toward coordination-intensive capability demands.

Building Capability to Achieve Utilization at Scale

By the early 2000s, the primary constraint shifted again. Facilities existed and functioned more reliably, but many women still delivered outside the formal system due to financial, social, and informational barriers (Lim et al., 2010; Paul et al., 2011). The challenge therefore became behavioral and transactional rather than purely technical. Progress depended not only on service availability but on the system's ability to influence household decisions, mobilize communities, and manage large-scale service utilization.

National reforms under the National Rural Health Mission focused explicitly on these challenges. Programs such as the Janani Suraksha Yojana conditional cash transfer scheme and the Accredited Social Health Activist network aimed to incentivize institutional delivery, reduce financial barriers, and strengthen community–facility linkages (Government of India, 2005; Powell-Jackson et al., 2015; Seshadri and Rajan, 2014). These initiatives were supported by donor engagement through World Bank health system strengthening projects and technical assistance from development partners, particularly in program design, monitoring systems, and evaluation.

These reforms expanded administrative and behavioral capability by enhancing the system's empowered ability to manage high-volume transactions at scale. The system had to identify eligible beneficiaries, enroll them in incentive programs, coordinate community mobilization, process payments efficiently, and manage rapidly increasing facility demand. India's health system demonstrated increasing empowered competence in these tasks, reflected in dramatic

increases in institutional delivery rates and continued declines in maternal mortality (WHO, UNICEF, UNFPA and The World Bank, 2014).

Yet success in utilization also altered the nature of maternal mortality. As more births occurred within facilities, deaths became increasingly concentrated in emergency complications and failures of escalation rather than absence of care (Kruk et al., 2018; O'Neil et al., 2017). This revealed persistent gaps in adaptive coordination capability, particularly in referral functioning and emergency response under pressure. The system had thus crossed the utilization frontier, shifting the capability challenge toward quality and real-time performance.

Building Capability at the Adaptive Quality Frontier

By the mid-2010s, maternal mortality in India had become primarily a problem of emergency management rather than access or routine service delivery. Most women who died had accessed facilities and received antenatal and delivery care. Mortality was increasingly associated with high-acuity complications such as hemorrhage, hypertensive disorders, and sepsis—conditions requiring rapid clinical judgment, coordinated team response, functioning referral systems, and timely access to critical resources including blood and surgical care (Kumar, 2010; O'Neil et al., 2017; WHO, UNICEF, UNFPA and The World Bank, 2014). This shift corresponds to a structural deceleration in the rate of mortality decline, reflecting rising capability demands rather than diminishing effort. Remaining maternal deaths occurred in complex and unpredictable scenarios where standardized protocols alone are insufficient and outcomes depended heavily on how systems performed under stress (Kruk et al., 2018; Press Information Bureau (PIB), 2025).

Policy initiatives during this period have therefore emphasized quality improvement and emergency readiness. Programs such as LaQshya and SUMAN have sought to strengthen intrapartum monitoring, referral coordination, and facility preparedness (Ministry of Health and Family Welfare, 2017; O'Neil et al., 2017). External partners including the World Bank, WHO, and UNICEF have supported these efforts primarily through technical assistance, quality measurement frameworks, and system diagnostics rather than large-scale infrastructure financing (WHO, UNICEF, UNFPA and The World Bank, 2014). Yet success at this frontier depends heavily on dynamic capability: the locally embedded and empowered ability of clinical teams and organizations to recognize deterioration, coordinate effectively in real time, adapt to unexpected complications, and learn from rare but high-stakes events. These capabilities are

deeply context-specific, socially embedded, and difficult to transfer from outside. As a result, improvements at this frontier occur more slowly and unevenly, reflecting the increasing complexity of the capability demands involved.

Conclusion: Development as Becoming Better at Becoming Better

Development, understood as good change, is not about reproducing solutions. Instead, it is about helping societies become better at becoming better. India's maternal mortality journey shows this, with progress unfolding through a multi-decade iterative process of capability building, where early gains exposed new constraints and raised the demands placed on evolving systems. As performance improved, the work shifted from expanding reach, to strengthening reliability, to coordinating behavior at scale, and ultimately to managing high-stakes uncertainty. Slow progress at advanced stages was not failure but rather indicated a society confronting harder frontiers—where outcomes depend less on knowing what to do than on being able to do it, consistently and adaptively, in real settings, and adapt to the next frontier's challenges.

This perspective carries direct implications for international development practice. Much of the global aid system remains organized around two defaults: money as the primary instrument and solutions as the primary content. Both are attractive because they are legible, measurable, and fundable. Disbursements can be tracked, 'best practices' can be packaged, and projects can be appraised against checklists. But a focus on such tools and mechanisms can pull attention away from what drives durable change: the slow construction of locally embedded empowered ability (capability). When external finance substitutes for domestic authorization, or when imported templates displace local problem-solving, interventions may achieve activity without compounding capability—producing visible gains that plateau once attention and incentives fade and when local people are found unable to respond to the capability demands of advanced development frontiers.

A capability-centered approach requires international actors to reorient from *delivery of solutions* to *development of capability*. This does not mean abandoning solutions or finance. It means treating both as inputs to learning rather than as ends in themselves. Three practical shifts follow:

- First, fund capability pathways, not just outputs. Programs should specify *how* they expect local actors to build and embed new routines, professional norms, data use, and coordination mechanisms—and then resource those pathways. That implies financing mentoring, practice-based training, learning loops (including around failed attempts at local solutions), and team-level problem solving, not only infrastructure and commodities. Monitoring should track intermediate capability markers—such as the reliability of referral transactions, functioning of supervision routines, time-to-decision in emergencies, uptake of local data in management, improvement of ‘managing up’ systems, and creation of policy learning networks—alongside traditional output and outcome indicators.
- Second, change the accountability bargain from compliance to learning. Many aid relationships reward conformity to pre-set plans rather than adaptation to real conditions. Capability building needs ‘permission to iterate’: space for local teams to test, fail safely, learn, and revise. Donors can enable this by using adaptive results frameworks, phased financing tied to verified learning milestones, and supervision that prioritizes diagnosis and course correction over paperwork. In capability terms, this is about strengthening empowerment as much as competence—authorizing discretion and backing it with credible support.
- Third, invest in the political and organizational conditions that let capability compound. Capability is not simply technical skill; it is skill mobilized through authority, motivation, identity, and ownership. International actors therefore need to engage the authorizing environment—not only ministries but subnational governments, professional bodies, facility leadership, and communities. This means supporting institutional arrangements that sustain performance beyond projects: career incentives, professional standards, budget reliability, procurement and HR systems that function, and leadership routines that make cross-unit coordination normal. It also means treating local ownership as operational—who decides, who learns, who is accountable—rather than as rhetorical.

The hardest step is cultural. A capability focus asks international organizations to give up the comfort of believing that the right solution blueprint—or the right financing volume—will produce development. It requires accepting that progress is often nonlinear, that the ‘binding constraint’ moves with often-unpredictable frontiers, and that enduring gains emerge through locally rooted learning. In this view, successful international development is not the transfer of solutions but the strengthening of a society’s capability to generate, implement, and improve

solutions across progressively harder frontiers and problems. Durable progress depends less on delivering the right answers than on building systems that can keep producing them.

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