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Towards Universalisation of Maternity Entitlement:

An Exploratory Case Study of the Dr. Muthulakshmi Maternity Assistance Scheme, Tamil Nadu

Public Health Resource Network

M.S. Swaminathan Research Foundation

Tamil Nadu – Forum for Crèche and Child Care Services

TN-FORCES

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Contents

List of Tables

List of Annexures

Foreword

Acknowledgments

Message by Syeda Hameed

Chapters

1. Introduction, Objectives and Methodology
Mina Swaminathan, Vandana Prasad, Ganapathy Murugan, Rama Narayanan and K. Shanmugavelayutham
2. Maternity Entitlements: Past and Present
Mina Swaminathan and Vandana Prasad
3. Data and Findings
Mina Swaminathan,Ganapathy Murugan, Vandana Prasad and Madhurima Nundy
4. Discussion and Conclusion
Vandana Prasad

Annexures

Abbreviations

References

Notes on Contributors

List of Tables

S. No.	Title	Page Number
2.1	Distribution of Informal and Formal Sector Workers by Sector and Sex, 2004-05 (in percentage)	
2.2	Work Participation Rate by Sex in India (2001)	
2.3	Utilisation of the Scheme (N = 370)	
2.4	Year wise fund allocation and women/mothers who received financial assistance	
2.5	DMMAS, 2008-09 (for the two study districts)	
3.1	Educational Qualification of Respondents	
3.2	Number of Adults in the Household by Type of Family	
3.3	Number of Children by Type of Family	
3.4	Age of Target Child	
3.5	Time of receiving money	
3.6	Items on which money is spent	
3.7	Major portion on which money was spent	
3.8	Knowledge of the Scheme	
3.9	Information given on the Scheme by the VHN	
3.10	Suggestion given by the respondents on the Scheme	

List of Annexures

S. No.	Title
A 1	Tamil Nadu GOs on DMMAS
A 2	Tamil Nadu Fact Sheet
A 3	Comparative Fact Sheet on Maternity Entitlements
A 4	Biographical sketch on Dr. Muthulakshmi Reddy

Foreword

Over 90% of working women – about 150 million, belong to the informal sector, and all poor women contribute to the economy of their households, whether through paid or unpaid work. How to reach social security to the vast majority of Indian people in the informal sector has always been a challenge since identification and enumeration has been highly inadequate and clear employer–employee relationships do not exist. These factors, combined with an overall lack of political will have contributed to a neglect and denial of basic rights that has led to deepening poverty and inequity. Simultaneously, there is a growing recognition of the seriousness and all–pervasive nature of issues of malnutrition, low birth weight, maternal and child ill-health and mortality. These, expectedly, are also located most and most severely in the same population described above.

Maternity entitlements are now recognised as a labour right, with a significant role to play in the promotion of maternal and child health, and the growth of maternity entitlements in the policies related to the organised sector and government service rules are some evidence of a commitment to this right. We have also had a Maternity Benefits Act since 1961. However, its lack of application and the absence of implementational mechanisms has left over 90% of working women who are the poorest, uncovered. In this context, experts have been making recommendations to the government of India for universalising maternity entitlements and this has been taken cognisance of in the Eleventh Five Year Plan. As a result, the Ministry of Women and Child Development has declared its intent to launch a maternity benefits scheme in some districts as a pilot.

The Dr. Muthulakshmi Maternity Assistance Scheme (DMMAS) is a pioneer state-wide scheme for maternity benefits to poor women launched by the Tamil Nadu Government in 1987. Since then, to our knowledge, this valuable and unique scheme has not been formally studied. Now that the country is at the brink of launching a country-wide maternity benefits scheme with the intention of going to scale, many of us who have been involved with the issue for some time felt it was worth learning lessons available from the Tamil Nadu experience.

This study looks at the DMMAS with a view to analysing its history and objectives, as well as current implementation, utilisation and benefits. We hope that it will inform imminent policy and programmes with a view to ensuring more equitable entitlements in the best interests of poor women and children.

Dr Vandana Prasad
National Convenor
Public Health Resource Network

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The preparation of the study report on Dr. Muthulakshmi Maternity Assistance Scheme has been an initiative of the Public Health Resource Network (PHRN) in collaboration with the M. S. Swaminathan Research Foundation (MSSRF) and the Tamil Nadu Forum for Crèche and Childcare Services (TN-FORCES).

The research study was taken up as a collaborative exercise. A core team from these organisations undertook this task with Dr. Vandana Prasad, Dr. Ganapathy Murugan and Ms. Madhurima Nundy from PHRN, Ms. Mina Swaminathan and Dr. Rama Narayanan from MSSRF, Dr. K. Shanmugavelayutham from TN-FORCES as members. The preparation of the study report has been possible owing to the untiring efforts of the team who collected and furnished a lot of data and information and ensured that it was woven into an integrated report.

Principal Contributors for the Chapters of Report

Chapter 1: Introduction, Objectives and Methodology *Mina Swaminathan, Vandana Prasad, Ganapathy Murugan, Rama Narayanan and K. Shanmugavelayutham*

Chapter 2: Maternity Entitlements: Past and present *Mina Swaminathan and Vandana Prasad*

Chapter 3: Data and Findings *Mina Swaminathan, Ganapathy Murugan, Vandana Prasad and Madhurima Nundy*

Chapter 4: Discussion and Conclusion *Vandana Prasad*

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The names of others, who made a contribution to the Report, are listed below in alphabetical order:

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Mr. Shahjahan Rahman and Mr. Jaikumar undertook the formidable task of translating the data from Tamil to English and entering the data in the format. We thank all of them who contributed their might in making this effort fruitful.

1. Introduction, Objectives and Methodology

Introduction

Maternity entitlements are deeply linked to the health of women and children and have been recognised as part of labour rights for working women the world over. However, the issue of how to deliver maternity entitlements to the poorest women in the largest majority, those working in the informal sector has remained a vexing problem, not just because of an utter lack of political will, but also because of genuine operational complexities. One of the pioneering attempts in this regard is the Dr. Muthulakshmi Maternity Assistance Scheme[1] (henceforth DMMAS) of Tamil Nadu which came into being in 1987 but has evolved to its present status only in 2006. Despite its existence for some period of time, this scheme has never been formally studied.

Currently, a pilot project has been proposed by the Ministry of Women and Child Development to launch a conditional maternity benefits scheme, Indira Gandhi Matritva Sahyog Yojana (henceforth IGMSY), in 95 identified districts from all the States/UTs across the country, with a view to universalise it in coming years and Rs. 4,500 crores has been set aside for 2010-2011.

It was considered appropriate to formally study the DMMAS in this context to make recommendations that would be useful for the pilot as well as the scale up of any such scheme, so that the objectives of maternity entitlements, i.e. support to the health of women and children, and wage compensation for poor labouring women be well met.

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[1] The literal translation of the name of the scheme from Tamil to English is Dr. Muthulakshmi Maternity Assistance Scheme in the name of Dr. Muthulakshmi Reddy (1886-1968) who was an eminent medical practitioner and social reformer. In many policy documents on the scheme, the term 'assistance' and 'benefits' are used interchangeably. For the purpose of the study we are using the title 'Dr. Muthulakshmi Maternity Assistance Scheme (DMMAS)'.

Objectives

Thus the objectives of the study are as follows:

1. To trace the history and developments in maternity entitlements concepts and delivery through a review of literature

2. Analyse the current implementation of DMMAS scheme vis a vis its own objectives as well as the objectives of maternity entitlements

3. Make recommendations for better implementation of the DMMAS as well as for the proposed IGMSY on the basis of the study

Methods and Tools

The research study on DMMAS was undertaken jointly by three organisations that work on public health and food security. The organisations are Public Health Resource Network (PHRN), M S Swaminathan Research Foundation (MSSRF) and Tamil Nadu FORCES. The present scheme is being implemented in the state of Tamil Nadu since 2006. This is a pioneer as well as the only scheme on maternity entitlements in the country and, therefore, of considerable interest. This study was undertaken in Tamil Nadu to identify processes, problems and outcomes of such a scheme.

To explore and understand various issues of maternity entitlements, primary and secondary data were collected. The secondary data include censuses, surveys, reports, organisational records and also previous studies on similar schemes in other countries. Primary data on DMMAS were collected from the districts of Kancheepuram and Dharmapuri in October-November 2009. The two districts in Tamil Nadu were purposively selected to include backward and well developed areas. According to the Tamil Nadu State Planning Commission (2001), out of the total 29 districts in Tamil Nadu, Kancheepuram ranks 2nd and Dharmapuri ranks 29th in Human Development Index. Moreover the districts also had a well-established network of NGOs that

helped in collecting the background information and providing the logistics necessary for data collection. Data was collected from:

1. Mothers who received financial assistance from DMMAS;
2. Village Health Nurses (VHN) / Auxiliary Nurse Midwife (ANM)[2] and;
3. Anganwadi Workers (AWWs).

In order to understand the working of the scheme from the perception of the mothers and, the linkages with various domains of their life, structured interviews were conducted with a total of 207 women/mothers who received the financial assistance. In both the districts, the study team selected the sample purposively to include rural and urban areas. The list of the women/mothers who benefited was provided by the AWWs and this list was complemented by getting more information from the VHNs union. A comprehensive list was then generated and it was used as the sample frame. The selection of the women/mothers who received financial assistance from the overall sample frame was done by convenience till the investigators completed interviewing 50 women/mothers in each area (rural/urban). The survey comprises 50 women/mothers who received the assistance from Urban Dharmapuri and 54 from Rural Dharmapuri. Similarly 50 women/mothers from Urban Kancheepuram and 53 from Rural Kancheepuram were interviewed.

The research team also conducted structured in-depth interviews with the VHNs and AWWs. Within the villages where the women who benefited from DMMAS were interviewed, the VHNs/ANMs and AWWs were also interviewed and they were selected through snowball sampling technique. This sample comprises 32 VHNs/ANMs and 33 AWWs from both the districts. Prior to the data collection, the research team had a discussion with three senior VHNs. These nurses were initially selected to include those persons expected to have deep knowledge about the scheme. This discussion was subsequently used to validate information gained generally about the scheme and also to shape the tools. Similarly, a pilot survey was also conducted to pre-test the tools of data collection. The tools of data collection were developed in local language.

[2] In rural areas VHNs were interviewed and in urban areas ANMs were interviewed.

All interviewers were fluent in both English and the local language and they underwent two days' training in ethical issues, conducting in-depth interviews, probing and in documenting the observations.

Data Analysis

The data collection was conducted in local language. The interview schedules and additional notes were translated into English and entered in computer in MS-Excel spread sheets. The open-ended responses in the interview schedules were organised and listed. They were later coded for quantitative analyses. For urban-rural differences, test of significance (t-test) was carried out for data collected from the mothers. The data collected from VHNs/ANMs and AWWs were thematically analysed. The reading and re-reading of the interview responses helped in listing and coding key ideas, perceptions and facts according to the themes. The data was finally arranged according to major themes and sub-themes.

Limitations of the Study

There are two limitations that need to be acknowledged and addressed regarding the present study. The first limitation concerns the outcomes of the study. Information on nutritious food for mothers, wage compensation for poor working women, delay in getting back to work and exclusive breast-feeding are some of outcomes of the study. However, the responses on these outcomes elicited from the women/mothers, anganwadi workers and village health nurses are only perceptions. These perceptions do have recall bias and the responses are not measured through any scales. There is degree of triangulation based on information from VHNs/ANMs and AWWs but no other means of verification have been used. Therefore, the outcomes have been studied within the context of qualitative understanding (perception).

The second limitation has to do with the extent to which the findings can be generalised beyond the cases studied. The number of cases is too limited for broad generalisations. However, the four different clusters in two districts of Tamil Nadu represent rather different aspects of the social and economic factors. So, the findings represent rural-urban and developed-underdeveloped regions. Further empirical evaluations, however, are needed to compare the findings in different contexts and surroundings.

2. Maternity Entitlements: Past and Present

Historical Developments in Maternity Entitlements

The Background: International Experience

The history of maternal protection goes back only to the period after the Industrial Revolution. In the pre-industrial period, the vast majority of the people, both men and women, were workers, and women everywhere managed childbirth and child care as best they could, with the help and support of other female members of the family. The upper classes employed domestic servants, including wet-nurses, for the care of their children and to feed infants, and neither childcare nor breastfeeding were seen as appropriate activities for more privileged women. With the entry of large numbers of women into factories and other establishments, the workplace and the home became separate entities, sometimes physically far apart, working hours that were long and tiresome and the conditions of work extremely difficult. Children could not be brought to the workplace, except those who were able to take part in the work, in order not to introduce diversions into the speed and order of the "assembly line". Child care was more of a nuisance than childbirth, so informal institutions for child-minding sprang up in the community. Meanwhile, for a long time only young unmarried girls were employed in such establishments wherever possible to avoid the problems that inevitably accompanied married women. These were all considered private problems of the workers, and employers were not seen to have any responsibility on that score (Swaminathan, M. 1993).

Early History

It was only in the twentieth century, especially as a result of World War I, that the consciousness of welfare support to working women grew because of the need to attract women in the work force during the war, and some efforts began to be made. Two major streams of events made their mark in developing welfare measures to ameliorate the conditions of women in the industrial work force. The first was the Communist Revolution which led to the setting up of the Soviet Union, and the second was the combined and powerful effect of several movements - the Socialist

movement, the Labour movements and the women's movement which together led to the Welfare State in Europe, its full flowering being only after the Second World War. These, especially the Soviet model, led to some schemes both for maternity and for child care services of various kinds. However, they were all conceived in terms of the needs of the female industrial work force, and other kinds of "work" were not taken into consideration, except in the Soviet countries, when agriculture was also collectivised for a period. The main difference was only that among Soviet countries, since all enterprise was in the State sector, all welfare measures were also in the State sector. In the Western democracies, the burden continued to be on the employer, as far as maternity was concerned, but the strong influence of Labour parties during this period and the emphasis on charity led to its acceptance even in a capitalist world. The concept of rights was yet to be born (ibid. 1993).

With globalisation, there has been an increasing informalisation of the economy in all countries. In 1993, a comparative study of maternity and child care provision in many countries based on ILO data attempted to rank countries according to the level of provision and explore the reasons for the similarities and differences (ibid, 1993). It was found that those with the most generous provisions were either the highly developed countries with democratic Socialist Governments committed to welfare policies, or those following the Soviet model of State-owned or nationalised enterprises, whether poor or rich. Thus, Cuba and Vietnam figured in the second group, along with their much richer counterparts in Russia and Eastern Europe. On the other hand, in the first group, the best providers were the Scandinavian countries, followed by the small countries of Western Europe, with Britain trailing behind. How did this group of high performers face the challenge of globalisation and informalisation? On the whole, the economies of most of the Soviet-style economies, with the exception of Cuba, found it difficult after the collapse of the Governments to adjust to the economy of market mechanisms, and faced lay-offs, unemployment and poverty, followed by out-migration of both men and women and a rise in crime, and the almost invisible growth of an underground informal sector. Governments had no funds even to meet their basic expenses, so welfare measures had to take a back seat, and benefits became the preserve, as in India, of government employees, for reasons already mentioned (ibid. 1993). The wealthier democratic Welfare States, on the other hand, have been able to face the challenge with greater resilience, partly because of

their high level of development, the willingness to increase taxes and subsidise those considered to be needy, though many, especially immigrants and unregistered persons fall through the gaps. Thus, the informal sector is a big challenge to any government's ability to provide welfare, and more so to a developing country with limited resources and already large informal sectors.

Simultaneously, there is growing trend for even the 'organised sector' to become more casual with many appointments being made on contract even within government service sectors (Palriwala, R. and N. Neetha, 2009). Contractual appointments manage to evade many welfare requirements even as laws have been amended to safeguard against this.

International Conventions on Maternity Entitlements

There are two conventions that followed one another in the 1970s:

1. *International Covenant on Economic, Social and Cultural Rights (ICESCR)* on Maternity benefits, 1976 that listed the following benefits

Article 10:

Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

2. *The Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), on Maternity benefits, 1979 that listed the following benefits

Article 11

In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;

Article 12

States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

3. International Labour Organisation (ILO) felt the need to revise the *Maternity Protection Convention* of 1952 in 2000 (C183-Maternity Protection Convention, ILO 2000) and stated the following on maternity protection.

Article 4: On Maternity Leave

On production of a medical certificate or other appropriate certification, as determined by national law and practice, stating the presumed date of childbirth, a woman to whom this Convention applies shall be entitled to a period of maternity leave of not less than 14 weeks.

Article 6: On Benefits

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

Article 10: On Breastfeeding Methods

A woman shall be provided with the right to one or more daily breaks or a daily reduction of hours of work to breastfeed her child.

Comparative data on parental leave worldwide shows that European countries are way ahead in providing parental leave and benefits with Sweden and Estonia topping the list. Sweden provides 16 month paid leave per child. Other Scandinavian countries follow suit. In the Americas, it is only Canada that provides benefits to parents for up to 50 weeks. In most African and Asian countries, maternity benefits on an average extend to 12 weeks and in some cases much less (ILO, 2000).

The Indian Case

In India, early post-Independence labour legislation was based on Article 41 of the Constitution (Directive Principles) which clearly stated that it was "the duty of the State to provide for just and humane conditions of work, and for maternity relief." But when it came to working out laws, there was nothing to draw upon but the colonial inheritance, so it closely modelled itself on the model we knew best, the British one, though, even at that time, that was not relevant to our economy. It was built on Nehruvian concepts of industry as the prime mover of development in the future, and forgot to notice that the maximum number of women at the time were working elsewhere, for example, in agriculture, not in large establishments where they could easily be enumerated. The first three Acts, the Factories Act (1948), the Plantations Act (1949) and the Mines Act (1951) dealt with three industries which

were important to British interests and all of which employed a relatively large female work force as manual labour, and the provision of crèches at the work site was made mandatory where a certain number of women were employed. There are seven legislations relating to crèches[3] in India and two that focus on maternity benefits. The latter two are the Employees State Insurance Act, 1948 that has provisions for maternity benefits and the Maternity Benefit Act, applicable to a broader swathe of the population, came only in 1961. Both apply to the organised sector.

These Acts were to be the harbingers of a new era in industrial welfare. All these Acts focused only on women working in 'establishments' of a certain size and above, that is, what we call the 'formal sector' or the 'organised sector', even though the 'informal sector' was always much larger in India.

It is interesting to note that Tata Iron and Steel Company was one of the first private corporate sector in India to introduce schemes of maternity benefits in 1928-29. Subhas Chandra Bose as the President of Jamshedpur labour Association was the one to sign an agreement with the Company representatative N B Saklatwala.

The informal sector

Today, more than 80 percent of the entire work force (both men and women) is in the informal sector, while taking women alone, the ratio is more than 90 percent.

Table 2.1: Distribution of Informal and Formal Sector Workers by Sector and Sex, 2004-05 (in percentage)

Overall work force	Informal sector			Formal sector		
	Male	Female	Total	Male	Female	Total
Rural India	90.34	94.50	91.84	9.66	5.50	8.16
Urban India	68.52	75.5	69.77	31.48	25.5	30.23
All India	83.96	91.26	86.32	16.04	8.74	13.68

Source: Computed from NSSO (2004-05), 61st Round Survey on Employment-Unemployment.

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[3] The seven legislation relating to crèches include – Factories Act 1948; Plantation Labour Act 1951; Mines Act 1952; Beedi and Cigar Workers Act 1966; Contract Labour (Regulation and Abolition) Act 1970; Inter-state migrant Workers Act 1980; Building and Construction Workers Act 1966.

This entire informal sector, which today accounts for most of the poor, and for most of the female work force, does not have any support for maternity. Social activists also emphasise that all poor women should be considered working women, since they contribute economically to the family, whether they earn wages or not.

The Present Provisions in India

The Maternity Benefit Act of India (1961), following the British model, provided 12 weeks of paid leave, of which 2 to 4 weeks could be taken prior to the expected date of childbirth, for reasons of health, thus reducing the available post-partum leave to two months or a little more. At this point, protection of the health of the mother was the main justification. It also, through several amendments, gave legal assurance that the women could return to her job after leave, without fear of dismissal, transfer, or lack of promotion. Since then, some other amendments have been introduced, such as providing six week paid leave for miscarriage, pregnancy or tubectomy at the same rates, and reducing the period of employment for eligibility for maternity leave from 160 days to 80 days.

However, even this narrowly focused Act has not been effectively implemented for several reasons; while government establishments are obliged to follow the law, most in the private sector prefer to avoid it, seeing it as an unnecessary burden caused by the employment of women. Women, fearing discrimination, prefer not to ask for it, nor do Trade Unions fight for it. Sometimes, indeed, leave is given, but rarely is it paid leave. As a result, after fifty years, about 2 percent of the "eligible" women (that is those who are permanently employed) have been getting the "benefits". So even the group the Act targeted has not benefited much. Meanwhile, the entire informal sector, which today accounts for about 91 percent of the female work force, does not have any support for maternity.

New Developments and Issues

Meanwhile, during the same fifty-year period, there has been an enormous amount of research and many new discoveries about / within the whole area of women's reproductive and children's health, linking nutrition, pregnancy, and child

development and casting new light on topics like low birth weight and its causes, anaemia in women, brain growth of infants, genetics, immunity to disease, breastfeeding and so on. These delineate certain “critical periods” when some interventions/inputs are desirable or essential and lack of which could be damaging. These have influenced health care practices considerably, but the implications for maternity protection have yet to be thought through in India.

Similarly, there has been a great expansion of knowledge about the economy and its different sectors, and in techniques of measurement of work, output and its value. Unfortunately, women have been seriously neglected in these calculations, not only because most of them are in the informal sector, but also because of many of them are engaged in unpaid labour either in family enterprises, or in gathering natural resources, or in activities which are classified as being in the household domain, since they cannot show direct monetary returns for this kind of activity. These contributions are never taken in to consideration while calculating the economic contribution of women thus reinforcing the invisibility of their labour. For example, the Census of 2001 registered only 25.79 percent women as being working.

Table 2.2: Work Participation Rate by Sex in India (2001)

Total/ Rural/ Urban	**Persons**	**Males**	**Females**
Total	39.22	51.75	25.79
Rural	41.96	52.22	31.12
Urban	32.23	50.56	11.91

Source: Census of India (2001) Office of the Registrar General, India.
*Excludes Mao Maram, Paomata and Purul sub-divisions of Senapati district of Manipur

Subsequently, in recognition of the invisibility of women’s work, a conscious effort has been made to rectify the situation. Fortunately, the methodology of *Time Use Studies* points to new possibilities (Palriwala, R. and N. Neetha, 2009). Their paper makes a detailed examination of current status of problems related to enumeration of women in workforce and of schemes in support of childcare. Policies generally tend to neglect the huge investment of time that people spend on care work. Based on Time Use Studies in 1998-99, they state that, *“on average men spent 36 minutes per day on unpaid care work, while women spent about 5 hours. If the average is calculated only*

for those who actually participate in care work, men spent 1 hour and 12 minutes on such work, while women spent 5 hours and 36 minutes, the pattern of change in the average time indicating that the proportion of men engaged in care work is small. The gendered patterns were more or less as expected. Men spent less time on unpaid care work than on paid work, while women spent much more time on it than on paid work" (ibid. 2009).

Thus, when the health of the mother and infant are taken into consideration from pregnancy to early childhood, as well as women's status as worker, as well as a mother, urgent social solutions are needed that relate to maternity entitlements. Besides, once the language of rights enters the discourse, laws and schemes must have universal applicability. All this implies an obligation to look at the vast majority of poor women in the informal sector, most of whom are extremely poor.

Policy Issues

Three main issues need to be considered and each points to different policy outcomes:
i. If Low Birth Weight is the outcome of poor maternal nutrition, then support must be provided in the later stage of pregnancy. How can food and rest, adequate and appropriate, be provided at the right time to poor pregnant women? Is it better to provide food directly or cash? Can special foods be added on to existing food distribution programmes?

ii. If exclusive breastfeeding is essential for infants for six months (and no other foods are to be given to the baby till that period is over), how can poor mothers be induced to stay away from work to feed the child on a round-the-clock schedule for such a long period? Can cash allowances do the job? How much should be provided? What other incentives are needed? Is monitoring possible and how? Can these two objectives be combined in one law or scheme?

iii. While the first two issues pertain to child health and child rights, the third issue pertains to the rights of the working woman to avail support for the social business of bearing and rearing children. It needs to be noted that precisely in those countries (such as the Scandinavian ones) that both place a premium on promoting child birth

and where women play a major and recognised role in the economy do the most liberal maternity benefit laws exist.

The Tamil Nadu Story

Meeting the challenge, the Tamil Nadu Government, has built up a long tradition during the 40 year post-Congress regime of the Dravida parties of welfare measures for the needy, and has maintained a focus on the social sector. These include scholarships for girls and Dalit students, pensions for widows and old people, marriage support and grants for inter-caste marriages and many more, including of course the "jewel in the crown", the Midday Meal Scheme. The first attempt to enter the informal sector with support for maternity came in 1987, when Tamil Nadu launched a modest Childbirth Assistance scheme in the name of Dr. Muthulakshmi Reddy. It was soon followed by a clutch of States (including Andhra Pradesh, Gujarat and Haryana) and to begin with, Rs.300/- was offered, one-time, to cover the expenses of childbirth. In 1995 the amount was raised to Rs 500/- to encourage more takers, and in 1996 was made payable in a single instalment at childbirth to reduce administrative difficulties. A study conducted in 1995 showed that the uptake of this scheme was low (Narayanan, R. 1997).

Table 2.3: Utilisation of the Scheme (N = 370)

Eligible	Aware	Applied	Partially received	Fully received
370	185	114	34	20

Source: Narayanan, R. 1997

This was partly due to lack of awareness, but also due to delays, the need for repeated visits and paperwork, transport expenses and corruption. Many of the women questioned actually said the small amount received (average Rs.200) was not worth the trouble of getting it, and that too sometimes months after the childbirth.

Current Situation

A year later, in 1995-96 the Central Government adopted the model, calling it the National Maternity Benefit Scheme (NMBS), again with a similar paltry one-time payment of Rs. 500/- eight to twelve weeks prior to delivery, that was hardly enough for immediate expenses. Later in 2005 the scheme was subsumed into the Janani

Suraksha Yojana (JSY) or Maternal Protection Scheme. The JSY had a clear health objective, as the payment was conditional on an institutional delivery, and aimed, by that method, to promote safe childbirth and reduce maternal and neonatal mortality, especially in those States where the levels of institutional delivery are very low. In fact, it had to be argued through the Supreme Court Right to Food Case that the NMBS be protected to ensure that Rs 500 be given to every BPL woman for nutrition during pregnancy regardless of her place of delivery and that this amount be considered separate from the JSY amount which was an incentive for institutional delivery. Confusions between the NMBS and JSY have hindered any monitoring of the NMBS at state level.

Increasing the gross inequity still further, the Sixth Pay Commission in 2008 has given as maternity benefit, a generous allowance of 180 days of maternity leave on full pay, (as opposed to the present 135 days) further extendable for a period of up to two years as part of maternity entitlements. In addition two years child care leave is granted to women employees having minor children (see box). This privilege has been given, not indeed for all workers in the organised sector, nor even to all government employees, but only to employees of the Central Government, thus conferring upon a minuscule fragment of women, an “island within an island” of privilege (Swaminathan, M. 2009).

Recommendations: Sixth Pay Commission

(a) The existing ceiling of 135 days **Maternity Leave** provided in Rule 43(1) of Central Civil Services (Leave) Rules, 1972 shall be enhanced to 180 days.

(b) Leave of the kind due and admissible (including commuted leave for a period not exceeding 60 days and leave not due) that can be granted in continuation with **Maternity Leave** provided in Rule 43(4)(b) shall be increased to 2 years.

(c) Women employees having minor children may be granted **Child Care** Leave by an authority competent to grant leave, for a maximum period of two years (i.e. 730 days) during their entire service for taking care of upto two children whether for rearing or to look after any of their needs like examination, sickness etc. **Child Care Leave** shall not be admissible if the child is eighteen years of age or older. During the period of such leave, the women employees shall be paid leave salary equal to the pay drawn immediately before proceeding on leave. It may be availed of in more than one spell. Child Care Leave shall not be debited against the leave account. Child Care Leave may also be allowed for the third year as leave not due (without production of medical certificate). It may be combined with leave of the kind due and admissible.

Source: GOI (2008), *Sixth Central Pay Commission*, Ministry of Finance. Available at http://india.gov.in/govt/paycommission.php (Accessed: 15th March 2010)

Dr. Muthulakshmi Maternity Assistance Scheme (DMMAS), 2006

Adopting an Integrated Approach

It is only in its latest version of 2006 that the DMMAS was modified sufficiently to qualify as a maternity support scheme and not as one-time child birth support. The scheme was to provide Rs.6000/- spread over two instalments. The amount has obviously been chosen arbitrarily, without reference to prevailing wages, which, if taken as the basis for calculation would point to a far higher sum. At first the scheme was intended only for agricultural labour in rural areas, but after protests from urban groups, was modified to include all women below the poverty line. To begin with, it was to be paid in six monthly instalments of Rs.1,000/- each; then that was found too

cumbersome administratively and it was altered to two 3-monthly instalments, one in the seventh month of pregnancy for registered mothers and the second after childbirth. Thus, the scheme has already tried to include two objectives, one of providing additional income for nutrition during pregnancy and the other of partial wage compensation for three months after childbirth.

Thus the scheme states its aim as:

> *"Financial assistance of to Rs. 3000 before delivery and Rs. 3000 after delivery is provided to poor pregnant women, to compensate their loss of income during the delivery period and for consuming nutritious diet so that they give birth to a healthy child. This financial assistance is provided only for two deliveries."* (Government of Tamil Nadu, 2008; translated from Tamil)

Regrettably, since 2009, it has again gone back to being paid only in one instalment, after childbirth, thus subverting one of the original objectives of nutritional support during the last phase of pregnancy.

Selection criteria are stated as follows:

- Application form should not be issued in case the annual income of the pregnant women is more than Rs. 12,000 per annum
- Those who are living in thatched huts; daily waged labourers
- Those who are living in small tiled houses
- Those who are living in small rented houses under poverty conditions
- Landless poor
- Those who own small amount of dry / unirrigated lands yielding meagre income
- Those who are so poor as not to be able to send their children to school and send them to work
- Those who are so poor as not to afford three square meals.
- Those whose head of family go for seasonal labour work in outstations and support the family
- Poor families headed by women due to inability of the husband to earn.

The following are debarred:

- Families of those who have regular income (Large private sector organisations, Government organisations, Government companies, private schools, etc.)
- Those who own motor bike, car, tractor, minitar (*sic*), auto, lorry, etc.
- Those who own comfortable houses
- Those who are doing business with good income and are well off.
- Those who have telephone connections

Innovative Solutions and Specificities

An interesting aspect of this scheme is the way it has sought to meet the challenge of the informal sector. Instead of trying to define the potential beneficiaries in terms of their work status and employment, it goes by another route and defines them by relative poverty. It has also bypassed the usual income definition, in money terms, which is notoriously hard to capture, and goes by several other indicators such as the kind of house occupied, whether husband and/or wife are daily labourers, the ownership of household assets, type of transport used and so on which can be observed and checked more easily. Thus, the scheme is fairly realistic and open in defining 'poverty' and applies little conditionality apart from being for the first two children only.

Financial Outlay

An amount of Rs.100.00 crores was sanctioned for implementing the scheme in 2006-07. So far an amount of Rs.723.69 crores has been disbursed to 14, 65,845 pregnant women (Government of Tamil Nadu, 2009-10).

Table 2.4: Year wise fund allocation and women/mothers who received financial assistance

Year	Fund Sanctioned (in crores)	Total number of women/mothers who benefit	Average number of women / day	Average per woman/mother (in Rs.)
2006-07	Rs. 100	241095	661	4148
2007-08	Rs. 300	679831	1863	4413
2008-09	Rs. 350	579821	1589	6036

Source: Government of Tamil Nadu (2008-09), Annual Public Health Administration Report 2008-09, Department of Public Health and Preventive Medicine, Chennai.

Table 2.5: DMMAS, 2008-09 (for the two study districts)

S. No.	Name of District	No. of women/mother benefiting	Amount allotted (in Rs.)	Amount disbursed (in Rs.)	Average per woman/mother (Amount disbursed/No. of women/mothers who received financial assistance) in Rs.
1.	Dharmapuri	18626	112253000	111753000	6000
2.	Kancheepuram	9460	58161000	58137000	6145
	Total for all districts	**574395**	**3500000000**	**3466906000**	**6035**

Source: Government of Tamil Nadu (2008-09), Annual Public Health Administration Report 2008-09, Department of Public Health and Preventive Medicine, Chennai.

Some Contradictions

During the year 2008-09 a sum of Rs. 350 crores was allotted to the DMMAS. The scheme benefited 5, 74,395 women which is 46 percent of total deliveries[4] in the State of Tamil Nadu. [5] The number of live births occurring below poverty line is less than the number of women benefiting from the scheme. However, this calculation is merely indicative and there may be a possibility that the poorest might still be excluded while benefitting more middle and upper income households.

The government 'Form 2' that relates to complaints of irregularities in identifying women/mothers uses BPL as the regular way of identifying them; non BPL is seen as an 'irregularity.'

However, it is noteworthy that it does not see a role for itself either in the promotion of breast feeding or in wage compensation following delivery.

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[4] The total number of live births for Tamil Nadu is 12, 49,326 lakh births for the year 2008-2009 (Government of Tamil Nadu, 2009).

[5] The latest estimates of poverty for Tamil Nadu given in Tamil Nadu government Annual report for 2008-09, states that 32.1 per cent of the State's population lives below the poverty line (Government of Tamil Nadu, 2009).

Towards Universal Maternity Entitlements

The implementational approach taken by the DMMAS paves the way for universal maternity entitlements, since obviously the needs of the poorest section of the population deserve priority attention, while the better-off may be brought in later and may need only partial support. Such a plan for universal maternity entitlements has indeed been developed on a four-tier basis by the Second National Labour Commission (2002) which made a thorough study of the issue. In their proposal they suggest four levels: a) the lowest level, for the destitute and those with no visible source of income; b) the second level for women who are working but where the employer cannot be identified or who are self-employed, c) the third level, where both workers and employers can be clearly identified and the fourth and highest level for voluntary participation. The first two levels are to be funded entirely by the State, which may draw upon additional resources like a labour cess or tax-exempt donations to build up the Fund; the third is to be with the contribution of both employers and employees but without attempting to put the entire burden on either; and the last is intended for the better-off sections who can voluntarily contribute to something like an insurance scheme. This innovative scheme, which can be put in place step by step, has unfortunately received no publicity or attention from the authorities, illustrating the neglect of women's issues.

Indira Gandhi Matritava Sahyog Yojana

Currently, a scheme is being proposed for implementation by the Ministry of Women and Child Development; the Conditional Maternity Benefits Scheme (Indira Gandhi Matritava Sahyog Yojana). This scheme is to be piloted in 95 districts and Rs 4,500 Crores has been allocated for the purpose. It applies to pregnant women of 19 years of age and above for first two live births and its objectives are to improve the health and nutrition status of pregnant, lactating women and infants by:

- promoting appropriate practices, care and service utilisation during pregnancy, safe delivery and lactation,
- encouraging the women to follow (optimal) Infant and Young Child Feeding (IYCF) practices including early and exclusive breast feeding for six months,

- contributing to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and nursing mothers.

Notably, only health-related objectives are mentioned, and not labour-related, or wage compensation.

It will provide Rs 4000 to eligible women (over and above JSY incentives), that is less than the amount provided by DMMAS, in three instalments conditional upon utilisation of ANC and immunisation of the child. The scheme has been welcomed but has given rise to various questions and debates leading to the following recommendations by health and nutrition activists (Letter from WGCU6 to Secretary, Ministry of Women and Child Development, 2009):

> **"Conditionalities:** Conditional cash transfers (CCTs) are most effective where 'supply side' problems have already been taken care of. The persons who most need CCTs are also the most likely to face supply side issues. We are concerned that the conditionalities are attached to services such as immunisation which may not even exist in the neediest areas since coverage is still quite deficient, specially in tribal and other difficult – to reach areas. Thus we would recommend that conditionalities be removed for now and the cash be transferred with an intensive focus on behaviour change communication for IYCF (breastfeeding and nutritional counselling) with adequate training of the AWW and helper to deliver the same.
>
> **Age Eligibility Criteria**: The age of 19 years should not be kept as a criterion for eligibility since the children of underage mothers are more prone to Low Birth Weight and malnutrition. This is also part of the Supreme Court order dated 20th of November 2007 on National Maternity Benefit Scheme stating that benefits will be given "**irrespective of number of children and the age of the women".**
>
> **Wage Compensation**: The amount should be increased to 6 months of compensation at atleast minimum wage to make it more equitable with what women in the organised sector receive as maternity benefits."

These recommendations, in turn, fail to specifically demand wage compensation for a period of six months *following delivery* in addition to a period during late pregnancy.

The proposal for introducing the pilot IGMSY makes it even more urgent that the experience of the DMMAS be understood, documented, analysed and used for better scale – up of maternity entitlements especially in terms of balancing the administrative requirements with the objectives, and adhering to judgments and court orders.

The present study is expected to throw light on some of these issues and point the way forward in order to be able to achieve all the objectives of maternity entitlements; namely to enable rest and nutrition of the woman during late pregnancy and the post natal period, prevention of low birth weight, and care and exclusive breast feeding of the newborn child for the first six months, with wage compensation at the prevailing minimum wage.

The following sections give the findings from the field study and discuss some of the key findings. The final section gives the recommendations.

3. Data and Findings

The data is presented in three sections relating to A) women/mothers who have received financial assistance B) VHNs/ANMs and C) AWWs

A. Response from women/mothers receiving financial assistance from DMMAS

Demographic Profile of Respondents

Among the respondents, 72 percent of the women were in the age group of 18- 25 years out of which 50 percent are between 22-25 years. Another 25 percent were between 26-30 years.

Forty four percent of the respondents were from the *most backward classes*, 30 percent of the total were *Scheduled Castes* and 24 percent were *backward castes*. 64 percent of the *most backward classes* in the sample were from the rural area. 90 percent of the sample mothers were Hindus, 6 percent Christians and remaining were Muslims.

Seventeen percent had qualified Class 10th and 16.5 percent were qualified till Class 9th. Only around 4 percent who had studied beyond 12th. 11 percent had never gone to school and 25 percent studied till seventh class or below.

Table 3.1: Educational Qualification of Respondents

Educational Qualification	No. of women	Percentage
Not gone to school	23	11.11
Below 5th class	13	6.28
5th class	14	6.76
6th to 7th	25	12.08
8th class	28	13.53
9th class	34	16.43
10th class	35	16.91
Plus 1	2	0.97
Plus 2	25	12.08

More than plus 2	8	3.86
Total	**207**	**100**

Ninety three percent of the spouses of the women respondents were in the unorganised sector. Only 6 percent were employed in the organised sector and 1 percent unemployed.

Sixty eight percent had only two adult members in the family while 23.5 percent had 3-4 adult members in the household.

Table 3.2: Number of Adults in the Household by Type of Family

Type of family	**Number of adults in the household**								
	1	2	3	4	5	6	7	8	Total
Nuclear family	1	141	-	-	-	-	-	-	142
Joint family	-	-	19	27	9	3	5	2	65

Table 3.3: Number of Children by Type of Family

Number of children	**Nuclear family**	**Joint family**	**Total**
Single child	73	44	117 (56.5 %)
Two children	69	21	90 (43.5 %)
Total	142	65	**207**

Fifty seven (117 of 207) percent of the households had one child and the rest (90 households) had two children. The target child is the younger of the two children in these 90 households. 70 percent of the target children were 7-12 months old and 13.5 percent were 0-6 months old or less and the rest were above 12 months.

Table 3.4: Age of Target Child

S. No.	**Age of the target child**	**No. of households**	**Percent**
1	6 months	28	13.53
2	7-12 months	145	70.05
3	Above 12 months	34	16.43
Total		**207**	100

Out of the 90 households that have two children, the age difference between the target child and the elder child for 33 percent households was above 3 years and in 34 percent households the age difference between the two children was in the range of 1 year 3 months to 2 years.

Women in paid and unpaid work

Out of the total number, 85 percent do household work, only 12 percent (26 out of 207) are in paid work and 3 percent are in family labour without salary. Aggregate 88 percent are unpaid workers.

Seventy four percent say that no one helps them with any household chores and 17 percent say the mother-in-law helps them. Only 4 percent say that the husband helps in the house.

Time of applying for the scheme and receiving money

Applying for the scheme

Sixty three percent of the women had applied for the scheme during the seventh month of pregnancy and 15 percent between the 5th and 6th month. Thus, 90 percent applied during pregnancy and 9 percent applied post delivery while 1 percent of them could not recall the exact time.

Number of instalments

Ninety percent of the women received Rs. 6000 while a little over 5 percent received Rs. 6,700 under the scheme (In the latter group the extra Rs. 700 is the JSY money that these women received). Out of women (199 women) who received the entire financial assistance, 87 percent (173) of the women received the entire money in the first instalment itself and the rest 13 percent (26 women) got it in two instalments. Four percent of the women (9 women) are yet to receive the full financial assistance, however most of them have received three fourths of the money in the first instalment and we may presume there is a delay in them receiving in the second instalment. Significantly, 23 (89 percent) out of the 26 women who were getting money in two instalments were from urban areas.

Out of the 26 women who received the money in second instalment, 17 (65 percent) of them got it in instalments of Rs 3000. For the rest of this group it varied from Rs. 600, Rs. 700, Rs. 1000, Rs. 2000, Rs. 3,700 and one each got Rs. 4000 and Rs. 5000 as second instalment.

Time of receiving money

All the women received the money post delivery and none received it during pregnancy. 86 percent received the money within the first 6 months of delivery.

Table 3.5: Time of receiving money

S.No.	When did you receive the money? (In months post delivery)	No. of women	Percent	Cumulative percent
1	**Before childbirth**	**0**	**0**	**0**
2	**One month after delivery**	**46**	**22.22**	**22.22**
3	**Two months after delivery**	**26**	**12.56**	**34.78**
4	**Three months after delivery**	**35**	**16.90**	**51.68**
5	**Four months after delivery**	**35**	**16.90**	**68.58**
6	**Five months after delivery**	**22**	**10.62**	**79.20**
7	**Six months after delivery**	**15**	**7.24**	**86.44**
8	Seven months after delivery	8	3.86	90.3
9	Eight months after delivery	3	1.44	91.74
10	Nine months after delivery	1	0.48	92.22
11	Ten months after delivery	4	1.93	94.15
12	Eleven months after delivery	2	0.96	95.11
13	Twelve months after delivery	4	1.93	97.04
14	First and fourth month after delivery	1	0.48	97.52
15	Third and fourth month after delivery	1	0.48	98
16	Fourth and fifth month after delivery	3	1.44	99.44
17	Seventh and tenth month after delivery	1	0.48	100
Total		**207**	**100**	

Spending the money and how it has benefited

Table 3.6: Items on which money is spent

S.No.	How did you spend the money?	No. of women	Percent
	Savings and investments for future only	51	24.64
	Medical Expenses only	44	21.26
	For buying food items only	19	9.18

	Medical Expenses & for buying food items	63	30.43
	Medical Expenses & Savings and investments for future	11	5.31
	For buying food items & Savings and investments for future	9	4.35
	Others (Loan repayment; medical expenses and loan repayment; loan repayment and savings and investments for future; other household expenses)	10	4.83
Total		**207**	100

If we look at women who have spent only on one item, savings and investment ranks first followed by medical expenses and food. But 30 percent women spent money on two items i.e. medical expenses and buying food.

If we calculate further, 58.45 percent mention medical expenses as one thing that they spent money on. 44 percent mention food as one of the items they spent money on. Around 35 percent mention Savings and Investments as one of the things they put money in.

Table 3.7: Major portion on which money was spent

S. No.	On what the major portion of the money was spent?	No. of women	Percentage
1	Medical Expenses	80	38.65
2	Savings and investments for future	65	31.40
3	For buying food items	36	17.39
4	Not clear what the major portion was spent on	18	8.69
5	Loan Repayment	8	3.86
Total		**207**	100

When asked on what they spent the major portion of the money on, medical expenses topped the list with 38.65 percent responses, followed by savings and investments which is 31.4 percent and then buying food i.e. 17.4 percent.

Decision to spend

Sixty percent of the women took the decision along with their husbands on how to spend the money. Amongst those who took decision with husband, significantly more women were in the rural area as compared to urban. 14 percent decided on their own while 12 percent said that decision was made by husband alone. Only 5 percent said that decision was made by in-laws.

Knowledge and information of the scheme before applying

Table 3.8: Knowledge of the Scheme

S. No.	How did you get to know about the scheme?	Rural	Urban	Total	Percent
1	Village Health Nurse / ANM	73	45	118	57.00
2	Anganwadi Worker	22	25	47	22.71
3	Nursing staff at Municipality Hospital	0	12	12	5.80
4	Through TV News	0	5	5	2.42
5	Through Relatives	0	4	4	1.93
6	Through Neighbours	0	3	3	1.45
7	Village Health Nurse/ANM & Anganwadi Worker	12	6	18	8.70
Total		**107**	**100**	**207**	100

Whether rural or urban, majority of mothers (about 80% in rural, and 63% in urban) got the information from the health functionaries. Nearly a quarter, about 22% and 25% in rural and urban areas respectively got it from the anganwadi workers who do not have the responsibility for implementing the scheme.

Table 3.9: Information given on the Scheme by the VHN / ANM

S. No.	What did the Nurse tell you about the scheme?	Rural	Urban	No. of women	Percent
1	For mother & child welfare	52	34	86	41.55
2	To eat nutritious food & to take rest	13	13	26	12.56
3	To eat nutritious food & to take rest & to breast feed	3	2	5	2.42
4	Rs. 6000 Financial help by the Government	12	13	25	12.08
5	For medical expenses	4	2	6	2.90
6	Money given for child's future	8	3	11	5.31
7	Did not receive any information	15	33	48	23.19
Total		**107**	**100**	**207**	100

Communication about the scheme happens in late pregnancy whereas as we have noted instalments of money tend to come in much after delivery. As far as communications about the scheme are concerned, (Table 3.9), 42 percent of the total number of women said that they were told that the *scheme* was meant for mother and child welfare. What is important to note here is that 12.5 percent of them were told that it is some kind of financial help from the government while the rest of the

answers indicate that the scheme is to do with some kind of welfare measures like maternal and child health, breastfeeding and so on. 69 percent of those who did not receive adequate information were from the urban area.

Fifty eight percent (120) were told that they could have the delivery only in PHC/local government hospital. Out of these only 9 percent said that they would have preferred a private hospital if the scheme had permitted. There are more women in rural area who were told that they could deliver only at a government institution.

Seventy two percent (150 women) were told what the *money* was meant for. Twenty eight percent of the women did not receive any advice with the money. It is likely that the advice given with the money would depend upon the timing of the instalment. Thus out of the 150 women, 53 percent were told that the money was to take care of mother and child and to eat nutritious food while 26 percent were told that it was for taking care of mother and child, eat nutritious food, breast feeding and to take rest. Significantly, 70 percent of those who were not told what the money was for were from the urban area as compared to 30 percent in rural.

All the women said that they were advised to take nutritious food during pregnancy and after child birth. 33 percent were advised by village health nurse, anganwadi worker and the doctor while 24 percent were told by the village health nurse and anganwadi worker. 15 percent were told only by the village health nurse.

Knowledge of availability of nutritional supplements

Nutrition supplements are provided to pregnant and lactating mothers at the Anganwadi. 94 percent had the knowledge of nutrition supplement being distributed to pregnant women. Out of those who knew about it (194 women), 91 percent said that they had collected nutritional supplements when pregnant. Out of the 16 who did not receive supplement most stated ‘no specific reason’.

While all women in rural areas knew that nutrition supplement is being distributed to pregnant women, 9 percent were not aware of it in urban areas. Correspondingly, there were more pregnant women collecting nutritious supplements in rural as

compared to urban. At the time of the survey, 50 percent of all women said that they were collecting nutritional supplements.

There were 90 families who have two children. Out of these 7 did not respond to the questions. Out of the 83 who responded 82 percent (68) said that they ate nutritional supplements from Anganwadi during their *previous* pregnancy. Out of the 68 women who took nutritional supplements 49 took it regularly while the rest occasionally. For the *target child,* out of the 83 respondents 80 percent took nutritional supplements for six months during pregnancy. Thus, there was no difference between previous pregnancy and this one for taking nutritional supplements.

Difficulties in applying for the scheme and getting the money

A significant percentage i.e. 94 percent did not face any difficulty when *applying for the scheme*. The 6 percent that did face difficulty had to either pay bribe to get the forms or had difficulties in getting the necessary certificates so as to purchase the form. Although in all very few had difficulties in applying for the scheme and getting the money but out of those who face difficulties there were more from urban areas.

Ninety three percent had no difficulty in *getting the money*. Out of the 15 respondents who did have difficulty, 3 had to bribe to get money, 4 had to face delays and for 3 there were family planning conditionalities imposed.

Only 5 women (2 percent) out of the total faced problems opening an account in the bank and all 5 were from the urban.

Breastfeeding practices

At the time of the study 146 (70 percent) of the mothers were breastfeeding.

Out of the total number of respondents 28 women had children below 6 months and 6 out of these 28 had given up breastfeeding. 3 out of the 6 said that there was not enough milk.

At the time of the study 182 (83 percent) respondents were giving some other food to the child apart from breastfeeding. Out of the 182 respondents who give some other food apart from breastfeeding, 145 (80 percent) started other food after six months. In other words these 145 women exclusively breast fed for six months and only 37 mothers started before 6 months.

Out of the 26 women who are paid workers, only 4 women breast fed till 6 months.

Out of the 83 families who had two children, 33 percent breast fed their *previous child* for six months and some over six months but less than a year. 61 percent breast fed for more than a year. 70 percent of these women started giving other food only after six months. About 18 percent started giving other food after 4 months and 10 percent after a year. For the *second child* (target child), out of the 83 respondents 61 percent started giving other food besides breast milk after six months. So there is not much difference in the time for introduction of other foods for the first and the second child.

Suggestions for the scheme

Though 79 percent (164 women) said that they had suggestions for the improvement of the scheme, 18 percent out of these 164 women said that the scheme was good in its present form. 22 percent suggested that there should be no delay in payment. 17 percent also suggested that it would be better if the money is given in two instalments i.e. before and after delivery. 12 percent also said that the entitlement should be more than Rs. 6000. 7 percent said that there should be no conditionalities attached. 9 percent also said that it should be universalised and not just targeted for the poor.

Table 3.10: Suggestion given by the respondents on the Scheme

S. No.	Suggestions	No. of women	Percent
1	Good scheme in the present form	30	18.29
2	No delay in payment	37	22.56
3	Better if the money is given in two instalments (before and after delivery)	28	17.07
4	Financial entitlement more than Rs. 6000	20	12.20
5	Should be universalised	15	9.15
6	No conditionalities	12	7.32
7	Should reach poor people	8	4.88

8	Need to advertise more about the programme and details	8	4.88
9	Money can be directly paid by the VHN / ANM	6	3.66
Total		**164**	100

B. Village Health Nurses / Auxiliary Nurse Midwife

The Village Health Nurses / Auxiliary Nurse Midwife (VHNs / ANMs) were interviewed in the Kancheepuram and Dharmapuri districts. In the Kancheepuram district two PHCs in the rural area was covered namely in Achrapakkam which is an upgraded PHC and Ramapuram which is an additional PHC. In the urban area of the same district, VHNs / ANMs at Alandur Municipality Maternity Hospital and Tambaram Municipality were interviewed. In rural Dharmapuri district two PHCs namely Chola Kottai and Palaya Pudur were covered and in urban area, VHNs / ANMs from Dharmapuri maternity hospital were interviewed.

A total of 32 VHNs / ANMs, 17 from Dharmapuri (Rural – 9, Urban – 8) and 15 from Kancheepuram (Rural – 8, Urban – 10) were interviewed from both districts.

Knowledge on objectives of the scheme

The VHNs/ANMs are the primary link between DMMAS and the women/mothers. They are involved in identifying the women/mothers, informing them about the scheme, disseminating health information according to the scheme, and finally disbursing the financial assistance provided under the scheme. Twenty nine VHNs/ANMs mentioned that they have received training for implementing the scheme.

The stated objectives of the scheme are “Financial assistance of Rs. 3000 before delivery and Rs. 3000 after delivery is provided to poor pregnant women, to compensate their loss of income during the delivery period and for consuming nutritious diet so that they give birth to a healthy child. This financial assistance is provided only for two deliveries.”

However, the responses of VHNs / ANMs regarding the objectives are more general such as "scheme to protect and improve the health of mothers and infants." When asked about the objectives of the scheme, the responses from VHNs / ANMs were not uniform and they varied from "a government scheme of financial assistance for poor people" to "a scheme for improving the health of mother and infant by giving financial assistance so that it can compensate for their income and thereby can take good rest and eat nutritious food during pregnancy".

- Around three fourths of the respondents felt that consuming nutritious diet during pregnancy and thereby giving birth to healthy child is the major objective of the scheme.
- Six respondents felt prevention of low birth weight infants is a major priority for the scheme.
- Only one respondent mentioned about wage compensation.
- Only three respondents mentioned about mothers taking rest before and after delivery.
- Among the thirty two respondents, only one respondent mentioned about exclusive breast feeding as an objective of the scheme.

Identifying women/mothers

The scheme has elaborate guidelines for the VHNs / ANMs to identify poor families and differentiate them from rich households. Almost all respondents replied that people in BPL category are the eligible people for the scheme. The BPL category households can be identified through the BPL ration cards and farmer ration cards in rural areas. The VHNs / ANMs also identified the women through the nature of housing, income certificate (indicating less than Rs. 12,000 per annum), type of employment, social background (SC/ST) and landholding patterns. Similarly the VHNs / ANMs were quite clear that the scheme is meant only for mothers who have only two children or less. Nine VHNs / ANMs thought the guidelines were not very clear. A few others had problems identifying poor people in urban areas. Two VHNs /

ANMs felt that they were not certain whether to exclude families with mobile phones and two wheelers.

Thirty one VHNs / ANMs mentioned that they could easily identify poor women who are eligible for scheme. But when asked if they felt that the scheme benefited eligible women, twenty three VHNs / ANMs replied that sixty per cent out of the total number of women selected fulfilled the eligibility criteria. Out of the nine VHNs / ANMs who felt that scheme was not necessarily benefiting eligible women, two VHNs / ANMs mentioned that among the women identified, 'really eligible women' comprised less than forty per cent.

Advice on spending the financial assistance

All the VHNs / ANMs interviewed advised the women/mothers on using/spending the money that is for assistance. All of them were advised to eat nutritious food with the financial assistance (only three VHNs / ANMs specified the nature of nutritious food) and there were also other messages. The other messages include three VHNs / ANMs advising mothers to give breastfeeding for children, two VHNs / ANMs had in fact advised to use the money for feeding supplementary food for the children, five VHNs advised to use it for future medical expenses. Many (twenty) VHNs / ANMs had advised to deposit the money in the bank for future use and quite a few (two) had reinforced that money is only for mother and child and it should not be used by either husband or in- laws.

Impact of the scheme

The main impact of the scheme according to most of the VHNs / ANMs is the general improvement in the health of mother and child. Some VHNs / ANMs mentioned certain other specific points as impacts of the scheme:

- Compensates loss of pay for working women (1 VHN / ANM)
- To eat nutritious food (4 VHNs / ANM)
- To give exclusive breast feeding for at least three months (2 VHNs / ANM)

- Helps the child gain proper weight and reduces anemia among children (2VHNs / ANM)
- Decreases infant mortality (4 VHNs / ANM)
- Increases and promotes family planning (3 VHNs / ANM)
- Increases regular checkups, ANC and PNC visits (1 VHN / ANM)
- Increases deliveries in PHCs and Government hospitals (5 VHNs / ANMs)
- Increases the respect for VHNs (1 VHN / ANM)
- Increases self-confidence among poor people (1 VHN / ANM)
- Benefits poor and downtrodden people (1 VHN / ANM)
- Helps poor people to borrow money during deliveries against the scheme's financial assistance (1 VHN / ANM)
- Helps poor people to meet medical expenses (3 VHNs / ANMs)

In the follow up question, twenty-nine out of thirty VHNs felt that this scheme improves women's health and nutrition. Some of the other specific responses were:

- Helps purchase and eat nutritious food on a regular basis (10 VHNs / ANMs)
- Financial assistance eases the burden and there is a psychological relief and they also can take proper rest (4 VHNs / ANMs)
- Also improves health through proper and routine medical checkups (2 VHNs / ANMs)
- Good food and regular medical care decrease premature delivery, ante-partum haemorrhage/low birth weight (2 VHNs / ANMs)
- Family planning/birth control after second child also improves women's health (1 VHN / ANM)
- Helps to improve the health of poor, SC/ST women (1 VHN / ANM)

Almost (twenty nine) all VHNs / ANMs feel that this scheme has advised and helped mothers in taking proper rest and nutritious food before and after delivery. This according to them has helped to improve their health and thereby also ability to properly breastfeed their children. Further, for a few VHNs / ANMs, advice and reinforcement on breastfeeding has also encouraged mothers to give breastfeeding for

children. In the interview and in group discussion, the VHNs / ANMs were quite sceptical on the issue of exclusive breastfeeding. They felt that the issue of exclusive breast feeding has received very little support from doctors, paediatricians and other traditional practices followed in households. Seventeen VHNs / ANMs felt that this scheme had helped to prevent poor working mothers from early return back to livelihood-related work post-delivery. However, fifteen VHNs / ANMs did not share the same view.

Some of the responses were on how the scheme has benefited households apart from its stated objectives. Some of them are listed below:

- To deposit the money in child's name for future (4 VHNs / ANMs)
- Helped mothers in joint families (1 VHN / ANM)
- Helped mothers who were separated from families due to love marriages (read inter caste, inter-religious marriages) (1 VHN / ANM)
- Medical expenses post-delivery for both mother and child (1 VHN / ANM)
- To repair house (1 VHN / ANM)
- To buy jewels (1 VHN / ANM)
- To buy livestock (1 VHN / ANM)

Suggestions to improve the scheme

Twenty one respondents out of the 32 VHNs / ANMs interviewed had suggestions to add more objectives to the scheme. Four VHNs / ANMs felt that the conditionality of family planning (promoting family planning) should be there in the scheme. Two VHNs / ANMs mentioned that the scheme should be universalised instead of targeting only poor people. Six VHNs / ANMs felt that the financial assistance should be made timely and should be in two instalments to meet the objectives of the scheme. Two VHNs / ANMs mentioned about having health education as part of the scheme and one VHN / ANM felt that the delivery should be insisted in a primary health centre (PHC) (most women prefer to have their deliveries in a community health centre (CHC) or District Hospital since these institutions have surgical facilities and better infrastructure to handle emergencies).

There were many other suggestions from the VHNs / ANMs to improve the scheme. They are:

- The eligibility criteria should be clearer and it is difficult to reject applications on certain obsolete guidelines (like having mobile phones). A few felt that the VHNs / ANMs should be free to choose the woman using her own criteria to identify poor people. There were a few VHNs / ANMs who suggested that the scheme should be universalised.
- VHNs / ANMs are already overworked and need to be relieved from this scheme or Government should recruit more VHNs / ANMs.
- A few VHNs / ANMs felt that in many places VHN / ANM general public relationship has reached a low because of this scheme. There are too many issues in identifying the women/mothers and paying them the assistance timely.
- The assistance should be made timely and can be paid before and after delivery in two instalments, so that it actually helps women during that time.
- Some conditionality can be added to the programme, such as: family planning, spacing between children, delivery in PHC/Government hospital
- Instead of cheque, cash could be directly paid and this would avoid the difficulties in opening an account.
- The financial assistance should be increased (now mothers are able to eat nutritious food but have to return work early since the money is not sufficient).
- A few VHNs / ANMs felt that financial assistance should be given even for poor mothers who deliver in private hospitals. Presently, this scheme covers only people delivering in government facilities.
- Government should design and implement awareness programmes in order to reinforce eating nutritious food, regular ANC/PHC visits, and exclusive breastfeeding

C. Anganwadi workers

Anganwadi workers (AWWs) were interviewed from the two districts of Kancheepuram and Dharmapuri. From Kancheepuram district, rural anganwadis were

covered in Achrapakkam and Ramapuram and anganwadi's in urban municipalities of Alandur and Tambaram were covered. In rural Dharmapuri, the anganwadis covered were Chola Kottai and Palaya Pudur and in urban Dharmapuri, anganwadis in the Dharmapuri municipality were covered.

A total of 33 AWWs (18 from Dharmapuri and 15 from Kancheepuram) were interviewed, out of whom 16 AWWs were from rural areas and 17 were from urban localities.

Functions of AWW

The AWWs listed out the regular activities that they were involved with specific reference to mother and child care and welfare. Most of the responses given by AWWs were similar and they were:

- Giving nutrition powder to pregnant women and mothers.
- Giving nutritious food to children.
- Iron and folic tablets to young women.
- Education to young adults, children, mothers and pregnant women about nutritious food.
- Regular check up of weights of pregnant women and young children.
- Encouraging regular medical checkups.
- Maintaining a register with details of pregnant women, adolescent girls and young children.
- This apart they are also involved in being the primary health care providers for minor ailments sometimes.

Some of other responses were:

- Advising exclusive breastfeeding for six months (3 AWWs).
- Supplementary food for low birth babies/children (1 AWW).
- Identifying anaemic women and giving supplementary food (1 AWW).
- Informing about the DMMAS (1 AWW).

All the AWWs believe that the anganwadi scheme helps in creating awareness amongst pregnant women on nutritious food and both pregnant women and young children are also provided nutritious food in the anganwadi centres. They have also promoted institutional deliveries, regular medical and weight checkups and improved immunisation coverage.

Understanding of DMMAS by AWWs

All the 33 AWWs are aware of DMMAS and they all feel that the scheme is useful and helpful for women in many ways. They are:

- For healthy diet and nutritious food (16 AWWs)
- For healthy mother and child (12 AWWs)
- To help poor women and BPL families (9 AWWs)
- To meet hospital expenses during delivery (9 AWWs)
- For emergency medical care and other expenses (4 AWWs)
- Loans can be taken for delivery related expenses in anticipation against the scheme's financial assistance (2 AWWs)
- Gives confidence to poor women (2 AWWs)
- For taking care of mother before and after delivery (1 AWW)
- For breast feeding the new-born children (1 AWW)
- For taking rest (1 AWW)

Knowledge about DMMAS eligibility

On the eligibility question, all AWWs responded that women from poor households especially those with BPL cards are eligible for the scheme. Only a few AWWs could add the other conditionality in the eligibility criteria such as:

- Income per annum less than Rs. 12000 (2 AWWs)
- Only for first two children (2 AWWs)

DMMAS Benefits

Almost all AWWs have women in their respective population/area who have benefited from the scheme. According to the AWWs, the benefits are:

- To bear medical expenses (9 AWWs)
- To eat nutritious food (8 AWWs)
- Proper care and treatment of mother and child (6 AWWs)
- To deposit in bank (6 AWWs)
- To invest in jewels or buying livestock (3 AWWs)
- For day to day household expenses (3 AWWs)
- Met all emergency/unplanned expenditure (3 AWWs)
- To prevent anaemia (2 AWWs)
- To prevent low birth weight and disability (2 AWWs)
- Encouraged institutional delivery in PHC/ Government hospital (2 AWWs)

DMMAS vis a vis Breastfeeding

All AWWs felt that this scheme helps improve the health and nutrition of mother and child. On the question of whether this scheme helped in the promotion of breast feeding, except for five AWWs, all other twenty eight AWWs felt that this scheme helped in promoting breast feeding. Out of the five AWWs who felt that this scheme does not help breast feeding, one AWW mentioned that since the money is given six months after child delivery it is not useful. However, twenty eight AWWs mentioned that this assistance helps women take rest and eat nutritious food (which helps in breast feeding). On the issue of exclusive breast feeding for first six months, nineteen AWWs responded unlike the VHNs / ANMs that they perceive that there has been increase in the awareness level of mothers on exclusive breastfeeding and many mothers practice exclusive breastfeeding. They also added that the financial assistance scheme might also have helped mothers be healthier by eating nutritious food and thereby encouraged to practise exclusive breastfeeding. However, this perception was not shared by their colleagues (fourteen AWWs).

DMMAS vis a vis Return to work

Similarly, on the question of whether the scheme/financial assistance helps working mothers to delay in going back to livelihood-related work after delivery, seventeen AWWs responded that it did help mothers to delay going back to their work and (however) sixteen AWWs responded in negative. The seventeen AWWs who responded positively also added that this scheme helps mother to take more rest since the financial assistance eases the economic burden.

DMMAS vis a vis Nutritious supplements from AWW

According to twenty five AWWs, many women of the DMMAS also avail the nutritious supplements provided in the anganwadi. Eight AWWs responded only few women of the scheme received the nutritious supplements from anganwadi.

DMMAS vis a vis use of Anganwadi services

Nineteen AWWs also responded that the maternity benefit scheme had not brought any change (neither decrease nor increase in interest) in more women receiving assistance coming to the Anganwadi to avail nutritious supplements from the anganwadi. However, twelve AWWs felt that the maternity benefit scheme had encouraged more women receiving nutritious supplements from anganwadi. Only two AWWs felt that the scheme had decreased the interest of the women who received assistance from availing the nutritious supplements from anganwadi.

AWWs role in DMMAS

Twenty three AWWs feel that can play useful roles in implementing DMMAS. This includes:

- Jointly working with VHNs / ANMs in meeting and counselling pregnant mothers (10 AWWs)
- Maintaining register of pregnant mothers and new-born children (8 AWWs)
- Encouraging regular medical checkups (8 AWWs)
- Identifying the women/mothers for VHN / ANM (5 AWWs)
- Encouraging pregnant mothers to eat nutritious food (2 AWWs)

- Encouraging institutional delivery (1 AWW)

Twenty nine AWWs felt that there should be better collaboration/linkage with the VHNs / ANMs since AWWs are very much involved in mother and child care. They also felt since they have better knowledge of households/villages, they would be very resourceful and helpful for implementing such schemes.

Suggestions to improve the scheme

The AWWs provided various suggestions for improving the scheme. They are:

- Involving self-help groups in implementing the scheme
- To include regular medical checkups and vaccinations
- To pay the financial assistance before and after delivery
- Financial assistance should be paid without delay
- Financial assistance should focus more on women's nutrition. The scheme should have a proper strategy to address this issue. Nutritious food items can be directly distributed during pregnancy and post-delivery period.
- Anganwadi workers can be involved in identifying the women
- Opening a bank account should be made easier
- The financial assistance should properly reach BPL population. There needs to be better guidelines to identify BPL population
- Conditionality of family planning should be included to promote family planning
- Should provide financial assistance for mothers delivering in private facilities
- The scheme should be universalised
- The scheme can be implemented through anganwadi centres. AWWs are more involved in work related to mother and child welfare.
- Need to create awareness about the scheme and its objectives.

List of Key Findings

From women/mother's data (207 interviewed)

- Age of respondents mostly between 18-25 years; 90 percent were Hindus; 6 percent were Christians and 4 percent Muslims
- 93 % of husbands of respondents and all respondents who were in the labour market were in the unorganised sector
- Most women applied for the scheme during pregnancy
- Most women received the entire money in the first instalment
- All women received the money only post-delivery and within the first 6 months of delivery. None of them received it during pregnancy
- Money received from the scheme was primarily spent on medical expenses, food and savings and investments respectively.
- Decision on how to spend the money in 60 percent cases was taken along with husband
- Most women got to know about the scheme from the VHN / ANM followed by AWW
- Most were told that the scheme was meant for mother and child welfare
- Out of the 70 percent respondents who were told what the money was meant for more than 50 percent were told that the money was meant to take care of mother and child and to eat nutritious food
- All the women said that they were advised to take nutritious food during pregnancy and after delivery
- Most women had the knowledge of nutritional supplements distributed in the anganwadi and most collected it during pregnancy
- Most women (more than 90 percent) had no difficulty in applying for the scheme and in getting the money
- Out of those who reported giving other food to the child (88 percent of the respondents), 80 percent started giving only after 6 months
- Suggestions to improve the scheme included there should be no delay in payment, money should be given in two instalments (during pregnancy and after delivery) and that the financial entitlement should increase

Urban-Rural differences in responses (women/mothers)

- 64 percent of the *most backward classes* in the sample were from the rural area.
- Out of the 30 women who were getting money in two instalments, 27 (90 percent) were from urban areas.
- Significantly more women took decision with husband in the rural area than urban on how to spend the money.
- Significantly more number of women got to know about the scheme from the VHN / ANM in rural areas than urban.
- While all women in rural areas knew that nutrition supplement is being distributed to pregnant women, 9 percent were not aware of it in urban areas. Correspondingly, there were more pregnant women collecting nutritious supplements in rural as compared to urban.
- There were more number of women (33 out of 48) i.e. 69 percent who did not receive information about the scheme in urban area.
- There are more women in rural area who were told that they could deliver only at a government institution.
- Overall, very few had difficulties in applying for the scheme and getting the money but out of those who faced difficulties there were more from urban areas.
- Only 5 out of the total had problems opening an account in the bank and all 5 were from the urban.

Key findings from VHNs / ANMs (32 interviewed)

- The responses of VHNs / ANMs regarding objectives vary and are general. Three-fourth VHNs / ANMs interviewed felt that consuming nutritious diet during pregnancy to avoid low birth weight of the child is the major objective of the scheme. Only one mentioned wage compensation.
- Most mentioned they advised the women of the DMMAS on eating nutritious food and breast feeding children, and few advised using it for medical expenses.

- BPL category households are identified through the BPL ration cards, nature of housing, income certificate, type of employment, social background and landholding patterns. Some said there was lack of clarity in the guidelines of selecting a woman or mother who would receive the financial assistance. There were contradictions – while almost everyone (31 out of 32) said that they were able to easily identify poor women, 23 VHNs / ANMs said that only 60 percent of the women/mothers selected, fulfilled the eligibility criteria, and 9 felt that the scheme was not benefiting eligible women.
- 29 out of 30 VHNs / ANMs felt that this scheme improves women's health and nutrition; 10 said it helps buy nutritious food; allows to take proper rest.
- 20 VHNs / ANMs felt that exclusive breast feeding could be possible.
- Only 17 felt that the scheme helped poor working mother from early return back to livelihood-related work.
- Suggestions to improve the scheme varied from need for timely payment, need for conditionality of family planning to the need for universalising the scheme.

Key findings from AWW data (33 interviewed)

- All feel that the scheme is useful and helpful in many ways – for healthy diet and nutritious food, for healthy mother and child, to help poor BPL women, to meet hospital expenses during delivery, to invest in jewels. Some even said it gives confidence to poor women.
- When they reported about benefits that women received through this assistance – medical expenses topped the list followed by eating nutritious food, proper care and treatment of mother and child, to deposit in bank. Some reported that the women invested in jewellery
- 28 out of 33 AWWs felt that the scheme helped in promoting breast feeding. One mentioned that since the money reaches women after 6 months after delivery it is not useful.
- AWWs feel awareness of exclusive breastfeeding has increased and many practice exclusive breastfeeding
- A little over 50 percent AWWs felt that the scheme helped mothers to take more rest and therefore delay their returning to work.

- Many women/mothers of the scheme also avail nutritional supplements provided in the anganwadi
- 19 AWWs said that maternity benefit scheme had not bought any change in more women/mothers coming to anganwadi. 12 said it had encouraged more women in taking supplements from anganwadi and two said that there was a decrease in women/mothers availing supplements
- 23 AWWs feel that they could play an important role in implementing the scheme since they are involved in mother and child care. They feel they could jointly work with VHNs / ANMs in meeting and counselling pregnant mothers; maintain registers of mothers and new-born children and encourage medical check ups. Some said they could help identify women/mothers for VHN / ANM.
- Suggestions to improve scheme include involving them in implementing the scheme; focus more on women's nutrition; involve self-help groups in implementing and that scheme could be implemented through anganwadi centres and should be universalised.

4. **Discussion and Conclusion**

This study attempts to establish the concept of maternity entitlements through following its historical progress internationally and in India, as a universal entitlement to compensate economic loss faced by women during child bearing and rearing. It establishes the aims to support women through pregnancy, delivery and the period of exclusive breast feeding and early child care. Further such a scheme is conceptually expected to achieve impact in terms of reductions in maternal morbidity (specially maternal anaemia) and mortality, low birth weight, exclusive breast feeding and neonatal care leading to ultimate gains for neonatal and child survival, health and nutrition (WGCU6, 2007).

Adherence to Concept: The DMMAS is a pioneering and sole effort to provide maternity entitlements for poor women in the informal sector through a scaled-up state-wide scheme. This scheme has many laudable features as discussed below. However, in terms of a conceptual framework, it does not fulfil all the criteria above. Its objectives are stated as providing wage compensation for 'delivery' and nutritional support to the pregnant woman. However, the important issue of child care and exclusive breast feeding is not specifically related to the scheme.

Universality: The study shows that the scheme offers greater universality than schemes limited by the BPL framework by including women on the basis of wide criteria. Even in practice, the study finds that poor women are hardly excluded as a result of not being able to fulfil the criteria. In fact, the number of women covered by the scheme compares well with an estimation of how many children would be born to women under the poverty line each year. Suggestions from the women who receive assistance and providers are mostly related to making it even more inclusive and cutting back conditionalities; for example, by including women who deliver in private facilities.

Nonetheless, BPL is found as term used for identification of women/mothers in many of the responses as well as in the complaint form for irregularities in the identification of women/mothers. Thus there is a contradiction between the intention of the scheme,

its rules and the perceptions of the VHNs / ANMs and AWWs. However, this study did not include any eligible women who are excluded from the benefits of the scheme in its sampling. That is the issue of exclusion has been really beyond the scope of the study.

It is worth noting that a few women (3) had suffered the imposition of family planning conditionalities even though they did not exist in the scheme. There is concern that unwritten targets for family planning still persist despite the change in policy to an 'untargeted approach' and this needs to be guarded against.

Studies on vulnerable groups in Tamil Nadu (construction workers, marginalised nomadic tribes and pavement dwellers) show that awareness regarding available maternity assistance is low and that the government also fails to reach them. Therefore, the percentage of women/mothers in these groups was very low (Belinda, R. and K.Shanmugavelayutham, 2005; John Jeya Kumar, A and K.Shanmugavelayutham, 2006; Annapuraman, K & K.Shanmugavelayutham, 2007). It needs to be noted here that these studies were carried out before or around the same time that the revised DMMAS was implemented and therefore may or may not be reflective of the revised scheme.

Profile of women/mothers who have benefited: Most of the women are in the age group with one to two children only. 72 percent were in the age-group of 18-25 years. This may explain the low numbers who reported for wage work. However, it is understood from the first part of the study that all poor women contribute economically to the survival of the family through paid or unpaid work (Narayanan, R. 1997; Palriwala, R. and N. Neetha 2009).

Leakages: It is laudable that the study hardly found any evidence of corruption or leakages, with some women getting full amounts of JSY and DMMAS both. Significantly 94 percent did not face difficulty in applying for the scheme and 93 percent did not face any difficulty in getting the money. In this connection, it is also significant that no major problems were perceived with getting bank accounts opened, and this has implications for other schemes that have suggested the use of bank accounts to minimise corruption. This argument can be supported by evidence from

Andhra Pradesh in relation to the NREGA experience. NREGA wages were paid through post offices and this separation of payment agencies from implementing agencies helped in reducing corruption related issues (Dreze, J., R. Khera and Siddhartha, 2008). The lack of leakages is likely to be related more to the overall governance and environment in the state than to a notion that cash transfers are more corruption proof. There are several studies that take Tamil Nadu as a case study for good governance. The analyses suggest that good governance in terms of the allocation of public finances, bureaucratic efficiency, and the implementation of innovative development policies in compulsory education and health make Tamil Nadu a better performing State (Visaria, L. 2000; Prabhu, K. Seeta, 2001; Joshi, D. 2007; Das Gupta, M., B.R. Desikachari et al. 2010).

Convergence with the ICDS: It is worth noting that incidental findings of the study show that SNP through ICDS is working well and this has been found in previous surveys (FOCUS, 2006). The study also shows that the DMMAS does not supplant the use of SNP through the ICDS programme and that women tend to use both.

Delays: Delays of payment were ubiquitous. These are likely to be the result of inclusion of most women/mothers vis a vis an inadequate budget. During the study, it was noted that there was a continuous backlog of women waiting to receive the money. No women had received the money during pregnancy and only 22% had received it by the first month following delivery. While most women received the money, it was too late to make any difference to nutrition during pregnancy or wage compensation for the first six months of exclusive breast feeding. Another study that looks at the implementation of the scheme in Chennai shows that there were delays in payments and most women received it after the first month of delivery (Irudaya Veni Mary, A. and Dr.K.Shanmugavelayutham, 2009).

Training and Capacity Building: there is a distinct lack of focus to link the cash compensation with its objectives. The scheme providers did not get specific training on the technical issues related to the scheme specially exclusive breast feeding, improving the quality of nutrition and delaying going back to work. Training was given for procedural elements only. Not surprisingly, there was an absence of clear focused messages accompanying the money even to the women/mothers who received

the assistance. This is a huge missed opportunity. Significantly even amongst AWWs very few (3 out of 33) were able to correlate exclusive breast feeding as one of the benefits of the scheme.

Contribution of other village level functionaries: Even though the scheme was to be administered by the VHNs / ANMs, only 15 percent received information by the VHN / ANM alone whereas the AWW participated in many ways for the majority. Similarly, the AWWs helped the VHNs / ANMs identify the potential women/mothers and in many cases interact with them on utilising the entitlement money. This has implications upon fixing incentives for any one village level health/WCD worker at the exclusion of others.

Utilisation: Most women used the money for health expenditures, savings and food for themselves and their child. 58 percent mention medical expenses as one of the items that they spent money on and 44 percent mentioned food as one of the items they spent the money on. Many women take loans during delivery as they are sure of reimbursement by the scheme. Details on the nutritional value of the food are not available from the study. It is interesting to note that health expenditure comes first in the list even in a state like Tamil Nadu which is famed for its availability of free drugs and free quality health care at PHC level. This point needs to be further investigated. Hardly any women used the money for what could be termed frivolous expenditure on their part, not directly related to health and nutrition of either self or child.

Urban- Rural Differences: The study on the whole suggests that while the profile of respondents is not very different apart from higher SC women in rural areas, in terms of scheme delivery, urban areas are far poorer. All the women who had difficulty in opening bank accounts were from urban areas and 69 percent of those who were not told what the scheme was for were from urban areas.

Recommendations

1. Recommendations for future research (based on limitations of the study): The entire study is based on reported events and perceptions of women/mothers who received financial assistance and providers. Sample sizes are too small to make many quantitative comparisons though they have been attempted. However, triangulation

between three different sets of respondents with different vantage points suggests that most of the qualitative findings are reliable. They would require further validation by more rigorous prospective studies that can provide factual evidence. Evidence is also required to see the impact of such a scheme on indicators such as maternal weight gain, maternal anaemia, maternal mortality, low birth weight (LBW), neonatal and infant mortality, breast feeding indicators, delayed return to economic activity. This was far beyond the scope of our exploratory study and would require formal comparative studies. Our study looked only at women/mothers who benefited and did not make an attempt to identify eligible women who were left out of the scheme and the reasons for the same. As discussed above, women who are socially excluded or women in special situations of vulnerability, such as belonging to nomadic, migrant or homeless populations may be getting excluded and this point needs further study to be able to make schematic recommendations for their inclusion.

2. Programmatic Recommendation

1. Schemes for maternity entitlements need to understand and acknowledge the full scope of the conceptual framework of this particular right to be able to do justice to all its objectives as well as to be able to provide equity with other women working in the formal sector.
    a. Thus, they should be universal and not have a BPL, age or 'first two children' cut off, institutional delivery or any other conditionalities attached.
    b. They should provide adequate wage compensation for a period in late pregnancy as well as for six months post delivery. At a minimum they must be consistent with the law and the benefits made available to women in government service.
2. There should be no confusion between the objectives of a maternity entitlements scheme and schemes to promote institutional delivery, supplementary nutrition during breast feeding and pregnancy, immunisation, family planning etc. Thus, it should not attempt to overlap with other strategies such as promotion of institutional deliveries (JSY) and supplementary nutrition (ICDS), but remain faithful to the main

concept of maternity entitlements which is wage compensation in late pregnancy and six months after.

3. If the conceptual framework is clear and comprehensive, it needs to be translated into well defined objectives which are supported by capacity building at all levels.
4. Good implementation must include the timely release of money as per the objectives of the scheme. This requires adequate and realistic budgeting. Delays nullify the entire set of objectives of the scheme.
5. The use of bank accounts seems feasible and may help prevent corruption and leakages.
6. The AWW and the ICDS are well placed to deliver such schemes in collaboration with the health workers. A collaborative arrangement needs to be worked out between the two systems for the delivery of such a scheme. This is specially important for the scheme to be made applicable for women delivering at home as is very much more the case in States other than Tamil Nadu.
7. Special attention needs to be made for better implementation for the urban poor.
8. Expenses on health services seem to be taking precedence over nutrition and health care services need to be made universal and free so that this scheme can fully achieve its objectives.

Of course, all the above require great commitment to the framework of rights and equity, and political will backed by adequate budgets and a well formulated and implemented scheme. Such a scheme can go a long way to achieve major goals of maternal and child health and complement other strategies.

Abbreviations

ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BPL	Below Poverty Line
CCT	Conditional Cash Transfer
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHC	Community Health Centre
DMMAS	Dr. Muthulakshmi Reddy Maternity Assistance Scheme
TN-FORCES	Tamil Nadu - Forum for Crèche and Childcare Services
ICDS	Integrated Child Development Scheme
ICESCR	International Covenant on Economic, Social and Cultural Rights
IGMSY	Indira Gandhi Matritava Sahyog Yojana
ILO	International Labour Organisation
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
MSSRF	M.S. Swaminathan Research Foundation
NMBS	National Maternity Benefit Scheme
PHC	Primary Health Centre
PHRN	Public Health Resource Network
VHN	Village Health Nurse
WGCU6	Working Group for Children Under Six

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Notes on Contributors

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Dr. Prasad is a community paediatrician with an MRCP from UK. Her special areas of interest are child health and nutrition, specifically in the areas of early childhood care and development with particular focus on training, research and advocacy. She has published many papers and articles in the leading journals and magazines.

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Mina Swaminathan, trained as a teacher, has been a teacher, teacher educator, and writer in the fields of ECCE, day care and gender studies for nearly fifty years. One of the founders of FORCES (Forum of Crèche and Child Care Services) she has worked extensively on issues of maternity entitlements as well as child care and education and drafted the FORCES Maternity and Child Care Code. She has many publications, including two popular training manuals. Hers is a prominent voice speaking for day care and for considering the rights of the working woman and the young child together.

Dr. Rama Narayanan has a PhD in nutrition with 25 years of professional experience in the development sector. Her area of specialisation has been on Maternity and Infant and Young Child Feeding Practices. Her professional activities have included research, documentation, programme implementation and capacity building. She has worked with academics, activists, government departments, training institutions and women's groups. She currently holds the Ford Foundation Chair for Women and Food Security at the M. S. Swaminathan Research Foundation.

Dr. K. Shanmugavelayutham has been serving as a Professor in social work for nearly three decades at Loyola College, Chennai. He was a president of Professional Social Workers' Association. He is a Convenor of Forum for Crèche and Child Care Services in Tamil Nadu (TN-FORCES) for more than 10 years and made a paradigm shift to focus on ensuring the rights of socially deprived. He is Managing Trustee of Foundation for Rights of Young Child (FORYOUCHILD) and also the advisor of Unorganised Workers' Federation.

In 2004, he delivered a speech at the Conference on the Rights of Young Child in United Nations Human Rights Commission at Geneva. He has authored nearly 15 Books and 50 Research Papers. He has conducted various capacity building training

programmes for government officials working in Child Development Projects at all levels across the state of Tamil Nadu. He has been known as a foremost and prominent campaigner in the field of Child Rights and Development.

Public Health Resource Network (PHRN) seeks to identify like-minded, motivated individuals and organisations through existing state level resource support agencies, NGO networks and state health societies, and reach out to them in order to accelerate and consolidate the potential gains from the National Rural Health Mission that can truly change the health scenario of disadvantaged people. PHRN has been active since 2005 in the states of Chhattisgarh, Jharkhand, Bihar, and Orissa. It has also supported similar action in many other states, such as Rajasthan, Haryana, Uttarakhand and the North Eastern states. PHRN believes in refining its objectives and strategies in accordance with its experience as well as circumstances of its work.

The **MS Swaminathan Research Foundation** started its work 20 years ago in the thematic areas of coastal systems, biotechnology, biodiversity, ecotechnology, food security and information, education and communication. The approach was based on strategic and participatory research, capacity building, networking and partnership building, based on the principles of social inclusion in access to technologies which help to enhance income and environment. Research and outreach strategies were devised to bridge the rich-poor and gender divides in the areas of information, knowledge and skill empowerment.

Tamil Nadu-Forum for Crèche and Child Care Services (TN-FORCES) represents a semi-structured Network of organisations, institutions and individuals concerned with issues relating to women working in the unorganised sector and care of their children. The network is committed to the survival and development of the young child (0-6 years) and women working in the informal sector.
The core vision of TN-FORCES is that every child has the right to early childhood care and development including crèches and childcare services. And also that it is the state's responsibility to ensure such services for all children, especially those of women working in the unorganised and informal sector.

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