REPORT ON THE STUDY OF THE INDIRA GANDHI MATRITVA SAHYOG YOJANA

To Enhance Inclusion and Preparedness to Implement Provisions under the NFSA

2015

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Abbreviations

AAY	Antyodaya Anna Yojana
AHS	Annual Health Survey
ANC	Ante-natal Care
ANM	Auxiliary Nurse Midwife
ASCI	Administrative Staff College of India
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BCG	Bacillus Calmette Guerin
BPL	Below Poverty Line
CDPO	Child Development Project Officer
CHC	Community Health Centre
DBT	Direct Benefit Transfer
DLHS	District Level Health Survey
DPC	District Programme Coordinator
DPO	District Programme Officer
DPT	Diphtheria Pertussis Tetanus
DSWO	District Social Welfare Officer
EBF	Exclusive Breastfeeding
EGoM	Empowered Group of Ministers
FLW	Frontline Worker
GoI	Government of India
ICDS	Integrated Child Development Services
ICESCR	International Convention on Economic, Social and Cultural Rights
IEC	Information Education Communication
IFA	Iron Folic Acid

IGMSY	Indira Gandhi Matritva Sahyog Yojana
ILO	International Labour Organisation
IYCF	Infant and Young Child Feeding
JSSK	Janani Shishu Suraksha Kosh
JSY	Janani Suraksha Yojana
MCP	Mother and Child Protection
MFP	Minor Forest Produce
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MMSY	Mukhyamantri Mazdoor Suraksha Yojana
MoWCD	Ministry of Women and Child Development
MPR	Monthly Progress Report
MPW	Multi-Purpose Worker
NAC	National Advisory Council
NFSA	National Food Security Act
NHM	National Health Mission
NMBS	National Maternity Benefit Scheme
OBC	Other Backward Classes
PHC	Primary Health Centre
P & LW	Pregnant and Lactating Women
PNC	Post-natal Care
PUCL	People's Union for Civil Liberties
PVTG	Particularly Vulnerable Tribal Group
RTFC	Right to Food Campaign
SC	Scheduled Caste
SDM	Sub-Divisional Magistrate
ST	Scheduled Tribe
THR	Take Home Ration
VHND	Village Health and Nutrition Day
ZBA	Zero Balance Account

Never ending work

1. Maternity Entitlements: Background

Introduction

The quick pace of India's economic growth over the past few decades has failed to translate into the wellbeing of many of its people, especially women and children. India ranks 55th out of 76 countries on the Global Hunger Index 2014, which is 11 ranks below its neighbour Nepal, an economically much weaker country in South Asia.[1] The healthcare indicators are equally, or perhaps more, worrisome. Out of every 1,00,000 live births in a year, 178 women die as a result of complication during pregnancy.[2]Nearly a quarter of women in India do not have access to a single Ante Natal Check (ANC).[3] The situation is even more alarming with postnatal care as over 50 per cent women did not receive any care for up to two weeks.[4] Similarly, infant mortality rate indicated in the latest SRS Statistical Report 2013 shows that 40 infants out of every 1,000 live births die within the first year and 52.5 per cent of these deaths are of infants less than seven days of age.[5]

[1] See Grebmer et al. (2014, p. 16)
[2] See GoI (2013h)for information on maternal mortality.
[3] See IIPS (2010) for the data of District Level Health Survey-3 2007-08.
[4] See (ibid.) for data on post-natal care.
[5] See GoI (2013i) for data related to infant mortality.

It is amid this context that the National Food Security Act (NFSA) was passed unanimously by both the houses of Indian Parliament in September 2013. The enactment of this law was preceded by four years of intense debate on what its contents and scope should be (for details see box 1.1). Based on the careful considerations, the NFSA adopted the human life cycle approach to address nutrition and hunger in the country. Broadly it provides three types of legal entitlements, namely, food grains, meals and cash transfers. The Act specifies that the food grains are to be provided through the Targeted Public Distribution System (TPDS), meals through the Integrated Child Development Services (ICDS) and school mid-day meal programmes, and the cash maternity benefit through a scheme as the central government would prescribe.

However, the implementation deadline for the NFSA has been extended thrice since its passage already- from 5th July 2013 to 4th October 2014, subsequently to 4th April 2015, and presently up to 30th September 2015. Out of these, the last two extensions are actually in violation of the law as these were given by the government without making amendments to the NFSA. On 1st May 2015, the status of implementation as stated by the Food Minister, Ram Vilas Paswan, is that by June 2015 about 90 per cent of the states would implement NFSA,[6] which too is only in reference to the implementation of TPDS. It still remains unclear how the provision for maternity entitlements will be implemented, which is the second largest entitlement under NFSA after subsidised food grains in terms of budget requirements.

The text of the NFSA only specifies that every pregnant and lactating woman is entitled to not less than Rs 6000; rest of the details have been left to be carved out as per the discretion of the central government. While India has significant experience with implementing food grain and child nutrition programmes in the form of the Public Distribution System since 1942, the ICDS since 1975 and the Mid-Day Meal Scheme since 2004, a universal maternity entitlements scheme has not been in place yet, except in a couple of states. Its past experience with provisioning of maternal benefits, in particular for women in the unorganised sector (91.3 per cent of the total women workforce[7]) has been limited and at best patchy.[8]

Presently, the only cash maternity benefit scheme by the Government of India (GoI) is the Indira Gandhi Matritva Sahyog Yojana (IGMSY), which itself has been running only on pilot basis. Therefore, this study of the IGMSY has been conducted to understand the issues

[6] See Business Standard (2015) for the Food Minister's statement.
[7] See NCEUS (2009)
[8] See Abraham, Singh, & Pal (2014) for discussion on implementation of maternity related legislations..

involved in provision of cash transfers for maternity entitlements and to inform the design and implementation of a universal scheme to fulfil the obligations under the NFSA. There are also indications that the IGMSY itself will be converted into a universal scheme under the NFSA.[9] This makes it even more important to understand the current progress in delivering a cash maternity entitlement and analyse the gaps in the implementation of this scheme so that corrections can be made when the scheme is expanded.

Box 1.1: Passage and Provisions of the National Food Security Act

The passage of the NFSA was a significant step forward after a long struggle for the right to food. In 2001 when chronic hunger in drought affected areas intensified and simultaneously India's food stocks kept increasing, the People's Union for Civil Liberties (PUCL, Rajasthan) filed a writ petition "PUCL vs Union of India and others (Writ Petition [Civil] No. 196 of 2001)" in the Supreme Court seeking legal enforcement of the right to food.

The petition argues that the right to food is a basic right enshrined in the Indian Constitution since it is a logical extension of Article 21 - the fundamental "right to life". The case, which initially named the Government of India, the Food Cooperation of India and six state governments, was later expanded to include all state governments, holding them answerable "to the larger issues of chronic hunger and under-nutrition."[10] In its initial orders the Supreme Court listed all the schemes which would come under the purview of this case. These schemes included the direct food transfer schemes as well as programmes for social assistance and food for work, and thus, laying out the framework for the right to food. Maternity entitlements became part of this framework as the Supreme Court orders included within their purview the National Social Assistance Programme (which at that time included the National Old Age Pension Scheme, National Maternity Benefit Scheme (NMBS) and the National Family Benefit Scheme.

PUCL, the petitioner, needed to take the assistance of hundreds of organisations if they were to counter, factually, all the affidavits that were being filed by the Central Government and the 35 states and union territories. It was in this context of filing the writ petition and the prolonged legal proceedings that the need for the Right to Food Campaign (RTFC) to have a pan-Indian presence was realised. Over the years the petition also widened the issues it addressed and presently covers "implementation of food-related schemes, urban destitution, the right to work, starvation deaths, maternity entitlements and even broader issues of transparency and accountability."[11] As a result of the public mobilisation done by RTFC, which included "public hearings, rallies, dharnas, padyatras, conventions, action-oriented research, media advocacy, and lobbying with Members of Parliament," a National Food Security Bill 2010 was drafted by the Empowered Group of Ministers (EGoM).[12]

Since the bill was not up to expectations, the RTFC galvanized the public outrage against the draft bill through protests and called for the immediate revision of the bill. The main demands

[9] See letter from Ministry of Women and Child Development, Government of India, F.No. 4-3/2014-IGMSY dated December 30, 2014.

[10] See Right to Food Campaign Secretariat (2008)

[11] (ibid.)

[12] (ibid.)

made were the creation of multiple entitlements and an enabling environment for promoting food production by prioritising people's control over productive resources including land, forests and water. In response to the agitations the first meeting of the newly reconstituted National Advisory Council (NAC) gave priority to the re-drafting of the bill.

However, despite several rounds of debates the final National Food Security Bill (NFSB) was a significantly diluted version of the NAC drafted bill. The NFSB was introduced on 22nd December 2011 in the Lok Sabha. This bill went through several round of deliberations but was not being passed. As a result the United Progressive Alliance government pushed for implementation of the bill in the form of an Ordinance in July 2013. Subsequently, in October 2013 the NFSA was passed.

Although diluted, the NFSA did give a range of legal entitlements to households, children below six years, children between 6-14 years and pregnant and lactating mothers based on human life-cycle approach. It provides three types of entitlements and the selection of beneficiaries for the entitlements differs from provision to provision. Following is a tabular presentation of the provisions of the NFSA.

Table 1.1: Provisions under the National Food Security Act, 2013

Type of Entitlement	**Target group**	**Entitlement**	**Price**	**Coverage**
Food grain	Eligible Household[13]	Priority household- 5kg wheat or/and rice per person per month	Rice @Rs. 3/kg & Wheat @Rs. 2/kg	Rural Areas- 75% & Urban Areas- 50%[14]
		AAY households- 35 kg per household per month		
Meals	Pregnant and lactating women during pregnancy and six months after child birth	Take home ration	Free	Universal
	Children between 6 months-3 years			
	Malnourished children between 6 months–6 years			
	Children between 3-6 years	Morning snack and hot cooked meal at anganwadi		
	Children between 6-14 years	One hot cooked meal at school		
Cash Transfer	Every pregnant and lactating woman	Not less than Rs. 6000	-	Universal

Source: National Food Security Act, 2013[15]

[13] See GoI(2013g)
[14]See Section 3 sub-section (2) of GoI (2013g)

Rationale for Maternity Entitlements in India

During pregnancy women's need for nutrition, particularly iron, increases sharply and if unmet it leads to anaemia. Among the pregnant women in the age group 15-49 years, 57.9 per cent are anaemic in India.[16] Moreover, in the Indian context many women are involved in hard manual labour till the last day of their pregnancy and resume work soon after delivery due to various social and economic constraints. These facts and reasons make a strong case for the need to recognise every woman's right to maternity entitlements in the form of adequate rest and nutrition during pregnancy. In addition, since the right to food of children below the age of six months is intricately linked with their mother as children are solely dependent on breastmilk as their food and nutrition for this period, the maternity entitlement has to be such that also promotes breastfeeding.

Under the NFSA, pregnant and lactating women are provided supplementary nutrition through anganwadi centres for nutritional support as well as a cash entitlement which is interpreted as wage compensation to women during the period of late pregnancy or post-delivery to create enabling environment for rest and exclusive breastfeeding for six months. Hence, the cash maternity entitlement under NFSA has been conceptualised as a wage compensation for being away from work as well as a social protection for pregnant and lactating women. Maternity Entitlement is envisioned and defined to broadly address the following issues:[17]

- **Women's labour rights** i.e. protection of employment, wage compensation and support during pregnancy, delivery and lactation.
- **Improvement of health of the mother and child** through proper nutrition of the mother for a healthy pregnancy, to improve birth weight of the children and in turn reduction of neonatal and infant mortality.
- **Reduction of maternal morbidity and mortality** through appropriate medical care, improved nutrition and provision of time for rest and recuperation.
- **Increased support to mothers** to enable exclusive breastfeeding to ensure growth and development of child.

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[15] See GoI (2013g)
[16] See IIPS (2007)
[17] See Minutes of June 2nd Planning Commission Presentation and Discussion on Dr.Muthulaksmi Maternity Assistance Scheme (DMMAS) Room No. 122, Yojana Bhawan (can be accessed at http://www.phrnindia.org/researchAdvocacy/Report_PlanningCommissionMeeting.pdf)

Locating Maternity Entitlements

Various international and national provisions on maternity entitlements precede the NFSA. This section traces the international and national landmark conventions and programmes which contribute to providing maternity protection. It also critically engages with design and scope of such programmes.

International Conventions: Genesis & Current Gaps

The International Labour Organisation (ILO) in 1919 passed the first international legislation, Maternity Protection Convention (No. 3), to give due recognition to maternal entitlements of women employed in "public or private industrial or commercial undertakings, or in any branch thereof."[18] This convention was a result of the "increased participation of women in the labour market and the growing recognition of their work as an economic activity."[19] In 1952 the ILO revised this resolution and passed the Maternity Protection Convention (Revised) (No. 103), which further set the pace for future national and international policy by extending the scope of protection to include "women employed in industrial undertakings and in non-industrial and agricultural occupations, including women wage earners working at home."[20]

Alongside, the importance of maternal health was established in the international domain through various declarations and conventions. The Universal Declaration of Human Rights, 1948, acknowledged the right of a mother and child to special care and assistance. Further, the International Convention on Economic, Social and Cultural Rights (ICESCR) (1966) drew attention to the need for prenatal, neonatal and intra-natal care to ensure a healthy child. It highlighted the role of the State in providing social security benefits and paid maternity leave.

Another significant legislation in the movement to secure maternal entitlements was the Convention on Elimination of all forms of Discrimination against Women, 1979. It advocated for maternity as a 'social function' and highlighted that childcare is the responsibility of not only women, but also men and society at large.[21]

[18] See ILO (1919)
[19] See (ILO, 2012a)
[20] See (ibid.)
[21] See part I, article 5 of UN General Assembly (1979)

However, despite the growing recognition of equality in the workplace and in the private sphere, the number of countries which ratified the prior conventions was not significant. With the changing forms of employment and the growing participation of women from the child bearing age in them,[22] a need was felt to discuss the challenges in meeting the standards and widening the scope of maternity benefits.[23] The Committee on Maternity Protection was formed in 1999 to revise the existing standards. This revision was hoped to "enable wider ratification of a Convention on this important subject, whilst at the same time ensuring effective protection and equality at work for the greatest possible number of women around the world."[24] ILO's convention on Maternity Protection, 2000 (No. 183) mentions the right of all employed women to paid maternity leave. This includes those doing 'atypical forms of dependent work'[25] such as part-time, domestic and intermittent employment.[26] This move was a step ahead from the previous conventions on maternity as the coverage was now increased to include all employed women that was previously limited to women in non-industrial, agricultural and wage work at private households. The convention also incorporates at least 14 weeks of maternity leave and vouches for paid breastfeeding breaks as a right of working women.[27]

Though the recognition of informal workers by the ILO accounts for marginalised groups, the scope is still limited to informal workers who have an employer, thus continuing to exclude self-employed workers, those in family enterprises and the large number of women who are engaged in unpaid work.[28]

Approaches to Deliver Maternal Entitlements: Shifting Liabilities & Programme Design

As per the ILO's 2014 report based on the review of national legislative provisions on maternity protection at work in 185 countries and territories, "Virtually every country around

[22] Female labour force participation rates have been increaseing for all age groups except 15-24 years, see ILO (2010, p. 19-20) for further details.
[23] See ILO (1990).
[24] See (ibid.).
[25] Atypical forms of dependent work include a broad range of non-standard work arrangements, such as part-time, casual and seasonal work, job-sharing, fixed-term contracts, temporary agency work, home work and remote working; pieceworkers; informal employees in all sectors as well as women in disguised employment relationships (disguised self-employment). These forms of work differ from the historical norm of "typical" or standard work, which is full-time, legally protected employment of unlimited duration, with a single employer, performed at a single employer's workplace and with a guaranteed regular income (ILO, 2012a).
[26] See (ILO, 2012b)
[27] The 14 weeks of leave figure was reached after considering both – an adequate period of rest for the mother, deterioration of skills of the workers', as well as the burden of lost labour borne by the employer in the absence of the employee. 14 weeks is considered a reasonable amount, which would not negatively impact "women's position in the labour market" (ILO, 2012b)
[28] See ILO (2012c)

the world has adopted some type of maternity protection legislation or laws and measures to support workers with family responsibilities." [29] The laws have evolved over a period of time in response to movements by liberal reformers and women's action group. However, this evolution of laws and policies in different countries has to be seen in the context of their socio-economic realities. In developed countries (Scandinavian and Western Europe) "the maternal and child care policy has to be seen in context of dwindling family size and official population policy promoting a higher birth rate, universality of nuclear families as well as increasing incidence of single parent families, and influence of powerful labour and women's movements in shaping social policy."[30] In developing countries, the growth of the maternity legislation has to be seen in a different context. It was inspired from the market based approach with least intervention of the State.[31] However, with the increasing proportion of women constituting unorganized workforce and the growing understanding of maternity as social protection, a new trend is observed where the upcoming legislations and policies related to maternity are to be seen in the context of existing poverty, gender and social inequalities, high birth rates and poor health indicators.

Hence, to provide adequate rest to women and child, maternity benefits include different types of support like maternity leave, medical care, cash benefits as income replacement/wage compensation, protection from arduous work, crèche facility/provision for breastfeeding on return to work, protection from dismissal and discrimination. These benefits aim to provide a homogeneous and hospitable environment for working women. Amongst these, cash benefits act as an important source of economic security to the mother and child. The ILO 2014 report also states that the number of countries not providing statutory cash benefits during maternity leave has dropped in 2013 from seven to two.[32]

There are three main approaches to provide such cash benefits: social insurance, employers' liability and social assistance. Social insurance is based on contributions made by the employer, the employee and also in some cases by government or public funds. It is based on the idea of solidarity as it does not burden one person to bear the sole responsibility of providing the cash benefit. Just over 50 per cent of countries provide maternity benefits as social insurance. In about one-quarter of countries, such protection is provided entirely by the employer but such cases are rare and over a period of time there has been a positive shift

[29] See ILO (2014)
[30] See Swaminathan (1993).
[31] (ibid.)
[32] See ILO (2014, p. 29)

away from employer liability systems towards sole reliance on social security systems for financing cash benefits.[33] However, these two approaches cater to the dependent workers i.e. workers with an employer thus, leaving a high percentage of workers without any cash benefit in the event of child birth.

"Globally, just over two-fifths of employed women (40.6 per cent) enjoy a statutory right to maternity leave, while only 34.4 per cent of the total, benefit from mandatory coverage by law and thus are legally entitled to cash benefits as income replacement during their maternity leave. Therefore, just over one-quarter (28.4 per cent) of employed women (330 million) worldwide would receive maternity leave cash benefits in the event of childbirth. In Africa and Asia, this share represents less than 15 per cent of women in employment," states the ILO 2014 report.[34]

The Maternity Protection Convention, 2000 (No. 183) asserts, "eligible women shall be entitled to adequate benefits out of social assistance funds, subject to the requisite means test, when they do not meet the conditions to qualify for cash benefits of social insurance."[35] Social assistance is typically financed by public funds (i.e. state general revenues and/or earmarked taxes) and administered by governments alone, often at the local level.[36] To get social assistance benefits, a woman does not necessarily have to be a contributory or an employee or be previously employed.

The provision of social assistance also finds recognition under the Social Protection Floor Recommendation, 2012 (No. 202) of the ILO. It includes "access to essential health care, including maternity care that meets the criteria of availability, accessibility, acceptability and quality and basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, particularly in cases of sickness, unemployment, maternity and disability."[37]

One such form of social assistance is conditional cash transfers. CCTs are grants provided mostly on a targeted basis based on condition that the beneficiaries would engage in human capital investment. It is based on the idea of participation of the beneficiaries for their own wellbeing as the beneficiaries are expected to bring a behavioural change in order to enjoy

[33] See ILO (2012c)
[34] See ILO (2014)
[35] See ILO (2012c)
[36] (ibid.)
[37] See ILO (2012d)

the benefits. They run with a twin objective of social assistance in the form of cash transfers and human capital formation to break the intergenerational poverty trap.

In recent years, CCTs have become popular in many national and local programmes. Some CCTs are mainly maternity entitlements providing for maternal care while others provide family benefits which also require fulfilment of maternity related conditions like maternal check-ups, using pre and post-natal services, and others.[38] The most successful and oldest CCT schemes have been running in South American countries, such as Bolsa Familia (Brazil) and Oportunidades (Mexico) which are not maternity entitlements but social protection programmes for women and children. Similarly, various other countries have been running CCTs. However, the successful implementation of these programmes depends on a variety of factors. CCTs are demand driven and might be a challenge in countries where the supply side issues exist. In such cases, fulfilling various conditions may not be a possibility, thus, obscuring the purpose of the CCTs. "CCTs can only be effective where no supply biases and geographic barriers exist; they can only be complements to broader social provisioning, never substitutes. They can only work where social services exist and are delivered with an acceptable level of quality."[39]

Maternity Entitlements in the Indian Context: Legislations and Schemes

In India Maternity benefits started as early as 1928-29 through a scheme by a private corporate firm, Tata Iron and Steel Company.[40] This was followed by several legislations in the 1940s and afterwards that had provisions for pregnant and lactating women[41] but these Acts were limited to women working in specific industries.[42] There were other limits to these legislations as well. For instance, the Factories Act, 1948 is one of the first Acts to include crèches at work places but it is conditional on the number of female employees. On a national level India's recognition of the need for maternity benefits is articulated in the Directive Principles of State Policy, in two articles:

- Article 39 clause (e) - "The State shall, in particular, direct its policy towards securing – that the health and strength of workers, men, women, and the tender age of children are

[38] See ILO (2012c)
[39] See Britto (2006)
[40] See PHRN (2010)
[41] The Plantations Act, 1949, the Mines Act, 1951, Beedi & Cigar Workers Act, 1966, Contract Labour (Regulation & Abolition) Act 1970, Inter-state migrant workers Act, 1970 and Building & Construction Workers Act, 1966 have provision for crèches besides maternity leave and feeding breaks as these industries employed a large number of women (ibid.).
[42] The Employees State Insurance Act, 1948 also has provisions for paid maternity leave. It covers women employed in factories (ibid.).

not abused and that citizens are not forced by economic necessity to enter a vocation unsuited to their age or strength."[43]

- Article 42 - "The State shall make provision for securing just and humane conditions of work and for maternity relief."[44]

Despite the existence of such constitutional principles and legislation, till the 1960s women's maternal roles were located in the domain of health and not work. A study of maternity benefits rights notes, "State recognised their maternal roles and located them with reference to programmes of Family Planning and Maternal and Child Health (MCH), and missed comprehending the paid and unpaid work roles that women play which intermesh with their maternal roles."[45]

The Maternity Benefit Act, 1961 was a significant move towards recognising this complex work and maternal roles of women. Under the Act, women employed in factories, mines or plantations are entitled to receive financial incentives at the "rate of average daily wage" and a medical bonus. They are also entitled to maternity leave for up to 12 weeks and nursing breaks twice a day till the child is 15 months old.[46] However, this too was limited to women employed in the organised sector. Nevertheless, this act laid the foundation for future maternal entitlements.

Addressing the need for maternity benefits for women outside the organised sector the state and union governments started implementing schemes in the late 1980s and early 1990s. These schemes had a mix of cash and in-kind transfers for pregnant and lactating women to cover for food, medicine, travel expenses and others to access health care services. The only exception was the scheme started by Tamil Nadu which had the objective of providing compensation for wage loss. Tamil Nadu became the first state to introduce a maternity benefits scheme called Dr. Muthulakshmi Maternity Assistance Scheme (DMMAS) in 1987 where it gave Rs.300 cash incentive to all pregnant women to meet childbirth expenses.[47] Although the scheme began on the lines of the earlier legislations on maternity benefits in India and offered compensation for wage loss during pregnancy and made provisions for childcare, by 2006 the scheme became applicable only to BPL women and added conditions

[43] See Constitution of India (1950)
[44] Ibid.
[45] Refer to Lingam & Yelamanchili (2011)
[46] Details in GoI (1961)
[47] See PHRN (2010)

for cash transfers.[48] It, thus, acquired the traits of a targeted poverty alleviation programme and CCT.

Later, based on the same objective of providing partial compensation for wage loss, Odisha started the Mamata scheme in 2011 in which pregnant women above the age of 19 are given Rs.5,000 in four instalments for first two live births.[49] This scheme also has several conditions such as attending counselling at AWCs to getting the child fully immunized. These conditions need to be fulfilled by the beneficiaries before they are eligible to receive each instalment.[50]

In between the period of 1987 and 2011, there have been many state and central government schemes for providing support to pregnant and lactating women. However, except for IGMSY, which too is a conditional maternity benefit scheme by central government, and Mukhyamantri Mazdoor Suraksha Yojana (MMSY) by Madhya Pradesh government, none of them had the objective of providing wage compensation to women during pregnancy. While IGMSY began in 2010 on the lines of DMMAS, Madhya Pradesh's MMSY began in 2007 on quite a different note. Under this scheme, pregnant women of agricultural labourers' families are given "expenses incurred on delivery as well as six weeks' wages", her husband also receives wage for two weeks and paternity leave.[51] The primary objective of the scheme was to provide security to landless agricultural labour in the times of distress and need, and pregnancy is just considered as one such time.[52]

Besides the schemes by the state or central governments, maternity benefits are also given through industry-specific schemes in states like the Welfare Board of Fisheries Sector in Kerala that gives cash to women for two live births (details in Annexure 1).[53]There are industry-specific schemes that are implemented across the country such as Handloom Weavers' Comprehensive Welfare Scheme, which is an insurance cover, where a handloom weaver's wife can claim Rs. 2,500 per child for up to two children (details in Annexure 1).[54]

However, the only truly wage-compensation kind of maternity entitlements in India are provided to women in the organized sector in the form of paid leave and this is guided by the

[48] See Balasubramanian & Ravindran Sundari (2012)
[49] According to Government of Odisha (2011)
[50] Ibid.
[51] See "Mukhyamantri Mazdoor Suraksha Yojana," (n.d.)
[52] See The Sunday Guardian (2013)
[53] See Government of Kerela (n.d.)
[54] Found in Letter from the Office of the Development Commissioner for Handlooms, Ministry of Textiles, Government of India, Order No. 1/1/2007-DCH/WW/HWCWS dated 2007.

Maternity Benefits Act. Here, the obligation is on the employer (including the state when it is the employer) and not on the state.

Other Schemes for Pregnant and Lactating Women

There are a number of other schemes in India which provide support to mothers. Some of these scheme run by the central government are ICDS, SNP, JSY and NMBS. However, they significantly differ from the schemes covered in the above section in terms of their objective.

The Union government had been giving food supplements to pregnant and lactating women to meet their nutritional requirements during pregnancy and lactation period from the AWCs through its ICDS programme that began in October 1975. However, it is not a direct maternity benefit scheme as it doesn't give cash or wage compensation.[55] Cash transfers were introduced in the Union government's National Maternity Benefit Scheme (NMBS), India's first countrywide maternity assistance programme, in 1995 where pregnant women from only BPL families are given Rs.500 before delivery. The NMBS began as a nutrition support to pregnant women as a part of National Social Assistance Programme (NSAP) but was later changed to a maternity entitlement where it intended to meet the cost of delivery.

Among the states, Maharashtra started maternity benefits for women in 1995. It launched Navsanjivani Yojana in the tribal areas of the state for providing basic health services, drinking water supply, medical treatment and food supplements to children for their better nutrition. Another scheme, Matrutva Anudan Yojana, in the same region gives women medicines worth Rs.400 and a cheque of the same amount conditional on delivering in a public hospital (details in Annexure 1).

It is apparent from the objectives of these schemes that the perception of maternity entitlement as woman's right to wage compensation has been missing. Instead, these programmes resembled more in traits with poverty reduction, nutritional or healthcare support programmes.

Indira Gandhi Matritva Sahyog Yojana: An Overview

Launched in 2010, the IGMSY became the first central government scheme to provide cash maternity benefit to women as partial wage compensation and thus laid the foundation for a nation-wide maternity entitlement scheme. In 2011 the Ministry of Women and Child

[55] See Dasgupta (2013).

Development (MoWCD) implemented only a pilot of the IGMSY in 53 districts of the country, as a 100 per cent centrally sponsored CCT scheme that addresses the needs of pregnant and lactating women by promoting "appropriate practices, care and service utilisation." The IGMSY provides a cash incentive of Rs. 4,000 for pregnant and lactating women who are 19 years or older and are not government employees. The benefits are limited to a woman's first two live births. The cash is transferred in three instalments (Rs. 1,500 + Rs. 1,500 + Rs. 1,000) extending from the end of the second trimester of pregnancy till the child is six months old. The benefits are provided only after fulfilment of conditions defined in the scheme (see Annexure 2 for these conditions).

Until 2012-13, the implementation of IGMSY has been quite disappointing in terms of meeting target beneficiaries as well as utilisation of funds released. According to the data shared by the MoWCD on physical target and achievement (see Annexure 3), even in the second year of implementation, which is 2012-13, more than 40 per cent target beneficiaries remained uncovered from benefits under the scheme. Similarly, out of the total sum of funds released between 2010-11, 2011-12 and 2012-13, about 25 per cent funds remained unspent (see Annexure 4). The data for the first two years on target achieved and fund utilisation points out the slow take off of the scheme, which increased in the following years, but still remained quite unsatisfactory.

IGMSY since NFSA

The enactment of NFSA brought significant changes for IGMSY. Section four of the NFSA states that in accordance with a scheme of the Central Government "every pregnant woman and lactating mother shall be entitled to…maternity benefit of not less than rupees six thousand,"[56] except those employed by "Central Government or State Governments or Public Sector Undertakings or those who are in receipt of similar benefits under any law."[57] Since the current central government scheme for provision of maternity benefits is the IGMSY, with the passage of the NFSA the Ministry of Women and Child Development, GoI issued a letter to state governments, stating "This is in connection with universalisation of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) from 53 pilot districts to all the districts of the country in accordance with the provisions of the 'National Food Security Act, 2013'."[58]

[56] See GoI (2013a)
[57] Ibid.
[58] Letter from Ministry of Women and Child Development (MWCD), Government of India (GoI).F.No. 5-10/2012-IGMSY dated 13 November 2013

Although the scheme still awaits expansion, from 5thJuly 2013 the money given to women for each delivery under the scheme has been increased to Rs. 6,000 to be given in two instalments of Rs. 3,000 each.[59] This has implications for the budget allocation and implementation of the scheme.

The budget allocation for IGMSY in Budget 2015-16 is Rs. 438 crore.[60] However, if IGMSY is to be universalized then the expected budget requirement is Rs. 12537 crore. Following is a table on this calculation:

Table 1.2: Budget Estimates for IGMSY in 2015-16

S. No.	Details	
1.	Pregnant and lactating women registered under ICDS in 2014-15	199 lakh
2.	Assuming total no. of beneficiaries of IGMSY in 2015-16	199 lakh
3.	Amount of assistance to be paid to each beneficiary under IGMSY	Rs. 6000
4.	Fund needed for IGMSY beneficiary in 2015-16 (Rs. 6000*199 lakh) (Assuming one live birth)	Rs. 11940 Crore
5.	Incentives for AWW/AWH per beneficiary	Rs. 300
6.	Fund needed for incentives (Rs. 300*199 lakh) (Assuming each beneficiary is covered by one AWW/AWH)	Rs.597 Crore
7.	Total Fund for IGMSY (sl4. + sl6.)	**Rs. 12537 Crore**

Courtesy: Centre for Budget and Governance Accountability

Amidst this situation of slow implementation and unachieved targets before enactment of

[59] Letter from the Ministry of Women and Child Development, Government of India, F.No. 9-5/2010-IGMSY dated 27th September 2013
[60] See (GoI, 2015)

NFSA, the anticipated "universalisation"[61] of the IGMSY poses both opportunities and challenges.[62] Accounting for India's limited experience with provisioning of maternal entitlements, the IGMSY pilot provides an opportunity to study the difficulties faced in implementing the scheme and fine-tuning it for scale up. Additionally, there exist different opinions on the programme design and the delivery systems that should be utilised to provision for maternity entitlements under NFSA. Broadly the debates address whether provisions should be universal or targeted, conditional or universal, through banks or post offices and others. The next section discusses these debates in theoretical and empirical light.

Issues with the IGMSY

The objectives of a social welfare programme determine its design. For instance, to deal with the pervasive issue of malnutrition India's supplementary nutrition programme, ICDS, is designed as a universal in-kind transfer to all children below six, pregnant and lactating women. Similarly, a maternity entitlement programme should have a design that best addresses the issue of providing all women a fair compensation for wage loss and creates an enabling environment for exclusive breastfeeding for six months. With the recognition of maternity entitlement under NFSA, such design related issues in relation to IGMSY have now come forth, as in its present form the IGMSY is exclusionary and inconsistent with the provisions of the Act. Therefore, some key policy issues with respect to the design of this programme are about deciding whether eligibility conditions and conditionalities of IGMSY should stay or not, whether payments are to be made through bank or post office, AADHAR to be linked or not, and others. The following sections discusses these IGMSY specific issues in reference to theoretical arguments and empirical evidence in relation to implementation of CCTs in India.

Inconsistent objectives of ME and CCTs

It has already been pointed out that CCTs have become the widely accepted approach to deliver social assistance. However, the role of conditionality has been highly debated. While some portray conditionality as a mechanism capable of attaining the dual objective of financial assistance (cash transfer) and behaviour change. Others argue that it is an endeavour

[61] Hereon referred to as scale-up.

[62] In this report we make a distinction between universilisation and scale up of the NFSA. We define universalisation as unconditional coverage of a particular population, i.e. a person is entitled to benefits by virtue of being part of a particular population. Scale-up is synonomous with extension of coverage, but not characterised by unconditionality. In the case of the IGMSY this would mean, increase in coverage to all districts but also removal of selection criteria.

to thwart the rights based approach. The IGMSY is perfect example of this conflict. Although IGMSY was launched as partial wage compensation as well as CCT scheme, its revision under the NFSA has changed its nature from being a mere benefit to legal entitlement. Additionally, the objective of CCTs is human capital formation whereas that of cash maternity entitlement is to provide economic security to women. Even though CCTs and cash maternity entitlements are not mutually exclusive, they are significantly different from each other in terms of their nature. Theoretically, both of these fall in the two separate domains of social assistance and labour or social rights. The rational of one undermines the objective of the other. The CCTs are meant to benefit those who comply with the conditions whereas maternity entitlement is perceived as every woman's universal right to wage compensation. The IGMSY states itself as a partial wage compensation, but in practice the conditionalities of its design reduce it only to a CCT.

Conditional versus Unconditional: Supply Side Gaps and Exclusion

Most of the schemes mentioned earlier in this chapter for maternity benefits or other support to pregnant and lactating women in India are conditional cash transfers. Maharashtra was the first state to introduce CCTs as part of its Matrutva Anudan Yojana in 1997-98 (details in Annexure 1). In 2005, the Union government also introduced CCTs through Janani Suraksha Yojana (JSY) under the National Rural Health Mission (NRHM) where women are given a cash incentive if they deliver in a hospital.[63] In 2006, Tamil Nadu too revised DMMAS and introduced CCTs for giving the maternity benefit in two instalments. The amount was raised to Rs.6,000 per delivery up to two deliveries under the scheme (see Annexure 1). However, the success of CCTs depends closely on institutional capacity and adequate health services, both of which are often insufficient in the developing world.[64] The design of CCT schemes is complicated and requires specific skill to implement and monitor schemes.[65]

Despite this we see that the implementation of such schemes has been successful in parts of South America. However, Narayanan argues that in the South American countries CCTs were preceded by large scale expansion of state facilities which were related to the conditions but most evaluations of CCT programmes did not "disentangle the effects of the cash transfer

[63]Cash incentive is given to women depending on whether the state is high or low performing. If pregnant women deliver in a hospital they receive Rs. 700 in a high performing state and Rs. 1300 in a low performing state. In case they deliver at home, they receive Rs. 500 that they are entitled to receive under NMBS. The health ministry, therefore, gives all pregnant women Rs. 500 as NMBS and an additional Rs. 200 for JSY if the women deliver in a hospital. In low performing states, an additional Rs. 600 is given as ASHA's package (GoI, n.d.-c)

[64] See Powell-Jackson, Morrison, Tiwari, Neupane, & Costello (2009)

[65] See UNDP (2009)

from the in-kind transfers that conditionalities might entail."[66] This suggests that, among other things, for CCTs to succeed the states' preparedness to supply services is crucial.

India's experience with CCTs too has been mixed. It has been found that after JSY institutional delivery increased from 10.8 million in 2005-06 to 17.5 million in 2011-12, perinatal[67] and neonatal deaths have reduced by four and two per 1,000 live births, respectively, but the quality of public healthcare institutions remains a concern.[68] There is a lack of skilled staff at healthcare facilities to conduct deliveries and the referral of emergency delivery cases is high.[69] A Public Actions Committee report of 2010-11 on NRHM records that health centres in the country lack basic infrastructure like water supply, separate toilets for men and women, storage tanks and proper biomedical waste disposal system.[70] Similarly, after DMMAS, which is considered one of the most successful maternity benefits schemes in the country in terms of coverage,[71] the number of women seeking institutional delivery, especially in a public health care sector increased significantly.[72] However, a study found that out of the five districts it covered,[73] those with poor socio-economic and health indicators had the lowest percentage of DMMAS beneficiaries. Further, some of global findings on effectiveness of CCTs show that the objective of bringing behavioural change through CCT schemes could have limited success because of substantial exclusions.[74]

Such empirical evidences suggests in absence of the facilities and infrastructure to meet the condition of a CCT those who are anyway marginalized get excluded (see chapter 4 for further evidence and discussion on this). Therefore, having conditionalities or not should be carefully considered in the case of IGMSY as it would lead to denial of a basic social right to women.

Targeted versus Universal

The choice between a targeted and universal programme is about cogently identifying beneficiaries for a scheme. While a poverty alleviation programme may have a rationale for income based targeting, a supplementary nutrition programme has a rationale for being

[66] See Narayanan (2011)
[67] Five months before and one month after delivery
[68] See Lingam & Kanchi (2013)
[69] Ibid.
[70] See HRLN (2010)
[71] See Balasubramanian & Ravindran Sundari (2012)
[72] Ibid.
[73] Kancheepuram & Nagapattinam have socio-economic indicators close to the state averages; Cuddalore & Dharmapurihave poor indicators; and Kanyakumari has better socio-economic and health indicators.
[74] See Bastagli (1998)

universal while targeting groups, such as women and children, if malnutrition is high among these specific groups. The real question is, as Sen pointed out, "how far to push the discrimination and where to stop."[75]

The general rationale behind targeting is that it gives subsidy to only those who deserve it to avoid wastage and achieves maximum results in lesser costs. However, this rationale works with the assumption that target beneficiaries are identifiable.[76] It has been well established by studies that targeted programmes suffer from errors of inclusion and exclusion, and associated costs.[77] Swaminathan notes, "Universal programmes are likely to have low errors of exclusion but high errors of inclusion….. Errors of wrong exclusion, however, lead to welfare costs – that is, costs to individuals and society due to the inadequacy of food, malnutrition, ill health, etc."[78]

Similar arguments on selecting between targeted and universal schemes are made by Narayanan.[79] She suggests that the choice between a targeted and universal CCT programme is based on the trade-off between efficiency and redistribution. She explains that even though targeted programmes like the JSY have increased institutional deliveries and reduced prenatal and neonatal deaths in India since its implementation, the poorest and less educated women continue to remain excluded. Also, reducing inclusion errors by targeting has not proved to be effective in all cases. Empirical finding from Mexico, Brazil and Honduras suggest that the percentage of inclusion error is high even in targeted CCT programmes.[80]

In India most maternity benefits schemes are targeted on the basis of income, age and number of children, such as NMBS, JSY etc. These eligibility conditions have been critiqued for their patriarchal values. However, such exclusionary conditions often "victimise the victim." Lingam and Yelamanchili explains, "Assumption that inclusion in schemes sends a signal that early age at marriage and having more children is being rewarded misses the point that early age at marriage, fertility and infant mortality are outcomes of deep-seated patriarchal values and social disadvantages which are not amenable to cash incentives."[81]

[75] See Sen (1995)
[76] See Sen (1995).
[77] See UNDP (2009)
[78] See Swaminathan (1998)
[79] See Narayanan (2011)
[80] For details see UNDP (2009).
[81] See Lingam & Yelamanchili (2011)

Studies have argued that the unquestioned adoption of the eligibility criteria that currently exists in the IGMSY i.e. mother's age to be above 19 years and payment to be made only up to two live births, poses a challenge to inclusion of the most vulnerable women.[82] A Government of India commissioned evaluation of the IGMSY states that the application of the minimum age criteria to National Family Health Survey III (2006) data results in exclusion of 48% women.[83] Additionally, "59% women having any one of the vulnerabilities in terms of caste, class or education will get left out. 56% of Scheduled Caste/Scheduled Tribe, 63% of the poor and 66% of the uneducated women will fall out of the purview of this scheme."[84] In effect, the IGMSY has been excluding those who need these benefits the most, and further increasing the social costs.[85]

Our calculation of the number of women excluded from the IGMSY due the age and two child criteria also reflected higher percentage of exclusion among the SCs and STs than the national average.

Table 1.3: Proportion of Women Excluded from the IGMSY

Area	% of Excluded Women	% of Excluded Women among SCs	% of Excluded Women among STs
INDIA	37.70	40.93	46.84
State – MEGHALAYA	52.68	37.00	53.82
State – NAGALAND	49.96	0.00	51.29
State – RAJASTHAN	48.08	51.35	55.52
State - MADHYA PRADESH	46.43	49.16	56.78
State - ARUNACHAL PRADESH	45.98	0.00	47.79
State - JAMMU & KASHMIR	45.75	30.21	55.23
State – BIHAR	45.35	49.73	44.96
State – MIZORAM	44.99	50.00	45.13
State – JHARKHAND	44.32	48.70	46.70
State - UTTAR PRADESH	43.58	47.28	48.58
State – ASSAM	41.43	37.85	38.12
State – CHHATTISGARH	37.16	41.50	41.38
State - WEST BENGAL	36.52	35.96	37.06
Union Territory - DADRA & NAGAR HAVELI	34.75	24.76	45.65
State – GUJARAT	33.35	31.80	43.64
Union Territory – LAKSHADWEEP	33.22	0.00	33.48

[82] For more details on exclusion see (Ibid.)
[83] For details look at ASCI (2013)
[84] Ibid.
[85] See Lingam & Yelamanchili (2011)

State – KARNATAKA	33.10	39.73	40.04
State – HARYANA	32.73	36.36	0.00
State – MANIPUR	32.39	27.17	40.44
State – TRIPURA	32.34	30.89	38.58
State – UTTARAKHAND	32.26	40.66	36.20
State – MAHARASHTRA	32.24	34.61	43.46
State – SIKKIM	30.51	37.24	31.21
State – ODISHA	30.41	32.66	41.15
State - ANDHRA PRADESH	28.77	31.87	39.45
State - NCT OF DELHI	27.24	31.03	0.00
Union Territory – CHANDIGARH	24.79	32.24	0.00
Union Territory - DAMAN & DIU	24.63	23.08	28.57
Union Territory - ANDAMAN & NICOBAR ISLANDS	24.07	0.00	35.21
State - HIMACHAL PRADESH	23.38	28.86	27.18
State - TAMIL NADU	23.38	29.28	40.79
State – PUNJAB	22.44	27.59	0.00
State – KERALA	19.32	14.09	26.84
Union Territory – PUDUCHERRY	16.58	21.36	0.00
State – GOA	16.52	23.55	16.68
*Zero exclusion means no SC/ST population *Source: Census of India (2011)*[86]			

Equity Issue

Apart from debates regarding the appropriate approach to providing maternal entitlements, critics also question the partial wage compensation. The amount of Rs. 4,000 (presently Rs. 6,000) is a "part wage loss compensation for approximately 40 days @ Rs.100 per day, given as maternity benefit," states the IGMSY implementation guidelines.[87] This is less than half of the revised minimum wage fixed by the Chief Labour Commissioner at Rs. 204 per day for unskilled agricultural workers.[88] At this rate even the revised provision of Rs. 6,000 manages to compensate the poor and vulnerable pregnant and lactating women only for 29 days approximately. Thus, considering the Ministry of Health and Family Welfare's guidelines that advocate for six months of exclusive breastfeeding, the provision of partial wage compensation of Rs. 6000 falls way short of the mark.[89]

[86] See (GoI, 2011a)
[87] See (GoI, 2011b, p. 7)
[88] For minimum wage for unskilled agricultural workers in C category areas, (where wages are the lowest) see Order from the Office of Chief labour Commissioner, Ministry of Labour and Employment, Government of Inda, No. 1/3(1)/2015-LS-II dated 30th March, 2015.
[89] The guidelines were issued via a letter from the Ministry of Women and Child Development, Government of India, F.No. 9-5/2010-IGMSYon 4th April 2011.

Additionally, proponents of wage parity question the lack of parity in leave entitlements across various sectors. The Sixth Pay Commission in 2008 recommended that Central government employees be granted maternity leave on full pay up to 180 days, an increase from 135 days. This recommendation was in keeping with the Ministry of Health and Family Welfare's guidelines that advocate for six months of exclusive breastfeeding. Further, women may extend this leave to two years. Besides, women employees having minor children are entitled to two years child care leave. There is no explanation for this differentiation between unorganised workers who receive partial wage compensation for one-third of the recommended time versus central government employees who are entitled to full wage compensation for six months.

Timely Payments and Other Issues

Given the objective of IGMSY to provide support during pregnancy and six months after delivery, it is extremely crucial to have timely payments to beneficiaries. However, the evaluation of IGMSY found that there is one to two years delay in payment to the beneficiaries.[90] There are a range of issues which require careful consideration while designing a scheme to ensure timely delivery of cash transfers. These include the number of instalments, access to financial institutions and process of fund transfer.

A study by Innovations for Poverty Action evaluated the impact of an unconditional cash transfer, given in different structures (large, small, lump sum and instalment) on the welfare of the recipients, and found that monthly cash transfers have stronger effect on food security than lump sum transfers while lump sum transfers are more likely to be spent on high cost assets.[91] Similarly, a study of a conditional cash transfer scheme in Tamil Nadu, India records that the beneficiaries demand money in two instalments – one during the pregnancy and one after delivery.[92] Same suggestion was made at a Planning Commission meeting during the release of the study in 2010.[93] The study concluded that to prevent low birth weight babies and to promote breastfeeding, the woman should receive the entitlement starting the seventh month of pregnancy and it should go up to six months after delivery.[94]

[90] ASCI (2013)
[91] See Haushofer & Shapiro (2013)
[92] See PHRN (2010)
[93] Minutes of June 2nd Planning Commission Presentation and Discussion on Dr.Muthulaksmi Maternity Assistance Scheme (DMMAS) Room No. 122, YojanaBhawan (accessed at http://www.phrnindia.org/researchAdvocacy/Report_PlanningCommissionMeeting.pdf)
[94]Refer to PHRN (2010)

Although the above evidence suggests an inclination for instalments, some other factors such as accessibility to banking services, out of pocket expenditure on travel etc. should be considered before making a choice between instalments and lump sum. The mode of payment, which are banks and post offices in the case of IGMSY, also becomes an extremely important consideration from the perspective of accessibility of marginalised groups residing in remote rural areas. A study on maternal entitlements in Tamil Nadu found that several beneficiaries prefer receiving cash than cheques as opening bank accounts can be a difficult and extended process.[95]

About this Study

Owing to India's limited experience in implementing maternal entitlements the provisions of the NFSA are largely unprecedented in terms of scale and finances. Several opinions and arguments exist in favour of different delivery mechanisms, questions about how this money will be used, what it contributes to and how it impacts the quality of life of a sizeable proportion of women. Despite these debates that surround maternal entitlements in India and the criticism of the provisions, the inclusion of maternal entitlements under the NFSA is a significant step towards a holistic understanding of food security. For these reasons this study focuses on maternal entitlements enshrined in the Act and will involve a thorough study of the pilot of the IGMSY, which is the proposed scheme for implementation of NFSA's provisions for pregnant and lactating women.

Currently there exists one evaluation commissioned by the MoWCD, GoI. This was done by the Administrative Staff College of India (ASCI) and examined the performance and effects of the IGMSY till December 2012.[96] The study surveyed 12 states from five different zones and used a mixed methodology of examining administrative data and conducting surveys with both beneficiaries and supply side functionaries. The selection did not account for some of the poorest states and also failed to delve into issues faced by vulnerable communities in realising their entitlements.

Hence, this study goes a step beyond and assesses the implementation of IGMSY in Bihar, Chhattisgarh, Jharkhand and Madhya Pradesh. The study explores the impact IGMSY can have on women's access to health care, nutrition, rest and breastfeeding for the child. Using

[95] Ibid.
[96] See ASCI (2013, p. 13).

qualitative tools it attempts to understand the challenges faced in delivering maternity related services to all eligible women with particular emphasis on marginalised communities. In sum, it assesses the preparedness of states to implement the maternity entitlements defined in the NFSA and advocate for measures to address the challenges faced in implementation of maternity entitlements through IGMSY to maximise the impact of the NFSA.

In the following chapters, we present our methodology and findings from the field study and conclude with a chapter on recommendations related to the IGMSY arising from this study. Following is the structure of this report:

Chapter 2, Methodology, gives a brief account on the methodology used in selection of the areas and respondents.

Chapter 3, Profile of the Women, captures the socio-economic background of the women selected in this study and analysis their work burden and diet practices during pregnancy and six months after delivery to assess how these contribute to their wellbeing or stress.

Chapter 4, Access to Health and Nutrition Services, discusses the various dimensions of access to health care services which are part of the conditions under IGMSY. It highlights the issues of corruption, supply side gaps, and high out-of-pocket expenditure which severely constrain access to basic health services.

Chapter 5, IGMSY: Access and Issues, comprehensively covers the issue related to the implementation of IGMSY. It accentuates the various gaps related to information, record-keeping, training, counselling, staffing, coordination between departments, monitoring and others, which exist in the vision and reality of the IGMSY.

Chapter 6, Delivering Maternity Entitlements, discusses the issue of delay in payments to IGMSY beneficiaries. It highlights the procedural issues which contribute to delay from the government' end. It also emphasises the issues related to access to banks and post offices which contribute to undermine the successful implementation of the IGMSY.

Chapter 7, Challenges and Recommendations, summarises the range of issues identified in this study which affect the implementation of IGMSY and provide specific recommendations.

Chapter 8, Conclusion, discusses the current policy scenario related to IGMSY and presents the concluding arguments of the study.

2. Methodology

The IGMSY is being piloted in 53 districts across the country (see Annexure 5). In Kerala, Uttarakhand, Himachal Pradesh, Sikkim, Goa and Haryana, north-eastern states and the union territories, the scheme is implemented in one district each. In the rest of the states, two districts each are selected for IGMSY, except in Uttar Pradesh and Chhattisgarh where the initial IGMSY districts were bifurcated. Therefore in these two states, there are three districts in which IGMSY is being piloted.

For the purpose of the present study, Chhattisgarh, Jharkhand, Bihar and Madhya Pradesh were selected. These states were selected purposively keeping in mind the objective of focussing on marginalised populations and the presence of local partners. Within each state, both IGMSY pilot districts were visited. From Chhattisgarh, Dhamtari and Bastar were covered although since 2012 the scheme has also been running in Kondagaon district after bifurcation from Bastar.

For the field interviews, one block from each district and two villages from each block were selected from all four states. A preliminary selection of blocks from the IGMSY districts of Jharkhand, Chhattisgarh, Bihar and Madhya Pradesh was done by collecting demographic details such as percentages of Schedule Caste, Schedule Tribe and PVTG population from the Census of India. From the shortlisted blocks there was a deliberate attempt to select the blocks with more primitive tribal groups or other marginalised populations. Remoteness and inaccessibility from the district headquarters was also a prime condition based on which the blocks were selected. Selection of blocks was finalised after consulting the local partners in the states. The selection of villages in blocks was also based on similar criterion. The villages that were farthest from the block headquarters and with marginalised population were selected for the study after inputs from the local partners in the states who assisted the researchers on the field.

Within a village, amongst the frontline workers the AWW was interviewed along with one ASHA and the ANM who is assigned that village. While the IGMSY is implemented through the ICDS and AWCs, the ANMs and ASHAs were also included in the FLWs interviews as they play a major role in providing services such as immunisation for the mothers and children, distributing IFA tablets, conducting ANCs and counselling sessions at the AWC.

These services are important for receiving IGMSY benefits as most of these are conditions of the scheme.

A pilot visit was conducted in August 2014 in Dhamtari district of Chhattisgarh where AWW, ANM, ASHA and ASHA Trainer of the village were interviewed at the village's AWC and focused group discussions were conducted for interviews of beneficiaries and non-beneficiaries. Based on this the interview guidelines were finalised. It was also decided that instead of focused group discussions individual interviews will be conducted with the beneficiaries and the non-beneficiaries to extract as much details as possible of women's pregnancies, deliveries, their experience with IGMSY and access to AWCs and banks amongst others.

Finally, five women were interviewed from each village out of which three were beneficiaries of IGMSY and two non-beneficiaries. Those women who have received at least one of the IGMSY instalments for their first or/and second child/children were counted as beneficiaries. Women who delivered post 2010 and were eligible to receive benefits under the IGMSY but had not been registered under the scheme at the AWC were counted as non-beneficiaries.[97]

Collection of Data

The field work was later conducted in two phases. Two teams were formed with two researchers each. The researchers were supported by local organisations for logistics, translation, giving local information etc.

Table 2.1: Block-wise list of Local Partners

State	District	Block	Local Partner
Bihar	Saharsa	Sonbarsa	Jan Jagran Shakti Sangathan
	Vaishali	Patepur	Samaj Parivartan Shakti Sangathan
Chhattisgarh	Bastar	Bastanar	State Health Resource Centre

[97] Non Beneficiaries Definition: Pregnant women, 6 months or above, who had not received any installment and women who did not receive any IGMSY installment for their first child given the child was less than 3 year old were selected..Women were considered to be non beneficiary if their first child was more than 3 year old and the second was under 3, or if both were less than 3 and she hadn't received any installment for the second child.Women who were not eligible as per the IGMSY conditions were also selected to get the experiences of excluded women.

	Dhamtari	Magarlod	State Health Resource Centre
Jharkhand	Simdega	Jaldega	AROUSE
	East Singhbhum	Dumaria	PRADAN (Professional Assistance for Development Action)
Madhya Pradesh	Sagar	Shahgarh	National Institute of Woman, Child and Youth Development
	Chhindwara	Tamia	Pararth

Jharkhand and Chhattisgarh were covered in the first phase of field work in September 2014 and Madhya Pradesh and Bihar were visited in November 2014 in the second phase. A total of 16 villages were visited for the study (see Annexure 6 for details). All interviews for this study in all states were semi-structured aiming to collect qualitative information. A total 127 interviews were conducted (see table 2.2 for details).

Few cases of non-beneficiaries from all states where women belonging to marginalised caste groups had multiple pregnancies and deliveries were also recorded. As per the scheme's guidelines, they are not eligible for IGMSY benefits but they were interviewed to get a better understanding on exclusion from the scheme because of the condition of restricting IGMSY benefits up to two children.

Table 2.2: State-wise Number of Interviews Conducted

	Beneficiary	**Non- Beneficiary**	**FL Workers**	**Officials**	**Total**
Chhattisgarh	11	9	11	3	34
Jharkhand	8	11	10	2	31
Bihar	11	9	6	2	28
Madhya Pradesh	12	8	10	4	34
Total	**42**	**37**	**37**	**11**	**127**

The beneficiaries to be interviewed were selected randomly[98] from the lists of IGMSY beneficiaries maintained by the AWWs. In cases where the AWCs did not have the lists of IGMSY beneficiaries, the lists of pregnant women or deliveries were referred to. Names of women who had received IGMSY benefits from those lists were then noted on a separate sheet and the women to be interviewed then selected through random selection.

However, within each village the initial target of interviewing three beneficiaries and two non-beneficiaries was not possible. There were multiple reasons for this. Factors like migration or refusal to be interviewed had to be considered during village visits. Also there were cases where women were in the fields far away from home or had gone to the forest for the day. In such cases the women next on the list were interviewed. Similarly, if women were at natal home or had migrated, the next name in the list was picked. Further, there were also cases of villages where there were no beneficiaries at all or very few beneficiaries. Therefore an attempt was made to interview five women in total in each village even if the ratio of beneficiary to non-beneficiary could not be achieved for any reason.

Interviews were also conducted with the District Programme Officer or District Social Welfare Officer at district level, and with the representative of the nodal department responsible for the implementation of IGMSY at the state level. Besides these, in order to get a clear picture of the implementation, details from other actors like CDPOs, postmasters, CHC staff, ground level facilitators and administrative staff involved in the implementation of IGMSY at various levels were also collected, wherever required.

[98]Since three beneficiaries were to be interviewed in each village, the number of beneficiaries in the list was divided by three and then women whose serial number matched the resulting interval were selected. For example, if there were 30 women on the list then every 10th name.

Four generations in one frame due to early marriage and pregnancy

3. Profile of the Women

The implementation of IGMSY marks a shift from maternity entitlements being perceived as a right meant only for working women in the organised sector to recognising that all women work, and thus, entitled to wage compensation. Further, the provision of maternity entitlement within NFSA 2013 strengthens the legitimacy of every woman's claim to be entitled to support from the state during pregnancy and post-delivery.

In theory, such a provision of maternity entitlements recognizes the backbreaking paid and unpaid work undernourished women do, mostly in unorganised sector, during pregnancy and immediately after childbirth at the cost of their own health and wellbeing due to social and economic constraints.[99] As already mentioned, the IGMSY aims to ease women's burden by providing them partial wage compensation in the form of a cash conditional maternity benefit. The underlying idea is to empower women to use this cash for their rest during pregnancy, nutritious diet and recovery after delivery, and promote exclusive breastfeeding for the child. It is important to understand the economic, social and cultural environment in

[99] See IGMSY Implementation Guidelines (GoI, 2011)

which women live during pregnancy and the period immediately after delivery, to comment upon the effectiveness of the scheme vis-a-vis the above mentioned goals.

The chapter's first part provides a brief account on women's socio-economic conditions using field findings as well as secondary data. The second part is entirely based on our field findings and examines the various practices followed during pregnancy related to women's work, rest, diet and childcare in four states - Bihar, Chhattisgarh, Jharkhand and Madhya Pradesh - and how they contribute to women's wellbeing or stress. It also discusses the social support women have during pregnancy and six months after delivery so that they can exclusively breastfeed. The third part presents the findings related to the changes in women's diet, or the lack of it, during pregnancy and after delivery.

Women's Socio-Economic Background

Social groups

The selection of most remote villages and marginalised groups for this study led to inclusion of women from diverse castes and tribes in our sample. Three particularly vulnerable tribal groups (PVTGs), five dalit or scheduled castes, seven scheduled tribes and four OBC castes were included (see Table 1). Linguistically as well the sample was diverse as a total of six languages, excluding Thethi, Chhattisgarhi and Bundelkhandi dialect of Hindi, were covered in the four states. Often translators were required to communicate with women during interviews. The following table on state-wise information on socially excluded groups and languages covered in this study helps to identify women, their caste or tribe and languages in each state.

Table 3.1: Social Groups and Languages

State	PVTG	SCs	STs	OBCs	Languages
Bihar	-	Musahar (Mahadalits)[100]	-	Kumar Sah (Surname)	Hindi- Thethi dialect
Chhattisgarh	Kamar	Satnami	Madhiya and Gond	Patel, Raut and Sahu	Gondi, Halbi, Chhattisgarhi and Hindi
Jharkhand	Sabar	Turi and Baraik	Ho, Lohra, Munda and	-	Hindi, Ho, Mundari and

[100] Mahadalits is an official category in the State of Bihar comprising of the poorest and most marginalized dalits.

			Santhal		Santhali
Madhya Pradesh	Bharia	Ahirwar and Bansal	Gond, Mawasi and Pardhan	Yadav	Bundelkhandi, Gondi and Hindi

The accounts given by women from the above mentioned socially marginalised backgrounds, on what work they do, what they eat, who takes care of the child, how they got their entitlements under IGMSY and when (more on this in the following chapters), provided the evidence to critically engage with the design and practices involved in the implementation of IGMSY. Before moving into this discussion, the remaining part of this section attempts to locate women's socio-economic status in the four selected states.

Social Hierarchies and Segregation

In most of the villages covered, social hierarchies were rigid as hamlets were divided on the basis of caste and tribe and being socially marginalised coincided mostly with being economically marginalised in our sample. In Madhya Pradesh's Shahgarh block of Sagar district Yadav families, who are the dominant caste, are a little better off, informed the frontline workers. "Gonds and Ahirwars are poor," said a frontline worker in Shahgarh. Yadavs belong to OBCs, Gonds to STs, and Ahirwars and Bansals are SCs. Bansals are the lowest in the caste hierarchy. This block is in the Bundelkhand region which is known for caste discrimination.[101] The villagers informed that the extent of exclusion of dalits was such that none of the other communities, including adivasis, eat at dalit households.

Similar social hierarchies were seen within tribal groups. In Navri Tola village, Tamia Block, Chhindwara only STs lived in the village, i.e. Gond, Mawasi and Bharia tribes. Among these three tribes, Gonds come above Mawasis, who come above Bharias. The villagers informed that marriages happen only within the tribe. Gond families do not attend functions and eat food at Bharia familes, but they eat Mawasi's food.

However in Chhattisgarh's Bastanar block of Bastar district, where ST population is about 92.1 per cent,[102] the villages were not divided strictly on the lines of tribe. The common names of such hamlets are Patel Para, Raut para, Kumhar Para and others. While Madhiyas come in STs, Rauts and Patels are in OBCs. In Raut Para of Korangali villages, the

[101] See new story by Sarkar (2014)
[102] See GoI (2011c)

Madhiya's too were divided in two sub-groups on the basis of their eating practices. One group had converted to Hinduism, revered god Shiva and doesn't eat meat anymore; the other group had maintained the traditional diet practices of their tribe. Such converted households were also found in other villages later. As a practice, they put a white flag on their house to indicate that they have converted.

On the other hand, Dhamtari District's Magarlod block has a mixed population of PVTGs, STs, SCs and OBCs. Sahus or Patels are OBCs; Gonds are STs and Kamars are PVTGs. The villages informed that Kamars usually live in a separate hamlet. However, in Maragaon village some families were in living in the main village and some were living on the outskirts. In the villages visited in Jharkhand's Simdega district the *tolas* (hamlets) were not necessarily divided on the lines of tribe. There was one village with a high concentration of Turis. In most villages *tolas* were spread quite far from each other and had a mixed population of SCs or STs, or both. The only exception is the *tola* in Lango village where the Sabars reside. A frontline worker in Lango village stated that the Sabars resided on a hill located at some distance from the main village. However, in Bihar it was observed that the SC communities generally resided at some distance from the other castes.

Education

The level of education among most women in our sample was very low. Among the women interviewed for whom we have this information (68 women), almost half of the women were illiterate in our sample. Among those who were literate, almost one fifth of the women had not attained primary level of education, almost two fifth had studied at least up to primary level, less than two fifth studied at least up to upper primary and only less than one fifth had studied till the secondary level or above. The overall level of education among literate women ranged between second and twelfth standard.

The existing secondary data suggests that there are urban-rural and gender disparities in the literacy rates in the states and districts where this study was conducted (see table below). Since the study only selected rural areas, literacy rates for rural areas of the state and district are used. Among the districts of our study, the gender gap is highest, about 24.8 per cent, in rural parts of Saharsa district, Bihar. East Singhbhum is second in regard with a difference of 23 per cent between female and male literacy. In all other districts the difference between female and male literacy rate ranged between 15.6 and 18.4 per cent. This low educational

status and gender gap reflects the gender bias against women and their disempowered status in the areas covered for this study.

Table 3.2: State-wise Literacy Rates

State & Selected Districts	Overall Literacy Rate (%)	Literacy Rate in Rural Areas (%)	Literacy Rate among Men in Rural Areas (%)	Literacy Rate among women in Rural Areas (%)
Bihar	68.7	66.4	72.1	56.2
Saharsa	66.9	63.5	75.6	50.8
Vaishali	72.3	71.4	80.4	62.0
Chhattisgarh	76.4	73.1	83.1	62.8
Bastar	66.3	64.4	73.5	55.1
Dhamtari	84.3	83.9	92.5	75.2
Jharkhand	73.3	68.2	79.6	56.9
East Singhbhum	78.7	65.9	77.3	54.3
Simdega*	68.0	66.6	75.0	58.2
Madhya Pradesh	76.9	70.6	80.6	59.7
Chhindwara	79.4	74.0	81.6	66.0
Sagar	81.8	76.1	84.0	67.0

*The figures for Simdega are from Census of India (2011)[103] as they were not available in the AHS

Source: Annual Heath Survey 2012-13 Fact Sheets of Bihar, Jharkhand, Chhattisgarh & Madhya Pradesh[104]

Since the study did not collect any primary data on male literacy, the above gender disparity in education can be considered a general indicator of women's socio-economic development and empowerment in these states. As for the level of education among women, according to the Sample Registration System (SRS) Statistical Report 2013,[105] out of the 52.3 per cent

[103] See (GoI, 2011c) or can be assessed at http://www.census2011.co.in/census/district/116-simdega.html
[104] See (GoI, 2013b) for Bihar, (GoI, 2013c) for Chhattisgarh, (GoI, 2013d) for Jharkhand and (GoI, 2013a) for Madhya Pradesh.
[105] The SRS report doesn't provide disaggregated data for urban and rural areas for women's educational level or up to district level.

literate women in Bihar, 22.5 had studied up to primary level or below.[106] For Chhattisgarh, Jharkhand and Madhya Pradesh these percentages were 31.7 out of 68.8, 22.9 out of 55.6, and 27.4 out of 64.8, respectively. These low levels of education suggest that women's agency is weak and their basic rights, such as education and schooling, are being denied to them in the patriarchal structure of the society.

The study also observed regional disparities in the level of education on ground, both within state and across states. In Chhattisgarh's Dhamtari district, the two AWWs were 12th pass and post graduate, but in Bastar district they were 10th and 8th pass. The situation was quite worrisome in Bastanar Block, Bastar district as the population is predominantly scheduled tribe and most women in our sample were found to be illiterate or literate below primary level. The level of education of the AWW in Tamia block's village Karaem Rated, who belonged to Bharia tribe, was even lower. She had studied only till fifth standard. The AWC is run in one of the two rooms in the school, both of which are in dilapidated condition. The only woman who was 10th pass in the village had come to Karaem after marriage and she refused to either take up the AWC's work or help the AWW with record keeping. In Bihar the AWWs were sufficiently qualified. In three villages the AWWs were 12th pass and in the fourth she was 10th pass. However, overall Bihar has highest proportion of illiterate women at 47.7 per cent.

Table 3.3: Percentage female population in the age group 15-49 by level of education

India & Selected States	**Educational Level of Women**								
	Illiterate	Literate							
		Total Literate	Without any formal education	Below primary	Primary Level	Middle	Class X	Class XII	Graduate and above
India	29.0	71.0	2.0	8.7	12.2	19.9	14.8	7.9	5.4
Bihar	47.7	52.3	6.3	7.7	8.5	13.1	10.9	4.2	1.6
Chhattisgarh	31.2	68.8	2.0	13.2	16.5	18.3	9.4	6.0	3.4
Jharkhand	44.4	55.6	3.7	9.3	9.9	16.3	10.0	3.8	2.6
Madhya Pradesh	35.2	64.8	1.4	12.8	13.2	17.7	11.6	5.0	3.1

[106] See Statement 32: Percentage female population in the age group 15-49 by level of education. SRS Statistical Report, 2013, pg. 57.

Source: Sample Registration System Statistical Report, 2013.[107]

Such low levels of literacy also have implications for women's fertility as female literacy negatively affects total fertility rate[108]. This study also found that women's illiteracy also created women's greater dependency on their families, AWWs, ASHAs, or ANMs for support in doing the paper work involved in opening bank and post office accounts (see chapter 6 for details).

Fertility and Health

Early marriage, pregnancy and spacing

As stated earlier the sampling methodology or our study was purposive and it does not claim to represent any trends or proportions. However, there are certain noteworthy points in relation to women's fertility in our sample. In the sample of 79 women more than one third women didn't know their age. Among the two third women who did know their age, it was found that almost half of them were married below the age of 18 years. More than half of the women who were married below 18 years were from Madhya Pradesh and Bihar; and many of them had given birth to their first child before they turned 18 years old. This corresponds with the AHS 2012-13 data on currently married women aged 20-24 years married before legal age and women aged 15-19 years who were already mothers or pregnant during the survey.

Table 3.4: Status of Early Marriage and Pregnancy

State & Selected Districts	Marriages among Females below legal age (18 years) (%)		Currently Married Women aged 20-24 years married before legal age (18 years) (%)		Women aged 15-19 years who were already mothers or pregnant at the time of survey (%)	
	Total	Rural	Total	Rural	Total	Rural
Bihar	13.8	15.1	49.2	50.3	42.7	42.6
Saharsa	17.1	18.4	48.4	47.8	39.1	38.4
Vaishali	8.7	9.1	44.2	44.2	52.1	53.1
Chhattisgarh	4.3	4.8	33.1	34.8	40.2	40.1
Bastar	1.4	1.2	46.1	44.8	52.7	55.6

[107] See GoI (2013g)

[108] See Murthi, Guio, & Dreze (1995)

Dhamtari	2.3	2.3	18.1	18.3	40.6	40.9
Jharkhand	11.0	13.2	45.2	48.4	41.5	40.7
East Singhbhum	6.2	8.0	32.8	36.0	45.0	43.3
Simdega*	-	-	-	-	-	-
Madhya Pradesh	10.6	14.1	42.0	46.5	41.9	41.6
Chhindwara	3.5	4.3	23.3	26.2	54.5	53.8
Sagar	8.2	11.2	41.2	47.6	45.8	46.9

*The estimates for Simdega are not available

Source: AHS Fact Sheets 2012-13 for Bihar, Chhatisgarh, Jharkhand and Madhya Pradesh[109]

The frontline workers in Shahgarh block, Sagar, Madhya Pradesh, also informed that girls in the village are married at the age of 12-15 years and by the age of 15-17 years they begin bearing children. As per the AHS 2012 fact sheet Madhya Pradesh, the second highest number of maternal deaths in the state occur in the age group 15-19 years. This suggests that early marriage and pregnancy have a negative effect on women's health and mortality. It is also important to note that among all the divisions of Madhya Pradesh and Bihar, maternal deaths were second highest in Sagar Division and Tirhut division, respectively. The districts visited in these two divisions for this study were Sagar and Vaishali.

Table 3.5: Indicators of Maternal Mortality

State & Divisions	**Maternal Mortality Rate**	**MMR**	**Maternal Deaths**
Bihar	30	274	675
KOSI (Madhepura, **Saharsa**, Supaul)	33	254	59
TIRHUT (Pashchim Champaran, Purba Champaran, Sheohar, Sitamarhi, Muzaffarpur, **Vaishali**)	33	282	110
Chhattisgarh	20	244	203
BASTAR DIVISION	20	272	33

[109] See (GoI, 2013b) for Bihar, (GoI, 2013c) for Chhattisgarh, (GoI, 2013d) for Jharkhand and (GoI, 2013a) for Madhya Pradesh.

(Kanker, **Bastar**, Dantewada)			
RAIPUR DIVISION (Kawardha, Rajnandgaon, Durg, Raipur, Mahasamund, **Dhamtari)**	17	211	69
Jharkhand	22	245	334
KOLHAN (Pashchimi Singhbhum, **Purbi Singhbhum**)	20	252	45
DAKSHINI CHOTA NAGPUR[110] (Ranchi, Lohardaga**,** Gumla)	23	244	72
Madhya Pradesh	20	227	378
JABALPUR (Katni, Jabalpur, Narsimhapur, Mandla, **Chhindwara**, Seoni, Balaghat)	21	246	62
SAGAR (Tikamgarh, Chhatarpur, Panna, **Sagar**, Damoh)	32	322	54

Source: AHS 2012-13 Fact Sheets Bihar, Chhattisgarh, Jharkhand and Madhya Pradesh[111]

The above mentioned data suggest worrisome state of women's mortality in the four states. It was also found that women are unable to keep the medically advisable gap of three years between two pregnancies. Gainda Bai in Karеam Raated village, Madhya Pradesh, hasn't started agricultural work since her first child was born because she became pregnant again while she was still nursing the first child. With adolescent marriages spacing becomes even more difficult. An ANM in Madhya Pradesh said, "*kisi ka bacha toh char-paanch mahine ka bhi rehta hai, aur doosra dekho toh pet main. Chhoti hi hai woh (women) toh. Adhiktar dehaaton main hota hi hai aisa. Bahut kam hai jo teen saal ka antar le aaye, aur shaadi chhoti umar main ho toh waise hi nahi ho pata*" (some women have 3-4 month old child, and they are pregnant with another. They are also young. In most rural areas such things happen.

[110] Although Simdega district falls under this division the AHS data doesn't include information from the district.
[111] See (GoI, 2013b) for Bihar, (GoI, 2013c) for Chhattisgarh, (GoI, 2013d) for Jharkhand and (GoI, 2013a) for Madhya Pradesh.

Very few manage to keep a gap of three years, and if they are married at a young age then it can't be maintained). This reflects how women's lack of agency combines with lack of awareness and access to contraception to create negative outcomes for women. This also highlights the degree of women's non-agency as they continue to have very little control on when they want to get married or have children. The statistics mentioned on maternal mortality and early pregnancy are women's reality in these areas and are only some of the many forms in which status of women's health related indicators and lack of agency can be observed.

Repeated Pregnancies

It was found that women are being excluded based on the number of children they have. This was extremely problematic because the most marginalised were getting excluded for reasons that were mostly beyond their control. Many cases of frequent and repeated pregnancies among women were observed in the selected villages. Although repeated pregnancies were observed in women from all social groups, the numbers of pregnancies were higher in women among marginalised groups, i.e. the PVTG, STs and SCs. Among the tribal women in the villages of Jharkhand, Chhattisgarh, and Madhya Pradesh four and more pregnancies were quite common. This is often the case due to poor access to health services, higher infant and child mortality, low literacy amongst the most marginalised.

An ANM in Bastanar block of Bastar District stated that most women in her area have more than two-three children, but Madhiya's have more than four children. Often the marginalised groups were also among the poorest. A Mitanin (ASHA) in the same block said, "Adivasi, Madhiyas are the most backward community in the village. They are the most-needy." Similar opinions were recorded in other districts, which suggested the being socially marginalised coincided with poverty and higher fertility rate. However, this doesn't mean that denying women IGMSY benefit through the exclusionary eligibility criteria would lead to population control. Unfortunately, the government officials believe otherwise. "We understand that needy women are deprived of the benefits but we have to control population. More children will be produced. Governments relaxation on the condition will be encouragement (to produce more children)," said the DPO, Dhamtari district, Chhattisgarh.

Repeated pregnancies are result of various factors such as education, access to family planning methods, agency and social norms. It has already been pointed out in the section on education that the literacy negatively affects total fertility. In the districts of this study too,

the literacy levels are low and fertility rates high. The AHS 2012-13 Fact Sheet also suggest that the family planning needs of 21.5 per cent rural women in Madhya Pradesh have been unmet.[112] The same percentage is 32.4 in Bihar, 24.1 for Chhattisgarh and 24.9 for Jharkhand. This implies that women in these states remain illiterate and without access to family planning methods. The next chapter on access also highlights the other issues with accessing health care encountered by women in this study.

Another reason that emerged as a factor for repeated pregnancies was preference for a male child. An ANM in Sagar district, Madhya Pradesh said that she recommended women who have more than two children to go for sterilization, but some women refused to opt for sterilization because they were waiting for a boy child. "K*uch kuch mahila toh aisi bhi hai jinki ladki ladki hai, par ladke ki chaah main nahi kara rahi hai,*" (some women only have girls, but they want a boy so they don't go for sterilisation) she said. This boy child preference is not specific to one village. Sumantra Ahirwar, 32, a dalit agricultural wage labourer and part-time beedi roller in Jhadola village of Sagar District said that she hasn't opted for sterilisation because she doesn't have a boy yet. She already has four daughters. This strong preference for a boy child was also seen in tribal areas of Bastar district. Gayatri, a Madhiya woman in Raut para of Korangali village, said that even if she becomes a beneficiary in IGMSY scheme she will have more than two children because she wants a son. She has two daughters and believes that they belong to another family as they will be married in some other house. However, "a boy will live with us," she stressed.

It is apparent from these factors of repeated pregnancy that exclusion from maternity entitlements is not going to address the issue of repeated pregnancy. It will only leave ineligible women, who are anyway marginalised in multiple ways, more vulnerable. Interestingly, even women who had been IGMSY beneficiaries had more than two children. In Madhya Pradesh an AWH, who was a beneficiary for her first child under IGMSY had three children. This suggested the futility of the conditionality of the two child norm based on the assumption that it would decrease fertility rates and would not wrongly incentivise women to have more children. As the above cases and data reflect, decisions on how many

[112]As per the AHS, this percentage represents,"proportion of pregnant currently married women (CWM) whose pregnancy was mistimed; CMW in lactational amenorrhoea who are not using any family planning method and whose last birth was mistimed, or whose last birth was unwanted but now they say they want more children; fecund CMW who are neither currently pregnant nor in amenorrhoea, and who are not using any family planning method and say that they want to wait for two or more years for the next birth, including those who say that they are unsure whether they want another child, or want another child but are unsure when to have the birth."

children to have are based on a number of other complex factors, and were not always in the control of the women themselves.

High Risk Pregnancies: Undernourished and Overworked Women

A pregnancy is considered risky if the woman is anaemic or has had repeated pregnancies. Across the four states, the frontline workers informed that most cases of high risk pregnancy were a result of anaemia and repeated pregnancies. Although anaemia is closely linked to poor diets, the ANM in Dhabara village, Sagar district of MP, said "women are mostly anaemic because they do *mazdoori* (heavy labour work) and many women have repeated pregnancies." This reflects how women's nutrition decreases over time due to the burden of productive and reproductive labour.

The frontline workers are not able do much about this because the women are not very receptive to their advice given their economic and social constraints. The ASHA in Dhabara village in Madhya Pradesh said that women usually work in the fields or go to the forest to collect *mahua* and *tendu* till the last day of their pregnancy. She tells them not to lift weight after 4-5 months, but women snap at her and say "who will do our work." The AWW in Kumar Sadra village, Bastar district told us that high risk pregnancies are frequent and women have faced repeated infant deaths. This is not to say that women are not aware about such risks, but often they had no other alternative except continue working. Girja Devi, in Agma village of Saharsa District, brought firewood till the last days of her pregnancy, despite being scared that it might harm the baby. Most women do understand the risk but continue to work because there is no alternative. This aspect will be discussed in detail in the section on women's reasons to work during pregnancy.

Maternity, Work and Rest

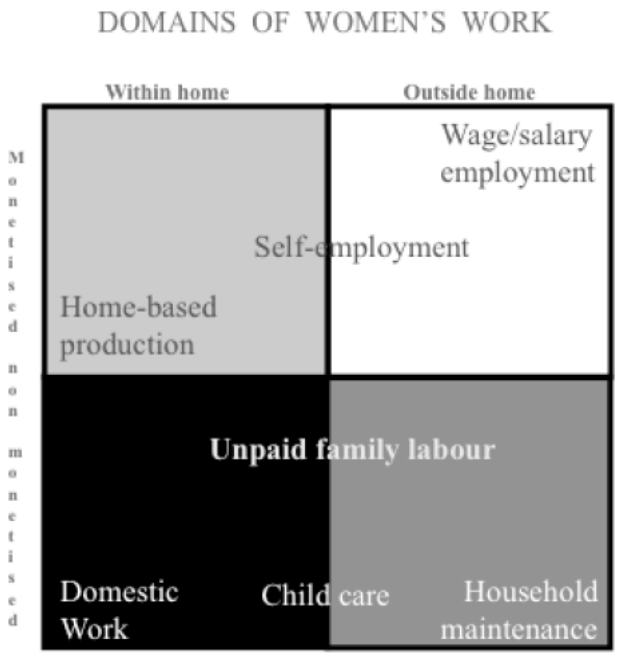
Despite swelling in their feet and suffering from anaemia during pregnancy, women in Korangali village walk 3-4 kilometres carrying heavy pots on their heads to fetch drinking water from the waterfall every day. This was often the case until the last day of their pregnancy. There is no hand pump in the village. Most women continue to do agricultural or heavy work till the time of delivery across the four states. "*Din bhar kaam karengi, sham ko bacha bana lengi*" (they work throughout the day, in the evening they deliver a baby), commented the AWW of Karеam Raated village, Tamia Block of Chhindwara District in Madhya Pradesh, referring to the domestic, agricultural and reproductive work in women's

lives. Women's work ranges from fetching water from the waterfall, bringing firewood, collecting minor forest produce (MFP), sowing, harvesting and ploughing[113] the fields, cooking, sweeping and rest of the household, while also carrying foetus till delivery. Besides agricultural and household work, women were found to be involved in alternative means of livelihood across the four states. Not only women were doing hard labour work under MGNREGA, but also other kinds of paid and unpaid work which varied across districts. They did beedi rolling in Sagar; MFP collection in Bastar, Dhamtari, Chhindwara, East Singhbhum, Simdega, and some parts of Sagar; basket making in Simdega and Sagar. Post-delivery within a week women start some or all the work mentioned above again, while additionally doing child care work. The following sub-section describes the field findings related to women's work from the perspective of their rights and well-being.

Triple burden of work

All the domains of women's work when put together create the complex continuum of the various types of work women do.[114] This highlights the triple burden of work created upon women during pregnancy and after delivery, where women are involved in monetised or paid work, unpaid work that is related to domestic duties or livelihoods and unpaid child care work. The work related findings from all states also resonate with this complex continuum of women's work. However, for our analysis heavy work has been kept distinct during pregnancy because medically women are advised to avoid such work. Therefore, for an analysis around women's work during pregnancy, it has to be treated specially. It can be in the domain of domestic work in the form of carrying firewood and others, or in the domain of monetised work both within and outside the home in the form of agricultural work, beedi making for long hours and others.[115]

[113] Although women in most parts of India do not plough, women in Chhattisgarh mentioned that they do ploughing. Rao (2008, p. 193) has also mentioned that there is no restriction on adivasi women to plough in Chhattisgarh. However, it was not confirmed explicitly on the field whether there is such a restriction or not.
[114] Swaminathan (2009) as quoted in Lingam & Kanchi (2013).
[115] The women who made beedis in Sagar district said that during last months of pregnancy it is difficult to make *beedis* because it requires you to sit for long hours.



Source: Lingam & Kanchi (2013)[116]

Invisibility of domestic work

In Bastar district of Chhattisgarh, "41 per cent of women work as agricultural labour," said Assistant Director, Department of Women and Child development, Chhattisgarh. It was also observed on the field that most of the women work on agricultural fields, but agricultural work is not all what women do. There is always the burden of unpaid domestic work, including heavy work that is mostly invisible to many. This burden of household work was observed in all the states irrespective of their social status.

Women were doing almost all of the domestic work during pregnancy, including firewood collection and carrying water which are considered heavy work and avoidable in late pregnancy in many cases. This was also the case in villages where women were not doing paid or unpaid agricultural work. And, often they kept working even if they had discomfort. In Jharkhand's Karmapani village Saro, never stopped household work during pregnancy. "*Takleef hota tha par kaam nahi rokna chahte the… Hum apne se laate the paani… paani lane mein takleef hota tha aur bartan utaarne mein"* (there was difficulty but didn't want to stop work...I used to go on my own...it was dififcult to lift utensils and carry water), she said. On being asked why, she said "*kaam toh karna hi padhta hai"* (work has to be done).

[116] (Ibid.)

Although she said that nobody pushed her to work and she did it on her own, it can't be ignored that she had no alternative.

The amount of paid or unpaid agricultural work varied among women depending upon economic conditions and cultural practices, but the amount of unpaid household work didn't vary as much, within this sample of women that we interviewed. This was also the case because the sample came from a few villages and focussed deliberately on marginalised populations. Shakun in Jhadola village of Madhya Pradesh's Sagar district belongs to a well off Yadav (OBC) family that employs labour on the field for Rs.150 per day. She said she will rest enough during pregnancy, but will also do what her mother-in-law says. Till the time of her delivery she fetched water from the well, which is ten minutes away, in two earthen pot and one bucket, besides doing the task of *ghar leepna*, harvesting on family's 25 acre land and cooking. This is despite the fact that the family hires about 10-20 labour every day, and only when they find no labour, all people from the family go and work. Post-delivery she did complete rest for one month, but soon began rolling beedis. She makes 600 beedis in a day between 12 P.M. to 8 P.M. For 1,000 beedis she gets Rs. 70 if she adds her own leaf. If she takes the contractor's leaf, she gets Rs.40. She can make beedis worth Rs. 200 in a week with her husband's help. She started going to the fields four months after the second delivery and seven to eight months after the first child was born.

There is also a caste or tribe dimension to practices around work. The AWW in Kumar Sadra informed that though women from almost all castes work for all nine months of pregnancy, women from Patel caste leave heavy work in the last months. However, "all Madhiyas do heavy work till the last days of pregnancy, including ploughing using *hal."* There are no tractors in these villages and labour is cheap. "*Saari auratein kaam karti hai. Jab ghar main koi nahi hoga toh kaam hi karengi*" (women from all caste and tribe work. When there is no one at home, then women have to do the work), said the AWW.

Risky work: To avoid or not to avoid

In some villages, there was no distinction between the kinds of work women do during pregnancy and otherwise. Devati, in Kornagali village of Bastar District worked till her delivery and her daily chores in the agricultural fields included ploughing, taking out weed, harvesting and others. She said she does all kinds of work in the field and found it odd that she was even asked to differentiate between the work she does during pregnancy and otherwise. Similar reactions were observed from women in Jharkhand, Madhya Pradesh, and

other parts of Chhattisgarh. Particularly, tribal women did not feel that the work they did, such as carrying a 20-30 kg load of firewood on their head or water filled utensils, was risky or 'hard work' as they have been doing this since childhood. Even in the most difficult terrains, like the one in Patal Kot region of Tamia where villages are situated at the bottom of a valley and climbing up and down a steep hill is the only way to connect to the outside world, both men and women, including young children, were seen carrying firewood on their heads to stock it for consumption or sale. Based on the experience of the research team, the terrain was so difficult that it wasn't possible to maintain balance without slipping and falling every minute.

This need for appropriate work during pregnancy also links with working under MGNREGA and daily wage work. Since MGNREGA involves hard manual labour, Dhani Hemrom in Karmapani village, Bihar, stated that she would prefer agriculture over MGNREGA work. Although the MGNREGA operational guidelines clearly state that "pregnant women and lactating mothers (at least up to 8 months before delivery and 10 months after delivery) should also be treated as a special category. Special works which require less effort and are close to their house should be identified and implemented for them,"[117] on the ground this has not be implemented as suggested by women's perception of MGNREGA as hard labour work.

The situation is much different in Chhattisgarh as many women worked under MGNREGA during pregnancy as the local wages were lower. However, it is not clear if they would prefer to do it even during the third trimester. Susheela, in Raut Para, Korangali village only has one acre of agricultural land and has to work on other people's land as well as under MGNREGA to make a living. She does all kinds of work on her land – like digging, weeding and making hedge. She goes to the field daily between 7 A.M. and 12 P.M. and again from 2 P.M. to 5 P.M. to work as a labourer on others farms for Rs.100 a day. The in-kind wages are 5 *peli* rice (10 kg) for 5-6 days of work on one farm. On her own field she says she can rest whenever she wants, but when she is on other's fields, she can only rest when other workers sit down to rest. Susheela also worked under MGNREGA at Rs. 155 per day wage rate during her pregnancy. However, whenever she feels unwell, she doesn't go to work (either to the fields or for MGNREGA). She sends her husband and does cooking at home besides clearing cow dung, washing utensils, getting water from the bore well, besides sweeping, mopping,

[117] See (GoI, 2013e)

washing clothes. She did all the work till delivery. "If I don't work, who else will," she felt. However, when she could not do heavy work she leaves it.

There is also a class dimension to MGNREGA work or probably hard manual labour. In Sagar district of Madhya Pradesh, MGNREGA work was considered menial work by the upper caste Yadavs who come under OBCs. *"Hum bade aadmi hain. Hum ye kaam nahi karte"* (we are affluent people, we don't do such work), said Shakun, 22, a Yadav women in Jhadola village of Sagar district.

Support for childcare

After delivery, segregation is practiced, where women and child are kept separately in the house, their clothes are not touched and their food is cooked separately, and the woman is not allowed to touch anything in the house. Madhiyas practice segregation for one month, but Yadavs practice it for one week. Yadav women resume all kinds of work after that. "Only if women have caesarean, they take more rest," she said. In the other OBC communities, like Yadav, women start work after one week. However, even among Madhiyas only agricultural work starts in a month, household work begins just after a week. Similar practices were observed in Maragaon village of Dhamtari district where women on Kamar tribe are afraid to step out before 45 days to six months after delivery to avoid any chances of falling ill, while other women resumed agricultural work after 15 days.

Once the women had begun working in the agricultural fields after delivery, child care work added the third domain of unpaid work. While post-delivery rest is very crucial for women to regain their strength, proper childcare during the first six months after birth is most crucial for the child's growth and survival. As a result, the conditions due to which women choose to work instead of rest also become the reasons for compromise on childcare. This is not to say that it was always compromised, but to highlight that child care definitely involves work over and above women's other household responsibilities.

Different arrangements existed for childcare in different areas. In Chhattisgarh's Bastar district since women go to the fields in a week's time after delivery, the family members take the child for breastfeeding to the field where their mothers work. For Susheela, in Korangali village, her husband stayed at home when she worked in the fields. He took the baby to the fields to be fed. On the other hand in Dhamtari's Maragaon village, Deewad came back home in breaks to breastfeed the child as her wages were not being deducted for this. "*Do ghante*

baad bache ko doodh pilane ghar aa jate the, paise nahi kat te the isk" (every two hours I would come home to feed the child, wages were not getting cut for this), she said. Otherwise, her mother-in-law looked after the children when she goes to work in the fields. Deewad had stayed at home only for the first 15 days after delivery. After this, she had been relying on her family to take care of her child.

In some cases women also took the child to the fields where either they, the elder daughter or family member looked after them. For Shakun in Jhadola village of Sagar district, her sister-in-law's 14-year-old daughter takes care of her son when she goes out. But she can't clean the baby after he defecates. Her mother-in-law does all that. She sometimes takes the baby to the fields and feeds the baby when he cries. Mother-in-law also goes to the fields and takes care of the baby there but she doesn't work in the fields. When Shakun was in the resting period after delivery, the sister-in-law and other members of the family took care of the house.

There was absence of even such arrangements in a few cases. In Madhya Pradesh's Navri Tola village of Chhindwara district, Anita had to leave her child alone at home for the entire time she was in the fields because her husband has migrated and her father-in-law remains inebriated most of the time. During the time she was working in the field the child remained unfed. In our study, few women who were involved in paid work after delivery could afford to stay at home for the first six months. Their wage loss was substantial. The kinds of arrangements for childcare discussed above suggest the need for better state support.

Reasons to work during pregnancy

Women had various social, economic and cultural reasons to be involved in strenuous and risky forms of work during maternity. A little probing revealed that the reasons to continue work were rooted in economic stress, culture and gender status. In all states women either worked in agricultural fields or in the confines of their homes till the time of their delivery. Some women liked working, while others said there was nobody else to do the work. Some women were forced to work and some said they had children to feed and work had to be done. Nevertheless, they were all working at the cost of their own health and well-being. These reasons were often intricately linked.

Economic Reasons

Along with all the following reasons, there is always an economic dimension to reasons for continuing work, particularly paid work, during pregnancy as most of the women interviewed in this study belonged to poor and marginalised background. Sukurmuni Nalgandi in PO Sukran village of Simdega district had to wake up at 5 A.M. during pregnancy, cook food till 8 am, then either make baskets or go for work in the fields between 8 A.M.-12 Noon and 2 P.M.-5 P.M. for a Rs. 70 per day wage. She comes back, cook food from 5 P.M. again, eat by 8 P.M., finishes cleaning dishes and other work, and then sleep, so that she can fulfil the monetary needs of her family. However, after delivery she couldn't work outside home for three months and lost wages up to Rs 7,000 to 8,000. Similarly, Deewad resumed paid work after 15 days of delivery. She said, "*Agar ghar main paisa nahi hoga to jayenge na kaam par. Ab bache hai ghar main hai toh jana hi padega*" (if there is no money in the family, then will have to work. Will have to go, there are kids in the house). She spends the money she earns on ration.

Om Bai, a tribal woman in Kumar Sadhra village of Bastar district, did weeding, sowing and harvesting in her own agricultural fields during pregnancy. She goes to others' fields and gets four *peli* grains (in-kind wages) for one day's work. In addition, she did the tasks of mopping, sweeping, cooking, and *ghar leepna* at home. After childbirth segregation was practiced for a week. She started work in her and others' fields after one month of delivery and household work after a week. While the reason for not beginning household work was cultural, reason for resuming agricultural work was financial. "*Ghar mein rehne se mujhe kya milega*" (what will I get by staying at home), she said.

Interestingly, there are also subtle differences which women bring in their work pattern during pregnancy to ease their workload slightly. Dhani Hemrom from Karmapani village in Jharkhand worked on her own fields, i.e. "*dhaan* laga*ne ka kaam*" (the work of sowing rice), between 8 A.M.-1 P.M. and 2 P.M.-5 P.M. which is eight hours. In addition, she brought water and firewood between 6 A.M – 8 A.M. and 5 P.M.-7 P.M., which is four hours. Till her delivery, she continued with her backbreaking daily routine, except for the changes that she did not carry heavy things, brought less firewood and worked in the dry areas in fields to avoid slipping. This reflects how little comfort and rest women can really afford during pregnancy, if they can afford it all.

Forced Work

There were cases where women reported being forced to work by their husbands or family. Halkibahu, in Navri Tola, Chhindwara district did all kinds of work during pregnancy, including carrying firewood and water. During her first pregnancy, she worked for six months and gave birth to a premature child in the seventh month. She felt that it was because her parents-in-law made her work a lot during pregnancy. They made her work on a manually operated grinder. They used to forcefully send her to forest for firewood and MFP collection. She had problems and couldn't carry wood, but they scolded and taunted her for not doing work. Her health deteriorated gradually and finally she separated from her parents-in-law after the second child was born. But, this didn't reduce her work and she still has to go to the forest for firewood collection because there is nobody to help her. Her husband has migrated for work and will return in a month. "*Dikat hoti hai to kisko batayein*" (whom do I share this discomfort with), she exclaimed.

Similarly, Devati from Korangali at first said that she wants to work, but later she mentioned that when she doesn't go to the fields her husband abuses her. "*Pati bolta hai kaam karo, nahi karte hai toh gali galoch karta hai,*" (Husbands tells me to work, if I don't he abuses) she said.[118] Many cases were recorded where women were forced to work in Chhattisgarh and Madhya Pradesh. Only one case was recorded in Bihar where the mother-in-law forced the women to work.

Cultural Reasons

In Bastanar, the villagers and frontline workers informed that tribal women considered believed that working till the time of delivery is good because the delivery will be normal and resting creates complications due to lack of movement and ambulance will have to be called. "*Zayada kaam karoge to normal delivery hogi, aaram karoge toh bacha hilega-dulega nahi*" (if you do more work, the delivery is normal. If you rest then the child doesn't get to move), said Devati.

Similar thoughts were present in Kamar tribe in Maragaon village, Dhamtari district. During her pregnancy Ramwati didn't want to rest till her delivery. She stated, "Women from her tribe want to work, she can't say about other women other caste and tribe if they work till the ninth month the child also remains healthy." She did all kinds of work during pregnancy such as cooking, collecting *tendua*, *mahua* and others from the forest, and agricultural work as a

[118] Translated from Gondi

daily wage labourer. She didn't collect firewood which her husband did to avoid risk, but earned Rs. 50 a day for an eight-hour long shift from 8 A.M. to 4 P.M. in the fields. Interestingly, after delivery she didn't leave home for six months. She explained, *"Humlog dehaati hai, darte hai har cheez se, taqleef ho gaya toh kahan utna paisa kharch kar sakte hai. Darte hai hum log pani se, hava se, thand se"* (we are rural folks, we are afraid of everything. If any complication happens then we can't spend that much money. We are afraid of water, air, cold). Since she avoided health risk by not going for work, she had to take loan to cover up for the increased household expenditure and loss of her wages after delivery.

Ramwati and Devati, both non-beneficiaries, belong to the remotest and most inaccessible part of Bastar and Dhamtari district. Their logic may have undertones of cultural practices but the pragmatism behind these practices can't be ignored either. It is apparent from their response that due to lack of basic services such as ambulance and health care centres in their areas combined with their fragile economic situation they have adapted to continue working till delivery and rest post-delivery.

Lack of Support

Women's rest depends on their support system because given their multiple roles and triple burden of work they mostly suffer with time poverty. There are sharp contrasts in the support women receive during pregnancy and child care from their families and husbands. While Kiran Devi from Jaisinghpur village in Bihar had stocked extra firewood by the time her seventh month of pregnancy began so that no one else had to do the collection, Mantla Bai Ahirwar from Dhabara village in Sagar District of Madhya Pradesh had her father-in-law and husband to take care of the heavy and risky work. Mantla also happens to be among the Oriya brides[119] of this region and doesn't have a mother-in-law. In Kirans's case her husband collected firewood for the first three months post delivery. Likewise, Sukurmuni Nalgandi in PO Sukran village of Jharkhand only had to do light household work. She discontinued heavy work like fetching water, collecting firewood in her 4^{th}-5^{th} month. But, she did household work till the end since there was no one else to do the work.

[119] In Shahgarh block the villagers informed that the boys who do not get married by the age of 25 years because they don't have enough land or money, get married to women from Odisha. This is arranged through brokers who find unmarried girls from the poorer regions of Odisha. Often the boy family takes loan to pay for the commission and marriage, roughly Rs. 25,000 not fixed though. Once the couple is married and the loan hasn't be repaid, often they migrate to work and pay it back early.

Halkibahu's case discussed above also reflects how an attempt to ease work burden might fail to bring any change in her situation. Although Halkibahu managed to avoid work which she finds difficult to do during pregnancy, the amount of her work has not reduced. She separated from her parents-in-law due to the work burden, but ended up doing all household work because she doesn't have anyone to help. In the absence of family member to support, women willingly or forcefully give up rest so that household chores get done. Bhago in Maragaon village of Dhamtari district had to work in the fields and at home till the time of delivery. Her mother-in-law didn't allow her to take rest. "*Ek bhi din aaram nahi karne diya*" (not even a single day I was allowed to rest), she complained. In the last stages of pregnancy, she didn't feel like working. No one forced her to work but her mother-in-law used to taunt – *"Kaam nahi karti. Ghar pe padi rehti hai"* (Does not do work. Just stays at home). After delivery within one month she resumed all work. She could completely rest only for seven days.

In Bihar it was a common cultural practice to visit natal homes during pregnancy for delivery. Although, no case was recorded where women explicitly said that the reason to visit was rest, in some cases the month in which women stopped agricultural work corresponded with visit to their natal homes.

Women's Diet

Changes in diet before delivery

Across all the four states most women did not report changes in their diets before delivery, except Bihar, where women reported introducing vegetables, meat/fish, fruits or milk during their pregnancy. Several women stated that due to nausea in the initial months their food consumption was reduced. In Madhya Pradesh and Chhattisgarh most women did not have knowledge regarding the need to improve diets during pregnancy. In Jharkhand largely there was no change in diet pre or post delivery. Some women reported a loss of appetite, a few reported introducing fruits, or introducing only THR as a change, and others just felt that there was no need to change their diet during pregnancy.

However, in all the states cases were recorded where due to lack of money women could not change their diet during pregnancy. Dhani Hemrom from Karmapani village of Simdega district said, *"Khaane ka iccha tha par badlaav nahi kar paayi"* (had the wish to eat but

couldn't change diet). PO Sukaran's Saraswati Kuntiya did not change her diet during pregnancies, though she felt that there should have been a change. But, due to cash constraints she ate the same food. In East Singhbhum's Kenduya village, Shubhangi Bhagel was severely anaemic during her pregnancy. Still she did not change her diet because she couldn't afford to buy fruits, vegetables or other nutritious items that were usually recommended.

Similar accounts were recorded in Bihar. Kiran Devi in Jaisinghpur village of Vaishali District said that she ate very little fruits and vegetables. She said, "I ate what I could afford." In Chhattisgarh and Madhya Pradesh, while cultural practices affect women's nutrition after delivery, poor financial condition affected nutrition before delivery. Anita, who belongs to a Yadav family in Dhabara, ate rice, chapatti, vegetable, pulses, and milk during pregnancy. However, she couldn't eat fruits because she is poor.

Diet Practices after delivery

The dietary practices varied a lot from district to district. The most inappropriate diet practices after delivery were seen in some villages in Chhattisgarh and Madhya Pradesh where women were made to survive on a meagre diet of salt and rice or *laddos* or *kutki ka bhaat* for a few days immediately after delivery. There were cases where women were starved but were not allowed to eat.

"I would have produced milk but my stomach was never filled," whispered Bhago Patel in Maragaon village of Dhamtari district in Chhattisgarh. She looked frail and didn't want her mother-in-law to hear our conversation. She told that after delivery, her mother-in-law didn't let her eat. She was given food only once a day after delivery. Her mother-in-law believes that when pregnant, women shouldn't eat more or else the baby's stomach will get upset. Bhago feels that she did not eat good food which is why she couldn't feed her baby. Her mother-in-law was aware that the doctor has advised Bhago to eat more, yet she did not give her food despite knowing the doctor's advice. For a month-and-a-half she was not given any vegetables after delivery. She was fed only rice and dal. Vegetables were given to her in less quantity after this time. Her Husband also believes in the old practice his mother follows and doesn't support his wife. "*Bhaari dukh deti hain*" (gives immense distress), resented Bhago referring to her mother-in-law. During pregnancy as well her diet did not increase. She continued with her usual diet of dal, rice, green vegetables

Bhago's case is not an exception. In both Chhattisgarh and Madhya Pradesh pregnant women are made to believe that eating more food would affect the child's health. *"Dhakka pahunchega bache ko, dai bolti hai, pachan kamzor ho jati hai bachon ka"* (the child will be harmed, the midwife says that it weakens child's digestion), said Ramwati. After delivery she just ate rice and salt, and sometimes boiled potato and onions. She changed her diet because the mid-wife told her that if she eats regular food then it will be difficult for the child to digest her milk. She ate only rice, dal and onions for two months. She felt that she should have eaten meat but then she was afraid that she and her child would become unwell.

A similar description of dietary practices was heard in Dudhwara village of Magarlod Block, Dhamtari. Somari said she ate rice, chapatti, dal, potato and *chutney* for five days after delivery. No vegetables were given for a month, even the Mitanin (ASHA) did not object to this because it is regular practice in their community. Salt is not eaten after delivery because it is believed that the umbilical cord of the child doesn't dry if the mother eats salt. She had less salt initially in dal but after five-six days she started eating everything. During pregnancy she had nutritious diet though as she ate pulses, rice, green leafy vegetables, fruits and also drank milk sometimes.

Such dietary practices existed in Bastar district as well. Somari, in Korangali village's Gulori para, said that she ate only rice for a week after delivery because if she eats other things then it would harm the child. She said, "If I eat spices then the child will feel inflammation in the umbilical cord and will develop a wound." Therefore, until the umbilical cord dries up and falls out, she doesn't eat anything but rice. After the cord dries up, she started eating regular food.

There are some supposedly positive practices as well. Susheela from the same village informed that segregation is practiced for three days after delivery. After this period woman is given jaggery and medicinal herbs. Child's *naam karan* happens on that day. The ceremony is called *Chhati*. It can be done any time after birth. That's when they call all relatives and villagers and have a feast. It is believed that all the "bad blood" goes out in three days. To ease this process, the woman is given medicinal herbs in three days. It's a mixture of garlic and medicinal herbs and root vegetables. It is believed to be a nutritious drink that acts as an antibiotic and pain killer. It also supposedly helps women in producing milk. Anyone can drink this preparation at home, but it is given to the woman who has delivered first.

However, after delivery even Susheela was given only rice and starch from rice water two-three times a day.

In Madhya Pradesh, the diet practices were different. Women were given only *ladoos* for extended periods of time post delivery. The rationale is similar to the practices in Chhattisgarh though. It was believed that this will affect the breast milk and if women eat anything else the child will not be able to digest the milk. Women were not even given enough food that can satisfy their hunger. Halkibahu, in Navri Tola village of Tamia block was given *harira*, that is ladoo, and spices. She ate that for two days. She drank only masala for twp days (mixed in ghee) and ate *kutakia (kutki ka bhaat)* and *tuar daal* for a month. In Sagar district's Jhadola village, Shakun ate only eight to ten laddos a day after delivery. Before delivery she had a nutritious diet. She ate ghee, milk, vegetables, potato, cauliflower, green leafy vegetables, maize, bottle gourd, banana, pomegranate, *vada*, *samosa*, and *mangodi*. Her diet improved during her second pregnancy. She ate well but was still weak at the time of childbirth.

These accounts of women reflect that most of the time women had no agency to decide what they should eat. But, even in situations where they could, they just followed the local practices at the expense of their own nutrition. Supposedly counselling should have changed such practices, but that clearly has not happened on ground.

Amid such accounts of dietary practices claims by officials that frontline workers are trained and IEC is conducted, falter badly, except for the state of Bihar. The DPO in Chhindwara said, "The district trained 35,000 women on good dietary practices like how to cook nutritious food at home from locally available things." This live demonstration was an initiative taken by the district to tackle for malnourishment funds from Atal Bal Mission. Also, every village is supposed to have a Vatsalya club where pregnant and lactating women who are under AWCs participate every Tuesday and are informed about various schemes that are being run for them. "This is lively at all AWCs," said the DPO. Women are taught to take care of their diet during pregnancy. The DPO stated that these achievements are also highlighted in the yearly book of WCD department at Bhopal and these costs are included in the IGMSY budget. Indeed, they are to be highlighted only in yearly books.

Conclusion

It emerged from the study that women deal and survive many overt and covert forms of discrimination and disempowerment in their everyday lives. It is apparent from women's socio-economic indicators discussed in the first section of this chapter that women are a disadvantaged group. Women's vulnerabilities are higher if they belong to remote rural areas or socially marginalised groups, be it in terms of education, early marriage, repeated pregnancies and others. This is also reflected in drudgery of women's work, lack of child care support and inappropriate nutritional practices in areas selected for this study.

The IGMSY while recognising these aspects attempts to bring positive change in women's situation by providing them a conditional cash maternity benefit as partial wage compensation. The immediate question then is how effective this intervention is vis-a-vis its objective. These objectives are enabling women to exercise their right to adequate rest, nutrition and recovery during maternity; promote appropriate practices for care and service utilisation; and encourage women to follow optimal Infant and Young Child Feeding (IYCF).

The findings related to repeated pregnancies suggest that women from the extremely marginalised groups are the ones who will get excluded from the scheme due to its eligibility condition. Due to the conditions of age and two live births, the scheme is limiting its reach. In other words, it is denying support to women who need it the most. This severely reduces the scope for any positive change. As seen in chapter one, this is borne out by national level data as well.

Secondly, it was found that during pregnancy women did not take rest from hard agricultural labour and heavy work, primarily because they cannot afford loss of wages and other household members to share her domestic and care work are absent. The IGMSY money could help women take more rest who continued to work till pregnancy or began hard labour work without properly recovering from delivery due to economic constraints. However in addition to these reasons, women were being forced to work by their husbands or other family members. Sometimes, cultural practices based on some misinformed notions did not allow women to rest adequately. It is difficult to assess what kind of effects this cash transfer could have on these issues. Not to forget that redistribution of domestic and care work, which could be helpful in reducing women's burden and increasing care to children, is not even an objective of the IGMSY.

Similarly, IGMSY money could be beneficial for fulfilling nutritional needs of women who citied financial incapability as their reason for not being able eat a nutritious diet. However, for the cultural practices around diet after delivery, cash transfer cannot do much. These practices are based on strongly held beliefs. In order to address this counselling has to be done in a more effective way, and not just of the pregnant and lactating women, but also elder women or mother-in-laws and husbands.

Fourthly, it was found that women do not have adequate support for child care to actually promote appropriate practice for care, service utilisation and breastfeeding. The arrangements for infant care were not really adequate. Among the government officials implementing the scheme, there is a similar cautious optimism. "This scheme is particularly good for working women, so that they get some kind of rest. We run so many schemes for pregnant and lactating women, but direct transfer is not there. We are providing supplementary nutrition, advocacy and other things, but this is cash incentive. We don't know, it might have its plus and minuses both," said Commissioner, Department of Women and Child Development, MP. In sum, IGMSY could have a more effective impact on women's health if it is more inclusive, i.e. without eligibility conditions. However, its effectiveness in relation to its stated objectives clearly has limits as long as it remains just a cash transfer scheme without accompanying policies and programmes towards reduction, redistribution and recognition of women's unpaid work.

Women at an Anganwadi in Chhattisgarh

4: Access to Health & Nutrition Services

The first step for women to be able to receive benefits under the IGMSY is to register their names under the scheme when pregnant. Upon doing so, they are supposed to start receiving regular services from the AWC such as packets of nutritional supplements every week, strips of IFA tablets to check anaemia, rounds of immunization and counselling on health and nutrition of the mother and the child. While counselling and supplementary nutrition are provided by the anganwadi centres run by the state's women and child welfare department, rest of the ante-natal services are to be provided by the health department. Women might be registered with the health care centres but not under the AWCs or the other way round. This usually depends on what services are easily accessible.

In this chapter, we discuss how crucial it is for women to have uninterrupted access to both AWCs as well as the government health care centres to receive the benefits of IGMSY. While the AWCs are usually located in the villages, sub centres are to be located near the

villages.[120] In the first two sections of this chapter, we bring an outline of the geographic, economic and social barriers women face in accessing the anganwadi and health care services. The third and the fourth sections look at corruption and out-of-pocket expenditure at the AWCs, banks and government health care centres that emerged as barriers in smooth service delivery of maternity benefits in the villages covered. The last section of the chapter briefly mentions the alternative schemes that offer maternity benefits in any form in the villages covered. The chapter ends with a discussion summarising the points raised.

Access to Anganwadi Centres

Geographic

Despite orders by the Government of India[121] on the flexibility in registering for the IGMSY the field study shows the rigidity practiced. The AWCs hold the sole responsibility of identifying and submitting names of women eligible for IGMSY. No names under the scheme can be submitted by the sub centres, primary health centres (PHCs) or the community health centres (CHCs) which women may access during their pregnancies. Nor do the AWWs and the ANMs or ASHAs share their data with each other for such purposes. The ANMs and ASHAs report to the health and family welfare department whereas the AWWs report to the women and child development department. Accessibility to the AWCs thus becomes crucial for women to be able to benefit from the maternity entitlements offered under the IGMSY.

It was observed in the villages visited for this study that mostly these were divided in hamlets based on social, cultural, caste or class bases. These hamlets may be geographically cut off from the section of the village where the AWC is located. This fragile connectivity between hamlets then limits women's access to the AWC and becomes a reason for exclusion from the IGMSY. Korangali village of Bastanar block of Bastar district in Chhattisgarh is one such example. It is one of the most disconnected and remote villages in the block and is spread widely. This predominantly tribal village is divided in three hamlets or *'paras*'. The most dominant *para*, Patel, is 15 kilometres from the national highway on kuccha road and from there a walk for seven kilometres on non-motorable route which involves crossing two streams. Patel *para* has the village's AWC that is run in the tribal head's son's house as there

[120] A sub centre is the most peripheral source of communities' health care needs. As per the Ministry of Health and Family Welfare, there should be one sub centre for 5,000 population. For hilly and tribal areas, there should be one sub centre for a population of 3,000.
[121] Women can register for IGMSY at either AWCs or health centres. Letter from the Ministry of Women and Child Developmnet, Government of India order No.9-5/2010-IGMSY dated 8.11.2010.

is no separate building for it. Besides households from Patel castes, the *para* has *Madhiyas, Rauts*, STs and OBCs. The second *para* – Gulori – has household of similar castes and is three kilometres away from Patel *para*. A stream divides the two *paras* making it risky to cross during monsoons. The third *para*, Raut, is separated from the two paras by a hill. The route from the national highway that leads to Patel and Gulori *paras* cannot be used to reach Raut *para*. A different *kuccha* route connects this third hamlet from the national highway. Though there is a shorter route passing through the hill from Gulori *para* that links Raut *para*, thick forest cover, streams, paddy fields, and fear of Naxalites make it less favourable for villagers.

Like most other women living in Raut *para*, Gayatri, who belongs to the *Madhiya* tribe, barely steps out of the confine of thirty-odd houses that form the hamlet. She has two daughters – three-and-a-half-year old and one-and-a-half-year old – but she never visits the AWC. To visit the AWC, she has to walk for seven kilometres and cross a hill. During her first pregnancy she walked to Baghmundi sub centre, which is 12 kilometres away, with her husband for an ANC. She also received IFA tablets there and her pregnancy was registered. But as she did not go to the AWC, she was neither informed of the IGMSY nor did she receive any benefits under the scheme even though she is an eligible beneficiary for both her deliveries as per the scheme's eligibility criterion.[122] The registration at the sub centre was for the records of the department of health and family welfare and her name was not added under the IGMSY beneficiaries list that is maintained by the AWW who works for the department of women and child development.

Susheela from the same hamlet has a similar story to tell. A mother of three, she never visits the AWC but often visited the government health care centres at Baghmundi and Dantewada (22 kilometres away) for her first two deliveries. Though she received immunization and other services from there, she could never be a beneficiary of IGMSY simply because she never accessed the AWC.

Like Korangali, Kaream Rated village in Madhya Pradesh's Chhindwara district is located in a difficult terrain. The village is at the bottom of a valley. From the main road it is a steep downhill climb for three kilometres. The village is also divided into hamlets or *'dhanas'* which are scattered. The village's main AWC is in Kaream *dhana* while the Rated *dhana*,

[122] Women who are above the age of 19 are eligible to get IGMSY for up to two live births from the AWC. See letter from Ministry of Women and Child Development, Government of India order no: D.O. No 9-5/2010-IGMSY dated 28.03.2011

which is separated by a four kilometre kuccha route, has its own AWC. But Chadha *dhana* is at an uphill climb from Karеam *dhana* and because of this women from the former never visit the AWC in the latter. Hence, they are deprived of the services offered at the AWC, including the IGMSY benefits.

There is a clear line of distinction between how the work is shared between the AWWs, ANMs and the ASHAs. Though both the AWWs and the ANMs have to maintain records of pregnancies, immunization and IFA consumption in the geographical areas they are assigned and their records should match,[123] submitting names of women eligible under the IGMSY is the responsibility of AWW. In the interviews conducted for this study, it was found in many villages that the ANMs and ASHAs were not even aware of the IGMSY. Most of them had never received any information or training for the scheme. Practicing flexibility in registering pregnancies for the IGMSY, as is allowed under the IGMSY guidelines, should help women. It can fix the geographical barrier to an extent, especially for those women who cannot access the AWCs but can visit health care centres during pregnancy.

Economic

Distance and connectivity between the AWC and women's places of work, mostly their agricultural fields or other's fields where they work as labourers, also determines whether women visit the AWC or not. The field areas for this study threw up several cases where women did not visit the AWC because they had to go for work and the timings and location of the AWC meant that they would have to miss wages for the day. The choice between going to work and to sit at the AWC for counselling or other related services is an easy one for most women – earning money wins over everything else due to the economic pressure to meet the household requirements.

"They do not leave their work to come to the AWC," complains an ANM from Chhattisgarh, as she goes all the way up a hill to reach the village and the women do not turn up for the meetings. An ASHA from Madhya Pradesh faces a similar challenge. She goes to call women for the meetings at the AWC yet only four or five women visit if they are free. An ANM from the same state says that most of the women are in a rush to go to work and do not sit at the AWC. Even if women come to attend the meetings, their mothers-in-law think that they just go, sit and pass their time, explains another ANM from Madhya Pradesh. On her field visits,

[123] It was informed at most of the AWCs that before submitting records at the end of the month to their respective departments, the ANMs and AWWs tally them.

she then tells the mothers-in-law to send their daughters-in-law for counselling at the AWC but she feels, "Those who should be counselled are still left, i.e. the mothers-in-law**.**"

In Karеam Rated village, Ramwati, a mother of six, never visits the AWC even though it is only a few metres away from her home. She has to rush to her field on the outskirts of the village before dawn each day and returns after dusk. If she misses a day on her fields, the monkeys destroy her entire crop and that is a loss she cannot afford. She takes her younger children with her and that is why neither of them can visit the AWC.

In cases where the women's places of work were closer to the AWC, women took out time to visit the AWC and in some cases left their children under the supervision of the AWW and the AWH while they worked in the fields. Like Parmodini, 25, from Karеam Rated village visits the AWC to drop her two young daughters – three-year-old and one-and-a-half-year-old – before she leaves for her fields. She comes back in time when food is served to children to feed her younger daughter and then takes both of them back home, or to the fields. For Halkibahu, 23, from Navri Tola village of Tamia block in Chhindwara district of Madhya Pradesh, dropping her two children at the AWC rather than with her parents-in-law who live next door is a preferred option. She separated from her parents-in-law as they never used to let her rest during her previous two pregnancies. Now eight months pregnant with her third child, she leaves her children at the AWC for a few hours every day. This gives her time to rest at home and to complete work in the field which is in close proximity to her home. The children get a hot cooked meal at the AWC which is only a few metres away from her home.

However, for the 38-year-old Kade, accessing the AWC which is in the same lane of the village as her house was next to impossible. Economic reasons forced her to migrate to the nearest city, Raipur, with her husband and two elder sons. Back in her village Dudhwara in Dhamtari district of Chhattisgarh, she has her remaining seven children under the care of her elderly mother-in-law and her eldest son's wife, who has her own infant to take care of. More money for daily labour in a city than in the village drove Kade out of the village to support her big family. She earns Rs. 100 for a day's labour in Raipur and comes back to the village each time in the last trimester of her pregnancies. She is hesitant to seek services from the village's AWC as she no longer considers herself a resident of the village. The AWW, Somari laments, never visits her house for counselling or to call her. Accessing free services like THR, immunization, IFA from an AWC in the city is something she never considered as an option.

From Karеam Rated village, Aarti and Parmodini migrated for 20 days each for work when they were pregnant. They receive between Rs. 100 and Rs. 200 when they migrate and work on others' fields against only Rs. 50 when they work on others' fields in their own village. Economic reasons forced both of them to shift out of the village temporarily. "There are women whose husbands are working in the cities. They decide to migrate because there is no money (in the house). If they get IGMSY money they will not migrate," explains an ASHA from Madhya Pradesh.

Cultural practice of delivering at natal home was also recorded as one of the reasons why women were unable to receive IGMSY benefits. This practice was widely reported in Bihar's Vaishali district. Women there were informed by the frontline workers[124] that they were entitled to receive IGMSY cash only at their marital home and not at their natal home. However, when the women asked for their entitlement on returning to their marital homes after delivery, they were denied the same because they had failed to register at the AWC of their marital homes in the first few months of pregnancy as required by the scheme's guidelines.

From Jaisinghpur village, Runa Devi went to her natal home in the fourth month of her second pregnancy and returned to her village when the child was three months old. But Runa could not receive benefits like THR, IFA or ANCs from the AWCs in Jaisinghpur even though she did not register herself at the AWC at her natal home. She was immunized twice at the Jaisinghpur AWC though. The AWW at Jaisinghpur also refused to register her name for IGMSY benefits. In another village Baligaon of the same district, Soni Devi, who was also staying at her natal place as soon as her pregnancy started, could only register at her village's AWC when she was in the seventh month of her pregnancy as that is when she returned to her village. She started receiving THR and IFA from the Baligaon AWC soon after returning. Her child was one-month-old when this interview was conducted but Soni has not received any instalment yet even though her account has opened in the post office. She has been told that she will receive Rs. 6,000.

Though delivering at natal home was not a practice in other states covered under this study, stray cases were recorded where women went to stay with their mothers during pregnancy and preferred delivering there. For instance, Aarti from Karеam Rated village in Chhindwara district of Madhya Pradesh went to her natal home in Badki Dhani when she was four months

[124] ASHAs, ANMs and AWWs

pregnant with her first child. She stayed there till delivery to avoid climbing a hill during labour as her home is in Kaream *dhana* which is inside a valley and her natal village is near the main road. She went to Tamia government hospital directly from her natal home when her labour pain started. Though she received all benefits from the AWC at her natal village during her entire delivery period, she was not informed about IGMSY there. She returned to Kaream *dhana* and that is when the AWW informed her husband about the scheme. Her child is now one-year-and-two-months old and she has not received any IGMSY money yet.

Meanwhile, there is no consistency in what instructions the AWWs have for registering those women for IGMSY who migrate to natal home for delivery. Most of the frontline workers interviewed for this study said that if women stay for long, they are given IGMSY benefits. Some AWWs define 'long' as two to three months while the others stretch it to one year. An ASHA from Madhya Pradesh says that if women stay at natal home for more than five months they will get the benefit. Women get the IGMSY benefits from only one AWC – either their own village's or their natal home's, she stresses. An AWW from the same state said, *"Betiyon ko koi labh nahi, bahuon ko milta hai"* (Daughters do not get benefits, daughters-in-law do).

An AWW from Madhya Pradesh registers only those women for IGMSY if they live in the village, while one AWW from Chhattisgarh and another from Jharkhand give women all other services but IGMSY if they are not residents of the village. An AWW in Bihar registers only those women who come to their natal home if they plan to get their children vaccinated at her AWC.

Thus, migrating out of village for work or cultural reasons for long periods of time were factors which emerged on the field and deprived women access to the AWC and the services offered there like the IGMSY.

Social

The social fabric of the village also determines who has the connectivity and reach to AWC's services within a community. Villages in Bundelkhand region in Sagar district of Madhya Pradesh that were visited for this field study had clear divisions on the basis of caste. OBCs such as Yadavs and Sahus are the most dominant caste groups in this region. They mostly have their houses clustered on one side of the village with wide cemented lanes, whereas, all Dalit households were clubbed on the other side of the village with *kuccha* roads wide

enough only for a bicycle to pass. In Jhadola village, there were barely 10 tribal households and in Dhabara village tribal households were built slightly outside the village.

The AWW and the AWH of one village of Madhya Pradesh are dalits and hence the food for the AWC was cooked in a school building opposite the centre. The food was cooked by the women of the village's *samuh,*[125] and all of them belonged to either Yadav or Sahu caste. "*Anganwadi pe khana banega to sab bacche (oopri jaati ke) nahi khayenge. Samuh ki aurten banti hai to sab kha sakte hain* (Yadav and Sahu children will not eat at AWC if the food is cooked here. If *samuh* women cook, all kids can eat the food)," said the AWH there. This form of caste-based discrimination was visible in the village. Cases of bicycles of young Dalit boys being broken and thrashing them for no reason by Yadav and Sahu boys of the village were briefly mentioned in hushed voices in the dalit *basti* of the village. But verifying these cases was beyond the skill and scope of this study. The villages were clearly divided on caste lines but it could not be established what direct impact it has on the pregnant women and their infants living there and whether it restricts their access to the AWC in any way. However, in another village of the same state, an ASHA belonging to the marginalised community complained that she has been held up several times by the Yadavs, whose house falls on the way to the village's AWC from her home, for walking in front of their house.

Though there were no cases in the villages visited where women were denied benefits from the AWC based on their caste or class, there were stray cases where women complained that they were not given nutritional supplements regularly or they were never informed about counselling sessions at the AWC. It could not be verified whether these individual instances where services were refused at the AWC was because of the caste of the women as most of the times other women of that same caste did not complain of similar issues.

There were few cases though where women were refused services from the AWC because of their personal issues with the AWW. For instance, eight-month-pregnant Kiran Devi from Amrita village in Bihar's Saharsa district was not registered for IGMSY benefits for her current pregnancy (her second) as she fought with the AWW over her post office account's passbook which the AWW had kept with herself. In Madhya Pradesh's Chhindwara district, Sapna was repeatedly refused nutritional supplements by the AWW for reasons unknown to her. "*Sabko deti thi, mujhe nahi deti thi* (She gave it to other women, but not to me)," she said. One day she complained to the village Panchayat and in a verbal spat with the AWW

[125] Village's Self Help Group of women who cook food for school's mid-day meal and in this case for the AWC too.

she told her she can eat her share of the ration, which Sapna believed the AWW was doing anyway. After the Panchayat's intervention in the matter, the AWW started giving her the nutritional supplement packets regularly.

There are communities within villages that live away from the rest of the population. For instance, Kamar tribe, a particularly vulnerable tribal group in Chhattisgarh's Maragaon village, has its houses at a distance from the main village. Members of this tribe mostly collect and sell minor forest produce for a living and that is why they spend most of the day in the forests. Accessing AWC then becomes difficult for women from such tribe or caste groups who are socially excluded within a village. Reaching such houses where women are out in the forests for most part of the day is also challenging for the frontline workers as such hamlets are then left out when they conduct field visits.

Access to Health Care Centres

As mentioned in the previous section of this chapter, the AWWs, the ANMs and the ASHAs have to complement each other's work as most of it is overlapping. For instance, ANCs of pregnant women, distributing IFA tablets to them, conduction regular immunization of the women and their children and monitoring their growth are services that are provided by both the AWCs and the health care centres. But to get specialised health care in case of a morbidity and health emergencies, it is important that villages have direct connectivity to functional health care centres. For women, easy access to health care institutions can help them in the time of delivery as well. Connectivity and access to health care centres is also a determining factor whether women seek institutionalised health care in the time of need, especially before, during and after pregnancy.

Geographic & Economic

To reach the nearest government sub centre in Bastanar block women have to travel 25 kilometres from Patel *para* in Korangali village. From Raut *para* the nearest sub centre is 12 kilometres away in Bagmundi. From Gulori *para*, Baghmundi sub centre is 20 kilometres away and Bastanar sub centre is 27 kilometres away. To reach these sub centres, hills with thick forest cover have to be crossed. Hence, in the cases of health emergencies and for deliveries, seeking health care from the village faith healers or *guniyas* is the first port of call for most of the households in all hamlets of this village.

As is the case with accessing AWCs, it is not just the distance to the health care centre in kilometres, but how well they are connected to the villages that is crucial for families to decide whether to visit them or not. For instance, the nearest sub centre from Jhadola village in Madhya Pradesh is nine kilometres away in Tarpur on kuccha road. The village is surrounded by forest cover which women are afraid to cross alone at night. Jhadola village is located close to Uttar Pradesh border and rapes, abduction of women and other criminal activities like theft and murder are regularly reported from the areas surrounding the village that adds to the fears of women. Such a crippled law and order situation discourages women and their families from visiting health care institutions outside the village unless unavoidable. Hence, geographical difficulties in accessing health care was a primary factor in deciding whether women seek institutional medical care when needed.

It was noted on the field that often families decided to visit hospitals which were far from the villages instead of choosing the nearest sub centres. They preferred travelling long distances because of direct road connectivity to the nearest town or city where a PHC or a CHC are located. There is often more surety of getting treatment and finding doctors at bigger hospitals. Distance and connectivity between the village and health care centre also determines how much money is spent on reaching the centre. Hiring a mode of transport or spending money on fuel to reach a health facility that is not connected by motorable roads is far more expensive than using public transport.

For Susheela and her husband Hira from Raut *para* in Korangali village, visiting Bagmundi sub centre is much more time consuming as they have to walk for 12 kilometres on a hill. Instead, visiting the government hospital in the neighbouring district Dantewada that is 22 kilometres away is a much more convenient option as they can catch a direct bus till the hospital from the national highway. The nearest sub centre also holds little significance for Susheela and Hira as each time they took their infant daughter there in the past, they found no doctor there. Since Dantewada has a CHC, they get assured treatment from there every time.

Deciding what kind of health care will be sought and from where also depends on when it has to be accessed. The timing of the need of health care is especially important in cases where women have to be rushed for delivery. Like in Shakun's case labour pain during the delivery of her second child started late at night. She informed the ASHA in her village who refused to accompany her to the hospital till a vehicle was arranged. In Jhadola village, it was a difficult yet a valid demand by the ASHA. To reach the state highway, a forest has to be crossed. The

area around the village is also notorious for criminal activities, as mentioned above. Since it was night, Shakun's family also could not take her on a motorcycle as they needed a group of people to go with them. By 1 A.M. she delivered at home with the help of her mother-in-law and other elderly women of the family. The midwife could only reach by 7 A.M.

In Bihar as well, a high number of deliveries happen at home because the families do not risk taking women out due to bad weather and in cases of late night labour pains as there is inability to arrange a transport vehicle for the pregnant woman. In Saharsa district, 22-year-old Ruby Devi from Amrita village lost her first child during delivery as it happened late at night and she could not be taken to a hospital in any vehicle even though there are three hospitals nearby – Patargarh PHC six kilometres away, Sonbarsa PHC 14 kilometres away and Mangwar government health centre seven kilometres away. But the village is 40 minutes by foot from the main highway with a path wide enough only for a bicycle. The lack of transport vehicle, including government's ambulances, hence, cost Ruby Devi heavily. Similarly, Kapurni Soren from PO Sukran village in Simdega district of Jharkhand delivered at home in the presence of a midwife as it was heavily raining and she could not go to a hospital.

Meanwhile, many families are aware and rely on the free ambulance services for taking pregnant women to government health care institutions for delivery. There were cases reported where the ambulance never arrived and women had little choice but to deliver at home. For her last of the six pregnancies, Pedli from Dudhwara village Chhattisgarh called the ambulance to go to the hospital when her labour pain started as she has had two miscarriages and one stillborn in the past. But before the ambulance could arrive, she delivered at home. Similarly, Mantla Bai from Jhadola village delivered her first child at home as the vehicle could not reach in time. Her fifth delivery, however, happened in the fields in the morning when she had gone to defecate. The baby was delivered by her sister-in-law who was with her. Pushpa from Kendua village in East Singhbhum in Jharkhand delivered at home as there was no facility for an ambulance. To avoid spending on private transport till the hospital, she decided not to go to one.

It was also noticed in some of the villages covered for this study that delivering at home was a preferred option for many women. An ASHA from Madhya Pradesh explained that women approach the sub centre only when they know that the delivery is not going to be normal.

Women decide to go to a health care institution if any complication is noticed during the pregnancy.

For women interviewed for this study, accessing the health care centres was less convenient than delivery the child at home. Some of the villages covered for this field study did not have road connectivity, as described in the above sections. For instance, Korangali village is surrounded by hills; two streams and one river have to be crossed to reach Navri Tola village in Madhya Pradesh; Kaream Rated village is in a valley and Jhadola and Dhabara are surrounded by forest cover. In these villages the ambulance can only reach a till certain point on the road. To access the ambulance service, women have to reach till the point where the pucca road begins. In most cases in these villages, it was recorded that women preferred delivering at home than going to the hospitals. In Sagar district, Madhya Pradesh women mentioned that given the lack of safety in the region, they considered delivering at home less risky than going to the health care centre.

There were instances where women in labour were referred from one hospital to the other as the hospitals did not have the required infrastructure or skilled manpower to provide medical care to the women. When Ram Bai, 20, was in labour with her first child she was rushed to Baraitha PHC which is nine kilometres away on *kuccha* road from her village Dhabara in Sagar district. From there she was referred to a CHC in Shahgarh block and from there to district hospital in Sagar. Learning from her bitter past experience of being sent from one hospital to the other, she went to Jhansi district hospital directly from Baraitha during her second delivery. She had caesarean deliveries both times.

From Bihar's Vaishali district, Bailgaon village's Meena Kumari also had a similar experience. When her labour pain started she first visited the PHC and was told by the doctors there that her baby is in the wrong direction and she would have to deliver at a more specialised hospital. She was then rushed to Vaishali's Hajipur Sadar hospital, which is the district level hospital, approximately 40 kilometres away where she finally gave birth to her boy.

CHCs are supposed to be equipped to take care of caesarean deliveries, but the cases recorded in this study suggest that this was not the case in these remote areas. Such supply side gaps at the block level lead to significant inconvenience and delay in treatment of the women at the time of delivery who anyway managed to reach the first nearest PHC or CHC with great

difficulty. Such experiences of accessing health services then deter women from seeking health care from government institutions. Instead, women turn to private doctors and hospitals in the vicinity which may be expensive. Also, there is no guarantee that the doctors running private clinics and hospitals are qualified to do so.[126]

Kamli's son was born premature in the seventh month of pregnancy. He was delivered through caesarean section in a private hospital in Rajim, which is 30 kilometres away from her home in Dudhwara village, as she did not trust the government hospitals with an untimely delivery. Her son did not cry after he was born and she took him to Raipur for treatment which continued for two months. The delivery and treatment expenditure was more than Rs. 1 lakh. For the second delivery two-and-a-half years later, she first went to a CHC near her village. The staff there waited for two hours for a normal delivery but because she was a high risk pregnancy case they referred her to another hospital. She again delivered through caesarean section at a private hospital in Dhamtari and spent between Rs. 20,000-22,000. But Kamli and her family could afford treatment as she belongs to one of the well-off families in the village. The family has their own vehicle and she says she does not prefer going to government hospitals. But for several other women interviewed for this study, expenditure on delivery in private hospitals is unaffordable and they end up delivering at home.

However, several women from the field sites preferred private health care practitioners for treatment pre and post-delivery. For most of the women from Navri Tola village, visiting a private practitioner at Jamun Donga, another hamlet of the village, was more affordable and accessible than visiting the nearest government health care centre. They walk till Jamun Donga which is three kilometres away on a *kuccha* route. They cross two small streams and one river, and pay the doctor a fee of Rs. 100-200 per visit for fever and weakness during pregnancy. But for the nearest sub centre in Kursi Dhana they will have to go four kilometres further from Jamun Donga after spending Rs. 10 on an auto for one person one way. The trip to the sub centre proves useless as the ANM who is stationed there is hardly ever available. To reach the PHC and the CHC, both within a distance of half-a-kilometre in Tamia block which is 35 kilometres from Jamun Donga, people from Navri Tola village will have to take an auto for Rs. 40 per person for one way. Hence, the cheapest and most accessible option is a private practitioner who also provides glucose drips and energy tonics on request.

[126] See Duggal (2000)

For all her illnesses Deewad from Maragaon village in Chhattisgarh always consults a private doctor at Gariyaband that is less than 10 kilometres from her village. For Rs. 500 he treats all illnesses and provides medicines and energy tonics. The nearest sub centre from her village is shut most of the times. If at all she meets the ANM, she sends her to Singpur for treatment which is 30 kilometres away and Deewad ends up paying money for transportation also. The free ambulance service offered by the government can only be accessed for taking women to the hospitals for delivery and nor for regular check-ups or other illnesses. This is discussed in details in the later sections of this chapter.

Economic impact on the households seeking institutional health care is also an important factor in deciding whether women go for delivery in a hospital or not. Numerous women spoken to for this study reiterated that delivery in a hospital, be it government or private, means high expenditure. Even though all services related to delivery and stay in the hospital are supposed to be provided free of cost in all government health care institutions,[127] money was being charged at most health care centres *(details in next section on corruption)*. Sukhwati from Navri Tola village who has had four pregnancies so far but only has two surviving children has never been to a hospital in her life. Five months into her fifth pregnancy, she vows that she will not visit the hospital as the delivery is expensive. She said, "*Delivery pe wahan bohot kharcha hota hai"* (delivery there costs a lot). She is the only earning member of her family. Her husband migrated four months back and has abandoned her. He sends no money home. Shakun has shifted to her mother's house and has to feed her two daughters – seven years old and three years old – and cannot afford an additional expenditure.

Access to Banks and Post Offices

Like in the case of AWCs and health care centres, accessing banks for withdrawing IGMSY instalments was also a big issue that emerged from the field visits. This aspect of the study is discussed in detail in chapter 7 of this report.

Corruption

The issue of corruption in various forms surfaced at several levels of interviews from all four states where fieldwork was conducted for this study. Although these corruption issues were not independently investigated, it was noted that it was stopping women and their families

[127] See (GoI, n.d.-b)

from accessing institutional health care as well as services at the AWC besides completing bank processes for receiving IGMSY benefits.

In Public Health Care Facilities

Services of pre- and post-natal care and of delivery in public health care institutions are supposed to be given to women free of cost[128]. But there were numerous cases recorded on the field where paying the ANM or the doctor who conducts the ANC, PNC or delivery is a norm. Money was also taken by cleaners and sweepers who work in the hospitals' delivery rooms. Sumitra from Kumar Sadra village of Bastar district delivered her third baby at home. But she had to be immediately rushed to the CHC in Kilepal, 12 kilometres away because her umbilical cord could not be cut at home. The senior nurse at the hospital took Rs. 700 for the procedure. In Kaream Rated village in Chhindwara, Aarti paid Rs. 50 to a hospital staff who cut the umbilical cord besides paying Rs. 100 each to the ANM and the midwife at Tamia block's government hospital.

In Sagar, Shyamwati from Dhabara village delivered all her three children in government hospitals. For her second delivery that happened at Shahgarh block hospital, she gave money to more than one ANM. "*Kisi ne Rs. 300 liye, kisi ne Rs. 400* (Some took Rs. 300, some took Rs. 400)," she recalled. She also paid Rs. 130 for her child's birth certificate that was given to her at the hospital. Shakun from Jhadola village also ended up paying Rs. 500 each to two ANMs and Rs. 100 to a doctor in a government hospital for delivery. Similarly, in Bihar, Soni Devi from Agma village of Saharsa district paid Rs. 400 to the ANM at Sonbarsa PHC at the time of her second child's delivery. Neelam Devi from Baligaon village in Vaishali district gave Rs. 50-100 to the nurse at Patepur PHC for delivery, whereas, in Jharkhand's Kendua village in East Singhbhum, Shubhangi paid Rs. 600 to an ANM. Kalia Bai from Dhabara village in Sagar does not know that delivery at government hospitals is conducted for free and gave the money to the hospital staff in Baraitha government hospital as they asked for it. "*Unhone maange to humne de diye* (They asked for it, so we gave it to them)," she said. She paid Rs. 700 out of which the ANM took Rs. 100. No medicines were given to her from the hospital.

Meanwhile, the health care activists working in Tamia block of Chhindwara informed that many cases where midwives, who are hired by the government hospitals to conduct

[128] (ibid.)

deliveries, harass women inside the hospital when they go for delivery. If the women refuse to pay money, the midwives do not conduct the deliveries. The woman's family ultimately give in to the demand and pays the bribe. Money is also asked from the ASHAs who take cases for delivery to the hospital. However, this could not be cross-checked with the hospital authorities. "*Agar koi* ASHA *mahila ko* delivery *ke liye aspatal* (Tamia government hospital) *le kar jaati hai to dai pehle paise mangti hai, phir delivery karti hai. Agar* ASHA *mana kar deti hai to garbhwati mahila ko pareshan kiya jaata hai. Ek case mein* ASHA *ne paisa dene se mana kar diya to dai* toilet *ke baahar kursi laga kar baith gayi aur mahila ko jaane nahi diya. Raat ka samay tha aur wo mahila dard mein aspatal ke bahar baar baar* toilet *ko gai. Ab aisa karenge aspatal mein to kaun mahila jayegi wahan* delivery *ke liye*?" (In the government hospital in Tamia, whenever ASHAs take women for delivery, the midwives first charge money. If ASHAs refuse, the dais just make the women in labour suffer. In one such case where ASHA did not pay for delivery, the midwife put a chair in front of the hospital's toilet and did not let the woman, who was in labour, use it. It was late at night and the woman had to go out of the hospital every time to urinate, which is highly risky and unsafe. Why should the women go to the hospital to deliver if they go through all this there?)," said a local health activist in Tamia.

As mentioned in the previous sections of this chapter, in many cases women visit the most accessible health care centres which may not be nearest from their villages. Also, since access to the AWCs is limited, some women visit PHCs and CHCs for immunization and ANCs as well. However, many ended up paying for these otherwise free services in the government health care institutions. Sumantra from Jhadola village was charged Rs. 15-20 for each immunization she received from the CHC at Shahgarh block for all her three pregnancies. Though she delivered her three children at home, she used to visit Shahgarh CHC for ANCs but only if she had money. In Dhabara, Ram Bai has two sons and both were delivered through caesarean sections. She visited Baraitha CHC thrice for ANCs during her first delivery and twice during her second pregnancy. Each time the doctor took Rs. 100 from her.

Under a Government of India's scheme implemented by the Ministry of Health and Family Welfare, women are entitled to get money under Janani Suraksha Yojana (JSY) if they deliver in a hospital.[129] Cases were recorded where women were given only a part of the JSY

[129] Cash incentive is given to women depending on whether the state is high or low performing. If pregnant women deliver in a hospital they receive Rs. 700 in a high performing state and Rs. 1,300 in a low performing state. In case they deliver at home, they receive Rs. 500 which they are entitled to receive under NMBS. The health ministry, therefore, gives all pregnant

money and it was not clear to them as to why they have received less money. In Chhattisgarh's Maragaon village Budri last delivery (sixth) was at Gariyaband government hospital. She only received Rs. 1,000 as JSY money. In Karеam Rated village Parmodini received Rs. 1,400 for her first child's delivery but only Rs. 1,000 for her second delivery which happened at Tamia government hospital.

Meanwhile, in some cases, a part of their JSY money was kept by the doctors or the ANMs at the government hospital where they delivered. For all her three deliveries Shyamwati from Dhabara village in Sagar district went to government hospitals. Her third delivery was at Baraitha government hospital where she went on a motorcycle with her husband spending Rs. 300. She spent an additional Rs. 1,500 on medicines in the hospital and this was the only time she received her JSY cheque of Rs.1,400 – but with a rider. She was given the cheque after she gave Rs. 700 to the doctor there who handed it to her.

Then there were cases where women did not receive any JSY money at all despite delivering in a hospital. When Lalita bai from Jhadola village was pregnant with her second and third children, she was taken to Shahgarh CHC by her husband on a tractor for delivery. She spent Rs. 500 each time on diesel for the tractor and spent Rs. 300 paying bribe to the ANM at the hospital yet she did not receive any JSY money. Her third child is two months old now. Sukurmuni from P O Sukran village in Jharkhand delivered at Tingina sub centre but has not received JSY money yet. Her daughter is two years old now. From Karеam Rated village, Aarti could not get JSY money despite delivering in a government hospital as she does not have a bank account in her name.

On the field it was also noted that for some women receiving money upon delivering in a hospital also acted as an incentive to go to the hospital. But many a times villages are completely disconnected from the health centres and the cost of reaching the hospital itself deters women and their families from making the effort to deliver the baby in an institutional health care centre. In cases where villages are disconnected from the pucca roads, women's families have few options of transporting them to the nearest and accessible health facility for delivery. Ambulances are hard to reach remote villages as mentioned in the section above and can only be called to a certain point on the nearest pucca road, if they come at all. In such a

women Rs. 500 as NMBS and an additional Rs. 200 for JSY if the women deliver in a hospital. In low performing states, an additional Rs. 600 is given as ASHA's package (GoI, n.d.-c)

case, families generally hire a private vehicle from someone in the village which may be much more expensive than the amount they receive under JSY.

The purpose of handing the JSY money in cash to the women when they are discharged from the hospital is to address this issue in accessing institutional health care centres and to save out-of-pocket expenditure on transportation to and from the health care centre. But the situation in the villages covered for this study show that the delays in disbursing JSY money, disbursing it in cheques instead of vouchers or cash and the corruption involved in it no longer makes it an attractive proposition to increase institutional deliveries.

It was witnessed in all the states that some women were handed cheques under the scheme and not cash as was practiced earlier[130]. During pregnancy, women are asked to open bank accounts so that they can deposit their JSY cheques when they receive it after delivery. The tedious processes of accessing banks, opening accounts and delays in receiving cash are mentioned in details in chapter 7 of this report. Handing money under JSY in cheques then defeats the purpose of the scheme as the families end up spending money out-of-pocket on delivery related expenses which are all supposed to be free[131].

Many houses reported taking loans to meet the expenses incurred on delivery, including cost of transportation. This is discussed in the following section in details. Households reported receiving JSY money two to six months after delivery which then gets spent mostly on household expenses. In several cases, the waiting period for JSY money is longer. For instance, Kaliya Bai from Dhabara village in Sagar delivered her fourth child in a hospital but received JSY money (she can't remember whether it was given by cheque or a voucher) after a year of delivery. Ram Bai from the same village delivered two months ago and received a cheque for JSY which she has not been able to encash as her bank account has not opened. Meena Kumari from Baligaon village in Bihar's Saharsa district received JSY money six months after delivery and so did Dhani Hemrom from Simdega district in Jharkhand which she used for the baby's clothes, sheet and powder.

In some cases women complained that the ASHAs and the AWWs who accompanied them to the banks to withdraw the JSY money took their share from the money received. Out of the

[130] The Janani Suraksha Yojana: Guidelines for implementation says that the "success of the scheme lies in making the cash assistance available to the poor pregnant women at the time of the delivery"(GoI, n.d.-c)
[131] See (GoI, n.d.-b)

Rs. 1,400 Rani Devi from Amrita village in Bihar's Saharsa district received, she had to hand over Rs. 500 to her ASHA who accompanied her to the bank in Sonbarsa.

Besides the JSY, women who deliver at home are entitled to Rs. 500 under NMBS[132]. Except Chhattisgarh, women in other states covered under this study did not receive this money. In Maragaon village Deewad received Rs. 500 under NMBS but the ANM there took the whole money as her "fee." Only one woman from the remaining three states reported receiving Rs. 400 by the ANM for delivering at home. Meanwhile, an ANM from Chhattisgarh informed us that women receive NMBS only if they have BPL cards.

In AWC's services

As per Government of India's ICDS, all pregnant and lactating women are entitled to a packet of dry nutritional supplement, also called the take home ration, every week from the AWC.[133] This extra food in the form of dry ration is given to women for their and their unborn child's better health. Even though collecting the take home ration from the AWC and consuming it is not a condition for receiving IGMSY benefits, the field findings suggest that it is a major incentive for women to visit the AWC. It was reflected in the interviews at many villages that for women whose houses are far from the AWC, collecting THR was the only reason they were visiting the AWC for. In remote villages and hamlets women walk for kilometres on difficult terrain to reach the AWC, often at the cost of the day's wage, and it is worth a visit only if they "benefit" – monetary or in-kind – from it. A day in a week is fixed at the AWCs for collection of this ration and the same day is then also fixed for counselling at some AWCs as the women do not visit the centre every day. But corruption in distributing THR to women prevailed in many villages. Women complained that they do not receive the packets regularly and some of them stopped going to the AWCs because of this.

For instance, in Korangali village Gayatri from Raut *para* never receives any take home ration. She has two children – three-and-a-half-year old and one-and-a-half-year old. Her para is seven kilometres away from the AWC across a hill and she never visits the AWC. For Somari from the same village but a different hamlet, the AWC is two kilometres away with a stream on the way. She goes to the AWC only if there is supply of the THR at the AWC. The supply of THR in this village is quite infrequent because of the inaccessibility. At the time of

[132] See (GoI, n.d.-c)

[133] This is also an entitlement under the NFSA 2013. The Act mentions that every pregnant and lactating women is entitled to a meal, free of charge, during pregnancy and six months after child birth. "Meal" is defined as hot cooked or pre-cooked and heated before its service meal or take home ration.

the interview, she knew that the THR has not yet reached the AWC and that was why she was not going to the AWC. As a result, she had not been accessing the other services at the AWC such as immunisation. Om Bai from Kumar Sadra village of Bastar district used to visit the AWC before her child was born but she received the ration only once. The AWC is three kilometres away from her home but she no longer goes there.

Bihar follows a quota system for distributing THR. Each AWC is allowed to give THR to only eight pregnant and eight lactating women irrespective of the number of eligible women. This is in violation of the NFSA, 2013[134]. In Vaishali district, all women interviewed received THR but the quantity varied. In Simdega none of the women interviewed had received THR. Kiran Devi from Amrita village has not been receiving the THR as she fought with the AWW of her village. Ruby Devi from Baligaon village registered at the AWC in the second or third month of her pregnancy. She is now nine months pregnant but has not received the THR yet. Runa Devi from Jaisinghpur village registered at the AWC but when she requested the AWW to give her the THR, she was told that the "seat is full," i.e. the AWC is already giving the THR to eight pregnant women and cannot accommodate more women.

It was also noted during field visits that the irregular supply of take home ration was not always created at the AWCs level. Often, the AWCs faced shortages from the block office. From off the record sources it was informed that at many block offices, money is taken from the AWWs to release their AWC's THR share to them every month. However, this could not be probed further. Nonetheless, it was an issue that was stopping many women from visiting the AWC that offers many other services besides handing over THR.

Money was also charged from women in Bihar in handing over MCP cards. This was widespread in Saharsa where payments ranging from Rs. 20 to Rs. 150 were made to the ANM to receive the card. In Agma village, Sundar Devi was asked for Rs. 10-20 for each MCP card for her three children. She refused to pay and was not given any card. Similarly, Sanju Devi from the same village was asked for Rs. 150 for her youngest boy who is one-year-old now which she refused to pay and does not have the card even for her younger daughter. Unlike Sundar and Sanju, Girija Devi paid Rs. 100 to get the MCP card for her child. She received the card after the child was born. Though shortage of MCP cards was also

[134] ibid.

recorded from several villages, it could not be established if taking bribe for the card in Bihar has any link to the shortage of cards.

For accessing IGMSY and JSY money from the banks and post offices, women in many villages visited took help from the AWWs, ASHAs and sometimes the ANMs. It was reflected through the interviews that the frontline workers took money from the women for accompanying them to the bank. An AWW from Bihar took Krishna Devi's post office passbook and asked for Rs. 1,000 commission for the Rs. 4,000 that Krishna received for her second child. Krishna gave the AWW Rs. 500 even though she received no help in opening the post office account for which she had to go alone thrice.

In Chhattisgarh, an AWW took the women who had received money under the IGMSY to the bank and took Rs. 500 from one woman and Rs. 1,000 from another. The AWW had also kept all passbooks with her at the AWC. In Madhya Pradesh, an AWW took Rs. 200 from Lalita Bai when she withdrew her first instalment saying that it is her share. From the same village, out of the Rs. 4,000 Shakun was promised, she received only Rs. 3,500 which the AWW handed her in cash in two instalments. The AWW told her that Rs. 500 was spent in the paperwork.

Money was also taken from women by the AWWs' and ASHAs' husbands. There were cases recorded where the frontline workers' husbands accompanied women to the banks and charged money from them or took "their share" from the IGMSY or JSY money women withdrew from the bank. Anita from Dhabara village received only the first instalment for her son as the baby died after 10 days of birth. She received only Rs. 1,000 from the AWC out of which the ASHA's husband took Rs. 100 for accompanying her to the bank to withdraw the money. In Bihar's Amrita village, the AWW's husband asked for Rs. 1,000 from Rani Devi after she received Rs. 4,000. When she refused to pay, the AWW kept her passbook saying that husband's and father's names are written incorrectly in her passbook.

Cases were also recorded on the field where women give money to the frontline workers and their husbands to not disturb the social fabric of the village. Shyamwati from Dhabara village had to pay Rs. 100 each time to the AWW's husband for accompanying her to the bank to withdraw money. When she objected he said, "*Koi aur kaam aayega to hamare paas nahi aaoge tum*?" (If you have other work later, will you not come to us?). In some cases, women felt that it is okay for the AWWs and ASHAs to take their share as they do not receive any

money for helping women with opening bank accounts and travelling all the way with them to withdraw the money. So women pay them out of their own pocket. Most women also depend on the ASHAs and the AWWs for things besides the IGMSY as they are mostly the literate women in the village and women do not want to spoil their relations with them. This has been discussed in more detail in the section on grievance redress. Besides, general lack of information amongst women about how much money is charged for what service and where money has to be paid is a big reason why most of them end up paying bribes.

Out-of-pocket expenditure and how it restricts access

Several households from all four states interviewed for this study mentioned that delivery brings major expenditure for the family. While most of the households reported not spending anything during the nine months of pregnancy, a substantial amount of money is spent during delivery, whether it is at home or in a hospital. Though at the outset, the study did not have a plan to probe the issue of out-of-pocket expenditure on health care and other related services; it emerged in the in-depth interviews as one of the critical issues that restrict households' access to public services, especially health care. In all households where money was spent on delivery and treating illnesses before and after delivery, it was spent out-of-pocket.

If the delivery is at a hospital or any other health care institution, most of the households rely on private vehicles available in the village that are hired to take women to the hospitals. Though free ambulance service is available for this, there is little dependence on it by villages that are remote and inaccessible by road. Cases were also recorded where women ended up taking very risky modes of transportation like tractors, motorbikes and bicycles to reach hospitals during labour, either due to unavailability of any other mode of transportation or to save cost.

In Jharkhand, Shrimati from Simdega district spent Rs. 400 on auto rickshaw to and from the sub centre that was in her village and Singo Mumu from P O Sukran village spent Rs. 200 on a tempo that her family hired to take her to a hospital in Kolebira that is 60 kilometres away from her village. In Chhattisgarh, Ramvati from Maragaon village spent Rs. 200 to hire the village's Multi-Purpose Worker's (MPW) bike to go to Gariyaband government hospital in the neighbouring district for her third delivery.

In Madhya Pradesh, Parmodini from Karam Rated village took a bus to go to the government hospital in Tamia with her husband as her phone had no connectivity and she could not call an ambulance. The bus ride till the hospital took Rs. 20 per person. Had she hired a private vehicle, she would have had to spend around Rs. 500 as Aarti from the same village did for hiring a jeep to the same hospital. The jeep had to be taken from a point on the main road as this village is in a valley where no vehicle can go. Though Aarti was staying at her natal home which is closer to the road, she had to walk uphill to reach the jeep. From the same village, Jamna had to walk for two hours to reach the road where a private jeep was waiting to take her to Tamia government hospital. The rent of the jeep was Rs. 400 one way and on her way back from the hospital, she spent Rs. 60 per person on the bus ride.

Shyamwati from Dhabara village in Madhya Pradesh spent most of her money on travelling to hospitals for all her three deliveries. For her first two deliveries she hired a jeep and spent Rs. 3,000 and Rs. 2,000 respectively. The first delivery was at Sagar district hospital and the second at Shahgarh government hospital. She hired a motorcycle till Baraitha government hospital and spent Rs. 300 for her third delivery. Lalwati from Jhadola village of the same district hired a tractor and spent Rs. 700 to reach Shahgarh government hospital. Besides, she spent Rs. 1,700 on medicines which she had to purchase from the market. "*Parcha likh dete hain, humme hi lana padta"* [They (doctors) just write it (prescription) on paper, we have to go get it ourselves (from the market)], she informed.

Medicines and Food at Hospitals

Once in the hospital for delivery, families had to shell out a major portion of their money on medicines which the hospital should be providing for free and on paying bribes to doctors and ANMs as mentioned in the previous section of this chapter. Women complained that hardly any medicines are given from the hospital. In few cases where women stayed back in the hospital after the delivery, they also had to spend on food during their stay. All of this expenditure is out-of-pocket. In Madhya Pradesh, the expenditure on health care ranged from Rs. 100 to Rs. 2,000 per delivery. In Jharkhand, it ranged from Rs. 200 to Rs. 1,000 and was mostly spent on transportation and medicines. Similarly, families in Bihar spent anywhere between Rs. 400 to Rs. 2,100 for health care and transportation expenditure.

In the hospital, Shrimati from Simdega, Jharkhand spent Rs. 700 on medicines which she purchased from a private pharmacy, while Singo Mumu from P O Sukran spent Rs. 60 on

medication and a tonic. Singo Mumu spent an additional Rs. 1,000 as she was very weak. To make up for all this expenditure, like most other families in her village, her family also took a loan from a local moneylender at the rate of Rs. 20 per Rs. 100 per month.

Halkibahu from Navri Tola village complained that she could not feed her baby immediately after her first delivery in Tamia Government hospital as she was unwell and had not eaten anything. She stayed in the hospital for three days and no food was provided to her there. Her relatives living in Tamia brought food for her in the hospital.

Even though there is provision for free ambulance service for bringing women to the hospital and taking them back, free medicines and free meals during the stay in government health care institutions besides free delivery, women and their families end up spending huge amounts of money on all of the above. No case was recorded from the villages covered under this study where a woman received an ambulance ride back home after discharge from the government health care centre as mandatory under the JSSK.[135] Shubhangi from Kendua village in Jharkhand paid Rs. 800 for a tempo till home. She used her savings to pay for the transportation.

High out-of-pocket expenditure on health care, hence, deters families to visit health centres in case of morbidities also. For instance, Sumantra from Jhadola village decided against taking her child to a health centre as she had no money. "*Paisa hai nahi, kya dikhaye doctor ko? Sarkari mein free ilaj nahi hota* (I do not have money, how can I take her to a doctor? There is no free treatment at government hospitals)," she said.

Private Health Care

Meanwhile, out-of-pocket expenditure is higher, sometimes almost double, on treatment and delivery at private health care centres yet it was recorded on the field that few households opted for it. In the interviews few families responded that if money is spent on both public and private health care, they might as well go to private health care providers as they get additional drips and energy tonics, which they feel helps them recover faster.

Renu Devi from Amrita village in Bihar was weak during her pregnancy and her mother-in-law approached a local doctor in the village who charges Rs. 1,000 to Rs. 1,500 for giving glucose through a drip. The cost of same procedure is about Rs. 3,000 at the nearest town

[135](GoI, n.d.-b)

Madhepura. Renu Devi and her mother-in-law did not go to a frontline workers for assistance because they are not aware that they can assist them as well.

Susheela from Kumar Sadra village in Chhattisgarh had to abort her third child due to complications. She spent Rs. 7,000 in three days in a private hospital in Kilepal and Rs. 7,500 on another private hospital in Jagdalpur. On glucose at sub centre and medicines the family spent an additional Rs. 1,000. To meet the high expenditure on Susheela's treatment the family had to sell three goats for a total of Rs. 7,500 and her husband earned the remaining amount. Meanwhile, from Amrita village in Bihar, Krishna Devi spent Rs. 4,000 on a private doctor for the treatment of her girl who was unwell.

Expenditure on home deliveries

In all the four states covered for this study, there was a high proportion of cases where women delivered at home. The reasons differed from access to health care institution to cost of travel and delivery in a hospital, as elaborated in the previous sections of this chapter. Delivery at home, it was observed, is no less expensive and in some cases even more expensive than delivering in a government hospital. Households spend money and pay in-kind to midwives and *guniyas* for helping in the delivery.

In Korangali village, where reach to health care institutions is difficult, most of the households depend on the local *guniyas*. Somari from Gulori Para has delivered thrice at home and has always taken the *guniya's* help. She has faith in his treatment even though two of her children did not survive soon after birth. Each time the *guniya* is called for childbirth or to treat any illness, he is given Rs. 300, a rooster and liquor.

Sumantra from Jhadola village has four children and she has never delivered in a hospital. For each delivery, she gave Rs. 300, a saree, cooked meal and 10 kilogram wheat to the midwife who came home to deliver. Similarly, Runa Devi from Jaisinghpur village in Bihar paid Rs. 300 and 20 kilogram rice to the midwife for delivery. For her last delivery, her 11th, Kade from Dudhwara village was at her natal home in Kirbai where she had called a midwife and a local doctor to help in the delivery. The doctor took Rs. 1,500 and gave her some seven to eight injections. Kade says she could deliver only after the injections. She does not like to go to hospitals and instead calls the local doctor home. Chandani Devi from Agma village in Bihar also called a private doctor home to deliver who took Rs. 400.

Sarita from East Singhbhum, Jharkhand, spent Rs. 500 on medicines even though the child was born at home. She has had five pregnancies so far but has only three surviving children – seven, six and one-year-old daughters. Her husband died of Tuberculosis and her father-in-law is suffering from it. For Sarita spending out-of-pocket is only possible if she earns. Like most other households, taking loan from relatives and neighbours in the time of emergency is not an option for her as nobody gives her family any credit.

The need for money for Aarti from Karеam Rated village is a few days before delivery so that she can do all preparations before the delivery date. This way, she says, she will not have to take a loan. "*Ab paisa nahi hai* delivery *ke samay to pair padna padta hai"* (We beg when it's time for delivery and if we do not have money then), she says. "*Apne haath mein rakam nahi hai, jab pair padte ho...de do, paise de do...Jab paisa nahi rahega to pair to padna hi padta hai"* (When you have no money in hand, you have to beg...please give me money...When there is no money we have to beg)," adds her husband.

Loan and Post Delivery Expenditure

Informal loans from neighbours, relatives, *baniyas* and *seth* in the villages or at the nearest town in the time of need is the most common way of getting instant cash for almost all households in the villages covered. Most of these loans are taken to meet the health care and transportation expenses and also in some cases for celebrations after the child survives the first week of birth. Poonam Devi from Baligaon in Bihar took a loan of Rs. 1,000 from a family member to meet the delivery expenses. Similarly, Kashti Devi from Jharkhand spent Rs. 500 on delivery at Dhumari PHC and she borrowed this money from her paternal uncle.

During her third pregnancy, Anita from Dhabara village in Madhya Pradesh started bleeding in the eighth month and had to be rushed to Baraitha government hospital where she delivered. Her bleeding continued two months post delivery and her treatment that switched between hospitals in Banda, Baraitha and Shahgarh cost between Rs. 10,000 and Rs. 12,000. Despite continuous efforts, her child could not survive and died after 11 days of birth. The family has taken a loan of more than Rs. 20,000 to meet the expenses of Anita third delivery and previous two deliveries. To repay this loan, her husband has migrated to Haryana where he earns Rs. 5,000 per month and sends money home.

Kileshwari from Kumar Sadra village in Chhattisgarh died after the birth of her second child. Within a month of birth, the child also died. Kade delivered at home but was taken to

Jagdalpur government hospital soon after that as she had swelling in her body and was severely anaemic. On the child's delivery, Kileshwari's husband, Kosi had given the *guniya* two pigs, one rooster, five to six chicks and six bottles of *landa* (local alcoholic drink) and for his wife's cremation, he took a loan of Rs. 5,000 from "rich people of the village" by mortgaging his piece of land that produces 20 *peli* rice.

In Bihar, many households also spent money on treating weakness experienced by mothers post delivery. For instance, Runa Devi from Jaisinghpur village spent Rs. 5,000 to Rs. 6,000 on food such as milk, fruits at her natal home as she was weak after delivery. Ramvati from Maragaon took a loan of Rs. 3,000 from the local shopkeeper in the village for her daily ration as she was not earning for some time after delivery. "*Bahut karza ho jaata hai paalne posne ke liye,* (Debts rise when raising children), she says, stressing that she needs the money after childbirth.

From Dhabara village in Madhya Pradesh, Ram Bai and her family has taken a loan of over Rs. 30,000. For her first delivery, Ram Bai had to be rushed to Sagar district hospital for a caesarean section. The family spent Rs. 20,000 on it and for the second delivery in Jhansi district hospital, they spent Rs. 10,000. An additional Rs. 4,000 was spent on medicines in Jhansi. Roughly Rs. 2,500 was also spent during her first pregnancy to reach Sagar hospital. Her father-in-law collected some money from villagers and the rest from a *seth* who deals in minor forest produce. The first loan has been repaid by selling minor forest produce the family collects and by earning from daily wage work. For the second loan, the family again approached the same *seth* and are now working to repay it. So far only Rs. 2,500 has been returned.

Anita from Navri Tola village who lives with her one-year-old son and her drunkard father-in-law took a loan of Rs. 4,000 to Rs. 5,000 from villagers to bring ration in the house post delivery. It was later returned by her husband who has migrated for work. During delivery, she had swelling in her feet but she did not go to any health care institution for treatment as she did not have money. She did not even call a *guniya*. She delivered at home and managed to give alcohol, coconut, ration (salt, red chilli) and two glasses wheat, rice and dal each to the midwife.

Access to Maternity Entitlement under Other Schemes

In Chhattisgarh, the state government has added its own initiative to the central government's MGNREGA. Women in the state who have job cards under MGNREGA and work for more than 15 days during pregnancy are entitled to receive maternity allowance equal to a month's wage.[136] This amount is approximately Rs. 4,380 per pregnancy.[137] This addition in MGNREGA was introduced in Durg district in June 2013. Later it was extended to the entire state.[138]

However, the awareness about the scheme is low among women in the villages. Rangoo from Dudhwara village worked under MGNREGA for 15 days during her first pregnancy but does not know about the extra money she is entitled to receive under it. She has no information about the scheme but has heard that some other women have received Rs. 3,000. Meanwhile, Somari from the same village was informed about the scheme by the *sahayak* (Panchayat helper or assistant) during her second pregnancy but she could not benefit from it as there was no MGNREGA work in the village. Kade from the same village worked under MGNREGA for five to six weeks during her last pregnancy but has not been informed about the scheme. Her daughter-in-law, however, knows that Rs. 4,700 is given to women for working under MGNREGA. The family feels that Kade has been refused payment as she has more than two children.

The same village's Kamli received Rs. 4,000 under MGNREGA on her second child even though she never worked during her second pregnancy. Her husband worked during that time yet she received the money through the "*rozgar sahib*" (Gram Rozgar Sevak) of the village. She had worked for four to five weeks under MGNREGA for her first pregnancy though.

Bhago from Maragaon village and Susheela from Kumar Sadra village both worked under MGNREGA when pregnant but have no information about the scheme. Meanwhile, Sanki from Maragaon village worked under MGNREGA for a month each during her two pregnancies but had no information about the scheme. Her husband found out about it when she was eight months pregnant during her second pregnancy and had filled the form for it but it was cancelled. They have now approached the *sachiv* (secretary) who has promised to help them get the benefit. The above cases suggest that there was no information about this

[136] See Das (2013)
[137] See the Times of India news story (Jaiswal, 2013)
[138] See Daily Pioneer (2014)

scheme in Bastar district. Where as in Dhamtari some people have learnt about this provision under MGNREGA

In Madhya Pradesh, under Mukhyamantri Mazdoor Suraksha Yojana (MMSY) started in 2007 by the chief minister for daily wage labourers, women who are daily wage agricultural workers are entitled to receive Rs. 8,000 per pregnancy up to two pregnancies.[139] The amount is equal to six weeks' wage loss. The scheme also has a provision for a two-week wage compensation along with paternity leave for the husbands. Cash under the scheme is given to meet the expenses incurred on delivery.

The AWW at Jhadola village knows that Rs. 8,000 is given to women under a chief minister's scheme for only the first and second child. She informed that the information about the eligible beneficiaries for this scheme is collected by the *sachiv* (secretary) in the village and few women from Patel caste have received Rs. 4,000 from the IGMSY as well as Rs. 8,000 from the scheme.

Lalvati from Jhadola village also received Rs. 7,000 under the MMSY. When Shakun from the same village found out about the scheme, she gave money to a middleman to get all documents ready for it. The middleman asked for Rs. 2,000 bribe but she gave him only Rs. 1,000. Later, the family fought with him and she has not received any money yet.

While, there was awareness about this scheme in Sagar district and case were recorded where women received the benefit as well, in Chhindwara district there was no awareness about this scheme. However, awareness about parallel welfare schemes running in states for pregnant and lactating women would be beneficial for women, particularly those who are left out of IGMSY until it is expanded or excluded due to the age condition. Since condition of restricting the benefits up to two children exist under these schemes as well, like IGMSY, exclusion of many women is bound to happen given Madhya Pradesh's high fertility rate.

Conclusion

The interviews throw up many complex issues women face in accessing the AWCs. Rigidity in registering women's names for IGMSY only at their village's AWC emerges as a main reason that excludes many eligible women from the benefits of the scheme. If flexibility in registering under the IGMSY is not offered at the village level, then it limits its reach. In

[139] Interview with Block Medical Officer, Shahgarh district, Madhya Pradesh

remote villages and in hamlets within a village that are difficult to reach, mini AWCs can be set up that provide essential services to pregnant and lactating women. Frontline workers can also be used for delivering services at the doorstep, for instance, ASHAs can be used as points of delivering services where AWCs are difficult to reach. Stray cases were recorded from the field where the AWWs went to women's homes to register their names for IGMSY but these were only in areas where the houses were very close to the AWCs. IGMSY registration during field visits of frontline workers can be implemented as ASHAs, ANMs and AWWs all have regular field visits and they have to identify pregnant and lactating women as part of their larger roles under their respective departments.

It must be kept in mind that delay in accessing AWC lead to late registrations, which then leads to late account opening for IGMSY, delayed payments and late services from the AWC like THR, IFA, counselling and immunization. It also leads to excluding eligible women sometimes. To address this better coordination between frontline workers in required.

While the government officials from the women and child development departments[140] of states interviewed for this report stressed that there are no issues in coordination between the WCD and the health and family welfare department, the frontline worker have a different story to tell. The ANMs and ASHAs in many villages complained that the AWW does not share any details of the scheme with them. Many ANMs did not even know the name of the scheme or the amount given to beneficiaries. Better and regular training and IEC for frontline workers must be organised to orient them to not miss women eligible under the scheme. This issue is discussed in details in chapter 5.

Better connectivity to health care centres is equally crucial. Enhancing the ambulance services especially during night hours and improving connectivity till remote villages will make accessing health care easier and more feasible for women. For remote villages birth waiting homes should be established and with the help of ASHAs birth plans can be made for women to avoid any last minute long distance travel till health care centres.

Corruption at government health care institutions, post offices and at AWCs poses a barrier for women in accessing services from these institutions during pregnancy and after delivery. The interviews from all four states bring out the need for transparency and better monitoring of these centres of services. Corruption by frontline workers and their husbands with regard

[140] In Jharkhand, it is called Department of Social Welfare, Women and Child Development and in Bihar it is called Department of Social Welfare.

to JSY and IGMSY must be checked by roping in Panchayats and by creating sound grievance redress systems functional till the village level. The AWCs and the sub centres from where cases of confiscating passbooks, charging money for handing MCP cards and refusing THR are reported should be investigated.

Timely payment of JSY is also important for a number of reasons. JSY is supposed to be an incentive for institutional delivery, payments being made three months later defeats the purpose if the scheme. Even though all the delivery related expenses, including transport, are supposed to be available for free, we find that women spend a lot of money during this time, often having to take debt. Receiving JSY on time can also help in easing this burden.

High out-of-pocket expenditure also means high dependence on informal sources for loan. As mentioned above, families should be compensated for transportation to and from the hospital as per JSSK and cash payments should be made for JSY. Also, supply side gaps in public health care services must be met so that there is low dependence on private health care that is relatively expensive. Provision of free medicines in government health care institutions would also help households as spending on medicines emerged as one of the main expenses in the interviews.

Better monitoring and transparency is needed in implementing JSY and JSSK under the National Health Mission (NHM) where families must be compensated for the travelling expenses incurred in case they hire their own vehicle to reach hospitals for delivery. Paying for transportation cost till the village after getting discharged from the hospital or providing ambulance services till home is also a part of JSSK, which must be implemented.

Although, some of these issues are not related to provisioning of maternity entitlement under IGMSY, but are very important for women who are supposed to meet its conditionalities. Thus, accessing health care centres and AWCs is the only way through which women can access their entitlement. Not having access to these services negatively impacts IGMSY as women fail to meet the conditions. For the women, inaccessibility not just deprives them of basic services, but also becomes the reason due to which they can be denied their entitlement under the IGMSY. The aspects of access discussed in this chapter, combined with corruption and inadequate supply of basic health and nutrition services strongly suggests that basic entitlements, such as wage compensation during maternity, should not be tied with conditionalities for which the state does not have an impeccably functional infrastructure.

Woman breastfeeding her child in Jharkhand

5. IGMSY: Access and Issues

A range of issues exists with regard to the implementation of IGMSY. This chapter discusses these issues as seen in the states of Bihar, Chhattisgarh, Jharkhand and Madhya Pradesh. Challenges and gaps related to awareness of the programme, access to services, cooperation between implementers, absence of grievance redress and existence of corruption The analysis indicates that in its current form, the impact of the IGMSY is compromised due to both structural and implementation related challenges. The following chapter discusses these issues in detail.

Information and Understanding

Devanti lives in Lango, a remote village in the Dumaria block of East Singhbhum, Jharkhand. She belongs to the Santhal tribe and is one of the few IGMSY beneficiaries in the village. She received the IGMSY money for her first child. At the time of the interview she was with her mother at her natal home, her sick child lying on a charpoy. She did not know why she was chosen to be the IGMSY beneficiary. Devanti had little information on IGMSY and the conditions she was required to fulfil to avail its benefits. She was not sure of the amount she was entitled to receive. She did not know that she was "entitled" to receive this money. On being probed what she thinks was the purpose of the money she said, "IGMSY is given for food and nutrition because if I am healthy and my body is good then I can have another child." Her husband however was aware of the Rs. 4,000 they were supposed to get. He received this information from the ASHA. He said that for the Rs. 4000 to be received one needs a passbook. The money Devanti received was spent on treating the child's recurring illnesses.

Amongst Beneficiaries

Like Devanti, there were women across the sample who despite receiving the IGMSY cash, had limited understanding of the conditions and the provisions under the scheme. Roshni who lives in Bumro village, East Singhbhum, thought she was only entitled to a cash provision of Rs. 1,500 which she received when her child was three months old. Confusion regarding the amount of cash provision was also observed in Bihar where few beneficiaries mentioned expecting a different amount for IGMSY.

Unlike Devanti, who received the money, there were many who despite being eligible did not receive it. Amongst other reasons, absence of knowledge about the scheme led to exclusion of eligible beneficiaries. Ram Bai who is from Odisha married in Sagar, Chhattisgarh, had her second child in September, 2014 when she was above 19 years. She registered at the AWC in the fourth month of her pregnancy and has an MCP. She even had an account opened to deposit the JSY cheque she received. However, she had no information on IGMSY. She did not know if such a scheme existed. She did not know if other women in her

village registered for it or had received it. There were other women like Jamna who get excluded due to absence of information on IGMSY due to improper dissemination and awareness building activities in their areas. In Gauri's case, in PO Sukran, Jharkhand, she was registered at the AWC in the fourth month of her pregnancy. She got to know about IGMSY after her child was delivered. She filled the bank account forms for IGMSY when her child had completed three months already.

Misinformation on eligibility criteria of IGMSY was also commonly observed. Women, including frontline workers sometime, appeared to conflate conditions of other schemes with IGMSY eligibility criteria. At Jhadola, a village in the Shahgarh block located in Sagar in Madhya Pradesh, Shakun had been a beneficiary of IGMSY for her first child. However, she thinks she isn't eligible for IGMSY for her second child as she delivered at home. According to her, to be eligible for IGMSY, institutional delivery is a prerequisite just like JSY. In Chhindwara, Madhya Pradesh, Ramwati thinks that women who give birth to a boy are eligible for IGMSY and those who give birth to a girl are eligible for Ladli Lakshmi Scheme. She says she could also get the money if she gets sterilized after delivering two sons. She thinks the money is given so that she can eat nutritious food, like *ghee*, and also feed her son.

Barring a few cases where women were aware about the correct provisions under the scheme, women had similar stories as described above. The improper and erratic information amongst the beneficiaries about the scheme was also a result of low level of awareness amongst the FLWs and the inefficient counselling. Since the IGMSY is premised on the fulfilment of conditions for receipt of entitlements, it is essential that women be aware of the IGMSY provisions, as well as its conditions. The lack of such awareness and clarity regarding the scheme and its conditions, often leads to the exclusion of eligible beneficiaries, and the failure to demand all entitlements. Besides, the low level of awareness amongst the beneficiaries also leaves scope of corruption and the reinforcement of power dynamics between the IGMSY beneficiaries and the facilitators.

Amongst Frontline workers

Frontline workers (ASHA/ANM/AWW) are the primary source of information on various health issues and government schemes for women especially in excluded areas. AWW as the prime facilitator of the IGMSY is responsible for holding the counselling sessions, support and monitor fulfilment of conditions and for identifying eligible beneficiaries. ASHA and

ANM work in coordination with the AWW and fulfil health related interventions under IGMSY[141].

Eligibility criteria

The information on the IGMSY amongst the FLWs was mostly inconsistent and improper. They often seemed to conflate information on various schemes.

An AWW in Bihar, was unhesitant when she said that a three year gap between two children is required to be eligible for IGMSY. She added that if a woman has not received the money for the first child and has the second child within 3 years, then she can register her name for IGMSY. She said that she was informed of the three year gap from her supervisor which she had noted in her register. She later added that she uses the three years gap condition as a threat so that women agree to use Mala D, a contraceptive pill. Similar response was given by an AWW of the same block in Bihar. AWWs interviewed in Chhattisgarh also mentioned three year gap as the eligibility criterion of IGMSY.

An ASHA in Chhattisgarh, stated that IGMSY benefits only women with girl child. When asked from where she had gathered this information she revealed that she heard it from the others in the village. Even the AWW never informed her about IGMSY. She is told that unless the women get *panjikaran* (registered), they would not get the money. The Mitanin (ASHA) Trainer also had no information on IGMSY.

ASHA in Chhattisgarh mentioned that sterilization after two children is an eligibility criterion for IGMSY. She was informed it by the AWW and the Mitanin (ASHA) Trainer. She herself is a beneficiary of IGMSY and knows that Rs. 4000 is given. She thinks that the sterilization condition should stay as it enables her to pursue women to come for operations, who otherwise do not. She thinks that going for operation is important because

> *"Chhota parivar, sukhi parivar.Ab bacha kahat ke padhale dukarke, ab zayada bache toh kahan se ledu? Kam bacha rai toh sab ki poorti kar sakte, padhai likhai sab kar sakte hai.Ab zayada main kahan kar sakte hai?"*

[141] See (GoI, 2011b)

(Small family, happy family. Now-a-days children ask parents to send them to school. If the family has more children then how can parents get them all educated? If families have fewer children, then the needs of all members of the household can be met, children can be educated. How can this be done if families have more children?).

Misinformation on eligibility criteria leads to the exclusion of eligible beneficiaries from the scheme. Sterilization was also mentioned as a criterion for eligibility for IGMSY in Chhattisgarh and Madhya Pradesh. Some FLWs also thought that the scheme was targeted to the BPL families.

Purpose

The understanding of IGMSY as a provision for "wage compensation" or to promote rest during pregnancy was absent amongst beneficiaries. Many women who were interviewed comprehended it to be given for improving food and nutrition of the child. There were few who did not know why they were given the money despite being the beneficiaries. Discrepancy in the understanding of the purpose of the scheme amongst the FLWs was observed. For example, an ANM in Madhya Pradesh thought that the scheme was meant to promote sterilization and institutional delivery. AWW in Chhattisgarh was informed that the money is given for educating the children. "*Bacchon ko padhane ke liye, usko aage badhane ke liye milta hai, baarvi pass kara ke unki shaadi ke liye,"* she said (Money is for educating the children and their future, help them attain senior secondary education and get married).

Linking the scheme to improve the nutrition of mother and child was a common response amongst the FLWs too. Few also associated it to incentivize birth control. An AWW in Jharkhand mentioned that "*Maa jab kamzor ho jaati hai wohi paise se acha khaye piye"* (when the mother becomes weak she can use this money to improve nutrition). An AWW in Madhya Pradesh said that the money is given so that people keep smaller families. "If families are big then there is a shortage of food, clothes, soap, oil, everything. Large families have more problems. Medicines expenditure is more if there are more kids," she said. Similar response was provided by AWW in Amrita, Bihar.

There were only few cases where workers mentioned wage compensation and/or rest as the purpose of the scheme. "The women receive the money so that they can rest and do not go out for work during eighth-ninth month of pregnancy," said the AWW in Chhattisgarh. She further added, "Since the women received Rs.4,000 their husbands should not make them

work for wages. In total woman manages approximately Rs.10,000 to Rs.12,000 per delivery which also includes compensation under MGNREGA (Rs. 4,200) plus JSY money, so that she is not made to work by her family." The ANM in Madhya Pradesh, mentioned that the government is giving women wage compensation because women's participation in paid work is reducing. She said, *"Mahila mazdoori chhodh rahi hai, iske liye sarkar unki madad kar rahi hai"* (women are leaving daily wage work, because of which government is helping them).

The misinformation and the lack of information about the IGMSY cannot be attributed to inefficiency or incapability of the FLW. There were workers who had enough experience and qualified for their work but lacked clarity on the scheme. An AWW in Jharkhand, was known to be the best AWW across the villages in her block. She played an active role in mobilising women of her village for demanding ANM visits to their village. She was well aware of her roles and responsibilities. However, she also had misinformation on certain fronts about the scheme leading to the exclusion of the eligible beneficiaries in her village. "Only those women who have a gap of three years between their two children will receive benefits," she said.

However, the Officials seemed to be oblivious of this situation. One of the senior ICDS official in Bihar, attributed the misinformation on three year gap between pregnancies amongst the AWWs to the information circulated in *mobile kunji,* a small booklet for the ASHA on child care practices. The booklet advertises promotion of three year gap. This booklet was now to be given to the AWW as well. An official from the department of WCD, Chhattisgarh, informed that to promote family planning some districts (though it is not clear which districts) have put a three year gap between two children as a condition, but it is not a strict condition and nobody is being rejected IGMSY benefits for this. However, an AWW Chhattisgarh informed that such women have been rejected.

Record keeping

Clear and systematic record keeping enables better management of programme implementation in general, however in the case of a conditional cash transfer it is essential. Efficient record keeping allows for smooth processing of payments through tracking of condition fulfilment. It enables the administration to assess if behaviour change is taking place and finally it allows for transparent functioning of the programme through scrutiny.

The IGMSY guidelines issued by the MWCD stipulate a comprehensive system of record keeping. The primary responsibility of record keeping for the IGMSY is that of the AWW, ANMs and ASHA do not have a role in maintaining IGMSY records. The AWW is required to open a new register at the start of every year. Maintenance of this register and filling of Monthly Progress Reports (MPR) is her responsibility. The supervisor and CDPO is supposed to ensure this register is well maintained and kept up to date. The register is divided into three parts and two sub parts. Using these data state level IGMSY report is created. State level data goes through a series of consolidations at different administrative levels. Village level data is forwarded by the AWW to the supervisor. The supervisor consolidates data for her sector and sends it to the block. Here the CDPO consolidates it and sends it to the DPO. When the DPO receives data for all blocks in their respective district, the data are consolidated and sent to the state department. This district level data are used to get state level data. Through this process the CDPO and DPO use the data maintained by the AWW to consolidate quarterly and annual physical and financial progress reports. These reports are to be submitted to the State government/UT administrations, who forward a consolidated state level report to the MWCD. Formats for all prescribed reports were provided by the MWCD in the implementation guidelines.

Despite the clear guidelines regarding record keeping, no consistent system is being followed across the four states. As part of the research study IGMSY related documents were collected at the district and state levels. While scrutinising the documents we observed several discrepancies in the numbers provided. In one case we received the same figure for all years. In another case we received two documents that provided data on the same heads, however the figures differed. In still another case we witnessed a district level staff call up the respective CDPO and ask her to alter figures so that no discrepancies were visible. In the above stated cases of manipulation, the intent may not have been to fudge data. It however does draw attention to the need to scrutinise record keeping, consolidation and tallying.

Other Recording Keeping Related Issues

Some other issues that affect quality record keeping under the IGMSY are:

Provision of Registers

All AWWs are not being provided registers designed for the IGMSY. AWWs in Bihar and Madhya Pradesh reported receiving IGMSY registers on a regular basis. However register distribution in Chhattisgarh and Jharkhand was not as well managed. In Chhattisgarh AWW

in Dudhwara said that she had to buy registers on her own when they were not provided. AWW in Maragaon, Chhattisgarh did not receive any registers till 2012 well as AWW in Kumar Sadra, Chhattisgarh was provided registers only three months ago. In Jharkhand AWWs were not using any standardised registers. One AWW reported being provided an IGMSY register, however since she was not trained on how to use it she was yet to fill it out. In Jharkhand's Karmapani the AWW reported keeping a photocopy of the MCP cards, filling out four to five forms, as well as collecting bank account details but did not mention filling out an IGMSY register.

Inconsistent Record Keeping Requirements

The record keeping responsibilities entrusted to the AWWs differed across states and districts. In Chhattisgarh the AWWs reported having to maintain different number of registers. One stated she maintained six while another said just one IGMSY register is filled. The AWW in Dudhwara stated that she maintained a list of pregnant and lactating women (P&LW), the immunisations and ANCs they have received as well as a list of the beneficiaries receiving ready-to-eat food. The AWW of PO Sukran in Jharkhand reported not maintaining any paperwork for the programme.

Similarly the documentation submitted for payment of IGMSY cash transfer differed within and across states. In Maragaon, Chhattisgarh AWW sent list of IGMSY beneficiaries every month along with the details of account number, the conditions they have fulfilled and due instalment to the supervisor. Generally a list of P&LW, immunization received and their bank account numbers is provided to the supervisor. In Bihar the AWW in Amrita reported that until she submits details of tetanus and booster vaccines for the women IGMSY money is not released. This was different than the process followed in Jaisinghpur, Vaishali where the AWW had to submit only an IGMSY specific form to the CDPO. AWWs in Jharkhand reported having to simply submit to the supervisor the list of registered pregnant women. Additionally the AWW in PO Sukran said she has to sign an IGMSY form and submit it for each beneficiary.

Complicated Records and Improper Training

The complicated format of record keeping[142] leads to the improper and incomplete maintenance of records and unnecessary burden on FLWs. A district level official in Chhattisgarh stated "Our AWWs are illiterate. Some were recruited in the 1981-82 batch. So

[142]See Annex F and Annex G in (GoI, 2011b)

they face a lot of difficulty in compiling the register." He went on to say that the AWWs take help from educated girls and the supervisors to maintain records. Such a lax attitude from the district level official in charge of the IGMSY is visible in the training, or lack thereof, in record keeping.

Some AWWs reported being provided training on record keeping and filling of IGMSY registers, while others received none. Even where training had been provided, there were inconsistencies and information gaps in record keeping. AWW in Kendua, Jharkhand, mentioned that she doesn't know how to fill the new registers which she has been given. The supervisor says she will teach her but it has been four-five months since she has got these registers.

State level officials' responses reveal that the situation was different in different states. An Officer from Social Welfare Directorate, Jharkhand mentioned that there is no specific budget for training of FLWs. There is an overall three percent allowance for IEC from which they use money to facilitate training at district and block level. Block level training included training the supervisors and *anganwadi* cluster leaders.

A possible reason for misinformation and conflated schemes seem to be stemming from the non-exclusive training of IGMSY. AWW in Patepur, Bihar, informed that it was in 2012 she attended training at the block health centre (Patepur) where trainers from Patna had come. The training was not specifically about IGMSY. In the training she recalls being told about family planning and three year interval between children but nothing on IGMSY.

District Program Officer at Bastar, Chhattisgarh, said that once in a while some selected supervisors and CDPOs are sent to Raipur for training. However, there are no special trainings for IGMSY for the AWWs. They are provided information on IGMSY by the supervisors in their sector meetings. He informed that even the orientation programme for IGMSY was not conducted well. The District Programme Coordinator in Sagar, Madhya Pradesh, informed that IGMSY training had been conducted for health and ICDS facilitators together in 2011-12. The IGMSY districts organised it as per the state's direction. The training included the Chief Medical Health Officers, Block Medical Officers, Supervisors, ANMs and AWWs. He did not mention any other training at the district or state level been conducted.

Given the absence of focused trainings of FLWs, they found it hard to recollect information provided in the trainings. AWW in Chhindwara informed that only one training has happened so far in which she was told everything but she found it hard to recall anything. Similarly, ASHA in a Jharkhand village reported that training had been conducted at block level at the SHC and PHC. But this happened long back and she does not remember what was covered in the training.

The current standard of record keeping defeats the purpose of record keeping. It prevents an understanding of coverage and access. It makes it impossible to monitor and identify shortcomings. Most importantly, it prevents the transparent functioning of a programme. Absence of exclusive training on the scheme creates scope for confusion regarding the provisions and eligibility amongst the workers. Also, record maintenance suffers which leads to a cycle of delayed payments.

Overburdened Frontline Workers

AWWs are expected to manage the overall functioning of the scheme at the village/ward level. Their primary duties with respect to IGMSY involve ensuring early registration of beneficiaries, checking fulfilment of conditionalities for each beneficiary using the MCP card, IGSMY register and growth monitoring register, to support beneficiaries in opening accounts whenever required, to ensure regular supplies of MCP cards, vaccinations so that conditionalities could be met and most importantly counselling the women. All this is to be done in close coordination with ASHA and ANM[143]. An official in Bihar stated, "Agar *AWW IQ istemal karke theek se identify kar leti hai…kyuki uska kaam yehi hai...ANM and ASHA ke sath...yeh uska regular duty hai...inke kaam se hatt ke kuch nahihai...jinka regular dekh bhaal karti hai unhi ka benefit dena hai"* (If the AWW uses her IQ and identifies the beneficiaries properly…this is her work…along with the ANM and ASHA…this is her regular duty…this isn't extra work…she has to provide further benefits to the women she looks after on a regular basis).

However the opinion amongst any AWW was different. "Officially an AWW has to work for four hours from 9 A.M to 1 P.M in a day," said an AWW in Bihar. An AWW in Bihar, on a usual day works for almost eight hours at her centre as she needs that time for extra work like filling out registers. She said "IGMSY has increased my responsibility. Now I have to open accounts, fill registers, conduct two *Mahila Mandals."*

[143] (Ibid.)

Another AWW in Chhattisgarh said that besides her daily chores at the AWC, she spends two hours daily to maintain all her records. These records are updated on weekly basis. She said her work has increased with IGMSY. She now has to maintain more registers. There are about three-four registers which she has to fill for IGMSY.

AWWs stated that after pre-school education timings, they have to fill registers. AWWs reported having to fill upto 11 registers in total including IGMSY. This unmanageable amount of work combined with low honorarium provides little incentive for quality record keeping.

AWWs are supposed to receive Rs. 200 per beneficiary for IGMSY after all the cash transfers are completed.[144] AWWs in Chhattisgarh, Dhamtari district, received Rs. 200 when beneficiaries receive all the instalments for IGMSY. AWWs interviewed in Bastar had not received any incentive. In Bihar, most said they receive the cash incentive in their bank accounts. AWWs in Madhya Pradesh, and Jharkhand informed that they did not receive the incentives and those who did, received less than the sanctioned amount. An AWW in Dhabar Madhya Pradesh did not know if she is supposed to receive any incentive for the IGMSY.

Counselling

Counselling forms an important part of the curriculum of all the FLWs. Under IGMSY, AWWs are required to ensure that all beneficiaries are counselled and it is a condition for all three instalments. In total, a mother is expected to attend at least five counselling sessions at the AWC during VHND or home visit done by the AWW, spread over a period of nine months. During counselling women are informed on issues related to health and child care. Post-delivery IYCF counselling is to be conducted.

Counselling women to increase awareness about good health and nutrition is crucial for the success of the IGMSY. Many AWWs informed that counselling sessions are organised at least once a month. Some had it on fixed days of the month while others they fixed the dates in the previous meeting. AWW in Navri Tola informed that she conducts counselling on fourth Tuesday of every month. If for any reason it gets cancelled she conducts it on the first Tuesday of next month. AWW in Jhadola conducted it on the immunization day when the ANM visited the village.

[144] (Ibid.)

In Jharkhand meetings were held once a month on VHND. AWW in a village mentioned that the only time counselling is provided to women is on VHND. The VHND is attended by the ASHA, the ward members and women residents of the village. The women are provided information on timely vaccinations for mother and child and filling of IGMSY form by second trimester. In Jharkhand women were distributed THR on VHND. An AWW said "even those who live far from the AWC are covered because they send a word to them about the VHND/THR day". There were no separate counselling sessions for pregnant and lactating women

There were cases where there were no fixed days for conducting counselling sessions. AWW in Chhattisgarh informed that she does not hold separate sessions for counselling. Women were counselled when they came to collect ready-to-eat food packets every Tuesday. Similar response came from an AWW in Bihar who said that there are no fixed days for these meetings. She informs women about the meeting and women from far also come if they are informed. This hurried and unstructured dissemination of information is resulting in communication gaps and low recall of information amongst the women.

Meetings were generally organised in the afternoon and they extended for an hour-and-a-half. However, mothers mentioned that it was hard for them to attend these meetings because of their busy schedule. A beneficiary in Agma village, Bihar mentioned that she could not attend the meetings because of work despite knowing about them. Similarly in Chhattisgarh, Susheela who was an IGMSY beneficiary said that meetings happen at the AWC but because of work she is unable to attend them. During pregnancy, she worked in the fields till her delivery and resumed work after 15 days of delivery. She had only been to such meetings two- three times. She said that "they tell us about children related things" but could not recall what information is provided.

In Jaisinghpur, Vaishali a mother said that there are meetings but she does not go because she does not see the purpose in going there. *"Kuch laabh milta toh laalach se jaate"* (if some benefit was given, then would have gone for that), she said. She did not feel that she gained anything from these meetings.

In Chhattisgarh women reported that they did not attend sessions because either they did not have access to the AWC services or did not know when such sessions were organised. Om Bai who belongs to the *Madhiya* tribe in Bastar said she doesn't know that these sessions are

held at the AWC. She said even the ASHA does not come to her side of the village. Of those who attended counselling, most were provided with incomplete information. Most of the information provided in these sessions were on immunization, nutrition, hygiene and childcare. Information on EBF is not provided clearly.

On Exclusive Breast Feeding (EBF)

Under IGMSY, counselling on Infant and Young Child Feeding (IYCF) practices and care during pregnancy is to be provided to the beneficiaries with focus on EBF and early initiation of breastfeeding. IYCF counselling is an important part of the scheme. Women have to attend at least four of these sessions post delivery in order to be eligible for the last two instalments of IGMSY.

However, not all women were practising EBF in the sample interviewed. There were many cases where women could not EBF as they felt they could not produce sufficient breast milk. Some could not practise EBF because they leave children at home when they went on fields for long hours. AWW in Jharkhand mentioned "women cannot feed on time when they are at the field or are collecting firewood. Some women have to take along small children". But there were many cases where mothers were not aware about correct practices of feeding.

Despite attending counselling sessions women did not have information on EBF. Women mentioned not being informed of these practices. Devanti at Lango village, in Jharkhand informed that at the counselling she was advised to eat fish and meat during pregnancy, i.e. to improve her diet but nothing about child feeding practices. Also, Information regarding EBF[145]was sometimes not clearly communicated to the pregnant women. A beneficiary in Agma, Bihar introduced water from the start and complimentary food from the third month to her child. When asked the reason for doing it she said that the AWW informed her to "give the child everything from the beginning." Such misinterpretation or inefficient communication does not provide any benefit.

Sarawati Devi at PO Sukran village, Jharkhand, introduced water after two-three months and complementary food (biscuits) before six months to her child. She started giving proper food including rice, pulses, and vegetables when the child was six months old. Even though she

[145]As defined in the Implementation Guidelines of IGMSY. 'Exclusive breastfeeding for the first six months means that for the first six months of life the infant receives only breast milk and nothing else (no food, drink or water) but allows the infant to receive ORS and vitamins/mineral/medicine as drops or syrup. Babies who are exclusively breastfed do not require additional food or fluid, herbal water, glucose water, fruit drinks or water during the first six months. Breast milk alone is adequate to meet the hydration requirements even under the extremely hot and dry summer conditions prevailing in the country'(GoI, 2011b)

was told to give food after six months she was not informed when to introduce water. Similar response was received from another woman. Kaushila, in Bumro, who had attended counselling sessions at the AWC introduced complementary food (biscuits) when the baby was six months old, but water was given to the baby on the fourth day of birth due to dry weather as she felt that the baby must be thirsty.

Not feeding solid food for six months appeared to be a common understanding of EBF. As a result several instances of giving water and other liquids like cow's milk, sugar water, traditional mixtures of herbs, to the infants within six months was observed. Additionally, several mothers informed us that they discarded colostrum before breastfeeding their child.

A 40 year old ASHA in Jharkhand has been at this post for five years. Her responsibility is to bring women to the AWC for registration. She also counsels them. She had no information on IGMSY. She does not have information on EBF. According to her the child should be provided water after a month and be fed complementary food at the age of one and a half months. She last underwent training a year back and couldn't recall what all was covered under it. She mentioned that it is hard for her to remember what she is told in the training. Even though no such cases were encountered where FLW had no information on the scheme and had misinformation on EBF this case highlights the need to conduct regular and effective training sessions amongst the workers.

IGMSY as a conditional cash transfer scheme aims to promote rest and increase the demand for health services by creating incentives for the mothers. However, to create such an impact strong awareness campaigns and effective techniques of information dissemination need to be implemented. Overall the knowledge on the scheme is low and it reduces with the administrative level. Proper information is important not only for the mothers who can claim their demands but also amongst the frontline workers who are the primary facilitators of the scheme. Lack of awareness and misinformation amongst the FLWs also creates possibility of exclusion of the eligible women. This accompanied by poor knowledge on record maintenance is symptomatic of ineffective and inadequate training of the FLWs.

Access and Exclusion

In addition to the general access issues discussed in the previous chapter there are certain IGMSY specific issues which lead to the exclusion of women from receiving the benefits.

Late Registration

A woman is required to register at the AWC within four months of pregnancy, or provide a reason for the delay to get registered in order to be considered an IGMSY beneficiary.

In Madhya Pradesh and Chhattisgarh women were being registered without any deadline. However, In Madhya Pradesh a worker reported that some women have missed their first instalments in that case. AWWs reported registering women even after the delivery till the child is six months old in Bihar. However, even though mothers who were refused registration for IGMSY for coming late were not encountered, few AWWs mentioned they do not register women if they come late. ANM of Dhabara, Madhya Pradesh mentioned failure in early registration leads to the exclusion of women from IGMSY.

Different practices were followed by different AWWs. An AWW in Bihar informed, "Women must register for IGMSY by the fourth month. Some come in the sixth month also". She registered women up to the sixth month of pregnancy but not women coming after that. AWW in Jharkhand mentioned only those women who register within three months of pregnancy get the IGMSY. *"Jo chhe-saat mahina mein karta hai uska nahi karte"* (those who come in sixth-seventh month she does not register them), she said.These women get all services such as vaccination from the AWC but they do not receive IGMSY cash.

Given the strenuous labour of paid and unpaid work women do in rural areas even throughout their pregnancies, keeping a limited time for registration would only exclude women from getting the IGMSY benefits. Issues of access due to location and distance also contribute to the delays that can happen. Also given the poor information amongst the women, such conditionalities would unnecessarily lead to the exclusion of eligible beneficiaries (access and women's work have been discussed in previous chapters).

Eligibility criteria and Opinions

The eligibility criterion of restricting benefits to women who are 19 or above with up to two children, leaves scope for exclusion of a considerable number of women from IGMSY. The instances of those getting excluded belonging to poor socio economic groups, were also high. One reason is that the two child criteria does not take into account the existing social and cultural practices of various communities. The incidents of exclusion amongst the marginalised were also mentioned by the AWWs.

AWWs in Jharkhand, informed that the *Sabar* and *Ho* were the most deprived in their village. They have the least land holding and are quite disconnected from rest of the residents. An AWW in Jharkhand, specifically mentioned that "As a result of the IGMSY exclusion criteria no Sabar women have received IGMSY because they have early pregnancies – they have babies before they are 19 years old. They marry as young as 11 to 12 years and get pregnant at the age of 13 to 14 years." Besides the 19 age criterion, the two child norm also led to exclusion of many women.

Sarita lives in Kendua, a remote village in the hilly terrain of Dumaria block in East Singhbhum. She belongs to the primitive tribe Sabar. She was married 10 years ago and could not recall her age. Since marriage, Sarita has had five pregnancies of which only three children survived, all girls. The eldest is seven- eight year old, the second is a six year old and the third, a one year old girl named Sunita. Sarita's husband died last year of tuberculosis (TB). She lives with her three children and elderly father-in-law who also has TB. He said that they do not have their own land and he is the only other member who can earn. He also mentioned that he was not capable of doing tough physical work anymore. She manages all household work like fetching water and firewood alone. She works on others' land for which gets five kilograms of rice per day. Sometimes she gets cash too but a very small amount. During her last pregnancy she worked till the day of her delivery. Her youngest girl Sunita was delivered at home. After delivery they incurred an expenditure of Rs. 400 to Rs. 500 on medicines for which they drew money from some previous savings. The father in law informed that they do not take loans as nobody gives it to them.

Sarita is not an eligible beneficiary for IGMSY as Sunita is her third child.

"It is not uncommon for women in this village to have more than two children", informed the AWW in Chhattisgarh. She said, "because of the two child norm, many women get left out. Since 2010, about 25 to 30 women are left out...Sometimes women keep delivering because they only have girls."

Another AWW in Chhattisgarh informed that "in the past four years there have been 20 pregnancies in her village. Among these 16 were beneficiaries for IGMSY. Among the four left out three belonged to Kamar tribe and one to a Patel family. The reason for exclusion of Kamars was that they have more than two children...*nasbandi* (sterilisation) is not allowed in Kamars as they are PVTG". Such cases problematize the contradiction in the existent government policies related to family planning amongst the PTG in Chhattisgarh.

Whether keeping such eligibility criteria is effective and justifiable is another question. On being asked about the perspective on the eligibility criteria different responses were received. The difference was more peculiar amongst the field level workers and higher administrative staff. AWW in Chhattisgarh felt that these women should get the money, "The women should get the benefit irrespective of the eligibility condition under IGMSY". However, she wants the other conditions such as immunization, counselling session, ANCs and PNCs to continue as then women come for immunization. She thinks that these conditions should remain, but to include the excluded communities, she suggests that even these conditions should not be strict." She mentioned that women who have more children are not getting benefits and therefore they do not abide by the other conditions as well. For instance, they will not come for immunization on time as they feel that they will not receive any money.

AWW Dudhwara also felt that all women should get money for all deliveries. "If the baby dies immediately after delivery, women get only one instalment. They should get full money as women have to take care of themselves. Needy women get left out. All women should get money for all pregnancies." Other FLWs resonated similar views. Most said that the poorest people are left out because of the eligibility criteria.

However, the State officials seemed to be disconnected with the above mentioned issue. An official of the ICDS department in Bihar said that "eligibility criteria do not lead to exclusion. They haven't received this issue in any meeting or report. No group or community has reported issue of exclusion." According to the official, age criterion should remain. "*Chhootte bhi toh koi nahi* (Even if people are left out because of this, it is ok.). If we allow women below the age of 19 to be included then we will be contradicting other government policies. We would be promoting early marriage also," said the official.

An official from the Social Welfare Directorate, Jharkhand who handled all the IGMSY related work from the initial phase of the scheme mentioned that removing eligibility criteria

would encourage higher pregnancies and more children. On the conditions associated with the instalments she said that women do not find it difficult to meet the conditionalities. They often learn from the other women of the village that the conditions must be fulfilled in order to receive benefits. The official stated that people are left out of the scheme but "they are not from a particular group." She does not advocate the removal of conditionalities because she feels there will be no incentive to adopt good practices in the absence of such conditions.

Similar views were upheld by the CDPOs in Jharkhand. They said no conditionality is tough to be met but if a woman goes to her natal home then she would not be able to meet them. However, if an AWW writes that the woman has been registered under her and is getting immunized then she adjusts in that case. They felt that conditionalities are good. According to them the purpose is being fulfilled, people are getting weighed and are immunized timely.

Assistant Director, Chhattisgarh said that "Chhattisgarh has a family planning mandate. It follows the two-child norm. It cannot incentivize women who have more than two children. Given the existing conditions, 40 per cent of women will be excluded from receiving benefits in Bastar. Women with more than two children are mostly excluded." With respect to the two child criterion he states, "The state sometimes needs these kinds of pressures (two child norm). However, we only stress on this condition, but give the money anyway. Conditionalities are not a barrier. We cannot go against our own mandate."

The conditions and the eligibility criteria are part of the structure of the scheme. If such targeting and conditionalitites lead to the exclusion then a re-evaluation is necessary. Additionally, if the excluded are those who are vulnerable and need such benefits then it thwarts the purpose of the programme. The targeting is problematic as it excluded those for whom fulfilling these conditions is a challenge. Women who fail to fulfil these criteria are mostly those who live in the remote areas, visit natal homes for delivery, migrate frequently for work, have more than two children and undergo early marriages. These women also suffer from poor healthcare practices and high mortality rates. If these women are excluded from the scheme, the scheme would fail to bring any positive impact in the lives of those who it claims to target. The contradicting views of the AWWs and the State officials on the eligibility criteria bring forth the issue of lack of coordination between the field level and administrative staff.

Vision and Reality

Pilot and Evaluation

IGMSY was introduced as a pilot scheme in 53 districts to draw learning from pilot and use them in up scaling. The districts were chosen on their composite score based on six maternal and child health indicators.[146]

An order was passed on 1.12.2010 by the Ministry of Women and Child Development (MWCD) directing the States and the UT's to conduct the baseline survey for this new scheme. The order stated "The Base line Survey of Pregnant and Lactating Women (P&LW) was meant to help the State / UT identify and list every P&LW in the area of the AWCs where IGMSY was to be implemented."[147]

The District Programme Coordinator of Chhindwara, mentioned that baseline was conducted in December 2010. Its purpose was to "find out how many women in the district are eligible to fit under the conditions of IGMSY. The women who fit under the scheme are the ones who have two children as on 1.1.2011, those who are not in government service or are not wives of men who are in government service. If they are either pregnant or have babies then they fit under the conditions. WCD conducted this survey. The purpose was to find out women who are in their first, second and third trimester."

The baseline designed by the MWCD does not record any information which could provide a base against which progress could be monitored during and after the implementation. Such an understanding of baseline obscures the vision of the pilot which is to draw comparisons and reason out the failure or success of the scheme in different districts with different indicators, capacities and infrastructure. Learning from the pilot would have helped in dealing with the implementation issues during scale up.

In Bihar, an official informed that districts were chosen by the Central Government and intimated through the guidelines. There was no information provided to the states on the basis of selection of districts. Baseline survey was done after Cabinet approval in December 2011. No prior consultation was done on that. She said that implementation guidelines are given to the CDPOs and they chose the beneficiaries using their records. In Jharkhand, no baseline

[146] See IGMSY Guidelines (GoI, 2011b)
[147] See letter D.O.No.9-5/2010-IGMSY from the Ministry of Women and Child Development, Government of India.

survey was conducted, an official from the directorate reported. They used the ICDS lists to select women eligible for the scheme. "The AWW sorted out the women who were under 19 or had more than two children and submitted the list to the Lady Supervisor. The lady supervisor further consolidated the lists at her level and sent it to the CDPO who in turn consolidated and sent the block list to the DSWO," she explained.

In states where the ICDS list was used and no baseline was done to count the number of eligible beneficiaries, there stands a chance of carrying forward the exclusion under the ICDS. Thus, those who were excluded from the AWC services would continue to be excluded under the scheme. The aim of the pilot is also lost when no concurrent evaluations are done. The implementation guidelines mention carrying out baseline and endline surveys to assess the effect of the scheme. Only one evaluation study has been conducted by the MWCD in consultation with Administrative Staff College of India (ASCI) on IGMSY so far. However, it does not seem to have been used for any revisions nor has it been shared publicly. No recent evaluation by the government has been commissioned.

IGMSY Cash and Wage Compensation

Under IGMSY, women are entitled to receive 40 days of compensation at Rs. 100 per day.[148] This amount is the minimum support women could receive for lost wages during pregnancy.

Sukurmuni in PO Sukran village, Jharkhand does paid agricultural labour. Her typical work day begins at 8 A.M. and ends at 5 P.M. including a two-hour break. She is paid Rs. 70 for a day's labour. Sukurmuni did not do paid work during pregnancy. She resumed working on fields from the third month of delivery. She informed that she wanted to rest more but she had to begin doing paid work as there was need for money. According to her, her total wage loss would range from Rs. 7,000 to Rs. 8,000. She received the IGSMY money when her child was one and a half year old. The money was then spent on household expenses.

Sukurmuni received her partial wage compensation of Rs. 4,000, however, there were many women who reported receiving less than that. Women in all four states reported getting different amounts ranging from Rs. 1,000 to Rs. 4,000 as IGMSY money. The reason for not receiving the entire amount varied from case to case. Shakun received Rs. 3,500 as IGMSY money from the AWW in two cash instalments of Rs. 1,100 and Rs. 2,400. There was no

[148] See (GoI, 2011b)

entry in her passbook. (The bank account number mentioned at the AWC did not match with the number on the passbook Shakun had with her. She said she has no post office account). The AWW had told Shakun that she would get Rs.4,000, but at the time of handing over cash she told her that Rs. 500 was spent on paper work.

In Jharkhand, Madhya Pradesh and in Dhamtari district of Chhattisgarh there were many cases where women reported receiving less than the sanctioned amount. Some did not get it because of corruption and some because there was lack of funds. Many women did not know the reason of not receiving the full claim. Women who had bank accounts had not received payment for extended period of time. The AWWs in Jharkhand were informed by the supervisors that there were no funds. While in Chhattisgarh, an AWW informed that her supervisor took the money and left. Of those who received IGMSY payments, the amount received barely compensates the lost wages.

Lump sum Vs Instalment

The logic behind giving the cash in instalments was to provide a constant flow of income for basic security at various stages of pregnancy. "The three instalments and amounts were worked out such that the beneficiary gets a reasonable amount every three months after the second trimester of pregnancy up to six months after delivery (including the JSY tranche)."[149] Barring Jaisinghpur in Bihar and Madhya Pradesh most women reported getting money in lump sum.

Women considered lump sum being more useful because it serves as a backup and could even be used to repay loans. Also at places where access to banks/post office was an issue lump sum is preferred. In Maragaon a woman preferred lump sum as she could then save Rs. 200 to 300 for each trip to the bank. Beneficiaries in Bihar also resonated this view.

The uncertainty of receiving the full IGMSY amount was also the reason for some to prefer lump sum over instalment. A non-beneficiary in Lango, Kashti had a 10-day-old child, had a bank account and was registered at the AWC and yet had not received any instalment. She said that she would prefer getting the full amount in lump sum as then there would not be any fear of not getting the full amount. Sushela Dhuru, Maragaon, Chhattisgarh, thinks it would be better if she gets the amount in lump sum because one visit costs the couple Rs. 100 and it would also save their time.

[149] (ibid. p. 7)

Those who preferred money in instalments reasoned that it is easier to save it and not spent it in one go. "*Ek saath milega to ek saath lag jayega*," (lump sum will get spend in one go) said Sapna Bai, Navri Tola, Chhindwara. She wants the money in instalments because otherwise all the amount will be spent in one go. She later added that her husband might spend it on tobacco and alcohol.

For some getting the money was more important no matter in which form. Ram Bai, a non-beneficiary from Dhabara, Sagar, said it does not matter if it is lump sum or instalment, important is that she gets her entitlement.

Concept of Rest and Delayed Payments

"The Scheme aims to provide partial compensation for the wage loss so that the woman is not under compulsion to work till the last stage of pregnancy and can take adequate rest before and after delivery", according to the guidelineds.[150] The money received under IGMSY, whenever and in whichever form, was important and helped in reducing the overall economic burden of the beneficiaries. But, whether it helps in providing rest during pregnancy, is doubtful.

Saro in Karmapani, received money six months after delivery. She spent it on clothes, rice and vitamin. Another beneficiary bought a bull for Rs. 4,500 out of which Rs. 2,000 was IGMSY money. Some used it for loan repayment while others handed it over to their husbands for household expenditure. Money was also used to treat the child's recurrent illness. Devanti, a beneficiary at Lango said, if they did not receive IGMSY money they would have cut down on other expenses. However she felt that the IGMSY does not affect how much rest a woman takes after delivery.

Women who were IGMSY beneficiaries continued to work till the end of the pregnancy and started working shortly after delivery (as seen in chapter 3). Amongst other reasons delayed payments seemed to be one of the impediments to it. Instalments were designed to keep a consistent flow of income to the women from the end of the second trimester till the baby is six months old. Of those women who received money in instalments the amount never came on time.

[150] (ibid., p. 5)

The case of Deewad in Korangali village, Bastar, who has a three-year-old child and has till date not received any instalment, reveals the extent of delays happening. There were other cases where women received two instalments together when the baby had crossed six months and those where full amount was not received even after three years.

Ramwati in Navritola, Chhattisgarh got the money eight to nine months after delivery. She said "*paise mile to sanwar gaye"* (the money made life easier).

An AWW in Jharkhand informed that on an average the IGMSY money is received only when the child is approximately 10 months old. The AWW attributed this to delay to both parties the government and the eligible women who do not try to open the account on time.

Concern on delayed payment and purpose of the scheme was also expressed by the Joint Director at WCD, Madhya Pradesh. He said, "The delayed payments are an issue due to which the purpose of the scheme is getting defeated." He also stated that, 'personally he doubts that cash transfers are used for the purposes they are given for. Beneficiaries first spend the money on clothes and other things, and at last on food. Food is her last priority'. But, he added that an evaluation would make things more clear.

Box 5.1: Responses of FLWs on IGMSYs impact on rest and nutrition

AWW in Jharkhand: It doesn't help in behavioural change.

ASHA in Jharkhand: There is no impact because women spent the IGMSY money on clothing and household expenses.

ASHA in Chhattisgarh: Women are more aware but because of overall health intervention not because of IGMSY alone.

ANM in Madhya Pradesh : No contribution to women's rest

AWW in Madhya Pradesh: Rest practices have increased after IGMSY. "*Sun sun ke zayada bache par dhyan deti hai. Pehle to bache ko khet main luta luta ke kaam karti hai, ab nahi karti mahila"* (the mothers have started focusing on children after counselling. Before they used to take their children on field while they worked, now they do not).

AWW in Jharkhand: Yes it contributes to nutrition in the sense that when the woman feels weak she can purchase tonic, however rest is not impacted. Women have changed their behaviour because they receive information and money under this program.

AWW in Bihar: Rs.4,000 helps as now women have only two children. *"4000 se fayeda hai ab bus do hi bache janma hai"* (Rs 4,000 helps now, women have only two kids).

Exclusive Breastfeeding

IGMSY conditions are designed to promote appropriate practices and increase service utilisation. Keeping them as conditions, however, does not necessarily guarantee improvement in the demand for services or bring behavioural change unless beneficiaries are well informed and have no barriers in accessing services.

Encouraging women to follow (optimal) Infant and Young Child Feeding (IYCF) practices including early and exclusive breastfeeding for the first six months is one of the objectives of the scheme. As has been discussed before, from the sample covered for the study, women were not practising EBF as most reported giving water before six months. There were other reasons than just lack of information. Deewad in Maragaon village in Dhamtari reported that she had to come back from field every two hour to breastfeed her two month old child. Not producing enough milk was reported by many. Frontline workers however felt that EBF had improved from before, but not all agreed that it is because of IGMSY. ANM in a village in Madhya Pradesh, said that "EBF can be increased only by spreading awareness. But this scheme helps her in convincing and influencing women to do EBF." She thinks behavioural change has not happened in all places. The AWW of the same village felt that women began doing exclusive breastfeeding for six months after the AWC opened, "earlier they used to give cow's milk as well." She said now water is given after six months. However, she doesn't attribute it to the IGMSY.

In Chhattisgarh too, FLWs felt that EBF practice has improved but not because of IGMSY. General awareness among women has increased and lots of schemes together have made it possible. In Bihar an AWW stated that women began EBF only when they were informed and told to do so. She attributed the improvement in EBF to the combined efforts of organisations working for the poor in building awareness. She said "various organizations like CARE helped. It was in 2004 that imparting information on EBF started." ASHA in Jharkhand, also said that EBF improved as a result of the meetings at AWCs not particularly because of IGMSY.

Growth monitoring and Ante-Natal Check-up

Growth monitoring of children was not regular across the four States. Only the weight of the child was reported to be measured at the AWC. In Jharkhand, mothers reported that their

children were weighed when they went for check-ups. There was just one case in which the height of the child was measured. Similarly in Chhattisgarh and MP, children were weighed, however no record of height was maintained.

In Madhya Pradesh, women went for ANCs only when they faced problems during pregnancy. In Navritola, Sapna, who is also a beneficiary of IGMSY, never went for any check-ups to the AWC despite having swelling. She had never been to a hospital. Instead she visited Jamundonga (main village) when she needed medicine. The doctor at Jamundonga was reported to be unregistered by the villagers. Also, there were some cases where women's weight was recorded during pregnancy but not all had check-ups.

ANCs are supposed to be conducted at the AWC by the ANM when she visits for immunization. In Chhattisgarh, women reported that they went for ANCs but at nearby government hospitals and not the village's AWC. In most such cases they only went if they had complications or any illness during pregnancy.

The MCP card is used to record details of immunization and check-ups. These are supposed to be used as a means of verification of fulfilment of conditionalities. "The AWW and the ANM are to ensure that the MCP card is provided to every beneficiary and required information is filled in this card, timely."[151] However, Bihar and MP recorded shortage of MCP cards. In the case of shortage they either printed the cards or used a temporary slip or register to keep the record of registered women.

The ANM in Jhadola, Madhya Pradesh informed that she has no stock of MCP cards and has to use old cards. She received 22 cards for eight villages in April, 2014. There was a shortage. She had smaller immunization cards. Similarly, the ANM in Jharkhand also said that there used to be MCP shortage – when there was a shortage they entered the descriptions in the registers.

The MCP card acts as a tracker not only for the FLWs but also for the mothers. However, not many women knew the information it contained. Despite the self-descriptive images on the card, only few were able to tell what information it records. For example, Pramodini Yadav in Madhya Pradesh, is from Odisha and could not understand Hindi. She said she does not know what the card is for. Shakun, only knows that she will get the money if her card is

[151] (ibid., p. 6)

filled. Anita Bai said that it is to be taken when she goes for immunisation, but doesn't know the purpose.

In Bihar and Jharkhand most women did not understand what was recorded in the card. Lalvati in Madhya Pradesh, was given a card but the AWW took it and did not give it back. When she asked the AWW for her card she was told that more cards were not available. The immunization was done without making any entry in her card. In another case the woman had received an MCP card only for her elder child.

Corruption related to MCP was reported in Bihar which deterred demand for MCP by women. These cases have been discussed in chapter 4. Among those who had an MCP card, most were not regularly updated. Even though no proper checking was done in this regard, but few cases highlighted this issue. The mishandling of MCP was also brought out in few cases. Women also reported losing their MCP cards. Such mishandling of MCP cards disrupts regular monitoring of the service utilization. In addition, there were cases of delays in providing MCP cards. In Agma village, Bihar, Girija Devi received the MCP card after her child was born.

According to the implementation guidelines, MCP card can also be used to receive IGMSY benefits even if all services are not received from the AWC where the woman registered. In such a case a woman can show the filled MCP to the AWC where she had registered to avail the IGMSY benefits. Even though no case of denial of IGMSY benefit to the beneficiary in the absence of an MCP was recorded, the improper management of the card, supply shortage mentioned by few AWWs, corruption associated with it and the irregularity in updating it, problematizes issues of keeping a growth tab and maintaining records.

IFA and Vaccinations

Except in Saharsa, Bihar, women reported receiving IFA tablets during pregnancy. However, not many women who reported receiving IFA, consumed it regularly. There were few cases where women reported feeling nauseous after taking IFA and thereafter stopped the consumption. The ANM in Jhadola informed that in her village women consume IFA on an empty stomach which causes vomiting and as a result they do not take it. She informed that a woman is required to consume 200 tablets in a year, especially those who are anaemic. AWW in Madhya Pradesh said that some women complain about the side effects, but she tells them to take IFA tablets because it improves haemoglobin.

There was a case where women did not consume IFA because she thought it might cause problems in her delivery. In PO Sukran, Jharkhand, Devanti did not consume IFA because she was afraid of having an overweight child. She received IFA twice and consumed them all. However, she did not ask for more tablets because others also did not eat and said "*Paet mein badha bacchha ho jayega"* (the child will become large in the womb), implying a difficult delivery. Soni Devi in Baligaon said that she got the IFA, but *"Paet mein garmi thi toh chodh dia"* (Had stomach upsets so left it).

Under IGMSY, the mother and child have to be immunized to receive full amount of the compensation. However, it was found that not all women and children were immunized. In Bihar and Jharkhand women were mostly immunized except in few cases of Saharsa, some of which were beneficiaries. Even in Madhya Pradesh at Navritola there were few cases where women did not receive vaccinations during pregnancy. Similarly in Chhattisgarh not all women were immunized during pregnancy and children were not vaccinated.

FLWs gave various reasons for mothers and children not getting immunised. An ANM in Chhattisgarh mentioned that people have a lot of misinformation regarding vaccination and it becomes difficult to pursue them. There are people who believe that if they get their children immunized, they will die. The ANM said that if she vaccinates the children or women forcefully and if anything happens to them, the villagers will hold her responsible and might even kill her. ASHA in Chhattisgarh informed that some women do not let their kids be immunized because the women have to go to work and when the kids cry after immunization it gets difficult for them to leave. ANM in Madhya Pradesh informed that if kids get fever (which she said is a common thing to happen after immunization) the mothers never bring the children for it again. AWW in Jharkhand informed that those who do not receive THR say that they will not come for vaccinations because THR has not been given. "*Aade log nahi aate hai. Bolti hain bacche ko bukhaar hai. Jhoot bolte hain. Ho log kehte hain, 'ration nahi diye do mahine se, sui dilane nahi jayenge'*" (Half of the women do not come. They say the child has fever. They lie. People from Ho tribe say "you have not provided us ration from two months, we will not come for immunization").

In all four states, variations in the IFA consumption and women's immunization during pregnancy were observed. Even though women were provided IFA in many cases, either they did not consume them in appropriate quantities or did not consume them at all. The reasons were mainly lack of awareness on the correct intake method and the myths around it. Given

this issue, incentivizing demand for IFA would not necessarily imply the increase in its intake. Similarly, women were not getting immunized due to lack of understanding of the importance of health services. It was observed that simply monetarily incentivizing behavioural change was insufficient. A more comprehensive approach and continuous interaction with the women appears to be necessary to impact the decisions of women.

Sundar is an IGMSY beneficiary in Agma Village, Saharsa. She lives with her four children; the youngest one is 15 days old. In three years she had three children. She received the IGMSY money (Rs. 4,000) for her second child who is three years old named Gamgam. Gamgam was delivered at home as she didn't have anyone to take her to the hospital. She resumed work from the sixth day after delivery. She did not go for any check-ups, did not have an MCP card, did not receive any vaccination, and did not consume IFA. There was no change in her diet during pregnancy. She wasn't provided any counselling. She did not practice exclusive breastfeeding. The child was sick from the age of one month. She spent Rs. 1,000 on medicines for the child. She also took a loan from a relative to meet this expenditure. Sundar had fever for a month after the delivery. She spent the IGMSY money on food.

Sundar's case is a classic example where despite being an IGMSY beneficiary, there was absence of an 'enabling environment' which IGMSY aims to provide. Firstly, the vision of the pilot is thwarted by the improper understanding of the baseline. With no parameters to gauge the progress of the scheme and no recent attempts of evaluation by the government, a lot has been missed out. Also, ideas of wage compensation and rest seem to be persistent only in theory given the delay in payments and absence of funds on ground level. There is a need to reconsider the 'conditionality' associated with the program. Better health practices should be promoted by creating awareness and counselling women and not by being punitive. Such conditions become more disconcerting when those who could not fulfil them are the ones who need those services the most. Moreover, monitoring them adds on to the burden of the frontline workers, thus complicating the entire process.

Staffing

A crucial step to a successful and effective programme implementation is sufficient, well trained and committed staff. The IGMSY is generally a well-considered programme. However the one point it fails to account for sufficiently is staffing. Several staffing related issues existed at the time of launch and continue to exist. These issues range from under-staffing to the previously discussed, insufficient training. This gap prevents the smooth implementation of the IGMSY.

The IGMSY guidelines specify "at the State and districts levels, the concerned ICDS Cells would be primarily responsible for the implementation of IGMSY."[152] Additionally, a State-level IGMSY Cell within the Department of Women and Child Development must be established. The Director appointed to implement the ICDS is to oversee day-to-day implementation. An officer must be designated at the UT/Sate level to act as the nodal person in-charge of implementing the IGMSY. The programme sanctions two additional staff at State/UT level – a State Programme Coordinator and a State Programme Assistant. It also sanctions two additional staff at the district level – a District Programme Coordinator and a District Programme Assistant.

Common IGMSY and ICDS implementation platform

The implementation of the IGMSY through the ICDS platform is problematic. The AWW is the first and most important link between women and the administration. This AWW was originally appointed for the implementation of the ICDS. Her responsibilities include village level surveying of women and children, running of the daily pre-school activities and feeding programme at the AWC, providing counselling to women and young girls and keeping records of services provided, amongst others. The monthly stipend provided to her by the MWCD is approximately Rs. 3,000.[153] In MP, an AWW reported having to maintain up to 11 registers alongside her other duties. The heavy work burden combined with low income provides little incentive to community level workers to perform. Additionally, the insufficient training provided to the AWWs and other community level workers makes their job even harder.

[152] IGMSY guidelines issued by Ministry of Women and Child Development, Government of India in letter F.No. 9-5/2010-IGMSY dated 4th April 2011
[153] See (GoI, n.d.-a)

This situation is compounded by vacancies at the panchayat, block and district level. Due to vacancies some AWWs manage more than one centre. In Bihar an official at the Directorate stated that nearly nine per cent of AWW positions are yet to be filled. This issue of insufficient staff also exists at the block level. In Bastanar, Chhattisgarh only two of six Supervisors' posts were filled. Similarly in Jaldega, Jharkhand the post of CDPO is vacant so currently the Block Development Officer is managing the ICDS and IGMSY. With regard to this issue a district level official in Jharkhand said, "Everyone is in deputation. There is no staff dedicated to just one scheme. Initially, when there was ICDS, one staff was handling it. Now the schemes have increased but the staff has not."

The frequent transfer of officials further compounds the issue of vacancies. Officials take time to familiarise themselves with the new work, programmes and the team. In Jharkhand's Simdega district and MP's Sagar district the DSWO/DPO had very recently been appointed to the position. As a result they were yet to acquaint themselves with the IGMSY. While attempting to speak to any official who had supervised the implementation of the IGMSY in Simdega, it was learnt that in the past three years two officials had occupied the position of DSWO. This practice of frequently transferring administrators hampers the functioning of the IGMSY.

The IGMSY guidelines state that in addition to the Secretary and the Director, a nodal officer must be appointed in every state/UT to handle the day-to-day functioning of the programme. Currently officers being appointed nodal officers are already heavily burdened. In Jharkhand the Communication Officer, in Chhattisgarh the Assistant Director and in Bihar the Statistical Officer, are nodal officers.

Though the IGMSY guidelines recommend the creation of a state and district cells, at the time of the study all four states had either not constituted or fully staffed these cells. Jharkhand and Bihar have not constituted either the state or the district cells. We were informed that due to the electoral model code of conduct being enforced the appointments were being further delayed. In Bihar the process of recruitment had been initiated and an agency had been hired to frame the norms of hiring. In Chhattisgarh state and district cells were created. However, no recruitment of dedicated staff had been done. Instead, existing staff was appointed to administer the cell. In MP, too, cells had been constituted at both levels and recruitment of new staff was done. Despite this, in Chhindwara district, the post of the District Programme Assistant had never been filled.

The failure to constitute or staff state and district IGMSY cells has resulted in the failure to take crucial implementation steps,[154] such as:

- Issuance of consolidated state specific guidelines[155] in any of the four states.
- Defining of a monitoring system including periodic reporting.
- Facilitation of timely fund transfer, streamlined and transparent payment procedure.

Currently, the block office and the CDPO play a significant role in the implementation of the IGMSY. The block officials are often the first point of complaint and clarification for the community level workers. Despite this, the IGMSY guidelines do not designate any block level posts. Officials in both MP and Chhattisgarh expressed the need for designated IGMSY staff at the block level. Varun Nagesh, DPO, state, said that more skilled staff is needed at the block level because the workload has increased. Chhindwara's DPC said, "Extra staff is needed at the Block level. It is a huge problem. Account of every woman has to be maintained. Additional staff is badly needed."

Increasing responsibilities of existing community level workers, staff and officials without addressing their concerns such as being overworked, underpaid or inadequately trained sets up the IGMSY for failure from the start.

Coordination and Cooperation

Successful implementation of the IGMSY requires a system of regular coordination and cooperation, be it within or across the respective administrative departments and personnel. The study reveals that though coordination and cooperation exists in some instances there are glaring gaps in other cases.

Selection of Districts

From the onset the implementation of the IGMSY, it has failed to include all stakeholders in the planning process. Conversation with officials at the state level and districts reveal that generally states were not involved in the process of selection of districts. Though officials in Jharkhand stated that they were consulted, state level officials in the other three states stated

[154]Functions of the state and district cells as defined in guidelines issued by Ministry of Women and Child Development, Government of India in letter F.No. 9-5/2010-IGMSY dated 4th April 2011

[155]The states have sporadically issued orders and guidelines for implementation of the IGMSY. However, these are not as effective as issuance of consolidated guidelines, primarily because accurate information reaching the village level is a time taking and challenging process. Multiple orders and instructions result in misinformation and inefficient implementation of a programme.

that no consultative process had taken place. In Bihar an official at the Directorate informed us that the Centre chose the districts and they were informed of the selected districts via official correspondence from the Centre. Officials at the district level too were largely unsure of whether the states had been consulted. A district official in Chhindwara, MP stated that a meeting had taken place in Bhopal, during which a decision regarding selection of IGMSY districts was taken. In the other states the district officials stated that a joint decision might have been taken between the State and Centre, however they had not been consulted.

Information regarding basis of selection of districts differed across states. In Chhattisgarh, at the district level it was believed that the district was selected based on the fact that there is a high birth rate, malnutrition is widespread and awareness levels are low. Similarly in Bastar district level staff stated that it was selected based on poor performance with regard to health indicators such as maternal and child mortality, as well as poor literacy rate. The nodal officer at the ICDS Directorate in Jharkhand was the only official who was confident of the basis of selection. She stated that one well performing and one poor performing district was selected for the pilot. Performance was measured based on implementation of other welfare schemes.

The failure to include states in the planning process has meant that the vision of the pilot of the IGMSY is not shared by the planners and the implementers. There is a lack of understanding of the purpose of the pilot. That it is meant to provide insight on and the significance of testing the programme has not been comprehended. There appears to be a lack of ownership of the programme and states were not provided sufficient preparation time for implementation. Sunil Sharma, Assistant Director, Chhattisgarh said that based on previous experience the state needs three months to prepare funding and transfer mechanisms. Additionally he stated that the staff took a long time, approximately six months, to understand the scheme. So for the programme to function smoothly it took about six to seven months. Involvement of the states in the planning process may have reduced this adjustment period. Additionally, as discussed above the district level officials and staff expressed concern about staff vacancies and other administrative gaps. In such a situation piloting a programme was very problematic. The factors affecting the outcomes would have been exogenous, making it difficult to comment on the effectiveness of the programme.

Centre – State Coordination

It is uncertain whether the Centre is playing the necessary role of facilitating the implementation of the IGMSY. The nodal officer for IGMSY in Jharkhand reported that meetings with the Centre take place. These meetings are usually attended by the department Secretary or Director, though sometimes the nodal officer also attends them. Similarly, Varun Nagesh, DPO of Dhamtari recalls attending two meetings organised by the Centre – the first was in Delhi in 2012 and the second in Bangalore in 2013. These were workshops to understand difficulties in implementation and provide training on the conditions. However it is unclear whether such meetings are sufficient. The Joint Director, WCD, Madhya Pradesh, Mahendra Dwivedi stated, "The scheme has been abandoned after launching it as a pilot. Nobody in the GoI asks about it…" There appears to be some truth in the matter. As discussed in the funds related section of this report, delays in receiving funds from the Centre are common. Communication is minimal especially regarding things such as changes in the implementation of the IGMSY, particularly in keeping with the NFSA. This can be seen through the fact that despite having attended meetings organised by the Central government, officials at the Directorate in Jharkhand were unaware about the then proposed scale-up of the IGMSY.

Inter and Intra Department Coordination

Coordination, particularly with the Department of Health and Family Welfare and banking/postal authorities is crucial for the successful implementation of the IGMSY. The Health Department in particular provides many services that constitute conditions under the IGMSY. These include issuing MCP cards, immunisation, ante-natal check-ups and issuing IFA tablets. Any lapses in these services affect the effectiveness of IGMSY.

Communication and co-ordination appears to be good between the Health Department and the department implementing the IGMSY i.e. Women and Child Development or Social Welfare Department. The two departments have worked together for an extended period implementing the ICDS and so the coordination for IGMSY has not led to any difficulties in implementation. Pushplata Singh, Commissioner, WCD, MP while listing the various fronts on which the two departments coordinate, stated that the WCD Department facilitates THR, growth monitoring and counselling, while health gives services related to immunization, health check-ups and IFA distribution. She said, "We never feel we are encroaching, we have

very good coordination." Similarly, in Jharkhand the nodal officer at the state said co-operation has never been a problem because they've always worked together. DPC, Sagar went as far as saying that the motto of both the departments is the same, so working together doesn't pose any challenges. A more practical DPO, Dhamtari, Varun Nagesh said, "Out of six, five works have to be done with the health department. We cannot work alone." Though, he stated that getting AWW to work with ANMs is difficult since ANMs are more educated and have permanent positions.

Department, district and block coordination is required under the IGMSY on several counts. This takes place while estimating beneficiaries, submitting request for the budget, record keeping and allocating and dispersing funds to the districts and below. These processes have been discussed in detail in chapter 6. One problematic process that has recently been seen in Bihar however needs to be highlighted here. We were informed by the nodal IGMSY officer that since 2014 Bihar has been disbursing funds directly from the department to the districts. As a result the Directorate staff stated they were unaware of fund and budget related decisions and were not privy to this. This decision was taken to make the process more efficient and cut out one level of administrative processes. However completely excluding the Directorate, that is responsible for implementation of the programme, from financial matters is detrimental to efficient functioning. It is essential for the implementation arm to be aware of the status of funding. Without this it cannot contribute to discussions on budget allocation, brace itself and make arrangements to counter fund flow delays and finally it reduces communication between two crucial stakeholders.

Community Level Health and IGMSY Workers

Close coordination and communication exists between the community level workers. This coordination is on various fronts. Nodal IGMSY officer in Bihar reported that the ASHA and ANM keep a track of conditions related to health such as registration of pregnancies, MCP cards, IFA distribution, ANCs and counselling. At the VHND AWWs and health workers provide services together. Some AWWs stated they clarify doubts from ANMs. An ASHA in Jharkhand reported consulting with ANMs and AWWs, when they have a doubt regarding the IGMSY. In Jharkhand an AWW said the ANM helps her with her registers and that they have meetings once a month to coordinate. The ANM in Chhattisgarh stated that she ensures her records match those of the AWW. The AWWs and health department workers also assist

each other in house visits. For instance the ANM in Madhya Pradesh stated she informs the AWW if during her house visits she discovers an unregistered pregnant woman.

As a result of the wide gamut of conditions and services under the IGMSY, there is need for stakeholders across the administrative ranks to work closely with each other. Though at the local level communication is largely smooth and coordination exists wherever required, the gaps appear to be at the higher end of the administrative hierarchy, particularly between the Centre and state and Department and Directorate. These gaps are sometimes a result of consciously maintained segregation of duties. However, often they are the result of failed communication, inefficiency or unplanned implementation. Additionally, the absence of IGMSY cells and staff, that exclusively monitor the implementation of the IGMSY, has also compromised inter-department coordination.

Monitoring and Grievance Redress

Monitoring

Programme monitoring is an essential aspect of effective policy implementation. Monitoring enables implementers to have a system of checks and balances. It discourages corruption and allows gaps to be plugged at the earliest. Quality record keeping goes a long way in simplifying monitoring. Monitoring of the IGMSY is taking place to some extent but not with the seriousness it should receive. The Joint Director WCD, MP reported that the last national level steering and monitoring committee meeting for review of the IGMSY was conducted in 2012. Furthermore since 2010, only two or three such meetings have been conducted. The infrequent monitoring of the program by the Central government has set an bad example for state governments.

Review of the program in Jharkhand takes place mainly at the state and district level. Official from Social Welfare Directorate, Jharkhand who supervises the IGMSY at the directorate level stated that meetings are conducted by the District Collector to review the IGMSY. The DSWO and all CDPOs are also present in these meetings. DSWO of East Singhbhum stated that no meetings of the state and district monitoring committee are held. Instead during the monthly meetings held to review all programmes the IGMSY is also followed up on.

In Bihar no state level review of the IGMSY is done. Additionally, Steering Committees at the district level are formed but they do not meet regularly. Ms. Nayyar said review meetings at the block level are more frequent.

In MP a district level official in Chhindwara explained that monitoring of the IGMSY takes place regularly at all administrative levels including the AWC, at the sector and the block. There exist district level and block level committees. At the state level review meetings happen on a quarterly basis, as well as monthly review meetings are conducted at the district level. In the monthly review with the DC the IGMSY is thoroughly reviewed. Furthermore, meetings with the Department regarding the IGMSY also take place via video conferencing. Every Tuesday & Friday Health and Women and Child Development staff visit villages to monitor the VHND meetings. Revenue department staff (sub-divisional magistrate) and CEO of the janpad panchayat, monitor the scheme at the block level. Scrutiny of records maintained by the AWW is done by the supervisor. The DPO stated that for the past four months supervisors have been using a GPS enabled tablet. This tablet is used to cross-check the entries at the AWC with those on record. However no AWW stated having seen such a tablet for monitoring purposes. Supervisors are required to visit AWCs on at least 12 days of the month. District level official in Chhindwara stated that no allowance for hiring vehicles required for field visits has been provided. This serves as a challenge to conducting field visits for monitoring purposes.

Besides review meetings scrutiny of records is also an important part of the monitoring process. In Jharkhand once beneficiary lists are submitted at the state level they are assumed to be genuine and free of any fake names. There is no official procedure for cross-checking these lists. The absence of such a system results in inclusion and exclusion errors going undetected.

Commissioner, WCD in MP informed us that the monitoring mechanisms for the IGMSY were the same as the ICDS. She went on to state, "We are making our data 100 per cent error free. We are not there yet, but we are reaching there." She added that they have 100 per cent data maintained for a management information system (MIS) however it has not been made public as yet. When asked if there was a system of ensuring the data is error free, she stated that there is no set system of verifying data but the fact that the Health Department also maintains the (same) data implies there cannot be irregularities. The DPC, Sagar stated that the records maintained at the AWC enable monitoring of the programme since fulfilment of

conditions can be tracked. He stated he checks only the IGMSY during his field visits. He examines pending payments, coverage and exclusions and also speaks to beneficiaries to check if there are any inclusion errors.

In Chhattisgarh a state level officer stated that quarterly meetings take place at the state level. He said that in monitoring at the state level, the focus is on fund utilisation and coverage. They examine gaps in estimated coverage and actual coverage, as well as in estimated expenditure and actual utilisation. He admitted that checking at the block level and below is not possible and is not done. He added that there exists a web-based monitoring system. Currently only 40 per cent of data is available online in one of the three IGMSY districts of Chhattisgarh. He felt there is a need to expand this system across the state. However the claim that data is checked up to the district level in Chhattisgarh is untrue as was gathered from the conversation with DPC in Bastar. He said, *"Cross-check kyun hoga? Aisa toh nahi hoga ki farzi registration kar denge." (Why should we cross-check, it isn't like they (AWWs) will register fake names.)*

There is a major gap in terms of understanding the purpose or need for monitoring. Monitoring is seen as yet another process that must be carried out. For this reason the enthusiasm to effectively monitor the programme is lacking. Conducting review meetings appear to be the only mechanism. Whether they are effective or not, whether other mechanisms would work better or not, is not explored. Additionally monitoring below the district level is not being done seriously. There is no system to cross-check records or implementation. As a result there exists no deterrence for corrupt practices.

Grievance Redress

A well founded and proactive grievance redress mechanism is a prerequisite for realisation of entitlements. Given India's limited experience with conditional cash transfers at a national level, grievance redress should have been prioritised during the drafting of the scheme. This is not the case with IGMSY, instead grievance redress is the most neglected. The guidelines issued regarding grievance redress are ambiguous – "The States may consider setting up of a formal grievance redress mechanism at project and district level…"[156] Additionally, it states that existing mechanisms such as "Collector's grievance redress unit or *Zilla Parishad*

[156] Guidelines issued by Ministry of Women and Child Development, Government of India in letter F.No. 9-5/2010-IGMSY dated 4th April 2011(GoI, 2011b)

(Council at the district-level)"[157] may be used for the IGMSY. This lack of commitment in the guidelines is reflected in the mechanisms (or lack thereof) in place to redress grievances within the IGMSY too. Given the quality of implementation of the IGMSY, during the field study various types of grievances were recorded. The most frequent complaints were being excluded from the IGMSY, delayed payments and incomplete payments and dissatisfaction regarding corruption in service provision.

Officials at the state and district level in Bihar and Jharkhand admitted that no dedicated system of grievance redress has been set up or even discussed for the IGMSY. An official in Bihar stated that if a complaint is received it is forwarded to the concerned DPO or CDPO. The DSWO in East Singhbhum stated that he was the point of complaint at the district level.

In Chhattisgarh the Assistant Director said that beneficiaries may approach any staff or official ranging from the supervisor to the Collector to lodge a complaint. It is no surprise then that he went on to add that no complaints have so far been lodged regarding IGMSY money not being received. At the district level the DPO of Dhamtari informed us that the AWW is the first point of complaint. Complaints are also made at the block level meetings held every month. When complaints are received from an area indicating that IGMSY money has not been received, a camp is set up there to distribute the unpaid dues. DPO in Bastar informed us that telephonic complaints can also be made to the DPO, however no complaint number is provided for complaints lodged. Presumably, follow up by the complainant is impossible in such a scenario.

There is no dedicated grievance redress system for IGMSY in MP either. However the District Programme Coordinator of Chhindwara stated there is a general Chief Minister's helpline and a web portal called Samadhan Online. Complaints registered through the helpline are forwarded to the district's ICDS office. Once the complaint reaches here, there is a four-stage process followed. The complaint is first forwarded to the CDPO who is provided one week to solve the problem. If a resolution is not reached the complaint is transferred to the DPO who is also provided one week to resolve the complaint. If the issue is not settled at this stage either, the complaint is forwarded to the Joint Director. The matter remains here for another week. Failure to address the problems results in escalation of the complaint to the level of the District Commissioner. The extent of the use and efficiency of this system with regard to the IGMSY is unknown. In addition to the Chief Minister's helpline and Samadhan

[157] (ibid.)

Online, there exists a Public Grievance Cell. There is a system of bi-weekly *jan sunwais* (public hearings) in place. These are organised at the district level and attended by the collector, DPO, SDM and CDPOs. Grievances are supposed to be redressed within a week.

The District Programme Coordinator of Sagar stated that besides the CM helpline, people can come and orally register complaints at the *jan sunwais* at both the district level and project level. There is a district level steering committee that keeps a track of grievances and the backlog in resolutions.

Despite state and district officials listing various grievance redress mechanisms, there exists a huge gap between the provisions on paper and in reality. While speaking with beneficiaries and non-beneficiaries across the states most were unaware of a system of grievance redress. Some did not understand that they have the right to complaint if they were not provided their entitlements. In the case of Anita in Dhabara she thought she did not have the right to complain because her child was delivered at home. She said she "would have complained had the child been born in a hospital." Kosi's wife passed away and he is not aware of whether or not she received the IGMSY cash. He said that there is widespread corruption but did not speak of reporting the matter. When informed that his wife is listed as a beneficiary he stated he would ask the AWW.

Generally women stated that the first point of complaint for them is the frontline worker, usually the AWW. Complaints submitted here are usually verbal with no follow up procedure. This system though convenient is not very effective especially since the solution is usually beyond the scope of the AWW. For instance in AWW in Jharkhand is bearing the brunt of delayed payments with the beneficiaries holding her responsible for the Rs. 500 stuck as initial deposit in the bank.

Additionally, the close proximity of eligible women and the frontline workers serves as a disincentive to complain. Sapna in Madhya Pradesh reported that when she did not receive her complete entitlement she asked the AWW. However the AWW did not help her because Sapna had in the past complained to the Panchayat about the AWW not providing her take home ration. Later, when she enquired from her about her second and third IGMSY instalment, which she never received, the AWW refused to help her and told her to ask the "*paise wala babu*" (post master) herself. The existent antagonistic relationship between Sapna and the AWW resulted in her grievance not being addressed. This case illustrates the

need for a grievance system that separates the implementer and the persons called on to redress grievances.

Amongst frontline workers too there was no clarity on whom or how to lodge a complaint. Across the states AWWs reported complaining to block level staff such as the CDPO or the supervisor. The AWW in Chhattisgarh reported that she complains at the tehsil office. An AWW in Chhattisgarh said that her complaints regarding banks not opening ZBAs falls on deaf ears. Similarly, AWW in Madhya Pradesh stated that written complaints have been submitted at the block office, however despite these no money has been received for the past year. In Jharkhand AWW in both PO Sukran and Lango stated that there was no grievance redress system. The ASHA in Jharkhand and Bihar reported complaining to the person who is incharge of the health care centre. In MP a toll free hotline exists. This was not set up specifically for the IGMSY but may be used for it. In addition to the hotline number, AWW in Madhya Pradesh mentioned that complaint boxes are placed in schools, at the CDPO's office and the panchayat secretary's house.

The rights based approach within which the IGMSY is being implemented[158] is premised on the ability of a person to demand her right. Grievance redress mechanisms are the first and foremost tool through which an entitlement can be ensured. The lack of awareness regarding one's right to demand grievance redress renders any and all provisions pointless. The existent system of grievance redress is limited in its functioning because the implementers of the programme are the people in-charge of redressing grievances and the system reiterates the bureaucratic hierarchy. In such a situation, there is little to no incentive to lodge, investigate or resolve complaints. Additionally, the complaint is often forwarded for enquiry to the same person against whom the complaint is filed. In such a situation the complainant cannot be kept anonymous and there is a high probability of complaints being targeted. None of the officials spoken with made mention of an appeals system. Considering that the chances of a biased investigation in the current setup are high, there is an urgent need for introduction of a time bound appeals process to address IGMSY related grievances.

[158] Post September 2013 when it was revised in keeping with the NFSA.

Conclusion

The issues discussed above highlight the gaps in the vision and the implementation of the IGMSY. These issues are a result of many interlinked factors like improper awareness, inadequate training, poor record maintenance, overburdened workers, and inadequate staff as discussed above. The clearly stated commitment of providing wage compensation to women for rest and better health and nutrition outcomes, as mentioned in the well drafted and detailed implementation guidelines of the IGMSY, appear to be completely shattered when seen in light of the ground realities. The time and energy spent on designing the IGMSY shall now focus on improving its implementation. Immediate attention shall be paid to creating more awareness amongst all the actors in the scheme. Besides proper implementation, the issues within the structure of the scheme should not be ignored. It is important to take into consideration the adverse impact of the eligibility criteria and conditionalities associated with the scheme. Moreover, as shown in this chapter, any misinformation or misunderstanding of the eligibility criteria further leads to exclusion. With proper implementation and revision of the scheme to avoid exclusion the scheme can achieve its stated objective to some extent.

'Had I received it on time, I would have stayed home'

6. Delivering Maternity Entitlements

In the sixth or seventh month of her pregnancy, Sangeeta walked on a 10-12 km long trail, climbing a hill on her way, to reach the road which goes to post office in Bastanar. She travelled another 12 km on road to reach the post office to get her IGMSY account opened with the help of her village's AWW. She is illiterate, does not know her age, and speaks only Gondi and Halbi. More than three years have passed since that day, but like all other eligible beneficiaries from her village she has not received any instalment so far.

No woman in Korangali village in Bastanar block, Bastar district, Chhattisgarh had received IGMSY money, at least till 17 September 2014. Although as per available records, the district has been receiving regular grants-in-aid since 2011-12.[159] Similarly, in one village in Jharkhand the AWW has stopped registering women for IGMSY because funds are not coming, and here too, grants-in-aid were received at the block level every year since 2011. These striking examples of delay and denial of payments to beneficiaries are not exceptions. In all four states of our study, women reported a delay of five months to three years in

[159] The amount received as grant-in-aid according government records is unreliable because the figures given by the state and district level offices of Department of Women and Child Development, Chhattisgarh, do not match.

receiving their instalments under IGMSY. Even though the first instalment is to be given at the beginning of the third trimester, no woman in the sample of this study received the money before delivery. An earlier evaluation of IGMSY by the Ministry of Women and Child development conducted in 2012 had also found a delay of one to two years.[160] Interestingly, the data given by the concerned departments of the four states did not reflect this anywhere. This raises serious doubts on reliability of the state government records on IGMSY. Since the subject of record-keeping has already been discussed in the previous chapter, this chapter primarily discusses the issues of delayed payments and access to assess the delivery of this cash entitlement to women both from supply side and demand side.

The reasons for delayed payments are multiple and vary from case to case. Based on interactions with the actors involved in implementation of IGMSY, following three kinds of delays can be identified:

- Delay at the government's end
- Delay at the banks and post offices end
- Delay in opening bank and post office account

Additionally, due to our focus to bring out women's experience with IGMSY from the most far-off places inaccessibility also becomes an inextricable cause for delayed payments to certain areas. For instance, in Bastanar block of Bastar district, Chhattisgarh, the CDPO stated that 40 AWCs are in the Naxalite-affected area out of the 152 functional AWCs. He defensively said, *"Mushkil hota hai aisi rukavaton ke saath kaam karna"* (It is difficult to work with such constraints). He implied that it is not possible to provide regular ICDS services, training and information to AWWs and make supervisory visits in such AWCs due to lack of safety and poorly developed infrastructure. While naxalism was an issue in only some parts of Chhattisgarh and Jharkhand, lack of properly developed roads, telephone connectivity and other basic infrastructure was found to be an issue in almost all areas of this study. These issues of access in general and in reference to IGMSY have already been discussed in chapters 4 and 5. Therefore, this chapter discusses them only in reference to accessing banks and post offices along with the issues related to transfer of IGMSY funds at all levels to understand how they contribute to delay.

[160] See (ASCI, 2013)

Problems with transfer of funds

IGMSY is a demand driven scheme, i.e. the funds are released at each administrative level on the basis of budget estimates and utilization certificates given by the levels below. These estimates are collated at the AWC, then sector, block, district and state level; and at last sent to the central government based on which funds are allocated to the states. Such processes are clearly laid down in the implementation guidelines.[161] However, the scheme is fraught with delays at all levels. This section examines the reasons for delay in release of funds by the government at central, state, district and blocks level; delay in payment to beneficiaries by banks and post offices; and delay at the beneficiary's end in accessing their entitlements.

Delay at the government's end

Lengthy Processes: Delay in demanding funds

Since the launch of the scheme, the government officials involved in implementation at different levels have been juggling with the tedious processes. "It is not easy to kick start any scheme", said the Assistant Director, Department of Women and Child Development, Chhattisgarh. He explained that the state has to clear the budget, then the state assembly has to pass it, opening bank accounts takes about six to eight months and recruitment of staff needs to be done. Only after completion of all these procedures grants are released and that is when the implementation process begins.

On the other end of implementation, for registration of women the AWW collects the application forms of all eligible women in the village along with the supportive documents, gives it to her sector's supervisor in the monthly meeting, the supervisor gives such lists from all the villages under her to the CDPO and data operator, who maintains these records in a computerised database. The block sends monthly progress reports (MPR) to the district specifying the number of beneficiaries for each month, and then the district compiles every block's MPR and sends it to the state government. Based on these numbers and utilization certificates, funds are released on quarterly or annual basis to the districts and blocks.

Similarly, utilization reports have to be sent from the block on quarterly basis to the districts, then to state government and finally to central government. Moreover, because it is conditional cash transfers scheme regular data on conditionality fulfilment has to be collected

[161] Letter from the Ministry of Women and Child Development, Government of India, F.No. 9-5/2010-IGMSY dated 4th April 2011.

for each beneficiary at the AWC. These processes are more or less the same in all the four states. The problem with lengthy processes is that they cause delay in payments to beneficiaries. The evaluation of the IGMSY in 2012 commissioned by the Ministry of Women and Child Development stated, "the somewhat cumbersome procedure of approvals and bills submissions in order for cash benefits to be released appear to create significant time-delays of between one to two years in delays in releases of funds for the scheme and payment of cash benefits."[162]

Box 6.1: Process of Collection and Compilation of Beneficiary Data

AWC-AWW

↓

Sector-Supervisor

↓

Block-CDPO

↓

District-DPO/DSWO

↓

State Department

↓

Ministry of Women and Child Development, GOI

In the villages of our study, not only was the delay more than one to two years in some areas as earlier noted, but different levels of administration were responsible for delay. In Jharkhand, demand for funds to the GoI is made annually in the month of June-July and after compiling inputs from the districts, informed the Communications Officer at the Women's Development Society in Social Welfare Directorate of Jharkhand. This suggests that a delay of four months is caused by the state government. In Chhattisgarh the district and block levels were responsible for delay. The Assistant Director in the Department of Women and Child Development stated that the state still has unspent balance in the funds allocated, which implied that the districts have not managed to fulfil their targets as reflected from the case of Korangali village in Bastar district. Hence, inadequate capacity of the block and district to implement the scheme is contributing to delay.

[162] ASCI (2013, p. 181).

It is difficult to pin down one reason or level for such time-delays in demanding funds in the whole process of implementation. Multiple issues cause delay in demanding funds, which have been discussed in detail in the previous sections. The point that needs to be stressed here is that any time-delay in demanding funds under IGMSY negatively affects the effectiveness of the scheme. Therefore, attention has to be paid to either simplifying processes or ensuring that work is done on time at all levels.

Late allocation of funds

In IGMSY demand and allocation goes hand in hand as per the processes given in the implementation guidelines. However, at the operational level allocation of funds is fraught with delays. One reason for such delay, i.e., delay in demanding funds has already been discussed. This section discusses other side of delay, which is allocation.

Since IGMSY is a 100 per cent centrally sponsored scheme, the GoI plays a very important role in timely implementation. However, the study findings suggest that the GoI has not been fulfilling its responsibilities on time. The Statistical Officer in Bihar informed that the first instalment for the annual IGMSY budget is released by the GoI in September, which is already the middle of second quarter. No funds for 2014-15 had been transferred to Jharkhand to until September 2014. Similarly delay happened in the month of March in Chhattisgarh. The DPO, Dhamtari district said that they required Rs 5 crore, but it got delayed due to elections.

In Madhya Pradesh too the funds from centre never come on time but the delay does not affect as much as it does in other states as the state's finance department lends money for IGMSY, stated the Joint Director, Department of Women and Child Development, Madhya Pradesh. He said, "This is a very big issue. Our finance department cooperates. I wonder what the situation would be like in states where it does not."

However, even if the state finance department cooperated the districts reported shortages of funds and pending payments. The DPO in Chhindwara district reported that in March, 2014 the district needed Rs. 1 crore to clear the backlog payments, but since there were no funds at the state level they could not transfer it to their districts. As a result of state's delay in disbursing fund, the money for the month of March 2014 was received in August, by Sagar and Chhindwara districts in Madhya Pradesh, stated the District Programme Coordinator and District Programme Officer of each district, respectively.

The situation is even worse when there is no mechanism of state government funding as there is no option but to wait till centre's funds are released. In 2013-14 in Bihar not only was the allocation from the centre late but also less than their demand. The issue of receiving less than the demand was also raised by the DPO in Dhamtari, Chhattisgarh, but it is not clear if the GoI gave less budgets or the state department. Due to delay and lesser allocation than demand payments were being prioritized to the old beneficiaries in all four states. Despite this, the data shared by the districts on pending and delayed payments to beneficiaries did not reflect this delay at all. All four states did not report or record any delayed or pending payments.

Given the delay in allocation of funds from the centre to states, then states to districts and blocks, ensuring timely payments to entitled women becomes almost impossible. This combined with lack of information and other issues covered in previous chapters aggravates the ineffectiveness of IGMSY. The price of this poor implementation is borne by women and children who are deprived of their entitlements and remain severely malnourished like Somari and her child, who still awaits her instalment in Korangali village of Bastar.

Delay at post offices and banks end

Procedural issues with post offices

Banks and post offices are the only permissible channels for transfers under IGMSY, but the procedure of transfer within each of them differs. In all states, except Bihar, once the money is approved for a block, the district releases money in the CDPO's official account, then the CDPO writes cheques to the banks and post offices with a list of beneficiaries and their due amount. In banks the managers transfer this money to beneficiaries when he receives the cheque from the CDPO. On the other hand, in post offices the post master has to send the cheque to post office department's head-office in the district for approval. Once the postmaster receives approval from head office he can transfer the money in accounts of the beneficiaries. This makes the money transfer process inherently lengthy in the case of post office. On account of this reason, in Chhattisgarh and Madhya Pradesh, wherever possible beneficiaries have been asked to move to banks, i.e. only bank accounts have been made acceptable under IGMSY, although there is no such condition in the scheme guidelines. In these two states at places where banks are not present post offices are used to transfer money. Such areas usually are the remote and tribal areas. An AWW informed that postal accounts were opened earlier but for past one year only bank accounts are used in Simdega, Jharkhand,

but it is not clear if the reason is the same as Chhattisgarh and Madhya Pradesh. On the other hand, in Bihar, accounts can be opened in both bank and post offices. However, the AWWs may not always be aware of such decisions.

An exception to the process of funds transfer is Bihar where the districts are not involved. Funds are transferred directly from state department to the blocks. Initially payments were sometimes made through camps at the block level. The Statistical Officer at the Department of Women and Child Development, Bihar, mentioned that camps were put for distribution of instalments to those who were fulfilling criteria in the districts of Saharsa and Vaishali. These camps were organised in blocks as well as panchayats, wherever CDPO could facilitate. Cheques were given to the district post office which was then sending the cheque to the panchayat post offices. However, this system was inefficient as this too required fund transfer within post offices which caused delays. Therefore as a procedural practice, in Vaishali the CDPO would transfer the money to the AWW's account, named Anganwadi Vikas Samit Account. Once instalment is due to beneficiaries the AWW would withdraw money from that and transfer it to the post office account of the beneficiary. By this procedure the delay caused by post office to post office transfer was supposedly reduced. Instances of corruption have been reported in our study, from Bihar as well as other states, where AWWs charged bribes from beneficiaries to open their accounts or withdraw their money (cases of corruption are discussed in detail in the access section below). In light of such evidence, the effectiveness of this practice of involving AWWs in the transfer of money is questionable.

It is apparent that there is no uniformity among the four states with respect to the protocol for opening accounts and payments to beneficiaries through banks or post offices. There is lack of communication of the protocols to the frontline workers as well. The reason for this complexity in the processes was lack of clear guidelines and their communication from the centre to states, then to districts, blocks and banks or post offices. In situations where banks and post offices were not complying with the instructions the officials seemed unprepared to deal and resolve the matter (see section below for case).

Delay in opening account by the banks and post offices

In many cases banks and post offices were responsible for the delay in opening accounts. In Jharkhand's Karmapani village, the bank took 6 months to open Dhani Hemrom's account for IGMSY, while in Madhya Pradesh's Karaem Raated village, the post office did not open Aarti Bharti's account because she was not ready to pay the deposit money. She also

mentioned that the post master was asking for bribe to open her account. Although, zero-balance accounts are to be opened under the scheme it was common for banks and post offices to insist on a minimum deposit. Other cases of corruption were also recorded which will be discussed later.

The local officials are aware about these issues, but do not think that they can do anything about it. The DPO in Bastar district said that banks keep making excuses, such as the bank manager not being present, or IGMSY accounts are opened only on Tuesday (no such day is fixed though) etc., due to which the beneficiaries end up wasting two-three visits to the bank. He also said that district level meetings with SBI, Bank of Baroda and Dena Banks, which are the only banks operational in Bastar, have not helped. Also, talks with the bank's ombudsman have been held to confront them on this issue. But, to take any action on this the DPO was asked to file a written complaint against the officials who have denied opening bank account to beneficiaries. He has not filed any complaints yet because he thinks that it will be of no use as the bank manager will simply deny that he ever refused opening anyone's ZBA. He had realized that social security schemes are a burden for banks.

Such attitude of bank and post office officials really tests the patience of beneficiaries. *"Unko account khulwane ke liye yahan (Sidholi) aana jana padta hai, ek do baar main kaam nahi hota toh phir wo taras jaati hai, aur phir aati hi nahi hai"* (women have to come to Sidholi to open their account. If their work is not done in one or two visits, then they get so disappointed that they stop coming), said the ANM in Karеam Raated village of Chhindwara district. This village is located in Patal Kot valley and people climb 3 km to reach Sidholi.

Data Entry Issues

The government officials often cited error in data entry as reason for delay. In Chhattisgarh, minor error in entering data, such as account number of beneficiaries, causes delay. The DPOs in Bastar and Dhamtari districts said that the reason for this delay is that each cheque to a bank or post office is sent with a list of beneficiaries and if there is an error in one account number the banks do not transfer money to anyone in that list. A new cheque and list with correct details has to be sent, and until then money for all the beneficiaries is held back. Similar issue was mentioned in Madhya Pradesh. The DPO in Chhindwara district, Madhya Pradesh mentioned that clerical errors at lower levels cause delays but there are no large administrative delays. In Sagar district the DPC complained that the post offices do not release money if they are given a long list.

The above mentioned issues bring out the various operational obstacles that affect last mile delivery of IGMSY cash transfer, i.e. from banks and post offices to beneficiaries. While the data entry errors are almost unavoidable given lack of training to AWWs in maintaining records, the delay in opening accounts can simply be avoided by giving clear and strict instructions to post offices and private banks to open zero-balance accounts and adhere to other norms of the schemes.

Delay in Opening Bank or Post Office Account

Late registration under IGMSY

IGMSY is a self-targeting scheme. Women have to come to AWC and register themselves by the fourth month of their pregnancy; upon doing so the AWW is supposed to note down their names, details, and ask them to sign a declaration, which says they are not related to central government employees. This process of registration is alright if only the women are well aware about the scheme, its conditions and their entitlements. Otherwise, it doesnot seem fair to expect women to comply with the four months registration condition and hold them responsible for the delay. The study found that no women had information about the conditionalities of the scheme. This lack of information issue has already been discussed; therefore, this section discusses only its effect on delay.

The AWWs in the tribal hamlets of Madhya Pradesh, Jharkhand and Chhattisgarh informed that many women were not registering their pregnancies on time, i.e. by their fourth month, due to which the entire process of accessing IGMSY entitlements was getting delayed. The ANM in Kumar Sadhra, a village in Bastar district complained that she learns about their pregnancy only when they come for check-up. In Kumar Sadhra, ASHA, ANM and AWW, all three reported that women hide their pregnancy from them, even up to seven months. It was learnt from villagers in Chhattisgarh that the reason why women do not report their pregnancy at the AWC on time is because they believe it prevents the child from evil eye.

However, most respondents in our study reported registering their pregnancy in the third or fourth month, except for a few who registered between the fifth and eight month. Those beneficiaries who registered late did not give any specific reason for the delay. They did receive their money in instalments or lump sum, but not on time. Lalita Bai in Jhadola village of Sagar district, Madhya Pradesh, received her first instalment five months after delivery, although she had registered in the fifth month and got her account opened in the sixth month.

Manju Devi in Jaisinghpur village, Vaishali district, Bihar, too received all her money after more than one and a half years of delivery. She had registered in the seventh month.

The cases of late registration make it is difficult to say if late registration was the only reason for delay because the delay has not been proportionate. For instance, there was a delay of four month from Manju Devi's end, but the overall delay in her payment was about one and a half years. This clearly suggests that other reasons also contributed to delay, and perhaps more than the delay at the beneficiary end.

Lack of Access

Another reason for beneficiary side delay was not opening bank or postal accounts on time. Although most beneficiaries registered on time, they took time in opening bank accounts for IGMSY. Girija Devi in Agma Village, Saharsa District Bihar, opened her IGMSY account after her child was 2-3 months old. She had not received her instalments till the date of her interview. She was interviewed on 7th November 2014 and her child was one year old at that time.

Similar cases were recorded in other states. From conversations with the frontline workers it also emerged that despite their repeated reminders women did not open accounts on time due to their incapability to access banks on their own. The AWW in Navri Tola village, Chhindwara Madhya Pradesh, said that she has to go and open women's account as their families do not open them. An ASHA in East Singhbhum district, Jharkhand stated that Sabars, a PVTG, get left out of IGMSY benefits because they do not open accounts. She said that Sabar *tola* is located quite far from the main village and the women have to be continuously pushed to open accounts. However, she added that apart from needing several people to convince them to open IGMSY account there are also issues of ZBA's not being opened and need for someone to accompany them to the bank.

The case of Sabars in Jharkhand points out that although these cases qualify as beneficiary side delays, the reasons why beneficiaries take time in opening account is that they have too many barriers to overcome, such as lack of documents, deposit money, time or others. One visit to a bank means losing one day wages because the bank or post office is 25 km away, which was often the case in villages in all states, except Bihar, where the distance was about 10 to 12 km. These issues of access have been discussed in detail in the next section.

Access to Bank and Post Offices

It had been pointed out in the previous section that often the reason behind beneficiary side delays is inaccessibility. These barriers to access are not just physical or geographical, but also economic, social, procedural and informational. Besides, they often cut across each other. This section outlines these issues with respect to access to banks and post offices.

Geographical Barriers

Distance

It is very difficult to access banks and post offices in remote and inaccessible areas. Girija, walked for 2 hrs to get her account for IGMSY opened in a bank located about 8 km away from her village Agma in Saharsa District Bihar. It took her three visits to open her account. She travelled with her mother-in-law and managed to get her account opened after paying Rs. 500 as deposit. She opened her account 8 months ago, and has not received her money or passbook yet. In Maragaon, Dhamtari district, Chhattisgarh women travelled up to 30 km with their husbands to reach the bank in Singpur. Similarly in Kaream Rated, Madhya Pradesh, beneficiaries had to make multiple trips to the post office located 3 km away, which involved climbing up a steep hill, in Sidholi.

In the villages visited for this study in Madhya Pradesh, Chhattisgarh and Jharkhand banks were situated as far as 25-30 km from the village. The difficult terrain made these banks even more physically inaccessible, particularly for the PVTGs. The DPO in Dhamtari, commented that people in Kamar tribe, a PVTG, don't want to open accounts as banks are distant, about 30 km. He also said that villages which are inside forest face more problem and some of them are 40-50 km away from nearest bank.

In Bihar the distances were shorter, but poor roads and lack of transport connectivity acted as barriers to accessing banking services. Allowing post office accounts for IGMSY cash transfers, was intended to address this issue, however it has proven to be insufficient as in some cases even post offices were located far from the village. For instance in Madhya Pradesh distances of post offices from the villages covered, ranged from 3 to 17 km, in Chhattisgarh 8 to 30 km and at least 3 km in Bihar.

Another negative effect of longer distances and inaccessibility is that women travel in either the company of the AWW or their husbands. While husband's company may defeat the

purpose of opening account in women's name as he would be operating her account informally, the company of AWW led to corruption as few AWWs charged money for helping women in opening bank accounts (see Chapter 4 for cases).

Thus, distance affects the difficulty or ease women experience in accessing their entitlements. Distance and terrain together pose a big challenge for financial inclusion. This was exemplified by Dhamtari district. Although, since 1st July 2013 Aadhar enabled direct benefits transfers (DBT) for IGMSY have been implemented in the district,[163] one of its block, Nagari, still does not have banks, informed the DPO in Dhamtari, Chhattisgarh.

Procedural Barriers

Compulsory Documents

Women were required to submit identification documents such as a voter identity card to open their bank accounts. The underlying reason for the need to provide these proofs is that banks need evidence to confirm people's citizenship. Although providing such documents is not directly an IGMSY issue, their absence acts as a barrier to access the entitlements under IGMSY. Anita, 20, in Navritola village of the tribal district of Chhindwara, Madhya Pradesh, did not even consider opening her account at the post office, which is located 20 km away in Kursi Dhani, due to lack of deposit money and required documents.

The documentary requirements were almost similar in all the four states. In general women are asked for documents such as residential proof, ration card, two passport size photographs, and in some cases mark sheets for age proof and BPL cards. However, acquiring these documents costs time and money. In Bihar and Jharkhand, a residential proof or *Awasiya* is required to open account. For this women reported paying between Rs. 50 and Rs. 500 as bribe at the block office in Bihar, although the document is actually supposed to be made at no cost. It takes time to get an *Awasiya* as Graamsevak's stamp and two copies of the document are required. Overall, it is a two month process and often leads to beneficiary side delays, on which they have no control.

Across the four states the frontline workers observed that women do not have complete documents. "Women face difficulties in opening account because women often don't have proof of identity. If they don't have it they have to go to the block and get residential proof

[163] Letter from the Ministry of Women and Child Development, Govt. of India, F.No. 9-5/2012-IGMSY dated 23rd April 2013.

(*Awasiya*)," said an AWW in Simdega district, Jharkhand. Due to these incomplete documents the AWWs, or ASHAs had to accompany women to help them open their accounts.

It is worthwhile to note here that the ASCI survey had found that 24.5% women beneficiaries under IGMSY did not have adequate documentation and could not register in time.[164] Not many alternatives to documents are available. Those who don't get an *Awasiya* can get a Citizen Certificate from the Sarpanch in Bihar. However, this is not the case with all documents. Given the scale of this problem, it becomes extremely important to address this issue to ensure that women are able to access their entitlements on time.

Economic Barriers

Zero-balance Accounts are not being opened

As per the implementation guidelines of the scheme no frill accounts with zero balance are to be opened up at banks and post offices for beneficiaries. However, the study found that across the four states most women had to pay deposit money to open bank or post office accounts. It was found that Rs.50-200 is charged as deposit in post offices and Rs.500-1000 in banks. This is a big issue, the beneficiaries were not aware about the provision of zero-balance account under the scheme and had to pay the minimum deposit required to open account to avoid delay in getting their money under IGMSY. One eligible woman, Anita, ended up not opening her account because she neither had the money nor the information that ZBA can be opened.

> *Anita, 20, does not earn her wages in cash and gets paid in kind for the agricultural work that she does. Her husband migrates to work but does not have a regular income; her father-in-law is a drunkard; she has a one and a half year old son, who she leaves alone at home when she goes out to do agricultural work. When the AWW informed her about IGMSY and opening account, she did not do anything. "mere pass paise nahi the" (I did not have the money), she said referring to the Rs. 100 opening deposited that had to be given at the post office. She wasn't the only one who faced difficulty in arranging the deposit money. The AWW of Lalita's village, Navritola, in Tamia district Navri Tola mentioned that there are other women as well who do not have the amount to open their accounts and sometimes she has to lend them money for deposit.*

[164] See ASCI (2013)

Similar voices were heard from other states. In Jharkhand's Simdega district, one of the ANMs felt that women who get left out of the scheme are those women who do not have a bank account. She added that Rs. 500 is a lot as an initial deposit and some people cannot afford it. Only a few frontline workers reported that zero-balance accounts were being opened. These were from Chhattisgarh and Madhya Pradesh. However, no women in our sample had a zero-balance account if it was opened specifically for IGMSY.

The state level officials did not acknowledge this issue. "It is no issue at all. We have done so much with MGNREGA. Every family must have two accounts. These orders were issued under Samagra Yojana," said the Commissioner, Department of Women and Child Development, Madhya Pradesh. However, the district and block level officials not only acknowledge but also understand the reasons behind it. "*Social security schemes banks ke liye bhaar swaroop hai…Khali saamaj ke liye bank kaam nahi karte hai, bank manager khud logon ko do teen baar ghumata hai, 'aaj nahi kal aana', 'Rs 500 jama karne padenge'*" (Social Security schemes are a burden for banks...Banks do not work only for society. The bank managers themselves make people visit multiple times, 'not today come tomorrow', 'Rs. 500 will have to be deposited'), said the DPO's assistant, in Bastar district. He explained that banks also have targets of opening accounts. Opening Zero-balance Account is a burden for banks because the beneficiaries close their account once they receive the money under the scheme, which is not good for their business.

It shall also be noted that the deposit money is among one of the reasons why accounts are opened in post offices even though banks are equally far. In Bastanar, the CDPO said that since post offices accounts are relatively affordable for most people and banks were not opening ZBA's, most women's account were opened in post office.

Cost of Accessing Banks or Post Offices

There are many costs other than deposit money which beneficiaries had to incur in order to access banks or post offices. Anita Yadav, a beneficiary in Dhabara village, had spent Rs. 500 on travel and food, Rs. 100 on deposit to get her account opened. She had to travel with her brother-in-law on a kaccha road to Baraytha that is 9 km away. She received only Rs. 1000 and went with the AWW's husband to withdraw it, who took Rs. 100 from her. In the end she just had Rs. 300 left in hand.

Similarly, Kapurni travelled 8-10 times to open her bank account from her village PO Sukran in Jaldega Block, Simdega. It took her 6-7 months to just open the account and each roundtrip costs Rs.40. She still awaits her instalments. Sometimes, despite incurring these associated costs women fail to access their entitlements. Reshma Devi, in Lango village, Jharkhand, does not have a bank account. She first submitted a form at the bank in Dumaria in January 2014, but forgot to sign that form. When she returned to sign it bank officials told her it was too late and she should fill out a new form. She had visited the bank twice, incurring a cost of Rs. 120 on each trip to open her account. However, to no avail.

These costs associated with accessing banks and post offices also emerged as a determining factor in the choice between lump sum and instalment amongst women. The findings from all four states discussed in Chapter 5 related to lump sums suggest that even if fewer trips were involved but the distances were long, women preferred to receive money in lump sum.

The expenditure on travel and food etc. on each trip to bank, acted as a barrier for women to open accounts, especially when it involved multiple visits. Since women had to spend a substantial amount of money and time on travel, in tribal areas of Chhattisgarh and Madhya Pradesh women travelled to the banks or post office only on the day of weekly markets because local transport was available only on that day and they could buy or sell local produce in the markets without losing on their earnings. This also reflects an important link with the opportunity cost of visiting the far off bank or post office, i.e. loss of one day's wages.

Corruption acts as a disincentive

There were a large number of women from all four states who reported corrupt practices in opening accounts for IGMSY or for withdrawing money. Some women in Madhya Pradesh complained that their accounts were not being opened despite several visits to the post offices and that the post master was asking for money for opening the account over and above what is normally charged. *"Ullu bana ke ghar bhej deta tha…pasie mangta tha Rs.200-400…dimag kharab ho gaya. Kahan tak bhugtungi"*(he used to make a fool of us and send us back…he used to asked for Rs. 200-400…I had lost patience, how much would I suffer), said frustrated Aarti Bharti, 21. She lives in Chhindwara, Madhya Pradesh and could not open her account at the post office after trying every day for a month. The post master is corrupt and irresponsible, she claimed. All beneficiaries in the same village, Karеam Raated, reported that they had to shell out between Rs. 100-200 to open their account.

Similar instances were recorded in other states. In Bihar, Ruby Devi was asked for Rs. 500 from the post master when she went to withdraw her IGMSY money. In another village, the post master took Rs. 200 from Sanju Devi, yet she has not received the IGMSY money. Her child is now two years old. In few cases it could not be confirmed how much money was actually to be paid for account opening as women gave money to the frontline workers to open their accounts. Such cases have already been discussed in detail in Chapter 4.

Many cases emerged where the passbooks were kept either with AWW or post master across the four states. The AWW in one of the villages in Chhattisgarh kept all passbooks with her. In two villages in Bihar, the AWWs kept the passbooks with them. Some of the women had never even seen their passbooks. Few such cases were recorded in Jharkhand as well. An important point to note here is that among all these corruption cases the women did not know or consider that complaining was an option. As earlier mentioned, most women in the study said that they don't know if they can complain and to who, except the AWW. This reflects the absence of information and knowledge about grievance redress mechanisms.

A block level corruption case was also recorded, but couldn't be verified. In Chhattisgarh, one of the AWW reported that she opened post office accounts for six women in her village. But she was told by her supervisor that the accounts should be opened again. She was told that the previous supervisor "took the money and fled."

In addition, corruption was found in relation to getting the documentary proofs for opening bank or postal accounts. The *Awasiya* in Jharkhand and Bihar is one such example and has already been discussed.

Informational Barriers

Misinformation among beneficiaries

It was found that sometimes women were not given the correct information. In the villages studied in Chhindwara district, the AWWs were informing women to open bank accounts after the child was born, not when they registered. The misinformation among these AWWs acted as one of the major reasons for delay in payment of instalment to women in these villages. On confronting the CDPO of Tamia on this issue, it was found that the AWW in Navri Tola was issued a show cause notice in 2010 for her poor performance and has consistently not been working efficiently. But, in Karaem the reasons were different. The AWW is only fifth pass. She openly acknowledges her incompetency but adds that someone

has to run the AWC. She belongs to Bharia tribe, which is a PVTG. She has the highest educational qualification among other women in her village, except one. These incidents add to the other issues related to poor orientation and training for IGMSY given to the frontline workers already discussed in Chapter 5.

Different Accounts for Different Schemes

In all four states different practices are followed with respect to merging bank/post office accounts. Sanju Devi, in Bihar's Agma village already had a bank account for IAY yet the AWW made her open a post office account for IGMSY. Due to this she ended up paying the deposit money of Rs. 50 to open her account and Rs. 200 to post master to release her IGMSY money. "ZBA's are being opened for IAY and NREGA but not for IGMSY," said one of the AWWs, in Vaishali, Bihar.

These practices also differed within states. In Chhattisgarh's Bastar district postal accounts are acceptable, but in Dhamtari district[165] only bank accounts are accepted since 2013. IGMSY beneficiaries who held postal accounts were asked to get a bank opened in Dhamtari, except Nagri where postal accounts are still acceptable. Some beneficiaries in the district reported having both postal and bank accounts for IGMSY. This implies that they ended up paying deposit money twice, which is Rs. 500-1000, for banks as zero-balance accounts are not being opened. Such high deposit money is mostly unaffordable for the most marginalised as has already been mentioned through the case of Sabar tribe.

There is lack of clarity on use of MGNREGA accounts which are in the name of the women. These are not being used for IGMSY in Chhattisgarh; whereas in Bihar MGNREGA and JSY accounts are acceptable, but perhaps not IAY accounts as the AWW mentioned. In Jharkhand only separate accounts for IGMSY are acceptable. This is not the case in Madhya Pradesh as any individual account in the name of women is accepted, irrespective of the scheme for which it was opened.

The deposit money and bribe that Sanju Devi, and many like her, ended up paying could have been easily avoided if old account was used. The absence of uniform practices creates confusions for which the beneficiary ends up paying the price.

[165] The process of Aadhar enabled direct benefit transfer (DBT) is in place in the district.

Social Barriers

Women's Dependency: Gender and Low Educational Levels

Across the four states most women were dependent on someone, mostly AWWs and their husbands, to help them open and operate their account or just to accompany them to the banks. This dependency stemmed either from their lack of education or agency, both a result of their subjugation under patriarchal norm of the society. However, the degree and nature of women's dependency varied with each case.

There were cases where women were not operating their accounts at all. For instance, Deewad Dhuru, 32, did not go to post office to open her account. She lives in Maragaon, Dhamtari and the post office is 30 km away in Singpur. Her husband took her signature on the application form and submitted it. "*Saath main toh purush jaati jana hi padega bank 30 km door hai*" (men will have to accompany women, bank is 30 km away), said the ASHA of the same village. However, women were operating their bank/postal account with the help of their husbands only in one district of Chhattisgarh. The situation was much different in Bastar district due to low levels of education as explained below.

In Jharkhand, some women operate their own account but usually helped by husband or male family member or also mother-in-law. The scene was quite similar in Madhya Pradesh as none of the women opened their own accounts. Mostly they took help of their husbands, otherwise of the AWW. The husbands or the AWW also accompanied women to withdraw money from the bank. In Bihar this dependency was less as either women withdrew on own or AWW accompanied women to Post office or bank when withdrawing. In a few cases frontline worker withdrew the money and gave it to the woman.

Women's dependency on AWWs or ASHAs or ANMs was equally high. In Madhya Pradesh's Sagar district for the past two months accounts are being opened only in banks, which is located about 25 km away. The region forms part of Bundelkhand and is considered quite unsafe for women to travel alone. Since the AWW of a village in Shahgarh block had too many women to open their accounts in bank, she took all women in a tractor.

Similarly, women's low educational levels in Bastar district become the reason why AWWs had to accompany them. Both the AWW interviewed in the district stated that they take all women whose account is to be opened, fill their forms and help them in getting photographs and other things. One of them said that it takes them 3-4 days of regular effort to open

women's account sometimes the documents are not complete or the names in the form have been spelled wrong. The ASHA in Lango village helped women to open their accounts in East Singhbhum district, Jharkhand.

There were also cases where women due to low levels of education and convenience depended on the frontline workers to open their account. Sundar Devi, who lives in Agma, gave her signed form to the ASHA to open her account. Jamna, in Chhindwara district asked the primary school teacher to open her account.

It is apparent from these cases that the reason for opening account with the help of husbands or AWWs is low level of education and lack of prior experience and knowledge of opening or operating bank accounts. This reinforces the dependency women have on their husbands and families in general. As a result, the envisioned aim of building financial agency among women by opening their individual accounts is only partially achieved. But, it is still a positive step because for many women this is the first time they own an individual account.

However, a negative effect was institutionalisation of their dependency. A few frontline workers in Chhindwara, Madhya Pradesh, stated that the post office refused to give money to the beneficiaries unless accompanied by her. "The post master tells them to come with the AWW so that they fill their withdrawal forms. If the woman is educated she doesn't need the AWW," said an ANM in one of the villages. Similar practice was found in Bihar where the AWW has to go with the beneficiary because she has to be a witness to the withdrawal of money. These can be problematic when the frontline workers are corrupt.

Conclusion

In the above section different barriers have been described, but on ground they cut across each other. Sangeeta from Korangali village managed to overcome the barriers of distance, out of pocket expenditure, illiteracy, gender and absence of ZBA to access her entitlement, but still could not get her entitlement due to delay or alleged corruption at the post office's end. In such a context it becomes important to critically look at the programme's design and make it as accessible as possible. For instance, Sanki, a beneficiary in Maragaon village of Magarlod block's tribal region, thinks that she should get the money in lump sum as it saves her time and money in going to Singpur, which is 20 km away. If Magarlod block being in

the DBT district of Dhamtari has distance issues, then this reflects that distance can act as a bigger barrier in other regions as well.

The different kinds of barriers to access also undermine the objective of the scheme. Issues with ZBAs, pre-requisite documents, misinformation can be dealt with at the operational level, but corruption, geographical and social barriers are institutional issues and cannot be dealt within the purview of one scheme. These issues require emphasis in broader social policy. As for IGMSY, delay of any kind, and at any level is ultimately going to affect the purpose of the scheme, which is to provide women and their children rest and nutrition during pregnancy and after child birth.

For the beneficiary, a delay is a delay. However, the reasons causing this delay are many and often intricately linked. If a beneficiary opens the bank account late, the AWW would demand the money from the block office late. And even if block and district clear the transfer in time, but the account number of the beneficiary is not correct, there will be delay. But, to avoid these delays the first step is to avoid delays from the government's end because unless there is money in the pipeline no transfer can be done. Since, IGMSY presently is a centrally funded scheme the Government of India must allocate budget and release the grant-in-aid on time to states. The plans to scale up the scheme to all districts,[166] even if with a cost-sharing agreement between the centre and the state,[167] would require allocation of sufficient funds to the scheme. The current allocation of Rs. 438 crore is extremely insufficient to implement the revised provisions, (see chapter 1 for more details on budget). Once the grants-in-aid are in place, the procedural causes of delay such as preparing proper utilization certificates, late transfer to beneficiaries by banks and post offices etc., can be avoided, at least to some extent, by issuing guidelines to districts, blocks, banks and post offices and ensuring adherence to them.

The issue of delayed payments demands utmost attention for this scheme to survive and have any meaningful impact, the worst part is that it is not even recorded. Given the lack of another evaluation after the ASCI survey and the inconsistency in the data provided by the state departments, it becomes extremely important that the central government exert some pressure on the states to maintain proper records. In the absence of correct data on delayed

[166]Letter from Ministry of Women and Child Development, Government of India, F.No. 4-3/2014-IGMSY dated 30 December 2014

[167] Letter from the Ministry of Women and Child Development, Government of India, F. No. 5-10/2012-IGMSY, dated 13 November, 2013

payments or other aspects of the scheme, it would become impossible to make any informed policy decision on it without the risk of being far away from reality.

Some of government officials very easily concluded that the scheme is not effective as money is not being spent on the appropriate items. "Women receive the money and they spend on their make-up and clothes first. Food is last on their minds," said Joint Director, Department of Women and Child Development, Madhya Pradesh. However, the government official failed to acknowledge that the money was not being given on time. It is obvious that unless women have the IGMSY money in their hand during pregnancy they will not consider resting or buying nutritious food for themselves. The delays earlier discussed in the chapter are operational issues, but they defeat the purpose of the scheme. If a woman receives the money one year after she was due that instalment, then it is obvious that later the money would get spent on things other than nutrition and rest of the woman during pregnancy. The support that the government had intended to provide her during a vulnerable phase would not reach her on time. It will also act as a demotivating factor for compliance to the conditionalities laid down in the scheme.

"*Jaldi milta toh ghar reh leti,"* (had I received the money earlier I would have stayed at home) said Dhani Hemrom, a beneficiary from Karmapani village in Jharkhand. Similarly, another beneficiary from Agma village in Bihar said that the money for the child could not contribute to nutrition because it came very late. Hence, the importance of timely payments must not be overlooked because delay would come at the price of women's and their children's well-being.

7. Challenges and Recommendations

Based on the findings of the study the following section highlights the problematic aspects of the IGMSY related to programme design, implementation, staffing, fund flow and corruption. Additionally, recommendations are provided for improving implementation and positive impact of the programme under NFSA.

Design Related

There are three aspects in the design of IGMSY which are problematic from the perspective of inclusion of the most marginalised women. These are the following:

- **Eligibility conditions (two live births and 19 years):** These conditions lead to exclusion of many women across states (see Table 10 for details).
- **Conditionality:** The various conditions such as health check-ups, immunisation and others, serve as a barrier for women to claim their maternity entitlements because there are issues of inaccessibility, supply side gaps and corruption.
- **Amount:** The amount of Rs. 6000 has been fixed without taking into consideration the minimum wages and inflation rate.

The following sections draw on the field finding and discuss the issues which make these aspects problematic and in what ways can they be addressed.

Targeting causes High Exclusion

The restriction of IGMSY cash transfer to women of 19 years or over, and for first two live births results in the exclusion of a large number of women who require these benefits. Exclusion of women as a result of the two selection criteria is 56 per cent in Bihar, 44 per cent in Madhya Pradesh, 49 per cent in Jharkhand and 40 per cent in Chhattisgarh.

Examining the two eligibility criteria separately, we find that the exclusion as a result of the two live births criterion results in higher exclusion than the minimum age criteria of 19 years.

The total fertility rate is above two in – Bihar 3.4, Madhya Pradesh 2.9, Jharkhand 2.7 and Chhattisgarh 2.6.[168] This fact means that TFR leads to exclusion from the IGMSY. The number of women excluded are: 40 per cent in Bihar, 32 per cent in Chhattisgarh, 37 per cent

[168] See GoI (2013i) for tables on total fertility rate

in Jharkhand and 40 per cent in Madhya Pradesh. The average rate of exclusion across these states as a result of the two live births criterion is 39 per cent.

Similarly, the eligibility criterion of minimum age alone leads to an average exclusion of six per cent women in the four states. The state-wise exclusion as a result of this criterion is – Chhattisgarh five per cent, Jharkhand eight per cent, Bihar six per cent and Madhya Pradesh six per cent. Additionally, exclusion amongst women who require maternal benefits the most, such as traditionally marginalised castes and tribes, is higher than the national average.

Table 7.1: Exclusion within Social Categories Due to Selection Criteria

Social Category	Women Not Benefitting Due to Two Child Criterion (%)	Women Not Benefitting Due to Age Criterion (%)
Scheduled caste	34	7
Scheduled tribe	40	8
India	32	6
Source: *Census of India, 2011*[169]		

Conversations with government officials reveal that the logic of an eligibility criteria is to encourage behaviour change. There is undoubtedly a need to educate women and their families about the benefits of marriage after 18 years and smaller families, but the approach to this must be preventive and not punitive.

Recommendation

- Removal of eligibility conditions: Any form of targeting shall be removed from the programme design of IGMSY to increase inclusion.

[169] (GoI, 2011a)

Inaccessibility

Remoteness and Inaccessibility

Registering at the Anganwadi Centre (AWC) is the first step to receiving benefits under the IGMSY. The AWC is usually located in the main village. As a result women residing in hamlets (*tolas*) located away from the main village find it difficult to access AWC services and fulfil the conditions of the IGMSY. Similarly poor road connectivity, weather and absence of 24x7 transport services also pose challenges and make accessing institutional healthcare facilities, especially during emergencies, impossible.

Entitlements Linked to Residence

It is common practice for pregnant women to stay at their natal home. Women in Bihar reported being informed by frontline workers that they were entitled to receive IGMSY cash only at their marital home, and not their natal home. However, when they asked for their entitlements on returning to their marital homes, they were denied the same because they had failed to register at the AWC of their marital homes in time.

There was a lack of consistency amongst frontline workers regarding this matter. Some stated that the entitlement is provided at one's natal home too, while others stated it is not. In MP and Chhattisgarh frontline workers stated that the decision depended on the duration of stay at the respective village. However, there was no standardised acceptable duration.

Linking entitlements to residence also poses an issue for women who migrate for work during pregnancy. No guidelines have been defined to ensure migrants can also access their entitlements.

Recommendations

The following recommendations may be adopted to address these issues:

- **Remove Conditionalities**: Behavioural change for seeking health care shall be promoted, but without making the instalment contingent upon fulfilment of any conditions.
- **Set up of 'Birth Waiting Homes'**: These homes shall be set up as detailed in the Maternal and New born Health Toolkit (November 2013)[170] in inaccessible and difficult

[170] See GoI (2013f)

to reach regions (remote, hilly and tribal). Pregnant women may stay here from a week before their expected delivery date. These homes are to be constructed within the compound of a health care centre or near it. This will ensure an easy transition when a woman goes into labour, from the Waiting Home to the health care facility. In Gujarat such homes are called Mamta Ghars.[171] Here a skilled birth attendant is available 24x7, and food is provided to the women.

- **Delivery Plans**: Advice on and assistance in creating a delivery plan by Anganwadi Workers (AWW) and ASHAs for pregnant women living in remote and difficult-to-reach locations, during the interim period, while Birth Waiting Homes are being constructed. This plan should be put into action a week before their due date. The plan should include stay at a relative's place that is more accessible, identification of a mode of transportation and driver, identification of a higher level health facility in case of complications. Additionally, women must be advised to put aside savings, if possible, from the start of their pregnancy to defray some delivery related expenses.

- **Portable MCP cards**: Transferable/portable Mother and Child Protection (MCP) cards, so that women can register at AWCs other than the AWC at their permanent residence.

- **Registration at Multiple Points:** Registration facility for pregnant women at multiple points of service delivery like sub-health centres, primary healthcare centres and community healthcare centres. Additionally, registration of women during home/village visits by AWWs, ASHAs and ANMs.

Inadequate Amount

The IGMSY amount was supposed to provide 40 days of rest to pregnant and lactating mother by giving Rs. 100 per day as wage compensation for 40 days. However, this is way below the minimum wages and undervalues women's economic contribution. Presently, even the increased amount of Rs. 6,000 provides wage compensation only for 29 days approximately at the current minimum wage rate of Rs. 204. This means that the amount is too low to provide adequate rest to women and create an enabling environment for exclusive breastfeeding.

[171] See NRHM (2012)

Recommendation

- **Inflation Adjusted Cash Transfer:** Fixing of the IGMSY cash amount at Rs. 6,000 is problematic keeping in mind the fluctuating prices and general trend of rising inflation. A provision to annually revise the amount in keeping with the rate of inflation must be considered.
- **Centre-State Cost Sharing:** The fixed amount of not less than Rs. 6000 shall be paid by the central government and the state governments shall add to this amount, and progressively increase it to minimum wages for nine months.

Implementation Related

Awareness and Campaign

Lack of Clarity amongst Frontline Workers on Eligibility

The misunderstanding of the IGMSY eligibility criteria is resulting in exclusion of potential beneficiaries. For example, the criterion stating women will receive IGMSY cash for their first two live births, has been misunderstood at the village level. AWWs in Dhamtari, Chhattisgarh and Vaishali, Bihar stated that there must be a three year interval between the first and second child. If this is not the case a women will not receive IGMSY cash for her second child. Another example of misinformation was observed in Chhindwara, Madhya Pradesh. Here it is believed that a woman must be sterilised after her second child in order to qualify for the IGMSY cash transfer. A possible reason for such misinformation is that IGMSY training is combined with training on other programmes.

Lack of Information and Awareness amongst Beneficiaries

Since the IGMSY is premised on the fulfilment of conditions for receipt of entitlements, it is essential that women be aware of what the IGMSY provisions are, as well as its conditions. The lack of such awareness and clarity regarding the scheme and its conditions, leads to the exclusion of eligible beneficiaries, and the failure to demand all entitlements. Issues related to Beneficiary awareness are discussed below.

Late Registration

Late registration at the AWC caused by temporary change in location, i.e. visiting natal home or migration for livelihood, lack of information, inaccessibility and others. These reasons vary on case-to-case basis but cause delay in payments.

Inadequate Counselling

Counselling of women for increased awareness about good health and nutrition is crucial for the success of the IGMSY. Unfortunately counselling sessions appear to be held sporadically, if at all. Sometimes information is provided to the women in passing at the Village and Health Nutrition Day (VHND). This hurried and unstructured dissemination of information is resulting in communication gaps and low recall of information amongst the women.

Counselling Curriculum

Frontline workers reported informing women about various pregnancy and lactation related matters. However there is no standardized set of information provided to women during counselling sessions.

Exclusive Breast Feeding (EBF)

Information regarding EBF is not being clearly communicated to pregnant women. Not feeding solid food for six months appears to be a common understanding of EBF. As a result several instances of infants being given water within six months, was observed. Additionally, several mothers informed us that they discarded colostrum before breastfeeding their child. The following recommendations may be adopted to address these issues

Recommendations

- Compulsory wall paintings at each AWC clearly stating eligibility for and entitlements under the IGMSY.

- Emphasis on counselling for newly weds on pregnancy, registration, AWC services, their entitlements etc.
- Removal of deadline for registration at the AWC, to ensure beneficiaries do not lose the entitlements for which they have fulfilled or can fulfil conditions.

- THR distribution after meetings/counselling takes place at the VHND, so that women have an incentive to stay for the meetings. The VHND appears to be an ideal space for such counselling sessions since it requires women to make only one visit to the AWC. The VHND timing must be set in consultation with the women so that it is held at a convenient time when most women can attend.

- Adoption of a standardised and structured four session counselling curriculum. This should be taught in an interactive and intensive setting. The counselling must be provided after other VHND services such as vaccinations, antenatal check-ups are completed. THR distribution should take place after all services and counselling is provided.

Inadequate Training

Gap between Envisioned and Actual Role of Health Workers

The IGMSY involves health workers (ASHAs and ANMs) to provide IFA tablets, antenatal check-ups and immunise mothers and infants. Receipt of these services is a condition for receiving benefits under the scheme. In some cases ASHAs are also the initial source of information about the IGMSY. In other words, the health workers are envisioned as an integral part of the IGMSY. However, the ANMs and ASHAs interviewed did not see their role as essential.

Lack of Timely Detection and Referral

To ensure a holistic health intervention it is essential to have timely referrals of pregnant women with complication and severely malnourished infants. Several instances were recorded wherein the frontline workers failed to provide necessary guidance and refer cases at the appropriate time. This led to increased financial burdens on the patient's family. The following recommendations may be adopted to address these issues.

Recommendations

- Improvement in training of field workers based on an intensive training module such as Indira Gandhi Matritva Sahyog Yojana – Training Module, Ministry of Women & Child Development (2011).

- Training of frontline workers in identifying and carrying out a plan of action for complicated/emergency cases.

- Training in smaller cohorts by a person familiar with popular practices, language and who is not within the ICDS hierarchy. This will make the training more interactive and in turn retention would be higher.

- Joint training of frontline workers (ASHA/ANM/AWW) on the IGMSY using the above mentioned IGMSY training module.

- Issue of joint orders by the Ministry of Women and Child Development and the Ministry of Health and Family Welfare on the role of ASHAs and ANMs in IGMSY.

Delay in Opening Bank and Post Office Account

Under the IGMSY banks and post offices are the only permissible channels for cash transfers to beneficiaries. For this reason it is crucial that they function in an efficient and beneficiary friendly manner. The key issues faced by beneficiaries relate to:

Question of Access

In remote and inaccessible areas it is very difficult to access banks and post offices. In Madhya Pradesh, Chhattisgarh and Jharkhand banks were situated as far as 25-30 kilometres, from villages. The difficult terrain made these banks even harder to reach. In Bihar the distances were shorter, but poor road and transport connectivity acted as barriers to accessing services. Allowing post office accounts for IGMSY cash transfers was intended to address this issue, however it has proven to be insufficient. In some cases post offices were also far from the village. For instance in MP, distances ranged from 3 to 17 kilometres and in Chhattisgarh 8-30 kilometres. An additional issue with post office accounts is the perennial delay in cash transfers.

Absence of Zero Balance Accounts (ZBAs)

ZBAs were absent across the sample. Beneficiaries had to deposit Rs.50-200 in post offices and Rs.500-1,000 in banks to open their accounts.

Different Accounts for Different Schemes

Existing accounts held by women e.g. for JSY/MGNREGA, are not being used for IGMSY due to misinformation among frontline workers. Most beneficiaries were instructed to open a new account for IGMSY. There are discrepancies across states on the matter. For instance, Chhattisgarh has completely ruled out using MGNREGA accounts for IGMSY, but Madhya Pradesh has not. The following recommendations may be adopted to address these issues.

Recommendations

- Coordination with RBI to ensure opening of zero-balance accounts.
- Issuance of clear orders on procedure for opening bank and post office account.

- Issuance of orders regarding usage of existing accounts in the name of the beneficiary such as JSY/IAY/MGNREGA accounts.

- Introduction of doorstep banking in remote villages through modes such as the Business Correspondent Model.

Staffing and Coordination Related Issues

Although staffing and coordination are implementation issues, they are discussed separately because they require more specific consideration. Sufficient well trained staff is crucial for the successful implementation of any programme. Several staffing related issues exist that prevent the smooth implementation of the IGMSY.

Common ICDS and IGMSY Implementation Platform

The implementation of the IGMSY through the Integrated Child Development Services (ICDS) platform results in the transfer of the problems plaguing the implementation of the ICDS, to the IGMSY. These include:

Overworked and Underpaid Staff

Staff at the village level is overworked due to the wide scope of ICDS. In such a scenario it is unlikely that additional IGMSY responsibilities will be properly fulfilled. At Sagar in Madhya Pradesh, IGMSY staff complained of low remuneration and impermanence of job. This is also the reason for seeking other jobs. As a result recruiting new staff under the scheme is difficult.

Vacant Posts

There exists an acute shortage of district, block and village level personnel, and the issue is worse in areas that have difficult terrain or are affected by insurgency movements. This issue is particularly significant at the level of Child Development Project Officers (CDPO), Supervisors and AWWs. As a result personnel are required to administer multiple programmes/project areas/AWCs. This prevents quality implementation of the scheme.

Frequent Transfer of Officials

The smooth functioning of the IGMSY is hampered by the frequent transfer of administrative staff. Officials take time to familiarise themselves with the new work, programmes and team.

In such a scenario frequent transfers are inefficient and hamper the implementation and monitoring of the scheme.

No IGMSY Cells

State or district IGMSY cells had not been constituted in Jharkhand and Bihar. In Chhattisgarh, state and district cells were created. However, no recruitment of dedicated staff was done. Instead, current staff were appointed to administer the cell. In MP, too, cells had been constituted at both levels and recruitment for new staff was done. Despite this, in Chhindwara district, the post of the District Programme Assistant had never been filled.

In Chhattisgarh and Jharkhand, the constitution of IGMSY cells were delayed due to the model code of conduct being enforced for the Lok Sabha and the Vidhan Sabha elections.

The failure to constitute or staff state and district IGMSY cells has resulted in the failure to take crucial implementation steps,[172] such as:

- Appointment of newly recruited personnel responsible for IGMSY implementation.
- Issuance of consolidated state specific guidelines[173] in any of the four states.
- Defining of a monitoring system including periodic reporting.
- Facilitation of timely fund transfer, streamlined and transparent payment procedure.

Inefficient Block Level Administration of IGMSY

The block is a significant administrative level. It helps bridge the gap between the district and the village, both in terms of access for beneficiaries, as well as implementation of the scheme. Despite this, the IGMSY guidelines do not designate any block level posts. As a result the speedy processing of IGMSY related work is hindered.

Inter-Departmental Coordination and Cooperation

The absence of IGMSY cells and staff, that exclusively monitors the implementation of the IGMSY, has also compromised inter-departmental coordination. Coordination with the Department of Health and banking/postal authorities is crucial for the successful

[172] Functions of the state and district cells as defined in guidelines issued by Ministry of Women and Child Development, Government of India in letter F.No. 9-5/2010-IGMSY dated 4th April 2011

[173] The states have sporadically issued orders and guidelines for implementation of the IGMSY. However, these are not as effective as issuance of consolidated guidelines, primarily because accurate information reaching the village level is a time taking and challenging process. Multiple orders and instructions results in misinformation and inefficient implementation of a programme.

implementation of the IGMSY. The health department in particular provides many services that constitute conditions under the IGMSY. These include issuing MCP cards, immunisation, ante-natal check-ups and issuing IFA tablets. Any lapses in these services affect the effectiveness of IGMSY.

Recommendations

The following recommendations may be adopted to address all these staffing related issues:

- Reconsideration of implementation of IGMSY through ICDS platform. If the programme is to be scaled up to the entire country, ideally a separate implementation platform is required. Till such time that scale-up does not take place, implementation of the programme should be done by the Ministry of Health and Family Welfare.

- Setting up of state and district level IGMSY cells in keeping with the guidelines issued by the Ministry, to be done on a priority basis, i.e. additional appointment of two persons (one coordinator and one programme assistant) at both state and district level.

- Filling of vacant posts of CDPOs and Supervisors at project (block) level to be done on a priority basis.

- Fixing of minimum period of appointment of staff (unless transferred for punitive reasons) to avoid difficulty in implementation.
- Reviews with the Health Department on a regular basis to address problems that require inputs from Health Department.
- To avoid MCC related delays in appointments, there is need for anticipation of such delays at state level reviews. In turn, the respective department must issue strict deadlines for appointments while accounting for election related formalities.

Fund Flow Related Issues

Several complaints were received related to the transfer of funds/cash at different administrative levels. Broadly the complaints related to delays in transfer of funds from:

- The Ministry to the department implementing IGMSY.
- The department implementing IGMSY to the block level.
- The block level to bank/post office.

Additionally, delayed transfer of cash to beneficiaries was also reported. These delays ranged from three months to two years. As a result beneficiaries sometimes make multiple visits to the bank/post office to determine if the cash has been deposited in their account. Aside from beneficiaries, frontline workers also reported often not receiving the incentive money they are entitled too. The following recommendations may be adopted to address these issues.

Recommendations

- Identification of bottlenecks and frequently occurring challenges through comprehensive tracking of fund flows across various administrative levels.
- Monthly review of delayed fund transfers with banks/postal authorities to address delayed payments.
- Issuance of orders by the Reserve Bank of India (RBI) regarding penalties for delayed bank payments.
- Weightage to amount of pending payments in annual appraisal of officials.
- Set up a SMS system to inform beneficiaries of cash transfers to their account. The beneficiary should be provided the option of registering a phone number while registering at the AWC.

Transparency and Record Keeping Related Issues

Consistent and reliable record keeping is not taking place under the IGMSY. There is a range of reasons for this. These are discussed below:

Overburdened Frontline Workers

AWWs are responsible for record keeping at the village level. AWWs stated that after pre-school education timings they have to fill registers. AWWs reported having to fill up to11 registers. This unmanageable amount of work combined with low income provides little incentive for quality record keeping. Similarly, at the block level offices, lack of staff is one of the biggest reasons for poor monitoring of records maintained by the AWWs. For instance in Bastanar, Chhattisgarh only two of six Supervisors' posts were filled.

Insufficient Training

Some AWWs reported being provided training on record keeping and filling of IGMSY registers, while others received none. In Jharkhand AWWs did not receive the standardized IGMSY register and were maintaining records in regular registers. This was also the case in Bastar. Even where training had been provided there were inconsistencies and information gaps in record keeping.

Manipulated Records

As part of the research study, IGMSY related documents were collected at the district and state levels. While scrutinising the documents we observed several discrepancies in the numbers provided. In one case we received the same figure for all years. In another case we received two documents that provided data on the same heads, however the figures differed. In still another case we witnessed a district level staff call up the respective CDPO and ask her to alter figures so that no discrepancies were visible.

Such instances defeat the purpose of record keeping. It prevents an understanding of coverage and access. It makes it impossible to monitor and identify shortcomings. Most importantly, it prevents the transparent functioning of a programme. In the above stated cases, the intent may not have been to fudge data. It however does draw attention to the need to scrutinise record keeping, consolidation and tallying.

Delayed Reporting and Fund Release

State level data goes through a series of consolidations at different administrative levels. Village level data is consolidated at the block level, block level data is consolidated at the district level and district level data is consolidated by the department. Delays in preparation of reports at each successive level, makes it impossible to submit Monthly Progress Reports (MPRs) in a timely manner. These delays also add to the delay in dispersal of funds from the Centre because the state is unable to submit records to the Ministry on time. In this manner a vicious cycle of delays is created.

In Bihar's Vaishali district we encountered a case where funding had been discontinued because the previous year's utilisation certificate had not been submitted to the CDPO. As a result no beneficiaries were covered that year in the given AWC. This practice of not

disbursing funds if reporting is incomplete, fails to hold the defaulter accountable. Instead it penalises potential beneficiaries due to the incompetence of the AWW.

Recommendations

The following recommendations may be adopted to address these issues:

- Regular training and supervision of frontline workers on record keeping.
- Implementation of a system of surprise check of records maintained by Supervisors and AWWs records by the CDPO.
- Implementation of a system of surprise check of block level records by members of the District IGMSY cell and district level records by the state IGMSY cell.
- In case of no reporting, immediate suspension and issue of show cause notice to the functionary, with time bound investigation of the matter. Appointment of neighbouring functionary as executor till such time that the matter is investigated.

Corruption and Grievance Redress Related

Corruption

Widespread corruption in service delivery often leads to high out-of-pocket medical expenditure for families. Additionally it acts as a disincentive for women to seek institutional health care. Corrupt practices were observed at various stages of the implementation of the IGMSY. These practices were recorded amongst both ICDS and health department workers, and are discussed below.

Bribes for MCP Card

Women interviewed in Bihar stated that they had to pay for their MCP card. The payments demanded ranged from Rs. 10-150. As a result some chose not to have a card made.

Bribes for Account Opening

Bribes and commissions were demanded by AWWs for opening of post-office and bank accounts. The amounts demanded ranged from Rs. 50-200. Women also reported that the postmaster and the AWW demanded a commission ranging from Rs.500-1,000 at the time of withdrawal of IGMSY money.

Passbook Being Held by AWW

It was common practice for women's passbooks to be held by the AWW till they received the IGMSY money from the post office. This was reported in Bihar's Saharsa district and Chhattisgarh's Bastar district. Such dependency on the AWW to get the cash withdrawn further enabled the AWW to demand a commission. In MP's Sagar district the post-master was also hoarding passbooks.

Charges for Free Services

Women report being charged for delivery related services at government hospitals. Such cases were reported in Saharsa, Bihar. In MP women alleged ANMs as well as cleaners and sweepers in hospitals demanded money. Women in Jharkhand and MP reported incurring costs on medication required for post delivery care. ASHAs in Madhya Pradesh and Bihar also stated that they were asked for money by hospital staff when they took women for institutional delivery.

Grievance Redress

Absence of a Grievance Redress Mechanism

Of the four states visited during the study, a Grievance Redress Cell did not exist at the Department level in three states – Bihar, Jharkhand and Chhattisgarh. This lack of attention to grievance redress is visible at the district and block levels too. No system of IGMSY related complaint filing, forwarding and time bound investigation exists here. Additionally, there is no appeals process to allow the complainant to contest a decision.

Lack of Awareness Regarding Grievance Redress

Most women at the village level were unaware that they can formally lodge a complaint about issues they are facing in accessing IGMSY services. Their first point of complaint is usually the frontline worker. Since the complaint is usually against this person itself the purpose of complaining is defeated. The following recommendations may be adopted to address these issues.

Recommendations

- Immediate constitution of a State Food Commission in keeping with the provisions of the National Food Security Act (NFSA),to monitor and review the IGMSY along with other provisions of the NFSA.

- Appointment of the department that implements the Public Distribution System, as the nodal grievance redress department.
- Immediate appointment of District Grievance Redress Officers (DGRO).
- Setting up of a Grievance Redress Cell at the block level that reports to the DGRO.
- Defining of a comprehensive grievance redress system to ensure grievances are addressed promptly. This must include complaint filing, forwarding, time bound investigation and an appeals process.
- Defining provisions for filing anonymous complaints.
- Issuance of a four digit toll free number and creation of an online complaint portal at state level.
- Publicising of grievance redress mechanisms existing at different administrative levels through radio, television and wall paintings at AWCs and schools.
- Utilisation of door step banking and Business Correspondent model or disbursal of cash at a public gathering such as the VHND, to avoid bribes being demanded at the time of withdrawal of IGMSY cash.

8. Conclusion

The introduction of maternity entitlements in the National Food Security Act (NFSA) has been hailed as a recognition by the State that all women are workers. While women in the organised sector are covered by the Maternity Benefits Act, apart from a few small state-level or sector-wise schemes, there is no provision for wage compensation for women in engaged in paid and unpaid work in the unorganised sector. More than 90% of Indian women are therefore deprived of any wage compensation for the period during late pregnancy, delivery and post-delivery. At the same time, maternity entitlements have also been recognised as an important intervention towards creating an enabling environment for six months of exclusive breastfeeding. Exclusive breastfeeding for six months has been recommended by WHO as it has been proven to prevent malnutrition and build immunity. The NFSA also states that along with cash-entitlements during maternity, supplementary nutrition for pregnant and lactating mothers, breastfeeding counselling should also be provided. Universal maternity entitlements therefore have the potential to meet multiple objectives including recognising women's rights as workers, providing social security for women during maternity and promoting exclusive breastfeeding which is a best practice for the child.

Although it has been almost two years since the passing of the NFSA, the Government is yet to operationalise this entitlement through a universal scheme. It is expected that the Indira Gandhi Matritva Sahyog Yojana, which was launched on a pilot basis in 2011, will be universalised to meet the requirements of the NFSA. In this study, we therefore, looked at the implementation of the IGMSY in the pilot districts to understand how it can be improved to ensure inclusion of most marginalised women.

The study was conducted in some of the remotest villages of Madhya Pradesh, Bihar, Jharkhand and Chhattisgarh, including women from most vulnerable communities. It was found that while the IGMSY did contribute positively to women who received the full amount, the implementation was limited in its reach and had many gaps. While in most cases the money was spent on health, food or other household expenses, the timing of the payment was often so delayed that it did was not available to women when they most needed it. Secondly, the amount is too little to have any impact on women's decisions to engage (or not) in paid work. Moreover, gender roles are so entrenched that the burden of work on women remains almost the same even during late pregnancy or very soon after delivery. In the

absence of any public debate on division of labour or support structures to reduce women's work either from within the household or outside (including by the state), the IGMSY entitlement has failed provide women any rest during pregnancy and afterwards. Further, there was no effective counselling on exclusive breastfeeding either.

Even within the limited framework that the IGMSY sets for itself, the scheme is marred with both design and implementation failures. Eligibility conditions such as limited benefits to women above 19 years of age or only up to two live births, it was found, result in the exclusion of the most marginalised. Further conditionalities related to utilising health and nutrition services are also meaningless in the absence of a service guarantee and the difficulties in accessing these schemes in the first place, as seen in most of the villages where this study was conducted. Administrative rigidities such as insisting on registration at the anganwadi centres (even if the woman was registered with the health department) and not including women in their natal homes add to the barriers in access to the scheme. Hurdles are also faced by women in opening zero balance bank accounts and accessing banks in general. For each of these issues, this report suggests some recommendations which can be easily implemented.

The question remains on whether the IGMSY in its current form, where there is link to wages on the one hand and is looked at as a conditional cash transfer scheme to improve health behaviours on the other, addresses the rights of all women as workers to have sufficient time for rest, recovery and child care during maternity. If this is indeed the true spirit behind the entitlement in the NFSA, then the design of the scheme needs to be completely overhauled.

ANNEXURES

Annexure 1

Name of the scheme/programme	**Year of initiation**	**Implemented in**	**Objective**	**Eligibility conditions**	**Conditions for receiving benefits**	**Maternity benefit**
Dr. Muthulakshmi Maternity Assistance Scheme[174]	1987	Tamil Nadu	To compensate women for wage loss during delivery; To ensure access to nutritional food	19 years and above From BPL households For first 2 deliveries	Avail all health services during delivery; Delivery in public health centre; Complete immunization of mother & child;	Rs.12,000 per delivery to be paid in three instalments of Rs.4,000 each
National Maternity Benefit Scheme (Merged with JSYin 2005)	1995	India	To meet the cost of delivery	From BPL household 19 years and above For first 2 deliveries	No conditions	Rs.500 per delivery 8-12 weeks before delivery
Navsanjivani Yojana[175]	1995-96	Tribal areas of Maharashtra	To improve health of population in tribal areas. (Various health-related schemes for tribals are clubbed under it.)	Tribal women and children	-	Health services, food, treatment to malnourished children
Matrutva Anudan Yojana[176]	1997-	15 tribal districts of	To reduce neonatal and maternal	Tribal women	Live two issues (children)	Medicines worth Rs.400 & Rs.400 in cash to pregnant women for visiting

[174] See Oder from Governmentof Tamil Nadu dated 2011
[175]Govt of Maharashtra, Public Health Department. Accessed on January 4, 2015 from http://testmahaarogya.mahaonlinegov.in/Site/Form/DiseaseContent.aspx?CategoryDetailsID=igzy0Gs2U8g%3d
[176]Ibid.

	98	Maharashtra	morbidity and mortality		and current pregnancy Visiting health centre for ANC	health centre for ANC
Chiranjeevi Yojana[177]	2005	Gujarat	To improve access to institutional deliveries for BPL families; To reduce neonatal and maternal mortality	BPL and APL Tribal families (who are not income tax payers); Resident of rural, municipal, municipal corporation and notified areas	-	Private gynaecologists enrolled in the scheme get Rs.1,795 per delivery from the government. Pregnant women do not have to pay anything for delivery; Women get Rs.200 for transportation costs.
Handloom Weavers' Comprehensive Welfare Scheme[178]	2005-06	India	To improve access to healthcare	For handloom weavers – covers four people in a family Age limit – 1 day to 80 years Maternity benefit for first 2 children	-	It's an insurance scheme where money can be claimed from the government. Maternity benefit of Rs.2,500 per child for first 2 children Baby coverage – Rs.500
Rajiv Gandhi Shilpi Swasythya Bima Yojana (as part of Handicrafts Artisans' Comprehensive Welfare Scheme)[179]	-	India	To cover hospital expenses	For Handicraft Artisans – covers four people in a family Age limit – 1 day to	-	It's an insurance scheme where money can be claimed from the government. Maternity benefit of Rs.2,500 per child for first 2 children;

[177]Accessed on January 4, 2015 from: http://www.narendramodi.in/chiranjeevi-yojana-special-care-of-mother-and-child/, http://suratdp.gujarat.gov.in/surat/english/shakho/health-branch/yojana-1.htm and http://www.unicef.org/devpro/46000_47108.html

[178]Accessed on January 4, 2015 from:http://www.delhi.gov.in/wps/wcm/connect/5f8f7b004efbf483b01db9fe99daf05a/hl_sch_hwcwshandloom.pdf?MOD=AJPERES&CACHEID=5f8f7b004efbf483b01db9fe99daf05a

[179]Accessed on January 4, 2015 from:http://handicrafts.nic.in/welfare/rajivgandhi.htm

				80 years Maternity benefit for first 2 children		Baby coverage – Rs.500
Welfare Board – Fisheries Sector[180]	-	Kerala	For pre- and post-maternity care	Fishermen's wives; Above 19 years; For first 2 live births	-	Rs.750 per child for first 2 live births
Janani Suraksha Yojana[181]	2005	India	To reduce maternal mortality ratio and infant mortality rate; To increase institutional delivery in BPL families	For BPL families; For first 2 live births	Delivery in a health institution	Rs.1,400* per delivery *(*amount varies in high and low performing states)*
Mukhyamantri Mazdoor Suraksha Yojana[182]	2007	Madhya Pradesh	To cover expenses incurred on delivery	From labourers' families;	-	Women are given six weeks' wages when pregnant; Husband is given two weeks' wages along with paternity leave
Rajiv Aarogyasri Community Health Insurance Scheme[183]	2007	Andhra Pradesh	To improve access of BPL families to quality healthcare	-	-	It's an insurance scheme where money can be claimed from the government.
Rashtriya Swasthya Bima Yojana[184]	2008	India	To provide health insurance cover to	For BPL families. Covers five members	-	Hospitalization coverage up to Rs.30,000

[180]See (Government of Kerela, n.d.). Accessed on January 4, 2015 from:http://www.fisheries.kerala.gov.in/index.php?option=com_content&view=article&id=111&Itemid=74
[181]JSY guidelines for implementation
[182]Accessed on January 4, 2015 from: http://shivrajsinghchouhan.org/cmsschemesdetail.aspx?id=10
[183]Accessed on January 4, 2015 from: http://www.iosrjournals.org/iosr-jhss/papers/Vol8-issue1/B0810714.pdf

			BPL families	of the family – head, spouse and 3 dependents		
Mamata Scheme	2011	Odisha	To compensate women for wage loss during pregnancy; For adequate rest & nutrition of women To encourage health seeking behaviour like immunization	Above 19 years; For first 2 live births	Registration of pregnancy at AWC; Attending counselling at AWC; Getting regular ANCs; IFA Full immunization of mother and child	Rs.5,000 in four instalments per delivery
MGNREGA Chhattisgarh	2013	Chhattisgarh		Women should have worked for 15 days in a years.		Rs. 4380 as a one-time allowance equivalent to one month's wage

[184]Accessed on January 4, 2015 from:http://www.rsby.gov.in/about_rsby.aspx

Annexure 2

Conditionalities under the IGMSY before

Instalment	Conditions to be Fulfilled	Entitlement Amount (Rs.)	Time of receiving instalment
First	▪ Registration of pregnancy at AWC/health centre within 4 months of pregnancy ▪ At least 1 ANC with IFA tablets and TT ▪ Attended at least one counselling session at AWC/VHND	1500	At the end of second trimester
Second	▪ Register birth of child ▪ Child's immunization: - OPV & BCG at birth - OPV & DPT at 6 weeks - OPV & DPT at 10 weeks ▪ Attended at least 2 growth monitoring and IYCF counselling sessions within 3 months of delivery	1500	3 months after delivery
Third	▪ Exclusive breastfeeding for 6 months & introduction of complimentary feeding as certified by the mother ▪ OPV & third dose of DPT ▪ Attended at least 2 growth monitoring & IYCF counselling sessions between 3rd& 6th months of delivery.	1000	6 months after delivery

Annexure 3

Year-wise and State-wise details Physical Target Fixed and Achievement								
States/UTs	**Target Beneficiaries in 2010-11**	**Beneficiaries covered in 2010-11**	**Target Beneficiaries in 2011-12**	**Beneficiaries covered in 2011-12**	**Target Beneficiaries in 2012-13**	**Beneficiaries covered in 2012-13**	**Target Beneficiaries in 2013-14 (Q-1)**	**Beneficiaries covered in 2013-14 (Q-1)**
Andhra Pradesh	105371	0	105371	17364	105371	65762	112500	72988
Arunachal Pradesh	1617	0	1617	1270	1300	270	1300	0
Assam	75073	0	75073	0	62633	13865	62633	46663
Bihar	104034	0	104034	26171	104034	75669	69186	60733
Chhattisgarh	45569	NR	45569	6295	73569	13613	73569	6972
Goa	7383	0	7383	0	7500	3612	7500	1271
Gujarat	29135	NR	29135	24169	48123	26226	28508	22982
Haryana	5455	0	5455	3760	5120	2483	8160	2915
Himachal Pradesh	7313	NR	7313	3884	5697	1780	5855	2654
Jammu & Kashmir	15665	NR	15665	7873	15665	10767	15665	430
Jharkhand	50096	0	50096	9247	12612	7417	14473	0
Karnataka	80814	0	80814	21780	80814	29069	67319	26141
Kerala	37144	NR	37144	15280	20600	31962	20600	25354
Madhya Pradesh	82844	0	82844	73865	49085	66431	49085	46494
Maharashtra	47800	0	47800	13897	47800	47071	85091	41651
Manipur	5523	NR	5523	3247	5523	0	4174	0
Meghalaya	6693	0	6693	0	6693	1199	6693	212
Mizoram	3490	0	3490	0	3593	0	3593	329
Nagaland	2857	NR	2857	NR	2857	864	1850	1503
Odisha	53735	0	53735	29325	53735	39714	53735	36012
Punjab	41791	NR	41791	690	27386	12247	25199	4665
Rajasthan	98813	0	98813	25067	59468	41932	85464	36947
Sikkim	1519	NR	1519	528	1042	0	1042	304

Tamil Nadu	49050	0	49050	39919	49050	43178	39969	29731
Tripura	9068	0	9068	2642	6255	5031	8136	1595
Uttar Pradesh	98573	NR	98573	11141	38415	14461	38415	4128
Uttarakhand	12686	0	12686	6766	12092	6955	12092	13074
West Bengal	108211	NR	108211	0	108211	58321	108211	36000
Delhi	47439	0	47439	3734	47439	12049	15997	15796
Andaman & Nicobar	2591	259	2591	300	3795	394	6738	2858
Pondicherry	628	0	628	1404	700	518	690	171
Chandigarh	12087	0	12087	1700	8206	2092	8206	1333
Daman & Diu	857	0	857	NR	857	554	857	77
D & NH	3638	0	3638	1104	984	1434	984	0
Lakshdweep	2004	NR	2004	NR	2004	0	2004	0
Total	**1256566**	**259**	**1256566**	**350924**	**1078228**	**636940**	**1045493**	**541983**

Annexure 4

Year-wise and State-wise Details of Funds Released and Outstanding U.C.													
S.No.	**State**	**Fund released 2010-11**	**Fund utilised in 2010-11**	**Fund released 2011-12**	**Fund utilised in 2011-12**	**Fund released 2012-13**	**Fund utilised in 2012-13**	**Total fund released in 2010-11, 2011-12 and 2012-13**	**Total fund utilised in 2010-11, 2011-12 and 2012-13**	**Unspent balance available with the state as on 01.04.2013**	**Fund released 2013-14**	**Fund utilised in 2013-14**	**Unspent balance available with the state as on 01.04.2014**
1	Andhra Pradesh	1021.11	0	2451.79	570.34	2734.68	2930.36	6207.58	3500.7	2706.88	1814.47	3174.35	1347.00
2	Arunachal Pradesh	15.8	0	41.6	57.4	23.59	0	80.99	57.4	23.59	0.00	11.90	11.69
3	Assam	674.85	0	1751.53	11.63	0	596.19	2426.38	607.82	1818.56	149.78	2187.00	-218.66
4	Bihar	983.53	0	2420.89	605.18	0	3051.263	3404.42	3656.443	-252.023	1758.10	3849.02	-2342.94
5	Chhattisgarh	435.73	0	1069.62	259.75	557.76	577.01	2063.11	836.76	1226.35	1456.53	440.72	2242.16
6	Goa	68.87	0	170.34	138.28	57.4	159.29	296.61	297.57	-0.96	300.95	115.68	184.31
7	Gujarat	276.09	0	689.79	965.37	1271.23	1078.67	2237.11	2044.04	193.07	1007.80	1085.70	115.17
8	Haryana	50.01	0	130.3	135.43	50.26	94.63	230.57	230.06	0.51	343.65	96.35	247.81
9	Himachal Pradesh	64.93	0	173.24	169.08	64.84	83.74	303.01	252.82	50.19	124.30	140.36	34.13
10	Jammu & Kashmir	148.08	0	378.46	502.6	349.04	172.03	875.58	674.63	200.95	665.24	9.11	857.09
11	Jharkhand	502.52	0	1174.25	251.03	0	307.1	1676.77	558.13	1118.64	34.64	NR	#VALUE!
12	Karnataka	740.61	0	1884.22	734.3	0	621.47	2624.83	1355.77	1269.06	1452.81	1124.55	1597.32
13	Kerala	357.69	0	862.72	1204.32	553.45	783.6	1773.86	1987.92	-214.06	1390.69	1182.20	-5.57
14	Madhya Pradesh	770.55	0	1931.14	3030.23	1698.75	2452.96	4400.44	5483.19	-1082.75	2128.07	1942.89	-897.57

15	Maharashtra	456.895	0	1121.18	540.06	0	2066.32	1578.075	2606.38	-1028.305	3160.24	2078.19	53.74
16	Manipur	48.81	0	131.88	138.7	43.72	0	224.41	138.7	85.71	0.00	0.00	85.71
17	Meghalaya	61.16	15	158.92	92.78	0	58.64	220.08	166.42	53.66	53.93	33.18	74.41
18	Mizoram	31.43	0	84.88	0.52	54.76	0	171.07	0.52	170.55	0.00	28.54	142.01
19	Nagaland	26.99	0	70.26	97.25	39.79	15.79	137.04	113.04	24	60.64	34.04	50.60
20	Odisha	557.81	0	1258.35	550.1	336.84	1498.41	2153	2048.51	104.49	2038.85	1549.84	593.50
21	Punjab	373.41	0	982.3	23	0	603.65	1355.71	626.65	729.06	66.20	216.91	578.35
22	Rajasthan	884.82	0	2300.22	744.9	0	1668.09	3185.04	2412.99	772.05	935.01	1750.97	-43.91
23	Sikkim	13.86	0	39.34	36.37	8.75	0	61.95	36.37	25.58	7.87	13.71	19.74
24	Tamil Nadu	449.085	0	1150.07	1020.74	0	1430.12	1599.155	2450.86	-851.705	3032.19	2274.54	-94.05
25	Tripura	85.59	0	213.81	67.61	0	190.3	299.4	257.91	41.49	60.94	60.94	41.49
26	Uttar Pradesh	901.81	0	2294.67	476.54	0	431.26	3196.48	907.8	2288.68	95.29	212.61	2171.36
27	Uttarakhand	134.45	0	297.43	419.87	332.14	299.17	764.02	719.04	44.98	322.64	525.19	-157.57
28	West Bengal	1023.05	0	2517.43	0	0	1941.95	3540.48	1808.83	1731.65	394.82	1038.85	1087.62
29	Delhi	426.56	0	1104.53	132.7	0	413.55	1531.09	546.25	984.84	58.65	580.78	462.71
30	Andaman & Nicobar	24.02	8.05	63.51	62.9	12.44	12.44	99.97	83.39	16.58	122.32	70.06	68.84
31	Pondicherry	5.76	0	18.76	15.4	7.61	7.77	32.13	23.17	8.96	32.75	11.70	30.01
32	Chandigarh	114.64	0	283.58	29.3	60.69	86.21	458.91	115.51	343.4	20.23	51.15	312.48
33	Daman & Diu	7.33	0	24.04	0	0	18.86	31.37	18.86	12.51	4.13	1.93	14.71
34	D & NH	35.8	0	88.3	55.66	0	21.6	124.1	77.26	46.84	11.29	NR	#VALUE!
35	Lakshadweep	22.24	0	50.52	0	0	0	72.76	0	72.76	0.00	NR	#VALUE!
		11795.89	23.05	29383.87	13139.34	8257.74	23672.443	49437.5	36834.833	12602.667	23105.02	25892.96	9814.73

Annexure 5

List of Districts Covered under IGMSY

S.No.	State	District
1	Andaman and Nicobar Island	South Andaman
2	Andhra Pradesh	West Godavari, Nalgonda
3	Arunachal Pradesh	Papum pare
4	Assam	Kamrup, Goalpara
5	Bihar	Vaishali, Saharsa
6	Chandigarh	Chandigarh
7	Chhattisgarh	Dhamtari, Bastar, Kondagaon[185]
8	Dadra & Nagar Haveli	Dadra & Nagar Haveli
9	Daman and Diu	Diu
10	Delhi	West, North West
11	Goa	North Goa
12	Gujarat	Bharuch, Patan
13	Haryana	Panchkula
14	Himachal Pradesh	Hamirpur
15	J & K	Kathua, Anantnag
16	Jharkhand	East Singh Bhumi, Simdega
17	Karnataka	Kolar, Dharwad
18	Kerala	Palakkad
19	Lakshadweep	Lakshadweep
20	Madhya Pradesh	Chhindwara, Sagar
21	Maharashtra	Bhandara, Amravati
22	Manipur	Tamenglong
23	Meghalaya	E.Garo Hills
24	Mizoram	Lawngtlai
25	Nagaland	Kohima

[185] This district was carved out of Bastar in 2012 and since then IGMSY is being implemented in the district.

26	Orissa	Bargarh, Sundargarh
27	Pondicherry	Yanam
28	Punjab	Amritsar, Kapurthala
29	Rajasthan	Bhilwara , Udaipur
30	Sikkim	West Sikkim
31	Tamil Nadu	Cuddalore, Erode
32	Tripura	Dhalai
33	Uttar Pradesh	Mahoba, Sultanpur[186]
34	Uttarakhand	Dehradun
35	West Bengal	Jalpaiguri, Bankura

[186] includes Musafirkhana, Amethi, Gauriganj tehsil of Chhatrapati Sahuji Maharaj Nagar

Annexure 6

List of Blocks and Villages Selected

State	District	Block	Village
Bihar	Saharsa	Sonbarsa	Amrita
			Agma
	Vaishali	Patepur	Baligaon
			Jaisinghpur
Chhattisgarh	Bastar	Bastanar	Korangali
			Kumar Sadra
	Dhamtari	Magarlod	Maragaon
			Dudhwara
Jharkhand	Simdega	Jaldega	Karmapani
			PO Sukran
	East Singhbhum	Dumaria	Kenduya
			Lango
			Bumbro
Madhya Pradesh	Sagar	Shahgarh	Jhadola
			Dhabara
	Chhindwara	Tamia	Navri Tola
			Karream Rated

Annexure 7

Questionnaires

INDIVIDUAL SURVEYS – Beneficiaries

Section 1

1. Name? Age? Education?
2. Are you married? If yes, at what age did you get married?
3. Is your family a joint or nuclear family? (Reside in this house – include chulha criteria)
4. Details of pregnancies – live births, still births, miscarriages, abortions, space between pregnancies.
5. Details of live children – age, space between them
6. Where did you deliver?
7. How much did you spend on delivery? (Travel cost, medicine cost, hospital expenditure etc.)
8. Did you take any loans to meet delivery related expenses?
9. Who did you take the loan from? How much?
10. During a crisis whom do you take financial help from?
11. Did you receive JSY cash? How much was it? When did you get it?
12. For what did you use the JSY money?

(Only in Chhattisgarh)

C1. Do you do NREGA work?
C2. (If yes) Did you do NREGA work while you were pregnant? How many days?
C3. During pregnancy did you receive any money through NREGA without working?
C4. Have you heard of others receiving such money?
C5. Why did you not get this money?
C6. For what did you use the NREGA money?

13. Did you register at the anganwadi when you were pregnant?
14. When did you register at the AW? What was the process?
15. Did you go for check-ups or vaccinations while you were pregnant? If no, why not?
16. Where was the doctor/health centre you visited?
17. How did you access the health services? (Transport)
18. How much did this cost you? (each trip)

19. Was there any change in diet during your pregnancy?
20. Any differences between pregnancies?
21. Do you think there should have been a change? What changes, according to you, are necessary?
22. Why could you not change your diet during pregnancy?
23. Did you receive take home ration from the anganwadi during your pregnancy?
24. How often did you receive iron and folic acid (IFA) tablets during your pregnancy?
25. Did you face any complications during your pregnancy and delivery?
26. Did you go to your mother's home to deliver?
27. How long do you stay at your mother's home after delivery?
28. What expenses did you incur after the child was born?

29. After delivery when did you first breastfeed your child?

30. Was the child given the colostrum (first milk) or was it discarded?
31. What food did you give your baby soon after it was born? (Other animal milk/dabbe ka doodh/water?)
32. When did you start giving him/her complementary food?
33. What kind of complementary food was given?
34. Did you give the baby water to drink? When did you start giving water?
35. Is there anything you feel you should have done differently?

36. Were you provided any information on nutrition and care of the child?
37. Who gave you this information?
38. What problems did you face in EBF?
39. Do you have an MCP card? (Ask to see it if possible. Record if updated or not.)
40. Is your MCP card filled regularly?
41. Do you understand what your MCP card is?
42. Has your child ever been vaccinated/weighed/height measured?
43. Have you ever attended a counselling session at the anganwadi?
44. What was told to you during counselling that you found helpful?

Section 2

45. Do you do any paid work?
46. What kind of paid work do you do? (Agricultural labour / NREGA/migrant worker)
47. Do you do any unpaid work?
48. What kind of household/unpaid work do you do?
49. How many hours in a day do you spend on paid work?
50. How many hours in a day do you spend on unpaid work?
51. How many days in a month do you work outside the house?
52. How much do you earn in a day?
53. Do you give the money you earn to someone else in the house?

54. Did you do paid work during your pregnancy?
55. Till when did you work? During which month of pregnancy did you stop working outside the house?
56. Did you do unpaid work during your pregnancy?
57. What kind of work did you feel was risky to your pregnancy?
58. Did you stop working when you wanted to?
59. (If no) Why didn't you stop working? Were you forced to work? Who forced you to work?
    (If yes) Why did you stop working?
60. Did you stop doing household work when you were pregnant?
61. What kind of work did you stop? For how long?
62. How many days after delivery did you start doing paid work?
63. What type of paid work did you start doing?
64. What the total loss of wages during pregnancy and after delivery?
65. Why did you choose to start work at this point?
66. Did you want to wait longer before starting work?
67. How many days after delivery did you start doing household work?
68. What type of work did you start doing?
69. Why did you choose to start work at this point?
70. Did you want to wait longer before starting work?
71. When you returned to work, who looked after your child?

72. Who looks after the child when you are doing household chores or working outside?(Relatives/neighbours)
73. What kind of help do they provide?
74. Is there any childcare related work that you don't like other relatives/neighbours doing for your child?
75. Is there any childcare related work that other relatives/neighbours don't like doing for your child?

Section 3

76. Have you heard about IGMSY? What does one receive?
77. Where did you find out about it?
78. Who is eligible to get money under IGMSY?
79. What do you have to do to get money under IGMSY? (Paper work, conditions etc.)
80. Did you have to sign an affidavit stating you will EBF?
81. Did you apply for IGMSY for any previous pregnancies? For how many?
82. Did you receive IGMSY money for any previous pregnancies/children?
83. *(Ask if knows about conditions)* Which IGMSY condition is the toughest to meet?
84. What do you think the IGMSY money is given for?

85. Do you have an account?
86. Is the account at a bank or post office?
87. Do you have more than one account? Why? For what purposes/programmes?
88. Are the bank accounts in your name?
89. How many accounts do you have in your name? (ask about each of the accounts mentioned above)

In Chhattisgarh only:

C7. What documents were required to open a NREGA account?
C8. Did you face any difficulty in opening the account?
C9. Is it a zero balance account?
C10. Who operates that account?
C11. Did you receive any money during pregnancy under NREGA? How much?
C12. When did you receive that money? (before, during or after delivery)
C13. What did you have to do to get the money?
C14. Did you register to get the money? Where did you register? Who informed you about registering?
C15. Where was that money used?

90. Did you open a new account for IGMSY?
91. (If yes) Did you have to deposit any money at the time of opening you're a/C?
92. Could you open the account without depositing this money?
93. Did you face any issues at the time of opening the account?
94. What documents did you need for it? (Aadhaar needed?)
95. How long did it take you to open the account?
96. How many times did you have to go to the bank to have your IGMSY account opened?
97. Who operates the account?
98. Do you go to the bank? Does anyone accompany you to the bank when you go to withdraw the money?
99. Do you have a passbook for your account?
100. Where is your passbook right now?
101. Did anyone ask you for your passbook at any point of time?

102. Were you refused services/cash at any point?

103. How much cash did you receive under IGMSY?
104. *(Ask if relevant)* Which condition did you not meet hence not given all instalments?
105. Did you receive the money at one time or in instalments? How many instalments?
106. If in one go, when did you receive it? If after delivery, how many months after delivery?
107. Did you give a part of this money to anyone?
108. What was the cash utilised for?
109. Was the money spent in one go?
110. What do you think the money was given for?
111. What are existing support systems before IGMSY?

112. Do you think getting a lump sum would be better or instalments?
113. Why would you want it that way?
114. When would you like to receive the lump sum or instalments amount?

Section 4

115. If you have an IGMSY related complaint who do you first go to?
116. What kind of paid work would you like to do when you are pregnant or lactating to earn a living?
117. Does the IGMSY help women rest during pregnancy and take care of the child post delivery?
118. If you work on your own fields, would you consider hiring agricultural labour using the IGMSY money?
119. After delivery did you go for a check-up at the AWC?
120. (If yes) When? How many times?
121. What kind of help would you like from the government schemes during your pregnancy?

INDIVIDUAL SURVEYS: Non-Beneficiaries

NOTE: Administer to person who has not received any cash benefits under IGMSY

Section 1

1. Name? Age? Education?
2. Are you married? If yes, at what age did you get married?
3. Is your family a joint or nuclear family? (Reside in this house – include chulha criteria)

4. Details of pregnancies – live births, still births, miscarriages, abortions, space between pregnancies.
5. Details of live children – age, space between them
6. Where did you deliver?
7. How much did you spend on delivery? (Travel cost, medicine cost, hospital expenditure etc.)
8. Did you take any loans to meet delivery related expenses?
9. Who did you take the loan from? How much?
10. During a crisis whom do you take financial help from?
11. Did you receive JSY cash? How much was it? When did you get it?
12. For what did you use the JSY money?

(Only in Chhattisgarh)

C16. Do you do NREGA work?

C17. (If yes) Did you do NREGA work while you were pregnant? How many days?

C18. During pregnancy did you receive any money through NREGA without working?

C19. Have you heard of others receiving such money?

C20. Why did you not get this money?

C21. For what did you use the NREGA money?

13. Did you register at the anganwadi when you were pregnant?
14. When did you register at the AW? What was the process?
15. If not, what were the reasons for not registering? (didn't know/at mother's house/AW didn't register)

16. Did you go for check-ups or vaccinations while you were pregnant? If no, why not?
17. Where was the doctor/health centre you visited?
18. How did you access the health services? (Transport)
19. How much did this cost you? (each trip)

20. Was there any change in diet during your pregnancy?
21. Any differences between pregnancies?
22. Do you think there should have been a change? What changes, according to you, are necessary?
23. Why could you not change your diet during pregnancy?
24. Did you receive take home ration from the anganwadi during your pregnancy?
25. How often did you receive iron and folic acid (IFA) tablets during your pregnancy?
26. Did you face any complications during your pregnancy and delivery?
27. Did you go to your mother's home to deliver?
28. How long did you stay at your mother's home after delivery?
29. What expenses did you incur after the child was born?

30. After delivery when did you first breastfeed your child?
31. Was the child given the colostrum (pehla doodh) or was it discarded?
32. What food did you give your baby soon after it was born? (Other animal milk/dabbe ka doodh/water?)
33. When did you start giving him/her complementary food?
34. What kind of complementary food was given?
35. Did you give the baby water to drink? When did you start giving water?
36. Is there anything you feel you should have done differently?

37. Were you provided any information on nutrition and care of the child?
38. Who gave you this information?
39. What problems did you face in EBF?

40. Do you have an MCP card? (Ask to see it if possible. Record if updated or not.)
41. Is your MCP card filled regularly?
42. Do you understand what your MCP card is?
43. Has your child ever been vaccinated/weighed/height measured?
44. Have you ever attended a counselling session at the anganwadi?
45. What was told to you during counselling that you found helpful?

Section 2

46. Do you do any paid work?
47. What kind of paid work do you do? (Agricultural labour/NREGA/migrant worker)
48. Do you do any unpaid work?
49. What kind of household/unpaid work do you do?
50. How many hours in a day do you spend on paid work?
51. How many hours in a day do you spend on unpaid work?
52. How many days in a month do you work outside the house?
53. How much do you earn in a day?
54. Do you give the money you earn to someone else in the house?

55. Did you do paid work during your pregnancy?
56. Till when did you work? During which month of pregnancy did you stop working outside the house?
57. Did you do unpaid work during your pregnancy?
58. What kind of work did you feel was risky to your pregnancy?
59. Did you stop working when you wanted to?
60. (If no) Why didn't you stop working? Were you forced to work? Who forced you?
    (If yes) Why did you stop working?
61. Did you stop doing household work when you were pregnant?
62. What kind of work did you stop? For how long?
63. How many days after delivery did you start doing paid work?
64. What type of paid work did you start doing?
65. What the total loss of wages during pregnancy and after delivery?
66. Why did you choose to start work at this point?
67. Did you want to wait longer before starting work?
68. How many days after delivery did you start doing household work?
69. What type of work did you start doing?
70. Why did you choose to start work at this point?
71. Did you want to wait longer before starting work?

72. When you returned to work, who looked after your child?
73. Who looks after the child when you are doing household chores or working outside?(Relatives/neighbours)
74. What kind of help do they provide?
75. Is there any childcare related work that you don't like other relatives/neighbours doing for your child?
76. Is there any childcare related work that other relatives/neighbours don't like doing for your child?

Section 3

77. Have you heard about IGMSY? What does one receive?
78. Where did you find out about it?
79. Who is eligible to get money under IGMSY?
80. What do you think the money is given for?
81. What do you have to do to get money under IGMSY? (details about requirements/paper work)
82. Did you apply for the scheme? If not, what were the reasons? (can be the same as registering at the AWC)
83. Why do you think you were not included in the scheme?
84. Did you apply for IGMSY for any previous pregnancies?
85. Did you receive IGMSY money for any previous pregnancies/children? For how many?
86. *(Ask if knows about conditions)* Which IGMSY condition is the toughest to meet?
87. *(Ask if relevant)* Which condition did you not meet hence not given any instalments?

88. Do you have an account?
89. Is the account at a bank or post office?
90. Do you have more than one account? Why? For what purposes/programmes?
91. Are the bank accounts in your name?
92. How many accounts do you have in your name? (ask about each of the accounts mentioned above)

In Chhattisgarh only:

C22. What documents were required to open NREGA account?
C23. Did you face any difficulty in opening the account?
C24. Is it a zero balance account?
C25. Who operates that account?
C26. Did you receive any money during pregnancy under NREGA? How much?
C27. When did you receive that money? (before, during or after delivery)
C28. What did you have to do to get the money?
C29. Did you register to get the money? Where did you register? Who informed you about registering?
C30. Where was that money used?

93. Did you open a new account for IGMSY?
94. (If yes) Did you have to deposit any money at the time of opening you're a/C?
95. Could you open the account without depositing this money?
96. Did you face any issues at the time of opening the account?
97. What documents did you need for it? (Aadhaar needed?)
98. How long did it take you to open the account?
99. How many times did you have to go to the bank to have your IGMSY account opened?

100. Do you have a passbook for your account?
101. Where is your passbook right now?
102. Did anyone ask you for your passbook at any point of time?
103. Do you think getting a lump sum would be better or instalments?
104. Why would you want it that way?
105. When would you like to receive the lump sum or instalments amount?

Section 4

106. Who is the first point of complaint if you do not get the IGMSY money?
107. What kind of paid work would you like to do when you are pregnant / lactating to earn a living?
108. Does the IGMSY help women rest during pregnancy and take care of the child post delivery?
109. If you work on your own fields, would you consider hiring agricultural labour using the IGMSY money?
110. After delivery did you go for a check-up at the AWC?
111. (If yes) When? How many times?
112. What kind of help would you like from the government schemes during your pregnancy?

INDIVIDUAL INTERVIEWS: Anganwadi Workers, Mitanins/ASHAs and ANMs)

1. Name?
2. Post?
3. Age?
4. Educational qualification?
5. Village, Block, District?

General

6. How long have you been employed at this post?
7. What do you have to do as a XXX (name of post)?
8. Did you hold another post before this? What was it?

Profile of women in the village

9. What are the occupations of women in the village?
10. What is common to women who have high risk pregnancies in your village/ area?
11. What work do women do in the last stages of their pregnancies?
12. Generally how soon after delivery do women resume work in the fields/ labour?
13. Which women in this village are the most needy/deprived?

IGMSY – General

14. Have you heard of the IGMSY?
15. How do you know about it?
16. Can you tell me about it? (To see what they understand the IGMSY as)
17. What are the conditionalities under IGMSY? (ask particularly about EBF)
18. Why do you think money is given under IGMSY?

Selection of Beneficiaries

19. How are beneficiaries for the programme selected?
20. Do you have any targets for beneficiary selection under IGMSY?
21. Do you have to identify the beneficiaries from your field area?
22. If yes, how do you do that?
23. Do you feel this criterion includes the most needy?
24. If no, then who gets left out?
25. Why do these women get left out of the scheme?
26. Who do you think needs the IGMSY benefits the most? (refer to group in Q13)
27. What changes are required to ensure these women are included?

Registration

28. How do women register with the AWC? Do you bring them/inform them or someone else does?
29. By when should women register to get the IGMSY benefits?

30. If a women comes late for registration, is there any way to register her for the scheme? How is it done?
31. Are women who are not residents of the village but are staying for a few months be included? (woman's *maike*) How?
32. Is it possible for a woman to receive the IGMSY benefits without getting the JSY benefits?

Coordination and Consultation

33. Who do you consult when there is a confusion regarding whether or not someone should get benefits?
34. Are there any women who should have received IGMSY benefits but were rejected after they registered?
35. If yes, what were the reasons for the rejection?
36. Are these women given any other benefits? (State scheme or from the panchayat/SHGs funds etc.)
37. Do you consult/coordinate with AWWs/ANMs regarding any IGMSY work?
38. On what do you consult them? (ask specifically about registration)
39. Is there a section of population in the village that never visits the AWC? (Details: caste/class etc.)
40. If yes, what are the reasons for it? (physical inaccessibility/class, caste based discrimination/any other reason)
41. Is Aadhar number required to receive benefits?
42. Do you have to submit any information before the beneficiaries get the money?

IEC Activities

43. Have there been any information sessions on nutrition, immunization and pregnancy registration?
44. How often are these held? Where?
45. What happens in these meetings? What are women told?
46. Who all attend these meetings?
47. Do women who stay a little far also attend these meetings? (Women from the hamlets outside the village attend?)
48. Do women actively participate in these meetings? Do they ask questions?
49. Mostly which women ask questions?
50. What are the common queries women have?
51. Do women demand such meeting? If yes, when do they ask for it? (Particular season? Eg. After harvest etc.)
52. Around what time of the day are these meetings held? (morning, afternoon, evening)
53. Does this time suit most women?
54. Has the demand for these meetings increased since the IGMSY started?
55. Do you face any difficulty in holding such sessions? Please give details.
56. Do women face any problems in exclusively breastfeeding? Details.
57. What, according to you, can increase the practice of exclusive breastfeeding?

58. Do you think IGMSY has contributed to an increase in exclusive breastfeeding?
59. Do you feel any overall behaviour change has taken place since the introduction of IGMSY?
60. Do you think the IGMSY can contribute to rest and nutrition of women?
61. Do women drop out of the scheme? What are the reasons for it?

Training, Responsibilities and Record Keeping

62. Was any training provided to you on the IGMSY? (Get details: esp. documentation, filling MCP cards)
63. What skills do you feel you received from the training?
64. Is there anything else that you feel should have been covered in the training?

65. How many hours do you work in total in a day?
66. What kind of IGMSY related work do you have to do?
67. When do you do IGMSY related work? How often do you do it?
68. Is publicizing IGMSY part of your job?
69. If yes, how when do you do it?
70. Do you also work on IGMSY at the AWC or sub-centre/PHC? How much time do you spend on it in a week?
71. Has the IGMSY increased your responsibilities? How?
72. Do you have to routinely submit estimated number of births/pregnant women in the village?
73. Do you have to maintain any paperwork/files for the IGMSY? Which ones? (have a look at them if possible)
74. Have you been short of books/registers to maintain IGMSY records?
75. Look at IGMSY & Growth Monitoring registers, pick every 5^{th} page till 30^{th} page and evaluate if record keeping is complete and legible.
76. During your Annual Performance Appraisal Report (APAR) are you evaluated on any family planning related indicators?
77. (If yes) What are these indicators?

Conditionalities and Cash Transfer Related

78. Do you experience a shortage of MCP cards?
79. Do you store iron and folic acid (IFA) tablets? If yes how often do you receive them?
80. Have you encountered a shortage of IFA tablets?
81. Do you help women in opening or operating bank accounts? If yes how?
82. Do women operate their own accounts?
83. If someone doesn't have a zero balance account can their postal account be used?
84. When do beneficiaries usually receive cash?
85. Where are the biggest clogs in the transfer of funds?
86. Are the cash transfers made in instalments or at one time?
87. Do you get any benefit under IGMSY? If yes, how much and when?
88. Does a grievance redress system exist?

ANMs

Besides the questions on bank accounts, all other questions from the ASHA questionnaire can be relevant for ANMs as well. In addition, ANMs can be asked:

89. Do you tally your record of pregnant women who come to the SHC/PHC/CHC with the ASHAs and AWWs?
90. Do you have to spread awareness about IGMSY when on field visits?
91. Do you provide women with any information regarding their baby? If yes, what? (Birth/feeding related…)?
92. How often do you hold such counselling sessions?
93. Where are these sessions held? (AWC, PHC, sub-centre, panchayat bhawan)
94. Do you ever face shortage of vaccines? (get details – arranging is her responsibility)

INDIVIDUAL INTERVIEWS – State and District Officials

Estimation and Budget

1. Were you consulted by the Centre when the districts were selected?
2. Was a baseline survey conducted?
3. What was the purpose of the baseline? (Was the purpose estimation of beneficiaries?)
4. Please explain to us how the baseline was conducted? (Who did it? What info collected, how is the data useful etc.)
5. What are the main factors accounted for in the baseline? (get performa, if any)

6. What all is taken into account while making the budget?
7. What is the process of making a budget?
8. Did you have to submit any estimates of beneficiaries to the centre/district?
9. What is the basis of district/block level allocation of funds?

10. Did the funds received from the Centre/State match the State's/District's/Block's demand?
11. Did the funds received from the Centre/State match the State's/District's requirements?
12. If not, what kind of unforeseen costs arose?
13. In case of shortage of Central/State government funds, what does the State/District do?
14. What is the process of fund transfer from the Centre to beneficiaries' accounts?
15. Do the funds from Centre/State arrive on time? If not, how late do the funds come?
16. In the meantime is there a backup of some sort?

17. Is money also transferred to postal accounts? If no, are there particular banks that are acceptable?
18. Are the beneficiaries' bank accounts linked to JSY or NREGA accounts?
19. How is the transfer of funds done if they are? (JSY by Health, NREGA run by Rural Dev, IGMSY by WCD)
20. What are the biggest challenges in transfer of funds at the different administrative levels?
21. Is the money transferred to beneficiaries in instalments or a lump sum?
22. If in lump sum, why? (if there is an administrative problem)
23. What is the problem in sending money in instalments?

Staffing and Training

24. Were contractual workers recruited at the IGMSY state/district cell? (Computer operators etc.)
25. Was any training on IGMSY provided to the staff? If yes, which staff received training? When did the training take place? Who provided the training?
26. (Only State) Is the scheme restructured according to the State's requirements?
27. What are the conditionalities?
28. Are the conditionalities met?
29. Is there a mechanism to cross-check whether women are meeting conditions? What is it?
30. Do conditionalities hinder greater inclusion/coverage?
31. Do certain groups get left out as a result of the conditionalities?
    If yes, who does it cover? If no, who is left out?
32. If not, then does the effectiveness of the scheme suffer?
33. Should the conditionalities be removed?

Resources

34. Has the district experienced any shortage of MCP cards?
35. What has been done to meet the requirement of MCP cards?
36. What is done when there is a shortage of MCP cards at an AWC?
37. How frequently are IFA tablets and vaccines supplied to AWCs?
38. Have AWCs, PHCs or sub-centres ever complained of shortage of IFA tablets and/or vaccines?

Monitoring

39. How are the records maintained for IGMSY?
40. How often are these updated?
41. How is monitoring of the scheme done at various levels – block, district, state?
42. How many people in the state/district are employed for record keeping and monitoring?
43. How are the list of beneficiaries submitted by the AW cross-checked and finalised?
44. Do you have to attend national/state/district level meetings related to the IGMSY?
45. Is inter-departmental (Women and Child Development, Social Welfare and Health) coordination difficult? (Regarding MCP cards etc.)

46. Does a grievance redress mechanism exist?
47. Could you tell us a little more about this system?
48. Is the IGMSY workload manageable?
49. What are the biggest challenges you face in implementing the IGMSY?
50. Has the pilot helped foresee difficulties in implementation?
51. Will any changes be made in the programme/scheme based on the pilot?
52. What are these changes? Why will they be made?

(For state officials only)

NFSA related

53. Did you have to submit any estimates/budget for the implementation of the NFSA?
54. Has there been any talks or steps towards scaling up of IGMSY to all districts, in keeping with the NFSA?
55. If yes, what are they? By when is expected to cover all districts?
56. Are there going to be any changes in conditionalities?

(For state officials only)

Universalisation

57. Do you think the scheme will be universalised?
58. Is the state equipped to universalise the scheme?
59. Do you think any changes are needed in the structure? What are they? Why?
60. What would the state have to do to implement it universally?
61. What would the burden on the state be if it is universalised? (financial and other)
62. If no, what do you lack? What do you need?

Annexure 8

Glossary

Awasiya	A documentary proof of residence
Baniya	Local shop owner and moneylender
Basti	Hamlet
Beedi	Locally produced smoking tobacco
Chakki	Manually operated grain grinder
Charpoy	A bed woven from jute rope
Chhati	A ceremony to celebrate child birth
Dhaan	Rice
Dhana	Hamlet
Ghar leepna	The act of applying a layer of cow dung on kuccha house
Ghee	A dairy product
Gramsevak	Village Development Officer
Guniya	Local faith healer or doctor in tribal areas
Hal	A plough which is operated using animal power
Harira	An edible item made of laddo and spices
Jan Sunwai	Public Hearing
Kutki ka bhaat	A preparation of local grain ‘kutki’ for women who delivered a child
Laddo	A sweet preparation for women to be eaten for a few days after delivery
Landa	Alcoholic drink locally produced in tribal areas
Mahua	Edible flowers of Mahua tree used to make alcohol
Mangodi	A spicy snack item eaten in Madhya Pradesh
Masala	A mixture of spices
Mazdoori	Heavy labour work

Naam Karan	A ceremony after child birth to give a name to the child
Nasbandi	Sterilisation
Panchayat	Lowest administrative unit
Para	Hamlet
Peli	Local unit of measurement of grains
Rozgar Sahib	Gram Rozgar Sevak, the official involved in implementing MGNREGA work at the village level
Sachiv	Secretary
Sahayak	Panchayat helper or assistant
Samosa	A snack made of potato and bleached wheat flour
Samuh	A self-help group
Seth	Local Money lender
Tendu	A leaf used to make *beedi*; a Minor Forest Produce
Tola	Hamlet
Tuar	Yellow spilt pigeon peas
Vada	A snack prepared from pulses

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