Maternity Entitlements in India:
A Question of Women's Health, Nutrition and Rights

National Alliance for Maternal Health and Human Rights (NAMHHR) India

NAMHHR URGENTLY RECOMMENDS THAT

1. Maternity entitlements should be unconditional - the Age Eligibility and Parity Criteria should be done away with
2. Maternity benefit should be linked to wages foregone, they should not be arbitrarily fixed, rather they should be compiled on the basis of highest minimum wages and should be periodically reviewed
3. Maternity Benefits should be provided for 9 months (beginning from the third trimester of pregnancy till six months after birth) to enable women to rest before pregnancy and promote six months of exclusive breastfeeding
4. The Public Distribution System must be made universal with protein items included
5. The Supplementary Nutrition Programme of the ICDS must be strengthened; be made more regular and include adequate supply of proteins and other nutritional needs
6. Universal health care coverage should be provided to all women to protect them from devastating out of pocket expenses
7. Crèche facilities be made mandatory in communities and the workplace

FOR SUCCESS OF THE MATERNITY BENEFIT SCHEME WE ALSO RECOMMEND

1. Set up state level Monitoring Committees which have 50% civil society representation
2. Develop strong accountability mechanisms to control corruption in health facilities
3. Promote spacing methods and quality counseling for contraception for both men and women
4. Recruit more Anganwadi Workers and Auxiliary Nurse Midwife (ANM) on priority basis and fill in the staff vacancies
5. Regularize Village and Health Nutrition Day (VHND) and ensure that they provide women with full ANC including checking hemoglobin and blood pressure
6. Pregnancy registration in any AWC should be a sufficient document for opening a zero balance bank account to enable the transfer of the IGMSY money
7. Disburse money in regular installments (women should get it even in case of miscarriage)
8. Setup easily accessible Grievance Redress Mechanisms
9. Conduct social audits and setup local monitoring committees involving local community women
10. Involve civil society in monitoring and evaluation of the pilot phase of the IGMSY Scheme and consider design corrections before 12th Plan

It is a chilly December morning. The researcher, Kaushalya walks through the lanes of Maroonda village in Mahoba, Uttar Pradesh to Leela's house to learn how maternity affects women workers in the unorganized sector. Leela and her husband Kashi belong to the Kushwaha caste, and make ends meet working as wage labourers in the stone quarries nearby. On the days that she does not get work Leela goes to the small field that they own to get fodder. Kaushalya enters the small hut which stands miserably in the midst of a little courtyard. As Kaushalya and Leela settle down onto a ragged cot, the six month-old baby in Leela's arms lets out a loud hungry wail and is promptly put to the breast. All of 28 years, Leela has already had seven pregnancies. Two of her children died when they were still young.

Kaushalya looks at Leela's lean body, wrinkled belly, and her face hidden by the ghoonghat, and feels hesitant to ask questions about food. But when she asks Leela what she ate and how often during her pregnancy, Leela quickly replies that she ate thrice a day - the morning tea (which is counted as a meal), then lunch and dinner consisting of rotis with vegetable or dal; or on some days it is only rotis, a piece of onion and some salt.

Kaushalya asks, "Did you get rest during your pregnancy?" Leela lifts her ghunghat with two fingers and says with a little indignation, "How can the poor rest? You tell me. I stopped going to the quarry for work after eight months of my pregnancy because I just couldn't do it. I stayed at home but had to do all the housework, and that lasts from dawn to dusk. Who else will do it?" She continues, "After the baby was born I rested for 10 days, but after that I had to be up and about doing all the housework. Of course I didn't fetch water or lift heavy weights. Then I started going out to work in the quarry within a month and a half after this baby was born. I would carry my little daughter to the site, leave her by the road and keep an eye on her while I worked. The maalik (owner) never complained when I got up to breastfeed her. Yes, I feel very tired and weak but I have to go for work. How will we eat otherwise? As it is, we had to take a loan of Rs.4000 from Pratap Thakur at an interest of Rs.5 per 100 Rs. But we somehow managed to pay back without much loss because I got back to work soon after my childbirth." She looks pensive and says, "It is so difficult to make sure everyone sleeps on a full stomach these days, and when I don't work it becomes even harder." Kaushalya realizes then that what Leela earlier said about her food intake is not entirely true.

Leela listens carefully when Kaushalya explains why she will not qualify for the maternity benefit under the IGMSY scheme, and looks puzzled. "Why are women with more children kept out of the scheme? We need more support, isn't it? We have more mouths to feed. If the government had given me that Rs.4000 then I wouldn't have had to approach Pratap Thakur for that loan!"

Leela is clear about what she wants from the sarkar: “free treatment for her children, free good quality medicines so that her children could also be healthy, and not miss school." She ponders about why the sarkar has left her out of the maternity benefit scheme but her thoughts are abruptly interrupted by the baby in her lap who wails and is awake now. Right now there are other pressing concerns that she must attend to…

The story of Leela and many others like her is the focus of a recently completed block level study of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) scheme in its pilot phase conducted by the National Alliance for Maternal Health and Human Rights (NAMHHR). The study examines how the IGMSY scheme has been implemented from November 2011-March 2012 and focuses on women who stand excluded due to the eligibility criteria of the IGMSY scheme.

Interviews with the excluded women who work in the informal sector throws light on how the vulnerabilities imposed by poverty and uncertain livelihoods both worsen and are worsened by the episode of maternity. The study reveals how for such women, each episode of maternity is embedded within the vicious cycles of poverty, ill health and under-nourishment.

NAMHHR concludes that the most vulnerable and socially marginalized women face a period of crisis during each pregnancy and after childbirth, for which they urgently require social security support. As they are informal sector workers, the government needs to arrange for this support since their workplace does not provide it. While the IGMSY is a very promising step in ensuring this, it can be strengthened and improved further so that it fulfills its intended objectives. The study findings are available in the report publication, *The Crisis of Maternity- Healthcare and Maternity Benefits for Women Wage Workers in the Informal Sector in India* (SAHAYOG and NAMHHR, 2012).

The following are some salient points and recommendations that emerged from the study and various discussions that followed:

CHILDBIRTH IS A PERIOD OF ECONOMIC CRISIS

In the Guidelines (MoWCD, 2011) it is clarified that the Scheme aims to 'provide partial compensation for 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.' However study findings indicate that the actual costs of accessing healthcare and the loss of wages incurred by staying at home is so high as to push families even deeper into poverty and debt.

RECOMMENDATIONS

1. If we are looking at rest before pregnancy and six months of exclusive breastfeeding, it should compensate for 9 months of wage loss
2. Provide a separate budget line for breastfeeding support, including crèches
3. Devastating out of pocket expenses have to be prevented by ensuring universal health coverage
4. Stronger accountability mechanisms have to be developed to control corruption in health facilities

- During maternity, women incur substantial costs in accessing healthcare. Although at public facilities[i] , the doctors' services are supposed to be free of cost, the medicines have to be bought and may cost between Rs. 100-500; informal payments have to be made to nurses (between Rs.100-Rs.300) and doctors (as much as Rs.200-300 in government hospitals for delivery). "You are at the edge of death! These people get salaries from the government and yet they want money from the poor," says 30 year old Bijaya angrily in Odisha. For serious problems the private services used may cost as much as Rs. 5,000- 7,000. Informal private providers charge between Rs.700-1400 for deliveries; the dai (who also provides services for the 21 days after delivery) is paid in cash (Rs. 50-600) and in kind (clothes, grain).

- There are not just direct costs pertaining to medical care, but also indirect costs of accessing care. In the absence of public transport women are forced to hire private vehicles for between Rs. 500 to 1500. Almost all women who approach health care facilities bear daily wage losses; long waiting hours mean a day's loss which is double if they are accompanied by their husbands. There are other indirect payments like food (between Rs. 200-400) for the woman and her care givers.

- Given their low incomes at daily wage rates of Rs.80, unemployment and under-employment and many competing needs at home, these expenses are difficult for the women and their families to meet. There are instances of care not being sought especially in the site at Purbi Singhbum (Jharkhand) due to what were perceived as prohibitive costs.

- The decision to avoid wage-work during maternity entails several economic hardships for the women who were respondents of the study. Across all the four study sites the costs involve losing wages for two to 18 months. Direct monetary losses range between 800 to 12,000 rupees across the various sites. Most of the women across the four study sites report having had to take loans to meet survival needs and having to take up additional work, cut back on food or returning to work early.

- They have to pay off the loans ranging from Rs.2000 to Rs.16000 from moneylenders (at 10% interest) or neighbours or from relatives which are usually interest free (in Mahoba and Purbi Singhbhum). A couple of women in Mahoba say that they were able to borrow from the bank as well. Others have tried to avoid loans by selling household assets and this is seen most commonly in Purbi Singhbhum and Bargarh (Odisha). Some of them pawn household items just to meet daily expenses.

WOMEN AS WORKERS

In India, Maternity Benefits (MB) have included the following legal provisions -

- Employees State Insurance Act, 1948- The Act is applicable to non seasonal factories using power and employing ten or more persons and non power using non seasonal factories employing twenty or more persons (eg shops). Maternity benefit rate is double the Standard Benefit Rate or is roughly equal to the average daily wage (for 3 months/12 weeks)
- Maternity Benefit Act, 1961- The Act is applicable to the women workers in establishments engaging 10 or more persons. This Act does not apply to any factory or other establishments to which the provisions of the Employees' State Insurance Act, 1948 apply. Women workers are entitled to MB at specified rates for specified periods. The Act prohibits employment of, or work by, women during the six weeks period immediately following the day of her delivery or miscarriage.

This covers roughly 6 million women, or 4% of women workers in India (ref. NCEUS 2007 based on NSS, 2004-05) who get paid to take rest for 12 weeks or 3 months.[ii]

- Out of the total female workforce of 148 million, 142 million or nearly 96 percent of all female workers are in the unorganized sector. They are not covered by any maternity benefits.
- The IGMSY (pilot phase[1]) covers all women[iii] regardless of their status as workers or home-makers, and has no target number to comply with; as such it is an intervention that promotes gender justice.
- However the IGMSY as a 'part compensation for wage loss' does not compute the Maternity Benefits on the basis of actual wages or minimum wages for a fixed number of days of rest.
- The present amount of Rs 4000 would enable the woman to take no rest before the birth and after childbirth, less than a month of rest (roughly 25 days wages for unskilled labour @ Rs 160 per day). [This is in contravention of the provisions of the Maternity Benefit Act, 1961.]

RECOMMENDATIONS

5. According to similar legal provisions, the maternity benefit should be linked to wages foregone, and be compiled on the basis of minimum wages at the least

NUMBER OF CHILDREN AS DISQUALIFICATION

The IGMSY (pilot phase) does intend to cover 'all women' without an APL-BPL difference; however it differentiates between women who have had 'two live births' who may be beneficiaries, and those who have had three or more live births and will therefore be disqualified.

According to the WCD Guidelines (ibid 2011), this is meant to 'promote family planning'.

- This is in reality a penalty imposed on those women who have not been able to follow the 'two-child norm'; it is thus a transgression of the government's own National Population Policy of 2000, where such punishments were replaced by a concept of free and informed choice that permitted women to have better planned families[iv].
- This penalty for more than 'two live births' also disqualifies and excludes women whose children may not survive[v], for in India, one child in every 17 live births does not survive. Child mortality is highest for poorest women (see Table 1).
- This will lead to social exclusion and discrimination against the most vulnerable women in the country (see Table 1), and will defeat the Scheme's own objectives and defeat the "inclusive agenda" of the government's Planning Commission.

RECOMMENDATIONS

6. IGMSY should be made available to all women, without any preconditions, as they are discriminatory. The Age Eligibility and Parity Criteria should be done away with, as they penalize the victims, exclude the most vulnerable women and defeat the very purpose of the Scheme
7. Promote spacing methods and quality counseling for contraception for both men and women

Footnotes: (1) IGMSY Implementation Guidelines April 2011, MoWCD.

An analysis of the possession of industry-wise skills (in terms of levels of education) among informal workers shows that 98-99 percent of those engaged in agriculture, construction and trade works, are illiterate.

Lingam and Yelamanchili (EPW, 2011) have analysed the NFHS 3 data for India to show the profile and parity of women from vulnerable groups (see Table 1). The data indicates that in all of India, half the women will get potentially disqualified for the IGMSY; and among vulnerable groups such as SC, ST and non-literate women, almost 60% will potentially get excluded, with two-thirds non-literate women unable to access the maternity benefit.

Table 1: Social Profile of Women in India Aged 15-49 who recently gave birth & Percentage of selected categories of women and under five child mortality

Category of Women	% of all Women Aged 15-49 who have given birth to children in last year	Among Women Age 15-49 Who Give Birth in a Year		% of Under-five child mortality
		% of Women Aged 19-49 Years having 2 or < 2 Births	% of Women Aged 15-49 years having More than 2 Births	
All women	100	52	48	
SC/ST/poor having no education[vi]	66	41	59	
SC and ST	31	44	56	66.4 and 54.4
Poor Women	40	37	63	92.1
No education	46	34	66	

Source: Lingam and Yelamanchili 2011 and India Alliance for Child Rights (Computed from NFHS-3, 2005-06).

In order to ascertain magnitude of disqualification from the IGMSY scheme on account of the two-child norm, an analysis of DLHS-3 data was done for the four study districts: Bankura, Bargarh, Mahoba and Purbi Singhbhum (see Table 2).

Table 2: District-wise Percentage of Potential Exclusion of Women

District	Categories of Women*			
	Women with one or 2 children	Potential beneficiaries (%)	Women with 3 or more children	Excluded women from IGMSY Scheme (%)
Bankura (West Bengal)	241	78	68	22
Bargarh (Odisha)	177	66.5	89	33.4
Mahoba (Uttar Pradesh)	186	48	202	52
Purbi Singbhum (Jharkhand)	180	69.50	79	30.50

**Note:* This includes women who had delivered last between 2004 and 2008 only

The data shows that the percentage of women who will be disqualified for the IGMSY scheme is at a high of 52% in the district of Mahoba, followed by Bargarh at 33.4%, Purbi Singbhum at 30.50% and Bankura at 22%.

A further disaggregation of the excluded women (computed above from DLHS 3 data) was done on the basis of age, religion, wealth, caste, and education levels. These variables were added to create a vulnerability score such that the higher the score, the greater is the vulnerability (see Table 3). The table below clearly shows that in all four states, **the greater the vulnerability of a woman, the greater are her chances of being excluded** from the IGMSY scheme

Table 3: Vulnerability of Excluded Women in Four states (based on DLHS-3 data)

State	% of Exclusion on the basis of vulnerability					
Vulnerability Scores (women who are vulnerable on one or more grounds such as Muslim, lowest wealth quintile, belonging to either SC or ST, age over 36 years, and having no education)	**0**	**1**	**2**	**3**	**4**	**5**
Bankura (West Bengal)	11	26	22	29	29	-
Bargarh (Odisha)	24	31	37	48	75	100
Mahoba (Uttar Pradesh)	29	53	67	81	100	-
Purbi Singbhum (Jharkhand)	24	27	33	47	100	-

SUPPORT FOR NUTRITION

In India, the official National Family Health Survey 2005-06 reports that 34.2 per cent of adult men and 35.6 per cent of adult women in the age group of 15 to 49, and in rural India 38.4 per cent of adult men and 40.6 percent of adult women, have a BMI of less than 18.5. This suggests conditions of endemic but unacknowledged near-famine in the country[vii].

Of the 40.6% women of reproductive age (15-49 years) who are extremely malnourished, those who become pregnant go through a period of heightened nutritional requirements. Towards this, the ICDS programme has been providing nutritional supplements (SNP) which in some states gives a cooked meal with eggs and in some states only gives dry rations.

- However our study respondents report that this SNP is being shared with other family members owing to overall hunger and lack of adequate food. Thus the pregnant woman herself actually gets a very small share.
- A little over half of the women are beneficiaries of the SNP in all these states; however there are variations in quality and items served. The SNP presents a picture of declining quality across the study samples from Bankura (where a hot cooked meal is given with half an egg) to Mahoba, where it is sodden and infested with insects. In Purbi Singhbhum the supply of dry rations (rice, sugar, dal, soyabeans and oil) is very irregular while in Bargarh the two kilos of "chhatua" each month appears to be insufficient although tasty.
- A functioning PDS system can provide additional support to the family at this time of lowered income and heightened nutritional needs; however the findings show that not all the women actually had access to a ration card. The situation seemed better in Mahoba (UP) where 11 out of 16 women had a family card; while it was worse in Bankura (WB) and Bargarh (Odisha) - 13 out of 26 women had no access to ration cards; while 10 out of 15 women in Purbi Singhbhum have no ration cards.
- Moreover the quantities of food obtained are widely different (a bare half kilo of rice and kerosene oil every week in Bankura, while in Bargarh it is 25-30 kgs of rice and 1-3 litres of kerosene oil). In some cases they have access to about a kg of sugar. In Purbi Singhbhum they receive 33 kgs of rice for Rs 40 and 2 and 1/2litres of kerosene oil. No dal or sugar is part of the rations.

RECOMMENDATIONS

8. Make the Public Distribution System universal, with protein items included
9. Strengthen the Supplementary Nutrition Programme of the ICDS to be more regular and include adequate supply of proteins and other nutritional needs

OPERATIONAL ASPECTS OF IGMSY IMPLEMENTATION

In all the states the numbers have been updated two to three times since the first survey of possible beneficiaries carried out in July 2010; however the first installment of the money arrived from the Centre quite late. In Uttar Pradesh, for instance, the ICDS department got money on 11 Nov '11; in Jharkhand, the DPO mentioned that they had received an instalment in July '11 and then on 16 Feb 2012; in West Bengal the money reached the pilot districts and blocks in early March 2012. In Odisha, the Department of Women and Child on 13 Oct'11, directed that funds be released towards the implementation of the IGMSY scheme in the selected districts.

- This delay in disbursement has caused many problems, as women who were included in the list of beneficiaries drawn up in 2010 had already delivered (and in many cases the child had completed a year) by the time the money reached the blocks.

- Operational failures on the ground (such as migration, date of childbirth, or forms being rejected) have excluded some of the women identified as beneficiaries in the state of Uttar Pradesh (37 in Mahoba had been left out) and Jharkhand (22 in Purbi Singhbhum). On the other hand in West Bengal, it was not possible to determine whether any women were missed out because the list of beneficiaries for women who delivered between June and Nov 2011 had still not been drawn up. In Odisha, no cases of women being missed out have been found, as the Scheme was administered along with the MAMATA scheme of the state government.

On being asked about provisions for grievance redress, and addressing complains, the CDPOs revealed that no formal grievance redress mechanisms have been put in place at the block and village levels.

- The CDPOs complain about the poor implementation of the VHND. They allege that proper counseling is not conducted at the VHND and premature death and infant death continue to be alarmingly high. According to them the health department has not responded adequately to these problems.

- Except for Odisha, women had no knowledge about the VHNDs. Women have reported that their infants were weighed only at birth and those who got the baby weighed twice or thrice after that have no document showing what is the weight, and no explanation regarding the importance of weight monitoring. However most women do have the MCP Cards and their babies have been immunized.

RECOMMENDATIONS

10. Increase Anganwadi Workers and Auxiliary Nurse Midwife (ANM) services on priority basis; fill in the staff vacancies
11. Strengthen Village and Health Nutrition Day (VHND) to be held on a regular basis, to provide women with full ANC including checking hemoglobin and blood pressure
12. The problem of migration and documents proving identity and residence must be removed; so that the most vulnerable women can get the maternity benefit. Pregnancy registration in any AWC should be a sufficient document for opening a zero balance bank account to enable the transfer of the IGMSY money
13. Disburse money in regular instalments independent of pre-conditions (women then also get it even in case of miscarriage)
14. Ensure easily accessible Grievance Redress Mechanisms which poor women can use. For any complaint there must be a report on prompt action taken (in case health-system failure prevents women from meeting service uptake condition)
15. Involve community women in social audit and local monitoring committees
16. Set up state level Monitoring Committees which have 50% civil society representation (Trade unions, women's organizations, mass-based organizations of the poor etc)
17. Involve civil society in monitoring and evaluation of the pilot phase and consider design corrections before 12th Plan

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ii. NAMHHR partners and those who were present during the report dissemination on 19th of Sep 12
iii. Advisors from the Right to Food campaign
iv. DFID for supporting the costs of the study

ENDNOTES

(i) Greatest use of public services was in West Bengal, followed by UP, then Odisha and last Jharkhand.

(ii) But three segments of workers are completely left out of the ESI and MB Acts - agricultural workers in the monetized sector; temporary and informal non-agricultural workers in both rural and urban India and the invisible workers everywhere - workers without a designated site of employment and/or an identifiable employer such as unpaid family help, self-employed poor, home-based workers, workers in private households and migrant labourers.

(iii) Except those women employed in the government or whose spouse is in government employment

(iv) Women do not want to have large families out of choice. According to DLHS 3, only 15% women want another child after they have two surviving children; and this desire is enhanced with greater vulnerability - among those who are very young (15-19 years) about half want a third child, and among the poorest women, almost one-third want a third child (DLHS 3, 2007-08 Section 3.6 page 44)

(v) 58 infants die per 1000 live births (NRHM- The Journey so Far; MoHFW 2010).

(vi) Figures in categories overlap with more than one variable

(vii) According to the WHO, a population with more than 40 per cent of the people having a BMI (a measure of weight to height) of less than 18.5 can be said to be living in famine conditions.

About NAMHHR

National Alliance for Maternal Health and Human Rights (NAMHHR) is a coalition of civil society organizations from seven states of India who came together on 20th January 2010 and agreed on the need to strengthen maternal health as an issue of women's human rights. Given the sheer scale of the problem, at seventy to eighty thousand women, dying each year in India of preventable maternal deaths, the Alliance is committed to work towards 'Attaining Highest Quality of Maternal Health for the Marginalized in India'. The group recognizes that strong rights-based strategies are needed to build greater accountability for these thousands of preventable deaths among women in India.

Over the last 3 years, the membership of NAMHHR has grown and individuals and organisations from 13 states have joined this network. The Alliance recognises that there is an urgent need for women's organizations, health organizations, mass-based organizations and groups working on law and human rights to come together on this issue.

National Alliance for Maternal Health and Human Rights (NAMHHR)

~Towards Attaining Highest Quality of Maternal Health for the Marginalized in India~

An alliance of civil society organizations and individuals from 13 states of India

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