THE CRISIS OF MATERNITY

Healthcare and Maternity Benefits for Women Wage Workers in the Informal Sector in India

A compilation of two national studies

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Informal Sector Women Wage Labourers
Access to Maternal Health Services
A block-level Study in Chhattisgarh, Uttarakhand and Uttar Pradesh, India
(2007- 2009)

And

Monitoring the IGMSY from Equity and Accountability Perspective
A block-level study in West Bengal, Odisha, Jharkhand and Uttar Pradesh, India
(2011-2012)

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SAHAYOG
A-240, Indira Nagar, Lucknow - 226016, Uttar Pradesh, India
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Contributors:

SAHAYOG

In partnership with
National Alliance for Maternal Health and Human Rights, India
and
PRAYAS, Nainital, Uttarakhand
Shikhar Prashikshan Sansthan, Mirzapur, Uttar Pradesh
Adivasi Adhikar Samiti, Koriya, Chhattisgarh

Editors:

Jashodhara Dasgupta, SAHAYOG
YK Sandhya, SAHAYOG
Ankita Mukerjee

Cover Design and Layout: Anju Sah

Photography: Mr. Dipankar Ghosal and Ms Bijaylaxmi Rautaray

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ACRONYMS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCG	Bacillus Calmette-Guerin
CDPO	Community Development Project Officer
DPT	Diptheria Tetanus & Pertussis
IGMSY	Indira Gandhi Matritva Sahyog Yojana
IYCF	Infant & Young Child Feeding
JSY	Janani SurakshaYojana
NAMHHR	National Alliance for Maternal Health and Human Rights
NMBS	National Maternity Benefit Scheme
OPV	Oral Polio Vaccine
PDS	Public Distribution System
PNC	Post Natal Care
SC	Scheduled Caste
SNP	Supplementary Nutrition Programme
ST	Scheduled Tribes
TT	Tetanus Toxoid
VHND	Village Health & Nutrition Day

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SAHAYOG

PREFACE

This publication is a compilation of two block-level research studies, both of which were anchored by SAHAYOG in different states of India within a space of a few years, and are related in that they investigate experiences of poor women wage workers in the informal sector, and the cross-cutting determinants of maternal health such as women's livelihoods, social security benefits, food security and nutrition, and women's access to health care.

The studies were initiated through different process, one by the momentum around the Tenth International Women's Health Meeting (IWHM) in 2005 and the other by the concerns of a civil society alliance on Maternal Health and Human Rights (NAMHHR) in 2010-11. Although the partners of the field study are different, women's health activists and researchers continue to be concerned with the health experiences of women wage workers in the informal sector, who were identified as most invisible and therefore vulnerable.

This concern arises from the fact that informal sector women wage workers are outside the parameters of state mandated labour legislations regarding wages, hours of work, occupational hazards, and welfare provisions such as paid maternity leave. Women who are in advanced stages of pregnancy or immediately following childbirth, miscarriage or abortion, may be compelled to continue working in hazardous occupations in the absence of any social security for maternity. Currently around 96% women workers (estimated at 148 million) are part of the unorganised sector, not covered by labour laws.

Lacking the collective bargaining activities of unions, these women have been unable to negotiate fair compensation for income lost during pregnancy and after childbirth, or remove the unjust preconditions relating to the number of living children they have, that disqualify them from maternity benefits. It is increasingly clear that the exclusionary criteria are going to prevent the most vulnerable women from accessing the benefits of maternity schemes: poor women, women belonging to the Scheduled Castes, Scheduled Tribes and illiterate women. While each episode of maternity exacerbates their vulnerability and they are never sure of child survival, the state has penalized them for having more than two living children and yet failed to ensure other forms of maternity protection in a period of increased impoverishment and high expenses.

Civil society organizations have concluded that unconditional maternity benefits, and universal food security for all women, without any conditions, in combination with state-financed maternal care of high quality, are primary requirements for the improvement of maternal well-being in India; including nutrition, maternal anaemia and maternal mortality[1]. It is hoped that the findings of these two studies presented here, the analysis and discussion will be of use to the larger community concerned with the experiences of women workers in the informal sector. It is also hoped that these findings will be relevant at this point in time, as the government of India plans to evaluate the Pilot Phase of the IGMSY maternity benefit and moves into finalizing the Twelfth Five Year Plan for the country.

We dedicate this report to the millions of women workers whose productive and reproductive labour strengthens our society, and whose travails in maternity as yet remain unseen and unrecognized.

Jashodhara Dasgupta,

Principal Investigator and Coordinator of SAHAYOG And

all study partners.

New Delhi, 19th September 2012

[1] The Registrar General revealed in 2006 that of the 70 to 80 thousand maternal deaths in India each year, 38% can be attributed to heavy bleeding (hemorrhage), 11% to infections (sepsis), 8% to unsafe abortions; all of these are aggravated by maternal anaemia

GENESIS OF THE STUDIES

During the North Zonal Consultation in India for the Tenth International Women's Health Meeting (IWHM) in 2005, an issue that came up was of women's health needs as workers in the informal sector. Within broader concern around the lack of social security for those who are working in the informal sector is the special concern of how women wage workers in rural areas are negotiating their reproductive health needs or occupational health care. They are often unable to access skilled maternity care owing to financial and other barriers, or negotiate the conditionalities imposed to receive maternity benefits. When such women workers live in remote or difficult areas, or belong to socially excluded castes and tribes, or come in as migrants from another area, these negotiations become even more complex. Yet the lack of additional support can severely damage family finances at a time when expenses on travel, medicines and food expenses are highest, and this in turn could make it difficult for women to negotiate better healthcare.

SAHAYOG worked with a volunteer researcher to put together a detailed review of literature that helped in designing an investigation into how such women negotiate health care. Three organizations working on women's health and labour rights in Chhattisgarh (Adivasi Adhikar Samiti), Uttarakhand (PRAYAS) and Uttar Pradesh (Shikhar Prashikshan Sansthan), came together in 2007 with SAHAYOG to study the access to health care, especially maternal health care, of informal sector women wage workers. The study findings were compiled with the support of advisors[i] and shared at a large dissemination event in New Delhi in September 2009.

In early 2010, a group of researchers, lawyers and civil society organizations formed the National Alliance on Maternal Health and Human Rights (NAMHHR) to work towards attaining the highest quality of maternal health for marginalized women; and one of the first issues that the Alliance focused on was maternity and the right to nutrition. While campaigning in various states for the implementation of the Supreme Court guidelines on unconditional maternity benefits under NMBS to all pregnant and lactating women, the NAMHHR was dismayed to note that this had been effectively discontinued almost all over the country, as the health ministry officials did not want to create any confusion with their conditional cash transfer for institutional childbirth. By the end of 2010, there was information about the new maternity benefit scheme that the government was launching called the Indira Gandhi Matritva Suraksha Yojana (IGMSY) which would benefit all women not employed in the formal sector.

The NAMHHR consulted with activists, researchers and other civil society groups working on maternal health, nutrition, right to health, right to food, women's rights and workers' rights; all of whom welcomed the IGMSY scheme as being a promising start to recognizing informal sector women workers' maternity entitlements such as wage compensation, and their additional nutritional requirements during this demanding phase of their lives. The IGMSY clearly had the potential to integrate work, health and nutrition for such women; remarkably it was not restricted to women below the poverty line, and recognized all women as workers, whether within or outside the home.

However a few concerns remained with regard to the IGMSY Scheme, especially equity and design related concerns besides those pertaining to the exclusionary criteria, by which women with more than two children were denied this benefit. NAMMHR and its allies shared these in May 2011 with the Planning Commission and representatives of the Women and Child Department, with some recommendations. However as the pilot phase had already been started, changes could not be incorporated. Consequently, NAMHHR decided to examine the IGMSY from an equity and accountability perspective in four sites across four states, in partnership with NAMHHR allies in these states, namely, Odisha (SODA), Uttar Pradesh (Healthwatch Forum and Gramonnati Sansthan), Jharkhand (Prerana Bharati) and West Bengal (ASHA) and a panel of expert research advisors[ii]. The initial plan was to investigate with women who were beneficiaries as well as those who were excluded, but owing to delays in the implementation and financing of the scheme, only the latter could be included in the study.

Chapter 1

WOMEN WORKERS IN THE UNORGANISED SECTOR AND PROVISIONS FOR MATERNITY PROTECTION: AN OVERVIEW

1.1 Size and Nature of the Unorganised Sector in India

An extremely high percentage of India's workforce is estimated to be employed in the unorganized sector, ranging from 86% to 92%.[iii] While there may be some disagreement over the exact definition of the unorganized sector, it is by and large understood that workers in the unorganized sector, unlike their counterparts in the organized sector, have little or no social security, little negotiating power in terms of choice of work, are often 'unskilled' and work in poor work conditions.

It must be understood that the unorganized sector is extremely complex and diverse and there can be no single determinant that can define the sector. There are wide differences in nature of work, employer employee relation, wage levels, degree of informality, size of enterprise and skill across the sector. On the one hand there are tribal communities who collect forest produce and on the other hand there are software professionals who work from home. Then again there are home based workers and those who do not have a direct employer-employee relationship. For instance a vegetable vendor who sells his produce or a fisherman who sells fish does not have a direct employer. In these cases it is difficult to put accountability on an employer. This kind of diversity in the sector makes it difficult to define.

The two National Commissions of Labour in have attempted to define the informal or unorganised sector. The First National Commission on Labour (1969) defined unorganized sector as "that part of the workforce who have not been able to organise in pursuit of a common objective because of constraints such as casual nature of employment, ignorance and illiteracy, small size of establishments with low capital investment per person employed, scattered nature of establishments and superior strength of the employer operating singly or in combination." The Second National Commission of Labour (2002) recognises several characteristics of the enterprises and employment in the informal sector which makes workers in this sector extremely vulnerable. It also mentions decline in direct employment and an increasing trend to recruit workers through contractors, especially visible in areas of home-based work.

The UPA I government, soon after coming to power in India, appointed the **National Commission for Enterprises in the Unorganized Sector [NCEUS]**, headed by Professor Arjun Sengupta, in September 2004 to make recommendations to improve conditions of workers in the unorganized sector. The NCEUS, after three years of intensive work, found the nature of the unorganized sector hazy and flexible to defy governmental attempts to define it within watertight parameters.

According to the NCEUS, almost the entire farm sector in India can be characterized as informal while, roughly 80 per cent of the work force in the non-farm sector is also informal. Ninety per cent of the poor are casual workers and 74.7 per cent of the 'self-employed' are poor.[iv] The NCEUS report also indicates that Indian agriculture is getting feminized with 73 per cent women being associated with it compared to 52 per cent men.[v] The gender break-up of the workforce in the informal sector, computed from unit level records of Employment-Unemployment Survey, 55th round of NSS, 1999-2000, shows an increased presence of female workers over male workers engaged in the informal sector in India - 95 per cent of female workers and 89 per cent of male workers. In rural India, however, roughly 97 per cent of male workers and 94 per cent of female workers are found in the informal sector.[vi]

Table 1.1: Estimate of Organized and Unorganized Workers/Employment by Industry (Million)

Category	Combined		
	Male	Female	Total
Total Workers	**309.4**	**148.0**	**457.5**
Agriculture	151.2	107.7	258.9
Non-agriculture	158.2	43.3	198.9
Organised Worker	**28.2**	**6.0**	**34.9**
Agriculture	2.0	0.8	2.9
Non-agriculture	26.8	5.2	32.0
Unorganised worker	**280.6**	**142.0**	**422.6**
Agriculture	149.2	106.9	256.1
Non-agriculture	131.4	35.1	166.5

Source: NCEUS, 2007 (based on NSS 64th Round, 2004-2005)

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. Among other sectors, 90 per cent of the informal workforce is found to be illiterate.[vii]

We see from this table that out of the total estimated workforce of 457.5 million workers, 148 million are women (roughly 38 percent). According to the NCEUS report 422.6 million workers or 92 percent of the total workforce are part of the unorganized sector. Out of the total female workforce of 148 million, **142 million or nearly 96 percent of all female workers are in the unorganized sector**. In all the states, unorganized or informal workers form the vast majority of the workforce.

1.2 Economic Contribution of the Unorganized Sector

While the unorganized sector employs the majority of the workforce, its economic contribution is often neglected. The ILO report "Decent work and the informal economy, 2002" notes that the informal economy contributes to economic growth in at least two ways. First, the output and the low wages of informal workers assist the growth of industries, including key export industries, in many countries. Second, the output of informal enterprises also contributes to economic growth[viii]. The National Council of Applied Economics Research (NCAER) calculated that the informal economy/ unorganised sector - generates about **62 per cent of GDP, 50 per cent of gross national savings and 40 per cent of national exports** (Chen et al, 2001). But conditions of workers who create so much wealth are abysmal. Though most of the labour laws in India are generic enough to apply to informal sector, they are rarely followed. The workers themselves are not aware and consider the laws not relevant to their situation.

1.3 Women's Work: Invisible and Unpaid

Large surveys have shown that larger number of women compared to men are concentrated in the unorganised sector; making an overwhelming proportion of women workers in low paid, unskilled jobs. It is important however to take into account not just women's paid work but also unpaid work, which is invisible yet takes up substantial portion of her time and has significant impact on her health. The conventional definition of 'work' often does a woman's contribution within the household. This may include daily domestic duties carried out at home (cooking, washing, cleaning and home maintenance, childcare or attending to the elderly and sick) or outside (fetching water, fuel and fodder), as well as important managerial functions such as handling the family budget or servicing social networks (clan and community) that provide emergency support when needed. This also includes women's unpaid contribution to household economic enterprise such as helping on the family farm or looking after family cattle or even contributing to a family trade or business. None of this, however, guarantees that women can take independent economic decisions or access family income for her personal needs, pleasure or relaxation.

Much of women's work is invisible, even though it substantially contributes to household economy and thus to national economy. The productive **contribution of women to household maintenance, provisioning and reproduction has traditionally been ignored** in macro-economic calculations. As a result, inadequate attention is paid to the conditions of women's work and its economic value and most of women's work goes unacknowledged and unrecognized. Internalizing the world's view of their work, most of the times women themselves do not consider themselves 'workers', even though their work is arduous, often unending and handled without support from male family members.

The Shramshakti (1988) report highlighted the invisibility of women's work through stories of women in different enterprises and industries in different parts of the country. The major Indian sources of data in this matter, the Census of India and the National Sample Surveys (NSS), have increased their attempts to recognize women's work by asking probing questions that seek to establish women's involvement in economic activity. However, this is still defined to include only participation in work for the household farm or enterprise, and does not include housework, childcare, care of the sick and old, and related activities associated with social reproduction. It also does not include related work necessary for provisioning for the household, whether it is fuel wood collection in rural areas, or attempts to obtain access to clean water in urban areas, activities that are typically the responsibility of the women of the household[ix]

Any attempt to understand impact of work on the health of women workers, must take into account not just paid work but also unpaid work within the household.

1.4 Legal Framework for Protection of Unorganized Sector Workers

The nature of the unorganised sector, makes workers in this sector extremely vulnerable. Poor wages, irregular availability of work, extremely difficult conditions of work and little social security to fall back on in case of a contingency like ill health has made it necessary to put in place a legal framework and policy prescriptions that protect these workers. The state has over time formulated several legal measures as well as social policies to provide workers in the unorganised sector with safeguards.

While there are numerous legislations for regulating conditions and work and ensuring social security, very few of them cater to the unorganized sectors, even though they are most vulnerable. The NCEUS report has made classification of various labour laws and the extent to which they can be applied to the unorganized sector. Some of these laws have been discussed in table 1.2.

Table 1.2: Legal framework for rights of unorganized sector workers

Laws which apply to All Sections of the Unorganized Sector	
Law	**Provisions**
Equal Remuneration Act, 1976	✓ The Act is applicable to the women workers and provides for the payment of equal remuneration to men and women workers for same work or work of a similar nature. ✓ By same work or work of a similar nature is meant work in respect of which the skill, effort and responsibility required are the same, when performed under similar working conditions. ✓ The Act also provides against discrimination while recruiting men and women workers.
The Bonded Labour System (Abolition) Act, 1976	✓ The Act defines 'bonded labour' as a service rendered under the 'bonded labour system' - a system of forced, or partly forced labour under which the debtor enters into an agreement, oral or written, with the creditor. ✓ This law provides for the abolition of bonded labour system
Laws Which Apply to Some Sections of the Unorganized Sector Labour	
The Minimum Wages Act, 1948	✓ The Act is applicable to the workers engaged in the scheduled employments[2] and provides for fixing minimum wage rates by the government in certain employments. It is applicable to agricultural, non-agricultural and to rural as well as urban workers. ✓ The Act covers wage workers, home-based workers but not the self-employed.
The Trade Unions Act, 1926	✓ The Act is applicable to trade unions and provides for the registration of trade unions. ✓ At least 10 percent of the members or 100 worker (whichever is less) engaged or employed in the industry with which the trade union is connected should be the members of the trade union.
The National Rural Employment Guarantee Act 2005	✓ The Act is applicable to those working under the NREGA ✓ In case of accident of accident or injury at work place, there is provision of free medical treatment ✓ In case of death or permanent disablement during work, there is provision for cash compensation ✓ The act provides for facilities of safe drinking water, shade for children and periods of rest, first-aid box with adequate material for emergency treatment for minor injuries and other health hazards connected with the work ✓ There is provision for crèche in case the number of children below the age of six years accompanying the women working at any site are five or more
Laws Extendable to the Unorganized Sector	
Workmen's Compensation Act, 1923	✓ The Act is applicable to workmen and provides for the payment by certain classes of employers to their workmen of compensation for injury by accidents arising out of and in the course of his employment with certain exceptions. ✓ The Act also specifies a list of diseases, which, if contracted by the worker, would be deemed to be occupational disease peculiar to that employment which shall be deemed to be an injury by accident liable for compensation under the Act.

[2] The Act provides a schedule of employments to which this act is applicable.

The above laws are directed specifically at workers and are meant to ensure minimum conditions of work, wages and compensation.

1.5 Maternity Protection for Women Workers

Women as bearers and rearers of children provide the foundation for generating future workers for any economy. Reproduction involves not only procreation but also the nurture and care of a growing child. The International Labour Organization believes that maternity leave is important as it reduces the risk of complications following labour and allows time to establish breast feeding (ILO, 2000). As early as 1919, the ILO had laid down maternity related entitlements for women workers. Women workers were entitled to 12 weeks of leave with cash benefits; daily breaks for nursing and protection against dismissal during leave. This convention was ratified by 29 countries. In 1952 it was revised to state that six weeks of leave should be given after delivery. It also stipulated that medical benefits provided should include prenatal and postnatal care by a midwife or a qualified medical practitioner or a hospital, if necessary. More recently, the ILO Convention 2000 extended the minimum paid maternity leave to 14 weeks with a compulsory leave of six weeks after the birth of the child (ILO 2000). The convention also provides for allowances to be paid out of public funds for women who do not qualify.

In India a Maternity Benefit Bill was passed for the first time by the Bombay Assembly in 1929, after much debate among representatives of mill owners, trade unionists and nationalists. Some women's organizations like Women's India Association (WIA) (which later became All India Women's Conference) were instrumental in raising demands for maternity benefit for women workers in the pre-independence era (Chhachhi 1998). After independence, the Indian Constitution in its Directive Principles recognized the importance of maternity

benefits. It stipulates that States should make provisions for securing just and humane conditions of work and for maternity protection. In the years following independence, two important legislations, **Employees State Insurance Act (1948)** and the **Central Maternity Benefit (MB) Act** of 1961 became operational.

Table 1.3: Important Legislations for Maternity Protection

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 is payable to an insured woman (or pregnant woman) in the following cases subject to contributory conditions: ✓ Confinement is payable for a period of 12 weeks (84 days) and miscarriage or MTP (Medical Termination of Pregnancy) is payable for 6 weeks (42 days) from the date following miscarriage. ✓ Sickness or complications arising out of Pregnancy, Confinement, Premature birth is payable for a period not exceeding more than one month. ✓ In the event of death of an insured woman during confinement leaving behind a child, maternity benefit is payable to her nominee. ✓ Maternity benefit rate is double the Standard Benefit Rate or is roughly equal to the average daily wage.
Maternity Benefits 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. ✓ The Act prohibits employment of, or work by, women during the six weeks period immediately following the day of her delivery or miscarriage. ✓ Women worker are entitled to maternity benefit at specified rates for specified periods. It also provides for payment of maternity benefit to the nominee in case of death, payment of medical bonus, leave for miscarriage for a period of six weeks immediately following the day of her miscarriage, leave for illness arising out of pregnancy, delivery, premature childbirth, or miscarriage, nursing breaks etc.
Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) New Guidelines	✓ Pregnant and lactating women (at least upto 8 months before delivery and 10 months after delivery) as a special category. ✓ Mandates for the provisioning of special work which is less strenuous and close to the homes pregnant and lactating workers. ✓ Provision for crèche for children of women wage labourers.

The above two major maternity protection schemes (ESI and the MB Act) are designed to basically cater to workers in the organized sector and are biased towards permanent, full-time workers, workers with identifiable employers and/or a designated place of work. Although "contract workers" are included in the MB Act, they need to be shown on the books of the employer to be eligible. Thus a large number of women workers who are a part of the informal sector fall out of the safety net provided by these two acts.

Data from NSSO (61st round) shows that **female workers aged 15-49 who are eligible for maternity benefits form a mere 3% of workers** (Lingam and Krishnaraj 2011). Hence, the reach of maternity benefit schemes on the basis of employment status is very small. The three segments of workers completely let out

of the ESI and MB Acts are agricultural workers in the monetized sector; temporary and informal nonagricultural 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.

> The MB Act also put in place a scheme for maternity benefit for all women; the National Maternity Benefit Scheme (NMBS) which provided a sum of Rs 500 during pregnancy. The NMBS was recognized by the Hon'ble Supreme Court as being part of the essential support for better nutrition during pregnancy (PUCL vs. UOI, SC order of 20 November 2007) and mandated to be provided to all pregnant women 2-3 months before childbirth. Despite this, the Ministry of Health and Family Welfare has sought the discontinuation the NMBS which was universal and has replaced it with a post-delivery conditional cash transfer scheme entitled the Janani Suraksha Yojana (JSY).

Hence, the government's support for maternity is limited only to public sector (permanent) employees, which as pointed out is a very small fraction of the workforce. Thus a woman's employment characteristics like - the industry in which she is employed and her occupational status (paid, unpaid, self-employed, regular, casual, etc), the sector of employment (organised or unorganised) and the nature of employment (formal or informal) - critically determine the quality of employment and entitlements like social security cover in general and maternity benefits in particular (ibid).

In the seventies and eighties, the women's movement was able to bring back focus on women's work and its invisibility. Two important reports namely the 'Towards Equality Report '(1974) submitted by the Committee on the Status of Women in India (CSWI) and the 'Shramshakti' Report (1988) by the National Commission on the Self-Employed Women were both crucial in highlighting contribution of women's work and need for strong institutional arrangements for maternity benefit and child care arrangement.

Other than the above mentioned legislations, a number of schemes and programmes are also crucial for poor pregnant women in providing them nutritional support and monetary support during pregnancy and child birth.

The **Integrated Child Development Scheme (ICDS)** which provides supplementary nutrition for pregnant and lactating women and the **Janani Suraksha Yojna (JSY)** which provides cash to women who give birth in government institutions are also important schemes for maternity care. The **Rashtriya Swasthya Bima Yojna (RSBY)** is an insurance scheme for Below Poverty Line (BPL) households, that provides them cashless hospitalisation for a specified list of procedures in empanelled hospitals (both private and public). The scheme also covers normal deliveries and caesarean section, so that women can deliver free of cost in any empanelled hospital.

The new guidelines for **MNREGA** defines pregnant and lactating (at least upto 8 months before delivery and 10 months after delivery) as a special category and mandates provision of special works which require less effort and those that are close to their house to be identified and implemented for them. There is also provision for creche for children of women wage labourers. In addition there is also provision for treatment and compensation in case of accident, disability or death due to work. The most recent intervention to ensure maternity protection is the **Indira Gandhi Matritva Sahyog Yojana (IGMSY).** Some of the key features and of scheme are discussed in the next section.

1.6 The Indira Gandhi Matritva Sahyog Yojana (IGMSY)

The revised maternity benefit scheme that has been launched in 2011 by the Union Ministry of Women and Child Development is entitled the Indira Gandhi Matritva Sahyog Yojana (IGMSY) for pregnant and

lactating women. This is a centrally-sponsored conditional cash transfer[3] scheme whose basic objective is to support women with support for nutrition and enhance early infant survival through promotion of exclusive breastfeeding for the six months[4].

The implementation of the scheme is through the platform of Integrated Child Development Scheme. Thus, the focal point of implementation is the Anganwadi Centre (AWC) and the key personnel are the Anganwadi Worker (AWW) and the Anganwadi Helper (AWH). The IGMSY is being rolled out as a pilot project in 52 identified districts from all the states and union territories.

1.6.1 Government Rationale for Introduction of the IGMSY Scheme:

Explaining the necessity for the introduction of the IGMSY scheme, it was noted that in the Eleventh Five Year Plan document (Vol. II) the Planning Commission had observed that poor women are forced to continue to work to earn a living for the family right up to the last days of their pregnancy. This prevents them from gaining weight, further; they are forced to resume working soon after childbirth which prevents their bodies from fully recovering. It was also noted that as poor women are out working, they are unable to exclusively breastfeed their new born in the first six months. Therefore, an urgent need for introducing a modest maternity benefit to partly compensate for their wage loss was felt. This was further justified using data from various sources (NFHS III, SRS, Lancet) that showed the following:

- In India, there are high levels of under-nutrition and anaemia in married adolescent girls and women (56%). This is made worse due to early marriage, early child bearing and inadequate spacing between births. Data shows that 63% of lactating women and 59% of pregnant women suffer from anaemia
- Quoting an article from Lancet (2003) India Analysis, it was noted that exclusive breast feeding for six months could reduce infant mortality rates - 16% of under 5 years child mortality can reduce when children are breastfed exclusively for 6 months
- ANC coverage and child immunization rates are also low, with less than half receiving first ANC in the first trimester as recommended. Further the data showed that just over half of the women had 3 or more ANC, with women in urban areas being more likely to receive it (NHFS III)

Thus in the light of all the above, the Government felt that there was a need to tackle the nutritional deficits of the pregnant and lactating mother by providing maternal support, counselling and services in an enabling environment with a view to enhance the demand and utilisation of existing maternal and child care services. Such a support it was felt could also be provided through a direct cash transfer system on achieving certain conditions which would enhance service uptake by the beneficiary for her own care and that of her child; this was the design of the Indira Gandhi Matritva Sahyog Yojana.[5]

1.6.2 Objectives of the Scheme:

The objectives of the scheme were thus to improve the health and nutrition status of pregnant & lactating women and infants by:

- Promoting appropriate practices, care and service-utilisation during pregnancy, safe delivery and lactation

[3] A conditional cash transfer is a scheme whereby usually a monetary benefit is given to a person once certain conditions have been met. These schemes usually target areas such as education, health or nutrition. The aim of a conditional cash transfer is to increase the utilisation of services by offering incentives. Use of a conditional cash transfer presumes that low utilisation of services is the result of a lack of demand for services rather than supply side issues.

[4] As cited in Order No.9-5/2010-IGMSY, Government of India, Ministry of Women and Child Development, Dated 8.11.2010

[5] As cited in Order No.9-5/2010-IGMSY, Government of India, Ministry of Women and Child Development, Dated 8.11.2010

- Encouraging the women to follow (optimal) Infant and Young Child Feeding (IYCF) practices including early and exclusive breast feeding for the first six months
- Contributing to better nutrition by providing cash transfer to pregnant and lactating mothers

Box 1: Criteria for Eligibility

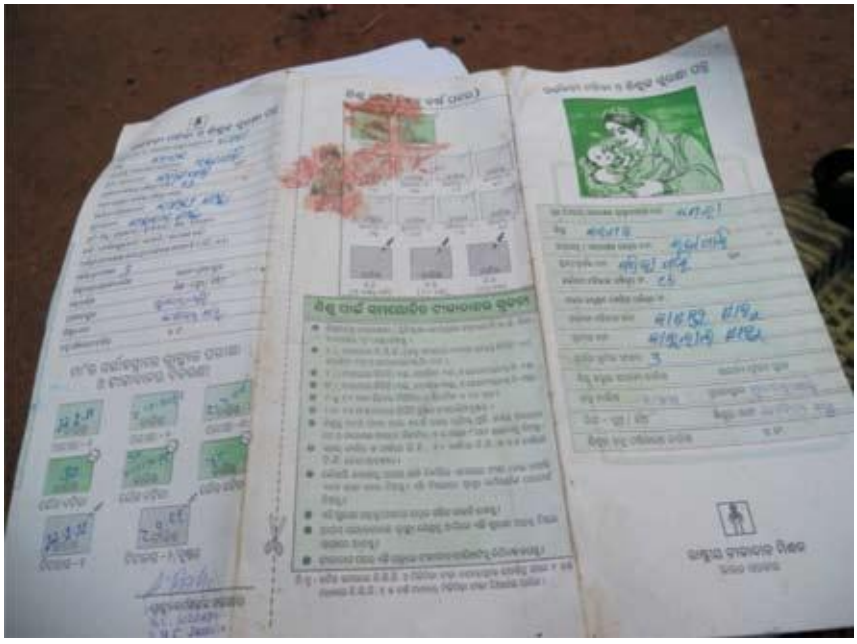
- All pregnant and lactating women:
- of nineteen years and
- for the first two live births
- women or their spouses **not** employed either in the State or Central Government and Public Sector Undertakings

Under the IGMSY, the government will provide Rs. 4000[6] to women fulfilling the criteria listed in the box (Box 1). The money is disbursed in three installments given that the conditions are mentioned in Table 1 are fulfilled.

In addition, there are two disqualifying criteria, in which women who are pregnant with their third living child do not qualify for the benefit, and women who are below 19 years of age during this pregnancy are also disqualified. These were intended by the government to promote the small family norm and discourage early marriage.

The logic is that this conditional maternity benefit that will provide women with money to compensate for wage loss and the taking of maternity leave, which will enable them to take leave from field work. The cash benefit is seen as enabling them to spend more on food and thus increase their nutritional intake.

Mother and Child Protection Card at the study site



[6] In Odisha the amount is Rs 5000, as the Odisha State Government has added Rs 1000 to make the benefit equal to that given under the MAMTA scheme which is operational in the other districts of Odisha. MAMTA is a state sponsored conditional cash transfer maternity benefit scheme which is operational in all the districts of Odisha, except the two IGMSY districts. The MAMTA scheme has the same eligibility criteria and conditions as the IGMSY, except that the amount of money that is given as maternity benefit under the MAMTA is Rs. 5000.

Table 1.4 Conditionalities under the Indira Gandhi Matritva Suraksha Yojana (IGMSY)

Cash Transfer	Conditions	Amount (In Rs.)	Means of Varification
First (at the end of second trimester)	• Registration of Pregnancy at AWC/health centres within 4 months of pregnancy • At least one ANC with IFA tablets and TT • Attended at least one counselling session at AWC/VHND	1500	Mother & Child Protection Card reflecting registration of pregnancy by relevant AWC / Health Centres and counter signed by AWW
Incentive under JSY	• JSY package for institutional delivery including early initiation of breast feeding and ensure colorstrum feed	As per JSY norms	
Second (3 months after delivery)	• The Birth of the child is registered. • The child has received: • OPV and BCG at birth • OPV and DPT at 6 weeks • OPV and DPT at 10 weeks • Attended at least 2 growth monitoring and IYCF counselling sessions within 3 months of delivery	1500	Mother & Child Protection Card Growth Monitoring Chart and Immunization Register (would also be available for still births and infant mortality)
Third (6 months after delivery)	• Exclusive breastfeeding for six months and introduction of complimentary feeding as certified by the mother • The child has received OPV and third dose of DPT • Attended at least 2 growth monitoring and IYCF counselling sessions between 3rd and 6th months of delivery	1000	Self certification, Mother & Child Protection Card, Growth Monitoring Chart and Immunization Register

Thus, under the IGMSY, the government will provide Rs. 4000 to women of nineteen years and over for their first two live births on the condition that they register the pregnancy, receive the tetanus toxoid (TT) injections and iron tablets, attend the required number of counseling camps, get the required antenatal check-ups, register the birth of their child, get the child immunized and breast feed exclusively for six months.

1.6.3 Critique of the IGMSY Scheme:

Lingam and Yelamanchili (2011) have expressed concerns over the exclusionary criteria of the IGMSY scheme; they hold that it will lead to women from most vulnerable sections of society being disqualified as they will be unable to satisfy the eligibility criteria. Using the NFHS 3 data they have shown that:

- 48% women will be ineligible if exclusion criteria as per the IGMSY are adopted
- 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 (see Table 2).

Table 1.5 Social Profile of Women Aged 15-49 Who Give Birth in a Year and Percentage of Selected Categories of Women Who Are Eligible and Ineligible for IGMSY

Category of Women	% of all Women Aged 15-49 who have given birth to children in the last year	Among Women Age 15-49 Who Give Birth in a Year	
		Eligible by IGMSY Criteria	Ineligible by IGMSY Criteria(%)
		% 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*	66	41	59
SC and ST	31	44	56
Poor Women	40	37	63
No education	46	34	66

*Source: Lingam and Yelamanchili 2011 (Computed from NFHS-3, 2005-06). **

Figures in categories overlap with more than one variable

Chapter 2

INFORMAL SECTOR WOMEN WAGE LABOURER'S ACCESS TO MATERNAL HEALTH SERVICES

A block-level Study by SAHAYOG and partner organizations in three states of India (2007-2009)

This study enquires into the experiences of informal sector women wage workers in deprived areas, in selected blocks across three states of India, Chhattisgarh, Uttarakhand and Uttar Pradesh.

2.1 METHODOLOGY

2.1.1 Purpose and Objectives:

The primary purpose was **to study across three states of India, the access to health services for women wage labourers in the informal sector, with special reference to maternal health services**. Specifically, to:

- Investigate the current status of health access to services, both public and private, for occupational and maternal health problems

- Analyze the causes behind the current health access, in the light of the current legal and policy framework

2.1.2 Area of Study

The study was done with the help of partner NGOs in three states. The study used a purposive sample and the districts and blocks chosen were those in which the partner NGO was already working.

Table 2.1- Area of Study

State	District	Block
Chhattisgarh	Koriya	Manendragarh
Uttarakhand	Nainital (NT) and Udham Singh Nagar (UDN)	Betalghat (NT) and Gadarpur (UDN)
Uttar Pradesh	Mirzapur	Rajgarh

Four blocks were chosen for the study, one each from Mirzapur, Koriya , Nainital and Udham Singh Nagar districts. In Uttarakhand due to the low population density, two blocks were chosen.

2.1.3 Content and Scope of Investigation

Community scoping using PRA methods was first done in around five villages in each block to understand the work and context of the women. All women workers aged 18-45 in the selected blocks were surveyed to identify roughly 1000 women in each site. From among these 3538 women, there was a detailed individual survey of 262 women who had gone through a delivery in the last three years. There were 25 focus group discussions (covering 242 women). In addition, there were 30 interviews with local healthcare providers in both formal and informal sectors, as well as eight employers/ contractors for whom these women worked.

Field investigation were carried out between January 2008 to June 2009 by staff members of the partner organization working under supervision and training of SAHAYOG, as well as direct investigations by SAHAYOG staff members.

Community Scoping exercises using PRA methods indicated that all three areas of study are remote areas, in that they are distant from banks, post-offices, police-stations and other government facilities. All of them are distant from equipped health centres, have poor transport linkages and communication systems. All villagers practice subsistence agriculture without irrigation, leading to low yields and compelling the women to seek wage-work locally and the men to migrate. The wage-work is poorly paid, often gender-discriminatory and has no extra benefits for labour welfare. In fact, contractors may provide loans when they are in need but the workers are unable to turn away from their work after that, no matter how unfair the conditions.

Table 2.2: Content and Scope of Investigation

Method used	Content of investigation	Number of respondents
Community scoping using PRA methods	✓ Mapping of the geographical terrain and important village resources, ✓ Social mapping, understanding daily routine, and time spent on different activities for both men and women, ✓ Mapping seasonal illnesses and availability and access to health services	Around five villages in each block

Method used	Content of investigation	Number of respondents
Identification and semi-structured interviews with local health providers both formal and informal	✓ Maternal health services provided/not provided, ✓ Major health problems of working women, reasons for health problems, ✓ Problems faced by service providers, satisfaction/ dissatisfaction with work, ✓ Perceived needs to improve quality of care.	30 Service Providers including ✓ 13 ANMs, ✓ 3 TBAs, ✓ 3 Government Doctors ✓ 11 Informal medical practitioners (Chattisgarh-11, UP-10 and Uttarakhand-9)
Identification and semi-structured interviews with local contractors or employers who paid the women for their work	✓ Kind of work and availability of work provided; ✓ Workforce Composition (age/ sex/caste), Attitude towards workers, ✓ Any changes in market conditions affecting their work, ✓ Change in demand/ supply /composition of labour over time, ✓ Conditions of work/Health and safety related provisions at the workplace	8 Employers/ Contractors (3 Chattisgarh,4-Uttar Pradesh, 1-Uttarakhand)
Overall demographic profiling of the women wage workers	✓ Listing of pregnant women, ✓ Socio economic profile and ✓ Distance from health center.	3538 women
Focus group discussions with women wage labourers	✓ To understand normative information on work conditions and health seeking behaviour, ✓ Preference for service providers, ✓ Perception about access, availability and quality of maternal health services.	25 focus groups of women (11-Chattisgarh 9 - Uttar Pradesh 5- Uttarakhand)
Individual survey (open-ended questionnaire) with women wage workers who had been pregnant or delivered a child in the last 3 years	✓ To understand work conditions, ✓ Access to maternal health services, preference in service providers, ✓ Rights awareness among women belonging to vulnerable socio-economic groups.	**262** women (120 -Chhattisgarh 85 -Uttar Pradesh 57 - Uttarakhand)

2.1.4 Study Limitations

Some of the limitations of this study are:

- It is a small-scale study with a purposive sample, based on the convenience of partner NGOs already working in that area with women wage labourers.
- The actual numbers of FGDs and participating women are uneven across the states, 11 FGDs (93 women) and 9 FGDs (89 women) in two states but only five FGDs (60 women) in Uttarakhand. Sometimes fairly older women wage workers (age 60+) from the village joined the FGD and could not be asked to leave.
- Similarly the survey with women who had delivered in the last three years is uneven - 120 in Chhattisgarh (perhaps due to high fertility) and 85 in UP, but only 57 in Uttarakhand.

- The study was planned using a collective process among partners of defining the study agenda and the fund-raising. However, the collective process was difficult to sustain from 2005 until 2007 when the funding finally came through, and interest had somewhat waned among partners when the implementation actually began. One partnership ended at the final stage of data gathering, leading to smaller coverage with women wage workers in Uttarakhand.

Ethical principles were followed in terms of consent and confidentiality.

2.2 FINDINGS

2.2.1 Characteristics of the Women Wage Workers

The overall demographic profiling indicated that a majority of the women wage workers belonged to socially vulnerable groups and were being paid by some local contractors or employers for different unskilled labour such as stone-quarrying and head-loading work, agricultural labour, collection of minor forest produce and some construction work.

Table 2.3: Characteristics of Women Wage Workers in the Area of Study

Characteristics	Uttar Pradesh Mirzapur Distt	Chhattisgarh, Koriya Districts	Uttarakhand, Udham S. Nagar and Nainital Districts
Number of women wage workers surveyed (total 3538)	1288	1209	1041
Name of block and number of villages where they were identified	Block -Rajgarh Villages - 19	Block - Manendragarh Villages - 36	Nainital Distt., Block -Betalghat, Villages- 27 US Nagar Distt., Block -Gadarpur, Villages - 11
Primary occupation	Breaking stone in quarries	Collection of Minor Forest Produce (MFP)	Agricultural labour
Caste /ethnic composition	16.8% SC, 19.3% ST and 61.4% OBC	87.8% ST	59% SC (40% General castes) in Nainital; 98% ST in US Nagar
Non-literate women	93.1%	55.8%	72%
Number of women studied Class 8+	6	94	24
Sample age range below 18 years	17	13	24
Sample age range 18-35 years	57.2%	78.5%	55.8%
Sample age range 35+ years	40.3%	20.4%	41.8%
Currently married women	90.3%	89.6%	99.55%
Number of widowed +single women	107 + 18	58 + 10	54+45
Number of pregnant women at the time of survey (Jan-June 2008)	33	56 (highest fertility)	21 (lowest fertility)

2.2.2 Women's Health is Shaped by the Nature of Their Work

Many of the health problems reported in women can be directly related to the nature of work and conditions of work. A significant proportion of women reported muscular pains which can be linked to the arduous nature of work and the long hours women have to put into work (due to the burden of both outside and household work).

The survey focused on some key health problems and asked the women if they had suffered from any of these problems in the past one year. Muscular aches, pains and injuries were found to be common. An overwhelming 88.17% of the respondents reported pain in body parts, 72.90% reported weakness and giddiness while 70.23% of the respondents reported pain in the joints. More than half the respondents reported having suffered from some form of accident or injury in the past one year (64.50%). 30.92% of the respondents reported some form of respiratory problem.

Table 2.4: Health Problems faced in the past one year

Health Problems	Total number of respondents who had the problem in the past one year (as % of total respondents)	Caused Absence from work (as % of respondents who reported the problem)	Is a result of work (as % of respondents who reported the problem)
Pain in hands, legs, hips or other parts of body	231 (88.17%)	152 (65.80%)	207 (89.61%)
Weakness and Giddiness	191 (72.90%)	90(47.12%)	173 (90.58%)
Pain in the joints	184 (70.23%)	78 (42.39%)	176 (95.65%)
Accident and Injury	169 (64.50%)	48(28.40%)	154 (91.12%)
Difficulty in breathing or other respiratory illnesses	81 (30.92%)	17(20.99%)	69 (85.19%)

Not only are these problems highly prevalent, they are also severe enough to cause absence from work. 65.80% of the respondents, who reported pain in body parts, had to miss work as a result. Similarly for 47.12% of the women who reported weakness, and 42.39% of the women who reported joint pains, the problem was severe enough for them to miss wage work.

What is important here is that women acknowledge that these problems can be attributed to their work. More than 90% of the women who reported muscular aches, pains, joint pains and accidents reported that these problems were caused by their work. Nearly 85% of the women who reported respiratory illnesses attributed it to their work.

As seen in the previous chapter, the nature of work in the informal sector is extremely arduous and physically demanding. Survey findings do establish that women workers in the informal sector suffer from a range of occupational health problems that are severe enough to warrant absence from work.

Poor work conditions, poor wages and the resulting poverty has meant that a large number of women are not able to afford nutritious food and suffer from anemia. However it cannot be concluded that intake of nutritious food by women is only related to income. Patterns of intra household consumption patterns have not been explored in this study, hence the gender dimension of health problems like anemia has not been fully explored.

2.2.4 Work and Rest during Maternity

a) Gender Roles are an Important Determinant of Work and Rest

Women have to put in almost double the amount of time into work as men, by virtue of their gender. Rigid gender roles have defined household work as primarily women's responsibility. When wage work is added to this, women end up shouldering double burden of work.

The survey with women wage workers shows that majority of the women put in more than six hours into household work. In the survey, 47.49% women reported spending more than six hours on house hold work while 7.72% felt that it was difficult to quantify the amount of time spent on household work as there was work "all the time". If we look at this in the context of hours spent on income generation work we see that women spent at least 6 hours on income generation work. Therefore a woman worker not only spends 6-8 hours or more on income generation work; there is almost an equal amount of time spent on unpaid household work.

Wage labour itself is arduous and physically draining. Women respondents in Uttar Pradesh were employed by contractors in stone quarries and had to break stones. In Chhattisgarh most of respondents travelled several kilometers into the forest to collect forest produce and in Uttarakhand women were spending several hours in agricultural labour.

Table 2.5 Hours Spent on Household Work

Hours Spent on Work at Home	No. of respondents*
Less than 3 hours	16 (6.18%)
3 to 5 hours	100 (38.61%)
6 to 8 hours	119 (45.95%)
More than 8 hours	4 (1.54%)
Work all the time	20 (7.72%)
Total	259
*Answered by 259 out of 262 respondents	

FGD findings made it clear that gender norms dictate much of the practices related to work especially domestic work. Women in nearly all the FGDs mentioned that there was excessive work burden and no sharing of household responsibility among men and women. Men were engaged in household work only when the women were ill and could not do any work. Certain kinds of work have become women's domain, and are looked down upon by men.

The women in Chhattisgarh complained that the men refused even when they were asked for help and retorted that it was 'women's work'. For instance in Uttarakhand, men rarely help in the work in the fields and tending the cattle or fetching water. Men's attitude towards domestic work is expressed by one woman in a UP FGD in these words "Aadmi ghar ka kaam karenge to chote nahin ho jayenge, ghar ke kaam me aadmi bilkul haath nahi batate hai, aur pehle jaise tha abhi bhi aise hi hai" (If men do domestic work wouldn't they become small (low in status), men don't help with domestic work at all and things are just the way they have been). In another FGD in UP, women laughed at the suggestion that men should also be contributing to household work, they were unable to conceive of such a situation.

Given the double burden of household work as well as income generation work, it is not surprising the women report getting very little rest. Majority of the pregnant women could get only 1-2 hours of rest during the day while several others reported getting no rest at all. It is clear that women have to bear the burden of household and other work which leaves them little extra time for rest even during pregnancy.

Table 2.6: Hours of Rest during Pregnancy

Hours of Rest during pregnancy	No. of respondents*
No Extra time	35 (13.83%)
Less than 1 hour	64(25.30%)
1-3 hours	154(60.87%)
Total	253
*Answered by 253 out of 262 respondents	

Although more than half the women reported getting more than one hour of rest during pregnancy, a quarter of the women were able to manage only an hour's rest. There were also a small percentage of women who did not get any extra time during pregnancy for their rest. In the hill regions women have a particularly tough time during pregnancy. In Uttarakhand half the women report getting **no** extra rest in pregnancy. Women in Uttarakhand recounted that they had to wake up as early as 4 in the morning and had to work till 10 in the night and they had no time to rest or take care of themselves. They were constantly busy as they had to finish the household work, childcare and tending the cattle before they could go out for paid work. After work they had to start cooking and handling other household work: "subeh chai banane se lekar, khana banana, baccho ka kaam, kheto me khana dena aur janwaro ki vyavestha karke kaam pe jaana padta hai". (From preparing tea early in the morning to cooking, child care, taking food to the fields and tending to livestock, after doing all this we go for work). In one FGD women mentioned the situation had become worse in the present times because men migrated for work and the burden on women had increased.

Thus poverty and the necessity of earning wages coupled with household responsibilities has meant little rest for these women during pregnancy.

b) Financial Vulnerability a Hindrance in Rest During Pregnancy and After Child Birth

Discussions with women clearly brought out the fact that pregnancy and childbirth was seen as a period of financial crisis and increased financial vulnerability by poor women wage labourers. Not only do women have to work till the very end of their pregnancy, they can also not afford to take long rest after childbirth.

In Chhattisgarh, women of FGDs reported that they continued to work till the 7-8 month of the pregnancy. This was because rest would mean lack of income, and extreme poverty meant that every single penny was important to survive. Since there is **no maternity benefit** and work may be lost to someone else in their absence, women had to start working soon after delivery. Post partum care is extremely important in order for the woman to recover fully and avoid post partum complication. Rest during this time is crucial for the woman to regain strength. But poverty can force the women back to work early: talking about the necessity for women to rejoin wage work soon, a woman from Chhattisgarh says : "**It is not possible to have both money and rest, we have to choose one, so we can't claim rest**".

Lack of work coupled with no maternity benefit meant that women had to start saving in advance and also borrow money. In the words of respondents of one FGD "Sometimes we may have to take credit from shopkeepers; sometimes we make savings for the pregnancy".

The postpartum period is also crucial for breast feeding the infant. The survey enquired about post partum rest taken by women in the unorganized sector.

Table 2.7: Period of Post Partum Rest (Survey data)

	Variations	No. of women who responded	No. of positive Responses
Rest Taken before resuming Domestic Work	Less than 10 days	259	51 (19.69%)
	10 to 15 days		122 (47.10%)
	More than 15 days		86 (33.20%)
Rest Taken before resuming house hold work outside home	Less than 20 days	259	65 (25.10%)
	20 days to 2 months		179 (69.11%)
	More than 2 months		15 (5.79%)
Rest Taken before resuming Wage Labour	Less than six months	214	49 (22.90%)
	6 to 12 months		78 (36.44%)
	12 to 18 months		54(25.23%)
	More than 18 months		33(15.42%)

According to Survey findings, more than half the women (173) reported starting domestic work within 15 days. Domestic work outside the house is mostly reported to start at least 20 days. 179 respondents reported resuming such work after 20 days to 2 months of rest. Much of the rest is only possible due to customs which forbid women to undertake certain tasks because she is considered 'polluted' immediately after childbirth. In Uttarahand, women said that even during this period of compulsory ritual confinement, they were only free from household work. They had to do their own cleaning and washing immediately after delivery.

Wage labour is reported as beginning only after the infant has grown up a bit, possibly to ensure breastfeeding and childcare. However this may not always be the case for some as 49 respondents (23%) reported resuming work within 6 months of child birth. In some FGDs women mentioned having to go for wage work 2-4 months after delivery. Till such time as women could resume wage work, men became the sole earning members. Given the inherent loss in family income when the women stay back from work, the question remains as to how these poor families manage to do this.

2.2.5 Women's Experience and Perception of State Provisioned Services

a) Health Services Distant from Women's Needs and Expectations

Under the National Rural Health Mission with its focus on the maternal health services through Janani Suraksha Yojana, the state has put in place an elaborate structure of health care services which is meant to be largely free at the point of service delivery. This should make state-provisioned services the most preferred for the poorest. The survey findings, however, show that that poor women wage labourers prefer untrained informal practitioners over supposedly 'free' government health providers.

Table 2.8: Place Where Treatment is Sought for Reported Ailments

Preferred option for Treatment of illness[7]	No. of respondents who answered this question (total sample 262 women)	No. of Respondents who prefer this option
Private hospital or informal practitioner	259	147 (56.75%)
Home Remedies	259	85 (48.85%)
Traditional healers/faith healers	259	97 (37.45%)
Government health centre	258	93 (36.05%)
No treatment	258	32 (12.40%)

More than half the women (56.75 %) who responded said that they preferred to go to private/informal practitioners compared to only 36.05% who said they prefer government health centers for seeking treatment. There are many reasons for the greater popularity of unqualified informal providers and even faith healers over qualified providers in a (supposedly) free for all government health facility. The most commonly quoted reason, both in the survey as well as the FGDs was easier physical accessibility of informal providers compared to government health facilities. The 'jholachhap' is usually a person from the local community who is available at any time that the community needs him. He is willing to visit the village of the patient and women find it much easier to interact with him compared to doctors.

Another extremely important factor for not going to government health facilities was the perceived non-availability of medicines. Women reported that at the government facility they were prescribed medicines from outside the hospital. This was despite the provision for free medicines at government health centres. In contrast to public providers, the money charged by private informal providers is inclusive of medicines. In the absence of medicines, the cost of treatment in a government hospital goes up making is as expensive as private treatment. In the words of one woman from Chhattisgarh: "Kharch lagbhag dono me barabar hota hai, sarkari mein davayiyon me lagta hai aur private mein fees ke saath-saath, davai ki bhi lagti hai" (expenses are almost the same in both; in government hospitals it is on medicines and private practitioners have fees along with medicines).

Women also reported facing poor behavior from staff at government hospitals. This was another reason for not preferring government hospitals, as put by one woman from Uttarakhand: "Isliye private me jana pasand karte hain kyonki sarkari mein koi gaur nahi karta, daant lagate hain aur davai bhi kam dete hain"(We prefer going to a private hospital because no one pays attention in the government hospital, they scold us and don't even give medicines). It is clear that that the state run health services are not able to meet the needs or expectation of poor women. In the absence of a good, functioning and sensitive health care delivery system, they have little choice but to opt for local, unqualified informal practitioners or faith healers who more easily accessible.

b) Maternal Health Services: Ill Equipped to Save Lives

Maternal health services are continuum of services which include ante natal, intra-partum as well as post natal services. Majority of the women who were surveyed had received at least some form of pre-natal counseling. However there were only six women, among all those surveyed, who reported getting all[8] the required ante natal services.

[7] The survey enquired from women about their preference for service providers for the general health problems that they had reported.
[8] Immunisation, Iron and Folic Acid,abdominal chek-up,Weight Checkup, blood pressure check up

Due the existence of the Janani Suraksha Yojana since 2006, the survey asked women about where they had delivered their last child and the person who facilitated their delivery in the years 2006 to 2009. Surprisingly, an overwhelming **majority of the women interviewed (almost 80%) had opted for home delivery for their last delivery**, mostly assisted by relatives and older women.

Table 2.9: Place of Last Delivery

Place of Last Delivery	**No. of Women respondents***
Home	209 (79.77%)
PHC	27 (10.31%)
CHC	17 (6.49%)
District/Women's Hospital	3 (1.15%)
Private Clinic/Informal practitioner	5 (1.91%)
On the Way	1 (.37%)
*Answered by all respondents	

Table 2.10: Person who facilitated last delivery

Person who facilitated delivery	**No. of Women respondents***
ASHA	13 (5%)
ANM/Nurse	32(12.31%)
Anganwadi Worker	1(.38%)
TBA	13((5%)
Doctor	9(3.46%)
Relatives and Older Women	167(64.23%)
Doctor with ANM/Nurse	13(5%)
Relatives with ASHA/TBA	12(4.62%)
*Answered by 260 out of 262 respondents	

Of the nearly 80% women who had opted for a home delivery, 64% said that their home delivery had been facilitated by an older woman or some family member **in the absence of any trained person**. In Chhattisgarh, the highest proportion or 114/120 deliveries took place at home, and in UP, 61/85 were at home. Uttarakhand has the lowest rate with 34/57 births at home.

It is also interesting to note that among the 262 surveyed women who had undergone a delivery in the last three years, 84% had received some form of counselling during pregnancy. Of **those who did not go to institutions, two-thirds had been counselled by their local ASHA worker**. All told, only 52 deliveries or 20% of the women delivered at institutions in the last three years, and each of them had received counselling from an ASHA worker.

Out of the institutional deliveries, most were in the PHC, some were in the CHC and only three were in the district level hospital. Only 5 out of the 262 women had had their delivery at a private clinic or hospital, perhaps owing to financial considerations.

During the detailed discussion in FGDs several reasons emerged for having home-based deliveries. One of the reasons mentioned by three women from FGDs in Uttarakhand was that they preferred home deliveries as it was the tradition and in the hospital they feared that they would be cut up: "Aspatal jana isliye pasand nahi karte kyonki wahan prasav ke liye cheer faar karte hain." (We do not like to go to the hospital because they tear up/operate there). They thought that home delivery was much more convenient: "Mahilawon ko ghar me prasav karne mein jyada suvidha hota hai, agar ghar mein na ho payen tabhi aspatal jana parega, abhi tak hamare gaon mein aisi naubat nahi ayi". (Women find delivery at home more convenient. It delivery cannot be done at home, then we have to take her to the hospital. Till now such an event has not occurred in our village). Other important reasons that women discussed during the FGD were large distance of the health facility and lack of transport facility.

However there were also responses to show that some women thought an institutional delivery was safer than to deliver at home. In Uttarakhand one of the groups felt that more births occurred at the hospital at the present times as there was more "facilities": "Pehle se ghar me bacche janna accha mante the parantu ab ki pri aspatal me jana acha maan rahi hai kyonki waha pe bacha aur maa swasth rehte hain" (Earlier home deliveries were considered good, but now deliveries at hospitals are considered good because the mother and infant are safer).

It was found that **even in cases of severe complications related to pregnancy and childbirth, most women did not go for institutional deliveries**.

Table 2.11: Pregnancy and Childbirth Complications Reported

Complications	No of Respondents*	Place of Delivery	
		Home Based Delivery	Institutional Delivery
Excessive Blood Loss	65 (53.72%)	47	18
Prolonged and Severe Labour Pain	96 (79.33%)	67	29
Excessive Nausea	6 (4.95%)	5	1
Fits	1 (.82%)	1	
Breaking of Water	6 (4.96%)	5	1
Breech Birth	7 (5.78%)	2	5
Other Compications (eg. Uterine prolapse)	7 (5.8%)	4	2
*Answered by 257 out of 262 respondents			

Among the surveyed women who had gone through pregnancy and childbirth in the last three years, **two-thirds (168 out of 257 or 65%) reported having severe complications**, such as prolonged labour pain, heavy bleeding or breech presentation for which **only about a third of them (31%) has gone for institutional delivery**. As the table shows, even out of 65 women who reported excessive bleeding, only 18 reached an institution. The rest delivered at home. A few others also reported extreme nausea and waters breaking early.

Some of the critical factors in preventing maternal deaths are access to skilled care and the preparedness of the system to address obstetric complications. There were severe shortages in both these areas.

For a large number of women who were interviewed, the nearest health centre did not have any arrangements to handle childbirth. The ANM, who is the frontline provider, is ideally expected to provide services for normal

delivery and detect complications and make referrals. However it was found that only limited number of ANMs reported assisting with deliveries. Only one ANM interviewed in UP mentioned conducting deliveries at her sub-centre while three other ANMs said they helped out with home deliveries. **In all the states, ANMs complained of inadequate facilities for delivery and referral. Many sub centres lacked basic facilities like delivery table, bathroom and drainage, water supply and electricity in their sub-centres**[9].

Referral from the sub-centre is difficult in the absence of an ambulance. There appears to be no clarity on where poor women may go when there is a complication. Since nearest health centres and the frontline health workers do not have the skills or facilities to deal with complications they refer women to CHCs. CHCs should ideally have facilities to deal with complications. However the CHC doctors in UP and Chhattisgarh stated the limitation that no operations could be performed as they had no qualified surgeons on the staff. Since the local CHCs which are already some distance away do not have skilled personnel, they may refer women to the district hospital even farther out, with little connectivity through public transport and an expensive option using private transport. In such a situation, a woman's life is put at risk due to the lack of preparedness of the health system to manage obstetric complications.

c) Supplementary Nutrition Services: Inadequate, Irregular and Poor Quality

Nutrition supplementation is a critical component of pregnancy care given high anemia and malnutrition among poor rural women. Anganwadis (AW) are expected to provide nutrition supplement to pregnant women and lactating mothers, and a functioning food security system is essential for the basic needs of the poor. In this study, food security and nutrition is included as an important determinant of maternal health. Therefore women respondents were asked about not only Anganwadi services but also the Public Distribution System (PDS).

When it came to Anganwadi services, it was found that in most cases services were irregular, of poor quality or completely absent. Women in 11 out of 25 FGDs mentioned some shortcoming in the area of quality and regularity of AW services such as the Centre being moved away or irregularity of distribution of food, and no response to their complaints. In another two FGDs in UP, the women said that the supplementary food distributed in the AW could only be used as fodder for the cattle and might even have insects in it. In two FGDs of Uttarakhand and one in UP, women reported that there was no AW and in another FGD in UP, people were not aware if there was an AW in the village. In other FGDs of UP women reported that it was no longer functional and the AW Worker came only at the time of inspection. Only women in three FGDs of Uttarakhand informed that there was Anganwadi in the village which provided nutrition supplement like biscuits and fortified salt.

d) Costs and Compensation for Maternal Health Services

Costs involved in childbirth include not only cost of health care but also cost resulting out of loss of wages for women in the unorganized sector, who do not get paid maternity leave. While the survey looked at healthcare costs, the FGDs further probed into financial vulnerability associated with maternity.

[9] The research team also observed these were all lacking and the place was indeed very basic

Childbirth is seen as a period of financial crisis by women from FGDs in Chhattisgarh (CG), since they did not get any maternity benefits, so rest meant lack of income, and as they were very poor they needed every single penny to survive. They also mentioned that they took loans and saved money ahead of the delivery.

However, according to the doctors at the CHCs interviewed in the various states, there are no User Fees (CG), no consultation fees (UP) and just a nominal fee of Rs 2 for registration (UK). They do mention a fee for admission (Rs 21), small amounts for X-rays (Rs 41) and lab tests, but all medicines are meant to be free. Yet according to the ANMs, TBAs and the women of one FGD in Uttarakhand, people would likely become indebted if they attempted to take the patient to the hospitals[10], and this made it very tough for poor families who could not afford treatment. Likewise, in UP, some women and an ANM mentioned lack of money as a barrier for accessing maternal health services.

The Jananai Suraksha Yojna is an important scheme which has the potential to compensate costs incurred during child birth. The Jananai Suraksha Yojna (JSY) is an important scheme which has the potential to compensate costs incurred during child birth. **Among the 46 women who had an institutional delivery in 3 years preceding the survey, 32 women received Rs.1400**, four received less than Rs 1400 while 8 women reported not getting any money. Two women did not respond to the question. Out of the 36 women who did get the JSY money, the time gap between the institutional delivery and payment varied between one week to over a year; with only one receiving the money within a week of delivery. Eighteen women received

[10] This is consistent with macro data that mentions hospital costs as the major reason for rural indebtedness

the money within 3 months, 7 within 6 months, 5 between 6 months to a year and two women received it after a year. Thus the JSY which provides some cash incentive which can play a significant role in mitigating delivery related expenses takes several months before reaching its beneficiaries.

2.3 CONCLUSION

Despite their contribution to the economy of the country, and their productive and reproductive contributions to the community, women workers in the unorganized sector have to bear the consequences of the dual burden of poverty and gender based discrimination. This is reflected in their health status. Much of the common morbidities reported by them are perceived by them to be a consequence of the nature of work they undertake. Poverty means that there is little choice but to carry on with such work, even if it adversely impacts health. Gender based segregation of work means that women workers have the sole responsibility of household work.

When such women undergo pregnancy and childbirth, it is seen as a period of financial crisis as it may mean several weeks or months away from work. However due to absence of any maternity benefit women often continue with physically strenuous wage work till the eighth month and shorten their post partum rest. Supplementary nutrition is crucial at this juncture; however, the Anganwdi services were reported to be irregular and of poor quality.

An ill equipped health system compounds the problem. An overwhelming majority of the women interviewed had opted for delivery at home; including those who had severe complications; and were largely assisted by family members. This has to be interpreted in a context where the nearest and most accessible health facility, did not have adequate facilities for childbirth. There is little clarity about how complicated cases were dealt. Complications were referred to the CHC, who being ill-equipped themselves, then refer cases to the district hospital.

This study brought to light the abysmal conditions of women wage workers in the informal sector, especially at the time of maternity, which is viewed as a period of crisis by these women. The study also highlighted poor access to maternal health services and the need for state supported maternity protection measures. In this context the launch of the Indira Gandhi Matritva Sahyog Yojna (IGMSY) is especially significant for women workers in the unorganized sector.

Since the IGMSY scheme will involve women not currently employed by the Central or State government, a large number of beneficiaries are expected to be women from the unorganised sector, such as daily wage labourers, women agricultural workers, home-based workers doing piece-rate work, or informal sector entrepreneurs like street vendors and so forth. As pointed out earlier, a majority of such women workers are from the vulnerable sections of society like poor women, women belonging to the Scheduled Castes, Scheduled Tribes and illiterate women. Thus it is necessary to examine the impact of the exclusionary conditions on these socially disadvantaged women.

Chapter 3

INDIRA GANDHI MATRITVA SAHYOG YOJNA (Indira Gandhi Maternity Support Scheme)

MONITORING THE IGMSY FROM AN EQUITY AND ACCOUNTABILITY PERSPECTIVE

A block-level study in 4 selected districts of four states of India (2011-2012)

The latest maternity entitlement of the Union Government of India - the Indira Gandhi Matritva Sahyog Yojana (Indira Gandhi Maternity Support Scheme or IGMSY) - is a promising start which recognizes all women's right to maternity entitlements, without restricting it to either 'women wage workers' or women below the poverty line. However, there remain several concerns regarding the scheme pertaining not only to equity and design but more importantly to the exclusionary criteria, which can limit its intended benefits to the most vulnerable groups.

The focus of this study conducted by the National Alliance on Maternal Health and Human Rights (NAMHHR) was on those women who stand excluded due to the eligibility criteria of the IGMSY scheme. The study explored their increased vulnerabilities during maternity in terms of loss of work, health, incomes, access to food and rest in four blocks (45 revenue villages) in four states of India.

3.1 STUDY METHODOLOGY

3.1.1 Objectives of the Study

- To examine the vulnerability of women wage workers **excluded** from IGMSY benefits, and the equity implications of this exclusion
- To examine the accountability of the IGMSY scheme in its pilot phase
- To examine service availability that is necessary to fulfil the conditionalities of the scheme, and assess budget flows

3.1.2 Method and Scope of the Study

This is an exploratory study which has been carried out in the four states of West Bengal, Odisha, Jharkhand and Uttar Pradesh between December 2011 to March 2012. In each of these four states, the study focuses

on one block (in one of the two selected pilot districts of the IGMSY scheme) that had a high proportion of women working as unorganised sector wage workers. It was also decided to select a block which was not affected by Naxalite activities, and one in which there was no presence of NGOs or CBOs working on the issue of women's health and rights, as these could be confounding factors.

Within each selected block, the study focused on a cluster of contiguous revenue villages whose population adds up to 10,000 (Census 2011). The total study population is therefore 10,000 x 4= **40,000 population** which is spread across a total of 45 revenue villages in the four blocks across the four states of Odisha, Uttar Pradesh (UP), West Bengal (WB and Jharkhand (JK).

In these villages, the study investigates all women who have had a live birth between June 2011 and November 2011 (see Table 3.1). The women were identified using the Pulse Polio listing available with local health functionaries. Based on the list, these women have been divided into two categories:

i. Potential IGMSY Beneficiaries -Women with 2 or less living children ii.

Non-Beneficiaries - Women with 3 or more living children

All the non-beneficiary women have been graded on the basis of certain criteria namely caste, occupation, and number of living children, average income and possession / type of ration card. Religion has not been taken into account here as in the study sites all the respondents are Hindus.

Based on these variables, a vulnerability index has been calculated and the most vulnerable of them (women with a score of 10 are the most vulnerable) have been selected for in-depth interviews. Given below are the scores of the 57 selected respondents from the 4 study sites who were short listed for interviews (see Table 3.1).

Table 3.1 Number of Deliveries between June 2011 and Nov. 2011, and women selected for interviews

District	Nr of women delivered Jun 30-Nov. '11	Potential IGMSY beneficiaries (with 1 or 2 children)	Non-Beneficiaries (women with 3 or more children)	Number of women shortlisted according to Vulnerability score*
Bankura (West Bengal)	118	102	16	13
Mahoba (Uttar Pradesh)	204	113	91	16
Bargarh (Odisha)	89	67	22	13
Purbi Singhbhum (Jharkhand)	135	108	27	15
TOTAL	**546**	**390**	**156**	**57**

In addition, the field researchers observed the Village Health and Nutrition Days in all the sites (where they actually occurred), visited and observed the Anganwadi centres and Public Health Facilities and interviewed 20 Anganwadi workers (5 in each site) and 4 CDPOs (Child Development Project Officers). They also prepared 30 Village Maps representing the physical features, roads and distances to facilities in the study sites and took onsite photographs.

3.1.3 The Study Respondents

The characteristics of the women respondents of the in-depth interviews indicate that of these women, who were already vulnerable in terms of economic security, food security, social exclusion and large family size, a

significant proportion are not literate (except for Bargarh block in Odisha) and they have all suffered from wastage of pregnancies (indicating poor foetal or infant/child survival).

Table 3.2 Description of the Respondent women (non-beneficiaries of IGMSY)

State and District	No. of Revenue Villages	Age Range	Caste	Education	Average no. of children per woman	Range of no. of pregnancies
West Bengal Bankura	(3)	24-30	All SC, ST only 1 OBC	9 of 13 are illiterate	3.6	6-3
Uttar Pradesh Mahoba	(9)	22-30	SC, ST and OBC	13 of 16 are illiterate	3.8	7-3
Odisha Bargarh	(9)	28-36	SC, OBC	Of 13, 2 illiterate, 7 primary school, 3 middle or high school	3.6	7-3
JharkhandPurbi Singhbhum	(9)	21-28	SC, ST (Primitive Tribes) and OBCs	12 of 15 illiterate, 3 middle or high school	3.3	7-3

Means of Livelihood

The women use a combination of various wage earning activities within the constraints of seasonal availability, childbearing and childrearing responsibilities to ensure survival. Although daily-waged work is the mainstay for some of them in each sample, its hallmark is insecurity. Further its availability depends on seasonal variation.

- Bankura: Households depend on agricultural labour, work in brick kilns,are engaged in beedi making; are domestic labourers and take up petty jobs for part of the year.
- Mahoba: All of the 16 households depend primarily on work in the stone quarries but also migrate to cities such as Delhi to work in the construction industry when the season is over.
- Bargarh: Of the 13 households, all depend on agricultural labour.4 families collect minor forest produce - tendu leaves and mahul in the non-agricultural season.
- Purbi Singhbhum: Out of the 15 women, 7 were engaged in daily wage work. 6 of them also worked for part of the year as migrant workers on contract in other cities. 3 women said they engaged in other activities such as gathering bamboo and making articles out of the grass. 1 woman said she worked in brick kilns while another cultivated her land in the agricultural season.

3.1.4 Study Limitations

1. There was a delay in making the IGMSY scheme operational, and in payments to beneficiaries. These delays made it impossible to study the impact of the IGMSY scheme on beneficiaries. (At the time of the first phase of the study (December'11 - January'12), there was no beneficiary who had received all three installments. While in Odisha, Uttar Pradesh (UP) and Jharkhand, disbursement had just begun, in West Bengal disbursement had not yet started)

2. Given the time constraints, household survey to obtain the number of children born between June to November 2011 could not be conducted. Therefore, the Pulse Polio list maintained by the PHCs was used in West Bengal and Odisha. In Jharkhand and UP, the list maintained by the Anganwadi worker had to be utilized as the Polio list was not available

3. Limitations of donor timelines limited the number of interviews (just 15-16 interviews with the non-beneficiary women) in each site, although 156 'disqualified' women had been identified.

4. In Odisha, Uttar Pradesh and Jharkhand, all shortlisted women could not be interviewed due to migration of women to their natal homes or workplaces. In these study sites, the woman receiving the next highest vulnerability score were selected.

5. In Odisha the presence of the MAMTA Scheme acted as a confounding factor. It provides increase in the IGMSY compensations money from Rs 4000 to Rs 5000.

3.2 FINDINGS

3.2.1 State Supported Services for the Poor: Experience with Health Care Services

The data collected from the four study sites shows that the infrastructure for public health services is available in most places. However various services still prove difficult to access. The accessibility of these services is hampered by a combination of different factors in the various sites.

a) Availability of Personnel

In Site 2 in Bargarh (Odisha) many of the women are opting for institutional deliveries in private institutions since the government functionaries such as doctors and ASHAs are unavailable at the time of need. Yet in Bankura (WB) the presence of an effective referral system here ensures that the pregnant women in the study site rely predominantly on the public health care system for maternal health services. In the sites at Mahoba (UP) it was the observed that the AWW were overburdened with multiple tasks such as weighing of infants, VHND, record keeping, repeated visits to banks to open JSY accounts and keeping track of health status of women and infants who seasonally migrate.

Box 2: Key Issues in health service utilisation during pregnancy

- Mix of public and private practitioners across the sites
- Differential patterns of use of public health care services in the four sites
- Use of public facilities for institutional delivery
- Lesser use of public institutions for ANC services
- In most places visits to public health care services only when faced with a health problem that becomes worrying
- No knowledge or utilisation of the Village Health and Nutrition Day in any of the Sites except in Bargarh
- Access to health care services shaped by presence of roads and public transport systems
- High opportunity costs- transport, wage losses and on food when seeking health care even in public health care facilities
- Direct expenditures on medicines and sometimes diagnostic services in public hospitals
- Proliferation of private facilities in Bargarh and Mahoba due to dysfunctional public health care sector
- Poor quality care in public health care services Bargarh, functionaries seeking informal payments hence a greater reliance on the private sector
- Perception of better quality care as being provided by the private sector- owing to use of technology, shorter waiting periods and greater time spent by doctors
- Anger towards the health care service system in Bargarh

b) Costs of Accessing Care

Costs of accessing care is another crucial factor which shapes utilization of health services. There are not just direct costs pertaining to medical care, but also indirect costs of accessing care.

Although at public facilities, the doctors' services are provided free of cost, the medicines have to be bought and may cost between Rs. 100-500. In the site at Bankura while the fees are as low as Rs.20 medication might bring the cost to anything between Rs.100-500 for one visit to the public hospital. In Mahoba about Rs.60 may be spent on a visit to a public institution, Rs.150 at Purbi Singhbhum and about Rs. 100 at Bargarh. The expenditure for medicines in a single visit for minor ailments like vomiting, giddiness etc. on an average does not exceed Rs.60, however over multiple visits the expenses came up to Rs.1200 even in public hospitals. This is a large amount for poor women to spend.

In all four places treatment is sought from a mix of private and public practitioners. Visits to the private provider for a minor problem may mean coughing up Rs 250-300 for fees and medicines. For more serious problems the private services may cost as much as Rs. 5,000- 7,000. Informal private providers charge between Rs.700-1400 for deliveries however their services can also be bought on credit. The dai's services were paid for in cash and kind (clothes, grain). In addition to attending to the delivery the dai visited the women at home for up to 21 days after the delivery to help with the care of the newborn and with washing clothes etc. The expenses vary with the length of time that the dai is called ranging from Rs.50 to Rs.600.

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 due to what were perceived as prohibitive costs and the women recovered over a period of time by giving up work.

Transportation cost adds up to the expense. In the absence of public transport forces women are forces to hire private vehicle for between Rs.500 to 1500 in Bargarh and Rs.400 in Mahoba. In Site 1 at Bankura the access to the Medical College and the Government Hospital is helped immensely by the presence of a well-maintained all-weather road. Availability of toll free government vehicles has also reduced costs. On the other hand facilities situated at short distances may be under-utilised because of the lack of good roads. This is evident in Site 1 at Bankura itself where poorly maintained kutcha intra village roads affects the access to sub centres and AWCs especially during the rains.

Box 3: Key Issues in Ante Natal care

Health and Health Problems during Pregnancy

- Self perceived health- Only 50%women in each sample report problems
- The common problems include nausea, vomiting, swelling of limbs, fever, malaria in Odisha
- Use of health care services
- Gradient in use of public services for check up- Highest usage in West Bengal followed by UP and then Odisha
- In UP- ANC checks ups are infrequent but health services are used by half of the women for health problems during pregnancy
- In Odisha dysfunctional public health care services has led to greater reliance on the private sector
- Relatively low direct expenditure in the public sector - Only on medicines
- Greater indirect expenditures for formal private and public facilities- transport, loss of wages, food
- Perceptions of quality of care
- Utilisation mediated by concerns of cost, time, wage loss

Almost **all women who approach health care facilities bear daily wage losses**; long waiting hours of up to 4-5 hours at the public hospital makes the visit a day long trip, and the loss is double if they are accompanied by their husbands. In Purbi Singhbhum district where one of the women reported wage losses of up to Rs.500 since her husband accompanied her for multiple visits to the hospital. During the time of delivery husbands stay back from work to support their wives and resultantly lose wages for three to seven days.

There are other indirect payments like those for food (between 200-400) for the woman and her care givers accompanying her; in addition there are informal payments to nurses (between Rs.100-Rs.300) and doctors. The women also complain angrily that the doctors and nurses demand additional money, as much as Rs.200-300 when the visit government hospitals for services such as 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. Sometimes expenses may also involve expenses that are considered traditionally mandatory like gifting money to hijras and on ceremonies after the birth of the child.

c) Perception of Quality

Utilisation of public health facilities is also determined by the perception of quality of services and previous experiences. The interviews reveal several dimensions that make up the notion of quality in the women’s minds. In the site at Bargarh the women speak of the indignity with which they are treated in the institutions they visit. Shabari[11] from Site 2 in Bargarh recounts an incident when the doctor at the government hospital taunted her cousin when she went there for delivery saying, “You never come to hospital for any treatment

[11] Names changed for confidentiality.

and now you have come here since you will get the money." She feels strongly about this: "Why would we want to go to the government hospital then, we want nothing from there". Most women in the sites at Bargarh and Purbi Singhbhum see the waiver of doctor's fees as the only advantage in the government hospital. They calculate that they still have to spend on medicines, transport, informal payments and have to wait in queues and yet receive inadequate attention from the government practitioners and other functionaries. These are markers of unsatisfactory care according to the women in all the study areas.

Four (out of 16) women in Mahoba have preferred private practitioners for treatments, despite the fact that they cost more. There is additionally a technological superiority that private doctors project with the use of 'computers' (ultrasound machines) that make the women in Site 2 at Bargarh feel that the treatment provided by them is better. Private doctors are seen to be providing more satisfactory care and attention despite the higher costs and and money spent. The women who access them feel more assured of the treatment they receive at these places because they find them more responsive even though that attention comes at a higher price.

3.2.2 State Supported Services for the Poor: Food Security and Nutrition

State supported services such as the Public Distribution System (PDS) and the Supplementary Nutrition Programme (SNP) are crucial to the food and nutritional security of the entire family in the study sites, especially of children, pregnant and lactating women. Yet there are issues about how far they actually benefit the women.

a) Utilization of Supplementary Nutrition Programme (SNP)

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 to Mahoba. Bankura (WB) has the most effective and functional SNP with fresh hot-cooked food: 8 of the 13 women in sample at Bankura receive a meal consisting of 2 bowls of khichuri (about 100 gms) and a half boiled egg. The food is served on a regular basis (six days a week except on Sundays and state holidays). The women like the food and appreciate its quality. In Bargarh (Odisha) the main item distributed to the women is chhatua powder (rice flour mixed with dal). The women receive two packets of two kilos each on a monthly basis. While almost all women report having the received the chhattua packets from the anganwadi the regularity is not very clear. The women mainly complain about the insufficient quantities of the supplement while appreciating the taste of the food that they receive. In Purbi Singhbhum (JK) the pregnant and lactating women receive dry rations by weight. These include rice, sugar, dal, soyabeans and oil. All the fifteen women have received the rations although none of them more than thrice since they registered at the AWC. On inquiring, the Anganwadi sevika explained that the supply was irregular. In Mahoba (UP) the SNP appears to be most ineffective. Even though the 900 gms of panjeeri has been provided on every Saturday it has hardly been consumed because of the poor quality. Most of the times it is sodden and infested with insects; which leads the women to use it as cattle feed. In all the sites women reported sharing food with their children or other family members.

b) Public Distribution System (PDS)

The Public Distribution System (PDS) distributes subsidised food and non-food items to India's poor through a network of Public distribution shops (PDS) across the country[12]. In Mahoba (UP) more households seemed to be in possession of ration cards as compared to Bankura (WB) and Bargarh (Odisha). The PDS in Bankura seemed to fare the worst with small quantities provided from the PDS shop and difficulties in getting ration cards. In the sample from Bankura (WB) half of the women interviewed have no ration cards. Half of the women interviewed in Bargarh (Odisha) and two-thirds of the women Purbi Singhbhum (JK) have no ration cards.

The rations are obtained on a monthly basis: 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 and there is no data on the regularity with which the rations are obtained. In Bankura, the rations are obtained on a weekly basis. In most cases it is half a kilo of rice and kerosene oil. On the other hand in Mahoba, 11 of the women interviewed have a ration card - either in their husbands' names or in the name of their fathers-in-law.

3.2.3 Maternity, Work, and Rest During Pregnancy and After Childbirth

As has been mentioned earlier almost all the women in the four samples work in the informal sector as daily wage labourers. Some in the sites from Bankura, Bargarh and Purbi Singhbhum are also working as homebased workers.

a) During Pregnancy

Most of the women in the study sites at Mahoba, Purbi Singhbhum and Bargarh continued waged work till about the 8th month of pregnancy. **Financial duress** was the main reason behind continuing work. In Bankura where the women engage in seasonal work such as beedi rolling and mahul collection for about three months in a year, some of them seem to be without work for some part of their pregnancy. However in all other study sites the women felt forced to reduce the amount of work they do, the hours they spend working outside the home, and also the number of days spent doing wage work. In the site at Bargarh for instance five of the thirteen women stopped paid work during their pregnancy. This was attributed to their inability to work, excessive vomiting, the need to care for elderly in laws and small children and the lack of support for this caring work along with the household chores.

Wage work is not a matter of choice for most of these respondents and hence when women opt out there are income losses for the entire family. The **income losses are made up for by taking loans**. Almost all women stop wage work and decide to be at home at 'rest' from the 8th month onwards when they feel unable to work any further. However they continue to do the household chores but avoid lifting anything heavy or drawing and fetching water from the well.

[12] The PDS, till 1992, was a general entitlement scheme for all consumers . The Targeted Public Distribution System (TPDS) was introduced with effect from June 1997 with focus on the poor and four types of cards are issued under this namely:APL Card (Above Poverty Line), BPL Card (Below Poverty Line) ,AAY Card (Antyodaya, meant for the poorest of poor BPL families) and Annapurna Card .

b) After Childbirth

Rest in their parlance rarely means 'complete rest' except for about a week to a maximum of three weeks following delivery. Rarely do women observe this culturally mandated and legitimate time of complete rest. In Bargarh, Purbi Singhbhum and Mahoba women do not have the luxury of taking time off. They resume all household chores, excepting heavy labour like drawing water, almost 7-10 days after the delivery. There are those who had no support whatsoever and were forced to resume work within a span of 2 days after childbirth. "In the day-time how can I rest?"- exclaims thirty year old Bimla Sahu , mother of three children at the site in Bargarh.

Some women are unable to excuse themselves from wage-work for more than three weeks after birth despite the unavailability of adequate help, since the family cannot afford to lose the precious income that comes from daily wages. However, **many of the women did avoid wage work after childbirth, despite the economic duress it entails, because they lack child-care support and feel that they could not take the infant to their place of work**. The decision to stay off wage work is a conscious one taken by women in order to ensure the health and well being of the infant.

c) The Costs of 'Rest' for Maternity

The decision to avoid wage-work during maternity entails several economic hardships for the women. 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 to pay off the loans ranging from Rs.2000 to Rs.16000** from moneylenders (at 10% interest) or neighbours or as in Mahoba and Purbi Singhbhum from relatives which are usually interest free. 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. Some of them pawn these items just to meet daily expenses.

In Purbi Singhbhum women mention instances of having to depend on borrowed rations from marital families or the unaffordability of meat, milk and other such foods for themselves and their families. They reiterate that they eat smaller quantities merely to ensure that everyone at home manages to eat something. In Bargarh, the women resorted to leaving the older children at their natal homes being unable to provide sufficient food for them. In Bankura and Bargarh they take credit from the local grocery shop.

The decision to return to work early involves trade-offs pertaining to their own health and that of their infants and other children. If children are not sent for work, the men bear the brunt of double shifts or multiple jobs in order to make ends meet. When the women get back to work as in Mahoba, they struggle with the care of the infant and have to depend on the child-care services of their slightly older girl children. Here the trade-off involves the loss of educational opportunities for the older girl child and also the compromised care of the infant. All important opportunity costs for future life chances of a better quality life which cannot be monetarily calculated.

3.2.4 Practices Around Food and Nutrition in Pregnancy

The experience of poverty has been critical in shaping patterns of food consumption in all the four states. Dietary patterns reflect scarcity of food experienced as a regular part of everyday life. The staple diets across the sites are heavier on carbohydrates and very low in protein content. One of the women from Mahoba remarks, "Bade log acchha achha chhappan tarah ka kha sakte hain, humen to jo mil jaye." (the well-off families can eat many-many varieties of good food, we have to be content with whatever is available).

The table below (Table 3.3) gives an idea of what a typical meal looks like in the four study sites.

Table 3.3 Food Consumed and Related Taboos in Diet during Pregnancy

Study Site	A Typical Meal	Sources of Protein	Taboos if Any
Site 1, Bankura	Rice, boiled potatoes, green leafy vegetables. Puffed rice and occasionally biscuits as snacks.	Milk in tea, in some cases Horlicks and dal but not in all households	Eating less so that the infant is small in order to be able to facilitate delivery
Site 2, Bargarh	Boiled rice, puffed rice and *panthi bhaat*. The accompaniments include leafy vegetables, dal in some cases, fried preparations mostly of potato and in some cases, roti.	Fruits, meat, milk and fish are rare in their diets making *dal* the primary source of proteins in case of those who consume it on a relatively regular basis.	No restrictions pertaining to types of food in their diet.
Site 3, Purbi Singhbhum	Puffed rice (*Muri*), Rice, Roti everyday with some vegetables. The women took between 2-3 meals a day. The questions about food were a cause of discomfort to the respondents.	Dal and milk occasionally	Mushroom, meat and eggs and in some cases small fishes, are foods that are restricted. However most women did not really restrict their diets since they could not any way afford these foods.
Site 4, Mahoba	3-6 rotis, a serving of either vegetables or dal. While dal or vegetables may be available for breakfast and lunch, dinner often consists of rotis and chutney or salt	Dal	Restrictions on eating sour foods and eggplants (brinjal) because they are thought to be gas-inducing and affect the eruption of teeth among infants; restriction on chillies because they are believed to weaken the mother's eyesight

3.2.5 Practices Related to Care of Infants

a) Breastfeeding

Many women across all the four sites are aware that the infants have to be exclusively breastfed for the initial period of their lives. However most are unsure about the exact duration for which to exclusively breastfeed. The period of exclusive breastfeeding varies greatly and **ranges from 21 days to 6 months**. Additional items are introduced into the infant's diet between 2-5 months. This is partly because the **women cannot produce sufficient breast-milk and also because the breast-milk appears to be inadequate** for the growing infant. Their inability produce sufficient milk may be linked with their poor nutritional status. One of the women in Mahoba mentioned resuming wage-work as one of the impediments in continuing exclusive breastfeeding.

If they leave the infant at home in the care of their parents-in-law and go for work, they return during breaks to be able to breast-feed the infant. However they are unable to feed the baby more than 4 times a day in such a case.

b) Weighing and Immunisation

The weight of the newborn infants ranges between 1.5 and 3.2 kgs. Most of the infants are **weighed only at birth**; or those who reportedly have been weighed twice or thrice after that, there is no documented evidence of the infants' weight. Some women across the all the study sites are aware that the weight of the infant is an indicator of his or her growth, however they have not been explained the significance of growth charts. At Bargarh there are no charts that they can look at in the AWC. The AWCs suffer from dysfunctional weighing machines and general laxity in weighing.

The infants are immunized, mostly in AWCs in the site at Bankura though the regular schedules are not always followed. In some cases the women are not informed about the Pulse Polio camps. Most of the women have the **MCP cards with information** on immunization recorded in them. Ten out of 13 women in Bankura had the immunisation cards with the vaccinations received by the children duly noted, but three of them had lost or misplaced the card.

3.2.6 Reproductive Histories and Family Planning

Box 4: Key Issues pertaining to pregnancy and delivery losses

- Gradient in pregnancy losses from West Bengal to UP
- Experience of child death in UP
- Multiple losses to same women
- Poor Maternal and Child health in UP and Odisha
- Underreporting of pregnancy losses in UP
- Is there a normalization of poor maternal health?
- Or is underreporting a result of recall bias?

This section thus looks at pregnancy outcomes and contraceptive practices among poor and vulnerable women in these samples. The data on the reproductive history of the women portrays a variable picture of pregnancy wastage in the four sites.

An inter-state comparison shows women in Bankura followed by those in Purbi Singhbhum have suffered the least pregnancy wastage. The data from the samples in the other two sites at Bargarh and Mahoba provides evidence of high levels of loss through still-births, infant deaths and miscarriages which are indicative of their poor nutritional and health status and that of their infants.

Table 3.4 Reproductive Histories of Non-Beneficiary Respondents

State (Number of women)	Total no. of Pregnancies (n)	Total no. of Live births (as proportion of total number of pregnancies)	Miscarriages	Induced Abortions	Still Births	Child Deaths	Missing Data
West Bengal (13)	48	47 (98.0)	1	0	0	0	0
Odisha (13)	54	45 (83.3)	4	1	3	3	4
Jharkhand (15)	57	55 (96.5)	0	0	2	2	0
Uttar Pradesh (16)	72	51 (86.1)	4	0	0	6	1

Across the four samples it is observed that most women were not using any means of contraception when the study was conducted. However that they want to control pregnancies and limit births is revealed by their understanding and the strategies they adopt for accessing contraceptive services. They make very clear connections between 'weakness' in their bodies and repeated child births at short intervals. Most of them prefer to use the permanent methods after they have achieved the desired family size (3-4 children) and composition (one or two sons), or after they have failed to have the desired number of male children despite repeated pregnancies and childbirths

3.2.7 Informal Sector Women Workers' Expectations from the State Regarding Maternity Benefits

The women articulate the need for monetary support during maternity to enhance access to nutritious food for their families, the children and their own selves. Realizing that they have been left out of maternity support schemes, they express hope that in the future women like them will get more support. But in the same breath the women regret that 'it is fated that the poor must continue to barely survive'. They critique the distance between the apparent intent and the actual practice of the state.

The women underline the importance of food and the need for food security provisions to be provided by the government. They demand free services - medicines, vehicles and treatment provision of warm water, mosquito nets and diagnostic tests. They also think that they should be reimbursed for expenditures even if they accessed private facilities. Thus it is evident that for women maternity benefits include not only a cash component, but a well equipped and functional health system that provides them with free quality health care.

3.2.8 Operational Problems and Issues in the IGMSY

IGMSY is a Centrally Sponsored Scheme with the Union Govt. providing the entire amount as grant in-aid to States and Union Territories. The scheme is expected to cover approximately fourteen lakh (14,00,000) women in the selected districts. The year 2011-12 was the first full year of the implementation of the scheme. It was also decided that the extension of the scheme to all the districts would depend on the evaluation of the Pilot Phase scheme in the first year. The table given below shows the planned allocation of funds for the IGMSY scheme by the Union Government.

Box 5: Key Issues in birth control and contraception

- Desire to limit births
- Perception of vulnerability of large families
- Self perceived connection between repeated births and weakness
- Most women not using any contraception at present
- Poor general health leads to doctors suggesting a postponement of tubectomy
- Intention to undergo a tubectomy gains strength after 3 children
- Lack of discourse on and use of reversible methods
- Overwhelming predominance of tubectomy
- Presence of men in the discourse- only in the context of decision-making

Decision to limit family size and seek services mediated by

- ✓ Long term considerations of
  - child survival,
  - family size and composition- the number of male children
- ✓ Short term tradeoffs
  - approval of husband
  - costs
  - precarious employment
  - loss of income
  - support for child care and domestic duties
  - Public health care services are most widely used for birth control purposes
  - PHC, CHC and District levels are approached for tubectomies
  - Very few women approach the sub centre for reversible methods
  - Even though the services are free of cost indirect costs of travel are quite high
  - The ASHA accompanies the women to the hospital in all three states
  - Variability in amounts and disbursement of cash compensation for tubectomies

Table 3.5: Union Government Allocations towards Indira Gandhi Matritva Sahyog Yojana

	Total Amount Allocated (in Rs. Crore)	Total Expenditure (in Rs. Crore)
2010-11 (BE)	344	111.6
2011-12 (BE)	455.6	-
2012-13 (BE)	455.6	-

Source: Expenditure Budget Volume II, Union Budget document 2012-13, Govt. of India

However, as Table 3.5 reflects, the allocations in the financial year 2012-13 are the same as the previous year indicating that the scheme would not be extended beyond the fifty two districts in the financial year 2012-13. The table 18 shows that in the first year of implementation across fifty two districts (i.e. in 2011-12), Rs 288.74 crores was released to the States/UTs for implementation of the scheme. Given below (Table 3.6) is the amount allocated by the Union government to the different states for the financial year 2011-12.

a) Disbursement Delay and Resulting Exclusion

According to the CDPOs, the budgets for disbursal of the IGMSY money are based on the actual number of beneficiaries that has been obtained through surveys conducted by the AWWs. There are **no targets** set that could have limited the number of pregnant women identified as beneficiaries. 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 as late as September 2011.

Table 3.6: Grants to States/Union Territories for IGMSY for the year 2011-12 (in Rs. Crores)

State/UT	Grant Released	State/UT	Grant Released
Andhra Pradesh	24.52	Mizoram	0.85
Assam	17.52	Meghalaya	1.59
Arunachal Pradesh	0.41	Maharashtra	11.22
Bihar	24.20	Nagaland	0.70
Chhattisgarh	10.70	Odisha	12.58
Gujarat	6.90	Punjab	9.82
Goa	1.70	Rajasthan	23.00
Haryana	1.31	Sikkim	0.39
Himachal Pradesh	1.74	Tripura	2.13
Jammu& Kashmir	3.78	Tamil Nadu	11.5
Jharkhand	11.74	Uttar Pradesh	22.94
Karnataka	18.84	Uttarakhand	2.97
Kerala	8.63	West Bengal	25.18
Manipur	1.32	Puducherry	0.19
Madhya Pradesh	19.32	Delhi	11.05

Source: Statement of Released of Grant-in-aid to States/Union Territories with Legislature under Centrally Sponsored Schemes, Ministry of Women and Child Development, 2011

The CDPOs in their conversations revealed that there have been delays in release of funds in all states. Further enquiries revealed that the funds reached the states and then the districts at widely varying times; this despite the fact that in all the states the first round of identification of beneficiaries was done in mid-2010. In West Bengal, it was found that the state government officials consider the IGMSY scheme to be a centrally sponsored scheme and therefore see a limited role for themselves in facilitating it.

- In Jharkhand, for instance, the DPO mentioned that they had received the first two installments of the IGMSY scheme. The 1st installment of Rs. 99, 18, 000 was received on the **3rd of July 2011** and the 2nd installment of Rs.3,38,70,770 was received on the 16th of Feb 2012
- In Odisha the Department of Women and Child, Government of Odisha on the **13th of October 2011**, directed that a sum of Rs 11,00,15,375 (Eleven crore fifteen thousand three hundred and seventy five) be released towards the implementation of the IGMSY scheme in the selected districts.

- In Uttar Pradesh the ICDS department on the **11th of November 2011** received Rs 1,68,59,300 (One crore sixty eight lakh fifty nine thousand three hundred).
- West Bengal, the funds reached the pilot districts in early March 2012. The DPO (ICDS) office in Bankura had issued a letter to CDPOs to open a joint account (in the name of the CDPO and the cashier) on the **6 March 2012**, to enable the transfer of the IGMSY funds. The funds have now been transferred to Blocks (by March 2012).

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. Anticipating this, in the states of UP and Jharkhand, a second list was drawn which included only those women who had conceived in the month of January 2011. Thus, **for no fault of theirs, women who had been identified as beneficiaries in the first list are no longer considered** while distributing benefits except in West Bengal.

A closer look at the various provisions and design of the scheme throw up some concerns which could prove to be hindrances in the effective implementation of the scheme and realization of providing much needed financial support to pregnant and lactating women.

b) Low Allocations at Aggregate and Unit Cost

- The main platform for implementation of IGMSY is the Anganwadi centre. The already existing budgetary provisions under ICDS are low and inadequate with no budgetary provision towards maintenance of Anganwadi centres.
- The budgetary norms under IGMSY have no allocation for implementation of the scheme from the platform of Anganwadi centres. Thus, the implementation of IGMSY hinges upon the overburdened infrastructure of ICDS with no additional allocations made under IGMSY.
- The compensation to AWW and AWH under IGMSY is provided in the form of incentives of Rs 200 and Rs 100 per beneficiary respectively, which is very small while the increase in work load is very large.
- In addition, the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)-Sabla, also currently in a pilot phase in two hundred districts is being launched from the platform of ICDS.

c) Understanding among ICDS Functionaries Regarding the Scheme

As pointed out elsewhere, the scheme is being rolled out by the ICDS officials and AWW, with the AWC being the focal point of implementation. Hence it is important to gauge the level of understanding among these workers. The interviews with the CDPOs in the four study sites reveal awareness about the scheme, its eligibility criteria and its guidelines at the higher levels. However at the level of the AWWs the information is much poorer.

The CDPOs recounted all the conditionalities of the scheme when asked during the interviews, but it is interesting to note that in Jharkhand they have **imposed additional conditions that further exclude women beneficiaries**. These include conditions regarding a time-bound immunization schedule, pregnancy registration within 4 months, 'adequate' gap between two children, a verifying signature of the ANM in the

application form, a copy of the infant's birth certificate, copy of mother and child health card. The claim made by the local frontline workers is that these will "aid cross-checking and verification". For example a gap in immunization due to any reason, even if it was owing to a lapse in service delivery, is a disqualifying factor.

In order to promote a greater understanding of the scheme, trainings were planned at all the levels. Various agencies were involved in the training of the functionaries in the four states. In Jharkhand UNICEF played an important role, in Odisha the training was conducted by department officials at the state level and in the UP NIPCCD was involved. The quality and rigour in the training also appears to be variable. In Jharkhand for instance training was imparted thrice at Ranchi to CDPOs and Supervisors; however no special training has been given to AWWs or ANMs. They are informed and oriented in monthly meetings by their respective supervisors. The content of the training also appears to vary by state, level and functionary. In West Bengal the training encompassed topics like selection of beneficiaries, calculating the number of beneficiaries and trimester wise installments. In Odisha and Jharkhand it also looked at aspects such as corporate and net banking.

d) Issues of Convergence

The success of IGMSY is contingent upon the successful convergence of ICDS and NRHM. It is assumed that the scheme will help enhance the demand for services offered by NRHM and the health system. Women's accesses to benefits under the scheme depend upon their access to services provided by NRHM and ICDS. Thus, deficiencies in services being provided under ICDS or NRHM programmes could hinder women's access to the provisions they are entitled to under IGMSY. It may even disqualify the women from IGMSY benefits if they have not fulfilled the service uptake conditions.

Convergence with the health departments is made possible through joint meetings as in the case of the UP and Jharkhand, or over the phone with ANMs in Odisha. The CDPO of Mahoba feels that the attempt at convergence was not working very well. She feels that the scheme should have been administered by the health department itself. In West Bengal the CDPO says that there is no role for the health department except in the training. According to the CDPO, convergence is being established by joint training programmes for functionaries from both departments.

However, 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. Further on being asked about provisions for grievance redress, and addressing complains, they revealed that no formal grievance redress mechanisms have been put in place at the block and village levels. Only in Odisha there is a mention of the existence of a 'control room for grievances', and that too only at the state level.

e) Inadequate Provision of Human Resources for Implementation of Scheme

The implementation of the IGMSY hinges upon the Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs) at the ground level. No additional human resources are being provided for the implementation of the scheme at the ground level. In addition to the responsibilities that AWW are already required to perform under ICDS, as part of their responsibilities under IGMSY they would be required to ensure registration of beneficiaries, support them to open bank accounts and counsel pregnant and lactating mothers and motivate beneficiaries in fulfillment of service-uptake conditions. They are also required to keep records pertaining to the beneficiaries for the implementation of the scheme.

Given the critical nature of the responsibility that AWWs are required to perform, there is a need to re-look at the human resource provision for the implementation of this scheme.

The problem of inadequate human resource availability is further compounded by vacancies in the existing structure. In India, twenty nine percent of supervisor posts and thirty percent of Child Development Project Officer (CDPO/ACDPO) posts were vacant as on November 2011.

Table 3.7: Vacancies at Supervisor and CDPO/ACDPO Posts

	Supervisor Posts Vacant (in %)	CDPO/ACDPO posts vacant (in %)
Jharkhand	44	40
Odisha	2	6
Uttar Pradesh	30	19
West Bengal	54	44

Note: Figures are as on November 2011. [Source: Accountability Initiative, Budget Briefs, ICDS, GOI 2012-13]

Moreover, under IGMSY, additional staff being hired at the State and District levels for the implementation of the scheme, like in most other Centrally Sponsored Schemes, is hired on a contractual basis.

f) IGMSY Scheme and Eligible Beneficiaries Who Have Been Excluded:

While the data cited in earlier sections serves to bring out the vulnerability faced by the women who are excluded on the grounds of parity, unfortunately **other factors are also contributing to excluding women.** Operational failures on the ground have failed to pick up all the women identified as beneficiaries in the state of Uttar Pradesh and Jharkhand. In Odisha, no cases of women being missed out have been found. 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 has still not been drawn up. Given below in Table 3.8 are the reasons on the basis of which 'eligible' women (2 or less children) were not included as beneficiaries the IGMSY scheme, as obtained from the study findings in two states:

Table 3.8 Additional Reasons for Exclusion of Eligible Beneficiaries from the Scheme

Reasons for Exclusion	Mahoba (UP)	Purbi Singhbhum (JK)
Migration	11	13
Supervisor rejected form	3	0
Month of pregnancy/delivery[13]	13	0
Bank account not opened	1	2
Beneficiary Did not want	3	0
No ID proof	2	2
'Insufficient' gap between pregnancies	0	1
Form not filled properly	0	1
Death of the Child	0	1
Immunization not done	2	2
Total	37	22

As is evident from Table 3.8, **migration** remains the main reason why women were left out of the preview of the scheme. A large number of these women migrated to Delhi in search of employment and therefore the Supervisors said they were forced to leave them out of the scheme. Besides, in Mahoba, there were women who were left out because of confusion over whether women having **premature births** were entitled to the IGMSY benefits.

[13] Only women who have conceived from Jan 2011 were eventually considered as beneficiaries (4th Month pregnant in April2011), although the first round of survey had included women from January 2010 to December 2010

Thus by the time the scheme translates into implementation at the ground level, a lot of new conditions seem to get added to the already complicated restrictions, which further limits the access of women to the IGMSY scheme.

3.3. Conclusions

Despite their contribution to the economy of the country, and their productive and reproductive contributions to the community, women wage workers in the unorganized sector continue to bear the consequences of the dual burden of poverty and gender based discrimination. This is reflected in the findings from this study examining how exclusionary criteria of this IGMSY Maternity Benefit Scheme impacts on the rural women who are working in the informal sector.

Working in an unregulated sector with no social security and low employment security, they are risking loss of income each time they stay away from work owing to ill-health or pregnancy. Their labour is arduous, and in addition are the dual responsibilities of managing household work, which is resumed shortly after childbirth. In the absence of food security, they are compelled to compromise on their own requirements, even in pregnancy. They report poor nutritional intake, 'weakness' and pregnancy losses.

An ill equipped health system compounds the problem. There are high opportunity costs in seeking ante-natal services that are often not available. Many of the women delivered in hospitals, but they report unaffordable expenses for seeking care, including direct costs (medicines, tests, supplies) and indirect costs like wage losses, food expenses and demands for informal payments. After childbirth too, household expenses may soar, if there is treatment needed for the baby, or special food and care for the mother or celebration.

When such women undergo pregnancy and childbirth, it is seen as a period of financial crisis as it may mean several weeks or months away from work. However due to absence of any maternity benefit women often continue with physically strenuous wage work till the eighth month and shorten their post partum rest. They cannot take their babies to the workplace in the absence of crèches, and are compelled to stay home to breastfeed, although that impacts on family incomes. Supplementary nutrition is crucial at this juncture; however, the Public Distribution System and Anganwdi services were reported to be irregular and inadequate.

This study once again brings light the abysmal conditions of women wage workers in the informal sector, especially at the time of maternity, which is viewed as a period of crisis by these women. In this context the launch of the Indira Gandhi Matritva Sahyog Yojna (IGMSY) is especially significant for women workers in the unorganized sector. Yet it is clear that the exclusionary criteria are going to prevent the most vulnerable women from accessing the benefits of this scheme: poor women, women belonging to the Scheduled Castes, Scheduled Tribes and illiterate women. While each episode of maternity exacerbates their vulnerability and they are never sure whether the baby will survive, the state has penalized them for having more than two living children and yet failed to ensure other forms of maternity protection in a period of increased impoverishment and high expenses.

To conclude, by imposing these conditionalities of parity, the IGMSY scheme in its very design defeats the purpose that it sought to address. **Unconditional maternity benefits, and universal food security for all women**, without any conditions, is a primary requirement for the improvement of maternal nutrition, reduction of maternal anaemia and prevention of maternal mortality, which is caused to a significant extent by high rates of anaemia[14].

[14] The Registrar General revealed that of the 70 to 80 thousand maternal deaths in India each year, 38% can be attributed to heavy bleeding (hemorrhage), 11% to infections (sepsis), 8% to unsafe abortions

Chapter 4

DISCUSSION and CONCLUSIONS

The last two chapters have given the findings from two different studies carried out by the same anchoring organization SAHAYOG in partnership with other civil society groups and advisors. The first study was done in 2007-09 to understand the factors which shaped health, especially maternal health and access to health care for poor women working in the unorganized sector.[15] The study highlighted how these women's health, including maternal health needs to be located within their status as unorganized sector workers as well as the larger context of gendered roles and responsibilities that they had to bear. It also showed how absence of maternity protection, poorly accessible and an ill equipped health system compounds the problem for women who become pregnant.

The launch of IGMSY in 2010 was an important step in providing some degree of maternity protection to women in the unorganized sector. However there were several concerns related to the exclusionary criteria (Box 1.) and the program design (Table 1.4) as well as equity related concerns that prompted SAHAYOG to anchor the second study in 2011-12. It was also an opportunity to revisit what was learnt from the first study done in 2007-09 and examine if the IGMSY had the potential to make the experience of maternity more secure and safer for poor women. This section synthesizes the analysis of the two studies.

I. Women's Health Intermediated by Multiple Dimensions

It is important to understand women's health through a broad multidimensional framework. The first study done in selected blocks of three states (Chhattisgarh, Uttarakhand, Uttar Pradesh), shows that women workers in the unorganized sector have to bear the consequences of the dual burden of poverty and gender based discrimination. This is reflected in their health status. Much of the common morbidities reported by them are perceived by them to be a consequence of the nature of work they undertake. Women report constant aches and pains and severe exhaustion. Poverty means that there is little choice but to carry on with such work, even if it adversely impacts health. Gender based segregation of work means that women workers have the sole responsibility of household work. Findings show that women's health is shaped by their status as informal workers which translates into long hours of arduous work with little social protection and poor conditions of work. Women's health is also located within larger gender structures where women have little choice but undertake additional household with little or no help from men. Her food intake is determined not by her nutritional requirements but by what is available for the entire family. Any intervention for women's health therefore must develop a holistic understanding of these determinants of the health of women.

[16] Additionally the study had also enquired into the conditions of work of women workers in the unorganized sector; the findings of which have not been discussed in detail in this report.

II. Need to Relook at Exclusionary Criteria in IGMSY through an Equity Lens

A very small percentage (less than 5%) of women workers in India enjoy unconditional maternity benefits and social security, including 3-6 months of fully paid leave. Further, women who work in the informal sector are usually poorly paid with no social security including maternity protection. Using the NFHS 3 data, Lingam and Yelamanchili (2011) have shown that 48% women will be ineligible if exclusion criteria as per the IGMSY are adopted. They further point out that 59% women having any one of the vulnerabilities in terms of caste, class or education will get left out. Thus 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 (see Table 1.5). The findings show that women who stand excluded due to the conditionality laid down in the scheme face severe constraints related to nutrition, work and rest during maternity.

Supplementary Nutrition (SNP) Services: Inadequate, Irregular and Poor Quality

Secondary data shows poor nutritional status of pregnant women on the whole that is reflected in the stubbornly high rates of anaemia irrespective of the efficiency in healthcare service delivery. The macro data at state and district levels are corroborated by the women's accounts of 'weakness' during pregnancy or weakness as a normalized condition in their lives. Anaemia among the women in study sites of West Bengal and Odisha has in fact become an impediment for them to accessing sterilisation services. The link between anaemia, high morbidity rates and susceptibility to infections has been well documented. The patterns of food consumption of women during pregnancy are defined by poverty and intra-household distribution patterns. Women talk about the cutbacks in food that they and their families have had to make due to the lower income (caused by their withdrawal from wage work). Thus a situation of poor access to food stands exacerbated during pregnancy, childbirth and care of the newborn.

On the basis of the findings, it can be said that the quality and regularity of these SNP and PDS services varied across the four study sites. However in none of the study sites were both these services functioning seamlessly at the same time. The conclusion that one draws is that SNPs cannot substitute for the PDS and vice versa. The SNP is critical for the most vulnerable in the families like pregnant and lactating women and children who need the nutritional support that the SNP provides through the allocation of protein-rich diets in the face of general lack of food. Access to food though the PDS ensures that there is enough basic food and fuel for the consumption of the entire family such that they do not have to face hunger given their economic and social vulnerability. If the PDS does not ensure basic food security, then women tend to share their SNP with other family members. This is because the women do not see their well being in merely individual terms and instead believe in sharing what they get especially with their children. Further patriarchal norms shape their actions and behaviour related to food; hence women are often the last to eat after they have served food to the elderly in-laws, the husband and children by when there is very little food left for them to eat. Thus a non-functioning or inefficient PDS eventually undermines the inputs and investments made through the SNP.

Work and Rest During Pregnancy

Over and above the poor nutritional status are the arduous work conditions that the women in the informal sector encounter. Given the lack of regulations and the insecure nature of labour in the informal sector, the women toil under difficult conditions - long hours, lack of minimum wages, gender-discriminatory wages and work places without child care services. However given their situation of poverty, their labour and the income that it brings are crucial to the family's survival. Thus work is not something that they can take off from during pregnancy despite the need for rest and the avoidance of heavy labour that is important for their own health and preventing pregnancy losses.

Towards of the end of their pregnancies they are forced to withdraw from paid work due to physical discomfort, even so they still do not have the luxury of taking off from domestic chores. They continue them till the time labour starts, and resume these tasks within a very short span after childbirth - usually less than a month, or mostly just a week to ten days in most places.

Costs of Maternity Leave and Child Care

For women in the informal sector every episode of pregnancy and childbirth is a period of increased physical, emotional and financial stress. Pregnant and lactating women are compelled to reduce the amount of work they do, the hours they spend working outside the home, and also the number of days spent doing wage work. After childbirth they are have stay at home if there is no one to take care of the infant. In the absence of child care, women may have to make the difficult choices to balance the need for child care, rest and income. This affects their health and the well-being of the entire family, both directly and indirectly. Direct monetary losses range between 800 to 12,000 rupees across the various sites. Loans are obtained at usurious rates from local money lenders. In an effort to avoid loans families tide over the lean period by selling or pawning precious assets like ornaments, livestock, or utensils.

Factors Determining Fertility and Use of Contraception

One of the conditions of IGMSY is to have two or less children. Such conditions are being visualized by the Government as leading to positive social and behavioural change towards 'small family norm'. Yet the findings show that given the poor nutritional status of the family as a whole and especially that of women and children, there is a historical experience of high pregnancy losses or infant and child deaths in these impoverished communities. Thus practices pertaining to birth control are shaped by this experience. This explains the high fertility rates and multiple pregnancies that women undergo. Across the four IGMSY study sites, most women were not using any means of contraception when the study was conducted. However they do want to control pregnancies and limit births, and recognize that multiple pregnancies cause 'weakness'. Thus pregnancy wastage further exacerbates the condition of ill-health that these women suffer, thus contributing to a vicious cycle.

III. Need to Relook at Design of the IGMSY

The major design related concerns emerged from the fact that the scheme has been designed as a conditional cash transfer scheme which is dependent on fulfillment of several conditions. The aim of a conditional cash transfer is to increase the utilisation of services by offering incentives. Use of a conditional cash transfer presumes that low utilisation of services is the result of a lack of demand for services rather than supply side issues. The design of the IGMSY is based on a diagnosis that the poor health status of women is only due to demand side barriers, and lays down conditions on the health services they must access to qualify for the benefit.

Yet these conditions apparently designed as 'incentives for service uptake', are not within women's control: they cannot determine whether they will be able to access care if their local health service system is not functioning. In addition the absence of services exacerbates the daily-wage losses faced by women and their family members who accompany them. National level data (NFHS 3)[x] also indicates that access to, and utilization of, ante-natal care is affected by women's poverty, lack of education and being part of SC/ST communities. The findings from both the studies throw light on women's health-seeking that demonstrates how supply side factors are a very important constraint in utilization of maternal health services.

Health Services Distant from Women's Needs and Expectations

The data shows that across all study sites utilization of maternal and child health care services are dependent on a host of factors like functionality and dependability of the health system, availability of health personnel, cost of accessing care, perception of quality and behavior of providers. Even though there is considerable variation in service provision patterns (with access to ANC and child care services being much better in West Bengal as compared to the other states), nonetheless maternal health services are poor in quality and irregular. The poor provisioning, lack of services, facilities and personnel coupled with long distances and lack of public transport further discourages women who want to access public health care services.

Despite the low direct costs, accessing public health care services involves high indirect costs in the form of - expenses on transport, food, loss of wages and demands for informal payments. Over and above these may be expenses for medicines and diagnostics given that these have to be purchased from the market. The quality of care that the women receive at public health facilities, including social abuse regarding their caste and poverty, is another deterrent which limits their utilisation. The poor and erratic nature of service availability does not encourage women to access them. Services like the VHND are nearly non-functional in all states or else women have no information about them.

In 2007-09, a similar situation was reported by women. An overwhelming majority of women (based on findings of study done in Uttarakhand, Chhattisgarh, Uttar Pradesh) opted to deliver at home instead of in health facilities institutions; including those who had severe complications, and were largely assisted by family members. This has to be interpreted in a context where women were advised by their local ASHAs to attend facilities for childbirth; yet despite a significant number facing life-threatening complications, less than half of those reached an institution. There is little clarity even among health services providers in sub-centres, PHCs and CHCs about how complicated obstetric cases are to be dealt with, and they resort to multiple referrals where women with their life at risk have to go to several providers before getting care.

Given this backdrop the incentives for institutional delivery appear more as mild or disguised coercion. While most women in the 2011-12 study had accessed institutional delivery in public facilities (in contrast to the earlier study of 2007-09), cash incentives like JSY can be counterproductive in places where health care services are inadequate. Women undertake many risks to access public providers during labour only so that they can claim the cash payments, a significant amount in their extreme poverty. This raises a question on such incentive-driven measures.

Operational Constraints in Implementing IGMSY

One of the objectives of the IGMSY was to promote a greater convergence between the ICDS and the health department. Rather than strengthening the existing framework of these programmes to improve their effectiveness, it was assumed that IGMSY will help enhance the demand for services offered by NRHM and the health system. Yet no specific measures have been instituted to enhance the convergence between the two programmes.

There have been large delays in release of funds in all states. This affects the scheme as some of the beneficiaries identified in the original list had already delivered by the time the money was released and were therefore no longer eligible for the scheme. Beyond this, beneficiaries have also been excluded due to restrictions devised by the local functionaries as they re-interpret the guidelines.

The implementation of the IGMSY hinges upon the Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs) at the ground level with no additional human resources. Given the critical nature of the responsibility that AWWs are required to perform, there is a need to re-look at the human resource provision for the

implementation of this scheme, since at the level of the AWWs the information about the scheme is quite poor. Another problem is very low budget allocations for the scheme, along with delays in disbursement.

Inadequate Child Care and Support Services

The inadequate support for child care and child health is reflected in the erratic provisioning of immunization, child-weighing and child care services. For most health problems of their children and infants, the women in both the studies consult private formal or informal providers who are seen to be more accessible and responsive, as well as providing 'better quality'. Yet this care comes at high costs, and sometimes healthcare has to be foregone owing to the expenses involved.

Women who are forced to go back to work early are not in a position to provide enough care for their infants. They can neither practice exclusive breastfeeding nor provide sufficient care, since in almost all workplaces, there is a lack of facilities like crèches or day-care centres where the children can be kept safely or attended to at regular intervals. Thus this work is often done by older children who forego school and attend to other domestic chores or take care of the infants.

Inadequate Maternity Benefit

While the provision of maternity benefit which will cover women working in the informal sector is laudable, the entitlement for beneficiaries under IGMSY of Rs 4,000 is inadequate. This amount has been arrived at by calculating wage loss compensation of approximately 40 days @ Rs 100 per day. Of course the 40-day compensation is grossly inadequate if women are expected to breastfeed exclusively for 180 days after childbirth. However, keeping in mind that even this amount is lower than the minimum wages in most states, the per day compensation does not seem adequate to effectively cover the financial burden faced by women during pregnancy due to wage loss and other expenses that have to be incurred for child birth and post natal care. Comparing the entitlements of pregnant and lactating women under IGMSY with State maternity benefit programmes also indicates that an amount of Rs 4,000 per beneficiary is too low. While MAMTA scheme of the Odisha government provides an amount of Rs 5,000, Dr. Muthulakshmi Reddy Maternity Assistance Scheme in Tamil Nadu provides cash assistance of Rs 12,000 per beneficiary.

The benefits are much lower that what women workers in the formal sector and Government employees are entitled to. Women in the formal sector are entitled to- without any conditionality- maternity leave for a period of upto 135 days from the date of its commencement and a salary equal to last pay drawn during maternity leave.

IV. Expectations from State and from Maternity Benefit Schemes

The women expect safe work, which pays enough wages, health care that is free of cost especially for children, services for child care and financial support that enables them to access sufficient food during exacerbated economic vulnerability. They believe that these support structures must be made available universal and they find the basis for their exclusion erroneous. The women clearly point out that with larger families they are in need of greater support from the government, hence maternity benefits schemes must not exclude them only on the basis of the number of children they have.

Thus maternity benefit schemes need to be designed in recognition of the fact that these women are more vulnerable during pregnancy, incur greater expenses during a period when family incomes are reduced, thus in greatest need owing to their conditions of poverty. As a woman from Chhattisgarh says about the imperative to join work soon after childbirth: "**It is not possible to have both money and rest, we have to choose one, so we can't claim rest**".

Chapter 5

RECOMMENDATIONS[16]

1. Maternity entitlements be made available to all women, **without any conditionality.** The Age Eligibility and Parity Criteria should be done away with. In this regard **the ruling of the Honourable Supreme Court dated November 20th 2007** on National Maternity Benefit Scheme is to be noted, which states that benefits will be given "**irrespective of number of children and the age of the women".**

2. Strengthen existing health systems to provide affordable quality comprehensive maternity care. This is possible through strong primary level care which is integrated with the secondary and tertiary level through effective referral system. Important services like ANC and immunisation cannot function well without strong primary health care system. Similarly dealing with maternal complications need a well functioning referral system along with strong secondary level care.

3. Provide universal food security: strengthen the Public Distribution System and the Supplementary Nutrition Progamme of the ICDS as these provide crucial support to vulnerable women and their families. The school mid-day meal is also essential for ensuring that women do not sacrifice their own nutritional needs for that of hungry children in the household.

4. Increase Anganwadi Workers and Auxiliary Nurse Midwife(ANM) services on priority basis to ensure pregnancy care and nutrition services; fill in the staff vacancies.

5. Women have the right to support for childcare especially for exclusive breastfeeding while at work[xi]. A constitutional entitlement cannot be made conditional and must be legally enforced.

6. There is urgent need for workplace initiatives for supporting women with infants and young children (less than 2years) through provision of crèches, so a separate budget line is needed for breastfeeding support, including crèches. If women are unable to access crèches, there should be complete reimbursement of six months wages if exclusive breastfeeding is expected

7. Disburse money in a single installment during pregnancy. This should be linked to minimum wages and should be equivalent to at least 6 months of minimum wages.

8. Pregnancy registration in any Anganwadi centre should be a sufficient document for opening a zero balance bank account to enable the transfer of the IGMSY money. This would help to tackle the problem of migration and documents proving identity and residence.

9. In case of a health-system failure that prevents women from meeting the service-uptake conditions, there needs to be an accessible grievance redress mechanism which poor women can easily use; with a report on prompt action taken.

10. Involve civil society in monitoring and evaluation; involve community women in social audit and local monitoring committees

11. Publicly specify framework of evaluation of the IGMSY scheme, including enhanced nutrition and health indicators.

[16] Some of these recommendations have been developed over 2011 with inputs from various civil society organizations and networks. Others have been drawn from our experiences in the field during this study

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ENDNOTES

[i] A Study Advisory Group (SAG) was formed at the time of formulating the proposal, with the roles of providing expert comments at various stages like the literature review, design of study tools and analysis of the findings. This consisted of the following national level researchers and subject matter specialists who have done earlier research or interventions on related issues. SAG members include -

a. Dr. Abhijit Das, Director, Centre for Health and Social Justice, New Delhi

b. Asha Kilaru, Researcher, (formerly with Belaku Trust, Karnataka)

c. Dr. Imrana Qadeer, Public health researcher

d. Priya Nanda, ICRW, New Delhi

e. Ramakant Rai, SAACS

f. Sanjai Sharma, Human Rights Law Network, New Delhi

The first meeting of the SAG was held in July 2008, to share the profile of the respondents and the situation in the study areas. Based on the inputs received, the study design was further sharpened and the data-collection instruments were prepared. These were field tested, reviewed, modified and then revised again after intensive inputs from one SAG member. The research team was trained with support from the organization of another SAG member. The study draft report was reviewed by three SAG members before the launch.

[ii] These included

a. Dr. Imrana Qadeer (formerly professor at CSMCH, JNU),

b. Dr. Abhijit Das, Director of the Centre for Health and Social Justice,

c. Dr. Vandana Prasad, Convenor of the Public Health Resource Network and

d. Ms Nayana Dhavan of SEWA

[iii] Estimated at 92% by S. Sakthivel, Pinaki Joddar, 'Unorganised sector workforce in India/Trends, Patterns and Social Security Coverage,' EPW, May 27, 2007, p.2107-8.

[iv] Times of India, Saturday, August 11, 2007

[v] The Hindu, Friday, August 10, 2007. Refer to debates on the global phenomenon of the feminization of the labour force in Women, Work and Poverty 2005, UNIFEM, p. 37.

[vi] ibid; this finding is however in contradistinction with the findings of the report prepared by the NCEUS in 2007 (see page 3), which indicates that Indian agriculture is getting feminised with 73 per cent women being associated with it compared to 52 per cent men. Also contrast UNIFEM 2005, p.45.

[vii] ibid. This requires careful handling for seldom the possession of industry-wise skills can be judged in terms of formal education. Experience and expertise are the two usual criterions (in most cases the former), for judging industry-wise skills.

[viii] International Labour Conference, 90th Session 2002, Report VI - Decent work and the informal economy

[ix] 'Uncovering Women's Work' Jayati Ghosh http://infochangeindia.org/200709196492/Agenda/Women-At-Work/Uncovering-women-s-work.html

[x] From NFHS-3 Report: "In summary, almost one out of every five women in India did not receive any antenatal care for their last birth in the five years preceding the survey. Women not receiving antenatal care tend disproportionately to be older women, women having children of higher birth orders, scheduled tribe women, women with no education, and women in households with a low wealth index. These differentials suggest that improving the coverage of antenatal programmes requires special efforts to reach older and higher-parity women and women who are socioeconomically disadvantaged." (Page 195 of Chapter Eight)

[xi] As per Article 42, the state should make a provision for securing just and humane conditions of work and maternity relief. Eleven years after the Constitution was adopted, the Parliament enacted the Maternity Benefit Act in 1961. The law was enacted following convention of International Labour organisation which guaranteed maternity protection to women, as well as wages for three months, irrespective of their age, nationality, race or creed with effect from Sept 7, 1955.

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ADDENDUM (pg 28)

Table 3.2 (b) Description of the Respondent women (non-beneficiaries of IGMSY)

Districts	Total respondent women non-beneficiaries	No MGNREGA job card	MGNREGA Job card in their own name	MGNREGA Job card in their husband's name/father in law name	Have RSBY card
WB - Bankura	13	1	0	12	0
Odisha- Bargarh	13	3	0	10	7
JK- East Singhbhum	15	6	1	8	4
UP- Mahoba	16	6	0	10	0

The data also shows that of all 57 women, only one woman in East Singhbhum has a job card in her name. In 40 cases, the MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act) job card is either in the name of their husbands or fathers-in-law. Sixteen of the 57 women have no job cards in their family.

In West Bengal, the Rashtriya Swasthya Bima Yojna (RSBY) scheme which is an insurance scheme for Below Poverty Line (BPL) households, that provides them cashless hospitalisation for a specified list of procedures including deliveries in empanelled hospitals (both private and public) does not exist and therefore none of the 13 respondents of Bankura district possess them. Of the remaining 44 women in the other 3 study districts, 16 women are BPL card holders; however only 11 of them have RSBY card.

Thus, it is clear that the existing social security provisions which could have provided women with important support do not cover all the respondents

SAHAYOG
A-240, INDIRA NAGAR, LUCKNOW-226 016, Uttar Pradesh
PH: 0522 2310747, 2310860; FAX : 0522 2341319
Website: http://www.sahayogindia.org/

National Alliance for Maternal Health and Human Rights, India
Blog: http://namhhr.blogspot.in/