

A Baseline Study Exploring Rural Maternal Health Practices and Services in Relation to the IGMSY Conditional Maternity Benefit



Student: Rachel T. Bell – 3570932

Supervisor: Dr Paul van Lindert

MSc Thesis: International Development Studies

Faculty of Geosciences, Utrecht University

Date of Submission: 27th July 2011



Acknowledgements

Thank you to the staff at Sahayog for allowing me to work with them and for all the help I received during my internship. In particular thanks go to Jashodhara Dasgupta and Y. K. Sandhya for help with the research design, Paula Das for all her help with my many enquiries and for her endless patience and Sangeeta Maurya for her help as my research assistant.

Also thanks to the PANI office in Faizabad for their support whilst we were conducting the field research and to the local PANI office and the village Pradhan for their time and help.

A final and big thank you to the women and their families for giving their time to take part in the study and sharing their experiences with me.

All photos on each title page throughout the thesis were taken by me during the field research. Each photo was consented for using the consent form in the appendix. Copies of all photos have also been sent to the women of the villages as an appreciation for their time and help.



Executive Summary

The research provides a baseline study of maternal practices and services of two villages in rural India prior to the implementation of the Indira Gandhi Matritva Sahyog Yojana maternity benefit. The IGMSY scheme will provide women with Rs. 4000 for the first two live births. Receiving the benefit is dependent on the completion of a number of conditions which include; registering the pregnancy, receiving ante-natal care, registering the birth, getting the child immunised and exclusive breastfeeding for six months.

The research was conducted in one of the pilot regions of the benefit. The main areas of focus during the research were the amount of rest and nutrition taken by the women, who would be excluded from the study in relation to the limit of two births and necessary age of nineteen years old, and whether the necessary services are available to complete the required conditions.

Globally there has been a rise in the use of conditional cash transfers (CCTs) by governments to increase the utilisation of services such as health and education. A program using a conditional cash transfer imposes certain conditions alongside providing incentives which encourages individuals to take action. In India due to a mix of social and cultural factors women's health is often the poorest. This poor maternal health can perpetuate a cycle of ill-health across generations. Women in India do not get adequate nutrition, particularly during pregnancy. As women do not gain enough weight during pregnancy this means they are more likely to have children born with a low birth-weight and/or suffer complications during delivery.

The IGMSY scheme aims to allow pregnant and lactating women to increase their rest and nutritional intake by providing compensation for wage loss. Conducting a baseline study allows the current practices and services to be explored and can help to identify any differences in the future once the benefit is implemented.

The research found that women take limited rest during and after pregnancy and often do not change their diet during pregnancy. The research found many actions were tied

in with cultural practices. The study concluded that most services required for the benefit could not be found locally and even services that are available may not be accessible to all. The research suggests that the goals of the scheme will not be achievable without major supply side investments.

This research gives understanding to the use of conditional cash transfers to achieve aims within maternal health. In the local sphere it is shown that the success of conditional cash transfers is dependent on the circumstances in which the conditional cash transfer is implemented, such as the services need to be available and there needs to be an understanding of the impact of culture. On a global scale the use of conditional cash transfers can often be seen as a reaction to targets set by the millennium development goals. Results show that whilst conditional cash transfers have been successful elsewhere in the world in improving areas such as health this success is clearly dependent on localised factors. The research shows that in this case the aims of the benefit (to improve health and allow for an increase in rest and nutrition) are out of line with the current health practices and services available in the area.

Table of Contents

1 Introduction.....	14
2 Regional Framework.....	20
2.1 Introduction.....	21
2.2 Demographics.....	21
2.3 India's caste system.....	25
2.4 India's success with the millennium development goals	27
2.5 India and gender inequality.....	28
2.6 The northern state of Uttar Pradesh	32
2.7 The district of Sultanpur	34
2.8 Understanding the local panchayat and health systems	37
2.9 Summary.....	39
3 Theoretical framework	40
3.1 Introduction.....	41
3.2 A rights based approach to development	41
3.3 What rights?	42
3.4 Whose rights?.....	42
3.5 Using a rights based approach in practice.....	43
3.6 The link between health and rights.....	44
3.7 Women's rights as human rights.....	45
3.8 The capabilities approach.....	47
3.9 Maternal health.....	47
3.10 Which issue to solve first?.....	49
3.11 Barriers of demand to healthcare	50
3.12 Barriers of supply to the utilisation of healthcare.....	52

3.13 Conditional cash transfers	53
3.14 The problems with a conditional cash transfer approach.....	56
3.15 Conditional cash transfers – An international perspective	57
3.16 Summary.....	60
4 Contextualised Thematic framework	Error! Bookmark not defined.
4.1 Introduction.....	62
4.2 Maternal health in India – Barriers of demand and supply.....	62
4.3 Anaemia, malnutrition and breastfeeding	64
4.4 Antenatal care	65
4.5 Maternity benefits – International recommendations	66
4.6 Maternal laws in India	67
4.7 IGMSY conditional maternity benefit.....	68
4.8 The host organisation - Sahayog	71
4.9 Summary.....	71
5 Methodology	73
5.1 Introduction.....	74
5.2 The research problem	74
5.3 The research objective	74
5.4 Central research question	75
5.5 Sub questions	75
5.6 Literature searches.....	76
5.7 Conceptual model	77
5.8 Ethics	79
5.9 The research process.....	80
5.10 The plan for the analysis.....	83
5.11 Methodological problems	84
5.12 Summary.....	85

6 Rest and nutrition.....	86
6.1 Introduction.....	87
6.2 Analysis – rest and nutrition.....	87
6.3 Discussion – rest and nutrition.....	91
6.4 Summary.....	92
7 Criteria of the scheme: who is excluded?	94
7.1 Introduction.....	95
7.2 Analysis – criteria of the scheme.....	95
7.3 Discussion – criteria of the scheme	100
7.4 Summary.....	101
8 The conditions of the scheme	103
8.1 Introduction.....	104
8.2 Analysis – conditions of the scheme	104
8.3 Discussion – conditions of the scheme	116
8.4 Summary.....	117
9 The scheme.....	119
9.1 Introduction.....	120
9.2 Analysis –the scheme	120
9.3 Discussion –the scheme	122
9.4 Summary.....	123
10 Conclusion	125
11 Recommendations for future research	129
References.....	131
Appendices	137
Appendix A – Information sheet	137
Appendix B – Consent form.....	140
Appendix C – Topic guides.....	141

Appendix D – Transcripts and fieldnotes..... 146



List of Figures

2.1 Map of India's states	22
2.2 India's religions.....	23
2.3 Cities with more than one million inhabitants	24
2.4 India's caste system.....	26
2.5 Sex ratio's for India and its neighbours	29
2.6 Sex ratio's in India: 1901 - 2011	29
2.7 Sex ratio of total population and child population in the age group 0-6 India: 1961 - 2011	30
2.8 Percentage of women receiving full antenatal check up	31
2.9 Percentage of institutional births.....	31
2.10 Percentage of children receiving full vaccinations aged 12-23 months.....	32
2.11 Map of the states of Uttar Pradesh.....	33
2.12 Association between child mortality and state's domestic product.....	34
2.13 Vaccination of children (12-23 months) in Uttar Pradesh.....	36
2.14 Local health workers and government departments	38
3.1 The main determinants of health.....	48
3.2 Diagram showing the intergenerational cycle of health and nutrition.....	49
3.3 Determinants and barriers to the utilisation of health care services	51
3.4 Supply and demand factors to the utilisation of health care	53
3.5 Types of intervention to reduce demand barriers	54
3.6 Growth of conditional cash transfers from 1997 - 2007	55
4.1 Percentage of women who received full antenatal care by states	66
5.1 Conceptual model for the IGMSY conditional maternity benefit.....	78
6.1 Anaemia among women.....	88

6.2 Share of underweight children under five years of age	89
7.1 Mean children ever born by district	99
8.1 Local primary health centre.....	105
8.2 The one room in use at the local primary health centre	105
8.3 Sub-centre	106
8.4 View inside the sub-centre	106
8.5 Mother receiving at least one TT injection by district.....	109
8.6 Examination room in X block PHC	110

List of Tables

2.1 India's poor and hungry.....	25
2.2 India's millenium development goal progress	27
2.3 Background characteristics of Sultanpur.....	35
2.4 Child immunisations in Sultanpur, Uttar Pradesh	35
2.5 Maternal health in Sultanpur, Uttar Pradesh.....	37
4.1 Conditions of the IGMSY scheme	70
5.1 Issue model matrix for the research	83
6.1 Response to questions about women's autonomy.....	90
7.1 Uttar Pradesh – Key indicators	96
8.1 Antenatal care in Uttar Pradesh	107
8.2 Child immunisation in Uttar Pradesh	110
8.3 Child feeding practices in Uttar Pradesh.....	115

Acronyms

AAY - Antyodaya Anna Yojana

ANC – Antenatal Care

ANM – Auxillary Nurse Midwife

APL – Above Poverty Line

ASHA – Accredited Social Health Activist

AWC - Anganwadi Centre

AWH – Anganwadi Helper

AWW - Anganwadi Worker

BCG – Bacillus Calmette-Guérin (Tuberculosis vaccination)

BMI – Body Mass Index

BPL – Below Poverty Line

CCT – Conditional cash transfer

CDPO – Child Development Project Officer

CEDAW – Convention on the Elimination of all forms of Discrimination Against Women

DFID – Department for International Development

DLHS – District Level Household Survey

DPT – Diptheria, Pertussis and Tetanus

GDP – Gross Domestic Product

GoI – Government of India

IGMSY – Indira Gandhi Matritva Sahyog Yojana

ILO – International Labour Organisation

MDG – Millennium Development Goal

MMR – Maternal Mortality Rate

MO – Medical Officer

NAMHHR – National Alliance for Maternal Health and Human Rights

NFHS – National Family Household Survey

NGO – Non Governmental Organisation

NREGA - National Rural Employment Guarantee Act

NSAP – National Social Assistance Program

PANI – People’s Action for National Integration

PHC – Primary Health Service

RBA – Rights Based Approach

TT – Tetanus Toxoid

UN – United Nations

UNDP – United Nations Development Programme

UNFPA – United Nations Population Fund

UNICEF - United Nations Children's Fund

U.P – Uttar Pradesh

WHO – World Health Organisation

1 Introduction



India is not on target to meet the millennium developments goals of reducing maternal mortality by three quarters or reducing the under-five infant mortality rate by two-thirds. Improving maternal mortality and infant mortality in India is hampered by an inter-generational cycle of ill health. Many women suffer from the lack of adequate nutrition, particularly during pregnancy. As the women do not gain enough weight during pregnancy they are more likely to have children born with a low birth-weight and/or suffer complications during delivery. The children do not receive adequate nutrition as they are growing and therefore have a low body weight and short stature. The cycle then continues for another generation.

The Government of India has proposed to implement a national maternity benefit that aims to help increase rest and nutrition for pregnant and lactating women by providing support for wage loss. This paper aims to explore current maternal health practices and services in rural India to provide baseline evidence of maternal health prior to the implementation of this benefit and to also assess the feasibility of such a scheme.

The Government of India is piloting a new conditional maternity benefit that will provide women with money to compensate for wage loss to aid the taking of maternity leave and an increase in nutrition. The government will provide Rs. 4000 to women of nineteen years and over for their first two live births on the provision that they register the pregnancy, receive the tetanus toxoid (TT) injections and iron tablets, attend the required number of antenatal visits, register the birth, get their child immunised and breast feed exclusively for six months. The scheme is being piloted in 52 districts of India.

Sahayog is a non-governmental organisation (NGO) based in Uttar Pradesh and works to promote gender equality and women's health from a human rights framework. Sahayog aims to conduct a baseline study of the IGMSY scheme to explore current maternity practices and services. Aspects of the scheme to be considered include current practices surrounding rest, nutrition and breastfeeding, looking into who will be included and excluded from the scheme, and assessing the availability and accessibility of local services with regard to the required conditions for the scheme.

The IGMSY scheme is a conditional cash transfer. The interest in conditional cash transfers (CCTs) for government social assistance schemes is growing around the world. 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. One argument for the rise of conditional cash transfers in government social policy is the impact of the millennium development goals (MDGs) with governments using conditional cash transfer approaches in areas they are not meeting the MDG targets.

Of all maternal deaths 99% occur in developing countries (Freedman, 2001). This statistic shows a clear imbalance in the pattern of maternal mortality. To understand the imbalance of health two aspects need to be considered: to what extent women are not enjoying the right to health; and to what extent the government is not meeting its obligations (Yamin, 2005). This can be considered as the barriers of demand and supply.

Demand barriers to accessing health care can include: education of the recipient, lack of knowledge or information of the service, location of the service, cost of the service both financially and in time, and barriers due to cultural norms. Supply factors that reduce access to services can include: lack of skilled staff, lack of technology, equipment and drugs, expectation of bribes, abuse or discrimination of patients by staff, infrastructural barriers to reaching the service and perhaps most importantly the availability of the service to begin with.

India is unlikely to meet the goals for reducing maternal mortality, child mortality or the incidence of disease. That India is unlikely to meet their millennium development goal targets in some areas, particularly those around health, is the result of a number of factors. The Indian health care system has had a long period of underfunding but the health problems faced by India are the result of more than just problems with the supply of health care. Many of the poor are not knowledgeable of services available or of their rights to these services, and those that are face costs both financially and in time to reach the services. Another problem to accessing services is India's strong patriarchal system, although India is considered a middle income country on a world wide scale India is one of the worst countries for gender inequality. This gender

inequality often creates many cultural and social barriers specifically reducing women's access to health care.

The IGMSY scheme is primarily aimed at increasing a woman's ability to take rest and additional nutrition during pregnancy and when breast feeding by offering support for loss of wages. Time off before and following the birth is important as it helps to prevent complications. The International Labour Organisation believes that maternity leave is important as it reduces the risk of complications following labour and allows time to establish breast feeding (ILO, 2000). Nutrition is another important component to a safer pregnancy. Anaemia in pregnancy is one of the contributors to maternal mortality and morbidity. The gender inequality in India is one of the biggest contributors to malnutrition of women as perceptions of women being of less worth causes unequal distribution of resources, which leaves women vulnerable to malnutrition (Neogy, 2010).

The main areas of focus during the research will include examining the amount of rest and nutrition currently taken by the women, exploring who would be excluded from the study in relation to the limit of two births and minimum age of nineteen years old, and whether all the necessary services are available in order to allow the required conditions to be completed.

The conditions required to be eligible for the benefit require that women register the pregnancy, attend antenatal check ups, receive the TT injection and iron tablets, register the birth of their child, get the child immunized, attend growth and monitoring appointments, and breastfeed exclusively for six months.

Breastfeeding is an important condition of the scheme as in the long term it could help reduce infant mortality and malnutrition. This is because breast milk contains a good mix of nutrients, natural immunities and it stops infants from receiving foods or liquids that may be contaminated (Brennan et al. 2004). In low income societies where infants are at a greater risk to environmental conditions breastfeeding may continue for longer. The international infant feeding recommendations suggested by UNICEF, the WHO and agreed by the Government of India are for exclusive feeding for six months.

Another of the key conditions is for pregnant women to attend ante-natal check ups and ensure that the women and infants are given the necessary immunisations. In India around half of all pregnant mothers do not complete three antenatal visits and a quarter do not receive the tetanus prophylaxis injection (Vora et al. 2009). In the district of Sultanpur (the pilot district of this research paper) only 28% have three antenatal visits yet 82% receive the TT injection whilst pregnant (DLHS-3, 2008). The number of children fully immunised is much lower with only 40-55% of children receiving the required vaccinations (DLHS-3, 2008).

One key area for discussion and that is discussed in the interviews with the local women is the availability and accessibility of services. In order for the conditions of the benefit to be met the conditions required need not just to be available but also accessible. Ensor and Cooper (2004) suggest that access to health services are restricted by both demand factors; education, location, cost, time and cultural norms, and supply factors; lack of skilled staff or equipment, expectation of bribes and abuse or discrimination of patients by staff (Jeffery and Jeffery, 2010).

The findings of this study come from interviews and focus groups with village women and local health workers. The women were picked to ensure a range of caste groups and different levels of poverty, however, this was a local study. It needs to be borne in mind that whilst it is hoped that aspects of the studies findings will be applicable to other parts of India the study used a sample frame from villages in one block of one district of one state. Whilst findings of service failures and cultural issues may be applicable elsewhere further multi-state research needs to be done to ensure the findings can be generalised to other areas. Further more it is hoped the research will add to the global debate on the use of conditional cash transfers.

The paper begins by outlining and giving a clear picture of modern India. India has a large population with a diverse mix of religions and cultures. Whilst many changes have occurred in the last few decades the chapter shows India to still have a predominantly rural population, to be having mixed success in achieving the MDGs and ranking low internationally for its gender equity.

The theoretical chapter outlines the focus on the rights based approach and links human rights to the right of health. Women's health is then discussed at both

international and national level along with the current debate over the increasing use by governments of increasing social welfare by conditional cash transfer schemes.

The paper then outlines the IGMSY scheme and provides information about the host organisation. The research problem and objective are outlined along with the methodological approach that is to be used. Each research question is analysed and discussed using the data from the research in the chapters following the methodology. The paper ends by concluding the main points and making recommendations for future research.

2 Regional Framework



2.1 Introduction

The regional chapter helps to explain the demographics of India's population and give an understanding to aspects of Indian culture that are relevant to the research. India has a massive population, so large that the numbers can be difficult to comprehend and so in some cases country equivalents have been used to provide a relatable comparison. The chapter uses data from the most recent census (2011) and also from household surveys. The surveys are conducted by the government every five years. The national family household survey (NFHS) was last conducted in 2006 and the district level household survey (DLHS) was conducted in 2008. Indian culture is heavily shaped by a caste and patriarchal system. These dominant systems heavily impact upon Indian culture and are explained throughout this chapter so that there is an understanding of the consequences of these systems on Indian culture. The system of patriarchy has led to a large gender inequality in India and the impact of this gender inequality is discussed. India is a vast country and each state has a very different culture. Further information is given about the state and district the research took place in so as to provide an understanding of the area that the research took place in.

2.2 Demographics

India is the world's largest democracy and is the second most populated country after China. India comprises 28 states and 7 union territories (see Fig. 2.1) and has a population of 1.21 billion which accounts for 17.5% of the world's population (GoI, 2011). India's annual population growth rate is 1.6% meaning that India's population increases by the size of the Netherlands every year (UNDP, 2009).



Figure 2.1 Map of Indian states (Utrecht University, 2001)

The annual population growth of India is now higher than that of China and it is expected that the India will have a higher population than China by 2030 (GoI, 2011).

India is a diverse mix of cultures, religions and languages. Hinduism accounts for the religion of 80.5% of the population, 13.4% are Islamic, 2.3% Christian and 1.9% are Sikh (GoI, 2001). This diverse mix of religions along with caste and regional differences has led to tensions. Famous examples of such religious tensions include the assassination of Prime Minister Indira Gandhi in 1984 by her Sikh body guards

and widespread violence between Hindu's and Muslim's following the demolition of the Babri Mosque in Ayodhya (BBC, 2010).

Figure 2.2 shows the distribution of the religions in the different states. Hinduism is the majority religion in most states. The states bordering Pakistan and Bangladesh, as well as the southern state of Kerala and Lakshadweep islands have a higher than average Muslim population. The majority of Christians live in the southern states and the eastern states that border Bangladesh and Myanmar (formerly Burma).

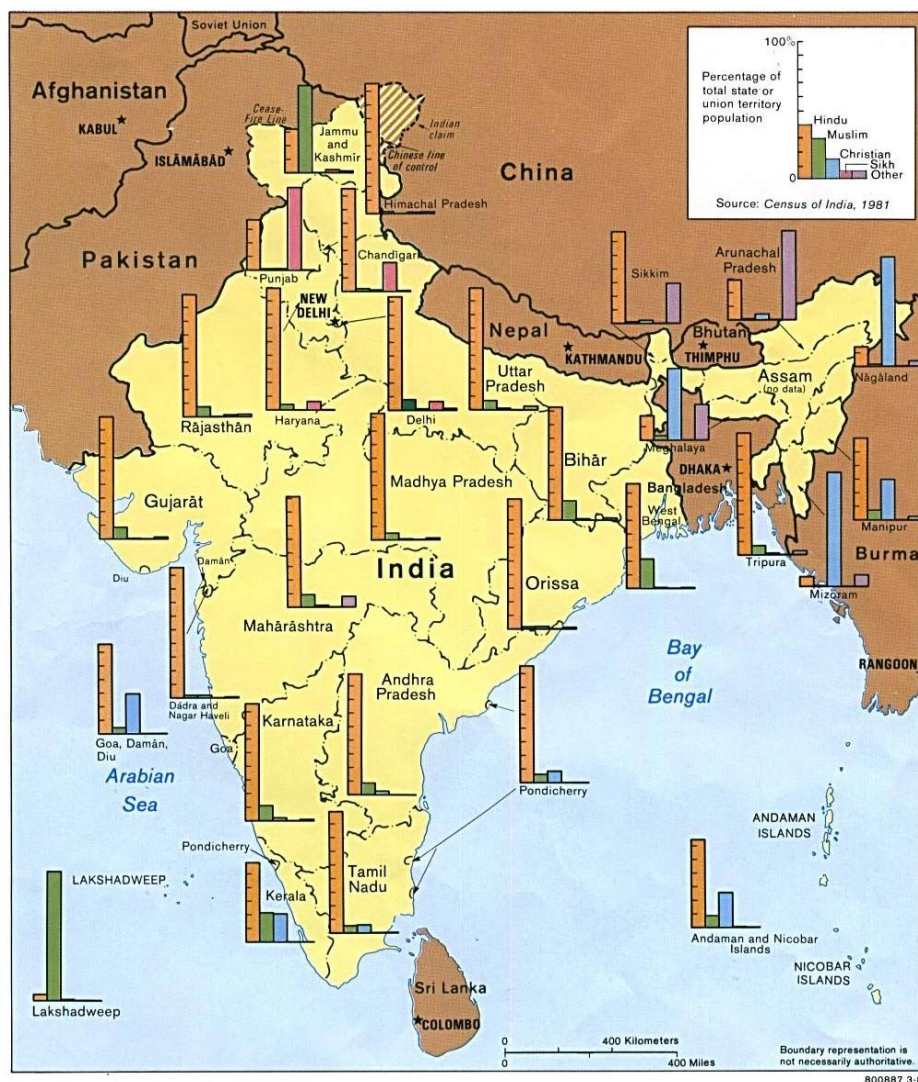


Figure 2.2 India's religions (Utrecht University, 1987).

India is a largely rural country with 72% of the population residing in rural areas (GoI, 2001) yet India also has many 'mega cities' where population levels exceed one million people (see Fig. 2.3). Since the 1990's India has emerged as a major power

and has a strong and fast growing economy. However the majority of the rural population remains impoverished.



Figure 2.3. Cities with more than 1 million inhabitants (Gol, 2001)

Nationwide 27.5% (equivalent to the population of the US and Australia together) of Indians live below the national income poverty line (UNDP, 2009). India's national poverty line is Rs.12 per capita/day for rural and Rs.18 per capita/day for urban areas (UNDP, 2009). Those that are chronically poor are mainly women (60%), the scheduled tribes (47%) and schedules caste groups (36%) (UNDP, 2010). In India women comprise 48% of the population, scheduled castes 16% and scheduled tribes 8% (UNDP, 2009). More than 90% of the overall workforce is employed in the informal economy and of those 96% are women (UNDP, 2010).

Table 2.1 shows the states of India with the largest amounts of poor people. A country with the equivalent population to the number of poor within that state has been included to allow for comparisons to be made within our frames of reference.

Table 2.1 India's poor and hungry (UNDP, 2009)

State	Poor (%)	Number of poor (million)	Equivalent population (million)
Bihar	41.4	36.9	Poland (38)
Chhattisgarh	40.9	9.09	Sweden (9.3)
Jharkhand	40.3	11.64	Greece (11.2)
Madhya Pradesh	38.3	24.96	Saudi Arabia (25.7)
Orissa	46.4	17.85	Holland (16.5)
Rajasthan	22.1	13.49	Mali (13)
Uttar Pradesh	32.8	59	United Kingdom (61)

2.3 India's caste system

India's complex caste system is rooted in Hinduism which assigns each person a place in the social hierarchy traditionally related to occupation. All the castes fall under four basic 'varnas' or categories. Discrimination on the basis of caste is illegal and measures have been introduced to empower disadvantaged groups and provide them with easier access to basic services. Despite efforts to prevent discrimination based on caste the system is still recognised by most people. People entering into inter-caste marriages or relationships are often victims of abuse, assault or even murdered. The caste structure has softened in urban areas regarding education, jobs and access to health but it is still clearly entrenched in daily life, one example being that most places that have a person who cleans the home will have a separate person who cleans the toilet. Figure 2.4 shows a diagram of the caste structure, each of the four varnas includes a number of different castes. The categories used now for population monitoring are general caste, backward caste, scheduled caste, scheduled tribe.

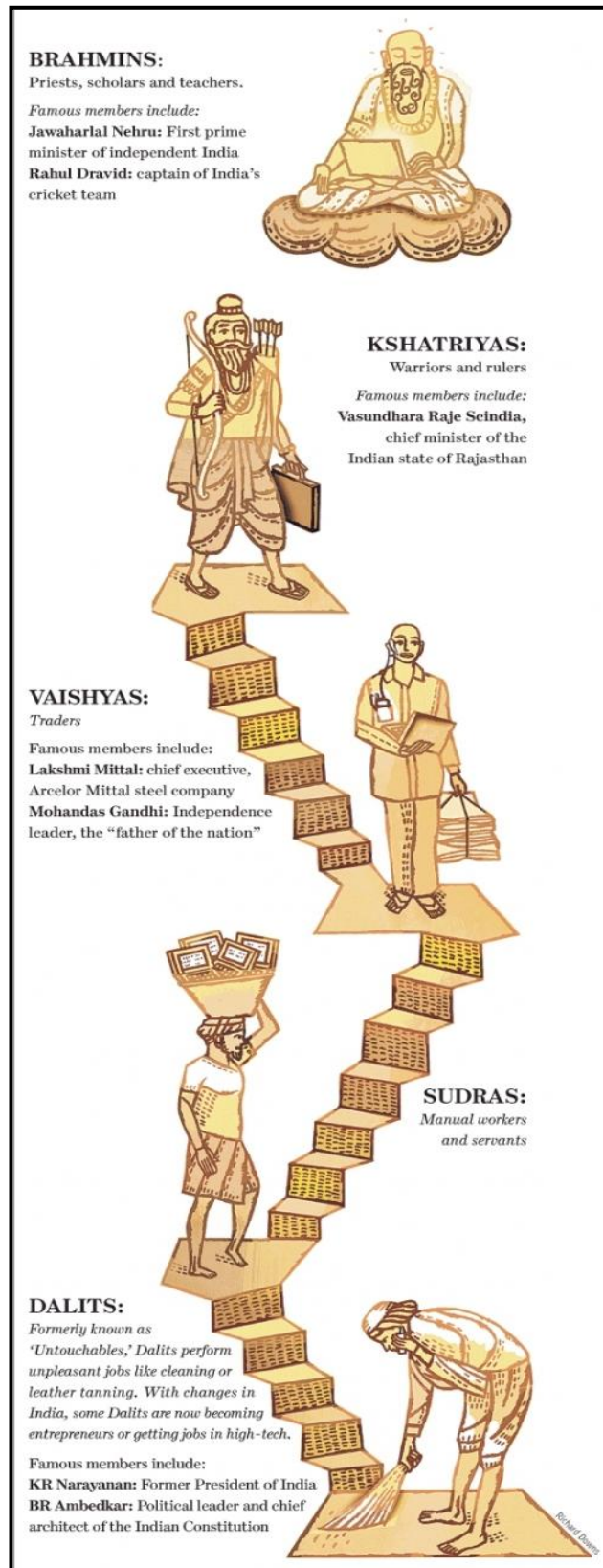


Figure 2.4 India's caste system (Spagnoli, 2008)

2.4 India's success with the millennium development goals

The Millennium Development Goals (MDGs) were developed out of the United Nations Millennium Declaration. The eight goals are: eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria, and other diseases, ensure environmental sustainability and develop a global partnership for development (UNDP, 2009). There are some areas in which India has been doing well, India is on target to achieve universal primary education by 2015 and has integrated sustainable development programmes into many policies, as shown by table 2.2 India is not on target to reduce the under-five mortality rate by two-thirds, the maternal mortality rate, or halt malaria and other diseases.

Table 2.2 India's MDG progress (Menon-Sen and Kumar, 2010)

Target No.	Target Description	Progress Signs
1.	Halve, between 1990 and 2015, proportion of population below national poverty line	Δ
2.	Halve, between 1990 and 2015, proportion of people who suffer from hunger	⊖
3.	Ensure that by 2015 children everywhere, boys and girls alike, will be able to complete a full course of primary education	ΔΔ
4.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	Δ
5.	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	⊖Δ
6.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	⊖Δ
7.	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Δ
8.	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	⊖Δ
9.	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	ΔΔ
10.	Halve, by 2015, the proportion of people without sustainable access to safe	Δ⊖

	drinking water and basic sanitation	
11.	By 2020, to have achieved, a significant improvement in the lives of at least 100 million slum dwellers	ϕ
12.	In cooperation with the private sector, make available the benefits of new technologies, especially information and communication	ΔΔ

Symbol	Meaning
ΔΔ	On-track or fast considering all indicators
Δ	Moderately/almost nearly on track considering all indicators
ϕ	Slow/almost off-track considering all indicators

2.5 India and gender inequality

India is ranked by the United Nations as a middle-income country but is among the lowest ranked nations for gender equity (UNDP, 2010). One indicator of gender inequality is the sex ratio of the country which is the number of females per 1000 males. The latest Indian census states India's sex ratio as 940, which is 7 points higher than the census of 2001 (GoI, 2011). Whilst this is significantly lower than the global average (984) when India is compared to its direct neighbours the results are mixed, see figure 2.5. Nepal, Sri Lanka and Myanmar all have over 1000 females per 1000 males and China, Afghanistan and Bhutan have a lower ratio than India (GoI, 2011).

India among its neighbours 2001-2011		
Countries	2001	2011
India	933	940
China	944	926
Pakistan	938	943
Bangladesh	958	978
Sri Lanka	1010	1034
Nepal	1005	1014
Afghanistan	930	931
Bhutan	919	897
Myanmar	1011	1048

Figure 2.5 Sex ratio's for India and its neighbours (Gol, 2011)

As shown by figure 2.6 India's sex ratio was at its lowest point on the in the 1991 census. Over the last two decades this has increased from 927 in 1991 to 933 in 2001 to 940 in 2011.

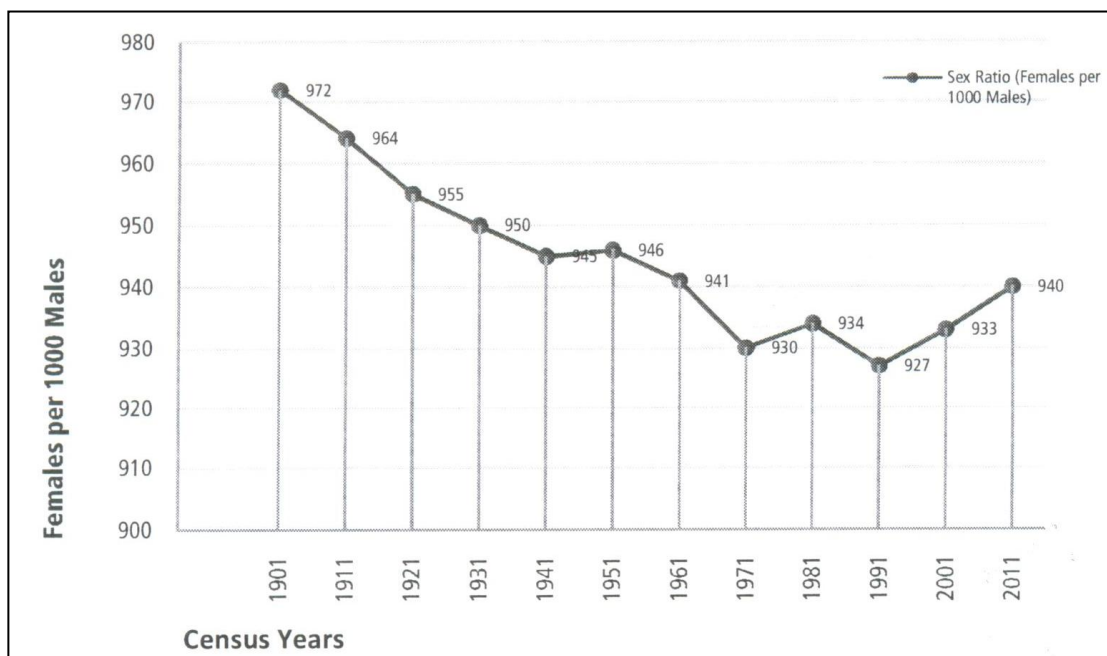


Figure 2.6 Sex ratio in India: 1901 - 2011 (Gol, 2011)

Whilst India seems to be making progress with the sex ratio problems emerge when a closer look is taken at the sex ratio for those aged 0-6 and it emerges that this ratio has fallen for the last 50 years from 976 to 914 (see figure 2.7).

Year	Sex ratio in age Group 0-6 years	Overall sex ratio
1961	976	941
1971	964	930
1981	962	934
1991	945	927
2001	927	933
2011	914	940

Figure 2.7 Sex ratio of total population and child population in the age group 0-6, India: 1961 - 2011 (GoI, 2011)

To understand the sex ratio problem in India it is important to understand the patriarchal nature of India's society. Within many families it is men that are valued and men that hold the decision making power. In India women are less likely to be literate or continue their education, are less likely to participate in the formal labour force or hold a political position than are men (Raj, 2011). These inequalities link to gender specific health vulnerabilities in the country such as the marriage of young girls, pregnancy at a young age and successive pregnancies, which cause the high rates of maternal morbidity and mortality in India (Raj, 2011). The maternal mortality rate (MMR) for women in India is 254 per 100,000 live births (UNDP, 2010). The MMR in India has been declining each year and when compared to the global MMR of 400 is not one of the worst countries (WHO, 2005). However due to India having such a large population the total number of women dying during and post birth is staggering and needs to be significantly reduced. In comparison the MMR for the developed world is 9 deaths per 100,000 live births (WHO, 2005).

Maternal health in India has a clear north south divide. The states of Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttarakhand and Assam equate to half of India's population yet account for two-thirds of maternal deaths in India (UNDP, 2009). The north has higher rates of MMR and a low percentage of women attending all recommended ante-natal visits (figure 2.8)

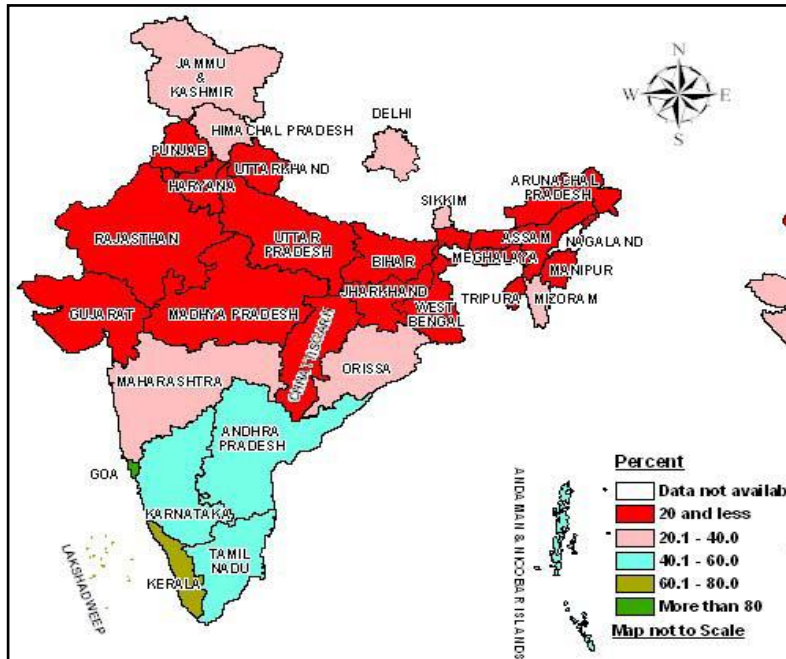


Figure 2.8 Percentage of women receiving full antenatal check up (DLHS-3, 2008)

Figure 2.9 shows the percentage of women giving birth in institutions which is lower in the northern states than in the south. This difference between the north and south does not end at maternal health. Of the annual 10.8 million deaths of children under-5 around a quarter, 2.38 million, occur in India (UNDP, 2009). In India 43% children were considered underweight in 2005 and only 42% of Indian children are fully vaccinated (UNDP, 2009).

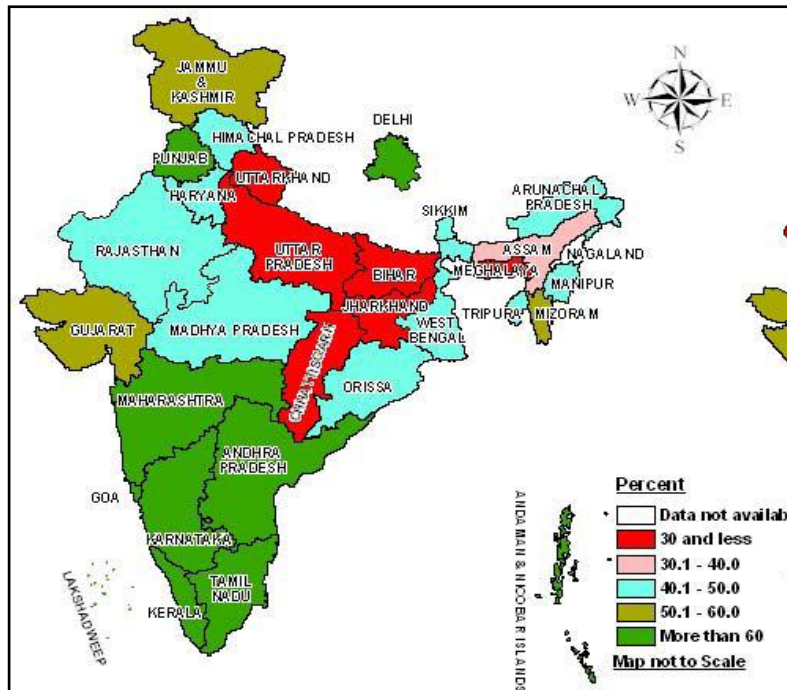


Figure 2.9 Percentage of institutional births (DLHS-3, 2008)

Figure 2.10 shows the percentage of children that receive full vaccinations. The northern states have the lowest immunization levels with the states of Uttar Pradesh and Madhya Pradesh being the worst.

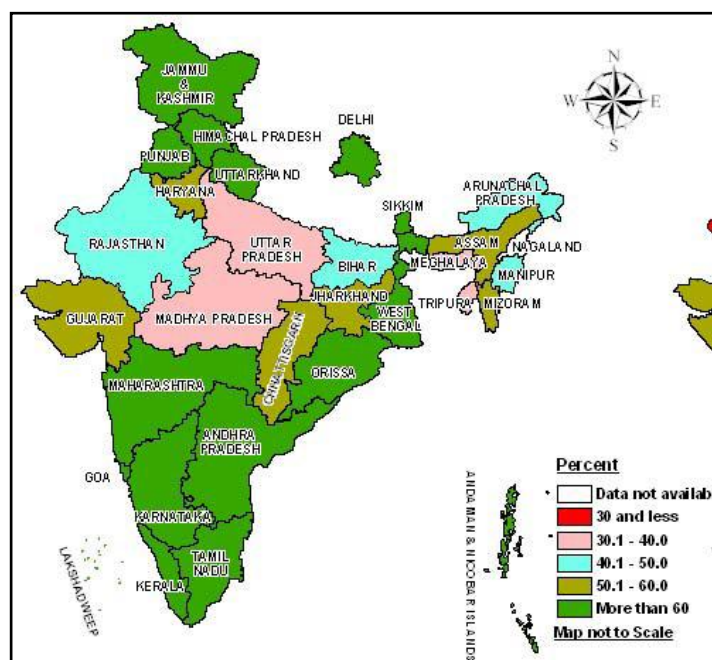


Figure 2.10 Percentage of children receiving full vaccinations aged 12-23 months (DLHS-3, 2008)

This stark contrast between the northern and southern states of India can be understood through the system of patriarchy and gender inequality. The southern states are richer and the women have higher levels of education and autonomy. They are able to access health care and given that the states are richer the health system is that much better than the northern states. The women have greater autonomy to be able to attend antenatal checks and choose institutional births. The patriarchal system in the north is much stronger and the gender inequality much greater creating this strong north-south divide.

2.6 The northern state of Uttar Pradesh

The research will be conducted in the state of Uttar Pradesh (UP). Uttar Pradesh is the most populated state in India with a population of 199.6 million (GoI, 2011). Uttar Pradesh is a state in the north of India (see figure 2.11). The IGMSY scheme is being

piloted in 52 districts across India and two of those pilot districts are in Uttar Pradesh; Mahoba and Sultanpur.

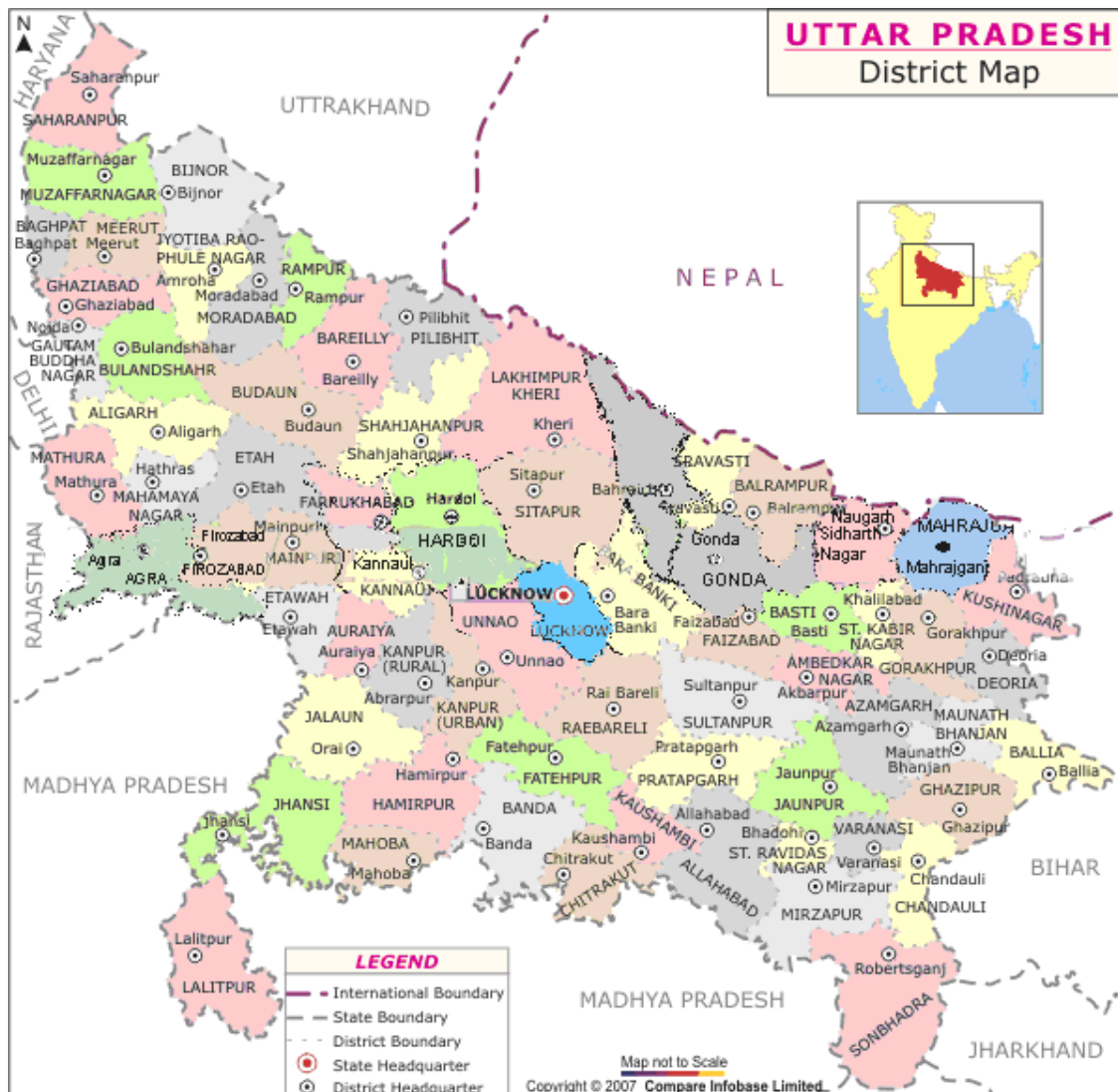


Figure 2.11. Map of the state of Uttar Pradesh (Gol, 2007)

Table 2.1 showed that 32% equal to 59 million people in the state of Uttar Pradesh are classified as poor which is equivalent to the entire population of the United Kingdom. Uttar Pradesh has one of the highest levels of maternal mortality and child mortality in India. Figure 2.12 shows comparisons of Indian states for child mortality. Uttar Pradesh, being one of the poorest states, perhaps unsurprisingly has high levels of child mortality when compared to the richer southern states of Kerala and Goa.

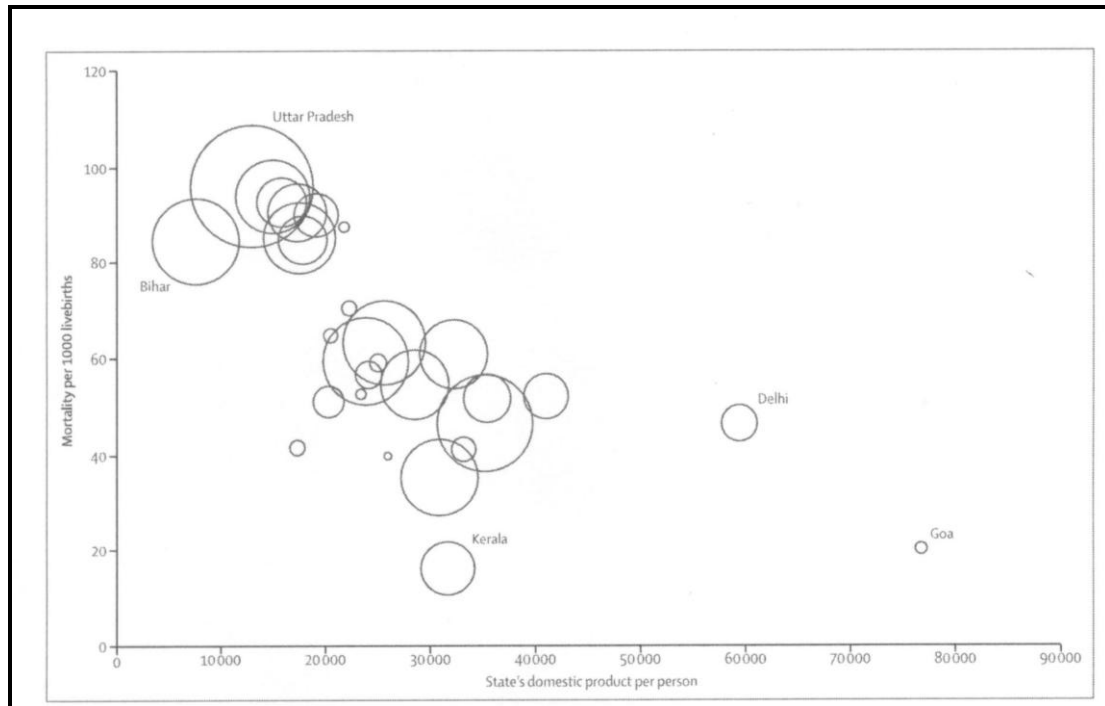


Figure 2.12. Association between child mortality and state's domestic product (Balarajan, Selvaraj and Subramanian, 2011)

2.7 The district of Sultanpur

Sultanpur is a district of Uttar Pradesh, to the east of Lucknow (see fig. 2.11). The district of Sultanpur is one of the 52 pilot districts for the IGMSY scheme and the chosen location for the research. The research will be conducted in two villages within a block of Sultanpur. In the latest census the population of the district has been recorded as 3.7 million (GoI, 2011). Sultanpur has a literacy rate of 64% but this breaks down to 79% for men and 51% for women (DLHS-3, 2008). The district of Sultanpur has achieved near universal access to education with 99% of girls and 98% of boys aged 6-11 years old attending school (DLHS-3, 2008). Whilst 98% of the population own their own house only 36% have electricity and only 13% have access to a toilet facility (DLHS-3, 2008). The district has a large poor population as 49% have a government issued Below Poverty Line (BPL) card (DLHS-3, 2008). Table 2.3 shows further background characteristics for Sultanpur taken from the District Level Household Survey – 3.

Table 2.3 Background characteristics of Sultanpur, UP (DLHS-3, 2008)

Background Characteristics	DLHS - 3	
	Total	Rural
Percent total literate Population (Age 7 +)	64.1	63.3
Percent literate Male Population (Age 7+)	79.1	78.6
Percent literate Female Population (Age 7+)	51.5	50.5
Percent girls (age 6-11) attending Schools	99.0	99.0
Percent boys (age 6-11) attending Schools	98.3	98.2
Have Electricity connection (%)	36.5	33.8
Have Access to toilet facility (%)	13.8	10.8
Use piped drinking water (%)	2.7	1.4
Own a house (%)	98.9	99.2
Have a BPL card (%)	49.2	51.3
Own Agriculture Land (%)	71.9	75.3
Have a television (%)	20.1	17.4
Standard of Living Index		
Low (%)	76.5	79.0
Medium (%)	14.2	14.2
High (%)	9.3	6.8

In

Sultanpur between 40-55% of children receive the required vaccinations (see figure 2.13). When this is compared to the rest of state it shows that Sultanpur does not the lowest levels of vaccinations but could significantly improve. Table 2.4 shows there is wide coverage for the BCG vaccination but low levels for polio and diphtheria, pertussis and tetanus (DPT).

Table 2.4 Child immunisation in Sultanpur, Uttar Pradesh (DLHS-3, 2008)

Child Immunization:	Total	Rural
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and one dose of Measles) (%)	45,0	45,8
Children (12-23 months) who have received BCG (%)	84,7	84,1
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	54,5	54,3

Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	54,4	54,2
--	------	------

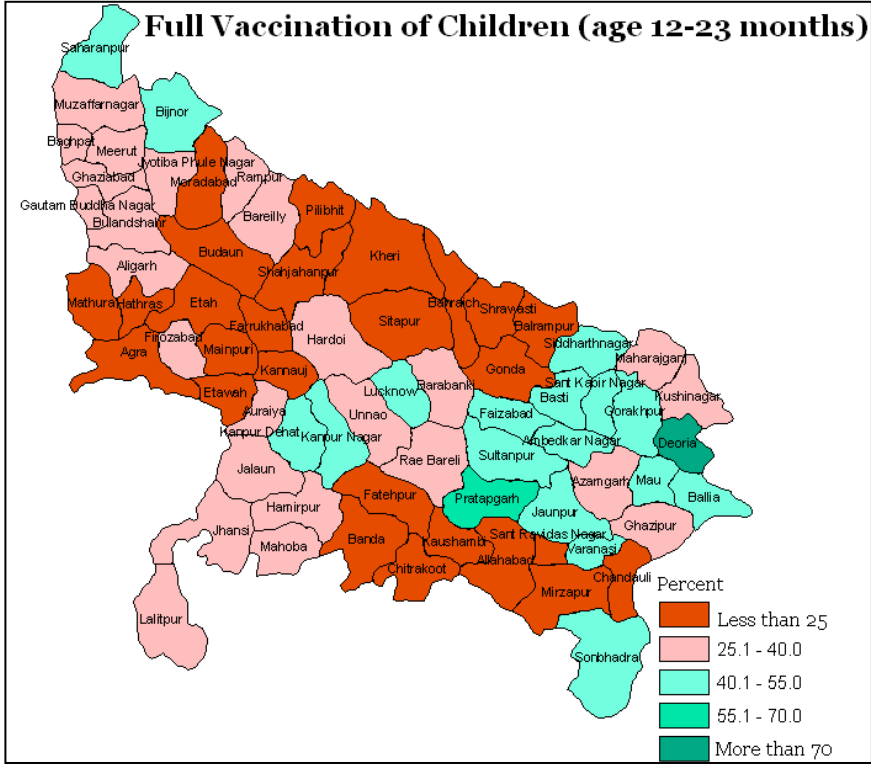


Figure 2.13 Vaccination of children (12-23 months) in Uttar Pradesh (DLHS-3, 2008)

In the district 6% of births are from those aged 15-19 years old, by 24 years old 58% have two children or more and by 44 years old women have an average of 5.5 children (DLHS-3, 2008). Use of maternal health services is low in Sultanpur. Only 28% have three antenatal visits yet 82% receive the TT injection whilst pregnant (see table 2.5). In Uttar Pradesh only 36% of women give birth in institutions (DLHS-3, 2008). Of those that give birth at home only 19% are assisted by a health worker (see table 2.5). In Sultanpur only 14% of children are breastfed within one hour of birth and only 7% are exclusively breastfed for 6 months despite India agreeing to international recommendations which suggest these points (DLHS-3, 2008).

Table 2.5 Maternal health in Sultanpur, Uttar Pradesh (DLHS-3, 2008)

Maternal Health:	Total	Rural
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	38,1	37,0
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	27,8	27,0
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)	82,1	81,5
Institutional births (%)	36,6	35,5
Delivery at home assisted by a doctor/nurse /LHV/ANM(%)	18,7	18,3
Mothers who received post natal care within 48 hours of delivery of their last child (%)	14,9	14,0

2.8 Understanding the local panchayat and health systems

Each state is split into a number of districts as shown in figure 2.11. Each district is split into a number of blocks, these blocks are further sub-divided at village level to a panchayat. Often a number of small villages are clubbed together, these are known as Gram Panchayats and are local governments at village or small town level. The head of the Gram Panchayat is the Village Pradhan. This system of district, block and panchayat is known as the ‘3 Tier Panchayat System’.

Local health workers fall under two different government departments; the Health Department or the Ministry of Women and Child Development (see figure 2.14). The IGMSY scheme is being run through the Integrated Child Development Services (ICDS) which falls under the Ministry of Women and Child Development.

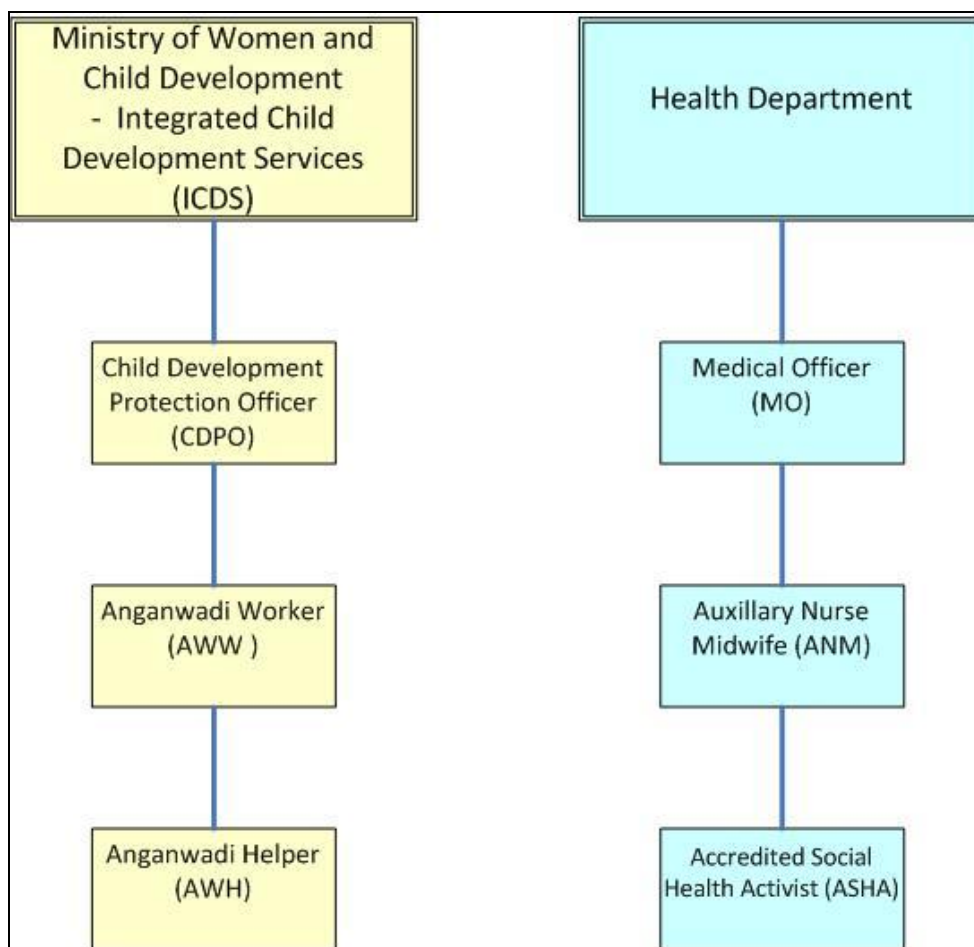


Figure 2.14 Local Health Workers and Government Department (created by the student)

On the side of the ICDS the anganwadi worker (AWW) is a health worker chosen from the community and given four months training in health, nutrition and child-care. The duties of anganwadi worker include; regular health check-ups, immunization, health education, and non-formal pre-school education. The anganwadi helper (AWH) assists the anganwadi worker and they are both overseen by the child development protection officer. There should be one AWW and one AWH per 1000 population. The anganwadi worker and anganwadi helper work out of an anganwadi centre (AWC).

Under the Health Department is the auxiliary nurse midwife (ANM), a key skilled health worker who interacts directly with the community and is the central focus of reproductive and child health programs. The auxiliary nurse midwife is assisted by the Accredited Social Health Activist (ASHA), a community link worker tasked with strengthening the link between the community and the health sector. There should be one ASHA per 1000 population and one ANM per 5000. The auxiliary nurse midwife

works out of a local sub-centre and then for every 30,000 people there should be a primary health centre (PHC). In the 2011 census it was observed that in the state of Uttar Pradesh sub-centres were found per 8000 people on average and the PHC per 69,000 (GoI, 2011). This helps to show how overstretched the health workers are, often dealing with much larger populations than they should be.

2.9 Summary

This chapter has shown that India has a diverse population with a mix of different religions and cultures. It is also the second most populated country in the world and is becoming a fast rising power. However there are still many problems. India has a large poor population with 30% living below the poverty line and a high proportion of those affected are women. Indian culture is dominated by a unique caste system and highly patriarchal society which creates inequality in society. This inequality is not just in accessing services but in living. India has a high gender inequality which stems from this system of patriarchy. The inequality can be seen through comparison of India's sex ratio to the global average. This inequality can be seen to go some way to explain why India is failing to meet the millennium development goal targets for infant and maternal mortality. The issue of inequality and maternal health is explained further in the next two chapters.

3 Theoretical framework



3.1 Introduction

This chapter discusses the importance for using a rights based approach in research and considers current literature on this approach. When beginning a research project a theoretical approach has to be determined. Often a few different theories could be used. This chapter shows how the rights based approach is the best theory for this research by using a number of academic debates. First there is a discussion of rights which is then followed examining current works that link health and rights. Health and rights is narrowed further to explore the subject of women's rights to health and specifically current academic work on the subject of maternal health. There are a number of areas considered when looking at literature on maternal health but the main issues discussed are the barriers of demand and supply to accessing health care. The chapter ends with a discussion of the current academic debate around the use of conditional cash transfer schemes. Conditional cash transfer schemes are being piloted all over the world and this chapter discusses why they are used, when they are most successful and what the limitations of the schemes are.

3.2 A rights based approach to development

The move toward a rights based approach to development started in the 1990's. There was an emerging interest in rights to bring about a real change in the lives of the poor and marginalised (Pettit and Wheeler, 2005). Yet the link between development and human rights was made as far back 1948. Article 28 of the Universal Declaration of Human Rights states:

‘Everyone is entitled to a social and international order in which rights and freedoms set forth in this Declaration can be fully realised’ (Hamm, 2001:1008).

Throughout the 1990's there was a series of United Nations world conferences linking human rights and development policy. The main conferences were the World Conference on Human Rights (1993) in Vienna, the World Conference on Women (1995) in Beijing, and the World Summit for Social Development (1995) in Copenhagen. After the Vienna Declaration of 1993 the right to development became part of the mandate of the UN High Commissioner for Human Rights (UNHCR)

(Hamm, 2001). The conferences resulted in the agreement that democracy, human rights, sustainability, and social development are interdependent (Hamm, 2001).

The idea of a rights based approach had some criticism with people asking whether the approach would be different this time, or whether it was not just ‘new labels on old wine?’ (Pettit and Wheeler, 2005:1). The rights based approach to development did differ from previous approaches in that the right to development is not considered as a right of its own but a synthesis of all human rights and that these rights are integral to the development process (Blackburn et al. 2005).

3.3 What rights?

Using a rights based approach (RBA) changes which rights are central and focussed upon as certain rights are seen as more fundamental to development. Primary rights are seen as those pertaining to human rights violations and concerns with protecting civil and political rights. Rights in terms of development shifts the focus to broader concerns of dignity, access to resources and economic, social and cultural (ESC) rights (Pettit and Wheeler, 2005). These ESC rights are often considered as second generation rights with political and civil rights being the first priority (Hamm, 2001). A rights based approach to development encompasses all human rights but emphasises ESC rights as the rights that are central to development policy (Hamm, 2001).

3.4 Whose rights?

To use a rights based approach means to not just consider who is able to claim their rights but to understand the processes that have led up to the formulation of those rights (Pettit and Wheeler, 2005). For example; rights for marginalised groups may be the consequence of many years of social mobilisation. A key consideration when using a RBA is the participation of actors in the research and the importance of understanding requirements at the grass roots level. Consideration at a local level is important because although rights are pursued in a number of ways they are often rooted in the local context, history and conditions (Pettit and Wheeler, 2005).

With rights there can be a conflict over ‘whose rights count?’ (Miller et al. 2005:36). The rights of some groups can be ignored or undermined whilst the rights of other

groups can be inflated. When we are considering ‘whose rights?’ there needs to be an understanding of underlying power dynamics. Miller et. al state that it is often those that already have more power within a community that benefit from rights (2005). Trying to explore any issues of power dynamics can upset the balance in a community. Rights are part of ‘dynamic, sometimes messy, processes of resistance and change’ which can create conflicts at both household and community level (Miller et al. 2005:36).

3.5 Using a rights based approach in practice

A rights based approach means that project goals should be formulated within a human rights framework. Human rights provide a common frame of reference as the moral commitment to human rights is universal (Hamm, 2001). Human rights are internationally recognised agreed standards which have been negotiated and accepted by governments (Freedman, 2001). Human rights are often linked to basic needs, however the concept was strengthened changing basic needs from a moral commitment to a legal claim of rights to education, health and food. This legal claim of rights means that states are required to create policies that respect, protect and fulfil human rights (Hamm, 2001). The change from needs to rights caused a shift not just within governments but within NGOs as well. Some human rights NGOs focussed on exposing and denouncing state’s actions where there has been a failing of human rights but sometimes ignored that it is not a question of what a state will not do but what it does not know how to do (Yamin, 2005). In recent years NGOs are increasingly providing technical assistance to states to help reduce this knowledge gap.

Working from a rights based approach means to challenge power relations which can be visible or hidden forces and which impact a person’s rights. A RBA also needs to address structures of inequality and exclusion at all levels and in a number of spheres including; legal, political, social, cultural and economic. In order to achieve this it is recognised that there is a need to work with a number of actors, civil societies and social movements (Pettit and Wheeler, 2005).

A rights based approach to development means considering both the claims for rights by people and the duty of the state to uphold those rights (Pettit and Wheeler, 2005).

A RBA will help to explore to what extent people are not claiming their rights and to what extent governments are not meeting their obligations (Yamin, 2005). Both Yamin and Miller et al. agree that laws themselves are not enough and that political, social, cultural and economic factors need to be considered when looking at rights (2005; 2005). Working from a rights based approach is tricky as ‘there is not one rights agenda’ (Pettit and Wheeler, 2005:1).

3.6 The link between health and rights

The right to health has a long history but was first internationally recognised in the Constitution of the WHO (1946), which stated that:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

Two years later the right to health was also included in article 25 of the Universal Declaration of Human Rights (1948) and for the first time made specific reference to women:

‘Everyone has the right to a standard of living adequate for the health and well being...motherhood and childhood are entitled to special care and assistance’.

The argument that women’s health needed to be ensured separately from ‘health’ generally was made stronger in the 1978 the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). By 1989 almost 100 nations had agreed to be bound by its provisions. Article 12 of CEDAW states that:

‘States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning...States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation’.

Article 18 of the Vienna Declaration (1993) on human rights firmly linked the notion of women’s health and human rights stating that:

‘The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights.’

Since the Universal Declaration of Human Rights in 1948 to all the aforementioned conventions and declarations the concept of human rights has been becoming more and more central. This can be seen clearly in the MDGs. The principles of the MDGs, which include some key issues of health and education, stem from the Universal Declaration of Human Rights and are fundamentally located within a human rights framework. The goals aim to identify and monitor the duty bearers and empower the claim holders (Shetty, 2005). For example using the target of goal 5 (maternal health) the underlying idea is not only does a woman have the right not to die during delivery but that the state has a responsibility to ensure that this does not occur.

3.7 Women’s rights as human rights

Health is a basic right for life, for human dignity but also from the perspective of human agency. The definition of health given by the world health organisation’s constitution is that:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (1946).

To establish human rights is to emphasise human dignity. Human dignity with regard to health ‘is not only a question of being free from avoidable disease.....Dignity is also a function of the way in which individuals, communities and whole societies engage in the process of obtaining and maintaining a standard of health’ (Freedman, 2001:55). To be denied health care is tantamount to being excluded from society (Gauri, 2003). The idea of the right to life therefore goes beyond the notion of not dying (Yamin, 2005). Sen writes that it is in fact ‘the ability to appear in public without shame’ (1999 cited in Gauri, 2003:467).

Everyone has the right to health yet currently it is women’s rights to health that are often being undermined. Of all maternal deaths 99% occur in developing countries (Freedman, 2001), this shows clear imbalance in the pattern of maternal mortality as despite technological advances some women are not receiving adequate care. The technical knowledge and capability to treat complications during child birth is

available yet one woman dies in child birth every minute (Freedman, 2001:54). This is because health is not just about technical knowledge and capabilities, both women and the health services they need are affected by different social, economic, cultural and political forces. As Freedman states ‘health is profoundly driven by the social and cultural contexts in which it exists’ (Freedman, 2001:53). The UN stated at the World Conference on Women in Beijing that ‘women’s rights are human rights’ (UN, 1995). Tackling women’s rights from a human rights perspective is important, ‘a human rights lens underscores that death from pregnancy-related causes is not “natural”, but rather a product of social priorities and policy decisions’ (Yamin, 2005:1202).

Despite the external forces that impact a person’s health there is a clear consensus that death during pregnancy and childbirth is unacceptable (Freedman, 2001) and we do have the knowledge and capacity to change this. However to make a change requires more than to publicly agree that an issue is a human right. Upon recognition of an issue as a human right there is a legal obligation to make changes towards the realisation of that right (Freedman, 2001). This can be argued as going beyond making a law but making sure the law is enacted and upheld, ‘mere legislation is not enough. The state is obliged to achieve the intended result’ (Yamin, 2005:1217).

Human rights within health and policy can be considered in two ways. Firstly as the use of human rights to establish a formal law based on the previous international agreements or secondly, as a way to bring human rights into the underlying philosophy by using key values and principles to shape programs and policies. This can be considered as rights as ‘high priority goals’ which can be seen through various international constitutions, conventions and declarations (Gauri, 2003:468). With regard to health the WHO explains that this means that governments should put into effect ‘policies and action plans which will lead to available and accessible healthcare for all in the shortest possible time’ (2002 cited in Gauri, 2003:468).

One challenge with a rights based approach to health is that it is difficult to quantify human dignity. Therefore which aspects of health need to be prioritised can become a close call (Gauri, 2003). Traditionally a human rights approach has relied on individual narratives. These stories are often emblematic of experiences of discrimination and structural inequality (Yamin, 2005). For a rights based approach to be effective in changing policy individual stories need to be converted into data. A

quantitative approach when used alone will not tell the full story, ‘merely counting cases of maternal deaths does not tell us what needs to be done’ (Yamin, 2005:1206) and yet a qualitative approach will not reveal the full extent of the problem.

3.8 The capabilities approach

As a rights based approach to health considers a persons dignity and agency it is important to also consider the capabilities approach. Sen’s capability approach refers to a person’s ‘capability set’ and their ‘functionings’ and was discussed in the book ‘Development as Freedom’ (Sen, 2001). A person’s ability to access health care may be dependent on their capabilities.

The main idea of the capability approach was to move away from a focus on income centred methods and instead focus on a person’s ability to attain the things that they value (Frediani, 2010). However the capabilities approach is about much more than that, Deneulin and Stewart suggest that the core concept for the justification of a capability approach is that ‘development is about providing conditions which facilitate people’s ability to lead flourishing lives’ (2002: 62).

To relate capabilities to health it is interesting to consider the capability approach at differing scales. The capability space can include individual, local and structural factors (Frediani, 2010). An individual’s capacities are dependent on their human capital, such as number of years of education, local factors are associated with available services and collective norms and finally there are also structural factors which shape the capability space (Frediani, 2010). The capability approach can be used to help understand a person’s ability to access health and can be visualized using the determinants of health structure (see figure 3.1). A person’s capability can be used to explain the demand factors that influence accessing health, this concept of factors of demand in relation to health care is further explained in the following section.

3.9 Maternal health in context

There are a number of determinants that influence health and individuals can often not control very many of these determinants. As stated above a person’s capability space includes individual, local and structural factors (Frediani, 2010). This statement can also be applied to a person’s health.

Health is determined by many different aspects; biological determinants, behavioural and lifestyle factors and socio-economic, cultural and environmental factors. The famous determinants of health model by Dahlgren and Whitehead (1991) shows both the individual contextual factors of health, alongside all the external factors including socio-economic, cultural and environmental conditions (see figure 3.1).

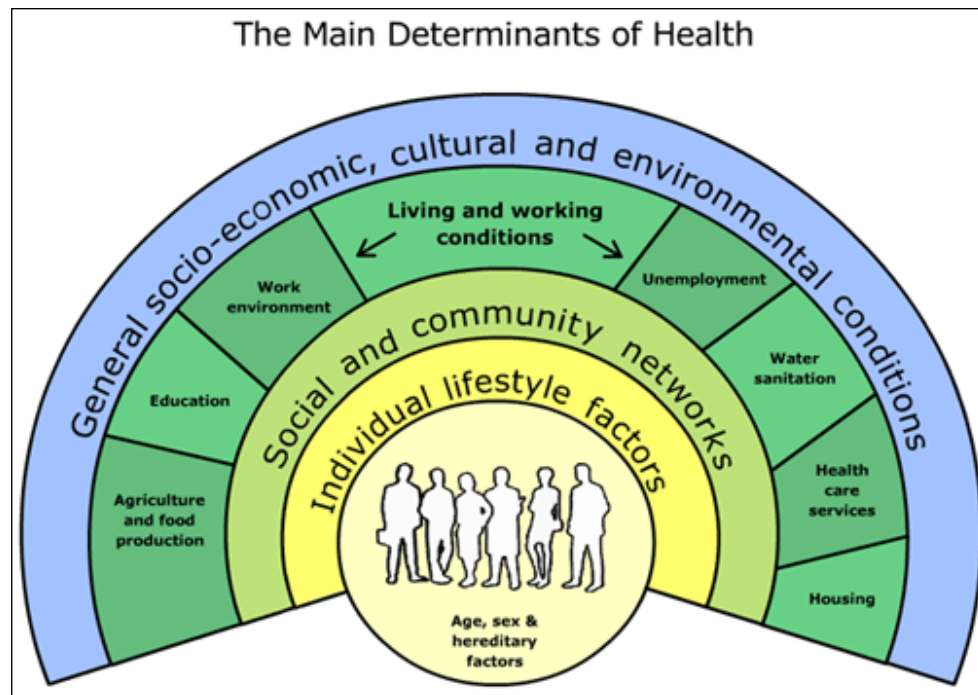


Figure 3.1 The main determinants of health (Dahlgren and Whitehead, 1991)

Maternal health is an important topic as a woman's own health and survival also directly affects the health of her child (Gill et al. 2007). A woman's maternal health can affect her status and empowerment, the education of her children and the welfare of her household.

Poor maternal health perpetuates a cycle of ill-health across generations (see figure 3.2). Women in the developing world often have a low body weight and in patriarchal societies such as India this is further compounded by cultural practices of women eating 'last and least' (Neogy, 2010:479). During infancy, childhood, and adolescence women are under nourished, causing a low body mass index (BMI) and short stature. The women do not gain enough weight during pregnancy meaning they are more likely to have children born with a low birth-weight (Gill et al. 2007). The cycle then continues into the next generation. These factors can also cause a higher risk of maternal morbidity. The physiological factors from being an adult with a low BMI

can include a small pelvis which can increase the risk of complications during childbirth and can lead to obstructed labour (Freedman, 2001). It is important to note that many of the factors leading to this cycle of poor maternal health are determinants outside of a woman's control and many are the result of social and cultural practices such as discriminatory feeding practices, early marriage and a high order of pregnancies (Freedman, 2001).

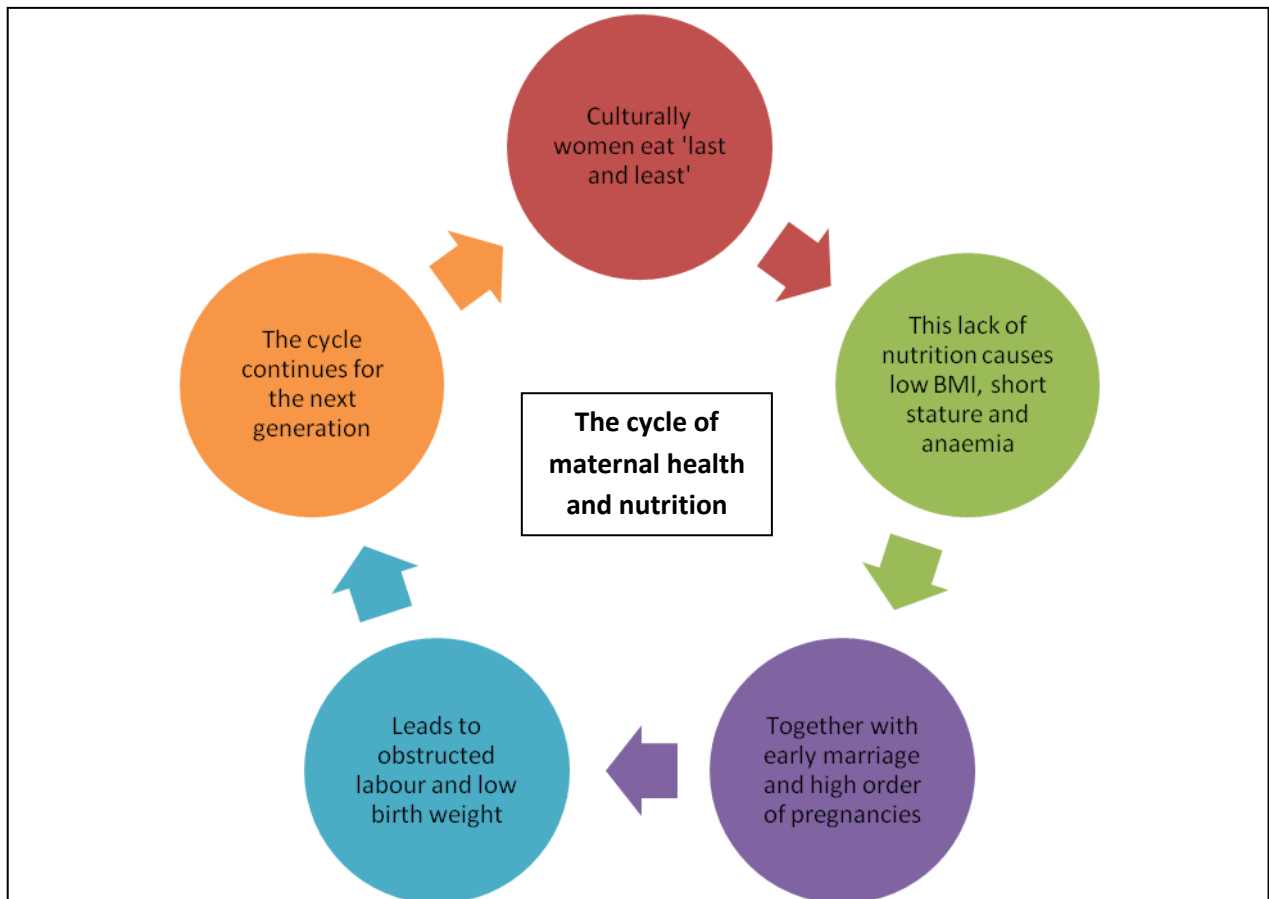


Figure 3.2 Diagram showing the inter-generational cycle of health and nutrition (created by the student)

3.10 Which issue to solve first?

There are numerous reasons that women either do not access the care they need or do not receive the care they need. Freedman explains this as the three-delays model; one - the absence of information causing a delay to seek care, two – a delay in getting to the appropriate facility due to infrastructural deficiencies, and three – a delay in receiving care at the facility due to capabilities of the staff or availability of technology or drugs (2001:54). When trying to solve the issue of access to health care and reducing maternal mortality there also needs to be a certain amount of

prioritisation. Everyone has the right to adequate nutrition and anaemia causes many complications during pregnancy but it is worth considering this statement; ‘a major haemorrhage, untreated, will kill any woman, anaemic or not’ (Freedman, 2001:56). Showing that whilst anaemia is important when trying to tackle maternal mortality it may not be the first priority.

When considering health and rights two aspects need to be considered: to what extent women are not enjoying the right to health; and to what extent the government is not meeting its obligations (Yamin, 2005). This can be considered as the barriers to health of supply and demand.

3.11 Barriers of demand to health care

Access to health services are restricted by both demand and supply factors. Research into demand for health care can be understood as considering why when there are services in place women are not using them. Figure 3.3 shows two of the main issues in accessing health care are poverty and gender inequality.

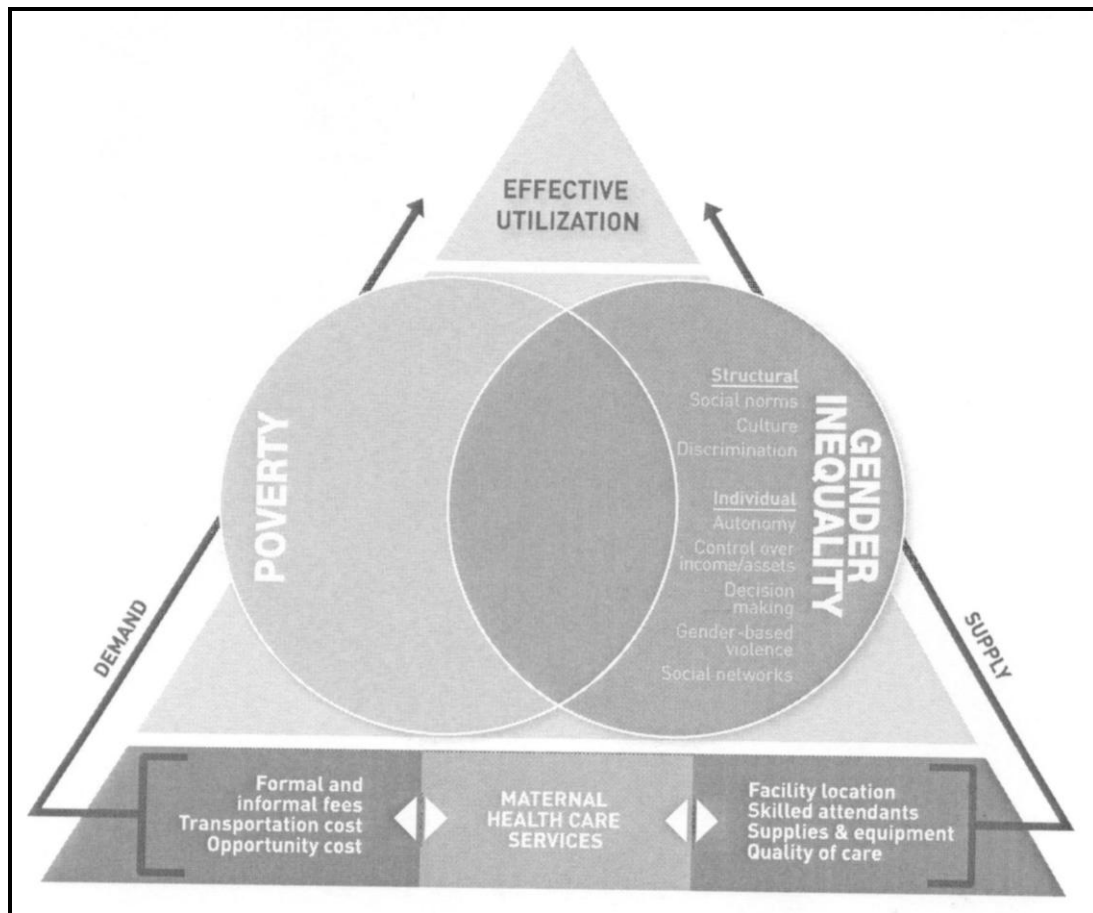


Figure 3.3 Determinants and Barriers to the Utilisation of Health Care Services (Paruzzola, 2010)

Demand barriers to accessing health care can include; education of the recipient, lack of knowledge or information of the service, location of the service, cost of the service both financially and in time, and barriers due to cultural norms. A woman’s inability to access health is often interwoven with social and cultural norms. Education and employment are considered to be enabling factors to accessing health care as they increase knowledge, confidence, skills and opportunities (Gill et al. 2007). A lack of education deprives women of the knowledge and ability to make informed decisions. The location of the service is also important. A service located too far away will cost money to travel to and will take time to get to. Often poor people cannot afford to take time off from work in order to seek health care. Cultural norms can also prevent women from trying to access health care. This can include whether the woman has any decision making power or whether she has to obey the laws of purdah. These cultural restraints can prevent a woman from accessing help outside of the house, and often women can not travel without a man with them. Families can be reluctant to invest in maternal care as childbearing is often regarded as an expected part of

woman's role and therefore pregnancy and childbirth are not considered worthy of medical attention (Gill et al. 2007).

The idea of the barriers of supply and demand stem from earlier work by Penchansky and Thomas (1981). Penchansky and Thomas produced an article discussing the term 'access' and proposed that although it was a term used frequently it was not well defined. Penchansky and Thomas wrote that when the term access was used by academics they were not meaning the term to be equated with actual entry but for access to characterise the factors that influence the entry to or use of a service (1981). These factors have become known as the five A's of health care: availability, accessibility, adequacy, acceptability and affordability. In work by Obrist et al. it is noted that there is another factor that limits the degree of access reached along any of these dimensions (2007). Obrist et al. consider the importance of a person's capability set along side the factors of the five A's that determine access to health care (2007). This is similar to the ideas raised by Dahlgren and Whitehead in figure 3.2 which shows the socioeconomic and environmental factors that also impact access to health. Penchansky and Thomas had made clear that these five dimensions of access are easy to separate (1981). By considering the factors as barriers of demand and supply all the five areas can be covered in one model (see figure 3.3). Within figure 3.3 are references to: skilled attendants and supplies; availability, informal and formal fees; affordability, location and transportation costs; accessibility and quality of care; adequacy. One area that both figure 3.2 and figure 3.3 cover that the notion of the 5A's do not cover is the importance of cultural norms and possible constraints.

3.12 Barriers of supply to the utilisation of health care

Access to health care is also determined by supply factors. Supply factors that reduce access to services can include; lack of skilled staff, lack of technology, equipment and drugs, expectation of bribes, abuse or discrimination of patients by staff, and infrastructural barriers to reaching the service. Figure 3.4 shows examples of both demand and supply barriers.

	Example of barrier
Demand side	
1) Information on health care choices/providers	Lack of knowledge of providers
2) Education	Low ability to assimilate health choices and negotiate access to appropriate providers
3) Indirect consumer costs	Long and slow travel to facilities
• distance cost	Need for patient and carer to stop working for long periods in order to seek care
• opportunity cost	Asymmetric control over household resources
4) Household preferences	Reluctance to seek health care for women outside home; community resistance to using modern medical care to assist with pregnancy
5) Community and cultural preferences, attitudes and norms	Patients seek treatment through providers that are inappropriate for their condition such as drug sellers
6) Price and availability of substitute products and services	
Demand and supply interaction	
Direct price of service of a given level of quality (including informal payment)	High cost of services
Quantity rationing	Large unofficial payments to staff
	Long waits to see medical staff
Supply side	
1) Input prices and input availability	Absenteeism, staff not attracted to the area
• Wages and quality of staff	Scarcity of supplies, weak cold chain
• Price and quality of drugs and other consumables	Inability to treat disease with given technology
2) Technology	Poor quality of management training, lack of management systems
3) Management/staff efficiency	

Figure 3.4 Supply and Demand Factors to the Utilisation of Health Care (Ensor and Cooper, 2004)

Governments have started to use incentives to break down demand barriers to accessing health care. Studies have shown that cash payments can be an effective way to encourage patients to seek or continue to attend health services (Barber and Gertler, 2009). This approach is known as a conditional cash transfer (CCT).

3.13 Conditional cash transfers

Strategies to increase utilisation of health services can include the removal of user fees, improvements in any supply side problems, dissemination of information, better cultural sensitivity and the use of conditional or unconditional cash transfers (see figure 3.5). Figure 3.5 shows that nearly all barriers either from demand or supply side can be overcome by two things; information/education and financial incentives.

	Example of barrier	Possible market failure	Example of interventions	
			Supply	Demand
1) Information on health care choices/providers	Lack of knowledge of providers	Information & education	Staff conduct outreach to provide services	Provide information on when to seek care and range of providers; accreditation systems to indicate better providers
2) Education	Low ability to assimilate health choices and negotiate access to appropriate providers	Information & education		Improve access to primary education, particularly for girls Stimulate demand using financial incentives to seek treatment
3) Indirect consumer costs				
• distance cost	Long and slow travel to facilities	Uncertainty & equity	Provide an emergency transport service with communication system; increase outreach work and numbers of peripheral facilities; more flexible working times	Transport loan funds; provision of cheap/flexible transport
• opportunity cost	Need for patient and carer to stop working for long periods in order to seek care	Uncertainty & equity		Incentives to reduce cost of lost-working time
4) Household preferences	Asymmetric control over household resources	Equity	Lower user charges for certain groups	Target subsidies at members of household with least access to services
5) Community and cultural preferences, attitudes and norms	Reluctance to seek health care for women outside home; community resistance to using modern medical care to assist with pregnancy	Information & education	Culturally sensitive health care delivery	Information to correct misapprehensions
6) Price and availability of substitute products and services	Patients seek treatment through providers that are inappropriate for their condition such as drug sellers	Information		Information on best treatment for disease

Figure 3.5 Types of Intervention to reduce demand barriers (Ensor and Cooper, 2004)

The use of and interest in conditional cash transfers by governments for social assistance have grown over the last decade. Figure 3.6 shows the rise in conditional cash transfer programs around the world between 1997 and 2008. Interest in programs that use cash to incentivise household investments has also spread from developing countries to developed countries (Fiszbein, et al. 2009) with programmes being set up in areas such as Harlem of New York.

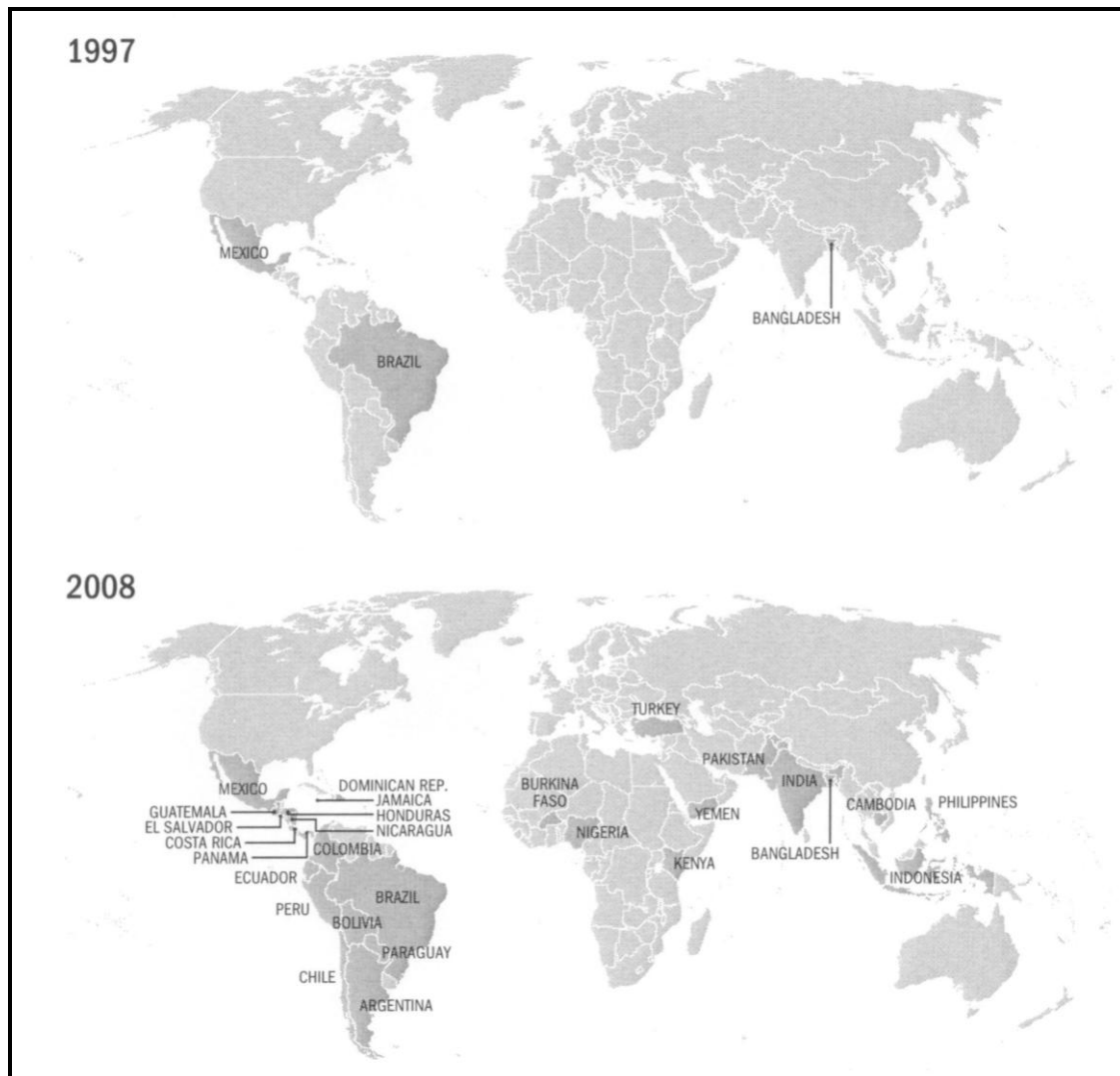


Figure 3.6 Growth of conditional cash transfers from 1997 to 2008 (Fiszbein, et al. 2009)

Conditional cash transfers are used to increase the demand for services and improve health seeking behaviours. A conditional cash transfer requires conditions to be imposed alongside incentives for individuals to take action or make decisions that they may not usually make, ‘either by protecting people from their own irrationalities or by providing incentives for them to gather more information’ (Das et al. 2005:60). The programs have a long term aim for investment of human capital and a short term aim providing immediate assistance.

Conditional cash transfers are an innovative approach to the delivery of social services (Rawlings and Rubio, 2005). Incentive based welfare programmes are in place throughout most of Latin America including Mexico, Peru, Argentina, Brazil (Bolsa Familia), Honduras and Nicaragua (Red de Proteccion) but also in Bangladesh, Indonesia, Turkey and pilot programs in Cambodia, Malawi and Pakistan (Fiszbein, et

al. 2009). In Latin America programs using a CCT approach have been so successful that in countries such as Brazil and Mexico they have become the largest programs for social assistance and cover millions of households. Mexico's Oportunidades was one of the first conditional cash transfers and is often used as a model for other countries. Oportunidades started with 300, 000 households in 1997 but by 2009 was up to 5 million households, which is 40% of all rural households (Fiszbein, et al. 2009). In Brazil the Bolsa Familia program covers 11 million families and Colombia's program started with 400,000 households but expanded to 1.5 million households by 2007 (Fiszbein, et al. 2009).

Conditional cash transfers are used to actively try and help households break out of inter-generational poverty cycles, by giving cash incentives and in the longer term improving health and education. Conditional cash transfers involving health and nutrition conditions usually included conditions such as; periodic check ups, growth monitoring, vaccinations, perinatal care and attendance at health information talks (Fiszbein, et al. 2009). There is an assumption that the use of financial incentives will result in higher quality health care because people become more active consumers (Barber and Gertler, 2009). It is also true that there is a pattern emerging of governments using conditional cash transfers to help in areas where they are unlikely to meet the MDG targets (Fiszbein, et al. 2009).

Conditional cash transfer programs seek to create a feeling of co-responsibility between the government and the families involved for the responsibility of health care, education, and nutrition (Rawlings and Rubio, 2005). It could be seen that use of conditional cash transfers infantilises consumers and takes away their ability to make choices and decisions. However others argue that the state is trying to be a partner in the process, rather than paternalistic (Fiszbein, et al. 2009). It can be argued that conditions can be justified when households are under-investing in human capital (Fiszbein, et al. 2009).

3.14 The problems with a conditional cash transfer approach

Conditional cash transfers can be perceived as a response to failures in supply-side interventions, however, CCTs are not a substitute for supply-side investments and are meant to address problems with demand for services (Rawlings and Rubio, 2005). In

order for a conditional cash transfer to be successful there also needs to be large supply side investments as there may be the need for the provision of services in new areas. The World Bank found that to maximise the effects on human capital conditional cash transfer programs need to be combined with other supporting services (Fiszbein, et al. 2009).

Another issue is the aim of the scheme does not necessarily fit with the priority of a household. When recipients have been interviewed it has often been found that if the cash was unconditional the money would be spent very differently then how it is spent as part of a conditional scheme (Das et al. 2005). Low participation can be another problem faced by conditional cash transfers as objectives of the scheme can not be reached if individuals do not participate. Low participation can be the result of too low an amount of cash being offered or if the conditions attached are too demanding and do not outweigh the monetary compensation (Das et al. 2005).

3.15 Conditional cash transfers – an international perspective

Mexico

Mexico's Oportunidades scheme is an iconic example of a conditional cash transfer scheme. The program was one of the first to be implemented and is one of the most successful cases, it is often used as a model for other CCT programs. The program was introduced by the Mexican Government in 1997 in an effort to break the cycle of poverty. The program has a number of objectives but primarily aims to improve the educational, health and nutritional status of poor families, particularly of children and their mothers (Behrman and Hoddinott, 2005).

In order to receive money the families have to abide by certain conditions. These conditions include; family members accepting preventative health services, school aged children attending school, nutrition supplements to be taken by pregnant and breast-feeding women and children aged four months to two years, and that the growth of preschool children be monitored. Pregnant women were obliged to obtain prenatal care and health education. Participation is also required by all adult family members at regular meetings that discussed health and nutrition issues. One of the objectives thought to come from this was that through the educational sessions and

community meetings beneficiary women would be encouraged to become more proactive in their right to access services (Barber and Gertler, 2009).

The program started initially with 140,000 households and by 2009 had increased to 5 million households by 2009, equating to around 40% of all rural families and one-ninth of all families in Mexico (Behrman and Hoddinott, 2005). Of the eligible households 97% are enrolled in the program (Gertler and Boyce, 2001). Once enrolled the households receive the benefits for three years, receiving the cash transfer every two months as long as the conditions are met. One reason that the scheme has been so successful is there has been regular evaluations were made of the impact of the project and this data has been made public (Fiszbein, et al. 2009). This made the scheme very transparent and also meant that changes were made when aspects were found not to be working.

The scheme could be seen as successful thanks to the amount of cash given as part of the program. The size of the cash transfer amounts to about one-third of household income for families enrolled in the scheme (Gertler and Boyce, 2001). Another reason for this success can be linked to the fact that the cash transfer is given to the mother of the family. The targeting of funds at the mother of the family is a likely result of growing literature that suggests when funds are controlled by women they are more likely to be spent on improvements to both the education and nutrition of the children and the woman, than if the money was controlled by a man (Adato et al. 2000). Research also suggests that the program empowers women to insist on better care through informing them, providing them with skills to negotiate and increasing their control over resources (Barber and Gertler, 2009).

There are numerous evaluations of the program. An evaluation by Behrman and Hoddinott focussed on child nutrition and growth and found that although not all the children designated to receive the supplements actually did so, there was a positive relation in growth for those that did receive the supplements, with the effects being larger for children from poorer communities but with literate mothers (2005). The program was also found to increase the utilisation of public health clinics for preventative care, lower the number of inpatient hospitalisations and improve the number of nutrition monitoring visits (Gertler and Boyce, 2001). As a longer term evaluation utilisation of health services may not be the best indicator. In the beginning

utilisation of services should increase as the conditions are directly linked to using the services for preventative visits, but if the preventative interventions succeed there will be less increase and therefore less demand for curative medical care (Gertler and Boyce, 2001).

Brazil

Brazil's social assistance program using a conditional cash transfer approach is called Bolsa Familia (previously Bolsa Escola). The scheme is similar to Mexico's Oportunidades in its reach and importance and covers 25% of the population (Fiszbein, et al. 2009). The aim of the program is to increase school enrolment and reduce child labour for children aged 6-15 years old. The scheme targets poorer households and provides a cash transfer when children have a school attendance of at least 85%. The households included in the scheme are targeted carefully with a mean test based on detailed household information (Das et al. 2005). Although targeting only poor households the scheme also provides extra help to the very poorest households (defined by per capita income) (Lindert et al. 2007). The extreme poor receive a base benefit, supplemented by the benefit per child, whereas the (less) poor beneficiaries only receive the benefit given to each child (Lindert et al. 2007).

The benefits of many conditional cash transfer programs are dependent on the number of eligible persons in the household, based on the understanding that the services offered by the scheme have certain costs (implicit and explicit) (Fiszbein, et al. 2009). The Bolsa Familia caps the number of children that can be covered by the program at three children per household. Another condition of the scheme is that the cash payment is only made into a bank account therefore beneficiaries need to be able to access a bank account. One of the aims of this condition is that this will help reduce the stigma of being enrolled in such a scheme (Fiszbein, et al. 2009). One other effect that has not been researched yet is that it may also encourage those involved to make more use of the formal banking sector (Fiszbein, et al. 2009).

The scheme has been successful in increasing school enrolment numbers, with larger improvements for poorer households, however there has been no impact on improving poverty levels of households (Bourginon et al. 2002).

3.16 Summary

The chapter shows that when considering health a rights based approach ensures that the research represents the views of the marginalised. In the context of India, as shown in the regional chapter, the system of caste and patriarchy within society creates a marginalised population. Using a rights based approach ensures that their voices are heard. The notion of human rights is internationally understood, particularly with regard to the right to health. Women's health is specifically highlighted in a number of international conventions. Women's health and particularly that of maternal health is seen as important due to the inter-generational cycle that maternal health impacts. This chapter has shown that whilst rights are important there is also the need to consider a persons capabilities as this can determine to what extent they can claim or control their rights. The debate on maternal health focuses on the availability of health care and the accessibility of this care which is dependent on barriers of demand and supply. There is an increasing amount of academic work on schemes involving conditional cash transfers which are being used to increase utilisation of certain services. The idea behind a conditional cash transfer is that by using an incentive changes can be made to health seeking behaviour. The success of such a scheme is dependent on there being good supply side investments. The two examples of successful schemes are highlighted so that they can be compared with the Indian IGMSY scheme during analysis. That the research focuses on a maternal health conditional benefit scheme shows just how topical to current academic debate this research will be.

4 The Contextualised Thematic Framework



4.1 Introduction

In order to understand maternal health within the Indian context the knowledge about the patriarchal system learnt in the previous chapters is required. This chapter explores the extent to which the international academic debate surrounding maternal health is also true within India. The barriers of supply and demand are examined to see what the specific issues to accessing health services in India are. The topics of anaemia, malnutrition, breastfeeding and antenatal care are used to show the specific impact of Indian culture on maternal health, stemming from the patriarchal nature of society. The chapter outlines international maternity standards before giving an overview of maternity laws in India. The new maternity benefit that is to be researched is summarised along with the intention of the host organisation. The immediate areas of concern with the scheme are suggested which will become the basis of the research questions outlined in the next chapter.

4.2 Maternal health in India – barriers of demand and supply

The health system in India has been chronically under-funded for the last forty years with the government only spending 0.9% of GDP on health services, one of the lowest in the world (Vora et al. 2009). The population of Uttar Pradesh is 80% rural (Jeffery and Jeffery, 2010) but the state has an urban bias with regard to the location of services. Uttar Pradesh has high rates of maternal mortality and fertility which can be considered the result of underinvestment in the supply side of health, a lack of demand for health care (cost, location, socio-economic and cultural factors) and due to the inter-generational cycle of poverty and ill health. Attempts have been made to address the medical causes of maternal mortality, but there are few policies which address the socio-economic factors of; early marriage, high fertility, low nutritional intake, and low access to health care that result in the high maternal mortality (Jeffery and Jeffery, 2010).

Health care provision in rural Uttar Pradesh is plagued by long term mistrust of staff by local people. This mistrust stems from supply side problems of lack of staff and equipment but also complaints of illegal demands for payment and discriminatory practices by staff (Jeffery and Jeffery, 2010). This mistrust causes local people to not seek services when needed. The lack of access is wider than just a mistrust of staff at

health services. Ensor and Cooper (2004) suggest that access to health services are restricted by both demand factors; education, location, cost, time and cultural norms, and supply factors; lack of skilled staff or equipment, as well as the expectation of bribes and abuse or discrimination of patients by staff.

Another reason for low uptake of health services by women during pregnancy is cultural norms and expectations. Childbearing is often regarded as an expected part of woman's role and therefore families are reluctant to invest in maternal care (Gill et al. 2007). In Uttar Pradesh less than 30% seek an institutional birth, a quote from during a research project helps to show that institutional births are seen for emergencies only:

‘children are born in the village inside houses. Women are not taken to the town. Only when the boat has started sinking...do they run off to town’ (Jeffery and Jeffery, 2010:1711).

A woman's health seeking behaviour is positively correlated with freedom of movement and decision making power (Bloom et al. 2001). Gill et al. suggests that ‘the stronger the woman's decision making power, the greater the effect on maternal health’ as she is able to access health care (2007:1351). In Northern India a women's status and autonomy is defined by the household structure and relationships (Bloom et al. 2001). This status is ‘a product of socially structured gender norms and personal attributes’ (Mistry et al. 2009:926). For example once married most daughters-in-law are not only dependent on their husband but are also subject to their mother-in-law's authority (Bloom et al. 2001). A woman's autonomy is linked to her individual power and personal agency, giving her the capacity to act and control outcomes. If the power lies with her husband or mother-in-law it is difficult for her to seek health care if not agreed with by other members of the household.

Improving access to health care needs to go beyond improving access to facilities, equipment and staff and should include the attitude of staff (Jeffery and Jeffery, 2010). Consideration also needs to be given to a woman's autonomy and decision making power, as this may prevent her from seeking services even if they are available.

4.3 Anaemia, malnutrition and breastfeeding

Globally anaemia affects 1.62 billion people (24.8% of the population) and of those nearly half live in India (Rohilla et al. 2010). One of the reasons for such a high rate of anaemia in India is malnutrition. As explained in figure 3.2 malnutrition and poor maternal health can be an intergenerational cycle. The ill health of women in Uttar Pradesh is part of a cycle of poverty that starts before birth. Women in India do not get adequate nutrition, particularly during pregnancy. There is often no provision of special food and culturally the women often 'eat last and least' (Neogy, 2010:479). This lack of nutrition causes a low BMI, often a short stature, and anaemia. These factors, together with early marriage and high fertility, can lead to obstructed labour, a baby of low birth weight, and greater complications during and after the birth. The gender inequality in India is one of the biggest contributors to malnutrition of women as perceptions of women being of less worth causes unequal distribution of resources, which leaves women vulnerable to malnutrition (Neogy, 2010).

Pregnant women everywhere are recommended to take iron supplements during pregnancy. One study conducted in India found that only 8% of women had received iron-folic acid for 6 months before delivery (Jeffery and Jeffery, 2010). Anaemia in pregnancy is one of the largest contributors to maternal mortality and morbidity. The levels of anaemia are so high in India as malnutrition is a problem from birth. Studies shown that anaemia can be controlled during pregnancy if anaemia is prevented or controlled during adolescence (Rohilla et al. 2010). In order for anaemia to be tackled during pregnancy attempts need to be made to combat anaemia during adolescence as well. The results of malnutrition are made worse by the young age of marriage, the high order of pregnancies and lack of spacing between births (Neogy, 2010).

Child malnutrition can be helped by the encouragement of exclusive breast feeding for the first few months. Breastfeeding in developing countries is often encouraged for longer than in more affluent societies as the environmental conditions can expose infants to more risk (Brennan et al. 2004). Whilst it is internationally agreed that breastfeeding exclusively for the first few months is highly beneficial for physical development (Brennan, et al. 2004) it is not as clear for how long exclusive breast feeding should be continued. The international infant feeding recommendations suggested by UNICEF, the WHO and agreed by the government of India include 5

core principles: 1- attempt to feed within 1 hour of birth; 2- exclusively breastfeed for 4-6 months and continue for 2 years or longer; 3- include the colostrum (first milk) in the first feed; 4- introduce supplementary foods by 7 months; 5- no nipple should be used on the feeding bottle (Brennan et al. 2004). To achieve all these points women need to be educated about the benefits of breast feeding during pregnancy. This is usually done during ante-natal check ups but in Uttar Pradesh only 20% of women attend all the required ante-natal check ups.

Brennan et al. states that 'educating mothers in good infant feeding practices is a cost effective way to reduce the risk of chronic malnutrition' (2004:152). If a child is fed only on breast milk they are less likely to be given food or liquids that could be contaminated. Breast milk contains essential nutrients and has natural immunities helping the infant develop. Breast feeding is also beneficial for the mother too as breastfeeding lengths the period of post-partum infertility which can help to lengthen birth intervals (Brennan et al. 2004).

4.4 Antenatal care

The take up of antenatal care in India is low. According to the NFHS only 65% of women receive any antenatal care (Pallikadavath et al. 2004). The purpose of antenatal care is to monitor for complications and provide vaccinations, supplements and identify high risk pregnancies. Antenatal visits also provide an excellent platform for health education, health promotion, and social support (Pallikadavath et al. 2004).

The uptake of antenatal services is determined by socio-economic and demographic factors and the availability of the services. Low utilisation of antenatal services is linked to low levels of education and those with higher order pregnancies (Pallikadavath et al. 2004). Around half of all pregnant mothers do not complete three antenatal visits and a quarter do not receive the tetanus prophylaxis injection (Vora et al. 2009). In Uttar Pradesh female literacy is low and women often lack empowerment to make decisions. Figure 4.1 shows that less than 10% of women receive all the antenatal care suggested. Figure 4.1 also shows another example of the north south divide discussed in the regional chapter.

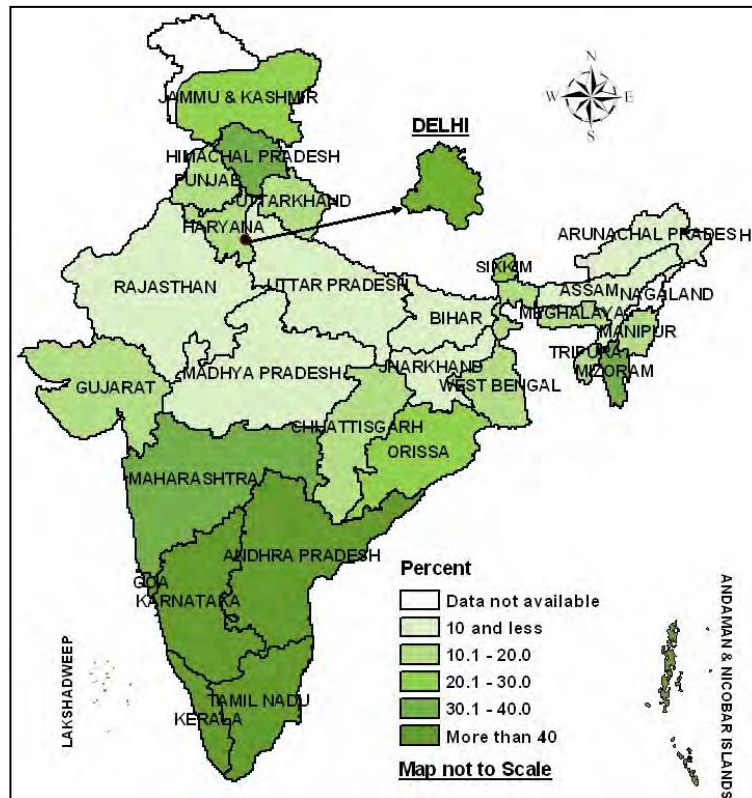


Figure 4.1 Percentage of women who received full ANC by states (DLHS-3, 2008)

4.5 Maternity benefits – international recommendations

Research in Ghana found that women lost 26 days of work due to reduced productivity during pregnancy, and 23 days during postpartum (Gill et al. 2007). The International Labour Organisation (ILO) states that ‘pregnancy is not an illness’ and has set international standards relating to maternity (ILO, 2000). Countries differ in their maternity laws and benefits as to how much leave and payment is offered. Many pregnant women fear for job loss or face a lack of financial security which causes many women in the developing world to work up until the birth.

The ILO has made recommendations and created international dialogue to discuss maternity protection. Conventions for maternity protection were held in 1919 and 1952 with the most recent being the ‘Maternity Protection Convention 2000 (No. 183)’ resulting in ‘Maternity Protection Recommendation, 2000 (No. 191)’. The ILO defines maternity protection as; ‘maternity leave, cash and medical benefits, health protection, breast feeding, employment security, non-discrimination’ (ILO, 2000). The ILO aim to ensure women are protected against discrimination and that equality is promoted. The convention of 1919 relates to women in public or private industry,

the 1952 convention extended the protection to those in non-industrial and agricultural occupations, and the convention in 2000 extended the protection to all employed women ‘including those in atypical forms of dependent work’ (ILO, 2000). The previous ILO conventions only referred to those in formal employment but the ‘Decent work for all’ strategy introduced in 1999 adopted a broader perspective and included forms of unpaid work (Ginneken, 2003). The ILO Convention no. 183 declares that maternity leave should not be less than 14 weeks which should include 6 weeks compulsory postnatal leave (ILO, 2000).

The ILO believes that maternity leave is important as rest is necessary to prevent complications, time off after birth is therefore important too as it reduces the risk of complications following labour and allows time to establish breast feeding (ILO, 2000). As well as length of time off one of the key components of the convention is the need for a secure income. ILO states that ‘cash benefits shall be at the national level which ensures that the woman can maintain herself and her child in proper conditions of health and with suitable standard of living’ and suggests this should be no less than two-thirds of the salary (2000). In relation to breast feeding the ILO advocate the right to one or more daily breaks (with the number and length to be decided nationally) (2000). Breast feeding is important as it helps the mother recover after birth, strengthens the child’s immune system and importantly for developing countries is bacteria-free (ILO, 2000). Along with the UN notion that ‘women’s rights are human rights’ (1995) the ILO believes that ‘protecting maternity is not a women’s issue. All society is concerned’ (ILO, 2000).

4.6 Maternity laws in India

India has a number of laws that provide benefits to women during maternity. The Employees’ State Insurance Act 1948 provides benefits in case of sickness, maternity or employment injury. It provides periodical payments to an insured woman in case of miscarriage, sickness arising out of pregnancy, or premature birth. The Act prohibits employees from being dismissed, discharged, or having their hours reduced during the period they are in receipt of the benefit. Two years later the Indian constitution (1950) made provisions for health and maternity: Article 47 states that the State has a primary duty to raise the level of nutrition and improve public health. Article 42

requires the State to make provision for maternity relief and Article 43 entails the State to secure workers a living wage to ensure a decent standard of living.

In 1961 India passed the Maternity Benefit Act which recognised the rights of mothers to maternity benefits and aimed to protect the dignity of motherhood by providing for maintenance of women and children when not working. However the act is only applicable to mines, factories, circuses, plantations, shops and establishments employing more than ten persons or more.

The Central Civil Services (Leave) Rules of 1972 went further than this and guaranteed maternity leave for 180 days. However this has a limited scope as it is for government servants with less than two children. The act does however also provide up to 45 days leave in case of miscarriage or abortion.

With limited national maternity rights it was not until 2001 that a more comprehensive scheme was launched. The National Maternity Benefit Scheme (NMBS) 2001 provides nutrition support to pregnant below poverty line (BPL) women with a one time payment of Rs. 500 eight to twelve weeks before delivery. However this was a scheme not a law. India has launched other maternity benefit schemes including some that are a conditional cash transfer benefit.

All these acts fall well below the international recommendations set by the ILO. The research is focussing on a new maternity benefit set by the Indian government called the Indira Gandhi Matritva Sahyog Yojana (IGMSY) scheme. This is the most comprehensive scheme to date and does emphasise the importance of time off and nutrition to maternal well being.

4.7 IGMSY conditional maternity benefit

The Indira Gandhi Matritva Sahyog Yojana (IGMSY) is a conditional maternity benefit scheme (known in an international context as a conditional cash transfer). The scheme will run on a pilot basis for pregnant and lactating women in 52 selected districts across India. The scheme will provide cash directly to pregnant and lactating women in response to the individual fulfilling specific conditions. The short term aim of the scheme is to compensate for wage loss during pregnancy allowing for maternity leave, but it is also hoped it will tackle the problem of under-nutrition (maternal and

child). The longer term objectives are for behaviour and attitudinal change leading to an increased demand for services.

The scheme is the result of the Government of India's Eleventh Five Year Plan document (Vol. II), from the Planning Commission which noted that:

“Poor women continue to work to earn a living for the family right up to the last days of their pregnancy, thus not being able to put on as much weight as they otherwise might. They also resume working soon after childbirth, even though their bodies might not permit it—preventing their bodies from fully recovering, and their ability to exclusively breastfeed their new born in the first six months. Therefore, there is urgent need for introducing a modest maternity benefit to partly compensate for their wage loss”.

The scheme will be implemented within the two remaining years of the 11th Five Year Plan (2011-2013).

Pregnant women aged nineteen years or older are eligible for the scheme for their first live births. The scheme excludes government employees as they are already entitled to paid maternity leave. The beneficiaries are paid Rs. 4000 (~€70) in three instalments from the second trimester until the child reaches six months of age. The instalments are dependent on certain conditions being met. The health workers (Anganwadi worker and Anganwadi helper) also receive an incentive of Rs. 200 and Rs. 100 respectively per beneficiary.

The conditionalities of the scheme include registering the pregnancy, attending antenatal visits, taking nutrition supplements, registering the birth, getting the child immunized and breastfeeding exclusively for six months. Table 4.1 shows the conditions required of the scheme, the timings and amount of payments, as well as the means of verification.

Table 4.1 Conditions of the IGMSY scheme (GoI, 2010)

Cash Transfer	Conditions	Amount (In Rs.)	Means of Verification
First (at the end of second trimester)	<ul style="list-style-type: none"> • 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 breastfeeding and ensure colostrum feed.	As per JSY norms	
Second (3 months after delivery)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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

There are concerns regarding the design of the scheme and the underlying assumptions. The research proposes to explore the conditions set by the scheme against the services available and current health practices of the women. Areas for

concern include the exclusion of those under the age of nineteen and those with more than two children. The scheme aims to increase demand for services which assumes that poor maternal-neonatal health is the result of a lack of demand, rather than limitations of supply or the quality of care received. Most importantly there is no consideration for the social determinants of maternal health. The scheme implies the women's health will improve by attending antenatal care without considering any of the other determinants (such as cultural constraints) that will not be changed.

4.8 The host organisation – Sahayog

Sahayog is an NGO working to promote gender equality and women's health from a human rights framework and is based in the state of Uttar Pradesh. Sahayog is part of the National Alliance for Maternal Health and Human Rights (NAMHHR). Sahayog and the NAMHHR want to research the new pilot maternity benefit IGMSY. Sahayog works at the community level in partnership with local NGOs to build capacities and provide information so that the marginalized can exercise their rights and access services (Sahayog, 2010).

Sahayog's mission is:

‘To promote gender equality and women's health from a human rights framework by strengthening partnership-based advocacy’ (Sahayog, 2010).

Sahayog has been advocating on various issues of women's rights at state, national and international level. Sahayog together with the recognise that strong rights-based strategies are needed to build greater accountability for these thousands of preventable deaths among women in India (NAMHRR, 2010).

4.9 Summary

The chapter outlines the specific demand and supply issues that prevent access to healthcare in India. Whilst the issues of demand and supply are mostly the same as on an international scale the importance of Indian culture is made clear. Many of issues are specifically linked to cultural constraints that result from the patriarchal nature of Indian society. The women do not have the autonomy or freedom to seek out health services and also maternal health care is not seen as important by the family. The cultural impact on health is clear when the issues of malnutrition and anaemia are

considered. The patriarchal system in India results in women eating less resulting in low body weight, short stature and high levels of anaemia among girls and women. The international standards on maternity laws are outlined before the laws within India itself are summarised. The Indian laws seem to fall short of international standards. The new maternity benefit that is the focus of the research is considered much more comprehensive than previous benefits but pays little attention to the cultural constraints to accessing health. With the guidance of Sahayog these concerns are posed as research questions in the next chapter and form the basis of the research in the field.

5 Methodology



5.1 Introduction

The research design for a project is very important. Without a solid research design the data collected may not fully answer the research questions. This thesis was the result of data collected during a research internship and therefore the research had to meet the needs of the host organisation and Utrecht University. The resulting research design was a collaboration between Sahayog and myself. This chapter outlines the research problem and objective along with the central research question and sub questions. In order for someone to be able to re-create a similar piece of research the search terms used in the theory chapter have been explained. When conducting research in a developing country research ethics is an important component and so the consideration for ethics behind the research design is discussed. The research used a mixed method approach and the reasoning for this is explained. The research approach and intended method of analysis were designed together as the methods to be used during analysis should be known before the data is collected in order for the data to be useful.

5.2 The research problem

The government is launching a pilot of a conditional maternity benefit across 52 districts of India. Consideration needs to be given as to whether the project can achieve its intended goals. The study will explore the enabling environment for the pilot stage of implementation of the IGMSY maternity benefit in one district of Uttar Pradesh. Research will be conducted to assess the maternity services in the area and whether the design of the benefit fits with what the women need and want from a maternity benefit. Components of the benefit to be assessed include; the figure of Rs. 4000, the participant criteria and the conditions attached to the benefit.

5.3 The research objective

The IGMSY project is primarily aimed at supplementing the wage loss of pregnant women, allowing for more rest during the end of pregnancy and therefore aiding nutritional intake. The scheme is not limited to women who are below the poverty line and from a long term perspective the scheme is trying to change care-seeking behaviours and attitudes of women as well as increase the demand for services.

The project is currently in its pilot phase and this study will attempt to understand the initial design related challenges. By exploring the enabling environment of one of the pilot districts it will be possible to research how long women currently take off during maternity, who would be left out of the scheme and whether the conditions placed on the women are feasible. Investigating these possible challenges to the scheme may allow for possible recommendations for improvement or further research. The results should also allow for baseline comparisons to be made once the scheme has been implemented.

This study will help to build a baseline of women's current maternity practices and the services available in the area. The study will investigate how long women currently take off work, what general breastfeeding practices are and build up a picture of nutritional intake during pregnancy. The research will also assess whether the conditions of the scheme are feasible by investigating what services are available and which are used. The research should help show the initial challenges, bottle-necks and ambiguities of the IGMSY scheme.

5.4 Central research question

Is the design of the IGMSY in line with current maternity practices and services?

5.5 Sub questions

1. What is the current practice of pregnant and lactating women taking time off to rest and increasing their nutritional intake?
 - How long do women take off during maternity (before and after the birth)
 - What are the reasons preventing fewer days of rest?
 - Are the number of days off dependent on the household income and the woman's position in the household?
 - What is a woman's average daily nutritional intake and does this change during pregnancy?

2. Who will be included and excluded due to the scheme's selection criteria?
 - Will the age barrier of nineteen years old leave many women excluded from the scheme?

- Will the limit of two children for the scheme exclude many women from the scheme?
3. Are the conditions required for the benefit available in Uttar Pradesh?
- Which of the conditions required for the benefit are available in Uttar Pradesh?
 - Of the services available which do the women currently access?
 - If any, what are the barriers to accessing health services (demand factors at household and individual level)?
 - What are the women's current breastfeeding practices? How long do they currently breastfeed exclusively for?
 - Do conditions in the workplace allow women to breastfeed at work?

5.6 Literature searches

The key questions of the research were the result of background reading and topics that were well explored in the regional, theoretical and thematic chapter. Meth and Williams write that to complete a good literature search there needs to be information gathered on the case study area, research themes and the theoretical approach (2010). Literature for all areas was researched looking at the broader theme down to narrower themes. In the case of the regional chapter this went from information on demographics across India, to information about health in the state of Uttar Pradesh down to statistics at district level. The research themes started with literature about maternal health globally to topics of nutrition, maternal mortality and issues of breastfeeding specifically in India. With the theoretical approach the chapter was narrowed from a look at work on the rights based approach, to articles on the right to health and then to specific readings on a woman's right to health.

The readings were found using keywords in searched on academic databases (such as Scopus) and internet searches (such as Google). More specific searches were conducted on the specific websites of the WHO, World Bank, UNFPA and the ILO. Searches were also made in journals that came up often during the academic database search. These journals included; Social Science and Medicine, The Lancet, Health Policy and Planning, Journal of International Development, Studies in Comparative

International Development, Development in Practice, Gender and Development and Human Rights Quarterly.

The key words searched for when completing the literature searches were as follows; ‘rights based approach to; maternal health; reproductive health; development’, ‘maternal rights’, ‘maternity benefits’, ‘impact of conditional cash transfers’, ‘pregnancy and nutrition’, ‘breastfeeding and developing countries’, ‘maternal health in India’, ‘maternal health in Uttar Pradesh’, ‘antenatal care in Uttar Pradesh’, ‘immunization in Uttar Pradesh’, and ‘nutrition in Uttar Pradesh’.

Further information was then gathered using a snowball technique from the references of the wide variety of works found. Information was also gathered using publicly available datasets. Three main data sets were used including the Indian Census of 2011, the District Level Household Survey (DLHS) of 2008 and the National Family Household Survey (NFHS) of 2006.

5.7 Conceptual Model

A conceptual model shows the essential components and relationships of the system to be studied (Jarvelin and Wilson, 2003). The conceptual model shown in figure 5.1 illustrates the main components of the IGMSY scheme and how they relate. The model shows that the scheme is centred around the financial compensation given to pregnant and lactating women to allow them to take rest and increase their nutrition during maternity. Receiving this financial compensation is dependent on meeting the conditions of the scheme and the eligibility criteria (shown by the purple boxes).

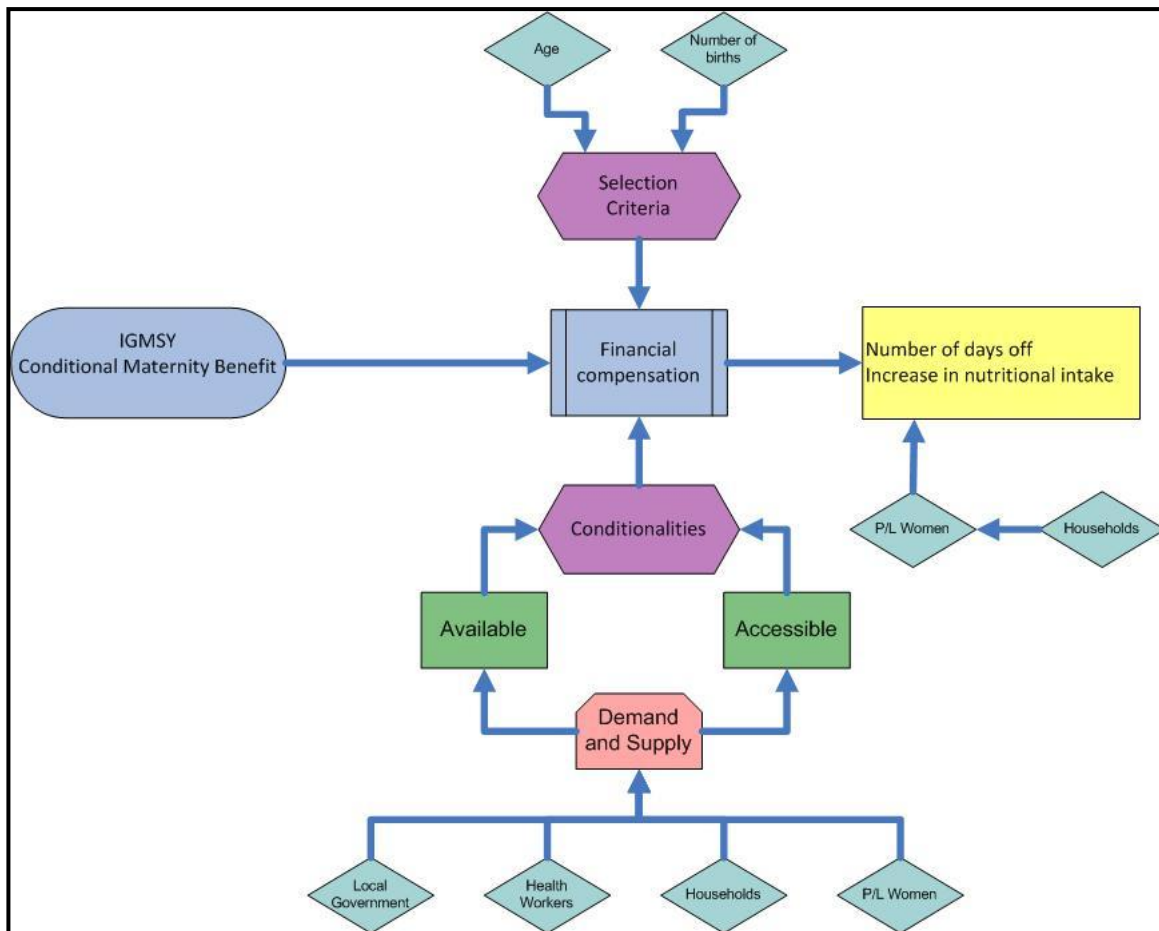


Figure 5.1 Conceptual Model for the IGMSY Conditional Maternity Benefit (created by the student)

Meeting the selection criteria is dependent on the woman being aged nineteen years or older and having only two children or being pregnant with a second child. In order to meet the conditions the services need to be available and accessible. Whether there are demand or supply issues is reliant on all actors involved; local government, health workers, households and the women themselves. Once a woman is eligible for the scheme and meets the agreed conditions how much time off and increased nutritional she is able to take may not depend on just herself. Below the yellow box outlining time off there is a box including households, this is because whether the woman can take time off or increase her nutrition may be dependent on her position within the household and whether she has any decision making power.

The conceptual model of a research area should always be constructed to map reality, guide the research and systematise knowledge (Jarvelin and Wilson, 2003). Figure 5.1 outlines the key actors of the scheme, the key areas to be researched (time off and

nutrition, selection criteria, and the conditions) and is therefore a map of the planned research.

5.8 Ethics

Many ethical issues need to be considered whilst planning and conducting a research project. One key factor is the importance of seeking informed consent from the participant. Informed consent is described as the participant fully understanding and agreeing to freely take part in the research. For someone to give their informed consent they need to understand the aims of the research, their role and part in the research, what the research will be used for and who will have access to the data (Scheyvens, Nowak and Scheyvens, 2003). To achieve informed consent in the research project usually an information sheet explaining the research project is provided to participants. In the context of this research it was important to consider that not all the women to be interviewed would be literate. The information was translated into Hindi and read out to participants when necessary. Once the information sheet had been read and the participant understands the research and are willing to take part in the research then consent was sought. Care was taken to ensure that participants understood that participation was voluntary and that they were free to withdraw at any time. Anonymity and confidentiality was also explained as part of the consent process. Consent was taken for the use of audio recording of interviews, the use of direct quotes and the use of any photographs. It was agreed that where possible written consent would be sought, for those that could not provide a signature an ink pad was supplied for a thumb print. In India this is an acceptable method of consent and is often used for the receipt of benefits and during elections.

Ensuring a participant's confidentiality, anonymity and privacy during the conduct of the research is important. Anonymity is guaranteed once transcription of the interview is completed by removing identifying data, however confidentiality, anonymity and privacy was near impossible to maintain in the field itself. The interviews often took place out in the open, often surrounded by other villagers who had come to see what was going on, and family members (see photo on methodology title page). Even when interviews took place in houses, others were also present in the room or sat just outside the open door. It needs to be considered that this may have impacted on what the women said during the interview. In order to maintain anonymity the names of the

villages and the block that the research took place in are not being identified. This decision was made based on the sensitive nature of some of the questions and subsequent answers given during the research. Providing the name of the block or villages the research took place in could allow for the possibility of the health workers and local officials to be indentified, therefore the name of the district is given only.

During the focus groups it was important to consider power dynamics between the women. Power dynamics can come into play through knowledge, feelings of inadequacy, gender differences and economic differences. To reduce the possibility of power struggles between participants during the focus group it was made sure that the focus group participants were of a homogenous caste.

Participation in the research is important. Effort needs to be made to ensure that the marginalized groups are also included. Consideration needs to be given to the timing and location of interviews and focus groups. For this research, interviews were completed at the woman's home and focus groups were held in two locations, a public building and a hut in one of the villages. There is a high level of ethical and social responsibility on the researcher (Johnson and Mayoux, 1998) it is imperative that women can access the interview locations and that no groups are ignored.

5.9 The research process

The research was conducted from a rights based approach using qualitative research methods and the use of secondary data to allow for both qualitative and quantitative analysis. To use a mixed method approach is important as using both qualitative and quantitative approaches helps to avoid the research having the weaknesses that comes from using a single approach. This mixed method approach has been termed by Hulme as researchers attempting to 'use both eyes' (2007:2). The use of both qualitative and quantitative methods is particularly important when researching a subject such as maternal health. Yamin writes of the need for a qualitative approach when considering maternal mortality as 'merely counting cases of maternal deaths does not tell us what needs to be done to prevent women like Elena from dying in the future' (2005: 1206). Likewise the use of qualitative only gives the story or reasons behind the mortality but no quantifiable data, meaning that the scale of the issue is not known. In order to impact policy or give more weight to the findings a combined

approach can help to create knowledge that is more useful (Hulme, 2007). For this project using a rights based approach is necessary to make sure the voices of the marginalized are heard, in this research that refers to the lower castes. Yamin states that using a rights based approach can help to explore to what extent women are not able to claim their rights to health and to what extent governments are not meeting their obligations (2005).

Research was conducted at individual and household level and was done through a mix of focus groups, semi-structured interviews, questionnaires and the use of secondary data from the census and national and district household surveys.

The first step was to obtain the list of pregnant and lactating women of the panchayat, which had already been compiled by the anganwadi health worker. At this stage it was not a list of those eligible for the scheme but a list of all pregnant and lactating women in the area. The list of those that would be eligible for the scheme would not be released until June 2011.

The list of pregnant and lactating women was the sample frame for the research. With the use of the list and the expertise of the village Pradhan two villages were selected for the research with differing distances to services. The first village chosen had a population of 2575 and was 15km from the primary health centre, and the other had a population 2457 and was 8km from the primary health centre.

For the study it was important that the voices of each different group were heard. This meant that women from both scheduled and backward caste needed to be interviewed. It was also important to have women from a range of poverty levels (above poverty line, below poverty line and antyodaya anna yojana). The list of pregnant and lactating women was used as the sample frame as it specified the caste and card group of each of the women. The decision of which individuals to interview was made from the list using purposive sampling as we needed to include women that were of a specific caste and card group. In a larger study this approach would not be necessary as the larger number of interviews would likely include all necessary castes and card groups. A random approach would be less likely to cause any bias in the research however, for the numbers involved and the time available for the study purposive sampling was the best strategy.

The next stage of the research was to conduct a situation analysis of local health services to see what services were available and which were accessed. The situation analysis was completed through the observation of the functioning of the anganwadi centre, primary health centre and the auxiliary nurse midwife sub-centre. This was conducted through the use of photographs of the services, field notes and also information gathered during the interviews and focus groups.

It was the intention as part of the study to conduct interviews with the three different health workers (accredited social health activist, anganwadi worker, and the auxiliary nurse midwife). Each of the villages had at least one accredited social health activist and anganwadi worker. Due to the population size of the villages there was only one auxiliary nurse midwife and she was responsible for the two villages. Interviews were also to be held with the local health officials (Child Development Protection Officer and the Medical Officer) at block level as explained in chapter 2.8.

Focus group discussions were held with women of reproductive age within the villages. In order to allow for free discussion the focus groups were required to be of homogenous caste therefore two focus groups were required per village one for backward caste and one for scheduled caste. The village also had women of general caste but as they are not daily wage earners they were not selected for the study. Although the focus group was to be homogenous on a caste level it was hoped to get a balance of different public distribution service cards. These cards come in three different forms; above poverty line (APL), below poverty line (BPL) and antyodaya anna yojana (AAY). The AAY card is given to the poorest ten per cent of the population. The cards entitle the families to rations at the public distribution centre and the rations include different grains, rice, lentils and often cooking oil. Following the focus groups in-depth interviews would be conducted with a mix of women that would be included and excluded from the benefit in each of the villages.

The issue model matrix (see table 5.1) shows the topics to be covered with the different participants in the study.

Table 5.1 Issue Model Matrix for the Research (created by the student)

Sub-Issue	Focus Group	Interview with health workers	Interview with local officials	Interview with beneficiaries	Interview with those excluded	Observation
Number of days off						
Reasons for not taking more time off						
Food consumption on a typical day						
Overall economic status						
The selection criteria						
Reasoning for the selection criteria						
Services available						

5.10 The plan for the analysis

The research was conducted using qualitative methods. There were observations of the local health services and a series of focus groups and interviews. All the interviews were conducted in Hindi with the use of a translator. A copy of the topic guides used, the information sheet and consent form can be seen in the appendix. The interviews were recorded (with consent) and notes were also taken. The full transcript was later written up and then translated by an intern at the host organisation. The plan for the analysis of the data was to code the transcription using a number of general categories. After a careful read through of the transcript it was decided to code under four general categories; rest and nutrition, selection criteria, services and conditions, and the scheme. The codes within these categories were as follows:

- **Rest and nutrition;** time off, chores, food intake, household income and expenses.

- **Selection criteria;** age, number of births, still births, miscarriages and migrants.
- **Services and conditions;** breastfeeding, conditions of scheme, where services are and what services are given, how the women travel to the services, supply issues and problems of demand.
- **The scheme;** payments, recommendations by the women, recommendations by the officials.

As it was not known what answers would be given during the interviews the coding was done after the event when the transcript had been thoroughly read through to find the main categories. Another option for coding is to decide on the categories beforehand but this is better used when there is a clearer idea of the answers that will be given. The interviews provided many interesting examples about health care in India and so another tool of analysis will be the use of narrative analysis where the stories described during the research are used to give real life examples. The use of narrative analysis used to be restricted to life histories but is becoming a more essential part of qualitative research to help give understanding to the data.

5.11 Methodological problems

In the field there were a number of methodological issues. The first stemmed from the list of pregnant and lactating women itself. As this was not the finalised list of those eligible for the scheme we had to decide who would be eligible and ineligible from the criteria of the scheme. It was clear who would be excluded from the number of children they already had but from the list of lactating women those who would be eligible was unknown. This was because the scheme only provides cover until the baby is six months old and the list of women who were lactating had no ages for the children, therefore the interviews with eligible women all had to be chosen from the pregnant list.

The focus group discussions were a little chaotic and ranged from six in one session to seventeen in another. One session was not very useful as most of the women did no paid work and so perhaps we had not stressed this clearly enough to our partners in the field.

Problems arose from the two chosen villages. After conducting a number of interviews it became clear that the villages were too close to one another. The women interviewed all used the same services therefore the same answers were being given by both villages leading to repetitive answers after the first few interviews.

The original plan had been to conduct interviews with the village women prior to the scheme starting and come back once it was up and running to come back and do a second stage of interviews. It became clear that the roll out of the scheme was taking longer than expected and that it would not be possible to do the second stage of research during the timeframe for the study.

5.12 Summary

The main issue that occurred during the research was that the IGMSY scheme had not been implemented yet and so the research design changed to become a baseline study focussing on exploring the conditions required for the study in the research area. As the main aim of the scheme was to provide money for increased rest and nutrition during pregnancy it was important to assess how much time the women currently took off during maternity and explore their normal nutritional intake. The other factors considered were the inclusion criteria of the scheme and whether the conditions required for the scheme were available and accessible in the research area. The emphasis for not only availability but accessibility was the result of the literature found when completing the theoretical chapter. It was clear that a mixed method approach would achieve the best results the research was designed to use quantitative data in the analysis to substantiate any claims, providing more reliability to the data. The ethical considerations when completing research in a developing country is very important, particularly a country such as India which has such strong cultural values. Issues of power, consent and confidentiality needed to be considered during the design of the research as they are integral to the research process.

6 Rest and nutrition



6.1 Introduction

The aim of the research was to be able to provide a baseline study allowing the IGMSY scheme to be better assessed. The scheme intended to aid women to take time off from work and to increase their nutrition during maternity. It was important to find out how much time the women currently took off during maternity, what their nutritional intake was on a daily basis and whether this currently changed during pregnancy. Data relating to malnutrition and anaemia is explored along with evidence surrounding women's autonomy in Indian households. The chapter explores the issue of autonomy in order to consider whether the benefit would be able to change behaviour.

6.2 Analysis – Rest and nutrition

Questions were asked during the interviews and focus groups to build up a picture of current practices regarding rest and nutrition during pregnancy. When asked how much time is taken off from work during pregnancy most women reported working up until the birth of their child.

‘Sometimes it also happens that after working for an entire day, the child is born on the same night.’ (Female respondent)

The reasons for continuing to work during pregnancy and right up until the birth itself seem to be a mix of the need for a wage and that pregnancy is not regarded as a reason for taking rest by the family.

‘Family members say that if you will not work, you cannot give birth to a child. If we start taking rest, then how would we earn money?’ (Female respondent)

Those that take time off from paid work still do household work until the birth with no time to rest.

‘If I take rest, who will work? There is no such rule like I am not supposed to work during pregnancy etc. washing utensils, clothes, taking care of children, cooking food, cutting fodder for cattle, picking up cow dung, I do it all.’ (Female respondent)

The experiences of most women suggest that no longer than two weeks is taken before paid work is commenced again as the wage is needed by the household. Another explanation for the lack of rest can be found in the cultural importance of the wife living with her in-laws. When a woman is in her in-laws house she does not have the same freedom as at her own parents, for example the ability to sit on the bed outside is prohibited.

‘During my first childbirth, I was at my mother’s home so I got rest now I am at my husband’s house so I won’t get much rest.’ (Female respondent)

Information was sought about the daily food intake of the women. One aspect researched was whether the women changed their food consumption during pregnancy. A lack of nutrition from birth and following on through adolescence to adulthood creates high levels of anaemia among Indian women. Figure 6.1 shows that 52 percent of women in India suffer from anaemia.

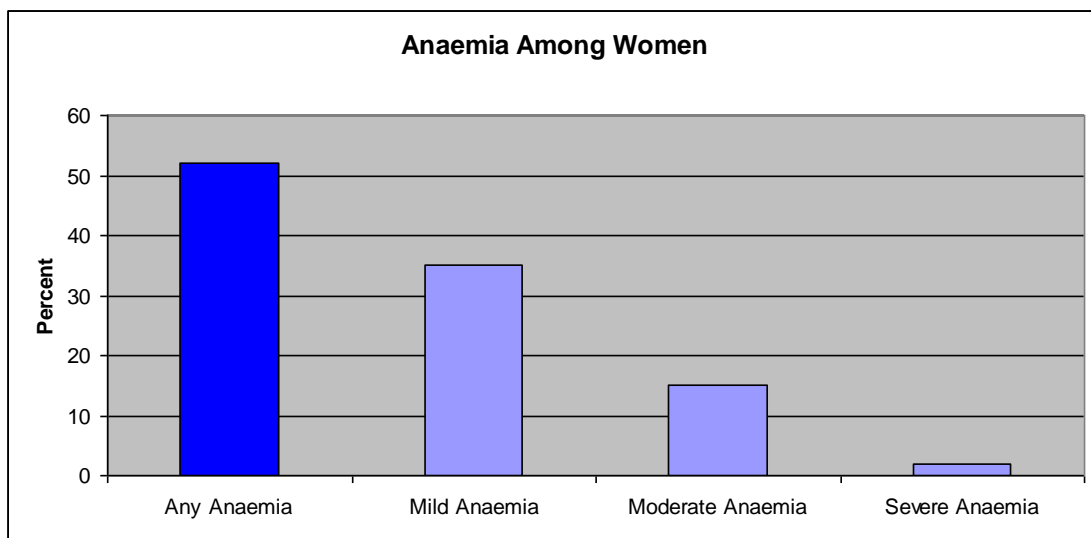


Figure 6.1 Anaemia among women (NFHS-2, 1999)

From observations in the field it was clear that all the women and children interviewed were under-weight. Malnutrition is known to be a widespread problem in India, causing high rates of anaemia and low body mass index. Figure 6.2 shows that India has the largest share of underweight children aged under five years old. Of the total number of underweight children 42% of them reside within India.

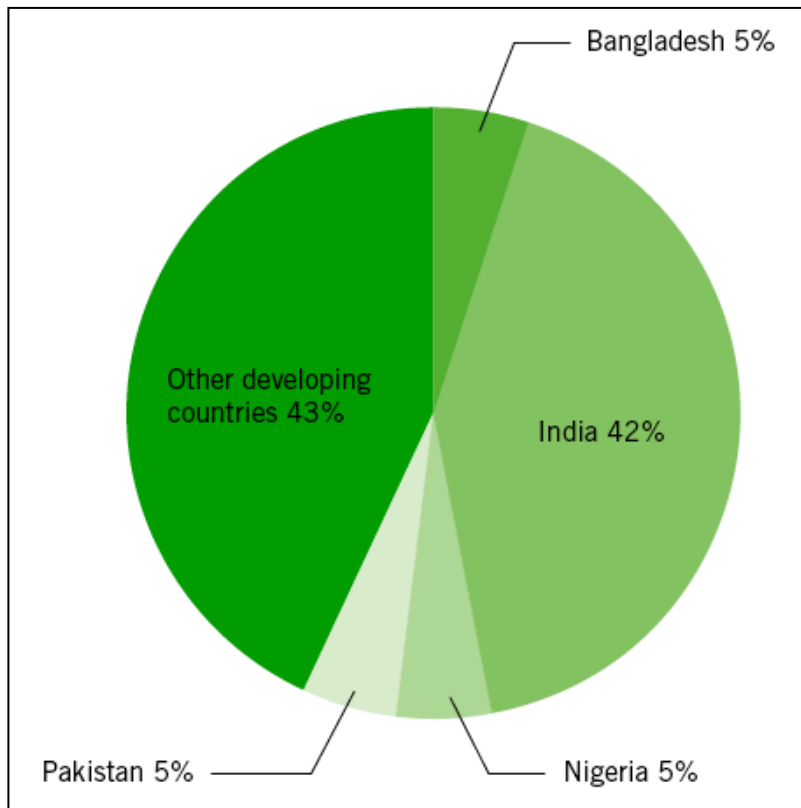


Figure 6.2 Share of underweight children under five years of age (UNICEF, 2009)

Many women commented on struggling to provide enough food for the family. It was clear that the notion of women in India of women culturally eating little and last is true but that this is often in an attempt to make sure there is enough food for the family.

‘We have large families, dearness is so much, and everyday it is not possible to have pulses, rice, chapattis, and vegetables. Food we take on common day that is also what we take during pregnancy. We try to give everyone daily food and cannot think about ourselves.’ (Female respondent)

The women were aware that they should be changing their diet during pregnancy but expressed that it is not possible, not only due to a lack of money but also due to a lack of decision making power within the home.

‘Nurse told me to have more of milk and green vegetables but whom should I say in my husband’s home?’ (Female respondent)

Most women were unsure of how much of the household income was spent on health as they did not hold the decision making power.

‘How much to spend and where to spend, all these decisions are taken by my father-in-law and husband. It’s mandatory to take their permission before going to any place.’ (Female respondent)

Women of husbands who worked away had more decision making power.

‘Since my husband works outside and comes home once a week, hence all the important decisions are taken by me.’ (Female respondent)

Table 6.1 shows that only 20% of respondents were able to make decisions relating to their own health care with 55.6% not involved in the decision at all. Table 6.1 helps to show how little autonomy the women have, with decisions mainly being made by the other household members without the need for joint discussion.

Table 6.1 Responses to questions about women’s autonomy (Mistry et al. 2009)

Women’s Autonomy (n= 11,648)	Percent		
	Respondent alone decides	Jointly decides with family member	Respondent not involved in decision
Obtaining health care for herself	20.0	24.4	55.6
Buying major household item	4.5	40.1	55.4
Going and staying at natal kin’s	6.9	33.5	59.6
Permission to go out			
	Yes	Needs permission	Not allowed
Go to market without permission	20.2	71.3	8.6
Visit relatives or friends without permission	15.5	82.2	2.3

Financial autonomy	Yes	No	
Can have money set aside for personal use	51.1	48.9	

Though health came across as one of the major expenses in the research it was food and education that were found to be more critical. For these critical expenses and often for health care as well the women spoke of requiring loans.

‘Food and children’s education is the most expensive. Once or twice I took loan from the union which I returned later on.’ (Female respondent)

‘Often we have to take loans to tackle health issues. Rs. 10,000 in a year.’ (Female respondent)

6.3 Discussion – Rest and nutrition

One main aim of the IGMSY scheme is to allow women to take rest and increase their nutritional intake by providing compensation for wage lost. Analysis of the comments given during the interviews shows a woman’s capability to take time off to rest is limited. The women are still expected to complete household chores and may have limited options for taking rest due to living at their mother-in-laws. The gender inequality found in India as discussed previously in the theoretical chapter creates a cycle of maternal ill health. Culturally the women eat ‘last and least’ ensuring that the men and children of the house are fed (Neogy, 2010:479). This gender inequality creates a cycle of poor maternal health as shown by figure 3.2, where babies are born with a low birth weight and grow up to have a short stature and low body mass index, continuing the cycle (Gill et al. 2007). The factors leading to this can be considered using Sen’s capabilities approach (1999), that as a result of gender inequality and cultural practices a woman’s capability for rest and nutrition is reduced.

The issue of malnutrition in India is widespread. Around the world 25% of the population suffers from anaemia (Rohilla et al. 2010) within India a staggering 52% of women suffer from anaemia (NFHS-2, 1999). The IGMSY scheme aims to provide

women with the opportunity for rest and nutrition during maternity. Increasing nutrition during the final trimester of a pregnancy is unlikely to have a large impact on the woman's health as it will not substantially increase her body weight and is unlikely to undo the effects of years of malnutrition and anaemia. However it is likely that the increased nutrition and encouragement to breastfeed will have an impact on the babies health. To stop the cycle of maternal ill health this increased nutrition needs to continue on through infancy/childhood to adolescence and adulthood. Whilst the rest and nutrition may not help a woman's body mass index or problems of stature, encouraging rest during maternity will help. The International Labour Organisation advocates fourteen weeks maternity leave, with six weeks of those being compulsory post-natal leave (ILO, 2000). This maternity leave is seen as important as taking rest during pregnancy and after birth reduces the chances of complications and so may help to reduce the problems of maternal morbidity.

The aim of the benefit to allow women to take time off and increase their nutrition is compounded by the fact that women are often not the main decision makers of the household. This means that they may not be able to use the extra money towards increased nutrition. If additional food is bought with the IGMSY money due to cultural and behavioural practices the women may not be the recipients of any of the extra food as the feeding of the men and children of the household is seen as the priority. The research showed that the time off after birth was also dictated by the family rather than the woman. Partly this is due to the need of the daily wage by the household. The interviews showed that the decision making power regarding expenditure lies with the male members of the household and therefore costs for health linked to pregnancy and the birth may not be a key concern. For all the benefits and aims of the scheme to be enjoyed consideration needs to be given towards the patriarchal nature of Indian society causing the women to have reduced autonomy over decisions.

6.4 Summary

From the previous chapters and the data provided above it is clear that one of the biggest issues relating to rest and nutrition is that of autonomy. The patriarchal culture in India means that women often lack decision making power. There is a lack of autonomy over the ability to seek healthcare, visit family or going out alone. With

regard to the IGMSY scheme the data shows that women may find it difficult to make decisions about rest and nutrition during pregnancy. The data shows there are high levels of anaemia and problems with infant malnutrition however due to cultural constraints creating a lack of autonomy it is not clear whether the women will be able to benefit from the scheme.

7 Criteria of the scheme: who is excluded?



7.1 Introduction

This chapter considers the inclusion and exclusion criteria of the IGMSY scheme. The scheme is only intended for the first two live births and the beneficiary also needs to be a minimum of nineteen years old. This criteria raises a concern that in rural areas the criteria will result in a number of women being excluded from the scheme. Interviews, focus groups and secondary data are used in this chapter to gauge how many women will be excluded from the scheme. The women were also asked about their opinion on the selection criteria.

7.2 Analysis – Criteria of the scheme

There are two main parts to the eligibility criteria of the IGMSY scheme. The first is that the woman must be aged nineteen years or over and the second that the scheme is only intended to aid with the first two live births.

One concern before the research was conducted was that by having a minimum age there would be women in the rural areas that this scheme excluded. When health officials were questioned about the reasoning for the age of nineteen years it emerged that it was the result of a number of factors, one being the legal age for marriage (eighteen for girls and twenty-one for boys) and the second that below this age the body is not physically prepared for pregnancy. Table 7.1 contains data from the latest district level household survey and shows that the average age for marriage is around the legal ages of twenty one for boys and eighteen for girls. However the data also shows that during the period in question (1999 – 2001) nearly 48% of boys and 37% of girls married below the legal age in the rural areas. When this is restricted to women aged 20-24 years old nearly 60% of those in rural areas were married before the age of eighteen years old.

Table 7.1 Uttar Pradesh - Key Indicators (DLHS-3, 2008)

Indicators	DLHS-3 (2007-08)		
	Total	Rural	Urban
Marriage			
Mean age at marriage for boys (marriages that occurred during the reference period) ¹	21.6	21.1	23.9
Mean age at marriage for girls (marriages that occurred during the reference period) ¹	18.4	18.0	20.4
Boys married below age 21(marriages that occurred during the reference period) ¹ (%)	43.3	47.9	22.3
Girls married below age 18 (marriages that occurred during the reference period) ¹ (%)	32.9	37.1	15.2
Currently married women age 20-24 who were married before age 18 (%)	54.9	59.1	30.8
Fertility			
Births to women during age 15-19 out of total births ¹ (%)	6.3	6.8	4.0
Women age 20-24 reporting birth of order 2 & above ¹ (%)	57.9	59.0	51.3
Women with two children wanting no more children (%)	53.2	55.3	43.0
Mean children ever born to women age 40-44 years	5.5	5.6	4.9

¹ DLHS-3 reference period is from 1-1-2004 to survey date; DLHS-2 reference period is from 1-1-1999/1-1-2001 to survey date.

It was thought that the age barrier would cause the exclusion of many women in rural areas. From the results shown in table one it would be fair to assume that the scheme will indeed exclude a reasonable amount of women in the rural areas. However the sample frame of women for the study included no women pregnant or lactating below

the age of nineteen years old (from the list provided by the anganwadi worker). When the local women were asked whether women did marry and have children below the age of nineteen years they said this did not happen.

Case Study – Marriage customs in rural India

‘Those belonging to the general caste get married at an age between 25-30 years old. Here, scheduled caste and backward caste can be found more in number but they too are getting married at eighteen years old now and not before. If they do get married before eighteen, then the “Gauna” (*the tradition in which the girl remains in her own father’s house and does not sleep with her husband until she is eighteen years old*) is done.’ (Health worker)

One consideration to come out of the interviews was a statement made by one of the health officials when asked about whether there were pregnancies to women under the age of nineteen years.

‘Women in villages, especially those belonging to the lower caste do not know their right age. If you tell them about this scheme and then ask their age, they would not tell their age less than nineteen years. Mostly it happens that whenever Anganwadi / ASHA members ask their age, they in turn ask these health workers to write whatever they feel is the appropriate age. Moreover, whatever age is once written down in the registration card becomes a proof.’
(Local health official)

The comment made by the health official shows that marriage and births may take place below the age of nineteen years with subsequent documents detailing the wrong age. One reason for the confusion in age is the lack of birth certificates for those born in rural areas. Yet the list of pregnant and lactating women used for the sample frame did include one nineteen year old that was pregnant for the second time, and therefore must have had her first child below the age of nineteen years. Table 7.1 does show that 6.8% of births in rural Uttar Pradesh are from those aged 15-19 years old. If a girl married at eighteen and fell pregnant immediately it could be the case that her first child would be born when she is still aged eighteen years old. In the focus group sessions there was a girl who stated she was eighteen years old and was currently

pregnant and another girl who also stated she was eighteen years old and was breastfeeding her baby.

Women can also be excluded from the scheme depending on the number of children they have as the scheme is only available for the first two live births. Much discussion was had around why there was a limit of two children for the scheme. The main explanation given was that the criteria is linked to the government aims for family planning. Many women and even health workers commented that the benefit should be given to all pregnant women as the need for rest and nutrition is required by all for each pregnancy.

‘If we talk of humanity, then I think a woman pregnant for the third time should also get benefits but we have been pressurised from the authorities that we should make women more aware of having only two children.’ (Health worker)

It was also noted that the aim of the scheme is not to restrict the number of births but to improve maternal and infant health, and that more help is required with a higher order of births.

‘I think this scheme should be majorly for those who are having their third or fourth child as their bodies are weaker than the rest.’ (Female respondent)

Figure 7.1 shows that the average children ever born is 3.6 for the state of Uttar Pradesh and 3.4 for the district of Sultanpur. The average of children born per mother within the districts of Uttar Pradesh ranges from 2.9 to 4.2 (DLHS-3, 2008). Given that this figure shows the average of births it can help to show that many women would be excluded by the ‘first two live birth’ stipulation in the scheme’s selection criteria.

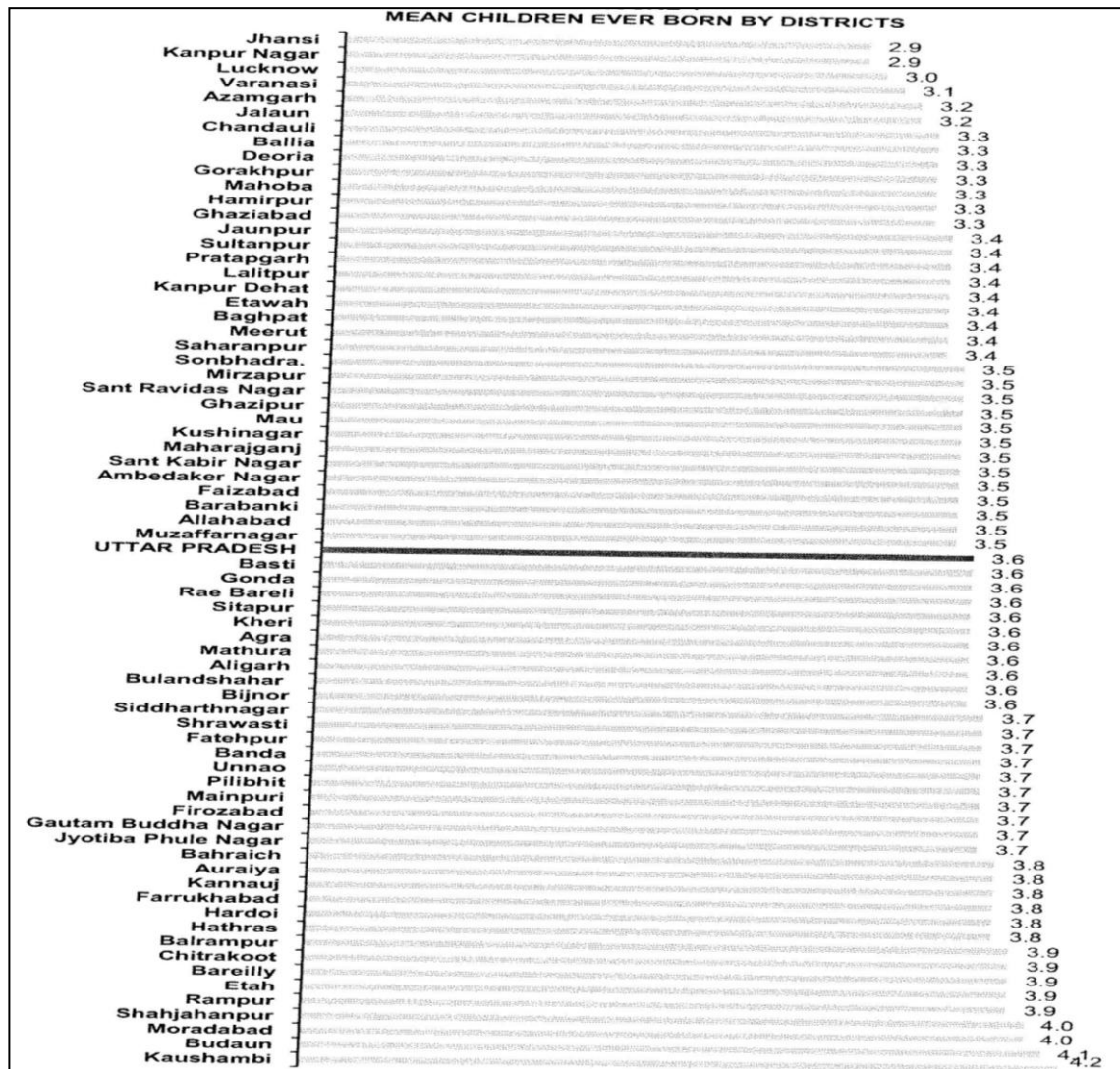


Figure 7.1 Mean children ever born by district (DLHS-3, 2008)

The two villages in the study have a total population of 5032 of which 65 were women currently breastfeeding and 43 were pregnant. From the list prepared by the anganwadi worker the number of women eligible for the scheme (currently pregnant with their first or second child or those breastfeeding their first or second child) accounted for 73% of those on the list. This means that the scheme would not be available 27% of those on the list. Those excluded had between 3-6 children. When

asked about the average number of births the women commented that many women had more than two children.

‘These days two or three deliveries are very normal hence the benefits should be extended to those as well who are getting pregnant for the third time.’
(Female respondent)

Women who suffer a still-birth would still be entitled to the first two payments of the benefit, but not to the third as this relates to child growth monitoring, immunisations and exclusive breastfeeding. As the scheme was not rolled out yet the health workers and local health officials did not know what would happen in the event of a miscarriage. When the women were asked their thoughts on this matter they agreed that the benefit should still apply as those women still need help with nutrition as such an event weakens their bodies.

‘I believe that the woman should get benefits of the scheme because even if she gives birth to a dead child or undergoes a natural miscarriage, then too her body suffers.’ (Health worker)

7.3 Discussion – Criteria of the scheme

The IGMSY scheme is not aimed as a family planning initiative. The government outlined the short term aims as improving maternal and infant health with longer term aims for increasing demand for services. Every woman has the right to food and rest during pregnancy. The 1978 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) which India has signed up to states that:

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

Other declarations such as that the Vienna Declaration (1993) or the world conference on women in Beijing (1995) all make clear that the specific rights of women and the ‘girl-child’ are an integral part of universal human rights. If the scheme aims to help achieve improved rest and nutrition for pregnant and breastfeeding mothers then there should not be a need for selection criteria. Each woman requires rest and nutrition with each pregnancy, not with the only the first two, and arguably as suggested in the

analysis those excluded could be worse off as those with higher order pregnancies and young mothers need the most help. From the opinions given during the interviews it is clear that the women and health workers felt that if the scheme is really aiming to aid rest and nutrition then it should be available for all and that this benefit is not the place to be making a stance on family planning. As the main aim of the scheme is to allow the women to increase their rest and nutrition it would be logical that the scheme be made available for everyone.

The lack of birth certificates in the area may lead to girls being excluded or included wrongly as it is not possible to prove their age. With the lack of structure for issuing birth certificates many women are unsure of their actual age. The age of nineteen years as a selection criteria is therefore difficult to assess and may lead to the responsibility for inclusion or exclusion being up to health worker.

The IGMSY scheme is not the only conditional cash transfer programme to have eligibility restrictions. The Bolsa Familia scheme in Brazil also caps the scheme at a maximum of three children per family. Unlike the IGMSY scheme, this restriction on the number of children does not mean that the scheme gives no benefits to families with more than three children. In the case of a family with more than three children the scheme still provides money but the amount is capped to the equivalent of three children (Lindert et al. 2007).

7.4 Summary

The concern with the selection criteria for the scheme was that the minimum age and limit on the number of births would exclude a number of women in the rural areas. The data from the district level household survey showed that 59% of women aged 20-24 years had been married before the age of eighteen years old, however, only 6.8% of them had a child below the age of nineteen years old (see table 7.1). This can be explained using the information from the focus group where the tradition of 'gauna' was explained. 'Gauna' is the practice where the girl becomes married but stays at her natal home until she is eighteen. The interviews highlighted another problem which is that many women in the village did not know their correct age or have a birth certificate and this needs to be considered when considering the quantitative data. Both the interviews and quantitative data suggested a number of

women would be excluded due to the number of births. The data from the district level household survey shown in table 7.1 gives the number of births to those aged 40-44 at 5.6 per female, but even only by the age of 24 59% of rural women have had at least two births and so would be excluded from the scheme. The women argued that the scheme should be available to all. The main aim of the scheme was to provide rest and nutrition, a longer term aim was to improve health seeking behaviour but nowhere does the scheme mention it is a family planning initiative. Other conditional cash transfers do sometimes cap the amount of benefit given to each household but do not exclude the households.

8 The conditions of the scheme



8.1 Introduction

The IGMSY scheme is a conditional maternity benefit which means that in order to receive the money certain conditions have to be met and is seen as incentivising the utilisation of health services. The conditions required for the scheme include registering the pregnancy, attending antenatal visits, taking iron and folic acid supplements, having the necessary immunisations, registering the birth of the child, growth monitoring of the child, getting the child immunised and exclusive breast feeding for six months. In order for the women to be able to complete the conditions required for the scheme they have to be available and accessible as outlined in chapter three. This chapter analyses the practicalities of these conditions given the data from the field. Photographs and observations were made of the available services and a case study is given about the experience of using these services. The supply side constraints are considered and data is provided from the local health official and local health workers. Other barriers identified in the field (financial, cultural norms and issues of corruption) are also discussed. The chapter ends by examining the reality of breastfeeding in rural India and therefore how achievable the condition of six months exclusive breastfeeding is in this environment.

8.2 Analysis – Conditions of the scheme

The health services in the research area include a local primary health centre, an anganwadi centre, a sub-centre and the block level primary health centre not too far away. Both the village primary health centre (figure 8.1) and sub-centre buildings (figure 8.3 and 8.4) were in a state of disrepair. The sub-centre building had almost completely fallen down and was not in use, the auxiliary nurse midwife confirmed that she instead gave services from a local woman's house. The local primary health centre was found to have one room in use (see figure 8.2) where a doctor supposedly sits for a few hours a day, however this is at no set times and they were not present during the field observation.



Figure 8.1 Local primary health centre (photo taken by the student)



Figure 8.2 The one room in use at the local primary health centre (photo taken by the student)

The interviews confirmed that the building of the primary health centre has been in this condition for the last ten years and that the local sub-centre is in an even worse condition (figure 8.3 and 8.4).



Figure 8.3 Sub-centre (photo taken by the student)



Figure 8.4 View inside the sub-centre (photo taken by the student)

Although there should be a building for the anganwadi workers to be based there was no anganwadi centre in the area. Instead a local school was used as a base with the anganwadi workers using the Panchayat building on a Saturday in order to distribute nutrition grains.

The field observations and interviews showed that there was not just a problem with the buildings of the local health services. Most women reported a lack of services at both the primary health centre and the sub-centre.

‘For blood pressure, blood and urine- facilities for checkups are not available.’
(Female respondent when questioned about the primary health centre)

‘She (ANM) comes once a month on Saturdays. When I went to get myself vaccinated, she did not check my weight nor conducted any tests.’ (Female respondent when asked about the sub-centre)

Table 8.1 shows that over 60% of women in rural areas do at least receive one antenatal check up. This is much lower than the 73% in the urban areas. The number of women receiving an antenatal check during the first trimester of pregnancy is low in both the rural and urban areas. Very few women, as suggested during the interviews and substantiated by the data in table 8.1, receive the advised full antenatal check ups which include three antenatal visits, one TT injection and 100 iron and folic acid tablets. Despite nearly 63% of women in rural Uttar Pradesh receiving one antenatal check only 2.7% receive all the advised antenatal care (DLHS-3, 2008).

Table 8.1 Antenatal care in Uttar Pradesh (DLHS-3, 2008)

Antenatal care (based on women whose last pregnancy outcome was live/still birth during the reference period):			
Indicator	Total	Rural	Urban
Mothers who received any antenatal check-up (%)	64.4	62.7	73.6
Mothers who had antenatal check-up in first trimester (%)	25.1	23.2	35.4
Mothers who had full antenatal check-up ² (%)	3.3	2.7	6.6
Mothers who consumed 100 IFA Tablets (%)	41.6	42.6	36.5

¹ DLHS-3 reference period is from 1-1-2004 to survey date; DLHS-2 reference period is from 1-1-1999/1-1-2001 to survey date.

² Full ANC: At least three visits for antenatal check-up, one TT injection received and 100 IFA tablets or adequate amount of syrup consumed.

However it was also clear that even when services are offered the women sometimes choose not to use them.

‘I went there to get the injections but did not take iron tablets as I don’t like it.’
(Female respondent when talking about the primary health centre)

‘One day a month the ANM comes and also doctor who is responsible for government hospital comes daily but no one goes there.’ (Female respondent when talking about the primary health centre)

From the interviews it appears that although few women had their growth monitored or blood pressure checked most women received TT injections and iron tablets during pregnancy. A few examples of this imbalance of services were noted during one of the focus group sessions.

Case Study - Services

Before one of the focus group discussions two pregnant women showed us their pregnancy cards. On the card is a list of observations and measurements to be taken at each appointment. These include: weight, measurement of stomach, heartbeat of the baby, situation of the baby, condition of the body (any swelling), blood pressure, TT injections and number of iron tablets. Of all the points to be done (at all three appointments) one woman had only received the TT injections and the other had received the TT injections and the iron tablets (2x50 tablets). Another woman whose child is two years old said the girl had never been vaccinated. When asked why, she said that since her husband was working and she was all alone and therefore unable to reach the services.

Table 8.1 shows that nearly 43% of women in rural Uttar Pradesh completed the necessary course of iron tablets. The distribution of TT injections seems far more widespread than other antenatal services from the data gathered during the interviews. This assumption is further supported by data collected during the district level household survey. Figure 8.5 shows that in the research area of Sultanpur over 80% of women were given at least one TT injection during pregnancy. This supports the evidence given during the interviews where most women spoke of receiving a TT injection and some iron tablets although no often no other monitoring such as blood pressure or growth.

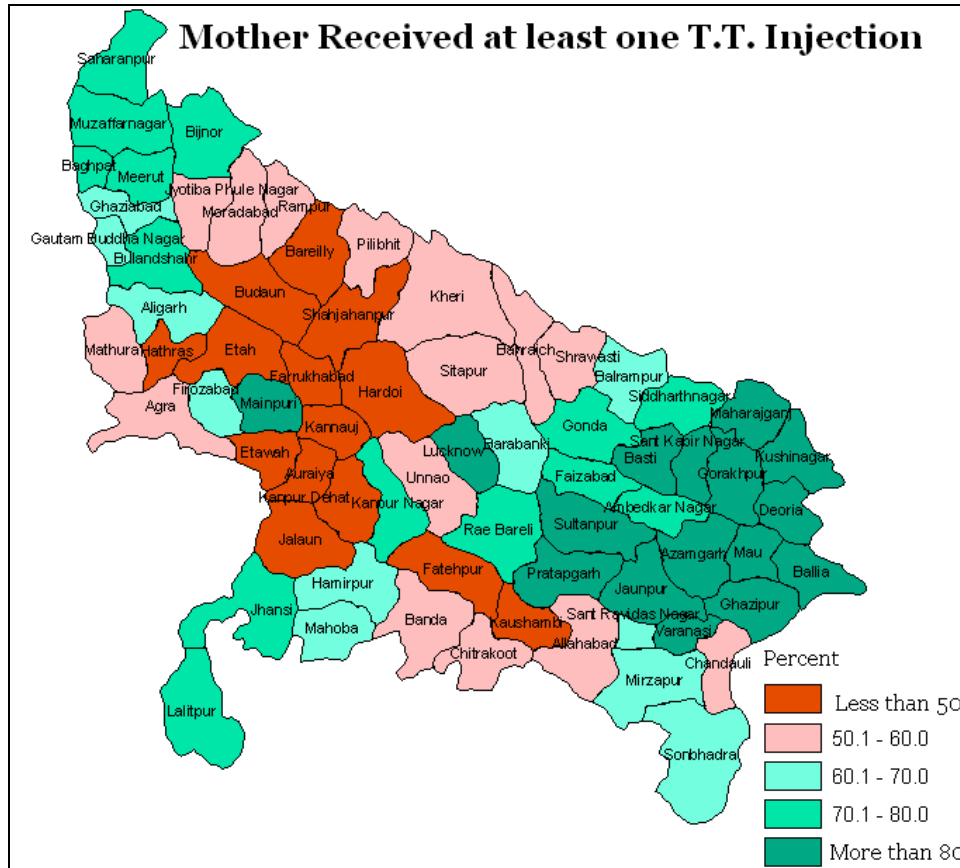


Figure 8.5 Mother received at least one T.T. Injection by district (DLHS-3, 2008)

Although the distribution of TT injections for pregnant women may be seen as widespread there are still problems with immunisation of children. In the case study above a woman explained how her two year old child had never been given an immunisation, the reason being the mother’s difficulty in reaching the services. Table 8.2 shows that in rural Uttar Pradesh only 29% of children have been fully immunised. The cases of no immunisations at all are not a common occurrence with only 3.5% of children having not received any vaccinations at all (DLHS-3, 2008). Other immunisations differ in their coverage with the BCG vaccination being given to 73% of children in rural areas compared to the DPT vaccination which is given to around only 38% of children (DLHS-3, 2008).

Table 8.2 Child immunisation in Uttar Pradesh (DLHS-3, 2008)

Child Immunization			
Indicator	Total	Rural	Urban
Children 12-23 months fully immunized (%)	30.3	29.4	35.3
Children 12-23 months not received any vaccination (%)	3.4	3.5	2.9
Children 12-23 months who have received BCG vaccine (%)	73.4	73.1	75.1
Children 12-23 months who have received 3 doses of DPT vaccine (%)	38.9	37.9	44.6
Children 12-23 months who have received 3 doses of polio vaccine (%)	40.4	39.5	45.3
Children 12-23 months who have received measles vaccine (%)	47.0	45.8	53.7

The block level primary health centre (figure 8.6) is where most women described going for health services.



Figure 8.6 Examination room in X PHC (photo taken by the student)

The experience at X block primary health centre appears to be mixed, with services available but often only at a cost.

‘They do not conduct any sort of tests. When we say we have pain in stomach, then they make us lie down and then touch us to check and for this they charge Rs. 20 for this.’ (Female respondent)

Women spoke of being treated with a lack of care by staff, where as others see the staff at the block level primary health centre as more skilled than in the local PHC.

‘Once she (ANM) vaccinated a child in my house who fainted soon after getting vaccinated. Since they are not skilled we, prefer going to X for vaccinations.’ (Female respondent)

‘When I went to X for the first time, then the nurse injected in me without asking me anything, she did not make any card, just wrote it on a piece of paper. She didn’t examine me, nor did she ask how many months pregnant I am.’ (Female respondent)

The supply side problems are not just related to the state of the buildings. One local official gave a clear picture of the constraints that hamper him from delivering a better health service.

Case Study – Supply side constraints at X block PHC

‘There is many problems. Problems related to infrastructure, we do not get the infrastructure within time and when we need it, all types of infrastructure, including equipment and medicines. Before March we had no iron tablets, in March we got 200,000 iron tablets (end of financial year), what are we supposed to do, how do we give services at the time that women need it? We always get at the end of the financial year. Everyday we have 5-6 deliveries and we don’t enough wards or beds for this. There is no drinking pure or safe drinking water for everyone in India so how can you say that they get the benefit from this kind of scheme. There is no light, water, building and night security for we people (officials) without these things how you expect we will be able to give services. If people will come to the primary health centre from village to take the services they spend twenty rupees on transport, so how many times will they be able to come here. I am sure that conditions will not be fulfilled by the women because from two years we just focus on immunisation and yet there are still people not reached.’ (Local health official)

Unless the basic infrastructure of services is strengthened it is unlikely that women like this would be able to complete the required conditions to allow them to qualify for the benefit. From the interviews and focus groups it is clear that not all the necessary antenatal checks are completed, sometimes this is a result of the woman failing to attend the service but most examples were that the service was not fully provided by the health workers.

To complete the conditions is dependent not just on what services are available but what is accessible. The women interviewed mentioned numerous problems surrounding the conditions required in order to obtain the benefit. To be eligible for the benefit requires multiple visits to services. The need for multiple visits to services may not be possible for all the women due to the loss of the daily wage and family constraints not allowing her to travel. These are problems that create a lack of demand for services. A conditional cash transfer is usually put in place to help reduce demand side problems of health services. However it is often not that simple. In the area the research took place women explained about the number of barriers they faced in reaching services. For many women travelling alone impossible and therefore

accessing the services is difficult. If a family member is taken along then this causes the loss of another wage and the expenses of a second person must be paid. Also to travel the services is not easy and women commented on having to make repeat journeys. Another consideration is a lack of female staff. One woman commented that X block primary health centre was too far to travel but that the local PHC did not have a female health worker, therefore she often sought the advice of a quack (unqualified doctor) for herself and her child as this is what is accessible to her. Many of the women interviewed admitted to the use of ‘quacks’ (unqualified doctors) and other private services. This was found to be due to numerous reasons such as ease of accessibility, the cost of government services and a distrust of staff.

‘Since the expenses in the private as well as the Government hospital is more or less the same, hence we prefer going to a private doctor/hospital.’ (Female respondent)

‘Apart from the medicines, jhaad phoonk (black magic) is also going on to remove all the evil spirits that are riding on me.’ (Female respondent)

The biggest barrier to accessing services was that of cost. Maternal health services in India are supposed to be free. One major finding of the research was that all the women spoke of having to pay to use the health services whilst pregnant.

‘As soon as I reached there (X primary health centre), the nurse took me inside and administered two injections. Thereafter, the child was born. The nurse then said that injections and medicines are not free of cost. Then I had to pay her for medicines and injections.’ (Female respondent)

‘When my child was born in X, the nurse took Rs. 500; dai took Rs. 150 for cutting the umbilical cord and Rs.500 for birth certificate. ASHA Bahu initially said that it would take only Rs. 500. After coming back from there, ASHA also took Rs. 50 from us.’ (Female respondent)

‘If a woman doesn’t have money, then she is forced to get a loan first and then come for delivery etc. they make sure that whoever comes to X does pay first and then get the facilities.’ (Female respondent)

Case study – Cost of services

Another woman said that once she took her daughter-in-law for delivery to X (block level primary health centre). The woman stated that she not only gave money for all the facilities but also her daughter-in-law's sari was asked by the nurse there. Her daughter-in-law had just one sari so the nurse said that when she would come next for the vaccinations, then she should get one sari for the nurse. From then on, she explained whenever her daughter-in-law went to get the child vaccinated, she hide herself each time so that the nurse did not see her.

Women were not just concerned about the cost of paying for services but the possibility of having to pay money in order to receive the benefit.

Case Study – Corruption

One woman told of her experience with another benefit in which she was asked by officials to give them money before they would provide her with the signature required to obtain the benefit.

‘There is a scheme by which for the first or second girl baby some money is fixed from the government in the name of that baby and when she turns 18 years old she will get that money (20,000 rupees). When I went to take sign of auxiliary nurse midwife and child development protection officer the auxiliary nurse midwife demanded 400 from me to sign and when I went to the child development protection officer she told me it is a big money scheme for your baby girl so give me 2000 rupees and then I will sign the form. This happened in that scheme. It is my concern that in this scheme the money is in three parts. When we go to auxiliary nurse midwife, accredited social health activist, or anganwadi worker they will probably ask for money to sign. That is my concern. It means we will lose more money than we will get.’ (Female respondent)

The rest of the conditions relate to services being available or accessible to the beneficiaries. One of the final conditions is impacted by very different problems, the final payment of the benefit is dependent on the achievement of six months exclusive breastfeeding. The key components of this condition include six months exclusive breastfeeding and to encourage the first feed within one hour of the birth. Table 8.3

shows that within rural Uttar Pradesh only 15% of mothers feed their baby within the first hour, this first feed is important as it contains the colostrum which can help aid a child's immune system.

Table 8.3 Child feeding practices in Uttar Pradesh (DLHS-3, 2008)

Child feeding practices (based on last-born children)			
Indicator	Total	Rural	Urban
Children under 3 years breastfed within one hour of birth (%)	15.4	15.2	17.0
Children age 6-35 months exclusively breastfed for at least 6 months (%)	8.2	8.5	6.7
Children age 6-9 months receiving solid/semi-solid food and breast milk (%)	54.5	54.9	51.6

The women interviewed were found to feed their children for varying lengths of time (6 months to 4 years). When asked specifically about the length of time for exclusive breastfeeding most women knew that they should exclusively feed for 6-7 months. This does not seem to be a regular practice though as table 8.3 shows that only 8.5% of babies in rural Uttar Pradesh are exclusively breastfed for six months. Possible reasons for this low number were provided during the interviews with the village women. One such reason was that many of the women interviewed explained that they experienced problems producing breast milk.

‘I don’t produce milk at all and I am sure there are many such women who are unable to produce milk. Government should think about this as well.’ (Female respondent)

The women who worked also explained that they faced difficulties breastfeeding their child and working.

‘Before going to work we feed the baby and in the afternoon we come back and feed the baby and in the evening we feed regularly. It is not easy to take the baby to the work, it is warm and there is no place to put baby.’ (Female respondent)

8.3 Discussion – Conditions of the scheme

The long term aim of the IGMSY scheme is that by linking the cash benefit to a number of conditions there will be a change in behaviour and attitude towards health care over the long term. There are a number of barriers to health care which can be considered as barriers of demand and barriers of supply. The barriers of demand to health care include the location of the service, the cost (both financially and in time), and prevention due to cultural norms (Ensor and Cooper, 2004).

To complete the conditions necessary for the scheme would require the women to travel to services numerous times. A lack of infrastructure in the area makes reaching the services difficult, as does the loss of the resulting daily wage. Through the information gathered during the interviews it was clear that there was a lack of demand for services as a result of the distance to the service and the resulting loss of a daily wage. The women also spoke of the expected cost of the services once they are reached being a barrier. As a result of these problems the women often sought care from an unskilled doctor (quack) instead.

It was also found that women struggled to access the services as a result of family constraints. As child birth is seen as a natural role for a woman families are often willing to spend household income in order for her to access services (Gill et al. 2007). This notion was discussed by many of the women during the research, along with the inability to travel alone hampering them from accessing health care. Many husbands were found to work away which limits the services the women can access, also if another family member is taken along this results in the loss of a second daily wage, causing further hardship for the family.

The problems of demand for health care can be seen as barriers to accessing health care. Often even if the service was available as a result of issues with demand the service would still not be accessed. The aim of a conditional cash transfer is to overcome these demand side issues. A conditional cash transfer aims to increase the utilisation of services by overcoming demand issues using a cash incentive (Barber and Gertler, 2009). However, a conditional cash transfer can not help to overcome supply side issues.

Barriers of supply to health care include a lack of skilled staff, lack of equipment and drugs, the expectation of bribes and infrastructural barriers. This can also be considered as the problems with the availability of health services. In the research area it was found that many of the services required to complete the conditions were missing. Local officials complained of a lack of drugs and a limited number of beds. From the data gathered it is apparent that there is a lack of infrastructure in the area. Photographs of the local health services show the buildings in a state of disrepair and in the case of the sub-centre completely abandoned.

A problem with corruption also reduces the both the availability and accessibility of services. A study by Jeffery and Jeffery in Uttar Pradesh found instances of illegal demands for payment and discriminatory practices by health staff to be common (2010). This issue came up in nearly every single interview and focus group. Many interviewees complained of the treatment received by health staff and of a mistrust for the health workers. That women are made to pay for services which should be free and a general mistrust of staff causes many to instead seek help from private and unqualified doctors (quacks).

The research has shown that the condition of six months exclusive breastfeeding, will be difficult for working women to fulfil. Little thought has been given to those women that do not produce any milk, which is often a consequence of malnutrition or a result of a high order of pregnancies. Women are aware that six months of exclusive breast feeding is the ideal but this is not matched by the reality in which they live.

8.5 Summary

The research data helps to show that to achieve all the necessary conditions in order to qualify for the benefit will be very difficult. The health services in the research area clearly lack investment or are often just not available. One of the findings of the research was that sometimes even when a service was available it was not accessed. A conditional cash transfer can increase the utilisation of services by offering a cash incentive however the research showed that there will be a problem in fulfilling all of the conditions. Not only are all the conditions clearly not available but the scheme does little to consider the social and cultural barriers that prevent a woman from accessing health care.

By using a conditional cash transfer approach the suggestion is being made that the low utilisation of health services is the result of issues with demand rather than issues with supply. The data from the research shows that there are clearly problems with both sides and so there needs to be an investment in health services as well as a benefit to incentivise women to use health services.

9 The scheme



9.1 Introduction

The final empirical and discussion chapter ends with opinions on the scheme collated during the research. The previous chapters have already considered the selection criteria of the scheme and the conditions necessary for the scheme in relation to the research area. As the aim of the scheme to increase a woman's rest nutritional intake the current practices of this have also been explored (so as to provide a baseline for further research). This chapter collates together the recommendations and opinions given about the scheme from the village women, local health workers and local health officials. Opinions were given as to how the final cash incentive should be transferred to the beneficiary, whether a conditional benefit is the right approach and what aspects could be improved. The IGMSY scheme is then compared to successful conditional cash transfer schemes in Mexico and Brazil (from chapter three) as to what parts of the scheme is similar and what is different.

9.2 Analysis – The scheme

In order to receive the cash incentive the women need to be able to access a bank account as that is how the money will be transferred. The women were asked for recommendations and thoughts on the scheme, particularly about how the money should be transferred and whether this transfer would be better given as three separate amounts (as shown in table 4.1) or one lump sum. The majority of the respondents agreed that the money from the benefit was better given in three instalments as this allowed them to better control how and when the money was spent.

‘It is good if we get it in three instalments. Money is one thing that we spend once we get it in hands.’ (Female respondent)

‘If given in one time it will not be used for the health of the women but by others.’ (Female respondent)

The money from the benefit has to be transferred into a bank account. Questions were asked during the research as to how many women had access to a bank account. It was found that some women have their own account but all stated that they at least had access to an account within the family.

‘Most of the women work in NREGA and hence all of them have an account already opened.’ (Health worker)

‘I don’t have a bank account but my father in law has one, if money is transferred to that account, I can easily get it.’ (Female respondent)

The conditions required for the scheme were commented upon by all the women and health workers. The majority agreed that it would not be possible to comply with all of the conditions as they were not all available.

‘All the clauses mentioned in the scheme cannot be fulfilled. We are trying our best from our side.’ (Health worker)

Most agreed that in fact the conditions could be met at the block level hospital. However, to access this health centre is difficult for those that are far away or for those who are daily wage earners.

‘Only those who stay at home can fulfil this scheme well, for those of us who stay away for work, it is difficult for us..... If we will go to block (hospital) not only spend money to get to service and at the service but we also lose our daily wage.’ (Female respondent)

Most women and health workers agreed that to have conditions was necessary but that they must be attainable.

‘It is important to have conditions as it results in better health of mother and child.’ (Health worker)

‘Conditions should be limited up to an extent that women can fulfil them. They (policymakers) should realise that women have to go for work as well and X block is very far off.’ (Female respondent)

Some final quotes point to question as to whether a conditional cash transfer is the right approach. As the initial aim of the scheme is to provide rest and nutrition for women during maternity there were concerns with the exclusion of some women. Whilst one positive of the scheme is that it is not just for women below the poverty line, the limit of two children still excludes many women. The exclusion of some

women raised a concern for the health workers who explained that those who are excluded will blame them.

‘The scheme should be for all or for none else the beneficiaries will fight with us.’ (Health worker).

The opinion was raised by many of the respondents that the infrastructure of the local health services was not strong enough to support the scheme and that the required conditions could not be met. It was also suggested that not including health education or the dissemination of information at times such as village meetings was an oversight.

‘You should first provide us with facilities and then talk about benefits.’
(Female respondent)

‘There are so many schemes and they do not succeed and Indians are not getting the benefit of any of these schemes because we first have need to improve health education and health infrastructure.’ (Local health official)

9.3 Discussion – The scheme

A scheme using a conditional cash transfer approach can have low levels of participation if the money being offered is too low or if the conditions are believed to be too demanding (Das et al. 2005). From the interviews with the village women and local health workers it was clear that most thought the conditions would be difficult to comply with without travelling to the block level health centre and therefore losing their daily wage. With corruption being described as ubiquitous the women voiced concern that they in order to complete the conditions the costs would be higher than they ultimately receive. The women, health workers and health officials all agreed that the money would be helpful for the women as long as they receive it but suggested that perhaps the government is attempting too much and that first the infrastructure required for the necessary conditions should be strengthened.

The cash benefit under the IGMSY scheme is given to the mother. Giving the benefit money to the mother has been found in a number of research projects to be the most beneficial (Adato et al. 2000). This notion of women spending the money best also

came across during the interviews when women explained that if the money entered the household in one lump sum the money would be used by others for different purposes. The Mexican and even Brazilian scheme had a much more inclusive approach. Although the Brazilian scheme does have a cap for the number of eligible children this does not exclude households with more but just means they get no further money for children in addition to the first three (Lindert et al. 2007). The IGMSY scheme excludes women who already have two living children and offers them no help with rest or nutrition during maternity. The scheme will hopefully reduce stigmatism of being involved in such programmes as it is not just aimed at women below the poverty line (Fiszbein et al. 2009). It could be argued that the sensible approach is that of the Brazilian Bolsa Familia where all households are included but more money is given to those in those in the worst poverty.

Another big difference between the approach of the conditional cash transfer schemes in Latin America and the IGMSY scheme is the lack of family involvement. The Latin America schemes include an educational component where topics of health and hygiene are discussed at local meetings and all adult members of the household are required to be present (Barber and Gertler, 2009). For there to be a serious attempt to change the patriarchal nature of India and change the feeling of ambivalence toward maternal health the scheme needs to involve health education and dissemination of information and this needs to be given to the women, their husband and mother-in-law.

9.4 Summary

The majority of women interviewed admitted to being able to access a bank account and agreed that to receive the money in three payments would reduce the chances of the money being used for something else. There was a great deal of concern as to whether the conditions can be met but all agreed that some form of conditions were necessary. However there was a clear consensus that there needed to be large supply side investments to ensure all the conditions are available and that the benefit should be given to all women. When compared to the successful conditional schemes in Mexico and Brazil the IGMSY scheme is similar in that it gives the money to the mother. Another positive of the scheme is that it is not just aimed at women below the poverty line, which may reduce the stigma of receiving the benefit. With the selection

criteria the scheme does exclude a number of vulnerable women and also lacks the family involvement seen in the Latin American schemes. By ignoring the family the IGMSY scheme is missing the opportunity to increase health education and make positive changes to some of the current cultural norms.

10 Conclusion



By the deadline of 2015 India is likely to have failed to reach a number of the millennium development goals. Two targets that India is currently unlikely to meet are the reduction of the under-five mortality rate and the reduction of the maternal mortality rate. Schemes such as the IGMSY scheme can be seen as a response to the probable failings of India to meet these goals.

The rates for infant mortality and maternal mortality are high in India for a multitude of reasons. Health care in India has been underfunded for years and there has been a heavy urban bias despite the majority of the population being rural. India is also a highly patriarchal society leading to wide disparity in gender equality. Examples of some of the shocking consequences of this gender inequality include; female foeticide and infanticide, dowry deaths and instances of sati. The consequence of India's high gender inequality also leads to less high profile but far more widespread examples of malnutrition, maternal morbidity and maternal mortality. The preference of sons in India has created a cultural practice of women eating after men and usually substantially less which creates widespread malnutrition among girls and high numbers of cases of anaemia. The system of gender inequality creates an intergenerational cycle of maternal ill health with babies being born with a low birth weight, the girls then grow up to have a small stature and low body mass index, further complicated by not gaining the necessary weight during pregnancy and in turn giving birth to a baby of low birth weight. Women with a low weight and small stature also have increased chances of complications during pregnancy and delivery that could lead to maternal morbidity or mortality. Maternal health outcomes are further compounded by the resentment of the use for household income to pay for health services during maternity as it is seen as a natural event.

The IGMSY scheme aims to improve maternal health. The short term aim of the scheme is to increase the availability of rest and nutrition during maternity, with a longer term aim of increasing health seeking behaviour. This could help to improve India's millennium development targets for maternal mortality and infant mortality. The premise is that by providing wage compensation women can take time off from work to rest and also increase their nutritional intake. One issue with this assumption is that it fails to take note of the lack of autonomy women have within the Indian household. Women often work right up until the birth of their child. Taking rest is often difficult due to the responsibility of household chores and family constraints.

Often the women have limited time off after delivery as there is a need to earn a wage again as soon as possible. The money given as part of the IGMSY scheme may help increase the rest taken but often when to stop work is not in the control of the woman herself. The scheme is further hampered by cultural beliefs that working during pregnancy leads to an easier birth.

With regard to increasing a woman's nutritional intake a large number of women in India are undernourished. Despite this their priority is often that of their children and the household. One concern is that as women do not have the decision making power in the house they may not be able to determine how the money is spent or negotiate additional food for themselves. The extra nutrition if it was received would be given in the final trimester of pregnancy. This is too late to make much of an impact on maternal health although may help increase the birth weight of the baby. In order to reduce maternal mortality help needs to be given in infancy and adolescence to increase a girl's weight and reduce the chances of malnutrition and anaemia. This requires the issue of gender inequality and system of patriarchy to be tackled.

The IGMSY makes no reference in its aims to family planning and therefore questions are raised as to why the scheme is limited to the first two births. If the main aim to increase rest and nutrition then the scheme should be available for all. Other schemes using a conditional cash transfer approach do impose some limits but not absolute exclusion. The Brazilian Bolsa Familia scheme caps the payment to families at the equivalent of the cost for three children however those with more than three children can still receive the benefit. One positive aspect of the scheme is that it is open to all households, not just those below the poverty line, though it would perhaps be beneficial to provide some additional help to those that are the most impoverished.

It was agreed by most that for such a scheme conditions are necessary but that they should also be attainable and the cash proportional. It was clear from the research that the services and infrastructure were not of a standard so as to allow for the conditions to be met. There needs to be an increase in the funding of services to make sure all the necessary conditions can be completed. The research showed that women could usually obtain the required TT injections and iron tablets but that registration of the pregnancy often occurred late. The buildings the services should be given from were

in a state of disrepair and the women also described very little growth monitoring or counselling being given by the health workers.

It is important to consider not just what services are available to the women but what is accessible. The research showed that working women find it difficult to take time off from work to access services as they lose their daily wage and that this is further hampered by family constraints which prevent the women from travelling to services alone. Corruption was a major complaint of nearly every woman interviewed. High levels of corruption make services less accessible as staff are not trusted. The research found that women often sought the services of informal 'quacks' instead. When considering the conditions of the scheme it is important that all the services required are available but that thought is also given to accessibility.

A conditional cash transfer scheme should not be used when it is supply side issues that are causing a low utilisation of services. In the research area the buildings were dilapidated and mostly not in use, there was a lack of drugs, beds and generally weak infrastructure. The research showed that there is a need for major supply side investments in health services in the area in order for the conditions to be met. A conditional cash transfer can help to overcome demand related problems with accessing health services, however, if a scheme is going to be made conditional the conditions need to be attainable and not put pressure and blame on the women for the lack of utilisation. It is clear there are demand related factors that are reducing the use of health care in this area and these often stem from a lack of health education. In order to overcome some of the demand side issues there needs to be consideration of barriers such as cultural constraints which are unlikely to be overcome by financial incentives.

Conditional cash transfers have been successful across Latin America. One aspect of the success of these schemes is missing from IGMSY and this is the inclusion of the whole household. Due to a lack of autonomy women in India are often not the decision makers of the house and maternal health care is seen as a low priority. In order to change cultural beliefs and overcome the system of patriarchy the whole household needs to be made aware of the importance of maternal health and its impact on the next generation. Only then may there be a possibility in reducing the inter-generational poverty cycle and improving maternal and infant mortality rates.

11 Recommendations for future research



During this research the IGMSY scheme had not been fully implemented but once the scheme has been rolled out (after June 2011) and has been in place for the first cycle of payments, research could be done to assess the impact of the scheme. For a smaller project one area of the scheme could be looked into more carefully, such as the condition of six months exclusive breastfeeding, or the impact specifically to rest and nutrition. Sahayog has recently been given funding from DFID to begin a multi-state research project into the IGMSY scheme.

Other aspects that could be further explored could be some of the interesting observations made during this study. A study of health services in rural India looking at either accessibility or availability could be interesting and help to further the knowledge of health in rural areas. Another key finding was the frequent use of non-qualified doctors known as quacks. A study relating to the reasons for the use of these informal health service providers could also be of interest.

References

- Adato, M., de la Briere, B., Mindek, D., and Quisumbing, A., 2000. *The Impact of PROGRESA on Women's Status and Intra-household Relations*. Washington: International Food Policy Research Institute.
- Balarajan, Y., Selvaraj, S., and Subramanian, S., 2011. India: Towards Universal Health Coverage 4. Health care and equity in India. *The Lancet*. Article in Press.
- Barber, S., and Gertler, P., 2009. Empowering women to obtain high quality care: evidence from an evaluation of Mexico's conditional cash transfer programme. *Health Policy and Planning*. Vol. 24, pp. 18-25.
- BBC. 2010. India Country Profile. Available from: http://news.bbc.co.uk/2/hi/europe/country_profiles/1154019.stm [Accessed: 19 January 2011].
- Behrman, J., and Hoddinott, J., 2005. Programme Evaluation with Unobserved Heterogeneity and Selective Implementation: The Mexican PROGRESA Impact on Child Nutrition. *Oxford Bulletin of Economics and Statistics*. Vol. 67, No. 4, pp. 547-569.
- Blackburn, J., Brocklesby, M., Crawford, S., and Holland, J., 2005. Operationalising the Rights Agenda: Participatory Rights Assessment in Peru and Malawi. *IDS Bulletin* Vol. 36, No. 1, pp. 91-99.
- Bloom, S., Wypij, D., and Das Gupta, M., 2001. Dimensions of Women's Autonomy and the Influence on Maternal Health Care Utilisation in a North Indian City. *Demography*. Vol 38, No. 1, pp. 67-78.
- Bourginon, F., Ferreira, F., Leite, P., 2002. Ex-ante Evaluation of Conditional cash transfer Programs: The Case of Bolsa Escola. *Policy Research Working Paper* 2916. World Bank, Washington D.C.
- Brennan, L., McDonald, J., and Shlomowitz, R., 2004. Infant feeding practices and chronic child malnutrition in the Indian states of Karnataka and Uttar Pradesh. *Economics and Human Biology*. Vol. 2, pp. 139-158.

- Dahlgren G., Whitehead M. 1991. *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Futures Studies.
- Das, J., Do, Q-T, and Ozler, B., 2005. Reassessing Conditional cash transfer Programs. *The World Bank Research Observer*. Vol. 20, No. 1, pp. 57-80.
- Deneulin, S., and Stewart, F., 2002. Amartya Sen's contribution to development thinking. *Studies in Comparative International Development*. Vol. 37, No. 2, pp. 61–70.
- District Level Household Survey – 3 (Government of India). 2008. Available from: <http://www.rchiips.org/PRCH-3.html> [Accessed 21 January 2011].
- Ensor, T., and Cooper, S., 2004. Overcoming barriers to health service access: influencing the demand side. *Health Policy and Planning*, Vol.19, No. 2, pp. 69-79.
- Fiszbein, A., Schady, N., Ferreira, F., Grosh, M., Kelleher, N., Olinto, P., and Skoufias, E., 2009. *Conditional cash transfers Reducing Present and Future Poverty. A World Bank Policy Research Report*. Washington: The World Bank.
- Frediani, A., 2010. Sen's Capability Approach as a framework to the practice of development. *Development in Practice*. Vol. 20, No. 2, pp. 173 — 187.
- Freedman, L., 2001. Averting maternal death and disability. Using human rights in maternal mortality programs: from analysis to strategy. *International Journal of Gynecology & Obstetrics*. Vol. 75, pp. 51-60.
- Gauri, V., 2003. Social Rights and Economics: Claims to Health Care and Education in Developing Countries. *World Development*. Vol.32, No. 3, pp. 465-477.
- Gertler, P., and Boyce, S., 2001. *An Experiment in Incentive-Based Welfare: The Impact of PROGRESA on Health in Mexico*. Berkeley: UC-Berkeley Press.
- Gill, K., Pande, R., and Malhotra, A., 2007. Women deliver for development. *The Lancet*, Vol. 370, pp. 1347-1357.

- Binneken, van W., 2003. *Extending Social Security: Policies for developing Countries*. Geneva: ILO.
- Government of India. 2001. Census Data. Available from: <http://www.censusindia.gov.in/2011-common/CensusDataSummary.html> [Accessed: 12 January 2011].
- Government of India. 2007 District map of UP. Available from: <http://www.imd.gov.in/section/nhac/distforecast/uttar-pradesh.htm> [Accessed 23 January 2011].
- Government of India, 2010. *Approval of Indira Gandhi Matritva Sahyog Yojana (IGMSY)- a Conditional Maternity Benefit (CMB)Scheme*. New Delhi.
- Government of India. 2011. Census Data. Available from: <http://censusindia.gov.in/> [Accessed: 24 June 2011].
- Hamm, B., 2001. A Human Rights Approach to Development. *Human Rights Quarterly*. Vol. 23, No. 4, pp. 1005-1031.
- Hulme, D., 2007. Integrating quantitative and qualitative research for country case studies of development. Paper for the Global Development Network (GDN) meeting on 'Comparative Analysis: Methodological Workshop' in Beijing, January 2007.
- ILO. 2000. *Maternity Protection Convention, 2000 and Maternity Protection Recommendation, 2000*. Geneva: ILO.
- Jarvelin, K., and Wilson, T., 2003. On conceptual models for information seeking and retrieval research. *Information Research*. Vol. 9, No. 1, paper 163.
- Jeffery, P., and Jeffery, R., 2010. Only when the boat has started sinking: A maternal death in rural north India. *Social Science & Medicine*, Vol. 71, pp. 1711-1718.
- Johnson, H., and Mayoux, L., 1998. Investigation as Empowerment: Using Participatory Methods. In: Thomas, A., Chataway, J., and Wuyts, M., (Eds.) *Finding Out Fast. Investigative Skills for Policy and Development*. London: SAGE Publications.

- Lindert, K., Linder, A., Hobbs, J., de la Brière, B., 2007. "The Nuts and Bolts of Brazil's Bolsa Família Program: Implementing Conditional cash transfers in a Decentralized Context." *Social Protection Discussion Paper 0709*, World Bank, Washington, DC.
- Menon-Sen, K., and Kumar, S., 2010. *UNDP India Mid Term Review of the Country Programme Action Plan 2008-2012. FINAL REPORT*. Delhi: UNDP India.
- Meth, P., and Williams, G., 2010. Literature Reviews and Bibliographic Searches. In Desai, V., and Potter, R., (Eds.). *Doing Development Research*. London: SAGE.
- Miller, V., Veneklasen, L., Clark, C., 2005. Rights-based development: linking rights and participation – challenges in thinking and action. *IDS Bulletin* Vol. 36, No. 1, pp. 31-39.
- Mistry, R., Galal, O., and Lu, M., 2009. "Women's autonomy and pregnancy care in rural India: A contextual analysis". *Social Science & Medicine*. Vol. 69, pp. 926-933.
- NAMHHR. 2010. National Alliance for Maternal Health and Human Rights. "Towards Attaining Highest Quality of Maternal Health for the Marginalized In India". Available from: <http://namhhr.blogspot.com/> [Accessed 22 January 2011].
- National Family Household Survey – 2 (Government of India). 1999. Available from: <http://www.nfhsindia.org/nfhs2.shtml> [Accessed 21 June 2011].
- Neogy, S., 2010. Gender inequality, mothers' health, and unequal distribution of food: experience from a CARE project in India. *Gender and Development*. Vol. 18, No. 3, pp. 479-489.
- Obrist, B., Iteba, N., Lengeler, C., Makemba, A., Mshana, C., 2007. Access to health care in contexts of livelihood insecurity: A framework for analysis and action. *PLoS Med* Vol. 4, No. 10, pp. 1584-1588.

- Pallikadavath, S., Foss, M., and Stones, W., 2004. Antenatal care: provision and inequality in rural north India. *Social Science and Medicine*. Vol. 59. pp. 1147-1158.
- Paruzzola, S., Mehra, R., Kes, A., and Ashbaugh, C., 2010. *Targeting poverty and gender inequality to improve maternal health*. Washington: International Center for Research on Women.
- Penchansky R, and Thomas J. W, 1981. The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care*, Vol. 19, No. 2, pp. 127-140
- Pettit, J., and Wheeler, J., 2005. Developing Rights? Relating Discourse to Context and Practice. *IDS Bulletin* Vol. 36, No. 1, pp. 1-8.
- Raj, A., 2011. Gender equity and universal health coverage in India. *The Lancet*. Article in Press.
- Rawlings, L., and Rubio, G., 2005. Evaluating the Impact of Conditional cash transfer Programs. *The World Bank Research Observer*. Vol. 20, No. 1, pp. 29-55.
- Rohilla, M., Raveendran, A., Dhaliwal, K., and Chopra, S., 2010. Severe anaemia in pregnancy: A tertiary hospital experience from northern India. *Journal of Obstetrics and Gynaecology*. Vol. 30, No. 7, pp. 694-696.
- Sahayog. 2010. Available from: <http://www.sahayogindia.org/> [Accessed 21 January 2011].
- Scheyvens, R., Nowak, B., and Scheyvens, H., 2003. Ethical Issues. In: (eds.) Scheyvens, R., and Storey, D., 2003. *Development Fieldwork: A Practical Guide*. London: SAGE.
- Sen, A., 2001. *Development as Freedom*. Oxford: Oxford University Press.
- Shetty, S., 2005. Can a Rights-based Approach Help in Achieving the Millenium Development Goals? *IDS Bulletin*. Vol. 36, No. 1, pp. 73-75.

- Spagnoli, F., 2008. Human Rights in India. Available from: <http://filipsagnoli.wordpress.com/2008/08/19/human-rights-facts-54-the-indian-caste-system/> [Accessed: 20 January 2011].
- UN, 1995. Fourth World Conference on Women Beijing Declaration. Available from: <http://www.un.org/womenwatch/daw/beijing/platform/declar.htm> [Accessed: 15 January 2011].
- UNDP. 2009. *India Situational Analysis Are the MDGs achievable?* Delhi: UNDP India.
- UNDP. 2010. United Nations Development Programme: India. Available from: http://www.undp.org.in/whatwedo/poverty_reduction [Accessed: 20 January 2011].
- UNICEF 2009. *Tracking progress on child and maternal nutrition: A survival and development priority*. New York: UNICEF
- Utrecht University 1987. *Map of India's religions*. Library Digital Map Collection.
- Utrecht University 2001. *Map of Indian States*. Library Digital Map Collection.
- Vora, K., Mavalankar, D., Ramani, K., Upadhyaya, M., Sharma, B., Lyengar, S., Gupta, V., Lyengar, K., 2009. Maternal Health Situation in India. *Journal of Health, Population and Nutrition*. No. 2, pp. 184-201.
- WHO, 2005. Maternal Mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. Available from: www.who.int/whosis/mme_2005.pdf [Accessed: 20 June 2011].
- Yamin, A. E., 2005. The Future in the Mirror: Incorporating Strategies for the Defense and Promotion of Economic, Social, and Cultural Rights into the Mainstream Human Rights Agenda. *Human Rights Quarterly*, Vol. 27, No. 4, pp. 1200-1244.

Appendix A



INFORMATION SHEET

Title of Project: A baseline study of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) conditional maternity benefit during its pilot stage in Uttar Pradesh, India.

Name of Researchers: Miss Rachel Bell and Miss Sangeeta Maurya

*We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. **One of our team will go through the information sheet with you and answer any questions you have.***

What is the purpose of the study?

The study is investigating a new maternity benefit that will provide pregnant women with Rs. 4000 to allow for time off work and increased food intake.

Rachel Bell is a student at Utrecht University in The Netherlands, undertaking a Masters in International Development Studies. The researchers, together with SAHAYOG, are conducting a baseline study to assess the design of the new conditional maternity benefit Indira Gandhi Matritva Sahyog Yojana (IGMSY) during its pilot stage in Sultanpur, Uttar Pradesh. The study will be used for educational purposes, a final thesis will be based upon analysis of the field research data. The research will also inform a provisional report with the main findings from which will be presented and discussed with relevant stakeholders.

Why have I been selected?

You have been selected as a possible participant for the study as either; a possible beneficiary of the scheme, a person who will not be eligible for the scheme, a person working in the field of maternal health service provision, or as a local official. You

are invited to participate in either interviews or focus group discussions on the subject of the new maternity scheme.

What will happen to me if I take part?

During the study we will be conducting group discussions with village women of reproductive age. We will also be conducting interviews with beneficiaries of the scheme, those who are not eligible for the scheme, and government and community health care providers.

If you agree to take part you will either be invited to an interview (lasting no longer than one hour) or to a group discussion (lasting one to one and a half hours). During the discussions we will ask you to share your experiences and thoughts about maternal health in Uttar Pradesh and the impact the scheme may have.

The information you share will be included in a report assessing the challenges faced by the IGMSY scheme during the pilot phase. We cannot and do not guarantee or promise that you will receive any direct benefits from this study. However this study aims to identify the initial challenges of the IGMSY scheme allowing for possible recommendations for improvement. Your participation in this research will be anonymous and will in no way influence the level of care you receive or are able to access.

Confidentiality and disclosure of information

With your consent the discussions will be audio-recorded, and later written up removing identifying data. You can choose to stop the recording at any time. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, except as required by law. Information from the discussions will be used for the researcher's MSc thesis, however all comments will be anonymised and you will not be identified.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent

form. You are free to withdraw at any time, without giving a reason. If you withdraw from the study the anonymised data you have provided may still be used.

Feedback to participants

A summary of the final report and key recommendations will be shared with the participants and local stakeholders.

Further questions?

If you have any questions, please feel free to ask us. If you have any additional questions later, Rachel Bell (rtbell@students.uu.nl) will be happy to answer them.

[\(rtbell@students.uu.nl\)](mailto:rtbell@students.uu.nl)

Appendix B



CONSENT FORM

Title of Project: A baseline study of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) conditional maternity benefit during its pilot stage in Uttar Pradesh, India.

Name of Researchers: Miss Rachel Bell and Miss Sangeeta Maurya

1. I confirm that I have read/been read and understand the information sheet explaining the research project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I agree to the use of audio-recording and understand that all comments will be anonymised and will remain confidential.
4. Should I give my consent for photographs I understand that they may be used in the final research report.
5. I agree that the information I provide may be directly quoted in the final report but that all comments would be anonymised.
6. I agree to take part in the project.

Participant Signature Date

Researcher Signature Date

Translator /Witness..... Signature Date

Appendix C

Topic Guides

Focus group with local village women:

What basic health services are there in the area?

- Where is it possible for women and children to be immunised?
- How is the AWC functioning (which services is it providing)?
- What ANC services provided?
- What nutrition supplements given out?
- Where do you register the pregnancy and the birth and how easy is this?
- What transport is available to the services?
- Barriers: gender, household (what is the women's decision making power within the household), daily wages, no doctor available, do staff demand bribes, discrimination by staff, time and location.
- Are informal or private services used? If so, why?

What is the general practice for breastfeeding (how long currently)?

- What would be the desirable length you want to breastfeed for?
- For how long is the baby only fed on breast milk?
- What stops you from continuing for longer?
- What facilities at work would allow you to breastfeed?

What types of food do you eat daily?

- Where do you source your food ?
- What food do you get with your ration card?
- Has the increase in food prices impacted the amount of food you eat? If yes, how?
- What do you eat on a normal day?
- Does the food you eat change when you are pregnant or breastfeeding?

During pregnancy have you taken time off to rest?

- How many days rest from paid work: before the birth and after the birth?

- What are the reasons for not taking more time off?
- Are household tasks done over this time?

IGMSY Scheme

- What is known about the new maternity benefit that pays Rs. 4000? (describe if not known)
- Feelings about the selection criteria (explain if not known – over 19 and first 2 live births), who should be included?
- What is known about the conditionalities for the scheme? (explain – register pregnancy, ANC visits, breastfeeding counseling, register birth, immunizations, breastfeed for 6 months).
- What is the feeling about the conditions required for the scheme?
- What would you want from a maternity benefit scheme?
- Would you prefer a one time cash benefit or a strengthened PDS?
- When should the money be given (explain that in the scheme the Rs. 4000 is paid in three installments (at the end of the second term of pregnancy, and three and six months after birth).
- What would be the best way to transfer the money?
- In the scheme it is transferred into a bank account
 - o What is your understanding and experience of opening accounts?
 - o Are the staff helpful to those that are illiterate?
 - o Do the bank staff take payments?
 - o Is there any additional travel to access a bank?

Interviews with women excluded from the scheme

1. How many days do/did you take off from work (household or income generating) during the pregnancy?
2. How many days do/did you take off after the birth before returning to work (household or income generating)?
3. How close up to the birth do/did you work?
4. What are the reasons for not taking more time off?
5. What is your average daily food consumption?
6. Does/did this change during and after the pregnancy?

7. What is your knowledge and understanding of the selection criteria (if it is not known explain the selection criteria).
8. How does it feel to be left out of the scheme?
9. What services are **available** in the area?
10. Are these services **accessible**?
 - a. Are transport services available and is the cost in time and financially a barrier?
 - b. Are there gender issues to accessing the services (barrier from the household)?
 - c. How is accessing health care affected if you earn a daily wage?
 - d. Once at the service are staff available and accommodating or are informal payments sought for services.
11. Do you use any private or informal services? If so why?
12. What conditions are needed to allow you to breastfeed at work?
13. What is the overall economic status of the house?
 - a. How much income is coming into the house?
 - b. From what sources?
 - c. How much is spent on health?
 - d. Are there any pressing household debts or critical expenses (school fees)?
14. What position do you have within the house?

Interview with beneficiaries

1. How many days do/did you take off from work (household or income generating) during the pregnancy?
2. How many days do/did you take off after the birth before returning to work (household or income generating)?
3. How close up to the birth do/did you work?
4. What are the reasons for not taking more time off?
5. What is your average daily food consumption?
6. Does/did this change during and after the pregnancy?
7. What is your knowledge and understanding of the selection criteria (if it is not known explain the selection criteria).

8. What services are **available** in the area? Explain which services are necessary as part of the conditions (services to register the pregnancy and birth, antenatal services, and immunisation clinics).
9. Are these services **accessible**?
 - a. As there is a repeated need for mobility during the scheme are transport services available and is the cost in time and financially a barrier?
 - b. Are there gender issues to accessing the services (for the benefit you would need to leave the house on repeated occasions to meet conditions and to collect the money), how would this work for you if you earn a daily wage and how would your household feel about this?
 - c. Once at the service are staff available and accommodating or are informal payments sought for services?
10. Do you use any private or informal services? If so why?
11. The benefit requires 6 months exclusive breastfeeding. For how long is your baby fed exclusively on breast milk? What conditions are needed to allow you to breastfeed at work?
12. What is the overall economic status of the house?
 - a. How much income is coming into the house?
 - b. From what sources?
 - c. How much is spent on health?
 - d. Are there any pressing household debts or critical expenses (school fees)?
13. What position do you have within the house?

Interviews with local health care providers

1. What is your knowledge and understanding of the selection criteria regarding the number of living children (for example if other children have died from an earlier pregnancy)?
2. What is your knowledge and understanding of what benefits accrue in the case of still births and miscarriages?
3. Are all the conditions required for the scheme available in UP? (Services to register the pregnancy and birth, antenatal services, immunisation clinics and help with breastfeeding?).

4. What is the consequence if a woman cannot access a service to complete one of the necessary conditions?
5. What is the consequence if a woman uses a private or informal service?

Interviews with local officials

1. What is the logic/reasoning for the selection criteria?
2. Do you think it is justified to have a selection criteria? If yes, why?
3. What is the logic/reasoning for the required conditions for the scheme?
4. What is the logic/reasoning for the amount of compensation given?
5. What is the consequence if a woman cannot access a service to complete one of the conditions.
6. What is the consequence if a private or informal service is accessed?
7. What benefits accrue to those who suffer miscarriages and still births?

Appendix D

Transcriptions and field notes

1. Interview with ASHA (Village Y) 04/03/2011 – 1pm.

How many days have you been in the post of ASHA?

- From 2006

How many ASHA's in the area?

- We are 2 ASHAs.

Are you in comfortable position to talk and do you have a problem with the person with us (PANI worker)?

- It will be good if he is not here

He made clear to her to ask us if she did not understand a question and not to feel any pressure to answer our questions.

(PANI worker left).

Which type of services are available for women here, related to health?

- I do the work of registration of pregnant women, take them to ANM centre, take them for institutional delivery and take them for TT injections. Also I counsel the women to start breastfeeding within one hour of delivery. When they come back to home from the institution I take care of them in their home. This is my responsibility, it's my responsibility to do this.

You are saying this facility is given to women by you, but where do you take the women and where women go to take the services?

- There is a PHC in village Y and in village V there is a sub-centre.

Are you telling me about the PHC along the road here, we were there earlier and it is a structure only, already destroyed?

- Yes, doctor does give service there. There is a 'ward boy' there and doctor, and one more person who gives medicines.

The building is destroyed, where do they live and where do they give services?

- There is one room and it is not good but it is ok. They sit there and they give services.

Where do they live?

- I know their personal things, they live in their home and everyday they come and give services. They don't stay during night time.

How many years this PHC in this condition?

- 10 years before there were services of every level and doctors also lived there. That time there was ANM, doctor and delivery also happened there.

You are saying that people of your area get immunisations (TT) at this PHC. This is one place to get services but where are others going?

- 2km away is a sub-centre in village V but in present time there is no room, the centre is also destroyed. ANM gives services (immunisation), near to village V, near the centre there is a home, a village person's home and she (ANM) sits there to give the services. Before the ANM lived in the sub-centre but at present time not.

During the night time if a woman needs the services where do people go?

- I have given my contact number to my area's people. If they contact me I take them to block X, another PHC. Other peoples take themselves to services, if they don't contact me they take their own responsibility for getting there. They go to village W, where ANM lives. Also an ASHA there who is experienced to deliver baby. We never leave them in, if doctor refers her I go with her, maybe in Sultanpur district, I go there with her and her family and try to help them and don't come back to my home, I go with them to the services and come back with the lady.

People also use private services?

- The person who don't contact with me they take private.

Where is the private services?

- They take private services in Sultanpur district. They also go to village W where also get private services. ANM and ASHA live there at rent, it means they give private services.

Is she (ANM and ASHA) take some money?

- I don't know, I have no idea because I never went there. It depend on the people whether they give money I don't have any clear about this.

How many times immunisation services here?

- Because our ANM is alone, she has the charge of four gram subha's she comes here first Wednesday of month. She also immunisation in V, which is in our area, on fourth Saturday of month. Due to pulse polio campaign this Wednesday (of this week) did not happen. So now she will decide a new day for immunisation services. Immunisations always happen on this day normally it is only affected by the pulse polio campaign.

Are you aware about the IGMSY scheme?

- IGMSY?

It's a pilot project launched in two UP districts, Sultanpur and Mahoba.

- It's a scheme for the pregnant women?

Yes.

- The scheme is for AWW?

Yes.

- Before I was a little aware but not much but during the immunisation day this month I went there and the AWW's were telling me about the scheme.

What they (AWW) tell you?

- 4000 or 4500 money for the pregnant women.

Do you know the criteria for which type of women this scheme is?

- For first pregnancy and second pregnancy.

Do you know which age group women are eligible for the scheme, how many times the women get money and when?

- I have no idea of this.

It's for women of 19 year, for the first two living births and the scheme has many conditions such as the woman needs to register the pregnancy, go to ANC, growth monitoring.

- We do these things, register pregnancy, take them for TT injection and monitor weight.

The money is given in three parts, first after six months of pregnancy (1500), then after three months (1500) and final at six months after birth once there has been six months exclusive breastfeeding and growth monitoring (1000). If these conditions are not done by the women they will not get money. What are your feelings about the conditions, are the services of level according to the conditions.

- In AWC there is a weight machine where they take the weight and with ribbon they take the measurement of the pregnancy to check the growth of the baby (primary school in Y).

Where do they do this?

- Usually during immunisation day when they come for TT injection there is an AWW worker in that place and she does the measurements for size and weight of mother and baby (at the PHC).

If women miss that day for some reason how can they get that service?

- Every Saturday AWW gives nutritional powders with panjiri (5 types of cereals and vitamins).

Which type of immunisation and check up is given by ANM?

- It's not check up, its AWW giving these things not ANM. ANM don't check up.

What is your feeling about the conditions, can the women meet the conditions with present services?

- If women get the money then it is good for the women. She will get good nutrition, if there family is not economically strong then this scheme is good for this type of women. For the poor women it is a good scheme.

I am asking you about your feeling about the conditions.

- (no answer)

What about your experience of the JSY scheme. How many days after delivery did the women get the money?

- When the woman went to the block PHC the woman got the cheque straight after delivery.

What was your experience of JSY when it launched in 2006, how long did it take for the women to receive money?

- It was not easy it often took 5, 6, 10 days to receive money. But now it is straight after delivery. There are different kinds of people, some people don't want to go to block PHC because block PHC is 12 km away from here. When they contact with me I always try and take them to block PHC for delivery.

What are the other places that women go for delivery?

- There is a sub-centre in village U which is 7km from here and there are ANM and Dai's, the women get 1400 still but not straight away after delivery, it takes time.

Which types of travel are there to the services?

- There is different types of vehicle that women go in. If women are suffering from severe pain then need to reserve the vehicle. During the night time the vehicle takes 400 to go to block PHC.

What happens in day time if someone wants to go to block PHC?

- If women is in normal condition then the women prefer to share a taxi and in a serious condition they book a seat on the auto.

Imagine if women do not fulfil the conditions (get TT injection, ANC, or immunise baby) what will happen in this scheme?

- We always try to fulfil everything with the women. If she was not present we try and take her somewhere else on another time. If someone goes elsewhere to services and not with me then I can't say what happen to these people. I try to do everything, I make the lists about children's immunisations, who is pregnant, which children die and give this lists to ANM.

Is it real that there are no babies born to women under 19?

- Yes it is real. If they are married before 18 they don't go to their inlaws home until after 18.

What would happen to women in the scheme whose children die after delivery, or after one month, or if the baby is still birth, what happens to the women in this scheme?

- No-one know before whether the child will die after birth or still birth, its confirm after delivery. If someones child dies after delivery or is still born we write this down and send it to officials.

I am asking you what is in the scheme for that type of women, and what would happen to women that miscarry?

- If someone give birth a still baby, or after birth a baby died or if miscarry that woman still needs nutrition to help health.

What you say about the migrant women in the scheme?

- You people can tell me about these things better.

What your experience tell?

- Yeah if she registered here and goes away for 3-4 months and then comes back then she should be eligible for the scheme.

What about your feeling of third pregnancy?

- That woman also need nutrition and everything. If it is possible then the government should give to every women not just first and second.

Which type of pregnancy do you register most, first, second, third, fourth?

- Most of pregnancy register is second and third pregnancy, some fourth and fifth.

Where is the bank in your area?

- 3km from here.

Is it easy to open an account at the bank?

- Yes it's ok. Not every woman has an account. But usually one family member has an account (husband, father-in-law).

What do you think about the benefit being given in three parts?

- It is good in three parts. It will be useful for the women to take nutrition and spend related to health. If given in one time it will not be used for the health of the women but by others. It will be good for women for some money in their account at the bank 2km away but if the money is put into a bank in X it will not be good as it will take time and be expensive to get there.
- In this scheme there is facility for women who deliver in institutions or home?
Benefits relating to birth still fall under the JSY scheme. This scheme is for before and after the birth.

- If people are not forced and no one says to go to hospital for delivery then they won't go as no-one wants to go to hospital to have baby. The officials above us force us to take them for institutional delivery. If they are given money for home birth they won't go.

Why people prefer home delivery?

- Because it is low cost and if everything is normal then it is good to give birth at home. If go to have baby in hospital it costs money, time and other people have to go with her. Women and family people say if easy to deliver at home why go to hospital. Women say that if there is no problem with the home birth there is no need for money. Officials say to tell them that institutional delivery is good for your health and your babies health and to explain to them that if they are unwell after home delivery to go to hospital.

Any type of benefit for women who deliver their baby at home?

- Yes there is a scheme by which BPL women get 500 rupees but I never fill this form in for any women. For 500 rupees it takes time to go to search the ANM and get her signature and in this process already spent 200-300 rupees and time. So people say why will she fill out the form for 200 rupees. People also say to me I take the money and I don't want people saying I am a corrupt ASHA and so I never fill out the form. Also we have not fixed salary and so how will we go here and there to get the different people to sign from our pocket. We take care of the women who deliver at home and make the home delivery list.

2. Interview with Anganwadi Worker, Village Y

4/3/11

The facilitator told the interviewee about the purpose of the interview and asked if she had read the Interview sheet. She said that they can ask whatever questions they wanted to. The facilitator then talked about the consent form and took permission for audio recording. Initially the interviewee was a bit hesitant about the audio recording but when the facilitator told her about the objective behind it, she gave us permission. This way we started / proceeded with the interview.

Q1. Since how long have you been working as an Anganwadi worker?

A1. I have been working as an Anganwadi worker since 2003. I had been temporarily suspended for 8 months but again resumed my duties and since then, I have working as an Anganwadi member.

Q2. Recently, as a pilot project, this scheme of Indira Gandhi Matritva Sahayog Yojana has been implemented in 2 districts of Uttar Pradesh. How are women chosen for the same?

A2. Interviewee said: I got to know about this scheme only 15 days back from the CDPO. She told us about the scheme and asked us to help her out with this scheme. She said that Rs. 4000 will be given to the pregnant women and help would be required for such activities.

Q3. The scheme says that women would be chosen for this scheme that are pregnant for the first or the second time. How is that done?

A3. Interviewee said: delivery of women would be done by Asha in a Government hospital and would be given Rs. 1400 for the same.

Q4. What is the basis on which women would be chosen in this scheme that is first time or second time pregnant? What do you know about the age factor?

A4. Interviewee said: I do not have any idea about it.

The supervisor has asked the December's name list of those women who are pregnant for the first or the second time. This list is ready.

Q5. Do you know that women below 18 years of age would not get this benefit?

A5. Interviewee said: yes I know that marriageable age defined in this age should be 18, 19, and 20 etc.

Q6. If we take a look at the customs and traditions of the village, what is the condition of your workplace?

A6. Interviewee said: there are customs but it is prevalent only with people of lower caste. Those belonging to the "General Caste" get married at an age between 25-30 yrs. Here, Schedule Caste and Backward Caste can be found more in number but they too are getting married at 18 yrs now and not before. If they do get married at 18, then the "Gauna" (*the tradition in which the girl remains in her own father's house and doesn't sleep with her husband till she is 18, after gauna she can sleep with her husband*) is done. People are slowly becoming more aware.

Q7. According to this scheme, only those women are considered beneficiaries who are pregnant for the first time or second time. What is there in this scheme for a woman who gives birth to a dead child or suffers a miscarriage?

A7. Interviewee said: I believe that the woman should get benefits of the scheme because even if she gives birth to a dead child or undergoes a natural miscarriage, then too her body suffers. What is there in this scheme for her, I do not know.

Q8. If the first child of a woman is dead and she becomes pregnant again, then what is there in the scheme for her?

A8. Interviewee said: a living child is considered to be the first child in such a case.

Q9. Cannot understand the question

Q10. Under this IGMSY Yojana, what are the clauses put before women?

A10. Interviewee said: I do not know about the clauses but they should take care of their health.

Q11. All the clauses were told to the interviewee and asked: Do you have all facilities related to the clauses in your workplace?

A11. Interviewee said: the facilities are there in the workplace but sometimes, some women refuse to take T.T. injection. They said that if they get vaccinated from A.N.M. then their arm would pain. They would instead go to some private doctor (*jholachaap doctor*). We explained them that the Anganwadi members have impure vaccines which the doctors do not have. We also told them that if they do not get vaccinated from Anganwadi members then they would not get Rs. 4000. Then many women got themselves vaccinated and also got registration cards. Now even we –Anganwadi members, have got a card now. Initially it was given only to Asha and A.N.M. members only.

Q12. What will happen to a woman who is not able to meet all the clauses mentioned?

A12. Interviewee said: all the clauses mentioned in the scheme cannot be fulfilled. We are trying our best from our side. People are becoming more aware after the implementation of this Yojana. If a woman is not able to fulfil certain condition, then it is her fault. We would explain her again and again that if she doesn't fulfil all the conditions, then she would not get the benefits. If she wants to get benefits, she would definitely fulfil all the conditions.

Initially women did not get themselves and the child vaccinated but the time since Anganwadi, Asha Bahu etc have started visiting them in their houses and educating them about the same, people have become more aware and now, even more women and children are getting vaccinated.

Q13. What will happen to women who misses her/ child's vaccination because of reasons like- she has to go to work, doctor is unavailable or she goes for the pulse polio campaign?

A13. Interviewee said: if the woman goes to a pulse polio campaign and could not get herself or her child vaccinated on a Wednesday or a Saturday, then we contact the A.N.M. workers and they are vaccinated on a Thursday or a Tuesday.

If a woman/child doesn't get vaccinated because mother goes to work etc, then we suggest her to go to the nearest sub-centre and get herself vaccinated. We even suggest her to go to the private hospital and get vaccinated as it is very important and this should not be missed.

Q14. What will happen if a woman seeks help from a jholachaap doctor, neem-hakeem etc?

A14. Interviewee said: It is not apt/ right if they go to such a place. They should get vaccinated from A.N.M. sister. But if her treatment is being done somewhere else and she is saying that she has got all the vaccines etc, then we maintain her record so that at least she gets the benefit of the scheme.

Case Study:

A lady sitting next to the interviewee who was also “Asha Bahu” told us about a case.

Generally, Government hospitals are very crowded. Once there was a woman who was 8 months into pregnancy and was taken to a hospital in Sultanpur. She got late in reaching the place and it was 12:40 at that time. Doctor examined her and told her to get her blood tested. At the blood test centre she was told to come at 9 a.m. next day even though a hospital is not supposed to close down before 2 p.m.

Asha Bahu said that how is it possible for a woman to travel 35-40 kms and have nowhere to stay overnight in the city. The pregnant woman also said that she could not come again the next day. Then I (Asha Bahu) took her to a private nursing home. There the doctor examined her carefully, talked to her and told her to get the ultrasound testing done. The ultrasound report showed that the child’s head is not getting developed. Doctor told her that there is no use keeping such a child in womb and suggested her to go for abortion. She got her child aborted later. Thus, negligence from the Government hospital’s side forces people to go for private doctor’s treatment.

Only those go to government hospitals that do not have money and they undergo whatever treatment is given to them.

Q15. What all facilities are available for check up?

A15. Interviewee said: For Blood pressure, blood and urine- facilities for checkups are not available. We need to strengthen the structure. Village Y P.H.C. Is in a dismal state from the past 15 years- doing even ask about it!

To help the women get the benefits of IGMSY’s scheme, it is imperative that the facilities are nearby, within reach. Women cannot go to the city again and again. Hence to fulfil all the conditions would be a little difficult.

When asked about transparency, she said she has no idea about it.

Extra Responsibilities:

Provide with lists every month

Vaccination should be taken care of

Consult about food intake

Registration card

When we vaccinate and register a pregnant woman, we get Rs. 30.

3. Interview with ASHA (Village Z)

Date: 5/3/11

Q1. What all health related facilities are available in your area?

A1. The interviewee said: all the facilities are available in our centre.

Vaccination: for vaccination, camps are put up, cards are made, and panjiri is given to all. Visits are made to the pregnant women's homes to check that they are not facing any sort of problems. If there is any sort of problem, then they are taken to Block X (PHC) for check up. For delivery, women are taken to the Block and thereafter care of both mother and child is taken. If still some problem arises, she's taken to the block for check up and medicines are given to her.

Vehicle (ambulance) expenditure: The interviewee said: we get Rs. 250 if the house of the patient is nearby. If the house is faraway, then the family of the woman takes care of the expenditure. We cannot contribute more than Rs. 250 in this.

If a woman is taken to the PHC for delivery and we get to know that still one or two days are left for the delivery, then she is brought back to her home. How many times will we bear the expenditure of taking her to and fro?

The interviewee said: the amount of work we do is far more than the work done by the ANM workers. When we get a phone call, we leave our food in-between (lunch) and rush to the patient. We are also fed up with the Government as it only formulates rules and policies and we have to do all the work.

Q2. What happens when a woman doesn't get vaccinated due to any reason?

A2. The interviewee said: we take those women to nearby centre. If a woman says that she would not go to ANM as she is sitting in someone else's home. Then we take her to the X block and get her vaccinated or they themselves go to the block with their families. We cannot take vaccines to their homes.

Q3. If you take a woman 2 or 3 times to X then how are the expenses taken care of?

A3. The interviewee said: since we have got the job of doing this, the guardians come to us and then we have to go. Nobody from the hospital asks us that how did we manage to come here.

If we do not work according to their (pregnant women's) demands, then they would complain that they did not take us during the time of delivery and would also say that "ASHA BAHU" do not help us at the time of need.

Q4. Where do deliveries take place?

A4. The interviewee said: Deliveries happen in X Block (PHC) and U sub centre. This area has both rich and poor people. U centre is nearby so whoever wants, goes to that centre else who wants to go to the Block is taken there.

The interviewee said: if the unborn tilts in the womb or gets entangled inside or if something else happens in complicated deliveries, then they are referred to Sultanpur district hospital from X as well as from PHC centre. If the mother and child are well then it is ok else the mother is taken for operation.

Q5. How far is Sultanpur?

A5. The interviewee said: Sultanpur is 23-24 kms. There are so many difficulties that often the patient has to stay there for 2-3 days. Because of the distance, it becomes very difficult. We do not get anything. If an operation is done, injection is written for the patient. If a baby is delivered, then too lots of injections are written. Everyone there is a miser. I am not telling stories, I am telling the truth.

Q6. Tell us about the facility for ultrasound.

A6. The interviewee said: in X PHC, there is no facility for ultrasound but there is facility for it in Sultanpur, then too those who want money (bribe) do take it from the patients. If it's done from the government hospital, then the charges are Rs. 150. If you want instant report, then you have to go to a private nursing home. In X PHC, blood, urine checkups do take place but if we are not with them, then they are charged from the government hospitals as well. These days, not a single work can be done without money. Everyone wants to grab with both hands. Unless and until, strict rules are made, this will continue like this.

Q7. What kind of tests is done by ANM?

A7. The interviewee said: ANM doesn't test for anything. It is mostly done by us. They come once a month in the village for Routine Immunization.

Q8. What type of tests do you conduct?

A8. The interviewee said: we do pregnancy tests by conducting urination tests.

Tests done by block: Block PHC conducts tests to know how old is the unborn inside the womb, how is the growth and development inside and then medicines are written for them to be taken from outside.

For delivery: during delivery, most of the medicines are brought from the outside, only vaccines are given by the block. Sometimes the deliveries take place without giving them a single vaccine.

For blood pressure: Before delivery, blood pressure, blood, urine tests are conducted and if the blood pressure is found to be abnormal then medicines are given and only when it becomes normal is when delivery is done.

Tests done in U village sub- centre: here ANM tests for blood pressure but no other testing facility is available there. During vaccination in the villages, no other tests are done by the ANM. I am not lying; you can confirm it from other women as well. I don't fear telling the truth.

Q9. What is your opinion about the criteria used for selecting women for IGMSY?

A9. The interviewee said: first time and second time pregnant women are getting the benefits is rather good but a woman who is getting pregnant for the third time will not get benefit and she might feel bad about it. In this area, women are not much in favour of getting *nasbandi* contraception an operation done to prevent pregnancy example tubectomy etc. they feel that they would become patients after having undergone this operation, they might also die. They are ready to have as many children as there would be and then it would stop after some time. We cannot take them forcefully for such an operation.

One who is pregnancy for the third or fourth time would take tension for not getting the benefit as others are getting. Hence some amount should be given to them as well as it would benefit all in this way.

Q10. What is your opinion about the fact that this scheme doesn't say anything about miscarriages, still births and migrants?

A10. If a miscarriage takes place after 3-4 months, then the scheme should not extend benefits in this case but if a miscarriage happens after 7-8 months or a still child is born, then some benefits should be extended as her blood loss continues to happen and she needs nutrients for her body. The scheme should be for all or for none else the beneficiaries will fight with us.

Q11. What do you think about the clauses in the scheme?

A11. The interviewee said: there should be certain conditions in all the schemes. A scheme cannot be implemented without conditions.

Q12. What will happen if a woman fails to fulfil a condition?

A12. The interviewee said: we will try our best that she fulfils all the conditions; we will explain her that it is important to fulfil all conditions to get the benefits.

Q13. What if a woman goes for private treatment?

A13. The interviewee said: we will explain the woman and her family members that she will not get benefit if she goes to a private doctor. If a woman goes to the private doctor just because she is not getting all facilities in the Government hospital, then we have to see to it that she gets all the facilities and the Government should also do something about it.

Extra Responsibilities:

We have not been given any extra responsibilities under this scheme.

4. Interview with Anganwadi workers, Village Z

Date: 05/03/11

After giving introduction of the researcher, Sahayog and self, the facilitator explained the purpose behind conducting the base line studies of Indira Gandhi Matritva Yojana and who all are involved in this study.

The interviewee discussed about the consent form and information sheet and said that her boss/ seniors have said that anybody who is not from a Government organisation seeking any kind of information about this Yojana should not be given any detail. They then asked us if by giving any detail, will their job would be at stake. We again told her about the purpose of this study and also ensured her about the confidentiality and voluntary participation.

Since two females were present at the time of the interview, hence we interviewed both of them. One woman showed the information sheet and consent form to her husband and when he reassured that it was safe, and then they proceeded with the interview. All these activities took approximately 40mins of our time. We also got permission for video recording.

Q1. What all facilities are available in your area regarding health?

A1. The interviewee said: women living in villages require a lot of nutrients which they do not get because of poverty. Therefore the Government has provided them with *panjiri* from Anganwadi side but still some make use of this scheme and some don't.

For delivery women go to ANM but the delivery actually takes place in a private ward. They also go to U, a sub centre 3kms away; women generally go to Sultanpur district Block and PHC.

Q2. When did you got to know about IGMSY?

A2. The interviewee said: we do not have much information about this Yojana. We were told about this Yojana in December 2010 but the details like who will get the benefits etc is still not known to us.

CDPO asked for a list of the beneficiaries but told us not to tell about this scheme to the villagers till the list gets finalised. If they get to know about it, then they will be after us. If they do not get benefit then they would say that they had written down our names and later on ate away our money.

Every month we send a list of pregnant women to the CDPO.

Q3. What is the basis on which women are chosen for this scheme?

A3. The interviewee said: CDPO has asked us to get a list of names of those women who are pregnant for the first or the second time only but we give them an exhaustive list. Choosing people is their work.

Q4. What happens to a woman who is pregnant for the first time but undergoes natural miscarriage? What happens if she becomes pregnant for the second time?

A4. The interviewee said: the authorities will consider it her first pregnancy. Even we have reported it as her first pregnancy.

Q5. What is there for a woman who gives birth to a still child or a dead child?

A5. The interviewee said: we do not have any information about it. Once the scheme gets implemented, we would be able to tell you better about such problems.

Q6. Do such women need nutrients after giving birth to a dead child?

A6. The interviewee said: the officials have said that in such cases no benefits would be extended. Since the child is already dead, the woman does not need extra nutrients to feed her child.

But I think such women do need nutrients. When we say so, the authority says that we are giving them *panjiri* so that they get enough nutrients to take care of their bodies.

Q7. What is your opinion about the age limit that has been set at 19?

A7. The interviewee said: I think that 19 years is the right age cap that has been set. In some cases women were married at age below 18 and they gave birth to a child that did not survive. Before 18, their bodies are not prepared to carry a child and even we suggest most of them not to bear a child before 18 years.

Q8. What is your opinion about the conditions of this scheme?

A8. The interviewee said: the conditions are important as most of the women do not want to get themselves or their child vaccinated and some of them do not want to breastfeed their child. Women will at least fulfil the conditions out of greed.

Why don't they want to breastfeed?

In villages, there are not many facilities and women also get fewer nutrients because of which they do not produce enough milk. Some do not like breast feeding and hence avoid it while some have to go for work that gives them very little time to breast feed.

Q9. What all facilities are available as listed down in the Yojana?

A9. The interviewee said: we have all the facilities. ANM come twice a month for vaccination. We get women's names registered and also write it in our records. We also check their weights but we do not have facility for measuring blood pressure.

When asked about getting benefits in the third visit, the interviewee said that a woman thinks when she has to get out of her home for the first time but when she has to get out of her house for the 10th time then it becomes difficult for her. If we give her money in the first time itself, then her family members will use it for something else.

Q10. What happens if a woman is unable to fulfil the criteria mentioned for the scheme?

A10. The interviewee said: it is too early to comment. Let the scheme be implemented first then we will see.

Q11. Have you seen any added responsibilities in your work?

A11. The interviewee said: no additional responsibilities as such. We have been given a Jaccha-baccha card; we have no idea what to do of it.

Q12. What kind of females is found more in your area: pregnant women or women already having children?

A12. The interviewee said: mostly we find women who are pregnant for the second or the third time. If we talk of humanity, then I think a woman pregnant for the third time should also get benefits but we have been pressurised from the authorities that we should make women more aware of having only 2 children.

5. Interview with women excluded from the scheme.

6/3/11

Village Y

After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study.

Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. What facilities are available in your area?

A1. The interviewee said: when somebody becomes seriously ill, then he is taken to the Sultanpur Private Hospital or sometimes to a government Hospital. Cold, cough, fever- for such illness, the doctor at W circle gives the medicine. The doctor who sits at centre in W also comes to our homes when we call him.

Q2. Sultanpur must be far off (24kms)?

A2. The interviewee said: since the expenses in the private as well as the Government hospital is more or less the same, hence we prefer going to a private doctor/hospital. Child care is much better in the private sector.

Most of the people go to X block Government hospital for the child delivery. When my child was born in X, the nurse took Rs. 500; dai took Rs. 150 for cutting the umbilical cord and

Rs.500 for birth certificate. Asha Bahu initially said that it would take only Rs. 500. After coming back from there, Asha Bahu also took Rs. 50 from us. I went to X with 4 people in a taxi and it costs Rs. 262 each.

Do they ask for money in the hospital?

The interviewee said: as soon as I reached there, the nurse took me inside and administered two injections. Thereafter, the child was born. The nurse then said that injections and medicines are not free of cost. Then I had to pay her for medicines and injections. In the hospital there were facilities like cleanliness and electricity. The doctor also came on rounds and gave medicines to those who wanted it.

Q3. Where do you get vaccinated?

A3. The interviewee said: earlier we got vaccinated at V Centre but after it has been broken down completely, ANM comes to a xxxxx's house and vaccines are given there. After vaccination, women are given 50 iron capsules.

Anganwadi centre: this centre runs in the primary school, 6 glasses of panjiri is given to us every Saturday.

Do they explain you anything? They do not say anything while giving panjiri. They only go from one house to the next and collect women and children.

Q4. What all facilities do you get during pregnancy?

A4 the interviewee said: we get vaccinated twice and get 100 iron capsules. Neither tests were conducted nor did anyone give us advice of any kind. They took Rs. 10 for registration. After childbirth, they took R. 50 for the birth certificate. If the child is born at home, then the birth certificate is not made.

Q5. What happens if someone has to go to X at night?

A5. The interviewee said: it takes about Rs. 1000 to Rs. 1200 is someone has to go at night. After child delivery, when I was coming back home, Asha Bahu took me from PHC X to the taxi stand on foot. The doctor saw me in the way and scolded Asha saying why she made me walk just the day after my delivery. Then Asha brought a Rickshaw for me and I bore all the travel expenses.

Q6. Does delivery take place nearby?

A6. The interviewee said: The nurse at W helps in delivering the child. She charges according to the paying capacity of the person. She takes 800-900 from some people and from others she charges less as well.

Q7. Who decides who will do the household work and who will take up the new responsibility as it arises?

A7. The interviewee said: my work is to take care of the household stuff, cook food, help children get ready. All the expenses are taken care of by my husband. If I have to go to any place, then I tell my husband about it and then he pays for it.

Q8. How do you get your daily bread and butter?

A8. The interviewee said: both me and my husband work at NREGA and earn money there. We do not have farms like others have but we work on half-half basis (we help them out and

get 50% of the revenues in return). My eldest son earns outside. He also sends Rs. 1000-1200 in a month.

Q9. For how long do you breast feed your child?

A9. The interviewee said: I feed my child for 2.5years. The last time I gave birth to a child, I started feeding him in 1 hour. I feed my child throughout for 8 months. After 8 months, I start giving him solid food items as well.

Q10. How do you breast feed your child during your work?

A10. The interviewee said: I dint go for work for 10 months. Then after I started going for work, I used to breast feed my child in the morning, once during daytime and then finally in the evening when I get back to home from work.

Q11. If you will not go for work for 10 months, how will take care of the expenses?

A11. The interviewee said: all the food items like rice, wheat, potatoes have already been bought. My husband will earn and take care of daily expenses.

Q12. What about your daily food needs?

A12. The interviewee said: we cook pulses in the morning and make vegetables, rice, and chapattis in the afternoon. I like rice and that is all what I want.

Red ration card: I get 25 kgs rice, 10 kg wheat, 1 kg pulses and 2 kg sugar. We have to spend around Rs.110 to Rs. 150. We get oil, wood from the market but in pulses, we prefer peas only. We cannot afford *tuar dal* as it is Rs. 80 per kg.

Q13. What type of food intake is there during pregnancy?

A13. The interviewee said: we eat more of green vegetables, lettuce, etc. I took dry fruits for a month after child birth and also had *ashokarishta* a tonic recommended for mothers.

Q14. What about having rest during pregnancy?

A14. The interviewee said: when I had the child in womb, I used to rest for half an hour or so. As far as work is concerned, I dint work on the day I gave birth to my child. When my child was in womb, I lost my work that I used to do in NREGA. I used to go there for cutting but they did not give me heavy load.

After child birth, I am not going for work. I just sit in front of the stove. My other children do most of the work; I just cook food for them. I don't do heavy work.

Q15. How much do you spend on health issues?

A15. The interviewee said: Rs. 10,000 in a year.

Q16. What about loans/debts etc?

A16. The interviewee said: often we have to take loans to tackle health issues. I generally take loans from the union and if the union refuses to give, then I take it from the village at Rs. 10 per Rs. 100. I have not taken loans so far.

IGMSY

Q17. Do you know about any such scheme wherein you get Rs. 4000 if you are pregnant for the first or second time?

A17. The interviewee said: no I have no such information. I got Rs. 1400 some time back.

Q18. What do you think about the conditions of the scheme since you would not get any of those benefits?

A18. The interviewee said: I think this scheme should be majorly for those who are having their third or fourth child as their bodies are weaker than the rest. I think there are more women who are pregnant for the third or the fourth time than the first/second ones.

Q14. What is your opinion about the conditions?

A14. The interviewee said: it is important to lay down certain conditions. Government has done the right thing. People will be forced to limit their children as its time of high inflation.

Q15. Are facilities available according to the conditions laid down?

A15. The interviewee said: registration and vaccination facilities are in place but the facilities to check the child weight, height etc.

Q16. What do you think about giving benefits in three instalments?

A16. The interviewee said: if you give it all in one go, it will be spent on something else so it is better to give in three instalments.

Q17. How can we extend benefits to most of the women?

A17. The interviewee said: all the money can never reach the beneficiary. It can go to someone who is read/ educated but someone who is not educated will not get the entire amount. Government will give the entire amount but since it comes via many channels, it won't reach us.

Q18. What do you think about the benefits being transferred to the bank accounts of the women?

A18. The interviewee said: I have a bank account and it is very easy to withdraw money from there. W bank is just 1km away from this place so people generally walk to that place. It is expensive to go to X for money withdrawal.

6. Interview with the women excluded from the scheme Village Y

6/3/11

After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study.

Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. Who all are there in your family?

A1. The interviewee said: father-in-law, mother-in-law, husband, 2 children- the elder one is 14 years old and the daughter is 9 years old. This is my third child in the womb.

Q2. Where do people generally go when they suffer from cold, cough, fever etc?

A2. The interviewee said: women generally go to X PHC for delivery, for vaccination, they go to Y PHC. Also for stomach aches, fever we go to Y PHC, doctor comes at 11 and leaves at 2. Private Doctors can be found in W too. The nurse in W is very good, she helps in delivering during emergency.

Anganwadi: The interviewee said: Anganwadi centre in the primary school. We get panjiri there. From a 50 Gms box, we get 9 boxes of panjiri but I don't go there for panjiri. People get food for me. I eat some and throw away the rest to the goat. Since the goats are also mine, I have to take care of the goat as well.

Q3. Why don't you go to take panjiri?

A3. The interviewee said: I feel shy going to the primary school. Since relatives bring it for me, I don't need to go there. Anganwadi workers do not come to us as they are Brahmins. If someone becomes very ill, then they come but that happens rarely. Even Asha Bahu came once and said that I should inform them when my delivery date is coming. I will take you to X and you will get Rs. 1400. If you deliver in a private ward, then you will not get anything.

Q4. What about the ANC facilities that you have?

A4. The interviewee said:

Vaccination: I got myself vaccinated in the fifth month and the second time during seventh month. ANM also gave me iron capsules and the registration card costs Rs. 10.

Tests: none of the tests were conducted, even the ANM dint say a word about it.

Q5. What sort of problems you faced during pregnancy?

A5. The interviewee said: when it was seven months into pregnancy, my whole body swelled and I went to W circle to the nurse who took Rs. 500 from me.

Q6. Why dint you go to the Government hospital?

A6. X is far off and the Y Government hospital does not have a lady doctor.

Q7. Do you work to earn money?

A7. The interviewee said: I work at home and sometimes I do cutting grass as well. My husband works at NREGA.

Q8. When you are pregnant, what changes in food intake do you experience?

A8. The interviewee said: I am not able to take all food all at once. I eat 2-3 times a day. Vegetables are sown in my farms so I get it from there.

Q9. How much do you participate in taking household decision?

A9. The interviewee said: since both of us (husband and I) are responsible for all work, both of us take care of our home and hence both take decisions collectively.

Q10. Which ration card do you have and what all do you get on it?

A10. The interviewee said: every month I get 35kgs ration: 2kg sugar, 1 kg pulse and kerosene oil. Sometimes when we don't have money, we are not able to buy all stuff.

Q11. What food items do you buy from the market?

A11. The interviewee said: since we don't have many farms, hence we buy wheat, rice in small quantities. These days we are facing some problems as I am not able to work in the fields. During initial months of pregnancy, I vomited a lot and hence avoided work and now my weight has increased a lot and hence I cannot work.

Q12. What kind of work do you do at home?

A12. The interviewee said: cooking, taking care of children, house cleaning, getting fodder, picking cow dung, and sometimes working in the field.

If I take rest, then my feet start aching, so most of the times, I keep walking slowly and keep doing light work.

Q13. How are the expenses taken care of?

A13. The interviewee said: my husband works at NREGA so some of the expenses are take care of by him. Since I don't have any brother, hence my father helps me. Once my son was very ill, then my father took care of my child and these days my son lives with them and studying there.

Q14. When did you take a loan to fulfil your needs?

A14. The interviewee said: food and children's education is the most expensive. Once or twice I took loan from the union which I returned later on.

Q15. Do you know of any scheme that promises to give you Rs.4000?

A15. The interviewee said: no I have no idea about it.

If Government has formulated any such scheme, it must be for our benefit. But there are expenses for third child as well. Those who are pregnant for the third or fourth time need all the more.

Q16. What is your opinion about the conditions of this scheme?

A16. The interviewee said: I don't produce milk at all and I am sure there are many such women who are unable to produce milk. Government should think about this as well. We do get vaccinated here but there is no facility for tests etc.

Q17. What is your opinion about the benefits being extended in three instalments?

A17. The interviewee said: it is good if we get it in three instalments. Money is one thing that we spend once we get it in hands. If we get it all at once, we will spend it on something else.

With these words, our interview came to an end.

7. Interview with excluded women on scheme

6/3/11

Details of the interview:

I went to house to take an interview but she had gone to the fields to dig potatoes. I went to take someone else's interview in the meantime and came back at 3 to her house again. I saw a child sleeping on a khatiya (a kind of bed) and there were houseflies all around him. After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study. Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. Where do people go to take medicines for illnesses like fever, cold cough etc?

A1. The interviewee said: people go to the fraud doctor in W for cold, cough, fever, stomach ache. My son is mad from his childhood. I showed him to a doctor in X PHC and Sultanpur hospital. The doctor took Rs. 70 as fees and Rs. 500 for medicines but it was of no use.

Q2. What type of facilities is available for immunization/vaccination and ANC?

A2. The interviewee said: we go to Y PHC which is 1 km away for immunization. I went there to get the injections but did not take iron tablets as I don't like it. The nurse takes Rs. 10 to make the registration card. **Anganwadi:** it runs in the primary school that is 1 km away from this place. We go there to get ourselves and our kids vaccinated. We get panjiri there (mixture of different kind of vitamins and cereals). But I don't go to get pajiir as I can't leave my little children all alone as there is no one to take care of them. Moreover my one child is mad, so I can't leave him and go to the Anganwadi centre.

Q3. What type of problems you faced during pregnancy and delivery?

A3. The interviewee said: in the initial months, I felt severe pain in the womb, I got myself tested and it took Rs. 1200 for the treatment. When I was into 4 months of pregnancy, then I felt pain in the same area and also burning sensation in urinal passage. I showed myself to a private nurse she gave me injections and medicines, and then I felt better. I spent about Rs. 1000 on this treatment.

Q4. Why didn't you go to the Government hospitals for the same?

A4. The interviewee said: they charge money from us and also write medicines that we have to buy from outside. After buying medicine we have to show it to the doctor again, so its better to show to a private doctor.

Q5. Where did you deliver your child?

A5. The interviewee said: I delivered my child at home. When asked about the problems faced during delivery, she said that she called nurse to give her an injection to increase pain in stomach and to induce faster delivery. After delivery, she aksed for rs. 450. I gave her Rs. 200 and promised o give the remaining after sometime.

Q6. Why didn't you for institutional delivery in Government Hospitals?

A6. The interviewee said: there was no one at home to take care of my other children, it was night time and I had no conveyance.

Q7. When do you start breastfeeding your child and for how many months do you breast feed your child?

A7. The interviewee said: some women start beast feeding in 1-2 hours and some start after a day or two. I started beast feeding after child birth. I have been breastfeeding my daughter for the past 7 months. (*her baby daughter looked very weak, she wasn't more than 3 months old*).

Q8. Do you work to earn money?

A8. The interviewee said: my children are very small so I cannot work to earn money. I work in the fields/ farms that we own.

Q9. For how many days do you rest after delivery?

A9. The interviewee said: if I take rest, who will work? There is no such rule like I am not supposed to work during pregnancy etc. washing utensils, clothes, taking care of children, cooking food, cutting fodder for cattle, picking up cow dung, I do it all.

Q10. How do you take care of household expenses?

A10. The interviewee said: my husband works at NREGA and when there is no work here, he goes to a bakery and comes home once in a week. We spend maximum amount on medical facilities, we spend some Rs. 400-500 on medicines in a month. I took loan for my mad child but have not been able to repay the loan yet. It has been 7 month now.

Q11. What do you have in food?

A11. The interviewee said: pulses, rice, vegetables, chapattis, and fish –mutton once a month.

Q12. What all is written on your ration card?

A12. The interviewee said: I have white BPL card. I pay Rs. 200 for 35 kg ration, 2kg sugar for Rs. 50, 1 kg matar pulse and kerosene oil. If we have money, we buy 35 kgs of ration and when we don't have, then we buy only 20kgs of it. Generally, we don't buy food stuff from outside market, we use whatever we have at home.

Q13. What are the changes in your food intake after delivery?

A13. The interviewee said: when I had this child in my womb, I could not eat at all as I used to vomit a lot and when the child was born, I could not eat as I had a lot of pain in my womb/vagina. Then I got medicine from W worth Rs. 500 and then I got some relief. After childbirth, I ate dry fruits for 15 days.

Q14. How much do you participate in decision making in household matters?

A14. The interviewee said: since my husband works outside and comes home once a week, hence all the important decisions are taken by me.

IGMSY - When asked about this scheme, the interviewee said that she has no knowledge about it. After telling her about the criteria and conditions, we asked her about her opinion. The interviewee said: Government should extend benefits to those as well who are pregnant for the fourth-fifth time. We also need food and nutrients.

Q15. Do you think women will be able to fulfil the requirements laid down as conditions in the scheme?

A15. The interviewee said: if women will get money, they will fulfil all the conditions for sure. If we get it in three times, then we will not have to take loan from elsewhere, so it's good that we get it in three times.

Q16. Which is the convenient way in which money would reach the poor?

A16. The interviewee said: it is better if money is transferred to our bank accounts. Women can easily walk up to the bank and withdraw money.

8. ANM interview, Village Z

7/3/11.

(refused to sign the consent form, said first speak to MO and get permission then I can speak to you, I am a government official and don't have permission to speak to you.)

Do you know about the IGMSY scheme?

- I have no idea about the scheme, I have no clue.

The scheme is to give help with wage loss and increase nutrition of pregnant and lactating women. The scheme is for those of 19 years old and for the first two live births.

- It is ok, it is good because the criteria is related to family planning. If the government make the criteria it is necessary to consider family planning.

The scheme is only for first two living births.

- Oh. It is only for two living births. There is much weakness during second and third delivery and so it should include that type of women. To implement that scheme will take a long time because there are so much people who belong to local caste and have more than three child. If you are saying about the nutrition then every women need the nutrition not just the first two births.

What us your opinion if someone gives birth to a still baby?

- If a still birth happen it is not the mistake of the women and so she should be eligible because its not her mistake.

Are you aware of the conditions of the scheme?

- No I have no idea.

The conditions include registering the pregnancy, getting ANC, registering the birth, receiving immunisations and exclusive breastfeeding for 6 months.

- The government implementing the scheme according to their own ideas. All the conditions are ok. Services are of level according to conditions.

What is your opinion about distributing the money in three parts?

- Its good for the women because if they will got money at one time then it will be taken by family members and they will use the money in other ways. She will have no rights to spend that money if the money is given at one time. If the women get money at one time they will the money to make their home. Then the women will not get nutrition.

Which system will be good for women to take the money easily and also the full amount (e.g the 1500).

- Cheque system and also account system. By both systems they will get the money easily.

Where is the delivery services?

- In PHC (X block)

Where is your sub-centre and what is the facility for delivery at the sub-centre.

- My sub-centre is destroyed, there is nothing to sit there. Delivery does not happen at sub-centre. In a month I sit in Y PHC and there I do the immunisations.

There is a Y PHC which is destroyed, there is no facility there?

- When the centre was made the material of the buildings was very cheap due to which it started to come down after one or two years. There was a plan to re-build it 3 or 4 years ago but it did not happen.

Where is the check up services (ante-natal) like blood test, urine test and sugar test?

- These services are available in X block.

Have you got any extra responsibility as part of the scheme?

- I have no responsibility in this scheme and already have much responsibility. I am only one ANM for 10,000 population and spend 10 days on pulse polio campaign and there are so many registers to maintain. I am just going here, there, there and there and have no time.

9. MO – (X block)

9/3/11

(When we arrived at the PHC in X the MO was busy with patients, we let him know we were there and went to look around the PHC. We viewed the medicine dispensary, the two wards, met the doctor who delivers the babies, whilst in there a woman was having a checkup for her third pregnancy and had a baby with her who looked no older than 9 months and was 2 years old. In another room there were two women waiting to deliver their babies. One had been accompanied by her ASHA. The rooms to the wards, consulting room and the room where the women were waiting to give birth had no doors and no possibility for private discussion with the doctor).

What is the logic/reason for the selection criteria?

- There is a high rate of MMR and IMR in India, mostly in village area, and it usually happens within 24 hours of birth, and happens due to anaemia. This scheme is to fulfil this purpose. Before 19 years the body is not fully prepared for pregnancy and this also causes death of the women. For this is there is the provision to deliver baby in hospital (JSY) and to keep women in hospital for 24hours to avoid maternal and infant mortality and now new reports say that MMR has reduced by 70%.

When we went to the village we saw that there two or three women under 19 years with a child.

- Every Thursday in our area at sub-centre there is a meeting organised by the ANM and ASHA's bring the pregnant women and adolescent girls. ANM gives medicine to kill parasites (one reason for anaemia) and to pregnant women ANM gives the iron tablets. Also they give iron tablets twice in the week to adolescent girls to avoid anaemia. Every Wednesday and Saturday is the routine immunisation day and ANM's come from cities and go back to her home at 4 o'clock in the evening so how will she cover the 3-4 villages. She may not reach the villages until 10 or 11 in the morning if she has come from far away. Also some ANM's are older and do not have the energy to do work and there is so much work for the ANM. When we monitor the ANM's and see the work is not going good then when we try to say something their links to the political party threaten us, if you say something to the ANM you are given threats of violence and death.
- There is many problems. Problems related to infrastructure, we do not get the infrastructure within time and when we need it, all types of infrastructure, including equipment and medicines. Before March we had no iron tablets, in March we got 2 lakhs iron tablets (end of financial year), what are we supposed to do, how do we give services at the time that women need it? We always get at the end of the financial year. People don't like the hospitals medicines. There is no decoration on packet of medicines and so people don't like. The village health knowledge is very low. There is a lack of health education. Everyday we have 5-6 deliveries and we don't enough wards or beds for this.

There is a big aim of NRHM to strengthen the infrastructure in remote areas, as you know. There is one year left on NRHM.

- Turn off the recorder and I will tell you the real things.
- There is so much Netagiri (interference from politicians at every level). No one understand that this is my own country and everyone always tries to get more and more money. There are so many politicians that come to the hospital and misbehave with the officials. Always a scheme is made in Delhi in AC by some people who are not aware about here, what kind of festivals and what kind of problems we are facing. You are saying there is a big aim in NRHM to strengthen infrastructure but every scheme works good on paper but not in real. There is no drinking pure or safe drinking water for everyone in India so how can you say that they get the benefit from this kind of scheme. There is no light, water, building and night security for we people (officials) without these things how you expect we will be able to give services.

What is your feeling about the conditions?

- It is very necessary to do meetings in villages, such as health awareness and education awareness meetings. But in present time this is not in good function. If people will come to PHC from village to take the services they spend 20 rupees on transport, so how many times will they be able to come here. I am sure that conditions will not be fulfilled by the women because from 2 years we just focus on immunisation and yet there are still people not reached. If you are saying about

promoting nutrition through this scheme then there is greater malnutrition in villages women and children. Where is the nutrition of that women and child? In block (CDPO office) every month they take 2 lakhs of nutrition packets and where does this go? There are so many schemes and they do not succeed and Indians are not getting the benefit of any of these schemes because we first have need to improve health education and health infrastructure.

What is your opinion about the Y PHC and also V sub-centre , as the building is run down and there are limited facilities?

- It is made by a contractor and after completing it was not handed over to our department as it was cheap material and after 2 years it start to go down. I have no allotted money from the government to give rent on that PHC and the money we get from the registration fees (1 rupee per visit) we give that as rent for Y PHC.

You people are also facing so many problems so why not you say these problems to your upper officials?

- To get the post of CMO the person gives 25 lakhs as a bribe. So how he or she have the willingness to do work? Anganwari department takes money from the people so how will they implement this scheme. If you really want to give the benefit of this scheme then you need to implement this scheme by the block under the BDO's (block development official) and because BDO's is under DM (district magistrate) there will be less chance of corruption because DM has so much power and he can monitor the scheme closely and independently (high enough level to not have pressure placed on by superiors). Left to the ICDS system for this benefit they will eat the money.

10. Interview with the CDPO (X block)

09/03/2011

After introducing the organisation and self to the interviewee, the facilitator informed them about the purpose of their visit and inquired if she had read the answer sheet. After going through the information sheet, the interviewee asked us if we have contacted the district officer of ICDS. We replied that the type of information needed for our study will be more apt if taken directly from her as she was the CDPO of the entire X block and that the baseline study was also being done by us in this very block. Hence, we felt that it would be more appropriate to contact the CDPO for the interview than any other official.

The interviewee then said that if we needed information about "Indira Gandhi Matritva Sahayog Yojana", then we would get better information from the district and that she did not have all the information about the same. She also requested that she would be able to provide us with more info if we come to her the next day.

The facilitator replied that since we had taken prior appointment from her, it would be better if we interview the very day. We even convinced her saying that we would not be going into the technicalities of the Yojana but would need information about her analysis of the implementation of the Yojana as she was closer to the rural people of the village.

We asked her permission for an audio recorded interview which she denied. She asked us to write down whatever was needed by us.

Q1. When did you first get to know about the Sahayog Yojana and what is the basis on which women are chosen?

A1. The interviewee said: there was a meeting regarding this Yojana in the district but since I was not well, I was unable to attend the meeting. Instead, my supervisor went for this meeting and she would be able to tell better.

The Supervisor said: there was a seminar organised about IGMSY in which we were asked to give our views about the Yojana. Some time was given to all of us and we wrote about this Yojana by whatever we could understand of it.

Q2. What were your views that you had put forth? (Asked to supervisor)

A2. Supervisor said: when the guidelines about the Yojana were read out to us, there was a clause that said that money would be transferred to their bank accounts. The question that rose was that very few women had bank accounts as minimum balance needed to open accounts was Rs. 300 and it was difficult for them. We then advised them to let them open bank account under zero balance schemes.

Q3. What is your opinion about the criteria used behind choosing the women for Indira Gandhi Sahayog Yojana? What do you think behind the reason used behind the choice of these criteria?

A3. The interviewee said: The reason behind the criteria used is simple – “Family Planning”. If a woman having 2 children gets the benefit out of this Yojana, the other women will get inspired too and will not go for the third child. In the seminar, some people also talked about extending benefits to those women as well who are pregnant for the third time but some people were of the view that if we extend benefits to such women, then the objective of Family Planning – “Ham Do Hamare Do” will not be achieved. Hence, it should be given to only those who have two children.

Q4. We have even met some women in the village who have a child and they are just 18 years old.

A4: Interviewee said: Women in villages, especially those belonging to the lower caste do not know their right age. If you tell them about this scheme and then ask their age, they would not tell their age less than 19 years. Mostly it happens that whenever Anganwadi / Asha members ask their age, they in turn ask these members (Anganwadi members called Didis) to write whatever they feel is the appropriate age. Moreover, whatever age is once

written down in the Registration Card becomes a proof. A.N.M. also estimate the age of these women and write it down as proof.

Q5. What is the reason behind the clauses proposed to women under IGMSY?

A5. Interviewee said: certain clauses are very important to be stated like: registration of Pregnancy and child birth, antenatal care, vaccination, 6 month breast feeding. Greed for money would serve as an excuse to them and they would then go for health check-up of both mother and child.

In the villages, people do not give much importance to the Anganwadi members. They are equally indifferent if they get a registration or they do not get one (they are cool about it). Such schemes coming into implementation has certainly increased the importance of Anganwadi. From the time when this scheme called “Mahatma Gandhi Ashirwad Yojana” has come into implementation, people have started coming into our offices and our importance.

In the Indian system, women generally pay little attention to themselves and more to the family and children. They are even careless about their own food intake. Such schemes at least help them to take care of their eating habits.

Q6. What all clauses written down in this scheme are available/ implemented in your area?

A6. Interviewee said: Vaccination of mother and child is done every month. The AWW and AWH help in bringing all women together for the vaccination. When asked about the check-ups, the interviewee said that they have provided with a weighing machine in every Anganwadi centre and also a Growth Chart. New centres do not have a Growth Chart but have been provided with a booklet based upon this growth chart that helps them in registering the growth of the child.

Q7. What are the activities already done under the scheme of IGMSY?

A7. Interviewee said: during 1st to 31st December, 2010, first time and second time pregnant women’s list was asked by the district. We gave all the information about the same written in a Compact Disc (C.D.). Nothing has happened from then and we haven’t even got any budget after that.

Q8. What is your reasoning behind the sum/ amount being given to the women who come under the beneficiaries of this scheme?

A8. Interviewee said: there is no logic behind this. Rs. 4000 is just an experimental sum kept aside to know how many women are really benefitting from this scheme. If given more than this amount, other family members will spend it elsewhere, hence this amount is appropriate.

Q9. If women are not able to meet all the criteria written down in the scheme due to any reason like- she’s working somewhere else and is unable to reach the facilities or if reaches the facilities but finds the facilitators missing- then what will be the result?

A9. Interviewee said: if a woman is not able to meet the criteria written down in the scheme, then too she will receive benefits from the scheme. We will take care that she meets all the criteria and we would provide her with all the benefits that she deserves.

Q10. If a woman goes to a private doctor or a fraud doctor during this time, then what will happen?

A10. Interviewee said: I do not know about this.

Q11. Opinions about Still Birth, Miscarriage, and migrant.

A11. Interviewee said: since we do not have a guideline, I will not be able to say anything about it.

Q12. Comment on the transparency maintained under this scheme.

A12. Interviewee said: the list of the beneficiaries has not been finalised yet. The criteria have been decided by those who have formulated the scheme but they do take our opinions on the same.

Q13. Tell us about the way complaints are dealt and who is answerable?

A13. Interviewee said: I do not have any idea what is written in the guidelines about this. I believe that CDPO should be responsible on the block level; even we would listen to the complaints.

Q14. How are the schemes audited?

A14. Interviewee said: Most of the schemes today have this facility of getting audited so I believe even Indira Gandhi Matritva Yojana would be having some way of getting audited. I do not have any detailed information about it.

Q15. Under IGSMY, what type of added responsibilities have you seen?

A15. Interviewee said: I have not seen any added responsibility under IGSMY. We have received a "*Jaccha-baccha card*" or the Mother- Child card by the Anganwadi centre so that health details of both mother and child can be entered in the card.

The challenges that we will face will only be known once this scheme will be implemented. Only then will we know the challenge and accordingly, changes can be made in the scheme.

Interview with excluded women on scheme

11. Interview with beneficiary

10/3/11

Address: Village Z

Children: first child is 14 months old and second pregnancy is of 3 months.

The facilitator first introduced the researcher, Sahayog and self and also informed her about the purpose of visit. We also told her about the purpose of this study and how important is the role of the interviewee in this study.

After hearing about the scheme, the facilitator said that is she supposed to pay bribe to get the benefits of the scheme. We told her that we are not the Government employees who are here to give you the benefit of the scheme nor can we help you in getting it. We are here just to know the ways in which this scheme implementation can be improved. In the meantime, the women's sister in law entered the room and some 9-10 children along with some more 3-4 women. The facilitator requested the rest of the women to leave and also asked the children to go outside. After telling her a number of times about the interview process, we finally started with it.

Q1. Where do people go for medical facilities in your area?

A1. The interviewee said: for normal problems, we go to T which is 2kms away from this place. There are many private fraud doctors sitting there and there is a nurse too. For delivery most of the people go to X PHC and if the situation is quite critical, then they go to X Block PHC or to a private hospital. If they are unable to handle the case, then the cases are referred to Lucknow or Sultanpur. There is a doctor that sits at T and he gives medicine for abortion.

Tell me about immunization.

The interviewee said: During my first childbirth, I got myself vaccinated once when I was at my mother's house and the second time I got vaccinated at X PHC. I got the child vaccinated at X and for the registration card, I had to pay Rs. 10.

Q2. When ANM comes to the Panchayat, then why don't you go to her to get yourself vaccinated?

A2. The interviewee said: earlier there was no facility of vaccination at a Panchayat but now such a system is in place but there is no fixed timing for such a thing. Once she vaccinated a child in my house who fainted soon after getting vaccinated. Since they are not skilled we prefer going to X for vaccinations.

Anganwadi centre: The interviewee said: the Anganwadi centre is 2km away at village Z. I have never been to that place so I don't know what all facilities are there.

Do you get panjiri there? Yes we do get panjiri there. Children of my house have registered my name there, they get it for me.

Do Asha and Anganwadi workers come to you?

The interviewee said: I won't lie. Nobody comes to us from Asha Bahu or Anganwadi workers. If someone has to deliver a child, then we call asha bahu and she accompanies the women to the PHC X for delivery. The other woman said that we haven't told anyone about the second pregnancy as she didn't like discussing it with others.

Transportation facilities: f The interviewee said: we take a jeep to go to X block. It takes Rs. 20 to go to and fro for 2 people. We do not get any taxi, jeep or auto while returning after 5:45 p.m.

What if somebody needs to go at midnight?

The interviewee said: there is no facility to take people at midnight. If they have to go, people take their wives on a cycle or a thela or we have to call the driver.

Where was your first child born?

The interviewee said: during my first childbirth, I was at my mother's house that was quite close to the Sultanpur district. The child stopped all kinds of movement three days before delivery. My mother took me in emergency to a private hospital so the doctor said that an operation has to be conducted to take out the child. My brother refused to get me operated and then we went to the local district hospital where I underwent normal delivery. But I had to pay Rs. 3000 for the same. I didn't get Rs. 1400 as there was a delay in getting the card from my husband's house.

Government says that all the facilities at the government hospital are available free of cost. Is it true?

The interviewee said: they just say things. No matter how big is the government hospital, they do take money from us. There is a facility to give medicines to mother once the child is born but they do not follow it. There is no facility of bed also, they keep 2 women on one bed. They ask us to get medicines from outside even in the government hospital so people find it convenient to go to a private doctor instead.

Breastfeeding:

The interviewee said: I fed my child continuously for 10 months. Some feed for more than three years.

Do you work for money?

The interviewee said: I have plenty of work at home, I can't even think of going outside for work.

How is your food like during pregnancy?

The interviewee said: when we do not have sufficient money, how can we get nutritious food. If you have money, you can get good food else not. We are not taken care of. We have such a huge family that if we feed the entire family with pulses, rice chapattis and vegetables, that would be sufficient.

Facilities you have for ration

The interviewee said: we have farms and white BPL card as well. We get 35kgs of ration, 2kg sugar and 1 kg pulses. Since our family is quite large, we have to buy it from outside like

wheat, rice and oil and firewood. The inflation has an effect on our daily consumption. We think twice before spending money.

Tell us about rest you get during pregnancy

The interviewee said: during my first childbirth, I was at my mother's home so I got rest now I am at my husband's house so I won't get much rest. I am feeling pain in my stomach and would go to a doctor but since I don't have money I will not go to the doctor. I am waiting for money, as soon as I get some I will go to a doctor.

When asked about their financial condition, we got to know that 3 brothers-in law have gone to the city for work. Father in law works at NREGA but these days he is not going as he is not well.

From whom do you take loan in such a case?

The interviewee said: this is a routine affair. A lot of money gets spent on food items and medicines. Once, one of my brother in law and mother in law had fractured their bone, we had to take loans for their treatment. Since we take it from our relatives and friends, so we do not give interest.

All the decisions of my house are taken by husband and brother in law.

IGMSY

The interviewee said: when I went to my mother's home, then I had met Asha bahu who told me that we would get Rs. 4000 after child delivery.

When asked about criteria and conditions, she said she has no information about it. After registration and vaccination, we go to X block PHC but there are no facilities available for measuring weight, height etc. a mother would know how to judge a child's growth but there is no proof.

Is it important to have conditions?

It will be beneficial for mother and child if certain conditions are laid down.

When and how should you get benefits?

The interviewee said: we should get money all at once as we do not have enough money to go to X again and again. When we are into 6 months of pregnancy, the benefits should be given to us. If we eat food afterwards, it does not affect our health.

How can a woman get an entire sum?

The interviewee said: I don't have a bank account but my father in law has one, if money is transferred to that account, I can easily get it. Money can also be sent to Asha Bahu, she will take Rs. 100-200 but will give the rest to us. We face a lot of difficulty in withdrawing money from bank as there is a lot of rush and often we have to go to 2-3 times to finally get the money. Men can go on a cycle but it's really difficult for women to walk all that way.

You were talking about bribery, tell us something more about it.

The interviewee said: when Asha bahu takes us for delivery, she takes Rs. 50-100 from the family and she gets money from Government as well. I was talking about this bribery.

Why don't you speak about it?

The interviewee said: we don't say anything about it. They take money everywhere, in Government as well as in private.

12. Interview with beneficiary

10/3/1

Address: Village Z

Children: first child

Details of interview:

Since the husband of the beneficiary was known by some other name in the village, the team found it really difficult to locate the actual house of the interviewee. When we finally reached their house, we couldn't find anyone in the house. Then the local interviewer went and talked to her and explained her the purpose of our visit.

We gave us the introduction of Sahayog and the team and after explaining everything we started with the interview.

Q1. Where do people generally go for treatment in your area?

A1. The interviewee said: those who have money they go to private ward and those who are poor they go to government hospitals. Pregnant women go to X Block PHC and get medicines from there and they go at the time of delivery. For other ailments, people go to T, X and Sultanpur. Since I m new to ths place, I havnt spent much time here, only 2 years and I don't go outside my house ofen so I don't know much about it.

Q2. Why do people go to government hospital for delivery?

A2. The interviewee said: we don't have to spend much so we prefer going to the Government's hospital and we also get Rs. 1400 s people go there. But they are very careless in Government hospital, they don't take care of us.

Immunization:

The interviewee said:I got myself vaccinated at X block PHC. ANM come to village Panchayat for vaccination but there is no fixed date and timing of their visit. When I went to X for the first time, then the nurse injected in me without asking me anything, she did not make any card, just wrote it on a piece of paper. She dint examine me, nor did she ask how many months pregnant I am.

When asha bahu came to give polio drops to children, she asked us to contact her in case we faced any problem.

What facility do you have for transportation?

The interviewee said: X is 6kms away so people generally go to that place on a cycle or taxi. Village W is 2-3 kms away so people either walk or go there by cycle.

What problems you faced during pregnancy and where did you go for medicines?

The interviewee said: I had gas in stomach and also had headache. I showed myself to a nurse at T, she gave me medicine worth Rs. 300. She said that I am anemic and also gave me a powder that I should mix with milk and then have. She advised me not to have fried and oily stuff.

It is said that if we go outside, some ghost will ride on us. I don't go outside in dark. I went in the evening for latrine, n felt a lot of pain. Then got bhabhoot on me to get relieve of the pain.

Anganwadi:

The interviewee said: it is quite far from this place. I have heard that we get panjiri there but I have never been to that place. I don't go out of my home.

Food:

The interviewee said: I eat everything, rice wheat, vegetables. Sometimes when I feel like I drink milk.

What do you get on the ration card?

The interviewee said: we have the red ration card. We get 35kgs of ration on it. Kerosene oil, 2kgs of sugar and 1 kg matar peas.

Do you buy it from outside?

The interviewee said: we have to buy oil and firewood from outside. All this is taken care of by my father in law.

Any change in your food intake during pregnancy?

The interviewee said: I eat whatever I get. Nurse told me to have more of milk and green vegetables but whom shoul I say in my husband's home? My husband works in city and comes once in a year so I cannot say anything to anyone.

When asked about the amount of rest they take, The interviewee said: I always stay at home, cooking, washing clothes, cleasing nad stuff, all that is my work. I get rest for 1-2 hours in a day. Others members say that if you keep walking, you ca deliver the child easily.

Tell us how you manage the household expenses.

The interviewee said: my father in law goes out for work and husband does furniture work in the city. He comes once in a year.

How much does your husband earn?

The interviewee said: I have no idea. My husband and father-in law knows about it. How much to spend and where to spend, all these decisions are taken by my father in law and husband. Its mandatory to take their permission before going to ay place. Whatever my father in law says, the whole family agrees to it.

IGMSY

The interviewee said when asked about this scheme she said that the Anganwadi members came to give polio drops to other children of the house. She said that women would get money after child birth, when asked how much she said that she did not have any idea about it.

The facilitator then explained her about the IGMSY scheme and the criteria as well as the conditions and then asked her about her opinion about the same.

The interviewee said: the criteria laid down is okay because these days, educated people do not want many children and marriages also take place after 19 years of age. The conditions laid down are okay but Asha bahhu never comes to us for vaccination. There is a facility for vaccination in X PHC but people there are very careless. I still have to get myself vaacinated for the second time and have to get myself registered as well.

How do you want this scheme to be implemented?

The interviewee said: its good to get the money in two instalments, first time when we are into 6 months of pregnancy and the second time after child birth. Its difficult to goto X again and again.

13. Interview with Beneficiary

10/3/11

Address: Village Z

Children: 1 child (5 years)

Interview details:

Q1. Where do people go for medical facilities in your area?

A1. The interviewee said: for small ailments like fever cold cough etc, people go to Village W that is 3 km away from this place and show to a fraud doctor. We also go to X that is 6kms or to Sultanpur hospital. If we have to show our children to the doctor, we prefer going to X block PHC or to a lady doctor.

The interviewee said: I had a child five years back but afterwards I became pregnant three times but had a miscarriage. This is the fourth time I am pregnant.

Q2. Tell us how the miscarriage took place the other three times?

A2. The interviewee said: when my first child was 1 year old, I became pregnant but when I was into 4 months of pregnancy, it started bleeding that continued for another 15 days. I showed myself at X block. The nurse asked me to get the abortion done but since I was very weak, I did not get it aborted, and instead I took medicines for it.

After this abortion, I got pregnant after another 6-7 months but the same thing happened after 3 months into pregnancy. When I showed myself at X block PHC, the nurse did my abortion and took Rs. 500 for medicines.

Nurse also said that the uterus lining is weak, that's why the child gets aborted. Don't pick up heavy weight etc. when I became pregnant again one year back, I showed to a doctor. He said to strengthen the uterus lining; we have to give you injections and medicines. He wrote medicines worth Rs. 400, he also gave me injections but I underwent another miscarriage in 2.5 months.

This is my fourth pregnancy and I have been taking medicines right from the beginning and I have been taking medicines for strengthening the uterus wall. Every month I spend approximately Rs. 450 on medicines and after every 15 days, I get an injection worth Rs.115.

Q2. Since you are getting treatment in a government hospital, tell us about the facilities you get in this hospital.

A2. The interviewee said: we do not get any facility in the Government hospital. Dr. xxxx writes some medicine on the medical store's prescription page and asks us to buy from that shop. We do not get any medicine from the hospital.

When we looked at the prescription form, we saw there was no mention of the government hospital's name anywhere and it was not the regular PHC's letter head as well. They conducted urine testing free of cost and the doctor has asked me not to lift heavy weight

Apart from the medicines, jhaad phoonk (black magic) is also going on to remove all the evil spirits that are riding on me. I have to go to the hospital for another injection this Friday.

Facilities for immunization

The interviewee said: there is no facility available for immunization in our village. I have heard that the ANM comes to Panchayat but nothing is certain as such. She comes in 3-4 months. That's why everyone goes to X for immunization.

Transportation facility:

The interviewee said: I go there with my brother in law so I do not face any difficulty. Those who do not have anyone at home, they face problems.

Anganwadi

The interviewee said: we get panjiri there but I have not registered my name there and the card is also not made as I have yet to complete 3 months of pregnancy.

Tell us about your diet etc.

The interviewee said: I don't like food and after another 2 months, I will be into 5 months of pregnancy, then perhaps I will like eating food. Nobody takes care of me in my husband's house. I eat pulses, rice and vegetables here. I was thinking of going to my mother's place but have decided to stay back for the medicines. My brother in law is taking care of all the medical expenditure and is asking me to stay back here.

What all do you get from your ration card?

The interviewee said: we have white BPL card. We get 35kgs of ration every month and 2 lts of kerosene oil. Sometimes we also get 2 kgsof sugar and 1 kg of matar peas.

What do you buy from the market?

The interviewee said: since we have our own farms , we generally do not buy from the market. Pulses, oil, sugar, firewood we have to buy no matter how costly it is.

IGMSY

The interviewee said: I don't have information about this scheme. I think the benefits should be extended to those who have 3 children as even now, poor people do have 3-4 children. Those who undergo miscarriages after 3-4 months should also get some benefits as they become quite weak after a lot of bleeding.

When asked about the conditions to be fulfilled, The interviewee said: we do not have testing facilities in pur village nor do we have weight chekng facilities. I don't have any information about growth chart as well. Even when we go to X block, they do not check our weight or blood pressure. Some women do not get permission to go to T for medicines, how can they goto X alone.

If money is transferred to our bank account, we would get all of it but there is a lot of rush in the bank and our whole day gets wasted. We get money after running for 2-3 days.

A. FGD with local village women Z

Date: 7/3/11

Central group discussion venue: Panchayat House Z

Age group: 21-40 years

Caste: Backward caste

After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study.

While introduction we got to know that 2 participants from ASHA Bahu and one member of Anganwadi was also present in that interview. We told everyone that we would be interacting only with the village women that day but still those women continued to say there. Then facilitator took help of the local helpers to get the Asha Bahu and Anganwadi members away from the local village women. Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. Where do you go to get health related facilities?

A1. The interviewee said: if we are not much ill, then we go to the X Block (PHC 12 kms) else we go to Sultanpur for treatment and if it is a major case, then we go to Lucknow.

Q2. What all facilities are available locally/nearby?

A2. The interviewee said: cold, cough, fever, stomach ache –the medicines for such illness is available at every jholachaap doctor's place. Such doctors sit at the T.

In the Government hospitals that are in X and Sultanpur, we get facilities there. Village Y too has a broken dilapidated hospital building but we are not sure if a doctor sits there. Since Y falls in opposite direction, hence we prefer going to the X.

During delivery, mostly women are taken to the X block (PHC) but if it is late night then the delivery takes place in the homes.

For vaccination, people generally go to X to get the mother and child vaccinated. Sometimes, the tetanus vaccines are injected to the mother and child by calling the jholachaap doctor at home.

The ANM of our locality doesn't meet us. Their centre is at place S but whenever we go there we do not find her. In November 2011, she was here.

Q3. Tell us about Anganwadi centre.

A3. There is an Anganwadi centre here. Usually children go there to study. The members there teach our kids, give them panjiri and khichdi to eat. When asked about how much panjiri they get, they replied that in a week they get 2-3 glasses of panjiri (100 grams). Those women who fail to reach the centre and go there only once a month get a little more panjiri.

Q4. What all facilities are available in Anganwadi apart from the ones mentioned above?

A4. The interviewee said: there is no other facility there. When asked about the weighing machine, they said they have never seen one. When asked about counselling done by Anganwadi members, they said that nobody comes to our home and no sort of counselling is done.

In that group, there was only one woman who had a child of 2.5 years of age. When about the vaccines given to the child, she said that till date, no vaccine has been given to her child. When asked why, she said that since her husband was working and she was all alone. Since husband is mostly away, there is no one to take her to X. Twice I got ready to go there but *pradhaan* of the village said not to go. Instead I should ask the ANM to come to my place for vaccination. Since then, no ANM can be seen here and my child has not been vaccinated since then. The woman also said that if we take someone else along with us, then we have to bear the travel expenses of that person as well.

Facilities available at X: The interviewee said: when pregnant women go to X, then vaccines are administered and iron capsules are given. When asked about the tests conducted, they said that they do not conduct any sort of tests. When we say we have pain in stomach, then they make us lie down and then touch us to check and for this they charge Rs. 20 for this. One woman said that those who do this job, they have a habit of charging for everything and the poor people are exploited everywhere.

When asked about the expenses, the interviewee said: when delivery takes place in X, then the expenses are above Rs. 1000. They prescribe medicines from outside worth 300-400 Rs. And nurse takes Rs. 400-500. Another woman said that now the nurses take Rs. 600.

Another woman said that once she took her daughter-in-law for delivery to X. We not only gave money for all the facilities but also her daughter-in-law's sari was asked by the nurse there. Her daughter-in-law had just one sari so the nurse said that when she would come next for the vaccine etc, then she should get one sari for the nurse. From then on, whenever I go to get the child vaccinated, I hide myself every time so that the nurse doesn't see me.

The *Dai* too charges Rs. 121 as *shagun* (good omen) by bathing the child. The transportation also comes to close Rs. 200-300.

If a woman doesn't have money, then she is forced to get a loan first and then come for delivery etc. they make sure that whoever comes to X does pay first and then get the facilities.

Q5. For how many months do you breast feed your child?

A5. The interviewee said: usually a child should drink mother's milk till the age of 2 or 3 years but here women breast feed only for 6-7 months. One woman said that she always gave outside milk to her child as she couldn't produce milk for more than 3 days. Two women there said that they have been feeding their children with outside milk for the past 3 months. Another woman said that since milk is very expensive, hence only those who have cow/buffalo at their home can only afford to pay, the rest cannot afford milk for their children. Those who for work outside, it are very difficult even for them to provide milk to their children.

Q6. What food do you eat?

A6. The interviewee said: whatever is available in or homes, we eat that. Peas lentils, *urad* lentils, wheat and rice. In vegetables, we have more of potatoes as it is cheap and easily

available. One woman said that since everything is very expensive, hence we are always on the lookout to get cheap food. Green vegetables like *sarson*, *chana*, *matar*, *bathua*, *palak* is what they usually have during winters.

Q7. What all is mentioned on the ration –card?

A7. The interviewee said:

LALcard: Rs 100 for 25kgs of rice and 10 kgs of wheat. Sometimes we even get 1kg sugar, salt and 2lts of kerosene oil.

White card: 15kgs of rice and 15kgs of wheat. It is distributed for 3-4 days and is distributed every month.

What do you buy from outside market?

Since we are not much into farming, we have to buy most of the items. Since it is becoming dearer day by day, we have to spend a lot but since we have to eat, we have to pay.

When asked about household expenses, they said: our husband works in NREGA.

Q8. What kind of food do you take after delivery?

Q8. The interviewee said: if there is milk at home we drink it else we eat general food what is cooked at home. After having a child, we eat dry fruits for 10-15 days. That too is difficult because of excessive dearness. Rs 2000 gets only a handful of dry fruits. In villages there is so much of work that you don't care to eat.

Q9. What type of household work do you do?

A9. The interviewee said: cooking, picking up dung and making *kande*, cutting grass, taking care of child. Sometimes we even do farming but women are never called farmers. Women sleep after men and get up before them.

Q10. What type of work do you avoid during pregnancy?

A10. The interviewee said: we do all sorts of work. If we do not work then how will we earn money? Till we are pregnant we do all work, if there is any complication and doctor advises not to do heavy work then only we avoid it else we do all sort of work.

After having a child, then from the 12th day, we again start doing all work. One woman said that I started cooking after 8th day itself.

Indira Gandhi Matritva Sahayog Yojana

Q11. Do you know about any scheme that promises to give a pregnant woman a sum of Rs.4000 for her childbirth?

A11. The interviewee said: one woman said that *Didis* had told her about this scheme that a pregnant woman would be getting Rs. 4000. Others said they do not know anything about the scheme.

Q12. After telling them about the IGMSY, we asked:

What is your opinion about the conditions laid down for selection of women who would get benefits of this scheme?

A12. The interviewee said:

Some women asked questions like: is there any benefit for those who have gone for contraception? Is it not for women who are getting pregnant for the third or the fourth time?

The facilitator again explained all the conditions.

The interviewee said: these days, marriages take place after 18 years of age and children are born only after 19. But women do go in for 2, 3 or 4 children to have a son as their heir. Some go for 5 children to have a son. These days 2, 3 deliveries are very normal hence the benefits should be extended to those as well who are getting pregnant for the third time.

Q13. What is your opinion about the conditions laid? Are the facilities available?

A13 the interviewee said: the facilities must be available at the X (6 kms) away but is not here. Anganwadi will write all false data. Since women are getting money, they will go to collect it out of greed even if they are forced to go to X or Sultanpur. It is important to have conditions as it results in better health of mother and child.

Q14. What is your opinion if you get money in three instalments?

A14. The interviewee said: it is good if we get money in three instalments. This way they can spend some part on themselves and some on the child. If we get it all at once, then it would be spent on some other household expenditure

Q15. What do you think is the easiest way money can reach to you all?

A15. The interviewee said: one woman said that it's better if money is given in hand directly while the other said that it's better if it is transferred to their account. The account opening process is indeed difficult but once the account is opened, the transactions become very easy.

B. Focus Group Discussion with Scheduled Caste women, Village Z

Date: 07/03/11

Place of central group discussion: women's house

Caste: Schedule Caste

After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study.

Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. What kind of facilities is available around this place?

A1. The interviewee said: we go to X block and also get vaccinated at Panchayat, Z. A doctor as well as a nurse sits at the T. We also go to the Government sub-centres. Medicines for cold, cough, fever is given there. Pregnant women and children are vaccinated at the X Block.

When do ANM come to you?

The interviewee said: We do not get any information as to when ANM comes to the village. ASHA Bahu has given their phone numbers to some of us and has asked us to inform them when we get pregnant. We will take you to the hospital and you would get Rs. 1400.

When asked about Anganwadi, The interviewee said:

Anganwadi workers give us *panjiri* – a type of nutritional food. We are given 2 glasses of panjiri (300-400grams) of panjiri which we don't like to have. We do not get any facilities there. Since we belong to the labour class, none of the facilities actually reach us. Any scheme made for us would not reach us as the General caste people won't let it happen.

Q2. Why do you go to jholachaap (fraud) doctor?

A2. The interviewee said: jholachaap doctor is nearby and even T is nearby. It takes longer duration and more money to go to X and hence we prefer going to a private doctor.

Q3. After childbirth, for how long do you breast feed your child?

A3. The interviewee said: we breast feed our child till we do not become pregnant for the second time. For 6-7 months, we feed our milk.

Q4. How do you manage breast feeding when you go out for work?

Q4. The interviewee said: going for work is important else we do not get money. When we come back in the afternoon then we breast feed our children.

Q5. Why don't you take your children along?

A5. The interviewee said: the place of work is very hot and then we would need someone there to take care of the child so it is better to leave it at home.

Q6. Has anyone been appointed from NREGA to take care of the child?

A6. The interviewee said: nothing as such happened the year before but one woman has been appointed this year to take care of the children.

Q7. Instead of labour work, what facilities do you need to take care and breast feed your child?

A7. The interviewee said: during work, we are not allowed to go to toilet or urinal, drink water etc. even we are not allowed to have food. In such a situation it is out of question to feed our child. If we go home during break and come back a little late, we are told to go back.

Food: The interviewee said: we eat rice, chapattis, vegetables, pulses everything. Sometimes we have rice and sometimes chapattis. These days we add bathua (amaranthus spinosus) to pulses and then have it.

Ration-card: The interviewee said: we get wheat, rice and kerosene oil on that card. The ration distributor informs about it the day he comes from distribution. If you do not have money that very day, you will not get ration the next day.

Effect of rising prices and super inflation: The interviewee said: the stuff we used to get before, now we get it in small instalments every time the need arises

How many times do you have food? The interviewee said: we have meals twice a day. During pregnancy, we have this normal kind of food rice, pulses chapattis. We would look after the child or ourselves?

Rest during pregnancy: The interviewee said: we do all the household work; there is no rest for us. Family members say that if you will not work, you cannot give birth to a child. If we start taking rest, then how would we earn money?

After how many days do you start working after childbirth?

The interviewee said: I started working in the field on the 12th day itself. Those who have others in their home to look after the work, they rest for 15 days or so. Thereafter, it becomes extremely important to work else we will be deprived of food.

IGMSY

Q8. Have you heard about this scheme?

A8. The interviewee said: no, I haven't heard anything about this scheme.

Q9. What is your opinion about the conditions stated in this scheme?

A9. The interviewee said: women do get married before the age of 18 and have children before this age. In FGD too, we have such women who were married off at an early age and are pregnant for the second time. They are hardly 19 or 20 years old. Those who are pregnant for the third or the fourth time are very weak (comparatively) and hence the benefits should be extended to all.

Still birth and miscarriage: The interviewee said: women should get some benefits in case of still birth and miscarriage as she cries a lot after this happens and hence she body becomes weak.

Q10. What is your opinion about the conditions laid down in this scheme?

A10. The interviewee said: tetanus injections and registration is done in X block (PHC) but there is no facility for weighing mother and child

Condition should be limited up to an extent that women can fulfil them. They (policymakers) should realise that women have to go for work as well and X block is very far off. We have to really work hard to fulfil all conditions but a person does anything to earn money.

Q11. What is your opinion about money being given in three instalments?

A11. The interviewee said: if we get the whole amount in one payment, then it would be spent on other household activities. So it is better they get it in instalments, this way they can spend it on themselves.

Q12. What is your opinion about the benefits being transferred to your bank account?

A12. The interviewee said: after running to a bank for 1-1.5months, then a bank account gets opened. It also takes money to open an account. Some said that under MNREGA, their husbands have an account. Once an account is opened, then money deposit and withdrawal becomes very easy. Hence money should come to our accounts only.

C. Focus Group Discussion with Schedule Caste women in Y

Date: 8/3/11

Central group discussion venue: Panchayat House Village Y

Age group: 21-40 years

Caste: Scheduled caste

After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study.

Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. Where do people in your area generally go for medicines when they fall ill?

A1. The interviewee said: we go to Sultanpur, village W and X Block.

In villages, we go to a doctor who sits near roadside who gives medicine for fever, cold, cough etc. a private nurse sits in W, she sees pregnant women, gives medicine to women during menstruation cycle.

Q2. What happens in the broken dilapidated building of Barjhana?

A2. The interviewee said: that is the Government hospital (PHC). Women and children are vaccinated there. When we go there to get medicine, it is written to be bought from outside.

Nothing happens from their medicines and if we have to go to W to buy medicine, then its better we show it to the doctor sitting there. We do get medicines in X and Sultanpur but nowhere is it free of cost.

X: women generally go to X for delivery. When doctors are not able to treat us, then we go to X. Every month, vaccines are administered in PHC.

Q3. Where is Anganwadi centre ad what happens there?

A3. The interviewee said: Anganwadi centre is on the roadside in the primary school's premises. Workers there teach our children, give them *khichdi* to eat. 4-5 boxes of *Panjiri* is given to pregnant women. When we go back to our homes, we are advised to get ourselves vaccinated and also tell us the importance of polio drops.

Q4. What tests are conducted by the ANM during vaccination?

A4. The interviewee said: no tests are done here. It is done only when we go to Sultanpur

Urine/ blood tests: it is done in Sultanpur or X. When asked about the weighing machine, only two women had seen the weighing machine.

They said that ANM sisters give us iron capsules after vaccination and suggests us to eat green vegetables and spinach.

Q5. How is the panjiri that you get to eat there?

A5. The interviewee said: sometimes it is good, other times it remains uncooked. Sometimes it is rotten so we give it to cow/goat. The quantity that is given is very less; mostly children eat it so we are left with very little.

Q6. What equipments are available in case of emergency?

A6. The interviewee said: if we go to W, we go on foot or on cycle. For X, we take shared vehicles/taxi, and book a taxi for emergency.

Q7. How is a woman taken for delivery at night?

A7. The interviewee said: night booking charges are Rs. 600. Nurse takes Rs. 500 and *Dai* takes Rs121 for cutting the umbilical cord. Medicine expenses are Rs. 300-400. **“Those who are poor deliver at home, no matter their child lives or dies.”**

Q8. Who delivers at home?

A8. The interviewee said: firstly, people from the neighbourhood try to deliver the baby else a nurse is called from W. She charges Rs. 500. If the delivery is done by *dai* then it takes only Rs. 500 in all. The doctor is later on called at home for vaccination.

Q9. For how many months do you breast feed your child?

A9. The interviewee said: generally, a child is given milk for 4 years but is breast fed for 5-6 months. In summers when a child is born, we start giving him water instantly. I know about a

woman who gave birth to a child but could not produce milk for 6 days. This was her fourth child.

Q10. What type of work do you generally avoid doing during pregnancy? How much rest do you get?

A10. The interviewee said: if we do not take out time, we never get free time for ourselves. When we finish off our daily work quickly, that day we get some rest. We don't get rest in our in-laws house. We get only at our (mother's) house.

We do all sort of work, from farming to household work. Sometimes it also happens that after working for an entire day, the child is born on the same night. From cutting to pruning, we do all work, also lift heavy sacs etc.

Q11. For how many days do you take rest after childbirth?

A11. The interviewee said: we rest for 10-12 days. Those who have people in their homes, they rest for 20-25 days. We have normal food only during this time. We do take tonic those who have cow/ buffalo their homes are able to drink milk for a month.

Q12. How do those of you feed your child who goes for labour type work?

A12. The interviewee said: we feed our children in the morning and also keep aside some milk for them so that someone from home feeds them.

Q13. How do you take care of your food etc after delivery?

A13. The interviewee said: nobody takes care of us. We have large families, dearness is so much, and everyday it is not possible to have pulses, rice, chapattis, and vegetables.

Indira Gandhi Matritva Sahayog Yojana (IGMSY)

Q13. Have you heard any such scheme where women get Rs. 4000?

A13. The interviewee said: we don't have any idea about such a scheme.

Q14. After telling the women about the criteria, we said: what do you think about the criteria laid down in this scheme?

A14. The interviewee said: some women were of the view that everyone should be given the benefits whereas some felt that Government cannot keep giving benefits to those who go on having 12 children or so. Another one said that it should be extended to those who have three children.

When we discussed about the age limit of 19 years, then the women said that now they are not married off before 18 years of age. But we have seen that two women had their first child before the age of 18 years,

Q15. What is your opinion about the criteria that you have to fulfil to get the benefit of the scheme?

A15. The interviewee said: only those who stay at home can fulfil this scheme well, for those of us who stay away for work, it is difficult for us. Another woman said that we would get benefit only when ASHA Bahu, ANM or Anganwadi workers will take our signatures on the card but the problem is that they take bribe from us to get our names registered.

If facilities would have been nearby, we would have taken out time and gone for the treatment. It takes Rs. 100 for two people to go to X, tell me how it is possible to go to X.

The Y hospital (PHC) should be maintained (repaired). Nurse should be present there all the time. All the facilities should be made available in the hospital. Some pressure should be put on the doctor so that he stays in the hospital for 24 hours.

Q16. When and how should you get the benefits of the scheme?

A16. The interviewee said: when a baby is born, the whole amount should be given then and there. Other women said that no matter how many instalments you want to give, all I want is I should **get** money.

Q17. How much money do you keep? If you get money all at once, will you be able to spend it according to your way?

A17. The interviewee said: we have different types of families/women here. Some have the liberty to spend money as they like but others don't. If a person spends Rs. 50-100 on oneself, how does it harm anyone?

After childbirth, more money is spent as expenses increase and even our bodies become very weak. In such cases, we need more money to spend on ourselves. If we get money, we can bear travel expenses and can also spend on having nutritional food as well.

Q18. How many of you have bank accounts?

A18. Bank is close by, and account gets easily opened as well. Most of the women work in NREGA and hence all of them have an account already opened.

D. Focus Group Discussion with Backward Caste women in Village Y

Date: 8/3/11

Central group discussion venue: Panchayat House

Age group: 21-40 years

Caste: Backward caste

After introducing the Sahayog society, self and the researcher, we told all the participants the objective behind conducting such activities and that we have decided to conduct interviews with them for the research study.

Then facilitator discussed about the information sheet and consent form and after taking signature of all the members present, we started with the discussion.

Q1. What types of facilities are available in your area?

A1. The Interviewee said: we go to W circle (@kms) away, X (12 kms) Sultanpur or Lucknow. People usually go to X for delivery. If it is a case of operation, then we go to Sultanpur.

A private nurse is there at W who takes Rs. 500 for conducting deliveries at home. If they give medicine from their side, then they charge Rs. 1000-1500.

Barjhana PHC: The Interviewee said: whatever is the illness, the medicine given is the same for all types of illness. Usually, we have to buy it from outside and come back to show them that medicine. It's better to show it to a private doctor. Barjhana hospital has completely broken down. The qualified doctor rarely comes to see us; usually the compounder sits there who also give us the medicines. The attendance of all is taken by that compounder himself.

ANM used to live at the V Centre (sub centre) but that is totally broken down now. She comes once a month on Saturdays

Q2. How is the registration and vaccination done?

A2. The Interviewee said: they come once a month for vaccination. They charge Rs. 10 for Registration. When asked why they charge, they say that since they come from a far off place, they need some *kharcha-paani* i.e. bribe.

One woman said that once she had gone to register herself for the *Balika Ashirwad Yojana*. The then ANM had charged Rs. 500 from her. When the papers reached the Block, CDPO asked for Rs. 1500. I said I have R. 200 so she said that the insurance is worth Rs. 1 lakh so she should give at least Rs. 1500 to them. I asked her to take Rs. 200 but she got angry so I came back with the papers.

Q3. What do you get in Anganwadi?

A3. The Interviewee said: we get two glasses of *panjiri* which is about 400 grams. The workers fight with us. When we asked reason, they said that the workers fight with us is that if we miss taking panjiri once and ask them to give us double the next time; they simply refuse to give us.

When asked why they miss going on Saturdays they said that owing to a lot of work, they forget at times. When we do remember and go to take panjiri, they refuse to give us. Even if we don't go to take panjiri, our names are always written on the register that we have collected.

Asha and Anganwadi workers stop us and ask if we are pregnant or not.

One woman said: my daughter-in-law had ache in her stomach, so Asha Bahu took her to X PHC. She said that if there is any kind of trouble, then we should report it to her.

Another woman said that Asha takes us Tuberculosis patients to the hospital that gets medicines free of cost but if it's the case of a child/ childbirth, then money is involved everywhere.

We get Rs. 1400 to go to a hospital but more is spent if treatment is done there. We take Asha Bahu on our expenses and they too take money from us. We are not able to say anything to them and since they are *pundit/Brahmin* by caste, hence nobody open their mouth.

Q4. How much of your involvement is there in decisions taken about your house/household work?

A4. The Interviewee said: if our man works and earns money, then we ask them before spending. If it is our hard-earned money, then we spend it according to our wishes. Decisions like how a work is to be done or what is to be done is usually taken by the man himself.

Q5. What kind of food intake is there for women once they get pregnant?

A5. The Interviewee said: women in villages do not get help of any kind. When we earn Rs. 100, we look after ourselves or our 4 children. We get pulses, rice, chapattis and vegetables after a lot of effort.

Q6. What do you get from the ration shop?

A6. The Interviewee said: we get 20 kgs rice, 10 kgs wheat, sometimes even pulses and sugar. Even if we do not have money, the kotedar gives us ration.

Q7. What is the effect of inflation on your eating habits?

A7. The Interviewee said: we often miss our night's sleep thinking how we would bear the expenses of the next day. Oil, ration and firewood we have to buy but we buy it in lesser quantities. Since the shopkeeper sells everything on cash, we have to buy stuff in small quantities.

Q8. How much rest is needed by women after delivery?

A8. The Interviewee said: when we are pregnant, we earn money by working and then feed ourselves and when the child is born then we leave the child and work again to feed both child and ourselves. Work doesn't even let us feed our children. We leave our children till the time they sleep but when they wake up and cry, we leave our work to feed the child.

Those of us who have others at home; they can rest for 15-20 days. Those who don't have anyone at home; they start working in a week or so. In 15 days, they start doing work like picking up cow dung, cutting grass etc.

Q9. For how many days do women feed their children?

A9. The Interviewee said: those who do not produce milk feed the outside milk and those who do produce feed their children for 1.5-2 years.

IGMSY

Q10. Have you heard anything about a scheme that gives women Rs. 4000 if they are pregnant?

A10. The Interviewee said: when I went to Anganwadi to get panjiri, she said that when she delivers a child, she should go to X block to get Rs. 4000. She also said that only those who are pregnant for the first or second time will get the benefit. She also said that after getting vaccinated twice, they will get Rs. 500.

Q11. What is your opinion about the conditions laid down in the scheme?

A11. The Interviewee said: if benefits are being given, it should be given to all. Every woman who gives birth to a child has to bear the same amount of pain and her body undergoes a lot of pain. A woman who has 4 children would not throw away her two children to claim the benefits on the other two. There are more women in village who are pregnant for the third or fourth time and they need more nutrients. One of them also said that if you are giving, then give to all else don't give to anyone.

Q12. What is your opinion about the conditions of the scheme?

A12. The Interviewee said: one woman responded angrily saying that how would a woman who doesn't have money fulfil these conditions. Another one said that since we are labour

class women, it is not possible for us to run every other day. When we will not have enough money to go to X, how will we get ourselves tested?

Q13. But the Government says that all the facilities are available in your area.

A13. The Interviewee said: when I went to get myself vaccinated, the ANM did not check my weight nor conducted any tests. Another woman said that in Government hospitals they give a *parchi* for a rupee but prescribe all medicines from outside.

One woman said: its good to keep conditions in any scheme but the non-availability of money makes it impossible for us to fulfil these conditions. Either rich women would benefit from this scheme or those living close to the Sultanpur Hospital would benefit from it,

One woman said that she earns Rs. 100 after a lot of hard work; we would spend it on our children rather than on our tests.

You should first provide us with facilities and then talk about benefits. Poor people do not get loans as well. When we ask Asha Bahu to come with us, they say they would go the next day or after that and in this way our 3-4 days get wasted. What will we do even if we get Rs. 4000?

Money transfer: The Interviewee said: its better if we get cheques or if amount is directly transferred to our bank accounts.

E. Observations from the field from 3rd – 11th March 2011 (field notes and photos).

State: Uttar Pradesh

District: Sultanpur

Block: X

Villages: Y and Z

Y population 2575 with 30 women breastfeeding and 23 women pregnant.

Z population 2457 with 35 women breastfeeding and 20 women pregnant.

No one on the list prepared by AWW's is under 19.

Full list of beneficiaries not distributed yet.

Interview with ASHA, done in house of her mother-in-law as ASHA's work from home, or sometimes from the sub-centre. In this area the sub-centre building is not fit for purpose. The ASHA's job is to take women for delivery and immunisations etc. ASHA's are not salaried and are paid per completed job.

AWC - Should be an AWC but there is not one in Y. Instead the AWW and AWH use a local school and also the panchayat building. The AWH use a local school from 10-2pm as their role is to focus on the nutrition of children and help teaching those 0-5 years. After 2pm they go door to door to counsel and provide education and information to women and

adolescent girls. Was difficult to track down the AWW as she was out on the pulse polio campaign.



Figure 1 village Y PHC



Figure 2 village Y PHC

The building has been in this condition for 10 years.



Figure 3 village Y PHC

A doctor visits daily and sits in this room. However the timing is sporadic and he was not present when we looked around the PHC.



Figure 4 Panchayat building used by AWW's to distribute cereals and grains

Saturday is nutrition day and so the AWW's (the two on the left of the photo) use the panchayat building to distribute cereals and grains which can be seen in the background of the photo. The nutritional grains are supposed to be distributed to pregnant and lactating women. The women often send their husband or children to get the cereals and grains. Women in the FGD commented that sometimes the cereals are bad by the time they receive them and they feed them to the animals.



Figure 5 FGD 1 – village Y

Before the FGD began two pregnant women showed us their pregnancy cards. On the card is a list of observations and measurements to be taken at each appointment. These include: weight, measurement of stomach, heartbeat of the baby, situation of the baby, condition of the body (any swelling), blood pressure, TT injections and dissemination of iron and folic acid. Of all the points to be done (at all three appointments) one woman had only received the TT injection and the other had received the TT injection and the iron and folic acid tablets (2x50 tablets). One woman whose child is 2 years old said she had not been vaccinated yet.



Figure 6 Image of the nutrition grains at the CDPO office in X block

The sacks of cereals and grains behind are what is given to the AWW to distribute to women and children in the villages. The same sacks can be seen in the figure 4.



Figure 7 Block X PHC

The PHC includes a medicine dispensary, room for minor problems (such as bandages), 2 wards (with 4 beds and small side tables), 1 delivery room (with two beds), 1 waiting room (with 2 beds). There is no privacy with examinations occurring in front of other patients. Whilst we were there 2 women were waiting to deliver. In the examination room a woman was being examined and was being spoken to rudely by the nurse who was berating her for being pregnant again and not using condoms. The woman had her other child with her who looked to be only a few months old but was in fact 2 years old and very malnourished.



Figure 8 Examination room in X block PHC



Figure 9 Delivery room in X block PHC

Field notes from conversations outside the PHC:

One woman told us of the girls blessing scheme 'Maha Maya Balika Ashirvad Yojana'. The scheme provides girls with 20,000 rupees when they turn 18 years old as long as their birth has been registered.

Another woman stopped to talk to us. She explained that although she had received her TT injection she has still not been given her pregnancy card. The MO of the PHC has told her she has to get the card from the ANM. The woman explained that she has tried to meet with the ANM 5 times but has not been able to see her. The woman is in her 7th month of pregnancy.



Figure 10 Sub-centre in village V



Figure 11 Inside the sub-centre at village V

This is the building that the ANM should be giving immunisations from. This pictures shows why the ASHA explained that the ANM gave injections from a woman's house in the village, rather than the sub-centre.