

Pradhan Mantri Matru Vandana Yojana (PMMVY): Impact Evaluation for Rajasthan

June, 2020

A report exploring the process as well as intended impact of the PMMVY policy, focusing on two districts in Rajasthan, India



INDUS ACTION

TATA TRUSTS



Authors

The report has been commissioned by TINI (The India Nutrition Initiative), a concern under the Tata Trusts, led by Dr. Ishaprasad Bhagwat, Dr. Nilesh Yadav, Ms. Anushka Chaturvedi.

The data was collected by Aim Consultancy, led by Mr. Yogen Rajyaguru and Mr. Hitesh Patel.

The report has been written and designed by Indus Action, led by Ms. Madhuri Dhariwal.

Data Analysis and collation was a collaborative effort from the following people: Ms. Kaveri Dhawan, Mr. Kushal Kumar, Ms. Madhuri Dhariwal, Ms. Pragyna Divakar, Ms. Saloni Bhardwaj, Mr. Sravan Potnuru, Ms. Surabhi Trivedi, Ms. Vagmi Gupta.

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About Indus Action

Indus Action, set up in 2013, is a non-governmental organization anchored in New Delhi, India with a mission to enable the disadvantaged, sustainable access to legislated rights. Indus Action's overarching goal is to expand access to transformative legislated rights for disadvantaged families.

We currently work towards the implementation of section 12(1)(c) of the Right to Education Act that mandates 25% reservation for children from Economically Weaker Sections in private unaided schools and are also examining the implementation scope of Pradhan Mantri Matritva Vandana Yojana (PMMVY), the maternity benefits program, which finds its backing in section 4(b) of National Food Security Act.

In addition to this, we are also running a COVID Rapid Response Campaign to facilitate food and essential services to disadvantaged groups across India, and are also working with state governments for facilitating migrant travel back to home states as well as carrying out surveys to help Governments in ensuring last-mile delivery of essentials in quarantine centers.

About TINI

The India Nutrition Initiative was registered as a trust on 28th May 2015. TINI has been created under the aegis of the TATA Trusts and is envisioned to carry forward the work of the Trusts to address the problem of malnutrition in India by identifying, undertaking and supporting relevant initiatives in the said thematic area.

In the last 3 years, TINI has implemented a diverse portfolio of projects which include staple food fortification, nutritious foods for children, pregnant and lactating women and enabling activities such as advocacy, monitoring, learning and research.

TINI's programs have strong linkages with the Government of India's and respective State Government's ongoing nutrition/health programs. Our programs are designed such that they complement and add value to the government's programs - piloting sustainable approaches within respective local/regional contexts.

The current portfolio is diverse and the projects, while meeting the needs of the communities through focussed learning and research, also inform and enable the Government to take appropriate policy decisions on future investments for scale up and sustainability.

Executive Summary



Background

The Maternity Benefit (Amendment) Act, 2017 has placed India among one of the top 5 countries with the best maternity policies around the world. One of the main provisions was an increment in the duration of maternity leaves from 12 weeks to 26 weeks on the average pay of the last three working months which surpasses the ILO standards of a minimum 14 weeks of maternity leave (ILO).

However, this provision only covers those who work in formal establishments. It leaves a huge chunk of women who are not being benefited by the Act. 118 million women, which is 97% of the total working women, are involved in the unorganised sector in India (ICEHM 2015). It was to combat this, that the government came up with the Conditional Cash Transfer scheme, Pradhan Mantri Matru Vandana Yojana.

The Pradhan Mantri Matru Vandana Yojana, was launched in January 2017, with the main motive of improving health-seeking behaviour of the pregnant and lactating mothers, which would in-turn impact the child.



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Executive Summary



Scope of the Study

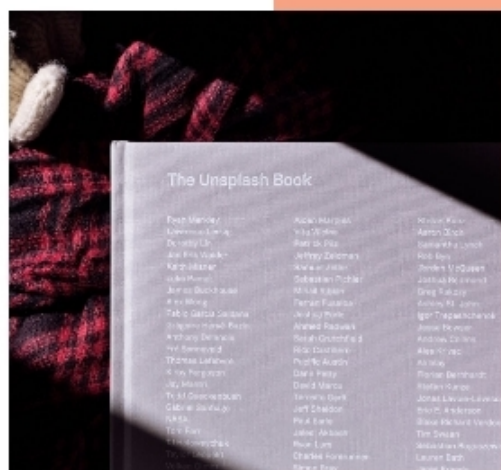
The objective of the research was to understand the gaps in the implementation and evaluate the impact of the scheme. This paper looks at the implementation and impact of the scheme in the 2 districts of Dausa and Dhaulpur in Rajasthan in India. The evaluation is based on 4 broad themes; process evaluation, evaluation of awareness and target assessment, evaluation of immediate outputs, and behavior change. The hypotheses the study started out with were process related challenges becoming hindrances in availing the scheme, a lack of awareness of the process among women availing the benefit, and the pregnant mother not having the sole authority in deciding utility of the money as well as being part of the workforce.

Primary results of the study indicate that there is a lack of awareness about the specifics of the scheme among a majority of the respondents, including the front-line workers delivering the scheme on the ground. A lot of the mothers who didn't avail the scheme, did so due to a lack of proper knowledge as well as the difficulties faced in the process. There is no definitive indication that the money received through the scheme is leading to a fundamental shift in the way women think of their own healthcare.

There are some policy suggestions that this paper ends with regarding the eligibility criteria, ease of documentation, increase in the amount given under the policy, targeted awareness campaigns, among others, which are crucial to ensure a wider coverage and actual implementation of the main purpose of the policy.

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Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWD	Anganwadi
BM	Beneficiary Mother
BMIL	Beneficiary's mother-in-law
JSY	Janani Suraksha Yojana
LMP	Last Menstrual Period
NBF	Non-Beneficiary Father (husband of the Non-beneficiary Mother)
NBM	Non-Beneficiary Mother
NBMIL	Non-Beneficiary (mother's) Mother-in-Law
NFSA	National Food Security Act
PMMVY	Pradhan Mantri Matru Vandana Yojana
VHN	Village Health Nurse

Definitions

- Early Child Development – The cognitive, physical, language, socio-emotional and motor development of children from conception to eight years of age.
- First 1000 days – The period from conception (270 days) to the end of the second year (365 + 365 days = 730 days).
- Maternity Benefits – A payment or other allowance made by the state or an employer to a woman during pregnancy or after childbirth.
- Beneficiary Mothers – These are the women who have received the benefit of the scheme, and hence were included to understand their experience and challenges. They have filled all 3 forms.
- Beneficiary Mother-in-laws – The socio-cultural system of India is structured in a way that it often gives the mother-in-law authority to dictate the choices of the daughter-in-law, including what to eat, where to spend money, during the pregnancy.
- Non-Beneficiary Mothers – These are the women who have not availed of the PMMVY scheme, due to a variety of reasons (there might be some that have filled one form, but not the others.)
- Non-Beneficiary Mothers-in-law – These are mothers-in-law of the NBM.
- Non-Beneficiary Mothers' Husbands – This group refers to husbands of the Non-Beneficiary Mothers. This group was included under the assumption that they often influence decisions like applying for schemes, and setting up bank accounts.
- Wasting: Low weight-for-height is wasting. It represents the failure to receive adequate nutrition leading to rapid weight loss or failure to gain weight normally. Children are defined as wasted if their weight-for-height is more than two standard deviations below ($< -2SD$) the WHO Child Growth Standards median (NHM 2019).
- Stunting: low height-for-age, is a sign of chronic undernutrition that reflects failure to receive adequate nutrition over a long period and is also affected by recurrent and chronic illness. Children are defined as stunted if their height-for-age is more than two standard deviations below ($< -2SD$) the WHO Child Growth Standards median (NHM 2019).
- Underweight: Underweight, or low weight-forage, is a composite index that takes into account both acute and chronic undernutrition. Children are defined as underweight if their weight-for-age is more than two standard deviations below ($< -2SD$) the WHO Child Growth Standards median (NHM, 2019).
- BMI (Body mass index): BMI is defined as a person's weight in kilograms divided by the square of his height in metres (kg/m^2) (NHP, n.d.).

Introduction

Research on the linkage between cognitive, language, social-emotional development, and nutrition, shows that millions of children under 5 years of age, in low and middle income countries, are unable to reach their potential, which impacts their education and adult functioning (Walker, 2014). Numbers suggest prevalence of iodine deficiency (40% in Africa and 31.6% in Asia), zinc deficiency (23.9% in Africa and 19.4% in Asia), and anemia (hemoglobin < 110g/L, mostly due to iron deficiency: 20.2% in Africa and 19.0% in Asia) (Black & Dewey, 2014). Reversal of these nutritional deficiencies beyond two years of age, is extremely difficult (World Health Organization, 2014).

In Rajasthan, among children 0-4 years of age, stunting has been found in 36.8%, wasting (having a low weight-for-height) (Bose et al., 2007) in 14.3% and 31.5% of them have been found to be underweight. Iron deficiency was found in 44.4% of the children and in 39% of the children aged 5-9 years (National Health Mission 2019). With respect to maternal health, the rate of reduction in Rajasthan's maternal mortality ratio (MMR) has been slow, and it has remained at 445 per 1000 live births in 2003. The government system provides the bulk of maternal health services. Although the service infrastructure has improved in stages, the availability of maternal health services in rural areas remains poor because of low availability of human resources, especially midwives and clinical specialists, and their non-residence in rural areas. 32% of women delivered in institutions in 2005-2006. A 2006 government scheme to give financial incentives for delivering in government institutions has led to substantial increase in the proportion of institutional deliveries (Iyengar et al., 2009).

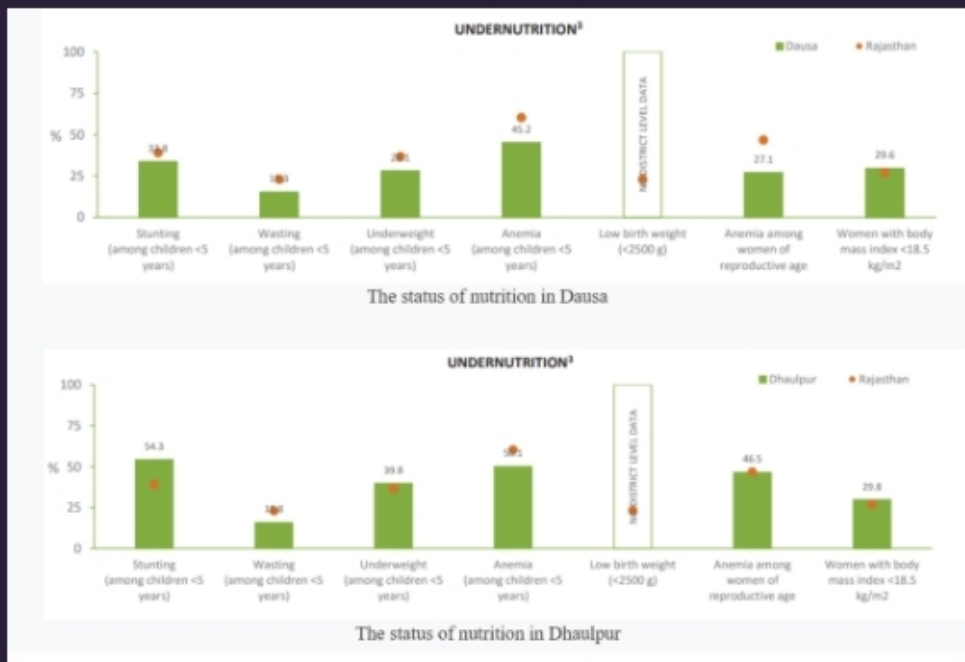
The study is done in 2 districts of Rajasthan - Dausa and Dhaulpur. Dausa district consists of 87.7% rural and 12.3% urban population. The sex ratio of Dausa district, 905, is significantly lower than the state sex ratio (928). In Dausa district among the workers, the percentage of cultivators, agricultural labourers, workers in household industry and other workers (category of workers) are 57.1%, 11.1%, 2.5% and 29.2% respectively. The literacy rate in Dausa district is 68.2% which is higher than the State Average (66.1%) (DCO, Dausa, 2011). Dhaulpur district consists of 79.5% rural and 20.5% urban population.

The sex ratio of Dhaulpur district is 846. The literacy rate in Dhaulpur district is 69.1% and it ranks 9th among the other districts of the state. The Gender Gap of the literacy rate is 26.5% in the district. The economy of Dhaulpur district is mainly dependent on agriculture as 58.1% workers in the district are either cultivators or agricultural labourers. However the district percent of such workers is lower than the state average of 62.1% (DCO, Dhaulpur, 2011).



Introduction

The following graphs give an idea of the status of nutrition in Dausa (POSHAN, Dausa, n.d.) and Dhaulpur (POSHAN, Dhaulpur, n.d.) districts of Rajasthan.

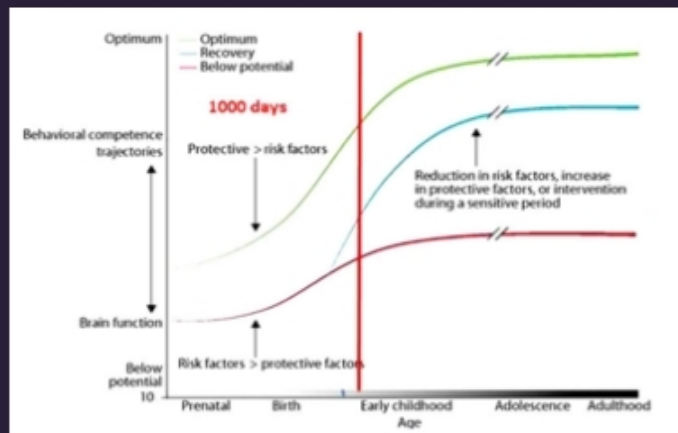


This points us towards the need for an integrated child development plan, which includes health, child development, and nutrition. The Integrated Child Development Services (ICDS) programme in India is a crucial component in the implementation of any scheme aimed at mothers and children, whether it is centrally or state sponsored. It was started in 1975 as a flagship programme for children, pregnant women, and lactating mothers. (Lokshin et al., 2005).

ICDS covers 84 crore out of the total 1645 crore children below the age 6 years in the country and 1.91 crore pregnant and lactating mothers through 7066 projects and 1342 lakh AWCs (NITI Aayog, 2015). Rajasthan ranks in bottom 10 in ICDS coverage. It ranks in the top 4 in underweight prevalence (these 4 states also receive the least funds for ICDS from the government) (Gragnolati et al., 2006).

Introduction

If we look at the global scenario, sustainable development is the talk of the hour. The United Nations Sustainable Development Solutions Network for the post-2015 global agenda, depends on healthy, productive citizens with the intellectual skills, creativity, and motivation to lead, govern, and implement the policies and programs of the future. The preparation of such citizens begins before birth and continues through childhood, with the well-accepted recognition that the origins of adult health and well-being stem from the genetic–environmental interactions that begin in the first 1000 days (from conception through 24 months) (Black & Dewey, 2014).



Life-span development of equity/inequality may be modified by early intervention (Black & Dewey, 2014)

It is in this context that we started studying the Pradhan Mantri Matru Vandana Yojna, a maternity entitlement scheme launched by the Government of India, in 2017, under the National Food Security Act, 2013, with the following two objectives:

- Supplementing the nutritional requirements of women during pregnancy and lactation
- Providing partial compensation for the wage loss in terms of cash incentives so that the woman can take adequate rest before and after the delivery of the child

In the sections that follow, we will be doing a brief review of the existing literature around maternity benefits from around the globe. There will be an in-depth explanation of the PMMVY scheme, along with specific numbers for the state of Rajasthan, where this study was conducted. The methodology section explains the technicalities of the study and sample chosen. Thereafter, we present the findings in the research, discuss the implications, and conclude with certain policy recommendations based on the study.

Literature Review

Countries around the world have worked on strategies to ensure maternity benefits to help the mother and child. The following section will shed light on initiatives in India, and some international examples.

Indian State	Scheme	Amount/Benefit	Coverage	Results
Odisha	Mamata (Government of Odisha, 2011; WCD, Odisha, n.d).	CCT of Rs. 5000	Pregnant and lactating women of 19 years and above, for 2 live births	>95% of beneficiaries have used the money on food, medical expenses, savings for child
Tamil Nadu	Dr Muthulakshmi Maternity Benefit Scheme (DMMBS) (Tesz, n.d.; Rajyayojana , 2020)	CCT of Rs. 14,000 and Amma Maternity Nutrition Kit worth Rs. 2000	All women under BPL for first 2 deliveries	Reached 4.7 mil mothers, worth Rs. 4337 crore
All India	Supplementary Nutrition Program (MWCD, 2017)	Nutritious food at AWC for 300 days a year	All pregnant/nursing women till 6 months after childbirth, every child from 6 months to 6 yrs	
Andhra Pradesh (Telangana)	Indiramma Amrutha Hastham (Department for Women, Children, Disabled & Senior Citizens, n.d.)	Nutritious food at AWC, 1 meal = 40% of the nutrition/calorie requirement	Pregnant and lactating mothers	3.5 mil women; 5,100 federations of women SHGs engaged to support the implementation (Boga, 2015)
Karnataka	Mathru Poorna Scheme (The Hindu, 2017)	Nutritious food at AWC	From conception to 6 years of age	
Gujarat	Kasturba Poshana Sahay Yojana (NARI, n.d.)	CCT of Rs. 6000	BPL women	
Gujarat	Chiranjeevi Yojana (National Health Portal of India, n.d.)	Compensate costs for institutional delivery	BPL women	

The MAMATA scheme: A closer look

The scheme by the Odisha government - MAMATA was launched in 2011. It is also a CCT scheme and has been a success in ensuring maternity benefits to the pregnant women in the state. The objectives of the scheme are:

- To provide partial wage compensation for pregnant and nursing mothers so that they are able to rest adequately during their pregnancy and after delivery.
- To increase utilization of maternal and child health services, especially ante-natal care, post-natal care and immunization.
- To improve mother and child care practices, especially exclusive breastfeeding and complementary feeding of infants.

The scheme is applicable for the first two live births. This number has been relaxed for Particularly Vulnerable Tribal Groups (PVTGs). Exceptions like these are very helpful as they indicate respect and consideration for the most vulnerable groups and ensure equity in the coverage of the scheme.

The documentation requirement is as follows -

- Photocopy of the 1st page of the passbook of the woman's bank account
- Photocopy of the MCP card (for verification of conditionalities)
- 2 copies of self declaration form given by the AWW to the women along with photographs of the women
- Photocopy of the Aadhaar card of the beneficiary
- Undertaking by Husband/Guardian

The documents need to be submitted only once at the Anganwadi centre after 4 months of pregnancy.

The money is transferred in 2 instalments:

- First instalment - Rs 3000, after the completion of 6 months of pregnancy
- Second instalment - Rs 2000, after the completion of 10 months after delivery

Some of the conditionalities for each of the 2 instalments include registration of pregnancy at the Anganwadi centre, exclusive breastfeeding for the first 6 months, registration of child birth and vaccination of the child and the mother, among others. These conditionalities ensure that the health seeking behaviour of the women for themselves and their children is encouraged. At the same time, the minimal documentation related conditionalities ensure increased accessibility of the scheme.

The Anganwadi workers and helpers are given an incentive for the implementation of this scheme which is credited to their bank accounts. AWWs receive Rs 200 per beneficiary and AWHs receive Rs 100 per beneficiary after all the due cash transfers are completed.

As per the Jaccha Baccha Survey 2019, among women who had delivered in the last 6 months, 88% of those eligible for Mamata benefits had applied, and 75% had received at least one of the two instalments.

Signs of active teamwork between anganwadi, ANM and ASHA workers in Odisha was also reported in the survey. Basic services like health check-up, tetanus injections, iron and folic acid tablets and food supplements are provided to pregnant and nursing women registered at the anganwadis.

Literature Review

As we zoom out from the different maternity benefits in Indian states and look into the global scenario, the situation seems quite uneven. The approaches and lenses vary according to specific cases (Save the Children, 2012).

Country	Scheme	Amount/Benefit	Coverage	Results
Africa (Malawi)	International Code of Marketing of Breast-Milk Substitutes	Preventive health care, supplements, counselling	Not applicable	Provisions of the code have been included in the law
Africa (Madagascar)	Essential Nutrition Actions (ENA)	Nutrition support	Children under 2 years and their mothers	Early initiation of breastfeeding more than doubled among newborns (Guyon et al., 2009)
Peru	Qali Warma	Ensure quality food services to school-going children	Children above the age of 3 who attend public educational institutions	3.5 million of the targeted 4 million children have benefitted from this program (FNS, n.d.)
Cambodia	Mother support groups	Promotion of breastfeeding	Pregnant/nursing mothers	Reached 5.17 mil women
Nepal	Female community health volunteers (FCHVs)	Family planning, child and maternal care, supplements	Pregnant/nursing mothers	FCHVs have contributed to reducing Nepal's mortality ratio by 80% (Panday et al., 2017)
Mongolia	Community health workers		Supplements for children over 6 months	Reached 13,000 children in 1 yr
Norway	General policy	Family planning, maternity leave, female education and political representation	All women	Maternal mortality rate is <0.1% (World Health Organization, n.d.)
Timor-Leste (The World Bank, 2017)	Community Driven Nutrition Improvement Program (CDNIP)	Nutrition support	Young mothers and pregnant women	Reached over 1000 families
Bangladesh (Faruque et. al., 2008)	National Nutritional Programme	Promotion of breastfeeding	Pregnant/nursing mothers	
United States of America (HRSA, n.d.)	Maternal and Child Bureau (MCHB), Dept of Health and Human Services	Mental health and well-being of the mother and child	Pregnant/nursing mothers	Maternal mortality rate remains comparatively high, especially among African-American women (MHTF, n.d.)

Literature Review

Family planning is one of the most effective ways through which both maternal and infant deaths can be reduced. Due to family planning measures, Kenya has seen a decrease in the number of unwanted pregnancies as well as the spread of HIV/AIDS. In Kazakhstan, contraceptive prevalence has increased by 50% between 1990 and 2000, while abortion rates decreased by 50%. The lack of access to contraceptives in Ghana has increased rural pregnancies by 12%, leading to 2,00,000 additional abortions and 5,00,000 unwanted births (NCBI, n.d.)

These schemes and plans around maternal and child health and well-being point to the significance of care during the early developmental years of a child. They also stress the need for a focus on the mother as the primary care-giver for the infant. The implications of early childhood development go beyond these primary growth years of a child's life. With that in mind, let us understand the Pradhan Mantri Matru Vandana Yojna scheme.



PMMVY

Under NFSA, 2013, the Government of India launched a Conditional Cash Transfer (CCT) scheme, Pradhan Mantri Matru Vandana Yojana (PMMVY), 2017 under which the beneficiary will get Rs. 5,000 in three instalments for the first childbirth along with the incentive of Jeevan Suraksha Yojna (JSY) for institutional delivery, accounting for an average benefit of Rs 6,000 (MWCD, 2017) with an objective of compensating the wage loss of pregnant and nursing mothers and thus providing an opportunity for women to rest and get better nutrition.

Conditionalities

Instalment	Conditions	Amount (Rs)
1st	Registration of pregnancy within 150 days from the start of pregnancy as specified on the Mother-Child Protection (MCP) card.	1,000
2nd	Receipt of at least one ante-natal checks up within six months of pregnancy.	2,000
3rd	Registration of childbirth and receipt of the first round of immunisations recorded on MCP.	2,000

The initial cost of the programme from 1st January 2017 to 31 March 2020, was estimated at Rs 12,661 crore. For FY 2017-18 to FY 2019-20, Gol's share was Rs 7,348 crore of which Rs 6,295 crore has been allocated till FY 2019-20 (Shukla & Kapur, n.d.).

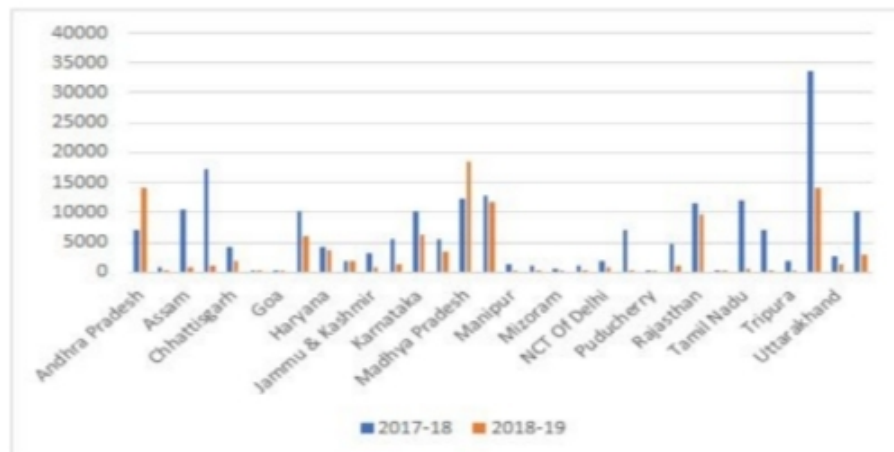


PMMVY

The graph here shows a state-wise Gol release and it's clear that only Andhra Pradesh and Madhya Pradesh have an increment in the release amount in the year 2018 than 2017 (MWCD, 2019). 83% of the enrolled beneficiaries have got at least one Installment until June 2019 (Shukla & Kapur, n.d.). Only 61% of the beneficiaries registered between April 2018 and July 2019 (38.3 lakh out of 62.8 lakh enrolled) have received the full amount according to an RTI reply (Chandra, 2019). 12% of women received all three instalments under the policy (IndiaSpend, 2019).

Figures for Rajasthan

	Registration
Target	658,532
Target achieved	817,478 (124%)
% funds utilised	83.9%
Number of days after which the installment was received (w.r.t LMP)	1st installment - 254 2nd installment - 307 3rd installment - 451



Year	Target	Target achieved (millions)	% funds utilised	Number of days after which the installment was received (w.r.t LMP)
2017	5.17	0.29	-	-
2018	7.7	6.5	51.52%	-
2019	11.2	9.84	70%	258

*Last updated report is Sept 2019 (Indus Action Sources)

Methodology

There were 4 major areas of focus for the study:

- Process evaluation
- Evaluation of awareness and target assessment
- Evaluation of intermediary outputs
- Behavioural change

This research study was conducted with the objective of understanding the implementation of the Pradhan Mantri Matru Vandana Yojna at the ground level.

The representation is of the rural population. The responses are not corroborated with the records present in the Anganwadi. A mixed methods approach was used to collect data. Quantitative surveys were conducted with five of the respondent groups (BM, BMIL, NBM, NBMIL, NBF). The AWD/ANM/ASHA workers had mixed qualitative and quantitative questions asked to them.

* Under Findings, survey responses have been reported in terms of percentage of total respondents, considering the above figures as the base. For some questions, not all respondents have answered. This could either be because it is a follow-up question based on the answer given to a previous question, or some exceptional reason which will be given for clarity.



Respondents	Beneficiary Mother	Beneficiary Mother-in-law	Non-Beneficiary Mother	Non-Beneficiary Mother-in-law	Non-Beneficiary Father	ASHA/ANM/AWC Worker	Total
Dhaulpur	70	33	67	33	29	34	266
Dausa	61	29	51	20	23	40	224
#	131	62	118	53	52	74	490

Findings

I. Process Evaluation:

Hypothesis: There are process-related challenges (form-filling, documentation, bank account-related issues) that are hindrances in both availing the scheme as well as utilising the money on maternal and child nutrition.

Main Findings: Most (over 90%) pregnant mothers register their pregnancy with the Anganwadi on time. However, most of the beneficiary mothers faced some difficulties during the process - about 35% of surveyed women had issues with document collection, and 19% had Aadhaar-related issues. This included adding their husband's name to the card, gathering documents for bank accounts, and withdrawing money. The main reason for rejection of forms was due to issues with the documents. ~19% of the surveyed front-line workers reported Aadhaar card related issues and 945% of them reported bank account related issues, with money not coming into their bank account despite providing details.

A majority of the women surveyed were unaware of the number of times the form needs to be filled.

While going to the hospital for check-ups was not reported as a problem by the majority of women, there were about 20% who reported problems in going to the hospital for check-ups. Another interesting finding about the process gap, is that lack of knowledge among the front line workers, of the rejection of forms despite having received training for the scheme.

According to the ASHA, AWW, and ANM workers, the main reasons for not receiving money were budgetary constraints (reported by 39.19% of respondents) and mistakes in the Aadhaar card/bank account (reported by 17.57% of respondents).

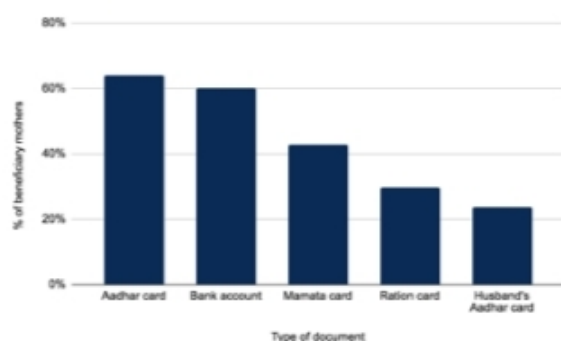


Fig. 1.1 Documents applied for/alterd by beneficiary mothers during the application process

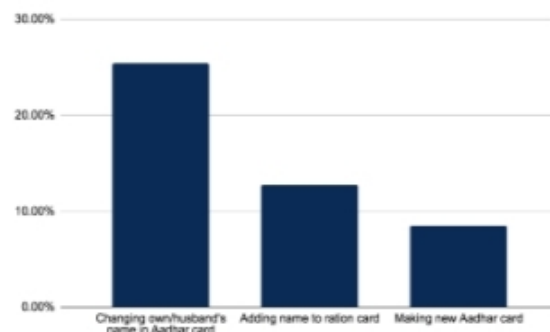


Fig. 1.2 Issues faced by non-beneficiary mothers in submitting documents

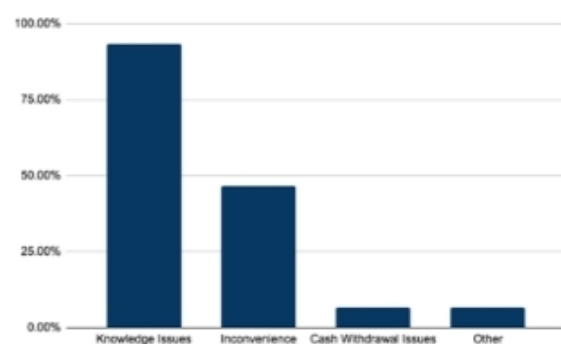


Fig. 1.3 Problems faced in withdrawing money

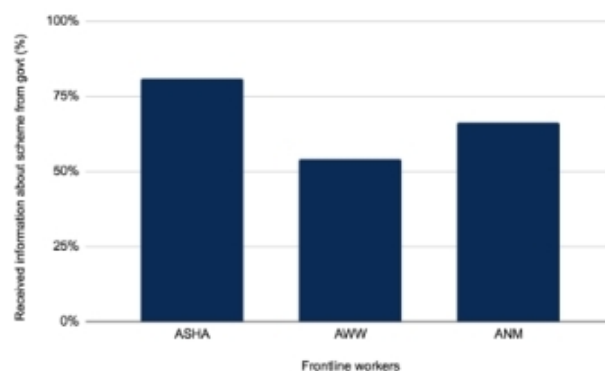


Fig. 1.5 Information levels of frontline workers

Discussion

I. Process Evaluation:

There is lack of clarity/awareness of the process itself. Women are unsure of how many times the forms need to be filled. While a majority (65%) of the women who had applied said that they didn't face any issues, about 35% faced challenges with document collation and creation.

About 19% of the respondents faced Aadhaar issues, which has been a point of contention for the policy since a long time. Mismatching spellings of names in the Aadhaar Card and bank account don't allow the application to be processed. This gets more complicated as the husband's name has to compulsorily be present on the woman's Aadhaar Card.

Beneficiary groups have reported that despite entering correct bank account details on the form, they don't end up receiving the money. There is definitely a correlation between the form being transferred from paper to an online portal, and the transmission loss that thus ensues.

About 50% of the ASHA/AWD/ANMs don't have a track record of the number of rejected forms. These forms might be in the queue correction or reject pile, but there isn't any clarity on the status of the application once it is submitted.

When we look at the above figure in comparison to the 97% of the AWD/ASHA/ANM workers who say that they receive training for the scheme, it raises some questions on the content and/or scope of the training given. Even among the 3 groups, Anganwadi workers have reported having the least information being provided, preceded by ANMs and then ASHA workers. This is concerning as over 75% of all surveyed persons report getting their information from Anganwadi workers.

When checking for capacity to be filling these forms online directly, about 45% of the front-line workers interviewed responded saying they prefer the paper form to the online one. If we are to reduce the transmission loss, capacity building of those at the front-lines is essential.

A major reason attributed to the money not coming on time has been the paucity of funds with the state, according to about 40% of the frontline workers. We are unsure of the communication that has led to this understanding, and this is an area that needs to be delved deeper into.

About 80% of women have reported no issues with hospital check-ups. However, the remaining 20% have responded with issues such as unavailability of health workers or not being able to go without an attendant to accompany them. One positive trend noticed in the respondents is that nearly 100% of the beneficiaries delivered in hospitals.

There is no established channel of grievance redressal available to mothers. Both beneficiary and beneficiary mothers-in-law preferred approaching the Anganwadi worker, with 274% of each group responding as such. This reveals that targeting the Angwandhi worker for training in grievance redressal would be optimum as they are already trusted by the respondents.



Findings

II. Evaluation of Awareness and Target Assessment

Hypothesis: There is an acute lack of awareness regarding the process (eligibility, documentation, registration) as women do not have complete information. The targeting of women is not very efficient.

Main Findings: The targeting inefficiency was made evident by the large number of mothers who are eligible but could not avail the scheme, which are non-beneficiary mothers. Nearly 89% of non-beneficiary mothers said they would have availed the scheme if they had known about it. Lack of awareness is a significant issue as we found that 60% of beneficiary mothers did not know how many times the form needs to be filled. The intent of the scheme is also not clear to all women. There is also inconsistency in terms of awareness of the scheme names - some know JSY, some know PMMVY, some the 5000 rupees scheme, and some with other names.

An overwhelming majority of respondents got to know of the scheme through Anganwadi workers. The front-line workers mentioned major drawbacks of PMMVY to be: not receiving the money on time (20%), 2nd child not being included (10%), age bar of 18 years (10%).

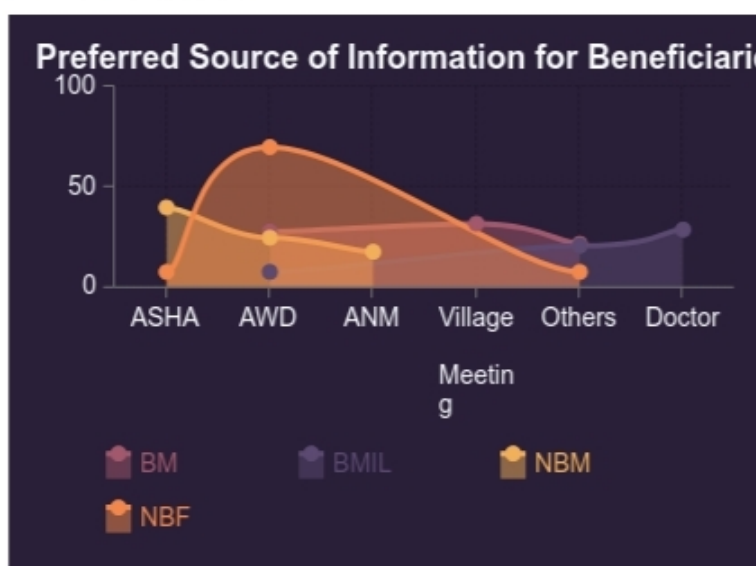


Fig. 2.1 Preferred medium of scheme awareness

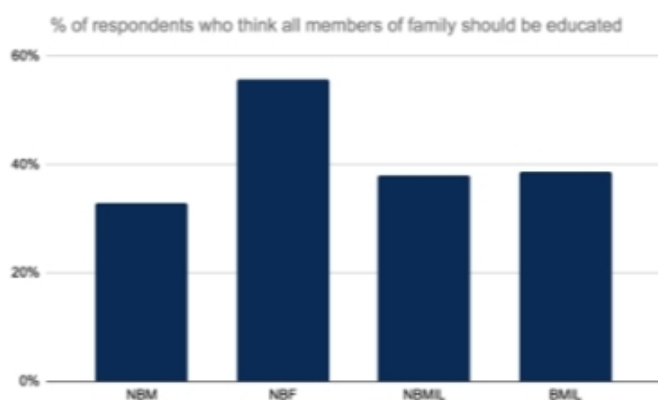


Fig. 2.2 Preferred target of scheme awareness



Fig. 2.3 Percentage of respondents who learnt about scheme from AWW and ASHA workers

Discussion

II. Evaluation of Awareness and Target Assessment

Looking at what the beneficiaries think, the intent of the policy is: Out of the 118 beneficiary mothers, ~87% think that the money is to be used for nutrition. Only 35% responded that this is compensation for work not done. It is a very important point since it indicates that women don't consider this as part of paid maternity leave. We don't have insight into the exact professions of these women, but out of the ones who are working, we do know that the respondents are largely working in the unorganized sector. Thus, there is a correlation between them not receiving paid maternity leave and thus thinking that this is a substitute for that. If we look at minimum daily wages that need to be paid to labor, the Rs. 5000 they receive under the PMMVY scheme actually covers only 1 month of their salary. Thus, they will never be able to take the 6 months of maternity leave that a woman in the organized labor sector has the right to.

About 28 respondents from the 118 felt that this CCT was done to support household expenses. There is a clear indication that targeted awareness campaigns are needed, to ensure women know what the intended use of the money and aim of the policy is.

~89% of the non-beneficiary mothers said they would definitely want to avail of the scheme, if they had complete knowledge of the process.

A majority of all respondents feel that the entire family should be educated about the scheme and related issues. This is another point which reflects that it is not only the mother who gets impacted by this scheme, but the entire family. Also, she requires the support of the entire family to be able to act on the policy's intended outcome.

When asked about the preferred choice for information dissemination, a majority of the NBMs trust the ASHA worker. For the NBF, the Anganwadi worker seems like a better choice. BMs get informed through village meetings, whereas their mothers-in-law trust doctors to accurately relay information to them. This vast variety is interesting and can be an area of exploration, as to why certain groups prefer certain mediums more than others, and what can be the best way to reach all of them. Another area of exploration can be the channels the front-line workers use to reach out to and target beneficiaries.

When talking of target assessment to the front-line workers, they expressed a few points which would enhance the scheme: money to be received on time, the scheme to extend to the second child as well, including women below 18 years in the scheme's coverage.



Findings

III. Evaluation of Immediate Outputs

Hypothesis: Evaluation of intermediary outputs: The beneficiary mother is not able to spend the money due to two reasons: (i) Not receiving the money on time, and (ii). Lack of awareness of the intended use of the money.

Main Findings:

10% of the beneficiary mothers were working and 80% returned to work within 6 months of delivery. We see that a majority of women feel that the amount of Rs. 5000 is sufficient to cover their leaves. However it has also been observed that the respondent don't think that they should or can be taking leaves for a long duration.

When looking at hospital check-ups, there is a significant difference in the number of times beneficiary versus non-beneficiary mothers have gotten check-ups, with BM at 94% with over 3 check-ups and NBM at 67%. We're not sure whether there is a direct causal relationship with availing the scheme, however there might be some relation between the two. 68.64% of the NBM and 76.33% of the BM have claimed to be able to get access to all necessary food and medicines. Almost 100% of the women have delivered in the hospital. Almost half the women worked on farms or in animal husbandry during their pregnancy and did household chores within a few months of delivery. Thus, rest was not a top priority for the pregnant or lactating mothers. However, the frontline workers do believe that the duration of time taken off, has increased since the introduction of the scheme.

One extremely crucial finding, which has been raised by many groups in the past, is that the front line workers are not covered under these maternity benefits by the government.



Fig. 3.1 Spending patterns of beneficiary mothers

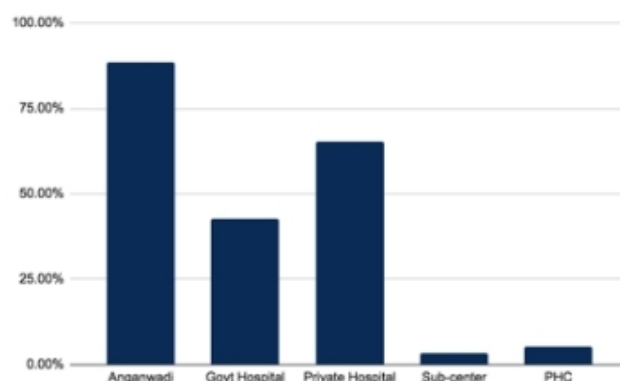


Fig. 3.2 Distribution of location for check-ups

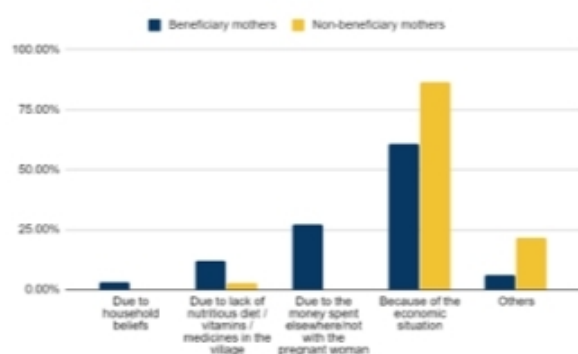


Fig. 3.3 Reasons for not being able to consume nutritious food/medicines

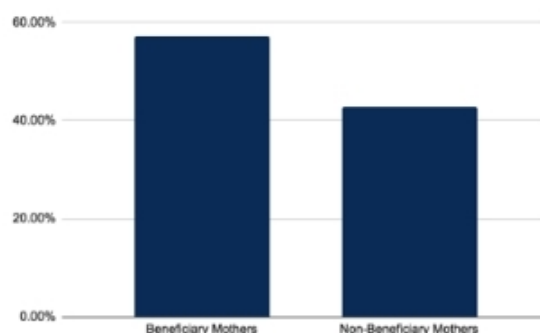


Fig. 3.4 Participation in intensive work during pregnancy

Findings

III. Evaluation of Immediate Outputs

Food item/Medicine	NBM (number)*	NBM (percentage)	BM (number)**	BM (percentage)
Dry fruit	0	0.00%	0	0.00%
Item of Ghee	1	0.85%	5	3.82%
Green Vegetables	17	14.41%	2	1.53%
Milk	17	14.41%	5	3.82%
Fruits	12	10.17%	18	13.74%
Beans	0	0.00%	2	1.53%
Medicine/Health	21	17.80%	20	15.27%
Have taken all the necessary food/nutrition	81	68.64%	90	68.70%
Not Answered	0	0.00%	10	7.63%

**9 beneficiary mothers gave opted for 2 options and 6 of them have opted for 3 options

*22 non-beneficiary mothers opted for 2 options, 3 opted for 3 options and 1 opted for 4 options

Table 3.1 Gap in non-beneficiary mothers' and beneficiary mothers' access to nutritious food

Discussion

III. Evaluation of Immediate Outputs

Spending patterns for the money received, showed some surprising results. About 35% of the money was claimed to be unspent by the BMs. The results also show that despite a lot of the mothers saying the money was for nutritious food, for a previous question, the amounts spent on activities other than food is substantial, putting the actual implementation of the intent of the CCT into question.

In checking for availability of nutritious food, results show that milk is mostly available to all mothers. Dry fruits and items made out of ghee, are more difficult to access. With the Anganwadis being instructed to provide panjiri/sattu/laddoos to pregnant women, it is important to be checking this gap in access.

While we were talking of the money helping women to not work during their pregnancy or immediately after their delivery, we see that about 67% women stopped working only in or post the 7th month of pregnancy, and 80% of them returned to the work-force within 6 months. We know of the caregiver-child bond, which is essential for the physical, emotional, and social growth of the child. Returning to the workforce correlates to the mother spending lesser quality time with the child.

About 50% of women also engaged in intensive work such as farming or animal husbandry, during their pregnancy. A majority of the MILs also feel that their daughters-in-law can get back to work within 4 months of the delivery with ease.

About 94% of the respondent women went for at least 3 check-ups during their pregnancy, which is a very positive sign. The Anganwadi was the most visited place for check-ups, followed by private and then government hospitals. PHCs and sub-centres aren't an option as such for the women.

The front-line workers have also given a similar viewpoint with regard to check-ups, claiming that the number of check-ups has gone up by about 20% since the introduction of the scheme. The workers also feel that more women are taking leave before and after delivery due to the scheme.

A very pertinent point that has come up is that the ASHA/ANM/AWD workers themselves don't receive any maternity benefit from the government. This is ironic, considering they propagate and help other women avail the scheme themselves.



Findings

IV. Behaviour Change

Hypothesis: (1). Beneficiary mothers are not the decision makers on the spending of money. (2). Beneficiary mothers are not decision makers about re-entering the workforce as not enough value is placed on the mother's rest and nutrition.

Main Findings:

Majority of the respondents said that an increase in the amount of funds received would allow them to consume more nutritious food, take their medicines on time, and not want to return to work immediately. Not all women are able to make decisions about where to spend the money they get. MILs and husbands have a say in that matter. About 75% of the frontline workers have responded that there is a positive trend of women asking more about their own health, since the inception of the scheme. There is a trend noticed in women from APL families having more awareness than women from BPL families. However, this has not been explored in depth.

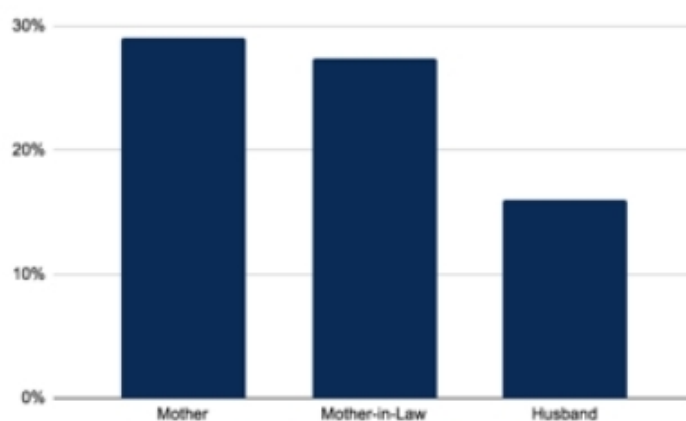


Fig 4.1: Decision making about scheme money

Discussion

IV. Behaviour Change

The spending patterns as well as thought process around what the scheme is trying to do in the first place, tells us that mothers aren't looking at this solely from the position of improving their own and thus the baby's health. Coupled with this is the fact that the amount of Rs.5,000 doesn't do much to ease the financial pressure on them. The daily minimum wages in Rajasthan, [Per day/per month(25 days) average wages - Unskilled = Rs. 225/Rs.5850, Semi-skilled = Rs. 237/Rs.6162, Skilled = Rs. 249/Rs. 6474, Highly skilled = Rs. 299/Rs.7774)] (Department of Labour, n.d.). Thus we can see that the Rs. 5000, is on average only equal to about 1 month's wages for the women.

An increase in the amount would definitely mean more opportunity to access nutritious food and medicines. The financial burden would also be eased, and help in keeping the mothers mentally calm as well.

We did see that about 51% of the mothers claimed that they had the freedom to spend the money of their own will, 35% of them felt that the MIL had a say in not only the spending but other pregnancy related decisions. This gives a clear insight into who we should be targeting, to change the health-seeking behavior of the pregnant mother. Since nearly half of the women report that they are not free to make decisions regarding where the money should be spent, it would be beneficial to spread awareness among mothers-in-law as well as husbands. Mothers-in-law are unaware of the amount of rest the mother needs during and after pregnancy. Reaching out to husbands is important, too, because not only do they take financial decisions but also accompany their wives for health check-ups. Frontline workers can be trained to target them in their door-to-door awareness campaigns.

When asked about this health-seeking behavior, about 75% of the front line workers felt that women had started thinking and enquiring more about their health post the start of the scheme.

Thus, while we are seeing that there has been a positive impact of the scheme on the health-seeking behavior of the pregnant woman, the different answers do not help us triangulate that, and allow us to conclude that there has been a shift in the mindset of pregnant/lactating women.



Conclusion

In conclusion, when we look at the 4 themes being evaluated, and the hypotheses associated with them, we see that there is evidence to prove all four hypotheses as valid and true.

The research presents many facets of the scheme, some of which are similar to previous results, like in the Jaccha Baccha Survey:

- The restriction of benefit to only the first live birth. First-order birth accounts for only 43% of all births in India (Priya, 2018).
- The complicated application process which requires the applicant to fill the 22-page long-form with compulsory attachments like mother-child protection card, Aadhaar card of the mother, her husband's Aadhaar card, bank passbook and requires the linking of the Aadhaar with a bank account which seems very hard for a majority of people.
- The applications are often returned, delayed or rejected with error messages pertaining to an incomplete application process due to missing attachments. There is no help available to the mothers in case they are struggling with the application (IndiaSpend, 2019).

We also see that the primary objective of changing the health-seeking behavior of the mother is not clearly articulated, and thus we cannot be sure if it is being met.

Recommendations

The scheme needs to aim for much wider coverage. In order to do so, the following steps can be taken:

1

Reduce conditionalities:

- The money order should be reversed to Rs. 2000 for the first two instalments and Rs. 1000 for the final instalment, even if the conditionalities are being kept.
- The beneficiaries should receive the money irrespective of the check-ups, as that is the basic amount needed to avail maternity leave for a month.
- The form length should definitely be reduced to 1-2 pages.
- The second pregnancy should also be covered by the policy.

2

Change documentation processes:

- Documents should be collected only once.
- Husband's Aadhaar Card should not be made mandatory, and neither should having his name on the mother's card be a compulsion.

3

De-linking age and marriage as conditions for the scheme: Every child born in India should have the right to good health and every woman a healthy pregnancy.

An exceptional clause can be added to include women under 18 years of age. While the legal age of marriage in India is 18 years, and child marriage is illegal on paper, practically we still see the rate of child marriage in India to be 27% and in Rajasthan to be 354% (MoHFW, 2016).

There are multiple reasons why women under 18 years give birth, and while it is not the ideal child-bearing age, enforcing moral standards on those situations harms them further.

- Under-age marriages are linked to possible child-birth before the age of 18 years.
- There are rape victims, who get pregnant as a consequence, who might be minors. They might also be unmarried.
- In certain tribal cultures across the country, girls still get married before they turn 18. It is also not considered wrong to have a child out of wedlock (BBC, 2017). An example is the Garasia community in Rajasthan (Akhtar, 2014).



Recommendations

The scheme needs to aim for much wider coverage. In order to do so, the following steps can be taken:

4

Increase in amount:

- As mentioned in the section above, Rs. 5,000 is approximately equal to a month's wage. To compensate for at least 3 months of wages, and allow the woman to rest post-pregnancy and bond with the child, the amount should be changed to Rs. 15,000.
- For the current fiscal year (2020-21), the Government of Rajasthan has reduced the budget for the Women and Child Development department from Rs. 2,74841 crore to Rs. 2,352.77 crore. Rs. 384.30 cr. has been allotted for women development programs, and the remaining Rs. 1,96847 cr. for child development services — Rs. 1,032.86 cr. for ICDS and Rs. 121.99 cr. for PMMVY (Jain, 2020). This is 5% of the WCD budget, and 0.11% of the overall state budget. One recommendation here is that using an integrated database for all child development schemes could reduce the technical costs, make targeting more effective, and allow more money to be diverted for the implementation of the scheme. Even though the centre has increased the budget allocation for PMMVY from Rs. 2,300 crore to Rs. 2,500 crore (8.3% of the WCD budget), this is not reflected in Rajasthan's budget.

5

Queue Correction:

- There should be a transparent listing of the beneficiary names once they enrol.
- They should receive regular messages on their mobile phones about the status of their application.
- There needs to be a mechanism to edit and rectify mistakes in the application.
- The front-line workers should be able to check the status of the application as well.



Recommendations

The scheme needs to aim for much wider coverage. In order to do so, the following steps can be taken:

6

Targeted communication strategy for behaviour change:

- Almost 40% of the stakeholders surveyed felt that all family members should be made aware of this policy. Thus, there needs to be a focused communication strategy, targeting the mother and other influential members of the family like the mother-in-law and husband.
- Awareness campaigns also need to be short, crisp and creative, to catch and hold the attention of the beneficiaries.
- Different exercises can be undertaken during existing activities such as the Poshan Mah, Village Health and Nutrition Day, to explain the importance of both nutritious food and rest for the pregnant/lactating mother and child, in the early years.
- In the short-term, there should be a focus on explaining the enrollment and related activities such as document creation to the husband, and the utility of the money to the mother and mother-in-law. This is because in a majority of places, the women are still dependent on the husband for documents and bank-related work. In the medium and long-term however, women should be given workshops/training/videos, on how they can independently procure documents, and attend to the bank-related issues themselves. Thus the strategy needs to focus on making women realize that they should be self-dependent/independent.
- Set up mandatory quarterly meetings for the husbands, to understand about maternal healthcare. (A husband/father-support group)
- Mental health and well-being needs to be added as a part of the intent of the maternity benefit, with topics such as post-partum depression, dealing with first-borns, changes in the mother's physical and mental state during and post pregnancy, and the need for self-care.



Recommendations

The scheme needs to aim for much wider coverage. In order to do so, the following steps can be taken:

7

Capacity building for front-line workers:

- The front-line workers need to be given short-term skill-based training on multiple details of the scheme like queue correction, grievance redressal etc.
- They can also be trained to directly fill out the form online, removing the transmission loss.
- Delivery of nutritious food by the AWDs also needs to be closely monitored, as these gaps would lead to lack of nutrition for the mother and child.

8

Strengthen M&E:

- The monitoring mechanism needs to be made more stringent, and streamlined, starting from the front-line workers, all the way to the exchequer.
- If the number of middle-men in the process are reduced, it will make the process of evaluation much simpler.
- Details of the process also need to be made publicly available, for an added layer of check by the community stakeholders.





Conclusion

The Pradhan Mantri Matru Vandana Yojna is aimed at increasing health-seeking behaviour in pregnant and lactating women. While the intent is in a positive direction, there needs to be more focus on the implementation machinery, ensuring the spirit of the scheme is understood and imbibed in the actions of the women.

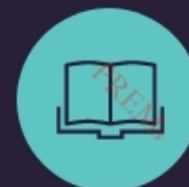
The majority of the beneficiary mothers, overall, have reported correctly with respect to the process of registration, documentation, objective of the scheme, etc. Significant improvement still needs to be made for easing the conditionalities related to documentation and making women aware of taking rest during pregnancy and spending time with their children. This needs to be accompanied with an increase in the cash amount to be given to the women. The results have also shown that there needs to be a targeted program for awareness of the mothers-in-law as they have an influence on the pregnancy related decisions of their daughters-in-law.

In the field research, 9245% of the women surveyed were homemakers. To build on to this study, a more targeted field study can be done with the working women to understand their challenges better, especially their financial condition during their pregnancy and ease of transitioning back into the workforce. It is intervening in the first 1000 days of a child's life, that sets the foundation for growth and development throughout their adulthood. Investment in early years for nutrition and caregiver-child relationship, will yield long-term results for all stakeholders involved.

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<http://www.wright.edu/~david.wilson/eng3000/samplerreport.pdf>

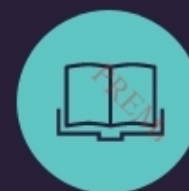


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