



Pradhan Mantri Matru Vandana Yojana

Evaluation of Implementation and Impact in Gujarat

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About Indus Action

Indus Action, set up in 2013, is a social impact 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 ran a COVID Rapid Response Campaign to facilitate food and economic security to disadvantaged groups across India. We are working with state governments to facilitate migrant travel back to home states as well as carrying out surveys to help Governments ensure last-mile delivery of essentials in quarantine centres.

Executive Summary

The Government of India has been focusing on initiatives to improve maternal health indicators. Maternal Mortality Ratio of India has declined by 8 points from 130/100,000 live births in 2014-16 to 122/100,000 live births in 2015-17 (6.2% decline) (UNICEF, n.d.). The government introduced the Maternity Benefit (Amendment) Act 2017, which has placed India among one of the top 5 countries with the best maternity policies. One of the main provisions was increasing the duration of maternity leave from 12 weeks to 26 weeks which surpasses the ILO standards of a minimum 14 weeks of maternity leave (ILO, n.d.).

However, this provision only covers those who work in formal establishments. It leaves a huge portion of women unable to access the benefits of the Act. 118 million women, which is 97% of the total working women, work in the unorganised sector in India (ICEHM 2015). It was to address this that the government introduced the Conditional Cash Transfer scheme — Pradhan Mantri Matru Vandana Yojana (PMMVY).

The Pradhan Mantri Matru Vandana Yojana was launched in January 2017 with the main objectives of providing partial compensation for the wage loss in terms of cash incentives so that the woman can take adequate rest before and after delivery of the first living child, and improved health seeking behaviour amongst Pregnant Women and Lactating Mothers (PW&LM). It was launched

Since the scheme's launch, 1.28 crore beneficiaries have received Direct Benefit Transfer in their accounts. The time period of receiving the money has reduced from 18 months (in the earlier maternity benefit scheme) to 239 days (MWCD, 2020). However, there are several gaps in the

system that must be addressed. A study by NITI Aayog shows that only 13.3% of the beneficiaries reported receiving a mobile message about money credited to their bank accounts and only 19% of the first instalments have been paid within 150 days from the last monthly period (LMP). Certain categories of women are excluded from the scheme by design. Mothers who are divorced, widowed and abandoned by their husbands will find it difficult to avail the benefit of the scheme as submission of husband's Aadhaar card is mandatory. Those who are unmarried or were married when underage are not eligible to avail the benefits of the scheme.

Indus Action conducted this research to understand the gaps in the implementation of the scheme and to evaluate the impact of the scheme. We aim to use these findings to advocate to the government and other organisations/people working in the space of maternal health for ensuring that:

1. No pregnant woman is excluded from the purview of the Act
2. Objectives of the scheme are met

This paper looks at the implementation and impact of the scheme in the districts of Mahesana and Kheda in Gujarat, India. The evaluation is based on 4 broad themes: process evaluation, evaluation of awareness and target assessment, evaluation of immediate outputs, and behavior change.

We hypothesised that there were process-related challenges that were 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 the utility of the money as well in deciding when to return to work after childbirth.

The study was conducted using mixed methods (quantitative and qualitative): survey and interviews of the different stakeholders involved, namely the beneficiary and non-beneficiary mothers and mother-in-laws, non-beneficiary fathers, and the front-line government workers — AWD workers, ASHA workers, ANMs, Female Health Workers and Community Health Officers.

One of our main findings is that awareness about the scheme is low. Only 49.2% of the husbands and mothers-in-laws of non-beneficiaries and non-beneficiary mothers (members of the non-beneficiary households) were aware about the existence of the scheme. Documentation-related challenges have been reported as one of the main reasons for not availing the benefits of the scheme. 21.9% of beneficiaries had not yet withdrawn the money transferred to their accounts. Another finding points to the inadequacy of the amount transferred. Responses from beneficiaries, non-beneficiaries and frontline workers indicate that Rs 5000 is not enough to compensate for maternity leave. It is a little over half of the minimum wage and, when combined with other expenses that come with pregnancy, it is much below the required amount. It is encouraging that since the scheme has been introduced, 82.29% of frontline workers believe that women have been consuming more nutritious food. It is interesting to note that 16.67% also reported that their family members or neighbours would want to avail the scheme.

Some of the recommendations to the government are

- a. Documents should be collected only once
- b. Husband's Aadhar card submission should be made non-mandatory,
- c. The amount of the cash transfer should be increased to Rs 15000,

- d. Meetings should be organised by the Panchayats to make more people aware about the scheme
- e. Transparent listing of the beneficiary names once they enrol and short term skill based training on multiple details of the scheme.

These are crucial to ensure wider coverage and effective implementation of the main purpose of the policy. PMMVY, if extended to all eligible beneficiaries, has the potential to positively influence the health-seeking behaviour of mothers, and encourage autonomy in making financial and nutritional decisions for themselves and their child.

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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

- **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-for-age, 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.).

1. Introduction

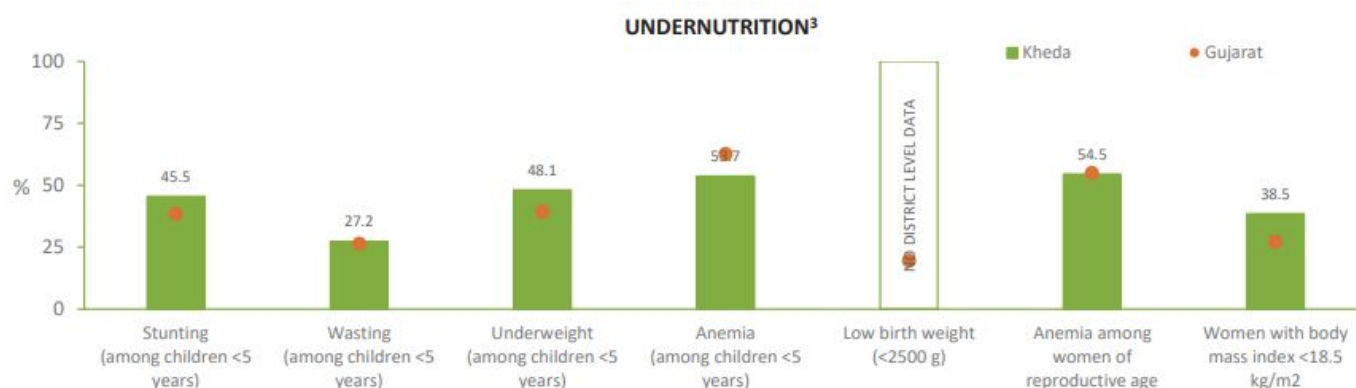
Maternal Health in Gujarat

Gujarat performs well on several development demographic and health indicators with a high literacy rate, low fertility rate, and low infant and child mortality rates. However, the sex ratio of 920 compared to the national average of 933 hints at the relatively low status of women, and the preference for a male child. Female literacy rate also lags behind at 70% compared to the male literacy rate of 81% (NCBI, 2009). The average age of marriage for women between the ages of 20 and 49 years is 19.7. Twenty-five percent of women between 20-24 years were married before the legal age of 18 (NFHS, 2017).

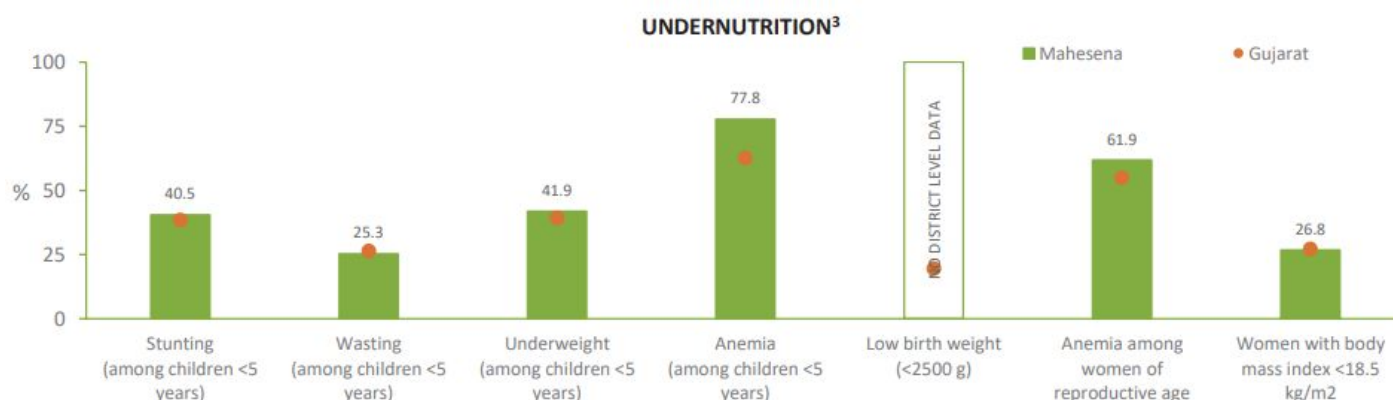
The infant mortality rate is 30 as compared to the national average of 34 (NITI Aayog, IMR, n.d.). This number is higher in rural areas than urban areas, as well as among scheduled caste children (NFHS, 2017). The neonatal period is especially critical in Gujarat as nearly 70% of all infant deaths occur within the first month (WHO).

The maternal mortality rate has steadily fallen over the past decade and, as of 2016, stands at 91 compared to the national average of 130 (NITI Aayog, MMR, n.d.). Among mothers who gave birth between 2012 and 2017, 81% received antenatal care (ANC) from a skilled professional, according to an NFHS survey. More than 85% registered their most recent pregnancy and live birth. Urban women are more likely than rural women to seek ANC. The district of Mahesana recorded the second-highest percentage of institutional births at 96%, and Kheda recorded 90%, both higher than the state average of 89% (NFHS, 2017).

The two districts that the survey was conducted in are present just above and below the capital of Gandhinagar, with Mahesana in the north and Kheda in the south. Mahesana has an urban and rural population of 25.27% and 74.73% respectively. The sex ratio is 926 — higher than the state average but lower than the national average. The literacy rate is 83.6%, with male literacy at 91.4% and female literacy at 75.32% (Census 2011, Mahesana, n.d.). Kheda has an urban population of 22.77% and rural population of 77.23%. The sex ratio is 940, and the average literacy rate is 82.65%, with men at 91.3% and women 73.5%. The literacy rates of Mahesana and Kheda rank 6th and 7th respectively among the 26 districts (Census, 2011, Kheda, n.d.).



The state of nutrition in Mahesana (IFPRI, Mahesana, n.d.)



The state of nutrition in Kheda (IFPRI, Kheda, n.d.)

ICDS in Gujarat

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. ICDS centres, called anganwadis, are staffed with anganwadi workers who are important liaisons between health department officials, and pregnant mothers and children. These workers provide health education and ensure that the pregnant mother and child receive immunizations, health check-ups, and nutrition supplements (Lokshin et al., 2005).

As ICDS is implemented by state governments, its performance depends on the efficiency and commitment levels of the state. ICDS has been fairly well-implemented in Gujarat and has been credited with combating malnutrition — undernourished children declined from 73% in 2003 to 25% in 2013 (NCBI, 2018). Nearly a 100% of pregnant and lactating mothers registered at the anganwadis, and 61% of children under 6 years of age availed the various services (Chudasama et al., 2014; NFHS, 2017).

Pradhan Mantri Matru Vandana Yojana (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 Janani 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. (*Appendix: Basic Flow*)

The conditionalities for the scheme are mentioned below :

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

2. Review of Literature

Some states in India and countries around the world have maternity benefits schemes to support the mother and the child. The following section will shed light on the schemes in India and examples from some other countries.

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	CCT of Rs. 14,000, including Amma Maternity	All women under BPL for first 2 deliveries	Reached 4.7 mil mothers, worth Rs.

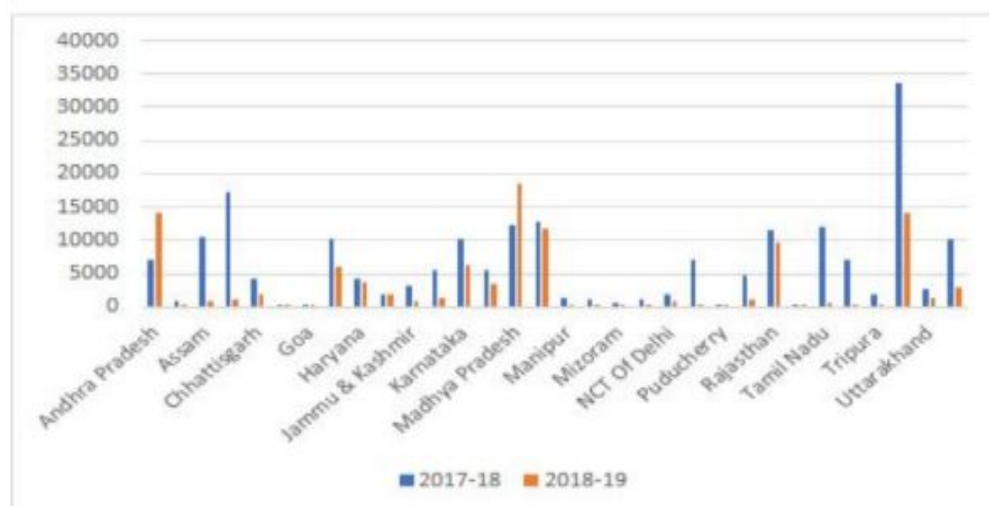
	Benefit Scheme (DMMBS) (Tesz, n.d.; Rajyayojana, 2020)	Nutrition Kit worth Rs. 2000		4337 crore
All India	Supplementary Nutrition Program (MWCD, 2017)	Nutritious food at AWC for 300 days a year	All pregnant/nursing women till 6 months after childbirth, every child from 6 months to 6 yrs	
Andhra Pradesh (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)
Telangana	KCR Kits	Mother and kid care items are provided to the newborn babies and their mothers and a financial aid of Rs 12000	Pregnant and lactating women (3 months post delivery) and the child till 3 months of age	Institutional deliveries rose by 22% over a period of 30 months
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	

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
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)
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.)
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.)

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.)

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



The graph here shows a state-wise GoI 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). From the start of the scheme till 22 July 2019, only 49% of the beneficiaries enrolled had received

all three instalments. Coverage of the scheme has been low. Only 46% of the estimated eligible population was enrolled in FY 2018-19, and 42% in FY 2019-20 by January 2020. 28% of the estimated mothers enrolled in 2019-20 as on 2nd January 2020. 29% of the cumulative PMMVY estimated beneficiaries have received any payment until 31st December 2019 in Gujarat. 77% of the total beneficiaries paid have received the 1st instalment, 76% have received the second and 61% have received the third (Kapur, A et al, 2020).

Figures regarding the target set and achieved for the scheme since its inception, across the country:

Year	Target (in millions)	Target achieved (in millions)	% funds utilised	Number of days after which the first instalment was received (w.r.t. LMP)
2017	5.17 (Shukla & Kapur, n.d.)	0.29	-	-
2018	7.7 (MWCD, 2017-18)	6.5	51.52% (MWCD, 2017-18)	-
2019*	11.2	85% (9.84)	70%	258

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

Figures for the state of Gujarat**:

	Target	Target achieved	% funds utilised	Number of days after which the installment was received (w.r.t LMP)
Registration	580633	462288 (80%)	83.9%	1 st installment - 239 2 nd installment - 278 3 rd installment - 416

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

Relationship between maternity benefits and maternal and child health:

In 1987, the country's first maternity benefit scheme was introduced by the Tamil Nadu government called the Dr Muthulakshmi Reddy Maternity Benefit Scheme. The state has the lowest infant mortality rate after Kerala, with 20 deaths per 1,000 live births, half of the India average of 40. Tamil Nadu also has lower maternal mortality than most states in the country – 79 maternal deaths per 100,000 live births. There's a correlation observed between the provision of maternity benefits and low IMR (Mander, H., 2017). The Janani Suraksha Yojana and other initiatives launched under NHRM, have contributed to reducing the infant mortality rate from 58 in 2005 to 50 in 2009 (Gender and Economic Policy Discussion Forum, 2016).

A High Performing Scheme: Dr.Muthulakshmi Maternity Benefit Scheme

This scheme aims to provide optimal nutrition for pregnant and lactating women and compensates the wage loss during pregnancy. The scheme provides a cash transfer of **Rs 14000 and benefits in kind worth Rs 4000**. The instalments are spread over the duration of the pregnancy and the 1st year of the child with conditions for each instalment. Registration of pregnancy and completion of vaccination are some of the conditionalities involved in the scheme. This scheme is **strengthened with a nutrition kit** with a view to reduce MMR and IMR (Government of Tamil Nadu, n.d.).

The scheme has one of the widest umbrellas to include as many women as possible. It includes the Srilankan refugee women too. The DMMBS grants benefits to women for **two live births**. As of 2017-18, some 4.7 million pregnant women had received financial assistance worth Rs 4,337 crore under the scheme. Potential beneficiaries are required to furnish 3-4 documents to establish their identity and prove their eligibility. **Less than 6% women had faced any difficulty** either in applying for DMMBS or in getting their entitlement, according to a 2010 survey of 207 women in two districts

in Tamil Nadu (Ali, S, 2019) About 50-60% of the deliveries which occurred in the state were covered under the programme. The scheme has had a significant effect on the proportion of women seeking institutional delivery and has especially increased the use of public sector health facilities for delivery use. Utilisation of delivery care increased significantly and the private sector share to total institutional delivery started declining in recent years.

3. Methodology

This research study holds importance as it attempts to look holistically at the evaluation of the process, evaluation of awareness and target assessment, evaluation of outputs and behavioural changes in pregnant women (beneficiaries and non-beneficiaries) and their family members, along with evaluating the awareness levels of the frontline workers. Hence, it covers multiple stakeholders involved in the implementation of the scheme. The research was conducted to understand the gaps in the implementation of the scheme and to evaluate the impact of the scheme and to use the findings to advocate with the government and other organisations/people working in the space of maternal health for ensuring that:

1. No pregnant woman is excluded from the purview of the Act
2. Objectives of the scheme are met
 - a. Partial compensation is provided for the wage loss in terms of cash incentives so that the woman can take adequate rest before and after delivery of the first living child.

- b. Improved health seeking behaviour amongst the Pregnant Women and Lactating Mothers (PW&LM).

The evaluation was done along four main aspects of the scheme. The 4 areas and our hypotheses for each are given below:

1. Process evaluation: 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.
2. Evaluation of awareness and target assessment: 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.
3. Evaluation of immediate 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.
4. Behavioural change: (i) Beneficiary mothers are not the decision makers on the spending of money. (ii) Beneficiary mothers are not decision makers about re-entering the workforce as not enough value is placed on the mother's rest and nutrition.

Assumptions:

1. Beneficiary fathers were not included as their responses would be captured within the responses of beneficiary mothers. Since these women are enrolled, beneficiary mothers would not be able to influence them to get the benefit any more.

2. Non-beneficiary fathers were included to understand how they might support the mothers in enrolling.

Limitations:

1. The study was conducted in two districts in Gujarat, Mahesana and Kheda.
2. The study is representative of the population of rural women.
3. The responses have not been corroborated with the Anganwadi records.

Method: 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.

(Interview questionnaire is attached in the Appendix)

District	BM	BMIL	NBM	NBMIL	NBF	On-ground Workers	Medical Officers	Total
Mahesana	65	32	65	32	32	43	4	273
Kheda	63	32	58	35	30	53	2	273
#	128	64	123	67	62	96	6	546

4. Findings

I. Process Evaluation

1. Registration: Registration at the Anganwadi is fairly common practice among both beneficiaries and non-beneficiaries. 100% of beneficiary mothers said they registered

their pregnancy at the anganwadi. 100% of non-beneficiary fathers and 99.2% of non-beneficiary mothers also said the same.

2. Form-filling: The form needs to be filled three times to avail each of the three instalments. Respondents were asked about their awareness levels and the ease of filling out the form.
 - a) Awareness is highest among beneficiary mothers and beneficiary mothers-in-law at 30.5% and 17.2% respectively.
 - b) Awareness is least among non-beneficiary mothers, fathers, and mothers-in-law with 91.9%, 95.2% and 94.02% of them respectively not knowing how many times the form needs to be filled.

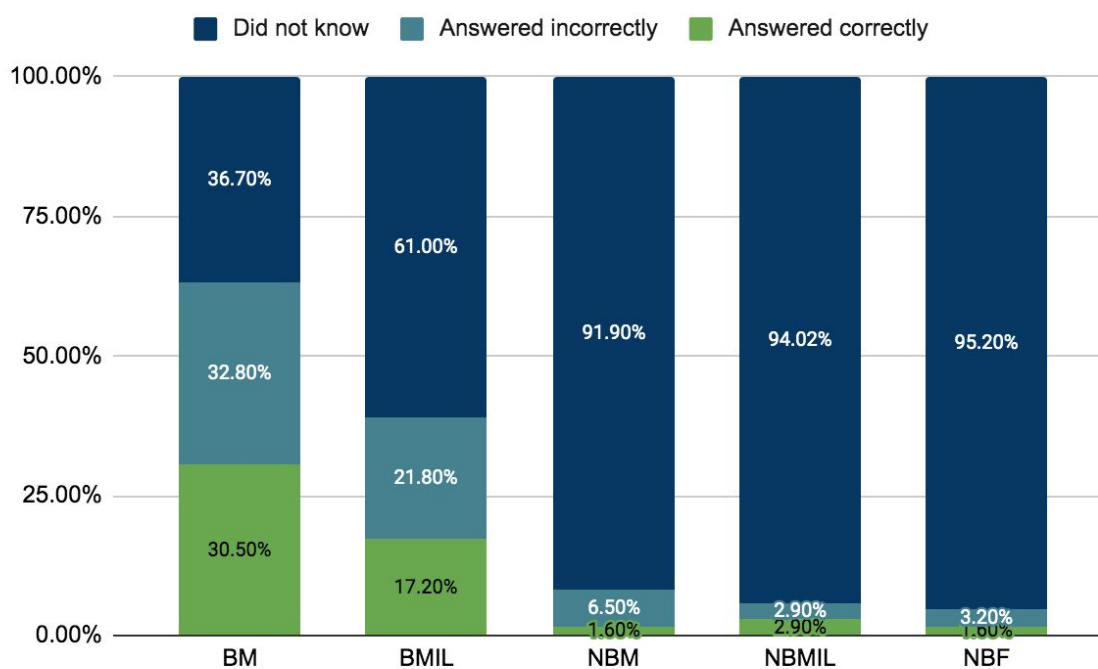


Fig. 1.1. Awareness of the number of times form needs to be filled

- c) 86% of beneficiary mothers and 14.5% of non-beneficiary mothers had no difficulties in filling the form.
 - i) Among beneficiary mothers who had difficulties, 13.3% had trouble gathering the eligibility documents.
 - ii) Among non-beneficiary mothers who had difficulties, 76.4% had trouble collecting the required documents, and 30% of them had other issues such as having to go to the AWC multiple times, and seeking the help of others to fill the form.

3. Document Submission

- a) 57% of beneficiary mothers and 32.5% of non-beneficiary mothers said they had no issues in collecting the eligibility documents required to fill the form.
- b) 38.3% of beneficiary mothers and 80.4% of non-beneficiary mothers had various issues relating to the Aadhaar card — having to apply for an Aadhar card, difficulties with changing their own name or adding their husband's name to the card.
- c) Adding the husband's name to the Aadhaar card was one of the major issues faced by non-beneficiary mothers. While 95.3% of beneficiary mothers said their husband's name had been added to their Aadhar card, only 43.9% of non-beneficiary mothers reported the same. The majority of non-beneficiary mothers, i.e., 56.1%, had not been able to complete this step.

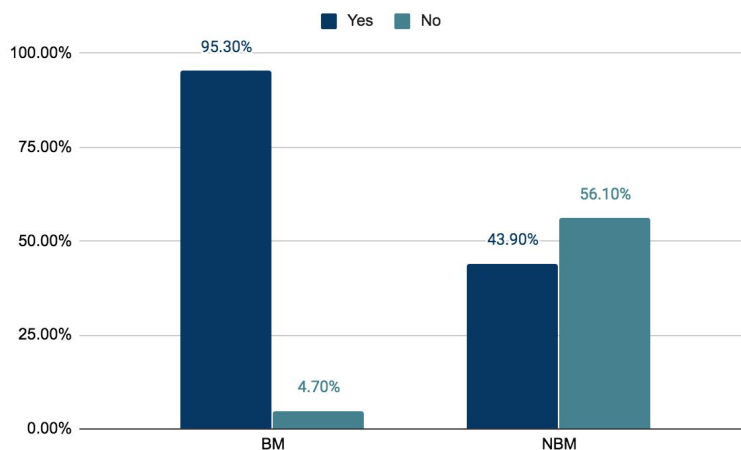


Fig. 1.2. Percentage of BM and NBM who were able to add their husband's name to the Aadhaar card

4. Bank Account

- a) 71.2% of beneficiary mothers had no issues with opening and using the bank account. 22.7% found the bank to be too far away to visit multiple times, and 5.5% had trouble filling the form required to open the account.
- b) Non-beneficiary mothers gave the following responses:

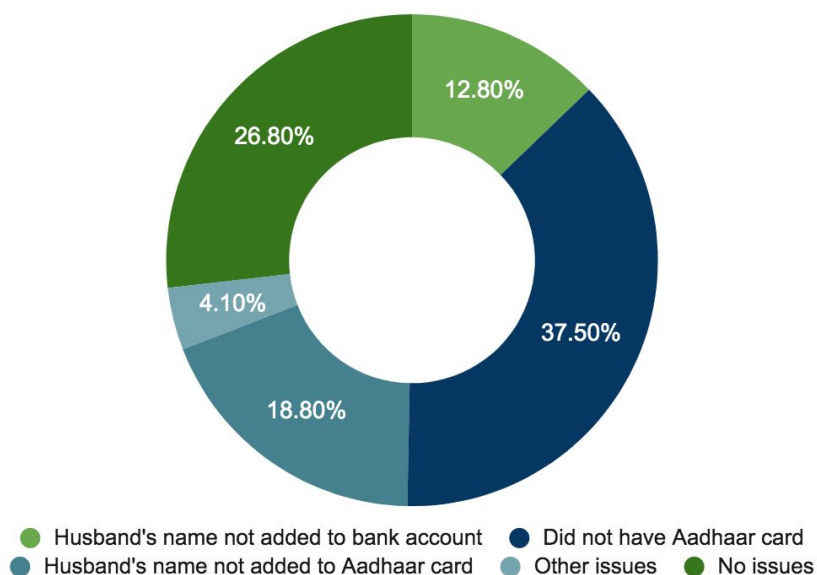


Fig. 1.3. Bank account-related issues faced by

non-beneficiary mothers

5. Check-ups

- a) 71.1% of beneficiary mothers and 67.5% of non-beneficiary mothers reported no issues with getting check-ups done.
- b) Among the beneficiary mothers who faced issues,
 - i) 15.7% said that the person accompanying them to the hospital had to take leave from work
 - ii) 14.8% said doctors were not present in the government hospital on time
 - iii) 6.3% reported that they have to go when the person accompanying them is available
 - iv) 5.5% said that they have to take leave from work

6. Responses from frontline workers

- a) Frontline workers were asked how many times the form needs to be filled:

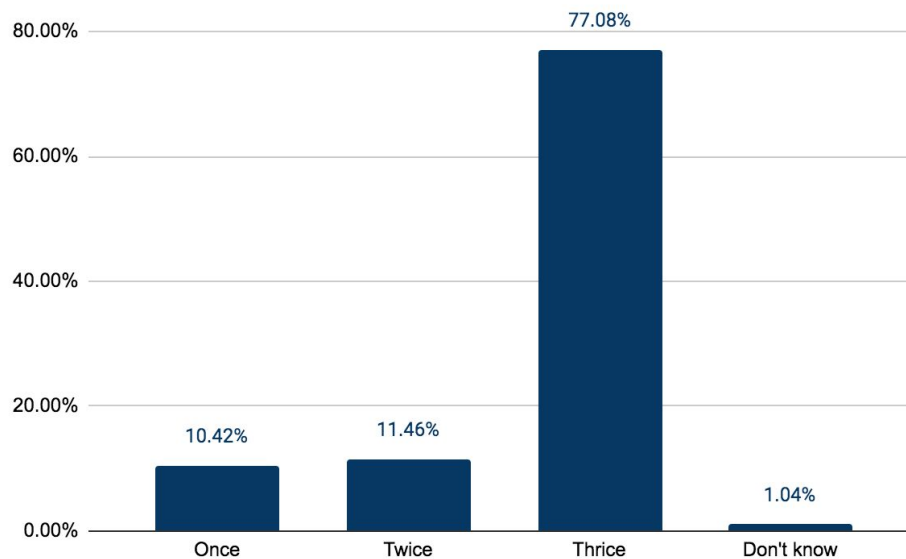


Fig. 1.4. Form-filling awareness among frontline workers

b) They were also asked about the timeline for filling them

- i) First form: 79.17% of frontline workers correctly said that the first form needs to be filled within 5 months of the pregnancy. 12.5% said it should be filled within seven months of pregnancy, and 8.33% did not know.
- ii) Second form: 41.67% of them correctly said the form needs to be filled between seven to nine months of pregnancy.
- iii) Third form: 45.83% correctly responded that the form needs to be filled after the child's vaccinations have been completed, 14.58% said within 4-5 months after delivery, and 9.38% said post-delivery.



Fig. 1.4. Actual timeline for form filling

c) According to the frontline workers, these were the three main issues faced by the beneficiaries in availing the scheme:

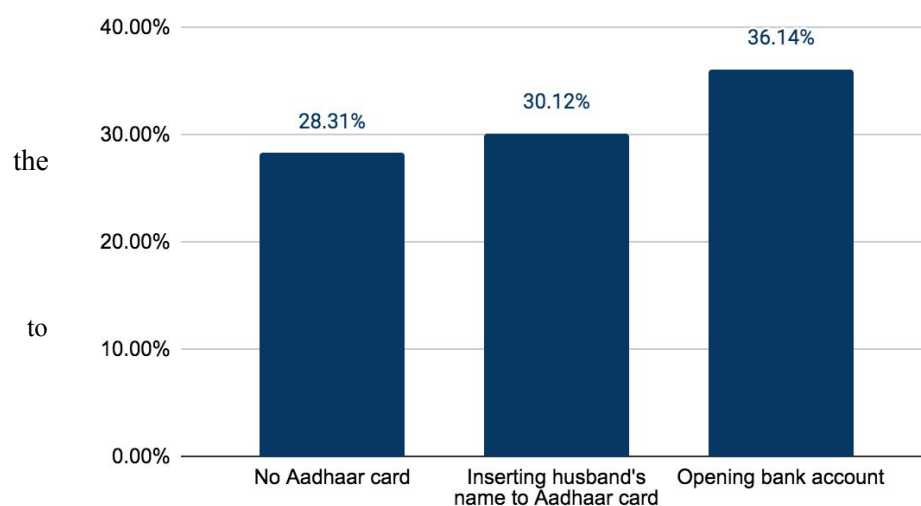


Fig. 1.5. Major challenges in availing scheme*

*5.43% of the respondents gave other answers such as having to go to AWC multiple times, distance from bank

d) Frontline workers were asked about the respondents' level of awareness of the form-filling process

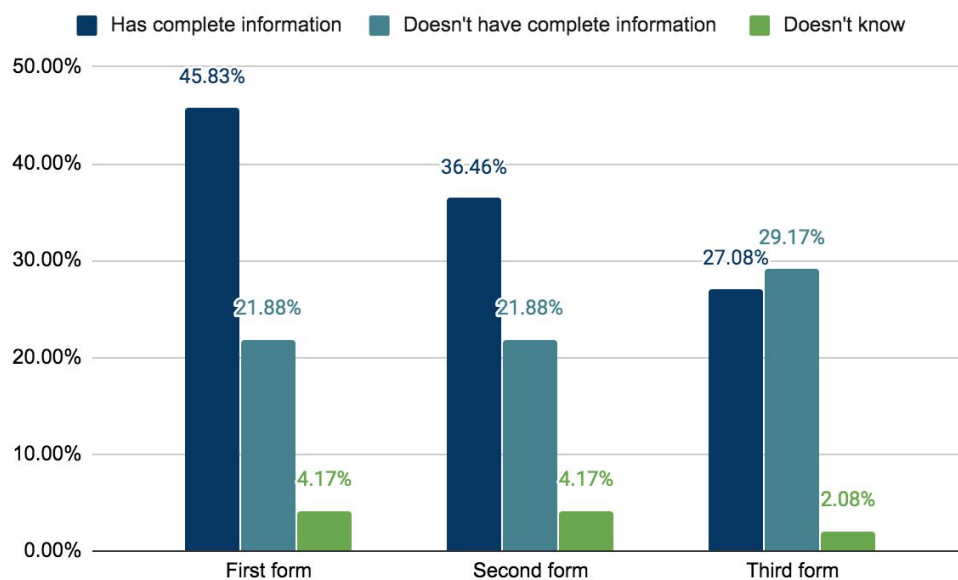


Fig. 1.6. Form-filling awareness of respondents according to frontline workers

e) 47.92% of frontline workers said they had not come across any rejected forms.

31.25% did report rejected forms, and 17.71% were unaware.

f) Among those forms that were rejected, the following reasons were given:

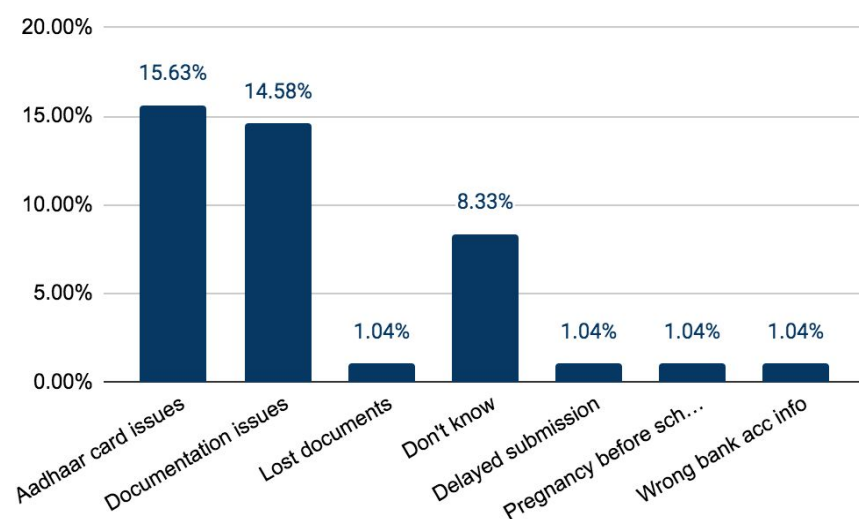


Fig. 1.7. Reasons for form rejection

7. Grievance Redressal

- a) Beneficiary mothers and mothers-in-law were asked who they complained to if they did not receive the money on time (any of the installments). 50% of beneficiary mothers, i.e., 62 of 128, and 65.6%, i.e., 42 of 64, of beneficiary mothers-in-law answered this question. Both groups preferred approaching the Anganwadi worker, with 43.7% of beneficiary mothers and 33.7% beneficiary mothers-in-law responding as such.
- b) They were then asked whether they were satisfied with the responses they received. Their responses are given below.

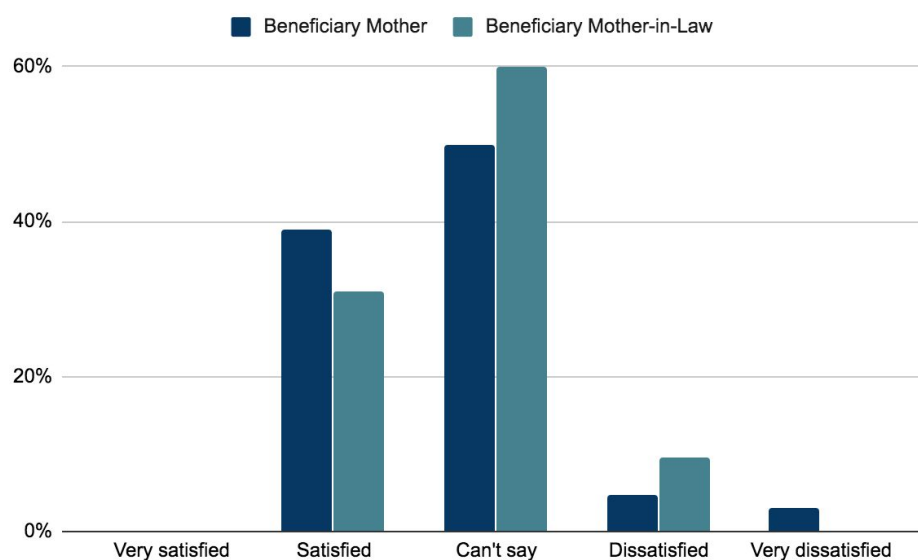


Fig. 1.8. Level of satisfaction with grievance redressal*

*A majority of the respondents who answered "Can't say" said so because they did not attempt to complain to anyone

II. Evaluation of awareness and target assessment

1. Awareness of the respondents with respect to the existence of the scheme

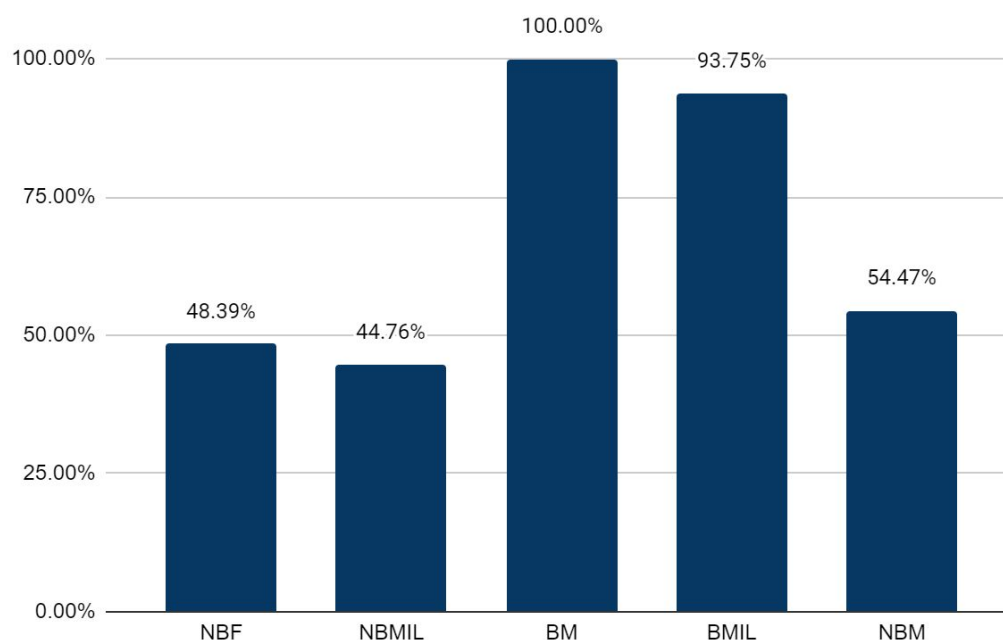


Fig. 2.1. Awareness about PMMVY*

*The corresponding numbers are 30 (NBF), 30 (NBMIL), 128 (BM), 60 (BMIL), 67 (NBM).

2. Sources of information about the scheme

There are different sources of information about PMMVY. The percentages have been given out of those who were aware about the existence of the scheme. Majority of them reported receiving the information from Anganwadi workers or ASHA workers. Some other sources of information were Anganwadi helpers, PHCs, field health workers, etc.

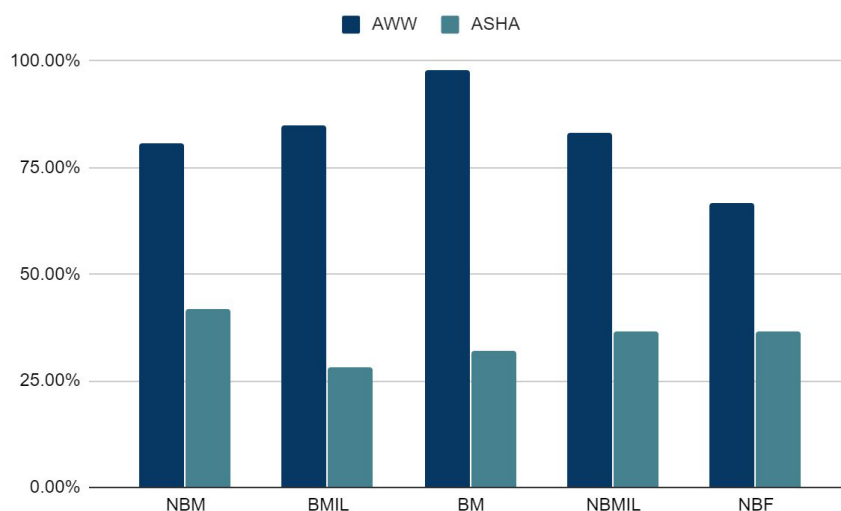


Fig. 2.2. Sources of information for the scheme*

*NBF - 9 respondents gave 2 responses, 1 respondent gave 3 responses

NBMIL - 14 respondents gave 2 responses, 11 gave 3 responses, 2 gave 4 options, 1 gave 5 options

BM - 35 respondents gave 2 responses, 21 gave 3 responses

BMIL - 16 respondents gave 2 responses, 4 gave 3 responses

NBM - 24 respondents gave 2 responses, 6 gave 3 responses, 1 gave 4 responses

3. Reasons for not availing the benefits of the scheme

- a. Of the respondents who were aware about the scheme, 30 (48.39%) of the NBFs, 30 (44.76%) of the NBMILs and 67 (54.47%) of the NBMs, following is the split of the top reasons as to why the pregnant woman didn't avail the benefits of the scheme.

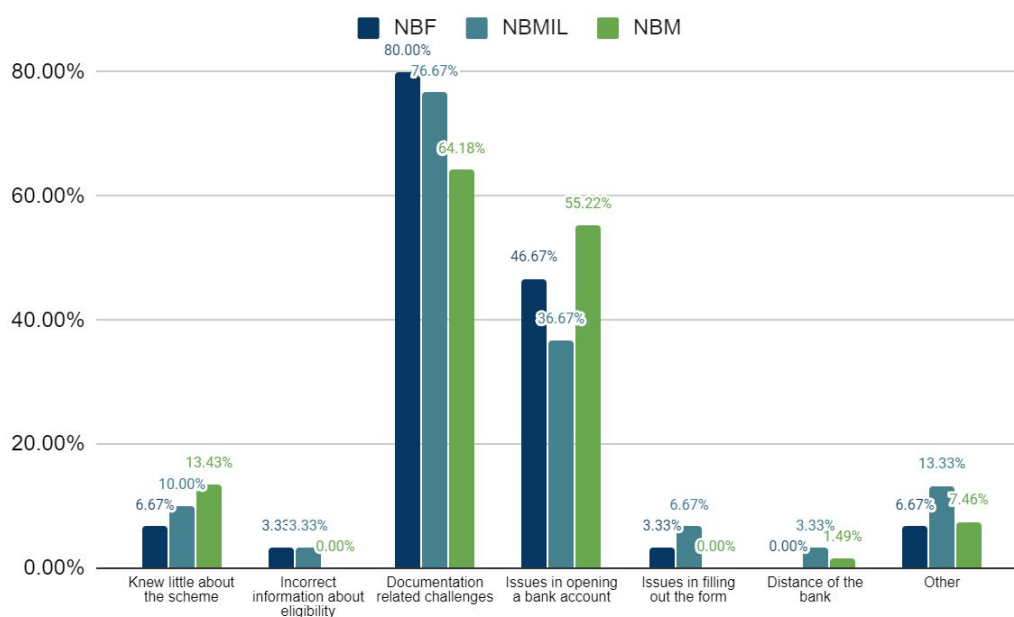


Fig. 2.3. Reasons for scheme non-availment*

* The data was unclear for 1 NBF, 4 NBMIL and 3 NBM.

13 NBFs gave 3 responses, 9 gave 4 responses and 6 gave 5 responses

8 NBMILs gave 2 responses, 4 gave 3 responses

20 NBMs gave 2 responses, 14 gave 3 responses, 4 gave 4 responses

4. How many of the respondents know the objective/s of the scheme?

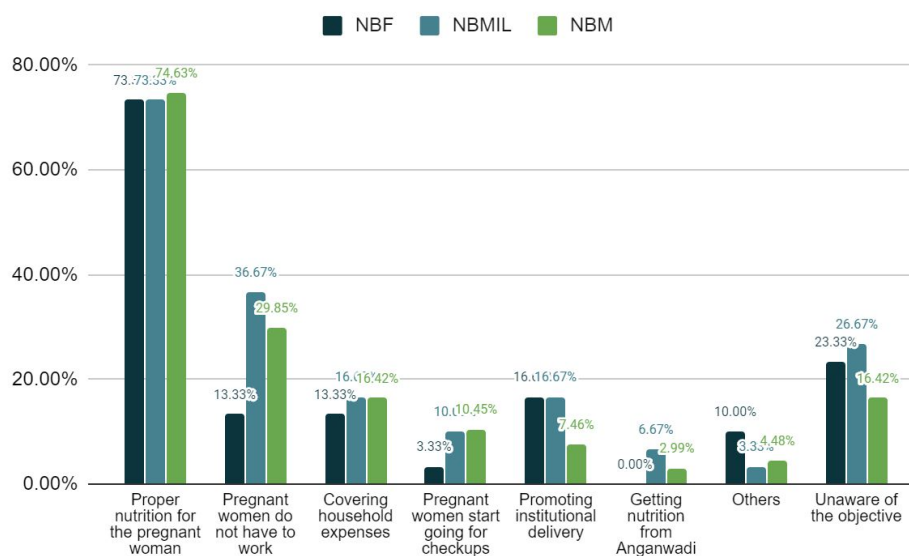


Fig. 2.4. Awareness of scheme objectives among non-beneficiaries*

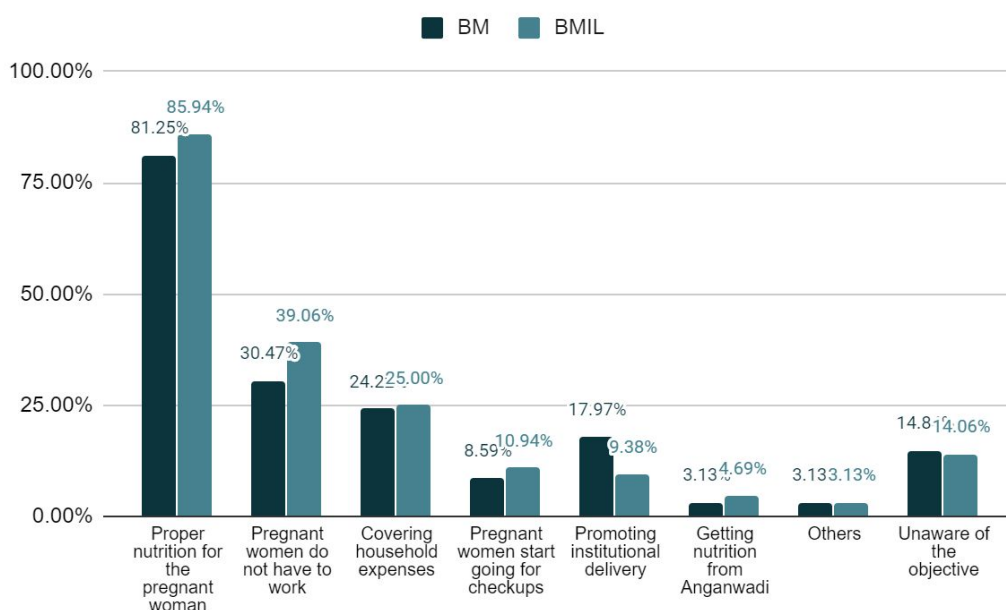


Fig. 2.5. Awareness of scheme objectives among beneficiaries

*14 NBFs gave 2 responses, 1 gave 3 responses

10 NBMILs gave 2 responses, 3 gave 3 responses, 2 gave 4 responses, 1 gave 6 responses

54 BMs gave 2 responses, 23 gave 3 responses, 1 gave 4 responses

26 BMILs gave 2 responses, 11 gave 3 responses, 2 gave 4 responses, 1 gave 6 responses

24 NBFs gave 2 responses, 9 gave 3 responses

5. What more information do you need about the scheme?

- a. 49.2% NBMILs reported that they need full scheme information. The corresponding percentages for BM, NBF, BMIL, NBM are 22.66%, 66.13%, 26.56% and 54.47%, respectively.

6. How would they prefer to be informed about the scheme?

- a. 56.45% of the NBFs would prefer to be made aware of the scheme through the Anganwadi workers. The corresponding figures for NBMIL, BM, BMIL and NBM are 67.16%, 60.94%, 57.81% and 60.98% respectively.
- b. The modes of communication most preferred by

- i) NBFs are village/community meetings (29.03%) and videos (22.58%)
- ii) NBMILs are village/community meeting (58.21%) and verbal communication by the frontline workers (28.37%)
- iii) BMs are village/community meetings (46.88%) and verbal communication by the frontline workers (38.28%)
- iv) BMILs are village/community meetings (54.69%) and verbal communication by the frontline workers (29.69%)
- v) NBMs are village meetings (49.59%) and verbal communication by the frontline workers (39.02%)

7. Responses from frontline workers:

- a. 95.83% of them are aware about PMMVY, whereas 4.17% of them are not.
- b. On an average, 71.88% of them reported that they are informed about this scheme by the government. The split across different frontline workers is given in the graph below:

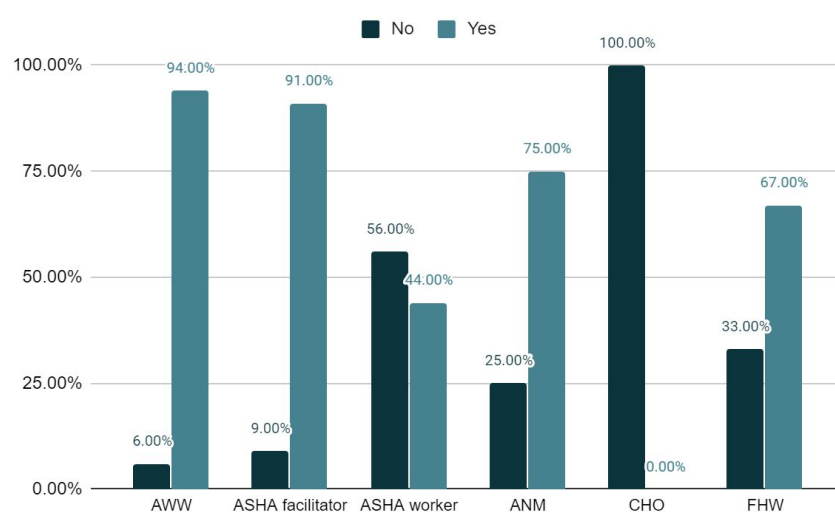


Fig. 2.6. Information about the scheme to the frontline workers by the government*

*Percentage of different frontline workers who participated in the study -
 AWW - 33.33%, ASHA facilitator - 11.46%, ASHA worker - 28.13%, ANM - 4.17%, CHO - 1.04%, FHW - 21.88%

- c. 63.54% of them reported being trained for the scheme, out of which 45.9% reported being trained 4 or more times in a year on this scheme.
- d. Level of awareness regarding the objective of the scheme*

Objective	Number	Percentage
Nutritious food and/or medicines for the pregnant woman	50	52.08%
Vaccination of the child	13	13.54%
Institutional delivery	11	11.46%
Nutritious food and/or medicines for the child	5	5.21%
Good health of the mother and/or child	6	6.25%
Prevention of maternal and/or death of child	21	21.88%
Don't know	17	17.71%

*There is overlap in data: 26 frontline workers gave 2 responses and 3 gave 3 responses.

- e. 78.13% of the respondents reported that they inform the pregnant woman that the cash amount should be utilised for food and medicines.
- f. 82.29% reported that they have observed pregnant women take more nutritious diets post the launch of the scheme.
- g. 27.08% of them reported that they need more information regarding form filling and timeline of cash transfer.

8. Medical Officers

- a. Intent/motive behind this scheme

Of the 6 respondents, 66.67% said the intent is to register birth, get timely check-ups, assistance with hospital expenses, prevent maternal and child

mortality, 16.7% said it is to make sure vaccinations are given, ensure institutional delivery and 16.7% said it is to ensure good nutrition for the mother.

III. Evaluation of Immediate Outputs

1) Spending patterns

a) Beneficiary mothers spent the money in the following ways:

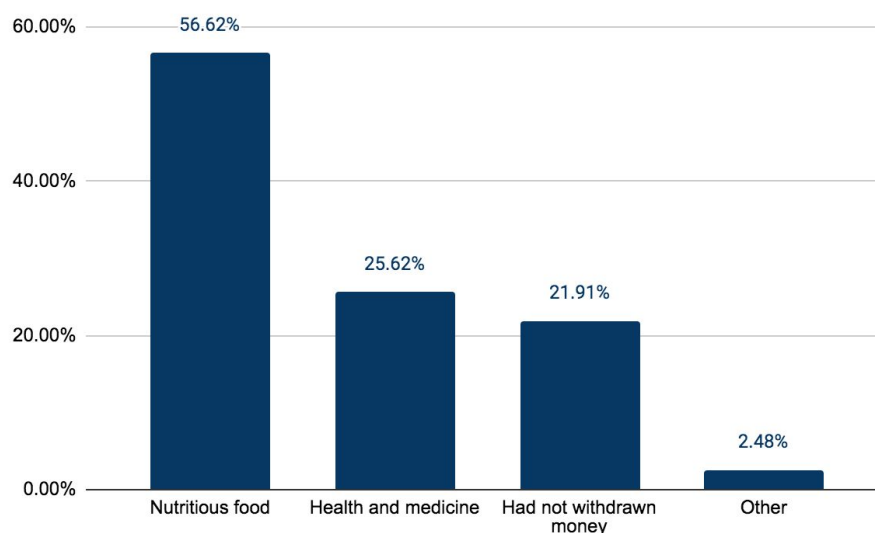


Fig. 3.1. Spending patterns beneficiary mothers*

*This question was asked to those respondents who had received at least one installment. 75, 72, and 71 women had received the first, second, and third installments respectively.

b) Without the benefits of this scheme, beneficiary mothers reported that their intake of nutritious food would reduce by the following percentage:

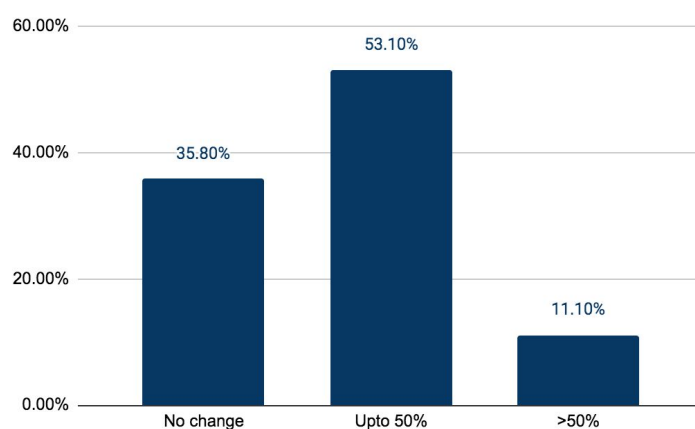


Fig. 3.2
Reduction in nutritious food intake in absence of scheme

2) Maternity Leave

a) Period of rest during and after pregnancy:

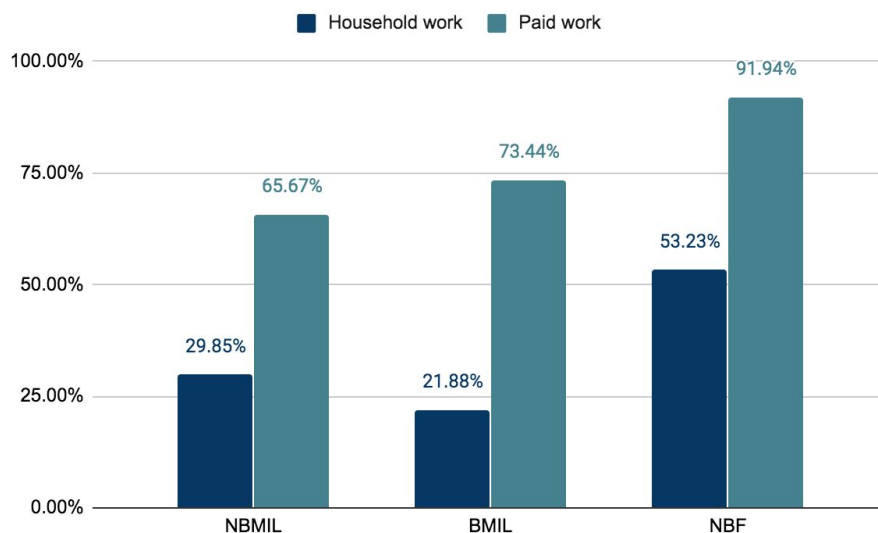


Fig. 3.3. Percentage of respondents who think that pregnant woman should work upto 7 months during pregnancy*

* Paid work refers to wage or salary work; household work refers to unpaid work done by the woman in her own home.

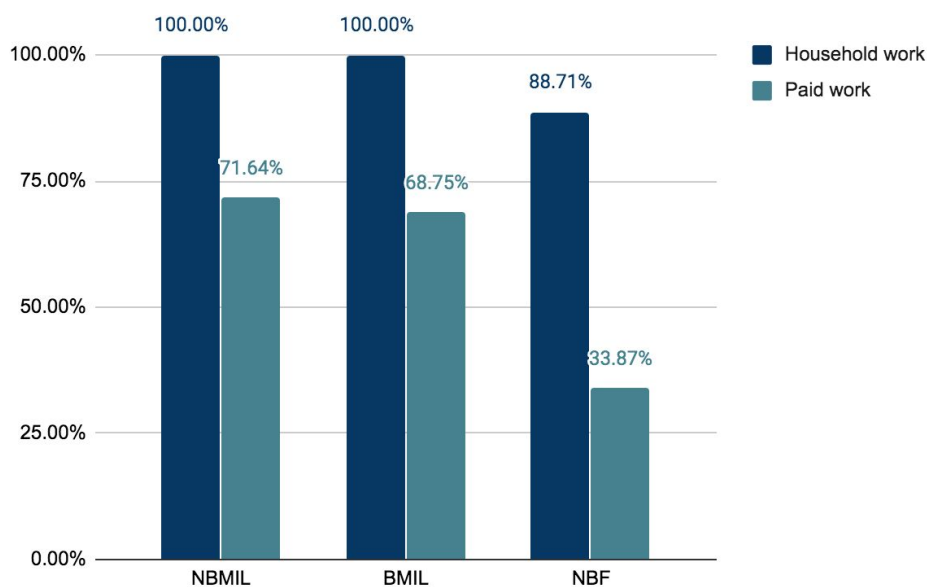


Fig. 3.4. Percentage of respondents who think that the pregnant woman should start working within 3 months after delivery

b) Reasons

- i) 24.19% NBFs think that the women should continue household work only upto 7 months during pregnancy to avoid any complications during pregnancy or delivery and 45.16% of them think that they should continue paid work upto 7 months for these reasons.
- ii) 11.94% NBMIL think that the women should continue doing household work only upto 7 months during pregnancy to ensure that the body remains healthy and 10.45% think it'll avoid complications during pregnancy or delivery. 37.31% NBMIL think that the women should continue doing paid work only upto 7 months to ensure that there's no complication during pregnancy or delivery. 7.46% think that they should continue doing paid work even after 7 months for financial support.
- iii) 4.69% BMILs think that the women should continue doing paid work even after 7 months for financial support. 17.19% BMILs think that women should work only upto 7 months so that there's no complications during pregnancy or delivery and 18.75% think that their body will remain healthy.

c) Duration of leave taken

- i) Of all the BMs who were working (9.38%), 33.33% (4) reported that they stopped going to work before or in the 7th month, 66.67% (8) reported that they stopped going to work post the 7th month. 4 of the women (66.67%) mentioned that they continued working post the 7th month due to the economic situation.

- ii) Of the NBMs who were working (6.5%), 50% left work within 7 months of pregnancy and the rest 50% left work after 7 months of pregnancy. The top reason was due to the economic situation at home.
- iii) Of all the BMs, 8.59% were working and had delivered, out of whom, 18.18% had started working before or in the 3rd month and 81.82% started working post the 3rd month.
- iv) Of all the NBMs, 4.88% were working and had delivered, out of whom, 66.67% respondents returned to work within 2 months after delivery 33.33% respondents returned to work 3 months post delivery.

3) Check-ups:

- a) Beneficiary and non-beneficiary mothers were asked how many times they went for a check-up during their pregnancy. The mothers visited various health centres to get their check-ups done but anganwadis and private hospitals were the most popular choices.

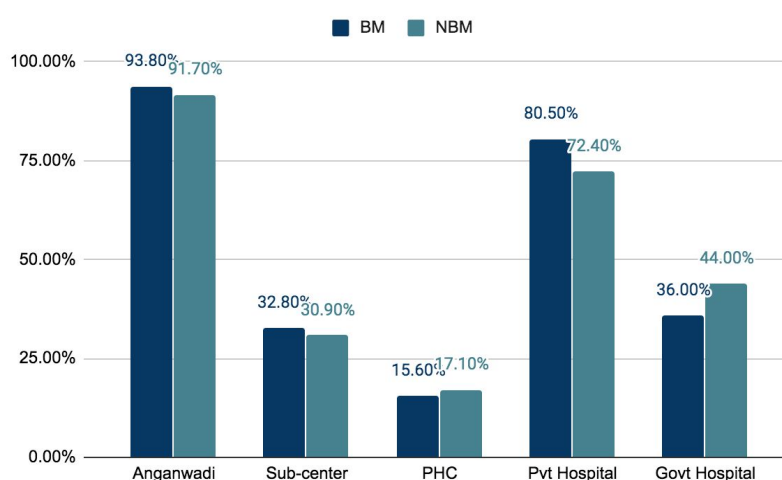


Fig. 3.5 Locations for check-up (There is overlap in the responses as women visited different health centres as per their convenience)

- b) 34.4% of beneficiary mothers and 32% of non-beneficiary mothers got more than ten check-ups during their pregnancy. 45.3% of beneficiary mothers-in-law and 22.4% of non-beneficiary mothers-in-law said that their daughters-in-law went for more than ten check-ups.
- c) 82.8% of beneficiary mothers and 83.7% of non-beneficiary mothers were aware of when they need to go for check-ups. Their responses are given below.

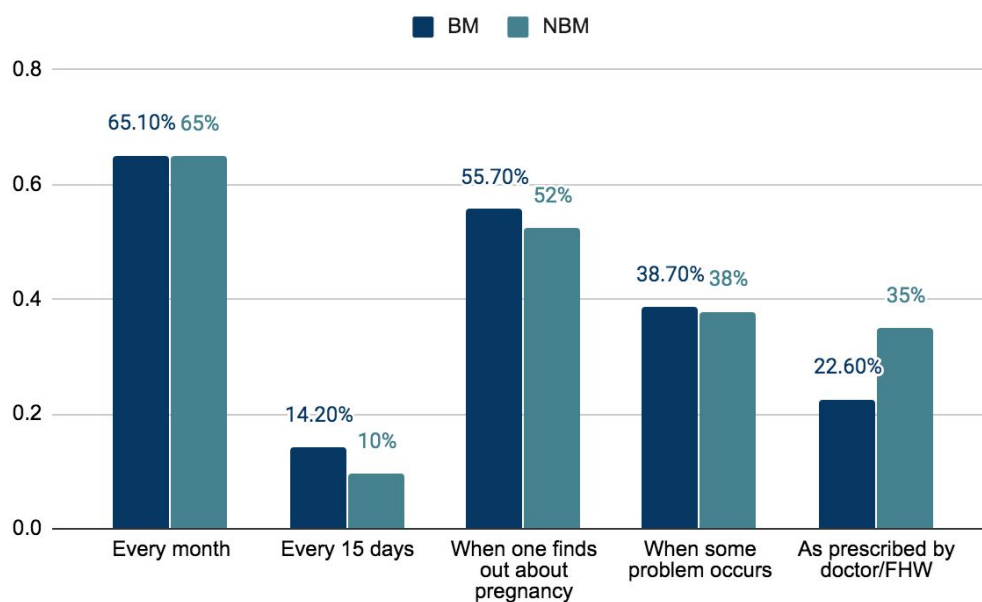


Fig. 3.6 Awareness about frequency of check-ups

4) Delivery

a) Location of delivery

- i) 125 of the 128 (97.7%) beneficiary mothers had already delivered their baby. 100% of them delivered in the hospital. 100% of beneficiary mothers-in-law also said their daughters-in-law delivered in the hospital.
- ii) 74 of the 123 (60%) non-beneficiary mothers had already delivered. 98.6% of them delivered in the hospital and 1.4% (1) delivered at home. 100% of non-beneficiary mothers-in-law said their daughters-in-law delivered in the hospital.
- iii) 100% of beneficiary mothers said they would deliver in a hospital even if they had not received financial assistance from the government.

b) Reasons for delivering in the hospital

- i) 88.8% of beneficiary mothers said it is not the custom to deliver at home anymore. 41.6% said they preferred delivering in the hospital because they would not be able to get a birth certificate for a home birth. 46.4% chose the hospital so as not to go through undue pain.
- ii) 82.2% of non-beneficiary mothers chose the hospital because immediate treatment would be available in case of any complications with the pregnancy. 46.6% gave the reason of experts being present at the hospital.

5) Adequateness of Rs 5000

- a) Of those NBFs who are aware of the scheme, 90% think that the amount is equivalent to the number of leaves taken by the pregnant women during their

pregnancy. 10% think that the amount is not equivalent, reasons being that the medical expense or other expenses are not covered in this amount.

- b) Of those NBMILs who are aware of the scheme, 76.6% of them think that this amount is equivalent to the number of leaves taken by pregnant women during their pregnancy.
- c) 26.6% of beneficiary mothers-in-law answered this question. Among them, 58.8% said the money was inadequate due to inflation, and 11.8% because the woman's salary is more than what the scheme provides. 17.6% said the money was not enough to cover the medical expenses. 11.8% had not yet received the money.
- d) 54.5% of the 123 non-beneficiary mothers answered this question. 82% believed it was adequate and 18% said it was inadequate.

5) Responses from frontline workers

- a) 69.79% reported that if women want to consume nutritious food during pregnancy and post delivery, Rs 5,000 is only going to last for 1-3 months.
- b) Frontline workers reported that only 25% of beneficiary mothers spend the money from the scheme themselves. 19.79% spend half the money themselves and the other half is given to their families. 33.33% of beneficiaries give most or all of the money to their families.
- c) 66.67% of them reported that women are using their money according to the advice given by frontline workers. 82.29% believe that women have been consuming more nutritious food since availing the scheme. 77.1% have also noticed that women have been getting more health check-ups since the scheme's

launch. 90.62% believe that there has been an overall improvement in maternal health over the past two years.

- d) Frontline workers were asked how long after delivery women returned to work.

The top responses are given below:

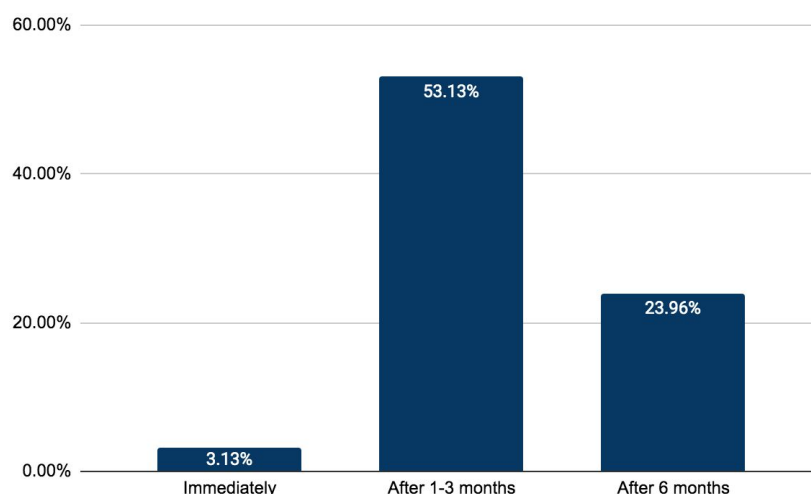


Fig. 3.7. Time period after delivery that women returned to work

IV. Behavioural Changes

1. Increase in amount:

- a. When asked if they are given Rs 15,000 instead of Rs 5,000, what can they do about taking in nutritious food/medicines etc, 80.47% BMs said that they can take more nutritious food, 73.44% said that they can take proper medicines in a timely manner, 7.81% said that there'll be financial support so they need not worry about going to work. The corresponding figures for BMILs are 73.44%, 70.31%, 7.81%. (#BM - 33 gave 1 response, 88 gave 2 responses and 7 gave 3 responses, BMIL - 14 gave 1 response, 30 gave 2 responses and 3 gave 3 responses)

2. Decision on withdrawal and spending money:

- a. Withdrawal of money: Of the 128 respondents, 81 BMs (63.3%) answered this question. (The question was asked to those who knew the number of times they had filled up the form)*

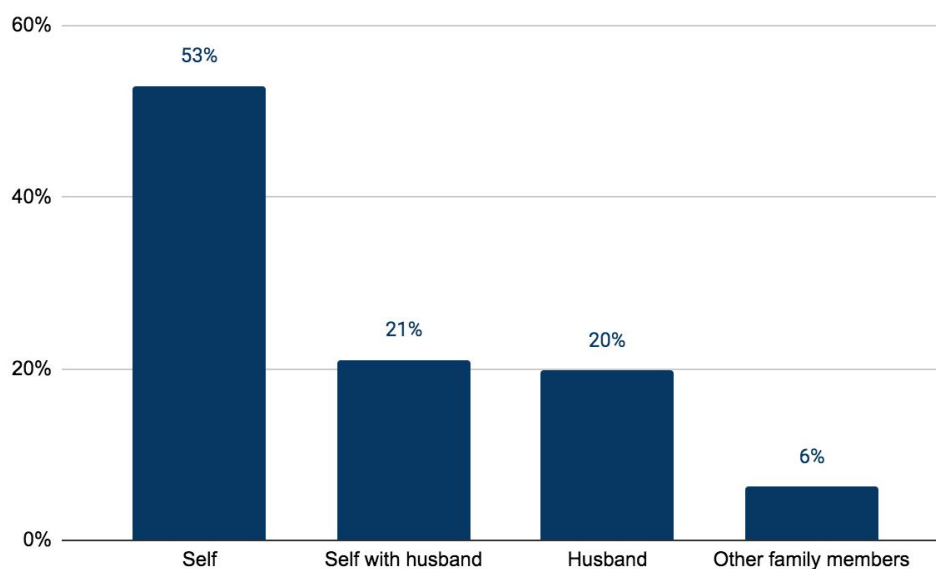


Fig. 4.1. Responses about who withdraws scheme money
*19 respondents gave 2 options in their responses

- b. Of the 60 women who withdrew money themselves or with their husbands, 95% said they were able to spend the money on their and their baby's needs. 5% said they were not able to do so.
- c. Decision on the spending of money: Of the 64 BMIL respondents, 57 (89%) answered this question.* (The sample size is 57 because those who were not aware when the money is deposited after the submission of each form did not answer this question).

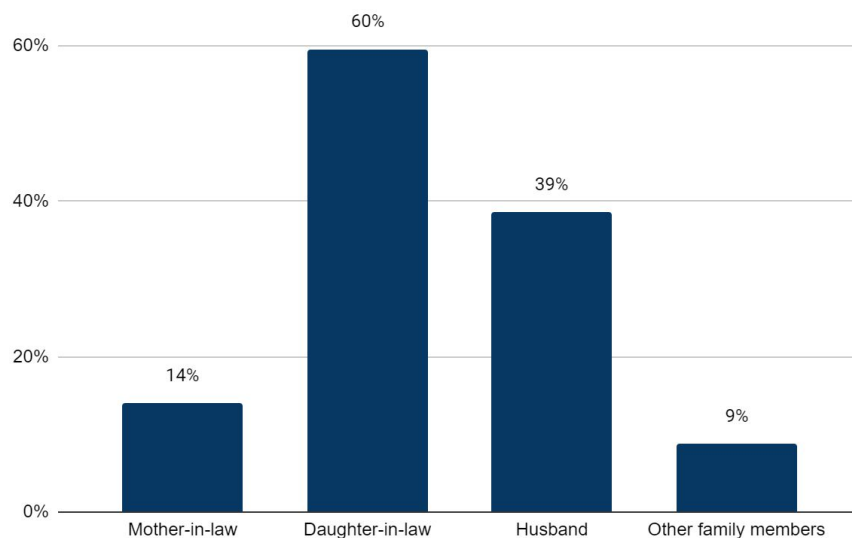


Fig. 4.2. Decision making regarding spending the money

*There's overlap in data: 12 respondents gave 2 responses, 2 respondents gave 3 responses

3. Who manages the pregnant woman's bank account?*

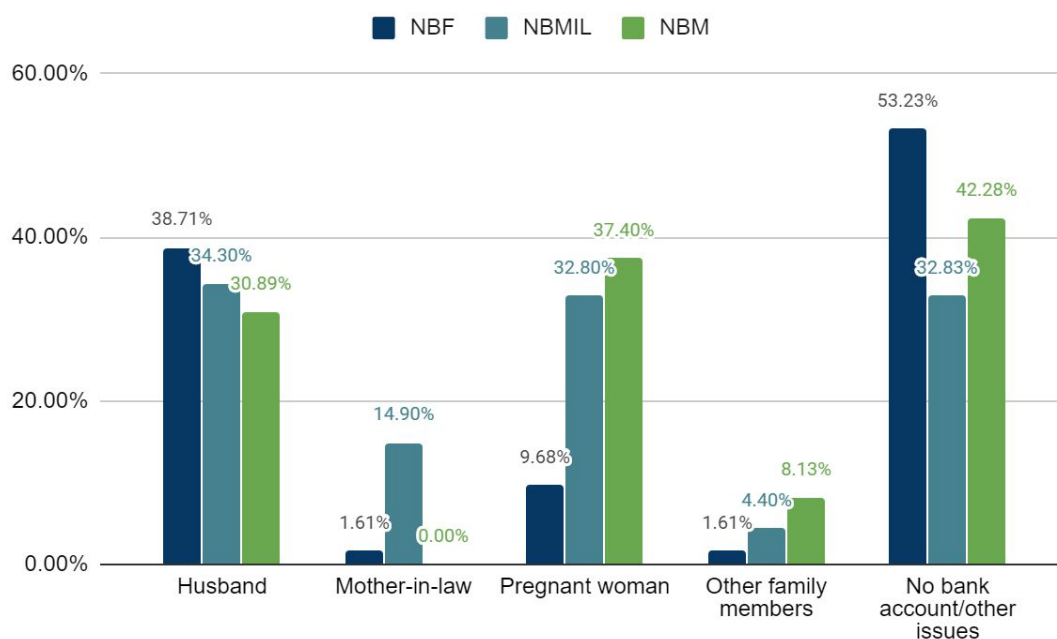


Fig. 4.3. Management of non-beneficiary mothers' bank accounts

*NBF - 3 respondents gave 2 responses

NBMIL - 14 respondents gave 2 responses, 1 gave 3 responses

NBM - 21 respondents gave 2 responses, 1 gave 3 responses (For NBMs, the percentage of respondents who answered mother-in-law have been covered under other family members)

4. Relationship between social or economic class and awareness levels

a. Relationship between social class and awareness levels

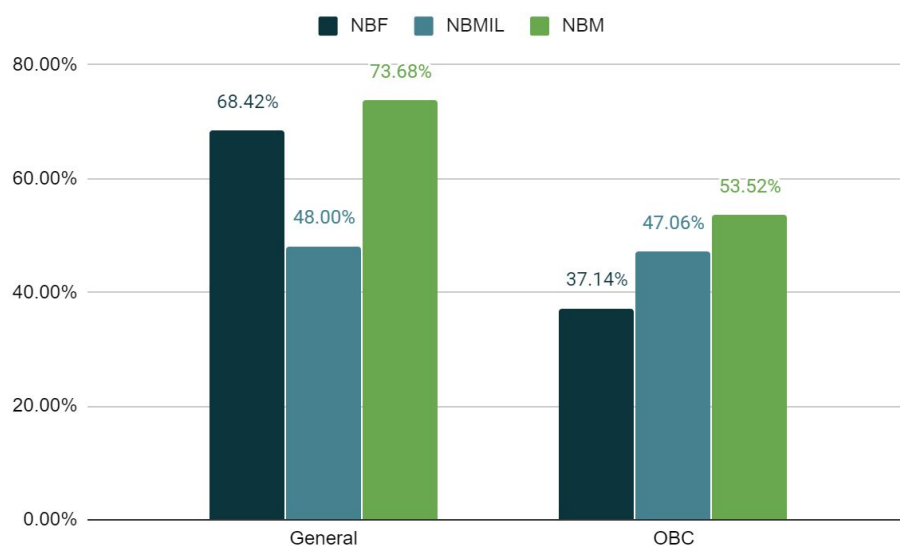


Fig. 4.4. Relationship between social class and awareness levels*

*The sample was less for SCs and STs and hence their percentages haven't been shown: Sample - NBF(ST) - 1, NBF(SC) - 6, NBMIL(ST) - 0, NBMIL(SC) - 8, NBM(ST) - 0, NBM(SC) - 14

b. Relationship between economic class and awareness levels

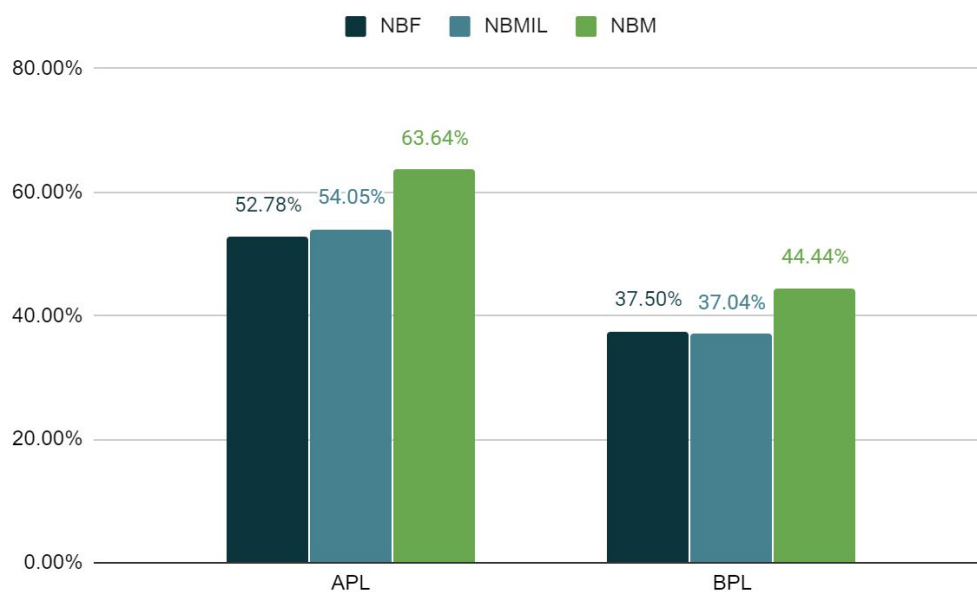


Fig. 4.5. Relationship between economic class and awareness levels

*The sample of the Antyodaya card holders was less and hence their percentages haven't been shown. Sample - NBF - 2, NBMIL - 3, NBM - 3

5. Responses from frontline workers

- a. 83.33% think that women should be educated about their health to ensure that they use the money to consume nutritious food.
- b. 59.38% reported that if the pregnant women use the money by themselves, their family members feel good about it and 14.58% reported that they don't like it. (11.46% reported others, 5.21% said that they don't know and 9.38% did not respond or the data was unclear)
- c. 58.33% reported that family members and neighbours feel good when they come to know that the women will receive money in their own bank accounts and 10.42% reported that they don't like it. (6.25% said others, 4.17% said that they don't know, 16.67% reported that they'd want to avail the scheme or the others also should avail the scheme and 4.17% didn't respond or the data was unclear).
- d. 73.96% reported that more women have started taking food from the Anganwadi after the launch of the scheme.
- e. 69.79% reported that if given Rs 15,000 instead of Rs 5,000, the pregnant women will use it for availing better food and medicines and 20.83% reported that they'll use it for household expenses.
- f. 77.08% of them reported that more women have started asking about theirs and their children's health and well being.

5. Discussion

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.

Awareness about how many times the form needs to be filled to avail each instalment is low across respondents. It is highest among beneficiary mothers with 30.5% of them answering correctly. This shows that even beneficiaries might not be receiving all three instalments due to lack of awareness. Awareness is very low among all non-beneficiary respondents — more than 90% of the non-beneficiary mothers, fathers, and mother-in-laws are unaware. Not only is the mother unaware of the scheme, even those family members who would inform her are not being reached.

85.5% of non-beneficiary mothers faced issues in filling out the form as they were unable to gather the eligibility documents, had to go to the AWC multiple times, or seek the help of someone else to fill the form. Getting a new Aadhar card made and making changes to existing ones is also one of the main challenges with documentation with 38.3% of beneficiary mothers and 80.4% of non-beneficiary mothers facing problems. This can further lead to difficulties with opening a bank account.

Awareness among frontline workers regarding the form-filling process falls for the second and third form. Since they are the main points of contact for most of the pregnant women (97% of beneficiary mothers reported Anganwadi workers as their main source of

information), it is important that they are properly trained and informed about the conditions and timelines for availing the scheme.

17.71% of frontline workers were unaware of whether forms had been rejected. 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.

71.1% of beneficiary mothers and 67.5% of non-beneficiary mothers did not have any issues with getting the hospital check-up done. This shows that the biggest challenge is with awareness as most women will be able to fulfil the conditionalities with ease.

There is no established channel of grievance redressal available to mothers. 43.7% of beneficiary mothers and 33.7% beneficiary mothers-in-law preferred approaching the Anganwadi worker if they had not received the money on time. The main reason for doing so was because they trusted the Anganwadi worker to provide them with the correct information. This reveals that targeting the Angwandi worker for training in grievance redressal would be optimum as they are already trusted by the respondents.

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.

Awareness among the non-beneficiary mothers, fathers and mothers-in-law with respect to the existence of the scheme is not very high. On an average, 49.2% of them are aware about it. This clearly points towards the need for more awareness in the community. However, the awareness among the BMILs is high (93.75%). The source of information for the majority of the respondents is the Anganwadi workers. 66.67% of the NBFs, 83.33% of the NBMILs, 97.7% of the BMs, 85% of the BMILs and 80.60% of the NBMs (all those who were aware about the scheme) have been informed about the scheme by the Anganwadi workers. It shows that the Anganwadi workers are a great source of information for all categories of the respondents.

64.18% of the NBMs who were aware about the scheme have cited documentation related challenges as the reason for not availing the scheme and 55.22% of them have cited issues in opening up a bank account as the reason. These are also the main reasons given by the NBFs and NBMILs for their wives and daughters-in-law respectively, not being able to avail the benefits of the scheme.

On an average, ~78% of all the respondents who were aware about the scheme reported getting proper nutrition as the objective of the scheme (73.76% of the NBFs, NBMILs and BMILs). A lesser number of respondents reported women being able to take leave from work as the reason. On an average, 34.77% of the BMs and BMILs reported women being able to take leave from work and 26.62% of the NBFs, NBMILs and NBMs reported this to be the reason. Overall, the awareness regarding the intent of the scheme is

higher among the BMs and BMILs as opposed to the rest of the categories of respondents.

With respect to the information required for the scheme, 56.6% of the NBFs, NBMILs and NBMs reported that they need full scheme information, however, only 24.61% of the BMs and BMILs reported that they need full scheme information. These figures point towards the need for awareness about the scheme in the non-beneficiary households.

Majority of the respondents would prefer to be informed about the scheme by the Anganwadi workers, on an average the figure is 60.67% across the different categories of respondents. Majority of the female respondents (52.34%) shared that they'd like the information to be given through village or community meetings. Other ways that they'd prefer the information to be given is by verbal communication from the frontline workers. Among the NBFs, the percentage of those who said that they'd like the information to be shared through village/community meetings is lesser (29.03%), but it is still the highest if we compare it to the rest of the mediums (poster, videos, etc).

Among the frontline workers, the awareness regarding PMMVY is high (95.83%). Only 71.88% of them reported that they were informed of this scheme by the government. It is important that all of them are informed about this scheme from a credible source like the government as they are the ones who give the information to the pregnant women. CDPO/Supervisors and PHCs are the major sources of information for the frontline workers. 33.33% of them got to know about the scheme from the CDPO/Supervisor and

29.17% of them got to know about it in a PHC. Only 63.54% of them reported being trained for the scheme. This can be correlated to the fact that 27.08% of them reported that they need more information regarding form filling and timelines of cash transfer. This shows that all the frontline workers don't have adequate information to be given to the pregnant women. With 82.29% of them reporting they have observed pregnant women take more nutritious diets post the launch of the scheme, it can be inferred that the scheme has had a positive impact on the health seeking behaviour of the pregnant women.

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.

56.62% of beneficiary mothers spent the money on nutritious food and 25.62% on health and medicines. However, 21.9% of them had not yet withdrawn the money. The effectiveness of these conditional cash transfers must be examined if a significant portion of the women are not spending the money. We also note that 53% of women said that their intake of nutritious food would reduce by upto 50% if they had not availed this scheme. This means that a little more than half of the beneficiary mothers are using the money for the intended purpose and without it their nutrition would be affected.

65.67% and 91.94% of non-beneficiary mothers-in-law and fathers respectively believe that the woman should work upto 7 months of pregnancy. This percentage is 73.44% for beneficiary mothers-in-law. 29.85% of non-beneficiary mothers-in-law and 53.23% of fathers believe that the woman should do household work upto 7 months of pregnancy. 21.88% of beneficiary mothers-in-law believe the same. It is not clear whether the scheme has encouraged a behavioural change when it comes to the necessary period of rest that pregnant and nursing mothers require. A higher percentage of beneficiary mothers-in-law expect the woman to do wage work 7 months into pregnancy as compared to non-beneficiary mothers-in-law, but a lower percentage of them believe the same thing about household work. 66.67% of beneficiary mothers and 50% of non-beneficiary mothers worked up to the seventh month of pregnancy. 81.82% of beneficiary mothers and 66.67% of non-beneficiary mothers returned to work between two and three months after delivery. The actual numbers show that a higher percentage of mothers are returning to work than what is expected of them by their mothers-in-law and husbands. However, since the economic situation at home is one of the main reasons why women are forced to work during and soon after pregnancy, it is important to look at how the scheme can alleviate their financial constraints.

Both beneficiary and non-beneficiary mothers go for regular check-ups though the numbers are slightly higher for the former — 34.4% compared to 32%. The awareness of when they should go for check-ups is also similar with ~65% of beneficiary and non-beneficiary mothers answering that they should go for check-ups once every month. The scheme does not seem to have impact on the location of delivery since nearly 100%

of beneficiary and non-beneficiary mothers delivered in the hospital. This points to a changing norm as 100% of beneficiary mothers said they would have delivered in the hospital even if they had not availed the scheme.

Responses from beneficiaries, non-beneficiaries and frontline workers indicate that Rs 5,000 is not enough to compensate for maternity leave. The daily minimum wages in Gujarat add up to monthly wages of Rs 8,278 for unskilled labourers, Rs 8,486 for semi-skilled labourers, and Rs 8,720 for skilled labourers (Raj Consultancy, 2019). Rs 5,000 is a little over half of the regular wages and when combined with other expenses that come with pregnancy, it is much below the required amount.

It is encouraging that since the scheme has been introduced, 82.29% of frontline workers believe that women have been consuming more nutritious food, 77.1% that they have been getting check-ups more frequently, and 90.62% have observed an overall improvement in maternal health.

IV. Behavioural Changes

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.

When asked if the pregnant women are given Rs 15,000 instead of Rs 5,000, what they'll do about consuming nutritious food and medicines, an average of 76.95% BMs and BMILs reported that pregnant women can take more nutritious food and 71.88% BMs

and BMILs reported that they can take proper medicines in a timely manner. This goes to show that the cash amount needs to be increased under the scheme.

Majority (53%) of the BMs go to withdraw the money transferred to their accounts on their own, which is a positive sign as it shows that women have some agency on the management of the money that is transferred to their accounts. 20% of them mentioned that their husbands withdraw the money.

60% of BMILs reported that pregnant women decide where they want to spend the money. 39% reported that the pregnant woman's husband decides, which is concerning. If the decision on the utilisation of the money is left to anyone other than the beneficiary, there's a high possibility of the money being spent elsewhere.

A concerning trend was seen with respect to management of the bank account of the pregnant women. On an average, 34.63% of the respondents (NBF, NBMIL, NBM) reported that the husband manages the bank account of the pregnant women. Only 26.63% of them said that the pregnant woman herself manages the bank account. This is concerning as it shows that the agency of the pregnant women is less as there are others in the family involved in managing her bank account.

58.33% of the frontline workers reported that the family members and neighbours feel good when they come to know that the women will receive money in their own bank accounts. It is interesting to note that 16.67% also reported that the family members or the neighbours feel that they'd want to avail the scheme or the others also should avail the scheme. It can be inferred that others who may or may not be directly made aware of

the scheme by the frontline workers may also avail the scheme and encourage others to do so. 73.96% reported that more women have started taking food from the Anganwadi after the launch of the scheme, which is a positive sign. 69.79% reported that if given Rs 15,000 instead of Rs 5,000, the pregnant women will use it for availing better food and medicines and 20.83% reported that they'll use it for household expenses. This shows that there's a need for more awareness among the pregnant women and their families on the utilisation of the money.

On an average, 63.37% of the NBFs, NBMs and NBMILs in the general category are aware while only 45.91% of those belonging in the OBC category are aware of the scheme. This shows that awareness levels are lower in those belonging to the OBC category and could be an indication of discrimination and seclusion.

Those with better economic conditions are also more aware of the scheme among the NBFs, NBMs and NBMILs. On an average, 56.82% of the APL card holders are aware of the scheme while only 39.66% of the BPL card holders are aware of the scheme.

6. Recommendations:

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

1. *Reduce conditionalities:*

- a. 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.
- b. 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.
- c. The form length should definitely be reduced to 1-2 pages.
- d. The second pregnancy should also be covered by the policy, as in the Mamata and DMMBS schemes. The Jaccha Baccha Survey estimated that PMMVY excludes 55% of pregnant women in India because of this restriction (Ali, 2019). The National Food Security Act, 2013 (NFSA) provides that subject to such schemes as may be framed by the Central Government, **every** Pregnant Women & Lactating Mother (PW&LM), except those who are in regular employment with the Central Government or State Government or Public Sector Undertaking or those who are in receipt of similar benefits under any law for the time being in force, shall be entitled to maternity benefit of not less than rupees six thousand, in such instalments as may be prescribed by the Central Government. By excluding the women who are carrying their second child, PMMVY violates a provision under this law. (MWCD, 2019)

2. *Change documentation processes:*

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

3. *Increase in amount:*

- a. As mentioned in the section above, Rs. 5,000 is approximately equal to a month's wage. The Maternity Benefit (Amendment) Act, 2017 guarantees 26 weeks of paid maternity leave to women in the organised workforce (Ministry of Law and Justice, 2017). We recommend a similar consideration for informal women workers. To compensate for at least 12 weeks of wages, and allow the woman to rest post-pregnancy and bond with the child, the amount should be changed to Rs. 15,000.

4. *Targeted communication strategy for behaviour change:*

- a. With ~51% of the respondents from the non-beneficiary households reporting that they are not aware about the scheme and with most respondents reporting that they would prefer village/community meetings to be the mode of communication, the village/city administration should hold meetings on regular intervals to make the pregnant women and her family members aware about the scheme. For example, the USAID-funded Vistaar Project adopted in Uttar Pradesh suggested that monthly meetings among Anganwadi workers must be encouraged so that they can frequently revise their knowledge about such schemes as well as be

better able to counsel mothers on health-seeking behaviour (USAID, 2012). The same frequency of meetings, i.e., once a month, can be followed for eligible mothers to raise awareness.

- b. Awareness campaigns also need to be short, crisp and creative, to catch and hold the attention of the beneficiaries. An example is the National Family Planning Programme's slogan "Ham Do, Hamare Do" (One Family, Two Children) and the accompanying graphic of the inverted triangle. Beneficiary mothers can be enlisted to advocate for the scheme at village meetings.



- c. Different exercises can be undertaken during existing activities such as the Poshan Mah, Village Health and Nutrition Day and Matru Vandana Saptah to explain the importance of both nutritious food and rest for the pregnant/lactating mother and child, in the early years. The Behaviour Change Communication (BCC) strategy and Nutrition and Health Education (NHED) adopted by ICDS is another way to encourage health-seeking behaviour.
- d. 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.

- e. Set up mandatory quarterly meetings for the husbands, to understand about maternal healthcare (a husband/father-support group). The Panchayat should take the responsibility for organising these meetings in villages. A meeting of the men in a village can be best driven by the Sarpanch and the rest of the members of the Panchayat, as they are respected members of the society in their respective villages. In the urban areas, the meetings can be organised by the CDPOs for specific areas of the city/town.
- f. 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.

5. *Queue Correction:*

- a. There should be a transparent listing of the beneficiary names once they enrol.
- b. They should receive regular messages on their mobile phones about the status of their application.

- c. There needs to be a mechanism to edit and rectify mistakes in the application.
This can be done by training Anganwadi/ASHA workers as they are responsible for checking the application before submission to the Supervisor/ANM.
- d. The front-line workers should be able to check the status of the application as well.

6. *Capacity building for front-line workers:*

- a. 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 on regular intervals.
- b. They can be trained to directly fill out the form online, removing the transmission loss.
- c. 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. Under the Poshan Abhiyan, AWW are entitled to smart phones/tablets. Through the use of ICDS- CAS software, AWWs can capture data through these smartphones and tablets and this data collection can be linked to PMMVY-CAS.

7. *Strengthen M&E:*

- a. The monitoring mechanism needs to be made more stringent, and streamlined, starting from the front-line workers, all the way to the exchequer. This must involve a three-pronged approach — empowering the community to raise grievances, establishing a grievance redress mechanism, and designating persons to resolve these issues.

- b. If the number of intermediaries in the process are reduced, it will make the process of evaluation much simpler.
 - c. Details of the process also need to be made publicly available, for an added layer of check by the community stakeholders.
8. *Expand the scope of the scheme by broadening the eligibility criteria of the beneficiaries:*

We have the following categories of mothers in India (apart from the ones that are covered under the scheme):

- a. Underage mothers: Under-age marriages are linked to possible child-birth before the age of 18 years.
- b. Rape victims: There are rape victims, who get pregnant as a consequence, who might be minors. They might also be unmarried.
- c. Unmarried mothers: 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).

There should be an exception made for such women so that they can avail the benefits of the scheme, and their right to nutritious food. Every child born in India should have the right to good health and every woman a healthy pregnancy.

There are multiple reasons why women under 18 years give birth (as given above). The figures are also significant. 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 35.4% (MoHFW, 2016). While it is not the ideal child-bearing age, enforcing moral standards on those situations harms them further. Currently, there is no evidence to suggest that giving the child brides the benefit of this scheme will incentivise child marriage*.

UK's Care to Learn Program allows teenage mothers to pursue their education while giving childcare costs for their children (Government of the United Kingdom, n.d.) New Zealand too has a Young Parent Payment program under which cash benefits are given to parents aged 16-19 years (Government of New Zealand, n.d.).

*Indus Action doesn't support or encourage child marriage. It fully supports programs that are actively seeking to curb child marriage, and teach family planning.

7. Conclusion

In conclusion, we reiterate our initial hypotheses and find that they are valid and true.

- 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.
- There is an acute lack of awareness regarding the process (eligibility, documentation, registration) as women do not have complete information.

- We find that most beneficiary mothers are able to spend the money on their and their child's needs but there is lack of awareness on what exactly they should be using this money for.
- Behavioural change: (i) Beneficiary mothers are not the decision makers on the spending of money. (ii) Beneficiary mothers are not decision makers about re-entering the workforce as not enough value is placed on the mother's rest and nutrition. The inadequacy of the Rs 5,000 is also discouraging behavioural change as women's financial precarity is forcing them to return to work.

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. 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. Finally, it is important that the scheme be made more inclusive. The divorced, unmarried or the underaged pregnant women have little in terms of support, moral and financial. PMMVY can be a scheme that provides the much needed support to those who need it the most.

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Appendices

Appendix 1

PMMVY - Pradhan Mantri Matru Vandana Yojna **Basic Flow**

Background:

- Objectives of PMMVY:
 - a. Providing partial compensation for wage loss, thereby enabling women to receive adequate rest and better nutrition before and after the birth, and;
 - b. improving health seeking behaviour of pregnant women and lactating mothers
- NFSA, 2013: PMMVY has been launched under the National Food Security Act, 2013. PMMVY seeks to improve the nutritional status and hence the health of the pregnant and lactating women and therefore there's a high possibility of this leading to better nutrition and health of the newborn child as well.
- Previously known as IGMSY (Indira Gandhi Matritva Sahyog Yojana)
- Changes made to IGMSY when it was replaced by PMMVY in 2017:
 - a. Under PMMY , the payment from revised to Rs 5000 and the rest of the payment (minimum Rs 1000) is to be made under JSY. Under IGMSY, the payment was Rs 4000.
 - b. PMMVY is restricted to first live birth while IGMSY covered 2 live births
 - c. PMMVY is operational across India and IGMSY was operational in 53 districts of the country¹
 - d. PMMVY is based on a cost sharing model between centre and states (60:40 - Centre and states with legislatures, NE and Himalayan states - 90:10, 100% for UTs without legislature), while IGMSY was 100% centrally sponsored².

¹ <https://pib.gov.in/newsite/PrintRelease.aspx?relid=92842>

² <https://pib.gov.in/newsite/PrintRelease.aspx?relid=92842>

- Date of implementation of policy: 01-01-2017³

Documentation:

Area	Specifications	Challenge/s
Documents ⁴	<u>For 1st installment</u> 1. Duly filled application form 1A 2. Copy of MCP card (Date of LMP and registration health ID) duly certified by rank of ANM and above 3. Copy of Aadhaar Card (Both Husband and Wife) or Identity Proof. 4. Copy of Bank / Post Office Account Passbook(Name, Bank, Branch, Account Number, IFSC, MICR) of Beneficiary only. Joint Accounts not acceptable.	- Need to re-submit the same documents for every tranche
	<u>For 2nd installment</u> 1. Duly Filled Application Form 1-B. 2. Copy of MCP Card (Date of ANC) duly certified by rank of ANM and above. 3. Copy of Aadhaar Card. 4. Copy of Acknowledgment Slip Form 1-A.	
	<u>For 3rd installment</u> 1. Duly filled Application Form 1-C. 2. Copy of MCP Card (Details of Immunizations) duly certified by rank of ANM and above. 3. Copy of Aadhaar Card. 4. Child Birth Registration Certificate 5. Copy of Acknowledgment Slip Form 1-A, 1-B.	- The mother may not have the birth certificate and this might be a hindrance for the mother to get the 3rd installment.
	Husband's Aadhaar Card	- what do you do for unmarried women/ divorcees/rape victims

³ https://wcd.nic.in/sites/default/files/PMMY%20Scheme%20Implementation%20Guidelines%20-%20MWCD%20%281%29_0.pdf

⁴ <http://wcdde.in/PMMY.html>

		- husband doesn't live there anymore but not divorced
Form Filling	1. Offline form filled by AWD worker	- spelling mistakes in name
	2. Form taken to Asha worker for approval	- Loss of forms while transferring them to the ASHA worker
	3. Form made online by computer operator	- Loss in data during transmission
	4. Length of form	- The form is 22 pages long, and thus is time taking as well as lead to more delays
Post application updates	NIL	<ul style="list-style-type: none"> - no way to get updates directly to beneficiary about progress - no way of receiving msgs on the registered phone number about acceptance or rejection of application - no way to correct the form in case of any errors
Bank Transfer	Provision of bank documents	- even after providing account details, money going into different bank accounts

Conditions for disbursal of installments:

Cash transfer	Conditions	Amount in Rupees
1st installment	Early registration of pregnancy at the Anganwadi centre/approved health facility (Early registration - within 150 days from the date of LMP)	1000/-
2nd installment	Received at least 1 ante-natal check-up (After 6 months of pregnancy)	2000/-
3rd installment	1. Child birth is registered 2. Child has received the first cycle of BCG, OPV, DPT,	2000/-

	Hep-B or equivalent	
Janani Suraksha Yojana (JSY) ⁵	1. LPS: All pregnant women delivering in government health centres of district and state hospitals or accredited private institutions 2. HPS: BPL pregnant women, aged 19 years and above 3. LPS and HPS: All SC and ST women delivering in government health centres of district and state hospitals or accredited private institutions	LPS (Rural area) - 1400 LPS (Urban area) - 1000 HPS (Rural area) - 700 HPS (Urban area) - 600

General Flow⁶:

1. Registration and submission of claims of instalments to AWW/ANM/ASHA
2. Beneficiary to obtain acknowledgement from AWW/ANM/ASHA post registration (how to do this hasn't been clarified)
3. AWW/ANM/ASHA to send the details to supervisor/ANM
4. Supervisor/ANM to check and submit form+docs to CDPO/Medical Officer for payment processing/ online registration on the PMMVY-CAS portal
5. State Nodal Officer (SNO) to ensure that the payments are initiated within 3 working days from the receipt of sanctioned list from CDPO/MO after verifying the correctness of the data.

Appendix II - Interview Questionnaire

([Link](#))

⁵ <https://nhm.gov.in/showfile.php?lid=420>

⁶ https://wcd.nic.in/sites/default/files/PMMVY%20Scheme%20Implementation%20Guidelines%20-%20MWCD%20%281%29_0.pdf