18 November, 2019

JABS 2019

Briefing Material

This document is a set of briefing notes based on the Jaccha Baccha-Survey (JABS), a survey of pregnant and nursing women in rural India conducted in June 2019 – see BN8 for details. See also below for a list of additional material available on request. For further information, please write to hardworknopay00@gmail.com or contact Anmol (9953042948) – thank you!

("The World of Anganwadis", a short film, will be on Youtube very soon.)

Briefing Notes

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Table comparing Odisha and Uttar Pradesh

GOI circular of 14.10.19, regarding changes in Aadhaar card

Hidden Hardships
Pregnancy and Child Birth in Rural India

The hardships endured by rural women during pregnancy and childbirth tend to go unnoticed. Their husbands and in-laws rarely go out of their way to support them as they experience fatigue, illness and pain. Public services, too, are grossly deficient. A recent survey sheds light on this hidden ordeal.

The JABS Survey

The Jaccha-Baccha Survey (JABS), conducted by student volunteers in June 2019, took place in six states: Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Odisha and Uttar Pradesh. In each state, the survey teams visited 10 to 12 randomly-selected anganwadis (spread over two blocks, in the same district) and interviewed as many as possible of the pregnant and nursing women registered at those anganwadis: 342 and 364 respondents, respectively.* For further details, see Briefing Note 8.

Special Needs Ignored

We were shocked to find how little attention was paid, in the sample households, to the special needs of pregnancy – good food, extra rest and health care. Often, family members or even women themselves had little awareness of these special needs. For instance, 48% of pregnant women and 39% of nursing women in UP had no idea whether or not they had gained weight during pregnancy. Similarly, there was little awareness of the need for extra rest during and after pregnancy.

Frugal Diets

Among other neglected needs is the need for nutritious food. Only 22% of the nursing women reported that they had been eating more than usual during their pregnancy, and just 31% said that they had been eating more nutritious food than usual. The main reason for not eating more is that many pregnant women feel unwell or lose appetite. The proportion of nursing women who reported eating nutritious food (e.g. eggs, fish, milk) "regularly" during pregnancy was less than half in the sample as a whole, and just 12% in UP.

Low Weight Gain

Poor diets lead to low weight gain during pregnancy. Compared with a norm of 13-18 kg for women with low BMI, the average weight gain in the sample was barely 7 kg (in UP, just 4 kg). Even these figures are likely to be overestimates, as they exclude women who did not know their weight gain at all. Some women were so light to start with that they weighed less than 40 kg at the *end* of their pregnancy.

Lack of Rest

Rest is another unmet need of pregnant women. Almost all the respondents had done household work regularly during their last pregnancy. A significant minority (21%) of nursing women said that no-one (not even a grown-up child) was available to help them with household work during pregnancy. Almost two thirds (63%) said that they had been working right until the day of delivery.

Weakness and Exhaustion

Due to lack of food and rest, most of the respondents had felt tired or exhausted during pregnancy. As many as 49% reported at least one symptom of weakness, such as swelling of feet (41%), impairment of daylight vision (17%) or convulsions (9%).

Dismal Health Services

Pregnant and nursing women are acutely deprived of quality health care. Many of them receive some basic services (e.g. tetanus injections and iron tablets) at the local anganwadi or health centre, but they get very

* "Nursing women" refers to women who delivered a baby during the 6 months preceding the survey.

little beyond the basics. Small ailments easily become a major burden, in terms of pain or expenses or both. At the time of delivery, women are often sent to private hospitals when there are complications. A significant minority also report rude, hostile or even brutal treatment in the labour room. There is an urgent need for radical expansion of quality health care close to home. Two signs of hope here: high rates of institutional delivery and widespread use of public ambulance services.

Delivery as an Economic Contingency

Institutional deliveries are supposed to be available free of cost to all women in public health centres. In practice, we found that nursing women had spent close to ₹ 6,500, on average, on their last delivery. This amounts to more than a month's wages for a casual labourer, in the survey areas. One third of these women's households had to borrow or sell assets to meet the costs. The economic risks associated with pregnancy and delivery add to other arguments for universal maternity entitlements.

Denial of Maternity Benefits

Under the National Food Security Act 2013 (NFSA), all pregnant women are entitled to maternity benefits of ₹ 6,000, unless they already receive benefits as formal-sector employees. The central government ignored this for more than three years, before launching the Pradhan Mantri Matru Vandana Yojana (PMMVY) in 2017. In flagrant violation of the Act, PMMVY restricts benefits to one child per woman – the "first living child". Further, benefits have been arbitrarily reduced from ₹ 6,000 to ₹ 5,000 per child.

Even these meagre benefits are elusive. Among nursing women eligible for PMMVY, only 39% had received the first instalment. The government's own data show that PMMVY covers less than one fourth of all births as things stand. (For further details, see Briefing Notes 2 and 3).

Signs of Change

Against this gloomy picture, we observed a few signs of positive change:

- The use of public ambulance services is now very common – a majority of nursing women had used them, just by dialling "108". Some had to pay small charges – ₹ 58 on average.
- Some states, notably Odisha, are now giving eggs as "take-home ration" (THR) to pregnant and nursing women. This is a good practice that should be replicated in all states.
- Odisha also has a well-functioning maternity benefit scheme of its own, the Mamata scheme.
- Some states have started providing a cooked meal to pregnant and nursing women at the local anganwadi. This, incidentally, is a legal right under Section 4 of the NFSA.

Leaders and Laggards

In this survey, once again, Himachal Pradesh stood out as a state with relatively good public services including maternal care. Women in Himachal were also relatively well-off, well-educated and self-confident. Their predicament was much better than elsewhere, with, for instance, an average weight gain in pregnancy of more than 11 kg. (For further details, see Briefing Note 4).

In Chhattisgarh and Odisha, we also found many signs of positive change, e.g. brightly painted anganwadis, breakfast for the kids, a pre-school education syllabus, collaboration between anganwadi and health workers, and eggs as THRs (in Odisha). Some of these initiatives are yet to make a difference, but there is a trend of improvement at least.

It is in Jharkhand, Madhya Pradesh and – especially – UP that the situation was absolutely dismal. In UP, all the anganwadis were closed at the time of the survey – allegedly because of the school holidays. Women and children disliked the "panjiri" (ready-to-eat mixture) being distributed as THR, if they ate it at all. No food was cooked at the anganwadi, even for children in the age group of 3-6 years. Pregnant women, left to their own devices, were struggling with the worst possible hardships and pains.

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Selected Findings

	Nursing women*	Pregnant women
Socio-economic status		
Proportion of respondents who were unable to read (%)	23	26
Average years of schooling	8	8
Average age at marriage (years)	19	19
Average number of living children	1.9	0.9
Proportion of households with a toilet (%)	61	63
Pregnancy		
Average weight gain during pregnancy (kg)	7.0	-
Proportion of respondents who were eating less during pregnancy (%)	47	49
Proportion of respondents who were eating nutritious food every day during pregnancy (%)	20	22
Proportion of respondents who were eating nutritious food more often than usual during pregnancy (%)	31	24
Proportion of respondents who had symptoms of weakness during pregnancy (%):		
Swollen feet	41	26
Impairment of daylight vision	17	19
Convulsions	9	8
Proportion of respondents who worked on family farms during pregnancy (%)	20	18
Proportion of respondents who had no-one around to help with household work during pregnancy (%)	21	26
Proportion of respondents who felt they did not get enough rest during pregnancy (%)	38	30
Proportion of respondents who faced problems during pregnancy due to lack of money (%)	30	34
Delivery		
Proportion of respondents who delivered their last child at home (%)	12	-
Proportion of households who had to borrow or sell assets to meet delivery expenses (%)	30	-
ICDS, health services and PMMVY		
Proportion of respondents who received the following services from the local AWC or PHC		
At least one health check-up	86	74
Tetanus shots	96	84
Iron & folic acid tablets	93	74
Food supplements	92	77
Advice related to pregnancy/diet/delivery	75	64
Proportion of eligible respondents who applied for PMMVY (%)	72	50

* Women who delivered a baby during the six months preceding the survey.

Maternity Entitlements: Women's Rights Denied

1. **In 2013, maternity benefits became a legal entitlement of all Indian women** (except those already receiving similar benefits as regular government employees or under other laws) under the National Food Security Act, Section 4: *"… every pregnant and lactating mother shall be entitled to [nutritious food and] maternity benefit of not less than rupees six thousand, in such instalments as may be prescribed by the Central Government".*

2. At that time, **a pilot scheme called Indira Gandhi Matritva Sahyog Yojana** (IGMSY), with benefits of ₹ 4,000 per child, was being implemented in 53 districts. Under IGMSY, maternity benefits are conditional and restricted to two live births.

3. On 30 October 2015, the Ministry of Women and Child Development **filed an affidavit in the Supreme Court**, claiming that it was planning to extend IGMSY from 53 to 200 districts in 2015-16 and all districts in 2016-17. Yet, the budget allocation for IGMSY in the 2016-17 Union Budget remained a measly ₹ 400 crore (as in 2015-6 and 2014-5), making it impossible to go beyond the 53 pilot districts.

4. The importance of maternity entitlements was well articulated in the **Economic Survey 2015-16**, in a chapter on 'Mother and Child'. However, this was not reflected in the 2016-17 Budget.

5. On 31 December 2016, **Prime Minister Narendra Modi announced** that pregnant women nation-wide would soon be getting maternity benefits of ₹ 6,000.

6. Further to the PM's announcement, an **allocation of Rs 2,700 crores** was made for "maternity benefit programme" in the Union Budget 2017-18. However, this is a fraction of what is required: universal maternity entitlements of ₹ 6,000 per child would need close to ₹15,000 crore per year (assuming a birth rate of 20 per thousand and an effective coverage of 90%).

7. On 3 April 2017, the Ministry of WCD stated in an affidavit to the Supreme Court: "…the Government of India has announced pan-India implementation of Maternity Benefit Programme with effect from 01.01.2017 in all the districts of the country. **All the pregnant women and lactating mothers would be given ₹ 6,000 in instalments** [except those already receiving similar benefits as regular government employees or under other laws]".

8. In August 2017, the MoWCD released the guidelines and draft Rules for **Pradhan Mantri Matru Vandana Yojana**. Under PMMVY, maternity benefits (₹ 5,000 only) are restricted to the first live birth - a flagrant violation of the Act. Conditionalities also apply.

9. Two years later, information obtained in response to an RTI query reveals that only half of eligible women received any PMMVY money in 2018-19. Since 55% or so of pregnant women are not even eligible (because of the "first living child" condition), this means that **the effective coverage of PMMVY is just 22% or so (see attached table)**.

10. In fact, in terms of disbursement of all three instalments of PMMVY women, coverage is even lower: **just 14%!**

All-India Coverage of PMMVY

(based on official data)

	Number of PMMVY beneficiaries, 2018-19		
	Absolute number (lakh)	As a proportion of first births (%)	As a proportion of all births (%)
Enrolled	62.8	51	**23**
"Paid" [a]	60.4	49	**22**
Received 3rd instalment	38.3	31	**14**

[a] At least one instalment.

Notes:

(1) The number of births is estimated at 270.5 lakh, based on 2017 data for India's population (133.9 crore) and birth rate (20.2 per thousand). Of these, 123 lakh are counted as first births, based on a total fertility rate of 2.2 children per women (implying that 45.5% of all births are first births).

(2) Information on number of beneficiaries was obtained from the Ministry of Women and Child Development in August 2019, in response to an RTI query. The figures provided by the Ministry pertain to the 16-month period from 1 April 2018 to 31 July 2019. To convert this into 12-month estimates for 2018-19, we assumed that the beneficiaries were evenly distributed over that 16-month period (i.e. we multiplied the original figures by 0.75). If anything, this is likely to overestimate the number of beneficiaries in 2018-19, since the number of beneficiaries is increasing over time.

What's Wrong with PMMVY?

All pregnant women are entitled to maternity benefits under the National Food Security Act, but actual coverage is just 22 per cent or so.

Six years after the National Food Security Act became law, the central government is yet to redeem one of its main responsibilities under the Act: payment of maternity benefits to all pregnant women.

Under the Act, all pregnant women are entitled to maternity benefits of ₹ 6,000, unless they already receive similar benefits under other laws, e.g. as formal-sector employees.

The central government ignored this for more than three years, before launching the Pradhan Mantri Matru Vandana Yojana (PMMVY) in 2017.

India's population is estimated at 1,339 million in 2017. With a birth rate of 20.2 per thousand (2017 estimate), this implies 270.5 lakh births per year. As against this, the number of women who received any maternity benefits (even just one instalment) under PMMVY in 2017-18 was just 60 lakh or so, i.e. **just 22 per cent of the total number of births.***

How did this happen? The JABS survey sheds some light on this issue. Briefly, women's rights have been denied in three steps.

Step 1: Restriction of entitlements

In flagrant violation of the Act, PMMVY restricts benefits to one child per woman – the "first living child". Further, benefits have been arbitrarily reduced from ₹ 6,000 to ₹5,000 per child.

Step 2: Cumbersome application process

To receive these meagre benefits, eligible women need to fill a long form for each of the three instalments (combined length: 23 pages!). They also have to produce their "mother-child protection card", Aadhaar card, husband's Aadhaar card, and bank passbook, aside from linking their bank account with Aadhaar (see Briefing Note 5). Further, they depend on the goodwill of the Anganwadi worker and CDPO to ensure that the application is filed on-line. This entire process is challenging, especially for women with little education. Many are not even aware of PMMVY benefits.

Step 3: Unreliable payments

On-line applications are often rejected, delayed, or returned with error messages for a series of reasons that are familiar from studies of Aadhaar-enabled payments of welfare benefits in other contexts (e.g. pensions and NREGA). Examples include: (1) incomplete information, (2) inconsistencies between Aadhaar card and bank passbook; (3) diversion of payment to a wrong person's account. In cases of unsuccessful application, there is no provision for informing the concerned women and explaining to them what needs to be done.

Bottom line: a promising scheme has been ruined by stinginess and technocracy. Aside from undermining women's rights, this is a major loss for Indian children.

* Based on a response to RTI query, indicating 80 lakh beneficiaries for the period 1 April 2018 to 31 July 2019. See Briefing Note 2.

Coverage of PMMVY: JABS Survey

Consistent with all-India data received under RTI (see Briefing Note 2), we find that only 23% of nursing women have received any PMMVY benefits. In Odisha, the coverage of the Mamata scheme is much better in every respect – awareness levels, application rates, and actual benefits. Note also that outside Odisha, very few women get anything before the end of their pregnancy.

	All sample states		Odisha	
	Pregnant women (3rd trimester)	Nursing women	Pregnant women (3rd trimester)	Nursing women
Eligible for PMMVY (%) [a]	50	57	95	89
Aware of PMMVY (%)	66	69	95	91
Applied for PMMVY, among those eligible (%)	60	72	89	88
Received some benefits, among those eligible:[b] (%)				
First instalment	15	39	37	75
Second instalment	1	17	0	7
Received some benefits, among all women (%)	8	23	35	67

[a] "Eligible" means first birth, except in Odisha where second births are also eligible (the "mother's age" criterion is ignored as very few pregnant or nursing women were under-age).

[b] Under PMMVY, women are supposed to receive the second instalment before the end of pregnancy (and a third instalment later on). In Odisha, there are only two instalments, and the second instalment is generally disbursed later than 6 months after delivery – beyond the survey's time frame.

JABS 2019: Leaders and Laggards

The sample size of the JABS survey is too small to make detailed inter-state comparisons, but some contrasts familiar from earlier surveys did emerge once again. For instance, Himachal Pradesh is way ahead of the other sample states, whether we look at people's living conditions, women's education, or the quality of public services. At the other end, Uttar Pradesh is the eternal straggler, with abysmal socio-economic conditions, dismal services and abominable corruption. Women in Himachal Pradesh and Uttar Pradesh live in different worlds, as the attached table illustrates.

In earlier surveys, we had also noted how Odisha, a very poor state often clubbed with the BIMARU states not so long ago, was making steady progress in matters of food security, child nutrition and public health. This time, once again, we saw important signs of hope in Odisha. For instance:

(1) Odisha has its own maternity benefit scheme, the Mamata scheme. This scheme covers two births, not one, and seems to work relatively well: among the nursing women we interviewed, 88% of those who were eligible for Mamata had applied, and 75% of those who had applied had received at least one instalment.

(2) It is raining eggs in Odisha's anganwadis. Not only do children aged 3-6 years get an egg 5 times a week with their midday meal, eggs are also distributed as "take-home ration" (THR) for younger children as well as pregnant and nursing women. And of course, eggs are also on the menu in primary and upper-primary schools.

(3) Judging from the survey, the reach of ICDS services is relatively good in Odisha, with near-universal coverage of basic services (health checkup, tetanus injections, iron & folic acid tablets, food supplements, etc.) among pregnant and nursing women registered at the anganwadi. There are also signs of active team work between AWW, ANM and ASHA.

(4) Odisha was the only survey state where a majority of the respondent households were covered under some form of health insurance – RSBY, Ayushman Bharat or the state's own health insurance scheme (Biju Swasthya Kalyan Yojana, launched in 2018).

Odisha has every reason to aim at the same high standards of health and nutrition services as Himachal Pradesh – indeed, in some respects (e.g. coverage of maternity entitlements and health insurance), it is already ahead. Odisha being a very poor state, the predicament of pregnant and nursing women there was not as good as in Himachal Pradesh, but it was better than in the other sample states.

As in earlier surveys, we also found many signs of hope in Chhattisgarh. The state has made sustained efforts to improve anganwadis and primary health care. This shows, for instance, in joint health checkup and immunization sessions involving the local Mitanin (ASHA), AWW and ANM.

The laggard states, so to speak, were Jharkhand, Madhya Pradesh and especially Uttar Pradesh. In Madhya Pradesh, the picture was not all bleak – the "model" (aadarsh) anganwadis were relatively good, and hopefully similar standards can be achieved everywhere. Almost every nursing woman there had delivered in a public institution and used a public ambulance. The general predicament of pregnant and nursing women, however, was not much better in Madhya Pradesh than in Jharkhand or Uttar Pradesh.

In all the sample states, child attendance at anganwadis was relatively low. Sending young children to the anganwadi needs to become the norm, just like sending older children to school has become the norm. Fostering this norm requires special measures such as attractive food menus and awareness drives through community institutions like gram panchayats, gram sabhas and self-help groups. In some areas, anganwadis also need to be more accessible, especially to marginalised communities.

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Leaders and Laggards

	Uttar Pradesh	Laggards [a]	Leaders [b]	Himachal Pradesh
Socio-economic status				
Proportion of respondents who were unable to read (%)	39	32	16	4
Average years of schooling	6	7	9	12
Average age at marriage (years)	18	18	21	22
Average number of living children	2.4	2.1	1.8	1.6
Proportion of households with a toilet (%)	36	42	79	93
Pregnancy				
Average weight gain during pregnancy (kg)	4	5	9	11
Proportion of respondents who were eating less during pregnancy (%)	74	59	35	21
Proportion of respondents who were eating nutritious food every day during pregnancy (%)	6	10	29	62
Proportion of respondents who were eating nutritious food more often than usual during pregnancy (%)	15	25	37	53
Proportion of respondents who had symptoms of weakness during pregnancy (%):				
Swollen feet	49	46	35	37
Impairment of daylight vision	26	20	15	7
Convulsions	10	9	8	4
Proportion of respondents who worked on family farms during pregnancy (%)	39	28	13	18
Proportion of respondents who had no-one around to help with household work during pregnancy (%)	28	25	17	4
Proportion of respondents who felt they did not get enough rest during pregnancy (%)	54	57	21	9
Proportion of respondents who faced problems during pregnancy due to lack of money (%)	64	44	18	12
Delivery				
Proportion of respondents who delivered their last child at home (%)	35	19	6	6
Proportion of households who had to borrow or sell assets to meet delivery expenses (%)	51	43	19	13
ICDS, health services and PMMVY				
Proportion of respondents who received the following services from the local AWC or PHC				
At least one health check-up	64	80	91	88
Tetanus shots	87	93	98	97
Iron & folic acid tablets	84	91	94	88
Food supplements	84	89	94	94
Advice related to pregnancy/diet/delivery	46	61	87	79
Proportion (%) of eligible respondents who applied for PMMVY	46	53	82	90

[a] Jharkhand, Madhya Pradesh, Uttar Pradesh. [b] Chhattisgarh, Himachal Pradesh, Odisha.

Base: Women who delivered a child during the six months preceding the survey.

Aadhaar Spanner in PMMVY Wheel

The PMMVY application process is complicated to start with. The imposition of Aadhaar has created further complications. One-fifth of the respondents who had applied for PMMVY reported experiencing Aadhaar-related problems. In addition to this, there are Aadhaar-related problems at the payment stage (e.g. when payments are made using the Aadhaar Payment Bridge System), which women were mostly unaware of. Some of them were reported by Anganwadi workers (AWWs) who take care of application formalities on behalf of the women. One third of AWWs reported general Aadhaar-related issues, and 15% reported bank-related issues.

Remember, these are young women in their *sasural*, either carrying a baby or nursing an infant, who are in need of rest. Instead, they are constrained to spend time and money on fixing errors that have crept in for no fault of their own – with no guarantee that the issues will be resolved.

Here is a brief recap of the Aadhaar-related issues we encountered during the survey.

1. Aadhaar is the only acceptable ID document for PMMVY

The requirement of an ID while applying for government benefits is understandable. For PMMVY benefits, however, the only acceptable ID is the Aadhaar card, even if women do not have one, or they have lost it, or there are errors in their Aadhaar records, etc. This makes the application process costlier and more cumbersome. Some women had to pay anything between ₹ 50-200 to enrol for Aadhaar.

When Sushman Devi (from Sonebhadhra, UP) was trying to make corrections in her Aadhaar records, local officials kept delaying the matter. Ultimately she had to borrow money to go to the Block headquarters to get the corrections made. She borrowed ₹ 2,000 from her sister to get corrections made to her and her husband's Aadhaar card.

2. Linking the benefits of PMMVY with the husband

In contrast with Odisha's Mamata scheme, PMMVY benefits require identification documents of the husband. There were cases where women had not been able to apply, or the application had been delayed, because of failure to produce the husband's Aadhaar card. Some husbands did not have Aadhaar cards, some women were living with men to whom they were not married, or were single mothers.

There were several cases where applications had been delayed or stalled because Aadhaar cards with the father's name or address were not accepted. Pooja is from Uttar Pradesh and married to someone in Surguja, but she had no way of providing a proof of address for her new address. The Aadhaar enrolment centre advised her to get a certificate from the sarpanch. It was rejected. Many women such as Krishna Baiga and Sunita in Umaria (Madhya Pradesh) tried to have the address changed but failed. When Dinesh Mehta (in HP) went to get her address updated, the machine did not work. Some women in Odisha reported being able to get their Mamata benefits in spite of this issue.

3. Inconsistencies of demographic information between Aadhaar and other databases

Demographic data glitches (e.g. typos in Aadhaar number, misspelling of names, wrong date of birth on Aadhaar, mismatch between Aadhaar card and other records, etc.) can all lead to the PMMVY application getting rejected or delayed. In Odisha, Rani Gope had to get multiple corrections made to her date of birth; Hulari Munda has three IDs each of which shows a different date of birth. Marcilin Munda's Aadhaar card overstates her age by 10 years (1980 instead of 1990).

In most cases, these errors crept in for no fault of the women who were applying for PMMVY, but they are paying the price for it. Further, the processes for making these corrections are not clearly laid out or communicated. For instance, we came across several women who were told that a "No objection certificate" was required from the sarpanch, but when they got it, it was rejected. We also met women who came back with new errors when they went to correct an earlier mistake in their Aadhaar records. In what will likely make matters worse, a recent central-government circular (dated 14 October 2019, available on request) restricts the number of changes of demographic information in the Aadhaar card to once in a lifetime for gender and date of birth, and twice in a lifetime for name.

4. Problems arising from the requirement to link bank accounts with Aadhaar

Women such as Sukiya Baiga (in MP) could not open a bank account because she did not have Aadhaar; others faced difficulties because their bank account was not linked to Aadhaar (despite repeated attempts in some cases). Sadhna has an account and an Aadhaar card, but linking is creating difficulties. Others, such as Santoshi (in HP), find that their Aadhaar is linked to an account different from the one they submitted when applying. Resolving these issues is cumbersome, time-consuming and uncertain.

5. Other Aadhaar related issues

There were other unspecified issues – cases where even the Anganwadi worker and/or bank official are unable to figure out what the problem is. Laxmi, a Dalit woman in HP, was told that there's an "Aadhaar card problem" with her application. Some women are asked for a bribe by ASHA or AWW when there were Aadhaar issues (to bypass the issues). For instance, the ASHA worker in Parvati's natal village in UP told her that she could get the PMMVY form filled without the presence of her husband for a charge of ₹ 500. The costs associated with photocopying Aadhaar for submission with their PMMVY application form was also mentioned by many respondents.

Some Women Are More Equal Than Others:

Maternity Benefits in India

India's Maternity Benefits (Amendment) Act in 2017 was widely celebrated as it raised the number of weeks of paid maternity benefits to 26 weeks. However, these provisions apply to a tiny fraction of women in the country – those working in formal employment. An infographic credited to UNICEF on Twitter (see below) suggests that India has among the most generous maternity leave provisions in the world – this is misleading.

A legal recognition of universal maternity entitlements in India only came with the enactment of the National Food Security Act 2013 which made a provision of ₹ 6,000 per child. Unfortunately, for more than three years after the NFSA was passed, nothing happened. In 2017, the government finally formulated the Pradhan Mantri Matru Vandana Yojana (PMMVY). The PMMVY, however, is in violation of the NFSA as it restricts the benefits to the first child and reduces the amount to be paid to ₹ 5000. Some states have their own maternity benefit schemes (see table below).

In other words, some women are more equal than others as far as maternity benefits are concerned: the most privileged women get maternity benefits using the wages compensation principle (as they should), but the most disadvantaged are entitled to niggardly amounts. The existence of stark discrimination is not even acknowledged.

Maternity Benefits in India: A snapshot

Law/scheme	Entitlement	Funding	Eligibility	Coverage (2017-18)
Maternity Benefit (Amendment) Act, 2017[1]	26 weeks paid leave for first two children; 12 weeks thereafter	Employer	Women working in establishments with 10 or more employees	"Government does not maintain data centrally" as per answer in parliament on 11.2.19
Employees State Insurance Act, 1948[2]	Up to 26 weeks	Government [or private employer and employee]	For women whose establishment is covered by ESI Act, whose salary is below ₹ 21,000pm	45,400
National Food Security Act, 2013	₹ 6000 lump sum	Government	All births to be covered	-
Pradhan Mantri Matru Vandana Yojana 2017	₹ 5000, in three instalments	Government, 60:40 sharing between centre and state	First child only, fulfilment of various ANC conditionalities	Approximately 60 lakhs, in 2018-19
Mamata (Odisha), 2011	₹ 5000, in two instalments	State government	Women aged 19 and above, for the first two children; no restriction for PVTG women	6.1 lakhs[3]
Dr. Muthulakshmi Reddy (Tamil Nadu) 1987[4]	₹ 18,000 (₹ 14,000 cash + ₹ 4,000 maternity nutrition kit), in five instalments	State government	BPL women	5.8 lakh, 2016-17[5]
Kasturba Yojana (Gujarat) 2017	₹ 6000 lump sum, in three instalments	State government	BPL women, all births	Not available

[1] See https://www.epw.in/engage/article/how-can-maternity-benefit-act-increase-female.

[2] Government incentive scheme provides 7 weeks leave for women not covered by ESI Act, whose salary is less than Rs. 15,000pm and registered with EPFO for a year at least.

[3] The state government spent Rs. 263cr in 2017-18. Source: https://finance.odisha.gov.in/Budgets/2019-20/Vote_on_Account/Budget_Highlight_English.pdf

[4] See https://www.rajyayojana.in/tamil-nadu-pregnancy-scheme-2019/

[5] The state government spent approximately Rs. 1,000 cr in 2017-8. Source: http://www.tnbudget.tn.gov.in/tnweb_files/Budget%20Speech_2017-2018(Eng).pdf

Case Studies

Renu Raidas (Umaria, MP)

Renu Raidas went to the Umaria district hospital three days before the delivery. The staff was ill-mannered. She was given sleeping pills when she was in pain. Even though she wanted a normal delivery, she was advised a C-section. On the third day, the nurses started pushing her stomach vigorously – one nurse on each side. She shouted at them and they moved away, but after that denied her care. Her father had to bribe them to get them to look after her. The child was born stiff and could not move its body. Here, at the hospital, they spent Rs. 5000. From there, they went to a private hospital in Katni and spent three days there. They had to spend another Rs. 35,000 at this hospital. In spite of this, her child was not fully cured. She blames the nurses for the child's deformity. The family had to borrow Rs. 40,000 from a moneylender at Pipariya at an interest rate of 5% per month. During her pregnancy, a family member advised her to eat less.

Kunta Kol (Umaria, MP)

Kunta Kol is a young Adivasi with no formal education. The village is situated close to a reservoir, and this family's land remains mostly submerged. She was pregnant with her third child when we met her. She is among the few women who did not have a "jachha-baccha card" (mother and child card). Quite likely, she did not receive much by way of ante-natal care. She had a premature delivery, in her 8th month. She managed to get an ambulance to take her to the hospital (it seems they were trying for a while, and it was delayed), but the child was born at the doorstep of the hospital, in the ambulance at about 9pm. A doctor was present at the time of her delivery, and left soon after. When the doctor returned at 8am, the child was dead. She said that she had to pay Rs. 500 to the doctor, Rs. 400-500 to the nurse, Rs. 200 for the sweeper and Rs. 500 for the ambulance.

Alia Naz (Sundergarh, Odisha)

Alia Naz delivered her child in the dead of the night at 3am. There was no doctor to attend to her. The nurses who looked after her delivered without anaesthesia or hot water. The nurses demanded Rs. 1500. Two days after being discharged from Birsa Hospital, the child stopped drinking milk and on being taken to the hospital, it was found that she was suffering some infection. She was admitted to the ICU in Rourkela government hospital. The family rented a room in a lodge nearby. A week later, the child was discharged. The doctor was of the opinion that this was because of unhygienic conditions at the time of delivery.

Rani Gope (Sundergarh, Odisha)

Rani Gope delivered her child at the Birsa Hospital. She is weak and has low blood pressure – five months after her delivery, she loses consciousness from time to time. She is advised by her family to eat less. The child did not cry after being born, so they carried her to Rourkela government hospital. There they were referred to a private hospital ("Aastha"). This was very expensive – the child was kept in ICU for five days. They had to mortgage their land (for a loan of Rs. 50,000) and borrowed from relatives as well (another Rs. 50,000). After a few days, they had exhausted all their cash reserves and

moved back to Rourkela government hospital where they got affordable care. The child continues to be unwell – does not sleep comfortably, there's swelling in the head, they have been consulting a doctor (each session costs Rs. 700), but there's no clear diagnosis yet.

Kunti Nagesh (Sarguja, Chhattisgarh)

Kunti Nagesh delivered her child at the government hospital in Ambikapur. She had to have a C-section. She faced a lot of financial difficulties because the child had to be kept in ICU for 15 days. Though they were not charged for the ICU, they spent Rs. 12,000 on four units of blood. She said they did not receive proper attention from the nurses. Because of the improper dressing of the caesarean wound, a lot of pus developed in the wound. Yet, the doctors paid no attention. She was forced to leave the hospital without getting officially discharged. In her village, she took the help of a quack. The family spent Rs. 15,000 in all. The family met these expenses by taking a loan from a shop (it was repaid by selling grain) and by selling tomatoes harvested at the time of the baby's birth.

Sangeeta (Sonebhadra, UP)

Sangeeta lives with her five children in a miserable hut on the edge of their small plot of land. Her husband works in Bhabani and other places from time to time as a casual labourer. Sangeeta's situation looks very difficult (she had eight children, of whom three died) but she does not seem to think that her last pregnancy and delivery was a big deal. She said that she rested for six days after her delivery – more because in their community women who have delivered are not supposed to touch any vessels, as they are considered untouchable at the time. If she had worked, she would have been ostracized, she said. She does not report any special problem though she would have liked to eat better food. She used to work in NREGA but not recently.

Sarita (Sonebhadra, UP)

Sarita is a Dalit woman. When she reached the hospital for delivery, she found it closed. The doctors, it seems, had taken a day off. So she had to deliver her baby in the verandah with the help of her badi saas, chhoti saas and chhoti bua. When she applied for Janani Suraksha Yojana, she was denied the money as they were not sure if the baby was born in this hospital as it happened in the absence of hospital staff, on a "self-declared holiday".

Rita Devi (Kullu, HP)

Rita Devi, childless, was currently pregnant but could not get PMMNY benefits because she had to abort her previous pregnancy. According to the Anganwadi worker, the child was aborted in the fourth month, after the pregnancy had been registered. As a result, it counts as the first child and she cannot get PMMVY benefits. The AWW consulted the CDPO on this, who said nothing could be done.

Hima Devi (Kullu, HP)

Hima Devi is a shy young mother, whose first child was born premature at home. The AWW tells her that she cannot get PMMVY benefits because the child was born prematurely (possibly because it was not an institutional birth).

The JABS Survey in a Nutshell

The Jaccha-Baccha Survey (JABS) was conducted by student volunteers in six states of north India: Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Uttar Pradesh, and Odisha. It took place in June 2019, except that Jharkhand was added later, in October 2019.

Bearing in mind our shoestring budget, we proceeded as follows. The survey covered one district in each state.[1] In each district, two blocks were selected at random. In each sample Block, our aim was to survey six villages: three villages selected at random among those with a population between 800 and 1200 (the "target villages"), and a "neighbouring" village in each case.[2] In each village, we asked the anganwadi worker for her list of pregnant and nursing women (here "nursing women" refers to women who delivered a baby during the preceding 6 months) – these lists are supposed to be fairly comprehensive. Then we interviewed as many as possible of these women. Prior to this, investigators made a surprise visit to the anganwadi and interviewed the anganwadi worker.

That, at any rate, was the idea. Of course, there were hurdles. Some villages had two anganwadis – we selected one at random. Some (about one fifth) of the nursing women turned out to have delivered earlier than 6 months before the survey – we retained them in the sample. Some women, especially among those who were pregnant, had gone to their "maika" (parents' village) at the time of the survey. In some villages, the team ran out of time. In Jharkhand, the survey period (overlapping with Dusshera holidays) turned out to be too short and anganwadi workers were on strike, so the survey work fell short of target.

Still, the teams managed to complete most of the survey plan in about 12 villages in each state: fewer (8) in Jharkhand, and more (19) in Himachal Pradesh because anganwadis there tend to have a small catchment area. In all, 706 women were interviewed in the six states: 342 pregnant women and 364 nursing women. Further details are given below. Given the small sample size at the level of individual states, these Briefing Notes focus mainly on the sample as a whole.

Women in sample	**Chhattisgarh**	**Himachal Pradesh**	**Jharkhand**	**Madhya Pradesh**	**Odisha**	**Uttar Pradesh**	**All States**
Pregnant	67	70	26	58	57	64	**342**
Nursing	59	68	49	53	66	69	**364**
All	126	138	75	111	123	133	**706**

The JABS survey was coordinated by Jean Drèze, Reetika Khera and Anmol Somanchi. The survey teams included both student volunteers and local volunteers - too many for a roll-call. We are grateful to Chaupal in Ambikapur (Chhattisgarh) for hosting the training and debriefing workshops, and to Shyamasree Dasgupta, Sachin Jain, Rajkishor Mishra, Sangeeta Sahu, Sulakshana Nandi and Gangaram Paikra for their guidance in specific states. For further information, please write to hardworknopay00@gmail.com

[1] The survey districts were: Sarguja (Chhattisgarh), Kullu (Himachal), Gumla (Jharkhand), Umaria (Madhya Pradesh), Sundargarh (Odisha) and Sonebhadra (Uttar Pradesh). Since a random sample of size one makes little sense, we selected the districts purposely – mainly relatively deprived districts at a reasonable distance from Ambikapur (Chhattisgarh), our headquarters. In HP, we selected a district in the mid-altitude region, which is more closely associated with Himachali culture and society than Lahaul and Spiti on the one hand, and the plains adjoining Punjab on the other.

[2] The basic criteria for on-the-spot selection of a neighbouring village were: (1) it should be within or near the same gram panchayat, but preferably not close to the target village; (2) it should preferably be a Dalit or Adivasi hamlet; (3) it should have at least one anganwadi; (4) it should be roughly within the 800-1200 population range, like target villages.