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Discussion and Conclusion

This study attempts to establish the concept of maternity entitlements through following its historical progress internationally and in India, as a universal entitlement to compensate economic loss faced by women during child bearing and rearing. It establishes the aims to support women through pregnancy, delivery and the period of exclusive breast feeding and early child care. Further such a scheme is conceptually expected to achieve impact in terms of reductions in maternal morbidity (specially maternal anaemia) and mortality, low birth weight, exclusive breast feeding and neonatal care leading to ultimate gains for neonatal and child survival, health and nutrition (WGCU6, 2007).

Adherence to Concept: The DMMAS is a pioneering and sole effort to provide maternity entitlements for poor women in the informal sector through a scaled-up state-wide scheme. This scheme has many laudable features as discussed below. However, in terms of a conceptual framework, it does not fulfil all the criteria above. Its objectives are stated as providing wage compensation for 'delivery' and nutritional support to the pregnant woman. However, the important issue of child care and exclusive breast feeding is not specifically related to the scheme.

Universality: The study shows that the scheme offers greater universality than schemes limited by the BPL framework by including women on the basis of wide criteria. Even in practice, the study finds that poor women are hardly excluded as a result of not being able to fulfil the criteria. In fact, the number of women covered by the scheme compares well with an estimation of how many children would be born to women under the poverty line each year. Suggestions from the women who receive assistance and providers are mostly related to making it even more inclusive and cutting back conditionalities; for example, by including women who deliver in private facilities.

Nonetheless, BPL is found as term used for identification of women/mothers in many of the responses as well as in the complaint form for irregularities in the identification of women/ mothers. Thus there is a contradiction between the intention of the scheme, its rules and the perceptions of the VHNs / ANMs and AWWs. However, this study did not include any eligible women who are excluded from the benefits of the scheme in its sampling. That is the issue of exclusion has been really beyond the scope of the study.

It is worth noting that a few women (3) had suffered the imposition of family planning conditionalities even though they did not exist in the scheme. There is concern that unwritten targets for family planning still persist despite the change in policy to an 'untargeted approach' and this needs to be guarded against.

Studies on vulnerable groups in Tamil Nadu (construction workers, marginalised nomadic tribes and pavement dwellers) show that awareness regarding available maternity assistance is low and that the government also fails to reach them. Therefore, the percentage of women/ mothers in these groups was very low (Belinda, R. and K.Shanmugavelayutham, 2005; John Jeya Kumar, A and K.Shanmugavelayutham, 2006; Annapuraman, K & K.Shanmugavelayutham, 2007). It needs to be noted here that these studies were carried out before or around the same time that the revised DMMAS was implemented and therefore may or may not be reflective of the revised scheme.

Wage Compensation : Most of the women were young and 57 percent had one child only. 72 percent were in the age-group of 18-25 years. This may explain the low numbers who reported for wage work. However, it is understood from the first part of the study that all poor women contribute economically to the survival of the family through paid or unpaid work (Narayanan, R. 1997; Palriwala, R. and N. Neetha 2009).

Leakages: It is laudable that the study hardly found any evidence of corruption or leakages, with some women getting full amounts of JSY and DMMAS both. Significantly 94 percent did not face difficulty in applying for the scheme and 93 percent did not face any difficulty in getting the money. In this connection, it is also significant that no major problems were perceived with getting bank accounts opened, and this has implications for other schemes that have suggested the use of bank accounts to minimise corruption. This argument can be supported by evidence from Andhra Pradesh in relation to the NREGA experience. NREGA wages were paid through post offices and this separation of payment agencies from implementing agencies helped in reducing corruption related issues (Dreze, J., R. Khera and Siddhartha, 2008). The lack of leakages is likely to be related more to the overall governance and environment in the state than to a notion that cash transfers are more corruption proof. There are several studies that take Tamil Nadu as a case study for good governance. The analyses suggest that good governance in terms of the allocation of public finances, bureaucratic efficiency, and the implementation of innovative development policies in compulsory education and health make Tamil Nadu a better performing State (Visaria, L. 2000; Prabhu, K. Seeta, 2001; Joshi, D. 2007; Das Gupta, M., B.R. Desikachari et al. 2010).

Convergence with the ICDS: It is worth noting that incidental findings of the study show that Supplementary Nutrition Programme (SNP) through ICDS is working well and this has been found in previous surveys (FOCUS, 2006). The study also shows that the DMMAS does not supplant the use of SNP through the ICDS programme and that women tend to use both.

Delays: Delays of payment were ubiquitous. These are likely to be the result of inclusion of most women/mothers vis a vis an inadequate budget. During the study, it was noted that there was a continuous backlog of women waiting to receive the money. No women had

received the money during pregnancy and only 22% had received it by the first month following delivery. While most women received the money, it was too late to make any difference to nutrition during pregnancy or wage compensation for the first six months of exclusive breast feeding. Another study that looks at the implementation of the scheme in Chennai shows that there were delays in payments and most women received it after the first month of delivery (Irudaya Veni Mary, A. and Dr.K.Shanmugavelayutham, 2009).

Training and Capacity Building: there is a distinct lack of focus to link the cash compensation with its objectives. The scheme providers did not get specific training on the technical issues related to the scheme specially exclusive breast feeding, improving the quality of nutrition and delaying going back to work. Training was given for procedural elements only. Not surprisingly, there was an absence of clear focused messages accompanying the money even to the women/mothers who received the assistance. This is a huge missed opportunity. Significantly even amongst AWWs very few (3 out of 33) were able to correlate exclusive breast feeding as one of the benefits of the scheme.

Contribution of other village level functionaries: Even though the scheme was to be administered by the VHNs / ANMs, only 15 percent received information by the VHN / ANM alone whereas the AWW participated in many ways for the majority. Similarly, the AWWs helped the VHNs / ANMs identify the potential women/mothers and in many cases interact with them on utilising the entitlement money. This has implications upon fixing incentives for any one village level health/WCD worker at the exclusion of others.

Utilisation: Most women used the money for health expenditures, savings and food for themselves and their child. 58 percent mention medical expenses as one of the items that they spent money on and 44 percent mentioned food as one of the items they spent the money on. Many women take loans during delivery as they are sure of reimbursement by the scheme. Details on the nutritional value of the food are not available from the study. It is interesting to note that health expenditure comes first in the list even in a state like Tamil Nadu which is famed for its availability of free drugs and free quality health care at PHC level. This point needs to be further investigated. Hardly any women used the money for what could be termed frivolous expenditure on their part, not directly related to health and nutrition of either self or child.

Urban- Rural Differences: The study on the whole suggests that while the profile of respondents is not very different apart from higher SC women in rural areas, in terms of scheme delivery, urban areas are far poorer. All the women who had difficulty in opening bank accounts were from urban areas and 69 percent of those who were not told what the scheme was for were from urban areas.

Recommendations

1. **Recommendations for future research (based on limitations of the study)**: The entire study is based on reported events and perceptions of women/mothers who received financial assistance and providers. Sample sizes are too small to make many quantitative comparisons though they have been attempted. However, triangulation between three different sets of respondents with different vantage points suggests that most of the qualitative findings are reliable. They would require further validation by more rigorous prospective studies that can provide factual evidence. Evidence is also required to see the impact of such a scheme on indicators such as maternal weight gain, maternal anaemia, maternal mortality, low birth weight (LBW), neonatal and infant mortality, breast feeding indicators, delayed return to economic activity. This was far beyond the scope of our exploratory study and would require formal comparative studies. Our study looked only at women/mothers who benefited and did not make an attempt to identify eligible women who were left out of the scheme and the reasons for the same. As discussed above, women who are socially excluded or women in special situations of vulnerability, such as belonging to nomadic, migrant or homeless populations may be getting excluded and this point needs further study to be able to make schematic recommendations for their inclusion.

2. Programmatic Recommendation

i. Schemes for maternity entitlements need to understand and acknowledge the full scope of the conceptual framework of this particular right to be able to do justice to all its objectives as well as to be able to provide equity with other women working in the formal sector.

   a. Thus, they should be universal and not have a BPL, age or 'first two children' cut off, institutional delivery or any other conditionalities attached.

   b. They should provide adequate wage compensation for a period in late pregnancy as well as for six months post delivery. At a minimum they must be consistent with the law and the benefits made available to women in government service.

ii. There should be no confusion between the objectives of a maternity entitlements scheme and schemes to promote institutional delivery, supplementary nutrition during breast feeding and pregnancy, immunisation, family planning etc. Thus, it should not attempt to overlap with other strategies such as promotion of institutional deliveries (JSY) and supplementary nutrition (ICDS), but remain faithful to the main concept of maternity entitlements which is wage compensation in late pregnancy and six months after.

iii. If the conceptual framework is clear and comprehensive, it needs to be translated into well defined objectives which are supported by capacity building at all levels.

iv. Good implementation must include the timely release of money as per the objectives of the scheme. This requires adequate and realistic budgeting. Delays nullify the entire set of objectives of the scheme.

v. The use of bank accounts seems feasible and may help prevent corruption and leakages.

vi. The AWW and the ICDS are well placed to deliver such schemes in collaboration with the health workers. A collaborative arrangement needs to be worked out between the two systems for the delivery of such a scheme. This is specially important for the scheme to be made applicable for women delivering at home as is very much more the case in States other than Tamil Nadu.

vii. Special attention needs to be made for better implementation for the urban poor.

viii. Expenses on health services seem to be taking precedence over nutrition and health care services need to be made universal and free so that this scheme can fully achieve its objectives.

Of course, all the above require great commitment to the framework of rights and equity, and political will backed by adequate budgets and a well formulated and implemented scheme. Such a scheme can go a long way to achieve major goals of maternal and child health and complement other strategies.