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Efficacy and Accessibility of Maternity Benefit Schemes in Improving Neonatal and Maternal Health in Underprivileged People - Findings From the Implementation of Dr. Muthulakshmi Reddy Maternity Benefit Scheme in the Stateof Tamil Nadu

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Abstract

The Framers of our Constitution recognizes the duty of the state to improve the health of its people. Right to health is a fundamental right under Article 21 of our constitution and the right of citizens to be treated with dignity and care is both a fundamental right and human right. The Directive Principles of State Policy in Part IV of the Indian Constitution obligates the state to act for the welfare of its citizens by promoting affordable healthcare and maternity benefits for new mothers and infants. At the time of Independence, India's Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) were abysmal, and improving health indexes and nutrition was made the foremost priority by successive governments. Health policy, however, remains on the state list of our constitution to make sure that local conditions and concerns are taken into consideration when formulating welfare and healthcare policies and for effective penetration of such policies within the concerned state. Maternity benefit policies would include monetary emoluments, free and/or concessionary healthcare services, particularly, prenatal and neonatal checkups, free and/or affordable supplements and medication to ensure maternal health, regular monitoring of pregnant women and immunisation process, and greater rates of institutional deliveries. Maternity benefit packages, such as those under the Dr. Muthulakshmi Reddy Maternity Benefit Scheme in Tamil Nadu, even include nutritional supplies. The MRMBS scheme remains one of the most effective maternity benefit schemes enacted in India, and has improved the state's health and social markers to a great extent. The empirical study is carried out with 200 responses, and concludes with the knowledge that maternity benefit schemes should expand coverage to include adolescent mothers.

Keywords

Infant mortality, maternal benefit, maternal mortality, MRMBS, neonatal health.

INTRODUCTION

During Independence, India's maternal mortality rate was over 200 for every 1000 births, and reducing MMR and IMR was a major priority for successive governments at both the central and state level(Sample Registration System: Maternal Mortality in India, 1997-2003 : Trends, Causes and Risk Factors 2006). Public welfare, in this regard,

included not only social security measures, but also accessibility to affordable healthcare and nutrition to increase baseline health indexes(Sharma 2011). Such schemes included public distribution of essential foodgrains and produce, free and mandatory immunisation campaigns to combat tuberculosis, polio, and smallpox, establishment of anganwadis and ASHA workers associations to promote cooperative healthcare facilities at rural and backward regions of the country, amongst others. Increasing nutrition and immunity in impoverished populations can reduce poverty and promote economic and social development of the community(Krishna, Kulkarni, and Srinivasan 2021). However, the Indira Gandhi government's policies aimed at poverty reduction and reproductive health only widened the distrust between the populace and the state, as forced and botched sterilisations effectively violated the bodies of the citizens(Coffey, Khera, and Spears 2022). At the state level, Tamil Nadu has been one of the leading states to formulate an effective and comprehensive maternity benefit program aimed at BPL groups to reduce mortality and increase nutrition. Named after the fierce feminist and educator Dr. Muthulakshmi Reddy, the Maternity Benefit Scheme can be availed by pregnant and lactating mothers who have attained at least 19 years of age and this scheme was introduced by Health and Family welfare department of Government of TamilNadu(Ri and Bhuvaneswa Ri 2017). The scheme which aims to provide both optimal nutrition for pregnant and lactating mothers also compensates for wage loss during pregnancy and provides financial assistance of Rs. 18,000/- (Rupees eighteen thousand only) paid in five installments, along with medicinal and nutritional kits, free vaccination, and reimbursement of institutional deliveries if done in a private hospital. When the scheme was introduced financial assistance was fixed at 12,000/-(Lingam and Yelamanchili 2011). The benefit for all the five installments, however, can be claimed only for the first two children. The scheme also provides concessions and benefits for family planning and contraception, and provides medical benefits for economically disadvantaged groups(Chitra, n.d.). The eligibility criteria to avail the scheme are wide enough to ensure effective coverage of a major portion of the population, and thus, the implementation of the scheme has resulted in an increase in the rates of institutional deliveries and decreased intrauterine foetal deaths in the years post the launch of the scheme(Prabeena 2014). The various provisions of the scheme also provide for enhanced nutrition and immunisation of infants along with family planning, to reduce under five mortality and improve public health. However, the needs of adolescent mothers are unmet as virtually all maternity welfare schemes exclude them to not grant any form of legitimacy to child marriages, however, it is argued that adolescent health schemes should include maternity benefit and psychological counselling for such mothers and provide them with financial, nutritional, and medical assistance. The need for greater medical infrastructure, particularly in remote regions, cannot be understated.

Payment Mode under the Scheme
First Instalment– Antenatal registration on or before 12 weeks 2000 rs, Kind benefit– Completion of third month 2000 rs, Second instalment— After 4 months Rs 2000, Kind benefit— second nutrition kit –Rs 2000, Third instalment— after delivery 4000 rs, Fourth instalment after completion of all 13 doses of OPV/ ROTA/PENTAVALENT/and two doses of IPV-4000 rs and Fifth instalment after completion of Measles rubella vaccination between 9th and 12 th month of their infants.

Objectives
- To study the scope of the MRMBS policy
- To study the issues faced by disadvantaged pregnant women
- To appraise the MRMBS policy's efficacy in reducing mortality
- To understand how maternity benefits reduce impoverishment
- To garner public opinion on the same.

Review of Literature:

"Arguing that maternity and neonatal benefit programs are human resource investments, the authors note that apart from improving short-term markers and health indexes, such as increasing nutrition levels, reducing infant and maternal mortality, and narrowing the sex ratio, effective maternal health schemes have the long term effects of increasing literary and participation of women in the organised workforce." (Bishnoi and Bishnoi 2022). "The authors note that ignorance regarding Dr. Muthulakshmi Reddy Maternity Benefit scheme in mothers can be attributed to lack of effective communication on part of the medical practitioners, particularly in primary health centres."(Ri and Bhuvaneswa Ri 2017). "Comparing outcomes at primary health centres in both urban and rural areas, the study notes that it is imperative on part of healthcare professionals, including doctors, nurses, student attendants, and frontline workers to provide the necessary information to the women." (Simpson and Mangalagowri 2013). "Tamilnadu has been a leading state in terms of providing maternal and neonatal healthcare from the 1990s, with various schemes such as conditional cash transfer for institutional delivery, assistance, maternity benefit scheme, free nutrition and supplies, etc. under various Dr. Muthulakshmi Reddy schemes."(Neogi and Mistra 2013). "The study observes how maternity welfare schemes must include medical and nutritional supply, and the persons handling the implementation of the same, such as ASHA workers and Anganwadi workers must promote awareness of the benefits of taking these essential nutrients in order to reduce infant and under-five mortality." (Rajendran 2016) "It is argued that maternity welfare schemes should provide comprehensive coverage of monetary and non-monetary benefits to ensure that the maximum number of women are able to access the welfare schemes."(Atmavilas 2016).

"Comparing a central maternity welfare proposal with a similar maternity benefit welfare scheme being implemented within state limits, it is found that the largely exclusionary provisions of the central scheme restrict the accessibility of the scheme as compared to the Dr. Muthulakshmi Reddy Maternity Benefit Scheme implemented in Tamil Nadu, providing for wider coverage."(Lingam and Yelamanchili 2011) "Increasing awareness of the family planning program under the Dr. Muthulakshmi Reddy Maternity Benefit Scheme is required to facilitate greater rates of adoption of population control methods." (Chitra, n.d.) "By focusing upon improving birth weight rates and providing nutrition to the mother, the MRMBS aims to improve health markers in BPL category and acts as a poverty alleviation program by providing wage loss compensation." (Prabeena 2014) "Women who had been pregnant more than once showed significantly greater awareness of the MRMBS welfare scheme as compared to women who were pregnant for the first time."(Lakshmi and Rajkumar 2019) "There were disparities on the lines of caste and landlessness as Scheduled Caste and landless women were disadvantaged in receiving assistance under the MRMBS." (Balasubramanian and Ravindran 2012) "Greater utilisation of state maternity welfare schemes are associated with improvements in health markers such as increased rates of institutional birth and decrease in intrauterine foetal death due to nutritional deficiency." (Suganthi 2020) "The differences between the first and the second generation maternity benefit schemes in India show how the later schemes are more carefully designed than their predecessors." (von Haaren and Klonner 2021) "Women claiming benefits under various maternity benefit schemes face various obstacles when attempting to get treatment for obstetric complications, with inadequate and inefficient referral systems, coupled with unethical practices by apathetic staff leaves women disadvantaged at such vulnerable times." (Learnt 2014)

"The authors propose that monetary maternity benefits must be revised and increased regularly to provide for increasing inflation and wage loss faced by the women at both central and state levels." (Kalra and Priya 2019) "While appraising the efficacy of maternity welfare schemes in India, the authors observe that while monetary benefits do provide greater short term benefits, particularly for economically disadvantaged people, immunisation protocols must be promoted simultaneously." (von Haaren and Klonner 2020) "The enhanced participation of medical professionals in the empirical sample has been a major impetus behind the removal of procedural difficulties, promoting safe motherhood." (Anusuya and Udhaya 2018) "First time mothers continue to remain largely misinformed about governmental maternity welfare schemes, even in urban

areas. Increasing awareness is necessary to facilitate healthy childbirth." (Somu and Narmatha D. 2020) "Adolescent mothers often find themselves unable to avail maternity benefit services, including the MRMBS. Sociocultural demographics show significant differences in utilisation of services." (Singh et al. 2012) "Institutional deliveries are to be promoted, while appropriate training is to be provided for midwifery in remote areas in preparation for contingencies." (Lee et al. 2022)

RESEARCH METHODOLOGY AND MATERIALS

The study starts with a review of the Dr. Muthulakshmi Reddy Maternity Benefit Scheme and its implementation in Tamil Nadu. A review of secondary data collected from journals and gazettes is the next step followed by the collection of data through a survey of public opinion. The analysis of raw data through statistical methods is the penultimate step and the study concludes with a discussion of the same. The study is carried out in an empirical method with **convenient sampling** undertaken.
The sample size taken for this study is **200**. Raw data is statistically processed and represented in the form of easy-to-understand graphs in order to discuss the results. The gathered data was encapsulated and coded into spreadsheets, which were then run through SPSS software and the processes applied include Frequency Analysis.

Analysis:
Independent variables &Dependent variables - Age, Gender Identity, Education, Background, Occupation. Have you ever accessed reproductive healthcare facilities such as family planning, contraception, abortion, prenatal and obstetric care from public health centres?(MCQ), Q2 - Do you agree that the Tamil Nadu government's maternity benefit schemes have improved health indexes in the state? (Agreeability), Q3 - How satisfied are you with the services and amenities provided at the Primary Health Centres in the state? (5-point scalar), Q4 - Were you aware that as per NITI Aayog's 2021 health index rankings, Tamil Nadu is ranked second in the country for performance in health, just behind Kerala? (Awareness), Q5 - Are you satisfied with the monetary benefits provided under the Dr. Muthulakshmi Reddy Maternity Benefit Scheme? (5-point scalar)

ANALYSIS AND RESULT:

Respondent details:

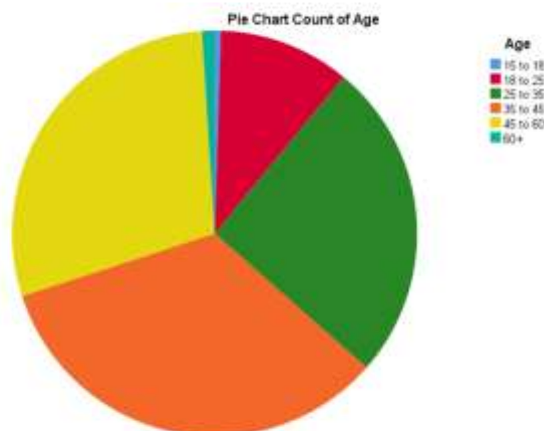

Figure 1 Legend: Pie chart depicting distribution of responses to Age
Figure 2

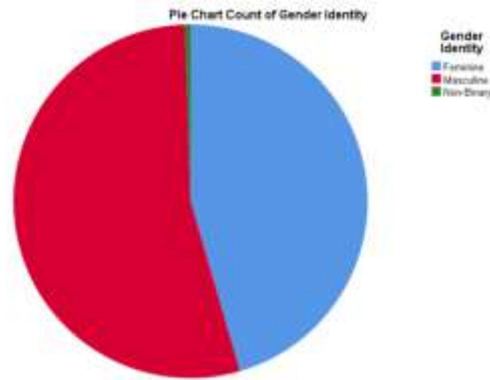

Figure 2 Legend: Pie chart depicting distribution of responses to Gender Identity

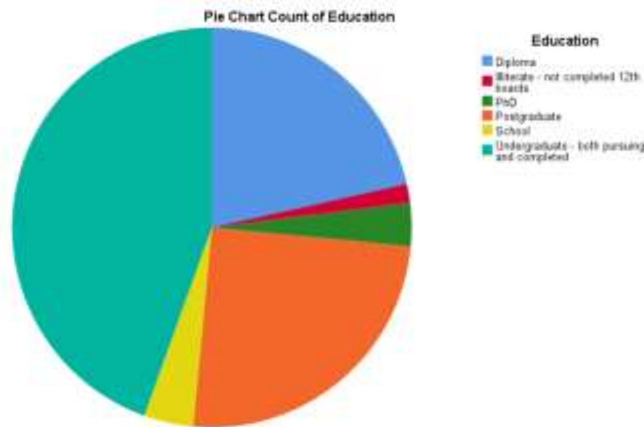

Figure 3 Legend: Pie Chart depicting distribution of responses to Education

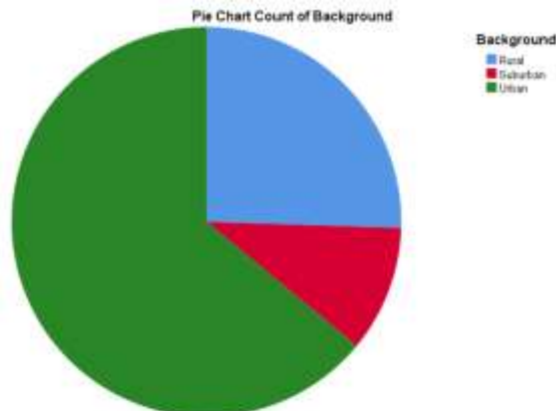

Figure 4 Legend: Pie chart depicting distribution of responses to Background

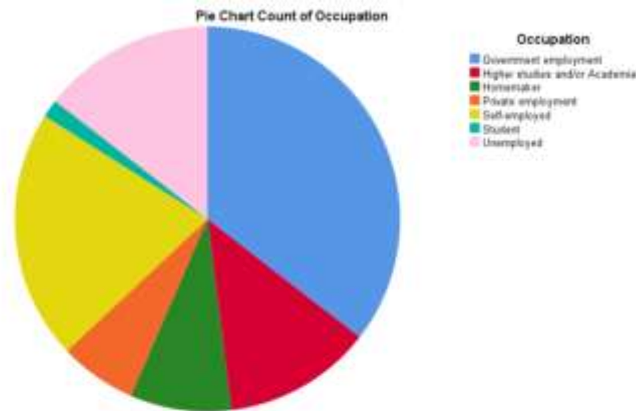

Figure 5 Legend: Pie chart depicting distribution of responses to Education

Statistical analysis:

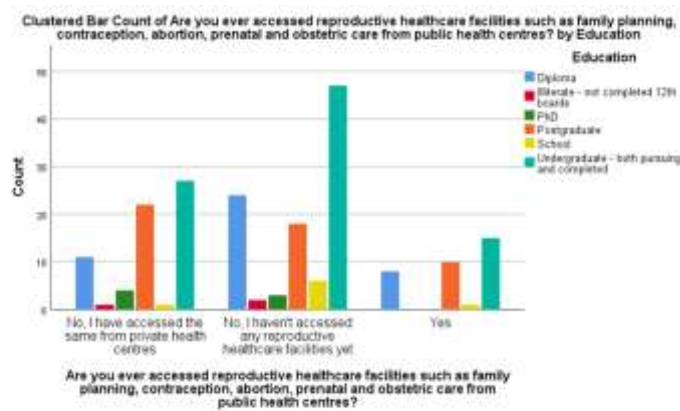

Figure 6 Legend: Clustered bar chart depicting the distribution of responses to Q1 across Education

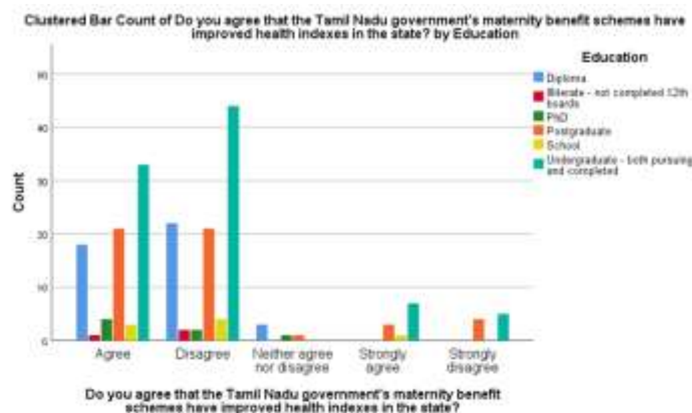

Figure 7 Legend: Clustered bar chart depicting the distribution of responses to Q2 across Education

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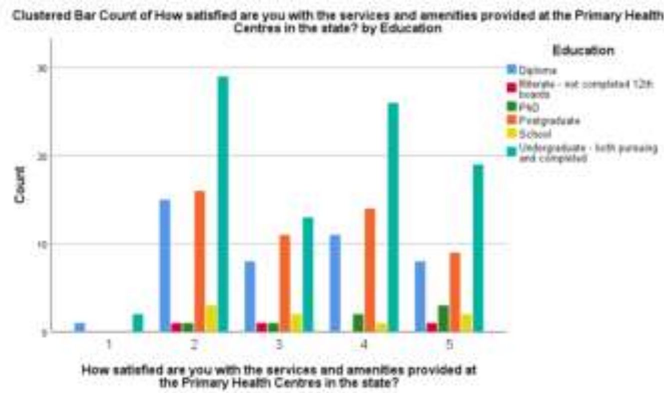

Figure 8 Legend: Clustered bar chart depicting the distribution of responses to Q3 across Education

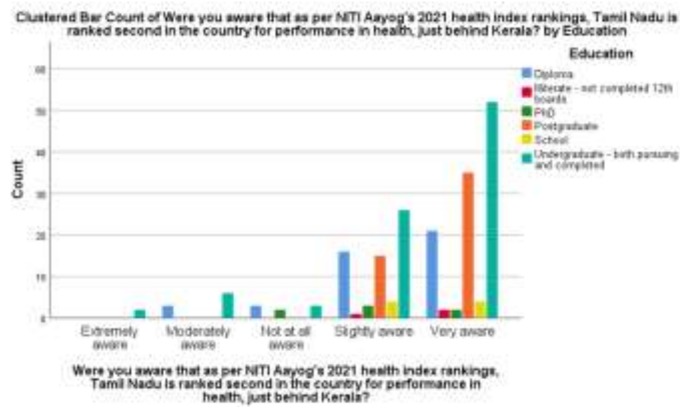

Figure 9 Legend: Clustered bar chart depicting the distribution of responses to Q4 across Education

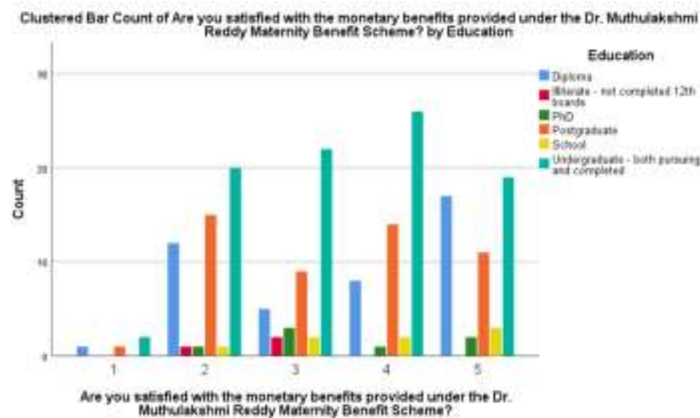

Figure 10 Legend: Clustered bar chart depicting the distribution of responses to Q5 across Education

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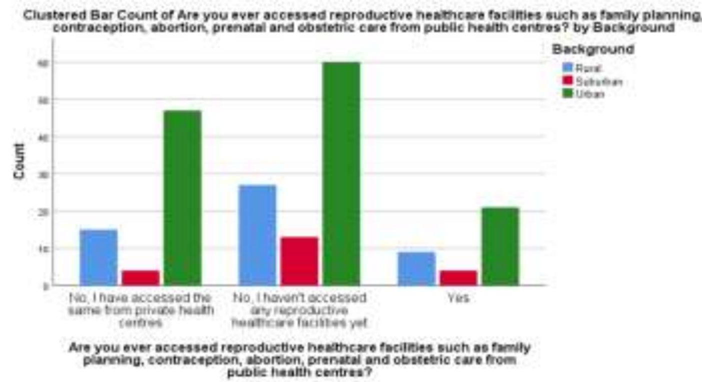

Figure 11 Legend: Clustered bar chart depicting the distribution of responses to Q1 across Background

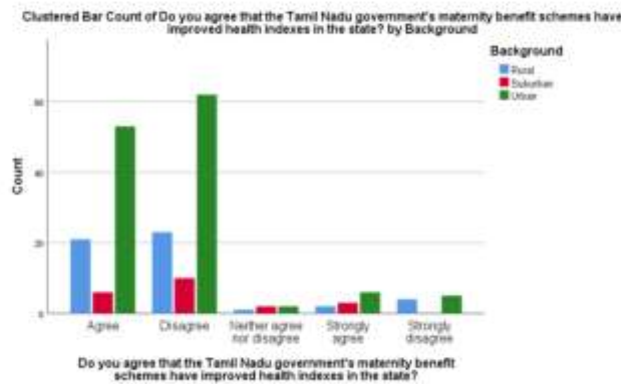

Figure 12 Legend: Clustered bar chart depicting the distribution of responses to Q2 across Background

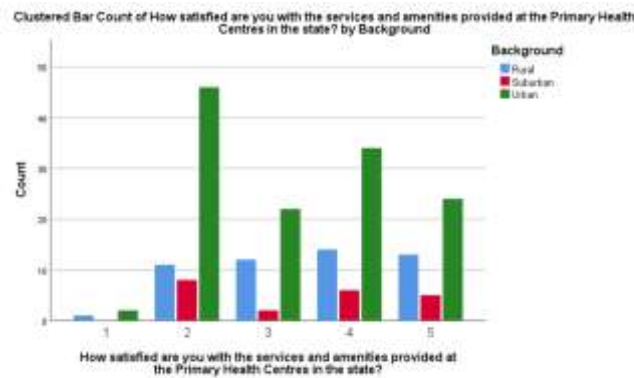

Figure 13 Legend: Clustered bar chart depicting the distribution of responses to Q3 across Background

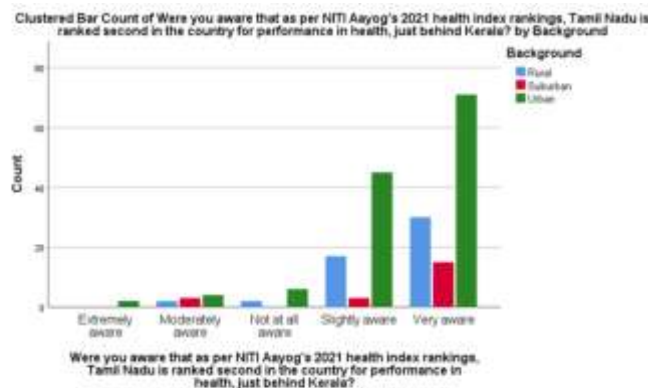

Figure 14 Legend: Clustered bar chart depicting the distribution of responses to Q4 across Background

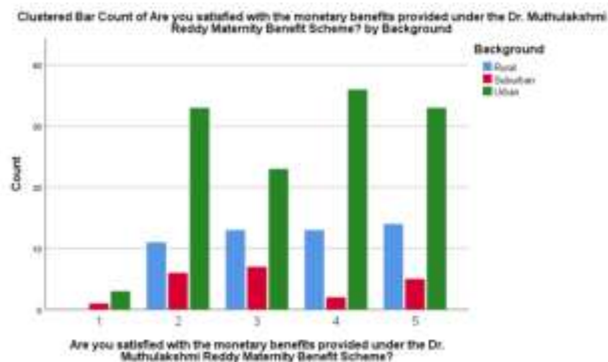

Figure 15 Legend: Clustered bar chart depicting the distribution of responses to Q5 across Background.

RESULT

In **figure 1**, we can observe that out of the 200 respondents, 22 respondents were belonging to the age group of 18 to 25, 51 respondents were belonging to the age group of 25 to 35, 67 respondents were belonging to the age group of 35 to 45, 58 respondents were belonging to the age group of 45 to 60, while the remaining 8 respondents were belonging to the age group of 60+. In **figure 2**, we can observe that out of 200 responses, 107 respondents identify as masculine, 92 respondents identify as feminine, and 1 respondent identifies as non-binary. In **figure 3**, we can observe that out of 200 responses, 88 respondents are either pursuing or have completed their undergraduate major, 50 respondents are postgraduates, 7 respondents are PhD holders, 43 respondents are Diploma holders, 9 respondents have finished school and 3 of them are illiterate. In **figure 4**, we can observe that out of 200 responses, 128 respondents are from urban areas, 51 respondents are from rural areas, and 21 respondents are from suburban areas. In **figure 5**, we can observe that out of 200 responses, 72 respondents are employed under government agencies, 42 respondents are self-employed, 17 respondents are homemakers, 28 respondents are unemployed, 3 respondents are students, 25 respondents are pursuing higher studies or are in the academia, and the remaining 13 respondents are privately employed. In **figure 6**, variations within subgroups are observed, with the undergraduate group not accessing any reproductive healthcare facilities yet. In **figure 7**, Agreement and disagreement can be observed in equivalent parts, with the undergraduate group primarily disagreeing. In **figure 8**, variation across categories is observed with a trend leaning towards low to moderate satisfaction. In **figure 9**, a strong trend towards awareness is observed across all categories. In **figure 10**, low to moderate satisfaction is observed with non-significant variations across subgroups. In **figure 11**, we can observe that a major urban group has not accessed any reproductive facilities yet. In **figure 12**, we can observe a stronger trend towards disagreeability across all subgroups. In **figure 13**, we can observe low to moderate satisfaction across all subgroups. In **figure 14,** a strong trend showing awareness across all groups is observed. In **figure 15**, we can observe that overall, subgroups show similar patterns of satisfaction, which is moderate to high.

DISCUSSION

We can observe that overall, the respondents are aware of the importance and efficacy of maternity benefit programs in Tamil Nadu. With a primarily urban male sample, a majority of the respondents have not accessed reproductive facilities yet, and the results are inconclusive. The sample size is limited by both number and location and thus, the results cannot be extrapolated for the entire population.

Limitations:
The study was carried out in a primarily urban area as evident from the demographic study. With a majority of the surveyed population being urban males who had not accessed any reproductive facilities yet, the credibility of such responses is hampered vis a vis the subject matter of the study being maternity benefit. As far as the surveyed populace is concerned, the reliance upon private institutions is of note, and the results cannot be extrapolated for the entire population.

SUGGESTIONS AND CONCLUSION:

Effective implementation of maternity benefit schemes requires both institutional infrastructure and effective community action, particularly within rural and suburban areas. Enthusiastic cooperation between administrators and medical personnel is necessary to fully realise the objectives of the Dr. Muthulakshmi Reddy Maternity Benefit Scheme. Furthermore, cooperative health organisations should be promoted to bridge the gap between private and public health services, and public welfare schemes should include adolescent mothers in their policies. Medical personnel and supporting staff at all kinds of healthcare institutions must be proactive in promoting awareness of those schemes among eligible populace.
The obligations of the state regarding improvement of public health and reducing poverty are intertwined, as only through nutrition and necessary immunisation can the people be able to live a life of dignity. The study was aimed at analysing the provisions and impact of Dr. Muthulakshmi Reddy Maternity Benefit Scheme in Tamil Nadu and the role the implementation of the scheme played in raising public health indexes and reducing impoverishment, particularly in rural and remote hilly areas of the state. The vast coverage provided under the scheme through very few eligibility conditions have made the state lead in socioeconomic development indexes as per the NITI Aayog Report, 2022. Tamil Nadu, which ranked 2nd in the country in healthcare, has been able to achieve the Millennium Development Goals of reducing IMR and MMR only through having comprehensive coverage of maternity benefit schemes. While the empirical study conducted after analysing data from a sample size of 200 was inconclusive due to demographic factors, the satisfaction of awareness of the surveyed population is of note.

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