International Labour Office

Extending maternity protection to women in the informal economy

The case of VimoSEWA, India

Working Paper

Strategies and Tools against social Exclusion and Poverty

Social Security Policy and Development Branch

Vimo SEWA

Conditions of Work Branch

Strategies and Tools against Social Exclusion and Poverty (STEP)

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Conditions of Work Branch (CONDIT)

Decent work carries with it a concern both for jobs and for the quality of those jobs. People's conditions of work can have an important impact on their performance at work, as well as more broadly on their lives. The hours they must work, the ways in which their work is organized, whether they are able to balance their work with their family and other personal obligations, and their freedom from harassment and violence at work, are some of the ways in which their working lives are defined and experienced.

The Conditions of Work Branch encourages and assists governments, employers' and workers' organizations to adopt policies and practices aimed at the progressive improvement of conditions of work and respect for workers' dignity. The Branch's programme is a blend of continuity and change: traditional working conditions areas are examined to seek innovative ways to tackle long-standing problems while, at the same time, new and emerging issues are addressed.

The main technical areas of work are: working time and work organization; work and family; maternity protection; improving working conditions of informal economy and rural workers and workers in small enterprises; wages; sexual harassment and violence at work.

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The Self-Employed Women's Association (SEWA)

The Self-Employed Women's Association(SEWA) is a trade union of women workers engaged in the informal economy. Founded in 1972, SEWA has 500,000 members in Gujarat. The SEWA movement has also spread to other states: Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Delhi and Kerala. The combined strength of the movement is now close to 600,000 workers.

SEWA organizes workers towards the goals of full employment at the household level, and self reliance. Full employment means work and income security, food security and social security in terms of health care, child care, insurance and shelter. Self-reliance is the financial viability of a woman's economic activity and that of her organization (producers' group or cooperative), as well as autonomy in decision-making.

Organizing is undertaken through the joint strategy of 'struggle' and development', of uniting to build up women's collective bargaining power, voice and representation and at the same time creating constructive development activities. This strategy is implemented through worker-run unions cooperatives and producers' groups in both urban and rural areas. Supportive services including banking, healthcare, childcare, insurance and housing are also organized by SEWA. In addition, capacity-building through training and action research focussing on workers' lives are key activities.

SEWA builds its grass root-level strength through mobilizing members and also influencing policy action at district, state, national and international levels. It promotes campaigns led by women for policy changes in favour of self-employed workers. One such campaign is for safe motherhood, including maternity benefits.

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Preface

Social protection for all workers is a human rights issue for the International Labour Organization (ILO). The ILO actively promotes all countries to extend social protection to all groups in society across the full range of contingencies and to improve working conditions and safety at work.

Maternity protection has been a priority for the ILO since the year of its founding, 1919, when it adopted the first Maternity Protection Convention. Recently, the ILO adopted the Maternity Protection Convention, 2000 (No. 183), greatly broadening the scope of protection and specifically encompassing for the first time, women employed in the informal economy, including those in atypical forms of work and the self-employed. Since these are amongst the most vulnerable workers, extending protection to them is of immense significance.

During the general discussion on social security of the 89th Session in June 2001, the International Labour Conference reached a new consensus. It places the extension of social protection, including health care, to those who are not covered by existing statutory systems as one of ILO's highest priorities. The recommended action also ensures that gender equality is promoted in all of the ILO's activities on social protection.

One of the contingencies to be addressed by social protection is maternity protection. The Social Security (Minimum Standards) Convention, 1952 (No. 102) and Maternity Protection Convention, 2000 (No. 183) spell out specific provisions for extending maternity protection to all women workers. These two Conventions are a step forward for advancing the well being of all working women during their maternity period.

As part of the ILO's mandate and major campaign to extend social security coverage to all workers, the Social Security Policy and Development Branch, through its Global Programme STEP (Strategies and Tools against social Exclusion and Poverty), is involved in identifying concrete ways to extend effectively social protection, especially for health care, to workers excluded from access to statutory social security schemes. This pursuit has led to examine various micro-insurance schemes and other community-based social protection initiatives around the world.

Promotion of maternity protection is one of the priority goals of the Conditions of Work Branch. The overall goal is to ensure and extend maternity protection to as many women as possible. The strategy is three-pronged:

1. Secure ratification of the Maternity Protection Convention 2000 (No. 183);
2. Where ratification is not yet feasible, secure improvements in maternity protection by implementing elements of the Convention, including measures to reach out to women in the informal economy;
3. Secure general improvements in the overall employment situation of women.

The ILO is therefore exploring possibilities to extend maternity protection to women in the informal economy through micro-insurance and other community-based health-financing schemes. Initial exploratory research has been carried out, which looks into how these community-based initiatives have integrated maternity protection within their offered services to their members and their families.

Information on how maternity benefits are included in different community-based health-financing systems has been gathered in nine countries from Africa, Asia and Latin America. The countries are Argentina, Chile, Colombia, India, Nepal, Philippines, Senegal, Tanzania and Uganda. The collected information and the subsequent analysis have provided the evidence-base for the development of practical guidelines to be used as a tool to promote community-based health financing schemes that embody relevant maternity protection services.

This paper, prepared by SEWA's Social Security team and supervised by Mirai Chatterjee, forms part of the initial research. The responsibility for opinions expressed in this document rests solely with the author.

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Abbreviations

FD – fixed deposit
ILO – International Labour Organization
MB – maternity benefits
SEWA – Self-Employed Women's Association
STEP – The ILO's Strategies and Tools against Social Exclusion and Poverty (STEP) programme.

Glossary

Aagewan: a local, grass-root level women leader of SEWA

Dai: a traditional midwife

Home based workers: include women working as beedi (indigenous cigarettes) and agarbatti (incense stick) rollers, garment workers, and rag collectors working at home under piece-rate contracts.

Jianoo ritual: ceremony in which the maternal grandparents of the recently delivered child present gifts to the new mother, baby, and the paternal grandparents. This occurs just prior to the return of the new mother (and her baby) to her marital home.

Manual labourers and service providers: include construction and factory workers, paper, coal and plastic pickers, agricultural labourers, tobacco workers, head loaders, childcare providers, miners, porters, cart pushers, street sweepers, domestic servants and other daily or casual wage, labour-intensive jobs.

Producers: include women working in dairy cooperatives, as gum collectors, embroidery workers, bindi makers, tailors, cobblers, and other artisans.

Vendors: include vegetable, fruit and flower sellers, cutlery workers, pan peddlers and other hawkers and sellers.

VimoSEWA: SEWA's Integrated Insurance Scheme.

INTRODUCTION

Women working in the informal economy are physically and financially vulnerable, particularly at the time of pregnancy, delivery and the months that follow. During this time, the woman is at an increased risk of succumbing to various illnesses and the burdensome expenses they entail. Even if she remains healthy throughout this period, she will face the extra expenses associated with pregnancy, delivery and caring for the newborn child, and at least for a time she will be unable to work.

The burden of maternal illness is high in Gujarat (2001 population, 50.6 million) and India as a whole. In terms of official maternity care indicators, Gujarat tends to be an average performer; it is reported that the total fertility rate (1997 data) was 3.0 pregnancies per woman compared with 3.3 nation-wide. The maternal mortality rate (1992-93) was 3.89 per 1,000 deliveries compared with 4.53 nation-wide.[1] Such statistics reveal little, however, about the problems (in terms of illness, disability and expenditure) faced by women during pregnancy and the period that follows, and whether and how these problems can be overcome.

This study aimed to increase knowledge regarding the maternity care needs of women working in the informal economy and how these needs can be addressed by a community-based health insurance scheme. More specifically, the study aimed to identify ways of strengthening the current maternity benefits/services provided by SEWA's Integrated Insurance Scheme (or VimoSEWA). The study consists of two sub-studies, herein referred to as Study A and Study B. The objective of Study A was to assess the maternity care needs of women working in the informal economy and the maternity care currently being used by these women. This objective was addressed by administering a short survey among members and non-members of VimoSEWA. The objective of Study B was to assess the maternity benefits and related services provided by VimoSEWA. This objective was achieved by administering a survey among VimoSEWA members who had received the maternity benefit, and by conducting in-depth interviews with other key informants (including other members of the family/household, and the local VimoSEWA leader or organizer).

This paper is divided into four parts. The first provides background information on India's informal economy and the maternity benefits provided by VimoSEWA. The objectives, methodology and results of Study A are presented in the second part of the paper, and Study B is presented in the third. The fourth and final section of the paper summarizes and discusses the results and makes conclusions and policy recommendations.

The informal economy in India

In India, 93 percent of the workforce is engaged in the informal economy. An estimated 400 million workers in India are in the unorganised sector or informal economy, and at least half, are women. The informal workers are the country's poorest of workers. They toil from dawn to dusk, working long hours often in the most difficult and even hazardous of conditions. There are very few provisions for social protection for these informal workers. They get no weekly day off, no sick leave and no maternity leave nor benefits.

In India, maternity benefits are available to women workers under the Employees' State Insurance Act, 1948, which covers factories, shops, hotels, restaurants, newspaper offices, road and motor transport establishments. In addition, the Maternity Benefit Act, 1961, covers workers in the mines, plantation and the circus industry. Under these Acts, workers must receive full pay during twelve weeks of maternity leave which can be extended to an additional four weeks for medical reasons. Despite these provisions, very few women workers receive maternity benefits in India. However, these laws exclude all temporary, seasonal,

[1] Source: Census of India 1991; Government of India: Year Book, 1996-97; Government of Gujarat: Socio-Economic Review 2000: Directorate of Economics and Statistics.

contract and daily workers. Thus, the large numbers of women who work in the informal economy do not have access to any maternity benefits, as mentioned earlier.

The Self-Employed Women's Association, SEWA, is a trade union which began to organize poor self-employed or informal workers thirty years ago because of their need for their own organization. Today, it has a membership of over 420,000. Since its inception in 1972, SEWA has organized for economic and social security of its members who can be broadly divided into four categories: home-based workers, producers, vendors and manual laborers and service providers. Two-thirds of SEWA's members are rural and one-third are urban women.

Maternity benefits at VimoSEWA

Most of SEWA's activities and programmes developed from the experiences of the workers. In 1975, a survey of SEWA Bank's loan defaulters revealed that of the 500 women who were not repaying the loans regularly, 20 had died. Of these twenty women, fifteen had died from causes related to childbirth. Many others reported their own illness or that of a family member as reasons for their irregular loan repayments. This steered SEWA to develop maternity benefits, health and insurance activities for its members.[2]

The initial maternity benefits programme was put into effect in 1975. It entitled any SEWA member in her fifth or sixth month of pregnancy to register for maternity benefits by paying Rs.15. Along with a cash benefit of Rs.51, the benefits included assistance to obtain antenatal care from government health providers, iron tablets and tetanus toxoid immunization. When it was realized that many of the members were using the money to buy ghee (traditionally eaten during pregnancy and childbirth), a tin of this was also provided.

In 1978, this programme was extended to the rural areas and the government began to support it. Here also the women were given cash benefits and antenatal care at the government primary health centres, along with a tin of ghee and basic health information. Between 1975 and 1980, 2600 SEWA members received maternity benefits with support from the government. Slowly the government support decreased due to lack of funds. This affected SEWA's credibility with its members and hence we discontinued the programme.

In 1986, at SEWA's request, Gujarat became the first state in India to have a maternity benefits programme for the informal workers. Under the special scheme developed, women agricultural labourers are given cash benefits equivalent to minimum wages for six weeks during first pregnancy and four weeks' worth for the second pregnancy. The programme was implemented by the labour department. In 1989, the maternity benefit scheme was shifted from the labour to the health department. The health department then linked maternity benefits to family planning. Only women with small families (up to two children) could obtain the cash benefit. And all the women applying for the benefit had to attach a birth certificate to prove that they were above eighteen years of age. As a result of this many women were excluded from the scheme. Currently, the government says its has insufficient budget to pay out such benefits. Furthermore, while the scheme is still in existence, women workers have little knowledge about it, if at all.

As members were not obtaining maternity benefits, SEWA decided to explore other avenues of action. By the early nineties, SEWA approached the nationalized insurance companies for coverage arguing that maternity, even today, is a risk for the poorest of women, especially in rural areas. The insurance companies rejected the proposal that childbirth is a planned event, and therefore, such risk coverage was not possible.

Thereafter, in 1992, SEWA developed its own maternity benefits scheme, as part of an integrated social insurance programme (VimoSEWA). Under this scheme, women can pay

[2] A more indepth case study of SEWA and its Integrated Insurance Scheme is presented in "Women organizing for social protection: The Self-employed Women's Association's Integrated Insurance Scheme, India", published by ILO-STEP Programme.

either an annual premium or a fixed deposit, the interest on which pays the premium for the insurance package (Table 1). Regardless of the mode of payment, the member is provided with life, medical and assets insurance. As an incentive for members to pay by fixed deposit, members who have paid in this way are provided with "free" maternity benefits – "free" insofar as they are paid for out of a fund established by the German Technical Cooperation (GTZ) and not out of members' premiums. The maternity benefit consists of: (1) Rs. 300 cash; (2) antenatal care including weighing, iron and folic acid tablets and referral to hospitals for further care; and (3) traditional and modern nutrition information and education to prospective mothers, based on local diet and the household budget.

Today, SEWA members who choose the fixed deposit-linked insurance and are pregnant can avail of this benefit within a stipulated period of six months, that is from the onset of the seventh month of pregnancy till after three months of childbirth. It is paid out to the workers in the VimoSEWA office in Ahmedabad and the respective district SEWA offices for rural workers. A member puts in her claim for maternity benefits during the seventh or eighth month of pregnancy or after the childbirth. Those who claim maternity benefits after childbirth register the birth and provide a birth certificate for VimoSEWA's records.

Table 1: Description of packages offered under VimoSEWA (With effect from 01/01/2003)

Risk Covered	Package I	Package II	Package III
Member's Insurance Premium (Rs.)			
Annual Premium	85	200	400
Fixed deposit	1,000	2,400	4,800
Member's Insurance Benefits (Rs.)			
Hospitalization	2,000	5,500	10,000
House & Assets Insurance	5,000	10,000	20,000
Natural Death	3,000	20,000	20,000
Accidental Death of Member	40,000	65,000	65,000
Accidental Death of Husband	15,000	15,000	15,000
Husband's Insurance Premium (Rs.)			
Annual Premium	55	150	325
Fixed deposit	650	1,800	4,000
Husband's Insurance Benefits (Rs.)			
Hospitalization	2,000	5,500	10,000
Natural Death	3,000	20,000	20,000
Accidental Death	25,000	50,000	50,000
Joint Insurance (Rs.) Premium			
Annual Premium	140	350	725
Fixed deposit	650	4,200	8,800
ADDITIONAL BENEFITS FOR FIXED DEPOSIT MEMBERS:			
(1) Maternity benefit: 300/-	(2) Denture: 600/-		(3) Hearing aid: 1000/-

VimoSEWA's maternity coverage is available to its members regardless of the number of children they have (parity). The popularity of the scheme can be gauged from the number of members claiming maternity benefits (Table 2). VimoSEWA is interested to further improve and strengthen its maternity benefits, and tailor it to women's needs. It is in this context that this study was undertaken with the support of ILO-STEP.

Table 2: Number of maternity benefits claims and amount (in Rs.) disbursed

Year	Number of claims			Total amount disbursed (Rs.)		
	Urban	Rural	Total	Urban	Rural	Total
1998	393	26	419	117,900	7,800	125,700
1999	428	87	515	128,400	26,100	154,500
2000	432	85	517	129,600	25,500	155,100
2001	271	77	348	81,300	23,1000	104,400
August 2002	139	30	169	41,700	9,000	50,700

VimoSEWA's latest introduction to promote the concept of family package amongst women members, is the **Child Mediclaim Insurance** (with effect from 01/01/2003) which is available when women and men are insured. It covers all children in the family between 2 months and 18 years, irrespective of number of children per family. The premium is Rs. 100 and the insurance covers Rs. 1000 for hospitalisation (for total number of insured children per family).

STUDY A: MATERNITY CARE NEEDS AND SERVICES AMONG WOMEN WORKING IN THE INFORMAL ECONOMY

Objectives

The objective of study A was to assess the need for maternity benefits among VimoSEWA members and non-members, especially with a view to the costs incurred by women.

Methodology

Six-hundred eighty district-level samples of members and non-members were selected. District-level sample sizes are shown in Table 3. The sample sizes were determined according to the level of SEWA's involvement in these areas, and also the ability of the local insurance promoters or 'aagewans' to collect the information required by the study. Thus, for example in the Banaskantha and Kutch districts, SEWA is very active but the aagewans have not yet been able to administer questionnaires, due to the fact that their literacy levels are very low. Thus, we have smaller sample sizes in these districts.

Table 3: Number of respondents selected per district

District	Number
Ahmedabad city	150
Ahmedabad district	100
Anand district	100
Banaskantha district	50
Bodeli (Vadodara district)	50
Gandhinagar district	50
Kutch district	50
Mehsana district	50
Surendranagar district	80
Total	680

The questionnaire (see Appendix 1) was jointly developed by VimoSEWA organizers (staff) and a representative of the Asian Development Bank who happened to be visiting SEWA at the time of the Study. It included information on:

- The family;
- Socioeconomic status, including income;
- Information on type of care sought;
- Cost of childbirth, including transport;
- Source of resources to cover childbirth;
- Maternity benefits needed – their type and amount.

Results

Description of respondents

Six-hundred and eighty households were interviewed for the purpose of this study. SEWA members made up 66.8 percent of the women interviewed, while 32.4 percent of the respondents consisted of non-members and 0.9 percent that failed to respond to the question regarding membership status.

The majority of respondents, 65 percent, worked as *manual labourers and service providers*

(this includes construction workers, agricultural labourers and domestic workers).[3] Other respondents were employed as *producers* (12 percent; includes artisans, embroidery workers and gum collectors), *home-based workers* (10 percent, includes beedi makers and rag collectors), and *vendors* (2.5 percent, includes vegetable, fruit and flower sellers).

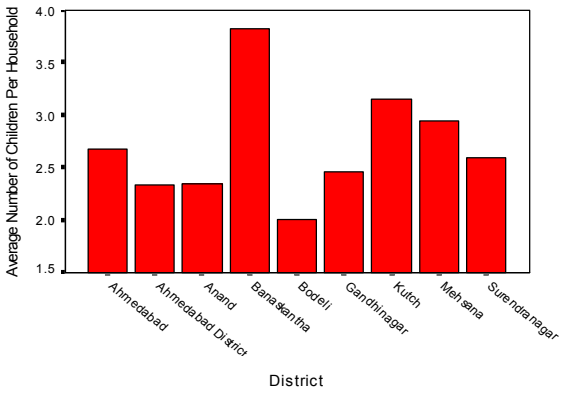
The household and individual (women's) incomes reported were very low. On average, respondents reported annual household incomes of approximately Rs. 15,000, with considerable variation by district. Ahmedabad City fell in the higher range of roughly Rs. 20,000/household/year and the Banaskantha District at the lower range of approximately Rs. 6,000/household/year. On average, VimoSEWA members were slightly wealthier than non-members (Rs. 15,500 versus Rs. 13,500/household/year). Reported incomes reflect the poverty of SEWA members;[4] however, under-reporting and estimation of incomes must be acknowledged as a factor in the significantly low yearly incomes. Yearly incomes were often not provided. Thus, data analysts estimated yearly income based on given information, such as daily or monthly wages. Daily and monthly wages were multiplied by 200 days and 10 months respectively, to estimate annual incomes. Estimations of 200 days and 10 months were used to accommodate an inability to work due to illness or scarcity of employment. Total household income was then calculated by summing the women's and their families' yearly incomes.

Women's average annual income was estimated at Rs. 6,400. Highest annual incomes ranged between Rs. 10,000 in Ahmedabad City and Bodeli and less than Rs. 4,000 in the Banaskantha District. Women's incomes were slightly higher among VimoSEWA members (Rs. 6,700/year) than for non-members (Rs. 5,900/year).

Need for maternity care

The average number of children per family, in this study, was 2.7 amongst members and 2.6 amongst non-members (Figure 1). The Banaskantha District averaged the highest number of children, 4, per household. Bodeli averaged the lowest at 2 children per household. However, there was a possibility of underreporting.

Figure 1: Average number of children per family



A noteworthy feature seen here was that a substantial number of women could not recall the place of childbirth (15 percent; see Table 4). However, many women (both members and non-members) used private hospitals (23.5 percent) followed by the category 'hospital' (20.5 percent), which included mainly government facilities like the primary health centres

[3] See glossary for a more detailed description of the employment categories.

[4] The poverty line in 1999-2000 was an income of Rs. 254 per person per month income (Times of India, Ahmedabad, 'Where does state's BPL figure stand?', 2001). Assuming a household size of 5.4 people (from Ranson 2002, a household survey in Kheda district) the poverty line was an income of Rs. 16,459 per household per year.

(PHCs). The large government hospitals constituted another 20 percent. Thus government facilities accounted for 40 percent of all places for childbirth, for both members and non-members.

Table 4: Place of delivery

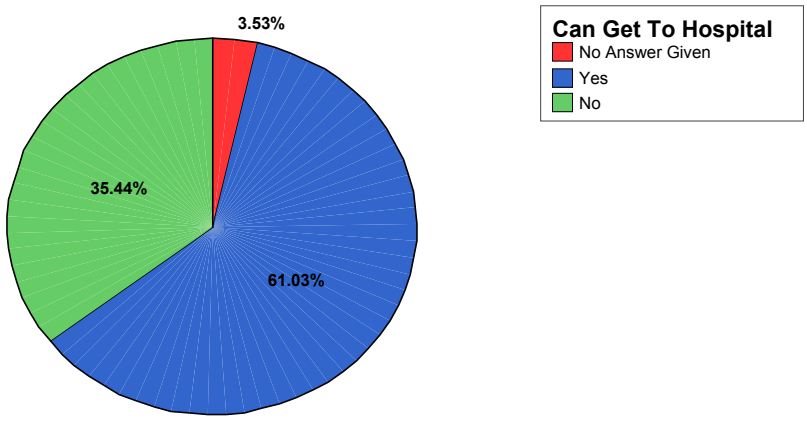
Place of childbirth	Members	Non-members	Non-responders	Total	Percent of total
Pvt. Hospital	94	65		159	23.5
Govt. hospital	80	53		133	20
Hospital	85	49	5	139	20.5
Home with dayan	86	39		125	18
Not answered	95	8		103	15
Hospital & Home	5	4		9	1
Trust hospitals	5	2		7	1
Home with doctor or nurse	5			5	1
Total	455	220	5	680	100

Twenty-eight percent of SEWA members did not report how much they had spent for childbirth. The study showed that 36 percent of SEWA members spent between Rs. 0 and 500 on childbirth and another 14 percent spent between Rs. 501 and 1000. Thus, for 50 percent of the members, childbirth costs were less than (or equal to) Rs. 1000.

The pattern of spending was generally the same among non-members. Only eleven percent of non-members failed to report how much they had spent for childbirth. Of the non-members, 39 percent spent between Rs. 0 and 500 and another 18 percent spent between Rs. 501 and 1000. Thus, 57 percent of non-members spent less than (or equal to) Rs. 1000 at childbirth.

Sixty-one of the respondents said that they can get to a hospital when the need or emergency arises (Figure 2). But more than a third of both members and non-members reported no access.

Figure 2: Access to a hospital for emergency obstetric care



The average cost of transport to a hospital was Rs. 98 (Table 5), which represents 1.5 percent of the annual income of these women (Rs. 98/6,438). This figure was calculated by using roundtrip costs and special transport, for emergencies. However, within each district,

transport cost varies from a minimum of Rs. 10 to 20 for daytime travel in local transport vehicles to large amounts, such as Rs. 190 in the Surendranagar District for nighttime emergency vehicle transport. This is so for both members and non-members.

Table 5: Cost of transportation

District	Average Cost of Transport (Rs.)
Ahmedabad City	34.27
Ahmedabad District	127.97
Anand	54.55
Banaskantha	94.89
Bodeli	70.00
Gandhinagar	97.80
Kutch	152.11
Mehsana	147.99
Surendranagar	190.69
Total Average	97.95

Even when women and their families do not have money, they have to make some arrangements to cope with the costs associated with childbirth. As shown in Table 6, both members and non-members relied on their own savings primarily. A significant number also borrowed from employers or took money on interest from moneylenders. In the case of employers, some charged interest (often the rate was not clear to women) and some did not.

Table 6: Sources of resources to meet hospitalisation and other childbirth related expenses

Assorted by frequency	Members	Non-members	Non-responders	Total	Percent of total
Savings	174	103	2	279	33.2
Borrow from employers	129	99	1	229	27.2
Money on interest	102	52	3	157	18.7
Assets/ornaments pawned	31	16		47	5.6
Borrow from neighbours/relatives	7	5		12	1.4
Joint family	3	1		4	0.5
Relief/exemption	2	1		3	0.4
No answer	101	10		111	13.1
Total	549	287	6	842	100.1

Women were asked, "What kind of services do you need at the time of delivery?" The majority of respondents voiced a need for hospitals or at least health care centres (Table 7). Since many of the respondents live in remote villages, where there are no adequate basic infrastructure like hospitals, electricity, transport or roads, hospitals or some form of emergency care was their major need. This need was followed by that of nutritious food and medicine, as is clear from the table.

Women were asked how much money should be provided under VimoSEWA's maternity benefit. The mean amount suggested was Rs. 700 (approximately Rs. 600 among VimoSEWA members and Rs. 800 among non-members). This represents roughly 10 percent of the mean annual income of these women (Rs. 669/6,438).

Table 7: Maternity related services required (requested) by respondents

Assorted by frequency	Members	Non-members	Non-responders	Total	Percent of Total
Hospital	99	67		166	17.1
Nutritious food	96	61		157	16.2
Medicine	118	33		151	15.6
Money	49	41		90	9.3
Nurses	66	20		86	8.9
Midwives	43	11	5	59	6.1
Doctors	45	9	5	59	6.0
SEWA health centre/hospital	19	7		26	2.7
Health centres	14	9		23	2.4
Transport	11	4		15	1.5
Good roads	4			4	0.4
No answer	116	19		135	13.9
Total	680	281	10	971	100.0

Summary of findings

This study draws attention to the maternity care needs of women working in the informal economy. These women, largely employed as manual labourers and service providers, generally had very low (individual and household) incomes; the mean household income among respondents was below the official "poverty line" for Gujarat. These women, who on average reported three childbirths, faced very significant costs in accessing maternity care. While public providers were the most commonly used source of care, many had used private-for-profit providers. For many women, the reported costs of childbirth were high relative to income. One-third of respondents reported that they had no access to hospital for emergency obstetric care, and among those who did have access, the costs of return transportation could be high relative to income. While many were able to draw on their savings to pay for maternity care, significant numbers had to borrow from employers or moneylenders. Respondents voiced the need for hospitals, nutritious food and medicine at the time of childbirth, and felt that financial support should be provided for maternity care.

STUDY B: MATERNITY BENEFITS PROVIDED BY VimoSEWA

Objectives

The objective of this study was to review and examine existing maternity benefits and related services available through VimoSEWA to its members.

Methodology

We interviewed women who had obtained maternity benefits from VimoSEWA over the past eight years. The members were randomly picked from the record files maintained at VimoSEWA (every third worker). We took care not to include claimants who were VimoSEWA organizers (staff), as these were not informal workers. A total of 50 rural and 55 urban workers constituted the sample. They were from Ahmedabad city (ten neighbourhoods) and Kheda District (nineteen villages).

The questionnaire (see Appendix 2) was drafted after a number of inputs from other teams within SEWA, especially those working on health care, childcare and research. The questionnaire itself was divided into five sections:

1. Personal information and social status of the respondents;
2. Economic status of the respondents and their families;
3. Maternity history, including information about number of childbirths, miscarriages and causes (if known), hospital and medical expenses incurred before, during and after childbirth and other costs;
4. Questions related to maternity benefits schemes, including: knowledge of the government's maternity scheme; number of times maternity benefits were received from VimoSEWA; knowledge of the various components of the Vimo SEWA maternity package; how the benefits were used; and the maternity-related services required.
5. Willingness to make contributions towards a revised, upgraded maternity package (at VimoSEWA) and what the components of this should be.

The questionnaire was pilot-tested with five respondents each in Kheda and Ahmedabad.

Given the small size of our sample, we decided to conduct in-depth interviews of the members along with the questionnaire. While one of the members worked on the questionnaire, the other interviewed the members of the house, or the local leader, or the organizer. Family members were also interviewed. The interviews helped in covering issues which otherwise might not have emerged in the questionnaire. Moreover, it helped us understand their needs more clearly.

Various methodological issues were encountered in the course of our survey, including the following:

- The respondents could not remember their age;
- Due to seasonal and irregular work opportunity most of the respondents could not give an exact figure of their income; hence, we had to put in an estimated amount;
- Some of the respondents thought that we were there to distribute something and hence may have provided incorrect information;
- The respondents were most of the time accompanied by their mothers-in-law, who would not always give them a chance to speak;
- It was difficult sometimes to locate claimants as they had moved or because our records did not have their full name;
- When a women had several children, she could not recall when she received her maternity benefit and for which child;
- As per custom, the young woman's first childbirth takes place at her 'piyar' (natal home) and after three four months she would return to her 'sasural' (in-laws home).

Consequently, it became difficult to locate those women who had recently given birth;
- Most of the respondents had no idea of the expenses incurred for their first delivery, as either their parents or brothers covered the expenses;
- A majority of the rural respondents did not have much understanding about insurance in general, and all the aspects of VimoSEWA's services. They submitted their claims only when the aagewans, the local SEWA leaders, encouraged them to do so;
- The members could not remember for how long they had been insured.

Results

Description of respondents

Sixty-seven percent of our respondents were between 25 and 30. Eighteen percent of our respondents were in the 20 to 24 years age group. There was no discrepancy in these percentages when comparing rural and urban populations.

The surveyed population was predominantly Hindu, both in rural and urban areas, comprising altogether 84 percent of the total surveyed. The next largest cohort was that of the Christians at 10 percent, followed by the Muslim community, representing 6 percent of the total number of women surveyed. In certain cases, belonging to a particular community may have impacted the socio-economic status of the respondents. Table 8 shows the highest level of education achieved by respondents in rural and urban areas. It appears that in the Kheda District (rural), a higher level of education was attributable to the Christian population in many villages (accounting for 22 percent of rural respondents) among whom education is a priority, encouraged by the church and local leaders. For example, in Chikhodra and Khambolaj villages, women are encouraged to pursue secondary education, as a result of which 6 of the 14 women who were educated up to the 12th standard were from these two villages. In contrast, our urban sample does not include any Christian respondents, which may account for lower education levels. Thus, it is important to keep such factors in mind when analysing data on levels of education.

Table 8: Education levels among respondents

Level of Education	Frequency			Percent of total		
	Rural	Urban	Total	Rural	Urban	Total
None	11	22	33	22	40	31
Primary	16	16	32	32	29	31
Secondary	7	9	16	14	16	15
10th grade	4	4	8	8	7	8
12th grade	12	2	14	24	4	13
Degree	0	2	2	0	4	2
TOTAL	50	55	105	100	100	100

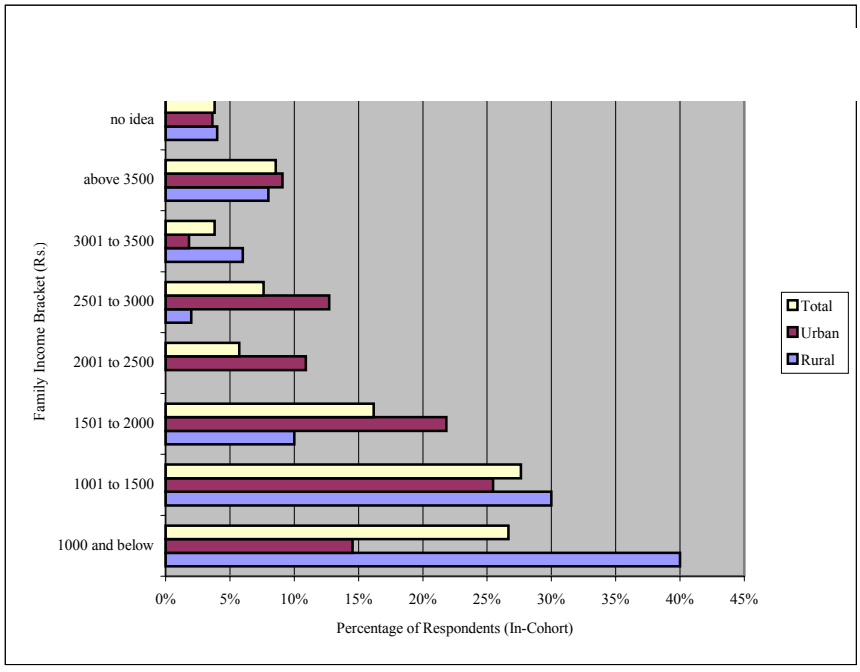
Sixty-nine percent of our respondents had undergone at least primary level education. In addition, 38 percent of our respondents had furthered their education to secondary level and above (Table 8). This statistic is misleading insofar as it is skewed by the high education level of our rural cohort, whose literacy rate was 78 percent (i.e. 78 percent of rural respondents have acquired primary and/or higher education). Furthermore, 46 percent were educated at and above secondary level. The high percentage of high school-level respondents is also remarkable, considering the usual situation in rural areas, where local schools only go up to the 7th standard and girls have to leave their villages for higher studies. It must also be mentioned that the villages in the Kheda District are known to have greater access to education and social services in general in comparison to other districts such as Banaskantha and Sabarkantha. Thus, in terms of education and many other socio-

economic markers, the women in this report cannot be considered representative of rural Gujarat.

In comparison to the rural women of the Kheda District, the urban dwellers of Ahmedabad had a 60 percent literacy rate and comparatively lower secondary level education. This is unexpected as one assumes greater accessibility to education in urban areas. It should be noted here, however, that for many women, Ahmedabad was their marital home while their natal home was in various villages scattered all over Gujarat. It may well be that these women came from areas with lower access to education. Thus, this cannot be interpreted as being representative of the access to education in the city. Nonetheless, with the higher cost of living in urban areas, it could also be that young girls were made to discontinue or altogether forgo their education in order to stay at home and take care of siblings or their household.

Despite being more educated, rural women were earning less than their urban counterparts. Most were daily-wage, farm labourers, with 80 percent earning below Rs. 2000/household/month (Figure 3). In contrast, the less educated urban women were most often home-based workers, and together with their husband's income, their income range was such that only 60 percent were in the below Rs. 2000/household/month category.

Figure 3: Frequency distribution of respondents by monthly household income



Use of maternity care and VimoSEWA's maternity benefits

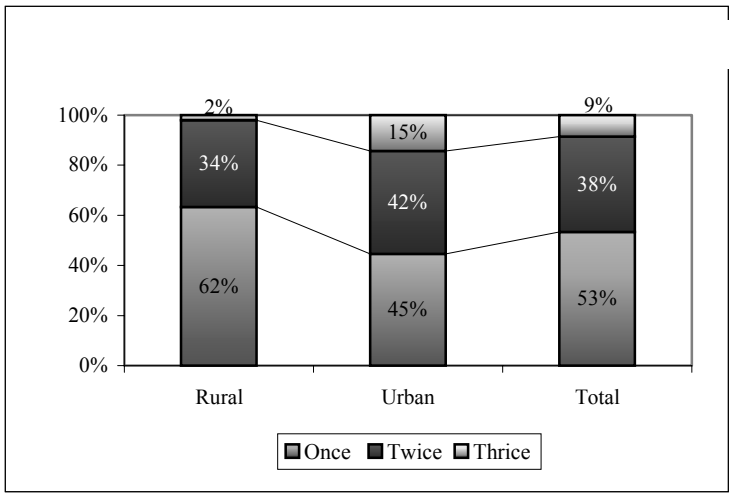
We observed a low mode for number of children in our sample population. The most common number of children per respondent was two. However, there was a large standard deviation, indicating that some women did have as few as one child and as many as six. Another interesting observation was that more urban women, contrary to our expectation, were having more than three children as compared to rural women. Based on our surveys, the average number of children urban women had was 2.90 as compared to 2.42 for rural women. Furthermore, as evident in Table 9, 31 percent of urban respondents had more than three children as compared to 18 percent in rural areas. As education is known to be correlated inversely with family size, the smaller families in the Kheda District may be the effect of higher levels of education, mentioned earlier.

Table 9: Number of children per respondent (in percentage)

Area/Number of Children	1	2	3	4	5	6 and above
Rural	16	44	20	16	2	0
Urban	15	33	24	20	7	4
TOTAL	15	38	22	18	5	2

Urban women who had used VimoSEWA's maternity benefits were more likely to have used them more than once (Figure 4).

Figure 4: Number of times VimoSEWA maternity benefit availed



The higher 2nd time claim rate for urban women may be related to the fact that on average, they have been VimoSEWA fixed deposit members for longer. Rural women accounted for only about a fourth of the 23 respondents who were fixed deposit members for between 7 to 10 years, while the remaining three-fourths were urban members (data not shown). Table 10 shows that women who had been members of VimoSEWA for 7 to 10 years accounted for only 9 percent of women who had used the scheme once, 33 percent of women who had used the scheme twice, and more than half of women who had thrice used the scheme. Thus, greater and more long-term exposure, proximity and habituation to the concept of insurance and VimoSEWA in particular is likely to account for the fact that the benefit was availed of more often by urban women. Another supplementary explanation is the fact urban women are more likely to have three children or more.

Table 10: Cross tabulation of number of times maternity benefit availed and length of VimoSEWA membership

Years of membership	Once		Twice		Thrice	
	Number	Percent	Number	Percent	Number	Percent
1- 3 years	15	26.8	4	10.0	0	0
4-6 years	34	60.7	23	57.5	4	44.4
7-10 years	5	8.9	13	32.5	5	55.6
11+ years	2	3.6	0	0	0	0
Total	56	100	40	100	9	100

Moving further, it is important to connect the issue of maternity benefit claims to the process of pregnancy and SEWA members' work patterns around this time in their lives. From Table 11 below, it appears that most women in both urban and rural areas worked right until delivery. The next most common trend, seen in 18 percent of the women, was to take 'maternity leave' from work around 1 to 3 months before delivery.

Table 11: Time taken off work prior to childbirth

	Frequency			In-Cohort Percentage	
	Rural	Urban	Total	Rural	Urban
None	16	22	38	33	40
Less than 1 month before the birth	0	0	0	0	0
1 to 3 months before the birth	8	10	18	16	18
4 to 6 months before the birth	4	2	6	8	4
More than 6 months before the birth	4	3	7	8	5
Unemployed	17	18	35	35	33
TOTAL	49	55	105	100	100

As for the resumption of work after delivery, most members – both rural and urban – returned to work between one and three months after delivery. This is detailed in Table 12. In many cases, if not most, this was because women return to their natal home for at least the first child-birth and return to their marital home around three to four months after child-birth, having completed the *jianoo ritual*. Thereafter, they resume work and take on all the responsibilities of the household. Another tendency seen in 10 percent (12 percent among rural and 7 percent among urban) of our respondents was the termination of employment after pregnancy. Taking care of children is full time work and often, after the first baby, women are busy taking care of their children and even having more children.

Table 12: Time after childbirth when work was resumed

	Frequency			In-Cohort Percentage	
	Rural	Urban	Total	Rural	Urban
Up to 7 days	0	4	4	0	7
Less than 1 month	0	1	1	0	2
1 to 3 months	18	22	40	37	40
4 to 6 months	5	3	8	10	5.5
More than 6 months	3	3	6	6	5.5
Never resumed	6	4	10	12	7
Unemployed	17	18	35	35	33
TOTAL	49	55	104	100	100

Detailed data was collected for the first (and/or only) maternity benefit claimed by our respondents. As far as delivery is concerned, only 20 cases of complications in pregnancy were recorded, out of which 11 resulted in caesarean sections. Hence, about 89 percent of our respondents underwent normal deliveries.

The place of delivery most often cited by our respondents was the government hospital. The rural-urban breakdown of place of delivery is shown in Table 13.

It appears that private hospitals are very much sought after in rural areas as sites for delivery, in spite of their high cost. This is a special characteristic in the Kheda District where private clinics abound, as compared to other rural districts. Respondents informed us that the services are better in private hospitals. Procedures are explained more comprehensively to them and they are given greater attention in general. Unfortunately, rural women in general face poor quality of care in government hospitals according to our respondents.

Table 13: Place of delivery of first or only delivery for which maternity benefit was claimed

Location	Frequency			In-Cohort Percentage (percent)		
	Rural	Urban	Total	Rural	Urban	Total
Home with Dai	15	12	27	30	18	23
Home with Nurse/Doctor	1	0	1	2	0	1
Government Hospital	15	38	53	30	58	46
Private Hospital	16	11	27	32	17	23
Trust Hospital	0	3	3	0	5	3
Home with both Dai and Doctor	3	1	4	6	2	4
TOTAL	50	65	115	100	100	100

Compounding this is the lack of basic emergency obstetric services to all the women. Two respondents, among others, brought to our attention the fact that government hospitals in their vicinity do not undertake caesarean cases, leaving women no choice but to go to private hospitals where exorbitant fees are charged. Consistent with this, Table 14 shows that all seven rural caesarean deliveries took place at private hospitals. Therefore, 14 percent (7 out of 50 deliveries) of the cases, which ought to be covered by government hospitals in rural areas, were not. Sadly, rural women are denied care in government hospital for the kind of delivery that is more likely for them than their urban counterparts. As for the cost of these deliveries, they all fall in the Rs.3001-10,000 per delivery category if not higher. The most commonly cited amount for a private caesarean is around Rs. 10,000 in both rural and urban areas. This must be taken into account when looking at the data on cost of delivery and pregnancy (Figure 5). Also, it must be noted that when a woman's first child is delivered by caesarean, there is a high probability that all the subsequent deliveries will be caesareans as well. This is partly for the safety of the mother, but sometimes can be attributable to the hospital personnel who feel that if a woman has a caesarean once, it is better if her second delivery also is a caesarean. The fact is that during pregnancy, some women borrow at compound interest rates from family, neighbours, employers and/or moneylenders to pay for their delivery. Successive caesareans result in households sinking into deeper debt.

Table 14: Frequency cross tabulation of place and type of delivery of first or only delivery for which maternity benefits received

Place of Delivery	Normal			Complicated (Breach, Forceps, etc.)			Caesarean		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Home with Dai	15	12	27	0	0	0	0	0	0
Home with Nurse/Doctor	1	0	1	0	0	0	0	0	0
Government hospital	15	24	39	0	3	3	0	1	1
Private hospital	8	5	13	1	3	4	7	3	10
Trust hospital	0	3	3	0	0	0	0	0	0
Home with Dai and Doctor	1	1	2	2	0	2	0	0	0
TOTAL	40	45	85	3	6	9	7	4	11

The range in costs incurred for delivery (hospital fees, doctors' fees, operating fees, etc.) is normally distributed. The mean and median cost both in rural and urban areas, per delivery (normal, complicated, and caesarean aggregated), was in the Rs. 201-500 range. At least for respondents in Ahmedabad, this coincides with our discussions and an interview with the municipal (public) hospital personnel at the Vadilal Sarabhai Hospital in Ahmedabad. For a normal delivery, described by cashier Mr. Vaghela as a single day's affair, the charges in a normal ward were Rs. 500 for delivery and Rs. 20 each as bed and food charges. This total of Rs. 540 is low in comparison to the rates for a caesarean, for which the patient has to remain in the hospital for up to one week. Bed and food charges alone amount to Rs. 280. In addition to this, the operation charge for a caesarean is Rs. 500 and the anesthetist's

charge Rs.200. As discussed earlier, many VimoSEWA fixed deposit members were dissatisfied with government facilities and preferred to go to private hospitals, which tend to be far more expensive.

A pregnancy involves more than just in-patient/delivery costs. The costs of travel to/from the place of delivery, antenatal care, special medication for anaemia (which is very common in our surveyed sample), and special nutrition for pregnant women are just some of the costs that have to be borne by the women and their families. Among the 89 percent of respondents who experienced a normal delivery (non-complicated, non-caesarean) most incurred total expenditures (including delivery costs plus indirect costs) in the range of Rs. 500 to 2,500. Total expenditures were generally higher in urban than rural areas. Both government and private hospitals tend to be more expensive in the city. In the villages of the Kheda District, as many women have at home births with dais or midwives as are attended to by medical practitioners in government hospitals. Dais receive anywhere from Rs. 50 to Rs. 250 per delivery and often offer their services for free. For rural women, the financial burden is less though the risk may be more for various reasons, including inadequate emergency obstetric care, transportation-related problems etc.

The maternity benefits provided to VimoSEWA fixed deposit members were generally claimed after delivery (Table 15). This is especially the case for rural women, of whom 96 percent claimed their benefit after delivery. The most common subset within these respondents is that of women who claimed their benefit three months or so after their delivery, in many cases having returned to their in-laws' residence. Most commonly, thereafter, the Rs. 300 maternity benefit goes into household expenses, as cited by almost a fourth of the rural women interviewed.

Table 15: Time at which VimoSEWA maternity benefit was claimed

	Frequencies			In-Cohort Percentages (percent)		
	Rural	Urban	Total	Rural	Urban	Total
7th month of pregnancy	1	17	18	2	31	17
8th month of pregnancy	1	8	9	2	13	9
9th month of pregnancy	0	2	2	0	4	2
Up to 6 weeks after delivery	15	16	31	30	29	29
Up to 3rd month after delivery	27	7	34	54	13	32
Around/more than 3 months after delivery	6	0	6	12	0	6
First child at 7th month and second up to 6 weeks after delivery	0	2	2	0	4	2
First child at 8th month and second up to 6 weeks after delivery	0	2	2	0	4	2
First child at 7th month and second more than 3 months after delivery	0	1	1	0	2	1
TOTAL	50	55	105	100	100	100

Our survey also indicates that for 43 percent of our respondents, aagewans (local grassroots leaders) were the source of information regarding VimoSEWA's maternity benefits scheme. After aagewans, health workers and SEWA staff had the most impact, mentioned by over a fourth of the rural respondents and almost a fifth of the urban ones, or collectively 22 percent of the total population surveyed. Another very common scenario observed was that the women claiming maternity benefit were related to aagewans or health workers. This was more common in urban areas. Aagewans do serve as VimoSEWA linchpins. In fact, for over a fifth of the rural respondents, the aagewan went alone to the SEWA headquarters to claim the Rs. 300 maternity benefit (data not shown).

Some respondents listed several uses of a single maternity benefit claim. Similarly, many had more than merely one suggestion for VimoSEWA. We have calculated percentages of the total number of uses mentioned, and suggestions made, so the totals generally sum to

more than the number of respondents interviewed. For example, 31 rural women mentioned that they used their maternity benefit to supply nutrition for their baby and themselves, as shown in Table 16.

Table 16: Reported uses of maternity benefit

Declared Use	Frequencies		
	Rural	Urban	Total
Nutrition for the mother and/or baby	31	27	58
Medicine for mother and/or baby	8	15	23
Household expenditure	8	12	20
Put in FD to renew membership	1	7	8
Spent on baby alone	4	3	7
Debt/loan repayment	4	2	6
Medical expenses unrelated to pregnancy	4	1	5
Given to mother-in-law directly	0	4	4
Transport to/from SEWA	0	3	3
Reimbursement of lost income	1	1	2
No idea/no comment	1	1	2
Husband's expenses only	2	0	2
Deposited in bank savings account	1	1	2
Returned to mother, who covered pregnancy expenses	0	2	2
Got a copper T placed	1	0	1
TOTAL	66	79	145

In our interviews, we sensed that respondents perceived their own health to be of little significance. A mother's health and well-being is of significance insofar as it is inextricably linked to that of the child during pregnancy. The whole concept of maternity is viewed even by women themselves not from the viewpoint of the mother, but that of the child. Even though the most frequent of the declared uses from rural and urban respondents were related to nutrition (Table 16), this was almost always in reference to the child's health. Nutrition for the mother in the months prior to delivery, from her personal perception, is directly related to that of the child; thus, even for the third of urban respondents who claim their benefits early, the nutrition is for the baby, not the mother. Similarly, months after birth, the health of the baby is seminal and the main reason to worry about the mother's health has to do with her nursing.

As discussed earlier, almost half of our respondents claimed their benefit three months (or more) after delivery. Therefore it is no surprise that one in seven responses (20 of 145) indicated that the money was used to cover household expenditures. We found that for the majority of our respondents, maternity benefit money goes into buying vegetables, utensils and daily use supplies for the household, indistinguishable from other income.

Members' suggestions for improvements in VimoSEWA's maternity benefits

We asked women for their suggestions as to how to improve VimoSEWA's maternity benefits. Seventeen of the 105 respondents had no suggestions (16 of 50 women in the rural sample and 1 of 55 women in the urban sample). Only when we persisted with our questioning did women start making suggestions. Still, the rural women were not active contributors to the pool of suggestions which we accumulated. The urban cohort, in contrast, had a wider-ranging group of suggestions.

Roughly one-third of suggestions for improvement involved increasing the amount of money provided under the scheme. Approximately 14 percent of responses related to providing food, in kind, to the expectant mother. These women discussed how a financial benefit could very often go into household expenditures and not to the mother. At least with a tin of ghee, the women said that the maternity benefits would go directly to the women. Ten percent of the responses given related to providing supplies for the newborn baby, such as baby food and other supplies. Other, less common, suggestions for improving the scheme

included: improving access to maternity benefit services (for example, by decentralization); providing medicines at a subsidized rate; providing transportation services for the delivery; covering the in-patient costs in full; providing the maternity benefits earlier during the pregnancy; providing employment to women when they are ready to return to work, providing more or better trained dais.

Thirty-six percent of our respondents demanded a higher amount per pregnancy. All the women were aware of the fact that this money is not derived from their insurance premium but instead from SEWA's own offers. There was consensus that a reasonable amount to receive per pregnancy was around Rs. 500.

Summary of findings

This survey of 105 women who had received maternity benefits from VimoSEWA highlights the maternity care needs of VimoSEWA members, as well as the strengths and weaknesses of the maternity benefits provided. The demographic data collected suggest that most respondents were literate, employed as farm labourers (rural) or home-based workers (urban), and most reported very low monthly household income (i.e. below Rs. 2,000/household/month). On average, rural respondents had 2.4 children and urban respondents 2.9 children. Urban women who had used VimoSEWA's maternity benefits were more likely to have used them more than once. Most respondents worked up until the time of delivery and returned to work one to three months after delivery. While most women delivered in a public hospital, it was also common to deliver in a private hospital or at home with the assistance of a dai. The mean (and median) cost of delivery services was in the range of Rs. 201 to 500, and the total costs of the pregnancy (including indirect costs such as transportation and antenatal care) fell in the range of Rs. 2,500. Costs were higher among urban than rural women, and were far higher among those who had experienced complications at delivery or had undergone caesarean section. Most respondents received their VimoSEWA benefits only after delivery (usually around three months afterwards). Most had learned about the benefits from their local aagewan, and in some cases the aagewan had delivered the benefits directly to the recipient. The most common suggestions for improvements to the scheme were for: increased financial benefit; provision of food, in kind, to the mother; and provision of supplies for the newborn baby. There was a consensus that the VimoSEWA maternity benefit be increased to approximately Rs. 500.

SUMMARY AND CONCLUSIONS

Summary of major findings

- The majority of women work right up to childbirth – for both urban and rural workers;
- Most women return to work one to three months after childbirth;
- In both sub-studies (Studies A and B) government facilities were the most common locations for childbirth, while it was also common to deliver in private hospitals or at home with the assistance of traditional midwife or dai;
- Costs of childbirth followed a similar pattern in both sub-studies. In government facilities, costs were the least for normal births – up to Rs 500. These increased dramatically if the births occurred in private facilities –up to Rs 2,500. In Study A, 50 percent of the women, both SEWA members and non-members, said that they spent up to Rs 1,000;
- Births by caesarean section raised costs by several thousand rupees. Moreover, this type of care was not available in the smaller government health facilities (particularly in rural areas);
- With regard to getting to a hospital in an emergency, 61 percent of women in Study A said they could do so. But significantly, a third of the women, especially in rural areas did not have this access. Transport for emergency care averaged Rs. 98, and was more expensive at night for an emergency;
- Study A found that sources of funds to meet childbirth costs were mainly from savings, borrowing from employers and loans from money-lenders, in that order;
- Urban women obtain maternity benefits from VimoSEWA more than rural women, possibly due to greater access to information and because historically, VimoSEWA began in urban areas;
- Urban women obtained benefits more often than their rural counterparts. But women generally availed of maternity benefits from VimoSEWA a maximum of three times;
- With regard to receipt of maternity benefits from VimoSEWA, 96 percent of the women obtained these after the birth, generally within three months after the birth;
- 43 percent of the women who obtained the maternity benefits did so with the help of their local SEWA union leader or 'aagewans';
- Presumably because most women received the benefits after the birth of their child, they used the benefits (cash) for food for themselves and the baby and household expenses;
- Most of the women in the study indicated that they needed more holistic services as part of a maternity benefits package. The latter should include:
    - -more cash benefit – women in part A of our study suggested Rs. 700 instead of the current Rs. 300; women in part B wanted Rs. 500 on average
    - -more health care – especially access to emergency obstetric care
    - -food
    - -medicine
    - -supplies for the newborn baby.

Conclusions and recommendations

There is a huge, unmet need for maternity benefits for women workers in the informal economy. They are still not entitled to statutory maternity benefits. Women need integrated, holistic maternity benefits with services like health care (especially emergency obstetric care) and special nutrition. Enhanced cash benefits before the birth of the child are needed, preferably during (or before) the seventh month of pregnancy. Maternity benefits must reach the poorest of women, especially in rural areas.

Action plan for SEWA

- SEWA will renew its policy action efforts with regard to maternity benefits;
- SEWA will consider extending its maternity benefits programme through VimoSEWA;
- SEWA will provide a more integrated holistic package of maternity services. The traditional midwife or dai could be the primary service provider at the village level;
- SEWA must strengthen its work with local, grassroot leaders, aagewans, and dais (traditional midwives), so that: a) women get timely maternity benefits, and b) they are referred quickly in cases of high-risk pregnancies, so that women have access to safe childbirth. The latter needs to be done mainly in government and trust (charitable) facilities with a view to keeping costs low and helping women avoid indebtedness due to childbirth;
- SEWA must link all poor women workers with existing health, food and nutrition programmes of the government, so as to ensure that workers obtain coverage under these, especially during pregnancy;
- SEWA's maternity benefit should be made more accessible prior to pregnancy, i.e. in the seventh month. This is often the time when regular check-ups are taking place, a nutritious diet is essential, and in many cases, a time when families are burdened with the responsibility of taking out loans for the childbirth expenses. Tthis message must be clearly communicated to SEWA's members;
- Maternity benefits need to be distributed efficiently and through the quickest possible route.

Recommendations for the government

- The government should collaborate with the above efforts by contributing to and/or coordinating with SEWA's efforts;
- The government's health department will have to extend health care, especially emergency obstetric services, to the remote rural areas. While it has been trying to do so for many years, it must now re-examine how these services can reach the poorest of women in rural areas;
- Government may improve targeting of services towards the poor if they involve local women's groups, people's organizations/unions and NGOs in this effort. One way could be making mobile health services and emergency transport, managed by local organizations, available to remote rural communities.

Appendix 1:
Study A questionnaire

1. Are you a VimoSEWA member? (Yes or no)
2. Do you have a dispensary in your area/village?
3. Where do you go for delivery? How much do you spend?
4. How do you manage the costs of delivery?
5. If you become a VimoSEWA insurance member, you will get Rs. 300 as a maternity benefit, in addition to other benefits. Is this sufficient (yes or no)? If no, how much should it be?
6. What kind of services do you need at the time of delivery?

Study B questionnaire

1. Name of respondent
2. Age
3. Address
4. Marital status
5. Education
6. Main occupation and secondary occupation
7. Woman's income (primary and secondary source)
8. Family income
9. How long have you been with VimoSEWA?
10. Age at marriage
11. Age at the first delivery.
12. Number of children
13. Any miscarriage? If yes, when, how and where did you go for treatment?
14. Details of first (and/or only) maternity benefit claimed
    a. How long did you work during pregnancy?
        - Till delivery
        - Till one week before
        - Till two weeks before
        - Till one month before
        - Others
    b. When did you start working after delivery?
        - Next day
        - After one week
        - After six weeks
        - After two months
        - After three months
        - Others
    c. Where did you go for delivery?
        - Midwife
        - Private hospital
        - Government hospital
    d. Why did you prefer this treatment?
    e. For delivery services how much did you spend?
    f. What is your total expense for delivery (including indirect costs)?
15. Have you ever received maternity benefit from somewhere other than VimoSEWA? If yes, then provide details.
16. a. How many times have you received VimoSEWA maternity benefit?
    b. How did you come to know about the maternity benefit?
    c. Do you know about maternity benefit?
    d. Fixed deposit members
    e. Rs. 300
    f. Calcium and vitamin tablets

g. Weighing
h. Nutritious food and immunisation counseling
i. Referral health
j. Midwives
k. When did you go for maternity benefit?
l. Before delivery
m. After delivery

17. a. How did you spend this maternity benefit?
b. Emergency transportation (which vehicle and how much)
c. Midwives (how much and for which service)
d. Treatment expense (tests, medicines and sonography)
e. Nutritious food (ghee, fruits and others)
f. Loss of income (how many days of work did you miss, and how much money was lost)
g. What other facilities do you require?
h. More money
i. Longer period during which to claim benefits
j. Benefit provided in kind
k. Child health care (like immunization)
l. It should be expanded to annual members
m. Only up to two children
n. Miscarriage and abortion should also be included
o. Do you wish to pay more premium for more benefit? Yes or no.

18. Other suggestions.